The Women's Justice and Empowerment Initiative

Lessons Learned and Implications for Gender-Based Violence Programming in Sub-Saharan Africa

MEASURE Evaluation
TECHNICAL REPORT

The Women's Justice and Empowerment Initiative

Lessons Learned and Implications for Gender-Based Violence Programming in Sub-Saharan Africa

by

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“I think the benefit of the WJEI is that it probably opened the eyes of the countries themselves, the four countries … hopefully other countries around said ‘if we are not doing something we should be doing something and if we’re doing something we should be doing more.’ And I think that’s certainly one of the take-away benefits that I saw.”

—USAID, Zambia

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APHIA	AIDS, Population and Health Integrated Assistance
CBO	Community based organization
CFK	Carolina for Kibera
CLAN	Children's Legal Action Network
COVAW	Coalition of Violence Against Women
CPS	Social Services Centers or Centres de Promotion Sociale in Benin
CRC	Coordinated Care Response Center
CREAW	Center for Rights Education and Awareness
DOJ	U.S. Department of Justice
GBV	Gender-based violence
GBVRC	Gender-Based Violence Recovery Center at Kenyatta National Hospital
ICITAP	International Criminal Investigative Training Assistance Program
IEC	Information, education and communication
IPV	Intimate partner violence
KNH	Kenyatta National Hospital
KWPF	Kibera Women for Peace and Fairness
MEGEN	Men for Gender Equality Now
MoH	Ministry of Health
MSF	Medecins San Frontieres
NGO	non-governmental organization
OPDAT	Office of Overseas Prosecutorial Development, Assistance and Training
PEP	Post-exposure prophylaxis
PSI	Population Services International
SAFE	Sexual assault forensic examinations
SOA	Sexual Offenses Act in Kenya
SOCA	Sexual Offenses and Community Affairs
TCC	Thuthuzela Care Centers
WEL	Women's Empowerment Link
WJEI	Women's Justice and Empowerment Initiative
WKF	Wangu Kanja Foundation
WLSA	Women and Law and Southern Africa
YWCA	Young Women's Christian Association in Zambia

The Women's Justice and Empowerment Initiative (WJEI) was a three-year, 55-million-dollar program to bolster women's justice and empowerment in four sub-Saharan African countries, from 2008–2011: South Africa, Zambia, Benin, and Kenya. The three major components were: 1) raise the awareness of gender-based violence (GBV), 2) improve the ability to investigate, prosecute, and adjudicate GBV cases, and 3) provide victims with medical, psychosocial, and legal support to enhance their reintegration into their respective societies.

The four country settings in which the WJEI was implemented were very different. Traditional norms that reinforced gender inequality were present in all four countries. However, the levels of GBV-related research, legal infrastructure, and programmatic experience varied considerably between the countries.

South Africa has a long history of extensive GBV research and programmatic interventions and had GBV-related laws in the country since 1998. There is wide acknowledgement by both government and civil society that violence and GBV are major problems in there. There was no GBV-specific law in **Zambia** before the WJEI and little GBV-related research is has taken place. The exiting GBV service programs targeted mostly children. **Benin** also had no GBV-specific laws before the WJEI. There were some small GBV-related programs in the country. The WJEI in **Kenya** was implemented only in Kibera, the largest urban slum in Africa, located in Nairobi. GBV-specific laws had been enacted and there was a sizeable body of GBV-related research there. In Kibera itself, there were many GBV-related programs. The project design in each country reflected these differences.

MEASURE Evaluation conducted this evaluation of the WJEI from late 2011–2013, with the fieldwork in Benin and Kenya taking place in the summer of 2012. The evaluation aimed to examine the implementation and results of the project in each of the countries, and compare them across the four countries. The assessment focused on the strengths and challenges that resulted from the WJEI's technical strategy, and its potential sustainability in each country.

A desk review of existing project documents was conducted. Qualitative, in-depth interviews were carried out with a variety of stakeholders to gather information on the WJEI in each site. Budget constraints limited fieldwork to two of the four sites (Benin and Kenya). The fieldwork involved individual interviews with a range of stakeholders and focus groups with community beneficiaries. A limited number of interviews took place by phone with key stakeholders in Zambia and South Africa, and six in-person interviews were conducted in Zambia by a MEASURE Evaluation colleague who happened to be working there during the data collection period.

Information was gathered on four key areas:

1. the broader environment in which the program was implemented
2. key project design decisions
3. strengths and challenges of project implementation
4. sustainability of the WJEI Project activities

In total, 104 stakeholders were interviewed across the four countries. This included five interviews in South Africa, eight in Zambia, 30 in Kenya, and 67 in Benin. In addition, 39 focus group discussions were conducted in the two field sites, including 31 in Kenya, and eight in Benin.

All of the qualitative data was transcribed and analyzed using ATLAS.TI. The analyses proceeded in four stages:

1. listening and recording for content,
2. coding,
3. identifying emerging themes, and
4. data reduction and interpretation.

A coding quality check was performed on 10% of all the interviews. The observed country-specific strengths and challenges resulting from the implementation of the WJEI are as follows:

- **South Africa:** One of the major accomplishments of the WJEI was the establishment of 23 new Thutuzela Care Centers (TCCs). These were one-stop centers integrating psychosocial, medical, and legal support for women and children. The administration of the TCCs was successfully transferred to Government of South Africa. In addition, services were expanded to rural areas, and significant capacity building took place within judicial system. The project there also faced challenges. Women's use of TCC services was limited; they were still mainly used by children. There was also little capacity for follow-up care after individuals were serviced at the TCCs. The prosecution of cases was hampered by lengthy delays.

- **Zambia:** The Anti-Gender-Based Violence Act was passed in 2011, which had previously twice failed in parliament before the project. The two existing Coordinated Care Response Centers (CRCs, also one-stop centers) were improved and an additional six were established. There was notable success in raising awareness and transforming GBV-related norms. Case reporting and adjudication improved. The WJEI greatly strengthened the country's commitment to GBV response. Several challenges were observed. The heavy reliance on volunteers reduced the efficacy of care provision at the CRCs. Standalone were under-staffed and open during business hours only. The majority of women had to return to their community and there were no reintegration services or efforts to make communities safer. There was also a lack of coordination between the Department of Justice (DOJ) and USAID arms of the project.

- **Benin:** Strengths of the project included a close collaboration between the DOJ, Department of State, and USAID, and strong national and local collaboration with the Benin government. The awareness campaigns transformed norms and attitudes, and the case reporting process improved. Another achievement of the WJEI was the facilitation of the passage of the GBV law in 2011 and its enactment in 2012. Among the challenges faced in Benin was less project coverage in rural areas. There was community resistance to focus on imprisonment of perpetrators. The awareness messaging left out men and boys. Care and support for survivors support was weak. For example, there were no funds for or means of transportation to help survivors seek medical care or to obtain an emergency medical certificate in the case of rape.

- **Kenya:** Strengths included a strong communications approach and a high level of community ownership. Community-managed systems of care and support for GBV survivors were strengthened with increased support to the national hospital for GBV services. The WJEI had success in raising awareness, promoting attitudinal change, and breaking the cultural of silence around GBV. There was increased support from police and judicial uptake of defilement cases. As in Zambia, one of the main challenges faced by the project

was the heavy reliance on community volunteers and lack of community resources. The very short project period limited what could be accomplished. Also noted was the lack of coordination between the DOJ and USAID in Kenya. There were also continuing barriers to justice in the legal system. The planned one-stop center in Kenyatta National Hospital did not take place. The project in Kibera was a pilot and may not be easily replicated in all of Kenya.

Key recommendations for future GBV response in sub-Saharan Africa are drawn from the observed successes and challenges of the WJEI in these four countries. The recommendations are presented by the WJEI's three specific components. Overarching recommendations related to the implementation of the project across the four sites are presented last.

- **Awareness-raising:** Initiatives to raise awareness about GBV should be tailored to specific audiences, taking into account age and gender. Community members should be engaged as change agents. Campaigns should strategize to involve men and boys.

- **Justice system strengthening:** Bottlenecks in the legal system need to be addressed in order to both motivate people to report incidents and promote case prosecution. A major challenge that each of these countries faced was the lengthy process required to prosecute cases of violence through the court system. This proves to be a major disincentive for women to report cases.

- **Care and Support:** Acute care and support services for women should be integrated at one location when possible, and should include medical, psychosocial and legal personnel. The one-stop-shop center for integrated care is a best practice model for acute GBV services for women. However, several lessons learned during the WJEI raised issues that must be considered in implementing this model in sub-Saharan Africa: 24 hour access is critical, access to the one-stop-centers must be provided in in rural areas, and the service structure must incorporate a longer-term focus on the needs of women following assault.

- **Overarching Recommendations:** When two sectors are involved with one project, such as the DOJ and USAID in the case of the WJEI, effective coordination should be planned into the design and implementation of project. Countries implementing GBV programs based on justice initiatives must include acute services for women. Multi-country projects employing similar GBV responses, such as the WJEI, should have planned coordination mechanisms to enable sharing experiences between countries. GBV projects need better monitoring and evaluation and countries need GBV M&E systems. The lack of baseline data hampered a rigorous evaluation of the WJEI. The scope of the project should be carefully considered since the intensity of the programmatic reach is affected. For example, the focus on Kibera exclusive to the rest of the country allowed for a very intensive campaign that reached the majority of the target population, but this factor was limiting in that the approaches used could not be readily extended to a larger geographic area. GBV programs in sub-Saharan Africa should be built on existing models when and where they are present and effective. Programs should be aware of the benefits and risks of engaging volunteers in the implementation of a program.

The Women's Justice and Empowerment Initiative (WJEI) was a three-year, 55-million-dollar program to bolster women's justice and empowerment in four sub-Saharan African countries from 2008–2011: South Africa, Zambia, Benin and Kenya. The four countries were selected because they had already demonstrated governmental commitment to combat gender-based violence (GBV) within their respective settings. The program was designed to raise awareness, improve the capacity in these countries to investigate and prosecute perpetrators, and assist female survivors of rape and abuse. The program was implemented slightly differently in each of the four contexts, but the three major components were:

1. **Raise the awareness of GBV.**
   This component sought to increase the awareness of the prevalence of GBV, care and support resources available to survivors; enhance public policy and laws regarding women's rights; assist communities to overcome the barriers to recognizing GBV as a problem and ultimately contribute to changing peoples' behavior related to GBV incidents, care and support, and accepting attitudes towards GBV.

2. **Improve the ability to investigate, prosecute, and adjudicate GBV cases.**
   This component sought to strengthen the capacity of legal systems to protect women from violence and to punish violators. Activities in this component were focused on increasing the capacity of the police, prosecutors, and judges to understand and combat criminal conduct associated with GBV. Efforts were also directed towards teaching how to conduct effective investigations and use forensic techniques.

3. **Provide victims with medical, psychosocial, and legal support to enhance their reintegration into their respective societies.**
   This component sought to strengthen the capacity of health, legal, and social organizations that provide assistance to GBV survivors.

In this report, these three components are referred to as:
1. **Awareness Raising,**
2. **Legal System Support,** and
3. **Care and Support of Survivors.**

The initiative brought together the knowledge and resources of USAID, the U.S. Department of Justice (DOJ) International Criminal Investigative Training Assistance Program (ICITAP) and Office of Overseas Prosecutorial Development, Assistance and Training (OPDAT), and the U.S. Department of State Bureau of International Narcotics and Law Enforcement to fight GBV.

The project was initially designed from the DOJ perspective, focusing on the adjudication and prosecution of cases. When USAID became a donor partner, the project evolved to include the awareness and comprehensive care components. The WJEI therefore had two arms—one that was implemented by the DOJ and there other implemented by USAID. The two arms of the project operated differently in the four countries and their respective activities were often not well coordinated together. One informant stated that the project would have been designed and implemented very differently had the two donor aims been designed together from the beginning. Instead, the objectives, staffing, and implementation of the objectives of the two operated separately.

> The goal [of the DOJ end of the project] was to increase the number of cases and the number of successful prosecutions, with women having access to legal systems, the police collecting data correctly … leading to more men in jail for the appropriate amount of time. So the starting point of the project was prosecution, not prevention of GBV or care and support. —*Foreign Service Officer*

The WJEI was implemented in four very different settings. Traditional norms that reinforced gender inequality were present in all four countries. However, the levels of GBV-related research, legal infrastructure, and programmatic experience varied considerably between the countries. The project design in each country reflected these differences. Details about the context and implementation are described in detail in the country-specific chapter. Here is a short summary of the GBV-related contexts across the countries (see also Table 1):

- **South Africa** has a lengthy history of extensive GBV research and programmatic interventions, and has had GBV-related laws in the country since 1998. Both stranger and spousal rape is illegal. There is wide acknowledgement by both government and civil society that violence and GBV are major problems in South Africa. Nearly half South Africa's deaths due to injury are caused by interpersonal violence and the rape rate is one of the highest reported in the world. Most interventions have focused on the legal and care aspects, with non-governmental organizations (NGOs) focusing on prevention. Innovative research on preventing GBV has taken place in South Africa, and there was an established network of one-stop centers in the country.

- **Zambia** had no GBV-specific law in the country before the WJEI. There has been little GBV-related research there. The care and support programs for GBV survivors began in refugee camps and grew to a couple of one-stop centers and a safe house. However, most of the GBV survivors serviced before the project began were children. There were strong proponents advocating for more GBV services and laws in the country, but there were no widespread programs aimed at the general population.

- **Benin** also had no GBV-specific laws in place, only general ones protecting against violence. There were a few scattered GBV-related programs in the country, but none at the national level. The WJEI was the first intensive program of its kind there. There was less GBV-related research conducted in Benin than in Zambia.

- Unlike the other three country settings, the WJEI in **Kenya** was implemented in one place, Kibera. Kibera is the largest urban slum in Africa and is located in Nairobi. This accounted for many of the differences in the way the project was implemented there, since the other three countries had much larger geographical targets. Kenya had enacted GBV-specific laws before the start of the WJEI. There was also considerably more GBV-related research than in either Zambia or Benin. In Kibera itself, there were many organizations that worked on various aspects of GBV.

Table 1—Programmatic, Legal, and Cultural Context for GBV in the Country Sites

	South Africa	Zambia	Kenya	Benin
Programmatic	• Existing national network of one-stop centers • Extensive research on GBV	• Existing one-stop models from pilot project	• Existing small-scale efforts by local organizations focusing on awareness raising • Some research exists on GBV in Kenya and Kibera	• Very few prior GBV programs and none on a national level • Limited research on GBV
Legal	• Rape and spousal rape illegal • Sexual harassment illegal	• Addresses extra-marital rape, but not other types of GBV	• Covers all forms of GBV, but not marital rape	• Domestic violence illegal • Rape illegal, but with weak enforcement
Cultural	• Violence and injuries are the second leading cause of death • Rate of rape in South Africa is among the highest in the world • Poverty, inequality and dominant patriarchal constructions of masculinity drive the high rates of GBV	• General acceptance of wife beating, sexual assault, especially in the case of children, was not generally tolerated • IPV an important demonstration of masculinity within marriage in traditional culture	• Kibera is ethnically and culturally diverse, with variation in norms and practices surrounding gender and GBV • IPV is widely seen as a form of disciplining one's wife and there is a strongly held belief that men have a right to do so • Kibera became a hotbed for ethnic conflict and violence against women and children during post-election period in 2007-08	• Women held a lower social position than men and violence was highly normalized, particularly between intimate partners • Community members widely observed physical and sexual violence before the project

This evaluation was conducted by MEASURE Evaluation from 2012–2013, with the fieldwork in Benin and Kenya taking place in the summer of 2012. The goal of this evaluation was to examine the implementation and results in each of the countries and compare them across the four countries. As it was only possible to conduct in-depth fieldwork in two of the countries (Benin and Kenya) due to budget constraints, the results presented for these two countries are considerably more in-depth than those for South Africa and Zambia. While it was possible to reach certain conclusions about the implementation of the WJEI in these two countries, the results were necessarily less complete.

The variation in both country-contexts and technical approaches of each of the WJEI sites provided a unique opportunity to examine the relative strengths of different initiatives to prevent and respond to GBV. With funding granted as part of a competitive proposal process from the USAID Bureau of Policy, Planning and Learning (PPL) /Office of Learning, Evaluation and Research (LER), MEASURE Evaluation undertook this evaluation at the request of USAID. Additional funding for this activity was provided by the Kenya USAID Mission.

The purpose of the evaluation was to:

1. assess WJEI technical strategies in four countries, why they were developed and implemented the way they were, and determine the extent to which these strategies have been effective in reaching the program objectives using;
2. identify best practices and lessons learned; and
3. determine the extent to which strategies can be replicated.

The methods section describes evaluation design in detail. One chapter is devoted to each of the four countries. Primary collection of qualitative data was conducted only in Benin and Kenya. The evaluation in South Africa and Zambia was based mainly on desk review. Phone interviews were conducted with a few informants who could be reached that way. In Zambia, a few face-to-face interviews were conducted by an additional researcher who could add two days to a trip to the country for another project. It is for this reason that the country sections on South Africa and Zambia are much shorter and less in-depth than those on Benin and Kenya. The concluding chapter of the report summarizes the main results for each of the countries and provides recommendations for GBV programming based on our findings.

Guiding Evaluation Questions

The goal of this evaluation was to describe the implementation and assess the strengths and challenges of the WJEI project in the four countries. The evaluation focused on the following key questions:

Assessment of Technical Strategy

1. What technical approaches were used to implement the WJEI in each of the four countries?
2. What types of GBV-related services were made available, how were they utilized, and how did programs respond to the needs of various populations living within the targeted program areas?
3. What outputs and effects did the WJEI achieve and how did these influence and affect contextual factors related to GBV in each of the four countries?
4. What were the strengths and challenges of the design and management of the programs in each of the four countries and as a whole?
5. What are the lessons learned that could impact ongoing and future programs? What were the key components that can be attributed to the program's successes and challenges, and how can these be replicated in other settings?

Replication and Sustainability

1. What aspects of the programs have been sustainable in each country, and how was sustainability affected by program design and implementation?
2. Which and in what ways have programs been continued by national and local governments and by communities?

Overview of Evaluation Methods

The evaluation team used a combination of a desk review of existing project documents and qualitative, in-depth interviews with a variety of stakeholders to gather information on the WJEI project in each site. Budget constraints limited fieldwork to two of the four sites (Benin and Kenya). The fieldwork involved individual interviews with a range of stakeholders and focus groups with community beneficiaries. A limited number of qualitative interviews were conducted by phone with key stakeholders in Zambia and South Africa.

Desk Review

Desk Review Aims

The first aim of the desk review was to understand more about the context of program implementation in each site, including information on the cultural, legal and programmatic landscape in which the project was implemented. The second aim was to develop a consistent description of how the WJEI project was implemented in each country.

Desk Review Methods

A variety of documents were acquired on each country's WJEI project for the desk review. These included program reports, program implementation materials, and existing evaluations from the USAID contacts associated with each site, and from the implementing partners in each country.

Below is a list of the documents reviewed:

South Africa

- USAID/South Africa and the WJEI. Fact Sheet: Establishing Thuthuzela Care Centers to Assist Victims of Rape and Sexual Violence. Aug 2008.
- RTI International. National Audit of Multi-Disciplinary Services in South Africa Dealing with Sexual Offenses. Volume One. Final Consolidated Report. June 2009
- RTI International. National Audit of Multi-Disciplinary Services in South Africa Dealing with Sexual Offenses. Volume Two. Final Consolidated Report. June 2009
- RTI International. Performance Monitoring and Evaluation Plan. WJE: 2011–2012
- Introduction to the Justice Sector Strengthening Programme (JSSP)
- Thuthuzela Brochure. Turning Victims into Survivors.
- USAID South Africa Program in Support of PEPFAR: Thuthuzela Care Centres FY06. Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault. July 2007.

Zambia

- Asaza Baseline Report. 2008
- Asaza Baseline Report, Revised. 2009
- Sexual and Gender-Based Violence Training Manual
- Caregiver Pocket Guide
- Asaza Mid Term Evaluation Report Final Draft Feb 2008–Nov 2009
- Asaza M&E Plan. 2008
- Asaza Annual Narrative report: Oct 2008–Sept 2009
- Asaza Paralegal training manual for paralegals
- National guidelines for the multidisciplinary management of survivors GBV in Zambia. 2010

Benin

- Baseline study: Etude de base du Projet EMPOWER. December 2008
- EMPOWER project evaluation report. Aug 2010
- EMPOWER reporting cable. Sept 2011
- EMPOWER Project External Evaluation Report. Aug 2010
- EMPOWER Illustrative Performance Monitoring Plan. Date unknown
- WJEI Benin country profile update. 2009
- Memo: Presentation of EMPOWER Project. Date unknown
- Manuel de formation des journalistes. May 2009
- Presentation: Agressions Sexuelles. Date unknown
- Sexual violence campaign posters. Dates unknown
- Workshop materials: Atelier de Validation des Conclusions Preliminaire de l'Analyse du Projet EMPOWER. March 2012
- Project film: Halte aux violences faites aux femmes et aux filles. Date unknown
- Project film: Mariées Malgré Elles. Date unknown
- Project film: Le revers de la Medaille. Date unknown

Kenya

- Pathfinder International. WJEI Report of Current Situation of Gender-Based Violence in Kenya, with special focus on Kibera, Nairobi. Jan 2009.

- Pathfinder International. WJEI Program Design Document. Jan 2009.
- Pathfinder International. WJEI Program in Kenya Organizations fighting SGBV in Kibera and their activities. Jan 2009.
- PSI. WJEI. Concept Note for a Communications Intervention Empowering Men, Women and Youth to Prevent SGBV.
- Pathfinder International Trip Report: Technical Assistance Visit July 15–21 2010
- Review of WJEI Activities Implemented During APHIA Ii Nairobi Project Period. Oct 2011
- WJEI: Kenya Report. Oct 2008
- WJEI: End of Project Report. Oct 2009–Feb 2011
- Women Educational Researchers of Kenya (WERK). A Study On Sexual And Gender-Based Violence In Kibera, Nairobi. May 2011.
- FilmAId International. Sita Kimya. Combatting Sex and Gender-Based Violence Through Film: A Case Study. Jan 2012
- MEGEN. Final Report For Technical Assistance in Facilitating the Development of Male Champion's Network In Kibera under the WJEI. Aug–Dec 2010
- PSI. Communication to Empower the Men, Women, Youth and Children of Kibera, to Prevent and Reduce the Impact of SGBV. Quarterly Report: Oct–Dec 2010.
- PSI. Communication Partners on the WJEI.
- WEL in Collaboration with Pathfinder International Under APHIA II. Progress Report on Safe Spaces/Shelters And Working Group. Jan–Dec 2010
- WEL. Women Economic Empowerment WJEI project 2010

From the information synthesized for each country, a standardized country summary was developed which included information on the local project name, the implementing partners, the timeline of activities, the geographic scope, the target population, the venues of delivery, a summary of project activities, and results from any evaluations that were conducted.

Qualitative Research

Qualitative Aim

The aim of the qualitative interviews was to gather more information on the implementation and evaluation from the perspective of key stakeholders.

Qualitative Data Collection Methods

Interview guides were developed for different audiences and used to conducted in-depth interviews and focus group discussions to gather information from the perspective of the project stakeholders. The guides laid out the key questions in each topic area and suggested probes. The instruments served as guides and interviewers were encouraged to follow up on relevant lines of enquiry as they emerged, even if they were not explicitly included in the guides. Information was gathered on the following areas to assess the implementation of the four WJEI sites.

- The broader environment in which the program was implemented. This covered the cultural, legal and programmatic context in which the WJEI program was implemented in each setting.
- Key project design decisions. This was how key decisions about the design of the WJEI in each site were made both from the perspective of the US government donors and on the ground in terms of the implementing partners.
- Strengths and challenges of project implementation. Information was gathered on the perceived strengths of and challenges faced by project implementation in each site. This

included information on the perceived successes of the project in each site and key obstacles to implementation that each site faced.

- Sustainability of the WJEI Project activities. This covered extent to which the WJEI was planned with regard to sustainability beyond the project period, and the steps that were taken to try to ensure sustainability.

Table 2 below provides sample questions in these different domains:

Table 2—Qualitative Research Topics and Question

Topic	Example questions
Broader environment	• How would you describe people's attitudes towards violence against women and girls in X? • How would you say awareness about GBV has changed in X in the past decade?
Resource allocation across 3 project components	• Can you describe the process through which WJEI was designed in X? • How would you describe the balance of activities across the 3 project areas?
Key project design decisions	• What role did the main stakeholders play in the design of the project? • How was the geographic focus of the project determined? • What alternative project designs were considered?
Perceived strengths and challenges	• What were some of the successes of the WJEI Project? • What were some of the challenges of the WJEI Project? • Have any of the three program areas shown more success than others? If so, why do you think this is the case?
Sustainability	• What structures, personnel and ongoing activities continue to exist? Who is funding these services and/or activities? How do you view the sustainability of the project?

The questions on the guides were adjusted for the different types of stakeholders that were interviewed. All of the interviews were audiotaped, transcribed and computerized for analysis with the permission of the interviewee.

Qualitative Sample

Fieldwork was conducted in two of the four countries—Benin and Kenya. In the two countries where fieldwork was not conducted due to budget constraints (South Africa and Zambia) phone interviews along with a limited number of face-to-face interviews with stakeholders were conducted. Table 3 below presents information on the sample of participants from the four countries. The extensive fieldwork in Benin and Kenya afforded the opportunity to interview a broader range and larger number of informants there.

Table 3: Sample of Informants from Face-to-Face Interviews in Each Site

Organization Type	South Africa	Zambia	Kenya	Benin	Total (by type)
USAID	2	1	2	3	8
Project Awardee		4	3	3	6
Host government partner	–	–	–	4	4
NGO Partners	2	–	10	5	17
Project extension agents	–	–	–	14	14
CBOs	–	–	9	3	12
Health providers	–	–	3	3	6
Judicial system/police	1	1	1	5	8
Non-WJEI Stakeholders	–	–	2	11	13
Community members	–	–	–	16	16
Total	5	6	30	67	104

In addition to individual interviews, focus group discussions were also conducted in the two field sites. Table 4 below provides information on the types of focus groups that were conducted in Benin and Zambia.

Table 4: Types of Focus Group Discussions that were Conducted in Each Site

Group type	Kenya			Benin		Total
	M	F	M/F	M	F	
Community base managers	–	–	5	–	–	5
Peer educators	6	8	1	–	–	15
Community participants	3	6	2	4	4	19
Total	31			8		39

Qualitative Data Analysis

All of the qualitative data was transcribed and analyzed using ATLAS.TI. The qualitative data analysis occurred in four steps including:

1. **Listening and reading for content.**
   During data collection, when a member of the research team was not present for the interview, recordings were checked for content to ensure that the data collection was responsive to ideas that were emerging from the interviews and adjust questions that were not yielding pertinent information. Recordings were transcribed after the data collection phase in the U.S. Prior to coding the data, transcripts were read in their entirety and memos were written about the data in a preliminary phase of analysis. During this phase, emerging patterns from each site were noted in memos.

2. **Coding.**
   A codebook was developed to code all of the interviews and focus group discussions. There were two levels of coding that took place. At the deductive level, the transcripts were coded according to the topics that were directly assessed by questions in the interview guide. This level of coding allowed us to easily index the data by topics and more efficiently review data related to a specific topic. Inductive codes were applied to the data to flag emerging themes within and across the different topics (see example in table below). This level of coding allowed us to identify emerging themes and to compare these themes across the different sites. Lastly, a coding quality check was performed on 10 % of transcripts. These transcripts were double-coded and application of codes was checked for accordance between the two coders.

3. **Identifying emerging themes.**
   Using tools, such as summary reports and matrices, data were systematically summarized and key themes were identified that were related to each topical area, and ideas that emerged across different topics.

4. **Data reduction and interpretation.**
   During this final stage of data analysis, the findings were synthesized within and across sites to develop the final report.

Local name: Thuthuzela Care Centers (TCCs)

Broader Environment

There is wide acknowledgement in South Africa, both by government and civil society, that GBV is a significant problem for the country. In comparison to other African settings, there has been extensive research on the epidemic of violence in South Africa. Violence and injuries are the second leading cause of death and lost disability-adjusted life years in South Africa. In 2000, South Africa had 59 935 deaths due to injury, resulting in an overall death rate of 157.8 per 100,000 population.[1] This rate is higher than the continent's average of 139.5 per 100,000 population and is nearly twice the global average of 86.9 per 100,000 population.[2] Nearly half South Africa's deaths due to injury are caused by interpersonal violence,[3] four and a half times the proportion worldwide.[4] Violence in South Africa is gendered, with young men (age 15–19 years) disproportionately involved in violence both as victims and perpetrators. Half of female homicide victims are killed by their intimate partner[5] and the homicide rate of women by intimate partners is six times the global average.[6]

There is limited reliable national data for the prevalence of intimate partner violence (IPV). The best population-based estimates are from 1998 and estimate lifetime prevalence of physical violence to be 25% and past-year prevalence to be 10% in adult women in three provinces.[7] IPV is often sexual and emotional, and many women undergo several forms of violence. One-fifth of women surveyed in antenatal clinics in Soweto reported sexual IPV and 68% reported psychological abuse, such as threats of violence, controlling movement, eviction from home, insults, and humiliation.

The rate of rape in South Africa is among the highest in the world. There are 55,000 rapes of women and girls that are reported to the police every year, which is estimated to be nine times lower than the actual number.[8] In a population-based random sample of men, 27.6% reported that they had ever raped.[9] Black African women and girls have a much higher risk of rape than do those of other racial groups.[10] There are a range of obstacles to reporting cases of rape, which

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[1] Norman R; Matzopoulous R; Goenwald P; Bradshaw D. The high burden of injuries in South Africa. *Bull World Health Organization* 2007 85: 695–702.

[2] Matzpoulous R; Norman R, Bradshaw D. *The burden of injury in South Africa: fatal injury trends and international comparisons*. In Suffa S, Van Niekerk A; Duncan N eds. Crime violence and injury prevention in South Africa: developments and challenges. Tyberg: MRC-UNISA *Crime, Violence and Injury Lead Programme*, 2004: 9–21.

[3] Norman R; Matzopoulous R; Goenwald P; Bradshaw D. The high burden of injuries in South Africa. *Bull World Health Organization* 2007 85: 695–702.

[4] Peden, M; McGee K, Sharma G. *The injury chart book: a graphical overview of the global burden of injuries.* Geneva: World Health Organization. 2002.

[5] Seedat, 2009: Seedat, M.; vanNiekerk, A; Jewkes R; Suffa S; Ratele K. Violence and Injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374: 1011–22.

[6] Seedat, 2009: Seedat, M.; vanNiekerk, A; Jewkes R; Suffa S; Ratele K. Violence and Injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374: 1011–22.

[7] Jewkes R; Penn-Kekana L., Levin J. Risk fctors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine*, 2002; 55: 1603–18.

[8] Jewkes, R; Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science and Medicine*, 2002; 55: 153–66.

[9] Jewkes R; Sikweyiya Y; Morrell R; Dunkle K. U*nderstanding men's health and use of violence: interface of rape and HIV in South Africa*. Technical Report. Pretoria: Medical Research Council, 2009.

[10] Vetten I; Jewkes R; Fuller R; Christofides N; Loots L; Dunseith O. *Tracking injustice: the attrition of rape cases through the criminal justice system in Gauteng, Johannesburg.* Tshwaranang Legal Advocacy Centre, 2008.

include fear of not being believed, problems of physical access to police and fear of the legal processes involved, including treatment by the police.[11]

Cultural Context

Poverty and inequality are social dynamics that have contributed to South Africa's burden of violent injury. They are inseparably related to other key drivers, such as the dominant patriarchal constructions of masculinity, the intergenerational cycling of violence, the proliferation of firearms, alcohol and drug abuse. Patterns of violence show that almost all perpetrators are men. The dominant ideals of masculinity, across racial groups, lead to demonstrations of toughness, bravery, and defense of honor. In turn, these translate into risk-taking behaviors and the high status gained by resolving conflict through fighting rather than more peaceful strategies.[12] Furthermore, patriarchal social norms sanction the use of violence by men to discipline and control female partners, and so long as violence is not severe, the use of violence against female partners is viewed as socially acceptable.[13]

Legal Context

The government of South Africa has long recognized the urgency of addressing the problem of GBV, and has taken several important steps in this regard. Among these are key legislative and policy developments, including:

- The Domestic Violence Act (1998);
- The Sexual Offenses Act and subsequent Amendment Act (2007); and
- The Department of Health Management Guidelines for Sexual Assault Care.

Despite these important pieces of legislation, the legal infrastructure designed to respond to the high volume of domestic and sexual violence cases is lacking in South Africa. The vast majority of cases of GBV are not tried effectively within the legal system. In 2000, only 16.8% of rape cases were referred to court, and of those, half of the rape cases were seen through final stages. A guilty verdict was achieved in 7.7% of all reported rape cases. In a national audit of 56 courts across the country, it was found that 18 of the 56 courts audited dealt with sexual assaults only among adults and children, and 25 courts had specialist prosecutors in place. The infrastructure of the audited courts were lacking in facilities to assist with the processing of cases, such as including separate toilets for survivors. Only 22 courts had separate consultation rooms, and 21 courts had separate waiting spaces for survivors.[14] The time that it takes to prosecute cases of GBV through the court system is notoriously long, dissuading many survivors from pursuing legal action.

Programmatic Context

There are many organizations throughout South Africa that address the problem of GBV from the legal and health perspective. Efforts, which have mainly focused on services for survivors and criminal justice measures, rather than on primary prevention, have resulted in many accomplishments.[15] Respondents noted that coordination among the organizations that provide

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[11] Kim JC; Martin LJ; Denny L. Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa. *Reproductive Health Matters*, 2003; 11(2): 101–12.

[12] Coovadia H; Jewkes R; Barron P; Sanders D.; McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 2009; 374(9692):817–34.

[13] Coovadia H; Jewkes R; Barron P; Sanders D.; McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 2009; 374(9692):817–34.

[14] RTI International. 2009. *National Audit of Multi-Disciplinary Services In South Africa Dealing With Sexual Offences*. Final Consolidated Report.

[15] Seedat, 2009: Seedat, M.; vanNiekerk, A; Jewkes R; Suffa S; Ratele K. Violence and Injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374: 1011–22.

GBV services is problematic throughout the country. In 2007, the Deputy President launched the 365-Day National action Plan to end violence against women.[16] This plan was a multisectoral prevention scheme intended to be a blueprint for prevention across government and civil society, but there has been very little evidence of any implementation.

Facilities for survivors are available through the state and NGOs. Primary prevention efforts to change attitudes towards GBV have primarily been implemented through NGOs. Actions to raise awareness and shift norms have included campaigns in the media, community based workshops, and efforts to engage traditional leaders. There have been awareness raising national campaigns to bring attention to the problem of violence. There have also been notable violence prevention interventions that have been implemented and evaluated in South Africa, and have been shown to have positive effects in reducing the problem of GBV.[17,18] There are national leaders who have drawn attention to the problem, and accomplished researchers who have documented the problem and led interventions to address the problem. A national audit of GBV infrastructure assessed the extent to which the existing facilities provide comprehensive services for survivors. Ninety-three percent of the services that were audited provided both sexual offense and domestic violence services, and 61% of facilities provided comprehensive post-exposure prophylaxis (PEP) services, which is critical in a setting such as South Africa, with such high HIV prevalence. Only 4 of the 76 facilities that were audited were not operational 24 hours.

Key Findings: Broader Environment

- South Africa is disproportionately affected by GBV. The homicide rate of women by intimate partners in South Africa, for example, is six times the global average underscoring the scope and the severity of GBV in South Africa.
- There is widespread acknowledgement of the problem of GBV both by the government and in civil society.
- South Africa has been at the forefront of countries in Africa, and globally, at implementing prevention and care programs for GBV.

Implementation

WJEI in South Africa addressed the three project components including awareness raising, legal system support and care and support for survivors. However, the main focus of the WJEI activities that USAID supported was the care and support for survivors in the form of the Thuthuzela Care Centers (TCCs), one-stop center models where integrated GBV services are available to survivors. The awareness raising and legal components of the WJEI in South Africa are briefly described, with more extensive details provided on the implementation successes and challenges of the survivor care and support component.

[16] South African Government, 2009.

[17] Vetten I; Jewkes R; Fuller R; Christofides N; Loots L; Dunseith O. *Tracking injustice: the attrition of rape cases through the criminal justice system in Gauteng, Johannesburg*. Tshwaranang Legal Advocacy Centre, 2008.

[18] Pronyk PM, Hargreaves JR, Kim JC, Morison LA. Phetla G; Watts C; Busza J, Porter JD. Effect of structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet*, 2006, 368(9551): 1973–83.

Awareness Raising

The awareness raising component of the WJEI project focused primarily on raising the profile of TCC services in communities where these centers were launched. Activities included public service announcements through the radio, as well as outreach through billboards and posters in local community venues. The project leveraged key events, such as the 16 Days of Activism and International Women's Day, to raise awareness of the services.

Legal System Support

Activities under this component focused on improving law enforcement and prosecution of GBV cases. This set of activities were implemented by the DOJ and focused primarily on the South African Police Service (SAPS). Beginning in 2010, USAID implemented additional activities aimed at strengthening the dedicated Sexual Offenses Courts and building capacity in the judiciary. The ICITAP program provided a senior law enforcement advisor to provide technical assistance to different South African government agencies. The DOJ activities focused on:

1. developing and implementing training curriculum and train-the-trainer programs for the SAPS focusing on the role of "first responders" and on sexual offense investigations,
2. providing quality assurance during the roll-out of the national training program; and
3. field officer training.

USAID assistance was used to support:

1. developing judicial training curricula and materials on sexual offenses in conjunction with the new Judicial Education Institute;
2. building skills for court personnel (prosecutor led investigation, medical evidence/testimony, use of intermediaries in cases involving child witnesses);
3. analysis of sexual offenses judgments; and
4. study tours and professional exchanges.

Care and Support of Survivors

The survivor care and support component was the main focus of the WJEI in South Africa. The cornerstone of this component was the establishment of 23 new TCCs across nine provinces. This activity brought the total number of USAID-supported TCCs in South Africa from 17 to 40 by 2012. The Danish International Development Agency funded an additional 12 TCCs. The network of TCCs was already national in South Africa prior to WJEI, so the plan was to expand the number of TCCs into areas that had not yet been serviced. The site selection for TCCs was based on a national audit that was carried out by RTI prior to project implementation.

History of the TCC Model in South Africa

In 2000, the South African government established an Interdepartmental Management Team (IDMT) made up of seven national departments to develop an integrated national strategy to address the problem of rape. Under the leadership of the Sexual Offenses and Community Affairs (SOCA) unit of the National Prosecuting Authority (NPA), the IDMT has established dedicated sexual offenses courts, trained prosecutors and magistrates, conducted public awareness and outreach campaigns, and introduced integrated rape management services at public hospitals, known as TCCs.

The TCC model envisions a "one-stop" center providing a range of essential services to rape survivors from emergency medical care and PEP to counseling and court preparation in an integrated and survivor-friendly manner. By establishing effective linkages between various

government stakeholders, as well as civil society organizations, TCCs seek to effectively address the medical and psycho-social needs of sexual assault survivors, while improving conviction rates and reducing time to court. The model works to ensure that rape survivors do not experience secondary trauma while seeking justice and/or medical treatment. Access to justice is also increased through better integration of survivor support with criminal investigation and court processes.

The US State Department, together with the South Africa government and USAID made the decisions from the outset about how funds for WJEI would be used to support the TCC model. This was seen as best practice model-widely endorsed in South Africa.

> Well, actually this is not a model that either RTI or USAID proposed to do in South Africa. It's a South African government model, to manage rape in the country and the first TCC was set up in 2000. It has been scaled up since then. —*USAID*

The thrust of the USAID involvement for WJEI in South Africa was the support of the TCC model. In conjunction with the establishment of new TCCs, WJEI also provided:

1. technical assistance to both new and existing TCC sites to improve care and treatment for survivors;
2. targeted grants to NGOs to provide follow-on care to survivors and to assist women and children in communities in accessing the justice system;
3. management support to the SOCA to strengthen implementation and the long-term sustainability of the TCC program; and
4. assistance to SOCA with South-South activities, including disseminating and promoting best practices in sexual and GBV internationally and regionally.

Key Findings: Implementation

- The Thuthuzela Care Centers (TCC) were the cornerstone of the WJEI in South Africa. The WJEI funds were used to establish 23 new TCCs in 9 different provinces throughout South Africa.

Project Strengths and Challenges

Strengths

TCC Model

The TCC model has a number of important strengths that has led to the successful implementation of these center s throughout the country. First, the multisectoral approach to handling cases in a one-stop centers format places survivors at the center and is seen globally to represent best practices in terms of survivor support.

In South Africa, the widespread support and endorsement for this model from the government, has eased the establishment and implementation of these centers throughout the country.

> We have a long way to go, but the model has been supported by the President himself at the Access to Justice Conference in July, 2011. He specifically mentioned the TCC model as increasing access to justice for South Africans. On a national level it is a priority. —*USAID*

Another important strength of this model is that it provides a blueprint for how to deliver services across vastly different settings, addressing what is often a disparity between access to services for rural and urban communities.

> The aim of the South African government is to actually ensure that any person in a rural or an urban area would seek the same services. Because in rural areas, there is less resources, so there is always the huge probability that people will get sub-standard services. —*Primary awardee*

Challenges

Implementation of The TCC Model

There were a number of challenges faced in the implementation of the TCC model. First, there continues to be barriers for women coming forward to access the services. Most of the cases that were being brought forward to TCCs were cases of abuse of children.

> The largest number of people seen at the TCCs are children between the ages of 8 and 12. There are all sorts of reasons for that others are exploring. The key is that people are receiving services and not be secondarily victimized at every step of the way. —*USAID*

A central weakness of the TCCs acknowledged by respondents was that facilities are only open from 9 a.m. to 5 p.m., when many cases that require services happen at night and on weekends. The linkage to other NGOs that provide services 24 hours a day helps to offset this challenge, but this continues to be an implementation challenge for the TCC model.

> We are dealing with a population with limited resources. So coming back for follow-up is very difficult. So it is important that the NGO's provide the after-hours and follow up care for TCC survivors. —*USAID*

Another challenge acknowledged in the reports and the interviews was the follow up for survivors. The TCC model was designed to provide services during the acute period following victimization. The model itself is not designed to address the ongoing psychosocial and other needs that survivors have.

While the TCC model is a successful model of providing survivor support, the post-follow up services required to prosecute cases are problematic. The lower courts in South Africa continue to be overwhelmed with cases, resulting in very long periods of time for case prosecution.

> The courts are not in good shape…they are not being managed properly. There are a lot of issues that need to be addressed, and they can only be addressed with funding … Service is just one piece of puzzle. If people are not getting convicted, then people seeking services are not going to come forward. You have a system that does not lend itself to expedited justice, so that creates a disincentive to report cases. It does not necessarily create a disincentive to seek services. We need to move away from just reporting on number of people who received services and move towards a longer-term engagement in trying to increase prosecutions and convictions. —*USAID*

Key Findings: Project Strengths and Challenges

- The TCC model is widely cited as a best practice model for survivor support, providing integrated medical, legal and psychosocial services in one facility.
- The TCC model shares widespread support from the government of South Africa.
- There are some challenges to implementing the TCC model including (1) continued barriers to adult women seeking services in TCCs; 2) Limited ability to provide follow-up services for survivor and 3) poor follow up on prosecution of cases because of long delays and inefficiencies in the court system.

Sustainability

When WJEI funds were invested into expanding the TCC model in South Africa, there was already widespread support for the services from the government, and a plan for how the government would eventually assume control and costs for these services. Planning for the sustainability of these services was at the core of the WJEI funding in South Africa.

> The US government is trying to assist the South African government with implementation of a model which could be sustainable beyond donor assistance. —*Primary awardee*

There has been a gradual process of moving the TTC's over to South Africa government funding. The staff at TCCs will become South African government employees.

> There is no MOU (memorandum of understanding) between USAID and SOCA. However, it is something that SOCA is doing. They are putting into the budget. After one year on our funding, these people are going to be on contract with RTI for a year. And then they would become an employee of SOCA. It is happening. We can see it is happening … The recruitment and retention of staff remains a challenge for the SA government. It is a problematic issue that the SA government needs to address, but they do have a budget for these positions. They just have to work out a system for a more smooth transition. —*USAID*

At the same time that the government is assuming responsibility for supporting the TCCs, there is a plan in place to continue to scale up of these centers throughout South Africa. The goal is to establish a total of 80 TCCs throughout the country, an increase of 38 from the current number of 42 TCCs.

Key Findings: Sustainability

- Because the TCC model is widely endorsed by the South African government, the likelihood that these services would be supported and sustained through government funding was high.
- As part of the WJEI implementation process, the government assumed responsibility for the support of some of the TCCs and the WJEI implementing partners worked with the government to ease this transition.

Local name: ASAZA (A Safer Zambia)

Broader Environment

GBV is widespread in Zambia, but very little research has taken place there. Almost all studies on GBV and its effects on health outcomes in Zambia have been based on the Zambia Demographic and Health Survey (ZDHS). The ZDHS collected data on GBV through its domestic violence module in 2001 and in 2007. The 2007 ZDHS shows high levels of GBV prevalence among women of reproductive age. Almost half of women interviewed (47%) reported experiencing physical violence at some point in their lives, and 20% experienced sexual violence. The vast majority of perpetrators (92%) of physical violence were intimate partners.[19]

The 2007 ZDHS also showed that there was a high tolerance of GBV among both women and men. The survey asks people if they believe that a man is justified in beating his wife for a number of reasons, ranging from burning the food to being unfaithful. The majority of women (62%) and nearly half of men (48%) interviewed stated that it was acceptable for a husband to beat his wife for at least one of those reasons.

Only two studies pertaining to cultural norms related to GBV in Zambia were found. One study documented that a high tolerance of violence that negatively influenced the likelihood that adult women and men would get tested for HIV.[20] Another study showed that gender equality—assessed by looking at women's decision-making power and their tolerance for GBV—was positively associated with the likelihood of breastfeeding. Women who expressed less tolerance for GBV and rated high on women's autonomy factors were more likely to exclusively breastfeed their infants.[21] Attitudes and beliefs supporting gender inequality, which drive GBV, also influence other related outcomes in Zambia. These studies demonstrate that these norms were widespread in Zambia before the start of the WJEI and were therefore critical to include in the response to GBV.

Clearly, GBV is a major issue for Zambia. This was recognized by factions of the government, but had not materialized in legal action or a widespread care system. There were efforts from women's advocacy groups to pass a GBV law, and NGOs offered some service provision.

Cultural Context

Individuals who worked with the WJEI in Zambia (ASAZA) supported that there was widespread tolerance for violence, as documented by the ZDHS. This was expressed publicly in the press, and in stories and sayings. IPV was considered to be a normal part of marriage. One anecdote related that IPV is expected as part of marriage:

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[19] 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.

[20] Gari S, Malungo JR, Martin-Hilber A, Musheke M, Schindler C, Merten S. 2013.HIV testing and tolerance to gender-based violence: a cross sectional study in Zambia. *PLoS One*. Aug 21;8(8):e71922. doi: 10.1371/journal.pone.0071922.

[21] Singh K, Luseno W, Haney E. 2013 Gender equality and education: Increasing the uptake of HIV testing among married women in Kenya, Zambia and Zimbabwe. *AIDS Care*. Feb 26 [Epub ahead of print]

> At what they call the 'kitchen party,' which is sort of the woman's engagement party … older women will tell you, 'Your husband beats you because he loves you.' So there's a tacit acceptance of that kind of violence. —*USAID*

An element of Zambian masculinity is for a man to demonstrate that he can stand up to his wife. If a woman beats a man, he is not considered manly. At the same time, part of a woman's accepted role is being passive enough to accept being beaten. These norms around husband and wife roles were noted to be deeply ingrained in Zambian culture by everyone interviewed. A member of the police in Lusaka agreed, stating that the major problem in addressing GBV in Zambia was the wide acceptance that this kind of behavior is not only normal, but also expected.

Although there is a general acceptance of wife beating, sexual assault, especially in the case of children, was not generally tolerated. Sexual assault is seen as both a crime against the individual survivor and his/her family. However, even in the case of sexual assault, the norm is for the parties to work it out in the community rather than report the incident to the authorities.

> Sexual offenses … are frowned upon … and when they happen … the solution is not take this person to the police, it's more conversation, compensate the family, compensate the parents. —*CARE*

Legal Context

There was no specific law pertaining to GBV before the beginning of WJEI. However, Zambia had ratified both international and regional international Human Rights declarations, which make it clear that GBV violates human rights. For example, Article 3 of the Universal declaration of Human Rights reads: "Everyone has the right to life, liberty and security of person".[22]

There were attempts to pass the Anti-GBV Act before the project began. A bill had gone to parliament twice and failed. While he was still alive (until 2008), President Mwanawasa's wife initiated the bill and was a very strong proponent of GBV response in Zambia Rape and sexual assault were covered by the penal code, but there was no specific law stating that IPV was illegal.

If a case of IPV was actually reported and dealt with outside the woman's community, the police handled them. This was a problem because they were not sympathetic to survivors of GBV.

> Even towards the end [of the project] you would still find places where people would say the police are trying to adjudicate rather than going to a court … they would say to the woman, 'It wasn't that bad. Why don't you go on home?'

The case would therefore not move forward to litigation. The police were not sensitive to the health or other needs of the woman who had come forward to report the incident. Women were well aware of this and were therefore reluctant to report cases.

Programmatic Context

In the years prior to WJEI, CARE coordinated GBV service provision in Zambia in refugee camps. When cases arose in the camps, CARE helped get the police and court system involved. The idea for the CRCs arose from CARE's experience in the camps in Zambia. CARE coor-

[22] Universal Declaration of Human Rights (UDHR). http://www.un.org/en/documents/udhr/

dinated mutisectoral service provision in the camps, which included legal, health and police services for survivors. Funding was secured by CARE from the European Union to launch two CRCs, one in Lusaka and one in Chipata.

The Women and Law and Southern Africa (WLSA), a local NGO, conducted GBV-related legal work in Zambia before the WJEI. WLSA provided legal aid to survivors and advocated for GBV response in Zambia. Women in Law and Development in Africa also conducted a number of GBV related advocacy activities in the country. Some police stations had victim support units that were coordinated by the Young Women's Christian Association in Zambia (YWCA). These units were established in police stations primarily to take care of orphans and vulnerable children with the rise of HIV/AIDS in Zambia. As time went on, GBV survivors were taken care of by these units as well.

The ASAZA Baseline Evaluation provided a comprehensive picture of GBV-related service provision in Zambia before WJEI. The survey collected data from service providers across several sectors in the seven districts WJEI targeted in order to assess the levels of existing service provision. Study subjects included the police, judiciary, health and social welfare providers, safe houses representatives, and community/traditional leaders. The results were used to inform the ASAZA project of where CRCs should be located and which services they would provide.

The survey found that in the seven districts, there was no coordinated GBV service provision across sectors for survivors. No system of referral or follow-up between different organizations and services dealing with GBV existed. Among current service providers such as the police and clinical personnel, training and knowledge related to GBV was inadequate. Among those surveyed, over 80% had no specialized GBV training. Health service providers lacked training in collecting evidence that could be used for prosecuting cases, and in managing GBV survivors' care. In health centers and hospitals, there were few if any informational materials relating to GBV and available services. Record keeping in health facilitates providing GBV services were not of high quality and there was no follow-up or referral for clients who came for services. General hospitals were found to be the best prospective locations for the planned CRCs. Most community respondents who lived within the two districts where safe houses were located were unaware of them.

Key Findings: Broader Environment

- GBV is a widespread problem in Zambia, but apart from the ZDHS there has been very little GBV-related research there.
- Cultural norms around expected roles within marriage support the normalization and tolerance of physical IPV. While sexual violence in the case of children is less accepted, it was expected that even these cases be resolved within communities.
- There were no specific laws against GBV before the ASAZA project; attempts at passing the anti GBV bill failed twice in parliament.
- There was some service provision for GBV survivors, but care coordination, case management protocols, training and GBV-specific care knowledge were lacking.

Implementation

ASAZA was implemented for three and a half years, from 2008-2011. USAID was the donor organization for the health part of the project. The other arm of the project was funded by the DOJ. ASAZA was conducted in seven districts: Livingstone, Mazabuka, Lusaka, Kabwe, Kitwe, Ndola, and Chipata.

Several Zambian government agencies were involved in the implementation: ZP-VSU (Victim Support Unit, under Zambia police service), the Ministry of Health (MoH), the Ministry of Community Development and Social Services, Child Justice Forum, Gender in Development Division, and others. There were many NGO implementing partners as well, including CARE International Zambia, the major implementing partner, World Vision Zambia, WLSA, YWCA, Catholic Relief Services, AFRICARE, and the International Justice Mission (which oversaw the safe homes).

ASAZA aimed to decrease the rate of GBV in Zambia and increase care and support for survivors there. The two main project objectives were to:

1. Improve gender equitable attitudes among men and women in the community, and
2. Increase access to comprehensive services to meet medical, psychological and legal needs of GBV survivors.

Quality comprehensive services were to be provided at CRCs in selected locations.

Awareness Raising

In order to improve gender equitable attitudes, ASAZA implemented intense awareness raising and behavior change activities in the targeted districts through a multisectoral approach. The campaigns sought to reach as much as the population as possible and therefore involved schools, legal service organizations, and communities. Several strategies were employed to change norms around GBV at the community level. Using existing men's networks, men in the communities were trained as advocates and change agents to address GBV in communities. Training programs also targeted traditional leaders and youth to act as change agents. Community facilitators generated conversations about GBV. Awareness raising materials were developed and disseminated through print, radio and electronic media. "Edutainment" programs about GBV took place in the form of performances, songs, dances, and were integrated into national and community TV and radio. There were public service announcements about GBV. National and international events, such as Women's and Caregiver's Day, were used to promote information about GBV.

Care and Support of Survivors

CARE and the Zambian MoH worked together to develop minimum standards of care for GBV survivors. The two existing CRCs providing comprehensive services were supported and six new one were established. These one-stop centers provided health and psychosocial services, as well as legal assistance. Legal assistance included trained personnel to help survivors, but not the police. The CRC service development included standardizing information gathering, service tracking, and establishing provider referral networks. Support groups for survivors were created, and hotlines were established.

Legal System Support

Two safe homes for survivors were established. Caregivers and other service providers (police, teachers, health workers and paralegals) were trained. Because USAID does not have a mandate to work within the legal system and with uniformed personnel, (unless a waiver is obtained), the DOJ was needed to train the police and work within the court system. The DOJ also trained individuals acting as paralegals who assisted survivors in bringing their cases to court. Also, survivor networks were established among people who had been through the centers who were willing to provide support to other survivors.

Project Design

USAID/Donor

At the USAID/donor level, the design decisions were based on the results of the baseline evaluation and on existing information in the country, such as available material at the victim support unit in the police service of Zambia. USAID sought to ensure that the ASAZA project enhanced and expanded the services that were already taking place in Zambia. The goal was to fill in the gaps and harmonize the project with efforts already taking place. During the project design phase, staff worked closely with other organizations implementing GBV activities in Zambia. The originally established two CRCs funded by the EU were viewed as very successful, so the new project was designed to build on that existing model. In considering where to locate the new CRCs, priority was given to places with the highest rural populations and close to the urban centers where the CRCs were. Areas that were harder to reach were avoided due to concerns about how they would be staffed.

One of the factors that influenced the decision of where to put most of the funding was the need to get the CRCs up and running. The CRCs were considered a unique aspect of the project design in Zambia in that they would offer services that involved sectors, which traditionally did not work together (e.g., health and justice). In the words of one informant:

> The provision of a one-stop center [was unique because] people can access comprehensive medical, psycho-social, legal support. It's like a one-stop-shop. —*USAID*

The police were targeted for awareness and training because they were known to be very unfriendly to GBV survivors. Police training took place in all but one province. In addition to awareness, they were also trained in the collection of evidence, so that cases would make it through the courts. The two arms of the project—the DOJ focus on the justice system and the USAID focus on awareness and service provision—mainly worked separately with little coordination. The DOJ focused on the GBV bill, since one of the aims was to increase the number of prosecuted cases. Working with parliament members, to deepen their understanding of its importance, ensured that when the bill went before the body again, it would pass (and it did) since there was enough interest. The new focus on the service and awareness components of WJEI also helped push the legislation along because GBV was hard to ignore when there was so much activity around it. However, there was no conscious coordination between DOJ and other WJEI staff on activities.

> USAID and the DOJ worked in tandem with each other without really working together. For example, the DOJ lawyers went to the CRCs when they were opened, but while they trained the legal system workers, USAID employed staff would train the health service providers. —*USAID*

Key Findings: Implementation

- The goal of the project was to build on the existing model of CRCs in Zambia.
- Project design decisions were based largely on the baseline evaluation surveys and on the goal of strengthening existing services.
- The awareness and behavior change portion of the project was expansive and participatory, involving men, youth and others as change agents in their communities.
- The two arms of the project—the USAID service end and the DOJ justice end—worked separately to achieve the overall aim of reducing GBV in Zambia; the project may have been more effective if these two arms were coordinated.

Project Strengths and Challenges

Strengths

A mid-term process evaluation was conducted in consultation with CARE Zambia. Results showed that the existing GBV programs in Zambia that had been developed and implemented according to the Inter-Agency Standing Committee (comprises all UN agencies) recommendations had good collaboration between the ASAZA project, national and other organizations. Ongoing training for service providers and other staff was deemed essential. The capacity of the safe houses was strengthened. In general, though some components were lagging, the project was well on its way to achieving its objectives.

The collaboration between USAID funded partners, the MoH and the Ministry of Gender was very successful. For example, in order obtain proper permissions to establish a new CRC, a lot of bureaucratic work was needed. USAID worked with the Zambian government bodies to ensure that all the paperwork and legal requirements were met. This paved the way for the implementing partner to open the facility. This kept activities moving on target throughout the duration of the project.

A source at the donor level stated that not enough attention had been given to GBV in the past since the scope of the problem was not and is still not recognized by a lot of people in the field. The feeling was that more resources and effort should have been put into GBV. Currently, there is a push around putting money into GBV in sub-Saharan Africa.

> I think the benefit of the WJEI is that it probably opened the eyes of the countries themselves, the four countries … hopefully other countries around said if we are not doing something we should be doing something and if we're doing something we should be doing more. And I think that's certainly one of the take-away benefits that I saw. —*USAID*

Awareness and Behavior Change

There was a very strong awareness raising and behavior change portion of the project. Many sources of media involved. Since there was little TV coverage outside the capital, the radio was used for messages around the country since most people have radios. The success of the campaigns was demonstrated through a range of examples:

GBV awareness was much more apparent in the large cities and there was more coverage in the media. People were aware of cases being brought forward through the court system. GBV was openly discussed as not acceptable.

> The media presented GBV cases as shameful, even when the perpetrator was important, as in the case of one minister. Coverage from that angle would not have happened before ASAZA. —*USAID*

A very large demand for services was created by the awareness campaigns—so much so that the CRCs were overwhelmed by the number of GBV survivors.

One reason given for the success of the awareness campaigns in communities was the strategy of using men's networks:

> Involving the men's network who were advocates for change was a real strength of the project … This was why community awareness increased, because people listened to their own men. —*CRC coordinator*

The campaigns focused on raising community awareness of the existence and purpose of available services. For example, in order to increase incident reporting, an understanding of the process that took place after a case was reported was related change agents. This brought traditional leaders, the men's network and other community networks together to support people in seeking care and reporting cases.

> It was more of a community response … when it happens, rather than keeping quiet, which has been the practice in the past, people would [know] there were services available for victims and people should … report … and the perpetrator brought to justice —*USAID*

Comprehensive Service Provision

The ASAZA program was successfully established in the two previously existing CRCs in Chipata and Lusaka. Six new CRCs were opened after the start of the project. Training the nurses and other CRC personnel in GBV case management and effective referral was a major emphasis of the project. Each CRC was staffed by health, psychosocial, and legal personnel who had been trained on GBV and its management, according to the guidelines developed by CARE and the MoH. Through training the CRC personnel, a protocol was developed that is now used nationally; this came directly out of the project.

The relationship between ASAZA staff and service providers at the CRCs and elsewhere was well developed, and strengthened at the national and district levels. Training materials and guidelines were developed and distributed widely to survivors, families and communities. There was a widespread use of electronic and print media, as planned.

There was a difference in the extent of services offered between CRCs, particularly between those located within health centers/hospitals and those that were stand-alone. The stand-alone CRCs were not as successful as those within the hospitals, because

> Even though you could report everything there, people would have to go to the hospitals and other places and the cases would drop. The CRCs in hospital settings were more comprehensive because there were more resources and staff available. Once cases were reported and the women received care and support at the CRCs, women with strong social networks would seek safe shelter with relatives, but others who were alone went to the safe houses. The safe houses were only used as a last resort, and there were only 2 in the country. —*CARE*

Case Reporting

Informants stated that more cases had been reported since the start of the project. They also felt that there were a higher proportion of reported cases being followed through prosecution.

> We know that GBV has always happened in our communities…my sense is that is that people feel confident in the system, the protection mechanisms that are there because of the WJEI and therefore, they are reporting more. —*USAID*

Victim support units in the police stations worked with survivors reporting to the CRCs to generate a police report, which documented that a crime occurred. This was the first step in prosecuting a case. Actual prosecution was difficult, however, due to a confluence of factors. Many cases reported at the CRCs were dropped before they went into court because the perpetrators were the family members who supported the household. Because women often had no external support, they ended up returning home and withdrawing their cases.

> The challenge in Zambia … in other countries you have a fund to help support people who have been abused. We don't have that here, so what started to happen is that the police … would say the perpetrator's family has agreed to pay X amount of money to the victim's family and the victim's family would agree rather than going through a long drawn-out, arduous court process and then you know at the end of the day you come out with nothing. —*USAID*

Legal System Activities

With regard to the legal component of the project, USAID staff stated that having the DOJ involved was very helpful because of their mandate to work with parts of the police and legal system that USAID could not. USAID needs a waiver to work with personnel in uniform—the military, the police, etc. This meant that there were certain activities that could only be facilitated by the DOJ. USAID was able to work with these bodies in connection with HIV programming, but GBV was not one of the areas for which this could explicitly take place, meaning that there were limits to exactly what they could do with them under this project.

One of the major accomplishments of the WJEI project was being instrumental in getting the Anti GBV Act passed through parliament, it was passed in 2011. After successfully lobbying parliament members targeted by the project, the Act passed when it next came into session. This facilitated the adjudication of cases since there was now a specific law pertaining to IPV.

Key Findings: Project Strengths

- Strengthening the 2 existing CRCs and establishing 6 more went as planned.
- CRCs offering more comprehensive services—those in hospital settings—were more successful than stand-alone centers.
- The awareness campaign was very successful, raising the profile of GBV and moving it into the realm of unacceptable behavior in communities.
- More cases were reported, and a higher proportion went to prosecution.
- The DOJ presence in the country was instrumental to the success of the legal component.
- One of the major accomplishments of the WJEI project was the passage of the Anti GBV Act through parliament in 2011.
- The collaboration between USAID and Zambian government partners was very successful.

Challenges

Cultural Norms, Stigma and Fear

One informant identified changing norms in all sectors of society as a major challenge to all GBV programs in Zambia—WJEI included.

> I think it is still the biggest issue…the government doesn't really take it seriously. So my famous quote is listening to a minister stand up and say, 'I will no longer beat my wife.' And he said that in public … and how do we expect (other) people … to behave any differently than the ministers behave? —*USAID*

The same was observed for communities and the people who serve them: health practitioners, police, judges, lawyers, etc.

> How do you get people to say, no, actually, this isn't acceptable? … that's probably going to happen with the new cohort of the younger generation coming up and saying, 'We don't have to stand for this' … until there's that kind of a cultural shift, you're still going to have a high rate of gender-based violence. —*USAID*

Women are reluctant to report adult rape due to the stigma, which results in personal shame and could even end in a divorce. Women are also reluctant to report physical violence because:

> … the husband is always the breadwinner … They are scared that if I report him, he's going to … be put into prison … They don't want the marriages to end, they just want the beating to end … most of them … will continue … going to traditional structures [community leaders] for counseling. —*CARE*

The same informant stated that cultural values around keeping the family together prevent people from reporting cases, since society is still very traditional with an emphasis on family unity. Anything that threatens that core value is difficult to overcome, no matter what the consequence.

For people living outside the area of a CRC, cases would have to be reported to the local police. These individuals were likely not trained, and already had a reputation for being unfriendly and unsympathetic to survivors. Women in these places are reluctant to report cases because most are afraid of the police.

Transportation Between Referral Sites

For individuals who did not live near the CRCs, transportation was a significant barrier preventing women from seeking services. Nothing was done to address this within the project period. The CRCs were established in more populated areas. This meant that women in outlying areas did not get served.

Collaborations

While the ideal CRC locale was within existing health services in Zambia, these were the most difficult centers to establish because they required collaboration with several different ministry sectors. Although USAID maintained a strong collaborative relationship with various government ministries involved, the many different approvals needed slowed down the process.

While bringing together government ministries was difficult on the one hand, dealing with the number of partners implementing the program was a challenge on the other. All the partners had different styles, which affected how work was carried out and sometimes created bottlenecks.

Heavy Reliance on Volunteers

Several sources at the donor, partner implementation and service staff levels commented on the difficulty posed to CRC services due to the reliance on volunteers. People were trained through project programs, acquired skills and experience through working on the project. Many left shortly afterwards because they were hired for paying positions because they had good GBV-related service skills. This led to training and retraining many cohorts of volunteers. There were only three core staff in each CRC who were paid. Nurses and clinical staff were all volunteers who served at the CRC. As a result, the staff assisting survivors would be pulled away for more pressing duties.

Lack of Safe Houses For Survivors

There were only two in the whole the country. The houses have limits on how long a woman can stay, and how many people can stay at once. Women without support networks and nowhere else to go would be forced to return to their situations because there was no room at a safe house.

CRC-Related Barriers

One informant said that much of the first year went by without activity because of the wait for the government to allocate space for the CRCs.

> This bureaucratic red tape applied to other aspects of the project as well, causing a very slow start to planned activities. —*CARE*

Several informants mentioned issues pertaining directly to the CRCs. A shortage of materials hampered work at the CRCs. One source stated that after the CRC was set up:

> … the lack of follow-up was based on an assumption that after the CRCs were set up, they would have everything they needed, but of course that wasn't the case. They were also often short staffed. There was so much demand that the CRCs were overwhelmed. —*CARE*

Finally, the stand-alone CRCs were not open 24 hours. Staff left for the night and they had to be locked up. If a woman needed help after hours there was nowhere for her to go. This occasionally happened at the CRCs within the hospitals settings too.

Key Findings: Project Challenges

- While much has been accomplished through the awareness campaigns, gender norms, fear and stigma still pose issues to GBV service implementation and case prosecution.
- Transportation for women not in geographic proximity to the CRCs was not provided.
- The heavy reliance on volunteers meant spending extra resources on training new individuals and much time and energy on replacing staff after attrition.
- There are not enough safe houses or options for women without relatives to help.
- More CRCs with 24-hour care are needed; as they are, staff shortages and very high demand hamper their efficiency.

Sustainability

At the end of the project the CRCs were handed over to the MoH. There was a phased approach of handing over the CRCs to ensure they would be successful. The MoH is now running the CRCs, and they are staffed with knowledgeable personnel. While the attrition of volunteers was hard for the project when it was being implemented, it also contributed to the sustainability of the CRCs since most of the volunteers who left during the project after being trained and skilled ended up at the MoH.

Two sources noted that the sites that are still running are still partially funded by the international donors. He remarked,

> Even though people see a need for these type of facilities, they are still not a priority. —*USAID*

Next Steps

The very rural areas were left out of the CRC system because it would be hard to find staff willing to work in those areas. This means that women living in these areas are still in need of quality GBV services. Attempts could be made to work with rural health facilities.

The safe house system needs to be expanded to provide temporary shelter. However, women will ultimately have to return to their communities.

> Making communities safe is ultimately more important than scaling up the CRCs, since in the end women have to return to the community and their environments should be changed to ensure they feel safe. Part of this work lies in the comprehensive efforts needed to change cultural norms about how people treat returning women. The feeling was that making communities safer was more important than providing facilities. —*CARE*

One way of making communities would be transforming the norms around who should leave the community after a report is made. Currently it is assumed that the woman leaves—and then returns to the same community where the perpetrator resides. Behavior change programs could focus on turning this pattern around so that perpetrators would have to leave instead. One source suggested scaling up men's networks as change agents in communities to forward this idea.

The survivor's network of women and those who left their situations and are doing well could be used as champions to demonstrate that women have a choice. This would be a powerful way of showing women in abusive situations that even after years of abuse, life can go on and a person can thrive.

The one-stop centers model CRC was received very well and there is motivation to create more of them.

> There's definitely a huge scope for more CRC-like models. I think that model makes sense; people seem to like it. The idea of a one-stop-shop, where you can get your legal and clinical services all in one place, seems to make logical sense. The government said they liked it. —*USAID*

Key Findings: Sustainability

- The CRCs were passed over to the management of the MoH in a phased plan.
- Many of the former CRC staff are now working there, either because they left the program to work for the MoH, or they remained and have now been given posts.
- Donor funding is still needed to balance the costs of running the CRCs since the government has not taken them fully on.
- More CRCs are needed, especially in rural areas, but there should be more work done in communities to make them safe for women.
- The One-stop-model was received very well and stands as a sound way to deliver comprehensive services for GBV.
- More attention to GBV programming is happening at the donor level, and GBV should be a major priority given its scope.
- The WJEI was a huge endeavor that helped publicize the need for more attention towards GBV programming and response.

Local name: Enabling Mobilization and Policy Implementation for Women's Rights (EMPOWER)

Broader Environment

Cultural Context

WJEI in Benin was implemented in a culture with patriarchal gender norms. About half (49%) of women endorse the opinion that men have the right to beat their wives for reasons ranging from burning the food to being unfaithful, though this opinion is more widely held in rural than in urban areas (55% versus 35%, respectively). Further, 26% of women and 17% of men view that women do not have the right to refuse to have sex with their husband. The proportion of the population holding this opinion is roughly the same across age groups, reflecting the stability of this norm across generations.

Though women are often highly involved in the informal economy of the country, they have a much smaller presence in formal positions. In 2006, only 53% of were remunerated in cash (whether self-employed or in the formal or informal economy). Women also often have little decision-making power or control over financial resources in their families and intimate relationships. Only a quarter of women have control over decision making about their own health, and 34% have little or no power over daily purchases and expenses in their household.[23]

The high level of GBV, particularly IPV, was recognized at the time of implementation, but there was also resistance to involving government authorities in such cases. Participants expressed that GBV was common before the start of the project and along with a general sense that there was a lack of resources for survivors of violence and their families.

> The level of violence was truly blatant, there was no accountability, no justice, no social aid … there was even a sense of fear in the area —*Male community member*

Though GBV was widely acknowledged, a certain level was viewed as normal and women and girls were accorded few rights. Informal methods of resolving intimate partner disagreements (which often mounted to violence) were well established in families, clans, and villages, but resolutions typically did not involve strong punishments for perpetrators. Though there appeared to be recognition of unacceptable, extreme cases of violence, women were discouraged from taking legal recourse after an assault as this was seen as shameful for the woman and her family.

Knowledge Of And Attitudes Toward GBV

Participants discussed physical IPV, most often husbands hitting their wives, occurring as a form of punishment or out of anger. Rape was the second most commonly discussed form of GBV, though there was little mention of rape within intimate relationships. Another form of GBV mentioned was food deprivation. Participants explained that as the ones in control of the family's resources, husbands withheld food from their wives as a form of punishment, and would sometimes deprive children of food, which was painful for the mother to witness.

[23] Institut National de la Statistique et de l'Analyse Économique, Programme National de Lutte contre le Sida, and Macro International Inc. 2007. *Enquête Démographique et de Santé Bénin 2006*. Calverton, Maryland, USA: CSO and Macro International Inc.

Beyond physical violence, verbal harassment and forced marriage were named as forms of existing GBV. One community member explained that in some cases, mothers of the girls being forced to marry disagreed with the decision, but were powerless to stop the process short of helping the girl to escape the country:

> Sometimes mothers are against the forced marriage, but they don't have the ability to overrule the decision of the father. So sometimes they have to help their daughter flee to Nigeria just to avoid the forced marriage. Sometimes there are girls who kill themselves to avoid marrying someone they don't love. —*Female community member*

Forced marriage was one of the most common types of GBV mentioned by community members, though beyond these discussions mention of non-physical GBV was limited. One implementing partner explained that emotional violence was difficult for the project to note, as psychologists or other persons qualified to evaluate cases of emotional violence are rare in Benin.

Some people expressed that there was some level of community perception of GBV as a problem, though this was not common. In fact, most participants who reflected on the matter explained that in their communities violence against women, and rape in particular, was seen something women deserved for being sexually promiscuous:

> In our custom, in our culture we normalize it, we say 'she was asking for it and now she thinks she was raped!' —*Regional implementing partner*

At the government level, there was a low level of awareness and appreciation of GBV as an issue. One program implementer expressed that there was close to no discussion of the issue at the governmental level. Rather, GBV had been a taboo subject on the national level and this attitude was reflected by the lack of any legislation on GBV before the WJEI.

Attitudes Toward Women and Girls

Participants related this normalization of GBV to their lower position in traditional society. Despite legislation, traditional gender norms and women's rights continued to overshadow the legal rights of women. As this participant describes, women were seen as the property of their husbands with no individual rights of their own:

> Women have no rights or duties and so forth. When the laws were passed and communicated, and someone would attempt to apply them they were taken as an absurdity, we imagine that women don't have a right to this, women have no right to land, we can beat her whenever, once we have paid the dowry…the woman becomes an object, the man's property, and he can do to her what he wants, when he wants, and how he wants.
> —*Regional implementing partner*

Many participants expressed this attitude. Women were expected to obey their husbands and accept their actions toward them, including physical violence. Some participants further generalized the cultural normalization of violence beyond husbands and wives to between men and women in general.

> Women are the weaker sex and men are strong, so it's normal that men should use violence against women. —*Implementing partner*

Key Findings: Broader Environment—Cultural Context

- At the time of implementation women had a lower social position than men and GBV was highly normalized, particularly between husbands and wives.
- Community members widely observed GBV before the project, primary noting physical and sexual violence.

Legal Context

Legislation in Benin previous to the WJEI that protected women's rights and prohibited and punished violence included the following:

- Benin's Constitution of December 11, 1990.
- Ratification of the Protocol to the African Charter on the Rights of Women in Africa of March 2003.
- Establishment of the "Code des Personnes et de la Famille" of August, 2004.
- The passing of two laws against sexual violence and trafficking in 2006.

Despite these protections against GBV, implementers largely perceived that the penalties for GBV perpetration were obscure in the law and neither widely known, nor applied.

> Before [the project] there was nothing! It was under the Penal Code somewhere so abuse would be general abuse…but specifically gender based that we can't say… —*Implementing partner*

Attorneys and other government officials involved in the project were aware of some of the previous laws relevant to GBV, though in some cases vaguely so, perhaps because laws were neither specific nor well known. Enforcement was difficult, even though this type of violence, as well as others, was technically prohibited before the enactment of the WJEI promoted law.

> It's now that the new law is passed that punishments for perpetrators are laid out in detail, so effectively the project was implemented in a legal context that was essentially nonexistent. It was very difficult for us. —*CPS representative*

Implementers were often aware of the laws, but they observed that much of the target population was not, before the project.

> The new law really specifies prevention of GBV, punishments, and protections. All is well defined in this law. But there was even a Penal Code before the new law. In the implementation, what we realized was that the law was not widely known. Especially women who are mostly illiterate who don't know their rights, their duties. —*Implementing partner*

Interviews with community members and community facilitators confirmed this notion, as they shared that they had been unaware of laws against GBV before the project. A few facilitators had been vaguely familiar with punishments being in place for perpetrators, but not certain of specifics of laws or rights.

> There was no law to my knowledge concerning GBV before the project. Before when your parents would decide to give you away in a forced marriage there was no law to protect you, there was no one to help you, you were obliged to obey, you had no choice. —*Female focus group participant*

The few community members who were aware of GBV-related laws before the project expressed that laws were vaguely known in general and were poorly enforced.

> There were laws but they weren't often enforced. Before [the project] we did not fully understand the law. Before we knew that if you perpetrate violence you will be punished, that's all. People were arrested and put in prison and sometimes and sometimes they were fined. —*Female community member*

Traditional Sanctions

While the Centres de Promotion Sociale (CPS) and police had worked to combat GBV along with other types of violence before the project, most community members mentioned primarily talking to chiefs and other traditional leaders to resolve cases of GBV before the project.

> Our wise men dealt with it, people presented their cases to them and they would manage the problem with us. But for the cases that surpassed them it was necessary to go to a higher power like the mayor, the police, or others. —*Male community member*

> There was nothing besides what was done traditionally. When we couldn't handle it in the family, we went to the traditional chief. —*MC N'Dali*

Customary punishments for acts of GBV were mostly for physical IPV. Again, despite formalized laws and punishments, most incidences of violence were resolved either within the family or by village or neighborhood leaders, meaning that decisions and punishments varied greatly. The resolution of these conflicts was very closed off from the official forces of the law due to the high legitimacy of traditional leaders' power in many areas, as this participant shares.

> Before EMPOWER, when there was domestic violence, the clans took care of it. The clan chiefs would call together the family—the perpetrator, the victim, and the parents, and within the collectivity they would deal with the situation, so it was difficult for a case to be brought to the police. —*Community facilitator*

When perpetrators were punished by family and traditional leaders, the punishment was often not proportionate to the gravity of the violence. As this participant expressed, with all levels of violence being addressed with a slap on the wrist, men were able to continue these practices without a worry.

> Before there was so much violence against women and men did it without a care because it was possible to settle the matter within the family regardless of the gravity of the situation, I mean to say there were no severe punishments, you try to give only some advice to the two parties and that's all. —*Religious leader*

Norms Against Case Reporting

GBV survivors were sometimes aware of legal resources at their disposal, but they were discouraged from reporting cases to the police. Family often advised women who had experienced violence that reporting the act to social services or the police created embarrassment for the family. This norm against venturing outside the family before there had been interfamilial attempts at resolving it may have prevented intervention by traditional leaders in some cases, as this community leader describes:

> This is Africa and tradition rules; you mustn't put the blame on, give a bad name to a woman who has experienced violence because once this information becomes public, it could come back on the name of the woman's family so the best is to try to wash the dirty laundry in the family first, and then see what you can do. —*Community leader*

With personal and family reputation at stake, survivors of violence typically avoided speaking out about their experience. Community facilitators and members expressed that reporting a case would be viewed as an act of rebellion on the woman's part. Some participants explained that women would be intimidated by family member to prevent them from reporting cases, sometimes with threats of further violence. Beyond threats, women's financial dependence on their husbands or male partners made the cost of turning against their provider (by reporting abuse) too high.

> Very few cases are denounced because of the culture … because of the poverty of women, when a woman denounces her husband, her husband is the only one who attends to the needs of the woman and her children, so it's really the culture that is at the root, the culture which doesn't encourage [denouncing acts of violence]. —*USAID*

Many participants reflected that women's financial dependence on husbands and other men was powerful disincentive to reporting violence. Others stated that women who were financially independent gained more respect from husbands and were therefore at less risk for GBV.

Key Findings: Broader Environment—Legal Context

- Laws protecting women from acts of violence were in place before the WJEI, but they were not specific to GBV and legal consequences for specific types of violence were not clear.
- Understanding of these laws was vague and many community members were unaware of their existence.
- There was resistance to reporting violence to formal authorities in most communities; GBV cases were expected to be resolved within the family or by traditional leaders.

Programmatic Context

The Ministry of the Family is the primary government agency addressing GBV in Benin. In the early 1980s the Ministry established the CPSs (i.e., Social Services Centers) and there are now CPS in all 77 districts of Benin. CPS agents serve primary as conflict resolution specialists in cases of conflict resolution, and provide referrals to legal, medical, and other social services.

Prior to WJEI, USAID funded a five-year Women's Legal Rights (WLR) project, which ended in 2007. This activity aimed to promote women's rights through awareness raising and training on women's rights under the Benin Family Code. Through this project, assistance was given to the government of Benin to draft and pass the law on sexual harassment. Other donor countries including Denmark, the Netherlands, European Union, Belgium, and France have funded projects in Benin to address GBV. For example, the Netherlands funded an initiative to provide women with documentation such as birth certificates, which are essential to filing legal complaints, including those related to GBV. Belgium and France have also supported training sessions for police to identify and assist survivors of GBV. Multilateral organizations have also funded initiatives. UNICEF focused on promoting child/girls' rights and helping survivors of child trafficking, and the UNFPA supported work on women's socio-economic status and legal rights.

National organizations have also made strides in this arena, including the National Council of Negro Women and Women in Law and Development in Africa. These organizations have established of the Center for Women's Rights and Development to assist female survivors of violence. The Association des Femmes Juristes du Bénin distributed legal information materials and provided of legal assistance to survivors of violence.

A few community members were also aware of small, local projects addressing GBV mostly through awareness raising, such as the Victory Way project of the Parakou region, which was established by a group of young local activists. Implementers perceived that previous projects paved the way to an extent for EMPOWER.

> So there were all these elements which prepared the field a little bit. And now EMPOWER added itself so that the population is more and more sensitized and understands more and more, but as we say, if you haven't finished the task there remains a lot to be done. —*Implementing partner*

On the other hand, many more community member and implementers were unaware of previous GBV projects and identified EMPOWER as the first project to make a mark in the national consciousness in the fight against GBV.

> It was EMPOWER that came to wake us all up regarding GBV. It was a huge opportunity for Benin. Honestly, we recognized all this because of the project. —*Implementing partner*

> It was WJEI that was the first to really invest in the issue of GBV that I really knew. Today EMPOWER is synonymous with the fight against GBV. —*Implementing partner*

Though awareness of official projects prior to EMPOWER was low, community members and project agents often knew of the work of the CPS and the police. Some expressed dissatisfaction with these efforts.

> Before it was only the CPS and the police [who worked with GBV], but what they did was very insignificant. —*Community project agent*

Key Findings: Broader Environment—Programmatic Context

- There had been multiple smaller-scale projects addressing GBV in Benin before EMPOWER, but participants expressed that EMPOWER had a much greater impact.
- Most community members and many implementers perceived there to never have been any prior GBV initiatives in the country.

Project Design

Implementers were interviewed at USAID-Benin, CARE-Benin, as well as regional implementing partners to discuss the details of the design process that took place. EMPOWER's initial design process began with USAID-Washington visiting Benin in 2005 to assess the feasibility of WJEI activities. During the project period in 2008, CARE-Benin conducted a baseline study that measured the level of common forms of violence across the nation, attitudes toward the perpetration of GBV, and knowledge of relevant rights and legislation. While actors in Washington made some key design decisions up front, many decisions were made through

a process of interaction between US and actors from Benin. Some activities were added during the project period as recommendations from implementing partners and as a result of the midterm evaluation.

Justice Focus

Overall, the project aimed to reduce the level of GBV. Many different approaches were implemented to achieve this goal, including awareness raising, financial promotion of women, and the prosecution of perpetrators. Implementers perceived a programmatic emphasis on the punishment of perpetrators and awareness raising around relevant punishments. Some perceived that the project should have focused more on shifting gender and GBV-related norms rather than on the punishment of perpetrators, as the former would have yielded more long-lasting results.

> The objective of the project was to reduce GBV across the country, but reducing GBV doesn't necessarily mean imprisoning 2,000 people. Reducing GBV meant to sensitize, to change perceptions, to change mentalities … If we had been able to do enough trainings, enough sensitizations … we could have achieved a reduction in violence. When we imprison people, does that really reduce violence? Now the project is no longer there to put these people in prison, what will happen? We don't know. —*Implementing partner*

Target Population

EMPOWER aimed to cover the entire nation and had a partner NGO in each of the six project zones. On average, the zones covered two of the country's 12 provinces. Initially, the plan was to contract a total of 12 partner NGOs, but ultimately the decision was made to involve only six. Partners stated that it was logistically simpler to manage six organizations, and they were capable of satisfactorily reaching the entire population. In the end, however, some implementers found that there was less concentrated coverage of project activities in the north since those provinces are much larger. The NGO partners in the north ended up with more territory to cover.

> Originally we planned to recruit 12 NGOs, six in the first year and six more in the second so each NGO would have one region to better assure coverage. It seems that at the end of the first year, CARE suggested 12 NGOs would be too much to manage and that the first six were already carrying out the work well and assuring coverage. That's what I heard when I arrived … I wouldn't have authorized this decision had I been there because I know the problems of north. In the north the regions are very large, so once you take one province, it's huge. Two, three, or four provinces in the south would make up one. So we couldn't ask one NGO to cover all these provinces. I would have said no … But this cut down costs for CARE. —*Implementing partner*

EMPOWER ended up having a stronger impact in urban areas due to the fact that most project agents lived in urban areas.

> We didn't decide to limit the project to urban areas … We trained community mobilizers who served as the go-betweens to higher up agents, but we noticed that even the community mobilizers lived in urban areas, so even though we intended to reach the whole population we ended up reaching urban areas more. —*Implementing partner*

The target population of the project was limited to women and girls age 14 and over. In-country staff found this to be unnecessary and restrictive and did not enforce this age constraint in implementation.

> We talk about 'GBV against women and girls.' I heard when I arrived that a woman from Washington … said that the project was not for girls but more for women, and by 'girl' meaning females under 14 years. So that means that it drew the project a little toward domestic violence between husband and wife. We really wanted to focus on that. However there had been a law already passed on sexual harassment that could have covered girls in terms of GBV. How is sexual harassment of girls not GBV? So I had to insist that we take all that into account all of that. —*Implementing partner*

Implementing Partner Decisions

CARE Benin, as the primary implementing partner, made some recommendations and decisions about how to implement the project such as paying community mobilizers rather than expecting them to perform project duties on a volunteer basis. A major suggestion they made was to introduce the Challenge Fund program in the project. This was a prize-based motivation system for communities to innovate ideas to protect women and raise awareness about GBV issues.

> The other thing that I didn't think ah much of, but I later changed my mind was that CARE had this idea to give prizes to communities … I think that that brought action to the community level … a lot of NGOs stepped up to the plate and did stuff at the community level. —*Implementing partner*

Mid-course programmatic decisions were made in response to the results of the midterm-evaluation. For example, the evaluation pointed to a need for counselors to facilitate the reintegration of survivors and perpetrators into their families and communities. In response, implementers made the decision to involve religious and other leaders to serve this role, recruiting and training these agents in the final year or the project period.

> The decision for the champion program came from the recommendations from the midterm evaluation, which suggested that the support we were giving focused much more on victims and suggested that there wasn't much psychological support. It was suggested that trained psychologists but traditionally religion is valued so we chose people with these values who could easily counsel perpetrators and families. —*Implementing partner*

Design Process Issues

In-country actors perceived that the initial design process did not sufficiently consider the resources and expertise of actors on the ground, and instead relied on the expertise of Washington-based staff. Some implementers found this to be problematic.

> I think the realities in Washington are different than those in country … When projects are designed in the United States they have to be 'tropicalized.' So it's important to associate personnel in the country missions, the local personnel who know the realities relevant to the choice of activities and how to execute them. —*Implementing partner*

Host country national implementers also suggested that their motivations, and not only their knowledge and experience, would make them ideally placed to consult in the initial design of the project.

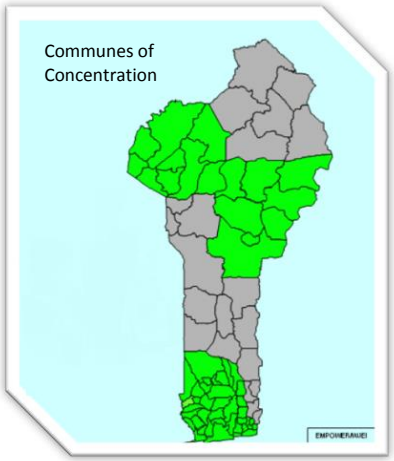
I'm doubly invested, I'm Beninese and so if there is a sustainable change in Benin it's good for me. I also work the US government, and so I would have wanted a more strategic use of the government's resources. —*Implementing partner*

Key Findings: Project Design

- In-country implementers felt that they were under-utilized in the initial design process conducted by personnel from Washington.
- Some design decisions, such as the selection of target regions, were made as part of an ongoing process over the course of implementation.

Implementation

WJEI in Benin (EMPOWER) was implemented in cooperation with CARE International from 2007 to 2012. The project was implemented on a national level, with 56 communes receiving a focused intervention (out of a total of 77 communes). Awareness raising activities in Benin involved multiple approaches including mass media campaigns and community sensitization sessions. The project also provided support to the legal system through advocacy trainings and the promotion of GBV legislation among members of the judicial system and forces of law. Care and support was provided to survivors of GBV though local referral mechanisms of existing government services and local NGOs (the CPS). Later in the project period, community leaders were trained in counseling and reintegration support for survivors and perpetrators of violence.



Project Organization

US Government actors, which included USAID, the DOJ, and the Department of State, worked in cooperation with Benin government agencies including the Ministry of Justice, and the Ministry of Family and National Solidarity. These U.S. and Benin government actors cooperated with the primary beneficiary, CARE International, who contracted six local NGOS, each covering two of the nation's 12 departments, to implement the initiative.

Local referral networks (CPS) were put into place by the Ministry of the Family to facilitate case reporting and care and support of survivors at the local level. CPS agents coordinated with government health care providers, police, employees of the supervising local NGOs, and community volunteers to raise awareness of GBV and related issues, facilitate case reporting, and ensure the care and support of survivors in need.

Awareness Raising

The awareness component of the project engaged community volunteers, traditional leaders, religious leaders, local elected officials, police, and members of the press. The project trained local volunteers called community mobilizers who held education sessions in their communities, spreading project messages, raising awareness of GBV and women's rights related issues and laws, and providing referrals to legal and care and support services. The project also used a multi-media approach in their awareness activities, which included village level sensitization

sessions, radio and TV broadcasts, national celebrations and media events, and trainings of professionals like police and journalists.

Key Findings: Implementation—Awareness Raising

- Community mobilizers were trained as awareness agents and facilitators of case referrals at the local level.
- Mass media campaigns were employed using radio and TV broadcasts.
- Journalists were trained on GBV reporting to get better coverage in printed media.

Legal System Support

The project led advocacy trainings of police, members of the judicial system, and local and national government authorities. Conferences were held for gynecologists and prosecutors on collecting and processing forensic evidence for cases of rape. The project also successfully aided in the promotion of GBV law, which was passed in Benin in 2011 and enacted in 2012. At the local level, police were trained to appropriately handle GBV issues to enhance the services extended to survivors. CPS and community mobilizers made referrals to the police for GBV cases.

Key Findings: Implementation—Legal System Support

- Advocacy led to the passing of the GBV law in 2011.
- Judges and police were trained in the adjudication of GBV cases.
- Doctors were trained to perform post-rape exams and to issue medical certificates attesting to the evidence of rape for legal purposes.

Care And Support of Survivors

The project provided care and support services for survivors, including psychosocial, medical, and financial support. CPS agents in the 56 focus communes were trained in psychosocial counseling and in making referrals to legal, medical, and other services. With the CPS as the focal point, local survivor referral systems of public and private services were able to reach into project communities by cooperating with community mobilizers, who served as additional referral agents.

In the middle of the project period, an effort to train religious and traditional leaders as "Champions" to provide counselling to GBV offenders, survivors and survivors' families and create a safer environment for survivors.

Key Findings: Implementation—Care and Support of Survivors

- Establishment of local referral systems for survivor care and support involving social services, police, health care providers, and other key local actors.

Other Activities

Other activities conducted by the project included the establishment of a national tracking system, which was a database of GBV cases collected with the help the Ministry of the Family. To further encourage community engagement and participation, CARE initiated a Commune of Excellence programs, in which awards were given on a competitive basis to communes that were the most progressive in their efforts in the fight against GBV. Lastly, through the Challenge Fund the project gave grants 15 local NGOs for small projects in line with the goals of the initiative.

Project Strengths and Challenges

Process

Strengths

EMPOWER engaged diverse government and private actors in its implementation at the local level. The level of synergy and cooperation among these members of the local referral mechanisms was heralded as a success of the project by many implementers. Engagement of community members and groups was also applauded by many, as was the training received by community mobilizers.

Community Engagement—The initiative successfully engaged project communities by tapping into partners' existing relationships with community groups and leaders. These included religious leaders, youth groups, and village elders and chiefs. This served to increase community support and commitment the project.

> A strength of the project was the involvement of beneficiaries which allowed it to plant roots in the community. —*Implementing partner*

The Challenge Fund program, which provided small grants to local NGOs, meant that project messages could be powerfully disseminated through already existing relationships with youth, church, and other community organizations. One such religious-based organization worked with their youth choir and local scout troops, and took advantage of sermons to spread project messages:

> We take advantage of mass to develop a theme related to the project. —*Challenge Fund NGO partner*

Synergy and Cooperation—Implementers applauded the project for high levels of multisectoral collaboration, making national level coordination, as well as local referral systems effective. There was an efficient, hierarchical system for project organization for training and implementation.

> The project was well implemented because there was an agent for every level. The NGO is in charge at the departmental level. We began with a training of trainers. Once we trained the trainers, they trained the people. Then there was a MC in every village. In every village you will find an agent to whom you can refer cases of violence. —*Implementing partner*

Implementing partners held periodic meetings to coordinate the actions of members of local referral systems (gendarmes, which are armed police officers, technically part of the military, CPS, hospital, etc.). These meetings helped local actors to assure a continuum of care and support for survivors. Such meetings encouraged good communication and coordination between actors in different sectors.

> Every six months we had a synergy meeting with all of the CPS, the mayor's office, and other actors, to discuss the feasibility and continuation of the project. We were also invited to Parakou for such meetings. —*CPS representative*

Many CPS were able to work effectively as point people for local referral systems, making referrals and coordinating the actions of community mobilizers, health service providers, and the legal system.

> It's the CPS who is in charge. If there is a problem, he knows about it. There is also a committee, so it's not the CPS alone. —*Health service provider*

Community Agent Training—Community mobilizers and other local project agents appreciated the training that they received from regional implementing partner NGOs. They felt that the trainings promoted a synergy of actors, facilitating better care and support of survivors.

> The training of the project agents, health, police, and CPS actors, was a good one. This training permitted us to act in synergy, for example sometimes we would be working in parallel and could collaborate to our mutual benefit. For example, if we were with a victim we would call the chief doctor. With the doctor and the mayor together we would try to see what we could do for the victim. —*CPS representative*

Not only did the training include information on GBV, related laws, and facilitating referral, but they also provided agents with practical skills for communication and conflict resolution.

> What I really liked was in the case of those who beat their wives who we should have severely punished in the field but the project asked us to wait till they become tranquil before acting, so as to be able to bring him to bring him to understand the situation and that really reduced cases of GBV in Kalale. —*Community mobilizer*

Challenges

Lack of support for and motivation and awareness agents—While many community mobilizers were happy with the initial trainings they received, at least as many were less than satisfied with the follow-up trainings and in-field support. Some suggested that there should have been refresher trainings and more follow-ups on the ground from project coordinators.

> Since our training we've met a few times but there should have been visits so that we could share our difficulties because we are not paid. There was even dissatisfaction in our ranks. —*Community mobilizer*

Community mobilizers bemoaned an under-budgeting of transportation costs, which often discouraged project activities in hard-to-reach areas.

> If there had been funds we would have been able to do more. I had to get around on my bike, there was really a lack of funds for transportation to go into other villages to sensitize and address cases of GBV among the Peulh ethnicity because it's only me who did everything among the all three ethnicities in the area. —*Community mobilizer*

Local agents often had to pay out of pocket for survivor care costs. There was also no money in the budget to motivate community mobilizers. The lack of fund combined with the difficulty of the work affected the motivation of awareness agents. They often discussed low morale in their ranks as they felt that they had too many people to cover and many faced resistance to their work.

> The work is difficult so in the end it's the passionate ones who are left … for example in this town there were two of us, but the other quit in the end because he became discouraged, so I find myself working alone now. —*Community mobilizer*

The lack of funding also made community awareness agents feel that their work was not appreciated. Community members and leaders suggested that pay for community mobilizer should have been included in the project budget. However, among implementers the feeling was different. One suggested that the selection process might have been responsible for the lack of motivation, and that the right community members were not selected.

> The community mobilizers weren't paid and they shouldn't have been. The NGOs made this decision, which was validated by us. They shouldn't have to be paid, but we had the problem of complaints because the mobilizers weren't selected well. They should not have been graduates unemployed and looking for work. They should have rather been village teachers, CPS agents, police, somebody who was already working, and someone who already had an income and was interested in protecting women's rights. —*Implementing partner*

Incomplete Geographical Coverage—Due to the transportation difficulties and the low ratio of personnel to large geographic areas, the project faced barriers in getting out its messages and intervention. Many participants suggested that there were too few agents covering too much territory, particularly in the north and in rural areas.

> In this area there are no reception centers until you get to the departmental capital. In the south there are such centers, but not here and it's not good. —*Police chief*

Community mobilizers were well distributed, but the facilitators who supported and managed them were often responsible for multiple communes. Many partners suggested that it would have been better to have one facilitator per commune.

> The number of facilitators was limited. The first year I was responsible for three communes, starting in the second year, I was responsible for six communes. It was humanly impossible for me to manage it. It was the entire department. That made it such that the activities in certain places were underemphasized. —*Implementing partner*

Project offices and services were concentrated in areas of higher population, and there were only limited services available at the local level. This produced barriers to accessing care and support in smaller or more isolated villages.

Communication and Coordination Deficits—Better communication channels were needed between agents involved in the project (e.g., free unlimited calls). The difficulties in coordinating actions at the local level were attributed to the lack of easy communication. Some felt that the involvement of the CPS and other government institutions was problematic because they were inefficient and their workers were not motivated to truly lead the project with enthusiasm. Police also reflected that communication between the local referral agents and their office had been too slow. In some cases, it often took days for the police to be informed of a case.

> The project was a little slow in giving information. Sometimes we would wait three or five days before we were informed of a case. They had problems with communication means. As soon as were are informed we would be on site, but we can't do that if we're not informed. —*Police chief*

Types of Violence Addressed—Many participants perceived that the project was limited in that it typically only addressed violence against women in it messaging. Others viewed that it was

limited in addressing physical rather than psychological violence due to lack of resources to address the latter, as this implementer discusses.

> In this context it is difficult to have the means to evaluate emotional violence … So in reality we were a little limited in Benin to observe and address this type of violence … Typically in Benin we don't go talk to a psychologist or psychiatrist to note mental or physical pain. There isn't the means in Benin. But what is visible is physical violence, sexual violence. When there is a rape everyone can notice it, a doctor can attest to it. When there are cuts or bruises it's easily visible. So the project really went in that direction. —*Implementing partner*

At the community level, a lot of resistance to the project was due to men's frustrations with the sole focus on women as survivors. Many wished the project had considered men as potential survivors as well.

> Violence isn't only perpetrated against women, there are also women who are violent toward men. We should have talked about violence of men by women so that there would have been more of a balance. —*Male community member*

Government Engagement—Though the project engaged decentralized government services, some participants expressed that there could have been better involvement of the government at the national level, as such support would have bolstered the project and its actors.

> I would have hoped that the project would have been able to better involve the Ministry of the Family, to have better support from the State at the federal level. —*CPS representative*

On the other hand, some project sites may have benefited from greater involvement of local officials since this would have increased the acceptability of project messages. Local officials in some sites may have even acted against the project by their opposition to the enforcement of GBV laws.

> A major issue was the resistance of the population, the resistance of local elected officials who are thinking about their next election. They don't want the population, men, to be angry at them because it's them who will vote for them, so elected officials would hide cases of violence. —*Implementing partner*

> For political reasons, there are deputies of the National Assembly who categorically oppose the sanctions against perpetrators of GBV because of the coming elections. —*Community leader*

Perhaps better engagement of local leaders in the project at the community level could have reduced these issues, as this community member suggests.

> I would ask the managers of the project to respect the realities of the context because they come and impose their programs and activities that the population doesn't appreciate so they assemble the population to get their advice for the success of their project. They go to town hall or to the police station to impose their programs without the advice or the impressions of the population. —*Male community member*

Key Findings: Process

Strengths and Successes

- There was good cooperation between USAID, DOJ, and State Department, largely due to a liaison housed at USAID.
- Community members and organizations were effectively engaged.
- Collaborative processes and local referral systems encouraged synergy between actors of different sectors at the national and local level.
- Implementers provided effective training to community mobilization agents in awareness raising and referral of survivors to appropriate services.

Challenges and Limitations

- There was insufficient ongoing monitoring and support of community mobilizers in the field.
- Due to access related issues, there was often unequal coverage of the project target area, particularly in rural places.
- Communication at the local level was often hampered.
- Community expectations about the types of GBV to be addressed did not always coincide with what addressed by the project.
- In some project areas there was insufficient engagement of local leaders, diminishing the efficacy of awareness raising and case reporting.

Awareness Raising

Strengths

Attitude and Norm Changes—Participants nearly universally acknowledged attitude changes toward GBV in their communities. Often these changes in attitudes were reflected in a reduced number of GBV incidents. Women noted that men behaved differently toward them.

> When I think about behavior in my community regarding forced marriage, female circumcision, violence in couples, before the project came men declared themselves chief of the family and his wife and daughters were his property. So men thought they had absolute power over women to do with them as they pleased, but since the project came and sensitized, even though there are many who have been punished many have understood that we can't be violent toward women without being punished. Attitudes have really changed. Before imams would marry children, but since they've been involved in the project you don't hear about it anymore. —*Male community member*

Community members talked about how they had personally changed, one saying that she now knew that she couldn't marry off her child without her consent, something she had learned from the project.

> With the project's activities the population has understood that it's not good to beat a woman, forced marriage, and child trafficking. —*Female community member*

In some instances the awareness messages faced resistance, but implementers understood the slow process through which cultural practices changed. Some changes in cultural norms around the discussion of violence were noted.

> The project questioned a lot of habits. Even though there were critics, people couldn't help but think about the project, but it's not easy for people to understand such issues. It's with photos, documentaries, testimony, people living with wounds, psychological and physical wounds, that people can notice and understand that that such situations exist and join

> the fight. The project enabled people to express themselves on the question of violence, to express experiences they were living, subjects which are taboo. —*Implementing partner*

While many men disagreed with the aims of the project, some expressed having come to understand the project's merit and the merit of the laws and punishments accorded to perpetrators of GBV.

> EMPOWER came to help us understand the laws protecting our wives. Little by little we have come to understand that these laws are a good thing and it was out of ignorance that we hit our wives without knowing that we were in the wrong. A man is nothing without a woman, a family cannot flourish without a woman. —*Male community member*

Effective Messaging—The project was successful in employing diverse communication strategies, which led to high levels of awareness of the project's services and GBV laws. Survivors became more aware of reporting and support resources. Changes in attitudes toward GBV were primarily attributed to two aspects of project messaging by participants: a focus on laws and punishments for GBV convictions, and a focus on women's rights which gave them the courage to report cases of violence.

> Men understand now that they are in fault after the act. Women know that there are laws that protect them…It's the information, the meetings held and the diffusion of information by leaders and community mobilizers … All the population knows that today GBV is punished. —*Community mobilizer*

This awareness of GBV laws and women's rights instilled fear in men and provided a motivation to avoid perpetrating violence. Many participants voiced a fear of consequences or reflected that this fear raised consciousness among the population and reduced cases of violence.

> Those who commit such act will say to themselves, 'I better watch out, there is a project that punishes these things.' It's no longer the collectives that deal with the case but the victim goes to the police or social services. —*Community mobilizer*

> Today when you want to force a little girl into marriage there are people who will prevent it, even within the family. People have begun to understand and they are afraid to marry their daughters of at a young age now. —*Community mobilizer*

Challenges

Limited Population Reached—Some participants were unsure if project messages had sufficient reach in their communities. Most awareness raising was in medium sized gatherings of 20 to 40 people. Though there were local radio spots, many actors felt that the project should have taken more of a national-level mass media approach. Some suggested more targeted techniques, such as door-to-door education.

> The sensitization wasn't well done. It doesn't suffice to go on the radio, you have to think about how many people listen to the radio, how many people listen to the shows? It would have been better to go door to door or to organize neighborhoods for sensitization meetings. —*School principle*

> Since the start the project had mostly small sensitizations of 20, 30, or 40 people. There were also spots on local radio stations. So this limits the information to the locality. I would have more likely chosen to do spots on national station that cover practically the whole country. —*Implementing partner*

Many participants noted that the awareness activities did not reach isolated rural communities. Mobilizers were typically responsible for multiple villages and project facilitators were typically located in larger towns. This resulted in less exposure for isolated communities. Community members wondered if residents of smaller communities were even aware of the project or that GBV was not a normal part of life. They suggested that isolated rural areas be a focus in future programs in Benin.

> Many ethnic Peulh are illiterate as they didn't go to school so not the entire population benefited from our sensitization sessions on GBV. Also we should have held sensitization sessions for each age group because there are a lot of problems among women that they don't like to reveal to elders. —*Community mobilizer*

> I would do a lot more sensitization, especially in the most isolated villages so that everyone can be informed to eradicate GBV in the community . . . We did sensitization but it was insufficient, the sessions didn't reach all the villages, but it's in the villages where people are not informed about the law. —*Community mobilizer*

Negative Community Reactions—The major cultural shifts the project attempted to influence created issues in many areas. Some participants suggested that gender equity was culturally impossible. Participants reflected on a cultural disconnect between project values and community values, as it was difficult to enforce laws in certain communities where leaders are adamantly against the legal repercussions advocated by the project. Some participants found the prosecution of perpetrators to be overly emphasized the project.

> It's important to be clear that though it's true that we are equal in the eyes of the law, but culturally speaking that's not possible. It's important to take into account certain cultural factors such as the fact that men are the heads of families as God intended. —*Male community member*

Community mobilizers often met hostility in their work. They endured anger from both men and women in communities for helping to put people in jail. As a result, there was initial mistrust of community organizers. In some cases this led to wariness toward mobilizers, and many people criticized them for their work.

> We are seen badly in the community even though we are working for the wellbeing of everyone. Even certain women reproach us for imprisoning their husbands. It bothers us but it's doesn't stop us from acting against violence. —*Community mobilizer*

> I'm considered a crazy person in the community. —*Champion*

It was difficult for mobilizers to engage a community when its leaders were resistant to the key messages of the activity. They indicated that the project needed better engagement of local leaders from the start, to facilitate the work of community organizers.

Negative Reactions From Men—Men were often upset with the project, as they perceived that its focus was only on women's rights and not men's, assuming women to be the only survivors of GBV. Some found this to be imbalanced.

> The project should talk about men's rights as well, why is it only women's rights that are talked about? —*Male community member*

Many expressed that the project's intervention made their wives unruly, upsetting traditional values.

> Since the project came our wives know that we can't touch them anymore, they have become arrogant. So I hope that in the same way that the project was able to promote the rights of women, that they remind themselves likewise of their duties toward their husbands. —*Male community member*

Key Findings: Awareness

Strengths and Successes
- The project succeeded in transforming normative changes pertaining to gender roles and GBV.
- Project messages were particularly effective in highlighting women's rights and raising awareness of GBV laws and punishments.

Challenges and Limitations
- The project often failed to reach people living in more remote areas.
- Men needed to be included in the focus of the activities, which would have mediated their reactions to the project and instead engaged them in the process of cultural change.

Legal System Support

Strengths

Many actors viewed the new GBV law that was passed in 2011 as a milestone in Beninese legislation, and as the major success of the project. Some actors and community members also appreciated the legal enforcement promoted by the project.

> When somebody commits a crime, he is taken immediately, and the victim is taken care of. The sanction that is imposed is a good thing. —*Implementing partner*

> When the project hears about a battery, the perpetrator is sent to prison. When someone hits their child, they are sent to prison. That's what gives this project power, is the fact that people are sent to prison. —*Community leader*

Case Reporting—Participants reported that the project had helped to increase reporting of cases of violence, particularly among women. Many felt that women had much more courage than before to denounce and report cases of violence.

> When women are victims of violence, they didn't know where to go, but today they know that there is this project and they go quickly to find help there. It's a positive change. —*Religious leader*

> Women aren't afraid anymore to report to EMPOWER, they are exercising their rights. Today once you start to mistreat your wife, your neighbors will start to warn you 'be careful or the

> people from EMPOWER will give you your due! Even if the woman doesn't want to report the case, her friends will urge her 'go see EMPOWER, they will save you,' and she'll go without hesitation. —*Male community member*

As communities embraced formal legal adjudication of cases, within-family or clan reconciliation of conflicts seemed to have decreased.

> Thanks to the project, now when a girl is raped, we don't settle it informally anymore, we report it to EMPOWER and the perpetrator is punished. When a woman is beaten by her husband, she doesn't wait anymore; she doesn't hesitate to report him with the project. —*Female community member*

> It's no longer the collective that takes care of the issue but the victim who goes to complain to the police, to social services. —*Implementing partner*

Threat of prosecution as a deterrent to violence—The combined awareness of the law and women's newfound courage to report GBV cases contributed to reduction in violent incidents in the view of many participants.

> Before there was not a day where we did not talk about cases of GBV in the commune but after the arrival of the project until today cases like beating of women has considerably diminished and you don't hear about it like before…Hoo! People are so afraid today to hurt their wives and to mistreat their children. As I just said, beating of women has gone down. —*Male community member*

Women, too, spoke of changing their behavior, particularly toward their children, fearing the repercussions from breaking the law.

> They have said there will be no more forced marriage. If your child brings you a man, you have to accept him to avoid forced marriage. There are no more cases of GBV, especially cases of forced marriage … People are afraid to commit cases of GBV now. I will certainly stop myself now. —*Female community member*

> When you beat their child until they bleed you are taken to the police, so when we think of EMPOWER we are afraid to beat them, and so we thank them very much. —*Female community member*

Challenges

Cultural Barriers to Law Application—As with the project's awareness activities, cultural issues again posed a barrier to the project's legal interventions. Community members often viewed that formal reconciliation too often led to divorce and difficulties for the children by disrupting family structure. Many felt that the laws put in place were not in sync with the culture and the punishments were too harsh.

> The government has already enflamed the country with this law which reduces men. The laws should be reviewed; they have no link with violence. Europe and Africa are not identical. Women don't respect tradition anymore. —*Male community member*

Individual resistance to GBV laws and program messages were nearly always explained by cultural norms. Men viewed themselves to be the heads of households and felt that their losing the power of physical punishment would be a detriment to the entire family unit.

> The project has taught us that men and women are equal in the eyes of the law, but what bothers me is the fact that a woman can report her husband to the CPS or the police. That I don't agree with. If you do even the slightest thing to your daughter, she tells you that the project said not to touch girls. You can't have a daughter and not be able to hit her if she misbehaves. You don't have to hit her violently but you need to punish her in any case. —*Male community member*

Because of the cultural controversy over the project's principles, it was often difficult to coordinate even among members of the local referral systems because they often disagreed on the issue of separating couples by sending the perpetrator to jail.

Resistance to reporting violence—While some embraced legal resolution of crimes, many community leaders and members expressed distaste for full enforcement of the law. As mentioned, many viewed that the police's way of dealing with perpetrators would disrupt family structure. For these reasons people often avoided reporting incidents.

> At the police station there is brutality, but we are not obliged to apply the laws. In my opinion the police lack delicacy, they always send people to prison, but we don't need all that. The father of a family just needs a little help in the right direction. The way the police deal with cases only leads to divorce. —*Local leader*

In the eyes of community members, many cases they referred to the gendarmes were not handled properly. This was based on the fact that legal intervention too often leads to divorce, which is culturally highly undesirable. Some participants were concerned that after the project closed that case reporting would become more difficult without protection of project agents.

> Once the husband goes to jail the woman is left alone with her children. When he gets out they will divorce and tell his children that it is their mother who sent him to jail. —*CPS representative*

> If the project doesn't come back people will start to disobey the laws, they'll say it's over, whose going to defend you women now? —*Female community member*

This resistance to reporting led to persistent informal reconciliation despite knowledge of GBV laws and the consequences for breaking the law. In many cases survivors themselves continued to want to settle the issue in the family.

> The law is not well applied, in some cases people informally reconcile the issue in the family because after all there are children. —*School principle*

Police difficulties—There was a general resistance to police intervention in all participating communities. Some viewed that the gendarme way of dealing with perpetrators is too indelicate. More often people were discouraged with the slow and inequitable case processing and corruption that they had come to expect from the police.

> Among the police there is corruption and abuse of power and their intervention only leads to divorce. Traditional resolution is better. —*Male community member*

Many noted slow processing of cases with the police and that only those who could pay were able to receive expeditious treatment by the gendarmes. Many survivors were discouraged by the difficulties they encountered with the gendarmes and abandoned their cases.

> People are dissatisfied. Often a case takes a long time to be processed and victims become discouraged. —*Female community member*

> I support the punishment of perpetrators, even if it's the president of the Republic, because sometimes be judge the status of the client. Most often it's the poor who are punished. —*Community mobilizer*

> If it's the child of the chief who is the victim, for example, we can't hide the situation. On the other hand if it's the average child the case might be forgotten. The chief knows his rights and can educate his child. If you take an illiterate woman, for example, who doesn't know her rights, she might not have justice. —*Male community member*

These difficulties were often attributed to corruption among the police.

> We're in Africa and money talks. But in the case of poor women, poor villagers, you are told to come back over and over again and in the end your file is sent. If you have money your case is dealt with quickly but otherwise, you are out of luck. —*Male community member*

Implementers felt that the corruption among the gendarmes made it very difficult for cases to be dealt with proper justice in a timely manner.

> Often police will try to address cases of violence to settle them informally, which isn't always the best resolution. There is a problem of corruption. Often the perpetrator will pay the police officer so that the case doesn't make it to court. Even if the officer isn't corrupt, he's also an African man who doesn't think a woman should report her husband. He tries to discourage the case. The same could be said of magistrates in some cases. —*Implementing partner*

In some cases, local project agents were sympathetic with community member's inclination to informal reconciliation, and facilitated these processes. Some participants noted and appreciated the light enforcement adopted by the project in certain areas.

> Since the project came cases of GBV have gone down a lot. Men and women have found peace … People aren't necessarily imprisoned; it's after investigations that sometimes people are put in prison. —*Female community member*

Some participants said they would rather have cases be handled by the NGO, not the police. They expressed that they would desire to avoid reconciliation in legal settings but try to have it done with project personnel in the local project office.

> For the project's success they should have avoided taking people to the police because the Bariba don't like the police at all. The project should have made an effort to settle cases at the project office … otherwise all you'll get is many cases of divorce related to violence. —*MC N'Dali*

Key Findings: Forces of Law

Strengths and Successes
- Many women were able to receive support from the project to report cases of GBV to the police.
- The project was instrumental in the promotion and passage of a GBV law.

Challenges and Limitations
- Community members viewed that police treatment of perpetrators was heavy-handed
- Case processing was often very slow.
- Due to perceived corruption, survivors were often discouraged and dropped cases
- There was persistent informal reconciliation despite police sensitization.
- In many communities there was resistance to formal case reporting as many viewed that incarceration disrupts family stability.

Care and Support of Survivors

Strengths

Implementers noted a strengthening of existing government services through provider capacity building. Survivors were aware of services and points of contact, and community members expressed trust in project agents as survivor advocates.

Reduction in GBV Incidents—Most participants noted that the level of GBV in their communities went down. Implementers noted the same, as the saw cases they received waned from the beginning of the project to the end.

> Before each week I had at least 12 to 15 cases and now that has gone down thanks to the project because of the sensitizations. —*Implementing partner*

> At the beginning of the project we received about six cases a month. Now we might go a month without receiving a case of GBV. This indicates that GBV has diminished. —*Community mobilizer*

Women also observed changes in men's violent behavior.

> Men don't hit their wives like before, they tread carefully, there is no more brutality. When I do something which irritates my husband, he doesn't react as he did before, he tries to be understanding. He says to me 'I don't want to go to the police station because with your project that you have going that's where you bring people.' So I think they are afraid now. —*Female community member*

Community members further noted a marked reduction in forced marriages and child trafficking. Participants attributed this reduction in violence to people's awareness of GBV-related laws, women's right, as well as project services for case reporting and support for survivors.

> My daughter was being mistreated by her husband. I talked to my friend about it, and she talked to me about EMPOWER, telling me that if I approached the project my problem would find a solution. I didn't hesitate to go to their office and today my daughter is exercising her rights thanks to EMPOWER. —*Female community member*

> After the project, cases have gone down a lot because people know now that women are protected by the law. They know that if they do certain things they will be put in prison if they don't want to have to run away from town. —*Community leader*

Survivor support—There was a high level of trust in project and its agents as supporters of survivors among community members. All were aware of the project's care and support resources.

> The CPS takes care of victims of student pregnancy, they give them food, school fees, and they help them be trained in apprenticeships. For all that we thank them very much. —*Female community member*

> When you go to the CPS you will see cases of students who have dropped out because of unwanted pregnancies who have recovered thanks to the CPS and are now learning crafts to have a career. There were even some who had left school in Middle School but who have now returned to school and are now in High School. —*Male community member*

At some project sites there were funds for professional training, though this may have dwindled toward the end of the project. Some community members noted that the project's effort to improve the economic power of women in the community was among the most important activities in getting at the root causes of GBV.

> We were given loans that give us financial freedom and allow us to deal with family financial issues. Because of this the little problems I was having with my husband have diminished and I have more power in my relationship. —*Female community member*

> Thanks to the small loans given by the CPS, women became financially independent and no longer depend entirely on men. If more women do this men will no longer view themselves as the supreme masters of their households. —*Religious leader*

Challenges

Survivor Support—Though there may have been some funds available for the physical care and support of survivors, implementing actors noted a lack of integrated care and support. Referrals were a barrier to continued care as medical certificates were only available in larger towns. There was also no housing for displaced survivors.

> One weakness of the project is the holistic care and support of victims. Our mission was to fight against GBV, so we had to begin by increasing denouncement and reporting. So the population adopted the attitude of denouncement. Women who before had been afraid to report battery began to do so. But once cases are detected, how can we assure their care? That was the problem the project had. We were able to do certain things, but in my mind it was insufficient, especially when it came to rehabilitation —*Implementing partner*

Obtaining funds for medical care was an issue, as it was often difficult to exact money from perpetrators or the project. Though there was a fund to guarantee free medical treatment and certificates for survivors, this did not work throughout the country. Because many costs were initially covered out of pocket by survivors, their families, and project agents, medical referrals, especially to far away cities, proved to be a major barrier to continued care.

> Once there is a rape we send them to the health center, but we don't have the funds to help them at that point. There are cases when the perpetrator is arrested but there aren't funds to get the medical certificate to prosecute the case of rape. —*Community mobilizer*

There was a lack of housing for displaced survivors, as the project was unable to give financial support or housing to women and girls. Some participants believe this would deter women and girls from leaving abusive situations because they were unsure about where they could go. Many implementers urged that future projects think about how to reintegrate women who are ejected from their husbands' homes.

> There should have been centers to receive female victims for short periods before they could return home … We had volunteer families who received girls for us. —*Implementing partner*

> Once a woman complains about her husband it's difficult to reintegrate her into her household because it's as if she has revealed the family's secrets. So the husband says to himself, I can't have you as a wife anymore. So how do we reintegrate these women into their households? It's a big problem. —*Implementing partner*

Despite some apprenticeships and other resources at the beginning of the project, many implementers reflected that not enough attention was given to women's financial needs. They felt that financial independence would give them power in their relationships and reduce the incidence of violence.

> There are women who are in need of small enterprises for income. A woman who is constantly the victim of violence because she has not economic power to be independent needs a small loan to start a business. But the project's budget didn't allow for the funding of such activities. —*Implementing partner*

Some participants suggested that future projects work on giving small loans or other financial support to women to help them to start income generating activities. This participant felt that gender-based projects would never succeed reach their ultimate goals as long as women were dependent on men for financial support.

> It would be good if the project could associate a micro credit to help to create women's groups … That would be important because their financial dependence on men is an issue. If it's men that have to do everything, they become all powerful … so if a woman can work to contribute to the family income, that will give her freedom. —*Police chief*

Health Care Provision—Health service providers often didn't know how or to whom to make referrals. In many cases, it was understood that referrals should be made to the CPS, but there was no organized mechanism for making it. Even if a referral was made there was no way for the health care provider to follow up with the patient. Service providers often felt that their ability to provide general support for survivors was limited to same-day care.

> All we do is provide them with medical care but I don't know where the money comes from. Medical certificates are free for all I know. If a woman needs a referral sometimes doctors will help them to pay for transportation, but otherwise if they don't have any money there is nothing to be done. —*Community mobilizer*

Though there were some funds available from the project for medical care, it was sometimes difficult to access these funds or to make perpetrators pay for care. As even basic care required by survivors of violence can sometimes involve referral, fees became a major barrier to survivor care.

> It's us who pay all the fees with our own money and then collect the money from the perpetrators, and some buy us gas for transportation. Otherwise there are no other funds for the care of victims. —*Community mobilizer*

Medical Certificates—It was difficult for survivors to obtain physical exams and medical certificates certifying rape for legal procedures. Due to transportation and medical fees, many women were deterred from obtaining these certificates, preventing them from pressing charges. The lack of money upfront for medical certificates and healthcare sometimes disrupted the legal process.

> Sometimes we send victims of rape to the health center and it's difficult to get the money to help them. There are cases where perpetrators are arrested, but there are not the funds to get the medical certification of rape. —*Community mobilizer*

> We are ready to provide medical certificates, but the law doesn't allow for them to be free and for many victims poverty is a problem. —*Health service provider*

Key Findings: Care and Support of Survivor

Strengths and Successes
- The project was successful in reducing GBV incidents, as reported by participants.
- Project actors successfully assisted survivors in reporting cases to the police.

Challenges and Limitations
- Implementers noted a lack of sustainable financial support and housing to survivors.
- There was a lack of funds and transportation to help survivors obtain medical care and medical certificates for case prosecution.

Sustainability

The Ministry of the Family and National Solidarity was heavily involved in the project both at the national and local levels, most notably involving its CPS agents who remain in the public service after the project. Police, health providers, and other permanent government employees trained by the project also remain in place.

NGOs involved in the project were no longer funded for project activities, and had yet to secure other sources of funding to continue these and similar activities. There had been no commitment in funding by the Beninese government to continue the activities of the main phase of the project (i.e. local referral systems). On the other hand USAID-Benin attempted to implement a one-stop-shop model during the six month no cost extension period. The Beninese government had committed salaried government employees such as health personnel to operate these centers.

Operations Sustainability

Implementers primarily discussed funding issues as they found that many project activities, especially those providing services to survivors of violence could not continue without some source of money. Further, even though community mobilizers had worked on a volunteer basis during the project, implementers found that lack of a small funds for transportation and other costs related to their activities would prevent them from working in the same capacity after its end.

> The project objectives are met, but they must be reinforced to be sustainable … Mobilization is no longer the same and the actors on the ground no longer do their work as is needed because when the project was there, they had some funds which allowed them to do the work, and now that the project is gone the funds are gone, too. The CPS continues to receive victims but the care and support services are not the same because the project isn't there anymore. —*Implementing partner*

One implementer suggested that the WJEI should have negotiated with the Beninese government before the project began to ensure that there would be state funds to sustain it. They suggested that this could have been done by ensuring that women's promotion and prevention of GBV was a government priority.

> We did everything so that the Ministry could put aside a small part of their budget … to support victims of violence with these funds … If it had been in the initial negotiations with the government, they would have respected this idea … We needed to bring the government to realize that [GBV] should be a priority … telling them that if women are beaten and weak, they can't contribute to the development of the country … I think we need to negotiate in this sense. If we don't do this projects will end, objectives will be met, but the effort will disappear because it won't be a priority for the government. —*Implementing partner*

On the other hand, another implementer argued that it would be difficult to sustain project activities with government funds even if an agreement could have been reached, because the resources of the state's budget are often not comparable to project funds.

> The resources in the state's budget aren't the same as those of the project and aren't enough to ensure that activities continue as before. If it had been possible to find other finances or governments funds within the Ministry of Health that might have worked but unfortunately that was not the case. —*Implementing partner*

Government agents involved in the project also commented that there might be flexible funds available at the local level, which could be used to continue providing services to survivors, but that it was unreasonable to expect the majority of CPS offices to do so. They explained that government employees have high levels of local turnover and so many new agents in project areas were likely to have not received training or other contact from the initiative.

> There are funds for the management of CPS and these funds can be used to support victims … but it's unlikely that every CPS will continue to do so. Not all the country's CPS agents benefited from the projects trainings. —*CPS representative*

Comments made by implementers reflected what they found to be a delicate balance in ensuring project sustainability through a joint dependence upon NGOs and host government agencies. They explained that as NGOs' activities are typically difficult to make sustainable as they

continually need external funding, while government agencies have sustainable funding but they lack the level of personnel found in NGOs. Some implementers found that the planned one-stop-shop centers would be able to ensure both sustainable government funding and sufficient personnel.

> The problem with this type of project is sustainability … If you work half with NGOs and half with government personnel and it works that's great, but how do you work effectively if you can't trust the government and since it's always difficult to have sustainability with NGOs? When NGOs have personnel, they work well. On the other hand the government doesn't have sufficient personnel and most of the time it's difficult to establish new programs with them. So that's a big success for the sustainability of the new centers, the government employees involved are already paid, and there has been a decree putting them at the disposal of these new centers. —*Implementing partner*

Despite optimism over cooperation with the government in these new centers, some participants were less enthusiastic over collaboration with civil servants in general.

> Your salary as a civil servant in theory is a result of the service you provide, but I have the impression that as a group we don't have the organization and professional conscience to do our work well … If you take a chief CPS, he's a lone individual. He plays the role of the manager, the coordinator, and the chief of post. He's responsible for everything that happens in the center; he's alone, and thus he is limited. —*Community facilitator*

Other participants further reflected on the low level of professionalism among civil servants and difficulty with their reliability in some communities due to lack of supervision. Some suggested that because of these difficulties it was typically necessary for projects to rely upon NGO actors as well despite the fact that government actors in theory could be contracted for free.

> Before people had no idea what their CPS did. But today when you say CPS, at least people associate it with violence against women and girls … but this needs to be reinforced. They need to be supported to ensure better sustainability … Government structures alone can't do the work. Civil servants' professional conscience, the manner in which they work is not the same as everyone else. Their tools and manner of conducting monitoring, quality assurance, it's not the same with them. The level of professionalism is not the same. Some will leave their office for the day at 1:00 p.m. Nobody knows if he's at his office or not. So you must reinforce their capacity but you must also involve diverse actors to ensure the care and support of victims. —*Implementing partner*

Some suggested it was because some civil servants had been given money for their participation in the project that weakened the sustainability of project activities, as their motivation to continue these activities was weakened in the absence of this financial motivation. This implementer felt strongly that after the project government employees were no longer willing to work now that there is no more project funds.

> "What's left of personnel who were involved in the project who are still working? Well, it's not clear. The personnel were recruited for the project and when there is no longer money to pay them … they may even leave. During the project I told people 'stop organizing meetings where people need to be paid to attend, use government facilities.' If that were the case after the project the habits and the motivation would remain the same, they would have

> continued to meet. But as always we had the problem of excessive financing for certain activities of the project, such as meeting. CARE systematically paid everyone … for transportation … to the point where no one will go anywhere unless they receive some money … If you make a habit of paying, you'll be stuck paying … so at the end of the project everything stopped … there are no more services to victims … high level synergy meetings are no more because civil servants were used to being paid every time. On the other hand ICITAP [of the Department of Justice], who worked with the police, didn't pay them anything at all! —*Implementing partner*

> Synergy meetings which should have taken place in each department, certain departments aren't able to do this as frequently … because before transportation to the meetings was paid by the project. —*Implementing partner*

Aside from considerations of civil servant professionalism and the difficulty of contracting and working with host government agencies, it became difficult for CPS agents to continue project activities, such as survivor support and case reporting facilitation, due to the fact that they didn't have the support of NGO project facilitators.

> The CPS often now works alone now that project agents are not there. Community mobilizers are not numerous, either. —*Implementing partner*

On the other hand, community mobilizers who had worked on a volunteer basis shared that they had continued their activities in the community.

> The effects of the project will last because we haven't stopped working even though the project is over. We continue to sensitize. Even if there isn't really much money, the CPS is willing to continue to work with us with the funds that are available. —*Community mobilizer*

> The project is over so we are left asking ourselves, can its actions last? I think yes, as long as we are on the ground, the mobilization continues. —*Project facilitator*

Community mobilizers also viewed that their own motivation and that of their peers to continue to spread project messages and aid survivors or violence would remain the same.

> People will want to continue to work because it's a good thing … when you want to see the advancement of your country you have to want to keep working. —*Community mobilizer*

In contrast, some project agents viewed that in the absence of project facilitators who managed and supported these community level agents made for reduced motivation.

> Before everyone worked together cohesively, but after the project it's not the case … Our activities haven't continued. —*Community partner*

As community mobilizers were not paid for their participation during the project, it makes sense that their motivations would not have changed, as some explained. However, other community mobilizers and those who worked with them at the community level emphasized the need for follow-up with these field agents for sustainability of the project, suggesting that if there could be continued trainings and meetings with mobilizers that this would help to keep up their motivation.

> When you're not sick and not yet well and you stop to take care of yourself, the sickness comes back again. In the same way it would be difficult to continue this work without periodic sensitizations sessions and trainings. Perpetrators of violence still exist and once they sense the project letting up they'll just start again. Many of us have stopped to work because they get nothing in return … During the project we were always in the field … We're still supported by the CPS, and they do their best, but they need help they lack personnel. —*Community mobilizer*

> There are no more training for community mobilizers, which means they are no longer motivated… —*CPS representative*

Awareness Sustainability

Many participants viewed that the awareness raising around GBV at the community level brought by the project would be sustainable, as knowledge of women's and survivors' rights would not be forgotten. They viewed that this continued knowledge would ensure the continuation of case reporting and women's resistance to suppression of their rights pertaining to GBV.

> It's the project that helped women to know their rights and where to go when their rights are threatened. It's as if women were liberated, so they will never again accept to be raped without consequences … it's a permanent change. —*Religious leader*

Others also emphasized that the new awareness of the CPS's capability to help survivors of violence would contribute to continued case reporting.

> We understand know and we can't go backwards … We will not stop to report cases even though the project is finished … The CPS is there for us, we know it now.
> —*Female community member*

> For the moment the change is still there even though men know that the project is over. They can't practice GBV like before when there wasn't a structure to address it.
> —*Female community member*

Some attributed this permanence of knowledge to the law, and viewed that the law would assure permanent change at the local level.

> The laws are written and will be there forever. All has been explained to women from the youngest age and you hear women telling their daughters to not let themselves be teased by a man. —*Male community member*

> There have been punishments and by the sensitizations people know that there are laws against GBV. Certain people have understood and others not. —*Community facilitator*

Many viewed that the decreased level of GBV perpetration that was observed in project communities would continue because people, especially men, would continue to be afraid of the punishments incurred by perpetrators of violence. These punishments were publicized and heavily enforced during the project period.

> The project is sustainable because the fear of being punished is really embedded in the community. —*Community mobilizer*

> People still sense the presence of the members of the project and they are afraid of that. —*Male community member*

> When you plant a tree it continues to grow on its own. People are afraid to perpetrate cases of GBV now. —*Community mobilizer*

Some community level project agents said that people did not seem to know the project was over, so the fear of punishments for committing violence continued.

> Everybody in town knows that there is this project and when you do wrong the project and its actors can bring you themselves to the police station! So in a way people are afraid of the project. When you say EMPOWER, they are afraid. People don't know that the project is over … so they are still afraid. —*Police chief*

While many participants thought that awareness and fear of GBV perpetration would last, others stated that awareness and lasting behavior change around GBV would need more time.

> You must continue to sensitize in the long term to truly change people's habits. —*Community mobilizer*

> If we abandon efforts right away, violence could return because society forgets very quickly … It will require more time for every level of the society to fully accept these principles. —*Male community member*

Other participants found that the coverage of awareness efforts had not been sufficient, making sustainability of project messages difficult.

> Now that behavior change has begun, we can't stop mid-route … continue to help people to understand rights because all of this is a result of rights. We don't know where the resistance lies. —*Implementing partner*

> Sustainability will be difficult because of the lack of mass sensitization of the population. —*Community leader*

While most women predicted that men would continue to be afraid of committing acts of violence, some women rather feared that men would start to perpetrate violence again. In the absence of the project, they will not be afraid since the level of enforcement would drop.

> EMPOWER's presence corrected people's attitudes about GBV. But I'm afraid that if EMPOWER leaves that this change won't last because if men have changed their behavior it's because they are afraid of the presence of EMPOWER. Many don't yet know that the project is over so the change is still there, but if they ever learn that it's over they could go back to their old ways. —*Female community member*

Case Reporting Sustainability

Similar to the community mobilizers, police and other government employees involved in receiving and adjudicating cases of GBV shared that they continued to receive and serve survivors and their families as they did during the project.

> Our activities have to continue even without the project. We were doing these things before the project and the project offered us support that helped us to be more informed. When a woman is a victim of violence she is afraid to come to the station, and now she has the possibility to present her problem to the CPS where she is less afraid … and through this avenue we receive a lot of reports. —*Police chief*

However, despite their continued work, some actors noted that lack of funds necessary to continue to meet the needs of survivors posed a significant barrier.

> When we receive cases we still send them to the CPS. In the case of victims, perpetrators will be there to support them. Thanks to the project we no longer have to keep these cases quiet…but there are still women who are abandoned to need help… There still needs to be funding to continue the activities of the project. —*Health service provider*

However, community actors and members emphasized the continued availability of the CPS which helped survivors to continue to report cases of violence at the same level as they did during the project.

> The project is over but our agents are still there as well as the CPS to address GBV. For example when a girl is raped the community mobilizer brings her to the CPS, whose agents address the case until it is resolved. —*Community mobilizer*

> The CPS is still there, the police, too, and men know that if a woman is raped she will go and report it, so the change will last in my opinion. —*Female community member*

Participants at the community level also noted that women were no longer shy of reporting cases of violence and they would be unlikely to lose this motivation due to the awareness of their rights.

> The motivation to report cases of GBV is there, it's rare that women today will suffer violence without runner to report to the CPS and then to the police. —*Community mobilizer*

> The project sensitized women about reporting so much that they won't stop to report even though it is over in theory, the actions will continue to produce results forever.
> —*Male community member*

> I think that it will continue because, well partly because we've got another WJEI that is now going to focus on making sure everybody knows about this new law. So this is no longer some USAID project saying it's a bad thing it's now part of your law that you have rights, and you don't have to put up with gender-based violence. So that will be different. And so you know and so, then it gets more systematic in the courts with the lawyers ah, especially female lawyers. Then that will become more that you'll see more of those cases. Well they sit in jail forever before they're actually their court comes up so it might be two or three years before they even are heard in court. —*Implementing partner*

Implementers and actors in the field confirmed that there continued to be many survivors reporting cases of violence.

> People still call us when there is a case of GBV. The collaboration continues. —*Police chief*

> We try to do what we can, we send people to the police station, we try to pay medical costs with the perpetrator. So people continue to refer cases to us and when we receive them we try to address them with our own budget. When we can't handle the case we call CARE or the CPS. —*Implementing partner*

Once survivors are received by former project agents, there may no longer be the resources to provide for their care and support, or even the funds to pay for transportation to facilitate case reporting.

> There needs to be follow up … women continue to report cases of violence but there is no more support for them. —*Male community member*

> For behavior change … in my opinion three or four years is too short. I think it's too early to hope for a change in behavior, replicability … You must recognize that there are many, many victims who continue, who are waiting to be supported. Its true their families pay but it's not the same thing or the same satisfaction, it's very different. —*Implementing partner*

> With EMPOWER were certain materials and funds provided to help victims … to support them from the CPS to the court. The costs are still there but the funds are not. —*Implementing partner*

One project agent had observed that after the project period some perpetrators had been released from prison, suggesting that perhaps though case reporting had not lessened that perhaps standards of enforcement and adjudication of cases of GBV had in certain areas.

> Sensitization and punishment must be maintained … The project didn't have the result that it should have had. For example, toward the end of the project there are two people who committed acts of violence who were put in prison. But when the project had barely ended, these people were set free and have since been at large. Instead of continuing project activities and maintaining punishments, if you went for example to the courts the months following the end of the project, just try to find perpetrators of violence, the people who were brought by EMPOWER, see how many were let go, how many are left in prison? What is the motive for their release, we must ask? We have the impression that it was because we were there that people went along with us. A project is a project, it has a beginning, and it has to have an end. This project to combat GBV concerns behavior, so it's not something that you can change over a few years. —*Community coordinator*

Key Findings: Sustainability

- Many implementers felt that stronger sustainability would have been ensure by working with salaried government employees. Due to difficulties working with the government, the project was obliged to involve NGOs execute activities efficiently.
- There was lower motivation among government employees and community volunteers to continue the roles they had adopted during the project. This was true for government employees, due to reduced financial motivation. The same was true for volunteers due to the lack of field support from dedicated project facilitators posed.

Local name: Sita Kimya

Broader Environment

GBV is fairly common in Kenya, with 39% and 21% of women ages 15–49 having ever experienced physical or sexual violence, respectively. In terms of IPV, nearly half (47%) of women ages 15–49 have experienced emotional, physical and/or sexual violence (30% emotional; 37% physical; and 17% sexual). These statistics are slightly reduced in the capital city of Nairobi, with 29% and 15% of women having ever experienced physical and sexual violence, respectively. Additionally, 30% of women in Nairobi have experienced at least one of the three forms of IPV.[24]

In Kibera, a large urban slum located within Nairobi, GBV is present in many forms. One survey of 200 women, ages of 18–30 from 2009, estimated that 85% of respondents had ever experienced IPV. Nearly two-thirds of women (63%) reported having been humiliated. Additionally, women reported other forms of violence at varying prevalence (36% forced sex, 36% being threatened, and 36% being slapped).[25] Another study that reviewed the clinical records of sexual violence patients at the MSF clinic in Kibera found that the caseload increased from seven in 2007 to 866 in 2011. In 2011, 92% of the patients were female, 34% were children and 54% knew the assailant; 73% of the incidents occurred in a home at night.[26] Many of the community participants and project agents confirmed the widespread occurrence of physical, sexual and emotional abuse in Kibera. Community members shared that IPV is quite common and is often not even regarded as a real issue. However, many of the community participants and project agents expressed deep concern for the widespread sexual abuse of children in Kibera, often by someone the child or adolescent knows, such as close friends of the family, neighbors, teachers, and even family members (parents, uncles, etc.). Respondents shared that it was not just young girls, but also young boys who were being "sodomized."

Kibera Socio-political Context

The programmatic reach of WJEI in Kenya was the urban slum area of Kibera, located in Nairobi, the capital city of Kenya. Kibera is one the largest slums in East Africa and has an estimated population size of 500,000 to 700,000.[27] Exact estimates are difficult to ascertain due to measurement challenges in informal dwellings. Additionally, Kibera is a highly migratory area, with many of its residents originally from rural areas outside of Nairobi. Covering 2.5 square Kilometers, Kibera is divided into 14 villages and is home to all of Kenya's ethnicities, with largest group coming from the Luo tribe.[28]

2007/08 Post-Election Violence

In Kenya, politics are very intertwined with ethnic identity. The 2007 presidential election served as a catalyst for ethnic-related violence at a national level. After the election, Orange

[24] 2008–09 Kenya Demographic and Health Survey (KDHS).

[25] Swart, E. 2012. Gender-Based Violence in a Kenyan Slum: Creating Local, Women-Centered Interventions. *Journal of Social Service Research*, 38:4, 427–438, DOI: 10.1080/01488376.2012.676022

[26] Buard, V., Van den Bergh, R., et al. 2013. Characteristics, medical management and outcomes of survivors of sexual gender-based violence, Nairobi, Kenya. *Public Health Action*. 3(2): 109–112

[27] UN-HABITAT. http://www.unhabitat.org/content.asp?cid=3220&catid=206&typeid=13.

[28] Mutisya, E., & Yarime, M. 2011. Understanding the Grassroots Dynamics of Slums in Nairobi: The Dilemma of Kibera Informal Settlements. *International Transaction Journal of Engineering, Management, and Applied Sciences and Technologies*. 2: 197–213.

Democratic Movement leader Raila Odinga appeared to be in the lead, but in the following days Party National Unity leader Mwai Kibaki began to take the lead. The Electoral Commission of Kenya raised suspicion of ballot rigging and political parties publically quarreled, resulting in ethnic tensions across the country. Mwai Kibaki was eventually declared President, leaving many Kenyans feeling like the election had been stolen and sparking widespread ethnic violence at a national level.[29]

From December 2007 to February 2008, nearly half a million people were displaced and an estimated 1,300 to 2,000 people were killed.[30] In Kibera, conflict was particularly rampant and involved looting and plundering, uprooting of the railway line, retributive gangs killings, and GBV. Respondents shared that during that time the police even avoided certain areas of Kibera as the violence was too difficult to control. One of the implementers living in Kibera explained,

> After the post-election violence, you know, things were happening so fast. So many women got raped. Children were defiled. There were killings everywhere. —*Kibera community member, implementer*

Widespread ethnic conflict across the country increased the prevalence of GBV throughout many communities in Kenya, such as Kibera, and it was against this backdrop that the WJEI was launched in Kenya.

Substance Use

Kibera is very densely populated. On average, 4–6 people reside in one room.[31] Many respondents in this study discuss how the housing structure contributes to GBV in the community. Respondents described how parents, children, and other relatives live in a single structure, approximately 10 feet by 10 feet. The rooms are often divided with curtains, but there is limited privacy. Some of the respondents explained that the small houses coupled with common alcohol use in Kibera results in children witnessing the sexual acts of adults. Women describe men abusing alcohol and coming home demanding sex with their partners as he is less conscious of his surroundings. One explained how men do not need romance and will "jump" right on the woman while the children are present.

> At times, I have a drunkard husband, he comes home, drunk and he wants us to go to bed and the kids are still awake. At times, they have not eaten and he wants us to have sex. What can I do? My husband has to have sex. If I refuse, he will say that I had sex outside …What can I do? —*Kibera community member, awareness facilitator, female, over 25 years (translated from Swahili)*

Another respondent, who also spoke about male alcohol abuse, stated,

> They don't need to romance, they just jump on you and they start having sex when the children are not asleep. So, it is risking the life of our children. —*Kibera community member, awareness facilitator, female, over 25 years*

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[29] Kagwanja, P. 2009. Courting genocide: Populism, ethno-nationalism and the informalisation of violence in Kenya's 2008 post-election crisis. *Journal of Contemporary African Studies*. 27(3): 365–387.

[30] Ibid.

[31] Sartori, G., Nembrini, G., & Stauffer, F. 2002. *Monitoring of urban growth of informal settlements and population estimation from aerial photography and satellite imaging.* Occasional paper. 6.

Respondents felt that such exposure normalized sexual acts for children and sometimes even influenced them to emulate such behaviors with other young children.

Key Findings: Broader Environment—Kibera Socio-political Context

- Toward the end of 2007, Kenya experienced widespread ethnic violence due to a highly contested election. Kibera was a hotbed for such acts of violence and many women and children were sexually and physically violated during this time.
- The congested living conditions in Kibera contribute to the early exposure to violence among children.

Cultural Context

Gender Attitudes, Norms and Roles

Many respondents in Kibera referenced an "African" or a "Kenyan" culture in which patriarchal values and practices are the "traditional" norm. One participant explained what it means to be a man in his community.

> There is the African way of thinking. According to African society, men are supposed to be the leaders. They dominate in everything. —*Kibera community member, awareness participant, male, 18–25 years*

Additionally, many of the young female respondents felt that within their community, women and girls are widely seen as subordinate and African men expect women to be seen, and not heard. Other respondents expressed how women in Kibera are often emotionally and economically dependent on men. A number of respondents explained how women should be submissive to men.

> To be a lady, a girl or a woman in Kibera, you have to be submissive because you are considered a weaker sex. My brother can do things that I don't entertain, but I won't say anything, I will just submit and keep quiet and move ahead. So, that's how it is in Kibera … We are trying to go against that, but the men see us as a threat. They are trying to pull us down, but the more they pull us down, the more we are trying to come up and we hope someday we will be up there again. —*Kibera community member, awareness facilitator, female, 18–25 years*

As this community member explained, there is some resistance to women's empowerment initiatives, because they are seen as a threat to the male authority and sense of power. However, many alluded that such patriarchal values and practices are dissipating amongst the younger generations in Kibera.

On household gender roles, community respondents explained that men are typically the breadwinners and women are responsible for child rearing. Some of the men and women support a traditional notion of a clearly defined gendered division of household labor, whereby women are primarily responsible for domestic activities and men work in the public sphere. One female respondent stated that in the community, women's work is typically "to serve a man, you know, washing, cooking, taking children to school, you know." However, while the African norm is for a male-headed household, respondents explained that there are a significant number of female-headed households in Kibera, due to conflict and partner abandonment.

Views regarding household gender roles varied across respondents. Some female respondents expressed that roles within the household do not necessarily need to be static and hierarchical.

One respondent expressed her desire to share responsibility with her partner, as well as to be respected and considered an equal. She concluded, "You know in this generation, what a man can do, a woman can do. Me, I am still supporting that." Others expressed an appreciation for clearly delineated gender roles, but preferred a sense of equity in this structure. One male respondent explained,

> Everybody has their own right and their own role to play. For example, in the set of a marriage … men are supposed to be the head, but they should not impose everything to women, because they also have their own views and in most marriages men don't want to hear that. They say what they say is what should be and because of the emerging society and also the girl power, the women are being empowered so it's creating a lot of friction in the family. Yes, but in a marriage because it is civil, it's a relationship there should be cooperation. They should discuss everything, not just should wake up, think this should be done and that is law. —*Kibera community member, awareness participant, male, 18–25 years*

Kibera is an ethnically diverse community. Many respondents noted that gender norms and values are highly informed by the cultural values of the parents and the messages and lessons passed down generationally. Respondents also brought up how gender roles and norms are justified by ethnic and tribal traditions, of which there are many in Kibera. For example, respondents revealed that some tribes in Kenya believe it is necessary for a husband to beat the body of his dead wife if he has never beaten her during her lifetime, so that he will be considered a "real man" and can remarry.

Many young female respondents explained that there is a preference for male children in Kibera. Some of younger female respondents expressed that their parents, and often their fathers, invested their limited resources in their brothers' education and not theirs. One female respondent shared,

> This one I heard from my dad…a girl child is a waste to the society since she won't benefit in any way. After educating her, she'll go get married, hence benefitting the husband, not the family. —*Kibera community member, awareness facilitator, female, 18–25 years*

Boys are seen as investments for parents' social security, whereas girls marry at young ages and are of less value to the family's welfare.

GBV Attitudes

Many respondents explained how physical abuse is common in most marriages within in Kibera. One male respondent explained, "there is beating in most marriages because of that dominance." Both female and male respondents alike explained that physical violence against women in intimate partner relations is practiced as a form of discipline. One community respondent stated,

> You know, in African tradition, a man is believed, when a woman does wrong, he has the right to discipline the wife. So, in our African tradition, earlier we didn't think that thing was bad. You know, sometimes women do silly mistakes, so, you have to discipline. —*Kibera community member, awareness participant, male, over 25 years*

One female respondent also explained that women are conditioned to accept wife beating as part of cultural traditions that have existed for generations.

Additionally, some respondents explained how men in the "African tradition" are afforded full sexual rights, such that when the man wants to have sex, his female partner is expected to concede, as she does not have rights over her own body. One female respondent explained,

> When you are raped by your boyfriend, you can't start saying my boyfriend raped me because when you have a boyfriend, you are supposed to submit to your boyfriend - whatever he wants to do with you, he's supposed to do with you. So, if a rape does occur and you tell other people that he raped you, they won't agree, they'll say, you ate his money, so you owe him that. —*Kibera community member, awareness participant, female, 18–25 years*

This respondent revealed how sexual force in intimate partner relations is also normalized within society.

Stigma and a Culture of Silence

Many respondents discussed the stigma associated with rape and incest in the community, explaining that both are considered shameful. Respondents explained how people in the community often refer to sexual violence survivors as prostitutes, or justify the occurrence of rape by saying that the survivor was wearing a provocative outfit, or that she was walking alone at night. The blame is often placed on the one who was raped, not the rapist. Some described this as very isolating for rape survivors, despite the fact that many young girls have been raped.

Incest was also seen as particularly shameful. When a parent or a relative sexually violates a young child, referred to as defilement in Kenya, the family is often inclined to keep the incident(s) discreet.

> Most girls who are raped by their own fathers, they used to keep quiet. —*Kibera community member, awareness facilitator, female, 18–25 years*

Instead of reporting cases of child sexual abuse, cases are often ignored or settled within the family. Respondents explained that the perception of these normative patterns in society serve to further silence survivors of violence.

Additionally, there was a strong perception that divorce is not good. Upsetting the family is seen as a shameful act. One respondent shared that many women who are abused by their husbands keep quiet on the matter.

> There are people who feel free to speak, and they speak very openly, but there are people who still hide it so much … she'll tell you I fell down, because it's like what are people going to say and I'm not willing to move out, so it's still a bit of a challenge, a higher percentage of the people will still not talk. —*Kibera community member, awareness facilitator, female, over 25 years*

These norms along with economic and emotional dependency on partners offer an explanation of why women rarely upset their marriages by speaking out against IPV.

Key Findings: Broader Environment—Cultural Context

- Kibera is an ethnically and culturally diverse community with variation in norms and practices surrounding gender and GBV.
- Some adhere to more traditional and restrictive gender roles whereby men are the head of households and women are responsible for child rearing; while others strive for a more egalitarian or equitable division of labor and household roles. The younger generations in Kibera tend to identify with the latter sentiments.
- IPV is widely seen as a form of disciplining one's wife and there is a strongly held belief that men have sexual rights over their partner's bodies.
- There is a deep sense of stigma and shame associated with incest and rape in Kibera and as a result, many keep silent about occurrences of violence that happen to them or their family members.

Legal Context

GBV Laws

In Kenya, there is a penal code that has been used to guide criminal justice procedures for addressing sexual violence, including rape, defilement, assault, incest, and sexual harassment. In 2001, the Kenyan government enacted the Children's Act to address the rights of children and provide minors protection from female genital cutting, sex tourism and child trafficking. In 2006, the Kenyan government passed the Sexual Offenses Act (SOA), which provides for the protection of all persons from rape outside of intimate partner relations, defilement (sex with a minor), sex tourism and sexual harassment and prescribes the penalties for each. Implementing partners express how the SOA was critical in specifying sentence terms for various GBV acts, including sexual abuse of a minor.

> I think especially with the enactment of the new Act, things have changed because initially we had the penal code just talking about rape and defilement. We didn't have all these other offenses, like indecent act, sexual assault. All these crimes were not there and it came up with stiffer penalties. Initially the penalties, you'd find somebody walk away with 8 months, one year. So, that kind of punishment made people feel there's no need of reporting if somebody will go and a few months, he will be let loose. But now with the strict and the stiffer punishments in the Sexual Offenses Act, we have defilement of 0 to 11 years going up to life imprisonment … and 12 to 15 year olds, the sentence should not go below 20 years. So, the penalties are stiffer and people know at least the law is behind us and backing us. —*Judiciary officer, implementer*

However, some gaps still exist in the SOA. For instance, the SOA does not recognize marital rape. It was originally in the Act, but later removed.

> When the Sexual Offenses Act was introduced by one of the nominated MP Njoki Ndung'u in 2006, the parliamentarians later deleted a clause that was talking about the marital rape … We have heard of date rape, we have heard of marital rape, but these things go underground because they are not being addressed. The government is reluctant because the clause that was actually dealing with marital rape was actually deleted. —*Kibera community member, awareness facilitator, male, 18–25 years*

Additionally, the SOA includes a clause that stipulates that the punishment for perjury of a violation is equivalent to the sentence, which the defendant would have received if convicted. This clause is open to abuse by perpetrators in the event that a case brought by a rape survivor is thrown out of court. Additionally, a survivor of rape must prove to the police and prosecuting

authorities that she did not consent to the act, or that that she only agreed through coercion, which is often hard to do.

In 2010, Kenya adopted a new constitution. One implementer described,

> In terms of gender equality, the old constitution had nothing … So the new things in the new constitution … talks about the rights of individuals … it talks about equality issues between men and women … it talks about the right of the child…old people …it also talks about the issues of land … It also talks of citizenship … it organizes the fact that woman can be a single mother and can go and apply for a certificate as a sole parent of the child. Initially, you could not get a birth certificate as a woman for your child. They had to ask you, 'where is the father?' And without you bringing the father's documents, you will not get the certificate … in terms of the governance structures, it brings support now to the county governance … And it's giving representation of women in all structures and portions of the country. So that's very, that's a plus in the constitution. —*Implementer*

This implementer revealed that the new constitution helps to enforce laws related to gender equality in Kenya. Not only are women given more parental rights, but they are also increasing their representation in government bodies.

Law Enforcement

Implementers and community members alike expressed that enforcement of GBV laws by police and other authority figures is weak. For example, respondents explained that bribery and corruption are rampant and prevent justice from being served. One participant stated simply,

> Before Sita Kimya, you'll find a man sleeping with a kid and then you take him to the police station. You find he bribes and then he's out. —*Kibera community member, awareness participant, female, 18–25 years*

Some of the community members in Kibera explained that GBV law enforcement has been improving since WJEI, but many respondents brought up that they still have difficulties with authority figures and GBV law enforcement.

In addition to the police, there are provincial government structures that exist at the village or community level. Chiefs are appointed to districts to oversee problems that arise within the community or village. One judiciary offer described,

> [The Chiefs in Kibera] are very fundamental in this process because the Chief, especially in the society of Kibera, the Chief is seen as the person who is the closest authority, the closest person who has the government backing. The chief also has some police in the station.—*Judiciary Officer, Implementer*

The judiciary officer goes on to explained,

> [The Chiefs] are very open to bribery…In an ideal world he should be the person who is to observe that law and order is kept in the society. He should be there to oversee that the community's living harmoniously. He should be there to oversee that the community, or the people he represents, are cohabiting with peace, but more often than not, that is not the case. —*Judiciary officer, implementer*

Furthermore, many respondents shared that the local administration staff partake in bribery, preventing justice from being served in many GBV community cases.

Due to local administration corruption, some respondents expressed that it better to report cases of violence to the police, as some of them take those issues more seriously.

> Somehow, when you go to the chief, the chief solves that issue the first day. The husband will know when I beat my wife, we will still go to the chief and talk. Then, the second time the husbands beats up the wife … he'll want to go back to the chief knowing that somehow he will bribe the chief … So, I feel it's good to go to the police, so that justice can be served. —*Kibera community member, awareness participant, female, over 18 years (translated from Swahili)*

Other participants expressed that police can be antagonistic to GBV survivors, especially with the occurrence of rape. One health provider described,

> The police ask, 'are you sure you were raped? Where were you coming from? Were you wearing a short dress? No wonder you were raped, if this is the way you were.' And they take a long time, 'come tomorrow…' They have other things to do, so they don't want to waste time coming tomorrow. And maybe the sad thing, by the time the medical doctor is examining them, there's no evidence, so they say, 'there is no case here.' So, it's tiresome, time-consuming. —*Health provider*

Such a lengthy and drawn-out process is discouraging for GBV survivors and contributes to the lack of follow-up on cases.

Additionally, many of the respondents described the court process as "lengthy" and "intimidating." Some respondents expressed that the court processes are easier to navigate since the WJEI project, but it is still a very intimidating process with many existing barriers to justice. For example, some explained how it is difficult to obtain witnesses for such cases, as community members fear threats from the perpetrators. When cases have been brought to court, they are most often dealing with sexual abuse of children, as those cases are taken more seriously than others. None of the respondents recalled any IPV cases advancing through the courts. In those instances, the survivor often dropped the case, as they do not want to upset her family. However, this is not the situation for sexual offenses towards minors, as only the Attorney General can withdraw such cases from court.

Given that many cases of GBV do not progress through proper legal channels, many respondents stated cases are often dealt with in the community or even the family. Respondents explained that if the community becomes aware of an adult male who sexually abuses a young child, they become enraged and take justice into their own hands. Respondents referred to this as "mob justice."

> The neighbors may come out being angry. Maybe a person raped the daughter, my daughter who is maybe 10 years old. You see the mobs will come and beat you up and kill you. —*Kibera community referral group member*

However, if the perpetrator is within the family or even tribe, community members are likely to conceal it from the public, as not to bring shame upon the family or ethnicity. Respondents

alluded to the kangaroo or village-level court as a way of dealing with GBV cases within the community. In these courts, village elders or community opinion leaders serve as mediators between the relevant parties. One community member described,

> You will find that most of the cases are not being referred to the legal authority. Most of the cases are being held at kangaroo level. Those are the courts whereby I call my mom, you call your dad, and then you sit together. Then you say how much is it. I don't want this case to be taken to the next level. So, I have like about 50 dollars here or I have like 20,000 Ksh. —*Kibera community member, awareness facilitator, male, 18–25 years*

This demonstrates that community mechanisms of settling GBV cases that compete with the legal court processes.

Key Findings: Broader Environment—Legal Context

- The government of Kenya has enacted national level laws addressing most forms of GBV. Laws include the penal code, the 2001 Children's Act, the 2006 Sexual Offenses Act (SOA), and the revised 2010 Constitution. The SOA outlines specified sentence terms for perpetrators, including sexual abuse of minors. However, none of the laws address marital rape and there is no guidance for the authorities or courts on how to address it.
- Despite the existence of these laws, GBV cases are not often pursued through proper legal channels due to corruption of police and local administration authorities, intimidating court processes and competing community ways of dealing with such cases.

Programmatic Context

Prior to WJEI in Kenya, there were some GBV initiatives in Kenya nationally, as well as in Kibera locally. The national actors were primarily NGOs, including CARE International Kenya, the Coalition of Violence Against Women (COVAW), Federation of Women Lawyers (FIDA) Kenya, the African Women's Development and Communication Network (FEMNET), Children's Legal Action Network (CLAN), Wangu Kanja Foundation (WKF) and Men for Gender Equality Now (MEGEN), amongst others. Activities included community-based awareness, prevention, civic education, and media campaigns. Many of the groups promoted special days/periods, such as the 16 days of activism against gender violence and International Women's Day, to promote awareness around GBV.

In November 2008, FEMNET launched the "We Can" campaign in Kenya.[32] The campaign focused on ending violence against women and used posters and recorded skits on radio stations. The campaign tried to show how violence affects everyone and how all people are responsible for ending violence. According to one Kibera activist, the campaign laid a foundation for inspiring local change-makers within Kenya. However, due to limited funding, the campaign had limited funding and did have a quick enough "pace."

CARE International was working with Children's Legal Aid Network (CLAN) and Women for Justice in Africa (WOJA) in Kibera to create a network of paralegals to support clients through the judicial process. Paralegals help connect GBV survivors to health facilities and ensure that evidence is recorded, so that cases can be tried in court. One primary awardee described,

[32] http://kenya.wecanglobal.org/

> Paralegals were very keen in supporting cases of litigation, offering fast aid to survivors of GBV. They'll quickly connect all the GBV survivors to a health facility, ensure that the right documentation has been done, and the case is forwarded to the court. —*Primary awardee*

The primary awardee went on to note that during the post-election violence, paralegals supported over 300 women in testifying to the National Commission investigating the violence.

Pathfinder International was also working with Nariobi Women's Hospital to strengthen the health system capacity to deal with GBV cases, especially after the influx of cases from the post-election violence. Nariobi Women's Hospital trained fifteen other health facilities on the administration of PEP.

There were also a plethora of community based organizations (CBOs), such Kibera Women for Peace and Fairness (KWPF), POLYCOM, Carolina for Kibera (CFK), Center for Rights Education and Awareness (CREAW), Medecins San Frontieres (MSF), Shining Hope for Communities (SHOFCO) amongst others, who used grassroots techniques to promote positive messaging around GBV in Kibera. One respondent from a CBO in Kibera described,

> The community-awareness activities included outreach, drama outreaches, or participatory educational theater. Groups in Kibera would go out in a field and do a specific dramatic, like theatrical piece on demonstrating on how values occur in homes, and then involve the community members to discuss about what are the effects and all that … They were very active, but not really geared only towards gender, sexual gender-based violence but other issues also like child education and all that. —*CBO, female*

Despite these efforts, many of the implementing partners and community members described the initiatives before WJEI as isolated from one another and with limited coordination.

Key Findings: Broader Environment—Programmatic Context

- There were some GBV activities in Kenya and Kibera implemented by multiple NGOs and CBOs prior to the WJEI. Activities included community-based awareness, prevention, civic education, and media campaigns. However, these initiatives were not well coordinated.
- CARE International was working with Children's Legal Aid Network (CLAN) and Women for Justice in Africa (WOJA) in Kibera to create a network of paralegals to support clients through the judicial process.
- Pathfinder International was working with Nariobi Women's Hospital to strengthen the health system capacity to deal with GBV cases.

Project Design

Design Process

In preparation for implementing WJEI in Kenya, USAID and the DOJ contracted a Kenyan consultant in December 2008 to conduct a situational analysis to identify gaps in current interventions to address GBV and potential activities that the project could implement in each component area. The report included a literature review as well as analysis of focus groups conducted with Kibera residents, as well as key information from GBV prevention groups, and government officials. A representative from Pathfinder International, the primary awardee, explained that USAID provided them with key formative documentation to assist in the design process.

> We were given documents because there was a lot work that had actually gone into preparation, so…we went through those documents ourselves. —*Primary awardee*

Another primary awardee respondent shared that the formative research provided was useful in having a point of reference upon which to design the project.

> [The consultant] had gone around and marked the whole place geographically, socially, and so we had a good sense of what was going on. She did a bit of all over Kenya, but a lot on Kibera … So based on that, we were able to immediately embark on program design. — *Primary awardee*

The respondent also explained that the design process involved a series of meetings with the USAID team to understand the scope of the project and generate appropriate activities.

> We did have a lot of meetings with the USAID team. We used to have regular meetings at the initial phase in terms of trying to understand the program. We needed to break down the scope of work and make it coherent for implementation. So, we had quite a number of meetings at the onset just to see what they were thinking and then that is how the whole design really came to play out. —*Primary awardee*

At the very early stages of the project design process, the design team engaged with a wide range community stakeholders identified in the situational analysis. The design team made a concerted effort to collect existing information, education and communication (IEC) materials. The primary awardee shared,

> One of the activities that we did before we even finalized the work plan was to organize a meeting for the groups that work at community level, because we wanted to understand what it is that they do and the groups that work at facility level … We had an initial meeting with some community leaders, local administration partners, and we got their sense of what is happening in Kibera and also the hospital. Just to understand what the needs were and what kind of, what kind of—what we needed to make and what kind of structures we could build on. So, based on that we were able to come out with some kind of design that actually, that informed our activities. —*Primary awardee*

USAID and the primary awardee formed a design team. Population Services International (PSI) was included, as they were partnering with them on other communication-based projects. PSI developed a communications strategy for increasing demand for GBV services within Kibera. The design team also included the consultant, who had done the situational analysis, and key Kibera community groups and individuals identified as potential partners. One CBO respondent shared,

> We have so many campaigns in Kibera that have never worked with because people don't know what works for us. They impose their ideas on us … I stood up and gave my views and I think they thought, this is the right person to work with. What I told them is that it is important to talk to the people, and ask them what works for them because at some point, research can be misleading. Because in Kibera, the way people are cultured, we tell you what we know you want to hear, and not the reality. So, at some point, if you don't, if you're not open to ideas, you may end up coming up with something wrong. —*CBO*

The design process was considered a collaborative process from the perspective a of some key Kibera community members.

Key Findings: Project Design—Design Process

- USAID and the DOJ hired a consultant to conduct a situational analysis to inform the project design in Kenya. The analysis included data from community member focus groups and key informants working on GBV in Kibera.
- The primary awardee consulted a wide-range of GBV stakeholders to assess the potential of strategies and activities in Kibera.
- USAID and Pathfinder International convened a design team, including PSI, a project consultant, and members from key CBOs. The Kibera community members involved considered the design process to be more collaborative than other projects in their community.

Strategic Decisions

One of the key project decisions of WJEI in Kenya was to have the program only in Kibera. In 2007 to 2008, Kenya's presidential election left a wake of ethnic and tribal violence all over the country, however this violence was particularly heightened in Kibera and many actors felt the need to address issues that arose in that community. One of the representatives from the primary awardee revealed,

> Kibera was actually chosen by USAID, but it had a good premise for being chosen. Largely because of the post-election violence, it was highlighted as one of the areas where there was so much sexual violence and a lot of survivors went to report at Kenyatta National Hospital. A lot of information had been collected by some partner organizations, such as CARE and based on that, we were able to say, 'why don't we focus in Kibera?' Because we know a little bit about it and we have a health facility that we can link, we have a police station… and I believe that is what informed the choice of Kibera. —*Primary awardee*

Another key decision of USAID and the primary awardee was to focus the care and support efforts solely on strengthening Kenyatta National Hospital (KNH) as a health facility to provide comprehensive services to GBV survivors from Kibera. KNH is a government hospital in Nairobi located approximately 8 kilometers from Kibera. One primary awardee respondent explained the rationale for choosing KNH.

> [KNH] is the biggest training and referral hospital in Kenya. It can accommodate thousands of people and they had already started a gender-based violence recovery center, so we are not going to reinvent the wheel. And the only thing they needed was a little bit of support to be able to accommodate the numbers from Kibera. —*Primary awardee*

The project design team was also aware that MSF had multiple locations in Kibera and was also providing medical care to sexual violence survivors in Kibera. However, the project team did not formally support their efforts as MSF had its own established funding. Nevertheless, they did partnered with them informally in the awareness campaign and referred GBV survivors to their clinic.

Additionally, during the project design phase, the primary awardee consulted with the Kenyan National Gender Commission, who at the time was putting together a taskforce to draft the National Framework Towards Response and Prevention of GBV. The primary awardee explained that both the national framework and the situational analysis motivated them to adopt the multi-sectoral approach.

> We chose to adopt the multi-sectoral approach because that is what the national GBV framework had adopted and also what was coming out from the situation analysis … So it all came in together. I would say we had built a consensus around it and also international practice around gender-based violence. That's the kind of model you'd want to have in place. So, I would say we just went ahead with what we had to work with." —*Primary awardee*

As a result, WJEI in Kenya adopted a multi-sectoral approach to GBV, which advocates for GBV programs to include health services, psychosocial support, legal aid, and safety and security.

Key Findings: Project Design—Strategic Considerations

- A key project decision was to confine the program to Kibera. In 2007 to 2008, Kenya's presidential election left a wake of ethnic and tribal violence all over the country, but this violence was particularly heightened in Kibera and many actors felt the need to address issues that arose in the community.
- Care and support efforts were to focus solely on strengthening KNH as a health facility to provide comprehensive services to GBV survivors from Kibera.
- WJEI in Kenya adopted a multi-sectoral approach to GBV that was currently being put forth by the Kenyan National Gender Commission. This approach advocates for GBV programs to include health services, psychosocial support, legal aid, and safety and security.

Communication Strategy

PSI Kenya was brought to oversee the GBV awareness campaign in Kibera. One PSI respondent explained that their primary objective was to increase awareness of the SOA and uptake of GBV services in Kibera. In order to do this, they carried out formative research with focus groups in Kibera to understand how best to construct messages around GBV. The implementer describes,

> We tried to understand what's going on from the mouths of the beneficiaries. —*Implementing organization*

One primary awardee respondent explained that the process of conducting formative research was helpful in creating messages that resonate with the community.

> In terms of message development, we actually sat down with community members … [we] got their input in terms of how they perceived gender-based violence within the community, and what kind of messages would be relevant and how to deliver them and that is how basically now the campaign actually developed, evolved, and became the way it was. —*Primary awardee*

From this experience, they also discovered that community members lacked information about options of where to go after incidences of GBV, especially rape. It was therefore important for them to convey in the messages that there are points of service, particularly health-related facilities, where they could access medical care. One implementer explained,

> We figured out particularly that just letting people know, even if you don't follow up with the case at the courts, you can get help and you can get help for free … we were close with MSF and we mapped out which [health] facilities are around as a first stop. —*Implementing organization*

Through the focus group process, they also generated descriptive profiles of archetypes of Kibera community members. One implementer shared,

> We had sessions where we would just ask them to describe a day in the life, what they do. And we would come up with an archetype and they would profile that person … what's this person? What do you think this person would be called? What do they do in their daily activities? What are some of the challenges they face? And then getting to understand that whole audience better, so that we would be able to develop relevant communication messages … [Kibera is] a sort of a melting pot of different tribes, different cultures … and it has its own culture as a slum. So, you have to be very careful even how you communicate and that's why we did that profiling activity. We didn't want to just do a general mass campaign and then for it to flop. —*Implementer*

Using formative research to craft tailored messages was critical in conveying information effectively to wide and varied audiences.

Key Findings: Project Design—Communication Strategy

- PSI Kenya oversaw the GBV awareness campaign in Kibera, with the primary objective being to increase awareness of the SOA and uptake of GBV services there.
- PSI carried out formative research in Kibera to understand how best to construct messages around GBV that would resonate with the community. Messages focused on points of service, since many community members lacked information about where to go for GBV incidents.
- PSI generated descriptive profiles of archetypes of Kibera community members to craft tailored messages so that information could be effectively disseminated to wide and varied audiences.

Implementation

In Kenya, WJEI was implemented from October 2009 to February 2011. The project aimed to address GBV through a three-prong approach of awareness raising, GBV law enforcement strengthening and increasing care and support services for survivors. Pathfinder International in Kenya implemented the awareness raising and care and support components of the project and the DOJ implemented the component that dealt with GBV law enforcement.

Awareness Raising

The awareness component of project sought to increase knowledge of GBV as an issue, laws that govern GBV, and points of service for survivors. This component also included activities to strengthen and develop community-managed systems of care and support so that as awareness was increasing, survivors were able to seek and access services.

Pathfinder International partnered with numerous stakeholders at various levels to implement these activities. PSI Kenya developed a communications strategy and oversaw the awareness raising activities in Kibera. Additionally, local NGOs and CBOs in Kibera were identified and recruited to join the initiative. These groups included the Centre for Rights Education and Awareness (CREAW), Women's Empowerment Link (WEL), CLAN, WKF and MEGEN, CFK, KWPF, Kibera Community Youth Programme (KCYP), Kibera Peace and Reconciliation Network (KIPERNET), Pamoja Youth Foundation (PYF), Youth Reform Self-Help Group (YRSHG), Sapta, and Kibera Paralegal Network (KIPNET).

PSI developed a branded slogan for the project. The slogan read "Sita Kimya. Jitokeze Ukomeshe Ubakaji," which in Swahili means, "I will not be quiet. Come forward and stop rape." The message behind the slogan was intended to promote community members to speak out about violence and to serve as recognition of the laws that protect against such violations. One community member shared,

> When we heard about Sita Kimya, what came in my mind was we should not keep quiet... when someone is raped, most people always keep quiet about it. So, you should not keep quiet when you are raped, or you are harassed by anyone, or even during domestic violence. —*Kibera Community Member, Awareness Facilitators, Female, 18–25 years*

Sita Kimya-branded IEC materials were developed and distributed to partners working in Kibera. These materials included posters, brochures, T-shirts, lesos (cloth wraps), bandanas, and key chains and were instrumental in marketing the Sita Kimya campaign throughout Kibera. One community member described how wearing the Sita Kimya T-shirt helped to identify you as a community change agent. They explain,

> Those t-shirts had a message…meaning if you wear that, you are promoting something and you are advertising something, saying that you should stop rape. —*Kibera community member, awareness facilitator, female, 18–25 years*

Community members shared that the IEC materials helped get the message out to a wide-range of community members, even those with limited literacy.

> Even my grandma, she can't read, she just looks at that … she will understand it. —*Kibera community member, awareness facilitator, male, 18–25 years*

Another explains,

> Even when someone wore a Sita Kimya T-shirt, a little child can read and recognize the words. —*Kibera community member, awareness facilitator, female, over 25 years (translated from Swahili)*

There was also a Sita Kimya mural that was painted on the exterior of different slum-structures, such as community groups, churches, and schools, and conveyed that the place where survivors could come and share their stories of abuse. One community member described,

> Sita Kimya came up with the idea that a safe place could be painted with the slogan Sita Kimya, so that people could speak out about rape. —*Kibera community member, awareness facilitator, female, 18–25 years*

The branded IEC materials helped to maximize the visibility of the Sita Kimya campaign in Kibera.

Audience-Tailored Messages

In order to begin the process of creating awareness around GBV, PSI tailored messages for different audiences, based on age and gender. Messages were developed based on the six archetypes that were created during their formative research. Each archetype was given a name and a descriptive adjective. Brian and Lavender were children, ages 6–10, and described as *precocious*;

Junia and Doreen were children, ages 11–14 years, and described as *susceptible*; Morios were young men, ages 15–24 years, and described as *struggling survivors*; Stella-Maries were young women, ages 15–24 years, and described as *sly survivors*; Oyoos were older men, ages 25–45 years, and described as *worried, escapist men*; and Sophias were older women, ages 25–45 years, and described as *tough, vulnerable, sacrificing mothers*. One community facilitator describes the meaning she associated with the Sophia archetype.

> Sophia is a mother and a mother is the role model of the house, getting all the household activities … A mother has a role in the house or in the family to keep everything moving and going. —*Kibera community member, awareness facilitator, female, over 25 years*

Each group received similar information regarding GBV, national GBV laws, steps to take after sexual abuse, and points of service for survivors. However, messages were tailored to address the needs and concerns of the target audience. One implementer explains,

> The core messages did not differ so much … The difference was in how the delivery and also the relevance. So if it's the men, we're talking to them as caregivers and empowering them on what they need to do to protect the community … [when] we are talking to … the older woman - her messages were for her serving as an individual and as a caregiver … For the children it was about speaking out, not keeping quiet … it was more of empowering them to speak up and to identify inappropriate touches … places to avoid…who you should report it to when somebody touches you inappropriately. But the key messages of … what to do or not do to do if somebody is raped, those messages were all the same because everybody needed to have the same information. —*Implementer*

Messages were crafted to specific populations, so that the information could be more effectively conveyed to the community members of Kibera.

Community Facilitator Training

Using the archetypes, PSI developed guidelines for teaching messages to different audiences. These guidelines served as curriculum for training community members as GBV peer-educators (i.e., awareness facilitators). PSI identified existing CBO working in Kibera to implement the awareness sessions and the groups selected their own members to be trained as awareness facilitators. PSI staff trained 160 community members as peer educators and 20 as child facilitators on GBV awareness and community facilitation.

The facilitator training used an education through listening approach, which is a model for interpersonal communication and community engagement. The core of this approach was for the facilitators to listen first to the concerns and issues of their participants and then to respond to their issues and offer guidance through a discourse. One facilitator explained that this was a new technique for him.

> I'd been working in this community as a paralegal and we knew the basic laws … so when Sita Kimya came, it was a refresher training for me, but what they added … was the education through listening … Because we were dealing with children, we had to go and listen to what the children say, not to go and lecture, not to go and teach. We are to go and just ask the question that leads these children to come up and speak their mind … So, these trainings, we really enjoyed. —*Kibera community member, paralegal & school facilitator, male, over 25 years*

During the training, facilitators were given information on how to follow up with cases they encountered in the sessions. Awareness facilitators explained that they were given contacts of community referral agents and other key people and they were taught to rely on these contacts, especially when dealing with particularly difficult cases.

> We were being taught you should not show the girl that this is hard [case] to handle. You should just talk to the girl, listen to her, then give the little you have. Then, go on ask somebody else for the other part of the advice. —*Kibera community member, awareness facilitator, female, 18–25 years*

Community facilitators networked with people in their community who could offer more concrete assistance to GBV survivors, so that they could refer people seeking help to these community agents. Community facilitators discussed how the training helped strengthen their skills and increase their capacity for facilitating group sessions.

> When we were in the training, we got to meet new facilitators, people who have more experience in facilitation than you and we got more skills and ideas on dealing with someone who is older than you … So that was new, and then also getting to work in the community, feeling that you belong in that community, it was a very nice experience. —*Kibera community member, awareness facilitator, female, 18–25 years*

Another facilitator shared that the training gave her the "courage" to help others.

Peer Education Awareness Sessions

To create an atmosphere where the community members in Kibera could openly talk and share their GBV experiences and concerns, PSI used a peer-to-peer education approach. Community groups were tasked with facilitating awareness sessions for one of the population groups identified. SAPTA, PYF, KCYP, and YRSHG dealt with youth and facilitated the "Mario" sessions. CFK facilitated the "Stella-Marie" sessions. KIPRENET was assigned the facilitation of the "Oyoos" and KWPF facilitated the "Sophia" sessions.

With the help of the community partners, PSI mapped out the villages of Kibera and identified 14 villages, which they grouped into 4 regional areas. Community facilitators from all the groups were assigned to one of the regions, so that all of Kibera was covered. Venues for sessions varied depending on the group, but examples of such spaces were group meeting spaces, community halls, churches, mosques, homes, and street corners.

Community facilitators were responsible for recruiting participants of similar demographics. Facilitators aimed to conduct two awareness sessions with the same of group of 15-30 participants in order to cover all the material. Most of the participant recruitment happened through pre-existing networks. However, not everyone in Kibera is associated with a group, especially men. So, in order to cast a wider net of participants, facilitators would go to churches, football fields, bases, bars, video shows, and barber shops. One male facilitator explained the process of recruiting from bases.[33]

[33] Base refers to street corners in Kibera, where male peers gather. A number of activities can happen here, including political discussions, gambling, and chewing khat, a plant that contains cathinone, an amphetamine-like stimulant and causes excitement, loss of appetite and euphoria.

> Each base has got their leaders, like the base where they normally play gambling, they got people who normally they listen to. So we get to those people. —*Kibera community member, awareness facilitator, male, 18–25 years*

Because the facilitators came from within the community, they were able to utilize novel strategies for recruiting a wider range of participants.

The sessions aimed to teach community members about rights afforded to them under the Kenyan SOA, as well local strategies to seek medical and legal care for GBV offenses. According to the primary awardee, the goal of the sessions was to explain the kinds of GBV laws that exist in understandable language, and convey to community members that when a violation occurs, they are ways to seek justice. One facilitator explained that he would educate his participants on the different forms of GBV, including defilement, rape, sodomy, incest, indecent acts, sexual harassment, and child pornography. After discussing these, he would introduce the legal ramifications of committing violations under the Kenyan SOA.

Community members were told distinct procedures for treating sexual abuse cases, so that survivors are treated and evidence is preserved for legal action. One facilitator recited these steps.

> She should not bathe. The second step, she's not supposed to carry the panties on the nylon paper. She's supposed to use polyethylene or the newspaper. She's not supposed to cut the hair or the nails, because she will lack evidence. And then she's supposed to be referred to the hospital within 72 hours. In the hospital, she will be counseled, and then she will be given [medicine] to prevent pregnancy or STIs. —*Kibera community member, awareness facilitator, female, 18–25 years (translated from Swahili)*

Facilitators would refer survivors to various health facilities, including KNH, MSF, Tabitha Health Clinic, Mbagathi Hospital, Wangu Clinic and Nairobi Women's. Additionally, a few facilitators stress the importance of counseling for survivors. One respondent explained,

> Most of these victims—they have traumas. They feel like their life is over. If we don't take them to counseling … one victim … [committed] suicide. She jumped out of her railway and died. So, that's why the counseling thing came up. —*Kibera community member, awareness facilitator, female, 18–25 years*

Facilitators also told that if the survivor wants to follow up legally, they would refer them to CREAW, an organization that provides free legal aid and has an office location in Kibera. However, not all of the community facilitators knew of CREAW's existence.

In the sessions, facilitators addressed forms of GBV, other than sexual abuse. One facilitator explained that in her sessions she addressed the normative acceptance of IPV with her participants.

> In Kenya, women believe that when they are being beaten by their husbands, that means love. And that was the silence that we wanted to break because some of the women are in abusive marriages and relationships … someone hitting you everyday and you just keep quiet and take it to be something normal and it is not normal. So, that is what we were really fighting for and for the rape thing. —*Kibera community member, awareness facilitator, female, 18–25 years*

Another young female facilitator explained that she tried to teach her participants how physical IPV is also associated to emotional abuse.

> When someone puts a scar on your body, that means that that person doesn't love you … So we sensitized on not allowing that person to injure your body, because whenever he is hurting you physically, he's also hurting your emotions. You can't face people in the society. So we sensitized them on not allowing their husbands or their boyfriends to batter them. —*Kibera community member, awareness facilitators, female, 18–25 years*

Single-Sex and Coed Awareness

The program aimed to conduct sessions with participants who were similar in age and gender; however, this was not always the case, due to the fact that some of the participant recruitment happened outside of existing groups. One facilitator explained,

> [It] depends on areas we go … at some areas, you find men only. At some areas, we put both males and females together. —*Kibera community member, awareness facilitator, male, over 25 years*

Another male facilitator gave the example of when he conducted sessions at community halls, women who would sit outside and inquire about the meeting.

> They ask us what are you going to talk about? So we explain we are going to talk about the gender-based violence. So they say we also included in this program, so we are also coming there to listen. —*Kibera community member, awareness facilitator, male, over 25 years*

Another male facilitator explained that he would encourage male participants to bring their female partners, because in actuality, everyone needed to hear the messages.

> When we started it was like more men used to come than women, but because we wanted to include everybody, we encouraged many men to go and pick their spouses and come with them because this is a message that each and everybody needs to listen to. —*Kibera community member, awareness participant, male, 18–25 years*

Some of the youth groups who facilitated the Mario sessions also included their female members in the sessions.

Many of the facilitators and participants appreciated the mixed environment. A few male participants explained that having a mixed group allows them to understand each other's problems. Another male participant shared that it is particularly useful for a couple to hear the information together.

> If you have a husband come and the spouse does not know where the husband has gone, when he goes back in the house, the other partner tends to imagine where the other partner is coming from. So, instead of promoting conflict in the household, it is better we engage all of them, so that they may understand the importance. —*Kibera community member, awareness participant, male, over 25 years*

Another male participant in the same focus group expounded on this by saying,

> Both men and women, some had problems communicating in the houses. They have that failure of communication, so when they come to the facilitation … people freely communicate and express their problems to the people. When they leave there, they go home, they get an experience that they have achieved something … when they go home, they sit down and talk their problems. —*Kibera community member, awareness participant, male, over 25 years*

Participants and facilitators also acknowledged that single-sex awareness sessions have benefits. One male participant explained that having a single-sex environment created a space where participants who have similar problems can consider solutions to their problems.

> I prefer one sex only because … let's take the elderly women and men, you've mixed them together. You've told them to share your problems. You see, they won't be free enough to tell you … [When you do only one sex,] you can find people are sharing the same problem. So, like when I say I have this problem and I know she has this problem, we are sharing the same problem. —*Kibera community member, awareness participant, male, over 25 years*

Additionally, one young male facilitator who supported having mixed sessions brought up how mixing is challenging because it had the potential to make GBV survivors have "discomfort."
Awareness Sessions For Children

PSI developed messages for two different age groups—6–10 years and 11–14 years—and trained a set of facilitators to conduct awareness sessions for children in Kibera. The sessions for the children included discussion of private parts and good versus bad touches. Children were also given access to people who they can talk to if situations arise.

Some of the facilitators explained that they had been doing similar activities prior to WJEI, but the Sita Kimya project made their efforts more coordinated and efficient. One facilitator gave an example of this efficiency by describing how they would go to a school as a group of facilitators and then each take their own classroom of students to educate.

Facilitators explained that they would do most of their sessions in private schools within Kibera, but many of them also tried to recruit children who were out of school. For out of school children, facilitators would recruit participants through churches or other community structures. For school-based sessions, they would contact a head teacher at a school to coordinate. However, some facilitators revealed that some teachers were reluctant to engage with the facilitators because they feared potential ramifications of the sessions. One facilitator described,

> Teachers were reluctant to do the right thing. They fear that if they were to bring out these issues, this could give the school a bad name … People will start to say, 'in that school, there is a defilement case … so people will fear taking their children there. —*Paralegal & school-facilitator*

The facilitator went on to explain that teachers may even know that a fellow teacher is abusing a student, so they would want to keep this hidden out of fear that the government shuts down the school, rendering them jobless.

Despite the challenges with the teachers, many of the facilitators shared that some of the children would easily open up about their experiences during sessions. One facilitator revealed that

the younger children were particularly open. They would interject in class and open up about sexual actions they had observed. Another facilitator described,

> The children started reporting the cases themselves and we were so friendly with them. You can find a child … telling you, 'my dad did a, b, c, d, and z to me.' Now the children were open, they started speaking up. —*Kibera community member, paralegal & school facilitator, female*

Some facilitators expressed that it was more difficult for older children to speak out publicly about incidents. One facilitator would ask them to write down questions or comments and some would submit notes like, "I was raped by my father. I never told my mother and that was three months ago" or " my father keeps raping me and I don't know what to do." In response to these comments, facilitators would provide the students with numbers of community referral people and information about places to go, such as MSF for medical health and CLAN for legal assistance.

Community Forums

In addition to the peer-education sessions, CREAW conducted two-day community forums to reach a wider audience in Kibera. The forums were conducted in community halls and involved approximately 100 participants from Kibera's 14 villages with representation across the community by age and sex. The first day of the forums focused on GBV as an issue, its effects, service provider expectations, and community roles in prevention. The second day delved into the national laws that govern GBV, highlighted particular areas around child sexual abuse (i.e., defilement), discussed the steps to be taken if sexual abused and the importance of evidence preservation. They would also discuss the issue of domestic violence. One implementer described,

> People look at domestic violence as something that's a norm. It's allowed by the tradition in Kenya, but then they forget that we have a law in Kenya that governs issues of assault. So, you tell people, if you're beaten by your husband, you need to report that, and this is what we expect in court, this is the sentence, and all that. So, we could break down all the offenses and be able to give it to them in a very simplified language. —*Implementer*

The forums aimed to engage participants in a participatory way. With the help of PSI, CREAW incorporated a magnet theatre at these events whereby skits on defilement, gang rape, early marriage, domestic violence, forced prostitution and sex tourism were performed. These brought out the underlying power differences between men and women, control, and the link between HIV and GBV. The performances also encouraged the community to participate by engaging them in focused dialogue based on the skits and poems.

CREAW also distributed IEC materials to the forum participants.

> At the end of the training there was a take-home package, just some summarized notes on what we had learned, though some of them do not know how to read. But if they carried that leaflet, another person might benefit if they go. And for those who know how to read, because some of them came from groups, self-help groups, they're leaders, and so we expect that when they go home, they can have another session where they train their group members. —*Implementer*

The IEC materials served to continue the process of awareness raising within the community.
Provincial Administration Training

During the WJEI project, CREAW also conducted trainings on GBV for provincial administration staff, including chiefs and their assistants from seven villages in Kibera. Provincial administrators are government contacts for people in communities and often serve to troubleshoot community issue and concerns.

These awareness sessions focused on GBV laws in the Kenyan SOA, as well as the Children's Act, and the revised Constitution. The sessions stressed how sexual violations are criminal offenses and must be handled seriously under the law. The primary awardee explained,

> We also worked very well with the provincial administration … districts commissioners, the district officers and chiefs and assistant chief, and ensuring that they understood the Kenyan laws … in case of any violation happening within their areas of jurisdiction, there are procedures that they are supposed to follow. —*Primary awardee*

One implementer stressed that it was critical for the provincial administration to know how to advise GBV survivors and know that they are capable of caring the case forward through the proper channels.

Male Champions Network

While men were targeted through the peer-education sessions, Pathfinder International also partnered with MEGEN to conduct additional male-targeted awareness sessions. MEGEN, whose mandate is to engage men and boys to promote gender equality and prevent GBV and the spread of HIV/AIDS, organized a series of sensitization forums on GBV for men from Kibera. The goal was to create a critical mass of men and boys who are sensitized on GBV issues and would commit to work together to combat it.

> We wanted to identify people who could speak up to these issues, who could promote gender equality, who will bring about a stop to sexual gender-based violence including the spread of HIV and AIDS. We thought that men could really do this better, if they were brought on board and being enlightened and … we're looking at men as potential perpetrators. Yeah, including myself even as the facilitator, my potential for being a perpetrator, if I don't do anything about it. —*Implementer & facilitator*

The sensitization sessions included a general orientation to GBV and its forms, the spread of HIV/AIDS and its relationship to GBV, and masculinity and power. These sessions aimed at building a sustained network of male GBV activists in Kibera called the Male Champions.

MEGEN conducted two phases of awareness sessions. The first sessions involved 175 men from all 14 villages within Kibera. Leaders from various CBOs and village elders helped to identify participants, which included community religious and opinion leaders and "community gatekeepers." One implementer explained,

> They were the people that knew whatever needed to be done in Kibera … We saw that was a very good entry point for us as an organization to bring them on board and then see how we can anchor the project within the already existing structures, so it was locally owned. —*Implementer & facilitator*

Some of these participants even overlapped with participants and facilitators of the peer-education sessions. From these participants, 70 were selected by peers to take part in a more comprehensive two-day training in Kibera. Participants were divided into two groups of 35, so that the facilitator could genuinely engage with the participants during the sessions. The facilitator explained what is possible to do in two-day forum.

> You could identify people who were really forthcoming and they were outright in their perceptions of how they see things … we could tell very plain that somebody was passionate about the things that they were doing. —*Implementer & facilitator*

This facilitator goes on to describe how at the sessions the men strategized about projects and initiatives that they could do to address GBV in their communities. After the second training, the men formed teams for outreach activities within their villages. However, the facilitator explained that the men did not have the resources to follow up with these ideas.

Locally Produced Film

As part of the campaign, PSI partnered with FilmAid Kenya to produce a locally produced film. FilmAid uses film and media to provide key information, psychological relief and hope to vulnerable populations. They use participatory methodologies, placing an emphasis on community involvement and consultation. One of their staff described,

> Our methodology is a bit rigorous … We have a strict guideline in terms of the level of community participation, the level of community involvement and ownership, the approval process. —*FilmAid*

FilmAid drew heavily on PSI's formative research to develop the script, so that it was in line with the overall Sita Kimya campaign. However, one FilmAid staff explained that it was important for them to do their own validation process in order to produce the film.

> We just didn't take it to heart … we have to validate this. So, we tried our own audition processes, we had to form an advisory committee, different stakeholders from the community, who we used as a bridge to reach, and those who helped us in validating, in organizing groups, meetings different people … [We did this] through focus group discussions … and key-informant interviews. —*FilmAid*

FilmAid recruited a community advisory committee, made up of local representatives and leaders from different demographics to provide feedback throughout the process, from scripting to casting and location selection.

The film was written and directed by a Kenyan filmmaker who grew up in the slums and has experience working with community issues. It was designed to raise awareness and understanding around issues of GBV by following a series of interlocking narratives, using all of PSI's archetypes as film characters. In the film, Morio assaults his girlfriend Stella after she breaks up with him. His friends then invite him to participate in a gang-rape, however Morio is horrified when he discovers that the survivor is his younger sister. Morio changes his attitudes and behavior and becomes involved in the Sita Kimya campaign, raising awareness and providing assistance to survivors. One implementer explains,

> The film was successful in terms of recording daily happenings in the community, the timings of this thing happening, and the form in which they happened … the negotiations that go on in the community of the families … daily happenings of when you report, what you go on at the police station, what will go on between the families … we tried to show … the person who is a perpetrator in the movie be one of the anti-rape activists [and] stay within their communities. —*Implementer*

The film also focused on practical information relating to GBV—what it is, how to report it, and the services that are available for those affected.

The film was shot in Kibera with a cast and crew of approximately 300 residents and included many of the peer-educator facilitators. The involvement of the Kibera residents in the film from the early stages of development was viewed as critical to the success of the film. The production team had to deal with some local political and tribal tensions arising from filming in Kibera. FilmAid relied heavily on the project's community advisory committee and established relationships with CBOs and leaders to overcome these local issues.

The purpose of the film was to provoke discussion and dialogue within the community. FilmAid used two methods for screening the film within Kibera. First, they set up mobile screenings on large inflatable screens in public spaces. These screenings reached large audiences who were not involved in other awareness activities. One community facilitator described,

> So those people who were not involved in the groups, group discussion, they can see through the movie, through the acting … the issues of rape and sexual violence, they can see in the movie. So, that they can be educated more through those movies. —*Kibera community member, awareness facilitator, female, 18–25 years*

FilmAid also created a facilitation guide to screen the film with smaller groups, in order to better elicit discussion around key points.

> [The guide] makes it easy to engage with audiences from every age. So, most of the time when we engage with audiences, we have never had a passive audience … Most of the time, we have extended sessions for more than 2 hours … because people want us to continue discussing the issues. —*FilmAid*

Overall, the film sessions provided in-depth information and discussion, reinforcing the campaign's messages amongst wider audiences.

Key Findings: Implementation—Awareness Raising

- The awareness component sought to increase community knowledge of GBV, GBV laws, and points of service for GBV survivors.
- A locally branded awareness campaign was launched in Kibera. The campaign was branded with the "Sita Kimya" slogan. In Swahili this means, "I will not be quiet." The brand was associated with many of the awareness raising activities, such as peer-education sessions and sessions for children and community forums.

Legal System Support

The DOJ oversaw the legal system support component, which aimed to improve Kenya's ability to investigate, prosecute, and adjudicate GBV cases. The activities under this component

sought to increase the capacity of the police, prosecutors and the judiciary to punish perpetrators of violence. The DOJ conducted workshops with Kenyan police, prosecutors and judges on how to recognize and address GBV cases. The sessions included information on the SOA, role of police and prosecutors, witness protection, trial advocacy, investigation and prosecution of sex crimes, and forensic evidence and nursing.

In addition to these activities being implemented by the DOJ, there was limited coordination between this component and the other components of the project. Due to this, it was difficult to collect information from stakeholders involved in the legal component. However, some information was gathered from police who were involved in WJEI legal activities. According to a police officer stationed near Kibera, since 2004 the DOJ and other stakeholders, such as Physicians for Human Rights, had been conducting GBV training for police officers. The officer shared that during the WJEI project, there were two groups of 22 officers trained. The training lasted approximately three weeks. The officer shares,

> We learned about cases that relate to children, men and ladies … we learned about sexual offenses, rape, defilement, sodomy … physical [domestic] assault … sexual assault and how to handle such cases, how to deal with the survivors. We really learned a lot, the procedures, how you are supposed to handle the [evidence], how you're supposed to prosecute cases in court. We were taught so much. —*Police officer*

The officer went on to explain that the DOJ also trained select officers, so that they could serve as GBV police trainers at the Kiganjo Kenya police College in Nairobi on an ongoing basis.

Additionally, the US DOJ assisted in establishing a desk at the divisional police headquarters near Kibera to deal solely with GBV cases. This desk is called the gender desk and exists at other divisional police units in Nairobi. One Kibera community member shared,

> They actually have a desk outside the police station where you go to report there directly, rather than … like before, you just go through like a criminal or an accident that happened. You go through the same desk. But nowadays, we have a desk that deals with violence, with rape, all those things. —*Kibera community member, awareness participant, female, 18–25 years*

The respondent revealed that the gender desk offers survivors more direct access to the police officers. The police officer, who attended trainings under WJEI and who serves as one of the gender desk officers, explained that social workers or a "good samaritans" (i.e., a community activists) are often the ones to bring in the GBV survivors after they have received medical care at KNH, Nairobi Women's Hospital or MSF. The police officer records a statement of the survivor. However, the police officers shares that if it is a child who is abused, which they explained is often, it is difficult for the child to share their story. The officer then goes to the health facility to pick up any available forensic evidence and deliver it to the government chemist office for inspection.

Additionally, a police doctor (there is only one in Nairobi) must issue a specific form, known as a P3, for the case to progress efficiently through the court system.

> [The survivor] has to be escorted [to the police doctor] by the police officer … he's in Nairobi, just next to Kenyatta National Hospital … in the morning, sometimes he's in court and then he tells those who are in the office you have to come back at 11. He's not always there,

> as in 24 hours. But the most important one is the first doctor, who actually examines the patient. —*Police officer*

The police doctor, as well as any other doctor who has examined the survivor, is expected to testify in court. While it is important to be seen by the police doctor, the officer stressed that it is critical for a sexual abuse survivor to be a seen by any doctor within 72 hours of the incident to collect the appropriate evidence for the case to carry weight in court.

> If the 72 hours have elapsed, and I have not taken [the sexual violence survivor] to police doctor, I don't need to do that. I'll just take it with the medical report … I have so many cases that have no P3 and have really succeeded in court. The P3 is from the police doctor. —*Police officer*

Other respondents emphasized the important for sexual violence cases to have a P3 form and credible evidence to proceed through legal channels.

Key Findings: Implementation—Legal System Support

- The US DOJ oversaw the legal system support component, which aimed to improve Kenya's ability to investigate, prosecute, and adjudicate GBV cases. Activities under this component sought to build the capacity of the police, prosecutors and the judiciary to punish perpetrators of violence.
- The DOJ conducted workshops with Kenyan police, prosecutors and judges on how to recognize and address GBV cases. Sessions included information on the SOA, role of police and prosecutors, witness protection, trial advocacy, investigation and prosecution of sex crimes, and forensic evidence and nursing.
- The DOJ assisted in establishing a gender desk at the divisional police headquarters near Kibera to deal solely with GBV cases and offer survivors more direct access to the police.
- There is one police doctor in Nairobi who must issue a specific form for GBV cases to advance efficiently to the courts.

Care and Support of Survivors

The care and support component of WJEI aimed to strengthen the capacity of health services to GBV survivors. In preparation for this, Pathfinder International organized a meeting for clinical partners in Nairobi to map out the services available to GBV survivors in Kibera and identify gaps in provision. Attendants included representatives from KNH, Mbagathi District Hospital, MSF, Marie Stopes Clinic, Liverpool VCT Care & Treatment and COVAW. The project team wanted to integrate GBV response into the existing health care system and as such, Pathfinder International formally partnered with KNH to strengthen their existing GBV center.

KNH GBVRC

The project team planned to complete structural renovations at KNH in order to consolidate all the GBV services into one physical space; however, the Ministry of Public Works did not approve of the plans because of concerns around the structural capacity of the site. Due to a prolonged approval process, project activities at KNH-GBVRC were limited to five months. During this period, minor renovations at KNH were completed. This included separate admission wards for both children and female adult survivors and increased counselling facilities and security features.

WJEI also supported staff at the GBVRC during the project period to model the potential of a well-staffed center. This included a doctor, a project manager, a psychologist, two counselors, two social workers, a data analyst, an accountant, and an administrative assistant. Additionally,

a psychosocial care manager and three project coordinators were supported part-time. After the project's closeout, the hospital was not able to support the new staff and the center went back to its original staff capacity.

One KNH health provider shared that the addition of a medical doctor to the GBVRC during the project was critical to take care of the medical needs of GBV patients. Patients would often have to wait in a line in another department for a doctor, which delays their treatment. The health provider explained,

> A patient can come with severe bleeding and so the sexual abused client will be set aside, so that they can help this patient who is dying. —*Psychologist*

In addition to having a doctor, other key personnel that are critical to servicing the needs of GBV patients are social workers. One social worker discussed her role.

> At the GBV center … there's a lot that a social worker does. First, you are link person, the person to link the survivor with the police, with the legal justice system … Suppose if a child comes to the hospital and I find that the child is being abused within the same environment where they are living, I'm supposed to rescue this person. I identify where to take a place, this child. —*Social worker*

The project also sponsored two trainings for KNH staff on the Sexual Assault Forensic Examinations (SAFE) curriculum. A total of 50 staff, including doctors, nurses and clinical officers, at the hospital were trained.

One nurse explained that community members, such as relatives, peer-educators, referral agents and community health workers typically escort survivors to KNH. When a GBV survivor comes to KNH, an observation nurse typically sees them. That nurse directs and escorts the patient to the GBVRC nurse, who will interview the survivor about the incident to determine what kind of medical attention the patient needs. The nurse shared that when somebody is physically injured badly, they are triaged to the intensive care unit.

> There's those ones who come badly off … they are beaten, they have severe injuries. We admit them even to the ICU [intensive care unit]. We admit them even to the wards and then we care for them until they get well. —*Nurse/counselor psychologist*

Most patients wait to see a doctor elsewhere in the hospital. However, not all of the doctors at the hospital have been trained, so the nurse may assist with the examination for the purposes of collecting the appropriate evidence to send to the laboratory.

For sexual abuse patients, they are able to administer PEP, emergency contraception and combivir free of charge because of support from Liverpool VCT Care & Treatment. The GBVRC also provides free counselling. However, not all services are complimentary, especially those from other departments. Some of the costly services are x-rays, blood tests and surgery. Additionally, patients incur transportation costs coming from Kibera.

Nurses shared that they would refer their patients for legal assistance to either CREAW or COVAW, but only if that was the intention of the survivor. One nurse described,

> I will also talk about the legal side of it and then I will help the people to understand that if they have not reported to the police, there are these forms we fill here … we tell them this will help you to report to the police and then we would also give … if there is any other evidence. —*Nurse/counselor psychologist*

When the patient is a child, another nurse explained that they would involve the police and legal community agents. They could also admit the child to the children's ward.

Despite the limited project period, the results helped to show the project team what would be possible with more time.

> We were able to support them with staffing for five months only, but it demonstrated what is possible, if you have the resources in place … the quality on-hand, we started seeing areas of improvement. So, what I think was demonstrated was that it is possible. —*Primary awardee*

Many of the implementers felt that more could have been done in a longer time period, however the project was still able to strengthen linkages within the KNH setting, as well as train staff, strengthen GBV survivor support groups, improve information management and monitoring of cases. A few health providers explained that due to the increase of awareness around GBV in Kibera, they observed an increased number of patients at the GBVRC during the project period.

Médecins Sans Frontiérs in Kibera

Despite the fact that MSF was not a formal WJEI partner, MSF in Kibera provided GBV medical services to GBV survivors during the project period. For over a decade, MSF has had a presence in Kibera. In October 2010, they opened a fourth center in Kibera to specifically deal with cases of sexual abuse. One MSF nurse explained the rationale behind opening up the rape clinic in Kibera.

> If a [GBV] survivor walked in and saw so many people in the clinic, they might fear to say they've been raped and go on unattended … nobody knows they are there. By the time they are being treated, maybe it's already late in the evening and we all know that the earlier they get the medication, the better … Also, stigma. A survivor would think if I walk into a clinic, people would know that I'm raped … So that is why we decided as much we are still treating rape cases in the clinics, we thought why don't we have one aside, so that it's less stigmatizing. There is no queue. When you walk in, you can say 'Sita Kimya' or 'Tumaini,' [Swahili] word for hope … And it will be known that you've come for medical services. —*Nurse*

The nurse went on to explain that the opening up of MSF's rape crisis center coincided with the Sita Kimya campaign.

> As we were opening it up, Sita Kimya was still doing their campaign, so that's why we thought for people to identify with this clinic, why don't you join hands together and do the campaign … Because we are responding to rape, if we do something different from Sita Kimya, we'll confuse the community … And yet at the end of the day, it's one message. —*Nurse*

The MSF clinic had its own slogan, which was Respond to Rape, but the MSF staff felt it was important to make the GBV message coherent in Kibera. When MSF produced T-shirts to

promote their clinic, they included the Sita Kimya slogan as well. MSF informally partnered with the Sita Kimya campaign and their presence was considered a part of the project.

MSF's rape crises center is staffed with six health providers, including nurses, counsellors and a midwife. In 2012, the MSF rape clinic started operating on 24-hours a day. MSF also conducts awareness sessions for children in primary and secondary schools and sponsors survivor support groups. One nurse from MSF stressed the importance of empowering those who have been raped to come and share their stories.

> We started a support group and girls were looking at each other, even you were raped? … It's just a matter of sharing … bringing them together, they share, they give each other lots of moral support and encourage each other … for the life to go back to normal. —*Nurse*

When a survivor comes to MSF, a counsellor and a nurse initially received them, so that the survivor does not need to repeat their story. The nurse then does a medical examination. If a female comes in within 72 hours of her violation, she is given emergency contraception and PEP. Then, the counsellor is there to speak with the patient once again about her emotional condition and any test results from the examination. A one-week follow up appointment is made with the survivor to assess how they are doing psychologically.

A MSF nurse recounted that when the clinic began, they would see three to four cases a month, but around January of 2011, their caseload increased to around 10 per month and it has continued to rise to about 25–30 cases a month. The nurse explained that most of these cases are sexual abuse of young girls, approximately 7–11 years.

Community-Managed Systems of Care and Support

In order for the Sita Kimya campaign to be able to respond to the increase in demand for GBV services in Kibera, community-managed systems of care and support were needed. It was mandated as part of the awareness raising component, Pathfinder International and PSI partnered with existing community groups to strengthen community mechanisms that could assist survivors in overcoming barriers to GBV services.

Community Referral Mechanism—During the early stages of implementation, community members started to call project staff at PSI to seek help, however this was not a sustainable way of referring survivors to points of service. As a result, project staff established a community referral mechanism, drawing largely from the 2009 Kenyan National Framework Towards Response and Prevention of GBV, which advocates for a multi-sectoral approach to GBV services, including health services, psychosocial support, legal aid, and security.

PSI selected 27 community leaders based on the criteria of possessing a good social standing with the community and diversity of religion, age, gender and profession. The participants included village elders, community health workers, community paralegals and those from faith- and CBOs. To strengthen their capacity, the groups received in-depth training on GBV coordination and one of the sectoral areas. Participants were grouped into five location-based referral teams with representatives from each of the four sectors—psychosocial, health, safety and security, or legal aid.

The multi-sectoral referral team helped to ensure that all areas of GBV services were provided to survivors. One of the psychosocial community referral agents explained that their role was to offer counsel to the "traumatized" survivors.

> We counsel the survivors on basic training about how they are being traumatized because of the rape or defilement. So for the psychosocial, we went for training on counseling basic skills so in case we have a survivor, we must address and counsel him or her. —*Community referral agent, psychosocial*

The health community referral agents would relay information to the survivor on post-rape protocols, as well as escort them to seek medical care.

> We were being given information on how to know when someone has been raped, on the way to follow up, giving them information, taking them to the medical care, before 72 hours … and mostly following them up, following their parents, following the person who has defiled, who has done that. —*Community referral agent, health*

The agents listed a range of health facilities, including KNH's Gender-Based Violence Recovery Center (GBVRC), MSF Clinic at Olympic, Mbagathi District Hospital, Nairobi Women's Hospital, Medical Center Otiende and Langata Hospital. One of the referral agents explained that they preferred to take sexual violence survivors to KNH because they are the most helpful in providing proper documentation for the survivor. The same agent described that they had difficulty securing similar documentation from other facilities, such as Nairobi Women's Hospital.

One of the legally trained referral agents explained that they normally got involved a little bit further in the process.

> After the medical team, then the matter now comes … to legal. So, I go to the police station; I report the matter … First, the medical team must take the responsibility of taking the patient to the hospital to be treated. We have to get the evidence before going to the police, because whenever you go to the police, you have to go with the evidence to say that this and this has happened … after you have taken the matter to the police, we have to follow up. —*Community referral agent, legal*

The safety and security community referral agents would try to encourage the affected community members to take matters to the police. The safety and security community agents explained that they would escort perpetrators to the Chief's office or a police station, especially if the community was enraged at the perpetrator, so that they could avoid situations of mob justice. One safety and security agent described how they would assuage an incited crowd.

> We normally told [the crowd] that this person has committed an offense, but killing will not be a solution. He needs to be talked to so that he can change with time; so killing him is not a solution. Let us give the law a chance to take its course, so that the person can be proved guilty and then the child even again can get justice. —*Community referral agent, safety and security*

The team functioned as a network, so that they could comprehensively address the needs of GBV survivors in their communities. One referral agent described,

> Our role mainly was to identify those cases which are on the grass root and then after you refer them to various sectors … psychosocial … medical, security and legal. So we had to network. —*Community referral agent*

Another shared that they would go on house calls as a team.

> When we come at that house, we are about 5 to 6 people. Then, we ask you some questions. If you are the husband, what is happening … And then we ask the lady and she will give us the story. So, after hearing those two dialogues … we'll come up with a structure of how we can talk first to these people. —*Community referral agent*

Community members in Kibera became aware of the community referral agents over time through a variety of different channels. One agent shared that the referral network was advertised on the local radio station, Pamoja FM, so that people could contact the radio station to get in touch with the appropriate point person Referral agents shared that they would also introduce themselves at community events, such as funerals or church gatherings. Additionally, another agent shared that they would make themselves known to the existing community health workers.

> These community health workers, they know the households in which they deal with, so if they know there is an incident of rape in this house and they know this is [says name] and they deal with this kind of cases, so I'll call them. So, you find most of the community health workers have our cell phone numbers, so they call us. —*Community referral agent*

Another agent explained that having identification badges from Pathfinder International helped to identify them to the community.

The community referral pathways were sustained by monthly case conferences, during which the community volunteers and partners, such as the CREAW, CLAN, Women's Empowerment Link (WEL) and Government departments, reviewed cases that had been referred by the community volunteers.

> We used to meet with our colleagues and address the different challenges we have been having and how we can address the challenges. —*Community referral agent*

The conferences were instrumental in identifying bottlenecks to faster and more effective referrals for survivors.

The Kibera GBV Working Group—WJEI formed an additional community body that oversees GBV case reporting and activities in Kibera. The mandate of the group was to coordinate GBV prevention and response activities within Kibera based on the multi-sectoral approach to GBV. The working group members received additional training on GBV coordination, which enabled them to develop structures and a constitution to guide them.

The group comprised 50 representatives of local organizations and service sector representatives in health, legal aid, psycho-social support and security services, including representatives from the five community referral mechanisms. The primary awardee described,

> It is a multi-sectoral kind of thing, so we have all the sectors that have a stake. So in this GBV working group, you may even have a representative from the Ministry of Health or from a health facility, you can have community health workers, you can have the CBOs that are supporting gender activities at the community level. They are coordinating the GBV activities at the community level. —*Primary awardee*

Following the post-election violence in Kenya in 2008, the National Commission on Gender and Development formed the National GBV Working Group to facilitate rapid assessment and response to cases of GBV in the country. The National GBV Working Group continued to carry out coordination activities even after the emergency situation subsided. The Kibera GBV Working Group currently has representation in the National GBV Working Group, ensuring that community issues are heard at the national level and informing policy.

Paralegals and Community Legal Aid—Prior to WJEI, CLAN and CREAW had established a network of community volunteers who could help GBV survivors navigate the legal system. These legal aid agents are referred to as paralegals and the model was adapted from South Africa. Paralegals were selected based upon their association with a CBO. The implementer explained that this was a successful entry point for their organization to the community and the vision for the paralegal network.

> They were the first response mechanism at the community level, they would receive cases of abuse or gender-based violence. They would do the initial assessment … they would then refer to those services and if they needed further legal advice, [we would do an] assessment on whether this was a case that would go further … or it was just a matter of mediation or alternatives to litigation. —*Implementer*

Both CLAN and CREAW continue work with lawyers to provide legal aid to those in need. CREAW typically handles cases involving women, whereas CLAN provides legal assistance to cases involving abuse of children.

Paralegals described their role as a first responder to GBV cases in their community. If the case involved a child, they would liaise with the Children's Office in the District Administration compound in Kibera. If a sexual abuse of a child occurred, they would escort this child to a health facility to get treated and would work toward acquiring the proper evidence to be able to follow up the case in court.

As part of the project, CLAN oversaw the management of 6 groups participating in the paralegal network. CLAN also conducted additional capacity building trainings for approximately 25 people from these existing community networks. One paralegal described these trainings,

> We were taken through the trainings on how you could be able to write a report, you've got a case, can you be able to report this case? … we were taken for a training on children rights … to know to the best interest of the child, and discrimination, confidential, so that in all our dealings, we do this thing in a professional way, that could deliver justice to the offender or the survivor. —*Paralegal*

The paralegal went to explain that the trainings taught them how to advise and prepare GBV survivors for court

> You have to prepare the client on what's she expect or we expect in the process of going to court, how long it really take, so that we know she should not expect things to come with ease. —*Paralegal*

One implementer explained that the project provided increased coordination to these existing community actors.

Shelters and Safe Spaces—During the project, WEL strengthened existing safe spaces and shelters for survivors in Kibera. One implementer shared that the concept was to empower the individuals and structures that are already working in rescue, response and prevention of GBV and to provide them with technical support to continue their work. Safe spaces are homes where a community members host a GBV survivor for a period of two days. Shelters are often run my community groups and are places where GBV survivors can stay for a longer period.

WEL conducted an initial assessment, together with the Kibera GBV working group, and government representatives, to identify these shelters and safe spaces within the 14 villages in Kibera. The spaces were selected based on availability of space, willingness to act as a safe space, experience working as a safe space, security of the area, and referral networks. Five shelters and four safe spaces were identified within Kibera. One implementer explained the process of partnering with them.

> We asked them would they like to partner in such a project … We would not reinvent the wheel; we'll just go and empower them to do what they do, but … in a more coordinated way. —*Implementer*

In coordination with KNH, WEL conducted trainings for these individuals and organizations on the multisectoral approach to GBV and various health and legal referral resources throughout the community. During the training session, a set of standards was developed by the participants to maintain quality of the safe spaces and shelters. In addition, record books for monitoring cases, supplies and equipment were provided to support their services. An agreement was made between the safe spaces and shelters with WEL for the protection of the survivors.

WEL undertook efforts to inform key members, such as provincial administration, community health facilities and the various community referral networks about the existence of these safe spaces and shelters. One implementer explained that it was important for the spaces to be known, but not too known.

> Once they are known too much, then you put them at a threat. So, at least we give the partners their location and the contact people. —*Implementer*

The implementer went on to explain that the provincial administration invested their own resources into the safe spaces and shelters. Specifically, the provincial administration provided the spaces with food, such as maize, beans, and other dried food. Safe space and shelter representatives were also brought on board to join the Kibera GBV working group.

Women's Economic Empowerment Training—WEL conducted women's economic empowerment training for women's groups in Kibera and survivors who are part of KNH-GBVRC's support group. WEL conducted needs assessments with 15 groups. Thirty selected representatives from these groups attended a five-day training on the group savings and loan model and support group formation. The women came up with work plans on how they would reach their group members that were not at the training. The training also covered issues on gender roles, cultural beliefs, interpersonal relationships and communication, GBV and HIV/AIDS, which aimed at strengthening communication skills, critical thinking and leadership.

WEL held economic innovation spaces where members of specific groups discussed the possible innovative business opportunities. WEL linked the groups to reputable microfinance in-

stitutions, where they could apply for loans and expand their entrepreneurial initiatives. Some of the groups were involved in the following paid activities: dramatic performances, garbage collection, day-care provision, selling sandals, kale production and selling, selling second hand clothes, running cyber cafés, and being a landlord. Additionally, many of the groups were successful in increasing their savings and establishing group-lending protocols.

Key Findings: Implementation—Care and Support of Survivors

- The care and support component aimed to strengthen the capacity of KNH's existing GBV center.
- GBV services were to be consolidated into one space at KNH. Only minor renovations were completed because the plans were not approved by the Ministry of Public Works. The completed renovations included separate admission wards for both children and adult survivors, counseling facilities and security features.
- WJEI supported additional staff (including a doctor) at the GBVRC to model the potential of a well-staffed center. After the project's closeout, the center was not able to support the added staff.
- The project sponsored two trainings for 50 KNH staff, including doctors, nurses and clinical officers, on the Sexual Assault Forensic Examinations (SAFE) curriculum.
- Community-managed systems of care and support were established and strengthened to respond to increased demand for GBV services. These systems included a community referral mechanism, the GBV working group, community legal assistance, shelters and safe spaces for survivors, and women's economic empowerment training.

Project Strengths and Challenges

Awareness Raising

Strengths and Successes

Strong Communications Approach—Many of the community respondents expressed a strong appreciation for the Sita Kimya campaign, especially the tailored messages and the peer-educator approach. One community member exclaimed,

> I like the strategy, which [the sita kimya campaign] was using…the youth, they were choosing us, the youth who were targeting the youth. The old ladies, they were targeting old ladies…it was easy to interact and understand them at the same time … So, the strategy … was plus, plus, plus. —*Kibera community member, awareness facilitator, male, 18–25 years*

Respondents shared that campaign engaged all people in the society – fathers, mothers, young ladies and small kids – and covered a vast portion of Kibera.

> Sita Kimya, I can say it involved like women, we had a women's thing, a girl's and then, the men had their own thing. So, you could find that men were being empowered, so they were not left out. —*Kibera community member, women's economic empowerment group, female, over 18 years*

Some community respondents felt that the project had a distinct focus to include men, and not just women, as projects had done in the past.

All of the community outreach activities were linked with branded message of Sita Kimya. Many participants described this as a powerful, yet simple message that strongly resonated with the community. Community members felt the branded materials (t-shirts, lessos, bags,

etc.) were useful even after the project ended. Respondents cited that they continued to use the materials to spread the message and prompt discussion within the community, especially when they traveled elsewhere in Kenya. Some cite Sita Kimya as a kind of social movement or an anthem that helped to deter perpetrators.

Additionally, producing a film in the local environment proved to be a successful way to engage community members in the project. It enabled the campaign to reach a greater number and people otherwise not reached through peer education and community forum sessions. The production of the film was a highly participatory process and involved people within the community who were respected, could speak out and mobilize others.

Capacity-Building of Community Change Agents—The project built the capacity of many of existing CBO and individuals. Many of the facilitators who deal with children explained that the trainings helped build their capacity to frame effective messages to primary school age children. One community group representative explained that the project increased their capacity to work in schools.

> It opened ways for us to work in schools … we really utilized the opportunity that was created by Sita Kimya to continue working very harmoniously with the schools. —*Community-based implementer*

One paralegal shared that the project provided them skills and enhanced their authority to teach on these subjects.

> Through the knowledge that the Sita Kimya gave us, we felt strengthened … We moved from one level to another level … operation area was now bigger, so we felt that that courage, that authority of interacting and meeting new people. —*Paralegal*

Some community-based agents cited that they learned to manage cases calmly and not fear them. Others cited that the trainings increased their self-esteem and empowered them to talk to the community.

Some of the facilitators revealed that serving as peer educators helped them to be seen as leaders or resource people in their community.

> We became popular in the society. We not only handled rape cases only, but also problems between a husband and a wife, since we were known. The wife ran to us seeking help, we sat down and dialogued. —*Kibera community member, awareness facilitator, female, over 25 years (translated from Swahili)*

The Sita Kimya campaign helped build the capacity of community change agents in Kibera who continue to serve as leaders and GBV change agents in their community.

Community Engagement and Ownership—The Sita Kimya campaign utilized existing community networks and structures to implement the awareness activities. As a result of the extensive community engagement, there was a high sense of community ownership of the project. One community facilitator felt that the Sita Kimya campaign was different from other projects in Kibera, because it included the people from the community.

> Actually some other projects … they normally come from the West. When they come to Kibera, you find actually find a quarter of the people are not coming from Kibera. But actually Sita Kimya included a lot of people from Kibera, like 90 percent. It was kudos. —*Kibera community member, awareness facilitator, male, 18–25 years*

One paralegal disclosed that the implementers came to the "ground" often, they were not hierarchical in their approach, and they gave the community members a lot of leadership roles. One implementer described,

> This WJEI was unlike [other projects in Kibera]. The community was mobilized to own the project. So what I'd say is that community ownership was the biggest success of the project and even that community mobilization. So, that it was not only going top down, but there was that very unity from the down going up. —*Implementer*

Many of the community-based agents also cited that they liked Sita Kimya because it involved the people and enabled them to own project. They felt that the level of community involvement was a real accomplishment of the campaign.

Increased GBV Knowledge and Awareness—Respondents felt that community members were aware of the Sita Kimya campaign. One community member explained that before Sita Kimya, women were often raped and did not know how to handle the issue, but after the project, they now know their rights and that there are specific procedures to follow when raped.

> We, women, had trouble walking around. When you are walking, you would find people waiting for you … He just stands there and tells you that you are a woman. He grabs you and throws you down and rapes you. We did not know what you are supposed to do when you are raped, even that you could report the incident. You would stay silent, but when Sita Kimya came, I can say it brought along changes to us, women. We are now empowered. We can now walk around without fear, because now there are no people waiting to attack you and not be arrested. Now when Sita Kimya came, we learned the post-rape procedures and what you should do first … We are very grateful for Sita Kimya. It has empowered women. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

An overwhelming number of participants and facilitators shared that they observed an increase in community awareness around available GBV-services, appropriate reporting procedures for sexual abuse, and rights consciousness. Another community member explained that women in marriages are particularly more aware of their rights.

> At times you are with your husband in the house and he oppresses you in the house. He beats you every day. And we did not know that we have rights and can report to the law. We used to stay silent. Now, when Sita Kimya started, we found out we have rights that protect us in our marriages … I used to be beaten all the time and stay silent, but nowadays, I don't keep quiet. I have to go and report at the chief and meet there with my husband and deal with the matter there. So Sita Kimya has really helped us a lot. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

Sita Kimya was instrumental in creating rights consciousness around GBV amongst community members in Kibera.

Attitudinal Changes—The awareness sessions aimed to change people's religious and cultural attitudes around GBV, as well as other patriarchal values that promote gender inequality. A number of the male facilitators discussed successful strategies they employed to tackle the hard task of changing community attitudes. One male facilitator explained that when he would get hard-headed participants, who used culture as a way to justify behaviors the promote gender inequality.

> People are stubborn; they justify their deeds using tradition and we tried to enlighten them using all possible means, even the word of God. —*Kibera community member, awareness facilitator, male, over 25 years (translated from Swahili)*

He would engage the men in an argumentative dialogue and explain the legal ramifications for their actions. Similarly, another male facilitator explained that he would have his male participants think about the issue of IPV from the female perspective.

> We just ask the question, you as a man, if someone comes and forces you, how would you see [it]? So, if he says that I will see [it as] bad. That is also the way the woman sees, bad, so if you force someone, it means that you are the one who is doing the bad thing, so you need to change, start talking, not forcing things … if we talk, we can get a solution. —*Kibera community member, awareness facilitator, male, over 25 years*

Another male facilitator described that in his group sessions he tackled the issue of normative IPV with male participants. When he broached the subject, the male participants shared that women are beaten because they make mistakes and need to be disciplined. This facilitator would counter this by posing questions to the participants that made them empathize with their female partner.

> You start from somewhere, before you [introduce] them to the law. Tell them, how do you think your son is feeling when you are beating his mom? Very bad. Or you start by asking them, if somebody is beating your mother, how would you feel? You hear how they react … So, you see that argument comes in a way that lets them try to know that it inflicts pain when we beat and … somebody is being offended. Then, you come back and you [explain] the law and you let them know that this is punishable. —*Kibera community member, paralegal and school facilitator, male, over 25 years*

The facilitator also stressed the importance of knowing your audience when tackling attitudinal change.

> Changing people's attitudes depends on the information you give … these are people with different background and education background … you have to know the target, who is your audience … lead by knowing who are your people … Let them talk, let them bring all the information, start asking them questions … —*Kibera community member, paralegal and school facilitator, male, over 25 years*

Another male facilitator explained that male participants would often cite cultural and religious rationales for perpetuating GBV. He stated,

> When you start talking to people about issues of gender issues, gender-based violence, there are those cultural values that they want to cling onto. —*Implementer, awareness facilitator*

He went on to share that he used his knowledge of religion to engage his participants in dialogue and refute their claims.

> Well Christians will tell you in Ephesians, chapter 5; verse 22, they will tell you it says, 'Women submit to your men because they are the heads of your house.' And then I will counter them and tell them, 'Read it all the way to verse 25, which tells must love your wife as girls love their child.' Between love and submission which is stronger? … And then they go, 'Oh, ok we didn't see it that way.' The Muslims will tell you that the Koran does not allow them to associate with women … But I will tell them that if they read Koran, chapter 3, verse 495… [women] need also to be educated and given space for them to enlighten themselves and enhance their capacity knowledge-wise and in terms of skills. —*Implementer, awareness facilitator*

The facilitator also tried to encourage his participants to think more critically and broadly about tradition and culture.

> I really delve deeper … looking at the male privileges and costs. None of them have ever looked at it as if they're a leader, a decision-maker, a protector, and with the changing times, also a provider … I was looking at the deeply entrenched masculinity issues … and if we really need to cling to these hegemonic kind of masculinities or if we need to have some concessions. —*Implementer, awareness facilitator*

Community respondents cited that after the project they observed attitudinal and some behavioral change. Facilitators explained that the awareness session helped to dissipate some of the tribal attitudes in Kibera because the sessions promoted the caretaking of others, despite ethnic allegiances.

> When Sita Kimya came, it has made us now live in the community with love. It taught us and let us know that we are all Kenyans. We stopped tribalism. We stopped and now we love one another, as neighbors. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

Another community participant shared that the project helped make people more respectful and well mannered.

> What I liked most is that it has brought improvement and that people are respectful and mannered. Those who thought to do bad things and rape because of fear and the law, things have cooled down here in the neighborhood. This issue was very rampant in the neighborhood. Now, you can stay up to almost six months without hearing anything. It has brought about respect among the youth and that I am so happy. —*Kibera community member, awareness participant, female, over 18 year (translated from Swahili)*

Respondents explained that there had been real attitudinal change in those who participated in the project.

Breaking the Silence—The sessions were interactive and aimed to inspire participants to speak out against GBV, especially amongst the female participants. Facilitators emphasized that they used the sessions to break the cultural silence around GBV in their community. One young facilitator explained,

> I was a Stella Maries facilitator—our role mainly included mobilizing girls to form a group and then in that group, we would sensitize the community about women's rights. In case you are raped, you shouldn't keep quiet, you should express yourself. —*Kibera community member, awareness facilitator, female, 18–25 years*

Another facilitator described that the sessions enabled participants to understand the importance of speaking out and reporting GBV cases.

> As we work together, those who had kept quiet about [GBV] see the importance of speaking out and reporting … so that one is treated before they get infected. —*Kibera community member, awareness facilitator, female, over 25 years (translated from Swahili)*

In order to facilitate such openness, facilitators used different strategies. One of the male facilitators explained that it is first important to create rapport with your participants.

> First, we create a rapport … you give yourself as an example first. Once you give yourself as an example, they open up to you, and then you find people starting to contribute … people were exchanging ideas and from the same experience, you get the answer to your problems. —*Kibera community member, awareness participant, male, over 25 years*

Another facilitator explained that she would share personal stories to which survivors could relate.

> You stand up and try to give a similar story to the young girl who is affected … so when you give your story out, you can get one or two girls who have the same story as yours. So, they can come to you and explain to you what happened. So as you give your solution, what you did, they can also get the solution to their problems. —*Kibera community member, awareness facilitator, female, 18–25 years*

Even if you don't have a similar experience, some facilitators shared that they would construct a story in order to relate to the survivors.

Other facilitators described that engaging in a dialogue with the participants would inspire breaking the silence. One male facilitator shared that participants would engage with them by asking them questions. Similarly, one female facilitator explained that she posed questions to her participants to open up.

> For the most part, we were just posing questions to bring up to open the session, so then the mothers could just express themselves. As they talk to us, we refer them where possibly to find solutions within ourselves, within the mothers, as mothers … we were trying to teach, as we listen to them. Then we counsel them; we find solutions to their problems … For example, when you find a child has been defiled, we refer them to the medical response team … In the case we find it's something that happened a long time ago and there is a person with that trauma, we take the person to the counselor. —*Kibera community member, awareness facilitator, female, over 25 years*

Through the process of breaking the silence and opening up, the community facilitators were able to work through problems with the participants.

Respondents shared that they felt that through the message of Sita Kimya, people were increasingly speaking out about cases and there was a reduction in the stigma associated with experiencing violence. One facilitator explained,

> Before Sita Kimya came, people were fearing to say that I'm raped because they fear that people may discriminate them … when Sita Kimya came, we were able to open our heart to say what we feel, to say what we say, on what we see. So, that came. —*Kibera community member, awareness facilitator, female, 18–25 years*

Many respondents expressed that they knew GBV was harmful prior to the Sita Kimya campaign, but they would not speak openly about it due to stigma. However, through the sensitization sessions, many shared that they are now able to speak up about GBV incidents.

Empowered Children—The campaign was successful in that it explained GBV concepts to children in a very accessible way. One community member explained,

> These children act as agents of change … The information reached them at their tender age, that could allow them now to start knowing what is right and what is wrong, and again this will help us to change the new generation. —*Kibera community member, awareness participant, female, 18–25 years*

Additionally, school facilitators explained that they observed children increasingly speaking up about incidences of violence and abuse. One paralegal, who conducted sessions in schools, described,

> At the end of the sessions, I believe the children they could express themselves and know that these should not be done to me. So, if this is done to me I should be able to report. And with the slogan the Sita Kimya, it came out very clearly, because the children now understood that, if such and such is happened to me that I should not keep quiet. —*Kibera community member, paralegal*

Another community member, who is also a parent, shared her appreciation for Sita Kimya teaching her children about good and bad touches. She explains,

> I am grateful to the people of Sita Kimya because they have gone through schools teaching our children. Even when you meet a child, and touch them like this, they say to you, 'don't touch my private part' … So, I am grateful to the people of Sita Kimya. They have penetrated. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

The respondent went on to describe how one time her 9 year old son was approached, suspiciously, but because of the lessons he learned through the Sita Kimya campaign, he was able avoid this suspicious person and return home. Through the messages of Sita Kimya, children were able to avoid suspicious people and risky predicaments.

Challenges and Limitations

Lack of Community Resources—Due to lack of resources and poverty, many of the community-based agents explained that it was difficult to complete project tasks when they also needed

to earn daily wages. Many of the as awareness facilitators and community referral agents were volunteers with a small stipend to assist their work, but many of the respondents shared that it was not enough to do the work. Many facilitators and community agents cited spending personal funds to take survivors to points of service or serve refreshments at sessions.

Additionally, many of the community referral agents cited that it was difficult to fully do the work when they did not have the financial resources to fully support the survivors. Many of the community agents escorted survivors to service facilities and often used their own money to pay for transportation and phone costs. Many cited that people would call them in the middle of the night, which was particularly difficult because of a lack of security at night and first aid kits. One agent described,

> You don't have the first aid kit and … you wait till dawn to take her to the hospital. Because for the security purpose, you can't just walk in midnight … So, there has to be a first aid for this mama to survive, maybe to stop bleeding until morning, then you take her to the hospital. —*Community referral agent, health*

The community agents expressed passion for their volunteer work, but explained that it is difficult when they were called upon to follow a case and someone else was calling with a work opportunity.

A similar problem existed for the participants, as their time in the sessions competed with their ability to earn a living. One female participant explained that many of her peers have children and while they were interested in the awareness sessions, they also practically needed money or milk for their children. Another female participant explained that many of the participants were too preoccupied with acquiring income to thoughtfully attend the sessions.

> At times you are in training, but you cannot concentrate because you are thinking of what your children are going to eat when you leave there. You would be worried and could not concentrate … Our problem is many of us are unemployed. We come here for training … We would like you to continue to bring us this training, but also consider empowering us financially, so that we are not worried, since most of us here are single mothers and we have no income. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

One male facilitator explained that people were willing to stay for one hour, but after that they would often leave to earn money for food and they would ask him why this wasn't provided for them.

Community Facilitation Difficulties—Some of the community-based project agents expressed that they were not always equipped to deal with the complexities of all cases because their training had only focused on a specific aspect of the multi-sectoral approach to GBV. One facilitator suggested that community agents should be trained comprehensively on the multi-sectoral approach, so that they are better equipped to deal with actual cases.

Additionally, many facilitators explained that it was often difficult to secure venues in Kibera where they could conduct awareness sessions. While, there are a number of community halls in Kibera, they often cost money to rent and the project did not provide such compensation. One facilitator explained,

> It was our responsibility to look for a hall … there were some organized groups, but their room is very small and you need other people, because the classes were supposed to be not less than 30. There are some offices, which cannot accommodate that number, so you have to hire a hall and the hall fee was not being given. —*Kibera community member, awareness facilitator, male, 18–25 years*

Facilitators were given branded materials to distribute to the participants, but due a limited amount of materials, there were sometimes conflicts within the groups. One facilitator shared that some participants found such materials petty.

Some facilitators felt nervous about going to the areas of Kibera where police would not go. One female facilitator explained this fear.

> When someone knows you are a leader and you teach people … they threaten you because they know you are one to forward cases to authorities. —*Kibera community member, awareness facilitator, female, over 25 years (translated from Swahili)*

Despite this sense, no one reported having any major security incident. Some community agents were given identification badges and they expressed that these helped, but more were needed for all the project agents.

Limited Community Commitment to Case Follow Through—It was difficult to follow-through with cases, as many survivors or parents of survivors would drop the issue. Many agents described that there was often a lack of follow through on the part of the survivor or survivor's family. Some cited that mothers of abused child were often uninformed or tired of the legal process to pursue the case further. Additionally, cases were often dropped due to lack of evidence or witnesses from the community not showing up to court out of fear.

Difficulty Getting Involved with Domestic Issues—Community project agents revealed difficulties they had when getting involved in people's personal affairs, especially given the normative acceptance of domestic violence. Some respondents explained that women complained about IPV, but then would return to their partners.

> Dealing with marital issues was a very big challenge … it's really a delicate issue because sometimes this woman will come and report that she has been battered, but again you'll find her going back to the same house … So, it was really hard to tackle that. —*Kibera community member, awareness participant, male, 18–25 years*

Additionally, community agents revealed that domestic disputes between intimate partners are challenging because it was difficult to know who is to blame. One participant explained,

> When it is a husband and wife, you cannot come in between that, because you come between … you become the bad one. —*Kibera community member, awareness participant, male, 18–25 years*

One facilitator stressed the importance of understanding the problem first, before reporting it.

Varying Acceptability of Messages—Even though the messages were tailored to specific-population groups, there were some instances where the messages were not acceptable to some in

the community. Some facilitators cited that certain schools or teachers were not open to these messages as well as those with dissenting opinions or attitudes with regards to rape, physical IPV, and the existence of marital rape. One facilitator reveals,

> Some of [people] still believe in cultures, whereby they believe they are not supposed to change some of the issues that actually are happening. Like men, you find that men are not really willing to accept some of the messages that we are giving out. You'll find a man who still believes that whenever his partner or wife messes up or does something, wrong thing, he has to hit. So, they still believe that for them to be regarded as real men they have to batter their wife. So, those are some of the challenge, actually to take their minds out of what they believe. —*Kibera community member, awareness facilitator, male, over 25 years*

Another community member explained that it is difficult to change the minds of substance users in Kibera.

> When you meet with drunkard and drug abusers … and start talking to them about these issue, you are asking for trouble … they might say they'll beat you up. That is a challenge that we have … They are the non-receptive lot. —*Kibera community member, awareness participant, female, over 25 years (transated from Swahili)*

School facilitators cited that some religious schools or teachers were not open to new teachings around sex, sexuality and violence. Additionally, teachers were sometimes the perpetrators.

Limited Population Reach—Some respondents felt that the project did not reach all of Kibera. They cited various reasons for this being the case, including limited time-frame of the project. One paralegal explained,

> The impact was good, but it had a short period … Everybody knew this issue of Sita Kimya, but now we could not reach the Kibera, as a whole. As much as we reached the target areas, but not Kibera, as a whole … we wanted it to be something like … one or two years for the impact to be felt in the community. —*Kibera community member, paralegal*

Additionally, facilitators shared that it was difficult to reach all of Kibera because males are difficult to recruit and there is high community turnover, so that many who we were trained have left KIbera and new residents settled.

Short Project Period—An overwhelming number of respondents explained that the Sita Kimya project period was too short, as community facilitators only implemented the awareness sessions over a 3 to 4 month period of time. One implementer explained that with such a short period, the project may have achieved attitudinal change, but it was difficult to observe any real behavior change.

> In terms of behavior change, what is happening? Have people now stopped violence because they are more … or is that just information that, yes, we know gender-based violence is wrong, but what is it we are doing about it? And I think that has not happened up to today. —*Implementer*

One community member shared a similar sentiment explaining that the project needed to more awareness sessions in Kibera in order for real change to occur.

> Even though the project has ended, there is still work to do with GBV in Kibera. We need more than a short time period to make people really change or make them realize that violence is happening, so we still need to sensitize people to deal with the issue in our community. —*Kibera community member, awareness facilitator, female, 18–25 years*

Key Findings: Project Strengths and Challenges—Awareness Raising

Strengths and Successes

- The awareness-raising component of WJEI in Kenya was regarded as the project's strongest. The Sita Kimya campaign had strong communications approach that incorporated a well-branded slogan, tailored messages, peer-education, comprehensive geographical targeting, male engagement, and locally produced film.
- The project built the capacity of community change agents and the extensive community engagement resulted in a strong sense of community ownership of the project.
- The campaign contributed to an increase in GBV knowledge and awareness around available GBV-services, reporting procedures for sexual abuse, rights consciousness, and children speaking out about incidences of abuse.

Challenges and Limitations

- Due to lack of resources and poverty, it was difficult for volunteers to participate in the project when they also needed to earn a living.
- Facilitators encountered difficulties, such as having a limited knowledge base, securing session venues, and getting involved in domestic affairs.
- Sometimes the campaign's messages were not acceptable to certain community members, such as some teachers, religious leaders, people with strong dissenting views, and substance users.
- Due to the limited project period and high community turnover, the campaign did not reach all of Kibera and did not comprehensively achieve sustainable behavior change.

Legal System Support

Strengths and Successes

Increased Police Support and Judicial Uptake—Some respondents explained that the gender desk at the police station has helped to reduce some of bribery and corruption.

> Now the police, if you take the issue to them they help you follow up, but they did not do that before because the perpetrator would offer a bribe and the case would end there. —*Kibera community member, awareness participant, female, over 25 years (translated from Swahili)*

Additionally, many respondents shared that after WJEI community members were increasingly coming together to apprehend perpetrators through formal channels.

> The successes were like when people now started getting together to maybe even apprehend a perpetrator … so I think that was very successful. —*Kibera Community Member and Activist)*

Other community respondents revealed that there is less mob justice as a result of the project, because community project agents were active in rationalizing with angry crowds and successful in encouraging them to seek legal redress.

Additionally, respondents shared that within the judiciary, the adjudication of child sexual abuse cases increased. One police officer revealed that the Kenyan judiciary takes cases of that nature more seriously than other forms of GBV.

> Especially the defilement … you cannot escape that … whether there is consent or there's no consent, once the offense has happened, I'm telling you can't escape that … in defilement, unless you prove to court that you didn't know the age … the punishment is always there. —*Police officer*

Despite the fact that they are taken more seriously by the judiciary, still many cases of child defilement take very long to come to any conclusion.

Challenges and Limitations

Lack of Coordination with DOJ—One of the major challenges with regard to this project component was that the DOJ implemented this component and there was a lack of coordination between them and the USAID/Pathfinder International team. The primary awardee respondent explained that due to USAID guidelines, they could not work directly with the judiciary or police (i.e. legal authorities). USAID was supposed to coordinate with the DOJ in Kenya to see where the teams could coordinate their work, but this streamlined communication did not function as expected. The primary aware respondent expressed,

> [There] needed to be better coordination, because at some point, as we worked and we were identifying the policemen who we thought needed to be trained and we get back to the US Embassy, the person who was coordinating, that was before the current one, they would say that they're supposed to be doing training elsewhere. So, we thought … if we are implementing in Kibera and this is where all the three components are supposed to work together, I thought that needed to be better understood and strengthened, so that at the end of the day you can actually say this is what we were able to do in Kibera. —*Primary awardee*

Additionally, during the course of the project, the DOJ changed the personnel managing this component.

Deficits in the Law—In Kenya, the national GBV law, the SOA, does not address the issue of marital rape, making it nearly impossible to prosecute in court. One police officer explained,

> So that is a challenge to us, you see. How do you take somebody to court, under which section? They report it, especially married women, they report such cases, so what do you do? … Which offense, if it's not in the SOA? … What will I charge this person with? … Something should be done about the SOA … I will not lie to you. They have never gone to court, never. —*Police officer*

Without proper legislation addressing all forms of GBV, willing authorities are prevented from moving cases forward.

Judicial Barriers—Respondents cited a range of judicial barriers that impede case follow through in court. The Kenyan courts take a very long time to process and settle cases. Many cases stay pending for long periods of time because of the limited judges and magistrates. One implementer estimated that cases typically take 3 to 5 years in court and shared that due to WJEI, there was an influx of cases presented to the judiciary, which contributed to a significant backlog of cases.

Additionally, the court drops cases due to lack of evidence. One Judiciary intern explained,

> In terms of evidence, you find some cases don't have the merit, or the required evidence to sustain that matter before the court, and finally you have the accused being acquitted … Because when the medical examination is done after quite some time, you always find that there is not enough grounds for it to sustain such kind of a case before court. —*Judiciary intern, implementer*

Child abuse cases are often dropped in the court system. One police officer stated,

> When such a case goes to court and the child is under the care of the mother. You'll find she's threatened in the community and when the hearing date comes, you do not see this child. So, if you do not see the child for like three hearing days, the defense will say they are not interested, my client was brought in court, no one has come to testify … And it is a straight forward case. —*Police officer*

Another respondent shared that the court often requires the child's testimony, which can be a deterrent for many. Defendants also drop cases due to court delays, fear of ruining their family's reputation, received-threats, especially mothers of defiled children because the sentence for defilement is heavy. Lastly, incentivizing witnesses to come to court is difficult.

> That a big challenge because in in Kibera, nobody will be willing to become a witness, because now they think maybe they can be arrested. Most people here in Kibera live from hand to mouth, so going there, you waste all the day … so you find that nobody might be so willing to become a witness. It's a big challenge. —*Kibera community member, school awareness facilitator*

One barrier to moving cases through courts is that witnesses who are key to moving cases forward in the courts are often scared to testify or they prioritize work over going to court for the day.

Cases being handled within the community by elders or other respected leaders also impede the ability to prosecute perpetrators through proper legal channels. One facilitator shared,

> Most of the cases are not being referred to the Judiciary authority. Most of the cases are being held at kangaroo level. Those are the courts, whereby I call my mom, you call your dad, and then you sit together. Then you say, 'how much is it? I don't want this case to be taken to the next level. —*Kibera community member, awareness facilitator, male, 18–25 years*

Families convene with elders or opinion leaders and settle on a financial amount as to not pursue the case any further. Some respondents cited that this is particularly common of child sexual abuse cases.

Police Difficulties—There was the perception from many community respondents that the police are unsupportive of GBV cases and sometimes even harass survivors, leading some to drop the case. Some respondents shared that the officers who were stationed at the gender desk and trained during the WJEI project were sensitived to GBV survivors, but unfortunately, these trained officers were few. Some were also transferred and not being used in their GBV capacity. One police officer explained,

> In [GBV] desk we are only ladies now. The guy who has trained with me, he's not here, he was transferred … if you take me to somewhere, like a department that doesn't deal with such cases … you're wasting me … I am supposed to be helping because I have been trained for it … Yeah, transfers are too much. —*Police officer*

The officer went on to describe that high police turnover and staff shortages impede their abilities to serve as witnesses in court.

There was a lack of coordination between the police and health sector for the purposes of obtaining justice. There is only one police doctor in Nairobi who must certify the initial medical examination or examine the survivor for a sexual violence case to proceed to court.

> He's not only dealing with sexual cases, he deals with the assault, domestic violence, those ones, he deals with the murder cases. He's so tired … Sometimes you go there, people are so many … the survivor gets tired. —*Police officer*

One judicial intern shared that there is small window of time survivors are able to go see the doctor and it can often take a while for a patient to be seen. Additionally, the respondent explained that the police officers who are supposed to collect the evidence from the hospital do not always follow through, impeding case follow-through.

Perceived Government Corruption—Many of the respondents perceived corruption at all levels of the government, which discouraged them from seeking help from the authorities. One awareness facilitator explained that community members gave them reports of bribery with police and local administration.

> Referring someone to the chief is very challenging, because, here in Kenya, what I can say, corruption works out, so the person can go there and give out money and he is released and the case is over.—*Kibera community member, awareness facilitator, female, 18–25 years*

One community member explained that people who have some money or connections to the government are not culpable for their actions. Another male community member shared,

> You will find out that most of the people who are the perpetrators have money, but the victims come from poor families and the government is corrupt. How can we help the victims to get legal aid? … There's a very big gap between the rich and the poor. So, you find that I have got money … I cannot be taken anywhere. —*Kibera community member, awareness facilitator, male, 18–25 years*

Additionally, respondents explained that the charges for which the perpetrators are tried can change without explanation.

Key Findings: Project Strengths and Challenges—Legal System Support

Strengths and Success

- The gender desk at the local police station helped to reduce some of the bribery and corruption previously encountered with the police.
- Community members participated in less mob justice after the project and perpetrators were increasingly apprehended through formal channels.
- The adjudication of child sexual abuse cases in the courts increased.

Challenges and Limitations

- There was a lack of coordination between the DOJ and the USAID/Pathfinder International team on the implementation of the legal component.
- The SOA in Kenya does not address the issue of marital rape, making it nearly impossible to prosecute in court.
- There were a number of judicial barriers, including the delay in in processing and settling cases in court, lack of evidence, defendants dropping cases and the community continuing to handle cases on their own.
- There were difficulties with the police, including the perception of police as unsupportive of GBV cases, high turnover of trained officers, and a lack of coordination between the police and health sector.
- There was a perception of corruption at all levels of the government, which discouraged many from seeking help from the authorities.

Care and Support of Survivors

Strengths and Successes

Increased Support for GBVRC—During the WJEI project period, respondents cited a useful increase in support for the GBVRC. One of the KNH health providers revealed that her favorite aspect of the WJEI project was the addition of key staff to increase the capacity of the GBVRC. She specifically cited the importance of having a medical doctor on staff, as well as the administrative help to systematize the information management system. Unfortunately, after the project ended, the center was no longer able to retain the doctor. Based on the institutional memory of the having that doctor, another KNH health provider explained,

> Having a medical doctor in this center would be, it would really make a difference, a big difference to the survivors … [patients] are not able to pay for the services that we cannot offer [in the center], and sometimes they cannot get that service because of the lack of money. —*Psychiatrist*

When GBV patients received care outside of the GBVRC at KNH, they were often financially liable for the services provided. Not having a doctor within the center free-of-charge is an ongoing challenge for the GBVRC.

Additionally, respondents cited that the project increased hospital staff sensitization on GBV due to the SAFE curriculum trainings. The project also helped to increase the GBVRC's visibility to the KNH administration, as the hospital is now devising a five-year strategic plan for the GBVRC

Helpful Community-Managed Systems of Care and Support—One of the strengths of the project was the helpful community-managed systems of care and support for GBV survivors. The safe spaces and shelters helped facilitate the follow-through of cases. One implementer explained,

> The shelters also have helped their response because many cases we are able now to follow up. Because most of the times the survivor disappeared, we were not able to follow up … So, the cases just disappeared like that. —*Implementer*

Additionally, the community referral mechanism proved to be a successful strategy to deal with GBV cases arising from the community. Respondents cited that there were numerous referral people, allowing cases to be reported more frequently. Additionally, many respondents feel that the existence of referral agents and paralegals greatly improved the follow up of GBV cases. It also helped to reduce the number of community-handled cases, as some observed that fewer cases were being dealt in the kangaroo court.

The Kibera GBV working group also proved to be a useful mechanism to oversee local GBV activities and cases. The group's members informed each other of upcoming awareness sessions, which reduced the duplication of efforts in Kibera and facilitated greater coverage of areas. The group facilitated networking amongst community stakeholders and enhanced partnerships. Since the project, the group has grown and is more systematic in tracking GBV cases in Kibera.

Challenges and Limitations

One-stop-shop Model Not Completed—The project design team intended to undergo serious renovations to the GBVRC at KNH in order to strengthen its capacity to provide comprehensive health care to GBV patients. However, due to administrative challenges and delays in structural tests, the project was not able to complete the objective of establishing a one-stop model at KNH.

Personnel Issues—The respondents from KNH revealed their disappointment when the hospital was not able to retain the added GBVRC staff after the project was completed. GBV survivors are still able to receive mental health and basic health services from the GBVRC, but they have to wait if they need to be seen in the casualty department. One health provider explained,

> We have to work with the casualty department. There are very many difficulties in this, many challenges because sometimes after we have done our bit, and we take the patient to the casualty department, you find that the doctor who is supposed to see the patient is engaged elsewhere … because it's only one doctor at call at a time … Sometimes, you wait for three hours or four hours before he or she shows up. So that's another challenge that we have. —*Psychiatrist, KNH*

Respondents also expressed the need for onsite pediatric surgeons, gynecologists, and social workers. Additionally, respondents shared that there is high turnover, especially within the casualty department, and many hospital staff are still not sensitized on the proper GBV protocols.

Hospital Barriers to Access—While many of the services provided to GBV patients are complimentary, such as PEP and counseling, many critical GBV needs were not, such as antibiotics, x-rays, inpatient visits. Additionally, KNH respondents shared that the hospital complex is quite large and because patients need to go to other departments to seek services, the process and the multiple queues often intimidate them. Lastly, respondents explained that the center is not open on the weekends or holidays when many GBV cases arise.

Limited Women's Economic Empowerment Training—Some of the women participating in the economic empowerment training and the implementers expressed that the training was limited. The training did not train all the members of each economic empowerment group and, as a result, there were sometimes internal leadership conflicts within some of the economic empowerment groups. Additionally, many of the groups were still very limited in their capacity. When they come up with products to sell, it was hard to market. WEL linked the groups with markets through the Kenya Export Council & Women Enterprise Fund, but it was still a challenge because women were not able to produce at a high enough scale, because they lacked raw materials and skills. Many of the women in the groups who were not trained could not access bank loans, because they needed guarantees or existing accounts. As a result, many women did not use their loan money available to them from the Women Enterprise Fund.

Limited Resources for the Shelters and Safe Spaces—Despite the fact that the shelters and safe spaces helped ensure the follow through of more GBV cases, many respondents explained that the shelters and safe spaces were often not adequately equipped with food, bedding, and transportation costs for GBV survivors. These spaces were also not permanent solutions for the survivors.

> We don't have a shelter that can shelter somebody for a long time. Even if I said it's a few days, they themselves, they have other people there. So, they don't have food, maybe, beddings is a challenge. So, they would want to take more, but they don't have that capacity. —*Nurse, MSF*

One USAID Kenya respondent shared that this model can be difficult to sustain because of their ongoing needs.

> I'm not quite sure how this model can be sustained because one of the biggest challenges we're facing is in terms of food. Many people are hesitant to take in people because they still don't know how will I feed them. And you're not able to buy food because you can't distinguish what goes to the survivor or what goes to the family. So, the safe space, as much as it's a very community-focused concept and very useful in protecting survivors, it's challenging to sustain…the key question will be how do they accommodate survivors, and for how long can they accommodate survivors. —*USAID Kenya*

Additionally, there were many GBV survivors needing space and only a few safe spaces and shelters, so they were not able to meet the demand for their service in the community.

There were also no opportunities for survivors to partake in income generating activities while at the spaces. Many respondents explained that this is necessary in order to provide alternative options for survivors, especially women who are abused by their husbands. Some safe space managers revealed that it was difficult to reintegrate survivors back into the community and often survivors ended up going back to the source of abuse.

Key Findings: Project Strengths and Challenges—Care and Support of Survivors

Strengths and Successes

- During the project period, the GBVRC benefitted greatly from increased staff support and hospital-wide sensitization to GBV.
- The project strengthened community-managed systems of care and support for GBV survivors.

Challenges and Limitations

- Due to administrative challenges, the project was not able to establish a one-stop-shop model at KNH.
- The GBVRC was not able to retain the added staff after the project ended.
- Due to high turnover of hospital staff, many staff at the hospital are not sensitized on GBV.
- While some services provided to GBV patients are complimentary, many critical GBV-related needs are not.
- The shelters and safe spaces were often not adequately equipped with food, bedding, and transportation costs for GBV survivors.

Sustainability

Ongoing Community Based Activities in Kibera

The WJEI project built the capacity of many of the CBO and individuals who still continue some of the activities they were doing during the project. Respondents shared that the community referral mechanism, awareness sessions, and the GBV working group continue to assist GBV survivors in accessing medical and legal services.

> We have continued … on our own … We just voluntary ourselves and we continue with the work … Since it is helping our community, we have to continue with this work because we cannot leave it. We are continuing on our own just to help the community. —*Kibera community member, community referral agent, security and legal*

However, some respondents expressed that when the project ended, the level of engagement amongst community agents declined. One male facilitator shared,

> We had these referral programs and they were really working … there were people ready on the ground, if this thing happened, then you would contact directly … but then after the project ended, it's like everything has died with it, slowly. —*Kibera community member, awareness facilitator, male, 18–25 years*

Many of the awareness facilitators and participants explained that through their existing community networks and groups they are still involved in GBV awareness outreach activities, such as group awareness session, one-on-one peer counseling, and community drama events. One facilitator shares that her group continues to use the Sita Kimya IEC materials, such as pamphlets, to educate community members about GBV. Other community project agents shared that they are also still conducting school-based GBV awareness sessions through CBOs. The CREAW paralegals conduct forums to sensitize selected teachers from schools in Kibera and have instituted children's rights clubs.

> The children right clubs, this is a place where the children meet on a monthly basis … to work on-talk on issues that affect them. So, if any child has a problem, either in the family setup or within the school, they could write about that and then the club would be able to discuss … we left our numbers as the facilitators with them … they could just send the text message … then we will call back … this is something that we had to do to make sure that

> you get this information [to the children] because relying on teachers alone, this would not let us get information because some of the teachers are perpetrators. —*Kibera community member, paralegal and school facilitator, male*

Similarly, another CBO started "talking boxes" in Kibera schools. Students write down their concerns and grievances anonymously on pieces of paper and leave them in the boxes. One community respondent explained that Sita Kimya empowered many children who do not want to be silent, so the talking boxes provides an outlet for them to speak out about issues that they cannot express verbally.

A few of the community project agents shared that they are still seen as GBV teachers or "ambassadors of change," which helps them to sustain their community activism. One facilitator cited that she is sometimes stopped on the street to answer questions about GBV. Another awareness facilitator shared,

> Once you have the knowledge, you are a graduate in economics, you will always be an economist, you see? So, it means for what we gained from USAID and the Sita Kimya project, that knowledge will always remain in our heads till the end of time. So, we actually use it, even in our houses, even when I see something bad happening here, I won't even be able to cope with it. I will actually be able to stop it. —*Kibera community member, awareness facilitator, male, 18–25 years*

By endowing the community facilitators with GBV knowledge and information, these community members were able to help to sustain the mission of the project even after its conclusion.

Key Findings: Project Sustainability—Ongoing Community Based Activities in Kibera

- Some of CBOs and community members continue some of the activities from the project. However, when the project ended, the level of engagement amongst community agents declined.
- By endowing the facilitators with GBV knowledge and information, these community members were able to help to sustain the mission of the project after its conclusion. Community project agents are seen as "ambassadors of change," which helps to sustain their activism.

Continuation of USAID GBV Activities in Kenya

USAID currently supports GBV activities in Kenya through the current phase of the APHIA funding mechanism. One primary awardee respondent explained that these funds are being used to build upon the Sita Kimya model and replicate best practices from WJEI elsewhere in Kenya. One of the implementers shared that WJEI demonstrated a useful community response model that was complementary in its approach and this is one the key strategies they are working on replicating.

Under this new funding mechanism, GBV working groups have formed in Dagoretti, Kangemi, Makadara, Kamukunji, Coast, Mombasa and Malindi. These groups slightly differ from the community level working group model in Kibera in that they are at the district level and comprised of actors from the health sector, judiciary, and the police. The groups ensure that cases are reported and that structural issues within the district are addressed. The implementers also work through these groups to ensure that APHIA health facilities have the appropriate medicine and equipment for GBV related cases, as well as issues with corrupt police posts are addressed. Despite the difference in the levels, the KIbera GBV working group, which has continued operating, is seen as a learning site for burgeoning groups elsewhwere in the country.

Additionally, the new phase of funding has continued to use the Sita Kimya messaging, as they extend their awareness raising activities. One implementer expressed,

> We've tried to keep the Sita Kimya campaign alive … We all along thought that this would make a really good national program because just Kibera is not huge and just with the impact we saw in there, in Kibera. If you could extrapolate, or if you could just imagine being asked all over the place nationally, you'd have greater impact. —*Implementer*

The primary awardee shared that the Sita Kimya campaign was a "hit" and they are currently using the same training curriculum, wall branding, and messaging strategy in other communities in Kenya. Partners under this new phase work to have GBV messages integrated into existing programs that deal with family planning, condom use, VCT, HIV/AIDS drug adherence, men who have sex with men, sex workers, and other vulnerable populations.

There is also an emphasis in this new phase to focus on strengthening partnerships and linkages between GBV stakeholders. The primary awardee is continuing to work with key WJEI partners, such as PSI, CREAW, WEL and MEGEN. In the steering committee, they also added representatives from the police station near Kibera, the gender officer, MSF and the Kibera law court prosecutor. On the health service front, the primary awardee is partnering with KNH GBVRC, MSF, Nairobi Women's Hospital, and Mbagathi District Hospital. The primary awardee is also hoping to work more strategically with the judiciary and the Chief Justice's Office, so that they can address the backlog of cases.

Key Findings: Project Sustainability—Continuation of USAID GBV Activities in Kenya

- USAID currently supports ongoing GBV activities in Kenya and is building on the Sita Kimya model, replicating best practices.
- GBV working groups have formed in elsewhere in Kenya, but these groups differ from the model in Kibera in that they are implemented at the district level.
- USAID sponsored awareness activities use the same training curriculum, wall branding, and messaging strategy in other communities in Kenya. Partners are working to integrate GBV messages into existing programs that deal with sexual and reproductive health.

Next Steps

Continued Awareness Raising Activities in Kibera

Many of the community respondents express that there is still a need to conduct more GBV awareness raising activities in Kibera. They explained that because the Sita Kimya campaign only operated for a short period of time, they were not able to reach all of Kibera. Some referral agents expressed that more education efforts are needed around rights consciousness, legal procedures, and first aid. One facilitator shared,

> We need to go on empowering the community, so that they can get more knowledge how they can handle such cases. So, we need more people to be empowered. —*Kibera community member, awareness facilitator, female, over 25 years*

Another facilitators explained that inspiring behavior change around GBV and gender equality takes time.

> You know change is gradual, so as much as we sensitize the community and women on not to keep quiet, but to air out their views, I think it didn't spread that much … We did a good job, yes, but our efforts didn't spread and go far … Kibera is wide. —*Kibera community member, awareness facilitator, female, 18–25 years*

Implementers also acknowledged that the Sita Kimya campaign was too short to inspire widespread change around the social norms that fuel GBV. One implementer explained that it is particularly important to integrate GBV messages into school curriculum to create a generational change. This indicates that GBV projects should be longer and focus on integrating GBV messages into existing activities and structures. Another implementer shared her preference for a 3-year GBV project, as that would allow more time to support sustainability during the project closeout.

One paralegal shared that GBV messages should be ongoing in the community.

> It doesn't matter where we stopped; it doesn't matter who has got it, but it could be like a song that people sings everyday. —*Kibera community member, paralegal and school facilitator, male*

The respondent stressed that they continue to reach the entire society, especially the younger generation, because they are the ones who are able to eliminate this kind of injustice within the community.

National Priorities

Many of the respondents identified ongoing needs for GBV infrastructure within their country. Respondents emphasized the importance for GBV activities to be replicated in other parts of the country. One community member shared her enthusiasm for replicating the Sita Kimya campaign elsewhere in Nairobi.

> We should spread the gospel of Sita Kimya all over Nairobi now, not in Kibera, but all over Nairobi. —*Kibera community member, awareness facilitator, female, 18–25 years*

Another community member expressed,

> You can see in rural areas, the information of Sita Kimya is very low … So if they can at least hire people to go in those areas and pass those information, it would be a good idea. —*Kibera community member, awareness facilitator, female, 18–25 years*

One implementer explained that it is important for Kenya to strategize and focus on regions where this is a high prevalence of violence (e.g., Coast, Western, Central, and Kajiado, near the Tanzania border). One legal aid lawyer shared that when she travels to rural areas of the country, people are particularly unaware of the SOA and their rights. The primary awardee explained that increasing awareness in other communities will mean that the citizens of Kenya start holding the government more accountable.

> Today, the Kibera community is able to hold the government accountable. But we need many other Kenyans to hold the government accountable. —*Primary awardee*

Address Underlying Causes of GBV—Respondents also shared that it is important for GBV projects to address the underlying and root causes of GBV in order to make GBV programs more sustainable.

> Let us always address the root causes of the problem because where we have been failing is we address the symptoms, rather than looking at what is actually happening. —*Kibera community member, awareness facilitator, male, 18–25 years*

The respondent went on to share that one way to do this would be to provide economic empowerment support for survivors, so that they can thrive in their communities. One implementer stressed the importance of demonstrating GBV as an issue of power and control, addressing gender stereotypes, and promoting positive masculinities that embrace gender equality.

Engage Men and Boys—Relatedly, respondents stressed actively engaging men and boys in GBV activities to promote sustainability. GBV is typically viewed as a woman's issue, but it should be presented as an issue that affects the entire family. One USAID respondent shared,

> I think the whole component of working with men is very crucial. After all, we are now beginning to hear increased reporting of men as victims. And so, a lot of our work has maybe focused on women as victims. Men are victims, and we have not been able to do much more on men and boys as victims. And yet KNH is reporting that so much of the clients are men or boys. —*USAID*

Additionally, community respondents shared that some men feel excluded from the development initiatives and some even fear the increased focus on women's empowerment.

> Men should be involved in the forums to enlighten them that on the issues, still on the issues of the rights of the women … So that the understand why we are educating the women on their rights. It is not because we want to break this homes; it's because we want to bring the harmony to the family. We want to lift up the standard of the living. —*Kibera community member, paralegal, male*

One implementer suggested focusing on men as protectors, not perpetrators, explaining it is important to build their self-esteem and train them on the importance of taking care of girls and women in their community.

Promote Community Based Initiative—Additionally, respondents emphasized the importance of investing in local initiatives and networks as a way to sustain GBV efforts. One implementer stressed that it beneficial to be aware of the local ways of responding to GBV and child abuse. Similarly, another implementer explained that it is important to establish local initiatives because implementing organizations eventually leave. Another implementer shared that CBOs are the ones implementing project, but are often not receiving the funds.

> The small organizations are the ones … on the ground, they are the ones who are talking to the survivors and implementing it … How do we help them to grow to get to a certain level because they are the ones that are doing the dirty work? The national organizations they get a lot of money but they don't go to the ground. —*Implementer*

One community project agent suggested that donors involve local community members in the design of projects as a way for their efforts to sustain.

> [Donors] should always be involving community in terms of helping them to design the program … We have seen programs designed by outsiders, as I may put it, where communities are not involved in designing, they just work for the organization that brought it and not for the community…I would propose that in the near future when certain institutions want to do something in a certain community or society, they should be involved at the word go in terms of designing the program. —Kibera community member, awareness facilitator, male, 18–25 years

Strengthen Kenyan Judiciary and Train Police—Respondents stressed the need to strengthen the capacity of the Kenyan judiciary to prosecute perpetrators as a necessary next step for GBV efforts in Kenya. One community member revealed,

> The procedure of reporting and the procedure of taking your case to legal assistance, it becomes so long so that even the victim himself or herself loses hope. So the procedure should also be shortened. —*Kibera community member, awareness facilitator, male, 18–25 years*

One implementer explained there are laws in place, but that there is still gap in the enforcement and implementation of those laws. It is important to constantly examine inadequacies and improve upon them. Many respondents expressed that there is also a significant backlog of cases in the judiciary that needs to be addressed. Acknowledging the bottleneck, one police officer offered a suggestion.

> If we have a specific court that deals with such cases, not even court, just a specific magistrate…that deals with SOA cases, actually that one will speed … So, I think something should be done about that. They should put special court … because these cases are very sensitive. —*Police officer*

Respondents also cited the need for police reforms, supporting that is the role of the Kenyan government to sensitize officers on issues of GBV, encourage friendliness and a gender-sensitive environment.

> Most of [the police] should be taught about this sexual offenses, they should all know, I think they should put it as a subject from the word go when you are in training, and you know how to handle about this. —*Police officer*

One judicial intern cited that the police need to be better at collecting evidence and the investigations because this is where they "are losing a lot of grip" in the courts.

Promote One-Stop Service Models—Respondents supported the need for more one-stop GBV service models. One USAID respondent explained that this network of GBV service does not necessarily need to be in one physical location, but instead can operate as a streamlined referral mechanism that incorporates all the critical sectors of GBV response.

> The one-stop-shop is … working through partnership. A lot of the Kibera GBV partners provide different services along the path … it's almost like a virtual pathway … survivors who are simply tired of being tossed from one place to another, sometimes they don't have the energy … So, what Kibera project is trying to do is just create some continuum. —*USAID*

Referring to comprehensive health services (i.e., medical and psychosocial), one of the health providers expressed the desire it to be available in one space.

> I wish we would get somebody who can really fund [a one-stop center], so that we have everything under one roof. —*Social worker, KNH*

A lawyer identified the need for there to be a community center where survivors can at the very least access a doctor and a legal and/or a police officer, citing that this would solve many problems.

Increase Kenyan Government Support—Respondents cited that the government of Kenya has been increasing its attention to gender issues since the institution of the new Constitution. One implementer described,

> We interacted with the Ministry of Health, we interacted a bit with the Department of Children Services, the police a little, but … I didn't see any deliberate move to make the government embrace what was going on and build up on it, that link was missed … There was involvement; there was enthusiasm when WJEI was on, a lot of enthusiasm from government, but … there wasn't a lot of government pick up and running with it … putting measures in place, or building upon the gains of the WJEI project. —*Implementer*

The government needs to invest more resources in GBV in order for GBV activities to be sustained after donor sponsorship has concluded.

Key Findings: Project Sustainability—Next Steps

- In Kibera, there is a further need for GBV awareness raising activities as the Sita Kimya campaign was too short to influence sustainable change in social norms that fuel GBV.
- For Kenya, it is important to focus awareness efforts on regions where this is a high prevalence of violence and invest in local initiatives and networks to sustain GBV efforts.
- Projects need to address the root causes of GBV and present GBV as a concern for the entire family, not just as a woman's issue.
- There is still gap in the enforcement and implementation of GBV laws and a significant backlog of cases in the judicial system that must be addressed.
- There is a need for more one-stop service models for GBV survivors. They do not necessarily need to be in one physical location, but instead can operate as a streamlined referral mechanism that incorporates all sectors of GBV response.
- The government needs to invest more resources in the response to GBV in order to sustain efforts.

This in-depth examination of the WJEI has yielded a number of lessons learned with important implications for GBV response in sub-Saharan Africa. In this section, the key strengths and challenges of the project are summarized for the four country settings individually and across the project as a whole. Drawing from the research, recommendations pertaining to the three WJEI components are presented: awareness raising/behavior change, strengthening legal/justice response, and service provision for survivors. The chapter concludes with overarching recommendations for future GBV programming in sub-Sahara Africa based on the strengths and gaps which emerged from the evaluation.

South Africa

Strengths of WJEI Project

Establishment of 23 New Thutuzela Care Centers (TCCs)
South Africa had an existing structure for survivor support services, called TCCs. The one-stop-shop model was widely regarded as a best practice for providing GBV survivor services, integrating psychosocial and medical support for women and children, as well as legal services to help survivors to report cases. The WJEI project in South Africa used the funds to expand the network of the TCCs, building an additional 23 centers in 9 provinces. Extending the reach of these TCCs was an important accomplishment of the WJEI project in South Africa.

Facilitating the Transfer of TCCs to Government of South Africa
During the course of the WJEI project, the Government of South Africa was assuming responsibility for managing and staffing the TCCs throughout the country. The WJEI implementing partners collaborated with the government to ensure that this transfer happened smoothly.

Expanding Services to Rural Areas
The TCCs were implemented in urban and rural sites throughout South Africa. An important strength of this model was that it provided a blueprint for services that could be replicated in rural areas, where access and quality of services had been a problem.

Capacity Building Within Judicial System
USAID assistance was used to support the development of judicial training curricula and materials on sexual offenses. This was conducted in conjunction with the new Judicial Education Institute. Skills for court personnel were also strengthened, including prosecutor led investigation, medical evidence/testimony, and the use of intermediaries in cases involving child witnesses.

Challenges Faced By WJEI Project

Women's Use of TCC Services Was Still Limited
Despite the expansion of TCCs throughout South Africa, the implementers acknowledged that the majority of cases seen within TCC facilities were children, not women. Encouraging more women to use the services was an ongoing challenge. Awareness raising efforts within the WJEI project were focused on providing information on TCC services. Despite this, there were still challenges associated with getting adult female survivors to access services.

Limited Capacity for Follow-Up Care
The TCCs model is limited to the acute period of time following an assault. There is need for more follow-up care for survivors that cannot be provided through these centers. In addition, many of the TCCs were only open during normal working hours, and many assaults occurred in the evening or on weekends, when these services were not operational.

Delays in Prosecution of Cases
There was also recognition that the lengthy delays in the legal system caused problems for prosecuting cases that were seen in the TCCs. Despite the WJEI efforts to improve the training of courts regarding sexual offenses, the courts were backlogged and cases often took long to prosecute through the system. This presented a major disincentive for women to follow through on cases through the legal system.

Zambia

Strengths Of The Project

Passage of the Anti-Gender-Based Violence Act in 2011
The Act had come before parliament twice before the implementation of the WJEI project, but did not pass due to lack of interest among members. As a result of targeted lobbying of parliamentary members by the DOJ arm of the project, the law was passed by parliament on the third try and enacted in 2011.

Improving the Existing Two CRCs and the Establishment of an Additional Six
In Zambia, the WJEI was designed to strengthen GBV initiatives that were already on the ground. Funding was therefore dedicated to strengthening service provision in the two existing CRCs and establishing six more. The locales of the CRCs were selected based on high rural populations. The CRC one-stop-shop model was received very well and stands as a best practice to deliver comprehensive services for GBV.

Success in Raising Awareness and Transforming GBV-Related Norms
The awareness campaign was very successful, raising the profile of GBV and moving it into the realm of unacceptable behavior in communities and among those in the public sphere. Some of the success is attributed to using community change agents—men's groups, traditional leaders, etc. who lived within the communities in which they worked.

Strong Collaboration Between USAID and Zambian Government Partners
The relationship allowed for the speedy establishment of new centers because permits were forwarded to the right sectors with priority. At the end of the project, the MoH took over the management of the CRCs, leading to a sustainable continuation of services in a phased plan. Many of the former CRC staff are now working for the MoH.

Improved Case Reporting and Adjudication
There were more cases were reported to the police. Among reported cases, a higher proportion of them were prosecuted than before the project. The passage of the Anti GBV Act at the end of the project period made it easier to prosecute cases. Previously, it was difficult to build evidence for conviction in a GBV-related case based on the general criminal code.

New Focus on GBV Response

The WJEI was a large endeavor that helped publicize the need for more attention towards GBV programming and response. As a result, the Zambian government is now giving more attention to GBV programming, and there has been an increase in donor funding for GBV-related activities.

Challenges Faced By The Project

Heavy Reliance on Volunteers Reduced Efficacy of Care Provision

The CRCs in Zambia were primarily staffed by volunteers, who required specialized training in GBV-related service provision. This included health practitioners—who were employed in different parts of the health system, paralegals and others who provided direct services to women and children. Volunteer health practitioners prioritized their paying jobs over their duties to the centers, which amounted to less availability of care for CRC clients. Other types of volunteers, such as counselors and paralegals, left the CRCs if they were able to obtain paid employment for doing the same job elsewhere (mostly within the MoH). Therefore, this potentially cost-effective and high community-engaged system of care weakened care provision and strained the project as new volunteers had to be recruited and trained often.

Stand-Alone CRCs Were Less Successful Than Those Located Within Health Establishments

CRCs in health facilities housed all types of staff who were more available and these centers were open for longer hours. Women seeking care in CRCs outside the city did not receive the range of services that the CRCs were planned to offer and were often turned away because of staff shortages. Similar to South Africa, these centers were effective for women in the acute period of time following an assault, but were limited in what they could provide women on a longer term basis.

More CRCs Are Needed.

Related to the issues described, 24-hour crises care was very limited. This applied even to those CRCs located within health establishments, which often closed in the evening due to staff shortages. Rural access to any CRC was a problem because of poor roads, limited public transport and long distances; no form of transport was offered to women who did not live within walking distance to a CRC. CRCs need to be established in rural areas.

Lack of Safe Houses and Reintegration Services

There were only two safe houses in the country, meaning that the vast majority of women had to return to their community with no reintegration services.

Strategies to Make Communities Safer Are Needed

Much has been accomplished through the awareness campaigns. However, gender norms that reinforce GBV as well as fear and stigma around GBV still pose threats to service implementation and case prosecution. Related to this is the need for more work focused on making communities safer for women in general and for those who are returning after seeking service.

Lack of Coordination Between the DOJ and USAID Arms of the Project

The USAID service end of the project and the DOJ justice end worked mainly separately to achieve the overall aim of reducing GBV in Zambia. A closer working relationship with the DOJ personnel would have bolstered the awareness and service provision parts of the project by facilitating easier referrals between the health and legal systems. The legal piece was not tailored to the Zambian context. DOJ personnel had much less experience with Africa than

USAID personnel, and there was little effort to leverage USAID's experience in the country. This experience would have ended in a stronger project.

Ongoing Need for Donor Funding
Even though some of the CRCs are being run by the MoH, some are still dependent on donor funding to balance the costs. It is unlikely that the government can raise the funds needed to provide services and fill the gaps noted here without donor assistance.

Benin

Strengths Of WJEI Project

DOJ, Dept. of State, and USAID Collaborated Closely for a Harmonized Approach
The presence of an initiative coordinator facilitated a successful collaboration between USAID, the DOJ, and the State Department. This led to an integrated programmatic approach between the justice, awareness and care and support arms of the project, maximizing the use of existing resources.

Strong National and Local Collaboration
Part of the strategic approach was to ensure collaboration between actors at the national and local levels to ensure smooth service delivery. The establishment of national and local synergy groups along with local referral systems encouraged cooperation and coordination across sectors at the local level. The approach also engaged community members and organizations in program activities.

Awareness Campaigns Transformed Norms and Attitudes
The project succeeded in transforming attitude and normative changes pertaining to women's rights and GBV. Project messages were particularly effective in highlighting women's rights, which helped awareness campaigns resonate with the population and encouraged women to report cases of violence.

The Case Reporting Process Improved
The project promoted formal reporting of GBV cases and helped many survivors through the process of reporting cases of violence to the police. A possible result of more cases being brought forward was an observed success in reducing cases of violence in communities.

Passage of the GBV Law in 2011
DOJ actors were instrumental in the drafting, promoting, and passing Benin's first GBV-specific law. The project effectively lobbied law makers and conducted media campaigns. Project staff brought members of civil society, the justice system, and government workers and officials together to build momentum for the passage of the bill.

Challenges Faced By WJEI Project

Less Project Coverage in Rural Areas
There was often unequal coverage of the intended project area, particularly in isolated rural areas. Smaller communities were left out of the project's awareness efforts. More work should focus on these underserved areas.

Resistance to Focus on Justice for Perpetrators
Though there was widespread support of anti-GBV sentiments and messages, there was resistance to the punitive approach promoted by the project. In many communities, there was resistance to formal case reporting since many people view incarceration of community men to be disruptive to family structure and order. Mistrust of police, who were perceived to be corrupt and inefficient, proved to be a further barrier to the acceptance of formal case reporting as the primary recourse for survivors of GBV.

Omission of Men and Boys in Awareness Messaging
Many men felt left out of the GBV messaging, which was solely focused on women. Community members thought that if men and boys and their rights had been addressed in the messages, local awareness campaigns would engaged them more effectively in the project's aims.

Lack of Means for Survivor Support
There was a lack of funds and transportation to help survivors seek medical care and obtain medical certificates necessary for charging perpetrators of rape. This limited the efficacy of local referral networks. Secondary medical facilities and courts were difficult for many women to access, limiting both the quality of support for the adjudication of GBV cases.

Lack of Integrated Survivor Support
Many implementers pointed to the lack of financial support and housing for survivors as an oversight and detriment to the project's primary goals. The lack of these resources was a critical gap in care and support services, as many survivors were rejected by their families as a result of their decision to hold perpetrators legally accountable for their actions. Implementers found that the availability of such integrated support would help survivors to build courage to report cases of violence.

Kenya

Strengths of the Project

A Strong Communications Approach Was Employed
Formative research led to tailored messages around GBV, reaching all sectors of Kibera's population. Messages were disseminated at community forums, peer-education, and school-based sessions. PSI developed the locally branded slogan, Sita Kimya, which means "I will not be silent." The slogan was printed on IEC materials and used in murals painted on community structures. The campaign name, logo, and content were tailored to local community appeal, resulting in messages that resonated with community members.

Community Ownership Was Created Through Participatory Methodologies
The project involved individuals and organizations in the community already mobilized and working on GBV. The project also strengthened community-managed systems of care and support for GBV survivors. By extensively engaging with the community and building the capacity of change agents, there was a high sense of community ownership of the project.

Strengthened Community-Managed Systems of Care and Support for GBV Survivors
The project built the capacity of existing networks and groups to manage sustainable community systems of care and support for GBV survivors. These systems included the community

referral mechanism, the GBV working group, safe spaces and shelters, and economic empowerment training. The community referral mechanism was successful in facilitating case reporting and directing GBV survivors to services. The GBV working group was useful in overseeing local GBV activities and managing community cases, and the safe spaces and shelters helped facilitate the follow-through of cases.

Success in Raising Awareness, Promoting Attitudinal Change, and Breaking the Cultural of Silence Around GBV

The Sita Kimya campaign was successful in raising awareness of GBV as an issue in Kibera. The campaign increased knowledge and awareness around available GBV-services, reporting procedures for sexual abuse, and national GBV laws The campaign also resulted in more community members speaking out about incidences of abuse and breaking the culture of silence and stigma around GBV that was the norm in Kibera, prior to the project.

Increased Support from Police and Judicial Uptake of Defilement Cases

The gender desk at the local police station helped reduce the bribery and corruption that impedes the process of GBV perpetrators being brought to justice. More child sexual abuse cases were tried in court. Community members participated in less mob justice after the project, and more perpetrators were apprehended through formal channels.

Increased Support to the National Hospital for GBV Services

The center at KNH dealing with GBV survivors, the GBVRC, markedly increased their functional capacity as a one-stop-shop model of GBV services during the project. The center increased staffing to include a doctor, administrative support and more mental health specialists. General hospital staff was also trained on GBV and appropriate clinical protocols. While the hospital was not able to retain the increased staff after the project period, the project demonstrated to implementers what is possible when resources are available to provide comprehensive health care to GBV patients.

Challenges Faced by the Project

Heavy Reliance on Community Volunteers and Lack of Community Resources

It was difficult for participants and community volunteers who served as project agents to work for the project because it required hours of effort, and they also needed to work. Community project agents also often lacked the resources needed to complete their work, such as funds to rent venue halls for awareness sessions, phone credit to speak to survivors, or money for transportation to assist GBV survivors in accessing care and support services. When incorporating local community change agents in a project, they need adequate funding in order to carry out their duties, otherwise they end up frustrated and disheartened.

Short Project Period Limited What Could Be Accomplished

Due to the limited project period, the awareness raising campaign was not able to reach all of Kibera. The short time also made it difficult for the community awareness facilitators to promote widespread behavior change around GBV. Project implementers and/or evaluators were also unable to assess any changes in attitudes and behaviors since the project did not operate for a long enough period to observe such a change.

Lack of Coordination Between the DOJ and USAID

In Kenya, the DOJ implemented the legal activities and USAID oversaw the awareness and

care and support components. During the project, there was limited communication between the DOJ and the USAID/Pathfinder International team and as a result, there was also a lack of coordination between these two arms of the project. While WJEI employed a three-prong approach to address GBV, the project components ended up functioning as independent projects, ultimately minimizing the effects of an integrated approach.

Continuing Barriers to Justice in the Legal System
A number of judicial barriers existed prior to the project and persisted afterwards. These included lengthy court processes, lack of evidence, defendants dropping the case, and cases being handled by the community. The SOA in Kenya does not address the issue of marital rape, making it nearly impossible to prosecute in court. There was also widespread community perception of corruption at all levels of the government, discouraging many from seeking help from the authorities. Lastly, police challenges, such as lack of coordination between the police and health sector, high police turnover of trained officers, and the community's perception of police as unsupportive, impeded justice from being served.

Ongoing Struggles for KNH's GBVRC
The project aimed to enhance the capacity of KNH's GBVRC to function as a one-stop-shop model for GBV services in Nairboi. However, due to administrative challenges, the project was not able to complete the full renovations it had originally proposed and the center continues to face challenges that impede their work. After the project ended, the GBVRC was not able to retain added staff. Due to high turnover, some hospital staff have not been trained on GBV protocols. More coordination with and buy-in from the Kenyan government and hospital administration may have facilitated more sustainable changes with regard to this project component.

Pilot phased project in Kibera may not be easily replicated in all of Kenya—Building on existing assets from the community is a strong approach to programming. However, coordination among the various local actors across the country can be challenging. While implementing GBV activities that rely heavily on community engagement is a real asset for sustainability, management of such activities on a national scale is difficult. Additionally, Kibera is a unique environment where there are high concentrations of organized community activists able to take on these roles. Such civil society development does not exist in all communities throughout the country. The challenge associated with this targeted geographic reach is that it is difficult to draw conclusions from this approach that could be replicated on a larger scale in disparate contexts.

Recommendations

This section describes the key recommendations for future efforts for GBV response in sub-Saharan Africa. The recommendations are drawn from the successes and challenges of the WJEI initiative that were observed. First, recommendations specific to each of the three components of the project are discussed. Overarching general recommendations related to GBV response are presented last.

Recommendations For Each Project Component

1. **GBV awareness-raising Initiatives should be tailored to specific audiences, accounting for age and gender, strategized to involve men and boys. In addition, community members should be engaged as change agents.**

The success of the Sita Kimya campaign launched in Kibera, Kenya demonstrated how a tailored communication campaign could effectively resonate with the community. The messages of the campaign were relevant to and resonated with the community and were communicated in a way that powerfully reached the audiences. The engagement of community members as change agents in Zambia and Kenya showed the power of such people to transform community norms. The experience from Benin demonstrated the need for engaging men and boys.

2. **Bottlenecks in the legal system need to be addressed in order to both motivate people to report incidents and promote case prosecution.**
   A major challenge faced by each of these countries was the lengthy process required to prosecute cases of violence through the court system. There are already disincentives for women to come forward and bring charges against their assailants. The long delays in getting the cases addressed through the court systems create even more of a disincentive for women. For example, in Benin, women dropped cases reported to the police before they even got to court because of frustration linked to the lengthy delays in the process. This was compounded with the police encouraging reconciliation with their partners, rather than moving forward with a formal complaint. The lack of coordination between the DOJ and USAID in three of the sites limited the success of making meaningful changes to the legal processing of cases in these four settings. Having specialized courts for GBV cases such as the ones in South Africa would provide better security for women and could potentially alleviate the delays.

3. **Acute care and support services for women should be integrated at one location when possible, and services need to extend beyond the acute period.**
   The integrated care model that was implemented in two of the four WJEI project countries (South Africa and Zambia; Benin planned to implement the model after the project period) is considered a best practice for providing acute care to women following an assault. The centers provide integrated psychosocial, medical, psychosocial and legal services at one locale. The one-stop centers facilitate the many types of care that women need without having to rely on a referral system which also requires women to seek services at multiple locations. The effectiveness of this model was demonstrated most clearly in South Africa, where the largest network of centers is housed, and even reaching rural populations in remote areas. The one-stop center model was also very successful in Zambia. Lessons learned from the WJEI raised several issues that must be considered in implementing this model in sub-Saharan Africa:

   - **24 hour access is critical.** The programs in South Africa and Zambia both had centers that were only open during business hours—the time when an assault is least likely to occur. This meant that women dependent on those centers had no access to care when they needed it most.

   - **Access in rural areas.** In South Africa, the TCCs extended into remote areas, but in Zambia, they did not, due to concern over staffing. If it is not feasible to locate a center in a rural area, resources should be dedicated to solving transport and other access barriers for women living in remote areas.

   - **The service structure must incorporate a longer-term focus on the needs of women following assault.** Transitioning women from the one-stop centers to the

community for longer term follow up and support was challenging in each country. There was a lack of safe house networks that could accommodate women, and there were no strategies for reintegrating women back into their own communities.

Overarching Recommendations

1. **Effective coordination between multiple donor sectors should be planned into the design and implementation of projects like the WJEI.**
   There was variability in how much overlap between the programming arms of the DOJ and USAID in each site. All sites would have benefitted from greater coordination between these two arms of the project. Both pieces are critical to GBV response. Mechanisms must be put into place for women to be able to report perpetrators, and for those cases to proceed through appropriate legal channels. Psychological and physical health services will aid case evidence and provide women with essential care. As mentioned, the support offered should address the acute crisis, but go beyond and address women's long term needs.

   » **Countries implementing GBV programs based on justice initiatives must include acute services for women.** In Benin, where the emphasis was on the legal and justice aspect, integrated GBV services for survivors were insufficient, particularly in medical follow-up. Encouraging women to come forward to report a case without providing comprehensive care can further endanger them physically, psychologically and socially.

2. **Multi-country projects employing similar GBV responses, such as the WJEI, should have planned coordination mechanisms to enable sharing experiences between countries.**
   Each of the countries included in the WJEI project were very different with regard to what was known in each about the context of GBV (e.g., prevalence, risk factors, cultural norms), the extent of GBV programming (e.g., health, social and legal services), and the level of awareness about GBV in the government and civil society. The approach to address GBV in each place varied as a result of these different landscapes. However, more communication and coordination among the four sites could have resulted in a stronger response.

3. **GBV projects need better M&E; countries need GBV M&E systems.**
   One major limitation of this evaluation study was a lack of baseline data in all of the sites. Each GBV project needs a sound M&E plan that includes an evaluation design. Evaluations that are planned as part of project design will assess its various approaches and their effects. The information gleaned from a rigorous evaluation can be used to build evidence for best practices. Programs with good monitoring systems will run more efficiently since there will be constant feedback from the data about how well the program is operating, including collaboration with various stakeholders. This relates to both the coordination between different project arms within one site as well as different program sites. None of the WJEI sites had M&E plans. An M&E plan for each of the country sites would have included a description how the DOJ and USAID arms worked together. An M&E plan for the WJEI as a whole would have defined how countries would share and benefit from each other experiences. On another level, if each of the countries had a national GBV plan, the interventions implemented by the WJEI would be part of a wider system of GBV response and effectively coordinated with initiatives already taking place, thus maximizing program impact.

4. **The scope of the project should be carefully considered.**
   The project sites varied in their geographic scope, which affected the intensity of the programmatic reach. For example, the site in Kenya was one community in a small geographic locale, while the site in Benin was comprised of the entire country. The focus on Kibera exclusive to the rest of the country allowed for a very intensive campaign that reached the majority of the target population. On the other hand, this factor was limiting in that the approaches used could not be readily extended to a larger geographic area. The program in Benin tried to achieve a national impact, but quality of services was highly variable and rural areas were underserved. In selecting such a large scope, the effectiveness of the project was compromised because it was logistically impossible to reach everyone. In Zambia, the project focused on seven districts and was more balanced in its scope, which has enabled Zambia to craft a model that can be scaled up with the right resources and planning.

5. **GBV programs in sub-Saharan Africa should be built on existing models when and where they are present and effective.**
   In countries with effective GBV program models, further programming should seek to augment them. This was consciously planned in both South Africa and Zambia and demonstrated how effective programs can be when harnessing existing efforts in implementing a new endeavor.

6. **Programs should be aware of the benefits and risks of engaging volunteers in the implementation of a program.**
   In Zambia the over-use of volunteers wasted resources and left gaps in service provision; however, some of those same volunteer drop outs served to help the sustainability of the project since most went to work for the MoH, which took over the management of the CRCs. In Kenya, people did not have the time or resources to carry out their duties. In Benin, volunteers were highly motivated but limited in their impact due to lack of resources to help survivors seek necessary care and support.

South Africa

Implementation

- The Thuthuzela Care Centers (TCC) were the cornerstone of the WJEI in South Africa. The WJEI funds were used to establish 23 new TCCs in 9 different provinces throughout South Africa.

Strengths

- The TCC model is widely cited as a best practice model for survivor support, providing integrated medical, legal and psychosocial services in one facility.
- The TCC model shares widespread support from the government of South Africa.

Challenges

- There are some challenges to implementing the TCC model including (1) continued barriers to adult women seeking services in TCCs; 2) Limited ability to provide follow-up services for survivor and 3) poor follow up on prosecution of cases because of long delays and inefficiencies in the court system.

Sustainability

- Because the TCC model is widely endorsed by the South African government, the likelihood that these services would be supported and sustained through government funding was high.
- As part of the WJEI implementation process, the government assumed responsibility for the support of some of the TCCs and the WJEI implementing partners worked with the government to ease this transition.

Zambia

Implementation

- The goal of the project was to build on the existing model of CRCs in Zambia.
- Project design decisions were based largely on the baseline evaluation surveys and on the goal of strengthening existing services.
- The awareness and behavior change portion of the project was expansive and participatory, involving men, youth and others as change agents in their communities.
- The two arms of the project—the USAID service end and the DOJ justice end—worked separately to achieve the overall aim of reducing GBV in Zambia; the project may have been more effective if these two arms were coordinated.

Strengths

- Strengthening the 2 existing CRCs and establishing 6 more went as planned.
- CRCs offering more comprehensive services—those in hospital settings—were more successful than stand-alone centers.
- The awareness campaign was very successful, raising the profile of GBV and moving it into the realm of unacceptable behavior in communities.
- More cases were reported, and a higher proportion went to prosecution.
- The DOJ presence in the country was instrumental to the success of the legal component.
- One of the major accomplishments of the WJEI project was the passage of the GBV Act through parliament in 2011.
- The collaboration between USAID and Zambian government partners was very successful.

Challenges

- While much has been accomplished through the awareness campaigns, gender norms, fear and stigma still pose issues to GBV service implementation and case prosecution.
- Transportation for women not in geographic proximity to the CRCs was not provided.
- The heavy reliance on volunteers meant spending extra resources on training new individuals and much time and energy on replacing staff after attrition.
- There are not enough safe houses or options for women without relatives to help.
- More CRCs with 24-hour care are needed; as they are, staff shortages and very high demand hamper their efficiency.

Sustainability

- The CRCs were passed over to the management of the MoH in a phased plan.
- Many of the former CRC staff are now working there, either because they left the program to work for the MoH, or they remained and have now been given posts.
- Donor funding is still needed to balance the costs of running the CRCs since the government has not taken them fully on.
- More CRCs are needed, especially in rural areas, but there should be more work done in communities to make them safe for women.
- The One-stop-model was received very well and stands as a sound way to deliver comprehensive services for GBV.
- More attention to GBV programming is happening at the donor level, and GBV should be a major priority given its scope.
- The WJEI was a huge endeavor that helped publicize the need for more attention towards GBV programming and response.

Benin

Implementation

- Community mobilizers were trained as awareness agents and facilitators of case referrals at the local level.
- Mass media campaigns were employed using radio and TV broadcasts.
- Journalists were trained on GBV reporting to get better coverage in printed media.
- Advocacy led to the passing of the GBV law in 2011.
- Judges and police were trained in the adjudication of GBV cases.
- Doctors were trained to perform post-rape exams and to issue medical certificates attesting to the evidence of rape for legal purposes.
- Establishment of local referral systems for survivor care and support involving social services, police, health care providers, and other key local actors.

Strengths

- The project succeeded in transforming normative changes pertaining to gender roles and GBV.
- Project messages were particularly effective in highlighting women's rights and raising awareness of GBV laws and punishments.
- Many women were able to receive support from the project to report cases of GBV to the police.
- The project was instrumental in the promotion and passage of a GBV law.
- The project was successful in reducing GBV incidents, as reported by participants.
- Project actors successfully assisted survivors in reporting cases to the police.

Challenges

- The project often failed to reach people living in more remote areas.
- Men needed to be included in the focus of the activities, which would have mediated their reactions to the project and instead engaged them in the process of cultural change.
- Community members viewed that police treatment of perpetrators was heavy-handed
- Case processing was often very slow.
- Due to perceived corruption, survivors were often discouraged and dropped cases
- There was persistent informal reconciliation despite police sensitization.
- In many communities there was resistance to formal case reporting as many viewed that incarceration disrupts family stability.
- Implementers noted a lack of sustainable financial support and housing to survivors.
- There was a lack of funds and transportation to help survivors obtain medical care and medical certificates for case prosecution.

Sustainability

- Many implementers felt that stronger sustainability would have been ensure by working with salaried government employees. Due to difficulties working with the government, the project was obliged to involve NGOs execute activities efficiently.
- There was lower motivation among government employees and community volunteers to continue the roles they had adopted during the project. This was true for government employees, due to reduced financial motivation. The same was true for volunteers due to the lack of field support from dedicated project facilitators posed.

Kenya

Implementation

- The awareness component sought to increase community knowledge of GBV, GBV laws, and points of service for GBV survivors.
- A locally branded awareness campaign was launched in Kibera. The campaign was branded with the "Sita Kimya" slogan. In Swahili this means, "I will not be quiet." The brand was associated with many of the awareness raising activities, such as peer-education sessions and sessions for children and community forums.
- The US DOJ oversaw the legal system support component, which aimed to improve Kenya's ability to investigate, prosecute, and adjudicate GBV cases. Activities under this component sought to build the capacity of the police, prosecutors and the judiciary to punish perpetrators of violence.
- The DOJ conducted workshops with Kenyan police, prosecutors and judges on how to recognize and address GBV cases. Sessions included information on the SOA, role of police and prosecutors, witness protection, trial advocacy, investigation and prosecution of sex crimes, and forensic evidence and nursing.
- The DOJ assisted in establishing a gender desk at the divisional police headquarters near Kibera to deal solely with GBV cases and offer survivors more direct access to the police.
- There is one police doctor in Nairobi who must issue a specific form for GBV cases to advance efficiently to the courts.
- The care and support component aimed to strengthen the capacity of KNH's existing GBV center.
- GBV services were to be consolidated into one space at KNH. Only minor renovations were completed because the plans were not approved by the Ministry of Public Works.

The completed renovations included separate admission wards for both children and adult survivors, counseling facilities and security features.

- WJEI supported additional staff (including a doctor) at the GBVRC to model the potential of a well-staffed center. After the project's closeout, the center was not able to support the added staff.
- The project sponsored two trainings for 50 KNH staff, including doctors, nurses and clinical officers, on the Sexual Assault Forensic Examinations (SAFE) curriculum.
- Community-managed systems of care and support were established and strengthened to respond to increased demand for GBV services. These systems included a community referral mechanism, the GBV working group, community legal assistance, shelters and safe spaces for survivors, and women's economic empowerment training.

Strengths

- The awareness-raising component of WJEI in Kenya was regarded as the project's strongest. The Sita Kimya campaign had strong communications approach that incorporated a well-branded slogan, tailored messages, peer-education, comprehensive geographical targeting, male engagement, and locally produced film.
- The project built the capacity of community change agents and the extensive community engagement resulted in a strong sense of community ownership of the project.
- The campaign contributed to an increase in GBV knowledge and awareness around available GBV-services, reporting procedures for sexual abuse, rights consciousness, and children speaking out about incidences of abuse.
- The gender desk at the local police station helped to reduce some of the bribery and corruption previously encountered with the police.
- Community members participated in less mob justice after the project and perpetrators were increasingly apprehended through formal channels.
- The adjudication of child sexual abuse cases in the courts increased.
- During the project period, the GBVRC benefitted greatly from increased staff support and hospital-wide sensitization to GBV.
- The project strengthened community-managed systems of care and support for GBV survivors.

Challenges

- Due to lack of resources and poverty, it was difficult for volunteers to participate in the project when they also needed to earn a living.
- Facilitators encountered difficulties, such as having a limited knowledge base, securing session venues, and getting involved in domestic affairs.
- Sometimes the campaign's messages were not acceptable to certain community members, such as some teachers, religious leaders, people with strong dissenting views, and substance users.
- Due to the limited project period and high community turnover, the campaign did not reach all of Kibera and did not comprehensively achieve sustainable behavior change.
- There was a lack of coordination between the DOJ and the USAID/Pathfinder International team on the implementation of the legal component.
- The SOA in Kenya does not address the issue of marital rape, making it nearly impossible to prosecute in court.
- There were a number of judicial barriers, including the delay in in processing and settling cases in court, lack of evidence, defendants dropping cases and the community continuing to handle cases on their own.

- There were difficulties with the police, including the perception of police as unsupportive of GBV cases, high turnover of trained officers, and a lack of coordination between the police and health sector.
- There was a perception of corruption at all levels of the government, which discouraged many from seeking help from the authorities.
- Due to administrative challenges, the project was not able to establish a one-stop-shop model at KNH.
- The GBVRC was not able to retain the added staff after the project ended.
- Due to high turnover of hospital staff, many staff at the hospital are not sensitized on GBV.
- While some services provided to GBV patients are complimentary, many critical GBV-related needs are not.
- The shelters and safe spaces were often not adequately equipped with food, bedding, and transportation costs for GBV survivors.

Sustainability

- Some of CBOs and community members continue some of the activities from the project. However, when the project ended, the level of engagement amongst community agents declined.
- By endowing the facilitators with GBV knowledge and information, these community members were able to help to sustain the mission of the project after its conclusion. Community project agents are seen as "ambassadors of change," which helps to sustain their activism.
- USAID currently supports ongoing GBV activities in Kenya and is building on the Sita Kimya model, replicating best practices.
- GBV working groups have formed in elsewhere in Kenya, but these groups differ from the model in Kibera in that they are implemented at the district level.
- USAID sponsored awareness activities use the same training curriculum, wall branding, and messaging strategy in other communities in Kenya. Partners are working to integrate GBV messages into existing programs that deal with sexual and reproductive health
- In Kibera, there is a further need for GBV awareness raising activities as the Sita Kimya campaign was too short to influence sustainable change in social norms that fuel GBV.
- For Kenya, it is important to focus awareness efforts on regions where this is a high prevalence of violence and invest in local initiatives and networks to sustain GBV efforts.
- Projects need to address the root causes of GBV and present GBV as a concern for the entire family, not just as a woman's issue.
- There is still gap in the enforcement and implementation of GBV laws and a significant backlog of cases in the judicial system that must be addressed.
- There is a need for more one-stop service models for GBV survivors. They do not necessarily need to be in one physical location, but instead can operate as a streamlined referral mechanism that incorporates all sectors of GBV response.
- The government needs to invest more resources in the response to GBV in order to sustain efforts.

Kenya and Benin WJEI Audiences

WJEI Audience	Kenya	Benin
Funder	USAID	USAID
Primary Grant Awardees	Pathfinder; PSI	CARE
Sub-Grant Awardees (implementers; CBOs)	CFK; CREAW; CLAN; KWPF; MEGEN; PSI; WKF; WEL	Equi-Fille (Borgou-Alibori), APROFEJ (Mono Couffo), Ligue-Life (Zou Collines), AFVPA (Atacora Donga), Autre Vie (Oueme/Plateau), and FADeC (Atlantique/Littoral)
Awareness Trainers & Community Referrals	CFK; CREAW; CLAN; KWPF; MEGEN; PSI; WKF; WEL	Community mobilizers, community facilitators
GBV Service Providers	KNH; MSF; gov't dispensaries; Nairobi Women's Hospital; Mbagathi; Shelters/Safe Houses	CPS, Assistants Juridiques, Gendarmes, Medical Professionals
Police/Paralegal	CLAN - Paralegal Network	Courts, CPS, Assistants Juridiques, Gendarmes
Community Women/Men	Community Forum Participants (678 women: 15–24 & 25–45 years; 664 men: 15–24 & 25–45); Male Champions' Network: Women's Economic Empowerment Group	Community focus groups
Community Leaders	District Administration & Community leaders (6 forums, 336 people à 5 location-based GBV working groups); Kibera GBV Working Group (subset of latter)	Traditional chiefs, mayors, village development committees, community health workers

Research Questions by Audience

RQ How were the key project design decisions made?

Funder

RQ What was the broader environment in which the program was implemented?

Funder
Primary Grant Awardees
Sub-Grant Awardees
Awareness Trainers & Community Referrers
GBV Service Providers; Police/Paralegal

RQ How did the implementation of the project go?

Funder
Primary Grant Awardees
Sub-Grant Awardees
Awareness Trainers & Community Referrers
GBV Service Providers; Police/Paralegal
Community Women/Men
Community Leaders

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

Funder
Primary Grant Awardees
Sub-Grant Awardees
Awareness Trainers & Community Referrers
GBV Service Providers; Police/Paralegal
Community Women/Men
Community Leaders

RQ How do project partners perceive the sustainability of the project?

Funder
Primary Grant Awardees
Sub-Grant Awardees
Awareness Trainers & Community Referrers
GBV Service Providers
Police/Paralegal

RQ What is the attitudes of community toward GBV?

Community Women/Men
Community Leaders

Funder Interview Guide

- Were you around during the design and/or implementation of the project?
- How would you describe your role in the design of the project? In the implementation of the project?

RQ How were the key project design decisions made?

- Can you describe the project design of the WJEI project?
  - » What was the rationale behind the project designed?
  - » What are some reasons it was designed the way it was?
  - » How were key decisions made?
- How did the USAID HQs, Mission and the regional implementing partners influence the design of the project?
- What logistical considerations were taken into account in the design of the project?
- How was the geographic focus of the project determined (i.e. which regions, sites, and the like)?
- To what extent was the government of Kenya involved in the planning of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political
- What relevant GBV laws exist in Kenya/Benin?
- How are these laws enforced?
- How did laws play a role in the project design? In its implementation?

Organizational
- What GBV activities were going on before WJEI?
- Who were the implementers?
- What GBV actions were being taken by the government before WJEI?
- By international and/or community-based organizations?

RQ What are some of the perceived barriers to and enabling factors for case reporting and management?

- What are some reasons a woman would not want to report violence?
  - » What are some reasons a woman would not report a case of violence to police?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some circumstances when a woman would be incentivized to report a case of violence?
  - » In your opinion, why do some women report cases, while others do not?
- Do you think these incentives and disincentives have changed over the project period? How?

RQ How did the implementation of the project go?

- With regards to the implementation of the project, what were some of the challenges?
- What were some of the successes?
- In retrospect, what should have been done differently?
- How did the programmatic outcomes compare with expectations and/or objectives?

Benin
- Have any project zones been more successful than others? What are some reasons this might be the case?
- How successful has implementation of the one-stop shop sites been thus far?

Kenya
- It has been explained to me that that funding to the various implementing partners was not distributed according to the original timetable. What were some of the reasons for this?
  - » More specifically, with regards to the GBV Recovery Center at the Kenyatta National Hospital, what were the reasons for the funding delays?

RQ How do project partners perceive the sustainability of the project?

- What structures, personnel, and ongoing programs has the project left behind? Probes:
  - » Have project supported staff remained in place? If so, who is funding their salaries?
  - » What other recurring costs are there for the continuation of project services and activities?
  - » Who is funding these services and/or activities?
- To what extent was the government of Kenya/Benin involved in the project and how that affected sustainability of the project?
- How do you perceive the potential to scale up the WJEI project in Kenya/Benin? And if so, what are the next steps in addressing GBV in Kenya/Benin?

Benin

- How sustainable do you think the one-stop shop sites are?
- How replicable is this model in other parts of the country?
- Who is funding the recurring costs of these centers?

Kenya

- How is does the WJEI objectives and evaluation outcome fit into the larger Kenya USAID gender assessment currently being conducted?

Primary Grant Awardees Interview Guide

- How would describe your role in this project?
- Were you around during the design and/or implementation of the project?
- How would you describe your role in the design of the project? In the implementation of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political
- What relevant GBV laws exist in Kenya/Benin?
- How are these laws enforced?

Organizational
- What GBV activities were going on before WJEI?
- Who were the implementers?
- What GBV actions were being taken by the government before WJEI?
- By international and/or community-based organizations?

Cultural
- How would you describe people's attitudes toward violence toward women and girls in Kenya/Benin?
  - » Is it generally acceptable?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in Kenya/Benin before WJEI?
- Has there been a trajectory of change regarding awareness and opinions about GBV?
  - » If so, how would you describe this trajectory?

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- What are some reasons a woman would not report a case of violence to police? To a health worker? To their family?
  - » What are some reasons a woman would not want to report violence?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some reasons a woman would report a case of violence?
  - » Why are women who do report cases able to do so, while others are not?
- Do you think these incentives and disincentives have changed over the project period? How?

RQ How did the implementation of the project go?

- From what you know of the WJEI activities in Benin, Kenya and South Africa, how would you describe the local/national focus of the WJEI project?
- How did the programmatic outcomes compare with expectations and/or objectives?
- With regards to the implementation of the project, what were some of the challenges?
  - » In retrospect, what should have been done differently?
- What were some of the successes?
  - » In terms of the program's objectives to increase GBV awareness, victim services, GBV cases tried, what are some of the most noteworthy achievements of WJEI?
  - » Have any of the three programmatic areas (legal, services, awareness) shown more success than others?
  - » If so, how?
  - » What are some reasons this might be the case?
- As awareness of GBV was presumably increasing due to media campaigns, was the existing program infrastructure able to support women seeking psychosocial and legal services?

Benin
- Were some project zones more successful than others?
- What are some reasons this might be the case?
- How successful has implementation of the one-stop shop sites been?
  - » What are some reasons this might be the case?

RQ How did the implementation of the project go? *continued*

Kenya

- In your opinion, how was the coordination between the main implementing partners of WJEI?
- Which partners were particularly active in the implementation project?
- Who was in charge of tracking and storing data?
  - » Was project data (i.e., indicators, case reporting, etc.) tracked in a centrally located place?
  - » Is this data accessible and are there any plans for additional analysis?
- The baseline study conducted by Women Educational Researchers of Kenya (WERK) was intended to inform the project design.
  - » How did it come to pass that it was conducted after the launch of WJEI?

RQ How do project partners perceive the sustainability of the project?

- What structures, personnel, and ongoing programs has the project left behind?
  - » Have project supported staff remained in place? If so, who is funding their salaries?
  - » What other recurring costs are there for the continuation of project services and activities?
  - » Who is funding these services and/or activities?
- To what extent was the government of Kenya/Benin involved in the project and how that affected sustainability of the project?
- How do you perceive the potential to scale up the WJEI project in Kenya/Benin? And if so, what are the next steps in addressing GBV in Kenya/Benin?
- What do you perceive to be the major challenges to the sustainability of the program?

Benin

- How sustainable do you think the one-stop shop sites are?
- How replicable is this model in other parts of the country?
- Who is funding the recurring costs of these centers?

Sub-Grant Awardees (Implementers, CBOs) Interview Guide

- How would describe your role in this project?
- To what extent were you able to fulfill your role as an awareness trainer/community facilitator?
  - » What are some reasons this might be the case?
- Were you around during the design and/or implementation of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political
- How are GBV laws enforced in your area?
- How would you describe the experience of GBV victims in the legal system in your area?

Cultural
- How would you describe people's attitudes toward violence toward women and girls in Kenya/Benin?
  - » Is it generally acceptable?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in Kenya/Benin before WJEI?
- Has there been a trajectory of change regarding awareness and opinions about GBV?
  - » If so, how would you describe this trajectory?

Organizational
- What GBV activities were going on before WJEI?
- Who were the implementers?
- What GBV actions were being taken by the government before WJEI?
- By international and/or community-based organizations?

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- What are some reasons a woman would not report a case of violence to police?
  - » What are some reasons a woman would not want to report violence?
- Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some reasons a woman would report a case of violence?
  - » Why are women who do report cases able to do so, while others are not?
- Do you think these incentives and disincentives have changed over the project period? How?

RQ How did the implementation of the project go?

- How did the programmatic outcomes compare with expectations and/or objectives?
- With regards to the implementation of the project, what were some of the challenges?
  - » In retrospect, what should have been done differently?
- What were some of the successes?
  - » In terms of the program's objectives to increase GBV awareness, victim services, GBV cases tried, what are some of the most noteworthy achievements of WJEI?
  - » Have any of the three programmatic areas (legal, services, awareness) shown more success than others?
  - » If so, how?
  - » What are some reasons this might be the case?
- As awareness of GBV was presumably increasing due to media campaigns, was the existing program infrastructure able to support women seeking psychosocial and legal services?

Kenya
- In your opinion, how was the coordination between the main implementing partners of WJEI?
- Which partners were particularly active in the implementation project?
- Who was in charge of tracking and storing data?
  - » Was project data (i.e. indicators, case reporting, etc.) tracked in a centrally located place?
  - » Is this data accessible and are there any plans for additional analysis?
- The baseline study conducted by Women Educational Researchers of Kenya (WERK) was intended to inform the project design.
  - » How did it come to pass that it was conducted after the launch of WJEI?

RQ How do project partners perceive the sustainability of the project?

- What structures, personnel, and ongoing programs has the project left behind?
  - » Have project supported staff remained in place? If so, who is funding their salaries?
    - What other recurring costs are there for the continuation of project services and activities?
    - Who is funding these services and/or activities?
- To what extent was the government of Kenya/Benin involved in the project and how that affected sustainability of the project?
- How do you perceive the potential to scale up the WJEI project in Kenya/Benin? And if so, what are the next steps in addressing GBV in Kenya/Benin?

Awareness Trainers & Community Referrers Interview Guide

- How would describe your role in this project?
- To what extent were you able to fulfill your role as an awareness trainer/community facilitator?
  - » What are some reasons this might be the case?
- Were you around during the design and/or implementation of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political
- How were/are these laws enforced in your community?

Cultural
- How would you describe people's attitudes toward violence toward women and girls in your community?
- How would you describe people's attitudes toward violence toward women and girls in Kenya/Benin?
  - » Is it generally acceptable?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in Kenya/Benin before WJEI?
- Has there been a trajectory of change regarding awareness and opinions about GBV?
  - » If so, how would you describe this trajectory?

Organizational
- What programs related to violence toward women and girls were going on in the community before WJEI?

RQ How did the implementation of the project go?

- How did people in your community react to your work?
- How, if it all did this influence your ability to fulfill your role in the project?
- How would you say awareness of GBV in the community changed over the course of the project?
- With regards to conducting the training sessions (Kenya) or acting as a community facilitator (Benin), what were some of the challenges?
  - » In retrospect, what should have been done differently?
  - » What could the (implementing organization) have done differently to help you fulfill your role in the project?
- What were some of the successes or achievements you saw in your work on this project?
- As awareness of GBV was presumably increasing due to media campaigns, was the existing program infrastructure able to support women seeking psychosocial and legal services?

Kenya
- What was your role as a trainer?
- Who was your target audience?
- How many trainings did you conduct?
- How do you feel your training sessions went?
- What was some of the noteworthy responses you had from your sessions?

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- If a woman or girl experiences physical violence in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- If a woman or girl is sexually violated in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- What are some reasons a woman would not report a case of violence to police?
  - » What are some reasons a woman would not want to report violence?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some reasons a woman would report a case of violence?
  - » Why are women who do report cases able to do so, while others are not?
- Do you think these incentives and disincentives have changed over the project period? How?
- What resources are available in this community and this area to address violence against women and girls?
- How effective are these resources?
- How reliable are these resources?

RQ How do project partners perceive the sustainability of the project?

- How do you perceive the potential to replicate this project in other communities?
- What are the next steps that the government and organizations should take to address GBV?

GBV Service Providers Interview Guide

- How long have to occupied this post?
- How would you describe your role in this project?
- To what extent were you able to fulfill your role in the project?
  - » What are some reasons this might be the case?
- Were you around during the design and/or implementation of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political
- How are GBV laws enforced in your area?

Cultural
- How would you describe people's attitudes toward violence toward women and girls in your area?
  - » Is it generally acceptable?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in this area 5 years ago?
- Have there been changes regarding awareness and opinions about GBV?
  - » If so, how would you describe this?

Organizational
- What programs related to violence toward women and girls were going on in this district the before WJEI?

RQ How did the implementation of the project go?

- What are some of the most noteworthy cases you worked on?
- How did your colleagues react to your work?
- How did people in the community react to your work?
  - » How, if it all did this influence your ability to fulfill your role in the project?
- What could the (implementing organization) have done differently to help you fulfill your role in the project?
- What would you say were some of the successes of the project?
- What would you say were some of the challenges?
  - » In retrospect, what should have been done differently?
- How would you say awareness of GBV in the community changed over the course of the project?
- As awareness of GBV was presumably increasing due to media campaigns, was the existing program infrastructure able to support women seeking psychosocial and legal services?

Benin
- What are some reasons women in your service zone do not report cases of violence?
- What are some reasons women in your service zone might be able to report a case of violence?
- CPS Lead Centers
- How were the CPS managed?
- Were some CPS more successful than others?
- What are some reasons this might be the case?

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- If a woman or girl experiences physical violence in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- If a woman or girl is sexually violated in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- Do you think these incentives and disincentives have changed over the project period? How?
- What are some reasons a woman would not report a case of violence to police?
  - » What are some reasons a woman would not want to report violence?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some reasons a woman would report a case of violence?
  - » Why are women who do report cases able to do so, while others are not?

RQ How do project partners perceive the sustainability of the project?

- What structures, personnel, and ongoing activities continue to exist?
- Have project supported staff remained in place? If so, how are they being funded?
- What other recurring costs are there for the continuation of project services and activities? Who is funding these services and/or activities?
- How do you perceive the potential to scale up this project in other districts?
- What are the next steps in addressing GBV in Kenya/Benin?

Police/Paralegal Interview Guide

- How long have you occupied this post/brigade?
- How would you describe your role in this project?
- To what extent were you able to fulfill your role in the project?
  - » What are some reasons this might be the case?
- Were you around during the design and/or implementation of the project?

RQ What was the broader environment in which the program was implemented?

Legal/political

- What GBV laws are you charged with enforcing?
- How does your brigade/paralegal network enforce these laws?
- Are all cases of the same offense addressed in the same manner?
- If no, how does the action taken differ?
- Why might this be the case?
- How has the role of the gendarmerie changed in the past five years with regards to GBV?
- How do would you evaluate these changes?

Cultural

- How would you describe people's attitudes toward violence toward women and girls in your area?
  - » In your brigade/paralegal network?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in this area 5 years ago?
- Has there been a trajectory of change regarding awareness and opinions about GBV?
- If so, how would you describe this trajectory?

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- If a woman or girl experiences physical violence in your jurisdiction, what does she do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- If a woman or girl is sexually violated in your jurisdiction, what does she do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- What are some reasons a woman would not report a case of violence to police?
  - » What are some reasons a woman would not want to report violence?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What are some reasons a woman would report a case of violence?
  - » Why are women who do report cases able to do so, while others are not?
- Do you think these incentives and disincentives have changed over the project period? How?
- What do you think are the biggest challenges to reporting by women?
- What do you think are the biggest challenges to prosecuting cases of GBV?

RQ How did the implementation of the project go?

- What would you say were some of the successes of the project?
- What would you say were some of the challenges?
  - » In retrospect, what should have been done differently?
- To what extent were you able to fulfill your role in the project?
  - » What are some reasons this might be the case?
- What are some of the most noteworthy cases you worked on?
- How did your colleagues react to your work?
- How did people in the community react to your work?
  - » How, if it all did this influence your ability to fulfill your role in the project?
- What could the (implementing organization) have done differently to help you fulfill your role in the project?
- How would you say awareness of GBV in the community changed over the course of the project?
- As awareness of GBV was presumably increasing due to media campaigns, was the existing program infrastructure able to support women seeking psychosocial and legal services?

RQ How do project partners perceive the sustainability of the project?

- How do you perceive the potential to scale up this project in other district?
- What are the next steps in addressing GBV in Kenya/Benin?

Community Women/Men Focus Group Guide

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

- If a woman or girl experiences physical violence in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- If a woman or girl is sexually violated in your community, what does she do?
  - » Who can she turn to?
  - » What are some reasons this might be the case?
- What does her family do?
  - » What are some reasons this might be the case?
- What usually happens to the perpetrator of the violence?
  - » What are some reasons this might be the case?
- What are some reasons a woman would not want to report violence?
  - » What are some reasons a woman would not report a case of violence to police?
  - » Given that a woman wants to report a case of violence, what are some reasons she may not do so?
- What about the courts? Are people using the services? Why? Why not?
- What are some reasons a woman would report a case of violence?
  - » Why do some women report cases, while others do not?
- Do you think these incentives and disincentives have changed over the past couple of years? How?
- What resources are available in this community and this area to address violence against women and girls?
  - » How effective are these resources?
  - » How reliable are these resources?
  - » If you were to experience violence yourself, what resources would you turn to?

RQ What is the attitudes of community toward GBV?

Legal/political

- Whose responsibility is it to punish perpetrators of violence against women and girls?
- Whose responsibility is to prevent cases of violence against women and girls?
- What laws exist against GBV?
- How are anti-GBV laws enforced in the community?

Cultural

- How would you describe people's attitudes toward violence toward women and girls in your community?
- How acceptable would you say physical violence in your community?
- How acceptable would you say forced sex is in your community?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in the community 5 years ago?
- Have there been changes regarding awareness and opinions about GBV in the last 5 years?
  - » How would you describe these changes?

Organizational

- What programs related to violence toward women and girls have there been in your community in the past 5 years?
- Do you think WJEI or similar programs should continue in the community?
- If they were to continue, what suggestions would you make?

RQ How did the implementation of the project go?

- Are there any GBV programs currently going on in your area?
- Have you ever heard of (EMPOWER/SITA KIMYA)?
- If so, how would you describe this program?
- What affect has this program had in your community?
- What did you like about the (WJEI) project?
- What didn't you like about it?
- What should the program have done differently, if anything?
- How did the community react to this program?
- How did you react to this program?
- How did your family react to this program?

Community Leaders Focus Group Guide

RQ What are some of the perceived barriers to and enabling factors for case reporting and case management?

If a woman or girl experiences physical violence in your community, what does she do?
- » Who can she turn to?
- » What are some reasons this might be the case?

What does her family do?
- » What are some reasons this might be the case?

What usually happens to the perpetrator of the violence?
- » What are some reasons this might be the case?

If a woman or girl is sexually violated in your community, what does she do?
- » Who can she turn to?
- » What are some reasons this might be the case?

What does her family do?
- » What are some reasons this might be the case?

What usually happens to the perpetrator of the violence?
- » What are some reasons this might be the case?

What are some reasons a woman would not report a case of violence to police?
- » What are some reasons a woman would not want to report violence?
- » Given that a woman wants to report a case of violence, what are some reasons she may not do so?

What about the courts? Are people using the services? Why? Why not?

What are some reasons a woman would report a case of violence?
- » Why do some women report cases, while others do not?

Do you think these incentives and disincentives have changed over the past couple of years? How?

What resources are available in this community and this area to address violence against women and girls?
- » How effective are these resources?
- » How reliable are these resources?

RQ What is the attitudes of community toward GBV?

Legal/political
- Whose responsibility is it to punish perpetrators of violence against women and girls?
- Whose responsibility is to prevent cases of violence against women and girls?
- What laws exist against GBV?
- How are anti-GBV laws enforced in the community?
- What role do you play in preventing GBV and punishing offenders?

Cultural
- How would you describe people's attitudes toward violence toward women and girls in your community?
- How acceptable would you say physical violence and forced sex is in your community?
- Are certain forms more prevalent than others?
- What was the state of GBV awareness in the community 5 years ago?
- Has there been a trajectory of change regarding awareness and opinions about GBV?
- If so, how would you describe this trajectory?

Organizational
- What programs related to violence toward women and girls have there been in your community in the past 5 years?
- Do you think WJEI or similar programs should continue in the community?
- If they were to continue, what suggestions would you make?

RQ How did the implementation of the project go?

- Are there any GBV programs currently going on in your area?
- Have you ever heard of (EMPOWER/SITA KIMYA)?
- If so, how would you describe this program?
- What affect has this program had in your community?
- What did you like about the (EMPOWER/SITA KIMYA) project?
- What didn't you like about it?
- What should the program have done differently, if anything?
- How did the community react to this program?
- How did you react to this program?

Introduction and Background

The Women's Justice and Empowerment Initiative (WJEI) was a three-year, 55 million dollar program to bolster women's justice and empowerment in four sub-Saharan African countries: Benin, Kenya, South Africa and Zambia. The initiative brought together the knowledge and resources of USAID, the U.S. Department of Justice International Criminal Investigative Training Assistance Program (ICITAP) and Office of Overseas Prosecutorial Development, Assistance and Training (OPDAT), and the U.S. Department of State Bureau of International Narcotics and Law Enforcement (INL) to fight gender-based violence (GBV). The program was designed to raise awareness and improve the capacity in these countries to investigate and prosecute perpetrators and assist female victims of rape and abuse. The four countries were selected because they had already demonstrated governmental commitment to combat GBV. WJEI was envisioned to respond to four very different contexts. The program was implemented slightly differently in each of the four contexts, but the three major components were:

1. Helping to raise awareness of the problem of GBV

This component sought to increase the awareness of the prevalence of GBV, care and support resources available to survivors; enhance public policy and laws regarding women's rights; assist communities to overcome the barriers to recognizing GBV as a problem and ultimately contribute to changed behavior and attitudes towards GBV acceptance.

2. Improving the ability to investigate, prosecute, and adjudicate GBV cases

This component sought to strengthen the capacity of legal systems to protect women from violence and to punish violators by increasing the capacity of the police, prosecutors, and judges to understand and combat gender-based criminal conduct through, in part, effective investigations and use of forensic techniques.

3. Providing victims with medical and psychosocial support to enhance their reintegration into their respective societies

This component sought to strengthen the capacity of health, legal, and social organizations that provide assistance to survivors of GBV. Assessments have been conducted within each of the country programs, but the initiative has not been evaluated across the four countries. The variation in both country-contexts and technical approaches of each of the WJEI programs provides a unique opportunity to evaluate the relative strengths of different initiatives to prevent and respond to GBV. With funding granted as part of a competitive proposal process from the USAID Bureau of Policy, Planning and Learning (PPL) /Office of Learning, Evaluation and Research (LER), USAID will implement this evaluation through MEASURE Evaluation, which is managed within the Global Health Bureau's Office of HIV/AIDS. Additional funding for this activity was provided by the Kenya Mission.

Purpose, Objectives, and Expected Outcomes

Purpose of the Evaluation

The purpose of the evaluation is (1) to assess WJEI technical strategies in four countries, why they were developed and implemented the way they were, and determine the extent to which these strategies have been effective in reaching the program objectives using. The evaluation will focus on qualitative data collection and if appropriate, use existing quantitative data; (2) identify best practices; and (3) determine the extent to which strategies can be replicated.

Objective

The objective of the evaluation is to conduct a comparative analysis of the GBV programs in four sub-Saharan African countries, and identify practices that are both replicable and sustainable in different contexts within the sub-Saharan African region.

Methodology

- Desk review of relevant literature
- Key informant interviews with:
  - » USG, implementing partners
  - » Services and facility staff and practitioners working in places within the reach of WJEI activities
  - » People in the target community
- Focus groups—to be determined

Activities

1. Background Review: Assessment of Program Literature and Existing Data Sources

The literature, data and material from the WJEI programs in each of the four countries will be reviewed to ascertain the quality of collected data and available resources. DHS survey data which include the domestic violence module are available from Benin (2006, and a survey is taking place through this year), Kenya (2008) and Zambia (2007). Since these data were collected before the start of the WJEI initiative, these data could serve as baseline levels for programmatically related outcomes such as knowledge and attitudes towards GBV. The process evaluations carried out by some of the countries will also provide baseline data.

The review of programmatic literature, data from process evaluations, and other available data related to GBV in these countries will provide some of the information needed to develop research questions for the evaluation. The other source of information will be key informant interviews with program implementer staff, government staff, and USG staff.

2. Working with Country Teams and Partners

Country partners will be contacted and engaged in preliminary steps for the evaluation design. Key informant interviews will take place with USG staff and implementing partners to assess areas in which programmatic successes and challenges have taken place. These interviews will take place after the background literature review. They will be used to augment information gaps and to gain additional perspectives on the process of program implementation and M&E activities that have taken place. Fieldwork will take place in Kenya and Benin. Phone interviews will be used to speak with partners and key informant in Zambia and South Africa.

3. Evaluation Design

The evaluation will examine the processes and results achieved by the individual WJEI programs in the four countries, as well as strive to compare the various technical approaches used in project implementation and assess the potential for scale up and sustainability. Fieldwork using qualitative methods will take place in Benin and Kenya, phone interviews will be conducted with implementing partners and others in South Africa and Zambia. Evaluation designs will be based on the literature and data review and depend on the available data in each

country. The evaluation will seek to combine quantitative and qualitative methods as feasible and appropriate, to effectively demonstrate programmatic strengths and effects. The details on the quantitative design will be developed based on available data since primary data collection is not feasible under the given budget.

Qualitative methods will be used for research questions pertaining to changes in the health, legal and social organizations targeted by the programs. The relevant evaluation domains will be identified along with the organizations, and individuals within these organizations to be interviewed. Appropriate methods to use for these interviews will be determined based on both the literature review and key informant interviews. Semi-structured interview guides to use in these interviews will be designed.

Key Questions to be Addressed by this Evaluation

1. What was the broader legal/cultural/organizational environment in which the program was implemented?
2. How did project partners decide to operationalize their definition of GBV? How was this decision made?
3. How was the budgetary/programmatic balance between the 3 WJEI focus areas determined?
4. How were key project design decisions made (i.e., focus on national vs. local campaigns, involvement of beneficiaries, geographic focus, etc.)?
5. What do project partners perceive to be the strengths and weaknesses of the project?
6. How do project partners perceive the sustainability of the project?
7. Do community leaders and members perceive a change in gender norms and attitudes toward GBV?

The evaluation will be designed to be as rigorous as possible to demonstrate the strengths of different programmatic approaches of the three major components: raising GBV awareness, influencing changes in the legal system, and the provision of medical and psychological support. Work with USG country teams and implementing partners will continue through the evaluation design process and the beginning of data collection planning. By the end of March 2012 there will be an updated, detailed evaluation plan with timeline.

4. Data Collection

Qualitative fieldwork will take place in Benin and Kenya. Planning trips to both countries will take place in March 2012 to conduct preliminary interviews with Mission and program staff, and to plan for extended data collection to take place during the summer. In South Africa and Zambia, where fieldwork will not be conducted, interviews will be conducted with key informants by phone to gather data and perspectives. Although the DHS data cannot be used to measure change attributable to programs specifically, we can explore whether changes have taken place in certain areas, such as attitudes towards and awareness of GBV, while controlling for several factors

5. Analyses, Report/Paper Writing

Analyses will be conducted as soon as data are available. Preliminary findings from the initial trips in March will be used to guide further data collection to take place May-July. Analyses of qualitative data collected during the summer will take place as it is collected and after data collection ends. Ongoing analyses during data collection will be used to guide further data collection in the identified evaluation domains. Once analyses are complete, a report will be written, and it is anticipated that several peer review papers will be written.

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