SYNTHESIS REPORT

EVALUATING THE EFFECTIVENESS OF GENDER-BASED VIOLENCE PREVENTION PROGRAMS WITH REFUGEES IN CHAD, MALAYSIA, AND UGANDA

April 2014

This publication was produced at the request of the United States Department of State. It was prepared independently by Erica Holzaepfel and Shannon Doocy through Social Impact, Inc.

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April 16, 2014

IDIQ Contract Number: S-AQM-MA-12-D-0086
Technical and Advisory Services for Program Evaluation Requirements

Task Order Number: S-AQMMA-13-F0964

COVER PHOTOS
Top Left: Refugees at Women's Center, Touloum Camp, Iriba, Chad. (Photo Credit: Sylvie Morel-Seytoux)

Top Right: Social Impact evaluation team member discusses gender-based violence prevention programming with Burmese and Somali refugee teachers based in Kuala Lumpur, Malaysia. (Photo Credit: Diane Paul)

Bottom: Mural featuring gender-based violence prevention messages in the languages of refugee populations, displayed on a public building in the central administration area of Nakivale settlement, Uganda. (Photo Credit: Shannon Doocy)

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ACRONYMS

ACTS	Kampulan A Call To Service
ADES	Agence Sociale pour le Développement et Education
ARC	American Refugee Committee
AWAM	All Women's Action Society
CAR	Central African Republic
CBT	Cognitive Behavior Therapy
CDC	Centers for Disease Control and Prevention
CDU	Community Development Unit
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CELC	Community Empowerment and Livelihood Center
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
DoS	U.S. Department of State
DRC	Democratic Republic of Congo
DV	Domestic Violence
FGD	Focus Group Discussion
FY	Fiscal Year
GBV	Gender-Based Violence
GBVIMS	Gender Based Violence Information Management System
HEI	Health Equity Initiative
HIAS	Hebrew Immigrant Aid Society
IASC	Inter-Agency Standing Committee
ICMC	International Catholic Migration Commission
IDP	Internally Displaced Person
ILO	International Labor Organization
IOM	International Organization for Migration
IPT	Interpersonal Therapy
IRC	International Rescue Committee
KAP	Knowledge, Attitudes, Practices
KII	Key Informant Interview
LGBTI	Lesbian, gay, bisexual, transgender, intersex
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MTI	Medical Teams International
NGO	Non-governmental organization
OPM	Office of the Prime Minister
PKGS	Pusat Kebijikan Good Shepard
PRM	Bureau of Population, Refugees, and Migration
RBM	Results-based Management

RWPC	Refugee Women's Protection Corps
SASA!	Start Awareness Support Action
SMART	Specific, Measurable, Achievable, Realistic, and Time-bound
SOP	Standard Operating Procedure
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
USD	United States Dollar
WAO	Women's Aid Organization
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

Overview and Purpose

This synthesis report examines the effectiveness of gender-based violence (GBV) prevention programming funded directly by the U.S. Department of State Bureau of Population, Refugees, and Migration (DoS/PRM) or indirectly by one of its multilateral partners, the United Nations High Commissioner for Refugees (UNHCR). The report is the culmination of a one-year evaluation project that included a desk review of relevant literature and PRM-funded GBV programs in three regions and field evaluations of PRM-funded GBV prevention programs in Chad, Malaysia, and Uganda.

The goal of the synthesis report is to hone and refine the extensive research conducted under this contract in order to identify the overarching effectiveness of PRM's GBV prevention programs. To achieve this goal, the evaluation team elected to conduct its analysis through the lens of the seven key topic areas identified in the desk review phase of this contract. The first six topics are based on prevention program objectives outlined in UNHCR's 2003 *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*. The seventh topic, male engagement in GBV prevention and response, is included to reflect PRM's learning priorities for this evaluation.

a. Transforming socio-cultural norms, with an emphasis on empowering women and girls
b. Rebuilding family and community structures and support systems
c. Creating conditions to improve accountability systems
d. Designing effective services and facilities
e. Working with formal and traditional legal systems
f. Assessment, monitoring, and documentation of GBV
g. Engaging men and boys in GBV prevention and response

Evaluation Questions

This performance evaluation of PRM GBV prevention programs sought to answer the questions below:

1. Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
2. Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
3. Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
4. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals specific, measurable, achievable, realistic, or time-bound (SMART)? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?

6. What factors explain intended and unintended negative or positive consequences?
7. What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?
8. To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

Gender-Based Violence Prevention Program Background

Contextual Challenges to GBV Prevention

A commonality among the three field evaluations was the extremely challenging context in which all of the PRM-funded NGO partners were working. Limited resources and infrastructure, donor fatigue, and competing refugee crises are challenges that affect organizations working in GBV prevention.

In Uganda, NGO partners are dealing with both an acute and protracted refugee crisis. This influx was a particular challenge in Kyangwali settlement, which was receiving twice-weekly convoys with more than 1,000 Congolese refugees and experiencing a need for significant expansion of services in all sectors to keep pace with the rapidly growing settlement population. However, the refugee situation in Uganda is also protracted—for example, Nakivale settlement was established in 1959 and has been in existence for more than 50 years—which comes with another set of challenges.

Chad is also dealing with a combination of acute and protracted refugee crises, with the escalation of new refugees arriving in southern Chad due to the conflict in CAR, as well as the decade-long existence of hundreds of thousands of Sudanese refugees in the east who lack durable solutions to their marginalization. The life-threatening difficulties that refugees in Chad face on a daily basis—related to food, water, shelter, medical care, and education—prevent NGO partners and refugees alike from dedicating significant focus to the issue of GBV. While GBV is tied to basic human rights, the evaluation team found that GBV can often seem secondary to the aforementioned basic needs.

In Malaysia, NGO partners face severe limitations due to the political sensitivities of their work. Working with refugees and asylum-seekers is a particularly sensitive and complicated issue in Malaysia given the fact that these populations are not afforded legal status by the Malaysian government. Although there are no direct threats made to NGOs for working with refugees, there is a thin patina of tolerance of their efforts and some have expressed concerns about possible difficulties with the government. NGO partners also face the constant threat of arrest and detention of their staff and clients. UNHCR noted that local NGOs in Malaysia typically are quite small and originate from charitable organizations and individuals with a shared interest; UNCHR reported not being able to find appropriate NGOs to implement programs with available funds.

Program Response

DoS/PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world. PRM directly funds NGO programs designed to fill critical gaps such as GBV prevention in humanitarian assistance and protection. UNHCR and NGO implementers funded by PRM provide crucial services to refugee populations in addition to information that is critical for policy development and advocacy.

In Chad, the evaluation team examined GBV prevention programs implemented by three NGOs with

PRM funding:

1. Agence Sociale pour le Développement et Education (ADES), a local NGO that has been working on multi-sectoral programming in refugee camps in eastern Chad since 2005
2. CARE International, an international NGO and UNHCR implementing partner serving refugees from the Central African Republic (CAR) in the southern and eastern camps
3. Hebrew Immigrant Aid Society (HIAS), which maintains an advocacy network and community-based referral system to prevent, identify, and respond to GBV in camps in eastern Chad

In Malaysia, the evaluation team examined GBV prevention programs implemented by three NGOs working in Kuala Lumpur with PRM funding:

1. Health Equity Initiative (HEI), a local organization pursuing the objective of improving mental health and medical services for Burmese and other refugees and asylum-seekers, with an emphasis on victims of torture, forced labor, human trafficking, and exploitation
2. International Catholic Migration Commission (ICMC), which has programs that aim to reduce the risk of GBV among refugee women and children and to improve access to emergency support services for survivors
3. Women's Aid Organization (WAO), a local organization that provides mental health services for refugees and asylum-seekers, counseling for GBV survivors, and a shelter to protect women who are in danger

The field evaluation in Uganda focused on GBV prevention programs conducted by two PRM-funded NGO implementing partners working in refugee settlements:

1. American Refugee Committee (ARC), which has been working on GBV-related issues with refugee communities in Uganda's western settlements since 2010. ARC aims to empower refugees in Kyangwali, Kyaka, and Nakivale refugee settlements to prevent and respond to GBV
2. Medical Teams International (MTI), which provides clinical services to GBV survivors visiting primary healthcare clinics in Nakivale and Oruchinga settlements but does not receive funding from DoS/PRM for primary GBV prevention activities

Comparative Analysis

Transforming Socio-Cultural Norms with an Emphasis on Empowering Women and Girls

Findings

The majority of PRM-funded GBV programs included in the **desk review** had objectives focused on raising awareness of GBV among the refugee population; however, they did not focus on changing norms that promote or allow GBV. The vast majority of GBV programs included in the desk review were funded for one-year cycles; in this timeframe, it is unlikely for programs to be able to measure the impact of their activities on social norms that promote and sustain GBV.

- In **Malaysia**, all NGO implementers were engaged in GBV prevention and awareness activities; while changing of socio-cultural norms was not an explicit objective, many of the awareness-raising activities appeared to be focused on this aim. Male engagement was a key strategy used by all NGO implementers that was perceived to be successful in awareness-raising and changing socio-cultural norms because males may be more persuasive when training other males on gender roles and responsibilities.

- In **Uganda**, only ARC was engaged in primary GBV prevention programming that aimed to promote awareness and social norms change. Since 2010, ARC has used Start Awareness Support Action (SASA!), a four-phased intervention in which ideas are introduced to a subset of community members over time via activities and discussions around power. SASA! was perceived as galvanizing community participation and likely to lead to both short- and long-term positive GBV prevention and response services—as well as, at the larger settlement and host community level, increases in awareness and social norms change.

- In **Chad**, the work of NGO implementers in the areas of awareness and transforming socio-cultural norms was variable, and the effectiveness of these efforts was difficult to assess.

Conclusions

With respect to primary GBV prevention, NGOs used a variety of awareness-raising strategies and approaches to target refugee communities and specific population subsets. Overall, they were effectively able to engage with refugee communities. However, best practice models and program indicators that can demonstrate the success of awareness programming and its impact on social norms change are lacking—and this adversely affects the evaluation of GBV prevention programs. Activities designed to empower women and change socio-cultural norms were observed in all three field evaluations; however, no evidence of their effectiveness was collected—a likely result of the challenges, cost, and complexity of measuring outcome-level indicators. Little is known about the actual changes in knowledge, attitudes, and behaviors that have occurred due to the GBV prevention efforts of NGO implementers.

Rebuilding Family and Community Structures and Support Systems

Findings

In the **desk review**, PRM-funded approaches and program activities used to strengthen family and community support structures varied by context and region. In Southeast Asia, community health workers (CHWs) were trained in mental health needs and services to support refugee women in self-care and reducing victimization. In the African Great Lakes region, female refugee leaders participated in leadership, advocacy, and human rights training to support them in developing action plans to address protection issues in their communities. In both Africa and Southeast Asia, safe houses and shelters were available to provide safe and confidential locations for survivors to receive needed resources and support. Many of the programs included activities to strengthen family and community structures and support systems; however, evidence of their effectiveness was not collected by NGO implementers.

- In **Malaysia**, ICMC, HEI, and WAO all work closely with refugee community organizations; these partnerships have helped to facilitate both GBV prevention and response efforts. The strength of community structures and support systems was evident in NGO implementers' responses to the safety, protection, and medical needs of GBV survivors by providing them with, or referring them to, necessary and appropriate services. However, most GBV programs were designed to respond to rather than prevent GBV. While certain activities do contribute to the prevention of GBV, this was not the core focus of programming in Malaysia.

- In **Uganda**, community structures for GBV prevention and response included community social workers, trained activists responsible for community mobilization, gender task forces, youth groups, and men-to-men support groups. Support structures available to GBV survivors included

GBV hotlines, safe houses, and legal services; efforts were ongoing to build community referral mechanisms that encourage GBV survivors to avail these services. In Uganda, strong community support structures were in place within the settlements for GBV response, and the SASA! intervention—along with training activities and support to refugee leadership—were perceived as effective means of building and supporting community structures and support systems.

- In **Chad**, efforts were ongoing to strengthen community support systems and structures, but significant challenges remain. NGOs are working toward the full involvement of the refugee community and supported groups within the community to share information about incidents through formal and informal networks. HIAS was the only one of the three NGOs evaluated that explicitly focused on strengthening community support systems and referral networks. Despite a variety of ongoing activities to strengthen community structures for GBV prevention in Chad, important shortcomings were observed in community support systems for GBV response.

Conclusions

NGO implementers in all countries mentioned in the desk review and in the three field evaluations worked closely with refugee community organizations and leadership groups, and these partnerships helped to build community capacity and local support structures and also facilitated both GBV prevention and response. A variety of efforts were underway to strengthen family and community structures for GBV prevention including awareness training and refugee capacity development. Specific groups targeted for trainings varied slightly by setting but commonly included children, youth (13-17 years), men, teachers, community leaders, social workers/activists, and health workers; in addition, community support structures such as gender task forces, peer support groups, and youth groups, among others were either supported or established by implementing partners to facilitate GBV awareness and outreach within refugee communities. In most cases, referral systems for GBV survivors and GBV response were well established; community support structures available to GBV survivors varied by setting. Approaches used to strengthen family and community support structures varied by context and region; however, evidence of their effectiveness was not collected by NGO implementers.

Creating Conditions to Improve Accountability Systems

Findings

In the **desk review**, all PRM-funded programs incorporated elements of international guidelines for prevention strategies, as well as the Core Standards and Protection Principles outlined in the Sphere Standards. Programs in all three regions reported on indicators that reflected organizational capacity to deliver safe and effective services. The creation of conditions to improve accountability systems was evident for programs in Chad and Malaysia. No objectives or indicators related to accountability were noted in the review of PRM-funded programs in the African Great Lakes region. Program documentation suggested that improvements in accountability systems were successful and resulted in a reduced number of GBV incidents; however, no indicators or measures were provided.

- In **Malaysia**, discussions with NGO implementers about international standards and guidelines for GBV treatment and prevention revealed limited staff familiarity with codes of conduct and international guidelines. Despite not being able to cite various guidelines, the implementation of PRM-funded programming that responds to GBV cases appeared to conform to most guidelines. None of the NGO staff or refugees interviewed mentioned use of complaint mechanisms to ensure accountability to beneficiaries. Perpetrators of GBV in Malaysia were rarely held

accountable for their actions, and NGO implementers noted the inability to successfully prosecute cases as a major barrier to their programs.

- In **Uganda**, both ARC and MTI program objectives were informed by international guidelines, and programming strategies reflected the Core Standards and Protection Principles outlined by Sphere Standards and some elements of best practices in prevention. ARC and MTI regularly engaged with refugee community leaders and activists implementing SASA!; both NGO implementers were perceived as accountable to beneficiaries, however, no specific indicators were reported. Despite efforts to improve accountability systems, key informants identified the Ugandan legal system as a barrier: prosecution of cases is perceived as difficult, only a minority of cases was prosecuted, and an even smaller number of perpetrators were convicted.

- GBV prevention activities in **Chad** were generally aligned with internationally accepted guidelines, whereas weaknesses were noted in GBV response programming. Provision of medical care and the delivery of psychosocial services were not fully in compliance with international standards. NGOs face significant challenges in creating conditions to increase accountability for perpetrators of GBV because the majority of cases is handled through traditional systems, managed by families, or dealt with in refugee community structures.

Conclusions

With respect to NGO implementer accountability, primary GBV prevention programming was for the most part designed and implemented in accordance with international standards and best practices. Implementation of GBV response programming was less likely to be in accordance with international standards, and in some cases, basic infrastructure such as medical services or safe houses was inadequate. Complaint mechanisms to ensure NGO accountability to beneficiaries were not employed by implementers. Perhaps the most universal challenge in the creation of conditions to improve accountability systems was difficulties associated with holding GBV perpetrators accountable.

Designing Effective Services and Facilities

Findings

The majority of PRM-funded programs included in the **desk review** did not include specific information about NGO partner efforts to design effective services and facilities as a means of primary prevention of GBV. However, GBV prevention programs evaluated in all three countries included a strong integration of both refugee community members and survivors in program delivery. The core staff of most of the NGO partners was composed of refugees.

- In **Uganda**, stakeholders unanimously agreed that the SASA! program is successfully engaging refugees at all levels—especially preparing community activists and others to raise awareness and develop actions to help prevent and respond to GBV cases. At the same time, both ARC and IMC noted the absence of refugee community participation in GBV program planning (including establishing realistic objectives and activities) as a potential limitation for successful implementation. Another challenge faced by NGO partners was their inability to provide refugee leaders, activists, and volunteers with adequate incentives to support their work in GBV prevention. The NGOs observed that some volunteers are committed and participate without any incentives, but these are a small number of individuals.

- In **Malaysia**, ICMC, HEI, and WAO all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. ICMC's close cooperation with peer organizations and creative use of alternative spaces and times to provide information to refugees have led to the trend that refugees will often call ICMC before UNHCR to get a faster response and referral.

- In **Chad**, UNHCR, HIAS, and CARE depend on the noteworthy support they receive from refugee community organizations. Collaboration with internal camp leadership committees was frequently cited as an effective and efficient method for distributing information and services to the community. NGOs recruit staff members and volunteers from the refugee community, who are recognized as extensions of the service providers and sought out for communication about problems and inquiries about types of assistance. In addition, NGO partners in Chad cited examples of ongoing activities and projects to establish strong relationships with the local communities living around the refugee camps.

Conclusions

It is widely recognized that the key to developing effective services and facilities is strategically engaging refugee populations in the planning and implementation of interventions across all sectors. Direct collaboration with refugee community members not only helps to ensure that gender and protection concerns are considered, but also that interventions do not unintentionally exacerbate the safety and security risks to women and girls. Programs must ensure the inclusion of participants at all levels of design, implementation, and evaluation. To ensure that these fundamental aspects of effective services and facilities are functioning properly, NGO partner staff must possess the necessary knowledge and skills and be provided with the appropriate mentorship, management, and financial supports.

Working with Formal and Traditional Legal Systems

Findings

In the **desk review**, only PRM-funded programs in the Africa regions reported work with formal and traditional legal systems. Training was provided to traditional clan chiefs and police on mediation skills, human rights, and legal instruments related to GBV. Documents reviewed did not provide information on the effectiveness of these programs. Continuous monitoring and evaluation (M&E) of these efforts is essential given that traditional legal systems and police may or may not support women's rights.

- In **Malaysia**, the formal legal system presents challenges for NGO implementers and refugees. Due to resource constraints, UNHCR is unable to register refugees and asylum-seekers within a reasonable period, and the influx of new refugees increases concerns about the human rights and security abuses they may face. Lack of access to at-risk populations in detention centers and near total impunity for perpetrators of GBV suggest that additional efforts to work with formal legal systems is required for NGO implementers to realize broader success in client services and GBV prevention and response.

- In **Uganda**, ARC worked with the Uganda National Police and the court systems on issues related to GBV. Barriers included high turnover rates of officers assigned to the settlements as well as small numbers of policewomen available to speak with GBV survivors about their cases. ARC supports prosecution efforts with training, transportation, and translation for court cases. Mobile courts were recently introduced in Nakivale and perceived to be successful from a

community perspective; however, the high cost and the difficulty in finding judges were barriers to continuing and expanding their use. Overall, ARC's efforts to support the legal system were perceived as effective, though not without challenges given the weakness of the system, as indicated by the increased demand for services.

- In **Chad**, the lack of a viable legal system to address incidents of GBV among refugee communities was noted as a major barrier. The constitution recognizes traditional and customary rules as having the status of laws; the influence of this legal dualism is pervasive. Both the refugee community and service providers indicated that socio-cultural norms of refugee communities in eastern and southern Chad strongly favor the resolution of GBV cases within the confines of the family or extended family, rather than involving outside legal or other types of interventions. Despite these challenges, NGOs are working to support the legal systems and small number of GBV survivors who wish to bring their cases to court.

Conclusions

Formal and traditional legal systems present challenges to GBV prevention and response programming in each of the three field evaluation settings. Legal systems in refugee environments are often weak or non-existent; Malaysia, Uganda, and Chad were not exceptions. Prosecution of GBV cases in formal legal systems is often time- and resource-intensive and, in many cases, unsuccessful. This is a source of discouragement for NGOs, refugee communities, and perhaps most importantly GBV survivors. Despite the barriers posed by both the formal and traditional legal systems, PRM-funded NGOs in both Uganda and Chad worked with these systems in an effort to improve responses for survivors and hold perpetrators accountable. However, despite these efforts, few cases were prosecuted and an even smaller number of convictions resulted.

Assessment, Monitoring, and Documentation of GBV

Findings

Program documents examined in the **desk review** revealed a mixed performance among PRM-funded NGO partners regarding the application of program monitoring and assessments.

- In **Chad**, CARE and ADES program documents did not provide sufficient information to determine whether assessments were conducted to inform program design and implementation. HIAS conducted regular surveys to assess knowledge, attitudes, and practices related to GBV in each camp and used findings to inform and adjust programming.

- In **Uganda**, ARC conducted a number of assessments including a baseline survey on knowledge, attitudes, skills, and behaviors; an assessment of capacity among health service providers on clinical management of rape services; and a technical and organizational capacity assessment of community volunteers and community structures during the first year of program implementation. ARC conducted follow-up assessments to monitor shifts in knowledge and attitudes among community groups and in the general community, as well as assessments on health workers' capacity and the traditional justice systems.

- In **Malaysia**, HEI conducted two studies about the healthcare needs of refugee communities in Kuala Lumpur. Program documents demonstrate that HEI has significant experience and expertise with addressing health problems faced by GBV survivors; however, its reporting does

not focus on GBV prevention efforts. ICMC conducted an extensive GBV mapping exercise that involved interviewing service providers, NGOs, 14 refugee organizations, and UNHCR.

A review of findings from each of the three field evaluations indicates that program M&E is overall quite poor. The limited M&E conducted by NGO partners focuses on the output level, which is capable of showing progress at the activity level. The majority of indicators measure the number of people trained and the types of services provided. The limitation is that NGO implementers cannot demonstrate program outcomes using their current M&E systems. Connected to the practice of output monitoring is the feeling that GBV response interventions are easier to measure than prevention interventions—as it is difficult to prove that something did not happen, and also to explain how or why it did not happen. Attribution of change to a specific program is challenging given that multiple organizations may be implementing different interventions in the same settlements or within the same communities. The evaluation team also found that NGO implementers across the board were confused about the difference between indicators and targets, as well as conflate indicators with activities. Both the desk review and the field evaluations revealed an absence of standardized indicators across NGO implementers; despite sharing common GBV prevention goals, each implementer developed its own indicators. The lack of standardized indicators in the field presents a major obstacle for measuring the overall impact of PRM-funded GBV prevention programs—both within and across countries.

Conclusions

UNHCR and NGO implementers are struggling to measure the outcomes of all GBV prevention programs. For each of the three field evaluations, the evaluation team was not able to effectively identify GBV prevention program outcomes. Outcome measures such as acceptability of physical and/or sexual violence against women/girls are less frequently used, presumably because they are more difficult to assess and require additional M&E resources. The absence of standardized indicators used by PRM's implementing partners prevents PRM from learning about the overarching impact of the GBV prevention initiatives that it funds. In addition to the need for outcome monitoring, indicators and targets must be separated in order to provide accurate and useful information about program performance.

Engaging Men and Boys in GBV Prevention and Response

Findings

The **desk review** indicated that men must be approached not as "the problem" but as part of the solution, using positive and affirming messages that emphasize their potential to act as agents of change. Literature also notes the importance of recognizing that some men and boys experience effects of GBV when a family member is victimized, including shame and a sense of powerlessness or inability to act as a protector of the family—especially when there is no justice for their female relatives. Men and boys should have access to tailored assistance programs when they have experienced sexual violence.

- Program documents revealed that although engaging men and boys in GBV prevention and response was not an explicit objective of HIAS programs in **Chad**, engaging male heads of households in discussions on gender equality and involving men in voluntary committees to promote the rights of women and girls was a key component of the NGO's efforts to transform socio-cultural norms and rebuild family and community support structures.

- Male refugees reported to ARC that they were not involved in GBV programs implemented by the NGO's predecessor in **Uganda** and that the previous programs characterized all men as potential perpetrators and encouraged women to disobey and/or divorce their husbands. Some men explained that these misperceptions were the reason for frequent backlash against women and even against NGO program staff, as this previous work thwarted any advancement toward social change in the settlement.

- ICMC **Malaysia** integrated male involvement in GBV awareness-raising training from the inception of the project. ICMC reports that the overall response, including that of men, to community GBV awareness-raising trainings has been positive. Program documents do not provide any specifics that indicate how training has affected attitudes, behaviors, or norms.

The evaluation team found several differences not only at the country level, but also at the NGO partner level, in terms of the engagement of men and boys in PRM-funded GBV prevention programming. In Uganda, male engagement is an explicit component of ARC's SASA! program. SASA!'s male engagement strategies focus on: 1) males as victims of violence, 2) males as supporters of female survivors, and 3) males as agents of change. ARC's SASA! program was the only one with indicators explicitly designed to measure the engagement of men and boys in GBV prevention programming. The evaluation team found that while the participation of men and boys in PRM-funded GBV awareness campaigns is quite consistent, there remain thematic areas of importance to reducing incidents of GBV. For example, addressing—and transforming—the established roles of men and boys has not yet received adequate attention or emphasis within PRM-funded GBV awareness campaigns and outreach efforts.

Conclusions

Like all sensitive topics, exploring and questioning traditional norms associated with femininity and masculinity is a difficult endeavor and must be carried out with thoughtful planning and within a culturally respectful environment. While NGO partners are engaging men and boys in their activities to a varying extent, a higher level of intention and purpose is needed to effectively contribute to GBV prevention. Across the board, NGO partners are not sufficiently monitoring the ways in which they are currently engaging men and boys, nor are they able to measure the extent to which this engagement may be having an effect on desired program outcomes. Despite the lack of data to this end, it is clear that additional attention must be given in each country to address and counter the harmful effects of traditional norms, particularly those associated with men and boys, on the perpetuation of GBV.

Recommendations

Transforming Socio-Cultural Norms with an Emphasis on Empowering Women and Girls

- NGO implementers should design and implement GBV prevention programs from a social norms perspective.
- PRM should maintain the extended funding cycle length for GBV prevention programs.

Rebuilding Family and Community Structures and Support Systems

- NGO implementers, UN agencies, and host government stakeholders should improve coordination at the refugee settlement level.
- PRM should support and promote the use of SASA! and other similar approaches that support community structures.

- PRM and UNHCR should identify funding opportunities to expand education opportunities for girls and integrate GBV messaging into school curricula.
- NGO implementers should ensure that shelters are culturally appropriate and that locations are known.

Creating Conditions to Improve Accountability Systems

- PRM and UNHCR should require NGO implementers to expand training for program staff on GBV awareness, prevention, treatment, and self-care.
- PRM should require NGO implementers to report on accountability measures, including directly linking GBV prevention programs and indicators to international guidelines and best practices.
- UNHCR and PRM should support expanding the use of the GBV Information Management System (GBVIMS) in other countries as a means to promote coordination and accountability.

Designing Effective Services and Facilities

- NGO implementers should involve communities in the early stages of program design for GBV prevention and response.
- UNHCR should be encouraged by PRM and other donors to work with NGO partners and refugee committee leaders to ensure that roles and responsibilities for GBV prevention are not duplicated.
- All PRM- and UNHCR-funded partners implementing GBV prevention activities should routinely collect confidential feedback from survivors about their levels of satisfaction and perceptions about quality of treatment and services received.

Working with Formal and Traditional Legal Systems

- PRM should continue to fund awareness-raising activities that increase refugees' demand for legal services.
- PRM and UNHCR should encourage capacity building and female recruitment among local law enforcement.
- PRM should continue to support traditional legal systems with both material inputs and capacity building, as well as consider increasing attention to formal legal systems in relevant countries.
- UNHCR and NGO implementers should investigate the reportedly overwhelming trend of domestic violence (DV) cases being resolved at the family or community level (rather than by means of local legal systems).
- In contexts where UNHCR has a significant backlog, PRM should work with UNHCR to address the backlog and reduce delays in refugee status determination and registration.

Assessment, Monitoring, and Documentation of GBV

- PRM should provide financial support for an extensive situational analysis to understand the needs and priorities of refugee communities; subsequently, PRM should ensure that baseline assessments are conducted prior to program implementation.
- PRM should consider providing specific resources to UNHCR and NGO partners for program evaluation, particularly in the case of short-term (less than 3 years) funding, which is a challenge with respect to assessing effectiveness.

- PRM should require programs that focus on healthcare, livelihoods, or other areas to develop specific and measureable objectives that clearly relate to the particular GBV activities being implemented in a country, community, or region.
- PRM should develop an internal results-based management system to support the implementation of its Functional Bureau Strategy.
- PRM, in consultation with UNHCR, should disseminate required GBV M&E methodologies and tools to NGO implementers. Specifically, PRM should require NGO partners requesting funding for GBV prevention programs to monitor and regularly report on a selection of required internationally accepted outcome indicators to determine the impact of their programs.[1]
- PRM should support NGO implementers and PRM Regional Refugee Coordinators to build capacity in required M&E methodologies.

Engaging Men and Boys in GBV Prevention and Response

- UNHCR and NGO implementers should increase discussions and questioning of traditional norms associated with femininity and masculinity within their GBV prevention awareness campaigns—while at the same time reinforcing positive masculine behavior that decreases GBV within the refugee community.
- UNHCR and NGO implementers should develop engagement strategies that emphasize men as part of the solution.
- UNHCR and NGO implementers should work toward providing refugee men and boys access to specially-designed assistance programs.

[1] The GBV Prevention Indicator Compendium (Annex II.B) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

INTRODUCTION

Overview and Purpose

This synthesis report examines the effectiveness of gender-based violence (GBV) prevention programming funded directly by the U.S. Department of State Bureau of Population, Refugees, and Migration (DoS/PRM) or indirectly by one of its multilateral partners, the United Nations High Commissioner for Refugees (UNHCR). The report is the culmination of a one-year evaluation project that included a desk review of relevant literature and PRM-funded GBV programs in three regions and three field evaluations of PRM-funded GBV prevention programs in Chad, Malaysia, and Uganda. As the synthesis report for the one-year performance evaluation of GBV prevention programming supported by PRM and UNHCR during fiscal years 2010-2012 (October 1, 2009 – September 30, 2012), this document aims to synthesize findings from these diverse evaluations to 1) assess the effectiveness of GBV prevention programming for individuals and communities at risk; 2) identify appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings; and 3) characterize best practices and lessons learned in engaging men and boys in GBV prevention and response interventions in refugee settings.

The focus of the evaluation activities and the synthesis report is primary prevention of GBV. Primary prevention aims to prevent violence before it occurs, whereas secondary and tertiary prevention focus on response to violence immediately (secondary prevention) or in the longer term (tertiary prevention).[2] Based on definitions used by the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and United Nations (UN), primary prevention can be understood as follows:

- Carried out before violence first occurs;
- Aims to prevent initial perpetration or victimization;
- Addresses social norms and environmental factors that contribute to violence (e.g., attitudes and beliefs that condone the use of violence against women, policies and legislation, institutional practices, economic inequalities, etc.); and
- Appears to be most successful when carried out as part of comprehensive, multi-sectoral efforts to transform communities.

The goal of the synthesis report is to hone and refine the extensive research conducted under this contract in order to identify the overarching effectiveness of PRM's GBV prevention programs. To achieve this goal, the evaluation team elected to conduct its analysis through the lens of the seven key topic areas identified in the desk review phase of this contract. The first six topics are based on prevention program objectives outlined in UNHCR's 2003 *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*. The seventh topic, male engagement in GBV prevention and response, is included to reflect PRM's learning priorities for this evaluation.

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[2] Linda L. Dahlberg, L. and Etienne G. Krug, "Violence—a global public health problem," in *World report on violence and health*, ed. Etienne G. Krug et al. (Geneva: World Health Organization, 2002), 3-21.

a. Transforming socio-cultural norms, with an emphasis on empowering women and girls
b. Rebuilding family and community structures and support systems
c. Creating conditions to improve accountability systems
d. Designing effective services and facilities
e. Working with formal and traditional legal systems
f. Assessment, monitoring, and documentation of GBV
g. Engaging men and boys in GBV prevention and response

The evaluation team followed a meta-analysis framework to provide PRM with a systematic overview of the primary research presented in the three field evaluation reports and the secondary research presented in the desk review report. The evaluators utilized the seven key topic areas as lenses for the analysis by comparing, contrasting, and appraising the findings, conclusions, and recommendations across each of the nine evaluation questions to identify patterns and sources of disagreement and to synthesize the information most relevant to the seven topic areas.

For additional detail on the topics discussed in this synthesis report, please consult the following documents produced by Social Impact for DoS/PRM:

- Desk Review Report and Annexes (July 2013)
- Evaluating the Effectiveness of GBV Prevention Programs with Refugees in Malaysia (July 2013)
- Evaluating the Effectiveness of GBV Prevention Programs with Refugees in Uganda (October 2013)
- Evaluating the Effectiveness of GBV Prevention Programs with Refugees in Chad (January 2014)

Evaluation Questions

This performance evaluation of PRM GBV prevention programs sought to answer the questions below:

1. Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
2. Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
3. Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
4. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals specific, measurable, achievable, realistic, or time-bound (SMART)? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?
6. What factors explain intended and unintended negative or positive consequences?
7. What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?
8. To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

GENDER-BASED VIOLENCE PREVENTION PROGRAM BACKGROUND

Country Contexts for Field Evaluations

Chad

The Republic of Tchad (Chad) is among the poorest countries in the world, with approximately 55 percent of the population living below the poverty line and approximately 36 percent of the population living in extreme poverty.[3] As of 2013, Chad hosted 348,528 refugees from Sudan and 74,131 refugees from the Central African Republic (CAR), 90,000 internally displaced persons (IDPs), and additional urban refugees and asylum-seekers.[4] Refugees in Chad currently reside in 18 camps that are primarily located in the southern and eastern regions of the country bordering CAR and Sudan, respectively. The Chadian government and refugee agencies are faced with a complex situation due to the diverse backgrounds and needs of the refugee populations.

Since the 2011 signing of the Darfur Peace Agreement, the political and security situation in Chad has improved, and a joint Chadian-Sudanese border monitoring force has been in place. Nevertheless, a majority of the Sudanese refugees in Chad are unable to return home due to ongoing instability in some parts of Darfur.[5] Likewise, due to volatile conditions in CAR, large-scale voluntary returns are unlikely. Because the situation in this area remains tense, there is a possibility of an additional influx of CAR refugees into Chad. The presence of a large population of refugees from Sudan and CAR weighs heavily on the country's resources.[6] The government's restriction of refugee movements, mobility, and integration in some regions has also served as a barrier to the attainment of refugee self-reliance.

The Government of Chad launched its National GBV Strategy on December 8, 2011, which presents an opportunity for UNHCR and other organizations to advocate for a stronger legal framework to address GBV in the country, as well as in the refugee camps. The document emphasizes that "refugees and displaced persons are a priority in the fight against GBV in Chad, given that rates of GBV are high in the humanitarian zones where legal structures are the weakest."[7] Although Chad ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995, it has not ratified either the Optional Protocol to CEDAW or the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Positive reforms include the adoption of Law No. 06/PR/2002 of April 15, 2002, which "prohibits female genital mutilation (FGM), early marriage,

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[3] CIA - World Fact Book 2013. Poverty is concentrated in rural areas, where 87 percent of the country's poor reside.
[4] 2014 UNHCR Country Operations Profile – Chad
[5] 2014 UNHCR Country Operations Profile – Chad
[6] In eastern Chad, where the climate is semi-arid, Sudanese refugees put a strain on already scarce natural resources, which leads to tensions with host communities. In southern Chad, where the climate is tropical, flooding regularly destroys refugees' homes and crops. This has hampered UNHCR's efforts to improve the self-reliance of CAR refugees and made them more vulnerable to malnutrition.
[7] SGBV Strategy 2012-2016: UNHCR Chad

domestic violence (DV), and sexual violence."[8] However, it is important to note the legal dualism that prevails in Chad, given that the constitution recognizes traditional and customary rules as having the status of laws.

Malaysia

Malaysia has not acceded to most major human rights instruments. As Malaysia is not a signatory to the 1951 Refugee Convention or its 1967 protocol, refugees and asylum-seekers hold no legal status and are treated as illegal immigrants subject to harsh penalties such as arrest, detention, caning, and deportation. Malaysia ratified the Convention on the Rights of the Child (CRC) in February 1995, which requires member states to provide appropriate protection and humanitarian assistance to refugee children. Malaysia is also a signatory of CEDAW. However, the government maintains reservations on several CRC and CEDAW articles. The absence of a legal framework that regulates the status and rights of refugees and asylum-seekers leaves these populations vulnerable to human rights abuses. In a human rights report endorsed by 54 organizations working in Malaysia, key concerns included "the slow pace of the attainment of substantive equality and, in some instances, the roll-back in women's rights; the failure of the legal system to ensure that perpetrators of violence against women are held accountable and sentenced appropriately; the discrimination faced by women, (especially Muslim women), during divorce and other matters related to marriage and family; and the escalation of discrimination and violence against lesbians, bisexual women, and the transgendered."[9] Domestic non-governmental organizations (NGOs) have limited capacity to support asylum-seekers and refugees, while international NGOs face significant difficulties operating in the country. The achievements made by PRM-funded GBV prevention programs should be considered in light of this difficult working environment.

Malaysia depends heavily on the cheap and readily available migrant labor force from the Asian region. The demand for labor has resulted in unwanted, irregular movements of economic migrants. Malaysia's relative political and economic stability has also attracted refugees and asylum-seekers who are fleeing conflict and persecution. Low-skilled migrant workers have a marginal and semi-marginal existence in Malaysia. However, policies toward irregular migrants and refugees, tempered by issues of ethnicity and racism, are less tolerant.[10] Malaysia makes no distinction between refugees and undocumented migrants. There are an estimated 4 million migrants in the country, including 2 million who are undocumented and considered illegal. In January 2014, there were 91,398 registered refugees and 14,286 asylum-seekers; the total population of concern to UNHCR was 225,685. There are large numbers of undocumented, urban refugees—90 percent of which come from Burma, but also from other countries throughout Asia. Refugees are subject to arrest, detention, physical punishment, and deportation. In the past several years, a decrease in arrests of documented refugees and asylum-seekers has been observed; however, large-scale arrests and detention of unregistered asylum-seekers persist.[11]

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[8] Africa for Women's Rights: Chad (2013)

[9] "Stakeholder Report on Malaysia for the 17th Session in the 2nd Cycle of the HRC's Universal Periodic Review in 2013," Coalition of Malaysian NGOs in the UPR Process (COMANGO), <http://www.awam.org.my/web/wp-content/uploads/2012/11/Comango-Report-11Mar2013-FINAL-+-Annexure.pdf>

[10] Kaur, A., "Refugees and Refugee Policy in Malaysia," University of New England (Australia), UNAEC Asia Papers No. 18, 2007.

[11] 2014 UNHCR Country Operations Profile—Malaysia, UNHCR, <http://www.unhcr.org/pages/49e4884c6.html>

Uganda

Refugees in Uganda reside in eight settlements, primarily in the eastern part of the country and an additional three UNHCR transit centers. According to UNHCR figures from January 2013, refugees in Uganda were 70 percent Congolese, 11 percent South Sudanese, 9 percent Somali, and 10 percent from other countries including Rwanda, Burundi, Ethiopia, and Eritrea. The population of concern to UNHCR has remained stable over the last few years with voluntarily repatriations and refugee resettlement nearly keeping pace with new arrivals. However, renewed conflict in the Democratic Republic of Congo (DRC) led to a steady influx of refugees beginning in 2010 and by mid-2011 the surge in refugees fleeing violence in eastern parts of DRC had become an emergency with large numbers of Congolese, in excess of 40,000 new arrivals, seeking refuge in Uganda. Uganda's refugee and asylum-seeker population surpassed 215,000 by the end of 2013.[12]

Uganda's Citizenship and Immigration Control Act limits naturalization and legal residency options for refugees, however, some progress in the legal area is being made with the establishment of a Refugee Appeals Board in 2011 and ongoing legal review processes. The Government of Uganda has a generous policy toward refugees with respect to land rights, freedom of movement, health, and education services. Refugees are granted plots of land in the settlements and have access to government-supported health and education services. In the area of GBV, the Ugandan government with leadership from the Ministry of Gender, Labour, and Social Development has responded by passing laws such as the Domestic Violence Act (2010), Prohibition of Female Genital Mutilation Act (2010), and Prevention of Trafficking in Persons Act (2009). However, budget constraints have resulted in curtailment of programs to prevent and respond to GBV in host and refugee communities.

Contextual Challenges to GBV Prevention

A commonality among the three field evaluations was the extremely challenging context in which all of the PRM-funded NGO partners were working. In Uganda, NGO partners are dealing with both an acute and protracted refugee crisis. Over the past several years, Uganda has seen a steady stream of new arrivals with renewed conflict in eastern parts of the DRC as the primary source of increasing refugee flows. This influx was a particular challenge in Kyangwali settlement, which was receiving twice-weekly convoys with more than 1,000 Congolese refugees and experiencing a need for significant expansion of services in all sectors to keep pace with the rapidly growing settlement population. However, the refugee situation in Uganda is also protracted—for example, Nakivale settlement was established in 1959 and has been in existence for more than 50 years—which comes with another set of challenges. Limited resources and infrastructure, donor fatigue, and competing refugee crises are challenges that affect NGOs working in GBV prevention and must be considered in the program evaluation landscape.

One advantage in Uganda's operating environment is the country's more generous policy toward refugees compared with those of many countries in the region; in Uganda, refugees are granted land and the right to engage in employment. Overall, this is very positive and has contributed to integration and feelings of normalcy among the refugee community; however, there are also tensions relating to the amount of support that older arrivals should continue to receive. With respect to primary and

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[12] UNHCR, 2012 <http://www.unhcr.org/51b1d6350.html>, <http://www.unhcr.org/50a9f8230.html>

secondary GBV prevention programming, specific barriers that were identified as key challenges in Uganda are described below.

Chad is also dealing with a combination of acute and protracted refugee crises, with the escalation of new refugees arriving in southern Chad due to the conflict in CAR, as well as the decade-long existence of hundreds of thousands of Sudanese refugees in the east who lack durable solutions to their marginalization. The life-threatening difficulties that refugees in Chad face on a daily basis—related to food, water, shelter, medical care, and education—prevent NGO partners and refugees alike from dedicating significant focus to the issue of GBV. While GBV is tied to basic human rights, the evaluation team understood from respondents that GBV can often seem secondary to the aforementioned basic needs. Decreased food rations in several camps were cited as a cause of increased household stress levels as hunger and competition for household resources increased. In particular, refugees in Touloum camp suffer from a deficient availability of water and firewood. Refugees obtain water from a shared well with the local population, which is located outside the camp at a distance of four to five kilometers. To locate firewood, women often travel more than 30 kilometers and are still unable to gather sufficient quantities. Women expressed concern about the distances they must travel to obtain these needed resources, citing examples of GBV that often occur during their journeys.

The Government of Chad applies different policies toward the integration of refugees. According to UNHCR staff members in Iriba, despite the fact that the majority of Sudanese refugees in the eastern camps are of the same ethnicities as the local Chadians—with whom they share cultural values and similar cultural practices—the Government of Chad does not permit local integration. The evaluation team learned that this is not the case for CAR refugees in the southern camps, who are able to obtain Chadian nationality and are given access to land and resources. Resources are scarce in Chad and the south is a more favorable area in terms of access to resources, land, and climate. The north is much harsher in terms of livelihoods, which places even greater constraints on refugee survival in light of the government's unfavorable integration policies in that region.

In Malaysia, NGO partners face severe limitations due to the political sensitivities of their work. Working with refugees and asylum-seekers is a particularly sensitive and complicated issue in Malaysia given the fact that these populations are not afforded legal status by the Malaysian government. UNHCR noted that the International Catholic Migration Commission (ICMC) has to work within the UNCHR compound because it has no ability to obtain an agreement with the government and that local NGOs in Malaysia typically are quite small and originate from charitable organizations and individuals with shared interest. UNCHR reported difficulties with finding appropriate NGOs to implement programs with its available funds, given that Malaysian NGOs are limited in number and capacity. The Malaysian authorities view organizations that work with refugees with suspicion, regarding them as aiding and abetting lawbreakers rather than acting to ensure the protection of human rights. Although there are no direct threats made to NGOs for working with refugees, there is a thin patina of tolerance of their efforts; some NGOs have expressed concerns about possible difficulties with the government.[13]

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[13] As one UNHCR official observed: "There is very little variety of NGOs and to complicate matters is the fact that refugees here are considered to be the same as undocumented migrants and are subject to arrest. And there are also problems in the legislation directed at employers, by [put in general terms] saying that an individual or a

In addition, NGO partners in Malaysia face the constant threat of arrest and detention of their staff and clients. Health Equity Initiative (HEI) expressed major concern about hiring unregistered refugees, stating that to do so would place those refugees at substantial risk. To address cases of police harassment of refugee staff members, HEI established a protocol to respond to law enforcement and trained coordinators to prevent refugees' arbitrary arrest and detention. In June 2012, police detained 10 HEI clients following a raid in their community.

Program Response

DoS/PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world. PRM provides life-sustaining assistance through multilateral systems to build global partnerships and promote best practices in humanitarian response; in addition, PRM works to ensure that humanitarian principles are integrated into U.S. foreign policy. The work of UNHCR and NGO implementing partners is instrumental to ensuring that PRM achieves its humanitarian objectives and fulfills its mandate. PRM directly funds NGO programs designed to fill critical gaps such as GBV prevention in humanitarian assistance and protection. NGO implementers funded by PRM provide crucial services to refugee populations in addition to information that is critical for policy development and advocacy.

In Chad, the evaluation team examined GBV prevention programs implemented by three NGOs with PRM funding:

- **Agence Sociale pour le Développement et Education (ADES):** ADES is a local NGO that has been working in refugee camps in eastern Chad since 2005. It is operational in the Am Nabak, Touloum, Iridimi, Goz Amir, and Oure Cassoni camps and conducts GBV prevention and response activities in Oure Cassoni camp and Goz Amir camp. In each of these camps, ADES implements multi-sectoral programming that includes a variety of activities such as livelihoods promotion, environmental protection, shelter construction and maintenance, child protection, information dissemination, psychosocial and health services, and water and sanitation. ADES works closely with UNHCR, refugee groups, and other NGOs to implement these activities.

- **CARE International (CARE):** CARE is an international NGO and UNHCR implementing partner serving refugees from CAR in the southern camps of Belom, Dosseye, and Gondje Amboko. CARE began working in these camps in 2013. Previously, CARE was supporting refugees with specific needs in the northeastern camps of Am Nabak, Touloum, and Iridimi. In addition, CARE works closely with UNHCR as well as local and international NGOs to protect children and adolescents from abuse and exploitation.

- **Hebrew Immigrant Aid Society (HIAS):** HIAS maintains an advocacy network and community-based referral system to identify and prevent GBV and sexual exploitation and abuse; respond to sexual and intimate partner violence by providing psychosocial support to survivors; and encourage women's and girls' self-reliance, leadership, and decision-making ability in 11 of the 13 camps for Darfuri refugees in eastern Chad. HIAS trains and supports refugees to implement

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group housing undocumented migrants can be subject to prosecution. This scares NGOs off as well because they think they will get in trouble [by working with refugees]."

theater productions and radio programs to transmit awareness-raising messages and sensitization activities. HIAS also works closely with UNHCR, governmental authorities, and international and local NGOs.

In Malaysia, the evaluation team examined GBV prevention programs implemented by three NGOs with PRM funding:

- **Health Equity Initiative:** HEI is a local organization based in Kuala Lumpur with the objective of improving mental health and medical services for Burmese and other refugees and asylum-seekers, with an emphasis on victims of torture, forced labor, human trafficking, and exploitation. To achieve this objective, HEI builds the capacity of refugees to work within their communities on mental health issues; reinforces referral and case management systems in conjunction with UNHCR, other NGO implementers, and medical facilities; and conducts mental health outreach and screening.

- **International Catholic Migration Commission:** The mission of ICMC is to reduce the risk of GBV among refugee women and children in Kuala Lumpur's Klang Valley and surrounding areas and to improve access to emergency support services for survivors. ICMC works in collaboration with UNHCR and four local NGOs to meet its objectives, and it coordinates with other organizations to identify and assist GBV survivors. ICMC and its partners provide emergency support services for GBV survivors, including emergency shelter and auxiliary services such as interpretation, transportation, and psychosocial support. ICMC and partners also raise awareness about GBV-related issues and promote community involvement in preventing and responding to GBV.

- **Women's Aid Organization:** WAO is a local organization based in Kuala Lumpur that provides mental health services for refugees and asylum-seekers and is under contract with UNHCR to provide counseling for GBV survivors on the UNHCR compound. It also maintains a shelter to protect women who are in danger. ICMC has a memorandum of understanding (MOU) with WAO to provide PRM-funded shelter and mental health services to survivors referred by ICMC.

The evaluation in Uganda focused on GBV prevention programs conducted by two PRM-funded NGO implementing partners working in refugee settlements:

- **American Refugee Committee (ARC):** ARC works to strengthen locally-owned systems for addressing GBV by transforming socio-cultural norms, rebuilding family and community support systems, designing effective services, working with legal systems, and documenting GBV incidents. ARC has been working on GBV-related issues with refugee communities in Uganda's western settlements since 2010. ARC aims to empower refugees in Kyangwali, Kyaka, and Nakivale refugee settlements to prevent and respond to GBV. To accomplish this objective, ARC strengthens the capacity of community partners to address GBV in Kyangwali settlement via improved access to multi-sectoral services for GBV survivors and strengthening of GBV referral pathways. In Kyaka and Nakivale settlements, ARC promotes coordination, case management and technical support to community partner organizations that are working to address GBV in the settlements. ARC coordinates with the Office of Refugee Affairs within the Ministry of Relief and Disaster Preparedness, housed within the Ugandan Office of the Prime Minister (OPM); UNHCR; and various international and local NGOs.

- **Medical Teams International (MTI):** MTI provides clinical services to GBV survivors visiting primary healthcare clinics in Nakivale and Oruchinga settlements but does not receive funding from DoS/PRM for primary GBV prevention activities. MTI has been providing direct emergency and primary healthcare services since 2009 in Nakivale settlement (the evaluation site) in facilities constructed by UNHCR. MTI is not responsible for GBV prevention activities in the refugee settlements but responds to cases with medical treatment and after counseling with referrals to other sectors as needed for survivors. MTI provides out-patient health services, community outreach activities, infrastructure development, and systems strengthening; in addition, MTI supports HIV/AIDS awareness messaging, health promotion campaigns, and capacity building of CHWs. In January 2012, UNHCR chose MTI to take the lead in health and nutrition across Nakivale and Oruchinga settlements—overseeing a total of five health clinics and a sixth that is under construction.

COMPARATIVE ANALYSIS

Transforming Socio-Cultural Norms with an Emphasis on Empowering Women and Girls

The transformation of social-cultural norms is necessary to achieve positive sustainable change in behaviors over the long term. Changing socio-cultural norms that legitimize GBV requires collaboration from and capacity-building of service providers across diverse sectors (e.g. health, protection, psychosocial, and livelihoods) to successfully engage influential individuals (e.g. husbands, religious leaders, youth, mother-in-laws, etc.) and groups (e.g. traditional leaders, religious leaders, peer groups) in identifying, discussing, and challenging social norms that legitimize GBV. International guidelines encourage transformation of socio-cultural norms to support positive gender relations and mobilization of populations to end harmful social norms and traditional practices. The importance of rebuilding or creating family and community support structures that uphold respect for the equal rights of all members of the community is also emphasized. At the same time, pressing protection problems in refugee settings require programs that develop practical, field-level strategies to prevent GBV in the short term.

Findings

The majority of PRM-funded GBV programs included in the **desk review** had objectives focused on raising awareness of GBV among the refugee population; however, they did not focus on changing norms that promote or allow GBV. Further, the extent to which awareness-raising activities (i.e. community mobilization, workshops, radio, theatre, cinema, and training for community outreach workers) engaged community members and leaders in promoting respect for women's rights and changing socio-cultural norms related to gender discrimination, equity, and GBV was not documented in program reports. The vast majority of GBV programs included in the desk review were funded for one-year cycles; in this timeframe, it is unlikely for programs to be able to measure the impact of their activities on social norms that promote and sustain GBV.

In **Malaysia**, all NGO implementers were engaged in GBV prevention and awareness activities; while changing of socio-cultural norms was not an explicit objective, many of the awareness-raising activities appeared to be focused on this aim. In Malaysia, a key challenge is that refugees come from male-dominated societies with traditional backgrounds where cultural norms are permissive of GBV. NGOs and sub-grantees explained that many people did not realize that DV is a crime and that if people knew such violence was criminal, they might be reluctant to commit acts of violence. Male engagement was a key strategy used by all NGO implementers in awareness campaigns and efforts to change socio-cultural norms. Use of male staff and volunteers was perceived to be successful in awareness-raising and changing socio-cultural norms because males may be more persuasive when training other males on gender roles and responsibilities. As well, when refugee men are involved, they may be more successful in reaching refugee men from similar backgrounds (such as the relatively insular Rohingya and Burmese Muslims). As one refugee community leader in Malaysia said:

> *"We… have a different traditional background. We want to share the knowledge so that [people] know what is GBV—sometimes they think that when some men touch the men they think this is not GBV and the boss does this to them but they don't understand… what we are doing here is to open the discussion to know what is GBV and how can we prevent [it]. We have to go to another country – in America we cannot beat our children, this is child abuse…*

we have to overcome our traditional knowledge and our assumptions, this is what our focus is now."

ICMC's Refugee Women's Protection Corps (RWPC) provided a very comprehensive approach to raising GBV awareness and changing cultural norms with age-specific programming that included: GBV prevention training for adults, covering the topics of sex and gender during sessions two-three hours in length; training for youth ages 13-17, covering the topics of healthy relationships, respecting the opposite sex, how to characterize your friends using a spectrum of "acquaintance" to "close friend," and misplaced trust (how to say no, to protect yourself, and to avoid being forced into an unwanted relationship); and safety training for children 8-12 years of age, aiming to prevent future violence against them. While ICMC's monitoring and evaluation (M&E) approach was not designed to detect socio-cultural norms change, this group of activities is perhaps best positioned to affect socio-cultural norms change over the near and long term as it addresses all age groups, including future generations.

In **Uganda**, only ARC was engaged in primary GBV prevention programming that aimed to promote awareness and social norms change. ARC uses Start Awareness Support Action (SASA!), a community-level GBV prevention model based on the approach developed in Uganda by Raising Voices.[14] SASA! has been implemented in Kyangwali beginning in 2010 and was expanded into Nakivale and Ourchinga in 2013. SASA! is a four-phased intervention in which ideas are introduced to a subset of community members over time via activities and discussions around power. The SASA! approach includes a practical resource kit with guidance on activities, monitoring and assessment tools, communication materials, and training curriculum. These tools serve as a basis from which implementing organizations can adapt the intervention to a particular context, such as the refugee settlements in western Uganda.

The SASA! approach has been implemented and evaluated in urban areas of Uganda and adapted for use by 35 organizations in 12 countries.[15] There is an emerging evidence base on the effectiveness of SASA!, and as one PRM staff member observed: "there is little GBV prevention work with evidence behind it. SASA! is novel because it is evidence-based." UNHCR, PRM, ARC, and partner organizations identified SASA! as being a facilitator of awareness and social norms change because of the focus on engaging men and its flexibility with respect to timing and engagement of community members. One key informant observed, "SASA! is embraced because you can meet people anywhere anytime—it is more flexible so this [work] is very possible." Other informants felt that the approach had prevented violence again women and girls but noted that the sustainability of this success remained unclear. Another informant noted "changing that attitude is a big challenge—sometimes we create awareness, the person changes today, and then tomorrow repeats old behaviors—so we need persistent messaging." In general, SASA! was perceived as galvanizing community participation and likely to lead to both short- and long-term positive GBV prevention and response services—as well as, at the larger settlement and host community level, increases in awareness and social norms change. There were some challenges observed with new arrivals in Nakivale, but efforts to expand SASA! into this group were ongoing. While an evaluation of SASA! effectiveness is underway in Kampala, additional evidence on the effectiveness of SASA! in refugee settings, the challenges of applying phased interventions in

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[14] For more information, see the Raising Voices website: http://raisingvoices.org/sasa/#tabs-419-0-0>.

[15] See Raising Voices website http://raisingvoices.org/sasa/#tabs-419-0-2> for a list of organizations implementing SASA! and the contexts and countries where they work.

protracted settings with new arrivals, and determining when SASA! has achieved success in terms of social norms change would expand the current evidence base and help to inform GBV prevention programming in emergencies.

In **Chad**, the work of NGO implementers in the areas of awareness and transforming socio-cultural norms was variable, and the effectiveness of these efforts was difficult to assess. CARE's work had recently started to focus on GBV prevention, with work in the southern camps beginning in March 2013; CARE conducted GBV programming in the Iriba camps in 2012, but this work has been transitioned to another organization. CARE's GBV prevention work focuses on awareness-raising programming that includes conducting educational talks and skits and broadcasting radio messages about the consequences of FGM, early and forced marriage, and DV. CARE has a broad scope of program activities that is implemented with limited staff and resources. CARE's GBV prevention activities appeared not to reach a significant portion of the refugee community, which is a concern for social norms change where high coverage levels are imperative.

HIAS' programs focus on transforming socio-cultural norms through theater groups, radio programs, door-to-door awareness-raising and community engagement, mass sensitizations, discussions with teachers and students, organization of men's and women's groups, and trainings. While the focus of programming activities was on changing socio-cultural norms, effectiveness was difficult to evaluate because HIAS did not report outcome-level indicators. ADES, a local NGO that has been working in refugee camps in eastern Chad since 2005, was perceived by key informants to have limited contributions to social norms change.

Deeply-rooted cultural barriers were one of the most challenging obstacles to social norms change and GBV programming in Chad. One informant summarized these difficulties well:

> *"It's very difficult to challenge FGM in the community because… they don't think they're doing anything wrong. Culturally it's an honor to be excised… it's a shame for a young girl to not be excised… in the young girl's mind it's a good thing. The victims are not really victims so that makes it very difficult because they are willing to do it… all of these young girls are totally willing to be excised. Now they are avoiding the boundaries of the camp by going outside to get excised… First we need to have them understand that this practice is very bad for the girls, and then maybe they will be able to report to us so that we can know the extent of the issue."*

Another respondent had insightful observations on changes in refugee cultural practices related to FGM, which suggests increased awareness—an important step in the process of social norms change: "Even when people are hiding themselves to do this [FGM], it demonstrates that they are aware that the practice is not good, and this is a step toward changing attitudes." In general, evidence of the effectiveness of GBV awareness activities was largely anecdotal and based on the perceptions of UNHCR and NGO implementer staff as well as feedback from refugees. Overall, it was perceived that the socio-cultural environment in refugee camps in Chad is becoming more open to and accepting of positive practices such as education of girls and delayed marriage; and harmful practices such as DV, early marriage, forced marriage, and FGM are becoming less acceptable. Awareness-raising activities of HIAS and CARE in Chad were aligned with international guidelines and exhibited regard for the refugees' traditional cultures and values while at the same time introducing ideas and concepts about GBV that appropriately and sensitively challenge these norms.

Conclusions

GBV prevention requires the transformation of socio-cultural norms in gender relations—a lengthy process of deepening inquiry and discussion over time. Despite the numerous barriers to program implementation, NGOs carried out an impressive array of awareness activities aimed at socio-cultural norms change. With respect to primary GBV prevention, NGOs used a variety of awareness-raising strategies and approaches to target refugee communities and specific population subsets. Overall, they were effectively able to engage with refugee communities. However, best practice models and program indicators that can demonstrate the success of awareness programming and its impact on social norms change are lacking—and this adversely affects the evaluation of GBV prevention programs. Little is known about the actual changes in knowledge, attitudes, and behaviors that have occurred due to the GBV prevention efforts of NGO implementers. Activities designed to empower women and change socio-cultural norms were observed in all three field evaluations; however, no evidence of their effectiveness was collected—a likely result of the challenges, cost, and complexity of measuring outcome-level indicators. Furthermore, in the case of empowerment and social norms change, the multi-year time periods often required for population-level changes to occur make evaluation and attribution a challenge in many refugee contexts where programs are funded on an annual basis. Longer program cycles, better tracking of program achievements over time, and requiring implementers to conduct pre/post knowledge, attitudes, and practices (KAP) surveys and measure other outcome-level indicators could improve documentation of the effectiveness of different interventions on social norms change.

Rebuilding Family and Community Structures and Support Systems

When populations flee conflict-affected areas, the family and community support systems that guide moral and social standards and behavior are often weakened or destroyed. Displacement and subsequent life in unfamiliar and challenging environments engenders new risks for refugees that can be combatted and addressed through community structures and support systems. There is a critical need to strengthen family and community structures and support systems that have been weakened due to conflict. This includes re-establishing or creating structures and systems that uphold respect for the equal rights of all members of the refugee community as quickly as possible, including identifying assets and resources in the community—such as expertise, previous experience, innovation, and courageous or effective leadership—that could contribute to providing protection and preventing violence.

Findings

In the **desk review**, PRM-funded approaches and program activities used to strengthen family and community support structures varied by context and region. In Southeast Asia, community health workers were trained in mental health needs and services to support refugee women in self-care and reducing victimization. In the African Great Lakes region, female refugee leaders participated in leadership, advocacy, and human rights training to support them in developing action plans to address protection issues in their communities. In both Africa and Southeast Asia, safe houses and shelters were available to provide safe and confidential locations for survivors to receive needed resources and support. Many of the programs included activities to strengthen family and community structures and support systems; however, evidence of their effectiveness was not collected by NGO implementers.

In **Malaysia**, ICMC, HEI, and WAO all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. These partnerships have helped to facilitate both GBV

prevention and response efforts. The strength of community structures and support systems was evident in NGO implementers' responses to the safety, protection, and medical needs of GBV survivors by providing them with, or referring them to, necessary and appropriate services. One ICMC staff member reported:

> *"We want to make sure someone is under the care of the Community Development Unit (CDU), which has trained professional counselors and is more equipped to suggest certain responses to survivors. In low-risk cases we can provide peer counseling, emergency funding, or shelter. In some instances we can also get special funds from ICMC for non-registered refugees to get a 50 percent discount from hospitals. We try to fill in the gaps between the referral to UNHCR, which can take some time for them to respond to—when there is an emergency and there are immediate needs."*

ICMC refers survivors to shelter services provided either by WAO or Pusat Kebijikan Good Shepard (PKGS). One ICMC staff person reported: "All people in the shelter get in-house counseling sessions, medical services, police reporting, interim protection orders… we have a nice female taxi driver who can transport the survivors and most of the time they are escorted by RWPC and then we do an initial intake session and then hand over to a social worker who manages her case." At the same time, several key informants commented that locating shelters for boys who have been abused or are at high risk is a challenge. An additional consideration for shelters is the need for halal spaces. Currently, the lack of halal shelters means that Muslim refugees cannot accept and inhabit them.

With respect to GBV prevention, a variety of efforts were underway in Malaysia to strengthen family and community structures. This included GBV awareness training and capacity development for refugees to address problems in their own communities. ICMC was working to build capacity among Burmese refugee communities via GBV prevention training for adults, training for youth ages 13-17, safety training for children ages 8-12, and teacher trainings; community leaders and schools help to arrange these training sessions. WAO also trains members of the RWPC, peer counselors, community leaders, and refugee community members on various aspects of GBV. Finally, HEI works to develop refugees' capacity to address mental health in their own communities using a community health worker (CHW) program, which trains members of refugee communities how to identify, refer, and assist individuals with mental health needs. However, most GBV programs were designed to respond to rather than prevent GBV. While certain activities do contribute to the prevention of GBV, this was not the core focus of programming in Malaysia.

In **Uganda**, community structures that were in place for GBV prevention and response included community social workers, trained activists responsible for community mobilization, gender task forces, youth groups, and men-to-men support groups. NGO implementers also worked closely with refugee leadership in the settlements and provided support to enable them to better address protection issues. The SASA! approach of engaging and building capacity of community members and developing a sense of responsibility to respond to GBV within communities was perceived as an effective means of building support structures for GBV prevention and response. The SASA! approach involves the community at all levels of GBV prevention implementation—especially training community activists and others to raise awareness and develop actions to help prevent and respond to GBV cases. Key informants credited SASA! with contributing to increased willingness of survivors to take their cases to the legal system because they had a better understanding of the legal process from SASA! trainings and were thus more willing to pursue legal cases.

Support structures available to GBV survivors that were facilitated by NGO implementers in Uganda included GBV hotlines, safe houses, and legal services. There were ongoing efforts to build community referral mechanisms that encourage GBV survivors to avail these services. The GBV Information Management System (GBVIMS) was perceived as a critical tool for information sharing between implementing organizations and for tracking trends in reported GBV cases and other service quality outcomes. While it is not a support structure that directly serves the community, NGO implementers observed that the GBVIMS was helpful in improving their capacity to coordinate support to survivors, provide a better understanding of trends of GBV cases in settlements, and distinguish new cases from older cases that occurred in the country of origin. In Uganda, strong community support structures were in place within the settlements for GBV response, and the SASA! intervention—along with training activities and support to refugee leadership—were perceived as effective means of building and supporting community structures and support systems.

In **Chad**, efforts were ongoing to strengthen community support systems and structures, but significant challenges remain. NGOs are working toward the full involvement of the refugee community and supported groups within the community to share information about incidents through formal and informal networks. HIAS was the only one of the three NGOs evaluated that explicitly focused on strengthening community support systems and referral networks. HIAS community mobilizers received quarterly training on how to work with GBV survivors and share information referral services. UNHCR, HIAS, and CARE all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. Collaboration with internal camp leadership committees was frequently cited by key informants, and NGOs recruit staff members and volunteers from the refugee community, who are recognized by refugees as extensions of the service providers and sought out for communication about problems and inquiries about types of assistance. HIAS also trains teachers in GBV, who in turn are supposed to integrate GBV prevention lessons in their teaching. However, the effectiveness of this approach and other ongoing community outreach is unclear. Students unanimously reported that they were not exposed to important topics such as early and forced marriage at school; they also reported not participating in sensitization campaigns which HIAS reports as being conducted on a regular basis.

In addition, many refugee community members have been trained in GBV awareness and outreach techniques as reflected in activities aimed at changing socio-cultural norms. GBV referral pathways exist for survivors to access services and to obtain support in Chad; however, in some cases they are limited. In some camps, an increased demand for legal services was reported, which may be linked to greater awareness of GBV and response services and improved referral pathways. NGOs have not been able to successfully mobilize the community to establish a community-based system for survivors to access safe shelter; HIAS operated a safe house at one point in time, but it reportedly created more problems than it alleviated and was thus discontinued. Due to confidentiality requirements of working with GBV cases, shared NGO offices for counselors and legal officers were a challenge and counseling spaces were inadequate with respect to quantity or size; safe houses were also reported to be inadequate, either in number or physical condition. Despite a variety of ongoing activities to strengthen community structures for GBV prevention in Chad, important shortcomings were observed in community support systems for GBV response.

Conclusions

NGO implementers in all countries mentioned in the desk review and in the three field evaluations worked closely with refugee community organizations and leadership groups, and these partnerships

helped to build community capacity and local support structures and also facilitated both GBV prevention and response. A variety of efforts were underway to strengthen family and community structures for GBV prevention including awareness training and refugee capacity development. Specific groups targeted for trainings varied slightly by setting but commonly included children, youth (13-17 years), men, teachers, community leaders, social workers/activists, and health workers; in addition, community support structures such as gender task forces, peer support groups, and youth groups, among others were either supported or established by implementing partners to facilitate GBV awareness and outreach within refugee communities. In most cases, referral systems for GBV survivors and GBV response were well established. Community support structures available to GBV survivors that were facilitated by the NGO implementers varied by setting and included GBV hotlines, safe houses, legal services, and livelihoods programs. Approaches and program activities used to strengthen family and community support structures varied by context and region, however, evidence of their effectiveness was not collected by NGO implementers.

Creating Conditions to Improve Accountability Systems

The creation of conditions to improve accountability systems is a salient issue on several levels. First, NGO implementer staff conducting humanitarian programs have an obligation to deliver services in a sensitive and effective manner in accordance with both agency-specific codes of conduct and international standards. Codes of conduct are important for protecting refugees and asylum-seekers from humanitarian aid workers who engage in abusive or exploitative behavior. Several guidelines provide specific recommendations on how to support refugee populations in creating conditions to improve accountability systems within their own communities. The 2006 *IASC Gender Handbook for Humanitarian Action*[16] recommends establishing mechanisms to ensure that community members can confidentially report harassment or violence, and the 2005 *IASC Guidelines for GBV Interventions in Humanitarian Settings*[17] suggests improving security by combining a targeted, proactive presence around specific "hotspots" with a less routine, widespread, and mobile presence. Both guidelines are widely used for GBV programming in humanitarian contexts. Second, there must be accountability for the perpetrators of GBV, which can be challenging in refugee communities where issues of legal status in the host country, barriers to prosecuting cases, and poorly functioning formal legal systems are common.

Findings

In the **desk review**, most program documents did not make explicit reference to international guidelines, but all PRM-funded programs reviewed did incorporate elements of the prevention strategies and best practices as well as the Core Standards and Protection Principles outlined in the Sphere Standards. Programs in all three regions reported on indicators that reflected organizational capacity to deliver safe and effective services, such as: the proportion of healthcare staff trained in sexual violence medical management and support, or the proportion of community-based workers trained in sexual violence psychosocial support. The creation of conditions to improve accountability systems was evident for programs in Chad and Malaysia. For instance, the evaluation team identified measures that fostered accountability of staff and stakeholders in Chad. For example, Standard

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[16] See http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-genderh
[17] See www.humanitarianinfo.org/**iasc**/downloadDoc.aspx?docID=4402

Operating Procedures (SOPs) developed by UNHCR and followed by NGO partners outlined responsibilities for reporting, monitoring, psychosocial support, case management, and coordination of GBV response service providers via weekly stakeholder meetings. Trainings on the UNHCR Humanitarian Code of Conduct and prevention of sexual abuse and exploitation were offered for humanitarian staff and camp security officers. No objectives or indicators related to accountability were noted in the review of PRM-funded programs in the African Great Lakes region. Program documentation suggested that improvements in accountability systems were successful and resulted in a reduced number of GBV incidents; however, no indicators or measures were provided.

In **Malaysia**, discussions of international standards and guidelines for GBV treatment and prevention with NGO implementers revealed little staff familiarity with codes of conduct and international guidelines. Only HEI mentioned a code of conduct. Despite not being able to cite various guidelines, the implementation of PRM-funded programming that responds to GBV cases appeared to conform to most guidelines. Activities in the area of GBV response such as confidentiality, medical care, and provision of psychosocial services appear to be in compliance with international standards. None of the NGO staff or refugees interviewed mentioned use of complaint mechanisms to ensure accountability to beneficiaries. Perpetrators of GBV in Malaysia were rarely held accountable for their actions, and NGO implementers noted the inability to successfully prosecute cases as a major barrier to their programs. NGO implementers were engaged with legal systems to a limited extent, and more work in this area of accountability is clearly required to ensure that laws criminalizing GBV are upheld. PRM-funded NGOs in Malaysia have mobilized the community to establish a system for DV survivors to access safe shelter if places of residence are unsafe, undertaken work to prevent abuse in places where children gather for education, and worked toward the full involvement of the refugee community to share information about incidents through formal and informal networks.

In **Uganda**, both ARC and MTI program objectives were informed by international guidelines, and programming strategies reflected the Core Standards and Protection Principles outlined by Sphere Standards and some elements of best practices in prevention. Indicators of organizational capacity to deliver safe and effective services, such as training of staff members on relevant topics, were reported by both organizations. However, staff desired additional training and support on a variety of topics and noted that high turnover rates meant that some new staff went untrained for an extended period because trainings were not routinely offered. Both ARC and MTI regularly engaged with community members including refugee community leaders and community activists implementing SASA!; both NGO implementers were perceived as accountable to beneficiaries, however, no specific indicators on accountability to beneficiaries were reported.

Creation of conditions to improve accountability systems for GBV perpetrators was evident in both ARC and MTI programs. Despite efforts to improve accountability systems, key informants identified the Ugandan legal system as a barrier: prosecution of cases is perceived as difficult, only a minority of cases was prosecuted, and an even smaller number of perpetrators were convicted. ARC's SASA! intervention was noted as effective in educating refugee communities about the legal process and increasing their willingness to pursue legal cases. ARC efforts to train and support police and MTI training of medical providers also contributed to improved accountability because of better case documentation and evidence. Some informants noted that additional training for clinical providers on medical evidence collection and preservation could be useful for attaining higher conviction rates of GBV perpetrators. The GBVIMS was observed by donors, NGO implementers, and partner organizations to provide valuable information on GBV indicators and to facilitate coordination of cases—including legal services, which to a certain extent support the creation of conditions to improve accountability of perpetrators. However,

challenges in interpretation of existing indicators were noted by both donors and NGO implementers—for example, GBVIMS indicators can be misleading because the reported cases may increase over time with prevention efforts despite an overall decrease in the total number of cases. For example, an increase in reported cases may be interpreted as a reflection of an unsuccessful project rather than successful prevention that led to increased awareness and reporting. The creation of conditions to improve accountability systems was evident at numerous levels in Uganda, including NGO engagement with communities to build community capacity for GBV prevention and response, within medical and legal services to GBV survivors, and more broadly via efforts to support the police and legal system

In **Chad,** NGO implementers have developed many of their programs and designed several of their activities to conform to a selection of the aforementioned best practices in GBV prevention as outlined in IASC and UNHCR guidelines. All the partners expressed that they are well aware of the SOPs provided by UNHCR for coordination of GBV response. Weekly GBV coordination meetings were perceived as an important forum for sharing, learning, and supporting effective work and an opportunity to receive input and guidance from the other partners about how best to address challenging incidents of GBV. Both NGOs and Chadian governmental partners are striving to institute practices in line with international GBV guidelines within the domain of refugee protection. Good practices followed to ensure the protection of young girls and single women during the new refugee registration process are one such example of this:

> "*If there is a new girl who is 17 years old or younger, she is considered at risk and it's important that we follow this girl. We identify young girls, particularly those who come to the camp without any members of their family – we are obliged to follow them. We need to see who the girl will live with. We cannot accept that these girls live alone or live with a group where there are many boys and men; we prefer to settle her with a family that has children, for her not to feel alone. And then we tell UNHCR about these girls so they can follow them. Also women who come without their husbands and who live alone are considered at risk. For these cases, we try to see if we can put these women together and separate them from the men*."

GBV prevention activities in Chad were generally aligned with internationally accepted guidelines, whereas weaknesses were noted in GBV response programming. Provision of medical care and the delivery of psychosocial services were less of a priority and were not fully in compliance with international standards. Quality of medical facilities ranged from poor to critical condition, which in conjunction with lack of medical staff and supplies, resulted in poor service quality and availability; refugees did not always receive treatment in line with international standards. Use of complaint mechanisms to ensure accountability were not in place, although some NGO staff said they would welcome their use. With respect to accountability for the perpetrators of GBV, NGOs face significant challenges in creating conditions to improve accountability systems. The situation is well summarized by UNHCR, which reports "SGBV is overwhelmingly resolved by traditional leaders without consideration for national laws that punish DV, rape, and other forms of SGBV, and thus impunity prevails in most cases and perpetrators usually only pay a fine."[18] The majority of cases is handled through traditional systems, managed by families, or dealt with in refugee community structures. In these instances, most perpetrators may only pay a fine, and long-term resolution for survivors may be inadequate. Few cases

[18] SGBV Strategy 2012-2016: UNHCR Chad

make it to court and those that are prosecuted often experience multiple postponements, delays, and low rates of conviction. Many victims are unsatisfied with the legal response. Difficulties working with traditional and formal legal systems remain a key challenge in holding GBV perpetrators accountable in Chad.

Conclusions

With respect to NGO implementer accountability, primary GBV prevention programming was for the most part designed and implemented in accordance with international standards and best practices. Implementation of GBV response programming was less likely to be in accordance with international standards, and in some cases, basic infrastructure such as medical services or safe houses was inadequate. Complaint mechanisms to ensure NGO accountability to beneficiaries were not employed by implementers.

Perhaps the most universal challenge in the creation of conditions to improve accountability systems was difficulties associated with holding GBV perpetrators accountable for their offenses. Socio-cultural norms that favor resolution of cases in traditional legal structures, dysfunctional formal legal systems, and the resource-related and logistical challenges associated with prosecuting perpetrators of GBV were all formidable barriers to accountability. It was universally observed that only a minority of survivors pursue legal cases and that, among these, a small proportion results in convictions. Despite these challenges, NGO implementers were working with both traditional and formal legal systems to improve accountability for the perpetrators of GBV; however, significant shortcomings persist.

Designing Effective Services and Facilities

Designing effective services and facilities is a necessary means to achieving the goal of preventing GBV. International guidelines underscore the importance of prioritizing the refugee community's active role throughout all stages of programing development—from identifying causes of GBV, advising how best to disseminate information about the problem, and knowing which preventive measures will be most successful—while recognizing that there may be competing priorities in low-resource settings where people may not see the relevance of gender equality given the daily struggle to meet basic needs. Literature reviewed by the evaluation team noted the critical nature of identifying safe spaces where women and girls can meet, working to raise women's self-esteem through solidarity groups, and enhancing child protection through improved access to childcare. Gaps exist in reproductive health service provision to displaced populations, including gaps in adherence to international guidelines and standards for prevention and response to GBV. The design of effective multi-sectoral services and facilities for displaced populations requires the identification and minimization of barriers to sexual violence survivors' utilization of clinical response services. Finally, there is a need to address gaps in funding and encourage donors to consider longer funding cycles, as sustainable change requires long-term, committed engagement.

Findings

The majority of PRM-funded programs included in the **desk review** did not include specific information about NGO partner efforts to design effective services and facilities as a means of primary prevention of GBV. In **Chad**, none of the documents reviewed provided information on this topic area however, documents identified multiple barriers in the design of effective services and facilities:

- Security situation and theft of vehicles, communication equipment, and money (HIAS Chad)

- Logistical challenges including lack of vehicles for transportation between camps (ADES Chad, HIAS Chad)
- Limited funding for staff salaries (ADES Chad)
- Limited participation in program activities because of refugees' need to leave camps for farming and commerce
- Limited participation in program activities around seasons and holidays (e.g. harvest, Ramadan)

The same was true for the programs in **Malaysia** implemented by ICMC, WAO, and HEI, where program documents reviewed by the evaluation team provided limited information on safety and security risks to refugee populations—or about how the community was engaged by NGOs in designing programs to identify and reduce these risks. However, documents reviewed identify multiple barriers in the design of effective services and facilities:

- Loss of staff due to resettlement (noted by ICMC Malaysia) and resources to identify and train new staff
- Difficulties in accessing services due to cost of transport and cost of services (ICMC Malaysia)
- Competition between community-based organizations and diverse ethnic groups in refugee settings.
- Challenges in training community workers due to their work schedules and inability to participate in extended trainings (ICMC Malaysia)
- Work commitments create time constraints that make it difficult for refugees to attend program activities (ICMC Malaysia)

In **Uganda**, ARC conducted consultative meetings to gather input from stakeholders in each settlement and inform the development of SOPs and community referral pathways in each settlement. In addition, ARC trained service providers on the development and coordination of referral systems, trained community-based organizations on psychosocial support and case management for GBV survivors, trained police and justice sector actors on working with survivors, and established a hotline that survivors can call to request support services. Documents reviewed by the evaluation team suggest that these efforts were effective: all targeted villages now have community-based organizations trained in caring for survivors, all hotline requests were responded to, and the number of survivors seeking services from ARC increased during the 2011-2012 project period.

PRM-funded GBV prevention programs evaluated in all three countries included a strong integration of both refugee community members and survivors into program delivery. The core staff of most of the NGO partners was composed of refugees. Refugee staff were predominantly in charge of implementing core GBV prevention program activities in the form of home visits, advocacy, and training as well as delivering GBV response services through counseling, medical assistance, and legal support.

In **Uganda**, both beneficiaries and representatives from PRM, UNHCR, OPM, ARC, and MTI unanimously agreed that the SASA! program is successfully engaging refugees at all levels of GBV program implementation—especially preparing community activists and others to raise awareness and develop actions to help prevent and respond to GBV cases. At the same time, however, both ARC and IMC noted the absence of refugee community participation in GBV program planning (including establishing realistic objectives and activities) as a potential limitation for successful implementation of the programs. Refugees were most often engaged after funding was received and when programs had already been designed; with respect to primary prevention programs where ARC was the sole implementer, NGO staff indicated that lack of refugee engagement was likely a result oversight (not

specific barriers) and appeared willing to engage beneficiaries earlier in the planning process. Another challenge that NGO partners faced in Uganda was their inability to provide refugee leaders, activists, and volunteers with adequate incentives to support their work in GBV prevention. The NGOs observed that some volunteers are committed and participate without any incentives, but these are a small number of individuals. The fact that activists are selected by their communities often encourages them to continue working without incentives; however, provision of basic materials to enhance their work is an important challenge that remains to be adequately addressed. A small monthly allowance or additional incentives that volunteers and activists could share with their families (such as soap, cooking oil, non-food items) would help them demonstrate that they are productive and bring resources to the family and that time spent working as an activist is not lost time for the family.

In **Malaysia**, ICMC, HEI, and WAO all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. ICMC's close cooperation with WAO, HEI, and the Women's Centre for Change Penang has enabled ICMC to strengthen its capacity to work with women and youth on gender affairs in Malaysia and to become familiar with counseling and the sensitivities that are involved. In an exceptionally creative spirit, ICMC has used spaces and times that might not ordinarily be considered to provide information to refugees. For example, ICMC worked with IOM to conduct awareness-raising sessions in a hospital waiting area where IOM conducts its pre-departure medical examinations for refugees. Largely due to the work of ICMC, refugees know a great deal about where to get help and will often call ICMC before UNHCR as they may get a faster response and referral. ICMC has, in that sense, become a clearinghouse of information and referral.

In **Chad**, UNHCR, HIAS, and CARE depend on the involvement of, and support they receive from, refugee community organizations. Collaboration with internal camp leadership committees was frequently cited by NGO staff as an effective and efficient method for distributing information and services to the community. In addition, NGOs recruit staff members and volunteers from the refugee community, who are recognized by refugees as extensions of the service providers and sought out for communication about problems and inquiries about types of assistance. In addition to their noteworthy engagement with the refugee community, NGO partners in Chad cited examples of activities that they are undertaking and projects that they are pursuing in order to establish strong relationships with the local communities living around the refugee camps. As most refugees rely on natural resources as well as many services, such as medical care and education, that are located in the communities, NGO partners stressed the importance of building and maintaining positive relationships with the host community. In Maro, where UNHCR was forced to relocate the refugee camp due to widespread damage sustained from flooding, extensive negotiations were held with the local authorities to identify land where the new camp could be built. To appease the tension between the local community and the refugees, UNHCR and CNARR agreed to build schools in the village to compensate the local community for the loss of their lands.

The evaluation team found that particularly strong attention is devoted toward referral networks and support systems for GBV survivors in Malaysia, followed by Uganda and then Chad. This finding is likely due in large part to the stronger focus of **Malaysia** NGO partners' programs on treatment rather than prevention. ICMC and HEI programs were especially strong in terms of their attention to and support for GBV survivors. The majority of refugees interviewed by the evaluation team said they had either received services from ICMC or had reached out to ICMC for assistance. Citing the responsiveness and resourcefulness of ICMC staff, many refugees expressed a preference for working with ICMC over UNHCR—even in instances when UNHCR provides the service they require. The evaluation team was

also impressed with the information, education, and communication materials (IEC) that ICMC and HEI distribute widely to refugee community members.

As highlighted in the section of the report below on Engaging Men and Boys in GBV Prevention and Response, NGO partners in **Uganda** have established sound referral pathways for both female and male survivors of GBV. An added feature that contributes to the strength of the PRM-funded programs in Uganda is the extensive array of IEC materials and messaging in settlements: billboards for referral pathways; messages, stickers, and flyers for community hotlines; and GBV prevention messages on signs placed on school and health facilities grounds.

The field evaluation in **Chad** revealed that psychosocial counseling protocols may not be adequately survivor-centered and would benefit from further refinement. This may be due in part to the redundancy of roles and responsibilities among the various NGO partners and refugee committees regarding the prevention and treatment of GBV within the camps. The majority of key informants cited conducting community sensitizations and carrying out household visits to speak with and provide advice to GBV victims and victims' families. Among others, CNARR, the GBV Committee, community mobilizers, DPHR, the Youth Committee, and refugee leaders reported engaging in these activities. In addition to the duplication of roles and responsibilities, the evaluation team also found that the majority of cases were labeled as DV and that these cases were predominantly resolved at the family and community level rather than within the referral pathway. HIAS was the only one of the three NGOs evaluated that explicitly focused on strengthening community support systems and referral networks. Community mobilizers received quarterly training on how to work with GBV survivors and share information about the status of available referral services. The evaluation team was unable to obtain anything other than anecdotal information on the nature or outcome of activities beyond the number of events conducted and the number of people reached. Despite the lack of explicit focus on referral pathways and the duplication of roles and responsibilities, the evaluation team found that NGO partners do place a high level of importance on the practice of maintaining survivor confidentiality, which is one of the bedrocks of international GBV guidelines. Survivor confidentiality was widely discussed as a priority in the provision of GBV services and support among respondents. Several refugee committee members and volunteers expressed particular regard for upholding this essential principle.

The evaluation team found a significant discrepancy among the three countries in terms of the identification of safe spaces where women and girls can meet and work. PRM-funded programs in **Malaysia** were most impressive regarding the establishment of shelters and safe facilities for GBV survivors and their children. All of ICMC's survivors are referred immediately to shelter services with either WAO or PKGS. Although **Uganda** does have safe houses for GBV survivors, the evaluation team noted several issues with respect to facilities and material support. The situation for survivors in **Chad** was most concerning due to the complete lack of safe spaces and shelters. For more information about shelters and safe spaces for survivors, please refer to the above section of this report that covers Rebuilding Family and Community Structures and Support Systems.

The design of effective services depends on both the skills of the NGO partner staff as well as the training and support they receive to successfully implement their programs. In **Malaysia**, the evaluation team found several sensitivities surrounding GBV prevention work that contributed to less than effective service delivery. Working with refugees and asylum-seekers is a particularly sensitive and complicated issue in Malaysia given the fact that these populations are not afforded legal status by the Malaysian government. Additional details about these challenges are provided in the Contextual Challenges to GBV Prevention section above.. The evaluation team also found a great deal of inhibition and lack of comfort

among NGO partner staff regarding certain types of GBV. When asked about the issue of sexual violence in detention, refugee workers responded, "We don't know for sure, but we have never heard of it." When asked if they thought it could be happening and people might not be reporting it, at least two key informants said, "it would be impolite for us to ask." This is concerning because, unless the question is asked (and asked in a safe environment), many survivors will not often talk about incidents of GBV. Both ICMC and HEI refugee staff members make home visits, which provide an important opportunity to raise such issues when conditions are deemed appropriate. But refugee workers' own discomfort with the topic makes it highly unlikely that anyone would disclose to them.

The situation was similar in **Chad**, where the preponderance of prevention activities and messages disseminated through awareness campaigns focused on various types of violence against women and girls. Little to no discussion of violence against men and boys was included, and NGO partners' lack of training on LGBTI issues was identified as a barrier to service delivery. Due to the lack of comfort among many UNHCR and NGO partner staff with issues such as homosexuality, these important issues may not be receiving adequate attention in the NGO implementers' GBV prevention work. While some conversations with NGO staff exhibited an acknowledgement that GBV could be happening to men and boys, others were less confident that this type of phenomenon exists.

In **Uganda**, the evaluation team found inadequate funding for NGO staff at all levels—both in terms of insufficient numbers of staff for the current programming demands and inadequate support for staff working under challenging conditions. There was a general perception that community services are underfunded and that additional staff are needed to support and advocate for GBV survivors. For example, in Kyangwali, there is a single ARC staff member on call 24 hours/day for seven days/week to answer the GBV hotline. Limitations in the number of service providers were nearly ubiquitous and included clinicians, counselors, legal officers, and drivers to facilitate transfers of GBV cases. The importance of and need for female providers, particularly with respect to counselors and policewomen who may be perceived as more accessible by women and children survivors, was also noted by governmental and NGO staff. The stressful nature and the remote conditions of the work were also noted as a challenge and reason for high levels of staff turnover. Specific unmet needs included additional staff training and mentoring on GBV-related issues that are difficult to address including LGBTI issues, child protection and survival, and commercial sex workers.

Challenges to effective service delivery due to donor funding cycles were noted by NGO implementers with concern expressed over the need to address gaps in funding and to consider longer funding cycles. In **Uganda**, the primary barrier identified in GBV prevention programming at the donor level was the length of funding cycles. Key informants noted that sustainability of programs is challenging given PRM's historically typical one-year funding structure and the difficulties associated with meeting stated objectives in that short funding period. PRM recently created an alternative to one-year funding cycles in 2011, and the ARC program in Uganda is benefiting from a longer-term three-year funding period for its GBV primary prevention program that encompasses a longer-term community-driven social norms change strategy.

In **Chad**, PRM and UNHCR's alternating annual funding cycles were cited by CARE and HIAS as presenting substantial barriers to effectively implementing program activities. Key informants explained that the timing does not allow them to design activities to effectively complement what they are doing with funding from the other donor. They cited needing to lay off staff and then hire them back again as well as having to stop some activities in the middle of implementation to wait for funding to come through. One HIAS staff member stated, "If we could have a proposal for two or three years, it would allow us to

concentrate more on long-term goals, but each year we have to start over again." Key informants stressed that one-year funding structures do not allow adequate time to carry out needs assessments, collect baseline data, and put into place sufficient M&E mechanisms as a means to prevent possible negative consequences through solid pre-planning and program design.

Conclusions

It is widely recognized that the key to developing effective services and facilities is strategically engaging refugee populations in the planning and implementation of interventions across all sectors. Collaborating directly with members of the refugee community not only helps to ensure that gender and protection concerns are considered, but also that interventions do not unintentionally exacerbate the safety and security risks to women and girls. To this extent, the delineation of clear, comprehensive, and functioning referral pathways, where survivors are fully supported to avail themselves of all the essential services, is critical to both the prevention of, and response to, GBV. In addition, the establishment of shelters and safe space facilities for GBV survivors should be a top priority for all GBV prevention programs. Programs must ensure the inclusion of participants at all levels of design, implementation, and evaluation. To ensure that these fundamental aspects of effective services and facilities are in place and functioning properly, NGO partner staff must be equipped with the necessary knowledge and skills and provided with the appropriate mentorship, management, and financial supports. NGO partners that actively place importance on needs assessments, and who disaggregate data by sex and age and identify individuals and groups at special risk in order to tailor programs to meet the specific needs of the target population, will realize the intended outcomes of their activities.

Working with Formal and Traditional Legal Systems

The extent of GBV within a refugee community is sometimes influenced by the existence of laws that proscribe such violence and/or the extent to which laws are enforced in the host country and/or country of origin. GBV can be perpetrated with impunity where there is limited legal protection for women's rights, no laws against GBV, judicial practices that reinforce gender-based discrimination, or where poor administration of justice has resulted in a lack of trust in law enforcement agencies. Work with both formal and traditional legal systems is necessary to end impunity for perpetrators of GBV, improve responses for survivors, and send strong messages that GBV will not be tolerated. Legal systems in refugee environments are often weak or non-existent, and a lack of clarity regarding legal definitions and relevant international and domestic law is not uncommon. Traditional legal systems may or may not be focused on assisting survivors and must be understood and analyzed to determine why some behaviors may not be considered a problem. Balancing support for survivors to seek legal remedies and working to advance both traditional and formal legal systems is a challenge in many refugee contexts.

Findings

In the **desk review**, only PRM-funded programs in the Africa regions reported work with formal and traditional legal systems. Training was provided to traditional clan chiefs and police on mediation skills, human rights, and legal instruments related to GBV. Documents reviewed did not provide information on the effectiveness of these training programs. Continuous monitoring and evaluation of these efforts is essential given that traditional legal systems and police may or may not support women's rights.

In **Malaysia**, the formal legal system presented a challenge to NGO implementers and refugees in several ways. Due to resource constraints, UNHCR is unable to register refugees and asylum-seekers within a reasonable period (during evaluation fieldwork in summer 2013, initial appointments to register

with UNHCR were being offered for fall 2015—and initial appointments do not usually result in obtaining a UNHCR card). The recent arrival of many new refugees, especially Rohingyas from Burma, increases concerns about the human rights and security abuses they may face. There is a nearly complete lack of legal aid available for refugees who want to challenge decisions about their resettlement. ICMC, WAO, and HEI all work with UNHCR to expedite registration for GBV survivors who are unregistered at the time of disclosure. The informal system of alerts between NGOs, UNHCR, and U.S. Embassy officials appears to work relatively well, but there are still some cases that involve serious protection concerns and do not receive a rapid response due to an overburdened UNHCR system.

Lack of access to at-risk populations in detention centers and near total impunity for perpetrators of GBV were two barriers posed by the Malaysian legal system that suggest that additional efforts to work with formal legal systems may be required if NGO implementers are going to realize broader success in client services and GBV prevention and response. In detention centers, the operating environment is quite limiting; NGOs are prohibited from advocating for refugee rights and are obliged to be discrete about their activities. For this reason, ICMC and WAO elected not to seek access to detention centers. HEI has attempted lawyers' visits to detention centers, but its access remains limited. Perhaps more troubling is the near total impunity for perpetrators of GBV. The evaluation team obtained only one example of a case in which a perpetrator of DV was jailed, and the police failed to take action until the NGO became heavily involved in the case; the NGO made seven reports before the police arrested the perpetrator, and then only after he nearly killed the couple's child. In Malaysia, improved working relationships between NGO implementers and both police and court systems is essential if GBV perpetrators are to be held accountable.

In **Uganda**, ARC worked with the Uganda National Police and the court systems on issues related to GBV. At the settlement level, support to National Police included training and in some cases material inputs such as motorcycles or fuel to facilitate travel to follow-up on GBV cases. Barriers to working with the police included high turnover rates of officers assigned to the settlements as well as small numbers of policewomen, as it was reported that GBV survivors would be more comfortable reporting their cases to female officers. The formal legal system (or lack thereof) was noted as an impediment to proper care and support of GBV survivors. It also presented a challenge to GBV prevention efforts because of the community perception that perpetrators are likely to go unpunished. Of cases reported to the police, few make it to court and those that are prosecuted often experience multiple postponements, delays, and a low rate of conviction. ARC supports the legal system and prosecution of cases with efforts such as training, transportation, and translation for court cases. Awareness-raising and support to legal services have contributed to increasing demand for legal services in the Uganda settlements, in particular Kyangwali. As one implementer observed, "we can see that people have GBV awareness and they know where to go, which case to report, and to whom." However, difficulties working through the existing legal system remain a key challenge. Mobile courts were recently introduced in Nakivale and were perceived to be successful from the community perspective. However, the high cost associated with mobile courts and the difficulty in finding judges willing to travel to the settlements were noted as barriers to continuing and expanding their use. Overall, ARC's efforts to support the legal system were perceived as effective, though not without challenges given the weakness of the system, as indicated by the increased demand for services.

In **Chad**, the lack of a viable legal system to address incidents of GBV among refugee communities was noted as a major barrier to GBV prevention and response. The constitution recognizes traditional and customary rules as having the status of laws; the influence of this legal dualism is pervasive, and GBV cases are overwhelmingly resolved via traditional legal structures. Both the refugee community and

service providers indicated that socio-cultural norms of refugee communities in eastern and southern Chad strongly favor the resolution of GBV cases within the confines of the family or extended family, rather than involving outside legal or other types of interventions. Social awareness campaigns have raised refugee awareness regarding legal options to resolve GBV incidents, and in some camps, there has been increased demand for legal services—which may be linked to increased awareness. However, refugee community leaders in the camps prefer to resolve cases themselves rather than go through the local court and legal system, which continues to be a major hurdle in reporting of GBV cases and providing adequate long-term resolution for survivors. Despite the presence of NGOs in each of the camps and NGO staff with experience in the rule of law, refugees expressed a preference for solving problems among themselves. UNHCR and NGOs confirmed this reality, in which even criminal issues that would normally be taken to court are managed at the camp level by community leaders. One informant aptly summarized the issue as follows:

> *"Traditional practices like circumcision are very difficult to address; people are not reporting this for the court to judge the case. The laws are not very useful for reinforcing our work. It's important to change the mentality of the population. We know in Chad there are a lot of social difficulties, the people in the village are not very educated, so it's very difficult to change their mentality. At the same time, it's important to work within the law and building the law. There are already laws on early marriage and forced marriage, FGM, DV, child abuse – these can be used, but the big challenge is the weight of the traditional behavior on society. The laws can be applied but the great need is to change the behavior."*

Despite these challenges, APLFT and other NGOs are working to support the legal systems and GBV survivors who wish to bring their cases to court. APLFT supports the legal system and prosecution of cases with efforts such as training, transportation, and translation for court cases. APLFT and other NGOs offer transportation assistance to survivors, but refugees are often unwilling to travel to the court because of long distances. Many survivors are not satisfied with the legal response process. Courts are far from camps—in some cases, more than 100 kilometers—which means that after judgment, most survivors do not pursue civil reparations to which they are entitled. Difficulties working through the existing legal system remain a key challenge in GBV prevention and response in Chad.

Conclusions

The formal and traditional legal systems present challenges to GBV prevention and response programming in each of the three field evaluation settings. Legal systems in refugee environments are often weak or non-existent; Malaysia, Uganda, and Chad were not exceptions. Prosecution of GBV cases in formal legal systems is often time- and resource-intensive and, in many cases, unsuccessful. This is a source of discouragement for NGOs, refugee communities, and perhaps most importantly GBV survivors. Despite the barriers posed by both the formal and traditional legal systems, PRM-funded NGOs in both Uganda and Chad worked with these systems in an effort to improve responses for survivors and hold perpetrators accountable. In both Uganda and Chad, it was noted that GBV survivors were more willing to take their cases through the legal system after exposure to awareness-raising activities. This is likely the result of increased knowledge in the community about what to do in the event of GBV and how to access and use referral systems. However, despite these efforts, few cases were prosecuted and an even smaller number of convictions resulted. Many GBV perpetrators were not held accountable, and community awareness of this reality influenced survivor decisions to forego legal cases and also posed a challenge for GBV prevention programming. In instances where cases were handled through camp leadership structures or traditional legal systems, punishments for perpetrators were minimal and long-term solutions for survivors often inadequate. In general, legal support to

survivors seeking remedy through the formal legal system was available from NGOs and relatively comprehensive. Efforts focused directly on the legal systems themselves were more limited and emphasized training of police and traditional leaders, as many GBV cases are resolved outside the traditional court system.

Assessment, Monitoring, and Documentation of GBV

To develop and conduct effective GBV prevention programs and activities, it is essential to have a clear understanding of the problem in a particular setting and to use monitoring data to inform decisions about program implementation. International guidelines recommend conducting regular participatory assessments to gather information and understand GBV-related issues in the context of community capacities, cultural practices, and available services. Literature reviewed by the evaluation team emphasizes the importance of following guiding principles of safety, confidentiality, respect, and non-discrimination in all data collection, as well as the value of common reporting tools, standardized indicators, and information-sharing mechanisms for GBV prevention and response programming. NGO implementers conducting GBV prevention programs should prepare strong analysis of risk and protective factors, define clear and measurable objectives, identify indicators to assess impact, collect baseline measurements, use consumer research with intended audiences to identify the most relevant materials and methods, and consult ongoing research to monitor and improve interventions.

Findings

Program documents examined in the **desk review** revealed a mixed performance among NGO partners regarding their application of program monitoring and assessments. In **Chad**, CARE and ADES program documents reviewed did not provide sufficient information to determine whether assessments were conducted to inform program design and implementation. HIAS conducted regular surveys to assess knowledge, attitudes, and practices related to GBV in each camp and used findings to inform and adjust programming. In **Uganda**, ARC conducted a number of assessments including a baseline survey on knowledge, attitudes, skills, and behaviors; an assessment of capacity among health service providers on clinical management of rape services; and a technical and organizational capacity assessment of community volunteers and community structures during the first year of program implementation. ARC then conducted follow-up assessments in subsequent years to monitor the shifts in knowledge and attitudes among the community groups and in the general community, as well as assessments on health workers' capacity and the traditional justice systems. In **Malaysia**, HEI conducted two studies about the healthcare needs of refugee communities in Kuala Lumpur. While it is clear that HEI beneficiaries have experienced GBV, program documents do not provide details on the numbers served through HEI activities. Program documents demonstrate that HEI has significant experience and expertise with addressing health problems faced by GBV survivors; however, its reporting does not focus on GBV prevention efforts. ICMC conducted an extensive GBV mapping exercise that involved interviewing service providers, NGOs, 14 refugee organizations, and UNHCR. The initiative expanded upon previous programming and a gap analysis conducted with UNHCR in 2009.

A review of findings from each of the three field evaluations indicates that program monitoring and evaluation (M&E) is overall quite poor. In Malaysia, Chad, and Uganda, the limited M&E that NGO partners engage in focuses on the output level, which is capable of showing progress at the activity level. The majority of indicators are measuring the number of people trained and the types of services provided. The limitation is that NGO implementers cannot demonstrate program outcomes using their current M&E systems. Connected to the practice of output monitoring is the feeling that GBV response interventions are easier to measure than prevention interventions—as it is difficult to prove that

something didn't happen, and also to explain how or why it didn't happen. It was also noted in each country that because multiple organizations may be implementing different interventions in the same settlements, or within the same communities, attribution of change to a specific program is a challenge. The evaluation team also found that NGO implementers across the board were confused about the difference between indicators and targets, which should be two separate measures but were frequently jumbled together. In addition to conflating indicators with targets, many NGO implementers confuse indicators with activities. Both the desk review and the field evaluations revealed an absence of standardized indicators across NGO implementers—despite sharing common GBV prevention goals, each implementer developed its own indicators. The lack of standardized indicators in the field presents a major obstacle for measuring the overall impact of PRM-funded GBV prevention programs—both within and across countries.

The challenges of developing and using indicators to measure program outcomes were widely recognized across the three field evaluations. In **Chad**, one UNHCR staff member noted "our indicators are difficult because they are predominantly outputs and quantitative. What are these really telling us about the work we're doing and the capacity we're building? It's very crude information… we don't have much information about attitudes or the quality of our work." In **Uganda,** the SASA! program, implemented by ARC in Uganda, assesses change in four key outcome areas (knowledge, attitudes, skills and behaviors) and has a community baseline against which change over time is measured.[19] Pre-defined indicators are advantageous because the NGO implementer does not need to define its own indicators, indicators have been proven to be accurate gauges of intervention progress, and the use of standardized indicators enables cross-site comparisons of effectiveness. Nonetheless, the indicators ARC and MTI use for GBV prevention and response are primarily measures of outputs, such as the number of health providers, police, and community activists trained; numbers of survivors who access medical services; and number of calls to the hotline. Outcome measures such as acceptability of physical and/or sexual violence against women/girls are less frequently used. In **Malaysia**, interviews with NGO partners underscored their confusion between indicators and targets: "So far, even without staff positions being filled, we are still going to fulfill all the indicators" and "We follow the indicators—for example, we need to achieve 30 schools that receive the children's safety program. If it's eight youth centers to receive the curriculum, then we plan accordingly." In **Uganda,** the evaluation team noted that, in some cases, output indicators described activities and that indicators are stated as targets rather than neutral gauges of progress. Indicators were also difficult to understand in some cases because percentages or counts represented progress toward a target that was not directly stated or lacked clarity with respect to the actual measure.[20]

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[19] The SASA! Rapid Assessment Survey has questions on each of the four outcome categories of SASA!*:* knowledge, attitudes, skills, behaviors. The 20-question survey is designed to be used as a baseline and sections of the survey are repeated during the different phases of implementation with the aim of measuring change over time. The SASA! toolkit, which includes a description of this and other monitoring and assessment activities, can be accessed at http://raisingvoices.org/sasa/download-sasa/

[20] For example, the ARC indicator "With survivor consent, direct or referral services made available to GBV survivors who report the incident" would be easier to interpret if expressed as "percent of reporting and consenting GBV survivors provided with direct or referral services." Another example of the confusion between indicators and targets was seen in the case of MTI indicators; instead of the current indicator, "100 percent of SGBV survivors who report to a clinic are examined and treated" a better indicator would be "percent of SGBV

The evaluation team uncovered some differences among NGO implementers in terms of prioritization of and level of skill with assessments, monitoring, and evaluation. In **Uganda**, both ARC and MTI program objectives were informed by numerous assessments. From 2010-2011, ARC conducted a number of assessments of knowledge, attitudes, skills, and behaviors (KASB); capacity among health service providers on clinical management of rape services (CMRS); and technical and organizational capacity (T/OCA) of community volunteers and community structures. ARC then conducted follow-up assessments to monitor the shifts in knowledge and attitudes among the community groups and in the community, as well as assessments on health workers' capacity and the traditional justice systems. MTI health programming was informed by the Age Agenda Diversity Mainstreaming assessments in 2009, 2010, and 2011 and a GBV survey conducted by UNHCR and partners in 2010.

On the contrary, the evaluation team found that in **Chad** the design of program objectives and activities was generally not informed by comprehensive needs assessments or surveys. The NGOs neither carried out baseline surveys nor determined the incidence or prevalence of GBV within their respective refugee communities, the types of GBV experienced by refugees, the places and persons at highest risk of GBV (risk mapping), or the likely perpetrators. Information on the types of GBV refugees face is limited, which may lead to incorrect assumptions. NGO implementers' programming appears to emphasize DV over other types of GBV; however, the decision to focus resources on this area does not appear to be evidence-based. There is a lack of information about the level of GBV perpetrated by the police and other authorities, GBV committed against men and boys, the number of refugees forced by circumstances into survival sex, and the extent of needs and/or challenges faced by LGBTI refugees.

The situation in **Malaysia** regarding the use of assessments to inform program design was somewhere between the situations in Chad and Uganda. The design of program objectives and activities was generally informed by one-off surveys and assessments; however, many of those assessments relied upon secondary data and were not developed or carried out by the NGO implementers themselves. As in Chad, PRM's Malaysian NGO partners had not conducted baseline surveys or needs assessments among their target beneficiaries, nor had they determined the incidence or prevalence of GBV within the refugee community, the types of GBV experienced by refugees, the places and persons at highest risk of GBV (risk mapping), or the likely perpetrators. There is a lack of information about the level of GBV perpetrated by the police and other authorities, GBV committed by employers, the nature and extent of GBV among refugees and asylum-seekers in the forced labor market, the number of refugees and asylum-seekers forced by circumstances into survival sex, and the extent of needs and/or challenges faced by LGBTI refugees or asylum-seekers. Although there have been allegations of rape, sexual assault, and humiliation of refugees and asylum-seekers in detention, none of the NGOs interviewed documented the number of allegations. There are no recent reports regarding the severity of the problem. One key informant who has direct contact with detainees reported that while she is sure that such abuse occurs, it is very difficult to "get at" the problem; most people are very reluctant to report abuses in detention.

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survivors who report to a clinic are examined and treated" which could then be reported on routinely and progress compared against the target of 100 percent.

Conclusions

UNHCR and NGO implementers are struggling to measure the outcomes of all GBV prevention programs and activities. The overall lack of exposure to and training in M&E practices and principles places NGO staff, in particular, at a disadvantage in conceptualizing how they might identify outcome-level results using different and more accurate methods than the anecdotal and perceptions-based approaches they currently employ. For each of the three field evaluations, the evaluation team was not able to effectively identify GBV prevention program outcomes. Outcome measures such as acceptability of physical and/or sexual violence against women/girls are less frequently used, presumably because they are more difficult to assess and require additional M&E resources. NGO implementers reported that PRM guidance on M&E strategies was limited to the proposal submission process and that it would be helpful to receive guidance and support on indicator development following contract award and during the program development and implementation stages.

The absence of standardized indicators used by PRM's implementing partners prevents PRM from learning about the overarching impact of the GBV prevention initiatives that it funds. In addition to the need for outcome monitoring, indicators and targets must be separated in order to provide accurate and useful information about program performance.[21] Indicators should be neutral gauges of progress that can be compared against an objective or target. When used appropriately, targets can orient NGO implementers to tasks that need to be accomplished and provide guidance for monitoring whether or not program progress is being made on schedule and if results have been achieved over time.

In Malaysia and Chad, the lack of comprehensive needs assessments focusing on GBV as well as baseline assessments of program beneficiaries undermines the learning potential of PRM-funded programs. Information on GBV remains largely anecdotal and there is no accurate characterization of the problem at large. NGO implementers have a clear understanding of some aspects of GBV within the refugee community such as forced and early marriage, DV, and rape, but they have not fully explored additional forms of GBV such as survival sex and sodomy; this not only threatens the development and implementation of effective programs, but also hinders reliable understanding about the outcomes of GBV prevention programs. The lack of data for NGO implementers to use in targeting prevention efforts toward high-risk geographic areas and sub-groups results in a failure to translate knowledge into practical prevention strategies and reduces the effectiveness of GBV prevention programs.

Engaging Men and Boys in GBV Prevention and Response

Targeting and involving men and boys in GBV prevention programing is a key strategy for transforming socio-cultural norms. Recent guidelines recognize that men and boys can be critical change agents in GBV prevention efforts and engaging men allows them to challenge negative gender stereotypes—based in socio-cultural norms—that are imposed on them as well. Guidelines note specific strategies for engaging men as role models and change agents including establishing and supporting groups of men committed to ending GBV to reinforce the idea that GBV is not only a "women's issue"; emphasizing

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[21]The GBV Prevention Indicator Compendium (Annex II.B) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

positive norms and values that are part of masculine identities; developing programs that involve men and women working together and build on men's skills and capacities to help redress the disempowerment felt by men as a result of displacement; working with male community leaders to mitigate male resentment over the apparent focus on women, while bringing about positive change for women and girls; and creating conditions that allow men to discuss GBV, keeping in mind that men may also be survivors of GBV.

Findings

The **desk review** indicated that men must be approached not as "the problem" but as part of the solution, using positive and affirming messages that will encourage men and boys to develop their potential to act as agents of change. Literature also notes the importance of recognizing that some men and boys experience effects of GBV when a family member is victimized, including shame and a sense of powerlessness or inability to act as a protector of the family—especially when there is no justice for their female relatives. Men and boys should have access to specially-designed assistance programs to meet their needs when they have experienced sexual violence. Several documents reviewed by the evaluation team note that programs that focus on boys and men often lack the necessary resources and technical skills to develop, implement, and evaluate theoretically-grounded interventions and that there is a need for longer-term funding.

Program documents revealed that although engaging men and boys in GBV prevention and response was not an explicit objective of HIAS programs in **Chad**, program documents reviewed by the evaluation team suggest that engaging male heads of households in discussions on gender equality and involving men in voluntary committees to promote the rights of women and girls was a key component of the NGO's efforts to transform socio-cultural norms and rebuild family and community support structures.

Male refugees reported to ARC that they were not involved in GBV programs implemented by the NGO's predecessor in **Uganda**, and that the previous programs characterized all men as potential perpetrators and encouraged women to disobey and/or divorce their husbands. Some men explained that these misperceptions were the reason for frequent backlash against women and even against NGO program staff, as this previous work thwarted any advancement toward social change in the settlement. Together with partners and community members, ARC agreed to recognize and continually engage the many men who are ready and willing to use their influence to encourage women's equality.

ICMC **Malaysia** integrated male involvement in GBV awareness-raising training from the inception of the project. ICMC reports that the overall response, including that of men, to community GBV awareness-raising trainings has been positive. Program documents do not provide any specifics that indicate how training has affected attitudes, behaviors, or norms.

The evaluation team found several differences not only at the country level, but also at the NGO partner level, in terms of the engagement of men and boys in PRM-funded GBV prevention programming. In **Uganda**, male engagement is an explicit component of ARC's SASA! program. SASA!'s male engagement strategies focus on: 1) males as victims of violence, 2) males as supporters of female survivors, and 3) males as agents of change. Through male engagement groups, SASA! attempts to reach men where they are, such as bars and pool clubs, to have discussions on GBV and their role in prevention. Other mechanisms ARC reported as successful for engaging men involved using sports events to convene community members and having male leaders provide testimonials and lead discussions about GBV prevention at those events. MTI did not identify specific male engagement activities given its focus on

response to survivors through medical care and referral. ARC's SASA! program in **Uganda** was the only one with indicators explicitly designed to measure the engagement of men and boys in GBV prevention programming. While the indicators for male engagement were primarily focused on outputs—number of men and boys attending activities, number of men and boys working as community mobilizers, and number of visits to community or youth clubs—the existence of routine data collection focused on male engagement was significantly advanced in comparison to programs in Malaysia and Chad. NGO partners face difficulties in measuring changes in perceptions of males in the community at large and of the men/boys engaged as activists in the behavior change process. The use of the predefined SASA! indicators and the KASB surveys that ARC has been conducting in Kyangwali settlement offer the potential to better assess the outcomes of the SASA! male engagement strategy.

In **Chad**, although engaging men and boys in GBV prevention and response was not an explicit objective of HIAS, CARE, or ADES programs, engaging male heads of households in discussions on gender equality and involving men in voluntary committees to promote the rights of women and girls were key components of the NGOs' efforts to transform socio-cultural norms and rebuild family and community support structures. Men and boys have been consistently included in Chadian NGO partners' awareness campaigns and associated activities implemented in the refugee camps. There was evidence of the active engagement of men and boys—including male NGO staff—on many levels:

- Consistent selection and targeting of both males and females for participation in gender sensitization training opportunities
- Purposeful inclusion of men and boys on the refugee committees that carry out GBV awareness campaigns, such as the GBV Committee, Social Mobilization Committee, and Central Committee
- Targeted selection of both boys and girls to serve on youth committees that carry out GBV awareness through theater group activities such as drama performances, skits, and role plays
- Inclusion of both male and female students as focal points to work with the GBV Committee and other committees that carry out GBV awareness campaigns and activities
- Strategic targeting and outreach to men and boys who have been identified as at risk of becoming perpetrators or who have already been involved in GBV incidents, to ensure that they attend community GBV awareness campaigns and activities

In Chad, despite the strong evidence of men and boys' active engagement—including male NGO staff—on many levels, NGO partners were not specifically measuring the outcome of their engagement.

In **Malaysia,** ICMC made a strong effort to engage men and boys in GBV prevention and awareness activities. ICMC deliberately recruited men to join the RWPC, noting that male volunteers facilitate outreach training when groups have more male participants—especially when dealing with male leaders is required. Additionally, males may be more persuasive when training on gender roles and responsibilities. Implementers reported that the recruitment of men and boys into GBV prevention activities is a key challenge in Malaysia due to cultural norms; they also reported difficulty with reaching most males over the age of 12 years, as their time is partially consumed with employment. While HEI's programs reach a significant proportion of men in the communities they target, (as much as 70 percent of participants), it does not intentionally design its programs to engage men and boys. While NGO partners in Malaysia were actively reaching out to, and seeking to engage with men and boys through their prevention programs, the weak state of M&E observed among these programs included the absence of measures for male engagement.

The evaluation team found that while the participation of men and boys in PRM-funded GBV awareness campaigns is quite consistent, there remain thematic areas of importance to reducing incidents of GBV. For example, addressing—and transforming—the established roles of men and boys has not yet received adequate attention or emphasis within PRM-funded GBV awareness campaigns and outreach efforts. In **Chad**, among the refugee camps visited, awareness raising focuses primarily on improving knowledge and understanding regarding specific types of GBV and their harmful consequences—but without also encouraging (the very difficult and probing) discussions that question traditional norms associated with femininity and masculinity and that reinforce positive masculine behavior.

In **Uganda**, male community members raised concerns that GBV programming was empowering women to challenge social and cultural norms and reduce their roles in the family and community. Social and cultural norms, in particular acceptance of violence and the power imbalance between men and women, contributed to men's resistance to GBV programming. Furthermore, some male community members were under the perception that NGO staff working on GBV prevention view all men as perpetrators and, thus, men have little to gain from engagement in GBV prevention programming. However, Uganda was the only country visited by the evaluation team in which a referral pathway for male survivors exists. Pathways are in place for survivors to access the health center and other support services in the settlements, and they are appropriate for both male and female survivors. Yet, both ARC and MTI reported that very few males have come forward for services to date. NGO partners expressed that men do not want to disclose their experiences and it is believed that the majority do not report. Increased confidence of male survivors due to a better understanding of the referral pathway, support groups, open discussion of GBV in the community, and the arrival of new refugees who have widespread exposure to GBV were noted as reasons for the increase in reported GBV cases among males. Key informants noted that male survivors are best approached from a medical perspective and that protocol and capacity specific to male GBV survivors needs to be developed. It was observed that cases of male survivors are increasing and there is a desire among providers to identify more cases; however, there is a need to build response capacity of service providers to better identify and respond to men/boys who experience physical and sexual violence.[22]

In **Chad**, the evaluation team found that GBV programs implemented in the camps of Belom, Dosseye, Goz Amir, and Touloum do not adequately address the issue of male survivors of sexual assault or DV. This is likely due to a combination of NGO implementers' lack of knowledge with respect to the existence or possible existence of GBV perpetrated against men and boys and the socio-cultural norms of the refugee communities, which tend to strongly deny the existence of these issues and/or consider their discussion taboo.[23] While some NGO staff acknowledged that GBV could be happening to men and

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[22] In Nakivale Settlement, Refugee Law Project had pilot tested a screening tool developed by Johns Hopkins University to identify male survivors of violence (use of the tool is currently being expanded).[22] GBV cases were referred to ARC staff and received immediate medical and psychosocial support as needed.

[23] Refugee focus group discussion (FGD) participants in all visited camps were specifically asked whether they were aware of any incidents of sexual assault or DV against a man or boy in their communities. The overwhelming responses were: 1) they had not heard of any cases of men or boys being sexually assaulted, 2) they did not think that sexual assault against boys or men was happening in their community, or 3) they had heard of one or two isolated cases of DV against men but argued that most of these cases were caused by the female head of household defending herself from a husband who was beating her, drinking heavily, beating her children, or depriving her and her children of food, i.e., they felt there was contextual or situational justification. When asked

boys, others were less confident that this type of phenomenon exists. The evaluation team found that the preponderance of prevention activities and messages disseminated through awareness campaigns focused on various types of violence against women and girls and that little to no discussion of violence against men and boys was included.

The evaluation team found that PRM-funded GBV prevention programs in **Malaysia** did not address the needs of male survivors of sexual assault and violence, and key informants identified unmet needs in this area. UNHCR explained that refugees predominantly belong to male-dominated societies, "and the way to get men involved in GBV prevention successfully has not yet been identified." There is openness among both NGO implementers and refugee communities to engage men and boys in GBV programming. However, most implementing partners have yet to identify specific engagement strategies. Programming for male survivors of sexual violence and GBV is limited and could be expanded to address unmet needs, especially with respect to boys and unaccompanied minors. Several respondents commented that locating shelters for boys who have been abused or are at high risk is a challenge, and UNHCR indicated a need for a shelter for boys due to traumatizing events that occurred during boat journeys. Sexual assault is frequent among individuals who were incarcerated (often in their countries of origin), whereas DV is common in Malaysia. One community leader, when speaking about male victims and survivors of abuse, noted that "In Malaysia most men don't report sexual violence or GBV, but what we have is DV—sometimes the man reports that the wife is beating him or that the wife married another man and ran away." A number of respondents said they would like to move forward with providing counseling for perpetrators of DV, and several women expressed a desire for their husbands to receive counseling. UNHCR has also expressed an interest in working with DV perpetrators.

Conclusions

Like all sensitive topics, exploring and questioning traditional norms associated with femininity and masculinity is a difficult endeavor and must be carried out with thoughtful planning and within a culturally respectful environment. While NGO partners in each of the countries are engaging men and boys in their activities, to a varying extent, it is not carried out with the level of intention and purpose that is needed to effectively contribute to GBV-prevention. Across the board, NGO partners are not sufficiently monitoring the ways in which they are currently engaging men and boys, nor are they able to measure the extent to which this engagement may be having an effect on desired program outcomes. Despite the lack of data to this end, it is clear that additional attention must be given in each country to address and counter the harmful effects that traditional norms have, particularly those associated with men and boys, on the perpetuation of GBV.

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whether they thought it was possible that men and boys could be experiencing DV or sexual assault, a majority agreed that it is, in fact, possible. However, it was evident that this was a somewhat new or odd perspective from their vantage point because they were consistently and noticeably more hesitant and less likely to actively engage in the FGD when this particular topic was raised.

RECOMMENDATIONS

Transforming Socio-Cultural Norms with an Emphasis on Empowering Women and Girls

NGO implementers should design and implement GBV prevention programs from a social norms perspective. NGO implementers should use programming strategies that focus on traditional power imbalances and traditional gender roles, which are important to the success of GBV awareness and prevention efforts. SASA! is a community-driven social norms change strategy that is perceived to be effective in a diverse range of settings and has an emerging evidence base. SASA! and other approaches including Partner4Prevention, Stepping Stones, and Gender Communication[24] should be reviewed and evaluated for effectiveness in refugee settings. PRM should then provide guidance to NGO implementers on social norms change strategies that may be effective in specific contexts.

PRM should maintain the extended funding cycle length for GBV prevention programs. Social norms approaches to GBV prevention require significant investment (e.g. time, training, mentorship, and support for staff and activists) that requires multi-year funding cycles to enable NGO implementers to conduct prevention programs as well as measure progress in terms of outcome indicators that reflect changes in awareness and social norms. An important element to achieving social norms change and effective GBV prevention programming is the length of donor funding cycles. Key informants noted that sustainability of programs has been challenging given the historically typical one-year funding structure at PRM. Recognizing that socio-cultural change requires time and comprehensive, careful planning by NGO implementers, PRM has recently created an alternative to one-year funding cycles; this shift has allowed some GBV prevention programs to benefit from longer funding periods.

Rebuilding Family and Community Structures and Support Systems

NGO implementers, UN agencies, and host government stakeholders should improve coordination at the refugee settlement level. Barriers in coordination were noted at several settings. Regular monthly coordination meetings of NGO implementers were sometimes lacking, and there was insufficient communication between different providers on GBV cases. At the settlement level, monthly meetings were sometimes irregular as key staff needed to address other pressing issues or timely meeting notification was a problem. Ensuring participation of all stakeholders, including the local government, is ideal and can improve communication between stakeholders. Requiring the consistent participation of grantees and incentivizing other local stakeholders to participate are possible means of addressing the issue of irregular meetings; formalizing agendas and establishing fixed meeting schedules may also increase regularity and improve participation.

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[24] See http://www.partners4prevention.org/, http://www.steppingstonesfeedback.org/ and http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html.

PRM should support and promote the use of SASA! and other similar approaches that support community structures. The SASA! approach of involving the community at all levels of implementation—especially preparing community groups to help prevent and respond to GBV cases—galvanized participation and is likely to lead to lasting changes in GBV prevention and response. The flexibility of the SASA! approach, its standardized M&E system and indicators for measuring success, and its relative sustainability over the long term were considered positive features that would contribute to the lasting presence of community support structures. The use of SASA! and other similar social norms approaches that engage the community at multiple levels, thereby building support structures, should be considered as an effective means for NGO implementers to build community support structures.

PRM and UNHCR should identify funding opportunities to expand education opportunities for girls and integrate GBV messaging into school curricula. Both the integration of GBV prevention into the educational curriculum and increases in secondary school enrollment for girls in refugee communities are critical strategies for the long-term achievement of social norms change. The need for increased educational opportunities for girls was observed in both Uganda and Chad and is consistent with humanitarian guidelines. Provision of additional schools for refugees, increased teacher pay (at least to subsistence levels), and increased teacher training and curriculum strengthening are all possible strategies to help meet education needs of girls. Messaging about GBV-related topics such as early marriage is also an effective strategy for social norms change among younger generations, which can help to reduce future GBV. Education is an exceptionally important area for GBV integration and a proven approach for improving opportunities for girls, by reducing economic dependency on men and GBV risk and increasing equality between the sexes. Furthermore, education is considered a "best approach" for achieving intergenerational changes in cultural norms surrounding GBV.

NGO implementers should ensure that shelters are culturally appropriate and that locations are known. Increasing awareness of shelter locations among relevant stakeholders and local authorities could improve accessibility for survivors (in instances where locations were reportedly difficult to find). Ensuring that shelters are acceptable to a range of local beneficiary populations is important if they are to be utilized; for example, shelters serving Muslim refugee populations may need to be halal, and other religious and cultural considerations may need to be addressed depending on the context.

Creating Conditions to Improve Accountability Systems

PRM and UNHCR should require NGO implementers to expand training for program staff on GBV awareness, prevention, treatment, and self-care. NGO staff training and capacity building will help to ensure that GBV activities are implemented in accordance with international standards and that GBV response programming meets the needs of survivors. UNHCR, NGO implementers, and local partners should collaborate to identify and prioritize technical assistance and resources needed to address gaps in prevention and response services for survivors. These could include training and mentorship for staff on GBV-related issues that are difficult to address including lesbian, gay, bisexual, transgender, intersex (LGBTI) issues, male survivors, child abuse/neglect, and commercial sex workers; trainings for medical providers on how to collect forensic evidence and document GBV cases, how to serve as expert witnesses, and how to testify in court cases; trainings on situational management and conflict resolution so that staff have skills to assist difficult clients and resolve tense situations; and attention to staff well-being and self-care including peer counseling and/or guidance on best practices, such as those provided in UNHCR's 2013 Mental Health and Psychosocial Support for Staff and procedures for staff self-care following handling of difficult cases. This would strengthen linkages between GBV prevention and

response service provision and international standards and enhance the ability of NGO implementers to create conditions that improve staff accountability.

PRM should require NGO implementers to report on accountability measures, including directly linking GBV prevention programs and indicators to international guidelines and best practices. Methodologies should allow flexibility related to context while supporting the need for standardization of accountability indicators, timeframes, tracking of unintended positive and negative consequences, and staff performance and accountability in humanitarian settings. Mechanisms to improve accountability to beneficiaries including comment boxes and complaint reporting should also be required, in particular, in the context of GBV response programming.

UNHCR and PRM should support expanding the use of the GBVIMS in other countries as a means to promote coordination and accountability. The GBVIMS, which was used in Uganda, is perceived as an important tool that will help providers and communities understand progress in GBV prevention and response over time. The GBVIMS also facilitates collaboration among NGO implementers and improves coordination of services across partner organizations for GBV survivors. The GBVIMS was perceived as helpful in coordinating support to survivors, better understanding trends of GBV cases in settlements, and distinguishing new cases from older cases that occurred in the country of origin. Regular meetings among partners should be encouraged as an effective complement to the GBVIMS that can facilitate case management across partners and understanding of information collected in the GBVIMS.

Designing Effective Services and Facilities

NGO implementers should involve communities in the early stages of program design for GBV prevention and response. Specifically, established networks with local partners should be leveraged to engage refugee leadership and beneficiaries in GBV prevention program planning at the time when program objectives and activities are developed for initial review and consideration by PRM or UNHCR. Earlier collaboration on program planning would likely result in more ownership of the programs by the community, reduce unintended negative consequences, and increase effectiveness in addressing implementation barriers.

UNHCR should be encouraged by PRM and other donors to work with NGO partners and refugee committee leaders to ensure that roles and responsibilities for GBV prevention are not duplicated. UNHCR and NGO implementers would benefit from streamlining their referral and counseling systems to eliminate existing duplication among partners and committees, as it may be diluting the integrity and effectiveness of counseling efforts, as well as increasing the possibility of breaches of confidentiality. Partners should also work together to develop a more refined protocol for survivor follow-up after cases have been both referred and closed. To operationalize this recommendation, PRM could require as part of the proposal process, a referral network plan of action detailing roles and responsibilities for each of the partners involved in the network.

All PRM- and UNHCR-funded partners implementing GBV prevention activities should routinely collect confidential feedback from survivors about their levels of satisfaction and perceptions about quality of treatment and services received. This kind of information could also be built into PRM's requests for monitoring data from grantees on a quarterly basis. PRM should use this information to engage with partners about the quality and effectiveness of their programs and to suggest changes or provide additional support from PRM Regional Refugee Coordinators where needed.

Working with Formal and Traditional Legal Systems

PRM should continue to fund awareness-raising activities that increase refugees' demand for legal services. Expanding the coverage of NGO programming on GBV awareness in refugee communities and ensuring that referral systems are in place and appropriately functioning can increase demand for legal services among GBV survivors and increase accountability of perpetrators.

PRM and UNHCR should encourage capacity building and female recruitment among local law enforcement. Engaging local police, national and international security forces, detention personnel, and immigration authorities to address issues related to GBV and behavior toward (un)registered refugees could be helpful in many refugee contexts. Efforts to train police are reported as effective in improving response to GBV cases and increasing arrests of perpetrators. Encouraging the hiring and retention of female officers trained in GBV in refugee settlements and communities can also improve the ability of law enforcement to provide assistance in GBV cases. The presence of female officers on security teams can be a facilitator of GBV prevention because they are able to gain the confidence of women and have open dialogues about GBV-related issues in refugee communities.

PRM should continue to support traditional legal systems with both material inputs and capacity building, as well as consider increasing attention to formal legal systems in relevant countries. NGO implementers should increase both the coverage and intensity of training and sensitization on GBV-related issues for community leaders and others influencing traditional legal systems. This strategy could prove effective in promoting change of social norms and community structures, which would benefit GBV prevention and response efforts in refugee contexts. At the same time, both NGO implementers and UNHCR could engage in capacity-building programs and/or support to GBV survivors in accessing available formal legal systems. It is possible that, in some countries, insufficient attention has been given to formal legal systems—either because the majority of cases are resolved outside the court system or because of NGO efforts to keep peace with the refugee communities and work within their social norms and traditional structures. The applicability of mobile courts and legal clinics should also be evaluated, as they have proven an effective means for providing timely justice to survivors. However, these interventions can be expensive. Thus, location-specific cost-benefit analysis should be conducted by UNHCR or other appropriate organizations given the many unmet needs and funding limitations that are often pervasive in refugee settings.

UNHCR and NGO implementers should investigate the reportedly overwhelming trend of DV cases being resolved at the family or community level (rather than by means of local legal systems). The assessment would require a careful, systematic, and confidential analysis of the outcomes of previous DV cases, primarily from the point of view of survivors; a review of existing GBV social awareness campaign curricula and messaging goals; and a review of GBV counseling protocols and referral networks.

In contexts where UNHCR has a significant backlog, PRM should work with UNHCR to address the backlog and reduce delays in refugee status determination and registration. The length of time required for refugees and asylum-seekers to obtain UNHCR cards can be a contributing factor to increased risk of abuse and a barrier for survivors who may be hesitant to report GBV and seek services because of their uncertain legal status. PRM could consider providing short-term funding that enables UNHCR to hire additional staff to address backlogs or providing other support to UNHCR on request-by-request basis.

Assessment, Monitoring, and Documentation of GBV

PRM should provide financial support for an extensive situational analysis to understand the needs and priorities of refugee communities; subsequently, PRM should ensure that baseline assessments are conducted prior to program implementation. Situational analysis should include participatory assessments to identify the protection concerns of men, women, girls, and boys. Data collected should be disaggregated by sex and age. Situational analysis should focus on risk mapping, immediate and root causes of GBV cases, and the use of international and domestic legal standards as a framework for analysis and action. Baseline assessments are necessary to evaluate the effectiveness of programming, and mapping of available services is important to identify gaps and develop referral pathways for survivors. In its requests for proposals, PRM could introduce requirements for baseline assessments of entire programs, discrete activities, or any new or pilot activities proposed by NGO partners. NGO implementers' plans and efforts to develop data collection tools and better understand their beneficiary populations are laudable. However, to maximize the benefits of this information, the efforts need to be well coordinated and used to inform ongoing monitoring as well as mid-term and final evaluations.

PRM should consider providing specific resources to UNHCR and NGO partners for program evaluation, particularly in the case of short-term (less than 3 years) funding, which is a challenge with respect to assessing effectiveness. To establish evaluation as an explicit requirement of PRM-funded programs, PRM could require that 3-5 percent of requested funding be dedicated specifically to evaluation. Dedicated funding to support evaluation designs that are implemented across the lifespan of programs and capable of assessing attribution and change over time are preferred to final evaluations that are conducted only at the end of the program period and often draw insufficient conclusions. One potential approach for addressing concerns about attribution would be coordinated multiagency evaluations that assess change in key outcomes over time (in addition to organization-specific process measures that are most-commonly reported).

PRM should require programs that focus on healthcare, livelihoods, or other areas to develop specific and measureable objectives that clearly relate to the particular GBV activities being implemented in a country, community, or region. Additional mapping exercises of resources and GBV risk should be undertaken. The GBV Prevention Indicator Compendium (Annex II.B) includes examples of indicators that could be used to measure progress against these objectives.

PRM should develop an internal results-based management system to support the implementation of its Functional Bureau Strategy, including a logic model that demonstrates the sequence of cause-and-effect relationships between activities, outputs, outcomes, and goals. The logic model could explicitly cover GBV prevention programs, or the logic model could demonstrate how GBV prevention should be integrated into all PRM interventions.[25]

PRM, in consultation with UNHCR, should disseminate required GBV M&E methodologies and tools to NGO implementers. Specifically, PRM should require NGO partners requesting funding for GBV prevention programs to monitor and regularly report on a selection of required internationally

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[25] DoS institutional resources include Managing for Results: Department of State Project Design Guidebook (October 2012) and Performance Management Guidebook: Resources, Tips, and Tools (December 2011).

accepted outcome indicators to determine the impact of their programs. Required M&E methodologies should allow flexibility related to context while supporting the need for standardization of GBV indicators, timeframes, tracking of unintended positive and negative consequences, and staff accountability in humanitarian settings. Use of common M&E methodologies—including standardized indicators[26]—will enable PRM to make comparisons across settings about the impact of GBV prevention programs, thereby providing monitoring data for PRM's internal results-based management system. Tools could include logical frameworks, NGO partner M&E plans, and indicator reference sheets, among many others.

PRM should support NGO implementers and PRM Regional Refugee Coordinators to build capacity in required M&E methodologies. Many of PRM's Regional Refugee Coordinators are generalists who would benefit from increased information and guidance on M&E to prepare them for recommending GBV-specific indicators and M&E tools to field-based NGO implementers. NGO implementers are using multiple methods for M&E as well as diverse GBV indicators within and across countries. A PRM-funded capacity building workshop—possibly conducted by UNHCR—would provide NGO partners with increased understanding of required M&E methodologies and important tools to collect and report evidence about the successes of GBV prevention programs in humanitarian settings. To maximize resources and efficiencies, the workshop could be designed as a training of trainers (ToT) in which one or two key headquarters staff members from each NGO partner participate and subsequently train field staff in relevant countries on the same methodologies.

Engaging Men and Boys in GBV Prevention and Response

UNHCR and NGO implementers should increase discussions and questioning of traditional norms associated with femininity and masculinity within their GBV prevention awareness campaigns—while at the same time reinforcing positive masculine behavior that decreases GBV within the refugee community. To change individual attitudes and socio-cultural norms, GBV prevention programs should be ecological in nature and give due attention to community-based gender analysis, including a thorough examination of stereotypes related to males and masculinity. Men must be encouraged to reflect, over time, about the threat of sexual violence and how their own lives are affected. UNHCR and NGO implementers are encouraged to apply the proven, effective methods they have used to address other sensitive topics such as FGM and forced marriage. For instance, sensitization theater groups could expand their skits to include messages that suggest ways men can decrease GBV incidents toward women. To support these efforts, PRM and UNHCR should provide NGO partners with training and mentorship for staff on GBV-related issues that are difficult to address including LGBTI issues and male survivors, including how to identify and respond to men and boys who have experienced multiple forms of violence.[27]

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[26] The GBV Prevention Indicator Compendium (Annex II.B) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

[27] International Rescue Committee's multi-media training tool on Clinical Care for Sexual Assault Survivors includes a module about male victims of sexual violence: <http://clinicalcare.rhrc.org>. The Refugee Law Project in Uganda has been working in settlements in Uganda with male survivors primarily from DRC, and it has established support

UNHCR and NGO implementers should develop engagement strategies that emphasize men as part of the solution. The literature underscores the importance of involving men who are influential in the community and held in esteem by young men and boys; examples include coaches, fathers, elders, religious leaders, musicians, sports figures, and others. Strategies should focus on the use of positive messaging to encourage men and boys to develop their potential to act as agents of change. GBV prevention programming should be tailored to each community context and engage men and boys where they congregate. NGO implementers should create a safe place within each refugee community where men and boys feel they can discuss sensitive issues and reveal their anxieties and vulnerabilities. Young men who have been trained in GBV prevention messaging could meet with other men at local places of congregation to discuss the negative impacts of alcohol on domestic relations.

UNHCR and NGO implementers should work toward providing refugee men and boys access to specially-designed assistance programs to meet their needs when they have experienced sexual violence, DV, or any other form of GBV. The equal participation by women, men, girls, and boys in planning, implementing, monitoring, and evaluating GBV prevention programs should be encouraged.

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groups led by men in Kampala and the settlements. In partnership with the Refugee Law Project and with funding from DoS/PRM, Johns Hopkins University developed a GBV screening tool for male survivors.

ANNEXES

Annex I: Evaluation Statement of Work

STATEMENT OF WORK

U.S. Department of State
Bureau of Population, Refugees and Migration

Evaluating the Effectiveness of Gender-Based Violence (GBV) Prevention Programs with Refugees in Chad, Malaysia, and Uganda

NATURE AND PURPOSE
The purpose of this solicitation is to obtain the services of a contractor to carry out an evaluation, lasting up to 12 months, of Gender Based Violence (GBV) programs supported either directly by the Bureau of Population, Refugees and Migration (PRM) or indirectly through one of its multilateral partners, the United Nations High Commissioner for Refugees (UNHCR) in targeted countries. The evaluation will consist of: (1) a comprehensive desk review and analysis of GBV program reporting by PRM and UNHCR; and (2) field-based evaluations in three countries (Chad, Malaysia, and Uganda) where PRM and UNHCR support GBV prevention programming. Both the desk review and the field-based evaluations should prioritize identifying: (1) the effectiveness of GBV prevention programming; (2) appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings and (3) best practices and lessons learned in engaging men and boys in GBV prevention interventions in refugee settings. Evaluation recommendations should include guidance that PRM can consider when: (1) writing requests for GBV proposals; (2) when reviewing GBV proposals; (3) monitoring GBV programs in the field; and (4) engaging host governments, International Organizations (IOs), and Non-Governmental Organizations (NGOs) on GBV issues. The contractor will coordinate with PRM, UNHCR, and NGOs.

BACKGROUND
PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world on behalf of the American people by providing life-sustaining assistance, working through multilateral systems to build global partnerships, promoting best practices in humanitarian response, and ensuring that humanitarian principles are thoroughly integrated into U.S. foreign and national security policy. PRM is the largest bilateral funder to UNHCR and other multilateral humanitarian responders. PRM funds NGOs to fill critical gaps in programming by UNHCR and host governments.

Preventing and responding to GBV in refugee settings is a PRM priority. PRM's Multilateral Coordination and External Relations (MCE) Office oversees PRM-supported GBV prevention and response activities. Prior to FY 2010, MCE maintained a central pot of funding for GBV prevention/response programs. On an annual basis, MCE would issue a Request for Proposals (RFP) through which NGOs could apply for any region with PRM populations of concern. After FY 2010, MCE instead made the majority of these funds available to regional PRM offices, reserving only a small amount of central funding to promote research, capacity-building, and innovation concerning GBV prevention/response in humanitarian settings. For

this reason, the scope of the evaluation will be projects carried out between FY 2010 to the present. MCE is the main source of expertise on GBV related issues for the Bureau, complemented by technical assistance from USG partners such as the Centers for Disease Control and Prevention's International Emergency and Refugee Health Branch (CDC/IERHB) and the United States Agency for International Development's Office of Foreign Disaster Assistance (USAID/OFDA).

There seems to be an inherent challenge in measuring the impact of GBV programs, particularly where prevention activities are concerned. In a humanitarian context especially, GBV interventions tend to focus on health, legal and psychosocial *response* activities, given the urgency of the situation, funding constraints by donors (PRM generally funds activities 12 months at a time, for example), and the ability to measure impact more quickly, while the understanding of how to best support and measure the impact of GBV prevention activities in humanitarian contexts continues to be a challenge. As part of GBV prevention, PRM has raised the importance of determining how best to engage men and boys to reduce gender inequalities and prevent violence through questioning traditional norms associated with femininity and masculinity, and reinforcing positive masculine behavior, rather than behaviors that harm women. Although more has been done in the development context on this issue, the humanitarian community still has much to learn in identifying best practices on engaging men and boys in GBV programming. Strong monitoring and evaluation contributes to the identification of best practices that can be promoted in future GBV prevention and response programs, and we hope that this evaluation will identify appropriate indicators for measuring the effectiveness of GBV prevention interventions, as well as best practices on engaging men and boys in GBV prevention interventions in humanitarian settings. In addition to best practices, we should learn from mistakes that we and our partners have made so they are not repeated.

Monitoring the performance of PRM partners is a responsibility shared by MCE, regional offices, PRP and PRM's Regional Refugee Coordinators based at embassies throughout the world. The Bureau's Office of Policy and Resource Planning (PRP) will oversee administration of the evaluation and be the primary point of contact. Upon award, PRP will work closely with the contractor for the duration of the evaluation. In accordance with the standards of good management and performance-based results, the contractor will be held accountable for cost, schedule, and performance results.

SCOPE OF WORK

The contractor will:

- Conduct a comprehensive desk review and analysis of selected NGO GBV projects supported by PRM and UNHCR between FY 2010-2012 with an emphasis on measuring the effectiveness of prevention interventions.
- Carry out field-based evaluations in three countries where both PRM and UNHCR fund GBV prevention programs with refugee populations. For this study, the research sites would include refugee camps in eastern Chad, refugees living in settlements in western Uganda, and neighborhoods with high concentrations of urban refugees in Kuala Lumpur, Malaysia.
- The evaluations should answer the following questions, with an emphasis on developing best practices, lessons learned, and actionable recommendations that can inform PRM supported GBV programming in the future.

- Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
- Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
- Did the GBV programming conform w/ internationally accepted GBV guidelines produced by the humanitarian community? Relevant guidelines include: (1) IASC Guidelines for GBV in Humanitarian Settings; (2) UNHCR Handbook for the Protection of Refugee Women; (3) UNHCR Guidelines on the Protection of Refugee Children; (4) GBV AoR Handbook for Coordinating GBV Interventions in Humanitarian Settings; and (5) IASC Gender Handbook in Humanitarian Action.
- Are the indicators in the above guidance documents (where available) appropriate for measuring the outcomes of PRM funded GBV prevention programs? Are the indicators in the project proposals Specific, Measurable, Achievable, Realistic or Timely? How can proposal indicators be improved? Do indicators from the above guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
- Were there any unexpected negative or positive consequences of PRM funded GBV programs? Did organizations address negative consequences and how?
- What factors explain intended and unintended negative or positive consequences?
- What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs specific, measurable, achievable, realistic or timely? How can indicators be improved for GBV awareness campaigns?
- To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
- What were the short and long term outcomes of PRM funded GBV prevention programs?

Annex II: DoS/PRM Tools for M&E of GBV Prevention Programs

Annex II.A: Checklist for Reviewing GBV Proposals and Negotiating Indicators with Partners

The Inter-Agency Standing Committee (IASC) Guidelines on Gender-based Violence (GBV) Interventions in Humanitarian Settings define GBV as "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. The nature and extent of specific types of GBV vary across cultures, countries, and regions." Within this definition, PRM includes violence based on gender identity and/or sexual orientation. This checklist is for PRM to review proposals (RfPs) for GBV prevention and response projects. In order to get the maximum value from performance data, indicators should be valid, reliable, timely, precise, credible, practical/useful, and disaggregated.

Element	

Reviewing Proposals	Background/problem analysis
	
	• Does the proposal indicate that the applicant has a clear understanding of the problem or need, the root causes, and the operating environment?
	• Do the activities fall under PRM's definition of the GBV sector?
	  ○ Responding to current, identified needs, such as provision of health and psychosocial care, livelihoods interventions, legal assistance or other activities that directly address GBV;
	  ○ Public information and rights awareness campaigns among returnees, refugees, health and social service workers and justice officials working with beneficiaries; and,
	  ○ Activities designed to create local capacity to respond to GBV in a competent and timely manner, such as training for local staff or beneficiaries themselves in prevention, recognition, and treatment of GBV (including victim counseling), or activities to enhance the timeliness of response to GBV.
	  ○ Projects with GBV components should measure the percentage of survivors of GBV who have referred for and received psychological, medical, legal, or any other form of support. This number should be measured with a numerator of the total number of survivors reporting GBV who have received or been referred for psychological, medical, legal, or any other form of support and a denominator of the total number of survivors reporting GBV.
	• Does the proposal explain how the project's objectives fit within PRM's protection goals?
	• Does the required gender analysis adequately explain the existing gaps between males and females? Will the activities reduce these gaps?
	• How are men and boys engaged?

	Project design • Does the proposal articulate a "theory of change" that elucidates how activities address the root cause of problems/issues? • Does the proposal list specific results that the project will achieve? • Does the proposal include an analysis of, or plan for addressing, possible negative consequences of program activities? • Have GBV prevention considerations been adequately addressed (if the proposed project is not GBV-specific?)
	Monitoring, evaluation, and reporting • Does the project list gender-specific indicators? • Are indicators included for the inputs, outputs, outcomes, and impacts articulated in the proposal? • Impacts may include: improvements in physical/mental health access/delivery • Are indicators structured as gauges of progress? Are there indicators and targets?
Negotiating Indicators	Relevance to internationally accepted indicators • Are the indicators borrowed from IASC or other major guidelines? Please see GBV Indicator Compendium checklist. • If so, are they the best fit for the project? • If not, are there IASC or other indicators that would be appropriate for this project?
	Disaggregation Is the indicator appropriately disaggregated by sex, age, location, or other relevant dimensions important for programming?
	Validity For each indicator, is there a direct relationship between the result and what is being measured (i.e. are outcome-level indicators used to measure outcome-level results)?
	Reliability Will the implementer be able to ensure consistent indicator data collection? If the project operates in an insecure environment, is there a risk mitigation plan?
	Precision Can the indicator data collected be trusted in terms of its accuracy? Is there risk of missing key data or double-counting?

	Integrity Is the indicator data objective and independent? Is there any significant threat of bias in reporting?
	Practicality and usefulness Will the data be useful for management decision-making (i.e. will it provide insight on what component of the projects are succeeding or failing? Could this information be used to inform decisions about scaling up or replicating components of the project)?
	Timeliness Will indicator data be available to PRM in time to inform program management decisions?

References:

USAID PMP Toolkit
PRM NGO guidance
USAID TIPS Note: Selecting Performance Indicators

Annex II.B: GBV Prevention Indicator Compendium

International guidelines recommend the use of standardized indicators and M&E tools across GBV prevention programs. The GBV Prevention Indicator Compendium includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation. PRM-funded NGO implementers sometimes use adaptations of indicators presented in the compendium. Increased use of common indicators across programs, countries, and donors would enable more rigorous reporting and evaluation of impact. In addition, indicators that collect information about measures taken to prevent or reduce GBV would be useful in planning, monitoring, and evaluating other non-GBV-focused programs funded by PRM. Indicators in bold text are "priority" indicators. Managers should encourage NGO partners to use at least one of these indicators if relevant for each project.

Indicator	Sector, Activity	Source
Designing services		
There is a comprehensive understanding of the specific risk factors faced by women, girls, men, and boys in camp settings and this analysis is incorporated in security provisions within the camps.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Training on GBV-related issues and potential risk factors is conducted for an equal number of female and male humanitarian workers to enable them to provide support to affected persons and direct them to adequate information and counseling centers. Training one male and one female meets this indicator.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Women participate directly in decision-making on local security arrangements for the camp community.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Percentage of teachers signing codes of conduct.	Education	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
"Safe spaces" are created at the distribution points and "safe passage" schedules created for women and children head of households.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men are involved in the process of selecting a safe food distribution point.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Distribution is conducted early in the day to allow beneficiaries to reach home during daylight. *	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Food distributions are done by a sex-balanced team.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of females involved in food distribution committees.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of food distributed to women.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
24-hour access to sexual violence services.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Confidential referral mechanism exists for health and psychosocial services for rape survivors.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Staff are trained on the clinical management of rape.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of community-based workers trained in sexual violence psychosocial support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of health staff trained in sexual violence medical management and support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Survivors/victims of sexual violence receive timely and appropriate medical care based on agreed-upon medical protocol.*	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Percentage of reported rape cases where survivor receives post-exposure prophylaxsis for HIV (PEP) within 72 hours of incident	Health & Community Services	"United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Response.info Indicators Registry" 2014

Indicator	Sector, Activity	Source
Number of copies of resource list in local language(s) distributed in community.	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are in place to ensure income-generation activities and economic options for women and girls so they do not have to engage in unsafe sex in exchange for money, housing, food, or education—or are exposed to GBV because of being economically dependent on others.*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men participate in the identification of safe and accessible non-food item NFI distribution sites.*	Non-food items	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
NFI distribution points are monitored to ensure they are safe and accessible.*	Non-food items	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate quantities of sanitary supplies distributed to women and girls.*	Non-Food Items	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Both women and men participate in the identification of safe and accessible sites for water pumps and sanitation facilities.*	Water and Sanitation	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate number of latrines for each sex constructed and have locks (Sphere standard).*	Water and Sanitation	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Improving accountability		
Proportion of key actors who participate in regular GBV working group meetings.	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Staff are aware of and abide by medical confidentiality.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of actors issuing codes of conduct.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

Indicator	Sector, Activity	Source
Proportion of reported sexual exploitation and abuse incidents resulting in prosecution and/or termination of humanitarian staff.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Security mechanisms instituted based on where incidents occur, and monitored for effectiveness.*	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
A referral system for reporting of security and abuse incidents is operational.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Mechanisms put in place to ensure people can report any harassment or violence.*	Shelter	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Monitoring and documentation		
A mechanism is in place for monitoring security and instances of abuse.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Facilities and collection points are monitored to ensure they are safe and accessible (e.g. locks, lighting).*	Water and Sanitation	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
High risk security areas are monitored regularly at different times of day.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Multisectoral and interagency procedures, practices, and reporting forms established in writing and agreed by all sectors.*	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are monitored for possible negative effects of changes in power relations (e.g. rise in domestic violence due to women's empowerment).*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Regular observation visits are undertaken to distribution points, security checkpoints, water and sanitation facilities, and service institutions (e.g. schools and health centers).*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Reports on sexual violence incidents compiled monthly (anonymous data), analyzed, and shared with stakeholders. *	Assessment & Monitoring	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Routine spot checks and discussions with communities to ensure people are not exposed to sexual violence due to poor shelter conditions or inadequate space and privacy.*	Shelter	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Security and instances of abuse are monitored.*	Protection	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Workplaces are monitored and instances of discrimination or GBV are addressed.*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Rebuilding support systems		
Community-based plan for providing safe shelter for victims/survivors developed and used effectively.*	Shelter & Site Planning	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Transforming norms		
Informational campaigns for men and women about the health risks of sexual violence to the community.**	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of IEC materials using verbal or visual messages (i.e. accessible to non-literate populations).	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of individuals who know any of the legal rights of women.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of individuals who know any of the legal sanctions for GBV.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who have been exposed to GBV prevention messages.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who say that wife beating is an acceptable way for husbands to discipline their wives.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010

Indicator	Sector, Activity	Source
Proportion of people who would assist a women being beaten by her husband or partner.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Women and men in the community, including village leaders and men's groups, are sensitized to violence against women and girls, including domestic violence.*	Protection	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Working with legal systems		
Police officers (male and female) patrol the camps.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of reported incidents of sexual violence where survivor/victim (or parent in the case of a child) pursues legal redress.	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

Nota bene: These indicators listed in the IASC and other guidelines as examples to follow. According to M&E best practices, the "indicators" marked with an asterisk are not truly structured as indicators, but rather as results statements, i.e. specific results that an intervention would hope to achieve through its activities. The "indicator" marked with two asterisks is an activity that an NGO might undertake to achieve a given result. Social Impact does not feel comfortable changing these indicators, as they have been produced by the humanitarian community for GBV programming. The 2005 IASC indicators are currently under review and subject to revision. In the meantime, Social Impact recommends that PRM examine the "United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Response.info Indicators Registry" in order to seek out adaptations of these results statements in true indicator format.

Annex II.C: Checklist for Monitoring GBV Programs in the Field and Engaging International Organizations and NGO Partners on GBV Issues

Field Monitoring Topics
Consultation
Individuals to consult and coordinate with: • UNHCR protection, community services, or program officers • UNHCR GBV Coordinator • NGOs/UNHCR Implementing Partners in community services, health, security, and/or GBV programs • Refugees, especially women • Local police • Other NGOs not working on GBV programs • Doctors/nurses/birth attendants • Community groups/leaders, including youth groups, faith groups
Good questions to ask UNHCR staff: • Are there protocols in place to address GBV? If not, is there a system in place to address GBV when it occurs? • Which groups of individuals are considered to be the perpetrators of GBV? • Review GBVIMS (if it is in place). Use data to understand trends of GBV occurrence in order to understand context and efficiencies of current programming. • What do you think is working well in your program? What activities need more attention?
Good questions to ask NGOs: • Are there regular community consultations on GBV? • Are there records with number of referrals or complaints that can be seen? • Is outcome monitoring taking place on whether GBV prevention efforts are effective? • What do you think is working well in your program? What activities need more attention?
Good questions to ask refugees: • What do refugees mention as activities or behaviors used by UNHCR and NGOs to build trust with GBV prevention?
Coordination
• Are there meetings to discuss the implications of aid effectiveness agreements and GBV prevention for NGO grantee operations by the Regional Refugee Coordinator and appropriate IO representative? • How are host governments and host communities engaged on GBV issues? • What specific measures are being used by UNHCR and NGO partners to maintain and enhance collaboration? • Are there any activities that are being duplicated by UNHCR and NGO partners? • Do NGO implementers (PRM and UNHCR grantees) have a common understanding of what is meant by GBV prevention programming? • Are there any other IOs involved with GBV prevention?
• Are the monitoring agreements (e.g. performance monitoring plans) of PRM NGO grantees shared between the Regional Refugee Coordinator and the in-country IO representative, or most appropriate person? • Are there joint field visits by IOs and NGO field representatives with shared agendas of looking at GBV prevention mechanisms at refugee camps?

- If other development actors are working at the camp, or in urban neighborhoods with high density of refugees, who initiates coordination and engagement and when does it occur?
- Are GBV prevention indicators being used by IOs and NGOs? Are there significant differences in the GBV prevention indicators used by each group?

Assessment and Monitoring

- Is there a monthly statistical report available on the incidence of GBV that you can view or obtain from UNHCR?
- Does the NGO grantee have records on GBV prevention and incidence (e.g. clinic intakes, training attendance)?

Protection

- Are there local laws that criminalize GBV?
- If there is a refugee court or tribunal, do refugees consider it effective? How many cases do people say have been prosecuted?

Information, Education, Communication

- Are there periodic trainings or awareness sessions on GBV for the community?
- Is there a mass sensitization outreach on GBV that is sustained, or is outreach conducted on a one-off basis?
- What forms of social messaging are used in the camp?
- Within urban environments, how are social messages conveyed to refugees?

Shelter and Site Planning

- Are there shelters for GBV survivors in the camp?
- Are firewood or alternative fuel sources being provided on a regular, sustainable basis?
- Is there adequate lighting in the camp? If in an urban settlement, is there adequate nighttime lighting on the roads?
- Is there lighting near latrines at night?
- Where do women and children go to relieve themselves?
- In urban environments, are there shelters that focus on the needs of refugees?

Health and Community Services

- Is there a clear referral pathway (on paper and understood by NGOs and camp officials) for GBV survivors? For urban environments, does this hold for NGOs and community leaders?
- Are GBV survivors briefed about shelter conditions before they enter the shelter?
- Are there referral or complaint system mechanisms for GBV incidents? Are they used?
- Are data being collected on FGM at the camp health centers? If in an urban environment, does the health center collect data from refugee clients on FGM?
- Are the psychosocial counseling protocols used survivor-centered?

Camp Coordination and Management

- Are women involved in leadership and decision-making bodies?
- Does the camp have effective security in that the layout regarding borders and entries and exits that provide safe space?
- In an urban environment or in camps, are women involved in refugee councils or management committees?

• Are there curfews in camps and are they enforced? If in an urban neighborhood, are there curfews? • Within urban environments, are there refugee run/managed local security policies and plans? Are women involved with the creation of these plans and their execution? • Are there bars that operate beyond 12 pm? • In a camp, are there male and female security officers? • Are there reported incidents of extortion by camp officials? Security? Police?
Involvement of Men and Boys
• Are incentives used to engage males in GBV prevention activities? • Are there male-only support groups for men and boys to address and prevent the issue of male GBV survivors?
• Are there incidents of backlash toward females from males regarding empowerment activities undertaken as part of GBV prevention programs?

Annex III: Disclosure of Conflict of Interest

Name	Erica A. Holzaepfel
Title	Evaluation Specialist
Organization	Social Impact
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(or RFTOP or other appropriate instrument number)*	RFTOP 1037-350011
DoS Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	
I have real or potential conflict of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Erica A. Holzaepfel
Date	2/10/13

Disclosure of Conflict of Interest for DoS Evaluation Team Members

Name	Shannon Doocy
Title	Associate Professor
Organization	Johns Hopkins School of Public Health
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(or RFTOP or other appropriate instrument number)*	
DoS Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	None
I have real or potential conflict of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	Jan 23, 2013

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