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MIDTERM EVALUATION: STAMPING OUT AND PREVENTING GENDER-BASED VIOLENCE IN ZAMBIA

December 2015

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Jessica Menon, Tasila Mbewe, Oscar Mutinda, Kasubika Chibuye and Eugene Wafula.

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MIDTERM EVALUATION OF STAMPING OUT AND PREVENTING (STOP) GENDER-BASED VIOLENCE (GBV) ZAMBIA

December 2015

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DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect those of the United States Agency for International Development or the United States Government.

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ACRONYMS

ASAZA	A Safer Zambia
C&T	Counseling and testing
CARE	Cooperative for Relief and Assistance Everywhere
CM	Child marriage
DFID	Department for International Development (UK)
D2G	Direct to government (One Stop Center)
EC	Emergency contraception
ECM	Early child marriage
ECR	Expanded Church Response
FAWEZA	Forum for African Women Educationalists of Zambia
FGD	Focus group discussion
GBV	Gender-based violence
GBVIMS	Gender-based violence information management system
GBVSS	Gender-Based Violence Survivor Support Services
GH Pro	Global Health Program Cycle Improvement Project
GRZ	Government of the Republic of Zambia
HIV	Human immunodeficiency virus
IDIs	In-depth Interviews
IEC	Information, education and communication
KAP	Knowledge, attitudes and practice
KII	Key informant interview
LoP	Life of project
MCD/MCH	Ministry of Community Development and Mother and Child Health
MGCD	Ministry of Gender and Child Development
MoH	Ministry of Health
M&E	Monitoring and evaluation
NGO	Nongovernmental organization
OPD	Outpatient department
OSC	One Stop Center
PEP	Post-exposure prophylaxis
PMP	Performance Monitoring Plan
SGBV	Sexual and gender-based violence
SIA	Sports in Action
STOP GBV	Stamping Out and Preventing Gender-Based Violence
STOP-GBVAJ	Stamping Out and Preventing Gender-Based Violence Access to Justice
ToC	Theory of change
UNFPA	United Nations Population Fund

UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VfM	Value for money
VSL	Village Savings and Lending
VSU	Victim Support Unit
WHO	World Health Organization
WiLDAF	Women in Law and Development in Africa
WLSA	Women and Law in Southern Africa Research and Educational Trust
WVZ	World Vision Zambia
YMEP	Young Men’s Empowerment Program
ZARD	Zambia Association for Research and Development
ZCCP	Zambia Centre for Communication Programmes
ZDHS	Zambia Demographic and Health Survey
ZMW	Zambian Kwacha (currency)

EXECUTIVE SUMMARY

Background

The overarching purpose of this midterm process and performance evaluation is to assist the United States Agency for International Development (USAID)/Zambia, Department for International Development (DFID) UK, and implementing partners to understand preliminary results of STOP GBV Zambia.¹ Preliminary results identify gaps in program design and implementation across the three program components and across existing and scale-up sites that require improvement to achieve results.

STOP GBV is comprised of three components working simultaneously toward a GBV Theory of Change (ToC) with the expected impact to reduce gender-based violence (GBV) and child marriage (CM) in Zambia. To achieve the desired project impact, STOP GBV is working to provide: (1) GBV survivor support services; (2) access to justice; and (3) prevention and advocacy. An additional objective, engaging men and boys through sports, was added to six scale-up sites as part of the first component in 2014. STOP GBV is implemented by World Vision Zambia (WVZ), Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP); each has an individual agreement/contract to implement separate components. In total, USAID and DFID are contributing \$27.4M (2013-2018).

Evaluation Method

This midterm evaluation took place over the time period of May–September 2015 and utilized primarily qualitative research methods combined with limited quantitative analysis drawing from existing project monitoring and evaluation (M&E) and financial data to answer the defined research questions. All primary and secondary data collection and review adhere to strict internationally-recognized safety and ethical considerations for handling sensitive information and interacting with GBV survivors. Six project sites were purposefully selected, where 57 in-depth interviews (IDIs) and 18 focus group discussions (FGDs) were conducted. In addition, quantitative and cost analysis was conducted based on existing available data provided by implementing partners across all project sites.

Key Findings

Program Design and M&E

The STOP GBV program is well designed, rooted in international best practice and lessons learned from its predecessor program, ASAZA². The STOP GBV ToC provides a clear and comprehensive multi-sector prevention and response roadmap toward the expected impact of reduced GBV and early child marriage (ECM). The STOP GBV ToC may benefit from a midcourse review among partners focused on identifying additional advocacy efforts to improve program sustainability; addressing constraints such as underlying economic vulnerability of survivors and potential survivors and barriers to access to justice (including inadequate support for witnesses and ongoing issues with community confidence in police); and supporting national efforts to improve retention of health care workers involved in management of GBV.

Implementing partners are currently using different definitions of GBV³ operationally, resulting in communication inconsistency in outreach, differences in types of GBV cases driven to One Stop Centers (OSCs), and ambiguity in how GBV cases are categorized for M&E and learning purposes. Adapting a unified program-wide definition of GBV may support program cohesiveness in implementation.

¹ Stamping Out and Preventing Gender-Based Violence

² A Safer Zambia

³ As further elaborated in the report, different partners use definitions from the UN or Anti-GBV Act, or no definition.

Efforts are made among implementing partners to monitor and evaluate outcome-level results, beyond outputs, and the baseline assessment includes meaningful outcome-level data that may be evaluated at endline. However, baseline assessment data are limited for purposes of outcome-level endline evaluation in two ways: (1) the baseline only collects data from five out of the 16 OSC sites and one former ASAZA site currently operated by the Government of the Republic of Zambia (GRZ), one of which is no longer supported by the program, which will limit the ability to conduct rigorous analysis; and (2) data focus on GBV prevalence, prevention and awareness, as well as OSC services; there is little baseline data at the outcome level on access to justice or long-term survivor outcomes.

Coordination

Memoranda of understanding are in place among the implementing partners (WVZ, ZCCP, and WLSA), and national-level coordination is strong across implementing partners and with national government partners. Stronger horizontal coordination across all sub-grantees, which currently communicate vertically with their direct implementing partners, will be useful to drive holistic interactions across all partners to implement activities with efficiency. Further, consistency across sites of coordination among partners at the district and community levels could be strengthened, particularly among coordination of community volunteers with various organizations.

Value for Money (VfM)

VfM indicators and targets set out in the DFID Business Case include:

- Economy: Unit cost of training per capita; unit cost per GBV survivor receiving OSC services
- Efficiency: Unit cost per GBV case adjudicated; percentage of administrative costs of implementing partners
- Effectiveness: Cost of GBV case averted

Per capita training costs ranged from \$13 for a one-day training for police officers outside of Lusaka to \$728 for a five-day Gateway to Grants training. The average unit cost for training is \$316 per capita for paralegals, \$13 per capita for police (excluding indirect costs), \$28 per capita for magistrates and \$628 per capita for judges.

In the two years from project inception in 2013 to March 2015, 24,245 clients have received OSC services for a total direct cost reported by WVZ of approximately US\$1.7 million, at a unit cost of \$113 per OSC client across all sites.

From project inception to the most recent date when financial data were made available, WVZ administrative costs expended were 37 percent of its total expenditures, WLSA's were 44 percent, and ZCCP's were 45 percent. Data are not currently available to calculate unit costs per GBV case adjudicated or per GBV case averted.

Overarching Program Performance

Overall, reported cases of violence to OSCs have more than quadrupled from the first quarter of STOP GBV operations to the latest quarter for which there are data (2015), indicating significant success of the program. Reported cases of child neglect and abuse (non-GBV cases), physical assault and emotional abuse are increasing exponentially. Gains have also been made in increased reporting of more stigmatized sexual and gender-based violence (SGBV) cases, such as rape and sexual assault, as well as ECM and denial of resources, but not at the same rate as the aforementioned case types.

Two indices⁴ were created to measure STOP GBV program and process performance to date, based on available partner M&E data. Only one site received a "high" capacity-building index score (Nakonde, a

⁴ Further details on the indices, including variables included and calculations used, appear in the main body of the report.

direct/original site). Seven sites received “medium” scores (all seven direct sites, zero “direct to government,” or D2G, sites), and eight sites received “low” scores (three direct, five D2G). This means that, as of the midterm evaluation, these eight sites did not yet receive a threshold “dose” of program inputs from all partners, mostly in the form of training for staff and relevant program stakeholders. It indicates the need for partners to intensify and move forward with planned capacity-building for the D2G sites.

The output index score measures whether or not, across partners, certain targeted outputs have been achieved. In other words, how many sites are demonstrating direct results as planned? Six sites received “high” scores (five direct, one D2G), nine received “medium” scores (six direct, three D2G), and one D2G site received a “low” score. Again, this simply indicates that partners need to intensify planned activities with D2G sites in order for them to move forward toward STOP GBV intended results.

Gender-Based Survivor Support Services (World Vision Zambia)

To meet the first objective of strengthened GBV survivor services, WVZ has successfully opened 16 fully operational OSCs in 16 districts in eight provinces (Central, Copperbelt, Southern, Lusaka, Eastern, Western, Northern, Muchinga). Services provided by most OSCs include: comprehensive case management; on-site services including psychosocial counseling for adults and children, HIV counseling and testing, provision of post-exposure prophylaxis (PEP) and emergency contraception (EC), legal advice for adults and children, and referrals to services including medical care, legal service, shelters and livelihood opportunities. Although most OSCs operate during regular business hours from 9:00 to 17:00 Monday through Friday, some sites provide 24-hour on-call services, and at other sites the outpatient department (OPD) at the hospital to which the OSC is attached handles basic in-take services until the OSC staff are available during normal operating hours. GBVSS is on target to meet the life-of-project (LoP) target of 51,300 individuals who receive post-GBV care, with a reported 26,468 who have received services at an OSC to date.

Six sites were scaled up to receive additional activities to engage boys and young men through sport. Sport in Action (SIA) developed a Young Men’s Empowerment Program (YMEP) curriculum, held meetings with the stakeholders where they began operating in late 2014, and trained 150 (out of a targeted 300) peer leaders and coaches (25 per district) in sports programs integrated with anti-GBV messages and life skills. So far SIA has directly reached 6,728 boys and young men who have completed the 10-hour minimum criteria by June 2015.

Key successes of this GBVSS component include anecdotal evidence across the six sampled sites, with corroborating GBVSS M&E data in some instances, of decreased reporting barriers, expanded services, improved quality of services and improved access to justice.

Key challenges in increasing demand for and supply of services to GBV survivors include lack of transport, inconsistency in timely receipt of free medical reports, inconsistent availability of adequate physical infrastructure and supplies, varying quality of services and staff, and weak referral systems, including inadequacies of certain types of referred services.

Access to Justice (WLSA)

WLSA signed its contract in April 2013 and began implementing this component in August 2013 in 8 districts (Lusaka, Chongwe, Nakonde, Mongu, Kafue, Kapiri-Mposhi, Choma and Katete), but was scaled up in 2015 to six additional districts (Mpika, Kalomo, Mumbwa, Chingola, Nyimba and Monze) to a total of 14 districts in seven provinces.

To meet the objective of raising awareness of GBV laws and gender issues in the community, WLSA has exceeded its set target (44) in sensitizing 101 community leaders, although it has fallen short of meeting

the target of 6,900 individuals, reaching 1,970 individuals in Year I, which WLSA attributes to delays in funding.

To meet the second objective to strengthen the capacity of service providers in handling GBV cases, WLSA has made progress in meeting targets to hold consultative meetings with judges, develop training materials, and train all paralegals across the 14 OSCs where WLSA operates. Progress has also been made in training of magistrates, police officers, doctors and others, although targets have largely not been met, again due to funding limitations cited by WLSA.

Key successes in increasing demand for and supply of access to justice services for GBV survivors include progress toward strengthened policies, expanded knowledge and tools for handling legal aspects of GBV cases, expanded paralegal services in OSCs, increases in total numbers of prosecuted GBV cases, and contributions to efforts in expanding knowledge of rights.

Key challenges in demanding and supplying access to justice services to GBV survivors include stigmatization and economic vulnerability of survivors; lack of survivor documentation; weak witness support; lack of logistics and supply for evidence collection; weak legal system for implementing laws; corruption and mishandling of cases by police; and inadequate OSC staff support to survivors.

Prevention and Advocacy (ZCCP)

ZCCP carried out activities to achieve its objectives to decrease societal acceptance of GBV and child marriages in Zambia, enhance protective factors against GBV and improve the enabling environment to prevent and respond to GBV and child marriages.

To meet its objective to decrease societal acceptance of GBV and child marriages in Zambia, ZCCP has engaged 98,629 and 10,695 individuals in community dialogues and community conversations, respectively, on gender and HIV, 48,376 individuals in dialogues on child marriages, and 458 traditional leaders in FGDs. To meet its second objective to enhance protective factors for GBV, it has trained 350 female Village Savings and Lending (VSL) members in financial literacy, GBV and child marriage, and has supported Lifeline to counsel 15,055 individuals on child marriages, GBV and HIV/AIDS-related issues through telecommunications. To improve the enabling environment to prevent and respond to GBV and child marriages, ZCCP has engaged three traditional leaders as change agents, and facilitated more than 10 District Development Gender Sub-Committee meetings.

Key successes in GBV prevention and advocacy include active and passionate community volunteers; traditional leaders fulfilling roles as change agents; increased community awareness of GBV; increased demand for OSC services; and increased ownership of community in GBV prevention and advocacy.

Key challenges in demanding and supplying GBV prevention and awareness include ongoing accepting attitudes among community members regarding GBV; lack of knowledge regarding some GBV issues; distance to harder-to-reach rural communities; logistical constraints for community volunteers; fear-based awareness raising; limited reach in the current absence of mass media use; incorrect use of GBV definition that may reinforce gender inequality; limited support for GBV survivors informally conducting outreach, which is not currently in ZCCP's scope or mandate; and increasing demand for Lifeline without adequate manpower and capacity to handle current demand.

Conclusions and Recommendations

STOP GBV is providing urgently needed critical services to a broad range of survivors of violence, including widespread non-GBV cases such as child abuse and neglect. It is also showing preliminary anecdotal evidence of influencing knowledge, attitudes and practices (KAP) about violence in communities where it operates. There is evidence of determination and group work with both governmental and non-governmental stakeholders coming together to implement GBV services and improve response and coordination capacity. The engagement of men and boys via SIA is underway to

various extents across six scale-up sites, with preliminary indication that it is enhancing prevention and advocacy.

At the same time, there are ongoing challenges in this multi-faceted problem. It is recognized that GBV is rooted fundamentally in entrenched gender inequality, poverty and other drivers, and as a result is a problem that requires intensive multi-sector cooperation and patience in observing long-term change.

Programmatically, this change may be driven by STOP GBV by adapting a cohesive operational definition of GBV consistently used by all partners, as well as review of outcome-level indicators across components and ongoing analysis that informs decision-making. Key service provision gaps include limited transport options, lack of shelters and lack of widespread livelihood opportunities that provide income required for survivors to securely leave unsafe living arrangements.

Recommendations are presented for consideration in order to make adjustments to improve or enhance success in achieving the intended STOP GBV Program results. These overarching recommendations include:

- **STOP GBV Program:** Ensure implementation is on the road to change as laid out in the ToC and ensure partners are using cohesive definition of GBV theoretically and operationally.
- **GBV Survivor Support Services:** Focus on service and referral quality; strengthen linkages to programs to remove constraints to services and longer-term well-being; and work with national partners to integrate performance assessment standards for OSC and staff.
- **Access to Justice:** Improve data collection and analysis programmatically and with national partners; continue work to provide technical support and reference guides to stakeholders (e.g., police, prosecutors) nationwide; focus on technical solutions to remove underlying barriers and root causes to accessing justice.
- **Prevention and Advocacy:** continue expanding awareness efforts, with a focus on awareness regarding PEP and targeting reduction of stigmatization of SGBV, especially marital rape; collect quantitative outcome-level change measurements in addition to planned KAP surveys, such as effects of awareness campaigns on reporting and incidence of ECM; review definitions and operational implementation of materials by male change agents.

I. EVALUATION PURPOSE

This section provides an overview of the purpose of this midterm evaluation, including the evaluation type, objectives, research questions and the intended use of the evaluation results.

A. EVALUATION PURPOSE

The overarching purpose of this independent midterm formative evaluation is to assist the United States Agency for International Development (USAID)/Zambia, Department for International Development (DFID) UK, and implementing partners to understand preliminary results of STOP GBV Zambia. Preliminary results will identify any gaps in program design or implementation across the four program components and across existing and scale-up sites that require improvement to achieve results.

This midterm evaluation is designated as a performance and process evaluation, which focuses on descriptive and normative questions primarily targeted at the implementation of STOP GBV. This is not an outcome evaluation. The midterm evaluation assesses the effectiveness and efficiency of all four STOP GBV components and the likelihood that the program will achieve the planned goals and targets.

- **Objective 1:** Determine what project components and aspects are working well or not, and why.
- **Objective 2:** Make recommendations for modifications and midcourse corrections, if necessary, that will help guide the STOP GBV project over its second half.

This midterm evaluation assesses the performance of implementing partners from project inception (April 2013) to date (June 2015), in following the roadmap of the STOP GBV Theory of Change, and progress to date in meeting indicator targets as indicated in each implementing partner's Results Framework and Performance Monitoring Plan (PMP) found in Annexes E-G.

Evaluation questions defined in the scope of work for this evaluation, found in Annex A, include the following:

- Is the STOP GBV program and all its components designed in such a way as to achieve its outcomes, and is the program on track to achieve the latter? (Effectiveness)
- If some interventions are more successful than others, why, and are they the right combination of interventions? (Effectiveness)
- What operational program improvements can be made to ensure impact and outcomes are achieved? (Efficiency)
- How did coordination and collaboration between the implementers and the Government of the Republic of Zambia (GRZ) bolster or hinder project outcomes? (Efficiency)
- Do the results being achieved represent value for money as set out in the Business Case? (Efficiency)

Specifically, this evaluation assesses what STOP GBV has achieved to date, how well it is implemented, how services and management practices are perceived and valued, and whether expected results are occurring. The evaluation further assesses whether the program design was sound, effectiveness of management and operational decision-making, coordination among stakeholders, sustainability and how to improve handover, and cost effectiveness. The evaluation also assesses differences across sites, including access to services and how the services are delivered, and differences that may be observed in sites operated directly by the government and those receiving the full "dose" of all project components, including the most recently added component of engaging men and boys through sport.

B. USE OF FINDINGS

The primary audiences for this midterm evaluation are USAID/Zambia and DFID staff, implementing partners, sub-grantees and government partners. This midterm evaluation is intended to be used as a tool for these stakeholders to recognize and build upon successes achieved to date while understanding challenges and opportunities to strengthen the project to sustainably achieve planned results.

- USAID, DFID and implementing partner program managers may make decisions about the project (e.g., improvements, replication, services, modifications, etc.).
- Implementing partner and sub-grantee program staff may make changes throughout implementation (e.g., expanding services/outreach to a new target group, changing meeting times, etc.).
- Implementing partner and sub-grantee managers and staff may make decisions on using and sharing monitoring and evaluation (M&E) data with key stakeholders for advocacy and programming needs.
- USAID, DFID and government partners may inform other agencies or government departments of gaps and opportunities to strengthen the national GBV prevention and response efforts.
- USAID, DFID and government partners and policymakers may use evidence to advocate for new laws, policies and strategies to address GBV.
- USAID, DFID, implementing partners and government partners may identify ways for the project to strengthen national GBV data collection, analysis and use efforts.
- Community leaders, local activists and community-based organizations may use evidence to promote community-based awareness regarding GBV.

Ultimately, lessons learned and key findings of this evaluation are intended to be institutionalized within USAID/Zambia, DFID and their partners in making current decisions regarding STOP GBV and future decisions about GBV prevention and response programming in Zambia.

II. PROJECT BACKGROUND

This section provides an overview of the original problem that the evaluated project addresses and a project description to understand the context of the evaluation. Various definitions of GBV are utilized by implementing partners and stakeholders, further explored in Section V and defined in Annex D.

A. ORIGINAL PROBLEM

The prevalence of violence against women and girls is very high. Globally, 35 percent of women are estimated to have experienced physical or sexual violence. In Zambia, nearly half (47 percent) of ever-married females age 15-49 report ever experiencing physical, sexual and/or emotional violence from their current or most recent partner; 43 percent of all females experienced physical violence at least once since age 15, and 17 percent ever experienced sexual violence (Zambia Demographic and Health Survey (ZDHS) 2013/14).

Children are vulnerable to violence, especially sexual abuse. Almost 50 percent of sexual assaults worldwide are against girls age 15 and younger (USAID 2012). A survey found that 31 percent of girls and 30 percent of boys age 13-15 in Zambia were forced to have sex (Brown 2009). In another survey, 25 percent of women and 16 percent of men in Zambia reported they had sex before age 18 because they were threatened or forced, with a suggested link between a boy's experience of physical or sexual abuse and perpetration of violence and of rape as adult men (UNICEF 2013).

Zambia has one of the highest rates of child marriage in the world.⁵ Nearly one-fifth (17 percent) of girls in Zambia age 15-19 are married, and 65 percent are married by age 20 (ZDHS 2013/14). A UNFPA study conducted in six districts in Zambia found that the most common unions are those that take place between peers—girls (from age 12-13) and boys (from age 14), usually with an age difference of about two to three years. (UNFPA, draft report 2015). Girls from the poorest 20 percent of households are five times more likely to be married before age 18 than girls from the richest quintile (ZDHS 2013/14). The UNFPA study concluded that marriages in girls are more likely to marry than boys due to poverty and limited access to a wide range of programs, information and services. Specifically, many families find it cost-prohibitive to send girls to secondary school.⁶ In one district, other risks that may precipitate marriage included girls who are living far from school exchanging sex for transport to avoid punishment for tardiness, exposing girls to pregnancy, HIV and violence, further lowering parents' desire to support girls to remain in school (UNFPA, draft report 2015).

Gender discrimination and inequality affect all aspects of women's and girls' lives. Zambia ranked 124 out of 137 countries on the 2011 Gender Inequality Index with a score of 0.627 (GII 2011). Women have lower status than men and are less likely to participate in politics and decision-making. Only 19 of Zambia's 287 traditional leaders are women (GII 2011). While the Constitution prohibits discrimination on the basis of sex, Article 23(4) allows application of customary law, which on issues such as inheritance, financial and property rights and marriage often discriminates against women.

Women are often economically dependent on men. Women in Zambia are more likely to be poor because they lack access to productive resources such as land, credit and technology (2010 Gender Audit of the Social Protection Sector). Less than 20 percent of statutory land is owned by women. Women have fewer employment opportunities and are less likely to be employed in the formal sector than men; economic dependence on men often forces women to remain in abusive relationships.

⁵ In Zambia, statutory law defines child marriage as marriage below the age of 18, while in the Anti-GBV Act (2011) a child is defined as a person below the age of 16.

⁶ The UNFPA 2015 study reports that in rural areas, annual family income is, on average, 9,000 kwacha, while secondary school tuition is, on average, 2,770 kwacha before indirect costs (e.g., uniforms, materials, transport).

Social and cultural norms legitimize male power and control of women and girls. Deeply entrenched social and cultural norms underpin gender inequality and discrimination in Zambia. Women are regarded as subordinate to men, and they have little voice, autonomy or status within communities. Women are taught not to speak in the presence of men, including their husbands (2011 Gender Sector Analysis). Men and women condone GBV as normal, and women and girls have little scope to negotiate sexual relationships (ZDHS 2013/14). Many women and girls do not report sexual violence by partners, because social and cultural norms reinforce male sexual entitlement. Social and cultural norms also condone consumption of alcohol by men, closely associated with GBV.

GBV has a serious impact on health. Physical consequences include injuries and trauma, unwanted pregnancies, gynecological problems, chronic pelvic pain, sexually transmitted infections including HIV, and infertility. WHO estimates that 42 percent of women globally who were physically or sexually abused by a partner experienced injuries (WHO 2013). Women who experienced sexual violence are more likely than non-abused women to use family planning clandestinely, to have partner stop them using family planning, and to have a partner refuse to use a condom (Garcia-Moreno et al 2002). A link is also suggested between short birth intervals and the mother's experience of violence (ZDHS 2013/14), which has an adverse effect on infant health and survival. Psychological consequences of GBV include fear, anxiety, post-traumatic stress and suicide (WHO 2002). The UNICEF 2013 survey found that 35 percent of women who were raped had attempted suicide (UNICEF 2013).

Sexual violence is a factor in adolescent pregnancy and HIV infection. Sexual coercion increases the risk of HIV, sexually transmitted infections, unwanted pregnancy and unsafe abortion. In a survey in Zambia, 26 percent of females in urban areas and 20 percent in rural areas reported being forced to have sex (Zambia Sexual Behaviour Survey 2009). Rates of adolescent pregnancy are high—29 percent of girls age 15-19 in Zambia are pregnant or already have at least one child, more than one-third of women give birth by age 18 and more than half give birth by age 20 (ZDHS 2013/14). Further HIV prevalence among females 15-19 years old is 4.8 percent, compared with 4.1 percent for males, and 11.2 percent among 20-24 year-old females, compared to 7.3 percent among males (ZDHS 2013/14). The UNICEF 2013 survey in Zambia found that women who experienced partner violence in the previous 12 months were more likely to be HIV-positive than women who were not abused (UNICEF 2013).

GBV has economic costs. A 2014 study of the costs of GBV in Zambia estimated that approximately ZMW 1.78 billion was spent nationally in 2013, representing just over one percent of the GDP, out of which ZMW 1.03 billion were direct costs to survivors and their families (ZMW 836 million) and perpetrators and their families (ZMW 192 million), which include medical, legal and displacement costs (ZARD, 2015). In addition, ZMW 682 million was estimated to be spent on indirect costs (0.42 percent of GDP), such as lost income due to permanent injury, displacement of survivor or perpetrator, and attending to legal cases (ZARD, 2015). The 2013 survey in four districts in Zambia found that 38 percent of women who were physically abused suffered injuries; 30 percent spent an average of five days in bed and 7 percent took an average of five days off work because of injuries (UNICEF 2013).

Awareness and uptake of services for GBV survivors is low. Forty-two percent of females age 15-49 in Zambia who experienced physical or sexual abuse did not seek help (ZDHS 2013/14). The UNICEF 2013 survey found that only 14 percent of females who were raped and 12 percent who were physically abused by partners reported the incident to the police, while only 7 percent of physically abused women obtained a protection order against their partner (UNICEF 2013). The majority of survivors presenting to police are children, attributed to social perceptions of child sexual abuse as an unequivocal crime, as opposed to ambiguous attitudes towards adult sexual violence (UNICEF 2013).

There are significant challenges in access to justice. Zambia has a dual legal system—statutory law based on English common law, and customary law. Although statutory law takes precedence, in practice in rural areas customary law has primacy. It is estimated that only 10 percent of GBV cases in the

Southern African Development Community region are reported to the police, and few of these cases are successfully prosecuted. Women and girls are often encouraged by community leaders and sometimes by police to settle cases outside the legal system (Leonardi, C. et al 2010). Women and girls often request that cases are dropped, either because compensatory payments are arranged, they are economically dependent on their perpetrators, pressure is brought on them, or they have little faith in the formal justice system (Gender Research and Advocacy Project 2009). When women and girls do proceed, they face barriers to achieving a prosecution, including limited police investigative and forensic capacity, lack of lawyers providing legal aid, failure of witnesses to appear, and court system delays.

Efforts to change attitudes and social norms concerning GBV need to be scaled up. The ZDHS 2013/14 found that 47 percent of women and 32 percent of men believe that a husband is justified in beating his wife for at least one reason. The UNICEF 2013 survey found that 47 percent of women and 48 percent of men agreed that if a woman has done something wrong her husband has the right to punish her; 55 percent of women and 47 percent of men agreed that a woman does not have the right to refuse sex with her husband; 36 percent of women and 43 percent of men agreed that in some rape cases women want it to happen; and 41 percent of women and 48 percent of men agreed that in a rape case it is worth questioning whether the woman is promiscuous (UNICEF 2013).

Prevention efforts targeting men and boys must be strengthened. There is consensus that empowering women and changing laws alone will have limited impact on GBV in the absence of interventions to address attitudes and behaviors of GBV perpetrators. The UNICEF 2013 survey found that 73 percent of men admitted to having perpetrated an act of GBV, and 31 percent reported that they have perpetrated rape (UNICEF 2013).

Better data and more effective monitoring are required. GBV is under-reported, and official statistics tend to underestimate the problem. Many forms of GBV, such as emotional and economic abuse, are not recorded, as there are no official police categories for these abuses. The police, courts and clinics do collect data, but there is a need to standardize and strengthen systems for reporting GBV cases, to ensure that standard case definitions are used and to avoid double-counting of reported cases.

B. PROJECT DESCRIPTION

USAID and DFID launched the STOP GBV project in 2012 with a combined funding level of over \$15 million in ten districts of Zambia to reduce GBV and child marriage. DFID Zambia scaled up its support to STOP GBV with an additional \$11.7M in February 2014 to cover an additional 6 districts with GBV services and to expand programming to include an objective of engaging boys and men through sport. In total, USAID and DFID are contributing \$27.4M over a five-year period (2013-2018). STOP GBV comprises four components working simultaneously toward a GBV theory of change (ToC) with the expected impact to reduce GBV and child marriage in Zambia.

STOP GBV supports GRZ efforts to prevent and respond to GBV. The GRZ has ratified numerous relevant international conventions.⁷ It is a signatory to the 1998 Addendum on the Prevention and Eradication of Violence against Women and Children, which includes measures to: enact and enforce relevant laws, provide information, provide protective and health services, introduce training programs for law enforcement officials and the judiciary, and gather data on incidence of violence against women and children. The GRZ also enacted the Anti-GBV Act No. 1 (2011), which constituted the Anti-GBV Committee within the Ministry of Gender and Child Development (MGCD), vested in the District

⁷ International conventions ratified by the GRZ include: International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Convention for the Elimination of Racial Discrimination; and Convention on the Rights of the Child. Zambia has signed but not yet ratified two Optional Protocols to the CRC.

Commissioner’s Office with the District Administrative Officer, and includes provisions for protection orders, occupation orders and shelters.

To achieve the desired project impact, STOP GBV is implementing comprehensive prevention and response activities with the following program components: (1) GBV survivor support services; (2) access to justice; and (3) prevention and advocacy, with an added objective to the first component of engaging men and boys through sports. The expected impact of STOP GBV is reduced GBV and child marriage in Zambia. STOP GBV is implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP), each with its own agreement or contract to implement separate components. The results frameworks and logframe matrices for each program component are attached in Annexes E-G. Table I provides an overview of each component.

Table I. STOP GBV Zambia Program Component Overview

Component	Overview
GBV Survivor Support Services (GBVSS)	<ul style="list-style-type: none"> • Implementing Partner: World Vision (<i>Sub-grantees: SIA, ECR, FAWEZA</i>) • Objective: Increase availability of comprehensive, quality services for GBV survivors through One Stop Centers that employ a culturally sensitive, survivor-centered approach. • Illustrative Activities: Provide integrated package of medical care, counseling, HIV counseling and testing, provision of PEP and EC, legal advice and support for adults and children; train One Stop Center staff and service providers; refer survivors to services (e.g., medical, shelter, economic support), and liaise with services; conduct mobile outreach in rural communities to promote awareness and provide services; and conduct organizational assessments of STOP GBV partners and conduct capacity-building. • Timeline: October 2012–October 2017 • Target Population: 576,482 community members reached through community dialogues and conversations, 288 community volunteers trained, 120 traditional leaders, and 53,642 individuals counselled via Lifeline or Helpline • Total Budget (USD): \$14,202,362 federal, \$1,029,070 match • Geographic Coverage: 24 districts in eight provinces (16 WWZ OSC sites with eight additional sites including Kabwe, Kitwe, Luanshya • Government partners and roles: Ministry of Community Development/Mother and Child Health (MCD/MCH), Ministry of Health (MoH), MGCD⁸
Access to Justice (STOP-GBVAJ)	<ul style="list-style-type: none"> • Implementing Partner: WLSA (<i>sub-grantee: WILDAF, Lifeline</i>) • Objective: Provide support for GBV survivors to obtain access to justice and strengthen the capacity of the police and legal system. • Illustrative Activities: Train paralegals located in OSCs to provide legal advice and support survivors; sensitize police and strengthen capacity for investigation, evidence, prosecution, protection; train legal/judicial stakeholders including lawyers, judges, magistrates and prosecutors; sensitize traditional chiefs/headmen on GBV, statutory law and referrals; train service providers (e.g., health and social workers) to refer survivors for legal support; and increase community awareness of legal aspects of GBV through mobile outreach activities. • Timeline: April 2013–March 2018 • Target Population: 1,304 service providers trained; 51,300 GBV survivors provided with legal advice; 2,565 GBV cases taken to court; 3,450 community members sensitized • Total Budget (USD): \$4,497,135 (scaled-up from \$3,298,237 previously)

⁸ Current names of these Ministries at the time of the evaluation. Names may have been changed since publication due to realignment.

Component	Overview
	<ul style="list-style-type: none"> • Geographic Coverage: 14 districts in six provinces: eight original districts (Choma, Kafue, Katete, Kapiri-Mposhi, Lusaka, Mongu, Nakonde and Chongwe) in six provinces (Lusaka, Central, Eastern, Southern, Western and Muchinga), scaled to an additional six districts in 2015 (Mpika, Kalomo, Mumbwa, Chingola, Nyimba and Monze), adding Copperbelt Province • Government partners and roles: Ministry of Justice, National Prosecutions Authority, High Court, Supreme Court, Victims Support Unit Headquarters
Prevention and Advocacy	<ul style="list-style-type: none"> • Implementing Partner: ZCCP (<i>sub-grantees: CARE, Lifeline</i>) • Objective: Change social norms, attitudes and behavior; tackle GBV risk factors by sensitizing and mobilizing communities through comprehensive communication program. • Illustrative Activities: Sensitize traditional, community and religious leaders about GBV and early child marriage; train men as advocates or 'change agents' to communicate with other men about GBV; use community dialogue, drama and radio to increase community awareness on GBV; run a telephone helpline for GBV survivors and perpetrators; work with traditional and community structures to shift negative social norms on ending child marriage • Timeline: April 2013–April 2018 • Target Population: 375,495 community members reached through community dialogues, 288 community volunteers trained, 120 traditional leaders, and 53,642 individuals counselled via Lifeline or Helpline • Total Budget (USD): \$8,714,766 • Geographic Coverage: 24 districts in eight provinces (16 WVZ OSC sites with eight additional sites including Kabwe, Kitwe, Luanshya, Ndola, Chipata, Sinda, Chinsali, and Monze). • Government partners and roles: MGCD, Ministry of Chiefs and Traditional Affairs
Engaging Boys and Young Men through Sport ⁹	<ul style="list-style-type: none"> • Implementing Partner: World Vision (<i>sub-grantee: Sports in Action</i>) • Objective: Use football as a means of engaging boys and young men (ages 12-23 years) to complement change attitudes and behaviors related to GBV and harmful social norms. • Illustrative Activities: Build positive attitudes and increase awareness of gender and GBV through existing teams and clubs; train football coaches as mentors to reinforce positive messages about gender; organize district tournaments where GBV messages are disseminated to a wider audience; organize weekly meetings of boys' and young men's groups to reinforce anti-GBV messages; and work with parents to improve inter-generational communication. • Timeline: July 2014–April 2018 • Target Population: 300 coaches trained, 43 schools in 50 communities, 3,000 boys and young men age 12-23 • Total Budget (USD): \$1,133,416 • Geographic Coverage: Six districts (Mumbwa, Chingola, Nyimba, Kalomo, Monze, Mpika) in Central, Copperbelt, Eastern, Southern and Northern provinces • Government partners and roles: Ministry of Youth and Sport

⁹ This is **not** its own component, but is embedded as an objective under GBVSS (Component 1). However, separate detail is presented here due to interest in the evaluation terms of reference.

III. EVALUATION METHODS

This section provides an overview of the evaluation methods used, including data sources, sampling of sites, safety and ethical considerations, data analysis and the evaluation timeframe. Annex H includes expanded description of evaluation methods with further detail.

A. DATA SOURCES

Because this midterm evaluation is intended to be a formative evaluation with relatively expedient results to inform the second half of the STOP GBV project, primary data sources selected were primarily in-depth interviews (IDIs) and focus group discussions (FGDs) in a sample of six STOP GBV project sites. This primary data collection was complemented by review of available implementing partner project documents, annual reports, financial reports and monitoring data. Existing qualitative and quantitative baseline assessment data collected in November–December 2014 and published in the final report in March 2015 were used for analysis, where appropriate (Futures Group 2015). A full list of these partner project documents and other literature reviewed are available in Annex M.

A total of 57 IDIs with key informants and 18 FGDs with a total of 146 participants were held to obtain information about what is working, the shortcomings and obstacles of the program, and to suggest alternative strategies and activities that may be considered for implementation. The full list of all IDIs and FGDs conducted may be found in Annex L.

Five distinct IDI guides were developed for: community leaders; government partners; implementing partner and sub-grantee staff; OSC staff; and legal stakeholders, including police and magistrates. Three distinct FGD guides were developed for different groups of participants at each site: GBV survivors (OSC beneficiaries), male change agents trained by ZCCP, and community members.

B. SAMPLING OF SITES

In cooperation with USAID, a purposefully selected sample of five of the 16 supported STOP GBV sites, in addition to one former “A Safer Zambia” (ASAZA) site, were selected.¹⁰ Sample settings were purposefully selected from settings identified as urban and peri-urban or rural, those that have recently received an additional scale-up intervention in the form of Component 4: Engaging Boys and Young Men through Sport, and those that were implemented as direct-to-government (D2G) from inception with technical support from World Vision Zambia (WVZ). Sampled sites included: Lusaka, Kafue, Choma, Mazabuka, Mumbwa and Katete, with scaled-back interviews conducted in Chongwe.

C. SAFETY AND ETHICAL CONSIDERATIONS

Safety and ethical protocols were developed and approved by *ERES Converge*, a private Zambian research ethical review organization, to ensure privacy and confidentiality of human subjects. All data collection and analysis teams and individuals were trained on implementing these protocols prior to field work commencing. The internationally recognized *World Health Organization (WHO) Safety and Ethical Guidelines (2007)* were utilized in protocol development, training and data collection. Primary data collection included an informed consent process that appropriately informed all participants of the purpose of the evaluation. This consent process for adults over the age of 18 (e.g., no one under the age of 18 years participated in this study) included verbal explanation, in addition to handing out copies of the informed consent.

¹⁰ Mazabuka was selected, which is not currently supported by STOP GBV but was formerly supported until 2011 by the STOP GBV program predecessor, ASAZA. This site was chosen in order to assess issues of sustainability.

D. FIELD STAFF AND TRAINING

A total of 30 field staff were led by experienced key team members (Annex B), and were placed in five teams, each with one supervisor, two moderators and three local recruiters per site. All field staff were selected based on the following qualifications: prior experience conducting interviews; demonstrated ability to understand and follow safety and ethical protocols; Zambian nationality with ability to speak the local language; balance of male/female staff; and ability to appreciate local cultural norms.

Before commencing primary qualitative data collection, all field staff participated in four full days of intensive training in Lusaka, consisting of one day of classroom style lecture and discussion, followed by three days of practice with the data collection tools, with feedback processes and group discussion.

E. DATA ANALYSIS

All primary and secondary data were analyzed comprehensively in order to present findings that are as robust as possible. Qualitative, quantitative and cost data, including primary qualitative data collected via FGDs and IDIs and secondary project document and M&E data received from partners, were triangulated. Qualitative data collected via IDIs and FGDs were documented in comprehensive notes, and analyzed by themes to identify key successes and challenges per site and across sites. Existing monitoring and cost data collected regularly by implementing partners were analyzed using descriptive statistics. Two composite indicators were created to rank the performance of the 16 OSC sites in relationship to one another and to support analysis, elaborated in section 4.4, selecting key M&E indicators already measured by partners in their Performance Monitoring Plans (PMPs). *Composite Indicator 1* focuses primarily on inputs such as training of staff and project affiliates, while *Composite Indicator 2* focused primarily on outputs, or immediate results.

F. EVALUATION TIMEFRAME

The evaluation planning, implementation and analysis took place May–September 2015. Planning, tool development and training took place in May– June, fieldwork in June, analysis and writing in July and August, and finalization of the deliverable in August–September. This includes dissemination and endline evaluation for the STOP GBV project planning period in October 2015.

G. LIMITATIONS

Although adequate data, time and resources were spent on this evaluation, there were some limitations in data sources and quality, methodology and timing. For example, site selection criteria included proximity to Lusaka for ease, timeliness and cost-effectiveness of the evaluation, which potentially reduces the breadth of qualitative information gathered. Effort was made to replace Chongwe with Katete to include a site further away. Further, because interviews were primarily held with program staff and stakeholders, there may be a natural bias to focus on program successes, although when asked about challenges the majority of interviewees were forthcoming, and FGDs held with GBV survivors and community members provided additional information. Additionally some important stakeholders were not included, such as trained medical staff/health workers, which limited the ability to glean insights on the continuum of health care for GBV survivors, and other critical services such as receipt of medical certificates to pursue legal action. In addition, no primary quantitative data were collected for the purposes of this midterm evaluation, so data analysis depends solely on data reported by partners. Cost data were not readily available, was not aligned with activities, and had notable variances; this resulted in cost findings that may be interpreted more as indicative/preliminary findings at this point, with a key lesson learned to ensure consistency in cost reporting across partners. Lastly, some partners (SIA, ZCCP) only recently began implementation, which limits ability to analyze progress to date.

IV. KEY FINDINGS

This section identifies key findings at the program level that cut across the entire STOP GBV program (program design, coordination and value for money), as well as key findings across the project components (activities completed to date, PMP indicator performance, successes and challenges). It integrates qualitative and quantitative analysis into findings and lessons learned, highlighting anecdotes from the six project sites visited for this evaluation in conjunction with existing implementing partner project documents and data across all project sites. Key successes and challenges of the project components are derived from anecdotal evidence across the six sampled sites, with corroborating M&E data where available. Available data limit the ability to make analytic conclusions regarding successes and challenges; thus, this information is drawn primarily from anecdotal qualitative evidence.

A. PROGRAM DESIGN

This section provides an overview of key findings and lessons learned related to the design of the STOP GBV program.

Successes

The STOP GBV Theory of Change (ToC) provides a clear and comprehensive prevention and response roadmap toward the expected impact of reduced GBV and early child marriage.

The roadmap to this desired change is comprehensive, focusing on both prevention and response, and is a multi-sector approach, following international best practice. The key outcomes include improved access to services and justice for GBV survivors (**response**), and changes in social norms concerning GBV and child marriage and strengthening of the GBV M&E evidence base (**prevention**). Activities planned to achieve the desired change focus on training of various stakeholders (capacity building) and expanded access to various direct and referral services. The ToC is based on current international understanding of the multi-layered challenges associated with GBV prevention and response, as well as on programmatic experience of STOP GBV's predecessor, ASAZA. The ToC lays out a roadmap to both deliver critically needed services for GBV survivors in Zambia, and to prevent GBV and ECM. The activities defined in the ToC are being implemented by respective partners, as detailed in subsequent sections.

Efforts are made among implementing partners to monitor and evaluate outcome-level results, beyond outputs and “bean-counting,” although such efforts will benefit from additional support and systematization.

ZCCP, for example, is interested in monitoring and evaluating the outcomes of meetings and ownership of actions by establishing clear linkages between awareness and observed benefits. During community dialogues, the community identifies action points, and ZCCP conducts follow-up to see if those action points are implemented and if solutions are resulting in the desired change. Referral forms are also used by community volunteers to refer survivors to the OSC or Victim Support Unit (VSU), and transformation stories based on referred cases are documented and stored by project officers, later compiled by the head office. Male change agents in Choma have community referral books kept by the chairperson; the book, assessed by ZCCP regularly, is used to record every case referred to ZCCP or the OSC in order to follow up with cases that require attention, including access to justice. However, this is not standard practice, but could be highlighted as a best practice across other sites. It will be helpful to either include 1-2 outcome level indicators in its PMP to support systematic collection and analysis of this type of data. ZCCP's current PMP states that various methods will be used to collect information on anticipated outcomes, including FGDs and KAP surveys beginning in FY16. Other

methods that are currently in use include observations and interviews (especially key informants) during monitoring visits by staff, and the findings are documented in field reports. Some of the visits have included visits by staff from USAID/Zambia country office.

WVZ also recognizes the need to measure the difference that training and the program is making, although formal changes to its draft PMP to systematically measure such changes have not been made at the time of this evaluation. Anecdotally, WVZ observes staff improvement following training when conducting monitoring visits. For example, in Choma a SGBV case was brought to the hospital where service providers recommended she receive post-exposure prophylaxis (PEP), but the new doctor chose to not provide the PEP and two months later she was HIV-positive. Although this is a negative experience, the OSC staff and hospital have learned from this experience with support from WVZ, scaled up support to staff in using guidelines, and now in Choma PEP provision has become more regularized. WVZ currently tracks outcomes of training activities during the routine quarterly monitoring of implementation of project activities at the OSCs by following up on how well teams are adhering to implementation guidelines. Further, a client satisfaction survey will be implemented, which aims to assess the quality of services provided at the OSC by type (i.e., signage and reception, quality of counseling, medical treatment, police, legal services and referral process), and which will provide insight into whether the training may have improved the quality of services provided. In addition to this, WVZ could be supported to include outcome-level indicators in its PMP to ensure ongoing systematic collection and analysis of this type of data.

WVZ influenced government and civil society stakeholders working on separate databases to agree to the establishment of a national database.

WVZ is part of a technical committee set up to establish a national GBV database. WVZ developed a paper on global GBV definitions, which was circulated to both government and cooperating partners. It is working closely with the Central Statistical Office and other stakeholders implementing GBV activities to discuss the standardization of definitions for the national database. WVZ, through its support office, World Vision U.S. and international partners, identified the Gender-Based Violence Management Information System (GBVIMS) for adaptation of GBV data management in Zambia, which is expected to be rolled out in year 4. WVZ is leading the process of adapting the database; this has included orienting civil society and government staff in Zambia on the GBVIMS. It has conducted two workshops that have resulted in harmonization of data collection tools among all implementing partners.

However, challenges remain in the use and conflation of different GBV definitions and classifications by the Zambian government (e.g., including defilement, child neglect as GBV classification case types). Advocating for changes in laws can be a lengthy process, and the paper presented by World Vision includes a discussion on how information on universally used GBV definitions can be collected and how variables can be produced to provide information on Zambian categories.

The baseline assessment includes meaningful outcome-level baseline data.

Baseline data were collected in six OSC districts (Monze, Kalomo, Nyimba, Mumbwa, Chingola and Mpika) in November–December 2014, published with findings in March 2015. Qualitative and quantitative data were collected via IDIs and community surveys, focused on assessing GBV, reasons for GBV, and existing levels of service provisions and quality of service provision. Baseline data at the outcome level across prevention and response indicators will be available for measuring change at the time of the endline evaluation.

Challenges

The STOP GBV ToC will benefit from review and additional constraints analysis with all partners and stakeholders.

The ToC is based upon standardized approaches recognized internationally as promising practices. It is important to note that the ToC does benefit from a constraints analysis, and necessarily *does* consider that it cannot accomplish everything in one program, and thereby establishes linkages and support to address constraints outside of the STOP GBV framework.

Many of the activities developed are rightfully, according to best practice, focused on building capacity. However, in the context of Zambia with a government system of frequently moving staff from post to post, there is a risk of “train drain.” Particularly in the health sector in Zambia, the sustainability and success of capacity building relies very much on human resources; frequent shifting of those human resources jeopardizes investments in not only capacity, but in team-building, passion for the cause, and long-term commitment to making change in a specific community. It is not clear that the emphasis on capacity building in the ToC takes into consideration potential shifting and “train drain” over the long term, in terms of how the STOP GBV program links to other efforts across sectors, particularly at the advocacy level with MOH and its work on retaining health workers, but also looking more broadly at other sectors (justice). Adding activities at the national level may be useful in promoting the sustainability of the STOP GBV capacity-building activities.

WVZ reported that, to date (June 2015), out of the 91 WVZ staff working directly for OSCs or at the national WVZ office who were trained in multi-disciplinary management of GBV, eight have since left, four of whom were OSC officers or coordinators from Katete, Nakonde, Nyimba, and nationally, and one who was a counselor from Kafue. This represents a 9 percent drop-out rate, which is not exceptionally high. However, this rate is only a snapshot of the past two years and does not provide indication of what the drop-out rate of trainees will be past the project end or after transition to government management.

One indication of potential drop-out of trainees is to look at the previous ASAZA site of Mazabuka. Although the passionate and dedicated OSC Project Coordinator remains working in his position at the site, the previous ASAZA-trained staff all left at the time of transition to the government, as did the trained DMO who had been a champion for the site prior to her departure. The ASAZA center staff reportedly left because they did not fulfill the government requirements for their positions and/or there were challenges with their pay. The current staff at the Mazabuka OSC (not currently supported by WVZ) noted their need for training. The DMO at the district hospital departed as per routine relocation of health staff across the country, and although the current DMO appears to be sympathetic to the OSC's needs, he lacks the institutional history and the commitment to ensuring the OSC thrives that longevity would provide.

Although WVZ tracks the trainees outside of direct WVZ staff that have received various training, such as hospital health workers, police officers, etc., it does not track data on drop-out rates or shifting of those trained individuals. However, national efforts in Zambia recognize, for example, challenges in retention of health workers, resulting in a *Zambian Health Workers Retention Scheme Sustainability Strategy (2014)*¹¹ to address known retention challenges. Recognizing this national problem is critical when planning for and investing in training and capacity building of health workers for GBV case management to ensure that such efforts are realistically working within the current constraints, and that STOP GBV programming is part of national advocacy efforts to ensure the Sustainability Strategy considers how retention may impact OSC operation and sustainability. Integration of GBV case management and prevention in the training curricula of health staff such as nurses is important to achieve this; for example, the nursing training programs (Registered Nursing and Enrolled Nursing programs) were revised to include GBV, with the new curriculum effective since January 2015. This

¹¹ See *Zambian Health Workers Retention Scheme Sustainability Strategy (March 2014)* by Republic of Zambia Ministry of Health at: http://pdf.usaid.gov/pdf_docs/PA00K486.pdf

means that Ministry of Health will have trained staff with skills and competencies to manage cases of GBV at health facility beyond the STOP GBV lifetime.

WLSA also anticipates, for example, that currently trained paralegals will move forward with their careers into positions that are able to provide remuneration commensurate with their investments in their legal educations. WLSA plans on paralegals working with nurses to take over their duties when they leave, although this remains to be tested in the success of both the quality of legal services that nurses will be able to provide, and the sustainability of this approach given the possibility that nurses may be overburdened with other responsibility, may feel they should receive improved compensation with this added responsibility, or may be shifted to other districts/locations in the future, as per known national challenges stated above.

The ToC in review may also further consider root causes, assumptions, constraints and the enabling environment in relationship to the desired outcomes. For example, systemic poverty is a fundamental problem not only to GBV occurring in the first place, but also to achieving outcomes laid out, such as accessing justice and services. Although it is recognized that GBV cuts across socioeconomics and wealth, it is important to note the additional financially based barriers that the poor face in accessing critical services, such as transportation to get to an OSC or fees associated with pursuing legal cases and representation. Further, although there are many non-financial reasons for GBV survivors remaining in unsafe environments, lack of financial independence was cited among FGD participants as a key impediment to leaving an unsafe environment. Serious structural challenges exist that inhibit access to justice and moving forward with prosecutions, such as systemic lack of safe houses to protect survivors and witnesses throughout legal proceedings, timely provision of medical reports, and lack of livelihood opportunities to realistically empower survivors to leave abusive environments. Although STOP GBV includes activities advocating for GRZ to invest in shelters and creation and support of some Village Savings and Lending (VSL) groups, these activities (and investments in these activities) may not be intensive enough to meaningfully remove these constraints to create an enabling environment where access to justice becomes a tangible and attainable goal.

Therefore, it will be constructive for the STOP GBV program and its partners to review the ToC collaboratively. This recognizes that the STOP GBV program cannot address all of the complicated and multi-faceted challenges facing the prevention and response to GBV in Zambia. However, ensuring that underlying constraints and assumptions give adequate voice, for example to discuss for inclusion in the ToC as both constraints and activities to support desired outcomes:

- Advocacy and collaboration with national efforts, such as those of the MoH, to improve retention of staff, and in particular GBV-trained health workers, with advocacy efforts focused on importance of retention of not only OSC staff, but those staff trained in multi-disciplinary management of GBV. For example, STOP GBV could advocate with the MoH to ensure that transfer decisions consider whether that staff has received training in GBV and how their departure may impact operation of the OSC or services to GBV survivors.
- Clear programmatic and operational linkages to other national NGO efforts for concrete skills building, financial literacy, and training or job opportunities, as well as advocacy for and participation in efforts to expand tangible livelihood opportunities for GBV survivors. OSCs and staff would provide added value by making tangible economic opportunities available for screening for the most economically vulnerable and high-risk GBV survivors living in unsafe environments and matching and linking them with programs or opportunities.

Implementing partners are using different definitions of GBV, resulting in communication inconsistency in outreach, types of GBV cases driven to OSCs, and ambiguity in how “GBV cases” are categorized for M&E and learning purposes.

Figure 1. Definitions of GBV Used by Implementing Partners

UN	Anti-GBV Act	GBV-IMS	None
<ul style="list-style-type: none"> • Used formally by WVZ • Defines GBV as violence based on one’s gender • Operationally, simply categorizes violence by types, dropping the “because of one’s gender” portion of the definition 	<ul style="list-style-type: none"> • Used formally by WLSA • Adopts UN definition and expands on types • Operationally synthesized with WVZ • Nationally, legal systems not yet using “GBV” as legal definition in practice 	<ul style="list-style-type: none"> • Developed by UN, UNFPA • Used in baseline report • Categorizes types: rape, sexual assault, physical assault, forced marriage, denial of resources, psychological/emotional abuse • Data should only be reported if gender-based 	<ul style="list-style-type: none"> • ZCCP uses no formal definition • Defines GBV as “person-to-person” violence • Operationally, male change agents define GBV as any violence perpetrated against a woman, man, or child

Full definitions of various forms of GBV are found in Annex D. WVZ adopts the UN definition, WLSA adopts the Zambia Anti-GBV definition through a legal/statute-oriented definition, and ZCCP does not cite a specific definition but defines GBV as “person-to-person” abuse, or “nkanza” in the *Nyanja* language. USAID, UN, and the Zambia Anti-GBV Act all clearly state that GBV is defined as violence directed at an individual **because of his or her gender**. In practice, however, especially at district and community levels, there are varying uses of “GBV.” It is often described as any abuse between a husband and a wife, or any violence between two people of the opposite sex. Frequently, GBV is defined as **types of violence** (e.g., rape, property-grabbing, spousal battery, etc.), but the defining factor is often forgotten—that the reason for the type of violence must be because of that individual’s **gender or gender identity**. The baseline study conducted in 2015 also utilizes the GBV-IMS definitions for types of GBV, which clearly define it as violence because of someone’s gender.

The GBV definition used operationally is critical programmatically and for evaluation purposes. Optimal targeting of services and prevention requires adoption of consistent definitions, ideally streamlined with internationally recognized definitions, such as with GBV-IMS, consistently breaking down GBV by type across indicator reporting.

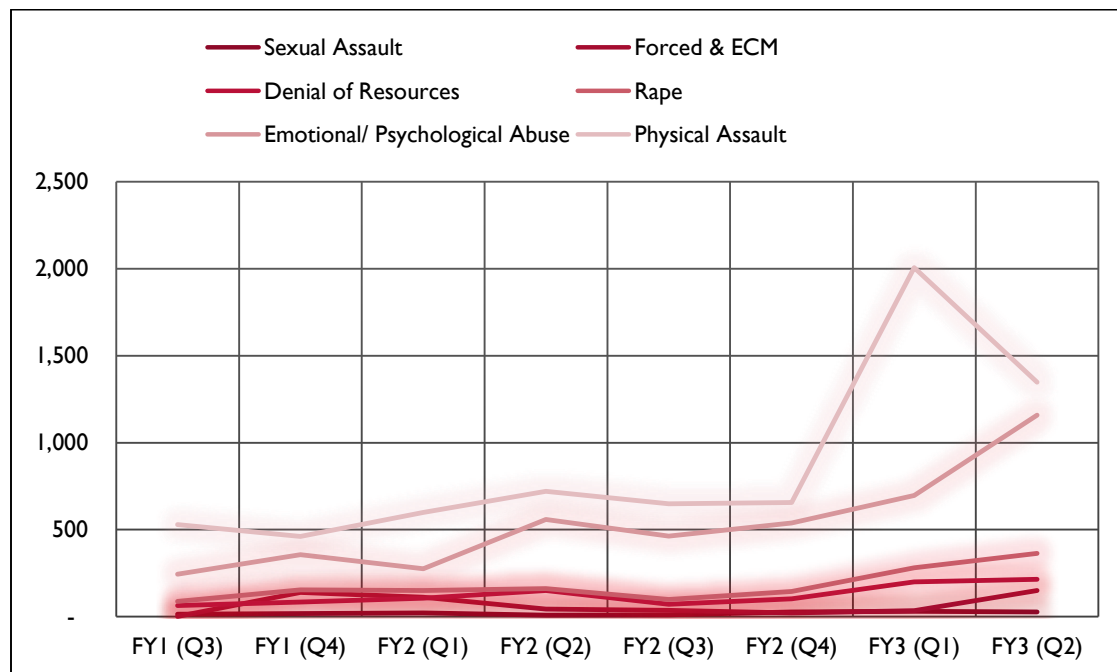
While it is certainly a very good thing that the STOP GBV program is providing urgently needed services to a broad range of violence survivors, including all children experiencing abuse and neglect that may or may not be due to their gender, STOP GBV specifically targets GBV programmatically because of the stigma and challenges involved. In the original problem statement for STOP GBV and in the DFID Business Case, the stigmatization of GBV is identified as a key problem that requires a targeted solution to reduce the stigma, bring GBV cases forward, and ensure that GBV survivors are getting the services they are often denied due to the stigmatization.

Figure 2 below demonstrates that STOP GBV has been quite successful at driving certain types of GBV cases to OSCs, looking at increased reporting across seven out of the eight original OSC sites from inception in 2013 to the most recent reporting period in 2015 for which there is complete data. In

addition to increased reporting of child abuse/neglect cases, which have increased dramatically,¹² reports of physical assault by both women and men have nearly quadrupled, from 529 cases in the first quarter to 2,005 reported cases in the first quarter of FY3. Some GBV case types presented below are lumped together, according to GBV-IMS categorization, for analysis purposes. Cases of emotional/psychological abuse for women and men have also increased significantly from 245 reported in Q3 of FY1 to 1,159 in Q2 of FY3.

Reporting of other types of GBV has also increased, but on a lower scale compared to child abuse/neglect cases, as indicated in the graph. For example, reported rape cases per quarter have increased four-fold from 89 to 363 (89 percent of which are defilement cases in both Quarter 3 of FY 1 and Quarter 3 of FY 3, indicating that the majority of reported rape cases are those of minors), sexual assault from 15 to 28, and denial of resources from 65 to 218. SGBV cases are increasing. However, the increase is at a lower rate compared to other reported cases, and they are comprising a lower percentage of overall cases reported to OSCs. Only seven marital rape cases were reported to OSCs from 2013 to June 2015 (Lusaka, Mongu, Kafue, Mpika). However, according to ZDHS 2013/14, 17 percent of women age 15-49 reported ever experiencing sexual violence, and out of those women 91.2 percent reported that the perpetrator was a former or current husband, partner, or boyfriend (ZDHS 2013/14). This indicates a widespread problem of SGBV within intimate partnerships, without commensurate reporting, for reasons further explored in the upcoming sections. SGBV in intimate partnerships is also a serious problem for addressing ongoing HIV/AIDS prevalence in Zambia.

Figure 2. Reporting Trends in GBV-IMS Categorized Cases in Seven Original OSCs 2013–2015

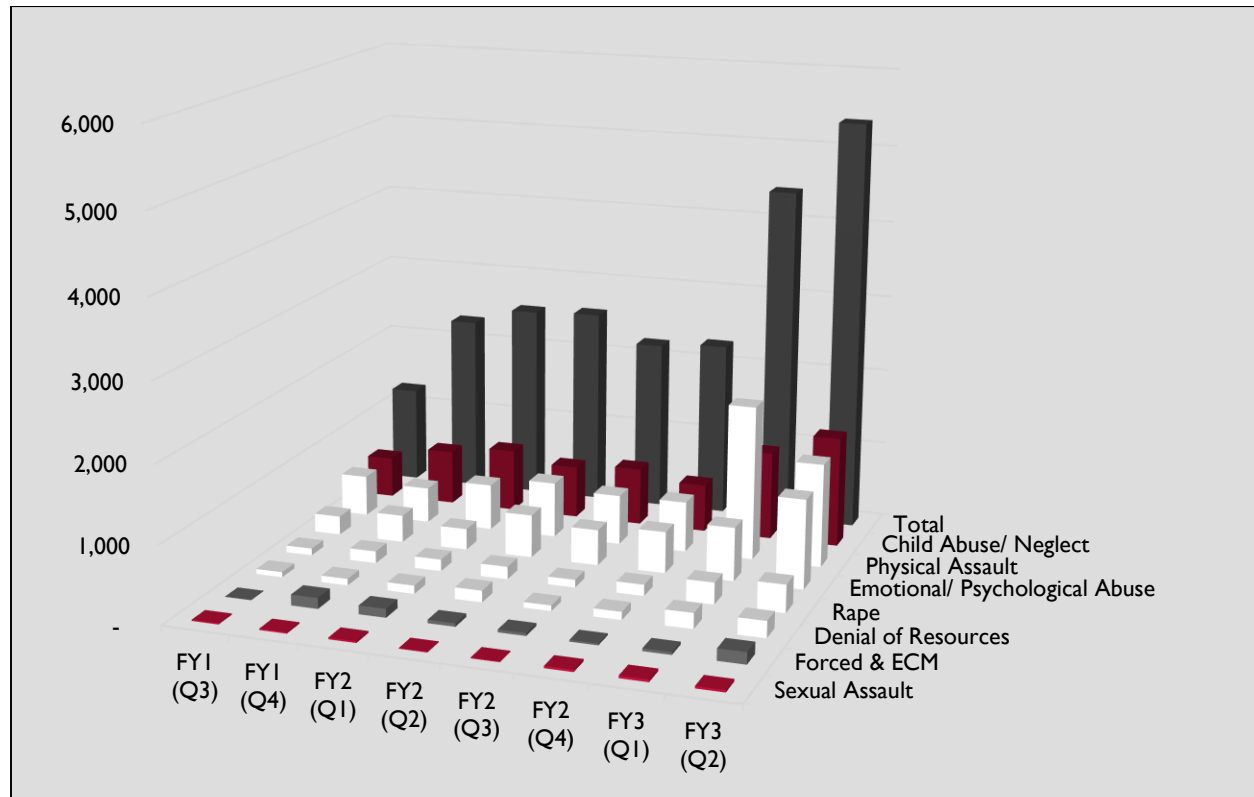


The key message is this: STOP GBV is clearly demonstrating, through increased reporting, that it is meeting needs of various GBV survivors. However, it is critical to disaggregate and analyze this data on an ongoing basis in order to take stock of successes and ongoing challenges, such as responding to data trends by working with ZCCP to drive awareness targeted at more stigmatized SGBV violence, in order to address a current unmet need in serving the needs of the many more SGBV survivors that ZDHS

¹² Reported cases of child neglect and abuse are excluded from this graphic, which only shows reported cases that are categorized as GBV cases per GBV-IMS.

estimates than are currently coming forward. Figure 3 below further demonstrates the increase in total cases reported to seven of the original OSCs, with more cases of child abuse/neglect, physical assault, and emotional/psychological abuse than rape, denial of resources, ECM, and sexual assault.

Figure 3. Reporting Trends in All Cases in Seven out of the Eight Original OSCs 2013–2015



Opportunities to systematically collect, report and analyze qualitative data that illustrate outcome-level change are not fully taken advantage of.

WVZ observes that systems have been strengthened since inception based on improved response to GBV cases and success stories told by service users. One anecdote describes a woman who was suicidal but now has hope, which is a very important indicator of outcome-level change at this critical individual level. However, without systematic collection of this data, it is challenging to illustrate systematic change and progress that can be directly attributed to the program. In this instance, the ideal would be to have a quantifiable baseline measurement of the level of suicidal thoughts among GBV survivors and the length of time and inputs required to provide hope, and an endline measurement that shows a decrease in suicidal thoughts and increase in hope.

This type of information could be systematically collected, for example, via client satisfaction surveys planned by WVZ. However, exit interviews alone will provide only limited information about a survivor’s satisfaction with services immediately that day, and will not provide longer-term, outcome-level data that could be useful in evaluating programmatic impact. For example, someone may experience temporary relief after speaking with someone at an OSC following a GBV incident, but what is the long-term impact on that individual’s life? In one year, is she living in a safe environment, was she able to seek and receive justice to her satisfaction? Is she happy and hopeful for the future?

Data collected via upcoming client satisfaction surveys may be helpful in providing more systematic information regarding the quality and effectiveness of counseling. However, it will be important for such

surveys to be designed longitudinally to ensure that data are collected not only when a client is exiting an OSC from services, but to follow-up with those clients after some period of time (such as one year) to identify outcome-level change and satisfaction. For example, a one-off counseling session for a rape survivor may help a survivor to feel hope on the day of counseling, but this feeling of hope may dissipate over time unless she is provided with regular counseling sessions over a prolonged period of time. As further discussed in the subsequent session, psychosocial counseling from site visits conducted for this evaluation appears to be primarily a one-off event provided at the time of visiting the OSC, or may entail one more follow-up session provided at the time of reporting. However, only anecdotal evidence from qualitative data collected during this evaluation may be considered, since data are not regularly tracked to quantify if survivors receive ongoing, longer-term psychosocial counseling over an extended period of time to provide them with necessary emotional support to proceed with a legal case, move to a safe environment, or heal from abuse. For example, in FGDs with survivors accounts were told of women who experienced temporary relief from abuse in their marriage after visiting an OSC, but reported currently living in situations of ongoing abuse, primarily due to lack of economic options. This points to a need for systematic quality data to track long-term outcomes of GBV survivors served. This is further addressed in the next section.

The baseline assessment collects data from five of the 16 OSC sites, one of which is no longer supported by the program (Solwezi), which will limit the ability to conduct rigorous analysis at endline.

The STOP GBV is an opportune program to set-up a quasi-experimental design for rigorous evaluation. It includes 16 sites where WVZ is located, out of which 14 also have WLSA presence, ZCCP is in the 16 plus an additional eight where no other partners are, and SIA is only in six of the sites. Further, the sites are a mix of peri-urban and urban (with some rural), and have various models of direct or D2G “treatments.” This provides the opportunity to conduct a cross-site analysis with a high level of rigor. However, while recognizing that data on five of these sites will certainly be useful, the lack of specific baseline data for all outcome-level indicators at all sites will limit the ability to conduct rigorous quasi-experimental, outcome-level, cross-site analysis. One way to mitigate this is to utilize ZDHS district-level data that may be available from ZDHS 2013 SPSS or STATA raw files, utilizing the “SLOCAL” recode variable, where possible, as baseline data. Since collection of the ZDHS data took place around the same time period as the baseline assessment (2013/2014), outcome-level indicators such as early child marriage prevalence, can be utilized by site. Further, it will be wise to collect data at endline at the same sites, with the exception of Solwezi, which was dropped from the STOP GBV programming.

Although baseline data focuses on GBV prevalence, prevention, and awareness, and OSC services, there is limited baseline data for outcome-level access-to-justice data.

The baseline assessment offers a full list of indicators for evaluation at endline, but none of these indicators or baseline data collected provide comparative data, for example, of percentage of cases prosecuted, withdrawn, convicted, and why. Baseline data are also not available that measure people’s satisfaction levels with the legal processes; average length of time to receive a medical certificate; average length of time to prepare a case for court; or average length of time for adjudication. Lastly, baseline data are missing to measure improvements in survivor outcomes, such as protection and safety, such as percentage of survivors successfully removed from an unsafe/abusive environment or percentage of survivors who report being hopeful for the future.

B. COORDINATION

This section describes successes and challenges of coordination among implementing partners and sub-grantees; government at national, provincial and district levels across each other and with the program; service providers; and community groups and stakeholders.

Successes

Memoranda of Understanding (MoU) are in place among the implementing partners (WVZ, ZCCP and WLSA) with strong national-level coordination.

Monthly, quarterly, semi-annual and end-of-year reviews are planned. Core coordination guidelines at the national level guide them on what should be discussed and how often. Nationally, monthly meetings are planned with consortium partners (WVZ, ZCCP and WLSA). This process is intended to contribute to strengthening collaboration and information sharing among the members, planning and review of activities on the project.

Monthly meetings also take place between key implementing partners (WVZ, ZCCP and WLSA) and their respective sub-grantees. For example, at the national level, WVZ discusses with its sub-grantees (ECR, FAWEZA and SIA) coordination issues that need to be addressed at the national and district levels, and responses to challenges from the field. WVZ conducts quarterly monitoring visits to all project sites where district-level challenges discussed at the national level are addressed. They are also working on standardization of activities. For example, WV and ECR do the same work but in different districts/sites, and they want to ensure they are using the same Detailed Implementation Plan (DIP), guidelines, data collection tools, and work plans to standardize the work across sites.

Additionally, partners hold monthly technical working group (formed in the first half of year 3) meetings for M&E and finance. Implementing partners agreed to share their monitoring plans to conduct joint monitoring and to foster higher efficiency so that if one organization goes for a monitoring visit, monitoring may also be conducted programmatically for all partner activities.

Partners recognize that although national coordination efforts currently are improving and going relatively well, there were challenges in the beginning with coordination, avoiding duplication, and standardizing models used (for example, SILC or VSL for economic activities). For example, at times WLSA could only conduct semiannual monitoring visits due to lack of funding (e.g., transportation); better planning could have mitigated this challenge by enabling joint monitoring trips.

Challenges

Successful coordination varies across sites among partners at the district and community levels.

Although WVZ has guidelines on how partner coordination meetings should be conducted at the district level, those guidelines are applied with varying levels of success across sites. One example provided by partners is that paralegals at some sites were denied review of incident forms by the OSC staff, who told them that the forms are “confidential,” inhibiting the paralegal’s ability to assist survivors legally.

Some interviewees, particularly implementing partners at the national level, attribute this type of coordination challenge to different personalities and management styles. Some attribute it to competition for space and partner turf battles, where some staff believe they are doing more work than other implementing partner staff, for example. Another challenge noted at some sites is that some instances of staff turnover (four out of 16 OSC coordinators/officers) have resulted in “train drain,” where staff previously trained on the coordination guidelines are replaced by new staff lacking the necessary knowledge on the guidelines.

District-level management was originally designed to have collaboration across implementing partners within the districts. However, due to the challenges, in the last national coordination meeting (Q1 of 2015) partners agreed that leadership, planning, and coordination of district-level STOP GBV activities should be through the OSC. This is a recent decision, so there are not yet findings related to the

success of this restructuring. There are identified capacity issues among certain OSC leaders, although WVZ makes efforts to clarify guidelines and expectations with individuals as needed.

Another contributing problem is that although WVZ have staff at all OSCs and WVZ at 14 out of the 16 sites, ZCCP is not present at all OSCs, reportedly due to budgetary restrictions, resulting in a USAID-driven management decision to assign coordination responsibility of multiple districts to one permanent staff. Some partners interviewed suggest that in districts where ZCCP does have an office or permanent staff presence there is better coordination among partners.

Implementing partners report that the different funding streams pose challenges to coordinating activities. For example, WLSA and ZCCP may receive funding at different times and do not have the benefit of having a liquid funding stream as does WVZ. Thus, they may not be able to move together, as desired, to conduct outreach or sensitization campaigns due to the varied funding. To address this, from the end of 2015, WLSA will ask the OSC Officers/Coordinators to help provide feedback as a stakeholder to consolidate the WLSA performance appraisal.

WVZ rolled out the program as “WVZ” in communities, rather than as “STOP GBV,” which presented communication and community buy-in challenges when other implementing partners began rolling out other program components.

According to some implementing partners, community-level and district-level stakeholders were reportedly confused when new partners (ZCCP and WLSA) were introduced and rolled out. However, each community that was contacted first by WV, WLSA, or ZCCP may tend to be more aligned with these partners. Stakeholders began identifying themselves with one project partner that they were introduced to, rather the program as a whole. They reportedly wanted to know how ZCCP was different from WV or WLSA. Now efforts have been made to correct this so that stakeholder meetings are attended collectively by ZCCP, WV and WLSA, where they present common objectives rather than as separate organizations. However, according to implementing partners, this initial lack of coordination slowed program efficiency and caused some challenges with community buy-in.

There are varied levels of successful coordination among community volunteers from different implementing partners (ZCCP, WV, and CARE).

At this time, ZCCP and CARE volunteers are trained together, but WV training is still separate. Part of this is due to the different types of training provided by various partners (e.g., WVZ trains volunteers in multidisciplinary management of GBV placed at the OSC, while CARE and SCCP are focused on prevention activities in the community). Although volunteers have discrete training and roles, it is important that they are coordinated, since they are often interacting with the same survivors. Some challenges are reported by partners nationally. For example, CARE volunteers were asked to report to a ZCCP coordinator, which resulted in turf battles and arguments among community volunteers. To respond to this, coordination efforts were made in April 2015 where all CARE and ZCCP volunteers from all 24 sites gathered in Livingstone for one week to discuss challenges, engage in team building, and review data collection tools and forms. Results are yet to be seen as there are ingrained territorial challenges (e.g., reports of volunteers going to an OSC but saying they do not feel welcomed or invited for OSC trainings, whereas WVZ claims volunteers are not cooperating). This indicates an ongoing need for team-building and strong leadership in each site.

Improvements in horizontal collaboration and coordination across sub-partners reporting to different implementing partners may also be useful in facilitating improved cohesion among community volunteers.

C. VALUE FOR MONEY (VFM)

This section presents findings for Vfm and cost efficiency for the overall program. The DFID Business Case for STOP GBV set indicators that could be measured to assess Vfm in the program. Pending at the time of this evaluation is a Vfm approach to set: (1) clear definitions of indicators of value for money at economy, efficiency and effectiveness levels; (2) benchmarks and targets for each of these indicators; and (3) process for collecting and analyzing this data that is integrated into existing management systems and processes. DFID Vfm analysis uses “3Es” (economy, efficiency and effectiveness). Vfm indicators and targets set out in the DFID Business Case include:

- **Economy:** Unit cost of training per capita; unit cost per GBV survivor receiving OSC services
- **Efficiency:** Unit cost per GBV case adjudicated; percent administrative costs of implementing partners
- **Effectiveness:** Cost of GBV case averted

However, it is critical to appreciate the limitations in conducting the cost analysis and interpreting results. For example, some necessary data were not available, such as costs for adjudicating cases or for efficiency, which requires more robust outcome-level data that is not yet available. There were challenges in consistency of financial data from partners aligned with activities. In addition, revaluation of the ZMW against the dollar impacts obligated amounts and expenditures. Finally, because some components and scale-up/D2G began recently with high capital costs, drawing comparative conclusions about Vfm between original and scale-up sites is not appropriate at this time.

Economy

Unit Cost of Training per Capita

DFID measures of unit cost of training per capita for: (1) health workers (428 health workers at a unit cost of £251 per beneficiary in 2014); (2) paralegals: (target of unit cost of £361); (3) police officers at a target unit cost of £352; (4) judges and magistrates at a target unit cost of £431; and (5) male change champions with no targeted unit cost.

Table 2 below presents total and per capita costs of various trainings conducted by implementing partners for which financial and activity data were made available at the time of the evaluation. Per capita training costs ranged from a one-day training for police officers outside of Lusaka for \$13 per capita to a five-day Gateway to Grants training for \$728 per capita. One- to two-day trainings are generally less expensive per capita than week-long trainings, as the longer sessions presumably include higher costs for participants’ accommodation and meals.

The average unit cost to train paralegals is \$316 per capita, under the targeted DFID unit cost of £361, *excluding indirect costs*.¹³ The average unit cost to train police is \$13 per capita, *excluding indirect costs*, under the targeted DFID unit cost of £352, although this was only a one-day training that appears to have been scaled back in content from original plans. Training of magistrates costs, on average, \$28 per capita for a one- to two-day training, while a two-day training for judges cost \$628 per capita.

¹³ Financial data provided by implementing partners excluded some costs that should be included in these calculations, such as fees for external facilitators and overhead costs such as stationery, photocopying and printing of training materials, etc.

Table 2. Training Cost per Capita (US\$) by Training Type¹⁴

Training Type	Total Number of Training days	Total Number Trained	Total Direct Training Costs	Average Cost per Capita
<i>Paralegal-Lusaka</i>	6	48	\$29,913	\$623
<i>Paralegal-Out of Lusaka</i>	4	55	\$2,669	\$49
Paralegal (Total)	5	103	\$38,252	\$316
Multisector	3	44	\$19,174	\$436
<i>Magistrates-Lusaka</i>	2	38	\$333	\$9
<i>Magistrates-Out of Lusaka</i>	1	49	\$2,105	\$43
Magistrates (Total)	1.5	87	\$2,438	\$28
Judges	2	30	\$18,844	\$628
Police Officers-Out of Lusaka	1	55	\$688	\$13
Multi-disciplinary Case Management	6	437	\$134,536	\$308
Men's Network	4	40	\$13,333	\$333
Forensic Evidence	5	60	\$25,320	\$422
Gateway to Grants (G2G) ¹⁵	5	45	\$33,662	\$748
Traditional Counsellors	4	27	\$6,027	\$223
SILC	5	171	\$20,348	\$119
Nursing Tutors ¹⁶	5	31	\$19,178	\$619
Gender Training	1	26	\$576	\$22
Coaches & Peer Leaders	3	150	\$12,280	\$82
Community Volunteer	2	288	\$44,069	\$153

Unit cost per GBV survivor receiving services from a One Stop Center

The DFID Business Case originally projected that 9,000 GBV survivors would be provided services by the eight original OSCs in the first year at a projected cost of £134 per survivor. From project inception in 2013 to March 2015, over a two-year period, a total of 24,245¹⁷ clients have received OSC services for a total direct cost reported by WVZ of approximately US\$1.7 million, at a unit cost of \$113¹⁸ per OSC client across all sites. This is an underestimate of costs since it only includes WVZ direct

¹⁴ Number of days, people trained, and costs are all calculated based on implementing partner reports and financial data made available. Discrepancies in M&E data, financial data, and reports are noted—for example (discrepancies with M&E numbers in brackets): Multi-disciplinary training 437 (631), SILC training 171 (120); Gateway to Grants (G2G) 45 (22); Men's Network 40 (30); Medical Management of GBV not provided in cost data (M&E 66). Further, costs include direct training costs (such as venue, food), and do not include other costs that were not made available (e.g., trainer allowance, stationary and supplies, overhead or program costs).

¹⁵ G2G is a capacity-building initiative to increase capacity among program staff from the STOP GBV program in management of USG grants, rules and policies.

¹⁶ Trained nurse tutors are part of the institutionalization process of GBV into the nursing curriculum. The training was conducted in collaboration with General Nursing Council, which facilitated the process of inviting the nursing schools to the training while WVZ organized all the training logistics. The objective of the workshop was to train nursing tutors in the multidisciplinary management of medical GBV management in order to integrate GBV in the nursing curriculum. The total number of nurses that attended the training was nineteen (19): four (4) males and fifteen (15) females.

¹⁷ This is the reported GBV survivor number reported with financials per site, which is different from other reported client figures.

¹⁸ Costs are based on reported direct OSC operational expenditures only and do not include program overhead, WLSA paralegal costs, SIA costs, and D2G sites exclude government worker salaries. Direct OSC costs include OSC coordinators' salaries and benefits, OSC staff salaries and benefits (except for the D2G sites where the staff costs are not included), travel and transportation, program supplies, furniture and equipment, vehicles, cameras.

expenditures and excludes programmatic costs and government contributions, such as seconded staff salaries, from D2G sites.

The unit cost is \$59 per OSC client in original vs. \$166 in scale-up sites, and \$75 per client in direct vs. \$194 in D2G sites. However, it is too early to draw conclusions about VfM by site type, since most scale-up sites are D2G sites, and higher costs likely reflect high capital costs as they have just begun serving clients this year, compared to original sites. For example, if expenditures remain the same at D2G and scale-up sites over the next two years from July 2015 to December 2017, based on current expenditure patterns, an expected reduction of 20 percent in costs (taking into consideration capital costs of new scale-up sites), and an average of 2,000 clients per year, original sites are estimated to cost US\$76, on average, per client served, compared to US\$30, on average, per client served for scale-up sites. This only takes into account direct costs, and excludes government worker salaries from scale-up site costs.

Table 3. Unit cost per client receiving services from an OSC from OSC start to June 2015¹⁹²⁰

District	Direct or D2G	Original or Scale-Up	Total Direct OSC Cost	Total Clients Served	Average Cost per Client
Nakonde	Direct	Original	\$143,413	2,402	\$ 59.71
Choma	Direct	Original	\$188,793	3,913	\$ 48.25
Chongwe	Direct	Original	\$137,532	1,200	\$ 83.08
Kafue	Direct	Original	\$158,638	2,250	\$ 57.00
Katete	Direct	Original	\$151,234	2,722	\$ 55.56
Mongu	Direct	Original	\$135,357	3,472	\$ 38.99
Kapiri-Mposhi	Direct	Original	\$158,237	2,250	\$ 70.33
Lusaka	Direct	Original	\$139,806	2,298	\$ 60.84
Kalomo	Direct	Scale-Up	\$66,365	681	\$ 97.45
Mpika	Direct	Scale-Up	\$62,256	452	\$ 137.73
Nyimba	Direct	Scale-Up	\$66,936	541	\$ 123.73
Chingola	D2G	Scale-Up	\$64,490	632	\$ 102.04
Monze	D2G	Scale-Up	\$54,721	330	\$ 165.82
Mumbwa	D2G	Scale-Up	\$52,593	249	\$ 211.22
Chibombo	D2G	Scale-Up	\$5,652	134	\$ 415.31
Luanshya	D2G	Scale-Up	\$55,867	719	\$ 77.70

Efficiency

Unit Cost per GBV Case Adjudicated

The unit cost per GBV case adjudicated could not be calculated during the midterm evaluation, due to lack of data available from the implementing partner. Although M&E data with the total number of cases

¹⁹ This is the cost indicated per *client*, as not all clients served are GBV survivors (e.g., cases of child abuse and neglect) by any international or Zambian definition used.

²⁰ All costs are based on WVZ reports of direct OSC operational expenditures and do not include program costs as noted above.

adjudicated were made available, detailed financial data aligned with case adjudicated were not provided to the evaluation team.

Administrative Costs of Implementing Partners as Percent of Total Budget

Based on financial raw data and annual reports received from each partner, administrative costs²¹ have been calculated as a total percentage of each partners’ total costs. Over the life of the project from inception to the most recent date when financial data were made available, WVZ administrative costs expended were 37 percent of its total costs expended, WLSA’s was 44 percent, and ZCCP’s was 45 percent.

Table 4. Estimated Administrative Cost as a Percentage of Total Costs

Partner	Total Cost US\$	Administrative Cost US\$	Administrative Cost Percentage of Total Costs
WVZ (to April 2015)	3,960,722	1,448,772	37%
WLSA (to May 2015)	1,168,673	514,355	44%
ZCCP (to March 2015)	2,274,486	1,023,608	45%

Effectiveness

The DFID Business Case set an indicator for effectiveness, *cost per GBV case averted*, but did not set a target. Unfortunately, little data regarding cost-effectiveness of GBV interventions are available nationally or internationally in terms of international standards for comparison. STOP GBV provides an important opportunity in filling this existing data gap. For example, the social rate of return could be calculated for STOP GBV at the endline with adequate data, including the cost per GBV case averted, although the required data input is currently unavailable at the time of this midterm evaluation.

Some existing cost data from Zambia may be utilized at endline in conjunction with collected programmatic outcome-level data. This includes cost data collected by CARE in a 2014 study that explored direct costs of GBV in Zambia (ZARD, 2015) and direct medical costs of GBV survivors (UNICEF, 2013). Data from other countries may also be used as proxies at endline when calculating social rate of return. For example, a 2010 study in Vietnam estimated that women experiencing violence earn 35 percent less than those who are not abused. In South Africa, interpersonal violence accounted for 840,000 Disability Adjusted Life Years (DALYs) or 10.2 percent of all DALYs in females in 2000. A SIDA study in Zimbabwe estimated that the costs to survivors for medical fees, transport, and fees for legal and other support services was US\$200 for rural women and US\$4,000 for urban women. In Uganda, violence against women is estimated to cost an average household over £3 per incident in health care and legal aid, while average income is £233.

D. CROSS-SITE INDEX PERFORMANCE

Figure 4 below provides two indices created using reported M&E data across partners.

The Capacity Building Index measures whether or not, across partners, multi-sector stakeholders have been trained. In other words, *how many sites have received the intended “capacity-building dose”*? Only one site received a “high” score (Nakonde, a direct/original site).

²¹ Administrative costs include personnel salaries and fringe benefits.

Seven sites received “medium” scores (seven direct, zero D2G), and eight received “low” scores (three direct, five D2G).

Out of the 16 sites, seven (Chibombo, Chingola, Kalomo, Monze, Mpika, Mumbwa and Nyimba) were ranked as low-scoring on the Composite Training Index. This means that, as of the midterm evaluation, these seven sites did not yet receive a threshold “dose” of program inputs from all partners, mostly in the form of training for staff and relevant program stakeholders. This does not mean that the sites are low performing—many of these are newer sites where activities have more recently begun, which may explain why they have not yet received the ideal training “dose.”

Simply put, these scores indicate that D2G sites have not yet received as much capacity-building or training inputs, as direct sites. This is likely a product of the recent roll-out of the D2G sites, which are all recent scale-up sites. It simply indicates the need for partners to intensify and move forward with planned capacity-building for the D2G sites.

The Output Index Score measures whether or not, across partners, certain targeted outputs have been achieved. In other words, *how many sites are demonstrating direct results as planned?* Six sites received “high” scores (five direct, one D2G), nine received “medium” scores (six direct, three D2G), and one D2G site received a “low” score. This simply means that more direct sites are demonstrating more direct results than are D2G. However, many of the medium scores and the low score, are new sites, and it is perhaps too early on in their opening or scale-up for them to demonstrate direct results. Again, this simply indicates that partners need to intensify planned activities with D2G sites in order for them to move forward to get on track toward STOP GBV intended results.

Figure 4. STOP GBV Composite Indices

Composite Indicator #1: Training Inputs	Composite Indicator #2: Outputs (Direct Results)
<ol style="list-style-type: none"> 1. (WVZ) Number of community health and para-social workers who successfully completed a pre-service training program (target: 744 LOP total across sites; 15 per site set as 'pass' threshold for evaluation) 2. (WVZ) Number of health care workers who successfully completed an in-service training program within the reporting period (target: 400 LOP total across sites; 10 per site set as 'pass' threshold) 3. (WLSA) Number of OSC paralegals trained (target: 2 per site) 4. (WLSA) Number of police officers trained (target: site-specific, 30% of LOP per site 'pass' threshold set for evaluation) 5. (WLSA) Number of doctors trained (target: 5 health workers, 5 social workers per site LOP; 10% or at least 1 health worker per site set as 'pass' threshold for evaluation) 6. (ZCCP) Number of male change agents (community volunteers) trained (target: 12 per site) 7. (ZCCP) Number of traditional leaders oriented in GBV (target: 150 LOP; 1 chief per site set as hold for evaluation) 8. (SIA) Number of coaches trained via training workshops (target: 25 per site) 	<ol style="list-style-type: none"> 1. (WVZ) Number of people receiving post-GBV care (target: site-specific meeting planned targets to date) 2. (WVZ) Number of survivor networks established (target: site-specific; 2 per site set as 'pass' threshold for evaluation) 3. (WVZ) Number of men's networks with capacity to identify and address GBV (target: site-specific, 1 per site 'pass' threshold set for evaluation) 4. (WLSA) Percent of reported GBV cases prosecuted or litigated (target: 10% 'pass' threshold set for evaluation) 5. (ZCCP) Number of active VSL group members trained in financial literacy (target: 597 targeted total across sites to date, 25 per site set as 'pass' threshold for evaluation) 6. (ZCCP) Number of individuals reached via community dialogues conducted on gender and HIV/AIDS under small group and community-level interventions (target: 66,000 total across sites in 2014/15; 1,000 per site set as 'pass' threshold for evaluation) 7. (ZCCP) Number of individuals reached via community dialogues conducted on child marriages under small group/community interventions (target: 36,048 FY14/15 across all sites; 500 per site set as 'pass' for evaluation)

E. COMPONENT I: GBV SURVIVOR SUPPORT SERVICES

The purpose of the Gender-Based Violence Survivor Support Services (GBVSS) component is “to increase the availability and uptake of quality GBV services for adult and child survivors of GBV.”

This section provides an overview of activities completed from inception (April 2013) to the time of the evaluation (June 2015), progress in meeting key performance indicators, and analysis of key successes and challenges. From project inception (April 2013) to March 2015, WVZ carried out activities based on the three objectives of this component: (1) strengthen the GBV survivor services, (2) strengthen GBV response and coordination efforts and (3) expand the engagement of young men and boys through sport. The last objective was added in 2014 to six of the new scale-up sites.

Additionally, Sports in Action (SIA) was sub-contracted in 2014 to scale up efforts to engage boys and young men in six new sites, embedded as an objective under GBVSS. The purpose of the Engaging Men and Boys through Sports objective is “to strengthen male engagement in GBV prevention and response through the use of sports games to reach boys and young men with anti-GBV messages.” Sports in Action began (SIA) began implementing this component in October 2014 (following contract signing in

July 2014)²² in six districts (Mumbwa, Chingola, Nyimba, Kalomo, Monze and Mpika) in five provinces (Central, Copperbelt, Eastern, Southern and Muchinga), although there was a three-month delay in commencing activities and implementation began in October. As such, SIA was in operation for six months when the midterm evaluation was conducted.

Activities Completed

To meet the first objective of strengthened GBV survivor services, WVZ has successfully opened 16 fully operational 16 districts in eight provinces of Zambia (Central, Copperbelt, Southern, Lusaka, Eastern, Western, Northern, Muchinga). WVZ began implementing this component in April 2013 in eight districts (Choma, Chongwe, Kafue, Kapiri-Mposhi, Katete, Lusaka, Mongu, Nakonde) and expanded with sites in eight additional districts in 2015 (Chibombo, Chingola, Kalomo, Luanshya, Monze, Mpika, Mumbwa, and Nyimba). The eight original sites are operated by either WVZ or ECR, with plans in place to transition to government operation, while six of the eight new sites began as D2G sites, operating from the beginning by the government with WVZ or ECR technical support.

Services provided by most OSCs include comprehensive case management and on-site services, including psychosocial counseling for adults and children, HIV counseling and testing, provision of PEP and EC, legal advice for adults and children, referrals to services including medical care, legal service, shelters, and livelihood opportunities. Although most OSCs operate during regular business hours from 9:00 to 17:00 Monday through Friday, some sites provide 24-hour on-call services, and at other sites the outpatient department (OPD) at the hospital to which the OSC is attached handles basic intake services until the OSC staff are available during normal operating hours.

To meet the second objective of strengthened GBV response and coordination efforts, WVZ is actively coordinating national monthly and quarterly meetings with government partners, including the MCD/MCH, MoGCD, VSU and MoH, as well as with other USAID-funded projects such as ZCCP II, FHI360 STEPS OVC and others.

Activities planned by SIA were, for the most part, in accordance with the set objectives and planned targets. SIA developed a YEMP curriculum following research in Monze, Nyimba and Mpika. SIA held meetings with the stakeholders in the six sites where they began operating in late 2014. Out of the targeted 300, SIA trained 150 peer leaders and coaches (25 per district) in sports programs integrated with anti-GBV messages and life skills. So far SIA has directly reached 6,728 boys and young men, who have completed the 10-hour minimum criteria by June 2015. A tournament was hosted in all six districts with 187 boys and 160 men participating. During World AIDS Day and 16 Days of Activism, SIA commemorated events with awareness raising messages on GBV, and supported 66 boys and 22 girls to participate in International Women's Day and Youth Day events.

Table 5 below highlights the activities completed to date, by objective, as indicated in WVZ's three annual reports, reporting targets and results where that data were made available.²³ Activities are denoted by Y1 (April 2013-September 2013), Y2 (October 2013-September 2014), and Y3 (October 2014-March 2015, semiannual). Activities for SIA are denoted by Y3 (October 2014-March 2015) when activities began.²⁴

²² Sport In Action (December 2014). Quarterly Report on Gender-Based Violence Prevention through Sport Project, 1 October 2014-15.

²³ Table describes completed activities according to documentation provided by WVZ, including: WVZ in Gender-Based Violence: Survivor Support (GBVSS) Project Semi Annual Report: 1st October 2013 to 30th September 2014, Project Semi Annual Report: 1st October 2013 to 30th September 2014, Gender-Based Violence: Survivor Support (GBVSS) Project Annual Report: October 2013. WVZ checked for accuracy and updated in September 2015.

²⁴ Sport In Action (December 2014) Quarterly Report on Gender-Based Violence Prevention through Sport Project, 1 October 2014-15; Sports In Action Revised Budget 2.

Table 5. GBVSS Activities Completed April 2013–June 2015

Objective	Activities Completed
<p>Objective 1: Strengthen GBV survivor services</p>	<ul style="list-style-type: none"> • Y1: Established eight new OSCs in eight districts (Choma, Chongwe, Kafue, Kapiri-Mposhi, Katete, Lusaka, Mongu, Nakonde). Y2: Established eight new “expansion” OSCs in eight districts (Chingola, Choma, Luanshya, Chibombo, Mumbwa, Monze, Mpika and Nyimba). • Y2: GBV multidisciplinary training was conducted for 440 service providers, falling below the target of 1,144 service providers. • Y3: Facilitated the certification of nine lay counselors in voluntary HIV counseling and testing (C&T), and 8,899 (F-5,351, M-2,460) individuals accessed HIV C&T services. • Y2: Conducted 57 mobile OSCs in eight original sites where 3,215 (F-2,893, M-322) clients were provided with services. Y3: Conducted 65 mobile OSCs in 16 sites where 4,725 (F-3560, M-1165) clients were provided with services. • Y2: Mobile OSC guidelines were revised and are now being used. • Y1-3: Provided 26,468 individuals with post-GBV support services to June 2015 (against LOP target of 51,300). • Y3: Designated child-friendly spaces equipped with toys, beds, mattresses in eight OSCs. • Y1: FAWEZA established two safe houses (Mongu and Luanshya). • Y2-3: Established 26 men’s networks with a total of 556 members, exceeding the LOP of 10 networks. • Y3: In collaboration with the General Nursing Council, integrated GBV core competencies into the nursing curriculum for enrolled and registered nurses. • Y2: Conducted 28 trainings of trainers from nine districts (Lusaka, Kapiri, Nakonde, Kafue, Katete, Choma, Mongu and Chipata) in multidisciplinary management of GBV. The trainers then rolled out the trainings to a total of 331 service providers in seven districts. (DFID GBVSS Annual Review 2014).
<p>Objective 2: Strengthen GBV response and coordination efforts</p>	<ul style="list-style-type: none"> • Y3: Meetings held nationally with MCD/MCH, MoGCD, VSU, MoH, ZCCP II, FHI360 STEPS OVC and other government departments and NGOs. • Y1: Meetings held with Lifeline to establish how the hotline can be used to refer GBV survivors to OSCs. A few referrals are being made through the Lifeline toll-free lines. The project will train hotline staff in multidisciplinary GBV management by the end of Y3. • Y1-3: Trained 123 police officers in the multidisciplinary management of GBV as well as in forensic evidence collection. • Y3: Linkages were created with STEPS OVC, ZCCP and other community volunteers in 12 districts. The volunteers were oriented in GBV management and to identify and refer GBV cases to OSCs.
<p>Objective 3: Expand the engagement of young men and boys through sport</p>	<ul style="list-style-type: none"> • Y3: Conducted teacher and parent meetings with 125 individuals in five of the targeted six districts to open communication channels with parents regarding gender, sexuality and GBV and to spread awareness of the project. • Y3: Mapped stakeholder partnerships in all six implementation sites. • Y3: Identified 30 schools and 72 football teams to engage with in six districts. Commemorated World AIDS Day and 16 Days of Activism by providing messages on dangers of GBV and HIV/AIDS and their impact on families through sports

Objective	Activities Completed
	<p>tournaments, life skills education and engaging boys and men on GBV issues. Number of families, communities, or individuals targeted or attended not reported.</p> <ul style="list-style-type: none"> • Y3: Integrated monthly sports league events with GBV messages in all six districts where boys and young men share their GBV experiences while playing football. Numbers were only reported for Mumbwa District launch (15 teams comprising 187 boys and 160 young men). • Commemorated International Women’s Day (36 boys, 52 boys) and Youth Day (66 boys, 27 girls) by spreading awareness regarding the role of boys and young men in ending GBV in schools and communities and importance of working with girls and young women as equal partners. • Y3: Tested six males and two females for HIV during the GBVSS Launch in Namundi Village. • Y3: Trained 150 peer leaders and coaches in sports programs integrated with anti-GBV messages and life skills (25 per district), out of 300 targeted. • Y3: Distributed in-kind material and sports equipment with WVZ support. • Y3: Conducted research started in Monze, Nyimba and Mpika to develop YMEP learning materials and manuals for boys and young men “to realize their role in preventing GBV in their families, schools and communities, creating a new way of looking at power relations and ensuring commitment to self-responsibility and reducing GBV.” • Y3: Implemented YMEP sessions in 43 schools and 50 communities in six districts, reaching 2,130 boys who completed 10-hour minimum criteria (target: 96-168 boys per quarter, with targets depending on district population).

PMP Indicator Performance

Table 6 below provides a snapshot of the GBVSS PMP indicators currently tracked with data reported by WVZ to date. Indicators draw from standard USAID and PEPFAR indicators, with additional indicators primarily focused on measuring training and service provision inputs and outputs. The indicators allow for measurement of the process and performance of WVZ in expanding GBV survivor support services. However, there are also opportunities to modify or add to indicators to collect more meaningful outcome-level data.

Table 6. GBVSS Indicators and Progress²⁵

Key GBVSS Indicators				
Key Indicator	Life of Project (LOP) Target	Number Total (cumulative) of LOP Target Reached	Percent of LOP target reached	Sex disaggregation (LOP)
Number of people receiving post-GBV care	51,300	26,468	52%	6,422 male 20,046 female
Number of people provided with PEP	3,150	601	19%	1 male 600 female
Number of individuals who received HTC services for HIV and received their test results	17,875	8,899	502%	2,460 male 5,351 female
Number of health care workers who successfully completed an in-service training program within the reporting period	400	174	44%	78 male 96 female
Number of community health and para-social workers who successfully completed a pre-service training program	744	522	70%	199 male 323 female
Number of targeted health training institutions that have integrated or mainstreamed GBV in training curricula	44	0	0%	NA
Number of men's networks with the capacity to identify and address GBV	10	23	230%	NA
Number of survivors' networks established	64	274	42%	NA
Number of coaches and peer leaders trained (SIA)	300	150	50%	NA

However, as demonstrated in the preceding sections highlighting key successes and challenges of the GBVSS component, the currently tracked quantitative data are limited in robustness, quality and ability to demonstrate outcome-level activity results. Thus, conclusions regarding outcome-level results are based primarily on anecdotal information collected from IDIs and FGDs. For example, conclusions cannot be drawn regarding the intensity and quality of care received by GBV survivors, their overall well-being and safety following a GBV incident and service, or regarding the ideal “dose” of a range of support services for various types of GBV survivors.

Currently, indicators focus primarily on measuring if services were rendered or referrals were made, and some data are captured in terms of HIV C&T follow-up (physical health), but the emotional health of a GBV survivor is unknown. The box below provides illustrative examples of current GBVSS indicators and opportunities to add, modify, or strengthen to provide more robust quality data for comprehensive analysis at the outcome level.

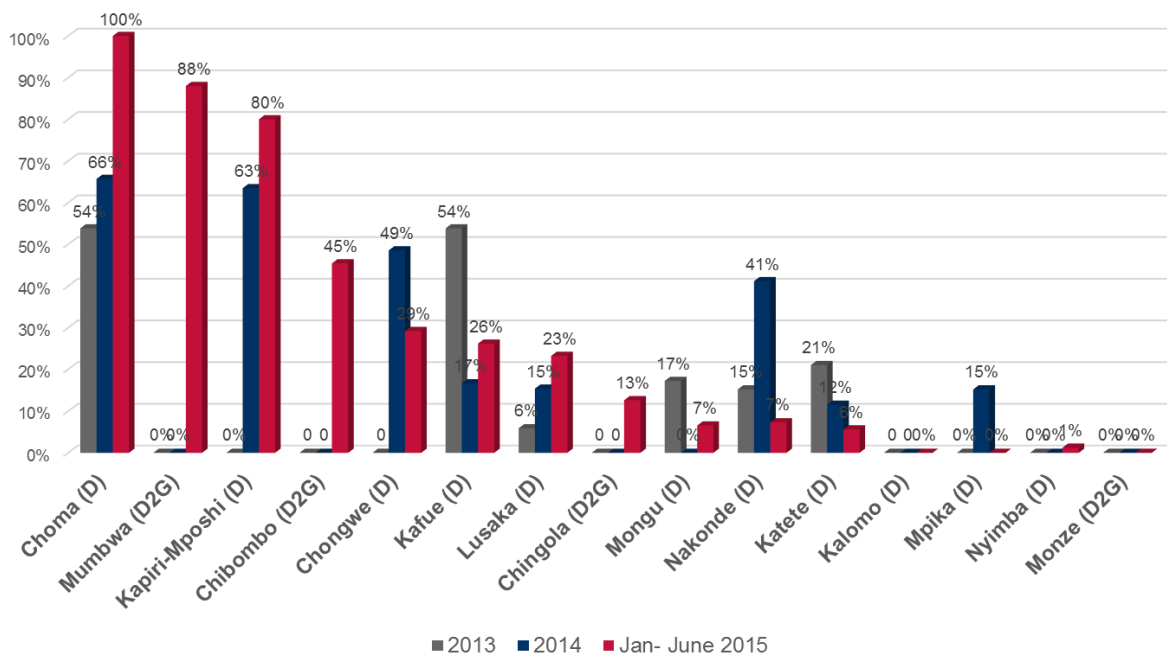
Figure 5 below is intended to illustrate the current limitations in data reporting, analysis and interpretation. It is not intended to draw conclusions about PEP provision performance or outcomes. The data for PEP are currently reported solely as the number of PEP provided, but not as a percentage of eligible SGBV survivors who arrive within the 72-hour reporting period. These percentages were

²⁵ As reported by WVZ in *Gender-Based Violence: Survivor Support (GBVSS) Project Semi Annual Report: 1st October 2013 to 30th September 2014*, *Project Semi Annual Report: 1st October 2013 to 30th September 2014*, *Gender-Based Violence: Survivor Support (GBVSS) Project Annual Report: October 2013*, and *M&E data provided June 2015*. Data reviewed by WVZ in September 2015 and corrected for data accuracy.

calculated by the evaluation team by dividing the total number of persons provided with PEP by the total number of SGBV cases reported. Thus, the figure below could be demonstrating, for example, higher levels of awareness of community members in certain areas (such as Choma) where a higher percentage of SGBV survivors are receiving PEP. It could also be an indication of staff performance on following PEP guidelines. However, this is confounded by the way in which the data are reported, without clear specification of who exactly is receiving PEP, and who is not. Although it is clearly assumed that PEP recipients are survivors of SGBV, data do not break down numbers of percentages of various types of SGBV survivors who presented to the OSC and received PEP.

What the data do show is that there are certain sites where higher percentages of SGBV survivors are receiving PEP (Choma, Mumbwa, Kapiri)—which cannot be directly linked to STOP GBV since Mumbwa and Kapiri are new scale-up sites—and certain sites where these percentages are very low. Most of the low-percentage sites are new scale-up sites, but Katete also has recorded a decrease. This requires further analysis, consideration and unpacking of this very important indicator, by site, to identify if challenges are predominantly awareness issues, staff provision issues, or a combination of both.

Figure 5. Percentage of SGBV Survivors Provided with PEP by Site and Year



Successes

Key successes of this GBVSS component include removing reporting barriers, expanded services, improved quality of services and improved access to justice.

Removing reporting barriers: Across all six OSC sites visited for the midterm evaluation, community members, GBV survivors and other key informants reported that there is less fear of reporting cases to OSCs than before OSCs were introduced (Lusaka, Katete, Kafue, Mumbwa, Choma, Mazabuka). The main reasons cited for this across sites include: ease of access, reporting to police beforehand often resulted in re-traumatization of survivors, police abuse of perpetrators and survivors, bribing of police, and perpetrator retribution following reports. Now there are increased reports across sites of improved confidentiality provided by the OSC, as well as improved follow-up and handling of cases. Female GBV survivors in Katete noted that the OSC helps survivors bypass queues at the hospital

for treatment and medication and for police paperwork, as well as expedite court dates. This has presumably contributed to observed increase of reported cases and demand for services. The reported monthly estimate by OSCs during the baseline assessment ranged from 30 to 40 in all the districts (Baseline Assessment 2015).

“We used to have a situation where you go to the police and then the police refers you to a health center which is another 2 to 5 kilometers. As a result the victims used to be discouraged, but now all the services can be accessed at one place. That is the positive.” (National government partner)

There is indication among FGDs with community members and male change agents that there is increased information provided to men about services available to men who are survivors of violence, which may or may not be attributed to the formation of men’s networks.

Providing expanded services: Across all sites in FGDs with community members and GBV survivors, and with IDIs with OSC staff and other key stakeholders, anecdotal evidence was offered in the form of individual stories of client satisfaction. This includes stories of improvements in romantic relationships and marriages as a result of receiving counseling following a visit to the OSC. Interviewees largely attribute this to the presence of more qualified, trained staff (nurses and counselors) and staff providing comprehensive case management services, including escorting clients to referred services in more high performing OSC sites (Choma).

“When [a couple] goes together to the One Stop Center, they will be counseled together, and when they return home, there will be peace in the house because they would have been counseled.” (Female GBV survivor, Choma)

“The OSC helped me by counseling us and, as we speak, my husband is really helping to take care of the children. He even tells me that it was good that I reported the matter as he feels he is now a better person. I am now even freer to teach others through drama about the dangers of GBV.” (Female GBV survivor, Katete)

Referrals to other services have also increased from 139 survivors referred to other services in 2013 to 5,167 in 2014.²⁶ However, the data are limited in documenting if these referrals are successful and result in the desired outcome for a survivor (e.g., a child is referred to Department of Social Work for shelter and is appropriately placed in shelter; a battered wife is referred to a livelihoods program where she is able to earn enough income to support herself and leave a violent marriage).

Further, the baseline assessment (March 2015) identified the key challenge of lack of supplies such as PEP at some sites. However, there appears to be anecdotal evidence during the midterm that this has since been corrected. Some OSC staff interviewed reported that PEP supply used to be a challenge but is now always there, and the presence of guidelines for staff to follow has significantly improved staff understanding of PEP provision (Choma, Chongwe).²⁷

Improving the quality of services: There is anecdotal evidence where OSC staff and VSU officers self-report their passion and commitment to the clients they serve by utilizing their personal resources to assist survivors (Choma, Katete, Mazabuka). This includes offering their own transportation (vehicles) to pick-up survivors or perpetrators, follow-up, or providing clothing or lunch to survivors.

²⁶ Gender-Based Violence: Survivor Support (GBVSS) Project Semi Annual Report: 1st October 2013 to 30th September 2014.

²⁷ PEP supply was a previous challenge that OSC staff report has been resolved at this time. However, PEP supply remains a challenge (according to ZCCP nationally) at some ASAZA sites, raising challenges for conducting awareness to increase demand for PEP in former ASAZA sites, and suggesting an important potential challenge in transition to government management and future sustainability.

All OSCs are implementing the 24/7 approach, wherein GBV survivors who seek services outside working hours are managed by trained OPD staff and later referred to the OSC.²⁸ However, OSC staff in some sites note that they are unsure if OPD staff handle all after-hours cases appropriately, and they believe that there are some survivors who leave and do not return for services (Mazabuka). Data do not provide ability to analyze the quality of care rendered after hours.

Improving access to justice and preventing GBV: More detail will be provided in the next section (5.2 Component 2: GBVAJ) focused on direct legal services. However, it is important to note that across sites, interviewees and FGD respondents noted that the mere presence of the OSC is believed to have an “OSC effect,” whereby staff and community members observe that a certain level of fear of consequence is instilled in potential perpetrators, motivating them to “behave” as they know they should (Lusaka, Choma, Katete, Mazabuka, Mumbwa, Kafue). Some also believe that the presence of the OSC may decrease susceptibility of cases to bribes and corruption with police and within the justice system, thereby expanding access to justice. However, M&E data do not allow for quantification or analysis.

Laying the groundwork for sustained success beyond the project life. The hospital in Katete is already putting in place plans to take over the OSC and services. There are seconded government staff workers working alongside OSC staff to learn and train. Further, once the donors pull out, the local government is planning on building a safe house next to the center.

Engaging men and boys. SIA is working closely with religious leaders, community members and parents in all the six targeted districts, increasing the number of participants and presumably awareness of GBV as a result.²⁹ SIA highlights the success of involving government partners in mapping the program, as well as involving 167 parents and teachers in addition to other religious leaders and community members in the start-up of the program, noting their willingness and enthusiasm to be involved.

Interviews and FGDs in Mumbwa, the only site visited during the evaluation where SIA is operating, indicated high interest, excitement and demand among young men and women to participate in the program. SIA notes the success of having a close working relationship between their staff and OSC staff.

Challenges

Key challenges in demand for and supply of GBV survivor services include lack of transport, inconsistency in timely receipt of free medical reports, inconsistent availability of adequate physical infrastructure and supplies, varying quality of services and staff, and weak referral systems including inadequacies of certain types of referred services.

Ongoing stigmatization, awareness challenges and fear of delays prevent reporting. Implementing partners and OSCs are well aware of the problem that delayed reporting causes, particularly of SGBV cases, rendering services such as provision of PEP and EC ineffective.³⁰ Across all sites visited, the majority of interviewees and FGD participants reported that SGBV survivors, and often children who rely on caretakers to bring them for services, continue to report late. Reasons provided for delayed or non-reporting include stigmatization and blaming of GBV survivors by family or community; fear of economic loss if the perpetrator is prosecuted; fear of abuse and corruption in the legal system; and low awareness of the need to report within 72 hours to receive PEP and EC (Lusaka, Mazabuka, Choma, Kafue, Mumbwa, Katete).

²⁸ Project Semi Annual Report: 1st October 2013 to 30th September 2014.

²⁹ Sport In Action Quarterly Report. October 1 to December 15, 2014.

³⁰ Semi Annual Report: April 2013.

All five female GBV survivor groups shared that common reasons for not visiting or delaying a visit to an OSC are fear of the husband's arrest and/or immediate divorce (Lusaka, Katete, Mazabuka, Mumbwa, Choma). A GBV survivors group in Choma has tried to help a young woman experiencing physical abuse in her marriage, *"but the wife says if they go to the police, he will be jailed and she is going to remain alone."*

Despite some improved attitudes among men about the presence and role of the OSC, there remain some observed negative attitudes and misconceptions. In Katete, male community members participating in a FGD shared their belief that the OSC encourages divorce and disrupts families. Female community members participating in an FGD in Mumbwa discussed fear of being bewitched by the husbands' family if she brought him to the OSC.

"[The OSC] is just there to protect women and to make women disrespect men." (Male community member, Mazabuka)

"We men are very much suffering. When you are having problems in the house, then you take the woman to these organizations, when you both explain your sides of the story there, the case will always be against you as a man." (Male community member, Mazabuka)

"The community reacts differently to survivors of GBV, some mistreat the survivors for reporting 'matters of the home to the OSC' while others feel it's good that they reported so that men learn a lesson." (Female GBV survivor, Katete)

Although these insights are anecdotal, as discussed in FGDs during site visits, they highlight the need for further attention on awareness campaigns and messaging that convey the positive benefits of OSCs. Further, these statements were taken in the context of asking FGD participants about their viewpoints on OSCs in their community; it should be noted that these types of views, although stated regarding OSCs, are not necessarily exclusive to OSCs, but may be a generalized viewpoint of community members about any service/NGO perceived as "meddling" in family affairs.

Throughout FGDs, both men and women continually mentioned the women's role in the household as that of subservient to the husband. Traditionally, this also means that women are not allowed to deny the husband sex and must endure his beatings and abuse, as this is part of their marriage vows (Lusaka, Mazabuka, Mumbwa, Choma, Katete, Kafue). Male community members in Katete agreed that women may only deny sex with their husbands if they are menstruating, have just given birth, or are sick.

Accessing reliable and affordable transport: This well-known challenge is critical across all sites by GBV survivors and community members, OSC staff, implementing partner staff and government partners. Due to long distances to OSC sites for those who may live in rural areas, and lack of vehicles or money for transport, many survivors do not come to the OSC to access services. (Lusaka, Choma, Kafue, Mumbwa, Katete, Mazabuka).

OSCs will reimburse survivors for transport costs when the OSC vehicle is not available, but this also does not come without challenges. Not all survivors qualify to receive a reimbursement, as criteria stipulate that OSC staff only provide reimbursement to those assessed as most in need. Some OSC staff report using their own vehicles to assist survivors (Lusaka, Mazabuka, Katete). There are inconsistencies in survivor reports of OSC reimbursement for transport. GBV survivors participating in a FGD in Mumbwa report inconsistent patterns in transport reimbursement, while survivors in Choma shared that they often pay for a cab or take survivors themselves to the OSC offices, without reimbursement. One female survivor in Katete mentioned *she was asked to buy fuel for the OSC vehicle*, which is consistent with reports by OSC staff there that they have difficulty paying for fuel (Katete). In Lusaka, one female respondent mentioned that without transport they *"have to call a relative to help the victim."* Quantifying this challenge is limited in the absence of M&E data to track how survivors arrive to the OSC, if transport was paid by the survivor, and if they are reimbursed.

“We only have one vehicle so for example the vehicle has gone to Chanyanya then you receive about 5 cases from other far land areas so they will have difficult to travel. [Survivors] are told to wait and in case of defilement some come late and are not given PEP.” (IDI respondent, Kafue)

Attempts have been made to mitigate this challenge by providing mobile OSC services. However, in the six FGDs with community members and the six with GBV survivors, no individual was aware of mobile services being provided (Lusaka, Choma, Kafue, Mazabuka, Mumbwa, Kafue). As a result, this evaluation does not benefit from feedback regarding utility or quality of mobile services to the community and survivors. This may not be a function of actual availability of mobile services, since annual reports and OSC staff indicate that they are provided, but a rather may be a function of the location of the evaluation’s FGDs, which predominantly took place near OSCs rather than in rural areas where there may be more awareness of the mobile services.

Inconsistency in timely receipt of free medical reports: Although OSC staff, survivors and community members participating in FGDs report that in some sites free medical reports are issued by a qualified doctor at the affiliated health facility, in many sites OSC staff and/or FGD participants reported cases of K50 being charged for a medical report, with reported delays between one week and one month (Mumbwa, Lusaka, Mazabuka, Kafue). There is also some inconsistency in the application of these charges: a survivor may be charged the K50 if she attends her appointment with the medical doctor alone, or not charged if she is accompanied by an OSC staff person (Mumbwa, Mazabuka). This indicates inconsistent application of known guidelines that medical certificates should be issued for free. In Mumbwa, several female GBV survivors participating in an FGD during the evaluation reported that they were told to pay K50 at the clinic to obtain a signed medical report; only after they paid would the authorities go and arrest the perpetrator. One respondent mentioned that she pleaded with them and did not have to pay after all. However, another survivor elaborated, *“All [OSC] services are free. But if you just pay a K50 then they will go and arrest the perpetrator. If you don’t pay, they will not go. So it is up to you.”* She was told that the K50 is for the doctor’s signature on the medical report. In Kafue, a male GBV survivor noted that he had to pay K22.5 to receive his medical report, while another noted, *“You are moving around the hospital with wounds, and they will be saying the doctor is not around.”*

Charging for a medical certificate can create a major impediment to having the documentation required to pursue a legal case. Delayed provision of the medical report presents additional challenges, including assisting a survivor to secure a safe environment, or apprehending and keeping a perpetrator. Challenges frequently noted by OSC staff include busy doctor schedules that delay appointments with GBV survivors; this may be mitigated by changing laws to allow for other medical staff (such as a nurse) to sign medical certificates, or by ensuring appropriate medical staff are available within the OSC to provide this essential service.

Inconsistent availability of adequate space/physical infrastructure: OSC staff and GBV survivors at some sites indicate that inadequate space is allocated for OSC operation (Katete, Kafue, Choma, Mazabuka). This impacts patient confidentiality, privacy and comfort in places where counseling spaces are shared with other functions. Two national government interviewees cited ongoing challenges with physical resources at some OSCs, including ongoing needs for proper equipment to collect and analyze evidence on-site to facilitate legal cases.

GBV survivors in Choma also identified the need for a security guard at the OSC to protect survivors from perpetrators, which survivors also linked to the ongoing gap of protection and shelter for survivors so that they are in a safe place as they proceed with services and resolution.

“As others were saying that we should have a house for the victims. We should have a room where they can sleep and where they cook and eat from. The way things are now, is that we just keep them in the church when they come to report and this is not safe, the perpetrator might come back at night.”
(Female GBV survivor, Choma)

Inconsistent quality of services: Despite some anecdotal evidence of high-quality and improved services at some sites, there are also anecdotal reports of ongoing challenges in quality of services at most sites, ranging from staff shortage and inadequate staff training to inadequate service hours (Lusaka, Katete, Kafue, Mumbwa, Mazabuka).

One national-level interviewee cited ongoing challenges with inconsistent and inadequate OSC staffing levels and ill-defined roles of staff. Another national government interviewee is of the opinion that many OSC health staff may prefer rotating out of the OSC than remaining, pointing to sustainability issues and loss of trained staff available to handle cases according to guidelines.

“It’s a mixed [bag] because of human resource shortage. For instance you may have a victim, a survivor who has come, let’s say sexual violence, and you need a doctor—let’s say an obstetrician to attend—if they are busy in the theater somewhere there will be a delay in getting that support, even if it’s in one building.” (National government partner interviewed)

Specialized care training (medical, psychosocial) for children who are GBV survivors was noted as lacking during the baseline assessment (March 2015), and also cited as a current challenge among staff at some OSC sites, many of whom noted the need for refresher training (Lusaka, Mazabuka).

Although sites operate 24/7 by way of on-call services, actual hours of operation (M–F, 9:00–17:00) limit service provision for survivors. For example, if medical officers are not present immediately to collect evidence for a medical case, police officers and prosecutors may not receive sufficient evidence to bring the accused abuser to justice. If a police officer or psychological counseling is not present at an OSC to guide a survivor through next steps, the survivor may return home rather than proceeding to a shelter or receiving critical services, particularly in the usual absence of money for food. To provide 24/7 services after the OSC is closed during normal business hours, OPD staff attend to GBV cases and OSC staff are on-call in case of critical emergency; however, OSC staff are unsure of the quality of support survivors receive after hours (Katete, Mazabuka).

Further, psychosocial counseling appears to be primarily a one-off event provided at the time of visiting the OSC, or may entail one more follow-up sessions provided at the time of reporting. However, it is not evident, and data are not tracked to quantify, if survivors receive ongoing longer-term psychosocial counseling over an extended period of time to provide them with necessary emotional support to proceed with a legal case, move to a safe environment, or heal from abuse. In FGDs with survivors, accounts were told of women who experienced temporary relief from abuse in their marriage after visiting an OSC, but reported currently living in situations of ongoing abuse, primarily due to lack of economic options. The baseline assessment (March 2015) also included accounts of survivors living with ongoing verbal/physical abuse over the long-term (i.e., short-term change, long-term return to old patterns). This points to the critical gap of long-term, sustained psychosocial counseling, as well as the need for better quality data to track long-term outcomes of GBV survivors served.

Lastly, although some cases were shared of satisfaction with OSC staff attitude, some anecdotal evidence was also shared of poor OSC staff attitude or behavior, including disrespect of a survivor’s wishes. One female survivor in Katete stated, *“I think the attitude of people at the Center is bad.”* Another male survivor from Kafue explained that he was not happy with the advice from the OSC, particularly in their encouragement of divorce. He elaborates, *“When we went to the OSC they called me and wife and the recommendations they made were not very good. They were not supposed to encourage divorce.”* In Mumbwa, a female GBV survivor relayed a story of visiting the OSC specifically to avoid police calling her partner, yet the OSC staff called him regardless, so she was unhappy with how her case was handled in terms of her wishes being respected.

During OSC site visits, some OSC staff were observed to have low levels of motivation and passion for their work. Further, particularly among seconded government employees, there was an expressed desire for additional compensation for “additional” work performed at the OSC (Mazabuka, Mumbwa).

Weak referral systems and few high-quality referral services. A referral system directs survivors to services that are required but not available at an OSC. Three national government interviewees cited the lack of guidance and follow-through throughout the referral system as a key service provision gap. This was also observed during evaluation site visits; although some sites demonstrated high levels of OSC staff accompaniment (Choma, Katete), in other sites community members and survivors discussed challenges in receiving adequate referral assistance. For example, in some locations, survivors were simply provided with a note providing information and instruction to proceed to the court system (Kafue), which is burdensome and difficult for a survivor to navigate alone. This points to a real need for data to be tracked on referral outcomes and not only referrals made.

In addition to the referral system itself, there is a range in quality of referral services available. For example, 41 percent of respondents surveyed during the baseline assessment (March 2015) report that economic independence was the most important factor for GBV survivors to leave unsafe environments. Although CARE is supporting ZCCP in offering VSL options to a limited number of targeted people, with anecdotal evidence of positive outcomes, there are limited tangible, secure, long-term livelihood opportunities for enough GBV survivors to make leaving an unsafe environment a reality. In Katete, GBV survivors reported that they received training on income-generation and savings, and some received assistance in starting community banks for small business, which gave one woman the confidence to divorce a perpetually abusive husband. However, higher numbers of female survivors participating in FGDs reported the lack of economic opportunity as a key gap in their path to healing and safety. One female GBV survivor in Choma noted, *“We are not financially empowered. The only ‘empowerment’ is the knowledge.”* A female survivor from Lusaka elaborated, *“They should also observe women who are interested and have the talent and skill, and should also train them ‘how to catch a fish’...how to manage a business.”* Another stated, *“There is no empowerment for us. They just train us. We [survivors] after our cases are closed need jobs. I was stranded when my husband left me, I had nowhere to go. So at least if there provide me with where to stay, they train me and I raise some money and become independent. In that way we can fight GBV.”*

Unavailability of shelter services in the districts for referrals of GBV survivors for protection and security³¹ was cited in WVZ’s first year of operation as a major challenge, and this continues to be a major impediment to providing high-quality services to GBV survivors. Two government-level interviewees noted that plans are in place for shelter construction, although to date no shelters have been constructed by the government. WVZ supports one sub-grantee, FAWEZA, which operates shelters for school-aged girls so they may be in a safe environment and stay in school. However, lack of shelter presents problems for survivors traveling long distances, creating barriers to accessing comprehensive case management services, short-term stability, removal from unsafe environments, and long-term care.

³¹ Semi Annual Report: April 2013

“For adults we don’t have [shelter], but some [survivors] are kept at the police for a time. For children we take them to the CPU and from there the child is taken to Social Welfare where they are taken to an orphanage. At that One Stop Center there is no transport. There is an orphanage somewhere near that place, so we took a case there at night because we don’t have where to take them.” (Lusaka community member)

FAWEZA Safe Houses and Safe Clubs

In Lusaka, Southern, Western and Copperbelt provinces, FAWEZA assists girls at risk of dropping out with safe places to live and safe clubs to encourage ongoing school attendance. Matrons are trained over a one-week period in financial management, home management and psychosocial support.

FAWEZA trains peer educators in schools to support clubs open to boys and girls age 12-23, where they discuss life skills, sexuality, and HIV/AIDS. FAWEZA also runs a mentorship program focused on Banachimbusa (traditional counsellors) to empower girls within a culturally appropriate context.

The greatest challenge the organization reports facing is that parents may not support the child living in the facility. Children living in the safe houses may also face stigma at school.

In order to encourage sustainability, FAWEZA is engaging in advocacy with the government and demonstrating the need for the safe houses. They suggest surveys with headsmen to identify the number of girls “squatting” in villages to demonstrate the high need for such houses.

Challenges in scaling up the added objective of engaging boys and young men through sport. SIA noted some challenges in terms of delayed activity start-up due to: delayed production of the manual, which affected the implementation of YMEP sessions; exam periods in schools delaying start-up of school-based programs; and insistence of some schools for formal Ministry of Education permission to be granted before implementing the program, delaying involvement of teachers.³²

In Mumbwa, several IDI and FGD participants noted that some girls feel marginalized by the program, since it targets boys. This is particularly the case in school settings where there are co-ed classes. One IDI respondent noted, “Girls are complaining that the boys get to play sports and they are just their cheerleaders.” Although the focus is on male engagement, the exclusion of girls from this desired sports program may have an unintended negative consequence of reinforcing existing gender stereotypes among girls.

Costs

The contract amount for this component is \$13.068 million³³ inclusive of expansion funds, but excluding the SIA amount. Out of this amount \$6,421,234 is the approved budget for the first three years. A total of \$3,828,079 was spent to date (\$736,625 from expansion funds) representing 57 percent of the total budget, or 28 percent of the total contract amount. The current obligated amount, excluding SIA, is \$4,774,699, and expenditure to date is 80 percent of obligated funds, which is adequate through September 2015. The average burn rate from inception to April 2015 is over 31 months. WVZ is on track to spend the budget, but may require an increase in the burn rate to spend the total contract amount by project end.

The total approved contract amount for the GBVSS SIA component life of project (LoP) is \$1.133 million, out of which \$400,000 has been obligated. As of April 30, 2015, SIA spent a cumulative amount of \$155,810³⁴ (13.75 percent of approved budget or 38 percent of obligated funds). This translates to a

³² Sport In Action Quarterly Report. October 1 to December 15, 2014.

³³ Costs reported are in U.S. dollars.

³⁴ WVZ reports SIA expenditures of \$132,643, a variance in what SIA reports.

burn rate of US\$15,581 for the 10 months since inception. At the current burn rate, it would take 15 months to spend the balance of obligated funds, indicating that this component could have an unspent amount of \$572,496 unless the burn rate is increased. In their semiannual report for the period ending April 30, 2015, SIA attributes the low spending to delay in the start of activity implementation and impact of the school calendar. Additionally, review of SIA's Year I work plan budget against its semiannual report revealed that planned start-up procurements of \$102,438 were not completed in the reporting period, including purchase of a motor vehicle (\$46,000), office equipment (\$12,600), specialized equipment (\$6,000) and consultancy fees (\$37,838).

SIA conducted six trainings of 150 coaches and peer leaders Mumbwa, Kalomo, Monze, Mpika, Chingola and Nyimba (25 per site). The cost for each training is reported as the same across all districts (\$2,047), translating to a total of \$12,280 spent for trainings, at a unit cost of \$82 per beneficiary.

F. COMPONENT 2: ACCESS TO JUSTICE

The purpose of the Access to Justice (STOP-GBVAJ) component is “to improve access to justice for adult and children survivors of GBV, by strengthening the capacity of GBV service providers as well as policymakers in GBV cases management and implementation of laws. The service providers targeted in this project are the police officers, health workers, social workers, judiciary, paralegals, legal practitioners and traditional leaders. Additionally, the project aims at raising awareness of GBV matters in the community and provides legal aid and advice to GBV survivors.”

WLSA began implementing this component in April 2013 in eight districts (Lusaka, Chongwe, Nakonde, Mongu, Kafue, Kapiri-Mposhi, Choma and Katete), but scaled up in 2015 to six additional districts (Mpika, Kalomo, Mumbwa, Chingola, Nyimba and Monze) for a total of 14 districts in seven provinces.

This section provides an overview of activities completed from inception (April 2013) to the time of the evaluation (June 2015), progress in meeting key performance indicators, and key successes and challenges.

Activities Completed

Table 7 below highlights the activities completed to date, by objective, as indicated in WLSA's three annual reports, reporting targets and results where that data were made available.³⁵ Activities are denoted by Y1 (April 2013–September 2013), Y2 (October 2013–September 2014), and Y3 (October 2014–March 2015, semiannual).

To meet the objective of raising awareness of GBV laws and gender issues in the community, WLSA has exceeded its set target (44) in sensitizing 101 community leaders, although it has fallen short of meeting the target of 6,900 individuals, reaching 1,970 individuals in Year I, which WLSA attributes to delays in funding.

To meet the second objective to strengthen the capacity of service providers in handling GBV cases, WLSA has made progress in meeting targets in holding consultative meetings with judges, developing training materials, and training all paralegals across the 14 OSCs where WLSA operates. Progress has also been made in training of magistrates, police officers, doctors and others, although targets have largely not been met, again due to funding limitations cited by WLSA.

³⁵ Table describes completed activities according to documentation provided by WLSA, including: *Stamping Out and Preventing Gender-Based Violence Access to Justice (STOP-GBVAJ) Project. Women and Law in Southern Africa Year Two Detailed Work Plan October 2013–September 2014. Stamping Out and Preventing Gender-Based Violence Access to Justice Project (STOP-GBVAJ). Report for the Period April to September 2013. Stamping Out and Preventing Gender-Based Violence Access to Justice Project (STOP-GBVAJ). Report for the Period October 2013 to September 2014. Submitted to USAID 20 October, 2014.*

In meeting its third objective to provide legal aid services to GBV survivors, WLSA deployed paralegals to all 14 sites where they operate, exceeded targets in Year one by providing 7,695 clients at the eight original OSC sites or via the telephone hotline with legal counseling, and to 6,078 GBV survivors through March 2015 in Year three, with reported cases taken to court increasing in Year three from 95 cases in Quarter one to 129 cases in Quarter two. From inception to April 2015, a total of 22,971 (7,020 male and 15,951 female) received legal counseling, while 606 cases have gone to court and there have been 36 convictions (WLSA Semi-Annual Report, April 2015).

WLSA's fourth objective to strengthen referral and linkages for comprehensive GBV services was in progress at the time of the midterm evaluation, with support from CARE and an independent consultant.

Table 7. STOP-GBVAJ Activities Completed to Date

Objective	Activities Completed
<p>Objective 1: Raise awareness of GBV laws and gender issues in the community</p>	<ul style="list-style-type: none"> • Start-up activities implemented, including recruitment of key staff (including seven paralegals at all OSCs except for Solwezi), work plans and PMP submitted. Y1 • Community sensitizations conducted with communities in the eight original districts at OSCs, reaching 1,970 people, falling short of the target of 6,900 individuals sensitized in two sensitizations per quarter). Y1 • Community sensitization conducted with communities and 101 traditional leaders (exceeding the target of 44 leaders): Ng'ombe: one day at Kamwala OSC with 121 school children grades 5 to 7 (54 girls, 67 boys), one day with nine village headmen and one chief's retainer, one day with constituency leaders (leaders from the Neighborhood Health Committee and the Ward Development Committee under the Lusaka City Council); Kafue: one sensitization meeting with 50 headmen in Old Kabweza; Mongu: one-day meeting with 10 village heads (seven male, three female). The set target for sensitization of communities is 863 community members for Y3. Y3 • Sensitization meetings with 10 magistrates conducted (31 March, 2015) for Mongu, including 10 magistrates and one police officer from the Child Protection Unit. The LOP target is 160 magistrates (80 in Y2 and 80 in Y3, but Y2 work was delayed and pushed into Y3). Y3
<p>Objective 2: Strengthen the capacity of service providers in handling GBV cases</p>	<ul style="list-style-type: none"> • Baseline data collection tools developed and data collected from service providers, with the exception of courts. Y1 • Curricula were collected for analysis from Lilayi Police College, University of Zambia, University of Lusaka and Zambia Institute of Advanced Legal Education (ZIALE). Obtained buy-in from University of Zambia, ZIALE, Law School of Lusaka University) to mainstream gender in their curriculum. The University of Zambia's curriculum was found to be already gender mainstreamed. ZIALE and Law School of Lusaka University invited WLSA to submit a proposal for GBV integration in curriculum development in the last quarter of 2013. Y1 • Conduct consultative meeting with training institutions to integrate GBV into curricula, after which curriculum was developed, followed by a dissemination workshop with stakeholders. Y2 • Three separate training materials developed (Anti-GBV Act, gender, and anti-GBV related laws) for service providers (1: police, legal practitioners and the judiciary; 2: social workers, health workers and traditional leaders; 3: traditional leaders). Y1 • Training material developed for paralegals finalized in Y2 and updated with material in Y3, with the main topics of: family law, law of succession, criminal procedure, land law, human rights law, constitutional law, Matrimonial Causes Act,

Objective	Activities Completed
	<p>penal code, tort law, domestic relations, litigating inheritance cases, legal drafting, employment law, and the Anti-GBV Act. Y2/Y3</p> <ul style="list-style-type: none"> • Police officers trained: Mpika=17 (out of 0 targeted), Lusaka=9 (out of 182 targeted), Chongwe=1 (out of 26 targeted), Choma=2 (out of 78 targeted), Mongu=24 (out of 52 targeted), Kafue=2 (out of 52 targeted), Katete=25 (out of 78 targeted), Kapiri-Mposhi=4 (out of 26 targeted), Nakonde=17 (out of 26 targeted). The target was one police officer each from the Victim Support Unit, Child Unit, prosecutors, and investigators (total of four officers from one police station in each constituency of each district. At the end of the training, police officers were supposed to develop action plans to implement how they handle GBV cases, and an additional 28 officers were supposed to receive additional training in case management; however, this was not done, as WLSA explained that the police already have their own protocols. Y2 • Two legal practitioners from the Legal Aid Board were trained, out of 30 legal practitioners targeted from the Directorate of Legal Aid (civil legal representation), the National Prosecutions Authority (prosecution of criminal cases), and legal practitioners in private practice (legal representation). Y2 • Thirty judges have participated in consultative meetings (out of 19 targeted in Y2), 24 subordinate court magistrates (out of 30 targeted in Y2 and 90 for the LOP), and 55 local magistrates. Y3 • Two doctors were trained from Choma, one from Chongwe, one from Kafue, one from Mongu, one from Katete, one from Kapiri-Mposhi, and one from Nakonde were trained (out of a total of five targeted health workers and five targeted social workers who provide medical treatment or counseling services, including those in OPD). Y2 • Paralegals were trained: 27 in Lusaka, two in Chongwe, 21 in Mongu 21, 10 in Katete, one in Chipata, nine in Kapiri-Mposhi, 11 in Kafue, two in Choma, two in Nakonde, two in Mpika, four in Mumbwa, one in Kalomo, one in Mazabuka, one in Monze, one in Chingola and one in Nyimba. (Originally five paralegals from each district were targeted for training, but this targeted number was scaled-back to two per district). Y2/Y3 • None of the targeted policy makers were reported as trained in case management to get buy-in from the policy makers, particularly for those commanding police officers. Y2 • Training for paralegals and social workers from 14 OSC sites conducted in Lusaka over six days with 28 participants (13 male, 15 female) including eight original formerly trained paralegals, six new paralegals from added districts, eight social workers and six WLSA national office legal officers. Y3 • Workshop conducted for 38 magistrates (19 male, 19 female) of the subordinate and local courts in all eight original districts. Content included: international women’s and children’s rights legal instruments; Anti-GBV Act; maximum sentencing levels for magistrates; child witnesses; medical forensic evidence; and challenges of case management in sexual offenses. Y3 • Consultative meeting with 12 judges (four female, eight male) from the Supreme Court and High Court held over two days on the topic of “Due Diligence of the Courts in GBV cases.” The objective was to hear participants’ views. Discussion included: Section 191A of the Criminal Procedure Code dealing with need for corroboration of evidence in sexual offenses; need for more adjudicators exposed to information on medical forensic evidence; need for finalization of Evidence Code; need for sensitization on issues relating to marital rape and peer defilement; and need for improved information on judiciary website and High Court library and via gazettes. Y3

Objective	Activities Completed
<p>Objective 3: Provide legal aid services to GBV survivors</p>	<ul style="list-style-type: none"> • Fifty-four of the targeted 64 GBV survivors were provided with legal aid in September through paralegals stationed at the OSCs in eight districts. Due to prolonged baseline data collection processes, paralegals had a reduced number of days in the OSCs to provide legal aid. Y1 • WLSA and Lifeline/Childline collectively provided legal advice to 7,695 clients (2,243 male, 5,452 female) at the eight original OSC sites or via the telephone hotline, exceeding the set target of 4,135 GBV survivors to receive legal aid in Y2. A total of 382 cases were taken to court. While 59 had positive outcome, eight had negative outcomes such as dismissal due to lack of evidence, and 92 were withdrawn due to intimidation and threats or choosing to settle out of court for monetary compensation by the perpetrators. Y2 • All eight paralegals (Field coordinators) at the original OSC sites were actively involved in the mobile legal clinics organized at the OSC. Following community sensitization meetings, mobile clinics were conducted quarterly on joint visits with WVZ and ZCCP, during which paralegals from the OSC provided legal advice (planned quarterly starting in March 2014). Y2 • Two GBV survivors were planned to receive legal aid and case follow-up per week from each OSC, for a total of 64 survivors per site or 768 per year, but data were not made available to identify if this was achieved. Y2 • Lifeline/Childline provided free psychosocial counseling services to 8,302 GBV survivors (3,207 male, 5,095 female) via 24/7 toll-free services so far this year. Y3 • Deployed paralegal officers in the six additional districts. Y3 • Provided legal advice and counseling services to 6,078 GBV survivors (1,550 male, 4,528 female) in all eight districts during the first quarter, and in all 14 district in the following quarters after operational expansion. Reported cases taken to court increased from 95 cases in Q1 to 129 cases in Q2. WLSA has reduced its original target of 10 percent of reported GBV cases to the OSC taken to court to 3 percent, based on recognized limitations outside of WLSA's control. However, withdrawn cases also increased from 105 withdrawals in Q1 to 261 in Q2. Most withdrawn cases were wife/husband battery and assault, and were withdrawn when cases reached the police (before court proceedings). Survivors, often women, reportedly withdrew cases once they realized that the perpetrator—frequently the economic provider in their homes—may be arrested. Y3
<p>Objective 4: Strengthen referral and linkages for comprehensive GBV services</p>	<ul style="list-style-type: none"> • Developed a referral system: Consultative meeting led by CARE with STOP GBV implementing partners and sub-grantees held to discuss current referral system, identify gaps and provide recommendation on how to improve the system. Y2 • Engaged a consultant to develop the referral system; presented to IPs and sub-grantees for feedback; and WVZ provided data fields of importance to include in the system in order to capture comprehensive data at each OSC. Y3

PMP Indicator Performance

Table 8 below provides a snapshot of the GBVAJ PMP indicators currently tracked with data reported by WLSA to date. Indicators measure training and service provision inputs and outputs. The indicators allow for measurement of the process and performance of WLSA in expanding access to justice for GBV survivors. Although there are also important outcome-level indicators tracked, such as number of convictions, there are also opportunities to modify or add to indicators to collect more meaningful outcome-level data.

Table 8. Key Access to Justice Indicators and Progress³⁶

Key Access to Justice Indicators				
Key Indicator	Life of Project (LOP) Target	Number (total cumulative) of LOP Target Reached	Percent of LOP target reached	Sex disaggregation (LOP)
Number of service providers trained in GBV	1,304	357	27%	234 male, 123 female
Number of GBV survivors provide with legal aid advice	51,300	22,971	45%	3,793 male, 9,980 female
Number of GBV cases reported to OSC taken to court	2,565	606	24%	Not disaggregated
Raise awareness in community ³⁷	3,450	2,042	59%	Not disaggregated

Although WLSA is tracking important outcome-level data, there are limitations in analysis because data are not currently disaggregated by important factors. For example, cases prosecuted, convicted, and withdrawn were not reported by case type, age, or gender, nor reported as a percentage of cases reported, litigated, etc. This becomes important for analysis—as stated in the original problem statement, some cases, such as child abuse and neglect, are unequivocally considered a crime by society at large; however, marital rape is not. Without disaggregating the type of GBV cases that are prosecuted, withdrawn, or convicted, it is difficult to quantify whether progress is being made toward changing societal attitudes towards more stigmatized types of GBV, and if the formal legal system is handling those cases in a way that results in the ultimate outcome, or indication of true change, which is conviction in cases of the more stigmatized types of GBV cases.

In addition, some important data that would be of great utility in measuring success of the program in improving justice are not currently tracked locally or nationally. Such indicators include the length of time it takes to bring a case to court or to adjudicate a GBV case, which may measure progress in streamlining evidence processes, assisting survivors and witnesses in providing testimony, and magistrates facilitating more efficient court processes. Other indicators that could be useful to measure are trained police, magistrate, and prosecutor knowledge of the penal code and Anti-GBV Act (before and after training), which would help to ascertain if knowledge is increasing and if that knowledge is correlated with increased prosecutions, convictions, or shortened length of time of cases. In addition, tracking the number of pieces of policy and legislation created with assistance of WLSA would help to capture the important high-level policy work it is currently engaged in.

Successes

Key successes in increasing demand for and supply of access to justice services for GBV survivors include progress toward strengthened policies, progress toward expanded knowledge and tools for handling legal aspects of GBV cases, expanded paralegal services in OSCs, increases in total numbers of prosecuted GBV cases, and contributing to efforts in expanding knowledge of rights.

Progress toward strengthened policies. Ongoing coordination and progress is observed with the Ministry of Justice, High Court, and justices to review required revisions to the Anti-GBV Act to make it

³⁶ As reported by WLSA in *Stamping Out and Preventing Gender-Based Violence Access to Justice Project (STOP-GBVAJ) Report* for the Period October 2014 to 31st March, 2015. Submitted to USAID on April, 2015.

³⁷ These WLSA-reported numbers are inconsistent with other WLSA-reported numbers that appear in the table above.

more actionable and aligned with the penal code, and to review other policies and laws to remove known legal constraints to adjudicating GBV cases. Legal amendments are a slow process because of the system and the length of the drafting process. To address this, WLSA is currently reviewing the civil part of the Act, such as occupational and protection orders, to ensure they are actionable, and also lobbying for amendments to the penal code and expedient policies to ensure government constructs safe houses and implement the Anti-GBV fund.

Progress toward expanded knowledge and tools for handling legal aspects of GBV. Progress is being made with Chief Justice Chalwe Mchenga on developing a manual, or a three-page quick reference guide, to be distributed at all police stations to assist officers and prosecutors with clear direction on required evidence collection, laws and requirements for prosecuting a GBV case. It is assumed that providing this critical information throughout the country, particularly in rural areas, will improve access to this knowledge and, as a result, improve evidence collection and successful adjudication of cases. A comprehensive checklist has been formulated, providing details on requirements for each of the 32 GBV-related crimes.

It will be of great utility for WLSA to ensure that as policies and related knowledge tools are adopted and rolled out, there is a systematic way to track their outcomes.

Expanding paralegal services in OSCs. Improved paralegal training and services appear to be noted in the 14 sites since the baseline in March 2015. There are some reports of escorted services throughout the legal process. Some improvement since baseline has been noted: paralegals sampled across the five sites (not in Mazabuka) seemed active, engaged and integrated in the OSC, an improvement since the baseline when many informants reported that paralegals were not knowledgeable or not performing well.

Across all sites, GBV survivors noted that legal support and counseling was a cornerstone of OSC services for GBV survivors. Survivors across sites indicated the important role paralegals play, and in many sites respondents reported availability of paralegals for questions and support during the legal process. In Mumbwa, for example, GBV survivors agreed that prior to the OSCs, survivors would go directly to the police to report the incident and perpetrator, but the police would frequently fail to follow up and see the case to completion. The women reported that, as a result, women returned to a worse situation—increased violence at their homes—as they faced retribution from the perpetrator for reporting. Now, they see a difference with the paralegal providing support and follow-through for cases. This was also noted in Katete, where one survivor explained, “The OSC also helps with court cases. They give legal advice until your case is disposed of by the courts, and if during the process you spent money you just give them the receipts and they refund everything.”

Women in Mumbwa also expressed that the OSC has helped them avoid the corruption previously experienced when reporting to the police. A respondent in Mumbwa mentioned, “If you take a case [to the police] for example, a defilement case, the defiler may bribe them and there will be no case at all.”

Additionally, the OSC in Katete is making progress towards transition to government hand-over. WLSA is currently training a chaplain who will take over from the paralegal to increase the chances of paralegal services continuing at the site following project close-out and transition of OSC to government.

Increasing total numbers of prosecuted and convicted GBV cases. Although data for only half of 2015 are currently available, WLSA has recorded five cases adjudicated in 2013, increasing to 42 cases in 2014 and 114 in the first half of 2015 alone. WLSA also recorded one conviction in 2013, 27 in all of 2014, and 27 in 2015 through June 2015, indicating a positive trend in the number of convictions. However, the convictions are not disaggregated by sex of the survivor or type of GBV case to conduct analysis on the types of cases proceeding forward.

Expanding knowledge of rights. There is anecdotal evidence among legal respondents that they observe increased knowledge of women during divorce hearings. For example, one respondent observed that women are now very knowledgeable about their rights to property and other assets, more so than just a few years ago when “tradition would discourage them from going for property.” Even if women do not contribute financially to the property, the law in Zambia recognizes that women contribute to households non-financially and must be provided their “fair share” in the event of a divorce. However, there are currently no quantitative data or qualitative evidence from the GBV survivors or community members who participated in FGDs during the evaluation that there has been an increase in knowledge regarding rights that may be directly attributed to WLSA from 2013 to present.

Challenges

Key challenges in demanding and supplying access to justice services to GBV survivors include stigmatization and economic vulnerability of survivors; lack of survivor documentation; weak witness support; lack of logistics and supply for evidence collection; weak legal system for implementing laws; corruption and mishandling of cases by police; and inadequate OSC staff support to survivors.

Ongoing stigmatization, varying levels of awareness, and economic vulnerability delays or prevents reporting: GBV survivors are reluctant to take cases to court, primarily due to fear of losing their source of income if the perpetrator (often the primary breadwinner) is jailed. Others would prefer that perpetrators pay them something, rather than taking them to court where the survivor’s family would have no material gain. Survivors are often compelled either by relatives or community members to withdraw the GBV cases.

“If the husband is prosecuted, who is going to put food on the table? The kids will suffer. For a woman it usually takes more than one incident to go and report when she decides, ‘enough is enough.’ You find many of the times, in fact, that in GBV cases, the victim—the woman—will go to court and ask to withdraw the case against her husband. [Some courts] will be generous enough to note the personal nature of the case; sometimes they will give a second chance so it allows them to settle it out of court.” (National IDI interviewee)

Further, there are varying levels of awareness regarding the importance of coming to an OSC as soon as possible for the purpose of evidence collection. When there is a lack of evidence, particularly for SGBV cases, it is challenging for prosecutors and magistrates to adjudicate cases in the favor of survivors.

Missing survivor documentation: In some cases families are missing key documents, such as a birth certificate, used in proving age in a defilement case, leading to some cases being withdrawn (WLSA 2014 Annual Report). As discussed in further detail in the GBVSS component (Section 5.1), there are also reports of delays in filling the ZP 32 form (medical form), or incorrect charging for the completion of the form. This is a problem especially in rural areas where clinics may not house a doctor. (WLSA Annual Report 2014).

“It is very important that the medical reports are processed in the quickest possible time or it will impact on their cases. Even if the report is written after the attack, it must also have a doctor signature soon after. Otherwise, it might not be seen as legitimate.” (National IDI interviewee)

Weak witness support: Magistrates in several sites noted that a key challenge in prosecuting cases was the delay or withdrawal of cases due to non-appearance of witnesses, often medical doctors, or poor preparation of witnesses for trial (Mazabuka, Lusaka, Kafue). Since only medical doctors can perform medical examinations on GBV survivors, fill out the medical form, and serve as a witness, this presents particular problems in rural areas where no clinical doctors are available, and during prosecution when doctors may be unavailable to serve as witnesses. Further, there is no systematic

support provided to prepare and counsel witness for testimony across sites. Court dates are often delayed or moved to accommodate the witnesses from both the defense and prosecution team.

“Sometimes the [medical] witness doesn’t say something which they should have said because they don’t know that their requirements as medical personnel to this to make the case strong. Sometimes we end up acquitting people who should have actually been convicted, but there is nothing we can do. We can actually see that if the witness knew that they should have said this, this person would have been rightly convicted.” (Interviewed subordinate court magistrate)

Challenges in logistics and supply for evidence collection: Four national-level government partners cited the challenges of lack of transportation (for reporting cases, following up with cases, and appearing in court) and lack of key supplies to collect evidence such as DNA machines (Mazabuka, Choma).

“So in the sense that, these One Stop Centers, especially, we don’t have transport to make follow-ups with cases which were there.” (National government stakeholder interviewee)

“We need DNA machines. Suspects even know that this child will mention [the suspect], but [the suspect will ask], ‘Where is the collaboration?’ No [evidence will be there] and he will be acquitted. Those are the first questions that [suspects] ask the children when they come, ‘Okay, the medical report says you were defiled. Did the doctor write that it was me?’ So you can hear from those questions that the [suspects] know what they are doing.” (Interviewee from Choma)

Weak legal structure to implement laws: This includes weak laws to apprehend and indict GBV offenders. The law also needs to be strengthened in order to cover other types of GBV such as emotional, economic and psychological abuse as well as SGBV that is not penetrative in nature (WLSA 2014 Annual Report). Laws also need to be reviewed to ensure inhibiting factors do not prevent cases from moving forward unreasonably, such as rules regarding child witnesses, or requiring a medical doctor to provide testimony or evidence.

“GBV laws are implemented very, very poorly in practice. There has been a conflict between the GBV Act and the codified penal code in Zambia. In the GBV Act there is a lot more emphasis on counseling and the primary idea is not to punish—it is not punitive; however, with the penal code, there is no room for counseling. When a husband is legally married to a wife, and in she is not feeling well, so she cannot benefit from sex and does not give consent, the penal code does not say that this can be charged against the husband. [However] the GBV Act clearly states that this is unlawful. “There is very selective implementation of the laws. There must be some harmony.” (National-level legal key informant)

Corruption and mishandling of legal cases, particularly by police: Across all sites anecdotal reports of police, VSU, and/or court corruption were reported in FGDs and some IDIs (Lusaka, Choma, Mazabuka, Kafue, Katete, Mumbwa). Forms of corruption described by community members include officers accepting bribes from perpetrators’ (generally male and generally in a better economic position than the survivor) families to “drop” cases or release perpetrators, mistreatment of both survivors and perpetrators.

Across all sites community members, GBV survivors and male change agents noted in FGDs that cases are sometimes “lost” with VSU or police before reaching court. In Mazabuka, community members reported specific prices, where some families are reportedly paid off (K10,000–15,000, and sometimes higher, depending on the perpetrator’s wealth) by the perpetrator for defilement cases, and police receive a kick-back for “resolving cases” out of court.

Lastly, police capacity and knowledge regarding evidence collection, investigation and procedures is reportedly limited in many instances, which may result in poor evidence collection and thus weakened cases, delays in cases, or inability to apprehend perpetrators. However, in some sites key informants

reported that they felt police had adequate training and knowledge, but the main challenge was in ongoing corruption (Mazabuka, Lusaka, Choma).

Abuse was noted in one reported instance in an FGD with male community members in Katete, where one participant relayed a story that a wife was brought to the OSC, and then the husband was “beaten up at the hospital police post, causing him to end the marriage in order to ‘protect his life.’”

Inconsistent paralegal support to survivors: Although anecdotal evidence in some sites supports high-quality support by paralegals and OSC staff, in some sites there are reported cases of lack of follow-through by paralegals and inconsistent levels of legal support that range from helpful to not helpful (Kafue, Mazabuka). One male GBV survivor in Kafue complained of lack of follow-up after bringing his case to the OSC. He reported that, “They just recently gave me receipt that I should go and check [case status] at the court.” Another male GBV survivor in Kafue also mentioned he had to pay to get a police report after the OSC staff told him to go to the police and get the report on his own, and to bring it back to them once he collected it.

WLSA has noted that paralegal staff salaries are not consistent with the market, which may result in lower staff retention and raises questions around sustainability, performance incentives, and the value of investing in capacity-building of paralegals who are expected to leave after a relatively short time. Ultimately, the lack of strong legal support to survivors will hinder access to justice.

All of these challenges combined may play a role in survivors choosing to withdraw cases after experiencing significant delays. Often traditional courts may provide more expedient and desired results for survivors than via the formal judicial system. In some OSC sites, no cases moved forward in court of law.

“The OSC seems to have misinformation on the legal aspect which is not working well. People at the OSC don’t seem to be aware of services like the stop orders. The paralegal needs to be made aware of all these services the court provides. Any public person they can be given this information which will be of real help to the victims.” (Key informant, Katete)

Costs

The total approved budget for this component is US\$ 4.5 million, out which \$865,000³⁸ is reported as expended by May 31 2015, a cumulative spending of 19.2 percent of the contract value (budget), or 53 percent of obligated funds (\$1.6 million). This translates to a burn rate of \$33,282 per month over the 26-month period. This implies that at the current cumulative average monthly burn rate, it will take close to nine years to spend the remaining budget of US\$3.6 million. Alternatively, close to 40 percent (\$1.8 million) of the budget may remain unspent at the end of the project unless the burn rate is increased. In its first semiannual narrative report, WLSA attributed the low expenditure to delayed start of activity implementation, alluding to the fact that implementation would start in the first quarter of 2014. However, in subsequent narrative reports, there are no sections on financial performance. Overall, WLSA trained 419 people at a cost of ZMW 442,364 (US\$ 73,727).

G. PREVENTION AND ADVOCACY

The purpose of the Prevention and Advocacy component is “to increase the prevention of and response to GBV in Zambia.” ZCCP began implementing this component in 24 districts in eight provinces,

³⁸ This includes previously reported expenditure revalued at the May 2015 rate of ZMW7.30/US\$1. However, previously reported expenditure is being revalued at current reporting period exchange rates. For the period April 2013 to May 2015, expenditure of US\$0.303 million has been under-reported due to revaluation of FY 2013 and FY 2014. The rate used to convert the additional budget of US\$1.8 million granted in May 2015 was also used to revalue the original budget of US\$3.298 million, which was originally converted at ZMW5.35.

including the 16 sites where WVZ is operating an OSC, in addition to Kabwe, Kitwe, Mazabuka, Ndola, Chipata, Sinda, Chinsali and Monze. This section provides a brief overview of activities completed from inception (April 2013) to the time of the evaluation (June 2015), results of key performance indicators, and analysis of key successes and challenges.

Activities Completed

ZCCP carried out activities to achieve its objectives to decrease societal acceptance of GBV and child marriages in Zambia, enhance protective factors for GBV and improve the enabling environment to prevent and respond to GBV and child marriages.

Table 9 below highlights the activities completed to date, by objective, as indicated in ZCCP's three annual reports, reporting targets and results where data were made available.³⁹ Activities are denoted by Y1 (April 2013–September 2013), Y2 (October 2013–September 2014), and Y3 (October 2014–March 2015, semiannual).

Table 9. ZCCP Activities Completed from April 2013 to June 2015

Objective	Activities Completed
Objective 1: Decrease societal acceptance of GBV and child marriages in Zambia	<ul style="list-style-type: none"> • Activity: 21 community theaters were performed out of 50 that were targeted (LoP). Y2-3 • Activity: 15 mobile video shows were conducted. Y3 • Activity: 43,418 individuals participated in community dialogues on GBV out of the annual target of 66,000. Y3 • Activity: 1,758 individuals participated in 713 men's networks ('Insaka') through peer-to-peer engagements against 2,100 men targeted in the reporting period. Y3 • Activity: 16 community radio station staff were oriented from six stations, and draft contracts were shared. Y3 • Activity: Conducted FGDs with 458 traditional leaders, exceeding the target of 120. Y3 • Activity: 32,181 individuals participated in dialogues on child marriages against LoP target of 167,227. Y2-Y3 (semiannual) • Activity: Production of PSAs were targeted for completion for 1,000,000 listeners targeted, but there have been delays in PSA production. Y3
Objective 2: Enhance protective factors for GBV	<ul style="list-style-type: none"> • Activity: 31 traditional marriage counselors were trained out of a targeted 300 (LoP target). Y3 • Activity: 350 VSL members were trained in financial literacy, GBV, and CM, out of targeted 350. Y3 • Activity: 9,613 individuals counselled on gender and HIV/AIDS-related issues through Lifeline⁴⁰ (18 percent of LOP target of 53,642). Y2-Y3 • Activity: 950 survivors participated in therapy meetings, out of 800 that were targeted. Y3

³⁹ Table describes completed activities according to documentation provided by ZCCP, including: *Stamping Out and Preventing Gender-Based Violence (STOP-GBV) Prevention and Advocacy Project. Annual Work plan October 1, 2014 to September 30, 2015; Zambia Center for Communications Program Stamping Out and Preventing Gender-Based Violence (STOP-GBV) Prevention and Advocacy Project. Annual Program Report October 1st 2013 to September 30th 2014; Zambia Center for Communications Program Stamping Out and Preventing Gender-Based Violence; (STOP-GBV) Prevention and Advocacy Project. Semi Annual Report October 1st 2014 to March 31st, 2015, ZCCP Semi-Annual Progress Report (SAPR) 2015.*

⁴⁰ This result is for the period 2014 to March 2015. It does not include the results for April to June 2015 and hence is smaller than what may have been reported by Lifeline.

Objective	Activities Completed
	<ul style="list-style-type: none"> • Activity: 1,729 ‘When Men and Women Run Together’ information, education and communication (IEC) materials were distributed to the community, against the target of 25,184 IEC (reporting period target) promotional materials (comic books, brochures, booklets). Y2-Y3 • Activity: Lifeline distributed 220 IEC materials to advertise the toll-free telecommunication services available. Y3
<p>Objective 3: Improve the enabling environment to prevent and respond to GBV and child marriages</p>	<ul style="list-style-type: none"> • Activity: Three out of the five targeted traditional leaders were engaged as active “change agents” in their communities. Y3 • Activity: ZCCP participated in 10 DDCC, out of 12 targeted meetings. Y3 • Activity: Facilitated one quarterly GBV Forum against planned activity to host meetings coordinated through MGCD where stakeholders will share best practices, joint planning and minimize conflict or duplication of efforts during implementation. Y3 • Activity: ZCCP participated in 11 coordination meetings (eight monthly and three quarterly) against a targeted 24 coordination meetings with District Commissioners in all 24 districts. Y2&Y3

PMP Indicator Performance

Table 10 below provides a snapshot of the Prevention and Advocacy PMP indicators currently tracked with data reported by ZCCP to date. Indicators measure training and knowledge/awareness provision inputs and outputs, although it also includes outcome-level indicators related to knowledge, attitudes and practices. The indicators allow for measurement of the process and performance of ZCCP in expanding GBV prevention and advocacy efforts. Although there are also important outcome-level indicators tracked, such as number of convictions, there are also opportunities to modify or add to indicators to collect more meaningful outcome-level data.

Trainings have largely been conducted as targeted. ZCCP has great numbers of community members to reach via various planned outreach campaigns in order to reach its LOP targets, although given the short amount of time that has elapsed since ZCCP has begun implementation, it is likely to make great gains in reaching those targets by program end. Ongoing M&E will be important to assess the quality and outcomes of the awareness and training conducted.

Table 10. ZCCP Indicators and Progress⁴¹

Key ZCCP Indicators				
Key Indicator	Life-of-Project (LOP) Target	Total cumulative number of LOP target reached	Percent of LOP target reached	Sex disaggregation (LOP) reached
Number of individuals who participated in community conversations and were sensitized on gender norms within the context of HIV/AIDS	33,760	10,695	32%	Male 10,130 Female 23,630
Number of individuals reached via community dialogues conducted on gender and HIV/AIDS under small-group and community-level interventions	375,495	98,629	26%	Male 167,996 Female 207,499
Number of men who participated in men's network meetings and were reached through peer-to-peer intervention	7,200	4,970	69%	Male 4,970 Female 0
Number of community volunteers trained to conduct dialogues and awareness in gender and CM in their communities	288	288	100%	Male 141 Female 147
Number of GBV mentorship clubs in schools formed	36	11	31%	Not applicable
Number of active VSL members trained in financial literacy	960	350	36%	Male 0 Female 360
Number of chiefs oriented as change agents against GBV	18	3	17%	18 Male 0 Female
Number of individuals who participated in FGD and community dialogues on child marriages	167,227	48,376	21%	Male 76,696 Female 90,531
Number of individuals counselled through telecommunications on CM, GBV and HIV/AIDS related issues through LifeLine/Childline Zambia on toll-free hotlines.	53,642	15,055	21%	

ZCCP does have numerous outcome-level indicators that it seeks to measure (knowledge, attitudes, practices), while the baseline assessment (March 2015) offers many outcome-level indicators to measure at endline, as well. However, there are some data that could be of use to bolster analysis and drive improved programming.

Successes

Key successes in GBV prevention and advocacy include active and passionate community volunteers; traditional leaders fulfilling roles as change agents; increased community awareness of GBV; increased demand for OSC services; and increased ownership of community in GBV prevention and advocacy.

Active and passionate community volunteers: As targeted, 288 community volunteers or male change agents (12 per site) have been trained. Most of the male change agents who participated in FGDs during the evaluation reported receiving training a minimum of two times, since they have been serving as volunteers for a period of between three months and two years, although some reported only receiving orientation to date (Lusaka, Kafue, Katete, Mumbwa, Choma, Mazabuka).

⁴¹ As reported by ZCCP in Zambia Center for Communication Programmes *Stamping Out and Preventing Gender-Based Violence (STOP-GBV) Prevention and Advocacy Project Semi-Annual Report, October 1 2014 to March, 2015* and M&E spreadsheets provided by ZCCP upon request of evaluation team with numbers reported as of June 2015, and updated figures provided by ZCCP based on SAPR to include results from April-June 2015.

Male change agents generally report that their main role is to educate the community about GBV and resources for help (e.g., OSC, where they can receive counseling, medical and legal assistance). Male change agents who participated in FGDs across all sites during the evaluation report feeling empowered, uplifted and motivated by a seeming sense of purpose or importance to “do good.” (Lusaka, Katete, Mumbwa, Choma, Mazabuka, Kafue). In Katete, the VSU officer and a religious leader worked together to form an active men’s network (male change agents) that continues to grow in membership.

Male change agents in Choma have community referral books kept by the chairperson. The book, assessed by ZCCP regularly, is used to record every case referred to ZCCP or the OSC in order to follow up with cases that require attention, including access to justice.

Traditional leaders fulfilling role as change agents: There is anecdotal evidence that headmen and chiefs are actively demonstrating commitment to change. During the baseline assessment (March 2015) it was found that reporting perpetrators to the headman can “backfire for women, with a women ending up being beaten or divorced.” Although this was also reported in some FGDs during the midterm (Mazabuka), there was generally more positive indication of how headmen handle GBV cases. ZCCP has thus far trained and enlisted three chiefs as change agents. Since project inception, in Eastern province and Chipata District, His Royal Highness Chief Madzimawe helped to withdraw 10 girls from marriages and enroll them in school.

In many of the sites visited, community members and stakeholders interviewed reported positive influences and messages against GBV by their community leaders (Kafue, Mumbwa, Mazabuka). A national government interviewee noted, “Chiefs are now embracing our crying call to end gender-based violence.”

Decreased community acceptance of GBV: Nearly half (47 percent) of women and 32 percent of men agreed in the ZDHS 2013 survey that a husband is justified in beating his wife for at least one specified reason (2013), a significant decrease from 62 percent of women and 49 percent of men who agreed in 2007. Although this is not attributed to the STOP GBV program or ZCCP, it is likely that the predecessor, ASAZA, and other national and donor efforts to raise awareness about GBV contributed to this change.

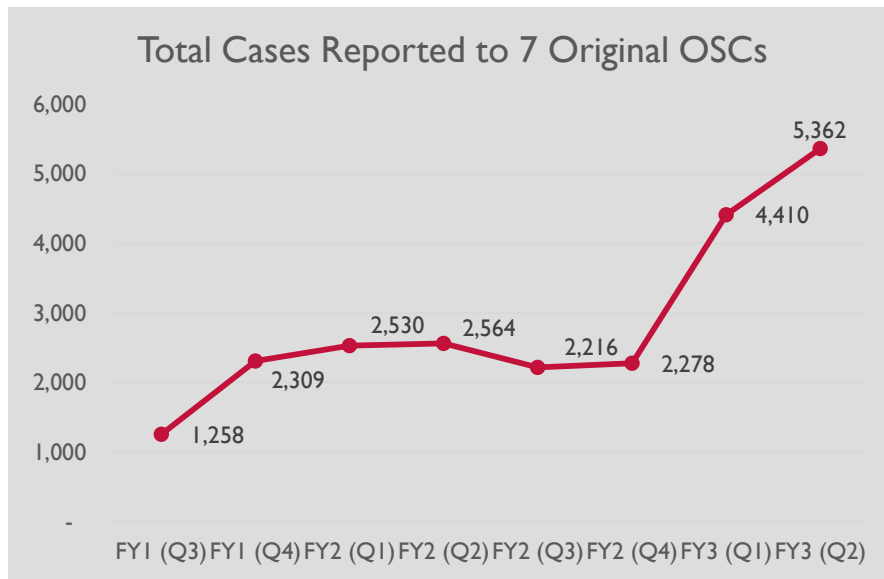
Across all 18 FGDs with community members, GBV survivors, and male change agents in the six sites where the evaluation took place, community members referenced traditional ceremonies as major contributors to GBV (Lusaka, Mumbwa, Mazabuka, Kafue, Katete, Choma). In the Nkolola/Chimoye tradition, a girl that has reached puberty is taken into seclusion and taught how to take care of a home and take care of her husband sexually. When the girl leaves the seclusion period, participants reported that she is “readied” for early marriage and bearing children. Adolescent males pass through initiation where they reportedly receive herbs that “make them sexually aggressive,” and they are expected to “practice” their sexual aggression with young girls following the ceremony. Although these traditions are reportedly still widely practiced, there appears to be recognition among male and female FGD participants of the longer-term consequences this has on gender inequality and perpetuating GBV.

Increased political awareness and uptake of GBV as a policy issue: There is anecdotal evidence that STOP GBV has continued forward momentum from ASAZA and other efforts to ensure GBV remains on the political agenda. National work of various government ministries (Ministry of Chiefs, Ministry of Gender, MCD/MCH, Ministry of Justice, etc.) demonstrate levels of political commitment to preventing and responding to GBV with past and ongoing efforts to strengthen laws and policies related to GBV, from engagement of traditional leaders and ECM, to strengthening the Anti-GBV Act and penal code.

“GBV has become part of the political agenda. The issues of gender was like an abstract, we didn’t even have a framework in which to discuss issues of gender-based violence, especially in the health sector. So I think that’s one success story that this project has helped to facilitate bringing gender-based violence issues to the top of their agenda. This project has been a pioneer in issues of heightening gender-based violence activities and services in the country.” (National-level interviewee)

Increased demand for OSC services: Four national government interviewees noted that there is growing evidence of community demand for OSCs and STOP GBV, citing increased reporting of GBV incidents. This is observed in increased cases of violence reported at OSCs according to GBVSS annual reports.

Figure 6. Total Cases to 7 Original OSCs from FY1 (Q3) to FY3 (Q2)



Further, three national government interviewees report that they observe greater community awareness, which reflects the ZDHS 2013/14 figures of decreased acceptance of wife beating by both women and men, indicated above.

In the baseline assessment (March 2015) one key finding was that in all districts visited there was “generally lack of or limited information on GBV and related support services including the STOP GBV Program.” However, during the midterm evaluation, most FGDs consisting of randomly sampled community members had some level of awareness of the STOP GBV program and/or OSC.

There is also anecdotal evidence of improved perceptions from community members viewing OSCs as something that helps builds up families rather than “destroys” them, as some people previously perceived (Mazabuka, Choma). Although some of these negative perceptions were still expressed, mostly by male community members across evaluation sites, there seemed to also be more positive expressions among both male and females regarding assistance offered to couples than were reported during the baseline assessment.

Increased community involvement and ownership of GBV prevention and response: Eleven District Gender Committees were reactivated out of the 24 districts where ZCCP is currently operating. In the sites visited, very active committees were noted in Kafue and Katete, with observed high and active participation of various government and civil society stakeholders. In Mazabuka and

Lusaka there was not an active committee to meet with, and in Mumbwa and Choma there were limited committee members available to meet with the evaluation team, indicating that there were not high levels of engagement or participation among committee members.

In some sites, religious leaders have been becoming more active, utilizing their platforms to raise awareness about GBV, ECM and spousal battery in particular (Katete and Mazabuka). Across all sites, community members in FGDs noted that an informal “neighborhood watch” has been created in their areas to be on alert for and assist with GBV incidents (Lusaka, Choma, Mazabuka, Katete, Kafue, Mumbwa).

Across several sites, female GBV survivors have become informally active within their communities, raising awareness and conducting outreach on behalf of the OSC (Katete, Mazabuka and Choma).

Challenges

Key challenges in demanding and supplying GBV prevention and awareness include ongoing accepting attitudes regarding GBV; lack of knowledge regarding some GBV issues; distance to harder-to-reach rural communities; logistical constraints for community volunteers; fear-based awareness raising; limited reach in the current absence of mass media use; incorrect use of GBV definition that may reinforce gender inequality; limited support for GBV survivors informally conducting outreach; and increasing demand for Lifeline without adequate manpower and capacity to handle current demand.

Ongoing accepting attitudes regarding GBV among community members: As noted as a success in the previous section, there are indications of positive progress made in improving “correct” attitudes regarding GBV nationally; agreement with the statement that a husband is justified in beating his wife decreased from 62 to 47 percent of women and 49 to 32 of men percent from 2007 to 2013 (ZDHS 2013). However, recognizing that attitude change takes time and requires ongoing effort, there still is much work to be done. Male and female community groups and female survivor FGDs conducted in all sites (Lusaka, Mumbwa, Choma, Kafue, Mazabuka, Katete) demonstrate varying levels of ongoing acceptance of violence against women (e.g., beating, slapping to correct behavior, forcing wife to have sex as it is her duty, property grabbing is husband’s family’s right).

In Katete, for example, two male community members said that wife beating is acceptable, while one male participant said it is not. A male community member in Mazabuka said, “Slapping a bit so that she can know that you are a man is okay, but beating your wife is illegal and isn’t taught in Christianity.”

Even among female GBV survivors, accepting attitudes toward GBV were expressed in some FGDs, also indicating ongoing need for strengthened psychosocial support. For example, the majority of the GBV survivors in Mumbwa believe that a lack of marital obedience (subservience in women) and dressing provocatively are the primary justified causes of GBV (Mumbwa). Female GBV survivors in Mazabuka expressed that their husbands have the right to beat them up if they “do something wrong or make a mistake.”

Knowledge and attitudes regarding marital rape continue to be challenging. Less than half (45 percent) of women in Zambia age 15-49, and 57 percent of men, believe that a wife is justified in refusing sexual intercourse with her husband (ZDHS 2013/14). ZDHS 2013/14 also reports that 17 percent of all women in Zambia report having experienced sexual violence by age 15, out of which 91.2 percent reported that the perpetrator was a current or former husband, partner, or boyfriend. Attitudes include the idea that sexual abuse between a husband and wife cannot be called rape; ‘rape’ is abuse outside of the institution of marriage. In all six sites, FGDs with female GBV survivors, many of whom reported experiencing sexual violence by their partner, indicated the attitude that women only have the right to refuse sex if they have a “legitimate” physical reason or excuse (e.g., they have just given birth or have their period).

“The case that is never reported is that of marital rape. We know it’s happening in these homes but no one has ever come forward to report a case, not even to the headmen.” (Community leader, Katete)

Varying levels of knowledge regarding some GBV issues: Despite increased knowledge about GBV, there are specific areas where people still have low knowledge. For example, there is anecdotal evidence that people largely lack knowledge about the importance of visiting a health facility or OSC within 72 hours of an SGBV incident. Community members, some male change agents, and GBV survivors participating in FGD discussions demonstrated little knowledge regarding PEP and the critical 72-hour timeline, while OSC staff and other informants at all sites noted the need for more awareness within communities due to observed late reporting of SGBV incidents (Lusaka, Mumbwa, Mazabuka, Katete, Choma, Kafue). Some FGD participants also reported recent cases of defilement due to ongoing beliefs that having sex with a child will cure HIV or increase wealth of the individual (Choma, Katete, Mazabuka, Mumbwa).

Logistical constraints for male change agents: Community volunteers, and male change agents drawn from traditional and community leadership, who participated in FGDs in the six sampled sites noted challenges they have due to lack of transport, rain boots, identification and allowances (Lusaka, Choma, Kafue, Mazabuka, Mumbwa, Katete). There are expectations of some sort of compensation for their time and work, which raises concerns regarding the sustainability or expectation that community volunteers will continue working without economic incentives beyond the project end.

This may be observed in Mazabuka, where community volunteers were trained during ASAZA. Although there is one incredibly committed and passionate ASAZA-trained male change agent who has been active for over eight years who met with the evaluation team and demonstrated great knowledge and commitment, many trained volunteers from ASAZA are no longer active. The community chairman noted that engaging younger men in their 20s to join male networks in Mazabuka is also a sustainability challenge they face, citing the need for the younger generation to “take up the torch.”

“The transition of the OSC to government-run left the OSC with limited to zero funding for outreach into rural communities in Mazabuka. When it was being funded fully it was really working and people really appreciated because whenever they see a vehicle ASAZA has come in the village they know that they have come to pick or to have some sensitization. Without sponsorship and activity now there is a spike in GBV. It is as if we have the fire again that we were trying to put off. There is no one to put off the fire again.” (Community leader, Mazabuka)

Fear-based awareness raising may not drive longer-term change in behavior: In some areas people note that the awareness they receive have made people more aware of the consequences of GBV, and they are afraid to commit GBV. While the result of this seems anecdotally positive (e.g., people are too afraid of consequences to commit GBV), it is important to consider whether this short-term change in behavior will be a sustained change over the long term if actual beliefs that GBV is wrong are not fundamentally changed. Most prominent in Mumbwa and Katete, female survivors shared during FGDs that they are seeing a change in their husbands’ behavior because the men are aware of the OSC and understand the legal consequences and know that women now have an avenue to report abuse.

“There is a change in the people’s lives. People are now afraid to commit GBV crimes.” (Male community member, Mazabuka)

“Our husbands will be afraid to beat us when we make a mistake because they know if we go back to One Stop Center, they will be arrested. My husband at this time is saying that he will never do the things that he was doing that time.” (Female GBV survivor, Mumbwa)

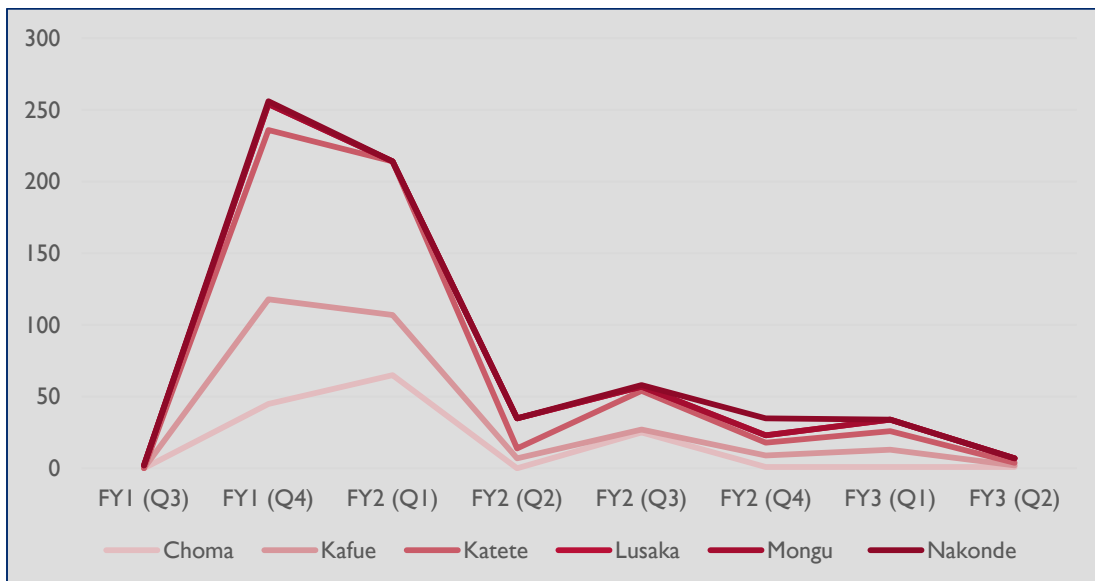
“My husband is not angry that I took him to Anti-GBV. My husband is scared to misbehave because he doesn’t want to be taken to GBV.” (Female GBV survivor, Mumbwa)

“Nowadays people know that if they do something wrong they will be taken to the OSC so at least they would rather talk than act.” (Female GBV survivor, Katete)

This was observed in Mazabuka, for example, which was a former ASAZA site. Before transition to government takeover when there was active international NGO presence, OSC staff and community members report that people were more fearful of committing a GBV crime, but when the NGO left, OSC staff and community members report that there was an observed decrease in this fear of penalty and described perpetrators becoming more brazen in their actions.

In addition, male change agents reported in Mazabuka that they believe there is increased awareness of ECM and consequences, resulting in pushing ECM “underground.” Although there is not a clear connection between increased ECM awareness and decreased reporting, there was a sudden spiked drop in ECM reports to OSCs in 2014 at the time of national ECM awareness campaign roll-out (Figure 7). However, there are not adequate data to support this finding; rather, there is an interesting trend in the data that may be observed below, with decreased reports of ECM, that warrants further qualitative and quantitative analysis to identify the cause.

Figure 7. Reports of ECM and Forced Marriage Cases at Six Original OSC Sites (FYI Q3–FY3 Q2)



Limited reach of awareness materials due to current lack of mass media use: Community members currently report lack of information sharing and awareness raising via radio and point to this as a major weakness in outreach (Kafue, Mumbwa, Mazabuka, Choma, Katete). In Zambia, radio is the most commonly accessed form of mass media among both women (51 percent) and men (67 percent), followed by television (40 percent and 46 percent, respectively), according to the ZDHS 2013/14. During the baseline assessment, 63 percent of respondents reported that they primarily receive information through TV, and 48 percent through radio. Although ZCCP has plans to utilize radio, there has been delayed production of mass media materials as a result of USAID requesting a delay in production until appropriate technical assistance can be identified to support the process. A consultant has been engaged to assist ZCCP in this activity. Community leaders in some sites also noted the importance of utilizing mass media to raise awareness beyond what workshops may be able to accomplish, particularly if refreshments, allowances, and other incentives are not provided for workshop attendance (Mazabuka, Katete).

Program and OSC staff, in addition to community members, note the ongoing difficulties of reaching community members in rural areas, who may be most in need of information (Mumbwa, Katete, Mazabuka, Choma, Kafue). Many cited transportation challenges to reach people in more remote areas, and in one place (Katete) cited radio as a more effective form of communication to reach people.

Incorrect use of GBV definition may reinforce existing inequalities or cloud stigmatized

GBV issues: ZCCP, with good reason given their male and female audience, purposefully avoids standard definitions of GBV, instead defining it as a “violation of rights” of anyone, or “person-to-person abuse.” They intentionally do this to avoid labeling GBV as a woman’s interest and to drive more male interest in the issue.

“The moment we talk about ‘gender’ in the community they think these are ‘women’s issues.’ So, to avoid perception that ZCCP is working on GBV only working on women’s issues we define it as person-person abuse.” (ZCCP interviewee)

Although the intent of hiding the definition is noble, this becomes problematic, as explained in Section 4. It may drive increased reports of “GBV” that are not actually GBV, but are cases of assault, for example. This may skew statistics and drive attention away from more stigmatized cases, such as marital rape, which remains a taboo form of GBV. Further, ZCCP labels GBV as any violence perpetrated by the opposite sex, which is also illustrated in a new indicator for raising awareness about GBV to this effect. However, GBV may be committed by someone of the same sex, and conversely, non-GBV acts of violence may be perpetrated by members of the opposite sex.

Limited support for GBV survivors conducting informal outreach and support: Although it is a very positive unintended consequence that GBV survivors in several sites are becoming active in preventing and responding to GBV in their communities, they also lack formal support and channels to assist them in this endeavor. Female survivors are interested in working formally with OSCs to conduct outreach. Survivors feel that provision of materials would be helpful, such as refreshments to host meetings in their communities or bicycles to assist with transport (Katete); uniforms or shirts to formalize their role in the community (Mazabuka); and OSC identification cards to safely intervene and provide counseling (Choma).

“When we are going to separate people from fighting, those people may not know who we are, hence we are asking to be provided with identity cards to show who we are. When we get there, before counseling them, we could show them the ID and then start counseling them. Otherwise we might also be beaten.” (GBV survivor, Choma)

Driving increased demand for Lifeline hotline services without capacity to meet existing demand: ZCCP provide a sub-grant to Lifeline and Childline, which are toll free numbers (966 and 116 respectively) aimed at providing psychosocial counselling and referral services to survivors and potential survivors of GBV and child marriage. This is a critical service, but there are significant gaps in adequate numbers of trained counselors to field the current demand for the service. Across all sites, there was little to no awareness among community members participating in FGDs of the existence of any telephone hotline to assist survivors (Lusaka, Katete, Mazabuka, Mumbwa, Choma, Kafue). Therefore, this evaluation is unable to draw conclusions regarding perceptions of utility or outcomes of the hotline, and is only able to report on Lifeline and implementing partner statements regarding the service. For example, VSU officers in Katete cited the line as “not very effective since the people who answer are in Lusaka,” and said that they “received no referrals from the helpline so far,” while other IDI informants reported, “I have never heard of anyone being referred from the helpline, maybe because this is a rural area district?”

Not all OSC staff reported awareness of a helpline that may be called, even with visibly displayed Lifeline/Childline posters in the OSC counseling room, such as the case in Mazabuka. Regardless,

generating increased demand without adequate staffing may have an adverse impact, resulting in low confidence or negative reputation within communities when callers are not able to get through or receive services they require.

Costs

The total approved budget for this component is \$8.7 million,⁴² out which \$2.03⁴³ million is reported as expended as of March 31, 2015. This represents a cumulative spending of 23 percent of the contract amount (budget), or 72 percent of obligated funds to date (\$2.8 million).⁴⁴ The calculated burn rate is \$84,628 per month over a 24-month period. At this average monthly burn rate, it will take over six years to spend the remaining budget of \$6.7 million, leaving 41 percent of the budget unspent unless the burn rate is increased. ZCCP attributes the low expenditure to delayed funding during the first part of the year ending September 30, 2014, which subsequently delayed implementation of activities for that year (Annual Report 2014). This challenge is reported to be resolved by changing funding from monthly to quarterly.

ZCCP trained a total of 288 community volunteers at a cost of \$44,069⁴⁵ over two days, or an average unit cost per volunteer trained of \$153 (ranging from \$52 in Mumbwa to \$255 in Lusaka). ZCCP reached a total of 8,020 community members through community conversations at a total cost of \$54,096, total or \$7 for each person reached in the six sites sampled for this evaluation. ZCCP conducted a total of 107,543 dialogues (75,362 GBV dialogues and 32,181 ECM dialogues) at cost of \$56,878, at an average cost of \$0.53 per dialogue.

Chongwe and Nakonde district administrations have provided free office space to ZCCP to effectively engage other district partners around issues of GBV and ECM. In Chongwe all office-related costs, including internet, are covered by the district administration, thereby reducing operational costs and increasing coordination and communication.

⁴² Values reported in this section are U.S. dollars.

⁴³ This expenditure includes FY 2013 and FY2014 expenditure at revalued amount

⁴⁴ However, a review of the reported expenditure shows that previously reported expenditure is being re-valued at current reporting period exchange rates. For the period of April 2013 to March 2015, a total expenditure of US\$243,418 is under-reported due to revaluation of FY2013 and FY2014 expenditure.

⁴⁵ These costs do not include stationery, which is centrally procured and drawn for trainings; currently there is no tracking for such costs by district as they are lumped in program supplies.

V. CONCLUSIONS AND RECOMMENDATIONS

STOP GBV is providing urgently needed critical services to a broad range of survivors of violence, including widespread non-GBV cases such as child abuse and neglect. It is also showing preliminary anecdotal evidence of influencing knowledge, attitudes and practices about violence in communities where it operates. There is evidence of determination and group work with both governmental and non-governmental stakeholders coming together to implement GBV services and improve response and coordination capacity. The engagement of men and boys via SIA is underway to various extents across six scale-up sites, with the preliminary indication that it is enhancing prevention and advocacy.

At the same time, there are ongoing challenges in this multi-faceted problem. It is recognized that GBV is rooted fundamentally in entrenched gender inequality, poverty and other drivers, and as a result is a problem that requires intensive multi-sector cooperation as patience in observing long-term change.

Programmatically, this change may be driven by STOP GBV by using a more cohesive operational definition of GBV consistently by all partners, reviewing outcome-level indicators across components, and ongoing analysis that informs decision-making. Key service provision gaps include limited transport options, lack of shelters and lack of widespread livelihood opportunities that provide income required for survivors to securely leave unsafe living arrangements.

Recommendations are presented for consideration in order to make adjustments to improve or enhance success in achieving the intended STOP GBV Program results. Recommendations are provided, alongside the analytic finding resulting in the recommendation. Recommendations are organized by component, specific to each implementing partner, although actions are noted that require USAID or DFID support or additional partner/sub-grantee action. Overarching recommendations include:

- STOP GBV Program: Ensure implementation is on the road to change as laid out in the ToC, and ensure partners are using a cohesive definition of GBV theoretically and operationally.
- GBV Survivor Support Services: Focus on service and referral quality; strengthen linkages to programs to remove constraints to services and longer-term well-being; and work with national partners to integrate performance assessment standards for OSC and staff.
- Access to Justice: Improve data collection and analysis programmatically and with national partners; continue work to provide technical support and reference guides to stakeholders (e.g., police, prosecutors) nationwide; focus on technical solutions to remove underlying barriers and root causes to accessing justice.
- Prevention and Advocacy: Continue expanding awareness efforts, with a focus on reducing stigma of SGBV and increasing reported cases; collect quantitative outcome-level change measurements in addition to the planned KAP surveys, such as effects of awareness campaigns on reported ECM cases; review definitions and operational implementation of materials by male change agents.

Table II. STOP GBV Recommendations

Actions	Supporting Findings
Program-Level Partner Coordination and Capacity Building	
Facilitate a ToC Workshop with IPs and sub-grantees, focused on constraints analysis to assess if activities and investment levels are on the roadmap to change as laid out in the ToC	Strengthening some areas and assumptions of ToC may assist in achieving results
Agree on theoretical and operational definition of GBV used consistently by all partners; consider supporting national government to adopt international GBV-IMS definitions, further breaking down in sub-categories or the Zambia context	Inconsistent operational use of GBV definitions; lack of harmony with international definitions
Review indicators to include/modify more outcome-level indicators across all components to provide meaningful data, set targets to drive quality, and disaggregate by GBV type and site	Current data are limiting in conducting analysis, especially at outcome level
Institute financial tracking and M&E systems that are consistent across all three implementing partners, ensuring that financial information is aligned with M&E data and activities so that data are streamlined and ongoing VfM calculations may be made without errors	Varied levels of quality in financial/expenditure data, reporting, analysis and alignment for VfM calculations
Improve district-level coordination across OSC staff, implementing partners and government partners by increasing monthly monitoring visits with mentorship and team-building	Ongoing lack of coordination, disjointed efforts and questionable sustainability at the district level
Improve linkages and coordination between the STOP GBV and other organizations offering economic programs at the district level (in coordination with ZCCP/CARE)	Not enough tangible livelihood opportunities to support survivors in leaving unsafe living situations
Gender-Based Violence Survivor Support Services (WVZ)	
Support the MCD/MCH/MoH to revise biannual top-down performance assessment criteria to include key performance indicators for OSCs (e.g., PEP and EC supply, percent of eligible SGBV survivors who receive PEP, average length of time between GBV reporting at OSC and issuance of medical certificate by doctor)	No incentives currently in place for DHO performance of OSCs, creating sustainability challenges
Support the MCD/MCH and MoH to task PMO with formal job duties responsible for OSC operational performance and conducting performance assessment at the district level	
Continue lobbying for greater number of shelters and safe houses across the country	Lack of shelters is a critical gap in providing protection and services
Proceed with meeting training targets for OSC staff and other targeted personnel, emphasizing survivor-centered, rights-based approach	Indication of ongoing knowledge gaps among staff
Work with national government partners to integrate specific GBV staff and management performance standards for health, social workers, etc.	Indication of varying staff performance
Proceed with client satisfaction surveys (exit interviews) with focus on quality of care, and interviews covering outcome-level indicators implemented at intervals over the longer term	Current data does not provide outcome-level information on results for survivors
Consider piloting scale-up of two sites to provide real 24-hour service with all staff onsite and transport available, and measure changes in outcomes	Current challenges reported in receiving quality service after hours

Actions	Supporting Findings
Review with national partners and experts ideal dosage to target per survivor (e.g., counseling, psychosocial support) and follow up over the longer term for quality continuum of care	Not enough evidence of survivor recovery over the long term
Facilitate exchange visits between D2G, original OSCs and former ASAZA sites to share knowledge and experience and standardize all forms and guidelines across all site types	Inconsistent availability and application of guidelines and standards, especially in former ASAZA sites
Review arrangements across sites for medical certificates to make more efficient and expeditious, and ensure fees are not being charged	Many reports of delayed (one week to one month) receipt of reports at K50
Strengthen tracking of referrals that are completed to a survivor's satisfaction and referral outcomes	Referrals made are only tracked, without reporting and analysis of referral quality or outcomes
Ensure each OSC and ASAZA site, in coordination with MCD/MCH is equipped with investigative/supportive equipment, including DNA lab tests (at least one per province)	Varying levels of appropriate investigative/supportive equipment at OSCs and former ASAZA sites
Create a service directory for all OSCs, updated on a regular basis, for use by all partners	Not all partners have up-to-date information for referrals
Access to Justice (WLSA)	
Lobby government to establish fast-track courts for GBV cases to be heard expeditiously	GBV cases take too long, resulting in high numbers of withdrawals
Support National Prosecution Authority to report nationally on GBV justice aligned with national GBV database (e.g., length of time for adjudication, percent of reported GBV cases convicted)	Lack of transparency of government-reported data on justice indicators
Continue support to government to establish a coherent national database and improve the information flow between different departments (e.g. health, police and judiciary)	Lack of coherent national database, reporting and analysis
Support national legislation to improve the penal code and harmonize it with the Anti-GBV Act (e.g., define sexual harassment, complement Anti-GBV Act, define marital rape as a crime)	Inconsistencies in application of the Anti-GBV Act and penal code
Support amendment to increase jurisdiction for local and subordinate courts to adjudicate and sentence more cases, including sexual assault, inheritance and other minor offenses	Local/subordinate courts are currently restricted in handling certain cases and conviction lengths, resulting in withdrawals and delays
Review options to ensure medical forms are completed in a timely manner and provide necessary evidence/witness	Ongoing challenges of doctors to complete medical forms in reasonable time and serve as legal witness
Expand training of police and VSU, particularly in rural areas, focused on customer service and empathy, and the ability to understand laws, collect and preserve evidence, and prosecute a GBV case	Ongoing reports of GBV cases not handled well at police or VSU, especially in rural areas
Review paralegal staff performance with clearly defined expectations for assistance and follow-up	Varying levels of paralegal staff performance
Move forward expeditiously with GBV evidence collection, prosecution, and procedure reference guidelines to distribute nationally, particularly in rural areas	Ongoing knowledge and procedural gaps in police stations, particularly in rural areas

Actions	Supporting Findings
Support VSU HQ to identify incentives and develop sustainable systems for accountability and transparency, including strengthened data tracking and transparency regarding GBV cases withdrawn and reasons for withdrawal	Ongoing complaints of police corruption and bribes resulting in withdrawal of GBV cases
Review sustainability and viability of paralegal positions, particularly after transition, looking at staff pay, training of non-legal staff to work as paralegals, etc.	Observation of paralegal turnover and expected dropout rates due to non-competitive wages
Prevention and Advocacy (ZCCP)	
Increase community sensitization on need for SGBV survivors to access OSCs within 72 hours for PEP and EC, mobile outreach services, and addressing stigmatization of SGBV generally	Indication of ongoing knowledge gaps about the need to visit OSC within 72 hours among community members and SGBV reports
Integrate GBV messaging into existing HIV communications/outreach conducted by MCD/MCH and others	Existing outreach/campaigns with funding for sustainability
Continue engaging more leaders and influential persons in the community as GBV change agents, including more religious leaders and more headsmen in rural areas	Preliminary success in traditional leaders trained and need for training more of them
Review training material for ZCCP male change agents and re-evaluate GBV definitions used to ensure it is driving desired awareness and change targeting underlying beliefs	Use of broad definition of violence may reinforce existing gender inequalities
Ensure close monitoring with quality qualitative/quantitative data and analysis of potential unintended consequences, such as forcing ECM issue “underground” in communities	Data do not currently support making clear analytic conclusions regarding awareness and impact on reporting
Coordinate closely with OSCs and ASAZA sites on weekly basis to provide feedback loops on: needs for services (from ZCCP) and service availability (e.g., PEP supplies, etc.)	Challenges, especially in former ASAZA sites, of creating demand for services that are not available
Increase awareness-raising “dose” and efforts in communities, especially with media such as radio to reach rural and other more remote areas	Indication of community demand for information via radio to overcome reach limitations
Continue providing capacity-building support to Lifeline, including improved counselor capacity, increased numbers of counselors to handle demand/call volume, referral/follow-up quality monitoring, and strengthened M&E data for outcome-level analysis	Critical service not able to meet demand or measure outcome-level impact
Target younger kids and their parents early on (as early as age 3), formally and informally, with age-appropriate behavior change and attitude messaging regarding gender equality and GBV	Ongoing attitude and knowledge challenges formed early in life

