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# USAID/Zambia Gender-Based Violence Programming Evaluation

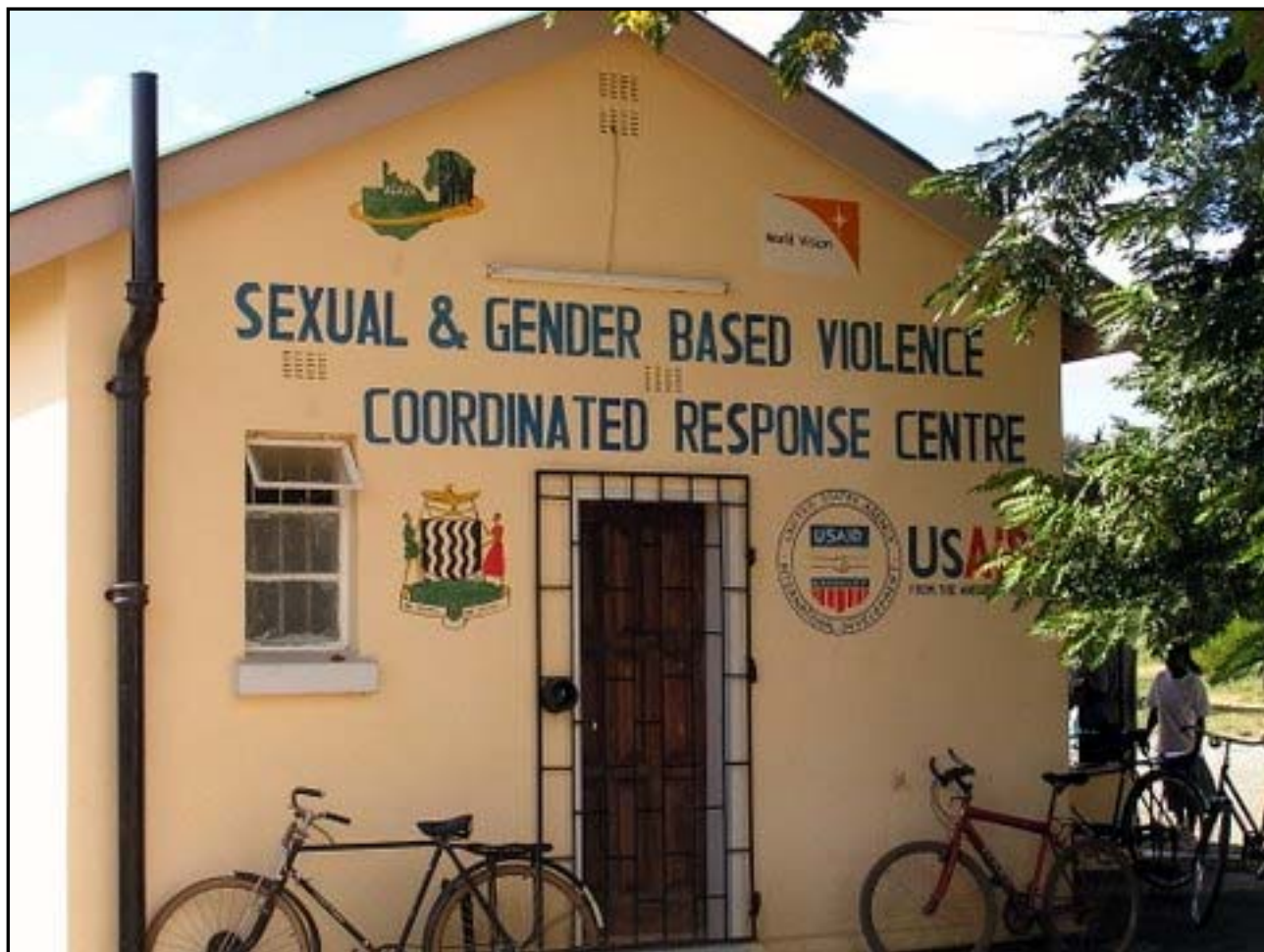
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# USAID/Zambia Gender-Based Violence Programming Evaluation

## USAID - A Safer Zambia (ASAZA) Program CDC - Child Sexual Abuse (CSA) & ZANELIC Programs

July 2010/Lusaka, Zambia



*ASAZA - Mazabuka Coordinated Response Center.*

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*Sylvie Morel-Seytoux  
Chief of Party, Zambia Evaluation Team*

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALANGIZI	Traditional Marriage Counselors
ART	Antiretroviral Therapy
ASAZA	A Safer Zambia Program – USAID/Zambia
BCC	Behavior Change Communication
CBO	Community Based Organization
CDC	Centers for Disease Control
CDWDA	Chipata District Women’s Development Association
CJF	Judiciary, Child Justice Forum
COP	Country Operational Plan
CRC	Coordinated Response Centre
CRS	Catholic Relief Services
CSA	Child Sexual Abuse Programme – CDC Zambia
EC	Emergency Contraception
ERE	Empowerment, Respect and Equality program
EU	European Union
FAWEZA	Forum for African Women Educationalists in Zambia
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GIDD	Gender In Development Division
GIK	Gifts-in-Kind
GRZ	Government of the Republic of Zambia
Hep B	Hepatitis B
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
IEC	Information, Education and Communication
IJM	International Justice Mission
KAP	Knowledge, Attitude and Practice Survey
LDC	Law Development Commission
LRF	Legal Resources Foundation
M&E	Monitoring and Evaluation
MCDSS	Ministry of Community Development & Social Services
NGO	Non-Governmental Organization
NGOCC	Non-Governmental Organization Coordinating Council
NLACW	National Legal Aid Clinic for Women
PCOE	Pediatric Outpatient Department
PEP	Post Exposure Prophylaxis
PEPFAR	The U.S. President’s Emergency Plan for AIDS Relief
PrEP	Pre Exposure Prophylaxis
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development and Support
RPR	Rapid Plasma Reagin (blood test for Syphilis)
SGBV	Sexual and Gender-Based Violence
STD	Sexually Transmitted Disease

STI	Sexually Transmitted Infection
TA	Technical Assistance
TCC	Thuthuzela Care Center
UN	United Nations
UNDP	United Nations Development Fund
USAID	United States Agency for International Development
USDOJ	United States Department of Justice
USG	United States Government
UTH	University Teaching Hospital
VAW	Violence Against Women
VCT	Voluntary Counseling and Testing
VSU	Victim Support Unit
WfC	Women for Change
WJEI	Women's Justice and Empowerment Initiative
WLSA	Women and Law in Southern Africa
WLSA	Women and Law in Southern Africa Trust
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association
ZAMWA	Zambia Media Women's Association
ZANELIC	Zambia New Life Center for Abused Children
ZANIS	Zambia News and Information Services
ZAPSCAN	Zambia Society for the Prevention of Child Abuse and Neglect
ZDHS	Zambia Demographic Health Survey
ZNBC	Zambia National Broadcasting Corporation
ZP	Zambia Police
ZPCT	Zambia Prevention Care and Treatment

## EXECUTIVE SUMMARY

### Background and Context

The extent of the problem, and need for gender-based violence (GBV) to be addressed in Zambia is enormous, with increasing numbers of cases of GBV being reported throughout the country. GBV is not an isolated problem or a side component of Zambian life. Rather, it is a widespread, tragic, and daily issue that touches and impacts most everyone's life in some way. GBV is broadly defined to include spousal abuse/wife battery; sexual violence against women and children; property grabbing; psychological abuse; family and child neglect; sexual cleansing, early marriage; and harmful traditional practices.

Zambia Demographic and Health Survey (ZDHS) 2007 data 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%) Zambian women have experienced sexual violence in their lifetime (64% of which is perpetrated by a current/former husband/partner or boyfriend). Among girls younger than age 15 surveyed, the sexual violence/abuse occurred 19% by a relative; 6% by a family friend; and 10% by the girl's friend. Almost half (47%) of the girls who experienced physical or sexual abuse did not seek help – and of these, six percent (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 as part of the 2007 ZDHS (ages 15-19) found to be pregnant or already raising children.

### USG Response

USG/Zambia is working closely with the Government of the Republic of Zambia (GRZ) and non-governmental organizations to prevent and respond to gender-based violence (GBV) in communities. USG/Zambia 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). USAID supports GBV programming through WJEI, while the Centers for Disease Control (CDC) supports GBV programming through PEPFAR.

- **USAID/Zambia** supports a three-year (February 2008 – January 2011) GBV program called “A Safer Zambia” (ASAZA). The ASAZA program is implemented through a cooperative agreement with CARE International under the WJEI. The program addresses GBV prevention, care, and support for survivors through coordinated response centers (CRCs) and shelters in seven districts: Chipata, Kabwe, Kitwe, Livingstone, Lusaka, Mazabuka, and Ndola. The goal of the ASAZA program is to decrease GBV through greater knowledge of and changed attitudes toward gender inequities, and improving GBV survivor's access to comprehensive services to meet their medical, psychological, and legal needs.
- **CDC Zambia** supports a GBV program, initiated in 2006, through direct funding to the University Teaching Hospital (UTH), Department of Pediatrics, and Pediatric Centre of Excellence (PCOE). This support provides a one-stop (medical, legal and psychosocial support) service for sexually-abused children (CSA) in Lusaka and Livingstone. In addition to supporting the CSA centers, UTH funding supports an organization called the

Zambia New Life Center for Abused Children (ZANELIC), which provides safe shelter and medical services to vulnerable children until a safe home can be established for them within their community.

Both GBV prevention and survivor restorative programs were motivated by the high prevalence of sexual and physical violence against women and children in the country, as well as the high prevalence of HIV, particularly among women. Zambia DHS 2007 data indicates that 14% of Zambian adults age 15-49 are HIV positive. Among women, the HIV rate is 16% compared to 12% for men, and for adult women, HIV prevalence peaks at 26% in the 30-34 age group. HIV prevalence in urban areas was found to be twice that of rural areas (20% versus 10%, respectively).

### **Evaluation Approach & Methodology**

During May-June 2010, a team of five international development, gender, education, public health, and evaluation experts conducted an evaluation of GBV-related USG activities with the overall purpose being to: 1) assess the ASAZA and CDC's GBV program (CSA centers) performance in accomplishing the terms and objectives of their respective agreements; and 2) utilize the information to assist USG/Zambia in formulating ideas regarding future GBV activities. The team utilized a victim-centered, culturally-responsive approach, using standard quantitative and qualitative evaluation methodology, including a desk review of 36 USAID and CDC monitoring and reporting documents; key informant interviews with 240 beneficiaries, stakeholders, and ministry officials; 24 site visits/observations, including all eight of the CRC sites (Chipta, Kabwe, Kitwe, Burma, Livingstone, Mtendere, Mazabuka and Ndola), both CDC sites in Lusaka and Livingstone, the ZANELIC center, seven emergency shelters for women and children, and multiple hospitals and Police Station Victim Service Units (VSU). Recent service statistics were collected from each ASAZA CRC and CDC service site to compare project-specific GBV program data with existing Zambia DHS 2007 (National) GBV prevalence data to identify and analyze current trends regarding GBV types and prevalence.

### **Key Findings/Accomplishments**

The team found the current coordinated community response approach, which aims to provide survivors with an integrated service provider (one-stop) support system, to be an effective model. The system provides the survivor with a more comprehensive, victim-centered service experience than if the services were provided piece meal from each service provider individually. The team's finding was corroborated by the 2010 ASAZA GBV Knowledge, Attitudes and Practices (KAP) survey, in which the level of satisfaction by primary beneficiaries was reported to be "high satisfaction in terms of the quality and manner in which the services were being provided." The KAP survey also reported similar findings to that of the evaluation team – that the service processes were found to be "engaging (inclusive) and consultative, thereby making clients feel empowered." This coordinated community approach to addressing physical and sexual violence is recommended (and in fact required) under the U.S. Violence Against Women Act (VAWA) guidelines, and also is considered a "best practice" in terms of WJEI programs in Africa.

The team found that the dual-pronged approach of providing direct services at the same time as conducting public outreach and sensitization campaigns/activities at all levels – from the



community to the national level – is the most effective approach to comprehensively address GBV in Zambia. These initiatives have successfully “broken the silence” regarding GBV in Zambia, transforming deeply entrenched attitudes and norms. In less than three years, the level of awareness regarding GBV increased from 67% to 82%; the number of individuals able to identify spouse battery as a form of GBV increased from 37% to 67%; 73% of individuals reported they had recently seen or heard messages regarding GBV; and 75% indicated they knew of specific activities in their community being undertaken to combat GBV.<sup>1</sup> These are major accomplishments to have been achieved in less than a three-year period.

## **Recommendations & Future GBV Directions**

Highlights of the team’s recommendations for improving existing programs, and suggested future GBV directions, are provided below.

Strengthen Existing Services: The evaluation team recommends consolidating and strengthening existing services and activities, with the possibility of a broader roll out geographically in the future. This includes:

- Build appropriate quality assurance mechanisms into the program design and implementation, including the incorporation of client satisfaction surveys; develop clear protocols for services provided at sites; strengthen the skill level of counselors through increased training and mentorship; require that action and safety plans be developed collaboratively with all survivors, especially those exiting shelters; and utilize the National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia as a strategic assessment and training tool.
- Review the staffing design, particularly the reliance on volunteers as core staff (counselors and paralegals), with consideration to the provision of stipends and other incentives to improve retention and recruitment of quality counselors and paralegals.
- Further integrate HIV services into GBV sites, including support to Counselors and Caregivers to provide ongoing care and support for HIV, including monitoring anti-retroviral (ARV) and Post Exposure Prophylaxis (PEP) adherence among children and adults. This also includes the integration of messages related to HIV prevention (and the links between GBV and HIV) into community outreach components.
- Expand specialized training in couple counseling and child witness counseling.
- Increase technical and in-kind support to the Men’s Networks, Survivor Networks, shelters, and Caregivers, using available resources and technical assistance from the region, such as Sonke Gender Justice and the MenEngage Network.

Build Sustainability: Critical to a long-term response to GBV in Zambia is the development of a sustainability plan. Both the USAID ASAZA and CDC CSA programs are encouraged to engage in a constructive dialogue with the NGO community, as well as relevant government

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<sup>1</sup> KAP 2010.

ministries, to develop a clear plan for building these activities into the national GBV response plan.

Review Management Structure: Management of the ASAZA program should be reviewed to streamline reporting and communication processes, with the goal of improving efficiency.

Implement ASAZA KAP Survey Recommendations: The team concurs with the seven clear and actionable recommendations offered within the ASAZA 2010 GBV KAP survey, and encourages their full implementation. Highlights include strengthening referrals to economic empowerment programs for victims of violence; expanding the effective role of the men's networks, especially where there is strong and committed local leadership (Chiefs and Village Headmen); increasing sensitization efforts to reach middle- and high-income areas; and working to ensure services are available on a 24-hour basis within all CRC sites. (See Attachment 6 for the full summary of recommendations.)

Analyze and Disseminate Data: Data collected by the ASAZA CRC and CDC CSA sites provide a rich and important picture of the magnitude and range of GBV in Zambia, including characteristics of survivors, information on the perpetrator, and the extent to which cases are moving through the legal system. Further analysis and information dissemination is recommended as a means to better capture reported changes in behavior and program impacts. Given the linkages between GBV and HIV, data analysis might also include how programs are assisting in HIV prevention and response. CSA sites are already collecting data on PEP provided to eligible clients and on HIV counseling, and testing is provided for all patients regardless of when they present. Future analysis under ASAZA could include tracking VCT results, PEP, or PEP adherence among its patients, especially with respect to rape and sexual assault survivors.

Along with consolidation and strengthening of existing GBV services and activities, the evaluation team recommends increased resources and focus on areas that have not received sufficient attention to date, as follows:

Increasing Economic Empowerment: Within all sites, respondents noted the importance of including economic strengthening activities, as much for prevention as for mitigation. The lack of economic opportunities was reported as limiting the ability of individuals to avoid or leave an abusive relationship and/or impacting the victim's decision regarding whether or not to report the incident – given that the perpetrator is often the primary breadwinner. This could entail building on existing activities, such as YWCA Women's Economic Empowerment Program and World Vision's Empowerment, Respect and Equality (ERE) program; further engaging the private sector; and adapting effective programs such as IMAGE in South Africa, which combines HIV and GBV prevention with micro-finance components. Economic empowerment should not only be provided to female victims of gender-based violence, but also to male victims and/or partners of these victims since economic stress was clearly one of the most commonly cited causes of domestic violence.

Enhance Advocacy: There is a need for greater sensitization and targeting of policy makers, including senior-level individuals in line ministries, in collaboration with civil society

organizations, to increase Zambia's commitment and resources for GBV. Specific recommended actions include lobbying and advocacy for:

- Passage of the pending Gender-Based Violence bill.
- Increased funding for additional emergency shelters for women, men, and children.
- Increased resources and GBV training for VSU Officers.
- Amendments to the Penal Code, especially with regard to corroboration requirements.
- Reforms to the Criminal Procedure Code, especially with respect to evidence, vulnerable witnesses, and child-friendly procedures.
- Reforms to the Matrimonial Code to increase women's rights in marriage.
- Reforms to multiple aspects of customary law, which leave women and children vulnerable to economic, emotional, and physical abuse.
- Expansion of the legal definition of who can sign a medical examination form and testify in court to allow clinical officers to also support this role.

In addition, the identification and support of key "GBV Champions" to advocate for GBV issues should be a top priority in any future GBV advocacy efforts. Further data collection, analysis, and dissemination of findings, as suggested above, provides one method of increasing awareness regarding the extent of the problem and the urgent need for a response.

Strengthen Criminal Justice Programming: Stakeholder interviews revealed an ongoing and urgent need for sensitization and training of law enforcement officers, particularly at senior and management levels, on issues related to GBV. Police Unit Victim Service Unit (VSU) officers interviewed requested additional training on police and prosecution training courses, including GBV witness courses. Most VSU Officers lack the most basic equipment and resources required to conduct GBV investigations, such as vehicles, supplies, communication equipment, and other forms of material support, including the longer-term development of forensic laboratory capacity. It is recommended that any future GBV efforts carefully evaluate the feasibility of enhancing the criminal justice programming component of GBV prevention and support.

Further Integrate HIV Prevention into GBV Programming: Several cross-sectional studies indicate that gender-based violence and gender inequity in relationships are associated with increased prevalence of HIV in women.<sup>2</sup> Further, research conducted by the University of Zambia indicates that child sexual abuse (commonly termed as "defilement" in Zambia) is a significant threat to HIV/AIDS prevention, as "the abusers infect minors with STIs that greatly facilitates the transmission of HIV/AIDS."<sup>3</sup> As such, the evaluation team recommends that any

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<sup>2</sup> S Maman, J Campbell, MD Sweat and AC Gielen, The intersections of HIV and violence: directions for future research and interventions, *Soc Sci Med* 50 (2000), pp. 459-478.

C Garcia-Moreno and C Watts, Violence against women: its importance for HIV/AIDS, *AIDS 14 (suppl 3) (2000)*, pp. S253-S265.

R Jewkes, K Dunkle, M Nduna, and N Shai, Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study, *The Lancet*, Volume 376, Issue 9734, 3 July 2010-9 July 2010, Pages 41-48.

<sup>3</sup> Lubungu J, Katuta C, Kamwengo M, Sichuundu W, Mwenge LM, Defilement as a threat to HIV/AIDS prevention in Zambia: International Conference on AIDS (15th : 2004 : Bangkok, Thailand). Jul 11-16; 15: abstract no. TuPeC4839. The University of Zambia, Lusaka, Zambia.

ongoing and future gender-based violence programming in Zambia incorporates and enhances the prevention and response to HIV. Key activities to be considered include:

- Enhance the capacity of GBV service and community providers to prevent HIV and provide referrals/follow-up to HIV care and support services. For instance, training could be provided to the VSU officers to enable them to provide emergency contraception to rape survivors, and potentially provide the initial PEP dose, which would increase PEP access in communities which do not currently have access to hospital-based services. At a minimum, GBV service and community providers should have good knowledge of HIV and of available referral services.
- Enhance the capacity of health services (including HIV counseling and testing, ARV, PMTCT, ANC sites) to identify and respond to GBV.
- Collect and analyze appropriate data from GBV and HIV service delivery sites.
- Strengthen monitoring and evaluation of USG-supported GBV programs to assess whether activities are working well towards HIV prevention and improved access for HIV services for women, men, and children.
- Explore other opportunities to incorporate gender-based violence prevention and response into existing PEPFAR programs.
- Utilize the PEPFAR Partnership Framework to build country ownership and support for policy development and implementation of a gender-based violence response.

## **Conclusion**

The positive response from the community, and literally, the outcry of support for the GBV efforts by USAID and CDC witnessed by the team, merit being clearly and boldly relayed within this report. Feedback from 240 of the ASAZA program's beneficiaries and stakeholders (as well as the 230 additional individuals surveyed as part of the May 2010 ASAZA GBV KAP study) confirm the continued need for these programs, and the overwhelmingly positive response regarding the integrated and coordinated community response and public outreach approach to addressing GBV in Zambia. It is the team's hope that all concerned Ministries, donors, and NGOs continue support for these and other GBV initiatives in Zambia over the long-term.

## I. OVERVIEW

### A. Background

USG/Zambia is committed to supporting programs aimed at promoting gender equality and gender integration in national policies, programs, frameworks, and laws. USG/Zambia is working closely with the Government of the Republic Zambia (GRZ) and non-governmental organizations to prevent and respond to gender-based violence (GBV) in communities. The USG/Zambia 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). USAID supports GBV programming through WJEI, while the Centers for Disease Control (CDC) support GBV programming through PEPFAR.

USAID/Zambia supports a three-year (February 2008 – January 2011) GBV program entitled "A Safer Zambia" (ASAZA). The ASAZA program is being implemented through a cooperative agreement with CARE International under the WJEI. The program is addressing GBV prevention, care, and support for survivors through coordinated response centers (CRCs) and shelters. ASAZA is being implemented in seven selected districts: Chipata, Kabwe, Kitwe, Livingstone, Lusaka, Mazabuka, and Ndola. The overall goal of the ASAZA program is to decrease GBV through greater knowledge of and changed attitudes toward gender inequities, and improving GBV survivors' access to comprehensive services to meet their medical, psychological, and legal needs.

To achieve this goal, ASAZA set two objectives:

- Improvement in gender equitable attitudes and behaviors among men and women.
- Provision of quality, GBV-coordinated response services in eight Coordinated Response Centers (CRCs).

CARE/Zambia is working in partnership via a subgrant with World Vision/Zambia (WVZ), a major partner. Other partners include Young Women's Christian Association (YWCA), Women in Law in Southern Africa (WLSA), Africare, Catholic Relief Services (CRS), and International Justice Mission (IJM). ASAZA also collaborates with GRZ agencies such as:

- Ministry of Home Affairs – Police Service, Victim Service Units (VSU)
- Ministry of Health – District Health Management Teams (DHMT), hospitals, and clinics
- Ministry of Gender and Women in Development - Gender in Development Division (GIDD)
- Ministry of Community Development and Social Services (MCDSS) – Department of Social Welfare
- Ministry of Justice - Judiciary - Child Justice Forum (CJF)

CDC Zambia supports a GBV program, initiated in 2006, through direct funding to the University Teaching Hospital (UTH), Department of Pediatrics, and Pediatric Centre of Excellence. This support provides a one-stop (medical, legal, and psychosocial support) service for sexually abused children (CSA) in Lusaka and Livingstone. In addition to supporting CSA

centers, UTH funding also supports an organization called ZANELIC which provides safe shelter to abused children (including sexual and physical abuse).

The GBV prevention and survivor restorative programs were motivated by the high prevalence of sexual and physical violence against women and children in the country, as well as the high prevalence of HIV, particularly among women. Detailed statistics pertaining to sexual and physical violence, and HIV prevalence in Zambia, are provided in Section D.

## **B. Purpose of Evaluation**

The purpose of the evaluation was as follows:

- Assess ASAZA and CDC's GBV program (CSA centers) performance in accomplishing the terms and objectives of their respective agreements, and;
- Utilize the information to assist USG/Zambia in formulating ideas regarding future GBV activities.

More specifically, the evaluation objectives included:

- Analyze the ASAZA, and CDC's GBV project objectives, the effectiveness of the executing parties, and the quality of services;
- Assess strengths and limitations and lessons learned from the ASAZA project components and the CDC project with respect to meeting their stated goals/objectives;
- Assess the similarities and differences between the ASAZA and CDC GBV programs and opportunities for modification and/or harmonization;
- Identify any gaps in GBV programs; and
- Provide comprehensive recommendations on future directions, including ensuring strengthened coordination of restorative services for survivors, women's rights, and program sustainability.

## **1. Culturally Responsive and Victim-Centered Approach**

A meaningful assessment of any gender-based violence program requires in-depth knowledge and experience in evaluation methodology, as well as a thorough knowledge base regarding the sensitive and complex nature of the gender-based violence subject matter within the specific country-context. It also requires sincere and thoughtful cross-cultural understanding, and an appreciation of different/new views and approaches to relationships, methods of service delivery, and modes of public outreach and dialogue.

Most importantly, it is critical that any approach or methodology put the victim clearly in the center, i.e., utilizing a victim-centered approach. A victim-centered approach means that the consideration of what is in the victim's best interest overrides any competing concerns – no matter how compelling – including the need for data when implementing a GBV project or conducting a GBV evaluation activity. A victim-centered approach aims to empower the individual toward making her/his own decisions, rather than imposing a course of action on the individual.

A common complaint among victims of abuse (around the world) is that when the sexual or other abuse is discovered, things get worse rather than better because their lives continue to be controlled by others, and they experience a variety of additional/new traumas. These may be repeated through insensitive, humiliating interviews; a frightening medical exam; a confrontation involving the perpetrator or the victim's family; an unpleasant placement experience (if a child is placed in a new home or shelter); treatment that the victim finds unhelpful or traumatic; or painful court testimony.<sup>4</sup> Often the most problematic aspect of any post-trauma intervention is that the victim doesn't know what is going to happen and has no say in the decision-making process. As such, it is critical that any contact with victims not exacerbate the victim's sense of powerlessness – and thus, re-traumatize the individual.

The team's approach was designed to be culturally-responsive and victim-centered – both in theory and practice – during each stage of the process. For instance, protection mechanisms were built into the evaluation to ensure survivors interviewed were volunteers whom had not recently been traumatized and clearly wanted to meet with the team. Additionally, survivors who wanted to be interviewed were never asked or probed about any personal questions regarding the abuse. Rather, the team only asked non-direct questions regarding the type and quality of service delivery obtained by the individual, with general questions such as:

- “Were the services affordable and accessible to you?”
- “What additional support services would be helpful to you?”
- “Would income generation activities in your community be useful?”
- “Did you receive any helpful references regarding other local support services from the CRC?” (Please see Attachment 3, Interview Guide: Survivor Support Groups.)

The majority of interviews were conducted with CRC and CDC staff and other service providers, with much less emphasis on direct interviews with victims – since staff counselors and paralegals are able to provide broad insights on common perspectives, themes, complaints, and concerns of the survivors whom they serve on a daily basis. However, many victims wanted to meet with the team, and expressed gratitude at the chance to share their thoughts and provide input into program recommendations. Interviewees were notified that all responses would remain confidential, and that no individual names would be included in the evaluation report.

The evaluation team displayed exemplary sensitivity and diplomacy when meeting with interviewees, especially survivors. All team members were skilled in the use of cross-cultural gender analysis techniques, which recognize the following fundamental concepts:

- Women's and men's lives and therefore experiences, needs, issues, and priorities are different;
- Women's lives are not all the same; the interests that women have in common may be determined as much by their social position or their ethnic identity as by the fact that they are women;
- Women's life experiences, needs, issues, and priorities are different for different ethnic groups;

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<sup>4</sup> Child Sexual Abuse: A Victim Centered Approach, Child Welfare Information Gateway, 2010.

- The life experiences, needs, issues, and priorities vary for different groups of women (dependent on age, ethnicity, disability, income levels, employment status, marital status, sexual orientation, and whether they have dependents);
- Different strategies may be necessary to achieve equitable outcomes for women and men and different groups of women; and
- Analyses aim to achieve equity, rather than equality.<sup>5</sup>

## 2. Quantitative and Qualitative Evaluation Methods

Within the context of a culturally-responsive and victim-centered approach, the team utilized standard qualitative and quantitative evaluation methodologies while carrying out a rigorous field visit schedule, as follows:

- Conducted a desk review of 36 key monitoring and evaluation reports and background documents, including progress reports, training materials, and other program records. (See references in Attachment 5.)
- Collected the most recent service statistics-related data from each ASAZA CRC and CDC service site to compare project-specific GBV program data with existing Zambia DHS 2007 (National) GBV prevalence data, to identify/analyze current, on-the-ground trends regarding GBV prevalence and types in each district.
- Conducted 240 key informant interviews, using pre-tailored interview guides, with line ministries officials, CRC staff, District Officials, UN Agencies, community leaders, religious leaders, police officers, NGOs, health care providers, women’s groups, men’s groups, doctors, nurses, lawyers, and court officials from project sites or organizations associated with project sites and shelters.
- Conducted 24 site observations/visits to all USAID/Zambia and CDC Zambia-supported GBV activity locations, including seven emergency shelters for women and children, and key participating hospitals and police stations, as follows:
  - ASAZA CRC Site Visits: Site visits to all eight CRC sites, including: Chipata CRC, Kabwe CRC, Kitwe CRC, Burma CRC (Lusaka), Mtendere CRC (Lusaka), Mazabuka CRC, Livingstone CRC, and Ndola CRC.
  - CDC CSA Site Visits: Site visits to both of the CDC CSA (one-stop centers) located in Lusaka and Livingstone (2 total).
  - ZANELIC: One site visit to the CDC-supported ZANELIC shelter in Linda Compound, Lusaka.

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<sup>5</sup> “Towards a Gender Analysis Framework to Assist the Application, Adoption and Use of Environmentally Sound Technologies,” Global Development Resources Center, Hari Srinivas, 2010.



- Emergency Shelters for Women & Children: Site visits to seven emergency shelters for women and children: YWCA Women’s shelter, Lusaka; YWCA Children’s shelter, Lusaka; City of Hope shelter, Mazabuka; Lushomo Children’s shelter, Livingstone; YWCA Women’s shelter, Chipata; MCDSS Bwacha shelter, Kabwe; and YWCA Kitwe shelter, Kitwe.
- Hospitals & Police Stations: Visited at least eight other relevant sites, including the Ndola Central Hospital; Chipata District Hospital; Mtendere Clinic; and the Victim Service Units of Police Stations in Chipata, Lusaka, Livingstone, and Mazabuka.
- Developed/utilized two customized Interview Guides: “Survivor Focus Groups” and “CRC Staff.” (Please see Interview Guides in Attachment 2 and 3.)

### **3. Team Composition**

Given the complex, sensitive, and serious nature of the evaluation task, the evaluation team was composed of five carefully selected experts from around the world, each with 10-20 years of relevant professional, sectoral, academic, and regional experience suitable for the assignment.

Highlights of relevant team experience are provided below.

- Sylvie Morel-Seytoux, the Chief of Party, is President and Founder of International Development, Research and Evaluation Consulting, LLC, based in Tucson, Arizona. She has provided on-going technical advisory and evaluation services to USAID missions in Rwanda, Burundi, Ethiopia, Malawi, Uganda, and Kenya for the past 21 years; served as Education Officer/Africa WID Advisor with USAID; worked as Director of the International Refugee Committee in Tucson; and taught as an Adjunct Faculty at the University of Arizona. She served as Chief of Party with Save the Children in Tajikistan, and as Refugee Officer with the Office of Foreign Disaster Assistance in Croatia. She serves on the Board of the Arizona Evaluation Network, and in addition to international work, she has provided evaluation services for the last seven years to Native American populations in Arizona on victim advocacy issues. She is trained in evaluation methodology, and holds an MA in International Development, with a concentration in international economics.
- Clint Liveoak serves as a Senior Advisor on Gender and HIV/AIDS with the Global AIDS Program with CDC in Atlanta, Georgia. He holds a law degree, and also serves as Co-Chair of the PEPFAR Gender Technical Working Group. He has over six years of experience working on gender-related issues and has experience providing mediation and implementing dispute resolution programs.
- Audrey Mwansa, an independent consultant based in Lusaka, is an Education and Gender expert, with eleven years of experience in the areas of training, girls’ education, and vulnerability issues. She is on the National (Zambia) Steering Committee for Orphans and Vulnerable Children and has extensive experience working in the SADDCC region on

gender issues. She speaks multiple Zambian languages and is a Doctoral Candidate in International Education and Development from the London School of Economics.

- Diana Prieto serves as Senior Advisor on Gender and HIV/AIDS in the Office of HIV/AIDS Global Health Bureau of USAID/W. She is Co-Chair of the PEPFAR Gender Technical Working Group. Within PEPFAR, she provides direction on GBV activities globally. A sociologist by training, she has served with USAID for 10 years, and has worked with vulnerable populations for 15 years.
- Jill Thompson, based in Gaborone, Botswana, is a lawyer and independent consultant with 20 years of GBV experience and 10 years experience working in the region of SADCC. She served with USAID/South Africa as the CTO for the Criminal Justice Strengthening Program and as CTO for the Women's Justice and Empowerment Initiative (WJEI) program – which is also implementing a one-stop model.



*From left to right: Beatrice Simwapenga Hamusonde, Women's Justice and Empowerment Initiative Specialist, USAID/Zambia; Ministry of Community Development and Social Services Representatives; Audrey Mwansa, Evaluation Team Member; ASAZA Sub-Grantee Officers.*

#### 4. Evaluation Limitations

Limited M&E Documentation: The team was able to conduct a review of ASAZA M&E documents provided by CARE Zambia, allowing for a fairly substantive assessment of the quantitative measurements of progress under the ASAZA program toward meeting its goal and two primary objectives. While the M&E reporting data received from CDC was useful, it was insufficient for the team to fully quantify progress for all activities toward meeting goals and objectives of the CDC activities. Given this limitation, the team concentrated heavily on efforts to capture qualitative measures through key informant interviews – and thus was still able to capture solid accomplishments, barriers, and opportunities pertaining to the CDC GBV activities.

Interview Structure: While a majority of interviews were structured in a way which allowed for open discussion and freely spoken opinions, some of the interviews included CRC and CDC staff in the same interview groups as that of their work superiors. For example, in one interview session, the CRC Site Director was in the same interview group as the CRC counselors and paralegals, who work *for* her. As such, it is possible the evaluation team may have missed some important feedback due to employees diplomatically restraining from criticizing the management abilities of his/her superior or expressing complaints regarding compensation levels, for instance, whilst the superior was also in the room. In such cases, the team did not solicit feedback on management issues or any other sensitive topics during group interview sessions.

The evaluation team made several careful judgment calls regarding interview structures that were set up by the CARE and CDC staff prior to the team's arrival. First, any interview structured in a way that had the potential of being non-victim centered was quickly and diplomatically re-structured to ensure the protection/comfort of the survivors. For instance, female survivors were not interviewed with males present. Second, careful consideration was given to balance the evaluation team's desire for pristine interview protocols (based upon American Evaluation Association standards) – with the existing cultural norms and social etiquette in Zambia. There were several instances during which cultural norms (and the need to ensure a victim-centered approach) demanded that standard interview protocols (which typically provide the most accurate and reliable data outcomes) be adjusted – with some interviews left to unfold in a more flexible, community-driven process.

For instance, interviewing survivors by themselves, without a CRC staff present, might possibly have brought forth more candid complaints by survivors regarding the quality of care provided by CRC staff. However, the CRC staff member present during the focus group was always an individual that the survivors knew and trusted in their community; had worked and supported them previously; and the CRC staff person – being a local Zambian–knew the cultural norms and spoke the local language(s). In these circumstances, the team always erred on the side of the victim's immediate protection and comfort level over the need for the collection of “perfect” evaluation data.

In the context of Zambia, it was the best choice within the circumstances provided to have the CRC staff present during focus group sessions with survivors. In fact, given the survivors obvious comfort level with having someone they trust and appreciate with them to facilitate the focus group discussion, it is the opinion of the Evaluation Team's Chief of Party that the data

collected were most likely more accurate and complete than if the CRC staff member had not been present.

These evaluation limitations were very minor in the context of conducting rapid evaluation field work overseas within a constrained timeframe. The overall high quality and depth of the interviews, the number of interviews and sites visited, and the quality and level of data collected from each site far surpassed the minor evaluation limitations experienced by the team.

## **C. Background & Policy Context of GBV in Zambia**

### **1. Description of the Problem and Prevalence**

Both the extent of the problem and need for GBV to be addressed in Zambia is enormous, and there are an increasing number of cases of GBV being reported throughout the country. GBV is clearly not an isolated problem or a side component of Zambian life – but rather, it is a widespread, tragic, and daily issue that touches and impacts most everyone’s life in some way. The 2007 DHS data, and other studies, have documented that GBV in Zambia occurs across all socioeconomic, cultural backgrounds and regions of the country.

The USAID and CDC GBV prevention and survivor restorative programs were motivated by the high prevalence of sexual and physical violence against women and children in the country, as well as the high prevalence of HIV, particularly among women. The types of GBV being addressed by USAID and CDC activities are broadly defined, including spousal abuse/wife battery; sexual violence against women and children; property grabbing; family and child neglect; sexual cleansing<sup>6</sup>; early marriage; and many harmful traditional practices. However, in the interest of brevity, only national statistics regarding spousal abuse and sexual abuse are highlighted below, with more updated and detailed information regarding other forms of GBV being provided in the sections that follow (which review ASAZA-specific data findings).

Some statistics also are provided pertaining to HIV/AIDS, given that strong evidence links women’s and girls’ subordination and related exposure to violence to their increased vulnerability to HIV.<sup>7</sup> For instance, research from the University of Zambia indicates that child sexual abuse (commonly termed as “defilement” in Zambia) is a significant threat to HIV/AIDS prevention, as “the abusers infect minors with STIs that greatly facilitates the transmission of HIV/AIDS.” The study found there to be a widespread “wrong perception [in Zambia] that having unprotected sex with a minor or child who is a virgin will cure the one who has HIV/AIDS” and given that a majority of defilers are either the child’s father or an adult male living in the same home (or in close proximity) to the girl or boy child, these “sexually abused children do not come out in the open because most of their defilers are their guardians.”<sup>8</sup>

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<sup>6</sup> In the Zambian context, “sexual cleansing” typically refers to a traditional practice in which a widow is obligated to have sex (often multiple times over a prolonged period) with a male member of the husband’s family (usually a brother) in order to remove the ghost or spirit of the deceased husband

<sup>7</sup> Strategic Framework for the Prevention of and Response to Gender-Based Violence in Zambia, Zambia Central Statistics Office, March 2007.

<sup>8</sup> “Defilement as a Threat to HIV/AIDS prevention in Zambia.” Lubbungu J, Katuta C, Kamwengo M, Sichuundu W, Mwenge LM; International Conference on AIDS 2004, University of Zambia.

## **1a. Zambia DHS Data**

The 2007 Zambia Demographic and Health Survey (ZDHS) is a follow up to the 1992, 1996, and 2001-2002 ZDHS surveys. It provides nationally representative estimates of basic demographic and health indicators based upon feedback from 7,146 women (ages 15-49) and 6,500 men (ages 15-59). The 2007 ZDHS is only the second DHS that includes the collection of information on violence against women and HIV testing.

Physical Violence: The ZDHS 2007 data indicate that almost half (47%) of all Zambian women experienced physical violence starting at the age of 15 (of which one-third experienced violence during the 12 months preceding the survey). Among these women, a total of 60% reported that their current husband or partner was the perpetrator, and 17% reported that the perpetrator was a former husband or partner. Seven percent reported the perpetrator as being a sister or brother, and 6% reported the perpetrator as their father or step-father.

Sexual Violence: Overall, one in five women (20%) of those surveyed reported that they have experienced sexual violence at some point in their lives. Thirty-five percent of women reported that their first experience with sexual violence occurred when they were age 19 or younger. The majority of women (64%) reported that their current or former husband, partner, or boyfriend committed the act of sexual violence. It is important to highlight that among women who were younger than 15 years old when their first experience of sexual violence occurred, 19% reported that the perpetrator was a relative, 6% reported that the person was a family friend, and 10% reported that the person was their personal friend. Forty-six percent of Zambian women who ever experienced physical or sexual violence have ever sought help from any source. Only 6% of abused women who never sought help even told someone about the violence, and 41% both never sought help and never told anyone. Note that teenage pregnancy is exceptionally high in Zambia. Three in ten (30%) of the young women surveyed (age 15-19) were either pregnant or had already given birth (and were raising) one or more children at the time of the survey.

HIV: Results from the HIV testing component in the 2007 ZDHS indicated that 14% of Zambian adults age 15-49 are HIV positive. Among women, the HIV rate is 16% compared to 12% among men. For adult women, the HIV prevalence peaks at 26% in the 30-34 age group, which is four times the rate among women 15-19 and around twice the rate observed among women age 45-49. Among men, the HIV prevalence increases from 4% in the 15-19 age group to 24% in the 40-44 years age range, and then decreases to 12% in the 55-59 age group. HIV prevalence in urban areas is twice that of rural areas (20% versus 10%, respectively). The differentials by province range from the highest prevalence rate in Lusaka (21%), to the lowest prevalence in North-Western and Northern (7% for both).

## **1b. Data Collected from ASAZA-CRC sites**

Overview: In addition to the 2007 ZDHS data, it is valuable to look at recent findings regarding reported numbers and trends obtained from the team's data collection efforts from the ASAZA-CRC response centers. Data available from the eight CRC centers varied from center to center, since some were established later, or had a late start-up date. Others weren't able to collect data the first few months due to lack of equipment or space within which to set up administrative offices. As such, it should be noted that the cumulative number of GBV cases reported would

have been much higher if every CRC had been able to start up quickly, and begin the data collection process immediately to cover the entire duration of the three-year program.

When reviewing the data provided below in Tables 1-2 and Figures 1-2, note that over the duration of the three-year ASAZA program, nine months of data were not available for the CRCs in Mtendere, Mazabuka, Livingstone, and Kabwe, and 18 months of data were not available for the CRCs in Kitwe and Ndola. Also, at the time of this report, the project was only in the second quarter of Year 3; thus, by the end of the project period in December 2010, there will be an additional six months of cumulative data – increasing the end-of-project total number of GBV cases (reported by the CRCs) substantially.

General Findings: Even with these limitations, the data compiled below in Tables 1-2 and Figures 1-2 are highly valuable in terms of looking at the extent and types of GBV occurring within the different communities across Zambia. In total, there were 5,755 gender-based violence cases reported to the eight CRC centers between January 2008 and May 30, 2010. Broken down by broad categories of GBV, there were a total of 995 spouse battery cases; 501 defilement/attempted defilement cases; 99 rape/attempted rape cases; 40 incest/attempted incest cases; 27 early marriage cases; 225 property grabbing cases; and another 3,868 “Other GBV cases.”

According to the ASAZA CRC database, this category of “other GBV cases” includes the following types of GBV: 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, bestiality, deprivation, and psychological abuse. Additional analysis regarding these 3,868 cases would be valuable to capture any quantitative trends regarding types of GBV, given such a substantial number of GBV cases fall into this “other GBV” category. This level of data detail was not made available to the evaluation team, thus further analysis is strongly recommended as a next step by ASAZA.

Note that the total figure of 5,755 GBV cases mentioned above does not include the additional 1,104 cases reported to the CRCs that were categorized/entered into the CRC database system as “non GBV cases.” (See Figures 1 & 2.) These “non GBV cases” include the following types of incidents (using CRC labeled categories): marital/relationship problems; desertion; extra marital issues; stigma/discrimination; psychological problems; witchcraft; breach of contract; illegal eviction; willful infection; abduction; abortion; counseling; sexual harassment; indecent assault; divorce appeal; prostitution; debt payment; excessive beer drinking; marriage interference; drug abuse; HIV testing counseling; theft; defamation of character; eloping, family dispute; health issues; employment related issues; finance-related issues; medial compensation; unfair judgment; child delinquency; contractual dispute; or success/property dispute. If GBV cases and non-GBV cases are combined, the total number of cases handled by the ASAZA CRCs reached 6,859 as of May 30, 2010. (See Figure 1.)

While these cases are most likely correctly labeled as “non GBV cases” when entered into the CRC database, some of the cases that fall into the categories listed (such as abduction) may, in fact, merit more careful review to ensure that all GBV cases are fully captured in the CRC reporting system. GBV definitions/guidelines vary between countries and agencies, thus a

review of definitions and data-base categories would be a worthwhile exercise for the CRCs to consider.

**Table 1. Type and Number of GBV and Non GBV Cases Handled by ASAZA CRC Sites (January 2008-May 2010)**

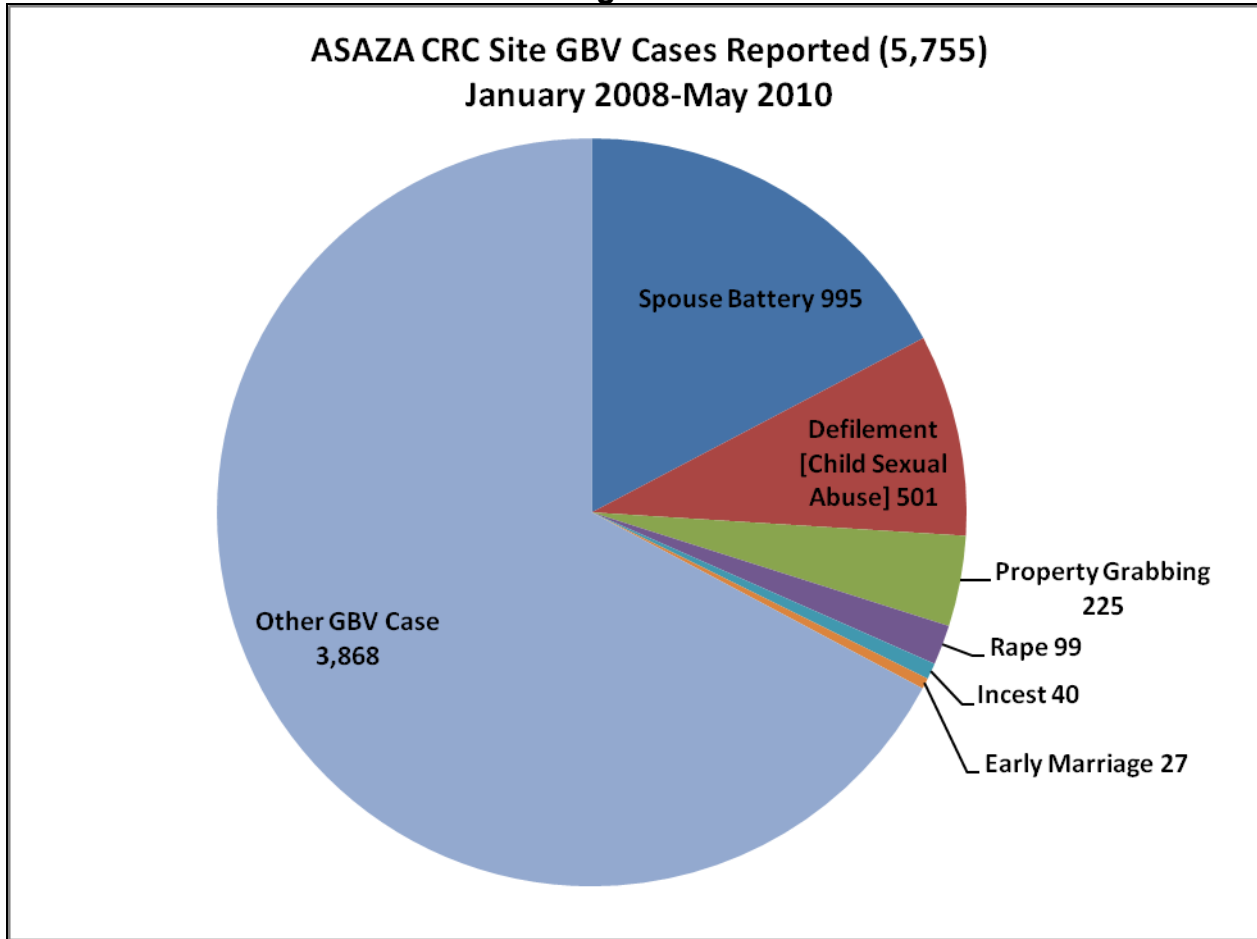
	BURMA	CHIPATA	KABWE	KITWE	LIVINGSTONE	MAZABUKA	MTENDERE	NDOLA	Total
Spouse Battery	141	258	148	27	26	206	138	51	995
Defilement [Child Sexual Abuse]	78	80	75	26	8	106	28	48	449
Attempted Defilement	2	1	3	23	5	18	0	0	52
Property Grabbing	10	77	9	46	29	24	19	11	225
Rape	13	17	8	1	4	27	12	11	93
Attempted Rape	0	0	0	0	2	1	3	0	6
Incest	3	5	0	0	0	0	0	0	8
Attempted Incest	0	0	0	0	32	0	0	0	32
Early Marriage	2	7	0	1	1	15	1	0	27
Sexual Cleansing	0	0	0	0	0	0	0	0	0
Total GBV Cases	249	445	243	124	107	397	201	121	1,887
Other GBV Cases*	467	1,130	233	220	292	905	428	193	3,868
Total GBV Cases + Other GBV Cases	716	1,575	476	344	399	1,302	629	314	5,755
Non GBV Cases**	0	532	58	0	187	0	216	111	1,104
Total GBV + Other GBV + Non-GBV Cases	716	2,107	534	344	586	1,302	845	425	6,859

\*Other GBV Includes: 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, Bestiality, Deprivation, and Psychological Abuse.

\*\*Non-GBV includes: Marital/relationship problems; desertion; extra marital issues; stigma/discrimination; psychological problems; witchcraft; breach of contract; illegal eviction; willful infection; abduction; abortion; counseling; sexual harassment; indecent assault; divorce appeal; prostitution; debt payment; excessive beer drinking; marriage interference; drug abuse; HIV testing counseling; theft; defamation of character; eloping, family dispute; health issues; employment related issues; finance-related issues; medial compensation; unfair judgment; child delinquency; contractual dispute; or success/property dispute.

(Source: Data was compiled by the evaluation team using statistics from the ASA's M&E reporting system.)

Figure 1



(Source: Data was compiled by the evaluation team using statistics from the ASAZA M&E reporting system.)

In total, within the primary categories in which the CRCs are collecting GBV data, the CRC-wide data indicate that spouse battery (995 cases) is the most commonly reported form of GBV reported to the CRCs, followed by defilement [child sexual abuse] (501 cases including defilement attempts). Property grabbing (225 cases); rape/attempted rape (99 cases); incest/attempted incest (40 cases); and early marriage (27 cases) follow in terms of frequency of reporting. Note again that a majority (67%) of the cases reported (3,868 of the total 5,755 GBV cases) fell into the large pool of “other GBV cases,” which has not yet been analyzed because this level of detail of data was not provided to the evaluation team.

While quantification of reported cases provides a glimpse into the prevalence of GBV and primary types of GBV being reported within CRC regions, there are several factors to keep in mind. First, some individuals may contact the local police station or go straight to the hospital or a local health clinic (such as the UTH CSA centers) for assistance (rather than the CRC). Thus, the CRC-specific numbers do not reflect *all* the cases in the community. As described in detail in Section III, Part D, since its opening in 2006, the CSA center at UTH has provided clinical services and follow-up to more than 4,000 sexually abused children between birth and the age 16. The center currently handles approximately 100 new cases of child sexual abuse per month,



of which 98% involve girls. Statistics were not available for the CSA center in Livingstone, but staff reported handling on average, one to three new CSA cases per day, i.e., 30 to 90 new cases per month.

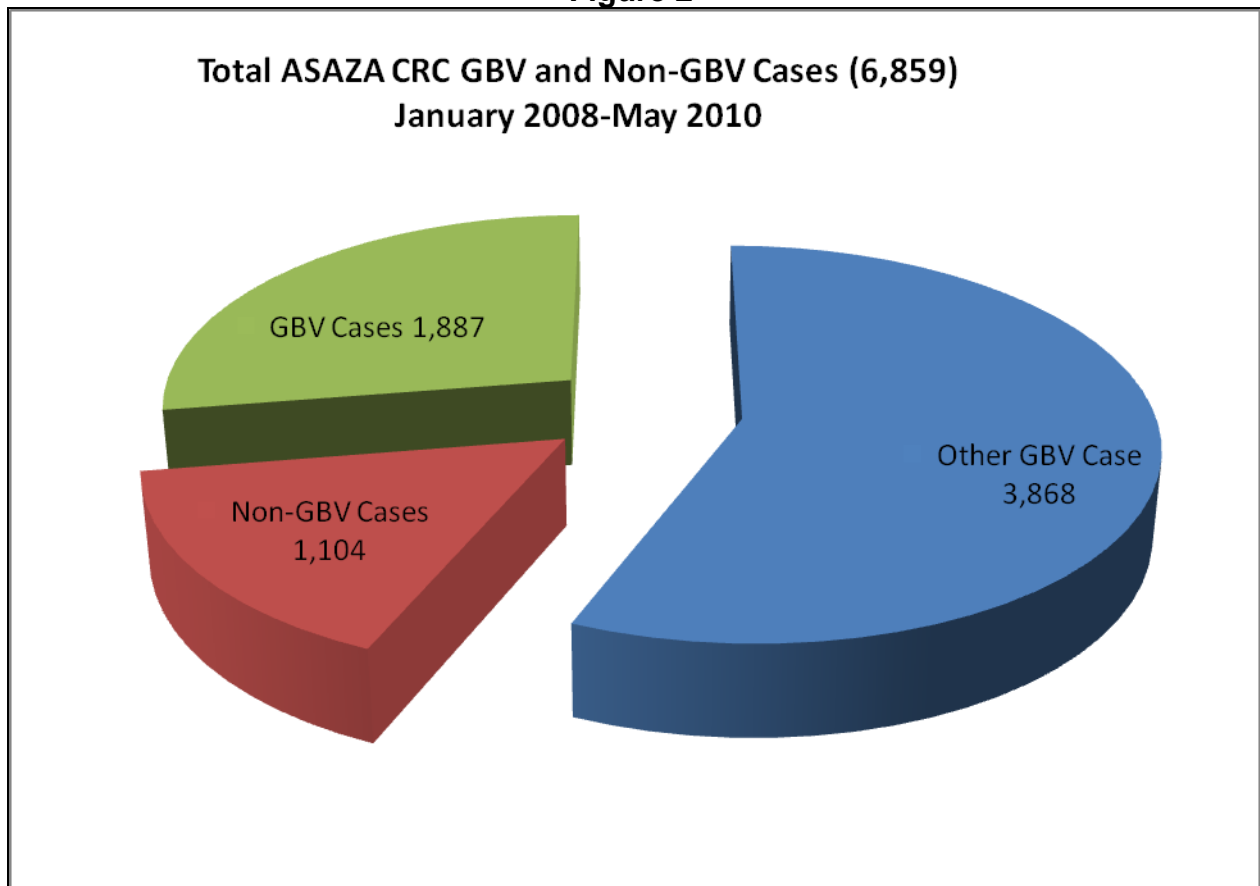
Second, a large proportion of victims of violence do not seek help (ZDHS estimate is 41% of cases among women age 15-19), and many remain silent for various personal, economic, and social concerns (fear of stigma), among other reasons. Studies further indicate that defiled children almost never speak up, and of course, defiled infants cannot speak for themselves. Finally, interview findings by the evaluation team revealed that males (both men and boys) face (and fear) severe social stigma if they admit to being a victim of sexual violence. Thus, it can be safely generalized that the actual number of GBV incidents is far higher for the CRC surrounding communities than is being reported.

Site Specific Findings: Details for each CRC are provided in Table 2 (below), with notations regarding the number of months of data available for collection from each site by the team. Comparing the sheer total number of GBV cases between sites is problematic, given the amount of time each CRC was operating and/or inconsistencies in data collection between sites. CRCs which have been operating and/or collecting data longer may have higher numbers – but this does not imply the situation is necessarily worse in one location over another. In fact, increased reporting does not mean an increased level of GBV – as the increases in reporting could be an indication that the GBV outreach messages (encouraging individuals to report incidences of GBV and to seek help and break the silence) are having a positive impact on the community. Also, the number of cases may be a result of population figures/density, for which an analysis that takes demographics into account is required – a task which is beyond the scope of this evaluation.

Nevertheless, several important trends have been identified from the site-specific data, allowing the team to offer a snapshot, outlined below, regarding both the frequency and primary types of GBV being reported and addressed, within and between each CRC location.

- Six of the eight CRC sites (75%) report spouse battery as the most frequent type of GBV reported to their CRC location. These include Mazabuka, Chipata, Mtendere, Burma, Kabwe, and Ndola. The remaining two CRCs (Livingstone and Kitwe) reported attempted incest and defilement, respectively, as the most frequent types of GBV reported.
- Seven of the eight CRC sites (87.5%) report defilement (child sexual abuse) as the second most frequent type of GBV reported to their CRC location, with Livingstone reporting property grabbing as the second most frequent type of GBV reported.
- Four of the eight (50%) CRC sites reported property grabbing as the third most frequent type of GBV reported within their CRC location, with 25% (two CRCs – Burma and Mazabuka) reporting rape as the third most frequent type of GBV reported, and 25% (two CRCs- Kitwe and Livingstone) reporting spouse battery as the third most frequent type of GB V reported.

**Figure 2**



*(Source: Data was compiled by the evaluation team using statistics from the ASAZA M&E reporting system.)*

<b>Burma CRC</b>	Data available from Burma starts the 1 <sup>st</sup> Quarter of Year 1, and runs through May 30, 2010 – covering a period of 29 months. During this time, GBV cases were reported as: 141 spouse battery; 78 defilement; 2 attempted defilement; 10 property grabbing; 13 rape; 3 incest; 2 early marriage; and 467 “other GBV cases,” totaling <b>716 GBV cases</b> . There were no “non GBV cases” reported in Burma.
<b>Chipata CRC</b>	Data available from Chipata starts the 1 <sup>st</sup> Quarter of Year 1 and runs through May 30, 2010 – covering a period of 29 months. During this time, GBV cases were reported as: 258 spouse battery; 80 defilement; 1 attempted defilement; 77 property grabbing; 17 rape; 7 early marriage; 5 incest; and 1,130 “other GBV cases,” totaling <b>1,575 GBV cases</b> . There were another 532 “non GBV cases,” totaling <b>2,107 GBV and non GBV cases, combined</b> .
<b>Kabwe CRC</b>	Data available from Kabwe begins within the 4 <sup>th</sup> Quarter of Year 1, and runs through May 30, 2010 – covering a maximum period of 21 months. During this time, GBV cases were reported as: 148 spouse battery; 75 defilement; 3 attempted defilement; 9 property grabbing; 8 rape; and 233 “other GBV cases,” totaling <b>476 GBV cases</b> . Another 58 “non GBV” cases were reported, totaling <b>534 GBV and non-GBV cases, combined</b> .
<b>Kitwe CRC</b>	Data available from Kitwe starts within the 3 <sup>rd</sup> Quarter of Year 2 and runs through May 30, 2010 – covering a maximum period of 11 months. During this time, GBV cases were reported as: 46 property grabbing; 27 spouse battery; 26 defilement; 23 attempted defilement; 1 rape; 1 early marriage; and 220 “other GBV cases,” totaling <b>344 GBV cases</b> . There we no “non GBV cases” reported in Kitwe.
<b>Livingstone CRC</b>	Data available from Livingstone starts within the 4 <sup>th</sup> Quarter of Year 1, and runs through May 30, 2010 – covering a maximum period of 21 months. During this time, GBV cases were reported as: 32 attempted incest; 29 property grabbing; 26 spouse battery; 8 defilement; 5 attempted defilement; 4 rape; 2 attempted rape; 1 early marriage; and 292 “other GBV cases,” totaling <b>399 GBV cases</b> . Another 187 “non GBV” cases were reported, totaling <b>586 GBV and non-GBV cases, combined</b> .
<b>Mazabuka CRC</b>	Data available from Mazabuka starts during the 4 <sup>th</sup> Quarter of Year 1, and runs through May 30, 2010 -- covering a maximum period of 21 months. During this time, GBV cases were reported as: 206 spouse battery; 106 defilement; 18 attempted defilement; 27 rape; 1 attempted rape; 24 property grabbing; 15 early marriage; and 905 “other GBV cases,” totaling <b>1,302 GBV cases</b> . There were no “non GBV cases” reported.
<b>Mtendere CRC</b>	Data available from Mtendere starts the 1 <sup>st</sup> Quarter of Year 1 and runs through May 30, 2010 – covering a period of 29 months. During this time, GBV cases were reported as: 130 spouse battery; 28 defilement; 19 property grabbing; 12 rape; 3 attempted rape; 1 early marriage; and 428 “other GBV cases,” totaling <b>629 GBV cases</b> . Another 216 “non GBV” cases were reported, totaling <b>845 total GBV and non-GBV cases, combined</b> .
<b>Ndola CRC</b>	Data available from Ndola begins within the 3 <sup>rd</sup> Quarter of Year 2, and runs through May 30, 2010 – covering a maximum period of 11 months. During this time, GBV cases were reported as: 51 spouse battery; 48 defilement; 11 rape; 11 property grabbing; and 193 “other GBV cases,” totaling <b>314 GBV cases</b> . Another 111 “non GBV” cases were reported, totaling <b>425 GBV and non GBV cases, combined</b> .

(Source: Data was compiled by the evaluation team using statistics from the ASAZA M&E reporting system.)

## 1. Contributing Factors

The causes of GBV are varied and complex, requiring a detailed economic, social, historical, political, and cultural analysis to accurately pinpoint and cultural analysis to accurately assess the situation in Zambia. Studies conducted by the ZDHS, the Ministry of Community Development

and Social Services (MCDSS), GIDD, CARE International, other NGOs, and government and research entities have captured some contributing factors that exacerbate the problem.

A few possible contributing factors are provided below, summarized primarily from the MCDSS's 2009-2015 *National Communication Strategy on Gender-Based Violence*, supported under the ASAZA project. The list also includes several findings from the evaluation team's key informant interviews and focus group discussions. Note that the list serves to provide context to this report; it is in no way a comprehensive or complete set of factors explaining the prevalence and extent of GBV in Zambia. In fact, an important finding is that while there are clearly many common contributing factors – such as extreme economic dependency and traditional norms which teach men that it is normal (and even proper) to beat one's wife – there are also many motivations, perceptions, behaviors, and traditional practices which vary greatly depending on the specific district, region, community, or even village being served by each CRC and CSA site. A separate study on this topic, in itself, would be required to address the matter properly and thoroughly.

Note that the list is not in any order of priority, and an in-depth analysis would be required to fully assess and analyze the types and prevalence of contributing factors to GBV from region to region.

- Extreme poverty, including high levels unemployment, which exacerbates property grabbing prevalence and economic abuse in relationships.
- Common misperception that sex with a virgin child will cure HIV/AIDS.
- Abuse of drugs and alcohol, including locally found plants/stimulants and substances.
- Extreme economic dependence of women on men, evidenced by the common problem of fighting after the harvest when profits obtained from sales are often not shared with the wife or children, even when needed for food and other basic necessities.
- Traditional/social norms which teach women to accept, tolerate, and rationalize battery, and teach men that it is normal (and even proper) to beat one's wife to "show love."
- Various sexual cleansing practices which vary from region to region.
- Initiation ceremonies which encourage young women to be extremely submissive to men.
- Male domination/patriarchy which promotes imbalanced power relations and sexual harassment.
- Socialization practices of boys and girls in schools and the community which exacerbate dependency roles, leaving individuals vulnerable to abuse and un-empowered.
- Inadequate laws on GBV to prevent GBV, and protect survivors, including the delay in passing of the GBV Bill.
- Forced early marriage practices, which interrupt the educational advancement of both children and youth and increase situations of extreme economic dependency and vulnerability.
- Legal system which maintains both a statutory and customary legal system that does not recognize sexual or physical assault within marriage as a crime.
- A criminal justice system which is not equipped in resources or status to fully uphold the rights of women and children.

- A high degree of trafficking of vulnerable children (both within Zambia and between bordering countries), allowing for widespread vulnerability among children and opportunism among abusers.
- Numerous traditional practices (which vary by regions and communities) with harmful emotional, physical, and health outcomes.
- Violent conflicts arising partially from the practice of polygamy, often caused by economic neglect and abuse to the first wife (who typically receives less economic security than the often younger (new) wife/wives).
- A lack of “political will” or priority given to combating GBV at the national level.
- Inadequate financial or technical resources in Zambia to implement or enforce change, such as limited number and capacity of police officers to enforce the law, and lack of transportation among police units.

## 2. Consequences & Impact

Clearly, the direct impact of gender-based violence on victims/survivors is enormous – including short and long-term emotional, health/physical, sexual, spiritual, economic, and social consequences. As described within the 2010 *National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia* report (produced under ASAZA):

By the time the problem is identified, the victim may have suffered long-established patterns of abuse. Perpetuation of sexual assault has negative health consequences that include infection with sexually transmitted infections (STIs) and infection with HIV, among others. Female survivors may also have unwanted pregnancies which may end up in unsafe abortions if not properly attended to. The survivors may also suffer psychological trauma of varying magnitude, and all the above call for the opportunity to seek justice.

However, there are many impacts of GBV that go beyond the victim/survivor. The *USAID 2009 Guide to Programming Gender-Based Violence Prevention and Response Activities* explains it as follows:

Children of both sexes raised in a violent family will be shaped by the experience. As a result, violence may be viewed as the preferred method for resolving disputes of simply getting one’s way. This ‘cycle of violence’ can ripple through successive generations creating physical, emotional and psychological scars along with a spiral of dysfunction in each affected family. Violence can become a norm in families, communities and society in general.

Further, the cost to national governments (such as Zambia) is manifested in higher health care expenditures; increased demands on courts, police, and schools; and losses in educational achievement, worker earnings, and productivity. 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. Finally, as described in detail earlier in the report, sexual violence increases the entire population’s vulnerability to STDs, including HIV.

## **II. FINDINGS**

### **A. USG/Zambia and Partner GBV Prevention & Survivor Support**

USG/Zambia is working closely with the Government of the Republic Zambia (GRZ) and non-governmental organizations toward prevention and response to gender-based violence in communities. The USG/Zambia 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). USAID supports GBV programming through WJEI, while the Centers for Disease Control (CDC) support GBV programming through PEPFAR.

Both GBV prevention and survivor restorative programs were motivated by the high prevalence of sexual and physical violence against women and children in the country, as well as the high prevalence of HIV, particularly among women.

Primary findings of the evaluation team are provided below, with the overall purpose being to:

- 1) Assess the ASAZA and CDC's GBV program (CSA centers) performance in accomplishing the terms and objectives of their respective agreements;
- 2) Utilize the information to assist USG/Zambia in formulating ideas regarding future GBV activities.

Specific progress made by each USAID and CDC initiative is provided below, followed by key challenges and recommendations for improvement.

### **Progress of USAID/ WJEI-ASAZA Program**

#### **1. Progress Toward Meeting Goal and Objectives**

The overall goal of the ASAZA project is to decrease gender-based violence in Zambia through greater knowledge of and changed attitudes about gender inequities, and to ensure that survivors of gender-based violence have access to comprehensive services to meet their medical, psychological, and legal needs. Toward this goal, the project has identified two key objectives:

- Objective One: To improve gender equitable attitudes among men and women; and
- Objective Two: To provide quality, comprehensive services at CRC in selected sites.

As indicated in Table 3, ASAZA has made substantial progress toward meeting its goal and objectives. This was measured in terms of implementation of activities, achievement of targets, results of the ASAZA 2010 GBV KAP survey, and qualitative data gathered from a broad range of government and non-governmental stakeholders during consultations and field visits. CARE Zambia has implemented all of the major activities under the Cooperative Agreement, with the exception of the GBV hotline, including the implementation of both national and community-based public awareness campaigns and the establishment of six new CRCs, which with the existing two CRCs made for a total of eight operational CRCs. As of March 2010, ASAZA had

already met or exceeded three out of six of its public awareness targets under Objective 1, and seven of 12 targets under Objective 2 despite the delayed establishment of new CRCs. Of those targets not met as of the beginning of the third quarter of Year 3, several involved activities still being implemented, with the expectation that the targets would be achieved by the end of the project.

The project has fallen short of its targets in two main areas: training community Caregivers (Activity 2.10) and support for a national network of safe houses (Activity 2.3). Both of these activities are important to the achievement of the project objectives and should be accelerated to the extent possible through the end of the project. It appears that due to prohibitive costs, it may not be feasible to establish a national GBV hotline by the end of the three-year project's duration. However, ASAZA has made solid progress integrating GBV information and support into an existing counseling hotline operated by Lifeline. It has also not been possible to roll-out and train service providers on the multi-sectoral guidelines as originally envisioned due to delays in the approval process at national government levels. CARE Zambia reports that it has oriented 457 of 1,400 service providers to the guidelines to date, and is focusing its efforts currently on supporting those service providers already trained in the use of the guidelines.

Achievement of significant and lasting change in attitudes and behavior is a long-term process, as is the transformation of service delivery systems and processes. Given this, the evaluators found that ASAZA has made significant inroads in both areas, and is clearly on the right track towards meeting the project's overall goal and objectives. Despite some minor weaknesses in the project's management structure and implementation, a solid foundation has been laid which can be strengthened and expanded over time. In terms of overall achievement of project objectives, it is notable that after only one year in existence, the CRCs were already exceeding the quarterly target of 1,200 survivors assisted. This is due to a steady increase in the number of clients accessing the CRCs since the project was initiated -- an upward trend that is likely to continue across sites and to increase demand on existing services.

## **a. Measuring Quality of GBV Coordinated Response Services (Objective 2)**

### **Description of Activities/Approach**

The ASAZA Coordinated Response Centers (CRCs) are local facilities where survivors of gender-based violence are assisted to access a comprehensive package of integrated legal support, psychological support, and medical care. The six new CRCs are located on the grounds of public health facilities, either hospitals or clinics, with one (Ndola) housed inside a hospital outpatient department. The two original CRCs (Chipata and Burma) are "stand-alone" facilities located a short distance from hospital facilities. The ASAZA CRCs provide counseling and referrals to clients with a wide range of GBV related issues, such as property grabbing.

The CRC approach has three primary components. First, there are direct services provided by the CRC which focus primarily on psycho-social and paralegal counseling and medical referrals. Second, the CRCs provide a coordinating role with other essential service providers such as police, health care providers, and shelters. This is accomplished through the establishment of advisory councils and service provider networks that work to ensure that services are provided to GBV survivors in an integrated and coordinated manner. Coordination is also facilitated by

having a VSU officer on site at the CRC (and establishing the CRC, where possible, on health facility grounds). Third, the CRCs serve as a focal point for other GBV-related prevention and outreach activities, such as community outreach/conversations, Men's Network, survivor groups, and special local, national and international events. These activities complement the direct services offered by the CRCs by focusing on prevention.

The core CRC staff includes a CRC coordinator, volunteer psycho-social counselors, at least one volunteer paralegal, a VSU police officer seconded to the site, a receptionist/data entry clerk, security guard, and driver. A client comes to the site and is welcomed warmly by the receptionist who completes a standard intake form. The client is then referred to a counselor who assesses the client's needs and provides psycho-social support. If the survivor requires urgent medical services, he/she is accompanied to the hospital by the CRC counselor who liaises with the hospital staff to expedite the services to the client. The CRC may also provide the fees required by the hospital for the consultation and medical care. If the client has a legal issue, s/he is referred to the paralegal for legal advice, and if necessary, to the VSU officer to open a



ASAZA – Mazabuka CRC (Coordinated Response Center) highlighting GBV services offered at the center.

criminal case. The CRCs may also refer clients to social services, legal aid, support groups, shelters, and/or safe houses, where available. The CRCs work on a case management basis, where the same counselor who sees the client initially continues to work with that client and provide follow-up. When needed, the counselor may conduct home visits. If a criminal case is opened, the paralegal officer and VSU will liaise with the prosecutor on the status of the case, and provide court preparation and support to the survivor and his/her family.

The CRC buildings are generally small, with only one or two counseling rooms, an office, and a kitchen. Some have children's play areas and a reception/waiting area. In general the stand-alone sites are larger than those based in the hospital buildings such as the Ndola and Mtendere CRCs. Most CRCs have a project vehicle to assist with activities and transportation of survivors



to the CRC or hospital after hours. The CRCs are generally open only on Monday through Friday during regular office hours. Only the CRC at Burma remains open after hours, with one or two counselors available to assist clients at night and on weekends.

### **Primary Accomplishments & Strengths**

Activities under Objective 2 focused on the establishment of six new CRCs, to add to the two CRCs which were established in 2006 with support from the EU, and the provision of integrated services and outreach in eight communities across Zambia. In support of this activity, CARE Zambia and its partners developed and successfully implemented training for staff, volunteers, service providers, and community stakeholders; established coordination and oversight mechanisms at each CRC site; strengthened local service networks and referral systems; initiated survivor support groups (at most sites); and provided support to shelters and safe houses for GBV survivors.

In close collaboration with the Population Council, ASAZA also assisted the Ministry of Health to develop minimum standards for GBV service provision by supporting the development of *National Guidelines for Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia*. Published in March 2010, this 143-page manual was a collaborative effort produced by the Government of Zambia; Gender in Development Division, Cabinet Office; Ministry of Health; Ministry of Home Affairs; Ministry of Community Development and Social Services; European Union; Population Council; United Nations Children's Fund; United Nations Population Fund; and USAID.

The evaluation confirmed that the eight CRCs planned under the project are currently operational and offer comprehensive GBV services which include medical, psychological, and legal services to victims of violence and their families. Although the quality of various activities and services varied from site to site, i.e. some having stronger Men's Networks or more shelter options or better linkages with the hospital or courts, all of the sites were offering the full complement of direct "core" services, and had several affiliated outreach and support activities in place, as well. As of the end of March 2010, ASAZA reported providing direct services to more than 4,000 clients and by the end of May 2010, a total of 6,859 clients had been served. (See Section I, Part D for details on the number of cases handled.)

The evaluation team found the coordinated community response approach to GBV implemented by ASAZA through the CRCs to be an effective multi-disciplinary approach. This system of integrated service delivery provides the survivor with a more comprehensive and victim-friendly service experience than if the services were provided piece meal. The CRC approach aims to link survivors to the full range of services recognized internationally as essential for comprehensive GBV management: medical, legal, protection/safety, and psycho-social. It also incorporates vital restorative, community outreach, and preventive components. In this way, the ASAZA approach has gone beyond the one-stop models being implemented in South Africa, for instance, most notably by fully integrating community-based awareness and outreach into the services of the CRC, as well as general paralegal, Men's Network, youth and caregiver components.

Medical services (including exam, VCT, and PEP) are not provided by the CRCs themselves, nor is there currently a strong institutional linkage (except through the VSU officer) to prosecution

services or courts. However, the CRCs are succeeding in both providing a number of essential services under one roof strengthening linkages with other key service providers. The evaluators found the co-locating of the CRCs on hospital premises to be an especially significant achievement in terms of increasing access to medical services, and believe it was worth the required investment of time and resources to have the structures set up in this practical manner. It is also significant that all CRC sites have a Victim Support Unit (VSU) officer seconded to the centers to open dockets, take statements, and follow up on the status of court cases.

The CRCs provide a link to health services and the criminal justice system, though these components are not yet fully integrated into the work of ASAZA and the CRCs. Going forward, ASAZA may be in an especially advantageous position to pro-actively collaborate with other key entities (such as the police, hospitals, and social welfare entities) to work toward ensuring that the National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence are adopted and implemented in a consistent and quality manner throughout Zambia. Highlights of primary strengths are provided below.

- **The ASAZA project and CRCs have become a focal point or “hub” for GBV initiatives in their communities.** The project has not only succeeded in improving coordination of services between the key service providers; it has helped bring together a wide variety of stakeholders and organizations around the cause of GBV, successfully leveraging resources to create a focal point for inter-sectoral cooperation and community action.
- **Stakeholders report an improvement in the quality of care and services provided to GBV survivors and other members of the community.** CRC staff is helping to reduce secondary trauma by accompanying survivors to the hospital and to court, and providing ongoing counseling, legal advice and follow-up services. In some sites, ASAZA has helped to expedite access to outpatient medical services and waive fees for medical exams; in others more survivors have access to safe shelter. Key informant interviews confirm that services provided by the CRCs are greatly appreciated by clients and other stakeholders in the community. As documented in the May 2010 KAP survey, beneficiaries of ASAZA report “high levels of satisfaction in terms of the quality and manner in which services were being provided.” Beneficiaries also report that they feel respected and empowered by the staff at the CRCs.
- **Counseling and paralegal components are filling a critical gap in services at the community level.** The CRCs provide GBV survivors with psycho-social support and advice on a wide range of issues ranging from spousal abuse and defilement, to family neglect. When specifically requested by the survivor, counselors are available to provide couples counseling and counseling of the perpetrator(s) to try to resolve problems in the family, and prevent further abuse. In addition to providing legal advice and referrals, many paralegals provide other vital legal support activities, such as tracking the status of court cases; liaising with the courts and criminal justice system; and providing court preparation and support to survivors testifying in court. In most communities, these types of services were not available to GBV survivors prior to ASAZA.

- **ASAZA is having a positive effect on survivors.** Not all of the CRCs have strong survivor support groups in place. At some sites, however, particularly in Mazabuka, Kabwe, and Chipata, survivor groups were highly motivated and organized. In Mazabuka, for example, survivors had organized healing workshops and retreats, participated in community outreach, and were in the process of applying for an economic empowerment grant from World Vision’s Empowerment, Respect and Equality program program. According to one CRC staff member, “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.”
- **More individuals appear to be seeking and receiving services relating to GBV, and more cases are being reported to police.** ASAZA’s monitoring data indicates that the numbers of clients accessing services at the CRC is steadily increasing, with upward spikes following specific community outreach activities. This suggests that more individuals are seeking assistance related to GBV than before the program was initiated. Stakeholders interviewed, most notably VSU Officers, stated that the number of individuals laying charges for GBV has increased since implementation of the ASAZA program. In Mazabuka, for example, the VSU officer reported that more women and men from the community were reporting domestic assaults as a result of the CRC’s community sensitization and local radio programs. Data were not available at the time of the evaluation to determine whether ASAZA is, in fact, having an impact on the number of cases proceeding to court. However, feedback from interviewees indicates that of those cases going to court, they are stronger and more likely to end in conviction as a result of ASAZA. In Mazabuka, for instance, two magistrates reported that they had seen an improvement in the quality of testimony provided by witnesses who had received court preparation services from the paralegal and VSU officers at the CRC.

### Limitations/Challenges

- **Most CRCs do not provide a 24-hour service.** For survivors who require access to urgent care after work hours or on weekends, not all of the CRCs are available to provide support with 24-hour services. Seven of the eight CRCs currently provide services during regular office hours – though not at night or on weekends when many sexual assault and domestic violence incidences occur. With a few exceptions, survivors reporting to the police or to hospital after hours are not being routed through ASAZA, and thus, are most likely not receiving the comprehensive and integrated level of care and support that s/he could have had via ASAZA. Stakeholders also reported that many victims are not accessing medical services in a timely fashion because of a lack of transport, especially at night.

Discussions with ASAZA staff indicate that the cost of providing 24 hour service is a central issue that will need to be taken into consideration, but given the emergent and time-sensitive nature of many gender-based violence incidences, innovative solutions will be needed to fill this gap in the future. This issue should be looked at more carefully, in consultation with the police and medical services, to determine the level of demand/numbers reporting after hours and to consider ways to strengthen after-hours management and care for GBV survivors within the resources available. It may be

possible, for example, to have an ASAZA counselor and VSU officer “on call” at the outpatient department if a rape survivor comes in, or a place where clients can stay overnight to more easily access CRC services in the morning. ASAZA can also engage with other stakeholders and service providers to develop clear management and referral protocols so that survivors reporting after hours receive the same quality of care and treatment as those reporting during office hours.

- **Insufficient quality assurance mechanisms.** Although ASAZA is effectively measuring and reporting project outputs, it does not have systematic programs in place to measure and closely monitor the quality and consistency of direct services being provided at the sites. This applies to direct services provided by the CRCs, such as psycho-social counseling and follow-up, as well as vital services being provided by other partners such as hospitals, shelters, police, and courts. Quality-control mechanisms recommended by the team are provided in the recommendations section of this report.
- **Need for additional training, monitoring and backstopping of counselors and paralegals.** The evaluation identified a number of areas where counselors and paralegals could benefit from additional training and support. For counselors, these include specific training on trauma counseling, child counseling, couples counseling, and HIV-related issues. Paralegals requested periodic refresher courses, as well as ongoing mentoring and technical backstopping by ASAZA’s legal partners. Discussions with ASAZA staff indicate that a comprehensive, four-week training was conducted by Chaimana College, during which four counselors from each CRC were trained. Also, at least three counselors were trained from each CRC regarding the management of children. For both of these trainings, however, the cost was great, and thus the training was not offered to all the counselors. Innovative solutions to these training gaps should be considered, given the critical role of counselors and paralegals to supporting victims of violence.
- **Over-reliance on volunteers to provide core services:** Under ASAZA, psycho-social counselors and paralegals provide services as volunteers, but many are working full-time at the centers and carry a heavy workload. As a result, most CRC centers are understaffed and/or experiencing high levels of turnover. Suggestions regarding staffing of core personnel are provided in the recommendations section.
- **Insufficient and underfunded shelter services.** Stakeholders at six of the eight CRCs visited reported continuing challenges in providing safe shelter for victims of GBV, including on a short-term emergency basis. In some communities there are no shelters available, particularly for adult women or boys. In other areas, existing shelters do not have the capacity to shelter additional clients or to meet the special needs of GBV survivors. Although ASAZA made some progress in identifying safe houses for GBV clients in areas where shelters are not available, visits to the safe houses indicated that the resources for clients and staff at the shelters are insufficient or minimal. These facilities are not enough to ensure that the survivors referred to these safe houses are obtaining an adequate level of care. There is a need to look closely at this component and consider ways the shelters can be strengthened.

- **Lack of transport remains a key challenge for all CRCs in the delivery of services.** The provision of a vehicle for each CRC site has helped staff conduct outreach and provide assistance to victims, but many survivors are still prevented from accessing services due to lack of transport. CRC staff and volunteers often need to travel long distances to assist victims with counseling follow up; community conversations; men's group outreach; and to provide legal assistance to families and to respond to emergency situations in rural areas. With the increasing numbers of cases being handled, transportation has become a major constraint for all the CRC sites. There is a need to develop creative and cost-effective solutions, for example: bringing more services directly to communities via mobile-support clinics; providing bicycles for counseling staff; or the provision of transport vouchers or refunds for clients.

**TABLE 3: ASAZA Quantitative Progress Summary**

Objective 1: To improve gender equitable attitudes and behaviors among men and women.	Target	Cumulative results through March 2010	Target met or exceeded
Activity 1.1 Participatory Baseline and ASAZA midterm Evaluation	700 service providers, 600 community and traditional leaders, and 771 households	Baseline completed, Midterm Evaluation completed; and KAP Survey completed. Another KAP Survey is planned for Nov. 2010, and an End of Project Evaluation is planned for January 2011.	√
Activity 1.2 Train men as advocates and agents of change	400 men (50 per CRC) 500,225 men reached through radio	165 men trained 3302 reached 15 men's networks formed	
Activity 1.3 Sensitize Community leaders/traditional leaders	Minimum of 350 Chiefs, Headpersons, Alangizi, etc 20 parliamentarians	1,479 reached (576 male and 903 female) 38 parliamentarians	√
Activity 1.4 Integrate GBV into RAPIDS youth life skills training	2,500 boys and girls	1,260 youths reached (656 male and 604 female)	
Activity 1.5 Hold community conversations around GBV	50 communities reached	40 communities reached	
Activity 1.6 Develop IEC Materials and BCC materials for community & CRC catchments areas	2,050,000 women, men and children reached in 7 districts	3,024,413 women, men and children reached in 7 districts	√
Activity 1.7 "Edutainment" materials with gender and GBV themes			
Activity 1.8 National and community radio programs with GBV and gender themes			
Activity 1.9 Air and print public service announcements			
Activity 1.10 Use international events for GBV educational activities			

(Source: ASAZA Quarterly Report - January to March 2010)

**TABLE 3: ASAZA Quantitative Progress Summary (Continued)**

Objective 2: Provision of quality, comprehensive services at CRC in selected locations.	Target	Cumulative Results, through March 2010	Target met or exceeded
Activity 2.1 Develop with MoH minimum standards for GBV service provision	1,400 service providers using the guidelines	457 service providers using guidelines	
Activity 2.2 Support two existing and launch six new CRC.	2 CRC supported 6 new CRC launched 14,400 reached	2 CRC supported and 6 new CRC launched. 4,180 survivors assisted	√
Activity 2.3 Support national network of safe houses	35 safe houses	19 safe houses supported	
Activity 2.4 Improve standardization of information gathering, tracking, and reporting of CRC	8 CRC	8 CRC trained and using standardized information tracking and reporting	√
Activity 2.5 Establish advisory council for each CRC	7 Advisory Councils established	7 Advisory Councils established and functioning	√
Activity 2.6 Establish service provider network for each CRC	8 Service Provider Networks established	7 Service Provider Network established and functioning ( <i>Lusaka is being served by one service provider network</i> )	√
Activity 2.7 Create survivor support groups	16 Survivor Support Groups, 2 per CRC	7 Survivor support groups. 1 in Lusaka, 1 in Mazabuka, 1 in Chipata, 4 in Kabwe, 1 in Kitwe, and 1 in Ndola	
Activity 2.8 Establish a GBV hotline	1	0 GBV hotline	
Activity 2.9 Improve/build capacity of 2 existing YWCA shelters	2 existing YWCA shelters improved 2 YWCA shelters established	4 shelters: 2 existing YWCA shelters improved and 2 YWCA shelters established.	√
Activity 2.10 Train Caregivers to respond to GBV	1,500 Caregivers trained	413 Caregivers trained – (196 males and 217 females)	
Activity 2.11 Train service providers (police, teachers, health workers)	700 professionals and volunteers 40 media trained	1033 professionals and volunteers (518 female and 525 male) and 30 media personnel trained	√
Activity 2.12 Train paralegals	32 paralegals trained	96 paralegals trained	√

(Source: ASAZA Quarterly Report - January to March 2010)

## **b. Measuring Improvements in Gender Equity Attitudes & Behaviors (Objective 1)**

### **Description of Activities/Approach**

Objective 1 of the ASAZA project is to “Improve gender equitable attitudes and behaviors among men and women.” Activities 1.1 through 1.10 under Objective 1 include: conducting a Participatory Baseline and ASAZA Midterm Evaluation; training men as advocates and agents of change; conducting sensitization for community leaders/traditional leaders; integration of GBV into RAPID youth life skills training; holding community conversations around GBV; the development of IEC materials and BCC materials for community and CRC catchment areas; “edutainment” materials with gender and GBV themes; national and community radio programs with GBV and gender themes; carrying out national and community radio programs with GBV and gender themes; air and print public service announcements; and use of international events for GBV educational activities. Through these activities, ASAZA has been successfully mobilizing communities to explore and challenge gender norms that perpetuate GBV and to support survivors. Note that progress relating to Activities 1.5 through 1.10 are reported as a cluster (i.e., one total number is provided), and thus, for purposes of the evaluation, there are six activity areas for which progress is assessed on a quantitative basis (see Table 3).

### **Primary Accomplishments & Strengths**

Accomplishments toward improving gender equitable attitudes and behaviors among men and women through the ASAZA efforts are many. The ASAZA M&E reporting system allowed the team to review progress through the project’s reporting documents, as well as qualitatively through key informant interviews. ASAZA successfully established a baseline of the situation in the seven target districts of Chipata, Kabwe, Kitwe, Livingstone, Lusaka, Mazabuka, and Ndola which provided a mechanism to measure project performance with regard to knowledge, attitudes, and practices (KAP) of the target group. Among other studies whose documents were available to the consultants that followed the baseline were the midterm evaluation, the annual progress report, quarterly reports, and the Knowledge, Attitudes and Practices (KAP) survey. General highlights are provided below, followed by activity-specific accomplishments.

- As of the end of March 2010, ASAZA had already met or exceeded 50% (3 out of 6) of its public awareness targets under Objective 1, despite the delayed establishment of new CRCs.
- A total of 3,024,413 women, men, and children (974,413 beyond the end-of-project target) were reached in seven districts throughout Zambia through Information, Education and Communication (IEC) and Behavior Change Communication (BCC) materials; “edutainment” materials with gender and GBV themes; national and community radio programs; air and print public service announcements; and ASAZA participation in international events for GBV education activities.
- A total of 1,479 chiefs, headpersons, and Alangizi (traditional marriage counselors) – 579 male and 903 female – and another 39 parliamentarians, were sensitized to GBV issues through the ASAZA program’s outreach activities (exceeding both end-of-project targets combined by 1,147 individuals).



- In addition, the target of reaching 50 communities with community conversations is currently 80% complete (40 communities reached) – with every indication that the target will be fully met by the end of the project period given the substantive and consistent progress reported every past quarterly report.

Only two of the activities reviewed under Objective 1 (Activity 1.4: integration of GBV into RAPIDS youth life skills training and Activity 1.2: training men’s advocates and agents of change) indicated progress to be occurring at a slower pace (as discussed below).

## **Activity Specifics**

### **Training men as advocates and change agents**

At the time of the evaluation, ASAZA had trained 41% (165) men from 7 districts – namely Livingstone, Kabwe, Chipata, Lusaka (with 2 CRCs in Lusaka), Mazabuka, and Ndola – as advocates and agents of change out of the 400 set target. Upon visiting the Kitwe CRC (the one center where training of mentors had not taken place), the consultants found that the Men’s Network was formed and was functional despite not having members trained. All sites visited reported to have had at least 15 of their network members trained. Conversely, the ASAZA Men’s Network had not been met at the time of this evaluation. The target was for the Men’s Network to have reached out to 500,225, though so far, 3,302 have been reached as of March 2010. The difference between what was targeted and what was actually achieved under this activity is large; however, note that the number reached had increased from 1,440 in September 2009 (ASAZA Annual Report) to 3,302 by the end of March 2010, representing an increase of 44%.

Despite the major strides made in reaching out to more men in the communities, the target set seems to be an ambitious target for ASAZA, taking into account the existing transportation challenges experienced within all of the CRCs. It would therefore be prudent to revisit this target in light of the remaining timeframe for the project. On the other hand, this is one of the activities that seemed to be popular in almost all (98%) sites visited. In all sites visited, the Men’s Networks reported to have been conducting monthly Community Conversation meetings popularly referred to as *insaka*. The delay in reaching more communities was reported to have been largely attributed to the late development and distribution of the community conversation tools, and subsequently the late training of facilitators, as well as transportation constraints.

### **Sensitization of community leaders**

The main aim of this activity is to engage traditional authorities and community leaders as agents of change in their communities. Interviews with four headmen in Chipata, for instance, confirmed the vital importance and effectiveness of engaging them in the program. One traditional leader reported that since he joined the Men’s Network, he has been participating in the monthly Community Conversations, and has encouraged the use of popular drama to challenge some of the cultural practices that he believed to be oppressive to women and children, particularly girls. He indicated that he has successfully banned the following traditional practices which were commonly practiced in this community through the community conversations initiated by ASAZA:

- *Kungenesa fisa* is a practice in which elderly men have sex with young girls who have just had their first menstrual period under the belief that they are opening the way for new life or a transition into adulthood.
- *Mpyani* is the practice of succession during which when a spouse dies (and this is usually among men) a young girl is given to the surviving widower to marry notwithstanding the cause of death.
- Giving young men *mvumbw* (a sex booster) and *mwanica mwanice* (for girls) which are traditional herbs that are strong stimulants which make young men and women have an aggressive and obsessive desire for sex which causes them to act out in a violent, forceful manner.

Under this activity, ASAZA had set a target of 350 head-persons, Alangizis, chiefs, and 20 members to be sensitized and trained in GBV issues. This target has already been met, and even exceeded. At the time of this evaluation, ASAZA had sensitized and trained 1,469 leaders and 39 members of parliament – exceeding the target by almost 50%.

### **Integration of GBV into “Reaching HIV/AIDS Affected People with Integrated Development and Support” (RAPIDS) youth life-skills training**

ASAZA had an activity planned to train youths in life skills and GBV, with a target of training 24,000 boys and girls by the end of the three-year project period. As of March 30, 2010, ASAZA had not yet met the set target, with 5% (1,260) of the youths trained as peer educators. Discussions with ASAZA staff indicate, however, that high priority is now being focused on this effort to quickly reach the target. Unfortunately, due to time limitations, the team did not meet the youth who were trained under ASAZA – missing an important aspect of the ASAZA effort.

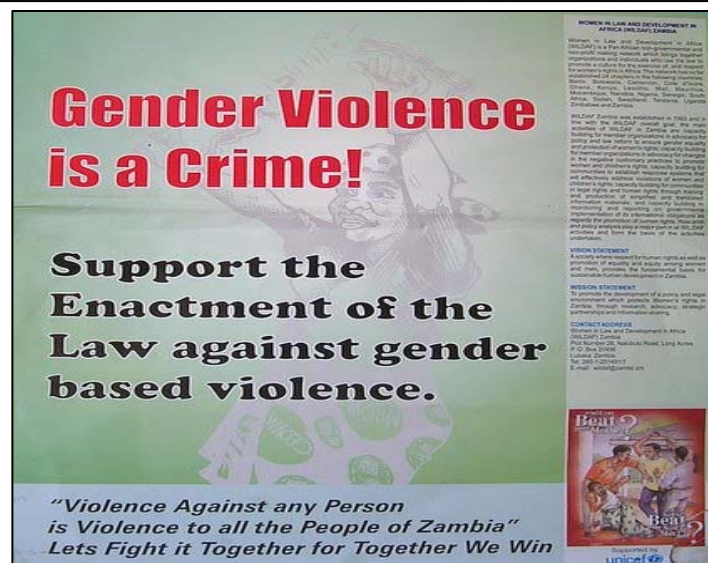
Youths trained by the RAPIDS consortium are being guided by ASAZA to reach out to other youth in their communities on GBV. Thus far, trainings have been conducted in Lusaka, Chipata and Mazabuka. Discussions with ASAZA implementers indicated that there is now a concrete plan in place that will work toward accelerating this training component rapidly.

### **Holding Community Conversations around GBV**

Under this activity, ASAZA had planned to hold at least 50 Community Conversations around GBV. At the time of the evaluation, 80% (40) Community Conversations or “*insaka*” had been held throughout all the CRCs on a monthly basis. Prevention tools developed by World Vision to support positive behavior change targeted at the individual, family, and community were reported to have successfully been utilized during Community Conversation meetings.

## GBV education/outreach through print, radio and visual media

Under this activity, ASAZA has exceeded its target of 2,050,000, having already reach 3,024,413 individuals as of March 2010 through the use of: IEC materials on GBV; BCC materials for community and CRC catchment areas; “edutainment” materials with gender and GBV themes; national and community radio programs with GBV and gender themes; carrying out national and community radio programs with GBV and gender themes; air and print public service announcements; and use of international events for GBV educational activities. As discussed below, the “edutainment” activities were reported to have been the most effective in raising awareness on GBV at grass-root level.



GBV prevention education outreach materials produced by ASAZA partners and UNICEF.

## **Qualitative Findings**

From key informant interviews and focus group discussions conducted in the eight sites, the team found respondents to be knowledgeable about the program, and they expressed sincere (and passionate) appreciation with regard to change of attitude towards GBV as a result of the range of ASAZA activities provided in their communities. In particular, there was overwhelming evidence from discussions with members of the Men's Network, for instance, that their perceptions and misconceptions about GBV (in particular spouse battery and family neglect) had been greatly enlightened through ASAZA outreach activities. This was also found within the KAP survey, which reported that the number of individuals able to identify spouse battery as a form of GBV increased from 37% at baseline to 67% at the time of the KAP survey.

When women survivors in nearly all sites (5 out of 7) were asked to define what constituted GBV from their perspective, a majority (90%) referred not only to physical abuse, but to psychological and emotional abuse. In particular, women in Chipata, Mazabuka, and Lusaka were able to refer to their spouses using abusive language in the presence of their children, and sometimes in the presence of their neighbors. Some also reported having been denied time to visit their parents or talking to neighbors as a form of abuse. One woman related how her husband constantly called her names, such as "property grabber," "good for nothing," etc. An especially common form of GBV the women interviewed referred to was economic abuse. During almost every focus group with survivors, the women stated that after the harvest, their husbands or partners keep the money from the sale of crops, and drinking, fighting, and often severe abuse follows. The KAP survey reported that levels of awareness with regard to what constitutes GBV among survivors had increased from 67% to 82%.

As indicated earlier, IEC and BCC materials developed under ASAZA have been catalytic not only in terms of raising awareness on GBV, but also in terms of their impact toward enabling perpetrators to change their perceptions toward their spouses. An overwhelming number of the Men's Network, Survivors, Paralegals and Caregivers reported that outreach activities at the community level are having an impact on raising awareness on what constitutes GBV, i.e., the definition of GBV is now more widely understood to include issues beyond sexual abuse to include issues such as spouse battery.

The Survivor Network has been valuable to victims of violence across all the target districts in Zambia. In Mazabuka, for example, survivor informants reported that belonging to the Survivor Network had enabled them to begin appreciating the value of talking to other friends about their problems and learning from each other. They further reported that as a result of their being involved in the network, they are able to help a number of their colleagues who were living in abusive marriages. Almost all (90%) of the Caregivers interviewed within five sites reported that during their house to house visits, they found the women who had learned about the ASAZA interventions had either learned about it from the phone-in programs on the local radio or from the posters on the streets. According to the KAP survey, 82% of respondents reported having been informed about the ASAZA program from the radio phone-in programs.

VSU Officers interviewed repeatedly stated that the ASAZA community sensitization and local radio programs were resulting in a “reduction in GBV cases in [their] areas.” A majority indicated that awareness efforts had also increased reporting of GBV cases to the police. In Mazabuka, for example, the VSU Officer reported that more victims of domestic violence were coming forward, including some men who claimed to have been assaulted or abused by their wives. Several medical doctors that were interviewed (such as in Chipata and Mazabuka) made similar claims, stating that the ASAZA sensitization campaign was increasing the number of individuals reporting incidents in the community and transforming men’s attitudes regarding violence in their homes.

Interviews with Women Survivors’ Networks, Men’s Networks, Caregivers, and Paralegals including traditional leaders revealed that while the ASAZA program was making a difference in the lives of the people, even more needs to be done. The four headmen interviewed, for instance, reported that while they themselves were proactive in ensuring that their villages became GBV free zones: “It was a still upward battle to win, it takes a long time to change what we term as acceptable traditional norms left by our ancestors.” In the words of a headman interviewed, “People’s knowledge may increase, but to change the attitude completely is not easy.”

## **Comparison of USAID/WJEI-Zambia Approach to other WJEI Country Programs**

Overview: In addition to Zambia, the USG is implementing the Women’s Justice and Empowerment Initiative (WJEI) in three other countries in Africa: Benin, Kenya, and South Africa. Although the specific approaches and activities under WJEI have varied somewhat between countries, all programs share the common goal of working toward reducing gender-based violence and mitigating its impact on survivors. Table 4 provides basic information pertaining to all four WJEI programs.

Implemented by USAID, in cooperation with the U.S. Department of Justice (DOJ), the WJEI has three major objectives:

- To prevent gender-based violence through improved public awareness, and transformation of attitudes, beliefs, and social norms;
- To provide support and assistance to victims of gender-based violence;
- To strengthen the investigation, prosecution, and adjudication of gender-based violence cases.

**1. Benin:** As in Zambia, WJEI in Benin is being implemented through a cooperative agreement with CARE International. Initiated in late 2007, the “Empower” program focuses on raising awareness regarding women’s rights and GBV, and providing support services to GBV survivors. The Empower program utilizes local media and community-based discussions in local languages to raise public awareness. Under the Benin WJEI, nearly 3,000 local volunteers and CBOs have been trained in 35 communities across Benin to facilitate community conversations, and to identify and refer victims for assistance. Support services for victims are provided under the program at the local level by partner NGOs, and include counseling, legal advice, and referral to medical care. The program is also working with the Ministry of Family to integrate GBV counseling and paralegal services into the existing services provided by the Ministry at Social Services Centers.

**2. Kenya:** In Kenya, WJEI has initiated a pilot project in the informal settlement of Kibera, Nairobi, to test the impact of having all WJEI components active simultaneously in one area. These include: 1) increasing awareness of the prevalence of GBV, care and support resources available to survivors, public policy and laws regarding women’s rights under the Sexual Offences Act (2006), and assisting communities to overcome the barriers to recognizing GBV as a problem; 2) strengthening the capacity of the Kenyan legal system to investigate, prosecute, and adjudicate GBV cases; and 3) enhancing services to GBV survivors through the establishment of a one-stop care center at Kenyatta National Hospital. The third component will involve renovating, furnishing, and equipping a Gender-Based Violence Recovery Center (GBVRC) at Kenya’s largest public hospital, which is also a teaching and national referral facility. The GBVRC will provide the basic package of post-rape care including medical attention, forensic examination, legal services, and psychosocial support.

**3. South Africa:** South Africa’s WJEI program is implemented in partnership with the South African government through a contract with RTI international. The program’s focus is toward the strengthening and expansion of the South African government’s existing network of Thuthuzela Care Centres (TCCs) from 17 sites to 40 sites, across all nine provinces. The TCCs are “one-stop” rape management centers located in public hospitals and linked to sexual offenses prosecutors and courts.

<b>Table 4: WJEI Programs in Benin, Kenya, South Africa &amp; Zambia</b>				
<b>Country</b>	<b>Focus Area</b>	<b>Public Awareness (USAID)</b>	<b>Victim Support (USAID)</b>	<b>Criminal Justice Strengthening (USDOJ)</b>
<b>Benin</b>	All GBV	√	√	√
<b>Kenya</b>	Sexual Offences	√	√	√
<b>South Africa</b>	Sexual Offenses	--	√	√
<b>Zambia</b>	All GBV	√	√	√

*(Source: Data compiled by the evaluation team from multiple unclassified cables.)*

## **Learning from Comparative Approaches**

The team found it of value to briefly review the different approaches and activities among the four WJEI countries, providing context to the evaluation assignment in Zambia. Insights from this review are shared below.

A strong similarity between the South Africa and Zambia victim assistance model is that they both place special emphasis on facilitating access to services and helping survivors to navigate the legal and medical processes in a victim-friendly manner – such as providing many services in one location. The Zambia WJEI appears to be taking one of the broadest approaches to GBV, going beyond sexual violence and domestic violence to include a wide variety of abuses which discriminate against women and girls and increase their vulnerability to violence, poverty, and HIV. For instance, Zambia is helping women fight property grabbing and other economic and

psychological abuses, in addition to domestic violence and rape. In contrast, the WJEI programs in Kenya and South Africa appear to be focusing primarily on sexual offences.

A particular strength of Zambia's program (which is less present in South Africa) is the manner in which it has fully integrated local community-based public outreach, awareness, and support into the core work of the ASAZA CRC's. Activities have included local radio talk show programs, IEC materials, community conversations, men's network activities, engaging with local and traditional leaders, survivor support groups, youth programs, training local stakeholders, participation in local events, mobile clinics, and training of community Caregivers to provide referrals and victim support. In addition to supporting ASAZA's prevention objectives, these activities have contributed significantly to awareness of CRC services in the communities they serve and have directly resulted in an increase in clients seeking assistance. ASAZA has also successfully leveraged other resources by integrating GBV components into existing programs by ASAZA partners in the same communities.

On the other hand, a particular strength of the South Africa approach is that the Thuthuzela Care Centres (TCCs) – which are managed by the South African National Prosecuting Authority—have stronger links to the criminal justice system through the dedicated case manager. This has reportedly resulted in improved case outcomes for TCC cases (reduced time to court, fewer withdrawals, and increased conviction rate). Unlike the ASAZA Coordinated Response Centers (CRCs) in Zambia, however, few TCCs have a police officer actually onsite and none provide independent paralegal information and advice beyond that related to opening a case of rape/sexual assault.

The TCCs have also struggled to provide psycho-social counseling services and follow-up to TCC clients. The core staff of the TCC does not include psycho-social counselors; TCCs must rely on the hospital or NGOs to provide these services and not all sites are able to do so. Many sites also do not have counselors or other staff to assist clients after hours. The WJEI program is currently providing grants to NGOs to fill this gap. In contrast, counseling is one of the core services provided by the ASAZA CRCs in Zambia.

Follow-up is also a challenge for the TCCs in South Africa, as there is only one person at each site (the Victim Assistance Officer) who is responsible for following up with all new and existing clients. The VAO is based at the site, and does not generally go out to communities or conduct home visits. With multiple counselors and community networks, the CRCs in Zambia are in a better position to follow up with clients who are not able to return to the site for follow-up care. Community Caregivers can also be trained and supported to fill this role.

Another finding is that, in general, medical/clinical services appear to be more fully integrated into the TCCs in South Africa than the ASAZA CRCs in Zambia. Like the CSA centers, most TCCs have dedicated health providers (usually a forensic doctor or nurse) who are able to provide all clinical services (medical exams, VCT, PEP, etc.) on site at the TCC, at least during regular office hours. Where there is not a dedicated doctor, on-call doctors generally come to the TCC to provide medical services to the client. The challenge with this model is that it requires adequate space and sufficient human resources. The CRC model of referring and accompanying clients to the hospital may be more cost-effective and sustainable in Zambia where resources are

more limited. Given that each country's overall level of economic development and service infrastructure is different, the approaches do and should vary between WJEI countries to accommodate/be tailored to the existing country-specific circumstances.

Another particular strength of the TCC model in South Africa is that each TCC has developed a site specific service protocol based on a standardized model or blueprint, which lays out the roles and responsibilities of each service provider, as well as the processes/procedures to be followed in each case from the client's first contact until the end of the court case. The protocol acts as a management, training, and accountability tool for all service providers (including police and health care providers), not just TCC staff. The TCCs have also instituted monthly "implementation meetings" between the site coordinator and representatives of the other key role players to provide a regular forum for communication and problem solving on an operational level. These meetings include the case manager, police station commander, NGO partners, the head nurse, and the doctor in charge of GBV-related services.

A key role of South Africa's WJEI implementer is to provide ongoing technical assistance to new and existing TCCs to improve the quality of care to survivors. Planned activities include: facilitated self-assessments and action planning to identify and address gaps in services; targeted TA and skills training as needed; and "cluster" workshops to bring service providers from different TCCs together to discuss challenges and share best practices. More emphasis on these kinds of internal quality-control and monitoring mechanisms was recommended by the team within the recommendation section of the report.

Finally, an important insight found by the team, is that the TCCs have the advantage of having a strong and vocal champion in government at the national level who has put pressure on her own department (as well as other departments and ministries) to support the implementation and roll-out of the TCC model in South Africa. On the other hand, the advantage of the CRC model in Zambia is that the program has gained exceptionally strong local ownership and support in the communities they serve – though with less nation-level ownership. Ideally, the Zambia efforts will eventually attract more national-level support through increased advocacy at higher levels of government to sustain and build upon the solid progress of the ASAZA program to date.

## **Progress of CDC CSA & ZANELIC GBV Activities**

### **1. Progress Toward Meeting Goals & Objectives**

#### **a. Measuring Quality of One-Stop (medical, legal and psychosocial support) Services for Abused Children (CSA Center)**

##### **Description of Activity/Approach**

The Child Sexual Abuse (CSA) program funded by PEPFAR through CDC is one component of a much broader CDC program of support for the "Pediatric Center of Excellence" (PCOE) at University Teaching Hospital (UTH) Department of Pediatrics in Lusaka. The overall goal of the CSA program is "to improve care, management and data collection of CSA and HIV through the establishment of a multi-disciplinary approach for care of sexually abused children in the



PCOE.”<sup>9</sup> Key objectives include: strengthen the multi-disciplinary team for the care and treatment of victims of CSA; determine the prevalence and presenting circumstances of CSA in Lusaka by developing a detailed data collection and management system; strengthen management of CSA in Lusaka with the provision of HIV counseling support and clinical services; and strengthen linkages between the PCOE-CSA program, the community in Lusaka, the greater Lusaka area, and regional and international organizations. Over time, the program added a further objective: to expand CSA services to additional hospitals and/or community-based health centers in Zambia.

CDC funded the CSA program from 2005-2010 through a Cooperative Agreement with UTH Department of Pediatrics. Implementation of project activities began in 2006. Proposed activities included:

- Development and establishment of a model “one-stop center” for CSA at UTH in Lusaka;
- Development of a multi-disciplinary training module (with ZAPSCAN);
- Training of health care workers in the recognition and care of CSA;
- Community outreach and awareness;
- Purchase of tests, reagents, ARVs, and other supplies necessary to provide comprehensive clinical care;
- Expansion of CSA program/replication of “one-stop model” in Livingstone and the Copperbelt;
- Strengthening linkages to shelters; and
- Establishment of community support groups for victims of CSA.

### **Primary Accomplishments and Strengths**

The evaluation team review concluded that the CSA program has succeeded in meeting a majority of its stated objectives. The CSA succeeded in establishing two of the three centers planned, in Lusaka and Livingstone. The feasibility of establishing a third site at the pediatric hospital in Ndola is currently being investigated. Both sites are implementing an interdisciplinary model of care, which includes medical, legal and psycho-social services. More than 4,000 defilement survivors have been assisted to date at the UTH. The program also successfully developed a multi-disciplinary training program with ZAPSCAN and implemented training for healthcare workers on proper approaches and procedures in CSA cases, as well as sensitization programs for other stakeholders, including Lusaka police. Finally, a detailed data management system was established at both sites. Details on these accomplishments and strengths are provided below.

The Child Sexual Abuse (CSA) Program established two “one-stop” centers for child sexual abuse as of June 2010. The first CSA Center was established at the University Teaching Hospital (UTH) in Lusaka in 2006. The second CSA was established within the Livingstone Hospital in 2008. Although implementing slightly different models, both centers aim to provide comprehensive clinical management and care for victims of child sexual abuse, including free medical services and psycho-social support. At UTH, the project has also worked to facilitate

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<sup>9</sup> 2007-2008 COP

the process of reporting to police by including a VSU officer on site to open docket and record the patient's statement.

- CSA Clinic at UTH: At present, the CSA clinic at UTH is located in a separate building, not far from the pediatric outpatient department, ART, clinic and pediatric wards. Services are provided by a small dedicated staff, including a specially trained clinical officer (who also serves as the center coordinator), two nurse counselors, a VSU police officer seconded from the local police station, and a data entry clerk. A doctor from the Department of Pediatrics oversees the services of the center and is responsible for signing the medical examination forms. The doctor also conducts some exams and provides medical treatment in cases involving more complex or serious injuries. The facility is small but well organized within the available space to maximize privacy/confidentiality. The clinic includes two counseling rooms, a private examination room/office, waiting area/playroom, supply room, toilet, and an office shared by the VSU officer and data entry clerk. One counseling room contains a one-way mirror and equipment for recording statements. The clinic operates only during regular office hours (M-F 8:00-4:00). New patients must report first to the outpatient department to open a file, and are then referred to the CSA for services. After hours, CSA cases are seen by regular staff at the pediatric outpatient department, and referred to the CSA clinic for follow-up on the next business day. HIV-positive patients are referred to the pediatric ART clinic for enrollment in ART.
- CSA at Livingstone: At Livingstone, CSA services are provided within the pediatric outpatient department/PCOE, and are fully integrated into the regular pediatric/HIV services of the department. The department has set aside one private examination room for CSA cases, which also serves as the CSA office. A specially-trained clinical officer coordinates the clinic's CSA services and assists the PCOE doctors in the examination of patients. Psycho-social counseling and HIV counseling/testing are provided on-site by the nurse counselors employed by the PCOE. Due to space limitations, there is no police officer on-site at the center. Most patients are referred to the PCOE/CSA clinic after reporting first to the police station. Self-referred patients arriving during the day are referred to the VSU officer at the ASAZA CRC (also on hospital grounds) to take a statement there. A social worker at the PCOE reviews cases weekly, and follows up with any patients who do not return for follow-up. The center also refers patients to the Hospital's Family Support Unit for longer-term family intervention and support. As in Lusaka, the CSA only operates during the day. After hours, the child must go to the general outpatient department, where he or she will be seen by a doctor on call and referred to the CSA clinic for follow-up on the next business day. In some cases the CSA clinical officer will also be called to assist with the exam.

Since its opening in 2006, the CSA center at UTH has provided clinical services and follow-up to more than 4,000 sexually abused children between the ages of 0 and 16. The center currently handles approximately 100 new cases of child sexual abuse per month, of which 98% involve girls. Statistics were not available for the CSA center in Livingstone, but staff reported handling on average, one to three new CSA cases per day, i.e., 30 to 90 new cases per month.

The CSA program has trained and/or sensitized a wide range of stakeholders, including health care providers and police, to identify and respond to child sexual abuse through awareness-raising activities and provision of multi-disciplinary training. The CSA program developed a concise and well-organized multi-sectoral training program for child sexual abuse, and also provided technical support in the development of national multi-disciplinary guidelines for management of rape and abuse. These documents provide a strong foundation for expanded training to health practitioners and other service providers.

In addition, it should be noted that CSA program has recognized over time the importance of institutionalizing and decentralizing CSA services to improve both access and sustainability. While continuing to provide services at the PCOE sites, the project has increasingly focused on developing capacity to respond to CSA at the community level by providing PEP, training, and supportive supervision to four community health centers.



*From left to right: Mr. Clint Liveoak, CDC Global AIDS Program; Derrick Sialondwe, CSA Coordinator, Livingston Pediatric Centre of Excellence and Dr. Robert Fubisha, Pediatrician, Livingstone Pediatric Centre of Excellence.*

Finally, an important aspect of the CSA program is the prevention of HIV through the provision of PEP to CSA survivors. In this regard, the CSA program has succeeded in improving access to HIV services by fully integrating these services into their clinical model. The results are significant, but not as strong as the program had hoped. Project staff noted, for example, that while the CSA centers were serving more than 1,000 clients per year, more than half of these clients were reporting to the center too late to receive PEP. Of those that did receive PEP, only 27% were completing the full 28-day course.

To improve these results, it is recommended that the CSAs:

- Conduct targeted outreach to communities and schools which focus on the risk of HIV infection from sexual assault, the availability of PEP to prevent HIV transmission, and the need to urgently access services within 72 hours if possible;
- Decentralize PEP services to local clinics to improve accessibility of PEP and the ability to monitor PEP adherence;
- Strengthen follow-up procedures at UTH to increase return visits to the center;
- Consider replicating some of the reportedly successful follow-up strategies utilized at Livingstone at the CSA center at UTH;
- Refer CSA clients to ASAZA for community based follow up; and
- Train ASAZA counselors and Caregivers to monitor and support PEP adherence.

The principle strengths of the CSA program include the following:

- **Quality of services and counseling by clinical providers:** The CSA program appears to be implementing a best practice model in terms of clinical services. The process for delivery of services has been streamlined so that most clinical services (including PEP) are accessible in one place by trained service providers. Though limited by space constraints, the facilities do a reasonable job of protecting patients' privacy and confidentiality. Standardized medical protocols and checklists developed by the project ensure that victims reporting to the center receive clinical management consistent - in so far as possible - with international best practice (WHO standards), as well as the draft National Guidelines. This includes intake/medical history; counseling; medical exam; treatment of injuries; HIV counseling and testing (rapid test); Hep B and STI tests (RPR), STI treatment where indicated; post-exposure prophylaxis (PEP) to eligible patients (three-drug regimen); pregnancy testing; linkages to emergency contraception (EC) services; follow-up HIV tests to test for seroconversion after one month and three months; and referral of HIV positive patients for ART.

The program is also able to provide general psycho-social support to CSA survivors and their families through on-site counselors, as well as by referral to ASAZA. Project funding for rapid tests, reagents, medications (including PEP), and staff ensure that patients receive the full complement of tests and medical care not always available at



*Ministry of Health, Provincial Health Office, Livingstone, Zambia.*

- **Strong HIV prevention and treatment component:** HIV issues are fully integrated into the outreach messages as well as the services provided at the center. Substantial efforts are made to prevent HIV transmission from CSA whenever possible, and to ensure that HIV-positive patients are enrolled in ART programs and receive necessary followup and support from trained HIV-adherence counselors. All CSA patients are counseled and encouraged to test for HIV regardless of when they report. Although late reporting remains a significant challenge, the number of CSA patients eligible for PEP has increased over time from 26% in 2006 to 44% in 2009, which means that more patients are reporting within 72 hours. Location within the PCOE enables the Livingstone CSA to more fully take advantage of PCOE's resources, including high quality HIV counseling (including adherence counseling), access to a social worker, and specialized pediatric ART.
- **Good data management and analysis:** The project has developed a detailed system for collection and monitoring of CSA patient data. This system enables the project to track patient demographics, psycho-social data, eligibility for and adherence to PEP, pregnancy and STI test results, etc. as well as prevalence and presenting circumstances. This information is used internally for research purposes as well as to assess the effectiveness of the program in providing care and achieving key results such as prevention of HIV.

## Limitations/Challenges

The following limitations/challenges in the implementation of the CSA program were found:

- **Access to services and follow up:** While locating CSA services in the PCOEs ensures high quality of care, getting to the hospital remains a significant challenge for many patients. Lack of transport was consistently cited by service providers as a major obstacle, along with lack of awareness about the urgency of obtaining care. Like the Thuthuzela Care Centers (TCCs) in South Africa, CSA patients must travel long distances to reach the hospital and then return to the hospital in order to obtain follow-on care, including counseling, follow-up tests, and the full course of PEP. While Livingstone reported somewhat better results,<sup>10</sup> UTH staff expressed concern that the majority of their patients do not return after the first visit. Although some effort is made to follow-up with patients by phone, neither CSA has the capacity to conduct regular home visits to monitor patients or to provide home-based support and follow-up; nor do they provide transport support for survivors to facilitate access to services.
- **HIV prevention:** Both CSAs report limited success in preventing HIV transmission due to late reporting and lack of PEP adherence. In 2009, less than half of the patients (44%) reporting at UTH were eligible for PEP, and only 27% completed the full course. Livingstone reported that “very few” of their patients report to the clinic within 72 hours; indeed, many report “very late, only after they become pregnant or get an STI.” According to clinic staff, there is an urgent need for targeted awareness messages in the community aimed at increasing early reporting, as well as greater access to transport.
- **Linkages to be strengthened:** The CSA centers’ strength is on the medical/clinical aspects of sexual assault management, with some counseling also available. It would be of value for the CSA to establish stronger linkages and more systematic referral mechanisms to other service providers, including ASAZA, which provides legal assistance that would complement the needs of the CSA victims. Expanding hours and/or building the capacity of the general outpatient departments would better ensure that the hospitals are able to offer comprehensive clinical care to rape victims 24 hours a day.
- **Reporting to be strengthened:** The reporting documents available to the evaluation team regarding the CSA program were limited, particularly in the area of training, capacity building, and outreach. Reporting could be strengthened with more detailed narratives and clearer targets, analysis of lessons learned and success stories, as well as supplementary reports on patient data collected. Stakeholders interviewed frequently cited training and community outreach as the major successes of the CSA program, and yet reporting on these activities was minimal.

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<sup>10</sup> Staff at Livingstone reported that they had a “good return rate” after one week and that many patients continue to return for services such as ART for up to one year. This success was attributed the quality of the counseling, as well as strong follow-up mechanisms such as weekly case reviews, follow-up phone calls, and home visits by the counselors.

## **b. Measuring Quality of ZANELIC Shelter for Abused Children**

### **Description of Activity/Model**

In addition to CDC Zambia's support to the University Teaching Hospital (UTH) for the one-stop (medical, legal, and psychosocial support) service for sexually abused children (CSA) in Lusaka and Livingstone, UTH funding also supports an organization called the Zambia Children New Life Center (ZANELIC). ZANELIC is a shelter for physically and/or sexually abused children in Lusaka's Linda compound. It was initiated in 2002 as a result of increasing cases of reported child sexual abuse in Lusaka, as well as financial support and recognition through the Reebok Human Rights Award for Young Humanitarian Activists.

The center provides emergency accommodation for children at risk of harm in their current environment, psychosocial counseling, preparation for court sessions, medical care, and more recently, a link has been established with the "one-stop" center for post exposure prophylaxis (PEP) at the University Teaching Hospital Department of Pediatrics. The shelter provides refuge to abused children for between six months and one year until a safe home can be established for them within their community. The shelter has a capacity to accommodate up to 40 children (between birth and age 18), though CDC reporting documents indicate that due to the high rate of abuse in the region, the number of children at the facility is often much higher – typically exceeding 40 and as high as 60.

The main objective of the center is to work toward the prevention and protection of children against sexual abuse, and to promote children's rights by working closely with families, the community, and the Government of Zambia. A number of trainings on awareness about sexual abuse in children have been conducted in Lindo where the center is located. The shelter works closely with the Department of Social Welfare of the Ministry of Community Development and Social Services (MCDSS) and the Zambia Police Services. CDC reporting documents indicate that a majority of cases are referred by the Zambia Police, Department of Social Welfare, NGOs, and community members.

In addition to direct services, CDC reporting documents indicate that ZANELIC has "worked to be a champion for the rights of the child, as enshrined in the UN Convention on the Rights of the Child" through advocacy and lobbying efforts with the Government of Zambia and other organizations to strengthen child protection systems and create networks aimed at fostering the rights of the child.

### **Primary Accomplishments & Strengths**

CDC Zambia reporting documents indicate that since its establishment, ZANELIC has successfully implemented awareness activities on child rights and child abuse in the community through the use of the media, focus group discussions, and drama performances, resulting in "significant change in how people perceive the issue of child sexual abuse." Given CDC Zambia has not implemented a KAP survey, the evaluation team was not able to assess progress in quantitative terms, i.e., comparing baseline knowledge attitudes and practices to results from a KAP survey. However, qualitative feedback from key informant interviews was solicited to capture information on progress, strengths, and limitations regarding the ZANELIC shelter, and is summarized below.



The team interviewed the Senior Police Chief of the Lusaka Victim Support Unit, who was conducting a training for the shelter children during the team's visit. The interview confirmed the VSU's positive perception regarding the effectiveness of the ZANELIC outreach and sensitization activities. CDC reporting documents indicate that the Zambia Police Victim Support Unit in the region has noted "an increase in the number of cases being reported" as a result of the ZANELIC educational outreach efforts. The VSU officer interviewed confirmed that children and parents in the community are "now more aware of what child abuse is, their individual rights, and where to go for help – which has increased the number of individuals speaking up to report abuse." He emphasized that the work of ZANELIC is helping children to see the police force as a "support system" to obtain help, rather than seeing the police in a fearful way. VSU Officers regularly conduct trainings for the children to teach them about their basic legal rights, to help them understand the basic signs of GBV, and to show them how to obtain help. Training is also provided regarding HIV prevention and income-generation skills-building workshops are provided to community members in sewing and brick building.

The team also interviewed key ZANELIC center staff, including the Director, House Maid, Administrative Assistant, as well as several community members working on sewing project activities provided at the shelter. Topics discussed included shelter protocols, staffing patterns, shelter activities, income generating activities, the quality and type of medical care provided, counseling methods, training, and outreach efforts, among other service-related and advocacy topics.

ZANELIC staff emphasized that the major problem experienced in community, which they believe to be exacerbating the problem of GBV and child neglect, is that they are living in sheer poverty, stating "the lack of food, hunger and lack of money for books for children to go to school are our biggest problem in this community. The children are hungry, so they can't focus on learning. The parents sell charcoal or firewood for income, and it's not enough to pay for uniforms and books for school, so the children don't go to school. Many don't finish school and drop out because of early marriage." In response, ZANELIC helps individuals in the community pay for school uniforms, books, and school fees, and provides small-scale skills building activities to community members to support and strengthen family systems.

### **Challenges/Limitations**

Financial constraints: Clearly, the ZANELIC center is a well-intentioned, vital center, but it is suffering greatly from a lack of sufficient funding. The shelter infrastructure is extremely small and highly dilapidated. The building consisted only of beds, a kitchen sink, a table, a radio, a few chairs, and a broken oven. The shelter grounds consisted only of dirt, with no playground equipment, gardens, or any children's toys, musical instruments, or activity structures. In terms of staffing, the 24-hour house-maid serves on a volunteer basis, receiving only a small monthly allowance which is not enough to cover her daily family needs. The volunteer counselors are often hungry due to lack of income. The financial needs of the shelter are clear – just about every aspect of the shelter needs improvement – a new oven, toys, books, paint for the walls, a refrigerator, sewing machines, arts and crafts resources, playground equipment, funds for income generating activities and skills building, stipends or better allowances for staff, etc.



Insufficient medical support: ZANELIC staff stressed the urgent need for additional medical services for the shelter and community clients. At the time of the team's site visit, the UTH doctor's schedule included only a once-a-month visit to provide medical care, and a nurse was scheduled for once-a week. ZANELIC staff indicated a great need for the nurse and doctor to visit more frequently, suggesting twice a week from the nurse and once a week from the doctor as being a meaningful first step toward improvement. Staff expressed that additional funding would be needed to compensate these professionals for their time, in addition to their travel expenses.

Lack of quality protocols: The primary concern of the evaluation team was the lack of protocols and quality control regarding the operation of the ZANELIC shelter. While the intentions and outcome, by and large, is obviously beneficial – and far better than having a child on the street – the safety of the children still may be at risk, even at the shelter. Evaluation team members with extensive experience working with shelters in the U.S., South Africa, and other regions of the world, agreed that ZANELIC would strongly benefit from staff training and/or exchanges with other shelters in Zambia or elsewhere to improve its protocols to ensure it is operating within a victim-centered, safety-first approach. More specifically, the evaluation team's concerns included: gates to shelter were not locked during the time of the site visit; some parents are allowed to spend the night with their children; the children walk to school unaccompanied; community members can wander in and out of the shelter compound without any identity checks, etc.

Though the VSU personnel and ZANELIC staff assure the team that the children have not experienced any incidents of violence or other abuse at the shelter, it is suggested that all precautions and preventative measures should be taken to avoid any problems in the future. As such, basic training in shelter operation from a qualified trainer skilled in victim-centered shelter operation protocols (from within Zambia or from another African country) is highly advised and would significantly improve the operational safety protocols of the center.

Improving Reporting Mechanisms: The team encourages ZANELIC to improve its M&E system so that its accomplishments can be captured more thoroughly in the future. Interviews with the children at the center showed overwhelming appreciation by the children with the shelter and compassion they are receiving from ZANELIC. The children enthusiastically conducted a drama on child abuse and sang songs to the team about children's rights and the importance of educating all children for the future of Zambia. As such, the team encourages the highly committed and visionary Director of ZANELIC to continue with fund-raising efforts which will allow the organization to scale-up its services; obtain shelter operation protocol training to improve quality; and continue with the pro-active advocacy and lobbying efforts successfully initiated to date.

## **B. Assessing Coordination between ASAZA and CDC CSAs**

The evaluation team found varying levels of coordination between the USAID-supported ASAZA Coordinated Response Centers (CRCs) and the CDC-supported Child Sexual Abuse sites (CSAs). While these sites were designed with two separate populations in mind (CRCs for adults and CSAs for children), the team discovered that the two populations are presenting at

both the CRCs and CSAs. As a result, there is a need to promote better coordination and referral between the CRCs and CSAs. This coordination will also enable to CRCs and CSAs to bring to bear their complementary technical expertise.

In Lusaka, the CSA is located in the Pediatric Unit of the University Teaching Hospital, in close proximity to the Burma CRC. Although there are referrals between two sites, the team found no formal system or process for referral and linkages. Staff at the UTH CSA reported issues with loss of children at follow-up after the first seven days of PEP course, which could be mitigated by increased follow-up counseling and support offered through the CRC. Staff also noted opportunities for more outreach and better linkages with the CRC in order to increase awareness of services in the community.

In Livingstone, the team found greater cohesion and coordination. The CRC and CSA site are jointly located on the University of Livingstone Hospital campus. The CRC site is in a free-standing building, and the CSA site is co-located in the Pediatric Ward of the hospital. CRC and CSA staff reported awareness of the services provided by the other site, as well as confirmed that they had referred clients to other site. The CRC staff reported that they refer children who present at the site to the CSA for follow-up health services. In addition, the CSA staff report that they refer adults and children who present at their sites to the CRC for follow-up counseling, care, and support with the police and judicial process. The evaluation team also found that CSA staff participates in the CRC Service Provider Network and Advisory Council.

While there appears to be good coordination between CRC and CSA sites, the evaluation team did find some gaps and identified several actions to promote better coordination and collaboration between the CRC and CSA sites, as described in this report's "Recommendations Section." Each program constitutes an important component in the overall response to sexual and gender-based violence; enhanced coordination between the two merits attention and support.

### III. RECOMMENDATIONS FOR IMPROVEMENT AND FUTURE GBV ACTIVITIES

The evaluation team was impressed with the sexual and gender-based violence activities of both ASAZA and CSA programs. Many of the elements of these programs have been successful in addressing gender-based violence. As has been discussed, the multi faceted and multi-pronged approach is a strong and effective model that is responding to a need in the community and should be continued. The team recommends that USAID/Zambia and CDC Zambia continue to support the range of GBV activities both in terms of services and response, as well as outreach and prevention.

#### A. WJEI-ASAZA Program Recommendations

Strengthen existing services: The evaluation team recommends consolidating and strengthening existing services and activities, with the possibility of broader roll out geographically in the future. This includes:

1. Building appropriate quality assurance mechanisms into the program design and implementation. This includes:
  - Carrying out client satisfaction surveys;
  - Integration of assessment and action planning to strengthen the delivery of health and criminal justice-related services to CRC clients;
  - Integration of monitoring of health and HIV-prevention services into the CRC's current case management protocols and data management systems;
  - Provision technical assistance to build the clinical capacity of affiliated hospitals and health care providers;
  - Expansion of the existing CRC protocol/flow chart to include essential health and criminal justice aspects;
  - Observation of counseling sessions and review of case management;
  - Making a professional counselor available to oversee counseling and to provide mentoring and consistent debriefing support;
  - Development of standard protocols for conducting counseling sessions;
  - Development of action and safety plans for survivors; and
  - Use of the new Multisectoral Guidelines as an assessment and training tool for all service providers.
2. Reviewing staffing design. In particular, the reliance on volunteers as core staff (counselors and paralegals) is problematic. Perhaps a hybrid approach, such as providing a stipend and other incentives to improve retention and recruitment of quality counselors would improve morale and professionalize the staff.
3. Greater focus on integrating HIV issues into services. This includes determining whether counselors and Caregivers can be trained to conduct HIV counseling and testing, as well as provide ongoing care and support for HIV, including monitoring ART and PEP adherence among children and adults. This is an opportunity to provide HIV counseling within the counseling sessions for survivors, and in the context of couples counseling, when partners are invited into the CRC. Greater emphasis also includes increasing the

integration of HIV prevention messages and the links between GBV and HIV into community outreach components, such as the Men's Network.

4. Expanding areas for additional and specialized training, including trauma counseling, couples counseling, and a greater focus on child-witness counseling. All staff should receive orientation on the national guidelines, including those sections pertaining to other role-players, such as medical personnel, prosecutors, and police.
5. Increasing support to the networks and other support components of the program, which are critical but seem to receive relatively little support:
  - Additional technical and financial support to men's network, Survivor Network, shelters, and Caregivers, and
  - Additional training, materials, opportunities for sharing and learning. Increase access to resources and TA from the region with special emphasis on men's groups, e.g. Sonke Gender Justice, MenEngage Network.
6. Maintaining focus on outreach given recognition of the need and the effectiveness of the sensitization efforts.

Build sustainability: Critical to a significant and long term response to GBV in Zambia is the development of a sustainability plan. The USAID/ASAZA and CDC programs are encouraged to engage in a constructive dialogue with the NGO community, as well as the relevant Ministries in the Government, to develop a clear plan for transitioning some of these activities. In addition, work with implementing partners is needed to identify their technical assistance needs and plans for future integration of GBV activities.

Review management structure: Management of the ASAZA program might benefit from a review to better streamline reporting and communication processes with the goal of improving efficiency. There are several organizations and partners involved in the implementation of the ASAZA program. On the one hand, this comes as a result of the project's design to tap into existing activities, such as the work with Caregivers and youth through the RAPIDS program, and into the relationships that had already been built with communities. In this respect, the structure has allowed for increased capacity and commitment among participating partners. However, the structure has multiple management and implementation layers, which may result in challenges with communication processes to and from CRCs and HQ in Lusaka; limitations in oversight in some of the sites; and challenges with financial flows and capacity of partners to handle these management processes.

Implement ASAZA KAP Survey Recommendations: The team concurs with the seven (7) clear and actionable recommendations offered within the ASAZA 2010 GBV KAP survey, and encourages their full implementation. Highlights include strengthening referrals to economic empowerment programs for victims of violence; expanding the effective role of the men's networks especially where there is strong and committed local leadership (Chiefs and Village Headmen); increasing sensitization efforts to reach middle and high income areas; and working

to ensure services are available on a 24-hour basis within all CRC sites. (Please see a full listing in Attachment 6.)

Analyze and disseminate data: The team recommends increased compilation, analysis and dissemination of data collected by CRCs and CSAs. The data collected by the CRCs and the CSA sites, some of which are presented in this report, provide a rich and important picture of the magnitude and range of GBV in Zambia, including characteristics of survivors; information on the perpetrator; and the extent to which cases are going through the legal system. The monitoring systems that exist at each site provide an opportunity to collect more relevant data, and continued analysis can shed light on trends and behavior changes. Data analysis should also include how programs are assisting in HIV prevention and response. CSA sites are already collecting data on PEP provided to eligible clients and on HIV counseling and testing provided for all patients regardless of when they present. Future analysis under ASAZA could include tracking VCT results, PEP or PEP adherence among its patients, at least rape and sexual assault survivors. Since ASAZA does not provide clinical services, this data collection and analysis would require increased collaboration and monitoring of HIV-services delivery and follow-up.

## **B. CDC CSA & ZANELIC Activity Recommendations**

Decentralize CSA clinical services to improve access and sustainability. Timely access to essential health services remains a significant challenge where post-rape care is provided only at major hospitals. Although the one-stop model is comprehensive and victim-friendly, it is expensive and may not be an effective or sustainable model for Zambia as a whole. In the longer term, the more sustainable and accessible strategy is to work towards strengthening the quality and efficiency of clinical services for victims of sexual abuse in existing health centers throughout Zambia, and strengthening linkages with existing institutions and partners, rather than trying to replicate the one-stop center model outside Zambia's major hospitals. While continuing to offer CSA care at PCOEs, the CSA program should focus its efforts going forward on building clinical capacity at community-based health centers and district hospitals to provide CSA and rape-care management, including examination of rape victims and the provision of emergency contraception and PEP. In this regard, the Refentse Model developed and piloted in rural South Africa by Population Council with USG support provides an effective evidenced-based model for decentralized service delivery.

Engage Ministry of Health to provide funding for sustainable service delivery at hospitals and clinics. Although the CSAs are located at public hospitals and are to varying degrees integrated with existing pediatric services, a good deal of major operational costs of running the CSA centers, including clinical staff salaries, as well as some medical supplies, are paid with donor (CDC) funds. Donor funds are also being used to provide PEP, EC, and various tests to four community health clinics. In order to be sustainable, the Ministry of Health should gradually assume greater responsibility for the running costs associated with providing health services to victims of sexual assault including at the PCOEs. It is recommended that the Pediatric Centers of Excellence engage with hospital management, as well as the appropriate level of the Ministry of Health to develop a sustainability plan for Child Sexual Assault services at the PCOE and elsewhere. Ideally, this would include, at a minimum, a commitment by the Ministry to supply hospitals and clinics throughout Zambia with basic medications, tests, and other supplies

necessary for effective rape care management. This recommendation is also applicable to ASAZA, since most of the CRCs are situated in health facilities.

Strengthen linkages with ASAZA and particularly with the CRCs in the areas where CSA centers operate to take maximum advantage of comparative strengths. The CSA project can help ASAZA liaise with the UTH and Livingstone outpatient departments (both children and adult/general) to review outpatient processes and referral systems for rape and CSA survivors, and to ensure that GBV victims presenting after hours – with or without ASAZA counselors – receive expedited treatment and free, high quality and comprehensive clinical services consistent with national guidelines.

Lobby Ministry of Health to endorse and implement National Guidelines. The Pediatric Centers for Excellence, and the CSA program in particular, are encouraged to engage actively with the Ministry of Health to ensure that the draft National Guidelines for Medical Management are endorsed at Ministry level, and disseminated as policy to all public health facilities. Ideally, the CSA project is encouraged to work toward institutionalizing a CSA technical person within the Ministry to oversee the dissemination and implementation of the guidelines, manage a TA and training initiative in support of the implementation of the guidelines, and collect and report on CSA statistics, as well as HIV related outcomes. This recommendation is also applicable to ASAZA, as ASAZA supported the development of the National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia.

Build UTH's capacity to act as a resource for training, technical assistance, policy development, and M&E relating to child sexual abuse and GBV. UTH's strength lies in its capacity as a teaching institution and experienced CSA clinical service provider. It is hoped that expanded support will be obtain by UTH to provide training and technical assistance around the medical and multi-sectoral aspects of GBV. In particular, it would be ideal for UTH/CSA to engage in an expanded manner toward working with health centers to implement the national guidelines for medical management of GBV, if possible in collaboration with ASAZA. UTH is encouraged to fully integrate clinical management of GBV and CSA survivors into the regular training curriculum at UTH, as well as the curriculums of other teaching hospitals and medical schools as applicable.

### **Strengthening Coordination/Harmonization of GBV Programs**

Several actions were identified to strengthen the coordination and collaboration between ASAZA CRC and the CSA sites. These include expanding current activities and formalizing existing systems, as well as supporting each program to take on additional activities that build on their comparative technical expertise. These activities could be formalized in a memorandum of understanding (MOU) between the ASAZA and CSA, or could be written into the workplans for each agreement.

- Improved referral systems and sharing of materials/resources: In sites where CRC and CSA sites are both present, the evaluation team recommends that the staff work to promote more referrals between sites. This could be accomplished through a formal agreement or development of protocols for referral. The participation by the CSAs on the CRC Advisory Council and Service Provider Network, which exists in Livingstone and

could be instituted in Lusaka, should be used to promote referrals between the CRC and CSA sites. Harmonization and sharing of materials, such as training curriculum and useful victim-support methods and protocols, among other technical and material resources, should also be one of the areas the two programs can be jointly supportive.

- CSA lead in child sexual abuse counseling: The CRC sites in several cities expressed the need for additional support in handling child sexual abuse cases. They reported a need for specific training in counseling children, as well as more information to help them to better understand the unique needs of child survivors. Given that the CSA sites have provided specialized training counselors, the evaluation team encourages the CSA units to provide training and support in addressing the needs of children receiving services through the CRCs. This is especially important in cities where there is only a CRC site.
- Increased outreach of CSAs services by CRC: The CSA staff reported that there was little support dedicated to awareness activities in the communities for the child sexual abuse services. The CRC sites have strong awareness-raising and community outreach activities, and the evaluation team suggests that the CRC both incorporate the CSA activities into their outreach work, as well as provide technical support to CSAs in how to better promote awareness at the community level.

### **C. Recommendations for Future GBV Activities**

Along with consolidation and strengthening of existing GBV services and activities, the evaluation team recommends increased resources and focus on areas that have not received sufficient attention to date, as follows:

Increased Economic Empowerment: At all the sites, respondents noted the importance of including economic strengthening activities, as much for prevention as for mitigation. The lack of economic opportunities was reported as limiting individuals' ability to avoid an abusive relationship, and serving as a barrier to a victim's choice to leave (or not leave) a relationship and reporting the case, given the perpetrator is often the primary breadwinner. This could entail building on existing activities, such as YWCA Women's Economic Empowerment Program and World Vision's Empowerment, Respect and Equality (ERE) program, engaging the private sector, and adapting effective programs such as IMAGE in South Africa, which combines HIV and GBV prevention with micro-finance. USAID and CDC should include economic empowerment activities that benefit both victims and perpetrator.

Enhanced Advocacy: There is a need for greater sensitization and targeting of policy makers, including senior level individuals in line ministries, in collaboration with civil society organizations, to increase commitment and resources for GBV. Specific actions include better funding of shelters and VSU officers, and the passage of legal reforms including of GBV bill. The dissemination of data, as suggested above, will help in increase awareness regarding of the extent of the problem and the need for a response. Other areas for legal reform include amendments to the Penal Code (especially with regard to corroboration requirements), Criminal Procedure Code (with respect to evidence, vulnerable witnesses and child-friendly procedures), the Matrimonial Code (to increase the woman's rights in the marriage), and various aspects of

customary law. Stakeholders also identified an urgent need to expand the legal definition of who can sign a medical examination form and testify in court to allow clinical officers to play this role

Additional USG Support: The USAID and CDC teams should explore opportunities for enhanced/additional support for gender-based violence activities. The PEPFAR Partnership Framework could be utilized to build country ownership and support for policy development and implementation of gender-based violence response. USAID and CDC are encouraged also to incorporate gender-based violence prevention and response into existing PEPFAR programs, especially in the HIV prevention programming that is already occurring in Zambia.

Enhance Strategic and Integrated HIV and GBV programming: Several cross-sectional studies have shown that gender-based violence and gender inequity in relationships are associated with increased prevalence of HIV in women.<sup>11</sup> The evaluation team recommends that any ongoing and future gender-based violence programming in Zambia incorporate and enhance the prevention and response to HIV. In addition to existing HIV services at CSA sites, the evaluation team noted the interest on the part of respondents at CRC and CSA sites to adopt a more focused and strategic emphasis on GBV and HIV activities. Key activities that might be considered include:

- Enhance capacity of GBV service and community providers to prevent HIV and provide referrals/follow-up to HIV care and support services. CRC counselors, VSU officers, and other services providers as well as Men's Networks, Survivor Networks, Community Caregivers, and other outreach groups should receive training on HIV prevention messages that can be communicated to clients and to community members. Information on accessing services in a timely manner, in particular PEP, and on the links between GBV and HIV should be incorporated into the training manuals for all service and community providers. CRC service providers should also incorporate HIV counseling and testing, and HIV care and support follow-up into GBV services. Enhance capacity of GBV service and community providers to prevent HIV and provide referrals/follow-up to HIV care and support services. For instance, training could be provided to the VSU officers to enable them to provide emergency contraception to rape survivors, and potentially provide the initial PEP dose, which would increase PEP access in communities which do not currently have access to hospital-based services. At a minimum, GBV service and community providers should have good knowledge of HIV and of available referral services. At a minimum, GBV service and community providers should have good knowledge of HIV and of available referral services.

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<sup>11</sup> S Maman, J Campbell, MD Sweat and AC Gielen, The intersections of HIV and violence: directions for future research and interventions, *Soc Sci Med* 50 (2000), pp. 459–478.; C Garcia-Moreno and C Watts, Violence against women: its importance for HIV/AIDS, *AIDS* 14 (suppl 3) (2000), pp. S253–S265. ; R Jewkes, K Dunkle, M Nduna, and N Shai, Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study, *The Lancet*, Volume 376, Issue 9734, 3 July 2010-9 July 2010, Pages 41-48



- Enhance capacity of health services (including HIV counseling and testing, ART, PMTCT, ANC sites) to identify and respond to GBV. Health care service providers (including HIV service providers) should be trained to identify and respond to GBV, as well as to have good knowledge of available GBV services. This enhanced capacity entails ensuring that health service sites have instituted appropriate organizational steps such as training on screening protocols, guarantees for survivors' safety and confidentiality, and referral systems.
- Collect appropriate data from GBV and HIV service delivery sites. This includes collection of GBV prevalence data and referral/uptake of GBV services (including PEP and PEP adherence) at HIV and other health service delivery sites, as well as data on HIV status, referral/uptake of HIV services (including PEP adherence) at GBV service delivery sites.
- Strengthen monitoring and evaluation of USG-supported GBV programs to assess whether activities work well towards HIV prevention and improved access for HIV services for abused women and children.
- The USAID and CDC teams are also encouraged to explore other opportunities to incorporate gender-based violence prevention and response into existing PEPFAR programs, including activities with service providers, as described above, as well as HIV prevention programming. For example, Peace Corps volunteers who are already doing HIV outreach and training in communities could also deliver GBV messages and referrals. USAID and CDC are encouraged to utilize the PEPFAR Partnership Framework to build country ownership and support for policy development and implementation of a gender-based violence response.

#### **IV. CONCLUSIONS**

The extent of the problem and need for gender-based violence to be addressed in Zambia is enormous, with the number of cases of GBV being reported increasing throughout the country.

GBV is clearly not an isolated problem or a side component of Zambian life, but rather, it is a widespread, tragic, and daily issue that touches and impacts most every one's life in some way.

While the team offers a list of rigorous recommendations toward improving the quality of the USAID-ASAZA and CDC-supported GBV activities, the broader finding is that the programs are clearly on the right track – having successfully built a foundation of respectful, victim-centered, community response systems that are meeting the needs of victims and their families. The programs have diplomatically and creatively engaged communities, effectively transforming attitudes and norms to the benefit of the entire society for generations to come.

It is hoped that the findings and recommendations provided by the evaluation team serve to strengthen and guide future GBV activities in Zambia in a positive manner. The team was honored to share insights and work with USG/Zambia on this meaningful endeavor.

## **Attachment 1: Terms of Reference**

### **USG/Zambia Evaluation of the USAID and CDC Gender-Based Violence Activities**

#### **1. Background**

USG/Zambia is committed to supporting programs aimed at promoting gender equality and gender integration in national policies, frameworks and laws. USG/Zambia is working closely with the Government of the Republic Zambia (GRZ) and non-governmental organizations towards the prevention and response to gender-based violence (GBV) in communities. The USG/Zambia support towards addressing GBV in Zambia has been through the Women's Justice and Empowerment Initiative (WJEI) and PEPFAR. USAID supports GBV programming through WJEI while CDC supports GBV programming through PEPFAR.

USAID/Zambia supports a three year (February 2008 – January 2011) GBV program 'A Safer Zambia' (ASAZA). The ASAZA program is being implemented through a cooperative agreement with CARE International under the WJEI. The program is addressing GBV prevention, and care and support for survivors through coordinated response centers (CRCs) and shelters. ASAZA is being implemented in seven selected districts: Chipata; Kabwe; Kitwe; Livingstone; Lusaka; Mazabuka; and Ndola. The overall goal of the ASAZA program is to decrease GBV through greater knowledge of and changed attitudes toward gender inequities and improving GBV survivors' access to comprehensive services to meet their medical, psychological and legal needs.

To achieve this goal, ASAZA set two objectives:

- Improvement in gender equitable attitudes and behaviors among men and women.
- To provide quality, GBV coordinated response services in eight CRCs.

CARE/Zambia is working in partnership, via a subgrant, with World Vision/Zambia (WVZ), a major partner. Other partners include Young Women Christian Association (YWCA), Women in Law in Southern Africa (WLSA), Africare, Catholic Relief Services (CRS) and International Justice Mission (IJM). ASAZA also collaborates with Government agencies such as:

- Ministry of Home Affairs – Police Service (VSU),
- Ministry of Health – District Health Management Teams (DHMT), hospitals and clinics,
- Ministry of Gender and Women Development - Gender in Development Division (GIDD),
- Ministry of Community Development and Social Services (MCDSS) – Department of Social Welfare and
- Ministry of Justice - Judiciary – Child Justice Forum (CJF)

CDC Zambia supports a GBV program through direct funding to the University Teaching Hospital (UTH), Department of Pediatrics, and Pediatric Centre of Excellence since 2006. This support provides a one-stop (medical, legal and psychosocial support) service for sexually abused children (CSA) in Lusaka and Livingstone and Ndola. In addition to supporting the CSA center, the UTH funding also supports an organization called ZANELIC which provides safe shelter to abused children (includes sexual and physical abuse). Through this shelter, children

get support for education, food and income generation, until a safe home can be established for them within their community.

The GBV prevention and survivor restorative programs were motivated by the high prevalence of sexual and physical violence against women and children in the country, as well as the high prevalence of HIV particularly among women.

## **2. Purpose of the Evaluation**

The overall purpose of this evaluation is to:

- Assess ASAZA and CDC's GBV program (CSA centers) performance in accomplishing the terms and objectives of their respective agreements and to utilize the information to assist USG/Zambia in formulating ideas regarding future GBV activities.

Specific evaluation objectives:

- Analyze the ASAZA, and CDC's GBV project objectives, the effectiveness of the executing parties, and the quality of services;
- Assess strengths and limitations and lessons learned from the ASAZA project components, and the CDC project with respect to meeting their stated goals/objectives;
- Assess the similarities and differences between the ASAZA and CDC GBV programs and opportunities for modifications and/or harmonization;
- Identify any gaps in GBV programs (for example gaps related to advocacy, and other justice sector activities);
- Utilize the gap analysis from above to recommend areas for USAID programming (in a draft logical framework format) that takes into account CDC projects and addresses prevention as well as strengthening the coordination of restorative services for survivors, women's rights, and program sustainability.
- Compare, when relevant, WJEI accomplishments in Zambia with the other WJEI country programs (Benin, Kenya, and South Africa).

## **3. Methodology**

The evaluation will utilize both qualitative and quantitative methods which will include;

- A desk review of documents including progress reports, training materials, services statistics and other program records where available;
- Key informant interviews with line ministries officials, CRC staff, District Officials, UN Agencies, community leaders, religious leaders, police officers, NGOs, health care providers, women's groups and court officials from project sites; observations of the project sites; and focus group discussions with survivor groups.
- Field visits to project sites in all the seven targeted districts.

#### 4. Evaluation team composition

The evaluation team should comprise of one (1) lead consultant and at least three (3) additional consultants.

The team will include three consultants from DevTech (Team Leader, Legal Consultant, and National Consultant). In addition, one (1) USAID and one (1) CDC staff member will be members of the team.

#### 5. Level of Effort-DevTech

Suggested Level of Effort (LOE):

	Total Prep	Int'l. Travel	Internal Travel	Lusaka	Other Zambia	Analysis/ Writing (in country)	Final Report Writing*	Total
<b>Team Leader</b>	4	6	2	4	8	2	4	30
<b>Legal Consultant</b>	4	0.5	2	4	8	2	2	22.5
<b>National Consultant</b>	2	0	2	4	8	1	2	19

\*The time allocated to final report writing includes all of the time to prepare the evaluation report and the draft recommendations for future USAID program in a results framework format.

#### 6. Evaluation Findings Dissemination (hosted by USAID/Zambia)

Presentation by evaluation team to Implementing Partners (IP)  
Presentation by evaluation team of key findings to PGA members

#### 7. Draft Evaluation Report Outline

The Team Leader for the activity will consult with USAID/Zambia to finalize the outline and page length for the draft and final evaluation report. Several of the key elements are as follows:

- Executive Summary
- List of Abbreviations/Acronyms
- Acknowledgments
- Brief description of methods
- Background and Development
  - Context Prevalence
  - Causes
  - Consequences

- Response of the Government of Zambia
- The WJEI-ASAZA Project
- The CDC GBV (CSA/ZANELIC) Project
- Other players: NGOs/donors supporting GBV
- Recommendations on questions in the SOW
  - Findings
  - Conclusions
  - Recommendations
- Recommendations for future USAID programming that highlights lessons learned from current programming, with consideration to linkages to the existing CDC-funded program.

### **Potential Specific Evaluation Questions**

1. Is the USG/Zambia GBV strategy on the right course or should adjustment be made within the context of country context?
2. Is ASAZA and CDC GBV projects achieving the objectives, delivering outputs and producing outcomes identified in the agreement? If not, identify problem areas in program design and implementation strategies and recommend corrective action for follow-on project. Did the intervention yield results other than those planned?
3. Are established targets for ASAZA and CDC GBV projects reasonable in GBV programming?
4. Are there any significant or critical gaps in the ASAZA and CDC GBV projects that require adjustment? (What are the existing gaps in this sector –areas requiring intervention that are not already being addressed by other USG agencies or international/bilateral development agencies?)
5. How does the victim or survivor assistance mechanism (CRCs, one stop centers, ASAZA shelters, ZANELIC shelter, referral to non USG supported shelters, referral for medical treatment, and access to justice) function? Has the survivor care and support part of the project delivered appropriate and relevant benefits? How could the USG GBV program better support it?
6. Is the program working effectively in the area of economic opportunities for survivors of GBV?
7. What are the lessons learnt from pursuing GBV in Zambia that may be applicable to similar programs elsewhere?
8. Do other USG programs such as Education, Economic Growth, PHN, HIV/AIDS, DG, HA, Trafficking in Persons address issues of GBV, if not should they?

9. Is the ASAZA program cost efficient? Are some of the components more cost efficient than others? Should components that are not cost efficient be cut?
10. To what extent is government (all relevant government ministries or departments) engaged in the ASAZA, and CDC GBV project planning, implementation, and results?
11. How does ASAZA, and CDC work to ensure sustainability of GBV program both for the prevention and CRCs? What could the program do in future to increase the likelihood that outcomes are sustainable?
12. How do CARE, UTH and ZANELIC measure the end state, and how do USAID and CDC know they are getting there?
13. Have the ASAZA and CDC GBV projects sufficiently taken gender issues into account and efficiently addressed them? How has ASAZA involved males in the project?
14. How do the CDC GBV program and the ASAZA program work with already existing public private partnerships?
15. How do the CDC GBV program and the ASAZA program address the demand side of GBV services?

## **Attachment 2: Interview Guide - Agency-Specific**

### **INTERVIEW GUIDE – CRC STAFF**

*Good afternoon. We are a team of evaluators who are here to obtain some lessons learned about the ASAZA project. We would like to hear from you what you think has worked (primary accomplishments) and what needs to be improved. Please know that our goal is to provide USAID with some suggestions regarding how they can improve the project and promote the overall gender-based violence activities in Zambia in the long-term. The personal responses you provide will be **confidential**. We will write a report that will simply provide general recommendations without mentioning anyone's individual responses. We thank you sincerely for your generous time and valuable thoughts.*

#### **General Questions**

When was the site established and/or became operational?

What are the site's days/hours of operation? If the site is closed when a victim needs emergency assistance, what do clients do to receive assistance? Do you have a 24 hour phone line?

Who manages the site, i.e., CARE or World Vision?

How is the CRC funded, i.e., USAID-only, EU monies, other donors, etc.? What resources, if any, are provided by the Zambian government, i.e., staff, in-kind resources, etc.

Could you share with us information about the type/level of health facility the CRC is located?

Do you think the physical location has worked well or been beneficial in terms of service delivery and/or regarding issues of sustainability? Has working within a ministry health facility helped or hindered the provision of services? (Probe regarding sustainability issue.)

On average, how many clients do you handle per month?

If you have statistics available, could we please have a copy which shows the break-down in terms of gender; age; type of GBV incident, i.e., domestic violence, sexual violence, defilement, etc.? As CRC staff, what kind of trends have you seen in the last few years?

Do you have data which shows how each client was referred to the clinic, i.e., self-referral, brought in by the police or a friend, etc? What are the two most common forms of referral that you have seen during your time working with the CRC?

If you utilize a client entry sheet, could we kindly have a copy? What kinds of questions/data is collected when a client arrives at the clinic? Is the client asked how he/she heard about the CRC?

## **CRC Staffing Pattern**

Could you please describe the CRC site's staffing structure? If you have a staffing chart, may we please have a copy? Please let us know who works FT or PT, and whether they are serving as a paid or volunteer staff member.

Are there any vacancies or shortages regarding your staffing pattern? Are there issues pertaining to turnover? If so, what do you believe are the causes and solutions?

What are the responsibilities of each staff?

Could you please describe what kind of training is provided for each staff member? Does each staff member have enough training to fulfill their job duties? If not, what more needs to be provided to better support their roles? If you have copies of training manuals, thanks for sharing with our team.

Do the volunteer have sufficient training and guidance from CRC staff? If not, please describe what else might be needed to better support their role.

In addition to the dedicated staff, who else provides services at the CRC or off-site at clinics, etc.

Has the use of many volunteers been beneficial/effective? If so, please provide examples of successes. What are some of the problems or issues with volunteers that you have experienced, if any? Do you have some solutions?

## **Service Provision Protocols**

What kinds of services are provided for: 1) survivors of sexual violence, 2) survivors of domestic violence, 3) for families/caregivers/perpetrators, 4) other victims?

How are services provided? Are clients "walked through" each step? Are clients referred to any other locations/persons for additional assistance? If so, please describe.

Please tell us a bit about the following if we haven't already covered these topics:

- Medical/forensic examination for rape/sex assault cases
- HIV counseling and testing
- PEP and emergency contraception for rape/sex assault cases
- Long-term counseling (beyond crisis counseling)
- Court preparation or support (i.e. accompany victims to court)
- Role of Victim Service Unit (VSU) Officer (open docket or also take full statement – who responsible for investigating case?)
- Is there a place for the client to bathe at the CRC after examination?
- Tell us about transportation at the CRC – are there constraints/issues?
- What types of legal issues/questions are most often handled by paralegals?



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?

How are the staff and volunteers supervised and/or monitored?

How is the site managed on a day to day basis? Are there regular implementation meetings? If so, who attends?

What are the main referral organizations you utilize? Do you track whether your clients access/utilize referral services? If so, what agency supports have you found most useful?

How satisfied are you with the quality and consistency of services provided to survivors at your site? What do you see as its primary strengths and primary challenges? How could services be strengthened?

What kind of outreach/prevention activities are you involved with at this site? What have been the most and least effective/successful in your view? What would you like to expand? Do you have needed resources to do so?

How effective has the site's Advisory Council been in supporting the CRC, resolving issues, and addressing challenges? How could this structure be strengthened?

What kind of information are you able to give clients about the status of their court cases? Does the VSU Officer on site have access to this information?

What are the key lessons you have learned from your involvement in this project? Do you have any recommendations moving forward?

Are there any key gaps in services or activities that you would like to add or expand if you could?

Are there areas of training, technical assistance, reporting/data collection issues that you would benefit from obtaining in the future?

Do you have any suggestions on how USAID can expand or improve their support for GBV activities in Zambia as a whole, on any level?

What are the primary policy-level issues that impact GBV in Zambia. How do you see ASAZA playing a role in advocacy efforts?

Do you see a link between economic empowerment and GBV in Zambia. Would the incorporation of income generating activities into the ASAZA program be beneficial? What kind of economic activities or business skills training opportunities are available for victims in your community? Do you already refer clients to these activities/support services? Are they effective?

## **Attachment 3: Interview Guide – Survivor Support Groups**

### **INTERVIEW GUIDE – SURVIVOR SUPPORT GROUPS**

*Good afternoon. We are a team of evaluators who are here to obtain some lessons learned about the ASAZA project. We would like to hear from you what you think has worked and what needs to be improved, to better provide services to your community through the CRC. Please know that our goal is to provide USAID with some suggestions regarding how they can improve the project, and that your names will not ever be mentioned, and the information you provide will be **confidential**. We will write a report that will simply provide general recommendations without mentioning anyone's individual responses. We sincerely appreciate your generous time, and look forward to hearing your thoughts so that we can help ASAZ serve you even better. Please know that we will not ask about your personal experiences, and know that you do not need to share any personal stories about your experiences unless it is something you want to share with the group. Only share what you are comfortable with, and our questions will focus on the quality of services and support provided by the CRCs-- and finding out from you how you think they could be improved. We thank you sincerely for your generous time and your valuable thoughts.*

#### **Suggested Questions for Survivors of Violence**

Where the services provided by the CRC affordable for you? How much did it cost, if anything?

Where the paralegal, counseling, medical, VSU (police) and other services provided by the CRC of good quality?

Where the services accessible to you, i.e., how did you get to the CRC (walk, bike, bus, taxi, car?). How far is the CRC from your home (hours, miles?).

Did you feel the services provided were respectful, friendly and useful? If yes, please provide some examples. If no, let us know if you have ideas how services could be improved.

If you could improve the services of the CRC, what would you like to see changed or added?

From your perspective, how do you think the community perceives the CRC? Do they see it as a supportive place to obtain help or is anyone fearful about it or see it in a negative light?

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?

Would anyone like to share concerns regarding household income decision making? 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?

Do you find the Women's Survivor Support Network to be a helpful group?

How often do you attend Women's Survivor Support group activities?

How long have you been a member of the Survivor Support Group?

Where are the Survivor Support Group meetings held; how often; and what kinds of things do you do together?

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?

## **Attachment 4: List of Persons Interviewed & Sites Visited**

### **USAID/ZAMBIA**

Melissa Williams, Mission Director - USAID/Zambia

Sheila Lutjens, Deputy Mission Director - USAID/Zambia

Rene Berger, Team Leader - USAID Multisectoral HIV/AIDS Office

Beatrice Hamusonde, Women's Justice and Empowerment Initiative Specialist – USAID/Zambia

Ngaitila Phiri, Advocacy & Human Rights Specialist - USAID Multisectoral HIV/AIDS Office

### **CARE INTERNATIONAL ZAMBIA**

Steve Power, Assistant Director, Programs

Mary Simasiku, Head Health and HIV/AIDS

Christine Munalula, ASAZA Program Manager

Brenda Kanyengo, ASAZA Technical Advisor

Alex Musonda, ASAZA Assistant Program Manager

Adrian Katema, ASAZA Monitoring and Evaluation Coordinator

### **ASAZA SUB-GRANTEES**

Tazona Banda, World Vision GBV Manager

Patricia Ndhlovu, YWCA Program Manager

### **ASAZA COORDINATED RESPONSE CENTERS (CRCs)**

#### **Chipata CRC**

Dorothy Ndhlovu, Coordinator

CRC Staff (Paralegals; Counselors; Data Entry Clerk)

Men's Network

Survivor Support Group

Advisory Council

Service Provider Network

#### **Ndola CRC**

Leah Kumwenda Chimba, Coordinator

Harry Banda, Acting Coordinator

CRC Staff (Paralegals; Counselors; Data Entry Clerk)

Survivor Support Group

Men's Network

Advisory Council

Service Provider Network

#### **Kitwe CRC**

Sylvia Chishimba, Coordinator

CRC Staff (Paralegals; Counselors; Data Entry Clerk)

Survivor Support Group

Men's Network

Advisory Council

Service Provider Network

## **List of Persons Interviewed & Sites Visited (Continued)**

### **Mtendere CRC**

Wamusheke Mwenda, Coordinator  
CRC Staff (Paralegals; Counselors; Data Entry Clerk)  
Service Provider Network (Police, VSU, Magistrates, MOH, etc.)  
Men's Network  
Survivor Support Group  
Advisory Council  
VSU Officer

### **Burma CRC**

Leah Kumwenda Chimba, Coordinator  
Ngosa Mukupo, Acting Coordinator  
CRC Staff (Paralegals; Counselors; Data Entry Clerk)  
Men's Network  
Survivor Support Group  
Service Provider Network (Police, VSU, MOH, etc.)  
VSU Officer

### **Mazabuka CRC**

Grace Mwila, Coordinator  
CRC Staff (Paralegal; Counselors; Data Entry Clerk)  
Survivor Support Group  
Men's Network  
Advisory Council  
Service Provider Network (Police VSU; Magistrates, MoH)  
VSU Officer

### **Kabwe CRC**

Emmanuel Phiri, Coordinator  
Africare CRC Staff (Paralegals; Counselors; Data Entry Clerk)  
Survivor Support Group  
Men's Network  
Advisory Council  
Service Provider Network  
Youth Life Skills Group  
VSU Officer

### **Livingstone CRC**

Raphael Kambole, Coordinator  
CRC Staff (Paralegals; Counselors; Data Entry Clerk)  
Survivor Support Group  
Men's Network  
Advisory Council  
Service Provider Network (Police VSU; Magistrates; MoH)  
VSU Officer

## **List of Persons Interviewed & Sites Visited (Continued)**

### **ASAZA-SUPPORTED SHELTERS**

YWCA Women's shelter, Lusaka (Director; Counselors; House Mother)  
YWCA Children's shelter, Lusaka (Director; Counselors; House Mother)  
City of Hope shelter, Mazabuka (Director; Counselors; House Mother)  
Lushomo Children's shelter, Livingstone (Director; Counselors; House Mother)  
YWCA Women's shelter, Chipata (Director; Counselors; House Mother)  
Bwacha shelter, Kabwe (Director; Counselors; House Mother)  
Kitwe shelter, Kitwe (Director; Counselors; House Mother)

### **HOSPITALS/CLINICS & POLICE STATION VICTIM SERVICE UNITS (VSUs)**

Dr. Monze, Livingstone General Hospital, Child Abuse Project/Child Sexual Unit, Livingstone  
Livingstone Pediatric Hospital (Medical Superintendent & Principal Trainer)  
Ndola Central Hospital, Ndola  
Chipata Central Health Clinic, Chipata  
Lusaka Health Clinic, Lusaka  
Mazabuka District Hospital  
VSU Officers at Lusaka Police Station  
VSU Officers at Livingstone Police Station  
VSU Officers at Mazabuka Police Station

### **ASAZA IMPLEMENTING PARTNERS**

Africare Staff  
CRS Staff  
World Vision Staff  
YWCA Staff  
Police Victim Support Unit Officers  
Women in Law in Southern Africa Representatives  
International Justice Mission Representatives  
Ministry of Health Representatives

### **CDC ZAMBIA (CDC ZAMBIA)- CHILD SEXUAL ABUSE CENTERS (CSAs) & ZANELEC SHELTER FOR VULNERABLE CHILDREN**

Dr. Rokaya Ginwalla, CDC Zambia  
Dr. Kapakala - Pediatrician Ndola Pediatric Hospital  
Dr. Robert Fubisha - Pediatrician Livingstone Pediatric Centre of Excellence  
Dr. Jane Mutanga - Medical Officer Livingstone Pediatric Centre of Excellence  
Dr. Kaunda - Pediatrician Lusaka UTH CSA centre  
Derrick Sialondwe - CSA Coordinator Livingstone Pediatric Centre of Excellence  
UTH One-Stop Center (CSA) in Livingstone  
UTH One-Stop Center (CSA) in Lusaka  
ZANELIC, Ms. Kavumbu, Program Manager

## **List of Persons Interviewed & Sites Visited (Continued)**

### **BI-LATERAL AND MULTI-LATERAL DONORS**

EU  
UNFPA  
UNICEF

### **GOVERNMENT OF ZAMBIA**

Gender in Development Division  
Ministry of Health  
Police Victim Support Unit in Lusaka  
Ministry of Community Development and Social Services  
Judiciary  
Law Development Commission

### **NON-PROFITS & NGOS**

Save the Children, Zambia Field Office, Lusaka  
Council of Churches in Zambia, Lusaka  
Population Council, Lusaka  
FAWEZA  
WiLDAF  
WOP (Justice for Widows and Orphans), Lusaka  
Child Justice Forum Representatives

## **Attachment 5: List of References**

### **ASAZA DOCUMENTS**

A Safer Zambia GBV Training Manual

A Safer Zambia (ASAZA) Knowledge, Attitude and Practice (KAP) Survey Report, May 2010.

A Safer Zambia (ASAZA) Monitoring and Evaluation Plan, February 1, 2008 to January 30, 2011. CARE Zambia, March 6, 2008.

A Safer Zambia (ASAZA) Mid-Term Evaluation Report. Final Draft. February 2008 to November 2009. December 2009.

A Safer Zambia. Sexual and Gender-Based (SGBV) Violence Training Manual.

A Safer Zambia (ASAZA) Monitoring Form (2008)

ASAZA Annual Narrative Report, Final. Sept. 2008 to Oct. 2009.

ASAZA Quarterly Report, January to March 2010.

ASAZA Annual Narrative Report, October 2008 to September 2009.

ASAZA (A Safer Zambia) Baseline Report 2009. CARE Zambia.

ASAZA (A Safer Zambia) Baseline Report 2008. CARE Zambia.

ASAZA: International Women's Day Commemoration 8 March 2010 Eastern Province (Chipata CRC)

ASAZA: Nc'wala Ceremony Report 2010 Eastern Province (Chipata CRC)

Client Flow Chart for Chipata CRC; protocol for clinical services/medications for rape/defilement cases

Chipata CRC Profile

Cooperative Agreement between USAID and CARE for implementation of the ASAZA program.

CRC Incident Report Form (Case Record Form)

CRC (Draft) Flow Chart Diagram: Coordinated Response Centre Initial Steps for Reporting and Referral System Chart

CRC 2009-2010 cases statistics: Mazabuka, Mutendere, Burma, Ndola GBV National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia



National Communications Strategy on Gender-Based Violence, October 2009-2015. Ministry of Community Development and Social Services (with collaboration and funding from ASAZA).

National Guidelines for the Multidisciplinary Management of Survivors of Gender-Based Violence in Zambia. Produced by Government of the Republic of Zambia, Gender in Development Division, Cabinet Office, Ministry of Health, Ministry of Home Affairs and Ministry of Community Development and Social Services, in collaboration with European Union, Population Council, UN Children's Fund, UN Population Fund, and USAID. March 2010.

Paralegal Training Manual for Coordinated Response Centres. International Justice Mission (IJM) and ASAZA

Rapid Youth Life Skills Training Manual. Produced by Africare. and ASAZA program. CAREGIVER Pocket Guide. Produced by the ASAZA program for inclusion in the life skills manual and care-givers' guide.

WJEI-ZAMBIA AO Signature.

Misc. ASAZA IEC materials including "Woman II Woman" Television Talk Show DVD; GBV posters and brochures: "A Safer Zambia (ASAZA);" "Sexual and Gender-Based Violence (SGBV) Coordinated Response Centers (CRC);" "How to use the Coordinated Response Center;" "Property Grabbing! What you need to know;" "What is Gender-Based Violence?"

## **CDC DOCUMENTS**

Child Sexual Abuse Clinic Information Binder, University Teaching Hospital One Stop Centre, Lusaka, Zambia (including flow charts, protocols/checklists, data collection forms, and CSA data).

Child Sexual Abuse Programme (CSA) UTH PCOE Country Operational Plan (COP) Narrative 2005.

Child Sexual Abuse Programme (CSA) UTH PCOE Country Operational Plan (COP) Narrative 2007.

Child Sexual Abuse Programme (CSA) UTH PCOE Program Description. April 1, 2007 to March 31, 2008.

Child Sexual Abuse Programme (CSA) ZANELIC Program Description. April 1, 2007 to March 31, 2008.

Child Sexual Abuse Programme (CSA) UTH PCOE Country Operational Plan (COP) Narrative 2009.

Child Sexual Abuse Programme (CSA), Zambia New Life Center shelter for Abused Children (ZANELIC) Country Operational Plan (COP) Narrative 2005.

Child Sexual Abuse Programme (CSA) Zambia New Life Center shelter for Abused Children (ZANELIC) Country Operational Plan (COP) Narrative 2007.

Child Sexual Abuse Programme(CSA) Zambia New Life Center shelter for Abused Children (ZANELIC) Country Operational Plan (COP) Narrative 2009.

Multi-Disciplinary Training Manual, Zambia Society for the Prevention of Child Abuse and Neglect (ZASPCAN)

Non Competing Continuation Application, Zambia New Life Center shelter for Abused Children (ZANELIC) Carry Forward April 1, 2007 – March 31, 2008.

## **WJEI MATERIALS**

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October 30, 2008 - Subject: WJEI In South Africa: Building on Success. (Unclassified Cable).

December 18, 2009 - Subject: Benin: WJEI Organizes Training for Magistrates, Judicial Police Officers, and Public School Administrators on Combating Violence Against School Girls. (Unclassified Cable).

July 28, 2009 - Subject: Benin: WJEI leads Beninese Delegation on Study Tour of South Africa's Anti-GBV Facilities. (Unclassified Cable).

May 4, 2009 - Subject: International Team Visit: WJEI Turning Victims into Survivors. (Unclassified Cable).

Nov. 17, 2008 - Subject: Pretoria International/WJEI Quarterly. (Unclassified cable).

Oct. 13, 2008 - Subject: WJEI In South Africa (2) – Annexures. (Unclassified cable).

Women's Justice and Empowerment Initiative. Draft Fact Sheet.

Women's Justice and Empowerment Initiative (WJEI) in Zambia, Powerpoint Presentation.

## **OTHER BACKGROUND DOCUMENTS**

Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inc.

Child Witness Institute: Muller et al., Women and Children as Witnesses in Cases of Gender-Based Violence, April 2009.

Child Witness Institute child witness court preparation materials “Joe and Thembi;” “The Story of Zack and Thandi,” “Bobo and Annie.”

Save the Children: “Safe You, Safe Me” training materials for learners

Official Form: Zambia Police Report of Medical Examination for Rape/Defilement Case

Population Council: The Copperbelt Model of Integrated Care for Survivors of Rape and Defilement: Testing the Feasibility of Police Provision of Emergency Contraception Pills (October 2009)

Towards a Gender Analysis Framework to Assist the Application, Adoption and Use of Environmentally Sound Technologies, Global Development Resources Center, Hari Srinivas, 2010.

USAID WID Office: Key Terms in Gender Analysis ([www.usaid.gov/our\\_work/cross-cutting\\_programs/wid/gender/gender\\_analysis\\_term](http://www.usaid.gov/our_work/cross-cutting_programs/wid/gender/gender_analysis_term))

YWCA Council of Zambia: shelter Admittance Form

YWCA Council of Zambia: YWCA shelter Departure Form/Questionnaire (Lusaka)

YWCA: “Welcome to Laweni House”

Zambian Police Service/Population Council brochure: “Emergency Contraception for Rape Survivors.”

## **Attachment 6: Summary of ASAZA 2010 GBV KAP Survey Recommendations**

The May 2010 ASAZA GBV KAP Survey offered seven key recommendations which are provided below. Note that these are direct quotes from the KAP survey, and they are listed as they were provided within the original document – which was not provided in any order of preference.

- The use of edutainment has proved to be a very effective strategy to raise GBV awareness. However, this strategy can only be sustained if the project has its own drama groups in the site, as hiring these might prove difficult once external funding ends. The project therefore might wish to look into the possibility of helping the sites to set up peer educators who can also be used in drama groups.
- The project should develop culturally appropriate IEC materials (especially, leaflets, brochures and posters) to which rural communities can easily relate. It is also important that these materials are produced in local languages spoken in the project area.
- The project will need to target the people in the middle and high income areas better. Currently, the project has paid much attention to people in villages and compounds for much of its sensitization. There is evidence that the project hoped that through the use of leaflets, brochures and posters, more people in middle and high income areas will be reached, but results on the ground has not shown that this is the case.
- Initiatives such as “men’s network” should be supported and encouraged in all communities of the project especially where there is strong and committed local leadership (Chiefs and Village Headmen).
- Except in the case of Mazabuka and Mtendere CRCs, the project would need to consider housing the CRCs within health institution premises to ensure that medical attention is available on a 24 hours basis. Ideally, the project should have medical staff available at the Centre.
- Reliance on volunteers, challenge of keeping them motivated and committed. Since the project uses volunteers as the main vehicle for service delivery, the project should revisit its volunteer strategy in order to attract volunteers who are serious to be trained as peer educators, those who have the passion to serve without expecting huge rewards from the project. The new strategy should aim at removing the need for peer educators and other volunteers from covering long distances and program visits. If the project opts to continue with current arrangement, then it should provide enough resources (transport money, materials etc)
- Frequent withdrawal of cases e.g. due to fear of losing a bread winner, isolation or becoming unpopular. The project should seriously consider strengthening referral to economic empowerment programs especially sister programs such as the Finance and Improved Technology project.