A Safer Zambia Program (ASAZA)

Final Evaluation Report

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Contents

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ACRONYMS

ASAZA	A Safer Zambia
CJF	Child Justice Forum
CRC	Coordinated Response Centre
CRS	Catholic Relief Services
EU	European Union
GIDD	Gender in Development Division
IEC	Information, Education and Communication
IJM	International Justice Mission
MCDSS	Ministry of Community Development and Social Services
MOH	Ministry of Health
MOJ	Ministry of Justice
MOD	Ministry of Defence
MHA	Ministry of Home Affairs
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
NGOCC	Non-Governmental Organization Coordinating Committee
SGBV	Sexual and Gender Based Violence
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSU	Victim Support Unit
WLSA	Women and Law in Southern Africa
YWCA	Young Women's Christian Association of Zambia
ZINGO	Zambia Interfaith Networking Group
ZNBC	Zambia National Broadcasting Corporation

EXECUTIVE SUMMARY

The A Safer Zambia (ASAZA) Program was implemented by CARE Zambia and consortium partners from February 2008 – January 2011 in eight program centres in Zambia; Burma and Mtendere in Lusaka Province, Kabwe in Central Province, Ndola and Kitwe in Copperbelt Province, Mazabuka and Livingstone in Southern Province and Chipata in Eastern Province.
The evaluation showed that the program made notable progress toward meeting its goal of reduced SGBV cases and that program objectives; measured in terms of implementation of activities, achievement of targets, results were largely achieved.

The program trained 246 men as change agents and reached out 1,005,135 through insakas and community gatherings; sensitised 4,061 community leaders who included traditional leaders such as chiefs, headmen, , the clergy, Alangizi (female marriage counsellors) and 37 members of parliament. The program accomplished all public awareness activities reaching out to 3,225,682 people well above half the population in the seven districts. The activities included distribution of 3,225 682 edutainment materials with gender and GBV messages, and community conversations through radio and television broadcasts. The above efforts contributed to change in r SGBV attitudes as was demonstrated by the KAP Survey that the number of people able to identify spouse battery as a form of SGBV increased from 37% at baseline in 2008 to 67% in May 2010.

Further, the program successfully strengthened the two centres in Lusaka and Chipata and launched six new centres in seven districts. It established advisory councils, service provider networks, and survivor support groups for each centre. Standardisation of information tracking and reporting and the training of data entry clerks in data entry and management was another notable achievement. Other accomplishments include establishment of GBV hotline in collaboration with lifeline Zambia, improvements to the three shelter homes in Lusaka and Kitwe districts and the establishment of one new one in line with the expanded service provision. Training of caregivers, youths, service provider personnel (police, Magistrates health teachers) as well as paralegal personnel enhanced provision of comprehensive quality services at the centres.

The approach to SGBV service provision as described above has made a coordinated response system in Zambia a successful model. The CRCs provide under one roof, a coordinated and integrated way of responding to SGBV through a network and array of services by different actors thereby enabling clients to access all services under one roof.

The CRCs located within premises of GRZ supported health facility stand a better chance of integration into government system because it is logistically easy as medical staff are within reach. In future, it is also prudent to review staffing design, particularly the total reliance on volunteers as core staff (counsellors and paralegals) because this compromises quality in both service delivery and information management.

1.0 INTRODUCTION

1.1 Context of the Program.

Sexual and Gender Based Violence (SGBV) is a phenomenon that is negatively impacting the Zambian society especially women and children. There are increasing numbers of SGBV cases being reported in the media as daily occurrences. SGBV is not an isolated problem or a side component of Zambian life – rather, it is a widespread and tragic. SGBV is broadly defined to include spousal abuse/wife battery; rape , defilement ; property grabbing; family and child neglect; sexual cleansing; early marriage; and harmful traditional practices. *See annex 1 for more definitions*

The Zambia Demographic Health Survey (2007) indicates that almost half (47%) of all Zambian women have experienced *physical violence* since age 15 (77% by their current/former husband/partner; 7% by a brother or sister; and 6 % by their father/step-father); and one in five (20%) of Zambian women have experience *sexual violence* in their lifetime (64% by their current/former husband/partner or boyfriend). Among girls younger than age 15 surveyed, the sexual violence/abuse occurred 19% by a relative; 6 percent by a family friend; and 10% by the girl's friend. Almost half (47%) of these girls who experienced physical or sexual abuse did not seek help – and of these, an additional 6% never told anyone about it. Teenage pregnancy, some of which is an outcome of sexual violence, is alarmingly high in Zambia – with three in ten (30%) of the girls surveyed (ages 15-19) found to be pregnant or already raising children.

The Zambian government has responded to this alarming scourge by establishing institutions and structures that work and collaborate with other government agencies like USAID and Non-Governmental Organizations (NGOs) to prevent and respond to gender based violence (GBV) in communities. The Zambian government has established institutions and enacted legislation to combat the rising cases of SGBV. The American government support towards addressing GBV in Zambia has been through the Women's Justice and Empowerment Initiative (WJEI) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

1.2 The Program

ASAZA (A Safer Zambia) is a CARE Zambia led Sexual and Gender Based Violence (SGBV) Coordinated Response Program funded by the United States Mission under the Presidential Women's Justice and Empowerment Initiative (WJEI) and the European Union (EU) grant for the Expansion of the Coordinated Response to Sexual and Gender Based Violence in Zambia.

The program aimed to tackling the problem of SGBV through preventive and restorative approaches to the community. ASAZA has developed an array of informational, educational and behaviour-change communications (IEC and BCC) to create awareness and help Zambians reflect on rights, gender and power; and envision and adopt new forms of relationships based on equal dignity rather than subordination and violence. The program operated SGBV Coordinated Response Centres (CRCs) sometimes referred to as one-stop centres, at which survivors find medical help, legal support and psycho-social support. ASAZA has two established CRCs operating outside the hospital set up in Lusaka and

Chipata, and six CRCs in hospital settings in Lusaka, Kabwe, Mazabuka, Ndola, Kitwe and Livingstone.

ASAZA was implemented through a network of government and nongovernmental organizations. Each of the partners/stakeholders brought on board specific skills/advantages which allowed a nationally coordinated response for SGBV interventions. This approach resulted in survivors of SGBV being able to access comprehensive services at a one-stop shop in a timely manner; a critical aspect in dealing with GBV especially in cases of sexual assault.

In order to provide extra protection and continued counselling to clients of GBV (especially for rape, defilement and assault), the program in collaboration with other partners is supporting 19 safe homes or shelters to accommodate victims of GBV prior to being integrated to their families or communities.

1.3 The Program Budget

The program's total approved budget was US$ 5,525,000. Cumulative expenditures from the beginning of the program to December 2010 amount US$ 4,665,920 leaving a balance of US$ 859,080. This expenditure gives an effective utilisation rate (burn rate) of 85% which is acceptable, considering that part of the grant to WVI had not yet been received for retirement at the time of evaluation.

The funding for program activities to CRCs was activity based and was disbursed upon submission of acceptable monthly returns to the sub grant managers at CARE and WVZ. The two sub grant managers contracted organisations to implement activities in responsive districts. CARE sub contracted YWCA to implement activities in Chipata, Burma, Ndola, Kitwe and Mtendere CRCs while WVZ sub contracted Africare in Mazabuka and Kabwe; and Caritas through Catholic Relief Service Services in Livingstone. It was noted that the administrative layers contributed to the delayed funding to some centres which, consequently affected timely activity implementation.

1.4 Partner Roles

The program implemented activities through collaboration with multi disciplinary partners within Government and Non Government Organizations. Each of the partners provided appropriate manpower with comparative skills complementing each other's strengths. The core partners and their roles are outlined below:-

CARE International in Zambia

Being the Lead partner, CARE provided overall program oversight including; financial administration, monitoring and evaluation, training and coordination of partners. Since 1992, CARE has focused on long-term, community-based development encompassing several sectors including health, HIV/AIDS, economic development, local capacity building, education, livelihoods, food security and emergency relief.

Young Women's Christian Association of Zambia (YWCA)

Provided management and guidance in the implementation of program activities and supported networks that sensitise and influence and advocate for behaviour change to

eliminate SGBV in communities. The organisation provided counselling services, shelter homes to survivors, support community education and awareness in 5 districts.

Women and Law in Southern Africa (WILSA)
Provided legal advice to survivors, supported community education and awareness and provided technical and legal advice to CRCs under YWCA management.

Ministry of Health (MoH)
Approved and promoted standardized management protocols/guidelines for the SGBV response. MOH seconded personnel to CRCs for medical services when required, provided equipment and testing materials for SGBV survivors. Provided office space to six CRCs in Livingstone, Lusaka, Kabwe, Kitwe, Mazabuka and Ndola

Ministry of Home Affairs, Zambia Police - Victim Support Units
Enforced the law on crime perpetrators provided counselling and legal advice to victims of SGBV. Handled cases of abused children, women, , men and the elderly..

Child Justice Forum (CJF)
Provided technical support in training judges and other members of the judiciary as well as technical assistance to child survivors and witnesses

World Vision Zambia (WVZ)
WVZ provided technical support in training caregivers and general management of CRCs. It utilized its approach to development (Area Development Programs) to support operations at CRCs. Further WVZ utilized its long experience in working with communities on developmental and child protection activities.

Catholic Relief Services (CRS)
Its role was management and administration support to one CRC; it oversaw CRC management and community awareness activities.

Africare
Its role was management and administration support to one CRC; it oversaw CRC management, implementation activities and technical support in training youth across ASAZA sites.

International Justice Mission (IJM)
Trained paralegals; provided technical support for activities related to legal protection and legal services in communities where WVZ led implementation.

2.0 PURPOSE OF THE EVALUATION

The purpose of this evaluation was to systematically and independently assess the achievement of (ASAZA)'s specific objectives and expected results as described in the program logical framework and analyzed lessons learnt. The evaluation compared the progress from baseline and the midterm evaluation report. Specifically the evaluation aims:-

1. To assess the efficiency and effectiveness of program implementation;
2. To assess the sustainability of program activities;

3. To assess the achievement of the program's specific objective and expected results (including unintended results);
4. To identify lessons learned and present evidence-based recommendations.

3.0 METHODOLOGY

This evaluation was conducted in a consultative manner employing key informant interviews as the main tools of information gathering; with officers from the partner institutions such as VSU, MOH staff, judiciary staff, CRC staff, Local Court staff, beneficiaries (survivors and perpetrators), staff at shelter/safe-homes and implementing partners. Data was collected in December, 2010 and the whole process lasted for a period of eight weeks. The team analyzed both qualitative and quantitative data, reviewed program design documents, survey reports (baseline and Mid-Term), M&E framework, monthly progress and financial reports, training materials, and other statistics and program records. *See annex 2 for details*

Qualitative information data were collected from 150 people. *(see annex 3 for details)* Participants were drawn from all partners such as the Ministry of Health, Ministry of Community Development and Social Services, Ministry of Gender and Women in Development, Ministry of Home Affairs (Zambia Police – Victim Support Unit) Caritas Zambia, Catholic Relief Services and all the eight CRCs

3.1 Limitations of the evaluation study

Owing to the busy schedules of some government officers, it was difficult to meet them as arranged; and several follow –ups had to be made thereby contributing to delays in data collection. Another limitation was that the evaluation team did not talk to 2 CRC Coordinators for Mazabuka and Livingstone because there were attending a planning meeting in Lusaka. Their views are therefore not represented in this report.

However, cited limitations did not affect the quality of final output of the evaluation. The quality and depth of the interviews backed by the number of interviews and sites visited guarantee validity and reliability of the findings.

4.0 FINDINGS OF THE STUDY

4.1 Total cases recorded at CRCs
There were 12, 092 cases reported at all centres during the three year period Jan08 – Dec10. The "GBV cases" make up 25% (3024) of all cases reported and they are; rape, incest, early marriages, spouse battery, property grabbing and sexual cleansing.

Cases classified as "other GBV cases" constituted 56% (6,756) of the total cases reported. They include spouse/family neglect, child neglect, exploitation, verbal abuse, economic violence, domestic violence, assault, child abuse, child support, child custody, child molestation, threatening violence, physical torture, spouse abuse, , deprivation and psychological abuse.

The "non GBV cases" form 19 % (2,312) of total cases reported and these include; marital/relationship disputes, desertion, stigma/discrimination, witchcraft, breach of contract, illegal eviction, , abduction, , sexual harassment, divorce appeal, debt payment, excessive beer drinking, marriage interference, drug abuse, defamation of character, eloping, family dispute, health issues, employment related issues, finance-related issues, medical compensation, unfair judgment, child delinquency, contractual dispute and success/property dispute.

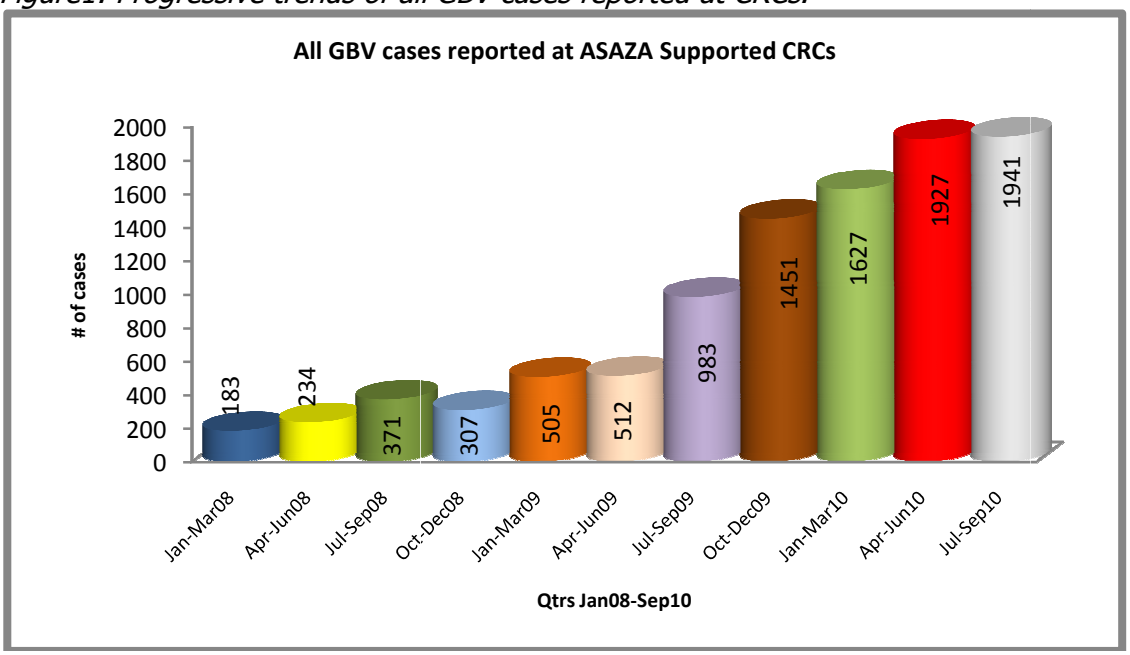
It was established that the high numbers of both "non" and "other" GBV cases was due to friendly and hospitable environment that CRCs offer to the victims of abuse to present all their problems and seek relief from the centres. The evaluation noted that abuse is widespread and that stakeholders need to do more to address it. For example, the cases indicate the need for the legal framework to be reviewed so that survivors of GBV can be protected from continued victimisation by perpetrators.

Table 1 Number of Cases Reported at CRCs (January 2008 – December 2010)

DISTRICT /CASE	Mazabuka	Chipata	Mtendere	Burma	L/stone	Kabwe	Kitwe	Ndola	Total
Attempted defilement	19	1	5	3	13	6	23		70
Attempted Rape	2			6	2				10
Attempted Incest					44				44
Defilement	123	116	19	144	46	119	35	65	667
Rape	32	21	7	33	19	15	7	17	151
Incest		9		5					14
Early Marriage	23	13	2	35	1	4	6		84
Spouse Battery	281	388	117	355	80	242	30	74	1,567
Property Grabbing	37	106	16	36	62	21	68	18	364
Sexual Cleansing							52	1	53
Other GBV Cases	1548	1725	524	587	1038	349	562	423	6,756
Non GBV Cases		941	246	393	274	99	239	120	2,312
Total	2,065	3,320	936	1,597	1,579	855	1,022	718	12,092

4.2 Progressive trend of SGBV Cases (2008 – 2010.).
Figure 1 below provides a progression trend of GBV cases recorded at CRCs from January 2008 to December 2010.

Figure1: Progressive trends of all GBV cases reported at CRCs.



The graph shows a sustained rise in the number of GBV cases. The rising trend did not in any way indicate that GBV incidences are getting worse. The increases are as a result of more CRCs which opened during the course of program implementation. Further, the rise is because of heightened GBV outreach messages which encouraged people to report incidences of GBV and to seek help (*breaking the silence*).

4.3. Performance by objectives and activities
Under this section, the program was measured in terms of implementation of activities under each specific objective.

4.3.1 Specific Objective 1: Improve gender equitable attitudes among men
All ten (10) activities outlined in the program M&E plan were implemented. Through these activities, the program has been successful in mobilizing communities to act against GBV incidences and to support survivors through men's networks.

4.3.1.1 *Conducting a participatory baseline survey.*
The survey was conducted and it indicated that "despite the majority of service providers having served for at least a year providing the broad range of services in handling cases of GBV; 72% were found not to have been trained in "GBV". Further, it showed that 63% of the respondents desired to receive comprehensive GBV Training while 15% desired psychosocial Counselling training and another 15% required training in case management. At baseline, one third of the service providers said there were no mechanisms in their districts for referring clients of GBV cases to other institutions.

4.3.1.2 Train men as advocates, agents for change

The program supported men and in turn played an important role in the fight against GBV through various interventions such as the men's networks, Insakas, community conversations, youth mentoring, perpetrator counselling, participation in community radio programs and community outreach facilitation. Discussions with men that were trained indicate a positive influence about their own behaviour as other people in the community. Men are progressively playing the role of change agents through their own actions.

In total, the program trained 527 men drawn from different backgrounds, exceeding the 400 target. The men then helped to reach out to 1,012, 995 people in the community through outreach activities during the program lifespan. In addition, 696 youths were trained and mentored. .

4.3.1.3 Sensitize traditional leaders as advocates for change

The baseline survey on knowledge, attitudes and practices revealed that 76 percent of community/traditional leaders indicated that they were aware of cases of sexual abuse in their community. The culture of initiation ceremonies and its curriculum is at variance with some gender roles and emerging issues on HIV/AIDS. In this regard, 4, 236 (2,015m, 2,221f) traditional and community leaders were sensitized on the effects of GBV and its consequences on society. There were 449 (333m, 116f) that were trained (in GBV. Further, 38 parliamentarians were sensitized on GBV issues through the program's outreach activities.

The heightened anti GBV activities are already bearing fruits because Chiefs Nyanje in Eastern Province and Hanjalika and Naluama in Mazabuka have outlawed sexual cleansing and early marriages in their chiefdoms. There are also amounting momentum chiefdoms like Mwanachingwala, Liteta, Mushili and Chipepo to outlaw traditional practices that perpetuate GBV such as sexual cleansing and early marriages.

4.3.1.4 Integrate GBV into RAPIDS youth life-skill training

A total of 696 youths were trained against a target of 2,500 representing 29% achievement. The trained youths reached out to 5,958 fellow youths against a target of 24,000 which is 25% achievement. The program did not perform well under this activity.

4.3.1.5 Hold community conversations around GBV

In all the districts, community facilitators were trained and implemented the action plans. 23 communities had active conversation points showing a positive trend. This activity is an ongoing interactive tool that is used to stimulate debate and is likely to have a long-term positive impact on many people's perception about GBV.

4.3.1.6 Develop and conduct anti-GBV campaigns through print, radio & visual media

In all the eight program centres, radio and TV coverage is available and were fully exploited. In addition, other methods were used. For example, different IEC materials were developed and used sensitization campaigns. Bill boards and posters were mounted at strategic places such as schools, highways, courts, social clubs, health centres and markets. *(See the billboard below mounted in Lusaka's downtown area*).

Kafue Road, at Down Town Facing traffic to Chawama
6m x 6m Citisquare

The target under this activity was to reach out to 2,050,000 people by the end of the program in January 2011. At the time of evaluation, the program had already reached out to 3,918,000[1] people. Radio and television programs supported by ASAZA were aired weekly on community and carried live debates/phone-in programs. Approximately, 500,000-800,000 people were reached with various GBV awareness messages each day. Further, records from CRCs indicated that more than 2,000,000 brochures on various themes were printed and distributed at workshops, meetings, national and international events. Additionally,

4.3.1.7 Develop edutainment materials with gender and GBV themes.

Edutainment were conducted by incorporating gender and GBV awareness and prevention themes and information into the content of mass media programming such as popular television and radio soap operas. Drama performances were a popular edutainment medium among a broad cross-section of the community. During these performances sensitization messages through songs, dances and actions including question and answer sessions were passed on to the communities. Additionally, services such as on-site counselling, referrals, legal advice and satellite clinics were provided. Edutainment provided information to survivors about the severe and life-threatening consequences of GBV, sensitized and created awareness to the community on the available GBV services and how to access them.

An edutainment drama session in Chipata, Eastern Province

It also served as means to building trust among community members and to inform about the need to protect and care for survivors of GBV and not to discriminate them. IEC and BCC materials developed under the program were also distributed during these events.

The men's network, survivors, paralegals and caregivers reported that outreach activities at the community level have an impact on raising awareness at grass-roots level.

[1] This is an estimate figure based on Radio 2 coverage. It should be interpreted with caution. Source: ZNBC Audience Data Survey 2009 by ZAMPS –Steadman's Research Services

4.3.1.8 Air national and community radio programs on GBV themes
Same as in 5.3.1.6

4.3.1.9 Public Service Announcements (PSA) on gender and GBV
GBV messages were also spread PSA. In Mazabuka for example, a total of 20 rounds of PSAs were aired using a mounted vehicle, while in Mtendere, a public address system mounted at the main market was for PSAs.

4.3.1.10 Use international GBV events for educational activities
All the eight centres made full use of international events (marked days) to disseminate information on GBV, sensitize members of the public and create awareness on the services provided by the program. There was active participation from groups such as men's network, survivors, youths and members of the advisory council. During these events the program mounted tents for counselling, distribution of IEC materials and referral. Drama shows were used to draw members to listen to messages on SGBV.

The major events participated in included the International Women's Day, World AIDS Day, 16 Days of Activism on SGBV, World Water Day, A Week Without Violence (under YWCA). In addition, the program participated in national events and traditional ceremonies Independence Day, Africa Freedom Day and Nc'wala, Lwiindi Chibwela Mushi respectively.

4.4.2 Specific Objective 2: Provide quality, comprehensive services at CRC in all the eight program centres.
The program implemented all twelve (12) activities planned under this specific objective. CARE Zambia in collaboration with its partners developed and successfully implemented training for staff, volunteers, service providers and community stakeholders, established coordination and oversight mechanisms at each centre, strengthened local service networks and referral systems, initiated survivor support groups and provided support to shelters and safe houses for SGBV survivors.

4.4.2.1 Develop with Ministry of Health minimum standards for GBV service provision
In close collaboration with Ministry of Health, Ministry of Gender and Women in Development , Ministry of Home Affairs; Ministry of Community Development and Social Services; European Union; Population Council of Zambia; United Nations Children's Emergency Fund; United Nations Population Fund; and USAID, the program developed minimum standards manual "*National Guidelines for Multidisciplinary Management of Survivors of Gender Based Violence in Zambia."* The document produced in 2009 is the key reference manual for training service provider's personnel in the program.

4.4.2.1 Support two existing and launch six new CRC
In addition to the two old centres (Chipata and Burma CRCs), ASAZA established six new additional centres in six districts. The program rehabilitated buildings which were under Ministry of Health to create a conducive working environment, provided all logistical requirements (Vehicles, Office equipment), and recruited staff to man the centres. Details of start dates and responsible partners are given below:-.

Table 1: CRC Establishment Dates and Sub Grantee Partners.

CRC Name	Start Date	**Sub Grantee**
Burma	2006 (Old Centre)	YWCA
Chipata	2006 (Old Centre)	YWCA.
Kabwe	December, 2008	Africare
Mazabuka	February, 2009	World Vision Intl.
Mtendere	March, 2009	YWCA
Livingstone	July, 2009	CRS
Ndola	July, 2009	YWCA.
Kitwe	September, 2009.	YWCA

The centers provided coordinated and integrated responses to GBV through a network and array of services by different actors under one roof. The coordinated response includes the provision of psycho social services, medical services and security services to GBV survivors. The centres trained service providers in standardised protocols which guided them on how to respond to diverse situations.

4.4.2.2 Support national network of safe-houses

ASAZA provided support to shelter/safe homes in Chipata, Livingstone, Lusaka, Ndola, Kabwe, Kitwe and Mazabuka. The program provided logistical support such as foodstuffs, stationery, office equipment, blankets and beddings. The program also collaborated with other institutions (Churches, government and NGOs) in running the homes. Safe houses/shelters provide restorative services of victims of GBV before they are reintegrated into their families or communities. The shelters further are essential to survivors waiting court outcomes and for those who can't be reintegrated into their families immediately. Survivors in shelter have access to all basic necessities of life as provided for by the program and other well wishers. In 2010, 397 clients were housed in the shelters across CRCs but later, all were reintegrated into their families.

4.4.2.3 Improve standardization of information gathering, tracking and reporting of CRC

In its quest to improve information management, the program equipped all CRCs with computers for data entry, tracking and reporting. The program further provided resources the Data Entry Clerk position for each CRC. All CRC members of staff were trained in the use of the upgraded MS Access database and other M&E tools.

4.4.2.4 Establish advisory council for each CRC

The program established and strengthened advisory councils and they are effectively functioning in all CRCs. They comprise members from implementation partners, Government and Non-Governmental Organizations and FBOs. This has encouraged community involvement and ownership of the program. Organisations such as Cindi and Zingo in Kitwe have mainstreamed some of the program activities into their programs.

4.4.2.5 Establish service provider networks for each CRC

All the CRCs have service provider networks that are complementing the activities of the program. The networks have strengthened coordination and collaboration and have enhanced effective service delivery. The service provider networks offer comprehensive survivor-friendly services that link survivors to the full range of services recognized as essential for comprehensive GBV management like medical, legal, and psycho-social counselling. The service provider networks incorporate additional restorative, community

outreach, and preventive components. Discussions with CRC staff during focus group discussions indicated that the networks were working well and held regular meetings to update each other on the services being offered.

4.4.2.6 Create survivor support groups

There are 16 survivor support groups created by members themselves. These survivor groups were highly motivated and organized. In Mazabuka, for example, survivors organized healing workshops and retreats, participated in community outreach, and accessed an economic empowerment grant from World Vision which enabled them to run small businesses. During discussions with the (Chairlady of Survivor group in Mazabuka) she said; "*We are seeing a tremendous change in the people we have assisted. Talk to these survivors, you will see. They really are survivors. They are not victims anymore."*

4.4.2.7 Establish a GBV hotline

The program partnered with Lifeline Zambia and provided support towards management of 24 hour toll-free telephone counselling services. The program trained call centre staff (counsellors) in GBV training and how to handle GBV enquiries. The toll-free telephone counselling services are accessed throughout the country from all mobile and landline telephone networks; MTN, Airtel, Cell-Z and Zamtel landlines. Through this facility, 737 people already received counselling through and 285 cases were referred to the nearest CRCs for further action.

4.4.2.8 Improve/build capacity of existing YWCA shelters

The program provided support to shelters homes in Lusaka and Kitwe, and recently included Chipata Safer home. The shelters are functioning properly and continue to offer different restorative care and support to clients. However, the shelter homes experienced financial inadequacies to meet costs of maintenance and other logistical requirements for survivors. Some survivors were admitted for long periods depending on the nature of problems leading to congestion in some CRCs.

4.4.2.9 Train caregivers to respond to GBV

The program trained 1,610 caregivers (597m, 1013f) in GBV against its target of 1,500. Trained ccaregivers acted, and continues to serve as frontline workers at community level for GBV clients. Discussion with program staff revealed that caregivers have provided relief to victims of GBV through counselling and other related services. It was further stated that victims of GBV build stronger ties with caregivers whom they tend to trust as fellow residents. To a large extent, trained caregivers are a proxy measure of program sustainability because they will always be closest to the actual and potential SGBV victims.

4.4.2.10 Train service providers (police, teachers, health workers)

The program trained 1,093 personnel from various stakeholder institutions (Police officers, teachers & health workers) against the target of 700. All training sessions were conducted according to standards outlined in the training manual. Training results are apparent in the survivors' confidence in the trained officials. Some survivors indicated during discussions that they now prefer to take perpetrators of GBV to CRCs than at police stations because services at CRCs were not only faster but non-judgmental in nature. Further, 138 media personnel were trained in GBV. Following the training, the media are increasingly giving prominence to GBV in their reporting.

4.4.2.11 Train paralegals

The program trained 217 paralegals who are providing legal advice to the CRC management. The paralegals were trained in the Zambian legal system, human rights law, GBV, marriage law, land law, law of succession, employment law, law of contract and criminal law and procedure. They were also given copies of relevant statutes and acts of Parliament. They further trained volunteers at the CRCs and also in the community in the basis of the law.

The training did not only help staff to prepare victims of GBV on court protocols and processes but also offered legal advice to members of the public. *"If you don't know what right is violated, you can't be compensated – that's why most court cases fail before they start. I realized how ignorant I was, but now I am equipped"* said one of the participants from Lusaka after he attended the paralegal training.

5.0 OVERALL PERFORMANCE BY EVALUATION CRITERIA

5.1 Relevance

The program was relevant to the needs of society at different levels and individual people because it addressed issues which cripple productive capacity (social esteem, economic, psychological etc) of women to a larger degree and men to some degree. The fact that 47% of women in Zambia suffer from gender based violence was enough justification for CARE to design and implement an intervention like the ASAZA project. Its relevance cannot therefore be overemphasised. The program is addressed SGBV prevention, care and support for survivors through coordinated response centres (CRCs) and shelter homes.

5.2 Effectiveness

The coordinated response approach was an effective multi-disciplinary, "one-stop" model, linking survivors to the full range of services recognized internationally as essential for comprehensive GBV management; medical, legal, and psycho-social. The model is an effective client tailored service and as was noted in the 2009 KAP survey, the clients showed high satisfaction in terms of the quality of service provided at CRCS. The evaluation team also found that the service processes were inclusive and consultative and made clients feel empowered. Through the planned activities, the program successfully mobilized communities to explore and challenge gender norms that perpetuate SGBV and support to victims of sexual and gender based violence.

From key informant interviews and focus group discussions conducted in the eight sites, the evaluation observed that respondents were knowledgeable about the program activities and linked changing positive attitude towards GBV to the activities conducted in their communities. The KAP survey reported that the number of individuals who are able to identify spouse battery as a form of SGBV increased from 37% at baseline to 67% at the time of the survey. This was echoed by members of the men's network during focused group discussions. Given the number of cumulative cases recorded at each CRC and the noticeable KAP changes among men and women, one can conclude that the ASAZA project's contribution towards the fight against GBV in Zambia was effective.

5.3 Efficiency

Efficiency was emphasized through regular planning which meant that all activities were implemented with strict adherence to the resources available. The evaluation team found that all activities related to direct implementation of the program produced results commensurate to the resources spent and some cases targets were surpassed as was the case for trained caregivers and service providers where both targets were overachieved. Administratively however, some inefficiency was evident in systems such as the MS Access database which was implemented at a considerably high consultancy cost with diminutive results. Further, CRCs reported inefficiency in the manner grants were being disbursed by CARE which subsequently affected the rate of implementation and the results thereof.

5.4 Sustainability

The program is working closely with the Government of the Republic Zambia (GRZ) and Non-Governmental Organizations (NGO's) towards coordinated response to sexual gender based violence (SGBV) in communities. Currently, there are strong institutional linkages with the Ministry of Health, Zambia Police, Ministry of Community Development and Social Services, Gender in Development and the Judiciary which were created by the program. All institutions are providing essential services to clients. CRCs that are housed within MOH grounds have a better chance of comprehensive GRZ support. Further, trained service providers are now able to effectively provide sustainable service to clients. This is made easier with new or renovated infrastructure within which CRC staff work.

5.5 Impact

The drive towards reducing GBV is acknowledged and supported countrywide, more especially in areas where the program is implementing its activities. The program has received support from government line departments, nongovernmental organisations, and other partners. The project's efforts are slowly paying off; and in as evidenced by the steady momentum towards formulating of legislature against GBV.

6.0 RECOMMENDATIONS.

1. Consolidate and strengthen existing services and activities by including economic empowerment programs in the stream of services available to victims of GBV. Government is already providing empowerment packages through Ministry of Community Development and Social Services which should be extended to victims of GBV. Without economic empowerment survivors are most likely to stay in an abusive relationship without reporting the case because the perpetrator is often the breadwinner.
2. There is need to allocate more resources towards evidence–based advocacy on policy makers so that GBV legislation is accelerated
3. Critical to significant and long term response to GBV in Zambia is the development of a sustainability plan. CARE Zambia needs to engage Government into constructive dialogue so that key activities are mainstreamed in government system. CARE could also lobby government that it waives some of the costs associated with providing health services to victims of GBV.
4. In future, GBV programs should be take services as close to the people as possible by opening up satellite centers in strategic locations especially in instances where accessibility to a CRC is a long distance. Thus focusing more on strengthening

response systems (informal ones in addition to GRZ institutions) through community structures – churches, mosques, traditional structures and–

5. GBV programs should in future engage the private sector so they adopt some activities at CRCs and mainstream them into their programs.

7.0 CONCLUSION

The coordinated response approach, which provided survivors with an integrated services (one-stop) support system, is an effective model. The model has considerably contributed towards the 'breaking the silence' campaign regarding GBV in Zambia, transforming deeply entrenched attitudes and norms into open discussions. This is backed by the rising GBV cases being reported to authorities unlike in the past where many cases went unreported.

Based on the current efforts against the GBV fight and if supported with a long-term GBV sustainability plan, CARE, government and other partners can achieve better results and a strengthened and an enhanced GBV response and prevention model.

8.0 ANNEXES

Annex 1: Definitions of integral concepts and role of partners

To provide clarity and uniformity of understanding of the subject under discussion in the report, key definitions of integral concepts are given here;

4.1.1. Sexual and gender Based Violence
It is an act of aggression intended to cause physical, psychological, or emotional harm to women, men and children. SGBV is exhibited in many forms which include sexual abuse, physical abuse and emotional/psychological abuse.

4.1.2. Sexual Offences
These are acts of violent aggression committed against a person on the basis of sex or gender. This form of violence may be in the form of rape, defilement, incest, indecent assault, forced marriage, forced cleansing of widows, sexual harassment at places of work or abduction.

4.1.3. Sexual Harassment
It is any sexual comment, physical contact or other gestures which annoys or upsets a person or makes him/her uncomfortable or interferes with work or studies. It also includes criticising a person sexually and treating that person as a sex object. It may also take the form of sexual bribery, asking for sexual activity and promising a reward, or demanding sexual activity and threatening violence if denied.

4.1.4. Incest
It is the act of having carnal knowledge of a person of the opposite sex who is a blood relative. Any male person who has carnal knowledge of a female person, who is to his knowledge his granddaughter, sister, or mother commits the offence. Furthermore, any person above the age of 16 years who consents or permits her grandchild brother or son to have carnal knowledge is guilty of the offence.

4.1.5. Child Pornography
Engaging a child in acting shows or talking about sexual activities in a very obvious way that is intended to make a person sexually excited. It also includes any person who sells a child pornographic materials, compels a child to watch pornographic film or material or view such materials with intent in any form intended to corrupt a child's mind commits a felony.

4.1.6. Harmful Practices
These are acts that infringe upon a person rights and liberties and include but not limited to sexual cleansing, female genital mutilation, and initiation ceremony that result in injury or transmission of an infection or a life threatening illness.

Annex 2: Documents Reviewed.

CARE. (2007). ASAZA Baseline Report. Lusaka. Zambia.
CARE. (2008). ASAZA M&E Framework Report. Lusaka. Zambia.
CARE. (2007). ASAZA 2010.Annual Report. Lusaka. Zambia.
CARE. (2007). ASAZA Mid Term Evaluation Report. Lusaka. Zambia.
CARE. (2007). ASAZA program Description. Lusaka. Zambia.
CARE. (2010).Evaluation of USG/Zambia GBV Programming. Lusaka. Zambia.
GRZ. (2007). Zambia Demographic Healthy Survey. Government Printers. Lusaka. Zambia.

Annex 3: List of people interviewed

S/N	NAME	POSITION	PLACE	ORGANISATION/ Group.
LUSAKA District- Burma and Mtendere Centres				
01	Peter Mwaba (Dr)	Permanent Secretary	Lusaka	MOH
02	John Siachanda (Dr)	Director – Planning & Dev.	Lusaka	MOH
03	Tresphord Kasale	National Director Victim Support unit	Police HQ	Zambia Police
04	Patricia Ndhlovu	Executive Director	Lusaka	YWCA
05	Nelson Mwape	Coordinator	Lusaka	Burma CRC
06	Nathan Mungo	Coordinator	Lusaka	M'tendere CRC
07	Fredah Phiri	Chairperson	Lusaka	Survivor network
08	Gertrude Mwale	Vice Chairperson	Lusaka	Survivor network
09	Gift Bwalya	Treasurer	Lusaka	Survivor network
10	Jones Nkwazi	Member	Lusaka	Survivor network
11	Ireen Shilupizhyi	Member	Lusaka	Survivor network
12	Judith Mulaya	Member	Lusaka	Survivor network
13	Majelani Sinakooma	Counsellor	Lusaka	M'tendere CRC
14	Namwiinda Kaswaya	Inspector	Lusaka	Zambia Police
15	George Phiri	Member	Lusaka	Men's network
16	Moffat Mbangu	Member	Lusaka	Men's network
17	Mathis Banda	Member	Lusaka	Men's network
18	Amon Njovu	Member	Lusaka	Men's network
KABWE DISTRICT				
19	Emmanuel Phiri	Coordinator	Kabwe	Kabwe CRC
20	Friday Kabwe	Counsellor	Kabwe	Kabwe CRC
21	Joyce Chisanga	Counsellor	Kabwe	Kabwe CRC
22	Lombe Chisanga	Counsellor	Kabwe	Kabwe CRC
23	Stella Malasha	Social Worker	Kabwe	Kabwe CRC
24	Gilbert Kayombo	Paralegal	Kabwe	Kabwe CRC
25	Chiza Chirwa	Driver	Kabwe	Kabwe CRC
26	Judith Monde	Inspector	Kabwe	Zambia Police
27	Mirriam Malekani	Inspector	Kabwe	Zambia Police
28	Mwenya Musonda	Chairperson	Kabwe	Men's Network
29	Charles Chamba	Member	Kabwe	Men's Network
30	George Kamwimbi	Member	Kabwe	Men's Network
31	Richard Salivaji	Member	Kabwe	Men's Network
32	Charles Mabbena	Dist Social Welfare Officer	Kabwe	MCDSS
33	Joyce Chitambala	Provincial Social Welfare Officer	Kabwe	MCDSS
34	Edward Chewe	Member	Kabwe -	Survivor network
35	Mutinta Liloya	Member	Kabwe -	Survivor network
36	Remmy Mutoya	Member	Kabwe	Survivor network

37	Peter Chilangisha	Member	Kabwe -	Survivor network
38	Prudence Kampita	Member	Kabwe -	Survivor network
39	Petronella Kampwita	Member	Kabwe -	Survivor network
40	Yotam Banda	Member	Railways Compound	Care Givers
41	Nicholas Bwalya	Member	Makululu Compound	Care Givers
42	Felicious Chanda	Member	Mwalala Compound	Care Givers
43	Fanny Zulu	Member	Shamabanse Comp	Care Givers
44	Alice Muchindu	Member	Kwama Compound	Care Givers
45	Ben Mwila	Member	Chindwin Barracks	Care Givers
NDOLA DISTRICT				
46	Leah CHIMBA (	Coordinator	Kitwe	Kitwe CRC
47	Ngoyi Mukonki	Data Entry Clerk	Ndola	Ndola CRC
48	Maggie Nzama	Counsellor	Ndola	Ndola CRC
49	Moonde Mweetwa	Counsellor	Ndola	Ndola CRC
50	Lweendo Nkoma	Counsellor	Ndola	Ndola CRC
51	Joy Shaba	Counsellor	Ndola	Ndola CRC
52	Alice M'tolo	Paralegal	Ndola	Ndola CRC
53	Christopher Chanda	Director - Comm Sevices	VSU	Zambia Police
54	Royfred Chishimba	Inspector	VSU	Zambia Police
55	Burston Siambulo	Chief Inspector	VSU	Zambia Police
56	Janet Chongo	Member	Advisory Council	Ndola CRC
57	Peter Machona	Inspector	Ndola	Zambia Police
58	Annie Bulambo	Coordinator	Ndola	YWCA
59	Andrew Nkandu	Member	Ndola	Advisory Council
60	Lindwa Mwale	Member	Ndola	Advisory Council
61	Ireen Chungu	Member	Ndola	Advisory Council
62	Maureen Nkata	Member	Ndola	Advisory Council
63	Andrew Kazeze	Chairperson	Ndola	Advisory Council
64	Andrew Musunga	Treasurer	Ndola	Advisory Council
65	Stephano Kabwe	Member	Ndola	Care Givers
66	Ireen Sambwa Chisanga	Member	Ndola	Care Givers
67	Getrude Banda	Member	Ndola	Care Givers
68	Mamble Kasonde	Member	Ndola	Care Givers
69	Cecilia Tembo	Member	Ndola	Care Givers
KITWE DISTRICT				
70	Liyungu Sichamba (Dr)	Chairperson	Kitwe CRC	Advisory Council
71	George Chiyeke	Member	Kitwe CRC	Advisory Council

72	Moses Sampa	Member	Kitwe CRC	Advisory Council
73	Chukafuna Banda. (Dr)	Director	Ministry of health	Kitwe DHMT
74	Sylvia Chishimba	Coordinator	Kitwe CRC	Kitwe CRC
75	Beauty Shawa	Sister In Charge	Buchi Clinic	Kitwe CRC
76	Theresa Nkonkola	Member	Kitwe	Care Givers
77	Ireen Nsofu	Member	Kitwe	Care Givers
78	Gladys Mubanga	Member	Kitwe	Care Givers
79	Godfrey Mwale	Member	Kitwe	Care Givers
80	Jurita Mutale	Regional Coordinator	Copperbelt Region	YWCA
81	Bowas Chansa	Counsellor	Kitwe	Kitwe CRC
82	Racheal Mwenda	Student	Kitwe	Kitwe CRC
83	Charlotte Bwalya	Counsellor	Kitwe	Kitwe CRC
84	Racheal Kumwenda	Data Entry Clerk	Kitwe	Kitwe CRC
85	Joseph Phiri (Rtd Capt)	Chairperson	Kitwe	Advisory Council
86	Kennedy Mambwe	Secretary	Kitwe	Advisory Council
87	Patrick Mubanga	Member	Kitwe	Advisory Council
88	Evans Chali	Secretary	Kitwe	Advisory Council
MAZABUKA DISTRICT				
89	Maria Beene Banda	Data Entry Clerk	Mazabuka CRC	Mazabuka CRC
90	Jermiah Mumbula	Para Legal Officer	Mazabuka CRC	Mazabuka CRC
91	Precious Sikwale	Counsellor	Mazabuka CRC	Mazabuka CRC
92	Dinda Nkete	Counsellor	Mazabuka CRC	Mazabuka CRC
93	Marvis Hamuntanga	Councellor	Mazabuka CRC	Mazabuka CRC
94	Jobina Kaiza	Office Assistant	Mazabuka CRC	Mazabuka CRC
95	Winnie Mwale	Counselor	Mazabuka	Mazabuka CRC
96	Gracious Divunda	Manager	Mazabuka	WVI
97	Sebastian Mwenya	Magistrate/Chair - Advisory council)	Mazabuka	Judiciary
98	Jennipher Simata	Secretary	Mazabuka	Survivor network
99	Naomi Phiri	Member	Mazabuka	Survivor network
100	Jennipher Mainza	Member	Mazabuka	Survivor network
101	Babra Mbewe	Vice Chairperson	Mazabuka	Survivor network
102	Bridget Mbiiza	Vice Secretary	Mazabuka	Survivor network
103	Magret Lifunda	Member	Mazabuka	Survivor network
104	William Mupeta	Chairperson	Mazabuka	Men's Network
105	Donald Chanda	Member	Mazabuka	Men's Network
106	Francis katongo	Member	Mazabuka	Men's Network
107	Lyton Mbewe	Member	Mazabuka	Men's Network
108	Kenny Chilufya	Member	Mazabuka	Men's Network
109	Austin Makwembo	Paralegal Officer	Mazabuka	Munjile Ward
110	Boyd Mwanansaluka	Paralegal Officer	Mazabuka	Kalama Ward

111	Wilson Chilanga	Paralegal Officer	Mazabuka	Ngwezi Ward
112	Crispin Moonga	Paralegal Officer	Mazabuka	Munenga Ward
113	Bilsent Chakatala	Paralegal Officer	Mazabuka	Ngwezi Ward
LIVINGSTONE DISTRICT				
114	Josephine Siamwala	Data Entry Clerk	Livingstone	Livingstone CRC
115	Theodola Imasiku	Councellor	Livingstone	Livingstone CRC
116	Fredrick Mainza	Counsellor	Livingstone	Livingstone CRC
117	Kebby Sianjane	Paralegal Officer	Livingstone	Livingstone CRC
118	Francis Chanda	Coordinator–Caritas (Z)	Livingstone	CRS
119	Patrick Nawa)	Chief Inspector	VSU	Zambia Police
120	Inonge Siamate	Producer	Livingstone	R/Mosi o Tunya
121	Joseph Tumawa	Clerk of Court	Livingstone	Judiciary
122	Derrick Siatondwe	Clinical Officer	Livingstone	MOH
123	Nelson Sibaniche	Member	Livingstone	Survivor network
124	Bridget Kunda	Member	Livingstone	Survivor network
125	Micheal Bwembya	Vice Chairperson	Livingstone	Advisory Council
126	Magret Banda	Manager	Livingstone	Safe House
CHIPATA DISTRICT				
127	Dorothy Phiri	Coordinator	Chipata	Chipata CRC
128	Joseph Ngoma	Chief Inspector	Chipata	Zambia Police
129	John Chitalima	Paralegal	Chipata	Human Rights Commission
130	Winstone Nukwe	Paralegal	Chipata	Human Rights Commission
131	Agness Bobo mwanza	Chairperson	Chipata CRC	Advisory Council
132	Abraham Mvula	Counsellor	Chipata	Chipata CRC
133	Mercy Mbewe	Data Entry Clerk	Chipata	Chipata CRC
134	Nancy Kapembwa	Counsellor	Chipata	Chipata CRC
135	Olipa Zulu	Counsellor	Chipata	Chipata CRC
136	Zachariah Chikumba	Paralegal Officer	Chipata	Chipata CRC
137	Dube Chimusebo	Chairperson(Headman)	Chipata	Men's Network
138	John Banda	Secretary	Chipata	Men's Network
139	James Mkandala	Member	Chipata	Men's Network
140	Martin Mvula	Trustee	Chipata	Men's Network
141	Kennedy Phiri	Chair – Magazine Com	Chipata	Men's Network
142	Elisha Banda	Chair – Chipangali	Chipata	Men's Network
143	Hezron Phiri	Sec – Chipangali	Chipata	Men's Network
144	Trywell Kachali	Chair – Jere Comp	Chipata	Men's Network
145	Philimon Katema	Chair – Navutika	Chipata	Men's Network
146	Isaac Ngoma	Sec – Navutika	Chipata	Men's Network
147	Kenny Banda	Chair – Kanyanja	Chipata	Men's Network
148	Argalon Zulu	Chief' Nyawa's rep	Chipata	Men's Network
149	Alvin Mitti	Headman	Chipata	Men's Network

150	Charles Lungu	Chair – Kanyanja	Chipata	Men's Network

Annex 4: Discussion guide for government ministries/departments and partners

- Name of the organization.
- Position held in the Organization.
- What is your organization role in the program?
- When did your organization start participating in this program?
- What programs is your organization implementing in the ASAZA program?
- What are Strengths, Weaknesses, opportunities and threats does your organization see in the ASAZA program.
- Has your organization made any recommendations to improve on the performance of the program?
- If yes, were the recommendations implemented!
- If no what were the reasons advanced for rejection.
- Which other partners does your organization collaborate with in implementing ASAZA programs?
- Has your organization participated in any training program under the ASAZ program?
- Has your organization made any proposals for enactment of legislature to strengthen the fight against SGBV?
- How many personnel have been seconded from your organization to the program? Has this development caused any staffing problems with your organization?
- How often does your organization receive reports from the program?
- What suggestions do your recommend to improve the performance of the program?

Discussion guide for service providers
What services does your organization provide to the CRC?

- How are your services provided?
- What type of clients do your normally/ usually serve?
- What are the categories of the cases that you normally handle?
- What kind of protocols does the CRC site utilize? Is there a flow chart or other written guidelines that you could share with our team?
- Which other organizations (NGOs and other) have been providing or promise to provide assistance in fighting GBV with the program?
- Are there areas which need strengthening? If yes; which ones?
- How often do you have program management or review meetings? Who attends these meetings and where are they held?
- What suggestions do your recommend to improve the performance of the program?

Discussion guide for survivors and men's network
Name of the organization.

- Position held in the Organization.
- What is your organization role in the program?
- When did your organization start participating in this program?
- What activities are you involved in?
- Do you find the support group network to be a helpful group?
- How often do you attend support group network activities?

- How long have you been a member of the Survivor Support Group?
- Where are the Survivor Support Group meeting held; how often; and what kinds of things do you do together?
- Does your organization formulate and annual/quarterly and monthly work plan to guide implementation of your activities? .
- If an income generation, economic empowerment or education/training component was provided as part of the services provided by the CRC, would it be useful to you?
- If you think an income generation activity would be useful, what kind of skills building or income generating activities would be of interest or most beneficial to you? Do you have ideas of what kinds of products might sell well in your community?
- Do you feel that income generating opportunities would be beneficial to you, or is there any concern that your spouse might not be receptive to the idea?
- What do you like best about the Survivor Support Groups?
- Is there anything that you could recommend to improve how the Support Groups operate or are supported by the CRC, i.e., such as better trained staff, more resources, income generating activities, more social events?
- Do you think GBV cases are declining or increasing? Please explain
- What is the level of awareness of GBV in the community?
- What activities are you involved in? In which ways are these contributing to addressing GBV cases in the community?
- Do you have any IEC materials? If yes which ones and where did you get them?
- What factors contribute to GBV in your community?
- How many members have received training or attended sensitization meetings? What topics did you cover?
- What topics do you still need to cover?
- Propose ways in which you intend to continue with your group beyond the life-span of this program?

Discussion guide for CRC staff

- Name of the centre
- Name of person in-charge
- How many staff members are working on the ASAZA program?
- How many of these staff have been trained in various skills needed by the program?
- When was the centre opened for GBV services?
- What services are provided at this centre?
- How many clients have been served from this centre since inception? If you have written statistics, could you avail us a copy..
- Where does the centre receive clients from?
- What reports do you send to ASAZA M/E?
- Can we have a look at the reports
- How can we begin to scale up services from this centre?
- What challenges do you encounter in the provision of services to clients? (not personal challenges)
- What suggestions do you recommend for improving services at the centre or the program at large?

ANNEX 5: Consultants details

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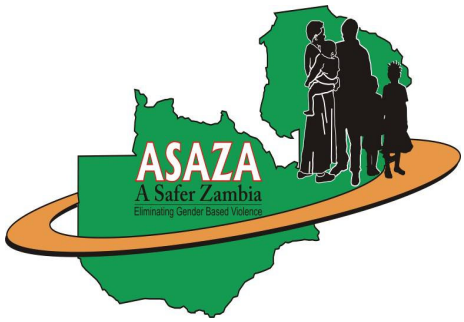
ANNEX 6: Terms of Reference



Final Evaluation of
A Safer Zambia (ASAZA) Program

CARE Zambia
599 Protea Road, Fairview
P. O. Box 36238
Lusaka, Zambia

November, 2010

1. BACKGROUND

Sexual and Gender Based Violence (GBV) is widespread in Zambia and is having a devastating impact on the lives of women and children. The existing regulatory framework and the justice system in Zambia are inadequate to address GBV, and especially violence within families. Few shelters exist for battered victims.

CARE's ASAZA program aims to assure that the rights of women and children in Zambia to live without fear of GBV are recognized and upheld, with protection and support provided for victims and survivors.

CARE's overall goal in the ASAZA Program is:

To extend the response to an unmet need in Zambia by addressing the service needs of women, children and men affected by sexual and gender based violence (GBV).

ASAZA Program Goal and Objectives

CARE's overall goal in the ASAZA program is:

Gender-based violence in Zambia decreases due to greater knowledge of and changed attitudes about gender inequities, and survivors of gender-based violence have access to comprehensive services to meet their medical, psychological and legal needs.

The goal assumes achievement of two objectives:

Improvement in gender-equitable attitudes and behaviors among men and women.

Provision of quality, comprehensive services at CRCs in selected locations.

2. PURPOSE AND OBJECTIVES

The purpose of this final evaluation is to systematically and independently assess the achievements of the ASAZA specific objective and expected results as described in the ASAZA program document.

The final evaluation is expected to provide insight into the efficiency, effectiveness, relevance, impact and sustainability of the ASAZA program interventions as well as factors that enabled and constrained the achievement of results. The final evaluation will compare the progress from baseline report to mid term evaluation report. Value added from this final evaluation is expected to be achieved through lessons learned and recommendations that can be utilized in future implementation of similar programs.

The final evaluation is part of the program monitoring and evaluation plan. The objective is to assess sustainability of the ASAZA program impact realised during the implementation of the program. The final evaluation is intended to generate knowledge through lessons learnt and best practices in the context of the ASAZA program delivery, management implementation, partner relations with the view to sustain the impact of the program. The final evaluation will also take into consideration results from the baseline/situational analysis/needs assessments and mid-term evaluation results

The specific objectives of the Final Evaluation are:

1. To assess the efficiency and effectiveness of program implementation;
2. To assess the sustainability of program activities;

3. To assess the achievement of the program's specific objective and expected results (including unintended results);
4. To identify lessons learned and present evidence-based recommendations.

3. COVERAGE AND SCOPE

The final evaluation will cover ASAZA program locations sites namely Burma and Mtendere in Lusaka Province, Chipata in Eastern Province, Kabwe in Central Province, Kitwe and Ndola in Copperbelt Province, and Livingstone and Mazabuka in Southern Province.
Within the specific objective outlined above, the final evaluation is tasked to explore and draw conclusions on the following evaluation questions/issues. The list is not comprehensive and will be reviewed and completed during the establishment of the final evaluation work plan.

Effectiveness
Outputs: to what extent have planned outputs been achieved? What is the quality of the outputs?
Data on indicators: have data been collected on the indicators of achievement? Do they provide adequate evidence regarding achievement of program outputs and contribution to outcomes and impact? Is it necessary to collect additional data?
Gender: what were the achievements in terms of promoting gender equity and equality (planned/unplanned)?
Capacity development: what were the achievements in terms of capacity development (planned/unplanned)?

Efficiency
Costs: did the actual or expected outputs justify the costs incurred? Have the resources been spent as economically as possible?
Duplication: did program activities overlap and duplicate other similar interventions (funded nationally and/or by other donors)?
Alternative Options: Are there more efficient ways and means of delivering more and better outputs with the available inputs?

Sustainability
Likely sustainability: is it likely that program achievements will be sustained after the end of program support? Are involved counterparts willing and able to continue program activities on their own? Have program activities been integrated into current practices of counterpart institutions and/or the target population?
Resources: have they been allocated by the counterparts to continue program activities?

Causality
What factors: what particular factors or events have affected the program results?
Internal/external factors: were these factors internal or external to the program?

Unanticipated Results
Were there any unexpected positive and/or negative results of the program?
How to address them: can they be either enhanced or mitigated to achieve the desired impact?

Alternative Strategies
More effective approaches: is there, or would there have been, a more effective way of addressing the problem(s) and satisfying the needs in order to achieve the outputs and contribute to higher level aims?
Relevance: are program strategies still valid or should they be reformulated in case of future similar programs?

Relevance
Needs, mandates, policies and priorities: Do the program's planned results address the national needs? Are they in line with the government's priorities and policies? Are they in line with USAID mandate? Does the target population consider them useful? Are they complementary to other donor interventions? In case of similar programs should results be adjusted, eliminated or new ones added in light of new needs, priorities and policies?

Lessons Learned
- What have been the barriers in GBV service delivery?
- What security concerns have presented themselves during the course of the program (e.g. risk to counselors during counseling sessions, security at shelter, etc)?
- What are the experience with various tools and forms, for example client incidence form, paralegal forms, referral forms and perpetrator forms?
- What are the specific challenges of managing CRC services in a smaller set-up (e.g. Chipata) in comparison to a large urban location (e.g. Lusaka)?
- What are the challenges concerning the recruitment, motivation and retention of counselors or/and volunteers and other service providers (e.g. minimum qualification requirements, incentives)?

4. METHODOLOGY

While the specific methodology will be outlined by the consultant as part of establishing the evaluation work plan, it is recommended that a methodological approach blending quantitative and qualitative techniques is considered.
As a first step, quantitative monitoring and reporting data and the ASAZA mid-term evaluation report will be availed to the consultant to review. Other relevant material will also be made available to the consultant to review. It is also suggested that the consultant conducts in-depth discussions (in person or through other means) with relevant partners, stakeholders and field staff at CRC level. The evaluation exercise is not expected to include surveys at household or beneficiary level. However, the consultant is encouraged to identify appropriate tools to capture data from the intended beneficiaries in line with the stated objectives and expected results.

5. CONDUCT OF THE FINAL EVALUATION

The evaluation team will consist of consultant (s) and a member of staff from Monitoring & Evaluation Unit (MELU). While ASAZA program staff will not form part of the evaluation team, they nonetheless will be expected to take part in the evaluation including in arranging for interviews and field visits. They will also be interviewed by the consultant on various programmatic evaluation issues.

The consultant (s) in consultation with the ASAZA program team will:
Perform a desk review of the documentation provided to gain an understanding of the context and environment in which the program operates;

- Develop an evaluation work plan[2] based on the ToR and the methodological approach including data collection and analysis;
- Design the specific evaluation approach and details of the procedures to be used, within the budget and timeframe available;
- Encourage partners, stakeholders and beneficiaries to communicate concerns, ideas, questions and suggestions to the consultant during the evaluation process and actively solicit their views;
- Draft the report according to the reporting timeframe and template;
- Ensure a logical and plausible link between information gathered and analysed and results and recommendations presented;
- Address recommendations for action and outline possible implications;
- Record all aspects of methodological choices, assumptions, and limitations of the evaluation process and present a critical review during a debriefing with CARE and as part of the evaluation report;
- Keep records of material collected and analysed, which will be submitted to CARE for reference.
- Present the preliminary findings and recommendations during a workshop at the end of the fieldwork phase.
- Other tasks as specified by CARE, ASAZA program staff and partners

The consultant will be accountable for delivering the following products of the evaluation, which include

- Evaluation work plan;
- Draft and final reports; and
- Brief presentation on preliminary findings and recommendations during a workshop
- He/she is expected to ensure that the information provided in the report is valid and complete and that the evaluation team works in a coordinated and efficient manner, both when physically together, or as a "virtual" team.

5.3 Reporting

The primary function of the evaluation report is to inform CARE, the USAID and the program partners and other relevant stakeholders about the findings, conclusions and recommendations developed through the evaluation process. The consultant is expected to follow a progression in logic to arrive at useful and valid interpretations of the information collected.

The consultant will provide a draft report not later than two weeks after the data collection has been completed, based on the following structure:

- Executive Summary
- Introduction
- Program Profile / Background Information
- Evaluation Methodology
- Evaluation Findings
- Conclusion / Lessons Learned
- Recommendations

[2] An evaluation work plan operationalises the TOR. The plan specifies the tools for data collection and analysis, information sources, the tasks of the evaluation team members, and outlines a detailed schedule of activities.

Annex
The Annex should include at least the ToR, evaluation work plan (incl. schedule), list of people met, list of documents reviewed and tools used (e.g. questionnaires).
CARE and ASAZA program partners will take part in reviewing the draft report. Once the reviewers have completed the task, the MELU representative will collate all the comments and submit them to the consultant for follow-up action. The consultant will review the comments and suggestions received and issue the final report within one week of receiving the reviewers input. CARE Zambia will submit a management response not later than three weeks after the issuance of the final report.
Dissemination will also include a presentation of the findings and recommendations by the consultant to selected partners and stakeholders during a workshop. The purpose will be to validate the findings and discuss the feasibility of the recommendations.

Key outputs

- Evaluation work plan
- Data collection tools
- Collated data from reviewed literature
- Data set (for quantitative data)
- Draft report highlighting program achievements and lessons learned
- Final report sensitive to reviewers suggestions

7. Timetable of the Evaluation
The Final Evaluation process will cover 30 days from the time of commencement.

8. Final Evaluation Budget
The Final Evaluation costs will be covered by CARE Zambia.