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**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 6

**Capacity Building to Prevent and
Respond to Gender-Based Violence:
Project Description and Evaluation of
RESPOND/Guinea**

Ashley Jackson, The RESPOND Project/EngenderHealth

October 2012

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Contents

Acknowledgments	v
Abbreviations and Acronyms	vii
Executive Summary	ix
Introduction	1
Background	1
Overview of the Package of Interventions	2
Methodology of the Evaluation	5
Objectives	5
Methods	5
Findings	9
Intervention 1: Immediate care for survivors of the September 28 GBV	9
Intervention 2: Provision of training and technical assistance to community-level committees to lead GBV prevention efforts	13
Intervention 3: Training of health care providers in the care of SV survivors	21
Supporting the capacity of local partners	27
Lessons Learned	29
References	33

Tables

Table 1. Summary of project activities	3
Table 2. Evaluation questions	5
Table 3. Characteristics of the GBV prevention activity participants interviewed	6
Table 4. Characteristics of the health care providers interviewed	7
Table 5. Self-reported steps taken toward gender norms transformation	19
Table 6. Self-reported examples of healthy conflict resolution	20
Table 7. Participants in SV training for health care providers	22
Table 8. Number (and %) of facilities offering services for various types of GBV	23
Table 9. Number (and %) of providers reporting various steps that they take when responding to rape	25
Table 10. Number and percentage of facilities offering various types of referrals.....	26
Table 11. Facilities with essential commodities and supplies consistently in stock over the past three months.....	26

Figures

Figure 1. Number of survivors served: planned and actual	10
Figure 2. Improvements in providers' knowledge of care of SV survivors	22

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Acronyms and Abbreviations

AGUIAS	Association Guinéenne des Assistantes Sociales
CEPAM	Cabinet d'Études de Promotion et d'Appui à la micro finance Guinée
CONAG-DCF	Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes
EC	emergency contraception
GBV	gender-based violence
GBVIMS	Gender-Based Violence Information Management System
HIV	human immunodeficiency virus
IPPF	International Planned Parenthood Federation
IRB	institutional review board
IRC	International Rescue Committee
MAP [®]	Men As Partners [®]
MOH	Ministry of Health
NGO	nongovernmental organization
PEP	postexposure prophylaxis
PTSD	posttraumatic stress disorder
SEED	supply–enabling environment–demand
SOP	standard operating procedure
STI	sexually transmitted infection
SV	sexual violence
TOT	training of trainers
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner on Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Guineans and international observers alike were shocked by the political violence, including brutal rapes, perpetrated on September 28, 2009, following a political demonstration in a stadium in Conakry. The response at the time of the incident was limited and underscored the urgent need for more and better-quality services throughout the country for survivors of sexual violence (SV) and other forms of gender-based violence (GBV).

The U.S. Agency for International Development (USAID) Guinea mission tasked The RESPOND Project with supporting follow-up services to women who had survived the September 28 violence, strengthening local capacity for GBV prevention, and improving the health sector's response to SV. RESPOND received \$823,000 in field support funding to cover one year of implementation. With a no-cost extension, activities spanned the 18 months from January 2011 to June 2012. The work was conducted in collaboration with the Ministry of Social Affairs and the Promotion of Women and Children and the Ministry of Health and Public Hygiene, as well as two local nongovernmental partners: the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes (CONAG-DCF) and the Association Guinéenne des Assistantes Sociales (AGUIAS). RESPOND's efforts built upon the work of the United Nations Population Fund (UNFPA) and other partners in Guinea.

Taking into consideration the project's short time frame and limited funds, RESPOND sought to build upon existing efforts, strengthen local capacity, and initiate or contribute to a process of change that extends beyond the duration of the project. Activities included:

- Immediate care for survivors of the September 28 GBV:
 - Assessing survivors' needs
 - Referring survivors for medical services, psychosocial care, and social and economic reintegration services
 - Covering the costs of referral services
- Provision of training and technical assistance to community-level committees to lead GBV prevention efforts
- The training of health care providers in the care of SV survivors

In April–May 2012, RESPOND collected endline data on the process, outputs, and short-term effects of the project through individual interviews and structured observations of community GBV prevention activities. Interviews were conducted with 149 stakeholders who contributed to or participated in the project, such as September 28 survivors, participants in GBV prevention activities, and health care providers.

The project vastly surpassed its benchmarks for the number of September 28 survivors whose needs were assessed and addressed, reflecting the enormous ongoing need for services following the violence. In total:

- The needs of 179 survivors were assessed (the goal was to reach 50).

- Eighty-seven received medical care related to the September 28 violence, such as sexually transmitted infection (STI) treatment, surgery for severe perineal tears, and treatment for uterine hemorrhage (the goal was to reach 20).
- Fifty survivors received psychosocial services from a psychiatrist (the goal was to reach 25).
- Social workers provided assistance to 153 survivors, to help them reconcile with family members who had rejected them after the incident (the goal was to reach 25).
- Sixty survivors received economic reintegration services, including trainings in business and vocational skills (the goal was to reach 25).

In endline interviews, September 28 survivors expressed great appreciation for the services they received. A number of survivors now earn an income with the business and vocational skills they learned through the project. However, some survivors had continuing medical, psychological, social, and economic needs that the project could not fully address during its brief duration.

To build local capacity to prevent GBV, RESPOND trained 10 CONAG-DCF trainers in the engagement of communities in challenging gender norms and GBV. The training materials built upon existing tools and approaches, including EngenderHealth’s Men As Partners® (MAP) resources, such as *Engaging Boys and Men in Gender Transformation: The Group Education Manual* (The ACQUIRE Project/EngenderHealth and Promundo, 2008). Trainers reported that the training they received helped strengthen their confidence and capacity to discuss topics that were previously taboo, make compelling arguments to prevent GBV, and lead the exercises that would be used in the committee trainings.

Local officials selected well-respected community members, men and women, to serve on GBV prevention committees, including religious leaders, youth leaders, and women’s group leaders. The 10 CONAG-DCF trainers then conducted two five-day trainings for 110 members of the 10 community-level GBV prevention committees.

Following the training, each GBV prevention committee conducted at least four GBV awareness-raising sessions per month, including sermons, community discussions, and dramas. They reached a total of 8,892 men and women over a four-month period. Interviews with CONAG-DCF trainers, committee members, local leaders, and participants showed that the training and activities were highly valued and perceived as having increased discussion and openness about GBV and gender norms. Committee members came to be seen as resources in their communities for GBV survivors and for others seeking advice and referrals.

To improve the health sector response to SV, RESPOND and the Ministry of Health (MOH) conducted five-day trainings in SV response for a total of 53 health care providers, surpassing the project’s objective to train 42 providers. The providers trained came from 21 public-sector facilities—eight in Conakry, seven in Labé, and six in Kissidougou—and were trained in two groups. Both groups of trainees made gains in knowledge of SV response: Posttest scores after both trainings were at least 15 percentage points higher than pretest scores. Most providers (88%) led debriefings for the staff at their facilities to share key parts of their training. Comparisons of baseline and endline facility audit data showed that the proportion of facilities with guidelines for addressing SV increased from 43% to 95% and that the use identification

codes to protect the confidentiality of survivors increased from 0% to 90%. After pilot-testing a curriculum on GBV services, RESPOND and the MOH revised it and the MOH validated it as their first national curriculum on the care of SV survivors. The MOH is seeking funding to scale up provider training with the curriculum.

Lessons learned by the project included identification of aspects that worked particularly well and suggestions for elements to improve or add to a longer project. Establishing and seeking guidance from a multisectoral steering committee cost very little and added much value by ensuring that activities met locally felt needs. This earned the project credibility in country, reinforced referral linkages between institutions represented by participants, and provided a forum for sharing knowledge, ideas, and tools across sectors. Another element of the project that worked especially well was the holistic approach to addressing the September 28 survivors' interlinking needs.

Among the suggestions for elements to improve or add to a longer project were:

- Link prevention and response activities more closely
- Ensure adequate time for building the capacity of health sector and community partners
- Build leveraging of local resources into the model of GBV prevention committees
- Update and disseminate the MOH protocol (Ministère de la Santé et de l'Hygiène Publique, 2009) on the care of SV survivors
- Prepare providers to offer survivors details on referral services
- Strengthen the supply chain for key products and supplies for the care of SV survivors

Introduction

Background

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

Rape and other forms of sexual violence (SV) are associated with significant reproductive health risks, including unwanted pregnancy and the transmission of HIV and other sexually transmitted infections (STIs). Results from a 2009 national survey in Guinea show that, depending on geographic region, between 13% and 52% of women aged 15–64 had been raped since the age of 15 (Ministère des Affaires Sociales, de la Promotion Féminine et de l'Enfance, 2009). SV is one type of gender-based violence (GBV), which is understood as interpersonal physical, sexual, or psychological violence resulting from normative gender roles and unequal power relationships based on sex. GBV is a pervasive problem worldwide. As in many countries in Africa, health, psychosocial, and protection systems in Guinea are stretched thin. While systems to respond to rape and other forms of GBV exist, survivors encounter access barriers, including cost, a referral system that is not yet fully coordinated, and limitations in service quality. Many organizations and service providers have noted that the events of September 28 underscored the urgent need for more and better quality GBV services throughout the country.

In October 2009, the U.S. Agency for International Development (USAID)/Guinea provided the RESPOND Project with \$823,000 in field support funds to partner with the Ministry of Social Affairs and the Promotion of Women and Children and the Ministry of Health and Public Hygiene (MOH) over a 12-month period to provide support and services to women survivors of the September 28 violence and to strengthen local capacity for GBV prevention in Conakry and improved health-sector response in three regions of Guinea (Conakry, Kissidougou, and Labé), building upon efforts by UNFPA and other partners. Project work began in January 2011, in collaboration with two local nongovernmental partners identified by RESPOND during an initial assessment: the Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes (CONAG-DCF) and the Association Guinéenne des Assistantes Sociales (AGUIAS). With a no-cost extension, project activities continued through June 2012, covering a total period of 18 months.

Overview of the Package of Interventions

At the onset of the project, RESPOND formed a multisectoral steering committee of stakeholders from key ministries and NGOs to oversee the project activities. RESPOND worked with the steering committee to identify a package of interventions informed by EngenderHealth's Supply–Enabling Environment–Demand (SEED) Programming Model™, with interventions in three areas: **supply**, to support delivery of quality services; the **enabling environment**, to facilitate the policy, program, and community environment and transform social and gender norms; and **demand**, to help individuals, families, and communities acquire increased knowledge and capacity to prevent GBV and to seek care, if necessary.

The project focused on three areas of intervention:

- Immediate care for survivors of the September 28 GBV:
 - Assessing survivors' needs
 - Referring survivors for medical services, psychosocial care, and social and economic reintegration services
 - Covering the costs of referral services
- Provision of training and technical assistance to community-level committees to lead GBV prevention efforts
- The training of health care providers in the care of SV survivors

The project's **supply**-side efforts included facilitating access to services for September 28 survivors and training health care providers. Work in the community to address GBV contributed to the **enabling environment** and **demand** for services. The formation of a steering committee was intended to further improve the **enabling environment** by connecting partners in a setting of knowledge-sharing and coordination.

Given the project's short time frame, RESPOND sought to contribute to changes that would continue after the project closed. RESPOND expected that connecting survivors with services and temporarily covering the costs of those services would facilitate their recovery and reintegration, but acknowledged that many of the survivors' needs could not be fully addressed through a one-year project. Training for GBV prevention committees and health care providers were selected as the first steps in longer processes of transforming gender norms and improving SV service quality. Table 1 summarizes the three interventions, which are described in more detail in the Findings section.

Table I. Summary of project activities

<p>Laying the Foundation</p> <ul style="list-style-type: none"> • Established a local steering committee • Developed standard operating procedures (SOPs) for work with survivors
<p>Intervention 1: Immediate Care for Survivors of the September 28 GBV</p> <ul style="list-style-type: none"> • Identified survivors • Assessed survivors' needs • Referred survivors to quality services and covered the cost of: <ul style="list-style-type: none"> ○ Medical care ○ Psychosocial care (counseling and medication from a psychiatrist) ○ Social reintegration services (home mediation assistance from social workers) ○ Economic reintegration services (training in business and vocational skills)
<p>Intervention 2: Provision of Training and Technical Assistance to Community-Level Committees to Lead GBV Prevention Efforts</p> <ul style="list-style-type: none"> • Developed the GBV prevention approach and curriculum • Trained trainers in GBV prevention • Formed GBV committees • Trained GBV committees • Conducted GBV prevention activities <ul style="list-style-type: none"> ○ Generated discussion about GBV ○ Served role of GBV resource people in the community
<p>Intervention 3: Training of Health Care Providers in the Care of SV Survivors</p> <ul style="list-style-type: none"> • Conducted a baseline assessment • Developed a curriculum for providers • Trained providers • Validated the curriculum for health care providers

Methodology of the Evaluation

Objectives

The end-of-project evaluation was conducted to document and assess the work that had been done under RESPOND in Guinea since January 2011 and to develop recommendations for improvement of the approach. The evaluation aimed to explain the project's process and answer the questions in Table 2.

Table 2. Evaluation questions

	Intervention	Question
1	Immediate care for survivors of the September 28 GBV	What needs of September 28 survivors did the project meet, and what needs was it unable to meet?
2	Provision of training and technical assistance to community-level committees to lead GBV prevention efforts	How has the project built capacity for GBV prevention in selected urban communities? What have the GBV prevention committees done to raise awareness about GBV?
3	Training of health care providers in the care of SV survivors	How has the capacity or readiness of health facilities to respond to SV changed since the start of the project?
	Overall	What lessons were learned?

The recommendations that emerged from the evaluation will be used to inform RESPOND's work in other countries where the approach may be replicated. Other organizations, too, should take the recommendations into account when implementing similar work.

Methods

In April–May 2012, a team¹ of RESPOND staff and consultants collected endline data on the process, outputs, and short-term effects of the project, through individual interviews and structured observations of community GBV prevention activities. Interviews were conducted with a wide range of stakeholders (n=149) who contributed to or participated in the project. An informed consent process preceded all interviews. EngenderHealth and the MOH both conducted ethical and technical reviews of the study protocol and tools and gave approval for their use. Approval by an Institutional Review Board (IRB) was not required.

Immediate care for survivors of the September 28 GBV

Semi-structured interviews were conducted with:

- The physician at Minière Medical Center, who received all of the survivors who were referred for medical care
- The psychiatrist at Donka Hospital, who received all of the survivors who were referred for psychological care
- Twenty of the 179 September 28 survivors who participated in the project.

¹ Data collection was conducted by Ashley Jackson (RESPOND), Binta Nabé (RESPOND/Guinea), Dr. Asmaou Diallo (CONAG-DCF), Dr. Camara Moussa Kantara (consultant), and Dr. Kadiatou Mama Diallo (consultant).

Selection of survivors was designed to include at least five survivors who received each type of assistance offered. Survivor interviews focused on whether and how the survivors benefitted from the project and how the project could be improved, not the survivors' experiences of GBV.

Provision of training and technical assistance to community-level committees to lead GBV prevention efforts

RESPOND conducted six structured observations of GBV prevention activities to supplement activity reports received through CONAG-DCF. In addition, semi-structured interviews were conducted with:

- Eight of 10 CONAG-DCF trainers who received training from RESPOND
- Eleven of 110 GBV prevention committee members who received training from CONAG-DCF
- Sixteen local leaders who attended GBV prevention activities
- Twenty other community members who attended GBV prevention activities

Interview participants were selected based on availability as well as several other factors:

- Committee members were selected based on their roles as leaders of committees.
- Local leaders were selected because they had been involved in the GBV prevention activities in some way and represented a mix of *Chefs de Quartiers* (Heads of Neighborhoods), women's leaders, religious leaders, *Chefs de Secteurs* (Heads of Zones), and youth leaders.
- For interviews with community members attending GBV prevention activities, the project sought to include a mix of individuals of different ages and sexes (see Table 3).

Table 3. Characteristics of the GBV prevention activity participants interviewed

Age-group (estimated by interviewer)	No. of women	No. of men
15–19	1	0
20–29	2	1
30–49	5	4
≥50	0	7
Total	8	12

Training of health care providers in the care of SV survivors

The project conducted semi-structured interviews with facility managers and health care providers at baseline (June 2011) and endline (April–May 2012). Baseline interviews took place at 21 facilities in three regions, selected based on their large catchment populations:

- *Conakry*: National Hospitals of Ignace Deen and Donka, Jean Paul II Hospital, and communal health centers of Ratoma, Minière, Yimbayah, Coleah, and Matam
- *Kissidougou*: District Hospital and its five satellite urban health centers
- *Labé*: Regional Hospital and its six satellite urban health centers

The facility manager at each facility participated in an interview and identified the provider(s) at the facility who were most likely to treat survivors of SV; interviews were conducted with those providers as well. In total, 120 providers were interviewed at baseline. Among these, 53 received training through the project.

At endline, the data collectors returned to the same facilities and interviewed 20 of the 21 facility managers. (The remaining facility manager was unavailable.) The data collectors sought interviews with the 53 providers who had completed training through RESPOND. Many of these providers were unavailable or had been transferred to different facilities. In all, 34 providers who had participated in the training were interviewed. Table 4 summarizes the characteristics of providers interviewed at baseline and endline. The two groups are similar, but not identical. Therefore, while differences between provider answers at baseline and endline are suggestive of effects of the project, it is important to note that they could be due to other factors.

Table 4. Characteristics of the health care providers interviewed

		Baseline (n=120)	Endline (n=34)
Sex	Female	74%	79%
	Male	26%	21%
Region	Conakry	51%	44%
	Labé	33%	35%
	Kissidougou	16%	21%
Professional Cadre	Doctor	31%	29%
	Nurse	8%	3%
	Midwife	23%	26%
	Health technician	36%	38%
	Other	2%	3%

In addition, interviews were conducted with:

- Two physicians at Conakry hospitals (Donka Hospital and Minière Medical Center) who conducted the baseline evaluation and facilitated the training of health care providers
- A national-level reproductive health trainer for the MOH

Data collection on the project as a whole

In addition to the data collection described above, semi-structured interviews were conducted with:

- Five of the eight members of the project’s local steering committee, selected based on their high level of involvement in the project. The five members represented:
 - CONAG-DCF
 - AGUIAS
 - MOH
 - Ministry of Social Affairs and the Promotion of Women and Children
 - Ministry of Security and Civil Protection

- Five additional CONAG-DCF staff and volunteers, including the Medical Officer for the project, the project supervisor, the accountant, and two social workers who accompanied survivors to the hospitals to which they were referred
- Five additional AGUIAS staff and volunteers, including the accountant, three social workers who conducted home mediation visits for survivors, and the social workers' supervisor
- Four EngenderHealth/Guinea staff members

Intervention I: Immediate Care for Survivors of the September 28 GBV

Identifying survivors

To invite survivors to participate in the project, CONAG-DCF social workers contacted the survivors whom they had previously identified in the aftermath of September 28. Support groups for September 28 survivors, AGUIAS, and other local NGOs that had worked with September 28 survivors put GBV survivors in contact with CONAG-DCF, to allow them to participate in the project as well. Furthermore, many of the survivors who received services from the project referred others who had been at the stadium with them on September 28. Some of those who were hesitant at first joined the project once they heard from other survivors that the staff and providers could be trusted. All 20 of the survivors interviewed approved of the means CONAG-DCF used to reach out to them.

Assessing survivors' needs

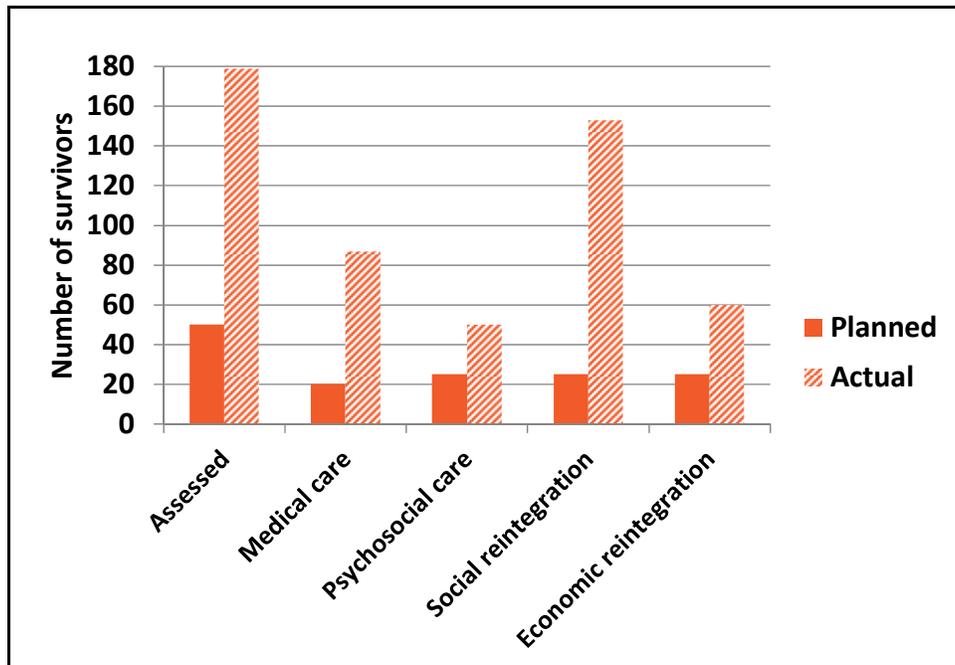
The Medical Officer conducted intake interviews with a total of 179 September 28 survivors to assess their needs and make referrals for services that the project would cover. Using the local languages of survivors, she explained all of the steps of the project, including measures to protect their rights and confidentiality. In addition, she offered that CONAG-DCF social workers would accompany survivors on referral visits. Social workers assisted with navigation through the hospital system to ensure that survivors' visits went smoothly.

With technical assistance from the International Rescue Committee (IRC), RESPOND trained the CONAG-DCF Medical Officer to use the state-of-the-art Gender-Based Violence Information Management System (GBVIMS) to record data about the September 28 survivors served. The system included a database, informed consent forms, and referral forms that are designed to protect survivors' informed and voluntary decision making and improve data quality. The GBVIMS was developed by the IRC, in collaboration with UNFPA, the United Nations High Commissioner on Refugees, and the United Nations Children's Fund (see www.gbvims.org for more information about this system).

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

The project vastly surpassed its objectives for the number of September 28 survivors whose needs were assessed and addressed, reflecting the enormous ongoing need for services following the September 28 violence. Figure 1 (page 10) presents the numbers of survivors the project planned to serve, alongside the numbers actually served.

Figure 1. Number of survivors served: planned and actual



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

Providing medical care

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

Among other tests and treatments, medical care included:

- All 87 survivors referred for medical care received a gynecological examination and voluntary counseling and testing for HIV.
- Eighty-one survivors (93%) received blood tests for other STIs, including hepatitis B.
- Eighty-one (93%) received treatment for STIs.
- Thirty-four (39%) received tests for cervical cancer.
- Fifteen (17%) received X-rays.
- Four received pelvic ultrasounds.
- Three received surgery for severe perineal tears.
- One was identified as HIV-positive and began treatment, provided for free by the government.

- One received treatment for vaginal fibrosis.
- One received treatment for uterine hemorrhage and anemia.

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

One survivor who was raped on September 28 had lesions that made it very painful to have sexual intercourse. This had put a strain on her relationship with her husband, and the two had separated. After receiving treatment through RESPOND, she was able to have pain-free intercourse again and reconciled with her husband. Near the end of the project, she happily reported to the Medical Officer that she was pregnant.

Providing psychosocial care

Psychosocial care included therapy with a female psychiatrist who has training and experience working with GBV survivors. Of the 50 survivors who saw the psychiatrist as a result of referral by RESPOND, all received a diagnosis and therapy. Of the 50, 49 (98%) received antidepressants or pain medication.

Several survivors expressed deep gratitude for the psychosocial care they received. A mother who received therapy and antidepressants from the psychiatrist said: “I wish to thank the project and tell the providers of the project that they changed our lives after that violence, because I even wanted to commit suicide after what happened to me, but it's they who gave me the courage to continue to live.”

The short time frame of the project posed a challenge to providing adequate psychosocial care, which often necessitates longer-term treatment. The psychiatrist reported that, while survivors showed improvement in their mental health, the duration of the project was too short to complete care for many conditions, such as posttraumatic stress disorder (PTSD). One survivor echoed the same idea, saying, “I continue to worry that what happened to me will happen again and I have nightmares.”

Providing social reintegration services

Many of the September 28 survivors had been rejected by family members after the violence, and some were blamed for the violence they experienced by husbands or parents, who felt that they had put themselves in harm's way by attending the political protest or by leaving the house without permission.

Through AGUIAS, 153 survivors requested and received home visits by trained social workers for mediation with family members. The most common type of mediation was counseling between the survivor and her husband and in-laws. Also common were mediations between the survivor and her parents or children. In a few cases, survivors received mediations with siblings. Social workers explained that the survivor had the right to show her support for opposition candidates and that the armed forces had no right to rape her. AGUIAS reported

that almost all home visits succeeded in reconciling survivors with family members, although sometimes only after repeated mediation sessions.

Social workers provided moral support to survivors before, during, and after mediation meetings. In some cases, survivors had been in very poor living conditions since having been rejected by their families. Social workers bought soap for these survivors so that they could wash themselves before going to see their families for mediation. A survivor who received psychosocial support from the psychiatrist and AGUIAS social workers said: “The project staff comforted and respected us all along the way. I always felt looked after by the staff. They gave us advice that allowed us to move forward and to overcome our sorrows, but especially to overcome our fear.”

Providing economic reintegration services

As a result of stigma, shame, and medical and psychological trauma, many survivors lost their jobs or livelihoods after September 28, and at least one dropped out of university. RESPOND sought to help these survivors build skills to provide for themselves and their families.

RESPOND aimed to provide economic reintegration services to 25 survivors, but found that the need for these services was much higher than anticipated. Services were given to 60 survivors on a first-come, first-served basis. More than 100 survivors who requested these services did not have the opportunity to receive them because of funding constraints.

- Twenty-five survivors participated in entrepreneurship training by the NGO PRIDE Finance, which covered business skills and basic financial management tools.
- Thirty-five survivors participated in a similar training from Cabinet d’Etudes de Promotion et d’Appui à la Micro finance Guinée (CEPAM)
- The same 60 survivors who received training from PRIDE and CEPAM participated in vocational skills training by the NGO SOS Vocational Training Center in:
 - Soap-making (38 women)
 - Dyeing cloth (nine women)
 - Food processing/preservation (13 women)

Four of the 20 survivors who were interviewed in depth listed the business skills training as the aspect of the project that they most appreciated. One said, “This project brought a positive change because we learned during the training to manage our money so as not to find ourselves bankrupt.”

The vocational skills training was popular as well, with six of the 20 survivors interviewed naming it the aspect of the project that they most appreciated. Several survivors reported that they now earn a living by using the vocational skills they learned. “I am now independent with the income that it yields me,” said one survivor, who now makes and sells soap. Another reported, “I currently practice dyeing when I have an order. I think I will be able to expand this business, because my work is well appreciated by my clients. This will allow me to work and earn a living.” Others said that they use the skills they learned to make soap and preserve foods for their families to use. A survivor who participated in business skills training and training on soap-making said: “I often make soap that I sell in the market. It earns money, thanks to which I manage to provide for the needs of my children.”

At the end of the training on soap-making, a group of 20 survivors pooled their resources to buy the materials they needed to make soap. They now regularly meet to make soap together and divide it between themselves to sell. They put a portion of their earnings back into buying materials to share.

One of the survivors in the soap-making group said, “The aspect of the project that I appreciated the most was the fact that I could meet other victims who have the same problems as me. We were able to form a group that is really united, and it is thanks to the project that we were brought together.” Another member reported, “We came together like a family. We always help and support each other.”

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

Following the SOPs

At the outset of the project, RESPOND developed project-specific SOPs for working with GBV survivors. The SOPs presented internationally recognized guiding principles for working with GBV survivors (IASC, 2005), outlined RESPOND’s referral pathways and specified how RESPOND would obtain informed consent for referrals and maintain survivors’ confidentiality. The SOPs were accompanied by a Code of Conduct that was signed by all RESPOND staff and partners before they interacted with GBV survivors under the auspices of the project.

Survivor interviews indicated that the project staff, partners, and referral providers followed the SOPs throughout the project. All 20 interviewed survivors reported that project staff and referral providers treated them with respect. Five specifically expressed their appreciation for the project’s use of confidential identification codes. One survivor said, “Since I was contacted for this project, the staff and the providers of the project treated us well. They always supported and encouraged us to move forward, by listening to us and comforting us.” All of the survivors interviewed said they had a positive experience with the project and would recommend it to a friend.

Intervention 2: Provision of Training and Technical Assistance to Community-Level Committees to Lead GBV Prevention Efforts

Developing a GBV prevention approach and curriculum

To engage communities in preventing GBV in Conakry, RESPOND adapted the successful “comité villageois” (village committee) approach of the Fistula Care project in Guinea. In rural areas where Fistula Care works, village committee members are chosen by local leaders. The committees facilitate community discussions on reproductive health, including fistula.

RESPOND modified the committee approach to focus on gender norms and GBV rather than reproductive health broadly. In addition, the project relabeled the committees as “comités

de quartier” (neighborhood committees), because RESPOND’s GBV prevention work took place in the urban setting of Conakry, rather than in villages.

EngenderHealth technical advisors in gender and MAP[®] and in community engagement developed training materials for RESPOND/Guinea by adapting and building upon existing tools. The training was designed to guide participants in exploring key concepts, attitudes, and values related to gender norms and gender equality; defining GBV; and developing action plans to address GBV in their communities. The first two days of the five-day training used activities and approaches from EngenderHealth’s MAP[®] resources and focused on exploring key concepts and norms related to gender equality and GBV. The second two days of the training focused on the external community environment and guided participants in prioritizing problems related to GBV in their own communities, mapping existing resources and support in their communities, and developing community action plans for addressing prioritized problems. Other sessions of the training focused on monitoring and evaluation, developing gender-equitable messages, responding to opposing views, and defining roles and procedures for working effectively as committees. Furthermore, RESPOND invited a legal expert to brief the participants on the parts of the civil and penal code that most apply to GBV and gender equality.

Training trainers in GBV prevention

RESPOND conducted a one-week training of trainers (TOT) for 10 CONAG-DCF trainers (five men and five women) who later led the trainings for GBV prevention committees. EngenderHealth’s technical advisor for gender and MAP[®] served as the lead training facilitator for the TOT, with co-facilitation from two EngenderHealth/Guinea staff. The TOT participants were CONAG-DCF staff and volunteers who had previous experience as trainers in related areas, such as women’s rights and legal aid for GBV survivors. For all eight of the trainers interviewed, RESPOND gave them their first training specifically focused on GBV prevention.

Through the TOT, trainers said that they built the capacity to discuss topics that were previously taboo, to make compelling arguments to prevent GBV, and to lead the exercises that would be used in the committee trainings. “During the training, we learned how to talk about sex,” said one female trainer. A male trainer reported, “The training from RESPOND allowed us to distinguish the true difference between gender and sex. We wrote out characteristics of men and women and then underlined all that are biological. We saw that all other characteristics of men were from customs, not birth. We realized that all of those aspects of man’s role, a woman could do.” He added that the facilitator “didn’t tell us the answers. He got us to generate them.” Trainers replicated this approach when later training committee members under supervision by RESPOND.

“Domestic violence is common, but we couldn’t talk about it before. We were ashamed to mention it to our friends. We were in silence.”

—A female CONAG-DCF trainer

All eight trainers interviewed expressed high praise for the training, although they also felt that a longer training would have been even more beneficial. A male trainer explained,

“There is more you could add to our training. I would have liked more arguments to respond to men who say that they earn money, so they should set the rules in their house.”

Forming GBV prevention committees

Through the project, local community officials established 10 GBV prevention committees in two neighborhoods of Conakry—five in Ratoma Commune and five in Matoto Commune. Each committee represented one neighborhood. The commune mayors selected neighborhoods based on their judgment that those neighborhoods are at high risk for GBV. The 10 neighborhoods selected represented 15% of the population of Conakry.

Mayors of the two communes asked the Chefs de Quartiers to select 11 members for each committee, for a total of 110 committee members. The selection criteria emphasized that the committee members should be respected role models in their communities who are also good public speakers in the local languages. Each committee included representatives of religious organizations, women’s groups, and youth groups. Committee members were volunteers who received a small amount of money to cover their transportation to events.

Involving local leaders in the process increased the acceptability of the committees and encouraged local ownership. All of the 16 local leaders who were interviewed approved of the process for selecting committee members. A Chef de Quartier explained, “The process was good because the members of the committee weren’t imposed, but they were chosen by the community itself.” An imam reported, “It’s the first time that anyone has asked us to represent ourselves on such a committee. It’s a very good thing that we welcome at the mosque.”

“The process is good because we were involved very early. So we are really responsible for it. It’s our activity. It’s not only EngenderHealth. It’s for us.”

—A Chef de Quartier

Training GBV prevention committees

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

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

Conducting GBV prevention activities

Each of the 10 committees conducted at least four awareness-raising sessions per month. In the four months between December 2011 and March 2012, they had reached 8,892 participants (3,564 men and 5,328 women). During awareness-raising sessions, committee members engaged community members in participatory discussions of gender roles, women's rights, the causes and consequences of GBV, and the need to end impunity for GBV perpetrators. Often, committee members shared information about where to seek help after a GBV incident. Some committees chose to focus on a different theme or topic during each session, such as forced marriage or the relationship between substance abuse and GBV.

Awareness-raising sessions took place in public places, neighborhoods, and secondary schools. Committees decided which types of events would be the most effective in their communities. Some sessions included theater performed by committee members. Other sessions involved traditional singers and dancers who volunteered to help draw a crowd. Some committees preferred to address large groups in marketplaces, while others gathered smaller groups in courtyards. Each committee had at least one religious leader (a Muslim imam or a Christian pastor) who delivered messages about GBV during weekly sermons.

Committee members reported that they encouraged participants to share their views and ask questions during sessions. One committee member explained, "We ask people to raise their hand if they agree with a statement about consent, for example, to focus on changing the minds of those with doubts." At the end of the session, they asked participants to raise their hands again, to see if their opinions had changed.



Albertine Louise Soumah (center), a committee member in Matoto Commune, addressed participants during an awareness-raising session in a neighborhood courtyard.

Photo: A. Jackson/EngenderHealth

CONAG-DCF trainers conducted regular follow-up with the committees they had trained and attended all of the sessions planned by these committees. When participants asked challenging questions that committee members struggled to address, trainers would step in and respond. At the conclusion of each session, committee members completed monitoring forms and wrote a short narrative report. The trainers collected these documents and submitted them to their supervisor at CONAG-DCF.

CONAG-DCF staff and committee members reported that Chefs de Quartiers provided strong support to the committees. In addition to selecting committee members, they mobilized people to attend activities organized by the committees, and they personally attended and contributed to the discussions during these sessions. They signed and stamped the committees' monitoring forms. In some cases, they helped plan sessions and identify venues. When possible, Chefs de Quartiers provided financial support for the rental of chairs, tents, and sound systems and for the purchase of water and juice for special guests. When schools and heads of households hosted awareness-raising sessions, they often provided chairs, water, and juice for free.

However, not all committees succeeded in leveraging local resources in these ways. Many committee members felt that they were unable to carry out some of the activities in their action plans—such as soccer tournaments with messages about GBV—due to a lack of resources.

Committee members found their activities to be very popular. Participants often came to thank them and told them how the session had affected them. “Even wise men and imams have encouraged us,” said one committee member. “They told us that they learned things from us that they didn’t know before.” Many reported that heads of families in their communities invited them to lead sessions in their neighborhoods.

When they first heard about the initiative, five of 16 local leaders said that they doubted that the committees would be effective. One Chef de Quartier said, “I confess that when I had the team before me for the first time, I said it's a flash in the pan.... But when I saw the committee members at work, I realized that it's a good action and I was really motivated to involve myself.” Another Chef de Quartier explained that he was not very sure about the committee, “but truly today, I thank God, because this committee is the pride of the neighborhood. The members are sought everywhere in the neighborhood to respond to questions.”

At the end of the project, all 16 of the local leaders interviewed perceived the committees as effective. All 16 recommended scaling up the GBV prevention approach. Half of them specified that committees should be created across the country, not just in Conakry. Four added that the duration of support from RESPOND should be extended to ensure that lasting change occurs. Four suggested creating committees in schools, and four recommended using the radio to reach a wider audience.

Interviews and observations suggested that the messages of the GBV prevention committees were largely consistent with those that the project intended to spread. However, a discussion with two committee members highlighted the challenges that some committee members may have had in internalizing and communicating equitable gender norms. In describing changes he had observed in his community, one committee member commented that “girls are now

ashamed to dress vulgarly before us.” He said that he himself warns schoolgirls to “avoid rape by dressing in a way to cover up.” Another member of the same committee countered this highly inequitable view by adding, “But we tell them: Even if she’s walking naked down the street, you don’t have the right to touch her against her will.” The exchange highlighted the complexity of the challenge of changing attitudes and the fact that more training and follow-up support may be needed to enable the committees to send unequivocal messages about GBV. Changing deeply entrenched attitudes around gender and GBV requires a significant investment of time.

Generating discussion about GBV

In its short time frame, the project sought to initiate the first steps of a longer process to prevent GBV. Therefore, RESPOND did not seek to measure change in social norms and in the incidence of GBV in the focus communities. Instead, information was gathered about how the intervention was perceived by those directly involved with it.

In interviews, the majority (11 out of 16) of the local leaders interviewed commented that the project had generated discussion about a previously taboo subject, and they saw this as the beginning of change. For example, they said:

- “It is difficult to clearly observe changes, but what is important is that people are talking about it. I believe that this is the start of change.”
- “Yes, now the taboo about discussing violence, and especially rape and sexual harassment, has been broken.”
- “Everywhere people are talking about violence, and there are people who have changed their behaviors, even me.”
- “Women talk about it in ceremonies, in meetings, and they explain their problems or opinions. This is very important.”

Of the community members who were interviewed after awareness-raising activities, all 20 reported that they plan to share the messages of the activity with others.

A number of key informants—including CONAG-DCF trainers, committee members, local leaders, and community members who attended GBV prevention activities—reported that their own attitudes and behaviors had changed considerably as a result of the project. Although such self-reported changes are difficult to verify and may not be sustained over time, numerous respondents described how the project activities had made them reflect critically on their own attitudes and behaviors and to make changes in their personal relationships. Tables 5 and 6 present examples of the major types of changes reported by those interviewed.

Table 5. Self-reported steps taken toward gender norms transformation

Role of those reporting changes	Examples
CONAG-DCF trainers	<p>Half of the male trainers reported that they now carry out household chores that they previously saw as solely the responsibility of their wives. For example, one trainer said that after the TOT, he washed his infant daughter for the first time. He continues to care for his daughter and has found that she shows him much more affection now. Another said, “Before, I acted like a king in my house, waiting to be served. Now when I get home, I don’t wait for my wife to serve me. I serve myself.” The men said they found it rewarding to make these changes, and they reported that their wives were very appreciative.</p> <p>A female CONAG-DCF trainer who had dropped out of school in her adolescence due to forced marriage said, “After the training, I understood that pressuring a woman to do something she doesn’t want to do is a form of violence. It allowed me to emancipate myself. Things I accepted before, I didn’t accept after.”</p>
Committee members	<p>A number of male committee members professed that they changed the way they think about the balance of power in the household and society. Some changes were small: For example, a man in his 50s stated, “Today, my wife asked me to shave coconuts while she went to the market. I did it. I wouldn’t have done it before the training.” Others were larger: One committee member had recently separated from his wife because she had disobeyed him. At the end of the training, he asked his fellow committee members—including representatives of youth and women’s groups—to accompany him to visit his family-in-law, apologize, and invite his wife to return.</p>
Local leaders	<p>All 16 of the local leaders interviewed reported that their own attitudes had changed as a result of the project. One leader said that he previously thought he knew all about violence and its consequences, but he realized through an awareness-raising session that forced marriage is also a form of GBV. He expressed regret that he had forced two of his daughters to marry without their consent.</p>
Community members participating in activities	<p>All 20 community members interviewed reported that, as a result of the activity, they intend to make changes in their lives. Their planned changes included prioritizing the education of their daughters, teaching their children to respect the rights of women and girls, seeking consent before sexual relations, and intervening when they see GBV or drug use. A male participant between ages 30 and 49 said, “I didn’t know that forcing your wife or girlfriend was an act of rape. Today when I go home, I will ask my wife for forgiveness.” A female participant in her 20s reported, “I was raped one day by a man who surprised me in my bedroom. He was a member of my family. Afterward, I had infections. I am going to tell this to my husband, so that we can go together to the hospital to be tested.”</p>

Table 6. Self-reported examples of healthy conflict resolution

Role of those reporting changes	Examples
CONAG-DCF trainers	<p>The majority of trainers, including both men and women, described how the training module on healthy relationships and conflict resolution had caused them to reflect on and make changes in their own relationships. In interviews, they told stories about how they have thought back to the training during arguments with their spouses and how it has helped them calm down and find a constructive solution. In one case, a trainer admitted to previously committing GBV and reported that he had stopped as a result of the training. He asserted, “My girlfriend saw a change. I no longer hit her. I became different, completely changed. Now I make concessions to my girlfriend. I don’t force her to do things she doesn’t want to do anymore.”</p> <p>In addition, several trainers said they use the skills they learned to resolve conflicts they witness between couples who are their friends or neighbors.</p>
Committee members	<p>Male and female committee members alike told the interviewer stories about how they have used the anger management and conflict resolution techniques they learned in the training. They also share these techniques with others in their lives. A female committee member, who said she has fewer disputes with her husband now, said, “When I see around me couples fighting, I succeed in advising them.” A male committee member said, “The training taught me to treat [my wife] as an equal. My wife didn’t used to talk with me. Now we talk about problems together and solve them. I have nine children. They learn from my example.”</p>
Local leaders	<p>Seven of the 16 local leaders also reported that they have changed their own behaviors at home. For example, one said, “My point of view changed a lot, starting with my family. I used to yell a lot at the members of my family, especially my two wives, to blame them for things needlessly. Now I have a dialogue with them; there is understanding between us. Truly, it is good.” In addition, a Chef de Quartier explained, “My perspective has changed a lot, because I used to resolve disputes by finding mutual agreement rather than using the law. Now it's the law that I apply, and I refer cases that I cannot resolve.”</p>
Community members participating in activities	<p>A male participant over age 50 reported, “I used to yell and insult, but today I understood that that is a form of violence that is psychological. I won’t do it any more to my wife, or even to other people.”</p>

Serving the ongoing role of GBV resource people in the community

Many committee members said they also now speak out against violence and, when appropriate, intervene when they see or hear couples, such as friends, neighbors, and even strangers in a café, fighting. A committee chairwoman stated, “When I see neighbors hit their wives and make them do all of the work, I tell the husband, ‘Your wife isn’t your slave. A husband can do that work too.’ They appreciate it. A man told me he was about to hit his wife because she didn’t heat the water, but he remembered what I had told him and he stopped. He realized he can heat his own water.” A male committee member said: “It’s our mission to fight GBV. Any time, any place. If I see GBV, I intervene.”

Many committee members came to be seen by as resource people for GBV survivors in their communities. The 11 committee members interviewed gave five examples of times when GBV survivors have come to them for help since the project began. They directed rape survivors, including a 4-year-old girl who was accompanied by her grandfather, to health centers first to receive prophylaxis and urgent medical care. After a girl brought a case of repeated sexual harassment to the committee members, they helped her take it to the Chef de Quartier and the

police. A local women's group leader reported that she learned through the committee where to go if she were to experience GBV. She sees the committee as a valuable community resource for referrals. Committee members expect that survivors will continue to come to them for assistance after the end of the project. They affirmed that, even without funding, they will continue to help survivors by referring them to services.

Intervention 3: Training of Health Care Providers in the Care of SV Survivors

Conducting a baseline assessment

As described in the Methodology section above, RESPOND conducted a baseline assessment of health facilities' readiness to respond to SV. The objectives of the assessment were to inform the SV curriculum for providers and to serve as a baseline for evaluation purposes. French and English versions of the assessment report are available. Electronic and print copies of the report were disseminated to partners. In addition, the findings were presented at a meeting of the Interagency Gender Working Group in Washington, D.C., in March 2012.

Developing a curriculum for providers

RESPOND developed a curriculum on SV for health care providers. The curriculum aimed to strengthen providers' knowledge, attitudes, and skills related to the provision of quality services to SV survivors. An international consultant worked closely with RESPOND staff in New York and Guinea, as well as with local SV experts and a representative of the MOH. The team reviewed, adapted, and built upon existing training materials on SV and GBV, including materials developed by the Family Violence Prevention Fund, the IRC, the International Planned Parenthood Federation (IPPF), UNFPA, USAID, and the WHO. They produced three products:

- Training modules
- A facilitator guide
- A participant guide

The five-day training covered:

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

Training providers

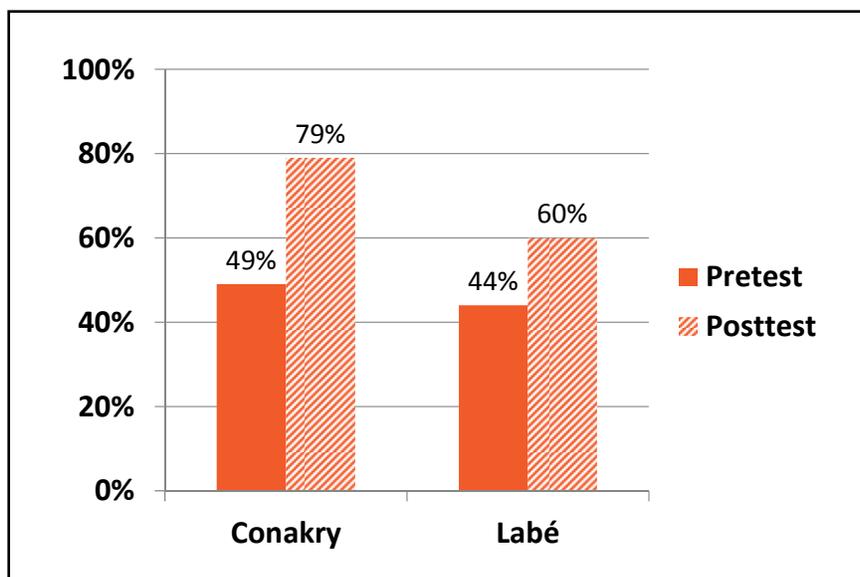
RESPOND conducted two five-day trainings of health care providers. The first training took place in Conakry for 27 providers based in the capital. The second training took place in Labé and brought together 26 providers who work in Labé and Kissidougou. The total number of providers trained (53) surpassed RESPOND's objective to train 42 providers. The providers trained came from 21 facilities: eight in Conakry, seven in Labé, and six in Kissidougou. Table 7 presents the breakdown of providers trained by sex, region, and professional cadre.

Table 7. Participants in SV training for health care providers

		Number	Total
Sex	Female	44	53
	Male	9	
Region	Conakry	27	53
	Labé	14	
	Kissidougou	12	
Professional Cadre	Doctor	14	53
	Nurse	3	
	Midwife	15	
	Health technician	21	

Participants demonstrated measurable improvements in their knowledge of the care of SV survivors from their pretraining to posttraining tests. Some of the largest gains were made in the percentage of providers who knew the duration of the windows in which they should offer emergency contraception (EC) and postexposure prophylaxis against HIV (PEP). Before the training, 19 of 48 providers (40%) knew the window period for PEP. After it, 40 providers (83%) did. The number who knew the window period for EC increased from three (6%) to 35 (73%) of the 48 providers who took both tests. In contrast, there were no gains on one question, which asked about the types of violence that were considered GBV. At both baseline and endline, only 58% of providers answered this question correctly. This finding suggests that the training may not have been as effective as had been hoped in increasing providers' understanding of the concept of GBV. Changes in knowledge from pretest to posttest are summarized in Figure 2.

Figure 2. Improvements in providers' knowledge of care of SV survivors



At both baseline and endline, only 58% of providers answered this question correctly. This finding suggests that the training may not have been as effective as had been hoped in increasing providers' understanding of the concept of GBV. Changes in knowledge from pretest to posttest are summarized in Figure 2.

Training participants also provided feedback on the training itself, using Likert scales to rate different aspects of the training (on a scale of 1 to 5, 1 indicated strong disagreement and 5 indicated strong agreement). The lowest average rating (3.8) was for the statement: “Five days of training were sufficient to learn how to offer quality services to survivors of sexual violence.” The statement with the highest average rating (4.9) was: “I will put into practice what I learned in this training.” All of the other statements received ratings above 4.4. In addition, participants rated the quality of each training session on a scale of 1 (minimum) to 5 (maximum). All sessions received a rating of at least 4.4.



Health care providers in Labé developing an action plan during the training.

Photo: B. Nabé/EngenderHealth

Increasing providers’ readiness to respond to SV

Four months after the provider trainings took place, RESPOND conducted supervision visits and endline interviews with providers who received training and with their facility managers. A comparison of baseline and endline interviews shows a number of results.

Lessons shared

After the training, 30 of 34 providers (88%) conducted a debriefing session to orient the staff at their facility on the key aspects of care of SV survivors, such as confidentiality protocols.

Services offered

The number of facilities with a program to respond to SV increased from seven to 20. At baseline, fewer than half of the 21 facilities had at least one provider specifically trained to respond to SV. At endline, all of them did. Table 8 shows increases in the percentages of facilities that offer services to respond to different types of GBV.

Table 8. Number (and %) of facilities offering services for various types of GBV

Type of GBV services	No. (and %) of facilities	
	Before (n=21)	After (n=20)
Rape	16 (76%)	20 (100%)
Other forms of sexual assault	16 (76%)	15 (75%)
Gender-based physical assault	17 (81%)	20 (100%)
Forced marriage	1 (5%)	8 (40%)
Other (e.g., denial of resources, psychological abuse)	0	9 (45%)
No services for GBV survivors	4 (19%)	0

Attitudes remained supportive

To gauge providers' attitudes about SV, the interviewers asked them three questions:

- a) "In your opinion, are there situations in which a person deserves to experience GBV?"
- b) "Imagine that a woman comes to this health center and says she was raped but doesn't want to tell anyone other than you, her medical provider, what happened. However, in private, her husband asks you what happened. In your opinion, should you tell her husband that she was raped?"
- c) "If a man has sex with a woman who says 'no' but does not put up physical resistance, has he committed rape?"

At both baseline and endline, at least 90% of providers gave answers indicating attitudes that are supportive of SV survivors.

Guidelines for care of SV survivors made available

At baseline, nine of 21 facility managers (43%) said they had written guidelines outlining how providers should care for SV survivors. At endline, 19 of 20 (95%) said they did. At baseline, only one of 120 (1%) providers showed the interviewers a protocol (the national guidelines) for how to respond to SV. At endline, 34 of 34 (100%) showed the interviewers the guidelines for SV care in the RESPOND training materials. As a next step, it would be ideal for facilities to adopt and use the national guidelines for SV care.

Identification codes used

Before the training, none of the 21 facility managers said they used identification codes for SV survivors. After the training, 18 of 20 facility managers (90%) interviewed said they now use identification codes, and all 18 were able to describe the coding system.

Understanding of GBV shifted

Half of the providers interviewed at baseline (51%) said that they knew the term "gender-based violence." By the end of the project, 100% of providers said that they knew the meaning of the term. Data collectors asked these providers what the term means to them. At endline, seven of 34 (21%) providers offered the internationally recognized definition given during the training, while none of the 120 providers interviewed at baseline gave this definition. Other definitions offered at baseline and endline captured similar concepts, such as "sexual violence" and "violence against women." While the percentage who defined GBV accurately increased somewhat, the gains were not as large as expected. This suggests that the training could have done more to deepen providers' understanding of GBV.

At baseline, 35 of 120 providers (29%) said their knowledge of Guinea's laws on GBV was good or very good. At endline, 22 of 34 (65%) said this knowledge was good or very good.

Steps of care mastered

Before the training, only six of 21 (29%) facility managers felt that providers at their facility had the necessary knowledge and skills to provide adequate care to SV survivors. After the training, this figure rose to 20 of 20 (100%).

Providers were asked to describe, step-by-step, what they would do if a client who had just been raped arrived at the facility. They were allowed to use any job aids they would normally use. The interviewers did not prompt the providers with answers; they simply recorded the steps that the providers spontaneously mentioned.

It is important to note that such unprompted recall questions are challenging for respondents, and providers' responses may not be wholly consistent with how they would actually manage a case. In addition, as explained in the Methodology section, the groups of providers interviewed before and after the training were not identical. While differences between providers' answers at baseline and endline may suggest potential effects of the project, it is important to note that such changes could be due to other factors.

With these caveats in mind, the data suggest that a far greater percentage of providers were able to recall the steps of care four months after the training than before it. The largest gain was in the percentage of providers who said they would comfort the client; this figure rose from 26% to 91%. The next largest increase was in the percentage who would offer PEP: While at baseline only 11% of providers said that they would offer it, 65% said at endline that they would do so. Very large gains were also made in the percentages who would treat STIs, administer vaccines, offer EC, and refer the client for other services. The percentage who would assure the client of his/her confidentiality doubled, from 29% to 65%. Gains were the smallest for the steps of informing the client of her legal right to press charges against the perpetrator and for asking whether children in the family are at risk of violence (in cases of domestic violence); both increased from zero to 6% of providers. Table 9 presents changes in the providers' recall of the steps of care.

Table 9. Number (and %) of providers reporting various steps that they take when responding to rape

Step	No. (and %) of providers	
	Before (n=120)	After (n=34)
Perform a physical examination.	77 (64%)	31 (91%)
Treat any wounds, if applicable.	75 (63%)	30 (88%)
Ask the client to describe what happened, any symptoms, and relevant medical history (e.g., HIV status).	70 (58%)	31 (91%)
Assure the client of confidentiality.	35 (29%)	22 (65%)
Provide psychosocial support/comfort the client (e.g., explain that he or she is not at fault for experiencing rape).	31 (26%)	31 (91%)
Test for HIV, if applicable.	31 (26%)	17 (50%)
Refer the client for other services, according to his or her needs and wishes.	29 (18%)	20 (59%)
Provide PEP, if applicable.	13 (11%)	22 (65%)
Test for pregnancy, if applicable.	11 (9%)	14 (41%)
Establish a medical certificate documenting the rape, according to the client's wishes.	10 (8%)	10 (29%)
Offer EC, if applicable.	9 (8%)	19 (56%)
Refer the client to another provider at the same facility for examination and care.	9 (8%)	8 (24%)
Test for other STIs, if applicable.	8 (7%)	6 (18%)
Treat STIs, if applicable.	5 (4%)	18 (53%)
Administer other vaccines, if applicable (e.g., tetanus, hepatitis B).	5 (4%)	18 (53%)
Inform the client of his or her right to accept or refuse any of the services offered.	4 (3%)	11 (32%)
Discuss the client's safety (e.g., if he or she is in danger of continuing SV).	1 (1%)	10 (29%)
In cases of domestic violence, ask whether children in the family are at risk of violence.	0 (0%)	2 (6%)
Assess whether the client may be at risk of depression or suicide.	0 (0%)	10 (29%)
Inform the client of his/her legal right to press charges against the perpetrator.	0 (0%)	2 (6%)

Referral system strengthened

During training, providers mapped out referral services in their communities. During debriefings, they shared this information with their facility managers and fellow providers.

Endline interviews showed noticeable, facility-wide changes in referral practices. Although the project was not able to track changes in how many referrals occurred, interviewers asked facility managers what types of referrals their facilities could offer SV survivors. As shown in Table 10, the percentage of facilities that offer referrals remained high for legal assistance and grew for all other types of services.

Table 10. Number and percentage of facilities offering various types of referrals

Type of referral offered	No. (and %) of facilities	
	Before (n=21)	After (n=20)
Legal assistance or law enforcement	18 (86%)	18 (90%)
Shelter or a safe house	7 (33%)	18 (90%)
Psychosocial counseling	14 (67%)	16 (80%)
Social reintegration	9 (43%)	12 (60%)
Economic reintegration	5 (24%)	12 (60%)

Interviewers asked facility managers to specify the organization or agency to which they would refer survivors for each type of service. Prior to the training, their answers were vague, and only one facility manager (5%) specified the name of an organization. After the training, their answers were much more precise, and 13 facility managers (65%) listed organizations by name.

Commodities procured

The provider training included a module on inventory management that was intended to reduce stock-outs of commodities and supplies that are essential to the care of SV survivors. As shown in Table 11, the percentage of facilities with consistent supplies of EC tripled, and the percentage with PEP supplies doubled. However, the percentage of facilities with consistent stocks of STI test materials declined over the course of the project. RESPOND did not have an opportunity to explore the reasons for these changes before the project ended.

Table 11. Facilities with essential commodities and supplies consistently in stock over the past three months

Commodities and supplies	No. (and %) of facilities with	
	Before (n=21)	After (n=20)
EC	4 (19%)	12 (60%)
Materials for STI tests	14 (67%)	8 (40%)
PEP	6 (29%)	12 (60%)

Services improved

At endline, 19 of 20 (95%) facility managers and 30 of 34 (88%) trained providers reported that services for SV survivors at their facilities had improved as a result of the training. A provider in Kissidougou explained, “I have succeeded in welcoming survivors well and

providing them care, listening to them, obtaining informed consent, and giving emergency care.” Those who did not report improvement explained that their facilities have not seen cases of SV since the training.

Validating the curriculum for health care providers

Following the two trainings of health care providers, RESPOND improved the curriculum based on feedback from providers and facilitators. The MOH led a workshop to revise and validate the provider curriculum. RESPOND is making the final formatting changes suggested, and the MOH will adopt the curriculum as its own national SV curriculum. Previously, the MOH had a protocol for the care of SV survivors, but no curriculum for training providers. The MOH is seeking support to scale up training across the country with this curriculum.



The Governor of Labé, Mr. Sadou Keita (right), presided over the closing session of the health care provider training. The session was broadcast on Guinean national radio.

Photo: B. Nabé/EngenderHealth

Supporting the Capacity of Local Partners

At the outset of the project, the chairwoman of the steering committee, who represents the Ministry of Social Affairs and the Promotion of Women and Children, conducted a study tour to Rwanda with two EngenderHealth/RESPOND staff. There, they interviewed government officials and the staff of NGOs and donor agencies on best practices in GBV prevention and response. The study tour team was impressed by the community-based prevention of GBV in Rwanda and used insights from their trip to improve RESPOND’s work with GBV prevention committees.

Upon their return, the study tour team delivered a presentation to the steering committee on their findings and disseminated a report to partners. In an endline interview, a steering committee member from the Ministry of Security and Civil Protection recalled learning helpful lessons from their presentation. He is the chief of police investigators for special victims, including GBV survivors. He noted that the study tour team described safe houses for

survivors in Rwanda. The chief investigator hopes to replicate this approach if he is able to secure funding.

In addition, the chief police investigator for GBV appreciated the project's SOPs for working with GBV survivors. Without prompting or funding from RESPOND, he took the initiative to orient his staff of 20 police investigators who handle GBV cases in the Office of Protection of Gender, Childhood, and Morals on key aspects of the SOPs. According to the chief investigator, a number of changes took place:

- Police investigators became more careful in the management of survivors' information. They began keeping files in locked filing cabinets.
- Police investigators stopped asking unnecessary questions about survivors' private lives.
- Before RESPOND, police investigators were only able to refer survivors to the court system. Now, they know to refer survivors to services in many sectors, including to the physicians, psychiatrist, and social workers who were involved in the project.

Over the course of their collaboration, RESPOND supported capacity at AGUIAS and CONAG-DCF. The finance personnel of both NGOs received training from the EngenderHealth Finance Officer. Both adopted the consent process and referral forms that RESPOND laid out in its SOPs. The training of CONAG-DCF trainers in GBV prevention increased the types of training offered by the NGO. Furthermore, the project reinforced linkages between the two organizations and providers of medical and psychosocial care for SV survivors.

Lessons Learned

Overall, the project laid a strong foundation for future programming in GBV prevention and health sector response. The project developed a number of tools² that are available by request and could be adapted for use in other contexts:

- SOPs for working with GBV survivors (French)
- GBV prevention TOT curriculum (French)
- Baseline health facility assessment protocol and tools (French and English)
- Health care provider curriculum (French and English)
- Endline evaluation protocol and tools (French and English)

For each of the project's interventions, lessons were learned about what worked best and what could be improved or added to a longer project. Overarching lessons learned are presented below, followed by lessons by intervention.

Overarching Lessons Learned

- **Seek guidance from a multisectoral steering committee.** The project's steering committee was instrumental in ensuring that activities met locally felt needs and in earning the project credibility in country. By involving local NGOs, service providers, and ministries in the steering committee, RESPOND also reinforced referral linkages between these bodies and provided a forum for sharing ideas across sectors. Another value of the committee—strengthening the capacity of participants and the institutions they represent—was illustrated when the chief police investigator oriented his staff on key principles and practices of RESPOND's SOPs.
- **Take a holistic approach to GBV.** It is important to recognize that the interrelated needs of GBV survivors span multiple sectors. While RESPOND addressed the medical, psychosocial, social reintegration, and economic reintegration needs of September 28 survivors, the did not cover legal aid, protection services, and safe houses. A strength of the curriculum for health care providers was that it included a module on referrals to nonmedical services; however, it did not train providers to lead survivors through safety planning. The health sector response to SV would be strengthened if safety planning were added to the provider curriculum and protocols. Furthermore, support is needed to improve services outside the health sector as well as within it. Nonmedical services for GBV survivors are extremely limited in Guinea. A holistic approach that seeks to ensure minimum standards for law enforcement, legal aid, safe houses/shelters, psychosocial counseling, GBV prevention, and assurance of quality medical care is crucial.
- **Link prevention and response.** The project could have been improved by linking GBV prevention and health sector activities more closely: Committee members could have contributed to providers' action plans for improving services or could have referred survivors to specific, trained providers if they had met them through the project.

² These tools are in draft form and are not currently available online.

- **Ensure adequate time for building the capacity of health sector and community partners.** With more time and greater funding, the project could have done more to build capacity for GBV prevention and the health sector’s response to SV. Capacity building is rarely achieved through a single training event, and considerable follow-up support and mentoring may be needed to foster the knowledge and skills needed by both health care providers and community members to address GBV effectively in their respective spheres. For example, if the project time frame had been longer, it would have been desirable to help individual trained health care providers to identify and address site-specific bottlenecks and barriers to the provision of an integrated package of SV services.

Response to September 28 Survivors

- **Address barriers to pursuing referrals.** The majority of September 28 survivors who were referred for each type of service pursued those referrals and received services. This high rate of acceptance of referrals was likely because the project covered the costs of services and offered to have a social worker accompany the survivor as she navigated to the correct referral site and provider.
- **Extend the duration of services.** The project ended before some survivors were able to complete care, especially for psychological trauma. As a result, some survivors had to discontinue their use of antidepressants and other prescribed medications. A longer-term project would be better suited for covering the costs of these services.
- **Assist survivors to access capital.** After receiving training in business and vocational skills, many survivors were unable to make use of their new skills due to a lack of start-up capital. Several solutions to this challenge are possible. The project could:
 - Serve as a guarantor to allow trained survivors access to microcredit or to establish a revolving credit amount for an association of survivors.
 - Assist survivors’ associations to apply for financing from the Ministry of Social Affairs’ fund for the economic reintegration of disadvantaged women.
 - Provide survivors with the initial equipment and materials needed to exercise their vocational skills.
 - Offer vocational training in trades that have lower start-up costs.

GBV Prevention

- **Build leveraging of local resources into the GBV prevention committee model.** While some local leaders provided support to the committees, this was not built into the intervention’s initial design . All committee members said that they wished to continue conducting awareness-raising sessions, but most said that they would need continued support to do so. The support they had received was a transportation stipend, and it made a meaningful difference to them. “We need logistical support to do this work,” one explained. Another stated, “What we are doing is for our country. We’re volunteers. But in addition to patriotism, we need money.” One committee chairman said that his committee would keep leading sessions without support, and two others had formed an association that is seeking funding from other sources to carry out the work. If training had prepared committee members to secure funding or in-kind donations, their efforts would be more sustainable. Trainers should share strategies for leveraging local resources and ask committee members to include resource mobilization activities in their action plans.

- **Coordinate exchanges between committees.** After the GBV prevention training, committees did not have an opportunity to learn from each other during the project. Were the project to be replicated in the future, it would be beneficial to invite committee members to attend awareness-raising sessions led by neighboring committees, learn from them, help them solve problems, and offer suggestions for improvement.

Health Sector Response

- **Update and disseminate the MOH protocol on care of SV survivors.** Facilities in the intervention areas adopted the RESPOND curriculum on SV care as a protocol because they lacked access to the official MOH protocol (Ministère de la Santé et de l'Hygiène Publique, 2009). The MOH and partners should update this protocol, produce copies, disseminate it to all facilities, and train facility staff in its use, to ensure that it is institutionalized.
- **Expand the content of health care providers' training.** Due to time constraints, the curriculum for health care providers did not cover a number of important topics, such as:
 - An in-depth discussion of gender and GBV
 - How to comfort survivors and offer psychosocial support
 - Action planning to address specific barriers to accessing high-quality care
 - Clinical training on how to offer medical treatments for SV survivors

The curriculum would be improved by adding the first three items in the list; for the fourth item, separate, in-depth clinical trainings would likely be needed. Training providers in the prescription of PEP, for example, should be part of a larger training in the prescription of antiretroviral drugs.

- **Prepare providers to offer survivors details on referral services.** During training, health care providers mapped available services in their catchment areas and increased their knowledge of where to refer survivors. However, it is unclear whether they gathered adequate information about those services before referring survivors. It can be dangerous to refer survivors without first verifying the types of services offered, the quality of services, and details such as costs, location, and contact information. Future trainings should give providers this information on nearby referral services. Ideally, health facilities should develop relationships with institutions before referring survivors to them.
- **Strengthen the supply chain for key products and supplies for the care of SV survivors.** Missing products and supplies, such as EC, materials for STI tests, and drugs for PEP, limited the services that providers could offer. Given that the window periods for EC and PEP are very brief, it is essential that facilities have consistent stocks of these drugs. Problem identification exercises could be used to uncover the reasons for stock-outs of these and other reproductive health products.

With adjustments to address these lessons learned, RESPOND recommends scaling up the GBV prevention approach and health care provider training over the course of a longer project.

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