Integrated GBV prevention and response to the emergency needs of newly displaced women, men, girls, and boys in Borno State, North-East Nigeria

Mid-term Evaluation Report

December 2019

Funded by
European Union
Civil Protection and
Humanitarian Aid

A project implemented by CARE

Table of Contents

1. Executive Summary

Context and project

Now in its tenth year, the crisis in North-East Nigeria remains one of the most severe in the world. Some 1.8 million people are internally displaced and human rights violations continue to be reported in the three worst-affected states of Borno, Adamawa, and Yobe (BAY). Over 80 percent of IDPs are in Borno State, the epicenter of the crisis and over 60 percent are living in host communities, exerting pressure on the already-stretched resources of these communities. An increased number of displacements and new arrivals continue to be recorded largely coming from hard-to-reach areas for reasons related to insecurity and military operations, the return of Nigerian refugees from Niger to Damasak Local Government Area (LGA), family reunification in Banki and Gwoza, secondary displacements caused by poor living conditions of IDPs in Pulka, as well as the active conflict that forced many to flee to Monguno. From November 2017 to mid-August 2018, Borno and Adamawa states have seen the movement of nearly 190,000 individuals (153,000 IDP new arrivals and 36,000 returnees). This further compounded a fragile setting where vulnerabilities are already intensifying as a result of the rainy season from June to September and where resources are already overstretched. Currently, 41 sites across 11 LGAs in Borno are in 'high congestion' status with 285,000 individuals above camp capacity resulting in the majority of individuals having no access to shelter and being forced to sleep in overcrowded shelters or outside. The provision of life-saving assistance to the most vulnerable persons of concern is hampered by a continuous unfavorable environment marked by conflict-induced insecurity and protracted displacement. Limited access to adequate services, particularly in newly accessible areas, continues to exacerbate protection risks to the affected population. The ECHO-GBV project is an 18 months' project funded by ECHO being implemented in Bama and Ngala LGAs of Borno state to provide lifesaving GBV prevention and response services to newly displaced women, girls, boys and men and vulnerable host community members.

The objective of the mid-term evaluation

The intended use of this evaluation is to: assess the performance of project indicators against set objectives, goals and targets, review Programme strategy and methods and inform learning; hence, the primary target of this report is the ECHO participants as well as staff.

Methodology

The midterm analysis used a mixed methodology; which involves qualitative and quantitative approaches, the survey took place throughout September – October 2019. The evaluation took place in the project location namely; Ngala and Bama. It conducted with the planned target project participants of the project, using a sample at 95% confidence level, with a margin of error, describing the acceptable error rate of 2.33%, and a standard of deviation of 50% for the quantitative study. A quantitative survey was conducted using key informant surveys, focus group discussion selecting at random; camp representatives, security personnel, health providers and community leaders.

Key findings

Knowledge and participation of GBV

The findings of the study have revealed that respondents are fully aware and have information on GBV. Majority of respondents revealed that rape had the highest occurrence with 10.6%, followed by sexual harassment 8.2%.", 4% mentioned early marriage, 3% mention both child abuse as well as sexual abuse

while 6% of respondents responded "I don't know. A striking 69.8% said GBV has declined in the community, followed by 10.9% of respondents who feel GBV has increased in the community and then 10.2% who feel GBV still at the same stage as it was before. It can be observed from the survey, that communities have indicated a change in the incident of sexual violence, as would be seen by the result which shows that: 30.2% of respondents answered they have or know someone who has experienced sexual abuse while 69.8% responded they have not experience and do not know anybody who has experienced sexual abuse.

Prevalence of violence

The survey indicates that sexual abuse and exploitation are the major protection/GBV concern associated with girls aged 18 years and below with 1.1% and 1% respectively in Bama communities. In Ngala, girl-respondents lamented sexual harassment as the major prevalent GBV concerns with0.7%. Young adults' women aged 19 – 39 cited that sexual harassment (4.5%) and sexual abuse (3.3%) are the major GBV concerns experienced in Bama while Ngala rape 7.1% and harassment 5.6% was mentioned. Male young adults also mentioned harassment 1.1% and rape 1% in Bama while in Ngala, it is marital rape 1.5% and sexual abuse 2.1%. Adult women in Ngala mention rape 4.7%, the same was mentioned for old-adults 0.6%, while in Bama, sexual exploitation with 1.4% was mentioned.

Findings of the survey also revealed that girls majorly first get married in the community at the age of 12 – 15 years 45.7%: (32.4% female and 13.3% male), while for boys it is at 19 and above 77.7%: (55.1% female and 22.6% male). The result shows that girls are more likely to be given up for marriage before 15 years of age than their male counterparts who stayed up to they are socially accepted and known to be a man i.e. 19 and above.

Project effectiveness

The project can be seen to have made an impact on the community, community members stated that the ECHO-GBV project is effective because: it provides information on GBV (82%), others mentioned it was because it supports GBV survivors (67%) and some mentioned it provides a safe home for survivors (12%). The specific objective indicator's outcome at the midline shows that approximately 92% of the population report to feeling safe and treated with dignity by the intervention. Also, 87.5% of participants feel humanitarian intervention is conducted in a safe, accessible, and participatory manner.

Main recommendations

Recommendation from the study includes:

- Build on previously increased local capacities and multiply the training effects by increasing the number of step-down training in each LGA;
- The project team should devise a means to better document and capture the success from participants linked to livelihood or survivor who has overcomes and has become stronger from the project;
- The project team should continue the effort towards changing the attitudes of the population by using the media available.

2. Programme Background and Conflict Analysis

a. About the conflict in Borno state
b. About the "Integrated GBV prevention and response" Project

The "*Integrated GBV prevention and response to the emergency needs of newly displaced women, men, girls, and boys*" is an 18months (2018-2020) project funded by the European Commission Civil Protection and Humanitarian Aid (ECHO) for gender equity in Borno State, Nigeria, with a total of € 800,000.

To create change, CARE Nigeria is implementing this GBV prevention and response programme working with a wide community, stakeholders, in coordination with other NGOs available in both field and state level. The overall goal of the project is to "contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in North-eastern Nigeria". The specific objective of the work remains to enhance the access of newly displaced, vulnerable women, men, girls, and boys to life-saving GBV prevention and response services through coordinated, principled humanitarian support and community-based prevention activities.

Geographical scope of the project:

The Programme targets key communities within two Local Government Areas (LGAs) of Borno State: Bama and Ngala LGAs. The project is actively being implemented in Kasugula, Shehuri, Mairi and Hausari wards in Bama LGA and Gambaru A, Gambaru B and Ngala wards in Ngala LGA. These areas undergo continuous threat from the protracted conflict.

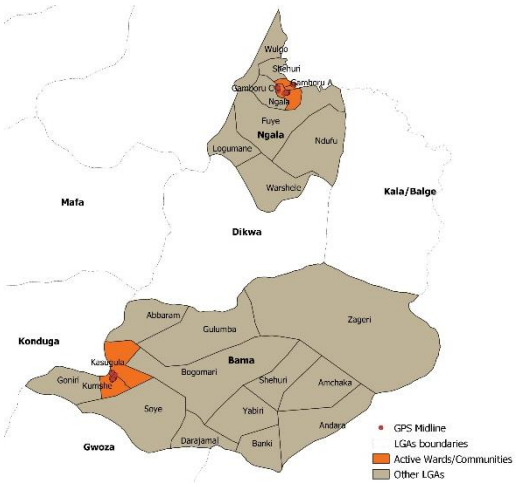

Figure 1: LGA selected for the Project

Project targets:

In January – February 2019, CARE Nigeria conducted a baseline survey as a starting milestone tracker for activities of the *GBV prevention and response* project, with the objective of (a) establishing a detailed baseline of the various qualitative and quantitative indicators of the project in the targeted areas so that the information obtained can inform the implementation of project activities (b) collecting information to define the baseline situation of households and facilitate projections (recognition) of changes during the life cycle of the project (c) collecting qualitative data to help project staff define effective approaches (d) defining recommendations for a better orientation of the various activities.

Objectives of the midterm study

1 - Main objective

The overall objective of this study is to measure the evolution of the various qualitative and quantitative indicators of the project in the targeted areas so that the information obtained can appreciate the performance of project activities.

2 - Specific objectives

More specifically, the study aims at:

- Collecting information to define the mid-term situation of households, to appreciate changes since the start of the project and redefine projections for the rest of the implementation period.
- Collecting data on the indicators defined in order to obtain their mid-term level;
- Measuring mid-term values of key indicators of GBV/Protection;
- Obtaining basic information for monitoring GBV/Protection;
- Collecting qualitative data to help project staff confirm effective approaches
- Defining recommendations for a better orientation of the various activities.

Methodology of the Evaluation

CARE Nigeria used a mixed-method; quantitative and qualitative method to conduct the internal mid-term evaluation.

Target population, Data collection and tools

Target population

At the time of the baseline, the questionnaire was administered to 5% of the general population taking into account different measures to avoid duplication. At this time the GBV prevention and response project had not started implementation. For the midline, which was approximately 7months into the implementation of the GBV prevention and response project, the target population was mainly project participants who have benefitted directly from the project activities thus far. But, the survey also collected substantial information from relevant community members who were not reached by the direct implementation but by contamination from the mass awareness or other sensitization activities/training, this group was known as indirect participants of the intervention.

Data collection activities

The data collection activity involves the administration of questionnaires covering GBV to randomly selected respondents in the project location (Ngala and Bama LGAs) in Borno State. Focus Group Discussions (FGD) was conducted with women, men, boys' and girls' groups in both community and camp, also, KII was conducted with relevant government/community stakeholders which include; community-level stakeholders, security personnel, camp management, and health facility. Finally, a household-level survey involving the administration of questionnaire on, socio-demographics, knowledge, attitude behavior and practice, access to information, cultural and traditional practices and inclinations and other areas of inquiry as linked to GBV was administered to head, alternates or other members of the family available and who gives consent to be interviewed.

Fieldwork occurred in Ngala and Bama, conversing Gambaru A, Gambaru B, Ngala, Kasugula, Shehuri, Mairi and Hausari, as well as GSSSS camp, Arabic and ISS camp during the period of 25th September to 8th October. Team composition comprised of enumerators and supervisors, each tasked with administering the household question in the location where the project participants reside. Supervisors were tasked with administering fewer questions while supervising, supporting the enumerators with clarification, and relaying feedback to the project team. Out of all enumerators' use, more than half were enumerators previously engaged for the baseline who had previously gained knowledge on GBV and its types and are also indigenes therefore, they understand the local context, as well as the predominant languages, are spoken. In total, 2068 respondents participated in the quantitative questionnaire while 69 respondents participated in the qualitative survey. Please see table 1 below for the demographics of the respondent

Type of questionnaire	Ngala		Bama		Total
	Female	Male	Female	Male	
FGD	7	8	4	4	23
KII	7	17	5	17	46
Household survey	701	330	760	277	2068
Total	715	355	769	298	2137

Table 1: Demography of respondent

Timeframe of the evaluation

The evaluation took place over September - November 2019 period and was articulated around the following main period/activities:

- September 4 - 13th: Recruitment of enumerators
- September 16 - 18th: Contract signing for enumerators
- September 19 - 20th: Enumerator training + pilot testing of the forms
- September 23rd - 4th-Oct: Surveying Ngala and Bama
- September 30th - 4th-Oct: Data collection: FGD and KII
- October 9th - 22nd: Final data entry and cleaning database
- October 23rd - 30th: Report development
- October 31st: Evaluation report submission

Tools

Data was collected using mixed data tools (quantitative and qualitative tools) which includes:

Key informant Interview: compared to the baseline, KII was made fully qualitative and were administered using the conventional paper and pen method. Enumerators were engaged in a rigorous two-day training using the practice to perfect their understanding of the tool before it was administered. KII was administered to security forces, community leaders, camp coordination and health providers. A total of 46 key informants were interviewed broken down into camp coordination = 8 (SEMA, Intersos and IOM), health providers = 13 (IOM, Intersos, MSF, FHI360, UNICEF, and government facility), Community leaders = 13 (women, men and youth leaders) as well as security forces = 12 (police, civilian joint-task-force(CJTF), civil defense, custom).

Focus Group Discussion: Focus groups were conducted with women, girls, men and boys respectively. A total of 23 discussions were recorded.

Household survey: in terms of quantitative tools, CARE Nigeria utilized the tools used at the inception of the project as its baseline but included key questions that assessed perception, behavior and practice not originally captured in the baseline survey as well as the protection mainstreaming tool that wad adapted from ECHO. Altogether, 2068 respondents participated in the individual household survey.

Sampling

The survey employed a stratified random sampling technique. Stratified sampling was used to obtain a suitable sample size, stratified random sampling is the technique of breaking the population of interest

into groups [in this case, the project participant for this project was broken down by sex and age (5-18; 19-49 and Greater than 50 years)] and then random sampling approach was used to administer the questionnaire within each of these groups. Breaking the population up into stratum helps ensure a representative mix from all groups and ensures that enough sample is allocated to all groups. Contrary to the baseline survey that sampled 5% of the total population of both Ngala and Bama, the sample size for the quantitative midterm evaluation will be determined based on expected change among respondents from the project's project participants which are 7894.

The sample size was obtained using the standard sample size formula at a 95% Confidence Interval and a 2.33% margin of error. Using the standard formula for sample size n,

$$= \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + (\frac{z^2 \times p(1-p)}{e^2 N})}$$

Where:

Z = Z value is 1.96 at 95% confidence level

e = margin of error, describing the acceptable error rate: 2.33%,

p = standard of deviation: 50%

N = Population size of the project's project participants: 7894

Replacing the variable placeholder with numerical values that applies to the specific survey gives 1445. 500 was selected as a suitable amount to administer the protection mainstreaming questionnaire therefore, the overall total respondent for the midline quantitative survey was 1945. However, the actual sample sizes exceeded the required amount which improved the quality of the survey.

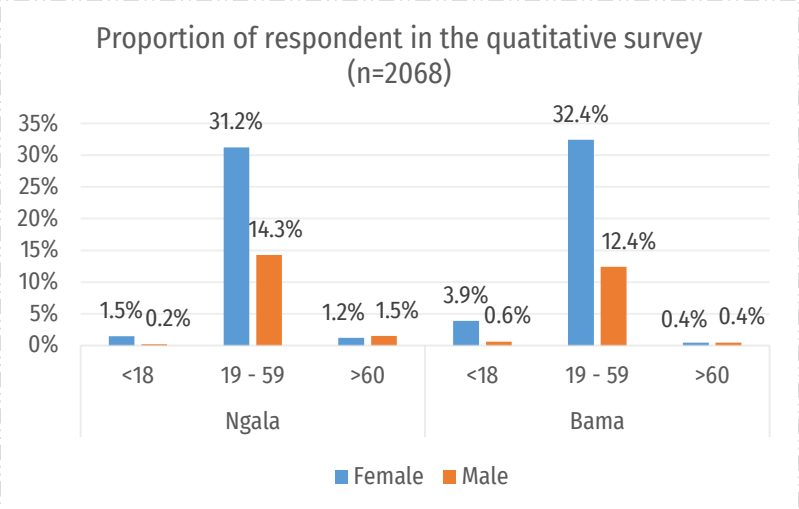

Figure 2: Proportion of respondent by sex and age

The evaluation team was aiming for an elaborate representation of all sex and age, most especially the adolescent; to assess how liberal and comfortable they are to accessing the services provided by the project. Approximately 30% of the sample size was allocated to girls and boys. The figure beside shows the actual reached mix of participants. It can be seen that girls and boys make up a total of 6.2% (5.4% girls and 0.8% boys), the highest representation remains Adult 19- 59 years with 63.6% female and 26.7% male and finally, older adults >60 had a representation of 1.6% female and 1.9% male across both LGAs.

Participation of the team

Contrary to the baseline that was solely administered and supervisors by the external services providers recruited for the services, for the midline, the mid survey saw a tremendous amount of participation from the project team including the newly recruited caseworker. From identifying where the project participants were densely located to briefly supervising how the enumerators translated the questions to the responders, the team was actively engaged. The team comprised of 12 enumerators and 4 supervisors; the enumerators, 12 (6F, 6M) were primarily responsible for administering the HH survey and protection mainstreaming questions, they were we directed to each participant's location by the caseworkers, while the supervisors 4, (2f, 2M) had a dual responsibility of supervising the enumerators as well as administering the qualitative questionnaire, in summary, they were 8 in Bama and 8 in Ngala. At the end of each day's survey, the GBV assistants with clerks, in each location, quizzed the supervisors on the status of the team in terms of questions assimilation and any concern they might have encountered during the assessment, all concerns and challenges faced were resolved in due time.

The team was trained on data collection using kobo and a field pre-test of the survey tools was first done as part of the training, to test each enumerators understanding of the questions.

Limitations

One limitation face during data collection was misinterpretation due to the overload of the enumerators. Enumerators who administered the household survey also administered the protection mainstreaming questions separately, almost at the same time due to budgetary implication, therefore most complained of being confused with the process. Although the mitigate this issue, extra budget implication had to be considered (e.g. increase workdays) but the likely affected the quality of the data collected.

During the design of the midline process, the study team recognized that they were not Knowledge, Attitude and Perception questions as part of the HH survey at the baseline, this was included to give the report an idea of the participant's attitude towards GBV and knowledge although this was assumed to have been contaminated by the ongoing response.

The MEAL officer was unable to actively supervise data collection in both locations. For the baseline, supervision was done in Ngala while for the midline, it was done in Bama, this affected the ability to resolve complaints and suggestions from other members in the field especially in Ngala with no network coverage at the time.

3. Findings

Evaluation theme: General findings

The findings illustrated in this section is meant to give a general overview of the perception and attitudes, options of people, who majorly are project participants, their behavior.

Knowledge and perception of GBV

Perception and knowledge about Gender-Based Violence

When asked "what does GBV mean to you?", there was no shortfall of answers. Only 6% of respondents to the open-ended question with an "I don't know". To keep the quality and authenticity of the responder's perception of GBV, a word cloud was generated to depict the wordings used via the respondent. Rape had the highest occurrence with 10.6% of all respondents, followed by harassment with 8.2%, 6% of respondents said "I don't know", 4% mentioned early marriage, 3% mention both child abuse as well as sexual abuse. The word cloud illustration in figure 2, depicts the occurrence of individual words. During the KII, respondents also had some things to say about what GBV means to them; it is clear that the majority of the respondent on both qualitative and quantitative surveys understood what GBV was.

Figure 2: Proportion of respondent by sex and age

To harass a person, because you are superior to him/her.

- SEMA (Camp coordination)

Harassing some body base on his sex

- Traditional leader Bama (Community leader)

"GBV means violation of human right"

- Bama (Community leader)

"Harassment between men and women or young and old"

- Bama (Community leader)

"Abusing some person's right, on the basis of social difference"

- Traditional leader Bama (Community leader)

GBV are socially ascribed differences in sex (male/female) which is usually due to power imbalance, it includes rape, forceful marriage, sexual assault etc.

- Intersos health clinic (Health provider)

To dive in further, a question was asked: is GBV common? It can be noticed from the chart below that majority of the respondent, a striking 61.7% said "yes" to GBV is common in the community, majorly in the camps (Arabic camp, ISS camp, and GSSSS camp) with 44.5%, followed by host community members with 13.1%, then refugees with 3,5% and finally 0.6% of returnees. Also, 35.3% of respondents said GBV is not common (broken into 5.3% from host community members, 29.2% from IDPs, 0.6% from refugees and 0.2% from returnees), while 3.1% of respondent "did not know" if GBV was either increasing or reducing.

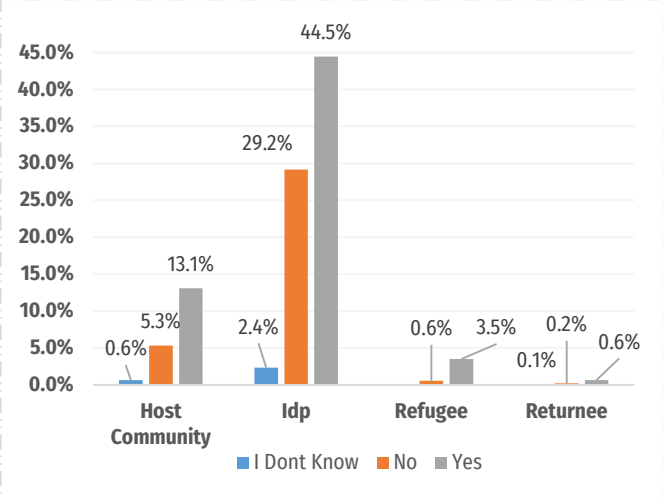

Figure 3: Is GBV common in your community/camp?

A follow-up would be, have you or anyone you know experienced GBV in the last 6 months? Because of the sensitivity around discussion around GBV, knowing how leader and community influencers frown from such discussion, the direct question which is have you experienced GBV? the response was not solicited, as it is also culturally inappropriate. Enumerators were trained to engage respondent on this question with care, to not come out as interrogating but to be observant, noting the responders' behavior, if he/she is free to speak about her personal experience, a listening ear should be given and at the end of the day's briefing, that should be discussed. Regardless, from the total respondent to "do you or someone you know experience GBV in the last 6months?": 49% of respondents answered "yes", 47% answered "no" while 5% were not sure and answered, "I don't know".

Types of protection/GBV experienced in community

The quantitative assessment data indicates that rape 19% in Ngala, harassment 15% in Bama and 14% in Ngala, Sexual abuse 13% and exploitation 14% in Bama, and FGM 12% in Ngala are the major protection/GBV concern associated with women and girls in the project location. The table below gives a summary of GBV experiences in the community.

The comparison of response by sex for this question shows that the female response was 78% in Ngala and 76% in Bama compared to 22% Ngala and 24% Bama male respondents. The details in methods of

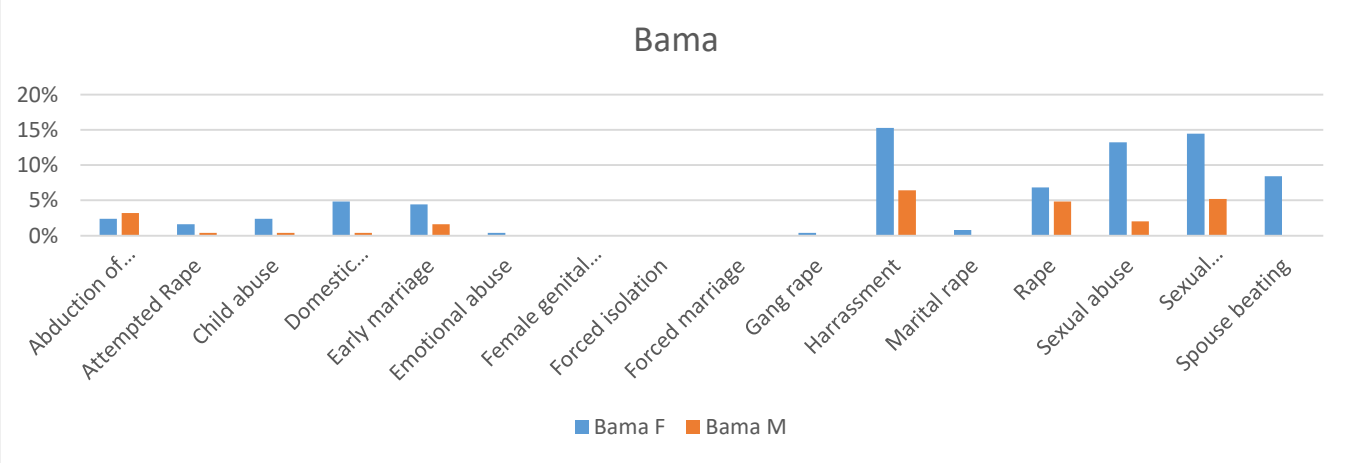

Figure 4a: protection and GBV concern from HH survey in Bama

GBV experienced in the communities show the impact of the regular and rigorous campaigns and awareness sessions implemented by the program.

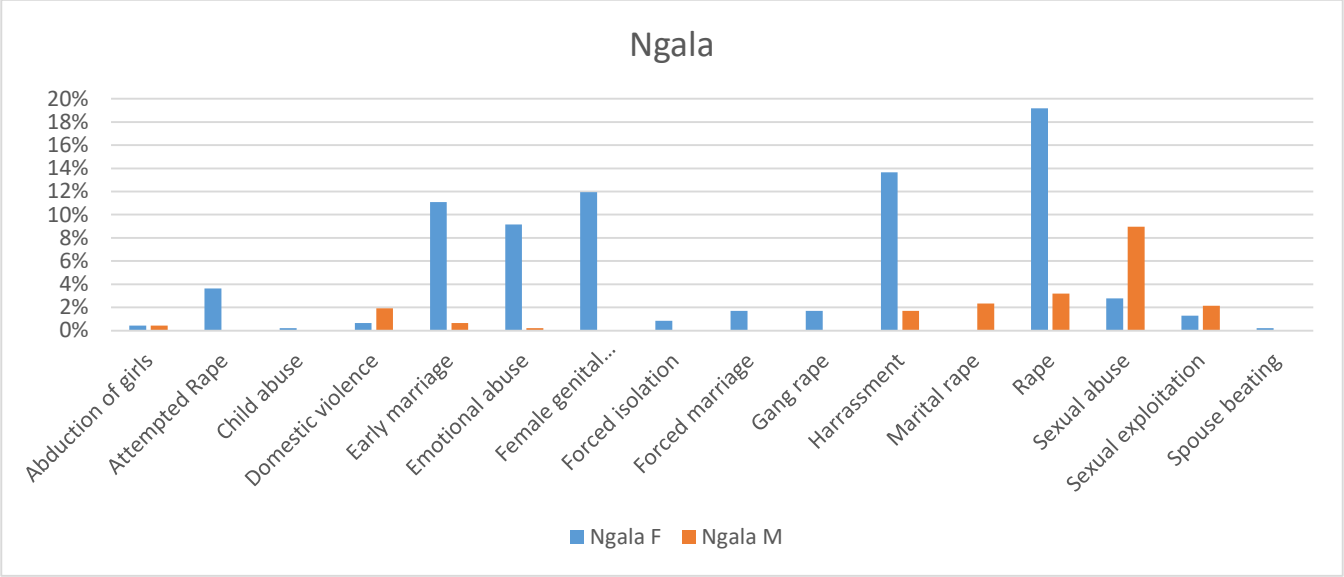

Figure 4a: protection and GBV concern from HH survey in Ngala location

A similar question was asked to in the key informant interviewed, "what types of GBV do you think are most prevalent in this community?" the figure below highlights the key responses extracted.

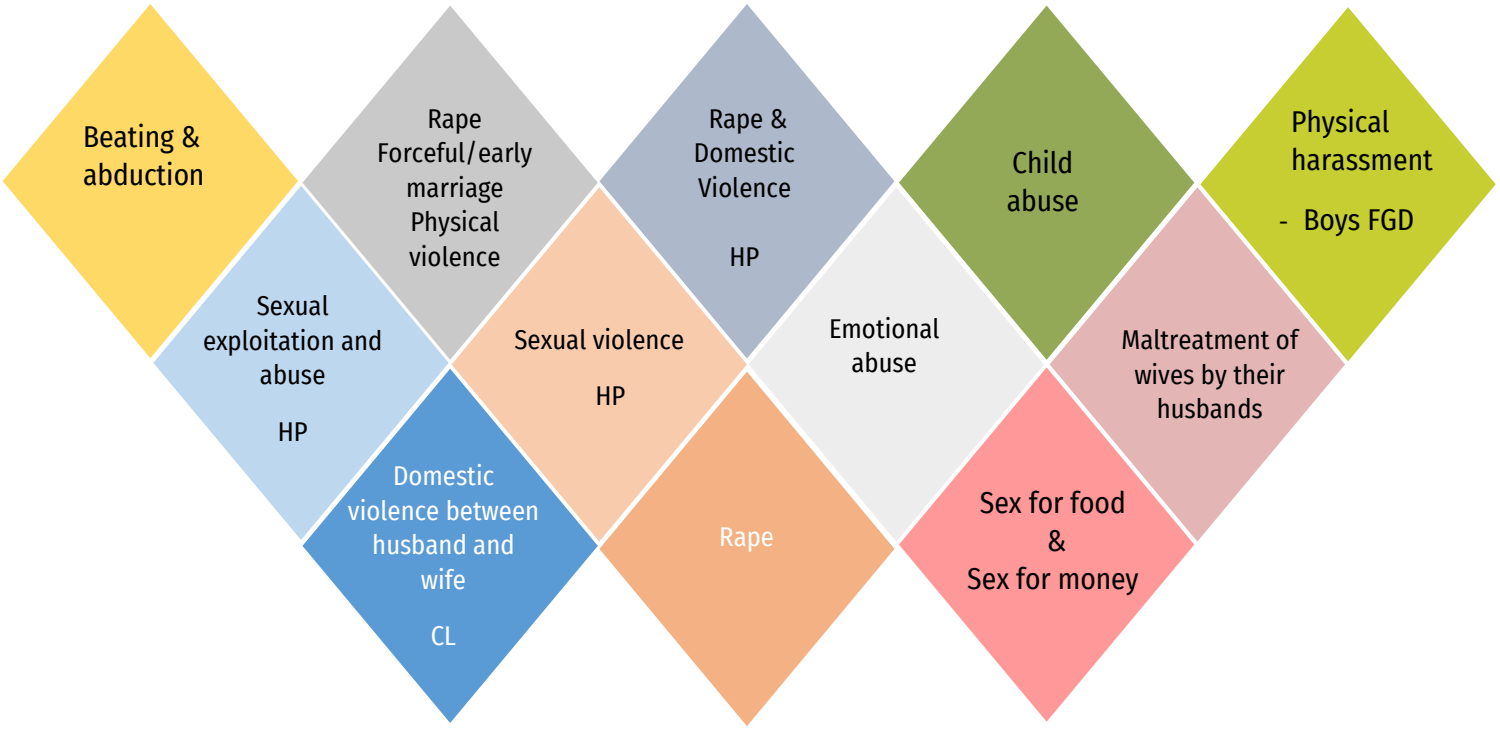

Figure 4b: protection and GBV concern from the KII and FGD in the project location

According to the respondent of the qualitative survey, women and girls are more vulnerable to all forms of GBV in the community with an emphasis on the forms of GBV mention by both qualitative and quantitative responders. Responders further deliberated on the status of GBV in the community; the

majority of both male and female responders mentioned that GBV is declining in the community [(Ngala – female 60.9% and 21.9% male) (Bama – female 43.1% and 13.7% male)]. Few also mentioned that GBV is increasing for Ngala they were: 3.9% female and 5.3% male, and for Bama, 8.5% female and 4.1% male. The figure below gives the full details on the status of GBV.

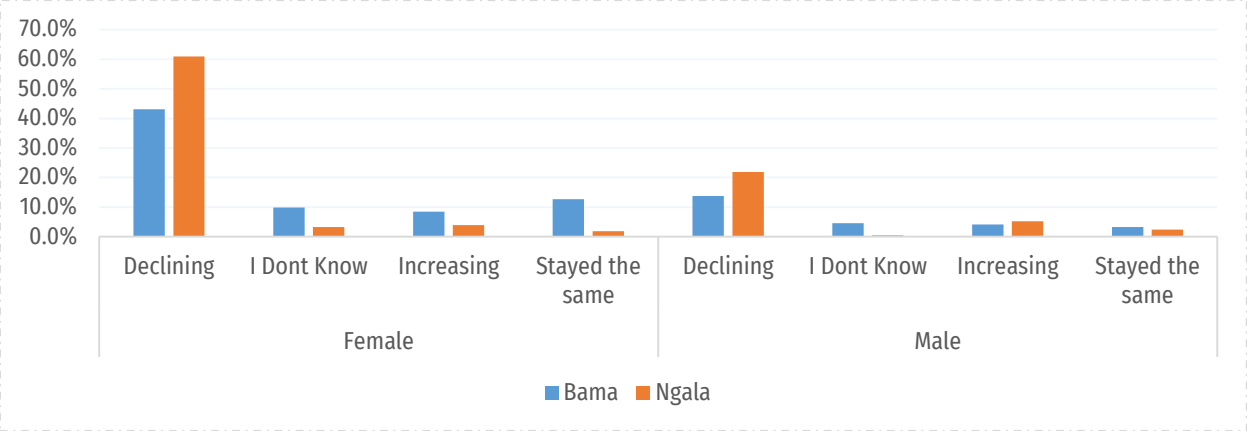

Figure 6: Status of GBV in the community

Early Marriage

Child/early marriage is a phenomenon that is now taken as a norm in northern Nigeria. Some family betroths their female children at births usually onto richer/wealthy families, some to keep the family in a particular class of society, some say their children brings men home for marriage at an early age. This is different for the male child, At the baseline, a total of 10% mentioned that early marriage was a form of violence identified by and experienced by the community[1], to further understand this, a standalone question; "at what age do girls/women usually first get married in this community? To further understand this form of violence was asked, the response was: at less than 12 years 13.6%: (6.6% female and 7.0% male), 12 – 15 years 92.5%: (45% female and 47.5% male), 16 -18 years 79.4%: (44.9% female and 34.5% male) and 19 and above 14.4%: (3.5% female and 10.9% male). This shows that the project's awareness program has made an impact as the communities are more aware of the various forms of violence experienced in the community.

[1] ECHO Baseline Report pg.15

The same question was asked about boys/men and the response was: at less than 12 years 1.6%: (0.9% female and 0.7% male), 12 – 15 years 8.7%: (6.7% female and 2.0% male), 16 -18 years 32.5%: (15.9% female and 16.6% male) and 19 and above 157.2%: (76.5% female and 80.7% male). The result shows that girls are more likely to be given up for marriage before 15 years of age than their male counterparts who stayed up to they are socially accepted and known to be a man: 19 and above.

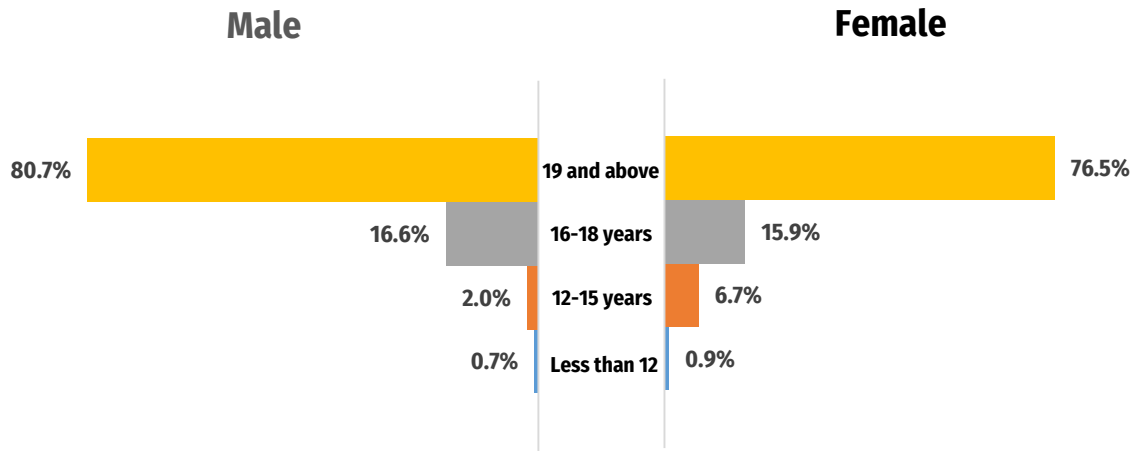

Figure 7b: At what age do boys/men usually first get married in this community

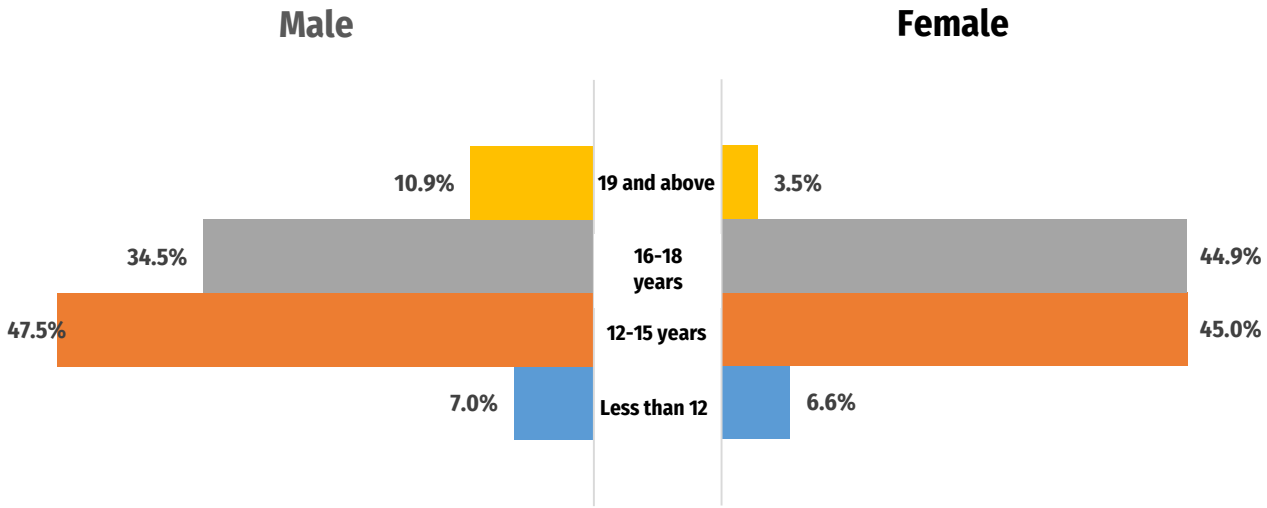

Figure 7a: At what age do girls/women usually first get married in this community

Prevalence of early/forced marriage

Respondents were asked how common is it for girls or boys to be married at this age? –, out of total female responders in Bama: 17.8% responded "not common", 33% responded "common", 44.6% responded "very common", and 4% responded "I don't know" and in Ngala: 16.9% responded "not common", 47.7% responded "common", 29.5% responded "very common" and 4% responded, "I don't know". Reasons, why a girl-child is given out early for marriage, include: for privacy, to perform expected roles, for economic freedom, for dowry, and to reduce promiscuity. Responded also mentions that it mostly occurs in the IDP camps 54.4%, others said it occurs in host community 26.7% and some said it occurs in both host communities and IDP camps 17.4%. details can be seen in the chart below.

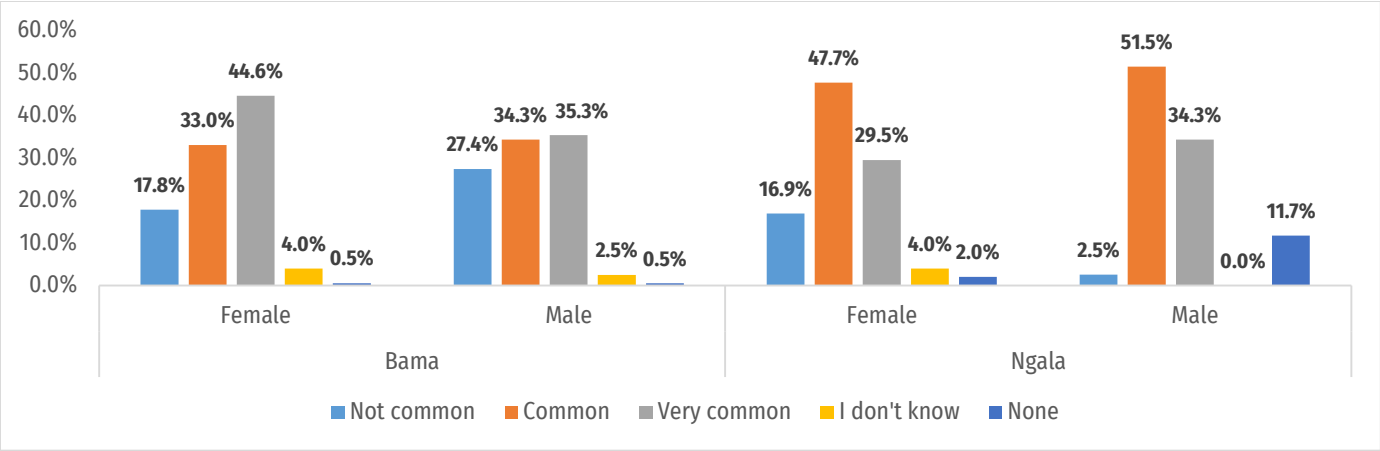

Figure 8: How common is it for girls or boys to be married at that age

Sexual violence

Rape, sexual exploitation, sexual assaults, forced marriage, and sexual harassment are the identified prevalent forms of sexual violence in the community – as stated by the respondent. The recently concluded Strategic Impact Inquiry (SII) studies show that sexual violence is more prominent in a rural setting than urban. Whereas boys in the rural community do not believe in sexual violence prominence in the community, instead of ties such acts to a rogue child.

> "In this community any woman or girl who give sex in exchange of something, she just is just doing it on her own and not because her parents/guardian cannot take care of her responsibilities" – Boys FGD

27% of the respondent (10% female and 3% male in Bama and 9% female and 4% male in Ngala) mentioned that they know of a woman or a child in the community who is a survivor of sexual violence, while 53% of the respondent (19% female and 6% male in Bama and 17% female and 11% male in Ngala) mentioned "no", 11% (2% female and 1% male in Bama and 7% female and 1% male in Ngala) mention "they rather not say" and 10% (6% female and 2% male in Bama and 2% female in Ngala) mentioned, "I don't know". –A follow-up question was asked to respondents although they were told this if they are not comfortable answering this question, they could always say it. The question was Do you know who the perpetrators are? – 15% of respondents (7% female and 2% male in Bama and 2% female and 3% male in Ngala) mentioned "Yes" –they do. When asked if they seek for help, majority of the respondent, 89% (32% female and 11% male in Bama and 33% female and 13% male in Ngala) mentioned "yes", further analysis shows that they mostly go to either hospital or a safe space for help.

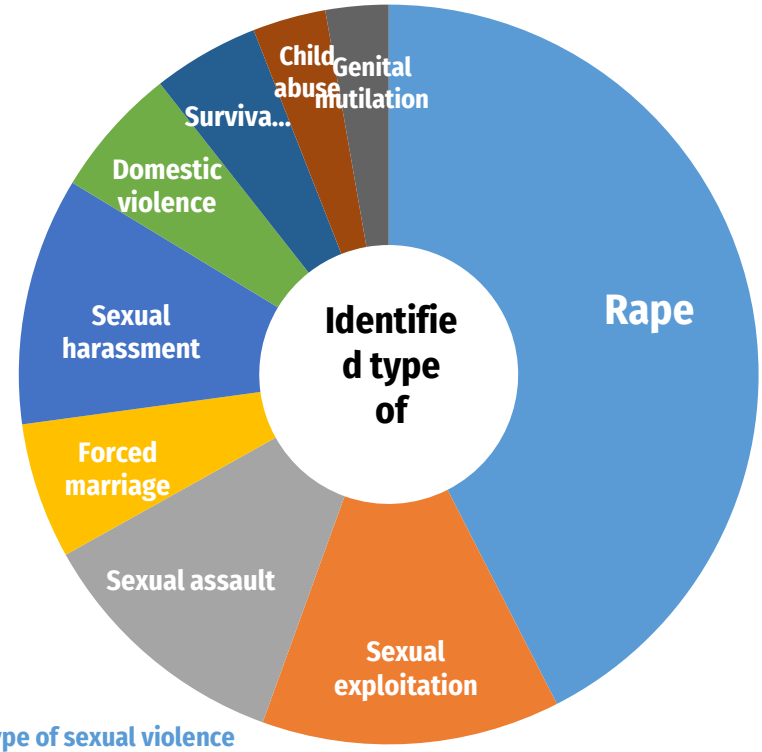

Figure 8: Identified type of sexual violence

Evolution of forms of GBV since baseline shows that the incidence of rape has always been in the increase since the inception of crises. The incident of other forms of violence like sexual violence, sexual exploitation, domestic violence, sexual harassment, forced marriage has always been in increase, due to CARE activities in Bama and Ngala, this has impacted the community to be able to report to relevant authorities who will be able to call the perpetrator to order. Women can now come out freely to report incidents of domestic violence, sexual exploitation and abuse, forced/early marriage due to the awareness created by CARE through her door to door and mass sensitization in the community.

Knowledge of the ECHO-GBV Programme

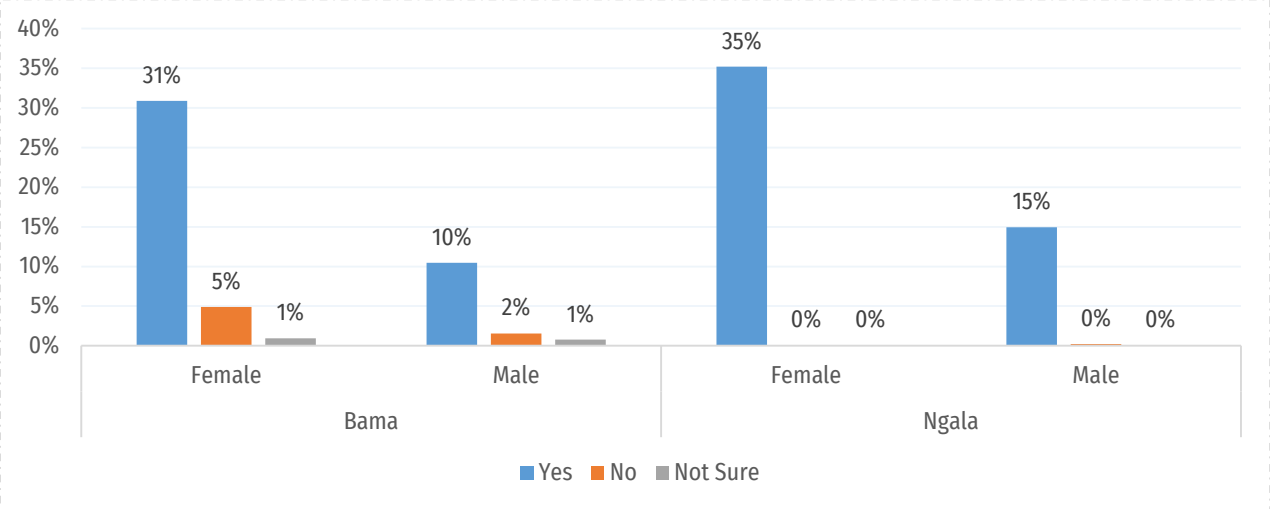

Figure 9: Have you heard of the ECHO-GBV project?

The majority of respondents knew about the ECHO-GBV project as can be seen by the chart above. The same respondents were asked what services/activities the ECHO-GBV Programme provided. The figure below shows the distribution of a multiple-response question from respondents who agree on the set activities as being carried out by the Programme.

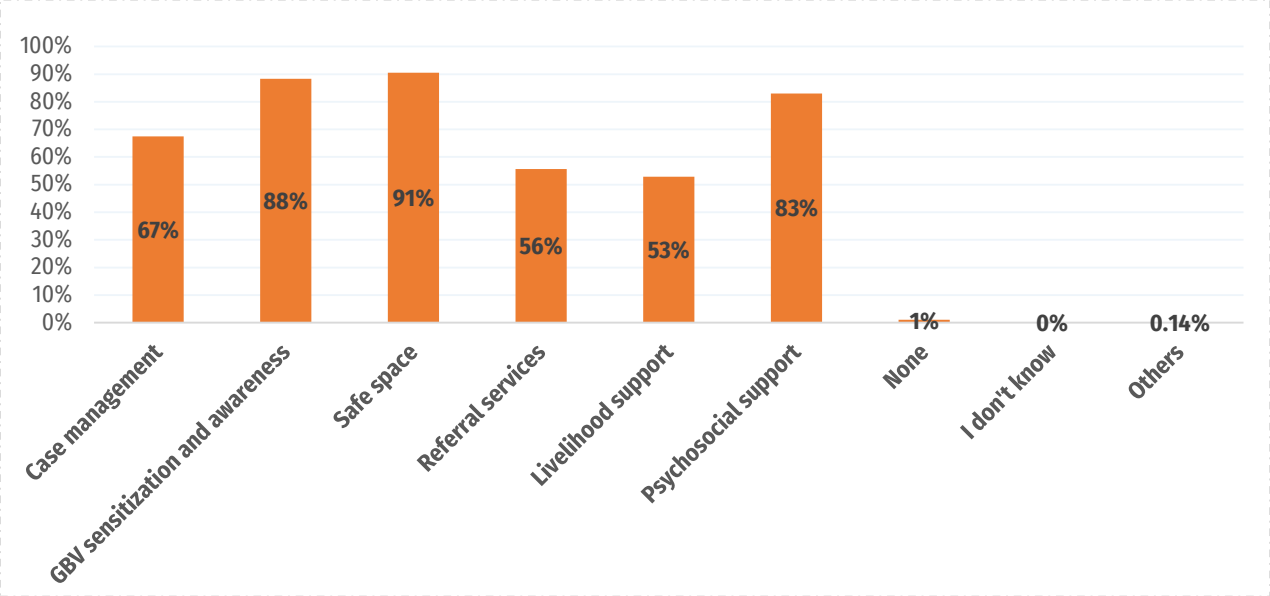

Figure 10: What specific services do ECHO-GBV project provide?

0.14% of respondents who chose others mentioned sensitization and awareness-raising on GBV prevention and response.

Perceptions of effectiveness/quality of the ECHO-GBV Programme

When asked about whether they thought the ECHO-GBV Programme was beneficial to their communities, the majority of respondents, 90% (31% female, and 10% male in Bama and also 35% female and 14% male in Ngala) thought it was beneficial to them. The majority of the responses came from women respondents because the majority of the ECHO-GBV participants are women.

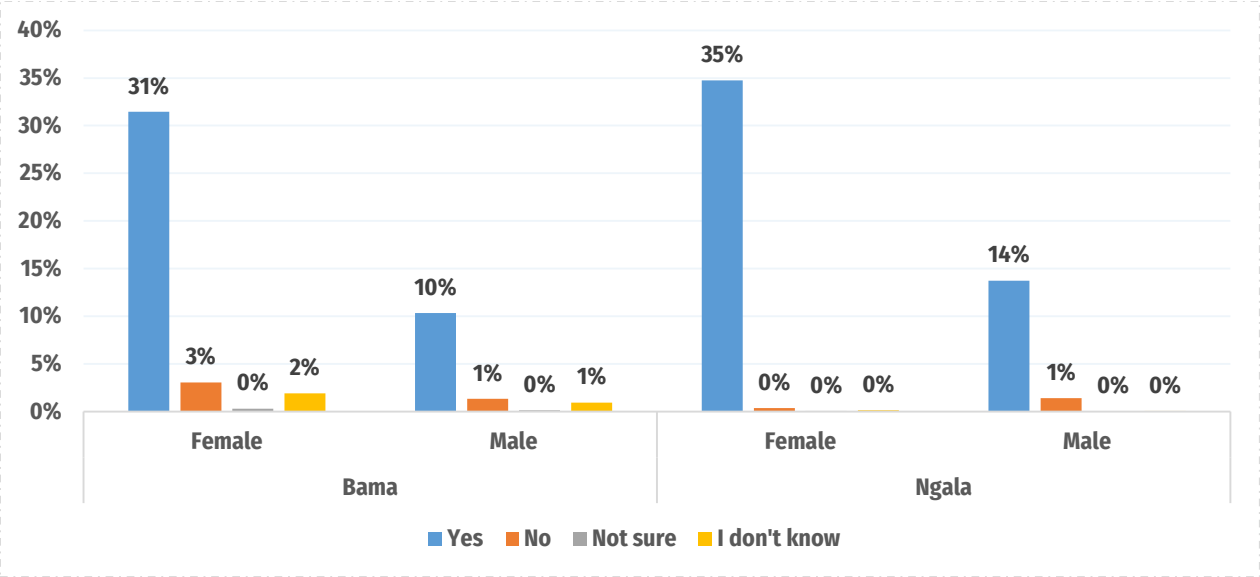

Figure 11: Do you think the ECHO-GBV project is beneficial to you?

Of the respondent who mentioned the ECHO-GBV Programme was beneficial, the majority mention it was beneficial because it provides information on GBV (82%), others mentioned it was because it supports GBV survivors (67%) and some mentioned it provides a safe home for survivors (12%).

Of those that felt the ECHO-GBV project was not beneficial, respondent felt that the information provided was not appropriate, also that services were too far, others were fearful of confidentiality issues, some group also said it does not address all post-incident needs and then lastly; services do not lead to persecution.

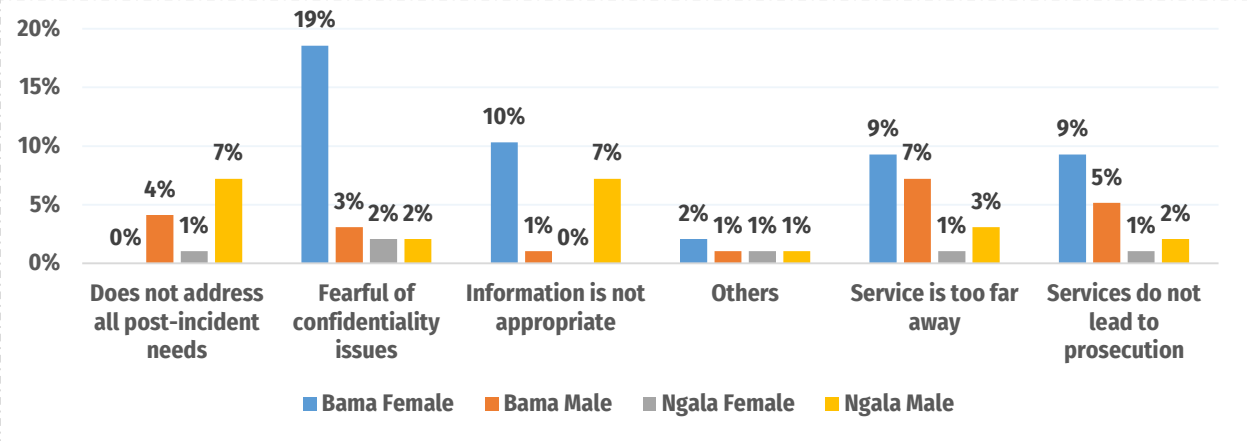

Figure 11: Why do you think the ECHO-GBV project is not beneficial to you?

Evaluation theme: Project's effectiveness

The section provides an analysis of the project's key-output indicators (KOI), and does not intend to provide an overall analysis of the program's effectiveness; instead, this section focuses on providing insight into the mid-term impact, mainly through the use of ECHO's protection mainstreaming manual.

Shortly after the baseline, ECHO organized a training on the use of its protection mainstream guidelines, for all organization implementing an ECHO-funded project. The guideline contains a series of 21 questions and guidelines on how to calculate the output/responses. The questions are meant to inform

the protection mainstreaming indicators. For this survey, the questions were modified to also provide data on specific indicator 1 as well as indicator 2.
At baseline, all activities leading to the impact indicators had not yet begun therefore, the outcome was not measured and was zero (0).

Progress made towards Specific objective 1

"% of the targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared to the beginning."

Program participants, who had been engaged in the project for its lifetime were asked: When you received assistance in the past 6 months did you feel safe while going to receive assistance, waiting for assistance and coming back to your home after assistance? and Did you feel that you were treated with respect by NGO staff during the intervention in the past 6 months? During training, enumerators were told what safe/safety and dignity meant in the context: Safety – describes the condition of being protected against physical and psychological harm, while dignity – describes the fact that people have a right to be valued, respected and receive ethical treatment. This unfortunately was not the orientation at baseline, therefore the emphasis was placed on the understanding of the terminologies.

Table 2a: Did you feel that you were treated with respect by NGO staff during the intervention in the past 6 months?

LGA	Response	Bama N=265	Ngala N=255
Female	I don't know	11.3%	1.2%
	Yes	56.2%	56.5%
	No	2.3%	2.0%
Male	I don't know	6.4%	0.4%
	Yes	22.6%	39.2%
	No	1.1%	0.8%

Table 2b: Did you feel safe while going to receive assistance, waiting for assistance and coming back to your home after assistance in the past 6 months?

LGA	Response	Bama N=265	Ngala N=255
Female	I don't know	0.4%	0.8%
	Yes	68.7%	56.9%
	No	0.8%	2.0%
Male	I don't know	0.4%	0.8%
	Yes	29.8%	38.0%
	No	0.0%	1.6%

Out of 520 respondents of which majority were women, each responded separately to the indicator question, 56.2% female respondent in Bama and 56.5% in Ngala reported that they feel well-treated with respected by humanitarian workers during the program, 22.6% of male responders in Bama and 39.2% in Ngala also agreed to the same. 2.3% of female in Bama, 2% in Ngala and 1.1% of male responders in Bama, 0.8% in Ngala said they do not feel well-treated by humanitarian workers while 12.5% (11.3% in Bama and 1.2% in Ngala) of female responders' and 6.8% (6.4% in Bama and 0.4% in Ngala) of male responders responded they do not know.

Of the total respondent who respondent to the second question on safety, in Bama, 68.7% female and 29.8% male respondent agreed –they feel safe while going for assistance, 0.8% (0.4% each for male and female) responded they do not know, while 0.8% respondent "no" –they do not feel safe while going for assistance. In Ngala, 56.9% of female and 38% of male respondent responded "yes" –they feel safe while going for assistance, 1.6% (0.8% female and 0.8% male responders) responded they do not know, while 2.0% female and 1.6% male respondent mention "no".

To calculate the output, each response per question was calculated separately and then an average was taken therefore, the result is 88.68% in Bama and 95.3% in Ngala.

Progress made towards Specific objective 2

"% of beneficiaries (disaggregated by sex, age and diversity) reporting that humanitarian assistance is delivered in a safe, accessible and participatory manner"

The outcome of this indicator was calculated using the ECHO's practical guide on protection mainstreaming, a tool specifically designed for this indicator. Series of seven (7) questions were asked to respondents, with further conditioned questions, but the main question for measuring the outcome of this indicator includes 1. Do you know of anyone in your community who was consulted by the NGO in the past 6 months on what your needs are and how the NGO can best help? 2. Was the assistance received in the past 6 months appropriate to your needs or those of members of your community? 3. Did you feel that every member of the household or the community who should receive assistance was included in receiving humanitarian assistance in the past 6 months? 4. When you received assistance [in the past X months] did you feel safe while going to receive assistance, waiting for assistance, and coming back to your home after assistance? 5. Did you feel that you were treated with respect by NGO staff during the intervention in the past 6 months? 6. Have you or anyone in your community ever raised any concerns on the assistance you received to the NGO using one of the above mechanisms in the past 6 months? 7. If yes, how satisfied were you with the response you have received?

Each question responses were calculated separately, after which they were compared using a response scale and an overall outcome was achieved.

Table 3a: Do you know of anyone in your community who was consulted by the NGO in the past 6 months on what your needs are and how the NGO can best help?

		Bama	Ngala
I don't know	Female	4.5%	4%
No		16.2%	11%
No response		0.0%	2%
Yes		49.1%	43%
I don't know	Male	4.5%	1%
No		7.2%	5%
No response		0.0%	0%
Yes		18.5%	34%
		100.0%	100.0%
Indicator score		74%	82%

Table 3b: Was the assistance received in the past 6 months appropriate to your needs or those of members of your community?

Bama	Ngala		
0.0%	2.4%	Female	I don't know
52.8%	9.8%		No
0.0%	2.0%		No response
14.7%	43.1%		Yes
2.3%	2.4%		Partially
0.0%	1.6%	Male	I don't know
21.1%	6.3%		No
0.0%	0.4%		No response
8.3%	31.4%		Yes
0.8%	0.8%		Partially
100%	100%		
26%	83%		Indicator score

When asked do you know anyone who has been consulted by aid workers on what your needs are, 49.1% and 43% of female respondent in Bama and Ngala said "yes", followed 18.5% and 34% of male respondent in Bama and Ngala who also answered "yes", more details can be seen in Table 3a above. Table 3b also shows responses on the appropriateness of assistance received in the past 6 months; the majority of the respondent answered "no" in Bama 52.8% female and 21.1% male, while in Ngala, the majority answered "yes" seen by 43.1% female and 31.4% male respondents. Table 3a and 3b show that although the majority of respondents agreed on participation in decision making around programming, not all agree on the appropriateness of its intervention.

Table 3c below shows responses on participants' inclusiveness, out of total respondent, majority of the respondent; 47% female and 23% male in Bama and 42% female and 34% male in Ngala all agreed and responded "yes", this was followed by "no" in which 22% female in Bama and 12% female in Ngala responded. This shows that participants majorly agree that interventions target groups are vulnerable groups.

Table 3c: Did you feel that every member of the household or the community who should receive assistance was included in receiving humanitarian assistance in the past 6 months?

		Bama	Ngala
I don't know	Female	0%	4%
No		22%	12%
No response		0%	2%
Yes		47%	42%
I don't know	Male	0%	2%
No		7%	5%
No response		0%	0%
Yes		23%	34%
		100%	100%
Indicator score		70.7%	81.8%

Table 3d: When you received assistance in the past 6 months did you feel safe while going to receive assistance, waiting for assistance and coming back to your home after assistance?

Bama	Female		
0%	1%	Female	I don't know
1%	0%		No
0%	2%		No response
69%	57%		Yes
0%	0%	Male	I don't know
0%	1%		No
0%	1%		No response
30%	38%		Yes
100%	100%		
99.2%	98.4%		Indicator score

Also, table 3d above illustrates responses on safety during the intervention. It can be seen that majority of the respondent 69% female and 30% male in Bama and 57% female and 38% male in Ngala responded "yes" – they feel safe while going to receive assistance and coming back home.

Table 3e: Did you feel that you were treated with respect by NGO staff during the intervention in the past 6 months?

		Bama	Ngala
I don't know	Female	0%	1%
No		2%	0%
No response		0%	2%
Yes		67%	56%
I don't know	Male	0%	0%
No		1%	0%
No response		0%	1%
Yes		29%	39%
		100%	100%
Indicator score		96.9%	99.6%

Table 3f: Have you or anyone in your community ever raised any concerns on the assistance you received to the NGO using one of the above mechanisms in the past X months?

Bama	Female		
7%	12%	Female	I don't know
29%	12%		No
1%	2%		No response
33%	34%		Yes
3%	5%	Male	I don't know
14%	5%		No
0%	1%		No response
14%	30%		Yes
100%	100%		
52.1%	79.6%		Indicator score

Table 3e above shows responses on the treatment of participants, it can be seen that a striking 67% female and 29% male in Bama and 56% female and 39% male in Ngala all responded "yes". This shows that almost all participants are being treated with respect.

Table 3g: If yes, how satisfied were you with the response you have received?

		Bama	Ngala
I don't know	Female	0%	0%
No Response		37%	27%
Partially Dissatisfied		12%	0%
Partially Satisfied		10%	4%
Very Dissatisfied		3%	0%
Very Satisfied		8%	29%
I don't know	Male	0%	0%
No Response		16%	10%
Partially Dissatisfied		2%	0%
Partially Satisfied		4%	2%
Very Dissatisfied		1%	0%
Very Satisfied		7%	27%
		100%	100%
Indicator score		61.79%	99.38%

	Yes	Yes	Yes	Yes	Yes
	100%-81%	80%-51%	50%-21%	20%-1%	0%
MARKS TO BE ASSIGNED TO EACH QUESTION	**4**	**3**	**2**	**1**	**0**

To measure the outcome of all seven questions, the scale above was developed by the ECHO team, they contain a percentage range and an assigned score after all scores are assigned and divided by the total 28. The table shows the final result received from the mandatory questions.

	Q1	Q2	Q9	Q10	Q12	Q20	Q20a	TOT MARK	Overall score
% YES	90%	89%	14%	70%	100%	60%	38%		
RANGE	80% - 100%	100%-81%	1% - 20%	50% - 80%	80% - 100%	50% - 80%	50%-21%		
Bama MARKS	3	2	3	4	4	3	3	22	78.57
Ngala MARKS	**4**	**4**	**4**	**4**	**4**	**3**	**4**	**27**	**98.43**

Progress made towards Specific objective 3

"# of surveyed communities that indicate a change in the incidence of sexual violence."

In both Bama and Ngala, all 5 communities (Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, IDP Camp Ngala) indicated a change in the incident of sexual violence, to get a clearer picture of the change in the incident, the proportion of the total in the community who have not witnessed sexual violence was measured using this question: Have you or know anyone who has been sexually abused within the last 6 months? and What would you say is the status of GBV in this community? thus, 70% of the respondent during the mid-line survey reported that the incident of GBV and sexual violence has declined within the last 6 months. However, about 30% of respondents lamented that they are aware of cases of sexual violence in the communities although, 14% of the alter group could not have ascertained if the status of sexual violence is declining or not.

Upon this finding, more awareness and sensitization are taking place to ensure a more positive outcome by the end of the intervention. In addition, CARE is collaborating with DRC to have joint protection risk monitoring in Bama to further monitor and mitigate these risks. While a protection monitoring tool was developed to complement the existing GBV risk mapping been carried out in Ngala.

Progress made towards Specific objective 4

"% of humanitarian staff trained and who can correctly indicate the referral pathway for GBV survivors."

All Staff trained on GBV, Case management and GBV referral pathway have shown and increased knowledge on the protection focus and can indicate the referral pathway effectively. Follow-ups to these training are being conducted through spot checks and monitoring likewise refresher training will be conducted in the coming months.

Summary of Project indicators

WHAT?	HOW MUCH?		
List of all project indicators	Baseline	Mid line	Target
Specific Objective Indicators			
% of targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared to the beginning.	0	*91.99%*	70%
% of beneficiaries (disaggregated by sex, age and diversity) reporting that humanitarian assistance is delivered in a safe, accessible and participatory manner.	0	*87.50*	80%
# of surveyed communities that indicate a change in the incidence of sexual violence.	5	*5*	5
% of humanitarian staff trained and who can correctly indicate the referral pathway for GBV survivors.	0	*100%*	100%
R1 Indicators			
Number of persons reached by the implementation of specific GBV prevention measures	0	*6,487*	7500
# of community members/leaders that are actively engaged in GBV protection and prevention.	0	*78*	32
Number of survivors who receive an appropriate response to GBV.	0	*191*	300
R2 Indicators			
Number of participants showing an increased knowledge on the protection subject in focus	0	*65*	25
% feedback/complaints received have been timely acted upon (disaggregated by sex and age).	0	*65%*	85%

4. Conclusion

The mid-term review indicated that progress has been made towards the outcome indicator of the project, while survivors of sexual violence might to openly discuss the incident in the community because of discrimination and victimization, they now have information at their doorsteps about GBV and where to access services from. The survey also shows that respondents in the project location know there has been a change in perception in the community since the arrival of the ECHO-GBV project, with awareness and sensitization on GBV information among others mentioned as the benefit of the project.

Although the project has seen significant changes, there is still work to be done, the survey shows that girls are still being given out early in marriages than their male counterparts, while the earlier conception highlighted that this is mostly due to issues around personal privacy and prevention of unwanted exposure, as well as giving their children

5. Recommendation

The recommendation is:

- Build on previously increased local capacities and multiply the training effects by increasing the number of step-down training in each LGA;
- The project team should devise a means to better document and capture the success from participants linked to livelihood or survivor who has overcomes and has become stronger from the project;
- The project team should continue the effort towards changing the attitudes of the population by using the media available.