



EVALUATION REPORT

EVALUATING THE EFFECTIVENESS OF GENDER-BASED VIOLENCE PREVENTION PROGRAMS WITH REFUGEES IN UGANDA

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COVER PHOTO

Mural featuring gender-based violence prevention messages in the languages of refugee populations, displayed on a public building in the central administration area of Nakivale settlement, Uganda. (Photo Credit: Shannon Doocy)

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Department of State or the United States Government.

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ACRONYMS

AAH	Action Africa Help
ARC	American Refugee Committee
CMRS	Clinical management of rape services
DoS	U.S. Department of State
DRC	Democratic Republic of Congo
FY	Fiscal Year
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IASC	Inter-Agency Standing Committee
IEC	Information Education Communication
KASB	Knowledge Attitudes Skills Behaviors
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
M&E	Monitoring and Evaluation
MTI	Medical Teams International
NGO	Non-governmental organization
OPM	Office of the Prime Minister
PEP	Post Exposure Prophylaxis
PRM	Bureau of Population, Refugees, and Migration
PTSD	Post-Traumatic Stress Disorder
RWC	Refugee Welfare Council
SASA!	Start Awareness Support Action
SMART	Specific, Measurable, Achievable, Realistic, Timebound
STI	Sexually Transmitted Infection
T/OCA	Technical and organizational capacity
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees

EXECUTIVE SUMMARY

Evaluation Purpose

This performance evaluation examines the effectiveness of gender-based violence (GBV) prevention programming funded in Uganda by the U.S. Department of State Bureau of Population, Refugees, and Migration (DoS/PRM) during Fiscal Years (FY) 2010-2012 (October 1, 2009 – September 30, 2012). Fieldwork conducted as part of this evaluation contributes to a one-year evaluation of GBV prevention programming supported directly by PRM or indirectly by its partner organization, the United Nations High Commissioner for Refugees (UNHCR). The purposes of the evaluation are as follows:

- Assess the effectiveness of GBV prevention programming for individuals and communities at risk;
- Identify appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings; and
- Characterize best practices and lessons learned in engaging men and boys in GBV prevention and response interventions in refugee settings.

The evaluation will provide DoS/PRM, multilateral organizations such as UNHCR, and non-governmental organization (NGO) implementers with guidance about conducting priority GBV prevention initiatives; monitoring and evaluating field-based GBV prevention programs; and engaging host country, international, and local NGOs in best practices for GBV prevention.

Evaluation Questions

The evaluation seeks to answer the following questions:

1. Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
2. Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measurable objectives? If not, how can the objectives be improved?
3. Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
4. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals specific, measurable, achievable, realistic, or timebound (SMART)? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?
6. What factors explain intended and unintended negative or positive consequences?
7. What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?
8. To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

Program Background

Refugees in Uganda reside in eight settlements, primarily in the eastern part of the country and an additional three UNHCR transit centers. Uganda was host to 161,440 refugees and 36,310 asylum seekers as of January 2013. According to UNHCR figures, around 70 percent of Uganda's refugee population is Congolese and renewed conflict has led to a steady influx of new arrivals beginning in 2010. Uganda's refugee and asylum seeker population is projected to reach approximately 200,000 by the end of 2013. The Government of Uganda has a generous policy toward refugees with respect to land rights, freedom of movement, health, and education services. However, budget constraints have resulted in curtailment of programs to prevent and respond to GBV in host and refugee communities. DoS/PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world. The work of NGO implementing partners is instrumental to ensuring that PRM achieves its humanitarian objectives and fulfills its mandate. PRM directly funds NGO programs designed to fill critical gaps such as GBV prevention in humanitarian assistance and protection. PRM programming goals in Uganda include the primary prevention of GBV. Primary prevention aims to prevent violence before it happens.

This evaluation focused on GBV prevention programs conducted by two PRM-funded NGO implementing partners working in refugee settlements in Uganda:

American Refugee Committee (ARC): ARC has been working on GBV-related issues with refugee communities in Uganda's western settlements since 2010. ARC aims to empower refugees in Kyangwali, Kyaka, and Nakivale refugee settlements to prevent and respond to GBV. To accomplish this objective, ARC strengthens the capacity of community partners to address GBV via improved access to multi-sectoral services for GBV survivors and strengthening of GBV referral pathways.

Medical Teams International (MTI): MTI provides clinical services to GBV survivors visiting primary healthcare clinics in Nakivale and Oruchinga settlements but does not receive funding from DoS/PRM for primary GBV prevention activities. MTI responds to cases with medical treatment and after counseling with referrals to other sectors as needed for survivors.

Evaluation Design, Methods, and Limitations

This performance evaluation employed the standard rapid appraisal methods of document review, key informant interviews (KIIs) with beneficiaries and stakeholders, two site visits, and direct observation of program activities. The Uganda performance evaluation complements, and builds upon, findings from the Desk Review Report submitted to DoS/PRM in July 2013 by providing primary information on best practices, lessons learned, and directions for future programming, support, and PRM engagement. The document review included guidelines on global GBV prevention and response in humanitarian settings; publications and reports on best practices and lessons learned for GBV prevention; and proposals, reports, program evaluations, and indicator data submitted by NGO implementers. The following organizations were identified as key informants for the field evaluation:

- **Donor/U.S. Government Partners:** DoS/PRM, UNHCR
- **NGO Implementers:** American Refugee Committee (ARC), Medical Teams International (MTI)
- **Local NGO Partners:** Action Africa Help (AAH)
- **Host Government Partners:** Office of the Prime Minister (OPM), Uganda National Police
- **Beneficiaries/Program Participants:** Refugee community members, Refugee Welfare Council (RWC) members and community leaders, community activists/volunteers, GBV survivors
- **External Stakeholders:** United Nations Population Fund (UNFPA)

The Uganda field visit took place from September 2-12, 2013. The evaluation team conducted a total of 22 KIIs, including 12 group and 10 individual KIIs, with 66 respondents including 36 males and 30 females. Key informants represented donors (15); implementing organizations, such as ARC and MTI (18); local organizations and host country partners, such as OPM and AAH (7); beneficiaries and refugee community members (24); and external stakeholders from UNFPA (2). KIIs were structured around the nine evaluation questions. Finally, the team observed program activities in Kyangwali and Nakivale refugee settlements and visited NGO and donor offices in Kampala, Hoima, Mbrara, and the refugee settlements.

The primary limitations included the influx of new refugees, where twice weekly convoys of more than 1,000 refugees were being settled in Kyangwali, which meant many organizations were struggling to meet these demands and could dedicate limited time to the evaluation. In addition, fieldwork took place during planting seasons in the settlements and the beginning of the rainy season, which posed logistical challenges including limited beneficiary engagement. Finally, MTI Kampala staff were traveling or otherwise unable to meet with the evaluation team in country, necessitating follow-up correspondence regarding additional information and select KIIs with ARC and MTI being conducted over the phone after fieldwork.

Evidence and Findings

Evaluation Question 1: Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?

Part I: Achievement of program activities as defined in project proposals

ARC and MTI consistently met, exceeded, or achieved progress toward planned GBV prevention and response program objectives and activities during the evaluation period of October 1, 2009 to September 30, 2012 (FY 2010-2012). Both organizations were also on target to achieve current program activities in FY 2013 based on data collected from fieldwork and quarterly reports.

Part II: Barriers and facilitators to implementing program activities

Organizations at multiple levels working to support refugees in Uganda are faced with a challenging situation in that the refugee crisis is both acute and protracted. Limited resources and infrastructure, donor fatigue, and competing refugee crises are challenges that affect organizations working in GBV prevention. Over the past several years, Uganda has seen a steady stream of new arrivals with renewed conflict in eastern parts of the Democratic Republic of Congo (DRC), with female and male arrivals reporting experiences of multiple forms of violence. Uganda's refugee policy is more generous than those of many countries in the region in that refugees are granted land and have the right to engage in employment. Overall, this is positive and has contributed to integration and feelings of normalcy among the refugee community; however, there are also tensions relating to the amount of support and types of programs that should continue over time for refugees.

The evaluation noted several facilitators of GBV prevention programming. For example, increased focus on GBV best practices by PRM and NGO implementers has led to funding for longer periods to implement prevention approaches such as Start Awareness Support Action (SASA!).¹ Further, the GBV

¹ Start Awareness Support Action (SASA!) is a community-level GBV prevention model based on the approach developed in Uganda by Raising Voices. For more information, see <<http://raisingvoices.org/sasa/#tabs-419-0-0>>.

Information Management System (GBVIMS) provides needed data for analysis to reveal trends of GBV cases in settlements to share with PRM, UNHCR, and implementing partners, which is critical for monitoring and evaluating GBV program activities and setting priorities for future initiatives.²

Evaluation Question 2: Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measurable objectives? If not, how can the objectives be improved?

ARC and MTI program objectives were informed by numerous assessments as well as ongoing work in refugee communities—in particular, the monthly coordination meetings among implementers; information from the GBVIMS; interaction with community members, including refugee community leaders; and regular monitoring meetings with activists implementing SASA!. ARC program objectives were realistic, however, in some cases challenging to measure within the multiple phases of the SASA! prevention program. MTI's GBV response objectives were both realistic and measurable. However, for both organizations, the absence of refugee community participation in GBV program planning (including establishing realistic objectives and activities) was noted as a potential limitation for successful implementation of the programs.

Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?

ARC and MTI GBV prevention and response programming was based on international guidelines such as Inter-Agency Standing Committee (IASC) guidelines and best practices such as SASA!.

Evaluation Question 4: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals SMART? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?

Indicators used by both ARC and MTI for GBV prevention and response are primarily measures of outputs, such as the number of health providers, police, and community activists trained; numbers of survivors who access medical services; and number of calls to the hotline. Outcome measures such as acceptability of physical and/or sexual violence against women/girls are less frequently used, presumably because they are more difficult to assess and require additional monitoring and evaluation (M&E) resources. The evaluation raised the potential of standard, uniform indicators that could be recommended for use across GBV prevention and response programs. A limited number (3-6) of standard and uniform indicators could facilitate comparisons of programs across settings and increase understanding of the success of programs. Programs could supplement the standard, uniform indicators with indicators tailored to the context and program specific activities.

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?

The evaluation noted unintended/unexpected consequences, specifically concern from male community members that GBV programming was empowering women to challenge social and cultural norms and

² The purpose of the GBVIMS is to use standardized incident reports with a standardized incident classification system for service providers to record and analyze data to better understand trends such as reported types of GBV, age, gender, referrals to additional services, etc. The GBVIMS provides an anonymous record for data sharing.

reduce their role in the family and community. Community activists and staff noted that efforts to engage men in all aspects of GBV programming were important in reducing potential backlash against women/girls and NGO program staff. Further, NGO staff identified concerns for their safety because of threats made by refugee survivors and families who perceived they were not receiving the resources needed. NGO staff asked for training to build capacity to de-escalate potentially dangerous situations and continue to support the refugees. The evaluation noted positive consequences related to the engagement of community activists and their ongoing commitment to GBV prevention despite limited incentives and resources.

Evaluation Question 6: What factors explain expected and unexpected negative or positive consequences?

Social and cultural norms, in particular acceptance of violence and the power imbalance between men and women, were viewed as the primary factor that explained unexpected/unintended consequences related to GBV prevention efforts. Another factor that contributed to resistance to GBV programming was the perception among male community members that NGO staff working on GBV prevention view all men as perpetrators and, thus, men have little to gain from engagement in GBV prevention programming. The positive consequences of the GBV programming were linked to the meaningful engagement of refugees in prevention activities and the practice of implementing these activities where refugees are located (e.g. working in their fields, in the market, at social gatherings) rather than calling refugees to a central location for “lectures” by NGO staff.

Evaluation Question 7: What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?

In the SASA! approach—which is based on the evidence-based work of Uganda-based NGO, Raising Voices, and has been adapted for use by 35 organizations in 12 countries—there are pre-defined recommended indicators for NGO implementers. SASA! uses four key indicators and has a community baseline against which change over time is measured. Pre-defined indicators are advantageous because the NGO implementer does not need to define its own indicators, indicators have been proven to be accurate gauges of intervention progress, and the use of standardized indicators enables cross-site comparisons of effectiveness.

Evaluation Question 8: To what extent have men and boys been included in GBV awareness campaigns? If they were not included, why was this? If they were, what was the impact and how was it measured? Do the GBV programs address the issue of the male survivors of sexual assault or domestic violence? If yes, how?

Part I: Male engagement in GBV awareness

Male engagement is an explicit component of the SASA! approach used by ARC. MTI did not identify specific male engagement activities given its focus on response to survivors through medical care and referral. Male engagement strategies used by ARC in SASA! focus on: 1) males as victims of violence, 2) males as supporters of female survivors, and 3) males as agents of change. Through male engagement groups, SASA! attempts to reach men where they are such as bars and pool clubs to have discussions on GBV and their role in prevention. Other mechanisms reported as successful to engage men involved using sports events to convene community members and then having male leaders provide testimonials and lead discussions about GBV prevention.

Part II: Male survivors of sexual assault or domestic violence

Referral pathways for survivors to access the health center and other support services exist in the settlements and are appropriate for both male and female survivors. Very few males have come forward for services as noted by both ARC and MTI. However, it was noted by GBV staff that male survivors exist in the settlements and there is an interest to build response capacity of service providers to better identify and respond to men and boys who have experienced multiple forms of violence.

Evaluation Question 9: What were the short- and long-term outcomes of PRM-funded GBV prevention?

In general, from the perspectives of both beneficiaries and representatives from PRM, UNHCR, OPM, ARC, and MTI, the SASA! approach, involving the community at all levels of GBV prevention implementation—especially preparing community activists and others to raise awareness, support, and develop actions to help prevent and respond to GBV cases—has galvanized participation and is likely to lead to both short- and long-term changes in prevention and response mechanisms. No other violence prevention models were observed as being implemented in the settlements and therefore could not be used to compare the effectiveness of the SASA! approach.

Conclusions

ARC and MTI consistently met, exceeded, or achieved progress toward planned GBV prevention and response program objectives and activities during the evaluation period of October 1, 2009 to September 30, 2012 (FY 2010-2012). Both organizations were also on target to achieve current program activities in FY 2013 based on data collected from fieldwork and quarterly reports.

ARC and MTI program objectives were informed by international guidelines, numerous assessments, and ongoing work in refugee communities—in particular, the monthly coordination meetings among implementers, information from the GBVIMS, interaction with community members including refugee community leaders, and regular monitoring meetings with community activists implementing the SASA! approach to GBV prevention. However, for both organizations, engaging refugee leadership in GBV prevention and response program planning—including establishing realistic objectives and activities—rather than waiting until program funding arrives would likely result in increased ownership of GBV programs by the community and potentially reduce unintended negative consequences, such as male community members' perception that GBV programs undermine their role in the family and community. Social and cultural norms, in particular acceptance of violence and the power imbalance between men and women, were viewed as the primary factors that explained unexpected/unintended consequences related to GBV prevention efforts. Another factor that contributed to resistance to GBV programming was the perception among male community members that NGO staff viewed all men as perpetrators of violence and thus they had little to gain from engagement in GBV prevention programming. Community activists and staff noted that the SASA! approach was important to reducing this perception as it engaged men in all aspects of GBV prevention activities (awareness, support, and action), reducing potential backlash against women/girls as well as NGO implementer staff. As noted above, there were no other violence prevention models being used.

Although the work of ARC and MTI in collaboration with multiple partners has advanced GBV prevention and response in the targeted refugee settlements, barriers to continued progress were noted by multiple key informants representing donors/USG partners, NGO implementers, local partner organizations, beneficiaries, and external actors. Specifically, GBV prevention and response activities

need to be better integrated into livelihood and income generation, education, family planning, HIV counseling/testing, and youth programs provided to refugee and host community members. Further, social norms approaches to GBV prevention require significant investment (e.g. time, training, mentorship, and support for staff and activists). Therefore, funding cycles should be a minimum of three years to enable NGO implementers to conduct GBV prevention programs in refugee settings, as well as measure prevention process and outcome indicators.

Best practice models and indicators that can demonstrate the success of GBV prevention programming are lacking, and this adversely affects the evaluation of GBV prevention programs. Indicators used by both ARC and MTI for GBV prevention and response are primarily output measures, such as the number of health providers, police, and community activists trained; numbers of survivors who access medical services; and number of calls to the hotline. Outcome indicators, such as acceptability of physical and/or sexual violence against women/girls are not provided and therefore, limit the ability of an evaluation team to determine the impact of the prevention and response programs.

The importance of standard, uniform indicators that could be recommended for use across programs was observed by the evaluation team. This would facilitate comparisons of programs in other settings and better understanding of program successes. A limited number (3-6) of common outcomes indicators could be supplemented by additional program-specific indicators that would be more tailored to the specific intervention/program. Specific guidance on GBV prevention and response indicators from PRM to implementing partners may be helpful in developing systematic indicators that all programs must have (in addition to individual program indicators). The SASA! approach, which has an evaluation methodology based on standard pre-defined indicators, may be a good first step toward comparison of the effectiveness of GBV prevention programming across contexts.

In general, from the perspectives of beneficiaries and representatives from PRM, UNHCR, OPM, ARC, MTI, the SASA! approach, which involves the community at all levels of GBV prevention implementation—especially preparing community activists and others to raise awareness, support, and develop actions to help prevent and respond to GBV cases—has galvanized participation. For example, RWC members are supportive by responding to community activists' requests for action, such as providing a safe place in the settlement for the survivor or contacting police to arrest a known perpetrator. These actions are likely to lead to both short- and long-term positive GBV prevention and response services for survivors and the larger settlement and host communities.

Recommendations

The following recommendations for continued progress in GBV prevention were noted by multiple key informants representing donors/USG partners, NGO implementers, local organizations and host country partners, beneficiaries, and external actors:

- 1. UNHCR should lead efforts for increased coordination and collaboration in the settlements between implementing partners, local partners, and beneficiaries in the following areas:**
 - a. Identify opportunities and resources to integrate GBV prevention activities into existing health and social programs, such as integration in family planning, education, income generation, livelihoods, and youth programs. Resources include GBV prevention and response training for staff, as well as culturally and linguistically appropriate materials such as posters and awareness information for settlement hotline and referral pathways for survivors.

- b. Identify funding opportunities to build capacity to integrate GBV prevention into the educational curriculum and increase secondary school enrollment for girls. Education is an exceptionally important area for integration, in particular for girls, and a best approach for achieving intergenerational changes in cultural norms surrounding GBV.
- c. Develop mechanisms for safe and confidential strategies to share essential information between counselors, medical providers, legal caseworkers, and police on the progression of cases for better addressing survivor safety, ongoing health and social needs, and improving case outcomes. For example, key service providers could conduct monthly case reviews to discuss progress, identify additional support needs (legal, psychosocial, safety, etc.), and determine who will take responsibility for providing that support to survivors.
- d. Provide technical assistance on training, mentorship, and support to GBV service providers to identify and respond to men and boys who have experienced multiple forms of violence.³
- e. Use established networks with local partners to engage refugee leadership and beneficiaries in GBV prevention program planning, including establishing program objectives and activities. Collaboration on program planning would likely result in more ownership of the programs by the community and potentially reduce unintended negative consequences associated with implementation.
- f. Integrate cost analysis in GBV prevention and response programs. For example, mobile legal clinics were viewed as effective in providing timely justice for survivors; however, the cost of continuing the mobile legal clinic program is perceived as too high by UNHCR for the benefits.

2. PRM and UNHCR should collaboratively lead efforts to advance collection and reporting of GBV prevention data, specifically advancing from primarily output indicators (i.e., number of community activists trained) to outcome indicators (i.e., acceptability of physical and sexual violence against women/girls in the home).⁴

- a. NGO implementers should be required to adopt internationally accepted indicators into their M&E practices. Further, efforts to collect and provide information by gender and age would strengthen evaluation.

For example, relevant indicators that could be applied from 2005 IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings include:

- Number of copies of a resource list in local language(s) distributed in community;
- Proportion of reported incidents of sexual violence where survivor (or parent in the case of a child) chooses to pursue legal redress;

³ International Rescue Committee's multi-media training tool on Clinical Care for Sexual Assault Survivors includes a module about male victims of sexual violence: <<http://clinicalcare.rhrc.org>>. The Refugee Law Project in Uganda has been working in settlements in Uganda with male survivors primarily from DRC, and it has established support groups led by men in Kampala and the settlements. In partnership with the Refugee Law Project and with funding from DoS/PRM, Johns Hopkins University developed a GBV screening tool for male survivors.

⁴ The GBV Prevention Indicator Compendium (Annex V) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

- Proportion of reported eligible incidents of sexual violence that were provided with post-exposure prophylaxis (PEP) counseling and treatment;
- Reports on sexual violence incidents compiled monthly (anonymous data), analyzed, and shared with stakeholders; and
- Proportion of key actors who participate in regular GBV working group meetings.

Relevant indicators that could be applied from 2006 IASC “Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action include:

- Number and percentage of women and men in the community, including village leaders and men’s groups, who are sensitized to violence against women and girls, including domestic violence;
- 24-hour access to sexual violence services exists;
- Number and percentage of staff who are aware of and abide by medical confidentiality.
- Extent to which confidential referral mechanism for health and psychosocial services for GBV survivors exists and is used;
- Number and percentage of men and women reached through informational campaigns about the health risks of sexual violence to the community;
- A mechanism is in place for monitoring security and instances of GBV;
- A referral system for reporting of security and GBV incidents is operational; and
- Mechanisms (i.e., confidential/safe settings, trained service providers, contextually/linguistically appropriate incident forms, referral pathways) are put in place to ensure people can report GBV.

b. NGO implementers conducting GBV prevention awareness campaigns should be provided guidance and required to increase specificity of the measures for knowledge gain and attitude change. The 2010 GBVIMS Resources provides examples of indicators that could be adopted. Further, the information should be collected and reported by gender and age as appropriate:

- Proportion of individuals who know any of the legal rights of women;
- Proportion of individuals who know any of the legal sanctions for GBV;
- Proportion of people who have been exposed to GBV prevention messages;
- Proportion of people who say that wife beating is not an acceptable way for husbands to discipline their wives; and
- Proportion of people who would assist a women being beaten by her husband or partner.

c. NGO implementers requesting funding for GBV prevention programs such as SASA! should be provided guidance and required to use established outcome indicators to determine the impact of the program, including:

- Attitudes towards the acceptability of violence against women/girls;
- Acceptability of a woman refusing sex (among male and female community members);
- Past year experience of physical intimate partner violence and sexual intimate partner violence (among females);
- Community responses to women experiencing violence (among women reporting past year physical/sexual partner violence and among women who report sexual violence); and
- Past year concurrency of sexual partners (among males).

3. PRM should encourage collaborations between UNHCR, NGO implementers, and local partners to identify and prioritize technical assistance and resources needed to address gaps in prevention and response services for survivors:

- a. Training and mentorship for staff on GBV-related issues that are difficult to address including lesbian, gay, bisexual, transgender, intersex (LGBTI) issues, male survivors, child abuse/neglect, and commercial sex workers;
- b. Trainings for medical providers on how to collect forensic evidence and document GBV cases, how to serve as expert witnesses, and how to testify in court cases;
- c. Trainings on situational management and conflict resolution so that staff have skills to assist difficult clients and resolve tense situations; and
- d. Attention to staff well-being and self-care including mental health support; off-site team retreats, trainings and skill building activities; and peer counseling and/or guidance on best practices, such as those provided in UNHCR's 2013 Mental Health and Psychosocial Support for Staff and procedures for staff self-care following handling of difficult cases.

EVALUATION PURPOSE AND QUESTIONS

Evaluation Purpose

This performance evaluation examines the effectiveness of GBV prevention programming funded in Uganda by DoS/PRM during FY 2010-2012 (October 1, 2009 – September 30, 2012). Fieldwork conducted as part of this evaluation contributes to a one-year evaluation of GBV prevention programming supported directly by PRM or indirectly by its partner organization, UNHCR. The purposes of the evaluation are as follows:

- Assess the effectiveness of GBV prevention programming for individuals and communities at risk;
- Identify appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings; and
- Characterize best practices and lessons learned in engaging men and boys in GBV prevention and response interventions in refugee settings.

The evaluation will provide DoS/PRM, multilateral organizations such as UNHCR, and NGO implementers with guidance about conducting priority GBV prevention initiatives; monitoring and evaluating field-based GBV prevention programs; and engaging host country, international, and local NGOs in best practices for GBV prevention.

Evaluation Questions

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5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?
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9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

PROGRAM BACKGROUND

Uganda Country Background

Refugees in Uganda reside in eight settlements, primarily in the eastern part of the country and an additional three UNHCR transit centers. Uganda was host to 161,440 refugees and 36,310 asylum seekers as of January 2013, and the refugee population is expected to increase to 172,850 by December 2013. According to UNHCR figures from January 2013, refugees in Uganda were 70 percent Congolese, 11 percent South Sudanese, 9 percent Somali, and 10 percent from other countries including Rwanda, Burundi, Ethiopia, and Eritrea. The population of concern to UNHCR has remained stable over the last few years with voluntarily repatriations and refugee resettlement nearly keeping pace with new arrivals. However, renewed conflict in the DRC led to a steady influx of refugees beginning in 2010 and by mid-2011 the surge in refugees fleeing violence in eastern parts of DRC had become an emergency with large numbers of Congolese, in excess of 40,000 new arrivals, seeking refuge in Uganda. Uganda's refugee and asylum seeker population is projected to reach approximately 200,000 by the end of 2013.⁵

In 2012, UNCHR reported working with 18 implementing partners to support refugee populations mainly focusing on food security, GBV, health, adult literacy, social activities, and advocacy. Uganda's Citizenship and Immigration Control Act limits naturalization and legal residency options for refugees, however, some progress in the legal area is being made with the establishment of a Refugee Appeals Board in 2011 and ongoing legal review processes. The Government of Uganda has a generous policy toward refugees with respect to land rights, freedom of movement, health, and education services. Refugees are granted plots of land in the settlements and have access to government-supported health and education services. In the area of GBV, the Ugandan government with leadership from the Ministry of Gender, Labour and Social Development has responded by passing laws such as the Domestic Violence Act (2010), Prohibition of Female Genital Mutilation Act (2010), and Prevention of Trafficking in Persons Act (2009). However, budget constraints have resulted in curtailment of programs to prevent and respond to GBV in host and refugee communities. In 2012, UNHCR noted that protection homes with professional counselors for survivors of GBV in refugee settlements could not be established due to funding shortfalls, and in 2013, an estimated 20 percent of identified GBV survivors will not have access to legal, medical, psycho-social, and material support, thereby perpetuating lower reporting of GBV incidents.⁵

Program Response

DoS/PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world. PRM provides life-sustaining assistance through multilateral systems to build global partnerships and promote best practices in humanitarian response; in addition, PRM works to ensure that humanitarian principles are integrated into U.S. foreign policy. The work of NGO implementing partners is instrumental to ensuring that PRM achieves its humanitarian objectives and fulfills its mandate. PRM directly funds NGO programs designed to fill critical gaps such as GBV prevention in humanitarian assistance and protection. NGO implementers funded by PRM provide crucial services to refugee populations in addition to information that is critical for policy development and advocacy.

⁵ UNHCR, 2012 <<http://www.unhcr.org/51b1d6350.html>>, <<http://www.unhcr.org/50a9f8230.html>>

PRM programming goals in Uganda include the primary prevention of GBV. Primary prevention aims to prevent violence before it happens, whereas secondary and tertiary prevention focus on response to violence that has already occurred immediately (secondary prevention) or in the longer-term (tertiary prevention).⁶ Based on definitions used by the World Health Organization, Centers for Disease Control and Prevention, and United Nations, primary prevention can be understood as:

- Carried out before violence first occurs;
- Aims to prevent initial perpetration or victimization;
- Addresses social norms and environmental factors that contribute to violence; and
- Appears to be most successful when carried out as part of comprehensive, multi-sectoral efforts.

The evaluation focused on GBV prevention programs conducted by two PRM-funded NGO implementing partners working in refugee settlements in Uganda:

American Refugee Committee (ARC): ARC works to strengthen locally-owned systems for addressing GBV by transforming socio-cultural norms, rebuilding family and community support systems, designing effective services, working with legal systems, and documenting GBV incidents. ARC has been working on GBV-related issues with refugee communities in Uganda’s western settlements since 2010. ARC aims to empower refugees in Kyangwali, Kyaka, and Nakivale refugee settlements to prevent and respond to GBV. To accomplish this objective, ARC strengthens the capacity of community partners to address GBV in Kyangwali settlement via improved access to multi-sectoral services for GBV survivors and strengthening of GBV referral pathways. In Kyaka and Nakivale settlements, ARC promotes coordination, case management and technical support to community partner organizations that are working to address GBV in the settlements. ARC coordinates with the Office of Refugee Affairs within the Ministry of Relief and Disaster Preparedness, housed within the Ugandan OPM; UNHCR; and various international and local NGOs.

Medical Teams International (MTI): MTI provides clinical services to GBV survivors visiting primary healthcare clinics in Nakivale and Oruchinga settlements but does not receive funding from DoS/PRM for primary GBV prevention activities. MTI has been providing direct emergency and primary healthcare services since 2009 in Nakivale settlement (the evaluation site) in facilities constructed by UNHCR. MTI is not responsible for GBV prevention activities in the refugee settlements but responds to cases with medical treatment and after counseling with referrals to other sectors as needed for survivors. MTI provides out-patient health services, community outreach activities, infrastructure development, and systems strengthening; in addition, MTI supports HIV/AIDS awareness messaging, health promotion campaigns, and capacity building of community health workers. In January 2012, UNHCR chose MTI to take the lead in health and nutrition across Nakivale and Oruchinga settlements—overseeing a total of five health clinics and a sixth that is under construction.

⁶ Dahlberg L. and Krug E. “Violence—a global public health problem,” in *World report on violence and health*, ed. Etienne G. Krug et al. (Geneva: World Health Organization, 2002), p3-21.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

Evaluation Design and Data Collection Methods

This performance evaluation employed the standard rapid appraisal methods of document review, KIIs with beneficiaries and stakeholders, two site visits, and direct observation of program activities. The Uganda performance evaluation complements, and builds upon, findings from the Desk Review Report submitted to DoS/PRM in July 2013 by providing primary information on best practices, lessons learned, and directions for future programming, support, and PRM engagement. The evaluation team identified the following five categories of target groups as data sources for the field evaluation:

- **Donor/U.S. Government Partners:** DoS/PRM staff in Washington, DC and Kampala; UNHCR staff in Kampala, Hoima, Mbarara, Kyangwali Settlement, and Nakivale Settlement;
- **NGO Implementers:** ARC staff in Kampala, Kyangwali Settlement, and Nakivale Settlement; MTI staff in Kampala, Mbarara, and Nakivale Settlement;
- **Local NGO Partners:** AAH staff in Kyangwali camp
- **Host Government Partners:** OPM staff in Kyangwali and Nakivale Settlement; Uganda National Police Staff in Kyangwali Settlement and Nakivale Settlement;
- **Beneficiaries/Program Participants:** Refugee community members, RWC members and other community leaders, community activists and volunteers, and GBV survivors; and
- **External Stakeholders:** UNFPA

Document Review

The evaluation team conducted a document review for the Uganda field evaluation in conjunction with work performed for the July 2013 Desk Review Report. The review included the following sources:

- Guidelines on global GBV prevention and response in humanitarian settings;
- Publications and reports on best practices and lessons learned for GBV prevention; and
- Proposals, reports, program evaluations, and indicator data submitted by the NGO implementers.

Key Informant Interviews

The evaluation team conducted in-person KIIs in Uganda from September 2-12, 2013. A map of the KII and site visit locations is presented in Annex II. Key informants were identified from each of the target groups described above based on input and guidance from PRM staff in Washington, DC and Uganda, NGO implementers, and UNHCR Uganda. The evaluation team conducted a total of 22 KIIs including 12 group and 10 individual interviews with a total of 66 respondents including 36 males and 30 females. Groups that were represented included donors (15), NGO implementers (18), local organizations and host country partners (7), beneficiaries and refugee community members (24), and external stakeholders from UNFPA (2). Annex IV: Evaluation Contacts and Key Informants contains a comprehensive list of respondents. The team conducted the KIIs on an individual basis or in groups to maximize efficiency, depending on circumstances, appropriateness, and the availability of resources. The KIIs were structured around the nine evaluation questions and aligned with the three evaluation purposes articulated by DoS/PRM (see Annex I: Evaluation Statement of Work). Interviews were semi-

structured, consisted of open-ended questions, and based upon the questionnaire presented in Annex III: Data Collection Instrument.

Site Visits and Direct Observation

The evaluation team observed program activities in Kyangwali and Nakivale refugee settlements in addition to visiting NGO and donor offices in Kampala, Hoima, Mbrara, and the refugee settlements. Observation of refugee settlement program activities involved 1) review of information, education, and communication (IEC) materials and messaging in settlements, including billboards for referral pathways and IEC messages, stickers and flyers for community hotlines, and GBV prevention messages on signs placed on school and health facilities grounds; 2) visits to facilities that provide services to GBV survivors including counseling centers, health centers, and safe houses; and 3) observation of GBV prevention activities implemented by a community activists trained by ARC using the SASA! approach.

Limitations

The evaluation team faced several limitations during the course of fieldwork. First, due to the high numbers of new arrivals into western Uganda from the ongoing conflict in eastern DRC, twice weekly convoys of more than 1,000 refugees were being settled in Kyangwali. As a result, donors, ARC, and its partner organizations were struggling to meet the demands of new arrivals and could dedicate limited time to the evaluation. Second, fieldwork occurred during the beginning of planting season and there were rains that complicated travel for the evaluation team, which had to cover large distances between settlements and other interview locations. Seasonal conditions also lessened the availability of beneficiaries. Third, the MTI Kampala staff were traveling or otherwise unable to meet with the evaluation team in country, which necessitated follow-up correspondence regarding additional information and select KIIs with ARC and MTI being conducted over the phone after fieldwork.

EVIDENCE AND FINDINGS

Evaluation Question 1: Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?

Part I: Achievement of program activities as defined in project proposals

A detailed account of ARC and MTI progress toward program activities as defined in project proposals is provided in Annex VI: NGO Implementer Progress Toward Proposed Objectives.

American Refugee Committee

ARC's primary GBV prevention program, SASA!, is a community-level GBV prevention model based on the approach developed in Uganda by Raising Voices.⁷ SASA is being implemented by ARC in Kyangwali settlement over a three-year period, as one of the few multi-year programs supported by PRM. In Nakivale and Kyaka settlements, ARC work during the evaluation period focused on secondary prevention, primarily referral pathways and services for GBV survivors. Beginning in July 2013 and continuing through 2014, ARC will expand primary GBV prevention activities to Oruchinga and Nakivale. Activities will include SASA! and GBV hotlines, which have already implemented in Kyangwali and are currently being introduced in Nakivale.

In discussions with UNHCR staff, it was noted that progress toward SASA! objectives is readily observable in Kyangwali settlement. UNHCR remains informed about ARC activities via coordination meetings, visits with service providers, and focus groups with refugees and notes that, in trainings, refugees will often refer to ARC and SASA! sensitization activities. In Nakivale, SASA! implementation began in July 2013. Community sensitization meetings in Nakivale have been held and communities have selected community activists to work on SASA! In total, 100 activists from all 72 settlements have been identified and training is planned to begin in September 2013; community workers and RWCs already have received some training.

Medical Teams International

MTI programs in Nakivale (and Oruchinga Resettlement Camp in 2012-2013) focus on provision of primary healthcare services with the objective of reducing morbidity and mortality due to common diseases; MTI is not engaged in primary GBV prevention. A GBV response component (secondary prevention) was introduced into the program in 2012-2013 where MTI activities will include serving as the primary provider of clinical care for GBV survivors and providing improved and confidential treatment of sexual violence with appropriate follow-up. The majority of MTI objectives and activities were not specific to GBV, however, the MTI program aimed to improve quality of response to incidences of GBV in six clinics in Nakivale and Oruchinga settlements.

⁷ For more information, see the Raising Voices website: <<http://raisingvoices.org/sasa/#tabs-419-0-0>>.

The SASA! Approach

SASA! is a creative and provocative approach for changing the social norms that perpetuate women's vulnerability to violence and HIV. The central question of the SASA! approach is *How are you using your power?* SASA is a Kiswahili word that means *now*. Now is the time to take action to prevent violence against women and HIV! It is also an acronym for the four sequential phases of community mobilization, each of uses different strategies to engage community members in a natural way.

- **Start:** violence against women and HIV/AIDS are introduced as interconnected issues and community members begin to foster *power within* themselves to address these issues.
- **Awareness:** community members experience a growing awareness about how communities accept men's use of *power over* women, fueling the dual pandemics of violence against women and HIV.
- **Support:** community members will discover how to support the women, men and activists directly affected by or involved in these interconnected issues, by joining their *power with others*.
- **Action:** community members will explore different ways to take action. Use your *power to* prevent violence against women and HIV.

Part II: Barriers and facilitators to implementing program activities

Organizations working to support refugees in Uganda are faced with a challenging situation in that the refugee crisis is both acute and protracted. Over the past several years, Uganda has seen a steady stream of new arrivals with renewed conflict in eastern parts of the DRC as the primary source of increasing refugee flows. The surge in Congolese refugees began in mid-2011 and by August 2012 had become an emergency; Kyangwali settlement is expected to more than double in size, reaching a total population of 60,000-70,000 refugees. This influx was a particular challenge in Kyangwali settlement, which was receiving twice-weekly convoys with more than 1,000 Congolese refugees and experiencing a need for significant expansion of services in all sectors to keep pace with the rapidly growing settlement population. However, the refugee situation in Uganda is also protracted—for example, Nakivale settlement was established in 1959 and has been in existence for more than 50 years—which comes with another set of challenges. Uganda's refugee policy is more generous than those of many countries in the region in that refugees are granted land and have the right to engage in employment. Overall, this is very positive and has contributed to integration and feelings of normalcy among the refugee community, however, there are also tensions relating to the amount of support that older arrivals should continue to receive. Limited resources, donor fatigue, and competing refugee crises are broader challenges that affect organizations working to support refugees in Uganda and must be considered in the program evaluation landscape. With respect to primary and secondary GBV prevention programming, specific barriers that were identified as key challenges are described below.

Barriers at the Donor Level

Funding Cycle Length: The primary barrier identified in GBV prevention programming at the donor level was the length of funding cycles. It was noted that sustainability of programs is challenging given the historically typical one-year funding structure and the difficulties associated with meeting stated objectives in that short funding period. PRM has recently created an alternative to one-year funding cycles, and the ARC program in Uganda is benefiting from a longer-term three-year funding period for its GBV primary prevention program. ARC program staff noted that it takes a long time to change attitudes, behaviors, and norms that support and maintain GBV in communities and that SASA!, a community-driven social norms change strategy, is a longer-term process where the short funding cycle and project

timeline have been challenges that necessitated starting the next phase of SASA! before the community is ready.

Barriers at the NGO Implementer Level

High Levels of Staff Turnover: Retention of staff, including both health workers and police (who have mandatory transfers) was noted as an issue with respect to institutional knowledge, staff capacity to address GBV cases, and overall program progression. As one NGO representative observed, “They come, they are trained, they know what to do... then in 3-4 months, they will go.” Another NGO staff member estimated that perhaps 30-50 percent of the medical staff had left the settlement within the past year. High levels of turnover in healthcare and police staff make it necessary to retrain frequently, and the sustainability of work is difficult as a result of retention issues. As a result, staff capacity building is constantly required. Trainings of healthcare workers are conducted regularly, (twice in the past year); however, more frequent training was recommended to better maintain staff capacity. Improved living conditions for staff in the settlements, regular opportunities for staff to visit their families, better pay, access to self-care and wellness support, and continued opportunities to build skills through participating in local and international conferences/workshops were suggested as possible means for reducing staff turnover.

Limited Staff Funding and Support: Inadequate funding for NGO staff was expressed by NGO staff at all levels, both in terms of insufficient numbers of staff for the current programming demands and inadequate support for staff working under challenging conditions. There was a general perception that community services are underfunded and that additional staff are needed to support and advocate for GBV survivors. For example, in Kyangwali, there is a single ARC staff member on call 24 hours/day for seven days/week to answer the GBV hotline. Limitations in the number of service providers were nearly ubiquitous and included clinicians, counselors, legal officers, and drivers to facilitate transfers of GBV cases. The importance of and need for female providers, particularly with respect to counselors and police women who may be perceived as more accessible by women and children survivors, was also noted by governmental and NGO staff. The stressful nature and the remote conditions of the work were also noted as a challenge and reason for high levels of staff turnover. Specific unmet needs included: 1) additional staff training and mentoring on GBV-related issues that are difficult to address including LGBTI issues, child protection and survival, and commercial sex workers; 2) training of medical providers on how to better document GBV cases, and trainings for staff on how to serve as expert witnesses and testify in court cases; 3) trainings on situational management and conflict resolution so that staff have skills to assist difficult clients and resolve tense situations; and 4) greater attention to staff well-being and self-care including mental health support; off-site team retreats, trainings and skills-building activities; and peer counseling and/or guidance on best practices and procedures for staff self-care following handling of especially difficult cases.

Inadequate Facilities and Material Support: Several issues were noted with respect to facilities and material support. First, due to confidentiality requirements of working with GBV cases, shared NGO offices for counselors and legal officers were a challenge and counseling spaces were inadequate with respect to quantity or size; safe houses were also reported to be inadequate, either in number or physical condition. Some NGO staff also noted that small counseling spaces and their location away from security officers was a concern for staff safety. Second, the detention of perpetrators is a persistent challenge—in Kyangwali the police have no holding cell, and in Nakivale holding cells are used as accommodations for police officers because no other housing is provided. Third, lack of material support for responding to GBV cases is a concern. This includes lack of cameras, handcuffs, fuel, and transport

for police that inhibits their ability to reach, interrogate, and follow up with perpetrators—some progress in addressing this challenge has been made via efforts to provide fuel to police in Kyangwali and a recent allocation of motorcycles to police in Nakivale by ARC. There is also a lack of essential medicines, supplies, and rape kits required to provide medical care to GBV survivors in some health facilities, particularly in Kyangwali. In Nakivale, MTI noted that ARC had been supporting facilities by providing PEP and other supplies, which has been critical for provision of medical care for survivors because the medicines are expensive and do not fall under the list of essential medicines. Before ARC support, many survivors did not receive PEP. Sustainable provision of PEP relies upon continued donor funding.

Poor Coordination: Barriers in coordination were noted at several levels. At the settlement level, monthly meetings were noted to be irregular as key staff were needed to address other pressing issues related to the refugee crisis. In addition, timely notification was a problem, and there was a lack of participation from district government. At the case level, meetings concerning GBV were considered to be lacking and there was insufficient communication between different providers on cases. Linkages between medical and legal services was noted as a particularly difficult challenge because medical evidence is hard to provide and may be inadequate to build a case on, which inhibits the ability to prosecute cases.

The Legal System: The formal legal system (or lack thereof) was noted as an impediment to proper care and support of GBV survivors and also to GBV prevention efforts because of the community perception that perpetrators are likely to go unpunished. Of cases reported to the police, few make it to court and those that are prosecuted often experience multiple postponements, delays, and a low rates of conviction. ARC does support the legal system and prosecution of cases with efforts such as training, transportation, and translation for court cases. However, difficulties working through the existing legal system remain a key challenge in GBV prevention. Mobile courts were recently introduced in Nakivale with some success, however the high cost associated with mobile courts was noted as a barrier to continuing and expanding their use.

Barriers at the Refugee Community Level

Cultural Norms: Early marriage and acceptance of violence are reported as pervasive among refugee communities, in particular new Congolese arrivals who have yet to be exposed to GBV sensitization. Girls can be married at the age of 13 or 14 (once menstruation begins) and key informants reported that young girls are pregnant, often having multiple children.⁸ According to NGO implementers, partner organizations, and UNHCR, young girls are marrying older men above age 18 for safety and economic security; however forced marriage was perceived as relatively uncommon. The area around Lake Albert in Kyangwali settlement was noted to be especially challenging because of the commercial sex work that involves young girls from the host and refugee communities.⁹ The attitude toward missing girls is “it doesn’t matter if she goes missing, if she gets involved with a man he will take care of her.” NGO staff noted that GBV prevention requires attitude and behavior change and that it has been difficult for

⁸ Medical service providers may have information about the number of pregnancies in adolescents, provided that antenatal care was sought and good records are maintained.

⁹ As a community reliant on fishing, Lake Albert is a hub of economic and social activity and where commercial sex industries operate. Fishermen are highly mobile and sufficiently funded to enable easy access to commercial sex with multiple partners. Other settlement areas do not support this level of temporary economic activity.

community activists to change beliefs that are entrenched since childhood. One key informant noted “changing that attitude is a big challenge—sometimes we create awareness, the person changes today, and then tomorrow repeats old behaviors—so we need persistent messaging.” That early marriage is normal in most refugee cultures and many community members do not want to acknowledge violence as a problem were observed by multiple informants as key challenges in GBV prevention that need to be addressed through long-term and integrated GBV prevention approaches.

Refugee Turnover and New Arrivals: The refugee flow in and out of settlements is a problem for implementing the prevention program SASA!, primarily because the four intervention stages are related and build on one another. It is difficult when people come and go from the community because of the sustained effort and time periods required to provoke thinking about use of power, create awareness, find solutions, and move to taking action. Loss of community activists is also a problem—because they leave due to resettlement, because they cannot support themselves and seek employment that does not allow them time to work as activists, and because they have many competing demands for their time even when they are engaged in the work. This adversely affects the SASA! approach because prevention efforts are built on the use of volunteers as community activists and mobilizers. A high GBV caseload is anticipated among the new refugee arrivals from eastern DRC, however, programming resources are not keeping pace with the growing number of refugees. The need to expand services and GBV prevention activities is critical, but it is complicated by the turnover problem as well because refugee leaders and activists who have been trained and are working effectively in their communities often leave the program because of the competing demands identified above. The large and expanding geographic size of the settlements, in particular Kyangwali, was noted as a challenge with respect to achieving coverage of GBV prevention activities, motivating community activists, and providing support services to GBV survivors.

Language: The number of different languages spoken by refugees (up to seven in a single settlement), was noted as a barrier. This is a challenge because it is time consuming and resource intensive to work in multiple languages and because some words or concepts are difficult to translate. ARC works with multiple translators to translate IEC materials and evaluation tools into two or three commonly spoken languages (i.e. English, French, and Swahili) and conduct community meetings in multiple languages to ensure all participants understand the messages. Despite these efforts, language continues to be perceived as a barrier to GBV prevention. One unmet need mentioned by both community members and NGO implementers was the need for additional IEC materials and message boards in additional languages to facilitate program implementation.

Incentives and Motivation: Implementing partners are unable to provide refugee leaders, activists, and volunteers with adequate incentives to support their work in GBV prevention. The NGOs observed that some volunteers are committed and will participate without any incentives, but these are a small number of individuals who are motivated by what they see in the community or because they feel they make a unique contribution. The fact that community activists are selected by their communities often encourages them to continue working without incentives, however, provision of basic materials to enable them to better do their work is an important challenge that remains to be adequately addressed. Support to RWCs could be expanded; having designated locations for RWCs to be based in the community would be a significant source of motivation for community leaders and could greatly enhance their support of GBV prevention activities and give them a sense of responsibility. With respect to community activists and volunteers, provision of bicycles, rain jackets, and gum boots that can facilitate their work in the settlements, which are quite large, would help to promote increased coverage of GBV prevention activities. A small monthly allowance or additional incentives that

volunteers and activists could share with their families (such as soap, cooking oil, non-food items) would also serve to help them demonstrate they are productive and bring resources to the family and that time spent working as an activist is not lost time for the family.

Case Reporting and Follow Up: GBV cases are often unreported, reported late, or do not receive sufficient follow up from the existing systems and survivors to enable successful prosecution of cases. The primary reasons for non-reporting identified by the evaluation team included fear, especially pressure from family members and safety concerns when the abuser is a husband or family member; low confidence in the legal system and lack of accountability of perpetrators; and the stigma and social isolation associated with being a victim. Late reporting is also a challenge because many people attempt to settle the issue within the family or they will first report to the police and then seek medical care as an afterthought. Decisions to not seek care and delays in care-seeking often mean that evidence is lost and that cases requiring PEP can go untreated (PEP must be received within 72 hours to be most effective).¹⁰ Another challenge is that survivors must give a statement to police in a short timeframe; police can hold perpetrators for 48 hours and must build a case in this time period or are otherwise required to release them back into the community. However, delays in reporting cases, time required for referrals, and long travel distances and poor access to transportation are critical challenges for community case follow up that often result in release of perpetrators back into communities without consequence.

Facilitators

Several facilitators of GBV prevention programming were reported by key informants. At the donor level, increased PRM funding for GBV prevention over the past several years and longer funding periods (three years as compared to one year) were perceived as facilitators of GBV prevention; it was also noted that proposals submitted to PRM are better integrating GBV prevention and response which makes them more competitive for funding. At the level of NGO implementers, the GBVIMS was noted as being helpful in better understanding trends of GBV cases in settlements and also in distinguishing new cases from older cases that occurred in the country of origin. UNHCR, PRM, ARC, and partner organizations identified SASA! as being a facilitator of GBV prevention because of its ability to engage men and its flexibility with respect to timing and engagement of community members. As one key informant observed, “SASA is embraced because you can meet people anywhere anytime—it is more flexible so this [work] is very possible.” It was also noted that prior GBV prevention programs focused on distinct populations and were less integrated into the community whereas the integrated approach of SASA! may result in reduced costs.

A common issue that emerged both as a barrier and a facilitator to GBV prevention programming was [lack of] integration of GBV prevention with other programs. Key areas that were noted for integration included family planning and child spacing, education, income generation and livelihoods, and youth programs. Many respondents recommended early introduction of GBV prevention into the curriculum and increased secondary school enrollment for girls. Education was noted as an exceptionally important area for integration, in particular for girls, and as a best approach for achieving intergenerational changes in cultural norms surrounding GBV.

¹⁰ As provided in Annex VI: NGO Implementer Progress Toward Proposed Objectives, 100 percent of those survivors eligible for PEP treatment, meaning seeking services within the window of 72 hours, received PEP.

Evaluation Question 2: Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measurable objectives? If not, how can the objectives be improved?

International guidelines emphasize the importance of assessment, monitoring, and documentation of GBV, as well as the inclusion of participants at all levels of design, implementation, and evaluation. Both ARC and MTI program objectives were informed by numerous assessments as well as ongoing work in refugee communities—in particular the monthly coordination meetings among implementers; information from the GBVIMS; interaction with community members, including refugee community leaders; and regular monitoring meetings of activists implementing SASA!. While ARC program documents and staff indicated that refugee communities were involved in planning, some community members indicated they were primarily involved only in implementation and that they desired to have their views and opinions considered more during the project design phase.

American Refugee Committee

ARC program objectives were informed by numerous needs assessments. These included: 1) a December 2008 assessment conducted by ARC in Nakivale and Kabahinda settlements that revealed unmet needs among GBV survivors and gaps in areas of reproductive health and protection; 2) a March 2009 assessment of reproductive health and protection needs focusing on new arrivals in Nakivale area conducted by UNFPA, which confirmed ARC findings; 3) a 2009 Knowledge Attitudes and Practice survey conducted by International Medical Corps in Nakivale, Kyaka, and Kyangwali that demonstrated the need for increased GBV services; and 4) a March 2010 ARC site visit to Kyangwali and a series of consultative meetings with stakeholders to identify priority areas for action. From 2010–2011, ARC conducted a number of assessments of knowledge, attitudes, skills, and behaviors (KASB), capacity among health service providers on clinical management of rape services (CMRS), and technical and organizational capacity (T/OCA) of community volunteers and community structures. In 2011-2012, ARC then conducted follow-up assessments to monitor the shifts in knowledge and attitudes among the community groups and in the community, as well as assessments on health workers' capacity and the traditional justice systems.

"We have limited time to exhaustively implement all phases of SASA!....for GBV programs we need a longer time to change attitudes and build skills. Sometimes change within the project timelines is not achievable... the phases are linked – you can't skip one and go to another one so you need to strike a balance when moving from one phase to another so the message is not lost [and implementation timelines are achieved]"

-ARC Staff Member

ARC objectives in 2012-2013 included strengthening the capacity of community partners to prevent GBV and improving access to high-quality multi-sectoral services for GBV survivors in Kyangwali; and strengthening GBV referral pathways and coordination mechanisms through provision case management and technical support in Nakivale. ARC program objectives were realistic, however, in some cases challenging to measure within the specified program timeframe. ARC recognizes that sustainable change requires long-term investments and that the SASA! approach is intended to be implemented in stages over a minimum of three years, and in some communities it may take longer. PRM's move toward three-year funding of SASA! has helped to address this concern in the case of ARC's programming in Uganda.

Medical Teams International

MTI health programming was informed by needs assessments. The Age Agenda Diversity Mainstreaming assessments in 2009, 2010, and 2011 indicated there was limited access to basic healthcare services, including maternal and child health, and a low coverage of doctors and other clinical cadres. The assessments also noted that poor refugee behavior and attitudes toward health issues contributed to high morbidity and mortality rates. Other relevant assessments that informed MTI program design included a GBV survey conducted by UNHCR and partners in 2010. The MTI objective of improving the quality of response to incidences of GBV in six MTI clinics in Nakivale and Oruchinga settlements was both realistic and measurable.

Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?

PRM representatives interviewed by the evaluation team observed that, in general, GBV prevention programs are not necessarily based on evidence or a systematic review of practices and noted that this varied annually based on the types and quality of the proposals received. In general, PRM noted that the larger international organizations seem to be more capable of integrating existing evidence and guidelines. In contrast, the smaller organizations with more limited resources are more likely to focus on what they have done rather than evidence or best practices. GBV programming conducted by both ARC and MTI was based on international IASC guidelines and best practices, such as SASA!.

“There is little GBV prevention work with evidence behind it. SASA! is novel because it is evidence-based.” -PRM

International guidelines encourage transformation of socio-cultural norms to support positive gender relations and mobilization of populations to end harmful social norms and traditional practices. The importance of rebuilding or creating family and community support structures that uphold respect for the equal rights of all members of the community is also emphasized. The main ARC primary prevention programming strategy, SASA!, has been implemented in Kyangwali beginning in 2010 and will be expanded into Nakivale and Ourchinga in 2013-2014. The SASA! approach is based on the evidence-based work of Uganda-based NGO, Raising Voices. The approach has been implemented and evaluated in urban areas of Uganda and has since been adapted for used by 35 organizations in 12 countries.¹¹ SASA! is a four-phased intervention in which ideas are introduced to a subset of community members over time via activities and discussions around power. The SASA! approach includes a practical resource kit with guidance on activities, monitoring and assessment tools, communication materials, and training curriculum that serve as a basis from which implementing organizations can adapt the intervention to a particular context, such as the settlements in western Uganda.

With respect to international guidelines, ARC program documents referenced the 2005 IASC Guidelines for GBV Interventions in Humanitarian Settings, the 2006 IASC Gender Handbook for Humanitarian Action, and the 2010 Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings (by the Gender-based Violence Area of Responsibility Working Group). ARC proposals documented deficiencies compared to IASC standards, noted that program activities would be monitored for consistency with IASC core principles, and cited the intention to use IASC tools and

¹¹ See Raising Voices website <<http://raisingvoices.org/sasa/#tabs-419-0-2>> for a list of organizations implementing SASA! and the contexts and countries where they work.

frameworks to establish effective coordination mechanisms and engage actors from different sectors on gender and GBV programming. ARC program indicators that were adapted from international guidelines (the 2005 IASC Guidelines for GBV Interventions in Humanitarian Settings) included: survivors of sexual violence receive timely and appropriate medical care based on agreed-upon medical protocol; health staff are trained in sexual violence support; staff are aware of confidentiality; confidential referral mechanisms are available for survivors; and community-based workers are trained in sexual violence psychosocial support.

MTI's programming in Nakivale focused broadly on health service provision with some elements of secondary GBV prevention, primarily medical care for survivors. MTI's programming reflected international guidelines, including the 2005 IASC Guidelines on Gender-based Violence Interventions in Humanitarian Settings and the 2006 IASC "Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action. Indicators that were reflected in MTI programming included survivors of sexual violence receive timely and appropriate medical care based on agreed-upon medical protocol; health staff are trained in sexual violence medical management and support; staff are aware of and abide by medical confidentiality; staff are trained on the clinical management of rape; and confidential referral mechanisms are available for rape survivors.

Evaluation Question 4: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals SMART? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?

Both donors and implementing organizations observed that most indicators used are measures of outputs, such as the number of people trained, and that outcome measures are less frequently used because they are more difficult to assess. A full list of ARC and MTI GBV prevention indicators is provided under Annex VI: NGO Implementer Progress Toward Proposed Objectives. Indicators related to the ARC awareness campaigns are discussed under Evaluation Question 7. Both ARC and MTI indicators are summarized in this section followed by a more general discussion of indicators used by the humanitarian community for GBV prevention programming.

American Refugee Committee

In general, ARC indicators were measurable, achievable, and realistic; however, they were not specific or timebound (because results were anticipated within each of the one-year funding cycles). It was noted by the evaluation team that in some cases, output indicators described activities and that indicators are stated as targets rather than neutral gauges of progress. Indicators were also difficult to understand in some cases because percentages or counts represented progress toward a target that was not directly stated or lacked clarity with respect to the actual measure. For example, the ARC indicator "With survivor consent, direct or referral services made available to GBV survivors who report the incident" would be easier to interpret if expressed as "percent of reporting and consenting GBV survivors provided with direct or referral services." ARC indicators could be improved to ensure that they are SMART and also stated as neutral measures of progress toward project targets and objectives.

Medical Teams International

MTI GBV indicators, which were initiated in 2012, were appropriate for measuring program performance. MTI indicators were SMART. However, most MTI indicators were stated as targets rather than neutral gauges of progress. This is one area in which MTI indicators could be improved. For example, instead of the current indicator, “100 percent of SGBV survivors who report to a clinic are examined and treated” a better indicator would be “percent of SGBV survivors who report to a clinic are examined and treated” which could then be reported on routinely and progress compared against the target of 100 percent.

Additional Observations

In practice, it was reported that donors provide examples of indicators but each program and organization identifies their own indicators. Limited resources are provided for program evaluation, particularly in the case of short-term funding, which is a challenge with respect to assessing effectiveness. Dedicated funding for evaluation and evaluation designs that implemented across the lifespan of the program and are capable of assessing change over time and attribution are preferred to post-hoc evaluations that are conducted only at the end of the program period and often draw insufficient conclusions. It was also noted that because multiple organizations may be implementing different interventions in the same settlements, attribution of change to a specific program may be a challenge. One potential approach for addressing this concern was coordinated multiagency evaluations that assess change in key outcomes over time (in addition to organization-specific process measures that are most commonly reported).

Both donors and implementers noted the GBVIMS as an important source of monitoring data at the settlement level. Two major improvements related to the introduction of the GBVIMS are that: 1) multiple reporting of cases by different organizations was eliminated, and 2) the reporting of only current cases (as compared to inclusion of cases that occurred in the country of origin) allowed for a more accurate understanding of GBV cases perpetrated in settlements. Despite significant improvements in reporting with the introduction of the GBVIMS, NGO implementers noted that the risk of duplicate reporting persists and that improved coordination and capacity building on how to best use and integrate systems and services is still needed. The GBVIMS is perceived as an important tool that will help providers and communities understand progress in GBV prevention and response over time. For example, measures of the number of GBV cases reported and the percent of cases where medical and legal assistance is provided will help providers and community members to better understand which areas and sub-populations are most at risk as well as assess the effectiveness of the referral pathway. However, challenges in interpretation of existing indicators were noted by both donors and NGO implementers—for example, GBVIMS indicators can be misleading because the reported cases may increase over time with prevention efforts despite an overall decrease in the total number of cases. Flawed interpretation can lead to the possibility of misinterpretation, where an increase in reported cases may be interpreted as a reflection of an unsuccessful project rather than successful prevention that led to increased awareness and reporting.

Most ARC and MTI GBV prevention outcomes and outputs were met based on targets indicated in program proposals. However, given short funding and implementation periods and the limited evidence of sustainability, it is difficult to evaluate if GBV prevention programs have a lasting impact. Identification of appropriate indicators to determine program effectiveness in short time periods is difficult. For example, rates of GBV are problematic indicators; rates may increase as awareness develops and services for identification and response to survivors are expanded. More appropriate

indicators for short-term programs might be women arriving for care within 72 hours of sexual assault, which could serve as a proxy for awareness of services and also indicate the extent of need for immediate attention to prevent HIV/STIs.

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?

Negative Consequences

The most apparent unintended negative consequence of primary GBV prevention, which was observed by donors, program staff, and beneficiaries alike, was a tendency for men to feel that women were too empowered by the SASA! approach. This was especially true when organizations worked with female activists on sensitization and capacity building and the women did not inform men of their participation. This was noted as a source of tension in the home and was attributed to the shift away from cultural norms. There also is a perception among men in the community that only women are being supported in GBV prevention programs. One community activist aptly summarized the problem: “men feel we support only women—they blame us for this. When we teach about a violence-free lifestyle we can be perceived by men as enemies.” Another key informant observed “there are situations where you need strategies to address GBV because men have rights and you might be perceived as trying to take these away—this can be very difficult.” Key informants mentioned that changing cultural norms is a process where these feelings might be expected and, therefore, that the ways in which men are engaged in GBV prevention is important.

ARC employed several strategies to address these issues, including male engagement, which is discussed in more detail under Evaluation Question 8. ARC specifically targets men and leaders for engagement in SASA!, noting that “if these people understand the reason [for women’s empowerment] they can help us...the community listens to them.” Community debates, which were used by ARC, were perceived by key informants as an effective strategy to address male concerns with women’s empowerment, violence, and NGO engagement of women. As one activist described, “there are a range of perspectives in the community—from supportive to blaming—for working with men, the one that blames you can be the chairperson of the debate and the activist sits in as a community member. So then the community addresses the issues itself and the blaming goes away because he had a leadership role and conversation is community driven.” It was also noted that it takes time for the community to feel ownership of SASA! and that male resistance to women’s empowerment is lessened as the community moves through the SASA! intervention and begins to feel ownership of the approach.

Another unanticipated consequence of GBV prevention work was the perception among field staff and community activists of the potential for risk and danger as result of their work. Among counselors, it was observed that survivors may become irritated and/or angry (often a normal symptom associated with post-traumatic stress disorder (PTSD) in counseling sessions because they are so traumatized or perhaps have underlying mental health issues, and that there is a need to diffuse very tense situations, at times requiring the involvement of security guards. Among community activists there was a concern, especially with rape and defilement cases, that the perpetrator or the family can make threats and become an enemy. While the threat of violence against GBV prevention workers was perceived among staff and community volunteers at the settlement, this was not mentioned by regional staff or Kampala headquarters as a program concern, therefore opportunities exist for improved communication

between field and headquarters staff about threats or risks of violence as well as training to build capacity for field staff and activist on de-escalation of threatening or violent situations.

Unanticipated Positive Outcomes

One unanticipated positive outcome was the demand for IEC materials, specifically the SASA! posters. The rate of use of the posters by community activists was high because community members request to keep the posters. As one ARC staff member noted, “we run out of IEC materials—but this is positive because the community has demand to keep them.” The high level of community interest in SASA! was also manifested in community members wanting to make appointments for additional follow up sessions at the close of community dialogue sessions. The increasing desire and interest in the community to participate in SASA! and work on prevention was noted as unanticipated positive outcome because this level of community engagement had not been observed with other GBV prevention strategies that had implemented in the settlements previously. Another unanticipated positive outcome was increased reporting of other issues, in particular child protection cases. NGO implementers attributed the increase in reported child protection cases to changes in social norms and increased awareness of referral pathways and services. This was noted as positive because it demonstrates increased awareness and helps to resolve issues within the community, however, it was also observed that referral pathways for the cases and linkages to other established need to be better established so that emerging cases can be addressed.

Evaluation Question 6: What factors explain expected and unexpected negative or positive consequences?

Social and cultural norms, in particular acceptance of violence and the power imbalance between men and women, were viewed as the primary factor that explained male resistance to primary GBV prevention efforts, women’s empowerment and the work of implementing organizations around GBV in the settlements. Another factor that contributed to men’s resistance to GBV programming was the perception among male community members that men were only viewed as perpetrators and thus have little to gain from GBV prevention programming. This sentiment was aptly summarized by PRM: “Previous programs created tension when engaging men and boys where the men in the community said the program was more focused on men as perpetrators and accusing men rather than engagement in prevention. The SASA! curriculum was found by the community to be more welcoming for men and boys.” Several respondents noted that past GBV prevention strategies, which were not received by communities as well as SASA!, might be a reason that contributed to the resistance encountered among some male community members. As one respondent noted, “previous programs that created tension with engaging men and boys where the men in the community.... overcoming previous program work is a challenge for new effort.” SASA! was noted to be different than other “teach to” GBV prevention strategies because the community identifies issues and recommendations. The engaging nature of SASA! and its’ questioning approach that encourages community action was noted as the primary factor that explained higher levels of community interest and participation (as compared to other GBV prevention activities conducted in the past).

Evaluation Question 7: What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?

An advantage to SASA!, which was developed in Uganda by Raising Voices, is that implementation is based on pre-defined standardized indicators. SASA! uses four key indicators and has a community

baseline against which change over time is measured. Pre-defined indicators are advantageous because ARC does not need to define their own indicators, indicators have been proven to be accurate gauges of intervention progress, and the use of standardized indicators enables cross-site comparisons of effectiveness. A summary of the types of outcomes that SASA! indicators are associated with in each SASA! phase is presented in Figure 1.

Figure 1: Overview of SASA! Outcomes

Knowledge	Knowledge= What facts and information people know	
	In the START phase, outcomes involve the knowledge gained by the SASA! team in preparation for planning and facilitating SASA!.	In the AWARENESS phase, outcomes involve the knowledge gained by community members about GBV, HIV and AIDs and the imbalance of power between men and women.
Attitudes	Attitudes=What people believe and feel	
	In the START phase, outcomes involve the attitudinal shift in members of the SASA team after exploring SASA! ideas in relation to their own lives and relationships.	In the AWARENESS phase, outcomes involve the attitudinal shift in community members after exploring the concepts presented in SASA Awareness activities.
Skills	Skills=What people know how to do	
	In the SUPPORT phase, outcomes involve the skills gained and used by community members for providing support to one another, and working to address power, GBV and HIV in their community	
Behaviors	Behaviors= How people choose to act	
	In the ACTION phase, outcomes involve the behaviors demonstrated by community members for making positive changes in their relationships and in their community	

SASA! awareness campaign indicators were measurable and time bound. Both key informants and documents reviewed suggest that SASA! awareness campaigns contributed to improvements in GBV-related knowledge and attitudes from one year to the next, but no objective quantitative evidence was presented on the effectiveness of the intervention with respect to changes in socio-cultural norms that promote or sustain GBV. ARC measured whether or not—and to what extent—KASB survey outcome areas displayed a progressive shift (in relation to the Objective 2 indicators). However, full outcomes of the intervention could not be adequately assessed because survey results for Year 2 were not reported and the intervention is still underway. ARC is however well positioned to demonstrate the effectiveness of SASA! through the repeated KASB surveys conducted over the span of the three-year project. Measures of outputs, for example the number of outreach sessions held by community activists, are generally the most common type of indicator collected, however, they do not reflect awareness outcomes. The GBVIMS was noted by donors, NGO implementers, and partner organizations to provide valuable information on indicators such as the incidence of reported rape cases, however, the fact that the GBVIMS did not reflect physical and economic violence and concerns related to interpretation of trends suggest that it is not a choice outcome measure for awareness efforts (despite being a suggest by multiple informants). Some informants noted that effective programming would reduce the number of reported GBV cases whereas others observed that the number of reported GBV cases should increase where greater reporting was a reflection of increased awareness.

In general, measurement of the outcomes of GBV awareness was observed to be a challenge. Longer term follow up KASB surveys, including beyond the three year intervention period, may be the best approach to evaluating outcomes of SASA! awareness phase.¹²

Evaluation Question 8: To what extent have men and boys been included in GBV awareness campaigns? If they were not included, why was this? If they were, what was the impact and how was it measured? Do the GBV programs address the issue of the male survivors of sexual assault or domestic violence? If yes, how?

Part I: Male engagement in GBV awareness

ARC uses the SASA! approach to engage males in GBV awareness activities; MTI did not conduct awareness campaigns and its programs focused on providing services to GBV survivors. As noted in Evaluation Question 6, male refugees were not involved in GBV programs implemented by ARC's predecessor, and they were skeptical about the nature and purpose of such programs. Male engagement in primary GBV prevention and awareness efforts is an explicit component of the SASA! approach. Specific male engagement strategies used by ARC in SASA! focus on: 1) males as victims, 2) males as supporters of female survivors, and 3) males as agents of change. Through male engagement groups, SASA! attempts to reach new venues for awareness raising such as bars and pool clubs. Other mechanisms reported as successful male engagement strategies included involving men in trainings, games and sports, and musical activities where GBV prevention messaging is included. SASA! uses men's support groups and testimonies of men who had in the past used violence and were subsequently reformed as successful male engagement strategies. Engagement of male victims in GBV prevention activities was also observed. One respondent self-identified as a male survivor and a pastor who was engaged in SASA! and noted the difficulties of responding to male survivors and his commitment to supporting other survivors including both men and women. Sharing statistics from the GBVIMS—in particular the number of cases among men, women, and children was also perceived as an effective engagement strategy because it helps to increase understanding of GBV in the community and may encourage survivors to report cases once they understand they are not alone.

The indicators for male engagement were primarily focused on outputs, such as the number of men and boys in programs, the number working as community mobilizers, and number of visits to community or youth clubs. It was noted that it was difficult to measure changes in perceptions of males in the community at large and of the men/boys engaged as activists in the behavior change process. The use of the predefined SASA! indicators and the KASB surveys that ARC has been conducting in Kyangwali settlement offer the potential to better assess the outcomes of the SASA! male engagement strategy.

Part II: Male survivors of sexual assault or domestic violence

A referral pathway to the health center and other support services exists for male survivors in the settlements. Male victims, when they come forward, are able to access services. However, as previously noted under challenges (Evaluation Question 1b), men do not want to disclose their experiences and it is believed that the majority do not report. Increased confidence of male survivors due to a better

¹² Raising Voices, CEDOVIP, the London School of Hygiene and Tropical Medicine, and Makerere University are investigating the impact of the SASA! approach. The study is a pair-matched cluster randomized controlled trial being conducted in eight communities in Kampala. It is one of the few cluster randomized trials globally to assess the community-wide impact of a violence prevention intervention. For more information, see <<http://raisingvoices.org/sasa/#tabs-419-0-3>>.

understanding of the referral pathway, support groups and, more open discussion of GBV in the community and the new arrivals which have widespread exposure to GBV were noted as reasons for the increase in reported GBV cases among males. In Nakivale Settlement, Refugee Law Project had pilot tested a screening tool developed by Johns Hopkins University to identify male survivors of violence (use of the tool is currently being expanded).¹³ GBV cases were referred to ARC staff and received immediate medical and psychosocial support as needed. It was noted that male survivors are best approached from a medical perspective and that protocol and capacity specific to male GBV survivors needs to be developed. It was observed that cases of male survivors are increasing and there is a desire among providers to identify more cases, however, there is a need to build response capacity of service providers to better identify and respond to men/boys who experience physical and sexual violence.

Evaluation Question 9: What were the short- and long-term outcomes of PRM-funded GBV prevention?

There was a general perception among community members, NGO implementers, and donors that the SASA! intervention was successful at preventing violence in the community. Informants believed that the community had changed and the process was effective. However, accurately capturing the outcomes of GBV prevention programming is more challenging. No other violence prevention models were observed as being implemented in the settlements and therefore could not be used to compare the effectiveness of the SASA! approach. As one informant observed, “it is easy to do GBV sensitization – but in the end what is the impact? It is hard to measure dissemination in terms of prevention, response and referral pathways.”

PRM noted in its Interim Program Evaluation that ARC’s SASA! approach of involving the community at all levels of implementation—especially preparing community groups to help prevent and respond to GBV cases—galvanized participation and is likely to lead to lasting changes in prevention and response mechanisms. Other informants felt that the approach had prevented violence against women and girls but noted that the extent of this success remained unclear. Short and long term outcomes of the PRM funded GBV programs refugee settlements in Uganda include:

GBV Hotlines are in Place: The GBV hotline in Kyangwali is operational 24 hours per day, 7 days a week and gets about approximately 50 beeps a month, these calls include requests for information on GBV and other services in the settlement. In Nakivale settlement a GBV hotline was established in the month preceding the evaluation and efforts are underway to introduce the service in the settlement.

GBV Referral Pathways Exist: GBV referral pathways are evident in IEC messaging in the camps and are functioning reasonably well, although some challenges remain. There are trained community activists, police, counselors, clinical providers and legal officers that coordinate to effectively provide services to GBV survivors.

GBVIMS is in Place: The GBVIMS is a critical tool for information sharing between implementing organizations and for tracking trends in reported GBV cases and other service quality outcomes such as the proportion of survivors receiving PEP and prosecuting cases.

¹³ The first tool developed was to identify female survivors; a separate tool is under development, in partnership between Johns Hopkins University and the Refugee Law Project in Uganda, for identification of male survivors.

Community Structures are in Place for GBV: This includes community social workers and activists that have been trained and are responsible for community mobilization. Other community GBV structures in place include gender task forces, youth groups and men-to-men support groups. The SASA! approach of engaging and building capacity of community members sense of responsibility to respond to GBV within communities was considered a positive feature of the approach because it is sustainable over long term.

Increased Demand for Legal Services: This is the result of increased knowledge in the community about what to do in the event of GBV and how to access the referral system. This is particularly evident in the old case in Kyangwali, as one implementer observed, “we can see that people have GBV awareness and they know where to go, which case to report, and to whom.” It was also noted that survivors are more willing to take their cases through the legal system than before SASA! programming began because they better understand the process and are thus more willing to use it.

CONCLUSIONS

In conclusion, ARC and MTI consistently met, exceeded, or achieved progress toward planned GBV prevention and response program objectives and activities during the evaluation period of October 1, 2009 to September 30, 2012 (FY 2010-2012). Both organizations were also on target to achieve current program activities in FY 2013 based on data collected from fieldwork and quarterly reports.

ARC and MTI program objectives were informed by international guidelines, numerous assessments, and ongoing work in refugee communities—in particular the monthly coordination meetings among implementers, information from the GBVIMS, interaction with community members including refugee community leaders, and regular monitoring meetings with community activists implementing the SASA! approach to GBV prevention. However, for both organizations, engaging refugee leadership in GBV prevention and response program planning—including establishing realistic objectives and activities—rather than waiting until program funding arrives would likely result in increased ownership of GBV programs by the community and potentially reduce unintended negative consequences, such as male community members' perception that GBV programs undermine their role in the family and community.

Social and cultural norms, in particular acceptance of violence and the power imbalance between men and women, were viewed as the primary factors that explained unexpected/unintended consequences related to GBV prevention efforts. Another factor that contributed to resistance to GBV programming was the perception among male community members that NGO staff viewed all men as perpetrators of violence and thus they had little to gain from engagement in GBV prevention programming. Community activists and staff noted that the SASA! approach was important to reducing this perception as it engaged men in all aspects of GBV prevention activities (awareness, support, and action), reducing potential backlash against women/girls as well as NGO implementer staff.

Although the work of ARC and MTI in collaboration with multiple partners has advanced GBV prevention and response in the targeted refugee settlements, barriers to continued progress were noted by multiple key informants representing donors/USG partners, NGO implementers, local partner organizations, beneficiaries, and external actors. Specifically, GBV prevention and response activities need to be better integrated into livelihood and income generation, education, family planning, HIV counseling/testing, and youth programs provided to refugee and host community members. Further, social norms approaches to GBV prevention require significant investment (e.g. time, training, mentorship, and support for staff and activists). Therefore, funding cycles should be a minimum of three years to enable NGO implementers to conduct GBV prevention programs in refugee settings, as well as measure prevention process and outcome indicators.

Best practice models and indicators that can demonstrate the success of GBV prevention programming are lacking, and this adversely affects the evaluation of GBV prevention programs.¹⁴ Indicators used by both ARC and MTI for GBV prevention and response are primarily output measures, such as the number of health providers, police, and community activists trained; numbers of survivors who access medical services; and number of calls to the hotline. Outcome indicators, such as acceptability of physical and/or sexual violence against women/girls are not provided and therefore, limit the ability of an evaluation team to determine the impact of the prevention and response programs.

¹⁴ Other possible models include Partner4Prevention, Stepping Stones, Gender Communication, and HIV.

The importance of standard, uniform indicators that could be recommended for use across programs was observed by the evaluation team. This would facilitate comparisons of programs in other settings and better understanding of program successes. A limited number (3-6) of common outcomes indicators could be supplemented by additional program-specific indicators that would be more tailored to the specific intervention/program. Specific guidance on GBV prevention and response indicators from PRM to implementing partners may be helpful in developing systematic indicators that all programs must have (in addition to individual program indicators). The SASA! approach, which has an evaluation methodology based on standard pre-defined indicators, may be a good first step toward comparison of the effectiveness of GBV prevention programming across contexts.

In general, from the perspective of representatives and staff from PRM, UNHCR, OPM, ARC, MTI, and beneficiaries, the SASA! approach, which involves the community at all levels of GBV prevention implementation—especially preparing community activists and others to raise awareness, support, and develop actions to help prevent and respond to GBV cases—has galvanized participation and is likely to lead to both short- and long-term positive GBV prevention and response services for survivors and the larger settlement and host communities.

RECOMMENDATIONS

The following recommendations for continued progress in GBV prevention were noted by multiple key informants representing donors/USG partners, NGO implementers, local organizations and host country partners, beneficiaries, and external actors.

1. UNHCR should lead efforts for increased coordination and collaboration in the settlements between implementing partners, local partners, and beneficiaries in the following areas:

- a. Identify opportunities and resources to integrate GBV prevention activities into existing health and social programs, such as integration in family planning, education, income generation, livelihoods, and youth programs. Resources include GBV prevention and response training for staff, as well as culturally and linguistically appropriate materials such as posters and awareness information for settlement hotline and referral pathways for survivors.
- b. Identify funding opportunities to build capacity to integrate GBV prevention into the educational curriculum and increase secondary school enrollment for girls. Education is an exceptionally important area for integration, in particular for girls, and a best approach for achieving intergenerational changes in cultural norms surrounding GBV.
- c. Develop mechanisms for safe and confidential strategies to share essential information between counselors, medical providers, legal caseworkers, and police on the progression of cases for better addressing survivor safety, ongoing health and social needs, and improving case outcomes. For example, key service providers could conduct monthly case reviews to discuss progress, identify additional support needs (legal, psychosocial, safety, etc.), and determine who will take responsibility for providing that support to survivors.
- d. Provide technical assistance on training, mentorship, and support to GBV service providers to identify and respond to men and boys who have experienced multiple forms of violence.¹⁵
- e. Use established networks with local partners to engage refugee leadership and beneficiaries in GBV prevention program planning, including establishing program objectives and activities. Collaboration on program planning would likely result in more ownership of the programs by the community and potentially reduce unintended negative consequences associated with implementation.
- f. Integrate cost analysis in GBV prevention and response programs. For example, mobile legal clinics were viewed as effective in providing timely justice for survivors; however, the cost of continuing the mobile legal clinic program is perceived as too high by UNHCR for the benefits.

¹⁵ International Rescue Committee's multi-media training tool on Clinical Care for Sexual Assault Survivors includes a module about male victims of sexual violence: <<http://clinicalcare.rhrc.org>>. The Refugee Law Project in Uganda has been working in settlements in Uganda with male survivors primarily from DRC, and it has established support groups led by men in Kampala and the settlements. In partnership with the Refugee Law Project and with funding from DoS/PRM, Johns Hopkins University developed a GBV screening tool for male survivors.

2. PRM and UNHCR should collaboratively lead efforts to advance collection and reporting of GBV prevention data, specifically advancing from primarily output indicators (i.e., number of community activists trained) to outcome indicators (i.e., acceptability of physical and sexual violence against women/girls in the home).¹⁶

- a. NGO implementers should be required to adopt internationally accepted indicators into their M&E practices. Further, efforts to collect and provide information by gender and age would strengthen evaluation.

For example, relevant indicators that could be applied from 2005 IASC Guidelines on Gender-based Violence Interventions in Humanitarian Settings include:

- Number of copies of a resource list in local language(s) distributed in community.
- Proportion of reported incidents of sexual violence where survivor (or parent in the case of a child) chooses to pursue legal redress;
- Proportion of reported eligible incidents of sexual violence that were provided with PEP counseling and treatment;
- Reports on sexual violence incidents compiled monthly (anonymous data), analyzed, and shared with stakeholders; and
- Proportion of key actors who participate in regular GBV working group meetings.

Relevant indicators that could be applied from 2006 IASC “Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action include:

- Number and percentage of women and men in the community, including village leaders and men’s groups, who are sensitized to violence against women and girls, including domestic violence;
- 24-hour access to sexual violence services exists.
- Number and percentage of staff who are aware of and abide by medical confidentiality.
- Extent to which confidential referral mechanism for health and psychosocial services for GBV survivors exists and is used;
- Number and percentage of men and women reached through informational campaigns about the health risks of sexual violence to the community;
- A mechanism is in place for monitoring security and instances of GBV;
- A referral system for reporting of security and GBV incidents is operational; and
- Mechanisms (i.e., confidential/safe settings, trained service providers, contextually/linguistically appropriate incident forms, referral pathways) are put in place to ensure people can report GBV.

- b. NGO implementers conducting GBV prevention awareness campaigns should be provided guidance and required to increase specificity of the measures for knowledge gain and attitude change. The 2010 GBVIMS Resources provides examples of indicators that could be adopted. Further, the information should be collected and reported by gender and age as appropriate:

¹⁶ The GBV Prevention Indicator Compendium (Annex V) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

- Proportion of individuals who know any of the legal rights of women;
 - Proportion of individuals who know any of the legal sanctions for GBV;
 - Proportion of people who have been exposed to GBV prevention messages;
 - Proportion of people who say that wife beating is not an acceptable way for husbands to discipline their wives; and
 - Proportion of people who would assist a women being beaten by her husband or partner.
- c. NGO implementers requesting funding for GBV prevention programs such as SASA! should be provided guidance and required to use established outcome indicators to determine the impact of the program, including:
- Attitudes towards the acceptability of violence against women/girls;
 - Acceptability of a woman refusing sex (among male and female community members);
 - Past year experience of physical intimate partner violence and sexual intimate partner violence (among females);
 - Community responses to women experiencing violence (among women reporting past year physical/sexual partner violence and among women who report sexual violence); and
 - Past year concurrency of sexual partners (among males).

3. PRM should encourage collaborations between UNHCR, NGO implementers, and local partners to identify and prioritize technical assistance and resources needed to address gaps in prevention and response services for survivors:

- a. Training and mentorship for staff on GBV-related issues that are difficult to address including LGBTI issues, male survivors, child abuse/neglect, and commercial sex workers;
- b. Trainings for medical providers on how to collect forensic evidence and document GBV cases, how to serve as expert witnesses, and how to testify in court cases;
- c. Trainings on situational management and conflict resolution so that staff have skills to assist difficult clients and resolve tense situations;
- d. Attention to staff well-being and self-care including mental health support; off-site team retreats, trainings and skill building activities; and peer counseling and/or guidance on best practices, such as those provided in UNHCR's 2013 Mental Health and Psychosocial Support for Staff and procedures for staff self-care following handling of difficult cases.

ANNEXES

Annex I: Evaluation Statement of Work

STATEMENT OF WORK

U.S. Department of State Bureau of Population, Refugees and Migration

Evaluating the Effectiveness of Gender-Based Violence (GBV) Prevention Programs with Refugees in Chad, Malaysia, and Uganda

NATURE AND PURPOSE

The purpose of this solicitation is to obtain the services of a contractor to carry out an evaluation, lasting up to 12 months, of Gender Based Violence (GBV) programs supported either directly by the Bureau of Population, Refugees and Migration (PRM) or indirectly through one of its multilateral partners, the United Nations High Commissioner for Refugees (UNHCR) in targeted countries. The evaluation will consist of: (1) a comprehensive desk review and analysis of GBV program reporting by PRM and UNHCR; and (2) field-based evaluations in three countries (Chad, Malaysia, and Uganda) where PRM and UNHCR support GBV prevention programming. Both the desk review and the field-based evaluations should prioritize identifying: (1) the effectiveness of GBV prevention programming; (2) appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings and (3) best practices and lessons learned in engaging men and boys in GBV prevention interventions in refugee settings. Evaluation recommendations should include guidance that PRM can consider when: (1) writing requests for GBV proposals; (2) when reviewing GBV proposals; (3) monitoring GBV programs in the field; and (4) engaging host governments, International Organizations (IOs), and Non-Governmental Organizations (NGOs) on GBV issues. The contractor will coordinate with PRM, UNHCR, and NGOs.

BACKGROUND

PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world on behalf of the American people by providing life-sustaining assistance, working through multilateral systems to build global partnerships, promoting best practices in humanitarian response, and ensuring that humanitarian principles are thoroughly integrated into U.S. foreign and national security policy. PRM is the largest bilateral funder to UNHCR and other multilateral humanitarian responders. PRM funds NGOs to fill critical gaps in programming by UNHCR and host governments.

Preventing and responding to GBV in refugee settings is a PRM priority. PRM's Multilateral Coordination and External Relations (MCE) Office oversees PRM-supported GBV prevention and response activities. Prior to FY 2010, MCE maintained a central pot of funding for GBV prevention/response programs. On an annual basis, MCE would issue a Request for Proposals (RFP) through which NGOs could apply for any region with PRM populations of concern. After FY 2010, MCE instead made the majority of these funds available to regional PRM offices, reserving only a small amount of central funding to promote research, capacity-building, and innovation concerning GBV prevention/response in humanitarian settings. For this reason, the scope of the evaluation will be projects carried out between FY 2010 to the present. MCE is the main source of expertise on GBV related issues for the Bureau, complemented by technical

assistance from USG partners such as the Centers for Disease Control and Prevention's International Emergency and Refugee Health Branch (CDC/IERHB) and the United States Agency for International Development's Office of Foreign Disaster Assistance (USAID/OFDA).

There seems to be an inherent challenge in measuring the impact of GBV programs, particularly where prevention activities are concerned. In a humanitarian context especially, GBV interventions tend to focus on health, legal and psychosocial *response* activities, given the urgency of the situation, funding constraints by donors (PRM generally funds activities 12 months at a time, for example), and the ability to measure impact more quickly, while the understanding of how to best support and measure the impact of GBV prevention activities in humanitarian contexts continues to be a challenge. As part of GBV prevention, PRM has raised the importance of determining how best to engage men and boys to reduce gender inequalities and prevent violence through questioning traditional norms associated with femininity and masculinity, and reinforcing positive masculine behavior, rather than behaviors that harm women. Although more has been done in the development context on this issue, the humanitarian community still has much to learn in identifying best practices on engaging men and boys in GBV programming. Strong monitoring and evaluation contributes to the identification of best practices that can be promoted in future GBV prevention and response programs, and we hope that this evaluation will identify appropriate indicators for measuring the effectiveness of GBV prevention interventions, as well as best practices on engaging men and boys in GBV prevention interventions in humanitarian settings. In addition to best practices, we should learn from mistakes that we and our partners have made so they are not repeated.

Monitoring the performance of PRM partners is a responsibility shared by MCE, regional offices, PRP and PRM's Regional Refugee Coordinators based at embassies throughout the world. The Bureau's Office of Policy and Resource Planning (PRP) will oversee administration of the evaluation and be the primary point of contact. Upon award, PRP will work closely with the contractor for the duration of the evaluation. In accordance with the standards of good management and performance-based results, the contractor will be held accountable for cost, schedule, and performance results.

SCOPE OF WORK

The contractor will:

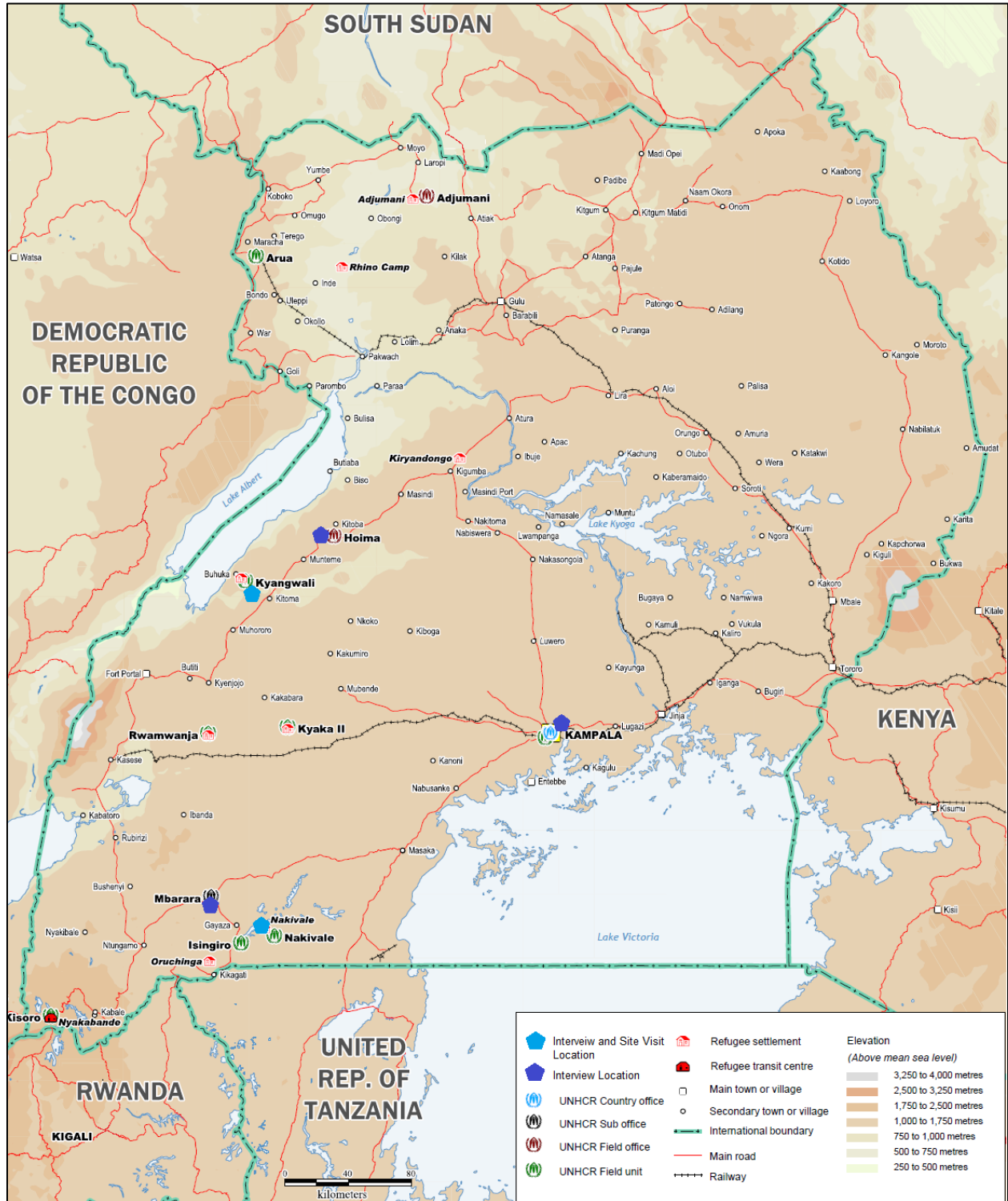
- Conduct a comprehensive desk review and analysis of selected NGO GBV projects supported by PRM and UNHCR between FY 2010-2012 with an emphasis on measuring the effectiveness of prevention interventions.
- Carry out field-based evaluations in three countries where both PRM and UNHCR fund GBV prevention programs with refugee populations. For this study, the research sites would include refugee camps in eastern Chad, refugees living in settlements in western Uganda, and neighborhoods with high concentrations of urban refugees in Kuala Lumpur, Malaysia.
- The evaluations should answer the following questions, with an emphasis on developing best practices, lessons learned, and actionable recommendations that can inform PRM supported GBV programming in the future.
- Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
- Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?

- Did the GBV programming conform w/ internationally accepted GBV guidelines produced by the humanitarian community? Relevant guidelines include: (1) IASC Guidelines for GBV in Humanitarian Settings; (2) UNHCR Handbook for the Protection of Refugee Women; (3) UNHCR Guidelines on the Protection of Refugee Children; (4) GBV AoR Handbook for Coordinating GBV Interventions in Humanitarian Settings; and (5) IASC Gender Handbook in Humanitarian Action.
- Are the indicators in the above guidance documents (where available) appropriate for measuring the outcomes of PRM funded GBV prevention programs? Are the indicators in the project proposals Specific, Measurable, Achievable, Realistic or Timely? How can proposal indicators be improved? Do indicators from the above guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
- Were there any unexpected negative or positive consequences of PRM funded GBV programs? Did organizations address negative consequences and how?
- What factors explain intended and unintended negative or positive consequences?
- What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs specific, measurable, achievable, realistic or timely? How can indicators be improved for GBV awareness campaigns?
- To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
- What were the short and long term outcomes of PRM funded GBV prevention programs?

Fieldwork Component: Uganda

- **American Refugee Committee (ARC):** ARC has been working on GBV related issues with refugee communities in Uganda's western settlements since 2010. Specifically, ARC aims to empower refugees in Kyangwali, Kyaka, and Nakivale Refugee settlements to prevent and respond to GBV. In order to accomplish this, ARC strengthens the capacity of community partners to address GBV in Kyangwali Refugee Settlement, improves access to multi-sectoral services for GBV survivors in sixteen villages within the Kyangwali settlements, and strengthens GBV referral pathways and coordination through case management and technical support in Kyaka and Nakivale Refugee Settlements. ARC coordinates with the Office of the Prime Minister (which is the governmental unit responsible for refugee affairs), UNHCR, as well as international and local NGOs.
- **Medical Teams International (MTI):** MTI has been providing direct emergency and primary health care services in Nakivale (Ngarama) settlement through a static clinic constructed by UNHCR at Ngarama in Juru zone since 2009. MTI provides the following health care services in Ngarama: out-patient department services, community outreach activities (immunization, sensitization and mobilization for antenatal care (ANC)), infrastructure development, and systems strengthening. MTI supports awareness messaging on HIV/AIDS, health promotion campaigns, and capacity building of Community Health Workers (CHWs). From January 2012, UNHCR chose MTI to take the lead in health and nutrition across Nakivale and Oruchinga settlements— overseeing a total of five health clinics and a sixth that is now under construction. MTI was asked by UNHCR and governmental authorities to assist new refugee arrivals at Kisoro and Ishasa border reception centers as they await transportation to the determined place of settlement.

Annex II: Uganda Country Map and Evaluation Locations



Note: Adapted from UNHCR's Uganda Country Map, available at <http://www.unhcr.org/500ea059.html>.

Annex III: Data Collection Instrument

Evaluation Questions Numbered for Coding of Interviews	
General/background questions to start interview	
PRM, UNHCR, Implementing NGOs, Partner Organizations, External Actors	
<ol style="list-style-type: none"> 1. What do you know about the refugee situation in Uganda? PRM's work with refugees in Uganda? 2. Please provide a brief overview of the GBV prevention programming your organization supports. 3. What kinds of "code words" are used by the community you work with to imply that someone has experienced GBV? 4. What are the most critical aspects of GBV among refugees in Uganda? 	
Beneficiaries	
<ol style="list-style-type: none"> 5. How long have you been in Uganda? 6. Are you a member of a community group? 7. How long have you been a participant in this program? 	
Evaluation Directive 1: Effectiveness of GBV Prevention Programming for Individuals and Communities at Risk – findings, best practices, lessons learned	
Evaluation Question 1a: Did partners achieve the program activities defined in their project proposals?	
PRM and UNHCR	
<ol style="list-style-type: none"> 1.a.1. What are the main GBV prevention and treatment activities your grantees have proposed to carry out this fiscal year with PRM funding? 1.a.2. Are your grantees on track to achieve their proposed activities? 1.a.3. How do you determine whether or not your grantees have achieved the activities defined in their proposals? 1.a.4. Were there any changes to planned activities? If so, what were the changes? 1.a.5. How were you informed about these changes? 1.a.6. How did/have the changes affect program success/achievements? 	
NGO Implementers	
<ol style="list-style-type: none"> 1.a.1. What are the main GBV prevention and treatment activities you have proposed to carry out this fiscal year with PRM/UNHCR funding? 1.a.2. Are you on track to achieve your proposed activities? 1.a.3. How do you determine whether or not you are making progress toward the achievement of the activities defined in your proposal to PRM/UNHCR? 1.a.4. Have you made any changes to planned activities? If so, what were the changes? 1.a.5. How have you informed UNHCR/PRM about these changes? 1.a.6. How did/have the changes affected the success/achievements of your program? 	
Local Partner Organizations	
<ol style="list-style-type: none"> 1.a.1. What are the main GBV activities you have proposed to carry out this fiscal year in collaboration with ARC/MTI? 1.a.2. Are you on track to achieve your proposed activities/objectives? 1.a.3. How do you determine whether or not you are making progress toward the achievement of the activities? 1.a.4. Have you made any changes to planned activities? If so, what were the changes? 1.a.7. How do these activities prevent GBV? 	
Beneficiaries	
<ol style="list-style-type: none"> 1.a.8. How did you learn about ARC/MTI? 1.a.9. What is your understanding of what this program is/was intended to do? 1.a.10. What types of services do you receive from ARC/MTI? (OR) What kind of program did you participate in? 1.a.11. How did the services meet your needs? Are there other services you would like to receive from this program? OR What did you learn from your participation in this program? (GBV Awareness) 1.a.12. How do you think that ARC/MTI could improve its services? 1.a.13. How do you think violence against women/girls can be prevented in families/communities? Please give specific examples. 1.a.14. How does this program prevent violence against women/girls? Please give specific examples. Are there specific services received from the program that have helped to prevent violence against women and girls? 	

<p>External Actors:</p> <p>1.a.15. What can you tell us about the challenges refugees in Uganda face in terms of GBV?</p> <p>1.a.16. Are you aware of the programs/services provided by ARC/MTI? If yes, what is your understanding of what the program(s) is/are intended to achieve?</p> <p>1.a.17. How well do you think the program has met the objectives you have identified?</p>
<p>Evaluation Question 1b: What were the barriers to implementing program activities?</p>
<p>PRM and UNHCR:</p> <p>1.b.1. What are some of the challenges to program implementation that you observed among the grantees?</p> <p>1.b.2. Do you know of instances where your grantees were unable to implement their programs or activities?</p> <p>1.b.3. Can you provide a specific example of a program that was unable to implement its activities?</p>
<p>NGO Implementers and Local Partner Organizations</p> <p>1.b.4. Did you experience any difficulties implementing your program activities? Please describe.</p>
<p>Beneficiaries</p> <p>1.b.5. Did you experience any difficulties in obtaining services from the program? Describe.</p> <p>1.b.6. Did you talk to the staff about the problems you were having?</p> <p>1.b.7. If you told the staff about the problems you were having, how did they respond?</p> <p>1.b.8. If you did not tell anyone about the problems you were having, why not?</p>
<p>External Actors</p> <p>1.b.9. Are you aware of any difficulties that beneficiaries might have had in accessing the services?</p>
<p>Evaluation Question 1c: What were the facilitators to implementing program activities?</p>
<p>PRM and UNHCR</p> <p>1.c.1. Can you identify some programs/activities that have been easiest for your grantees to implement?</p> <p>1.c.2. What aspects of these programs/activities made them easy to implement?</p> <p>1.c.3. Can you provide a specific example of a factor or characteristic that helped to facilitate program implementation?</p>
<p>NGO Implementers and Local Partner Organizations</p> <p>1.c.1. Which of your activities have been the easiest for you to implement?</p> <p>1.c.2. What aspects of these activities made them easy to implement?</p> <p>1.c.3. Can you provide a specific example of a factor or characteristic that helped you implement the activity?</p> <p>1.c.4. Did any of the organizations working with you in the area of GBV take actions to facilitate implementation of your program activities? If so, describe.</p>
<p>Beneficiaries</p> <p>1.c.5. Were there actions taken by MTI/ARC to encourage your participation in the program or to make it easier for you to use their services? (Some examples might be providing interpreters, transportation, child care).</p>
<p>External Actors</p> <p>1.c.5. Are you aware of any actions taken by ARC/MTI that have made it easier for program participants to access services? Please describe.</p>
<p>Evaluation Question 2a: Were the program objectives based on evidence such as needs assessments or other forms of data?</p>
<p>PRM and UNHCR</p> <p>2.a.1. How did the grantees develop their program objectives?</p> <p>2.a.2. What data or information did the grantees consult in the design of their program objectives?</p> <p>2.a.3. Were the objectives informed by needs assessments?</p> <p>2.a.4. If needs assessments were conducted, were they conducted specifically for the program or did they already exist?</p> <p>2.a.5. What evidence exists to substantiate/support the need for the program?</p> <p>2.a.6. What kind of work do you think it would be good to expand?</p>
<p>NGO Implementers</p> <p>2.a.7. How did you develop your program objectives?</p> <p>2.a.8. What data or information did you consult in the design of your program objectives?</p> <p>2.a.9. Did you conduct any needs assessments before designing your program? - If so, when?</p>

<p>- If so, what data collection methods were used?</p> <p>- If so, who was included in your assessment? Were men and/or boys included?</p> <p>2.a.10. What were the major findings of the assessment?</p> <p>2.a.11. What other forms of information did you use to design your program?</p> <p>2.a.12. Was the design informed by your prior or ongoing work in this area?</p>
<p>Partner Organizations</p> <p>2.a.13. Have you conducted any needs assessments or GBV studies? Please describe.</p> <p>2.a.14. Have you conducted any safety/risk mapping in your program? Please describe.</p>
<p>Beneficiaries</p> <p>2.a.15. What kinds of problems do you think led ARC/MTI to decide to start this program?</p> <p>2.a.16. What types of violence or harm (psychological/emotional/physical) do women/girls face in your community?</p> <p>2.a.17. What types of violence or harm do boys or men in your community face?</p>
<p>External Actors</p> <p>2.a.18. Are you aware of needs assessments or other analyses that were conducted prior to the planning and implementation of your ARC/MTI GBV programs?</p> <p>2.a.19. What suggestions would you have about modifying the objectives or activities of the ARC/MTI GBV program?</p>
<p>Evaluation Question 2b: Were the objectives realistic and measurable?</p>
<p>PRM and UNHCR</p> <p>2.b.1. Are the objectives realistic and/or achievable within the project timeframe? Please explain.</p> <p>2.b.2. Are there indicators in place to measure the objectives?</p> <p>2.b.3. If so, how well do the indicators measure project objectives?</p>
<p>NGO Implementers</p> <p>2.b.1. Are the objectives realistic and/or achievable within the project timeframe? Please explain.</p> <p>2.b.2. What indicators are used to measure progress in achieving program objectives?</p> <p>2.b.4. Do you have any information or data to show progress to date in achieving program objectives?</p> <p>2.b.5. Do you think the project objectives will be achieved within the timeframe? Why or why not?</p>
<p>Beneficiaries</p> <p>2.b.6. Have you been asked your opinion about whether or not you think the ARC/MTI program is effective?</p> <p>2.b.7. What kind of things do you think would show that the program is working well?</p> <p>2.b.8. How do you think the staff could tell if the program is working well?</p>
<p>External Actors</p> <p>2.b.1. Do you believe that the objectives of the ARC/MTI program relevant to GBV were/are realistic and measurable? (Discuss examples).</p>
<p>Evaluation Question 2c: If the objectives were not realistic and measureable, how could they be improved?</p>
<p>PRM, UNHCR and NGO Implementers</p> <p>2.c.1. Please explain why the objectives are not achievable within the timeframe of the project.</p> <p>2.c.2. Has the objective always been unrealistic or unachievable, or has there been a change in the project or the circumstances that affected the objective?</p> <p>-Please describe why/how the objective is unrealistic or unachievable.</p> <p>2.c.3. How would you change the objective to make it more realistic or more likely to be achieved within the timeframe of the project?</p> <p>2.c.4. What could be done differently to make the objective more realistic or more likely to be achieved?</p> <p>2.c.5. What other factors would need to change to make the objective more realistic or more likely to be achieved?</p>
<p>Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?</p>
<p>PRM & UNHCR</p> <p>3.a.1. Do the activities conform to international GBV guidelines and/or standards?</p> <p>-If so, which ones? Please provide specific examples.</p> <p>3.a.2. What guidelines and/or standards are most relevant to your grantees' programs?</p> <p>3.a.3. Are there activities or aspects of the programs that could better reflect international guidelines and</p>

standards? If so, please provide specific examples.

3.a.4. Are there activities or aspects of the programs that do not conform to international guidelines and standards? If so, please provide specific examples.

3.a.5. Do you have any suggestions for how the programs could better conform to or reflect international guidelines and/or standards?

NGO Implementers and Local Partner Organizations

3.a.1. Do your activities conform to international GBV guidelines or standards? Please provide specific examples.

3.a.2. What guidelines or standards are most relevant to your program?

3.a.4. Are there activities or aspects of the programs that do not conform to international guidelines and standards? If so, please provide specific examples.

3.a.5. Do you have ideas for how the programs could better conform to or reflect international guidelines and/or standards?

3.a.6. In what ways did you consider international GBV guidelines or standards when you were developing your program activities?

Beneficiaries

3.a.1. Do you believe that the program follows national and/or international standards?

-For example, if you told someone on the staff in the program something personal, do you trust them not to tell anyone else in your community?

-Do they treat people who come to them with respect? If so, please give some examples.

-Do you think they understand the needs that you/others have? How do they show they understand your needs?

3.a.7. In your opinion, has the ARC/MTI program helped to prevent violence against women and girls?

3.a.8. Has the ARC/MTI program resulted in better services for women and girls who have experienced violence?

External Actors

3.a.1. Did participants have confidence in the ARC/MTI programs because they followed national and/or international standards? Can you give examples of standards that you think the program meets?

3.a.7. In your opinion, has the ARC/MTI program helped to prevent violence against women and girls?

3.a.8. Has the ARC/MTI program resulted in better services for women and girls who have experienced violence?

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and if so, how?

PRM & UNHCR

5.a.1. Are you aware of any negative outcomes of the project?

-If so, please provide a specific example.

-If so, how have you addressed them? How has the grantee addressed them?

-Has ARC/MTI done anything to mitigate or prevent the outcome from happening again in the future?

-What do you think can be done differently to prevent negative outcomes in the future?

5.a.2. Did the project produce any positive outcomes that were not planned or expected?

-If so, please provide a specific example.

-What have you done to replicate this outcome?

-Has ARC/MTI taken any action to replicate this outcome?

NGO Implementers and Local Partner Organizations

5.a.1. Are you aware of any negative outcomes of the project?

-If so, please provide a specific example.

-If so, how have they been addressed?

-Has anything been done to mitigate or prevent the outcome from happening again in the future?

-What do you think can be done differently to prevent negative outcomes in the future?

5.a.2. Did the project produce any positive outcomes that were not planned or expected?

-If so, please provide a specific example.

-What has been done to replicate this outcome?

Beneficiaries

5.a.3. Have you had any bad experiences due to your participation in the program?

- If so, please describe.

- Did you make the organization/program staff aware of your experience? If so, how did they respond? How do you

<p>feel about how they responded? - If you didn't tell anyone about your bad experience, why not? 5.a.4. Were there any unexpected positive (good) things that happened as the result of your participation in the program? If so, please describe.</p>
<p>External Actors 5.a.1. Are you aware of any unexpected negative consequences of the PRM-funded GBV programs? -If so, which programs/activities? -Did the organization address negative consequences? If so, to what extent and how? 5.a.2. Did you observe any unexpected positive consequences of the planning, implementation, or evaluation of PRM-funded GBV programs? -If so, which programs/activities? Please describe.</p>
<p>Evaluation Question 6: What factors explain any negative or unintended positive consequences?</p>
<p>PRM and UNHCR 6.a.1. Why do you think the project experienced positive outcomes that were not originally planned? (What caused the positive outcomes)? 6.a.2. Why do you think the project experienced negative outcomes? (What caused the negative outcomes)?</p>
<p>NGO Implementers and Local Partner Organizations 6.a.1. Why do you think your project produced positive outcomes that were not originally expected or planned? (What do you think caused these positive outcomes)? 6.a.2. Why do you think your project produced negative outcomes? (What do you think caused these negative outcomes)?</p>
<p>Beneficiaries 6.a.3. You said that you did not expect ____ to happen. Why do you think that it happened?</p>
<p>External Actors 6.a.1 and 6.a.2 Describe your observations of the factors that influenced or caused either unexpected negative consequences or unintended positive consequences.</p>
<p>Evaluation Question 7a: What outcomes did GBV awareness campaigns achieve?</p>
<p>PRM and UNHCR 7.a.1 Among the grantees/programs that conducted GBV awareness campaigns, what were the results and achievements? 7.a.3. Do the outcomes match your expectations? Please explain why or why not. 7.a.4. Do you think the outcomes are sustainable? 7.a.5. How could awareness campaigns be improved?</p>
<p>NGO Implementers and Local Partner Organizations 7.a.1 Did your organization conducted GBV awareness campaigns? If so, what were the results or achievements? 7.a.2. Do you have specific information or data to demonstrate the results/achievements? 7.a.3. Do the outcomes match your expectations? Please explain why or why not. 7.a.4. Do you think the outcomes are sustainable? 7.a.5. How could awareness campaigns be improved?</p>
<p>Beneficiaries 7.a.6. Describe how your awareness about violence against women and girls was affected by participating in this program. Did your awareness result in any changes in your life? 7.a.7. Do you think that increased awareness of violence against women and girls has resulted in any changes in the behavior of others (family members, community members including neighbors, police, military, others)? For example, has there been a reduction of violence, improved healthcare access, or increased prosecution of cases as the result of the awareness-raising? 7.a.8. How did your participation in this program assist you and your family you're your needs (safety, health, protection)? 7.a.9. What other things do you think have changed as the result of more awareness about violence against women and girls? 7.a.10. What would you suggest to improve awareness campaigns about violence against women and girls</p>

<p>in the future?</p> <p>7.a. 11. How do you think GBV awareness campaigns have influenced men and boys? Please explain.</p>
<p>External Actors</p> <p>7.a. 1. What outcomes do you think PRM funded GBV awareness campaigns have achieved? (increased safety, reduced violence, improved healthcare for survivors, etc.?)</p> <p>7.a.12. Do you think the program is likely to continue after funding has ended? If yes, how will the program supported?</p>
<p>Evaluation Question 9: What were the short and long-term outcomes of PRM-funded GBV prevention programs?</p>
<p>PRM, UNHCR and NGO Implementers</p> <p>9.a.1. Are there program outcomes that you consider to be short-term versus long-term? -If so, please explain.</p>
<p>Evaluation Directive 2: Appropriate Indicators for Measuring the Effectiveness for GBV Prevention Interventions in Refugee Settings – findings, best practices, and lessons learned</p>
<p>Evaluation Question 4a: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs?</p>
<p>PRM & UNHCR</p> <p>4.a.1. Did you provide grantees with any guidance on how to develop their indicators?</p> <p>4.a.2. Do you think that indicators used by the grantees are reliable and appropriate performance measures?</p> <p>4.a.3. Are there other indicators you would like your grantees to use? If yes, which ones?</p> <p>4.a.4. Are there international indicators for GBV prevention that would be useful for your grantees?</p> <p>4.a.5. Which of your grantees' indicators are most informative about their projects' progress?</p> <p>4.a.6. Which of your grantees' indicators are least informative about their projects' progress?</p>
<p>NGO Implementers</p> <p>4.a.2. Do you think that the indicators you use are reliable and appropriate measures of project progress?</p> <p>4.a.4. Are there international indicators for GBV prevention that would be useful for you to use?</p> <p>4.a.5. Which of your indicators are most informative about the projects' progress? Please explain why.</p> <p>4.a.6. Which of your indicators are least informative about the projects' progress? Please explain why.</p> <p>4.a.7. How did you decide which indicators to use?</p> <p>4.a.8. Did you consult any international documents/guidelines/standards when developing the indicators?</p> <p>4.a.9. Did you receive any guidance on indicators or how to measure the effectiveness of the program?</p> <p>4.a.10. Can you provide specific examples (reduction of violence, healthcare access, prosecution, protection) of indicators that have improved as a result of the GBV programs?</p>
<p>Beneficiaries</p> <p>4.a.11. In your opinion, what has improved in your community because of the GBV programs? Can you give specific examples (reduction of violence, healthcare access, prosecution, protection)?</p>
<p>Partner Organizations & External Actors</p> <p>4.a.4. Which international indicators for GBV prevention do you feel are most useful?</p> <p>4.a.10. Can you provide specific examples (reduction of violence, healthcare access, prosecution, protection) of indicators that have improved as a result of the GBV programs?</p>
<p>Evaluation Question 4b: Are the indicators in the project proposal specific, measurable, achievable, realistic, and time-bound (SMART)?</p> <p>(S) Specific –Does it cover one rather than multiple activities?</p> <p>(M) Measurable—Can it be quantified? Can it be counted in some way?</p> <p>(A) Appropriate— Is the objective important to the work we are doing?</p> <p>(R) Realistic—Can the objective be achieved with the resources available?</p> <p>(T) Time-bound—Does the objective give a time frame by which the objective will be achieved?</p>
<p>PRM, UNHCR and NGO Implementers</p> <p>4.b.1. Are you familiar with what a SMART indicator is?</p> <p>4.b.2. Please explain whether you think your project indicators are specific, measurable, achievable, realistic, and time-bound. Please provide specific examples.</p> <p>4.b.3. If you do not think that program indicators are SMART, how could you change/improve them to ensure that</p>

they meet these criteria?
NGO Implementers and Local Partner Organizations
4.b.4. How do you determine if your objectives have been reached?
4.b.5. What specific measures (indicators) do you use?
4.b.6 How do you actually measure the above?
4.b.7. Do you think you will be able to achieve (the specific indicators identified above)?
Beneficiaries
4.b.8. Do you know how the organization knows if it has achieved its objectives?
4.b.9. How well do you think that information demonstrates the effectiveness of the program?
External Actors
Are you aware of the indicators used to measure effectiveness of the programs?
4.b.10. How realistic do you believe these indicators are?
4.b.11. In your opinion, which indicators are most useful for GBV programs?
Evaluation Question 4c: Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
PRM, UNHCR, NGO Implementers and Partner Organizations
4.c.1 Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, 1) which indicators, and 2) for what reasons?
Evaluation Question 7b: Are the indicators for GBV awareness campaigns SMART?
All Respondents (except beneficiaries)
7.b.1. Are the indicators for GBV awareness campaigns SMART? Describe how they are:
7.b.2 Describe how they are (S) Specific.
7.b.3 Describe how they are (M) Measurable.
7.b.4 Describe how they are (A) Appropriate.
7.b.5 Describe how they are (R) Realistic.
7.b.6 Describe how they are (T) Time-bound.
7.b.7. How can indicators for GBV awareness campaigns be improved?
Evaluation Directive 3: Best Practices and Lessons Learned in Engaging Men and Boys in GBV Prevention and Response Interventions in Refugee Settings
Evaluation Question 8a: To what extent have men and boys been included in GBV prevention programs?
PRM, UNHCR, NGO Implementers and Local Partner Organizations
8.a.1. What information do you have about sexual violence/exploitation of men or boys in the communities you work with?
8.a.2 To what extent have men and boys been included in GBV prevention programs?
-If they were included, describe.
-If they were not included, why was this?
Beneficiaries
8.a.1 Is sexual violence/exploitation of men or boys a problem in your community?
8.a.2. To what extent have men and boys been included in GBV prevention programs?
-If they were included, describe.
-If they were not included, why was this?
Evaluation Question 8c: Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
All Respondents
8.c1. Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?

Annex IV: Evaluation Contacts and Key Informants

PRM & UNHCR (n=14)

Name	Title	Association
Bryan Lupton (m)	Program Officer, Great Lakes Region	DoS/PRM – Washington, DC
Greg Shaw (m)	Refugee Coordinator, Great Lakes Region	DoS/PRM—Kampala
Annie Gacukuzi (f)	Refugee Program Assistant	DoS/PRM—Kampala
Sakura Atsumi (f)	Deputy Country Representative	UNHCR—Kampala
Elsa Bokhre (f)	Community Services Officer	UNHCR—Kampala
Josephine Ngebeh (f)	SGBV Expert	UNHCR—Kampala
Dr. Julius Kasozi (m)	Reproductive Health & GBV	UNHCR—Kampala
Alice Litunya (f)	Head of Sub-Office	UNHCR—Hoima
Olga Ruza (f)	GBV Focal Point, Community Services Associate	UNHCR—Kyangwali
Anwar Morshed (m)	Head of Sub-Office	UNHCR—Mbrara
Maureen McBrien (f)	Senior Field Coordinator	UNHCR—Mbrara
Kofi Dwomo (m)	Protection Officer	UNHCR—Mbrara
Christopher Kizito (m)	Assistant Program Officer	UNHCR—Mbrara
Tryphosa Byakika (f)	Protection Officer	UNHCR—Nakivale

Implementing Partners (ARC and MTI) (n=19)

Name	Title	Association
Gaznabi Mahmoud (m)	Country Director	ARC—Kampala
David Karamagi- (m)	Monitoring and Evaluation Manager	ARC—Kampala
Florence Adiya (f)	Regional GBV Program Coordinator (Nakivale Settlement)	ARC—Kampala
Bernard Ojom (m)	Regional GBV Program Coordinator (Kyangwali Settlement)	ARC—Kampala
Filder Sharon Odong (f)	Regional Program Coordinator – North	ARC—Kampala
Caroline Eonya Afim (f)	Program Officer	ARC—Kyangwali
Rehemah Kabatooro (f)	Program Officer	ARC—Kyangwali
Stephen Itiakorit (m)	Program Officer	ARC—Kyangwali
Janepher Nshemereorwe (f)	Case Manager	ARC—Kyangwali
Sam Obonyo (m)	Legal Officer	ARC—Kyangwali
Oyo Peace Michelle (f)	GBV Program Social Worker	ARC—Nakivale
Tangimpunda Mathilde (f)	GBV Assistant	ARC—Nakivale
Murning Philbert (m)	Legal Officer	ARC—Nakivale

Luuba Rogers (f)	Child Protection Assistant	ARC—Nakivale
Kamusiime Julian (m)	Protection Manager	ARC—Nakivale
Daniel Ward	Director, Africa	MTI- Kampala
Dr. Patrick Okello (m)	Program Manager, Southwestern Region	MTI—Mbrara
Dr. Charles Lajuu (m)	Senior Clinical Officer	MTI—Nakivale
Rose Sanyo (f)	Midwife and GBV focal point	MTI—Nakivale

Local Partner Organizations (n=7)

Name	Title	Association
Redina Kabasambu (f)	Gender and Community Development Officer	AAH—Kyangwali
Grace Asiimwa (f)	GBV Counselor	AAH—Kyangwali
Philippa Bbaale (f)	Medical Doctor	AAH—Kyangwali
Opendi Oweno (m)	Head Officer for the Settlement	Police—Kyangwali
Amos Kirya (m)	Assistant Settlement Officer	OPM—Kyangwali
Frank Katungye (m)	Officer in Charge at Post	Police—Nakivale
Alfonse Nshakirahe (m)	Detective Corporal	Police—Nakivale

Beneficiaries and Refugee Community Members (n=24)*

Name	Description	Association
3 males, 1 female	Refugee Welfare Council Members	Kyangwali refugee
3 males, 1 female	Community Activists (ARC volunteers)	Kyangwali refugee
1 female	GBV survivor at Safe House (new arrival)	Kyangwali refugee
2 males	Community Leaders	Nakivale refugee
8 males, 5 females	Community Volunteers	Nakivale refugee
1 male, 1 female	GBV survivors	Nakivale refugee

*15 refugees (10m, 5f) were interviewed in Nakivale; some fit multiple descriptions

External Actors (n=2)

Name	Title	Association
Roselidah Ondeko (f)	Senior GBV Coordinator	UNFPA—Kampala
Primo Madra (m)	GBV Programs	UNFPA—Kampala

Annex V: GBV Prevention Indicator Compendium

International guidelines recommend the use of standardized indicators and M&E tools across GBV prevention programs. The GBV Prevention Indicator Compendium includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation. PRM-funded NGO implementers sometimes use adaptations of indicators presented in the compendium. Increased use of common indicators across programs, countries, and donors would enable more rigorous reporting and evaluation of impact. In addition, indicators that collect information about measures taken to prevent or reduce GBV would be useful in planning, monitoring, and evaluating other non-GBV-focused programs funded by PRM. Indicators in bold text are “priority” indicators. Managers should encourage NGO partners to use at least one of these indicators if relevant for each project.

Indicator	Sector, Activity	Source
Designing services		
There is a comprehensive understanding of the specific risk factors faced by women, girls, men, and boys in camp settings and this analysis is incorporated in security provisions within the camps.*	Camp coordination and management	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Training on GBV-related issues and potential risk factors is conducted for an equal number of female and male humanitarian workers to enable them to provide support to affected persons and direct them to adequate information and counseling centers. Training one male and one female meets this indicator.*	Camp coordination and management	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Women participate directly in decision-making on local security arrangements for the camp community.*	Camp coordination and management	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Percentage of teachers signing codes of conduct.	Education	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
“Safe spaces” are created at the distribution points and “safe passage” schedules created for women and children head of households.*	Food distribution	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men are involved in the process of selecting a safe food distribution point.*	Food distribution	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Distribution is conducted early in the day to allow beneficiaries to reach home during daylight. *	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Food distributions are done by a sex-balanced team.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of females involved in food distribution committees.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of food distributed to women.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
24-hour access to sexual violence services.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Confidential referral mechanism exists for health and psychosocial services for rape survivors.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Staff are trained on the clinical management of rape.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of community-based workers trained in sexual violence psychosocial support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of health staff trained in sexual violence medical management and support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Survivors/victims of sexual violence receive timely and appropriate medical care based on agreed-upon medical protocol.*	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Percentage of reported rape cases where survivor receives post-exposure prophylaxis for HIV (PEP) within 72 hours of incident	Health & Community Services	"United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Response.info Indicators Registry" 2014

Indicator	Sector, Activity	Source
Number of copies of resource list in local language(s) distributed in community.	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are in place to ensure income-generation activities and economic options for women and girls so they do not have to engage in unsafe sex in exchange for money, housing, food, or education—or are exposed to GBV because of being economically dependent on others.*	Livelihoods	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men participate in the identification of safe and accessible non-food item NFI distribution sites.*	Non-food items	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
NFI distribution points are monitored to ensure they are safe and accessible.*	Non-food items	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate quantities of sanitary supplies distributed to women and girls.*	Non-Food Items	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Both women and men participate in the identification of safe and accessible sites for water pumps and sanitation facilities.*	Water and Sanitation	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate number of latrines for each sex constructed and have locks (Sphere standard).*	Water and Sanitation	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Improving accountability		
Proportion of key actors who participate in regular GBV working group meetings.	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Staff are aware of and abide by medical confidentiality.*	Health	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of actors issuing codes of conduct.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

Indicator	Sector, Activity	Source
Proportion of reported sexual exploitation and abuse incidents resulting in prosecution and/or termination of humanitarian staff.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Security mechanisms instituted based on where incidents occur, and monitored for effectiveness.*	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
A referral system for reporting of security and abuse incidents is operational.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Mechanisms put in place to ensure people can report any harassment or violence.*	Shelter	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Monitoring and documentation		
A mechanism is in place for monitoring security and instances of abuse.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Facilities and collection points are monitored to ensure they are safe and accessible (e.g. locks, lighting).*	Water and Sanitation	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
High risk security areas are monitored regularly at different times of day.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Multisectoral and interagency procedures, practices, and reporting forms established in writing and agreed by all sectors.*	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are monitored for possible negative effects of changes in power relations (e.g. rise in domestic violence due to women's empowerment).*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Regular observation visits are undertaken to distribution points, security checkpoints, water and sanitation facilities, and service institutions (e.g. schools and health centers).*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Reports on sexual violence incidents compiled monthly (anonymous data), analyzed, and shared with stakeholders. *	Assessment & Monitoring	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Routine spot checks and discussions with communities to ensure people are not exposed to sexual violence due to poor shelter conditions or inadequate space and privacy.*	Shelter	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Security and instances of abuse are monitored.*	Protection	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Workplaces are monitored and instances of discrimination or GBV are addressed.*	Livelihoods	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Rebuilding support systems		
Community-based plan for providing safe shelter for victims/survivors developed and used effectively.*	Shelter & Site Planning	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Transforming norms		
Informational campaigns for men and women about the health risks of sexual violence to the community.**	Health	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of IEC materials using verbal or visual messages (i.e. accessible to non-literate populations).	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of individuals who know any of the legal rights of women.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of individuals who know any of the legal sanctions for GBV.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who have been exposed to GBV prevention messages.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who say that wife beating is an acceptable way for husbands to discipline their wives.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010

Indicator	Sector, Activity	Source
Proportion of people who would assist a women being beaten by her husband or partner.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Women and men in the community, including village leaders and men’s groups, are sensitized to violence against women and girls, including domestic violence.*	Protection	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Working with legal systems		
Police officers (male and female) patrol the camps.*	Camp coordination and management	“Women, Girls, Boys and Men: Different Needs – Equal Opportunities,” Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of reported incidents of sexual violence where survivor/victim (or parent in the case of a child) pursues legal redress.	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

Nota bene: These indicators listed in the IASC and other guidelines are examples to follow. According to M&E best practices, the “indicators” marked with an asterisk are not truly structured as indicators, but rather as results statements, i.e. specific results that an intervention would hope to achieve through its activities. The “indicator” marked with two asterisks is an activity that an NGO might undertake to achieve a given result. Social Impact does not feel comfortable changing these indicators, as they have been produced by the humanitarian community for GBV programming. The 2005 IASC indicators are currently under review and subject to revision. In the meantime, Social Impact recommends that PRM examine the [“United Nations Office for the Coordination of Humanitarian Affairs \(OCHA\) Humanitarian Response.info Indicators Registry”](#) in order to seek out adaptations of these results statements in true indicator format.

Annex VI: NGO Implementer Progress Toward Proposed Objectives

As of May 31, 2013,¹⁷ ARC had achieved the following progress toward program objectives:

Objective 1. Strengthen the capacity of community partners to prevent GBV in Kyangwali Settlement.

- 100% of community groups displaying an increase in understanding and skills related to GBV prevention and response as evidenced by increased technical capacity assessment scores [80% progress toward target: 160 of 200 Community Activists trained and mentored]
- 100% of the community population reached during monthly awareness raising activities [40% of the community population of 21,789 reached]
- Two survey outcome areas of Knowledge and Attitudes displaying a progressive shift [survey to be conducted]
- 160 men involved in GBV prevention activities through sharing and/or receiving GBV prevention messages [100%, target realized]
- 160 men and boys trained in GBV prevention, mobilization, listening, and awareness creation skills [100%, target realized]
- 140 (one club of 20 members at each of the seven schools) youth trained on sexual reproductive health (SRH) information [100%, target realized]
- Seven schools receive monthly (or bi-weekly) information sessions on SRH, 25/56 planned sessions have been conducted [45% of target]
- Seven Youth Clubs formed in seven schools [100%, target realized]
- 21 parent-youth dialogues, youth debates/drama on SRH, GBV [to be conducted]
- 10 security personnel trained on GBV and referral pathways [to be conducted]

Objective 2. Improve access to high quality multi sectoral services for GBV survivors in sixteen Villages of Kyangwali Refugee settlement (Response).

- 100% of villages have trained GBV community-based structures that have completed the training series in psycho-social support and case management [to be conducted]
- 74 police, legal, and traditional justice participants trained who demonstrate an increased knowledge based on pre- and post-tests at the end of the training, 38/74 of police, legal and traditional justice trained [51% progress toward target]
- 30% increase in the number of survivors supported by ARC directly [100% progress toward target; all 75 reported cases received psychosocial support as well as appropriate medical support]
- With survivor (n=77) consent, direct or referral services made available to GBV survivors who report the incident [100%, target realized]
- 100% of calls to the hotline seeking GBV direct or referral services responded to, a total of 3,145 call responded to between September 2012-May 2013 [100%, target realized]
- 20 health providers trained on clinical management of rape (CMR) and referral pathways [no information]
- 100% of eligible rape survivors receive PEP and ECP within 72 hours and 120 hours respectively [80% progress towards target]

¹⁷ Results reported in ARC quarterly report covering March 1-May 31, 2013.

- 75% of health providers trained on HIV prevention, preventing mother to child transmission (PMTCT) testing and counseling, family planning (FP) counseling and method provision, informed choice and addressing issues of discrimination and stigma [to be conducted]
- Two health centers with Family Planning counseling and information integrated into antenatal care (ANC), CMR, HIV testing and counseling services [to be conducted]

Objective 3. Strengthen effective GBV referral pathways and coordination mechanisms through provision case management and technical support to Nakivale Settlement.

- One GBV Standard Operating Procedure and community referral pathway updated [100%, target realized]
- 100% of villages have trained GBV community-based structures who have completed the training series [54% progress towards target]
- With survivor consent, direct or referral services made available to GBV survivors who report the incident [100%, target realized]

As of April 31, 2013,¹⁸ MTI achieved the following progress toward stated GBV response objectives:

Objective G: Improved quality of response to incidences of SGBV in six clinics in both Nakivale and Oruchinga settlement.

- All cases of SGBV survivors receive timely and appropriate medical services in order to reduce risk to infection, stigma or other health consequences, 17 survivors were treated in the quarter and 67 total cases have received care and treatment including psychosocial support over the funding period [100%, target realized]
- 20 health workers trained in clinical management of SGBV survivors including forensic evidence, PEP, and emergency [15 health workers trained, 80% progress toward target]
- 100% of SGBV survivors who report to a clinic are examined and treated [100%, target realized]
- 100% of SGBV survivors who report to a clinic are screened for STI and provided PEP within 72 hours of incident [100%, target realized]
- 100% of SGBV survivors who are provided PEP are followed up with after one month [100%, target realized]
- 100% of SGBV survivors who report to a clinic receive psychosocial assessment and counseling in a private area of the clinic [100%, target realized]
- 100% of SGBV survivors who report to clinics are followed up at the home level with psychosocial counseling and support at week one, week six and in the third month [100%, target realized]
- 25 health workers trained in psychosocial counseling for SGBV survivors [12 health workers trained, 80% progress toward target]
- Referral pathway is established, distributed, and maintained to all six health centers [100%, target realized]
- Multi-sectoral and inter-agency SGBV working group established and meets quarterly, 3 meetings held [100%, target realized]

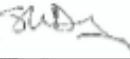
¹⁸ Results reported in February 1-April 31, 2013 quarterly report.

Annex VII: Disclosure of Conflicts of Interest

Disclosure of Conflict of Interest for DoS Evaluation Team Members


Name	Shannon Doocy
Title	Associate Professor
Organization	Johns Hopkins School of Public Health
Evaluation Position?	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
Evaluation Award Number (or RFTOP or other appropriate instrument number)	
DoS Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	None
I have real or potential conflict of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	Jan 23, 2013

Name	NANCY GLASS
Title	Associate Professor
Organization	Johns Hopkins University
Evaluation Position?	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
Evaluation Award Number (or RFTOP or other appropriate instrument number)	
DoS Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	
I have real or potential conflict of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	1/24/2013



U.S. Department of State
2201 C Street NW
Washington, DC 20520