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What's LOVES Got to Do with It?
An Evaluation of a First-line Response Training for Mentors on Responding to Disclosures of Violence in PEPFAR Programs

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Abstract

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Background: Children and adolescents in mentor-based programs may feel safe disclosing their fear of or experience with physical, emotional, or sexual violence. However, oftentimes, program mentors and peer supporters are not equipped with the knowledge and skills needed to appropriately respond to voluntary disclosures of violence within the scope of their role and their capacity. The CDC's Gender and Youth Team piloted a first-line response training called LOVES, to provide mentors and peer-supporters in The President's Emergency Plan for AIDS Relief (PEPFAR) programs with the knowledge and skills to respond to disclosures of violence from Adolescent Girls and Young Women (AGYW). The training also aimed to equip Implementing Partner (IP) staff with the tools to cascade the training in their organizations. This evaluation provides preliminary insights on the feasibility and acceptability of the LOVES training, and its ability to influence program outcomes, through the analysis of three pilot trainings conducted in 2021. The LOVES pilot trainings were implemented virtually through self-guided modules and live Zoom meetings.

Objective: The objectives of the evaluation are to 1) determine the feasibility and acceptability of the LOVES training program through assessment of training enrollment, completion, and satisfaction and 2) to assess the effect of the LOVES training on targeted outcomes including knowledge of first-line response and self-efficacy to cascade the LOVES training in their organizations.

Methods: The evaluation involved descriptive analysis of data collected during the LOVES pilot training with 114 mentors and IP staff from 10 PEPFAR countries. These data included enrollment and program completion data, pre-test/post-test scores on scales assessing knowledge of GBV response and self-efficacy to cascade the training in their organizations, satisfaction, and voluntary qualitative feedback from the participants.

Results: The overall average training completion rate was 66%. The course feedback indicated that more 80% of the participants were satisfied with the self-guided modules and the live Zoom sessions. There was a 10% increase on participants' knowledge of GBV response from pre-test to post-test and a 12% increase in self-efficacy to cascade the training among the IP staff. Qualitative feedback was mostly positive on training content, format, and facilitation. Recommendations for improvement included longer training sessions, more time for interactive activities, accommodations for people with connectivity issues, in-person training options, more culturally relevant content, and the need for additional trainings.

Implications and Recommendations: The findings confirm the feasibility and acceptability of the LOVES training. Recommendations have been provided to refine the data collection tools and program implementation to better assess knowledge, and self-efficacy outcomes, and expand to include measures of attitudes and practices. These recommendations can be used to improve the LOVES training for future participants and reinforce their capacity to provide a first-line response for survivors of violence within PEPFAR programs.

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Abbreviations and Acronyms

ALHIV	Adolescents Living with HIV
AGYW	Adolescent Girls and Young Women
CDC	Centers for Disease Control and Prevention
CSA	Child Sexual Abuse
DREAMS	Determined Resilient Empowered AIDS-Free Mentored Safe
GBV	Gender-based Violence
GYT	Gender & Youth Team, HIV Prevention Branch, Division of Global HIV and TB, CDC
HPC	Health Care Practitioner
IP	Implementing Partner
IPV	Intimate Partner Violence
LIVES	Listen, Inquire, Validate, Enhance safety, and Support
LOVES	Listen, Ongoing Connection, Validate, Encourage Safety, and Support
PEPFAR	President's Emergency Plan for AIDS Relief
POC	Point of Contact
VACS	Violence Against Children and Youth Survey

Chapter 1: Introduction

1.1.Introduction and Rationale

Over a billion children are victims of violence every year according to a systematic review conducted on the global prevalence of violence against children (Hillis et al., 2016). The most common forms of violence experienced by children and youth include physical violence, sexual violence, and emotional violence (CDC, 2021). Research conducted on gender-based violence (GBV) suggests that adolescent girls and young women (AGYW) are at higher risk of exposure to violence, especially sexual violence. More than 28% of adolescents (15-19 years) and 29% of young adult women (20-24 years) have experienced physical or sexual intimate partner violence (IPV) with more cases reported in the East and Southern Africa region (Decker et al., 2015). These experiences have serious health and social consequences on the victims, such as chronic disease, mental health issues, and reproductive health problems, including higher risks of HIV infections.

Evidence-based interventions to prevent violence against AGYW are limited. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program has several youth-focused programs targeting violence against AGYW and its intersection with HIV/AIDS. Such programs include DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, Safe), Mentor Mothers, and the HIV Peer Navigation Program. These programs support a mentorship approach and provide a safe environment where AGYW develop communication and financial literacy skills, build healthy peer relationships, and learn how to prevent HIV. In mentor-based programming, a participant may feel safe to disclose their fear of or experiences with physical, emotional, or sexual violence – especially when violence is being discussed in one of the educational sessions. As a result, it is critical to train these mentors and other peer educators/supporters on responding to disclosures of violence.

To support these efforts, the Centers for Disease Control and Prevention's (CDC) s HIV Prevention Branch, Gender and Youth Team developed the training, *LOVES: Responding to Disclosures of Violence with First-Line Support during PEPFAR Programming* (referred to as the "LOVES training"). LOVES stands for Listen, Ongoing Connection, Validate, Encourage Safety, and Support and is an adaptation of the World Health Organization (WHO)'s first-line support approach called LIVES, which is outlined in the *Caring for women subjected to violence: a WHO curriculum for training health-care providers, Facilitator's Guide, 2019.* The WHO's curriculum was created to train healthcare providers, particularly in low- and middle-income countries on responding to GBV in clinical settings. The CDC's LOVES training is an adaptation of this first-line support approach, specifically for the roles and needs of mentors/peer supporters working with AGYW. This adaptation prioritizes the safety of both the survivor and the person responding and also highlights the benefits of ongoing support facilitated by the mentor/mentee relationship. The training also prioritizes safety for the mentors and mentees and self-care practices given that mentors are often young adolescents who may be survivors themselves.

The Gender & Youth team is implementing the LOVES training virtually with PEPFAR-supported CDC country support staff, implementing partners (IPs) staff, and select mentors. Participants are trained on the LOVES approach as well as how to roll out this training with mentors and peer supporters in their organizations. This evaluation aims to assess the feasibility and acceptability of the LOVES training and determine its effectiveness in preparing participants to 1) cascade the training with mentors/peer supporters in their organization and 2) adequately respond to disclosures of violence from AGYW. This is done through secondary data analysis from 3 pilot trainings conducted virtually by the CDC Gender & Youth Team in August, September, and November of 2021

1.2.Statement of the Problem

Research on positive youth development has demonstrated that mentors are pivotal to the healthy development of youth. Mentors provide youth with the support and guidance, and opportunities needed to succeed in life and accomplish their goals (DuBois et al.,2011). AGYW in mentor-based programs may feel safe disclosing their fear of or experiences with physical, emotional, or sexual violence. However, oftentimes, program mentors and peer supporters are not equipped with the knowledge and skills needed to appropriately respond to voluntary disclosures of violence within the scope of their role and their capacity. Thus, there is a need for culturally and contextually relevant training to equip mentors and peer supporters with the skills needed to better support AGYW through experiences of violence.

1.3.Purpose

The purpose of the project is to conduct a process and outcome evaluation of the LOVES virtual training program to improve the LOVES training and its ability to positively influence response to disclosures of violence among AGYW in PEPFAR programming. The main goals of this project are:

1. To determine the feasibility and acceptability of the LOVES training program through assessment of training enrollment, completion, and satisfaction.
2. To assess the effect of the LOVES training on targeted outcomes including knowledge of first-line response and self-efficacy to cascade the LOVES training in their organizations.

1.4.Significance

Adequate monitoring and evaluation practices are necessary to establish an evidence-based program that will be beneficial to GBV response across PEPFAR countries. As the demand for

this capacity-building increases within PEPFAR-supported programs like DREAMS, this evaluation will provide insights on gaps, challenges, and best practices to strengthen the training to better meet the needs of mentors/peer supporters in responding to disclosures of violence. There are currently 15 PEPFAR countries implementing the DREAMS program (USAID, 2021) where the LOVES training program could support the capacity-building efforts of mentors and peer supporters. The training could be beneficial to other mentor-based programs such as Mentor Mother and HIV Peer Navigators. Moreover, the LOVES training is in alignment with the PEPFAR's capacity-building goals. The 2022 PEPFAR Country and Regional Operation Plan, outlines the need for psychosocial training for PEPFAR mentors, stating that “since mentors encounter trauma disclosures and may be survivors themselves, mentors should receive training in psychosocial support and communication skills to better equip them to navigate these circumstances” (PEPFAR, 2022). Lastly, the COVID-19 pandemic has created new barriers to capacity-building efforts for many international organizations. The LOVES virtual training model explores an innovative way to engage program teams across countries and thus understanding the benefits and challenges associated with this training approach is crucial for future programming.

1.5.Definition of Terms

First-line support: the minimum level of (primarily psychological) support and validation of experience that should be received by all children and adolescents who disclose experiences of violence, without intruding on their privacy (WHO, 2014)

Psychosocial Support (PSS): interventions that address the interlinked social, emotional, spiritual, and environmental wellbeing of individuals, families, and groups to cultivate health and wellness practices and improve HIV prevention and treatment outcomes (PEPFAR, 2022)

Chapter 2: Literature Review

According to WHO, violence against children involves physical, emotional, sexual violence, or neglect against people under the age of 18 years by parents, caregivers, peers, romantic partners, or strangers (WHO, 2020). The latest global estimates show over 25% of women aged 15-49 years who have been in a relationship have been subjected to physical and/or sexual violence by their intimate partner at least once in their lifetime, since age 15 (WHO, 2018). Additionally, Sub-Saharan has the second-highest prevalence rate of lifetime intimate partner violence for women aged 15-49 years (WHO, 2018). This literature review provides insight on research conducted on the topics of violence against children, trends in disclosures of violence, and how they can inform current interventions seeking to provide trauma-informed care and support for survivors. Additionally, this review seeks to highlight peer programs that provide psychosocial support for youth and considerations for designing effective and safer programs for the survivors as well as the peer supporters. Given that the LOVES program is a first-line response program for AGYW in PEPFAR programs in Africa, this review will examine existing evidence on this approach as well as the research gaps that could be explored by the LOVES program team.

According to data from sub-Saharan African countries that completed a Violence Against Children and Youth Survey (VACS), between 11% and 26% of adolescent girls and young women reported experiencing sexual violence in the past 12 months (CDC, 2021). Additionally, a 2016 study on 7 VACS countries (Kenya, Tanzania, Malawi, Zimbabwe, Swaziland, Haiti, and Cambodia) provided insight into the lifetime prevalence of different types of violence, among respondents aged 18-24 years. From these findings, 25% of girls and 10% of boys disclosed childhood sexual violence. And, while the prevalence of physical violence is higher than the

prevalence of sexual violence, this rate is consistent among boys and girls in the majority of the countries. Approximately 20-30% of boys and girls in the majority of countries reported experiencing emotional violence (Chiang et al., 2016). Children and adolescents living with HIV may be prone to specific types of violence due to their HIV status. In a study conducted with youth living with HIV in Zambia, they reported experiences of emotional abuse from family members and peers, sexual violence (especially for females), and physical violence from caregivers and teachers (Merill et al., 2021). Although these studies provide some insight into the prevalence of violence against children, there is limited evidence on some of the most vulnerable groups such as LGBTQ youth, indigenous youth, and youth with disabilities (Crooks et al., 2018).

Violence against children and adolescents can have a physical and psychological impact on the survivors, families, and countries. This includes an increased risk of HIV infection, poor mental health outcomes, delinquency, substance abuse, depression, and suicide (WHO, 2020). Additionally, child survivors of violence are more likely to experience other types of violence and also perpetrate violence later in their lives. In communities with low access to mental health and social services, the consequences of experiences of abuse may be more severe and long-lasting (WHO, 2011). For youth living with HIV, experiences of violence can also impact their engagement with HIV treatment. In a study conducted on adolescents living with HIV in Zambia, two-thirds of the participants reported that violence has impacted their adherence to medication, clinic attendance, and/or virologic results (Merill et al., 2021). In a similar study with adolescents living with HIV in Kenya, participants reported that their experiences of stigma, lack of social support, and isolation contributed to feelings of hopelessness, depression, and suicidality which then led to their disengagement from HIV care, caregivers, and healthcare workers (Enane et al.

2021). These findings suggest that experiences of violence against children have great public health implications for children living with HIV/AIDS.

2.1 Addressing the Impact of Violence on Survivors

PEPFAR names GBV prevention and response and child safeguarding as some of its main priorities due to the high prevalence of GBV in PEPFAR-supported counties and the critical relationship between the HIV epidemic and the GBV epidemic (PEPFAR, 2021). PEPFAR-funded CDC interventions provide post-GBV care services in over 20 countries. However, one of the challenges faced by programs is the identification of survivors to connect them to the resources needed. Since 2019, CDC's Gender & Youth Team has been working with PEPFAR countries to implement the LIVES training program. The training focus on teaching providers when and how to identify violence and to respond appropriately and sensitively to disclosures of violence. This training is based on a World Health Organization (WHO) approach to first-line support called LIVES (Listen, Inquire, Validate, Enhance safety, and Support). As a result of this training, implementing partners and CDC country offices recognized that their mentors and peer supporters also receive disclosures of violence in their PEPFAR programs. The Gender & Youth Team adapted the LIVES program specific for mentors and peer supporters and created the LOVES program. The curriculum of the LOVES program is designed specifically for the roles of mentors and their capacities in providing first-line support for young girls and young women.

Evidence on first-line support training for responders has mainly focused on training healthcare providers to identify, respond and support survivors of violence. Although these interventions have been successful in many settings, healthcare practitioners often face barriers to identifying, responding, and supporting survivors of violence. These barriers include systems levels issues such as lack of time due to staff shortage, lack of organizational support, and lack of

resources and training (Hegarty et al., 2020). Findings from a qualitative meta-synthesis on personal barriers faced by healthcare practitioners addressing IPV highlighted: the belief that it wasn't their role to interfere, fear that interfering might lead to more harm for the patient, feelings of helplessness, and inadequacy over the appropriate actions to take and reluctance to make addressing IPV their responsibility and lack of trust with the victims (Tarzia et al., 2021). These findings suggest that organizational, structural, and personal barriers of healthcare practitioners must be addressed to strengthen interventions using healthcare practitioners as first-line responders to disclosures of abuse, especially IPV. Additionally, disclosure processes of adolescents show that programs outside of clinical settings might be best suited for addressing the needs of adolescent survivors of violence.

2.2. Understanding the Disclosures of Violence in Children and Adolescents

2.2.1 Prevalence, Barriers, And Facilitators

Disclosure is often the first step for survivors to receive (physical, psychosocial, and medical) needed to overcome the experiences of abuse. Evidence suggests the existence of variations in the disclosure processes of children and adolescent survivors of violence. According to findings from a cross-country analysis on the prevalence of disclosure, among 13-17 years old survivors in Cambodia, Haiti, Kenya, Malawi, Nigeria, and Tanzania of violence, 23-54% of survivors sought support through informal disclosures, and under 1 to 25% sought help through formal disclosure (Pereira et al., 2020). Early studies conducted on the effect of age and gender on disclosure tendencies reported that girls and women are more likely to report abuse than boys or men, and young children (<6 years old) are less likely to disclose than older children (Townsend, 2016). Additionally, disclosures can be a dynamic process that unfolds over time rather than a single or static event (Mathews et al., 2015). This indicates that disclosure processes might be

different based on gender, age, and the type of abuse experienced and that support needed by survivors can vary and should be ongoing.

Understanding the barriers and facilitators to the disclosure process is essential in reaching survivors and connecting them with the resources they need to reduce the negative impacts of the abuse. A recent study conducted on the barriers to disclosing child sexual abuse in Zimbabwe found that stigmatization, fear of being doubted or labeled a liar, fear of being blamed for the abuse, and possible retaliation from the perpetrators against the survivors and/or their families were barriers to survivors' care-seeking (Obong'o et al., 2020). Earlier systematic reviews also looked at the facilitators of disclosure of abuse in children and adolescents. According to a study conducted in 2017, children and adolescents are more likely to disclose experiences of abuse if they are asked or prompted, and even more likely to disclose if the ask is coming from a person they trust. They are also more likely to disclose if the abuse was extra-familial and if they receive emotional support and understanding. Meanwhile, factors that hindered disclosures included: anticipated lack of understanding and limited support from others, perceived negative consequences for themselves and others, lack of information about the risks of the abuse, and the support available (Lemaigre et al., 2017). In addition to these factors, a systematic review of qualitative research conducted by Morrison et al. (2018) identified the presence of a safe, private and familiar space facilitated disclosures of abuse. However, feelings towards their abuser were a barrier to disclosure for some while for others, it facilitated the disclosure.

However, more evidence is needed on the disclosure behaviors of young people in Sub-Saharan Africa. Most of the studies mentioned were conducted in English-speaking countries, and thus the cross-cultural variations in the disclosure process are not captured. These variations can

further inform interventions providing psychosocial support for adolescents disclosing experiences of violence.

2.2.2. Peer Relationships and Disclosures Of Abuse

Relationship dynamics between peers have been shown to influence the disclosure process of children and youth. Evidence from various research studies demonstrates that children and adolescents are more likely to disclose experiences of violence with their peers. In one qualitative study conducted with survivors of child sexual abuse (CSA) in Switzerland, most of the accounts of immediate disclosures (within 24 hours) and delayed disclosures, occurred in peer relationships (Schönbucher et al., 2012). When asked about the reasons behind these disclosures, participants expressed that they viewed friends and peers as more reliable confidants than their parents or healthcare providers. In a study conducted with high school students in Sweden, 42.6% of the boys and 37.9% of the girls mentioned a "friend of my own age" as the only person to whom they had disclosed (Priebe and Svedin, 2008). A recent systematic found that older children and adolescents are significantly more likely to turn to peers than parents or healthcare providers, but gender differences were noted in the reasons behind this pattern. Girls were more likely to disclose to peers for emotional support whereas boys were more likely to disclose for practical reasons such as access to services or protection (Manay & Collin-Vézina, 2021). Recent VACS surveys also show similar trends in disclosures. Among male and female survivors of violence in Cote d'Ivoire, 53% of females and 66 % of males disclosed their experiences of sexual violence to a friend or neighbor. 28% of females and 47% of males told a friend or neighbor about their experiences of physical violence (MWFC, 2019). In Namibia, 35% of females and 28% of males, told a friend or neighbor about their experience of sexual violence and 24% of females and 34% of males told a friend or neighbor about their experience of physical violence (MGEPESW et al., 2019).

Additionally, a recent study conducted on disclosures and reporting of sexual harm committed by young people in a school context, demonstrated that peer groups set powerful rules that influence the ability and willingness of young survivors to report sexual harm (Allnock and Atkinson, 2019). These findings suggest that peer relationships might play a relationship in the disclosures processes of children and adolescents and can be leveraged to connect survivors to the resources needed.

2.3. Trauma-Informed Care for Survivors Of Violence

The disclosure process can also be a challenging experience for the survivors as well as the person providing support. Creating a more universal understanding of how anyone can provide compassionate support for survivors is critical, particularly for those who are working in violence prevention and response programs. Integrating trauma-informed, survivor-centered support for survivors of violence in public health programs such as PEPFAR could lead to improved outcomes in HIV prevention and care and treatment. Most of the research on trauma-informed first-line support for survivors of violence has been for professionals informal settings such as healthcare providers and social workers, aiming to address the barriers faced by these providers. Such findings have suggested training for healthcare practitioners that encourages them to reflect on their values and how these impact their commitment to addressing IPV, coaching them on adopting an advocacy approach rather a controlling one, and training on trust-building with survivors (Hegarty et al., 2020; Tarzia et al., 2021). These findings echo insights from a qualitative meta-analysis of women's experiences and expectations after disclosures of intimate partner abuse to healthcare providers. In research from the survivors' perspectives on trauma-informed care, participants emphasized the need for emotional connection, recognition, validation, and understanding. Additionally, the survivors also wished for practical support and advocacy fit to

their circumstances, and the need to recognize their agency and control over the outcome of the disclosures (Tarzia et al., 2020).

The World Health Organization (WHO) developed guidelines for responding to violence, especially violence against women and girls, that align with these findings. They recommend survivor-centered first-line support from providers that is non-judgmental, supportive and validates the stories of the survivor. HPCs should listen, provide practical care and support for her needs without intruding, help the survivor access information and resources, support the survivor in increasing safety for themselves and their children and provide or mobilize social support. Additionally, providers should ensure that the disclosures can occur in private and ensure confidentiality while remaining transparent about potential requirements for mandatory reporting(WHO, 2014). Evidence from recent studies shows that when survivor-centered first-line support is absent from care, it can have a negative emotional impact on survivors such as feeling dismissed, silenced, blamed, retraumatized, helpless, and disappointed in the care received (Tarzia et al., 2020). Although the recommendations for a survivor-centered first-line response have been designed for people seeking care in clinical settings, the WHO notes that the guidelines should be adapted to the specific local or national circumstances, based on the resources available and the policies of the targeted communities. These guidelines can be adapted for youth disclosing violence in non-clinical and informal settings, such as peer-support programs.

2.3.1. Peer Support Interventions for Trauma-Informed Care

Recommendations for designing successful interventions for the prevention of violence against children and youth have emphasized the need for trauma-informed care training not only for healthcare professionals, but paraprofessionals, and lay people (Meinck et al., 2014). Peer support programs have been especially highlighted since the peer mentoring environment can

facilitate disclosures of trauma from young survivors. A recent study on the psychosocial needs of youth living with HIV noted that peer mentorship is a critical component of trauma-informed care for ALHIV because of its impact on reducing stigma, isolation, and forging social connectedness (Enane et al., 2021). Adolescents living with HIV are more likely to have experienced life-threatening or highly stressful experiences that undermined their safety such as experiences of violence and thus peer-led psychosocial support is increasingly becoming a priority in HIV services and programs.

There is growing evidence on the efficacy of peer-led psychosocial support programs and the considerations involved. One evaluation of a program providing psychosocial support through a peer support model for adolescents living with HIV found that although there are benefits to peer support trauma support programs for both the recipient and the peer-supporter, there are potential risks for peer-supporters that are often overlooked. According to peer-supporters, the peer support model provides a safe space for adolescents to discuss their problems with someone from the same community, and with similar lived experiences as them. This can help both parties feel less alone or less overwhelmed by their situation (Teasdale & Besser, 2008; Bernays et al., 2021). Some peer supporters mentioned that talking about these experiences with their mentees/clients also helped them in processing their trauma (Wogrin et al., 2020). Peer mentors a study conducted in Zambia, noted that their role as mentors influenced their conception of self, and plans for the future, and encouraged a sense of responsibility to model positive health behaviors for their youth. Some of this impact was due to the intensive pre-service and in-service trainings they received with capacity-building specialists. They highlighted the importance of the trainings in reinforcing their communication skills, boundary setting, and unpacking their own experiences of trauma. For many, the training helped them reframe their narratives from a victimization perspective to one of

strength and ability to help empower others (Burke, et al 2022). In another study with peer supporters for survivors of sexual violence, participants listed feelings of fulfillment and empowerment, sense of purpose, sense of community, improved interpersonal skills as well as influence on career paths and opportunities, all as benefits of serving as peer supporters (Levenson, 2017). Additionally, adolescents voicing the need for more peer support programs expressed that peer supporters/navigators are more approachable, their advice is more credible and influential than that offered by adults because adults often fail to understand their issues or connect with them. Thus, peer supporters can facilitate access and utilization of existing health services, since young people are more likely to trust and follow the referrals conducted by their peers (Bernays et al., 2021).

However, the risks and potential harm to peer supporters should be considered in these interventions. Peer supporters might experience vicarious trauma or secondary trauma from constantly being confronted with experiences of trauma from their mentees. They also experienced retraumatization from having to recount their own traumatic experiences (Dhlamini et al., 2012). Mentors also expressed feeling responsible for resolving the complex issues brought by mentees, which is beyond their scope (Wogrin et al., 2020). Others reported experiencing burnout, blurred boundaries, and the burden of "knowing too much" (Levenson, 2017).

There are several recommendations from researchers on how to mitigate the risks associated with peer support models that may require peers to respond to disclosures of violence. From an individual level, peer-supporters listed coping mechanisms they have adopted on their own to mitigate the effects. For Mentor Mothers of an HIV peer support program in South Africa, these strategies included taking breaks for fresh air and water when they feel overwhelmed and carving some time along for reflection or prayer at the end of each encounter (Dhlamini et al.,

2012). At the organizational level, researchers have emphasized the need to equip peer-supporters with the proper skills and resources to be able to perform effectively while mitigating the risks involved. These include proper training on mental health and trauma, the scope of their roles, connection to referral pathways for cases beyond their scope, and organizational support to mitigate additional risks (Wogrin et al. 2020; Bernays et al., 2021; Simms et al., 2022). They should have access to ongoing counseling if available, training on coping mechanisms, and organized debriefing sessions (Dhlamini et al., 2012; Burke et al. 2022). Also, peer supporters should feel valued in their role. This can be done through appropriate remuneration, recognition of their contributions to the organization, and ongoing supervision, mentoring, and training (Bernays et al., 2020). Some peer-supporters also highlighted technology as a support needed to maintain the ongoing connection with their mentees, especially when working with migrant youth (Bernays et al., 2021). While these studies looked at the efficacy of peer-led interventions for trauma-informed care, to have a full understanding of the benefits and risks involved with these models there is a need for more research on the experiences of mentees and clients who are receiving these types of support from peer supporters/mentors.

2.3.2. Addressing the Psychosocial Needs of Peer Supporters

It's important for mentors and peer-supporters engaging in trauma work to have access to resources and skills needed to manage the impact of their work on their mental health. Some researchers argued that current interventions in Africa encouraging self-care, trauma healing, and building emotional resilience, are often designed through western psychology lenses and are not culturally and contextually relevant. Suggestions for adequate interventions include the reconceptualizing of trauma in the African context with a focus on understanding the role of social, political, economic, and other structural power relations. These interventions are also encouraged

to use traditional African therapeutic approaches which often emphasize the collective process of healing, activism, the use of music and dance, and the concept of 'livelihoods therapy' as it relates to the impact of economic agency on the emotional agency (Afuape 2011; Horn, 2020). Furthermore, they call for the reframing of the caregiver-community relationship through the concept of “vicarious resilience”. This framework encourages formal and informal caregivers to draw on the positive impact that their clients could have on them (Hernández et al., 2007). This allows the caregivers to reflect on the ways that their clients contribute to strengthening their emotional resources and capacities, and it also challenges the way marginalized survivors are often perceived as a burden (Afuape 2011; Horn, 2020). However, there is limited evidence of successful programs employing these methods to support the emotional and well-being needs of adolescents in peer-led psychosocial support programs.

2.4. Conclusion

Violence against women and children is a serious health issue with negative physical, social, and psychological impact on the survivors. Trauma-informed first-line care has been highlighted as a critical component of supporting survivors and connecting them to the resources needed. Evidence on trauma-informed first-line response trainings has mainly targeted health care providers, given their position to identify violence and support victims. However, trends in the violence disclosure processes of children and adolescents suggest that peers play an important role in the disclosure processes of young people and can serve as a resource for survivors seeking care. Given the novelty of this approach, evidence from HIV peer-support programs can inform the integration of first-line support in peer-led interventions. This includes best practices in ensuring the safety and wellbeing of both mentors/peer supporters and the recipients. The findings and recommendations provided can be adapted by the local program implementers with the input of

the children and adolescents in their community to adequately meet the needs of those who disclose violence and need support.

Chapter 3: Methods

The purpose of this evaluation is to assess the feasibility of the LOVES Training to improve responses to violence disclosures during PEPFAR Programming. The primary objective is to determine the feasibility and acceptability of the LOVES training program through assessment of training enrollment, completion, and satisfaction. The secondary objective is to assess the effect of the LOVES training on targeted outcomes including knowledge of first-line response and self-efficacy to cascade the LOVES training in their organizations. This evaluation involves the analysis of secondary data collected by the CDC Gender & Youth team during the implementation of the 3 initial trainings.

3.1. Population and sample

Although, the LOVES Training aims to support mentors/peer educators within PEPFAR service delivery on responding to disclosures of violence, the pilot trainings conducted by the CDC Gender & Youth team had an additional focus on equipping future facilitators of the LOVES Training with the knowledge and skills needed to cascade the training at their respective organizations. Thus, the 3 trainings conducted targeted CDC staff, implementing partner (IP) staff, and staff from other PEPFAR-supported programs, including mentors and other peer supporters. The participants were recruited through purposive sampling by in-country CDC point of contact (POCs) with the support of the CDC Gender & Youth team. The number of slots allocated for each participating PEPFAR country was based on training needs and program priorities. The 3 pilot trainings were conducted in August, September, and November of 2021 with 114 participants from 10 PEPFAR countries.

3.2. Research Design and Procedures

All training activities were conducted virtually, with a combination of three online self-guided modules and three live Zoom sessions. The Gender and Youth Team emailed all the registered participants a one-page training schedule called “Course on Page”, with links to the pre/post assessments, self-guided modules, and the live Zoom sessions. The participants were asked to complete the pre-assessment at the beginning of the training, and again immediately after completion of the Zoom sessions. The participants completed three self-guided modules including 1) Overview of GBV, Youth, and Trauma; 2) Responding to Violence Using LOVES, and 3) Self-Care. The modules were presented through Google Forms, with embedded course videos and reflection questions to monitor participants' engagement with the content and verify completion. Participants were also asked to provide their names and email addresses at the beginning of each module to monitor module completion. The live Zoom sessions involved 2-hour sessions over 3 days where facilitators got to further expand on the content presented in the self-guided modules through PowerPoint presentations and interactive activities to practice the LOVES approach and share their experience. The third day of the live zoom session served as an opportunity for IP staff to plan the rollout of the LOVES training in their mentoring programs and thus was optional for mentors/peer educators whose scope of work does not include training others.

3.3. Data Collection

The evaluator used information collected by the Gender & Youth Team during the training implementation to assess the evaluation objectives. The registration forms contained information on participants' demographic information (age, place of work, country of residence, job title), and how they plan on using the information from the LOVES Training. A count of unique responses to the registration form was used to determine the number of people enrolled in the training. The

self-guided modules included qualitative questions to obtain participants' reactions and feedback on each module. The outcome assessment involved a pre-test/post-test model using a *Knowledge, Attitudes,* and *Practices* (KAP) assessment approach. This assessment included questions on knowledge related to GBV and first-line support, as well as self-efficacy related to the provision of first-line support and facilitation of rollout trainings. Additionally, the team collected feedback on participants' satisfaction with training content, format, and delivery through an optional training feedback form. The pre-post survey and training feedback form included quantitative questions in Likert format, true/false, multiple-choice, as well as open-ended questions. Table 1. Provides an overview of the data variables assessed, the measurements used as well as the data sources for each variable.

Table 1. Summary of Data Collection Instruments and Variables

Variable	**Measurement**	**Data Source**
Objective 1: To determine the feasibility and acceptability of the LOVES virtual training program through assessment of training enrollment, attendance, completion, and satisfaction.		
Enrollment	# of people registered	Registration Form
Training completion	# of people who received the certificate of completion	Certificate Administration Lists
Satisfaction	Qualitative feedback on each module	Module Responses
Satisfaction	Likert scales results, range in opinions	Course feedback form
Objective 2: To assess the effect of the LOVES training on program outcomes: knowledge, self-efficacy to cascade the LOVES training and to identify and respond to disclosures of violence among AGYW using the LOVES approach.		
Knowledge	% of score change from pre-test to post-test	KAP Assessment/Pre-post Test
Self-efficacy (IP Staff only)	% Change in the level of comfort facilitating LOVES from pre-test to post-test	KAP Assessment/Pre-post Test

3.4. Data Analysis

The data analysis involved both quantitative and qualitative analyses using secondary data collected by the Gender & Youth Team. To assess enrollment the evaluator used a count of unique participants that filled out the registration form. To assess *Knowledge, Attitudes,* and *Self-Efficacy*, the evaluator used the scores generated by SurveyMonkey on the percentage answered correctly during the pre-test and post-test, results from the analysis of Likert scale questions, and open-ended questions. The questions were presented in true or false, multiple-choice, and Likert scale format in three different sections. The first section collected demographic information on participants namely gender and place of work. The second section is composed of 12 true or false, multiple-choice and Likert scale questions assessing *Knowledge*, Attitudes regarding GBV, the role of mentors, the LOVES approach, and secondary trauma. The last section reserved for IP staff only is composed of Likert scale questions aimed at understanding the resources available at the local, organizational, and individual levels, to enable the rollout of the LOVES Training and application of the LOVES approach. These questions focused on the availability of resources including existing operating procedures for responding to violence, reporting policies, safe spaces for violence disclosures, organizational support for first-line response, internal and external resources for the referral process, as well as experience with previous trainings on identifying and responding to violence.

The KAP assessment was conducted through SurveyMonkey which was able to provide survey scores for section 2. Each score was the percentage of questions answered correctly out of 12 questions, with each question worth 1-2 points. Additionally, descriptive analysis was conducted using SAS statistical program and Microsoft Excel to understand the breakdown of participants based on demographic information, as well as to obtain a frequency of responses in

the KAP assessment for questions related to knowledge, attitudes, and training satisfaction. The evaluator also assessed for differences in responses based on demographic information collected.

Qualitative analysis was used for open-ended questions on the course feedback form, and questions related to module feedback from the self-guided modules. To do so, the evaluator used inductive analysis to identify reoccurring themes related to the training and their frequency. This process involved reading through comments for each open-ended question to derive concepts and themes that can help categorize the data and manually quantify the number of times each theme was mentioned in the comments. However, the evaluator also highlighted unique comments that could be beneficial for the improvement of the training program team.

3.5. Ethical considerations

This project did not require IRB review because it is not "research" as defined in the federal regulations, confirmed by the Emory Intuitional Review Board. The analyses conducted will be used to inform programming and the findings will not be used to contribute to generalizable knowledge. Any external dissemination or publications resulting from this project will protect the confidentiality of information accessed or obtained in this project.

3.6. Limitations and delimitations

The limitations of the evaluation involved the use of secondary data for the evaluation. As the evaluator was not part of the design of the data collection instruments nor the data collection, the data provided to address the evaluation objectives were not comprehensive. However, the evaluator worked with the program team to tailor their evaluation needs to the available data and identify opportunities for future assessments that could address existing questions.

One of the limitations encountered was the lack of a unique identity, that would allow for extensive quantitative data analysis. The pre-test/post-test assessment was anonymous and did not include a unique identifier for each participant. This made it challenging to conduct additional analysis on the data collected and understand whether there is a difference in indicators like knowledge and self-efficacy between the scores at pre-test and post-test. Additionally, this made it difficult to determine whether participants who completed the pre-test and post-test assessments completed the self-guided modules and the live Zoom sessions. To address this, the evaluator used descriptive analysis to understand the overall averages of the pre-test scores compared to the post-test scores by major stakeholder groups. Also, given that not all participants took the pre-test and post-test, thus the results represent a subsample of the participants trained.

Secondly, self-efficacy was only explored through one question which asked the participants to express their level of comfort in facilitating the rollout training. Similarly, the assessment on the availability of resources was also only asked for IP staff, so it's not representative of the mentors' experiences and their ability to rely on these resources to implement the LOVES approach. However open-ended questions allowed the participants to express their needs, challenges, and barriers to their roles. This feedback provides insight into the environmental challenges that could influence participants' self-efficacy in fully applying the LOVES approach to first-line response and also supporting the rollout of the training to other colleagues at their organization.

Lastly, it wasn't feasible to disaggregate the data by gender or age, to understand if the experiences of the participants varied by gender. The data collection instruments only requested participants' gender on the pre-post tests of the third pilot group. Thus, there was limited data to conduct the findings disaggregation by gender at this level of the evaluation.

Chapter 4: Results

4.1. Assessing the Feasibility and Acceptability of the LOVES training

4.1.1. Training enrollment, and completion

More than half of the participants enrolled in each training group were able to complete the training and receive a certificate of completion (Table 2). Participants only received a certificate if they complete all the online self-guided modules and attended the zoom sessions. Thus, the training completion percentage was determined by dividing the number of people who enrolled in the training by the number of people who completed the training and received a certificate. The completion rate for the Pilot 2 is higher than the completion rate for the other pilot trainings.

Table 2: Overview of Training Participants

Pilot Group	**Date**	**Countries Represented**	**Registered Participants**	**Training Completion**	**Completion Rate**
Pilot 1	August 2021	Kenya, Zimbabwe, Malawi Uganda, Botswana	59	32	54%
Pilot 2	September 2021	Uganda, Cameroon, Zimbabwe, Tanzania, Zambia	45	35	78%
Pilot 3	November 2021	Eswatini, Kenya, Malawi South Africa, Uganda, Zambia, United States	68	47	72%
Total			172	114	66%

4.1.2. Training Satisfaction

Satisfaction with the Self-guided Modules

Training satisfaction was measured quantitatively through Likert scale questions and qualitatively through open-ended questions listed on the course feedback form and the self-guided modules. Participants were asked to provide their feedback on 1) self-guided modules 2) live zoom sessions 3) training format and 4) their overall satisfaction with the training. The participants also got to provide comments and rate their satisfaction with each of the modules covered, on a 5-point scale (1= *very dissatisfied*, 5 = *very satisfied*). However, qualitative responses often covered participants' overall sentiments about the training and were not specific to the modules.

Module 1: Overview of GBV, Youth, and Trauma

When asked to rate their level of satisfaction with the first module, 63% of the participants expressed that they were “very satisfied” with the module. Over 90% of the mentors and IP staff said they were either “very satisfied” or “satisfied” with the module (Table 3). Qualitative feedback from this module was positive for the most part as well. Participants expressed that the module content was informative and helpful. The presentation of the content helped reinforce participants' understanding of GBV, and trauma. The areas to improve included a request for shorter videos, and the need to include Adverse Childhood Experiences (ACEs) in the information provided on trauma.

Table 3. Satisfaction: Module 1 (n = 78))

	Very Satisfied	Satisfied	Moderately Satisfied	Somewhat Unsatisfied	Very Unsatisfied
Mentors	66%	30%	2%	-	2%
IP Staff	53%	37%	10%	-	-
All participants	**63%**	**31%**	**5%**	**-**	**1%**

Module 2: Responding to Violence Using LOVES

Similar to comments on module 1, over half of the mentors and IP staff expressed being either "very satisfied" or "satisfied" with the module (Table 4). In the qualitative feedback, the participants expressed that module 2 content was informative and helpful. Some commented on their likeness to the use of practical examples in the presentations. Others felt that the content was relevant to their experiences and that the content encouraged a better understanding of the roles of mentors and IP staff in responding to disclosures of violence. However, there were also comments on how the module can be improved. These included the need for content in the languages of participating countries and the need for the inclusion of post-rape care services when discussing referral resources to support AGYW.

Table 4. Satisfaction: Module 2 (n = 79)

	Very Satisfied	Satisfied	Moderately satisfied	Somewhat unsatisfied	Very Unsatisfied
Mentors	60%	29%	9%	-	2%
IP Staff	61%	35%	3%	-	-
All participants	**62%**	**31%**	**6%`**	**-**	**1%**

Module 3: Self-care

Quantitative feedback of this module indicates that this was the module that participants were the most satisfied with. 93% of the mentors and 98% of the IP staff said they were either "very satisfied" or "satisfied" with the module (Table 5). In the qualitative feedback, the

participants expressed that the content for this module was easy to follow and comprehend. They appreciated the use of TEDx videos and other visuals. A couple of respondents also mentioned sharing the videos with friends/family members outside of the training. Some people also found the content was not only uplifting and empowering but also challenged the mentors to be more effective in their roles. The suggestions on how to improve the module included a focus on changing organizational culture around self-care, the inclusion of protection policies for mentors, the inclusion of LGBTQ issues, and self-care for people living with HIV. Additionally, some of the comments seem to indicate a need for more clarification around specific terms used during the training, namely the difference between LOVES and LIVES, and the application of "Encourage Safety" which represents the letter "E" in the LOVES framework. Other comments included the need for more resources for self-care and the inclusion of self-care activities in all trainings. Lastly, participants mentioned the need for guidance on implementing policies in organizations that lack policies regarding GBV response.

Table 5. Satisfaction: Module 3 (n = 79)

	Very Satisfied	**Satisfied**	**Moderately satisfied**	**Somewhat unsatisfied**	**Very Unsatisfied**
Mentors	70%	23%	5%	-	2%
IP Staff	56%	42%	-	3%	-
All participants	**65%**	**30%**	**3%**	**1%**	**1%**

Satisfaction with the live Zoom Sessions

The course feedback form also included a question to measure participants' level of satisfaction with the facilitation of the live Zoom sessions.

The feedback from participants regarding the zoom sessions was mostly positive. Participants seem to have enjoyed the interactivity of the sessions and the facilitation of the training activities during the zoom sessions. When asked about their satisfaction with the facilitation of the live sessions, 67% of the respondents responded that they were "very satisfied" with the sessions while 29% said they were "satisfied" with the live sessions (Table 6).

Table 6. Satisfaction: Facilitation of Live Zoom Sessions

	Very Satisfied	**Satisfied**	**Moderately satisfied**	**Somewhat unsatisfied**	**Very Unsatisfied**
Mentors	75%	21%	2%	-	2%
IP Staff	58%	39%	3%	-	-
All participants	**67%**	**29%**	**2%**	**-**	**1%**

Additionally, when asked whether they found the training platform to be convenient for accessing course materials, participants answered positively as well. Nearly 99% of the participants strongly agreed (62.8%) or agreed (35.9%) that the platform was convenient for them (Table 7). However, qualitative comments on the platform convenience suggest that some participants had issues accessing training materials due to internet connectivity, and many still preferred an in-person training format).

Secondly, most of the participants also responded positively to the usefulness of role-plays in helping them understand the LOVES framework. This was also supported by reoccurring comments from participants expressing their engagement with the live zoom sessions and their request for more sessions that allow them to interact with one another. Lastly, most of the participants either "strongly agreed" (63%) or "agreed" (22%) that their opinions were respected during the training while 13% of the participants "strongly disagreed" with this sentiment.

Table 7. Training Satisfaction: Live Zoom Sessions

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
Platform Convenience (n =78)					
Mentors	60%	40%	-	-	-
IP Staff	68%	29%	-	3%	-
All participants	**63%**	**36%**	-	**1%**	-
Helpfulness of Selected Role-play Activities (n = 78)					
Mentors	61%	23%	-	-	16%
IP Staff	68%	23%	-	-	10%
All participants	**64%**	**23%**	-	-	**13%**
Opinions Respected by Facilitators (n =78)					
Mentors	60%	26%	2%	-	12%
IP Staff	68%	16%	-	-	16%
All participants	**63%**	**22%**	**1%**	-	**14%**

Satisfaction with Overall Training Format

Table 8. Satisfaction: Lecture and Interactivity Balance

	Too much lecture and not enough interactive learning	The right amount of both lecture and interactive learning	Too much interactive learning and not enough lecture
Mentors	4%	93%	2%
IP Staff	3%	94%	3%
All participants	**4%**	**93%**	**3%**

Suggested changes to the Format of the virtual training (recorded videos and Zoom sessions)

Out of the number of participants who responded to this question, (35%), expressed that they wouldn't change anything about the format of the virtual training. Accessibility (22%) was a reoccurring theme in the comments, with some participants wishing the video subtitles were provided in other languages for people who aren't fluent in English, and others explicitly

mentioning that they were French speakers and would have preferred to have the entire content in French. Internet connection was also mentioned as the reason why some people had issues accessing the training content. While recognizing that this issue might be beyond the control of the facilitators, participants suggested the use of handouts and the provision of training recordings for those who might miss parts of the live sessions due to internet connectivity. Additionally, 17% made comments related to time. Some wished they had more time for the group activities during the live sessions, while others suggested adding additional days for the live sessions. According to one respondent, "the course could be given more time. It seemed rushed" (IP Staff, Group 3). Although 93% (Table 8) of the participants who took the course feedback said the training was "the right amount of both lecture and interactive learning", 14% of the qualitative feedback on things to improve on was related to training interactivity. Some participants wanted more roleplay activities with the larger groups, and others stated their preference for in-person trainings. Other comments mentioned the provision of supporting materials as a way to reinforce the training. Suggestions on this included case studies, articles, resources for GBV report writing, and more community-centered examples.

Satisfaction with Overall Training

Table 9. Satisfaction: Overall Training

	Very Satisfied	**Moderately Satisfied**
Mentors	90%	10%
IP Staff	77%	23%
All participants	86%	14%

To assess participants' overall satisfaction from the training, quantitative data was used along with comments provided to requestions regarding training aspects they found helpful and

training aspects that could be improved for future trainings. On a 5-point satisfaction scale, 86% of the participants answered to have been "very satisfied" with the training while 14% said to have been "moderately satisfied" with the training. 90% of the mentors and 77% of the IP staff were "very satisfied" with the overall training (Table 9).

Most Helpful Aspects of the Training (N=80)

Participants were also asked which parts of the course were most helpful to their learning (Table 10). The recurring comments included the content presented on secondary trauma and self-care, the use of roleplays during the live sessions, the overall LOVES approach and its 7 guiding principles, and the roles and responsibilities of mentors. Additionally, comments focused on the format of the training, stressing the use of the live zoom sessions and the "course on page" training resources one-pager.

Table 10. Course Feedback: Most Helpful Training Aspects

Themes	**# of comments**	**Selected Examples**
Secondary trauma and self-care	21	"What stood out for me is the aspect of self-care, that I should engage myself in self-preservation activities that will enable to avoid burnout and secondary trauma as I attend to AGYW" (Mentor, Group 1) "Self care as we are always running to meet donor targets and forget about us" (IP Staff, Group 1)
Use of roleplays	20	"The role play because practicing it and being corrected helped my understanding more" (IP Staff, Group 2)
LOVES approach and principles	15	"I learnt that Listening makes the mentee to feel appreciated and cared and that gives them hope tat they really not alone in the problems they might be facing when giving validation" (IP staff, Group 2)
Live Zoom sessions	6	"The live sessions were very helpful and they increased my understanding of the course modules" (IP Staff, Group 1)

Role and responsibilities of mentors	5	"The role of Mentor. What He/She should not particularly do" (IP, Group 2)
LOVES guiding principles	5	"The 7 guiding principles of LOVES, it helped to understand LOVES better."(Mentor, Group 3)
Entire training	4	"All sessions, as it was my first training in GBV/IPV" (IP Staff, Group 3)
Overview of GBV	4	"Gbv and disclosure process because these are the common issues faced in my community" (Mentor, Group 3)
Other	3	"Course on page... It made the zoom sessions much easier to understand, and one was able to watch videos as much as they can to understand then the zoom meetings cemented what we already learned" (IP, Group 1)

Areas of Improvement (N=80)

When asked about aspects of the training that can be improved for future trainings (Table 11), most of the comments were related to the time allocated for the entire training, or the amount of time allocated for the role-plays. Participants felt that additional time would have allowed for richer discussions. They also mentioned the need for more role plays to make the sessions more interactive. Other comments that were brought up included their preference for in-person training over the virtual training format, training accessibility, additional training materials or training sessions as well as more culturally relevant and community-centered examples.

Table 11. Course Feedback: Areas of Improvement

Themes	**# of comments**	**Selected Examples**
Increase training and session duration	15	"The number of days and time should be added for giving out more discussion" (Mentor, Group 2)
More interactive	14	"More role plays and interactive sessions as opposed to power-point presentations." (IP staff, Group 1)

In-person training option	14	"It should be a live training not through online." (IP staff, Group 3) "Maybe if Covid-19 ceases, a face to face training will be of great importance as it will allow active interactions without being hindered by poor network connectivity." (IP staff, Group 1)
No changes need to be made	10	"All went well" (Mentor, Group 3)
More trainings and training materials	7	"More information to be provided for Encouraging safety." (IP staff, Group 1)
Training Accessibility	7	"We should also try the WhatsApp platform to make it easy for those who face network problems" (Mentor, Group 2) "Have subtitles in the videos so one can select their preferred language" (Mentor, Group 3)
More culturally relevant and community-centered examples	4	"…. provision of information in the African perspective so it will be more relevant to what we are facing in the African Countries" (Mentor, Group 3)

4.2. Assessing the effect of the training on targeted outcomes

4.2.1. Effect of the Training on Participants' Knowledge

The participants were asked to take the pre-post assessment before the training and after the completion of the live Zoom sessions. The assessment was conducted through SurveyMonkey which provided a percentage of questions scored correctly for each of the assessments completed. The scored questions assessed participants' knowledge of GBV and adequate first-line response for disclosures of violence. Overall, 162 participants (122 mentors, 39 IP staff) completed the pre-test while 103 participants (69 mentors, 32 IP staff) completed the post-test (Table 12). This indicates that 93% of participants enrolled completed the pre-test and of participants who have completed the training took the post-test. The test scores results show a 10% increase in the test scores between pre-test and post-test for each training group. The average score in the pre-test for all groups is 72% whereas the average score in the post-test is 82%. However, participants were

not provided a unique identifier that allowed for pre-test and post-test scores to be matched. Therefore, it is not certain whether all the participants that completed the post-test had initially completed the pre-test. Thus, although there is a possibility that the participation in the training influenced the increase in the knowledge on GBV and first-line response, there is little evidence to attribute this change in scores to their participation in the LOVES training.

Table 12. Pre and Post Test Scores of the Knowledge Questions

Type of Respondent	**# Respondents**		**Test Score**	
	Pre-Test	**Post-Test**	**Pre-Test**	**Post-Test**
Pilot 1				
Mentors	28	19	73%	86%
IP Staff	14	12	86%	89%
Total	42	31	77%	87%
Pilot 2				
Mentors	30	23	72%	80%
IP Staff	8	8	60%	88%
Total	39	31	70%	82%
Pilot 3				
Mentors	64	27	68%	78%
IP Staff	17	13	83%	84%
Total	81	40	71%	80%
All Participants	162	103	72%	82%

* Some participants did not disclose whether they were mentors or IP staff

Table 13. Previous Training in the LIVES approach for first-line support

Previous Training in LIVES Approach	**Yes**	**No**	**No, but someone in my organization has**	**Unsure/Can't remember**
Mentors	22%	64%	9%	5%
IP Staff	29%	50%	21%	-

Additionally, the participants were asked if they have had experience with previous training in the LIVES approach for first-line support, an adjacent GBV response training that focuses on

health care providers (Table 13). This question aimed to gauge the participants' exposure to first-line response content and how that may have impacted their performance on the pretest and posttest assessment. The IP Staff seem more likely to have had exposure to previous LIVES training either directly or through someone in their organization. There is a possibility that this might have influenced their test scores given that IP staff scored higher both at pre-test and post-test time points.

4.2.2. Effect of the training on Self-Efficacy

Table 14. Self-Efficacy in Facilitating the LOVES Training

How comfortable do you feel facilitating a training for mentors on how to respond to violence using pre-assembled materials?	**Pre-Test**	**Post-Test**
Very comfortable	51%	63%
I could do it with a little support	23%	28%
I could do it with a lot of support	5%	6%
Neutral	16%	3%
Not at all comfortable	0%	0%

Self-efficacy was assessed by asking IP staff were asked their level of comfort in facilitating the LOVES training for mentors using pre-assembled materials (Table 14). Based on the responses from the pre-post assessment, there is a 12% increase in the proportion of IP Staff who felt very comfortable facilitating the training before the training and after the training. Similarly, there's a 5% increase in the proportion who felt that they could lead the training with a little support. This indicates that the training has a possibility of positively impacting the self-efficacy of IP staff in taking on the role of training facilitators for mentors in their organizations.

4.3. Availability of Resources and Existing Needs of Participants

Participants were also asked about the additional support that exists or is needed to enhance their self-efficacy in implementing the LOVES training and applying the LOVES approach. The IP Staff were asked if they have access to resources in supporting mentors to respond to disclosures of violence. These resources included support from colleagues on how to respond to a difficult case, existing guides or standard operating procedures for managing cases, a private space to have discussions with AGYW or mentors on experiences of abuse, a supportive supervisor, internal and external personnel for GBV referrals, as well as knowledge from previous training on how to identify and respond to violence. More than 50% of the participants responded yes to having access to 6 or of the 8 resources listed. As seen in Table 15, the responses were much lower for the availability of mandatory reporting policy (32%), as well as skills from previous training on how to identify and respond to violence (42%). This indicated either a need to support the country teams in researching and understanding the reporting policy in their communities or advocating for the implementation of these resources. This also indicated the need for more GBV training for participants in reinforcing their knowledge and skills around response to disclosures of violence.

Table 15. Availability of Resources for IP Staff

Resources (n=39)	**Yes**	**No**	**Unsure**	**N/A**
A colleague with whom I can get advice on how to respond to a difficult case of violence or abuse if I don't know what to do	80%	-	5%	15%
Existing guide or standard operating procedure on how to manage cases of intimate partner violence and sexual violence	52%	23%	10%	15%
Existing mandatory reporting policy	32%	20%	30%	18%
A private space where I can talk to a mentor or AGYW confidentially about their abuse	72%	5%	3%	20%
A supervisor who supports me working with mentors and conducting training for mentors	80%	2%	-	18%

Names and contact information of people within this facility to whom I can refer AGYW who discloses violence for additional counseling or psychosocial support or clinical care	73%	5%	2%	20%
Names and contact information of people outside the facility to whom I can refer AGYW for additional psychosocial support or post violence care	68%	7%	5%	20%
Previous training on how to identify and respond to violence (e.g., LIVES)	42%	40%	5%	13%

Availability of Resources and Training Needs of Mentors (N = 31)

The needs assessment of mentors was conducted through an open-ended survey question that asked what they think organizations and CDC/PEPFAR staff should know for future trainings. This question aimed to allow mentors to provide insight into their training needs based on the challenges faced. However, many of the responses seem to be relevant to their general challenges beyond the scope of trainings. 45% of the participants felt that there is a need for additional trainings based on other topics and refresher trainings on the LOVES approach. According to the comments, these trainings will help them practice the skills learned, share experiences with other mentors, receive coaching from IP staff and obtain new skills related to GBV. However, answers vary as far as the format of these trainings. Many mentioned the difficulty with having virtual trainings because of internet connectivity. According to one mentor "As mentors in rural areas we face network challenges for virtual meetings" (Mentor, Group 1). Some expressed their preference for in-person or hybrid training, while others suggested the use of training manuals, so they have access to the supporting materials in case of internet connectivity issues. Additionally, participants expressed the need for counseling and mental health support to be able to cope with trauma around the experiences of GBV. Lastly, mentors expressed the need for resources to help them perform their roles effectively, and feel valued and appreciated. These resources included: stipends, allowances, internet access, and transportation support for trainings. One comment that touched on these needs stated:

"Organizations are doing a good job, but more implementation is needed in our organizations. As mentors we should be appreciated in our organizations because we do alot of work which is never appreciated, We should be provided with transportation when we engage in GBV cases, We as mentors experience alot of trauma that we are never given an ear. There are no follow up meetings about GBV like in our organization, and it's so sad since most of us are also victims of GBV We should be linked with organizations that deal with GBV ONLY so that we can help each other in sensitizations and everything, We need psychological support. As mentors we are doing alot of work with no appreciation" (Mentor, Group 1)

Chapter 5: Recommendations

5.1. Recommendation for LOVES' Training Implementation

Recruitment

Given that the program seeks to primarily target IP staff and train them to facilitate the LOVES training at their respective organizations, the recruitment process should emphasize the enrollment of IP staff with a quota on how many mentors should be enrolled. This would ensure that the participants who will most benefit from the Training-of-Trainer approach are reached. Additionally, the program team should work closely with the CDC POCs to reemphasize the role of IP staff and mentors being recruited for the training.

Data Collection

The pre-post assessment mostly assessed participants' knowledge regarding GBV practices and first-line response. The program team should consider including more questions targeting the attitudes and practices of the participants regarding first-line response. Additionally, self-efficacy needs to be further elaborated as well since only one question on the assessment tool targets this measure. Thus, the program team might consider including questions targeting 1) participants' self-efficacy in applying the LOVES model and 2) IP staff's self-efficacy in conducting the rollout of the trainings for future trainings.

Additionally, it could be beneficial to have consistent demographic information (i.e., gender, age, place of work) on the pre-post assessment, module answers, and feedback to assess for differences in experiences across these groups.

Lastly, although the program does not aim to train mentors as facilitators of the LOVES training program with the understanding that they might be asked to support their team in the rollout of the trainings, assessing their self-efficacy in providing this support could also be beneficial.

Ongoing support and trainings

The high number of feedbacks requesting more resources and additional trainings might indicate a need to better understand to what extent the current training effectively prepares the participants to apply LOVES in their roles and responsibilities as well as implement the rollout training with mentors. Additionally, it also suggests that participants might need refresher training to continue to practice the LOVES approach, share experiences and best practices as well as receive support from one another.

Virtual Training Format

Although the training format seems to have worked well for most participants, the course feedback indicates that someone participants, especially mentors living in rural areas, may have had difficulties participating in the lives zoom sessions, due to internet connectivity. They have suggested the use of handouts, and additional training materials that could be used to accompany the live zoom session, so they don't miss keys messages from the training in case of internet disruption.

LIVES and LOVES Clarification

The pre-post assessment refers to the training as LIVES(Mentors) which might create confusion between the LIVES training implemented by the program team with healthcare providers and the current LOVES training which is meant for mentors and peer supporters. Additionally, one of the pre-post assessment questions asks participants to identify what the "V"

in *LIVES* stands for rather than *LOVES.* Given that the participants of the LOVES training might have been recipients of the LIVES training as well, the program team should reemphasize the distinction between both trainings during the training implementation and through training materials such as the pre-post assessment.

5.2. Recommendations for future evaluations

There is a need to strengthen data collection tools to adequately assess targeted outcomes for future evaluations. The use of unique identifiers could be a way for the program team to track participants' engagement with all training components. This could be done by collecting the emails of participants and replacing these emails with unique identifiers. Each participant's email will correspond to a unique identifier that could be trackable from one form to another. However, the data analyzed will be de-identified (with unique IDs) and will not be able to be traced to the respondent. This would also facilitate the identification of duplicates, calculation of program completion, as well as the ability to conduct inferential analysis on the pre-post data and see if there are differences across groups.

5.3. Conclusion

This evaluation sought to assess the feasibility and acceptability of the LOVES training program by looking at the enrollment and completion measures, while also assessing the effect of the training on participants' knowledge on first-line response for disclosures of violence. Based on the findings from this evaluation, there seems to be a high level of feasibility and acceptability of the LOVES training program as a valid approach to reinforce the knowledge and skills of mentors in providing a first-line response to disclosures of violence from AGYW. The training content seems to be highly responsive to the needs of the participants. Both mentors and IP staff responded positively to the relevance of the training to their experiences with GBV, though it seemed that

there is a need for more culturally relevant content. The use of the Training of Trainers (ToT) model will hopefully address these challenges as facilitators find ways to adapt the training materials to the realities of their communities as they roll out the training with colleagues and other peer supporters. Additionally, although participants seem to have adapted to the format of the training, many still preferred the in-person training format. Furthermore, additional support and adaptations are needed to make sure the training is accessible for all participants especially those in areas with limited internet connectivity, and those with limited understanding of the English language. Although this evaluation provides some insight into the possible influence of the training on outcome measures, data collection tools will need to be refined to have a more robust understanding of the training's effect on change in knowledge, attitudes, practices, and self-efficacy of participants. Nevertheless, this evaluation provides insight into the feasibility and acceptability of the new virtual training model and the challenges involved. This insight can be used to inform future programming, especially at a time when organizations are looking for innovative ways to engage their participants given the barriers of the COVID-19 pandemic.

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Appendix 1: LIVES (Mentors) Training of Facilitators Assessment

We are requesting that you complete the following assessment before and after completing all course content. It will take approximately 10 minutes and you will have one opportunity to submit it. The results are anonymous, though you will be able to see your personal score for the graded questions.
Names, emails, and places of work are NOT collected through this form. The scores may be used as part of an evaluation of the CDC LIVES Training of Facilitators Package in the future, but the scores will not be linked to you or your personal information.

Please take note of your own score if you would like to track your personal progress. We will not be able to tell you your personal scores, as we are not collecting names on this form.

1. Please indicate your gender
   - ○ Man
   - ○ Woman
   - ○ Other/Non-binary
   - ○ Prefer not to answer
   - ○ Prefer to self-describe _____

2. Which best describes your place of work?
   - ○ U.S. Government Agency (e.g. CDC)
   - ○ Ministry of Health or other government ministry
   - ○ Non-governmental organization
   - ○ Health facility
   - ○ Other (please specify) _____

True or False:

3. GBV, which is the acronym for gender-based violence, is any form of violence against an individual based on biological sex, gender identity or expression, or perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl.
   - ○ True
   - ○ False
4. A mentor should serve as a social worker and counselor because the AGYW might not get any other help.
   - ○ True
   - ○ False

5. The purpose of listening is to give the AGYW a chance to share their experiences and express themselves in a place that is both safe and private.

   ○ True

   ○ False
6. It is a mentor's duty to convince a young woman subjected to violence to go to the police or the courts.

   ○ True

   ○ False
7. People in abusive romantic relationships may have valid reasons for not leaving, and mentors should avoid pressuring an AGYW to leave their partner.

   ○ True

   ○ False
8. A mentor can never **ensure safety** (guaranteeing that someone experiencing violence will avoid all harm) but they can **encourage safety.**

   ○ True

   ○ False
9. It is the mentor's job to look up all the mandatory reporting laws and policies and write standard operating procedures.

   ○ True

   ○ False

MULTIPLE CHOICE:

10. Which of these are things a mentor should **never** say to a person subjected to intimate partner violence or sexual violence? **(Please select as many as applicable)**

    ☐ a. "How do you feel about that?"

    ☐ b. "Why did you go there alone, don't you know it's dangerous?"

    ☐ c. "If it's so bad, you should just leave him"

    ☐ d. "I am worried that the violence may be affecting your health and your children's health"

    ☐ e. "You should go back home and try to keep yourself out of trouble in the future"

11. Secondary trauma can be emotional distress that results when an individual hears about the traumatic experiences of another individual. The symptoms can include:

    ○ feeling guilty, angry, or depressed

    ○ finding it difficult to relax

    ○ feeling angry or easily annoyed at people

    ○ having a hard time eating or sleeping

- ○ all of the above

12. First-line support is:
    - ○ a practical, survivor-centered, empathetic approach that responds to individual's needs (emotional, physical, safety and support) while respecting privacy
    - ○ only for counselors to use
    - ○ for helping people who have been in car crashes
    - ○ all of the above
13. The "V" in LIVES stands for Validate. What are the reasons for providing validation?
    - ○ Let the AGYW know that their feelings are normal
    - ○ Let the AGYW know it is safe to express their feelings
    - ○ Let the AGYW know that they have the right to live without violence
    - ○ Show the AGYW that you understand and believe them
    - ○ All of above
14. Which statement(s) best describes the role of the mentor in responding to violence?
    - ○ The mentor is responsible for stopping violence.
    - ○ The mentor is responsible for finding out the details of the violence that could help bring the perpetrator to justice.
    - ○ The mentor is responsible for responding empathetically to disclosures of violence.
    - ○ The mentor is responsible for telling the AGYW the best course of action they should take.
    - ○ All of the above
15. Have you ever received training in the LIVES approach for first-line support? **(Please select one)**
    - ○ Yes
    - ○ No
    - ○ No, but someone in my organization has
    - ○ Unsure/can't remember
16. Are you a mentor/peer supporter?
    - ○ Yes
    - ○ No

In order to better help you train mentors to respond to disclosures of violence as part of PEPFAR programming, we would like to know more about the resources that are available to you.

This portion of the assessment is not scored, and your responses should reflect your current situation to support mentors and responding to violence.

17. In supporting mentors to respond to disclosures of violence, do you have the following resources and support to help you to carry out your tasks: Answer yes, no, unsure, or n/a for each one**: (IP STAFF ONLY)**

a. A colleague with whom I can get advice on how to respond to a difficult case of violence or abuse if I don't know what to do

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

b. Existing guide or standard operating procedure on how to manage cases of intimate partner violence and sexual violence

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

c. Existing mandatory reporting policy

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

d. A private space where I can talk to a mentor or AGYW confidentially about their abuse

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

e. A supervisor who supports me working with mentors and conducting trainings for mentors

- ○ Yes
- ○ No

- ○ Unsure
- ○ N/A

f. Names and contact information of people within this facility to whom I can refer AGYW who discloses violence for additional counselling or psychosocial support or clinical care

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

g. Names and contact information of people outside the facility to whom I can refer AGYW for additional psychosocial support or post violence care

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

h. Previous training on how to identify and respond to violence (e.g., LIVES)

- ○ Yes
- ○ No
- ○ Unsure
- ○ N/A

18. How comfortable do you feel to facilitate a training for mentors on how to respond to violence using pre-assembled materials? Select a number from 1 (not at all comfortable) to 5 (very comfortable).

- ○ Not comfortable
- ○ I could do it with a lot of support
- ○ Neutral
- ○ I could do it with a little support
- ○ Very comfortable
- ○

Appendix 2: LOVES for Mentors 2021 Course Feedback

Thank you for completing the LOVES Training of Facilitators for Mentors. We are continuously updating and improving our LIVES/LOVES Training. Although this course feedback form is not required, we value your feedback. Responses to this form are anonymous and cannot be linked back to you. If these responses are ever used in future reports or evaluations, they cannot be tied back to you.

1. Please indicate your gender
   - ○ Man
   - ○ Woman
   - ○ Other/Non-binary
   - ○ Prefer not to answer
   - ○ Prefer to self-describe _____
2. Which best describes your place of work?
   - ○ U.S. Government Agency (e.g. CDC)
   - ○ Ministry of Health or other government ministry
   - ○ Non-governmental organization
   - ○ Health facility
   - ○ Other (please specify) _____
3. How satisfied are you with the overall training?
   - ○ Very satisfied
   - ○ Moderately satisfied
   - ○ Slightly satisfied
   - ○ Not at all satisfied
4. The Course on a Page/Google Forms platform was convenient for accessing course materials and presentations:
   - o Strongly Agree
   - o Agree
   - o Disagree
   - o Strongly Disagree
5. ***What changes would you make, if any, to the FORMAT of the training***
6. What is your opinion of the balance of lecture and interactivity in this course?
   - ○ Too much lecture and not enough interactive learning

- ○ Right amount of both lecture and interactive learning
- ○ Too much interactive learning and not enough lecture

7. Please rate your satisfaction with Module 1: Overview of GBV, Youth, and Trauma. (1= very unsatisfied, 5= very satisfied)
   - ○ 1. Very unsatisfied
   - ○ 2. Somewhat unsatisfied
   - ○ 3. Satisfied
   - ○ 4. Somewhat satisfied
   - ○ 5. Very satisfied
8. Please rate your satisfaction with Module 2: Responding to Disclosures using LOVES. (1= very unsatisfied, 5= very satisfied)
   - ○ 1. Very unsatisfied
   - ○ 2. Somewhat unsatisfied
   - ○ 3. Satisfied
   - ○ 4. Somewhat satisfied
   - ○ 5. Very satisfied
9. Please rate your satisfaction with Module 3: Self-Care. (1= very unsatisfied, 5= very satisfied)
   - ○ 1. Very unsatisfied
   - ○ 2. Somewhat unsatisfied
   - ○ 3. Satisfied
   - ○ 4. Somewhat satisfied
   - ○ 5. Very satisfied

10. How satisfied were you with the FACILITATION of the live sessions provided by the CDC Gender & Youth Team?
    - ○ 1. Very unsatisfied
    - ○ 2. Somewhat unsatisfied
    - ○ 3. Satisfied
    - ○ 4. Somewhat satisfied
    - ○ 5. Very satisfied

11. Please rate your agreement with the following statement: I felt my opinions were respected by the facilitators during the Zoom sessions.
    - ○ Strongly Agree

- ○ Agree
- ○ Disagree
- ○ Strongly Disagree

12. Please rate your agreement with the following statement: The role-play activities selected for Live Session 2 were helpful for my understanding of the principles of LOVES.

- ○ Strongly Agree
- ○ Agree
- ○ Disagree
- ○ Strongly Disagree

13. What part of this course was most helpful to your learning? Why?

14. In what ways could this training session be improved to make it a more effective learning experience?

15. Are you a mentor?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Mentors Only

16. For mentors: What do you think organizations and CDC/PEPFAR staff should know for future trainings? Including necessary support, the role of a mentor, and mentor challenges.

17. Please share any additional comments.