A Lifesaving GBV, Women’s Leadership, and SRMH Support for Refugees, in Uganda, Arua District, West Nile

ENDLINE EVALUATION - FINAL REPORT

Submitted To:
CARE INTERNATIONAL IN UGANDA

Submitted by:
CME SOLUTION (U) LTD

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CME Solution (U) Ltd would like to extend its sincere thanks to CARE International in Uganda for giving her the opportunity to conduct Endline Evaluation for the Lifesaving GBV, Women’s Leadership, and SRMH Support for Refugees in Uganda (GAC 3) Project.

The Evaluation team would like to acknowledge the contribution of all the respondents for the cooperation and information provided without which it would not have been possible to come up with these findings.

Signed:

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<thead>
<tr>
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<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere</td>
</tr>
<tr>
<td>CBFs</td>
<td>Community-based facilitators</td>
</tr>
<tr>
<td>CFRM</td>
<td>Complaints, feedback and response mechanisms</td>
</tr>
<tr>
<td>CMAGs</td>
<td>Case Management Assistance Groups</td>
</tr>
<tr>
<td>COVID-19</td>
<td>Coronavirus disease</td>
</tr>
<tr>
<td>CSAGs</td>
<td>Community Social Action Groups</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>DSC</td>
<td>District Service Commission</td>
</tr>
<tr>
<td>FAL</td>
<td>Functional Adult Literacy</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GAC</td>
<td>Global Affairs Canada</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender based violence</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Devices</td>
</tr>
<tr>
<td>PLWG</td>
<td>Pregnant and Lactating Women and Girls</td>
</tr>
<tr>
<td>PSHEA</td>
<td>Prevention of Sexual Harassment Exploitation and Abuse</td>
</tr>
<tr>
<td>PSN</td>
<td>Persons with Special Needs</td>
</tr>
<tr>
<td>PSS</td>
<td>Psychosocial Support</td>
</tr>
<tr>
<td>RMMBs</td>
<td>Role Model Men and Boys</td>
</tr>
<tr>
<td>RWCs</td>
<td>Refugee Welfare Councils</td>
</tr>
<tr>
<td>SDM</td>
<td>Standard Days Method</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and gender-based violence</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual reproductive health</td>
</tr>
<tr>
<td>SRMH</td>
<td>Sexual, Reproductive and Maternal Health</td>
</tr>
<tr>
<td>SSD</td>
<td>South Sudanese – refugees</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>VSLA</td>
<td>Village Savings and Loans Association</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WLIIE</td>
<td>Women Lead in Emergencies</td>
</tr>
<tr>
<td>WYCs</td>
<td>Women and Youth Centers</td>
</tr>
<tr>
<td>WYCMC</td>
<td>Women and Youth Centre Management Committees</td>
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EXECUTIVE SUMMARY

CARE International in Uganda commissioned an endline evaluation to establish the performance of the GAC 3 project on outcome indicators and related information to determine reasonable targets and guide for assessing the outcomes of the project interventions. This report presents the results of the end term evaluation for the GAC 3. The results are from the two sampled refugee settlements of Rhino and Imvepi in Madi Okolo and Terego District formerly Arua District in West Nile Uganda. Overall the end term evaluation survey reached a total of 280 household respondents (186F, 94M) within both settlements.

Fieldwork was conducted for five days, using mixed quantitative and qualitative data collection and analysis methods. Quantitative data was obtained through a household survey using mobile data collection devices. A detailed questionnaire was developed, pre-tested for incorporation of relevant information. Primary qualitative data was obtained through six Focus Group Discussions (involving women, girls, boys and men) and twenty Key Informant Interviews that comprised of GAC 3 project staff, district local government officials, health workers, health partners, Office of the Prime Minister, among others. Qualitative data from mainly key informant interviews and FGDs were analyzed using thematic analysis techniques and the findings were used to strengthen the interpretation of the quantitative findings.

The end line evaluation findings indicate that there is improved feeling of safety and dignity. This was measured at household and community level. There was an improved feeling of safety and dignity as shown by the survey at 91% (92%F, M89%). Further interrogated, the respondents indicated that they felt safe at both household and community levels. At the community level people feel safe at 86% (86%F, 86%M) and at the household level they feel safe at 93% (94%M, 91%F). The study findings indicate men as change agents and as clients in relation to Gender Based Violence (GBV) seem to have been successful exhibited by the high values.

It is however important to observe, that when the community was unpacked (public latrines, fuel collection points, firewood and charcoal collection points, water collection points), both men and women felt that public latrines, fuel collection points, firewood and charcoal collection points were not necessarily safe for all categories of respondents (men and boys, women and girls). This is based on the responses on the safety questions of these categories of the community. It was found the responses of not sure, disagree and strongly disagree as equal to or greater than 30%.

It is important to note that men’s response in relation to safety are in consonant or more positive than those of women which is an indicator of their active participation in or their appreciation of the project. This could be attributed to the Role Model Men and Boys (RMMB) approach.

The psychosocial support, Community Based Facilitators (CBFs), together with Community Safety Action Groups (CSAGs) were useful in enhancing satisfaction in the beneficiaries. This could be linked to the participatory processes that are embedded in these approaches which enhance ownership and relevant critical needs identification.

Measuring using the mean average, it was observed that on average 11.2% (9.3F, 15.1M) of the targeted beneficiaries were reverting to high risk behaviors and negative coping strategies which is way below the target of 20%. The unpacking of the high risk behaviors indicates that indicates
that the percentage of men reverting to high risk behaviours is higher at the end line than at baseline. For example taking alcohol to forget problems standing at 17% (29.4%M, 10.2%F) compared to the baseline 16% (15%F, and 17%M). Selling of household items is still high at 35% (52%M, 27%F) which was the same at baseline which stood at 35% (35M, 35F) and psychological and emotional abuse at 33% (41%M, 29%F) in comparison to the baseline levels which was at 17% (22%F, 9%M). The general reductions in women reverting to high risk behaviors could be attributed to two factors. The first factor could be the COVID-19, pressures on the males for household provisioning due to a reduction in food ratios in the community as was indicated in the focus group discussions. The second factor could be the women focused interventions by the project in terms of psychosocial support (at both individual and group levels) as well as livelihoods support.

Generally, the targeted population was satisfied with the GBV assistance at 81% (79%F, 86%M). The achievement of this indicator can be attributed to the psychosocial support, RMMB approach, the participatory nature of especially the CBFs and CSAGs.

The end line survey indicates that 75% (79%F, 70%M) demonstrated positive attitude towards ending GBV. This too may be attributed to the RMMB approach on one hand and on the other, it takes time to overcome male dominance.

On the overall, the project reached out to 3,350 persons (2,252W, 987G, 47M, 62B) with GBV services including psychosocial services, assisting with dignity kits among others. Awareness sessions reached a total of 34,350 persons (19467W, 1488M) which was more than three times above the target of 10,551 persons.

The project has generally increased women’ self-efficacy from 27% at baseline to 94% at end term against a set target of 70%. This is a great achievement taking into account the COVID environment. Men’s support for women’s empowerment is evident in the project (evidence by an achievement of 56% overall against a baseline indicator of 45%) and this has been critical to all aspects of the project. Fostered through the RMMB approach and inclusion of men on women’s committees has been pivotal to the success of the project. The various ways through which women’s empowerment include; women claiming that it has improved their savings as regards income generating activities and skills gained. However, it takes time to overcome patriarchy so the number of women in leadership spaces is still low at 32% compared to that of men at 43%.

Generally, beneficiaries reported satisfaction with SRMH services at an average of 78% (82%F, 72%M) against a 64% level of satisfaction at baseline. This level of satisfaction is linked to the support given directly to the government health facilities including the ambulance, support for health human resources, maternal health support equipment in the maternity wards, health unit staff quarter construction among others which increased the morale/ motivation of the health workers on one hand and availability of the actual services on the other. It is evident that the sexual reproductive health focus of the project has contributed to increased health facility deliveries, attendance of antenatal care and immunization of children among other achievements. However, the health units would benefit from more modern equipment in all aspects of the health centers.
In conclusion therefore, overall the beneficiaries reported satisfaction with the “Lifesaving GBV, Women’s Leadership, and SRMH Support for Refugees in Uganda, Rhino and Imvepi refugee settlements” project with a rating of 77% (73% F, 80% M) as evidenced by the outcomes achieved compared to how the situation was at baseline as mentioned in this report.
CHAPTER ONE: INTRODUCTION

1.0 Description of the GAC 3 Project

The Lifesaving GBV, Women’s Leadership, and SRMH Support for Refugees in Uganda, Rhino and Imvepi refugee settlements, Terego district, West Nile region was a 1 year Global Affairs Canada-funded project that was implemented from 1st April 2020 through 31st March 2021 as a continuation of the previous GAC 2 phase of implementation.

This project aims at:

1) Ensuring that identified GBV survivors and extremely vulnerable individuals, particularly women and girls, have access to quality, appropriate and timely protection-specific services.

2) Implementing Women Lead in Emergencies (WLiE), a 5-step approach developed by CARE to work with marginalized and crisis-affected women to strengthen women’s voice, leadership and representation in programming, governance and public decision-making. Women Lead in Emergencies (WLiE) is an innovative, CARE-created program that aims to increase the ability of women affected by crisis to meaningfully participate in formal humanitarian decision-making spaces. CARE’s successful pilot of the WLiE approach under previous GAC 2 funding is continued and scaled up in both Omugo zone, Ariaze II village and Simbili village.

3) Increasing access to critical SRMH services for refugees with a focus on Pregnant and Lactating Women and Girls (PLWG) and youth. CARE is supporting the strengthening of the health system’s to provide quality maternal and neonatal care services, as well as improving access to these critical services through capacity building and the provision of dignity kits to incentivize women to deliver in health facilities, and providing infrastructure to facilitate 24/7 access to critical healthcare.

The project supported refugees and host communities of Omugo Zone villages 4, 5 and 6 and Simbili, Ariaze A and B villages of Siripi zone in Rhino refugee settlement, with SRMH activities extending to Imvepi Refugee Settlement. The project targeted 27,208 beneficiaries with Lifesaving GBV, Women’s leadership and SRMH interventions as broken down in the table below.

<table>
<thead>
<tr>
<th>Sector:</th>
<th># of direct beneficiaries (M/F):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>16,498 individuals (6,910 W, 3,436 G, 4,312 M, 1,840 B)</td>
</tr>
<tr>
<td>Protection</td>
<td>10,500 individuals (3,820 W, 1,658 G, 3,516 M, 1,506 B) (</td>
</tr>
<tr>
<td>Women Lead in Emergencies</td>
<td>210 women</td>
</tr>
</tbody>
</table>
1.1 Evaluation Objectives

The purpose of the end line evaluation was to gather project data against all outcome level indicators included in the final approved proposal for GAC 3. It was to assess the extent to which planned targets at outcome level have been achieved and to conduct a final review to cover aspects of project design, implementation modalities, targets achieved and any uncompleted activities.

The specific objectives of the end line evaluation were:

1. To assess the extent to which the project contributed towards improving the lives of the communities in which it was implemented through measuring project indicators and comparing baseline and end line data.
2. To identify and document the intended and unintended outcomes, best practices, lessons learned as well as challenges that arose from project implementation.
3. To assess the relevance and sustainability of project outcomes, approaches, models and strategies.
CHAPTER TWO: METHODOLOGY

2.0 Introduction

2.1 Study Design

This evaluation study took a mixed-method approach employing both qualitative and quantitative data collection and analysis methods. The evaluation ensured a meaningful and safe participation of women and girls in the data collection and analysis process.

The study employed two approaches in the collection and analysis of evidence relating to the indicators of interest:

1. **Systematic review**: This entailed a document review and analysis of project reports and other related documents.
2. **Descriptive study design**: This involved collection of primary data from target beneficiaries in the targeted areas within the refugee settlements and host community.

2.2 Study Setting

This evaluation was conducted in Rhino and Imvepi Refugee settlements. In Rhino settlement data was collected from beneficiaries in **Omugo zone** (Villages 4, 5 and 6), **Siripi zone** (Ariaze A and B and Simbili villages). In Imvepi Refugee settlement, data was collected from beneficiaries in **Imvepi Zone 1** (Point J, Point H, Point G, and Point E) and in **Imvepi Zone 2** (Point I and Point C).

2.3 Data Collection Methods and Tools

Quantitative data was collected using the household/beneficiary survey questionnaire. Qualitative data was collected using Key Informant Interviews and Focus Group Discussions (FGDs). Key stakeholders were purposively selected based on their experience of working with the project and their expertise in giving insight on project outcomes. Data from key informants was analyzed using content analysis framework for qualitative research. Key themes and trends emerging from the data were used in relation to the objectives of the end line evaluation.

The following methods were employed:

a) **Document Review**: As a first step, a desk review of all relevant project documentation was carried out to identify areas of intervention. The desk review included documents such as:
   - **GAC 3 Project design document (Project proposal)**,
   - **Interim GAC III Activity Reports (July – September, October – December 2020)**,
   - **GAC III Baseline survey report**,
   - **GAC III Performance measurement framework**,
   - **Project logical framework**,
b) **Household survey:** A household is defined as a group of people who share the means of subsistence, economic burdens and benefits whether living under the same dwelling or additions to the main dwelling whether attached or unattached. *The sample size for the end line evaluation was 394 households.* A Household survey questionnaire was developed to this effect, uploaded to the server and downloaded on the data collection gadgets. Research assistants were taken through the questionnaire and how best to ask questions during the data collection process in the field.

c) **Key informant interviews:** Key informants were purposively selected depending on their positions, their deemed role and knowledge about the GAC III Project objectives. Two KII guides were developed to for the specific categories of respondents. A total of twenty (20) key informant interviews were conducted with CARE Project staff, District Local Government, Healthcare staff, Office of the Prime Minister (OPM) among others.

d) **Focus Group Discussion:** FGDs were used to explore the meanings of survey findings that could not be explained statistically, the range of opinions/views on a topic of interest and to collect a wide variety of local terms. FGDs were conducted, involving women, men, girls and boys. These groups of participants were guided by a moderator and an interpreter. A total of seven (7) FGDs were targeted and six (6) conducted in Rhino and Imvepi Refugee settlements in Terego District. There were representatives from each of the selected groups to participate in the FGDs at a designated location. These were mobilized with the assistance of the Community Based Facilitators (CBFs).

e) **Success Stories/ Stories of Significant Change.** We sought to investigate and report on success stories- where there has been noticeable behavioral change from project inception. These stories were gathered and have been documented attached in Annex 1.

### 2.4 Field Work Data Collection

**Training of field staff**

Training of the data collection team took two days. The training was to bring the interviewers to understand the purpose of the study and to train them on the best approaches to the conduct field work. On the first day of the training, participants were taken through the project background as well as the household questionnaire. The second day was for training on use of the Kobo Collect application that uses the open data kit software, pretesting of the data collection tools and revision of data collection questionnaires.

**Fieldwork**
Fieldwork lasted five days. The Interviewers conducted face-to-face interviews with the beneficiaries (refugees and their host communities – women, girls, men and boys) and key informant interviews with other key project stakeholders in the two settlements. The data collection team also conducted FGD sessions for the refugees and host community beneficiaries. The key informant respondents were interviewed face to face and online on scheduled appointments. These were conducted by the consultants’ team.

2.5 Sampling Procedure

The rationale for sample size determination took on The Yamane (1967) formula for determining the optimum sample size is:

\[ n = \frac{N}{1 + Ne^2} \]

\( n = \text{The optimum sample size} \)
\( N = : \text{Population size} \)
\( e = \text{Acceptable margin of error set at 0.05} \)

The 95% confidence level and \( p = 0.5 \) are assumed. \( p \) is the estimated proportion of an attribute that is present in the population.

We therefore set out to interview a sample size of 394 refugees (169 Women, 91 Men, 86 Girls, and 48 Boys\(^1\)) for the Lifesaving GBV, women’s leadership and SRMH support for refugees in Arua District of West Nile Uganda. However, due to a number of challenges the data collection teams faced in the field the greatest of all being the food distribution which went on for three (3) days, we were able to reach a total of 280 household respondents. Of these, 186 were female (41Girls, 145 Women) and 94 were males (35 boys, 59 men).

2.6 Quality Control Measures

Quality control is important to ensure quality outcome of the data. In this particular evaluation, it was achieved through the following;

- The completed structured questionnaires were saved and reviewed by the supervisor in the field and during the nights of each successive fieldwork to ensure that each relevant question was asked and the response properly recorded. This was done before uploading the filled questionnaires to the server.
- The Consultants and research assistants were selected according to the required competencies and were comprehensively trained before field data collection on question per question basis.
- The research assistants were selected from Arua District areas of intervention to guard against the risk of language barrier and to enable the Consultants evaluate the area with ease. Research assistants were assigned a Research supervisor to whom they reported at the close of each field day of data collection. The research supervisor supported the research assistants where there was

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\(^1\) Women and Men (18 years and above), Girls and Boys (15-18 years)
need during the field data collection. The research supervisor in collaboration with the research assistants checked the data for the previous day before embarking on collection of new data.

- There was use of more than one method (triangulation) and this guarded against instrument bias.

### 2.7 Data Management, Monitoring, Data Recovery and Disposal

The team put in place a system to monitor the results from the field. The data was summarized and statistically analyzed. Our analysis was linked to the objectives and questions in the performance measurement framework. The Report format also guided the data input.

Potential risks that could lead to damage or loss of data were analyzed and a mitigation plan developed. This among others involved: hard copy, power back up (power banks), uploading on server, anti-virus protection, among others.

All raw data, analysis tables and materials will be shared with CARE together with the final report.

### 2.8 Ethical Considerations

Ethical considerations were aligned to the CARE International in Uganda’s policy on conducting evaluations, and CARE International Uganda’s safeguarding and child protection policies, which CME obtained and dully consented to abide-by.

The safety of data collected along with the data collection gadgets in the field was the responsibility of the research supervisor. For all household/ beneficiary data collected, no names or unique identifiers were collected.

Prior to participation, informed consent was always sought from all key informants and project beneficiaries.

The data collection questionnaires specified that all information remained confidential, that participation of all respondents was voluntary and would not have an impact on their professional duties, thus, they can opt not to participate without any repercussions.

In addition, all audio recordings or any other such information will not be retained; the audio files will be destroyed immediately upon transcription.

### 2.9 COVID – 19 Standard Operating Procedures (SOPs)

We ensured conformity to standard operating procedures from the Ministry of Health, Uganda and the World Health Organization (WHO) to prevent the spread of the corona virus (COVID-19) pandemic. The following measures were taken in the data collection process for both household, key informant interviews and focus group discussions;

- Temperature checks for survey stakeholders. This was done mainly before walking through office spaces of key informants for example at Office of the Prime Minister.
• Social distancing. The interviewers maintained a 2 meter distance between the respondents.
• Wearing face masks (covering the nose and mouth)
• Hand washing by use of soap and water
• Sanitization for both the interviewers and the respondents (also for FGD sessions).
• Identification and record keeping (record names in all meetings) for follow up.
• Observation of protocols regarding research and COVID-19.
• Use of virtual meetings and audio tools to collect the relevant data remotely where it was deemed necessary. These included telephone calls and use of virtual meeting applications.

2.10 Study Limitations

Logistics and transportation constraints: The poor road conditions made transportation a daunting challenge, especially the roads which lead to Imvepi settlement. It occasionally took hours to travel from one village to another because of the impassible roads. The fieldwork study was conducted during the rainy season, and the unpredictable rainfall sometimes made roads treacherous or impassable especially in the mornings and evenings. In some instances, the data collectors had to hire motorcycles to access the villages which was risky.

Network challenges. Appointments were hard to make with some key informants (especially those who operate within the refugee settlements) due to network challenges in the field. For some key informants, we had to walk in and fix appointments face to face which caused delays.

Busy schedules for some project staff: Some key CARE Project staff had engagements which made it hard to schedule interviews. Mostly we had to hold interviews outside working hours and sometimes re-schedule them. This also caused delays in the data collection process.

Interruptions during data collection: Community events caused a lot of disruption for example, market days, food distribution days for the refugees which lasted 3 days in Rhino settlement resulted into unavailability of the beneficiaries especially the men who were the ones to receive food on behalf of their households. With the help of the CBFs, some beneficiaries were found and interviewed at the food distribution centers.
PRESENTATION AND DISCUSSION OF FINDINGS

3.0 DEMOGRAPHIC CHARACTERISTICS

3.1 Introduction

The chapter presents the findings of the study. It presents the study population demographics and the study findings based on project indicators.

3.2 Age Category of Respondents

The table below presents the categories (by age) of respondents interviewed. It was observed that majority of respondents were female (52% women and 15% girls). The rest of the respondents were male (21% men and 13% boys).

Figure 1: Age category of respondents

Table:

- Girls (15-18 years)
- Boys (15-18 years)
- Women (Above 18 years)
- Men (Above 18 years)

3.3 Marital Status of Respondents

It was noted that majority of the respondents reported to be married or single with no partner as shown in the table below.

Figure 2: Marital Status of respondents
3.4 Household head

Over the entire sample, it was noted that most respondents came from male headed (50%) households, whereas (48%) were from female headed households. Only 2% of the respondents came from child headed homes.

Figure 3: Household head type
3.5 Education background

On the average, majority of respondents had been to primary school but did not complete (41% - 42M, 40F) whereas 17% (20M, 14F) had completed primary, 17% (23M, 11F) attended Ordinary level, 2% (2M, 1F) attended advanced level, 1% (1F) tertiary education and 1% (1M, 1F) attended university level. It was also noted that on average 13% (8M, 18F) had attended FAL program whereas 9% (3M, 15F) had never been to school at all. What is evident is that more women than men do not complete primary education. More men are represented in the strata beyond primary education.

Figure 4: Education level of respondents
4.0 DISCUSSION OF PROJECT OUTCOMES

This section discusses the Ultimate indicator of the project and then moves to the Intermediate and immediate output indicators that are aligned to the three project focus themes which are, Gender Based Violence (GBV), Women Lead in Emergency (WLiE); and Sexual Reproductive and Maternal Health (SRMH). In each of these subsections, the various indicators are discussed with major focus on the outcome indicators; the levels of achievement and challenges. The measurement of the outcomes is at three levels, ultimate outcomes, intermediate outcomes and immediate outcomes. Thereafter, the focus is moved to the evaluation criteria of relevance, effectiveness, efficiency and sustainability. The chapter concludes by presenting the lessons learned and conclusion.

4.1 SAVING LIVES; ALLEVIATING SUFFERING AND MAINTAINING HUMAN DIGNITY IN RHINO SETTLEMENT, ARUA, WEST NILE, UGANDA

4.1.1 Ultimate Outcome: 1000 Lives Saved, Suffering Alleviated and Human Dignity Maintained Through SRH, WLiE and GBV Interventions for Crisis Affected Refugee and Host Community Women, Men, Boys and Girls in Rhino Settlement Camp in Arua, West Nile Region, Uganda.

Indicator 1100: % of beneficiaries (m/f) reporting an improved feeling of safety and dignity

The target for this indicator was 75% along a baseline value of 54%. Safety was measured at both household and community level. Based on the end line survey of the respondents, 91% indicated an improved feeling of safety and dignity generally at both community and household level. The percentage of women and girls who report an improved feeling safety are 92% and the percentage of men and boys feeling safe is 89%. The details are provided in the figures 5, 6, and 7 below.

Figure 5: % of beneficiaries (m/f) reporting an overall improved feeling of safety and dignity
However, there are areas where beneficiaries (male and female) feel that they are either not sure, disagree or strongly disagree that they are safely and easily accessible for both women and girls and men and boys and this overall percentage is just about 30% as shown in the tables 1 and 2 below. These include; fuel collection points, firewood and charcoal collection points and public
latrines. This was further evidenced in two FGDs for Women and Girls where they said that “girls are sexually harassed on their way to firewood collection points”.
## Table 1: Females who report safety at specific areas within the settlement

<table>
<thead>
<tr>
<th>Question</th>
<th>SA%</th>
<th>A%</th>
<th>NS%</th>
<th>D%</th>
<th>SD%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B34A</strong> Public latrines and bath houses are easily accessible to women and girls</td>
<td>26</td>
<td>43.2</td>
<td>17.8</td>
<td>10.8</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>B34B</strong> Public latrines and bath houses are easily accessible to men and boys</td>
<td>33.5</td>
<td>46</td>
<td>16.8</td>
<td>3.2</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34C</strong> Women and girls are involved in food distribution within the settlement</td>
<td>33.5</td>
<td>55.7</td>
<td>9.7</td>
<td>0</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>B34D</strong> Women and girls feel safe and secure in their households?</td>
<td>35.1</td>
<td>56.8</td>
<td>7.6</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34E</strong> Men and boys feel safe and secure in their households.</td>
<td>37.3</td>
<td>54</td>
<td>8.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>B34F</strong> Fuel collection points are safely and easily accessible by women and girls</td>
<td>12.4</td>
<td>54.6</td>
<td>19.5</td>
<td>13</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34G</strong> Fuel collection points are safely and easily accessible by men and boys</td>
<td>16.2</td>
<td>51.9</td>
<td>19</td>
<td>9.7</td>
<td>3.2</td>
</tr>
<tr>
<td><strong>B34H</strong> Women are involved in monitoring food distribution within the community</td>
<td>37.3</td>
<td>55.3</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>B34I</strong> Firewood and charcoal collection points are safely and easily accessible to women and girls</td>
<td>8.1</td>
<td>46.5</td>
<td>13</td>
<td>22.2</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>B34J</strong> Firewood and charcoal collection points are safely and easily accessible to men and boys</td>
<td>12.4</td>
<td>44.9</td>
<td>11.4</td>
<td>27</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>B34K</strong> Water collection points are safely and easily accessible to women and girls?</td>
<td>26</td>
<td>57.8</td>
<td>5.4</td>
<td>9.7</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>B34L</strong> Water collection points are safely and easily accessible to men and boys?</td>
<td>23.2</td>
<td>64.9</td>
<td>5.4</td>
<td>6</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34M</strong> Women are represented in the settlement watch teams patrolling inside this settlement?</td>
<td>31.9</td>
<td>50.8</td>
<td>9.2</td>
<td>7.6</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34N</strong> Camp members are aware of how to report a case of violence against a woman or girl living in the camp?</td>
<td>38.4</td>
<td>57.3</td>
<td>2.7</td>
<td>1.6</td>
<td>0</td>
</tr>
<tr>
<td><strong>B34O</strong> There are female health workers available in the health center to treat women and girls who have experienced violence?</td>
<td>33.5</td>
<td>63.2</td>
<td>2.2</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34P</strong> All settlement areas are safe and easily accessible to women and girls.</td>
<td>26</td>
<td>57.8</td>
<td>10.3</td>
<td>5.5</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>B34Q</strong> All settlement areas are safe and easily accessible to men and boys.</td>
<td>21.6</td>
<td>70</td>
<td>6</td>
<td>2.7</td>
<td>0</td>
</tr>
</tbody>
</table>

---

2 Source of Questions: GBV Toolkit, GBV Cluster Response In Syria & Turkey Hub - 2020
Table 2: Males who report safety at specific areas within the settlement

<table>
<thead>
<tr>
<th>Item</th>
<th>SA</th>
<th>A</th>
<th>NS</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B34A Public latrines and bath houses are easily accessible to women and girls</td>
<td>20</td>
<td>26.3</td>
<td>26.3</td>
<td>23.2</td>
<td>4.2</td>
</tr>
<tr>
<td>B34B Public latrines and bath houses are easily accessible to men and boys</td>
<td>23.2</td>
<td>34.7</td>
<td>19</td>
<td>21.1</td>
<td>2.1</td>
</tr>
<tr>
<td>B34C Women and girls are involved in food distribution within the settlement</td>
<td>33.7</td>
<td>58</td>
<td>8.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B34D Women and girls feel safe and secure in their households?</td>
<td>32.6</td>
<td>63.2</td>
<td>4.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B34E Men and boys feel safe and secure in their households.</td>
<td>33.7</td>
<td>64.2</td>
<td>2.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B34F Fuel collection points are safely and easily accessible by women and girls</td>
<td>19</td>
<td>50.5</td>
<td>23.2</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>B34G Fuel collection points are safely and easily accessible by men and boys</td>
<td>14.7</td>
<td>55.8</td>
<td>22.1</td>
<td>7.4</td>
<td>0</td>
</tr>
<tr>
<td>B34H Women are involved in monitoring food distribution within the community</td>
<td>30.5</td>
<td>64.2</td>
<td>1.1</td>
<td>4.2</td>
<td>0</td>
</tr>
<tr>
<td>B34I Firewood and charcoal collection points are safely and easily accessible to women and girls</td>
<td>17.9</td>
<td>42.1</td>
<td>12.6</td>
<td>20</td>
<td>7.4</td>
</tr>
<tr>
<td>B34J Firewood and charcoal collection points are safely and easily accessible to men and boys</td>
<td>14.7</td>
<td>44.2</td>
<td>15.8</td>
<td>19</td>
<td>6.3</td>
</tr>
<tr>
<td>B34K Water collection points are safely and easily accessible to women and girls?</td>
<td>22.1</td>
<td>65.3</td>
<td>7.4</td>
<td>5.3</td>
<td>0</td>
</tr>
<tr>
<td>B34L Water collection points are safely and easily accessible to men and boys?</td>
<td>22.1</td>
<td>64.2</td>
<td>9.5</td>
<td>4.2</td>
<td>0</td>
</tr>
<tr>
<td>B34M Women are represented in the settlement watch teams patrolling inside this settlement?</td>
<td>31.6</td>
<td>55.8</td>
<td>6.3</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>B34N Camp members are aware of how to report a case of violence against a woman or girl living in the camp?</td>
<td>28.4</td>
<td>70.5</td>
<td>1.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B34O There are female health workers available in the health center to treat women and girls who have experienced violence?</td>
<td>37.9</td>
<td>59</td>
<td>2.1</td>
<td>1.1</td>
<td>0</td>
</tr>
<tr>
<td>B34P All settlement areas are safe and easily accessible to women and girls.</td>
<td>21.1</td>
<td>66.3</td>
<td>5.3</td>
<td>6.3</td>
<td>1.1</td>
</tr>
<tr>
<td>B34Q All settlement areas are safe and easily accessible to men and boys.</td>
<td>26.3</td>
<td>66.3</td>
<td>2.1</td>
<td>5.3</td>
<td>0</td>
</tr>
</tbody>
</table>

The FGDs indicate that as a result of the improved feeling of safety and dignity, the following is currently happening in the community;

- Girls are going to and keeping in school.
- Economic empowerment of women because of the women spaces which were equipped to support capacity building in income generating activities like liquid soap making
• Financial knowledge, freedom and wisdom due to the trainings in savings and VSLAs.
• There is behavioral change due to psychosocial support sessions, awareness sessions by RMMBs and CBFs.
• Increased men’s participation in reproductive roles of child care and nurturing and household chores.
• Improved relations at household level
• Improved hygiene due to the support of the vulnerable girls with hygiene kits.
Indicator 1200: % of extremely vulnerable individual targets reverting to high risk behaviors and negative coping strategies

The overall percentage of people (m/f) reverting to high risk behaviors at end line was achieved at **11.2% (9.3F, 15.1M)** in comparison to a target of 20%. The end of project evaluation statistics suggests that there is a reversal indicated by the following; taking alcohol to forget problems standing at **17% (29.4%M, 10.2%F)** compared to the baseline **16% (17%M and 15%F)**. **Selling of household items is still high at 35% (52%M, 27%F) which was the same at baseline which stood at 35% (35M, 35F) and psychological and emotional abuse at 33% (41%M, 29%F) in comparison to the baseline levels which was at 17% (9%M and 22%F).** These have been presented in Figure 8 below.

Figure 8: % of extremely vulnerable individual reverting to high risk behaviors and negative coping strategies

<table>
<thead>
<tr>
<th>High Risk Behaviors</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selling household assets</td>
<td>52</td>
<td>27</td>
</tr>
<tr>
<td>Psychological or emotional abuse</td>
<td>41</td>
<td>29</td>
</tr>
<tr>
<td>Taking alcohol to forget problems</td>
<td>29</td>
<td>10</td>
</tr>
<tr>
<td>Drug consumption</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Extramarital affairs (including affairs with members of the extended family)</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Fighting</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Theft/Robbery</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Denial of sex to a spouse</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sex for money</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The reduction for the females reverting to high risk behaviors mentioned could be linked to the gender specific project interventions for women and women groups including livelihood support and psychosocial support at individual and group level. On the other hand for the men’s increased reversal to high risk behaviors could be linked to; the pressures for household provisioning in the context of GBV. It was reported that there is physical violence when women ask their men to stop drinking alcohol and economic violence when men do not provide for the household or sell household items including food ratios.
“I think we could have had more men on board. The target is more of women and girls, men are not happy with some of the interventions. If we give women power, the men are becoming insubordinate. Men are also having struggles, lost jobs, struggling because they have to take care of families, they have stress and trauma resorting to drinking.” – KII

“Women suffer psychological torture/ violence because food can get over in the house and for fear of their husbands scolding them over this, they strive to think about what to cook for their household members. This is very stressing for the women.” – FGD Women

“Men abandon households with few members for example, 4 and move to one with more household members (8). The reason they do this because he can be able to sell off some food ratios from AFI and get money for alcohol which is hard to do in a small size household as the food there is less.” – FGD Women

“Men are affected in such a way that since they have no jobs to do, they can’t be in position to provide and take care of their families. In the process, women attack the men for not providing hence fighting.” – FGD Women
4.2 INTERMEDIATE OUTCOME ONE – GENDER BASED VIOLENCE (GBV)

4.2.1 Increased and Equitable Use of Gender Responsive GBV Assistance by Crisis Affected People in Rhino Camp Settlement in Arua District, West Nile Region Uganda

Through its GBV assistance, the project supported the refugee settlements with the following:

The GAC 3 project supported GBV Prevention Assistance: GBV prevention assistance aimed at ending and preventing GBV in the targeted refugee settlements. It was mainly provided through the Community Based Facilitators approach (CBFs) that provide awareness raising sessions within the community. In addition, the reflection meetings by Role Model Men and Boys (RMMB) with men and GBV perpetrators are used to create opportunities for unlearning the negative gender norms and practices. The meetings also assist men, boys and perpetrators to adopt shared roles and responsibilities with women to end GBV (Interim Report June 2020).

Case Management Assistance: Through Case Management Assistance Groups (CMAGs), the project supported GBV and protection case identification, follow-up and closure. The Case Management Groups (CBFs and other trained community structures) referred GBV and protection cases to the case managers and police and other protection managers. The case management assistance also included sheltering of survivors until the case has been resolved in addition to other services in relation to case management.

Dignity kits distribution: The project supported vulnerable women and girls with dignity kits. These were in two forms that is maternity kits (given to vulnerable mothers who gave birth at the health centers) and hygiene kits (given to vulnerable girls in the settlements). The hygiene kits consisted of pads, soap, buckets, pants, sandals, jelly and wrappers (kitenge). On the other hand, the maternity kits consisted of wrappers (kitenge), maternity pants, slippers, baby clothes among other items.

The project supported the communities with psychosocial support: Psychosocial Individual Support included the provision of counseling sessions, dignity kits, post exposure prophylaxis, and home visits. Psychosocial support through provision of safe spaces for interaction was also provided. This support was mainly passed on to GBV survivors at the women centers and the sessions were led by the CBFs, RMM and women.

Equipping of Women and Youth Centers: Women and Youth Centers provide opportunities of survivor interactions to enhance confidence, self-esteem and resilience. The centers also act as safe spaces for reporting GBV cases, PSS engagements, experience sharing and Music dance and drama. The centers are managed by the Women and Youth Centre Committees (WYCMC) that consist of 9 women members including the chairperson, vice chairperson, secretary, treasurer and committee members. They work with men of their choice to oversee the activities of the center.
These centers were equipped with musical instruments, hand washing facilities, mats for sitting on, dummies for hair plaiting lessons, chairs for hosting meetings, children play equipment’s among others. The purpose for these equipment was to make them user friendly for women, youth and children.

**The project promoted Safety and Protection of the settlements:** Other than case management assistance, the Community Safety Action Groups (CSAGs) were supported to undertake night patrols and protection monitoring of the settlements to prevent GBV related crimes especially in hot spots.

**Capacity Building:** Capacity building was done to ensure effective and efficient management of the GBV assistance. Various groups of people including the community, health workers, CBFs, leaders, protection partners, HUMIC leaders among others were trained in GBV management and other areas of life including SRMH. GBV prevention and protection training covered various aspects including but not limited to; raising GBV complaints, feedback and response mechanisms (CFRM); leadership skills, case management skills through case conferencing.

**Legal redress:** The survivor fund facilitated the transfer of cases to other GBV service providers including the police, medical practitioners and courts. The fund supported the survivors to access the health facilities for treatment. It also facilitated survivors and witnesses in court appearances due to the long distances. Some of the settlement areas are as far as 10 kilometers from the health facility as is the case of Omugo village 4 (Ibid.)

In order to measure the intermediate outcome mentioned above, the following indicators were taken into consideration;

**Indicator 1110: % of targeted people (m/f) who report satisfaction with GBV assistance**

The end line evaluation survey indicates an achieved level of satisfaction (GBV assistance) for both male and female at **81% (86M, 79F)**. This was achieved against a target of 80% (80F, 80M) and whose baseline value was at 66% (69F, 62M). These results are shown in Figure 9 below. This could be attributed to the behavioral changes in their women at household level due to the project interventions. In addition, it could also be attributed to the Role Model Men and Boys (RMMB) approach.

A review of the report for the project period June – December 2020 shows a general satisfaction with the assistance. Some of the useful services include counseling that has resulted into positive coping mechanisms for the survivors and perpetrators. The survivors know the GBV service providers and can receive referrals of their cases.
The documents also have sentiments of satisfaction with the services provided by the CBFs and Community Social Action Groups (CSAGs) such as ‘good work’, happiness, and hope. A statement in one of the October to December project reports summarizes satisfaction with the assistance “Now I have a place to play and meet with other girls.

The specific statements in the report that demonstrate GBV survivors’ satisfaction with the service include, ‘feel loved, listened to, trusted, gained hope, enabled me to open up, heal from the pain among others.

Figure 9: % of targeted people (m/f) who report satisfaction with GBV assistance

![Chart showing satisfaction levels]

The respondents were further requested to mention the GBV related services that are available in their communities. It was noted that 90% of the surveyed male and female beneficiaries reported the availability of GBV awareness and prevention sessions, 75% acknowledged that there is referral of GBV cases, 67% for case management, 70% hygiene kit distribution among others as shown in Figure 9A below. In figure 9B below, beneficiaries further reported a reduction in the level of GBV incident occurrence rating the reduction with 81% overall (83%M, 78%F). 7% (7M, 7F) reported that the incident occurrence remained the same whereas only 4% (3M, 5F) reported an increase.
Figure 9A: % of beneficiaries reporting available GBV services in the community

- GBV Awareness Raising: 90%
- Referral of cases: 75%
- GBV Case Management: 67%
- Hygiene Kit Distribution: 70%
- Individual Psychosocial support...: 59%
- Psychosocial Group sessions: 48%
- Do not know: 2%
- Others (Specify): 1%

Figure 9B: Percentage of beneficiaries (m/f) reporting on level of GBV incident occurrence

- Increased
  - Male: 3%
  - Female: 5%
- Remained the same
  - Male: 7%
  - Female: 7%
- Decreased
  - Male: 83%
  - Female: 78%
- I don’t know
  - Male: 6%
  - Female: 9%
Indicator 1120: % of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV

The end line survey indicates that the target for this indicator was achieved at $\text{75\% (79F, 70M)}$ compared to the baseline indicator which was at 63% (57F, 72M). These statistics are further shown in table 3 below. Women were more optimistic towards ending GBV i.e. 79%, compared to men who were at 70%. This could be attributed to the observed behavioral changes in women and men at the household level on one hand and on the other, the RMMB approach. It could also allude to the fact that the project interventions were mainly targeted to women (especially the PSS which is given to more women than men) and that women are observing behavioral changes in their spouses.

A review of project reports indicates that Role Model Men and Boys have facilitated men and boys who are the main perpetrators of GBV to unlearn some of the negative gender norms and practices that foster GBV. The positive effects are seen in some men’s letting go of some negative masculine behaviors. The reports indicate some men have adopted positive masculine behaviors including sharing of roles and responsibilities with women at household level; understanding that women can participate in activities beyond the household and negating physical violence.

The community leaders are involved in case identification and referral to the police as exemplified by the male Chairpersons of Ariaze B and Omugo 5 that initiated monthly community meetings specifically geared towards discussing GBV/PSHEA issues to encourage case reporting to referral points within their community for support.

**Table 3:** % of women and girls, men and boys demonstrating positive attitude towards ending GBV

<table>
<thead>
<tr>
<th>M (Males/ females)</th>
<th>Agree (%)</th>
<th>Partially agree (%)</th>
<th>Don’t agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>There are times when a woman deserves to be beaten</td>
<td>7</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>A woman should tolerate violence to keep her family together</td>
<td>25</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>It is alright for a man to beat his wife if she is unfaithful</td>
<td>5</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>A man can hit his wife if she refuses to have sex with him</td>
<td>7</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>A man should defend his reputation with force if he has to</td>
<td>8</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

*Culturally, men are seen as powerful. The idea of male dominance is very high, when they support their women they are seen as weak people, bewitched by the women and collapse out of the approach (RMM) to identify with their peers. Some fall back from being role model men because of the challenge and mockery from fellow men.”* -KII
As a follow up, when further asked whether they are willing to contribute towards ending GBV, it was observed that on the overall, both men and women are willing to contribute to ending gender based violence but there is a fairly high percentage of 34% of women and girls that are either not willing or not sure whether they can contribute to ending GBV. On the other hand, men who are either not willing or not sure whether they can contribute to ending GBV are 20%. This is an issue of concern taking into account the fact that the major target population of the GAC 3 project was women and girls. These have been presented in figure 11 below;

Figure 11: Number of beneficiaries able to contribute towards ending GBV

![Bar chart showing the number of beneficiaries able to contribute towards ending GBV.]

Figure 12: Ways through which beneficiaries are able to raise GBV complaints
<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Volunteers</td>
<td>81</td>
<td>71</td>
</tr>
<tr>
<td>CAR E’s Information Desk</td>
<td>77</td>
<td>75</td>
</tr>
<tr>
<td>Refugee Welfare Committee</td>
<td>64</td>
<td>55</td>
</tr>
<tr>
<td>Settlement Authorities</td>
<td>63</td>
<td>65</td>
</tr>
<tr>
<td>CAR E staff</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>Police</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Complaint Box</td>
<td>39</td>
<td>42</td>
</tr>
<tr>
<td>Phone numbers</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Other NGO staff</td>
<td>24</td>
<td>33</td>
</tr>
<tr>
<td>Religious leaders</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Other leaders (Specify)</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>UNHCR</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Traditional leaders</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
4.3 IMMEDIATE OUTCOME ONE: GENDER BASED VIOLENCE (GBV)

4.3.1 Identified GBV Survivors and Extremely Vulnerable Individuals, Particularly Women and Girls, Have Access to Quality, Appropriate and Timely Protection Specific Response

**Indicator 1111: # of people who have experienced, or are at risk of, any form of sexual or gender based violence that have received related services in the previous 12 months**

Evidence from the reports for the period April to December indicate that 133 (122F/11M) reported having experienced GBV. The women centers for the period April to December supported 3350 persons (2254 women, 987 girls, 47 men and 62 boys). Of these, 1481 (910 women/571) girls accessed PSS services of these 67% were in the first quarter. On the overall, the services accessed was more in the first quarter (64.8%) in comparison to the second quarter (40%). As noted in the reports, the difference could be attributed to the fact that in the first quarter, communities had just gotten out of the lock down and had several psychosocial challenges. The reports indicate that 500 dignity kits were proportionately distributed in the various centers for the period June – December 2020. Other than PSS services and dignity kits whose statistics is accounted for, it is not clear what other forms of service were accessed at the centers.

**Indicator 1112: % of people (m/f) trained who have increased knowledge on GBV prevention and protection**

From the end line evaluation survey, a total of 62% beneficiaries (59%F, 67%M) indicated that they had received training in GBV prevention and protection (see table 6 below). These trainings covered the following topics; GBV referral pathways, reporting of GBV cases, supporting of GBV survivors, timely reporting of GBV cases (within 72 hours), protection from sexual exploitation and abuse (PSEA) among others. When further asked to rate the whether their knowledge of GBV prevention and protection had increased or remained the same, generally both females and males reported an increase in their knowledge of GBV prevention which is shown by an achievement of 83% (85M, 81F) in figure 13 below against a target of 80% (80M, 80F).

**Table 4: Number of beneficiaries who received training in GBV prevention and protection**

<table>
<thead>
<tr>
<th>Have you received any training in relation to GBV prevention and protection</th>
<th>A01. Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Male</td>
</tr>
<tr>
<td>Yes</td>
<td>64</td>
</tr>
<tr>
<td>Percentage</td>
<td>67.37</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
</tr>
<tr>
<td>Percentage</td>
<td>32.63</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
</tr>
</tbody>
</table>
The key stakeholders trained are more male than females. The way women reach out to women is not the same as men do. Secondly, appreciation and comprehension of Gender Based Violence by males and female is not the same.
5.1 INTERMEDIATE OUTCOME TWO: WOMEN LEAD IN EMERGENCIES

5.1.1 (1200) Increased and Equitable use of Gender Responsive WLiE Assistance by Crisis-Affected People to Meet Basic WLiE Needs in Rhino Settlement in Arua District, West Nile Region, Uganda

Focus on Women Lead in Emergencies is based on a 5-step approach developed by CARE to work with marginalized and crisis affected women to strengthen women’s voice, leadership and representation in programing, governance and public decision-making. The expected changes included increased ability of women affected by crisis to meaningfully participate in formal humanitarian decision-making as a safe space for nurturing women and girls’ leadership aspirations.

The services that women received to foster their leadership abilities include:

1. Functional Adult Literacy (FAL) Education
2. Working together with RMM to solve GBV cases
3. Exchange visits
4. Intergroup debates
5. Women conferences
6. Bargaining for agricultural land from host communities
7. GBV case referrals
8. Capacity building in saving, business management and income generating activities
9. Group economic start up grants

The Role Model Men was an approach in WLiE. The RMMBs empower and encourage women to take up front “seats” and take on leadership roles in the community. Role model men act as role models for men in the community by being good examples. They do sensitization and recruit fellow men and boys into the group to encourage them to adopt supportive behavior towards women in their communities. They are involved in awareness raising in the community and conflict resolution of amongst families experiencing GBV.

The capacity building support they received from GAC 3 project included; converting men from bad to good behavior, mediation, conflict resolution, GBV case management, GBV referral pathways among others.

Indicator 1210: % of women reporting high self-efficacy (CI)

Self-efficacy for women was measured at four levels (women being able to achieve a self-defined goal in their lives, ability to access education (FAL) services, the ability to speak up and address a gathering and the ability to leave their homes to participate in WLiE activities without prior
permission from their husbands). The findings indicate that women have more self-efficacy after the GAC 3 project interventions. This is evidenced by a **94% achievement** (figure 14) from the baseline level which was at 27% and against a target of 70%. The high efficacy for women may be attributed to their being the main targets of the project. Also the approaches that are being used are targeted towards changing men’s’ attitude towards women’s self-efficacy. These approaches include; psychosocial group support, livelihood group support, family planning, FAL, VSLAs and other income generating activities, RMMB approach, awareness sessions, working with CBFs and other leadership where some of these are men. In essence, these are changing the patriarchal context.

Documents review evidence suggests that women have gained public speaking skills. Some women that were unable read and write have benefited FAL The reports indicate that women can read and construct some English sentences, write their names and append their signatures as need may arise.

**Figure 14:** Percentage of women reporting high self-efficacy (CI)

<table>
<thead>
<tr>
<th></th>
<th>Extremely confident</th>
<th>Very confident</th>
<th>Fairly confident</th>
<th>Somewhat confident</th>
<th>Not at all confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>How confident are you that you can achieve a self defined goal in your personal life?</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>How confident are you that you can access educational services (Functional Adult Literacy)?</td>
<td>55</td>
<td>54</td>
<td>57</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>How confident do you feel that you can comfortably speak up and raise your</td>
<td>27</td>
<td>25</td>
<td>32</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>How confident are you that you can participate in WLiE activities without prior permission from your husband</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>
Indicator 1220: % of women reporting they can work collectively with other women in the community to achieve a common Goal

The indicator was measured using three parameters i.e. whether women can collaborate with other members of the community to address a community need, whether women can collaborate as a community to improve their quality of life and whether women can collaborate with other tribes to enhance their voice and participation. Against a baseline value of 92% and target of 70%, the end line mean average percentage in relation to the above three parameters of the surveyed women is 74%. The specifics in relation to each of the above parameters is further shown in figure 15 below. The target was achieved with an excess of 4 points. The key issue to note was that the target was realistic taking into account the lock down which limited collective working in a context of minimum virtual abilities to foster remote collective working. The technologies are limited within context. It is important to note that when the men were asked the same questions in relation to themselves, it was established that it was near parity with that of women since it was at 76% (see figure 15A below). The limitations in these statistical evidences is that COVID-19 led to a strict lock down that called for new ways of collaborating and networking. A review of the documents and focus group discussion (FGDs) indicates that women are hampered by a number of factors including but not limited to; illiteracy, heavy, domestic burden, language barrier, age related issues, social stigmatization, lack of civic education, lack of financial power. The targeted assistance towards women makes the men jealous and they refuse the women from participation. That said, changing culture to overcome these barriers takes time.

Review of the project reports shows that women work collectively to achieve a common goal including in Village savings schemes; the women and youth centers (WYCs).

Review of project reports indicates that women are networking amongst themselves and with other actors within and outside their communities to access the necessary support in case of a problem.

Evidence in the project reports also indicates that women are working collectively in income generating projects such as catering, liquid soap making, hair plaiting, bakery, groundnut paste making. Some of the business volumes have increased to as much 500%.

“...some women are prevented from speaking at gatherings due to language barrier. Some women can only speak “kakwa” and yet majority can speak Arabic, Keriko, Kuku, Baka, Avukaya among others which are all SSD languages...” – FGD Omugo 5

“Some men still refuse women to participate in decision making spaces even though RMM continue to do awareness in the community.” – FGD SSD Women

“...there is Block leader who is a woman in Tank 45 who is discouraged by men from attending and contributing in community gathering simply because she cannot read and write. Apparently, since she joined FAL, she can write her name.” – FGD

“...there is Block leader who is a woman in Tank 45 who is discouraged by men from attending and contributing in community gathering simply because she cannot read and write. Apparently, since she joined FAL, she can write her name.” – FGD
Figure 15: Percentage of women reporting they can work collectively with other women in the community to achieve a common Goal

![Bar Chart]

- I can collaborate with other members of the community to address a community need
- We can collaborate as a community or improve our quality of life.
- We can collaborate with other tribes to enhance our voice and participation.

Fig. 15A: Percentage of men reporting they can work collectively in the community to achieve a common goal

![Bar Chart]

- I can collaborate with other members of the community to address a community need
- We can collaborate as a community or improve our quality of life.
- We can collaborate with other tribes to enhance our voice and participation.
Indicator 1230: % of women who report being able to meaningfully participate in formal and informal humanitarian decision-making spaces

82% of surveyed women reported that they can meaningfully participate in decision making spaces. This indicator was measured at two levels: how many women are in leadership positions and women whose opinions are listened to with respect and considered in the decision making spaces. The statistics indicate that fairly a very small number of women are in leadership spaces. 32% of the women who were interviewed are in leadership spaces and 82% of these women reported that they can meaningfully participate and that their opinions are listened to and considered in the decision making spaces. This was achieved against a project target of 70%. In the same breath, 43% of men reported to have leadership roles out of whom 79% reported that their opinions are listened to and considered in the decision making spaces.

On the overall women indicate that they can be able to participate in formal and informal leadership spaces as shown in the figure 15C below. This can be attributed to the project interventions including, trainings, functional adult literacy classes and the livelihood interventions. However, this confidence cannot be over emphasized because of the patriarchal context (see figure 15B below) in which shifting power centers is complicated. For example, strategies to address barriers to women leadership and participation was underachieved and the same applies to co-creation space to validate RGA findings and develop action plans. That said, changes are happening as evidenced by the fact that the women are saying their voices are heard and respected in decision making spaces.

Documents review indicate that women are aspiring to compete in the fourth coming elections with men for Regional Welfare Committee leaders. There are several contributing factors to this confidence including participation in FAL.

Evidence in the project reports suggests that the women leaders in emergencies are being used as reference points in community consultative meetings and work GBV change agents.

Evidence from FGDs suggests that there are available positions in the community and that there are already women leaders in specific community and women groups e.g. in VSLAs (Chairperson, secretary, treasurer), Water user committees, representation in the clusters and RWCs, in churches among other platforms.
“...women wanted to go to school in form of adult learning. We started adult learning and recruited community leaders. They know that they understand them and their needs and address their needs. It has been one of the best interventions, we had women that could not write their names. Four months down the road in the project, they write their name, sign, speak in meetings, air out issues affecting other women, are able to count, we have seen women take up leadership opportunities, we have aspirants... More men on board would have impacted the outcome differently. Based on feedback, we might need to think about it differently in the future. In order to transform cultures, we need to transform men because they are the power holders...” - KII

**Figure 15B. Percentage of women who have leadership roles within their community**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>68</td>
</tr>
</tbody>
</table>

**Fig. 15C Percentage of men and women who report that their opinions are listened to with respect and considered in the decision making process**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>79</td>
<td>82</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>18</td>
</tr>
</tbody>
</table>
The focus group discussions indicate that women face three major patriarchal related barriers to their active participation in leadership spaces that are;

1. *The burden of balancing the triple gender roles of reproduction, production, and community*
2. *Marital impediments that is limited spousal support due to anxieties of either not paying attention to her presumed roles at household level or exposure to other men.*
3. *Limited self confidence that maybe linked to the complexity of rebuilding oneself especially after exposure to Gender Based Violence (GBV). The inferiority that comes after realization that one has not received formal education that enables one to read and write, and address the public.*
5.2 IMMEDIATE OUTCOMES WOMEN LEADERSHIP IN EMERGENCIES:

5.2.1 (1210) Increased Ability of Women Affected by Crisis to Meaningfully Participate in Humanitarian Decision Making

Indicator 1211: % of surveyed women who report confidence in their own negotiation and communication skills

The end line evaluation statistics confirm that women who have confidence are (89%) against a target of 75%, while that of men (97%) are more confident than women (see figure 16) below. This is not surprising because the decision making and communication terrain favors men who are generally presumed as decision makers at both household and community levels. The fact that women can express confidence to occupy this space is a major achievement as indicated in the FGD and KIIIs that women lead in emergencies was one of the very significant achievement in the GAC 3 project that women have established themselves, working collectively and even the neighboring communities were requesting for this initiative. This may be attributed to the psychological effects of COVID-19 that had restrictions that generally affected personal wellbeing including self-confidence.

A further interrogation on how confident women felt that they can effectively negotiate for services in their community, leadership spaces and their homes in regards to SRH, GBV and WLiE indicated that 90% of the surveyed women are confident which tallies with the statistical finding on confidence in general confidence and negotiation levels stated above.

**Figure 16:** % of surveyed women who report confidence in their own negotiation and communication skills
**Indicator 1212:** % of men reporting an increase in the level of awareness and support of women's right to participate in decision making spaces as a result of implementing Role Model Men & Boys approach in WLiE

**On the average, at end line 56%** of men reported an increase in their support of women to participate in leadership spaces compared to the baseline value which stood at 45%. 71% men disagreed that women should leave politics to men and thus women too should involve themselves in politics. This shows an increase in men’s support of women to take on leadership roles compared to the baseline level which was at 56%. 76% of surveyed men disagreed that a man who shares housework with his wife will be overpowered by her compared to the baseline indicator which stood at 77%. There is a percentage decrease in the number of men who believe that a woman’s role is taking care of her home and family from 65% at baseline to 53% at end term. These changes are all attributed to the role model men approach in the WLiE where men were involved as agents of change in the community. *The details are further presented in table 5 below.*
Table 5: % of men reporting an increase in the level of awareness and support of women's right to participate in decision making spaces as a result of implementing Role model men & boys approach in WLiE

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Partially agree</th>
<th>Don’t agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A man who shares house work with his wife will eventually be over powered by her</td>
<td>9</td>
<td>15</td>
<td>76</td>
</tr>
<tr>
<td>A man can cook food for his family</td>
<td>87</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>It is shameful to be found by friends and neighbours washing your wife’s clothes</td>
<td>14</td>
<td>25</td>
<td>61</td>
</tr>
<tr>
<td>Men do not know how to keep toddlers without a woman</td>
<td>15</td>
<td>27</td>
<td>58</td>
</tr>
<tr>
<td>Men who are seen playing or singing with children are considered to be behaving like women</td>
<td>7</td>
<td>18</td>
<td>75</td>
</tr>
<tr>
<td>I can determine the choice of business to do without my partner’s interference</td>
<td>28</td>
<td>27</td>
<td>44</td>
</tr>
<tr>
<td>I can do my domestic work at my own time</td>
<td>53</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>I can decide whom to marry and when</td>
<td>52</td>
<td>12</td>
<td>37</td>
</tr>
<tr>
<td>Changing clothes, giving a bath or feeding children is a mother’s responsibility</td>
<td>19</td>
<td>22</td>
<td>59</td>
</tr>
<tr>
<td>A woman’s role is to take care of her home and family</td>
<td>27</td>
<td>20</td>
<td>53</td>
</tr>
<tr>
<td>A man should decide to buy major household items</td>
<td>31</td>
<td>22</td>
<td>47</td>
</tr>
<tr>
<td>A man should have the final word on decisions in the home</td>
<td>25</td>
<td>25</td>
<td>49</td>
</tr>
<tr>
<td>A woman should obey her husband in all things</td>
<td>28</td>
<td>26</td>
<td>45</td>
</tr>
<tr>
<td>Women should leave politics and leadership roles for men</td>
<td>5</td>
<td>24</td>
<td>71</td>
</tr>
</tbody>
</table>

Indicator for GAC 4: % of beneficiaries (m/f) reporting satisfaction with WLiE services

The 81% (82%M, 80%F) level of satisfaction points to improving gender relations at both household and community level. It also points to a clear demonstration by women that they can cause positive change as leaders at community level. It can also point to the community appreciation of the awareness sessions on women as leaders and the functioning of the RMMB. All these can be attributed to the increase in women self-efficacy, and their being respected in formal and informal decision making spaces, their confidence in communication and negotiation skills among other aspects. The level of satisfaction with WLiE services has been presented in the figure below.
% of beneficiaries (m/f) reporting satisfaction with WLiE services in their community.

- **Very satisfied**
  - Male: 15
  - Female: 18

- **Satisfied**
  - Male: 67
  - Female: 62

- **Not sure**
  - Male: 17
  - Female: 11

- **Dissatisfied**
  - Male: 1
  - Female: 8

- **Very dissatisfied**
  - Male: 0
  - Female: 1

Legend: Male □ Female □
6.1 INTERMEDIATE OUTCOME THREE SEXUAL REPRODUCTIVE HEALTH AND RIGHTS:

6.1.1 (1300) Increased Demand and Equitable Use of Gender-Responsive Health Services by Crisis-Affected People, Particularly Pregnant and Lactating Women and Girls in Rhino Camp Settlement in Arua District, West Nile Region, Uganda

The intermediate outcome on gender responsive health services is linked to objective three of the project that aspires for increased access to critical SRMH services for refugees with a focus on pregnant and lactating women and girls (PLWG). Support is specifically geared towards strengthening of health systems to provide quality Sexual Reproductive and Maternal Health services as well as improving access to these critical services so as to ensure 24/7 service availability. Secondly it is geared towards provision of dignity kits as incentives to women to delivery in health facilities.

**Indicator 1310: % of targeted people (m/f) who report satisfaction with SRMH assistance (CI)**

Against a target of 80%, the end line evaluation results indicate that 78% (82% F, 72% M) of the targeted people are satisfied with SRMH services (see figure 17 below). Key informant interviews pointed to the fact that there is an improvement in health seeking behaviors and service delivery due to the constructed health workers house that ensures 24/7 service. The district has also been supported to pay salaries for the critical health workers. The provision of the ambulance has saved lives together with the provision of dignity kits that draw mothers to the health facilities. It was however observed from the FGDs that the needed SRMH related support at the health facilities is not readily available for the beneficiaries e.g. condoms.

**Figure 17:** % of targeted people (m/f) who report satisfaction with SRMH assistance

![Figure 17: % of targeted people (m/f) who report satisfaction with SRMH assistance](image)
Respondents were further asked about the currently available SRMH services in their communities. Family planning was highly scored with 83% which is an increase from 67% at baseline. Antenatal services were rated second highest with 81% which is also an increase from 53% at baseline. HIV Counselling and testing services were also rated highly with 71% from 50% at baseline among other services mentioned and shown in Figure 17A below. The services mentioned are accessed by the beneficiaries through the community outreaches supported by the GAC 3 project and at the health center level.

**Fig. 17A: SRMH Services available in the communities**

![Bar chart showing availability of SRMH services](image)

**Indicator 1320: % of births attended by skilled health personnel**

The achievement of this indicator at end line was 87% - (see figure 18) and is higher by a 7% point (in comparison to the project target of 80%). This target was realistic taking into account a number of factors including having worked with a newly established District on one hand and in a COVID-19 context. On the other hand, the accessibility of the health centers is hard because of the geographical terrain and distance as explained in one of the FGDs. In addition, there was a reduction of vehicle mobility, it was likely that several women would probably not go to the health facility. In fact the high achievement beyond the target can be attributed to the ambulance that could have filled the gap of the reduced mobility due to the lock down.
Evidence from the reports suggests that while 8684 women attended ANC, only 3218 delivered within the health facilities. Closely related is that 785 women received post abortion care and 856 women received referrals.

**Figure 18: % of births attended by skilled health personnel**

**Indicator 1330: % of women aged 15-49 who report confidence in making their own decisions regarding sexual relations, contraceptive use and reproductive health care**

This indicator was achieved at an average rate of 73%. On the overall, the indicator that relates to women’s control over their bodies was achieved at the level of sexual relations and reproductive healthcare. This is evident by the statistical data at end term (see figure 18) which is 76% and 82% respectively. However, for the level of contraceptive usage, it was at 62%.
Figure 19: % of women aged 15-49 who report confidence in making their own decisions regarding sexual relations, contraceptive use and reproductive health care

General Observations from Key Informants on SRMH Intermediate Outcomes

1. There is increased Antenatal care attendance  
2. There was increased maternal deliveries at the health facilities due to the community outreaches supported by the project  
3. Increased use of family planning services.  
4. Improved maternal and child health all due to the support at the maternity wards and health centers at large  
5. Improved privacy at the maternal wards for mothers who deliver at the health centers  
6. There is however need for youth friendly services  
7. There is need for antimalarial drugs  
8. There is need for an improved sterilization means at the maternity ward from crude to modern recommended means.
### 6.2 IMMEDIATE INDICATOR THREE: SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

#### 6.2.1 Increased Access to Critical SRMH Services for Refugees with a Focus on Pregnant and Lactating Women and Girls (PLWG) in Rhino and Imvepi Refugee Settlements

#### Table 6: Immediate outcome indicators for SRMH at baseline and end term

<table>
<thead>
<tr>
<th>Immediate outcome Indicator</th>
<th>Baseline Indicator</th>
<th>Target</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td># of disaster/crisis-affected women aged 15-49 supported through/by CARE who accessed at least one SRH service (including modern methods of contraception) CI</td>
<td>0</td>
<td>3000F</td>
<td>Issue Number of women</td>
</tr>
<tr>
<td>Family Planning</td>
<td>3655</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Abortion care</td>
<td>669</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC</td>
<td>8684</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Unit delivery</td>
<td>3218</td>
<td></td>
<td></td>
</tr>
<tr>
<td>referral</td>
<td>808</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SGBV</td>
<td>174</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17208</strong></td>
<td></td>
<td><strong>Source: Summary report</strong></td>
</tr>
</tbody>
</table>

# of people reached (disaggregated by sex, age and community) during SRMH awareness raising sessions by CBFs

| | 0 | 12,853 (5480W, 2348G, 3517 M, 1508B) | 20,160 (13331F, 6829M) |

% of technical SRMH staff /health workers trained with improved knowledge in Emergency Obstetric Care, Post-Abortion Care, Clinical Management of Rape and Cancer Screening procedures

| | 0 | 80%F/80%M | 89% (87%F, 100%M) |

*Source of data: Project reports by MEAL team*
7.0 OVERALL ASSESSMENT OF THE GAC 3 PROJECT

On the overall beneficiaries were satisfied with the GAC 3 project initiatives. The rate of satisfaction is represented by an overall average percentage of 77% (73F, 80M) as shown by the statistics in the figure below;

Figure 20: Overall beneficiaries’ satisfaction with the GAC 3 project

7.1 Relevance

Relevance was analyzed at level of meeting the beneficiaries’ needs, objectives, and strategies.

Relevance in Meeting the Beneficiaries needs: On the overall, the key informants both staff and community members felt that the project was relevant to the needs of the beneficiaries. The justification of the relevance was made on the basis of what in their view the project did. Some felt that the project addressed the health gaps of the health unit to including the SRH needs and enabling mothers to deliver from health centers and providing the basic family planning knowledge and raising the rights of women and men. Relevance was also justified due to the prevailing context at the time of inception. Uganda had had a two and half months’ lock down that had paralyzed wellbeing. The effects of the lock down were several including economic hardships and gender based violence. Reproductive Health Uganda observes that teenage pregnancies generally increased in the country at a rate of 19% for less than 18 years in 2020. One key informant (woman) observed that the district lacked the resources to meet these critical needs.
The specific observable needs that were met included learning how to read and write as a result of the FAL initiative; improved maternal and child health; reduction in GBV, maternal deaths and teenage pregnancies.

**Relevance of Project Objectives:** It was also observed that the project objectives were achieved. The level of achievement may have been affected by the stiff lock down that affected timely delivery of project activities and led to rushed implementation. The relevance of the project to the host communities cannot be emphasized because they were not included in the target population and one key informant called it a ‘glaring gap’ especially in contexts where they lived near each other such as Siripi zone. “The host community is not part of the beneficiaries because e.g. in Siripi zone 99% of the FAL classes were attended by local community and only 1% from host community.” - KII

**Relevance of Strategies:** The second level of relevance was linked to the strategies used that enabled the local involvement on one hand and on another meeting the critical needs, thus nurturing community ownership. Rapid gender analysis was conducted to understand the strategic and practical needs of the different categories of beneficiaries.

Secondly working with the community leadership including the Refugee Welfare Committees (RWCs), Community Based leaders and the women committees enabled the project to respond to the needs and to have a direct interface with the beneficiaries. Other than village local leadership, the project had strategic collaborations with various stakeholders including the Office of the Prime Minister (OPM) that provided valuable guidance on the project activities and decisions. Specific examples of informed decision making on project activities included the purchase of the ambulance and the construction of the safe space in Simbili instead of Ariaze village. Some of the services were provided by the government infrastructure for example the SRH component of the project was directly implemented by the health facilities. Lastly the monitoring of the project activities was done in close collaboration with the relevant district authorities including the district health and community development offices.

The participatory approaches including exchange visits, women conferences, community sensitization meeting, pregnancy mappings, FAL classes all worked together to reinforce community transformation towards prevention and mitigation on GBV one hand and on another hand the challenge the status quo of subordination of women by presenting them as co-actors in formal decision making process.

**7.2 Effectiveness**

Effectiveness was analyzed at the level of the strategies/tools, responding to the needs of the beneficiaries. Analysis of KI responses indicates the tools that CARE used are participatory and
ensure the voice of the project beneficiaries. Closely related to the tools are the project drivers of change (RWCs/CBFs/Women committees) that are from within the community. By virtue of their location in the project strata, they were useful in ensuring project effectiveness. The project focus was popularized through information dissemination in local languages that reduced the language barriers. The community leadership structures also administered the Community Score Card that took stock of the interventions. It was also observed by one key woman informant that staff leave within the community and where need, used some of Care services for example the ruby cups to have an experiential sharing of their relevance to the project beneficiaries.

Creativity was made to take care of and manage the COVID-19 situation by adjusting strategies to make them fit in the context while keeping the participatory aspect of the project.

Flexibility was also made in resource allocation for example the purchase of the health center ambulance which wasn’t part of the original plan to foster effectiveness of the project.

**Challenges in relation to effectiveness**

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**Partners:** The transition of Terego District from Arua District contributed to project delays because CARE needed to build working relations with the new District. This affected the timely delivery of project activities for example the health workers’ house was completed towards the end of the project.

Operationalization of inclusiveness is a challenge due the various ethnic groups and nationalities that mainly affects communication across the divides. One key informant (man) noted that “we use interpreters but this may not guarantee quality”.

Unwillingness of some respondents to participate in the court proceedings as witnesses for GBV cases. This may be due to fear of the community getting back at the witnesses.

Operational challenges that affected staff communication to interact with the project beneficiaries. Closely related to this is COVID 19 and the election period that made some refugees to flee the camps.

Lack of skills in dealing with some aspects of GBV that required extra support from sector experts. For example complex cases where psychosocial support may be complicated for some people to handle.

Sometimes there was poor coordination among the actors leading to collusion in activity implementation – (Marie Stopes, AMREF, Lutheran World Federation (LWF), and IRC).
Limited training for the implementers and beneficiaries. These are complex issues that the community was being trained on. To cover all the aspects and to ensure that change has come about (especially for GBV related training) in the community, there needed to be more time dedicated for the training for the community to best internalize and understand these issues.

7.3 Efficiency

CARE has financial procedures and processes that were adhered to by the project. It was observed by both men and women CARE staff that were interviewed mentioned that the institution has a solid finance and procurement process where service providers are prequalified. Secondly staff do not touch money because it is passed on directly to the recipients through CARE’s Beyon system that has a centralized payment structure that actually safeguards and ensures ethical practices. With these system in place, the project staff are protected from fraud.

Efficiency Challenges

The efficiency challenges are at two levels:

There were delays in payment of beneficiaries that resulted into relations of mistrust. According to the key informants (men and women), the beneficiaries did presume that staff have taken their money. This led to project leaders spending time in conflict resolution and firefighting to avoid negative impacts to the project implementation.

The second challenge relates to procurement delays that affect the implementation of activities. Efficiency was also affected by change in management which had an effect on staff morale.

Lastly one male respondent observed that some of the project staff are young mothers and hence need to take of maternity but with implications on the project timeline.

7.4 Integration of Gender

To inform integration of gender in the project, this was informed through the Rapid Gender Analysis (RGA) that assists in the identification of the critical needs (practical and strategic). The key informants (both men and women) noted that the project uses a gender transformative programming approach as exhibited by the Women Lead in Emergencies approach, the Role Model Men and Boys approach where men are clients, partners and participants.

The project challenges institutions, structures and power relations through involving the RMMB to work as clients, partners and change agents to unlock the community power structure that foster
Gender Based Violence (GBV), prevent the achievement of SRMH and women’s decision making and realization of safety and dignity.

Project data is sex disaggregated data and the changing capacities, vulnerabilities and the needs of participants monitored regularly.

**Challenges in ensuring Gender Integration**

The major challenge that was highlighted by the respondents is the patriarchy culture that affects behavioral changes. Shifting of norms takes time and the project duration may not be adequate in addressing cultural norms and practices.

In addition, there were staff changes during the project implementation period which rendered a need for new skilling for integration of gender into programs.

**7.5 Inclusive Governance**

According to the Key Informants (men and women), inclusive governance is assured by working through different structures including Zonal leaders, RWCs, Women leaders, district leaders, United Nations High Commissioner for Refugees (UNHCR) and Office of the Prime Minister (OPM). Governance is ensured through different means including consultation, collaboration in decision-making.

The project participation process is well articulated in the project and training assists in building the capacity of the various structures to participate in the project. To ensure inclusive governance, women’s capacity is built and nurtured to be part of the project community leadership structures.

The project staff felt that the project was working within existing structures and power relations and was challenging the situations, structures and power relations.

The intervention was informed by basic stakeholder and situational analysis that considers the needs and interests of different population groups and the responsibilities of power holders at the following levels:

1. Organized & empowered citizens;
2. Responsive power holders; &
3. Inclusive & effective spaces for negotiation)

The project worked with different Stakeholders (civil society, state, and private sector), at different levels (at the least, connecting community to subnational/district changes).
The intervention includes at least two components of CARE's approach to organizational accountability (transparency, citizen participation, feedback mechanisms through women’s spaces & organizational systems.

The intervention include strategies, or coordinate with actions of other actors across all three GPF domains

1. organized & empowered citizens;
2. responsive power-holders; &
3. Inclusive & effective spaces for negotiation.

7.6 Resilience

Resilience in the context of the project has been nurtured in different ways:

- One of the ways the project has developed resilience among the various categories of project stakeholders has been through capacity building. Capacity building in FAL, gender, economic empowerment, COVID 19 SOPs, livelihood interventions, long term investment infrastructure, SRH (MSP).
- Using more long term sustainable means e.g. the Menstrual cups, ambulance, working with and through the District to provide support supervision for healthcare workers
- Using the participatory and empowerment approach especially for women and girls.
- Working through partnerships to localize the agenda

The main categories of shocks and stresses that are relevant to the context of the GAC 3 Project;

1) Political & Conflict
2) Economic
3) Social
4) Diseases and epidemics

The project was informed by an analysis of secondary and primary data on vulnerabilities to shocks and stresses and forward looking and regularly updated

The project strengthened assets of vulnerable individuals or communities/ beneficiaries to deal with the three main shocks and stresses identified;

A. Human Potential e.g. first aid skills, health, education, SRH, women leadership/ GBV
B. Social capital e.g. community cohesion, advocacy kills, political influence, networking, RMM, supporting women’s groups, women’s spaces
C. Economic resources e.g. market access, savings
D. Physical capital e.g. tools and infrastructure and natural resources eg planting trees

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The GAC 3 project directly addressed the most significant drivers of risk that cause the three main shocks and stresses identified.

- The project engaged in adhoc actions to address the most significant drivers of risk

The GAC 3 project influenced formal or informal rules, plans, policies or legislation to increase resilience of vulnerable individuals and communities to the three main shocks and stresses identified:

- The project engaged in adhoc actions that influence rules, plans, policies, legislation

The project took into account potential harmful effects of its activities that could increase or create new risks:

- The project design took into account the potential harmful effects of its activities plus has a strategy to monitor the project’s unintended effects on the project participants. It is flexible and it is monitored to deal with any unintended effects and this is exhibited in the flexibility in the budget to manage COVID-19 effects.

## 7.7 Sustainability

Generally, the project was sustainable. Sustainability was analyzed at the level of the benefits, long-term viability, and exit strategies. In terms of sustaining the benefits, CARE has worked closely with local leadership and other partners including UNHCR, OPM, and other civil society organizations. The OPM was brought on board and other technical teams to ensure clarity of the referral pathway for the project beneficiaries.

Generally, both staff and local leaders (women and men) noted that long term viability will be ensured due to having worked with local leadership most notably the RWCs and Community Based Facilitators (CBFs).

The government has been engaged as a key partner, which will ensure sustainability. GAC 3 project leadership has had meetings with the OPM officials to explore possible opportunities for further collaboration and support. In some instances Local government have been used as resource persons.

The project has worked closely with both the government and other health partners as discussed above. This will provide a meaningful exit strategy especially where government takes up some of the work by integrating project activities in the planning framework. There is a need to extract commitment in the future projects. The local leaders and government officers in the implementation areas are today much better informed of the potential of strategies for GBV prevention among others. One major area to ensure sustainability is not only through
collaborations but also investing in strengthening the capacity of institutions on the ground, especially the community.

Working with groups improves sustainability and cohesion and collective action groups that have been known in the community for identifying GBV issues have each other to continue to be accountable for one another. The project is hence likely to continue even when the project is over.

**Long term viability**

Community engagement approach (through the Community Based Facilitators (CBFs), Refugee Welfare Councils (RWCs) which was done in a participatory manner. These groups are from within the settlements and were directly involved in the implementation of various project activities for example, awareness sessions for the communities, FAL trainings, and psychosocial counseling for GBV survivors among others. The GAC 3 project has left an impact for them to own the project even after its closure.

**Effectiveness of exit strategies**

The project implementation strategy included both inception and close out meetings with the beneficiaries and all relevant stakeholders to confirm to them the end of the project. These were informed at inception and that it will end at a particular time. This was emphasized along the way so all stakeholders were aware of its closure. The project involved various structures, besides the beneficiaries, the Representative of the PM office into the evaluation and the district local personnel to inform them of the closure and to get their feedback.

**7.8 Lessons Learned**

There is always need for flexibility in the implementation of project activities. COVID-19 affected the project due to a strict lock down countrywide and worldwide. The project adjusted the strategies to include COVID-19 mitigation plan through provision of personal protection equipments to the women and youth centers which was good to enable the project activities continue on as planned. Also under complicated situations, it is good to always be flexible and work outside the normal working hours and working online.

Community empowerment is critical when it comes to sustainability. This is due to the fact that there is need for ownership of the project activities and all its outcomes. Once the community ownership of the project has been realized, sustainability is not a question.

Bringing onboard project stakeholders for example Community Based Facilitators (CBFs) who are refugee community members is very important in the realization of project outcomes. This is key because they easily relate with the communities and know their needs.
7.9 Recommendations

Scaling up through diversification of the funding basket. It was noted that CARE needs to move into livelihood interventions to build resilience and self-reliance. There is need for funding for more than one year, so many activities in a short time with a big coverage of people and to have ample time to monitor the changes.

There is need for protracted action over a period of time. The issues of gender including women participation in leadership at both community and household level seem obvious and can easily be overcome by a set of interventions. The GAC 3 project in itself has demonstrated that they are embedded in community fabric. Protracted action over a period of time is needed to dismantle the basis for gender inequalities socially, politically and economically.

There is need for more understanding of men refugees including their critical needs and how these can be addressed. There is also a need for increased male involvement in project activities to avoid backlash and to realize the benefits of male involvement.

Continuous engagement with the Community and Government. The success of any project and sustainability depends on the involvement of government and community. This is a good practice and should be continued as it provides room to take into consideration the views of the community and government to incorporate best practices in her planning framework.

There is need for more deliberate engagement of the young people (boys and girls) in the decision making spaces, awareness raising to dialogue across the divide on pertinent issues. To focus on women’s leadership (WLiE) as a complementary strategy to achieve the project interventions. This has potential to achieve the goals in relation to GBV and SRMH.

There is need to understand the domestic burden of women around child care and how this can be managed, how it manifests itself for a more meaningful engagement of the women in the project.

Upscale the project in more settlement villages and host communities. The project was carried out in Rhino and Imvepi settlements. All project activities therefore need to be considered for up scaling in more settlements and their villages for realization of maximum effect.

Vying good relationship with the community structures for follow up on post project evaluation attention needs to be put on training and having CBFs have broader knowledge on some of the program interventions – FAL continued teaching after closure.

There is need for continued working through local partnerships ensure the localization of the GBV agenda as noted in the Charter for change, a global direction on humanitarian assistance.
Ensuring operational timely payment to support timely implementation of project activities is critical.

There is need to increase on the supply of the SRMH support.

Provision of free legal aid support to the GBV survivors. This may be achieved in collaboration with the government.

7.10 Conclusion

On the overall the project achieved its desired outcomes in alleviating suffering and maintaining human dignity through SRH, WLiE and GBV interventions for crisis-affected refugee and host community women, men, boys and girls in Rhino Settlement Camp in Arua District, West Nile Region, Uganda. This is evidenced by over 91% (89%M, 92%F) of the beneficiaries reporting an improved feeling of safety at both community and household level. It is also evidenced by the end line satisfaction with the GBV assistance at 81% (86%M, 79%F) and the demonstration of positive attitudes towards ending GBV that is turned at 75% (79%F, 70%M).

The women leadership in emergencies is one of the major achievements of this project and this leadership is very much needed in the COVID-19 context where women’s role in reproductive and productive roles cannot be underestimated.

The provision of SRMH services has led to an increase in women’s control over their bodies exhibited by a 73% increase from 44% at baseline. This is a major achievement in patriarchal context and can critically contribute to women’s empowerment.

However, it is important to also observe that the creation of Terego District with new structures and COVID-19 slightly affected the achievement of some of the indicators e.g. births attended by skilled personnel and women working collectively to achieve a common goal.

Participatory approaches, flexibility and creativity fostered project effectiveness. Project efficiency was managed by the project planning, financial and procurement policies and procedures. Gender equality was ensured through interventions that recognized the strategic needs of women and could cause transformation of gender relations at community and household level. The project nurtured resilience through capacity building initiatives, collaborations among the actors, localization of the project agenda and supporting livelihoods.

The GAC 3 project analysed the likely risks and established a monitoring framework to manage them. Sustainability was nurtured through maximizing the actors in engaging with the project including UNHCR, Office of the Prime Minister (OPM) and other Civil Society Organizations (CSOs). Major collaboration were made with government to ensure integration of the project into
its framework. Sustainability was also nurtured through building local capacity of women leaders, CBFs, RWCs and RMMBs and where possible working through local partnerships.

The key lessons learned include ensuring project flexibility, community empowerment and working with other stakeholders. Lastly, for long term benefits, the project needs to be implemented over a longer period of time to dismantle the basis for gender inequalities, socially, politically and economically and it should include young people (women, men, boys and girl) as well as linking in the host communities.
Annex 1: Success Stories

**Story 1: Health Center In charge at Siripi Zone**

“The GAC 3 Project has supported our health center in so many ways. Firstly, our midwives were trained by way of capacity building. The other support we received includes the following: facilitation for community integrated services for the community through outreaches, quarterly support supervision from the District, dignity kits for mothers who give birth at the health center, provision of an ambulance for referrals, maternity support by procuring of maternity kits (bucket, kitenge, Tshirt, baby’s clothes, panties for mothers and slippers), weighing scales for babies, resuscitation kits for newborn babies, screens for the ward, we also have a translator for Congolese nationals who come to the HC, support for quarterly HUMIC sittings, among other things. All this support has helped register a number of improvements at our Health center especially at the maternity ward. We now have improved facility deliveries and a reduction in home deliveries. This is because of the delivery kits that were provided for the vulnerable mothers. The other achievement we have is the absence of neonatal deaths, improved maternal and child nutrition (no malnourished babies) following the outreaches in the community. The other achievement is the reduction in the delivery of HIV positive babies. Other achievements include; improved capacity of the health workers, increased ANC attendance, improved maternal health as some mothers are now being referred for post abortion care. We would however also benefit from new modern sterilization methods in the maternity wards since the one we use right now is crude.”

**Story 2: South Sudanese Refugee Women’s Association**

“The project has supported us as women to start income generating activities and hence an improvement in our livelihoods. We have been empowered to be leaders and trained in a number of vocations for example liquid soap making and plaiting hair. As women, we started a restaurant business and our business idea was supported with start up materials including plates, saucepans, flasks, cups, chairs, tables, glasses, hand washing stations, jerricans, table clothes and cutlery. We opened business in December 2020 with earnings of about 20,000/= per day. We now earn our own money and the savings are kept in our group VSLA box. We divide work amongst ourselves since we are 30 members, so the restaurant is attended by 5 members per week. We pay our own rent. We also make liquid soap for both home use and commercial. We thank CARE so much for these new skills because we no longer depend on our husbands for financial support, we are able to support our families from the little we earn. We are also part of the FAL classes and one of our members who did not know how to write can now write her name very well.”
Picture above: Some of the empowered women who form the South Sudanese Refugee Women’s Association
**Annex 2: Performance Measurement Framework for GAC 3 Project**

<table>
<thead>
<tr>
<th>Expected Results</th>
<th>Indicators</th>
<th>Baseline Data</th>
<th>Targets</th>
<th>Actual Data (cumulative)</th>
<th>Analysis of Progress</th>
<th>Rating</th>
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<tbody>
<tr>
<td><strong>Ultimate Outcome</strong></td>
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<tr>
<td>1000 Lives saved, suffering alleviated and human dignity maintained through SRH, WLiE and GBV interventions for crisis-affected refugee and host community women, men, boys and girls in Rhino Settlement Camp in Arua District, West Nile Region, Uganda</td>
<td>% of beneficiaries (m/f) reporting feeling safe and dignified by the end of the intervention</td>
<td>54%</td>
<td>75% (75%F / 75%M)</td>
<td>91% (89%M, 92%F)</td>
<td>It is evident that by the end of the project interventions, most of the beneficiaries, men and women felt safe and dignified within the household and community.</td>
<td>EE: Exceeding/exceeded expected result</td>
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<td></td>
<td>% of Extremely Vulnerable Individuals targeted reverting to high risk behaviours and negative coping strategies</td>
<td>10% (11% F, 8%M)</td>
<td>20% (20% F / 20% M)</td>
<td>11.2% (15.1%M, 9.3%F)</td>
<td>The rate of reverting to high risk behaviours and negative coping strategies was much lower than the target of 20% for both males and females. However in comparison to the baseline value, the extremely vulnerable individuals reverting to the high risk behaviours and negative coping strategies has remained the same and it could be attributed to COVID-19 that has psychological effects of its own on both men and women.</td>
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<td><strong>Intermediate Outcomes</strong></td>
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<td>1100 (GBV) Increased and equitable use of gender-responsive GBV assistance by crisis-affected people</td>
<td>% of targeted people (m/f) who report satisfaction with GBV assistance</td>
<td>66% (69%F,62%M)</td>
<td>80% (80% M, 80%F)</td>
<td>81% (86%M, 79%F)</td>
<td>The planned target of 80% satisfaction was achieved for both men and women. The gender responsive nature of service delivery including RMMB approach. Compared to the baseline value, the extremely vulnerable individuals reverting to the high risk behaviours and negative coping strategies has remained the same and it could be attributed to COVID-19 that has psychological effects of its own on both men and women.</td>
<td>AE: Achieving/achieved expected result</td>
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<td><strong>in Rhino Camp Settlement in Arua District, West Nile Region, Uganda</strong></td>
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<td><strong>baseline value of 66%, it is evident that there is a 15% increase satisfaction with the GBV assistance. Men seem to exhibit more satisfaction in comparison to the women.</strong></td>
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<td>% of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV</td>
<td>63% (57%F, 72%M)</td>
<td>70% (70%M/70%F)</td>
<td>75% (79%F, 70%M)</td>
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<td><strong>The 75% achievement exceeded the target of 70% with women more optimistic to the ending of GBV in comparison to men. This is understandable taking into account their direct engagement with the project activities. Compared to the baseline value of 63%, it is evident there was a 12% change in demonstration of positive attitudes towards ending GBV.</strong></td>
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<td><strong>EE:</strong> Exceeding/exceeded expected result</td>
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<tr>
<th><strong>1200 (WLiE) Increased and equitable use of gender-responsive WLiE assistance by crisis-affected people to meet basic WLiE needs in Rhino Settlement Camp in Arua District, West Nile Region, Uganda</strong></th>
<th><strong>% of women reporting high self-efficacy (CI)</strong></th>
<th>27%</th>
<th>70%</th>
<th>94%</th>
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<tbody>
<tr>
<td>The end line result exceeded the target and this could be attributed to the integrated approach to the project focusing on the psychosocial, livelihoods and decision-making. The project strategic needs of women through the RMMB approach and the various strategic interventions to enhance women’s social, economic and political status. The comparison of the baseline and end line percentages indicates that there was a big increase in women’s self-efficacy that can be</td>
<td><strong>EE:</strong> Exceeding/exceeded expected result</td>
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| **EE:** Exceeding/exceeded expected result | | | |
attributed to the focus on the strategic needs of women with special focus on their participation in leadership

| % of women reporting they can work collectively with other women in the community to achieve a common Goal | 92% | 70% | 74% | The target was achieved with an excess of 4 points. The key issue to note was that the target was realistic taking into account the lock down which limited collective working in a context of minimum virtual abilities to foster virtual collective working. The technologies are limited. | AE: Achieving/achieved expected result |
| --- | --- | --- | --- | --- | |
| % of women who report being able to meaningfully participate in formal and informal humanitarian decision-making spaces | 14% | 70% | 82% | The target was achieved and can be directly attributed the changing context to accommodate women as leaders. The changing context can be on one hand linked to the gender specific project interventions directly targeting women including awareness sessions, training. On another hand, the gender transformative and redistributive approaches such as the role model men and WLIE and livelihood support enhanced women’s social status(empowered them) to engage in decision making. There are registered changes within the women based on the baseline value of 14% and the end of project change at 82%. | EE: Exceeding/exceeded expected result |
| 1300 (SRMH) Increased demand and equitable use of gender-responsive health services by crisis-affected people, particularly pregnant and lactating women and girls in Rhino Camp Settlement in Arua District, West Nile Region, Uganda | % of targeted people (m/f) who report satisfaction with SRMH assistance (CI) | 64% (66%F, 62%M) | 80% (80%M/80 F) | 78% (72%M, 82%F) | Near achievement of the target is explained by the provision of infrastructural and medical support to meet the reproductive and maternal health needs. It is evident that there is increase in the satisfaction levels from 64% at baseline to 78% at end-line and with women more satisfied with the service. AE: Achieving/achieved expected result |
| % of births attended by skilled health personnel | 96% | 80% | 87% | The target is realistic taking into account the geographical terrain, and the reduction of vehicle mobility, it was likely that several women would probably not go to the health facility. In fact the high achievement beyond the target can be attributed to the ambulance that could have filled the gap of the reduced mobility due to the lock down. AE: Achieving/achieved expected result |
| % of women aged 15-49 who report confidence in making their own decisions regarding sexual relations, contraceptive use and reproductive health care | 44% | 75% | 73% | The non-achievement of less than 2% of this indicator is attributed to some few women and men that women’s control of their bodies including their use of family planning services. Patriarchy takes time to change. It is however evident that the confidence levels have greatly improved in women’s control over their bodies, a key factor to their empowerment. AE: Achieving/achieved expected result |
Annex 3: Pictorial

Above left: SSD empowered women displaying some of the items received at their center in Omugo 5
Above right: SSD women in a focus group discussion in Omugo 6

Above left: Nurse in charge displaying the maternal kits received meant for vulnerable mothers who give birth at the health center. On the right above is the ambulance at Siripi Health Center to support in referrals.
Annex 4: Terms of Reference

UG-TOR for GAC III Endline evaluation .FVpdf.pdf
Annex 5: Data Collection Questionnaires

GAC 3 KII Questionnaire - CARE staff.pdf

GAC 3 Focus Group Discussion Guide.pdf

GAC 3 KII Questionnaire - stakeholders.pdf

GAC 3 Household Questionnaire.pdf