

**ENDLINE EVALUATION OF THE UNFPA SUPPORTED
PREVENTION AND MANAGEMENT OF GENDER
BASED VIOLENCE IN ETHIOPIA
PROGRAMME**



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Acronyms

ADA	Amhara Development Association
AWSAD	Association for Women Sanctuary and Development
BIGA	Bright Image Generation Association Safe House
CBO	Community Based Organizations
CC	Community Conversation
CCCs	Community Counselors Committee
DAB-DRT	DAB Development Research and Training
DAC	Development Assistance Committee
ECFE	Evangelical Church Fellowship of Ethiopia
ECS	Ethiopian Catholic Secretariat
EECMY-DASSC NAW	Ethiopian Evangelical Church Mekane-Yesus Development and Social Service Commission- North Area Work
EMDA	Ethiopian Muslim Development Agency
EOTC-DICAC	Ethiopian Orthodox Church- Development Inter-Church Aid Commission
ESOG	Ethiopian Society of Obstetricians and Gynecologists
EWLA	Ethiopian Women Lawyers Association
FBOs	Faith Based Organizations
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FPC	Federal Police Commission
GBV	Gender Based Violence
GTP	Growth and Transformation Plan
HEW	Health Extension Workers
HTPs	Harmful Traditional Practices
IGA	Income Generating Activities
IPs	Implementing Partners
IRCE	Inter-Religious Council of Ethiopia
MCRC	Mother and Child Rehabilitation Center
MDG	Millennium Development Goals
MEL	Monitoring, Evaluation and Learning
MFC	Model Fathers' Clubs
MMC	Model Mothers' Clubs
MLWDA	Mujejeguwa-Loka Women Development Association
NCA	Norwegian Church Aid
NCWH	National Coalition for Women against HIV/AIDS
NGO	Non-Governmental Organizations

ODA	Oromo Development Association
OECD DAC	Organization for Economic Cooperation and Development, Development Assistance Committee
OSSA	Organization for Social Services, Health and Development
SNNPR	Southern Nations, Nationalities and Peoples' Region
SRH	Sexual and Reproductive Health
ToR	Terms of Reference
UNEG	UN Evaluation Group
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
WAC	Woreda Advisory Committee
WDAs	Women Development Armies
WHO	World Health Organization

The views expressed and the arguments made in this document are those of the author and do not necessarily reflect the views of UNFPA

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Executive Summary

The evaluation team of DAB assessed the impact of Phase II of the UNFPA *Prevention and Management of Gender-Based Violence in Ethiopia Programme* implemented from October 2012-December 2015 with funding from the Kingdom of Netherlands Embassy. The programme was implemented by 12 implementing partners (11 NGOs and 1GO) in Benishangul-Gumuz, Amhara, Tigray, SNNP, and Oromia Regional States and Addis Ababa City Administration. The evaluation assessed the relevance, effectiveness, efficiency, impact and sustainability of the programme in order to identify lessons and good practices that can improve future efforts on the prevention and management of GBV in Ethiopia.

The evaluation involved the implementing partners, the funding agency, programme right holders including survivors, grass-root structures, religious institutions, club focal persons in schools and universities involved in the programme, health extension workers, Women and Children Affairs Offices and others. A blend of participatory tools and techniques were used in the evaluation including exhaustive desk review of secondary sources, and qualitative and quantitative research. Using a structured questionnaire as a tool and trained enumerators and supervisors, data was collected through an interview of 360 randomly selected programme participant households and the data was subjected to rigorous cleaning and statistical analysis to summarize and present the information.

The public protests that occurred in various locations in the country which coincided with the data collection period for this evaluation delayed the data collection process in some intervention areas and posed challenges to access direct information. The undertaking of the evaluation after the phase out of some of the programme initiatives also posed challenges to access implementers and project staff for interviews. However, phone interviews and additional interviews with central offices have been conducted to maintain the quality of the evaluation report. It was also challenging to generate data on GBV due to the sensitive nature of the subject matter and the cultural and social barriers surrounding the problem. However, the data collection process involved building trust with interview participants to obtain their perspectives towards the programme interventions as well as their personal experiences.

The programme's objectives were consistent with the evolving needs and priorities of right holders, partners and stakeholders, communities, the national priorities of the country and UNFPA's mandate. This was confirmed by empirical findings whereby more than 95% of individual right holders witnessed that the programme intervention was highly relevant from the perspective of their own and community interests. The programme's interventions were also relevant to build the capacities of implementing partners and government institutions, particularly law enforcement bodies at different levels through mainstreaming gender and GBV. The objectives remain to be valid for future work on prevention and control of GBV.

UNFPA and its implementing partners used different participatory approaches and strategies to carry out prevention, protection, care and capacity building activities. The interventions include awareness creation campaigns through community conversation using community ambassadors; media campaigns; provision of safe house services; livelihood support; and medical and psychological support. The family dialogue and community conversation strategies created spaces for dialogues on gender and GBV issues and prompted community solidarity to fight GBV while the use of role models and gate keepers such as religious leaders and local community elders was also found to be relevant to gain trust and break taboos on GBV. In contexts where there is a limited framework for women's agency, secret boxes and hotlines services enabled GBV information to be expressed and communicated anonymously. Peer education through girls'

clubs in schools and youth clubs and print media and radio transmissions of GBV have been powerful approaches to reach wider public.

Three key approaches – community conversation, training and awareness raising events – were used contributing to substantial achievement of programme interventions in raising awareness of the community about GBV and its associated health, economic and social consequences. This was witnessed by empirical findings whereby close to 50% of survey participants claimed that CC was the major source of their knowledge about GBV, with trainings being the second best source of information with 71%. Over the course of the implementation period, UNFPA used its wealth of expertise and contributed to capacity development of implementing partners through trainings, discussions, technical support, networking and other possible means to make the programme more efficient and effective.

The programme interventions increased communities' knowledge of GBV and created strong initiation among community members to protect girls from GBV and to undertake prevention measures. GBV incidences such as female genital mutilation, rape, early marriage and physical abuse have started to decline and reporting of such incidences has increased. Moreover, GBV survivors' confidence and assertiveness have also increased. The interventions have also contributed to overall improvement of livelihoods in terms of building confidence, decision making power, and economic benefits. Moreover, the programme interventions have increased involvement of men in prevention of GBV interventions and increased their participation in domestic activities.

However, there is still a gap between knowledge/awareness and practices, and GBV reporting is still very low due to survivors' fear of public discrimination and retaliation by perpetrators. Culture and traditions surrounding GBV and inconsistent, inadequate and biased responses of law enforcement bodies have also been found to be contributing factors for GBV occurrences.

Qualitative information from the Implementing partners indicated that several of them have managed to be cost efficient by adopting various mechanisms and the budget utilization was generally efficient. It has also been noted that some of the IPs which underutilized their budgets have reported lack of financial resources to accomplish their activities.

The relentless efforts and commitment of UNFPA and its IPs have also managed to bring about inspiring outcomes and impacts, and this can be proved by the 91% of programme right holders who affirmed that the GBV programme interventions have substantially impacted their health, social and economic status as well as their psychological perspectives.

Overall, most of the GBV services and activities have shown prospects of continuity after the UNFPA supported GBV programme phases out. UNFPA along with its IPs have made strong efforts in the exit strategy and these are believed to be instrumental in maintaining the impacts and sustaining the programme initiatives.

There are positive indications to sustain GBV prevention and management initiatives. In spite of a range of evidences to justify this, however, there are also observed challenges that could hinder its sustainability such as limited commitment of government offices, prevailing attitudes among communities condoning GBV, and weak capacity of community actors to sustain the activities in some intervention areas.

The GBV programme implementation has not been operating without challenges. One major challenge pertained to inadequacy of budget to accommodate the increasing demands of communities/GBV survivors. Delays in fund release and UNFPA's strict requirement of budget utilization report on a quarterly



basis limited the use of available finance and execution of trans-phase activities. However, UNFPA was flexible enough to transfer unutilized budget to next quarter on conditions that IPs submit reprogramming and transfer requests in a timely manner. The still prevailing attitude among communities to condone GBV and settle incidences out of court is an outstanding challenge to the programme which is compounded by shortage of safe houses and ineffective coordination among stakeholders.

A number of good practices were identified in the process of implementation of the programme warranting scaling-up. The livelihood interventions that were introduced in Phase II of the programme produced remarkable results in terms of equipping survivors with skills to lead normal and independent life after they leave the safe house. The use of existing community structures contributed to efficient and sustainable use of resources by IPs. Increased involvement of men in combating GBV was another good practice worth noting. The development of codes of conduct and standard operating procedures on response and prevention of GBV should also be mentioned. The introduction of a radio program and hotline services in this phase of the programme has also been very important in headways made in awareness creation on and reporting of GBV. The attempts made to engage faith-based organizations and introduce GBV in the curricula of theological training institutions was yet another good practice that paid dividends.

1. Introduction

1.1. Background of the Evaluation

The baseline survey that was conducted by UNFPA and its partners following the inception of the *Prevention and Management of Gender Based Violence in Ethiopia Programme* provided data on the prevalence of GBV mainly in the form of forced marriage, trafficking for sex, trafficking for labor, female genital mutilation/cutting, denying girls the right to education, underage sex work, and sexual abuse of children (under 15). The study also uncovered violence in the form of wife beating, bigamy and polygamy, dishonoring, requiring the wife to do some degrading work, wife inheritance, early marriage, and abduction.

The main causes of GBV in the sample communities were reported to be lack of awareness, substance abuse, poverty, misconduct, male superiority and disagreement. The report generally indicated that women were the disproportionate survivors of GBV – those women and children from poor economic background being even more victimized. The report also documented the prevalence of low self-reporting among survivors because of pervasive psychological pressure inflicted upon them in terms of social stigma for exposing the incidence, threats from perpetrators and social pressure from the elderly to resolve incidences amicably.

In response to the prevalence of GBV in Ethiopia, phase II of the *Prevention and Management of Gender-Based Violence in Ethiopia Programme* was implemented from October 2012-December 2015 with fund from the Kingdom of Netherlands Embassy. The programme mainly focused on addressing gender based violence through increased knowledge and response of communities and other stakeholders on GBV and sexual and reproductive health (SRH); increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV; and increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV. The programme employed various participatory intervention strategies such as (1) Enhancing capacity development of governmental and non-governmental organizations to address issues related to GBV; (2) Conducting advocacy, public education and awareness campaigns using various channels; (3) Building the capacity of law enforcement bodies, health service providers, university students and teachers, and youth, women, community leaders and religious groups through provision of trainings and other platforms; (4) Provision of shelter, health and psycho-social services to survivors of GBV and appropriate services for perpetrators of violence; (5) Engagement of popular figures as role models to address and strategically advocate against GBV; and (6) Strengthening coordination mechanisms on GBV at federal and regional levels.

1.2. The Context of Gender Based Violence

Gender based violence is violence directed at an individual based on his/her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. The United Nations Declaration on the Elimination of Violence against Women defines it as any act of violence that results in, or is likely to result in physical, sexual, and psychological abuse: threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. Gender based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/ cutting (USAID). GBV is one of the most systematic and prevalent human rights abuse in the world. It is a global health, human rights and development issue that transcends geography, class, culture, age, race and religion to touch every

community in every corner of the globe. Although violence cuts across all socio-economic groups and individuals of every sort, studies indicate that women living in poverty are at higher risks of violence than their counterparts with better economic conditions (Heise (1999) cited in Heise and Ellsberg (2001:43). GBV against women is a product of gender subordination, psychological behaviors, and mainstream beliefs about women's role in sexual situations (Eschborn 2003:16). Women's subordinate social, economic, and legal status in different settings often makes it difficult for them to get help once violence occurs (USAID 2006). Absence of laws and policies and lack of commitment to enforce the existing laws and policies (UN Women, 2011: vii) and excessive use of alcohol and drugs also contribute to GBV.

Among the cause of GBV in Ethiopia are culture, harmful traditional practices, poverty, and low level of community awareness. Studies indicate that violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors (Panos 2003; Belay Hagos 2005; UN 2005; WHO, 2002). For instance, traditions that approve of male superiority tolerate or even justify violence. In addition, sanctions imposed by the society against perpetrators are not tough and may also contribute to the problem.



According to the World Health Organization (2013), one in every three women has been beaten, coerced into sex or abused in some other way- most often by someone she knows, while another report from 2014 claims that one in five women is sexually abused as a child. In the case of Ethiopia, evidence from different community based studies indicate that 50 to 60 % of women experienced violence in their life time and sexual violence is reported to occur more than physical violence while the perpetrators are mainly intimate partners and close family members (Gossay et al 2003). 59% of women in Ethiopia reported that they face sexual violence by a partner and 46% of the women were physically forced to have sex while 71% of women face either sexual or psychological violence at some point in their lives (Garcia 2006). A school based study involving randomly selected 1,401 female high school students in

central Ethiopia also showed that sexual harassment was reported by 74% of the participant female students and about 85% of the reported rape survivors were under 18 years of age, while among the girls who reported to have been raped, 24% had vaginal discharge and 17% have become pregnant (Mulugeta et al, 2008).

The pervasive gender disparities and gender-based violence in Ethiopia can also be shown by the very low female literacy rate (16.9%), high prevalence of female genital mutilation (74.3%) and persistent violence against women. Based on a weighted index of health and survival, economic participation and opportunity, educational attainment and political empowerment, the 2015 Global Gender Gap Report ranked Ethiopia 124th among 145 countries covered in the report.

GBV prevents women from enjoying their human rights and fundamental freedoms such as the right to life and security of a person, to the highest attainable standard of physical and mental health, to education and participation in public life (UN In-depth Study 2006:57; DEVAW 1993; Beijing 1995), and jeopardizes their bodies, psychological integrity and freedom (Merry 2003:996). The physical injuries caused by GBV range from cuts and bruises to more serious conditions like broken bones and loss of consciousness while rape survivors are very likely to suffer from injuries resulting in unconsciousness or in some cases death (UNFPA 1998:13). Sexual victimization of women through rape and sexual assault also usually results in unintended pregnancy and is a risk factor for sexually transmitted disease like HIV/AIDS. GBV against women has also long-lasting psychological impacts including depression, high risks of anxiety, fear, low self-esteem, and anguish, post-traumatic depression, sleeplessness and lapses of concentration, isolation, and withdrawal (Eschborn 2003:13). The health and psychological impacts of GBV could also affect girls' academic achievement and full participation in development as women cannot fully devote their labor or creative ideas when they are burdened with the psychical and psychological harms (Bates 2004). In Ethiopia, GBV was found to be a factor to both the low enrollment and school dropout for girls (Save the children).

In spite of the overwhelmingly negative impact of violence against women on individuals and societies, it is often sanctified by customs and reinforced by institutions limiting women's rights, their decision-making power and their recourse to protection from violence. As such, violence against women is both an outcome and an expression of women's subordinate status in relation to men in societies in Ethiopia where women are greatly affected by the aforementioned forms of GBV in one way or the other, despite their numerical significance and remarkable contribution to socioeconomic development.

1.3. National Policy and Legal Frameworks

The Government of Ethiopia has acknowledged that gender based violence against women and girls is a fundamental violation of human rights and a constraint to development, and has issued relevant policy and legal frameworks towards challenging the problem. The 1991 National Policy on Ethiopian Women has the objective of ensuring the democratic and human rights of women, and modifying or abolishing existing laws, regulations, customs and practices which aggravate discrimination against women. The guarantee of human and democratic rights, a step-by-step elimination of prejudices and the legal protection of women has also been mentioned as a strategy to implement the policy. The 1995 FDRE Constitution, recognizing the historical legacy of inequality and discrimination as a ground for contemporary inequality between men and women in political, social and economic life, provides in its Article 35 that women are entitled to equal rights with men. . Art. 35(4) also stipulated that the state shall enforce the rights of women to eliminate harmful laws, customs and practices that cause bodily and mental harm.

The 2000 Federal Family Code of Ethiopia legislates against child, early and forced marriages while the whole Chapter III of the 2005 Criminal Code of Ethiopia is devoted to criminalizing harmful traditional practices that cause injuries, health problems and the deaths of human lives. Though the Chapter is of general application, it is particularly relevant to violence against girls and women. In particular, Articles 561-570 of the Code are relevant.

The 2001 “Blue Book” of the FDRE Ministry of Education, which serves as a Guide Book on educational administration, organization, societal participation and financial matters, also deals with the rights and duties of students, and under item number 2.5. The book has an extensive list of duties of students, including the duties to *refrain from threatening, harassing, raping, beating and violating the human rights of female students* (emphasis added) among others. In its third part, the guide also deals with societal participation, appeals to the society to send their girl children to schools and to participate in collaboration with schools administrations in fighting against the harassment and raping of schoolgirls, and through societal participation and the involvement of parents of students, it provides for measures to be taken against students who violate their duties mentioned in there. The other FDRE legislation addressing forms of GBV, particularly those occurring at work places, is the Civil Servant Proclamation (No.515/2007). Art. 68(13) of this proclamation explicitly integrates sexual violence among offenses that entail rigorous penalties while it also further stipulates about initiating physical violence at work place in Art.68(5) and (8). In Article 70, it indicates some of the measures to be taken against the offenses.

Among other legal efforts against GBV is the directive of the Ministry of Education (November 2010) which aimed at reducing and eliminating sexual harassment in higher education institutions by protecting students from harassment and punishing perpetrators. Application of the directive isn't limited to the institutions' compounds as long as harassment involves members of the campus community as perpetrators and survivors. The FDRE Ministry of Women, Children and Youth Affairs developed in 2013 a National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia.

Despite these relevant policy and legal frameworks, GBV remains rampant throughout Ethiopia and women continue to suffer from violence and denial of their rights in one form or another. In response to the widespread prevalence of GBV in Ethiopia, UNFPA has, with its partners, been engaged in implementing programmes aimed at reducing the intensity of the problem. The expected outcome of the UNFPA *Prevention and Management of Gender-Based Violence in Ethiopia Programme* was “to see by 2015, women, youth and children are increasingly protected and rehabilitated from abuse, violence, exploitation and discrimination.” While progress reports so far documented major achievements on the multi-dimensional aspects of GBV in the country, broader impact evaluations are needed by UNFPA to evaluate the program's achievements against baseline targets and prescribed expected outcomes.

With the ambitious expected outcomes of the programme and the baseline status quo in mind, DAB-DRT evaluated the impact of the three-year programme by assessing the effectiveness, relevance, impact and sustainability of the past implementation of the programme towards identifying lessons and good practices that can improve future efforts on GBV prevention and management. While undertaking this evaluation, robust qualitative and quantitative methods were applied that are to be discussed in detail.

2. Objectives and Scope of the Evaluation

2.1. Objectives of the Evaluation

The main purpose of the evaluation was to assess the relevance, effectiveness, efficiency, impact and sustainability of the implementation of the programme in order to identify lessons and good practices that can improve future efforts on the prevention and management of GBV in Ethiopia.

The specific objectives of the evaluation were to:

1. Review its effectiveness and efficiency in progressing towards the achievement and how the programme outputs were achieved;
2. Assess and verify the relevance of the programme to respond to the country's needs and challenges; to the intervention at national levels; and alignment with the United Nations Development Assistance Framework (UNDAF);
3. Examine the current programme challenges and opportunities;
4. Evaluate the coordination and sustainability of the programme;
5. Determine the impact of the intervention with respect to Gender Based Violence;
6. Assess the continuation of the programme towards the intended outcome aligned with UNDAF; and
7. Identify key findings and lessons learnt; and provide specific actionable recommendations in light of evidence on how to improve the programme that build upon this results.

2.2. Scope of the Evaluation

The specific focus of this evaluation was UNFPA and the 12 implementing partners; key stakeholders from government's sectors of health, women and children affairs; and different community based organizations and right holders who participated in the programme implementation process. Detailed enumeration of geographical locations for each implementing partner is presented under the methodology of this report. The review, analysis, findings and recommendations of the evaluation focused on the evaluation criteria that have been discussed in the objectives section and will be further detailed under the evaluation criteria section. The programme evaluation covered the time frame from October 2012 to December 2015, and selected Woredas in the six intervention regions.

3. Evaluation Approach and Methodology

3.1. Evaluation Approach

Designing an appropriate approach plays a crucial role in making the evaluation process much easier and effective in meeting its objectives. With this in mind, the evaluation team has basically adopted the approaches employed during baseline survey of the programme for ease of maintaining consistency and comparability with the end-line evaluation results. Most importantly, a participatory evaluation approach that is responsive to gender, human rights based and sensitive to cultural values was also employed. Partner organizations and key stakeholders who have been participating during the design and implementation stage of the programme were fully involved in the course of the evaluation processes. The Implementing Partners (IPs) which were the direct targets of the evaluation study were 11NGOs and 1 GO. Other actors who participated in the study include the funding agency, programme right holders which include GBV survivors, community members who received various kinds of orientations on GBV, individuals from grassroots structures who have participated during programme implementation (including 1 to 5 structures, model father groups, model mother groups, and safe house mothers), religious institutions, club focal persons in schools and universities involved in GBV, Health extension workers, Women and Children Affairs Offices and others.



The study approach aimed at being both consultative and collaborative with a view to providing both qualitative and quantitative results. More specifically, consultations were made with partner organizations and other relevant stakeholders; and right holders were actively involved in displaying and expressing their situation, their challenges and achievements in their own words. In addition, considering the programme implementation's emphasis on prevention, service provision and protection more focus was given on these during the design of the programme evaluation.

In order to assess the achievements of the programme towards the targets and to realize the extent of the programme's contributions in target areas, analysis was made of situations before and after programme implementation. Hence, our bench-mark for comparison was the baseline data that was documented at initial stages of the project. That means detail assessment of changes was made on target communities' knowledge and attitude towards GBV as a result of programme contribution by benchmarking baseline data.

The consulting team adopted standardized evaluation criteria recommended by the Development Assistance Committee of OECD (OECD-DAC) which include relevance, efficiency, effectiveness, impact and sustainability. The assessment did also look into coordination and management approaches adopted during implementation of the programme. In addition, the evaluation applied the value-for-money principle.

The evaluation was guided by the UN Evaluation Group's (UNEG) Norms and Standards for Evaluation in the UN System, UNEG guidance document on integrating human rights and gender equality perspectives in evaluations in the UN system, and the UNFPA Concept Note on Integrating Gender, Human Rights and Culture in UNFPA programs.

3.2. Data Sources and Data Collection Instruments

A blend of approaches and techniques were employed to collect information that address the objectives of the evaluation. The first approach was an intensive review of literature to learn all about the GBV programme including project document, annual reports, baseline report and other related documents. This approach has helped to design data collection instruments such as checklists and household questionnaire. Following this stage, a survey technique was adopted to collect qualitative and descriptive information from target groups, such as project right holders, implementing partners, community facilitators and community representatives. A checklist was used as a tool at this stage of data collection. A participatory approach has been commonly applied during the qualitative data collection stage.

Qualitative data was captured by using beneficiary survey, key informant interviews (KIs), in-depth interviews (IDIs) with survivors of GBV, focus group discussions (FGDs), observation, and case story development. Extensive review of secondary data obtained from programme partners, UNFPA, relevant sector offices at federal, regional, woreda, and other levels was also made. As illustrated in Table 3.1, a total of 92 KIs, 48 in-depth interviews, 31 FGDs and 19 case studies were conducted in the course of the study.

The third stage was collecting quantifiable data using a structured questionnaire as a tool which was developed based on the purpose of the study. Questionnaire based data collection was implemented for selected four IPs – Oromo Development Association (ODA), Amhara Development Association (ADA), National Coalition for Women Against HIV/AIDS (NCWH) and Mujejgua-Loka Women Development Association (MLWDA). The quantitative data was collected using experienced and well trained enumerators who filled questionnaires by interviewing randomly selected sample respondents. The total sample size selected for the questionnaire based interview from these four IPs was 360. The data collected was entered on SPSS software and cleaned for consistency and to make it ready for analysis while descriptive statistics was mainly adopted to analyze the data and summarize the information.

Proportions/percentages were obtained by dividing the sample observation (n) with the total sample size (N) of the respective IPs (N is 108 each for ODA and ADA, and 72 each for NCWH and MLWDA). For some of the questions with choices, responses could be multiple while for others, it could be single responses. For instance, for such questions as "what are the effects of GBV?" responses could be more than

one. In such cases, adding the percentages would be more than 100%. In the case of single response questions, such as “Do you agree that GBV is a violation of human rights?” there is only one response out of “strongly agree, agree, somehow agree, and disagree”. In such cases, percentages of these single responses can add up to 100%.

The study has also made attempts in comparing baseline findings with those of terminal results for selected variables. However, due to methodological issues, it was not possible to make such comparison of terminal evaluation findings with that of baseline values for all the other variables. The first reason is that the sample selected for baseline and terminal evaluations are not the same despite both studies being made in similar locations. Second, the questions included in the baseline study and terminal evaluation were not the same due to differences in the purposes of the two studies. The other reason is that baseline study results were presented by woreda while terminal evaluation results were agreed to be presented by IPs in the interest of assessing the status of programme implementation for each of the IPs.

Report writing commenced following data analysis. Information in the report was mainly presented in descriptions, tabulations and figures while there are also anecdotal texts and boxes describing case analysis of special circumstances, best practices and lessons drawn from programme implementation. As a matter of sensitivity of the issue and UNFPA’s principle, the names of participants on case stories have been kept anonymous.

Table 3-1: Table Allocation of KIIs, In-depth-KIIs, FGDs, case Stories and household surveys by IP.

Implementing partners	Key Informants	In depth interview with Survivors	Focus Group Discussions	Case Studies	Household Survey
NCA	9	-	-	-	-
AWSAD	4	9	1	2	-
MCRC	4	5	1	1	-
OSSA	5	-	-	-	-
ESOG	4	-	-	-	-
NCWH	14	10	6	2	72
MLWDA	14	10	6	4	72
ADA	15	5	8	3	108
BIGA	2	3	3	2	
ODA	12	6	6	3	108
Pro Pride	5	-		2	-
Federal Police	4	-	-	-	-
Total	92	48	31	19	360

4. Findings of the End-line Evaluation

4.1 Implementation Strategies

The programme focused on addressing violence against women through:

- Increased community response to promote and protect the rights of women and girls in relation to harmful traditional practices and gender-based violence; and
- Increased institutional response to address harmful traditional practices and gender-based violence and provide information and services to survivors of gender-based violence, including within a humanitarian context

Towards achieving these objectives, the implementing partners that have been working in different regions of the country employed various participatory programme interventions. One of the strategies that have been pursued was capacity building followed by awareness raising through social mobilization /community conversation (CC), media campaigns and public gatherings.



The *role model* approach of selecting influential actors from project target areas who received trainings to sensitize and train their community was also a strategy employed particularly by ODA, ADA, MLWDA and NCWH. Facilitation of partnership linkages and coordination of various stakeholders along the chain of legal processes, channeling operations through existing structures of the government such as women development army based at grassroots levels and provision of trainings to target right holders were also among the strategies adopted. These structures were supported by membership of Kebele administrative leaders, community leaders, women's associations, women's development army and health extension workers. Coffee and tea ceremonies, door-to-door services to brainstorm about GBV in the villages, and peer education through girls' clubs in schools were also commonly used to facilitate easy understanding of GBV and associated issues.

With regard to particular implementation strategies used by different IPs, the mass awareness creation strategy was used by NCWH in Tigray and Benishangul-Gumuz regions, and also by ODA and MLWDA. NCA, focusing on prevention and management of GBV in faith settings, worked specifically targeting religious institutions, which include Ethiopian Orthodox Church- Development Inter-Church Aid Commission (EOTC-DICAC), Evangelical Church Fellowship of Ethiopia (ECFE), Ethiopian Muslim Development Agency (EMDA), Inter-Religious Council of Ethiopia (IRCE), Ethiopian Evangelical Church Mekane-Yesus Development and Social Service Commission- North Area Work (EECMY-DASSC NAW) and Ethiopian Catholic Secretariat (ECS), as a way of addressing the followers of these religions. NCA's strategies include campaigns, dialogue forums, integrating GBV into marriage counseling centers, universities and schools as well as FBO structures such as mosques/churches, Sunday schools, *Tsiwa-Mahber*, youth and women fellowship. BIGA's awareness creation strategies in SNNPR included village outreach, facilitating regular family dialogue, community conversation, production and dissemination of IEC and BCC materials, annual celebration of MCs day, and provision of renewable and non-renewable materials such as ID card, T-shirt, brochures, and stationaries while it also works on referral linkage and networking. In addition, BIGA aimed to reduce maternal and child mortality through establishment of model mother /father clubs (MFC and MMC) and volunteer health scouts among the community members of the project areas. The health scouts and MC members are responsible for providing support to pregnant women participating on health campaigns and other community events such as the White Ribbon Day, annual HIV/AIDS celebration day, and submitting monthly report on their activities. The Community Counselors' Committees (CCCs) and Model Farther Clubs are the first to reach survivors and link them up with concerned government and justice offices. There are 7 Model Father Clubs in the 7 sub- cities with 5 members each that work jointly with CCCs in the sub-cities.

The Federal Police also exclusively worked on awareness creation, training and GBV mainstreaming. The trainings sought to create awareness and build capacity of young officers (particularly women), and Women's Affairs Desks. Mainstreaming GBV prevention and response issues in police education and community policing was also the focus of the Federal Police. To execute these targets, the Women's Affairs Division of federal police provided trainings and training materials, and consulted on GBV reporting and case building and developed code of conduct.

The other implementing partner that exclusively worked on awareness creation was Pro-Pride. In addition to broadcasting GBV related radio programs, case stories and drama series were also used to create public awareness. Pro-Pride also unveiled violence cases to gather public support for survivors of violence and gave trainings on radio programme production to media professionals to build their capacity. ESOG worked on the development of a national standard document on sexual and reproductive health issues and integration of reproductive health in university curriculum and trainings to health care providers and introducing national standards and guidelines procedure regarding sexual and reproductive health.

OSSA's strategies towards awareness creation on GBV and SRH issues included organizing gender day events, music and drama events, mini-media programs, Q&A sessions, provision of various trainings on assertiveness and other thematic areas, establishment and strengthening of gender and girls' clubs, creating peer learning groups and preparing and duplicating psycho-social, violence management and peer education manuals used by peer counselors. OSSA has also been using hotline services where university students had access to obtain information related to GBV and SRH through toll-free calls.

When it comes to provision of sexual and reproductive health and psycho-social services for vulnerable groups and GBV survivors, MLWDA, AWSAD, ESOG, BIGA, MCRC, NCA, ADA, NCWH and OSSA implemented provision of advocacy, prevention, protection and rehabilitation services.

Outreach coordination is one of the important successful implementing strategies that has been used by UNFPA and its implementing partners. UNFPA has played a role in coordinating the efforts of different implementing partners to provide medical service to GBV survivors, such as fistula and uterine prolapse cases. Implementing partners such as NCWH, MLWDA and ESOG in collaboration with government hospitals have been working to provide medical service to fistula and other GBV survivors. Grassroots structures were used to mobilize communities to bring survivors from rural and remote areas for treatment at the model clinics established by ESOG at government hospitals.

MLWDA worked towards creating abuse free environment for women, improving women and children's health status by providing basic social services such as education and health and advocacy for protection and rehabilitation, while AWSAD has maintained strengthened network and partnerships with different stakeholders towards effective rehabilitation and referral of survivors. It also provided trainings to empower survivors with self-defense, basic business and life skills. NCWH worked on identifying fistula and uterine prolapse survivors, linking them with medical centers, engaging them in different income generating activities and providing legal support to them in collaboration with the police. The interventions of ESOG, which focused on service provision included organizing model clinics, doing outreach programs for fistula and uterine prolapse patients, running a clinical care where the survivors get psycho-social support in addition to medical care, and referral linkage with other hospitals and provision of legal support. The overall objective of BIGA, which operates in Hawassa, Yirgalem and Dilla in Sidama and Gedeo zones of SNNPR respectively, was to protect vulnerable women and children from GBV. It also provided rehabilitation and psychosocial support and legal aid to survivors of violence at BIGA safe house, programme centers and grassroots level.

The MCRC also provided shelter, food, education, medical care, and therapy for survivors of violence and equipped them with the knowledge and skills necessary to be independent and successful in the future. It also provided training on self-defense, music, photography and dance therapy for vulnerable children and organized community conversation for experience sharing and peer-learning on GBV.

Through its partnership with UNFPA on engaging FBOs for the wellbeing of women and girls in Ethiopia, NCA worked to address GBV survivors' medical, economic and psychosocial needs in addition to its prevention and awareness creation interventions.

OSSA's service provision strategies include care and social support to university students facing gender and RH problems by creating linkage and referral system, establishing "dignity room" for female students during class sessions to put on their sanitary pads to help them not miss classes and material supports to female students who cannot afford to buy necessities, such as detergents and sanitary pads. OSSA supplied these materials to the students through the university clinic where the students got easy access to. Working in partnerships with institutions such as Police, Women and Children Affairs, Woreda Officials and others was also another strategy of OSSA that has been adopted to provide psycho-social, legal and counseling services for GBV survivors.

ADA, working in Dera, Basso Liben, Enarjinawuga, Kombolcha and Kobo Woredas of the Amhara National Regional State, is also another implementing partner that has been working to end all forms of GBV and to promote gender equity and participation of women in social, economic, and political dialogue in the community. The project interventions focus on awareness raising, capacity building of institutions and provision of services. While activities related to awareness creation are conducted through community dialogue, advocacy, public education, and community conversation and piloting family dialogues, health services for violence survivors were also provided through strengthening referral linkages with relevant

institutions. Legal service was provided to them by strengthening communication and information exchange between law enforcement bodies.

4.2 Relevance of the Programme

Together with its 12 implementing partners, UNFPA has been implementing the Prevention and Management of GBV Programme towards achieving outputs 9 and 10 of its Country Programme which had two objectives: (i) strengthened community response to promote and protect the rights of women and girls in relation to harmful traditional practices and gender-based violence; and (ii) strengthened institutional response to address harmful traditional practices and gender-based violence and provide information and services to survivors of gender-based violence, including within a humanitarian context.

This section is devoted to assess the extent to which these objectives were in line with the evolving needs and priorities of right holders, partners and stakeholders. The programme has been focusing mainly on addressing gender based violence through increased knowledge and response of communities and other stakeholders on GBV and sexual and reproductive health (SRH); increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV; and increased stakeholders' capacity for enhanced coordination and advocacy on issues of GBV.

4.2.1 Relevance of Programme Objectives to National Priorities

The government of Ethiopia has acknowledged that gender based violence against women and girls is a fundamental violation of human rights and a constraint to development, and has issued relevant policy and legal frameworks towards challenging the problem. To mention some of them, the 2013 National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia by the FDRE Ministry of Women, Children and Youth Affairs; the 2010 Ministry of Education Directive for Higher Education towards eliminating sexual harassment in higher education; the 2007 Civil Servant proclamation of GBV at work place; the 2001 "Blue Book" of the FDRE Ministry of Education; the 2000 and 2005 Federal Family law and the Criminal Code of Ethiopia are some of the witnesses that illustrate the commitment of the government toward elimination of GBV. In spite of these relevant policy and legal frameworks, however, GBV still remains rampant throughout Ethiopia and women continued to suffer from violence and denial of their rights in one form or another. In light of these facts, the two fundamental objectives of UNFPA GBV programme were perceived by government bodies, such as the Women and Children Affairs, Police and Justice Offices, to be highly relevant. In this regard, any of the programs and initiatives that intend to address the problems associated with GBV prevention and control are recognized to be highly relevant from the perspective of government policy.



4.2.2 Relevance of the Programme to UNFPA's Mandate and Priorities

UNFPA is mandated to support and respond to policies and to build institutional capacities to prevent harmful traditional practices and gender based violence. Accordingly, phase II of the programme was formulated and implemented to contribute towards output 9 and 10 of the 7th UNFPA Country Programme. Thus, UNFPA's and its implementing partners by using different participatory approaches have intervened in the prevention, service provision and protection, and capacity building activities of GBV in different regions of Ethiopia. Evidences from this final evaluation has shown that the intervention was appropriate towards achieving the two objectives.

To cite of some of the evidences that illustrate relevance, ADA was one of the implementing partners in Amhara region where women with uterine prolapse and fistula had been observed in the community due to the high prevalence of early marriage and heavy workload in rural areas. These women suffered from physical, social, psychological and emotional burdens as a result of poor medical conditions. The project in this regard has met the needs of women by addressing their medical and social needs. After ADA's intervention, fistula is declining in the target Woredas unlike the non-intervention Woredas in the region, and many who were detected had already received treatment. However, fistula and uterine prolapse survivors are still prevalent in the Benishangul-Gumuz Region.

Before its partnership with UNFPA, AWSAD used to give services on a smaller scale and 20 survivors were in the safe house. Partnership with UNFPA helped AWSAD to work on a large scale to meet the demands of those who were in need. Over the period of the intervention, AWSAD managed to give services to 1,205 women and children survivors, and 524 siblings of survivors (Table 4-1).

Table 4-1: Number of survivor in the safe house (2013-2015)

Physical year	Number of survivor(Women and children)	No of children (Sibling of survivors)	No of survivor who left the safe house
2013	180	93	108
2014	455	214	113
2015	570	217	118
Total	1205	524	331

Source: AWSAD, 2016

NCA's work with religious leaders and FBOs to increase their knowledge of GBV was very relevant to make them accept and embrace GBV as a common issue. NCAs effort was observed to be rewarding and it managed to work with ECS and ECMY in Mekele, which provided psycho-social, medical and protection services for survivors of GBV including fistula, and intimate partner and domestic violence survivors. ESOG with the support of UNFPA GBV fund has been working on the development of standard national level document on sexual and reproductive health issue and integrating reproductive health in university curriculum. These are highly relevant to issues of GBV because the development of national documents would assist other acting bodies of GBV. Despite the fact that the problem of GBV and SRH is vast and deep-rooted societal problem, UNFPA's and its IPs intervention was timely and relevant. Thus, we can conclude that the intervention was relevant and in line with UNFPA's mandate and priorities.

4.2.3 Relevance of the Programme to Individuals'/Communities' Interests and Priorities

Different forms of GBVs are practiced across programme intervention Woredas for cultural, economic and social reasons which necessitate the relevance/ importance of participatory GVB intervention approaches as stipulated in the programme log frame by UNFPA along with its IPs. Accordingly, FGM, physical abuse and sexual abuses are found to be the top three GBV practices in ODA intervention areas. Similarly, Sexual abuse, harassment and exploitation are the major problems in NCWH intervention areas. Early Marriage, FGM and abductions are the common GBV issues in MLDWA intervention Woredas. Physical abuse, abduction and FGM are also the three most common practices of ADA intervention Woredas (Table 4.2). Perpetuation of these forms of GBV justifies relevance of UNFPA GBV programme objectives that were crafted to address these societal problems.

Table 4-2: The most common types of GBV in the study Woredas, 2016

Types of GBV	ODA (N=108)	NCWH(N=72)	MLWDA (N=72)	ADA (N=108)
	% ¹ (n)	%(n)	%(n)	%(n)
Female Genital Mutilation/Cutting	46 (50)	22 (16)	75 (54)	44 (47)
Physical abuse	38 (41)	41 (30)	44 (32)	63 (68)
Sexual abuses	36 (39)	80 (59)	4 (3)	51 (55)
Early marriage	30 (32)	38 (28)	78 (56)	94 (102)
Sexual harassment	22 (24)	49 (36)	7 (5)	25 (27)
Limited participation in decision-making	19 (20)	9 (7)	6 (4)	26 (28)
Sexual exploitation	13 (14)	58 (43)	7 (5)	11 (12)
Emotional /psychological abuse	9 (10)	11 (8)	1 (1)	24 (26)
Forced prostitution	9 (8)	19 (14)	3 (2)	11 (12)
Forced marriage/Abduction	8 (9)	20 (15)	44 (32)	62 (67)
Discriminatory practices based on gender	8 (9)	8 (6)	22 (16)	8 (9)
Trafficking for forced labor	7 (8)	11 (8)	0	2 (2)
Others	13 (14)	0	0	1 (1)

Source: Household Survey, 2016 (N=360)

Awareness level of the community for some of the GBV has increased after the project (terminal phase) compared with baseline status. As provided in Table 4-3, For instance, the proportion of households who were aware of physical violence as GBV has increased from 27% at baseline stage (early 2014) to 47% at the terminal stage during which this terminal evaluation study was conducted (late 2016). This indicates that the programme has contributed to awareness raising of 20% of the population in the intervention areas. Similarly, the awareness level on female genital mutilation/cutting (FGM/C) as GBV has increased from 16% at baseline to 46% at terminal stages. This implies that the GBV programme intervention has contributed to raising awareness of 30% of the community on the negative effects of FGM/C.

Table 4-3: Comparison of baseline and terminal stage awareness levels of the community on selected GBVs, 2016 (% of respondents)

Type of GBV	Baseline status (before the program) ²	Terminal status (after the program)	% increment in awareness
Physical	27	47	20
Sexual	11	43	32
Forced marriage	10	34	24
FGM/C	16	46	30

Source: Current Household survey and baseline survey

Programme right holders also witnessed that interventions of IPs to prevent and control GBVs were relevant from the point of view of their own interests and priorities. Findings of this study have shown that more than 85% of households interviewed perceived interventions to prevent and control GBVs to be relevant for their interest and priorities (Table 4.4). Moreover, more than 80% of the respondents have also witnessed that programme interventions of UNFPA's IPs were relevant from the perspective of community interests.

¹ Percentages were computed by dividing an observation (n) with total sample size (N) of the respective IPs.

² Source: UNFPA. 2014. Baseline survey on the prevention and management of gender based violence in Ethiopia.

Table 4-4: Perception of programme right holders on relevance of GBV interventions from the point of view of community and their own interests and priorities

	ADA	ODA	MLWDA	NCWH	Total
The interventions made to prevent and control GBV especially by the project was highly relevant from the point of view of your interests and priorities (% of respondents)					
Don't know	0.9	1.9	5.6	0.0	1.9
Strongly disagree	0.9	0.0	0.0	0.0	0.3
Disagree	0.0	0.0	0.0	0.0	0.0
Somewhat agree	9.3	8.3	40.3	1.4	13.5
Agree	53.7	39.8	52.8	17.6	42.0
Strongly agree	35.2	50.0	1.4	81.1	42.3
The interventions made to prevent and control GBV especially by the project was highly relevant from the point of view of community interests and priorities (% of respondents)					
Don't know	1.9	1.9	4.2	0.0	1.9
Strongly disagree	0.0	0.0	0.0	0.0	0.0
Disagree	0.9	0.0	1.4	0.0	0.6
Somewhat agree	3.7	12.0	44.4	1.4	13.8
Agree	62.0	35.2	48.6	14.9	41.7
Strongly agree	31.5	50.9	1.4	83.8	42.0

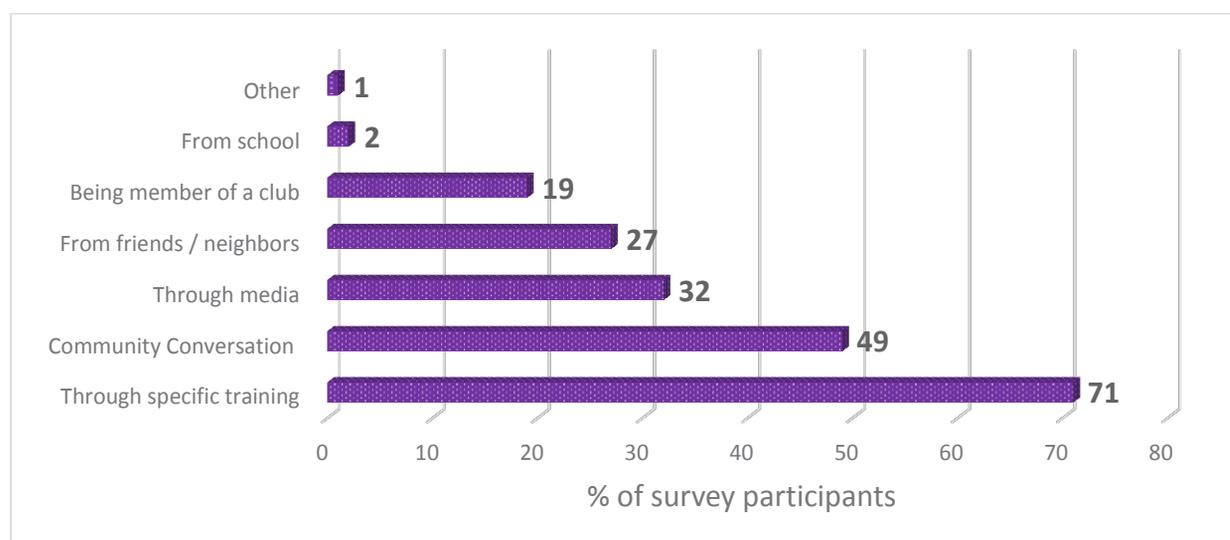
Source: Household Survey, 2016

4.2.4 Relevance of the Programme in Building the Capacities of Stakeholders

The GBV intervention has also helped in building the capacities of Implementing partners and government institutions particularly the law enforcement body of the government at different levels. Federal Police as an IP and a law enforcement body has built its capacity at federal and regional levels by mainstreaming gender and GBV so that the institutions become gender responsive. Similarly, other implementing partners collaborated with government offices and built their capacities by providing training and facilitating awareness creation workshops.

4.2.5 Effectiveness of Awareness Raising Interventions

Out of the three major sources of knowledge the IPs adopted in raising awareness of programme right holders and the public, community conversation (CC) was recognized to be a powerful approach next to trainings. This was witnessed by empirical finding that close to 50% of survey participants claimed that CC was the major source of their knowledge about GBV next to trainings (Figure 4-1). CC was participatory in nature involving various sections of the community with diverse age groups and experiences.

Figure 4-1: How programme right holders came to know about GBV; Source: Household Survey, 2016

Source: Household Survey, 2016

One of the many objectives of the implementing partners was to raise awareness and knowledge of the community about GBV and its consequences. As a result, the programme intervention increased communities' knowledge of GBV and created strong initiation among community members to protect girls and women from GBV. According to the findings of household surveys from different regions, 46% of the respondents regard GBV as a violation of human right while 56% regard GBV is caused by unequal power relations between girls/ women and men/boys (Table 4.5). About 27% of the programme right holders have also witnessed reproductive health problems as consequences of GBV.

Table 4-5: Knowledge of programme right holders about GBV practice in their locality

What do you know about GBV practice in your area?	ADA N=108		ODA N=108		MLWDA N=72		NCWH N=72		Overall N=360	
	n	%	n	%	n	%	n	%	n	%
It is a violation of human right	56	52	28	26	21	29	61	82	166	46
It is the result of powerlessness	68	63	41	38	45	63	21	28	175	48
It is caused by power inequality between men/boys and women/girls	56	52	71	66	47	65	27	36	201	56
It result in reproductive health problem	19	18	46	43	10	14	21	28	96	27
Other	2	2	1	1	0	0	0	0	3	1

Source: Household Survey, 2016

Apart from knowledge of project right holders on what GBV is all about, almost all of them have recognized the various negative effects of GBVs especially on women and girls. For instance, about 95% the respondents agreed with the statement that "GBV causes psychological and physical health problems for adolescent girls and women". Such understanding and recognition is helpful to find community supports for joint actions in GBV prevention. It also reveals that programme beneficiaries' knowledge of GBV

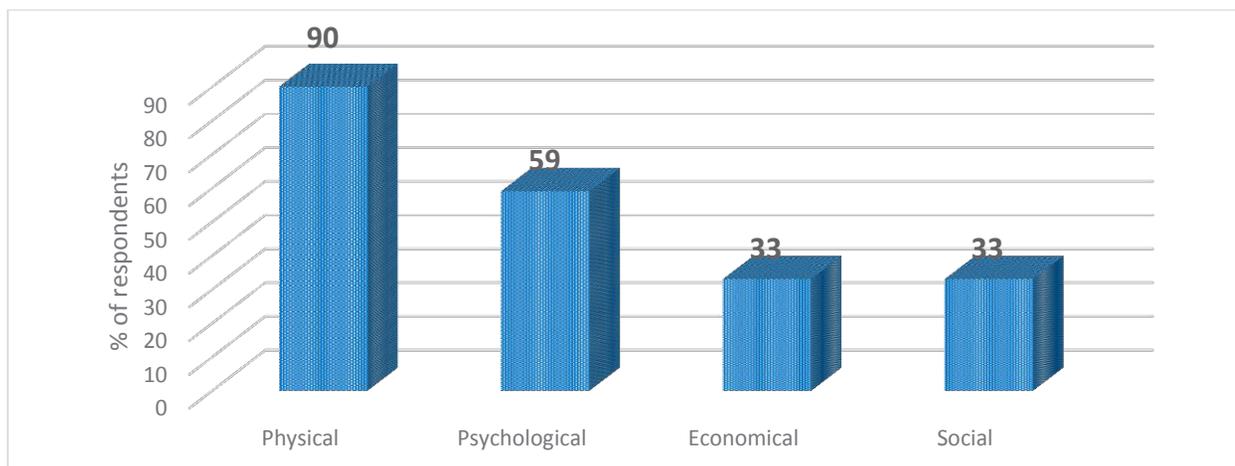
effects has been raised. This was supported by an evidence that 90% of the right holders have recognized that GBV brings physical damages on survivors while 59% of the right holders said GBV has deleterious effects on psychological feelings of survivors (Figure 4-2).

Table 4-6: Awareness of the right holders on psychological and physical health effects of GBVs for adolescent girls and women

GBV can cause psychological and physical health problems for adolescent girls and women (% of respondents)						
Implementing partners (IPs)	Don't know	Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
ADA	1.9	0.0	0.0	0.0	41.7	56.5
ODA	0.0	0.0	0.0	5.6	28.7	65.7
MLWDA	0.0	0.0	1.4	15.3	62.5	20.8
NCWH	0.0	0.0	0.0	0.0	8.1	91.9
Total	0.6	0.0	0.3	4.7	35.1	59.4

Source: Household survey, 2016

Figure 4-2: Awareness of programme right holders on effects of GBV on survivors; Source: Household Survey, 2016



Source: Household Survey, 2016

Different IPs have adopted CC approach to raise awareness about economic, health, legal and social consequences of GBV. The IPs have conducted more than 20,514 community conversation sessions and over 1,398,711 (776,545 F) community members were reached via community conversations throughout the three-year programme. Facilitators of the CC sessions were CCFs, influential community representatives, health extension workers (HEWs) and community policing officers. Overall, the implementers have managed to demonstrate inspiring achievements through CC sessions, such as cancellation of arranged abduction and child marriages, prevented more than 1,741 cases of FGM, and 467 cases of domestic violence were detected and settled by the community and were referred to health and legal institutions (see annex 1); case stories 4,11 and 13) for exemplary legal measures taken against perpetrators, and created opportunities for treatment of 817 fistula and 1,207 uterine prolapse cases. 191 cases of polygamy were prevented by ODA with the involvement of community members.

Community conversations had been conducted on a monthly basis involving female, male, old people, and young people. For example, In Basso Liban Woreda under intervention of ADA, six community conversation groups with 70 members (35 Female & 35 Male) and model family groups that consisted of 50 households were established to deliver awareness raising. In addition, 12 “Eye & Ear” individuals (community watch groups) were selected out of the six CC groups in Basso Liban Woreda. Individuals who were supposed to act as “eye witnesses” provided whatever events they observed on harmful traditional practices, and those who worked as “ear witnesses” provided whatever information they heard related to GBV.



It has been recognized that the IPs adopted various participatory mechanisms to raise awareness and knowledge of the community for responses to prevention and control of GBV. To substantiate the endeavors and ensure sustainability, the IPs have been linking the initiatives with existing government structures that extend up to grassroots levels. Moreover, the IPs have been engaging influential individuals, community leaders and elders, directors of the nearby schools, community facilitators, religious leaders, women’s and youth’s association leaders and health extension workers. The community conversations and trainings have brought significant effect in increasing knowledge of the community in general and students in particular. It has also created deeper understandings regarding the root causes of GBV. This is supported by the quantitative findings of the evaluation. As a result of GBV programme intervention, Table 4-7 witnessed that 85% the programme right holders managed to identify lack of awareness as a major cause of GBV. The other 51% identified harmful traditional practices as the second major cause of GBV while 39% of the respondents attributed culture as the third major cause of GBV

followed by women’s lack of power. As clearly observed from the table, the effect of culture is higher due to the pervasiveness of early marriage in Amhara Region which is often being considered as a culture rather than as a main type of GBV. Additionally, attitudinal perceptions are responsible for the incidence of various types of GBVs as attested by 23% of community members. All these are some of the evidences for contribution of the GBV programme in raising awareness and knowledge of the community on the root causes of GBVs which can be considered as a favorable opportunity for the prevention of GBV.

As witnessed by 87% of the study participants, lack of awareness about legal consequences of committing GBV was reported to be the major cause for pervasiveness of GBV (Table 4-7). This proportion was 39% at baseline status of community awareness implying that the GBV programme has contributed to awareness raising of 48% of community members who came to recognize that GBV incidence has really been driven by lack of awareness. Moreover, harmful traditional practices (51%), cultural problems (37%) and women’s lack of power (32%) are main causes of GBV. This indicates awareness of the community on GBV which can be attributed to programme interventions.

This indicates awareness of the community on GBV which can be attributed to programme interventions.

Table 4-7: The Most Common Causes of GBV (% of respondents)

Causes of GBV	ADA	ODA	MLWDA	NCWH	Total
Lack of awareness	85.2	82.4	94.4	87.8	86.7
Harmful traditional practices	66.7	51.9	41.7	35.1	50.8
Prevalence of poverty	5.6	18.5	6.9	9.5	10.5
Family disruption like divorce	3.7	11.1	0.0	9.5	6.4
Women's lack of power	38.0	38.9	8.3	36.5	32.0
Attitude related issues	31.5	19.4	2.8	20.3	19.9
Culture related issues	54.6	21.3	30.6	41.9	37.3
Religious related issues	12.0	4.6	2.8	0.0	5.5
Others	0.9	0.9	0.0	0.0	0.6

Source: Household Survey, 2016

Awareness raising and knowledge enhancement programme of the projects has been focusing not only on the contexts and negative consequences of GBV but also on legal procedures and associated measures. It was dealt that whenever is reported about GBV incidence, the community was advised to take subsequent measures apart from instant emergency solutions. As has been witnessed by the evidences, 43% of programme right holders said they would look for police assistance in case of GBV incidences. This proportion was only 8% at baseline indicating that the GBV programme intervention has contributed to awareness raising of 35% of community members to report GBV cases to police. Another finding of this study has revealed that 25% of the community members would go to Kebele administration and 12% would seek medical services to report GBV cases (Table 4-8). This can also be recognized as an evidence of the community and other actors in responding to GBV incidences which is in turn the result of enhanced awareness and knowledge of target right holders of UNFPA GBV program.

Table 4-8 Places where GBV survivors would go in case of incidences (% of respondents)

Places where survivors go at times of GBV incidences	ADA	ODA	NCWH	Total
Police	60	23	46	43
Medical services (hospital, health centre)	9	25	1	12
Kebele Administration	15	25	35	25
Social court/ <i>Mahiberawi Ferd Bet</i>	3	14	5	7
Legal aid/ services	1	6	8	5
NGOs/providing social services	0	2	1	1
Families, relatives, neighbours	3	4	0	2
Clan leaders/influential people in the Kebele	6	3	0	3
Churches/mosques	0	0	1	0
School teachers	1	0	0	0
Other	1	0	0	0

Source: Household Survey, 2016

As explained above, women's level of awareness on causes and consequences of GBV have been significantly increased. However, there is still gap between knowledge/awareness and practices. The qualitative reports from the police office showed that reporting of GBV is still very low, despite some improvements, due to survivors' fear of public discrimination and retaliation by intruders and tolerance of GBV by women and society as a whole. Similarly, a few respondents in the quantitative survey disclosed that they experienced sexual abuses by perpetrators, but none of them reported to police nor received legal aid services.

In contrast to the information from the police, the problem reported during KII and FGD with programme right holders and the surrounding community was that the responses of police and other legal institutions were not inspiring in some of the locations. There were also cases whereby police officers rarely appeared to be supportive of the GBV survivors because of informal negotiations with perpetrators. The role models in some of the locations expressed disappointment when they received less commitment and loose support from police officers.

In spite of the challenges community members face in legal processes, more of them believed that all sorts of GBV shall still be reported to concerned bodies, either to informal community based organizations or to formal legal institutions for necessary measures to be taken.

NCWH and its stakeholder started taking legal actions against early marriage in its operation areas. A good practice by NCWH in Tigray was that individuals who intend to marry must get a letter of certificate from Women and Children Affairs Office before undertaking wedding. Women's Affairs and Justice Offices worked together with NCWH to screen age of girls before marriage. The age screening minimized the occurrence of early marriage. For instance, Woreda Administration, Women Association, Woreda Police and Justice Offices in collaboration with NCWH have canceled 206 arranged early marriages in Benishagul-Gumuz and 377 in Tigray.

As explained above, the awareness raising activities were effective in changing the attitude of targeted communities toward GBV. However, youth were not adequately targeted and the messages addressed were not tailored to the specific needs of youth in ADA, ODA, MLWDA and NCWH intervention areas. In some occasions, the different forms of GBV were addressed simultaneously, which resulted in lack of focus and compromised depth and contents of messages that have been addressed.

4.2.6 Effectiveness of Capacity Building Interventions

Training programs had been powerful approaches to raise awareness of the community. This was because, training sessions provided a room for brainstorming with participants and it facilitates transfer of knowledge and information. This was confirmed during the evaluation study that more than 70% of programme right holders mentioned training as the means through which they received adequate awareness and knowledge about GBV (Figure 4 -1).

The trainings provided by UNFPA and its IPs have built the capacity of 16,518 people. These trainings focused on various pertinent themes, such as GBV management, reporting system and working collaboratively with government bodies, training on gender mainstreaming, care for survivors of sexual violence, training on radio programme production, and various other thematic areas.

For instance, ODA provided the training of trainers for role models and community facilitators in order to train and facilitate community conversation at kebele and sub-kebele levels on GBV and ways of HIV transmission. This approach was recognized to be effective in conveying relevant information according to local culture and language. The role models in some of the ODA sites, such as Wonji areas of Adama district, were influential in the community in creating awareness and preventing GBV. They have been standing as witness in court while other community members retreat in fear of reprisals from perpetrators when they are released. In some of the locations, the community has developed trust on role models rather than on community police. Discussion with role models has also revealed their commitment to continue preventing GBV in their locality along with community members despite the threat on their personal security.

Different trainings and services were provided to build capacity of right holders and targeted communities to bring behavioral changes and increase productivity of the trainees. ToT on methodology and skills and subject matters of community conversation and family dialogue was provided to programme officers and project coordinators, health extension workers, male and female police officers, Kebele and woreda level facilitators and Kebele administrators. The training was cascaded to health development armies. The training focused on systems of organizing community conversations and methods of handling review meetings and approaches of coordinating community level facilitators.

For example, from ADA experience, they provided a total of 415 CC trainings on awareness creation. The training greatly improved the participants' understanding of GBV issues related to prevention & controlling mechanisms, causes & consequences of GBV, and national & regional status of GBV incidences.

Training on family dialogue was provided to influential and respected men and women leaders every three months. The objective of family dialogue was to increase the involvement of men in traditionally defined women's household roles and to pilot the family dialogue in some model Kebeles. Influential men were selected as leaders to play mediating role and educate their family and community regarding GBV in different cultural events. In addition, women leaders were selected to create awareness among coffee ceremony participants locally termed as "Teretim". The trainees of family dialogue were expected to cascade the training to their respective family and neighbors who have not received the same. The training focused on types, causes, consequences, prevention, control, and impact of GBV on the social and economic lives of women. More specifically, identification of fistula & uterine prolapse cases, legal remedies of abduction, rape, and FGM were discussed in-depth in the training initiatives of the program. In Enarji Enawuga, 55,776 men and 41,540 women were reached through family dialogue in the three years. The project facilitators observed the trainees when they practically provided the training to community members. The trainees discussed GBV at traditional beverage (*tella*) houses, home, neighbors and other community gatherings.

In addition to the project, the Woreda Police's Gender Office drafted & disseminated awareness raising manuals and provided awareness raising trainings for police officers, community representatives & survivors on how to respond to reported & unreported GBV cases. These trainings thematically focused on documenting GBV cases, handling survivors & perpetrators, techniques of perpetrator & witness interrogation, establishment of evidences & building court cases, and mechanisms of following whether justice is served or not. These trainings changed the attitude & ability of the participants'. The office managed to execute all these endeavors as per the initial plan. The gender office received different training manuals from the regional and federal gender divisions as the gender offices at Woreda level have mandates to promote gender and gender based violence. The Woreda gender office has also addressed issues of GBV to its members, the community and survivors every year using the manuals.

NCA intervened to mitigate GBV through capacity building of theological institution teachers and marriage counsellors to integrate GBV and to establish marriage counselling centers. A total of 681(300 Female) marriage counselors and teachers in theology schools, church administrators, pastors and clergies received trainings. In addition, perpetrators were reached through the sensitization conducted in prison in Addis Ababa by ECFE. Counseling manuals, guidelines and ethics were developed and distributed to the counselling centers in addition to renovating the centers. The FBOs announced about the marriage counselling services during their worship services.

Accordingly, GBV was integrated in Genet Church Theological College and a 2 credit hour course was initiated. ECFE, EOC and EECMY-NAW established a model family and marriage counseling center to address issues of intimate partner violence and other forms of violence. Three model marriages and family counselling centers were strengthened at 3 Parish churches-EOC, ECFE, and DASSC NAW. Six marriage counseling centers, of which three belong to EOC (Addis Ababa Estifanos, Bole Michael, and Kidane Mihret Churches); two belong to ECFE (Alamora Mulu Wongel and Tabor Mekane Yesus churches); and one by EECMY NAW in Mekelle were established. The issues addressed during the marriage counseling included intimate partner violence, marital relations and child care. The counseling services provided referral linkages to GBV survivors. All in all, a total of 47 (31 Female) individuals benefited from the counseling services. In general, NCA has exceeded its plan to open three marriage centers and provided capacity building trainings to more individuals than the envisaged plan.

BIGA conducted capacity building training for 27 staff of its safe house and psychosocial counselors. The objectives of the trainings were to capacitate the staff and counselors with the latest methods, knowledge and skills for provision of better service to survivors. All in all, BIGA strengthen the capacities of 53 community counselors. Moreover, trainings were given on GBV to CCCs and Model Father Clubs to strengthen their joint effort with the concerned government organizations. The CCC in each sub-city of Hawassa, Dilla and Yirgalem towns has been providing counseling service at grassroots level. Particularly the CCCs of Hawassa worked jointly with Model Father Clubs (MFCs) in order to bring objective change in the communities.

BIGA also provided self –care training to 95 survivors, mainly focusing on self- protection techniques from gender based violence and other traumatic conditions, development of skills on communication, relationship building and problem solving, self – assertiveness and self -confidence. The training enabled survivors not only to care for themselves, but also to advise their friends to be aware of self-care.



OSSA organized awareness raising trainings on various thematic areas including assertiveness, life skills, socialization, stress management, GBV and its effects and SRH related issues. For instance, Adama University provided training to 32 students on club management, 66 students on GBV (both basic and refresher), 40 students on peer counseling (basic and refresher) and 50 students on assertiveness. As a result, the trainees acquired knowledge on communication skills, club management, safe abortion, HIV/AIDS, unplanned pregnancy, emergency contraceptive and family planning methods.

MCRC played crucial role in providing skill capacity building trainings and internship opportunities. MCRC set up IGA and small- scale projects for individual and groups of right holders. It also provided internal and external skills trainings in sewing and embroidery, hair- dressing, catering, basic consumer service, cooking and art based on the interests and levels of education of its right holders.

Regarding provision of IGA services, GBV survivors received seed money to run their own businesses, such as sewing, embroidery and others to help them improve their livelihoods. Most of the survivors had received advice and guidance before they started their business. MCRC found internship opportunities for a few of its right holders at various organizations.

Pro-pride has been contributing to capacity building of media experts through provision of material supports and trainings for the regional radio stations. In the face of unavailability of radio media education in the formal educational centers, capacity building initiative was reported to be highly supportive. For instance in 2014, a technical training was given to a total of 30 individuals working in the media in the Oromia Region out of which 18 were volunteers working in the Haramaya University Radio station, 7 journalists were from Dire FM, and the rest were members of Pro Pride's radio team in the Region. Digital editing, reporting, adobe audition, interviewing techniques, and GBV were among the topics covered in the training given to the media professionals in Oromia Region.

Overall, 145 participants (80 from Amhara and 65 from Oromia regions), have received two rounds of trainings. The participants were partner media organizations and other community groups. As a feedback, the participants explained that the training exercise was extremely beneficial to their work in the future and to produce better quality programs that deal with GBV in their respective regions.

UNFPA enhanced the capacity of IPs through training, discussions, technical and institutional support, and networking to make the programme more efficient and effective. 61 (28 female) representatives of IPs participated in different trainings organized by UNFPA on documentation, case story writing and reporting, community conversation techniques and methods, and training on Gender-Based Violence Information Management System (GBV-IMS) and Clinical Management of Rape Survivors. The trainings equipped participants with knowledge and skills to deliver quality and standard reports and enabled them to develop a plan of action for implementation of CC in their respective communities. UNFPA also enabled participants from IPs to attend national, regional and international workshops, conferences and organized experience sharing forums. For instance, UNFPA and representatives from implementing partners attended the East and Southern Africa Regional workshop held in Uganda; Second Men Engagement Global Symposium held in Delhi, India; and consultative meeting on GBV organized by UNFPA East and Southern Africa Regional Office (ESARO). In addition, UNFPA contributed for the Third Global Technical Consultation Meeting on Social Service Sectors' Response to Violence against Women and for the National Girl Summit held in Addis Ababa. In addition, UNFPA organized experience and knowledge sharing and monitoring visits among UNFPA GBV programme implementing partners. For instance, UNFPA arranged visits to AWSAD and MCRC safe houses located in Addis Ababa for all the 12 implementing partners.

UNFPA also employed various participatory and multi-stakeholder approach monitoring, evaluation and learning (MEL) mechanisms to track the implementation progress of the programme at UNFPA and partners' level. UNFPA consolidated partners' quarterly reports, provided necessary support, reviewed the progresses of IPs and conducted field visits for monitoring, and for cross checking IPs reports. UNFPA has also conducted review meetings with all partner organizations on a bi-annual basis to reflect on the programme implementation process, to identify major challenges and lesson learnt, and to undertake corrective measures.

4.2.7 Effectiveness and Adequacy of Service Provision

Besides awareness raising and capacity building, the programme also focused on service provision for GBV survivors. As revealed by the findings of the evaluation, the programme has achieved the intended outputs regarding service provision.

Provision of health and related services

One of the services provided by the programme is health service through referral linkage with different health institutions and partners. Fistula and uterine prolapse cases lived with the problems for a long time without receiving any medical treatment. According to the data from NCWH, 163 fistula cases received medical treatment in Benishangul-Gumuz Region and 78 in Tigray Region during the project period. Moreover, 303 uterine prolapse cases in Benishangul-Gumuz Region and 322 cases in Tigray Region received medical treatment. It was also observed that more than 570 fistula cases were waiting for the treatment in Benishangul-Gumuz. In addition to the above activities, NCWH provided referral and medical services for women with cervical cancer problems. This shows that NCWH has exceeded its proposed plan of reaching 80 fistula and 165 uterine prolapse survivors.

Data from ODA showed that 15 fistula cases were referred and treated and 45 women with 3rd degree stage of uterine prolapse without ulcer have got surgical treatment and 15 women got treated for ulcer. In addition to this, 147 women were screened for cervical cancer in collaboration with ESOG. Along with other six IPs, ODA contributed to 1,617 women and children to receive health care treatment through facilitating strong referral linkages.

In the case of ADA, 79 fistula and 134 uterine prolapse survivors received medical treatment and 180 domestic violence survivors were referred to health facilities. Fistula and uterine prolapse survivors received accommodation, food, clothing, bed, sanitary goods and awareness raising services focusing on early and forced marriage, causes of uterine prolapse and its prevention, and ways of keeping personal and family health during their stay at the medical center. The services provided at the treatment center was timely and very relevant from the women's perspectives. The treatment center at Bahirdar Hospital provided adequate health care services and enabled survivors to receive treatment without going too far, and fostered their level of understanding on gender related issues including GBV.

The medical treatment provided by the projects in general enabled fistula and uterine prolapse cases to regain their health. It improved their knowledge about uterine prolapse in particular and GBV in general and also scaled-up their confidence, self-image and ability to consult women in their village without fear and embarrassment. They managed to be engaged in social gatherings and ceremonies and church activities and in activities that increase the family's income. The survivors' lives changed dramatically and they became more viable physically, psychologically, socially and economically. Before receiving treatment, the women were physically weak, unable to do things on their own and not capable of participating in income generating activities. The psychological treatments of the center brought significant impact on their self-confidence and self-esteem and enhanced their social integration. The women felt insecure and unprotected and were not able to attend social gatherings, community meetings and religious ceremonies. Now this has changed for the better and the women openly shared their experiences with their neighbors in their locality.

However, there are also some problems reported regarding the situation after the medical treatment. For instance according to the qualitative information collected, it was revealed that after survivors undertook a surgery there was no follow up except that only nurses call and check on the patients. There is also lack of socioeconomic support to right holders: some may not be able to afford medicine and follow-ups, and there is no system to help them out.

Increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV was also another anticipated output of UNFPA GBV program. Towards achievement of this output, OSSA has been supporting the availability of essential commodities (sanitary pads and detergents) to female students coming from low income families. Apart from this, OSSA has been providing SRH related tools and kits (contraceptives, condoms and others) to students in the target universities. It was reported that OSSA provided sanitary pads and detergents materials to 2,048 disadvantaged female university students. In addition, 3,656 sanitary kits were distributed among girls' clubs in 30 schools in Pawi and Bullen woredas by MLWDA. These students described that the programme has made them feel equal with their fellow students, built their self-esteem and made them focus on their education and studies.

Apart from this, OSSA has been providing SRH commodities to the students in collaboration with the SRH clinics at the Axum, Assosa, Mekelle and Debre Tabor universities. OSSA provided accessible and standardized SRH information and service to the students on needs basis. The SRH items purchased and supplied included condoms, post pills, oral pills, Human Chorionic Gonadotropin (HCG) rapid test, sterile glove, cotton, examination glove, gauze bandage, and dressing set.

Like OSSA, ODA also facilitated the provision of different reproductive health services at health center sites using the established referral linkage by women development armies and peer educators for clinical management and youth friendly services. During the programme period 2,597 (1,908 female) adolescents and youths received different services including 1,754 for family planning (1,252 female), 78 for post abortion care service, 763 for other health service (576 female) (i.e., testing and treatment of VCT, STI and pregnancies); and 2 female for psychosocial support.

Unlike the services provided by other IPs, the MCRC programme emphasized in creating healthy and productive women and children by providing nutritional services at the medical center, and provided psychiatric care and psycho-social services at different private and public hospitals. The center provided psychological support to 1 male and 33 female adults, and 33 boys and 39 girls. Medical support was also provided to 52 male and 47 female adult patients and 51 boys and 37 girls. There were a few mothers who received rigorous psychiatric help. Moreover, MCRC provided nutrition service for all of the children three times a day and provided a special balanced diet for mothers, fathers and children who are living with HIV-AIDS. The mothers and fathers were served breakfast and lunch and the children were served with a special diet programs recommended by a pediatrician.



BIGA provided emergency victim support, which include treatment, food, and transport to help survivors recover from emergency situation. All in all, BIGA provided emergency victim support to 375 survivors. In addition, 121 survivors were given money for transportation for reunion with families or guardians when discharged from the safe house. In addition to its prevention and awareness creation interventions, NCA also provided psychosocial, medical and economic supports to 137 (16 M) GBV survivor.

Provision of safe house services

The other service provided by the GBV programme was safe house services to mothers and children. MCRC played a vital role in delivering this service for its right holders. It provided shelter to 34 people in 2013, 34 people in 2014, and 80 people in 2015. This shows that the center has exceeded its proposed plan to provide safe house services to 120 mothers and children. This has helped the mothers and children not to be exposed to street life and violence that came as a result of it. In addition, the safe house served as temporary accommodation place for mothers which helped them learn basic housekeeping and to reintegrate into their communities. After their short stay at the center, the latter provides financial assistance for renovation of their houses owned by the Woreda and pay for their house rent. The center in this regard enabled its right holders to adjust themselves to normal life and to be able to reintegrate into their communities.

AWSAD also registered significant progress regarding service provision. At the beginning, its goal was only to provide shelter for women, but in due course they were able to empower and assist them in getting justice as well. The factor that contributed to this was the commitment and team work of its staff. It also developed counseling and safe house guidelines and collected feedback from right holders through meetings. When survivors join the safe house, most of them were quiet. But in the course of various feedback meetings, progresses started to be seen. This shows how the counseling service actually worked in building their confidence.

The BIGA safe house accepted and supported 783 survivors (543 women and 240 children & infant). Most of the survivors came through the Women and Children Affairs, health institutions, law enforcement bodies and Kebele administrations. All the survivors who came to the safe house hated their existence and their children, and some did not even want to breastfeed and tried to kill their children. The psychosocial counseling service provided at BIGA safe house during their stay in the safe house helped them to recover from their traumatic experiences and to become hopeful and eager to live again. Now they are confident and lead their lives peacefully and are able to take care of their children.

Income Generation Activities

Income generating activities were also the other services that have been provided by IPs. For instance, in the case of NCWH, the programme provided 2,000 to 3,500 Birr to survivors as seed money for income generating activities. In this regard, 186 survivors benefited from IGA in Benishangul-Gumuz Region and 153 in Tigray Region during the programme period. This shows that NCWH has surpassed its proposed plan of providing IGA services to 110 right holders. The IGA right holders were involved in livestock production and petty trading, and it enabled women to support their children and to run their households. In spite of good attempts, it was reported that women were not provided with adequate training to run and manage their businesses and the amount of revolving fund that was provided to them was very small.

The MCRC formed a women association business group that consists of five members who were engaged in sewing and embroidery. The group sold its embroidery products at NGO bazars held at the International Evangelical Church once a month. The association has opened a saving account to the group. The center provided Birr 5, 000 for those who received skills trainings as startup capital for income generation activities.



The BIGA safe house provided skill trainings on traditional food preparation and hair dressing for 222 survivors. 10 survivors were supported with startup capital. BIGA started this training in order to ensure sustainability and to create opportunity for income generating and life improvement of the survivors when they leave the safe house.

Educational and therapeutic/counseling services

This service was especially provided by the MCRC. Many of the children supported in and outside of the center were not able to join schools due to poverty and the violence they were subjected to. The center in this regard played a key role in helping the street boys continue their education both at private and public schools. The center provided schooling from KG (pre-school) to high school levels. Accordingly, 23 male and 34 female students attended their education at private schools while 28 male and 9 female students attended at public schools. The center provided pre-school education to 22 boys and 10 girls and after-school tutorial support for all students within its compound. In addition to school fees, MCRC paid for their uniforms, books and school materials. Out of the total 106 students supported by MCRC, school materials were provided to all of them and uniforms were given to 74. The center has thus achieved its plan of providing informal and formal education children in the safe house.

The center also provided literacy and numeracy course for mothers and few of the mothers followed their formal education in colleges and universities. Training on personal hygiene, reproductive health and family planning was also provided to mothers at the center. The education enabled mothers to be independent and economically self-sufficient.

In parallel to formal education, the center provided specially designed art therapy lessons to 120 street children (both boys and girls). The lessons included self-defense, dance and music (instrument, vocal). In general, the programme supported the street children to protect themselves from violence, build their confidence and learn discipline.

BIGA provided psychosocial counseling service to survivors of violence and other clients at its 3 centers in Hawassa, Dilla and Yirgalem through professional psychologists. BIGA provided psychosocial counseling services to 669 survivors. The progresses of survivors were assessed every three months to track their recovery from their traumatic experiences after they received regular counseling service. In addition, BIGA provided counseling services at grassroots level to a total of 4,310 clients (2,557 women & girls).

In general, most of the GBV survivors who received support at the AWSAD, MLWDA, MCRC and BIGA safe houses explained that the services provided at the safe houses including food, shelter and therapeutic services were adequate and timely. However, the legal aid service was not satisfactory due to the legal and social challenges surrounding the problem. Regarding medical services provided to fistula and uterine prolapse survivors, despite significant improvement in health and social conditions of the survivors, some explained that the service was rendered late. They recommended the IGA services to be accompanied with adequate business skill trainings and revolving fund.

4.2.8 Effectiveness of Awareness Creation Programme by IPs

Awareness raising initiatives have been instrumental in sensitizing and empowering the community and other actors to combat GBV incidences and enhance their responses. Different awareness raising activities have been pursued, such as using girls clubs and introducing secrete boxes in schools. The IPs who have been adopting the awareness creation sessions included OSSA, ODA, ADA, BIGA and NCA. These IPs have managed to reach more than 1,398,711 (776,545 F) community members via community conversation throughout the three years of programme implementation. The IPs have been identifying and addressing various types of thematic areas. For instance, ODA has been focusing on creating awareness on early marriage, FGM, safe sex, SRH and utilization of secrete boxes through trained peer educators in primary and secondary schools. ADA has been focusing on such themes as SRH promotion and HTP prevention education, and OSSA on the topic of HIV/AIDS and GBV, STIs, family planning, and condom use through hotline services especially for Adama and Mekele university students. BIGA has been focusing on topics related to rape, domestic violence, forced marriage and family problems and has conducted a total of 65 discussion forums. These and other awareness creation programs have created a sense of actual determination in the community and other actors to prevent GBV through immediate responses.

Awareness creation programmes were conducted by IPs in different forms depending on the nature of their mandates, and the IPs have been adopting various approaches for raising awareness of right holders and the public. The case of three IPs (NCA, OSSA and Pro-pride) has been illustrated in subsequent sections.

The Case of NCA

NCA and the FBOs organized workshops, meetings, panel discussions and community mobilization at congregation level to create awareness on GBV and increase the involvement of religious leaders in the fight against GBV. The awareness raising sessions were attended by church leaders, ministers, youth clubs representatives and families, congregations, girls' club leaders and GBV survivors. A total of 2346 (1285 male and 1061 female) were reached through the awareness creation sessions in the year 2014 and 754 (257 Female) in 2015. The awareness raising sessions increased the level of religious leaders' commitment to address GBV and created space to discuss the need for integrating GBV into the curricula and teachings of theological institutions.

In addition, 11 clubs were established in FBO run schools, universities and congregations. Men and boys engagement was improved and their knowledge and understanding of gender relations and GBV was increased. Religious fellowships in Mekelle and Adigrat universities had been used to disseminate information about GBV including GBV reporting. EOTC-DICAC used Sunday schools (tsewa associations) to create awareness on GBV. ECFE created youth friendly environments or spaces for a continued dialogue on GBV among youth club members, and organized sessions that created dialogue between youth and their families on GBV. A total of 1, 303 right holders were reached through the youth clubs. This shows a minor gap with the planned figure of 1, 773.

The Case of OSSA

OSSA made strides using a range of approaches and techniques and achieved encouraging results though this varied from one location to another. OSSA also made strong exertions to address GBV prevention methods using its print media. Different pamphlets, brochures, bulletins, newsletters, and manuals were published and disseminated in higher learning institutions. For instance, the sexual harassment policy of Debre Tabor University which was at a mere draft stage and almost being abandoned was finalized and published through the financial support and facilitation of the GBV programme. Similarly, the development of the GBV curriculum at Mekele University is a good achievement. The university is now looking for support for the development of three modules (GBV, HIV/AIDS/ RH). Other universities in the region followed suit in striving to integrate gender policy and related codes of conduct. Adama University has also prepared a Psycho- Social & Violence Management and Peer Education Manual and distributed to be used by peer counselors.

OSSA was successful in organizing committees directly accountable to the universities' presidents' office with mandates of assessing, evaluating and giving decisions related to GBV. As a result of OSSA's intensive and series of consultative meetings with policy makers of the higher learning institutions, the institutions in Tigray formed committees accountable to their respective presidents, developed GBV training manuals, produced staff GBV codes of conduct, designed course outlines and incorporated GBV in their curricula. Similarly, Debre Tabor University was able to establish a taskforce composed of offices of Police, Justice, Health and Women and Children Affairs which meets on a quarterly basis to discuss on matters related to GBV incidences, legal provisions and protection, awareness raising, referral health support and other associated issues. This platform was essential to protect GBV cases effectively and provide the required medical services for survivors. On the other hand, the Gender Office of Assosa University along with the OSSA branch office in Assosa has established a platform where key members of the school community including university police/special forces, security offices, male and female proctors, university students association and Gender Office are members. This platform meets every quarter for one day and makes discussions on various matters related to GBV incidences, programme progresses and challenges to GBV prevention.

The programme has raised awareness of the students on GBV and SRH issues. This was demonstrated by the practice that female students started to report GBV committed on them or their colleagues to concerned bodies, such as GBV club facilitators, teachers, university management, police or GBV programme facilitators. As a result, three teachers of Assosa University who have been sexually harassing female students were fired from the university.

The welcome events that organized by OSSA in collaboration with the universities' administrations were also reported to be a successful programme in raising awareness of newly admitted university students about SRH, GBV and other related issues. Other events, such as World AIDS Day and annual gender days were also reported to be effective media through which pertinent information has been conveyed to students and the university community at large. For instance, OSSA in collaboration with other IPs and stakeholders has contributed in raising the awareness of more than 14,000 people on issues related to GBV and others. Out of these, about 3, 000 were Mekelle University students and the surrounding community.

Debre Tabor and Adama universities have been organizing other educational events to create awareness for large mass of students. For instance, there have been quarterly entertainment events such as dramas, music and others which conveyed information associated with GBV and SRH issues. Apart from this, leaflets were distributed and higher officials of the universities made speeches.

Gender clubs, student unions and councils have also been effective in playing key roles related to awareness raising and brainstorming on issues related to GBV and SRH in universities in Tigray. There was no GBV club in Debre Tabor and Assosa Universities before the programme intervention. The Gender Club of the Assosa University has been facilitating annual “Gender Day” which was celebrated with many functions that help raise awareness of the students and university community on GBV including management team. Coffee-tea programs were also events that contributed for enhancing awareness creation and information sharing on GBV. This club was instrumental in raising awareness of the students in the campus through creation of debates and brainstorming on essential issues. Many of the female students raise their queries and concerns to get better clarity from those peers who received training from the programme.

Peer learning groups were also established at Adama University meeting every quarter to discuss on various issues related to GBV and SRH. So far, 10 peer learning groups with 10 members each were established at Adama University. They in turn conducted peer education sessions for 4,000 students in the campus. Issues that have been raised and brainstormed during such sessions included drugs and narcotics use in the campus, unwanted pregnancy, friendship and peer group pressure among students, gender based violence and gender equality, behavioral changes, influences of harmful traditional practices, relationship and campus life, HIV/AIDS and STIs, HCT and other related issues.



OSSA also introduced hotline services to the students at Adama and Mekelle universities. Hotline service is a free call used by the students to help them report GBV and related problems. It is mainly aimed at increasing the knowledge and attitude of university students and communities towards GBV and SRH. Hotline counseling focused on such major issues as contraceptives, HIV/AIDS, sexual behavior, GBV, pregnancy, unintended pregnancy, ART, sex and gender difference, emergency contraceptive, condom access and use, relationship and campus life, abortion, and sign and symptom of STIs. It was reported that counseling services have enhanced the awareness and knowledge of most of the students. The hotline

service was effective in providing GBV and SRH related information to the students and helped to maintain their privacy when they receive the services. An expert on the subject under focus has been responding at the other end of the line to the students' queries mostly related to SRH issues. This strategy of OSSA has been appreciated by the students and the school community. In the project period, OSSA provided hotline service to 1,164 students who sought information on HTP/GBV and SRH issues. At Debre Tabor and Assosa universities students were also provided the option of using the secret box approach where they wrote their questions and dropped the note in the box anonymously. This box was opened once a week and the notes were collected and shared with experts on the subject under consideration. The responses to the questions were posted on notice boards where all the students can have access to information for the questions raised. This approach was reported to be very effective in Debre Tabor University and it has also created an opportunity to raise awareness for other students as well. The students have also provided a note of witness through secrete boxes on sexual harassment and other GBV acts they faced from either fellow students or teachers. Such witnesses were streamlined to university management for possible follow-up and action.

Before the GBV program, there was no SRH clinic in Debre Tabor University. However, with relentless facilitation and material supports of the program, a separate room was established for SRH along with its own specialist within university clinic. This initiative of the programme has created a favorable condition especially for female students to get the required services. The programme has also engaged a nurse to provide face-to-face counseling services though this service didn't go well as per expectation. Even though it was expected to provide services for many of the students, the numbers of beneficiaries was below expectation.

The other successful achievement of the GBV programme in Assosa University was installation of "condom boxes" in the university campus. About six condom boxes are still being filled with condoms for students to pick anonymously and use whenever required. This approach was noted to be effective in protecting the students from HIV/AIDS, unintended pregnancy and STIs. After the phase out of the programme, the university has started sourcing these condoms from the Health Bureau of the region.

The Case of Pro-Pride

Esemashalehu, the radio program of Pro-Pride played a crucial role in increasing the awareness and response of the community towards GBV. The programs were produced in a magazine format of 30 minutes duration consisting of case stories of GBV survivors, featuring legal processes, and cases of HIV/AIDS and commercial sex workers, and other stories with a focus on youth. These programs were aired to the public in time slots thought to be convenient to raise awareness on the severe negative effects of GBV and problems related to SRH.

To meet the objective of increasing awareness and response of communities on GBV, Pro-Pride has produced and aired a total of 687 radio programs in Amhara and Oromia Regions.

Pro-pride has also been giving more to production and transmission of stories of GBV survivors to raise awareness of the community and enhance their responses on prevention. This component of the radio program was appreciated by the community.

In addition to producing radio programs, Pro-pride has also been organizing trainings on techniques of radio production to media professionals working in both regions so that they could have a better capacity to continue producing programs on GBV even in the post-project period.

Pro-Pride used a mechanism of collecting feedback on the appropriateness of the programs through three ways. The first was collecting feedback through direct phone calls. For instance in Amhara Region, about 4,380 phone calls were made in 2013 by listeners to express their appreciation, comments and feedback on the programs. The second way was listeners send their comments and feedback through letters. The third was where listeners come physically to the radio station and share their stories in person. The stories of survivors were documented and transmitted to the audience. There were also opportunities where listeners expressed feedback during workshops or similar platforms.

In the Amhara Region, it is estimated that the radio program reached more than 1.5 million listeners, out of which more than 50% were female. In the Oromia Region, more than half a million listeners were estimated to have followed the radio programs which were broadcast from the Haromaya University Community Radio. The lessons taken from the earlier transmitted radio program of Pro-Pride called “*Yibekal*” has substantially contributed to the successful implementation of *Esemashalehu*.

Overall, the feedback from listeners of *Esemashalehu* showed that media campaign on GBV is contributing to increased awareness of the community as well as its response to violence perpetrated against women and children. It was also witnessed that the program has achieved its anticipated outputs. It has substantially raised awareness of the public on the harmful effects of GBV and issues related to SRH. GBV survivors have also received legal services because of awareness created through the program.

4.3 Efficiency of the Programme

This section examines the efficiency of the Prevention and Management of GBV Programme implementation by the 12 implementing partners of UNFPA in line with the programme costs and time frames. The evaluation mainly examined utilization of planned budget, and delivery of programme activities as per the initial plan to assess efficiency of the programme implementation. Factors that contributed to efficiency and delay in programme implementation are also presented to distill some lessons.

Data obtained from UNFPA indicates that a total of about 4.7 million USD was committed for the implementation of the programme by the 12 IPs. The fund was distributed to the IPs based on scope of their activities, implementation capacity and available facilities and structures. Accordingly, each IP received 5%-11% of the total budget. Out of the above mentioned total budget, about 3.4 million USD (72%) was utilized by the end of the program in December 2015³. However, absorption capacity varies across IPs, with budget utilization ranging from 49% by the Federal Police Commission to 98% by MLWDA. The data indicates that five IPs (Federal Police Commission, BIGA, OSSA, Pro-Pride and AWSAD) registered below average budget utilization by the end of the programme. As a result of the budget underutilization, UNFPA requested a no cost extension for a year and redistributed the remaining budget to the IPs engaged in safe house services. Hence, BIGA and MLWDA managed to extend their service for one more year and get a little over 170,000 USD for the 2016 fiscal year.

³ This figure does not include budget utilized through UNFPA Execution and indirect cost deducted by UNFPA Headquarters which amounted to 643,000 USD in total.



Despite underutilizing their allocated budgets, most of the IPs have reported lack of financial resources to accomplish their activities. For example, ODA, MCRC, ESO, NCA, OSSA and ADA reported lack of budget to carry out their activities. ODA mentioned that due to limited budget they could not provide safe house services and start IGAs for GBV survivors. Moreover, they also indicated the GBV programme has run with meager resources. Many of the IPs underscored that the allocation of limited resources for running the programme might have affected the achievement of the anticipated outputs. This happened due to increased demand for the services and IPs scope of work which goes beyond GBV prevention and control. In addition, AWSAD has established a safe house in Oromia Region, which can to some extent address the demands of GBV survivors. Second, though the fund is disbursed based on submission of financial and performance reports every 18 months as required by UNFPA, some IPs failed to do this on time. This created delay in fund release every year which in turn created budget shortage for the IPs. For example, the Federal Police Commission mentioned that 20,000.00 Birr was allocated every six month (an estimated 141, 685.00 Birr for 18 months) by the Federal Police Women's Affairs' division to each target Woreda's Police Women's Affairs desks to support control and prevention of GBV through training on communities, mobilizing communities action against GBV, and providing supportive services for survivors of GBV. This allocation seems small given the nature of the work and lack of alternative fund from government for control and prevention of GBV. However, the Federal Police has registered below average budget utilization and returned unutilized budget to UNFPA.

Table 4-9: Budget utilization by IPs (planned vs. actual)

Implementing partners name	Planned budget (USD)	Amount utilized (USD)	% utilized
ADA	257,404.96	187,842.83	73.0%
AWSAD	454,339.84	308,098.91	67.8%
BIGA	460,506.74	244,729.64	53.1%
ESOG	494,075.18	328,238.85	66.4%
Ethiopian Federal Police Commission	271,471.91	132,206.04	48.7%
MCRC	237,546.49	211,307.23	89.0%
MLWDA	487,753.83	476,631.63	97.7%
NCA	522,973.36	435,374.45	83.2%
NCWH	279,676.86	245,547.51	87.8%
ODA	475,195.40	356,994.66	75.1%
OSSA	490,721.96	281,830.82	57.4%
Pro-Pride	285,639.17	197,813.90	69.3%
Total	4,717,305.70	3,406,616.47	72.24%

Source: Household Survey, 2016

However, qualitative information from the IPs indicated that budget utilization was efficient. The projects were efficient in terms of using the resources provided by UNFPA. For example, ODA indicated that its interventions were mainly awareness creation through community facilitators or role models. The fund spent on coffee and tea ceremony was small, but helped to instill knowledge on GBV and all its consequences. Even the budget allocated for the purchase of such supplies as sanitary pads, detergents and school materials were limited. As the awareness increased in schools, the demand for such material support increased but the programme was not able to respond to this.

It was also mentioned that the effort to increase access to safe houses and adequate legal aid services was constrained by budget limitation. This was compounded by the fact that counterpart government offices in charge of GBV prevention and control didn't have adequate budget to contribute to GBV programme initiatives. Therefore, key informants indicated the GBV programme run with insufficient resources which might have affected achievement of anticipated outputs.

One of the key issues in efficiency assessment is delivery of programme activities on time. Even though most activities were completed on time there was also limitation in accomplishing the activities as per the plan. It seems limited institutional and human resource capacity of most IPs contributed in delays of programme activities. Moreover, there were delays in submitting financial reports and annual work plans which prevented IPs from submitting the reports on time.

The field assessment indicates that the programme design and approach has contributed to delay in implementation of some activities. For example, at MLWDA for the sake of convenience health professionals the number of women suffering from uterine prolapse must be ten at a time before making arrangements at the hospital for them to get treatment. This was difficult to organize. Moreover, ESOG's outreach programme requires the collaboration of many institutions which created delay in mobilizing GBV survivors. This is because it was not feasible to go to each and every woreda. Sometimes, mobilization of

⁴ This figure does not include budget utilized through UNFPA Execution and indirect cost deducted by UNFPA Headquarters which amounted to 643,000 USD in total.

survivors do not go in line with gynecologists' schedule. On the other hand ADA's time for dealing with fistula & uterine prolapse cases was not adequate given the cultural and social barriers inhibiting the survivors in Basso Liben Woreda. It took a while for survivors to disclose their status. It was at the end of the programme implementation period that survivors started to disclose themselves after they practically observed cured women in their villages. As a result, many women did not receive medical services because by that time the programme has already been phased out. Similarly, in NCWH target areas the service provision and prevention programs were initially designed to be implemented at the same time. However, the service provision component lagged behind because fistula and uterine prolapse cases did not come forward to receive medical treatment due to cultural barriers. As a result, the prevention component took longer than expected, and the timing for the service provision programme was short. Yet more survivors could have benefitted if the timing of the service provision component of the programme was longer.

At the Federal Police Commission there were some activities that dragged between the fiscal years and quarters. They mentioned that these resulted from issues that demanded involvement of members of the programme.

In general, the IPs used different strategies to overcome budget shortage and delay in release. Integrating the programme with their other initiatives (e.g. MLWDA, NCA, OSSA, ADA), working closely with government offices (e.g. ADA, NCWH, MLWDA, MCRC, NCA, ODA) and health centers (AWSAD, MLWDA, ESOG, NCWH), collaborating with other UNFPA IPs (ESOG) and use of volunteer services (NCA and OSSA) were some of the strategies used. NCWH worked with the agricultural office to facilitate training opportunities for IGA participants. ESOG and NCWH established linkages with health centers to screen fistula and uterine prolapse survivors. AWSAD reported that change in food price was observed after they submitted the proposal and this affected their implementation. However, they managed to buy food for beneficiaries during harvest time when price of food crops usually decline. OSSA effectively collaborated with universities to use their halls and other amenities for training on top of using volunteers to provide services.



Notable among the IPs is NCA and its partners which employed different measures to be more cost effective. Some of these measures included:

- NCA used a comparative advantage approach to assign distinct roles and tasks to the respective FBOs at the initial stage of the project. For example, service provision activities were assigned to FBOs that have facilities and structures for service provisions;
- NCA and the FBOs used their existing structures and facilities to be cost efficient. For example, rent expenses were covered by other projects, and vehicles were shared and salary costs were minimized;
- The FBOs used volunteer religious leaders and counselors to provide counseling services and to do awareness related activities; and
- FBOs work in collaboration with government referral hospitals and other Governmental Organizations to select beneficiaries and set aside premises for the latter's income generating activities. The coordinated effort ensured efficiency in terms of accessing expert support and services.

ESOG did not have an integrated approach but to be cost effective it collaborated with other organizations that can provide the service. For instance, ESOG utilized the Ayder Referral Hospital's human and infrastructural resources and also collaborated with the court and police for legal advice and follow up.

Lack of flexibility affected implementation of activities. For example, OSSA reported that the budget codes were not flexible enough for reprogramming depending on the changing realities on the ground. For instance, a budget allocated for one quarter of the year cannot be transferred to the next quarter when there is delay in implementing the planned activities due to issues beyond their control. However, it was reported that UNFPA was flexible enough to transfer unutilized budget to next quarter on condition that the IPs submit reprogramming and transfer requests in a timely manner.

One of the factors that contributed for better utilization of the budget was proper planning and budget allocation guidelines. For example, OSSA noted that financial, human and material resources allocated by UNFPA had been utilized as per the initial plan and each activity was made to have its own budget. Following UNFPA's rules and regulations on budget allocation, OSSA utilized 7% for administrative purpose, which contributed to budget efficiency. Only 5% of the total fund obtained from UNFPA was used by the Federal Police Women's Affairs Division for monitoring purpose while the remaining 95% was allocated for activities of the program.

The use of mass awareness creation through radio programs (Pro Pride) and community conversation (ADA and others) enabled to reach a large number of targets through limited budget. One recommended practice is that in ADA target areas government allocated financial, material and human resources to woreda police office for the prevention and control of GBV, though it wasn't adequate to execute all the activities. Most of the activities were carried out through regular budget of the police gender office because they received only 20,000 Birr every six month from the Federal Police Commission. Moreover, the gender office in Basso Liben Woreda faced institutional problem in using and mobilizing funds released from the Federal Police. However, the police office mobilized the available resources such as training manuals and human resources to effectively implement GBV activities.

UNFPA provided funding for BIGA safe house for one more year but is terminating this due to poor management, lack of accountability, and poor mobilization of resources. According to BIGA, some of its activities, such as the skill training, are currently stopped and the safe house ceased to provide a variety of food items as it used to be because of shortage of budget.

4.4 Outcomes and Impacts

The survey identified that the Implementing Partners (IPs) have used different intervention approaches to contribute to reduction of GBV in their respective areas. It was observed that these interventions had produced some outcomes and impacts on the target right holders and communities. This was supported by the evidences from household survey. According to the household survey, about 91% of programme right holders witnessed that the GBV programme interventions had brought impacts on their lives. This proportion ranged from 82% for ODA right holders to 100% for NCWH right holders. As provided in Table 4-10, the survey respondents attributed the following reasons for the success of the project: transparent criteria for selection of right holders (39%), participatory approach of the project (29%), the project's approach to prioritize needs of the community (48%), timely approach of the project (43%), efficient mobilization of resources (12%) and the project's collaboration with higher officials (10%).

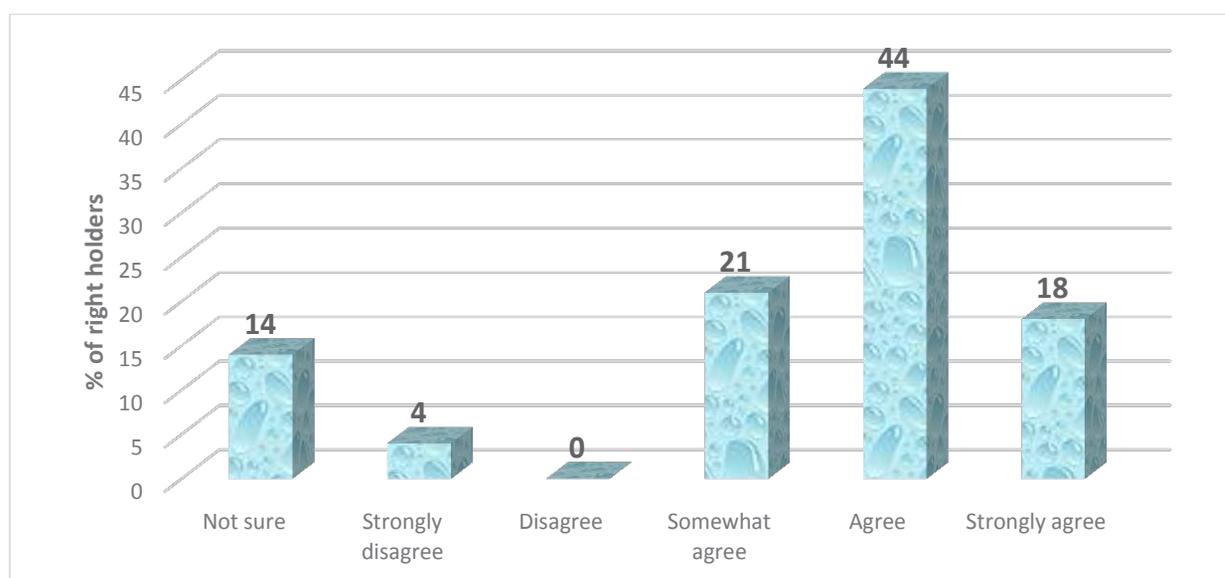
Table 4-10: The factors that contributed for programme impacts (% of respondents)

Reasons for impact	ADA	ODA	MLWDA	NCWH	Total
The project was timely	67.6	28.1	30.8	37.8	43.0
The criteria for beneficiary selection was transparent	42.2	31.5	29.2	54.1	39.4
Enough resources were mobilized	7.8	13.5	0.0	28.4	12.4
Project implementation was participatory with right holders	23.5	34.8	4.6	52.7	29.4
Project participation was participatory with higher officials	5.9	15.7	1.5	17.6	10.3
The project focused on priority problems of the community	49.0	36.0	58.5	51.4	47.9
The project was in-line with government policy and strategy	16.7	20.2	3.1	5.4	12.4
There was close monitoring and supervision of the project operations	0.0	0.0	0.0	4.1	0.9
Other factors	0.0	0.0	1.5	0.0	0.3

Source: Household Survey, 2016

The programme has brought positive impacts on the health and overall livelihoods of GBV survivors. As illustrated in Figure 4-3, 62% of the right holders agreed that the programme has brought positive impacts on health of survivors and helped them regain their health through service provision programs arranged by implementing partners and community facilitators. Key informant interviews have indicated that the right holders have resumed their normal life and have built confidence, self-esteem and self-values after receiving health services that has been provided through referral system.

Figure 4-3: GBV programme supports have brought positive impacts on health of survivors; Source: Household Survey, 2016



Source: Household Survey, 2016

According to the perception of 89% of the respondents, the various approaches and strategies adopted by the IPs have resulted in empowerment of the community. This is because of the fact that the knowledge and awareness of the community has been raised (94%) and that the programme has improved social values of GBV survivors (36%).

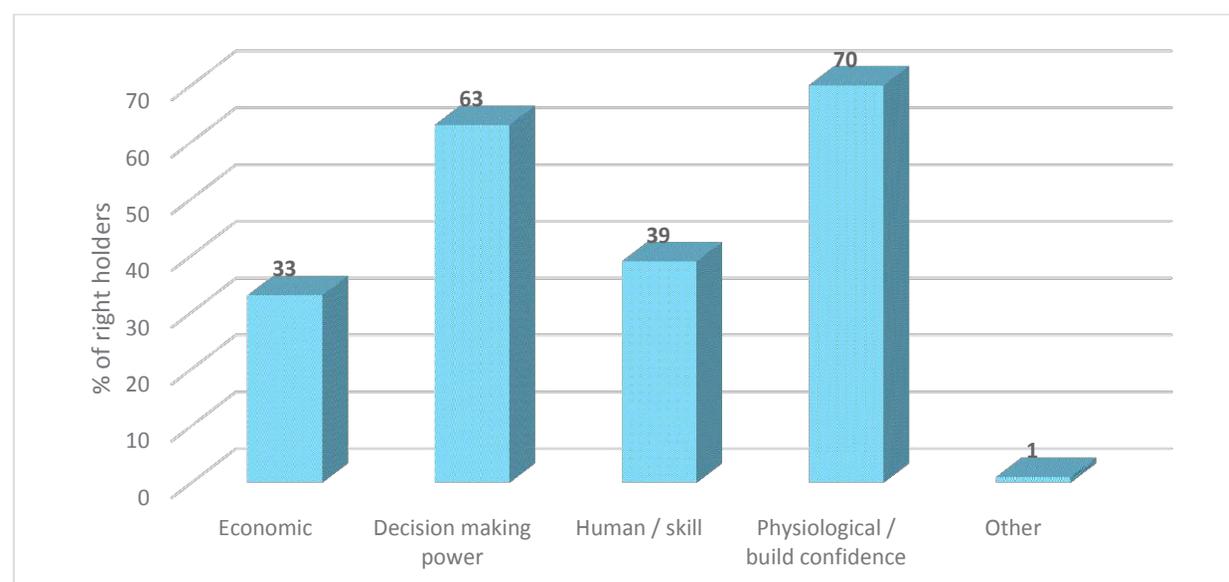
Some of the IPs, such as ODA, mentioned that the affiliation created through community conversation has led women to establish self-help saving and credit associations after rehabilitation. This has also helped them to continue discussing about GBV and HTP issues, decision making, resource control and others. For instance, a woman has started to convince her husband about equality on ownership, control and decision making on common resources.

However, the findings of the evaluation show a shift in the practice of early marriage as a result of the interventions. For instance in the operational sites in the Benishangul-Gumuz Region parents used to arrange early marriage for their daughters for the following reasons: to see the birth of their grandchildren before they pass away and to avoid stigmatization, unintended pregnancy and loss of virginity. Though the above perceptions are still valid, parents nowadays rarely give their daughters away in marriage at an early age. Instead, what is happening is that girls themselves get married at an early age in the name of love, mainly because of their misunderstanding of what their rights entail.

The programme did not only raise community awareness on GBV, but also significantly reduced the existing gender inequality by addressing underlying gender issues in relation to GBV. According to the quantitative findings, 95.6% of the respondents thought that the interventions changed their lives. As revealed in Figure 4-4, 33% of the respondents witnessed changes in economic conditions while 70% believed that they built their confidence. Key informant interviews with stakeholders have also reinforced this evidence. The safe houses with all the necessary provisions gave survivors a chance to rehabilitate from their psychosocial trauma and health problems. The counseling services have also helped them to become somewhat confident and to develop a sense of “I’m alive again”. Girls are going to school and some of them have managed to graduate. This was seen as a great success for some of the IPs such as

MLWDA. The achievement led to more survivors to report their problems to the police or staff of the safe houses.

Figure 4-4: Changes in livelihood situations of respondents; Source: Household Survey, 2016



The programme contributed to increase men’s participation in household activities has increased as well. This is supported by the findings of the survey as summarized below (Table 4-11):

The programme built the confidence and decision making power of women and girls.

- 66% have developed positive attitude about themselves;
- 68% have built confidence to make decision;
- 43% felt that they can accomplish what they set out to do; and
- 25% saw themselves as a capable person.

Moreover, 100% of the respondents felt that they have control over their future life, out of which 69% thought they can solve their problems by taking action, 57% believed that they could determine what will happen in their lives, and 57 % were generally optimistic about their future.

Table 4-11: Perception of GBV survivors on their confidence (% of respondents)

Confidence indicators	ADA	ODA	MLWDA	NCWH	Total
I can accomplish what I set out to do	59.2	39.8	20.6	44.9	42.9
I have positive attitude about myself	54.4	72.4	58.8	81.2	66.0
I have confidence to make decision	63.1	69.4	67.6	73.9	68.0
I can overcome barriers	27.2	11.2	1.5	17.4	15.4
I have self- worth	22.3	2.0	4.4	17.4	11.8
I see myself as a capable person	27.2	21.4	11.8	40.6	25.1
I am able to do things as most other people do	16.5	18.4	17.6	43.5	22.8
I feel I have a number of good qualities	6.8	14.3	16.2	11.6	11.8
Other	1.0	1.0	0.0	0.0	0.6

Source: Household Survey, 2016

The project has also enhanced the decision making power of women over control of resources and management of household. As shown in Table 4-12, the following inspiring impacts have been reported:

- 77% decided about marriage of their children;
- 69% decided about schooling of their children;
- 57% decided on household expenditure; and
- 46% decided on planning in the household.

Qualitative information also shows women started to discuss about gender and other sexual issues at home. Previously women were not allowed to make decisions regarding children's education and other family and economic issues. Now women make decisions regarding their children's education and other related issues. Couples have now started discussing about money and household expense issues. Overall, the project has contributed to of such inspiring social changes.

Table 4-12: Changes in decision making power of right holders (% of respondents)

Decision making power indicators	ADA	ODA	MLWDA	NCWH	Total
I decide about the schooling of my children	79.4	62.8	63.8	68.3	69.2
I decide about marriage of my children	90.2	67.0	69.6	78.3	76.9
I decide on expenditure of the household	52.9	63.8	58.0	53.3	57.2
I participate on planning in the household	29.4	47.9	68.1	46.7	46.2
Other	0.0	0.0	1.4	0.0	0.3

Source: Household Survey, 2016

In general, the project has economically, socially and psychologically empowered the community as a whole. Close to 93% of the survey respondents think that the community has been empowered by the project. As shown in Table 4-13 below:

- 93% of the survey respondents think that the project has increased communities' knowledge and understanding on GBV;
- 34% think that the project has empowered the community economically;
- 42% think the project has empowered the community socially;
- 40% think the project has improved the relationship between men and women; and
- 21% think the project has empowered the community psychologically.

Table 4-13: Impacts of the project interventions on the community (% of respondents)

Project impact on the community	ADA	ODA	MLWDA	NCWH	Total
Has increased the community's knowledge and understanding of GBV	97.1	93.8	94.2	84.5	92.9
Has empowered the community economically	15.7	28.1	18.8	84.5	34.3
Has empowered the community socially	35.3	36.5	37.7	63.4	42.0
Has improved the relationship between men and women	46.1	26.0	30.4	57.7	39.6
Has empowered the community psychologically	25.5	12.5	29.0	19.7	21.3

Source: Household Survey, 2016

The programme had also improved the health status of women thereby increasing the productivity of the community. The medical service enabled fistula and uterine prolapse survivors to feel safe and to be reintegrated into their community. Many of the survivors mentioned that they were confined to the house and excluded from social and economic activities because of the stigma associated with the condition. They even feared to go to hospital with the project facilitators due to fear of stigma by the hospital staff. Because of the medical interventions, these women had resumed normal life able to perform domestic activities and to participate equally in social activities. In addition many women who lived with fistula were divorced as a result of the condition. After the treatment these women regained their dignity and managed to get married and have children. Some of the women even became active participants in the fight against early marriage and fistula. Through the IGA support the survivors managed to open shops and engage in livestock production. By doing so, they were protected from violence that occurred when they travel long distances to fetch water and firewood.

As a result of interventions, visible changes have been witnessed in the fight against GBV. Due to MLWDA's intervention in the Benishangul-Gumuz Region, the programme's impact was mainly seen in terms of changes of attitudes in communities. Key informants indicated that now that the community has understood about GBV and is openly discussing about GBV and acting to eliminate it, people have come to realize that GBV is totally wrong and illegal. Parents have started to send their daughters to school and this is contributing to the reduction of early marriage. Women with fistula and uterine prolapse are speaking about their pain and looking for help. Even men have started to think differently. Communities in the Benishangul-Gumuz Region have started to take mothers to health centers to give birth contrary to the cultural belief that those who do not give birth alone in the jungle would be blind or crippled. As indicated in Table 4-14 below, right holders started to positively react when they encounter incidents of GBV. For instance:

- 89% of respondents would report the incident to police;
- 26% discuss about the incidence with their parents; and
- 16% discuss about the incidence with their friends.

This shows how the intervention has brought behavior change among the community and has started to uncover the incidence despite the fact that members of communities still feel insecure to stand as witness in court of law for fear of reprisals from perpetrators. In spite of this, however, changes are still evident compared to the situation before the programme intervention.

Table 4-14: Programme right holders' reaction against the incidence of GBV in 4 Regions (% of respondents)

Actions taken	ADA	ODA	MLWDA	NCWH	Total
Remain silent	3.7	0.0	0.0	0.0	1.1
Discuss about it with my parents	22.2	36.1	15.3	25.7	25.7
Discuss about it with my friends	5.6	24.1	11.1	21.6	15.5
Report it to police	91.7	79.6	88.9	97.3	88.7
Report to school teachers	1.9	10.2	1.4	12.2	6.4
Report to Kebele administration	3.7	7.4	0.0	0.0	3.3
Report to Social affairs	0.0	6.5	0.0	0.0	1.9
Other	5.6	1.9	0.0	1.4	2.5

Source: Household Survey, 2016

In general, the initiatives have brought commendable impact on the survivors. The services provided including shelter, medication, counseling, and economic and educational empowerment (integrated approach) have impacted the lives of right holders positively. In most cases safe houses are places where the right holders felt safe, got justice and were also prepared to reintegrate with society.

According to sources at AWSAD, the self-defense training and the continuous counseling have the longest impact on the lives of the survivors among all types of services provided to them. Both built the confidence of survivors and helped them to become more assertive. The self-defense training provided women a sense of security.

In the case of ESOG, addressing GBV among students of higher learning institutions is one of its activities. Accordingly, ESOG held in-depth discussions with MOH and the Addis Ababa University medical college and instructors which led to agreement to include GBV in the curriculum. ESOG's intervention has also brought many impacts on the lives of fistula patients and survivors. They established model clinics to help the survivors acquire legal evidence needed by the police and the court, and this helped the survivors to get justice. The one-stop centers of ESOG provided psychological and legal counseling alongside their usual business of treating GBV survivors. Generally, the clinics brought a relief and increased admission of GBV survivors. However, there is a significant lack of adequately trained health care providers giving immediate care to survivors. In order to solve this problem, ESOG has developed a training manual based on UNFPA and WHO guidelines. This can be considered as a positive impact brought about by the program. On top of this, as part of the program's intervention, ESOG conducted an outreach campaign to treat fistula cases.

Since the level of awareness and capacity of women on health issues has risen from time to time, institutional delivery in BIGA's intervention area has increased. As a result, maternal mortality was reported to have decreased noticeably in the target areas. The community also started to report violence to the police or other concerned bodies. This shows how survivors' awareness about what to do when they face or see GBV incidence is increasing. Perpetrators are increasingly realizing that rape will neither remain hidden nor mediated by elders entailing rigorous legal punishment. Moreover, due to the skills trainings, more and more survivors have managed to create their own income generating activity.

Community conversations conducted by MCRC enabled survivors to be aware of the different forms of GBV and to transfer knowledge to their communities. The sessions covered different topics such as causes and consequences of GBV, gender equality and GBV reporting. However, right holders have found the community conversation sessions to be repetitive and passive. MCRC empowered survivors economically through provision of the skill trainings and enabled the women to stand on their feet and to run their own business in sewing and embroidery. The center has created role models who inspired the other right holders to be hopeful and independent. For example, one of the right holders of the center has opened her own beauty salon and managed to successfully run the business. In general, MCRC has provided comprehensive services to its right holders that had positive effects in controlling GBV and rehabilitating those affected by it. One of the key informants stated that:

“The women and children were weak and sick when they came to MCRC, but regained their physical and psychological health after the rehabilitation service at the center. The safe house services enabled the right holders to be protected from GBV and resume normal life. The therapeutic support (counseling) provided to survivors enabled them to express their feelings, build their self-confidence and be psychologically empowered”.

Engaging religious leaders in GBV was also another approach used by some IPs such as NCA. Key informants stressed that initially it was difficult to get the consent of religious leaders to consider GBV as a concern to be addressed. However, NCA managed to break GBV taboos by building trust, working together with religious leaders, and using their own language to challenge them. In addition, the dialogue forums organized at national/regional levels were vital to break the taboos and to make GBV a topic of discussion in the context of religious institutions. Religious leaders now openly talk about GBV issues. Religious leaders have even come up with joint declarations to fight GBV.

IPs such as OSSA and its partners intervened in higher education institutions to reduce GBV and address SRH related problems faced by female students. Qualitative data indicates that at the commencement of the programme reporting GBV and SRH cases created embarrassment among students, especially among female students. Towards the end of the project, however, this feeling has improved and it has become an agenda of discussion. The programme has also saved many students from potential negative effects of GBV and SRH, such as sexual assault and intimidation, exposure to HIV/AIDS infection and unintended pregnancy. Thanks to OSSA's interventions the operational universities recognized the importance of GBV and SRH issues and are including them in their annual plans as one of the regular programs.

Key informants claimed that awareness level of students has improved particularly on GBV, HIV/AIDS and SRH problems. GBV incidence was also reported to have been reduced towards the end of the project period. The confidence of female students increased and school dropout and class absenteeism was reduced as well. Towards the end of programme period, high demand was created among female students who came from lower income families for essential sanitary supplies and seeking information related to SRH.

The other outcome is that after participating in OSSA's interventions students came to know where to go when they needed legal and health services, counselling and other needs. Even some of the instructors who used to sexually assault girls have now refrained from this act because of the awareness raised on legal consequences of committing GBV.

The "dignity room" where female students go and change their sanitary pads during sudden on-set of menstruation was highly appreciated and it has raised their confidence and self-esteem. They don't have to go to their dorms to change and miss classes in the process. Assertive female students were also created as a result of awareness raising and material supports.

Due to the transmission of the GBV radio programs by Pro-Pride, the public has started talking publicly about SRH, sexually transmitted diseases, GBV and others, which were embarrassing to discuss in public. It is believed that GBV related crimes are also decreasing because of awareness on legal consequences. For example, during feedback collection sessions of Pro-Pride, right holders and programme listeners have expressed the positive contribution of *Esemashalehu* radio programme on attitudinal changes. They stated that the radio programme being aired to the public, especially personal stories of survivors, has contributed to attitudinal changes.



Key informants from Pro-pride mentioned that these activities increased the communities' level of GBV awareness to a larger extent and the frequency of GBV reporting increased significantly and incidences of GBV cases related to abduction, physical abuse, rape, FGM, early and forced marriages were reduced.

In addition, ADA in collaboration with the Women Affairs and police office facilitated matters for justice to be served. Due to combined efforts, communities' and survivors' practice of reporting GBV cases has changed over time. Women who suffered from fistula and uterine prolapse were able to report and get medication with no fear of stigma and discrimination and the communities' level of awareness on all forms of GBV has improved and even men became more cooperative in prevention and control of GBV.

In one of the interventions, ADA contributed to adoption of legal protection mechanisms to prevent the occurrence of early marriage. According to the police department in Kobo Woreda, parents or couples must get a letter of permission from the Woreda police before undertaking wedding. The police has a mandate to suspend the wedding if it is conducted without their knowledge. As a result, reduction in early marriage is noticed in the Woreda. The legal process for rape cases is also speedy and smooth and three witnesses are not required to take the case to the court in same Woreda.

The Federal Police through its Women's Affairs Division has performed various activities and brought visible impacts. The division has given various trainings to its staff and brought about remarkable changes. For example, women staff in the office started to react positively and confidently to issues of GBV and take higher positions in different sections of the federal police after trainings are given. The trainings given to media personnel have also helped the television programme of the Federal Police and the Ethiopian Broadcasting Corporation to air a series of programs related to GBV. The Women's Affairs Division has

also provided counseling and legal services. As a result, the division and its desks in the operation Woredas have provided these services for more than 400 GBV survivors.

Because of the division's furniture, stationary and other supports to Woreda desks, staff members in these offices have run GBV related cases in a more comfortable environment. They started to provide quality services to GBV survivors. As a result of trainings given to interrogators on handling GBV cases, the cases have got popular attention in all operational Woredas. Due to efforts made to end and reduce occurrences of GBV through consultative discussions with police training institution managers, GBV has become part of the curricula of the Ethiopian Police University and other regional police training institutions.

In Bullen Woreda, the women affairs' desk in collaboration with MLWDA has brought about better results in the prevention of GBV in the Woreda where the problem is widespread. The collaboration of the desk and MLWDA has also helped to bring more and more GBV cases to the attention of courts that would have otherwise remained hidden forever. In addition, this joint work has helped most survivors from rural areas to be easily contacted by the Woreda police office. In Pawe Special Woreda, the women affairs' desk also worked in collaboration with MLWDA staff and it has brought about changes with regard to peoples' attitudes about the harmfulness of GBV. In the southern part, the programme was helpful to reunify survivors with their families or guardians when discharged from the safe house.

Unintended Outcomes and Impacts

The project activities had encountered unintended effects that negatively impacted the right holders. Some survivors developed dependency syndrome on the safe houses due to the financial assistance that was provided to them and complained when the safe houses stop the support holding the staff accountable for this.

The community awareness creation activities were focused on adults, and it did not target in-school and out- of-school youth. As a result of this the youth misunderstood their rights/freedom and started engaging in sex at early age and ended up with unintended pregnancy. This shows the importance of targeting youth and developing youth focused messages.

4.5 Prospect of Sustainability of the Programme

Sustainability of interventions is one the key objectives expected from programme support. To this end, UNFPA together with its partners has been working on a number of exit strategies to achieve sustainability. The results of the evaluation proved that overall most of the GVB services and activities show sign of continuity after the phase out of the UNFPA supported programme. This can be proven by community perception in which 82.6% of the right holders believed that the programme intervention would continue by the government, another NGO or the community itself. Only 17.5% perceived that the intervention may not continue.

Table 4-15: Perception of the community on sustainability of the programme results (% of respondents)

Name of IP	I think it will continue by the government	I think it will continue by another NGO	I think it will continue by the community itself	I think it will not continue
ADA	18.2	18.2	36.4	27.3
ODA	50.9	11.3	22.6	15.1
MLWDA	28.6	0.0	50.0	21.4
NCWH	0.0	50.0	50.0	0.0
Overall	41.3	11.3	30.0	17.5

Source: Household Survey, 2016

4.5.1 Sustainability of GBV Prevention

Evaluation findings from implementing partners indicate that the programme has built the capacity of community members, health development armies and health extension workers through trainings and provided them with training manuals so that they can replicate the trainings and sustain the activities. In some intervention areas, community conversation has been used as a strategy to ensure the sustainability of the program. For instance, MLWDA used CC strategy to reduce the occurrence of GBV, communities being part of the solution. The Woreda Women's Affairs Office is also supporting community dialogue on GBV.

Evaluation results obtained from ESOG also prove the sustainability of GBV prevention. For the sake of ensuring sustainability, ESOG prepared one training manual and one standard procedure. Prevention interventions (inclusion of GBV in curriculum, development of policy and procedure documents) were conducted while the programme was active, but no advocacy was conducted to validate the integration of GBV in school curriculum. This indicates that the intermediate and long-term achieved results and benefits of the programme will run in a sustainable manner. ESOG also integrated GBV in medical school curriculum at syllabus level; that creates awareness and sense of responsibility among medical professionals thereby ensuring the continuity of its work.

Moreover, faith institutions' structures and their rootedness in communities have also added values for sustaining the results. Hence, evaluation results obtained from NCA indicate that FBOs have continued the activities using their own structures and resources, and capacity. GBV is already integrated into the curriculum of theological institutions. In addition, the FBOs organized quarterly meetings and consultation experience sharing events and review meetings with stakeholders to ensure sustainability. Moreover, in order to strengthen sustainability, NCA plans to integrate GBV and RH issues into other thematic programs such as WASH and climate resilience.

On the other hand, UNFPA has supported community radio stations to implement GBV prevention program. Although the GBV programme support of UNFPA has terminated by the end of December 2015, managers of radio stations in both Amhara and Oromia Regions have pledged to continue producing radio programs on GBV. Accordingly, though the "Esemashalehu" radio program is phased out, considering achievements of the Oromiffa programme that was aired on Haremaya University community radio station, and the importance of the media in changing public perception, Dire FM radio station has given free air time to Pro-Pride, and *Esemashallehu* (Odeysi in Oromiffa) is still on air. One hour a week free air time is given by the station to Pro-Pride, and they also allowed Pro-Pride to have a repeat program once a week. Pro-pride has also been engaged in empowering media centers for production of

quality programs through providing capacity building trainings on production techniques, gender-based violence, investigative journalism, and gender mainstreaming.

With regard to OSSA, Debre Tabor University established a task force that is expected to reinforce sustainability through legal support and protection. The involvement of police and justice offices in the matter will help to minimize GBV incidences in the university and beyond. The referral supports that have been provided by the hospital in the Debre Tabor Town was also a contributing factor for sustainability of such supports through involvement of Women's Affairs Offices. The Gender Office of Debre Tabor University has taken over the responsibility of maintaining and sustaining secret box services. At Assosa University, secrete box and condom box approaches have after project phase-out, and awareness raising trainings are still underway accompanied by the challenge of limited student attendance.

4.5.2 Sustainability of Service Provision on GBV

With regard to service provision, there are some indications which proved to ensure sustainability of GBV service provisions supported by UNFPA's GBV program. Government partners have started to own the programme and pledged to provide financial and material support to the safe-houses in some intervention areas. For instance, in the case of MLWDA, the Woreda administration is willing to provide some financial support to the safe house. Farmland acquisition is also in process which will serve to cover the safe-house's food demand on a continuous basis.

In the case of AWSAD, it is currently working to acquire land from government to build its own premise for its safe house so that it can reduce the rental cost. Evidence from NCWH indicates that model Kebeles in BambasiWoreda have sustained the CC sessions and community mobilization activities. They took initiatives to mobilize resources by planting and selling trees to pay for girls' schooling and collect money to support GBV survivors and orphans. As a result, an estimated 131 students received free educational materials. In addition, school related awareness activities on GBV have been sustained sporadically through the already established teachers', students', and parents' committees.

After carrying out a series of discussions with concerned government officials, ESOG reached at a consensus with government to handover all the model clinics set up as part of the programme. The Adama and Hawassa were handed over to the hospitals they were set up in. The services of Ayder Hospital have also continued without any interruption since December 2015. The hospital allocated necessary financial, material and human resources. It also incorporated components such as provision of direct forensic medical support to survivors.

With regard to IGA, the MCRC has revolved the income generated from IGA to provide financial assistance to its right holders and to sustain programme activities. However, the center has not taken any measures to engage government partners to own the activities, and there is no known organization that has pledged to support the center's activities. On the other hand, FBOs such as EECMY – DASSC decided to distribute the seed money on credit basis to sustain the income generating activities.

Another good practice that ensures the sustainability of the programme is the one that was obtained from the ADA intervention area of Kobo Woreda. The family polices introduced in Kobo Woreda are serving the community in the spirit of voluntarism on sustainable basis. A family police is responsible to solve problems in the family, and negotiate between the family and police.



Challenges to Programme Sustainability

The programme has faced some sustainability challenges. This is mainly due to the following reasons:

- One of the challenges faced by all IPs was limited commitment of government offices due to either shortage or lack of budget allocated for GBV prevention and control programs. For instance, relevant government offices such as Women and Children Affairs, Police, and others started to include GBV programs in their plans, but were constrained by limited budget and resources for implementation.
- The commitment of the higher officials of Debre Tabor and Assosa universities was limited because of their attitudinal problems on the importance of addressing GBV and SRH issues. The issue of owning programme achievements and planning to institutionalize GBV in the university teaching-learning systems was not as such strong. In Adama University, the nature of the programme itself required financial resources and commitment to sustain the piloted initiatives. Out of the many programme components, the university demonstrated commitment to provide support for life skill trainings for the students. It, however, faced financial limitation to provide material support for needy students.
- Particularly with regard to service provision, the sustainability issue is questionable in most of the intervention areas including NCWH, MLWDA, ODA, ADA and the safe houses as well. After the programme has been phased out, survivors are not getting adequate care mainly due to financial constraints. For instance, in the case of NCWH, mobilization and screening of fistula and uterine prolapse survivors has been conducted on irregular basis after phase out of the project. Fistula patients were forced to seek medical treatment by themselves and were not able to easily access medical services. UNFPA has built the capacity of Assosa Hospital by providing the hospital with surgery beds, lights etc. The government needs to be accountable and continue providing medical service to fistula and uterine prolapse survivors based on their need and demand.

- The attitude of the community on GBV is not yet changed adequately in ODA, ADA, MLWDA and NCWH intervention areas despite some improvements due to limited coverage in awareness creation campaign in remote areas.
- Community facilitators, role models and community based institutions have not adequately been capacitated in ODA, ADA, MLWDA and NCWH intervention areas to sustain the activities in some of the intervention areas.
- In ADA and ODA intervention areas, Police and Justice Offices did not adequately demonstrate commitment to prevent and control GBV. Their commitment to make sure that perpetrators received the required justice has been inadequate and the unwillingness of witnesses to testify in courts has still persisted. Though the practice of reporting GBV is improving, communities are getting discouraged when they see perpetrators going scot free for underhand reasons. The perpetrators then start intimidating community facilitators and witnesses. This has been reported in both ODA and ADA intervention areas.
- Absence of skilled staff to address GBV and gender related issues is also recognized to be a challenge in many of the intervention areas including ADA, ODA and Federal police. Staff of government offices who have been assigned to support GBV programme activities are responsible for managing their own regular jobs. As a result, they consider GBV related activities as extra work and thus are not often committed.

4.6 Challenges and Good Practices of the Programme

4.6.1 Challenges of Program Implementation

In all of the UNFPA funded GBV programme interventions budget was inadequate to accommodate the increasing demands of society and to reach large numbers of survivors and students. For instance, even though there were more than 8, 000 students in Debre Tabor University, not more than 100 students received direct trainings on counseling and assertiveness, and it was not possible to meet increasing demands of students for SRH material supplies such as contraceptives due to budget shortages.

The family dialogue was at pilot stage. The majority of the interventions of ODA, ADA, NCWH, NCA, and MLWDA were functioning only in a very limited space and time with restricted accessibility to remote areas where GBV could be high. Financial supports provided to GBV survivors by the NCA, NCWH, MLWDA, ODA, and ADA were not adequate considering the topography and location, and budget for transporting survivors for diagnosis and even for fistula patients to get treatment at referral hospitals was so limited compared to the extent of GBV incidences.

All IPs have suffered from delays in the release of fund. Delayed budget release has created challenges to commence and resume the activities as planned thereby affecting implementation. It was noticed that reporting and communication mechanism of GBV programme was too lengthy. For instance, Assosa University prepared a code of conduct for GBV prevention to be published as pocket manual for the students. This was submitted to the OSSA Branch Office in Assosa during the programme implementation period. However, because of lengthy communication the programme got phased-out before the manual was published. Another challenge faced by OSSA and NCA in relation to fund transfer is the strict policy of UNFPA for reporting budget utilization on a quarterly basis. UNFPA budget allocated for a specific quarter was not transferable to the next quarter in cases of inability to implement the activities. This zero balance approach made the available finance out of use and limited the execution of some trans-phase activities. However, UNFPA was flexible enough to transfer unutilized budget to the next quarter on

condition that the IPs submit reprogramming and transfer requests in a timely manner. MLWDA's project implementation has been challenged by its lack of transparency in budgeting that GBV service was provided to native people only.

The other challenge faced by IPs including ADA, ODA, MLWDA, and NCWH was the not much changed attitude of the society that does not consider GBV acts as offensive and crime. Their limited awareness on consequences of GBV on social, economic and health perspectives have made implementing the prevention initiatives challenging on sustainable basis. The tradition of the influential people and religious leaders in these intervention areas to handle GBV cases in secret without giving fair decision for the survivors was also challenging to fight GBV on sustainable basis. The community still insults women and girls who are not circumcised.

The practice of early marriage and circumcision still remained big challenges especially in the project intervention areas of BIGA, NCWH and ADA. Community members have instead developed strategies to cover up early marriage and parents terrified their daughters that they will never let them back home if they took up their cases with the police and court.

Another challenge faced by the majority of the IPs including ODA and ADA was perpetrators' reactions and influences to escape legal charges. Underhand deals made by GBV perpetrators with legal enforcement bodies, perpetrators families trying to settle cases out of court amicably, intimidations by perpetrators and unwillingness of witnesses to testify in courts are among the challenges that made the effort of combating GBVs on sustainable basis difficult.



The language barriers of facilitators to approach target right holders in NCWH intervention areas , low level of survivors' confidence in general and unwillingness to accept male interrogators, problems of finding female professional interrogators in NCWH, ADA, and ODA intervention areas and limited

attention of police to incidences of GBV among commercial sex workers or among women who run 'tella' houses in ADA intervention areas has induced low level or delayed reporting of GBV incidents in the project areas of the majority of the organizations.

The lower skill of handling GBV incidents and inefficient capacity building trainings to reduce skill limitations have aggravated the lower/delayed reporting of GBV incidents in a number of project areas such as ADA and ODA intervention areas . Especially in ADA intervention areas, there was inconsistent legal enforcement due to variations in law practitioners' understandings and responses to GBV. Staff turnover was high whereby police and health officers who received trainings on GBV were transferred to other areas without benefiting the communities of the intervention areas.

Some of the IPs including NCWH, AWSAD and ADA have also faced implementation challenges related to lack/inadequacy of safe houses and its inclusion criteria. Safe house or other special and segregated interrogation rooms are places not only to provide food and shelter but also justice by making GBV survivors isolated from non-enabling environment. However, such places either have limited capacity or safe houses did not exist at all. On the other hand, in safe houses such as MCRC and BIGA, there was a challenge of appropriate selection criteria and emergence of dependency problems among right holders. While survivors that really needed help were rejected those with less problems of GBV or not GBV survivors at all were accepted. Moreover, those survivors accommodated in safe houses developed a dependency syndrome.

All IPs faced lack of coordination among stakeholders though they established strong partnership linkages with various governmental and non-governmental organizations, which ensured efficiency in terms of accessing expert support and services. Stakeholders at different operational areas of the intervention exhibited low level of commitment and reluctance to move forward. There were also low level of community and other stakeholders participation in meetings regarding GBV, lack of coordination among staff members at head office and lower levels by BIGA and OSSA, reluctance of some of Pro-Pride media managers to put their maximum efforts on GBV, unsatisfactory collaborative works with hospitals and referral linkages and irregularities and inconsistent relations between the regional and federal police offices in terms of administering donor's fund were among the challenges related to coordination.

With regard to OSSA, there has been overlap of the interventions with students' academic schedule and programme activities at Debre Tabor and Adama universities, and it was not easy to engage them as desired. The support and commitment of higher officials at Debre Tabor and Assosa universities was not as to expectation. For instance, Debre Tabor University only gave office but did not provide computers for timely documentation and reporting. Similarly, Assosa University committed to provide office along with facilities, such as computer. However, this did not materialize until the final year of the program. The GBV programme has been running from a temporary shelter for two project years. This was because of the fact that the university was newly established.

In addition, the hotline service was not functional at Debre Tabor University due to unavailability of direct telephone line for this service. Instead, the Gender Office of the university and programme facilitators have been encouraging students to call to Adama or Mekele University hotline numbers to get the services. However, this didn't go well due to poor network connection and frequent interruptions. Similarly, even though there was a plan to establish hotline service in Assosa University, it was not practical for unknown reasons. In addition, issues that have been noted and dropped in the secrete box at Assosa University were mainly problems related to poor governance and teaching-learning processes of the university with limited focus to reporting issues related to GBV cases.

It was reported that the GBV programme at Adama and Assosa universities faced problems of coordination, monitoring and supervision from OSSA. The university Gender Office and programme facilitators rarely received monitoring and follow-up services from OSSA.

The GBV programme at Assosa University focused on students without addressing teachers. Because of this, female students continued to face sexual harassment from teachers. An assessment made by the Gender Department of the university on the status of sexual harassment on female students through distributing questionnaire has revealed that harassment received from teachers ranked first. Even though direct sexual harassment on the female students has declined, it continued through indirect and unnoticeable mechanisms in such a way that the survivors cannot get witnesses.

4.6.2 Good Practices in Programme Implementation

IPs have developed their own ways to be cost efficient. IPs, such as ODA, NCWH, ESOG and OSSA tried to narrow the budget gap of projects through resource mobilization and volunteer arrangements. NCWH mobilized resources to support fistula and uterus prolapse survivors, ESOG organized Ayder Hospital volunteer doctors and OSSA persuaded and involved several volunteer professionals and facilitators in its operational areas.

The use of role models and model Kebeles in prevention and control of GBV and the use of existing government structures for programme implementation facilitated by ODA and NCWH has helped them implement awareness raising campaigns which resulted in a better communication and understanding of GBV and even sustainability of interventions.

ADA's community conversation and family dialogue, girls clubs and involvement of men in addressing GBV played a big role in creating awareness on GBV. Furthermore, NCWH formulated its own code of conduct to punish individuals who practiced early marriage and FGM. ESOG developed a national standard document on sexual and reproductive health issues and integrated reproductive health issues in university curriculum. In addition, the safe houses' comprehensive services to meet the social, psychological and economic needs of the survivors and use of secret box by ADA can be taken as good practices.

Pro-Pride's profound efforts to draw GBV to the attention of the public through radio programs that created opportunities for the survivors to tell their stories and OSSA's hotline GBV related information provision through toll-free calls and "dignity room" or special room can all be taken as good practices.

Attempts by some of the IPs, such as ESOG and OSSA to incorporate GBV into medical school curriculum, and NCA's effort to build the capacity of FBOs and to integrate GBV in Genet church theological college and marriage counseling centers can also be taken as a good practice.

5. Conclusion and Recommendations

5.1 Conclusion

The second phase of the UNFPA programme on “Prevention and Management of Gender-Based Violence” in Ethiopia has been implemented by 12 implementing partners in different parts of the country with the aim to strengthen community and institutional responses to harmful traditional practices and gender-based violence and to provide information and services to survivors. UNFPA employed a participatory approach that is responsive to gender, human rights and culture.

UNFPA and its implementing partners made efforts to end GBV by deconstructing GBV at institutional/cultural and individual level to bring social change. The programme interventions addressed GBV in school, religious institutions, and family and community contexts to raise awareness and knowledge on GBV and its consequences. UNFPA used effective strategies to increase awareness on GBV such as capacity building, community conversation (CC), media campaigns, public education, family dialogue, and hotline services. As a result, UNFPA programme interventions significantly increased awareness and knowledge on GBV in targeted communities and created strong initiation among community members to protect girls and women from GBV. Right holders’ level of awareness and knowledge on root causes and negative effects of GBV especially on women and girls and legal measures against GBV have increased. In addition, incidences of harmful traditional practices, particularly early marriage, have been considerably reduced. Such understanding was found to be helpful for mobilizing communities for joint actions against GBV occurrence and for recognition of GBV as a major social, health and human rights issue.

UNFPA GBV programme interventions have made considerable progress and achievements in empowering women and girls and in bridging gender gaps. In parallel with GBV, gender equality concepts have been promoted. As a result, men’s participation in GBV prevention as well as household activities has increased and women’s decision making power in the domestic and public spheres has been enhanced.

GBV affected the survivor’s autonomy, their productivity and quality of life, and reduced the range of options available to them in every sphere of life. The processes of abuse altered women’s view of themselves and their place in the world. In this regard, UNFPA and its implementing partners have made considerable achievement in empowering women through provision of comprehensive services that are essential to ensuring recovery and providing sustainable livelihoods for survivors.

The service provision programme of UNFPA played a big role in changing the lives of vulnerable groups and in creating alternatives to GBV survivors. The impact brought on the lives of GBV survivors cannot be measured in monetary terms. The safe house services created safe and enabling environment for GBV survivors and psychologically empowered the women and equipped survivors with different life skills and enhanced their economic status. The safe houses enabled GBV survivors to adjust themselves to normal life and created space for sharing experiences with women who went through similar experiences. Many of the GBV survivors developed habits of saving and paying debts, and they developed strong sense of self-reliance and independence. The therapeutic services enabled the survivors to protect themselves from further violence and enhanced their sense of security. GBV survivors were able to join schools and graduate from universities and colleges in marketing, information technology, medicine and engineering fields. These women were able to contribute to society and help other women/girls who were subjected to GBV. Formal and informal education provided at the shelter houses enhanced confidence and communication skills of the survivors. Medical treatment enabled fistula and uterine prolapse cases to regain their health, confidence, self-esteem and ability to consult women in their villages without fear and

shame. They managed to be engaged in social gathering and ceremonies, church activities and in activities that foster their family's income. The survivors' lives changed dramatically, and they became more viable physically, psychologically, socially and economically.

Despite the above successes, UNFPA encountered implementation, cultural/social and systemic challenges in relation to the prevention and service provision component of the programme. With regard to prevention the GBV campaigns addressed the different forms of GBV simultaneously which resulted in lack of focus and compromised depth and contents of messages that have been addressed. Moreover, the prevention programme had unintended effects that negatively impacted the implementation process and achieved results over time. Among others, the awareness creation activities did not adequately target in-school and out-of-school youth. As a result youth misunderstood their rights/freedom and involved in sex at an early age and ended up with unintended pregnancy.

Regarding the service provision component, challenges that compromised the safe houses' achievements and effectiveness include development of dependency syndrome among GBV survivors supported by the safe houses, lack of well-defined criteria for admission of GBV survivors and the safe houses inability to accommodate increasing demand of GBV survivors. In all of the UNFPA supported interventions, the allotted budget did not meet the increasing demands of society/survivors and was not adequate to reach targeted remote areas. Delay in release of donor fund and lack of coordination among stakeholders were found to be pervasive problems across all IPs.

Other social and cultural factors that challenged implementers include the lower level of awareness of community on GBV, cultures that tolerate and condone GBV, and traditional practices that settle GBV amicably without fair decision for the survivors. In addition, the practice of early marriage remains to be a problem in some project intervention areas, and communities use different strategies to cover up early marriage. In addition, youth practice early marriage without their families consent in the name of love. Family pressure hindered girls from reporting early marriage incidences to the police. In addition, police responses were frequently characterized as inconsistent, inadequate and biased. Offenders' personal and contextual characteristics and situations influenced the police and criminal justice responses. Intimidations by perpetrators and unwillingness of witnesses to appear in courts due to lack of trust in police affected performances of police.

In conclusion, UNFPA' programme on prevention and management of GBV contributed directly to women's empowerment and gender equality pillars articulated in the UNDAF as well as GTP I and GTP II of the country. In line with the policy of the Government of Ethiopia, UNFPA has identified gender based violence and harmful traditional practices against women as factors that hinder women's empowerment and has made considerable achievement in strengthening community and institutional responses through provision of comprehensive services. However, gender based violence is still rampant in the country, and it is still condoned in families and communities as ways of maintaining male superiority and privileges over women and girls. A lot remains to be done to translate the good level of understanding into practice and to sustain the activities. The challenges ahead are numerous to conclude that GBV cases have been effectively and sustainably controlled. In recognition of the challenges and lessons learnt from the programme implementation, the following recommendations have been suggested as a way forward.

5.2 Recommendations

- Men/boys' and perpetrators' involvement in GBV related programmes should be increased to eradicate the negative stereotypes that perpetuate violence against women and girls.
- The different IPs working on GBV prevention activities need to develop and implement strategies and messages targeting the youth. In addition, GBV programs in ADA intervention areas need to target commercial sex workers and women who run "tella" houses (local pubs).
- There is a need for additional finance to expand the safe houses to every region of the country and to accommodate the increasing demands of GBV survivors, including uterine prolapse and fistula survivors. In addition to the psychological and economic support, the safe houses need to provide legal aid to GBV survivors.
- There is a need to scale up the GBV prevention programme to universities, high schools and religious institutions as well as segments of societies/communities and remote areas that have not been reached by the UNFPA supported programme.
- There is still a need for capacity building for religious leaders, marriage counselors, health care providers, police officers, law practitioners, gender office staff of universities and government offices, teachers, and other relevant stakeholders.
- BIGA needs to revisit its internal management issue, to put in place a strong coordination system with different stakeholders and UNFPA. This urges the need for management adjustment and strong monitoring and evaluation from the donor side.
- The safe houses of AWSAD, MCRC, BIGA, and MLWDA need to devise strategies to make GBV survivors independent and self-sufficient through provision of trainings and psychological support.
- GBV needs to be further integrated and institutionalized into the training manual of the police, university annual programs/plans and curriculums and in the several media programs in the country. UNFPA and similar organizations need to make effort to influence the government to provide media coverage and other supports.
- There is also a need to strengthen the already existing structures in universities supported by OSSA such as gender offices and student councils, and GBV clubs through provision of material and other supports.
- Monitoring mechanism and accountability system has to be in place to make justice and police officers accountable to their handling of perpetrators. Continuous supervision and follow up of model clinics, FBOs and GBV survivors is required to ensure sustainability. The initiative taken by NCA to create a system of accountability needs to be supported.
- The commitments of religious leaders at top level needs to be cascaded to lower levels to bring meaningful attitudinal changes on GBV in religious institutions. There is a need to establish and strengthen GBV clubs supported by NCA through provision of material and other supports.
- OSSA'S GBV related activities shall include not only students, but also teachers, police and justice officers, Woreda administration and other bodies out of universities.
- Integrated approach of stakeholders is mandatory to make GBV initiatives and achievements sustainable. There should be strong coordination, support and supervision from higher officials, donors, government and other key stakeholders. Government involvement in GBV programmes needs to be enhanced to sustain GBV prevention and service provision and strengthen protection services.
- There is a need to install secret boxes and hotline services in OSSA intervention universities. Telephone line needs to be installed in Gender offices of universities or other appropriate offices with the placement of a fulltime expert responding to inquiries of students.

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Annexes

Annex 1: Case Stories

Case Story 1: Individual - Woman A

Woman A is 20 years old survivor of GBV. She was living in her aunt's house where the perpetrator was also living with them. After some time, when the aunt became sick and hospitalized, woman A was raped by the aforementioned relative. Although the perpetrator was immediately fired from the house, the sick aunt eventually passed away, leaving woman A without any support and in unfortunate situation. As the survivor did also become pregnant, she had to live with her neighbor until she gave birth. After three months, she joined the safe house where she received treatments and provisions such as food, clothing, sanitary pads and soaps. According to this violence survivor, the problems she faced due to lack of shelter, clothing and such provisions during her pregnancy makes the safe house relevant to alleviate her situation and is very important for all survivors that are vulnerable.

Case Story 2: Individual - Woman in Chiro Woreda

Woman B is a 42 year old married woman who lives in Ajebas Kebele, Chiro Woreda. She got married at the age of 14 and has 6 children. While giving birth to the seventh baby, she encountered a uterine prolapse problem which she has been living with for over 18 years. As a result of this problem she could not control the involuntary discharge of urine, which caused her loss of confidence and loneliness. Eventually, her husband also left her and married another woman. After suffering such miseries, she was found by the women development army which arranged for her to get support from the Oromia Development Association. .

Case Story 3: How the project intervention has changed the lives of the women –Assosa woreda

Case Story A

Case A is about 38 years old who got married when she was only 15 and has six children. Born in Wollo and currently living in Assosa, Benishangul-Gumuz, she was suffering from uterine prolapse due to excessive work burden and lack of proper recuperation when she was young. Her uterine prolapse lasted for five intolerably painful years and according to her, the most shocking thing she experienced was that she was able to see part of her uterus hanging outside her body. After five years, she conceived her last child, and during her pregnancy, the pain was less and her uterus was not visible at all but she experienced pain during sexual intercourse.

This woman's story with the programme started when she met one of the programme coordinators in her village during a meeting on GBV. The coordinator consulted her about the uterine prolapse she was suffering from and arranged a surgery. Later, the programme also provided her with free-of-interest loan that she used to start up a business of breeding sheep. This small business was successful in that she was saving 200 birr a month, which she used to support her household. While appreciating the economic support and awareness on GBV that she received from the program, this woman comments that it would have been more helpful if the loan were bigger and if trainings were provided on how to manage small scale businesses. She also expressed her idea that the programme would have stronger impact if it can incorporate provision of technical trainings in the areas of agriculture and livestock production.

Case Story 4: Institutional – The Case of Police Office

The case analysis was selected from Adami Tulu Woreda Police Office. The study team had a discussion with the Police Officer on the general status and cases of GBV in the locality. The Officer noticed that the major GBV cases commonly reported included rape, early marriage and FGM. As soon as the office received such reports, it has been supporting the survivors through facilitating legal supports, looking for tangible evidences for the GBV crimes and in turn report to the next responsible body (court, justice office). Depending on the extent of damage inflicted, the GBV victim could also be referred to Women and Children Affairs, hospitals, justice and courts, and to safe houses. The Police Officer noticed further that GBV incidences often increase at the time of harvest. . This could be associated with sales of produces, increased incomes and increased consumption of alcohol. Women with lower income levels and illiterate; people with different health problems, disabled people and children below 10 years old were the mostly affected groups of the society. The officer has also accentuated that before the implementation of this project, the practice of disclosing and reporting GBV cases and crimes was not strong. The case was instead reported to religious leaders and influential people where the perpetrator goes scot-free after making meager compensation to the victim. The officer has also mentioned a distressing story “there are cases where the family of the victim hides the case and removes possible evidences with the expectation to receive good amount of compensation from the perpetrator. Such families consider GBV cases as sources of income”.

Apart from legal processes after the actions have taken place, the Police Office is also engaged in prevention of GBV through awareness creation of the community and students using its community policing structures in collaboration with the community and schools. It also uses existing informal community based structures, such as ‘iddirs’, ‘ikubs’ and market areas to raise awareness of the community on GBV including its legal consequences.

However, the current organizational structure of the Police office was not strong enough in terms of human power to prevent and control GBV incidences efficiently. The services provided were not satisfactory compared to the level of GBV related crimes taking place in the locality. The legal support provided for survivors of violence was not adequate. Delays in court processes, unfavorable or unbalanced verdict against perpetrators, and sometimes the judge could be made to release the perpetrator free through unofficial dealings are the major challenges to achieve the objectives of the project and sustain the changes. Such practices have discouraged the community to report the cases to Police.

Inadequate monitoring of programme implementation, inadequate budget allocated for the program, top-down planning and unavailability of safe houses for the victims were the challenges recognized by the Police Officer.

Case Story 5: How the project intervention has changed the lives of women –Bambasi woreda

Case Story B

Case B who is 16 years old lives in Bambasi Woreda. She got married when she was 12. Her cousin who she was supposed to marry raped her and is in now in prison. Her uncle tried to force her family agree to a marriage between his son and her because she was already pregnant. But she and her mother refused the marriage. She quit school for a year because of the pregnancy. After she gave birth she continued her education with the help of the project. There were many girls under 18 who have children from their cousins in her neighborhood. She was engaged in income generating activities, which the project facilitated in collaboration with women’s association. She bought clothes and food for her kid with the money she earned. She took the national examination, and is now waiting for the results. Her mother took over her small-scale business since she preferred to take care of her baby till she starts her class. She wants to be a doctor so that she may help girls and women subjected to different forms of GBV.

Case Story 6: How MLWDA is relevant to the lives of the women - Pawe

Case Story A

Mesi lost her parents at the age of 7 and was raised by her aunt until she reached grade 5. But she couldn't continue beyond grade 5 because her aunt used to beat her and give her household chores beyond her capacity. Despite this Mesi excelled in school, getting better results than her aunt's children and this annoyed her aunt, and she refused to send her to school. Her neighbors referred Mesi to the safe house in Pawe where she was provided with a safe place to live. Mesi, in her own words, said: "My options at the time were two; going to the street or the safe house, and if I had chosen the former, I would have quit my education and might even have been raped. The safe house is very relevant for girls like me who have been through a lot at such young age. Now I have families in the safe house, who can understand not only my words but also my silence. I am continuing my education."

Case Story 7: How MLWDA is relevant to the lives of the women - Gumuz

Case Story B

"I was never in school as my family thinks school is for boys. When I turned 14, my parents arranged an exchange marriage for me and I got married. My husband did not have enough income to distribute to his three wives, and consequently, my livelihood was based on daily heavy work load. Even when I was pregnant, I used to collect wood for charcoal, and prepare traditional liquor. Therefore, during pregnancy, I encountered uterine prolapse. I did not tell anyone for six years because, in Gumuz, a woman with such kind of disease is treated as if she has committed some kind of sin.

The safe house, where I have got the appropriate medication after six years of waiting, is a very relevant place for me. Even sitting used to be a luxury for me, and my husband left me because I had a bad smell and could not satisfy his sexual desires. Therefore, the relief I have got after the treatment is beyond my ability to express. When I came to the safe house, nobody discriminated me and seeing other women going through a similar pain was a relief for me because I learned that it can happen to anyone and it's not the result of my sin". (Case B, Kebe from Bulen.)

Case Story 8: Role Model from Bulen

My name is Weinitu. I got into an arranged marriage and immediately got pregnant and gave birth to a baby boy. I told my husband I needed to start taking birth control pills but he refused. I didn't have any choice but to agree on everything he said. Within 6 years I became a mother of six children. Giving birth to six kids within that short period of time made me weak. I couldn't be as attractive as I was before for my husband and he started to abuse and beat me and call me names.

When my first daughter turned seven, my husband refused to send her to school. I cried my eyes out when I knew I couldn't make any decision on my daughter's life. That's when I decide to make changes in my life. My brother-in-law's wife sells different vegetables on the street and I told her I wanted to start to work and she lent me some money. She convinced my husband why it's important for me to start working especially in increasing the household income. He had no choice expect to agree, since she is his elder brother wife.

I started working and every night my husband took whatever money I got. When I told my brother-in-law's wife she advised me to join the self-help group. After joining the group I started saving; every two weeks we saved fifteen birr. Being part of the self-help group was a tremendous help for me. Besides saving, I was allowed to borrow and expand my business. After two years I was making money more than my husband and I started participating in the decision making process of the household. The first thing I decided was letting our daughter to go to school. I remember the feeling I had when I sent my daughter to school buying school materials with my own money.

After saving for three years, MLWDA gave us one sheep for each. The agriculture extension worker gave me technical expertise on how to take care of the sheep. It has been two years since I have received the sheep and now I have seven. Officers of the Women and Children Affairs Bureau kept a close look at my business and they gave me assistance on how to move my business forward. I am a changed person now thanks to MLWDA. Even though I am illiterate, participating in self-help group and community conversations taught me my rights and how I can stand up on my own. My husband doesn't beat me anymore; we have equal voice when it comes to making decision regarding the household. I give all the credit to MLWDA because they empowered me in many aspects.

Case Story 9: Individual Case 2 from Pawe

Case D

Before I was referred to Bahir Dar hospital, I spent three and half weeks at the safe house where I was provided with various kinds of support. Everything in the safe house, including the pills that I was taking to relieve my pains, the food and shelter were provided for free. In addition there was a smelly fluid coming out of my uterus but the safe house mothers wash me every now and then without scowling upon me.

The service I got was effective in terms of time and relevance. I am poor and covering the cost would have been unthinkable for me. But MLWDA covered all the costs. In my stay at Pawe safe house away from my family, all the safe house staff made me feel at home. Sharing your pain with someone who can understand and share your pain is on the top of the benefit I have received from the safe house.

Case Story 10: Individual Case 1 from Gondar**Case story A**

Ayelu was born in Gondar and came to her relatives in Addis when she was a grade five student. While she was with her relatives, she experienced different type of violence that she doesn't want to disclose now. She moved out of her relatives' house and started living with her friends but she was not feeling comfortable there. She discussed the violence she experienced with other people and they recommended her to go to the police. Following their advice she went to Yeka police station. After hearing her case, the police officer helped her to calm down and they brought her to AWSAD.

She was 8 months pregnant when she came to the safe house. At first, she was very scared thinking she will be exposed to more violence than in her relative's house but the reverse happened. For four days, she was not willing to talk to anyone but when she started to communicate she found out that the other survivors have gone through similar experiences. Sharing her experience with the other survivors was really helpful.

It has been a year and 2 months since Ayelu joined the safe house. The safe house made her forget her problems. She has received both pre-natal and post-natal care. In addition, they gave her food, cloth, a place to sleep, counseling, legal advice and skills training (i.e. hair dressing). With the initiation of the counselor her case was taken to the court and she is now waiting for her final verdict.

Ayelu's parents don't know where she is today except her sister. She is planning to tell them soon. When she gets out of the shelter; if possible she will continue her education, if not she will work as a hair dresser. Her kid is the reason why she lives; she envisions the future as bright. She wants to show her kid how strong she is. Prior to the violence, her dream was to finish school and help out her poor parents but after the violence, she lost her faith. She even tried to kill herself but the counseling she received at the safe house helped her to regain her faith.

The services she gets at the safe house are timely and adequate especially when she was pregnant.

Case Story 11: Role Model 1**Role model A**

Hirut came to Addis with her brother to continue her education. However, her brother never allowed her to go to school. She has been repeatedly raped by her brother, aborted several times and finally she became sick. Her brother used to warn her not to tell the story to anyone, but finally, when it all became beyond her control, she shared her story to one of her neighbors and they communicated her case to the Women's Affairs Bureau. Then they referred it to AWSAD. When her mother heard about her situation she couldn't control her anger and she eventually passed away. All her neighbors also hated her and accused her of defamation. When she joined AWSAD she was sick and it took her a long time to recover. The doctors said that she can no longer become pregnant. She stayed in AWSAD for three years and received counseling service, self-defense training and hair dressing. After her graduation she left AWSAD and was hired as a hairdresser. When AWSAD opened its own hair salon, she came back and helped in organizing the hair salon and she is now hired as a staff. In addition to working in the hair salon, she also advises and encourages survivors to be strong and thankful for the provision at AWSAD. She always said that if she did not have the chance of joining AWSAD she would have been a sick and worthless person. She also went to the newly established safe house in Adama and helped in organizing the place.

Case Story 12: Role Model 2

Role model B

Azeb was married for 16 years. A few years after her marriage her husband started to abuse her. She moved out many times but her family forced her to return back.

She could not report the violence to the police because her husband threatened to kill her. She thought of killing herself for many times. She even escaped to the Middle East but after she worked for a year her doctor told her if she kept working her left leg would be paralyzed. So she returned back to her country. The abuse from her husband continued.

After she learned about the Ethiopian Women Lawyers Association (EWLA) from her neighbor she went there and shared her story. The staff at EWLA treated her well and asked her to sue him. At first she was reluctant. She asked herself who would take care of her kids. What if he got away with the crime? How would her family treat her afterwards? and so on. After sharing her concerns with the staff of EWLA, they brought her to the safe house. Her first expectation when they said safe house was that she was going to live alone but when she went there it was all different. She got used to it with the help of safe house mothers.

Besides the provision of food and shelter, the safe house changed the way she perceived herself. The treatment she received built her confidence in suing her husband. After 8 months she got divorced and left the safe house. Even after she left the safe house she still came back and forth to seek legal advice regarding her share of properties. A year after her divorce, the court ruled for her to get her half of the property.

Now she is a staff as a safe house mother in AWSAD. She is living with her kids and this was made possible by the safe house. Now, her kids see her as their role model; she taught them how to be strong. She cannot say that this whole process didn't affect the kids psychologically but they would have been more affected if she stayed in that miserable marriage.

Case Story 13: Sidama zone

Mekdes is from the Sidama Zone and worked as a maid servant. She was raped by her employer and stayed in his house until she recognized her pregnancy. When she was 6 months pregnant she left her job and reported the case to the police. The police brought her to the BIGA safe house.

"When the police brought me to the safe house I was in despair and hated my very existence. After I gave birth, I hated my child and was not even willing to breastfeed him. I was always trying to abandon or kill him. However, I have been getting regular psychosocial counseling service during my stay in the safe house. As a result, I got great improvement from my traumatic conditions and became hopeful and eager to live again. Now, I developed confidence to work and lead my life peacefully by taking care of my child."

Case Story 14: Addis Ababa

She was married and has two children. She was living in Nifas Silk Lafto Sub-city. Her husband used to drink alcohol and come home late. He was not giving her money for food and for her children's clothing and school expenses. She was alone with two little kids when her husband left her. He left her without informing her where he went and disappeared for seven months. She did not manage to feed and to pay her house rent, and found it difficult to work since she needed to take care of her children. A woman informed her about MCRC, and she was asked to bring letter of evidence from Arada Woreda 6 after which she was accepted.

The center provided her and her children with house, food and clothes. After three months stay in the safe house, the center relocated her to a rented house and paid 100 birr for the rent every month. But her children are still provided with food, cloth and education. She received training in sewing and 800 birr salary. The center took care of her children when she was in training. She considered herself like a full time worker because she spends most of her time at the center. She is under the organization's support for the last 3 years and has no worries about house rent, her children's clothes and their education fee. She hoped to earn her own income after she finishes the trainings provided by the center. She said that the service provided to her is good but the salary (800 birr) is not enough to cover her expenses since she does not have another job.

Case Story 15: Case 2 from Addis Ababa

Case A

She has one child from her previous marriage. She was born in Addis Ababa around Tekle-Haymanot. She got married and moved to Assosa to live with her husband. Her husband was a driver and he was an alcohol addict. She was not economically empowered at that time and her husband was not giving her money for household expenditures. She was engaged in different activities to make money such as washing clothes. She was expecting that the behavior of her husband would change but it did not. Finally, she decided to divorce him and to take care of herself and her child alone. After the divorce, she started a new life with her son. Her husband came to take his child but she refused because she was very afraid that he might rape him as he had violated a little girl aged 8 who was living in the town. She came back to Addis Ababa and started living with her parents. Her parents were also addicted to chat and shisha. So the environment was not convenient to her and her son. Then she left her parents and became homeless. Her new life was bad; she built a small plastic house near MCRC. She was engaged in selling chewing gum and cigarette to help herself and her son. She made money for a living but it was not enough. One day the manager of MCRC met her son and took her and her child to the center. Then they started a new life: the center provided them with food, clothes and shelter. She worked as a security guard for the center. Her son is now 6 years old, and he is learning and getting support from the center. She is engaged in tailoring training and also gets payment (855 birr per month). Apart from the training and monthly salary, the center pays her house rent and provides her and her son with food and clothing. She is happy and safe now and plans to earn her own income in the future.

Case Story 16: Survivor of violence at the hands of her husband

Woman A was in her mid-thirties and a mother of six children. Three of these children are triplets born five years ago. At the time she was pregnant, her husband used to nag her to get involved in farming work he was engaged in. Because of her pregnancy, however, she was unable to work in the farm, and when her husband forces her to go hungry as punishment, she goes back to her family. As there was no health facility and medical follow-up in the area, she didn't even know the nature of her pregnancy. When she gave birth to triplets, there was no one besides her, and the three girl babies came within two hours of each other. That was how Woman A developed fistula at the time. But thanks to the medication and support that she got from the Hamlin Fistula Center in Bahir Dar, she regained her health and is now

Case Story 17: A student being sexually assaulted

This student pointed out that being a female student is always difficult given all the harassment and abuse from fellow students and teachers. She claims that "some teachers make sexual advances and saying no to such unwelcome advances may result in physical assaults and many other consequences. As a girl student, you have to deal with all these problems. Lodging complaints or accusing the perpetrator would take you nowhere as the words of the male perpetrator are more believable than that of ours. Most of us have tried to file accusations against our perpetrators, but nothing has happened to the offenders, and the attempt always ends as a futile exercise. When I finish my education, I want to become a lawyer because I want women to get the justice they deserve."

Case Story 18: Case story of a prisoner accomplice to rape

The prisoner is serving a 4 years sentence for being an accomplice to rape. The person who committed the rape is also in prison sentenced to 8 years of imprisonment. At the time when this person gave interview to the Esemashallehu radio program, he has been in jail for a year. He is 32 years old and puts a blame on too much alcohol use for his crime. He deeply regrets that he is serving a prison term leaving his family behind and destroying his marriage. He believes that he has wronged not just his family but the community as a whole by committing that shameful act, and would like to say a heartfelt sorry to all those who he harmed in one way or another. The prisoner promised that he is ready to make amends, to change his ways in the future and to compensate the community in practice and in any manner he can.

Case Story 19: Attitudinal changes

A listener of the Pro-Pride radio program says: "I listen to Esemashalehu radio programme on a regular basis, and I learned a lot from the program. My attitude towards women is changing by the day. I no longer see women as inferior to men, and I would do everything I can to protect women from all kinds of violence."

Case Story 20: Finding volunteer supports

Woman B suffered from continued violence at the hands of her husband who chased her out of their house and eventually married another woman from Haramaya town. She now lives in Dire Dawa, begging alms on the street and supporting all four of her children with that. She is accustomed to seeing her children go hungry most of the day, but the fact that the children will not be able to go to school is haunting her like a terrible nightmare. After the story of Woman B was aired on Odeysi, concerned individuals from the Women, Children, and Youth Affairs Bureau, Education Coordination Office, and Kebele 04 came together and decided to help her children continue their education. They not only bought the kids all the necessary school materials for the season but also promised to buy them uniforms and to follow-up their school performance all-round the year.

Case Story 21: From Meteya-Enedera**CASE A: Prevention Component**

Case A is 29 years old and she is a mother of three children. She lives in Meteya- Enedera Keble, Enarji Enawuga Woreda of East Gojjam Zone. She suffered from uterine prolapse for a year. She gave birth to her first daughter at an estimated age of 14 and second child at the age of 16. She did not receive antenatal care during her third pregnancy, and she gave birth at home with the assistance of a traditional birth attendant. The labor was long and intense. She was happy to have her third child. However, when days passed by, she recognized that there was something wrong with her uterus, but she kept it to herself. Her husband knew about her uterine problem, and took her to a nearby holy water place called Shewshengo-Medhanialm. But she continued suffering from the uterine prolapse. One day the local administrator called for a community meeting to talk about uterine prolapse and asked if they knew someone with such kind of problem. Her husband brought the facilitators home to observe her condition, and they recommended her to visit the Kebele health center, which referred her to Debir Health Center. She was finally referred to Bahir Dar Hospital. She joined the treatment center, and it enabled her to regain her health. The treatment center operated her within three weeks, and she received food, clothing, bed and sanitary goods. In addition, the center offered her awareness raising services focusing on early and forced marriage. The medical treatment at Bahir Dar Hospital was timely, and it can also be accessed without traveling long distance. She observed many changes in her life after the medical treatment. She regained her health and her self- confidence increased. She managed to consult women in her locality without fear and shame. She managed to actively participate in social gatherings and church activities and became engaged in activities that boosted her family's income.

Case Story 22: From Debir

CASE B: Prevention Component

Case B gave birth to seven, but lost her four children for unknown reasons. She developed a uterine prolapse problem when she was giving birth to her fifth child. Her labor was long and unusual bleeding occurred. She felt irrelevant and insecure due to the loss of her child, and she hid from people by engaging intensively and restlessly in tiresome activities. A Kebele police officer came to her house and informed her about the treatment in Bahir Dar. Even though she lost her hope of becoming healthy, she agreed to the police request. The police took her and other women to Debir Health Center and the health center referred them to Bahir Dar hospital. The problem occurred twenty years ago, but she received the treatment two years ago. Because of this she did not think that she joined the treatment center at the appropriate time. She received accommodation, medical treatment and awareness raising services during her three weeks stay at the treatment center. The awareness raising training was focused on different forms of GBV, gender equality and maintaining personal hygiene. After receiving medical treatment, she became more viable physically, psychologically, socially and economically. The psychological and medical treatment at the health center enabled her to attend social gatherings with no feelings of shame and insecurity. She forwarded her gratitude to police officers and those who provide her with money.

Case Story 23: Hawassa

Abebu, 21 and a student at a teachers' training center, is from Hawassa. After she was raped by her boyfriend and became pregnant, she gave birth in a hospital and the hospital linked her to the BIGA safe house for she did not have anywhere to go.

"I believed that the service in the safe house is very important for a girl like me. If this place was not available, my fate would have been to be a beggar or a street girl. No one could employ me with my baby. When I came to the safe house I was very depressed and full of hate. I hated and didn't want to see my child. There were times that I tried to kill him. It was very difficult to accept him as my own child.

It has been 7 months since I joined the safe house. Now, I am starting to think that the thing that happened on me is not the end of the world. I can continue my life again. The psycho-social counseling service during my stay in the safe house changed me a lot. Now, I want to continue my education and change my life and support my family".

Annex 2: Terms of References

Section II: Terms of Reference (TOR)

Please insert your specific TORs here; for assistance in the development of your TORs refer to the Guidelines for writing TOR available in [English](#). **(Attached Separately)**

1. BACKGROUND

UNFPA (United Nations Population Fund) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and women is treated with dignity and respect. Thus, the major working areas are maternal health, family planning, adolescent and youth development & HIV/AIDS prevention, data for development, and gender.

Under the area of gender, UNFPA response and supports to policies and institutional capacity building, engaging communities, preventing harmful traditional practices and gender based violence.

In the gender area, phase two of the programme on prevention and management of GBV funded by the Royal Netherlands Embassy (RNE) has been under implementation from October 2012 – December 2015. The programme is relevant to the UNFPA Ethiopia 7th Country Programme (2012-2015) stipulated under the gender equality component. The gender equality component contributes to UNDAF outcomes (which is the UN Strategic Framework to support the Government's Growth and Transformation Plan - GTP). The UNDAF outcome related to it is explained as "by 2015, women and youth are increasingly participating in decision making and benefiting from livelihood opportunities and targeted social services".

During phase one of the program, which was also supported by RNE, every effort was put into enabling women to speak out against gender-based violence, and to get support when they are victims of it. The programme was also committed to keeping gender-based violence in the spotlight as a major health and human rights concern. UNFPA advocates for legislative reform and enforcement of laws for the promotion and the protection of women's rights to reproductive health choices and informed consent, including promotion of women's awareness of laws, regulations and policies that affect their rights and responsibilities in family life.

Phase two of the programme was formulated based on two outputs (output 9 and 10) of the 7th UNFPA Country Programme. Output 9 is "Strengthened community response to promote and protect the rights of women and girls in relation to harmful traditional practices and gender-based violence" and, output 10 is "Strengthened institutional response to address harmful traditional practices and gender-based violence and provide information and services to survivors of gender-based violence, including within a humanitarian context".

The programme is implemented together with implementing partners of 11NGOs and 1 Governmental Organization operating in six Regions of the country (Amhara, Oromiya, SNNPR, Tigray, Benishangul-

Gumuz and Addis Ababa.) The programme was initiated in October 2012 and is ending in December 2015, with an outcome that “by 2015, women, youth and children are increasingly protected and rehabilitated from abuse, violence, exploitation and discrimination.

The programme is expected to contribute to the realization of four key outputs aims at:

1. Increased knowledge and response of communities and other stakeholders on GBV and SRH
2. Increased availability and accessibility of SRH and psycho-social services for vulnerable groups and survivors of GBV
3. Strengthened capacity of the law enforcement bodies to effectively handle and respond to GBV cases
4. Increased Stakeholders' capacity for enhanced coordination and advocacy on issues of GBV

UNFPA with implementing partners employed various methodologies for prevention and response area of intervention. In prevention side, they worked to fill the gap in identifying and addressing causes of violence to minimize the chance of violence from happens and to bring attitudinal and behavioral changes through mobilization of the wider community, advocacy and public awareness creation methodologies. Besides, the intervention is made to address the gap in service delivery to survivors of GBV in the country, which corresponds to the immediate response after violence has occurred to limit its consequences through care, support and referral linkages.

To accomplish the intended results UNFPA implement human rights-based, gender-responsive and culturally vested approach by involving and strengthening partnerships with United Nations System, Government organizations, non-governmental organizations (NGOs), academic and other entities to fulfill its mandate of addressing GBV.

The Programme has employed various participatory programme interventions strategies listed as follows;

- Enhancing capacity development of governmental and non-governmental agencies to address issues related to GBV
- Conducting advocacy, public education and awareness campaigns using various channels
- Building the capacity of law enforcement bodies including police officers, health service providers, university students, teachers, youth, women's, community leaders and religious groups through provision of trainings and other platforms
- Provision of shelter, health and psycho-social services to survivors of GBV and appropriate services for perpetrators of violence
- Engagement of popular figures as role models to address and strategically advocate against GBV
- Strengthening coordination mechanisms on GBV at federal and regional level
- Thus, the phasing out of the programme in December 2015 necessitates the undertaking of end evaluation in its implementation. UNFPA would like to engage the services of qualified professional firm in conducting evaluation with expected high quality standard.

2. PURPOSE OF THE EVALUATION

The main purpose of the programme evaluation is to assess the effectiveness, relevance, impact and sustainability of the past implementation of the programme in order to identify lessons and good practices that can improve future effort on preventing and management of GBV in Ethiopia.

The specific objectives of the proposed appraisal are to:

- Review its effectiveness and efficiency in progressing towards the achievement; and how the programme outputs were achieved
- Assess and verify the relevancy of the programme to respond to the country needs and challenges; to the intervention at national levels and alignment with the UNDAF in a view of assessing UNFPA contribution to the UNCT.
- Examine the current programme challenges and opportunities
- Evaluate the coordination and sustainability of the program
- Determine the impact of the intervention with respect to Gender Based Violence
- To assess the continuation of the programme towards the intended outcome align with UNDAF
- Identify key findings and lessons learnt; and provide specific actionable recommendations in light of evidence on how to improve the programme that build upon this results.

3. SCOPE

The reviewing, analyzing and providing of finding and recommendations shall focus on the relevancy, effectiveness, efficiency, sustainability, impacts, and management and coordination as it is described in detail below under evaluation criteria. The evaluation being conducted is end of programme covering from October 2012 to December 2015 time frame.

The evaluation will specifically focus on prevention and management of gender based violence programme supported by UNFPA and currently working with 12 implementing partners (11 NGOs and 1GO), key stakeholders from governments sector of health, women and children affairs; and different community based organization and beneficiaries participated in the programme implementation process.

For the thematic coverage all intervention found in prevention and management of GBV should be critically assessed; and for the geographical wise, the observance of the points described in the following table are mandatory; but not limited to it as others may considered necessary by the supposition of evaluator.

No	Implementing Partners (IPs)	Suggested woredas to be covered by the evaluation team
1	AWSAD and MCRC	AA Safe houses
2	NCWH	Assosazuria, Bambasi
3	ADA	Enargenaenawga, Dera, Kobo
4	ESOG	Mekele, Jimma and Gonder
5	MLWDA	Bullon and Pawi
6	OSSA	Mekele and Adama
7	ODA	Adamitul, Adama, Chiro
8	Pro-Pride	Bahirdar, Alemaya
9	EFPC	AA and other selected woredas of IPs
10	NCA	Mekele, AA, SNNPR
11	BIGA	SNNPR

4. EVALUATION CRITERIA

The evaluation approach need to be participatory and consultative that should carry out using the following evaluation criteria of relevance, effectiveness, efficiency, sustainability, outcome/impact and coordination that will provide the basis for reflection in the overall evaluation process. However, if the field situation required to raise additional vital issues, it would be covered as well in a flexible manner.

Relevance: to assess the extent to which the objectives of the programme are consistent with the evolving needs and priorities of the beneficiaries, partners, and stakeholders. Hence, evaluators need to consider:

- How has the programme addressed the relevant on-going needs in the country?
- How the programme has appropriately taken into account the priorities of the implementing partners;
- To what extent has the programme contributed to the mandate and priorities of UNFPA as an organization and to the national priorities of the country stipulated in key documentation (i.e. GTP, National gender policy, FDRE constitution etc.)
- How have the stakeholders taken ownership of the programme concept?
- How do the partners, target groups and beneficiaries consider that the programme achieved its goal in contributing towards enabling women & girls protected from violence and access services?
- Critically review the design of programme in terms of its effectiveness

Efficiency: to measure how the appropriate resources (funds, expertise, time, administrative costs etc...) have been utilized and converted into achieved results. Thus, the evaluators have to assess:

- What measures have been taken in planning and implementation to ensure that resources are efficiently utilized?
- The extent to which the programme funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks come upon?
- Have the UNFPA support and coordination mechanisms effectively supported the delivery of the programme?
- What were the constraints for efficient implementation? And the level of effort made to come up these challenges?

Effectiveness: the extent to which programme outputs have been achieved and contributed to the achievement of the overall outcomes, emphasizing tangible improvements for women's right and gender equality. This will requires a comparison of the intended goals, outcomes and outputs with the actual achievements of results. The evaluator will need to assess the below points by referring the logical framework of the theory of change of the programme

- What has been achieved desired output results with its reasons as the progress made towards it so as to identify factors contributed to effectiveness or ineffectiveness
- The extent to which these outputs have contributed to the achievement of the overall outcomes
- To what extent the target beneficiaries have been benefited from the programme activities and the level of theirs and partners satisfaction with programme implementation and results.
- Have the programme effective monitoring mechanisms in place to measure progress towards results; were it able to identify challenges and measures taken to address these challenges?
- To what extent the capacities of direct implementer have been strengthened?

Impacts: to see the successfulness of intervention strategies for example its impacts on gender equality; observed changes in people's life, attitudes, and beliefs who are benefited from the interventions; any unintended positive or negative outcomes due to intervention shall be seen.

Sustainability: relates to the continuation of the likelihood that benefits from the programme after UNFPA funding is terminated; & the corresponding interventions are closed. The following need to consider by evaluators:

- The actual flow of benefits after the interventions have ended; for instance is the programme supported by institution of government and civil society and do those institution demonstrate commitment for their leadership, ownership and technical capacity to continue to work with the program?
- The overall resilience of benefits to risks that could affect their continuation
- What might needed to support partners to maintain these benefits?
- The overall potential for continuation or upscaling of the initiative

Management and Coordination: how well the coordination functions have been fulfilled? The approach to manage the project, including the role of stakeholders, and coordination with other service providers/development projects in the same area shall be examined in this evaluation process.

5. METHODOLOGY

The evaluation shall employed both quantitative and qualitative methodology. Participatory methods should be occupied as the paramount method of evaluation to guarantee a high level of stakeholder participation and to emphasize on the learning process oriented. Hence, with this basic principal, partner organizations are being fully involved into the evaluation process and the following stated multiple method of data collection will be applied accordingly.

6. DATA COLLECTION METHOD

In order to increase the quality of the report and the usefulness of the evaluation results, a multi-method approach comprising both primary and secondary methods will be used. Thus, a rigorous document review; in-depth key informant interviews; focus group discussion, and observation shall be applied but not limited to it.

Document review: review of both UNFPA and IPs plan and reports, such as mandate and strategies document, project proposal, annual working plan, training curricula/modules, standard progress reports, previous evaluations documents, baseline survey doc, financial documents, national GTP, policy, publication produced by the project etc....will be conducted.

In-depth key informant interviews: in-depth interview with selected key informants from UNFPA, IPs and other key stakeholders shall be employed. Besides, the evaluator shall propose cases study stories from prevention and response interventions and take sample for an in-depth interview with individual survivors, households & other beneficiaries so as to proof the result of change in life associated with the action being evaluated. Structured, semi-structured and or unstructured interviews as a technique may be used as it deemed necessary and depend on the different target groups and demanded information.

Focus group discussion: FGD is the other proposed data collection method to be used for this evaluation. Thus, it will be carried out with represented target group from stakeholders, different organized community members (club, advisory groups etc....) and beneficiaries. The participants and number of each

focus groups, interview guides, procedures of FGD moderator, required materials, note-taking and/or recording should be clearly articulated in the evaluator’s technical proposal.

Observation: information may be gathered by means of physical participation on activities such as service delivery process, stakeholder meeting, etc.

7. QUALITY ASSURANCE

In the assurance of quality, evaluators should clearly show as to how they ensure the quality of evaluation work expressing clear management structure of coordination, quality assessment methods and team composition in their aspects. In order to ensure the quality, validity and credibility of both primary and secondary source of data gathering through various data collection methods and tools, should come together and should be triangulated well. Measures will be taken to review it accordingly.

The application of participatory evaluation approach from starting up to ending of evaluation process is found to be essential to assure its quality. In doing so, partner organizations shall be consulted & take responsibility, beneficiaries and other stakeholders shall actively involve to display and express their situation, their challenges and their achievements in their own words and images at grass root level.

On the other hand, a quality assessment procedure for getting competent evaluators meet the expected required service shall also be followed as per setting criteria and evaluation processes of their technical and financial proposal.

The observance of ethical aspects of evaluation process and utility, credibility, and appropriateness of the evaluation results will critically due considered as a means of ensuring quality.

8. DELIVERABLES AND TIMELINE

The expected time to complete evaluation report is **6** weeks from the signing of the contract.

No.	Milestones and Deliverables	Working weeks					
		1	2	3	4	5	6
1	Prepare and submit inception report of the evaluation study						
2	Feedback given by UNFPA						
3	Finalize inception report as per feedback						
4	Data collection and analysis						
5	Delivery of first draft report						
6	Review by UNFPA						
7	Finalize document incorporated feedback						
8	Present and facilitate validation workshop						
9	Final submission						

- The report has to be written in a clear, professional and unambiguous English language. It should be provided with the form of both soft and hard copy including words and power points.
- All information under the report has to be complete, clear, concise, well-structured and adequately documented and supporting the findings. In addition, the findings and recommendations in the report have to be presented based on evidence and it should be implementable.

- The report shall be presented with precise executive summary comprising the evaluation objectives, mandates, approach/methodology, key findings, conclusions and recommendations.
- All document reviewed, list of implementing partners and respondents used during evaluation process should be attached as annex.

9. Payment milestones and authority

The qualified consultancy firm shall receive its lump sum service fees upon certification of the completed tasks satisfactorily, as per the following payment schedule:

Installment of Payment/ Period	Deliverables or Documents to be Delivered	Approval should be obtained	Percentage of Payment
1st Installment	Up on Submission of Inception report and certified by the respective designated personnel	UNFPA Authorized Personnel	20%
2nd Installment	Up on submission of first draft report and certified by the respective designated personnel	UNFPA Authorized Personnel	30 %
3rd Installment	Up on submission of the complete final evaluation report incorporated feedback and presentation in workshop certified by the respective designated personnel (Hard Copy and Soft Copy)	UNFPA Authorized Personnel	50%
Total			100%

10. Institutional arrangement

- a. The Contractor, will be directly responsible to, reporting to, seeking approval/acceptance of output from UNFPA designated personnel
- b. The Contractor is expected to liaise/interact/collaborate/meet with in the course of performing the work with different stakeholders indicated in section 3, but not limited.
- c. Any travel costs for field site during evaluation will be fully paid by firm that has to be agreed prior of starting the duty
- d. The writing up for documentation has to be clearly, professionally and unambiguous written in English language. All information under the documents have to be complete, clear, concise, well-structured and adequately documented.

11. OWNERSHIP

Copyright of the final evaluation report produced and all information gathered by the firm in the evaluation process is solely belongs to the UNFPA Ethiopia Country Office. Therefore, the consultant shall not be entitled either directly or indirectly to make use of such documents for other purposes without the prior written consent of UNFPA.

The result of evaluation shall be used by the programme partners to reflect on the effectiveness and relevance of their interventions and to develop their intervention strategies in a joint learning process.

12. QUALIFICATION AND COMPETENCIES

- Open for national firm comprise at least a minimum of 4 professional evaluation team member with academic background of Master's degree or equivalent in social sciences or related fields
- Personnel who will be engaged in this assignment should have a minimum of 5 years relevant professional experience in monitoring and evaluation technical activities of GBV/SRH, M&E, RBM related programme
- Excellent knowledge of understanding of local country contexts; current policies and legislation
- Willingness and ability to travel to the different project's sites in the country
- Working expertise within UN context, familiarity with the UN evaluation policy, standards in the area of women's human rights and violence against women
- Familiarity with Netherlands fund supported programme evaluation
- Ability to consistently approaches to work with energy, positive and constructive attitude
- Capacity to work and deliver under pressure
- Excellent interpersonal and facilitation skills
- Excellent computer skill
- Excellent writing skills and proficiency in English language; knowledge spoken Amharic and Oromo & Tigrigna are preferable

13. Criteria for Selecting the Best Offer

This section should indicate the full list of criteria which shall serve as basis for evaluating proposals and awarding the contract, and the respective weight of each criteria. A General guide has been provided in the RFP Data Sheet.

Selecting of the best offer will be made based on: Combined Scoring method: where methodology, expertise of the firm and expertise of the experts will be weighted a maximum of 70%, and combined with the price offer which will be weighted a maximum of 30%.

Detail Evaluation Criteria is attached in **Annex I**

14. SUBMISSION OF APPLICATION

A technical and financial proposal need to be submitted separately (Two Envelop) with all relevant supportive documents. The content of technical proposal has to clearly show the understanding of the task, its specific objectives, and evaluation plan consisting a detailed proposed evaluation approach and methodology, steps/processes to be followed, specific tasks, timeframe and resources needed to complete the service.

Letter of expression of interest – explaining why the evaluator is the most suitable for the work of evaluation and brief profiles of the evaluation team member's CV should attached with technical proposal.

All applicants are required to submit non – returnable hard copies of their proposals (of the technical and financial breakdown with all relevant documents) with letter of expression of interest within 15 days from this announcement to the address indicated below.

Address for submission:

UNFPA Ethiopia Country Office

P.O.Box 5580

Addis Ababa

- Only short-listed consultancy firm will be contacted

15. OUTLINE OF EVALUATION REPORT FORMAT

The following outlined elements must be included in the evaluation reports, but not necessarily be limited.

- Title page
- Table of contents, including list of annexes
- List of acronyms
- Executive summary – not more than maximum of 2 pages
- Introduction – background and context of the programme
- Description of programs logical change theory
- Scope of the evaluation, key questions
- Limitations and de-limitations
- Methodology and process
- Findings- organized in different thematic areas
- Conclusions
- Recommendations
- Lessons learnt - best practice – success case
- Annexes

Annex 3: Evaluation Criteria and Questions

The consulting team understands the importance of selecting the appropriate evaluation criteria that could be able to produce the most desirable results from the end term evaluation study. Thus, we adopted the standardized evaluation criteria proposed by the Development Assistance Committee (DAC) of OECD-DAC⁵; which include relevance, efficiency, effectiveness, impact and sustainability. In addition, we also employed Value-for-money principle in the context of the nature of the project. We believe that this standardized approach would fulfill the requirement of the programs' evaluation objectives set on the TOR. Moreover, all the data collection tools required for this evaluation were designed in way that all OECD/DAC project evaluation criteria and Value-for-money principle. Hence, details of evaluation criteria and principles employed in GBV programme supported by UNFPA are presented in the following ways.

According to the terms of reference (ToR), it has been established that the evaluation approach need to be participatory and consultative that should carry out using the evaluation criteria of relevance, effectiveness, efficiency, impact, sustainability, management and coordination that would provide the basis for reflection in the overall evaluation process. Based on the ToR, each evaluation criterion and its set of questions are briefly described as follows:

Relevance of GBV program: In evaluating the relevance of GBV programme supported by UNFPA, it is necessary to examine whether or not programme purpose and overall goal are set in accordance with the needs, priorities and constraints of the target beneficiaries, partners, stakeholders and government policies. In order to evaluate the extent to which the objectives of the programme are consistent with the evolving needs and priorities of the beneficiaries, partners, and stakeholders, the following questions are considered:

- ✓ How has the programme addressed the relevant on-going needs in the country?
- ✓ How the programme has appropriately taken into account the priorities of the implementing partners;
- ✓ To what extent has the programme contributed to the mandate and priorities of UNFPA as an organization and to the national priorities of the country stipulated in key documentation (i.e. GTP, National gender policy, FDRE constitution etc.)
- ✓ How have the stakeholders taken ownership of the programme concept?
- ✓ How do the partners, target groups and beneficiaries consider that the programme achieved its goal in contributing towards enabling women and girls protected from violence and access services?

Effectiveness of GBV program: Under this criterion, assessment is made towards the extent to which programme outputs have been achieved and contributed to the achievement of the overall outcomes, emphasizing tangible improvements for women's right and gender equality. By considering the program's logical framework theory of change, comparison of the intended goals, outcomes and outputs with the actual achievements of results is also made. In order to evaluate how the appropriate resources (funds, expertise, time, administrative costs, etc.) have been utilized and converted into achieved results, the following questions are addressed:

- ✓ What measures have been taken in planning and implementation to ensure that resources are efficiently utilized?

⁵OECD.DAC Evaluation Network, Glossary of Key Terms in Evaluation and Results Based Management. OECD. June 2002. http://www.oecd.org/site/0,3407,en_21571361_34047972_1_1_1_1_1_00.html

- ✓ Have the programme funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks come upon?
- ✓ Have the UNFPA support and coordination mechanisms effectively supported the delivery of the program?
- ✓ What were the constraints for efficient implementation? And the level of effort made to come up these challenges?

Efficiency of GBV program: This criterion has measured the extent to which appropriate resources (funds, expertise, time, administrative costs etc.) have been utilized and converted into achieved results. On the other hand, we focused on the extent to which resources have been used to produce the intended outputs and how resources could be used more efficiently to achieve the intended results. The evaluation intended to show whether or not the results were obtained at reasonable costs, i.e. the cost, speed and management efficiency with which means/inputs and activities were converted into an acceptable level and quality of results. The extent to which programme outputs have been achieved and contributed to the achievement of the overall outcomes, emphasizing tangible improvements for women's right and gender equality. This particular evaluation criterion required a comparison of the intended goals, outcomes and outputs with the actual achievements of results. To critically review the design of programme in terms of its effectiveness, the following questions are addressed:

- ✓ What has been achieved desired output results with its reasons as the progress made towards it so as to identify factors contributed to effectiveness or ineffectiveness
- ✓ The extent to which these outputs have contributed to the achievement of the overall outcomes
- ✓ To what extent the target beneficiaries have been benefited from the programme activities and the level of theirs and partners satisfaction with programme implementation and results.
- ✓ Have the programme effective monitoring mechanisms in place to measure progress towards results; were it able to identify challenges and measures taken to address these challenges?
- ✓ To what extent the capacities of direct implementer have been strengthened?

Impact of GBV program: Under this criterion, the focus is to assess programme contribution on gender equality; changes observed in people's life, attitudes, and beliefs who are benefited from the interventions; any unintended positive or negative outcomes due to intervention and etc. On the other hand, changes produced by an intervention directly or indirectly have been assessed in the course of final evaluation. In order to evaluate the successfulness of intervention strategies (for example its impacts on gender equality; observed changes in people's life, attitudes, and beliefs), the following questions are addressed:

- ✓ Who are benefited from the interventions?
- ✓ Are there any unintended positive or negative outcomes due to the intervention?
- ✓ Are there any changes in the lives of beneficiaries due to the intervention?

Sustainability of GBV program: Sustainability measures the extent to which benefits of initiatives continue after external development assistance has come to an end. More specifically, the evaluation team assessed the likelihood that benefits from the programme would continue after UNFPA funding is terminated, and the corresponding interventions are closed. The sustainability of the programme initiatives are examined from the point of view of local stakeholders including target beneficiaries' participation, institutional arrangements, compatibility of project objectives and target community need, etc. In short, sustainability relays to the continuation of the likelihood that benefits from the programme after UNFPA funding is terminated and the corresponding interventions are closed. In order to evaluate the sustainability of the program, the following questions were considered:

- ✓ The actual flow of benefits after the interventions have ended; for instance is the programme supported by institution of government and civil society and do those institutions demonstrate commitment for their leadership, ownership and technical capacity to continue to work with the program?
- ✓ The overall resilience of benefits to risks that could affect their continuation
- ✓ What might be needed to support partners to maintain these benefits?
- ✓ What is the overall potential for the continuation or scaling-up the initiative?

Management and Coordination of GBV program: Under this criterion, the evaluation team examined the approach and mechanisms used in coordination of GBV programme supported by UNFPA including the role of stakeholders, and coordination with other service providers/development projects in the same area. This criterion was evaluated by considering the following issues:

- ✓ How well the coordination functions have been fulfilled?
- What was the approach used to manage the project, including the role of stakeholders, and coordination with other service providers/development projects in the same area?

Annex 4: Survey Tools

Household Survey Questionnaire for Programme Beneficiaries

Hello: Thank you for taking your time to answer the following questions. My name is _____ and I am working for DAB Development Research and Training PLC. Currently, we are conducting a survey to evaluate the knowledge, attitude and practices of beneficiaries towards GBV. There are different NGOs working on the provision of education and other services for the prevention and management of GBV in collaboration with UNFPA-Ethiopia. You might be one of such beneficiaries. We would appreciate you taking the time to respond to the following survey questioners.

Your participation in this survey will not only directly benefit you but it will help the funding organization to assess the overall impact of its partner organizations. Whatever you response it will be confidential and will not be shared with other than the survey team. We will not ask you questions that require you to reveal your name or any other information that may identify you. All of the response in the survey will be recorded anonymously. We also do not report any identifiable information. Whatever you response is, it will be very useful.

Participating in this study is voluntary and you have the right not to respond to all the questions and/or to withdraw from the interviews at any time. Your withdrawal from the interview will not affect your relationship with the service providing organization. The survey questionnaire may take a maximum of 45 minutes. If you have questions, you can contact the team coordinator (Name) of DAB Development Research and Training PLC. via cell phone: 0936637071

PART I: Characteristics of the Respondent

- Region _____
 Woreda _____
 Kebele _____
 Person ID _____
 Date of interview _____
 Start time _____
 Name of interviewer _____
 GPS coordination North _____
 GPS coordination East _____
 Implementing Partner _____
- 1 Name of Respondent _____
 - 2 Age _____
 - 3 Sex _____ 1. Male 2. Female
 - 4 Current place of residence _____ 1. Urban 2. Rural
 - 5 Place of birth _____ 1. Urban 2. Rural
 - 6 Current income per month _____ Per year _____
 - 7 Education type
 1. No education (can't read and write)
 2. Informal education (can read and write through adult literacy or religious education)
 3. Forma education (attained government or private school)
 - 8 Education level _____ grades complete if attended formal education
 - 1-12 grade completed
 - 13 Certificate (10+1, 10+2, 10+3, 12+1, 12+2)
 - 14 Diploma (10+4, 12+3)

- 15 Degree and above
- 9 What is your marital status?
- 1) Single (never married) 2) Married 3) Separated
- 4) Divorced 5) Widowed
- 10 What is your main occupation?
- 1) Housewife 2) Farmer 3) Trader 4) Teacher 5) Health worker
- 6) Student 7) Police 8) Attorney 9) Judge 10) Social worker
- 11) Other (please specify) _____

PART II: Awareness Related Questions

A: General Questions

- 11 What do you know about GBV practice in your area? (Multiple response is possible)
1. It is a violation of human right
 2. It is the result of powerlessness
 3. It is caused by power inequality between men/boys and women/girls
 4. It result in reproductive health problem
 5. Other If any (please specify) _____
- 12 Which of the following do you think is the most common form of GBV in your locality? (Multiple response is possible)
- A. Physical abuse
 - B. Sexual abuses
 - C. Emotional /psychological abuse
 - D. Financial abuses/unable to decide on economic matters
 - E. Forced prostitution,
 - F. Trafficking for forced labor
 - G. Sexual exploitation
 - H. Sexual harassment
 - I. Female Genital Mutilation/Cutting
 - J. Early marriage
 - K. Forced marriage/Abduction
 - L. Discriminatory practices based on gender
 - M. Other (please specify) _____
- 13 What do you think are the major causes of GBV? (Multiple responses is possible)
1. Lack of awareness
 2. Harmful traditional practices
 3. Prevalence of poverty
 4. Family disruption like divorce
 5. Women's lack of power
 6. Attitude related issues
 7. Culture related issues
 8. Religious related issues
 9. Other (please specify) _____
- 14 GBV can cause psychological and physical health problems for adolescent girls and women.
5. Strongly agree

4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure
- 15 What impacts do you think that GBV is likely to bring to the survivor in particular? Please tell us the major possible impacts. (Multiple response is possible)
1. Physical
 2. Psychological
 3. Economical
 4. Social
 5. Others (please specify) _____
- 16 GBV is a violation of human rights.
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure
- 17 If you ever become a survivor of GBV, where would you go for assistance or information?
1. Police
 2. Social court/ MahiberawiFerd Bet
 2. NGOs/ providing social services
 3. Medical services (hospital, health centre)
 4. Church /mosque
 5. Legal aid/ services
 6. Families, relatives, neighbours
 7. Close friends
 8. School teachers
 9. Kebele Administration
 10. Clan leaders/ influential people in the kebele
 11. Others (please specify) _____
 12. Don't know
- 18 If I encounter any type of GBV, I will report the incidence to the local police.
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure
- 19 All types of violence against women/girls (such as verbal, physical, sexual, FGM/C, early and forced marriage, etc) should be reported.
5. Strongly agree

4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure
- 20 If you witnessed an incidence of GBV (especially violence against women/girls), what would you do?
(Multiple responses is possible)
5. Report to school teachers
 4. Report it to police
 3. Discuss about it with my friends
 2. Discuss about it with my parents
 1. Remain silent
 0. Others (please specify) _____
- 21 If you witnessed an incidence of domestic violence at your neighbours or friends, what would you do?
I would personally intervene.
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure of what to do
- 22 In your opinion, what could be done to help prevent GBV (violence against women/girls) in your locality?
(Multiple response is possible)
1. Public education and awareness creation
 2. Education focusing on youth
 3. Survivors' support services
 4. Counselling services for victims
 5. Improving standard of living or create employment opportunities
 6. Strict penalties on perpetrators
 7. Don't know
 8. Others (please specify) _____
- 23 Do you know that anybody that instigates violence would face legal charges?
- 1) Yes 2) No
- 24 How do you manage to know about GBV (Multiple response is possible)
1. Through specific training
 2. Through media
 3. Community sensitization
 4. Being member of a club
 5. From friends / neighbors
 6. Other (please specify) _____
- 25 Do you know any GOs, NGOs and civic society organizations (CSOs) that are working to address the problem of GBV?
- 1) Yes 2) No

- 26 The interventions made to prevent and control GBV especially by the project was highly relevant from the point of view of my (the respondent) interests and priorities:
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure
- 27 The interventions made to prevent and control GBV especially by the project was highly relevant from the point of view of community interests and priorities:
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure

B. Awareness related to availability of services provided by the project

- 28 Have you ever experienced any form of GBV?
1. Yes
 2. No **—————> Skip to Q45**
- 29 If yes, what kind? (Multiple responses is possible)_____
- A. Physical abuse
 - B. Sexual abuses
 - C. Emotional /psychological abuse
 - D. Financial abuses/unable to decide on economic matters
 - E. Forced prostitution,
 - F. Trafficking for forced labor or prostitution,
 - G. Sexual exploitation
 - H. Sexual harassment
 - I. Female Genital Mutilation/Cutting
 - J. Early marriage
 - K. Forced marriage/Abduction
 - L. Discriminatory practices based on gender
 - M. Other (please specify)_____
- 30 If your response to question number 30 is yes, have you received any support to cope up with your problem of GBV?
- 1) Yes **—————> Skip to Q33**
 - 2) No
- 31 If no, why you failed to get support?
0. I never request support
 1. GBV is a tradition and I did not see the importance of reporting
 2. I didn't know where I should get support
 3. I report, but never get support
 4. Other (please specify)_____
- Skip to Q34**

- 32 If your response to question number 31 is yes, what kind of support did you receive?
1. Physiotherapy
 2. Counseling
 3. Awareness raising/creation training
 4. Clinical
 5. Economic
 6. Access to education
 7. Hotline/Telephone
 8. Legal service
 9. Shelter
 0. Any other (please specify)_____
- 33 Was the support relevant to the nature of the problem you faced?
1. Yes
 2. No
- 34 Would you please describe the support in terms of the level of adequacy?
1. Very Adequate
 2. Adequate
 3. Somewhat adequate
 4. Inadequate (it was not helpful) **Skip to Q37**
 5. It was even harmful
- 35 If you think that it is inadequate or harmful, what could be the possible reason?
1. It doesn't take the interest of the community
 2. Adequate resources are not allocated/provided
 3. Inappropriate beneficiary selection criteria/procedures
 4. Other(please specify)_____
- 36 How would you describe the support in terms of urgency?
1. Very prompt
 2. Somehow prompt
 3. Prompt
 4. Somehow late
 5. Too late
- 37 Do you think those GBV victims that are in need have received supports by the project?
1. Yes, all of them have received supports
 2. Yes, most of them have received supports
 3. Yes, but only some of them have received supports
 4. No one received supports
- 38 How do you perceive the quality of service provision by the project?
1. Very high
 2. High
 3. Medium
 4. Poor
 5. Very poor
- 39 Supports provided by the project have brought positive impacts on the health of the beneficiary:
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure

- 40 Supports provided by the project have brought positive impacts on the general livelihood of the beneficiary:
- 5. Strongly agree
 - 4. Agree
 - 3. Somewhat agree
 - 2. Disagree
 - 1. Strongly disagree
 - 0. Not sure

- 41 Do you believe such supports will continue even though the project stops its service?
- 1. I think it will continue by the government
 - 2. I think it will continue by another NGO
 - 3. I think it will continue by the community itself
 - 4. I think it will not continue

- 42 If you believe the support will continue, how do you think this is possible?

- 43 If you believe that the support will not continue, what do you think the reason would be?

Part III: Empowerment Related Questions

- 44 Do you think that the NGO (the project intervention) has increased your confidence?
- 1. Yes
 - 2. No **Skip to Q47**

- 45 If your response to question number 45 is yes, in what ways has it increased your confidence? (Multiple responses is possible)

- 1. I can accomplish what I set out to do
- 2. I have positive attitude about myself
- 3. I have confidence to make decision
- 4. I can overcome barriers
- 5. I have self- worth
- 6. I see myself as a capable person
- 7. I am able to do things as most other people do
- 8. I feel I have a number of good qualities
- 9. If any (please specify)_____

Skip to Q48

- 46 If your response to question number 45 is no, in what ways has it decreased your confidence? (Multiple responses is possible)

- 1. I cannot accomplish what I set out to do
- 2. I have negative attitude about myself
- 3. I don't have confidence to make decision
- 4. I failed to overcome barriers
- 5. I am depressed
- 6. I see myself as incapable person
- 7. I cannot able to do things as most other people do
- 8. I feel I don't have good qualities

9. Others (please specify)_____

47 Do you feel that you have control over your future life?

1. Yes 2. No → **Skip to Q50**

48 If your answer is yes to question number 48, in what ways? (Multiple response is possible)

- 1. I can pretty much determine what will happen in my life
 - 2. I am generally optimistic about the future
 - 3. I can solve my problems by taking action
 - 4. If any (please specify)_____
- Skip to Q51**

49 If your answer is no to question number 48, in what ways? (Multiple responses is possible)

- 1. I cannot determine what will happen in my life
- 2. I am pessimist about the future
- 3. I cannot solve my problems by taking action
- 4. Others (please specify)_____

50 Do you think that your community has been empowered by the project (NGO)?

1. Yes 2. No → **Skip to Q62**

51 If your answer is yes to question number 51, in what ways? (Multiple responses is possible)

- 1. Has increased the community's knowledge and understanding of GBV
- 2. Has empowered the community economically
- 3. Has empowered the community socially
- 4. Has improved the relationship between men and women
- 5. Has empowered the community psychologically
- 6. Other (please specify)_____

52 Do you think the empowerment made was relevant to your life?

- 1. Yes, it was very relevant
- 2. Yes, it was somehow relevant
- 3. No, it wasn't relevant
- 4. No, it was even harmful

53 Does the programme change your livelihood situation?

1. Yes 2. No → **Skip to Q58**

54 If your answer to question number 54 is yes what kind of change you have seen?

- 1. Economic
- 2. Decision making power
- 3. Human / skill
- 4. Physiological / build confidence
- 5. Other (please specify)_____

55 How was the adequacy of the change made?

- 4. Very adequate
- 3. Adequate
- 2. Somewhat adequate
- 1. Inadequate

- 56 The change you have got will remain sustainable even if the project implementer NGO stops the service and follow-up:
5. Strongly agree
 4. Agree
 3. Somewhat agree
 2. Disagree
 1. Strongly disagree
 0. Not sure of what will happen
- 57 Have you seen any change in your decision making and control over resource after the intervention of the NGO?
1. Yes
 2. No → **Skip to Q60**
- 58 If you have seen a change in your decision making and control power, can you mention some? (Multiple answers is possible)
1. I decide about the schooling of my children
 2. I decide about marriage of my children
 3. I decide on expenditure of the household
 4. I participate on planning in the house hold
 5. Other (please specify) _____
- Skip to Q61**
- 59 If the answer to question number 58 is no, what is the reason?
1. The programme doesn't change my confidence
 2. The programme doesn't change my economic position
 3. My partner doesn't have as equal understanding as me
 4. The intervention doesn't take my interest/ need into consideration
 5. Other (please specify) _____
- 60 How was the follow-up made by the project on the interventions?
4. There was frequent and regular follow-up
 3. There follow-up, but it was intermittent and occasional
 2. There was rare follow-up once in a while
 1. There was no follow-up at all

Part IV: Questions Related to Relevance, Impact, Coordination and Sustainability

- 61 Did the NGO contribute to your knowledge on issues of GBV?
- 1) Yes → **Skip to Q64**
 - 2) No
- 62 If your response to question number 62 is no, what could be the reason?
- 1) I had been aware of GBV and the measures to be taken before the NGO started operating in the *woreda*
 - 2) I have not been a beneficiary of the programme and thus not exposed to the awareness creation activities of the NGO
 - 3) The NGO is engaged in activities other than awareness creation
 - 4) I have not been interested or curious to benefit from the services of the NGO
 - 5) Other reasons (please mention them) _____
- 63 Which social group do you think has benefited from the project?
1. Mothers/women
 2. Fathers/men
 3. Daughters/Girls

4. Sons/Boys
 5. If any (please specify) _____
- 64 Do you think that the NGO is providing evidence based and adequate services to the community?
1. Yes
 2. No → **Skip to Q67**
- 65 If your answer to question number 65 is yes, which type of services the NGO provided in a tangible/practical manner?(Multiple response is possible)
1. Public education
 2. Education focusing on youth
 3. Survivors' support services
 4. Counselling services for victims
 5. Improved standard of living or created employment opportunities
 6. Other (please specify) _____
- 66 Did the programme benefit you?
1. Yes
 2. No → **Skip to Q70**
- 67 If yes, what do you think are the benefits of this project/programme for you as a woman/girl? (Multiple response is possible)
1. Helped me to know my rights
 2. I get enough information on the cause, consequence of GBV
 3. It enables me to know how to prevent GBV as individuals
 4. It empowers me how to report GBV
 5. I get economic benefit
 6. It boost my self confidence
 7. I received social therapy or counselling
 8. Other (please specify) _____
- 68 If the answer to question number 67 is yes, what do you think is the reason?
1. The programme is timely
 2. The mode of communication is very clear
 3. The type of support doesn't take the interest of the community
 4. The support is adequate
 5. If any please specify _____
- 69 If your answer for question number 67 is no what do you think is the reason
1. The timing of the programme is not appropriate
 2. The mode of communication is difficult to understand
 3. The mode of support / programme doesn't take my situation into consideration
 4. The support is not adequate
 5. If any please specify _____
- 70 What do you say about the NGO's selection criteria of target groups/ beneficiaries?
1. Transparent
 2. Impartial
 3. Participatory (direct involvement of relevant community members)
 4. If any (please specify) _____
- 71 How do you characterize the NGO's operation in the intervention area?
1. Transparent
 2. Impartial
 3. Accountable
 4. If any (please specify) _____

7. Project implementation was not participatory
8. If any (please specify) _____
- 78 In general, do you think that the NGO has successfully addressed the problem of GBV in your locality?
1. Yes, to a large extent
 2. Yes, it was satisfactory
 3. Yes, but it was limited and unsatisfactory
 4. No, it wasn't successful
- 79 If your answer to question 66 is no, what are the constraints/challenges?
1. Lack of access to education
 2. Lack of awareness creation projects in the community
 3. Inadequate law enforcement
 4. Exclusion of men and boys
 5. Exclusion of perpetrators
 6. The approach adopted to implement the project was not appropriate
7. Key stakeholders were not involved in the project implementation
8. Existing culture and attitudes
 9. Please mention if there is any other constraints _____

Questions Related to Sustainability

- 80 How do you view the project in terms of ownership?
1. I consider the project as it is mine, solving my problem
 2. I simply participate because it has to be implemented
 3. It is intended to satisfy the interest of NGO and donor
 4. I simply participated because I do not have any other option
 5. Other (please specify) _____
- 81 What are your suggestions for preventing and managing the problem of GBV?
1. Integration of GBV in school curricula and police training manuals
 2. Inclusion of men and boys in the programme
 3. Inclusion of perpetrators in the programme
 4. Strengthening community involvement
 5. Coordinated effort by GOs and NGOs
 6. Strengthening awareness creation programme
 7. Others(please specify) _____

82 How do you perceive the status of support of the following stakeholders in keeping project interventions go forwards?

S. No.	Stakeholders	Status of their support? 1. Highly supportive 2. Supportive 3. Somehow supportive 4. Not supportive 5. Even it was harmful
1	Community police	
2	Woreda police	
3	Kebele Administration	
4	Kebele influential people (clan leaders, elderly, etc)	
5	School teachers	
6	The community as a whole	
7	Woreda Administration	
8	Local justice (mahberawifirdbet)	

83 Has the community developed a sort of by-laws on how to protect and control GBVs?

1. Yes 2. No

84 Do you perceive that woreda administration has allocated adequate budget to prevent and control GBVs?

1. Yes, I believe it has allocated adequate budget
2. Yes, even though the budget is inadequate
3. No idea, because the woreda budget is not transparent to us
4. No budget allocated at all

85 How was the monitoring and follow-up practice of project initiatives by kebele or woreda administration, or any of the concerned expert or office other than implementing NGO?

1. It was very good and regular
2. It was not regular, but intermittent and unsatisfactory
3. It was rare and disappointing
4. There was no follow-up at all

86 Do you think the changes brought up by the project could also be scaled-up to other non-target areas?

1. Yes 2. No

87 Do you think project interventions will continue in the future in your area even though the NGO who has been operating stops services and goes away?

1. Yes, it will remain sustainable
2. Not sure of whether it will continue or not
3. For sure it won't continue and everything will go back

88 If you perceive that it will remain continue in the future as well, what are your reasons?

89 If you perceive that it will not continue in the future as well, what are your reasons?

90 Do you have additional ideas/suggestions related to GBV in your locality?

End time _____

Thank you very much for your time and for providing relevant information!!!

The Prevention and Management of Gender Based Violence Programme in Ethiopia” from October 2012 –December 2015

Checklists

Introduction

DAB Development Research and Training PLC has deployed a team of independent consultants to evaluate the **effectiveness, relevance**, efficiency, **impact** and **sustainability** of the (Oct 2012-Dec2015) implementation of the UNFPA programme in order to identify lessons and good practices that can improve future effort on the prevention and management of Gender Based Violence (GBV) in Ethiopia. The consultancy team aims at evaluating the performance of the Non-governmental organizations (NGOs) engaged in the implementation of this programme over the span of three years (2012-2015) of their operation. This NGO is one of the twelve NGOs working in collaboration with UNFPA on the prevention and management of GBV in Ethiopia. The different NGOs operate in different regions, where some work more than one region and *woredas* (districts). Based on the agreement between DAB and UNFPA, a *woreda* of operation has been randomly selected amongst many (if any more) for evaluation purposes. Given that you have been involved in the operation and management of this NGO, we would like to know your self-assessment of the performance, good practices and limitations of the NGO in terms of accomplishing the specific components of the GBV programme in general and the specific targets envisaged to be implemented in this *woreda*.

Interview guide for police

Background information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position/Title: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

General question

- What do you understand by GBV?
- What types of GBV cases are reported mainly to your office?
- What is the role of the Police Office to prevent and control GBV cases from happening? Is this role clearly indicated in the Police structure or mandate?
- How do you respond to these GBV cases
- In what occasions do the GBV cases often occur?
- which category of the society is most prone to and affected by GBV cases
- How is the practice of the community or victims in reporting GBV cases when viewed over time, such as before three years, after three years, etc
- If the practice of reporting GBV cases is still inadequate, what do you think are the reasons for this? How do you believe this can be addressed?
- In your opinion, how adequate is legal provision in protecting and controlling GBV cases

- How do you perceive the current organizational structure the Police Office to adequately and effectively prevent and control GBV cases?

Questions related to relevance

- How does your office work to combat GBV?
- How frequent GBVs are reported to your office?
- Have you incorporated GBV into your police training manuals?
- How do you think is project intervention relevant to the community in preventing and controlling GBV cases?
- Has the project interventions been supportive to Police in taking its mission a step forwards?
- How is the project relevant in relation to woreda priority?
- How has the project addressed the relevant on-going activities of the policy related to preventing and controlling GBVs in the woreda?
- How the project has appropriately taken into account the priorities of the woreda police in addressing GBV related problems;
- To what extent has the project contributed to achievement of the GTP-1 plans of woreda police?
- How was collaboration of the relevant actors or stakeholders with police in addressing GBV related issues?
- How do the woreda police perceive that the project has achieved its goal of contributing towards enabling women & girls protected from violence and access services?

Questions related to efficiency

- What mechanisms does your office use to handle reported GBV?
- What are the procedures that you follow once a case of GBV is reported?
- How adequately have the funds been raised and distributed among activities?
- Do you feel there is adequate funding to scale up the programme that you think is effective?
- Are there delays in reporting GBV cases to your office? If so, what do you think causes delays in reporting?
- To what extent are the resource mobilized in your institution to effectively support GBV interventions?
- Has the government been allocating adequate finance to help in the prevention and control of GBV?
- How adequately has the Woreda Police been allocating manpower to help in the prevention and control of GBV cases on the community?
- What do you think is lacking from the point of view of resources allocation to effectively prevent and control GBV cases
- What do you believe has been achieved from project implementation in the woreda? What do you think has contributed for this achievement
- To what extent has the project achievements contributed to the achievement of the overall all woreda police plans and targets?
- To what extent has the woreda police benefited from the project initiatives? How do you describe the level of satisfaction of project implementation and its achievements?
- How effective was the woreda police monitoring mechanism to assess project progresses and measure its achievements? How was the woreda police effective in identifying the challenges and addressing these challenges?
- To what extent the project contributed in building the capacity of woreda police? To what extent has the woreda police contributed in building the capacities of project implementer NGOs?

Questions related to Effectiveness

- To what extent your office achieved desired output in terms of GBV if any,
- To what extent that victim of GBV have been benefited from your service
- Does your office have effective monitoring mechanisms to measure progress towards combating GBV?
- Were it able to identify challenges and measures taken to address identified challenges?
- If you have received training on GBV, how has the training increased your capacity towards assisting both survivors and perpetrators?
- Did the training target both male and female police officers?
- How the participation of the woreda police in the planning and implementation of project initiatives?
- What was the role and contribution of the woreda police in making sure that project resources were efficiently utilized?
- Do you think the project funds were utilized reasonable for the planned activities in a timely manner? What do you think were the problems related to fund utilization?
- How do you perceive the support of UNFPA main office in the overall project coordination and monitoring to help the project deliver its goals?
- What do you think were the overall constraints for efficient implementation of the project? What do you think should have been done to address these constraints?

Questions related to Management and coordination

- What problems do you encounter when carrying out investigations?
- How far you are working with safe houses?
- What specific task your office do in relation to safe houses?
- How far you work in coordination with other stakeholders?
- What good lessons does your office provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?

Interview guide for teachers and principals/deans/presidents

Background Information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position: _____

School/College/University: _____

Woreda/Town: _____

Contact details: _____

General Questions

- What do you understand by GBV?
- What are the specific roles your school/college/university (club, media, peer learning, assertiveness training, hot line service ...) play to combat GBV?

Question related to relevance

- What is the rationale for your school/college to work on GBV?
- How has the programme addressed the relevant ongoing needs of beneficiaries?
- What kind of clubs have you established in your school/college/university?
- How beneficiaries (students) does and stakeholder (educationalist) taken ownership of the programme concept?
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Question related to Efficiency

- Have you conducted project orientation/launching in your school/college/university?
- What kind of mechanisms have you used to provide your students with relevant information on GBV?
- What kind of trainings have you provided to help victims of GBV?
- What kind of materials and manuals have you developed to address GBV?
- What are the mechanisms your school/college/university employed to strengthen the capacity of health facilities in your institution?
- What are the selection criteria for provision of sanitary and cleaning materials?
- Have the UNFPA support and coordination mechanisms effectively supported the delivery of the programme?
- What kinds of learning and linking programmes have you formed to address GBV?

- What were the constraints for efficient implementation of the programme?
- What are the levels of effort made to come up these challenge?
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Questions related to effectiveness

- To what extent the target beneficiaries have been benefited from the proggmm activities
- How do you evaluate the impact of your intervention?
- Does the programme have effective monitoring mechanism to measure progress toward result?
- Does the programme able to identify challenges and measures taken to address identified challenges?
- What mechanisms are avail to strengthen the capacity of direct implementers (club leader/ educationalist)
- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Questions related to impact

- Can you tell me any observed change after the intervention (gender equality, attitudinal change...)
- Can you tell me any unintended positive and negative change after the intervention?
- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Questions related to management and coordination

- What are the challenges you have encountered during programme implementation?
- What good lessons does your office provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?

Question related to sustainability

- Do you think that this programme will continue after the suspension of UNFPA support?
- How do you plan to continue this programme after the termination of UNFPA support?
- What do you think is the strong part that enables to continue this programme after the termination of the UNFPA support?
- What do you think is needed to support schools/ universities to maintain these benefits?
- According to your opinion what does the overall potential for continuation or up scaling of this initiative?
- Have you or your organization been participating in the planning, implementation and monitoring and evaluation of the initiatives in the course of the project?
- What do you think will happen to the initiatives after phase-out of the project?
- Has your organization included project initiatives in your annual plans?
- Has your organization allocated budget to resume project initiatives after phase-out period?
- Is there an expert assigned to let project activities keep on moving ahead in the absence of the NGO who has been implementing the project?
- Do you think the benefits achieved from the project will continue in spite of the problems it may face?
- What do you think is required to maintain the project benefits and stay long lasting?
- Do you think the best practices and achievements of the project can be scaled-up to other areas? How?

Interview guide for Woreda officials and gender officers

Background Information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

Questions related to relevance

- What do you understand by GBV?
- How does your office work to combat GBV?
- What do you think are the causes of GBV in your area of intervention?
- What types/forms of violence are common in relation to gender?
- How frequent GBVs are reported to your office?
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Questions related to efficiency

- What specific mechanisms does your office use to combat GBV?
- What is the role of your organization in ensuring effective enforcement of policy and legal provisions on GBV and better service delivery for survivors of violence?
- How far your office is involved in GBV related activities in relation to other tasks?
- To what extent are resource mobilized in your institution to effectively support GBV interventions?
- How adequately have the funds been raised and allocated/distributed among activities?
- Do you feel there is adequate funding to scale up the programme that you think is effective?
- Do you have any mechanism to evaluate your intervention?
- Have your employees received any kind of training related to GBV issues? If yes, what kind of training?
- Have you participated in discussions and workshops organized by the NGO on issues related to GBV?
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs

- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Questions related to effectiveness

- To what extent the target beneficiaries have been benefited from the programme activities
- If you have any specific programme on GBV, to what extent that the target beneficiaries have been benefited from the programme activities.
- What is the level of satisfaction of beneficiaries?
- Does the programme have effective monitoring mechanisms to measure progress towards results?
- Were it identity challenges and to address these challenges?
- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Questions related to impact

- Does your office observed any kind of impact on beneficiaries?
- If so, what kind of change your office has observed/brought in combating GBV?(Gender equality, attitudinal change...)
- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Questions related to coordination and management

- Did you work with NGOs and GOs for enhanced coordination and advocacy on issues of GBV? If so, in what ways?
- Have you received technical and institutional support from the NGO that enhanced the capacity of your organization?
- What good lessons does your office provide for future programme design?
- Do you have additional points/ideas about the issue under discussion?

Interview guide for Journalist/Reporter

Background Information

Name: _____

Sex: _____

Educational level _____

Qualification _____

Position/Title: _____

Woreda/Town: _____

Contact details: _____

Question related to relevance

- How far your reports focus on GBV?
- Which specific issues of GBV you deal with most?
- What are your sources of information on GBV?
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Question related to efficiency

- What mechanisms you use to address GBV on media?
- Do you think that the timing of your programme is appropriate to meet your objectives?
- Do you think that the coverage of your programme is adequate to meet your objectives?
- If no to the above two questions (9 & 10), what are the specific challenges you have faced?
- Have your employees received any kind of training related to GBV issues? If yes, what kind of training?
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs?
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?

- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Questions related to effectiveness

- What is the role of your organization in ensuring effective enforcement of policy and legal provisions on GBV and better service delivery for survivors of violence?
- Do you think that your programme has brought any change on the listeners/target groups?
- If so, what change have you observed?
- What mechanism did you use to bring the change?
- To what extent the targeted beneficiaries have been benefited the programme activities
- What is the level of your institution and partners satisfaction with programme implementation and result
- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Questions related to impact

- Have you seen any impact because of the radio programme (gender equality, attitudinal change)
- Were your programme objectives consistent with the UNFPA's overall objectives?
- Have you observed any unintended positive or negative impact because of the programme
- If yes, please explain the factors contributing to your achievement/success?
- If no, please explain the main factors that hindered your achievement/success?
- What corrective measures were taken to improve the programme, and how did they affect results over time?
- Have you ever received feedbacks from direct and indirect beneficiaries on the quality of the project?
- How well is the programme functioning?
- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Questions related to sustainability

- Do you think that this programme will continue without the support of UNFP
- If, so what are the mechanism planned so far (budget, ownership...)
- Is the programme supported by institution of government and civil society?
- If so what is the level of leadership commitment of these institutions.
- What do you think is needed to support this programme to maintain provision of service for the beneficiaries?
- Can you comment on the overall potential for continuation or up scaling of the initiative?
- Have you or your organization been participating in the planning, implementation and monitoring and evaluation of the initiatives in the course of the project?
- What do you think will happen to the initiatives after phase-out of the project?
- Has your organization included project initiatives in your annual plans?
- Has your organization allocated budget to resume project initiatives after phase-out period?
- Is there an expert assigned to let project activities keep on moving ahead in the absence of the NGO who has been implementing the project?
- Do you think the benefits achieved from the project will continue in spite of the problems it may face?
- What do you think is required to maintain the project benefits and stay long lasting?
- Do you think the best practices and achievements of the project can be scaled-up to other areas? How?

Question related to coordination and management

- Did you work with NGOs and GOs for enhanced coordination and advocacy on issues of GBV? If so, in what ways?
- Have you participated in discussions and workshops organized by the NGO on issues related to GBV?
- Have you received technical and institutional support from the NGO that enhanced the capacity of your organization?
- What good lessons does your office t provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?

Interview guide for judge

Background information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position/Title: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

Questions related to relevance

- Are there GBV cases reported to your office? If so, what do you say about these cases?
- Which type of GBV is most reported?
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Questions related to Efficiency

- Do you think that there is appropriate penal code to deal with GBV?
- How far GBV related cases are treated in comparison to other cases?
- How do you evaluate the involvement of your institution to fight GBV?
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs?
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Question related to effectiveness

- What do you think is the response of the victims in regards to the court's decision?
- Do you think that your institution gives appropriate justice/decision to GBV cases?
- If not, what are the main challenges?
- Does your institution work in collaboration with police, GO, and NGO?
- Does staff of your institution get technical and financial support from UNFPA?
- What good lessons does your office provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?
- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Interview guide for Survivors

Background Information

Name: _____

Sex: _____

Educational level _____

Qualification: _____

Position/Title: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

Relevance

- Would you please tell me the forms of GBV you have experienced?
- How did it happen to you and what do you think is the cause of this violence?
- Would you please tell me how you manage to be in this safe house?
- Do you think that you join the safe house at the appropriate time?
- Can you say something on the relevance of the safe house?

Questions related to Efficiency

- What specific support do you get from the safe house?
- How long have you been in this safe house?
- Do you think that the service you are getting now is effective in terms of timing and relevance?
- What do you think are the benefit of the safe house for you as a survivor?
- If it is not adequate, what do you think should be improved?

Questions related to effectiveness

- Can you tell us any change you have observed after joining the program?(self confidence, economic benefit..)
- Do you think that the safe house enable you to increase your self confidence and ecomic position to continue life alone?
- Do you have additional points related to the issue under discussion?

Interview guide for religious leaders

Background information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position/Title: _____

Name of your religious institution:

Woreda/Town: _____

Contact details: _____

Interview Questions

Questions related to relevance

- What is your understanding of GBV?
- Can you please explain your religious institution's specific activity on GBV?

Question related to efficiency

- Can you please explain your personal involvement in combating GBV?
- What mechanisms did you use to empower vulnerable groups in your religious institution with knowledge and awareness about human and legal rights?
- Have the religious leaders in your institution received any kind of training related to GBV issues? If yes, what kind of training?
- Have you organized girls' and boys' clubs at congregation as well as campus level to combat GBV? If so, could you please explain the type and purpose of each club?
- Were you involved in the design and implementation of locally/culturally appropriate GBV prevention programmes as well as in the mobilization and awareness creation forums organized by the NGO?
- What can be done to prevent cases of GBV in this locality/woreda? Who has to do what? What has to be changed?

Question related to effectiveness

- What are the changes you observed in your area after your intervention?
- To what extent the target beneficiaries have been benefited from the programme activities?
- To what extent is your organization satisfied with the programme implementation and results?
- Does the programme have effective monitoring mechanisms to measure progress towards results?
- Does the programme able to identify challenges and measure taken to address these challenges?
- What good lessons does your religious institution provide for future programme design?
- Do you have additional points/ideas about the issue under discussion?

Question related to impact

- Does the programme bring any observed change in people life (attitudinal change, gender equality...?)
- Have you observed any unintended positive or negative outcomes due to interventions?

Question related to sustainability

- Do you think that this programme will continue without the support of UNFPA?

- If, so what are the mechanism planned so far (budget, ownership, etc.)
- Is the programme supported by institution of government and civil society?
- If so what is the level of leadership commitment of these institutions.
- What do you think is needed to support this programme to maintain provision of service for the beneficiaries?
- Can you comment on the overall potential for continuation or up scaling of the initiative?

Question related to coordination and management

- Did you work with NGOs and GOs for enhanced coordination and advocacy on issues of GBV? If so, in what ways?
- Have you participated in discussions and workshops organized by the NGO on issues related to GBV?
- Have you received technical and institutional support from the GO and other partners that enhanced the capacity of your organization?
- What good lessons does your office t provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?

Interview guide for health professionals and safe house personnel and counsellors

Background information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position/Title: _____

Name of Health Center/Clinic/Safe House: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

Questions related to relevance

- What is your understanding of GBV?
- What specific services you provide for survivors/victims of GBV?
- What are the common cases you diagnosed in relation to GBV?
- What kind of service you provide for the survivors of GBV and that of fistula victims (self-care training for survivors, emergency victim support and transport service)?
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Questions related to efficiency

- Do you think that your service provision is efficient in terms of timing and current need?
- If not, what are the specific problems/challenges identified/encountered?
- Have you been involved in the establishment of referral linkages?
- Have you received trainings/orientations in how to screen and manage reproductive health problems such as fistula cases related to GBV?
- Have you developed standard operating procedures/guidelines for the management of GBV cases?
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs?
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?

- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Question related to effectiveness

- What are the changes you observed in the survivor after they join the safe house?
- To what extent survivors have been benefited from the programme activities?
- To what extent is your organization satisfied with programme implementation and results?
- Does the programme have effective monitoring mechanisms to measure progress towards results?
- Does the programme able to identify challenges and measure taken to address these challenges?
- How do you perceive the overall progress of the project in achieving its plans and goals?
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements?
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Question related to impact

- Does the programme bring any observed change in people life (attitudinal change, gender equality, economy, social capacity ...?)
- Have you observed any unintended positive or negative outcomes due to interventions?
- Is there any special case stories you would like to share us?
- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Question related to sustainability

- Do you think that this programme will continue without the support of UNFPA?
- If, so what are the mechanism planned so far (budget, ownership...)

- Is the programme supported by institution of government and civil society?
- If so what is the level of leadership commitment of these institutions.
- What do you think is needed to support this programme to maintain provision of service for the beneficiaries?
- Can you comment on the overall potential for continuation or up scaling of the initiative?
- Have you or your organization been participating in the planning, implementation and monitoring and evaluation of the initiatives in the course of the project?
- What do you think will happen to the initiatives after phase-out of the project?
- Has your organization included project initiatives in your annual plans?
- Has your organization allocated budget to resume project initiatives after phase-out period?
- Is there an expert assigned to let project activities keep on moving ahead in the absence of the NGO who has been implementing the project?
- Do you think the benefits achieved from the project will continue in spite of the problems it may face?
- What do you think is required to maintain the project benefits and stay long lasting?
- Do you think the best practices and achievements of the project can be scaled-up to other areas? How?

Questions related to coordination and management

- Did you work with NGOs, police, court and GOs for enhanced coordination and advocacy on issues of GBV? If so, in what ways?
- Have you participated in discussions and workshops organized by the NGO on issues related to GBV?
- Have you received technical and institutional support from the GO and other partners that enhanced the capacity of your organization?
- What good lessons does your office t provide for future programme design?
- Have you worked closely with the local women development army/group and health extension workers to promote referral linkages?
- Do you have additional points/ideas related to the issue under discussion?

Annex 10: Interview guide for facilitators

Background information

Name: _____

Sex: _____

Educational level: _____

Qualification: _____

Position/Title: _____

Health Center/clinic: _____

Woreda/Town: _____

Contact details: _____

Interview Questions

Question related to relevance

- What kind of beneficiaries you have encountered so far?
- Do you think project interventions were relevant to community interests?

Questions related to efficiency

- How do you select the beneficiaries?
- How does your programme approach the different age and sex composition of beneficiaries?
- What are the specific issues in your training/programme interventions?
- How do you see the timing of the implementation of the programme in line with the objective of the programme?
- What is the level of support you get from the necessary stakeholders?

Question related to effectiveness

- Do you have any assessment mechanisms in place to observe changes in your beneficiaries?
- If yes, please explain to us the mechanisms you employed and the changes you have observed?
- Do you think that the changes you observed go along with your objective or plan?
- What kind of training/orientation have you received?
- Do you have additional points/ideas related to the issue under discussion?

Focus group discussion (FGD) guide with stakeholders

Introduction

DAB Development Research and Training PLC has deployed a team of independent consultants to evaluate the **effectiveness, relevance, impact** and **sustainability** of the (Oct 2012-Dec2015) implementation of the UNFPA programme in order to identify lessons and good practices that can improve future effort on the prevention and management of Gender Based Violence (GBV) in Ethiopia. The consultancy team aims at evaluating the performance of the Non-governmental organizations (NGOs) engaged in the implementation of this programme over the span of three years (2012-2015) of their operation. This NGO is one of the twelve NGOs working in collaboration with UNFPA on the prevention and management of GBV in Ethiopia. The different NGOs operate in different regions, where some work more than one region and woredas. Based on the agreement between DAB and UNFPA, a woreda of operation has been randomly selected amongst many (if any more) for evaluation purposes. Given that you have been involved in the operation and management of this NGO, we would like to know your self-assessment of the performance, good practices and limitations of the NGO in terms of accomplishing the specific components of the GBV programme in general and the specific targets envisaged to be implemented in this woreda.

Background Information

Education level _____

Qualification _____

Name of the organization _____

Role in the your organization _____

Region _____ Zone _____ Woreda _____

Total Number of FGD Participants: At the beginning _____ At the end _____

FGD participants' contact details:

Discussion Questions

- What has been your role with the NGO and in what specific activities have you been engaged?
- How relevant are the activities and output targets of the NGO in addressing GBV?
- Do you think that the NGO has fair and objective beneficiary selection procedures to implement GBV intervention programme GBV?
- What do you think is the agency/organization's role is in addressing the problem of GBV?
- Do you think the NGO provide adequate, quality and timely service to its beneficiaries? If so, please explain to us your assessment based on practical evidences.
- Do you think that the NGO is successful in terms of bringing positive social change in the community and the concerned beneficiaries in particular? If yes, please explain to us how the change was brought about?
- Can you please specifically explain to us about the impact of the NGO in changing attitudes and practices related to GBV? Please also share with us your experiences based on some evidences?
- Could you please share with us the major good practices brought through the NGO interventions?
- What are the challenges the NGO faces in addressing GBV?

- Can you please tell us how far the NGO has been cost effective, or delivers the required service with a reasonable cost?
- How would you rate the scale of the intervention of this NGO in addressing the problem of GBV?
4. Very well 3 well 2 somehow well 1 not well
- Can you please tell us the different actions the NGO should undertake to be more efficient?
- Would you please describe the management system and working environment of the NGO?
- What is the linkage between the activities of this NGO and other governmental, non-governmental organizations?
- How relevant is the NGO in the context of this community?
- Are the objectives of the NGO in line with the objectives of your organization?
- What do you suggest being the way forward in terms of improving its performance (for continuity of the NGO in addressing GBV)?
- Can you please explain to us how the interventions can be sustained after the phase out of the NGO programme?
- Is there anything else you would like to share with us?

Relevance

- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Efficiency

- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs?
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?
- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Effectiveness

- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Impacts

- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Sustainability

- Have you or your organization been participating in the planning, implementation and monitoring and evaluation of the initiatives in the course of the project?
- What do you think will happen to the initiatives after phase-out of the project?
- Has your organization included project initiatives in your annual plans?
- Has your organization allocated budget to resume project initiatives after phase-out period?
- Is there an expert assigned to let project activities keep on moving ahead in the absence of the NGO who has been implementing the project?
- Do you think the benefits achieved from the project will continue in spite of the problems it may face?
- What do you think is required to maintain the project benefits and stay long lasting?
- Do you think the best practices and achievements of the project can be scaled-up to other areas? How?

Interview guide for project managers

Introduction

DAB Development Research and Training PLC has deployed a team of independent consultants to evaluate the **effectiveness, relevance, impact** and **sustainability** of the (Oct 2012-Dec2015) implementation of the UNFPA programme in order to identify lessons and good practices that can improve future effort on the prevention and management of Gender Based Violence (GBV) in Ethiopia. The consultancy team aims at evaluating the performance of the Non-governmental organizations (NGOs) engaged in the implementation of this programme over the span of three years (2012-2015) of their operation. This NGO is one of the twelve NGOs working in collaboration with UNFPA on the prevention and management of GBV in Ethiopia. The different NGOs operate in different regions, where some work more than one region and districts. Based on the agreement between DAB and UNFPA, a woreda of operation has been randomly selected amongst many (if any more) for evaluation purposes. Given that you have been involved in the operation and management of this NGO, we would like to know your self-assessment of the performance, good practices and limitations of the NGO in terms of accomplishing the specific components of the GBV programme in general and the specific targets envisaged to be implemented in this woreda. Therefore, you are asked to express your honest opinions about the following evaluation questions. Participating in this evaluation is voluntary. In addition, you will not be asked to provide any identifiable information about yourself to ensure the privacy and confidentiality principles of research ethics. Your participation provides us with an in-depth understanding about the **relevance, effectiveness, efficiency, impact** and **sustainability** of UNFPA supported GBV intervention. The results of the evaluation will be shared among study participants to validate the findings.

Background Information

1. Name of the NGO _____
2. Area of Operation: Region _____ Zone _____
Woreda _____
3. Age _____
4. Education level _____
5. Qualification.....
6. Position in the Organization _____
7. For how long did you work in this project? _____
8. Contact details:

Interview Questions

Part I: General Questions

1. What is your understanding of GBV?
2. Can you please describe your organization's mission in relation to GBV?

3. What are the specific activities your organisation undertakes to address GBV?
 - 1 Awareness raising training/community dialogue, sensitization through media?
 - 2 Direct service (food and shelter/safe house) for survivors of GBV?
 - 3 Capacity building training to clinics/health centers/hospital staff?
 - 4 Material support for health care providing institutions?
 - 5 Training legislatures and media personnel?
 - 6 Legal aid for survivors of GBV?
 - 7 Economic empowerment programmes?
 - 8 Girls' club strengthening project?
 - 9 Community mobilizing efforts?
 - 10 Education service for women and girls?
 - 11 Others (please specify)_____
4. Please describe the different services you provide to your beneficiaries?

5. Have you and your colleagues received any trainings on GBV?,If yes, how many and what are the contents and types of the trainings?
6. Is your organization affiliated with any women group that addresses GBV?
If yes, which one _____
What services does your organization provide?

7. Who are the main target groups of your organization (sex, age,)?

8. How do you rate your organization level of commitment in addressing GBV?
 - 4 Very well
 - 3 Well
 - 2 Not sure
 - 1 Do not know
9. Can you please tell us which intervention areas worked well?

10. What are the major challenges you encountered during the implementation processes?

11. Would you please share with us the good practices your organization experienced?

12. What are your recommendations for improvement of the programme and for scale up and expansion of the programme?

Part II: Questions on the Relevance, Effectiveness, Efficiency, Impacts and Sustainability of the Programme

1. Relevance

- Do you think that the objectives of the programme are consistent with the needs and priorities of target beneficiaries?
- How far the design of the programme goes in line with the local context, laws and policies of the government?
- Can you please explain how far the technical and financial support your organization received is consistent with your objective of addressing GBV?
- Do you think the strategies and the programme framework reflect the situation of GBV and are relevant to reduce its occurrence?

2. Effectiveness

- Were your programme objectives consistent with the UNFPA's overall objectives?
- Have you achieved the intended outcome and output of your organization?
- If yes, please explain the factors contributing to your achievement/success?
- If no, please explain the main factors that hindered your achievement/success?
- What corrective measures were taken to improve the programme, and how did they affect results over time?
- Have you ever received feedbacks from direct and indirect beneficiaries on the quality of the project?
- How well is the programme functioning?
- Have you encountered any unintended effect that has positive and negative impacts on the overall performance and the quality of results realized?
- What would you say about the overall strengths and weaknesses of the programme's focus and strategies in terms of achieving the intended programme objectives?
- To what extent are resources mobilized to support effective GBV interventions?
- How adequately have the funds been distributed among activities?
- How well were the funds used? Do you feel there is adequate funding to scale up the programme that you think is effective?

3. Efficiency

- Do you think that the project is cost effective? If yes, what is the cost per beneficiary?
- How do you relate the overhead /administrative cost with budgets spent on activities?
- What kind of measures did your organization employ to improve cost efficiency?
- How fairly and adequately have the funds been distributed among activities at the different stages of the project?

- Were there any alternative approaches to make the GBV interventions cost efficient, including reducing transaction costs? (from RNE – UNFPA – Local NGOs)
- Are the resources spent as economically as possible? Could a different intervention be used to address the same issues at a lower cost? Could more results have been produced with the same resources?
- What would you say about the implementation process of the project? Has the programme been implemented/completed as per the initial time period? If not, what were the main reasons for the delays?
- Does your organization use an integrated approach (legal, clinical, psychosocial and environment setting activities, etc)? If not, does your organization collaborate with other organizations that are providing some of the services? Does your organization have referral system? In your opinion, does an integrated approach ensure efficiency?

4. Impacts

Would you please tell us the major impacts brought about under the following specific programme intervention?

- **Preventive**
 - Awareness raising trainings
 - Community dialogue/conversations
 - Media
- **Basic survival services**
 - Food
 - Clothings
 - Shelter/safe house
- **Empowerment**
 - Economic
 - Political/rights
 - Basic literacy/education service for women
- **Psychosocial support**
 - Counselling
 - Organizing support group
- **Legal aid/services**
- **Linkage/referral to provide medical services**
- **Capacity building to strengthen institutions**
 - Strengthening girls; clubs
 - Providing material support for existing clinics/health centres
 - Establishing model clinics
 - Providing trainings for police, parliamentarian, health care providers
- **Advocacy activities to influence policy**
- Others (please specify) _____

5. Sustainability

- What is the comparative advantage of projects supported by NGOs in terms of ensuring the sustainability of the achieved results and probability of their continued long-term benefits?
- What phase out plans has your organization been implementing to maintain the sustainability of the programme activities?
- How would you describe UNFPA's support in terms of helping your organization in addressing GBV?
- To what extent the different community based organizations (CBOs) are prepared to sustain the activities of the project?
- If the CBOs are not ready to take over and sustain the interventions, what alternatives do you suggest?
- How far your organization consults various stakeholders relevant to the prevention and management of GBV projects?
- Please specify the level of stakeholders' involvement in the programme design and implementation?
- What measure did you take to help government partners to own some of your organization's programme intervention?
- Is there any indication of these government partners to own some of the programme interventions?
- Could you, please, describe the overall sustainability of the programme achievements after the completion of the programme period?

Focus group discussion (FGD) guide with stakeholders

Introduction

DAB Development Research and Training PLC has deployed a team of independent consultants to evaluate the **effectiveness, relevance, impact and sustainability** of the (Oct 2012-Dec2015) implementation of the UNFPA programme in order to identify lessons and good practices that can improve future effort on the prevention and management of Gender Based Violence (GBV) in Ethiopia. The consultancy team aims at evaluating the performance of the Non-governmental organizations (NGOs) engaged in the implementation of this programme over the span of three years (2012-2015) of their operation. This NGO is one of the twelve NGOs working in collaboration with UNFPA on the prevention and management of GBV in Ethiopia. The different NGOs operate in different regions, where some work more than one region and *woredas*. Based on the agreement between DAB and UNFPA, a *woreda* of operation has been randomly selected amongst many (if any more) for evaluation purposes. Given that you have been involved in the operation and management of this NGO, we would like to know your self-assessment of the performance, good practices and limitations of the NGO in terms of accomplishing the specific components of the GBV programme in general and the specific targets envisaged to be implemented in this *woreda*.

Background Information

Education level _____

Qualification _____

Name of the organization _____

Role in the your organization _____

Region _____ Zone _____ Woreda _____

Total Number of FGD Participants: At the beginning _____ At the end _____

FGD participants' contact details:

General questions

- What has been your role with the NGO and in what specific activities have you been engaged?

Questions related to relevance

- How relevant is the NGO in the context of this community?
- How relevant are the activities and output targets of the NGO in addressing GBV?
- What do you think is the agency/organization's role is in addressing the problem of GBV?
- 17.. Are the objectives of the NGO in line with the objectives of your organization?
- Do you think that the NGO has fair and objective beneficiary selection procedures to implement GBV intervention programme GBV?
- Do you think the NGO provide adequate, quality and timely service to its beneficiaries? If so, please explain to us your assessment based on practical evidences.
- What are the challenges the NGO faces in addressing GBV?
- Can you please tell us how far the NGO has been cost effective, or delivers the required service with a reasonable cost?

Questions related to effectiveness

- Do you think that the NGO is successful in terms of bringing positive social change in the community and the concerned beneficiaries in particular? If yes, please explain to us how the change was brought about?
- Can you please specifically explain to us about the impact of the NGO in changing attitudes and practices related to GBV? Please also share with us your experiences based on some evidences?
- Could you please share with us the major good practices brought through the NGO interventions?
- How would you rate the scale of the intervention of this NGO in addressing the problem of GBV?
4 Very well 3 well 2 somehow well 1 not well

Question related to sustainability

- Do you think that the programme will continue with the support of civil society or government institutions?
- Can you please tell us the different actions the NGO should undertake to be more efficient?
- What do you suggest being the way forward in terms of improving its performance (for continuity of the NGO in addressing GBV)?
- Can you please explain to us how the interventions can be sustained after the phase out of the NGO programme?

Questions related to management and coordination

- Would you please describe the management system and working environment of the NGO?
- What is the linkage between the activities of this NGO and other governmental, non-governmental organizations?
- Is there anything else you would like to share with us?

Focus group discussion guide with community representatives

Background Information

Education level: _____

Qualification: _____

Name of the organization _____

Role in the organization _____

Region _____ Zone _____ Woreda _____

Total Number of FGD Participants: At the beginning _____ At the end _____

FGD participants' contact details:

General Questions

1. Can you tell us what do you know about the GB practice in your locality?

Questions related to relevance

- What are the major types and causes of GBV in this locality?
- In what kind of community activity have you participated to combat GBV?
- In your experience, are there any difference in the occurrence of the practice(boy/ girl)
- To what extent is the project in line with the on-going similar initiatives or programs of your organization to prevent and control GBVs?
- Do you perceive the project activities are in accordance to the priorities of your organization to prevent and control GBVs?
- To what extent do you believe the project initiatives have contributed to achievement of GTP-1 plans of your organization?
- Has your organization taken ownership of the project concept and included in its annual plans?
- How do you perceive that the project has contributed to enabling women & girls protected from GBVs?
- Have you or your organization participated in the annual planning, appraisal and evaluation of the project activities?

Questions related to efficiency

- Do you know the NGO's beneficiary selection procedures/criteria? If so, do you think that the selection process is fair?
- Do you think the community has adequate knowledge about the impact? And where to go (report, service...)
- Do you think the community has adequate knowledge about the legal laws about GBV?
- What specific trainings or awareness raising programmes you received to understand GBV
- How is the status of allocation of your organization in allocating finance for the prevention and control of GBVs
- How is the status of your organization in allocating experts / human resources for the control and prevention of GBVs?
- How was the contribution of the project in reinforcing the achievement of your organizations plans for the prevention and control of GBVs?

- Do you believe your organization has benefited from project initiatives? How?
- Do you think the target beneficiaries have been benefited from the project activities? How do you perceive the level of satisfaction of beneficiaries on the project achievements?
- How do you think was the project being monitored? Was the monitoring mechanism satisfactory and was it problem solving?
- Do you think the capacity of your organization has been improved because of project interventions? How?
- How do you perceive that the involvement of your organization contributed in building the capacity of the implementer NGO?

Questions related to effectiveness

- Do you think that the intervention is adequate to address the problem of GBV in your locality?
- If your response to question number 11 is no, what do you suggest as a way forward?
- In your opinion, what type of changes and actions need to happen in your community for the practice of GBV to end?
- What are the barriers to combating the problem of GBV?
- What do you suggest for preventing and managing the problem of GBV?
- What do you think is the NGOs role is in addressing the problem of GBV?
- How do you perceive the overall progress of the project in achieving its plans and goals
- Do you think there are activities planned but not yet implemented or not completed? If so, which activities? What do you think are the reasons for this?
- How do you see the overall quality of project implementation?
- How do you perceive overall level of satisfaction of project implementation and its achievements
- What do you think are the problems of the project in implementing its planned activities? How would have these problems been addressed?
- What roles do you or your organization play in monitoring to ensure that project resources are efficiently utilized?
- Do you believe that the project funds and activities been delivered in a reasonable timely manner? If not, what were the bottlenecks? How should have these been addressed?
- Do you believe UNFPA main office has been supportive in the overall coordination of the project and addressing the problems?
- What do you think were the constraints that hindered the project from achieving its objectives and goals?

Questions related to impact

- What kind of impact does the project had on you, your community and family?
- Who do you think benefited from the overall project interventions? How?
- Are there any unintended positive or negative outcomes due to the project intervention? Please mention the major ones
- Are there any changes in the lives of beneficiaries due to project intervention? What are these changes?

Questions related to management and coordination

- What benefits you received from the NGO's project?
- What good lessons does the project provide for future programme design?
- Do you have additional points/ideas related to the issue under discussion?

Individual Case Stories

Background information

1. Name _____ (to be coded) Age _____
2. Marital status _____
3. Occupational status _____
4. Number of children _____
5. Place of birth _____
6. Place of residence _____
7. Educational level _____
8. Beneficiary status (survivor or perpetrator) _____
8. Contact details:

Interview Questions

8. What forms of gender based violence (GBV) did you experience?
9. What kind of impact you have experienced after the incident?
11. Did you ever report the incidence to a police or your teacher or women's affairs office?
12. Did you get adequate support from the police and other stakeholders?
13. Was your case taken to a court? If so, please explain the procedures of the prosecution.
14. How did you find the safe shelter house or who brought you to the shelter house?
15. What kind of support or service you have received at the shelter house?
16. Have you experience any delays in accessing the safe house service?
17. Were the survivors and the shelter supportive?
18. Has the shelter provided you with adequate, timely and quality services?
18. How long have you been in this safe house?
19. What do you think are the benefits of the safe house for you as a survivor?
20. Do you think that the services are adequate? If not, what should be improved?

