SAFAIDS

ENDLINE ASSESSMENT REPORT

Action Linking Violence Against Women and HIV Everywhere (ALIVHE) through *Integrated Male Involvement, Traditional Leadership Engagement and Stepping Stones Models in Malawi*.

May 2017

1

Action Linking Interventions on GBV and HIV Together Framework (ALIGHT) now known as Action Linking Violence Against Women and HIV Everywhere (ALIVHE) through *Integrated Male Involvement, Traditional Leadership Engagement and Stepping Stones Models in Malawi*.

TABLE OF CONTENT

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
CBO	Community Based Organisation
FGD	Focus Group Discussion
GBV	Gender Based Violence
HCA	Hospital Cooperation America
HIV	Human Immuno Virus
IEC	Information, Education and Communication
KII	Key Informant Interviews
NGO	Non-Governmental Organisation
PEP	Post Exposure Prophylaxis
RLs	Religious Leaders
YONECO	Youth Net and Counselling, Voluntary Service Overseas
SPSS	Statistical Product Services and Solutions
SRHR	Sexual Reproductive Health Rights
STI	Sexually Transmitted Infection
TLs	Traditional Leaders
VHW	Village Health Worker
VSO	Voluntary Service Overseas
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZIMSTAT	Zimbabwe Statistical Agency

Acknowledgements

I would like to sincerely thank management of SAfAIDS Malawi for entrusting me with the responsibility of conducting the final ALIGHT project assessment of Zomba District (T/As M'biza, Mwambo and Mlumbe) 2015-2016. Furthermore, I would like to register my sincere appreciation to SAfAIDS Malawi for providing both technical and logistical support throughout the endline assessment process. I especially wish to recognize the untiring support I received from Edward Chikhwawa, who provided all the necessary technical support that made this exercise easier and successful. He also provided comprehensive feedback on the endline assessment design and indeed interactive sessions from which the consultant sharpened his skills in managing SAFIADS Malawi endline assessment. In short, the entire SAFAIDS Malawi and SAFAIDS Zimbabwe Regional Office staff your untiring efforts made this work possible and simplified.

I would also like to acknowledge the wonderful cooperation and input from stakeholders and partners who responded objectively to our interview questions. I am grateful to the Executive Director for YODEP and all YODEP staff members for providing valuable support and information and a well-coordinated community mobilisation. I trust that I have conveyed your wisdom and insights accurately.

At the community levels, I am especially indebted to the chiefs, project champions for all the three Traditional Authorities, community members and chairpersons and members of various committees for sparing their time to talk to us. We learned a lot about SAFIADS Malawi /YODEP activities from these stakeholders and beneficiaries on the ground.

The views expressed in this report may not always coincide with the opinion of SAFIDS Malawi, resource persons or stakeholders. Any errors that remain, despite all the advice and support extended, are entirely my own.

May 2017

EXECUTIVE SUMMARY

Malawi is among the countries most affected by the HIV epidemic. According to the 2010 Malawi Demographic Health Survey (MDHS) data, national HIV prevalence was 10.6% amongst 15-49 year olds and was higher among women (13%) than men (9%) reflecting a widening gender gap between men and women. The largest disparity was in the 15-19 years age group with 1.3 % in males as opposed to 4.2 in females. The number of people living with HIV (PLHIV) was estimated at about 1,000,000 which included 850,000 people aged 15 years and above and 170,000 children below the age of 15. According to the 2010 MDHS 41% of women reported having experienced either physical or sexual violence. 16% had experienced physical violence only with 13% reporting to have experienced sexual violence only and 12% reporting to have experienced both physical and sexual violence. Recently Malawi developed its National HIV and AIDS Strategic Plan (2015-2020), National HIV prevention strategy (2015-2020) as well as the National Plan of Action to combat GBV.

The project was implemented in Zomba district which is in the southern region of Malawi. Southern region has a higher HIV prevalence that was almost double that of central and Northern regions combined. The ALIVHE project provided an opportunity to SAfAIDS and COHWLA to implement a joint project for the first time where SAfAIDS concentrated on **Male Involvement and Rock Leadership Models** while COWLHA focused their interventions on empowerment of couples and women living with HIV using the **Stepping Stones Model**

The project was designed to contribute to the reduction of GBV and HIV which were considered major human rights threats impacting negatively on people's health, well-being and livelihoods through the attainment of the following specific project objectives:

1. Strengthen community by-laws that promote women's safety and SRHR in the context of HIV and GBV developed and implemented in three TAs of Zomba District by February 2016
2. Support men and boys to contribute to a safe environment for women and girls and ensure gender equality in three TAs in Zomba, by April 2016
3. Increase open communication among couples, women and men around HIV, gender equality and address GBV in three TAs, by April 2016
4. Strengthen monitoring and evaluation systems for data and information generation.

In 2016 SAfIADS and COWLHA carried out a situational assessment to identify root causes of gender based violence and HIV in the three Traditional Authorities of Mwambo, M'biza and Mlumbe indicators in Zomba district. The assessment led to the birth of the project which focused on two themes namely **Gender Norms** and **Policies** and **Laws.** These two main project areas were derived from the WHO 16 ideas for ending violence against women and girls and HIV. Under the broad gender norms theme, the project aimed to address harmful cultural practices and empower women and men with technical skills and knowledge to confidently drive community programmes that address GBV and HIV. While, under the policies and laws' theme, the project aimed at facilitating the capacity enhancement of chiefs and communities to formulate community by-laws against GBV and HIV. The study found out that a higher proportion of the participants about 97% expressed that traditional leaders were critical in protecting women and girls against GBV and HIV, however, these participants also observed that these traditional leaders were playing a pertinent role in addressing issues of gender based violence and HIV due to like enough knowledge and skills. The

baseline also found out that though they were by-laws against gender-based violence in traditional authorities of M'biza and Mlumbe, there was no single by-law in traditional authority Mwambo. Traditional practices and beliefs were on average reported by 36% of the participants to be the common factors that fuel GBV and HIV in the three T/As, and average of 40% indicated that women and girls have less power to negotiate for safer sex as a factor that expose women and girls to GBV and HIV

Overall Purpose of the Final Evaluation:

The overall purpose of the final programme evaluation was to obtain an objective and independent analysis (defined in terms of relevance, effectiveness, efficiency, impact and sustainability) of the programme's implementation and achievements against the proposed objectives and expected results.

Specifically the Evaluation:

a) Reviewed the implementation of the project against planned activities and results.

b) Assessed the effectiveness and impact of the programme in meeting the specific objectives and results defined in the proposal and logframe.

c) Assessed how far the project has contributed to the overall goal outlined in the proposal and logframe.

d) Identified good practices and opportunities that could be replicated or scaled up and make recommendations for Education programming based on the evaluation findings.

Methodology of data collection

Two sources of primary data and information will be examined:

• Firstly, a wide variety of documents covering project design, implementation progress, monitoring and review, baseline report, and other relevant studies, District and National Development Plans, policies/ legislation/ regulations on GBV and HIV among others. • Secondly, face-to-face consultations with a wide range of stakeholders, using "semi-structured interviews" with a key set of questions in a conversational format. The questions asked aimed providing answers to the points described in the following section. Triangulation of results, i.e. comparing information from different sources, such as documentation and interviews, or interviews on the same subject with different stakeholders, was used to corroborate or check the reliability of evidence.

Qualitative data primarily informed this exercise; such data was collected through the use of participatory and rights based approaches including focus group discussions (FDGs) with traditional leaders, adult men and women aged 25-49 years adolescent boys and girls (15 -24 years), and in-depth interviews with key informants (chiefs, support group leaders, CBOs staff, and District level stakeholders). In addition, quantitative data was collected through the administration of a questionnaire with adolescent boys and girls and adults (men and women). Data was collected in all the three selected implementation traditional authorities in Zomba district. 300 individuals were targeted for interviews for quantitative data (100 individuals per TA comprised of 25 men, 25 adult women, 25 boys/young men and 25 girls/young women), 15 FGDs for the 3 TAs (5 FGDs per TA)

Qualitative data collection methods

Participatory Rural Appraisals (PRAs) Tools

As outlined in TORs, the research team employed PRA tools particularly the Seasonal Calendar, Trend Analysis and Community Maps. The seasonal calendar was used to show when certain GBV types occurred during the year in each of the three intervention communities while the community maps was used for community members to show where most GBV cases common occurred including service providers in the intervention sites. To show changes on GBV incidences in the past 1 year and 3 months, community members in each of the three intervention communities were requested to come up with trends analysis graphs which were not necessarily statistical specific but rather showing the generalised perceived trend. In each of the three intervention communities, PRA tools were administered to the following groups separately; 1) adult men aged more than 25 years; 2) adult women aged more the 25 years; 3) young women and girls aged 15 – 24 years; and 4) young men and boys aged 15 – 24 years. After the separate group sessions, participants were then convened into one big group for a plenary session so that there was sharing of knowledge and comparison of findings.

Focus Group Discussions with randomly selected individuals
The following FGDs will be conducted and the FGD participants will be selected randomly:
3 FGDs held with 8-10 traditional leaders and members of the traditional authorities
3 FGDs with 8 - 10 women aged 25-49 years
3 FGDs with 8 - 10 men aged 25-49 years
3 FGDs with 8 - 10 boys/young men aged 15-24 years
3 FGDs with 8 - 10 girls/young women aged 15-24 years
Key Informant Interviews
Data will be collected from at most 5 PLHIV and 5 GBV survivors per TA. Snowballing will be used to identify these two groups.

Quantitative data collection methods
Survey Questionnaire
The survey questionnaire will work as the main tool for quantitative data. The structured questionnaire will be administered using face-to-face interviews to generate quantitative information on individual demographics, perceptions on the capacity and influence of community leaders, men and boys, girls and women to influence communities to ensure gender equality and HIV incidences. A total of 300 individuals (100 individual questionnaires per intervention TA) will be selected randomly to participate in the interviewer administered interviews. 40% 25%adult men, 40% 25%adult women, 25% boys & young men and 25% girls & young women. For variability of data and purposes of data triangulation, FGDs will then be used as a platform for confirming some of the major issues raised in the interviews.

Data Collection Instruments and Data Collection Exercise

Different instruments were designed and pilot-tested for each group of subjects. The instruments were aligned to the project outcomes and indicators. *(see Annex 2)*. The consultant and the research assistant collected all the data from all the above listed subjects

Data Processing and Analysis

SPSS (version 20.0) was used for data entry as well as data analysis. Microsoft Excel was used to plot graphs.

Limitations

There were no major limitations that would affect the results significantly, however the first three limitations were met during the data collection exercise:

- The time allotted for FGDs was varied significantly between groups as a results the time to start administering questionnaires was not enough which led to some research assistants not finishing administering all the targeted number of respondents.

- Because of the condition of the road to Chingale, it took us slightly longer time than we expected which resulted in our late arrival at the venue and this also affected the administration of the survey questionnaire as some members did not finish the allotted copies.

Key Findings

Relevance:

The project significantly aligned with both global and National agenda on ending HIV and AIDS and Action to combat GBV. Globally the project contributed to SDGs' standalone goal (Number 5) on gender equality and the empowerment of women and girls. Underneath this is the target: "eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation." It also supported Sustainable Development Goal (MDG) #3- Ensure healthy lives and promote wellbeing for all at all ages and UNAIDS Fast-Track strategy to end the AIDS epidemic by 2030 . At national level, the project contributed to the National HIV and AIDS Strategic Plan (2015-2020), National HIV prevention strategy (2015-2020) as well as the National Plan of Action to combat GBV. Having aligned itself to global and national agenda, SAFAIDS also did the same at local level by ensuring that it met the needs of the women, girls and communities of the three traditional Authorities where it implemented its project.

Gender based violence posed a considerable risk in the target communities, as evidenced in the baseline report. The project fitted into the District Implementation Plan (DIP) through its contribution to the fight against GBV and HIV in Zomba. By contributing to the DIP and involvement of the stakeholders in Zomba, it is manifestation that the project is considered relevant. The reduction of gender based violence cases from 31% to 17% and improved knowledge on HIV and AIDS transmission and prevention from 27% to 34.7% and an increased knowledge on SRHR amongst women from from 26.8% to 53.2%, 16.4% to 60.7% and 23.7% to 59.6% in the traditional authorities of M'biza, Mwambo and Mulumbe respectively.prove relevance of the project at community level that the project was developed in response to the needs of the beneficiaries in the catchment area.

However, this effort was affected by the fact that the project was not implemented as per plan as evidence from FGDs and KII which revealed that their partner COWLHA did not implement their activities in traditional authority M'biza which made it difficult to compare the strategies/models to choose the best practices. However, there is a high degree of relevance of the project overall, and of all major strategies.

Effectiveness

There were no Men's Clubs in Traditional Authorities Mwambo and M'biza before the project and an influx of GBV cases were being reported directly and mostly to the T/As. By the end of the project, 77 Men's Clubs were established, with 47 men's clubs in T/A M'biza and 30 men's clubs in T/A Mwambo and there were also no women's clubs before the intervention but at the end 6 Women's clubs were established in T/A Mlumbe. The project targeted 2800 males in TAs of Mwambo and M'biza, however, the project ended up reaching out to 4668 males. A 66.7% increase in the number of beneficiaries of the project indicates that more males realised the importance of the project hence

an overwhelming participation from the community members. The use of football matches gathering for awareness and the use of men as champions proved to be an effective way of combating GBV and HIV in the project area. There was a significant decrease in the number of men who agreed that women sometimes deserved to be beaten from 17.3% to 2.3%. There was a reduction in the proportion of women of members of MasPs who agreed to the gender norms that there are times when a woman deserves to be beaten (20.9% **EL**, 39% **BL**), women should tolerate violence to keep her family together 3.6% **EL**, (30.1% **BL**) and it is right for a man to beat his wife when she is unfaithful (24.5% **EL**, 28% **BL**). The varying proportion between men and women who agreed to the gender norm that women sometimes deserve to be beaten is evident that the project reached out to more men than their females counter parts. Though the project was a success, it's take off was delayed for about two months which would have brought in more positive results if it were compensated at the end. More than half (54%) of the community members in the project area demonstrated that they are aware of the ways in which HIV is transmitted and how it can be prevented.

Efficiency

Through its use of innovative project strategies and emphasis on staff capacity development, the project achieved considerable impacts. It did so under significant time and delivering above average value for money in the estimation of this evaluation. Staff capacity was enhanced in a number of ways throughout the project, with skills gained in facilitation, monitoring and evaluation, and general planning and project management. In particular, SAfAIDS insistence upon the thorough training of Community facilitators (champions) paid dividends, in terms of the enthusiastic response of Men's Clubs to the project. YODEP Staff members willingly doubled their workloads to make up for lost time and triple the number of training workshops, to ensure the full implementation of a project they believed in. At the same time, there is scope for improved project management and more equitable distribution of workload.

Considering the fact that the project using MasP model targeted 2800 men and the establishment of 87 MasP Clubs in TAs of Mwambo (47 MasP clubs) and M'biza (40 MasP clubs) through, the cost per beneficially at the end of the project was USD4.15 and MWK2802.40. When compared to the intended cost per beneficially calculated at the inception of the project shows that the cost per beneficiary was the reports show that there was no difference in both USD and MWK. The analysis of the budget structure indicated all the two sub-granted organisations paid for the operational cost (USD300; MWK203,058.02) and funding from SAfAIDS (USD11,625; MWK7,846,875.00) was used for activity costs. All of the activities were implemented with minor delays and re-allocation of funds. Still, the approved budget did not provide sufficient information on budget categories- for example, budget categories "technical assistance" or "monitoring and evaluation". While for the Stepping Stone model targeted 40 trainers of trainers and 380 couples in both TA M'biza and Mlumbe, the cost per beneficiary was USD64.29 and MWK43,392.86. The cost per beneficiary under stepping stone model was higher compared to the cost per beneficiary under MasP model because the cost of training of trainers in Stepping stone was pegged USD375 and MWK253,125.00 per beneficiary which used 55.56% of the total budget.

The ratio of the cost for administration to the cost for results could not be computed as data was not available on how much was for administration or technical support and how much was used for the stepping stone model. However, the fact that almost all funds were spent on implementing project activities confirms that funds were efficiently spent on intended objectives.

Impact

With the reduction of in cases of gender based violence from 31% during baseline to 17% during endline across the project area and the establishment of 77 MasP clubs in the communities in T/A M'biza and Mwambo whose members (4668) have been trained in GBV and HIV prevention, it

means more women and girls are now living safely in their homes. This clearly testifies the contribution made by the project in fighting gender based violence in these traditional leaders. The testimony of more women and men from 16.9% during baseline to 34.1% during endline who reported knowledge of at least three ways of HIV prevention suggests that the intervention had a transformative impact on behaviours and relationships. From a gender perspective, a significant increase in knowledge on SRHR amongst women from from 26.8% to 53.2%, 16.4% to 60.7% and 23.7% to 59.6% in the traditional authorities of M'biza, Mwambo and Mulumbe respectively and these changes have addressed issues of equity, by improving the conditions of women, in terms of their freedom from violence, reduced workloads and reports more communicative and supportive emotional relationships with partners and across all family members. This strategy (men as champions) also shows evidence of addressing women's strategic interests, by starting to address the structures that oppress women – the establishment of the 77 MasP Clubs to fight GBV and HIV. This is seen in reports of women's involvement in decision making about and control of household resources. There are risks of gains to women's protection and empowerment being lost unless there are also clubs for women that would complement men's effort in the fight against GBV and HIV, particularly on issues of management of community conflicts as evidenced by the establishment of only 6 women's clubs as compared to 77 MasP clubs.

Sustainability

There was strong evidence that communities will continue with the interventions. The community structures Men's Clubs were empowered through training which enabled them to understand their roles and responsibilities. During the FGD, participants requested for mobility means like Bicycles to enable the champions to reach out to many families when there is a call for their intervention. These community structures have the potential to sustain the activities that they undertook when they were supported by SAFAIDS through YODEP. During the FGD, they indicated that they develop their plans and find means of implementing without depending or waiting for YODEP which is a strong signal that they have taken over the responsibility to protect women and girls from GBV and HIV. Having T/As and GVHs as patrons also ensures that at community level the community structures will always have the support that they require to function effectively. The mutual understanding between the Men's Clubs and the community leadership is in itself a strong bond that will always be there even without external stakeholders. As such the enforcement of community by-laws that were formulated would also enable the champions to function effectively.

The knowledge and skills imparted to champions on using men as protectors (Abambo ngati atetezi) will make the battle against gender based violence (GBV) and the spread of HIV a success as they send a thief to catch a thief. Once all men who have been perpetrating violence have been transformed, other would be culprits of GBV are likely to be motivated and refrain from GBV which would also lead to reduction in the spread of HIV.

Lessons learned

In summary, SAFAIDS has found an effective way to shift norms in communities to prevent GBV and HIV, as well as within GBV response services. However, there was need for SAFIADS to have more time for these prevention and response activities, and in making sure that the impact/gains of the interventions to women's protection and empowerment are efficiently monitored and to ensure that they become entrenched through a critical mass of community networks. Furthermore, there is to scale up on future campaigns bearing in the impact of the project within limited time frame.

The football tournament no doubt contributed to high participation of those who agreed to participate but the total number of participants was still relatively low. Future work might explore ways to reach more men by focusing more on existing community football leagues for example. Future work might also consult with community members to determine if football is the preferred sport or there are other sporting activities that would attract more patronage.

Recommendations

Based on the project achievements and in view of continuation of the efforts in the area of combating GBV and HIV, the consultant submits the following recommendations for consideration:

Trainings and relevant activities aiming at GBV and HIV sensitisation in the three TAs should continue:

- Bring in family role models (males who were at the herm of beating their wives but through the project they have stopped and members of the community have witness the transformation taking place in such a family) to their communities apart from the champions.
- The MasP Clubs and Women Clubs within the three traditional Authorities should continue operating as the strong policy and monitoring capacity, in ensuring that protection of women and girls against GBV and HIV is consistently promoted throughout the intervention area.
- Scale up Men as protectors (MasP) strategy by extending into social networks and neighbouring communities through organized diffusion, to create a critical mass and consolidate shift in social norms. And consider coming up with Women's Club as well to complement MasP's Clubs if the battle against GBV and HIV is to be successfully won.
- Continue training of community leaders empowering them on violence against women and gender equality so as to be a powerful voice for the messages and programs, as well as through resources not much has been done on this– both educational and financial. Creating a positive message via multiple points of entry within communities is critical to ongoing efforts to scale up programs at local and national levels.

Strengthen community by-laws and effectiveness in that promotion of women's safety and SRHR in the context of HIV and GBV:

- Build upon strong community support for the intervention to facilitate women's collective empowerment and rights awareness and taking advantage of the already existing by-laws and policies.
- Strengthen capacity of existing MasP club members in formulation and enforcement of sustainable by-laws and policies that are aimed at protecting women and girls against GBV and HIV.
- In some Men's Clubs, there were weak members who were selected because of their capability to lobby for positions. A selection criterion should be developed stipulating qualities of who can be a member of the executive team.

Strengthen monitoring and evaluation systems for data and information generation:

- Even though current management approach ensured high quality results, the key stakeholders did observe some gaps in the coordination and communication among the two implementing partners during the activities. It is highly recommended in the future to put a management system in place with a clear role for the Project Managers and Partners. It will enable projects to depend less on individual abilities, capacities and engagement but more on well-established roles and responsibilities within the team. Probably it would be better for partners to enter into a signed agreement to make sure each partner understands their role in the whole project.

- Specifically, the future monitoring system for similar projects should: i) provide objective, verifiable evidence of progress towards and achievement of results and objectives; ii) enable insights to be drawn and shared about what worked well or what did not work well and why that was the case; iii) enable reflection on the context in which the Project is being implemented and how this affects programming and iv) provide the basis for fine-tuning, reorienting and planning future development efforts in the gender based violence sector.

- The quality of reporting system within the GBV project was not very satisfactory, some discrepancies were recorded between very strategic and more activity focused parts. For the next project, it is recommended to use best guidance to strengthen reporting and prepare more strategic reports as the reports were not clear and some important information were missing.

- Share lessons learned from this project with other actors working on gender in Malawi and beyond, find out about the existence of similarly transformative approaches in-country and agree upon best practices.

- Considering the success of the GBV project, it is highly recommended to engage a Project manager with a solid technical knowledge in gender and gender based violence.

1.0 BACKGROUND

1.1 Introduction

Malawi is among the countries most affected by the HIV epidemic. According to the 2010 Malawi Demographic Health Survey (MDHS) data, national HIV prevalence was 10.6% amongst 15-49 year olds and was higher among women (13%) than men (9%) reflecting a widening gender gap between men and women. The largest disparity was in the 15-19 years age group with 1.3 % in males as opposed to 4.2 in females. The number of people living with HIV (PLHIV) was estimated at about 1,000,000 which included 850,000 people aged 15 years and above and 170,000 children below the age of 15. According to the 2010 MDHS 41% of women reported having experienced either physical or sexual violence. 16% had experienced physical violence only with 13% reporting to have experienced sexual violence only and 12% reporting to have experienced both physical and sexual violence. Recently Malawi developed its National HIV and AIDS Strategic Plan (2015-2020), National HIV prevention strategy (2015-2020) as well as the National Plan of Action to combat GBV.

The project was implemented in Zomba district which is in the southern region of Malawi. Southern region has a higher HIV prevalence that was almost double that of central and Northern regions combined. The ALIVHE project provided an opportunity to SAfAIDS and COHWLA to implement a joint project for the first time where SAfAIDS concentrated on **Male Involvement and Rock Leadership Models (MasP)** while COWLHA focused their interventions on empowerment of couples and women living with HIV using the **Stepping Stones Model.**

The project was an operational research project where the two models were implemented in two different locations (TA's) and then combined in one location (TA) to generate some lessons on which approach produce the best results in relation to violence against women and HIV. The project targeted three TAs namely, M'biza, Mlumbe and Mwambo. In Traditional Authority Mwambo the project was being implemented using the MasP (Abambo ngati atetezi) model only and in Traditional Authority Mulumbe the project was implemented using the Stepping Stone Model (Tiwoloke) only while in Traditional Authority M'biza, the project was to be implemented using both the MasP and Stepping Stone Models. The overall project goal was: **to reduce HIV and GBV incidences in three Traditional Authorities (TAs) of Zomba District** in Malawi, by March 2016 but later it was extended to December 2016 due the delay in disbursement of funds for the project. SAfAIDS partnered with COWHLA to reach out to the targeted populations. The project mainly focuses on HIV, GBV, SRHR, policies and laws that protect women and girls from GBV and HIV as well as gender norms. The project was also meant to strengthen community-based interventions targeting young adolescent girls and women, PLHIV as well as men and boys in order to reduce GBV and HIV incidences in the three TAs in Zomba District in Malawi. The project was to ensure that women and girls were empowered to respond to and were protected from GBV and HIV.

The project was designed to contribute to the reduction of GBV and HIV which were considered major human rights threats impacting negatively on people's health, well-being and livelihoods through the attainment of the following specific project objectives:

5. Strengthen community by-laws that promote women's safety and SRHR in the context of HIV and GBV developed and implemented in three TAs of Zomba District by February 2016

6. Support men and boys to contribute to a safe environment for women and girls and ensure gender equality in three TAs in Zomba, by April 2016

7. Increase open communication among couples, women and men around HIV, gender equality and address GBV in three TAs, by April 2016

8. Strengthen monitoring and evaluation systems for data and information generation.

In 2016 SAfAIDS and COWLHA carried out a situational assessment to identify root causes of gender based violence and HIV in the three Traditional Authorities of Mwambo, M'biza and Mlumbe indicators in Zomba district. The assessment led to the birth of the project which focused on two themes namely **Gender Norms** and **Policies** and **Laws.** These two main project areas were derived from the WHO 16 ideas for ending violence against women and girls and HIV. Under the broad gender norms theme, the project aimed to address harmful cultural practices and empower women and men with technical skills and knowledge to confidently drive community programmes that address GBV and HIV. While, under the policies and laws' theme, the project aimed at facilitating the capacity enhancement of chiefs and communities to formulate community by-laws against GBV and HIV. The study found out that a higher proportion of the participants about 97% expressed that traditional leaders were critical in protecting women and girls against GBV and HIV, however, these participants also observed that these traditional leaders were playing a pertinent role in addressing issues of gender based violence and HIV due to like enough knowledge and skills. The baseline also found out that though they were by-laws against gender based violence in traditional authorities of M'biza and Mlumbe, there was no single by-law in traditional authority Mwambo. Traditional practices and beliefs were on average reported by 36% of the participants to be the common factors that fuel GBV and HIV in the three T/As, and average of 40% indicated that women and girls have less power to negotiate for safer sex as a factor that expose women and girls to GBV and HIV

The final evaluation was conducted by an external consultant to determine the extent to which the programme had achieved its goal since inception in October 2015. The consultant undertook a combination of methods which aimed at soliciting both quantitative and qualitative data. Questionnaires were specifically designed to solicit quantitative responses in line with key indicators of the project. Selected Key Informant Interviews (KIIs) and Focus Groups Discussions (FGDs) were also conducted with Village Heads, Men (25-50+), Women (25-50+), Girls (15-24) and Boys (15-24), Survivors and PLWH and T/As, GVHs Champions and finally project officers. The results were then compared with the baseline indicators collected from the same area in 2016.

1.2 Overall Purpose of the Final Evaluation:

The overall purpose of the final programme evaluation was to obtain an objective and independent analysis (defined in terms of relevance, effectiveness, efficiency, impact and sustainability) of the programme's implementation and achievements against the proposed objectives and expected results.

Specifically the Evaluation:

e) Reviewed the implementation of the project against planned activities and results.

f) Assessed the effectiveness and impact of the programme in meeting the specific objectives and results defined in the proposal and logframe.

g) Assessed how far the project has contributed to the overall goal outlined in the proposal and logframe.

h) Identified good practices and opportunities that could be replicated or scaled up and make recommendations for Education programming based on the evaluation findings.

1.3 Methodology of data collection

Two sources of primary data and information will be examined:

• Firstly, a wide variety of documents covering project design, implementation progress, monitoring and other studies, District and National Development Plans, policies/ legislation/ regulations on GBV and HIV among others were reviewed. • Secondly, it was face-to-face consultations with a wide range of stakeholders, using "semi-structured interviews" with a key set of questions in a conversational format. The questions asked aimed to provide answers to the points described in the following section. Triangulation of results, i.e. comparing information from different sources, such as documentation and interviews, or interviews on the same subject with different stakeholders, was used to corroborate or check the reliability of evidence.

Qualitative data primarily informed this exercise; such data was collected through the use of participatory and rights based approaches including focus group discussions (FDGs) with traditional leaders, adult men and women aged 25-49 years adolescent boys and girls (15 -24 years), and in-depth interviews with key informants (chiefs, support group leaders, CBOs staff, and District level stakeholders). In addition, quantitative data was collected through administration of a survey questionnaire with adolescent boys and girls and adults (men and women). Data will be collected to all the three selected implementation traditional authorities in Zomba district .300 individuals were targeted for interviews for quantitative data (100 individuals per TA comprised of 25 men, 25 adult women, 25 boys/young men and 25 girls/young women), 15 FGDs for the 3 TAs (5 FGDs per TA). However, only 214 individuals were reached due to time constraints.

Qualitative data collection methods

Participatory Rural Appraisals (PRAs) Tools

As outlined in TORs, the research team employed PRA tools particularly the Seasonal Calendar, Trend Analysis and Community Maps. The seasonal calendar was used to show when certain GBV types occurred during the year in each of the three intervention communities while the community maps was used for community members to show where most GBV cases common occurred including service providers in the intervention sites. To show changes on GBV incidences in the past 1 year and 3 months, community members in each of the three intervention communities were requested to come up with trends analysis graphs which were not necessarily statistical specific but rather showing the generalised perceived trend. In each of the three intervention communities, PRA tools were administered to the following groups separately; 1) adult men aged more than 25 years; 2) adult women aged more the 25 years; 3) young women and girls aged 15 – 24 years; and 4) young men and boys aged 15 – 24 years. After the separate group sessions, participants were then convened into one big group for a plenary session so that there was sharing of knowledge and comparison of findings.

Focus Group Discussions with randomly selected individuals
The following FGDs were conducted and the FGD participants were selected randomly:
3 FGDs held with 8-10 traditional leaders and members of the traditional authorities
3 FGDs with 8 - 10 women aged 25-49 years
3 FGDs with 8 - 10 men aged 25-49 years
3 FGDs with 8 - 10 boys/young men aged 15-24 years
3 FGDs with 8 - 10 girls/young women aged 15-24 years
Key Informant Interviews -data was collected from at most 5 PLHIV and 5 GBV survivors per TA. Snowballing was used to identify these two groups.

Quantitative data collection methods
Survey Questionnaire
The survey questionnaire worked as the main tool for quantitative data. The structured questionnaire were administered using face-to-face interviews to generate quantitative information on individual demographics, perceptions on the capacity and influence of community leaders, men and boys, girls and women to influence communities to ensure gender equality and HIV incidences. A total of 214 individuals were selected randomly to participate in the interviewer administered interviews. 25% adult men, 25% adult women, 25% boys & young men and 25% girls & young women. For variability of data and purposes of data triangulation, FGDs were then be used as a platform for confirming some of the major issues raised in the interviews.

1.4 Data Collection Instruments and Data Collection Exercise

Different instruments were designed and pilot-tested for each group of subjects. The instruments were aligned to the project outcomes and indicators. *(see Annex 2)*. The consultant and the research assistant collected all the data from all the above listed subjects

1.5 Triangulation

Information collected from the key informant interviews, focus group discussions and lesson observation was cross-checked for consistency and accuracy by proper designing of questions in the questionnaire (using questions to check consistency of the respondent), asking the same key questions, and through observations.

1.6 Data Processing and Analysis

SPSS (version 20.0) was used for data entry as well as data analysis. Microsoft Excel was used to plot graphs.

1.7 Limitations

There were no major limitations that would affect the results significantly; however the first three limitations were met during the data collection exercise:

- The time allotted for FGDs was varied significantly between groups as a results the time to start administering questionnaires was not enough which led to some research assistants not finishing administering all the targeted number of respondents.

- Because of the condition of the road to Chingale, it took us slightly longer time than we expected which resulted in our late arrival at the venue and this also affected the administration of the survey questionnaire as some members did not finish the allotted copies.

2.0 KEY FINDINGS

2.1. Demographics

A total of four (4) groups of community members participated in the household survey which targeted 25% men aged between 25-50+ years ; 25% boys aged between 15-24 years; 25% women aged between 25-50+ years and 25% girls aged between 15-24 years, all from three (3) Traditional Authorities(T/As) from the project catchment area. Table 1 below shows the summary of the demographic characteristics (n=214).

Table 1: Demography

Sex	
Men	96 (44.84%)
Women	118 (55.16%)
Age	
Range	15-65
Mode	20
Mean	26.14
Marital Status	
Single	95 (45.9%)
Married	100 (46.9%)
Divorced	14 (5.6%)
Widow/widower	5 (2.3%)
Female Headed Household	
No	132 (62.0%)
Yes	82 (38.0%)
Religion	
Muslim	63 (29.4%)
Christian	151 (70.6%)
African Tradition Religion	0 (0%)
Other	0 (0%)
Traditional Authority	
Mwambo	56 (29.2%)
M'biza	79 (41.1%)
Mlumbe	57 (29.7%)

2.2 HIV and SRHR Knowledge

Knowledge on HIV Transmission by Traditional Authority

The endline results show an impact on knowledge on how HIV is transmitted. Survey results indicate that following the intervention there was a 7.6% increase in the proportion of respondents with comprehensive knowledge of ways in which HIV can be transmitted, in total sample across all the

TAs, 34.7% were able to identify three or more correct ways in which HIV can be transmitted as compared to 27% during baseline. There was also a significant increase in proportion of respondents from 23% during baseline to 31.2% during endline in M'biza who were able to identify three or more correct ways of HIV transmission compared 1% increase in Mlumbe (from 27% during BL to 28.3% during EL) and a 3.6% increase in Mwambo (from 30% during BL to 33.6% during EL). There were no significant knowledge differences across the TAs and also where MasP and Stepping stone models were only used and where the two models were combined with p-value =0.828

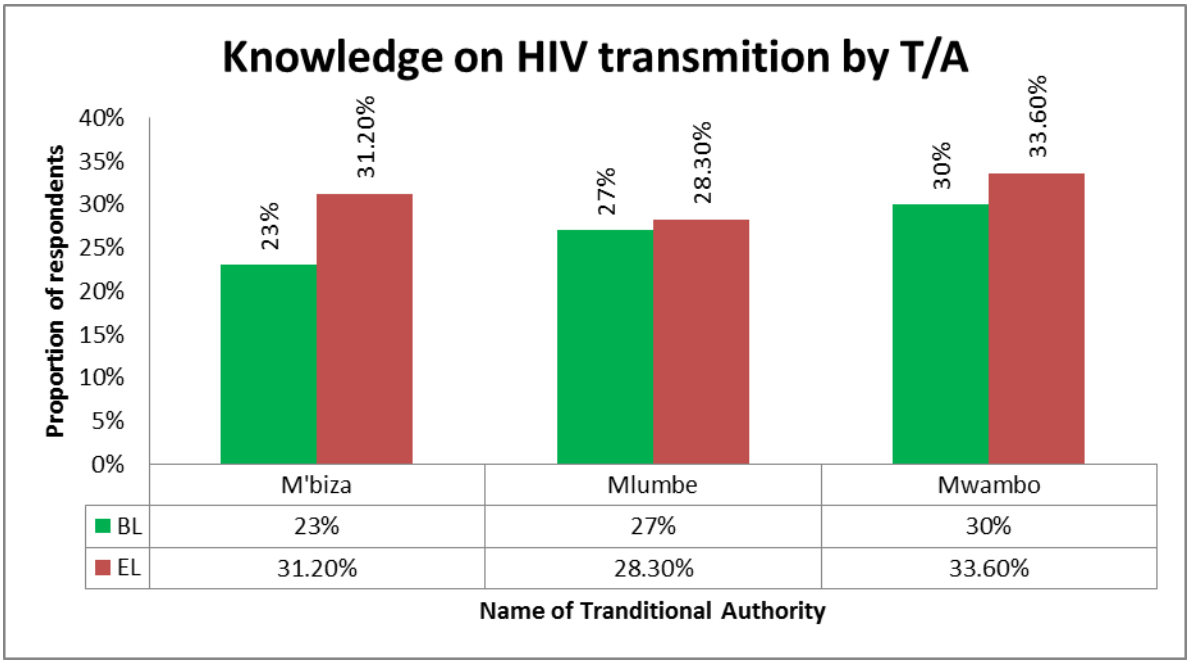


FIG 1: Respondents who were able to identify at least 3 factors in which HIV is transmitted

Knowledge on HIV and SRHR among the adolescents 15-24 years, adults 25-50 years

Endline results show impact on HIV most transmission methods with significant increases in youth groups; for age group 15-19 years (26.3% BL to 36.8% EL); for age group 20-24 years (19.1% BL to 29.4% EL) and there was a decrease in proportion in term knowledge for the age group 25-50+ years (44.1% BL to 39.4% EL), the decrease in proportion of respondents who were able to identify at least three HIV most transmission methods. The decrease for the age group of 25-50+ years could be attributed to the fact that mostly football tournaments where messages on GBV and HIV were being shared were patronised by young people. However, knowledge on HIV most transmission methods is not different between age groups, except when transmission of HIV through breastfeeding, injecting drug use and blood transfusion are taken into account. Most respondents (16.8%) in the age group of 15 to 24 years are less aware that HIV can be transmitted through breastfeeding compared to their counterpart age 25 years and above at 30.8% (p-value<0.05). Similarly blood transfusion is less known among the 15 to 24 year olds (29.9%) as a method for HIV transmission compared to 25 and above year olds (46.2%). The knowledge gap in injecting drug use as an HIV transmission method is even more pronounced statistically (p-value<0.01). Younger respondents are less aware of this method (12.1%) than older respondents (29.5%).

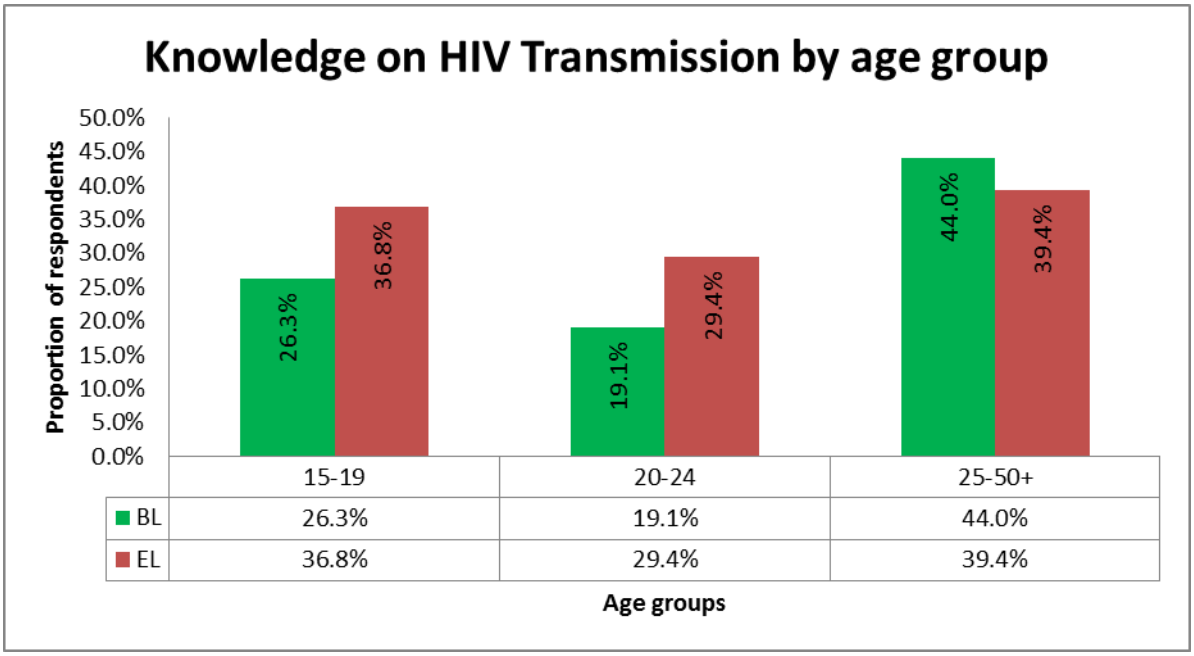


FIG2: Proportion of respondents who were able to identify at least 3 methods in which HIV is transmitted by age group

Comprehensive knowledge of ways HIV can be transmitted,

Results from the endline show no significant difference in the proportion of respondents who indicated having unprotected sex with person living with HIV as a method of HIV transmission with 94.4% during BL against 98.6% during EL. But the results show a significant increase of 21.8% in the proportion of respondents who mentioned sharing 'contaminated' sharp objects can transmit HIV from 75.5% during BL to 95.3% during EL. The results also show impact on knowledge on HIV being transmitted through mother-to-child transmission at birth, Transmission of HIV during breast feeding and blood transfusion with significant increases from 30.5% BL to 47.4% EL, 14.1% BL to 22.3% EL and 13.7% BL to 36% . Figure 3 shows commonly known HIV transmission methods.

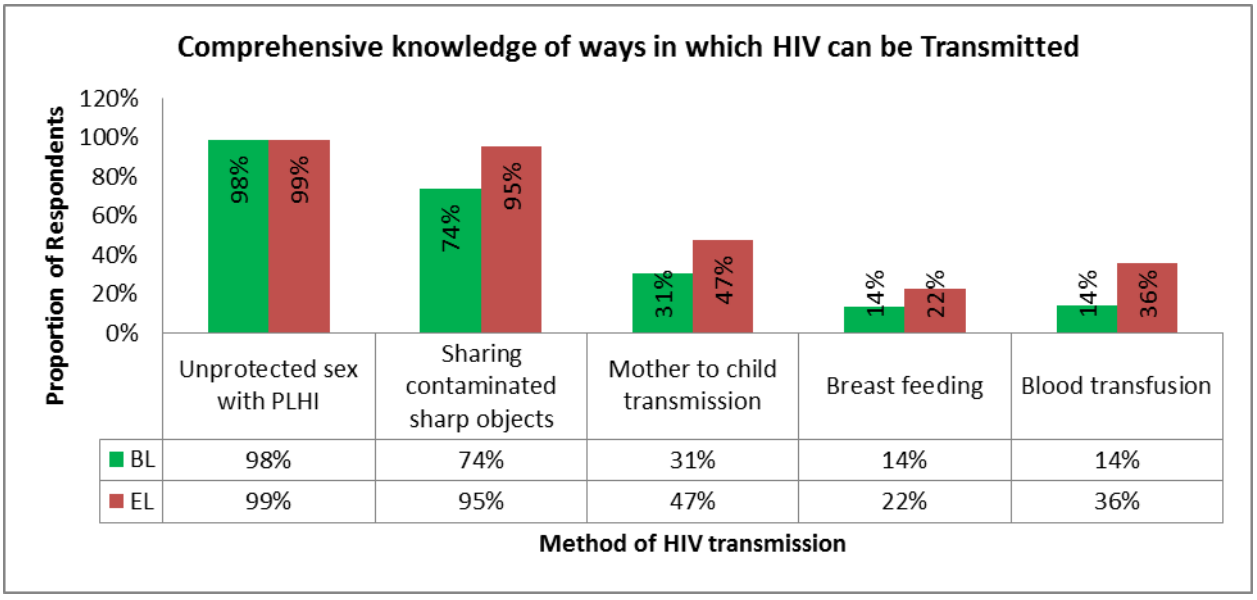


Figure 3: Commonly known HIV transmission methods.

Comprehensive Knowledge of ways in which HIV can be prevented, by sex

Figure 4 shows comprehensive knowledge of HIV prevention, disaggregated by sex for both the baseline and endline assessments. This indicative significant increase in the values during the endline assessment shows that the intervention had an impact on knowledge of HIV prevention methods on both male and female respondents. The increase in proportion of respondents with knowledge of at least three methods of preventing HIV meant a decrease in proportion of respondents with knowledge of two or less methods of HIV prevention. Chi-square p-values were used to determine whether respondents' knowledge on HIV prevention was different between males and females. Looking at each transmission method independently the p-values which are all greater than 0.05, demonstrated that knowledge was similar between males and females during the endline assessment. There were no significant differences across sex with p-value=0.345.

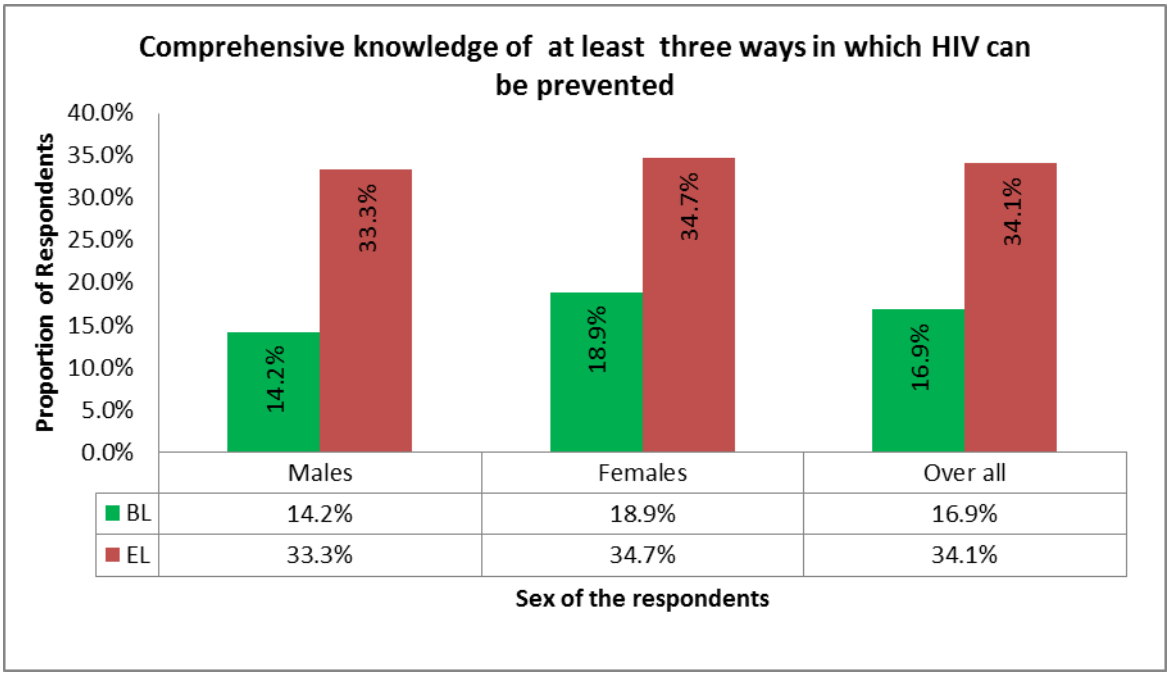


Fig4: Proportion of participants with comprehensive knowledge on how HIV can be prevented by sex

Comprehensive knowledge of ways in which HIV can be prevented

Figure 5 shows that there was an increase in comprehensive knowledge of HIV prevention across all the prevention methods during the endline assessment. This dramatic increase in the knowledge levels in 2016 than the baseline year 2015 means that a lot of work was done which resulted in an increase in knowledge level. Both project officers and also community members did their part which contributed to such results. The efforts of SAfAIDS in making YODEP officers use Men as Protectors (MasP) and Stepping stone models, coupled with the introduction of a football tournament, contributed to meaningful learning that resulted in increased HIV awareness gains that led to the increased in the knowledge levels.

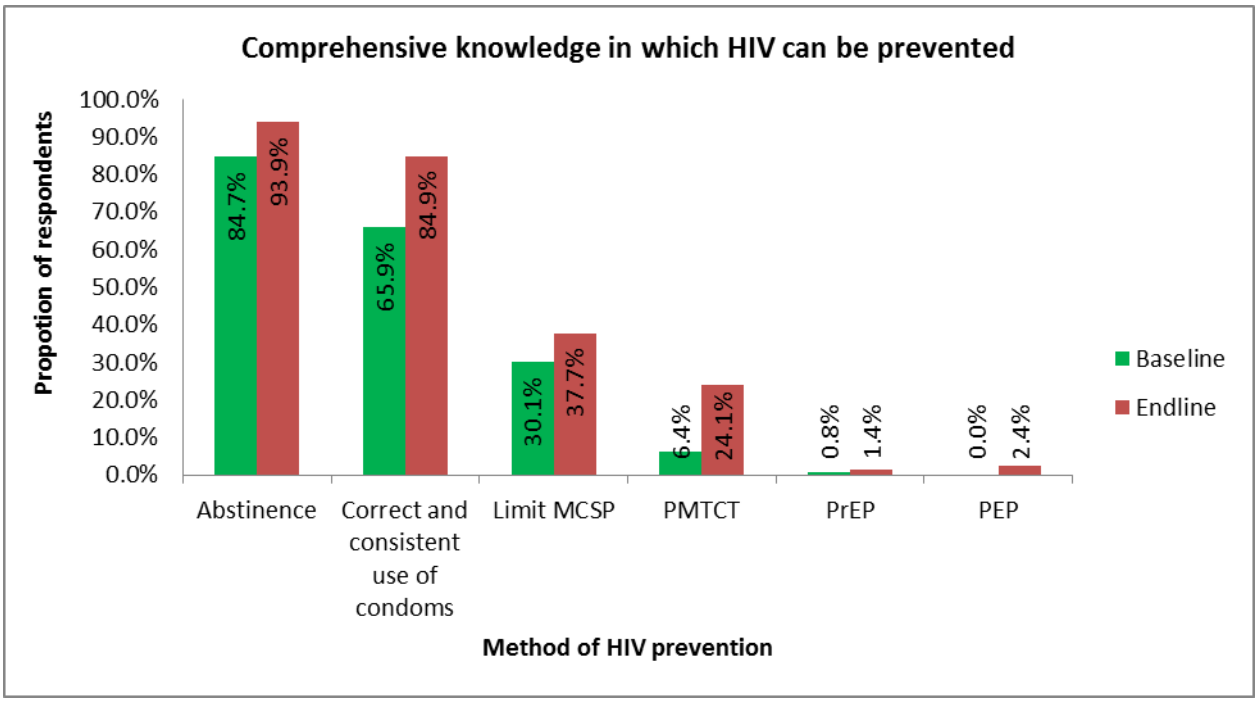


Fig5: Proportion of participants with comprehensive knowledge in which HIV can be prevented

Common knowledge of sexual reproductive health rights, by Traditional Authority

On knowledge on SRHR, Community members were assessed on their level of knowledge on SRHR in the context of HIV. The results show that there is an increase in knowledge level on SRHR amongst the respondents comparing the baseline and the endline values which surged from 26.8% to 53.2%, 16.4% to 60.7% and 23.7% to 59.6% in the traditional authorities of M'biza, Mwambo and Mulumbe respectively. The most significant impact was observed in Traditional Authority Mwambo with a 44.3% increase in knowledge level on SRHR for respondents who were able to identify at least three (3) SRHR. As shown in **figure 6** below, the values at the baseline were doubled during the endline assessment, however, it would be quick to attribute this dramatic increase in the knowledge level to the interventions by SAFAIDS and COWLHA because it was indicated during the baseline that within the catchment area of the project, there were already other organizations which were also working on GBV and HIV. The fact that the level of knowledge on SRHR has increased testifies that the project interventions had an impact in the catchment area. There were no significant differences across the models and also where the models were combined with p-value = 141.

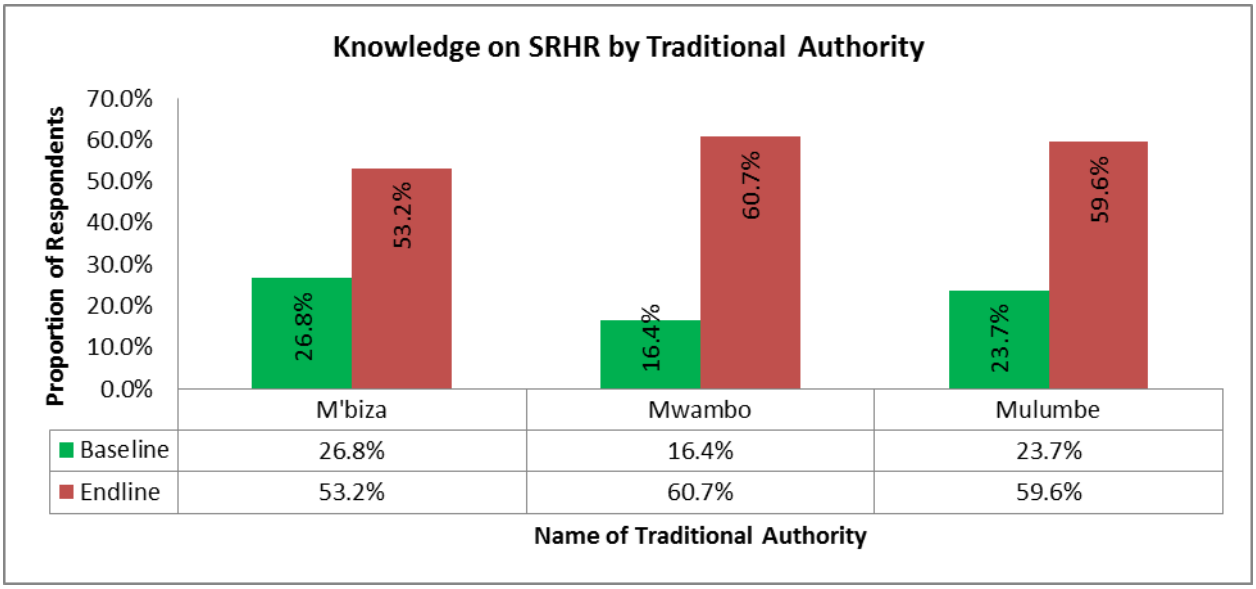


Fig 6: Proportion of respondents with comprehensive knowledge on SRHR by T/A

Comprehensive knowledge of sexual reproductive health rights, by Sex

Figure 7 below shows that there was an impact as evidenced by the significant increase in the proportion of respondents with comprehensive knowledge on sexual reproductive health rights, as disaggregated by sex. The results also show that the proportion of males respondents with comprehensive knowledge on SRHR had gone up from 26% during the baseline to 62.5% during the endline and while that of females had gone up from 20.3% to 40.8%. As indicated in figure 6 above, these positive results would not be entirely attributed to the intervention of the ALIGHT project since the project found some players already in the catchment area who were implementing projects focusing on the same problem, with the only difference in the models of implementation. The results show a significant difference in knowledge levels between males and females with p-value =0.023

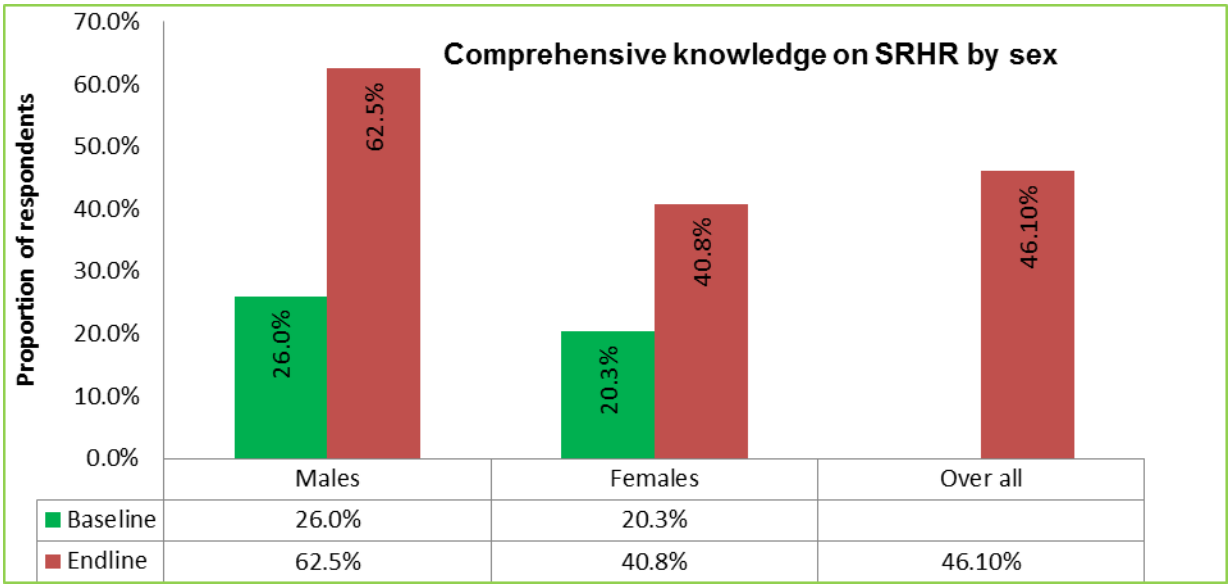


Fig 7: Proportion of respondents who have knowledge of at least three SRHR by sex

Comprehensive knowledge of sexual reproductive health rights, by Age

Just like the other forgoing figures 6 and 7, Figure 8 also shows a dramatic increase in comprehensive knowledge of sexual reproductive health rights, as disaggregated by age group. This significant increase in the level of comprehensive knowledge across all the groups could not be totally attributed to the implementation of the ALIGHT project as the impact is just so overwhelming taking into consideration the period that the project was implemented. This increase in values of the baseline by almost doubling during the endline assessment in groups of 15-19 and 2014, and then tripling in group of 25+ respondents, might have other factors at play for example the stratification of the sample size (where 25% of each group was interviewed) during endline assessment and secondly the presence of other NGOs working in the same area focusing on the same problems though using different approaches might have also contributed to the positive impact. There were no significant differences across the age groups in terms of knowledge on SRHR with p-value =0.452.

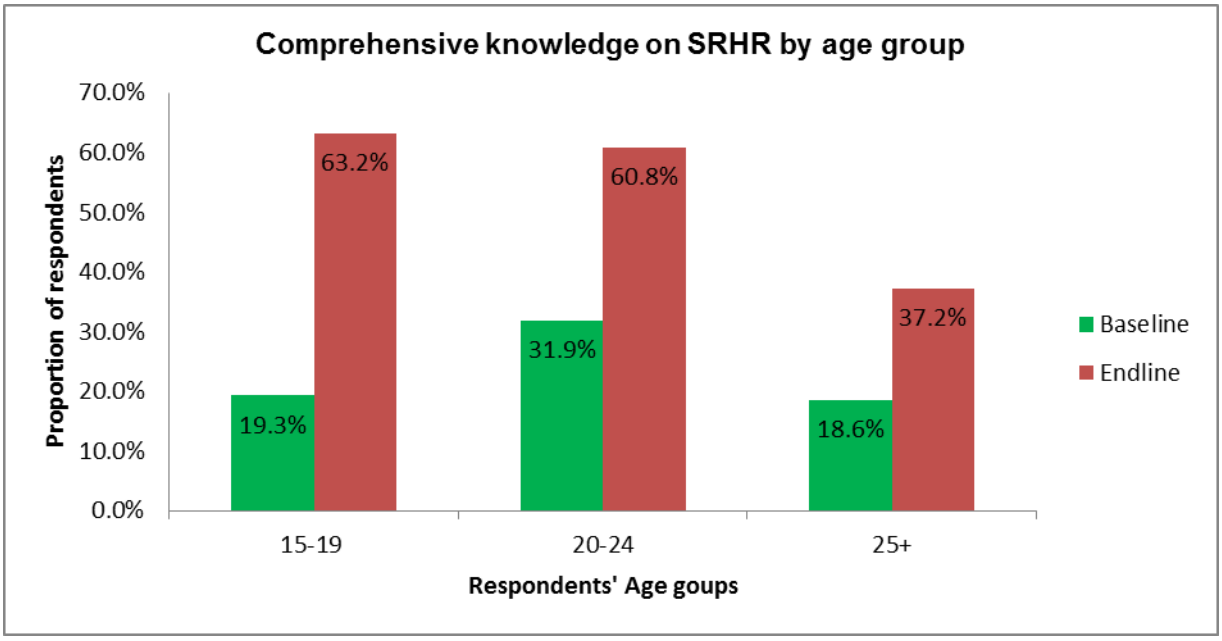


Fig 8: Proportion of respondents with comprehensive knowledge on SRHR by age group

2.3 Local Post-GBV and HIV Services Providers

Respondents in the community who know where to Access HIV and GBV Services

Figure 9 below shows the respondents who demonstrated knowledge of where to access HIV and GBV services in the community before and after the implementation of the project. Endline results show that there was a dramatic increase in the proportion of respondents who knew where to access GVB and HIV services within the community. There was a **20.1%** increase in number of respondents (from 78.5% during BL - 98.6% during EL) who knew a place in the community where to get HIV testing services. The results also show a **33.3%** increase in the number of respondents (from 61.1% during BL - 94.4% during EL) who demonstrated knowledge of a place in the community where someone could receive ART services. Further, results also show that there was a **39.4%** increase in the number of respondents (from 55.1% during BL- 94.5% during EL) who showed knowledge of a place in the traditional authorities where one could access post-GBV services like Counseling. An increase of about **22.3%** in the number of respondents (from 45.3% during BL-67.6% during EL) was also shown amongst those who demonstrated knowledge of a place in all the traditional authorities where to access post GBV services like PEP while an overwhelming increase of about **67.8%** in the proportion of respondents was shown amongst those who demonstrated knowledge on post-GBV (legal services) from 28.7% during baseline to 96.5% during endline. The results show that the

project had an impact since most respondents were able to demonstrate knowledge of where to access post GBV legal services during the endline as compared to the baseline.

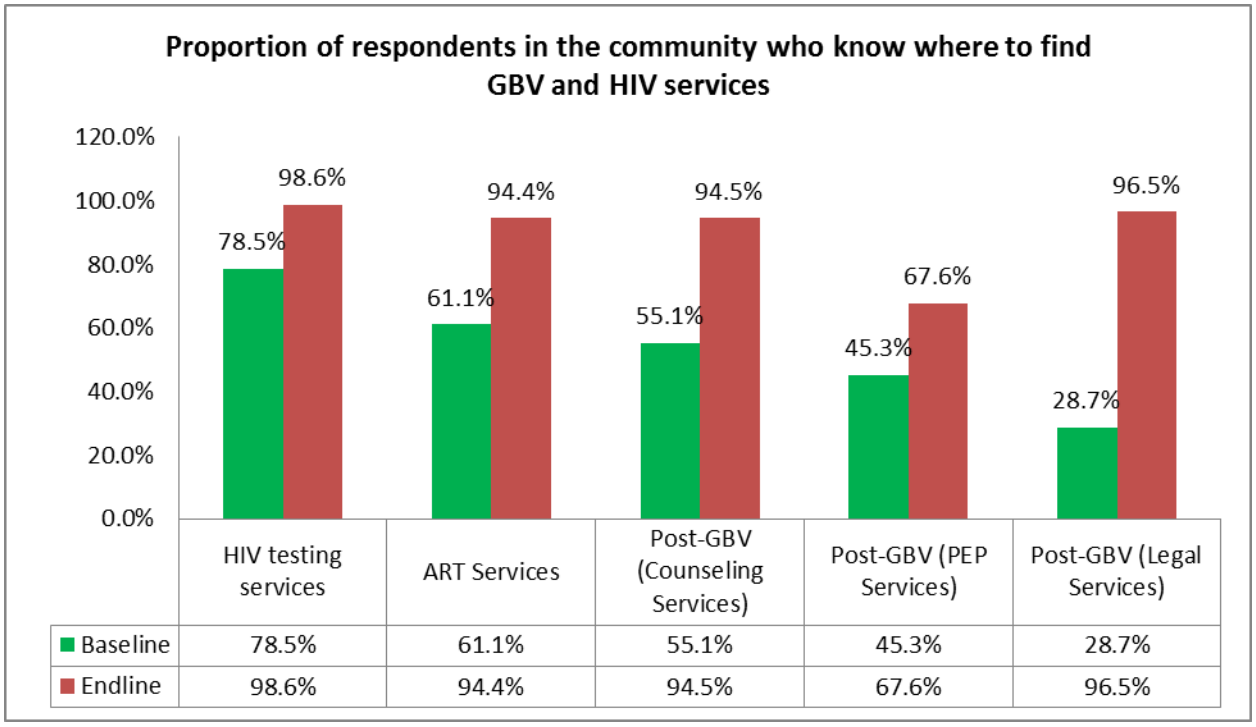


Fig 9: Respondents who know where to access GBV and HIV services in the communities

2.4 Factors that expose women and girls to GBV and HIV by Traditional Authority

Table 2 shows that there is positive shift and most community members in all the three T/As have come to realize that some traditional practices and beliefs play a greater role in exposing women and girls to GBV and HIV. The results also show no significant difference across the three T/As and the shift is positive which give room to women and girls to have power to negotiate safe sex. This is a rejection of the deeply rooted norms that portly women as powerless against safe sex negotiation. Endline results also show that there is also a positive shift which shows that masculine attribute that men can have multiple sex partners is being rejected and most men through the intervention of the project have realized that such behaviour would risk their contracting HIV and it is source of GBV. The endline assessment also show that there is a positive shift on tradition practice of encouraging early marriages where most community members have indicated that it is one of the factors that exposes girls to GVB and HIV.

Factors	Mbiza TA		Mlumbe TA		Mwambo TA		P-value	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Traditional practices and beliefs	30.1%	74.7%	37.1%	67.9%	41.8%	54.4%	0.029	**0.045**
Women and girls have less power to negotiate for safe	51.8%	36.7%	32%	32.1%	35.8%	19.3%	0.005	0.086

sex								
Men are allowed to have multiple concurrent sexual partners	27.7%	34.2%	24.7%	39.3	13.4%	36.8%	0.023	0.829
Child pledging due to hunger or spiritual appeasement	15.7%	22.8%	15.5%	12.5%	17.9%	14%	0.079	0.223
Intergenerational relationship	14.5%	7.6%	11.3%	10.8%	14.9%	1.8%	0.070	**0.045**
Child marriages	12%	62%	5.2%	76.8%	9%	57%	0.033	0.082
Religious beliefs and practices	3.7%	31.6%	7.2%	12,5%	6%	40.4%	0.063	**0.003**

Table 2

2.5 Participation of Traditional Leaders, Men, Boys, Women and Girls in Protection of Women and Girls against GBV and HIV

Perceived roles and capacities of traditional leaders in Protecting Women and Girls against GBV and HIV

When community members were asked whether traditional leaders are critical in addressing GBV and HIV, almost all (96.5% during EL from 97.2% during BL) respondents maintained their stand that traditional leaders are very critical in addressing issues of GBV and HIV. The slight shift in the perception was statistically insignificant. There were insignificant differences across the T/As on the standing on T/As criticality on GBV and HIV. The figure 9 below shows the comparison between the baseline values and endline value on community members standing about their traditional leaders and the fight against GBV and HIV. There were no significant differences across the models with p-value=0.122.

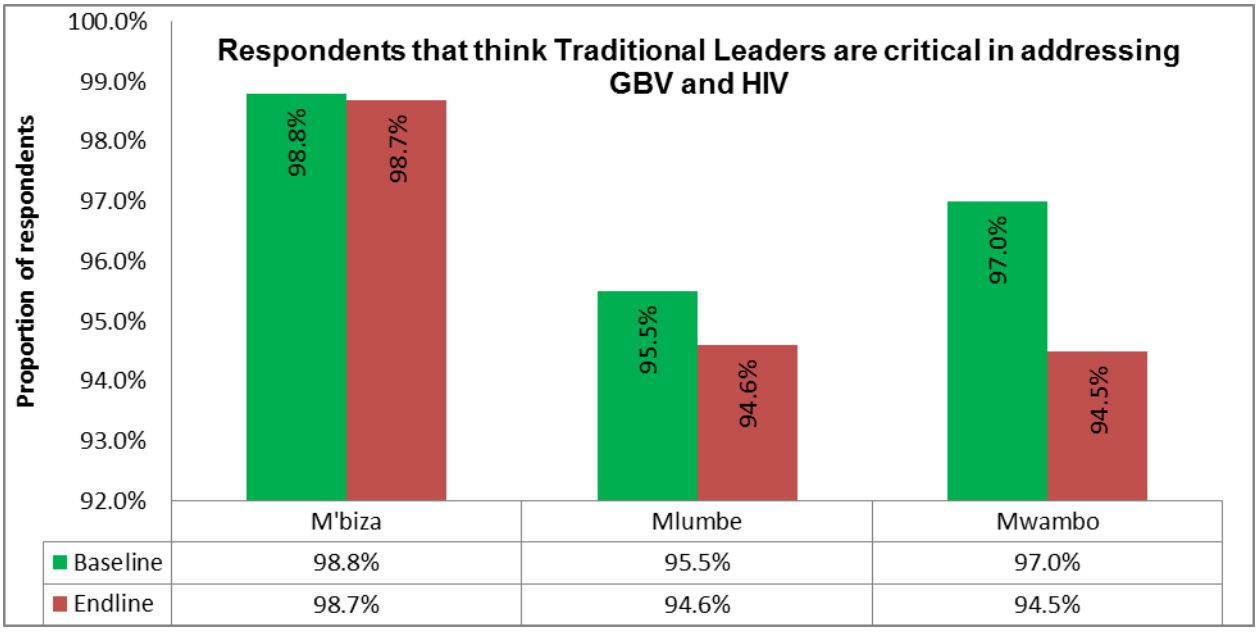


Fig 10: Traditional leaders as being critical in addressing GBV and HIV

Respondents that think Traditional Leaders are Critical in Protecting Women and Girls against GBV and HIV disaggregated, by Age

Figure 11 shows the respondents that think traditional leaders are critical in protecting women and girls against GBV and HIV, disaggregated by age during endline assessment against the baseline. The endline assessment results show that there was slight negative shift of about **5.9%** among young people aged 20-24 years' (100% BL - 94.1% EL) proportion of respondents that felt traditional leaders were important in protecting women and girls against GBV and HIV. The endline results also show that there was an insignificant increase of **1.7%** (from 96.5% BL – 98.2% EL) in the 15-19 years age group and a **0.2%** (from 96.5% BL – 96.7% EL) in the 25+ years age group. The endline results also show that significantly all the age groups from 15-50+ years believed that to a greater extent traditional leaders play a critical role in protecting women and girls against GBV and HIV. From FGDs conducted in all the TAs, it was also established that TLs were critical in protecting women and girls against GBV and HIV owing to their good social standing, power ascribed to them in the society and also due to the fact that they are the custodians of culture and signatories to community by-laws and policies.

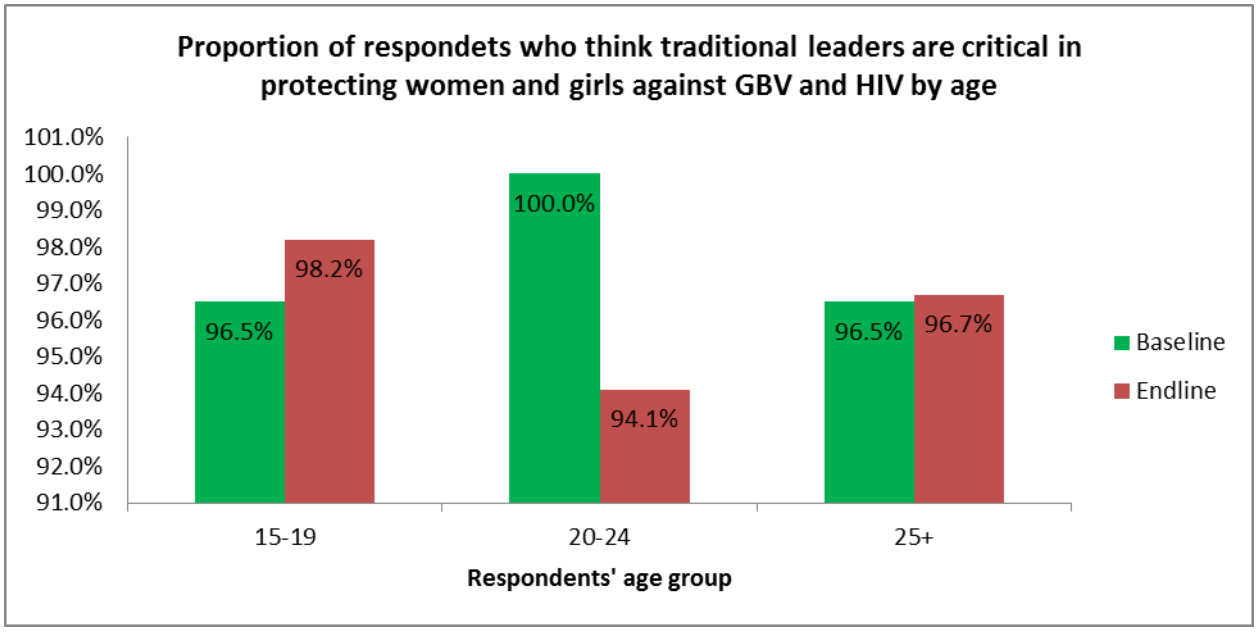


Fig 11

Respondents that think Traditional Leaders are Critical in Protecting Women and Girls against GBV and HIV disaggregated, by sex and traditional Leader

Figure 12 shows the respondents that think traditional leaders are critical in protecting women and girls against GBV and HIV, disaggregated by sex and traditional leader during endline assessment. The endline assessment results show that across the entire three traditional authorities, respondents still strongly believe that their leaders are very critical in the quest to protect both women and girls against GBV and HIV. There were no significant differences in the proportion of respondents between the two TAs of Mulumbe (94.5%) and Mwambo (94.65%) where the project was designed to use the stepping stone and MasP models respectively for those who felt that traditional leaders were important in protecting women and girls against GBV and HIV. The endline results also show that there was significant difference between males and females in all the three TAs. The endline results also show that there was significant difference between TA M'biza (98.9%) where the models

were combined and the other two TAs where the models were separated. From FGDs conducted in all the TAs, it was also established that TLs were critical in protecting women and girls against GBV and HIV owing to their good social standing, power ascribed to them in the society and also due to the fact that they are the custodians of culture and signatories to community by-laws and policies.

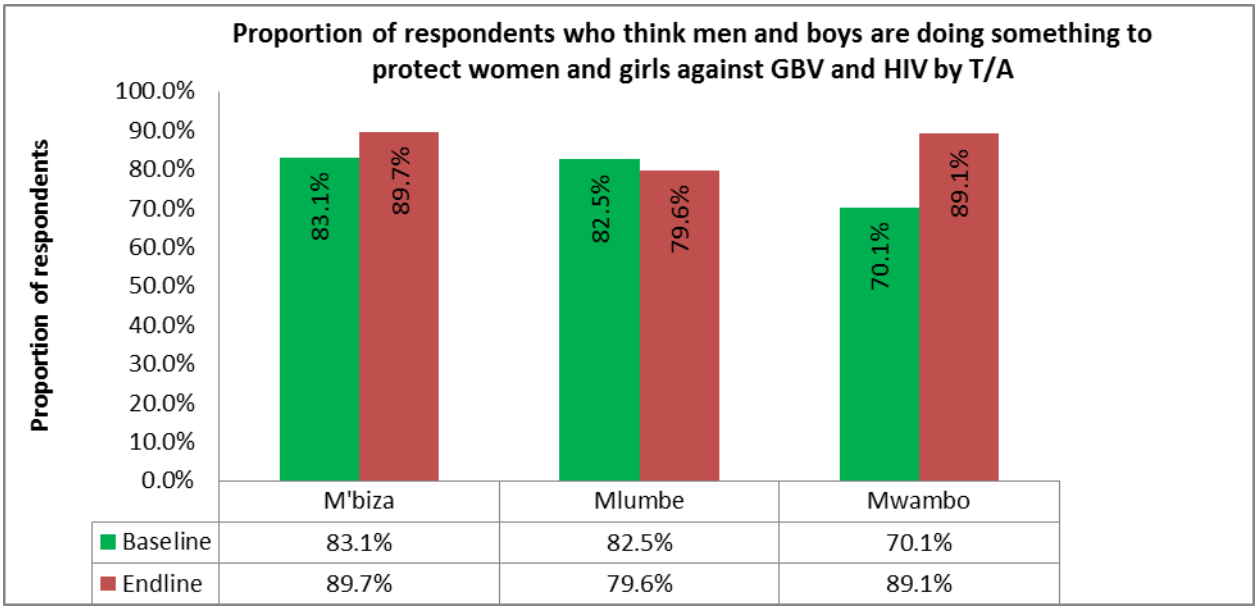


Fig 12

Distribution of Respondents by Traditional Authority who Feel Men and Boys are Doing Something to Protect Women and Girls against GBV

Figure 13 shows the proportion of respondents that reported women and boys were doing something to protect women and girls against GBV during both baseline and endline assessments. In the total sample participants, about 89.7% up from 79.4% during baseline, respondents indicated that men and boys were indeed doing something to protect women and girls against GBV in their traditional authorities whilst there was a decrease of **10%** during endline on those who indicated that men and boys were not doing anything in protecting women and girls against GBV and HIV. Across all the traditional authorities, there was a significantly higher increase (**19%**) in proportion of respondents in T/A Mwambo (70.1% BL to 89.1% EL) followed by M'biza with an increase of **6.6%** (83.1% BL - 89.7% EL). The significant increase of **19%** achieved in Mwambo was attributed to the fact that the intervention in this area only targeted men who are the perpetrators of GBV and overwhelming reception of the project, community member quickly owned the project. While the **6.6%** increase in endline results in M'biza was also attributed to the fact that the project targeted both men as perpetrators of GBV and women as victims of GBV, though not much was done on women as per KII and FGD reports. The project expected much from M'biza since the intervention targeted both men and women. However, COWLHA did not implement the activities with women as planned as a result a gap was created. In T/A Mulumbe endline results show a **2.9%** decrease in proportion of respondents that indicated men and boys were taking some action to protect women and girls against GBV which would be attributed to the fact that the intervention only targeted women as opposed to men who are perpetrators of GBV. The results also show that there were no significant differences across the traditional leaders with p-value was greater than 0.05.

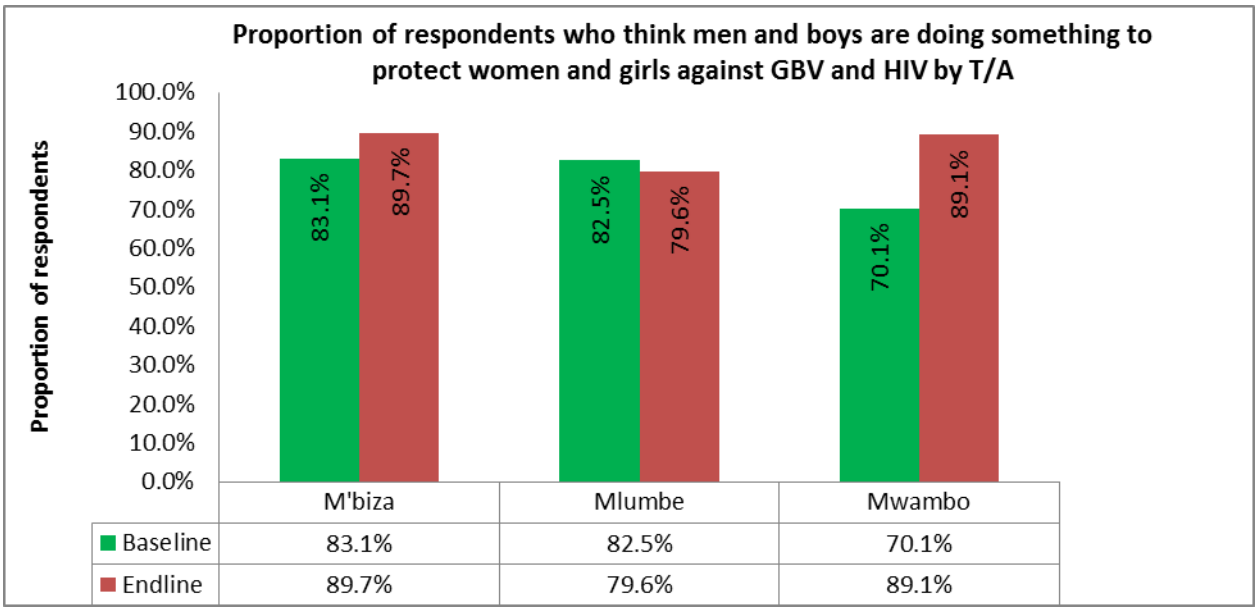


Fig 13

Activities Being Done by Men and Boys to Protect Women and Girls by Traditional Authority

Figure 14 shows activities being done by men and boys to protect women and girls, disaggregated by, traditional authority. In Mlumbe, the significantly higher proportion of the respondents (52%) indicated that men and boys were publicly speaking against abuse of women compared to 43% in M'biza and Mlumbe. Further, M'biza had significantly higher proportion (47%) of respondents who reported that men and boys were engaging other men to protect women and girls against GBV compared to Mlumbe (37%) and Mwambo (27%). Another activity reported was that men and boys were taking action against perpetrators of violence with Mlumbe (20%) and Mbiza (18%) having higher proportions of respondents compared to Mwambo 12%. In addition, men and boys were reported to be rendering support to GBV survivors, M'biza 13% and (9%) for Mlumbe and Mwambo. The results show that generally, men and women are doing something to protect women and girls against GBV in their traditional authorities, with public speaking against abuse of women being the common activity across all the traditional authorities and giving support to GBV survivors being least promoted.

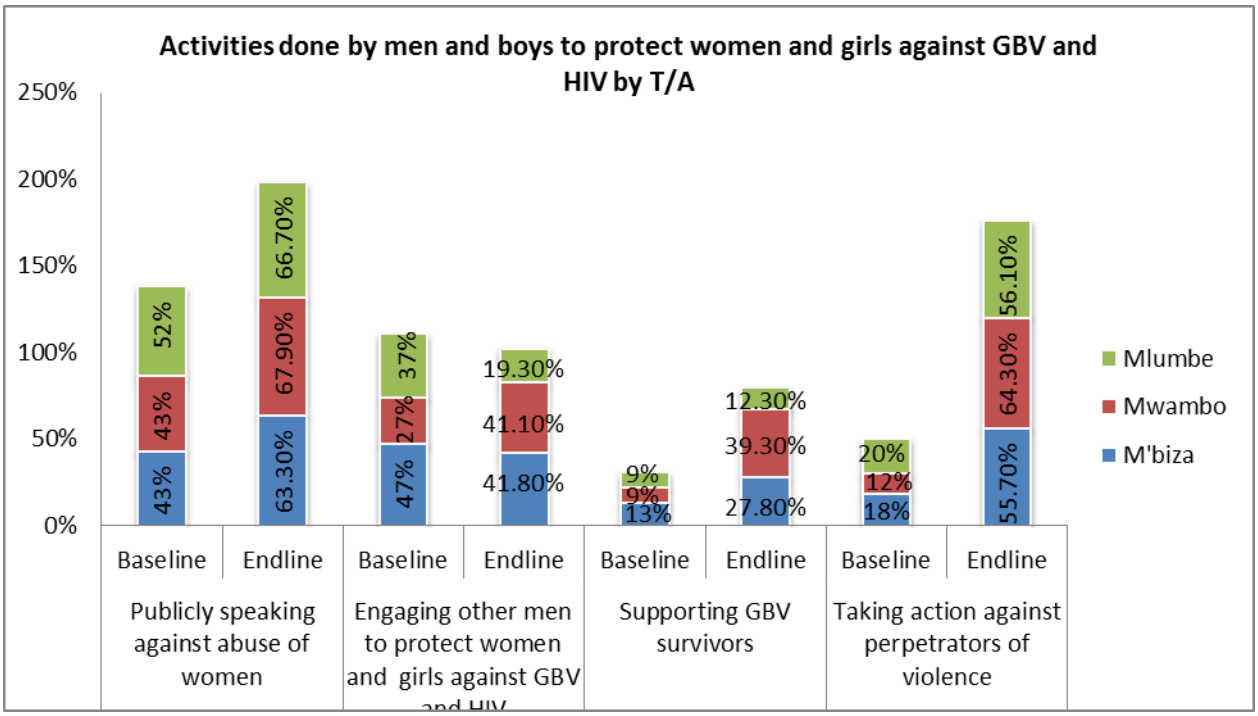
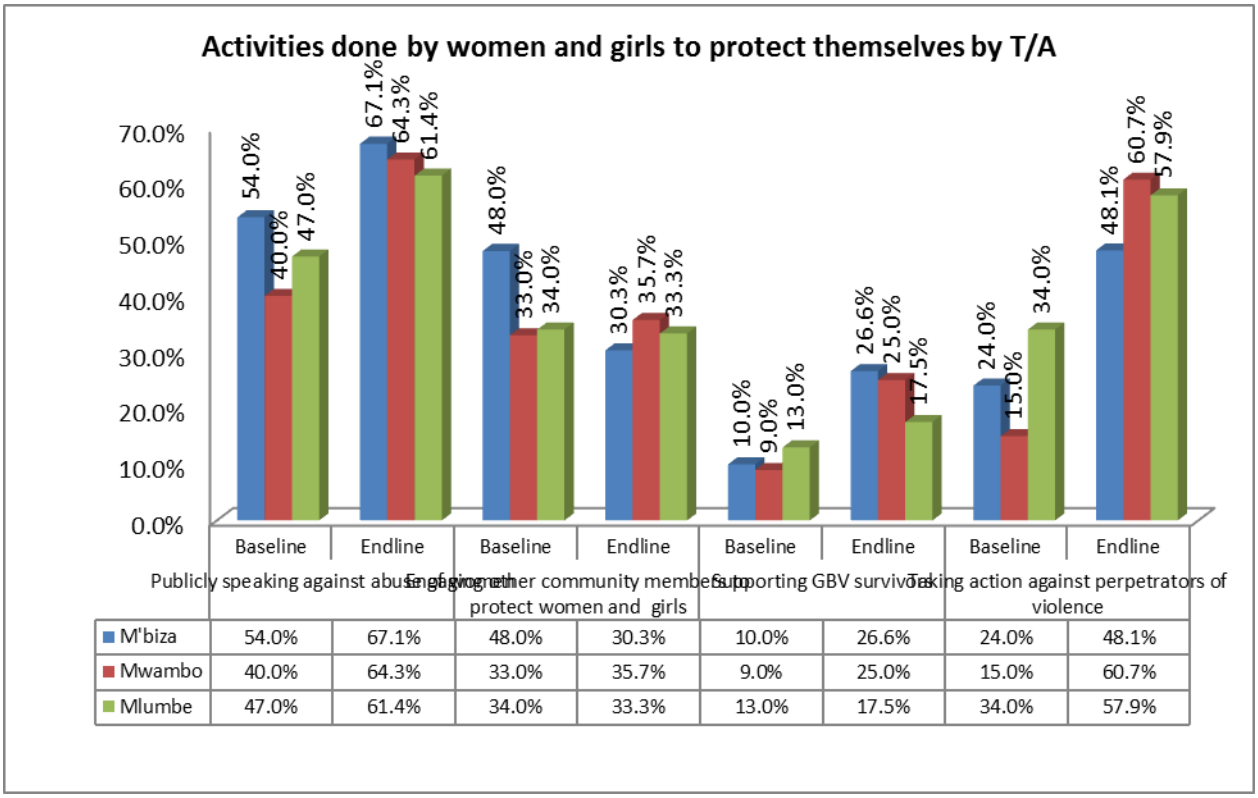


Fig 14: Activities done by men and boys to protect men and girls against abuse

Activities being done by women to protect themselves by Traditional Authority

Figure 14 shows activities being done by women to protect themselves from GBV abuses, disaggregated by Traditional Authority after the intervention. The endline results show a significant increase in all the activities under study that women were doing to protect themselves against GBV and HIV. Endline results show that 64.4% of the respondents reported that they were publicly speaking against abuse of women and girls which had relatively higher proportions compared to taking action against perpetrators of violence (55.6%), engaging community members to protect women and girls (32.6%) and (24.3%) supporting GBV survivors. In M'biza, 67.1% of the respondents highlighted that they were publicly speaking against abuse of women, compared to (61.4%) Mlumbe and (64.3%) Mwambo during endline from 54%, 47% and 40% respectively during baseline. In addition, a significantly high proportion of women in Mwambo (35.7%) reported that they were engaging other community member to protect women and girls compared to Mlumbe (33.3%) and M'biza (30.3%). Another activity, taking action against perpetrators of violence (57.9%) for Mlumbe, Mbiza (48.1%) and Mwambo (60.7%). Though the least in terms of proportion of respondents across the Traditional Authorities, also reported an increase activity levels compared to baseline, that women give support to GBV survivors Mlumbe (17.5% EL from 13% BL), M'biza (26.6% EL from10% BL) and Mwambo (25% EL from 9% BL). The results show that women are more engaged in publicly speaking against abuse of women and taking action against perpetrators of violence and supporting GBV survivors than engaging other community member to protect women and girls. The decrease in women and girls' engagement of other community member to protect themselves would be attributed to the fact that women were not fully involved in the project activities as planned.



	Publicly speaking against abuse		Engaging other community members to protect women and girls		Supporting GBV survivors		Taking action against perpetrators of violence	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
M'biza	54.0%	67.1%	48.0%	30.3%	10.0%	26.6%	24.0%	48.1%
Mwambo	40.0%	64.3%	33.0%	35.7%	9.0%	25.0%	15.0%	60.7%
Mlumbe	47.0%	61.4%	34.0%	33.3%	13.0%	17.5%	34.0%	57.9%

Figure 15

2.6 The Intervention and Settings

In Zomba, the ALIGHT project also targeted youth and adult men through a community-wide football (soccer) tournament, using weekly matches, outreach material about the tournament and group sessions organized around the matches as both a strategy to promote attitude and behavior change as well as to increase the likelihood of retention. A training manual relevant to the nature and content of the clubs settings was developed based on the Men as Protectors manuals. The curriculum was centered on the broad theme of discussing violence against women and girls and HIV. Individuals from the community, who were recruited as champions and trained, facilitated the clubs for men and youth between the ages of 15 and 64. During meetings of these clubs they focused on increasing awareness of gender norms and the consequences of violence against women and they also discussed the formulation of effective by-laws that would help stump out violence against women and girls in communities. To supplement the 18-week educational men's clubs, the three-month soccer tournament was held as an opportunity to bring the messages of the clubs also to the communities at a more informal and social level. For the men to participate in the soccer tournament they had to become members of the men's club.

The objective of the men's clubs and Tiwoloke clubs and campaigns were two-fold. The first was to see an increase in participants' knowledge of different forms of gender inequities and of different forms of violence against women, an understanding of the consequences of violence against women, and knowledge of the by-laws and policies related to violence against women. The second objective was to promote an increase in men and boys' capacities to denounce violence against women in their communities assessed both through an increase in self-reported use of violence

against women and girls and through increased questioning of others' use of violence against women and girls.

As the football tournament was taking place, the ALIGHT project seized the opportunity to launch a community-wide campaign on four sub-themes of the groupings that addressed violence against women and HIV. The themes included the division of household chores and responsibilities, domestic violence, sexual harassment and men speaking out against violence against women, transmission and prevention of the spread of HIV. Prior to the campaign, SAFAIDS developed campaign materials and the baseline mapping of the key communication outlets and material distribution sites. Additional campaign related events included community meetings and the creation of songs addressing GBV, which were being sung at football games and meetings.

The Stepping Stone Model

Since violence against women is manifested frequently within relationships, the project tried to find opportunities when it was possible to engage women and men together using the stepping stone model (Tiwoloke). Prior to starting the project a baseline assessment was conducted to evaluate the existing awareness of and attitudes toward gender equity and violence against women and HIV amongst participants in the three traditional authorities. Community members were surveyed alongside with their traditional leaders. The model was to be implemented in two T/As of M'biza and Mulumbe. However, the model was only and partially implemented in T/A Mulumbe.

2.7 Attitudes and Perceptions towards Gender Equality by Traditional Authority

The figure 16 shows attitudes and perceptions towards gender equality to which respondents (strongly agreed to, agree, disagree or not sure). For the sake this report the consultant only considered strongly agrees and agrees. In the total sample, endline results show a reduction in the proportion of respondents from 29% during baseline to 6.3% who strongly agreed to the gender norm that there are times when a woman deserves to be beaten by her partner, while there was also a dramatic reduction from 28% BL to 0.5% for those who strongly believed that a woman should tolerate violence in order to keep her family together and also it is okay for a man to hit his wife if she won't have sex with him. A relatively high proportion of residents in Mwambo (7.3%) strongly agreed to this gender norm compared to M'biza (1.3%) and Mlumbe (1.8%). M'biza had a relatively high proportion of respondents (11.4%) that strongly agreed to the gender norm that a man using violence against his wife is a private matter that shouldn't be discuss outside the couple than Mwambo (10.9%) and Mlumbe (8.8%%). While Mlumbe had a relatively higher proportion of respondents agreeing to the gender norm that women who carry condoms on them are easy compared to the other traditional authorities. The results in all the TAs especially in M'biza, endline results still show how people's ways of doing things are still being heavily rooted in culture and male dominance evidenced by their attitudes and perceptions towards gender equality.

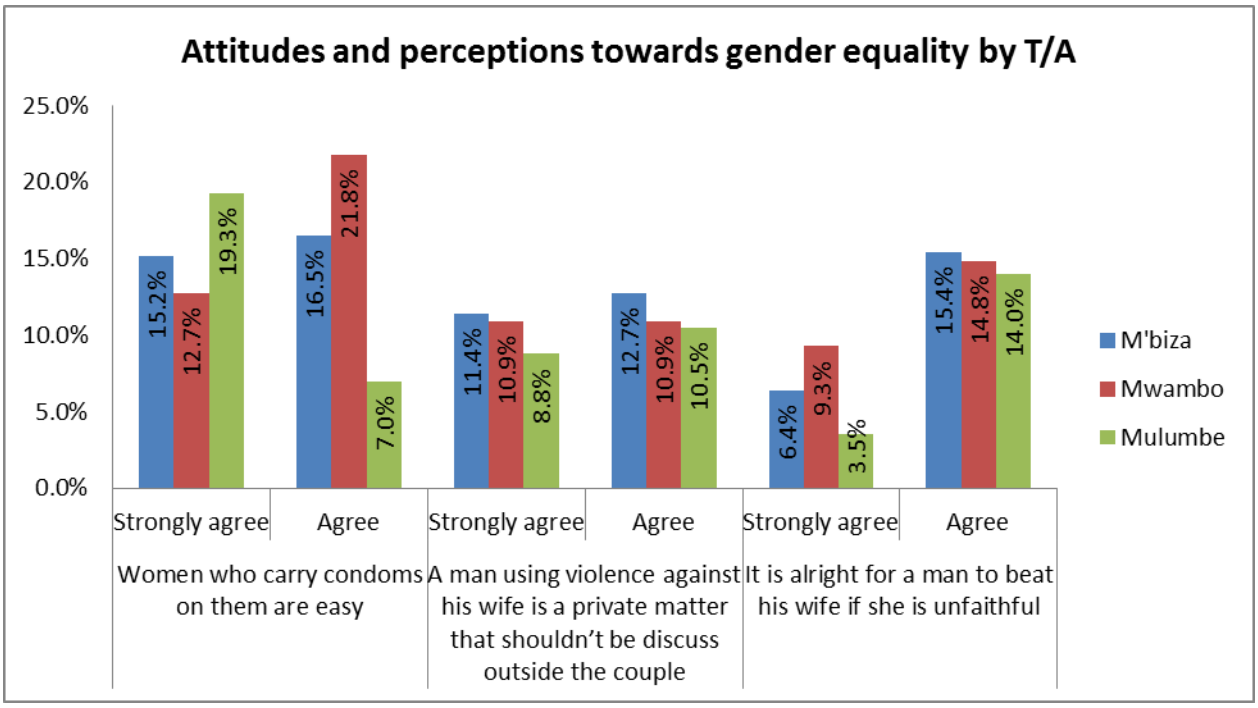


Fig 16

Perception and attitude towards gender equality amongst men

Endline results show impact both on attitudes and behaviors. Survey results show that following the training of Champions and campaigns there was a fifteen percent decrease in the number of participants in the intervention areas who agreed with the statement "there are times when a woman deserves to be beaten" from 26.3% during baseline to 6.2% during endline. Furthermore, following the intervention there was a significant decrease in the number of men in the three traditional authorities from 26.9 to 11.5 percent who agreed with the statement "violence in a relationship is the couple's problem and should not be discussed with others." Figure 17 below show proportion of men that believe that women sometime deserve to be beaten

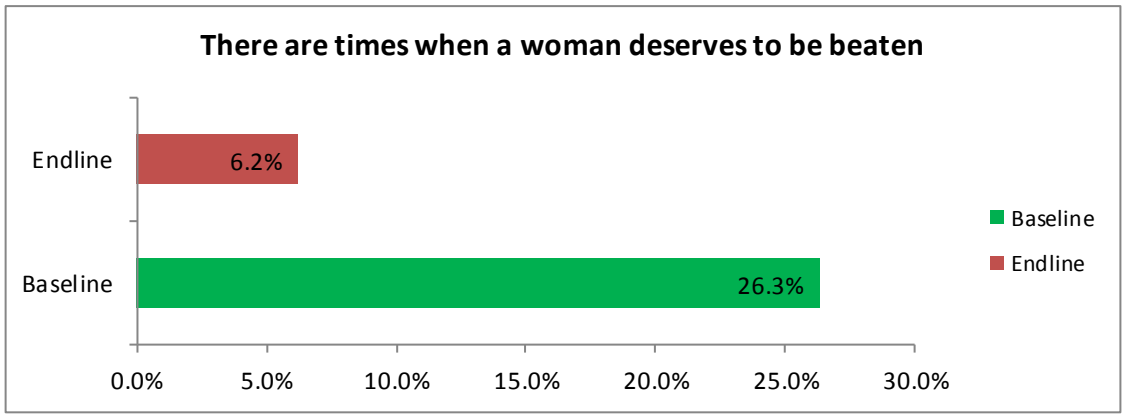


Figure 17

Figure 18: Percentage of individuals who agree with the statement "There are times when a woman deserves to be beaten" Participants self-reported continuing to use psychological violence during

instances of conflict within couples. These results affirm dissemination of the campaign messages in a diffuse way via a coach, as well as in the more intense intervention group may have led to changes. The results may also show social desirability.

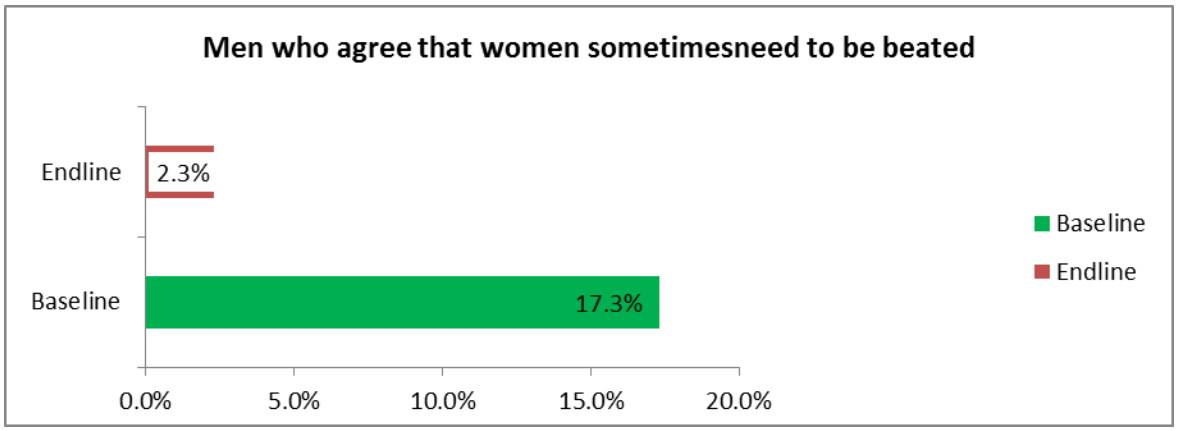


Fig 18:

Additionally there were statistically significant ($p<0.001$) increases in the sharing of household responsibilities among male participants (n=96) and their partners. Of the participants in the football tournament surveyed (n = 96), half said they learned how to interact with women differently and over 20% said they have learned how to better control themselves when they are tempted to act violently.

If COWLHA had implemented the project activities in M'biza, it would have given a clear picture as to whether the community that combined men's and women's groups for the intervention, would have shown a decrease or increase in men's reports of use of physical violence against women (VAW) at the endline survey and compare it with that of (T/A Mwambo) the community that worked with only men's groups. However, there was also a significant decrease of **13.3%** in the perpetration of physical VAW in T/A Mulumbe where the intervention targeted women groups only, from 20% percent at the baseline to 6.3% percent at the endline survey. These findings suggest that the issue of social desirability was present, possibly due to the close repetition of the surveys (between a period of 1year and six months) leading to interviewees anticipating survey results or program communities with similar messages that the implementers were unaware of.

While there was a decrease in men's reports of perpetration of physical violence against women and girls at the community level, there was no significant change in the justification of wife beating among men. However, women in all three traditional leaders showed a significant decrease in the belief that wife beating is justified at the endline survey. Given that this change was significant in all the three communities, this suggests that repeating asking of these questions either leads to social desirability or that merely asking these questions leads many women and men to question their attitudes towards gender equality.

2.8 Perception and attitude towards gender equality amongst women

On all the gender norms, as it was during the baseline, women still constituted greater proportions of respondents who agreed to the gender norms like, there are times when a woman deserves to be beaten (20.9% **EL**, 39% **BL**), women should tolerate violence to keep her family together 3.6% **EL**, (30.1% **BL**) and it is right for a man to beat his wife when she is unfaithful (24.5% **EL**, 28% **BL**), a

man should have the final word on decision in his home (20% **EL**, 27,3% **BL**). The results show that there is a positive shift on the proportion of women who are now becoming aware of their SRHR evidenced by the reduction in the proportion women who were agreeable to gender norms that expose them to GBV and HIV during the endline compared to baseline figures. The slight decrease in the proportion of women who were agreeable to the gender norms that expose them to GBV and HIV would be attributed to the period of time the project was implemented which was short for greater impact.

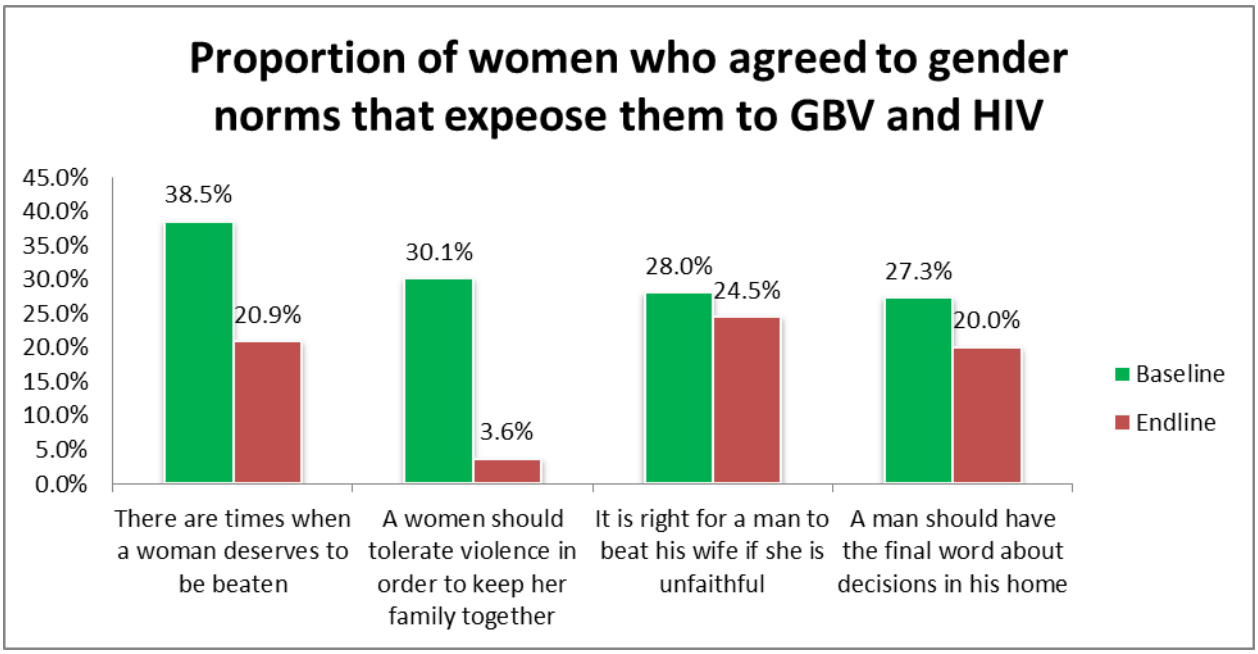


Fig 17

In the above figure 96.4% of respondents have shown greater change by scoring higher on the gender norm that says *"a woman should tolerate violence in order to keep her family together"* in the end line than in the baseline and 3.6% have shown a negative shift by scoring less in the end line as compared to the baseline. Lower p-value i.e. 0.00 suggests this to be a highly significant change. Higher scores mean more gender equitable attitudes.

Another important manifestation of stereotypical masculinity is the rule of single handed decision making by men in the domestic sphere. Women are specially kept out of it and the rationalization given is that they lack the courage and ability to take decisions. In the above figure 20% of respondents have shown no change in this particular gender norm that says " *A man should have a final word about decisions in his home"*, 80% have shown greater scores in end line than in baseline and 7.3% have shown a negative shift by scoring less in end line as compared to baseline. Lower p-value i.e. 0.00 suggests this to be a highly significant change. A positive shift in this item underpins the inclusion of women in decision making processes at home.

Endline qualitative interviews with participants and female partners had the goal of understanding if there were any changes in couple dynamics. Women who were interviewed agreed that some of the men who participated in the soccer tournament did not just talk about the tournament but also the themes of violence against women, gender equity and HIV. This created an opportunity for couples to discuss gender roles within their relationship. Survey results showed that the campaign was

recognized by more than 87 percent of individuals surveyed, evidence of the successful scope and resonance of the campaign efforts. Surveyed individuals reported that jealousy was the number one motivator for their use of physical, sexual and psychological violence against women. They also said that the ability to "talk between men" was one of the most positive aspects of the training and was at the core of their meetings during men's clubs and that it was critical to open communication within the group. The intergenerational approach to the trainings was also spoken of favorably. Furthermore, approximately 92 percent of men in the intervention area said that they spoke about the themes of the campaigns with others.

It is okay for a man to hit his wife if she won't have sex with him.
Endline results show that out of 96 respondents have shown no change in this particular item, 46 have shown greater scores in the end line than in baseline and 17 have shown a negative shift by scoring lower in the end line as compared to the baseline. Lower p-value i.e. 0.00 suggests this to be a highly significant change. Higher scores mean more gender equitable attitudes. In the baseline more men from the Intervention group agreed to the statement, but much fewer did so in the end line. This shift reflects not only the recognition of domestic violence but also social permission to women to raise their voices against it.

A man should have the final word about decisions in his home.
Another important manifestation of stereotypical masculinity is the rule of single handed decision making by men in the domestic sphere. Women are specially kept out of it and the rationalization given is that they lack the courage and ability to take decisions. One of the quantitative measures suggests the following change: 26 respondents out of 96 have shown no change in this particular item, 56 have shown greater scores in end line than in baseline and 14 have shown a negative shift by scoring less in end line as compared to baseline. Lower p-value i.e. 0.00 suggests this to be a highly significant change. A positive shift in this item underpins the inclusion of women in decision making processes at home.

Boys' and men's attitude that women earning was a challenge to men's masculinity was a theme that repeatedly arose in the baseline study. For example, in the baseline qualitative focus group discussion with unmarried men one respondent said, *"Mkazi ntchito yake ndikusamala pa khomo, ntchito yosaka ndalama ndiyabambo' (A woman's job is to take care of the home, the job to look for money to feed the family is form men).* The same stereotypical male role was mentioned by respondents in different ways, for example:

2.9 Project outcomes

Outcome 1: Strengthen community by-laws that promote women's safety and SRHR in the context of HIV and GBV developed and implemented in three TAs of Zomba District by February 2016

Outcome 2: Support men and boys to contribute to a safe environment for women and girls and ensure gender equality in three TAs in Zomba, by April 2016

Outcome 3: Increase open communication among couples, women and men around HIV, gender equality and address GBV in three TAs, by April 2016

Outcome 4: Strengthen monitoring and evaluation systems for data and information generation.

2.9.1 Overall finding related to Outcomes:

The project has managed to achieve most of the expected results in supporting men and boys to contribute to a safe environment for women and girls and ensure gender equality, and principally those results expected at the community level. The consultant assessed that the quality of general support services was indeed enhanced at the community level primarily by delivering much needed and practice-focused trainings for community champions and members of the men's clubs. Furthermore, consultative support to the traditional authorities have yielded visible results in raising the level and quality of discourse on GBV and achieving consensus on the use of men as protectors for addressing cases of GBV and HIV at community level.

The endline assessment found that for an effective and sustainable response to GBV and HIV at community level, there is need for support by the national level institutions like the judicially, police and must be continuous. For example, due to an insufficient support and lack of commitment at the national level, the tracking of cases of violence against girls more especially victims of early marriages will not be successful and sustainable as most culprits are left free without any action against them. Finally, the evaluation established that the level of information and awareness of individual roles and functions among key actors involved in providing response to GBV and HIV was significantly raised resulting in conclusions for actions consistent with the areas of project activities.

The largest progress and the best success in terms of impact and further multiplication of the results of this project is seen at the level of phasing out. The consultant assessed that at this level, the project had found an environment that was supportive, enabling and committed to addressing GBV and HIV in a systematic, coordinated and overall comprehensive way. Though SAFAIDS had not been working on mainstreaming gender for a long time in the district but their work had been seen as naturally progressing very well. Moreover, the project management made use of their good working relationship with traditional leaders and the communities at large and achievements and lessons learned of the previous projects it facilitated the implementation of the activities. Therefore, it was confirmed by the endline assessor that this project's added value was undeniable in that it had recognized the local capacities and the practices and attempted to support each partner building on the block that had already existed locally rather than building other parallel systems.

2.9.2 Relevance:

The project aligned very well to both global and National agenda on ending HIV and AIDS and Action to combat GBV. Globally the project contributed to SDGs' standalone goal (Number 5) on gender equality and the empowerment of women and girls. Underneath this is the target: "eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation." It also supported Sustainable Development Goal (MDG) #3- Ensure healthy lives and promote wellbeing for all at all ages and UNAIDS Fast-Track strategy to end the AIDS epidemic by 2030 . At national level, the project contributed to the National HIV and AIDS Strategic Plan (2015-2020), National HIV prevention strategy (2015-2020) as well as the National Plan of Action to combat GBV. Having aligned itself to global and national agenda, SAFAIDS also did the same at local level by ensuring that it met the needs of the women, girls and communities of the three traditional Authorities where it implemented its project.

Gender based violence posed a considerable risk in the target communities, as evidenced in the baseline report. The project fitted into the District Implementation Plan (DIP) through its contribution to the fight against GBV and HIV in Zomba. By contributing to the DIP and involvement of the stakeholders in Zomba, it is manifestation that the project is considered relevant. The reduction of gender based violence cases and improved knowledge on HIV and AIDS transmission and prevention from 33% to 54% and 17% to 31% respectively, prove relevance of the project at

community level that the project was developed in response to the needs of the beneficiaries in the catchment area.

The interviews and discussions with beneficiaries of the project activities under this outcome confirmed that the project has addressed very relevant rights and needs of women and girls to live a life free of violence and have implemented relevant project strategies in doing so. The project responded to the common but often misunderstood and tolerated problem of gender-based violence among women and girls and to the needs to sensitize and educate men and boys in gender equality as recommended in the baseline on GBV in the district in 2015. The use of Men as Protectors model on addressing GBV and HIV was relevant as the content of the training manual reflected both prevention (understanding gender and gender dimension of violence) as well as response to GBV for men and boys in the community settings. Relevance of this work was emphasized also by the fact that it addressed specific and community level issues, providing technical support to and utilization of existing expertise within the community (Project Champions) and by directly contributing to the strengthening of community capacities as an institutional response to violence against women and girls.

The outreach work with men and boys (as for Mwambo and M'biza) and establishment of men's clubs and the activities to football tournament in addressing GBV and HIV issues were highly relevant as they were part of the prevention strategy reaching out to men and boys at the community level, as well as the part of efforts to increase awareness among the wider public. Advocacy was assessed by the interviewed stakeholders and partners as very relevant as they raised their knowledge about issues such as gender/sex difference and gender roles and identities, with a focus on the stereotypical masculine identities as well as risky sexual behaviors, the subjects that were not otherwise addressed properly previously.

However, this effort was affected by the fact that the project was not implemented as per plan as evidence from FGDs and KII which revealed that their partner COWLHA did not implement their activities in traditional authority M'biza which made it difficult to compare the strategies/models to choose the best practices. However, there is a high degree of relevance of the project overall, and of all major strategies.

2.9.3 Effectiveness

There were no Men's Clubs in Traditional Authorities Mwambo and M'biza before the project and an influx of GBV cases were being reported to the T/As. By the end of the project, 77 Men's Clubs were established, with 47 men's clubs in T/A M'biza and 30 men's clubs in T/A Mwambo and only 6 Women's clubs in T/A Mlumbe. The use of football matches gathering for awareness and the use of men as champions proved to be an effective way of combating GBV and HIV in the project area. Though the project was a success, its take off was delayed for about two months which would have brought in more positive results if it were compensated at the end. More than half of the community members in the project area demonstrated that they are aware of the ways in which HIV is transmitted and how it can be prevented.

The consultant concluded that the project had achieved most of the set targets under the outputs of Outcome 1, 2 and 3. The comprehensive strategy intervention to engender community program against violence, train and motivate community men and boys to organize various activities and

strengthen monitoring and mentoring capacities of project champions to engage in prevention of and provide response to GBV was evaluated to be effective. However, the football tournament preparation was moved to the very end of the project in order to include feedback from the project implementation so its promotion and participation by other community areas like in TA Mlumbe still remains to be done. The stakeholders interviewed described the success of the project's intervention aimed at strengthening the capacity of men, boys and traditional leaders as mostly owing to the fact that it built on the previous excellent relationship between the communities and the implementing organization and the strategic models like using men as protectors in the area of prevention and intervention to violence in the communities. However, evidence from the interviews with selected beneficiaries in the communities clearly confirmed that this was primarily the community level success as the scope of engagement and achievements of the GBV project activities varied greatly among the three communities.

Same finding applies with regard to effectiveness of the work with men as perpetrators of violence at the community level. The trainings for the project champions working with perpetrators were assessed by the trainees tended to have sufficient duration to be effective and comprehensive. It was also highly considered that the project ensured not only training delivery but also the actual work with perpetrators through men's clubs. Public awareness, mobilization of men and boys educator activities were effective and results of those were visible at the time of the evaluation as confirmed by the interviews and public survey. The consultant assessed that the strategic intervention focusing on the use of football gatherings for awareness were successful as effects of the intervention could be clearly observed at the community level. However, the consultant was made aware that in the context of sustained awareness campaigns at community level process there were concerns whether these effects would hold in the long term once the project phases out.

2.9.4 Efficiency

Through its use of innovative project strategies and emphasis on staff capacity development, the project achieved considerable impacts. It did so under significant time and delivering above average value for money in the estimation of this endline assessment. Staff capacity was enhanced in a number of ways throughout the project, with skills gained in facilitation, monitoring and evaluation, and general planning and project management. In particular, SAFIADS's insistence upon the thorough training of Community facilitators (champions) paid dividends, in terms of the enthusiastic response of Men's Clubs to the project. YODEP Staff members willingly doubled their workloads to make up for lost time and triple the number of training workshops, to ensure the full implementation of a project they believed in. At the same time, there is scope for improved project management and more equitable distribution of workload.

Considering the fact that the project using MasP model targeted 2800 men and the establishment of 87 MasP Clubs in TAs of Mwambo (47 MasP clubs) and M'biza (40 MasP clubs) through, the cost per beneficially at the end of the project was USD4.15 and MWK2802.40. When compared to the intended cost per beneficially calculated at the inception of the project shows that the cost per beneficiary was the reports show that there was no difference in both USD and MWK. The analysis of the budget structure indicated all the two sub-granted organisations paid for the operational cost (USD300; MWK203,058.02) and funding from SAfAIDS (USD11,625; MWK7,846,875.00) was used for activity costs. All of the activities were implemented with minor delays and re-allocation of funds. Still, the approved budget did not provide sufficient information on budget categories- for example,

budget categories “technical assistance” or “monitoring and evaluation”. While for the Stepping Stone model targeted 40 trainers of trainers and 380 couples in both TA M’biza and Mlumbe, the cost per beneficiary was USD64.29 and MWK43,392.86. The cost per beneficiary under stepping stone model was higher compared to the cost per beneficiary under MasP model because the cost of training of trainers in Stepping stone was pegged USD375 and MWK253,125.00 per beneficiary which used 55.56% of the total budget.

The ratio of the cost for administration to the cost for results could not be computed as data was not available on how much was for administration or technical support and how much was used for the stepping stone model. However, the fact that almost all funds were spent on implementing project activities confirms that funds were efficiently spent on intended objectives.

The assessment finding on efficiency criterion for both outcomes relates to aspects of timeliness of the project interventions and the overall project management and steering structure success to ensure efficient project implementation. Namely, with regard to all outcomes, the project documentation did not show (clearly the implementation work plans and project reports) and the consultant was made aware that there were delays and carry-over of the activities that happened which were caused by the project management and steering structure. Though the project team was granted a non-cost extension to complete the activities but the consultant was informed that it was mainly due to the fact that the delay in the disbursement of project funds affected the starting time form implementation of some activities like training of project champions and other project activities as had been planned. The interviewed project team involved in training of the project champions did mention that some men’s clubs were not covered by the training during the actual implementation time period and that in general the project management showed well appreciated flexibility in the project activities implementation though eventually it affected the work plan execution. Based on the semi-structured interviews, almost all of the respondents felt that the inputs and outputs were timely.

Respondents were asked to comment on the qualifications and capacity of the YODEP staff and how well they have partnered with implementing organizations. There was positive feedback on both of these issues. YODEP staff was viewed as possessing high level of knowledge on GBV and HIV issues.

2.9.5 Impact

With the reduction of cases of gender based violence, in communities in T/A M’biza and Mwambo, it means more women and girls are now living safely in their homes. This has been evident in the project sites as many cases of women and girls reporting abuse were registered. A particular example is mbiza community where 4 girls under 18 years of age were withdrawn from forced marriages after community mobilization meetings on HIV, GBV and women’s rights. This clearly testifies the contribution made by the project in fighting gender based violence and HIV in these traditional leaders. The testimony of women and men suggests that the intervention had a transformative impact on behaviours and relationships. From a gender perspective, these changes have addressed issues of equity, by improving the conditions of women, in terms of their freedom from violence, reduced workloads and reports more communicative and supportive emotional relationships with partners and across all family members. This strategy (men as champions) also shows evidence of addressing women’s strategic interests, by starting to address the structures that oppress women. This is seen in reports of women’s involvement in decision making about and control of household resources. However, there were risks of gains to women’s protection and

empowerment being lost unless there were also clubs for women that would complement men's effort in the fight against GBV and HIV, particularly on issues of management of domestic conflicts.

The consultant was able to confirm that project champions became key community resources for protection of women and girls from violence and were active in establishment of men's clubs for protection of women and girls from violence and their response to calls on GBV cases when needed was assessed as adequate and timely. The change in attitudes of men and boys towards gender issues has occurred as a result of the implemented GBV project activities and formulation of community by-laws. The consultant was also made aware that though some community by-laws to address GBV and HIV were formulated, their implementation was still awaiting the legitimization by the legal experts. However, significant changes in the attitudes towards gender roles were found between the two studies manifested as a higher degree of disagreement with the gender biased and stereotyped statements questioned. Namely, most participants questioned by the assessors show a clear tendency against traditional gender roles and against GBV on a larger number of attitudes surveyed during endline as compared to the attitudes found by the research carried out during baseline

2.9.6 Sustainability

There was strong evidence that communities will continue with the interventions. The community structures Men's Clubs were empowered through training which enabled them to understand their roles and responsibilities. During the FGD, participants requested for mobility means like bicycles to enable the champions to reach out to many families when there is a call for their intervention. These community structures have the potential to sustain the activities that they undertook when they were supported by SAFAIDS through YODEP. During the FGD, they indicated that they would develop their plans and find means of implementing without depending or waiting for YODEP which is a strong signal that they have taken over the responsibility to protect women and girls from GBV and HIV. Having T/As and GVHs as patrons also ensures that at community level the community structures will always have the support that they require to function effectively. The mutual understanding between the Men's Clubs and the community leadership is in itself a strong bond that will always be there even without external stakeholders. As such the enforcement of community by-laws that were formulated would also enable the champions to function effectively.

The knowledge and skills imparted to champions on using men as protectors (Abambo ngati atetezi) will make the battle against gender based violence (GBV) and the spread of HIV a success as the saying goes "send a thief to catch a thief". Once all men who have been perpetrating violence have been transformed, other would be culprits of GBV are likely to be motivated and refrain from GBV which would also lead to reduction in cases of GBV and the spread of HIV.

The outputs achieved under the four outcomes have significantly contributed to the development of capacities of the project partners and beneficiaries to ensure durability of their effects. Namely, the establishment of men's clubs in T/A M'biza and Mwambo has become an official specialized group of men and boys that have taken a positive step in the fight against GBV and HIV. The training and creation of the pool of men's clubs in the communities was part of a strategy for capacity building of the community level system for prevention of violence against women and girls.

Selected trained ALIGHT project champions supported by the project have remained an community capacity for protection of women and girls from violence in their communities, both in monitoring and

supporting communities in violence against women and girls and HIV prevention, thus enabling sustainability of the community response to violence in the intervention areas and strengthening violence prevention in the district. The training manual produced for training project champions have also remained a significant resource for further implementation of the GBV prevention program in intervention communities. The knowledge and skills imparted to traditional authorities on using MasP and Stepping Stone Models, in combating GBV and HIV will make protection of women and girls meaningful as most would be perpetrators would be inspired by those that have changed their behaviour through this project and skills taught in various MasP Club meetings. With improved knowledge levels on gender equality and SRHR, women are likely to be motivated and be able to protect themselves against GBV and HIV.

2.9.7 Lessons learned

In summary, SAFAIDS has found an effective way to shift norms in communities to prevent GBV and HIV, as well as within GBV response services. However, there was need for SAFIADS to have more time for these prevention and response activities, and in making sure that the impact/gains of the interventions to women's protection and empowerment are efficiently monitored and to ensure that they become entrenched through a critical mass of community networks.

Furthermore, future campaigns should involve the community and their opinions from the initial development phases. During this project, however, community members were involved during the baseline survey only. The communications firm hired and the program coordinators formed a focus group of community members to discuss the success of the campaign and how to decrease cost and the amount of time spent on the campaign.

The football tournament no doubt contributed to high participation of those who agreed to participate but the total number of participants was still relatively low. Future work might explore ways to reach more men by focusing more on existing community football leagues for example. Future work might also consult with community members to determine if football is the preferred sport or there are other sporting activities that would attract more patronage.

The ALIVHE approach is a practical tool for implementation research where a lot of lessons drawn from the research can be applied during implementation as well as during post implementation period. In the case of Malawi, the combination of two different models implemented in one community to enhance the results has been seen to be a cost effective methodology of achieving results within a short period of time. The stepping stones model combined with male involvement and engagement of chiefs in reducing/eliminating GBV as it relates to HIV is a promising strategy towards women empowerment and achieving zero new HIV infections. The men engagement model has proved to be an effective model in ensuring that communities respond to gender issues in the HIV response

3.0 Discussion and Conclusion

3.1 Strengthen community by-laws that promote women's safety and SRHR in the context of HIV and GBV developed and implemented

The endline assessment results demonstrate that in a short, six-month time frame, SAFAIDS's intensive GBV and HIV awareness campaign achieved improvements in attitudes toward GBV, gender-equitable behaviors and response to HIV. Comparing findings at baseline and endline, women's attitudes related to GBV improved by more than 15% percentage points (in terms of justification), but among men there was a more 10% percentage-point change in the opposite direction. Eighty-six percent of men who responded to the questionnaire reported exposure to at least one aspect of the GBV and HIV awareness campaign, and the findings suggest that exposure was associated with a reduction in the belief that GBV is justified, possibly by as much as 10 percentage points.

Figure 4 Highlights of the Assessment Findings

- Respondents (especially women) were likely to expose gender inequality
- Improved communication was reported amongst couples
- Both women and men reported they were more likely to share ideas when making decision about their home
- Respondents (especially men) demonstrated improve knowledge and attitudes towards GBV
- Both men and women demonstrated increased knowledge levels on ways in which HIV can be transmitted and prevented
- More women demonstrated improved knowledge levels on SRHR
- Women reported that controlling behaviour by their partners (perpetration of intimate partner violation by men) had decreased

The baseline results indicated a strong need to work with women to help them become familiar with their SRHR, improve their independence, and find ways to support each other. Also at baseline, the study identified a need to work with men to improve attitudes toward GBV and its link to escalation prevalence of HIV, gender equality sharing of domestic chores, and sharing of decision making; in this study, at endline, both men and women reported improvements in shared decision making and some shared domestic chores. The MasP strategy implemented in the two traditional leaders in Zomba has been found leading to improved attitudes toward shared decision making, which has been found to be protective against GBV.

Findings from this study are consistent with other evaluations of similar community outreach and mobilization campaigns. At baseline, this study found that more women than men agreed with concepts that are gender-inequitable and that support GBV; this finding is consistent with other studies (Gage, 2005; Lawoko, 2006) and Men as Partners (MAP) in Côte d'Ivoire (2013). In this

study, after the campaign, significantly men thought rape was justified; similar results have been observed in assessments of the MAP approach in South Africa (Peacock & Levack, 2004), An evaluation of a MAP intervention in Ethiopia, which used both group education and community mobilization strategies, demonstrated a significant decrease in reported perpetration of intimate partner violence by men (Pulerwitz et al., 2010).

3.2 Support men and boys to contribute to a safe environment for women and girls and ensure gender equality

The intervention clearly challenged norms and expectations that support GBV, while at the same time promoting gender-equitable norms. As measured by the GEM Scale, women saw a significant improvement. Among men, high scores on the GEM Scale, indicating support for gender-equity concepts, increased by about eight percentage points, but low scores increased at almost the same rate—by six percentage points. Thus, improvements among some men were offset to some degree by decreased agreement with equity concepts among other men. After the intervention, respondents reported a two-fold increase in joint decision making, and there was greater agreement that women should have equal rights.

At endline, more women reported responsibility for house repairs, and there was more shared responsibility for purchasing food and paying bills. Even though most men and women at both baseline and endline reported they were satisfied with the division of labor within their households, the campaign produced a 32% increase in sharing and joint conduct of domestic chores (from 16% at baseline to 21% at endline); the majority of the observed change was attributable to changes among women.

According to the IMAGES multicountry survey conducted in 2009–2010 found that men generally held negative attitudes toward GBV laws (Barker et al., 2011). In this study in Zomba, attitudes about the by-laws that protect women and girls against GBV and HIV had improved among both men and women after the intervention. Certain relational aspects, such as shared decision making, controlling behavior, and improved knowledge on SRHR, improved significantly over the course of the intervention period; this finding suggests that an awareness campaign that targets both men and women to promote gender equitable relationships and to prevent GBV can lead to reflection on and promotion of more equitable behaviors. While project designers had hoped that the intervention would positively shift attitudes around GBV (which it did in many cases, especially among men), they did not expect the level of the intervention's impact on relationship behaviors. The establishment of both Men as protectors clubs and women's clubs in combination with an awareness campaign (such as the one done during football matches), might lead to even stronger attitudinal and behavioral changes; Failure by COWLHA to successfully implement their planned activities in T/A M'biza has created this gap as such there is need for further operational research, as inequitable decision making and controlling behavior among males are strongly associated with the incidence of GBV.

3.3. Exposure to GBV Messages

Respondents (more especially men) demonstrated a relatively low exposure to GBV prevention messages before the intervention; nevertheless, there was a substantial increase at endline in exposure to GBV prevention messages in general and considerable exposure to campaign messages in particular. The vast majority of baseline respondents had at some time seen or heard

messages about preventing GBV. Still, exposure to campaign messages, while less than universal, was broad (87% of endline respondents had some exposure).

3.4 Increase open communication among couples, women and men around HIV, gender equality and address GBV

The consultant examined beliefs about justifications for domestic violence, and witness responsiveness to GBV. It showed sex-specific mixed results on whether the campaign reduced the belief that GBV is sometimes justified. By endline, the percentage of men who believed in at least one justification for domestic violence had decreased significantly; among women, on the other hand, by endline there was a slight decline in the percentage agreeing with at least one justification for domestic violence as compared their male counter parts. Exposure to GBV campaign messages was associated with a reduction in justification among all endline respondents, though the association appears stronger and more consistent among men, more women and girls were not reached during this intervention.

At endline, significantly more women and fewer men agreed with most justifications for domestic violence. WHO and DHS multicountry assessments and other studies have found that women who support wife-beating are at increased risk of experiencing domestic violence (Hindin, Kishor, & Ansara, 2008; Uthman, Lawoko, & Moradi, 2009; Abramsky et al., 2011). Therefore, identifying and being able to address women's attitudes toward GBV is an important strategy that needs to be looked into seriously.

Few men or women agreed with the gender that says a man should have the final word on decision made in his home before the intervention, yet even with little room for improvement, there were significant shifts towards not agreeing that a man should have the final word on decision made in his home. Because men had more room for improvement during the intervention, it was not surprising that a larger improvement was observed in men's attitudes toward this gender norm than in women's attitudes.

3.5 Study Limitations

The results of this endline assessment must be interpreted with some caution, because there was no concurrent comparison group. Other local efforts to improve attitudes about and responsiveness to GBV may have influenced observed changes. For example, some NGOs who work on similar thematic area may have been ongoing during the intervention and endline assessment period. Campaigns that use mass media or that expose target areas to messages often use uncontrolled pre-post comparisons because identifying areas that are both unexposed to the campaign messages and sociodemographically similar is often not possible (Gage, 2005; Lawoko, 2006; Foubert & LaVoy, 2000).

Finally, social desirability may have biased the findings both at baseline and at endline. For example, if respondents believed acceptance of violence was undesired, then they may have given responses that they believed the interviewer was seeking. This bias may be more likely for the endline survey; if respondents had been exposed to the campaign's messages, they may have felt pressured to voice attitudes that condemn rather than condone violence, even if their own attitudes had not changed. For this reason, this bias would have overestimated the impact of the awareness campaign.

However, the interviewers received training on how to maintain neutrality throughout the interviews—when posing questions and when documenting answers.

4.0 CONCLUSIONS

Short interventions such as that implemented by SAFAIDS and its partners can significantly and broadly improve attitudes and knowledge about GBV and HIV and potentially improve relationship behaviors. The awareness campaign successfully promoted gender equity, increased joint decision making among couples, increased knowledge on SRHR, increased the belief that women should have equal rights, reduced controlling behaviors among men, decreased beliefs among women that domestic violence is sometimes justified, and increased awareness about Malawi's gender laws. While the project results indicate the GBV and HIV campaign was broadly successful, longer intervention periods coupled with group education workshops and engagement with women and men together may achieve stronger, more widespread, and more lasting success.

4.1 Recommendations

Based on the project achievements and in view of continuation of the efforts in the area of combating GBV and HIV, the consultant submits the following recommendations for consideration:

Trainings and relevant activities aiming at GBV and HIV sensitisation in the three TAs should continue:

- Bring in family role models (males who were at the herm of beating their wives but through the project they have stopped and members of the community have witness the transformation taking place in such a family) to their communities apart from the champions.
- The MasP Clubs and Women Clubs within the three traditional Authorities should continue operating as the strong policy and monitoring capacity, in ensuring that protection of women and girls against GBV and HIV is consistently promoted throughout the intervention area.
- Scale up Men as protectors (MasP) strategy by extending into social networks and neighbouring communities through organized diffusion, to create a critical mass and consolidate shift in social norms. And consider coming up with Women's Club as well to complement MasP's Clubs if the battle against GBV and HIV is to be successfully won.
- Lack of clear linkages between Men as Protectors clubs and the women living with HIV support groups in the community affected learning of how effective the two models were at community level. For sustainability purposes, the two models should have been clearly linked in the community so that communities appreciate the role of each in the fight against GBV and HIV.
- Continue training of community leaders empowering them on violence against women and gender equality so as to be a powerful voice for the messages and programs, as well as through resources not much has been done on this– both educational and financial. Creating a positive message via multiple points of entry within communities is critical to ongoing efforts to scale up programs at local and national levels.

Strengthen community by-laws and effectiveness in that promotion of women's safety and SRHR in the context of HIV and GBV:

- Build upon strong community support for the intervention to facilitate women's collective empowerment and rights awareness and taking advantage of the already existing by-laws and policies.

- Strengthen capacity of existing MasP club members in formulation and enforcement of sustainable by-laws and policies that are aimed at protecting women and girls against GBV and HIV.

- In some Men's Clubs, there were weak members who were selected because of their capability to lobby for positions. A selection criterion should be developed stipulating qualities of who can be a member of the executive team.

Strengthen monitoring and evaluation systems for data and information generation:

- Even though current management approach ensured high quality results, the key stakeholders did observe some gaps in the coordination and communication among the two implementing partners during the activities. It is highly recommended in the future to put a management system in place with a clear role for the Project Managers and Partners. It will enable projects to depend less on individual abilities, capacities and engagement but more on well-established roles and responsibilities within the team. Probably it would be better for partners to enter into a signed agreement to make sure each partner understands their role in the whole project.

- Specifically, the future monitoring system for similar projects should: i) provide objective, verifiable evidence of progress towards and achievement of results and objectives; ii) enable insights to be drawn and shared about what worked well or what did not work well and why that was the case; iii) enable reflection on the context in which the Project is being implemented and how this affects programming and iv) provide the basis for fine-tuning, reorienting and planning future development efforts in the gender based violence sector.

- The quality of reporting system within the GBV project was not very satisfactory, some discrepancies were recorded between very strategic and more activity focused parts. For the next project, it is recommended to use best guidance to strengthen reporting and prepare more strategic reports as the reports were not clear and some important information were missing.

- Share lessons learned from this project with other actors working on gender in Malawi and beyond, find out about the existence of similarly transformative approaches in-country and agree upon best practices.

APPEDICES 1: DATA COLLECTION TOOLS

Tool 1: Focus Group Discussion Guide

Ward Name:_____ Group: _____

Number of Participants: _____ Date of Data Collection:_____

A. Factors that expose women and girls to or protect women and girls against GBV and HIV in the three selected wards

i. What is GBV? Specify types of GBV that you know.

ii. Do you know someone who has experienced GBV in thiscommunity? Specify the group most vulnerable groups and common forms of GBV

iii. What is HIV? How is it transmitted and how can it be prevented?

iv. Do you think there is any linkage between gender and HIV? Explain

v. What factors (by-laws, policies & laws, traditional and religious practices, and gender norms & practices,) exposes women and girls to GBV and HIV in your community? Identify the specific by-laws, policies & laws, traditional practices and gender norms and practices.

vi. What factors (by-laws policies & laws, traditional and religious practices and gender norms & practices) protect women and girls against GBV and HIV in your community? Identify the specific by-laws, policies & laws, traditional practices and gender norms and practices.

vii. Do women and girls know how and where to report violence when it occurs?

viii. Do women and girls trust and utilise these mechanisms?

ix. Does GBV occur often in your community? What types of violence? How is GBV usually dealt with? How does the community respond?"

B. Roles and capacities (knowledge, skills, influence and competence) of traditional leaders, couples, men, women, girls and boys in promoting and protection of women and girls against GBV and HIV in the three selected wards.

i. What activities are traditional leaders doing to promote protection of women and girls against GBV and HIV in your community? Explore if community leaders are enforcing by-laws, changing by-laws, publicly speaking to promote protect women and girls, etc

ii. Comment on the capacity (knowledge on GBV, HIV, by-laws, gender policies & laws, skills and attitude towards gender equality) of traditional leaders to protect women and girls against GBV and HIV.

iii. What do you think should be done and by who to improve 1) capacity and influence of traditional leaders to be able to change by-laws and mobilize communities to ensure gender equality?

iv. What activities are 1) couples; 2) men 3) boys, 4) women and 5) girls doing to promote protection of women and girls against GBV and HIV in your community? (follow up prompt: Are these activities effective in protecting women and girls from GBV and HIV?)

v. Do you think 1) couples; 2) men 3) boys, 4) women and 5) girls in your community are doing anything to protect women and girls against GBV and HIV? Explain? Investigate about their knowledge, attitude and perceptions towards gender equality.

vi. Do you think it is their role to protect women and girls?

vii. What do you think should be done to couples, men, women, girls,and boys and by who to improve their knowledge and roles of couples, men, women, girls and boys to protect women and girls against GBV and HIV?

C. Determine the acceptability of approaches/methodologies- MasP and Stepping Stone Models by community members.

i. Are there any approaches or methodologies being used in the community to protect women and girls against GBV and HIV (Find out how they work and the names of the methodologies)
ii. What do you like and dislike about the models and approaches currently being used to protect of women and girls against GBV and HIV in your community? Explore their effectiveness
iii. Would your community embrace working with traditional leaders to protect and support women and girls against GBV and HIV in your community? Explain
iv. Would your community embrace working with men and boys in protecting women and girls against GBV and HIV in your community? Explain
v. Would your community embrace working with couples in protecting of women and girls against GBV and HIV in your community? Explain

INDIVIDUAL SURVEY TOOL

Instructions

All the questions require you to just select an answer from the given options. Please answer ALL questions as it is important for us to have complete information. ***Please CIRCLE the number next to your answer. If you make a mistake, cross out the incorrect answer}***

Guidance for introducing yourself and the purpose of the interview:

Muli bwanji? Ine ndine ……. ndikugwira ntchito ndi a SAFAIDS/YODEP. Ine ndi anzanga ena tikupanga kafufufuku wokhuzana ndi za nkhanza kwa amai. Nkhomo/nyumba yanu yasankhidwa/inu mwasakhidwa mwamayere kutenga nawo mbali mu kafufufukuyu. Monga ndanenera kafufufukuyu akuyang'ana zankhanza kwa amai and atsikana ndiponso mbali yomwe abambo akutengapo polimbana ndi mchitidwe umenewu. Mukucheza kwathu ndikupemphani kuti mukhale omasuka.Ndikukutsimikizirani kuti zomwe mundiwuze zidzasungidwa mwachinsinsi. Inu ndi apabanja lanu simudzatchulidwa mwanjira ina ili yonse mu malipoti omwe adzatuluke kuchokera mu kafufufukuyu. Koma, zomwe munene pano zithandiza kulimbikitsa ndondomeko ya ntchito za chitukuko mdera lino. Ndipo dziwani kuti muli ndiufulu kusiya kuyankha mafunso ngati mukuona kuti simukwanitsa.

Ndisanapitilize, kodi muli ndi mafunso pazomwe ndanenazi kuti ndifotokozere?

- **Kodi mungatipatseko nthawi yanu kwa ora kuti tichezelane pa zakafukufuku'yu?**

Starting time_____

HOUSEHOLD IDENTIFICATION AND INTERVIEW SUMMARY
TO BE COMPLETED AFTER INTERVIEW HAS BEEN DONE
No. of members in the HH: |____|____| No. of females in the HH : |____|____|
Is questionnaire complete? Yes |____| No |____|
Date checked |____|____||____|____||_1_|_7_| (D D M M Y Y) Supervisor's Signature: _____
Data entry clerk: _____ CODE |____| Date of data entry |____|____||____|____||_1_|_7_| (D D M M Y Y)

Section A: Background Characteristics	
Area Details	
T/A:	GVH:

Ward Name:		
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**
1	Age of respondent	Enter age _____
2	Sex of Respondent	1 = Male 2 = Female 3 = Other (Specify)
3	Marital status of respondent	1 = Married 2 = Widow/Widower 3 = Never married 4 = Divorced/separated
4	Status of household head	1 = Female below 25 years 2 = Male below 25 years 3 = Adult female aged between 25-54 years 4 = Adult male aged between 25-54 years 5 = Elderly female aged ≥ 55 years 6 = Elderly male aged ≥ 55 years
5	What is your religion?	1 = None 2 = Christian 3 = Muslim 4 = African Traditional Religion 5 = Other (Specify)_____
6	If Christian; specify the denomination	
A. Factors that expose women and girls to or protect women and girls against GBV and HIV in the three selected wards		
7	State ways in which HIV can be transmitted (circle all that apply)	1=Unprotected sex with person living with HIV 2=Sharing 'contaminated' objects such as sharp objects (razor blade, syringes, shaving sticks 3=Mother to child transmission at birth 4=Transmission of HIV breast feeding 5=Injecting Drug Use 6=Blood Transfusion 7=Other Specify
8	State ways in which risk of contracting HIV can be reduced (circle all that apply)	1=Abstinence 2=Correct and consistent use of protection 3=Limit multiple concurrent sexual partners 4=Seek early treatment of STIs 5=Prevention of Mother to Child Transmission 6=Treatment as prevention 7=PrEP 8=PEP 9=Other Specify
9a	In the setting could there be a place where you can get HIV-testing HIV testing,	a) HIV testing 1 = Yes 2 = No b) ART 1 = Yes 2 = No
9b	Name organizations that you know that provide HIV services	
10	In your community, are there organisations	1 = Yes

	involved in GBV or SRHR or gender equality interventions	2 = No 3 = Do not know					
11	In your community, do you know where you can access post GBV services such counseling, Post Exposure Prophylaxis, legal services?	a) Counseling 1= Yes 2 = No b) PEP 1 = Yes 2 = No c) Legal Services 1 = Yes 2 = No					
12	Mention any sexual reproductive health rights that you know *(Multiple responses)*	1= The right to life 2 = The right to equal treatment 3 = The right to personal security 4 = The right to privacy 5 = The right to HIV and SRH information 6 = The right to decide when and whom to marry 7 = Right to planning your family 8 = The right to health care 9.= The right to make decision about SRH free from cohesion 10. Other _____					
13	What factors expose women and girls to GBV and HIV in your community *(Multiple responses)*	1 = Traditional practices and beliefs 2 = Religious practices and beliefs 3 = Women and girls have less power to negotiate for safe sex 4 =Men are allowed to have multiple sexual partners 5 = Child marriage practices 6 = Child pleading due to poverty and/or hunger or appeasement of spirits 7 = Women and girls don't own assets 8 = Women and girls don't control assets or cant inherit 9 = Intergenerational relationships 10 = Women and girls are not aware of their rights 11 = It is difficult for women to exercise their sexual rights; eg, right to choose who to marry 12 = Existence of harmful by-laws					
14	Did any of the following happened to you or someone you know in the past 12 months?	**To myself** 1 = Yes 2 = No			**To Someone I Know in our Community** 1 = Yes 2 = No		
a	Girl married before 18 years						
b	Boy married before 18 years						
c	Girl child below the age of 18 years pledged due to poverty or hunger						
d	Girl child below the age of 18 years pledged to appease spirits						
e	Raped (specify sex and age)		Age___	Sex____		Age____	Sex____
f	Beaten by sexual partner (specify sex and age)		Age___	Sex____		Age____	Sex____
g	Beaten by a relative or any other person (specify sex and age)		Age___	Sex____		Age____	Sex____
h	Forced sex by sexual partner (specify sex and		Age___	Sex____		Age____	Sex____

	age)						
i	Unwanted kissing or sexual touching (specify sex and age)		Age___	Sex_____		Age_____	Sex_____
j	Psychological abuse e.g. accused of unfaithfulness, witchcraft, embarrassed in front of people						
B. Establish the roles and capacity (knowledge, skills, and competence) of traditional leaders, couples, men and boys to mobilize and influence communities to ensure gender equality							
15	Do you think that traditional leaders are critical in protecting women and girls against GBV and HIV?	1 = Yes 2 = No 3 = Not sure					
16	If 'Yes' in 15 above what type(s) of leaders? *(Circle all that apply)*	1 = Male traditional leader 2 = Female traditional leader 3 = Wife of a traditional leader					
17	What are the qualities of a traditional leader who can influence you to change your perceptions on GBV and HIV issues? *(Circle all that apply)*	1 = Trustworthy 2 = Good standing in the community 3 = knowledge on HIV and GBV issues 4 = Sensitive to confidential matters 5 = Mature 6 = Servant leader 7 = A rich leader 8 = Someone who does not abuse his/her authority 9 = Other Specify					
18	Are traditional leaders doing anything to protect women and girls against GBV and HIV in your community? **(If no, skip to 21)**	1 = Yes 2 = No 3 = Not sure					
19	If Yes in 18 above; what activities are they doing? (Circle all that apply)	1 = Speaking against abuse of women and girls during community meetings 2 = Raising awareness among community members on the rights of women. 3 = Redressing harmful cultural practices in the community 4 = Redressing by-laws that perpetrate abuse of women and girls 5 = Punishing pepertrators of violence in the community 6 = Supporting GBV survivors 6 = Other Specify_____					
20	Are you satisfied with the level of participation by traditional leaders in protecting women and girls against GBV and HIV?	1 = very satisfied 2 = Satisfied 3 = Not satisfied					
21	Are Men and boys involved in protecting women and girls against GBV and HIV in your community?	1 = Yes 2 = No 3 = Do not know					
22	If your response is yes in 21 above, what are they doing? (Circle all that apply)	1 = Publicly speaking against abuse of women 2 = Engaging other men to protect women and girls against GBV and HIV 3 = Supporting GBV survivors					

		4 = Taking action against perpetrators of violence 5 = Other specify_____			
23	Do you feel men and boys in your community have the appropriate knowledge and skills to promote protection of women and girls against GBV and HIV?	1 = Strongly agree 2 = Agree 3 = Disagree 4 = Not sure			
24	Do you feel women and girls are involved in protecting themselves against GBV and HIV in our community?	1 = Strongly agree 2 = Agree 3 = Disagree 4 = Not sure			
25	If your response is agree or strongly agree in 24 above, what are they doing? (Circle all that apply)	1 = Publicly speaking against abuse of women 2 = Engaging other couples to protect women and girls against GBV and HIV. 3= Supporting GBV survivors 4= Taking action against perpetrators of violence 5= Other specify_____			
Attitude and Perceptions Towards Gender Equality					
26	Do you strongly agree, agree, disagree or strongly disagree, with the following?				
		Strongly Agree	Agree	Disagree	Strongly Disagree
a	There are times when a woman deserves to be beaten				
b	A woman should tolerate violence in order to keep her family together It is okay for a man to hit his wife if she won't have sex with him				
c	It is alright for a man to beat his wife if she is unfaithful				
d	A man using violence against his wife is a private matter that shouldn't be discussed outside the couple				
e	Women who carry condoms on them are easy				
f	A man should be outraged if his wife asks him to use a condom				
g	A woman should obey her husband in all things				
h	A man should have the final word on decisions in his home				
i	It is the man who decides what type of sex to have				
j	A man needs other women even if things with his wife are fine.				
k	You don't talk about sex, you just do it.				
l	It disgusts me when I see a man acting like a woman.				
m	A woman who has sex before she marries does not deserve respect.				
n	It is a woman's responsibility to avoid getting pregnant.				
o	A real man produces a male child				

p	The husband should decide to buy the major household items				
Q	A woman should not initiate sex				
27	**Did you ever do any of the below (For men and boys only)**	**NEVER**	**ONCE**	**FEW**	**MANY**
A	In the last 12 months how many times did you slap your current or previous girlfriend or wife or throw something at her which could hurt her?	1	2	3	4
B	In the last 12 months how many times did you push or shove your current or previous girlfriend or wife?	1	2	3	4
C	In the last 12 months how many times did you hit your current or previous girlfriend or wife with a fist or with something else which could hurt her?	1	2	3	4
D	In the last 12 months how many times did you kick, drag, beat, choke or burn your current or previous girlfriend or wife?	1	2	3	4
E	In the last 12 months how many times did you threatened to use or actually use a gun, knife or other weapon against your current or previous girlfriend or wife?	1	2	3	4
28	**Did you ever do any of the below (For men and boys only)**	**NEVER**	**ONCE**	**FEW**	**MANY**
A	In the last 12 months, how many times have you physically forced your current or previous girlfriend or wife to have sex with you when she did not want to?	1	2	3	4
B	In the last 12 months, how many times have you used threats or intimidation to get your current or previous partner, girlfriend or wife to have sex when she did not want to?	1	2	3	4
C	In the last 12 months, how many times have you ever forced your current or previous girlfriend or wife to do something sexual that she did not want to do?	1	2	3	4
D	In the last 12 months, how many times have you forced your current or previous girlfriend or wife to watch pornography when she didn't want to?	1	2	3	4
29	**These next questions are about things you may have done with women who were not your girlfriend or wife. (For men and boys only)**	**NEVER**	**ONCE**	**FEW**	**MANY**
A	In the last 12 months how many times have you forced or persuaded a woman or girl who was not your girlfriend or wife at the time to have sex with you?	1	2	3	4
B	In the last 12 months how many times have you tried to force or persuade any woman	1	2	3	4

	who was NOT your girlfriend or partner to have sex with you, but did not succeed?				
C	In the last 12 months how many times have you had sex with a woman or girl who was not your girlfriend or wife when she was too drunk or drugged to stop you?	1	2	3	4
D	In the last 12 months how many times have you and other men had sex with a woman or girl who was not your girlfriend or wife at the same time when she did not agree to sex or you forced her?	1	2	3	4
E	In the last 12 months how many times have you and other men had sex with a woman or girl who was not your girlfriend or wife at the same time when she was too drunk or drugged to stop you?	1	2	3	4
30	**Did any of the following happen to you (For women and girls only)**	**NEVER**	**ONCE**	**FEW**	**MANY**
A	In the last 12 months how many times were you slapped by your current or previous boyfriend or husband or something thrown at you which could hurt you?	1	2	3	4
B	In the last 12 months how many times were pushed or shoved by your current or previous boyfriend or husband?	1	2	3	4
C	In the last 12 months how many times did your current or previous boyfriend or husband hit you with a fist or with something else which could hurt you?	1	2	3	4
D	In the last 12 months how many times were you kicked, dragged, beaten, choked or burnt by your current or previous boyfriend or husband?	1	2	3	4
E	In the last 12 months how many times did your current or previous boyfriend or husband threaten to use or actually use a gun, knife or other weapon against you?	1	2	3	4
31	**Did any of the following happen to you (For women and girls only)**	**NEVER**	**ONCE**	**FEW**	**MANY**
A	In the last 12 months, how many times did your current or previous boyfriend or husband physically forced you to have sex with you when you did not want to?	1	2	3	4
B	In the last 12 months, how many times have your current or previous boyfriend or husband used threats or intimidation to have sex with when you did not want to?	1	2	3	4
C	In the last 12 months, how many times have your current or previous boyfriend or husband forced you to do something sexual that you did not want to do?	1	2	3	4

D	In the last 12 months, how many times have your current or previous boyfriend or husband forced you to watch pornography when you didn't want to?	1	2	3	4
Acceptability of approaches/methodologies used in the MasP and Stepping Stone Models by community members					
32	Do you feel that traditional leaders are the appropriate group to be engaged so that they can mobilize and influence community members to protect women and girls against GBV and HIV?	1 = Strongly agree 2 = Agree 3 = Disagree 4 = Not sure			
33	Reasons for a Strongly agree or Agree in 32 above *(Circle all that apply)*	1 = Because of their ascribed power 2 = Trust worthy 2 = Good social standing 4 = They have wealth 5 = They are sensitive to confidential matters 6 =They are mature 7 = Because of their sex 8 = Their knowledge and skills 9 = They respect other people 10 = Other specify_____			
34	Reasons for 'Disagree in 33 above *(Circle all that apply)*	1 = I do not trust them 2 = Not of good standing in the community 3 = Lack knowledge and skills on HIV issues 4 = Not sensitive to confidetial matters 5 = Not mature 6 = Because of their sex 7 = They are proud 8 = Abuse their power on community members 9 = They are poor 10 =Other(Specify)_____			
35	Do you feel that men and boys are the appropriate group to be engaged so that they can mobilize and influence community members to protect women and girls against GBV and HIV?	1 = Strongly agree 2 = Agree 3 = Disagree 4 = Not sure			
36	Reasons for a 'Strongly Agree or Agree' in 35 above *(Circle all that apply)*	1 = Because of their ascribed power 2 = Trust worthy 3 = Good social standing 4 = They own and control assets 5 = They are sensitive to confidential matters 6 = They are the perpetrators of GBV so its good to involve them 7 = Because of their sex 8 = Their knowledge and skills on HIV and GBV issues 9 = Other specify			
37	Reasons for 'Disagree or Not sure' in 35 above or not selecting a particular group of	1 = I do not trust them 2 = Not of good standing in the community			

	leaders *(Circle all that apply)*	3 = Lack knowledge and skills on HIV issues 4 = Not sensitive to confidential matters 5 = They have negative perceptions and attitude on gender equality 6 = They are proud 7 = Other Specify)_____
38	Do you feel that couples are the appropriate group to be engaged so that they can mobilize and influence community members to protect women and girls against GBV and HIV?	1 = Strongly agree 2 = Agree 3 = Disagree 4 = Not sure
39	Reasons for a 'Strongly Agree or Agree' in 38 above *(Circle all that apply)*	1 = Trust worthy 2 = Good social standing 3 = They are sensitive to confidential matters 4 = Their knowledge and skills on HIV and GBV issues 5 = Other Specify
40	Reasons for 'Disagree or Not sure' in 39 above or not selecting a particular group of leaders *(Circle all that apply)*	1 = I do not trust them 2 = Not of good standing in the community 3 = Lack knowledge and skills on HIV issues 4 = Not sensitive to confidential matters 5 = They have negative perceptions and attitude on gender equality

THANK YOU

SAFAIDS- PROJECT EVALUATION QUESTIONNAIRE FOR KEY INFORMANT

THEMATIC AREA	MAIN QUESTION	RESPONSES
A RELEVANCE		
A.1 RELEVANCE OF OBJECTIVES	1. How are ALIGHT project objectives aligned to SAFAIDS priorities 2. In what way was the project strategic to SAFAIDS?	
A.2 RELEVANCE OF APPROACHES	1. How did you find the project's approaches relevant to the achievement of its objectives	
B EFFECTIVENESS		
B.1 PROGRESS TOWARDS ACHIEVEMENT OF OUTCOMES	1. In what way do you think the project implementation contributed to towards the stated outcomes	
C EFFICIENCY		
C.1 MANAGERIAL EFFICIENCY	1. To what extent was the project implemented within the deadlines and cost estimates 2. Were there any issues which arouse during implementation and how did the project manage that	
D SUSTAINABILITY		
D.1 DESIGN FOR SUSTAINABILITY	1. In what way were project interventions designed to have sustainable results, was there any exit strategy	
D.2 IMPLEMENTATION ISSUES: CAPACITY DEVELOPMENT AND OWNERSHIP	1. To what extent has the national capacity been developed so that SAFAIDS may realistically plan progressive disengagement	
D.3 IMPACT		
D.1 PERCEIVED IMPACT OF THE PROJECT	1. From your own perspective what would you say has been the impact of SAFAIDS project 2. What would you say is the most significant change which the project has brought about. 3. What factors do you think may have contributed to the success of the SAFAIDS project	
ADDITIONAL INFORMATION	1. What was the strategic Position of the project	