Burundians Responding Against Violence and Inequality (BRAVI)

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End-of-Project Evaluation

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Acronyms and Abbreviations

BRAVI	Burundians Responding Against Violence and Inequality
CBO	community-based organization
CDFC	Centre de Développement Familial et Communautaire (Center for Family and Community Development)
DHS	Demographic and Health Survey
FGD	focus group discussion
FP	family planning
MAP®	Men As Partners®
MOH	Ministry of Public Health and the Fight Against AIDs
PNSR	Programme National de la Santé de la Reproduction (National Program for Reproductive Health)
SGBV	sexual and gender-based violence
SWT	site walk-through
USAID	US Agency for International Development
WHO	World Health Organization

Acknowledgments

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1. Introduction

In Burundi, two-thirds of the population live below the poverty line, with limited economic opportunities and access to basic social services.[1] The total fertility rate is among the highest in the world at 5.5 lifetime births per woman. In addition, Burundi's maternal mortality ratio is considered high, at 334 maternal deaths per 100,000 live births.[2] In addition, Burundi is experiencing a generalized HIV epidemic, defined by the World Health Organization (WHO) as prevalence consistently exceeding 1% among pregnant women. The adult HIV prevalence rate is also high at 0.9% (1.2% in women versus 0.6% for men).[3] HIV infection rates are also much higher among women who have broken union, especially widows (8.2%) as compared to single women (0.5%), and women in union (0.9%).[4]

The disproportionate HIV rates among women in Burundi is linked closely to sexual and gender-based violence (SGBV) in particular, and cultural attitudes toward women in general. In 2010, a survey conducted by ACORD and Oxfam attempted to gauge the attitudes of the population regarding SGBV against women and girls. This study found that many Burundians, in particular those with low levels of education, do not value girls and boys equally. For example, 57% of respondents stated a family without a husband (man) "becomes despicable, not respectable". Furthermore, according a 2016-2017 independent study, 62% of women and 35% of men believed that wife beating is justified under certain circumstances.[5]

Due in large part to these cultural beliefs, SGBV is widespread in Burundi. More than one-third of women aged 15-49 (36%) and 32% of men aged 15-49 report having been physically abused at some point in their lives since the age of 15. Furthermore, 14% of women and 10% of men have experienced physical violence in the last 12 months. 23% of women and 6% of men have experienced sexual violence at some point in their lifetime. 13% of women and 2% of men have experienced sexual violence in the last 12 months.[6] Half of women in union or break-up (50%) experienced domestic violence (emotional, physical, or sexual) from their current or most recent husband/partner. 23% of men in union or union break-up experienced domestic violence.[7]

Groups most at risk of SGBV include young women, women who head households, and marginalized populations. Sexual violence is higher among women in rural than in urban areas.[8] Among women, domestic violence varies from 31% in Bujumbura to 50% in Ngozi province and 73% in Kirundo province. For men, spousal violence varies from 6% in Karuzi province to 45% in Kirundo province and 50% in Ngozi. According to Burundi's Seruka Center, which responds to

[1] The World Bank Group. 2018. "Republic of Burundi: Addressing Fragility and Demographic Challenges to Reduce Poverty and Boost Sustainable Growth." June 15. 2008. Report No. 122549-BI. http://documents.worldbank.org/curated/en/655671529960055982/pdf/Burundi-SCD-final-06212018.pdf.
[2] Demographic and Health Surveys, 2018. "Burundi: Demographic and Health Survey Report, 2016-2017." https://dhsprogram.com/publications/publication-FR335-DHS-Final-Reports.cfm.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] National Strategy to Fight Gender-Based Violence, 2009-2014.
[8] Ibid.

cases of sexual violence, only 22% of reported cases were under legal investigation and only a very small fraction of those accused were prosecuted (1.6%) and penalized (1.4%).[9]

In response to this context, the Ministry of Public Health and the Fight Against AIDS (MOH), in partnership with EngenderHealth, initiated the Burundians Responding Against Violence and Inequality (BRAVI) project. Made possible by the funding from the US Agency for International Development (USAID), the five-year project aimed to prevent and appropriately respond to SGBV through norms transformation, health provider strengthening, multisectoral coordination, advocacy, and the sharing of best practices. The project was implemented in the Ngozi province, which was selected based on the prevalence of SGBV and the limited capacity to address the issue. Specific objectives of the project were to: (1) strengthen health sector response to SGBV survivors; (2) promote awareness and use of SGBV services and strengthen referral networks; and (3) promote gender equitable norms in the community to prevent SGBV and support survivors.

1.1 BRAVI Project Context

Guided by a performance monitoring plan, the key strategic objective of the BRAVI project was to improve SGBV prevention and response efforts, including provision of integrated family planning (FP) and SGBV services (Figure 1). Over the life of the project, BRAVI supported three strategic results areas through a series of training, coordination and sensitization activities:

Trainings: 293 health providers trained in SGBV. At the community level, 410 leaders (community health workers, religious leaders, community-based organizations, and local leaders) and 425 men (traders, motorcycle drivers, bicycle drivers, hairdressers, and miners) participated in Men As Partners® (MAP®) community workshops and received training on confronting harmful gender stereotypes. 216 community health workers were also trained on basic psychosocial support to SGBV survivors.

Coordination and sensitization activities: BRAVI sensitized 43,935 individuals on root causes and consequences of SGBV and men on gender norms[10]. 143 site walk-throughs (SWT) were conducted in 45[11] health facilities where providers and 3,790 community leaders discussed SGBV. 212 action plans were made to improve access of SGBV survivors to appropriate services. Integration of FP and SGBV services resulted in the screening of 35,100 family planning service users in 39 health facilities, resulting in the identification of 503 SGBV survivors.

1.2 Evaluation Purpose and Questions

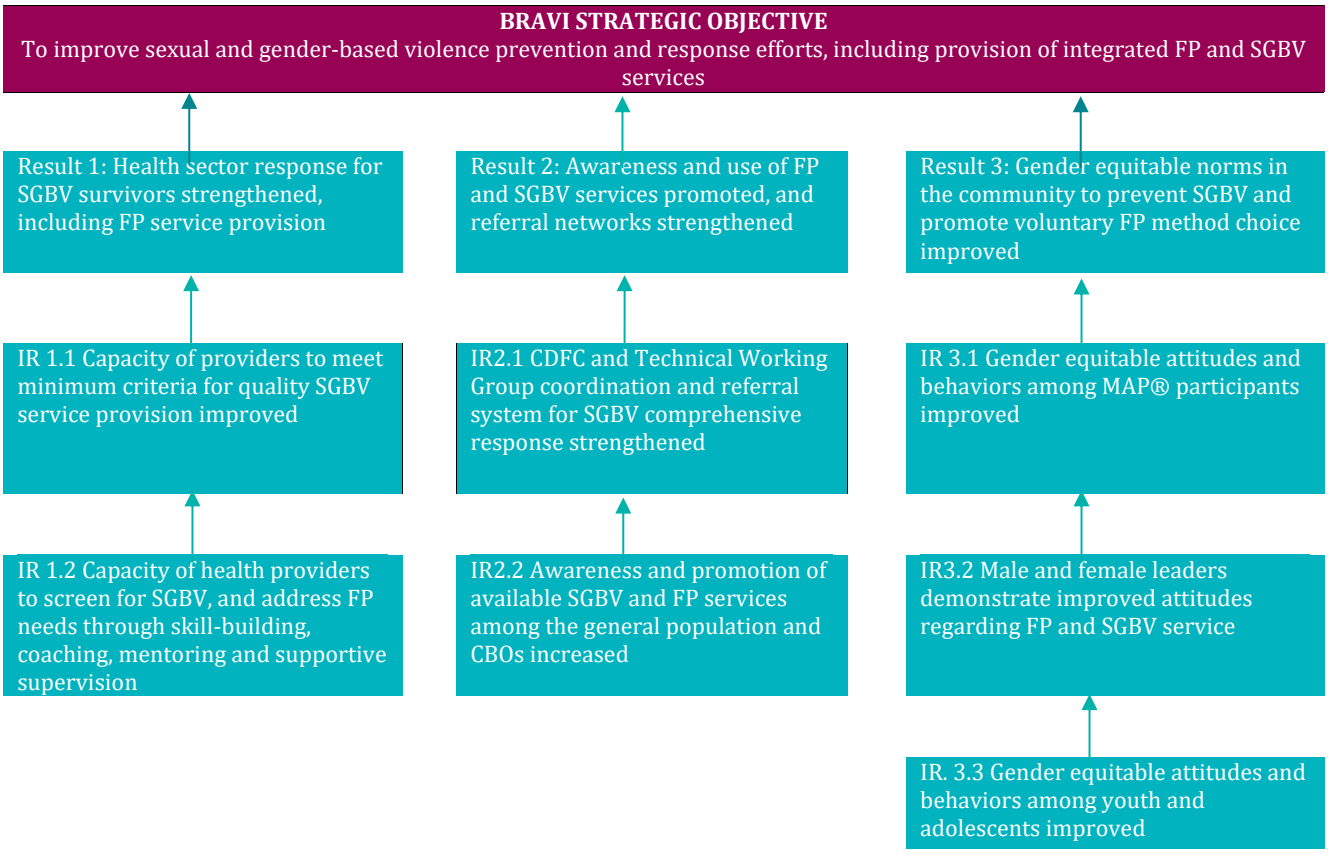
The purpose of this end-of-project evaluation was to document and assess the work that was done under BRAVI since its launch in September 2014 and to develop recommendations for improving and/or replicating the approach. The evaluation assessed the impact of different project approaches, as well as the delivery of those interventions and remaining challenges during the five years using

[9] Seruka Center Annual Report 2010.
[10] The sensitization was done by male champions identified among the trained men on the MAP® approach with use of the training manual: ""Hommes comme partenaires dans la lutte contre les violences sexuelles au Burundi "
[11] In the first phase, 45 health facilities were targeted for SGBV activities. With FP integration, the number dropped to 39 because 6 faith-based sites were removed. The baseline study surveyed an additional health facility (46 total).

quantitative and qualitative methods. Additional information on the BRAVI project can be found in Appendix 1. The specific evaluation questions were:

- How have gender norms, attitudes and behaviors related to SGBV changed among community leaders and providers over time?
- How has the status of SGBV service provision changed over time?
- To what extent have SGBV services been integrated with quality FP services at the facility level?
- What are the current perceptions of SGBV in the community, according to community members?
- How well did BRAVI contribute to the coordination of SGBV interventions at the national, provincial, and communal levels?
- What are ongoing challenges to providing SGBV care and what can be done to improve services?
- What are the key lessons for providing SGBV care in a context like the BRAVI project?

Figure 1: BRAVI Results Framework



2. Methodology

2.1 Evaluation Design

Prior to the BRAVI project launch, the evaluation team conducted a baseline assessment in 46 health facilities to inform programming, provide a benchmark for over-time comparisons, and to identify priority areas and existing best practices on which to build. More specifically, the baseline assessment aimed to measure facility readiness to provide quality care for SGBV survivors, to assess the coordination of intervention services regarding SGBV and the gender norms, attitudes and behaviors of community leaders and providers. The baseline assessment used the following quantitative tools: (1) a health facility assessment; (2) provider and facility manager interviews; (3) key informant interviews with representatives of the *Centre de Développement Familial et Communautaire* (Center for Family and Community Development)(CDFC) and the SGBV Technical Working Group; and (4) interviews with community leaders.

The end-of-project evaluation used the same methodology as the baseline assessment but also collected additional qualitative data to understand the effectiveness of the key approaches/strategies used by the BRAVI project. A total of 45 facilities were included in the end-of-project facility assessment. As this was not an experimental end-of-project evaluation, no control or comparison sites were assessed. In addition, questions were added to determine the extent to which FP and SGBV services have been integrated at facilities.

2.2 Data

Quantitative Data

Three quantitative tools were used to assess changes in service provision and attitudes/beliefs of service providers:

- **Facility assessment**: Data were collected on SGBV service availability and quality at 45 health centers in Ngozi province supported by the BRAVI project using a check-list tool. Specifically, data were collected on: (a) facility readiness (personnel, procedures, infrastructure, health care supplies, contraceptives, infection prevention, medical instruments/equipment, use of information systems); (b) the extent to which FP services have been integrated within SGBV services; and (c) the degree to which the facilities' systems, processes, and physical environment are gender-equitable and youth-friendly.
- **Provider and facility manager interviews**: Structured interviews were conducted with the providers and facility managers at all 45 health facilities to assess knowledge, training and experience in SGBV service delivery, as well as knowledge, attitudes, and behaviors related to SGBV. The interviews consisted of a questionnaire with pre-coded answers. At each facility, interviews were conducted with one randomly selected facility manager (n=45), and one facility provider (n=45).
- **Community leader interviews:** Structured interviews with community leaders were used to collect data using a survey with pre-coded answers. These interviews covered gender norms, attitudes toward SGBV, knowledge of SGBV services, information on current activities linking communities and facilities regarding SGBV service delivery, and perceptions on why services may or may not be used. 94

community leaders were interviewed by selecting a relative proportion based on the total number of leaders from each of the four key sectors providing SGBV services: local administration, religion, community health workers, and community-based organizations (CBOs). These leaders were identified as key to influencing normative changes in their communities.

Qualitative Data

Focus group discussions (FGD) and interviews were used to assess the norms, attitudes, awareness and experience with SGBV services and the BRAVI project among community members, SGBV survivors, and key stakeholders. The specific tools used were as follows:

- **FGDs with community members (n=12):** FGDs were used to capture individual and group experiences and perceptions on GBV and gender equity. Further, separate FGDs were conducted with community leaders in Ngozi province to identify the extent to which the outcomes of the project were achieved during the five years of implementation.
- **Key informant interviews (n=12):** Interviews with key informants from the Ministry of Health, PNSR (Provincial Directors of Health and District Supervisors), the Ministry of Human Rights, Social Affairs and Gender (Technical Working Group focal points and CDFC coordinators), and the Ministry of Justice (procurators of the Ngozi Court and judiciary officers) were conducted to assess the prevention and response to SGBV, challenges and future prospects to enable survivors to access service quality (i.e., medical, psychosocial, and legal services), and strategies for sustainability. Interviews with BRAVI project staff were also conducted to understand the approaches used, the challenges encountered, and the implementation strategies.
- **Interviews with SGBV survivors (n=9):** Survivors of SGBV were interviewed on their experiences with services provided as well as the challenges that still exist to allow all SGBV survivors to access quality services (i.e., medical, psychosocial, and legal services). In the case of underaged survivors, the parent or caregiver was interviewed.

Data Quality and Analysis

The evaluation team collected quantitative data using smartphones via a data entry application developed with KOBO software. This application used integrated checks to detect and alert investigators in real time to identify inconsistencies between answers. The evaluation team then merged and exported the data to STATA, a statistical software package. The team then analyzed the data using descriptive statistics and tests for significance between baseline and the end-of-project evaluation.

Qualitative data collected during key informant interviews were transcribed directly from audio files into Word documents. The EngenderHealth Monitoring and Evaluation team reviewed all transcriptions to ensure completion and comprehensibility. If any areas lacked clarity, the team referred back to the original recordings. All data were analyzed using deductive coding, with the protocol and tools as references.

Data Issues and Limitations

It is important to note the limitations in the data collected for this evaluation. Due to constraints on sample size and the non-probabilistic sampling methodologies, findings from this evaluation cannot be generalized to other provinces in Burundi. The BRAVI project also changed the number of sites since the initial baseline study: some of the original facilities were no longer supported by the BRAVI project, while other new sites were added. Due to turnover, not all providers interviewed during the baseline assessment were available for the end-of-project evaluation. The sample was also not powered to detect significant differences among different socio-demographic characteristics. As previously mentioned, the lack of a comparison or control group means the evaluation cannot differentiate between BRAVI project impacts and other external factors. The supporting qualitative information however does provide some insights into the project's probable impact.

3. Results

The results section presents the findings of the evaluation according to the original evaluation questions, noted above. Depending on the section, quantitative data, qualitative data, or a combination of the two are presented. For the quantitative findings, a selection of data is presented in the main body of the end-of-project report; additional tables presenting all of the quantitative data can be found in Appendix 2 and 3. For the qualitative sections, each finding is supported by 1-2 direct quotes in the body of the report; additional supporting quotes can be found in Appendix 4.

3.1 How have Gender Norms, Attitudes, and Behaviors Related to SGBV Changed Among Community Leaders and Providers Over Time?

In this section, we explore the changes in norms, attitudes and behaviors related to SBGV among community leaders and providers exposed to the BRAVI project. These changes were evaluated using both quantitative and qualitative methods and demonstrate significant improvements in these areas for both groups.

Changes in Community Leader Norms, Attitudes and Behavior on SGBV:

Awareness of SBGV and engagement between leaders and community members regarding SGBV increased from baseline to end-of-project (Table 1). Leaders' awareness of different types of SGBV increased significantly in all categories except that of emotional violence, where the change was not significant. While awareness of sexual and physical violence at end-of-project was above 90%, understanding of economic and emotional forms of abuse were still only around 60-66% among community leaders. Leaders also reported significant improvements in their ability to engage and work with community members on issues of SGBV. The evaluation found a 26% increase among community leaders working to educate others on SGBV and a 30% increase in community leaders stating they have assisted a woman or a girl who had been a survivor of violence (both increases were significant at $p<0.05$). Furthermore, by end-of-project, 100% of leaders reported knowledge of SGBV cases in their community (+20.7% from baseline, $p<0.05$). The majority of engagement with the community was through community meetings (88%), and working with community-based organizations (84%). Increased discussion may have resulted from increased awareness of SGBV and/or decreased stigma talking about SGBV.

Community leaders demonstrated significant decreases in a number of harmful beliefs and behaviors related to violence against women and girls (Table 2). Leaders reported a 64% decrease in the belief

that "men are not always to blame for violence because sometimes they can become so angry, they cannot control themselves", a near 55% decrease in the idea that "a woman who is raped brings shame to her family", and a 42% decrease in the acceptance that "men have many lovers because it is their nature to do so". There were also significant declines in acceptability of violence for a variety of reasons: leaders reported a decrease in the belief that a man can beat his wife if she refuses sex (-26%), talks back to him (-25%), goes out without telling him (-21%), or is unfaithful (-15%). There was also a near 72% increase in the percentage of community leader respondents who believe that "a husband has committed rape if he forces his wife to have sex". Community leaders also reported an improved sense of openness around the topic of SGBV, with only 26% of respondents believing violence is a private matter at end-of-project, compared to 41% at baseline. All of these results were significant at $p<0.05$. Finally, respondents demonstrated increases in affirmative beliefs ("positively phrased statements") around the significance of violence in their communities and the idea that forced sex between a man and his wife is, in fact, rape.

Table 1: Changes in community leaders' awareness and engagement on SGBV

	Baseline (n=92) n (%)	Final (n=94) n (%)	% change	z-score (*significant p<0.05)
Awareness of different types of violence:				
Sexual	78 (84.8)	92 (97.9)	+13.1	**-3.18***
Physical	75 (81.5)	86 (91.5)	+10	**-1.99***
Emotional	60 (65.2)	58 (61.7)	-3.5	**N.S.**
Economic	39 (42.4)	62 (66.0)	+23.6	**-3.23***
Perceptions of SGBV:				
Discuss SGBV with your friends, peers, community	86 (93.5)	94 (100)	+6.5	**-2.52***
Spoken with a man who admitted to using violence against his wife/partner (past 3 months)	25 (27.2)	37 (39.4)	+12.2	N.S.
Ever heard of SGBV against women/girls in community	73 (79.3)	94 (100)	+20.7	**-4.65***
Ever assisted a woman/girl who is survivor of violence (past 3 months)	53 (57.6)	82 (87.2)	+29.6	**-4.53***
Knowledge of SGBV support systems:				
Knowledge of places in community women/girls can go to for help when they've experienced violence	80 (87.0)	94 (100)	+13	**-3.62***
Types of knowledge where SGBV support can be obtained:				
Health facility	58 (72.5)	65 (69.1)		
Centre de Développement Familial et Communautaire	42 (52.5)	75 (79.8)		
Police	29 (36.3)	46 (48.9)		
Administration	21 (26.3)	34 (36.2)		
Community-based organization	29 (36.3)	7 (7.4)		
Other	2 (2.5)	0 (0)		
Education of others on SGBV:				
Ever educated others on SGBV or/and gender equality	68 (73.9)	94 (100)	+26.1	
Places where SGBV information was provided:				
Community meetings	N/A*	80 (87.9)	--	
Community-based organizations	N/A	76 (83.5)	--	
Youth clubs	N/A	54 (59.3)	--	
Religious meetings	N/A	32 (35.2)	--	
Other	N/A	3 (3.3)	--	

**N/A= Not applicable as the questions was not administered during the baseline assessment*

*p<0.05

Table 2: Changes in community leaders' attitudes and beliefs around SGBV

	Baseline (n=92) n (%)	Final (n=94) n (%)	% change	z-score (*significant p<0.05)
Negatively phrased statements of SGBV:				
Men are not always to blame for violence because sometimes they can become so angry, they cannot control themselves.	68 (73.9)	9 (9.6)	-64.3	**8.91***
A woman who has been raped brings shame to her family.	65 (70.7)	15 (16.0)	-54.7	**7.53***
Men have many lovers because it is their nature to do so.	40 (43.5)	1 (1.1)	-42.4	**6.98***
A man using violence against his wife/partner is a private matter that shouldn't be discussed outside the couple.	38 (41.3)	14 (14.9)	-26.4	**4.01***

It is acceptable for a man to beat his wife if she refuses to have sex with him.	28 (30.4)	4 (4.3)	-26.1	**4.73***
It is acceptable for a man to beat his wife if she talks back to him.	26 (28.2)	3 (3.2)	-25	**4.68***
A man should have the final say about decisions in his home.	62 (67.4)	41 (43.6)	-23.8	**3.26***
It is acceptable for a man to beat his wife if she goes out without telling him.	22 (23.9)	3 (3.2)	-20.7	**4.12***
It is acceptable for a man to beat his wife if she neglects the children.	24 (26.1)	8 (8.5)	-17.6	**3.18***
A woman should obey her husband in all things.	86 (93.5)	54 (78.7)	-14.8	**5.69***
It is acceptable for a man to beat his wife if she is unfaithful to him.	38 (41.3)	25 (26.6)	-14.7	**2.12***
Women can prevent violence by not angering their husbands/partners.	83 (90.2)	75 (80.6)	-9.6	**1.99***
A woman should tolerate violence to keep her family together.	53 (57.6)	47 (50.0)	-7.6	N.S.
It's the man alone who should decide when the couple will have sex.	12 (13.0)	9 (9.6)	-3.4	N.S.
Positively phrased statements of SGBV:				
A man who has forced his wife to have sex with him has committed rape.	18 (19.6)	86 (91.5)	+71.9	**-9.88***
Violence against men and boys is a problem in my community.	56 (60.1)	77 (81.9)	+21.8	**-3.18***
Violence against women and girls is a problem in my community.	80 (87.0)	93 (98.9)	+11.9	**-3.20***

*p<0.05

Changes in Provider Norms, Attitudes, and Behavior on SGBV

Similar to community leaders, providers demonstrated a decrease in harmful beliefs related to SGBV and gender equity between baseline and end-of-project. Providers showed significant declines in acceptability of violence and inequity against women, with decreases in the belief that women should always obey husbands (-43%), a woman who is raped brings shame on her family (-24%), beating is ok if a woman is unfaithful (-17%) or neglects the children (-17%). Notably, providers also demonstrated a significant decrease in the idea that there are always physical signs when a woman has been raped (-30%), a belief that could impact the way providers treat SGBV survivors. There were some increases in positive attitudes around treatment strategies for SGBV survivors, but none of these changes were significant. At end-of-project, 87% of providers reported having received SGBV training, compared to 46% at baseline.

It should be noted that percent changes of attitudes and beliefs among service providers was much lower than among other groups. In addition, many of the results were not significant at $p<0.05$. One possible explanation is that providers are already more aware of SGBV issues due to the nature of their work. Naturally, changes in their beliefs and attitudes will be less significant than of that of the general population because their baseline level was higher.

Table 3: Changes in Providers' Attitudes and Beliefs around SGBV

	Baseline (n=46) n (%)	Final (n=45) n (%)	% change	z-score (*significant p<0.05)
Negatively phrased statements of SGBV:				
A woman should obey her husband in all things.	36 (78.3)	16 (35.6)	-42.7	**4.12***
There are always obvious physical signs when a woman has been raped.	24 (52.2)	10 (22.2)	-30	**2.95***
A woman who has been raped brings shame to her family.	20 (43.5)	9 (20.0)	-23.5	**2.40***
It is acceptable for a man to beat his wife if she is unfaithful to him.	13 (28.3)	5 (11.1)	-17.2	**2.05***
It is acceptable for a man to beat his wife if she neglects the children.	11 (23.9)	3 (6.7)	-17.2	**2.73***
Domestic violence is a private matter which must be discussed between a man and his wife.	17 (37.0)	9 (20.0)	-17	N.S.
It is acceptable for a man to beat his wife if she goes out without telling him.	8 (17.4)	1 (2.2)	-15.2	**2.42***
There are times when a woman deserves to be beaten.	10 (21.7)	3 (6.7)	-15	**2.05***
Women who dress provocatively are asking to be raped.	37 (80.4)	30 (66.7)	-13.7	N.S.
Women can prevent violence by not angering their husbands/partners.	27 (58.7)	21 (46.7)	-12	N.S.
A woman should tolerate violence to keep her family together.	8 (17.4)	4 (8.9)	-8.5	N.S.
Women who remain in abusive relationships are weak.	21 (45.7)	18 (40.0)	-5.7	N.S.
Women play a role in making their partners angry and jealous, which contributes to violence.	11 (23.9)	12 (26.7)	2.8	N.S.
Positively phrased statements of SGBV:				
A man who has forced his wife to have sex with him has committed rape.	43 (93.5)	41 (91.1)	-2.4	N.S.

Women are equal to men and should have the same rights and opportunities	30 (65.2)	33 (73.3)	8.1	N.S.
SGBV can have an impact on the physical and mental health of a client, as well as on her sexual and reproductive health.	46 (100)	45 (100)	0	--

*p<0.05

3.2 How has the Status of SGBV Service Provision in Project-Supported Facilities Changed Over Time?

To gauge changes in health service provision from baseline to end-of-project, this evaluation team used three different data sources: provider surveys, health facility manager surveys, and facility assessments.

Facility-level Changes in SGBV Service Provision

Table 4 shows the changes in provider and health facility manager reports of SGBV services at the facility level. Providers reported a substantial jump in the presence of written protocols for treating SGBV survivors, increasing from 35% at baseline to 100% at end-of-project. 100% of providers at end-of-project also confirmed the use of a coding systems for patients and the use of patient informed consent before transferring patient data to a referral facility; these represent significant increases from baseline (44% and 54%, respectively). All health facility managers reported that they record statistics of all SGBV services provided, while 71% reported the availability of psychosocial counseling at their facility, a significant increase from baseline report of 46%. Nearly all respondents at end-of-project (89%) reported that survivors of sexual violence are given the choice to be treated by female providers (+41% from baseline).

Table 4: Changes in SGBV Service Provision

	Baseline (n=46) n (%)	Final (n=45) n (%)	% change	z-score (*significant p<0.05)
Presence of written standard operating procedures, protocols or organization charts for treating SGBV survivor	16 (34.8)	45 (100)	65.2	**-6.62***
Health information system has coding system for patients	20 (43.5)	45 (100)	56.5	**-5.97***
Patient informed consent required before data transfer to other facilities at time of referral	25 (54.3)	45 (100)	45.7	**-5.17***
Choice given to the survivors of sexual violence to be treated by a female service provider	22 (47.8)	40 (88.9)	41.1	**-4.20***
Provider has free access to all files of all patients	41 (89.1)	42 (93.3)	4.2	N.S.
Center records statistics of SGBV services provided[a]	37 (80.4)	45 (100)	19.6	**-3.13***
SGBV survivors can receive psychosocial counseling at this facility[a]	20 (45.5	32 (71.1)	25.6	**-2.46***
Health management and demographic characteristics				
Health District				
Buye	09 (19.6)	10 (22.2)		
Kiremba	14 (30.4)	15 (33.3)		
Ngozi	23 (50.0)	20 (44.4)		
Type of structure				
Regional hospital	0 (0)	1 (2.2)		
District hospital	4 (8.7)	3 (6.7)		

Public health center	32 (69.6)	32 (71.1)
Private health center	0 (0)	1 (2.2)
Private/Faith based health center	8 (17.4)	6 (13.3)
Other	2 (4.3)	2 (4.4)
Gender		
Male	26 (56.5)	23 (51.1)
Female	20 (43.5)	22 (48.9)
Position		
Medical Doctor	1(2.2)	2 (4.4)
Nurse	43 (93.5)	39 (86.7)
Assistant Nurse	2 (4.3)	1(2.2)
Midwife	**0 (0)**	**2 (4.4)**

[a] These questions represent responses from health facility managers, the rest of the responses are from health providers at the same facilities

The evaluation team assessed the facilities engaged by the BRAVI project using a checklist at baseline and end-of-project. The purpose of this assessment was to capture changes in patient care, confidentiality, presence of educational materials for SGBV, and presence of provider forms and protocols on SGBV treatment. The assessment revealed a significant increase in the availability of a separate, confidential space for treatment of SGBV survivors among facilities from baseline to end-of-project (24% vs 36%, respectively). Furthermore, nearly all facilities reported the presence of patient education materials (i.e., SGBV posters and pamphlets) as well as physical materials necessary for provision of SGBV care such as protocols, screening questions, consent forms, referral lists, etc.

The evaluation team also conducted interviews with 12 key informants who worked either directly or in collaboration on the BRAVI project. These key informants provided insights into the challenges of serving SGBV survivors from a provider perspective and shared their thoughts on BRAVI's contributions to improving SGBV awareness and services. They also offered their perceptions on the successes and challenges of integrating SGBV services into FP and overall lessons learned during this project.

Improvements in SGBV Awareness and Service Provision

Interviewees were asked to share their perspectives on specific SGBV activities undertaken and how awareness of and service provision for SGBV has improved since the BRAVI project began. Participants reported **increases in coordination between the various sectors** that comprise the continuum of care for a survivor including the health system, social services, and the judicial system. BRAVI partners achieved this through concerted efforts to create policies and strategize linkages between these various services and to provide training for those working in each sector. In particular, health care providers were trained as gateways for identifying, treating and supporting survivors, as health facilities are often the first place a survivor goes after a violent incident.

> *Before there were no services for the care. Now, what can be said, in health centers, there are units that can take over SGBV just as a gateway. Another element is the collaboration with the Ministry of Justice and the Ministry in charge of gender with which we collaborated to produce the rules of organization of the integrated centers of support of SGBV. In these integrated centers, we find that the health facilities are the gateway: the judicial files are established at this level and the psychosocial support and offered on site without making too much travel or refer the victims. – PNSR representative*

Currently, in all the health centers, the nursing staff knows how to receive, exchange, separate the case SGBV with other patients. There is a place reserved, we accompany him gently in a great discretion and we help him while trying to understand the circumstances in order to encourage the victims to lodge a complaint against the perpetrators and to facilitate the police and the services court. – Ngozi medical director

On a logistical level, partners **increased the number of trained personnel, established consulting centers, improved survivor tracking systems and integrated SGBV care** into existing services such as HIV or FP care as a means of increasing accessibility of SGBV services. BRAVI helped create SGBV focal points in the Ngozi province who act as first responders for SGBV survivors and who facilitate the delivery of timely care. These focal points accompany the survivor through each step of the process, from receiving emergency health care to completing the judicial process. According to interview participants, no such care existed before the BRAVI project.

> *Providers were trained. The staff, the orderlies, the community were sensitized. Everyone has been made aware to facilitate access to SGBV services by victims.*
>
> PNSR

To improve accessibility, we have established consulting offices. We have integrated family planning and SGBV services, family planning and HIV services and others. We have implemented a victim tracking system that helps us conduct surveys with questions to really know what happened in a very discreet way. And the results on authorization and request, are given to whom of right.. – Ngozi Key Informant

Partners also noted the effectiveness of **sensitization of community members on SGBV issues** and enabling a supportive environment for SGBV survivor care. By training community members, particularly men, partners established support structures for referring or accompanying victims to service providers. Furthermore, through a system of identifying and training specific men who may be challenging on the issue of SGBV, partners spread awareness among key target groups of potential perpetrators.

Before, when the woman left the training premises, she would apply what she learned about her husband but now we have associated the men; couples participate together in the development work at the same time as in the work of the homes; Finally, we train hard men and impossible men that we often hear and that disturb the movements back and forth in the locality, such as bikers, traders, or other couples who often have family problems. After training, we send them to raise awareness in the same company because they know others who are difficult. – CDFC representative

These **outreach and training activities** conducted at the community level **resulted in observable changes** noted by the key informants. Specifically, they mentioned a marked increase in the population's knowledge of how to support a SGBV survivor from beginning to end of the care

process. They also noted an increased awareness of SGBV issues in the community and how to pursue perpetrators through the legal system. This likely contributed to a decline in the incidence of violence. Indeed, the police commissioner reported a significant decline in cases of SGBV since the start of BRAVI. Members of the **medical community also noticed this change**.

> *Today, SGBV survivors know how to handle a problem. The steps are known from the beginning until the end. Even victims know how to take legal action through the Centre de Développement Familial et Communautaire; in collaboration with the doctors, supporting documents are easily found and these papers serve as a guide for the police and the courts to prosecute and punish the perpetrators. Also, there is the SGBV and family planning integration with the BRAVI program. – Ngozi medical director*

3.3 To What Extent have SGBV Services Been Integrated with Quality FP Services at the Facility Level?

Through interviews with key BRAVI partners, the evaluation team found that FP the project contributed to **the integration of SGBV screening and support into existing FP services** by strengthening the capacity of service providers to receive and treat survivors. BRAVI also increased awareness of community members and focal points to reduce stigma around violence and improve reporting and care-seeking behavior among survivors. Partners felt so positive about the SGBV-FP integration work that they encouraged its scale-up to other provinces outside of Ngozi.

> *BRAVI helps us a lot. Today we can say that if there is a case of SGBV that happens to us, we are able to help from beginning to end, there is good organization for good care. With BRAVI, we have data, we analyze it and we draw conclusions and try to find answers. BRAVI has trained many categories of people, caregivers and community health workers, community leaders and others. – Ngozi medical director*

Ongoing Challenges to SGBV Care and Integration with FP

Despite the progress made, key informants shared their thoughts on ongoing challenges to providing timely, quality care to SGBV survivors and integrating these services into existing systems. Concerns ranged from logistical training and material support to entrenched norms and stigmas.

Human resources, capacity, and logistics: One of the main concerns for providing appropriate SGBV care is the human resource, financial, and technical capacity of the various care systems. Facilities may not have enough capacity to hire, train, and retain sufficient SGBV service providers. Partners also noted the need for better management of SGBV cases and supplies to test and treat survivors. SGBV integration may also put strain on already limited and challenging service provision environments, particularly in smaller facilities. Furthermore, as FP services themselves may not be readily accessible in all communities, focusing integration primarily within FP services may hinder access. These limitations are important to consider for scale-up and sustainability of services.

> *The challenges often encountered are related to the lack of human resources in the health facilities as well as the capacities that are insufficient in the health facilities. We have to strengthen them for better management of*

SGBV cases. Other challenges are related to the package available in health facilities including products for the treatment of sexually transmitted infections and also the treatment of hepatitis D which is in the package to offer victims of SGBV. – Ngozi medical director

The challenges are not lacking. First, we have few SGBV staff trained, we lack special premises for victims, and another challenge is that many new staff members are not qualified to properly fill their SGBV roles. – Ngozi key informant

3.4 What are the Current Perceptions of SGBV in the Community, According to Community Members?

Through a series of in-depth interviews and FGDs, the evaluation team gathered information from SGBV survivors and members of their communities on their current knowledge and attitudes towards SGBV incidents. In addition, the team gathered information on the care provided for SGBV victims in their communities. Participants also shared their ideas on how to help decrease the incidence of SGBV and observations on changes in SGBV behaviors as a result of the project.

Acknowledgement of SGBV as a Problem in the Community

Overall, participants recognized that SGBV is present in their communities and warranted a targeted response. Though in a few cases, men and boys were mentioned as potential victims, the majority of FGD participants identified women and girls as the primary victims.

Women are beaten following rape attempts en route when they return home in the late hours.. – FGD with girls in Tangara

When asked about the risks of violence against women, responses ran the gamut. Some noted that **females may be attacked while tending to ordinary chores outside the home**. Others pointed to blaming female victims for putting themselves in compromising situations such as staying out late or drinking alcohol. Participants also explained that, in some cases the same reasons may elicit violent responses from husbands.

Discussants mentioned rape and spousal physical abuse as the main forms of violence against women. In a few FGDs, members cited polygamy, economic abuse, and gender inequality (such as lack of women's agency or decision-making power) as additional types of violence.

> *When a woman or a girl is raped during the night or in a cabaret or when returning late at night, it is said that she is the source of the misfortune that has happened to her.*
>
> FGD, Men

Participants believed that **women and girls can be seduced or enticed by men with offers of money or gifts**, increasing their risk of sexual violence. Transactional sex, where girls or women

offer sex in exchange for goods or services, is seen as a particular menace in these communities and a common source of unwanted pregnancy. A smaller subset of participants also noted the possibility of violence against men and boys, particularly by wives or women who demand sex or are physically violent.

> *Here at home, schools are very far from our homes and when the girls come home, they can meet the bikers who take advantage of their difficulty of travel by offering free transportation. But on arrival, taking advantage of the vulnerability of these girls, these bikers can seek in exchange for sex, which can be the cause of an unwanted pregnancy. – FGD with women in Mwumba*

> *Other girls are seduced by boys who offer them money or other luxury goods such as mobile phones, clothes, outings to restaurants or in hotels and this can lead to unsafe sex. protected and unwanted pregnancies. – FGD with men in Mwumba*

Knowledge of How to Respond to SGBV Survivors

The evaluation team asked participants to specify what should be done to care for a woman or girl who has experienced rape or sexual violence. Nearly all respondents identified the need to immediately **accompany the survivor to a local hospital or clinic for emergency medical care**. They mentioned that this care would include HIV testing, testing for other sexually transmitted diseases, and treatment for potential unwanted pregnancy. Participants also highlighted the importance of **following medical care with visits to the** CFCD **CDFC, and to local authorities to report and prosecute the offenders**. In at least one FGD, however, men noted some families' or survivors' preference not to report cases of violence.

> *The first thing the victim does is go to the hospital or health center for emergency medical care in order to be protected from HIV and unwanted pregnancy in girls and to be treated for wounds among men struck by their wives. After that, he goes to see a head of the CFCD and he accompanies him to a local authority. – FGD with girls in Gatsinda*

> *The entourage helps them to go to the hospital for the prevention of sexually transmitted diseases, unwanted pregnancies and HIV. Afterwards, they are sent to complain to the justice services. But others prefer to keep quiet. In this case, the situation is very serious because neither the entourage, nor the CFCD nor the health centers nor the services of justice, nobody is informed to bring help. – FGD with men in Busiga*

Perceptions/Treatment of Survivors by Community/Family

When asked about the types of responses that SGBV survivors receive from family and the community, the responses were mixed. In many cases, participants reported supportive, positive responses. In these cases, **the survivor is reassured, taken for medical care, and then further accompanied to** CFCD **CDFC or judicial authorities**. Several participants mentioned the

> *The close family takes care of her to calm her, to console her and finally to comfort her. We try to calm her down and visit her often. Community health workers visit the victim for assistance*
>
> FGD, Women

contribution of the BRAVI project, trainings, and community meetings, in creating an environment of care and support for SGBV survivors.

> *When it comes to girls, the close family takes care of the victim to reassure her, to console her and finally to comfort her. But this principle does not apply to men struck by women, they are criticized, humiliated and denigrated in the community. Often, community health workers refer victims to the various services. – FGD with girls in Gatsinda*

Despite this atmosphere of support, several FGD participants noted that not all families or community members are educated enough to provide proper care. In fact, **some families still** rejected **or** abandoned **girls or women who were sexually abused**. The problem may be even more pronounced for male SGBV survivors, whose experience is often diminished or discounted when compared to female survivors.

> *How victims are received varies by family. There are those who normally consider them victims by helping them of different kinds according to need (to bring them to the health facility, moral support, help them to complain in justice). But there are other families who reject the victims by driving them out of the house or stigmatizing them. – FGD with girls in Butsinda*

Perceptions of Medical and Judicial Care for SGBV Survivors

Both FGD participants and survivors were asked about their perceptions of or experiences with accessing care from the medical and judicial systems. When describing interactions with health service providers, survivors in particular reported positive experiences. **Survivors felt that they were welcomed, well-received, and given appropriate and timely medical care**.

> *I was welcomed and reassured that I did not have a physical injury and they gave me HIV prevention medication even though they could not tell me of this pregnancy. – Survivor from Kiremba, age 25*

None of the participants reported any stigmatization or discrimination on the part of health care providers. FGD participants also noted the readily available access to community health workers, if victims need care. At least one survivor noted the **need for adequate psychosocial care**.

> *There is a need for psychosocial care for victims so that they do not get lost in thoughts, giving them advice about what to do and not falling back on themselves. – Survivor from Gashihanwa, age 24*

While participants noted a high degree of access and care from the health system, their experiences with the judicial system were more complicated. CFCD participants cited the CDFC as an organization that facilitates the pursuit and prosecution of SGBV perpetrators. However, both survivors and community members expressed frustration that **abusers are not always brought to justice**. Some felt that perpetrators may be protected through corruption of local officials or lax judicial approaches that do not deliver sufficient punishment for SGBV crimes. **Power and resource imbalances between survivors and perpetrators further discourage those seeking justice.**

> *Most judicial police officers are corrupt, the rich are not punished even if they are arrested. After two or three days, they are released. In many cases, the authorities are the perpetrators of rape crimes (e.g., influential directors who rape girls in schools). – FGD with girls in Gatsinda*

It may happen that the victim lives far from the court to file a complaint and does not have the means of transportation to go to this court, so this is a problem. The perpetrator can be someone who has a lot of money and has influence to negotiate an amicable arrangement with the victim's family (usually the girl). Some prefer to abandon the case following the threats from the perpetrator. – FGD with women in Marangara

Perceptions on Changes in SGBV Attitudes/Behaviors at the Community Level

Finally, the evaluation team asked FGD participants to note any changes in SGBV attitudes or behaviors in their communities since the onset of the project. It is unclear whether these changes are connected solely to BRAVI and not to other factors. The timing and type of changes, however, suggest the project contributed to a decrease in SGBV behaviors, **improved knowledge of SGBV issues among the community**, **and increased access to care and services for survivors**. Furthermore, in several instances, interviewees mention BRAVI by name. Several participants pointed to a decline in SGBV cases in their communities, attributable to **awareness-raising activities and improved policies and punishment against perpetrators**. Respondents also observed improvements in dialogue between men and women around issues of gender equity, particularly among spouses.

Currently, there are improvements because in the past, the woman did not even know where to find care and rescue services. Women are no longer beaten in homes because of the sensitization often done by community health workers. – FGD with boys in Busiga

We notice a clear improvement thanks to the teachings, the meetings, the councils and especially to the sensitizations of the program BRAVI through men and men leaders IMBONEZA, the association NAWENUZE as well as the administration. It should also be noted the synergy between the administration and the police patrol all night in the community while cabarets and pubs must close before dark. – FGD with men in Busiga

3.5 How did BRAVI Contribute to the Coordination of SGBV interventions at the National, Provincial, and Communal Levels?

The evaluation team asked participants to name the specific ways in which BRAVI contributed to the coordination of SGBV service providers and improvements in SGBV care. Participants noted improvements in **meeting coordination and collaboration between the four key branches of SGBV services**: healthcare, social welfare, police, and judicial services. They also pointed to work at the ministerial levels to **encourage adoption of national policies and guidelines** for SGBV care, and to coordination of different stakeholders from national, provincial, and local levels.

The project contributed to the organization of the meetings. Even though I have been away, I know that BRAVI is helping to ensure that police, justice, health and Center for Family and Community Development services are all at the same level in order to fight against SGBV. – PNSR representative

BRAVI organized workshops that brought together Health, Justice, Police and Center for Family and Community Development representatives in the communes to promote SGBV care. – Ngozi prosecutor

Participants also credited BRAVI with **building capacity of providers.** This included training, follow-up support, and provision of financial and material goods (such as harmonized tools) for training providers on the specific needs of SGBV survivors. Participants specifically noted the assistance that BRAVI provided in **establishing systems for data collection and review.**

> *The project developed training modules that were compiled to form the national best practice document on the prevention and care of survivors of SGBV used at the national level*
>
> PNSR

The BRAVI project, in addition to the development of the module and support in training providers, supported us in post-training follow-ups. BRAVI also supported the production of tools, particularly for monitoring, and in this way, we could have data. BRAVI has also made sure that treatment data is reported and known at the national level. The results were used in the exchange of experience for other partners who can refer to it in organizing their interventions in their supporting provinces. – PNSR representative

3.5 What are Ongoing Challenges to Providing SGBV Care and What Can be Done to Improve Services?

Using the entirety of the qualitative data, including from key informants and community members, the evaluation team investigated which the remaining challenges of SGBV care. The team also asked participants to offer their suggestions on how services may be further improved.

Challenges to Providing SGBV Care

Cultural of silence around reporting violence: Perhaps the most frequently mentioned challenge to SGBV support is the local customs that impede timely reporting of cases. Partners recounted that in many instances, survivors are either too afraid to report their case or they prefer to use traditional methods of conflict resolution (i.e., mediation by local leaders or financial restitution to the victims) as opposed to formal legal or judicial channels. This culture of silence further stigmatizes survivors and may keep them from seeking critical medical services in the immediate aftermath of a violent incident. This tendency towards insularity is further exacerbated by logistical difficulties in accessing services (e.g., magistrates may be located far away from victims' homes) and the cost of pursuing health or justice in these cases. By operating outside of formal systems, victims may also forego access to essential medical evidence needed to pursue justice down the line. Partners saw continued training and awareness-raising as important to combat this challenge.

> *Burundian customs are among the challenges we often face. Indeed, many women suffer violence in the homes and do not dare to denounce their partners by saying that it has always been like that and that we must endure "niko zubakwa*[12]*. Others, in case of these crimes, solve the problem by amicable settlement and such cases will never be known in court. Other victims live in places far away from the courts, which becomes an obstacle for the [judicial police officer] handling the case because he cannot find the victim to send to the floor. – Ngozi prosecutor*

> *First, the victims' families hide the case and prefer amicable solutions because of customs or money, if the perpetrator is rich. If the victim is not accompanied by the Center for Family and Community Development, the process for making a complaint is difficult, the victim does not easily find the medical report. Because of the long journey (20 km) and even more, the victims are not able to travel this long journey and if they do not find money, they abandon the case; Victims arrive late [to the health facility] after 72 hours. – CDFC representative*

Lack of women's agency or empowerment: Although not mentioned as explicitly as some of the other challenges, the qualitative research revealed an undercurrent of gender bias facing providers of SGBV support. Women in these communities may not have the agency or feel empowered enough to pursue cases against their perpetrators. They may also not have the financial or logistical means to report cases. In many instances, they may be tied to the perpetrator through marriage or familial relation. Access to a FP clinic can also be limited due to pronatalist traditions and a woman's need to seek permission from her spouse to access FPthese services. This issue is particularly acute among rural, uneducated, or impoverished women.

> *The challenge is that women are socially and economically dependent on husbands because of their abusers. So that's a major challenge. There are even times when the woman has complained to the police or the court, and after she comes back to ask for release of her husband while he was imprisoned. – PNSR representative*

> *The challenges of family planning -SGBV integration are at two levels: first at family planning level, the community resists mainly because the country is still pro-natalist. In addition, when women want to use contraception, they have to ask permission from their husbands while they are using the method. It's SGBV. The man is the boss, he influences the decision for the integration of family planning in SGBV. – PNSR representative*

Bias in the judicial system: Finally, some partners (just as some community members), pointed out potential bias or flaws in the judicial system which may discourage survivors in pursuing their cases through formal channels. Some see the legal system as being biased towards those with money, not imposing stringent enough sentences, or being capable of manipulation by those with ties to police or prosecutors. In some cases, this may result in threats to actual service providers.

> *Even in the judicial services, the perpetrators are released without having served their sentences completely. – CDFC representative*

[12] "so goes the marital life" there is a harmful cultural norm expecting the married woman to bear violence in the marital life because divorce is badly seen and tarnishes the image of the family, in particular of the mother who is usually blamed for all failures of the female children in the family, including the divorce of a daughter.

How to Improve Services for SGBV Survivors

The evaluation team asked participants for suggestions on improving care and treatment of SGBV survivors. Many expressed a desire for **continued accessible, non-discriminatory care by health providers, as well as supportive and accepting attitudes from community members**. These could be achieved through additional sensitivity trainings for both local leaders and community members. Participants also noted the **need for more medical and CDFC personnel trained** to handle SGBV survivors and their cases. Finally, a number of participants, including many survivors interviewed here, expressed a desire to see harsher punishment for SGBV perpetrators to discourage acts of violence.

> *Community leaders such as hill chiefs must help the family of the raped child by denouncing the perpetrators instead of protecting them. There needs to be well-trained [medical] staff on SGBV cases because people who have experienced this kind of crime need someone to give them comfort. There is a need to increase the staff of the Center for Family and Community Development. For example, at the Center for Family and Community Development, we find that there is only one person so if it is not available, it is a problem for someone who wanted to confide in him. – Mother of survivor in Marangara, <10 years*

> *There is a need to increase training sessions for SGBV prevention in the community. The perpetrator must be severely punished. We must fight against corruption. There is a need to educate the entire community without exception. – FGD with men in Maranga*

3.7 What are the Key Lessons for Providing SGBV Care in a Context Like the BRAVI Project?

Finally, the evaluation team asked key informants to share key lessons learned on providing quality and sustainable SGBV services in the context of the BRAVI project.

Lessons Learned and Thoughts on Sustainability

Stakeholders provided key lessons learned from working with BRAVI as well as ideas for scale-up and sustainability. Overall, they were satisfied with the coordination, capacity-building, and sensitization provided through BRAVI support. As a result, most participants encouraged continuation of activities, particularly at the community level. However, several partners were concerned with the feasibility of continuing activities once the financial and technical support of the project is over. To this end, some partners pledged to carry on the work they started with BRAVI and suggested that the local and national governments step in to support all relevant partners in continuing SGBV work.

SGBV Sensitization of Community Members Works

Key informants mentioned that even in areas with deeply ingrained negative customs and beliefs around SGBV, **community members were able to be sensitized to improve attitudes and behaviors**. They explained how **individuals in these communities can now be recruited and trained** to become beacons for awareness and support on SGBV issues. Through a process of grassroots, inclusive approaches, community leaders, men, and women can now be empowered on SGBV issues and create a cascading effect of positive behavior change.

The lesson we learned is that the community has been sensitized. Now they are aware of the disadvantages of SGBV. And today, community members know where they can go to ask for SGBV services. – Ngozi SGBV key informant

The population is sensitized. They know how to help a victim, how to help, how to approach the victim, how to reassure her and provide advice and how to support her in all other necessary steps. – Ngozi SGBV key informant

Integration of SGBV into FP Services is Feasible, with the Proper Support

Another critical lesson uncovered by the interviews is that **integration of SGBV support into FP services is feasible, but it requires proper capacity building and follow-up support**. Psychosocial support remains a challenge for providers, particularly in facilities with low human resource capacity. As mentioned in the previous section, by focusing primarily on FP units for SGBV integration, portions of the population who do not have clinical access to this type of planning may fall through the gaps.

The lesson we can draw is that we have seen that family planning can be integrated with other services and this is really a good lesson for the sustainability of services. With regard to family planning, many dropouts can be observed, but if family planning is included in other services, drop-outs can be easily recovered. It's both an experience and a lesson learned, which is good for the future, because the use of family planning could change. So, by integrating and expanding family planning, we master fertility and finally we control the population growth in the country. – PNSR representative

Gender Bias and Inequity may Impede Work and Must be Addressed

An important lesson identified during the interviews, and one that is echoed in the challenges mentioned above, is the **need to combat gender bias or gender inequity which can impede women's access to services**. Even in cases where SGBV and FP are integrated, some women are forbidden from accessing FP services and are beholden to their husband's control. One individual recognized the importance of educating women directly, as a means of empowering them to communicate their needs and seek solutions for SGBV issues:

The lessons learned are that staff are trained to offer family planning and GBV services but in relation to family planning mainstreaming, the challenge is at the community level that comes for SGBV but does not require no family planning service because women always have to ask permission from their husbands. The other lesson is that education needs to be promoted. A woman who is educated is less exposed to SGBV compared to the illiterate woman in rural areas; Educated women are open and facing their husbands, it is easy to resolve SGBV issues for them. – PNSR representative

Partners Feel Motivated, Dedicated to Carry on Whatever Work they are Able

With BRAVI's closure, a number of partners expressed a **desire to continue the work they started, even without formal project support**. From focal points to prosecutors to medical personnel, the key informants relayed their plans to continue SGBV support. Among the efforts mentioned by informants include continuing coordination and awareness raising meetings and activities between partners and among the community, propagating training on SGBV services to more or new providers, and using BRAVI materials to support this organic approach to scale-up and sustainability. There was a clear sense of determination on the part of stakeholders to carry forth this important work even after BRAVI shuts its doors.

With regard to sustainability, we will stay close to the population, men, women and couples trained will continue to train others and we will increase awareness meetings in collaboration with the administration. – Ngozi Key informant

There will be a need to train other providers who will replace those who will be gone. Other than that, I think the community and the providers will continue the fight. – PNSR representative

Coordinated Efforts and Government Support are Foundations of Sustainability

Enthusiasm for continuing the work notwithstanding, partners recognized that long-term sustainability of BRAVI's gains will require **collaboration between partners and targeted support from national and local governments.** Partners spoke of coordinating efforts among themselves to propagate the SGBV support work. They also recognized the importance of taking ownership of this work once BRAVI officially ends, for instance, by **the state directly seeking funding or program support from other implementing partners**. Finally, the national PNSR representative explained a clear path for rooting SGBV services directly into existing district and national level health systems operations to ensure sustainability.

Since the situation is improved, we are giving orders to the Heads of Posts to work in agreement with the Administration or any other training that works on issues related to SGBV in particular and security in general in order to maintain this lull. At our [judicial police office], we give them injunctions to welcome victims by collaborating with the medical services and the families of the victims. – Ngozi police commissioner

The lessons learned are that currently there is a clear improvement, the population knows what it can do in case of SGBV, the victim knows how to move in case of problem. The carers are trained and help the victims without any problem. The justice services and the police work with the Center for Family and Community Development officers and they provide them with documentation that shows the seriousness or the state of health of the victims. In the future the state must take matters into its own hands, donating funds, looking for donors and other programs to evaluate and sustain this process. – CDFC representative

4. Conclusions and Recommendations

Overall, the BRAVI program was successful in meeting its three main result areas: (1) strengthening of the health sector response to SGBV through health sector capacity building activities; (2) increased awareness of and use of SGBV services through the strengthening of referral networks and coordination of multi-sector stakeholders; and (3) Improvement of gender equitable norms to prevent SGBV and promote FP use through behavior change activities at the community level. The findings of this evaluation suggest a clear contribution of the BRAVI program on number of outcomes related to these result areas, such as:

- Improved coordination between key SGBV services providers, including those from medical, social service, police, and judicial spheres.
- Reduced stigma and improved attitudes and beliefs around SGBV among target communities.
- Increased capacity of medical personnel to welcome and treat SGBV survivors, including providing emergency HIV/STI and pregnancy care.
- Integration of SGBV services into existing FP units.

- Creation of links between the community and service providers to encourage uptake of SGBV services.
- Positive changes in provider attitudes around SGBV and gender equity.
- Increased awareness and use of SGBV services among community members.
- Establishment of data and referral systems for coordinated SGBV care, starting at the medical facility level.
- Creation of a continuum of support for SGBV survivors from the first medical interaction the judicial conclusion of pursuing perpetrators.
- Greater understanding and motivation of all partners on the importance of SGBV support services, leading to a renewed dedication to continue this work.

Given the variety and richness of the evaluation data, we were able to identify several key areas of success for future SGBV work. Based on the lessons learned from this evaluation, we offer the following recommendations for any follow-on, replicated, or scaled work on SGBV programming in Ngozi or beyond:

- **Involve the community**: One of BRAVI's greatest assets and a crux of its success was involving all members of the community on awareness raising and sensitization activities. From working with local leaders, to recruiting difficult Men As Partners®, to educating and empowering women and survivors to seek care, the grassroots level engagement was key to ensuring the uptake of care and increased support for SGBV survivors.
- **Create collaborative partnerships across stakeholders and levels**: BRAVI created links between the health, social service, police, and judicial systems and enrolled all of these actors (as well as local and national coordinating partners) into a continuum of care for SGBV survivors. By established meetings and workshops with all significant stakeholders involved, BRAVI built synergistic partnerships that will continue beyond the limits of the project. Furthermore, BRAVI worked at both national and local levels to establish supportive policies for SBGV and foster the adoption of streamlined databases and procedures for coordinated SGBV care.
- **Establish links between community and care givers to foster service uptake**: Another essential feature of the BRAVI project was in organizing meetings and facilitating communication between community leaders and health care providers. By encouraging these two groups to interact and plan, BRAVI was able to strengthen the connection between the two groups and facilitate the uptake of services by SGBV survivors. Conducting SWTs, where community members could tour facilities and provide feedback on access issues, also helped both parties strengthen this connection and improve access to facilities for survivors.
- **Build the capacity of local care providers**: To ensure timely and quality SGBV services, future programs must increase the capacity of local caregivers, such as health providers, in SGBV screening and support. Doing so in a cascading manner, through training of trainers or provision of education materials, will not only ensure

the quality of care during the life of the project but may encourage the continuation of activities after the project has ended.

- **Provide streamlined tools and materials to support capacity building**: BRAVI worked at both local and national levels to create streamlined tools based for SGBV care. Through a process of coordination and adoption at the national and local levels, these tools are now available for all providers as a reference for continued care. Streamlining local databases and tracking/referral systems also helped improve the continuum of care for SGBV survivors and are a means of encouraging long-term viability of activities.
- **Emphasize gender equity as the basis of all SGBV work**: BRAVI worked closely with a multiple categories of people in the community to raise awareness and sensitivity to SGBC issues. However, partners and community members alike reported that strident cultural traditions rooted in gender bias against women can be a pervasive and a stunting element in the effort to stop SGBV. Additional and sustained programming that aims to bring gender norms into better balance is a crucial underpinning to any SGBV work.

Appendix 1: Additional Information on the BRAVI project

As the objective of the BRAVI project was to improve sexual and gender-based violence (SGBV) prevention and response efforts, including provision of integrated family planning (FP) and SGBV services, the project supported the provision of quality medical care for SGBV survivors, including post-exposure prophylaxis (PEP) for the prevention of HIV, while ensuring adherence to national protocols for meeting minimum SGBV service delivery standards. The project expectations and results were built around EngenderHealth's holistic Supply, Enabling Environment and Demand™ (SEED) programming model. This model is based on the principle that sex programs will be most effective if they include synergistic interventions that address various determinants of health-seeking behavior.

With additional funds to support the integration of family planning (FP), BRAVI sought to strengthen both the SGBV and FP services offered in the target region of Ngozi. BRAVI trained FP providers to recognize, screen for, and respond to the needs of SGBV survivors. Concurrently, BRAVI built the capacity of health providers trained to provide SGBV services, to respond to the sexual and reproductive health needs, including FP needs, of survivors of SGBV. BRAVI's work at the community level – including gender-synchronized workshops and engaging community leaders in FP promotion efforts – sought to raise FP awareness including around method options, as well as address the harmful social and cultural norms that permit SGBV to occur.

Geographic Coverage

At the national level, BRAVI collaborated with the Ministry of Health through National Program or Reproductive Health (PNSR) to provide support to the lower level health administration. BRAVI also worked with the Ministry of Human Rights, Social Affairs and Gender through the SGBV-Technical Working Group and *Centre de Développement Familial et Communautaire* (Center for Family and Community Development) (CFCD) to improve the national and provincial coordination of SGBV interventions and the referral system. The project was implemented in Ngozi province covering three health districts (Ngozi, Buye, and Kiremba), building capacity and technical support to health structures by targeting providers and supervisors.

Beneficiaries

Within the above-mentioned geographic scope, the project established a list of target beneficiaries including SGBV survivors, health providers, non-clinical staff, community leaders, men, couples, and community health workers.

Description of the Project intervention

Building on the lessons learned from EngenderHealth's previous project in Burundi (2011-2014),) as well as international best practices and lessons learned, BRAVI used available resources, and approaches to further improve and expand SGBV prevention and response efforts and access to

voluntary FP. BRAVI's technical approaches included a diverse set of activities that supported each intended objective/result. These activities are described below:

Result 1 - Strengthen health sector response for SGBV survivors, including family planning service provision (Supply)

The BRAVI project collaborated with the PNSR in Burundi to improve the performance in all health facilities through skilled and competent health providers. Strategies included trainings, monitoring and coaching on site, exchange visits, formative supervision and documentation and sharing of best practices. Furthermore, the project trained health service providers to make appropriate and comprehensive referrals for additional SGBV-related services, namely, psychosocial, and legal support. Trained providers were also equipped with job aids developed by the project for easy reference about FP and SGBV integrated services. In addition, BRAVI provided technical and logistical support to the district hospitals to institutionalize FP-related services.

Result 2 - Promote awareness and use of FP and SGBV services, and strengthen referral networks

BRAVI strengthened the Ministry of Human Rights, Social Affairs and Gender's ability to coordinate Burundi's multi-sectoral response, and to advocate, through partners, for improved SGBV services and response. The primary vehicle this was Burundi's SGBV Technical Working Group (TWG). Within this group, the project facilitated dialogue between SGBV programs, such as the one implemented by UN Women, to co-finance some activities, such as the TWG meetings.

The lack of a functional referral system impeded a comprehensive response for SGBV survivors. The FP needs of survivors could also be seen as part of ensuring survivors can access the fullest possible range of SGBV services. BRAVI coordinated meetings to improve the functioning of the referral system by linking SGBV survivors to service providers including health facilities, psychosocial, and legal support at the provincial and communal level.

Result 3 - Promote gender equitable norms in the community to prevent SGBV and to promote voluntary FP use

To address the root causes of SGBV at the relationship and community levels, BRAVI adapted and implemented aspects of EngenderHealth's Men As Partners (MAP®) program – specifically, group education. Using the same gender transformative approach, BRAVI conducted community outreach activities in the nine communes of Ngozi.

Appendix 2: Demographic characteristics of community leaders and providers

	Baseline (n=46) n (%)	End-of-project (n=45) n (%)
DEMOGRAPHIC CHARACTERISTICS OF PROVIDERS		
Health District		
Buye	9 (19.6)	10 (22.2)
Kiremba	14 (30.4)	15 (33.3)
Ngozi	23 (50.0)	20 (44.4)
Type of structure		
Regional hospital	0 (0)	1 (2.2)
District hospital	4 (8.7)	3 (6.7)
Public health center	32 (69.6)	32 (71.1)
Private health center	(0)	1 (2.2)
Private/Faith based health center	8 (17.4)	6 (13.3)
Other	2 (4.3)	2 (4.4)
Gender		
Male	26 (56.5)	23 (51.1)
Female	20 (43.5)	22 (48.9)
Position		
Medical Doctor	1 (2.2)	2 (4.4)
Nurse	43 (93.5)	39 (86.7)
Assistant Nurse	2 (4.3)	1 (2.2)
Midwife	0 (0)	2 (4.4)
DEMOGRAPHIC CHARACTERISTICS OF COMMUNITY LEADERS		
Role in the community		
Elected leader/administrative authority	41 (44.6)	--
Community health worker	39 (42.4)	--
Representative of an assoc. offers SGBV services	9 (9.8)	--
Hill Chief	--	25 (26.6)
Community leader	--	62 (66.0)
Association president	--	7 (7.4)
Other	3 (3.3)	0 (0)
Gender		
Male	54 (58.7)	56 (59.6)
Female	38 (41.3)	38 (40.4)
Commune		
Ngozi	20 (21.7)	21 (22.3)
Gashikanwa	7 (7.6)	6 (6.4)
Kiremba	10 (10.9)	7 (7.4)
Marangara	9 (9.8)	7 (7.4)
Mwumba	4 (4.3)	10 (10.6)
Nyamurenza	11 (12.0)	6 (6.4)
Ruhororo	6 (6.5)	9 (9.6)
Tangara	**13 (14.1)**	14 (14.9)

Appendix 3: Facility Assessment Data

	Baseline (n=46) n (%)	End-of-project (n=45) n (%)	% change	z-score (*significant p<0.05)

Is the client greeted by a staff/volunteer upon entering the clinic?	32 (69.6)	30 (66.7)	-2.9	N.S.
Is the client asked how she may be helped?	36 (78.3)	38 (84.4)	+6.1	N.S.
Is the client told where she can be seated?	34 (73.9)	36 (80.0)	+6.1	N.S.
Is there more than one chair for patients in the waiting area?	46 (100)	40 (88.9)	-11.1	2.33*
Are the restrooms in working condition today?	44 (95.7)	45 (100)	+4.3	N.S.
Is there a separate room used only for medical consultations?	46 (100)	38 (84.4)	-15.6	2.78*
Is there a separate room used only for counseling or/emotional support (separate from medical consultations)?	11 (23.9)	16 (35.6)	+11.7	N.S.
Are there posters about SGBV?	1 (2.2)	36 (81.8)	+79.6	-7.72*
Are there physical copies of the following resource documents? SOPs for providing care and treatment to survivors of GBV?	26 (56.5)	44 (97.8)	+41.3	-4.72*
Are there physical copies of a list of screening questions to detect cases of GBV?	23 (50.0)	44 (97.8)	+47.8	-5.17*
Are there physical copies of a form for documenting a client's account of GBV (e.g. History of Violence form)?	21 (45.7)	44 (97.8)	+52.1	-5.50*
Are there physical copies of a form for documenting injuries?	23 (50.0)	44 (97.8)	+47.8	-5.17*
Are there physical copies of a consent form for clients to sign if a provider is in need of releasing confidential information?	23 (50.0)	43 (95.6)	+45.6	-4.87*
Are there physical copies of a list of services and/or resources available to survivors of GBV (ex. a referral list)?	18 (39.1)	43 (95.6)	+56.5	-5.72*
Are there physical copies of a cooperative agreement between the structure and other institutions that offer services to survivors of GBV, to facilitate the referral process?	10 (21.7)	43 (95.6)	+73.9	-7.14*

*p<0.05

Appendix 4: Additional Quotes to Support Findings

Improvements in SGBV awareness and service provision	*To improve the accessibility and use of services for survivors, we have created what is known as the one-time service that is reserved for survivors only. There is also what is called the emergency kit containing everything the provider will need to treat the victim. All this has been done in order to avoid the delay in the care. – Ngozi SGBV focal point 3*
	What I know is that all groups work together to fight gender-based violence. The work I see in the community is often outreach, meetings, training seminars - Ngozi police commissioner
	Thanks to the teachings, we notice that the population has changed. The traditions and customs that prevented them from speaking have diminished significantly. - Ngozi SGBV focal point 1
	Also, thanks to the trainings, the tasks have become easy and the victims are welcomed and helped appropriately. The perpetrators of the crimes have also decreased because they know that the judiciary and the police are still at work. - Ngozi SGBV focal point 1
To what extent have SGBV services been integrated with quality FP services at the facility level?	*BRAVI has strengthened the capacity of providers and justice staff. He supervised the victims at the local level and even at the commune level. He also raised the awareness of community members to dare to talk about what was taboo. - Ngozi prosecutor*
	If a person is a victim of SGBV, if they arrive at the health center, in addition to the services that can be offered to them in relation to the management of SGBV, family planning services must also be involved. The survivor receives the information and the products but also, there is a follow-up that is there. I think it's a happy experience. But currently, this only exists in Ngozi province. After the presentation of the results of the BRAVI evaluation, we would like to learn from it and extend this experience to other provinces. – PNSR representative 1
	STI prevention products are not subsidized so CDSs lose a lot. Prevention, psychological care, hepatitis B vaccines are the main challenges we face and that have so far been without a favorable outcome. There are medical papers that are very expensive and the BRAVI program pays for the victims each time, and there is the question of who will continue to pay for these victims after the project starts. Another thing is that all trainings, benefits, upgrade seminars were funded by the BRAVI program, after his departure you understand that it will be a big challenge. – Ngozi SGBV focal point 2
What are the current perceptions of SGBV in the community, according to community members?	*Security is often disrupted by those who consume excessively alcoholic beverages or drugs because a woman attending the cabarets, when she returns home, may encounter criminals in the evening who may take her by force and rape her or even when she arrives at home late at night, she can be punished by her husband and this causes a general disorder in this home. – FGD with women in Busiga. - Ngozi SGBV focal point 1*
	Women who come drunk late at night may be raped or a woman who is going to get water and gets raped – FGD with boy in Tangara. - Ngozi SGBV focal point 1
	The first thing she does is 4o go to the hospital before 24 hours to protect her from AIDS and unwanted pregnancy. After she files a complaint with a local authority. – FGD with boys in Busiga
	The first thing she does is to go to a health facility before 24 hours to protect her from AIDS and unwanted pregnancy. After she goes to consult a head of the Centre de Développement Familial et Communautaire and he accompanies him to a local authority. – FGD with women in Mwumba
	Today, thanks to trainings, meetings, teachings, everyone stands up as one man to help a rape victim by transporting her directly to the hospital to prevent her from sexually transmitted diseases and unplanned pregnancies. wanted and seeking the administration, the police and the courts to punish the culprit. – FGD with women in Busiga
	Thanks to the various sensitizations made in the community, people take care of the victim very well to calm her, to accompany her in times of hardship and to comfort her. - FGD with girls in Tangara
	There are other people in the community who have not yet evolved who continue to criticize and humiliate the victim of rape or other SGBV. – FGD with women in Mwumba
	When it comes to girls, the close family takes care of the victim to reassure her, to console her and finally to comfort her. But this principle does not apply to men struck by women, they are criticized, humiliated and denigrated in the community. – FGD with men in Mwumba

	[Survivors] have easy access to emergency services because community health workers assist them closely to receive various services, including going to the health center for preventive care. - FDG with boys in Busiga
	At the hospital, they welcomed her, cared for her by protecting her from HIV / AIDS and unwanted pregnancy. Then they gave him medicine to take home. – Father of survivor in Mwumba, age 13
	It may happen that the perpetrator is in a position of strength, any leader, a wealthy trader or a close family member. In these cases, the case is resolved amicably because the victim is in a position of weakness to obtain justice. If the crime is committed in a more remote place than authorized bodies such as the police and the courts and the victim lacks financial means, she prefers to abandon the case. In this case, participants request that CFDC or trained people be made available to the public and that they be looked for lawyers. – FGD with men in Busiga
	Something has changed because many men who have committed this type of crime have been imprisoned. This has been felt as a lesson for others. Another thing is that thanks to the teachings of BRAVI, they notice an improvement in the communit. – FGD with women in Marangara
	Conjugal conflict has decreased in a remarkable way thanks to improved dialogue within the spouses; Rape is less frequent in the community thanks to the sensitization of community health workers and the authorities who take rape crimes seriously by promoting the use of the law for this type of crime. – FGD with girls in Tangara
How did BRAVI contribute to the coordination of SGBV interventions at the national, provincial and communal levels?	*The project has worked extensively with the Ministry of Human Rights, Social Affairs and Gender on this project. At the national level, there is a SGBV thematic group; it is through this group that we support the ministry in organizing meetings to discuss aspects of prevention, service-related challenges and also advocacy to ensure that quality services are available at all levels. level of structures. At this level, we discussed the need to develop, make available to partners some tools such as adapted national strategy, such as adapted or updated mapping of stakeholders and the analysis of other necessary texts. At the decentralized level, there is a structure of the Ministry of Human Rights of Social Affairs and Gender in each province and in each commune; so, we practiced at the province level. – BRAVI staff 1*
	BRAVI participates in capacity building and intervenes in the training of the population. BRAVI is our technical partner and intervenes in funding by relying on the field. For example, we have 200 couple actors of changes formed... We have reliable data to know which commune or hill is in danger in relation to the other and all this thanks to the data provided by BRAVI. – CDFC
	The BRAVI program provides tools such as the flow chart and protocols. It collects data and organizes meetings in which we analyze together to provide the necessary answers. – Ngozi SGBV focal point 1
What are ongoing challenges to providing SGBV care and what can be done to improve services?	*Arrived at the hospital or health center, you have to help by caring for free, protect against sexually transmitted diseases and girls unwanted pregnancies. It is necessary to follow the patient's file regularly and with great attention and to treat it with a lot of energy and love. – Survivor from Kiremba, age 30*
	Punishments must be increased to discourage the perpetrators of the violence so that everyone can see the exemplary nature and severity of the sanctions imposed on rapists and no longer have the slightest attempt to think about raping girls and the women. -Survivor from Mivo, age 12
	The challenges cannot be avoided because the Burundian tradition is there to impede us. For example, if a case of SGBV [is reported] too late after many days, we are not able to prevent sexually transmitted diseases and AIDS or unwanted pregnancies. Many victims prefer to shut up and come too late. It is true that the BRAVI program has trained and taught people, but it is also necessary to double efforts in training and teaching health workers, community health workers, leaders in the Imboneza community, and other women and men. men leaders. It is also necessary to ensure the participation and intervention of local chiefs by increasing field trips and hill meetings. – Ngozi medical director
	In case of SGBV, the problems we often encounter are related to tradition and customs as many families prefer to hide or manage amicably, others accept money because of poverty. To overcome these challenges, we have trained people, men and women leaders, community health workers (ABAREMESHAKIYAGO), and other leaders at the community level (IMBONEZA) and others as well as the various local administrative heads of the community. the base at the top. We organize meetings, awareness sessions and give advice to the community, we appreciate the results. – Ngozi SGBV focal point 1

For more information:
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