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

December 2015

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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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<td>ASAZA</td>
<td>A Safer Zambia</td>
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<tr>
<td>C&amp;T</td>
<td>Counseling and testing</td>
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<td>CARE</td>
<td>Cooperative for Relief and Assistance Everywhere</td>
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<td>CM</td>
<td>Child marriage</td>
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<td>DFID</td>
<td>Department for International Development (UK)</td>
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<td>D2G</td>
<td>Direct to government (One Stop Center)</td>
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<td>EC</td>
<td>Emergency contraception</td>
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<td>ECM</td>
<td>Early child marriage</td>
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<td>ECR</td>
<td>Expanded Church Response</td>
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<td>FAWEZA</td>
<td>Forum for African Women Educationalists of Zambia</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GBVIMS</td>
<td>Gender-based violence information management system</td>
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<td>GBVSS</td>
<td>Gender-Based Violence Survivor Support Services</td>
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<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<td>GRZ</td>
<td>Government of the Republic of Zambia</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IDIs</td>
<td>In-depth Interviews</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>KAP</td>
<td>Knowledge, attitudes and practice</td>
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<td>KII</td>
<td>Key informant interview</td>
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<td>LoP</td>
<td>Life of project</td>
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<td>MCD/MCH</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>Outpatient department</td>
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<td>One Stop Center</td>
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<td>PEP</td>
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<td>PMP</td>
<td>Performance Monitoring Plan</td>
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<td>Sports in Action</td>
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<td>STOP-GBVAJ</td>
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<tr>
<td>ToC</td>
<td>Theory of change</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VfM</td>
<td>Value for money</td>
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<tr>
<td>VSL</td>
<td>Village Savings and Lending</td>
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<td>VSU</td>
<td>Victim Support Unit</td>
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<td>WHO</td>
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<td>WiLDAF</td>
<td>Women in Law and Development in Africa</td>
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<td>WLSA</td>
<td>Women and Law in Southern Africa Research and Educational Trust</td>
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<td>WVZ</td>
<td>World Vision Zambia</td>
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<td>YMEP</td>
<td>Young Men’s Empowerment Program</td>
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<td>ZARD</td>
<td>Zambia Association for Research and Development</td>
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<td>ZCCP</td>
<td>Zambia Centre for Communication Programmes</td>
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<tr>
<td>ZDHS</td>
<td>Zambia Demographic and Health Survey</td>
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<tr>
<td>ZMW</td>
<td>Zambian Kwacha (currency)</td>
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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. 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, ASAZA. 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 GBV 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.

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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 indices 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

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4 Further details on the indices, including variables included and calculations used, appear in the main body of the report.
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 1, 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. 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. 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.

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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. 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

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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 1 provides an overview of each component.

Table 1. STOP GBV Zambia Program Component Overview

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<th>Component</th>
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| **GBV Survivor Support Services (GBVSS)**    | • **Implementing Partner:** World Vision *(Sub-grantees: SIA, ECR, FAWEZA)*  
• **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 WVZ 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)*, MGCD*8 |
| **Access to Justice (STOP-GBVAJ)**           | • **Implementing Partner:** WLSA *(sub-grantee: WILDAF, Lifeline)*  
• **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)* |

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8 Current names of these Ministries at the time of the evaluation. Names may have been changed since publication due to realignment.
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<th>Component</th>
<th>Overview</th>
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| **Prevention and Advocacy** | - **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. |
| | - **Implementing Partner**: ZCCP (*sub-grantees*: CARE, Lifeline)  
  - **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** | - **Implementing Partner**: World Vision (*sub-grantee*: Sports in Action)  
  - **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. |

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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. 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.

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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)\textsuperscript{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

\textsuperscript{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

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

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, 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

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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 subgrantees; 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. 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.

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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 Type

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Total Number of Training days</th>
<th>Total Number Trained</th>
<th>Total Direct Training Costs</th>
<th>Average Cost per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paralegal-Lusaka</td>
<td>6</td>
<td>48</td>
<td>$29,913</td>
<td>$623</td>
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<tr>
<td>Paralegal-Out of Lusaka</td>
<td>4</td>
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<tr>
<td>Paralegal (Total)</td>
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<td>Magistrates-Out of Lusaka</td>
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<td>Magistrates (Total)</td>
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<tr>
<td>Judges</td>
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<td>Police Officers-Out of Lusaka</td>
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<td>Multi-disciplinary Case Management</td>
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<td>Forensic Evidence</td>
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</tr>
<tr>
<td>Coaches &amp; Peer Leaders</td>
<td>3</td>
<td>150</td>
<td>$12,280</td>
<td>$82</td>
</tr>
<tr>
<td>Community Volunteer</td>
<td>2</td>
<td>288</td>
<td>$44,069</td>
<td>$153</td>
</tr>
</tbody>
</table>

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 24,245\(^{17}\) 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\(^{18}\) per OSC client across all sites. This is an underestimate of costs since it only includes WVZ direct

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\(^{14}\) 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 WV 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 2015

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

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

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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 costs\(^{21}\) 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**

<table>
<thead>
<tr>
<th>Partner</th>
<th>Total Cost US$</th>
<th>Administrative Cost US$</th>
<th>Administrative Cost Percentage of Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>WVZ (to April 2015)</td>
<td>3,960,722</td>
<td>1,448,772</td>
<td>37%</td>
</tr>
<tr>
<td>WLSA (to May 2015)</td>
<td>1,168,673</td>
<td>514,355</td>
<td>44%</td>
</tr>
<tr>
<td>ZCCP (to March 2015)</td>
<td>2,274,486</td>
<td>1,023,608</td>
<td>45%</td>
</tr>
</tbody>
</table>

**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).*

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\(^{21}\) 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, MBiaka, 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

<table>
<thead>
<tr>
<th>Composite Indicator #1: Training Inputs</th>
<th>Composite Indicator #2: Outputs (Direct Results)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>1. (WVZ) Number of people receiving post-GBV care (target: site-specific meeting planned targets to date)</td>
</tr>
<tr>
<td>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)</td>
<td>2. (WVZ) Number of survivor networks established (target: site-specific; 2 per site set as ‘pass’ threshold for evaluation)</td>
</tr>
<tr>
<td>3. (WLSA) Number of OSC paralegals trained (target: 2 per site)</td>
<td>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)</td>
</tr>
<tr>
<td>4. (WLSA) Number of police officers trained (target: site-specific, 30% of LOP per site ‘pass’ threshold set for evaluation)</td>
<td>4. (WLSA) Percent of reported GBV cases prosecuted or litigated (target: 10% ‘pass’ threshold set for evaluation)</td>
</tr>
<tr>
<td>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)</td>
<td>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)</td>
</tr>
<tr>
<td>6. (ZCCP) Number of male change agents (community volunteers) trained (target: 12 per site)</td>
<td>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)</td>
</tr>
<tr>
<td>7. (ZCCP) Number of traditional leaders oriented in GBV (target: 150 LOP; 1 chief per site set as hold for evaluation)</td>
<td>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)</td>
</tr>
<tr>
<td>8. (SIA) Number of coaches trained via training workshops (target: 25 per site)</td>
<td></td>
</tr>
</tbody>
</table>

### 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
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 11, 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

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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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities Completed</th>
</tr>
</thead>
</table>
| **Objective 1: Strengthen GBV survivor services** | - 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-3,560, M-1,165) 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). |
| **Objective 2: Strengthen GBV response and coordination efforts** | - Y3: Meetings held nationally with MCD/MCH, MoGCD, VSU, MoH, ZCCP 11, 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. |
| **Objective 3: Expand the engagement of young men and boys through sport** | - 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
tournaments, life skills education and engaging boys and men on GBV issues. Number of families, communities, or individuals targeted or attended not reported.

- **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 Progress

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

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

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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**

![Graph showing 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 expedites 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 to 2 to 5 kilometer. 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. 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).

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.

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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. 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. 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. 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).

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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, Mazbuka).

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 is 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 security 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.

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“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

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 1 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. 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 1, 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.

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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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities Completed</th>
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<tbody>
<tr>
<td>Objective 1: Raise awareness of GBV laws and gender issues in the community</td>
<td>• 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</td>
</tr>
<tr>
<td>Objective 2: Strengthen the capacity of service providers in handling GBV cases</td>
<td>• 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,</td>
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<tr>
<td>Objective</td>
<td>Activities Completed</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>- Penal code, tort law, domestic relations, litigating inheritance cases, legal drafting, employment law, and the Anti-GBV Act. <strong>Y2/Y3</strong></td>
<td>- <strong>Police officers trained:</strong> 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), 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. <strong>Y2</strong></td>
</tr>
<tr>
<td>- <strong>Two legal practitioners from the Legal Aid Board were trained</strong>, 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). <strong>Y2</strong></td>
<td>- <strong>Thirty judges have participated in consultative meetings</strong> (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. <strong>Y3</strong></td>
</tr>
<tr>
<td>- <strong>Two doctors were trained</strong> 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). <strong>Y2</strong></td>
<td>- <strong>Paralegals were trained:</strong> 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 Mposhi, 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). <strong>Y2/Y3</strong></td>
</tr>
<tr>
<td>- 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. <strong>Y2</strong></td>
<td>- <strong>Training for paralegals and social workers from 14 OSC sites conducted</strong> 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. <strong>Y3</strong></td>
</tr>
<tr>
<td>- <strong>Workshop conducted for 38 magistrates</strong> (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. <strong>Y3</strong></td>
<td>- <strong>Consultative meeting with 12 judges (four female, eight male) from the Supreme Court and High Court held</strong> 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. <strong>Y3</strong></td>
</tr>
</tbody>
</table>
Objective 3: Provide legal aid services to GBV survivors

- 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

Objective 4: Strengthen referral and linkages for comprehensive GBV services

- 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 Progress

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

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


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 $865,000\(^\text{38}\) 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,

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\(^{38}\) 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. 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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities Completed</th>
</tr>
</thead>
</table>
| **Objective 1: Decrease societal acceptance of GBV and child marriages in Zambia** | • Activity: 21 community theaters were performed out of 50 that were targeted (LoP). Y2-Y3  
• 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 6 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** | • 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 Lifeline 40 (18 percent of LOP target of 53,642). Y2-Y3  
• Activity: 950 survivors participated in therapy meetings, out of 800 that were targeted. Y3 |


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

<table>
<thead>
<tr>
<th>Activities Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity:</strong> 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). <strong>Y2-Y3</strong></td>
</tr>
<tr>
<td><strong>Activity:</strong> Lifeline distributed 220 IEC materials to advertise the toll-free telecommunication services available. <strong>Y3</strong></td>
</tr>
</tbody>
</table>

### Objective 3: Improve the enabling environment to prevent and respond to GBV and child marriages

<table>
<thead>
<tr>
<th>Activities Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity:</strong> Three out of the five targeted traditional leaders were engaged as active “change agents” in their communities. <strong>Y3</strong></td>
</tr>
<tr>
<td><strong>Activity:</strong> ZCCP participated in 10 DDCC, out of 12 targeted meetings. <strong>Y3</strong></td>
</tr>
<tr>
<td><strong>Activity:</strong> 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. <strong>Y3</strong></td>
</tr>
<tr>
<td><strong>Activity:</strong> ZCCP participated in 11 coordination meetings (eight monthly and three quarterly) against a targeted 24 coordination meetings with District Commissioners in all 24 districts. <strong>Y2&amp;Y3</strong></td>
</tr>
</tbody>
</table>

### 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 Progress

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

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).

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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 headsmen 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 (FY1 Q3–FY3 Q2)**

![Figure 7](image)

**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 of which $2.03\(^{43}\) 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 $44,069\(^{45}\) 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 11. STOP GBV Recommendations

<table>
<thead>
<tr>
<th>Actions</th>
<th>Supporting Findings</th>
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<tbody>
<tr>
<td><strong>Program-Level Partner Coordination and Capacity Building</strong></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>Strengthening some areas and assumptions of ToC may assist in achieving results</td>
</tr>
<tr>
<td>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</td>
<td>Inconsistent operational use of GBV definitions; lack of harmony with international definitions</td>
</tr>
<tr>
<td>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</td>
<td>Current data are limiting in conducting analysis, especially at outcome level</td>
</tr>
<tr>
<td>Institute financial tracking and M&amp;E systems that are consistent across all three implementing partners, ensuring that financial information is aligned with M&amp;E data and activities so that data are streamlined and ongoing VfM calculations may be made without errors</td>
<td>Varied levels of quality in financial/expenditure data, reporting, analysis and alignment for VfM calculations</td>
</tr>
<tr>
<td>Improve district-level coordination across OSC staff, implementing partners and government partners by increasing monthly monitoring visits with mentorship and team-building</td>
<td>Ongoing lack of coordination, disjointed efforts and questionable sustainability at the district level</td>
</tr>
<tr>
<td>Improve linkages and coordination between the STOP GBV and other organizations offering economic programs at the district level (in coordination with ZCCP/CARE)</td>
<td>Not enough tangible livelihood opportunities to support survivors in leaving unsafe living situations</td>
</tr>
<tr>
<td><strong>Gender-Based Violence Survivor Support Services (WVZ)</strong></td>
<td></td>
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<tr>
<td>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)</td>
<td>No incentives currently in place for DHO performance of OSCs, creating sustainability challenges</td>
</tr>
<tr>
<td>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</td>
<td>Lack of shelters is a critical gap in providing protection and services</td>
</tr>
<tr>
<td>Continue lobbying for greater number of shelters and safe houses across the country</td>
<td>Indication of ongoing knowledge gaps among staff</td>
</tr>
<tr>
<td>Proceed with meeting training targets for OSC staff and other targeted personnel, emphasizing survivor-centered, rights-based approach</td>
<td>Indication of varying staff performance</td>
</tr>
<tr>
<td>Work with national government partners to integrate specific GBV staff and management performance standards for health, social workers, etc.</td>
<td>Current data does not provide outcome-level information on results for survivors</td>
</tr>
<tr>
<td>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</td>
<td>Current challenges reported in receiving quality service after hours</td>
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<tr>
<td>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</td>
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<tr>
<td>Actions</td>
<td>Supporting Findings</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>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</td>
<td>Not enough evidence of survivor recovery over the long term</td>
</tr>
<tr>
<td>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</td>
<td>Inconsistent availability and application of guidelines and standards, especially in former ASAZA sites</td>
</tr>
<tr>
<td>Review arrangements across sites for medical certificates to make more efficient and expeditious, and ensure fees are not being charged</td>
<td>Many reports of delayed (one week to one month) receipt of reports at K50</td>
</tr>
<tr>
<td>Strengthen tracking of referrals that are completed to a survivor’s satisfaction and referral outcomes</td>
<td>Referrals made are only tracked, without reporting and analysis of referral quality or outcomes</td>
</tr>
<tr>
<td>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)</td>
<td>Varying levels of appropriate investigative/supportive equipment at OSCs and former ASAZA sites</td>
</tr>
<tr>
<td>Create a service directory for all OSCs, updated on a regular basis, for use by all partners</td>
<td>Not all partners have up-to-date information for referrals</td>
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<table>
<thead>
<tr>
<th>Access to Justice (WLSA)</th>
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<tbody>
<tr>
<td>Lobby government to establish fast-track courts for GBV cases to be heard expeditiously</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Continue support to government to establish a coherent national database and improve the information flow between different departments (e.g. health, police and judiciary)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Support amendment to increase jurisdiction for local and subordinate courts to adjudicate and sentence more cases, including sexual assault, inheritance and other minor offenses</td>
</tr>
<tr>
<td>Review options to ensure medical forms are completed in a timely manner and provide necessary evidence/witness</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>Review paralegal staff performance with clearly defined expectations for assistance and follow-up</td>
</tr>
<tr>
<td>Move forward expeditiously with GBV evidence collection, prosecution, and procedure reference guidelines to distribute nationally, particularly in rural areas</td>
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<tr>
<td>Actions</td>
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<td>-----------------------------------------------------------------------</td>
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<tr>
<td>Support VSU HQ to identify incentives and develop sustainable systems</td>
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<tr>
<td>for accountability and transparency, including strengthened data</td>
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<tr>
<td>tracking and transparency regarding GBV cases</td>
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<tr>
<td>Review sustainability and viability of paralegal positions,</td>
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<tr>
<td>particularly after transition, looking at staff pay, training of</td>
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<tr>
<td>non-legal staff to work as paralegals, etc.</td>
</tr>
<tr>
<td><strong>Prevention and Advocacy (ZCCP)</strong></td>
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<tr>
<td>Increase community sensitization on need for SGBV survivors to access</td>
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<tr>
<td>OSCs within 72 hours for PEP and EC, mobile outreach services, and</td>
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<tr>
<td>addressing stigmatization of SGBV generally</td>
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<tr>
<td>Integrate GBV messaging into existing HIV</td>
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<tr>
<td>communications/outreach conducted by MCD/MCH and others</td>
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<tr>
<td>Continue engaging more leaders and influential persons in the</td>
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<tr>
<td>community as GBV change agents, including more religious leaders and</td>
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<tr>
<td>more headsmen in rural areas</td>
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<tr>
<td>Review training material for ZCCP male change agents and re-evaluate</td>
</tr>
<tr>
<td>GBV definitions used to ensure it is driving desired awareness and</td>
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<tr>
<td>change targeting underlying beliefs</td>
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<tr>
<td>Ensure close monitoring with quality qualitative/quantitative data</td>
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<tr>
<td>and analysis of potential unintended consequences, such as forcing</td>
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<tr>
<td>ECM issue “underground” in communities</td>
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<tr>
<td>Coordinate closely with OSCs and ASAZA sites on weekly basis to</td>
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<tr>
<td>provide feedback loops on: needs for services (from ZCCP) and</td>
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<tr>
<td>service availability (e.g., PEP supplies, etc.)</td>
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<tr>
<td>Increase awareness-raising “dose” and efforts in communities,</td>
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<tr>
<td>especially with media such as radio to reach rural and other more</td>
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<tr>
<td>remote areas</td>
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<tr>
<td>Continue providing capacity-building support to Lifeline, including</td>
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<tr>
<td>improved counselor capacity, increased numbers of counselors to</td>
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<tr>
<td>handle demand/call volume, referral/follow-up quality monitoring,</td>
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<tr>
<td>and strengthened M&amp;E data for outcome-level analysis</td>
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<tr>
<td>Target younger kids and their parents early on (as early as age 3),</td>
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<tr>
<td>formally and informally, with age-appropriate behavior change and</td>
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<tr>
<td>attitude messaging regarding gender equality and GBV</td>
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</tbody>
</table>
ANNEX A: EVALUATION STATEMENT OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
May 4, 2015

TITLE: EVALUATION OF STAMPING OUT AND PREVENTING GENDER BASED VIOLENCE (STOP GBV) 2011-2018 (055)

Requester / Client
☐ USAID Country or Regional Mission
Mission/Division: Zambia ____________________________ / ____________________________

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 MCH
☐ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify): DFID

Requester’s Cost Estimate: (Note: GH Pro will provide a final budget based on this SOW. It will be budgeted by Stage, so that initially the Mission will receive a Stage 1 budget with a rough estimate for Stage 2. Following the refinement of the SOW for Stage 2, GH Pro will develop a more comprehensive Stage 2 budget.)

Performance Period
Expected Start Date (on or about): o/a May 1, 2015 (Stage 1)
Anticipated End Date (on or about): October 1, 2015 (Stage 1)

Location(s) of Assignment: (Indicate where work will be performed)
Zambia: Lusaka and One Stop Center Sites (locations for site visits TBD)

Type of Analytic Activity (Check the box to indicate the type of analytic activity)
EVALUATION:
☐ Performance Evaluation (Check timing of data collection)
☐ Midterm (Stage 1)
☐ Endline (Stage 2)
☐ Other (specify): ____________________________

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.
Impact Evaluation (Check timing(s) of data collection)
- Baseline
- Midterm
- Endline
- Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES
- Assessment
  Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

- Costing and/or Economic Analysis
  Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

- Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)
Note: If PEPFAR funded, check the box for type of evaluation

- Process Evaluation (Check timing of data collection)
  - Midterm (Stage 1)
  - Endline
  - Other (specify): ______________

  Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

- Outcome Evaluation (Stage 2)
  Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

- Impact Evaluation (Check timing(s) of data collection)
  - Baseline
  - Midterm
  - Endline
  - Other (specify):

  Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in
which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

**Economic Evaluation (PEPFAR)**

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

**BACKGROUND**

Background of project/program/intervention:

<table>
<thead>
<tr>
<th>USAID and DFID launched the STOP GBV project in 2011 with a combined funding level of over $15 million to improve comprehensive GBV prevention and response in ten districts of Zambia.</th>
</tr>
</thead>
</table>

Following a successful first annual review of the project, DFID Zambia decided to scale up its support to the STOP GBV programme with an additional $11.7M (£7.25 million) in February 2014 to cover an additional 6 districts with GBV services, and include a component of engaging boys and men through sport. In total, USAID and DFID are contributing $27.4 million over a five-year period, from 2013-2018 to: reach 5 million adults and children with preventive messages; assist 47,000 survivors; and train 160 police and 65 prosecutorial personnel. The expected outcome of STOP GBV is an improved GBV violence prevention and response in Zambia. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia.

STOP GBV is a successor programme to the USAID funded A Safer Zambia (ASAZA) which ran from 2008 to 2011 in seven districts of Zambia. An independent evaluation of the ASAZA programme found that it had successfully “broken the silence” regarding GBV in Zambia, transforming deeply entrenched attitudes and norms in the districts in which it operated. In less than three years, the level of awareness regarding GBV increased from 67% to 82%; the number of individuals able to identify spousal battery as a form of GBV increased from 37% to 67%; 73% of individuals reported they had recently seen or heard messages regarding GBV; and 75% indicated they knew of specific activities in their community being undertaken to combat GBV. The evaluation also found that the increased awareness had encouraged individuals to report incidents of GBV and to seek help.

Based on information in the 2007 Demographic and Health Survey (DHS), gender based violence in Zambia is high with 47% of women and girls aged 15 to 49 having experienced physical violence and

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1 The Business Case approval was based on a scale up of 5 additional districts but subsequent to value for money negotiations, an additional district was incorporated into the programme design.

2 DFID contributed approximately 10 percent of the funding for the first phase of the STOP GBV project and 100 percent of the scale-up funding.

3 The full evaluation can be found through USAID’s Development Experience Clearinghouse (DEC).

4 The DHS 2014 preliminary results are expected by October 2014 and will include updated data on GBV.
20% having experienced sexual violence at some point in their life. The DHS found that more women than men believed that GBV is justified (62 percent versus 48 percent) for example, if a woman neglects the children, goes out without informing her husband, refuses to have sex, argues with her husband or burns food (see Annex 1 and Business Case for more detail). Though GBV is primarily directed at women and girls, the evidence suggests that boys are also at risk of physical and sexual violence (see Annex 1).

USAID is the main bilateral donor for GBV programmes in Zambia. The Swedish International Development Agency and Irish Aid are also providing some funding for an UN-supported GBV program with the Ministry of Gender and Child Development to support implementation of the Anti-GBV Act. Efforts are being made through the Ministry of Gender and Child Development as well as through the Cooperating Partner Group on Gender to ensure that the various GBV-focused initiatives around the country are properly coordinated to avoid duplication and maximise synergies. While the Evaluation Service Providers are not expected to evaluate non STOP GBV activities, the extent to which the STOP GBV partners coordinate with each other, the Zambian government, and other donor initiatives is expected to be an important component of both the mid-term and final evaluation to assess STOP GBV effectiveness and sustainability.

STOP GBV Project Design
The project is being implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP), each with their own agreement/contract. The additional sports component will be managed by World Vision and implemented by a local Zambian NGO, Sport in Action with technical support from the UK Sport International Inspirations. The STOP GBV Evaluation will therefore be comprised of four components:

**Component 1: GBV survivor support services managed by World Vision**
This component aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centres that employ a culturally sensitive, victim-centred approach in sixteen districts. This component ends in October 2017.

Provide an integrated package of medical care, counselling, including HIV counselling and counselling for child survivors, provision of post-exposure prophylaxis and emergency contraception, psychological support, and legal advice and support for adult and child GBV survivors. Each centre is staffed by a co-ordinator, full-time health worker, social worker and Victim Support Unit police officer, all seconded and paid for by government, and by volunteer counsellors and paralegals. Training for One Stop Centre staff and other service providers will be conducted using national guidelines on multi-disciplinary management of GBV.

Refer GBV survivors to other services including medical facilities for further treatment, the police via Victim Support Units, economic support through micro-finance, savings groups and skills development, safe houses or shelters, and survivor support networks. Centre staff liaises with other services to ensure that survivors receive appropriate support. If necessary, fees for further medical care are provided. Traditional community counsellors will also be trained to provide ongoing support for survivors as well as referrals to One Stop Centres.

Conduct mobile outreach one day a week to reach rural communities that are less able to access the centre. Mobile outreach will promote awareness of the services available at the centre and offer services and support to GBV survivors in the community. Outreach is conducted by a team consisting
of a health worker, social worker, counsellor, paralegal and police officer. Mobile outreach guidelines include an emphasis on timely examination and preserving evidence to ensure effective identification and prosecution of perpetrators.

**Strengthen the capacity of STOV GBV local primes** by conducting organizational assessments resulting in improvement actions and processes of relevant organizational systems. Capacity building will also include implementing World Vision’s Gateway-to-Grants (G2G) certification program among sub-grantees and local primes, including providing STOP GBV relevant training opportunities for local primes aimed at equipping them to successfully implement STOC GBV actions.

**Component 2: Access to justice managed by Women in Law in Southern Africa (WLSA)**

This component aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018. Specifically it will:

- **Train paralegals** to be located in the One Stop Centres to provide legal advice and support survivors, together with the Victim Support Unit officer, during legal and court processes including applying for protection orders preparing court documentation, liaising with the prosecutor on the status of the case, and identifying legal representation.

- **Sensitize the police** on GBV, focusing on officers working in Victim Support Units and Child Protection Units, and provide training to strengthen capacity for investigation, evidence collection, including forensics, prosecution of cases, witness support and referral of cases.

- **Train key legal and judicial stakeholders** including lawyers and legal aid lawyers, judges, magistrates and public prosecutors.

- **Sensitise traditional chiefs**, headmen and headwomen and others responsible for administering customary law and the traditional justice system, on GBV issues, statutory law concerning GBV and domestic violence, and cases that should be referred to comply with these laws.

- **Train other service providers**, including health and social workers, on identifying which survivors require information about legal processes and on the legal aspects of managing cases of GBV, including issues such as documenting evidence.

- **Increase community awareness** of legal aspects of GBV through mobile outreach activities.

**Component 3: Prevention and advocacy managed by Zambia Centre for Communication Programmes (ZCCP)**

This component aims to change social norms, attitudes and behaviours and to tackle underlying risk factors for GBV by sensitising and mobilising communities through a comprehensive programme of complementary communication interventions in 24 districts. This component ends in April 2018. Specifically, it will:

- **Conduct targeted sensitisation of traditional, community and religious leaders** with messages about GBV and early child marriage to improve understanding and encourage stronger leadership and action to address GBV, including increasing the number of GBV cases that are reported to the appropriate authorities.
Train men as advocates or ‘change agents’ to communicate with other men in the community about GBV and to take action in their own lives and in their communities, supported by production and distribution of targeted information, education and communication materials with key messages.

Use community dialogue, drama and community radio to increase community awareness and promote discussion and reflection on GBV issues.

Run a telephone helpline for GBV survivors and perpetrators.

Work with traditional and community structures to shift negative social norms on ending child marriage.5

The selection of all programme sites has been based on a number of criteria:

- GBV Prevalence data within the district
- Accessibility of programme partners (i.e. existing programme activities in the proposed site
- Capacity of district level health facility (e.g. sufficient medical staff to accommodate needs of a One Stop Centre)
- Willingness of health facility to engage with the programme

Select One Stop Centres will be managed by the Zambian government from the outset with STOP GBV partners providing technical support, training, supplies and equipment, and support for outreach, monitoring and data collection. These are referred to as “as direct to government” One Stop Centres. See Annex 3 for a list of all project sites in both the original and scale up program indicating those sites which will be direct to government.

Component 4: Engaging boys and young men through sports managed by World Vision

In stakeholder consultations, it was made very clear that this is a key target group and there was strong support for use of sport as medium to reach them. Working with men is identified as one of the implementation strategies in the National Action Plan on GBV.

Based on the experience of other programmes and available evidence about effective approaches, this component would use football as a means of engaging boys and young men, focusing on those aged 12-23 years. This component builds on the proven Young Men as Equal Partners methodology employed by Sport in Action in Zambia and will:

Work through existing teams and clubs, to build positive group attitudes and norms and increase knowledge and awareness of gender-related issues.

Train football coaches as mentors and change agents, to enable them to communicate and reinforce positive messages directly to boys and young men about gender and GBV during regular weekly training and matches, as well as strengthening football coaching skills.

Organise district tournaments which will be used as an opportunity to communicate GBV messages to a wider audience of boys and men as well as other community members.

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5 This addition was agreed by USAID in 2013 and represents an add-on to the original programme design. It will be included in the scale-up programme.
Organise weekly meetings of boys’ and young men’s groups to allow more in-depth discussion of issues, reinforce anti-GBV messages and develop life skills that support positive and meaningful relationships.

Work in partnership with parents, to secure support and improve inter-generational communication, and with schools, for example, through use of school facilities for training and tournaments.

The component will complement and link with existing prevention and advocacy component interventions including training men as change agents and support for community men’s groups. It is also expected to contribute to strengthening the evidence base on working with men and boys and, more specifically, on use of sport as a medium for changing attitudes and behaviours. As this is a relatively untested approach, International Inspirations will provide support for design and implementation of M&E activities to ensure that the methodology used is rigorous and robust.

Describe the theory of change of the project/program/intervention.

STOP GBV Theory of Change

The Theory of Change underpinning STOP GBV assumes that:

- Effective responses to GBV involve both prevention and provision of integrated services for GBV survivors. A multi-sector approach linking health, justice, social services, economic empowerment and security is necessary to provide comprehensive protection and support for victims of violence and to prevent violence over the longer term.
- GBV survivors are better supported through stand-alone One Stop Centres with trained staff that can meet a range of needs and guarantee privacy, sensitivity and a victim-centred approach.
- GBV survivors need safe spaces and alternative means of generating independent income.
- Broad based interventions at community level can lead to changed attitudes and social norms, including improved perceptions about the value of women and improved notions of masculinity, which will result in a decrease in GBV including child marriage.
- Violence against women and girls is rooted in unequal power relations between women and men and it is essential to work with men and boys to address this.
- Promoting positive gender norms needs to be complemented by efforts to ensure that women are aware of their rights.

It is consistent with the Theory of Change in the DFID Zambia Gender Strategy, where empowerment of women and girls depends on: access to assets and services (e.g. productive resources such as land, agricultural inputs, credit); ability to exercise voice, influence and choice (e.g. freedom from GBV, control over assets, knowledge of rights and entitlements); and changing the rules of the game (e.g. structural factors, institutions, and social norms).

This intervention is also consistent with DFID’s Theory of Change on Tackling Violence against Women and Girls developed by the CHASE VAWG Team and focuses on specific aspects of the DFID VAWG Theory of Change and its 7 principles (see Annex 2). In addition, it is consistent with USAID’s Gender Equality and Female Empowerment Policy which aims to reduce gender disparities, reduce gender-based violence and increase the agency of women and girls to improve their life outcomes (http://www.usaid.gov/sites/default/files/documents/1870/GenderEqualityPolicy.pdf).
Figure 1: STOP GBV Theory of Change

Strategic or Results Framework for the project/program/intervention (*paste framework below*)
Each STOP GBV component has its own results framework and these are presented individually. Below is the results framework for the STOP GBVSS:

**Figure 1: GBVSS Results Framework**

**Goal:** To increase the availability and uptake of quality GBV services for adult and child survivors of GBV.

**Objective 1:** Strengthen GBV survivor services

- **Result 1.1:** Strengthen CRC capacity to provide comprehensive care to survivors of GBV
- **Result 1.2:** Strengthen shelter and safe house capacity to provide care to survivors of GBV
- **Result 1.3:** Institutionalize core GBV competencies

**Objective 2:** Strengthen GBV response and coordination efforts.

- **Result 2.1:** Strengthen coordination with other GBV programs
- **Result 2.2:** Strengthen community networks to address GBV
- **Result 2.3:** Strengthen the capacity of STOP GBV local prime implementers

**USAID (STOP GBV):** increase prevention and response to GBV in Zambia

**Zambia GBV NAP Objective 3:** eliminate GBV through build capacity of the relevant sectors for mainstreaming GBV prevention and case management interventions in their policies,
Goal: To increase the prevention of and response to GBV in Zambia

Objective: To decrease societal acceptance of GBV, enhance protective factors, and improve the enabling environment to respond to GBV

IR 1.1: Outreach efforts against GBV expanded

IR 1.2: Communities mobilized against GBV increased

IR 1.3: Protective factors enhanced

IR 1.4: Economic opportunities for vulnerable women, men and youth increased

IR 1.5: Political and institutional commitment to GBV prevention and response within government strengthened

IR 1.6: Engagement of diverse stakeholders in forming a national response against GBV strengthened

IR 1.7: Coordination with other GBV and BCC programs strengthened

IR 1.8: Campaign against early child marriage (ECM) in Zambia enhanced

GRZ/GIDD: Eliminated GBV in holistic, systematic and comprehensive manner through multi-sectoral and multi-dimensional approach and provision of appropriate care and services to survivors of GBV

USAID/Zambia DO3: Human Capital Improved IR3.2: Health Status Improved

Goal: To increase the prevention of and response to GBV in Zambia

Objective: To decrease societal acceptance of GBV, enhance protective factors, and improve the enabling environment to respond to GBV

IR 1.1: Outreach efforts against GBV expanded

IR 1.2: Communities mobilized against GBV increased

IR 1.3: Protective factors enhanced

IR 1.4: Economic opportunities for vulnerable women, men and youth increased

IR 1.5: Political and institutional commitment to GBV prevention and response within government strengthened

IR 1.6: Engagement of diverse stakeholders in forming a national response against GBV strengthened

IR 1.7: Coordination with other GBV and BCC programs strengthened

IR 1.8: Campaign against early child marriage (ECM) in Zambia enhanced

GRZ/GIDD: Eliminated GBV in holistic, systematic and comprehensive manner through multi-sectoral and multi-dimensional approach and provision of appropriate care and services to survivors of GBV

USAID/Zambia DO3: Human Capital Improved IR3.2: Health Status Improved
STOP GBV interventions target:
- GBV survivors
- Providers of GBV services
  - One Stop Centres’ staff
  - Police and those within the legal system
  - Persons making referrals to GBV services and One Stop Centres
  - Outreach mobile GBV providers
- Change agents
  - Religious leaders
  - Men & boys

The GHVSS One Stop Centres are located:

<table>
<thead>
<tr>
<th>Centre</th>
<th>District</th>
<th>Province</th>
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<tbody>
<tr>
<td>1. Chongwe</td>
<td>Chongwe</td>
<td>Lusaka</td>
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<td>2. Kafue</td>
<td>Kafue</td>
<td></td>
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<tr>
<td>3. Lusaka</td>
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<td>Lusaka</td>
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<tr>
<td>4. Katete</td>
<td>Katete</td>
<td>Eastern</td>
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<tr>
<td>5. Nyimba</td>
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<td>Nyimba</td>
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<tr>
<td>6. Choma</td>
<td>Choma</td>
<td>Southern</td>
</tr>
<tr>
<td>7. Kalomo</td>
<td>Kalomo</td>
<td></td>
</tr>
<tr>
<td>8. Monze</td>
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<td>Monze</td>
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<tr>
<td>9. Kapiri Mposhi</td>
<td>Kapiri Mposhi</td>
<td>Central</td>
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<tr>
<td>10. Chibombo</td>
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<td>Chibombo</td>
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<tr>
<td>11. Mumbwa</td>
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<td>12. Mongu</td>
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<td>13. Nakonde</td>
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<td>14. Mpika</td>
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<td>15. Chingola</td>
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<td>Chingola</td>
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<tr>
<td>16. Luanshaya</td>
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<td>Luanshaya</td>
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Note: The Evaluation Team will work with USAID to finalize the sample of sites and target populations for each method of the evaluation for Stage 1 and Stage 2.

SCOPE OF WORK
A. Purpose:

This scope of work for an external evaluation covers both a midterm and end of project evaluation. The external evaluation will be initiated at the chronological midpoint of the STOP GBV project.

As a midterm formative evaluation the objectives are:

1. to help determine what components and project aspects are working well and why;
2. to help determine what components and project aspects are not working well and why;
3. to make recommendations for modifications and midcourse corrections, if necessary, that will help guide the STOP GBV project over its second half.

The evaluation should provide pertinent information, statistics, and judgments that assist the STOP GBV Implementing Partners, DfID and USAID to learn what is being accomplished and what relevant management, financial and cost efficiency findings present themselves. In summary, the evaluation
will help all involved to better understand the initial results and contributions of the project, and help re-focus and strengthen it.

The end of project evaluation is meant to serve a dual purpose:
1. to learn to what extent the project’s objectives and goals—at all result levels—have been achieved; and
2. to provide recommendations for any future GBV interventions in Zambia.

Evaluation Structure
The evaluation will be divided in two stages, each with its own timeline and deliverables.

Stage 1 will begin with a desk review that (a) includes a document review of relevant background documents, and (b) a review of existing data to verify the availability, applicability and quality of existing data. This review of the documents and data will inform the design and methods of the midterm and end of project evaluations.

The mid-term evaluation, will assess the effectiveness of all components of the STOP GBV programme, and the likelihood that the current programme will achieve the agreed goals and targets. Sustainability and cost-effectiveness must further be considered. The evaluators will further consider the extent to which the four components of the STOP GBV program are operating in a coordinated and effective manner between themselves as well as with key stakeholders in the Zambian government, including the Ministry of Community Development, Mother and Child Health, the Ministry of Gender and Child Development, the police, the judicial system and others.

This midterm evaluation will inform DFID and USAID/Zambia of any gaps in programme design, delivery or implementation which need to be addressed and which could positively influence implementation of the programme across the existing and scale-up districts.

A further objective of Stage 1 will be to identify differences in efficiency and effectiveness between existing and scale-up sites (i.e., the inclusion of activities addressing boys and young men through sports) and whether there are any differential benefits in the scale-up districts which could be integrated into the original programme sites.

Stage 2 of the evaluation is the end of project evaluation, and will be designed to assess the extent to which the programme achieved its goals and the likely impact, relevance, effectiveness, cost effectiveness and sustainability of the results from the programme portfolio.

The final evaluation report should include lessons learned and provide recommendations for any future investments in gender based violence programming in Zambia.

B. Audience:

In general, the prime audience of this evaluation will be the DfID, USAID/Zambia, implementing partners, GRZ, and other health sector donors. A summary of the reports, including description of methods, key findings and recommendations will be provided to the GRZ, other donors, and academia. However, the primary audience for each stage of the evaluation is expected to vary slightly.
The key users of the findings from **Stage 1** (midterm evaluation) will primarily be DFID Zambia, USAID/Zambia, and the Programme Implementers, with the aim of adapting the programme where appropriate to ensure a stronger impact on the empowerment of women and girls. However, the Ministry of Health, Ministry of Community Development Maternal and Child Health, the Ministry of Gender and Child Development and the Ministry of Youth and Sports will also have interest in the findings on the delivery of GBV services.

The key users of **Stage 2** (end of project evaluation) will be DFID Zambia, USAID/Zambia, the above stakeholder ministries as well as Co-operating Partners in Zambia and wider Violence Against Women and Girls community in relation to lessons learned from the Zambia programme. Zambian stakeholders will be engaged through a series of stakeholder consultations (e.g. workshops at each stage of the evaluation) as well as potentially through focus group discussions or key informant interviews.

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

Stage 1, midterm evaluation findings, will be used to inform DFID and USAID, as well as their implementing partners (IP) about what is working and where course correction may be needed.

Stage 2, end of project evaluation findings will be used to determine if the STOP GBV interventions and programme achieved their intended outcomes, and what the follow on steps might be related to further investment (e.g., DFID and/or USAID funding) and sustainability.

D. **Evaluation questions**: Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

E.

**Stage 1: Midterm**

<table>
<thead>
<tr>
<th>Evaluation Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the STOP GBV programme and all its components designed in such a way as to achieve its outcomes and is the programme on track to achieve the latter? (Effectiveness)</td>
</tr>
<tr>
<td>2. If some interventions are more successful than others, why, are they the right combination of interventions? (Effectiveness)</td>
</tr>
<tr>
<td>3. What operational programme improvements can be made to ensure impact and outcomes are achieved? (Efficiency)</td>
</tr>
<tr>
<td>4. How did coordination and collaboration between the implementers and the GRZ bolster or hinder project outcomes? (Efficiency)</td>
</tr>
<tr>
<td>5. Do the results being achieved represent value for money as set out in the Business Case? (Efficiency)</td>
</tr>
</tbody>
</table>

**Stage 2: End of Project**

<table>
<thead>
<tr>
<th>Evaluation Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: The Evaluation Team will review these questions and propose 3-5 questions at the end of Stage 1 for the End of Project Evaluation.</td>
</tr>
</tbody>
</table>
1. Have all four programme components achieved the key impacts, outcomes and outputs as specified in the project documents? (Effectiveness)

2. Did the programmatic additions to the scale-up programme demonstrate any additional benefit in comparison with the original programme design? (Effectiveness)

3. What factors have been key in affecting the success (or otherwise) in achieving key results? Why and how have programmes been effective? (Effectiveness)

4. What impact have prevention and advocacy had on knowledge and attitudes concerning GBV, legal rights and availability of services? (Effectiveness)

5. Were there any gaps in strategic information/data for strategic decision making? (Effectiveness)

6. What are the key lessons learned and recommendations related to different programme components, for example, engagement and attitudinal shift of boys and men? (Sustainability)

7. Has the intervention built capacity to manage and sustain services for GBV survivors? (Sustainability)

8. To what extent did the STOP GBV Projects influence national programming on GBV by the end of the Program? (Sustainability)

F. Methods:

The Evaluation will be conducted in two phases (midterm formative and end of project summative) to address the evaluation questions, in addition to learning lessons directly from programme implementation.

In line with both DFID’s and USAID’s respective evaluation policies, the STOP GBV evaluation will be based primarily on (i) Effectiveness (ii) Efficiency (iii) Sustainability.

Note: The Evaluation Team will work with USAID to finalize the sample of sites and target populations for each method of the evaluation for Stage 1 and Stage 2. Priority sites include:

- Lusaka
- Mazabuka
- Choma
- Mumbwa

Protection of Human Subjects:

The Evaluation Team must develop protocols to insure privacy and confidentiality must be developed prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time.

Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion. If the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance.

Given the nature of GBV, the Evaluation Team should also take great care to insure privacy and confidentiality for victims of GBV, including victims of violence and coercion. If the data collector senses any discomfort on the part of a respondent, data collection should cease, and the respondent
should be reminded that they are free to end the session at any time, and should be reminded that anything they say is in privacy and in confidence, and that no identifying information will be shared.

An IRB is recommended for these evaluations. The following table of Deliverables and LOE reflects the extra time needed to develop protocols for submission and estimated 10-day wait time for IRB review should that option be required.

**Stage 1: Midterm**

The methods and timeline will be fully fleshed out and finalized during the Team Planning Meeting, following the Document and Database Review. What is listed below is a rough outline of the anticipated methods for the Midterm Evaluation.

**Document Review (list of documents recommended for review)**

Review STOP GBV project and donor documents, including proposals, workplans, performance reports, etc. These documents include:

(i) STOP GBV six monthly and annual performance reports
(ii) STOP GBV Business Case
(iii) Independent Evaluation of ASAZA
(iv) DFID Annual Review (2013)
(v) Programme Baseline Reports and SEQAS reports
(vi) Baseline data reports (Component 1 Survivor Support and Component 2 Prevention and Advocacy)

**Secondary analysis of existing data (list the data source and recommended analyses)**

Verify the availability and quality of data collected for use in the midterm and end of project evaluations. Determine content of databases that can be used for secondary analyses, listing data source(s), description of each data source, and recommended data analyses.

Datasets to be reviewed prior to Team Planning Meeting for utility and application during Midterm and Endline evaluations are listed below. Evaluation Team will complete this table determining the data sources and the recommended analyses for this Endline evaluation.

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zambia Demographic and Health Survey (ZDHS)</td>
<td>Provides the latest statistics on GBV and other demographic and health issues. Data can be accessed through DHS Statcompiler or by downloading dataset</td>
<td></td>
</tr>
<tr>
<td>Implementing partner (IP) Annual reports</td>
<td>Provides data/information on program performance and achievements. Data will need to be requested from IP or abstracted from Annual Reports</td>
<td></td>
</tr>
<tr>
<td>Baseline data: Component 1 Survivor Support</td>
<td>Provides baseline data on GBV survivors and support. Baseline</td>
<td></td>
</tr>
<tr>
<td>Survey Dataset</td>
<td>Purpose</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Baseline data: Component 2 Prevention and Advocacy</td>
<td>Provides baseline data on GBV prevention and advocacy. Baseline survey dataset will need to be requested from IPs.</td>
<td></td>
</tr>
<tr>
<td>Baseline knowledge, attitude and practice (KAP) surveys</td>
<td>Provides baseline data on knowledge, attitude and practice related to GBV. Baseline survey dataset will need to be requested from IPs.</td>
<td></td>
</tr>
<tr>
<td>IP budget and financial records, along with USAID and DFID STOP GBV budgets</td>
<td>Funding and costing data</td>
<td></td>
</tr>
</tbody>
</table>

### Key Informant Interviews (KII) (list categories of key informants, and purpose of inquiry)

Key stakeholders will be interviewed to get their impression of what is working, the shortcomings and obstacles faced by the programme, and what else they think is needed. Key stakeholders include:

- Zambian government representatives involved or affected by STOP GBV
  - Ministry of Health
  - Ministry of Community Development Maternal and Child Health
  - Ministry of Gender and Child Development
  - Ministry of Youth and Sports
  - Police
  - Judicial system
- STOP GBV IP staff
- 1-Stop Center Staff
- Community leaders where STOP GBV is implemented
- Change Agents and mentors trained as advocates (alternative: may be in focus group discussion)
- Beneficiaries of GBV programs and interventions

### Focus Group Discussions (FGD) (list categories of groups, and purpose of inquiry)

Inquiry will focus on why participants did or did not engaged in community STOP GBV activities, and their impression of gender and cultural norms transformation related to GBV. Focus Groups will be convened among:

- Community members, men and women who represent STOP GBV beneficiary target groups, who reside in communities where interventions have occurred, particularly around the 1-Stop Centers
  - Separate discussion groups for men and women will be convened, to adjust for the potential power differential between men and women, and to assure women’s voice is heard equally to men.
- Change Agents and mentors trained as advocates (alternative: may get feedback through KII)

### Observations (list types of sites or activities to be observed, and purpose of inquiry)
If timing works, observations of community activities and/or trainings are recommended. These data will provide input for continuing programming.

**Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

As needed: Costing analysis will require abstracting cost data from a variety of sources, including IP’s budgets and financials.

**Other** *(list and describe other methods recommended for this evaluation, and purpose of inquiry)*

1. Review and revise a comprehensive mixed-method methodology for Stage 1: Midterm evaluation.
2. Develop technical guidance to ensure robust data collection and analyses in follow up surveys
3. Develop a Communications and Dissemination Framework

**Stage 2: Endline Evaluation**

The Stage 2 Team Planning Meeting will be convened at the end of Stage 1, before the Evaluation Team disperses. During this meeting the Evaluation Team will recommend methods for Stage 2 Endline Evaluation. These methods will be reviewed with the Mission for concurrence. Below are some methods that are likely to be included in the Endline Evaluation.

**Document Review** *(list of documents recommended for review)*

Re-review STOP GBV project and donor documents, including proposals, workplans, performance reports, etc. These documents include:

(i) STOP GBV six monthly and annual performance reports
(ii) STOP GBV Business Case
(iii) Independent Evaluation of ASAZA
(iv) DFID Annual Review (2013)
(v) Programme Baseline Reports and SEQAS reports
(vi) Baseline data reports (Component 1 Survivor Support and Component 2 Prevention and Advocacy)

Review additional STOP GBV documents that have been developed since the Midterm Evaluation. The Mission will create a list of additional documents and share with GH Pro prior to beginning of Stage 2.

**Secondary analysis of existing data** *(list the data source and recommended analyses)*

Datasets to be reviewed prior to Team Planning Meeting for utility and application during Midterm and Endline evaluations are listed below. Evaluation Team will complete this table determining the data sources and the recommended analyses for this Endline evaluation.

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<td></td>
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</tbody>
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### Key Informant Interviews (list categories of key informants and purpose of inquiry)

Many of the same key informants interviewed in Stage 1, will be re-interviewed. Key stakeholders will be interviewed to get their impression of what is working, the shortcomings and obstacles faced by the programme, and what else they think is needed. Key stakeholders include:

- Zambian government representatives involved or affected by STOP GBV
  - Ministry of Health
  - Ministry of Community Development Maternal and Child Health
  - Ministry of Gender and Child Development
  - Ministry of Youth and Sports
  - Police
  - Judicial system
- STOP GBV IP staff
- 1-Stop Center Staff
- Community leaders where STOP GBV is implemented
- Change Agents and mentors trained as advocates (alternative: may be in focus group discussion)

### Focus Group Discussions (list categories of groups and purpose of inquiry)

Very similar to Stage 1, focus groups will to convene to determine why participants did or did not engaged in community STOP GBV activities, and their impression of gender and cultural norms transformation related to GBV. Focus Groups will be convened among:

- Community members, men and women who represent STOP GBV beneficiary target groups, who reside in communities where interventions have occurred, particularly around the 1-Stop Centers
Separate discussion groups for men and women will be convened, to adjust for the potential power differential between men and women, and to assure women's voice is heard equally to men.

- Change Agents and mentors trained as advocates (alternative: may get feedback through KII)

**Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

To be determined during Stage 1, as part of the Stage 2 planning process. This may be a KAP survey that is follow on to the baseline KAP implemented by STOP GBV. Baseline surveys will be reviewed as part of the Document and Data Review to determine if all or parts of these surveys can be replicated and be useful as part of the midterm or end of project evaluations.

The Team should consider alternative survey methodology, such as Lot Quality Assurance Sampling (LQAS), that requires and smaller sample, and therefore less time and resources.

**Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

As needed: Costing analysis will require abstracting cost data from a variety of sources, including IP’s budgets and financials.

**Other** *(list and describe other methods recommended for this evaluation, and purpose of inquiry)*

1. Review and refine (where appropriate) the programme theory of change for addressing gender based violence.
2. Review programme baselines in all sites and make recommendations on how to ensure robustness in data collection and operational monitoring and evaluation.
3. Review and assess program performance and likelihood of meeting stated outputs, objectives and goals. Provide recommendations to improve the effectiveness, sustainability, and efficiency of the programme, by component and collectively.
4. Review and assess coordination between the STOP GBV partners and between the partners and key stakeholders in the Zambian government. Provide recommendations for strengthening this coordination if needed.

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes  ☐ No

List or describe case and counterfactual*

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
</table>

**ANALYTIC PLAN**

For both Stage 1 and Stage 2:

- A qualitative and quantitative analysis of the achievements in relation to the objectives and targets of STOP GBV will be conducted. This analysis is aimed at answering the evaluation questions.
• Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location. In the report the Evaluators will describe the statistical tests used.

• Thematic reviews of qualitative data will be performed. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data does not exist. All qualitative data should be documented in comprehensive notes or entered into appropriate qualitative analytic software.

• Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., IP PMP data, GBV KAP report, and DHS) will allow the Team to triangulate findings to produce more robust evaluation results.

**ACTIVITIES**

**Background reading** – Several documents are available for review for this evaluation. These include STOP GBV proposals, workplans, M&E plans, quarterly and annual progress reports, and reports from internal project evaluations. Additionally, any external surveys and reports that include information related to GBV, such as the Zambia DHS. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation. (Stage 1, with review in Stages 2&3)

**Review of existing datasets** – The Team will review existing datasets that can be used for secondary data analysis for the midterm and end of project evaluations. Data will be reviewed for appropriate applications to address Stage 2 and Stage 3 evaluation questions, for completeness and all other data quality attributes (http://usaidlearninglab.org/library/data-quality-assessment-checklist-dqa). This activity will result in an analytic plan for datasets deemed useful in the midterm and/or end of project evaluations.

**Team Planning Meetings (TPM)** –

1. At the beginning of **Stage 1**, the Evaluation Team will meet to review documents and datasets to be reviewed, and assign individual roles and responsibilities for activities and desired results of this desk review. Additional time will be scheduled for this TPM as the Evaluation Team will need to determine usable datasets for secondary data analysis, and the feasibility of repeating the KAP survey, as well as finalizing plans, tools, logistics and timelines for this Midterm Evaluation. During this TPM the Evaluation Team will:
   • Review and clarify any questions on the evaluation SOW
   • Clarify team members’ roles and responsibilities
   • Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
   • Review and finalize evaluation questions for **Stage 1**
   • Review and finalize the assignment timeline for **Stage 1**
   • Develop data collection methods, instruments, tools and guidelines for **Stage 1**
   • Review and clarify logistical and administrative procedures for the assignment
   • Develop a data collection plan
   • Draft the evaluation work plan for USAID’s approval
   • Develop a preliminary draft outline of the Midterm Evaluation Report
   • Assign drafting/writing responsibilities for the Midterm Evaluation report
   • Review **Stage 2** SOW, particularly the methods
     ○ Ensure compatibility between Stage 1 and Stage 2 Evaluations.
2. At the end of Stage 1, the Evaluation Team will convene for a three-day Stage 2 TPM. This TPM will plan the Endline Evaluation, including:

- Review and revise as needed the Endline evaluation questions
- Review team members’ roles and responsibilities
- Review and finalize the assignment timeline and logistics
- Develop data collection methods, instruments, tools and guidelines for Stage 2
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
  - Detailed data collection plan for Stage 2
  - Scope of work for Stage 3 data collection
- Draft the Endline Evaluation workplan for USAID’s approval
- Develop a preliminary draft outline of the Endline Evaluation report

3. The Evaluation Team will reconvene for approximately 2 days for the initiation of Stage 2. At this time they will review Stage 2 plans, methods and data collection instruments. Any needed revisions will be made at this time. Detailed Stage 2 workplan, roles and responsibilities and needed logistics will be finalized. Additionally, the outline of the Endline Evaluation report will be reviewed and revised as needed, along with assigning drafting/writing responsibilities.

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings during Stage 1 and Stage 2 are:

- **Evaluation launch**, a call among the USAID/Zambia, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. The Mission will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review travel schedule. Each Stage will begin with a launch call.

- **In-brief with USAID/Zambia.** This can be incorporated into the TPM. This briefing will include the Evaluation Team, USAID/Zambia Health Office and M&E team representatives. The Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). Each Stage will include an in-brief.

- The Team Lead will brief the Mission **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email. **Note:** preliminary findings are not final and as more data sources are developed and analyzed these finding may change. (Weekly briefings will occur throughout Stage 1 and Stage 2.)

- A **final debrief** will be held approximately 3 days before departure, between USAID/Zambia and the Evaluation Team. During this meeting a summary of the preliminary and high level findings, along with draft recommendations will be presented. The Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. A final briefing will occur at the end of Stage 1 and Stage 2, just prior to the Evaluation Team departing Zambia.
- **Stakeholders’ debrief/workshop** will be held following the Mission’s debrief at the end of Stage 1 and Stage 2. USAID/Zambia will advise who should be included in this workshop.

**Fieldwork, Site Visits and Data Collection** – During Stage 1 and Stage 2, the evaluation team will conduct site visits to collect data per the evaluation methods. The site visits will involve key informant interviews, focus group discussions, observations, and surveys. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

### DELIVERABLES AND PRODUCTS

#### Stage 1: Midterm Evaluation

<table>
<thead>
<tr>
<th>Activity / Deliverable* / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Launch briefing]</td>
<td>o/a May 7, 2015</td>
</tr>
<tr>
<td>![Team Planning Meeting]</td>
<td>o/a May 14-15</td>
</tr>
<tr>
<td>![Analytic protocol with data collection tools for IRB submission]</td>
<td>o/a May 18, 2015</td>
</tr>
<tr>
<td>![Workplan with timeline]</td>
<td>o/a June 1, 2015</td>
</tr>
<tr>
<td>![In-brief with Mission]</td>
<td>Virtual in-brief: Around April 20 - 22, 2015 In-Country (following IRB clearance): o/a June 1, 2015</td>
</tr>
<tr>
<td>![In-brief with target project / program]</td>
<td>May 18, 2015</td>
</tr>
<tr>
<td>![Routine briefings]</td>
<td>Weekly or as determined by USAID/Zambia</td>
</tr>
<tr>
<td>![Out-brief with Mission with Power Point presentation]</td>
<td>o/a July 6, 2015</td>
</tr>
<tr>
<td>![Findings review workshop with key stakeholders (tentatively for 2-3 hours) with Power Point presentation and discussion of findings]</td>
<td>o/a July 6, 2015</td>
</tr>
<tr>
<td>![Stage 2 SOW developed during second TPM]</td>
<td>o/a July 23 - 25, 2015</td>
</tr>
<tr>
<td>![Raw data]</td>
<td>August 12, 2015</td>
</tr>
<tr>
<td>![Format, 508 Compliant, post Evaluation Report to the DEC]</td>
<td>September 30, 2015</td>
</tr>
<tr>
<td>![Dissemination activity]</td>
<td></td>
</tr>
<tr>
<td>![Other (specify):]</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: Deliverables schedule may need to be adjusted based on IRB approval and timetable*

#### Stage 2: Endline Evaluation

<table>
<thead>
<tr>
<th>Activity / Deliverable / Product</th>
<th>Timelines &amp; Deadlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Launch briefing]</td>
<td>2017 (TBD)</td>
</tr>
<tr>
<td>![Workplan with timeline]</td>
<td>TBD</td>
</tr>
<tr>
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<td>Activity</td>
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<td>-------------------------------------------------------------------------</td>
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<td>TBD</td>
</tr>
<tr>
<td>Stage 2: Draft report</td>
<td>Draft: Final: July 2017</td>
</tr>
<tr>
<td>Raw data</td>
<td>TBD</td>
</tr>
<tr>
<td>Format, 508 Compliant, post Evaluation Report to the DEC</td>
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<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated USAID review time**
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? ___________ 10 ______ Business days

**TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)**

**Evaluation team:** When planning this analytic activity, consider:
- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise required by the proposed analytics.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team Qualifications:** Please list technical areas of expertise required for this activities

Collectively, the evaluators should have the following skills and expertise:
- a. Extensive experience in conducting programmatic evaluations (essential).
- b. Experience in the field of gender and in particular gender based violence (essential).
- c. Skills in assessing value for money in terms of both cost efficiency and cost effectiveness (essential).
- d. Experience of gender programming and health service provision (essential) in Zambia and other Southern African countries (desirable)
- e. Excellent written and verbal communication skills (essential)

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

**Key Staff 1 Title:** Team Lead (international consultant)  
*Note: This person will be selected from among the other key staff, and will meet the requirements of both this and the other position.*
Roles & Responsibilities: The team leader will be responsible for (1) overall management of the evaluation team's activities, (2) ensuring that all deliverables, including the final reports, are of good quality and are completed in a timely manner, (3) serving as a liaison between the Mission and the evaluation team, and (4) leading briefings and presentations.

Qualifications:  
- Master’s degree in gender and development, public health or related field, a PhD is preferred  
- At least five years of experience, preferably with assignments of similar size and scope  
- Demonstrated record of successfully supervising evaluation teams, including local experts  
- Experience implementing USAID evaluations, with familiarity with USAID evaluation policies  
- Demonstrated experience in producing a high-quality analytical report.

Particular expertise and experience should include:  
- Strong analytical skills to collect, synthesize and analyze data  
- Prior experience as the team leader of similar assignment  
- Strong team management and supervisory skills  
- Demonstrated success in working across cultures  
- Strong technical English writing and communication skills  
- Experience working with a range of government officials, donors, local NGOs, academia  
- Experience working in the region – Zambian experience preferred

**Key Staff 2 Title:** Gender &/or GBV Specialists  
Roles & Responsibilities: Serve as a member of the evaluation team, and provide technical expertise on gender, gender transformation and GBV.  
Qualifications: Must have:  
- At least a Master’s degree in gender and development, Public Health, Statistics, Demography or other relevant academic degree  
- A depth of experience working on gender issues and GBV programs  
- At least two years of experience, preferably with assignments of similar size and scope.  
- Must possess the necessary skills set(s) to successfully conduct a mixed-methods evaluation of all components of the STOP GBV program.

Number of consultants with this expertise needed: 2-3

**Key Staff 3 Title:** Evaluation Specialist (This position may be filled by a local Research Firm)  
Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis.  
Qualifications:  
- At least 5 years of experience in USAID M&E procedures, project and organizational management  
- Master’s degree in analytic field preferred
• Strong knowledge, skills, and experience in qualitative and quantitative evaluation methods and tools
• Experience in design and implementation of evaluations
• Experience training and overseeing data collectors

Number of consultants with this expertise needed: 1

**Key Staff 4 Title:** Costing Specialist or Economist

**Roles & Responsibilities:** Serve as a member of the evaluation team, and provide technical expertise on program costing, efficiencies and other needed economic analyses.

**Qualifications:**
• Bachelor’s Degree (Master’s degree preferred) health economics or a related field
• Experience in costing related to program development and implementation;
• Demonstrated expertise in designing research instruments and methodologies, experience evaluating value for money of interventions, including complex package of interventions such as required by STOP GBV
• Previous experience in conducting economic analysis research and/or costing studies
• Excellent oral and written communication skills in English, including the ability to communicate complex costing and economic evaluation findings (presentations and reports)
• Demonstrated knowledge of USAID’s policies and programs
• Experience in working in a developing country context preferred

Number of consultants with this expertise needed: 1

**Other Staff Titles with Roles & Responsibilities (include number of individuals needed):**

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Roles &amp; Responsibilities</th>
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<tbody>
<tr>
<td>2-3</td>
<td>Research Assistants (local)</td>
<td>Will be hired to assist with qualitative and quantitative data collection, data entry, data analyses, and transcription of qualitative data. All Research Assistants should have background on gender and/or GBV programs/issues</td>
</tr>
<tr>
<td>1</td>
<td>Logistics/Program Assistant (local)</td>
<td>Will be hired to assist the team with arrangements for transportation, lodging, venues (as needed), setting appointments, and other assistance as needed. <em>Note:</em> The responsibilities for this position can be combined with those of a Research Assistant by giving one or the Research Assistant a higher level of effort (LOE).</td>
</tr>
</tbody>
</table>

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

- [ ] Yes – If yes, specify who:
- [ ] No

**Staffing Level of Effort (LOE) Matrix:**

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

b) Immediately below each staff title enter the anticipated number of people for each titled position.

c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding
to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then
multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in days for each Evaluation/Analytic Team member

**Note:** This is an illustrative chart as this GH Pro is subcontracting to two organizations: 1) for Team Lead
services, who will also provide technical expertise in gender, GBV, and costing; and 2) a local research
organization who will provide staffing, data collection and management, data analysis, and logistic
support as needed to field this evaluation.

<table>
<thead>
<tr>
<th>Estimated Days/Activity</th>
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<tbody>
<tr>
<td><strong>Stage 1</strong></td>
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<table>
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<tr>
<th><strong>Stage 2</strong></th>
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</tbody>
</table>
All One Stop Centres are easily accessible throughout the year. However, during the rainy seasons, some of the district outreach areas may become inaccessible. DFID and USAID will advise on optimal timings to ensure the evaluation field work is not negatively affected by rains.

If overseas, is a 6-day workweek permitted

☐ Yes  ☐ No

**Travel anticipated:** List international and local travel anticipated by what team members.

**LOGISTICS**

*Note:* Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access
   Specify who will require Facility Access: ________________________________

☐ Electronic County Clearance (ECC) (International travelers only)
☐ GH Pro workspace
Specify who will require workspace at GH Pro: __________________________________________

☐ Travel - other than posting (specify): __________________________________________
☐ Other (specify): __________________________________________

GH PRO ROLES AND RESPONSIBILITIES
GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting the report, editing for 508 compliance (accessible to people with disabilities) required, submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

**Before Field Work**
- SOW
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

**During Field Work**
- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders, as needed.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.
**ANALYTIC REPORT**

**Stage 1: Midterm Evaluation Report**
A midterm evaluation report not exceeding 15 pages (excluding the executive summary and any annexes)

A final complete report (1 unbound and 10 bound copies, multi-color) not exceeding 50 pages of main body (excluding an additional executive summary targeted to policy makers and any annexes), for final review and feedback to USAID/Zambia and DFID. The final report should be submitted in English, in both hard copy and using electronic media (CD ROM or thumb-drive) in MS Word/Excel/PowerPoint format. All reports must include survey tools as an annex. Where quantitative methods are used, the final, cleaned dataset will also be submitted.

The final report must be clear and grammatically correct. A final version of the report must be submitted to USAID/Zambia in hard copy as well as electronically and should abide with USAID’s branding and marking guideline, available online at [http://www.usaid.gov/branding](http://www.usaid.gov/branding). The report must be co-branded with USAID and DFID logos. The report format must be restricted to Microsoft products (MS Word, MS Excel, MS PowerPoint) and 12-point standard type font should be used throughout the body of the reports, with page margins 1” top/bottom and left/right.

All copyright of the outputs will belong to DFID Zambia and USAID/Zambia.

**Stage 2: Final Evaluation Report**
A final complete report (1 unbound and 10 bound copies, multi-color) not exceeding 50 pages of main body (excluding an additional executive summary targeted to policy makers and any annexes), for final review and feedback to USAID/Zambia and DFID. The final report should be submitted in English, in both hard copy and using electronic media (CD ROM or thumb-drive) in MS Word/Excel/PowerPoint format. All reports must include survey tools as an annex. Where quantitative methods are used, the final, cleaned dataset and other relevant support documents including data code books or data dictionaries MUST also be submitted. The evaluation team should liaise closely with USAID/Zambia to ensure datasets submitted are open and machine readable in appropriate format (CSV, XLS or JSON).

The final report must be clear and grammatically correct. A final version of the report must be submitted to USAID/Zambia in hard copy as well as electronically and should abide with USAID’s branding and marking guideline, available online at [http://www.usaid.gov/branding](http://www.usaid.gov/branding). The report must be co-branded with USAID and DFID logos. The report format must be restricted to Microsoft products (MS Word, MS Excel, MS PowerPoint) and 12-point standard type font should be used throughout the body of the reports, with page margins 1” top/bottom and left/right.

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](http://www.usaid.gov/branding) and Checklist for Assessing USAID Evaluation Reports.

All copyright of the outputs will belong to DFID Zambia and USAID/Zambia.
Evaluation Management

All consultants will be contracted through GH Pro.

Stakeholders in the evaluation include DFID, USAID, GRZ and STOP GBV Implementing Partners. DFID and USAID will set up a Reference Group comprising, at a minimum, representation from DFID, USAID, and GRZ (likely from MCDMCH and the MGCD). Final selection of the group will be done during the evaluation inception phase. The key responsibility of the Reference Group will be to ensure credibility and independence of the evaluation. The Evaluation Team Lead will serve as an honorary member of the Reference Group and will be expected to be available as necessary.

GH Pro will coordinate all evaluation work with the USAID Programme Manager, who will work in close collaboration with DFID-Zambia (Social Development Adviser) in the Human and Social Development Team. The Evaluation Team Lead will provide regular updates, as requested, to USAID/Zambia and/or DfID/Zambia.

USAID CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary Contact</th>
<th>Alternate Contact</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Chilemu</td>
<td>Josephat Kakoma</td>
<td>Jessica Healey</td>
<td>Project Development and Evaluation Specialist</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Capacity Development Advisor</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Population, Health and Nutrition Officer</td>
</tr>
<tr>
<td>USAID/Zambia</td>
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<td>100 Ibex Hill Road</td>
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<td>Lusaka, Zambia</td>
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<td>Lusaka, Zambia</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:kchilemu@usaid.gov">kchilemu@usaid.gov</a></td>
<td><a href="mailto:jjakoma@usaid.gov">jjakoma@usaid.gov</a></td>
<td><a href="mailto:jhealey@usaid.gov">jhealey@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>+260-211-357373</td>
<td>+260-211-357189</td>
<td>0211 357 000 ext. 7312</td>
</tr>
<tr>
<td>Cell Phone (optional)</td>
<td>+260-969-341-047</td>
<td>+260-969-341-076</td>
<td>(260) 969 341 055</td>
</tr>
</tbody>
</table>

List other contacts [OPTIONAL]

Cynthia Bowa cbowa@usaid.gov
Ky Lam klam@usaid.gov

REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above
Evaluation Design Matrix

This design matrix may be helpful for connecting your evaluation methods to questions. Often more than one method can be employed in an analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

*This Evaluation Matrix will be drafted by the Stage 1 Evaluation Team. GH Pro will provide guidance and examples.*

Stage 1 Evaluation Matrix

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Data Source/ Collection Methods</th>
<th>Sampling/ Selection Criteria</th>
<th>Data Analysis Method</th>
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Stage 2 Evaluation Matrix

<table>
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<th>Evaluation Questions</th>
<th>Data Source/ Collection Methods</th>
<th>Sampling/ Selection Criteria</th>
<th>Data Analysis Method</th>
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Attachment 1: Country Context

Gender-based violence is a serious problem in Zambia.

The prevalence of violence against women and girls is very high in Zambia. GBV is broadly defined to include spousal abuse, wife battery, sexual violence against women and children, property grabbing, economic and psychological abuse, family and child neglect, sexual cleansing, early marriage and harmful traditional practices. The 2007 Zambia Demographic and Health Survey (ZDHS) found that 47% of women and girls aged 15-49 had experienced physical violence and 20% had experienced sexual violence at some point in their life. Current or former partners were reported to be the perpetrators of 77% of physical violence and 64% of sexual violence. 15% of women had been sexually assaulted when they were aged 14 or younger and 20% when they were aged 15-19.

GBV prevalence in Zambia is higher than the global and regional average. Overall, 35% of women worldwide are estimated to have experienced either physical or sexual violence from a partner or non-partner sexual violence. Other sources of data on GBV in Zambia, including the MGCD 2011 Gender Status Report, GRZ 2006 GBV Survey Report and data from a 2013 survey in four districts in Zambia also indicate that prevalence of GBV is high. In the 2013 survey, 90% of women reported that they had experienced some form of GBV in their lifetime. Emotional abuse was the most common form of GBV. More than 80% of women had experienced abuse during pregnancy and 46% had experienced sexual violence. Rates of reported violence in these Zambian districts were higher than in other countries in the region, including Botswana and South Africa, where the same method of data collection has been used. The proportion of women who had experienced GBV from a partner during the previous 12 months was also very high. More than half of women had experienced some form of GBV, 42% had experienced emotional abuse, 32% economic abuse, 31% physical violence and 27% sexual violence. The survey also found that rape is commonplace: 29% of women had experienced non-partner rape in their lifetime, 10% had been raped in the previous 12 months, and 72% had experienced attempted rape in their lifetime.

Children are also vulnerable to violence, especially sexual abuse. Myths that sex with young virgins can cleanse the perpetrator of HIV have contributed to child rapes. Almost 50% of sexual assaults worldwide are against girls aged 15 and younger. Although data is limited, there is evidence that boys as well as girls are at risk of sexual and physical abuse. A global school-based survey found that 31% of girls and 30% of boys aged 13-15 in Zambia had been forced to have sex. In the 2013 survey cited above, 25% of women and 16% of men reported that they had had sex before the age of 18 because they were threatened or forced. The survey findings also suggest that there is a link between experience of physical or sexual abuse as a boy and perpetration of violence towards a partner and of rape as adult men.

Zambia has one of the highest rates of child marriage in the world. Child marriage, which is a form of GBV, discriminates against girls, violates their basic rights and limits their educational and employment opportunities. In

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6 The terms gender-based violence (GBV) and violence against women and girls (VAWG) are often used interchangeably. However, these concepts have different definitions. GBV relates to both women and men. In its National Plan of Action on GBV, the Government of the Republic of Zambia (GRZ) defines GBV as ‘any harmful act that is perpetrated against a person’s will and that is based on socially ascribed gender differences between males and females’. VAWG is understood to mean ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life’. For the purposes of this business case, which reflects a broad-based intervention that includes engaging with men and boys and is based on scale-up of an existing GBV programme, the term GBV is used.

7 UNICEF and Gender Links. The gender-based violence indicators research project in Kitwe, Kasama, Mansa and Mazabuka districts of Zambia. September 2013.

8 USAID. 2012. Preventing and responding to violence against women and girls globally.

Zambia, statutory law defines child marriage as marriage below the age of 18 (in the Anti-GBV Act 2011 a child is defined as a person below the age of 16). However, according to the 2007 ZDHS, two in five girls are married before they are 18, and there has been little change since the 2002 ZDHS. Child marriage occurs more frequently among girls who live in rural areas: in 2007, women aged 20-24 in rural areas were twice as likely to have married before age 18 than their urban counterparts. This is reflected in provincial differences in the prevalence of early marriage, which ranges from 60% in Eastern Province to 28% in Lusaka Province.

Child marriage is also strongly associated with poverty and lack of education. Girls from the poorest 20% of households are five times more likely to be married before age 18 than girls from the richest 20% of households. Child marriages often involve an exchange of money and assets that benefits the girl’s family. In her husband’s household, the girl becomes an important source of labour in addition to bearing children. Approximately 65% of women aged 20-24 with no education and 58% with primary education are married at age 18, compared with only 17% of women with secondary education or higher. Child marriage is also supported by culture, tradition and social norms, including customary law which, in rural areas, often takes precedence over statutory law.

Wider gender inequalities increase vulnerability to GBV and early child marriage in Zambia

Gender discrimination and inequality affect all aspects of women’s and girl’s lives. Zambia ranked 124 out of 137 countries on the 2011 Gender Inequality Index with a score of 0.627. Women have lower status than men and are less likely to participate in national and local politics and decision making. Only 19 of Zambia’s 287 traditional leaders are women. 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.

Social and cultural norms legitimise male power and control of women and girls. Deeply entrenched social and cultural norms underpin gender inequality and discrimination, and GBV, in Zambia. This was confirmed by the findings of the 2012 Nationwide Gender Perception Survey. Women are regarded as subordinate to men, have little voice and autonomy, and little or no status within communities. The 2011 Gender Sector Analysis noted that women are taught not to speak in the presence of men including their husbands. Surveys suggest that both men and women accept or condone GBV as normal. Women and girls also have little scope to negotiate sexual relationships. 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, although this is closely associated with GBV. The 2013 survey in four districts found that perpetrators often committed acts of violence against women when intoxicated and a higher proportion of women whose partners drank alcohol had experienced violence.

10 The Gender Inequality Index is a combined measure of maternal mortality, adolescent fertility, educational attainment, female representation in parliament, and female participation in the labour market; it ranges from 0 which means that men and women are equally treated to 1 which means women fare poorly with respect to equality.
### Attachment 2: VAWG Theory of Change – Key Principles of the Programme

<table>
<thead>
<tr>
<th>Key principle</th>
<th>How addressed in the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Context is critical:</strong> successful interventions are those that are tailored and based on rigorous analysis of the particular factors affecting violence against women and girls in a specific context, including setting, form of violence and population affected by the violence.</td>
<td>This intervention, including provision of services for GBV survivors and GBV and ECM prevention and advocacy activities will be tailored to the specific context. It will also contribute to the evidence base by funding additional studies and qualitative research and strengthening national data collection and reporting.</td>
</tr>
<tr>
<td><strong>2. The state has primary responsibility for action on violence against women and girls:</strong> national governments hold the ultimate responsibility for implementing laws, policies and services around violence against women and girls and can achieve change on violence against women and girls.</td>
<td>This intervention will promote sustainability through working in partnership with local government to ensure that services are managed by government after the end of the programme timeframe, and will support the leadership role of MCTA on ending child marriage. DFID Zambia is providing separate support to the MGCD to implement national laws and policies, including the Anti-GBV Act, and to strengthen its capacity to provide leadership of action on GBV.</td>
</tr>
<tr>
<td><strong>3. Holistic and multi-sectoral approaches are more likely to have impact:</strong> coordinated interventions operating at multiple levels, across sectors and over multiple timeframes are more likely to address the various aspects of and therefore have greater impact on tackling violence against women and girls.</td>
<td>This intervention involves coordinated interventions across sectors at district level complemented by national level support. DFID Zambia is funding a range of other sector programmes that will contribute to empowerment of women and reducing their vulnerability to GBV including education, health, livelihoods, governance and empowerment of adolescent girls.</td>
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<tr>
<td><strong>4. Social change makes the difference:</strong> sustained reduction in violence against women and girls will only occur through processes of significant social change, including in social norms, at all levels.</td>
<td>Social change, including in social norms, is the primary objective of the prevention and advocacy component of the STOP GBV programme and of the ECM campaign.</td>
</tr>
<tr>
<td><strong>5. Back lash is inevitable but manageable:</strong> resistance to tackling violence against women and girls, which may include increased risk of further violence against women and girls, is inevitable where root causes are being addressed but can, and should be, managed.</td>
<td>Enlisting the support of traditional, religious and community leaders will be critical to managing community resistance to tackling GBV and child marriage. Increasing awareness of the law and providing support to survivors and to ensure that perpetrators are prosecuted will also help to counter resistance.</td>
</tr>
<tr>
<td><strong>6. Women’s rights organisations create and sustain change:</strong> supporting these organisations, especially those working to tackle violence against women and girls, to make changes and build strong and inclusive social movements, is the most effective mechanism for ensuring sustainable change in the lives of women and girls.</td>
<td>WLSA is a women’s rights organisation. World Vision also works closely with women’s organisations. DFID Zambia is providing separate support for civil society organisations through its governance programme. Regional DFID funding is provided to women’s rights organisations such as Gender Links.</td>
</tr>
<tr>
<td><strong>7. Empowering women is both the means and the end:</strong> focusing on the rights of, and being accountable to, women and girls is the most effective way of tackling gender inequality as the root cause of violence against women and girls.</td>
<td>The prevention and advocacy and access to justice components of the STOP GBV programme and the ECM component of this intervention focus on increasing awareness of the rights of women and girls and ensuring that these rights are protected and promoted.</td>
</tr>
</tbody>
</table>
## Attachment 3: GBVSS One Stop Centres

<table>
<thead>
<tr>
<th>Centre</th>
<th>District</th>
<th>Province</th>
<th>Original</th>
<th>Scale up</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chongwe</td>
<td>Chongwe</td>
<td>Lusaka</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kafue</td>
<td>Kafue</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Lusaka</td>
<td>Lusaka</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katete</td>
<td>Katete</td>
<td>Eastern</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nyimba</td>
<td>Nyimba</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Choma</td>
<td>Choma</td>
<td>Southern</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Kalomo</td>
<td>Kalomo</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Monze</td>
<td>Monze</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Kapiri Mposhi</td>
<td>Kapiri Mposhi</td>
<td>Central</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Chibombo</td>
<td>Chibombo</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mumbwa</td>
<td>Mumbwa</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mongu</td>
<td>Mongu</td>
<td>Western</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Nakonde</td>
<td>Nakonde</td>
<td>Muchinga</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Mpika</td>
<td>Mpika</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Chingola</td>
<td>Chingola</td>
<td>Copper Belt</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Luanshya</td>
<td>Luanshya</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

Zambia has 10 provinces and the STOP GBV programme has One Stop Centres in seven of the ten provinces. Northern Province, North Western Province and Luapula Province are not covered within the programme.

Please note that all the One Stop Centres are accessible all year round; however, some parts of some districts may not be accessible during rainy seasons.
Attachment 4: Map of Zambia

Provinces & Districts’ Boundaries of Zambia
ANNEX B: EVALUATION TEAM COMPOSITION

Team Leader and GBV Specialist (Jessica Menon) Responsibilities: (1) Provides overall management of evaluation team's activities in planning, fieldwork and data collection; (2) Develops data collection tools, protocols and supervises implementation—IDIs, FGDs; (3) Develops IRB submission materials; (4) Develops and provides training on data collection tools and safety/ethical protocols; (5) Provides technical guidance on analysis of cost data; (6) Conducts quantitative analysis of M&E program data; (7) Conducts analysis and writing for draft evaluation report; (8) Ensures that all deliverables, including the final reports, are of good quality and are completed in a timely manner; (9) Serves as a liaison between the mission and the evaluation team; (10) Leads briefings and presentations.

GBV Technical Assistant (Tasila Mbewe) Responsibilities: (1) Serves as a key member of the evaluation team and conducts/supervises IDIs, FGDs; (2) Provides input into draft evaluation report; (3) Reviews comments from GH Pro and contributes to preparation of final draft report; (4) Attends briefing/presentation of final report to the mission.

Evaluation Specialist (Oscar Mutinda) Responsibilities: (1) Serves as a member of the evaluation team and on-the-ground project manager; (2) Provides quality assurance in the field on issues related to evaluation implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis; (3) Prepares materials for IRB submission and follow-up on the IRB approval; (4) Liaises between the evaluation team and the team leader.

Costing Specialist (Kasubika Chibuye) Responsibilities: (1) Serves as a member of the evaluation team; (2) Provides technical expertise on program costing, efficiencies and other needed economic analyses; (3) Develops data collection tools for gathering cost-related data; (4) Conducts fieldwork to collect cost data; (5) Analyzes and writes cost and economic analysis for integration in overall analysis; (6) Assists in training on tools for field staff; (7) Conducts IDIs with partners; (8) Provides written data output on ongoing basis from stakeholder interviews with written notes and review with other team members; (9) Provides input of costing data analysis into draft of qualitative evaluation report; (10) Reviews comments from GH Pro and provides revisions for final draft report; (11) Attends briefing/presentation of final report to the mission.

Field Manager & Logistics (Eugene Wafula) Responsibilities: (1) Coordinates all fieldwork and makes all logistical arrangements; (2) Serves as overall administrative manager of the project and ensures the evaluation is running smoothly; (3) Organizes funds for transport, allowances, communication and accommodation (where required).

Qualitative Moderator Teams: (10 total moderators, 70 percent female): Five teams were composed of six members: two moderators/note-takers, one supervisor and three recruiters. Responsibilities: (1) Conduct in-depth interviews and focus group discussions per training received to utilize data collection tools following safety and ethical guidelines; (2) Record discussions/interviews; (3) Document/request signature for informed consent of interviewees; (3) Provide written and transcribed notes, typed, in English, to team leader.
## ANNEX C: STOP GBV THEORY OF CHANGE

<table>
<thead>
<tr>
<th>Key principle</th>
<th>How addressed in the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Context is critical:</strong> successful interventions are those that are tailored and based on rigorous analysis of the particular factors affecting violence against women and girls in a specific context, including setting, form of violence and population affected by the violence.</td>
<td>This intervention, including provision of services for GBV survivors and GBV and ECM prevention and advocacy activities will be tailored to the specific context. It will also contribute to the evidence base by funding additional studies and qualitative research and strengthening national data collection and reporting.</td>
</tr>
<tr>
<td><strong>2. The state has primary responsibility for action on violence against women and girls:</strong> national governments hold the ultimate responsibility for implementing laws, policies and services around violence against women and girls and can achieve change on violence against women and girls.</td>
<td>This intervention will promote sustainability through working in partnership with local government to ensure that services are managed by government after the end of the programme timeframe, and will support the leadership role of MCTA on ending child marriage. DFID Zambia is providing separate support to the MGCD to implement national laws and policies, including the Anti-GBV Act, and to strengthen its capacity to provide leadership of action on GBV.</td>
</tr>
<tr>
<td><strong>3. Holistic and multi-sectoral approaches are more likely to have impact:</strong> coordinated interventions operating at multiple levels, across sectors and over multiple timeframes are more likely to address the various aspects of and therefore have greater impact on tackling violence against women and girls.</td>
<td>This intervention involves coordinated interventions across sectors at district level complemented by national level support. DFID Zambia is funding a range of other sector programmes that will contribute to empowerment of women and reducing their vulnerability to GBV including education, health, livelihoods, governance and empowerment of adolescent girls.</td>
</tr>
<tr>
<td><strong>4. Social change makes the difference:</strong> sustained reduction in violence against women and girls will only occur through processes of significant social change, including in social norms, at all levels.</td>
<td>Social change, including in social norms, is the primary objective of the prevention and advocacy component of the STOP GBV programme and of the ECM campaign.</td>
</tr>
<tr>
<td><strong>5. Back lash is inevitable but manageable:</strong> resistance to tackling violence against women and girls, which may include increased risk of further violence against women and girls, is inevitable where root causes are being addressed but can, and should be, managed.</td>
<td>Enlisting the support of traditional, religious and community leaders will be critical to managing community resistance to tackling GBV and child marriage. Increasing awareness of the law and providing support to survivors and to ensure that perpetrators are prosecuted will also help to counter resistance.</td>
</tr>
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<td><strong>6. Women’s rights organisations create and sustain change:</strong> supporting these organisations, especially those working to tackle violence against women and girls, to make changes and build strong and inclusive social movements, is the most effective mechanism for ensuring sustainable change in the lives of women and girls.</td>
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ANNEX D: GBV DEFINITIONS USED BY PROJECT

**USAID:** The U.S. GBV Strategy to Respond to and Prevent GBV Globally\(^ {11}\) defines “gender-based violence” as violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. Gender-based violence takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, “honor” killings, and female genital mutilation/cutting. Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms “violence against women” and “gender-based violence” are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional or financial power and control.

**Zambia Anti-GBV Act (2011):** GBV is broadly defined as “any physical, mental, social or economic abuse against a person because of that person’s gender,” and includes: “violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to the person, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life; and actual or threatened physical, mental, social or economic abuse that occurs in a domestic relationship.”

**United Nations:** The United Nations\(^ {13}\) defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. The term “gender-based violence” refers to violence that targets individuals or groups on the basis of their gender. The United Nations’ Office of the High Commissioner for Human Rights’ Committee on the Elimination of Discrimination against Women (CEDAW) defines it as “violence that is directed against a woman because she is a woman or that affects women disproportionately,” in its General Recommendation 19. This includes acts that inflict physical, mental or sexual harm or suffering, the threat of such acts, coercion and other deprivations of liberty. Together with “sexual violence” and “violence against women,” “gender-based violence” is used interchangeably. This does not mean that all acts against a woman are gender-based violence, or that all victims of gender-based violence are female. The surrounding circumstances where men are victims of sexual violence could be men being harassed, beaten or killed because they do not conform to the view of masculinity that is accepted by the society.

**GBV-IMS:** The UN Population Fund (UNFPA), the International Rescue Committee (IRC), and the UN High Commissioner for Refugees (UNHCR) developed a GBV classification tool strictly for the purposes of standardizing GBV data collection across GBV service providers. This was done explicitly to address the problem of the inability to collect, classify and analyze GBV-related information in a way that produces comparable statistics internationally. The criteria used to generate the classification tool’s six types of GBV are: (1) universally recognized forms of gender-based violence; (2) mutually exclusive (they do not overlap); (3) focused on the specific act of

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\(^ {11}\) United States Strategy to Prevent and Respond to Gender-Based Violence Globally is accessible at: http://www.state.gov/documents/organization/196468.pdf

\(^ {12}\) Zambia Anti-GBV Act is accessible at: http://www.zambialii.org/zm/legislation/act/2011/1

\(^ {13}\) United Nations definition is accessible at: http://www.who.int/topics/gender_based_violence/en/
violence, separate from the motivation behind it or the context in which it was perpetrated; and (4) each of the definitions below refers to the concept of consent, use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception or misrepresentation.

Six core GBV types were created for data collection and statistical analysis. They should be used only in reference to GBV even though some may be applicable to other forms of violence that are not gender-based:

1. **Rape**: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

2. **Sexual Assault**: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.

3. **Physical Assault**: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.

4. **Forced Marriage**: the marriage of an individual against her or his will.

5. **Denial of Resources, Opportunities or Services**: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

6. **Psychological/Emotional Abuse**: infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

Note: The STOP GBV Baseline Assessment (March 2015) utilized the GBV-IMS definition, adopting the six types of GBV as categories in the survey questionnaire in both the ‘Knowledge and Perception’ and ‘Experiences’ inquiries, adopting them slightly by adding sub-categories from standard DHS templates. For example, the ‘rape’ category included components on cultural rites (including sexual cleansing), marital rape and defilement (among others) while the ‘psychological and emotional abuse’ category included elements relating to the threat of physical violence, threat of sexual violence, forced isolation, and unwanted attention/stalking.
ANNEX E: WORLD VISION PMP INDICATORS

The following PMP Indicators are extracted directly from the draft GBVSS PMP provided to the evaluation team by WVZ in July 2015. This was extracted from a draft updated PMP that has not yet been finalized or approved. Please see Annex 1, Scope of Work, for project results frameworks.
Survivor Support Services M&E Matrix

Key performance indicators and expected outcomes of the GBVSS program are listed in the table below. Where appropriate, data will be disaggregated by sex, age group (<18 years, 18+ years) and district. These indicators have been drawn from PEPFAR, GBV national action plan and project performance monitoring plans.

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Type</th>
<th>Ref.</th>
<th>Indicator</th>
<th>Definition &amp; Unit of Measurement</th>
<th>Responsibility</th>
<th>Baseline/Cumulative total/LOP Target</th>
<th>Assumptions / Limitations</th>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Output</td>
<td>SITE _SUPP.</td>
<td>Number of PEPFAR-supported direct service delivery (DSD) and technical assistance (TA) sites</td>
<td>DSD sites: include centers that are provided with permanent staff, material (equipment, office supplies, etc.)&lt;br&gt;TA sites: include centers that are provided with policy and operations guidelines and periodic staff expertise&lt;br&gt;Other facilities: Existing or community facilities established or supported by the GBVSS project (shelters or safe houses, food banks, etc.) that receive material and technical support from the GBVSS project&lt;br&gt;Disaggregated by:&lt;br&gt;• Type (DSD, TA sites)&lt;br&gt;• Lead organization of OSC&lt;br&gt;• Service provided&lt;br&gt;• Type of support</td>
<td>WV</td>
<td>Baseline 2012: 0&lt;br&gt;2013: 2014: 8&lt;br&gt;2015: 16&lt;br&gt;2016: LOP: 16&lt;br&gt;(This indicator replaced indicators 1 &amp; 7 in the original PMP in line with the MER generation of indicators; LOP target was revised from 10 to 16 due to increased scope of project in 2014)</td>
<td>GRZ supports the establishment of sites</td>
<td>Project Reports</td>
<td>Annually</td>
</tr>
<tr>
<td>No.</td>
<td>Indicator Type</td>
<td>Ref.</td>
<td>Indicator</td>
<td>Definition &amp; Unit of Measurement</td>
<td>Responsibility</td>
<td>Baseline/ Cumulative total/ LOP Target</td>
<td>Assumptions / Limitations</td>
<td>Data Source</td>
<td>Frequency</td>
</tr>
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<td>-----------------</td>
</tr>
<tr>
<td>2</td>
<td>Output</td>
<td>GBVSS 1.1.4</td>
<td>Number of health care workers who successfully completed an in-service training program within the reporting period</td>
<td>In-service training: includes training for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Disaggregated by: • Sex of trainees • Entity of employment of trainees • Workstation of trainees • National vs. sub-national level of work of the trainee • Type of training</td>
<td>WV, MOH</td>
<td>Baseline 2012: 0 2013: 71 2014: 150 2015: 150 2016: LOP balance: 250 LOP: 400 (LOP target was revised upwards in 2013 from 90 due to realization of the need to train more health workers in multidisciplinary management of GBV)</td>
<td>Training reports</td>
<td>Semiannually</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Output</td>
<td>GBVSS 1.1.2</td>
<td># of community health and para-social workers who successfully completed a pre-service training program</td>
<td>Pre-service training: includes training for para-social workers (VSU, OSC, hotline, shelter, lay counselors and safe house staff) from a few days of training up to 6 months using the standard package of multidisciplinary training curriculum developed by GRZ. Lay counselors will trained and certified by the Zambia Counseling Council Disaggregated by: • Workstation of staff • Type of training • Paid/unpaid worker • Sex of trainees • Entity of employment of trainees</td>
<td>WV, ECR and FAWEZ A</td>
<td>Baseline 2012: 0 2013: 288 2014: 602 2015: 75 2016: LOP balance: 142 LOP: 744 (LOP target was revised upwards from 620 due to increase in project scope and number of OSC 2014)</td>
<td>GBV is integrated in training curricula</td>
<td>Training reports</td>
<td>Semiannually</td>
</tr>
<tr>
<td>4</td>
<td>Output</td>
<td>GBVSS 1.1.5</td>
<td>% of OSC counselors certified in VCT</td>
<td>Counselors will be considered certified if they have a valid practicing license obtained</td>
<td>WV, ECR</td>
<td>Baseline 2012: 0 2013: 2014: 100%</td>
<td>Counselor certificates</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Indicator Type</td>
<td>Ref.</td>
<td>Indicator</td>
<td>Definition &amp; Unit of Measurement</td>
<td>Responsibility</td>
<td>Baseline/ Cumulative total/ LOP Target</td>
<td>Assumptions / Limitations</td>
<td>Data Source</td>
<td>Frequency</td>
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</tr>
<tr>
<td>5</td>
<td>Output</td>
<td>HTC_TST #:</td>
<td>Number of individuals who received HIV testing and counseling (HTC) services for HIV and received their test results</td>
<td>All GBV and non-GBV survivors visiting an OSC are willing to access HTC services. SGBV survivors will be specifically targeted.</td>
<td>WV, ECR</td>
<td>Baseline 2012: 0 2013: 3,862 2014: 4,875 2015: 500 2016: LOP: 17,875</td>
<td>Increased demand creation for counseling and testing</td>
<td>Project reports</td>
<td>Quarterly</td>
</tr>
<tr>
<td>6</td>
<td>Output</td>
<td></td>
<td>% of people provided with HIV post-exposure prophylaxis</td>
<td>Survivors of SGBV will receive post-exposure prophylaxis within 72 hours of possible exposure to the HIV virus through penetrative sexual intercourse and any source of exposure resulting from GBV.</td>
<td>WV, ECR</td>
<td>Baseline 2012: 0 2013: 141 2014: 343 2015: 500 2016: LOP balance: 3,150</td>
<td>Survivors reporting within 72 hours of exposure to HIV</td>
<td>OSC reports</td>
<td>Semiannually</td>
</tr>
<tr>
<td>7</td>
<td>Output</td>
<td>GBVSS 1.1.7</td>
<td># of VSU (and police) staff that are trained in</td>
<td>Disaggregated by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Note:** Disaggregate by:
- Workstation/District
- Sex
- Age
- Test result
- Site (i.e. static vs. mobile)
- Exposure type (rape, defilement, incest, etc.)
<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Type</th>
<th>Ref.</th>
<th>Indicator</th>
<th>Definition &amp; Unit of Measurement</th>
<th>Responsibility</th>
<th>Baseline/Cumulative total/LOP Target</th>
<th>Assumptions / Limitations</th>
<th>Data Source</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| 8   | Output         | GEND _GBV: | Number of people receiving post-GBV care | Post-GBV care: includes all care and support services provided to survivors of GBV  
  * Disaggregated by:  
  • Sex  
  • Age  
  • Type of GBV  
  • Type of support received  
  • District/site | 2016:  
  LOP: 100  
  (WV stopped implementing and tracking these indicators. They being tracked by WLSA as they fall within its mandate.) | Baseline 2012: 0  
  2013: 9,504  
  2014: 13,948  
  2015: 17,000  
  2016:  
  LOP: 51,300  
  (This indicator was revised from indicators # 9, 10 in the original PMP in line with MER generation of indicators in 2014. LOP target was revised from 31,500 in 2014 following the addition of 8 new OSCs from the initially approved in July 2014) | Increased awareness of post-GBV care services | Project M&E data collection tools, program reports | Semiannually |
| 9   | Outcome        |        | % of survivors who report satisfaction with services provided in all project sites | Satisfaction: perceived level of contentment with the quality of GBV survivor support services received by survivors and/or their escorts | WV, ECR | Baseline 2012: 0  
  2013:  
  2014:  
  2015:  
  2016: | All necessary staff are placed in one-stop centers | Client satisfaction survey report | Semiannually |
<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Type</th>
<th>Ref.</th>
<th>Indicator</th>
<th>Definition &amp; Unit of Measurement</th>
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<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Output</td>
<td></td>
<td>Number of targeted health training institutions that have integrated or mainstreamed GBV in the training curricula</td>
<td>Disaggregated by: • OSC Center • Construct • Type of site (G2G, WV, CCR)</td>
<td>WV, UTH</td>
<td>Baseline 2012: 0 2013: 0 2014: 0 2015: 44 2016: LOP Balance: 0 LOP: 44 (LOP targets revised to track individual training institutions rather than training coordinating bodies for nursing schools)</td>
<td>Health training institutions willing to mainstream GBV in their curricula</td>
<td>Key informant interview, document review for the targeted medical schools and training records from medical institutions</td>
<td>Annually starting from year 3</td>
</tr>
<tr>
<td>11</td>
<td>Output</td>
<td></td>
<td>% of GBV survivors referred to relevant services</td>
<td>Referral: includes receiving relevant services (police, legal services, health care providers, safety and security, education and economic empowerment) and providing valid feedback to the referrer. Disaggregated by: • Age • Sex • Type of service received Internal vs. external referral</td>
<td>WV, ECR, FAWEZ A</td>
<td>Baseline 2012: 0 2013: 0 2014: 38% 2015: 60% 2016: LOP: 60%</td>
<td>All necessary referrals services are available</td>
<td>Project M&amp;E data collection tools, program reports</td>
<td>Quarterly</td>
</tr>
<tr>
<td>13</td>
<td>Outcome</td>
<td>GBVSS: 2.1.1-2</td>
<td>National and district-level GBV coordinating body facilitates linkages between referral partners</td>
<td>Facilitation: includes the national and district coordination body (Ministry of Gender and Child Development) coordinating meetings and making available the directory of mapped</td>
<td>WV, ECR, USAID primes, MOGCD</td>
<td>Baseline 2012: 0 2013: Milestones achieved • National, district and project</td>
<td>Meeting minutes, service mapping report and</td>
<td>Meetiing minutes, service mapping report and</td>
<td>Semiannually</td>
</tr>
<tr>
<td>No.</td>
<td>Indicator Type</td>
<td>Ref.</td>
<td>Indicator</td>
<td>Definition &amp; Unit of Measurement</td>
<td>Responsibility</td>
<td>Baseline/ Cumulative total/ LOP Target</td>
<td>Assumptions / Limitations</td>
<td>Data Source</td>
<td>Frequency</td>
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</tr>
<tr>
<td>14</td>
<td>Output</td>
<td>GBVSS 2.2.1</td>
<td>Number of men's networks with the capacity to identify and address GBV</td>
<td>Capacity to identify and address GBV refers to being trained on masculinities &amp; GBV, and the competency of primes.</td>
<td>WV, local primes</td>
<td>Baseline 2012: 0 2013: 0 2014: 12 2015: 11 2016: 0</td>
<td>Relevant GRZ agencies’ support</td>
<td>Database reports, training reports</td>
<td>Annually</td>
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<td>Relevant GRZ agencies’ support</td>
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<td></td>
<td>Database reports, training reports</td>
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<tr>
<td>15</td>
<td>Output</td>
<td></td>
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<td></td>
<td></td>
<td>Training reports, campaign documentation</td>
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</tr>
</tbody>
</table>

Implementation milestones will include:
- Coordination strategy developed
- National coordination meeting held quarterly
- Project-level coordination
- District-level coordination meeting held quarterly

Coordination guidelines developed
- Project-level technical working group formed
- One national coordination meeting held
- 2 project-level technical working group meetings held

2014: Milestones achieved
2015: Milestones achieved
2016: Milestones achieved

LOP: 8 meetings held semiannually

Database developed and used:
- Data from database used for monitoring of national implementation, improvement of GBV program, or planning of future programs. Milestones include:
  - Harmonization of GBV definitions and concepts
  - Adaptation of GBVIMS tools
  - Adaptation of GBV information management system
  - Roll out of GBVIMS
  - Use of GBVIMS to monitor and report on GBV

Baseline 2012: Non-existent
2013: Non-existent
2014: Milestones accomplished: GBV definitions and concepts harmonized
2015: Milestones accomplished: GBVIMS tools adapted
2016: LOP: Database developed and used to monitor and report on GBV

Directory of services
<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Type</th>
<th>Ref.</th>
<th>Indicator</th>
<th>Definition &amp; Unit of Measurement</th>
<th>Responsibility</th>
<th>Baseline/ Cumulative total/ LOP Target</th>
<th>Assumptions / Limitations</th>
<th>Data Source</th>
<th>Frequency</th>
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</tr>
<tr>
<td>16</td>
<td>Output</td>
<td>GBVSS 2.2.2</td>
<td># of survivors networks established</td>
<td>these networks to raise awareness on gender norms. Disaggregated by: • District</td>
<td>LOP: 16 The LOP target was revised to 16 in 2014 due to the increase in the number of OSCs. It was overachieved due to demand. The project will no longer track this indicator as the responsibility has been shifted to ZCCP in April 2015.</td>
<td>Baseline 2012: 0 2013: 2014: 14 2015: 12 2016: LOP: 64 (this was revised upwards from 20 due to change in scope and number of OSCs)</td>
<td>Program reports</td>
<td>Semiannually</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td># of GBVSS primes provided with training and mentoring</td>
<td>Training: includes U.S. Government grant management, M&amp;E tools and systems, financial reporting and budgeting. Mentoring: refers to technical support in the above mentioned areas throughout the life of the project Disaggregated by: • Type of support • Partner</td>
<td>WV</td>
<td>Baseline 2012: 0 2013: 2014: 2 2015: 2 2016: LOP: 2</td>
<td>Training reports</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>GEND _ NOR M :</td>
<td>Number of people completing an intervention pertaining to gender norms, Minimum criteria: refers to completing 10 contact hours of exposure to standard behavior change communication on</td>
<td></td>
<td>SIA, WV</td>
<td>Baseline 2014: 0 2015: 14,720 2016: LOP: 47,160</td>
<td>Standard program monitoring tools, such as forms, log</td>
<td>Data should be collected continuously at the health facility level</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Indicator Type</td>
<td>Ref.</td>
<td>Indicator</td>
<td>Definition &amp; Unit of Measurement</td>
<td>Responsibility</td>
<td>Baseline/ Cumulative total/ LOP Target</td>
<td>Assumptions / Limitations</td>
<td>Data Source</td>
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<td></td>
<td></td>
<td>GBVSS 3.2</td>
<td>GBV prevention messages integrated into sports leagues</td>
<td>Integrated: Leagues that have sessions that cover messages on GBV Implementation milestones include: • Formative research completed • Implementation strategy completed • Training manual completed</td>
<td>Baseline: Non-existent 2013: Non-existent 2014: Non-existent 2015: Milestones accomplished LOP: GBV prevention messages integrated in</td>
<td>Project reports</td>
<td>Semiannually</td>
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</tbody>
</table>

Within the context of HIV, that meets minimum criteria. Disaggregated by: • Sex • Target audience • District

Books, spreadsheets and databases that partners develop or already use and/or community level, including in a variety of venues such as schools, workplace, and community organizations. Data analysis and review should be done quarterly to monitor progress towards achieving the targets, and to identify and correct any data quality issue.
<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator Type</th>
<th>Ref.</th>
<th>Indicator</th>
<th>Definition &amp; Unit of Measurement</th>
<th>Responsibility</th>
<th>Baseline/Cumulative total/LOP Target</th>
<th>Assumptions / Limitations</th>
<th>Data Source</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Manual with GBV prevention messages used</td>
<td>Sports leagues in the target project areas</td>
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<td></td>
<td>Manual with GBV prevention messages used</td>
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<td></td>
<td>Monitoring and evaluation of intervention</td>
<td></td>
<td>Disaggregated by: District</td>
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</tbody>
</table>

MIDTERM EVALUATION OF STOP GBV ZAMBIA
ANNEX F: WLSA PMP INDICATORS

The following results framework and PMP indicators are extracted directly from the PMP provided to the evaluation team by USAID in May 2015. Please see Annex 1, Scope of Work, for project results frameworks.
## ACCESS TO JUSTICE INDICATOR DEFINITIONS AND DATA COLLECTION PLAN

The table below provides a definition for each project indicator and the data collection plan.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Operational definition</th>
<th>Indicator type</th>
<th>Disaggregation by</th>
<th>Source of data</th>
<th>Method of data collection</th>
<th>Data analysis</th>
<th>Responsible</th>
<th>Data collection frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>Number of judges,</td>
<td>Quantitative</td>
<td>Sex Age Geographical location</td>
<td>Attendance register/Training report</td>
<td>Training Focus group discussions</td>
<td>Pre-test and post-test questionnaires</td>
<td>Program manager M&amp;E officer</td>
<td>Annually</td>
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<td></td>
<td>magistrates, prosecutors, lawyers, police officers and traditional leaders trained on GBV laws and issues</td>
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<td>lawyers, police officers</td>
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<td>and traditional leaders</td>
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<td>trained on GBV laws and issues</td>
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<tr>
<td>1.1.2</td>
<td>Number of cases of</td>
<td>Quantitative</td>
<td>Sex Age Geographical location Education levels No. of household Income at household level</td>
<td>Case record data sheet</td>
<td>Interviews with client Observation</td>
<td>Coding of the clients that are attended to and tallying at the end of the day</td>
<td>Field coordinators</td>
<td>Weekly</td>
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<tr>
<td>GBV</td>
<td>GBV adjudicated per annum</td>
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<td>Cases that have been</td>
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<td>in the courts</td>
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<tr>
<td>1.1.3</td>
<td>Number of GBV cases</td>
<td>Quantitative</td>
<td>Sex Age Educational levels Household income level Geographical location</td>
<td>Case record data sheet Court case records</td>
<td>Interviews with client Observation</td>
<td>Coding of the clients that are attended to and tallying at the end of the day</td>
<td>Field coordinators</td>
<td>Monthly</td>
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<tr>
<td>taken to court</td>
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<td>Cases that are currently before the courts of law</td>
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<tr>
<td>1.1.4</td>
<td>Number of GBV</td>
<td>Quantitative</td>
<td>Sex Age Educational levels Household income level Geographical location</td>
<td>Client’s case record data sheet</td>
<td>Interviews with clients</td>
<td>Observations and analysis of the client database</td>
<td>Program manager M&amp;E officer</td>
<td>Monthly</td>
</tr>
<tr>
<td>survivors receiving legal advice</td>
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<td>GBV survivors who are</td>
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<td>legal advice</td>
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<tr>
<td>1.1.5</td>
<td>Number of key actions</td>
<td>Qualitative</td>
<td>Geographical location Name of institution Position of respondent</td>
<td>Reports from training workshops Action plans from service providers</td>
<td>Consultative meetings Follow-up meetings</td>
<td>Analysis of training reports and minutes from meetings</td>
<td>Program manager M&amp;E officer Field coordinators</td>
<td>Monthly</td>
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<tr>
<td>taken by policymakers to address GBV</td>
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<td>GBV and mainstream it</td>
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<td>in their work</td>
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</tbody>
</table>
### 1R 2.1. Design and production of curriculum and training materials

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Description</th>
<th>Methodology</th>
<th>Data Collection</th>
<th>Analysis of Training Reports and Minutes from Meetings</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Number of training materials developed</td>
<td>The different training materials developed for use during the training.</td>
<td>Quantitative</td>
<td>Name of institution Geographical location</td>
<td>Program reports Minutes of meetings</td>
<td>Program manager M&amp;E officer</td>
</tr>
<tr>
<td>2.1.2 Number of curricula developed</td>
<td>Training institutions that have been engendered by WLSA.</td>
<td>Quantitative</td>
<td>Name of institution Geographical location</td>
<td>Program reports Minutes of meetings</td>
<td>Program manager M&amp;E officer</td>
</tr>
</tbody>
</table>

### 1R 3.1 Training of service providers

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Description</th>
<th>Methodology</th>
<th>Data Collection</th>
<th>Analysis of Training Reports and Minutes from Meetings</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Number of police officers trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
<tr>
<td>3.1.2 Number of court officials trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
<tr>
<td>3.1.3 Number of legal practitioners trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
<tr>
<td>3.1.4 Number of social workers trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
<tr>
<td>3.1.5 Number of health workers trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
<tr>
<td>3.1.6 Number of paralegals trained</td>
<td></td>
<td>Quantitative</td>
<td>Name Sex Age Name of institution Position</td>
<td>Attendance register Training reports</td>
<td>Field coordinators Program manager</td>
</tr>
</tbody>
</table>

### 1R 4.1 Legal Aid representation and litigation
<table>
<thead>
<tr>
<th>4.1.1 Number of GBV cases referred to other service providers</th>
<th>Number of GBV cases that have been referred to other STOP GBV programs for specialized services</th>
<th>Quantitative Program-specific</th>
<th>Sex Age Geographical location Date Educational level Household income</th>
<th>Client data sheet Client referral sheets Program reports Data sheet entries on referral</th>
<th>Project reviews Consultative meetings with other GBV programs</th>
<th>Counting of all clients in reflected in the electronic referral system</th>
<th>Program manager M&amp;E person</th>
<th>Monthly and quarterly</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.2 Number of cases litigated</td>
<td>Quantitative program-specific</td>
<td>Sex Age Geographical location Date Educational level Household income</td>
<td>Client data sheet Client referral sheets Program reports Data sheet entries on referral</td>
<td>Project reviews Consultative meetings with other GBV programs</td>
<td>Counting of all clients in reflected in the electronic referral system</td>
<td>Program manager M&amp;E person Field coordinators</td>
<td>Monthly and quarterly</td>
<td></td>
</tr>
<tr>
<td>4.1.3 Number of cases prosecuted</td>
<td>Quantitative program-specific</td>
<td>Sex Age Geographical location Date Educational level Household income</td>
<td>Client data sheet Client referral sheets Program reports Data sheet entries on referral</td>
<td>Project reviews Consultative meetings with other GBV programs</td>
<td>Counting of all clients in reflected in the electronic referral system</td>
<td>Program manager M&amp;E person Field coordinators</td>
<td>Monthly and quarterly</td>
<td></td>
</tr>
<tr>
<td>4.1.4 Number of cooperative agreements with private sector law firms</td>
<td>Qualitative program-specific</td>
<td>Name of institution Geographical location</td>
<td>Project reports Evaluation reports</td>
<td>Project reviews Surveys Review of action plans</td>
<td>Counting of all agreements that have been made with private legal firms</td>
<td>Program manager</td>
<td>Quarterly Semiannual</td>
<td></td>
</tr>
</tbody>
</table>

**5.1 Institutionalizing Anti-GBV at relevant training institutions**

| 5.1.1 Number of training institutions whose curriculum has been developed and improved | Quantitative program-specific | Name of institution Geographical location | Project reports Evaluation reports | Project reviews Surveys Review of action plans | Counting of all agreements that have been made with private legal firms | Program manager | Quarterly Semiannual |
| 5.1.2 Number of curriculum developed | Quantitative program-specific | Name of institution Geographical location | Project reports Evaluation reports | Project reviews Surveys Review of action plans | Counting of all agreements that have been made with private legal firms | Program manager | Quarterly Semiannual |

**6.1 Lawmakers, police, courts and traditional leaders sensitized on GBV**
<table>
<thead>
<tr>
<th>6.1.1 Number of sensitization meetings conducted</th>
<th>Quantitative program-specific</th>
<th>Name of compound or village</th>
<th>Project report evaluations</th>
<th>Surveys</th>
<th>Project evaluation surveys</th>
<th>Reports for sensitization meetings</th>
<th>Documenting all sensitization meetings conducted</th>
<th>Program manager</th>
<th>Field coordinators</th>
<th>Quarterly and semiannual reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.2 Number of traditional leaders sensitized on GBV laws</td>
<td>Quantitative program-specific</td>
<td>Name of community Geographical location Sex and age</td>
<td>Project report evaluations</td>
<td>Surveys</td>
<td>Minutes from sensitization meetings</td>
<td>Count of how many sensitization meetings that have been conducted</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Quarterly and semiannual reports</td>
<td></td>
</tr>
<tr>
<td>6.1.2 Number of community leaders sensitized on GBV laws</td>
<td>Quantitative program-specific</td>
<td>Name of community Geographical location</td>
<td>Project report Evaluations Attendance register</td>
<td>Surveys</td>
<td>Minutes from sensitization meetings</td>
<td>Count of how many sensitization meetings that have been conducted</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Quarterly and semiannual reports</td>
<td></td>
</tr>
<tr>
<td>6.1.3 Number of constituency officers sensitized</td>
<td>Quantity program-specific</td>
<td>Name of community Geographical area</td>
<td>Project evaluation reports Attendance register</td>
<td>Surveys</td>
<td>Minutes from sensitization meetings</td>
<td>Count of how many sensitization meetings that have been conducted</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Quarterly and semiannual reports</td>
<td></td>
</tr>
<tr>
<td><strong>1R 7.1 Identification of challenges in the justice delivery system among service providers</strong></td>
<td></td>
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<tr>
<td>7.1.1 Baseline report produced and developed</td>
<td>Qualitative program-specific</td>
<td>Geographical location Name of community</td>
<td>Questionnaire interview guide</td>
<td>Surveys</td>
<td>Baseline report</td>
<td>Count number of questionnaires distributed and number of respondents</td>
<td>M&amp;E officer</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Semiannual reports</td>
</tr>
<tr>
<td>7.1.2 Number of service providers interviewed</td>
<td>Qualitative program-specific</td>
<td>Geographical location Name of community</td>
<td>Questionnaire interview guide</td>
<td>Surveys</td>
<td>Baseline report</td>
<td>Count number of questionnaires distributed and number of respondents</td>
<td>M&amp;E officer</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Semiannual reports</td>
</tr>
<tr>
<td>7.1.3 Number of questionnaires developed</td>
<td>Quantitative program-specific</td>
<td>Age Sex District Position Institution Profession</td>
<td>Questionnaire interview guide</td>
<td>Surveys</td>
<td>Baseline report</td>
<td>Count number of questionnaires distributed and number of respondents</td>
<td>M&amp;E officer</td>
<td>Program manager</td>
<td>Field coordinators</td>
<td>Semiannual reports</td>
</tr>
<tr>
<td><strong>1R 8.1 Coordination with other GBV programs strengthened</strong></td>
<td></td>
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<tr>
<td>8.1.1 Number of quarterly meetings conducted with Access to Justice Consortium</td>
<td>Quantitative program-specific</td>
<td>Name Organization Position</td>
<td>Minutes of meetings</td>
<td>Group discussion</td>
<td>Keep record of attendance register and record the attendance.</td>
<td>Program officer</td>
<td></td>
<td></td>
<td>Quarterly and semiannual reports</td>
<td></td>
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<tr>
<td>8.1.2 Number of high-profile cases discussed in the meetings</td>
<td>Cases that involve people of high standing in society</td>
<td>Quantitative program-specific</td>
<td>Name Organization Position Phone number Email address</td>
<td>Minutes of meetings Attendance register</td>
<td>Group discussion</td>
<td>Keep record of attendance register and record the attendance.</td>
<td>Program officer Field officer</td>
<td>Quarterly and semiannual reports</td>
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<tr>
<td>8.1.3 Number of high-profile cases documented</td>
<td>Cases that involve people of high standing in society</td>
<td>Quantitative program-specific</td>
<td>District Sex Age Educational background Socioeconomic status</td>
<td>Case record information Interviews with field coordinators Most significant change stories</td>
<td>Desk analysis Surveys</td>
<td>Analyze the information in the case records and in the MSC stories</td>
<td>Program officer Field Coordinators M&amp;E officers</td>
<td>Quarterly and semiannual reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IR 9.1 Coordination with survivor support program and other key players providing care and support for GBV survivors**

<table>
<thead>
<tr>
<th>9.1.1 Number of meetings held with prevention, advocacy and survivor support</th>
<th>Quantitative program-specific</th>
<th>Name Organization Position Phone number Email address</th>
<th>Minutes of meetings Attendance register</th>
<th>Group discussion</th>
<th>Keep record of attendance register and record the attendance</th>
<th>Program officer Field officer</th>
<th>Quarterly and semiannual</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1.2 Number of clients referred by survivor support linked to legal aid board providing legal aid services</td>
<td>Quantitative program-specific</td>
<td>Name District Sex Age Educational background Socioeconomic status</td>
<td>Case record register Electronic referral system</td>
<td>Electronic analysis and manual analysis of data</td>
<td>Data sheet entries Quarterly review meetings</td>
<td>Program officer Field officer</td>
<td>Quarterly and semiannual</td>
</tr>
</tbody>
</table>

**IR 10** Develop and continuously improve efficiency and effectiveness of referral system

| Quantitative and qualitative | Name District Sex Age Educational background Socioeconomic status | Case record register Electronic referral system | Electronic analysis and manual analysis of data | Data sheet entries Quarterly review meetings | Program officer Field officer | Quarterly and semiannual |
ANNEX G: ZCCP RESULTS FRAMEWORK AND PMP INDICATORS

The following PMP indicators are extracted directly from the PMP provided to the evaluation team by USAID in May 2015. Please see Annex 1, Scope of Work, for project results frameworks.
## ZCCP Project Output Indicators and Data Collection Plan

The table below illustrates the project indicators by data collection plan.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Indicator type</th>
<th>Disaggregation by</th>
<th>Source of data</th>
<th>Method for data collection</th>
<th>Data analysis</th>
<th>Responsible</th>
<th>Data collection frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IR 1.1: Outreach efforts against GBV expanded</strong></td>
<td>Program-specific</td>
<td>-Age (0-14, 15-24, 25+) -Sex (male and female) -District</td>
<td>-Formative research -Evaluation reports -Program report</td>
<td>-Focus group discussions, -In-depth interviews of key informants and individuals -Review of program activities</td>
<td>Calculation of proportions and counts of individuals reached with GBV messages. Furthermore, the analysis will yield information to help determine whether there are differences between individuals reached with GBV messages and those not reached.</td>
<td>-Program manager -M&amp;E officer -Program officers</td>
<td>Monthly Quarterly Semiannual</td>
</tr>
<tr>
<td><strong>MER 1.1.1: Number of men, women, girls and boys who participated in community conversations and were sensitized on gender norms within the context of HIV/AIDS</strong></td>
<td>Monitoring, Evaluation and Reporting (MER)</td>
<td>-Sex: male, female -Age: 0-9, 10-14, 15-19, 20-24 and 25+ -District</td>
<td>-Project activity reports -Project registers -Evaluation reports -Log books</td>
<td>-Review of project implementation documents -Review of community action plans</td>
<td></td>
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</tr>
<tr>
<td><strong>MER 1.2.1: Number of boys and girls reached with GBV messages through peer education and adult mentorship</strong></td>
<td></td>
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</tbody>
</table>
### IR 1.2: Communities mobilized against GBV increased

| IR 1.2.1: Number of communities and institutions mobilized for the prevention and response to GBV | Program-specific | Type of community/institution - Age 0-14, 15-24, 25+ - Sex (male and female) | Program report - Action plans - Evaluation reports - Activity progress reports | Review of implementation - Project evaluation studies | The data will be analyzed to determine the number of communities and institutions that were previously not involved but are now involved in the prevention and response to GBV. Furthermore, the data analysis will yield information to determine the level of sustainability in the fight against GBV. Community involvement and participation in the design of anti-GBV and anti-ECM programs | - Program manager - M&E officer - Program officers | Quarterly Semiannual |

### IR 1.3: Protective factors enhanced

| IR 1.3.1: Number of individuals who ever experienced or did not experience GBV and were provided with anti-GBV services during sensitizations by ZCCP or therapy meetings organized by Care International or through counselling by Lifeline/Childline Zambia or referred for other services | Program-specific | Age (0-14, 15-24, 25+) - Sex (men, women, boys and girls) - District | Activity Progress Reports - Community action plans | Review of program activities - Project evaluation studies | Data analysis will be done to count all individuals who received help from Care International, Lifeline/Childline Zambia, OSC, etc. Increases or decreases in the value over time could reflect a range of circumstances, such as scale-up of interventions and services, improved reporting of cases by victims and availability of anti-GBV services in the communities. | - Program manager - M&E officer - Program officers | Quarterly Semiannual |

### IR 1.4: Economic opportunities for vulnerable women, men and youth increased

| IR 1.4.0: Number of vulnerable individuals reached with services that increase access to income and productive resources | Program-specific | Age (0-14, 15-24, 25+) - Sex (male and female) - Marital status - Social and income status - District | Project activity reports - Project registers - Evaluation reports - Log books | Review of project implementation documents - Observations - Impact stories - Review of community action plans | Data will be analyzed to obtain the count of vulnerable adults and children provided with services that increase their access to income and productive resources. This analysis will yield information to determine if there are net gains or losses in women's and girls' vulnerability to HIV/AIDS, the level of scale-up of interventions and services aimed at reducing vulnerability of adults and children to GBV and HIV/AIDS. | - Program manager - M&E officer - Program officers | Quarterly Semiannual |
**IR 1.5: Political and institutional commitment to GBV prevention and response within government strengthened**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Program area</th>
<th>Activity</th>
<th>Review of project implementation documents</th>
<th>Data analysis</th>
<th>Data description and findings</th>
<th>Reporting frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR 1.5.1: Number of influential champions engaged in GBV prevention and response</td>
<td>Program-specific</td>
<td>-Program area</td>
<td>-District</td>
<td>-Evaluation reports</td>
<td>-Review of community action plans</td>
<td>Data analysis will be conducted to assess the level of commitment towards fighting against GBV by influential champions under the STOP GBV program coordination. The analysis will involve counting of all influential champions engaged in GBV prevention and response.</td>
</tr>
</tbody>
</table>

**IR 1.6: Engagement of diverse stakeholders in forming a national response against GBV strengthened**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Program area</th>
<th>Activity</th>
<th>Review of project implementation documents</th>
<th>Data analysis</th>
<th>Data description and findings</th>
<th>Reporting frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR 1.6.1: Number of stakeholders supporting GBV messages/interventions at the national level</td>
<td>Program-specific</td>
<td>Quantitative and Qualitative</td>
<td>-Name</td>
<td>-District</td>
<td>-Type of support</td>
<td>Counting the number of stakeholders under the alliance of cooperating partners that are supporting GBV interventions or messages.</td>
</tr>
</tbody>
</table>

**IR 1.7: Coordination with other GBV and BCC programs strengthened**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Program area</th>
<th>Activity</th>
<th>Review of project implementation documents</th>
<th>Data analysis</th>
<th>Data description and findings</th>
<th>Reporting frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR 1.7.1: Number of meetings held to coordinate efforts on GBV and other BCC programs</td>
<td>Program-specific</td>
<td>-Type of organization</td>
<td>-Activity progress reports</td>
<td>-Meeting minutes</td>
<td>-Attendance registers</td>
<td>Counting the number of meetings held to coordinate GBV and other BCC programs</td>
</tr>
</tbody>
</table>

**IR 1.8: Campaign against child marriage (CM) in Zambia enhanced**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Program area</th>
<th>Activity</th>
<th>Review of project implementation documents</th>
<th>Data analysis</th>
<th>Data description and findings</th>
<th>Reporting frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR 1.8.1: Number of individuals, community groups sensitized on child marriages during focus group discussions, GLOW Camps and Road shows</td>
<td>Program-specific</td>
<td>-Age (0-15, 15-24, 25+)</td>
<td>-Sex (male and female)</td>
<td>-District</td>
<td>-Focus group discussions</td>
<td>Counting the number of individuals and community groups sensitized on child marriages</td>
</tr>
<tr>
<td>OUTPUT INDICATORS</td>
<td>INDICATOR TYPE</td>
<td>OUTCOME/HIGH-LEVEL INDICATORS</td>
<td>METHOD OF DATA COLLECTION</td>
<td></td>
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<tr>
<td>IR 1.1: Outreach efforts against GBV expanded</td>
<td>IR 1.1.2: Percent of men, women and youth reached with GBV awareness messages</td>
<td>Program-specific</td>
<td>The percentage of men, women and youth who are able to identify various forms of GBV and believe that any practices and behavior that cause mental, psychological or physical injury to a child, spouse or individual of the opposite sex must not be practiced or must be reported to OSC, police or other appropriate institutions that are available to deal with abusers.</td>
<td>Focus group discussions, Surveys, Situational studies, Special studies</td>
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</tr>
<tr>
<td>IR 1.2: Communities mobilized against GBV increased</td>
<td>IR 1.2.1: Number of communities and institutions mobilized for the prevention and response to GBV</td>
<td>Program-specific</td>
<td>A community where there is collective action and total ownership of interventions by local community groups, institutions, community members that are participating in planning, designing and implementing of anti-GBV and anti-child marriage programs. There is consensus among local community groups and institutions that GBV and child marriages are not to be accepted or promoted as societal norms.</td>
<td>Focus group discussions, Surveys, Situational studies, Special studies</td>
<td></td>
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</tr>
<tr>
<td>IR 1.3: Protective factors enhanced</td>
<td>IR 1.3.1: Number of individuals who ever experienced or did not experience GBV and were provided with anti-GBV services during therapy meetings organized by Care International or through counselling by Lifeline/Childline Zambia or referred for other services</td>
<td>Program-specific</td>
<td>Individuals who understand the various GBV services available for people, know where to access them and are seeking the appropriate GBV prevention and support services from designated access points in their communities whenever they are in need or faced with any form of abuse.</td>
<td>Focus group discussions, Surveys, Situational studies, Special studies</td>
<td></td>
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</tr>
</tbody>
</table>
### IR 1.4: Economic opportunities for vulnerable women, men and youth increased

<table>
<thead>
<tr>
<th>IR 1.4.0</th>
<th>Number of vulnerable individuals reached with services that increase access to income and productive resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>IR 1.4.1</td>
<td>Number of vulnerable men, women and youth trained in income-generating activities (IGA) and received start-up capital</td>
</tr>
<tr>
<td>IR 1.4.2</td>
<td>Number of active Village Savings and Lending (VSL) group members trained in financial literacy and provided with start-up capital</td>
</tr>
</tbody>
</table>

- **Program-specific**
- Basic needs of all members of the household are met by families headed by survivors of GBV or child marriages.
- Vulnerable individuals have increased access to finance, business ownership and markets. This also includes improved women’s right to safe, fair and equal participation in local economies or markets.
- There is increased control over assets (such as productive assets like land, animals, machinery), increased share of household income provided by women, women having control over how to spend some cash or savings, etc., and decision-making (proportion to spend on herself and children) by women.

- **Focus group discussions**
- **Surveys**
- **Situational studies**
- **Special Studies**

### IR 1.8: Campaign against child marriage (CM) in Zambia enhanced

| IR 1.81 | Number of individuals, community groups sensitized on child marriages during focus group discussions, GLOW Camps and road shows |

- **Program-specific**
- Girls and boys aged below 18 years are well-informed about the appropriate legal age they can get into marriage and about their rights to decide on when to marry, who to marry and are not afraid to report anyone (including their parents or guardians) who forces them to get into marriage.

- **Focus group discussions**
- **Surveys**
- **Situational studies**
- **Special Studies**
ANNEX H: DETAILED DESCRIPTION OF EVALUATION DESIGN AND METHODS

This annex describes evaluation methods used in full detail (summarized in the main body of the report), including data sources, sampling of sites, safety and ethical considerations, data analysis and the evaluation timeframe.

This formative midterm evaluation uses both quantitative and qualitative research methods further described below 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.

DATA SOURCES

Because this midterm evaluation is intended to be a formative evaluation with relatively expedient results in order 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. In addition, a baseline assessment for STOP GBV was recently completed, including use of Knowledge, Attitudes and Practice (KAP) surveys less than one year ago (2014), so repeating a similar survey at this time was warranted as unnecessary.

This primary data collection was complemented by review of available implementing partner project documents, annual reports, financial reports and monitoring data. A full list of these partner project documents and other literature reviewed are available in Annex M.

In-Depth Interviews

A total of 57 IDIs or key-informant interviews (KII) were held to obtain information about what is working, the shortcomings and obstacles of the program and to suggest alternative strategies/activities that may be considered for implementation.

Five distinct interview guides were developed for each type of stakeholder in order to appropriately tailor questions to answer research questions appropriate for different targeted groups. IDI guides ask open-ended questions formulated to answer key process, performance and some outcome-level questions for analysis. The guides, including protocols and consent procedures, may be found in Annex J for:

- Community Leaders (KII #1)
- Government partners (KII #2)
- Implementing partner (IP) staff and sub-grantees (KII #3)
- One Stop Center staff (KII #4)
- Legal stakeholders, including judges and police (KII #5)

The full list of all IDIs conducted nationally and at each sampled site may be found in Annex L.

Focus Group Discussions

A total of 18 FGDs, or three per each sampled site, were held to obtain information from a range of STOP GBV beneficiaries about what is working, the shortcomings and obstacles of the program and to suggest alternative strategies/activities that may be considered for implementation. Each FGD targeted 8 same-sex participants, for a total final count of 146 participants.
Three distinct FGD guides were developed for each type of group in order to appropriately tailor questions to answer research questions appropriate for different targeted groups. FGD guides ask open-ended questions formulated to answer key process, performance and some outcome-level questions for analysis. The guides, including protocols and consent procedures, may be found in Annex I for:

**GBV survivors (OSC beneficiaries):** With the exception of one all-male group of GBV survivors in Kafue, all five other groups in each site comprised all females over the age of 18. GBV survivors were selected for participation with the assistance of an OSC counselor with whom the survivor was already familiar. Evaluation team members ensured that the OSC counselor was familiar with the informed consent and safety and ethical procedures, which may be found in Annex K.

**Community members:** Six total groups were held, one per site, with community members over the age of 18 (3 all-male groups, 3 all-female groups). Community members were selected independently and purposefully by IPSOS with the assistance of a local community-based organization.

**ZCCP-trained male change agents:** Six total groups (all men) were held, one per site, with ZCCP-trained male change agents over the age of 18. Change agents were purposefully selected with the assistance of ZCCP.

The full list of all FGDs conducted with number of participants at each sampled site may be found in Annex L.

**SAMPLING OF SITES**

In cooperation with USAID, GH Pro and IPSOS identified a purposefully selected sample of five of the 16 supported STOP GBV sites, in addition to one former “A Safer Zambia” (ASAZA) site. Sample settings were drawn from settings that work well and that do not work well, urban and peri-urban or rural, those that have recently received an additional scale-up intervention as an objective: Engaging Boys and Young Men through Sport (embedded under Component 1: GBVSS), and those that were implemented as direct-to-government (D2G) from inception with technical support from World Vision Zambia (WVZ).

Out of the 16 total One Stop Centers:

- 10 are original and 6 have received scale-up (add-on of Component 4)
- 12 are ordinary and 4 are D2G
- 4 are urban and 12 are peri-urban or rural

A sample of six sites were selected in order to take a “dipstick measurement” of performance to date from a representative sample of supported sites. A sample was selected rather than reviewing all 16 sites, as it was determined this would provide adequate information regarding what was working well and not working well in order to inform any need for mid-course corrections. Further, sites were also selected based mostly on their proximity to Lusaka in order to reduce time and costs for the evaluation, with the exception of Katete. As such, the following six sites were selected, where IDIs and FGDs were conducted.

---

14 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.
STOP GBV Zambia Sampled Sites

<table>
<thead>
<tr>
<th>OSC (Province)</th>
<th>Urban/Peri-urban/Rural</th>
<th>Original/Scale-up</th>
<th>Ordinary/D2G</th>
<th>Partners Operating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lusaka (Lusaka)</td>
<td>Urban</td>
<td>Original</td>
<td>Ordinary</td>
<td>WVZ, ZCCP, WLSA</td>
</tr>
<tr>
<td>Kafue (Lusaka)</td>
<td>Peri-urban</td>
<td>Original</td>
<td>Ordinary</td>
<td>WVZ, ZCCP, WLSA</td>
</tr>
<tr>
<td>Choma (Southern)</td>
<td>Peri-urban</td>
<td>Original</td>
<td>Ordinary</td>
<td>WVZ, ZCCP, WLSA</td>
</tr>
<tr>
<td>Mazabuka(^{15}) (Southern)</td>
<td>Peri-urban</td>
<td>Original (ASAZA)</td>
<td>D2G</td>
<td>ZCCP</td>
</tr>
<tr>
<td>Mumbwa (Central)</td>
<td>Rural</td>
<td>Scale-up</td>
<td>D2G</td>
<td>WVZ, SIA, ZCCP, WLSA</td>
</tr>
<tr>
<td>Katete (Eastern)</td>
<td>Rural</td>
<td>Original</td>
<td>Original</td>
<td>WVZ, ZCCP, WLSA</td>
</tr>
<tr>
<td>Chongwe(^{16}) (Lusaka)</td>
<td>Peri-urban</td>
<td>Original</td>
<td>Ordinary</td>
<td>WVZ, ZCCP, WLSA</td>
</tr>
</tbody>
</table>

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.

Further, data collection tools avoided asking unnecessary details or accounts about specific traumatic experiences and events, but rather focused questions on the STOP GBV program—how STOP GBV as a program addressed the needs of a GBV survivor, quality of service provision, etc.

Specifically, 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 (i.e., no one under the age of 18 years participated in this study) included verbal explanation of the following, in addition to handing out copies of the informed consent, available in Annex K:

- **Taking part is voluntary:** Participation in this evaluation is voluntary, and he/she may refuse to participate before the interview/discussion begins, discontinue at any time or skip any questions/procedures that may make him/her feel uncomfortable, with no penalty. Special procedures will be taken for female GBV survivors participating in FGDs: Upon arrival of participants when they sign or initial the sign-in sheet required to document that they receive transport reimbursement, each participant will be individually informed that GBV will be discussed, and if after the informed consent process is explained she does not feel comfortable participating, she may choose to leave with no consequence and may keep the transportation allowance provided for coming.

\(^{15}\) Mazabuka is not currently supported by WVZ; it is a former ASAZA site, although ZCCP recently begun prevention and advocacy efforts there.
\(^{16}\) Chongwe was initially included in the sample, but upon consultations with implementing partners, it was determined that Chongwe would be replaced with Katete due to the over-sampling of nearby OSC sites in Lusaka and the need to include a site further away. However, the Chongwe OSC staff and implementing staff in the area were still included in the sample.
• Potential risks and discomforts: If the participant has experienced GBV or knows someone who has, there may be a risk of experiencing or reliving traumatic feelings or emotions, including sadness, anger, grief and anxiety. GBV survivors, in particular, will be invited to take a moment or stop an interview if they become visibly upset.

• Provision of a specific trained psychosocial counselor’s contact information who will be immediately available following the conversation in the event that the participant requires support as a result of the discussion.

• Potential benefits: Benefits are primarily the improvement of prevention and response to GBV in Zambia; information provided will be analyzed confidentiality in aggregate to contribute to learning in order to improve the STOP GBV project.

• There is no payment for taking part in the evaluation.

• Precautions will be taken, particularly for community members and GBV survivors, to protect privacy and confidentiality:
  - Documentation where a name may appear will be secured in a locked file drawer at IPSOS.
  - Names and identifying information will be deleted from all computer or software files.
  - As part of existing document and data review, if any unique identifiers are found, no data will be abstracted for the evaluation report that has identifying information.
  - All information will be summarized into a general analysis that will be included in a publicly available report providing information about the STOP GBV project and will provide recommendations on the project. However, no individual names will be used in the analysis and report, and no identifying information for community members will be used.
  - Community members and GBV survivors will be requested to provide verbal, rather than written consent so as not to identify participants by name and raise issues with confidentiality or illiteracy, as per WHO guidelines.

Members of the data collection team were carefully selected and received targeted and specialized training in safety and ethical considerations, particularly for GBV survivors. They were also trained to offer contact information for a trained counselor to provide psychosocial support to participants, and were supervised and received ongoing support from GBV technical experts leading the evaluation.

FIELD STAFF TRAINING

A total of 30 field staff were led by experienced key team members (See Annex B), and were composed of five teams, 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, FGDs and research; demonstrated ability to understand and follow safety and ethical protocols and informed consent procedures; Zambian nationality and ability to speak the local language; balance of male and female staff; and ability to understand and appreciate local cultural norms.

Before commencing primary qualitative data collection, all field staff participated in four full days of intensive training in Lusaka. Training topics included:

• Purpose of research and familiarization with STOP GBV and program components
• Research and interview methods and best practice
• Interview procedures and protocols
• Safety and ethical consideration, with specific attention to special considerations for GBV survivors
• Familiarization with data collection tool questions, wording, and purpose

The training consisted of one day of classroom style lecture and discussion, followed by three days of practice with the data collection tools with close supervision, feedback processes and group discussion.

DATA ANALYSIS

Qualitative and quantitative analysis, including cost analysis, methods and instruments are described below. Analysis of the data collected consisted primarily of triangulating primary qualitative data collected via FGDs and IDIs with existing project documents and M&E data (e.g., work plans, annual reports, etc.). All qualitative and quantitative analysis was integrated and analyzed as a whole, rather than separate reporting of qualitative and quantitative analytic outcomes.

Qualitative Analysis

Qualitative data collected via IDIs and FGDs were documented in comprehensive notes, transcribed and translated into English, and analyzed utilizing concordance, or themes, to identify key successes and challenges per site and across sites programmatically.

Systematic analysis was conducted by utilizing analytic templates to organize qualitative data by site and stakeholder into relevant analytic themes such as: sustainability, coordination, political will, ongoing challenges to prevention, ongoing challenges to response, ongoing challenges to service provision, etc. After this qualitative data were systematically organized by theme, site and stakeholder, key successes, challenges and recommendations were identified within each site. Following this step, systematic analysis across sites was conducted to identify the key successes, challenges and recommendations across the program, by partner and by site type.

Quantitative Analysis

Existing quantitative data available from the STOP GBV baseline assessment (2014) were reviewed for utility in assessing measurement at endline, but due to the recent collection and lack of survey/quantitative data collected at the midterm, it was not deemed useful to repeat analysis of the data already conducted for the baseline assessment and readily available for use.

Existing monitoring data collected regularly by implementing partners were compared, where applicable and appropriate, to available ZDHS 2013-14 findings. Quantitative data were analyzed primarily using descriptive statistics and did not use statistical tests, primarily due to the limiting nature of the M&E data available (focused predominantly on outputs).

Composite indices were created to rank the performance of the 16 OSC sites in relationship to one another and to support analysis. Two composite indices were constructed, selecting key M&E indicators already measured by partners in their Performance Monitoring Plans (PMPs) and for which data were made available to the evaluation team. Composite Index 1 focuses primarily on training inputs for staff and project affiliates (capacity-building), while Composite Index 2 focused primarily on outputs, or immediate results.

A minimum of two indicators from each partner’s PMP were included in each composite index and tracked by site. Threshold targets were set for each indicator so that each has a pass/fail, set either by PMP indicator targets, in cases varied by site, and in some cases were set by some reasonable standard by the evaluation team in the absence of project-defined targets. Sites were then ranked according to the number of individual indicators where they met the threshold, and then ranked as high, medium, or
low depending on the number of indicators where they met the threshold.\textsuperscript{17} Indicators selected to comprise each composite indicator appear below.

### STOP GBV Composite Indices

<table>
<thead>
<tr>
<th>Composite Indicator #1: Training Inputs</th>
<th>Composite Indicator #2: Outputs (Direct Results)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 (WVZ):</strong> 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)</td>
<td><strong>1 (WVZ):</strong> Number of people receiving post-GBV care (target: site-specific meeting planned targets to date)</td>
</tr>
<tr>
<td><strong>2 (WVZ):</strong> 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)</td>
<td><strong>2 (WVZ):</strong> Number of survivor networks established (target: site-specific, two per site set as 'pass' threshold for evaluation)</td>
</tr>
<tr>
<td><strong>3 (WLSA):</strong> Number of OSC paralegals trained (target: 2 per site)</td>
<td><strong>3 (WVZ):</strong> Number of men’s networks with capacity to identify and address GBV (target: site-specific, one per site ‘pass’ threshold set for evaluation)</td>
</tr>
<tr>
<td><strong>4 (WLSA):</strong> Number of police officers trained (target: site-specific, 30 percent of LOP per site ‘pass’ threshold set for evaluation)</td>
<td><strong>4 (WLSA):</strong> Percent of reported GBV cases prosecuted or litigated (target: 10 percent ‘pass’ threshold set for evaluation)</td>
</tr>
<tr>
<td><strong>5 (WLSA):</strong> Number of doctors trained (target: site-specific, 30 percent of LOP per site ‘pass’ threshold set for evaluation)</td>
<td><strong>5 (ZCCP):</strong> Number of active Village Savings and Lending group members trained in financial literacy and provided with start-up capital (target: 597 targeted total across sites to date, 25 per site set as ‘pass’ threshold for evaluation)</td>
</tr>
<tr>
<td><strong>6 (ZCCP):</strong> Number of male change agents (community volunteers) trained (target: 12 per site)</td>
<td><strong>6 (ZCCP):</strong> Number of individuals reached via Community Dialogues conducted on gender and HIV/AIDS under small-group and community-level interventions (target: 77,00 total across sites in 2014/15; 1,000 per site set as ‘pass’ threshold for evaluation)</td>
</tr>
<tr>
<td><strong>7 (ZCCP):</strong> Number of chiefs oriented in GBV (target: site-specific, 30 percent of LOP per site ‘pass’ threshold set for evaluation)</td>
<td><strong>7 (ZCCP):</strong> Number of individuals reached via community dialogues conducted on child marriages under small-group/community level interventions (target: 47,227 FY14/15 across all sites; 500 per site set as ‘pass’ for evaluation)</td>
</tr>
</tbody>
</table>

#### EVALUATION TIMEFRAME

The evaluation planning, implementation and analysis took place May–September 2015. The following timeline provides an overview, by week, from the midterm evaluation inception to final deliverable and planning, taking into consideration the time required to appropriately plan, develop tools, train field moderators and conduct quality analysis. This includes an additional dissemination and endline evaluation planning period in October 2015.

\textsuperscript{17} For Input Composite Indicator: Low=1-3, Medium=4-5, and High=6-8. For Output Composite Indicator: Low=1-2, Medium=3-5, and High=6-7.
**Midterm Evaluation Timetable**

<table>
<thead>
<tr>
<th>Week</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 23-29</td>
<td>Team planning and review of available documents</td>
</tr>
<tr>
<td>June 1-5</td>
<td>Finalize data collection tools and submit for IRB review, prepare training material</td>
</tr>
<tr>
<td>June 9-12</td>
<td>Moderator training on data collection guides</td>
</tr>
<tr>
<td>June 15-19</td>
<td>Interviews with key stakeholders in Lusaka (IDIs, FGDs)</td>
</tr>
<tr>
<td>June 22-26</td>
<td>Team fieldwork in remaining five sites (IDIs, FGDs)</td>
</tr>
<tr>
<td>June 29-July 3</td>
<td>Qualitative documentation, analysis, reporting from field teams</td>
</tr>
<tr>
<td>July 5-31</td>
<td>Analysis and drafting of evaluation report, debriefing with USAID/DFID of key findings</td>
</tr>
<tr>
<td>August 3-7</td>
<td>Internal team review/GH Pro review</td>
</tr>
<tr>
<td>August 7</td>
<td>First draft of evaluation report sent to USAID for review</td>
</tr>
<tr>
<td>August 14</td>
<td>Comments received from USAID on first draft report</td>
</tr>
<tr>
<td>August 17-26</td>
<td>Preparation of the revised report</td>
</tr>
<tr>
<td>August 26</td>
<td>Submission of the revised report to USAID</td>
</tr>
<tr>
<td>September 2</td>
<td>Final written feedback received from USAID</td>
</tr>
<tr>
<td>September 29</td>
<td>Final evaluation report submission to USAID</td>
</tr>
<tr>
<td>October (date TBD)</td>
<td>Internal stakeholders’ debriefing</td>
</tr>
</tbody>
</table>

**LIMITATIONS**

Although adequate data, time and resources were spent on this evaluation, there were some limitations in data sources and quality, methodology and timing of note:

- **Sampling of sites**: Selection was purposeful with selection of representative sites; however, sites were chosen due to proximity to Lusaka in order to reduce evaluation time and costs, with the exception of Katete. This resulted in a bias of selected sites towards those that are more accessible to the capital city, and thus more likely to have better access to human and financial resources, and may be more exposed to “urban” campaigns and messages. As such, sites further away that may have more limited access or that may be more deeply entrenched in harmful traditional practices, were excluded and may bias the results. Further, although the sampling included urban, peri-urban and rural sites, all qualitative data collection took place within town centers where the OSC was located, and thus also omitted in-depth assessment of the “rural experience.”

- **Interviewees**: With the exception of the FGDs held with community members, survivors and change agents, most interviewees were directly working for, or associated with, the STOP GBV project. As such, there is a natural tendency for such interviewees to focus more on successes than challenges. The sample excluded, for example, health worker personnel such as doctors providing medical certificates to GBV survivors, and OPD staff who are often responsible for managing GBV cases on evenings and weekends when OSCs are not open. This limited the team’s ability to assess, for example, the continuum of care GBV survivors receive. Lastly, specifically in the cases of trained magistrates, there were discrepancies in what these interviewees told the evaluation team (e.g., that they had not been involved in a workshop or training related to GBV), and thus limited the team’s ability to collect data related to their training.
- **Quantitative data**: No primary quantitative data were collected for the purposes of this midterm evaluation. As such, all analysis of quantitative data depends solely on the M&E data currently tracked and provided by implementing partners. In some cases at the sites visited the team encountered data discrepancies in what was provided at the sites vs. data available nationally regarding those sites. In other cases, there were data gaps in what partners were able to provide. Thus, the quantitative data, and therefore analysis of the data, have some issues of quality.

- **Costing data**: Cost data are not readily available at the OCSs, as all the accounting work is done at the national office. Where they were available, there were variances with data at the national offices. Further, cost data at the national office were not provided in a disaggregated form by cost type and site, making tracking performance by OSC difficult. Variances were also noted between cost data and those tracked by the M&E data. Further, while activity budgeting is used for planning and implementation, the reporting is not necessarily done by activity. There are no expenditure variance reports, thereby making it difficult to match expenditures to activities reported as implemented in the programmatic reports. In most cases, the programmatic reports do not have sections for financial performance, and in a few cases where attempts are made to include financial performance, it is summarized into budget, expenditure and obligated funds. Lastly, ZMW to U.S. dollar exchange rate fluctuations were significant and varied over the program implementation period, and average exchange rates used by partners in reports were relied upon; however, expenditures are in the process of being revalued according to current expenditures, which will impact previously reported expenditures. Given these limitations, many assumptions had to be made in cost analysis.

- **Timing**: World Vision began implementing this program at the 16 OSCs in 2013. However, WLSA, ZCCP, SIA and their sub-grantees only recently began program operations at various sites, some only as recently as Quarter 1 of 2015. As such, it is not necessarily “midterm” for the three project components for which WLSA, ZCCP and SIA are managing, and provides little time from inception to now to observe activity implementation or assess progress. This is important in noting progress to date of these partners, understanding that they have in many cases just begun. In addition, the baseline report was recently published in March 2015, leaving less than six months between the baseline and midterm evaluation. Although the baseline assessment was reviewed, referenced and used where necessary, due to the timing it serves more as a source of information than a reference point and data to corroborate than for progress or change to date.
# ANNEX I: FOCUS GROUP DISCUSSION GUIDES

## FOCUS GROUP DISCUSSION (FGD) GUIDE #1: BENEFICIARIES (FEMALE)

### 1. General Methodology

**Goal:** To provide interviewers with guidance on preparing for FGDs.

**Time:** 5 minutes

**General Interviewer Procedural Guidance:**

1.1 Ensure that only two interviewers are present from the IPSOS team. One other person may be present (Team Lead OR GBV Technical Assistant). Avoid having too many people in the room that may make participants uncomfortable. Additionally, it is absolutely critical that no implementing partner staff or One Stop Center is present in the room to ensure that participants are able to speak openly, while also maintaining safety and confidentiality.

1.2 One IPSOS research team member will facilitate the discussion while another IPSOS research team member will take *detailed* notes.

1.3 Organize the chairs in the room in a close circle to facilitate discussion.

1.4 IPSOS should have previously invited no more than 5-8 project beneficiaries. Beneficiary groups should be all female. Participants will be requested to provide 2 hours of their time (with snacks and refreshment). Snacks should be arranged beforehand and distributed at an appropriate time so as not to disrupt or interrupt discussion, or waste time.

### 2. Materials Required

**Goal:** To ensure all required materials are present at each focus group discussion

**Materials:**

2.1 Informed consent document (for interview team)

2.2 Recorder

2.3 Pens and notepad (for interview team)

2.4 Refreshments (drinks, snacks for participants)

### 3. Relaxation/ Ice-breaker Exercise

**Goal:** To enable participants to feel relaxed before beginning the discussion.

**Time:** 5 minutes

**Interviewer Guidance:**

3.1 Conduct an ice-breaker exercise to put participants at ease.

### 4. Participant Introduction to Nature and Purpose of Discussion and Organization of Discussion

**Goal:** To introduce the purpose of the focus group session, the use of information gathered in the session, and to identify the ground rules for participation.

**Time:** 10 minutes

**Interviewer Guidance:**

4.1 **Welcome participants** and thank them for coming to participate in the session.
4.2 Introduce the research team.

4.3 Read the informed consent that provides a general overview of STOP GBV, purpose of the FGD, and information regarding benefits, risks, confidentiality, etc.

4.4 Further reinforce what will be done to ensure safety and confidentiality: “Again, we will be writing a report that will present information and recommendations in general. We will in no way mention your individual names anywhere in the report. Our primary interest today is learning from you how STOP GBV activities and One Stop Centers are working. Although we appreciate you sharing your personal experiences, you will not at any time be asked to share your personal experience related to GBV. Rather, our questions will focus on GBV within the community and on the quality of services and support provided to you by the project. Please only share what you are comfortable sharing.”

4.5 Explain that psychosocial support is available to participants: “Although you will not be asked to share your personal experience with GBV, you may find that a particular discussion topic may trigger difficult feelings for you. If at any time you need a break from the discussion, please feel free to stop or step out at any time, and return when you are ready. In addition, we will provide you with a referral and contact details of a psychosocial counselor that you may speak with in the event that you require this type of support following our discussion today.”

4.6 Ask participants to highlight some rules to guide the discussion (respect, listen while others are speaking, no phones, and confidentiality, laugh as much as possible).

5. Obtaining Participant Informed and Voluntary Consent

Goal: To obtain voluntary informed consent of the participants for their participation in the discussion.
Time: 5 minutes
Interviewer Guidance:

5.1 Explain to participants that: “It is very important that we document that we have informed you properly of the purposes of this discussion and that you have agreed to speak with us and narrate your experiences with the STOP GBV project services and activities.”

5.2 Ask participants to confirm that they have understood the purpose of the research, and that they agree to speak with us and narrate their experiences related to the STOP GBV project and One Stop Center: “We need to confirm that you understand the purpose of our discussion today—to share what you think has worked well and what could be improved about STOP GBV activities and One Center services. Will you provide a signal that each of you agree to participate—a thumb’s up with a vociferous ‘yes’?!” It is recommended to make this fun, rather than something serious. Although IPSOS interviewers will sign informed consent forms documenting that this verbal consent was received, it is NOT recommended to have FGD participants from the community read and sign written informed consent forms. This is for several reasons: 1) Illiteracy may prevent certain participants from understanding the written consent, or from signing it. Verbal consent, per WHO Safety and Ethical Guidelines, is appropriate in such instances; and 2) Providing a formal written consent document to participants may make them uneasy about confidentiality—their full names are now being asked and this may make them uncertain or uncomfortable about confidentiality; and 3) a formal written document that they are asked to sign may be off-putting to some and may make many participants uncomfortable to participate in the discussion, which will hinder the discussion.
6. **Discussion**

**Goal:** To facilitate discussion with focus group discussion participants and learn from them what they have found to be successful, challenging, and recommendations that they have to improve STOP GBV activities and One Stop Center services.

Understand the barriers to reporting and the sources most trusted by GBV survivors, including girls and boys.

**Time:** 90 minutes

**Interviewer Guidance:** Ask each main question (in bold) below to facilitate discussion. Ask probing questions, as required, depending on the information participants are providing.

| 6.1 | **What are the types of abuses that women, men, boys, and girls are at-risk for in your community/ households that you have witnessed, observed?** Probe: Where does abuse take place? Are there places in your community that are unsafe to go at certain times for certain members of your community? What, in your opinion, are the causes of abuse? |
| 6.2 | **Please describe any traditional practice that you think can be hurtful to women and girls.** Probe: How old are girls and boys when they get married in your community? If they are young (under 18)? Who decides when a couple gets married (man, woman, girl, parents)? |
| 6.3 | **What kinds of conflicts occur in marriages and families and what are the reasons? How are conflicts resolved?** Probe: What are examples of husbands treating their wives badly, and wives treating their husbands badly? Does a husband have the right to physically punish his wife for any reason? Why are wives abused by their husbands? Do women support husbands who punish their wives? If so, why? |
| 6.4 | **When does a woman have a right to refuse sex, in marriage and outside marriage?** Probe: If a woman refuses sex from her husband and he forces her to have sex, do you believe that is rape? |
| 6.5 | **What rights do women and girls have in your community?** Probe: What happens to a woman if a man divorces his wife (e.g. property rights, legal rights, traditional rights)? What if a woman’s dies? How do you learn about these rights? How much say do girls have in deciding about their education, careers, and sexual partners? How do they express this? |
| 6.6 | **What are the effects of GBV, including reactions of families, communities and individuals to GBV survivors and perpetrators?** Probe: Did you miss any school or work (business, farming, or other) due to your experience with GBV? Is there someone you can go to if you feel scared, threatened, or experience abuse of any kind [friend, security officer, police]? Where did women get help if they were raped before the One Stop Center was here? How do communities react to someone who has been raped? How does the community react to the perpetrator? How do women and men cope with violence against their male and female family members or friends? What do traditional leaders/religious leaders do to prevent GBV and help survivors? |
| 6.7 | **What does the One Stop Center do to help women, men, boys and girls who are at-risk of gender-based violence or who have experienced GBV in your community?** Probe: Who does it provide services to? What services does it provide? Did you or someone you know use the GBV Helpline? If so, describe the service received from the Helpline. How do GBV survivors access medical care or legal services? How has the One Stop Center assisted GBV survivors with financial/ savings skills, or income-generation opportunities? What types of security services/ measures does STOP GBV or the One Stop Center provide, such as shelter or protection? Do women’s support
networks exist to help survivors? If so, how do they help survivors? Which services do you have to pay for directly or indirectly (e.g., transport, medication, filing fees, bribes, etc.)?

6.8 **How did you learn about the One Stop Center?**

6.9 **How well are cases for each individual managed by the Center?** Probe: How is follow-up conducted, and over what period of time do you received services? How were you treated when receiving all services directly and any referral service such as police, lawyers, or health care providers? Were people friendly, respectful, and helpful? How have services to women, girls, men, and boys who experienced GBV improved from before the Center opened to now? What types of cases are commonly pursued in courts (forced marriage, domestic violence, forced prostitution, rape)?

6.10 **What do you think are the challenges of the One Stop Center services?** Probe: Do you know if there is anyone who does not go there but should? Are there challenges in accessing services? If so, which (medical, legal, counseling, etc.)? Did you have to pay for any services directly or indirectly (such as transport, copying/ printing fees, etc.)? Why are there challenges? What can be done?

6.11 **How have One Stop Services helped you and improved your well-being?** Probe: Can you describe how your life has changed as a result of receiving services from the One Stop Center? If you are making more income, how is this new source of money being spent and who in your family decides how it is spent? If there were negative reactions from others, how did the One Stop Center help you with those reactions? Do you have hopes for the future? If so, what are those hopes?

6.12 **What more can be done to prevent abuse and violence within families and communities to make it a safe place to live?** Probe: What more can be done by NGOs and the government to prevent and respond to GBV? What are the best ways to involve men and boys in preventing violence?

7 **Closing Focus Group**

*Time: 5 minutes*

**Goal:** To close the focus group, obtain consent to use information provided in the mid-term evaluation for STOP GBV, and to assist participants to feel more relaxed before departing from session.

**Interviewer Guidance:**

7.1 Thank participants for their participation in the discussion.

7.2 Ask participants if they have any questions about the discussion.

7.3 Ask participants if the information that they provided can be used in the STOP GBV evaluation: “Can I confirm that the points in our discussion today can be summarized in the evaluation that we will write? We will not identify any participant by name, but rather summarize the discussion and recommendations across all discussions we are having like this one.”

7.4 Explain to participants that they may approach any member of the interview team after the discussion to talk to them about anything else they wish to share. Also provide the name and contact information of a specific psychosocial support counselor for follow-up support.

7.5 After participants have departed, the interviewer should sign the enclosed consent form to indicate that they have obtained verbal consent from participants at the beginning of the interview for them to narrate their experiences, and at the end, to use information that they provided in summary fashion in the report (without any individual identifying information).
FOCUS GROUP DISCUSSION (FGD) GUIDE #2: CHANGE AGENTS (MALE)

1. General Methodology

**Goal:** To provide interviewers with guidance on preparing for FGDs.

**Time:** 5 minutes

**General Interviewer Procedural Guidance:**

1.1 Ensure that only two interviewers are present from the IPSOS team. One other person may be present (Team Lead OR GBV Technical Assistant). Avoid having too many people in the room that may make participants uncomfortable. Additionally, it is absolutely critical that no implementing partner staff or One Stop Center is present in the room to ensure that participants are able to speak openly, while also maintaining safety and confidentiality.

1.2 One IPSOS research team member will facilitate the discussion while another IPSOS research team member will take detailed notes.

1.3 Organize the chairs in the room in a close circle to facilitate discussion.

1.4 IPSOS should have previously invited no more than 5-8 change agents to participate in each FGD. FGDs with change agents will be all men. Participants will be requested to provide 2 hours of their time (with snacks and refreshment). Snacks should be arranged beforehand and distributed at an appropriate time so as not to disrupt or interrupt discussion, or waste time.

2. Materials Required

**Goal:** To ensure all required materials are present at each focus group discussion

**Materials:**

2.1 Informed consent document (for interview team)
2.2 Recorder
2.3 Pens and notepad (for interview team)
2.4 Refreshments (drinks, snacks for participants)

3. Relaxation/ Ice-breaker Exercise

**Goal:** To enable participants to feel relaxed before beginning the discussion.

**Time:** 5 minutes

**Interviewer Guidance:**

3.1 Conduct an ice-breaker exercise to put participants at ease.

4. Participant Introduction to Nature and Purpose of Discussion and Organization of Discussion

**Goal:** To introduce the purpose of the focus group session, the use of information gathered in the session, and to identify the ground rules for participation.

**Time:** 10 minutes

**Interviewer Guidance:**

4.1 **Welcome participants** and thank them for coming to participate in the session.

4.2 **Introduce the research team.**

4.3 **Read the informed consent** that provides a general overview of STOP GBV, purpose of the FGD, and information regarding benefits, risks, confidentiality, etc.
### 4.4 Further reinforce what will be done to ensure safety and confidentiality: "Again, we will be writing a report that will present information and recommendations in general. We will in no way mention your individual names anywhere in the report. Our primary interest today is learning from you how STOP GBV activities and One Stop Centers are working. Although we appreciate you sharing your personal experiences, you will not at any time be asked to share your personal experience related to GBV. Rather, our questions will focus on GBV within the community and on the quality of services and support provided to you by the project. Please only share what you are comfortable sharing."

### 4.5 Explain that psychosocial support is available to participants: "Although you will not be asked to share your personal experience with GBV or that of someone you know, you may find that a particular discussion topic may trigger difficult feelings for you. If at any time you need a break from the discussion, please feel free to stop or step out at any time, and return when you are ready. In addition, we will provide you with a referral and contact details of a psychosocial counselor that you may speak with in the event that you require this type of support following our discussion today."

### 4.6 Ask participants to highlight some rules to guide the discussion (respect, listen while others are speaking, no phones, and confidentiality, laugh as much as possible).

### 5. Obtaining Participant Informed and Voluntary Consent

**Goal:** To obtain voluntary informed consent of the participants for their participation in the discussion.

**Time:** 5 minutes

**Interviewer Guidance:**

5.1 Explain to participants that: "It is very important that we document that we have informed you properly of the purposes of this discussion and that you have agreed to speak with us and narrate your experiences with the STOP GBV project services and activities."

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### 6. Discussion

**Goal:** To facilitate discussion with focus group discussion participants and learn from them what they have found to be successful, challenging, and recommendations that they have to improve STOP GBV activities and One Stop Center services.

Understand the barriers to reporting and the sources most trusted by GBV survivors, including girls and boys.
**Time:** 90 minutes  
**Interviewer Guidance:** Ask each main question (in bold) below to facilitate discussion. Ask probing questions, as required, depending on the information participants are providing.

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<thead>
<tr>
<th>Question</th>
<th>Probe</th>
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<tbody>
<tr>
<td><strong>6.1 What are the types of abuses that women, men, boys, and girls are at-risk for in your community/ households that you have witness, observed?</strong></td>
<td>Where does abuse take place? Are there places in your community that are unsafe to go at certain times for certain members of your community? What, in your opinion, are the causes of abuse?</td>
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<td><strong>6.2 Please describe any traditional practice that you think can be hurtful to women and girls.</strong></td>
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<td><strong>6.3 What kinds of conflicts occur in marriages and families and what are the reasons? How are conflicts resolved?</strong></td>
<td>What are some things that might be examples of husbands treating their wives badly, and wives treating their husbands badly? Does a husband have the right to physically punish his wife for any reason? Why are wives abused by their husbands? Do women support husbands who punish their wives? If so, why?</td>
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<td><strong>6.4 When does a woman have a right to refuse sex, in marriage and outside marriage?</strong></td>
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<td><strong>6.5 What rights do women and girls have in your community?</strong></td>
<td>What happens to a woman if a man divorces his wife (e.g. property rights, legal rights, traditional rights)? What if a woman’s dies? How do you learn about these rights? How much say do girls have in deciding about their education, careers, and sexual partners? How do they express this?</td>
</tr>
<tr>
<td><strong>6.6 What are the effects of GBV, including reactions of families, communities and individuals to GBV survivors and perpetrators?</strong></td>
<td>Is someone you can go to if you feel scared, threatened, or experience abuse of any kind [friend, security officer, police]? Where did women get help if they were raped before the One Stop Center was here? How do communities react to someone who has been raped? How does the community react to the perpetrator? How do women and men cope with violence against their male and female family members or friends? What do traditional leaders/religious leaders do to prevent GBV and help survivors?</td>
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<tr>
<td><strong>6.7 What does the One Stop Center do to help women, men, boys and girls who are at-risk of gender-based violence or who have experienced GBV in your community?</strong></td>
<td>Who does it provide services to? What services does it provide? How do you work with the One Stop Center? Do you ever make referrals to the One Stop Center? If so, please explain how and when you would make a referral, and for what type of case. What challenges do One Stop Centers have providing services for GBV survivors or those at risk of GBV?</td>
</tr>
<tr>
<td><strong>6.8 Have you received training as a change agent regarding GBV and early child marriage? If you have, can you please describe the nature of the training?</strong></td>
<td>What type of information did you receive? Who trained you? What did you find useful about the training? What didn’t you like about the training?</td>
</tr>
</tbody>
</table>
| **6.9 Describe who change agents are (e.g., age, marital status, income level, job status, religion, attitude about GBV before receiving training, past history of violence, etc.).** | What types of men and boys are more likely to become change agents? How long does
one man stay “active” as a change agent? How long have you been a change agent for? What motivates you?

6.9.1 What are your responsibilities as a change agent? Please provide an example of how you use training as a change agent in your everyday life. Probe: How frequently do men hold discussions, individual talks, or lead activities related to GBV? How frequently do you meet with other change agents, for how much time each meeting, and over what period of time? Who leads the group sessions? What do you talk about? What challenges are there to sustaining boys’ and young men’s groups?

6.10 What has the reaction been from men, boys, and the community to the communication of male ‘change agents’ within the community? Probe: Please describe change that you have observed at both the group level and the individual level. How have you changed the way you communicate your wife, girlfriend, children, and others?

6.11 What more can be done to prevent abuse and violence within families and communities to make it a safer place to live? Probe: What more can be done by NGOs and the government to prevent and respond to GBV? What are the best ways to involve men and boys in preventing violence in your community?

7 Closing Focus Group

Time: 5 minutes

Goal: To close the focus group, obtain consent to use information provided in the mid-term evaluation for STOP GBV, and to assist participants to feel more relaxed before departing from session.

Interviewer Guidance:

7.1 Thank participants for their participation in the discussion.

7.2 Ask participants if they have any questions about the discussion.

7.3 Ask participants if the information that they provided can be used in the STOP GBV evaluation: “Can I confirm that the points in our discussion today can be summarized in the evaluation that we will write? We will not identify any participant by name, but rather summarize the discussion and recommendations across all discussions we are having like this one.”

7.4 Explain to participants that they may approach any member of the interview team after the discussion to talk to them about anything else they wish to share. Also provide the name and contact information of a specific psychosocial support counselor for follow-up support.

7.5 After participants have departed, the interviewer should sign the enclosed consent form to indicate that they have obtained verbal consent from participants at the beginning of the interview for them to narrate their experiences, and at the end, to use information that they provided in summary fashion in the report (without any individual identifying information).
FOCUS GROUP DISCUSSION (FGD) GUIDE #3: COMMUNITY MEMBERS

1. General Methodology
   **Goal:** To provide interviewers with guidance on preparing for FGDs.
   **Time:** 5 minutes

   **General Interviewer Procedural Guidance:**
   1.1 Ensure that only two interviewers are present from the IPSOS team. One other person may be present (Team Lead OR GBV Technical Assistant). Avoid having too many people in the room that may make participants uncomfortable. Additionally, it is absolutely critical that no implementing partner staff or One Stop Center is present in the room to ensure that participants are able to speak openly, while also maintaining safety and confidentiality.
   1.2 One IPSOS research team member will facilitate the discussion while another IPSOS research team member will take detailed notes.
   1.3 Organize the chairs in the room in a close circle to facilitate discussion.
   1.4 IPSOS should have previously invited no more than 5-8 community members to participate in each FGD. Each community group should be either only males or only females. Participants will be requested to provide 2 hours of their time (with snacks and refreshment). Snacks should be arranged beforehand and distributed at an appropriate time so as not to disrupt or interrupt discussion, or waste time.

2. Materials Required
   **Goal:** To ensure all required materials are present at each focus group discussion

   **Materials:**
   2.1 Informed consent document (for interview team)
   2.2 Recorder
   2.3 Pens and notepad (for interview team)
   2.4 Refreshments (drinks, snacks for participants)

3. Relaxation/ Ice-breaker Exercise
   **Goal:** To enable participants to feel relaxed before beginning the discussion.
   **Time:** 5 minutes

   **Interviewer Guidance:**
   3.1 Conduct an ice-breaker exercise to put participants at ease.

4. Participant Introduction to Nature and Purpose of Discussion and Organization of Discussion
   **Goal:** To introduce the purpose of the focus group session, the use of information gathered in the session, and to identify the ground rules for participation.
   **Time:** 10 minutes

   **Interviewer Guidance:**
   4.1 **Welcome participants** and thank them for coming to participate in the session.
   4.2 **Introduce the research team.**
   4.3 **Read the informed consent that provides a general overview of STOP GBV, purpose of the FGD, and information regarding benefits, risks, confidentiality, etc.**
4.4 **Further reinforce what will be done to ensure safety and confidentiality:** “Again, we will be writing a report that will present information and recommendations in general. We will in no way mention your individual names anywhere in the report. Our primary interest today is learning from you how STOP GBV activities and One Stop Centers are working. Although we appreciate you sharing your personal experiences, you will not at any time be asked to share your personal experience related to GBV. Rather, our questions will focus on GBV within the community and on the quality of services and support provided to you by the project. Please only share what you are comfortable sharing.”

4.5 **Explain that psychosocial support is available to participants:** “Although you will not be asked to share your personal experience with GBV, you may find that a particular discussion topic may trigger difficult feelings for you. If at any time you need a break from the discussion, please feel free to stop or step out at any time, and return when you are ready. In addition, we will provide you with a referral and contact details of a psychosocial counselor that you may speak with in the event that you require this type of support following our discussion today.”

4.6 Ask participants to highlight some rules to guide the discussion (respect, listen while others are speaking, no phones, and confidentiality, laugh as much as possible).

5. **Obtaining Participant Informed and Voluntary Consent**

**Goal:** To obtain voluntary informed consent of the participants for their participation in the discussion.

**Time:** 5 minutes

**Interviewer Guidance:**

5.1 Explain to participants that: “It is very important that we document that we have informed you properly of the purposes of this discussion and that you have agreed to speak with us and narrate your experiences with the STOP GBV project services and activities.”

5.2 Ask participants to confirm that they have understood the purpose of the research, and that they agree to speak with us and narrate their experiences related to the STOP GBV project and One Center services: “We need to confirm that you understand the purpose of our discussion today—to share what you think has worked well and what could be improved about STOP GBV activities and One Center services. Will you provide a signal that each of you agree to participate—a thumb’s up with a vociferous ‘yes!’?” It is recommended to make this fun, rather than something serious. Although IPSOS interviewers will sign informed consent forms documenting that this verbal consent was received, it is NOT recommended to have FGD participants from the community read and sign written informed consent forms. This is for several reasons: 1) Illiteracy may prevent certain participants from understanding the written consent, or from signing it. Verbal consent, per WHO Safety and Ethical Guidelines, is appropriate in such instances; and 2) Providing a formal written consent document to participants may make them uneasy about confidentiality—their full names are now being asked and this may make them uncertain or uncomfortable about confidentiality; and 3) a formal written document that they are asked to sign may be off-putting to some and may make many participants uncomfortable to participate in the discussion, which will hinder the discussion.

6. **Discussion**

**Goal:** To facilitate discussion with focus group discussion participants and learn from them what they have found to be successful, challenging, and recommendations that they have to improve STOP GBV activities and One Stop Center services.

Understand the barriers to reporting and the sources most trusted by GBV survivors, including girls and boys.

**Time:** 90 minutes
**Interviewer Guidance:** Ask each main question (in bold) below to facilitate discussion. Ask probing questions, as required, depending on the information participants are providing.

<table>
<thead>
<tr>
<th>Question</th>
<th>Probe</th>
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<tbody>
<tr>
<td><strong>6.1</strong> What are the types of abuses that women, men, boys, and girls are at-risk for in your community/ households that you have witness, observed?</td>
<td>Where does abuse take place? Are there places in your community that are unsafe to go at certain times for certain members of your community? What, in your opinion, are the causes of abuse?</td>
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<tr>
<td><strong>6.2</strong> Please describe any traditional practice that you think can be hurtful to women and girls.</td>
<td>How old are girls and boys when they get married in your community? If they are young (under 18)? Who decides when a couple gets married (man, woman, girl, parents)?</td>
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<tr>
<td><strong>6.3</strong> What kinds of conflicts occur in marriages and families and what are the reasons? How are conflicts resolved?</td>
<td>What are some things that might be examples of husbands treating their wives badly, and wives treating their husbands badly? Does a husband have the right to physically punish his wife for any reason? Why are wives abused by their husbands? Do women support husbands who punish their wives? If so, why?</td>
</tr>
<tr>
<td><strong>6.4</strong> When does a woman have a right to refuse sex, in marriage and outside marriage?</td>
<td>If a woman refuses sex from her husband and he forces her to have sex, do you believe that is rape?</td>
</tr>
<tr>
<td><strong>6.5</strong> What rights do women and girls have in your community?</td>
<td>What happens to a woman if a man divorces his wife (e.g. property rights, legal rights, traditional rights)? What if a woman’s dies? How do you learn about these rights? How much say do girls have in deciding about their education, careers, and sexual partners? How do they express this?</td>
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</tr>
<tr>
<td><strong>6.7</strong> What does the One Stop Center do to help women, men, boys and girls who are at-risk of gender-based violence or who have experienced GBV in your community?</td>
<td>Do people know about the One Stop Center? If so, what do they think about it? Who does it provide services to? What services does it provide? How have services to women, girls, men, and boys who experienced GBV improved from before the Center opened to now? Do you people know about a telephone helpline for GBV survivors and perpetrators available to people in your community? If so, how does it work, what hours is it available?</td>
</tr>
<tr>
<td><strong>6.8</strong> What do you think are the challenges of the One Stop Center services?</td>
<td>Do you know if there is anyone who does not go there but should? If so, why don’t they go? Are there any challenges in accessing the services? If so, which? Why are there challenges?</td>
</tr>
<tr>
<td><strong>6.9</strong> How are traditional and religious leaders in your community involved in preventing and responding to GBV in your community?</td>
<td>What are they doing to prevent and respond to GBV, and how frequently? Do you consider their efforts successful? If yes, why? What else could be done?</td>
</tr>
</tbody>
</table>
6.10 **What type of awareness-raising or information-sharing activities about violence did you receive?** Probe: Describe the type of information, how it was shared, who shared, who received it, and with what frequency. Describe community dialogue, drama and community radio that you see in your community related to GBV. Who in your community was exposed to the awareness raising? Who most needs to be exposed to awareness-raising? What is being done to address myths about HIV with men, women, boys and girls, from the community? What changes in attitudes or behaviors of community members (men, women, boys, girls, community leaders) related to GBV did you observe following the community awareness? What, in your opinion, have you seen as the most effective way to reach men, women, boys, and girls with the information?

6.11 **How are men in your community active in speaking out against GBV?** Probe: What do they say? How many boys’ and young men’s groups are organized? How frequently do they hold discussions, individual talks, or lead activities related to GBV? Can you provide examples where you have seen a man make a real difference in his family life or in the family life of another man related to GBV? What challenges are there to sustaining boys’ and young men’s groups?

6.12 **What more can be done to prevent abuse and violence within families and communities to make it a safe place to live?** Probe: What more can be done by NGOs and the government to prevent and respond to GBV? What are the best ways to involve men and boys in preventing violence?

7. **Closing Focus Group**

**Time:** 5 minutes

**Goal:** To close the focus group, obtain consent to use information provided in the mid-term evaluation for STOP GBV, and to assist participants to feel more relaxed before departing from session.

**Interviewer Guidance:**

7.1 Thank participants for their participation in the discussion.

7.2 Ask participants if they have any questions about the discussion.

7.3 Ask participants if the information that they provided can be used in the STOP GBV evaluation: “Can I confirm that the points in our discussion today can be summarized in the evaluation that we will write? We will not identify any participant by name, but rather summarize the discussion and recommendations across all discussions we are having like this one.”

7.4 Explain to participants that they may approach any member of the interview team after the discussion to talk to them about anything else they wish to share. Also provide the name and contact information of a specific psychosocial support counselor for follow-up support.

7.5 After participants have departed, the interviewer should sign the enclosed consent form to indicate that they have obtained verbal consent from participants at the beginning of the interview for them to narrate their experiences, and at the end, to use information that they provided in summary fashion in the report (without any individual identifying information).
1. Introduction

1.1 Interviewers and Interviewee to introduce themselves. Record the names and titles of the interviewee.

1.2 Provide a general overview of STOP GBV: “USAID and DFID are working together over a five year period, from 2013-2018 to support the project, STOP GBV. The expected outcome of STOP GBV is an improved GBV violence prevention and response in Zambia. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia. Four program components are implemented to achieve this outcome and impact: 1) GBV survivor support services; 2) access to justice; 3) prevention and advocacy; and 4) engage men and boys through sports. STOP GBV is being implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP), each with their own agreement/contract.

1.3 Explain the purpose of the discussion to the interviewee: “USAID has contracted an independent firm, GH Pro, working with a local research organization in Zambia, IPSOS, to conduct a mid-term performance and process evaluation of STOP GBV. To conduct the mid-term evaluation, the team is reviewing project documents; conducting key informant interviews like this one with you, conducting focus group discussions within selected communities where the project is operating; and conducting surveys of community members where the project is operating.”

1.4 Clarify that “once we have completed our fieldwork, we will summarize the information into a general analysis that will inform the development of the mid-term evaluation for the STOP GBV program for USAID and its implementing partners to use to make necessary programmatic changes to improve delivery of services and also to measure progress made since the inception.”

1.5 Tell the interviewee, “Your participation and information is very valuable. You have been selected for this interview because of your expertise, knowledge, and experience. There are no right or wrong answers, but we only want to know your opinion. This interview will also not identify individual opinions, but rather will use the information confidentially, reporting it in aggregate. You are participating in this interview voluntarily and of your own free will. If, at any time, you feel uncomfortable with any particular question or would like to skip a question or stop the interviewee you are free to do so and you simply need to inform me. We very much appreciate your input, time, and participation.”

2. Request verbal consent from interviewee

2.1 Ask the interviewee, “Do you understand the purpose of this interview? Do you have any questions regarding this interview, the purpose, or how the information will be collected?” Answer any questions the interviewee may have.
2.2 Will you please provide your verbal and written consent to participate in this interview. Will you also provide me with permission to record this interview?

2.3 Interviewer (IPSOS) and interviewee signs and dates the informed consent form, providing one copy to the interviewee and retaining the signed copy.

2.4 Interviewer requests the interviewees name, position, title, and organization he/ she works for and documents this in the notes.

3. **Discussion of GBV (Types, Incidence, Risks, Causes, Effects)**

3.1 **What are the most common types of GBV that occur in your community?** Probe: Child marriage, rape, domestic violence, physical abuse, emotional/ verbal abuse, economic violence (e.g., widow inheritance, property rights, etc.), other?

3.2 **What do people in your community think about human trafficking?** Probe: How do people define trafficking? What are the dangers of trafficking? Who is at risk for trafficking? What are the effects on survivors of trafficking?

3.3 **Among which populations/ groups do different types of GBV occur, and how frequently?**


3.3.2 With what frequency do various types of GBV occur (e.g., daily, weekly, monthly, annually)?

3.4 **Where does GBV take place within communities?** Probe: Homes, water sites, roads, schools, pubs, streets, etc.?

3.5 **In your opinion, what do you think are the main reasons for GBV in your community?** Probe: Is alcohol a problem? Is poverty a problem? Is there ignorance of laws and rights? Is promiscuity a reason for GBV? What about GBV and what men and boys are taught to value and how to behave at home and in public?

3.6 **How do families in your community resolve conflict?** Probe: How do men and women resolve intimate partner conflicts? How do men resolve conflicts with one another? How do women resolve conflicts among each other? How do parents resolve conflicts with their children? How do children resolve conflicts with one another?

3.7 **What are the emotional and health consequences of GBV that you have observed and within the community?**

3.8 **How have people’s attitudes towards GBV changed in the past two years?** Probe: Among community leaders, religious leaders, and others? Among law enforcement officials? Among women? Among men? Among adolescent boys and girls? How have your attitudes changed?

3.9 **Compared to two years ago, do you think people are more or less safe than they are now? Explain.** Probe: Are women more or less safe? Young girls? Men? Boys? Orphans? Disabled? Elderly? What makes them more or less safe?
3.10 Where do you believe progress has been made in preventing and responding to GBV?

3.11 Where do you believe challenges still exist that need to be addressed?

4. Discussion of STOP GBV Programming (GENERAL)

I would like to ask you some questions specifically about the STOP GBV programming and One Stop Centers.

4.1 How does the One Stop Center and STOP GBV project coordinate with you and your community?

4.1.1 How is coordination improving the delivery of service or leading to more benefits for individuals and community members?

4.1.2 What has been challenging about coordination with STOP GBV?

4.1.3 How can STOP GBV better coordinate with you and the community?

4.2 What do you believe are the main successes so far of the STOP GBV program and/or One Stop Centers?

4.3 What other community structures, resources, or organizations have been useful to support STOP GBV activities? Probe: Apart from STOP GBV, can you name other organizations involved in the control of GBV in your constituency? What kind of support do they provide to the GBV survivors?

4.4 What are the main challenges that you have observed in the implementation of the program and operation of the STOP GBV programming and centers?

4.4.1 What are challenges related to management?

4.4.2 What are challenges related to service delivery?

4.4.3 What are challenges related to cost efficiency?

4.4.4 What are challenges related to making real change?

4.4.5 What are challenges related to sustainability?

4.4.6 What can be done to overcome identified challenges?

4.5 How does STOP GBV communicate with you and the community about their activities and results?

4.5.1 With what frequency?

4.5.2 How is the community involved in collecting and reporting information?

4.5.3 How does the community use information about GBV risks, attitudes and other information shared?

4.5.4 How do you share information with the community?

4.6 What do you think is the best way to know that STOP GBV is making a positive difference in the community?

4.7 What role do you play as an individual in the objectives to prevent and respond to GBV?

4.7.1 How have you changed as an individual in your beliefs and practices since becoming part of this project?

4.7.2 How do you see your role changing in the prevention and response to GBV over time?
4.8 In your opinion, how do you think that community members and beneficiaries' lives have changed so far as a result of any STOP GBV project activity or service?

4.9 What gaps exist in the program design, delivery or implementation which need to be addressed in order to positively influence implementation of STOP GBV?
4.9.1 What operational program improvements can be made to ensure impact and outcomes are achieved and/or improved?

4.10 What are the roles of the CWAC, ACC, and SWO in preventing and responding to GBV?
4.10.1 How do they coordinate with the STOP GBV project and One Stop Centers?
4.10.2 What are these groups doing well?
4.10.3 What challenges do they face?
4.10.4 How can they be strengthened and supported in a sustainable manner?

5. STOP GBV Programming Component 1: GBV Survivor Services

This GBV survivor services component, implemented by World Vision, aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centres that employ a culturally sensitive, victim-centred approach in sixteen districts.

5.1 GBV survivors receive an integrated care package through the One Stop Centers.
5.1.1 What services are most commonly provided at the One Stop Centers?
5.1.2 Are women, men, boys, and girls using/demanding GBV services? Explain.
5.1.3 What do you think women, men, boys and girls know about the range of services available for GBV?
5.1.4 Are GBV survivors aware of HIV services available to them? Are GBV survivors routinely provided with information and referrals to HIV services? Explain.
5.1.5 What challenges have been encountered in delivering all services required by a survivor?
5.1.6 How have challenges been addressed?
5.1.7 What are the barriers for GBV survivors accessing services?
5.1.8 Are existing services available to meet current and increased demand for services?

5.2 What types of GBV cases do you typically see reported, and by whom?
5.2.1 What are GBV survivors comfortable reporting? What are they not comfortable reporting?
5.2.2 What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why?
5.2.3 Have you seen an increase or decrease in reported cases at the centers?
5.2.4 Who does a GBV survivor (boys, girls, men women) turn to in crisis to seek any type of support (emotional, psychosocial, medical, legal, financial, etc.)?
5.2.5 What reaction from others do GBV survivors face (boys, girls, men, women survivors)? How do family members react? How do communities react?
5.2.6 What types of cases are met stigma by family members of the GBV survivor? What types of cases are met with stigma by center staff? What types of cases are met with stigma by the community? How can stigma be overcome?

5.3 In your opinion, how do you think GBV survivors feel about the service that they receive?
5.3.1 Have you received any feedback from survivors or their families on what they have liked? If so, which?

5.3.2 Have you received any feedback from clients/ survivors or their families on difficulties they have faced in accessing or receiving services from a One Stop Center? If so, how have those been dealt with?

5.3.3 How do the staff at the Center treat people from the community? Have the same staff been there for some time? Are staff always available when they are needed? How are staff attitudes toward GBV survivors?

5.4 How are referrals working for GBV survivors to other services, such as medical facilities, police, economic support like savings groups, safe houses/shelters, or other support?

5.4.1 What works well with the referral system?

5.4.2 How are you involved in making and monitoring referrals?

5.4.3 How are individual cases tracked and followed? Probe: If an individual is referred, how is the outcome of the referral tracked to see if they received the service they referred to and what happened?

5.4.4 What challenges have been encountered when referring survivors to other services? How have these challenges been addressed?

5.5 How do STOP GBV Center staff liaise with other services to ensure that survivors receive appropriate support?

5.5.1 Are fees for medical care or transport to a health center and/or police provided to GBV survivors? If so, how often and how much? Does it cover the complete cost of care? Have there been any cases of individuals who have not received care because of the costs?

5.5.2 How have Center staff been successful in liaising with other services? Please provide examples.

5.5.3 What challenges have Center staff encountered when liaising with other services? Please provide examples.

5.6 Have you received training from World Vision as a “traditional community counsellor” to provide ongoing support for survivors as well as referrals to One Stop Centers?

5.6.1 If so, can you describe the nature of training? What type of information did you receive? Who provides the training? How long is the training? How often is the training for each individual trainee? Are there refresher trainings? What have you observed as the ideal amount of training, received by each trainee?

5.6.2 How many other community leaders in your area have also received the “traditional community counsellor training” from World Vision?

5.6.3 Please provide an example of where you have made changes as a result of the training. Please describe what positive change or difference you have seen in the way in which other traditional community counsellors provide support to GBV survivors or make referrals in your community.

5.6.4 Where have you encountered challenges with training or uptake of training for you or other traditional community counsellors in your community?

5.6.5 How have these challenges been overcome?

5.7 Describe how mobile outreach is conducted, including who is conducting it, the type of outreach provided, and how frequently it is conducted.

5.7.1 Please describe the types of communities where mobile outreach is conducted.

5.7.2 Who is typically reached during mobile outreach (e.g. women, girls, men, boys, GBV survivors)? Are the persons who need to be reached being reached?
5.7.3 What are both positive and negative reactions from the community you have heard about when mobile outreach is conducted?

5.7.4 How is follow-up to mobile outreach services conducted?

5.8 How are local organizations helping to implement STOV GBV being strengthened?

5.8.1 How are these local organizations improving?

5.8.2 What challenges remain with these local organizations?

6. STOP GBV Programming Component 2: Access to Justice

This component, managed by Women in Law in Southern Africa (WLSA), aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018.

6.1 What do you think people (men, women, boys, girls) know about laws that exist about GBV?

Probe: Do you think people feel the laws are respected by community members? How are laws implemented? By whom? Who is responsible for carrying out the implementation of laws?

6.2 WLSA is training paralegals, lawyers, police, and other health service providers to provide legal services to GBV survivors at One Stop Centers.

6.2.1 Please describe customary law on various GBV cases. Traditionally, how do you and your community handle GBV cases, survivors, and perpetrators?

6.2.2 How are statutory laws related to GBV implemented in your community?

6.2.3 What formal legal processes are helpful to GBV survivors and their families?

6.2.4 What challenges exist within the community to formally reporting incidences of GBV?

6.2.5 What has stopped survivors from formally pursuing cases?

6.2.6 How are children and adolescent survivors of GBV treated by law enforcement officials, health staff at health facilities, and other staff/community members?

6.2.7 Describe any observed stigma toward GBV survivors among any stakeholder, community members, or family members. What can be done to address this stigma?

6.2.8 How frequently are you involved in formal legal processes, or do you make referrals on behalf of GBV survivors?

6.3 Have you received training from WLSA regarding formal law related to GBV? If so, can you describe the training content?

6.3.1 If so, can you describe the nature of training? What type of information did you receive? Who provides the training? How long is the training? How often is the training for each individual trainee? Are there refresher trainings? What have you observed as the ideal amount of training, received by each trainee?

6.3.2 How many other community leaders in your area have also received the training regarding laws on GBV from WLSA?

6.3.3 How do you work with paralegals, police, lawyers, judges, and others on behalf of GBV survivors’ legal needs? Do you make referrals, or are you involved in other ways?

6.3.4 Please provide an example of where you have made changes as a result of the training. Please describe what difference you have seen in the way in which other community leaders talk about or refer cases to the formal justice system.

6.3.5 What type of additional training would you or others benefit to learn more about statutory law on GBV?
6.4 Describe the nature of community awareness of legal aspects of GBV through mobile outreach activities that has been conducted. What type of information is provided, via what mechanisms, and by whom?

6.4.1 Please describe the types of communities where mobile outreach is conducted.
6.4.2 Who is typically reached during mobile outreach (e.g., women, girls, men, boys, GBV survivors)? Who is not being reached that should be reached, in your opinion?
6.4.3 What are both positive and negative reactions from the community that you have heard about when mobile outreach is conducted?
6.4.4 How is follow-up to mobile outreach services conducted?
6.4.5 Please describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV and legal aspects.

7. STOP GBV Programming Component 3: Prevention and Advocacy

The prevention and advocacy component is managed by Zambia Centre for Communication Programmes (ZCCP). This component aims to change social norms, attitudes, and behaviors and to tackle underlying risk factors for GBV by sensitizing and mobilizing communities through a comprehensive program of complementary communication interventions in 24 districts. This component ends in April 2018.

1. Have you received information regarding GBV and early child marriage? If you have, can you please describe the nature of the training? What type of information did you receive and how?

1.1 Have you received information regarding GBV and early child marriage? If you have, can you please describe the nature of the training? What type of information did you receive and how?

1.1.1 Who is involved in providing information about GBV to you (e.g., male/ female, from the community, position of authority)?
1.1.2 What did you find useful about the information you received regarding GBV and early child marriage?
1.1.3 What didn’t you like about the information you received regarding GBV and early child marriage?
1.1.4 How many other community leaders in your area have also received information regarding GBV and early child marriage?
1.1.5 How do you use the information provided to you regarding GBV and early child marriage?
1.1.6 What other information would you like regarding GBV and early child marriage that could help you in preventing and responding to GBV? What is the best way to provide new information to you? How frequently?
1.1.7 Please provide an example of how you have used information about GBV or early child marriage in the community, with a family, or an individual. Please provide an example of how another leader has used this information.
1.1.8 How many total GBV cases were brought to your attention in the past year? How many of these GBV cases have you or other traditional chiefs, headmen, and headwomen referred to a One Stop Center or for formal processes in the past year?

1.2 How are religious leaders in your community involved in preventing and responding to GBV in your community? Probe: What are they doing to prevent and respond to GBV, and how frequently? Do you consider their efforts successful? If yes, why? What else could be done?

1.3 Describe the activities of men in your community who are advocates or ‘change agents’ who communicate with other men about GBV.

1.3.1 Who are these men acting as change agents (e.g., age, marital status, income level, job status, religion, attitude about GBV before receiving training, past history of violence, etc.)? What types of men and boys are more likely to participate in the program? Who are not likely to participate?
1.3.2 How frequently do men in your community hold discussions, individual talks, or lead activities related to GBV?

1.3.3 How long does one man stay “active” as a change agent? What motivates them to continue acting as change agents?

1.3.4 Can you provide examples, without naming anyone’s specific name, where you have seen a man make a real difference in his family life or in the family life of another man related to GBV?

1.3.5 What has the reaction been from men, boys, and the community to the communication of male ‘change agents’ within the community?

1.3.6 Please describe change that you have observed, measured and documented at both the group level and the individual level.

1.4 Describe community dialogue, drama and community radio that you see in your community related to GBV.

1.4.1 What topics are covered?

1.4.2 What is being done to address myths about HIV with men, women, boys and girls, from the community?

1.4.3 Who in your community is reached by different types of GBV awareness?

1.4.4 What, in your opinion, have you seen as the most effective way to reach men, women, boys, and girls with the information?

1.4.5 Who creates them, conducts them, and performs/ leads them? Where do they come from?

1.4.6 How frequently are each type of awareness conducted?

1.4.7 What have you observed to be positive change among individuals or broadly in the community that you can directly attribute to a community dialogue, drama, or community radio?

1.5 Is there a telephone helpline for GBV survivors and perpetrators available to people in your community? If so, how does it work, what hours is it available, and who staffs the hotline?

1.5.1 Do people (men, women, boys, and girls) in your community know about it?

1.5.2 Who typically calls/ utilizes the helpline, and what types of issues are commonly discussed?

1.5.3 Who do you think doesn’t call the helpline that would benefit and how can they be better reached?

1.5.4 How are referrals made and followed-up on?

1.5.5 How are referral services provided?

1.5.6 Do GBV survivors have adequate services available to meet the demand created by the helpline?

1.5.7 Do GBV perpetrators have adequate services available to meet the demand created by the helpline?

1.5.8 Please provide an example of a successful case where a GBV survivor called the helpline and received the support required.

1.5.9 Please provide an example of a successful case where a GBV perpetrator called the helpline and appropriate support and intervention was made.

1.5.10 What challenges exist to operating the helpline?

1.5.11 How do you believe that the helpline has improved prevention and response to GBV? Please provide examples.

1.6 What traditional and community structures exist in your community?

1.6.1 Describe how you have used information you have received regarding GBV and early child marriage to change behaviors within traditional and community related to child marriage.

1.6.2 What has been effective in ending child marriage?

1.6.3 What challenges remain in ending child marriage? How do you address these challenges?
1.7 Please describe the capacity of district level health facility to accommodate the needs of a One Stop Center.

1.7.1 What is the health facility medical staff capacity to address needs of GBV survivors?

1.7.2 What type of training do medical staff receive?

1.7.3 Please describe any challenges due to health facility staff capacity. How are these challenges addressed?

1.7.4 Please explain any stigmatization of GBV survivors among health facility staff. How is stigma addressed among staff?

8. STOP GBV Programming Component 4: Engaging boys and young men

Component 4 focuses on engaging young men and boys (age 12-23) through football managed by World Vision. This component builds on the proven Young Men as Equal Partners methodology employed by Sport in Action in Zambia.

8.1 Who are the existing football teams and clubs, and coaches in your community who are trained in GBV and as mentors for other young men and boys?

8.1.1 Can you provide examples, without naming anyone’s specific name, where you have seen a football coach successfully change the GBV-related attitudes and/or behaviors of the boys and young men they are coaching?

8.1.2 What are the challenges are there in working with young men and boys to change attitudes about GBV?

8.1.3 How can these challenges be overcome?

8.2 Have you seen organized football tournaments happen in your community where GBV messages have been disseminated to a wider audience of boys and men?

8.2.1 If so, what are the outcomes of these GBV messages at tournaments? What has the reaction been from men, boys, and the community to the communication of GBV messages at tournaments?

8.2.2 Please describe change that you have observed in the community as a result of GBV messages disseminated at tournaments related to GBV attitudes and behaviors, at both the group level and the individual level.

8.3 How many boys’ and young men’s groups have been organized in your community?

8.3.1 How frequently do they meet, and for how long, and over what period of time?

8.3.2 Who leads the group sessions? Please explain the structure.

8.3.3 What is the nature of discussion about GBV?

8.3.4 Please provide an example or two, without naming specific names, where you have observed a real change in the attitude or behavior of a young man or boy as a direct result of participating in a group.

8.3.5 What challenges are there to sustaining boys’ and young men’s groups in your community?

8.3.6 What role do you play in boys’ and men’s groups in your community? Do you participate?

8.4 How are you working with parents of boys and young men to prevent GBV?

8.4.1 How do families support their sons in participating in prevention of GBV activities?

8.4.2 What challenges do you encounter?
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<td>Who are not likely to participate who should? How could they be encouraged or supported to participate?</td>
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<td>What reactions do family members have to men and boys’ participation?</td>
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KEY INFORMANT INTERVIEW (KII) GUIDE #2: GOVERNMENT MINISTRY

1. Introduction

1.1 Interviewers and Interviewee to introduce themselves. Record the names and titles of the interviewee.

1.2 Provide a general overview of STOP GBV: “USAID and DFID are working together over a five year period, from 2013-2018 to support the project, STOP GBV. The expected outcome of STOP GBV is an improved GBV violence prevention and response in Zambia. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia. Four program components are implemented to achieve this outcome and impact: 1) GBV survivor support services; 2) access to justice; 3) prevention and advocacy; and 4) engage men and boys through sports. STOP GBV is being implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP), each with their own agreement/contract.

1.3 Explain the purpose of the discussion to the interviewee: “USAID has contracted an independent firm, GH Pro, working with a local research organization in Zambia, IPSOS, to conduct a mid-term performance and process evaluation of STOP GBV. To conduct the mid-term evaluation, the team is reviewing project documents; conducting key informant interviews like this one with you, conducting focus group discussions within selected communities where the project is operating; and conducting surveys of community members where the project is operating.”

1.4 Clarify that “once we have completed our fieldwork, we will summarize the information into a general analysis that will inform the development of the mid-term evaluation for the STOP GBV program for USAID and its implementing partners to use to make necessary programmatic changes to improve delivery of services and also to measure progress made since the inception.”

1.5 Tell the interviewee, “Your participation and information is very valuable. You have been selected for this interview because of your expertise, knowledge, and experience. There are no right or wrong answers, but we only want to know your opinion. This interview will also not identify individual opinions, but rather will use the information confidentially, reporting it in aggregate form without attributing specific information to individual informants. You are participating in this interview voluntarily and of your own free will. If, at any time, you feel uncomfortable with any particular question or would like to skip a question or stop the interviewee delete you are free to do so and you simply need to inform me. We very much appreciate your input, time, and participation.”

2. Request verbal consent from interviewee

2.1 Ask the interviewee, “Do you understand the purpose of this interview? Do you have any questions regarding this interview, the purpose, or how the information will be collected?” Answer any questions the interviewee may have.

2.2 Will you please provide your verbal and written consent to participate in this interview? Will you also provide me with permission to record this interview?

2.3 Interviewer (IPSOS) and interviewee signs and dates the informed consent form, providing one copy to the interviewee and retaining the signed copy.
2.4 Interviewer requests the interviewee’s name, position, title, and organization he/she works for and documents this in the notes.

3. Discussion of GBV (Types, Incidence, Risks, Causes, Effects)

3.1 What are the most common types of GBV that occur nationally? Probe: Child marriage, rape, domestic violence, physical abuse, emotional/verbal abuse, economic violence (e.g., widow inheritance, property rights, etc.), other?

3.2 Among which populations/groups do different types of GBV occur, and how frequently?
3.2.2 With what frequency do different types of GBV occur (e.g., daily, weekly, monthly, annually)?

3.3 Where does GBV take place within communities? Probe: Homes, water sites, public transport, community areas, roads, schools, pubs, streets, etc.?


3.5 What are the emotional and health consequences of GBV?

3.6 Where do you believe progress has been made in preventing and responding to GBV?

3.7 Where do you believe challenges still exist that need to be addressed?

4. Discussion of STOP GBV Programming (GENERAL)

I would like to ask you some questions specifically about the STOP GBV programming and One Stop Centers.

4.1 How are implementing partners across the four STOP GBV components coordinating with your ministry?
4.1.1 How is coordination improving the delivery of your service or leading to more benefits for individuals and community members?
4.1.2 What has been challenging about coordination with implementing partners?
4.1.3 How can coordination of STOP GBV project and partners with your ministry and district departments be improved?

4.2 What do you believe are the main successes so far of the STOP GBV program and/or STOP GBV centers?

4.3 What are the main challenges that you have observed in the implementation of the program and operation of the STOP GBV programming and centers?
4.3.1 What are challenges related to management?
4.3.2 What are challenges related to service delivery?
4.3.3 What are challenges related to cost efficiency?
4.3.4 What are challenges related to making real change?
4.3.5 What are challenges related to sustainability?
4.3.6 What can be done to overcome identified challenges?
4.4 What gaps exist in the program design, delivery or implementation which need to be addressed in order to positively influence implementation of the program?
   4.4.1 What operational program improvements can be made to ensure impact and outcomes are achieved and/or improved?

4.5 What are the roles of the CWAC, ACC, and SWO in preventing and responding to GBV?
   4.5.1 How do they coordinate with the STOP GBV project and One Stop Centers?
   4.5.2 What are these groups doing well?
   4.5.3 What challenges do they face?
   4.5.4 How can they be strengthened and supported in a sustainable manner?

4.6 How are STOP GBV program indicators feeding into national data collection and national efforts to collect data and conduct analysis on GBV?

5. STOP GBV Programming Component 1: GBV Survivor Services

This GBV survivor services component, implemented by World Vision, aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centers that employ a culturally sensitive, victim-centered approach in sixteen districts.

5.1 GBV survivors receive an integrated care package through the One Stop Centers.
   5.1.1 What do you think women, men, boys and girls know about the range of services available for GBV?
   5.1.2 What challenges have been encountered in delivering all services required by a survivor?
   5.1.3 How have challenges been addressed?
   5.1.4 What are the barriers for GBV survivors accessing services?
   5.1.5 Are existing services available to meet current and increased demand for services?

5.2 What types of GBV cases do you typically see reported, and by whom?

5.3 How are seconded government workers working with One Stop Centers?
   5.3.1 What has worked well?
   5.3.2 What are the challenges? How can challenges be overcome?

5.3.3 How is One Stop Center staff training and guidelines being used nationally and outside of the Centers?

5.4 GBV survivors are referred to medical facilities, the police, and to economic support programs, as well as safe houses, shelters, and survivor support networks.
   5.4.1 What works well with the referral system?
   5.4.2 What challenges have been encountered when referring survivors to other services? How have these challenges been addressed?

5.5 World Vision is training “traditional community counsellors” to provide ongoing support for survivors as well as referrals to One Stop Centers.
   5.5.1 How do you think the inclusion of traditional community counsellors in this process has been successful?
   5.5.2 Where do you see challenges? How can these challenges be overcome?

5.6 World Vision is conducting mobile outreach to improve access to services.
   5.6.1 What do you think works well about mobile outreach services for GBV survivors?
   5.6.2 What are the challenges?
6. **STOP GBV Programming Component 2: Access to Justice**

This component, managed by Women in Law in Southern Africa (WLSA), aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018.

6.1 **What do you think people (men, women, boys, girls) know about laws that exist about GBV?**

6.2 **WLSA is training paralegals to provide legal services to GBV survivors at One Stop Centers.**

6.2.1 What legal processes have found to be helpful to support GBV survivors?

6.2.2 How are laws related to GBV implemented in practice?

6.2.3 What legal processes have presented challenges for paralegals and GBV survivors?

6.2.4 What barriers (legal, social, cultural, economic) exist within the community to formally reporting incidences of GBV?

6.2.5 What has stopped survivors from pursuing cases?

6.3 **WLSA is training police in GBV and their role in investigations, etc.**

6.3.1 What is support like for trained police officers by their superiors?

6.3.2 How are trained police cooperative and helpful in investigation, evidence collection (including forensics), prosecution of cases, witness support, and referral of cases?

6.3.3 Where do challenges remain in police cooperation in the areas mentioned, and how can those challenges be addressed?

6.3.4 Describe any observed stigma toward GBV survivors among police? What can be done to address this stigma?

6.4 **WLSA is training key legal and judicial stakeholders, including lawyers, legal aid lawyers, judges, magistrates, and public prosecutors.**

6.4.1 What is support like for trained legal and judicial stakeholders by their superiors?

6.4.2 Describe how trained legal and judicial stakeholders have been cooperative and helpful in prosecuting cases brought forward.

6.4.3 Where do challenges remain in working with legal and judicial stakeholders?

6.4.4 Describe any observed stigma toward GBV survivors among legal and judicial stakeholders. If there has been stigma, how has this been addressed?

6.5 **WLSA is sensitizing traditional chiefs, headmen and headwomen and others responsible for administering customary law and the traditional justice system, on GBV issues.**

6.5.1 How are traditional chiefs and headmen/ women changing their actions and interactions with the community related to GBV?

6.5.2 What challenges remain in sensitization of traditional chiefs and headmen/ women?

6.5.3 Describe any observed stigma toward GBV survivors among traditional chiefs and headmen/ women. If there has been stigma, how has this been addressed?

6.5.4 How are traditional leader sensitization efforts coordinated with ongoing national efforts to sensitize traditional leaders?

6.6 **WLSA is training other service providers, including health and social workers, on identifying which survivors require information about legal processes and on the legal aspects of managing cases of GBV.**
6.6.1 What is support like for trained service providers by their superiors?
6.6.2 Describe how service providers have been cooperative and helpful in collecting evidence, serving as witnesses, and in other legal aspects.
6.6.3 Where do challenges remain in working with other service providers on legal aspects?
6.6.4 Describe any observed stigma toward GBV survivors among other service providers. If there has been stigma, how has this been addressed?

6.7 **WLSA is conducting community awareness of legal aspects of GBV through mobile outreach activities.**
6.7.1 Do you think that people who need to be reach being effectively reached?
6.7.2 Please describe any observed improvement or change in how the communities have become more aware about legal aspects of GBV.

7. **STOP GBV Programming Component 3: Prevention and Advocacy**
The prevention and advocacy component is managed by Zambia Centre for Communication Programmes (ZCCP). This component aims to change social norms, attitudes and behaviors and to tackle underlying risk factors for GBV by sensitizing and mobilizing communities through a comprehensive program of complementary communication interventions in 24 districts. This component ends in April 2018.

1.1 **ZCCP is working to sensitize traditional, community and religious leaders with messages about GBV and early child marriage.**
1.1.1 How are traditional and religious leaders involved in preventing and responding to GBV?
1.1.2 What are they doing to prevent and respond to GBV, and how frequently? Do you consider their efforts successful? If yes, why?
1.1.3 Please provide an example of positive change you have observed in the way in which traditional chiefs and headsmen women have dealt with GBV?
1.1.4 What challenges remain in sensitization of traditional chiefs and headsmen/women?
1.1.5 Describe any observed stigma toward GBV survivors among traditional chiefs and headsmen/women. If there has been stigma, how has this been addressed?
1.1.6 How are traditional leader sensitization efforts coordinated with national efforts to work with traditional leaders on GBV and child marriage?

1.2 **ZCCP is training men as advocates or ‘change agents’ to communicate with other men in their community about GBV and to take action in their own lives and communities.**
1.2.1 What change to see you in communities as a result of more men playing a role in the prevention and response to GBV?
1.2.2 What challenges remain in engaging men and seeing sustained behavior change at group and individual levels?
1.2.3 How can these challenges be overcome?

1.3 **ZCCSP is conducting community dialogue, drama and community radio that is used to increase community awareness and promote discussion and reflection on GBV issues.**
1.3.1 What are successful observations of positive change that you can directly attribute to a community dialogue, drama, or community radio?
1.3.2 What are challenges that have been faced?
1.3.3 How are community awareness efforts coordinated with other national community awareness efforts?

1.4 **ZCCSP is operating a telephone helpline for GBV survivors and perpetrators.**
1.4.1 Do GBV survivors have adequate services available to meet the demand created by the helpline?
1.4.2 Do GBV perpetrators have adequate services available to meet the demand created by the helpline?
1.4.3 How do you believe that the helpline has improved prevention and response to GBV?
1.4.4 What challenges exist to operating the helpline?

1.5 ZCCSP is working with traditional and community structures to shift negative social norms on ending child marriage.
1.5.1 What has been effective in shifting negative social norms on ending child marriage?
1.5.2 What challenges remain in shifting negative social norms on ending child marriage?
1.5.3 How can these challenges be addressed?

1.6 Please describe the capacity of district level health facility to accommodate the needs of a One Stop Centre.
1.6.1 What is the health facility medical staff capacity to address needs of GBV survivors?
1.6.2 What type of training do medical staff receive?
1.6.3 Please describe any challenges due to health facility staff capacity. How are these challenges addressed?
1.6.4 Please explain any stigmatization of GBV survivors among health facility staff. How is stigma addressed among staff?
1.6.5 Please describe the willingness of health facility staff to engage with the STOP GBV program. What type of staff (male/ female, position) are more or less eager to engage and supportive of the program?

1.7 Some One Stop Centers were selected to be managed by the Zambian government from the outset onset.
1.7.1 What is working well with the government-run One Stop Centers, compared to the other centers run by implementing partners?
1.7.2 What challenges do the government-run One Stop Centers faced, as compared to those run by implementing partners?
1.7.3 What are the lessons learned in supporting government-run One Stop Centers, and what changes can be made in the future?

9. STOP GBV Programming Component 4: Engaging boys/ young men
Component 4 focuses on engaging young men and boys (age 12-23) through football managed by World Vision. This component builds on the proven Young Men as Equal Partners methodology employed by Sport in Action in Zambia.

9.1 How is working through sports a useful and effective medium to reach boys and young men?

9.2 How have partnerships with football clubs and teams to engage young men and boys been successful?
9.2.1 Where have there been challenges?
9.2.2 How have challenges been addressed?

9.3 How well are boys’ and young men’s groups operating?
9.3.1 Are such groups resulting in real, sustainable change in attitudes and practices at individual and group levels?
9.3.2 What challenges remain in working sustainably with boys’ and young men’s groups?
9.3.3 How can such challenges be overcome?

10. Closing the Interview
10.1 Thank the interviewee for their participation in the discussion.
10.2  “Are there any other issues that have not been discussed that you think are important and would like to discuss?”

10.3  Ask the interviewee if they have any questions about the discussion.

10.4  Ask the interviewee, again, if the information that he/she provided can be used in the mid-term evaluation. Clarify that all information will be summarized and that the evaluation will not identify any participants by name unless he/she authorizes you to attribute what they said to them individually.
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2.4 Interviewer requests the interviewees name, position, title, and organization he/ she works for and documents this in the notes.

3. Discussion of GBV (Types, Incidence, Risks, Causes, Effects)

3.1 What are the most common types of GBV that occur (nationally, in the communities where you work)? Probe: Child marriage, rape, domestic violence, physical abuse, emotional/ verbal abuse, economic violence (e.g., widow inheritance, property rights, etc.), other?


3.3 Where does GBV take place within communities? Probe: Homes, water sites, roads, public transportation, community areas, schools, pubs, streets, etc.?


3.5 What are the emotional and health consequences of GBV that you have observed and within the community?

3.6 How do families in your community resolve conflict? Probe: How do men and women resolve intimate partner conflicts? How do men resolve conflicts with one another? How do women resolve conflicts among each other? How do parents resolve conflicts with their children? How do children resolve conflicts with one another?

3.7 What are the emotional and health consequences of GBV that you have observed and within the community?

3.8 How have people’s attitudes towards GBV changed in the past two years? Probe: Among community leaders, religious leaders, and others? Among law enforcement officials? Among women? Among men? Among adolescent boys and girls? How have your attitudes changed?

3.9 Compared to two years ago, do you think people are more or less safe than they are now? Explain. Probe: Are women more or less safe? Young girls? Men? Boys? Orphans? Disabled? Elderly? What makes them more or less safe?

3.10 Where do you believe progress has been made in preventing and responding to GBV?

3.11 Where do you believe challenges still exist that need to be addressed?

4. Discussion of STOP GBV Programming (GENERAL)

I would like to ask you some questions specifically about the STOP GBV programming and One Stop Centers:
4.1 Please describe the management structure of the programming for which your organization is responsible.

4.1.1 When did your organization first begin to implement the STOP GBV program component that you manage?

4.1.2 What management practices have contributed to successful in delivering services/activities to the targeted population?

4.1.3 What management challenges have been encountered? How have they been addressed?

4.2 How do you coordinate with other implementing partners?

4.2.1 How is coordination improving the delivery of your service or leading to more benefits for individuals and community members?

4.2.2 What has been challenging about coordination with implementing partners?

4.3 How do you coordinate with the Zambian government, including the Ministry of Community Development, Mother and Child Health, the Ministry of Gender and Child Development, the police, the judicial system and others?

4.3.1 How is coordination improving the delivery of your service or leading to more benefits for individuals and community members?

4.3.2 What has been challenging about coordination with implementing partners?

4.4 How do you coordinate with the community? Probe: Community leaders, community groups, religious leaders, individual community members?

4.5 What do you believe are the main successes so far of the STOP GBV program and/or STOP GBV centres?

4.6 What structures, resources, or organizations have been assets in implementing your activities (external to your program and staff)? Probe: Apart from your organization, can you name various organizations involved in the control of GBV in your constituency? What kind of support do they provide to the GBV survivors?

4.7 What are the main challenges that you have observed in the implementation of the program and operation of the STOP GBV programming and centers?

4.7.1 What are challenges related to management?

4.7.2 What are challenges related to coordination?

4.7.3 What are challenges related to service delivery?

4.7.4 What are challenges related to cost efficiency?

4.7.5 What are challenges related to making real change?

4.7.6 What are challenges related to sustainability?

4.7.7 What can be done to overcome identified challenges?

4.8 What sort of lessons learned or other forms of learning do you capture regularly

4.8.1 With what frequency?

4.8.2 Who is involved in capturing lessons learned?

4.8.3 How are lessons learned incorporated in programming?

4.8.4 How do you share lessons with implementing partners?

4.9 What you deem as the most effective indicators or measures of effectiveness of your programming?
4.9.1 How are you measuring real change in individuals and in communities, beyond output-level indicators that measure service or activity provision?

4.9.2 What types of outcome level indicators are you measuring, and how?

4.9.3 What types of impact level indicators are you measuring, and how?

4.9.4 How are implementing partners coordinating M&E efforts?

4.10 In your opinion, how do you think that community members and beneficiaries lives have changed so far as a result of any STOP GBV project activity or service?

4.11 What gaps exist in the program design, delivery or implementation which need to be addressed in order to positively influence implementation of the program?

4.11.1 What are the differences in efficiency and effectiveness between existing and scale-up sites (i.e., the inclusion of activities addressing boys and young men through sports) and what would you identify as benefits in the scale-up districts which could be integrated into the original program sites?

4.11.2 What operational program improvements can be made to ensure impact and outcomes are achieved and/or improved?

4.12 What are the roles of the CWAC, ACC, and SWO in preventing and responding to GBV?

4.12.1 How do they coordinate with the STOP GBV project and One Stop Centers?

4.12.2 What are these groups doing well?

4.12.3 What challenges do they face?

4.12.4 How can they be strengthened and supported in a sustainable manner?

5. STOP GBV Programming Component 1: GBV Survivor Services

QUESTIONS ONLY ASKED IN THIS SECTION OF WORLD VISION TECHNICAL STAFF.

This GBV survivor services component, implemented by World Vision, aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centers that employ a culturally sensitive, victim-centered approach in sixteen districts.

5.1 Please describe the integrated package of care that your organization provides to GBV survivors. Probe: Describe medical care, counselling, including HIV counselling and counselling for child survivors, provision of post-exposure prophylaxis and emergency contraception, psychological support, and legal advice and support for adult and child GBV survivors.

5.1.1 What services are most commonly provided at the One Stop Centers?

5.1.2 Are women, men, boys, and girls using/demanding GBV services? Explain.

5.1.3 What do you think women, men, boys and girls know about the range of services available for GBV?

5.1.4 Are GBV survivors aware of HIV services available to them? Are GBV survivors routinely provided with information and referrals to HIV services? Explain.

5.1.5 What challenges have been encountered in delivering all services required by a survivor?

5.1.6 How have challenges been addressed?

5.1.7 What are the barriers for GBV survivors accessing services?

5.1.8 Are existing services available to meet current and increased demand for services?

5.2 What types of GBV cases do you typically see reported, and by whom?
| 5.2.1 | What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why? |
| 5.2.2 | What are GBV survivors comfortable reporting? What are they not comfortable reporting? |
| 5.2.3 | What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why? |
| 5.2.4 | Have you seen an increase or decrease in reported cases at the centers? |
| 5.2.5 | Who does a GBV survivor (boys, girls, men, women) turn to in crisis to seek any type of support (emotional, psychosocial, medical, legal, financial, etc.)? |
| 5.2.6 | What reaction from others do GBV survivors face (boys, girls, men, women survivors)? How do family members react? How do communities react? |
| 5.2.7 | What types of cases are met stigma by family members of the GBV survivor? What types of cases are met with stigma by center staff? What types of cases are met with stigma by the community? How can stigma be overcome? |

5.3 **In your opinion, how do you think GBV survivors feel about the service that they receive?**

| 5.3.1 | Have you received any feedback from clients/ survivors or their families on what they have liked? If so, which? |
| 5.3.2 | Have you received any feedback from clients/ survivors or their families on difficulties they have faced? If so, how have those been dealt with? |

5.4 **Please describe the staffing structure of each center.**

| 5.4.1 | How do the coordinator, full-time health worker, social worker, and Victim Support Unit police officer, all seconded and paid for by government, and by volunteer counsellors and paralegals work with the center and with each other? |
| 5.4.2 | What are staff working hours and retention rates? |
| 5.4.3 | What are staff attitudes toward their jobs? |
| 5.4.4 | What are staff attitudes towards the survivors that they are serving? |
| 5.4.5 | What is staff retention and turn-over like? If turn-over is high, why is this? |
| 5.4.6 | Have there been any instances of complaints from the community or clients about the way in which any staff person treated them? If so, how were those complaints addressed? |
| 5.4.7 | Describe any observed stigma toward GBV survivors among paralegals. If there has been stigma, how has this been addressed? |

5.5 **What type of training do One Stop Center staff receive, and how regularly?**

| 5.5.1 | What guidelines and training materials are used for training? |
| 5.5.2 | What is the ideal “dose” of training for each staff member, meaning, how frequently, and in what length for each training, is required to ensure uptake and regular practice of training material? |
| 5.5.3 | What additional training and learning is required to continue building staff skills? |
| 5.5.4 | Please describe an example of a staff member who made positive changes as a result of training. |
| 5.5.5 | What challenges have been observed in training staff members (e.g. attitude, literacy, etc.)? |
| 5.5.6 | What challenges have been observed in the uptake and use of training material? |

5.6 **Describe the referral process for GBV survivors to other services.** **Probe:** Describe referrals to medical facilities for further treatment, the police via Victim Support Units, economic support through micro-finance, savings groups and skills development, safe houses or shelters, and survivor support networks.

| 5.6.1 | What works well with the referral system? |
| 5.6.2 | How are individual cases tracked and followed? **Probe:** If an individual is referred, how is the outcome of the referral tracked to see if they received the service they referred to and what happened? |
5.6.3 What challenges have been encountered when referring survivors to other services? How have these challenges been addressed?

5.7 Describe how STOP GBV Center staff liaises with other services to ensure that survivors receive appropriate support.

5.7.1 Are fees for medical care or transport to a health center and/or police provided? If so, how often and how much? Does it cover the complete cost of care? Have there been any cases of individuals who have not received care because of the costs?

5.7.2 How have Centre staff been successful in liaising with other services? Please provide examples.

5.7.3 What challenges have Centre staff encountered when liaising with other services? Please provide examples.

5.8 How many traditional community counsellors have been trained to provide ongoing support for survivors as well as referrals to One Stop Centers?

5.8.1 Please describe the nature of training of traditional community counselors. Who provides the training?

5.8.2 How long is the training? How often is the training for each individual trainee? Are there refresher trainings? What have you observed as the “ideal dose” of training, meaning how long and with what frequency, to observe a real change in the trainee?

5.8.3 Please provide an example of where you have observed positive change or difference in the way in which traditional community counsellors provide support or make referrals.

5.8.4 Where have you encountered challenges with training or uptake of training for traditional community counsellors?

5.8.5 How have these challenges been overcome?

5.9 Describe how mobile outreach is conducted, including who is conducting it, the type of outreach provided, and how frequently it is conducted.

5.9.1 Please describe the types of communities where mobile outreach is conducted.

5.9.2 Who is typically reached during mobile outreach (e.g. women, girls, men, boys, GBV survivors)?

5.9.3 What are both positive and negative reactions from the community that staff have experienced when conducting mobile outreach?

5.9.4 How is follow-up to mobile outreach services conducted?

5.10 How is the capacity of STOV GBV local primes being strengthened? Please describe the nature of organizational assessments, results, and action taken based on assessment results.

5.10.1 Describe examples of successful capacity building where change and improvement of local primes is observed.

5.10.2 Describe challenges in capacity building and sustainability beyond the project close.

5.10.3 How are capacity building efforts regularly monitored and evaluated? What indicators are used to measure success?

6. STOP GBV Programming Component 2: Access to Justice

QUESTIONS FROM THIS SECTION ARE ONLY ASKED FROM WLSA STAFF

This component, managed by Women in Law in Southern Africa (WLSA), aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018.

6.1 What do you think people (men, women, boys, girls) know about laws that exist about GBV?
Probe: Do you think people feel the laws are respected by community members? How are laws implemented? By whom? Who is responsible for carrying out the implementation of laws?

6.1 Please describe customary law on various GBV cases. Traditionally, how does the community handle GBV cases, survivors, and perpetrators?

6.1.1 How are statutory laws related to GBV implemented in the communities where you work?

6.1.2 What formal legal processes are helpful to GBV survivors and their families?

6.1.3 What challenges exist within the community to formally reporting incidences of GBV?

6.1.4 Has what stopped survivors from formally pursuing cases?

6.1.5 How are children and adolescent survivors of GBV treated by law enforcement officials, health staff at health facilities, and other staff/community members?

6.2 Describe training that paralegals have received, particularly in the content of the training and tools used, and who conducts the training.

6.2.1 How many paralegals have been trained, and who are they? Do they work only at One Stop Centers, or do they also work elsewhere?

6.2.2 What is the retention rate of trained paralegals at the One Stop Centers?

6.2.3 What is the ideal “dose” for training paralegals, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of training?

6.3 Describe the services that paralegals provide at STOP GBV centers.

6.3.1 What other staff, individuals, and organizations do paralegals work with?

6.3.2 What legal processes have presented challenges for paralegals?

6.3.3 How many GBV survivors have initiated legal processes with a paralegal at a One Stop Center? Out of those cases, how many have been prosecuted?

6.3.4 Describe any observed stigma toward GBV survivors among paralegals. If there has been stigma, how has this been addressed?

6.4 Describe training that police have received, particularly in the content of the training and tools used, and who conducts the training.

6.4.1 How many police have been trained and who are they (male/female, officer role/location, etc.)?

6.4.2 What is the ideal “dose” for training police, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of training? Does your training meet this “dose”?

6.4.3 What is support like for trained police officers by their superiors? Are there challenges that have been encountered?

6.4.4 Describe how trained police have been cooperative and helpful in investigation, evidence collection (including forensics), prosecution of cases, witness support, and referral of cases.

6.4.5 Where do challenges remain in police cooperation in the areas mentioned, and how can those challenges be addressed?

6.4.6 Describe any observed stigma toward GBV survivors among police? If there has been stigma, how has this been addressed?

6.5 Describe training that key legal and judicial stakeholders, including lawyers, legal aid lawyers, judges, magistrates, and public prosecutors, have received, particularly in the content of the training and tools used, and who conducts the training.

6.5.1 How many legal and judicial stakeholders have been trained and who are they (male/female, position/role/location, etc.)?

6.5.2 What is the ideal “dose” for training of legal and judicial stakeholders (including lawyers legal aid lawyers, judges, magistrates, and public prosecutors), in terms of how much training they receive
and how frequently, to ensure uptake and regular practice of training? Does your training meet this “dose”?

6.5.3 What is support like for trained legal and judicial stakeholders by their superiors? Are there challenges that have been encountered?

6.5.4 Describe how trained legal and judicial stakeholders have been cooperative and helpful in prosecuting cases brought forward.

6.5.5 Where do challenges remain in working with legal and judicial stakeholders?

6.5.6 Describe any observed stigma toward GBV survivors among paralegals. If there has been stigma, how has this been addressed?

6.6 Describe the sensitization of traditional chiefs, headmen and headwomen and others responsible for administering customary law and the traditional justice system, on GBV issues.

6.6.1 How are they sensitized on statutory law concerning GBV and domestic violence?

6.6.2 How many traditional chiefs and headmen/ women have been sensitized and who are they (male/ female, ages, etc.)?

6.6.3 What is the ideal “dose” for sensitizing of traditional chiefs and headmen/women, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of sensitization? Does your training meet this “dose”?

6.6.4 How have you observed traditional chiefs and headmen/ women to incorporate sensitization into their lives and interactions with the community and individuals?

6.6.5 Please provide an example of positive change you have observed in the way in which traditional chiefs and headmen women have dealt with GBV generally in the community, and with individual cases of GBV.

6.6.6 Please describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV. Please provide examples. How do you measure this change?

6.6.7 What challenges remain in sensitization of traditional chiefs and headmen/ women?

6.6.8 Describe any observed stigma toward GBV survivors among traditional chiefs and headmen/ women. If there has been stigma, how has this been addressed?

6.6.9 How many cases have traditional chiefs, headmen, and headwomen referred to a One Stop Centre or for formal processes?

6.6.10 How are traditional leader sensitization efforts coordinated with ZCCP’s prevention and advocacy efforts? Are they integrated in the same communities or independent?

6.7 Describe the training provided to other service providers, including health and social workers, on identifying which survivors require information about legal processes and on the legal aspects of managing cases of GBV, including issues such as documenting evidence. Please include a description of the training content, tools used, and who delivered the training.

6.7.1 How many other service providers have been trained and who are they (male/ female, position/ role/ location, etc.)?

6.7.2 What is the ideal “dose” for training of other service providers, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of training? Does your training meet this dose?

6.7.3 What results have you observed from this training, and how do you measure results of training?

6.7.4 What is support like for trained service providers by their superiors? Are there challenges that have been encountered?
### 6.7.5 Describe how service providers have been cooperative and helpful in collecting evidence, serving as witnesses, and in other legal aspects.

### 6.7.6 Describe how attitudes toward GBV has changed, and how you measure changes in attitudes and practices.

### 6.7.7 Where do challenges remain in working with other service providers on legal aspects?

### 6.7.8 Describe any observed stigma toward GBV survivors among other service providers. If there has been stigma, how has this been addressed?

### 6.8 Describe the nature of community awareness of legal aspects of GBV through mobile outreach activities that has been conducted. What type of information is provided, via what mechanisms, and by whom?

#### 6.8.1 Please describe the types of communities where mobile outreach is conducted.

#### 6.8.2 Who is typically reached during mobile outreach (e.g. women, girls, men, boys, GBV survivors)?

#### 6.8.3 What are both positive and negative reactions from the community that staff have experienced when conducting mobile outreach?

#### 6.8.4 How is follow-up to mobile outreach services conducted?

#### 6.8.5 How are community awareness efforts coordinated with ZCCP’s prevention and advocacy efforts? Are they integrated in the same communities or independent?

#### 6.8.6 Please describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV. Please provide examples. How do you measure this change?

### 7. STOP GBV Programming Component 3: Prevention and Advocacy

**QUESTIONS IN THIS SECTION ARE ONLY ASKED FROM ZCCP STAFF**

The prevention and advocacy component is managed by Zambia Centre for Communication Programmes (ZCCP). This component aims to change social norms, attitudes and behaviors and to tackle underlying risk factors for GBV by sensitizing and mobilizing communities through a comprehensive program of complementary communication interventions in 24 districts. This component ends in April 2018.

#### 7.1 Describe the targeted sensitization of traditional, community and religious leaders with messages about GBV and early child marriage. Describe the content and tools used.

#### 7.1.1 Who is involved in implementing the sensitization (e.g. male/ female, from the community, position of authority)?

#### 7.1.2 How many traditional chiefs and headsmen/ women have been sensitized and who are they (male/ female, ages, etc.)?

#### 7.1.3 What is the ideal “dose” for sensitizing of traditional chiefs and headsmen/women, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of sensitization?

#### 7.1.4 How have you observed traditional chiefs and headsmen/ women to incorporate sensitization into their lives and interactions with the community and individuals?

#### 7.1.5 Please provide an example of positive change you have observed in the way in which traditional chiefs and headsmen women have dealt with GBV generally in the community, and with individual cases of GBV.

#### 7.1.6 What challenges remain in sensitization of traditional chiefs and headsmen/ women?

#### 7.1.7 Describe any observed stigma toward GBV survivors among traditional chiefs and headsmen/ women. If there has been stigma, how has this been addressed?

#### 7.1.8 How many cases have traditional chiefs, headmen, and headwomen referred to a One Stop Centre or formal processes?

#### 7.1.9 How do you measure action taken by community leaders to address GBV? How do you measure their leadership in addressing GBV?
7.1.10 How do you track the number of GBV cases that communities and community leaders report to appropriate formal authorities?

7.1.11 How are traditional leader sensitization efforts coordinated with WLSA’s sensitization of traditional leaders on the legal aspects of GBV? Are they integrated in the same communities or independent?

7.2 Describe how men have been trained as advocates or ‘change agents’ to communicate with other men in their community about GBV and to take action in their own lives and communities. Please include a description of the tools and methodology used, type of information and communication provided, as well as a description of who provides the training.

7.2.1 What has been successful in the training?

7.2.2 Who are the men being trained (e.g., age, marital status, income level, job status, religion, attitude about GBV before receiving training, past history of violence, etc.)?

7.2.3 What have you observed to be the ideal “dose” of trainings, meaning how many sessions, on average, does one boy or man need to attend before an observed change in his attitude or behavior can be identified, as well as his ability to influence other men?

7.2.4 What types of men and boys are more likely to participate in the program? Who are not likely to participate?

7.2.5 What is the retention rate/ drop-out rate for men acting as change agents? What motivates them to continue acting as change agents?

7.2.6 Can you provide examples, without naming anyone’s specific name, where you have seen a man successfully uptake the GBV training material and integrate into their regular lives and make a real difference in his family life or in the family life of another man?

7.2.7 What are the challenges that you have faced in training?

7.2.8 How have you overcome the challenges that you have faced?

7.2.9 What has the reaction been from men, boys, and the community to the communication of male ‘change agents’ within their community?

7.2.10 How has this training been linked to other partners’ work with men, such as World Vision’s work with training of football coaches? Where has coordination been successful, and where have there been challenges?

7.2.11 How are you measuring real change in attitudes and behaviors among male beneficiaries and their family members?

7.2.12 Please describe change that you have observed, measured and documented at both the group level and the individual level.

7.2.13 How are you documenting lessons learned and incorporating learning on an ongoing basis?

7.3 Describe the community dialogue, drama and community radio that is used to increase community awareness and promote discussion and reflection on GBV issues. Identify the specific mediums, topics covered, and tools/ methods used.

7.3.1 Who creates them, conducts them, and performs/ leads them? Where do they come from?

7.3.2 How frequently are each type of awareness conducted?

7.3.3 Who are the targeted audiences?

7.3.4 How do you measure who is being reached?

7.3.5 How do you measure what change is being brought about in peoples knowledge, attitudes, and behaviors as a result of the community awareness?

7.3.6 What are successful observations of positive change that you can directly attribute to a community dialogue, drama, or community radio?

7.3.7 What are challenges that have been faced? How have they been overcome?
7.3.8 How are community awareness efforts coordinated with WLSA’s efforts on community awareness regarding legal aspects of GBV? Are they integrated in the same communities or independent?

7.4 Describe the telephone helpline for GBV survivors and perpetrators. How does it work, what hours is it available, and who staffs the hotline?

7.4.1 How are staff selected and trained? What is staff retention like?
7.4.2 How is the helpline coordinated with the One Stop Centers and World Vision’s service provision efforts?
7.4.3 Who typically calls/utilizes the helpline, and what types of issues are commonly discussed?
7.4.4 Who do you think doesn’t call the helpline that would benefit and how can they be better reached?
7.4.5 How are referrals made and followed-up on?
7.4.6 How are referral services provided?
7.4.7 Do GBV survivors have adequate services available to meet the demand created by the helpline?
7.4.8 Do GBV perpetrators have adequate services available to meet the demand created by the helpline?
7.4.9 Please provide an example of a successful case where a GBV survivor called the helpline and received the support required.
7.4.10 Please provide an example of a successful case where a GBV perpetrator called the helpline and appropriate support and intervention was made.
7.4.11 What challenges exist to operating the helpline?
7.4.12 How do you measure the success of the helpline? With what indicators?
7.4.13 How do you believe that the helpline has improved prevention and response to GBV? Please provide examples.

7.5 Describe how you work with traditional and community structures to shift negative social norms on ending child marriage. What are the structures, and what tools and methods do you use?

7.5.1 What has been effective in shifting negative social norms on ending child marriage?
7.5.2 How do you measure success in shifting negative social norms on ending child marriage? What indicators do you use, and how do you measure actual change?
7.5.3 What challenges remain in shifting negative social norms on ending child marriage? How do you address these challenges?

7.6 Please describe the capacity of district level health facility to accommodate the needs of a One Stop Centre.

7.6.1 What is the health facility medical staff capacity to address needs of GBV survivors?
7.6.2 What type of training do medical staff receive?
7.6.3 Please describe any challenges due to health facility staff capacity. How are these challenges addressed?
7.6.4 Please explain any stigmatization of GBV survivors among health facility staff. How is stigma addressed among staff?
7.6.5 Please describe the willingness of health facility staff to engage with the STOP GBV program. What type of staff (male/ female, position) are more or less eager to engage and supportive of the program?

7.7 Which One Stop Centers were selected to be managed by the Zambian government from the outset onset?

7.7.1 How has this been implemented?
7.7.2 How have STOP GBV partners provided technical support to these government-run One Stop Centers?
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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>7.7.3 How have STOP GBV partners provided training to these government-</td>
<td>run One Stop Centers?</td>
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<td>run One Stop Centers?</td>
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<td>7.7.4 How have STOP GBV partners provided supplies and equipment to</td>
<td>government-run One Stop Centers?</td>
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<td>government-run One Stop Centers?</td>
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<td>7.7.5 How have STOP GBV partners provided support for outreach,</td>
<td>monitoring and data collection to the Zambian government-run One Stop</td>
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<td>7.7.6 How have these worked better than implementing partner-run One</td>
<td>Stop Centers?</td>
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<td>7.7.7 How have they not worked as well as the implementing partner-run</td>
<td>One Stop Centers?</td>
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<td>One Stop Centers?</td>
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<td>7.7.8 What are the lessons learned in supporting government-run One</td>
<td>Stop Centers, and what changes can be made in the future?</td>
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<td>Stop Centers, and what changes can be made in the future?</td>
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<td>8. STOP GBV Programming Component 4: Engaging boys and young men</td>
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<td>QUESTIONS IN THIS SECTION ARE ONLY ASKED OF WORLD VISION STAFF</td>
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<td>Component 4 focuses on engaging young men and boys (age 12-23) through</td>
<td>football managed by World Vision. This component builds on the proven</td>
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<td>Young Men as Equal Partners methodology employed by Sport in Action in</td>
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<td>Zambia.</td>
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<td>8.1 Who are the existing teams and clubs you have partnered with?</td>
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<td>8.1.1 How have those partnerships been successful?</td>
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<td>8.1.2 Where have there been challenges?</td>
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<td>8.1.3 How have challenges been addressed?</td>
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<td>8.2 How many football coaches have been trained as mentors and change</td>
<td>agents?</td>
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<td>agents?</td>
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<td>8.2.1 How do you train them, and what has been successful in the</td>
<td>training?</td>
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<td>8.2.2 Can you provide examples, without naming anyone’s specific name,</td>
<td>where you have seen a football coach successfully uptake the GBV</td>
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<td>where you have seen a football coach successfully uptake the GBV</td>
<td>training material and integrate into their regular coaching, training,</td>
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<td>training material and integrate into their regular coaching, training,</td>
<td>and matches?</td>
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<td>and matches?</td>
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<td>8.2.3 What are the challenges that you have faced in training football</td>
<td>coaches?</td>
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<td>coaches?</td>
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<td>8.2.4 How have you overcome the challenges that you have faced?</td>
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<td>8.3 How many district tournaments have been organized?</td>
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<td>8.3.1 How have they been used as opportunities to communicate GBV</td>
<td>messages to a wider audience of boys and men as well as other</td>
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<td>messages to a wider audience of boys and men as well as other</td>
<td>community members?</td>
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<td>community members?</td>
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<td>8.3.2 How have outcomes of the district tournaments been measured?</td>
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<td>8.3.3 What has the reaction been from men, boys, and the community to</td>
<td>the communication of GBV messages at tournaments?</td>
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<td>the communication of GBV messages at tournaments?</td>
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<tr>
<td>8.3.4 How are you measuring real change in attitudes and behaviors</td>
<td>related to GBV among male beneficiaries and their family members?</td>
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<td>related to GBV among male beneficiaries and their family members?</td>
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<td>8.3.5 Please describe change that you have observed, measured and</td>
<td>documented at both the group level and the individual level.</td>
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<td>documented at both the group level and the individual level.</td>
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<td>8.4 How many boys’ and young men’s groups have been organized?</td>
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<td>8.4.1 How frequently do they met, and for how long?</td>
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<td>8.4.2 Who leads the group sessions? Please explain the structure.</td>
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<td>8.4.3 What is the nature of discussion about GBV?</td>
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<td>8.4.4 What has participation been like? Are groups comprised of the</td>
<td>same members, or are they different each week? What is retention like?</td>
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<td>same members, or are they different each week? What is retention like?</td>
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<td>8.4.5 What have you observed to be the ideal “dose” of meetings,</td>
<td>meaning how many sessions, on average, does one boy or man need to</td>
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<td>meaning how many sessions, on average, does one boy or man need to</td>
<td>attend before an observed change in his attitude or behavior can be</td>
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<td>attend before an observed change in his attitude or behavior can be</td>
<td>identified?</td>
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<td>identified?</td>
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<td>8.4.6 Please provide an example or two, without naming specific names,</td>
<td>where you have observed a real change in the attitude or behavior of a</td>
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<td>where you have observed a real change in the attitude or behavior of a</td>
<td>young man or boy.</td>
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</table>
8.4.7 What challenges have you encountered? How have you worked to overcome them?

8.5 How are you working with parents of boys and young men to prevent GBV?
8.5.1 How do families support their sons in participating in prevention of GBV activities?
8.5.2 What challenges do you encounter?

8.6 How are you working with schools?
9.1 How have school partnerships been successful?
9.2 What challenges do you encounter working with schools?

8.7 How has this component linked to the existing prevention and advocacy component interventions, including training men as change agents and supporting community men's groups?
8.7.1 Where has coordination been successful?
8.7.2 Where has coordination failed?
8.7.3 What can be done to improve coordination efforts?

8.8 How is this work with men and boys, specifically using sport as a medium for changing attitudes, contributing to strengthening the evidence base that exists?
8.8.1 Please explain your M&E framework, including the indicators that you use, the methodology you use?
8.8.2 How you are measuring real change in attitudes and behaviors among male beneficiaries and their family members?
8.8.3 Please describe change that you have observed, measured and documented at both the group level and the individual level.
8.8.4 How are you documenting lessons learned and incorporating learning on an ongoing basis?

8.9 How is working through sports a useful and effective medium to reach boys and young men?
8.9.1 What types of men and boys are more likely to participate in the program?
8.9.2 Who are not likely to participate?
8.9.3 What reactions do family members have to men and boys' participation?
8.9.4 What other mediums would be effective to reach other boys and men?

9. Closing the Interview

9.1 Thank the interviewee for their participation in the discussion.

9.2 “Are there any other issues that have not been discussed that you think are important and would like to discuss?”

9.3 Ask the interviewee if they have any questions about the discussion.

9.4 Ask the interviewee, again, if the information that he/ she provided can be used in the mid-term evaluation. Clarify that all information will be summarized and that the evaluation will not identify any participants by name unless he/ she authorizes you to attribute what they said to them individually.
1. Introduction

1.1 Interviewers and Interviewee to introduce themselves. Record the names and titles of the interviewee.

1.2 Provide a general overview of STOP GBV: “USAID and DFID are working together over a five year period, from 2013-2018 to support the project, STOP GBV. The expected outcome of STOP GBV is an improved GBV violence prevention and response in Zambia. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia. Four project components are implemented to achieve this outcome and impact: 1) GBV survivor support services; 2) access to justice; 3) prevention and advocacy; and 4) engage men and boys through sports. STOP GBV is being implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmes (ZCCP), each with their own agreement/contract.

1.3 Explain the purpose of the discussion to the interviewee: “USAID has contracted an independent firm, GH Pro, working with a local research organization in Zambia, IPSOS, to conduct a mid-term performance and process evaluation of STOP GBV. To conduct the mid-term evaluation, the team is reviewing project documents; conducting key informant interviews like this one with you, conducting focus group discussions within selected communities where the project is operating; and conducting surveys of community members where the project is operating.”

1.4 Clarify that “once we have completed our fieldwork, we will summarize the information into a general analysis that will inform the development of the mid-term evaluation for the STOP GBV program for USAID and its implementing partners to use to make necessary programmatic changes to improve delivery of services and also to measure progress made since the inception.”

1.5 Tell the interviewee, “Your participation and information is very valuable. You have been selected for this interview because of your expertise, knowledge, and experience. There are no right or wrong answers, but we only want to know your opinion. This interview will also not identify individual opinions, but rather will use the information confidentially, reporting it in aggregate. You are participating in this interview voluntarily and of your own free will. If, at any time, you feel uncomfortable with any particular question or would like to skip a question or stop the interviewee delete you are free to do so and you simply need to inform me. We very much appreciate your input, time, and participation.”

2. Request verbal consent from interviewee

2.1 Ask the interviewee, “Do you understand the purpose of this interview? Do you have any questions regarding this interview, the purpose, or how the information will be collected?” Answer any questions the interviewee may have.

2.2 Will you please provide your verbal and written consent to participate in this interview? Will you also provide me with permission to record this interview?
2.3 Interviewer (IPSOS) and interviewee **signs and dates the informed consent form**, providing one copy to the interviewee and retaining the signed copy.

2.4 Interviewer requests the interviewee's name, position, title, and organization he/she works for and documents this in the notes.

### 3. Discussion of GBV (Types, Incidence, Risks, Causes, Effects)

3.1 **What are the most common types of GBV that occur (nationally, in your community)?** Probe: Child marriage, rape, domestic violence, physical abuse, emotional/verbal abuse, economic violence (e.g., widow inheritance, property rights, etc.), other?

3.2 **Among which populations/groups do different types of GBV occur, and how frequently?** Probe: Who is at risk for what types of GBV? Among women? Men? Boys? Girls? Disabled? Elderly? Minority groups? Orphans? With what frequency (e.g., daily, weekly, monthly, annually)?

3.3 **Where does GBV take place within communities?** Probe: Homes, water sites, roads, public transportation, community areas, schools, pubs, streets, etc.

3.4 **In your opinion, what do you think are the main reasons for GBV in your community?** Probe: Is alcohol a problem? Is poverty a problem? Is there ignorance of laws and rights? Is promiscuity a reason for GBV? What about GBV and masculinities?

3.5 **What are the emotional and health consequences of GBV that you have observed and within the community?**

3.6 **How do families in your community resolve conflict?** Probe: How do men and women resolve intimate partner conflicts? How do men resolve conflicts with one another? How do women resolve conflicts among each other? How do parents resolve conflicts with their children? How do children resolve conflicts with one another?

3.7 **What are the emotional and health consequences of GBV that you have observed and within the community?**

3.8 **How have people’s attitudes towards GBV changed in the past two years?** Probe: Among community leaders, religious leaders, and others? Among law enforcement officials? Among women? Among men? Among adolescent boys and girls? **How have your attitudes changed?**

3.9 **Compared to two years ago, do you think people are more or less safe than they are now? Explain.** Probe: Are women more or less safe? Young girls? Men? Boys? Orphans? Disabled? Elderly? What makes them more or less safe?

3.10 **Where do you believe progress has been made in preventing and responding to GBV?**

3.11 **Where do you believe challenges still exist that need to be addressed?**
4. Discussion of STOP GBV Programming (GENERAL)

I would like to ask you some questions specifically about the STOP GBV programming and One Stop Centers.

4.1 Please describe the management structure of the programming for which your organization is responsible.
4.1.1 When did your organization first begin operating the One Stop Center where you work?
4.1.2 What management practices have contributed to successful in delivering services/activities to the targeted population?
4.1.3 What management challenges have been encountered? How have they been addressed?

4.2 How do you coordinate with the Zambian government, including the Ministry of Community Development, Mother and Child Health, the Ministry of Gender and Child Development, the police, the judicial system and others?
4.2.1 How is coordination improving the delivery of your service or leading to more benefits for individuals and community members?
4.2.2 What has been challenging about coordination with implementing partners?

4.3 How do you coordinate with the community? Probe: Community leaders, community groups, religious leaders, individual community members?

4.4 What do you believe are the main successes so far of the One Stop Centers?

4.5 What structures, resources, or organizations have been assets in implementing your activities (external to your program and staff)? Probe: Apart from your organization, can you name various organizations involved in the control of GBV in your constituency? What kind of support do they provide to the GBV survivors?

4.6 What are the main challenges that you have observed in the implementation of the One Stop Centers?
4.6.1 What are challenges related to management?
4.6.2 What are challenges related to coordination?
4.6.3 What are challenges related to service delivery?
4.6.4 What are challenges related to cost efficiency?
4.6.5 What are challenges related to making real change?
4.6.6 What are challenges related to sustainability?
4.6.7 What can be done to overcome identified challenges?

4.7 What sort of lessons learned or other forms of learning do you capture regularly
4.7.1 With what frequency?
4.7.2 Who is involved in capturing lessons learned?
4.7.3 How are lessons learned incorporated in programming?
4.7.4 How do you share lessons with implementing partners?

4.8 What you deem as the most effective indicators or measures of effectiveness of your programming?
4.8.1 How are you measuring real change in individuals and in communities, beyond output-level indicators that measure service or activity provision?
4.8.2 What types of outcome level indicators are you measuring, and how?
4.8.3 What types of impact level indicators are you measuring, and how?
4.8.4 How are implementing partners coordinating M&E efforts?

4.9 What role do you play as an individual in the objectives to prevent and respond to GBV?
4.9.1 How have you changed as an individual in your beliefs and practices since beginning work at this One Stop Center?
4.9.2 How do you see your role changing in the prevention and response to GBV over time?

4.10 In your opinion, how do you think that community members and beneficiaries lives have changed so far as a result of any STOP GBV project activity or service?

4.11 What gaps exist in the program design, delivery or implementation which need to be addressed in order to positively influence implementation of the program?
4.11.1 What are the differences in efficiency and effectiveness between existing and scale-up sites (i.e., the inclusion of activities addressing boys and young men through sports) and what would you identify as benefits in the scale-up districts which could be integrated into the original program sites?
4.11.2 What operational program improvements can be made to ensure impact and outcomes are achieved and/or improved?

4.12 What are the roles of the CWAC, ACC, and SWO in preventing and responding to GBV?
4.12.1 How do they coordinate with the STOP GBV project and One Stop Centers?
4.12.2 What are these groups doing well?
4.12.3 What challenges do they face?
4.12.4 How can they be strengthened and supported in a sustainable manner?

5. STOP GBV Programming Component 1: GBV Survivor Services

This GBV survivor services component, implemented by World Vision, aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centres that employ a culturally sensitive, victim-centred approach in sixteen districts.

5.1 Please describe the integrated package of care that your One Stop Center provides to GBV survivors. Probe: Describe medical care, counselling, including HIV
counselling and counselling for child survivors, provision of post-exposure prophylaxis and emergency contraception, psychological support, and legal advice and support for adult and child GBV survivors.

5.1.1 What services are most commonly provided at this One Stop Center?
5.1.2 Are women, men, boys, and girls using/demanding GBV services? Explain.
5.1.3 What do you think women, men, boys and girls know about the range of services available for GBV here?
5.1.4 Are GBV survivors aware of HIV services available to them? Are GBV survivors routinely provided with information and referrals to HIV services? Explain.
5.1.5 What challenges have been encountered in delivering all services required by a survivor?
5.1.6 How have challenges been addressed?
5.1.7 What are the barriers for GBV survivors accessing services?
5.1.8 Are existing services available to meet current and increased demand for services?

5.2 What types of GBV cases do you typically see reported, and by whom?
5.2.1 What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why?
5.2.2 What are GBV survivors comfortable reporting? What are they not comfortable reporting?
5.2.3 What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why?
5.2.4 Have you seen an increase or decrease in reported cases at the centers?
5.2.5 Who does a GBV survivor (boys, girls, men women) turn to in crisis to seek any type of support (emotional, psychosocial, medical, legal, financial, etc.)?
5.2.6 What reaction from others do GBV survivors face (boys, girls, men, women survivors)? How do family members react? How do communities react?
5.2.7 What types of cases are met stigma by family members of the GBV survivor? What types of cases are met with stigma by any staff? What types of cases are met with stigma by the community? How can stigma be overcome?

5.3 In your opinion, how do you think GBV survivors feel about the service that they receive?
5.3.1 Have you received any feedback from clients/survivors or their families on what they have liked? If so, which?
5.3.2 Have you received any feedback from clients/survivors or their families on difficulties they have faced? If so, how have those been dealt with?

5.4 Please describe the staffing structure at this One Stop Center.
5.4.1 How do the coordinator, full-time health worker, social worker and Victim Support Unit police officer, all seconded and paid for by government, and by volunteer counsellors and paralegals work with the center and with each other?
5.4.2 What are staff working hours and retention rates?
5.4.3 What are staff attitudes toward their jobs?
5.4.4 What are staff attitudes towards the survivors that they are serving?
5.4.5 What is staff retention and turn-over like? If turn-over is high, why is this?
5.4.6 Have there been any instances of complaints from the community or clients about the way in which any staff person treated them? If so, how were those complaints addressed?
5.4.7 Describe any observed stigma toward GBV survivors among staff. If there has been stigma, how has this been addressed?
5.5 What type of training do One Stop Center staff receive, and how regularly?

5.5.1 What guidelines and training materials are used for training?

5.5.2 What is the ideal “dose” of training for each staff member, meaning, how frequently, and in what length for each training, is required to ensure uptake and regular practice of training material?

5.5.3 What additional training and learning is requiring to continue building staff skills?

5.5.4 Please describe an example of a staff member who made positive changes as a result of training. This can be yourself or others you work with.

5.5.5 What challenges have you observed with staff implementing training material or information that they learn?

5.6 Describe the referral process for GBV survivors to other services. Probe: Describe referrals to medical facilities for further treatment, the police via Victim Support Units, economic support through micro-finance, savings groups and skills development, safe houses or shelters, and survivor support networks.

5.6.1 What works well with the referral system?

5.6.2 How are individual cases tracked and followed? Probe: If an individual is referred, how is the outcome of the referral tracked to see if they received the service they referred to and what happened?

5.6.3 What challenges have been encountered when referring survivors to other services? How have these challenges been addressed?

5.7 Describe how STOP GBV Centre staff liaises with other services to ensure that survivors receive appropriate support.

5.7.1 Are fees for medical care or transport to a health center and/or police provided? If so, how often and how much? Does it cover the complete cost of care? Have there been any cases of individuals who have not received care because of the costs?

5.7.2 How have Center staff been successful in liaising with other services? Please provide examples.

5.7.3 What challenges have Center staff encountered when liaising with other services? Please provide examples.

5.8 How many traditional community counsellors have been trained to provide ongoing support for survivors as well as referrals to One Stop Centres?

5.8.1 Please describe the nature of training of traditional community counselors. Who provides the training?

5.8.2 How long is the training? How often is the training for each individual trainee? Are there refresher trainings? What have you observed as the “ideal dose” of training, meaning how long and with what frequency, to observe a real change in the trainee?

5.8.3 Please provide an example of where you have observed positive change or difference in the way in which traditional community counsellors provide support or make referrals.

5.8.4 Where have you encountered challenges with training or uptake of training for traditional community counsellors?

5.8.5 How have these challenges been overcome?

5.9 Describe how mobile outreach is conducted, including who is conducting it, the type of outreach provided, and how frequently it is conducted.

5.9.1 Please describe the types of communities where mobile outreach is conducted.

5.9.2 Who is typically reached during mobile outreach (e.g. women, girls, men, boys, GBV survivors)?

5.9.3 What are both positive and negative reactions from the community that staff have experienced when conducting mobile outreach?
5.9.4 How is follow-up to mobile outreach services conducted?

5.10 How is the capacity of STOV GBV local primes being strengthened? Please describe the nature of organizational assessments, results, and action taken based on assessment results.
5.10.1 Describe examples of successful capacity building where change and improvement of local primes is observed.
5.10.2 Describe challenges in capacity building and sustainability beyond the project close.
5.10.3 How are capacity building efforts regularly monitored and evaluated? What indicators are used to measure success?

6. STOP GBV Programming Component 2: Access to Justice

This component, managed by Women in Law in Southern Africa (WLSA), aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018.

6.1 What do you think people (men, women, boys, girls) know about laws that exist about GBV?

Probe: Do you think people feel the laws are respected by community members? How are laws implemented? By whom? Who is responsible for carrying out the implementation of laws?
6.1.1 Please describe customary law on various GBV cases. Traditionally, how does the community handle GBV cases, survivors, and perpetrators?
6.1.2 How are statutory laws related to GBV implemented in the communities where you work?
6.1.3 What challenges exist within the community to formally reporting incidences of GBV?
6.1.4 What has stopped survivors from formally pursuing cases?
6.1.5 What are the legal processes helpful to GBV survivors and their families?
6.1.6 How are children and adolescent survivors of GBV treated by law enforcement officials, health staff at health facilities, and other staff/community members?

6.2 (FOR PARALEGALS ONLY): Describe training that paralegals have received, particularly in the content of the training and tools used, and who conducts the training.
6.2.1 How many paralegals have been trained, and who are they? Do they work only at the One Stop Center, or do they also work elsewhere?
6.2.2 What is the retention rate of trained paralegals at the One Stop Center?
6.2.3 What is the ideal “dose” for training paralegals, in terms of how much training they receive and how frequently, to ensure uptake and regular practice of training?
6.2.4 What other training would be useful for paralegals?

6.3 Describe the services that paralegals provide at STOP GBV centers.
6.3.1 What other staff, individuals, and organizations do paralegals work with?
6.3.2 Where have challenges been encountered?
6.3.3 What legal processes have presented challenges for paralegals?
6.3.4 How many GBV survivors have initiated legal processes with a paralegal at the One Stop Center? Out of those cases, how many have been prosecuted?
6.3.5 Describe any observed stigma toward GBV survivors among paralegals. If there has been stigma, how has this been addressed?
6.4 Describe how trained police have been cooperative and helpful in investigation, evidence collection (including forensics), prosecution of cases, witness support, and referral of cases.

6.4.1 Where do challenges remain in police cooperation in the areas mentioned, and how can those challenges be addressed?

6.4.2 Describe any observed stigma toward GBV survivors among police? If there has been stigma, how has this been addressed?

6.5 Describe how trained legal and judicial stakeholders have been cooperative and helpful in prosecuting cases brought forward.

6.5.1 Where do challenges remain in working with legal and judicial stakeholders?

6.5.2 Describe any observed stigma toward GBV survivors among paralegals. If there has been stigma, how has this been addressed?

6.6 How have you observed traditional chiefs and headmen/ women to incorporate GBV sensitization into their lives and interactions with the community and individuals?

6.6.1 Provide an example of positive change you have observed in the way in which traditional chiefs and headmen women have dealt with GBV generally in the community, and with individual cases of GBV.

6.6.2 Describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV. Provide examples. How do you measure this change?

6.6.3 What challenges remain in sensitization of traditional chiefs and headmen/ women?

6.6.4 Describe any observed stigma toward GBV survivors among traditional chiefs and headmen/ women. If there has been stigma, how has this been addressed?

6.6.5 How many cases have traditional chiefs, headmen, and headwomen referred to a One Stop Center or for formal processes?

6.7 How have you observed mobile outreach regarding community awareness of legal aspects of GBV assist survivors that you see at the One Stop Center?

6.7.1 What are both positive and negative reactions from the community that you may have heard about related to mobile outreach regarding GBV and laws?

6.7.2 Please describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV. Please provide examples. How do you measure this change?

7. STOP GBV Programming Component 3: Prevention and Advocacy

The prevention and advocacy component is managed by Zambia Centre for Communication Programmes (ZCCP). This component aims to change social norms, attitudes and behaviors and to tackle underlying risk factors for GBV by sensitizing and mobilizing communities through a comprehensive program of complementary communication interventions in 24 districts. This component ends in April 2018.

7.1 How have you observed traditional chiefs and headmen/ women to incorporate sensitization regarding GBV and early child marriage into their lives and interactions with the community and individuals?

7.1.1 Please provide an example of positive change you have observed in the way in which traditional chiefs and headmen women have dealt with GBV generally in the community, and with individual cases of GBV.
7.1.2 What challenges remain in sensitization of traditional chiefs and headmen/ women?
7.1.3 Describe any observed stigma toward GBV survivors among traditional chiefs and headmen/ women. If there has been stigma, how has this been addressed?
7.1.4 How many cases have traditional chiefs, headmen, and headwomen referred to a One Stop Center or for formal processes?
7.1.5 How do you measure action taken by community leaders to address GBV? How do you measure their leadership in addressing GBV?
7.1.6 How do you track the number of GBV cases that communities and community leaders report to appropriate formal authorities?

7.2 How are religious leaders in your community involved in preventing and responding to GBV in your community? Probe: What are they doing to prevent and respond to GBV, and how frequently? Do you consider their efforts successful? If yes, why? What else could be done?

7.3 How are men trained as advocates or ‘change agents’ communicating with other men in the community about GBV?
7.3.1 Who are these men acting as change agents (e.g., age, marital status, income level, job status, religion, attitude about GBV before receiving training, past history of violence, etc.)? What types of men and boys are more likely to participate in the program? Who are not likely to participate?
7.3.2 How frequently do men in your community hold discussions, individual talks, or lead activities related to GBV?
7.3.3 How do these change agents interact with the One Stop Center?
7.3.4 How long does one man stay “active” as a change agent? What motivates them to continue acting as change agents?
7.3.5 Can you provide examples, without naming anyone’s specific name, where you have seen a man make a real difference in his family life or in the family life of another man related to GBV?
7.3.6 What has the reaction been from men, boys, and the community to the communication of male ‘change agents’ within the community?
7.3.7 Please describe change that you have observed, measured and documented at both the group level and the individual level.

7.4 Describe community dialogue, drama and community radio that you see in your community related to GBV.
7.4.1 What topics are covered?
7.4.2 How is the One Stop Center involved in community awareness?
7.4.3 What is being done to address myths about HIV with men, women, boys and girls, from the community?
7.4.4 Who in your community is reached by different types of GBV awareness?
7.4.5 What, in your opinion, have you seen as the most effective way to reach men, women, boys, and girls with the information?
7.4.6 Who creates them, conducts them, and performs/ leads them? Where do they come from?
7.4.7 How frequently are each type of awareness conducted?
7.4.8 What have you observed to be positive change among individuals or broadly in the community that you can directly attribute to a community dialogue, drama, or community radio?
7.4.9 What is the effect of this type of community awareness on the One Stop Center?
### 7.5 Is there a telephone helpline for GBV survivors and perpetrators available to people in your community? If so, how does it work, what hours is it available, and who staffs the hotline?

**7.5.1** How is the One Stop Center involved in its implementation?

**7.5.2** Do people (men, women, boys, and girls) in your community know about it?

**7.5.3** Who typically calls/utilizes the helpline, and what types of issues are commonly discussed?

**7.5.4** Who do you think doesn't call the helpline that would benefit and how can they be better reached?

**7.5.5** How are referrals made and followed-up on?

**7.5.6** How are referral services provided?

**7.5.7** Do GBV survivors have adequate services available to meet the demand created by the helpline?

**7.5.8** Do GBV perpetrators have adequate services available to meet the demand created by the helpline?

**7.5.9** Please provide an example of a successful case where a GBV survivor called the helpline and received the support required.

**7.5.10** Please provide an example of a successful case where a GBV perpetrator called the helpline and appropriate support and intervention was made.

**7.5.11** What challenges exist to operating the helpline?

**7.5.12** How do you believe that the helpline has improved prevention and response to GBV? Please provide examples.

### 7.6 Please describe the capacity of district level health facility to accommodate the needs of a One Stop Centre.

**7.6.1** What is the health facility medical staff capacity to address needs of GBV survivors?

**7.6.2** What type of training do medical staff receive?

**7.6.3** Please describe any challenges due to health facility staff capacity. How are these challenges addressed?

**7.6.4** Please explain any stigmatization of GBV survivors among health facility staff. How is stigma addressed among staff?

**7.6.5** Please describe the willingness of health facility staff to engage with the STOP GBV program. What type of staff (male/ female, position) are more or less eager to engage and supportive of the program?

### 8. STOP GBV Programming Component 4: Engaging boys and young men

Component 4 focuses on engaging young men and boys (age 12-23) through football managed by World Vision. This component builds on the proven Young Men as Equal Partners methodology employed by Sport in Action in Zambia.

**8.1** Who are the existing football teams and clubs, and coaches in your community who are trained in GBV and as mentors for other young men and boys?

**8.1.1** Can you provide examples, without naming anyone’s specific name, where you have seen a football coach successfully change the GBV-related attitudes and/or behaviors of the boys and young men they are coaching?

**8.1.2** What are the challenges are there in working with young men and boys to change attitudes about GBV?

**8.1.3** How can these challenges be overcome?

**8.2** Have you seen organized football tournaments happen in your community where GBV messages have been disseminated to a wider audience of boys and men?
8.2.1 If so, what are the outcomes of these GBV messages at tournaments? What has the reaction been from men, boys, and the community to the communication of GBV messages at tournaments?

8.2.2 Please describe change that you have observed in the community as a result of GBV messages disseminated at tournaments related to GBV attitudes and behaviors, at both the group level and the individual level.

8.3 How many boys’ and young men’s groups have been organized in your community?

8.3.1 How frequently do they meet, and for how long, and over what period of time?

8.3.2 Who leads the group sessions? Please explain the structure.

8.3.3 What is the nature of discussion about GBV?

8.3.4 Please provide an example or two, without naming specific names, where you have observed a real change in the attitude or behavior of a young man or boy as a direct result of participating in a group.

8.3.5 What challenges are there to sustaining boys’ and young men’s groups in your community?

8.3.6 What role do you play in boys’ and men’s groups in your community? Do you participate?

8.4 How are you working with parents of boys and young men to prevent GBV?

8.4.1 How do families support their sons in participating in prevention of GBV activities?

8.4.2 What challenges do you encounter?

8.5 How is working through sports a useful and effective medium to reach boys and young men?

8.5.1 What types of men and boys are more likely to participate in the program?

8.5.2 Who are not likely to participate who should? How could they be encouraged or supported to participate?

8.5.3 What reactions do family members have to men and boys’ participation?

8.5.4 What other mediums would be effective to reach other boys and men?

9. Closing the Interview

9.1 Thank the interviewee for their participation in the discussion.

9.2 “Are there any other issues that have not been discussed that you think are important and would like to discuss?”

9.3 Ask the interviewee if they have any questions about the discussion.

9.4 Ask the interviewee, again, if the information that he/she provided can be used in the mid-term evaluation. Clarify that all information will be summarized and that the evaluation will not identify any participants by name unless he/she authorizes you to attribute what they said to them individually.
1. Introduction

1.1 Interviewers and Interviewee to introduce themselves. Record the names and titles of the interviewee.

1.2 Provide a general overview of STOP GBV: “USAID and DFID are working together over a five year period, from 2013-2018 to support the project, STOP GBV. The expected outcome of STOP GBV is an improved GBV violence prevention and response in Zambia. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia. Four program components are implemented to achieve this outcome and impact: 1) GBV survivor support services; 2) access to justice; 3) prevention and advocacy; and 4) engage men and boys through sports. STOP GBV is being implemented by World Vision, Women in Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programmed (ZCCP), each with their own agreement/contract.

1.3 Explain the purpose of the discussion to the interviewee: “USAID has contracted an independent firm, GH Pro, working with a local research organization in Zambia, IPSOS, to conduct a mid-term performance and process evaluation of STOP GBV. To conduct the mid-term evaluation, the team is reviewing project documents; conducting key informant interviews like this one with you, conducting focus group discussions within selected communities where the project is operating; and conducting surveys of community members where the project is operating.”

1.4 Clarify that “once we have completed our fieldwork, we will summarize the information into a general analysis that will inform the development of the mid-term evaluation for the STOP GBV program for USAID and its implementing partners to use to make necessary programmatic changes to improve delivery of services and also to measure progress made since the inception.”

1.5 Tell the interviewee, “Your participation and information is very valuable. You have been selected for this interview because of your expertise, knowledge, and experience. There are no right or wrong answers, but we only want to know your opinion. This interview will also not identify individual opinions, but rather will use the information confidentially, reporting it in aggregate. You are participating in this interview voluntarily and of your own free will. If, at any time, you feel uncomfortable with any particular question or would like to skip a question or stop the interviewee you are free to do so and you simply need to inform me. We very much appreciate your input, time, and participation.”

2. Request verbal consent from interviewee

2.1 Ask the interviewee, “Do you understand the purpose of this interview? Do you have any questions regarding this interview, the purpose, or how the information will be collected?” Answer any questions the interviewee may have.

2.2 Will you please provide your verbal and written consent to participate in this interview? Will you also provide me with permission to record this interview?

2.3 Interviewer (IPSOS) and interviewee signs and dates the informed consent form, providing one copy to the interviewee and retaining the signed copy.
2.4 Interviewer requests the interviewees name, position, title, and organization he/she works for and documents this in the notes.

3. Discussion of GBV (Types, Incidence, Risks, Causes, Effects)

3.1 What are the most common types of GBV that occur in your community? Probe: Child marriage, rape, domestic violence, physical abuse, emotional/verbal abuse, economic violence (e.g., widow inheritance, property rights, etc.), other?

3.2 What do people in your community think about human trafficking? Probe: How do people define trafficking? What are the dangers of trafficking? Who is at risk for trafficking? What are the effects on survivors of trafficking?

3.3 Among which populations/groups do different types of GBV occur, and how frequently?
3.3.2 With what frequency do various types of GBV occur (e.g., daily, weekly, monthly, annually)?

3.4 Where does GBV take place within communities? Probe: Homes, water sites, roads, schools, pubs, streets, etc.?

3.5 In your opinion, what do you think are the main reasons for GBV in your community? Probe: Is alcohol a problem? Is poverty a problem? Is there ignorance of laws and rights? Is promiscuity a reason for GBV? What about GBV and what men and boys are taught to value and how to behave at home and in public?

3.6 How do families in your community resolve conflict? Probe: How do men and women resolve intimate partner conflicts? How do men resolve conflicts with one another? How do women resolve conflicts among each other? How do parents resolve conflicts with their children? How do children resolve conflicts with one another?

3.7 What are the emotional and health consequences of GBV that you have observed and within the community?

3.8 How have people’s attitudes towards GBV changed in the past two years? Probe: Among community leaders, religious leaders, and others? Among law enforcement officials? Among women? Among men? Among adolescent boys and girls? How have your attitudes changed?

3.9 Compared to two years ago, do you think people are more or less safe than they are now? Explain. Probe: Are women more or less safe? Young girls? Men? Boys? Orphans? Disabled? Elderly? What makes them more or less safe?

3.10 Where do you believe progress has been made in preventing and responding to GBV?

3.11 Where do you believe challenges still exist that need to be addressed?

4. Discussion of STOP GBV Programming (GENERAL)
I would like to ask you some questions specifically about the STOP GBV programming and One Stop Centers:

4.1 How do you coordinate with STOP GBV Centers?
   4.1.1 With what frequency?
   4.1.2 How is coordination improving the delivery of your service or leading to more benefits for individuals and community members?
   4.1.3 What has been challenging about coordination with STOP GBV Centers?

4.2 How do you coordinate with the community? Probe: Community leaders, community groups, religious leaders, individual community members?

4.3 What do you believe are the main successes so far of the STOP GBV program and/or STOP GBV centers?

4.4 What are the main challenges that you have observed in the implementation of the program and operation of the STOP GBV programming and centers?
   4.4.1 What are challenges related to management?
   4.4.2 What are challenges related to coordination?
   4.4.3 What are challenges related to service delivery?
   4.4.4 What are challenges related to cost efficiency?
   4.4.5 What are challenges related to making real change?
   4.4.6 What are challenges related to sustainability?
   4.4.7 What can be done to overcome identified challenges?

4.5 What you think is the best way to know that STOP GBV is making a positive difference in the community?

4.6 What role do you play as an individual in the objectives to prevent and respond to GBV?
   4.6.1 How have you changed as an individual in your beliefs and practices since becoming part of this project?
   4.6.2 How do you see your role changing in the prevention and response to GBV over time?

4.7 In your opinion, how do you think that community members and beneficiaries lives have changed so far as a result of any STOP GBV project activity or service?

4.8 What gaps exist in the program design, delivery or implementation which need to be addressed in order to positively influence implementation of STOP GBV?
   4.8.1 What operational program improvements can be made to ensure impact and outcomes are achieved and/or improved?

5. STOP GBV Programming Component 1: GBV Survivor Services

This GBV survivor services component, implemented by World Vision, aims to increase the availability of comprehensive, quality services for GBV survivors through One Stop Centers that employ a culturally sensitive, victim-centered approach in sixteen districts.

5.1 What types of GBV cases do you typically see reported formally, and by whom?
   5.1.1 What are GBV survivors comfortable reporting? What are they not comfortable reporting?
5.1.2 What types of GBV cases, in your opinion, are going unreported, and who is least likely to report cases and why?

5.1.3 Have you seen an increase or decrease in reported cases at One Stop Centers or Victim Support Units?

5.1.4 Who does a GBV survivor (boys, girls, men women) turn to in crisis to seek any type of support (emotional, psychosocial, medical, legal, financial, etc.)?

5.1.5 What reaction from others do GBV survivors face (boys, girls, men, women survivors)? How do family members react? How do communities react?

5.1.6 What types of cases are met stigma by family members of the GBV survivor? What types of cases are met with stigma by center staff? What types of cases are met with stigma by the community? How can stigma be overcome?

5.2 Describe the referral process for GBV survivors to you or to other services. Probe: Describe referrals to medical facilities for further treatment, the police via Victim Support Units, economic support through micro-finance, savings groups and skills development, safe houses or shelters, and survivor support networks.

5.2.1 What works well with the referral system?

5.2.2 How are individual cases tracked and followed? Probe: If an individual is referred, how is the outcome of the referral tracked to see if they received the service they referred to and what happened?

5.2.3 What challenges have been encountered when referring survivors to other services either to you or from you? How have these challenges been addressed?

6. STOP GBV Programming Component 2: Access to Justice

This component, managed by Women in Law in Southern Africa (WLSA), aims to provide support for GBV survivors to obtain access to justice and to strengthen the capacity of the police and legal system. This component ends in April 2018.

6.1 What do you think people (men, women, boys, girls) know about laws that exist about GBV?

Probe: Do you think people feel the laws are respected by community members? How are laws implemented? By whom? Who is responsible for carrying out the implementation of laws?

6.1.1 Please describe customary law on various GBV cases. Traditionally, how does the community handle GBV cases, survivors, and perpetrators?

6.1.2 How are statutory laws related to GBV implemented in the communities where you work?

6.1.3 What formal legal processes are helpful to GBV survivors and their families?

6.1.4 What challenges exist within the community to formally reporting incidences of GBV?

6.1.5 What has stopped survivors from formally pursuing cases?

6.1.6 How are children and adolescent survivors of GBV treated by law enforcement officials, health staff at health facilities, and other staff/community members?

6.1.7 What change have you observed in how communities, traditional leaders, and formal legal bodies are handling GBV cases? Please provide an example of where you have seen a change.

6.1.8 What percentage of GBV cases that are reported are formally prosecuted?

6.2 What type of training have you received?

6.2.1 What was the training content that you received?

6.2.2 What information was most useful to you, and what was the most useful way to provide you with that information?

6.2.3 What did you not like about the training? What would you change about the training?
6.2.4 What additional training and learning is required to continue building staff skills for you and others that you work with?

6.2.5 How have you incorporated information from training into the regular work that you do?

6.2.6 Please describe an example of you or a colleague who made positive changes regarding how they deal with GBV cases as a result of training.

6.2.7 What is support like for trained police officers by your superiors and colleagues? Are there challenges that you have been encountered?

6.3 What type of training of your colleagues or others in the law enforcement field have you seen as helpful in your work or in pursuing justice for GBV survivors?

6.3.1 Describe how trained police have been cooperative and helpful in investigation, evidence collection (including forensics), prosecution of cases, witness support, and referral of cases.

6.3.2 Where do challenges remain in police cooperation in the areas mentioned, and how can those challenges be addressed?

6.3.3 Describe any observed stigma toward GBV survivors among police? If there has been stigma, how has this been addressed?

6.4 What, in your opinion, has been helpful in regard to community awareness of legal aspects of GBV through mobile outreach activities conducted in the community?

6.4.1 Who is typically reached during mobile outreach (e.g. women, girls, men, boys, GBV survivors)?

6.4.2 Please describe any observed improvement or change in how the community in general has changed their attitudes or practices in relation to GBV. Please provide examples. How do you measure this change?

7. STOP GBV Programming Component 3: Prevention and Advocacy

The prevention and advocacy component is managed by Zambia Centre for Communication Programmes (ZCCP). This component aims to change social norms, attitudes and behaviors and to tackle underlying risk factors for GBV by sensitizing and mobilizing communities through a comprehensive program of complementary communication interventions in 24 districts. This component ends in April 2018.

7.1 How have you observed traditional chiefs and headmen/ women to incorporate sensitization regarding GBV into their lives and interactions with the community and individuals?

7.1.1 What challenges remain in sensitization of traditional chiefs and headmen/ women?

7.1.2 How many cases have traditional chiefs, headmen, and headwomen referred to a One Stop Center or for formal processes?

7.1.3 How do you track the number of GBV cases that communities and community leaders report to appropriate formal authorities?

7.2 Can you provide examples, without naming anyone’s specific name, where you have seen a change in the way men and male family members of GBV survivors handle cases?

7.2.1 Where have you seen men support female GBV survivors in pursuing justice?

7.2.2 Where do challenges remain?

7.2.3 What can be done to address challenges and encourage more male support of female GBV survivors?

7.3 Describe how you perceive community awareness regarding GBV making a difference in GBV survivors pursuing justice, reporting cases, or the prevention of GBV.
7.4 Describe how the telephone helpline for GBV survivors and perpetrators is assisting in the prevention and response to GBV.
7.4.1 Do you ever receive referrals from the helpline?
7.4.2 How do you respond to helpline referrals?
7.4.3 Please provide an example of a successful case where a GBV survivor called the helpline and received the support required.

8. Closing the Interview

8.1 Thank the interviewee for their participation in the discussion.

8.2 “Are there any other issues that have not been discussed that you think are important and would like to discuss?”

8.3 Ask the interviewee if they have any questions about the discussion.

8.4 Ask the interviewee, again, if the information that he/she provided can be used in the midterm evaluation. Clarify that all information will be summarized and that the evaluation will not identify any participants by name unless he/she authorizes you to attribute what they said to them individually.
ANNEX K: INFORMED CONSENT FORM

I am asking you to participate in an evaluation. This form is designed to give you information about this evaluation. I will describe this to you and answer any of your questions.

Project Title: Mid-Term Evaluation of STOP GBV Project

Principal Investigator: Name
Organization
Contact Information (Phone, Email, Address)

What the evaluation is about
USAID and DFID are working together over a five year period, from 2013-2018 to support the project, STOP GBV in Zambia. STOP GBV is working to provide: 1) GBV survivor support services; 2) access to justice; 3) prevention and advocacy; and 4) engage men and boys through sports. The expected impact of the STOP GBV project is reduced gender-based violence (GBV) and child marriage in Zambia.

USAID has contracted an independent evaluator, GH Pro, which is not in any way associated with the STOP GBV project. GH Pro is working with a Zambian research organization IPSOS, to conduct a mid-term evaluation of STOP GBV. The purpose of the evaluation is to understand what is working about the project, what can be improved, and to make recommendations to improve the project in the latter half of implementation. As part of this evaluation, IPSOS is conducting interviews with individuals, focus group discussions with small groups, and surveys with community members in six project sites.

What we will ask you to do
I will ask you to participate in this interview/discussion by asking you a series of questions related to gender-based violence generally in Zambia and your community, as well as questions related to the STOP GBV project.

For interviews, this will take approximately 45 minutes to complete for most stakeholders, except for project partner interviews which are expected to take longer (approximately two hours). Focus group discussions are expected to take approximately two hours to complete.

Risks and discomforts
I do not anticipate any physical, legal, or economic risks to you participating in this interview/discussion. However, if you have experienced gender-based violence or know someone who has, there may be a risk that by participating today you may experience some feelings of sadness, anger, or anxiety.

If you are a survivor of gender-based violence, you may experience heightened emotional risks. Further, although this team will be taking specific measures to ensure confidentiality explained further below, if you are participating in a focus group discussion with others there may be a risk to your confidentiality and anonymity. I will provide you with the contact information of a counselor or psychotherapist who specializes in trauma who will be available to provide you with support following our discussion if required.

Benefits
The primary benefit to your participation in this interview/discussion is to improve prevention and response to gender-based violence in your community and in Zambia. Your participation and sharing of your knowledge, opinions, and experiences will contribute to learning in order to improve the STOP GBV project.
For those of you who may be a GBV survivor participating in a focus group discussion, although there is a risk of emotional discomfort, you may find that an indirect benefit may also be talking about/reflecting on an experience, which may also be therapeutic in sharing your feelings in a supportive environment.

**Payment for participation**
There is no payment for taking part in the study.

**Audio Recording**
I will audio record our conversation today. This is so that the conversation may be transcribed word-for-word by the research team in order to ensure accuracy of the discussion that we have today. This audio recording will not be shared with anyone outside of the research team, and will be archived after transcription. If you feel uncomfortable with the recorder, you may ask that it be turned off at any time.

**Privacy/Confidentiality**
Once this data collection is complete, the information you provide will be summarized into a general analysis that will be included in a publicly available report providing information about the STOP GBV project and will provide recommendations on the project. However, no individual names will be used in the analysis and report, and no identifying information for community members will be used. Information may be summarized, such as, “Community members reported that….” or “GBV survivors thought that….”

If you are a GBV survivor or community member, further precautions will be taken to protect your privacy and confidentiality by ensuring any documentation where your name appears, such as in a log noting that received transport allowance to come to this meeting today, will be kept in a locked file drawer at IPSOS. Your name and any identifying information will not be included in any computer file or software file.

**Taking part is voluntary**
Your participation in this evaluation is voluntary, and you may refuse to participate before the interview/discussion begins, discontinue at any time, or skip any questions/procedures that may make you feel uncomfortable, with no penalty to you.

**If you have questions**
Please ask any questions you have now. If you have questions later, you may contact the principal investigator, whose information is provided above in the contact information section of this form. You will be given a copy of this form to keep for your records.

**Statement of Consent**
I have read/been read the above information, and have received answers to any questions I asked. I consent to take part in the study.

---

**Only for community members and GBV survivors participating in focus group discussions will verbal consent via a “Yes!” and thumbs-up will be requested by the person obtaining consent after demonstrating understanding of the consent, in place of providing consent.**

Your Signature ____________________________ Date __________

Your Name (printed) __________________________________________

Signature of person obtaining consent __________________________ Date __________
Printed name of person obtaining consent

This consent form will be kept by IPSOS for at least five years beyond the end of the study.
ANNEX L: INTERVIEWS AND FOCUS GROUP DISCUSSIONS CONducted

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name (Position)</th>
<th>Data Collection Tool Used</th>
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</thead>
<tbody>
<tr>
<td><strong>Lusaka (National Level)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World Vision</td>
<td>Angella Chirwa (Finance &amp; Administration), Warren Kawisha (OSC Coordinator for D2G), Helen Lungu (Technical Advisor for Clinical &amp; Social Services), Annie Banda (COP), John Manda (M&amp;E), Derrick Chila (OSC Coordinator), Manyando Chisenga (Project Manager)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>WLSA</td>
<td>Womba Mayondi (COP), Russell Phiri (Finance &amp; Administration), Margaret Chabishi (M&amp;E), Maureen (National Coordinator), Douglas Chiama (Legal Officer)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>ZCCP</td>
<td>Johans Mtonga (Executive Director), Finance Manager, Kelvin Tambulukani (Grants Manager)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>CARE</td>
<td>Christine Munaluna (Gender Specialist, STOP GBV Coordinator)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>Sports in Action (SIA)</td>
<td>George Kakomwe (Program Officer)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>ECR</td>
<td>Josepah Mutale (Project Coordinator)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>WILDAF</td>
<td>Mr. Kamanga Chief (Executive Director)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>Lifeline</td>
<td>Florence Nkhuwa (Chief Executive Officer)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>FAWEZA</td>
<td>Christopher Mvula (Program Officer)</td>
<td>KII #3 STOP GBV Program Staff</td>
</tr>
<tr>
<td>MCD/MCH</td>
<td>Irene Munga (Chief Social Welfare Officer)</td>
<td>KII #2 Government Ministry</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Dr. Kennedy Malama (Lusaka Provincial Health Officer)</td>
<td>KII #2 Government Ministry</td>
</tr>
<tr>
<td>Ministry of Gender</td>
<td>Simon Kapilima (Assistant Director)</td>
<td>KII #2 Government Ministry</td>
</tr>
<tr>
<td>Ministry of Youth &amp; Sports</td>
<td>Mrs. Bessie Chelemu (Director of Sports)</td>
<td>KII #2 Government Ministry</td>
</tr>
<tr>
<td>Ministry of Chiefs</td>
<td>Peter Mucheleka (National Coordinator for Early Child Marriage, seconded by UNFPA)</td>
<td>KII #2 Government Ministry</td>
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<tr>
<td>High Court</td>
<td>Honorable Chalwe Mchenga (Chief Justice)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
</tr>
<tr>
<td>Victim Support Unit Headquarters</td>
<td>Senior Superintendent Kasale (VSU HQ Head)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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## Interviews and Focus Group Discussions Conducted (15-30 June 2015)

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<th>Organization</th>
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<th>Data Collection Tool Used</th>
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<tr>
<td>NA (Phone Interview)</td>
<td>Martin Mankinka (defense lawyer)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<tr>
<td><strong>Lusaka OSC Site</strong></td>
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<tr>
<td>Lusaka One Stop Center</td>
<td>Imelda Sembele (counselor), Mulemba Matoka (paralegal), Chisenga Zulu (OSC Officer), Chibesa Zulu (Acting In-Charge Ng’ombe Clinic).</td>
<td>KII #4 OSC Staff</td>
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<td>Lusaka Victim Support Unit</td>
<td>Lewis Pukeni (VSU Officer)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>Lusaka Subordinate Court</td>
<td>Honorable Ireen Wishimanga (Magistrate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<tr>
<td>Lusaka City</td>
<td>Aggrey Masumo (community leader)</td>
<td>KII #1 Community Leader</td>
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<td>Lusaka City</td>
<td>FGD with 8 female GBV survivors</td>
<td>FGD #1 GBV Survivors</td>
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<td>Lusaka City</td>
<td>FGD with 8 male change agents</td>
<td>FGD #2 Change Agents</td>
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<td>Lusaka City</td>
<td>FGD with 8 female community members</td>
<td>FGD #3 Community Members</td>
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<td><strong>Chongwe OSC Site</strong></td>
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<tr>
<td>Chongwe One Stop Center</td>
<td>Dr. Mwanza (Head of Hospital)</td>
<td>KII #4 OSC Staff</td>
</tr>
<tr>
<td>Chongwe One Stop Center</td>
<td>Eugenia Maliiwe (OSC Officer), Mwomba Mwanachingwala (administrative assistant), Edfy (driver), Angela Michelo (counselor), Christine Shanzala (nurse)</td>
<td>KII #4 OSC Staff</td>
</tr>
<tr>
<td>World Vision (Chongwe)</td>
<td>Eugenia Maliiwe (GBV Supervisor), Mwomba Mwanachingwala (administrative assistant), Edfy (driver)</td>
<td>KII #3 IP Staff</td>
</tr>
<tr>
<td>ZCCP (Chongwe)</td>
<td>Mulawuzi (Program Officer)</td>
<td>KII #3 IP Staff</td>
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<tr>
<td><strong>Kafue OSC Site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kafue One Stop Center/World Vision and ECR (Kafue)</td>
<td>Diana Daka (Project Coordinator)</td>
<td>KII #4 OSC Staff/ KII #3 IP Staff</td>
</tr>
<tr>
<td>Kafue One Stop Center</td>
<td>Nduka Emmanuel (ECR administrative assistant), Hiloa Kambilumbilu (ECR paralegal), Kalebaila Mastone (WLSA paralegal), Rachael Mutambo (ECR counselor), Florance Goma (hospital nurse), Hilda Mwaba (ECR counselor)</td>
<td>KII #4 OSC Staff</td>
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<tr>
<td>Kafue Subordinate Court</td>
<td>Honorable Esther Chifuwe (Magistrate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>Kafue Victim Support Unit</td>
<td>Joel Moyo (Inspector)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>District Development Gender Sub-Committee (Kafue)</td>
<td>Committee members: Linda EH Simuyani (Department of Social Welfare, Assistant Social Welfare Officer), Maggie Kamalondo (Administration Officer, Kafue District Council), Bertha Chulu (Public Relations Officer, Kafue District Council),</td>
<td>KII #2 Government Ministry</td>
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<td>Organization</td>
<td>Name (Position)</td>
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<td></td>
<td>Christopher Nsambu Kafue (Vice Chairman, District Council of Churches), Namakau Liywali (District Community Development Officer, Department of Community Development), Dickson Muleya (Deputy Secretary General, Kafue District Churches Committee), Florista Mutoloki (District Education Board Secretary), Collins Masupa (ZANIS), George Chuungu (Kafue Gospel), Kafishi Chitesha (District Communications and Transport Officer, Ministry of Communications and Transport), Catherine Chipeshamano (Gender Champion, Kafue District Council), Rodrick Kaliki (Technician, ZANIS), Mwiki Nyirenda (Secretary, DATF), Christopher Lombe (District Coordinator, PUSH), Cacious Muyande (Program Coordinator, KCDA), Namakau Nyumbu (Police Officer, VSU)</td>
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**Kafue Town**

- **Godfrey Chisoke (Headman)**

**FGD with 8 male GBV survivors**

**FGD #1 GBV Survivors**

- **FGD with 8 male change agents**

**FGD #2 Change Agents**

- **FGD with 8 male community members**

**FGD #3 Community Members**

**Choma OSC Site**

- **Dr. Shawa (Hospital Head), Dr. Emmanuel (Siame Senior Hospital Administrator)**

**KII #4 OSC Staff**

- **Edgar Chisuwo (coordinator), Sombo Masuwa (paralegal), Eastern Sakala (counselor)**

**KII #4 OSC Staff**

- **Rodwell Nzoolo (Program Officer), Catherine Mbokoma (Regional Coordinator)**

**KII #3 IP Staff**

- **Mr. Choongo (VSU Police Officer)**

**KII #5 Judges, Lawyers, VSU Police**

- **Honorable Mukela Mbololwa (Magistrate)**

**KII #5 Judges, Lawyers, VSU Police**

- **Committee Members: Florence Beenzu (NZPA District Coordinator), Nivile Marasanye (FPP), Anet Pukeni (ECR counselor), Doris Bwali (Victim Support Unit)**

**KII #2 Government Ministry**

- **Chrispin Mudende (Senior Headman, Mbabala)**

**KII #1 Community Leader**

- **FGD with 8 female GBV survivors**

**FGD #1 GBV Survivors**

- **FGD with 7 male change agents**

**FGD #2 Change Agents**
### Interviews and Focus Group Discussions Conducted (15-30 June 2015)

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<td>Head of Hospital Danny Samutemba (Project Coordinator)</td>
<td>KII #4 OSC Staff</td>
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<td>Mumbwa One Stop Center/ World Vision and ECR (Mumbwa)</td>
<td>Danny Samutemba (Project Coordinator)</td>
<td>KII #4 OSC Staff/ KII #3 IP Staff</td>
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<tr>
<td>ZCCP (Mumbwa)</td>
<td>Staff Carol Matanda (Project Officer)</td>
<td>KII #3 IP Staff</td>
</tr>
<tr>
<td>SIA (Mumbwa)</td>
<td>Stanley Mpanje</td>
<td>KII #3 IP Staff</td>
</tr>
<tr>
<td>Mumbwa Victim Support Unit</td>
<td>Christine Kahampa (Community Service Directorate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>Mumbwa Subordinate Court</td>
<td>Honorable Christopher Matipa (Magistrate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>District Development Gender Sub-Committee (Mumbwa)</td>
<td>Committee Member: Jacob Miti (District Social Welfare Officer)</td>
<td>KII #2 Government Ministry</td>
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<tr>
<td><strong>Mumbwa Town</strong></td>
<td>Shambwalu, Bornwell, Village Headman (Community Leader)</td>
<td>KII #1 Community Leader</td>
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<td><strong>Mumbwa Town</strong></td>
<td>FGD with 5 female GBV survivors</td>
<td>FGD #1 GBV Survivors</td>
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<td><strong>Mumbwa Town</strong></td>
<td>FGD with 8 male change agents</td>
<td>FGD #2 Change Agents</td>
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<td><strong>Mumbwa Town</strong></td>
<td>FGD with 8 female community members</td>
<td>FGD #3 Community Members</td>
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<td><strong>Katete OSC Site</strong></td>
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<tr>
<td>Katete One Stop Center</td>
<td>Dr. Chimodzi Tembo (Acting Medical Superintendent), Dr. Chisi (Medical Superintendent)</td>
<td>KII #4 OSC Staff</td>
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<tr>
<td>Katete One Stop Center</td>
<td>Sarafina Banda (WLSA lawyer), Martha Kabandama (psychosocial counselor), Rose Kunga (nurse)</td>
<td>KII #4 OSC Staff</td>
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<tr>
<td>World Vision and ECR (Katete)</td>
<td>Mrs. Beatrice Bwaly (OSC Officer), Mr. Wilson Chabala (Transition Officer)</td>
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<td>Katete Victim Support Unit</td>
<td>Mr. Stanley Kakisa (Inspector)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<tr>
<td>Katete Subordinate Court</td>
<td>Honorable Mary Musongole (Magistrate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<tr>
<td>District Development Gender Sub-Committee (Katete)</td>
<td>Mrs. Beatrice Bwaly (WVZ/OSC), Makunka K. Humphrey (Ministry of Chiefs), John Phiri (ZCCP), Brian Musesa (Police VSU), Joyce Msoni (Social Welfare), Josephine Mwanza (GBV Survivor Support Group), Gloria Phiri (Department of Community Development), Matrida Banda (Katete DWDA), Stanley Kakisa (VSU/OSC),</td>
<td>KII #2 Government Ministry</td>
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<td>Organization</td>
<td>Name (Position)</td>
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<td>Katete Township</td>
<td>McDonald Himoonga (VSU), Chibesa Musukwa (ZANIS), Sarafina Banda (WLSA lawyer), Shenga Muga (Buildings), Hellen Phiri (Community Development), Conas Mapulanga (GBVSS WVZZ Driver), Paul Mzinga (ZCCP)</td>
<td></td>
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<tr>
<td>Katete Township</td>
<td>Mr. Trywell Mbewe (Headman), known in community as “Headman Joel”</td>
<td>KII #1 Community Leader</td>
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<td>Katete Township</td>
<td>FGD with 8 female GBV survivors</td>
<td>FGD #1 GBV Survivors</td>
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<td>Katete Township</td>
<td>FGD with 8 male change agents</td>
<td>FGD #2 Change Agents</td>
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<td>Katete Township</td>
<td>FGD with 8 male community members</td>
<td>FGD #3 Community Members</td>
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<td>Mazabuka OSC Site</td>
<td>Steven Shajanika (District Medical Officer)</td>
<td>KII #4 OSC Staff</td>
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<tr>
<td>Mazabuka One Stop Center</td>
<td>Mr. Fashion Mudenda (Project Coordinator), Mrs. Victoria Mubita (nurse), Mrs. Bertha Sichone Chirwa (paralegal), and Ms. Mwangala (psychosocial counselor)</td>
<td>KII #4 OSC Staff</td>
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<tr>
<td>ZCCP (Mazabuka)</td>
<td>Mr. Bonwell Miti (Community Leader/OSC Volunteer)</td>
<td>KII #1 Community Leader</td>
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<tr>
<td>Mazabuka Township</td>
<td>Chairman Ackim Kalenga (Community Leader)</td>
<td>KII #1 Community Leader</td>
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<td>Mazabuka Victim Support Unit</td>
<td>Mrs. Dthineonti (VSU Officer assigned to OSC)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>Mazabuka Subordinate Court</td>
<td>Honorable Grinwel Malumani (Magistrate)</td>
<td>KII #5 Judges, Lawyers, VSU Police</td>
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<td>Mazabuka Township</td>
<td>FGD with 10 female GBV survivors</td>
<td>FGD #1 GBV Survivors</td>
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<tr>
<td>Lubombo Village</td>
<td>FGD with 11 male change agents</td>
<td>FGD #2 Change Agents</td>
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<td>Mazabuka Township</td>
<td>FGD with 10 male community members</td>
<td>FGD #3 Community Members</td>
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</tbody>
</table>
ANNEX M: INFORMATION SOURCES


Gender Inequality Index (2011).


Government of Zambia (2011). Zambian Anti Gender Based Violence Act


UNICEF and Gender Links (2013). The gender based violence indicators research project in Kitwe, Kasama, Mansa and Mazabuka districts of Zambia.


### STOP GBV Implementing Partner Documents, Data, and Information Received

<table>
<thead>
<tr>
<th>Implementing Partner</th>
<th>Document Name</th>
<th>Date</th>
<th>Description of Data</th>
<th>Analysis Use</th>
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<tr>
<td>DFID</td>
<td>STOP GBV Business Case</td>
<td></td>
<td>Provides background data/literature review of GBV in Zambia, justifying STOP GBV program and components, program description, preliminary cost data and economic analysis, Theory of Change and expected results.</td>
<td>Background GBV data utilized in qualitative analysis as reference; cost and economic data used in calculating value for money and economic analysis; other programmatic data, ToC, and results used to formulate research questions and tool development.</td>
</tr>
<tr>
<td>WVZ</td>
<td>PMP</td>
<td></td>
<td>Includes results framework, logic framework with indicators, and plans for M&amp;E.</td>
<td>Assisted in formulation of data collection tools; used as reference to measure progress to date.</td>
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<tr>
<td>ZCCP</td>
<td>PMP</td>
<td></td>
<td>Includes results framework, logic framework with indicators, and plans for M&amp;E.</td>
<td>Assisted in formulation of data collection tools; used as reference to measure progress to date.</td>
</tr>
<tr>
<td>WLSA</td>
<td>PMP</td>
<td></td>
<td>Includes results framework, logic framework with indicators, and plans for M&amp;E.</td>
<td>Assisted in formulation of data collection tools; used as reference to measure progress to date.</td>
</tr>
<tr>
<td>WVZ</td>
<td>GBVSS Annual Report</td>
<td>2013</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
</tr>
<tr>
<td>WVZ</td>
<td>GBVSS Annual Report</td>
<td>2014</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
</tr>
<tr>
<td>ZCCP</td>
<td>Prevention and Advocacy Annual Report</td>
<td>2014</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
</tr>
<tr>
<td>ZCCP</td>
<td>Prevention and Advocacy Semi-Annual Report</td>
<td>March 2015</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
</tr>
<tr>
<td>ZCCP</td>
<td>Prevention and Advocacy Annual Progress Report</td>
<td>2013</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
</tr>
<tr>
<td>WLSA</td>
<td>Access to Justice Annual Report</td>
<td>2014</td>
<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
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<td>WLSA</td>
<td>Access to Justice Semiannual Report</td>
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<td>Provides data and explanation of progress in implementing activities, achieving targets, challenges and recommended changes.</td>
<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
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<td>WLSA</td>
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<td>Assisted in formulating appropriate research questions and data collection tools; analysis of targets, cost-effectiveness, challenges and mediation measures.</td>
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<td>WVZ</td>
<td>STOP GBV Baseline Assessment Raw Database (Excel)</td>
<td>2014</td>
<td>Provides all raw data captured for STOP GBV Baseline Assessment.</td>
<td>Quantitative analysis via SPSS was utilized to compare site statistics to national statistics and identify utility of data for changes observed at endline.</td>
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<tr>
<td>DFID</td>
<td>Evaluations of Baselines</td>
<td></td>
<td>Identifies quality of baseline data and recommendations for improvement.</td>
<td>Provides guidance on expectations of quality data collection for evaluations to improve midterm and endline data collection and analysis quality.</td>
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<tr>
<td>WVZ</td>
<td>Work Plan</td>
<td></td>
<td>Target setting, budget, activity plans</td>
<td>Assists in identifying if targets are being met per the work plan and if budgets are being spent effectively.</td>
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<tr>
<td>ZCCP</td>
<td>Work Plan</td>
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<td>WLSA</td>
<td>Work Plan</td>
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<td>Target setting, budget, activity plans</td>
<td>Assists in identifying if targets are being met per the work plan and if budgets are being spent effectively.</td>
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<td>DFID</td>
<td>Annual Review</td>
<td>December 2014</td>
<td>Provides assessment of results, achievements, challenges to date with recommendations for changes.</td>
<td>Assess performance and if recommendations are being implemented.</td>
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<tr>
<td>USAID</td>
<td>ASAZA Independent Endline Evaluation</td>
<td>2010</td>
<td>Provides evaluation of achievement of results of predecessor program, including data collection tools used and recommendations for future evaluations and program design.</td>
<td>Assisted in formulation of data collection tools and analysis of what has been achieved, if recommendations made were taken and implemented programmatically; benchmark to identify if lessons have been learned or if mistakes are repeated.</td>
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<td>GBVSS Financial Status April 2015</td>
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<td>GBVSS Year 1 Work Plan and Budgets</td>
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<td>Funding and costing data</td>
<td>Estimate cost efficiency, value for money, and assess if spending is being done efficiently.</td>
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## STOP GBV Implementing Partner Documents, Data and Information Received

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<td>Results Aggregated by Case Type Annex Table 4</td>
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<td>SIA Revised Budget 2</td>
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<td>SIA</td>
<td>Semiannual Financial Report and Income Statement</td>
<td>2015</td>
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<td>Approved Year 2 DIP Revised</td>
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<td>Estimate cost efficiency, value for money, and assess if spending is being done efficiently. Estimate cost efficiency.</td>
</tr>
</tbody>
</table>
## ANNEX N: KEY FINDINGS FROM SIX VISITED SITES

### Katete OSC Site Key Findings

#### Key Successes

- Early indication of sustainability is observed. Transition of the OSC to government has begun, with a government-employed social worker heading the OSC since April 2015. Three new doctors from the St. Francis Hospital have expressed desire to be affiliated with the OSC. The hospital provided three rooms within the hospital for OSC use (one room allocated to the OSC officer, one to counseling, and one to the paralegal).

- The number of reported GBV cases increased, reportedly due to increased community awareness of GBV, including women’s recognition of marital rape, survivors’ rights, and knowledge about OSC and services offered. Men are also reporting GBV cases, reportedly with reduced fear of intimidation.

- Men’s network of male change agents, chaired by a pastor, is taking active interest in the fight against GBV and carrying out awareness sessions in community.

- 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 St. Francis Hospital doctors treats referrals from OSC with high priority due to the sensitization that doctors received.

- GBV Survivors Committee is active, with about 25 survivors who are also engaged in income-generating activities and sensitization sessions within communities.

- VSU police officer attached to the OSC is passionate about the fight against GBV; he is well known in the community and uses his own taxi that he owns to follow-up with cases in communities.

#### Key Challenges

- Lack of shelter or safe house for survivors impacts ability of service providers to protect survivors and follow-up on cases.

- Inadequate transport to pick up survivors and follow up with them results in lost GBV cases and inhibits access to services.

- Despite hospital provision of three rooms, there is inadequate space at the OSC, resulting in inadequate privacy and service provider ability to cater to high number of survivors demanding services.

- Inadequate number of medical staff, especially doctors, poses a challenge for urgent cases when doctors may be unavailable while attending to other urgent medical cases or in the operating theater.

- Weak coordination between hospital management and OSC staff results in a weak feedback system to improve services for survivors.

- Drop-out rate for community volunteers is very high: only 8 out of 70 trained male change agents are active.

- GBV cases taken to courts are not treated with high priority and referrals from the OSC are not accepted as special cases that warrant fast tracking within the courts.

- Defilement cases are often reported late, typically after informal agreements for monetary compensation between the survivor’s family and perpetrator fail, resulting in lack of evidence. Further, birth records for survivors are often missing, making proof of age of the survivor challenging.
### Katete OSC Site Key Findings

**Distance to the OSC to access services inhibits many outside of the immediate area from accessing services, particularly in light of lack of transport.**

**Strongly entrenched traditions and customs continue to perpetuate GBV, including Nyau and Chinamwali initiation ceremonies where boys and girls are separately initiated into adulthood—boys are encouraged to practice sex with as many as 6 different girls/women while the girls are defiled after being taught how to look after husbands.**

**Referrals to the Department of Social Welfare do not work very well due to lack of resources, so survivors are often lodged in the hospital where they may not receive adequate compassionate care.**

**There is little awareness of the GBV Helpline (Lifeline), although OSC staff are aware that it exists.**

**Early marriage and school withdrawal persists as a key challenge despite awareness efforts, attributed in the area to initiation ceremony teachings.**

**A high number of GBV cases reported by women are withdrawn due to pressure from family and community, while they are also frequently economically dependent on their perpetrators and have no other option.**

**Some men perceive the OSC to be a negative force in the community that is “breaking up marriages,” pointing to an ongoing awareness and attitude gap within the community.**

**There is a general lack of IEC materials for the OSC to utilize regularly in the community.**

**There are reports of accused perpetrators who are beaten by the VSU police, and reported cases of perpetrators bribing the police to drop or lose evidence for cases.**

**Lack of involvement of Immigration Department in the design of the program was cited as a challenge for following up with cases of perpetrators who run away to seek refuge in Mozambique.**

### Mazabuka OSC Site Key Findings

**Key Successes**

**Informed and caring project coordinator (trained one month before ASAZA closed) advocates for the OSC and GBV at the district level, including with the hospital and for district budget allocation.**

**Involved and caring community volunteer (volunteer for seven years, ASAZA-trained) is working closely with GBV cases and conducting follow-up, which has been made easier by a ZCCP bicycle provision.**

**OSC community volunteer or staff often accompanies survivors to court hearings, which reportedly increases accountability of police and courts and reduces likelihood of corruption.**

**Survivor support group is active (meeting monthly) and cited by the group as helpful for survivors.**

**There is demonstrated commitment of (new as of Q1 2015) recruited male agents in rural areas to get involved and expressed desire to make change within their communities.**

**Nurse at OSC demonstrates personal care and commitment to her job, such as utilizing her personal resources to attend to cases.**

**Desire of current lead magistrate to be an active participant in prevention and response to GBV; he expressed desire to be part of a committee or ongoing discussions regarding GBV (he currently is not).**

**Traditional leaders in Mazabuka Township seem aware about GBV, involved and proactive (although not as much in surrounding rural areas).**
### Mazabuka OSC Site Key Findings

**ZCCP coordinator appears to have zeal and willingness to be proactive.**

#### Key Challenges

No data reporting exist at the OSC for cases that go for legal proceedings; paralegal and VSU officer cannot identify how many cases proceed to court, are acquitted or convicted, etc.

Referral data are weak without tracking outcomes of referrals; due to lack of economic opportunity, acquitted cases, etc., many survivors may return to homes with perpetrators (although this is quantifiably unknown).

Protection is lacking; survivors often need to wait one month to get a medical certificate (due to hospital inefficiencies) to arrest a perpetrator, so the survivor and perpetrator may live at home together; only girls under age of 10 might be accepted at a nearby orphanage while waiting for her medical certificate.

It is not functioning as a true OSC; survivors need to go to adjacent hospital for medical exam (and must stand in long cue) and must make an appointment, sometimes one month later, to get medical certificate; they have to go to VSU for reporting the case (even though VSU officer is stationed there).

Staffing is inadequate—there is a counselor acting as a paralegal and who has not received training, and there is no social worker.

No dedicated transport or driver is available to fetch survivors, so cases are reportedly often lost, particularly for those further away, and perpetrators often get away.

Corruption: cases are sometimes “lost” with VSU before reaching court; some families are reportedly paid off (K10,000-15,000 kwacha) for defilement cases and police receive a kick-back for “resolving cases” out of court; doctors are still charging K50 for medical certificate (unless ASAZA staff accompanies the survivor to get it for free); and there are ongoing reports of corruption at the court level.

DDCC gender sub-committee and previous men’s groups disbanded after WVZ left because no one was owning groups, organizing, or providing incentives (snacks, transport, etc.).

New men’s network is in process of starting up with ZCCP support; some received an orientation on GBV, but underlying misunderstandings about gender equality and GBV were observed during the FGD, indicating need for further training beyond orientation before activities begin.

All OSC staff left after WVZ because OSC staff were already retired at time of working at OSC with WVZ, or they did not meet government qualifications; new staff are not trained and few show motivation.

OSC falls under DMO who is new; OSC does not have its own budget, so it is completely dependent on district budget allocation, transport, etc. and OSC/GBV are not high priorities among other competing priorities.

### Lusaka OSC Site Key Findings

**Key Successes**

VSU police are very passionate about GBV, such as using their personal vehicle to apprehend perpetrators rather than waiting for a vehicle to become available.

The OSC staff is coordinating well with the neighborhood committee, which reports GBV cases from the community; staff and community members work to assist survivors with personal resources, such as offering vehicles for transport and money for medical bills (although survivors should not have medical bills).

Community members from Kalingalinga, N’gombe, and Garden who participated in the FGD demonstrated awareness of the OSC in N’gombe and reported referring cases there.
### Lusaka OSC Site Key Findings

**GBV survivors have an active support group for both males and females.**

<table>
<thead>
<tr>
<th><strong>Key Challenges</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female community members who participated in the FGD in N'gombe were not aware of the GBV helpline (Lifeline).</td>
</tr>
<tr>
<td>The hospital charges K50 GBV to survivors for the medical report, and doctors often prolong signing of the medical certificate, sometimes up to one week.</td>
</tr>
<tr>
<td>There is reportedly no vehicle available for OSC use, presenting issues for picking up survivors and following up with cases, becoming a particular challenge at night.</td>
</tr>
<tr>
<td>VSU police report inconsistencies between OSC and police in terms of data on incident reporting; reports by community members and survivors of ongoing stigmatization of survivors at police stations.</td>
</tr>
<tr>
<td>GBV survivors who participated in an FGD were not aware of referral services offered by the OSC (e.g., economic empowerment, etc.), and they believe that these types of referral services would require payment.</td>
</tr>
<tr>
<td>There are no shelters or safe houses in Lusaka, and thus many children who are GBV survivors are taken to orphanages if there is space.</td>
</tr>
<tr>
<td>OSC staff lack adequate refresher trainings, which presents an ongoing challenge of staff forgetting service quality standards and decrease in feeling of responsibility and accountability.</td>
</tr>
<tr>
<td>Inadequate engagement of religious leaders as key partners in prevention and response, who stakeholders cite as key actors in assisting with marital conflict.</td>
</tr>
</tbody>
</table>

### Mumbwa OSC Site Key Findings

**Key Successes**

- All required staff are stationed at OSC.
- GBV survivor support group is active for both male and female survivors (combined mixed-sex group) who met weekly on Thursdays.
- Headmen are active in prevention of GBV, especially the headmen in Kamoto; one is a football coach trained by SIA.
- All male change agents participating in the FGD expressed enthusiasm and desire to make positive change in their community.
- SIA is running a daily school program and organizes football leagues every month. In addition to trained coaches and two headmen (also football coaches), they have peer educators. Men and boys involved in sensitization at school and monthly football leagues reportedly reduce “insults to women.”
- VSU police are observed to be very passionate about GBV, demonstrated through their reported use of their personal vehicles to follow up on GBV cases with survivors and investigations.

**Key Challenges**

- GBV Helpline (Lifeline) is unknown to Mumbwa community members who participated in FGDs, and they reported that many people in the area cannot afford to buy mobile phones.
### Mumbwa OSC Site Key Findings

<table>
<thead>
<tr>
<th>Finding</th>
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</thead>
<tbody>
<tr>
<td>The Mumbwa District Hospital charges K50 GBV to survivors to receive the medical certificate, even when accompanied by OSC staff; 3 out of 5 female GBV survivors who participated in an FGD reported that they were charged K50 for the medical certificate.</td>
</tr>
<tr>
<td>Doctors reportedly prolong signing medical documents, sometimes up to one week, due to competing priorities, which results in dropped cases or delays in securing survivor protection and legal proceedings.</td>
</tr>
<tr>
<td>VSU police are not free to share data regarding cases received and that go to report and were unwilling to provide requested data to the evaluation team.</td>
</tr>
<tr>
<td>No shelters/safe houses in the area to provide protection for survivors following a GBV incident or during case preparation/trial</td>
</tr>
<tr>
<td>OSC staff, and in particular the counselors, report that they feel they do not have sufficient training, particularly on new information.</td>
</tr>
<tr>
<td>Existing coordination gaps among implementing partners, such as poorly planned activities and weak information sharing/communication results in inefficiency, especially in outreach activities.</td>
</tr>
<tr>
<td>Most participants were not aware of the other services offered by the OSC, e.g., financial help, skills training.</td>
</tr>
<tr>
<td>Although required staff is present, it is inadequate—the two nurses are on duty at the clinic so they are not always available for survivors at the OSC.</td>
</tr>
<tr>
<td>OSC and SIA have no vehicle to use for outreach activities, which limits ability to sensitize communities and pick up survivors in need of services.</td>
</tr>
<tr>
<td>The two magistrates in Mumbwa have not received training by WLSA, and it is unclear if GBV is a priority for them.</td>
</tr>
<tr>
<td>In this government-run OSC there are identified service quality gaps with seconded staff—they do not always respond to matters with urgency and do not have incentives to perform; staff feel that they should be paid additional incentives for their work as they perceive implementing partners have a lot of funding.</td>
</tr>
<tr>
<td>Not all male change agents have received training on GBV, which may compromise the quality of messaging that is received in communities.</td>
</tr>
<tr>
<td>VSU share vehicle and driver with MoH, so transport is often a challenge depending on how GBV cases are prioritized.</td>
</tr>
<tr>
<td>SIA’s focus on young men and boys leaves girls excluded and reinforces stereotype that sports are only for boys.</td>
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### Choma OSC Site Key Findings

#### Key Successes

<table>
<thead>
<tr>
<th>Success</th>
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<tbody>
<tr>
<td>ZCCP community volunteers (e.g., male change agents) working on the ground have community referral books kept by the chairperson. The book 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. Books are assessed by ZCCP regularly.</td>
</tr>
<tr>
<td>A very active OSC coordinator, a clinical officer, demonstrates deep knowledge of his job and commitment to his work; he is waiting for a formal transfer to continue offering medical services to the hospital while also coordinating the OSC.</td>
</tr>
<tr>
<td>OSC staff coordination appears to be very high—the paralegal and counselor equally know how to operate and understand the OSC operations.</td>
</tr>
<tr>
<td>Choma OSC Site Key Findings</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>ZCCP, VSU and the OSC appear to coordinate well and support each other in their activities, especially in transport.</td>
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<th>ZCCP, VSU and the OSC appear to coordinate well and support each other in their activities, especially in transport.</th>
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</thead>
<tbody>
<tr>
<td><strong>Traditional leaders are active in communities, and often are the first people to refer cases to the OSC.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A survivor support group is active and started a program called SILC (a savings group) to assist survivors in saving money.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ZCCP-trained male change agents and some headmen demonstrate commitment to fighting GBV; for example, the headmen assist in resolving marital conflicts and refer cases to the police and male change agents.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Choma District Hospital is coordinating well with the OSC so that no GBV survivor is charged for seeking medical assistance (including issue of medical certificate and required drugs to treat the survivor).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Choma District Hospital gave office space for the OSC to use, which was once a ward for the patients; it is a space independent from the hospital, which includes the coordinator’s office, a counseling room, a paralegal’s room, kitchen and a children’s play room.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transport is usually available to pick up a survivor who is close in the vicinity</th>
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</thead>
<tbody>
<tr>
<td><strong>There is reportedly strong communication between the OSC and other stakeholders, including health care facilities and traditional leaders who refer cases to the OSC.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OSC staff and health workers demonstrate commitment to the OSC; a trained nurse visits the OSC when she is off-duty in preparation for learning about the program and how to run the OSC after the program end in 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Challenges</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of shelters or safe houses in the area forces the OSC to send survivors to orphanages or someone's private home, and sometimes results in survivors returning to home with perpetrator due to lack of options.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of transport in the villages for male change agents prevents activities for prevention (awareness) and response (receiving and following-up on GBV cases) in areas further away from the town center.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The GBV Helpline (Lifeline) is not understood or known by many in the community, and there was only one case that was documented as referred to the OSC via the Helpline.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community awareness regarding the existence of the OSC was low in the community FGD held.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Some reported GBV cases are withdrawn, reportedly due to influence of a perpetrator on the survivor’s family and fear of losing a home or marriage, or in particular that the perpetrator is also the bread-winner, and if arrested families will lose source of income for food and education for children.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District gender sub-committee meetings are difficult to hold, as the government is not fully involved in the programs; government officials often do not commit to meetings or postpone scheduled meetings.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reported lack of involvement of Ministry of Gender in OSC activities or coordination meetings held at the district level is a demotivating factor for the OSC staff and identified gap in sustainability.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evidence for defilement and rape cases are often lacking due to late reporting, and EC and PEP is often not an option due to delays in reporting (past 72 hours or more).</strong></td>
</tr>
</tbody>
</table>

| There are long delays between case preparation and court proceedings, attributed to police challenges in evidence collection (particularly in defilement and rape cases) and lack of DNA machines. If collected evidence is determined by the court to be inadequate for prosecution or acquittal it is adjourned for another hearing, delaying proceedings for another two months (minimum). |
### Kafue OSC Site Key Findings

#### Key Successes

<table>
<thead>
<tr>
<th>Success</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The District Development Gender Sub-committee is active</td>
<td>The District Development Gender Sub-committee is active, meeting quarterly to set activities and follow up on previous action items.</td>
</tr>
<tr>
<td>Community agents, previously oriented by CARE and some trained by ZCCP</td>
<td>Community agents, previously oriented by CARE and some trained by ZCCP, are actively disseminating GBV information within the community.</td>
</tr>
<tr>
<td>The nurse attached to the OSC runs an orphanage for GBV child and adult survivors</td>
<td>The nurse attached to the OSC runs an orphanage for GBV child and adult survivors and demonstrates passion to the welfare of GBV survivors.</td>
</tr>
<tr>
<td>Traditional leadership demonstrates willingness to spread awareness and deliberate over GBV cases in their respective communities</td>
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</tr>
<tr>
<td>An enthusiastic VSU officer, trained in forensic investigation and 18 other trainings related to gender</td>
<td>An enthusiastic VSU officer, trained in forensic investigation and 18 other trainings related to gender, demonstrates commitment to fighting GBV by taking time to meet people in the community rather than waiting for reports from his office for follow-up. He also shares his GBV knowledge with colleagues who are reportedly showing increased interest in the STOP GBV program as a result.</td>
</tr>
<tr>
<td>The passionate and hardworking OSC project coordinator is motivating staff performance</td>
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</tr>
<tr>
<td>OSC assists survivors from the beginning of the case to the end with ongoing follow-up that includes escorting survivors to orphanages, courts, etc., as required</td>
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#### Key Challenges

<table>
<thead>
<tr>
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<tr>
<td>Cases are frequently withdrawn by GBV survivors due to economic dependence on perpetrators</td>
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</tr>
<tr>
<td>Lack of shelters or safe houses to accommodate GBV survivors limits ability for service providers to protect survivors</td>
<td>Lack of shelters or safe houses to accommodate GBV survivors limits ability for service providers to protect survivors. An orphanage currently sheltering child GBV survivors also accommodates adult males and females, presenting additional protection/security concerns.</td>
</tr>
<tr>
<td>Lack of adequate office space to accommodate all members of staff (e.g., currently the paralegal officers share office space with the dental department of the hospital), results in a risk to the privacy of survivors, and may cause discomfort for survivors to report or pursue legal action</td>
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</tr>
<tr>
<td>Inadequate transport to pick-up survivors and follow-up with cases, as there is only one vehicle for use throughout all of Kafue, results in lost GBV cases</td>
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</tr>
<tr>
<td>The doctor in charge at the Kafue District Hospital is too overwhelmed with hospital duties to attend to GBV survivors, which results in their delayed treatment; the lack of a doctor stationed within the OSC is a challenge for survivors to receive true comprehensive “one-stop” care.</td>
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<tr>
<td>GBV cases taken to courts are not treated with priority and “referrals from the OSC” are not accepted as special cases that warrant fast-tracking</td>
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<tr>
<td>Coordination gaps among implementation partners, such as unclear communication between ZCCP (prevention and advocacy) and ECR (managing the OSC)</td>
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</tr>
<tr>
<td>Cases referred to VSU are often lost due to inefficient systems (e.g., VSU does not have a computer to save and track cases so this is tracked at the OSC only, and hard copies of papers given to VSU often are lost). This results in perpetrators often being released by police.</td>
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</table>

Apart from the trainings and reading material mentioned above, logistical support was provided to the TGI of Bandundu and Katanga. This support made it possible to hold mobile courts that helped process cases delayed due
to the absence of judges in specific remote sites, where people were kept in prison cells. According to the lead and deputy prosecutors of the Bandundu TGI, this logistical support was critical in avoiding prolonged detention.