



**INDEPENDENT EVALUATION OF THE GOVERNMENT OF THE
REPUBLIC OF ZAMBIA/UNITED NATIONS (GRZ/UN) JOINT
PROGRAMME ON GENDER BASED VIOLENCE**

FINAL EVALUATION REPORT



Presented to UNDP Zambia Country Office

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LIST OF ACRONYMS

| | |
|---------|--|
| AAH | Action Africa Help |
| AYE | Alliance for Young Entrepreneurs |
| CBO | Community Based Organization |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CEEC | Citizens Economic Empowerment Commission |
| CHD | Community for Human Development |
| CP | Cooperating Partner |
| CSO | Civil Society Organization |
| CSO | Central Statistics Office |
| DEC | Drug Enforcement Commission |
| DFID | Department for International Development |
| FAWEZA | Forum for African Women Educationalists of Zambia |
| FTC | Fast Track Court |
| GBV | Gender Based Violence |
| GRZ | Government of the Republic of Zambia |
| HIV | Human Immunodeficiency Virus |
| HRC | Human Rights Commission |
| IEC | Information, Education and Communication |
| ILO | International Labour Organization |
| IOM | International Organization for Migration |
| JP-GBV | Joint Programme on Gender Based Violence |
| LAZ | Law Association of Zambia |
| M&E | Monitoring and Evaluation |
| MCDSW | Ministry of Community Development and Social Welfare |
| MOCTA | Ministry of Chiefs and Traditional Affairs |
| MDG | Millennium Development Goals |
| MGCD | Ministry of Gender and Child Development (prior to MoG) |
| MOCTI | Ministry of Commerce Trade and Industry |
| MOE | Ministry of Education |
| MOG | Ministry of Gender |
| MOH | Ministry of Health |
| MOHA | Ministry of Home Affairs |
| MoIB &L | Ministry of Information, Broadcasting and Labour |
| MOJ | Ministry of Justice |
| MWO | Mulangile Women Organisation |
| NGCA | National Gender Coordinating Authority |
| NGOCC | Non-Governmental Organisations' Coordinating Council |
| NLACW | National Legal Aid Clinic for Women |
| NPA | National Prosecution Authority |
| OSAWE | Own Savings for Assets and Wealth |
| OSC | One Stop Centre |
| PC | Penal Code |
| PEP | Post – Exposure Prophylaxis |
| PITC | Programme Implementation Technical Committee |
| PS | Permanent Secretary |
| RC | Resident Coordinator |
| SGBV | Sexual GBV |
| SMAGS | Safe Motherhood Action Groups |
| SNDP | Sixth National Development Plan |
| SRHR | Sexual Reproductive Health and Rights |

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| UN | United Nations |
| UNDAF | United Nations Development Assistance Framework |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| VSU | Victim Support Unit |
| WFC | Women for Change |
| WHO | World Health Organization |
| WLSA | Women and Law in Southern Africa |
| YWCA | Young Women's Christian Organisation |
| ZAMDHARP | The Zambia Disability HIV/AIDS Human Rights Programme |
| ZCCP | Zambia Center for Communications Programme |
| ZDA | Zambia Development Agency |
| ZFAWIB | Zambia Federation Association of Women in Business |
| ZLDC | Zambia Law Development Commission |
| ZPS | Zambia Police Service |

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Although the authors of this report made every effort to interpret and reflect as accurately as possible the information and data provided by the various respondents, views expressed in this report are those of the Evaluation Team and not the UN agencies, the Government of the Republic of Zambia and the embassies of Sweden and Ireland as the donors. Any misrepresentations or inaccuracies that may be found in the report are entirely the responsibility of the authors.

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EXECUTIVE SUMMARY

Purpose of the Evaluation: The independent final evaluation of the Government of the Republic of Zambia/United Nations Joint Programme on Gender Based Violence was conducted by a team of three consultants (one international and two national) in February and March 2017 over a six-week period. The evaluation covered 6 provinces namely; Lusaka, Eastern, Southern, Northern, Central and North Western where the joint programme is being implemented by different stakeholders. The main purpose of the evaluation was to assess the impact of the programme and the level of achievement of the programme's objectives and expected results. The evaluation further sought to identify any emerging good practices or approaches, challenges encountered and lessons learnt in implementing the programme that can be documented and showcased for possible replication and up-scaling in the fight against GBV in Zambia. The following evaluation criteria were used to assess the performance of the programme: Relevance; Impact; Effectiveness; Efficiency; and Sustainability. The evaluation approach was participatory and data collection methods included review of literature and programme documents, key informant interviews with key stakeholders (53), Focus Group Discussions (17) and Case Studies. Field observations were also conducted during the evaluation.

Background of the programme: The Joint Programme on Gender Based Violence was a four year multi-sectoral programme (July 2012-December 2016), which was granted a one year no-cost extension to December 2017. The programme was designed to respond to the Gender Based Violence (GBV) context in Zambia, which is characterized by a high prevalence of GBV cases. The programme sought to respond to the GBV context through supporting the Government of the Republic of Zambia (GRZ) to implement the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), with particular focus on the recommendations on violence against women that are contained in the July 2011 CEDAW concluding observations and the recommendations of the Special Rapporteur on Violence against women, its causes and consequences. Records at the Victim Support Unit (VSU) of the Zambia Police Service show that reported GBV cases increased from 6,716 in 2008 to 12,924 in 2012. GBV cases jumped further to 18,088 in 2015; and 18,540 in 2016. The programme, which had a planned budget of USD \$ 15,570,000, was funded by the embassies of Sweden and Republic of Ireland, with core resource contributions from UNDP, UNICEF, UNFPA, UNHCR and ILO. The programme had a specific goal of reducing cases of Gender Based Violence (GBV) in Zambia. The overall objective of the programme was to establish an integrated and multi-sectoral mechanism for the implementation of the Anti-Gender Based Violence Act. The programme was anchored on four outcome areas of Health, Justice, Social Protection and Economic Empowerment and Coordination. A coordinated, multi-sectoral approach was used to implement the programme and this brought together seven UN agencies and more than 25 government and non-state actors led by the Ministry of Gender.

Key Findings of the Evaluation

Relevance and Strategic Fit

The evaluation found the programme to be relevant and strategically aligned to the development aspirations and needs of all the stakeholders that participated in the evaluation, from national level down to the ultimate beneficiaries (GBV survivors). There was universal concurrence across all the stakeholders that GBV in Zambia was a social, health, economic and psychological problem that needs coordinated efforts of all the relevant stakeholders. The programme objectives were also found to be in strong alignment with international and regional human rights instruments and priorities such as CEDAW and SADC Protocol on Gender and Development and national legislation and policies such as the Anti-GBV Act No.1 of 2011 and the National Gender Policy of 2014 amongst others. The programme objectives further reflected the mandates of all the development partners and stakeholders as well as with those of the donors. The four pillars of the programme were found to be highly relevant to the GBV needs of survivors and stakeholders. There is however need to also focus more on rehabilitation of offenders and on GBV related to People Living With Disability (PLWD), and violence against children and/or girls. GBV related to PLWD was however later mainstreamed in the implementation of the programme with the targeting of this socially excluded group in the two urban centres of Lusaka and Kabwe and the translation of the Anti-GBV Act into Braille.

Validity of Programme Design

The Theory of Change for the programme, reconstructed from the logical framework of the programme, was noted to be generally valid as the change process towards the goal of contributing to the reduction of GBV in Zambia was anchored around strengthening of GBV service delivery systems; capacity building of service providers for effective and quality GBV service delivery; implementation of innovative interventions and strategies such as the FastTrack Courts and One Stop Centers; awareness creation through campaigns, establishment of community networks and engagement of traditional leaders; improved partnerships, collaboration and coordination through the four pillars of the programme. The interventions and strategies triggered the desired results, although there was need for the goal to reflect both the prevention and response component of the programme. The major assumptions of the programme have also been noted to have been valid as there has been political will and support by the government of Zambia. Assumptions that did not play out to be as valid include adequacy of human and financial resources by government and non-state actors to deliver GBV services to survivors and this poses a potential threat to the sustainability of the programme.

The design of the programme was found to be largely valid as the multi-sectoral approach adopted by the programme was found to be very appropriate when responding to a multi-faced phenomenon such as GBV. This assertion is based on the assumption that no one stakeholder can effectively address all the facets of GBV and hence there is need for a coordinated approach where stakeholders complement each other by leveraging on each other's competencies, resources, mandates, skills and comparative advantages. The design of the programme was also informed by solid evidence on GBV from Police VSU statistics and corroborative studies such as ZDHS and by broad based stakeholder consultations. However, for increased validity, the

programme goal needed to be redefined to reflect both the preventive and response thrust of the programme and indicators need further refinement so that they are realistic and measurable and should be pitched at programme rather than national level particularly when the programme does not have as yet a national scope. To achieve its ultimate goal of contributing to the decline in GBV cases in Zambia, the programme needed a longer timeline mainly because it was implemented initially as a pilot and therefore good and effective practices need to be scaled up nationally for increased and far-reaching impact and because changing attitudes takes time and the process needs repeated messaging and actions over a longer period.

Programme Performance

Despite the fact that the programme had a late start-up, the programme performed well across all pillars. Of all the measurable targets, 54% of the output targets were achieved or surpassed; 42% were achieved by between 50 to 90% and were thus likely to be achieved within the remaining no-cost extension year of the programme. Only one output target on One Stop Centres was under achieved. A total of 72 One stop Centres were planned by the government of Zambia but only 14 were set-up or supported by the programme, which is a 21% achievement of target. The evaluators' view is that the target was too ambitious because it was based on the assumption that the OSCs would be established in all the country's 72 districts. The programme scope and budget could not cover all the 72 districts as OSCs are expensive to set up and the funds were justifiably diverted towards the setting up low cost Village Based OSCs. A total of 17 OSCs were supported or established (13 Village Based OSC and 4 hospital based OSCs). (Please see tables in annex 7.4 for tables summarizing programme performance for specific indicators)

Factors that had a positive influence on programme performance include: good political will, support and programme buy-in by all stakeholders including government; leveraging on technical capacity and expertise within UN agencies, government ministries and CSOs; motivation of national stakeholders as there was consensus on problematisation of GBV; improved coordination particularly after the appointment of a Programme Coordinator by Ministry of Gender; multi-sectoral approach that provided a platform for a holistic approach to the multi-faceted phenomenon of GBV; enhanced coordination through the establishment of functional Provincial and District Anti-GBV Taskforces; community buy-in and strong enthusiasm; support of traditional leaders; male engagement; and the existence of volunteers willing to spearhead anti-GBV activities.

On the other hand, factors that negatively impacted on programme performance include; delays in programme startup which necessitated the one year no-cost extension; inconsistent disbursement of funds for some implementing partners (e.g Kasama and Chipata OSC) partly due to partners' failure to adhere to reporting requirements before release of next batch of funds and partly as a result of bureaucratic red tape within some UN agencies; weak data collection and management system; some IPs had no office presence in programme districts and they operated from Lusaka which was not cost-effective; and lack of adequate equipment and resources for communication and transportation for some community networks.

Programme Effectiveness

The evaluation assessed the extent to which the programme was effective in reaching the desired outcomes. The assessment focused on effectiveness of programme design and the extent to which the four expected outcomes of the programme were achieved in terms of improved access and delivery of preventive and responsive GBV services, behavior change and functionality of the multi –sectoral coordination and referral system.

Programme Design and Approach: In terms of programme design and approach, the multi-sectoral approach was found to be largely effective as evidenced by the achievement of results at both output and outcome levels. The approach, buttressed by capacity building trainings that were conducted, enabled GBV survivors to access holistic and appropriate services in a much more efficient manner. Effectiveness was also enhanced through the UN Delivering as One model. A key challenge with the multi-sectoral approach was competition for space and resources amongst stakeholders which resulted in some partners focusing on areas where they did not have comparative advantage in terms of technical skills and capacity. As a pilot, the programme should have concentrated on a few provinces and districts where the whole range of programme activities would be implemented to enable easy assessment of the effectiveness of the coordination mechanism and activities implemented. Decision for location of programme activities was mainly based on pre-programme presence of UN agencies and hence the whole menu of programme activities was not available in all programme districts. The multi-sectoral approach is based on complementarity and mutually reinforcing activities and if one programme component is missing from the referral chain, it becomes difficult to assess the effectiveness of the coordination mechanism.

Outcome 1 was focused on increased access to timely and appropriate health services by GBV survivors. A total of 5,679 survivors received health services (which is 116% achievement of target) and interviews with the survivors as well as with the service providers revealed that the services were delivered according to guidelines of the GBV management protocol. A total of 1,013 health workers were trained on guidelines in the provision of medical and psychosocial services to GBV survivors. Statistics from the Lusaka Provincial Health Office shows that 87 % of the trained health workers were complying with the guidelines¹. Stakeholders interviewed attributed the increase in GBV survivors accessing services to increased awareness of the availability of services, increased capacity of health workers to offer the required services and the introduction of mobile clinics to reach out to some of the remote parts of the districts. Visits to OSCs such as Kasama showed that 95% of all the GBV survivors that reported their cases at the centres also accessed services offered at these centres. A few that reported (5%) did not access any services, mainly opting to voluntarily not to do so. The training received by health workers was regarded by the health workers to be very important as it had equipped them with new skills that have increased the effectiveness of health services delivery to GBV survivors. Some of the skills they have acquired include the multi-disciplinary manner in which GBV is handled and the interface between the medical, police and justice personnel.

¹ The Lusaka Provincial Medical Office

Key challenges are however being experienced by GBV survivors in accessing health services. Health centres are located long distances from communities (for example in Chipata District some communities are within a 60 km radius) and survivors need resources to access these centres. Where GBV survivors are experiencing transport challenges, it means survivors cannot easily access the health centres as they will have to pay for transport costs and some areas have poor transport networks. Some of the district hospital based OCSs reported that in some cases survivors who have been sexually abused are failing to access Post Exposure Prophylaxis (PEP) because they submit themselves after the required 72 hours deadline. In other cases, evidence of abuse is lost because survivors report to the health facilities late owing to access challenges.

Outcome 2 aimed at increasing access to an efficient justice delivery system for survivors of GBV. The evaluation established that there has been a gradual increase in the number of cases reported to the police from 12,924 in 2012 to 18,540 in 2016. This represents a 44% increase in reported cases from 2012 to 2016 and GBV survivors and the police VSU interviewed attributed this increase to GBV awareness activities supported by the programme. The police and judiciary officers, including magistrates and prosecutors, received training which they noted has amongst other things, improved their investigative and prosecution skills. Key skills gained include handling of evidence, handling of witnesses, handling survivors, techniques of prosecution of GBV cases, data management and an understanding of the multi-sectoral protocol on GBV. The courts have handled 16% of the GBV cases recorded, which is below the programme target of 60%. This is mainly because the concept of Fast Track Courts (FTCs) has not been rolled out to all parts of the country as there were only 2 functional fast track courts at the time of the evaluation. The indicator on FTCs should have therefore been pitched at programme level rather than at national level because it provides an erroneous picture of the performance of the FTCs. There is also a high rate of case withdrawal (44% from 2012-2016), and the reason for this trend has not been systematically investigated.

The FTCs have however proved to be much more efficient in disposing of cases compared to the conventional courts. For example, the Kabwe FTC Between 2016 and February 2017 handled a total of 68 GBV cases. Out of these cases, 52 cases (or 76%) had been disposed of by the time of the evaluation. Of the cases that had been disposed of, 38 cases (or 73%) were disposed of within 30 days of court receipt while only 27% went beyond 30 days. In a conventional court, for example the Solwezi magistrate's court visited during the evaluation, cases can go beyond 2 years and yet for the Kabwe FTC, the longest case took 72 days. However, the main challenge affecting efficiency of the FTCs is lack of adequate courtroom space as magistrates have to take turns to preside over cases in the few court rooms available.

The conclusion of the evaluation is that FTCs are an efficient way of delivering justice for survivors of GBV. The concept of the FTCs therefore needs to be scaled up across the country but with supportive infrastructure (more court rooms) and continuous training of judiciary officers. A sustainability plan for the FTCs needs to be developed particularly in regard to the maintenance of the expensive equipment that has been installed in the courts and the vehicles allocated for specific use by the FTCs. The equipment also needs to be incorporated into the rules of court to avoid legal challenges that might emanate from use of the equipment during trial since this is not explicitly stated in the Criminal Procedure Code which guides how matters should be tried and

how evidence should be adduced in Courts of Law.. The evaluation established that the Ministry of Justice is in the process of regularising the use of the equipment in court.

A total of 319 out of a targeted 300 Traditional and Local Courts adjudicators were trained on the provisions of CEDAW. Discussions with the trained adjudicators revealed that they now have a better understanding of how to adjudicate GBV cases within a human rights framework. The traditional courts and local courts also now appreciate better where their jurisdictions start and end, and this has lessened conflicts between the two courts which are primarily responsible for applying customary law cases. The discussions further established that there is a better understanding of provisions of the Anti-GBV Act and the realisation that the adjudications have to be in alignment with the gender equity and equality laws of the country. Some of the adjudicators, for example in the Southern Province, have been trained through a Training of Trainers (TOT) programme and they were expected to roll out the training to their subordinate colleagues. The roll out is still to take place because of limited resources.

Outcome 3 centered around increasing access of GBV survivors to protection and support services as well as economic empowerment activities through strengthened institutions such as the police, health centres, One Stop Centres, community networks, NGOs and other participating partners. By the time of the evaluation, 1,676 GBV survivors had been assisted with shelter, which is 168% target achievement. Despite achievement of target, there is still a challenge of limited space in these shelters and very few shelters can adequately cater for the needs of abused children (both boys and girls). The evaluation established that more GBV survivors were being linked up with service providers with support from the programme. Baseline data showed that only 11% of the survivors were linking up with established institutions and by end of 2016, this figure had risen to 30%. Support to GBV survivors was provided through the One Stop Centres (OSC) (both hospital based and village based) and community and men's networks.

Hospital based OSCs provided efficient and comprehensive health, paralegal and counselling services under one roof, which minimizes time and transport costs for survivors. The main challenge however with the hospital based OSCs pertains to poor prospects for sustainability after programme support has ended because the centres have largely been donor driven. Although the government has plans to incorporate the OSCs in mainstream care and support services, this is yet to be actualized. Neither the MoH nor the hospitals had provided financial allocations in their budgets and plans. Until this is done, it will be challenging for the centres to operate without donor funding as observed by hospital staff, police and paralegals currently involved with the facilities. Interlocutors cited examples of how some OSCs that were set up by CARE Zambia through USAID funding failed to thrive or collapsed once the project ended. Another reference point was the HIV/Aids Counselling and Support services provided by UNAIDS under the Zambia Care Prevention and Treatment (ZCPT) which could not be sustained after funding was phased out.

The village based OSCs provide an alternative cost-effective method of delivering GBV services as community based structures are used. The village based centres provide counselling, paralegal and referral services but they do not provide health services. The village based OSCs have been found to be effective in providing first line services to survivors that include awareness

creation, counselling, para-legal advice and referrals and the centres are easily accessible as they are located in the communities. They are also supported by chiefs, which gives them legitimacy and brightens prospects for sustainability. However some of the centres and their related men's and community networks are resource constrained and therefore provide limited services due to communication and transport challenges. At some police posts, for example Maheba Refugee Settlement, there is only one trained VSU officer who lacks the capacity to handle all GBV cases because she has other police duties assigned to her. Some villages have no police presence at all.

Out of a baseline of 350, a total of 5,725 GBV survivors (which represents 127% target achievement) received training in entrepreneurship skills to cushion themselves from economic hardships. The training was conducted using ILO modules such as GET Ahead. The evaluation established that after the training there was a noted increase in the number of survivors engaging in income generating activities. 60% of the trained survivors managed to pursue specific business opportunities and opened bank accounts, 2,446 are engaged in income generating activities (target achievement of 245%) compared to a baseline of only 150 and a total of 1,526 out of a programme target of 1,200 were referred to financial institutions for financial support through the programme. However, the majority failed to access loans due to stringent conditions applied by financial institutions for one to access loans.

Some of the trained GBV survivors have formed savings and lending groups and there is so much optimism amongst these groups as they are slowly realizing improved incomes from their business ventures. Group members interviewed are now able to contribute towards household income, and most reported positive attitude changes from their spouses and reduced tendencies towards GBV. For the groups to survive the difficult economic environment, they need further capacity support so that they can diversify and expand their businesses and be able to access cheap loans from financial institutions. Some of the OSawe groups formed have crumbled mainly because of lack of group cohesion and high mobility of some of the trained youth participants.

Outcome 4 relates to the strengthening of the Ministry of Gender to enable it to coordinate an effective, evidence based multi-sectoral response to GBV in Zambia. Coordination capacity of the Ministry has been strengthened through the appointment of a full programme coordinator, establishment of largely functional coordination structures at national, provincial and district levels.

Strengthened coordination structures through capacity building training have witnessed an increase in the number of GBV survivors that are handled or referred by both state and non-state actors as results show that 90% of these actors implementing the Anti-GBV Act are complying with GBV guidelines. The training of stakeholders on GBV Management guidelines has helped to ensure that the majority of both state and non-state actors are implementing components of the Anti-GBV Act in compliance with the guidelines. Interviews with health workers, police, counsellors and paralegals showed that they were adhering to the GBV management guidelines. The programme also supported the development of an Electronic Occurrence Book for use by the VSU, which will make recording, management of data and tracking of offenders much more efficient. UNCICEF and the Ministry of Gender led an Intimate Partner Violence (IPV) study which helped identify some of the different forms of GBV.

The sustainability of benefits accruing from the four outcomes of the programme is however threatened by limited financial contribution to the programme by the Ministry of Gender whose operations are hamstrung by a constrained fiscal space and budget.

Positive **unplanned outcomes** of the programme include: the multiple use of the Village Based OSCs which are becoming centres for non-GBV dispute resolution and social interaction and learning; strengthening of social safety nets of OSAWE group members and social capital formation as the groups have established a social fund to assist group members in times of critical need such as illness and funerals; and innovative incorporation of women in men's networks to specifically address the GBV needs of women and girls.

Programme Efficiency

Programme start-up was delayed which resulted in the need for a one year no-cost extension for the programme. The programme is however on course towards achieving most of its targets and objectives. Budget execution was low in the beginning as planned activities were taking off but subsequently picked up as programme implementation gathered momentum. At the time of the evaluation, the overall fund expenditure delivery rate was at 82 percent.

Disbursement of funds to UN agencies was timely, but a few agencies experienced delays in disbursing funds to implementing partner. This was attributed partly to implementing partners submitting incorrect or incomplete acquittal forms which would enable the next disbursement to be done and partly due to administrative bureaucracy within individual agencies. The late disbursements affected implementing schedules of implementing partners. Staff and personnel costs were reasonably pegged at 7.26% of the programme budget, while the other portion of the budget went to equipment, transfers and grants and suppliers which benefited the direct beneficiaries indirectly and directly.

The evaluation established that generally, programme partners consistently upheld the principles of economy and efficient use of programme finance by applying stringent procurement procedures based on competitive technical and financial bidding for all goods and services. Implementing partners could only receive the next disbursement after acquitting transparently use of the previous disbursement. The programme allowed budget flexibility in response to realities on the ground. For example after realizing that the hospital based OSC could not be rolled out to all the 72 districts because that was beyond the financial capacity of the programme, the stakeholder programme review recommended that the funds be diverted towards the more cost-effective village based OSCs. This ensured efficient use of resources.

Monitoring of programme activities was done periodically by programme stakeholders. Efficient M&E was however compromised by the lack of baseline for many of the indicators in the results framework and MTR, which were not conducted in line with the programme plan of implementation. Some of the indicators in the results framework had no baseline values and targets, which made it difficult to measure programme performance against these indicators. Challenges in data flow at district level were noted during the evaluation. In Petauke for

example, the District Anti-GBV Taskforce had challenges in getting statistics from the police VSU despite the fact that the police were part of the taskforce. Police cited security reasons for not divulging GBV statistics. Some implementing partners faced challenges in producing timely progress reports and the responsible UN agencies had to make continuous follow ups to get those reports. In some districts, for example Petauke, monitoring of community based activities by implementing partners was noted to be weak as some of the implementing partners did not return after training of community members to monitor progress. Monitoring was difficult for those partners without office presence in the programme implementation area, as the partners had to come all the way from Lusaka, which is not cost-effective.

Mainstreaming of cross-cutting issues

HIV and AIDS issues were well mainstreamed in the programme through the health pillar and HIV services were provided mainly at hospital based OSCs and through awareness creation activities. Youth and adolescents were also well mainstreamed as there were specific activities for this age group implemented through the safe-spaces programme. Absence of safe shelters for children was one of the gaps identified in the mainstreaming of adolescents and youth. Women economic empowerment was mainstreamed through the entrepreneurship training offered to GBV survivors and the subsequent formation of savings and lending groups, which generally have had a positive impact on livelihoods of survivors.

Human rights and refugee issues were also mainstreamed in the programme. The protection of the rights of refugees and immigrants was prioritized through empowerment activities targeted at the refugees.

Mainstreaming of women and children with disabilities was noted to be weak. Focus on PLWD was only in two urban centres of Kabwe and Lusaka and no interventions targeted the rural areas. Mainstreaming of PLWD needs to be strengthened within the programme.

Sustainability of the programme

Programme sustainability was assessed using a combination of the UNEG, OECD/DFAC and IFAD (2009) programme sustainability framework which categorises sustainability into political, social, ownership, institutional economic and financial, and technical sustainability. Sustainability of the programme was entrenched mainly through (1) broad based consultation in the design of the programme, (2) working with and through existing government and community structures, (3) and capacity strengthening of stakeholders. The evaluation concluded that the programme has potential for political sustainability because it has political support from the highest level in government, and the programme has received widespread support from stakeholders spanning from national level down to community level as there is general consensus that GBV is a scourge that needs to be urgently addressed.

Institutional sustainability is inextricably linked to financial sustainability. Although a lot of institutional capacity building activities have targeted institutions at different levels, institutions such as the One Stop Centres (both hospital and village based), the Fast Track Courts and Men's

Networks still need financial support until they reach levels where their sustainability potential is high. Financial sustainability is one of the key challenges that the programme will face in the post donor funding era in view of the funding challenges that government ministries are facing in general and in particular the Ministry of Gender. For institutional sustainability, there is need for a OSC policy framework that will integrate the hospital based OSCs within the Ministry of Health budgetary and planning framework and to link the community networks and village based OSCs to income generating activities. The institutional framework for the OSCs also has to be laid out to facilitate effective interventions and accountability. The FTCs also need to be integrated within the Ministry of Justice budget framework. Lobbying for increased budgetary allocation to the Ministry of Gender from treasury should leverage on pronouncements by the President of the Republic of Zambia supporting an increase in resource allocation to the ministry.

Key Lessons Learnt

- ✚ In designing a pilot multi-sectorial programme, there is need to concentrate on a few provinces, where the whole menu of programme activities are implemented, to assess the effectiveness of the interventions and the coordination mechanisms.
- ✚ In dealing with a multi-faceted phenomenon such as GBV, the multi-sectoral coordinated approach provides a holistic and effective platform where different key stakeholders with complementary skills, roles and responsibilities come together to respond to GBV in a coordinated manner.
- ✚ The delivering as one model provides an opportunity for UN agencies to efficiently utilize resources and leverage on each other's comparative advantages. UN agencies should however focus on programming areas falling under their mandate and where their comparative advantage is located to minimize conflicts between agencies caused by competition for relevance, space and resources.
- ✚ Working through existing government and community structures provides a firm ground for sustainability as no parallel structures are created.
- ✚ Working through traditional leader provides legitimacy to the programme and promotes buy in and support from the communities.
- ✚ Male involvement in a GBV programme is key in addressing patriarchal attitudes and practices that are key drivers of GBV

Recommendations

- ✚ **Future of the programme:** as a pilot the programme has scored significant successes at both output and outcome levels. Good practices such as the OSCs, Fast Track Courts, Men and Community Networks and the OSAWE groups have been found to be effective in delivering both preventive and responsive GBV services to survivors and should therefore be scaled up to more parts of the country in a possible Phase 2 of the programme.
 - *Hospital Based OSCs:* before scaling up, an assessment of the sustainability of the OSCs should be carried out across differently funded programmes that have pursued this model and generate lessons learnt. The assessment should also take into consideration the child friendliness of the OSC model considering that clients include both children and adolescents. For sustainability, the OSCs need to be

integrated within the Ministry of Health budgetary and planning frameworks, and personnel running them should be government employees. Multi-skilling of the OSC service providers is therefore essential so that each employee can offer a number of services e.g. a nurse or a police officer can also offer counselling and para-legal services. Already some of the nurses have been trained to offer counselling services in some of the hospital based OSCs. For better quality assurance and oversight/accountability it is suggested that the district hospital OSC are centers of excellence which provide oversight and support to the VBOSC as the Hospital based OSCs have been involved in outreach programmes where they have facilitated the establishment of men's networks and community networks.

- Village Based OSCs and Men and Community Networks: scale them up but ensure adequate resources for transport and communication in the initial stages and gradually link them to income generating activities before they are weaned off the programme for sustainability. Village based OCS also need to be part of the OSC policy framework to be developed by government with the aim of ensuring that district hospitals provide oversight and support to the village based OSCs.
- Fast Track Courts: should be scaled up but a sustainability plan needs to be developed and implemented particularly for the maintenance of the expensive court equipment.
- OSAWA Groups: the concept needs scale up with the programme facilitating linkages with financial institutions that can offer affordable loans for expansion and diversification of the women's businesses.

✚ **Programme Design:** Once funding for scaling up is secured, the scale-up should be well structured and concentrate only on a limited number of districts where resources permit the implementation of the whole menu of programme interventions rather than programme interventions being thinly spread across many districts and provinces. Scaling up should be phased in a manner commensurate with the resources available. Selection of programme areas should be based on assessed need rather than on pre-programme presence of UN agencies and implementing partners.

✚ **Programme Goal and Indicators:** The Goal of the programme needs to be revised to reflect both the preventive and responsive dimensions of the programme. Outcome and output indicators also need to be reviewed to ensure that they are realistic and measureable.

✚ **Operational Research:** To promote Evidence Based Programming, a number of researches are proposed to fill in knowledge gaps identified during the evaluation. These include:

- Evaluation on the sustainability of hospital based One Stop Centres as well as the Child friendliness aspects. Research is already planned by UNICEF on the child friendliness of the services offered in OSCs and case management processes

regarding children entering and leaving OSC. Research to understand better the causes and drivers of GBV in Zambia, particularly sexual violence against women and children. (This is in view of an increase in the number of “defilement” cases where fathers are abusing their own daughters, and grandfathers abusing their own grandchildren among other cases of sexual abuse).

- Research on the causes and impacts of GBV case withdrawal at both the courts and police on GBV survivors
- Research on the effectiveness and appropriateness of traditional court system in resolving GBV issues.

✚ **Other areas of intervention:** The programme needs to look at the possibility of increasing focus on GBV related to People Living With Disability. There is also need to focus on rehabilitation of GBV offenders as a prevention strategy as this aspect has not been given adequate consideration by the current programme. There is further need to also strengthen documentation and management. Linking the programme to Violence Against Children (VAC) initiatives and the international, regional and national frameworks on VAC will assist leveraging on the work being done on VAC as many of the services for GBV and VAC are the same, especially prevention work.

✚ **Coordination:** Needs to be improved particularly at lower levels between the various the stakeholders in the referral chain. Some taskforces at district level were failing to get GBV statistics from the local VSU which cited “security” reasons for not providing the statistics. There is need for the Ministry of Gender to effectively implement its research plan, which includes timely production of Gender Status Reports, Customary Practices Surveys and other related studies to address some of the noted data gaps. Some implementing partners were also not regularly in touch with District Taskforces, and in one case two implementing partners of the programme were implementing similar activities in one school (Nyampande School).

✚ **Sustainability:** For sustainability of programme activities and benefits, there is need for the Ministry of Gender to start contributing financially towards programme implementation. An exit strategy and sustainability plan for the programme needs to be developed and implemented before the programme comes to an end.

1.0 INTRODUCTION

This report presents findings of an independent evaluation of the Government of the Republic of Zambia/United Nations Joint Programme on Gender Based Violence. The evaluation was conducted by three independent consultants (one international and two local) in February and March 2017 over an eight-week period. The evaluation covered 6 provinces where the joint programme is being implemented by different stakeholders.

1.1 BACKGROUND, CONTEXT AND RATIONALE

1.1.1 GENDER BASED VIOLENCE IN ZAMBIA

Gender Based Violence (GBV) cases in Zambia are on the increase and widespread, occurring across all socio-economic, cultural backgrounds and regions of the country. The country has one of the highest rates of intimate partner violence in the world (CARE, 2013). Gender-based violence is defined as any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering among women, men, girls and boys, including threats of such acts and coercion or arbitrary deprivations of liberty, whether occurring in public or in private life (United Nations, 1993; United Nations, 1995). The common forms of GBV include spousal abuse/wife/husband battery; sexual violence against women, men and children; property grabbing; psychological abuse; family and child neglect; sexual cleansing, early marriage; and other harmful traditional practices (USAID/Zambia GBV Programming Evaluation 2010).

In a ministerial statement given to Parliament in 2015, the Minister of Gender stated that GBV in Zambia had become ‘brutal’, thereby necessitating the need for greater and concerted effort among relevant actors². Women and girls continue to be the most affected and the Zambia Demographic and Health Survey (2013-14) shows that 43% percent of women aged 15-49 have experienced physical violence at least once since age 15, and 37 % experienced physical violence within the 12 months prior to the survey.; 47 % of ever-married women age 15-49 reported having experienced physical, sexual, and/or emotional violence from their current or most recent husband or partner, and 31% reported having experienced such violence in the past 12 months. Among ever-married women who had experienced spousal physical violence in the 12 months before the survey, 43 % reported experiencing physical injuries. 10% of women reported experiencing violence during pregnancy. 9% of Zambian women who had experienced violence never sought help and never told anyone about the violence. Records at the Victim Support Unit (VSU) of the Zambia Police Service show the number of cases that were reported as follows: 6,716 in 2008: 8,382 in 2009: 8,464 in 2010: 11,914 in 2011: 12,924 in 2012: 10,217 in in 2013: and 12,998 in 2014. GBV cases jumped to 18,088 in 2015; and 18,540 in 2016.

² See Ministerial Statement to Parliament Delivered by The Minister of Gender and Child Development On the Acts of Gender Based Violence and Harassment Towards Women and Girls in Zambia, 25th March, 2015

The main drivers of GBV in Zambia include: poverty especially among women and young people to the extent that women's lack of economic empowerment is manifested in their lack of access to and control over resources such as land, personal property, wages, and credit (Milimo et. all, 2004); societal norms leading to unequal power relationships due to the patriarchal nature of the Zambian society; early or forced marriages; adultery and suspicion of adultery; excessive alcohol and substance abuse by perpetrators; denial of conjugal rights especially sex; traditional practices that reinforce a man's proprietary sense over wife such as payment of bride price; polygamous practices that lead to suspicion of unfaithfulness and beliefs that allow a husband to chastise his wife once in a while as a form of discipline³. Other forms of GBV include psychological, physical, sexual and emotional abuse by other people other than intimate partners.

This violence has led to loss of lives while those who survive suffer injuries, stigma and short term and lifelong mental disorders thereby necessitating protection and support services for survivors Evidence equally shows that GBV predisposes survivors to increased health risk of HIV and STI infection through early sexual debut, forced sex, transactional sex, and unprotected sex. (Population Council, 2008). ZDHS (2013-14) further notes that numerous population-based studies in the country have cited domestic violence as a cause for poor health, insecurity, and inadequate social mobilisation among women. GBV therefore has negative impacts for both the individual and society. The scourge of GBV goes against international and national frameworks which provide for the equal worth of men and women. These frameworks include the Sustainable Development Goals (SDGs), CEDAW, SADC Protocol on Gender Equality, and national constitution, policies and programmes.

1.1.2 NATIONAL RESPONSE TO GENDER BASED VIOLENCE

In response to the scourge of GBV, The Government of the Republic of Zambia (GRZ), has adopted several legal, policy and administrative initiatives that are discussed below.

a) Legal and Policy Frameworks

Zambia has ratified and domesticated a number of international and regional conventions such as CEDAW, International Convention on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of People With Disabilities and Convention on the Rights of the Child (CRC). It is a State party to the African Charter on Human and Peoples' Rights, African Charter on the Rights and Welfare of the Child and a signatory to the 1998 Addendum on the Prevention and Eradication of Violence against Women and Children which was incorporated in the Declaration on Gender and Development by the Southern African Development Community (SADC). The SADC Declaration mandates state parties to enact and enforce legislation for the prevention and punishment of violence against women and children; providing information, protective and health services to women and children affected by violence; gathering data, inclusive of statistics, on the incidence of violence against women and children; and introducing gender-sensitive training programmes for law enforcement officials and the judiciary⁴.

³ Ibid

⁴

Zambia is also a signatory to the Sustainable Development Goals (SDGs) which aim to: End all forms of discrimination against all women and girls everywhere; Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation; and Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

The national legal and policy framework includes the amended Republican Constitution, Act No. 2 of 2016, which provides for non-discrimination between men and women; The Gender equity and equality Act (2015), which among others provides for the taking of measures and strategic decisions in all spheres of life in order to ensure gender equity, equality and integration of both sexes in society, and prohibit harassment, victimization and harmful social, cultural and religious practices; The Anti-Gender-Based Violence Act of 2011 which provides for the protection of GBV victims, the establishment of the Anti-GBV Committee and Anti-GBV Fund. The Education Act of 2011 provides for GBV protection of employees, teachers and learners at educational institutions as well as the establishment of mechanisms for dealing with GBV cases. The Penal Code (Amendment) Act No. 15 of 2005 introduced the offence of sexual harassment and made indecent assault a felony. This Act also provides a custodial minimum sentence of 15 years for rape, statutory rape and incest. The Anti-Human Trafficking Act of 2008 proscribed trafficking of persons of either sex. It provides for medical care, psychological and legal assistance as well as family-tracing and skills-building and recreation for victims – as well as shelters, safety, security and legal status. The National Long-Term Vision 2030 recognises GBV as a critical area of concern in the provision of domestic security, particularly in cases related to violation of girls' rights and its contribution to the spread of HIV/AIDS. The National Gender Policy of 2014 provides policy direction and strategies for the development sectors to ensure gender-responsive programming. Both the National Action Plan on Gender-Based Violence 2010–2014 and the revised National Gender Policy and Action Plan have a goal to eliminate GBV in a holistic, systematic, complementary and comprehensive manner through a multi-sectoral and multi-dimensional approach, and to provide appropriate care and services to GBV victims.

Other initiatives include the Scorecard on Women, Girls, Gender Equality and HIV (the first ever in the region), which was developed in March 2011 to monitor the progress in reducing GBV and HIV infections resulting from sexual abuse of women/girls, and two communication strategies, one on GBV from 2009 and another on promotion of gender equality from 2010. Finally, Zambia has developed a National Gender Monitoring and Evaluation Plan (2011–2015), which aims at providing mechanisms through which the performance of the implementation of gender and development programmes will be measured.

b) Institutional and Administrative Measures

In addition to the legal and policy measures, Zambia has in place institutional and administrative measures. These include the Gender and Development Division (GCDD) which was previously under the Office of the Vice President, and is now a fully-fledged Ministry which is now headed by a Cabinet Minister. The Gender and Development Division is the National Machinery

responsible for coordination and monitoring the implementation of all national gender related legislation, policies and programmes.

The Judiciary of Zambia is an independent arm of Government which was established under article 91(2) of the constitution. It consists of the Supreme Court, high court, industrial relations court, subordinate court and local courts. Its core function is to administer justice through resolving disputes between individuals and between state and individuals; interpret the constitution and the laws of Zambia; promote the rule of law and contribute to the maintenance of order in society; safeguard the constitution and uphold democratic principles; and protect human rights of individuals and groups.

Under the Anti GBV Act no.1 of 2011, the Ministry of Community Development and Social Services is responsible for the establishment of shelters for survivors of GBV and to ensure that such shelters are spread throughout Zambia. Currently, there are inadequate shelters to provide temporal protective shelters for women and children fleeing from abusive environments. As a result, survivors are forced to remain in abusive environments and are in most cases forced to withdraw cases because of interference from the perpetrators. With the enactment of the Anti GBV Act, it is hoped that this will change as it provides for the suspected perpetrator to be moved out of the house through a court order if he is the Head or part of the family where the abused lives.

The Ministry of Health is responsible for ensuring that health care in Zambia is characterized by good clinical outcomes and professional standards, and that services delivered are appropriate to each patient's needs. In this regard, the health professional Act of 2009 makes provision for medical reports for GBV cases required for their prosecution.

Under the **Ministry of Home Affairs, Zambia Police**, two specialized institutions have been set up to address issues of gender based violence and these are:

Victim Support Unit (VSU) – This was established through the Zambia Police Amendment Act No. 14 of 1999 to ensure effective prevention, investigation and excellent service delivery when dealing with cases of gender-based violence and in particular with femicide, property grabbing, spouse battering and sexual abuse of girl children.

Child Protection Unit (CPU) - is a unit under the Zambia Police mandated to prosecute offenders of child abuse and works in Partnership with the Ministry of Community Development and Social Services. It also has the mandate to thoroughly investigate all crimes committed against Children through conducting objective forensic examinations and adopt methodologies for preparing Child witnesses before court proceedings.

Human Rights Commission – The Commission is an independent Constitutional body established under Article 125 of the Constitution of Zambia. Its broad mandate is to promote and protect human rights outlined in its constitutive Act. Its functions are basically protective, promotional, educative and advisory.

Zambia Law Development Commission – This was established through the Zambia Law Development Commission Act No. 11 of 1996 and its functions include conducting research on socio-political values and making recommendations that should be incorporated into legislation. Other functions of the ZLDC are to revise and reform the law in Zambia; translate any piece of legislation into local languages; encourage international co-operation in the performance of its functions.

c) Others stakeholders

Civil Society Organizations (CSOs) play a complementary role to government in improving the socio-economic status of women (and men) in Zambia. Some of the NGOs who are partners of the GBV programme include: the Non-Governmental Organization Coordinating Council (NGOCC) with nearly 75 NGOs and CBOs under it such as WILSA, CAMFED and FAWEZA. These organisations primarily work to improve the lives of women and girls in communities throughout Zambia.

d) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) & Concluding Remarks

Zambia ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1985 and since then both government and civil society have been reporting on strides made and challenges encountered in implementation of the convention. Zambia has also been actively participating and reporting on the Commission on the Status of Women (CSW) platform. So Far, Zambia has submitted four periodic reports, the last being in 1999. The July 2011 Concluding observations of the Committee on the Elimination of Discrimination against Women showed that Zambia had made strides in its crusade against GBV although challenges were observed. The Committee for instance noted that while the country had put in measures to address harmful traditional practices there was still persistence of adverse cultural norms, practices and traditions, as well as patriarchal attitudes and deep-rooted stereotypes regarding the roles, responsibilities and identities of women and men in all spheres of life. There was equally concern that such customs and practices perpetuate discrimination against women, and are reflected in women's disadvantageous and unequal status in many areas, including in public life and decision-making and in marriage and family relations. Concern was raised on the stereotypes as well as harmful practices such as sexual cleansing, polygamy, bride price (*lobola*), and property-grabbing which contributed to the persistence of violence against women and that the State party had not taken sustained and systematic action to eliminate stereotypes and harmful practices.

Zambia's Anti- GBV crusade was recognized, particularly with the enactment of the Anti-Gender-Based Violence Act (2011), amendments to the Penal Code that included stiffer penalties for certain sexual offences such as defilement, rape and incest, and the establishment of the Police Public Complaints Authority. Nonetheless, the Committee reiterated its concern at the high prevalence of violence against women and girls, including domestic violence, sexual violence in both the private and public spheres, as well as while in detention. The Committee was equally concerned that such violence appeared to be socially legitimized and accompanied by a culture of silence, impunity and unawareness, therefore contributing to high levels of underreporting. Concern was expressed at the low rate of convictions for reported incidents of rape and statutory

rape and the fact that marital rape was not explicitly recognized as a criminal offence in either the Penal Code or the Anti-Gender-Based Violence Act.

Against these observations, the government was urged to: (a) Put in place, a comprehensive strategy to eliminate violence against women and harmful practices as well as stereotypes that discriminated against women. These would include efforts, in collaboration with civil society, to educate and raise awareness on the subject, targeting women and men at all levels of society, including traditional leaders; (b) Criminalize sexual cleansing; (c) Use innovative measures to strengthen the understanding of the principle of equality between women and men, including through the full implementation of the National Gender Communication Strategy, whose main aim is to facilitate change in attitudes towards gender, and by working with the media, particularly in rural areas, to promote a positive and non-stereotypical portrayal of women throughout the country.

The government was further urged to a) prioritize and ensure adequate resources for the full implementation of the Anti-Gender-Based Violence Act and adopt comprehensive measures to address such violence, including domestic violence. (b) Expeditiously criminalize marital rape; (c) Strengthen training for the judiciary and law enforcement personnel and health-service providers in order to ensure that they are aware of the Anti-Gender-Based Violence Act, that they provide adequate gender-sensitive support to victims and that they strengthen efforts to prosecute and punish perpetrators of rape and defilement; (d) Provide in its follow-up report information on the implementation of the Anti-Gender-Based Violence Act as well as other measures taken to prevent such violence, to investigate and prosecute reported cases, to punish perpetrators and to provide protection, relief and remedies through civil procedure in the Courts of Law, including appropriate compensation to victims and their families.

The GRZ-UN Joint Programme on Gender-Based Violence (JP-GBV) therefore responds to these observations and recommendations.

e) Revised Sixth National Development Plan 2013-2016

The Revised Sixth National Development Plan 2013-2016 espouses government plans and commitments to various areas of development. The plan has gender sensitive specific strategies and programmes on Social Protection and Disability. In order to ensure the protection of human rights and provision of livelihood services to vulnerable groups the plan provides for: (ii) Establishment of one stop centres and places of safety in all provincial centres (ii) Providing empowerment for survivors of violence and human trafficking through the provision of livelihood services (ii) Promoting the participation of Civil Society Organisations in the provision of services to vulnerable groups (iv) Strengthen the capacity of law enforcement personnel in handling matters of human rights for vulnerable groups; (v) Conducting sensitization in communities on accessing legal rights for vulnerable groups; and (vi) Providing juvenile welfare services to probationers and licensees including empowerment through the provision of livelihood services.

The joint programme on GBV was thus designed to complement current efforts against GBV in Zambia.

1.2 PROGRAMME BACKGROUND AND THEORY OF CHANGE

1.2.1 BACKGROUND

The GRZ-UN Joint Programme on Gender-Based Violence (JP-GBV) is a four year programme (July 2012-December 2016) which was developed to support the Government of the Republic of Zambia (GRZ) to implement the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), with particular focus on the recommendations on violence against women that are contained in the July 2011 CEDAW concluding observations and the recommendations of the Special Rapporteur on Violence against women, its causes and consequences. The programme also aimed at supporting institutional transformation to facilitate the implementation of the Anti-Gender Based Violence Act and had a planned budget of USD \$ 15,570,000. The programme has been granted a one year no cost extension and will now end in December 2017.

1.2.2 PROGRAMME THEORY OF CHANGE

No explicit Theory of Change (ToC) was developed for the programme. However, the ToC was reconstructed from the logical framework of the programme. (Please see annex 7.5 for a diagrammatic representation of the ToC.)

As depicted by the Theory of Change diagram, the ultimate **goal** of the programme was *to contribute to the reduction of gender-based violence (GBV) in Zambia*. The overall objective of the programme was to establish an integrated and multi-sectoral mechanism for the implementation of the Anti-Gender Based Violence Act and that would be achieved through the following interrelated specific objectives:

- a) To increase the role of the health sector in addressing GBV in Zambia;
- b) To establish an appropriate justice and legal systems to effectively implement the provisions of the Anti-GBV Act;
- c) To scale up social protection systems for prevention and management of GBV, including integrated approaches to economic empowerment of GBV survivors/victims; and
- d) To establish an effective coordination mechanism for an integrated GBV response in Zambia.

The specific objectives also formed its pillars and structured the responses along the lines of priority sectors (health, legal, social and-economic as well as strengthening the Ministry of Gender (MoG). Similarly, the programme had four outcomes focused on strengthening the capacity of the government and stakeholders to establish an integrated and multi-sectoral mechanism for the implementation of the Anti-Gender Based Violence Act.

To achieve the objectives, specific activities were to be implemented under each pillar and these included the following:

- **Health Pillar:** Training of health workers; strengthening of health centre systems and establishing specialised units
- **Justice Pillar:** training of prosecutors and police in investigative and prosecutorial skills; training of statutory and customary adjudicators on GBV; fast track courts established & provision of specialized equipment
- **Social Protection and Support Pillar:** -offering shelter and facilitating issuance of protection orders to survivors; training of Ministry of Gender and partners on GBV awareness training and creation of coalitions for GBV cases
- **Coordination Pillar:** Assessments and operational research; establishment of national and district Anti-GBV level taskforces; -establishment of GBV service provision referral systems

The implementation of the above activities was expected to result in specific outputs for each pillar, and the following outcomes:

Outcome 1: GBV survivors have increased access to timely and appropriate health services

Outcome 2: GBV survivors have increased access to an efficient justice delivery system.

Outcome 3: Survivors of GBV have increased access to protection and support services

Outcome 4: GCDD has coordinated an affective, evidence based and multi-sectoral response to GBV in Zambia.

The achievement of the outcomes would then ultimately lead to the attainment of the programme goal. The achievement of the programme goal hinged on a number of **assumptions** which included the following:

Health Pillar: Adequacy of health staff in health centres; accountability systems are revised to include provisions of GBV guidelines; PEP Centres are within accessible distance for all eligible survivors and there are no stock outs.

Legal and Justice Pillar: Adequacy of staff in statutory and customary courts; Availability of tools/equipment for investigating GBV cases; Government is willing and has resources for establishment of fast track courts.

Social Protection and Support Services: relevant government institutions and other supporting organisations are adequately funded to support GBV survivors; the National Gender Communication Strategy is adequately funded and implemented; Zambia Policies has adequate staff and resources to respond to cases reported by the community; State and Non-State partner

organisations implementing the Anti-GBV Act have been adequately funded to address GBV issues.

Coordination: Ministry of Gender and State and Non-State Actors participating in the implementation of the Anti-GBV Act have developed and implemented accountability frameworks; Ministry of Gender has developed and implemented an operational plan for educating people and institutions on the Anti-GBV Act; willingness in established M&E and reporting systems for State and Non-State Actors supporting current Anti-GBV initiatives to accommodate this programme's indicators and other information needs.

1.2.3 PROGRAMME DESIGN AND IMPLEMENTATION STRATEGY

The programme's strategic approach was aimed at addressing legal and policy frameworks, working through national systems to build institutional capacities to scale up best practices and improving old systems or developing new ones whenever necessary. It sought to ensure an effective coordination mechanism and engaging communities and stakeholders to provide the necessary conditions for the sustainability of the programme. To achieve a holistic, systematic and multi-sectoral approach to curb factors that drive GBV, the joint programme worked to promote strong partnerships between Government, national partners and the UN.

Joint Programming

The UN is seeking to increase joint programming and pooling of resources to enhance the effectiveness of its interventions. The UN system has seen a number of reforms introduced to improve UN coordination, effectiveness and efficiency in supporting national goals and reducing costs for governments. Zambia is part of the UN Country Teams Delivering as One. The underlying principle is to improve programme delivery and results through a more coherent, better coordinated, funded and managed UN. This principle is central to the implementation of the Paris Declaration Principles on Aid Effectiveness and will guide the decisions taken by the UN Country Offices. The Delivering as One principle places strong emphasis on improving the synergy between and across programmes and agencies at all levels. Both thematic and geographic activities across agencies will be planned and implemented in a coordinative manner. This will ensure more effective contribution to and impact by UN programmes and interventions to the national development agenda. On a programme level this means increased joint programming and pooling of resources to enhance the effectiveness of the interventions. This is done through harmonisation of programme cycles, common country assessments and the United Development Assistance Framework (UNDAF), followed by the Partnership Framework (2016-2020). The GRZ/UN Joint programme on GBV is one of several joint programmes under the Delivering as One concept for the Zambian Country Office. The programme brings together seven UN agencies; ILO, IOM, UNDP, UNFPA, UNICEF, UNHCR and WHO working closely with the GRZ. The programme will bring leverage on competencies, comparative advantages and resources of the different UN agencies.

The coordinating agency is the Ministry of Gender. Other national partners comprised: MoJ, MoESVTEC, MoH, MoCTI, MoHA, MoIBL, MoCDSS, MoAL, MoCTA, Judiciary, HRC, DEC, ZLDC, CEEC,

ZDA, NGOCC, Women for Change, YWCA, NLACW, AYE, FAWEZA, ZWAFIB, Camfed, Africa Directions, House of Chiefs, NAZ.

The two donors of the programme, Sweden and Ireland, are both signatories to the Paris Declaration on Aid Effectiveness (2005). It is a practical, action-oriented roadmap to improve the quality of aid and its impact on development. The donors align, coordinate and simplify procedures and share information to avoid duplications in programming. In regard to the joint GBV programme, the donors pool their funds through the Multi Donor Trust Fund in New York. They receive the same reporting format from UNDP on the narrative and financial progress of the programme.

A responsive and preventive approach

The programme takes on a both preventive and responsive approach to GBV. The programme is facilitating legal and policy review to ensure the reforming, strengthening and implementation of relevant laws like the Criminal Procedure Code (CPC) Penal Code and the Anti-GBV Act. This will lead to improved court proceedings for GBV survivors. Through skills building, learning and training of professionals that provide services to GBV survivors the programme sought to improve linkages between sectors in order to provide a comprehensive and effective response to GBV. It will provide survivors with immediate post GBV care, protections, relief and rehabilitation through a comprehensive package including the expansion, renovation and improvement of the existing shelter systems. Additionally, the programme also focuses on research and data generation which will streamline data and data collection to be focused on 10 or less GBV categories. This will ensure that incidence data is recorded in a comprehensive and consistent manner which in turn will also strengthen and support existing mechanisms for gathering, processing and sharing data on GBV statistics.

The programme addresses advocacy and communication and a cross section of stakeholders to become aware of their legal and human rights and the impact of GBV. It includes community mobilisation programmes that are expected to help change violence-related attitudes and behaviors and promote more equitable relationships between men and women. This strategy will also engage young men through men's networks and other fora as potential change agents to undertake activities that help to shift unhealthy cultural attitudes.

Cross-cutting issues

Four main cross-cutting issues have been central in the design of this programme:

HIV – GBV and HIV are inextricably intertwined and can be mutually reinforcing. In addressing GBV, the issue of HIV and AIDS needs therefore to be mainstreamed. The programme has mainstreamed HIV services in GBV responses including Voluntary Counselling and Testing (VCT) and provision of PEP mainly through the One Stop Centres.

Youth – This group represents an ideal opportunity for GBV prevention, when attitudes and beliefs are being formed. It's easier to change norms for gender equality and GBV by targeting young rather than old men. Adolescents have been targeted through the safe spaces programme in

schools. There is also an urgent need to improve the institutional response to girls and young women who experience, in particular, sexual violence.

Women's Empowerment – Norms about gender and the acceptability of violence greatly influence prevalence of GBV. There are studies showing that men and women believe that husbands are justified in beating their wives if they disobey them or refuse sex. Society often blames and stigmatizes the female victims rather than male perpetrators. This can prevent service providers from offering appropriate assistance to survivors and it can also prevent women from seeking help from family, friends and other community members. The programme sought to promote a mindsets change amongst women and girls to make them realise that empowerment comes from within themselves, supported by capacity-building programmes for educational and economic empowerment.

Women and Children with Disabilities – These groups are more vulnerable to GBV and experience very particular forms of violence and abuse. Because of stigmatization of disability and the resultant social isolation, women and children with disabilities may endure GBV for longer periods of time and have difficulties in accessing GBV information and services. In the programme's interventions, increasing their access to information and GBV-related services is a key priority.

1.2.3 PROGRAMME MANAGEMENT AND COORDINATION

The Ministry of Gender had the overall responsibility for coordination of the implementation of the programme. This role is supported by the UNDP as the lead UN agency for the programme. Identified line ministries lead the implementation of programme activities under each relevant outcome and can delegate the responsibility of implementing some of the activities to other line ministries or civil society organizations. The different UN Agencies support the MoG in the implementation corresponding to each outcome. A number of civil society organizations are engaged in programme implementation. The cooperation and networking with women CSO's and CBO's is important as women and girls form the largest number of victims of GBV.

A programme Management Steering Committee was established with representation of Permanent Secretaries from all implementing line ministries, the UN Resident Coordinator and a representative from the NGOs. The Committee provided supervisory and technical guidance for effective implementation of the programme. A Programme Implementation Committee was also established with representation from all implementing agencies and partners. The coordinative approach strengthens and harmonises relations and information-sharing among the main programme implementing agencies and stakeholders.

1.2.4 REPORTING AND MONITORING

The Results Framework developed for the programme identifies the lead UN agency and responsible Ministry and the implementing partners for each outcome area. The framework also presents activities linked to the outputs indicating the cost per year for each activity. In addition to the Results Framework, there is a Joint Programme Monitoring Framework with indicators for

each outcome area, corresponding to the outputs. There is in total six outcomes presented in the Joint Programme Monitoring Framework, followed by 17 outputs with 59 corresponding indicators. The UN agencies report their results annually in the Joint Programme Monitoring Framework, using the identified indicators. The UNDP consolidates and coordinates the annual reporting to the UNDP Head Quarter and to the Donors.

The MoG in collaboration with the Gender Sector Advisory Group, Gender/GBV Focal Points, the Anti-GBV coordination units at district and community level, and the Programme Steering Committee is responsible for regular monitoring and evaluation of the joint programme. Monitoring is based on planned activities and resources allocated in annual work plans, as well as on the results and their corresponding indicators as outlined in the Joint Programme Monitoring Framework. The Steering Committee also monitors risks and assumptions to ensure the attainment of planned results.

1.2.5 PROGRAMME BUDGET AND FUND MANAGEMENT

The total budget of the programme is USD 15,570,000 and is divided between the four outcomes: Health USD 2 295 000; Legal USD 4 905 000; Socio-economic USD 5 848 000 and Coordination USD 2 355 000.

The total donor contributions to the programme amounts to USD 10,290,879, (Sweden USD 8,631,279 and Ireland USD 1,659,600, and the UN USD 2, 593, 000), the total amount of funds available to the programme being USD 14 542 879. Both donors do their contracts with the UNDP in national currencies (SEK and EURO) leading to some discrepancies in funds available at the time for the actual transactions. UN-agencies have different procedures in receiving the funds from their headquarters.

1.2.6 PROGRAMME TIMELINE

The planned lifespan of the Joint GBV programme was July 2012 to December 2016. Due to initial delays in implementation of programme activities, the programme was granted a one year no-cost extension running to December 2017 to ensure successful completion of planned activities.

2. EVALUATION OF THE PROGRAMME

2.1 PURPOSE OF THE EVALUATION

The **purpose** of the evaluation, as articulated in the terms of reference, was to assess how the GRZ/UN Joint Programme on Gender Based Violence has attained stated results, identify success factors and challenges encountered and document lessons learnt to inform future programme design and implementation. The evaluation also aimed at highlighting constraints and challenges affecting the implementation of planned activities and to document lessons learnt and best practices. The evaluation results provided a basis for informed and improved project delivery for future programming.

2.2 OBJECTIVES OF THE EVALUATION

The following were the specific **objectives** of the evaluation:

- a) To provide an in-depth and independent assessment of progress made so far towards achievement of the programme outcomes and outputs - looking at targets, and using indicators when possible
- b) To evaluate the programme strategic contribution and relevance to the 2011-2015 UNDAF and national priorities, and identify possible adjustments to the programme implementation and sustainability strategy.
- c) To evaluate and assess the Programme's partnership with the government, civil society and private sector, Cooperating Partners in Programme implementation and highlight what has worked and what has not;
- d) To identify lessons learned, best practices, constraints, challenges and opportunities and determine what adjustments are required in programme focus, results framework, implementation and funding strategy, management arrangements, and in monitoring and evaluation to achieve the stated/revised programme results;
- e) To identify weaknesses and strengths of the project design and to develop recommendations for any necessary changes in the overall design and orientation of the project.
- f) To address underlying causes of any targets that were adequately achieved and assess the achievement of indicators, evaluation progress against work-plans and budget.

These objectives were interpreted and operationalised for the study within the evaluation criteria and key questions.

2.3 EVALUATION SCOPE

The evaluation covered the programme's four outcome areas, which are (a) health, (b) legal and justice, c) social protection and economic empowerment and (d) coordination and all the activities linked to each area from the beginning of the programme in July 2012 until its planned

end in December 2016⁵. The evaluation applied a combination of the United Nations Evaluation Group (UNEG) evaluation norms and standards, the OECD evaluation criteria and the IFAD 2009 Guidelines on sustainability. The evaluation sought to answer key questions on Relevance, Efficiency, Effectiveness, Impact, Sustainability and Inclusiveness.

In addition to assessing the outcome areas and related components, the evaluation also covered the aspect of collaboration and coordination, given the range and number of partnerships included in the design of the programme. An assessment on the extent to which this approach was effective was undertaken. The four cross-cutting issues (HIV, Youth, Women's Empowerment, Women and Children with Disabilities) and their level of integration in the programme was also carried out. Capacity assessment of supported institutions was integrated in the design of the evaluation.

2.4 EVALUATION STAKEHOLDERS

The evaluation employed a participatory approach which involved stakeholders at all levels of the programme. Different stakeholders were engaged at national, provincial, district and community levels to provide input into the evaluation process.

The following were key stakeholders of the programme engaged or consulted during evaluation:

- *Cooperating partners/donors:* The Republic of Ireland, Swedish Embassy of Lusaka, UNDP, UNFPA, UNHCR, UNICEF, WHO, ILO, IOM
- *Implementing agency:* Ministry of Gender
- *Other national partners:* MoJ, MoESVTEC, MoH, MoCTI, MoHA, MoIBL, MoIBL, MoCDSS, MoCTA, judiciary, HRC, ZLDC, CEEC, ZDA
- *Civil society organizations:* NGOCC, Women for Change, YWCA, Africa Action Help Zambia, CHAMP, Mulangile Women's Organisation, Zambia Disability HIV/AIDS Human Rights Programme (ZAMDHARS), PPAZ, Community for Human Development (CHD), AYE and ZAFAWIB
- *Private sector:* financial institutions and mining company
- Target groups, beneficiaries, and others affected by the programme

2.5 EVALUABILITY ASSESSMENT

An evaluability assessment of the programme noted some gaps related to lack of a programme baseline and Mid-Term Review. Consequently, some indicators lacked baseline values against which programme performance could be assessed and some of the indicators in the results framework were not reported on by partners. However, other programme documents were

⁵ The programme was planned to end in December 2016, but has been extended for one year on a no-cost extension basis.

easily accessible and programme stakeholders were willing to share their views on the programme with the evaluators.

In the logical framework, some of the programme indicators were pitched at national level and yet some of the programme components had no national coverage. This made it challenging to assess the performance of the programme using these national level indicators.

2.6 EVALUATION PROCESS, APPROACH AND METHODOLOGY

The evaluation employed an exploratory and multipronged approach. In line with the UNEG Handbook for Integrating Human Rights and Gender Equality Perspectives in Evaluations in the UN System, a gender-responsive and human rights based approach was applied throughout the evaluation process. The evaluation was also utilization focused and was conducted in a transparent, inclusive and participatory manner. Key stakeholders of the programme (including direct beneficiaries) participated at the different stages of the evaluation process and were provided with an opportunity to express their perspectives about the programme.

2.6.1 SOURCES OF DATA AND COLLECTION METHODS

The evaluation utilized a mixed-method or a pluralist approach to integrate data from different data gathering methods. The team utilized standard qualitative and quantitative evaluation methodologies where qualitative data was basically derived from key informant interviews, FGDs and case studies. The quantitative data emerged from programme documents and progress reports summarizing expenditure, programme activities and programme quantitative results. Use of mixed methods not only offered diverse perspectives to the evaluation but also promoted participation of different groups of stakeholders, allowed multiple voices to be heard, provided a more holistic picture of the programme and allowed for triangulation of data for reliability and validity as data from different sources could be compared and any inconsistencies followed up on. Data from multiple sources provided means to develop defensible conclusions about the evaluation.

The following methods were used to collect information and data for the evaluation:

a) Desk/Literature Review

A repository of programme documents was developed. The evaluation team reviewed all programme documents to have an in-depth understanding of programme background and context, goal and objectives, implementation framework and approach, expected outcomes and milestones that the programme has achieved vis-à-vis what was planned, as well as challenges encountered. Programme documents reviewed included the following:

- SNDP, UNDAF 2011-2015, UNDP Country Programme Document (CPD) 2011-2015 and Country Programme Action Plan (CPAP) 2011-2015

- National Gender Policy, Anti-GBV Bill and other MGCD Reports and Publications
- CEDAW Concluding Remarks reports / CSW Recommendation Implementation Status
- Donor Reports
- Programme Annual Progress Reports 2012-2015
- Quarterly Project Reports
- UNDAF Annual Reports
- UNDP Annual Progress Reports
- Minutes of the Programme Implementation Technical Committee Meetings
- Technical Reports
- Minutes of Programme Review Meetings
- Work plans 2012/2013/2014/2015
- Publications from Ministry of Gender and other line ministries and CSOs

b) In-Depth Key Informant/Stakeholder Interviews

In-depth interviews with key stakeholders and key informants were conducted to solicit their views on key focus areas of the evaluation relating to relevance, efficiency, effectiveness, impacts, inclusiveness and sustainability of the programme as well as the extent to which the programme has contributed to UNDAF outcomes. Interviews with key informants from key institutions also assisted in institutional assessments to determine the extent to which the capacity of the relevant institutions to implement GBV interventions has been enhanced by the programme. In-depth interviews further provided an opportunity for the stakeholders to propose recommendations for future interventions aimed at tackling the menace of GBV.

The purpose of engaging key stakeholders during the evaluation was to enable stakeholders to be part of the evaluation process as participants for ownership of results, validation and accountability. Key informants were selected on the basis of their strategic positions, participation and knowledge of the programme and were interviewed using a semi-structured question guide. A total of **53** Key Informants were interviewed during the evaluation at national, provincial and district levels. (Please see Annex 2 for a list of key informants interviewed).

c) Focus Group Discussions (FGDs)

FGDs were conducted with the direct beneficiaries of the programme at community level and with service providers at the One Stop Centres. These included survivors and perpetrators of GBV; community leaders; and community members and boys and girls involved in anti-GBV initiatives. The purpose of the FGDs was to listen to and capture the voices and perspectives of the beneficiaries of the programme in terms of implementation processes, main achievements, weaknesses, challenges and the impacts it has had on the communities in general and the GBV landscape in particular. Participants were asked to reflect on the questions asked by the interviewers, provide their own comments, listen to what the rest of the group had to say and engage in a conversation. The strategy was to elicit ideas, insights and experiences in a social context where people stimulate each other and consider their own views along with the views of others.

FGDs were held ideally with small groups of between 8-10 programme participants from different gender groups. In some cases however, larger groups of up to 15 people participated in the FGDs in situations where there was a higher turnout than anticipated. Because of the sensitivity surrounding GBV issues, in some cases women only FGDs were conducted. A total of 17 FGDs were conducted during the evaluation.

d) Case Studies and Most Significant Change Stories

In-depth discussions with individual programme participants were conducted to provide specific case studies that capture the micro-impacts of the programme at institutional, individual or household levels. The case studies captured the before and after scenario and identified the most significant changes that have occurred to these institutions, individuals or households resulting from their participation in the programme. The case studies were used to support some of the generalised findings of the evaluation. The participants for case studies were identified with the assistance of local key stakeholders and community members participating in the FGDs.

The team conducted site visits to two village led One Stop Centers (Misolo and Kalindawalo), three One Stop Centers at hospital level (Kasama, Mporokoso, Solwezi), the YWCA Women's shelter (Chipata and Solwezi), the two Fast Track Courts (Lusaka, Kabwe), three Police Stations and their VSUs, (Petuake, Chipata, Livingstone), schools (Petuake and Meheba) and the refugee camp in Merheba amongst other sites.

2.6.2 SAMPLING

The study population consisted of key stakeholders of the programme as well as direct and indirect beneficiaries. Sampling for the evaluation was conducted in consultation with programme partners and other UN agencies participating in the programme.

Selection of Key Informants: the evaluation targeted key stakeholders of the programme based on key roles played in the design and implementation of the programme. The key informants were represented at all levels: national, provincial, district and local. The informants were identified in consultation with UNDP and other UN agencies.

Selection of Study Sites for Field Work: The selection of study sites was done in collaboration with UN agencies. The team followed a four-week long field visit schedule which covered six provinces in Zambia namely Eastern, Southern, Central, Lusaka, Northern and North Western. The study sites were selected based on their exposure to programme interventions and the need to capture the whole range of programme interventions. Sites were selected to also illustrate where the programme has performed well and areas where the programme has not performed according to expectations. The selected sites illustrated the geographical spread of the programme, cultural diversity as well as coverage of both urban and rural settings.

Selection of Beneficiaries: Beneficiaries were selected on the basis of their participation and exposure to the intervention and ability to provide the requisite information. Beneficiaries were clustered according to the outcome area that they participated in. Given the sensitivity of the

GBV subject matter, separate FGDs were held for men and women but in some situations both men and women were included in the same group.

2.7 DATA ANALYSIS

The evaluation gathered mostly qualitative data from desk review, key informant interviews, FGDs and MSC stories. Quantitative data mainly emerged from programme reports summarizing expenditure, geographical distribution of programme activities and programme quantitative results. Data analysis was continuously done throughout the data collection process, taking a sequential data analysis approach, as the consultants familiarised themselves with emerging research themes. A thematic framework was developed to identify key issues, concepts and emerging themes from the data. Data was then categorized according to the emerging thematic areas and analyzed through content analysis. An assessment of the various aspects of the evaluation was based on a triangulation of the primary data (including cases on best and worst performers at the level of activities and outcomes), document and literature review as well as expert judgment.

2.8 VALIDATION, PRESENTATION AND DISSEMINATION OF FINDINGS

The findings of the evaluation were validated with different stakeholders through de-briefs. The draft report is being presented to stakeholders for their comments and input before the finalization of the evaluation report.

2.9 LIMITATIONS OF THE EVALUATION

The following were limitations of the evaluation:

a) Limited M&E Documentation

While the M&E reporting data received from the UN agencies was useful, it was insufficient for the team to fully quantify progress for all activities toward meeting goal and objectives for all the activities undertaken in the programme. This was mainly due to the lack of a programme baseline study and national studies which could have provided national level baseline indicators. The team tried to compensate this through the interviews with key informants. Additionally, the fact that a mid-term evaluation was not conducted deprived this evaluation of critical independent benchmarks for the evaluation and limits this evaluation's capacity to assess the responsiveness of the programme to lessons learnt in the first half of programme implementation. An additional challenge was that some of the programme indicators were pitched at national level instead of programme level, thereby making performance assessment difficult.

b) Institutional Memory Loss

Staff turnover in some partner institutions resulted in some institutional memory loss about the programme. To manage this limitation, the evaluation team tried to collect information from as many sources as possible and to triangulate it through the use of several data collection methods.

2.10 EVALUATION ETHICS

The evaluation was guided at all times by the UNEG Ethical Guidelines and the UNEG Code of Conduct for Evaluation in the UN System. During the evaluation, the evaluation team observed the following ethical guidelines:

- a) Independence and Impartiality.
- b) Credibility
- c) Honesty and Integrity
- d) Accountability
- e) Confidentiality
- f) Respect for Dignity and Diversity
- g) Informed Consent and Assent
- h) Avoidance of Harm.
- i) Accuracy, Completeness and Reliability
- j) Transparency

2.11 ORGANISATION AND MANAGEMENT OF THE EVALUATION

The evaluation team comprised three independent individual consultants: an International Consultant (Team Leader) and two national consultants. The Team Leader was responsible for assessing coordination and the legal/justice related interventions of the joint programme, as well as consolidation of data, overall quality of the report and management of the national consultants. The national consultants were responsible for the technical assessments on GBV health related activities and Social Protection/Economic Empowerment and other responsibilities assigned by the team leader based on the agreed evaluation plan with the quality assurance team. Both the team leader and national consultants were involved throughout the entire duration of the evaluation.

The Gender Analyst at UNDP, With the guidance and quality assurance by the M&E analyst, was responsible for the day to day management of the evaluation in collaboration with the Programme Coordinator. Overall, the evaluation was under the supervision of Ministry of Gender. The above joint team was responsible for putting in place all the logistics for the evaluation. These included setting up meetings and interviews with stakeholders, and putting in place travel logistics.

3.0 EVALUATION FINDINGS

This section presents the main findings of the evaluation mission in terms of key thematic areas of the evaluation as outlined in the Terms of Reference. The evaluation assessed the Joint GBV programme in terms of Relevance, Performance, Effectiveness, Efficiency, Impact and Sustainability.

3.1 RELEVANCE AND STRATEGIC FIT

Programme relevance and strategic fit with the development aspirations and needs of national governments, development partners, civic society and targeted beneficiaries is essential for programme sustainability, ownership and support for development initiatives. The Goal of the Joint GBV programme was to *Reduce Gender Based Violence (GBV) cases in Zambia* while the objective was to *establish an integrated and multi-sectoral mechanism for the implementation of the Anti-Gender Based Violence Act*. In this evaluation relevance was assessed in terms of (1) stakeholder consensus around the problem, (2) the extent to which programme goal and objectives are consistent with the needs and priorities of the targeted groups, (3) alignment of programme objectives with national, regional and international priorities, policies and frameworks on GBV, (4) Alignment to mandates of Implementing institutions and structures. The relevance of the four pillars, namely health, Social protection, justice and coordination was also assessed.

3.1.1 GENDER BASED VIOLENCE AS A PROBLEM

Review of literature on GBV and programme documents as well as interviews with stakeholders at different levels, including the ultimate targeted beneficiaries, revealed that there is unanimous agreement that GBV is a socio-economic, health and human rights problem in Zambia. Researches and reports such as the Zambia Demographic Health Survey (2013-14), the ICGLR Zambia's Country report on Sexual and Gender Based Violence (SGBV) (October 2011), and statistics from the Victim Support Unit of Zambia Police provided evidence of the ubiquitous nature of GBV within the Zambian society. The Anti-GBV Act No. 1 of 2011 and the July 2011 CEDAW concluding observations and the recommendations of the Special Rapporteur on Violence against women, its causes and consequences specifically highlight GBV as a social problem that needs urgent and coordinated attention.

Virtually all the stakeholders interviewed concurred that GBV is a problem that needs to be addressed through a holistic and multi-sectoral approach. While the programme was mainly responding to the obligation of government as state party to the UN, this assessment observed that the programme was equally a targeted response to the challenges that had been observed by various stakeholders such including the Government of Zambia, Civil Society Organisations, Traditional Leaders and the citizenry at large. Victim Support Unit statistics showed that incidences of GBV were rising and the media had covered some of them extensively. Civil Society Organisations working on human rights and gender programmes such as NGOCC, YWCA and National Legal Clinic for Women were overwhelmed with the number of cases yet had no adequate tools nor resources to address the problem.

Concerns of these stakeholders were shared through consultative meetings convened by the Ministry of Gender prior to the development of the programme document. These consultative meetings facilitated the benchmarking of stakeholder's views against the CEDAW recommendations and GBV Act. This level of engagement facilitated the identification of relevant partners and key priority areas or pillars that the programme would implement. It further created an environment for ownership of the programme, which resonated throughout the study sites. This assessment revealed that there was general enthusiasm about the programme among key stakeholders such as the Judiciary, the police, traditional leaders, NGOs including the structures and networks that were formed or revived after the commencement of the programme. A member of a Men's Network in Petauke, Eastern Province, stated that their group had received minimal support from the "sponsors" yet, this did not stop the group from carrying out awareness programmes, contributing their own resources to transport GBV victims to the nearest health facilities and using their personal phones to alert the police about a perpetrator in their community.

The unanimous problematisation of GBV in Zambia by all stakeholders, provides a basis for support and cooperation in fighting GBV as there is a common understanding and appreciation of the negative impacts of this phenomenon.

3.1.2 RELEVANCE TO NEEDS OF TARGETED BENEFICIARIES

The evaluation assessed the goal, objectives and anticipated outcomes of the programme in relation to the needs of the direct and ultimate beneficiaries of the programme and concluded that the programme is fundamentally relevant to their GBV service delivery needs. Through review of literature and programme documents, the evaluation established that the programme sought to address identified health; legal and statutory; social protection and economic empowerment; and coordination gaps in responding to the problem of GBV in Zambia⁶. Because of its relevance in addressing the needs of GBV survivors, the programme has earned political will and commitment from the highest office in government as evidenced by the official opening of the Village Based One Stop Centre in Misolo Village by the President of the Republic of Zambia.

The sample quotes below provide generic views on programme relevance by different programme participants.

⁶ For example, the July 2011 Concluding observations of the Committee on the Elimination of Discrimination against Women noted key GBV gaps that stakeholders needed to address as a matter of urgency.

“GBV has not been a priority for WHO(in Zambia), but it has now become because of the programme. We haven’t had someone focusing on GBV and GBV has not been part of medical or nursing training. We had no systematic way of approaching survivors, we mainly focused on injuries only. Buy now the focus has changed because of the programme”

WHO

The project has been very helpful to the police in terms of training and the equipment that the programme has supported us with. It has made police work in fighting GBV easier. GBV cannot be successfully handled by the police alone, we need the support of other stakeholders. When police officers are not equipped with the necessary techniques, fighting GBV cases in court can be very difficult. Handling GBV cases requires high level of preparedness. We generate statistics on GBV that are used by stakeholders but we cannot do that without equipment such as computers. The programme supported us with computers you see and 7 vehicles that were distributed in areas with high GBV prevalence which has enabled us to reach areas in remote places. Our curriculum for police training was also devoid of GBV issues and we have developed curriculum with GBV focus that should be taught to all recruits right from inception, and this is more sustainable and saves resources for the police. The training we received from the programme has changed the attitudes of police officers who used to think that defilement is a lesser crime than other crimes”

Police VSU Head Quarters

“My husband used to beat me and ridicule me, especially towards harvesting so that he could sell our farm produce alone and not give me anything from the sale of the produce. I could not just move out of the marriage because I have a marriage certificate and had small children that I was concerned about. Because of the challenges I was facing, I was one of the women trained in business management. We were trained on Gender and Entrepreneurship together, Creating a business idea and how to create savings and lending clubs. The training really helped me because I now know about GBV and know where to go to seek help. We now see GBV as not normal. After training I bought village chickens and later sold them and brought 3 goats. I used to go through mental torture but now my husband respects me and he even borrows my training material for him to read”

GBV Survivor, Chongwe

“GBV is prevalent in this refugee camp, and in fact is highest in the camp compared to the rest of Zambia. We have people from different cultures such as the Angolans and Congolese who openly state that it is right to beat your wife if she disobeys you and some of them consider child marriages to be normal. This programme was very relevant because it targeted people who are normally socially excluded from mainstream society and yet a lot happens here in terms of GBV”

FGD with Meheba Multi-Functional GBV Team

“The programme by FAWEZA on safe spaces for children was introduced at this school when we having lots of challenges with schools girls that were falling pregnant. Before the programme, in

one year we had 24 school girls falling pregnant but this has reduced drastically as at most now we have only 2 or 3 girls falling pregnant. In 2016, we only had one pregnancy and we attribute this positive trend mainly to the awareness programmes created in the school through these GBV awareness clubs that the pupils are participating in”

(Headmaster of one of the schools visited by the evaluation team)

3.1.3 ALIGNMENT TO INTERNATIONAL AND REGIONAL AND NATIONAL HUMAN RIGHTS AND GBV INSTRUMENTS AND NATIONAL LAWS POLICIES AND /PRIORITIES

GBV is a matter that has received attention in high-level instruments and discussions, making the joint GBV programme relevant at international, regional and national level. As part of the global community, the Zambian government has ratified and domesticated various instruments aimed at protecting human dignity irrespective of gender. It is an obligation that is placed on nations and the steering has come through the United Nations. Some of the international instruments that the country has ratified and been domesticating include the pioneering UN Declaration on Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC). At the regional level, Zambia has signed on to the African Charter on Human and Peoples Rights (ACHPR), African Charter on the Rights of Women (ACRW) the SADC Protocol on Gender and Development and the International Conference on the Great Lakes Region Instruments on Sexual Violence.

A review of the programme revealed that that its priorities were equally aligned to laws, policies, plans and programmes at the national level. Among them are the Anti-Gender–Based Violence Act of 2011, Education Act of 2011, Penal Code (Amendment) Act No. 15 of 2005, Anti-Human Trafficking Act of 2008, The National Long-Term Vision 2030 National Gender Policy of 2000, National Action Plan on Gender-Based Violence 2010–2014, National Plan of Action to reduce HIV Infection among Women and Girls 2010–2014. Provisions in the revised sixth national development plan, National Gender Monitoring and Evaluation Plan 2011–2015, strategic plans and other national and administrative instruments and mechanisms were mainstreamed.

The Joint GBV programme document was explicit in its reference to the CEDAW recommendations on violence against women and the national Anti-Gender–Based Violence Act of 2011. The programme document thus stated “the GRZ-UN Joint Programme on Gender-Based Violence (JP-GBV) was developed to support the Government of the Republic of Zambia (GRZ) to implement the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), with particular focus on the recommendations on violence against women that are contained in the July 2011 CEDAW concluding observations and the recommendations of the Special Rapporteur on Violence against women, its causes and consequences and support institutional transformation to facilitate the implementation of the Anti-Gender based Violence Act.” As a party to the CEDAW, the Zambian government had an obligation to respond to the CEDAW recommendations, which among other things mandated the government to: (a) Put in place a comprehensive strategy to eliminate violence against women and harmful practices as well as stereotypes that discriminated against women. These would

include efforts, in collaboration with civil society, to educate and raise awareness on the subject, targeting women and men at all levels of society, including traditional leaders; (b) Criminalize sexual cleansing; (c) Use innovative measures to strengthen the understanding of the principle of equality between women and men, including through the full implementation of the National Gender Communication Strategy, whose main aim is to facilitate change in attitudes towards gender, and by working with the media, particularly in rural areas, to promote a positive and non-stereotypical portrayal of women throughout the country.

The government was further urged to a) prioritize and ensure adequate resources for the full implementation of the Anti-Gender-Based Violence Act and adopt comprehensive measures to address such violence, including domestic violence. (b) Expeditiously criminalize marital rape; (c) Strengthen training for the judiciary and law enforcement personnel and health-service providers in order to ensure that they are aware of the Anti-Gender-Based Violence Act, that they provide adequate gender-sensitive support to victims and that they strengthen efforts to prosecute and punish perpetrators of rape and defilement; (d) Provide in its follow-up report information on the implementation of the Anti-Gender-Based Violence Act as well as other measures taken to prevent such violence, to investigate and prosecute reported cases, to punish perpetrators and to provide protection, relief and remedies, including appropriate compensation to victims and their families.

Implementation of the Anti- GBV Act was part of the responsibilities that the government had to undertake in line with the CEDAW recommendations. An assessment of the programme document and discussions with interlocutors within the United Nations and Government showed that stakeholders set out to fulfil these instructions. Aligning itself to the Anti GBV Act, the joint GBV programme prioritized protection of victims of gender based violence through strengthening of: i) institutional coordination at national and subnational levels ii) support and referral structures for victims with particular attention to Health, Justice, Social and Economic considerations. This does not however mean that all provisions in the CEDAW recommendations and Anti GBV Act were implemented in entirety or that those that were implemented were perfectly executed as will be observed in the section on performance, but rather that effort was put in place to implement some of the requirements.

3.1.4 ALIGNMENT TO MANDATES OF STAKEHOLDERS

Alignment to UNDAF

According to the Programme Document, implementing institutions included the UN agencies, Government of the republic of Zambia and Civil Society. A review of the programme design and activities highlighted the fact that UN agencies were engaged based on their guiding framework, in this case the 2011- 2015 UNDAF. Of particular relevance in the UNDAF was Outcome 5 (Targeted government institutions ensure human rights based and gender responsive policies, frameworks and services by 2015). By supporting the joint GBV programme, the UNDAF outcome was executed through the relevant government ministries and departments. The Ministry of

Gender was the core government institution on the programme but other Ministries such as Health, Ministry of Justice, Ministry of Community Development and Social Welfare and the Ministry of Home Affairs were also engaged.

The joint GBV programmes equally responded to the United National Development Assistance Framework (UNDAF) Outcome 5.2 (Targeted government institutions reduce legal and cultural practices obstructing the realization of gender equality by 2015) and Output 5.2.2 (Statutory and customary law-makers, enforcement agencies and adjudicators with skills, resources and mechanisms to implement Convention on the Elimination of Discrimination against Women provisions). An assessment of the joint GBV outcomes, that is: 1) GBV survivors have increased access to timely and appropriate health services 2) GBV survivors have increased access to an efficient justice delivery system 3) Survivors of GBV have increased access to protection and support services and 4) GCDD has coordinated an affective, evidence based and multi-sectoral response to GBV in Zambia fitted squarely into the aspirations of the cooperating partners.

Interlocutors from implementing UN agencies such as UNDP, WHO, UNICEF, ILO, IOM, UNHCR, UNFPA were unanimous in stating that the joint GBV programme was aligned to their comparative advantages, priority areas and their mandate which was to work through government. However, UNICEF felt that the broad relevance was achieved yet more could have been done on the actual programming especially around the support and protection of children.

Relevance to Government Mandate

The identification of government ministries that were involved on the GBV programme went through a well-planned process which will be discussed in detail in the next section on Ownership. Consideration was placed on their competencies and comparative advantages on the programme goal, outcomes, objectives and activities. While it was a given that the Ministry of Gender would lead the coordination of the programme since GBV matters fell under its mandate, the other ministries, namely the Ministry of Home Affairs, Ministry of Community Development and Social Services and Ministry of Justice were co-opted based on their core functions which were in tandem with the programme focus. However, as a cross cutting matter, the GBV programme was relevant to many other ministries and government departments whose involvement in the programme was limited. For instance, the Ministry of Finance and National Planning should have been more involved and engaged strategically for funding purposes, ultimately linked to sustainability of government programmes. The programme however supported a consultancy that produced a Costed Implementation Plan for the Anti GBV Act. This was supposed to be used by Ministry of Gender to influence the budget of line Ministries for GBV programming as well as the Ministry of Finance to allocate resources based on the line ministry Anti GBV interventions. Despite this effort, funding to the ministry by the treasury remains very limited. The Ministry of Finance also has linkages with the banks and credit facilities that proved so difficult to penetrate by the agencies and implementing agencies that were working on Social protection.

Relevance to mandate of Implementing Civil Society Organisations

The UN's mandate does not stretch to implementation and this role was allocated to CSOs as Ministry of Gender mainly played a coordinating role. Civil Society organisations therefore played a key role in implementation of programme activities. Co-optation on to the programme was based on their core functions and respective niches. Their geographical location was also taken into consideration since the programme was implemented in selected provinces, districts and communities. However, a critical review of the mandate of some of the implementing NGOs showed that a few were misplaced. For instance, YWCA though experienced in GBV work did not have the competencies in training of survivors in entrepreneurship and yet they were given the responsibility of training and nurturing some of the beneficiary groups in Eastern Province.

Relevance to the Development Priorities of Donors

The objectives of the programme were assessed in terms of alignment with the development priorities of the two main donors-Embassy of Sweden and Embassy of the Republic of Ireland. The Swedish government has a feminist policy and its Results Strategy for 2013-2017 focuses on (a) maternal and child health; (b) Livelihoods (including social protection); and (c) Governance. The Results Strategy seeks to strengthen governance structures and accountability to improve service delivery, including on GBV and access to justice. The Irish Embassy Country Strategy for Zambia (2013-2017) has a strong focus on gender equality. Both embassies subscribe to the Paris Declaration on Aid Effectiveness and supported the joint programme and the delivering as one UN agenda as part of harmonization of aid. The Irish Embassy noted that,

“When the gender programme came up, we saw it as an opportunity to see how the delivering as one concept would work”

The programme resonated strongly with the development priorities of the two major donors.

3.1.5 RELEVANCE OF THE FOUR PILLARS OF THE PROGRAMME

While the priority areas were informed by various considerations, this assessment concluded that at the broad level, the pillars were teased out of the definition of GBV in the Anti-Gender Based Violence Act of 2011. In the Act, GBV is defined as any physical, mental, social or economic abuse against a person because of that person's gender, and includes: a) Violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to the person, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life; and b) Actual or threatened physical, mental, social or economic abuse that occurs in a domestic relationship. This definition subtly indicates that prioritizing health, social, economic and legal interventions is important in addressing this scourge. The four pillars of the programme were found to be highly relevant to the GBV needs of survivors and stakeholders.

Health Pillar

Evidence shows that a number of GBV cases involve physical injuries or assault. As observed by an interlocutor in the Ministry of Health, the continuum of care for the GBV victim in such a

situation is broad. Apart from the need for medical care, the victims require protection of the police and need the Judiciary to dispense justice on their behalf. It was widely recognized by all interlocutors responding to this pillar that health facilities in the country were operating below expectations due to inadequate human, financial and technical resources. While health workers have the competencies to deal with a myriad of cases in their care, there were gaps in the handling of GBV cases. A respondent at WHO stated that as doctors, their training was mainly *“about stopping the wound from bleeding and on to the next patient, never focusing on the mental problems that the patient could be facing...”*. This perspective of care was shared by other health workers such as nurses and clinical officers that took part in this assessment.

GBV survivors were therefore not prioritized as they sought medical care. A medical doctor in a Health facility in Kasama pointed out that

“ ..Before this programme, GBV victims lined up services like all patients, we did not see the need to give them special attention. We would attend to them and send them over to the police to report their case and that was it for us. We never thought about anything beyond that...”

In the case of those that were sexually violated, most of them missed the opportunity to get PEP. There were no measures put in place to ensure that health personnel handled the victims in a manner that they would be able to testify on their behalf in the courts of law. Samples were sometimes not properly secured. Against this background, interventions in this pillar included training of health personnel on how to handle GBV cases and setting up as well as reviving one-stop centres providing medical, psycho-social, legal, and police services under one roof.

Legal: The CEDAW and Anti GBV Act 2011 identifies cultural and traditional practices as some of the factors fueling GBV. The Joint GBV programme therefore sought to address the discrepancies between customary and statutory law. This was done through providing training and provision of platforms for interface between traditional leaders as custodians of customary law and judicial officers in the mainstream courts. The programme also addressed aspects of accelerating the dispensing of justice by setting up fast track courts. An examination of the operation of the fast track courts showed that the handling of GBV was reduced from a number of years to less than a month in line with the Anti- GBV Act. Magistrate in one of the fast track courts noted that,

“Before establishing the Fast Track Courts, we used to treat GBV cases as any other cases as these were not prioritised. This meant therefore that the cases could take up to 2 years before being resolved. In this case it means that justice will have been delayed with negative impacts on those seeking justice. With the Fast Track Courts, we aim to dispose of cases within 30 days, and this has ensured that justice is delivered on time “

Interviews with other courts that have not yet established the Fast track system (e.g Solwezi Magistrates Court) revealed that GBV cases are not even classified as such by the Clerk of Court and are handled like any other cases and taking up to two years to be concluded. The justice pillar is therefore not only relevant in terms of fostering efficiency in justice delivery, but also reduces the risk of GBV survivors being continuously exposed to GBV as they wait for justice to be delivered.

Social Protection: Activities in this pillar were mainly informed by evidence on poverty levels in Zambia and its overarching linkages to GBV (CSO, 2010: ZHDS, 2010). Records, including narratives from the Ministry of Gender, Judiciary, Police, Civil Society actors such as YWCA and NALCW exposed the fact that poverty and lack of empowerment were among the key drivers of GBV as victims opted to stay with a perpetrator or to withdraw cases initially filed in with the police to protect such a provider⁷. Several studies on GBV have revealed the inextricable link between poverty and GBV prevalence. A World Bank (2007) study for example, revealed that Columbian women who had suffered physical violence had 14% lower earnings than their counterparts who were in healthy relationships. GBV survivors in this evaluation shared that GBV contributed to not only physical injury but leaves psychological scars which affected one's ability to seek work or be optimistic about life. To illustrate this point, in the Tonga language spoken in Southern Zambia, GBV is known as Kutundululwa, literally meaning "being "deflated" and one female survivor in Livingstone narrated how deflated she was at one point,

"My former husband beat me so hard I had scars on my face, I could not go out to do anything for a number of days, I had no income, no food... soon after he left me to live with another woman"

There were also concerns raised during the stakeholders consultative meetings that more social economic activities needed to be done to protect and respond to victims in a targeted way. It was widely acknowledged that the Ministry of Community Development and Social welfare did not have the capacity to deal with the social economic situation of survivors of GBV.

In view of the above context, the programme undertook social protection programmes aimed at protecting and providing timely responses to GBV victims. Key among them were awareness programmes, entrepreneurship training and nurturing and support to existing shelters.

Coordination: GBV involves a wide spectrum of actors due to its nature. While there were a number of anti GBV interventions prior to the joint GBV programme, interviews with the Ministry of Gender revealed that these were at a low scale and incoherent as they were undertaken by individual organisations with limited links to the ministry. The Joint GBV programme intended to enhance the coordinating role of the Ministry of Gender and ensure that efforts on GBV were collectively managed. The UN emphasized that results were critical in programming and the weakness in coordination of GBV programmes made it difficult to track results.

The Joint GBV programme filled in this gap by providing technical support to the Ministry of Gender to enhance coordination of GBV activities in the country. The programme was therefore executed by various stakeholders at national and subnational levels who were aware of the responsibilities that were placed on the Ministry of Gender as well the multisectoral nature of GBV. The establishment of Anti GBV Taskforces at national, Provincial and District Levels with support from the Joint Programme, was meant to address the coordination gaps identified by the stakeholders. To a large extent, the existence of these taskforces improved coordination of GBV activities at district and provincial levels.

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3.2 VALIDITY OF PROGRAMME DESIGN

The key question in assessing the validity of programme design was: *is the design and implementation strategy appropriate for achieving its objectives?*. The evaluation assessed the logic and coherence of the programme in terms of (a) Programme's Theory of Change or Logic Model (b) Design Framework and Implementation Strategy; (c) Relevance and adequacy of foundational information base upon which the programme was conceptualized and designed and processes followed; (d) extent of consultations with constituents and other stakeholders during programme design and implementation; (e) Efficacy of the development model applied; (f) Adequacy of intervention mix (g) definition and clarity of performance indicators; and (h) Realism of the Programme time line.

(a) Programme's Theory of Change/Logic Model

Although there was no explicit theory of change framework for the programme, the envisaged change process towards the goal of contributing to the reduction of GBV in Zambia was anchored on the three well defined and integrated pillars of Health; Legal and Justice; Social Protection and Support; and Coordination. These pillars were in alignment with the identified needs of GBV survivors and national actions needed to combat the scourge of GBV. The change process was to be catalyzed by: legal and policy review and operationalization of the same; capacity strengthening of existing institutions and stakeholders for them to effectively prevent and respond to GBV; training of service providers for effective and friendly service provision; systems strengthening; awareness creation through campaigns and establishment of community networks and engagement of traditional leaders; introduction and adoption of innovative strategies such as the Fast Track Courts and Village Based One Stop Centres; and strengthened partnerships, collaboration and coordination.

The four pillars of the programme were found to be relevant to the GBV context in Zambia and activities implemented under each pillar would ultimately in the long term contribute to both the prevention and response to GBV. The prevention component, underlined by activities such as awareness creation and an effective and efficient justice delivery system, would ultimately lead to the reduction of GBV. Response to GBV was through health service provision and social protection and support to GBV survivors. Other initiatives such as the empowerment of survivors and legal support contributed to both prevention and response towards GBV. In this regard, the Goal of the programme needed to reflect both the prevention and response thrust of the programme.

As a pilot, there resources were generally sufficient to catalyze the change process under all the four pillars had the programme focused on a few districts instead of spreading thinly in some areas. The major assumptions for the achievement of objectives and goal were political will and government commitment to fighting GBV. This assumption was valid as political will and commitment by the Government of Zambia were identified by the evaluation as being amongst the key success drivers of the programme. Assumptions that did not become valid in the logic framework include: adequacy and availability of resources for state actors and other supporting

organization's to support GBV survivors; adequate human resources within the health, legal, justice and other sectors supporting implementation of the GBV programme; and non-state actors to effectively implement GBV; and an efficient M&E system. State actors in particular have financial and human resource challenges and there is need for improvement in data management system of the programme.

(b) Design Framework and Implementation Strategy

The Joint GBV programme was designed as a pilot to test the efficacy of GBV response initiatives that the programme planned to implement through a coordinated multi-sectoral approach. Those models and initiatives found to be effective in addressing GBV issues would then be replicated and up-scaled to the rest of the country. Ideally therefore, as a pilot, the programme should have focused on a few districts (say three to four) and then introduced the whole range of interlinked interventions in those few selected districts to effectively assess the effectiveness of the models and the multi-sectoral referral chain and coordination in these "controlled" provinces. Instead, the programme implemented different components of the programme in provinces and districts scattered around the country, resulting in some provinces having an incomplete menu of the programme activities. Location of programme activities was based more on pre-programme institutional presence of participating UN agencies in specific districts rather than on the need to bring programme activities to a few focused provinces. Resultantly in some provinces, other key interventions such as the Fast Track Courts (e.g Solwezi) were not available despite the fact that the programme had created demand for GBV services through awareness activities and the creation of the One Stop Centres.

The design of some programme indicators was also based on the assumption that programme activities would be up scaled to national level. The target for One Stop Centres, for example (72), was based on the number of districts in the country at the time the programme was designed and yet the programme had no capacity to reach all the 72 districts. The indicators should have therefore been designed to reflect programme performance in the specific programme areas than have a national focus when the programme itself was not national in nature. It seems there was a dichotomy between programme design and expectations of some stakeholders, who assumed the programme would be scaled up to national level when in fact it was designed as a pilot.

Although as highlighted in this report, the programme has scored significant achievements at both output and outcome levels, effectiveness could have been improved through a focus on a few districts with the full range of the programme menu.

(c) Relevance and adequacy of foundational information base upon which the programme was conceptualized and designed and processes followed

A programme that lacks an evidence base that justifies that particular interventions lacks validity, which in turn threatens ownership, sustainability and relevance of the programme. The evaluation concluded that the programme was anchored on a very strong foundational evidence base which provided solid justification for the Joint GBV interventions. Programme design was

informed by ZDHS surveys, ZP VSU statistics on GBV, CEDAW concluding remarks, GBV Act, National Gender Policy of 2000 and National Action Plan on Gender-Based Violence (2010–2014) amongst other studies and evidence bases. However, a baseline survey, that could have provided programme start-up benchmarks against which progress was to be measured, was not conducted as planned giving rise to the challenge of some missing targets and baseline indicators.

(d) Extent of consultations with constituents and other stakeholders during programme design and implementation

Extensive consultations with stakeholders preceded the design of the programme. National consultative and design workshops were conducted where stakeholders including Ministry of Gender and relevant government institutions; UN agencies and civic society organisations participated. Stakeholders interviewed during the evaluation were unanimously agreed that there were adequate consultations on the design of the programme which cultivated a sense of ownership and support for the programme.

(e) Efficacy of the development model applied

The programme adopted a multi-sectoral approach where different stakeholders with different competencies and roles came together in a coordinated manner. Given the multi-dimensionality of GBV in terms of causes and effects, no one stakeholder can adequately address the multiple facets of this phenomenon. The multi- sectoral approach leverages on the comparative advantages and competencies of different partners and stakeholders, which facilitates holistic delivery of GBV services. In the same vein, the delivering as one UN model sought to strategically place UN agencies in thematic programme focus areas where they have greatest competencies and to ensure efficient coordination, utilization of resources and minimization of duplication of initiatives. The development model applied was thus highly valid, given the highly complex challenges associated with GBV..

(f) Adequacy of intervention mix

As discussed under section 3.1.5 of this report, the intervention mix of the programme comprising Health, Legal, Social Protection and Empowerment and Coordination were found to be highly relevant to the multi dimensional needs of GBV survivors and capacity needs of key institutions and stakeholders. Forward looking, there is need for the programme to focus more on prevention and expand its focus to cover rehabilitation of offenders, more support and protection of children and support for GBV survivors living with disability. In terms of rehabilitation of offenders, this was noted to be a key area because currently the focus of the justice system is anchored on punishing without a focus on what happens to the offender when they have served their punishment. During the review, a few former perpetrators who claimed to have reformed gave some useful insights into how a focus on rehabilitation would be useful as a strategy to create awareness on GBV.

(g) Definition and Clarity of Results Framework and Indicators

The Goal of the programme is centered on contribution to the reduction of GBV cases in Zambia. While this goal reflects the commitment of partners and government to effectively address the

causes of GBV through prevention efforts, it does not reflect the response measures the programme is implementing to mitigate the impact of GBV on survivors. Outcome 1 focuses on ensuring that *GBV survivors have increased access to timely and appropriate health services* and Outcome 3 on ensuring that *Survivors of GBV have increased access to protection and support services and economic empowerment activities*. These expected outcomes are not in alignment with the goal of the programme. The goal of the programme needs to be couched in away that captures the holistic thrust of the programme which aims at both prevention (to reduce cases of GBV) and mitigatory response to GBV. Some of the activities of the programme, for example efficient justice delivery, act as both preventive and response initiatives

As mentioned elsewhere in this report, some of the performance indicators of the programme were pitched at national level and yet the programme was not national in scope. The indicators needed to be focused on specific programme interventions which the programme had influence on. A well-defined Theory of Change could have provided a framework for guiding implementation and analyzing barriers, enablers and processed of change that the programme sought to influence. Some of the targets and indicators are not defined or specified in the results framework because of a lack of a baseline study. Some of the indicators are written in % rather than numbers and so it was extremely hard to measure progress as there was no baseline and therefore hard to determine % increase or decrease. Other indicator targets were changed after programme reviews revealed that the targets were too ambitious. However other equally too ambitious targets such as the hospital based One Stop Centres were not revised which made assessment of performance a challenge.

(h) Realism of Programme Timeline

The programme was designed with a lifespan of 4 years. However, the programme had a late start-up and was justifiably granted a no-cost extension of 1 year to December 2017. As a pilot, the timeline is realistic, but for more long-term impact in order to achieve programme goal, the programme needs a longer lifespan to realise meaningful impact especially in terms of changing attitudes and practices. Some of the piloted models, for example, the Village based OSCs and Fast Track Courts need further support to reach self sustaining levels. These piloted models, which have been noted to be effective in tackling GBV and its effects, need to be rolled out to other parts of the country. There implies therefore that there is need for a second phase of the programme, where the activities and impacts of phase 1 are consolidated.

3.3 PROGRAMME PERFORMANCE

As mentioned elsewhere in this report, the Joint Objective of the programme was to *establish an integrated and multi-sectoral mechanism for the implementation of the Anti-GBV Act*. This objective was pursued through four pillars namely: Health; Justice; Social Protection and Livelihoods; and Coordination. The following sections provide an assessment of programme performance under each of the four expected outcomes (pillars) of the programme. The assessment focused on achievement of targets and outputs vis-à-vis what was planned in the results framework under each of the four pillars through which the programme is pursuing its development objective.

3.3.1 ASSESSMENT OF OVERALL ACHIEVEMENT

Overall, the programme performed well across all pillars. Despite the fact that implementation of programme activities started late, of all the measurable targets, 54% of the output targets were achieved or surpassed; 42% were achieved by between 50 to 90% and were thus likely to be achieved within the remaining no-cost extension year of the programme. Only one output target on One Stop Centres was under achieved. A total of 72 One stop Centres were planned but only 4 were set-up or supported by the programme, which is a 6% achievement of target. The target was too ambitious because it was based on the assumption that the OSCs would be established in all the country's 72 districts at the time, Zambia now has about 104 districts. The programme scope could not cover all the 72 districts as OSCs are expensive to set up and some of the funds were diverted towards setting up low cost Village Based OSCs. A total of 13 Village Based OSC were established.

3.3.2 ACHIEVEMENTS BY OUTPUT INDICATORS

Outcome 1: GBV survivors have increased access to timely and appropriate health services.

Output 1.1: Health workers have appropriate knowledge and skills to provide medical services to GBV survivors

The programme targeted to train a total of 800 health workers on guidelines for provision of medical and psychosocial services to GBV survivors. The target was exceeded by 29% as a total of 1,031 health workers have been trained. This output consisted of training health care providers, also including training of trainers, to provide appropriate skills and accurate and qualitative services in line with existing guidelines and protocols on GBV. The achievement of target was mainly a result of the Training of Trainers (TOT) coordinated by Ministry of Gender which enabled the training to be cascaded to provincial level.

With support from the programme, pre-service and in-service curriculum for health staff was to be revised to include medical and psychosocial needs of GBV survivors. Although no target was given in the results framework, 7 curricula were revised for midwives, CSE, enrolled nurses, clinical officers. This output was thus achieved by the programme.

Output 1.2: Ministry of Health (MOH) and partners have scaled up mechanisms for provision of integrated medical and psychosocial services to GBV survivors

A total of 400 health centres were targeted to have specialized units and staff (not necessarily OSCs) providing comprehensive services to survivors of GBV. The programme achieved 73% of the target as the specialised units and staff have been established in a total of 292 health centres. 270 of the health facilities are in UNFPA supported areas while 22 are in UNICEF supported areas of Mansa, Mporokoso and Kasama SRH/HIV/GBV guidelines that provide standards and quality of care protocols were finalized and will serve as a guidance in strengthening delivery of integrated services to women and girls affected and at risk of GBV. GBV survivors received PEP and EC services as well as routine counselling on sexual and reproductive health and HIV in drop-in centers. The target can be achieved within the remaining on year of programming.

The programme also targeted to ensure that 100% of eligible GBV survivors received PEP and EC. The indicator was however revised to indicate absolute figures than percentage because there was no national data to base the calculation on. The revised programme target was 1,916 survivors and this target was surpassed as a total of 5, 121 survivors received PEP and EC. This represents a target achievement of 267%. The overwhelming surpassing of the target was mainly attributed to the programme's leveraging of national events to access GBV survivors with services.

Output 1.3: MOH has established systems for generating, and reporting accurate, timely and reliable data on health related GBV issues

The programme target was have at least four accurate and verifiable reports timely submitted to GCDD on GBV cases addressed by the Ministry of Health (at least one per year). Before the programme, there had been no sharing of formal reports amongst partners handling GBV cases. A total of 6 reports were produced during the period under review, thereby surpassing the target by 50%. Stakeholders however noted that there is need for strengthening accountability systems to ensure that relevant ministries comply with reporting requirements.

At least two indicators were to be developed in the HIMS to capture reporting in GBV. This target has not been achieved and currently there is only one GBV indicator, measuring PEP and EC administration, included in the HMIS. During monitoring it was noted that no reporting was done frequently on this indicator and thereby the inclusion of one more indicator was questioned. Instead, the Ministry of Health has the intention to develop a separate tool to be rolled out to health facilities to capture GBV.

Outcome 2: GBV survivors have increased access to an efficient justice delivery system.

Output 2.1: Number of public prosecutors at Ministry of Justice and Zambia Police trained in investigative and prosecutorial skills

The programme managed to train a total of 702 public prosecutors and Zambia Police members out of an end of programme target of 1,000. This represents a 70% achievement of target. The non-achievement of target was mainly attributed to police participation in the general election that disrupted the planned training schedule. The remaining 30% of the target can easily be achieved within the one year no-cost extension period of the programme.

Output 2.2: Adjudicators in statutory and customary courts trained in adjudicating skills for GBV cases

The programme target was to train 300 customary adjudicators and 80 statutory adjudicators in skills for adjudicating GBV cases. A total of 65 statutory adjudicators (81% of target) and 319 customary adjudicators (106% of target) were trained by the end of December 2016. The target for statutory adjudicators was not reached because of their involvement in national elections which disrupted their training activities. On the other hand the target for the customary adjudicators was exceeded because two partners, WLSA and NLACW, were engaged to facilitate the training process which improved on delivery. The remaining 19% statutory adjudicators to be trained can easily be achieved during the remaining one year no-cost extension period.

Output 2.3: Ministry of Justice has developed an appropriate and efficient legal system for GBV survivors.

Under this output, the programme was to develop a strategy for development for GBV **Fast Track Courts**. The strategy was developed and operationalized with the introduction of Fast Track Courts in Lusaka and Kabwe. The Fast Track Courts were an initiation and innovation of the programme as non-existent in Zambia before. However, the programme did not manage to establish 4 Fast Track Courts as planned as it took longer than anticipated to train the judiciary and set up the courts. The high costs of establishing the Fast Track Courts also led to discussions with DFID for additional resources for the procurement of equipment for 4 additional courts. The programme has initiated the process of setting up these four additional courts. With the experience gained in setting up the first two courts, the target of four courts is likely to be achieved within the last no-cost extension year of programme implementation.

The programme also sought to ensure that GBV survivors receive legal support during their court cases. Unfortunately, no baseline was given and no target was specified in the results framework, which makes it difficult to assess the performance of the programme under this indicator. However, a total of 728 GBV survivors received legal support during the programme implementation period. Stakeholders interviewed during the evaluation noted that more GBV survivors could have been assisted if there were more institutions providing these services than the current limited number that is available.

Outcome 3: GBV Survivors have increased access to protection and support services and economic empowerment activities.

Output 3.1: MGCD, partners and communities equipped with skills and resources for creating awareness about GBV and negative social norms and cultural beliefs.

Awareness creation on GBV was one of the key focus areas of the programme. The programme aimed at increasing the percentage of people (18 years and above) in surveyed communities who have received information on GBV from a baseline of 51.7% (according to the 2011 Gender Perception Survey) to 80% by the end of the programme. This target was difficult to measure in % terms because the number of people aged 18 years and above in each programme needed to be known and a fully-fledged perception survey by the Ministry of Gender had not been conducted by the time of the evaluation. In the results framework, this indicator is reported in absolute figures, which seem to make more sense in measuring performance than the percentage.

In absolute terms, the programme reached a total of 33, 825 people with GBV messages in 2015 and this increased by 39% to a total of 47,054 by December 2016. While it is difficult to measure performance because of challenges explained above, the numbers indicate great strides in GBV messaging in the targeted communities. The increase in the number of people reached was attributed by stakeholders and communities during the evaluation to support from stakeholders such as chiefs, door to door campaigns and the engagement of male champions.

The programme also engaged male champions as agents of awareness creation and change in their respective communities. The programme targeted to engage a total of 5,000 male champions by the end of the programme, a more than 1,000% increase from the baseline figure of 400. By December 2016, a total of 2,586 males were participating as male champions in the programme which represents 53% target achievement.

Strategic organisations such as government institutions, NGOs, CBOs and FBOs were targeted by the programme to capacitate them provide to provide information on GBV. The programme target was 300 organisations, up from the 198 that existed at baseline. By December 2016, a total of 509 organisations were providing GBV information, a 167% achievement of target. The surpassing of the target can be attributed to the engagement and support of NGOs, CBOs and FBOs by the programme where men's networks, One Stop Centres and Safe spaces for girls were established.

Output 3.2: Communities in targeted districts/sites have developed networks and coalitions for surveillance, support, referral and reporting GBV cases

The programme sought to establish community networks to respond to GBV cases. From a baseline of 25 community networks, the programme target was 215 by December 2016 but this target was overwhelmingly achieved as a total of 747 community networks were established in all the targeted provinces and districts, representing a 347% target achievement. Number of

community networks increased through establishment of men's networks, One Stop Centres (both village and hospital based), safe spaces groups and engagement of FBOs and CBOs.

The establishment of community networks was expected to result in an increase in number of GBV cases reported to the police by community members. The programme targeted 4,500 cases but managed to 3,250 cases, which is a 72% achievement of target. The target is likely to be met in 2017 given the level of awareness existing in the program communities and the active nature of community networks.



Members of the Community network against GBV in Maheba (left), and the sign post of the Men's network in Pwata (right).

Men's and community networks visited during the evaluation were very active and they visited schools, clinics, churches and other public places to interact with community members and discuss about GBV (rape, spouse battering, statutory rape, domestic violence, public insults) drug abuse, early pregnancies and early marriages. They also explain to the communities about the GBV referral system and where they can access GBV services. They also conduct counselling sessions of survivors.

Output 3.3: Stakeholders implementing the Anti-GBV Act have established protection and support services for survivors of GBV

Provision of protection and support services for GBV survivors was of the key thrusts of the programme. The programme planned to establish a total of 72 One Stop Centres (OSCs) and Coordination Response Centres (CRCs) across programme districts, from a baseline figure of 11. By December 2016, only 15 One Stop Centres had been set up, which is 21% achievement of target. This output was underachieved mainly because the resources for the OSCs were channeled towards the establishment of community village based OSCs.

Stakeholders were expected to establish protection shelters for survivors of GBV to ensure their security while their cases are being handled by the courts. The programme target was to have 1,000 GBV survivors sheltered from a baseline of 410. The programme target was exceeded as 1,676 survivors were sheltered by December 2016. Stakeholders interviewed attributed the surpassing of the target (167% achievement) to increased awareness on the availability of GBV services.



Safe shelter at Maheba Refuge Camp and the management team of the shelter (left), and going through records in the office of the shelter coordinator (right).

The programme aimed supporting GBV survivors to access public welfare assistance from the MCDMCH now called MCDSW.. The results framework did not specify the baseline figure nor did it provide the programme target. However a total of 177 GBV survivors have managed to access assistance with support from the programme.

To cushion GBV survivors from GBV related impacts, the programme sought to support GBV survivors with economic empowerment initiatives. The programme target for this initiative was 5,700 survivors, from a baseline of 400. The programme target was surpassed by 14% as a total of 6,500 survivors were supported. Savings and lending groups were created and provided with technical skills to start small scale businesses. The groups were also linked to micro-finance institutions and private sector banks for capital support.

Output 3.4: Ministry of education has implemented the Anti-GBV provisions in the revised Act.

To increase awareness on GBV in schools, the programme aimed at supporting the review of the Ministry of Education Act and curriculum for pupils and primary and secondary school teachers and to include GBV issues. Both the Act and the curriculum have been revised to make them gender sensitive and to include the provisions of the Anti-GBV Act. The revisions to the Act and Curricula was expected to enhance the mainstreaming of GBV issues in schools that would in turn result in increased reporting of GBV cases in schools. Although the programme target for GBV cases in schools was not indicated in the results framework, a total of 2,540 GBV cases were reported in schools against a baseline of zero for the period under review, signifying increasing awareness of GBV issues in schools.

Output 3.5: GBV survivors have access to productive resources (land, finance, capital)

The programme recognized that survivors’ empowerment rested on their access to productive resources in the form of land, finance and capital. Under this output, activities that were to be undertaken included the identification of organizations that provide skills to enhance economic benefits to GBV survivors and training of 4,500 GBV survivors and vulnerable girls and boys in entrepreneurship skills. ILO, UNICEF and IOM implemented this activity and some of the

organisations that were identified included Mulangile Women Organisation, Africa Action Help (AAH), Zambia Disability Health and Human Rights, FAWEZA, Community for Human Development (CHD), AYE and ZAFAWIB. The organisations had the advantage of working with diverse clients such as women, youth, persons with disabilities, refugees and migrants. The program surpassed its target. Out of a baseline of 350, results pointed to the fact that 5725 survivors received training in entrepreneurship management to cushion themselves from economic hardships. This performance was above target (4,500). Furthermore, out of a baselined of 50 and target of 1200, a total of 1526 GBV survivors were referred to financial institutions to access business financial services. This performance was attributed to concerted efforts among the various stakeholders that were working on this activity.

3.6 Increased access to Income Generating Activities and decent work

This output was concerned with the promotion of 1,000 survivors to access employment and facilitation of GBV survivors' access to markets, including business linkages to large companies through ZDA. Other intentions were to collaborate with banks and money lending houses to train and open accounts for survivors of GBV and development of a monitoring and evaluation strategy for survivors that were going to benefit from training and loans. The programme performed well in some aspects. With a baseline of 150 and a target of 1000, it was observed that a total of 2446 GBV survivors had accessed employment mainly through starting their own businesses supported by the OSAWE groups. This assessment observed that most of the saving groups had performed well, enabling members to borrow and expand their business or diversify. GBV survivors were exposed to trade and agricultural shows, exhibitions and to companies in the relevant value chains although linkages with ZDA were challenging to actualize. Collaboration with banks and money lending houses to train and open accounts for survivors of GBV was partially achieved. Financial institutions such as Stanbic, NATSAVE, ZANACO and Indo bank supported survivors with opening accounts but borrowing was still linked to assets. The development of a monitoring and evaluation strategy for survivors was not completed as the Terms of Reference were yet to be finalised.

Outcome 4: MGCD has coordinated an effective, evidence –based and multi-sectoral response to GBV in Zambia

Output 4.1: MGCD and partners has developed tools and mechanisms for awareness raising and implementation of the Anti-GBV Act.

Under this output, MGCD and partners were to develop and implement a costed operational plan for education and awareness creation on the anti-GBV Act. A costed plan was developed in June 2013 and has since been operationalized during implementation of the programme. A simplified version of the Anti-GBV Act was also translated into 7 main local languages and Swahili, French and Kinyarwanda to also cater for the refugee and migrant population in Zambia. A braille version was also developed for the visually impaired. The translated versions of the act were used to

disseminate information on the Anti-GBV Act in targeted communities including the refugee communities in Meheba and Mayukwayukwa.

Output 4.2 MGCD and partners have implemented an evidence based and informed Anti-GBV programme.

The programme planned to conduct a number of assessments, including operations research and evaluations to provide a foundational information base to inform programme design implementation and monitoring. The target was to conduct a baseline, two evaluations and two operations researches. A programme baseline was not conducted as planned due to challenges experienced in coordinating the process amongst the stakeholders. Instead, a research on the *“Dimensions of Violence Against Women in Selected Districts of Zambia”* was conducted which provided some data/information on programme baseline values. The lack of a baseline provided challenges in assessing the performance of the programme in this evaluation.

The Mid-Term Review was also not conducted as planned because of delays in implementation of some of the programme which made it not feasible to conduct an evaluation when some of the programme activities had just taken off the ground. There has been a 40% achievement of target under this output.

All indicators in the programme results and monitoring framework were to be reported on. Analysis of the 2017 report on the results framework shows that there are a number of indicators that are still to be reported on, and some are waiting for results of national studies which are yet to be published.

Output 4.3: MGCD and partners have established national and district coordination mechanism for the implementation of the Anti-GBV Act.

The programme sought to facilitate the formation of one functional national coordination unit for GBV cases, 10 provincial coordination committees and 50 district committees. A national anti-GBV committee has been established and is functional and the committee meets on a quarterly basis. The target of 10 provincial committees has been met and at district level, the programme has achieved 68% of its target as 34 district committees have been formed out of the targeted 68. The district target is likely to be achieved in the remaining years as provincial committees can facilitate the formation of the remaining district committees in their respective provinces. The target for district taskforces was revised downwards to 50 from the initial programme target of establishing a taskforce in every district was found by the Joint Review Meeting to have been too ambitious and unrealistic.

Output 4.4: MGCD and partners have established a functional referral system for service provision comprehensive and integrated services to survivors of GBV

National Referral guidelines on GBV have been developed with support from the programme. The guidelines are functional and are currently being used by stakeholders in handling GBV cases.

The programme also targeted to establish referral systems at sub-national and sub-district levels. Out of the targeted 150 sub-district referral systems, a total of 139 were set up with support from the programme which represents 93% target achievement. Data base support was also provided to the Zambia Police VSU.

3.3.3 FACTORS THAT INFLUENCED PERFORMANCE OF THE PROGRAMME

The evaluation assessed the factors that influenced the performance of the programme, either negatively or positively, at national, sub-national and community levels. The factors are presented in the box below:

| Level | Positive | Negative |
|---------------------|---|---|
| National | <ul style="list-style-type: none"> -good political will, support and programme buy-in by all stakeholders including government -leveraging on technical capacity and expertise within UN agencies, government ministries and CSOs -motivation of national stakeholders as there was consensus on problematisation of GBV -improved coordination particularly after the appointment of a Programme Coordinator by Ministry of Gender and functional management arrangements e.g. project board meetings, PITC and Monthly Coordination Meetings; -Multi-sectoral approach that provided a platform for a holistic approach to the multi-faceted phenomenon of GBV | <ul style="list-style-type: none"> -delays in programme start up -inconsistent disbursement of funds for some implementing partners (e.g Kasama and Chipata OSC) partly due to partners' failure to adhere to expenditure and reporting requirements before release of next batch of funds and partly as a result of bureaucratic red tape within some Un agencies. -weak data collection and management system and stakeholder reporting system |
| Sub-National | <ul style="list-style-type: none"> -buy-in and support by stakeholders - enhanced coordination through the establishment of functional Provincial and District Anti-GBV Taskforces | <ul style="list-style-type: none"> -some IPs had no office presence in programme districts and they operated from Lusaka which was not cost-effective -non-presence of Ministry of Gender at district level and in some provinces (Anti-GBV Taskforces filled in this gap but needed legitimacy and leadership of Ministry of Gender to own GBV initiatives) -weak data collection and management system |
| Community | <ul style="list-style-type: none"> -community buy-in and enthusiasm was strong -support of traditional leaders -existence of volunteers | <ul style="list-style-type: none"> -lack of adequate equipment and resources for communication and transportation |

3.4 PROGRAMME EFFECTIVENESS (ACHIEVEMENT OF OUTCOMES)

The evaluation assessed the extent to which the programme was effective in reaching the desired outcomes. The assessment focused on effectiveness of programme design and the extent to which the four expected outcomes of the programme were achieved in terms of improved access and delivery of preventive and responsive GBV services, behavior change and functionality of the multi –sectoral coordination and referral system. The conclusion of the evaluation is that the programme, as a pilot, achieved to a great extent the expected outcomes of the interventions. However, the programme needs longevity and up-scaling to achieve the ultimate Goal, which is to contribute to the reduction of GBV in Zambia.

3.4.1 EFFECTIVENESS OF PROGRAMME DESIGN AND APPROACH

In assessing effectiveness of programme design, the evaluation analyzed the extent to which the design of the programme enhanced the achievement of programme outcomes.

(a) Multi-Sectoral Approach

The programme was designed as a multi-sectoral programme to leverage on multiple skills and competencies within UN, Government, CSO partners and the private sector. The evaluation's conclusion is that the multi-sectoral approach was largely effective as evidenced by the achievement of results at both output and outcome levels. The approach was strengthened through capacity building initiatives that improved the efficiency and quality of services by service providers. The multi-sectoral approach enabled GBV survivors to access holistic services to meet their needs in terms of health, social protection, economic empowerment and rights awareness. Stakeholders interviewed were generally agreed that the approach had been effective.

However, competition for space and resources amongst partners and stakeholders resulted in some agencies implementing activities in areas where they had limited competence and capacity on. According to the programme partnership agreement, the government was supposed to contribute up to 25% of the programme budget but has not been able to do so because of a constrained fiscal space. Increased and continuous lobbying of the Ministry of Finance by the Ministry of Gender is needed for increased resource allocation to the ministry.

(b) UN Delivering as One Model

The Joint GBV programme was implemented within the framework of the UN Delivering as One pilot approach. The “Delivering as one” approach emerged from intergovernmental decision-making on the operational activities of the United Nations system for development. One of the key recommendations of the High-level Panel appointed by the UN Secretary General in 2006 was that the United Nations system should “deliver as one” at country level. That would include the adoption of the “Four Ones”, namely One Leader, One Programme, One Budget and, where appropriate, One Office. The approach was aimed at making the United Nations development

system more coherent, effective and relevant⁸. The UN Zambia adopted the delivering as one approach in 2011 as a self-starter pilot.

The evaluation noted that under the delivering as one concept, the UN agencies managed to have One GBV programme which brought the comparative advantages of all UN Agencies together to cover all the four pillars of the programme namely Health, Legal/Justice, Social Protection and Economic Empowerment and Coordination. One implementation plan was developed for the programme with each of the participating UN agencies having a clear role and mandate within the programme. The programme was coordinated through UNDP and this enabled the UN agencies to speak with one voice, adopt one approach and have clarity on which agency was working where and on which component. The coordinated approach reduced chances of duplication of activities, enabled the UN system to respond more comprehensively to national needs and brought to together the comparative strengths of the agencies. The UN system was also more able to respond in a cohesive manner to the needs of external stakeholders as they are bound by one implementation framework and approach. No significant cases of duplication of activities amongst UN agencies were noted during the evaluation. Having one programme budget also helped in prioritization of GBV interventions through a participatory process. Budget allocations were led by the Ministry of Gender and activities were prioritized according to national needs.

The delivering as one model enabled cross-learning between UN agencies. At the beginning of the programme, there were some UN agencies (e.g. WHO and IOM) who had very limited focus on or experience in GBV programming. However, after joining the programme, the UN agencies started learning on how to mainstream GBV in their work and have since significant contributions to the GBV programme. The capacity of these agencies has thus been improved through the delivering as one model.

In theory, having one budget under the delivering as one model is supposed to reduce competition for resources amongst agencies. However, under the GBV Joint Programme, it was noted that UN agencies competed for space and resources, and some agencies ended up supporting implementation of activities that they had limited competence and capacity on. For example under the Safe Spaces initiative in schools, entrepreneurship component of the programme was not well executed in some schools and was not adequately monitored because the implementing partner had limited technical support from the responsible UN agency. Programme participants became demotivated because of this lack of support. This resulted in a downward review of some of the UN agencies' budgets by the Ministry of Gender after failure to produce expected results. This competition for resources led to tensions between some of the agencies.

Although there was one programme budget and funds were disbursed through UNDP to the different UN agencies, the different administrative fund management requirements of the different agencies affected in some cases, efficient disbursement of funds. For some agencies, funds had to go through their HQs, from which they would make requests on a need basis while for others, funds were directly transferred to their country office accounts. The administrative and bureaucratic burden experienced by some of the agencies resulted in late disbursement of

⁸ Report on the UN independent evaluation of lessons learned from "Delivering as one, 2012

funds to implementing partners which affected efficient and timely implementation of some of the programme's activities.

Despite these challenges, the delivering as one approach has however been found to be largely effective as most of the output targets and expected outcomes of the programme were achieved. The level of achievement would have been difficult to attain with the participation of only one agency.

(c) Engagement of Traditional Leaders and Male Champions

The programme engaged traditional leaders to be male gender champions in their respective areas of jurisdiction. Traditional leaders are custodians of culture and traditional norms and values, and these cultural beliefs, attitudes and practices were noted to be some of the key drivers of GBV in Zambia. Engaging traditional leaders and men was therefore strategic and communities and stakeholders interviewed during the evaluation all concurred that traditional leaders and men's networks were speaking out against GBV and were taking measures to ensure that perpetrators of GBV faced justice. Some of the traditional leaders were instrumental in the establishment of village based OSC and donated land and structures for the OSCs.

3.4.2 ACHIEVEMENT OF EXPECTED OUTCOMES

Outcome 1: GBV survivors have increased access to timely and appropriate health services

Indicator 1: % of GBV survivors receiving medical and screening services

The baseline value and the target for this outcome indicator are not specified in the results framework and there is no national data to do a comparative analysis. However in terms of absolute numbers, the programme target was 4,863 survivors accessing medical and screening services but the target was surpassed as 5,679 survivors received the service (116% target achievement). Stakeholders interviewed attributed the increase in GBV survivors accessing services to increased awareness of the availability of services, increased capacity of health workers to offer the required services and the introduction of mobile clinics to reach out to some of the remote parts of the districts.

The box below shows statistics of GBV survivors that accessed medical services at a few sampled One Stop Centres participating in the programme:

GBV Survivors accessing medical services at specific One Stop Centres

Mansa, Kasama and Mprokoso

-2012-2015: overall percentage of GBV survivors receiving medical and screening services at Kasama, Mansa and Mporokoso: **83%**

-2016: percentage of GBV survivors receiving medical and screening services:

Mansa: 95%

Kasama: 94% (was 60% in 2015)

Mporokoso: 21%

The above table shows the proportion of survivors accessing medical and screening services at facilities is quite high at 95% for Mansa and 94% for Kasama. The Mporokoso OSC is newly established and the men's networks are also relatively new and have recently started awareness programmes in the surrounding communities and hence the low coverage of GBV survivors accessing medical and screening services. The Mporokoso community networks were also facing transport and communication challenges as the programme has not yet assisted them with cell phones and bicycles as was done in other OSCs with support from the programme.

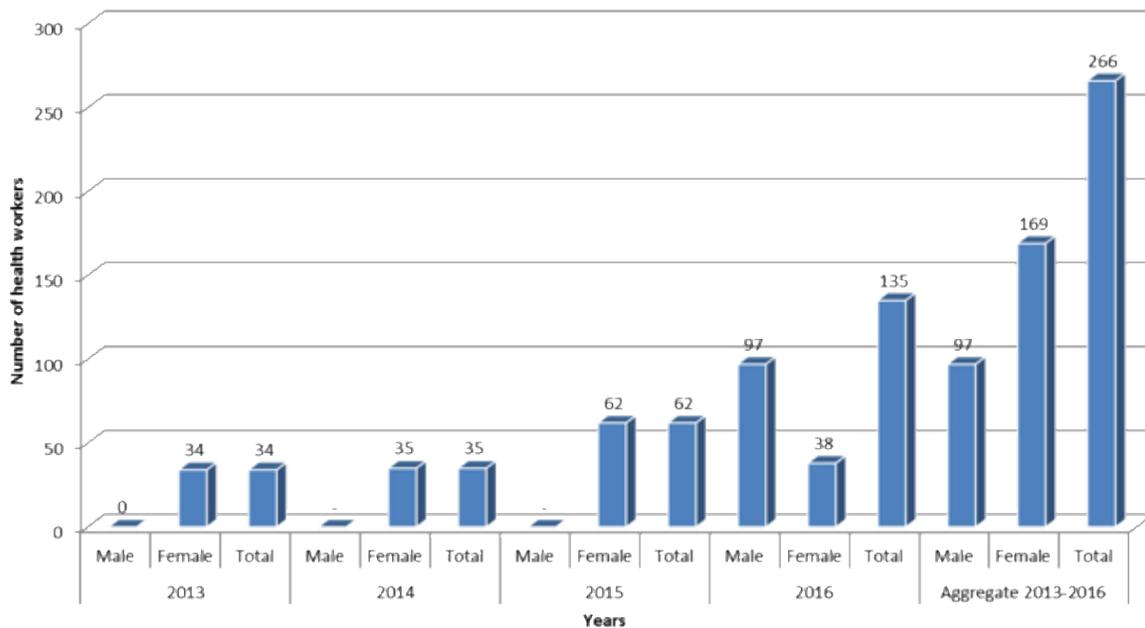
Indicator 2: % of health workers that comply with guidelines in the provision of medical and psychosocial services to GBV survivors

This indicator was difficult to measure because there is no national data available for comparative purposes and there has been no agreed programme level monitoring framework for compliance among health staff. However, in terms of absolute numbers, a total of 1,013 health workers were trained on guidelines in the provision of medical and psychosocial services to GBV survivors.

Migration was mainstreamed into these trainings to enable health workers to be better able to meet the needs and understand the vulnerabilities faced by migrants especially female migrants who are at heightened vulnerability to GBV including human trafficking.

The Lusaka Provincial Health Office did a follow up on staff compliance with guidelines in the provision of medical and psychosocial services to GBV survivors. The Provincial Health Office trained a total of 307 health workers between 2013-2016. The table below shows the number of health workers complying with guidelines on medical and psychosocial services to GBV survivors.

Figure 1: *Number of health workers complying with guidelines in the provision of medical and psychosocial services to GBV survivors.*



Source: *The Lusaka Provincial Medical Office*

The statistics shows that in total, 87 % of the trained health workers were complying with the guidelines. Interviews with health workers during the evaluation in other programme areas also confirmed that they were adhering to the multi-sectoral guidelines in the provision of medical and psycho-social services to GBV survivors.

All health workers interviewed acknowledged the importance of the training they received. Amongst other things, the training enabled the health workers to understand better the needs of GBV survivors and the GBV multi-sectoral protocol. The training also enhanced their counseling skills, which has enabled the health workers to also meet the psycho-social needs of GBV survivors.

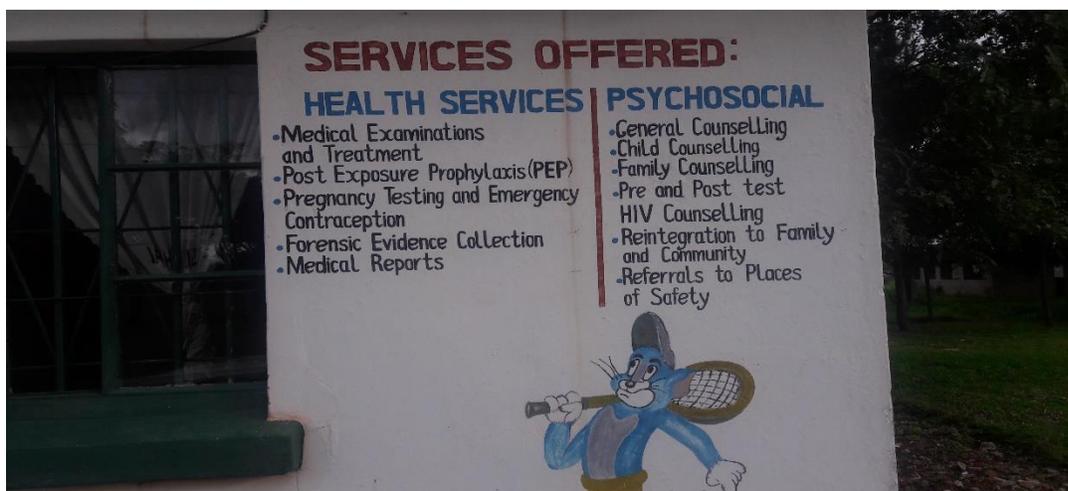
“Before training we treated GBV cases as any other cases. Sometimes survivors would wait here for two days wanting to see a Doctor because they were not accorded priority. Now when a GBV case comes to the OSC, I leave whatever I am doing to make sure that the survivor receives medical attention immediately. This mindset has come from the training that we received as health workers”. (Dr at Kasama Hospital).

At health facilities with OSCs, the evaluation team learned that health workers also did training for the registry, which created a coordinated response to the GBV clients at all levels of the health facility. Health workers also did sensitization campaigns in communities, informing GBV survivors of available services such as shelters, medical treatment and legal counselling. Another health care provider that participated in the training described it as an “eye opener” and several others underlined that they now had gained skills in handling GBV survivors. The multi-sectoral training

was highlighted by several of the respondents as very useful, and they gained understanding of case management and gained skills on how to improve referrals to judiciary and/or the police.

GBV survivors interviewed during the evaluation acknowledged that the service they receive from OSCs is very friendly and prompt.

Challenges highlighted by health workers and GBV survivors during the evaluation include limited access to health services by survivors located in remote areas due to transport challenges and limited resources. Some health institutions have critical shortage of personnel, making it difficult for health workers to handle their daily duties while at the same time responding to the special needs of GBV survivors



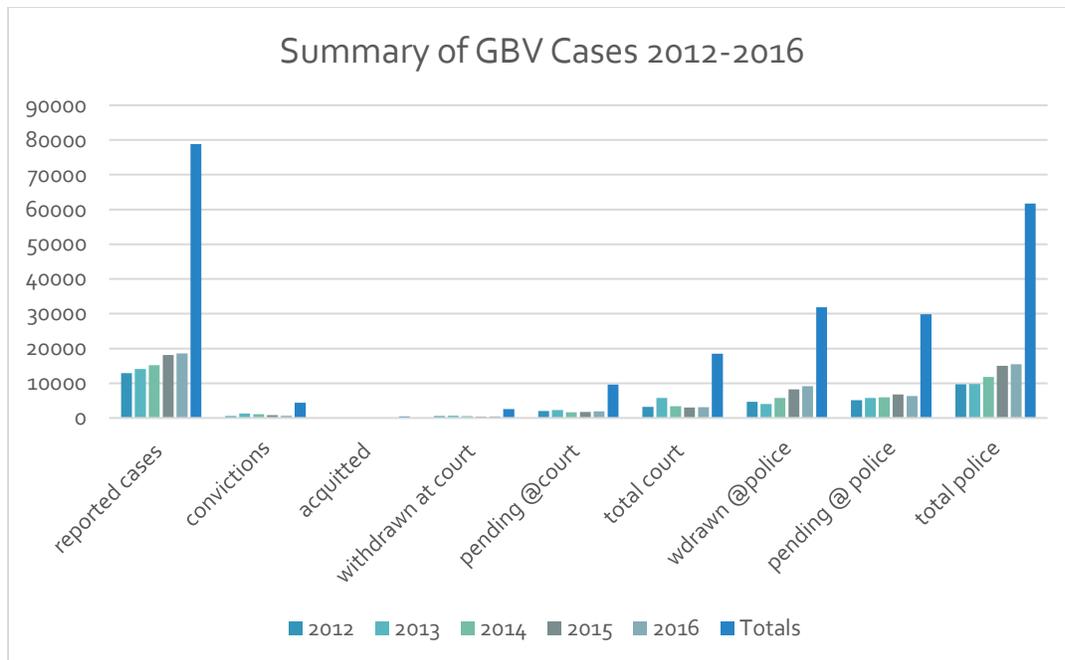
A board advertising services offered at Kasama One Stop Centre

Outcome 2: GBV survivors have increased access to an efficient justice delivery system.

Pillar 2 aimed at ensuring that GBV survivors had an increased access to an efficient justice delivery system. This entailed improved access to the police (for reporting cases) and the judiciary system for the cases to be resolved.

The graph below provides a summary of GBV cases reported to the police and handled by the courts.

Figure 1: *Summary of GBV cases handled by police and courts*



Source: Zambia Police Victim Support Unit

As the above graph depicts, there has been a gradual increase in the number of cases reported to the police from 12,924 in 2012 to 15,153 in 2014; 18,088 in 2015; and 18,540 in 2016. This represents a 44% increase in reported cases from 2012 to 2016. The police attributed this increase partly to the GBV awareness campaigns in the country that the joint programme has significantly contributed to. The total number of cases reported during this period is 78,802.

The evaluation concluded that an increase in the number of GBV cases reported to the police can largely be attributed to awareness creation by the programme on GBV and GBV services available from different stakeholders. Police VSU members interviewed during the evaluation generally concurred that the training had been very useful in enabling the department to offer efficient and friendly services to GBV survivors. The training, amongst other things, improved the investigative and prosecution skills of the police and judiciary officers. Key skills gained include handling of evidence, data management and an understanding of the multi-sectoral protocol on GBV. The following box contains some quotes from VSU police officers.

Under the programme, we have trained more than 700 police officers on several components of GBV, including data management, care and custody of evidence and preparation of witnesses. We have realised that if you are inadequately prepared, fighting GBV cases in court can be very difficult. When evidence is not secured, you can easily lose your case in court. The training has enabled us to have a high level of preparedness and to change our mind sets as police. We are moving from the “old police” mentality that GBV is just a domestic issue and that defilement is a lesser crime than other crimes. That mentality is changing through the training that we have received.

The programme has also enhanced our capacity by providing us with computers and vehicles. The vehicles have enabled us to reach out to far away places to fetch offenders and secure witnesses

where GBV cases are prevalent. Our curriculum as police was devoid of GBV matters and with the support of the programme, we have developed a curriculum that covers GBV issues that should be taught to the police recruits right from inception.

Zambia Police, National VSU Coordination Office

It is no longer business as usual because we now know how to handle GBV survivors in a more sensitive manner than we used to do. GBV survivors used to be afraid to come to report their cases because they were afraid of us as our approach was not sensitive to their situation. We treated them as if they were criminals. Through the training we received, we now have a better understanding and appreciation of the needs and circumstances of GBV survivors and I think that is why they now find it easy to come here and report because they know they will be counselled and listen to in privacy. We advise our fellow police officers at the reception area to direct GBV cases straight to the VSU because they have not been trained to handle such cases and might not be able to properly handle the cases with the sensitivity they deserve. The training really transformed the way we do our work”

VSU Officer in Choma.

With support from the programme, we have been creating awareness in communities on GBV using the PA system provided to us by UNDP. This has increased the number of GBV cases that we are now handling as VSU. We used to handle about 10 cases per day, but after community awareness activities we are now handling between 30-40 cases a day at this station. We have also received a lot of support from our chief. For example, our local chief Mumbi has donated 3 bicycles to be used by the village based OSCs neighbourhood watch committee. This has increased the mobility of these watch committees because they were facing transport challenges.

VSU, Petauke

The programme also provided the VSU with equipment for GBV awareness activities within their respective areas of jurisdiction. Equipment provided included PA systems, cameras and computers for data capturing. The VSU is working closely with the OSCs and some of the GBV cases are referred to the police from the OSCs.

Indicator 1: % of GBV cases addressed through the court system.

An efficient justice delivery system would see an increase in the number of GBV cases being handled by the courts as more and more survivors will have access to the justice system. The baseline value of GBV cases handled by the court system was 32% and the end of programme target was 60%. A total of 16% of GBV cases were handled by the courts (3,099 out of the 18,475 GBV cases) between 2012-2016), a decrease from the 2015 performance of 17%. The December 2016 performance is even below the baseline value of 32%.

In the opinion of the evaluation team, the target of 60% by end of programme was too ambitious given that the programme was not being implemented throughout the country and that only two fast track courts had been established in Lusaka and Kabwe. The evaluation also noted that there

is a high rate of case withdrawals at both the police and court levels. Cases withdrawn at court level have been declining from 559 in 2012 to 432 in 2016 (22% decline). On the other hand, cases withdrawn at police level increased from 4,621 in 2012 to 9,167 in 2016, an increase of almost 200%. The total number of cases withdrawn from both the courts and police between 2012 and 2016 total 34, 444, which represents 44% of all reported cases between the same period. The reasons for high case withdrawals need to be investigated and addressed, as case withdrawals are impacting negatively on the volume of GBV cases handled by the courts. The high rate of case withdrawals impacts negatively on the overall strategy that prosecutions and visibility of prosecutions is a form of prevention. It will also be interesting to learn why there are higher case withdrawals at police level compared to the court level. The impact of case withdrawals on survivors needs to be investigated to determine the extent to which the withdrawals are by free choice and how the withdrawals affect their GBV situation.

The fast track courts established in Lusaka and Kabwe have enhanced the efficiency with which GBV cases are handled by the courts. The Lusaka Fast Track court received a total of 207 cases in 2016 and managed to dispose of 83 cases by December 2016, which represents 40% of the cases.

The following box provides a narrative on the performance of the two Fast Track Court.

Kabwe Fast Track Court GBV Cases Disposal rate

Between January 2016 and February 2017, the fast track court had handled a total of 68 GBV cases. Out of these cases, 52 cases (or 76%) had been disposed of by the time of the evaluation. Of the cases that had been disposed of, 38 cases (or 73%) were disposed of within 30 days of court receipt while only 27% went beyond 30 days. Some of the cases were disposed of in one day while the longest case took 71 days to be disposed of.

Kabwe Fast Track Court Records

“The fast track court has really facilitated our handling of GBV cases. Previously GBV cases were treated just like any other ordinary cases and would take long to be concluded, sometimes up to 24 months. With the establishment of the fast track courts were now specifically categorize GBV matters and give them priority. The GBV programme has assisted us with renovations to our offices and furniture to make them user friendly and 2 vehicles that have made it easy to easily access witnesses or to move the court to the crime scene. Equipment has also been installed to create a court environment that is friendly to the victims of GBV when they testify in court. Our mindsets have also changed as the justice delivery system, as the police and prosecutors now come to court more prepared as they have been trained on how to handle GBV cases. We now conclude most GBV cases within 14 days where as previously we never used to know how many GBV cases we were dealing with because were never used to categorise the cases as such.

The Fast Track pilot has really been a success and we wish it can be replicated in all the country’s provinces. The major challenge we face however is the shortage of court space, so magistrates have to take turns to attend to GBV cases in one court room”.

Kabwe Fast Track Court Officials

The Fast Track Courts have provided GBV survivors with confidence on how the courts handle their cases. Before the introduction of the FTCs, we had no time limits in handling GBV cases. Some of the cases could go for years, but now the magistrate has to conclude each GBV case within 28 days. This programme is

good because we have seen that the FTCs are an efficient way of disposing of GBV cases. The programme should not end at pilot level but should be cascaded down to the other parts of the country. For the FTCs to be more effective, we need more court rooms and continuous capacity building for the magistrates so that we have more magistrates that can handle effectively GBV cases. We also need a rehabilitative approach, where the system rehabilitates offenders and monitors their integration back into society. It is also important that gender is mainstreamed in judiciary training.

Chief Magistrate, Lusaka Magistrates' Court

Shortage of office space was cited as a major challenge facing Fast Track Courts. Magistrates have to take turns to use one court room for GBV cases and this results in some of the GBV cases being unnecessarily prolonged. There were at times technical glitches that were experienced with the equipment that was installed in the courts, but these challenges have for now been overcome. More training is also needed for judiciary staff as staff transfers sometimes affect the operations of the Fast Track Courts.

Indicator 2: % of backlog of GBV cases in courts.

The introduction of the Fast Track Courts (FTC) was also meant to reduce the backlog of GBV cases at the courts as cases were going to be swiftly dealt with. At baseline in 2012, 53% of the GBV cases in court were pending and the end of programme target was to reduce the backlog to 10%. The backlog as at December 2016 had however increased to 61% (as shown in the box below), indicating failure by the programme to meet the target.

| ✓ Courts Backlog of GBV Cases | |
|---|-----|
| ❖ Baseline National Backlog of GBV cases----- | 53% |
| ❖ National backlog of GBV cases December 2016 ----- | 61% |
| ❖ Lusaka Fast Track Court backlog ----- | 60% |
| ❖ Kabwe Fast track Court Backlog ----- | 24% |
| ❖ Average backlog of the two Fast Track Courts----- | 42% |
| ❖ Programme backlog target ----- | 10% |

The evaluation team feels that the target under this indicator was too ambitious given the fact that only two FTC had been established in the country to deal with GBV cases. The target could have been more focused on the FTC for effective measurement of performance. The increase in backlog could have also emanated from an increase in the number of cases reported as GBV awareness programmes spread to many parts of the country. This calls for a corresponding increase in the number of FTCs so that they are able to cope with the upsurge in reported GBV cases.

An analysis of the two FTC shows that the Lusaka court received a total of GBV 207 cases in 2016 and by the end of the year it had a backlog of 124 cases (or 60% of the cases received). This is almost the same as the national average backlog of GBV cases (60%) despite the fact that the

other courts in the country are not fast track. The Kabwe FTC however had a backlog of 24% which is quite a significant improvement on the baseline, but still short of the targeted 10%. On average, the two FTCs had a backlog of 42%, which is better than the national average although is still lower than the programme target.

The major challenge at the Lusaka FTC is that it is the biggest magistrates' courts in the country and therefore handles high volumes of GBV cases and yet only two court rooms have been availed to handle GBV cases. Of the two court rooms, only one has the CCTV equipment. The lack of space has forced magistrates to take turns to handle GBV cases, which ultimately delays conclusion of cases by the three magistrates trained and assigned to handle GBV cases. The other challenge is that magistrates hear cases in the courtrooms in the order of seniority and the Court rooms can also be used to hear other matters because the court rooms are few in comparison to the number of cases.

There is need for further engagement with the Ministry of Justice so that the number of FTCs can be increased to cope with an increase in reported GBV cases. The Rules of Court also need to be reviewed to incorporate the use of the equipment that has been secured for the courts by the programme.

Comparative Analysis: the Case of Solwezi Magistrate's Court

The Solwezi Magistrates' Court has not participated in the Joint GBV programme and has no GBV fast track system that has been established. This affects the access to justice particularly for refugees as some eventually have to move (for durable solutions) without attaining justice. In the case of perpetrators long delays in processing their cases affects their ability to access durable solutions. In the following box, the discussion with the court officials is reflected and contrasts sharply with the way GBV cases are handled at the two FTCs in Lusaka and Kabwe.

We have not participated in the joint GBV programme you are referring to. At this court, GBV cases are handled as any other cases and are not given priority. Each magistrate is allocated a case and he or she will handle it accordingly as she or he sees fit. The cases can take several months or even years before they are finalized, we cannot afford at the moment to deal with the cases within a specified time because we do not categorize the cases as GBV. Besides we have a serious shortage of court rooms as 5 magistrates share 2 court rooms and hence the 28 day limit is impossible to apply in our case. We handle them as assault cases if there is physical violence involved because when the cases come from the police there is no indication whether the cases are GBV or not. We are however alive to the Anti -GBV Act but that has not affected the way we handle cases here".

Solwezi Magistrates' Court Officials

The above example shows that there are differences on how cases are handled between the FTCs and those courts that are still to adopt the system. In the non-FTCs, cases are not even classified as GBV and are treated like any other cases which implies that GBV cases are taking much longer to be resolved by these courts. In comparison, the FTCs are aware of the need to resolve the cases with speed, leading to a high rate of disposal compared to the non FTCs.

A comparison of Fast Track Courts and non-Fast Track Courts:

| Fast Track Courts | Non-Fast Track Courts |
|---|---|
| ✓ Court officials are trained on how to mainstream GBV in their work | ✓ No training as yet and court officials have limited appreciation of GBV issues |
| ✓ Trained magistrates are assigned to handle GBV cases | ✓ Magistrates handle GBV cases as any other case and not accorded priority |
| ✓ GBV cases are classified on their own | ✓ No classification of GBV cases, some treated as mere assault cases |
| ✓ Specific courts are assigned to deal exclusively with GBV cases | ✓ No exclusive courts for GBV, cases handled just like any other cases |
| ✓ At least one of the courts is equipped with CCTV to create a survivor friendly environment when giving evidence | ✓ No equipment for a GBV survivor friendly environment |
| ✓ The target is to finalise cases within 28 days, and the longest case has taken 72 days | ✓ No specific target for GBV cases as the cases are treated as other cases, taking up to two years for cases to be finalized. |

The conclusion of the evaluation is that FTCs are an efficient way of delivering justice for survivors of GBV. The concept of the FTCs therefore needs to be scaled up across the country but with supportive infrastructure (more court rooms) and continuous training of judiciary officers. The concept also needs to be introduced at high court level so that appealed GBV cases or those handled by the high court can be handled with the same level of efficiency as those at the magistrate court level.

Indicator 3: % of customary courts that have adopted provisions of CEDAW

No customary court at baseline had been oriented on CEDAW. The target was to have 60% of the customary courts adopting CEDAW provisions. However, data on the number of customary courts in existence was not available and hence it was difficult to assess the performance of the programme in percentage terms. In absolute terms however, 319 out of a targeted 300 adjudicators were trained on the provisions of CEDAW but it is not clear how many courts these adjudicators represented.

The need to train customary courts was identified after a gap assessment of the adjudication of cases by the local courts conducted by the National Legal Aid Clinic for Women. The Traditional Courts are presided over by Chiefs but are not formally recognized within the judiciary system while the Local Courts are presided over by local courts magistrates who do not necessarily have formal legal qualification but are employed on the basis of their knowledge of customary law. Both courts apply customary law. The assessment sought to establish the extent to which both courts' officials were familiar with the written law in Zambia.

The assessment revealed that:

- ✓ There was generally lack of understanding of written law by presiding officials from both courts
- ✓ There was clear conflict in terms of jurisdiction over cases as there was an overlap in the cases handled by the two courts
- ✓ Customary law is unwritten, and its application varied from community to community
- ✓ The courts were handling some cases such as statutory rape that they were not supposed to handle
- ✓ There was little familiarity amongst the court officials with human rights concepts
- ✓ Judgments were not gender sensitive and were not in alignment with human rights and gender equality standards.

Given the above gaps, a need to train both traditional and local courts adjudicators was identified and a total of 319 were trained on the provisions of CEDAW for them to appreciate and adopt a human rights and gender equality perspective in handling of GBV cases. A training manual was developed and covered aspects on CEDAW, GBV Act, child marriage and issues to do with witchcraft. Zambia Police and University of Zambia also participated in the training.

Interviews with trained adjudicators revealed that the training was considered very useful by both the traditional and local courts adjudicators. Conflicts existed between the traditional and local courts over jurisdiction of cases. The training enabled both courts to understand their adjudication boundaries as well as the need to mainstream gender equality in their adjudication processes. In the box below, a local court officer explains how they benefited from the training:

“We used to have serious conflicts between the local courts and the traditional courts. It was mainly about power and our respective jurisdictions. Chiefs did not understand that the local courts could overturn their judgments, and whenever that happened, that was not acceptable to them. When we were brought together during the training, we discussed the areas of conflict and it brought us to a common understanding of our respective jurisdictions. Chiefs used to grant divorces or handle defilement cases but they learnt that these cases are beyond their jurisdiction. Now we understand where each system starts and ends and we now have a good working relationships with the traditional courts and have not experienced any problem since our training.

In terms of training on GBV, we realized that there were a lot of traditional customs that we did not look at from a GBV and human rights perspective. To be frank, we were actually gender blind. For example, traditionally a woman could not own land after being widowed, but we now cannot enforce such a custom because it is not gender sensitive and a violation of human rights. We have realized that there are some customs, for example the issue of cleansing, that are a violation of the law and human rights and therefore cannot be enforced and should be discarded. The training has enhanced our ability to scrutinize cases in a gender sensitive manner. For example, a month ago a lady came to court wanting to divorce her husband. We realized that the husband she wanted to divorce was her late aunt’s husband whom she had been forced to marry in line with traditional customs. Although the traditional courts had reconciled them, we regarded this as a forced marriage and granted the divorce. In all cases involving violence we grant divorce, whereas previously we would have asked the complainant to go back and try reconciliation”.

Trained Local Court Magistrate, Southern Province

“In this chiefdom, GBV was very prevalent. As a royal council, we were trained on GBV and on how to adjudicate on cases involving GBV. In the past, if a man died, the wife would suffer because all the property would be grabbed by the husband’s relatives. We thought that was part of our customs but we realized after the training that this is a violation of women’s rights. Now property grabbing is a thing of the past. As a royal council we now adjudicate fairly and we were given a manual that guides us in adjudicating difficult cases. We also know that there are some cases, for example defilement, rape and serious assaults that we have no jurisdiction over and these we refer them to the police. And the police and the magistrate’s courts also know that issues to do with land disputes have to be handled by the traditional courts. So many of our traditional leaders have come to the royal council request for this training to be continued because it has really opened our eyes”

FGD with Royal Council, Mukuni Chiefdom

Those trained reported that they now have a better understanding of how to adjudicate GBV cases within a human rights framework. The traditional courts and local courts now appreciate better where their jurisdictions start and end. There is also a better understanding of provisions of the Anti-GBV Act and the realisation that adjudication has to be in alignment with the laws of the country. Provincial Local Court Officers monitor the adjudication of cases by district courts to ensure that the judgements are gender sensitive and in line with the written law.

Lack of adequate resources remains a key challenge in the monitoring of traditional and local courts. Although the Provincial Courts were trained so that they could roll out the training to their junior offices in the districts they preside over, they have not been able to do so because of inadequate resources. The Provincial local court office in Southern Province for example, has no vehicle or adequate resources to monitor the work of district local courts let alone train them.

Outcome 3: Survivors of GBV have increased access to protection and support services and economic empowerment activities

Under this outcome, GBV survivors were expected to have increased access to protection and support services through strengthened institutions such as the police, health centres, One Stop Centres, community networks, NGOs and other participating partners. The following were indicators for this outcome.

Indicator 1: % of GBV survivors in targeted districts that have been housed in shelters while handling their cases (proxy number instead of %)

Secured shelter is one of the key protection needs for GBV survivors. After reporting cases, survivors need safe places where they can stay while their cases are being finalized. Lack of safe shelter has been identified as one of the reasons for the high withdrawal of GBV cases at both police and court levels by GBV survivors and the police interviewed during the evaluation.

Without alternative accommodation, GBV survivors are forced to go back and live under one roof with the perpetrator, which puts the survivor under increased risk of further GBV or forces the survivor to withdraw their case from the police. The programme strengthened already existing ones to take care of the protection needs of survivors. To sustainably address this issue, the programme under outcome 2 helped the Judiciary to develop protection orders.

At baseline a total of 410 GBV survivors were being sheltered in safe houses and the programme target was to ensure that 1,000 GBV survivors would have been housed in safe shelters by the end of the programme in the targeted districts. By the time of the final evaluation, 1,676 GBV survivors had been assisted with shelter, which is 168% target achievement. Although the programme target has been reached, there is still limited space in the available safe houses and the safe houses cannot accommodate all those GBV survivors in need. Shelters visited in Chipata, Solwezi and Maheba during the evaluation provided some useful insights on the role that safe shelters play in the lives of GBV survivors.

Chipata YWCA Safe House

A safe house in Chipata run by YWCA was visited during the evaluation. The safe house had four occupants: an elderly lady in her 60s who had been evicted by her husband from a farm they bought together with her husband and her daughter in her late 30s who had a five year old son. There were also two other girls (one around 16 years and another around 7 years) who were survivors of abuse. The survivors narrated their stories that resulted in their stay at the shelter.

“We are very grateful to YWCA for bringing us to this shelter. After my husband forcibly evicted me and my children from the farm, we were desperate, I did not know where to go with my children because my husband chased me out of our matrimonial home. We did not expect that one day someone would look after us, and give us a home. We feel very welcome here, very comfortable and safe. We were given food and blankets and we cook as a family and we feel like human beings once again. I don’t know where we would be today had it not been of the assistance we got from YWCA.

Elderly GBV survivor at the YWCA shelter in Chipata

Safe shelters provide security to GBV survivors and enables them to pursue their cases in an environment with professional counsellors who will meet both their material and psychological needs. At the safe houses, trained counsellors document each GBV case through an established case management system that enables one to track the stages through which the case is going through and the ultimate outcome of the case. Managers at the safe houses continually liaise and make follow up with the police and the courts to ensure that the cases remain alive until the justice process is completed. GBV survivors sheltered at the safe houses have therefore a high chance of having justice delivered in their cases because of committed teams at the safe houses who will pursue the cases on their behalf. With support from the safe houses, children are able to continue with school while their cases are being handled. This enables the children to be re-integrated with other children in an environment of comfort and safety. Survivors are also supported in preparing for court cases.

It must be noted though that the limited number of shelters, which offer temporary sanctuary to GBV victims, was affecting progression to scaling up access to protection and support services. Apart from the constraints on number of shelters, site visits revealed that the shelters were only admitting women leaving out men and young boys who are also victims of GBV. In Chipata, it was reported that due to lack of such facilities, young male GBV survivors were kept in prison.

Indicator 2: % of GBV survivors that have received support from an institution while pursuing their cases.

An analysis of the results framework revealed that survivors of GBV had improved access to protection and support services. There were indications that survivors were receiving more support from established institutions while pursuing their cases as illustrated in the results framework. Baseline data showed that only 11% of the survivors were linking up with established institutions and by end of 2016, this figure had risen to 30%. Support to GBV survivors was provided through the following institutions.

Hospital Based-One Stop Centers

A total of 4 Ones Stop Centres (OSCs) were established or strengthened by the programme to provide key support services to GBV survivors under one roof. The main rationale for establishing or supporting the concept of OSCs was to bring all critical GBV services under one roof so that GBV survivors could be attended to in a timely and efficient manner. In a typical OSC, services offered under one roof include the following:

- ✓ *Police Services*-a VSU police officer is stationed at the OSC to record all GBV cases reported at the OSC and to fill out the incident form. The police officer will then collect all the evidence, including the medical report, and prepare the case for submission to the courts for prosecution
- ✓ *Health Services*- a nurse provides health services such as rapid HIV testing, Post Exposure Prophylaxis (PEP) for survivors that have been sexually abused but have been found HIV negative, emergency contraceptives and treatment of physical wounds. A doctor will then compile a medical report and specimens will be send to laboratories for testing. The medical report is key in prosecuting GBV perpetrators.
- ✓ *Counselling Services*-trained counselors at the OSC provide psychosocial counselling to the survivors to enable them to better handle the trauma that they would have gone through. Programme for counselling will be drawn for each survivor according to their identified needs.
- ✓ *Para-legal services*- trained paralegals at the OSCs provide legal advice to GBV survivors on how to pursue their cases from a legal perspective.
- ✓ *Referring to Safe Shelter*- where there are safe shelters, the survivors are referred to safe houses according to need.

Interlocutors were asked to rate the effectiveness and performance of the hospital based OSC in offering comprehensive and effective GBV survivor friendly services. The following table summarises the views of the interlocutors.

Assessment of OSCs

| Advantages/ Effectiveness of OSCs | Challenges with OSCs |
|---|---|
| <p>✓ GBV services are brought under one roof, which is cost effective for the survivors in terms of time, transport costs etc . Survivors no longer need to travel from one institution to the other in search of services</p> | <p>✚ OSCs are located centrally in districts and the centers are not easily accessible by survivors located in far away places. Transport costs were cited as the major inhibition cost.</p> |
| <p>✓ Trained personnel in the OSCs were viewed generally to be friendly and to be offering comprehensive services by GBV survivors</p> | <p>✚ Some of the OSCs are partly run by volunteers who are in turn supported by development partners. Once allowances for the volunteers stop coming, some volunteers stop coming altogether or come inconsistently. E.g OSC in Kasama had at one point ZPCT volunteers who provided counselling services but when the programme ended all the volunteers withdrew their services. Another OSC at Mazabuka supported by World Vision collapsed soon after the NGO pulled out. Challenges of sustainability.</p> |
| <p>✓ Services under one roof ensures prompt offering of services as service provision is well coordinated because the providers are all under one roof. It also reduces the security risk because survivors do not need to move from one institution to the other where they risk being waylaid by the abusers.</p> | <p>✚ At some OSCs, e.g Kasama, government employees such as Doctor, Nurse, Police and coordinator were given allowances by UNICEF as incentives. It is not certain that the level of commitment will remain the same when those allowances are no longer available. A OSC in Livingstone almost stopped being functional after the allowances were stopped as the police and nurses withdrew and went back to their work places.</p> |
| <p>✓ Confidentiality is guaranteed as there are specific rooms for counselling in private and some of the hospital based OSC are ideally located in infrastructure that can be accessed conveniently without going through the main hospital entrance.</p> | <p>✚ OSCs not fully integrated into the Ministry of Health planning and financing structures. In some cases OSCs not viewed as part of the hospital system.</p> <ul style="list-style-type: none"> • <i>“I cant use the hospital budget to support activities in the OSC at this hospital, because the centre has not been taken into account in our planning and budgeting process”</i> (Medical Superintendent at a hospital with a OSC). |
| <p>✓ OSCs have conducted community awareness programmes on GBV which has improved awareness on service provision by the communities. There has generally been an increase in people reporting to the OSCs because of increased awareness.</p> | <p>✚ Other OSCs such as Mporokoso still located inside the main hospital building and hence issues of confidentiality and anonymity are compromised. The OSC also has limited number of rooms for counseling.</p> |

| | |
|--|--|
| | <ul style="list-style-type: none"> ✚ Transport and fuel challenges which cause some cases to be attended to late. This has led to some perpetrators managing to escape before being apprehended, evidence being destroyed and some sexually abused survivors not meeting the 72 hours deadline for PEP. The Mporokoso OSC estimated that about 70% of the cases were being lost because they were not being followed up on because of lack of transport. The community networks have not been provided with bicycles and cell phones for communication as in other programme areas. |
| | <ul style="list-style-type: none"> ✚ High staff turnover which calls for continuous training of OSC staff. |
| | <ul style="list-style-type: none"> ✚ Late disbursement of funds at some of the OSCs affected implementation of planned activities, particularly community awareness activities |

The evaluation established that OSCs are an effective and efficient way of offering GBV services to survivors. Survivors who participated in FGDs acknowledged that OSCs provide an efficient and convenient service, as indicated in the narrative below.

Before the establishment of the OSCs, most GBV victims were reluctant to report their cases to the police or at hospitals. You would spend more than 5 days before the medical report was signed by the doctor and that means GBV survivors had to stay for those days at the hospital incurring expenses, which the majority of survivors cannot afford. Doctors would tell you that they are overwhelmed and will ask you to go to another doctor, and they would keep on referring you to each other. These days after the training and the establishment of OSCs, its just one call and the doctor will come straight away.

OSC Staff, Kasama

OSCs are highly effective in high resource settings. The centres are costly to set up and need financial and human resource support to achieve maximum effectiveness. The issues of sustainability however need to be addressed adequately through full integration of the OSCs into the Ministry of Health planning and budgetary framework and inclusion of the OSC concept in the curriculum training of service providers so that OSC services are viewed as part of the normal duties of the service providers rather than viewed as an extra load that needs incentives.



Evaluation team with OSC staff at Kasama (left) and Solwezi (right)

Village-Based One Stop Centers and Community and Men’s Networks

The Village Based One Stop Centres (VBOSC) were an innovative initiation of the GBV Joint Programme. After the realization that it was costly to develop and support 72 hospital based OSCs in each district in the country because of the high costs involved, the concept of the VBOSC was developed. These are community based OSCs that provide mainly referral, counselling and para-legal services to GBV survivors. Community members are trained to offer these GBV services and at each VBOSC there are counselors, para-legals, neighborhood watch committees who are linked to the police and community and men’s networks that are mainly responsible for GBV awareness raising in their respective communities. People who were trained to offer services included traditional leaders such as ndunas, headmen and village heads, local teachers, neighborhood watch committee members, health workers and local church members. The teams comprise diverse people with experience and expertise in different areas.

Some of the infrastructure for the VBOSCs were donated by chiefs while in some cases the buildings are being leased from community owners by the programme. Some chiefs, for example in Misolo village, have donated pieces of land where the VBOSC infrastructure will be constructed with communities providing labour and other locally available resources and the programme supporting with the designs for the infrastructure and other material that cannot be sources locally. In centers such as Misolo, the programme provided materials such as computers, bicycles and cellphones for the community network members who supported the running of the VBOSC.

Community one stop centres and community men’s networks were providing valuable protection and support services by way of sensitizing the community and referring GBV cases to established institutions. Unlike the centres located in hospitals, community one stop centres offer only psychosocial and paralegal services. Victims are then referred to the nearest police station and health facility. Interviews with members of community networks, community one-stop center volunteers, and communities as well as institutions they partner with revealed that these were determined and committed members of society who were filling in the gap in the absence of “formal” institutions. Their collaboration with respective chiefs and village heads had led to the recognition of their role in society to the extent that they were able to apprehend perpetrators on behalf of the police. Some community networks were utilizing their own resources to contact the police, ferry victims to health centres and they facilitated mediation in family disagreements which had the potential to lead to GBV. The observation of this assessment was that these

community structures were also bringing social cohesion among communities. For instance, one of the men's networks in Chipata, Eastern province had formed a parallel female network after observing that they could not deal with some of the sensitive cases, such as rape or defilement involving women due to traditional undertones. The women's network has added more responsibilities to itself by undertaking sensitization with the men to schools and nearby villages and communities.



Misolo (left) and Kalindawalo (right) Village Based OSCs visited by the evaluation team

The evaluation established that VBOSC were very effective in disseminating information on GBV, tracking cases of abuse and reporting the cases to the police and making referrals for GBV survivors to appropriate institutions for services. FGDs with communities served by VBOSC revealed a high level of awareness of GBV issues, including forms of GBV, cause and what the law says on GBV. The following box contains some direct quotations from communities that participated in FGDs.

“I did not know that not providing for my family is a form of GBV, but after awareness I now know that it is GBV. After harvesting and selling our produce, I used to take all the money and spend it on other women and whenever my wife asked about it that always sparked GBV. After going through counselling at the VBOSC, I realized that what I was doing was wrong and have since changed to become a role model. I used to be an abuser, now I am a role model and I move around educating other men about how bad GBV is and how it destroys family fabric”

Former Male GBV Perpetrator, Misolo,

“Before the training and establishment of VBOSC, this place was very notorious for GBV. People would just insult each other and even resort to violence over very small issues. Teachers at our local school did not last because they always sought transfers after being subjected to different

forms of violence. The training really opened our eyes. We did not know that marrying off young girls was an offence. Whenever a child got pregnant in this village, they were pushed into marriage. We have since realized that this is wrong and an offence”

FGD Participants, Misolo Village

“I had married off my daughter, not knowing that this is a form of GBV, but after awareness I went and retrieved her and now she is back in school. Whenever I preach against GBV, people now believe in me because I have done the right thing that needs to be done. I led by example by bringing back my daughter to school”.

Mother, during FGD, Misolo Village

“We used to think that being beaten by your husband is normal, but we have now realized that it is a form of abuse that must be reported to the police”

FGD, Pwata

“Before the programme, we used to have around 20 cases of GBV per year in block A, but after sensitization through our network, we have only recorded 3 cases between 2016 and 2017. Most of the cases were child marriages and defilements, and we addressed women who traditionally trained young girls on how to handle men in this community to stop it as it was fueling defilement and early pregnancies. Once the girls go through this training they look forward to having sex and getting married. The practice has since stopped and hence the reduction in early marriages and child pregnancies.

Community Network (Maheba)

The evaluation noted that VBOSC offered several advantages in terms of offering GBV services and creating awareness. Some of the advantages are articulated below:

- ✓ VBOSCs are community based and therefore can be established in remote areas that are not easily accessed by the hospital based OSCs. The VBOSCs therefore offer services in needy areas with limited coverage from centrally located GBV service providers. There is however need for the hospital based OSCs to have oversight of the VBOSCs to ensure adherence GBV service provision protocol and standards.
- ✓ VBOSC are easily accessible to the local communities in urgent need of GBV services. Their easy accessibility compared to the hospital based OSCs located at district level eliminates access barriers such as transport and time as these centres are located within the communities. However, where health services are need, the transport and time barriers come into play as the survivors would need to access Hospital based OSCs which are centrally located.
- ✓ The village based institutions are made up of people who know each other and thus understand better the context of some of the disputes. This enables the communities to have more effective influence on perpetrators. However, familiarity can also bring in issues of bias or pre-conceived prejudices that may compromise the handling of cases.
- ✓ The VBOSCs structures are a symbol of community ethos against GBV within the respective communities. *“When people pass through this OSC, the building always*

reminds them of the community commitment to fighting GBV”, noted the Secretary of Misolo Village OSC.

Compared to hospital based OSCs, the VBOSC are a cost-effective way of offering some GBV services to communities. The concept needs to be scaled-up particularly in hard to reach areas where communities are located far away from the hospital based OSCs. For sustainability, legitimacy and ownership, the VBOSCs need to be linked to the OSAWE programme and entrepreneurship training so that the networks running the centres can generate income that can be used to support GBV survivors with needs such as transport and communication. The fact that the VBOSCs are modelled around chiefs/traditional leaders who wield power and respect in their respective communities makes the prospects of sustainability higher. Even without physical infrastructure in place, the concept of VBOSC can be promoted, where resources are limiting, through the establishment of community networks similar to the one created in Pwata. The networks provided all the services provided by the VBOSC even though they do not have a physical structure similar to the one in Misolo.



A member of the community network in Misolo showing the bicycles and cell phones provided by the programme to support their work (left) and computers and printer in the Village Based OSC (right).

The major drawback however with the VBOSCs is that they are unable to offer health services because these need to be provided by technically skilled personnel such as nurses and doctors who are not available at every village. The fact that all the other services are however provided at the VBOSC provides an important initial step for GBV survivors. In any case not all cases would need to be referred further and some might be successfully resolved at the VBOSC and hence only critical cases would need to be referred to the next level. This lessens the burden on the district based service providers as they are left to deal with only critical cases warranting referral. The role of the OSCs in creating awareness has also been found to be critical and complementary to that of the district level service providers.

Indicator 3: % of reported GBV cases that have been withdrawn from court proceedings.

Withdrawal of cases from court proceedings has been rampant in Zambia. The programme expectation was that as community awareness of GBV and related services increases through sensitization programmes and through the provision of paralegal services offered in the one stop

centers and that as more GBV survivors participated in economic empowerment programmes which provides them with survival options after the arrest and imprisonment of the perpetrator, there would be a reduction in the number of cases withdrawn from court proceedings. In the results framework there is no programme target provided. However according to police records, 4.3% of reported cases were withdrawn at court level in 2012 and this decreased to 2.3% by 2016.

Although there has been a decrease in the number of cases withdrawn at court level, the opposite has been happening at police level. The proportion of reported cases withdrawn at police level is much higher and it increased from 36% in 2012 to 49% in 2016. The fact that almost half of all the reported cases are being withdrawn at police level begs for interrogation. There is need to understand the reasons for the high rate of case withdrawals and the fate of those GBV survivors who withdraw their cases. Research on this is recommended for the programme.

Indicator 4: % of GBV survivors trained in entrepreneurship and business management

Out of a baseline of 350, results point to the fact that a total of 5,725 survivors received training in entrepreneurship management to cushion themselves from economic hardships. The training, which was conducted by IPs using ILO modules and tools covered topics such as Gender and Entrepreneurship Together (GET) Ahead for women in enterprises, Start Your Business, Improve Your Business, Improve Your Exhibition Skills and Financial Literacy. This performance was above target (4,500) and was attributed to concerted efforts among the various stakeholders that were working on this activity. Some of those who were trained started their own businesses and formed saving groups. Alliance of Youth Entrepreneurs (AYE), one of the IPs in partnership with ILO, did a survey before and after the training of GBV survivors and noted that before the training three quarters of the survivors did not have bank accounts nor registered businesses. After the training, the survivors managed to open bank accounts, and 60% managed to identify specific business opportunities which they pursued. At baseline only 150 GBV survivors were engaged in an income generating activity but by the time of the evaluation 2,446 survivors were engaged in an income generating activity, surpassing the programme target of 1,000 survivors. A total of 1,526 out of a programme target of 1,200 were referred to financial institutions by the programme but the majority failed to access loans due to stringent conditions applied by financial institutions for one to access loans. Most turned to OSAWE groups for start-up capital.

Although a strategy is still being developed by the programme to track income generating projects of GBV survivors, this assessment observed that most of the saving groups had performed well, enabling members to borrow and expand their business or diversify. When sharing their experiences, members of these savings groups stated that being part of the savings group was liberating and that the economic independence they were enjoying had changed the dynamics in their homes as their spouses no longer abused them. In the following box, some of the voices of GBV survivors were captured during FGDs.

“In this group we are all survivors of GBV and we all had gone to YWCA for help. We were later called by YWCA to come and attend a training workshop where we were taught how to form our own businesses. We were also encouraged to form our own savings groups, which we did on 26

June 2016. We meet every Monday where each member contributes a minimum of K5, depending on ability. A member can then borrow up to three times her contribution. We then pay back the loan at 25% interest after contributing for 3 months. With the money we borrow from the group our members have started small grocery shops, stone crushing business and buying and selling. In 6 months we have had total savings of K5, 479.

We have also started a social fund and we contribute each 50 ngwee every week. We use this fund in times of need, say for funerals or hospital fees or for parties to celebrate our successes as a group. We are now more a family than just a savings group”.

FGD with OSAWE Group, Livingstone

“My issue with my husband was economic GBV. He never used to leave any money home and I used to scrounge around for food and whenever you asked him for money, he would turn violent. Now that I have got money of my own, he also leaves money home for groceries. And what he leaves home I invest in my business. Maybe he was punishing me for not contributing anything. It feels good to have your own money. My husband now respects me”

GBV Survivor and member of the OSAWE Group, Livingstone

My husband used to abuse me on a daily basis because he was alcoholic. My neighbor, who had been to YWCA before referred me to the organization for assistance. My husband was called to YWCA for counselling and he was very scared that he was going to be arrested. I was later called for training and after training we formed our own savings group.

After I joined the OSAWE groups and started doing my own small business and bringing income home, there is now happiness in the home. My husband does not beat me anymore, he respects me and consults me in decision making. After the counselling we got, he has not slapped me since 2013. Nowadays men do not want women who do not work. My husband is now fond of saying “we are together till death do us part, after all I have spoiled your face through beating you”

GBV Survivor, Livingstone

There is so much optimism among survivors. Such optimism is often dismissed considering the ‘low scale’ nature of the businesses that these women are often involved in. A visit to their stalls in the market showed that most of them sell the same commodities, mostly perishables. There is little diversification in their businesses, meaning any slight risk would tip them backwards. However, these low scale businesses mean a lot to these marginalized women considering where they were before they started participating in the OSAWE groups. One expert from ILO noted that,

“ .. for a poor person, any movement from having nothing to having even a little thing as bread is growth. We recognize that to be a success and that is why some of our training modules help survivors who believe they have nothing, to identify that they have assets even in the form of a ripped dress that they can turn into a door mat and sell”.

The refugee and migrant communities were also supported by the programme to embark on income generating activities. Through the GBV Empowerment Fund, the programme supported the training of refugees and migrant communities in entrepreneurship skills before supporting them with start-up capital. Some of the supported beneficiaries visited during the evaluation were involved in small scale business enterprises such as selling of fish, charcoal, groceries such as cooking oil. The beneficiaries were supported with an average of K1,000 as startup capital which they were supposed to pay back into a revolving fund for the next group of beneficiaries to benefit from. With the profits from their business activities, the beneficiaries are able to send their children to school and meet some of their household needs such as food.



GBV survivors supported by the programme to start income generating projects in Livingstone (left) and in Maheba (right) showing their wares.

Despite the overall success of the entrepreneurship training, a number of challenges were encountered in this component of the programme. These include limited access to loans from the banks, failure of some OSAWE groups because of a lack of group cohesion and high mobility of some of the trained youth participants. A few of the women were withdrawn from the groups by their husbands. These challenges need to be addressed in the remaining part of the programme for improved impact.

Outcome 4: MGCD has coordinated an effective, evidence based and multi-sectoral response to GBV in Zambia.

One of the key outcome areas of the Joint GBV programme is to improve the Ministry of Gender's capacity to coordinate GBV work in Zambia. Given the multiplicity of partners working in different sectors, the success of the programme in terms of results would only be guaranteed through effective multi-sectoral coordination of the programme. A number of measures were put in place to improve the coordination capacity of the Ministry of Gender. A Programme Management Steering Committee was set to provide supervisory and technical guidance for effective programme implementation. The Steering Committee comprised Permanent Secretaries of all implementing ministries, the UN Resident Coordinator and a representative from the NGOs. Ant

GBV committees were also set up at National, Provincial and District Levels to coordinate GBV interventions at their respective levels.

The evaluation concluded that coordination of the programme has largely been effective as evidenced by achievement of both the output and outcome results. Interviews with members of the Anti-GBV Taskforces revealed that the teams met regularly at all levels, had a clear understanding of their roles as stipulated in their Terms of Reference and were taking leading roles in coordinating GBV activities in their respective areas. The Anti-GBV Taskforces have filled in the gap left by the absence of the Ministry of Gender at provincial and district levels.

At national level, the appointment of a Programme Coordinator helped in increasing the effectiveness of programme coordination as a number of coordination challenges were experienced in the early stages of programme implementation. Reporting and implementation of activities improved after a coordinator was appointed by the Ministry of Gender and UNDP. There were however some coordination challenges that were noted during the evaluation, particularly at district level. In Petauke and Maheba, for example, the Anti-GBV taskforces were finding it difficult to get GBV statistics from the police VSU despite the fact that the VSU was part of the taskforces. Police cited security reasons for not divulging the GBV statistics. This makes it difficult for the taskforce to have a clearer picture of the magnitude of GBV in the district and this is an area that needs to be improved on. The programme also provided support towards development of an electronic database for victim related offences including GBV for Zambia police. This database will improve data management and enhance availability of records on GBV nationally.

The following were Outcome 4 indicators on coordination.

Indicator 1 : % of GBV survivors that have been referred among State and Non-State Actors providing support and protections services while pursuing their cases.

The baseline value for this indicator was 10% and the programme target was 60%. No data on this indicator was available during the evaluation. However, output indicator level data discussed in preceding sections of this report show that GBV survivors were being referred to VBOSCs, Hospital based OSCs, men's and community networks, the police and the courts through a referral pathway that has been clearly defined for the programme stakeholders. The referral system was noted to be functional and generally effective, signifying effective coordination of the multi-sectoral partners.

Indicator 2: % of state and non-state partners participating in the implementation of the Anti-GBV act that are complying with guidelines.

The programme target was to have all (100%) state and non-state partners implementing the Anti-GBV Act complying with GBV guidelines. By December 2016, 90% of the target had been achieved. The training of stakeholders on GBV Management guidelines has helped to ensure

that the majority of both state and non-state actors are implementing components of the Anti-GBV Act in compliance with the guidelines. Interviews with health workers, police, counsellors and paralegals showed that they were adhering to the GBV management guidelines.

Output 4. Amount of resources (cash and in-kind) leveraged from State and non-State partners participating in the implementation of the programme

To promote ownership and sustainability of the programme, state and non-state actors were expected by the end of the programme to contribute 25% of the total programme costs in both cash and in kind. The government has not directly injected financial resources into the programme but has contributed in kind mainly in terms of infrastructure and staff costs. This contribution in kind has however not been quantified.

3.4.3 UNINTENDED RESULTS OF THE PROGRAMME

The evaluation identified the following un-intended or unplanned results of the programme.

a) Village Based One Stop Centres

One unplanned outcome of the VBOSCs has been that the centres have become social centres where people in the community come even for non-GBV dispute resolutions including credit and land related issues. The credibility of the OSCs has been enhanced by the training that the community networks have received, which in the eyes of the community makes them good counsellors and fair adjudicators. Community members are also coalescing around these centres for socialization where GBV messages are shared through video screening using the IT equipment that was provided by the programme to the VBOSCs. Some of the community members are also learning how to use computers at the centres

b) OSAWA Group Social Capital

Survivors of GBV that were trained on entrepreneurial skills and formed savings and lending groups have transformed some of these groups to become social safety nets and support groups beyond the saving and lending mandate that the groups were established for. Group members, for example in Livingstone, contribute towards a social fund which is used for funerals, health care expenses, weddings and even parties for any one of the group members. This has enabled the group members to increase their social capital as they can rely on each other in times of need or when calamity befalls one of the group members. This was noted to be a positive unintended outcome of the programme.

c) Innovativeness of the Men's Groups

Men's networks, for example in Pwata, have coopted women to become part of the anti-GBV crusade so that the women could provide support services to other women and girls. The Men's network noted that,

"Although originally we were supposed to be a men's network only, we decided that we needed to include women in our group so that they can communicate better with other women and girls. When a girl or a woman has experienced GBV, its easier for her to tell her problem to another woman or girl than to a man and hence it was only logical to expand our group to also include women. We are working together very well although we are still referred to as a Men's Network"

The evaluation established that the men and women in Pwata complement each other very well and coordinate their reporting.

3.5 PROGRAMME EFFICIENCY

The evaluation assessed the extent to which the programme's outputs were efficiently delivered during implementation.

Implementation of programme activities

The implementation of programme activities was delayed at the start of the programme. The delays in programme start-up were caused by deferment in signing of the programme document. The document was eventually signed in July 2012 instead of the envisaged May 2012. The delay was partly a result of high turnover of permanent secretaries in the Ministry of Gender and Child Development and partly because of signing of the wrong programme document by the UNDP Country office of the Administrative Agent which required that the document be redone. Funds were only received in July 2013, resulting in partners not managing to implement some of their planned activities for that particular year and funds were rolled over to 2014. The request for a one year no-cost extension of the programme was to compensate for the delays that were experienced in the first year of programme implementation. Despite the initial delays, the programme managed however to make commendable progress towards the achievement of its output targets and outcomes. Most of the outstanding targets are most likely to be achieved during the one-year no cost extension period.

Budget execution

The planned budget for the programme amounts to USD 15 570 000. When designing the programme, the budget was divided according to the four outcomes: Health USD 2, 295, 000; Legal USD 4, 905, 000; Social Protection and Economic Empowerment USD 5, 848, 000 and Coordination USD 2, 355, 000. The programme document also presented budget figures for each activity per year. This gave an indication on how funds were spent during implementation. Detailed budgets and activities for each year were processed and approved during annual

meetings where work plans and budgets for each UN-agency were jointly presented and approved by the Ministry of Gender.

Total funds received (cumulative) by end of December 2015 by partners amounted to USD 9,192,071, and USD 8,605,482 was transferred to the six participating UN organizations, of which USD 7,097,213 was reported as expenditure. The Administrative Agent fee has been charged at the approved rate of 1% on deposits and amounts to USD 91,808. The total use of funds by end of 2015 amounts to USD 8,697,563. The balance with participating organisations at the end of 2015 was USD 1,508,269. This gives an overall fund expenditure delivery rate of 82 percent.

In terms of budget execution per year, for 2013 USD 5, 104, 633 was received and the total expenditure was USD 3, 600, 575 (or 70.5% of budget) ; for 2014 USD 2, 698, 524 was disbursed and total expenditure was USD 1, 528, 857 (57%) ; for 2015 USD 1, 388, 915 was received and the total expenditure was USD 3, 568, 132 (257%). The numbers show that budget execution was slow in the beginning of the programme but did accelerate closer to the end, again showing that the programme did struggle with some delays in its start up.

An analysis of budget allocation by UN agency shows that UNDP and UNICEF received the largest allocations of above USD 2 million. The table below shows budget expenditure patterns by UN agencies using the latest available financial data at the time of the evaluation.

| | | |
|--------|---------------|-----|
| ILO | USD 947,439 | 81% |
| IOM | USD 1,156,892 | 58% |
| UNDP | USD 2,681,709 | 96% |
| UNFPA | USD 1,000,440 | 67% |
| UNICEF | USD 2,276,481 | 85% |
| WHO | USD 542,521 | 84% |

The UN agencies are on course towards complete budget utilization although some agencies such as IOM and UNFPA are trailing at 58% and 67% budget utilisation respectively.

Disbursements

Disbursements of funds from UNDP HQ to UN agencies was noted by UN staff to have been timely save for the initial delays experienced during the project start-up phase. There were some delays experienced in disbursement of funds to implementing partners by some UN agencies. These delays were caused partly by some implementing partners incorrectly completing acquittal forms thereby delaying the disbursement process and partly by internal bureaucracies and administrative procedures of some UN agencies. Different reporting requirements between agencies caused complications which at times caused delays and frustrations amongst partners. With some agencies funding gets disbursed when you have exhausted 70% of your previous budget while for others funding was disbursed after completely exhausting the previous budget. With the later arrangements, gaps were created in the implementation process because of the

time lag experience between the exhaustion of the previous budget and the application and release of the next budget. There were also quality assurance concerns and before further funds were disbursed, field monitoring was undertaken to follow up on any concerns. This led to some delays and changes in modalities. These disbursement delays caused late implementation of some of the planned programme activities such as community awareness activities of some One Stop Centers in programme areas such as Mporokoso and Kasama.

Efficiency of Financial Resource Use

The following table shows the budget lines of the programme

| | |
|---|--------|
| Staff and Personnel Cost | 7,26% |
| Supplies, Commodities and Materials | 4,13% |
| Equipment, Vehicles, Furniture and Depreciation | 12,19% |
| Contractual Services | 17,36% |
| Travel | 17,28% |
| Transfers and Grants | 23,35% |
| General Operating | 18,44% |

Staff and personnel costs were reasonably pegged at 7.26% of the programme budget, while the other portion of the budget went to equipment, transfers and grants and suppliers which benefited the direct beneficiaries indirectly and directly.

Accountability, Economy and Efficiency of Resource use

The evaluation established that programme partners consistently upheld the principles of economy and efficient use of programme finance by applying stringent procurement procedures based on competitive technical and financial bidding for all goods and services. Implementing partners could only receive the next disbursement after acquitting transparently use of the previous disbursement. Although this process caused some delays, it ensured transparency and accountability in the utilisation of programme funds. Some agencies such as WHO conducted workshops in their board rooms instead of hotels to minimize on costs.

Flexibility of Budget Re-allocations

Allowing flexibility in budget adjustments/re-allocations within programme activities has helped the programme to respond and adjust to realities on the ground. For example, after realizing that it was not realistic to establish 72 hospital-based OSCs across all the districts because it was beyond the financial capacity of the programme to do so, the programme redirected the budgeted resources to innovatively pilot the concept of village based OSCs. The VBOSC have been found to be very effective in offering GBV services at village level.

Reporting, Monitoring and Evaluation

Partners were required to submit quarterly reports, which allowed for monitoring of achievements against targets. Furthermore, periodic field visits were conducted by the UN Joint Programme. Field monitoring visits were also conducted by the cooperating partners to observe

first hand in the field the programme results and challenges. Efficient M&E was however compromised by the lack of a dedicated M&E specialist for the project as originally provided for in the programme document, lack of a baseline and MTR, which were not conducted in line with the programme plan of implementation.

Challenges in data flow at district level were noted during the evaluation. In Petauke for example, the District Anti-GBV Taskforce had challenges in getting statistics from the police VSU despite the fact that the police were part of the taskforce. Police cited security reasons for not divulging GBV statistics. Improved coordination is needed in this regard at district level.

In some districts, monitoring of activities by implementing partners was noted to be weak. At one school visited during the evaluation, the mentor teachers that had been trained and were running the safe places clubs, had not been monitored ever since the implementing partner trained them. The teachers expressed concern that the implementing partner has not come back to see the work they are doing and the outcomes. Such monitoring visits motivate these teachers to continue with their work because they will know that their work is being appreciated.

3.6 MAINSTREAMING OF CROSS CUTTING ISSUES

According to the programme document, the following cross cutting issues were to be integrated in the programme design and implementation: HIV; Youth; Women's empowerment; and Women and Children with disabilities. Below is a brief on how the programme fared:

HIV and AID

A review of the design showed that the programme planned to incorporate HIV and AIDS messages and provide emergency medical examination and treatment for survivors including the provision of post-exposure prophylaxis for HIV and emergency contraception. Implementation results revealed that the programme endeavored to undertake these interventions. Firstly, one of the key pillars of the GBV programme was Health and it was in this component that HIV matters were addressed. Sensitization on HIV was undertaken at the community level mostly through community networks. Community networks that comprised the men's networks were trained on GBV/STI/HIV matters and this was in line with the manuals that UNFPA had developed on behalf of the GBV Joint Programme partners. Post-exposure prophylaxis for HIV and emergency contraception were administered through the One Stop Centres as per MoH guidelines that they can only be administered in a health facility. Some survivors were not able to access this service due to delayed arrival to medical facilities mainly caused by lack of transportation , distance and cost of transportation to the nearest OSC which is housed in the health facility.

Youth

According to the programme design, youth were going to be targeted especially for GBV awareness and prevention since they were still in the process of forming attitudes and beliefs about gender norms and violence. Conclusion was made that it was easier to change norms and

attitudes about gender equity and GBV among youth than among older women and men. The programme also stated the “urgent need to improve the institutional response to girls and young women who experience violence-particularly sexual violence”.

Results of this assessment highlight the fact that the joint programme, through the Safe Spaces initiative, undertook sensitization activities in schools mainly through the boys and girls clubs. Interactions with members of these clubs showed that their way of thinking on human rights and equal treatment of boys and girls had taken a sharp turn. This was remarkable considering that these children were being raised in a patriarchal society where violence, especially against women, was an accepted norm. Approximately 17,000 young people aged 10 - 24 years were reached with information on GBV and how it negatively impacts on young peoples’ health including unintended pregnancies, HIV, fistula, and maternal mortality. The box below describes the activities and outcomes of the Safe Spaces Club at one of the secondary schools that participated in the programme.

We formed our clubs in 2016 with support from our teachers and FAWEZA. The objective of the club was to provide a platform for us students to learn and be able to teach others about GBV, its causes and forms, children’s rights and other related issues. We meet three times a week after lessons and discuss topics such as GBV (types, causes, how to stop GBV); teenage pregnancies; early marriages; child abuse; HIV and AIDs and STIs; sex and sexuality; school dropouts; and stigma and discrimination amongst other topics. In terms of GBV, we have learnt that there are several forms, including physical, psychological, sexual and verbal GBV. We have come to realize through the education we have received that GBV is prevalent in our communities.

We try to create awareness through drama, poems and debates. We do the poems and drama during assembly time to create awareness amongst our fellow students. This has been very useful because we have had cases of girls coming to report to us about teachers that are proposing to them and we have in turn reported this to the school authorities. We have also our fellow students who develop STIs coming to us and we have counseled them and referred them to clinics. The level of awareness of GBV issues at the school is now very high, students know their rights and they can recognize GBV when they see it. Our wish is that if we can have the opportunity go to other schools to preform our drama and poetry so that we also create awareness in these schools. Even when we go to our respective communities during holidays, our members have reported a number child abuse cases they noted to the police.

FGD with students participating in the Safe Spaces initiative, Petauke, Eastern Province

The level of awareness of GBV and child rights issues was found to be very high amongst school children and the youth that participated in the Safe Spaces programme. They could easily articulate GBV issues and types of human rights violations and above all they were taking proactive action to prevent occurrence of GBV through awareness creation and reporting suspected cases of GBV amongst children.

The programme went even further by involving young GBV survivors in economic empowerment programmes. One of the Implementing Partners under ILO was the Alliance for Young Entrepreneurs (AYE) and this engagement allowed for the identification of young survivors who

eventually benefitted from the trainings and later as members of OSAWE groups. Other than the mainstream interventions for all survivors, this assessment did not come across any specific institutional response specifically for girls, young women and boys who experienced violence, particularly sexual violence.

Women's empowerment

The programme design highlighted women empowerment as key in GBV interventions based on studies that suggested that norms about gender and the acceptability of violence greatly influenced the prevalence of gender-based violence. Citing DHS, the programme document stated that men and women believed that husbands were justified in beating their wives if they disobeyed them and/or refused sex. Even in settings without such open support for violence against women, society often blamed and stigmatized women rather than male perpetrators of physical and sexual violence. It was observed that such beliefs prevented women from seeking help from family, friends, and other community members.

An assessment of the programme showed that women were main beneficiaries in all programme activities. Their large involvement in the OSAWE groups highlighted the fact that they were the majority in the entrepreneurship trainings offered by UNICEF and ILO partners.

Women and Children with disabilities

This category of beneficiaries was targeted in the programme design based on the fact that women and children with disabilities were more vulnerable to gender based violence and experienced very particular forms of violence and abuse. It was understood that because of stigmatization of disability, and the resultant social isolation, women and children with disabilities endured violence for longer periods and had difficulties accessing information and services on GBV. The programme document stated that there was need to increase (i) disability awareness and integration of training across all government, NGOs and other implementing partners in order for them to address the needs of women and children with disabilities who experience GBV (ii) access to information and GBV related services should be incorporated throughout the programme interventions.

This assessment established that there is more that needs to be done in this area even though attempts were made to address this matter by co-opting Zambia Disability Health and Human Rights as an implementing institution under IoM. Nationally, there are currently no indicators on disability (PLWD) in the National Action Plan on GBV. The programme interventions on disability were only limited to Lusaka and Kabwe, which are both urban areas. The evaluation established that People Living With Disability (PLWD) have special GBV services needs such as user-friendly environments and IEC material (e.g audio, brail), physically accessible courts and sign language amongst other needs. Community awareness regarding GBV for PLWD seems to be lacking. Mini-surveys done by IOM in Maheba revealed that some people with mental disability were being abused in the communities and mental illness was reported to be very common in the refugee camps. At Misolo village for example, participants in a focus group discussion from the Village Based OSC during the evaluation verbally and physically abused a mentally challenged woman

who wanted to participate in the discussion claiming that she has been sexually abused and has conceived a child after that abuse. It was ironical that the abuse happened during an FGD on GBV and the participants seemed unaware that what their actions amounted to GBV against the mentally challenged woman. Their actions indicated a serious gap in their understanding of PLWD issues. There is need therefore for oversight and technical support of the VBOSCs by hospital based OSCs to ensure adherence to GBV service delivery standards. Mainstreaming of disability issues needs to be strengthened in the programme. A plan for identification and mobilisation of survivors in this category needs to be drawn and implemented.

3.7 SUSTAINABILITY

In assessing sustainability, the evaluation looked at the likelihood of programme benefits continuing after donor funding has ceased. The evaluation also analysed the major factors that influenced the achievement or non - achievement of sustainability potential of the programme. A combination of the UNEG, OECD/DAC and the IFAD (2009) sustainability frameworks were used to assess the sustainability potential of the joint GBV programme. The framework identifies the following factors as key pillars upon which the sustainability potential of a project or programme hinges:

- **Political sustainability** – this includes government commitment, an enabling policy environment, stakeholder interests, strong lobby groups and political influence/pressure
- **Social sustainability** – social support and acceptability, community commitment, social cohesion
- **Ownership** – whether or not communities, local government and households accept and own the outcomes of the programme in ways that are sustainable
- **Institutional sustainability** – institutional support, policy implementation, staffing, recurrent budgets
- **Economic and financial sustainability** – resilience to economic shocks, financial viability, reduced household vulnerability and increased capacity to cope with risk/shocks
- **Technical sustainability** – technical soundness, appropriate solutions, technical training for operations and maintenance
- **Environmental sustainability** – projects' positive/negative contributions to society and management, resilience to external environmental shocks.

Based on the above criteria, the evaluation assessed the sustainability potential of the different components of the joint GBV programme.

a) Political Sustainability

The evaluation concluded that political sustainability of the programme will be achieved. Government has shown commitment to the anti GBV agenda by putting in place a supportive legal and policy environment, including the Anti GBV Act, Gender Equality Bill and the 2014 Gender policy. Provision of social protection for GBV survivors is provided for in the Anti GBV Act, which can be read along with the provisions in the 2014 National Social Protection Policy, comprising a holistic set of strategies and programmes aimed at enhancing social protection for

vulnerable groups. According to ILO (2016), the National Social Protection Policy envisages, the combination of measures to protect the income and basic needs of the most poor and disadvantaged (social assistance), promoting economic development and self-reliance (livelihood and empowerment), providing effective insurance mechanism for workers with contributory capacity (social insurance) and removing structural barriers leading to social exclusion (prevention and disability pillars). The policy informed the activities in the fifth, sixth and revised sixth national development plans. Within these instruments, social protection covers vulnerable groups such as those living in poverty, women, children and the aged, people with disabilities, vulnerable migrants, refugees, internally displaced persons and minorities. Women and children affected by violence are explicitly acknowledged.

This assessment has shown that there is strong stakeholder interest for the continuation of the anti GBV agenda. High-level government officials, Traditional leaders, NGOs, CBOs, school authorities, media entities and government departments such as the Police (Victim Support Unit) are committed to stopping GBV. Key non-state institutions such as YWCA, NLCW, CARITAS Zambia, NGOCC, World Vision, WFC and WILSA have had programmes aimed at advocating and responding to GBV in communities and the workplace prior to commencement of the joint GBV programme. Interlocutors in these organisations stated that their engagement on GBV will continue as it is part of their core mandates and some of the activities from the joint GBV programme will be mainstreamed into their annual work plans.

GBV and Social protection is equally prioritized in the plans of bilateral and multilateral partners working in the country. For instance, ILO works on improving livelihoods for vulnerable groups, UNHCR and IOM complements government on vulnerable refugee and migrant children's social protection and UNHCR has a global livelihood priority specifically targeted at refugees.

Despite these efforts, there is still need for Government to finalise the development of a Social Protection sector coordination mechanism and M&E framework. Government also needs to conclude the process of developing comprehensive legislation to operationalize the National Social Protection Policy.

b) **Social Sustainability and Ownership**

There was general acceptance and commitment to address factors that lead to GBV in most of the sampled sites, including in rural areas where patriarchal and traditional norms and practices encourage GBV towards women. However, the levels of social sustainability will differ from place to place. The joint GBV programme supported traditional leaders, men's networks, girls and boys in school clubs, also known as safe places in respective schools. These could play a critical role in social sustainability but as the discussion below shows, the sustainability of some of these entities is questionable and so is their future effectiveness and engagement.

Traditional Leaders: Interviews with chiefs, indunas and their subjects showed that the effectiveness of the top traditional leadership was instrumental in changing the discourse in their communities. In most of the visited sites, members of the community were open to discussing traditional practices that contribute to GBV in their respective areas with the aim of stopping the vice. Narratives from traditional leaders revealed that their capacities in handling GBV cases had

improved. They were aware that “reconciliation” cases among couples required thorough investigation and that assault and other complicated matters such as sexual abuse were to be referred to relevant authorities- the police or mainstream courts of law. In short, it was understood that the traditional courts needed to “bend in” much more than before. However, these traditional structures are male dominated and given the entrenched patriarchal norms and beliefs, support for female victims cannot be assured without continuous reinforcement of the new ideals. Social protection for victims cannot be assured either- more so for women.

Based on qualitative judgment, some traditional leaders were doing much better in addressing GBV and especially social protection. An outstanding example was Chief Mukuni of the Toka Leya people in Kazungula district of Southern Province.

Chief Mukuni and Mukuni Village- An Outstanding Case of Social Sustainability and Ownership

Before Chief Mukuni ascended to the throne in the 1980s, he worked in a private institution, British Petroleum. He inherited a chieftom, like most in Zambia, that was very patriarchal, but decided that he was going to rule differently. Women were co-opted into the governance system alongside their male counterparts.

In terms of hierarchy, the next in line after the chief is a chieftaincy, a woman known as *Byedyango* who is the chiefs’ sister. Together, they make decisions about the affairs of the kingdom in consultation with the prime minister, courtiers and senior village heads. Other than the *Bedyango*, other women known as the *Basi Muse* co-rule and are active especially at senior village head and village level, both powerful structures in the traditional governance system. Senior heads are in charge of zones, which comprise a number of villages while village heads oversee the villages which are made up of households. *Basi Muse* exclusively handle land allocation and by so doing ensure that both men and women benefit equally. Social protection, through land allocation is assured for GBV survivors.

More than two decades later, Chief Mukuni’s decision makes GBV interventions in the kingdom easy to manage as both men and women deliberate at such high-level matters affecting the subjects. Interviews held with *Bedyango’s* spouse, *Basi Muse*, a courtier, senior headmen, headmen and some subjects revealed that any programme, project or activity that was taken up by the village was for the whole village- both men and women. *In fact, this assessment observed that the women in the Focus Group Discussions at Mukuni palace were very assertive- they were the first to speak during the discussions and contributed throughout- while those in other sites had to be “encouraged” to speak.* It is from these perspectives that the assessment considers the Mukuni model as one of the best ways to achieving social sustainability.

All the traditional leaders interviewed during the evaluation showed commitment and readiness to dump old customs and traditions such as cleansing and forced and arranged marriages because they are a violation of human rights. Chiefs were also taking pro-active action in the

establishment of Village Based One Stop Centres by providing land and infrastructure. Community FGDs revealed that chiefs were playing an active role in speaking and acting against GBV. The fact that chiefs are the custodians of culture, are well respected and powerful in Zambia and that they are showing commitment to fighting GBV, provides fertile ground for long-term sustainability of anti-GBV initiatives.

Men's networks: The team interviewed members of eight networks, three networks in Kasenegwa, Musanzala and Misolo in Eastern province and five in Mporokoso, Northern Province. The networks in Eastern Province were on average 10-20 kms from the central business area while those in Mporokoso were within a five-kilometer radius of the central business area. The networks in Eastern Province were servicing communities in hard to reach areas because of a poor road network while in Mporokoso there were still discussions about spreading out to the furthest areas where GBV was reported to be rampant.

Overall, the networks were facilitating social support and acceptability of the anti GBV agenda by repackaging and sharing the provisions in the Anti- GBV Act. Their sustainability is however not guaranteed mainly due to their “dependency” on outside support. Discussions with members of the networks revealed that the levels of support from the implementing institutions towards the networks differed. All received training, which is a great resource to their work. Some networks were offered bicycles and phones to facilitate their work, while others did not receive any. For those that received these items, there were complaints of lack of funds to buy spare parts for the bicycles, the phones breaking down and lack of money to load airtime. On the other hand, those that did not receive such support wished they had. In both groups, there were requests for other support such as (i) T-shirts to help with identification when they are undertaking work in the communities (ii) need for meeting space/shelters where the members could convene and debrief each other on various issues concerning the networks (iii) stationery to help with record keeping and (iv) exchange visits to facilitate learning from each other. Groups that received bicycles and phones, including some airtime, were of the view that this initial support helped them do the groundwork in the communities. According to them, (a) awareness was increased (b) perpetrators were easily tracked down (c) survivors were given the necessary support and (d) linkages with law enforcement agencies and health facilities improved. A triangulation of the data shows that some of these results were shared or confirmed during interviews with the police and workers in one stop centres.

Those groups that did not receive bicycles or phones shared a similar story. The main successes shared by their counterparts also applied to them and they too did not have a plan on how to sustain their networks after the programme. They were still expectant that respective implementing institutions would still bring in some support.

The question therefore that needs an answer is, how the Men's Networks can be sustained. This assessment argues that the best way is to build on the voluntarism spirit which was very evident in all the groups and then find a way of linking these groups to respective traditional leaders and CBOs so that they can be part and parcel of the community structure. The networks also need to be linked with the hospital based OSCs for mentoring, training and other technical support

services. One of the greatest resource that these community and men's networks have gained is knowledge on GBV, and this information is likely to be shared with the community for a very long time.

School Clubs: Sustainability of these clubs is assured for as long as the mentors involved, mainly teachers (including the school authorities) and parents remain committed and those that move away are immediately replaced by other mentors. The school clubs need to be linked to income generating activities so that they can generate income to fund their activities. Pupils were eager to learn. The only challenge that could arise is as a result of parent mentors' "terms of reference" that require them to serve a larger community which is challenging in the absence of resources. Their engagement should therefore be streamlined so that it is restricted to a reasonable radius within their communities. Otherwise their engagement could be as difficult as that of the Men's Networks

c) Institutional sustainability

The evaluation assessed the sustainability of institutions created and supported by the programme. These included One Stop Centres (both those based in the villages and health centres), Shelters, Victim Support Unit and Fast Track Courts. In addressing the sustainability of one stop centres, key factors have to be teased out so that the analysis is at the specific and broad level. Key actors in the health center based one stop centres were the Police, Ministry of Health, Paralegals and Psychosocial counsellors, while only the Paralegals and Psychosocial counsellors were active in the village one stop centres.

Broadly, the programme was implemented through existing government and community structures and therefore did not create parallel structures. Working through existing structures entrenches a sense of ownership amongst the key stakeholders, which in itself is a key element underlining sustainability. These institutions were also capacitated through training and technical and material support by the programme. The training and support received will empower these institutions to continue implementing programme components even after donor support has ended. The main challenge to institutional sustainability is the high staff turnover experienced in government departments (which requires continuous training) and the constrained fiscal support from treasury.

Sustainability of Health Centre Based One Stop Centres: although the government is committed to establishing hospital based OSCs in every district, there is no policy framework as yet to guide the establishment and operations of the OSCs. The hospital based OSCs have not been adequately integrated into the Ministry of Health budgetary and planning frameworks and processes and have largely been driven and supported by development partners. The OSCs have not been included in the annual plans and budgets of hospitals where they are based. A Medical Superintendents at a hospital with a OSC noted that "*I cannot use the hospital budget to support activities in the OSC at this hospital, because the centre has not been taken into account in our planning and budgeting process*". Staff running the OSCs have been provided by the Ministry of Health, Police and development partners. In most cases, the personnel is awarded allowances for their work, even if they are Ministry of Health and Zambia Police employees. What this implies

is that while staff from the two institutions might continue to be seconded to these facilities, their operations will be compromised after the programme. Stationery, fuel and other logistics are required to ensure that the centres run effectively. Other than this, there will be challenges retaining the paralegals and psychosocial counsellors who are serving in a voluntary capacity. These were drawn from non-state institutions and made it clear that their presence in these facilities was not assured after the programme. According to them, the allowance that the programme provided gave some motivation and it was going to be challenging to continue without it. Below is a narrative by a medical superintendent at one of the hospitals hosting the OSC;

“To be honest, I don’t think the OSC can be sustained without external support. We cannot sustain the centre as a hospital because the services offered there are for free, the survivors do not pay anything. Our grant has already been drastically cut by the Ministry of Health and we already have serious challenges securing drugs for the hospital. So offering the OSC services for free will be a challenge for us.

The other challenge is that the OSCs are not fully integrated within the Ministry of Health planning and budget frameworks. They OSCs are kind of a parallel programme. We used to have ZPCT HIV counsellors at the OSC before, but when the programme support ended they all withdrew their services and left us in a bit of a crisis. Mazabuko also had a OSC supported by World Vision, and when they pulled out it the OSC crumbled. There is need for a proper exit strategy for the OSCs, otherwise they will collapse”

Medical Superintendent at a hospital based OSC

Some One Stop Centres under the ASAZA project that was funded by USAID between collapsed after programme support had ended. Sustainability can only be assured if the Ministry of Health, Ministry of Justice, VSU and other related ministries take full responsibility for them. Some hospital authorities interviewed have raised concern that the centres are taking away critical staff such as doctors and nurses from “major” clinical cases. In most cases, the hospitals are already understaffed, and committing nurses and doctors permanently to the OSCs will be a further strain on their human resources. Where GBV cases are not many, that would be inefficient utilization of the limited human resources that the hospital institutions have.

OSCs seem to be sustainable in high resource settings. However, of all the OSCs visited, the Mporokoso one seemed to have a more sustainable structure compared to the others.

Mporokoso Hospital Based One Stop Centre - A model for post programme survival?

The Mporokoso One Stop Centre, in the Northern Province was set up in 2016. Unlike the other centres, hospital staff offered four critical services, namely Psychosocial Counseling, Data entry, nurse and doctor interventions. The data entry clerk also served as a Lab Technician in the hospital while the nurse had training in psychosocial counselling. Staff providing paralegal services were from a local NGO and the police were available whenever called upon. In this model, the paralegal officer was the only one who was not on government payroll but indicated that since anti GBV was a mandate of their organisation, paralegal services would continue to be offered in the center. Those on

government payroll recognized the importance of external support but pointed to the fact that their being on government salaries meant that the operations of the center were not going to be adversely affected.

However, without the support of the ministry of health towards administrative and running costs, the Mporokoso one stop center might just be like any other.

For OSC sustainability, there is need for a well thought out exit strategy to be put in place. Although support from development partners is needed to support the OSCs, there is need for the integration of the centres within the Ministry of Health Policy Framework, so that the centres are also included in the ministry's budgets. Government employees from relevant departments and ministries should mainly run these OSCs so that there will be no need for extra salaries for the personnel. The government workers running the centres need to be trained so that they are multi-skilled to offer the range of GBV services needed at the OSCs. For example nurses and the police can be trained in counselling as well as para-legal work. The workers should also be trained to change their mindset so that they consider the work at the OSCs to be part and parcel of their normal duties and services they need to provide instead of viewing working at the centres as extra work.

Sustainability of Village Based One Stop Centres (VBOSC): VBOSC were a new concept, an addition to the Health Centre Based Centres. The first one, Misoro, was officially opened by the President of the Republic of Zambia, His Excellency Edgar Chagwa Lungu earning endorsement by the highest office in the land. The infrastructure for these centres was mostly rented or donated by the Chiefs for the short term with the understanding that the communities would contribute to the programme by providing buildings for the OSCs. With this understanding, traditional leaders in the sampled sites have donated land for that purpose. At the time of the evaluation, traditional leaders were raising concern that construction of the said facilities was taking longer than anticipated because some communities were resource challenged. Meanwhile, the joint GRZ/UN GBV programme supported the VBOSC with solar panels, computers, TV sets, phones and bicycles for members of the community networks.

Modelling VBOSC s around chiefs/traditional leaders has provided a basis for their sustainability. Traditional leaders are the custodians of customs and traditions and they command great respect and authority in their chiefdoms. Their demonstrated commitment to anti GBV efforts will be utilised to build a sustainable platform for the VBOSCs. Further, where resources are limiting, the concept of OSC can be promoted through community networks such as the men's networks. These work in the same manner as OSCs without the OSC physical infrastructure. There is however need to link the VBOSCs to economic empowerment activities, for example the OSDAWE groups, so that the volunteers can embark on income generating activities to sustain both their livelihoods and the activities of the centres.

Shelters: According to the Anti-GBV Act No. 1 of 2011, shelters in Zambia are supposed to be established and operated by the Social Welfare department under the Ministry of Community Development. Adults and child victims are supposed to have separate shelters. Article 27

provides that a shelter for child victims— (a) shall secure the physical safety of a child victim; (b) shall provide temporary basic material support for the care of a child victim; (c) shall offer a programme for— (i) the provision of counselling to child victims; and (ii) the provision of rehabilitation services to child victims; and (d) shall, in cooperation with the Ministry responsible for education, offer a programme aimed at the provision of education to child victims.

The Ministry of Community Development is also mandated to ensure an appropriate spread of such shelters throughout the country. To support these ventures, the Act provides for the establishment of an Anti-Gender-Based Violence Fund supported by donor and government contributions. According to the Ministry, this fund has been established although this assessment found out that the funds have not yet reached the beneficiaries such as those in the shelters. All the shelters that were visited during this assessment were established and managed by YWCA using funds sourced from both local and international donors. One in Solwezi was supported by a private mining company, Kansanshi Mines. The mine purchased the property as part of its corporate social responsibility. Joint GBV partners such as UNICEF and UNFPA supported YWCA by providing funds for renovations and extensions, furniture, food and other supplies.

There can only be sustainability for these shelters once the Ministry of Community Development takes full charge and effectively fundraises and manages the GBV fund. Since the GBV Act states that the fund is meant for (a) the basic material support of victims; and (b) any other matter connected with the counselling and rehabilitation of victims in their best interest, the shelters should be among the main institutions to benefit from such a fund. Mines and other private entities are potential partners as they are willing to contribute to social projects within their communities.

Fast Track Courts: the concept of FTCs has been accepted and endorsed by the Ministry of Justice. The courts were set up as a pilot and the evaluation established that these courts are showing signs of improved handling and disposal of GBV-cases. However, expensive equipment for these Fast Track Courts is being installed and before rolling this initiative out there is need for a sustainability plan of how this equipment can be maintained and used after the programme ends. The Lusaka FTC for example, has no back-up generator in the event of an electricity blackout and this means the equipment will not be used when such a scenario occurs. Maintaining this equipment requires financial support from the Ministry of Justice. The requirement also needs to be regularized and incorporated into the Rules of Court. The vehicles provided to the courts also need to be maintained for effective delivery of justice. More court room space is required so that more GBV cases can be handled concurrently. With this support, the concept is sustainable as it has high level buy in.

Victim Support Unit: the Zambia Police Victim Support Unit has been in existence since 1994. The unit has been in existence for this long because of support by different stakeholders including the government. The unit is now one of the integrated units within the police and therefore it is going to continue offering GBV services to survivors. There is however need to establish a sense of ownership and resource independence as the VSU seems to expect ongoing support from the development partners. There are concerns about the sustainability of the “hardware” provided by the programme. In interviews distinctions were made referring to ‘the programme’s vehicle’

and 'the equipment of the programme'. For example, at one VSU visited during the evaluation, one of the donated vehicles had broken down, the toner in the printer had finished and the VSU officers were expecting the programme to repair the vehicle for the unit and to buy the toner for the printer. The repairing of the VSU vehicle should have been done in the same manner other police vehicles at the station are being repaired.

d) **Economic and financial sustainability**

At the time when the evaluation took place, no government funds had been secured or provided for programme activities and their continuation. In the formation of the programme, it was expected that that the GRZ and non-state actors would contribute 25% of the total budget in cash and/or in kind. The government has mainly been able to contribute in kind. With limited funding it will be difficult to sustain some parts of the programme that require substantial funds, for example in maintaining or scaling up the Fast Track Courts. When designing the programme a sustainability and exit strategy should have been prepared clearly showing the options and responsibilities that needs to be in place when the programme comes to an end. This plan should take both financial and human recourse aspects into account.

According to the 2014 Labour survey, 89.3 of the total employed population in Zambia is in informal employment. Very few opportunities exist for people to be engaged in formal employment. One of the economically sustainable ventures under the joint GBV programme was the formation of the OSAWE Groups. A total of 5725 survivors received training under the programme and with support from implementing partners on the GBV programme, some went on to form the OSAWE groups comprising about 10 to 15 members per group. Unlike other saving groups that started off using borrowed funds, these groups used their own resources. Each member contributed to the group savings and once the fund had grown, loans were given according to an agreed upon repayment plan. The fact that most of the OSAWE groups made it to a point where members had started borrowing and repaying their loans is an indication of their sustainability. There was also enthusiasm among members in all the sampled sites to sustain the groups since members wanted to grow their businesses and diversify. More effort is needed to link these groups with financial institutions that can offer affordable loans so that the groups can expand their businesses and diversify to be better able to cushion themselves from external business shocks. The OSAWE concept needs to be extended to include volunteers who are supporting the village based OSCs so that they are able to raise funds to support the functionality of the centres, for example repairing of bicycles and cellphones as well as procurement of air time.

e) **Technical sustainability**

The capacity training of different stakeholders through the programme on the GBV management protocol and related services has enhanced the performance of these institutions to offer efficient and appropriate GBV services to survivors. The trained personnel will continue to apply these technical skills beyond the lifespan of the programme. There is however need for continuous training because in some institutions, for example Ministry of Health and Judiciary, there is high staff turnover. Continuous training will also expand the skills base of the GBV

programme stakeholders. The programme utilized trainers within existing government institutions and this is a sustainable strategy as the trainers will continue offering services beyond the programme.

4. KEY LESSONS LEARNED

A number of key lessons emerged from this evaluation based on review of programme documents, interviews and discussions with key stakeholders, Focus Group Discussions with communities and field observations.

- ✓ **Programme Design:** in designing a coordinated pilot programme with a number of initiatives implemented by different partners, there is need to concentrate the whole menu of interventions in a few selected districts than to spread the interventions in several districts where some of the interventions are not available. Concentrating all the interventions in a few selected districts makes it much easier to assess the effectiveness and impact of the coordinated approach.

- Multi-Sectoral Approach to GBV:** in dealing with a multi-faceted phenomenon such as GBV, the multi-sectoral coordinated approach provides a holistic and effective platform where different key stakeholders with complementary skills, roles and responsibilities come together to respond to GBV in a coordinated manner.
- ✓ **Delivering as One Approach:** the approach provides an opportunity for UN agencies to leverage on each other's comparative advantages, resources and skills in responding to a multi-faceted and multi-sectoral development challenge such as GBV. Effectiveness of this approach however depends on clearly defined roles and space for each agency to minimize competition for resources, recognition and space. Each agency needs to focus on programme areas within its defined mandate where it has appropriate skills and comparative advantage.
- ✓ **Working through existing structures:** working through existing government and community structures provides a basis for sustainability as no parallel and sometimes competing structures are set up. Where capacity gaps are identified, capacity strengthening initiatives need to be undertaken to improve effectiveness of programme delivery.
- ✓ **Working through traditional and religious leaders:** The programme has been working with traditional structures through the involvement of Chiefs to specifically address the challenges with GBV and the discrepancies between customary and statutory laws. The Chiefs involved in the training provided by the programme did bring the knowledge back to their Chiefdoms and they were supportive of the initiatives carried out by their community members, in particular the village led One Stop Centres. Working through these already existing traditional structures is one way of strengthening sustainability. All the 288 chiefs signed a pledge to end GBV and promote gender equality and a resolution

was made that all chiefs should not allow cleansing ceremonies and that they should facilitate women's access to land. There is need to work through religious leaders as well as these have influence on communities that they preside over.

- ✓ **Men's Involvement:** Men's networks if structured in a sustainable manner are key to changing attitudes as well as ensuring that real action is taken against GBV perpetrators and support given to survivors in communities.

5. KEY CONCLUSIONS

The following are the key conclusions of the evaluation:

Relevance: the programme was found to be largely relevant to the GBV context in Zambia. This conclusion is based on the following observations: (1) there was consensus amongst all key stakeholders interviewed on the problematisation of the phenomenon of GBV in Zambia and the need to take action to address this scourge; (2) the programme holistically addresses the health, legal, social protection and economic empowerment needs of GBV survivors; (3) the programme is in strong alignment with national, regional and international frameworks and provisions on GBV such as CEDAW, SDGs, SADC Protocol on Gender and Development, Anti-GBV Act, Gender Policy etc, and the design was based on a strong evidence base.

Programme Performance and Effectiveness: the programme performed well in terms of meeting its planned outputs and targets despite the fact that there was late start-up. At outcome level, there is evidence of improved access to health, justice and social protection services by GBV survivors.

Efficiency: late start-up of the programme affected timely implementation of some of the programme activities, which necessitated a one year no-cost extension. There were also instances of late disbursement of funds to some of the implementing partners by a few UN agencies which affected implementation of activities on the ground. However, the programme implementation was found to be generally efficient which resulted in the achievement of majority of outputs and outcomes. Coordination was also generally efficient although there were some coordination challenges experienced at lower levels in some of the programme districts.

Sustainability: this was entrenched mainly through (1) broad based consultation in the design of the programme, (2) working with existing government and community structures, (3) and capacity strengthening of stakeholders. The programme has political sustainability, social sustainability and ownership as well as technical sustainability. However, financial sustainability remains a challenge, particularly after programme support has ended and this is a threat to the

survival of some of the institutions and programme activities such as the hospital based and village based OSCs and FTCs.

6. RECOMMENDATIONS

Based on review of literature, key informant interviews with stakeholders and discussions with communities, the following recommendations are put forward by the evaluation team.

| Strategic Area | Recommendation | Responsibility |
|---|---|---|
| Future of the programme | The programme, as a pilot, has shown great potential as it has achieved most of its expected outputs and outcomes, effectively improving levels of awareness on GBV and improved access to health, legal, economic empowerment and social protection services by GBV survivors. The programme needs to be extended into phase 2, where all those identified good and effective practices will be consolidated and scaled up (informed by lessons learnt) to cover more provinces so that the ultimate programme Goal of contributing to the reduction of GBV cases in Zambia is ultimately achieved. In this regard, funding for phase 2 will need to be secured. | Donors, UN Agencies, Ministry of Gender |
| Programme Design | If funding for scaling up is secured, the scale-up should be well structured and concentrate only in the districts where resources permit the implementation of the whole menu of programme interventions. Scaling up should be phased in a manner commensurate with the resources available. The material support provided to implementing partners and communities implementing same programme activities should be standardized so that the same packages are delivered to all the programme areas. This makes assessment of effectiveness much easier. | Ministry of Gender, UN agencies & Implementing partners |
| | Given the key role that the Ministry of Chiefs and Traditional Affairs is playing in the implementation of the programme, there is need to sign an MOU with the ministry for formalized participation in the programme. The ministry is present in all districts and chiefs playing a key role in taking action against GBV in their respective chiefdoms | MoCTA, MoG, UNDP |
| Goal and programme indicators | The Goal of the programme needs to be revised to reflect both the preventive and response dimensions of the programme. Indicators should be further revised to reflect work done only in the programme areas rather than capture national level values that the programme has no direct influence on. | Ministry of Gender & UN agencies |
| Good and effective practices for scale-up | The following are recommended for scale-up because they have been identified as good practices: <ul style="list-style-type: none">  Fast Track Courts  Village based One Stop Centres | Ministry of Gender, UN agencies & Implementing partners |

| | | |
|-----------------------------|--|---|
| | <ul style="list-style-type: none"> ✚ Community and Men’s Networks ✚ Savings and Lending Groups | |
| Action Research | <p>Given some knowledge gaps identified during the evaluation, the following action research is recommended:</p> <ul style="list-style-type: none"> ✚ Research on the sustainability of hospital Based One Stop Centres. This research needs to be conducted across programmes (funded by other donors) and with the participation of key stakeholders such as the Ministries of Health, Gender and Community Development and UN agencies participating in the programme. UNICEF planning to do it in 2017, should coordinate with the stakeholders listed above and liaise with other donor funded programmes (e.g. EU and DFID/USAID funded programmes). Research to be done to inform decision on scaling up. ✚ UNICEF is planning an assessment of the child friendliness of OSCs and case management processes both within and after the child leaves the OSC in 2017. This would feed into the development of the OSC policy under MoH as well as case management processes. This will be undertaken in consultation with stakeholders including with other donor funded programmes (e.g. EU and DFID/USAID funded programmes). ✚ Research to understand better the causes and drivers of GBV in Zambia particularly sexual violence against women and children ✚ Research on the causes and impacts of GBV case withdrawal at both the courts and police on GBV survivors ✚ Research on the effectiveness and appropriateness of traditional court system in resolving GBV issues ✚ | UN agencies and Ministries of Gender, Health and Community Development, the judiciary, ZP-VSU, Chiefs, MoCTA. |
| Other areas of intervention | The programme needs to look at the possibility of increasing focus on GBV related to People Living With Disability. There is also need to focus on rehabilitation of GBV offenders as a prevention strategy as this aspect has not been looked at by the current programme. | UN agencies, Ministry of Gender, Ministry of Justice |
| Sustainability | For sustainability of programme activities and benefits, there is need for the Ministry of Gender to start contributing financially towards programme implementation. This calls for lobbying of the national treasury, for increased budget allocation leveraging on the recent call by the President of the Republic of Zambia, for increased financing of the ministry. An exit and sustainability plan for the programme needs to be developed and implemented | Ministry of Gender, Ministry of Finance, MNDP |

7. ANNEXES

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| 7.1 | Terms of Reference |  Terms of Reference.pdf |
| 7.2 | List of people interviewed and met and itinerary |  Final Joint GRZ - UN GBV Programme |
| 7.3 | Evaluation Tools |  FGD Guide for beneficiaries.docx |
| | |  In-depth Key Informant Interview |
| | |  MSC Story_Case Study Guide.docx |
| 7.4 | Programme Performance Tables |  Programme performance indicators |
| 7.5 | Theory of Change Framework |  The GBV Joint Programme Theory of Change |

