USAID
FROM THE AMERICAN PEOPLE

Women's Protection and Empowerment (WPE)

Final Evaluation of the International Rescue Committee's ESPOIR project in the North and South Kivu provinces of the Democratic Republic of Congo (DRC)

September 2014

This publication was produced for review by the United States Agency for International Development. It was prepared by Camille L. Evans, an independent evaluation consultant, who was recruited by the International Rescue Committee's Women's Protection and Empowerment Program

Table of Contents

1. Executive Summary…….....Page 4

2. Project Background……...Page 7

3. Evaluation Purpose and Questions……Page 7

4. Evaluation Methods and Limitations…… Page 9

5. Findings:
   a. **Effectiveness**
      i. Objective One - Gender based violence survivors in North and South Kivu are able to gain access to timely care and treatment services…….Page 13
      ii. Objective Two - Service providers have improved capacity to respond effectively to GBV and facilitate the recovery of survivors in emergency and post conflict settings……..Page 14
         – *Psychosocial Assistance*……Page 14
         – *Psychosocial Assistance: Challenges*……Page 16
         – *Medical Assistance*……Page 17
         – *Medical Assistance: Challenges*……Page 18
         – *Legal Assistance*……Page 20
         – *Legal Assistance: Challenges*……Page 21
         – *Social reintegration/economic empowerment assistance*……..Page 23
         – *Social reintegration/economic empowerment assistance: Challenges*…….Page 24
      iii. Objective Three - Key stakeholders have improved capacity to lead and participate in community based social integration and economic recovery activities that include strengthening community response to and prevention of GBV……..Page 24
         – *Improved local capacity: Challenges*……Page 25
         – *Improved local capacity to support women's empowerment: Male discussion groups*...Page 26
         – *Other Challenges: Access for girls (under 18)*……Page 28
   b. **Impact**.....Page 30
         – *Psychosocial Functionality*……Page 30
         – *Individual Questionnaire Analysis*…….Page 30
         – *Social Economic Outcomes - Women for Women, International*……...Page 34
         – *Community Based Organization Member Feedback*…….Page 34
   c. **Sustainability**……....Page 36
         – *Implementation via local women-led community based organizations and local community structures: Sustainable capacity building*……..Page 36
         – *VSLA, Social Reintegration and Income Generating Activities: Sustainable Economic Empowerment*……Page 36
         – *Increased capacity of women-led community based organizations to facilitate income generating / social reintegration activities and awareness building in the community*…Page 36
         – *Increased awareness of women's rights issues in the community*…….Page 37
         – *Increased social cohesion as an impact of the VSLA*……Page 37
         – *Sustainability Challenges*..... Page 37

Table of Contents (continued)

6. Lessons Learned……....Page 40

7. Recommendations…….....Page 41

8. Appendices
   - Appendix I: Documents Reviewed
   - Appendix II: Evaluation Focus Group and Individual Survivor Questionnaire Sites
   - Appendix III: Key Informant Interviews – Names and Titles
   - Appendix IV: Focus Group Discussion Interview Protocol with Community Stakeholders (including community based organization leadership, Relais Communautaire (RECO), health centers, civil/government actors, psychosocial assistants)
   - Appendix V: Focus Group Discussion Interview Protocol with Women and Girl Community Based Organization Members
   - Appendix VI: Focus Group Discussion Interview Protocol with Members of the Village Savings and Loans Associations (VSLAs)
   - Appendix VII: Focus Group Discussion Interview Protocol with Participants from the EMAP Male Discussion Groups
   - Appendix VIII: Key Informant Interview Protocol
   - Appendix IX: Individual Questionnaire for Survivors
   - Appendix X: Pre/Post Questionnaires Used to Interview Male Discussion Group Participants Before and After the Group
   - Appendix XI: IRC/ESPOIR Psychosocial Functionality Tool
   - Appendix XII: Evaluation Statement of Work
   - Appendix XIII: Signed Statement of Disclosure of any Conflict of Interest by Evaluation Consultant that Attests to a Lack of Conflict of Interest or Describes an Existing Conflict of Interest Relative to the Project Being Evaluated.

1. Executive Summary

With USAID support, the International Rescue Committee (IRC)'s Women's Protection and Empowerment (WPE) program implemented a project called Ending Sexual Violence by Promoting Opportunities and Individual Rights (ESPOIR). The overall objective of the project is to promote the well-being of women and girls and to mitigate the consequences of gender based violence (GBV). The five-year project ended on September 30, 2014, including an initial three-year period (ESPOIR-1), then an extension for an additional two years (ESPOIR-2).

A performance evaluation of the five-year ESPOIR project was conducted. Data collection for the ESPOIR end of project evaluation was carried out from 18 August – 1 September 2014. The evaluation focused on assessing the effectiveness, impact and sustainability of the project's activities and outcomes. The evaluation design includes a mix of quantitative and qualitative data collection methods based on participatory research methods. The following evaluation methodology was used to gather data on the indicators and evaluation questions included in the terms of reference for the evaluation: (a) Review of key documents; (b) Focus Group Discussions; (c) Key Informant Interviews; (d) Individual questionnaires with Women and Girl Survivors

The ESPOIR project objectives include activities and outcomes pertaining to: timely care for survivors; improved capacity to respond to GBV and facilitate the recovery of survivors; and community stakeholders having improved capacity to lead and participate in social integration and economic recovery activities. Evaluation findings include progress made and outcomes obtained on the project objectives as they relate each of project's activities: psychosocial, medical, legal and social reintegration/economic empowerment assistance. This report also discusses the sustainability of the project's activities and outcomes.

Summary of Evaluation Findings

Timely Care - Since October 2013, Fifty-eight per cent (58%) of cases of rape were reported within 72 hours by community members and an average of ninety-eight per cent (98%) of cases reported within 72 hours were referred for medical assistance. In fiscal year 2014 1,860 survivors received at least one essential service (psychosocial, medical and/or legal) and 1,821 women participated in socio-economic /reinsertion activities. Over the 5-year period of the project, North Kivu showed more reporting of rape within 72 hours. Overall, there was a decrease in the percentage of rape reported within 72 hours from Year 1 to Year 5 but it this is likely to have been affected by the disruption of awareness raising activities during times of insecurity. There was, however, a steady increase in the percentage of survivors referred for an essential service which evidenced the increased capacity for community stakeholder to refer survivors for services within the referral pathway. There was also a strong retention rate over the course of the five year period for survivors and other women engaged in socio-economic / social reintegration activities (including VSLA activities). These outcomes all surpass the projected estimates set by the project and reflect that ESPOIR has been effective in providing timely care and treatment services.

Psychosocial Assistance - IRC/ESPOIR implemented the provision of psychosocial assistance by training and providing ongoing technical support to psychosocial assistants based within each of the ESPOIR-funded community based organizations (CBO). Feedback from focus group discussions with CBO members and community stakeholders confirmed that the psychosocial assistants are well integrated into the referral pathway for survivors both within the community. Analysis of a sample of 227 survivors who accessed psychosocial support confirmed a dramatic increase in psychosocial functioning of survivors, both in the ability to resume performing everyday tasks and decrease in symptoms associated with depression, anxiety, trauma or other forms of decreased psychosocial well-being. The impact on psychosocial functioning of ESPOIR supported survivors was also assessed via a questionnaire developed by the evaluation consultant. Analysis of the questionnaire results showed that in both North and South Kivu, a higher percentage of survivor respondents who completed the psychosocial support intervention consistently answered "yes" to friends, people or services in the community which could support them and generally, a higher percentage of survivor respondents who completed the psychosocial support intervention reported higher levels of self esteem.

Medical Assistance - Health zones in North and South Kivu reported that the capacity of health zones and health centers had increased through training and provision of Post Exposure Prophylactics (PEP) kits. Training included the Clinical Care of Sexual Assault Survivors as well as training on the referral pathway for survivors. In over 90% of community leader focus groups conducted as part of this evaluation, community structures including the women-led community based organizations, health centers, *chef du groupement* and *Relais Communautaire* (RECO) demonstrated awareness of importance of referring to health centers. Challenges for the medical assistance provision include the sustainability of the service after the end of the project. With the ending of the ESPOIR project, there may be a challenge for health zones to fully step into the role of coordinating with UNICEF in regards to the ordering (i.e. monitoring how many PEP kits are available in health centers and making UNICEF aware when additional PEP kits are needed) and the distribution of the PEP kits from the health zones to the health centers.

Legal Assistance - There have been a number of challenges regarding legal services. In North Kivu, legal services stopped in October 2012 due to the escalation of conflict in the region. IRC/ESPOIR was not able resume legal assistance but completed a mapping exercise of other legal service provider in the region in June 2014. The final quarterly report will document whether ESPOIR partners have been able to integrate referrals to the newly identified legal assistance service providers into the established referral pathway in North Kivu. In South Kivu, IRC/ESPOIR had to change legal service providers due to performance issues but has now built a strong partnership with legal assistance partner, ADMR. ADMR reported that ESPOIR helped build the organization's capacity by providing financial management training, assistance with governance planning and technical support in the form of training. From September 2012 through end of June 2014, ADMR, provided legal assistance to 184 survivors of gender based violence. This is compared to 168 survivors who chose who pursue legal action in year one; 198 survivors in year two; and 165 survivors from February to September 2012. It is noted that there has been a shift in the perpetrator profile from armed actor to locally known perpetrator may provide some context for a decrease in the number of rape prosecutions. While the work of ADMR has surpassed its projected targets, the relatively low number of survivors receiving legal assistance (e.g. 57 cases of rape survivors assisted by ADMR versus 337 incident of rape reported under the ESPOIR project since January 2014) represents the difficulties faced by survivors and legal assistance providers when seeking legal prosecutions of perpetrators. Other challenges facing the legal assistance provision include the sustainability of the service after the end of the project as legal fees and transport costs represent an area where there is an ongoing need for financial support.

Social Reintegration/Economic Empowerment Assistance - According to ESPOIR project annual reports, as of June 2014, a total of 140 VSLA groups were created; 16 in North Kivu and 124 in South Kivu. By the end of Year 4 in North Kivu, at the share-out, the average amount in savings per VSLA was $1,263 and the average rate of return for the loans that were issued was 38.51%. In South Kivu, at the share-out, the average amount in savings per VSLA was $996, and the average rate of return for the loans that were issued was 51%, with the average amount shared-out for each VSLA being $1,506. IRC/ESPOIR worked with women-led local community based organizations (CBOs) to implement social reintegration / income generating activities such as tailoring, soap-making, pastry-making, embroidery, knitting and animal husbandry. During focus group discussions with local community based organizations, members clearly demonstrated local expertise in facilitating and teaching social reintegration and income generating activities. In focus group discussions, it was confirmed that VSLA groups and social reintegration / income generating activities have a positive social and economic impact on the lives of women and their status in the community.

Challenges for social reintegration / economic empowerment assistance included the impact of periods of intense conflict. Armed conflict impacted how quickly Village Savings and Loan Association groups could be implemented. In both North and South Kivu, there were several start and stops to implementing VSLAs. This meant that there was an extended period to carry out EASE curriculum which supports the community implementation of VSLAs. In South Kivu, the third phase of EASE curriculum has yet to be implemented.

Impact - IRC/ESPOIR developed male discussion groups to facilitate behavior change for men and to reduce violence towards women. During focus group discussions, former male discussion group participants confirmed that the male discussion groups have been well received by community members. In all of the evaluation focus groups with former male discussion group members, men were able to give concrete

examples of behavior changes they had made and the impact of attitude changes in the community. In focus group discussions with CBO members, women were also able to give examples of behavior changes of men who participated in the male discussion groups. Some of the behavior changes included changes in household decision making, gender division of household tasks and welcoming women's participation in public forums.

IRC partnered with international non-governmental organization, Women for Women International – DRC (WfWI), to provide socio economic reintegration activities to ESPOIR survivors and beneficiaries in some areas in South Kivu. The WfWI intervention resulted in women having an improved understanding of their rights and saving money, an increased income and upon graduation from the WfWI intervention, 100% percent of ESPOIR participants report being employed or self-employed.

One hundred percent (100%) of CBO member focus group participants reported positive outcomes as a result of their involvement with ESPOIR activities. The impact on women's lives described included: an improved relationship with their husband (including less physical abuse and more respect); contributing financially to the household including paying school fees (which has a secondary impact of more children going to school, including girls); more respect of women in the community (including community leadership seeking the opinion of women); secondary benefits related to improved hygiene and infant care gained from skills learned as part of vocational training (i.e. soap-making, knitting infant clothing), and improved psychosocial well-being.

Lessons Learned and Recommendations

A number of lessons learned emerged from the ESPOIR project which informed changes in program design and strategy over the fiver-year period of the project. This report includes a summary of those lessons learned which contributed to the more positive outcomes of the project. In addition, the following twelve (12) recommendations have been formulated to address the project's challenges described in the report:

1. Facilitate regular Lessons Learned workshops between the North and South Kivu teams in order to facilitate best practice learning.
2. Consider more overlap and joint working between IRC/ESPOIR staff and Rapid Response to Population Movement (RRPM) teams so that ESPOIR staff benefit from the same training and coordinated planning as the RRPM teams.
3. Disaggregate monitoring data regarding sexual violence from other forms of gender based violence.
4. Support community based organizations to use some portion of generated income to maintain an organizational budget.
5. Consider formation of VSLA-like groups for community structures to facilitate the sustainability of their activities once project resources are no longer available.
6. Implement child and/or youth specific programming which can access vulnerable and survivor children and youth.
7. Include organizational capacity building along with building of technical knowledge of community structures to implement project activities.
8. Consider building the capacity of local health centre staff and the local health zones to provide direct psychosocial support and provide training and quality assurance for the provision of psychosocial support by the women-led community based organizations / psychosocial assistants.
9. Consider building the organizational capacity of the police by organizing gender based violence sensitivity training for police and recommending background screening criteria for the recruitment of police.
10. Consider providing "training of trainer" training as well as facilitators training to facilitators of the male discussion groups so that training can potentially be cascaded.
11. Encourage the substantial involvement of government authorities and key ministries at the national, provincial, territory and community level in project implementation.
12. Consider co-locating Community Driven Reconstruction (CDR) programming with ESPOIR project sites to address multi-systemic development issues such as governance which can increase positive outcomes for project beneficiaries and communities.

2. Project Background

The International Rescue Committee (IRC)'s Women's Protection and Empowerment (WPE) program has been responding to and preventing gender-based violence and providing critical assistance to survivors of sexual violence and their families in eastern Democratic Republic of Congo (DRC) with USAID support since 2002. IRC projects aim to meet the safety, health, psychosocial, socioeconomic and justice needs of women and girls who are survivors of or are vulnerable to gender based violence (GBV) by institutionalizing effective short- and long-term protection from violence. Within this scope, on September 17, 2009, USAID awarded IRC cooperative agreement AID-623-A-09-00012 to implement a project called Ending Sexual Violence by Promoting Opportunities and Individual Rights (ESPOIR), with the overall objective of promoting the well-being of women and girls and mitigating the consequences of gender based violence (GBV). The ESPOIR project seeks to ensure women and girls access the life-saving services they need, and empowering community-led GBV response and prevention in eastern DRC. The initial three-year long project (ESPOIR-1) was extended in September 2012 for an additional two years, and ended on September 30, 2014 (ESPOIR-2).

The objectives of the ESPOIR project include:

- Objective 1: GBV survivors in North and South Kivu gain access to timely care and treatment services
- Objective 2: Service providers have improved capacity to respond effectively to GBV and facilitate the recovery of survivors in emergency and post conflict settings; and
- Objective 3: Key stakeholders have improved capacity to lead and participate in community based social integration and economic recovery activities that include strengthening community response to and prevention of GBV

The ESPOIR project aspires to meet its objectives by:

- Building the capacity of local women-led community based organizations to provide economic and social reintegration activities;
- Building the capacity of psychosocial assistants within local CBOs to provide case management and psychosocial support to survivors of violence;
- Building the capacity of health centers to respond appropriately to the medical, psychosocial and referral needs of survivors;
- Increasing the capacity of local community structures and leaders to respond and recognize to the needs and rights of girls and women, including vulnerable women and survivors
- Providing opportunities for economic empowerment through Village Savings and Loan Associations (VSLA);
- Advocating for the legal rights of survivors by supporting a local NGO providing legal assistance and increasing community knowledge.

The project operates in North Kivu (Rutshuru territory) and in South Kivu (Kabare, Kalehe, Walungu, Fizi and Uvira territories).

3. Evaluation Purpose and Questions

A performance evaluation of the five-year ESPOIR project was conducted over a 4-week period from August to September 2014. The evaluation focused on assessing the effectiveness, impact and sustainability of the project's activities and outcomes. Each of these areas is addressed through the following evaluation questions:

a) Effectiveness: Has the project attained its objectives?

The project aimed to promote the well-being of women and girls and mitigate the consequences of GBV, through actions outlined in the three project objectives (see above).

Sub-questions: Have all activities been implemented effectively? Has the project been managed effectively? What were the challenges in implementing the project? Were there common challenges faced across programmatic areas (access to medical, psychosocial, legal and income generating activities) and how were they overcome? Did the risk mitigation matrix anticipate these challenges? How were the risks mitigated? What were the main lessons learnt from activities implemented? What best practices have been identified on design and implementation of holistic GBV programming? How has the programming been the same or different in conflict-affected areas and in cases where perpetrators were associated with armed forces or armed groups?

b) Impact: What were the main positive and negative changes produced by the project implementation?

The IRC has outlined the following expected outcomes from the implementation of the project:

- Survivors of GBV receive timely and appropriate care and support; Community members know what services exist, why they are important, and how to access them in a timely manner
- Women-led CBOs and local service providers provide timely referrals for survivors of GBV
- GBV coordinating bodies identify and take action to address gaps in service delivery in North and South Kivu
- Service providers provide quality case management, psychosocial, health and legal services, and socioeconomic support
- The capacity of IRC and its partners to rapidly respond to sexual violence in emergencies is reinforced
- During emergencies, minimum interventions are implemented to meet the immediate safety and health needs of women and girls
- Women and girls participate in basic social integration and empowerment activities
- Communities take action to improve the safety and well-being of women and girls, including promoting support for survivors
- Women participate in economic recovery activities, including credit and savings projects, and carry out joint decision making with their partners.

Sub-questions: What outcomes can be identified as a result of the project implementation? What unintended positive and negative changes took place? What part of the project was most important in catalyzing the change? What has been the impact of the project on survivors' daily functioning and psychosocial well-being (analysis of functionality tool used)? What has been the impact of the project on women and girls' social and economic functioning/empowerment (self reported in discussion with women and girls) and reintegration into community life? How did the project activities address gender issues during project implementation, such as how were women/survivors economic empowerment/reintegration activities perceived in the communities, including by male members? What was the effect of the male engagement activities using the Engaging Men in Accountable Practice (EMAP) curriculum? What were the overall project outcomes and effect on males and females in target communities and the rates and trends of gender-based violence cases reported over time?

c) Sustainability: Did the project implementation promote lasting solutions by strengthening, through systematic capacity building, mentoring and follow-up, local institutions to promote the well-being of women and girls and mitigating the consequences of GBV.

As outlined in the project's sustainability and exit strategy, the IRC committed to local capacity building, partnership strategy, and a diverse funding base for its Women's Protection and Empowerment program. Some specific sustainability focus has been put on working with local organizations to offer case management to survivors, provide medical care through referrals to medical structures, using the Economic and Social Empowerment (EA$E) model with VSLA methodology for women's continued access to financial resources. The other two key activities mentioned in the sustainability and exit strategy (legal

support and Men's Dialogue Groups) were described as less likely to continue after the ESPOIR project. The evaluation should asses challenges related to sustainability of legal support for survivors of GBV.

Sub-questions: Did the IRC's technical support to local service providers including non-governmental organizations (NGOs) and community based organizations (CBOs) (trainings, ongoing technical visits, mentoring) provide demonstrated increase in the partners' organizational and technical capacity to provide essential services to gender-based violence survivors? If so, to what extent would this capacity permit the partners to continue providing quality services if there was no further funding from the IRC? What is the level of local ownership by community stakeholders (e.g. CBOs, *Relais Communautaire* (RECO), health centers, in ensuring that the activity or service (medical, psychosocial, legal and income generating activities) continues after project funding ends? What was IRC's contribution to GBV strategies in external coordination mechanisms, both at the national as well as provincial level? To what extent did project activities contribute to local capacity development of governmental and civil society actors to analyze, implement, and evaluate GBV prevention and response in target geographic areas?

4. Evaluation Methods and Limitations

Design and Implementation of Evaluation

Data collection for the ESPOIR end of project evaluation was carried out from 18 August – 1 September 2014. The evaluation design includes a mix of quantitative and qualitative data collection methods based on participatory research methods. The evaluation questions were developed according to the terms of reference of the evaluation consultant which respond to each of the evaluation objectives. The evaluation questions also reflect OECD-DAC evaluation criteria[1] indicators related to relevance, effectiveness, efficiency, impact and sustainability of the project's activities and of the project model. The evaluation methodology used to gather data on these indicators and respond to each of the evaluation questions included:

- Review of key documents (e.g. weekly and/or monthly reports, proposal documents, GBV IMS database)
- 41 Focus Group Discussions (FGDs) (10 sites in North Kivu; 10 sites in South Kivu):
  - 16 FGDs with community stakeholders (including community based organization leadership, Relais Communautaire (RECO), health centers, civil/government actors, psychosocial assistants)
  - 16 FGDs with women and girl community based organization members
  - 5 FGDs with members of the Village Savings and Loans Associations (VSLAs)
  - 4 FGDs with participants from the Engaging Men in Accountable Practice (EMAP) male discussion groups
- Interviews with key informants (civil/government actors, UN coordination agencies, key IRC ESPOIR project staff)
- 162 Individual questionnaires[2] with women and girl survivors (comparison of newly referred psychosocial assistance cases as control group with cases where survivors has completed the psychosocial assistance intervention)
  - 72 questionnaires in North Kivu (6 sites; 36 new cases, 36 old cases)
  - 90 questionnaires in South Kivu (9 sites; 41 new cases, 45 old cases, 4 not marked old or new)

The review of key documents provided program statistics used to evaluate year to year progress towards targets set by the project. Focus group discussions with community stakeholders focused on questions regarding implementation and sustainability of project activities and capacity building of community stakeholders. Focus group discussions with women and girl community based organization members focused on the activities accessed by women and girls and the impact of those activities on the lives and status of women and girls. Focus group discussions with the Village and Loan Associations (VSLAs)

[1] The DAC (Development Assistance Committee) Principles for the Evaluation of Development Assistance, Organisation for Economic Cooperation and Development (OECD), (Paris, 1991).

[2] Both categories of survivors, newly referred cases and cases where the survivors completed the psychosocial intervention, completed the same questionnaire. Please see Appendix IX for a copy of the questionnaire used.

focused on the processes, impact and sustainability of the VSLAs. Focus group discussions with the EMAP male discussion groups focused on topics discussed, the recruitment process, impact and the sustainability of the male discussion groups. Key informant interviews focused on coordination mechanisms for ESPOIR activities and capacity building of community stakeholders. Finally, the individual questionnaires for survivors focused on the psychosocial functioning and social connectedness of those who were starting and those who completed the psychosocial support intervention. Please see Appendices II - III for a table outlining the documents reviewed, focus group and survivor questionnaire sites, and the names/titles of all key informant interviews. Please see Appendices IV - IX for samples of the focus group discussion and key informant interview questions as well as the individual questionnaire for survivors[3].

The evaluation consultant conducted 2 one-day assessment training workshops with each of the evaluation teams in North and South Kivu. The evaluation team in North Kivu consisted of 4 project staff including 2 field officers (2 male), 1 monitoring and evaluation officer (male), 1 monitoring and evaluation assistant (male). The evaluation team in South Kivu consisted of 8 project staff including the Manager of Gender Based Violence (GBV) Services (male), 1 monitoring and evaluation officer (female), 1 psychosocial officer (female); 1 health officer (female), 4 other field officers (2 male, 2 female) The assessment training covered general research methods, confidentiality, informed consent and a review of the specific data collection tools used for the evaluation. The assessment training also included a focus group discussion with staff to review understanding, appropriateness and cultural relevance of the questions included in the informed consent document and the focus group discussion data collection tool. With feedback from project staff, the evaluation consultant chose 9 project sites in each province in which to conduct the evaluation. The project sites were chosen based on having a representation of each of the targeted focus groups (i.e. CBOs, community leaders, VSLA and EMAP male discussion group). Sites were also chosen based on geographic location and logistical factors related to what sites could be reached within the time frame allotted for the evaluation. In addition, the evaluation consultant reviewed the questionnaire developed to interview individual survivors with the psychosocial officers in North Kivu to confirm relevance, understanding and appropriateness. Changes were made to these documents based on the feedback received from the staff. The evaluation consultant also incorporated feedback from the Women's Protection and Empowerment (WPE) Program Advisor and the WPE Monitoring, Evaluation & Research Coordinator into the data collection tools.

All staff who attended the training were involved in data collection. The four ESPOIR project staff in North Kivu, the 8 project staff in South Kivu staff and the evaluation consultant made up the members of the evaluation team. During key informant interviews, the WPE Program Advisor, the North Kivu WPE Program Coordinator, the North Kivu WPE Community Education Supervisor, and the South Kivu GBV Services Manager identified ESPOIR external partners. Based on the information from these key informant interviews and the review of proposal and annual report documents, the evaluation consultant compiled and confirmed a list of external partners and arranged for additional key informant interviews of the external partners. Field officers were assigned to organize focus groups according to their domains of work (i.e. field officer working with VSLA organized VSLA focus groups, field officer working with CBOs organized CBO focus groups, etc.). The psychosocial officers in North and South Kivu were asked to work with a sample of psychosocial assistants based in the ESPOIR-supported community based organizations to carry out individual interviews with survivors using the questionnaire developed by the evaluation consultant. The evaluation team sought informed consent, obtaining signatures[4] on consent forms, from the participants of the focus group discussions prior to beginning the discussions. The psychosocial assistants also sought informed consent from survivors prior to completing the questionnaires with survivors. Various project staff that made up a part of the evaluation team assisted the evaluation consultant to facilitate focus group

[3] A summary of selected questionnaire results in provided in Graphs A - D in the *Findings: Impact – Individual Questionnaire Analysis* section of this report. The evaluation consultant has recorded the full questionnaire results in an Excel database which will be turned over to IRC Women's Protection and Empowerment program with a copy of this final evaluation report.

[4] The informed consent form was read aloud and explained in the local language of participants. Participants were given an opportunity to ask questions. Focus group discussion participants and questionnaire interviewees with limited literacy skills were assisted to create a mark or make an ink fingerprint on the consent form denoting their signature.

discussions by providing translation from French into local languages. The Monitoring and Evaluation Officer in North Kivu and the Manager for Gender Based Violence Services in South Kivu provided overall oversight for data collection and coordinated logistics for travel to each of the project sites.

The focus group discussions targeted girl and women members of community based organizations, members of VSLAs, community leaders, and members of the EMAP male discussion groups[5]. The evaluation consultant and the evaluation team facilitated each of the focus groups in a question and answer format using the questions from the focus group discussion protocol developed by the evaluation consultant (see Appendices IV - VII for the focus group discussion protocols used). Each focus group was assigned at least two members of the evaluation team; one person to facilitate the discussion, the other to record the responses from the focus group participants. ESPOIR project staff members of the evaluation team were able to conduct the focus group or interpret the focus group questions for the evaluation consultant into Swahili or local language of the group being interviewed.

The evaluation consultant, in consultation with the psychosocial officers, chose six sites in North Kivu and 9 sites in South Kivu where survivors would be interviewed. Psychosocial assistants in each of the selected sites were instructed to randomly select 3 survivors who had recently started receiving psychosocial support (1 visit or less) and 3 survivors who had received several sessions of psychosocial support (3 visits or more). Questionnaire respondents were randomly selected among survivors available in the project site locations during the evaluation period. Selecting survivor questionnaire respondents via the psychosocial assistants was done in order to protect the confidentiality of survivor respondents and not to cause undue risk or increase vulnerability of survivors by gathering them in one location or identifying them by name outside of the survivors' relationship with the psychosocial assistants. Comparison of the data from the two groups of survivors is intended to provide a snapshot of the impact of psychosocial assistance provided to survivors.

The focus group questions were developed based on evaluation questions listed in the previous section. The survivor questionnaire was designed to collect demographic information, information regarding income and the ability of respondents to meet their basic needs, survivors' social support network as well as survivors' sense of self-esteem and security. The questionnaire includes questions from the Rosenberg self esteem scale[6] . The questionnaire was developed in French and translated into Swahili. Interpretation of the questionnaire into local languages was also provided by the psychosocial assistants on an as-needed-basis[7] by each of project staff collecting data.

The evaluation consultant also had a feedback session immediately after the data collection period to review and receive feedback about the initial findings of the evaluation. The feedback session was with USAID Agreement Officer's Representative (AOR) Marcel Ntumba, several of his USAID colleagues covering women's protection, health and education programming and senior management of the IRC WPE program. Written feedback was also received from USAID in regards to the evaluation plan. The feedback from USAID has been incorporated into the focus of this evaluation report.

The use of the project staff as members of the evaluation team was not optimal as it posed a challenge as far as insuring objectivity of the data collection process. However, due to time constraints, limited resources to hire specific staff to conduct the evaluation and the benefit of using data collectors who could easily engage respondents due to being familiar with the community and having knowledge of the local language, the use of project staff proved more beneficial than not. To minimize potential bias, field officers were assigned to collect focus group data using a structured interview protocol where focus group facilitators were required to seek answers to every question in the protocol as well as potential follow up questions depending on the

[5] See beginning of *Evaluation Methods and Limitations: Design and Implementation of Evaluation* section for the question themes covered with each FGD group.

[6] Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press. The Rosenberg Self-Esteem Scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. Five of the items have positively worded statements and five have negatively worded ones.

[7] Psychosocial officers reviewed the questionnaires with the psychosocial assistants to clarify meaning and to review how to conduct the individual interviews with survivors prior to the psychosocial assistants completing the questionnaires with survivors.

responses of the focus group. This format also helped to reduce the level of subjectivity in the data collection and data interpretation process. Research ethics were reviewed as part of the assessment training session with the evaluation team. This included the necessity of reporting exactly what is said by focus group respondents. The same potential challenge existed in regards to having the psychosocial assistants interview survivors. However, the individual questionnaire for survivors includes multiple choice responses. This reduced the level of subjectivity in documenting and interpreting responses.

Another limitation of the evaluation was the inability to randomly select survivors from a list of beneficiaries as opposed to the psychosocial assistants choosing survivors to interview. This leaves the potential for selection bias. However, this could not be avoided as it would not have reflected ethical practice to breach the confidentiality of survivors by asking them to self-identify outside of their relationship with the psychosocial assistants. This also has implications for establishing a control group of survivors who did not receive psychosocial support. The preference would have been to make the comparison with survivors who did not receive the psychosocial support intervention. This could have been possible if there were survivors available to interview who did not choose psychosocial assistance. However, due to the limited time allotted for the evaluation, the stigma and sensitive nature of being a survivor, it was not possible to arrange for survivors who did not choose to have psychosocial support to be interviewed (i.e. via the health centre or other point of access within the GBV response referral network). Thus, the non-engagement of survivors who chose not to be referred for psychosocial support acted as a barrier to access this group of survivors for comparison. Instead the evaluation sought to compare the functioning of survivors at the beginning of the psychosocial support intervention and those who had more significant psychosocial support. There are other variables which might account for an increase in functioning among survivors other than the number of psychosocial support sessions (i.e. individual resiliency, level of functioning/trauma at time of referral, etc.). However, the comparison between newly referred survivors and survivors who had significant intervention is meant to provide a snapshot of the potential impact of psychosocial assistance.

The evaluation is meant to examine the five year period of the ESPOIR project. However, there was no baseline data collected at the start of the project[8] and no previous independent evaluation done during the five-year period of the project. This evaluation's data collection looks at the cumulative impact of the project at the end of the 5-year period as opposed to the impact made year to year and subjectively measures impact based on the current feedback of focus group participants. This provides limited information about what specific strategies or project changes contributed to project impact and decreases the objectivity of measuring impact by comparing baseline and endline results. To evaluate the impact made year to year, the evaluation consultant examined key data from project reports and the GBV Information Management System (IMS) database maintained by the project. This includes key indicators such as number of new cases identified, percentage of cases seen within 72 hours by health centers, source of referrals, number of girls/children (under 18) who have been able to access services, etc. The evaluation consultant analyzed this data from year to year over the five year period. As no baseline / endline comparison of data is possible, the evaluation consultant has attempted to triangulate data on the impact of the project by gathering information from multiple sources (i.e. multiple groups of community based organization members, community leaders, VSLA groups, male discussion groups; key informant interviews with external partners, project staff, etc.). This attempts to increase the objectivity of the reported impact by describing the project's impact from several sources confirming the same impact rather than one subjective source.

[8] Although a needs assessment was done at the start of the project, there was no formal baseline assessment of the overall project which would allow comparison using measures or data collection tools which could be used for an endline assessment. Instead the project uses baseline/endline measures to measure individual progress in a specific activity (i.e. psychosocial functionality tool for the psychosocial support provision) or a periodic review of service provision using a Quality Care Checklist (QCC).

5. Findings

a. Effectiveness

i. Objective One

A key measure of the effectiveness of the ESPOIR project is its ability to meet its project objectives. Objective 1 states, "Gender based violence survivors in North and South Kivu are able to gain access to timely care and treatment services". According to the *Guidelines for Gender Based Violence Interventions in Humanitarian Settings*[9], timely care refers to care provided within 72 hours of the incident of violence. To document striving to meet these standards, IRC/ESPOIR set estimates for the number of survivors who would potentially receive timely care based on the project's experience in the previous year (i.e. average per month per site)[10].

According to monthly and annual reports reviewed by the evaluation consultant, since October 2013, an average of ninety-eight per cent (98%) of rape survivors in ESPOIR assisted communities who reported cases within 72 hours of the incident were referred for medical assistance by community partners which make up the referral network. Fifty-eight per cent (58%) of cases of rape were reported within 72 hours by community members. This surpassed the project estimate of fifty-five per cent (55%). In fiscal year 2014 (September 2013 – August 2014), 1,860 (1,855 female; 5 male) gender based violence survivors received at least one essential service (psychosocial, medical and/or legal). This surpasses the Fiscal Year 2014 estimate of 1,830 survivors. In addition, 1,821 women participated in socio-economic /reinsertion activities in community-based organizations. This surpasses the fiscal year 2014 estimate of 1,300 women.

Table 1 (below) looks at three indicators for gaining access to timely care and treatment services over the 5 year period of the ESPOIR project. The table shows that North Kivu has consistently had more reporting of rape by survivors or community members involved in the referral pathway within 72 hours of the incident. ESPOIR annual reports suggests that this is because the North Kivu ESPOIR sites overlap with pre-established IRC Health Program sites which previously conducted community education around the importance of seeking treatment within 72 hours of an incident. One would expect with increased community awareness over time that the percentage of survivors reporting rape within 72 hours would increase. However, the table below shows a decrease. This is likely because of the insecurities which occurred in North and South Kivu towards the end of Year 2 and during Year 3 led to survivors and community members being displaced and services being less accessible as survivors and community members flee to areas where are not as accessible. The displacement of community members who were a part of the referral pathway also meant that community education activities may have been disrupted. In Year 4 and 5, there has been a steady increase in the percentage of survivors reporting within 72 hours. This is likely due to the stability of the population and increased community education activities.

When examining the percentage of survivors receiving or referred for one essential service, it is clear that there is a steady rise in these percentages over the 5 years of ESPOIR, indicating increased awareness of service providers within the referral pathway and increased accessibility for survivors once they make contact with a service provider within the referral pathway. As mentioned previously, ESPOIR has surpassed its fiscal year 2014 estimate of 1,300 women accessing socio-economic activities. Table 1 shows the steady increase year to year of women participants in socio-economic / social reintegration activities (including VSLA activities). This increase represents increased accessibility as well as the strong retention of women who once they became involved with an ESPOIR assisted activity or community based organization remain involved with the activity or organization. This strong retention rate has implications

[9] Guidelines for Gender Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, Inter Agency Standing Committee, September 2005.

[10] Only estimates can be set based on previous experience as it is impossible to predict how many women will suffer violence and seek assistance.

for increased positive impact for individual women over time but also for social and community cohesion built between women and the community during the 5 years of the ESPOIR project.

Table 1: Year to Year Analysis of ESPOIR Objective One Indicators (Year 1 to 5)

Year	Rape reported within 72 hours by survivor / community member		Survivor received/referred for one essential service		Women participants in socio-economic / social reintegration activities	
	North Kivu	South Kivu	North Kivu	South Kivu	North Kivu	South Kivu
Year 1	87%[11]	28%	68%	96%[12]	333	2099[13]
Year 2	77.5%	22%	100%	96%	772	3937[14]
Year 3	Not reported[15]	Not reported[16]	96%	94.5%	972[17]	1418[18]
Year 4	50.3%	49.8%	100%	100%	1,197[19]	1,771[20]
Year 5 (January to June)	62%	55%	100%	100%	1243	578

ii. Objective Two

Objective 2 states, "Service providers have improved capacity to respond effectively to GBV and facilitate the recovery of survivors in emergency and post conflict settings". To meet this objective the ESPOIR project has taken the approach of implementing key activities via women-led community based organizations and other community partners. These activities include provision of psychosocial, medical, legal and social reintegration/economic empowerment assistance.

Psychosocial Assistance

Under ESPOIR-1, the psychosocial support provision was originally implemented via local non-governmental organizations. However, with ESPOIR-2, IRC adjusted its project design strategy to include implementation of the psychosocial support provision via women-led local community based organizations. It was found that the women-led community based organizations already had a presence in the community

[11] The higher percentage of rape reported within 72 hours in North Kivu is reflective of ESPOIR overlap with IRC Health Program where previous community education was in place regarding the importance of accessing care within 72 hours.

[12] The higher percentage of survivors accessing one essential is South Kivu is reflective of the higher percentage of rape cases in South Kivu during Year 1 of ESPOIR.

[13] Includes 5 VSLA pilot groups x 25 VSLA members per group = 125 VSLA members + socio economic activities facilitated by community based organisations.

[14] Includes 42 VSLA groups x 25 VSLA members per group = 1050 + socio-economic activities facilitated by community based organisations.

[15] Of the 3,106 cases of GBV reported during the third year of implementation, 76% reported cases of rape, and among these cases, 50% of survivors reported within 72 hours of the incident. These percentages represent the average between North and South Kivus.

[16] Ibid.

[17] Includes the 772 beneficiaries of socio economic activities facilitated by community based organisations from Year 2 + 8 new VSLA groups x 25 VSLA members per group

[18] Includes beneficiaries of socio economic activities facilitated by community based organisations from Year 2 + 5 new VSLA groups x 25 VSLA members per group

[19] Includes the 772 beneficiaries of socio economic activities facilitated by community based organisations from Year 3 + 17 new VSLA groups x 25 VSLA members per group

[20] Includes beneficiaries of socio economic activities facilitated by community based organisations from Year 3 + 5 new VSLA groups x 25 VSLA members per group

prior to involvement with IRC/ESPOIR and would therefore be more likely to continue activities after the ESPOIR project period[21].

ESPOIR has implemented the provision of psychosocial assistance by establishing psychosocial focal points (psychosocial assistants) community volunteers within the ESPOIR-funded community based organizations. The model of using local community volunteers to provide psychosocial support is the preferred model in developing country, emergency setting contexts, according to the *Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings*[22]. *The Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings* discourages the use of foreign mental health professionals as they do not represent a long term sustainable intervention and may not have an understanding of local psychology and culture. Instead, the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* encourages the recruitment of local volunteers with good engagement skills who have an understanding of local culture, customs and traditions. For the IRC/ESPOIR project, two to three psychosocial assistants were recruited from the membership of the community based organizations. The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* recommends that community volunteers receive the appropriate training in providing psychosocial support. IRC/ESPOIR psychosocial focal points received training and ongoing support from psychosocial officers who are IRC / ESPOIR project staff. The *IASC Guidelines on Mental Health and Psychosocial Support* provides training resources which can be used by non-governmental organizations for community volunteers. The IRC/ESPOIR training of the psychosocial assistants reflects the training recommended by the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.

Quality assurance of the psychosocial assistance provision is facilitated through a Quality Care Checklist (QCC) which includes indicators around having a private space to see survivors, the skills the psychosocial assistant utilizes to engage, listen, share information and do follow up with survivors as well as indicators assess the psychosocial assistants ability to explain the importance of receiving medical assistance within 72 hours of an incident of violence, document counseling sessions appropriately and the length of counseling sessions. The ESPOIR psychosocial officers review the QCC with the psychosocial assistants periodically. This guides the individual development of psychosocial assistants as well as the development of additional training for the psychosocial assistants as a group. Part of the training of the psychosocial assistants includes understanding the referral pathway for survivors to access response and support services.

During the focus groups conducted as part of this evaluation with community based organizations and community leaders in both North and South Kivu, psychosocial assistants and representatives of the community structures were clearly and consistently able to identify the referral pathway[23] as well as the

[21] Women led community based organisations appeared to be a more sustainable implementing partner than local non-governmental organisations. Local non-governmental organizations' presence in the community appeared to be more dependent on the availability of funding for implementing and sustaining activities.

[22] *The Interagency Standing Committee (IASC)* (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva, IASC.

[23] *The Guidelines for Gender Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies* (Inter Agency Standing Committee, September 2005) recommend a "referral pathway" of service providers to assist violence survivors. Services include medical assistance, psychosocial support assistance, legal assistance and safety/security assistance. As part of best practice, women's protection programs identify, train and/or build the capacity of service providers that can provide these four types of services for survivors then set up a coordination/communication

psychosocial assistants' role within the referral pathway. In fact, psychosocial assistants are often identified as the entry point into the referral pathway. Community leaders, whether within local community structures or the leadership / membership of the women-led community based organizations, often refer survivors who approach them to the psychosocial assistants or the health centre. Psychosocial assistants are also approached directly by survivors. This is evidence that the psychosocial assistants are well integrated into the referral pathway for survivors both within the community based organizations and the community.

Cognitive Processing Therapy (CPT) is a specialized mental health intervention which has been implemented by IRC/ESPOIR as an extension of the individual counseling and case management support provided by psychosocial assistants as part of the psychosocial support provision. In 2011, the IRC partnered with John Hopkins University (JHU) and the University of Washington (UW) to introduce group-based Cognitive Processing Therapy to women who were wither raped or witnessed rape, had high symptoms of depression, anxiety and PTSD and were struggling to complete daily tasks, such as caring for children or working. CPT groups are facilitated by psychosocial assistants who are supervised by mental health specialist trained in the CPT methodology. Survivors are referred by the psychosocial assistants to the CPT groups if after several sessions of individual support sessions, the survivor is still showing high levels of trauma and a low ability to complete everyday tasks.

IRC, JHU and UW undertook an impact evaluation[24] using randomize control trials in 2011 to evaluate the effectiveness of CPT in the North Kivu, South Kivu, DRC context. The research study showed that CPT was effective in reducing symptoms associated with trauma, depression and anxiety as well as increasing functionality or survivors' ability to complete everyday tasks associated with healthy psychosocial functioning and well-being (J. Bass et al, 2013)[25]. Furthermore, the study provides some evidence that a mental health intervention, such as CPT, can have some secondary benefits on economic functioning. The research study showed that when CPT is combined with a socio-economic empowerment intervention, like the Village Savings and Loans Associations (VSLAs), CPT participants can have better socio-economic outcomes such as increased hours of economic work and food expenditures.

During the course of the research study, one hundred fifty seven (157) survivors received the CPT group intervention from April to July 2011. The progress of these survivors were tracked six months after the CPT intervention and they continued to show improved psychosocial functioning as a result of the CPT intervention. In addition, a sample of CPT group intervention survivors were enrolled in VSLA groups after the six month follow-up period. These survivors showed higher socio-economic outcomes than compared to their non-CPT counterparts.

Psychosocial Assistance: Challenges

During the evaluation focus group discussions with community based organization membership, psychosocial assistants expressed that the paperwork requirements, case management responsibilities and the time needed for counseling support requires a significant time investment from the psychosocial assistants. Psychosocial assistants emphasize that this impacts their ability to earn an income whether it is

---

mechanism so that all of service providers know how and when to refer survivors to each other. The process of ensuring referrals for survivors and between these services providers is referred to as the referral pathway.

[24] This impact evaluation was supported by multiple donors- USAID, World Bank, SIDA, ECHO and Open Square Foundation.

[25] Bass, Judith K., Ph.D., MPH, Jeannie Annan, Ph.D., Sarah Mclvor Murray, M.S.P.H., Decra Kaysen, Ph.D., Shelly Griffiths, M.S.W., Talita Cetinoglu, M.A., Karin Wachter, M.Ed., Laura K. Murray, Ph.D., and Paul A. Bolton, M.B. B.S. (June, 2013). Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. The New England Journal of Medicine 2013; 368:2182 – 91.

working in the fields to cultivate crops or selling goods in the market. A psychosocial assistant in Katana, South Kivu commented:

"*Don't forget the PSAs (psychosocial assistants) for training and help them with a bit of soap and pay. We pass the day here, completing the tools, counseling others and we don't have time to take care of our own families. I am starting to have problems at home*".

This has implications for the sustainability of the psychosocial support provision as psychosocial assistants are volunteers of the community based organizations and must find a way to balance their psychosocial assistant duties, their ability to earn an income and manage their own household responsibilities. At present, community based organizations are not able to offer psychosocial assistants a salary. It would be understandable for psychosocial assistants to choose to pursue finding a source of income rather than continuing in their role as a psychosocial assistant. This would have a devastating impact on the ability of the CBO to provide psychosocial support as psychosocial support training and the skills development of the psychosocial assistant is focused on the individual psychosocial assistants themselves. Psychosocial training support comes from the ESPOIR/IRC psychosocial officers, not the CBOs. So, the departure of a psychosocial assistant would also the departure of knowledge and capacity to provide psychosocial support. Without the ESPOIR funding of the psychosocial officers, there would be no capacity to train replacement psychosocial assistants.

IRC has attempted to address some of the work load issues experienced by the psychosocial assistants by reducing the length of the psychosocial functionality tool. This has been received well by the psychosocial officers and psychosocial assistants as far as reducing the amount of time it takes for psychosocial assistants to carry out their duties. However, the issue of sustainability rest in the ability of psychosocial assistants to establish a source of income. The evaluation consultant attempts to address this in the ***Recommendations*** section of this report.

Medical assistance

Medical assistance is a critical part of gender based violence response. The ESPOIR project has integrated a high quality, timely medical response to gender based violence by incorporating and building the capacity of existing health structures. The ESPOIR project design chose to target project sites which were already being supported by IRC's Integrated Health Program[26] in South Kivu. In key informant interviews with two Superviseurs de la Zone de Santé (health zone supervisors) and the Gestionaire de la Zone de Santé (health zone manager) in Rwanguba, North Kivu and the Chef de Zone de Santé (health zone chief) and a Superviseur de la Zone de Santé in Ruzizi, South Kivu, these representatives of the local health zone reported that the capacity of health zones and health centers had increased through training, provision of Post Exposure Prophylactics (PEP) kits and financial supplements in support of healthcare staff. Training included the Clinical Care of Sexual Assault Survivors[27] as well as training healthcare staff on the referral pathway for survivors. Referral pathway training included joint training with other service providers on available support services and referral mechanisms for psychosocial support and social reintegration / income generating activities via community based organizations. The effectiveness of medical treatment for survivors of sexual violence is linked to survivors receiving timely care (within 72 hours of the incident of violence). Outreach efforts and awareness building is necessary in order for potential survivors and community members to know to access medical care within 72 hours.

The *Relais Communautaire* (RECO) serve as community health outreach workers. They are part of the pre-existing healthcare structure. The ESPOIR project supports RECOs, community structures such as the *chef du groupement* (local community chief) as well as the community based organizations to do outreach

[26] The Integrated Health Program is funded by USAID and falls under IRC larger Health Program sector.

[27] Clinical Care of Sexual Assault Survivors is multi-media teaching curriculum developed by IRC to improve the clinical and psychosocial quality of care provided by health care providers to survivors of sexual violence in humanitarian settings. The teaching tool is utilised in IRC's gender based violence and health programs around the world.

emphasizing the importance of referring survivors to health centers. In over 90% of community leader focus groups conducted as part of this evaluation, community structures including the women-led community based organizations, health centers, *chef du groupement* and *Relais Communautaire* (RECO) demonstrated awareness of importance of referring to health centers. This supports the previously reported data highlighting that ninety-eight per cent (98%) of rape survivors in ESPOIR assisted communities who reported cases within 72 hours of the incident were referred for medical assistance by community partners which make up the referral network and fifty-eight per cent (58%) of cases of rape were reported within 72 hours by community members.

Post-exposure prophylaxis **(**PEP) kits are a critical part of the medical treatment provided to survivors of sexual violence. IRC/ESPOIR coordinates with UNICEF, the cluster coordinator responsible for the distribution of PEP kits in health centers and the health zones. In addition, the IRC Health program purchases PEP kits and other essential medicines in order to insure that they are available in the health centers and health zones for distribution.

Medical assistance: Challenges

In North Kivu, funding for IRC's Health program is currently coming to an end. In South Kivu, IRC's Health program funding will come to an end in March 2015. Part of IRC health funding provides financial supplements to healthcare staff salaries. As IRC Health program's support for the health zones ends, this may impact the motivation of healthcare staff to continue participating in the referral pathway. During key informant interviews with the health zones in Rwanguba (North Kivu) and Ruzizi (South Kivu) healthcare representatives expressed their concern that healthcare structures will continue to receive referrals for medical treatment of survivors, with increased outreach bringing potentially increasing number of survivors to present for care. However, healthcare staff will receive significantly less pay, medical supplies are likely not to be consistently available and the cost of care for survivors is likely to rise as heath centers try to decrease the gap in funding by requiring payment from those seeking care, including survivors. During the key informant interviews and focus group discussions with community leaders, health centre staff reaffirmed that they would continue to provide care to survivors but they emphasized that staff would be less motivated which ultimately could impact care. It is likely that there will be a decrease in the availability of well-trained staff as staff turnover increases and training opportunities decrease with the ending of IRC Health and ESPOIR funding.

As mentioned, IRC/ESPOIR is a key player in coordinating the distribution and purchasing of PEP kits. With the ending of the ESPOIR project, there may be a challenge for health zones to fully step into the role of coordinating with UNICEF in regards to the ordering (i.e. monitoring how many PEP kits are available in health centers and making UNICEF aware when additional PEP kits are needed) and the distribution of the PEP kits from the health zones to the health centers. During a key informant interview, the North Kivu UNICEF Child Protection Officer / Protection Cluster Coordinator advised, *"There can be insecurity that cause (health centers) not to be able to get PEP kits and other (necessary) medication from the health zones"*[28].

In South Kivu, the UNICEF Child Protection Officer / Protection Cluster Coordinator advised:

"*(Getting) feedback from the (health) zone is difficult. There is a problem with (UNICEF) partners reporting back the numbers of hospital / heath centers that have (PEP) kits. Also, (there are) distribution problems (due to the problems) with the feedback between the zone and health centre. This includes difficulty distributing to / accessing (health centers in) conflict zones".* In addition, *"coordination can be difficult as people change too often. There is no institutional memory and (staff) are not specialists in this area (medical response to sexual/gender based violence or reproductive health)".*

[28] This refers to insecurities which originate from armed conflict or the presence of armed groups and bandits on the route between the health zone and the health centres.

The South Kivu Protection Cluster Coordinator explained that health zones and health centers often wait until there is an incident of rape before a request for PEP kits is made. So, the supplies of PEP kits in the health zones and health centers often run out before more PEP kits are ordered although the protection cluster has recommended that regular inventory be taken and sent to the Protection Cluster Coordinator. This means that UNICEF is at a disadvantage in terms of planning for the ordering and distribution of PEP kits because they do not know beforehand how many kits are needed and where they need to be sent. This also means that a survivor may not be able to get access to a PEP kit within 72 hours because it may take longer than 72 hours to find, order and/or distribute the PEP kit to the health center where it is needed. Better coordination requires that the health centers and health zones become more proactive in feeding back information to UNICEF regarding their PEP kit inventory. However, this has not been possible due to the transport and communication difficulties[29] between the health zones and health centers and due to a diminished administrative capacity within the health zones and health centers. Although the protection cluster has advocated building the administrative capacity of the health zones and health centers, many remain dependent on the infrastructure and administrative capacity of international non-governmental organizations, like IRC, to keep track of inventory and coordinate the ordering and distribution of PEP kits with UNICEF.

IRC/ESPOIR has attempted to address these challenges. In North Kivu, IRC Health Program has left a stock of PEP Kits with the health zones. The North Kivu UNICEF Child Protection Officer / Protection Cluster Coordinator advised, "*IRC/ESPOIR can orient other actors to cover the zones where IRC (ESPOIR) is currently operating if support ends*". IRC's Rapid Response Mechanism (RRM) together with UNICEF has developed a contingency plan for the distribution of PEP kits, particularly for hard to access areas in conflict zones. The North Kivu UNICEF Child Protection Officer / Protection Cluster Coordinator advised:

"*For some health centers that are far, there are supposed to have satellite sites to distribute to sites that are far away. (This is also the case where) there is insecurity that cause them (health centers) not to get the PEP kits or medication from the health zone*. In addition, "*PEP kits have been given to the health minister as a back-up measure. There is also a depot with (access to) a MONUSCO helicopter which can deliver to certain locations*".

In South Kivu, this contingency planning does not exist. UNICEF expressed concern for the capacity of health centers in South Kivu to manage coordination and distribution of the PEP kits after the end of the ESPOIR project based on the difficulties with transport and communication between the health centers and health zones and the diminished administrative capacity mentioned previously.

Another challenge identified by the Rwanguba health zone is the coordination of community education and outreach efforts of the *Relais Communautaire* (RECO) and the community based organizations. In a key informant interview, the two Rwanguba nurse supervisors and health zone manager interviewed advised, "*The psychosocial assistants /community based organization structure was previously integrated into the health structure. Now, it is a bit separate which has some challenges for coordination*". The nurse supervisors and health zone manager advised that although there is a weekly planning meeting that IRC/Health, IRC/ESPOIR and other international non-governmental organizations (NGOs) providing support to the health zone attend, the local community based organizations implementing the ESPOIR project do not participate so there is no forum for coordination between the RECO health outreach workers and the community education efforts of the community based organizations.

"*Right now the health centre staff are trained separate from the psychosocial assistants who are based in the community based organizations. It would work better if it (the trainings) were (conducted) together*".

- Rwanguba health zone nurse supervisor

[29] Transport and communication difficulties between the health zones and health clinics were reported in key informant interviews with Nurse Supervisors and Health Zone Supervisors in North and South Kivu.

In South Kivu, IRC/ESPOIR staff report that community based organizations do participate in regular planning meetings with the health zones which allows coordination between RECO health outreach and the community based organizations' community education efforts. Progress has recently been made in North Kivu on this issue. A joint training between the healthcare staff and psychosocial assistants has been scheduled for September 2014. The training will review the referral pathway and facilitate coordination between the two structures. It is noted, however, that there is still a need to increase coordination between the RECO health outreach workers and the community education efforts of the community based organizations in North Kivu.

Legal assistance

Legal assistance was part of the original ESPOIR project design. Originally it was implemented in both North and South Kivu. Alpha Ujuvi, a local non-governmental organization, provided legal assistance under the ESPOIR project until October 2012. The American Bar Association (ABA) was present in North Kivu providing legal clinics and capacity building to local non-governmental legal providers, at the start of the ESPOIR project, although their work was not funded by the ESPOIR project. By late 2012, ESPOIR-assisted and other (i.e. ABA) provision of legal assistance ended due to insecurity caused by the armed conflict and presence of the M23.

In South Kivu, IRC/ESPOIR originally implemented the legal assistance provision with another local non-governmental organization, Arche d'Alliance. The partnership with Arche d'Alliance was ended due to performance issues. According to the annual report for year 3 of ESPOIR I:

"In South Kivu, the IRC confronted significant challenges throughout its partnership with its (previous) legal partner, Arche d'Alliance, in terms of the quality of legal services provided and reporting outputs. To respond to these challenges, two new legal partners were selected (RADHF and ADMR) and signed partnership agreements in January 2012 with the IRC in South Kivu until October 2012."

ADMR and RADHF continued to provide legal counseling and assistance to survivors until the end of October 2012. The partnership with RADHF ended at that time, as only ADMR corresponded to the geographical coverage sought for the ESPOIR-2 cost-extension[30]. Hence, after October 2012, ESPOIR-funded legal assistance in South Kivu was implemented via local non-governmental organization, ADMR **(**Action pour le Développement des Milieux Ruraux). The legal assistance provided by ADMR in South Kivu covers two territories, Kabare and Uvira. Within Kabare, there are 3 ADMR sites (in Grunga, Katana and Murhesa) and within Uvira, there is 1 ADMR site in Luvungi. Each of these sites have a consultation office or *maison d'écoute*. These sites provide assistance to each of the 13 sites supported by the ESPOIR project.

In each ESPOIR site, two female paralegal assistants are trained to do outreach and provide community education around legal rights and processes. These paralegal assistants are also part of the referral pathway (to respond to gender based violence). Some of the paralegal assistants are community based organizations members or can refer to the ESPOIR-assisted community based organizations. The paralegal assistants make up local legal committees which operate in targeted ESPOIR communities. The ADMR/ESPOIR model is an example of an innovative implementation design that provides sustainable building of local capacity while facilitating local access to assistance, consultation and legal training.

In a key informant interview, ADMR reported that ESPOIR helped build the organization's capacity by providing financial management training, assistance with governance planning (i.e. looking at how decisions are made within the organization) and technical support in the form of training. Training topics included:

[30] From ESPOIR-2 first quarterly report

advocacy with local leaders, the law (in general), Congolese legal procedure, penal law, gender based violence, how to organize legal service activities, how to conduct awareness building / community education campaigns and activities, information on service providers (within the GBV referral pathway), how to make a referral within the GBV referral pathway.

From September 2012 through end of June 2014 (under ESPOIR-2), ADMR provided legal assistance to 184 survivors of gender based violence[31]. During a key informant interview ADMR reported that in the last 8 months (since January 2014), they supported the prosecution of 57 cases of rape initiated by ESPOIR-assisted survivors. ADMR reports that this surpassed the estimate of 44 set for the same period. This is compared to 168 survivors who chose who pursue legal action in year one; 198 survivors in year two; and 165 survivors from February to September 2012[32]. It is noted that at the start of the ESPOIR project the majority of sexual violence perpetrators were armed actors[33]. During the key informant interview, ADMR advised that more recent prosecutions involve perpetrators who are local and known to the local community. This is also confirmed by the IRC/ESPOIR Gender Based Violence Information Management System (GBVIMS) statistics which tracks perpetrator profiles. GBVIMS shows a peak in armed actor perpetrators in fiscal year 2012 and a steady decrease in fiscal years 2013 and 2014[34]. This shift in the perpetrator profile from armed actor to locally known perpetrator may provide some context for the decrease in the number of rape prosecutions. There may also be an overall decrease in the number of incidents of sexual violence as security in the community increases due to the decreased level of conflict in the province.

ADMR made 40 referrals to via the referral pathway for other support services. These 40 referrals were cases where there were other forms of violence (i.e. other than rape) experienced by the survivor. This shows ADMR/ESPOIR's legal assistance provision is well integrated into the referral pathway and that there is reciprocity of referrals which originate from various actors within the referral pathway. While the work of ADMR has surpassed its projected targets, the relatively low number of survivors receiving legal assistance (e.g. 57 cases of rape survivors assisted by ADMR versus 337 incident of rape reported under the ESPOIR project since January 2014) represents the difficulties faced by survivors and legal assistance providers when seeking legal prosecutions of perpetrators. This is explained further in the *Legal Assistance: Challenges* section.

The IRC WPE Program Advisor advised during a key informant interview that in June 2014 IRC/ESPOIR staff completed a mapping exercise of legal assistance providers active in North Kivu. The results of the mapping exercise identified that there are plans for the American Bar Association (ABA) to reopen a legal clinic and for local non-governmental organization, Dynamique des Femmes Juridiques, to provide free legal consultation[35] in Rutshuru area of North Kivu. The mapping exercise was done in order to facilitate legal referrals for ESPOIR assisted survivors. Although the ESPOIR North Kivu legal assistance provision has faced challenges in its implementation, the mapping exercise represents a responsible effort on the IRC/ESPOIR to promote access to a needed service despite the limitations of implementation faced by the project.

Legal Assistance Challenges:

In April 2012, a group of army soldiers mutinied and formed a rebel group called M23. The M23 fought the Congolese army for control of territory in North Kivu and were present North Kivu from April 2012 until October 2013. During a key informant interview with the IRC Women's Protection and Empowerment (WPE) Program Advisor, she explained that by the end of 2012, it became unsafe to fully implement many ESPOIR activities, including legal assistance. ESPOIR funded legal assistance via national non-

[31] From ESPOIR Year 4 annual report and quarterly reports for ESPOIR Year 5.

[32] The number of survivors who pursued legal action quoted here was reported in the annual reports of Year 1, 2 and 3.

[33] From the ESPOIR Year 1 annual report.

[34] According to the IRC GBVIMS, in fiscal year (FY) 2011, 291 perpetrators (30%) were members of an armed group; in FY2012, 1063 perpetrators (41%) were members of an armed group. This decreased to 607 (33%) in FY2013 and 148 (25%) in FY 2014 (January to June 2014).

[35] Dynamique des Femmes Juridiques is being funded by the American Bar Association.

governmental organization, Alpha Ujuvi, ended after October 2012. There has not been an opportunity to restart legal assistance activities since North Kivu became more secure in late 2013. As explained above, IRC/ESPOIR has addressed the gap in legal assistance provision in North Kivu by conducting the mapping exercise of existing legal services and incorporating these services/organizations into the referral pathway used by ESPOIR-assisted communities[36].

In South Kivu, legal assistance ESPOIR partner, ADMR reported that the process of a survivor to file a complaint against a perpetrator has many barriers that a survivor must endure. First, the survivor must decide whether she would like to register a complaint against the perpetrator. This is often dependent on whether the survivor is able to identify the perpetrator. The police must initiate the investigation with 48 hours of the complaint. Within this time, the ADMR lawyer must travel to where the survivor is to make sure that the police report is properly registered and possibly be present once the perpetrator is arrested. Once the perpetrator is arrested, the lawyer must decide whether or not to go to court. The trial usually takes place in the administrative head office of the court, usually located in Bukavu. So, both the survivor and the lawyer must travel to where the trial will take place. At court, both sides, the perpetrator and the survivor, are heard. After the trial, the survivor must await a judgment. If the judgment is favorable, it is often difficult to enforce. For example, if a fee is levied against the perpetrator, the likelihood is that the perpetrator will not be able to pay and the survivor will not receive this compensation. The perpetrator could be sentenced to prison but while in prison a perpetrator and his family can possibly pay a bribe to be let out of prison early or other circumstances can arrive which will result in the perpetrator not serving the entire sentence. At each step of the process, there can be a possible hurdle for the survivor to overcome[37]. In an already vulnerable state, the survivor can decide to proceed through the arduous process or discontinue. The entire process should take 4 months but can last much longer. Many survivors choose not to begin the process at all.

Other challenges faced during the process of prosecuting a perpetrator include the absence of a judge or magistrate at times. It can take 5 months for a judge or magistrate to be available to hear the case. The survivor's lawyer must also pay a fee to execute the judgment. So, even if there is a favorable judgment, there must be financial resources available to pay the fee to carry out the judgment. Full prosecution can be diverted if the survivor is convinced to sign consent not to go forward with prosecution. In these cases, informal arrangements may be made with the family of the survivor in regards to compensation. Informal arrangements can also include the perpetrator being made to marry the survivor (although this appears to be happening less due to community education efforts). In other instances, the perpetrator's family may pay a bribe to stop the police investigation. All of these challenges contribute to the derailment of the legal process and an increased sense of impunity. With all of these challenges, however, some survivors still choose to pursue prosecution and ADMR has been able to support the increasing number of survivors who choose to follow the legal process through.

Finally, sustainability of the legal assistance provision is a challenge. During the key informant interview, ADMR reported that although their capacity had been strengthened, legal fees and transport costs still are a barrier to sustainability of legal assistance continuing after the end of ESPOIR funding. ADMR also advised that there experience has been that there aren't many international actors that support legal assistance so they have had difficulty accessing quality technical support, training opportunities and organizational capacity building prior to the IRC/ESPOIR project. One suggestion made by ADMR was for IRC/ESPOIR to connect ADMR with other international legal assistance / technical support actors or assist ADMR to apply and secure funding from other donors after the end of ESPOIR project funding. Grant writing, developing

[36] The final quarterly report for ESPOIR Year 5 will show the number of legal assistance referrals made to the legal assistance service providers identified in North Kivu as part of the mapping exercise. This will confirm if the referral mechanism for referring to these providers is truly integrated into the referral pathway used by ESPOIR-assisted communities.

[37] During the key informant interview, ADMR described the challenges and hurdles involved in the legal process for survivors. In focus group discussions with CBO members in North and South Kivu and with community leaders in Ntamugenga, North Kivu , focus group participants described that survivors could sometimes be threatened or harassed by perpetrators or perpetrators' families. It was highlighted that children survivors were more vulnerable to this type of harassment and threats.

relationships with potential funders, grant management and mentoring throughout the grant seeking process are additional areas of capacity building which would help ADMR insure the sustainability of legal assistance programming.

Social reintegration/economic empowerment assistance:
Social reintegration and income generating activities include Village Savings and Loan Association (VSLA) activities, literacy activities and activities training women and survivors in trades or skills which will allow them to generate income. The Village Savings and Loan Associations (VSLA) methodology provides for loans to individual group members. VSLAs are governed by a set of internal regulations developed by the group members themselves following a template. They determine eligibility for loans, interest fees and the repayment period among other issues. Groups are structured with a management committee (president, secretary, treasurer, money counters) which answers to the general assembly (VSLA members). A VSLA member who would like a loan simply appeals to the general assembly specifying the amount desired, the use of the loan, and the repayment date. It is up to the general assembly to decide whether or not to give the loan to that member.

VSLA groups utilize the IRC-designed EA$E (Economic and Social Empowerment) curriculum, which includes business skills training for members and discussion groups between members and their spouses to promote women's participation in household decision making and encourage a shift towards more equitable spousal power relations. The implementation of the Village Savings and Loans Associations include three phrases. The first phase is the establishment of the VSLA group. In this phase VSLA members are chosen, leadership of the group is chosen and members become familiar with the lending and repayment rules and processes of the VSLA. ESPOIR provided a small fund to begin the group. According to VSLA methodology, after the 1st cycle groups are considered to be independent and receive sporadic support. Following the EA$E curriculum, phase two includes discussion groups with women and their partners and phase three includes Competency based Economies, Formation of Enterprise (CEFE) business skills training.

According to ESPOIR project annual reports, by the end of October 2012 a total of 122 VSLA groups were created; 8 in North Kivu and 114 in South Kivu. As of June 2014, and additional 8 VSLA groups have been established in North Kivu and 10 additional groups in South Kivu. In focus group discussions with VSLA group members, respondents reported that in addition to the creation of "official" VSLA groups, a number of VSLA-like or "copycat" VSLA groups have also emerged in communities with community members emulating the success and benefits of established VSLA groups.

After the completion of the first cycle of savings and loans, VSLA groups have the option to share-out group profits and interest. By the end of Year 4 in North Kivu, at the share-out, the average amount in savings per VSLA was $1,263 (highest amount in savings was $1,952 and lowest was $790), and the average rate of return for the loans that were issued was 38.51% (highest rate of return was 61.5% and lowest was 33%). In South Kivu, at the share-out, the average amount in savings per VSLA was $996, and the average rate of return for the loans that were issued was 51%, with the average amount shared-out for each VSLA being $1,506. At the time of closeout, women noted that the VSLA had changed their lives in the following ways: creating small businesses, having enough resources to pay for basic needs and unexpected difficulties, being able to pay for children's education, improving their quality of life in terms of housing and clothing, and ensuring food security for women and their families.

IRC/ESPOIR works with women-led local community based organizations (CBOs) to implement social reintegration / income generating activities such as tailoring, soap-making, pastry-making, embroidery, knitting and animal husbandry. The local community based organizations chose the income generating activities based on their knowledge or experience doing the activity or the availability of a local expert who could teach the activity in the local community. Please see Appendix X for a list of social reintegration / income generating activities reported CBO members in each evaluation site. During focus group discussions with local community based organizations, members clearly demonstrated local expertise in facilitating and

teaching social reintegration and income generating activities. Many of the community based organizations started activities prior to ESPOIR funding. This demonstrates the feasibility of the community based organizations sustaining activities after the end of ESPOIR funding.

The formation of VSLA groups and implementation of social reintegration / income generating activities have both a social and an economic impact. The formation of VSLA groups require that community members who trust and make a commitment with each other and are within close geographic proximity, come together for a long term commitment to work and support each other within the community. In focus group discussions with VSLA groups in North Kivu, VSLA members described that because the VSLA process requires on-going cooperation and trust, if a disagreement arises between members of the VSLA, the other VSLA members come together to provide mediation between the disagreeing parties. Focus group participants described that it is in the best interest of the entire VSLA group membership to resolve any potential conflict as it puts the entire membership at risk of losing their investment and savings if someone leaves the community with the entire communal fund.

When discussing social reintegration/income generating activities during focus group discussions, it was reported that women and survivors who were able to learn a trade such as tailoring, pastry-making (beignets), soap-making, etc were able to earn an income. Focus group participants reported that as a result of contributing income to the household that their husbands respected them more. Many reported that their husbands abused them less and that they are seen by their husband as more equal than before. Focus group respondents reported using their earned income to pay for school fees. Women and survivors paying school fees also experienced an increase in social status in the community. For example, focus group respondents reported that school directors are more likely to listen and invite women to be part of school parent committees if they know they are paying school fees. Women's increase in income and payment of school fees potentially has the knock-on effect of increasing the number of children going to school. This also has the impact of increasing the number of girls going to school. The secondary benefits of the social reintegration / income generating activities are described further in the *Impact* section of this report.

Social reintegration/economic empowerment assistance: Challenges

Periods of intensified conflict, particularly the presence and fighting between Congolese armed forces and the M23 rebel group in North Kivu and fighting between Burundi and Congolese rebels in South Kivu, led to displacement of people in local communities and the disruption and/or delayed implementation of ESPOIR activities. The periods of conflict impacted how quickly Village Savings and Loan Association groups could be implemented. In both North and South Kivu, there were several start and stops to implementing VSLAs. This meant that there was an extended period to carry out EASE curriculum which supports the community implementation of VSLAs. In South Kivu, the third phase of EASE curriculum has yet to be implemented. The third phase includes business and marketing skills. This aspect of the VSLA implementation contributes to the sustainability of established VSLA groups as well as the ability for communities to establish other non-ESPOIR implemented VSLA-like groups which cascades the knowledge and benefits of the economic empowerment experienced in VSLA groups to others in the community.

iii. Objective 3: Key stakeholders have improved capacity to lead and participate in community based social integration and economic recovery activities that include strengthening community response to and prevention of GBV.

The IRC/ESPOIR strategy of implementing project activities via local women-led community based organizations and through supporting other community structures lends itself to improving the capacity and participation of key community stakeholders. ESPOIR capacity building efforts have focused on improving the quality of service provision, particularly services provided to survivors of sexual violence. In focus group discussions with community leaders and stakeholders (including ESPOIR supported community based organization, health centers and local government structure leaders), stakeholders were able to give specific

examples of how ESPOIR has increased their capacity to respond to and prevent gender based violence. Community based organizations described the increase in capacity as the provision of the materials and training necessary for the social integration / income based activities described in the previous section. RECOs and local community leaders described increased capacity through training in concepts of gender based violence, the rights of women, and awareness-raising activities focused on how to respond to survivors, services available in the community and ways to empower and raise the status of women. RECO and local leaders also reported receiving the IEC (information, education and communication) materials to do awareness raising campaigns and training on how to conduct community outreach and awareness raising campaigns. Health centers reported increased capacity to provide a higher quality of clinical care to survivors through receiving the Clinical Care for Sexual Assault Survivors (CCSAS) training from IRC as well as receiving medication and additional training regarding making referrals for services available in community.

Stakeholders also reported an increased capacity in the use of monitoring tools. This includes increased capacity to provide written reports on their activities as well as increased ability to gather data about activities which help with advocacy at the community level (i.e. appealing to governmental structures or other partners). All stakeholders highlighted the increased capacity to provide psychosocial assistance via the psychosocial assistants based in the community based organizations as a major outcome of the capacity building undertaken by IRC/ESPOIR. Ninety-four percent (94%) (15 out of 16 focus group discussions) described the increased capacity to provide psychosocial support as an example of one way communities now have increased capacity to facilitate social reintegration and to respond to gender based violence.

As part of the monitoring and evaluation plan established by IRC/ESPOIR, all of the community based organizations undergo an annual evaluation. During the data collection period of this end of project evaluation, IRC/ESPOIR staff were also conducting the annual evaluation for the community based organizations. The results of those evaluations will be included in the final annual report for the project.

Improved local capacity: Challenges

Although community stakeholders reported that their technical capacity has improved via training provided by ESPOIR, some community stakeholders described lacking materials to implement some of the work they had been trained to do. Community stakeholders specifically referred to materials to facilitate awareness-raising campaigns. Although it was acknowledged that stakeholders receive "boites d'image" (image boxes or drawings used to illustrate the concepts of gender based violence or other related issues described in a questionnaire or during a community awareness building activity), community stakeholders cited that additional materials would facilitate the work, such as a megaphone, pens, paper, water-proof clothes and boots for awareness raising activities during the rainy season. This feedback came from the community partners of the women-led community based organizations (i.e. RECO, chef du groupement, etc.). It should be noted that some of this feedback may be based on local community institutions (i.e. health centers, local community chief, schools, etc) wanting more concrete / material support from IRC/ESPOIR in light of the women-led community based organizations receiving what is perceived as concrete capacity building support in the form of financial support and materials for social reintegration / income generating activities. Therefore the feedback during focus group discussions from community leaders may reflect some subtle degree of competing for resources which has the potential to decrease effective partnership working in the long term if community partners feel that they are contributing to work of caring for survivors in the community but not receiving the financial support that the women-led community based organizations received under the ESPOIR project. Regardless the general request for materials to support awareness-building activities is a valid one and the question of how can community structures sustain having the materials readily available is a question of sustainability and the capacity of community structures to utilize or generate resources which will allow them to sustain community outreach activities. This is potentially a gap in current capacity building efforts.

Related to this, capacity building efforts of local community stakeholders focus on increasing technical expertise and knowledge to facilitate activities or raise awareness. However, many of the community structures themselves lack the organizational capacity to independent sustain activities. Besides a need for building technical or service provision capacity, there is also a need to build governance and organizational management capacity to appropriately manage resources and staff in order to facilitate sustainability as well as full community integration and ownership of activities.

An additional challenge discussed in a focus group discussion with community stakeholders in Ntamugenga, North Kivu was with regards to the cascade of gender based violence sensitivity training for police and the recruitment and background screening process for newly recruited police. Ntamugenga community stakeholder focus group participants confirmed that the police commandant was invited to participate in gender based violence and referral pathway training along with other service providers and community stakeholders. However, it was suggested that the information learned within the training was not cascaded down to the police ranks that actually deal with survivors and conduct the investigation of potential perpetrators. In addition, a concern was raised that former prisoners, perpetrators and others in the community known to have committed atrocities have applied and become police officers. Focus group participants explained that this is possible because the local government has made an appeal to recruit police and the only eligibility criteria is being able-bodied and under 30 years old. Focus group participants advise that police officers do not undergo background checks or screening due to a lack of resources and infrastructure to conduct such screenings. This is a major challenge in regards to building local capacity as the police represent a major partner in providing legal assistance and in the overall referral pathway. These challenges highlight that the capacity of police is only superficially being addressed by including police commandants in capacity building training. More would need to be done to insure that the training reaches all of the police ranks and that newly recruited police are screened in order to safeguard and protect the interest and well-being of survivors.

Improved local capacity to support women's empowerment: Male discussion groups

This evaluation also looked at the male discussion groups, which included the "Men as Partners" pilot groups in North Kivu under ESPOIR-I (from 2012) and the current use of the EMAP (Engaging Men in Accountable Practice) curriculum, starting in 2013 in North Kivu with the most recent group cycle ending in August 2014 in South Kivu. The purpose of the male discussion groups is to facilitate behavior change for men and to reduce violence towards women, particularly as the social reintegration and income generating activities of ESPOIR empower women economically and could potentially make them vulnerable to abuse or exploitation. In all, there were 6 male discussion groups implemented in North Kivu and 5 groups implemented in South Kivu. The criteria for inclusion in the male discussion group include a commitment on behalf of the male participant to come to all 16 weeks of the group cycle and a commitment not to use violence.

As part of the screening and group follow up process, IRC/ESPOIR staff visit group participants in each of their homes, meeting with the participant and their spouse separately. To recruit male discussion group participants, outreach presentations are made in the community and to community leadership. The husbands of women who are participating in ESPOIR assisted activities are not targeted but are often included in the discussion groups. The groups are facilitated by local community members who are trained as facilitators and supervised by ESPOIR/IRC community education staff. The EMAP curriculum is currently being adapted to improve the effectiveness of the group in changing attitudes and behavior. The group originally included 16 weeks of sessions with men only. However, the group became focused on issues faced by men rather than the empowerment of women. Currently, the curriculum has been adapted to include 8 weeks of sessions with women before the 16 weeks with men to insure focus on issues impacting women's well being.

The male discussion groups have been well received by community members. In the focus group discussions facilitated as part of this evaluation, participants described that there was a lot of interest from men in the

community to join the discussion groups. In all of the evaluation focus groups, men reported that when outreach was initially done for the male discussion groups, more men came forward than could be accommodated in the group and there is still a lot of interest in the group from other men in the community now that they have seen the difference that the group has made in the lives of former participants. In all of the evaluation focus groups, men were able to give concrete examples of behavior changes they had made and the impact of attitude changes in the community. Some of these examples are listed below:

- "Before, I didn't involve my wife in decision-making".
- "Recently I asked her (my wife) what should we do with the money we earned from selling sugar cane".
- "Previously, when I received my salary, I would go drink beer and bring the rest for my wife. Now, we go together to spend the salary... We have started working out together how we should allocate the salary".
- "I didn't want to become a part of the discussion group but wife insisted saying if I entered I would gain a lot. I joined the group and since then my household has changed".
- "I have found what I have learned allows me to organize my family".
- "For example, previously, I was at my friend's house who gave me flour but I didn't have anyone to carry it, and my friend's wife asked me to call my wife to come to carry (the flour). I said no and I carried it to my house my wife was happy".

Former EMAP participants in Cirunga, South Kivu

In response to, "How has the general view of women changed since the start of the male discussion group?":

- "Women (can) speak freely in public and sometimes even disagree with the opinions of men".

Former EMAP participants in Ceya/Tshengerero, North Kivu

The feedback from the former male discussion group participants above demonstrate the concrete behavior changes made by men but also illustrate the potential impact to empower women whether it be at the family level or at the community level. For example, for the man in the comment above who carried the flour from his friend's home, he not only empowered his wife but potentially the wife of his friend. In the evaluation focus group discussions, men also explained that they are empowered as a result of the group as well. This is seen in the comment, "I have found what I have learned allows me to organize my family". The role of the man in the household becomes easier because the man can now share responsibility and share in the tasks of managing the household so neither the man or woman is overburdened by their gender roles.

The evaluation focus group participants agreed that the male discussion groups should and could continue and there is continued interest from men in the community to participate in the male discussion groups. There was a split among the participants of the focus groups as to how the male discussion groups might continue. Some respondents suggested that former male discussion group participants could be trained to become facilitators. Others commented that former participants wouldn't have time to facilitate the group so a facilitator would have to be made available. Those that were interested in former participants running the groups advised that they would need training both on the content of information shared in the group as well as facilitation training. These focus group respondents suggested that IRC/ESPOIR provide the training, similar to the training provided to the community members who facilitated the current male discussion groups. This seems to imply that the current male discussion group facilitators were either not available to continue the male discussion groups or perhaps not able to cascade the training to potential facilitators. This may just be the perception of the former group participants but it perhaps also reflects that there hasn't been formal planning of how to cascade the male discussion group facilitator training or how the groups might continue after the end of the ESPOIR project.

The male discussion groups have clear monitoring and evaluation tools which have been carefully designed to measure behavior and attitude changes in participants (See Appendix XI for pre/post questionnaires used to interview male discussion group participants before and after the group). The behavior and attitude change data gathered by ESPOIR is centrally collated and analyzed. During the period of this evaluation, the

data was input for analysis and undergoing data cleansing, so it was not possible to assess the impact of the male discussion groups as part of this evaluation. However, the data analysis and impact of the male discussion groups will be included in the final report of the ESPOIR project.

Other Challenges: Access for girls (under 18)

During the focus group discussions with members of the women-led community based organizations, several questions were asked regarding girls under 18 accessing the survivor support, social reintegration and income generating activities available to women. Consistently focus group respondents reported that girls make up a small percentage of the beneficiaries of services. In a key informant interview with the WPE program Advisor, it was reported that children under 18 make up approximately 10-15% of ESPOIR beneficiaries. This was confirmed by ESPOIR field staff. In analyzing data from the GBV IMS database provided by the WPE Monitoring, Evaluation & Research Coordinator, it was confirmed that current number of children under 18 assisted by ESPOIR has averaged between 8.6 % to 14.5% in South Kivu and 12% to 25% in North Kivu (see Table 2 below).

Table 2 shows a higher percentage of children have consistently been able to access ESPOIR assisted support in North Kivu. This may be due to different outreach or awareness building techniques used by the community based organizations in North Kivu. The table also shows in increase in the percentage of child survivors accessing support from 2009 to 2012 then a drop from 2013 through 2014. This coincides with periods of insecurity in both provinces (i.e. November 2011 presidential elections; M23 in North Kivu; increased IDP displacement in South Kivu, increased insecurity in Fizi and Uvira, South Kivu). It is possible that as ESPOIR activities were established in 2009, outreach and awareness building activities increased and became reinforced allowing an increasing amount of children to know about and access ESPOIR support. With increased insecurity and displacement in the period from 2012 to late 2013, ESPOIR outreach and awareness building may have decreased with some ESPOIR activities being interrupted. This may have led to a lower percentage of children survivors being reached and therefore accessing ESPOIR support. The example of ESPOIR assisted legal assistance in North Kivu shows that ESPOIR activities have only recently begun to recover from the impact of M23 insecurities. It's possible that as children appear to be the most vulnerable in accessing support, it would take more time of stable programming in a secure environment until children survivors would have the same level of access they had in 2011/2012.

Table 2: Percentage of Children Survivors assisted by ESPOIR Support (2011-2014)

Year	North Kivu	South Kivu
2009 (October to December)	16.4%	14.5%
2010	19.7%	8.8%
2011	25%	15%
2012	24%	16%
2013	17%	14%
2014 (January to June)	12%	8.6%

When we look at the types of ESPOIR support services which children under 18 accessed in 2014 (January to June), it appears that children survivors currently more readily access medical assistance and economic assistance in North Kivu while in South Kivu children survivors more readily accessing legal assistance and psychosocial assistance (see Table 3 below). When North Kivu was able to offer legal assistance (until October 2012), it also appears that children were able to access legal assistance most readily. Until 2014, economic assistance was accessed by the lowest percentage of child survivors compared to the other types of ESPOIR support in North Kivu. This has changed in 2014, with more than one third of survivors currently accessing economic assistance in North Kivu being children. In South Kivu, with the exception of 2012, child survivors have been the smallest percentage of beneficiaries accessing economic assistance when compared to the other types of ESPOIR support. The types of support accessed by child survivors may represent their actual/differing needs when compared to adults as well the perceived needs of children in the community. Further study is needed to determine why, why not and how children survivors access the various types of ESPOIR support.

Table 3: Percentage of Children Accessing Each Type of Support (2011-2014)[38]

	North Kivu				South Kivu			
	Psychosocial	Medical	Legal	Economic Assistance	Psychosocial	Medical	Legal	Economic Assistance
2011	20%	23%	71%	15%	13%	11.5%	56.5%	0%
2012	19.6%	15.6%	44.4%	14%	13.7%	12.3%	34%	16.3%
2013	14.8%	21.4%	-	10%	12.5%	12.1%	19.6%	8.3%
2014 (January to June)	9.6%	27%	-	38%	20%	11%	60%	9.5%

A concern in regards to the percentages of vulnerable or survivor children accessing ESPOIR support is that children are believed to make up over 50% of the population[39]. In addition, according to the United Nations Population Fund in 2008 in DRC (just prior to implementation of ESPOIR), 65% of sexual violence survivors were children and adolescents younger than 18 years, with 10% of all sexual violence survivors younger than 10 years old[40]. Thus, the percentages of child survivors accessing ESPOIR support cited above appear to be low. During the focus group discussions, girls under 18 years old were described as being more vulnerable than older women to rape and abuse. It was also emphasized that children could only access support if their parents agreed. Focus group participants described the increased stigma that girl survivors have in relation to their peers and having future prospects of marriage. The presentation of a relatively low percentage of children participating in ESPOIR assisted activities in the context of these reports of stigma and increased vulnerability seems to point to possible barriers for girls (under 18) to access survivor support services and other social integration activities through the community based organizations.

When the evaluation consultant discussed this issue with field staff and the WPE Program Advisor, they explained that IRC/ESPOIR has already recognized that these barriers may exist. In partnership with Columbia University and with funding from the UK Department for International Development (DFID), the IRC is part of a multi-country impact evaluation of violence prevention and risk reduction activities for adolescent girls in humanitarian settings. This research will look at whether adding a specific intervention with parents or guardians of 10-14 year old girls who are taking part in life skills curriculum will increase the impact on the girls' empowerment or the reduction of the risk of violence they face. The research will also include studies of interventions with married girls and with girls in emergency settings to determine whether these interventions are acceptable and feasible within their communities. The grant will also fund interventions related to increasing access for girls to safe spaces in their communities and reinforcing the capacity of service providers, particularly for medical and psychosocial care, to respond specifically to the needs of adolescent girls.

The impact evaluation is currently in its data collection phase. Recommendations for program design will emerge from the research. This will help to unpick, understand and possibly address the potential barriers faced by vulnerable and survivor children under 18 and provide the context for a more targeted and specifically child-focused program design for children and young people accessing support.

[38] The GBV Information Management System (IMS) was established by IRC in North and South Kivu provinces in 2011. A breakdown of the types of services accessed by children prior to 2011 is not readily available. Thus the table above includes data from 2011-2014.

[39] According to UNICEF DRC country statistics – demographic indicators, children under 18 years old make up approximately 52% of the total populations. Adolescents (ages 10 – 19) make up 23.4% of the total population. The data source for the child population statistics is the United Nations Population Division. For more information, see UNICEF country statistics website at: http://www.unicef.org/infobycountry/drcongo_statistics.html#120.

[40] Peterman, Amber, Ph.D, Tia Palmero and Caryn Bredenkamp, Ph.D (June 2011). *Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo*. American Journal of Public Health. 2011 June; 101(6): 1060–1067. This article quotes figures on sexual violence reported in the DRC in 2008. New York, NY: United Nations; Population Fund; 2009

b. Impact

The impact of ESPOIR activities ranges from the impact that the activities have had in the lives of women beneficiaries to the impact on the communities in which they live. This evaluation looked at the impact on women from perspective of a sample of women who accessed psychosocial support and completed the psychosocial functionality tool with a psychosocial assistant, the reported impact of women community based organization members who participated in focus group discussion during the evaluation, reported socio-economic outcomes reported by ESPOIR partner Women for Women International and the comparison of a small sample of women who have not yet accessed psychosocial support with those who have.

Psychosocial Functionality

IRC/ESPOIR developed a tool used with survivors accessing psychosocial support which measures the survivors' ability to perform everyday tasks and symptoms associated with decreased psychosocial functioning at the start and at discharge of the psychosocial intervention. An example of the IRC/ESPOIR psychosocial functionality tool is included in Appendix XII. For the purposes of this evaluation, a sample of 227 survivors who accessed psychosocial support and completed the psychosocial functionality tool at intake and discharge was reviewed. The functionality tool is divided into two sections: Section A looks at the everyday tasks that a survivor is able to perform – the higher the score the less the survivor is able to complete these tasks; Section B looks at symptoms associated with decreased psychosocial functioning such as insomnia, having flashbacks, decreased appetite, etc. – the higher the score the lower the psychosocial functioning of the survivor. The average score for the sample of 227 survivors at intake in Section A was 24, then 3.6 at discharge. In Section B, the average score was 22.6 at intake then 4 at discharge. This shows a dramatic increase in psychosocial functioning, both in the ability to resume performing everyday tasks and decrease in symptoms associated with depression, anxiety, trauma or other forms of decreased psychosocial well-being.

Individual Questionnaire Analysis

The impact on psychosocial functioning of ESPOIR supported survivors was also assessed via a questionnaire developed by the evaluation consultant (see Appendix IX). The questionnaire looks at the ability of a survivor to earn income to cover basic needs, social connectedness and questions related to how the survivor feels about her/his self or self-esteem. A comparison was made between survivors at the start of the psychosocial support intervention provided by the psychosocial assistants and survivors who have completed the psychosocial support intervention.

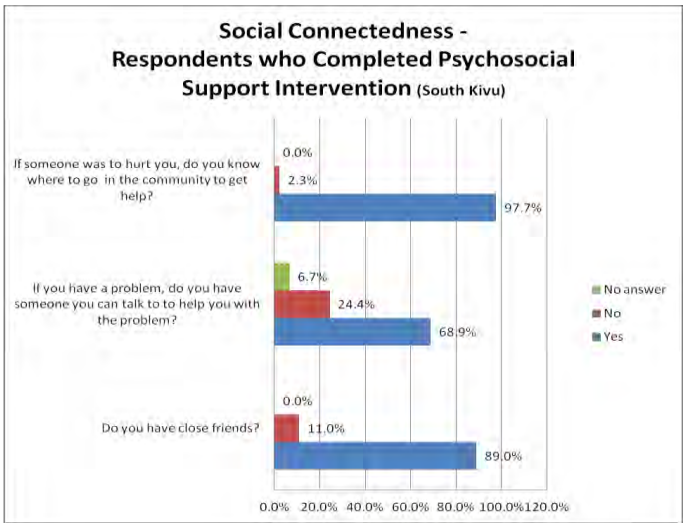
In South Kivu, eleven percent (11%) of respondents who completed the psychosocial intervention reported that they were able to earn income to meet their daily needs. Nearly 36% of "old" case respondents said that they earned enough income to meet their basic needs "sometimes". This is compared to 4.8% of new psychosocial support case respondents reporting earning enough income to meet their basic needs and nearly 41% reporting that they could meet their basic needs "sometimes". In North Kivu, 2.8% of "old" case respondents said that they could earn enough money to meet their needs and 58% reported that they are "sometimes" able to meet their needs compared to 0% of "new cases" earning enough to meet their basic needs and 20% sometimes able to meet their basic needs with the money they earn[41]. These results show a slight trend towards survivors who completed the psychosocial support intervention being more able to earn income to meet their basic needs. As the sample size of survivors is small and no further statistical analysis was completed to determine statistical significance of the difference between the two respondent groups, the questionnaire results are only meant to provide a snapshot of trends within/between the two groups of survivors.

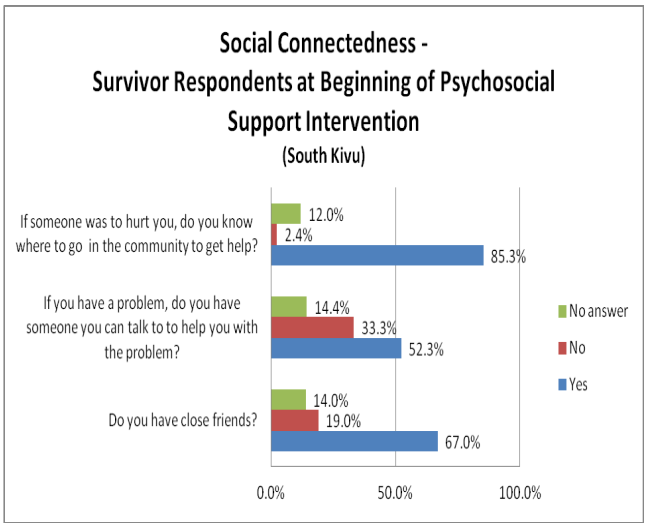
[41] One third of the North Kivu "old" case respondents did not answer this question. Over 71% of "new" case respondents did not answer this question.

The graphs below show the responses to questions related to social connectedness from "old" and "new" case respondents. In both North and South Kivu, a higher percentage of survivor respondents who completed the psychosocial support intervention consistently answered "yes" to friends, people or services in the community which could support them. It should be noted that in North Kivu, there is a marginal difference in the percentage of "new" and "old" survivor respondents who reported being able to identify where in the community to go for help if someone did them harm. These results are in line with the previously reported findings (see *Findings: Effectiveness – Objective One* section of this report) regarding a higher level of reporting of rape and presentation for services within 72 hours in North Kivu ESPOIR sites where there was overlap with the IRC Health Program and extensive community education regarding the importance of accessing care. It is likely that extensive community education has increased the likelihood of survivors and potential survivors alike, regardless of having received a psychosocial support intervention, to be able to identify where they can go for help if harmed. ESPOIR community education activities may also contribute to the relatively high percentage of "new" case respondents in South Kivu who also identified somewhere in the community they can go if they were harmed. In this sense, ESPOIR community education activities may also be seen as contributing to increased psychosocial functioning outcomes like social connectedness.

South Kivu

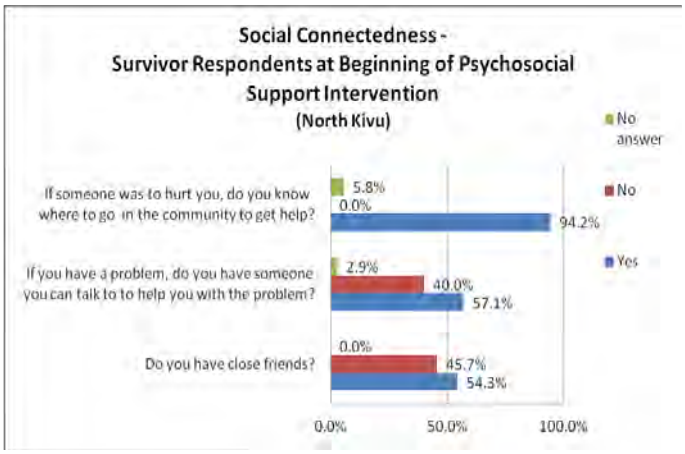
Graph A: Comparison of Individual Survivor Questionnaire Respondent: Social Connectedness (South Kivu)

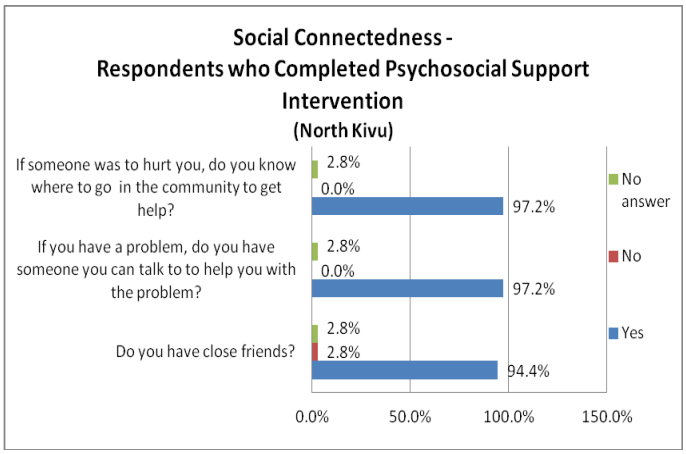




North Kivu

Graph B: Comparison of Individual Survivor Questionnaire Respondent: Social Connectedness (North Kivu)

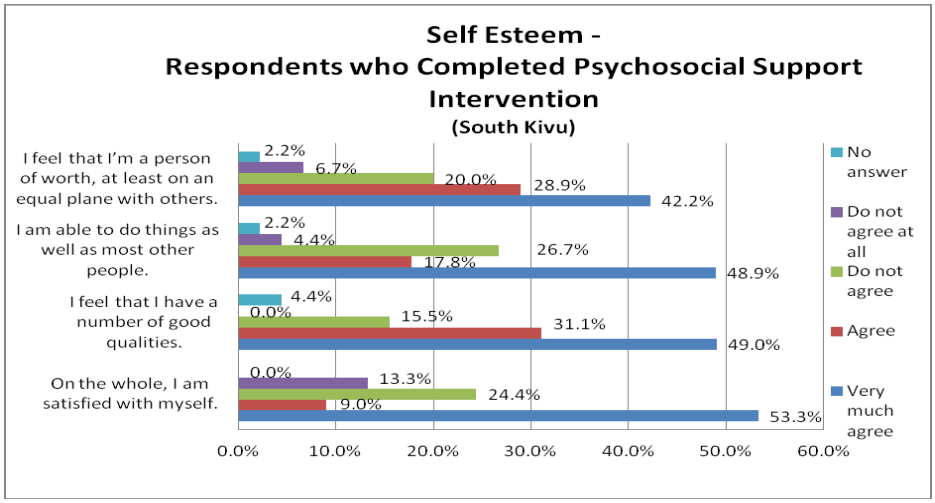


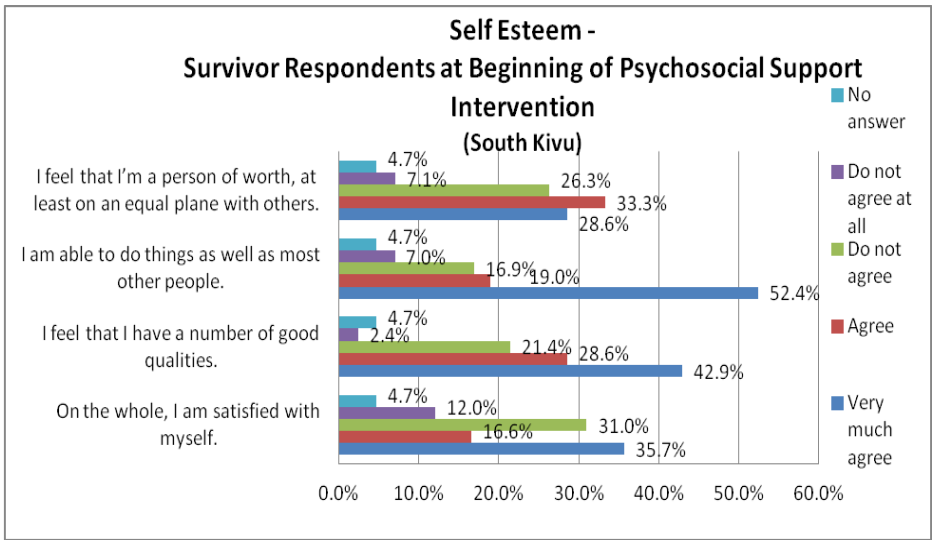


Generally, a higher percentage of survivor respondents who completed the psychosocial support intervention also reported higher levels of self esteem[42] in both provinces. In South Kivu, "old" case respondents reported higher levels of self esteem in 3 out of the 4 positive self-esteem questions asked in the individual questionnaire.

South Kivu

Graph C: Comparison of Individual Survivor Questionnaire Respondent: Self Esteem (South Kivu)



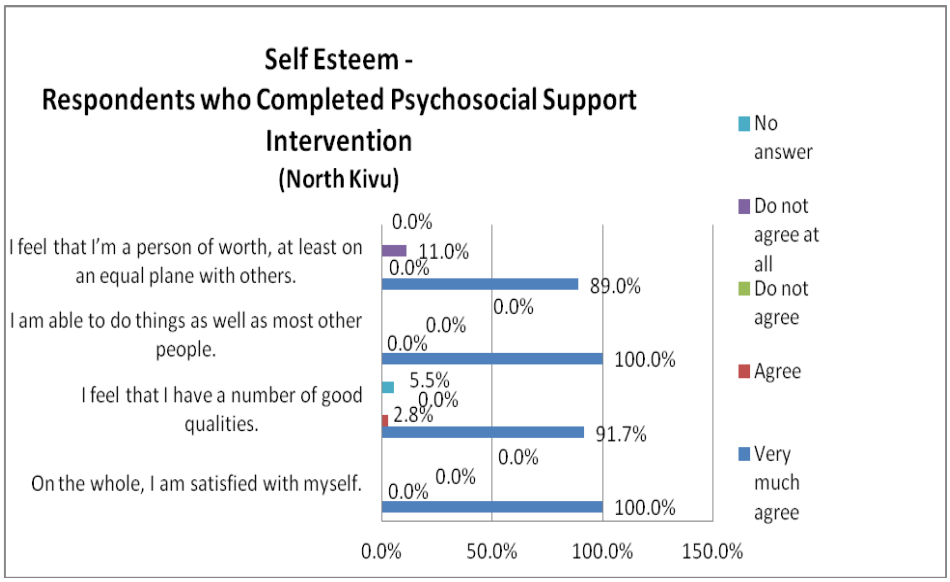


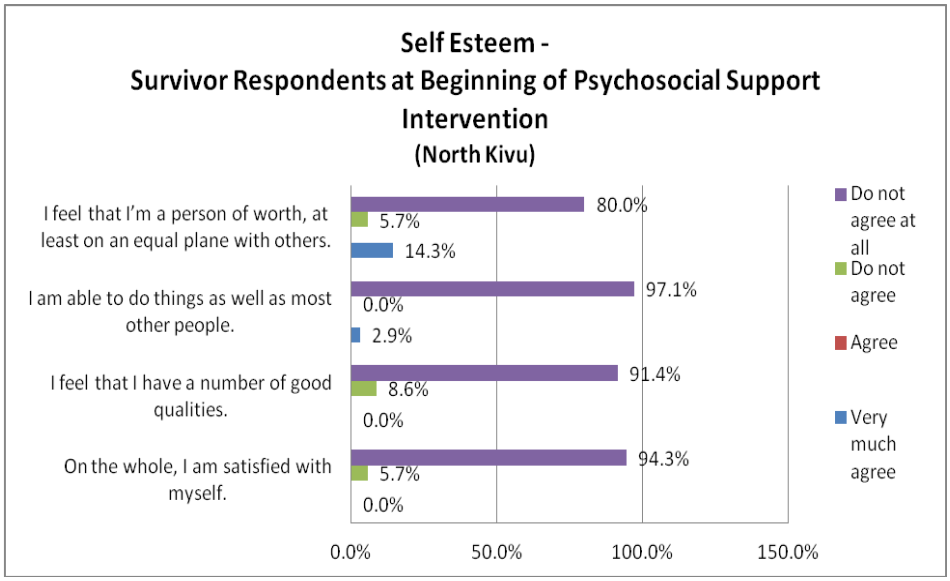
[42] Levels of self esteem were measured by positive responses to the Rosenberg self esteem scale questions.

In North Kivu, the results of the comparison between "old" and "new" case respondents were more dramatic, with an average of 95% of "old" case respondents reporting higher levels of positive self-esteem[43] and an average of over 90% of "new" case respondents reporting high levels of negative self-esteem.

North Kivu

Graph D: Comparison of Individual Survivor Questionnaire Respondent: Self Esteem (North Kivu)





The combination of the results reported from the individual survivor questionnaires related to ability to earn income to cover basic needs, social connectedness and self-esteem show a consistent trend towards increased psychosocial functioning of survivors who have completed the psychosocial support intervention provided by the psychosocial assistants. This provides further confirmation of the positive outcomes reported via the psychosocial functionality tool.

[43] These respondents responded that they "very much agree" with positive statements correlating with higher levels of self esteem.

Social Economic Outcomes - Women for Women, International

IRC partnered with international non-governmental organization, Women for Women International – DRC (WfWI), to provide socio economic reintegration activities to ESPOIR survivors and beneficiaries. WfWI provided life skills training, including modules on Sustaining an Income, Family and Community Decision-Making, Health and Wellness, and Social Networks and Safety Nets. WfWI participants also participated in vocational training (including agriculture and animal husbandry, brick-making, beauty care, culinary arts, retail sales and bread making) with a focus on business skills, cooperative development, and technical skills. Lastly, the WfWI intervention also included supporting groups of ESPOIR assisted women to develop cooperatives (shared funds of money to develop income generating activities). WfWI provided training on cooperative development focusing on practical understanding of what distinguishes a cooperative from other forms of business entities, the various types of cooperatives and how to use cooperatives for purchasing and marketing. This training also included decision-making processes and how to influence decision-making.

By the end of Year 4 of ESPOIR WfWI provided life skills trainings to 5, 610 ESPOIR assisted survivors. A mid-term evaluation of the impact of the WfWI intervention showed that ninety-eight percent (98%) of participants could identify two benefits of saving, and 97% of them could elaborate on two methods of savings. In Year 4, at baseline, ESPOIR Year 4 program participants were earning an average income of $0.68 per day and saving an average of $1.23 per month. At endline, all women included in the sample reported earning more than $1/day. On average, women save $2.54 each month. Upon graduation, 100% percent of ESPOIR Year 4 program participants report being employed or self-employed.

An end of project evaluation of the impact of the WfWI project revealed that women in the program had acquired valuable information about their rights, with all women (100%) in the evaluation sample reporting an understanding of their rights, most women (96%) able to identify two property rights to which they are entitled, and (91%) able to identify three human rights to which they are entitled. Findings also showed that women share this knowledge with others, with a majority of women (80%) reporting that they have educated another woman about rights. Of the sampled women, 94% were able to describe at least one way to address gender inequality in their communities.

Of the sample, 94% of women could articulate what a cooperative is. In addition, a total of 647 women are currently participating actively in business groups, pre-cooperatives or cooperatives. These groups of women received mentoring on effective organization leadership and teamwork from WfWI to strengthen cohesion within the groups.

Community Based Organization Member Feedback

During the focus group discussions with the women-led community based organizations, women expressed the impact that they felt that ESPOIR had for them as well as in the community. One hundred percent (100%) of participants in the women-led community based organizations in the 16 sites visited in North and South Kivu reported positive outcomes as a result of their involvement with ESPOIR activities. The spectrum of women participants' feedback is reflected in some of quotes below:

"The love between me and my husband have grown"

- Amajambere CBO member / focus group participant in Kabanero, North Kivu

Women participants consistently reported that their relationship with their husband had improved. Women reported that their husbands had more respect for them because they saw that they could contribute to the household as well. Women reported that abuse from their husband decreased, although it didn't totally disappear[44]. Women participants advised that a very small minority of men rejected women being able to contribute to the household. These husbands were described as refusing to eat the food cooked by the

[44] Many women who reported that abuse from their husbands continued also described their husbands as drinking a lot of alcohol.

women and eating "outside" so as to not accept the food and other benefits that the woman had contributed to the household. However, women consistently described these situations as a very small minority.

"With the money I make from beignets, I can pay school fees and buy things for the house. My husband has more respect for me because I can contribute."

- Femme lève-toi CBO member / focus group participant in Kamanyola, South Kivu

Over 90% of women who participated in focus group discussions (as part of this evaluation) who earned income from income generating activities or saved money as part of VSLA activities reported using earned income or savings to pay for school fees for their children. This had the secondary impact of more children, including girls, being able to go to school.

"*The chief he comes to seek out the opinion of the president of the CBO and other CBO members. They didn't do that before. Now we are given the right to talk"*

- Twisenge CBO member / focus group participant in Ntamugenga, North Kivu

When asked about the difference for women in the community, in approximately 80% of focus groups with women-led community based organization members, women responded that women now have the right to speak their opinions in a public domain where they didn't have the right before. In addition, community leaders were beginning to actively seek the opinions of women. Some of the increased right for women to speak in the community was attributed to awareness-raising done by the ESPOIR project with community leaders. However, women also described having an elevated status in the community due to having access to income. For example, school directors were interested in having women participate in parent committees at school because they are paying school fees for an increased number of children to attend school which raises the amount of revenue for schools. Therefore, participation of women (paying school fees) has become in the best interest of schools.

"Along with economic benefits of IGA activities, there are also health benefits. For example, knitting clothes for newborns helps protect them from pneumonia; making soap means more sanitary hygiene and (self) care of women and children."

- Health centre midwife / community stakeholders' focus group participant in Ntamugenga, North Kivu

Besides an increased number of children having access to education due to the increased ability of women to pay school fees, there were other secondary benefits reported during the focus group discussions in regards to the skills learned by women as part of the income generating activities. One midwife/nurse participant in a community leaders' focus group in North Kivu reported health benefits which impacted women and children. These secondary benefits have not been validated with empirical evidence but their description speaks to an increase in the quality of life for ESPOIR-assisted women and their children which go beyond purely economic measures.

"I couldn't take care of the house. I was depressed then I received psychosocial support, a goat, a blanket for my baby and learned how to do embroidery. I used to fight with people but I learned (how to behave differently). Other people notice the change and approach me now."

- IDJWI CBO member / focus group participant in Kabaya, North Kivu

The psychosocial support provided by the psychosocial assistants was consistently cited as making a difference in the lives of women. The psychosocial assistants are often described as a first point of contact in accessing support. The psychosocial support provided orients survivors towards services within the referral

pathway (i.e. medical, legal, security/safety, and psychosocial service providers), provides supportive counseling then refers survivors to social reintegration activities including life skills classes and income generating activities. In the example above (IDJWI focus group participant in Kabaya, North Kivu), the survivor described how psychosocial support acted as a gateway giving her the confidence to participate in social reintegration activities. Life skills classes reinforced that confidence and the act of participating in group oriented activities gave her more opportunities to practice interacting with others and building confidence. This combined with the economic empowerment of vocational skills training and income generating activities cemented her sense of confidence and recovery.

c. Sustainability

Sustainability describes both the ability of project activities to continue beyond the funding period and the ability of community structures to sustain the impact produced by project activities. Through focus group discussions and key informant interviews, this evaluation attempted to assess the organizational capacity of community structures as well as the aspects of impact on the larger community which were likely to have longer term effects on women and on the community.

Implementation via local women-led community based organizations and local community structures: Sustainable capacity building

IRC/ESPOIR's strategy to implement project activities via women-led community based organizations, particularly those that operated and had a presence in the community before the ESPOIR project, has within it a plan for promoting sustainability. The women-led community based organizations are self-motivated and as previously mentioned (see *Effectiveness - Objective Three: Key Stakeholders' Improved Capacity to Lead and Participate in Community Based Social Integration and Economic Recovery Activities)* demonstrated and described increased capacity during focus group discussions and observation visits which were a part of this evaluation. Local community structures also demonstrated increased awareness of women's rights issues and collaboration with the women led community based organizations and their membership. In focus group discussions, this was demonstrated by local community structures' knowledge of the referral pathway to assist vulnerable women to access support and descriptions of changes in the status of women and how women are seen, particularly around women's participation in community life and decision making. The building of capacity of the community based organizations and the awareness-raising with local community structures contribute to the likelihood that project activities will continue after the end of the project and the activities will continue to have a lasting impact on the lives and status of women in the community.

VSLA, Social Reintegration and Income Generating Activities: Sustainable Economic Empowerment

VSLA share-out outcomes and Women for Women International (WfWI) social economic outcomes show increased income, savings for ESPOIR participants and use of income and savings to meet household and family needs as well as invest in small business or other income generating activities. As the increased income is based on a program of savings, investment in a communal fund and income generation, ESPOIR participants who continue to use the skills learned from the VSLA groups or WfWI activities can potentially continue to generate savings and income. The VSLA groups and other social reintegration/ income generating activities are self perpetuating as therefore create sustainability of both the impact for ESPOIR assisted women and the outcome of increased income after the funding period of ESPOIR. In all of the focus group discussions with VSLA groups and women CBO membership as part of this evaluation, focus group respondents confirmed their experience of having access to increased income, being better able to meet their household/family needs and their ongoing participation in income generating activities which continued to be the source of their increased income.

Increased capacity of women-led community based organizations to facilitate income generating / social reintegration activities and awareness building in the community

In focus group discussions with community stakeholders (including the women-led CBO leadership), all of the community based organizations reported receiving training in community mobilization, making referrals

within the referral pathway and various income generation, vocational skills and social reintegration activities (i.e. soap making, agriculture, tailoring, animal husbandry, etc). In addition, the psychosocial assistants, who are based within each of the community based organizations, received specialized training in case management and supportive counseling as part of providing psychosocial support. The ability for the community based organizations to carry out these activities was demonstrated and observed during the evaluation and spoken about by CBO members and survivors during focus group discussions. Some of the community based organizations facilitated activities prior to ESPOIR support. However, the activities of all of the community based organizations have expanded significantly since the start of the ESPOIR project. This is evidence of the increased capacity of the women-led community based organizations to facilitate these activities. This increased capacity will stay with the community based organization beyond the funding period of the ESPOIR project. Even if the number or frequency of activities decrease after the end of the project, the technical capacity of those who received this training will remain and would have expanded to the participants of these activities. The choice of implementing the activities via community based organizations which were previously active in the community prior to ESPOIR support, contributes to the likelihood that these community based organizations will continue to be present and active in the community, but now with increased technical capacity.

Increased awareness of women's rights issues in the community

Focus group discussions with community stakeholders, women CBO members, VSLA and male discussion group participants demonstrated and made reference to increased awareness of women's rights and some degree of change in how women are seen in the community as a result of awareness raising activities and the increased economic and social empowerment of women made possible by the ESPOIR project. Examples given of the change in the status of women include increased participation of women in public life (i.e. women being able and invited to speak in community meetings, women participation in parent committees in local schools, seeking the opinion and participation of the women-led CBO leadership in general community leadership decision-making, etc.). The integration of women's opinions and voices has the potential impact to increase women's overall participation in decision making and to integrate the needs and priorities of women in community planning and representation. Although this change was initiated by ESPOIR project activities, it's integration into general community life and structures contributes to sustaining and building upon the positive impact for women beyond the funding period of the ESPOIR project.

Increased social cohesion as an impact of the VSLA

As previously mentioned, VSLA focus group participants described that it is in the best interest of the entire VSLA group membership to resolve any potential conflict as it puts the entire membership at risk of losing their investment and savings. Thus, the formation of VSLA groups require a level of trust and cooperation between VSLA group members which promotes social cohesion among VSLA members and potentially for the larger community with the creation of other VSLA groups (see *Effectiveness - Objective Two: Social reintegration/economic empowerment assistance* section of this report). The reinforcement of social cohesion through the economic empowerment of the VSLA promotes the sustainability and expansion of VSLA groups.

Sustainability: Challenges

Although the strategy of implementing ESPOIR project activities via women-led community based organizations promotes the overall sustainability of activities, during focus group discussions, key informant interviews and observation made during the evaluation period, several points were highlighted as potential challenges to the sustainability of activities and their impact for vulnerable women.

During focus group discussions, leadership and members of the community based organizations confirmed increase technical knowledge which will contribute to sustaining ESPOIR project activities. However, concerns were raised in regards to the purchasing of materials needs for the social reintegration and income

generation activities (i.e. fabric for tailoring, flour and oil for pastry-making, materials for soap-making, etc.). The expectation from CBO leaders and members appeared to be that they would need to continue to have funding in order to purchase activity materials. Without funding for materials, CBO leaders and members seem to imply that the frequency of activities and capacity to enroll new participants would decrease over time. There did not seem to be a plan or understanding that generated revenue from income earning activities or the income earned from those who have benefited from vocational training or social reintegration activities could be contributed towards purchasing materials for future activity cycles[45].

Although the concept of re-investing generated revenue into sustaining project activities is implicit in the IRC/ESPOIR's capacity building strategy, the concept of the community based organizations being self sustaining and eventually being able to operate independent of IRC/ESPOIR has not yet been imbedded within the community based organizations, local community structures or the community in general. In addition to capacity building of the community based organizations to lead and participate in community based social integration and economic recovery activities there is also a need for building the capacity of the organizational infrastructure to become more self-sufficient as a result of the social integration and economic recovery activities. This requires ongoing monitoring and mentoring during the life cycle of the project to insure that the community based organizations are oriented, planning for and moving towards self sustainability to maintain social reintegration and income generating activities after the end of the project. It is imperative that this type of capacity building begin at the start of the project life cycle in order to maximize the time spent supporting and monitoring the success of community based organizations moving towards self-reliance and sustainability.

Similar sustainability challenges exist for the legal and medical assistance service providers. Legal fees and transport costs impact the sustainability of legal assistance and the need for an ongoing supply of medicines and PEP kits impact the sustainability of medical assistance. The difference with legal and medical assistance service providers is that they did not benefit from facilitating income generating activities or participating in VSLA groups during the ESPOIR project funding period. So, the legal and medical assistance structures are dependent on an outside source of funding to meet these essential costs.

In North Kivu, IRC/ESPOIR has attempted to address this need by leaving a stockpile of PEP kits and medicines with the health zones. In addition, IRC/ESPOIR participated in coordination planning with UNICEF and the health zones in both North and South Kivu. As previously mentioned, even with coordination between UNICEF and the health zones challenges still exist in facilitating the distribution of PEP kits and essential medicines to the health zones (see *Objective Two: Medical Assistance – Challenges* section). There is also the reduced motivation and retention of health care staff who, no longer receive a financial supplement from IRC Health programming, to continue to offer free health interventions to survivors as part of the gender based violence referral pathway. Even with these challenges which can potentially compromise the sustainability of access to medical assistance in the community, enough infrastructure and planning exist that is likely that some level of medical assistance provision will continue after the end of the ESPOIR project. In regards to legal assistance, however, the gap in funding to cover legal fees and transport costs is not addressed. Therefore, the sustainability of legal assistance after the end of the ESPOIR project is severely impaired.

Another key point for sustainability is the ability of the community based organizations and psychosocial assistants to continue to provide psychosocial support for survivors at the quality and standard set by the IRC/ESPOIR project. In order for this to happen, there is a need for on-going professional development and quality assurance monitoring of psychosocial assistants. Under the ESPOIR project, psychosocial assistants

[45] It is possible that CBO leadership and members did not highlight using generated revenue for materials for future activities during focus group discussions as a way to advocate for the need for continued funding of materials for social reintegration and income generating activities.

receive quality assurance checks from IRC/ESPOIR psychosocial officers and on-going training from IRC as a larger organization. After the end of the project, there is no provision for quality assurance checks to continue. This combined with the lack of on-going training is likely to mean that the quality of the psychosocial intervention will decrease over time. In addition, psychosocial assistants currently advise that it is difficult for them to fulfill their duties in their roles as psychosocial assistants as well as their personal obligations and need to find income to support themselves and their families (see *Effectiveness - Objective Two: Psychosocial Assistance: Challenges* section). This sentiment is likely to increase after the end of the ESPOIR project thus jeopardizing the sustainability of the psychosocial support intervention which is solely dependent on the current psychosocial assistants continuing in their role with the community based organizations[46]. Unless there can be a way to balance the psychosocial assistants ability to earn income with the workload of the role, it is likely that there will be a need to provide some level of a financial incentive to retain the psychosocial assistants in their role in order to maintain the provision of psychosocial support.

Although IRC/ESPOIR has found it to be an effective strategy to work with community based organizations and to support community partners directly working with survivors and women in the community, another aspect of sustainability would be to coordinate intervention efforts and to build the capacity of government authorities to monitor and support project activities. Key informant interviews and community stakeholder focus group discussions confirmed that IRC/ESPOIR coordinates project activities with local government authorities at the community level (i.e. chef du groupement, chef du village and health zone). Key informant interviews with the Bureau de Chefferie (territory level government leadership office) and the Bureau de Genre, Famille et Enfants (Office of Gender, Family and Children) in Rutshuru territory in North Kivu evidenced joint working and capacity building with government representatives. The Administrative Secretary for the Rutshuru territory leadership reported that his office benefitted from IRC/ESPOIR training[47] and participation in community stakeholder meetings to coordinate and plan ESPOIR activities. In South Kivu, government leadership for the territories where IRC/ESPOIR operates are informed of IRC/ESPOIR's presence and activities but ongoing coordination and capacity building is focused on the chef du groupement, chef du village and health zone level[48]. The key informant interviews and focus group discussions did not provide evidence for IRC/ESPOIR capacity building and coordination efforts with community and/or territory level government authorities to monitor and provide technical support for activities after the end of the project. The capacity building efforts described were more focused on building awareness and sensitivity around gender based violence and participation in community mobilization to facilitate awareness raising campaigns. To truly imbed government support for project activities, IRC/ESPOIR would need more substantial involvement of government authorities at the territory and provincial level as well as project-specific advocacy and policy implementation[49] with key ministries[50] at the local, provincial and national levels.

Many of the points highlighted above, while pertaining to the sustainability of project activities, also have implications for the need for community development focused interventions and programming, as opposed to emergency response. The ability to generate income to fund social services, build organizational infrastructure and capacity to promote good governance over community and organizational resources,

[46] This point is highlighting that the capacity building efforts for psychosocial support is focused on the individual psychosocial assistants which received training to provide psychosocial support. Capacity building was not particularly focused on building the capacity or infrastructure for the community based organisations or other community structures to provide psychosocial support.

[47] Rutshuru territory leadership reported that IRC/ESPOIR invited representatives from their office to training on gender based violence and Congolese law. Rutshuru territory leadership reported that the *chef du groupement* and *chef du village* represented the local government at all other training offered by IRC/ESPOIR for community stakeholders.

[48] Based on key informant interview with the IRC South Kivu GBV Services Manager.

[49] IRC's Women's Protection and Empowerment program does engage in advocacy for policy implementation supporting women's rights and empowerment at the national level. However, there was no evidence presented during the evaluation that showed an emphasis on advocacy at the national and provincial government level to facilitate government financial and technical support and capacity building to take over project activities after the end of the ESPOIR project.

[50] Key ministries relevant to the IRC/ESPOIR project would include the Ministry of Social Affairs, the Ministry of Gender, Family and Children, the Ministry of Health and the Ministry of Justice and Human Rights.

promote participation in community decision making and socio-economic activities and the integration and retention of increased technical knowledge are all longer term community development outcomes.

The impact of larger development context issues on ESPOIR assisted communities was highlighted in the focus group discussion with community stakeholders in Bugobe, South Kivu. Bugobe is a community that did not have the benefit of having both IRC/ESPOIR and IRC Health programming overlap in the same location. Focus group participants advised that the community was currently experiencing a famine due to failing crops. In addition, the community was directly targeted during the most recent period of conflict. Focus group participants reported that during incursions with rebel forces, everything was taken, including clothes. Focus group participants explained that only since May 2013 had community members begun to sleep in their houses rather than in the forest for fear of attacks from rebel forces. Many community members were described as traumatized. Community members only recently returned to cultivating their fields and thus have only recently been able to begin earning an income. At the time of the focus group discussion, medication had run out at the local health centre and the cost of medical care for community members and survivors had started to go up.

Focus group participants were able to describe improvements in the lives of ESPOIR assisted survivors and capacity building for the community based organization. Improvements included participation and facilitation of social reintegration and income generating activities, establishment of a "VSLA-like" group, availability of psychosocial support, increased respect for women, women being able to access their legal rights, participation of women in community discussions and decision making. However, high levels of stigma were still reported for women and children survivors[51] and focus group participants saw the impact of ESPOIR activities as specific to ESPOIR beneficiaries not so much supported by or impacting the general community. The level and sustainability of improvements appeared to be tempered by what the community was experiencing as a whole[52] in regards to economic deprivation, trauma and access to services such as healthcare. The overall vulnerable status of the Bugobe community and its infrastructure is likely to impact how well ESPOIR project advances for survivors, and women in general, can be maintained and sustained after the project. This highlights the need for a community development focused programming phase as a strategy for sustainability to capitalize on maintaining project outcomes after the end of the project and during periods of increased community security and stability.

6. Lessons Learned

Over the five-year period of the ESPOIR project, there were a number of lessons learned which informed changes in program design and strategy. Below is a summary of what has worked and contributed to the more positive outcomes of the project:

1. Co-location and overlap of multi-disciplinary programming focuses resources in a smaller number of communities and allows multi-systemic issues to be addressed. This increases the impact and sustainability of programming and outcomes.

2. Local community partners (i.e. women-led community based organizations) who may have smaller organizational capacity but history of working locally in the community may make more sustainable partners than local non-governmental organizations with larger organizational capacity. (Note: This is true for implementation of legal assistance or socio-economic activities as well as psychosocial support activities).

[51] There was some acknowledgement that there had been some change in the level of stigma, with it being less than before, but focus group participants emphasised that there was still a lot of stigma towards women and children survivors of sexual violence.

[52] This is based on the observations of the evaluation consultant when comparing the feedback during focus group discussion from other ESPOIR assisted communities with the feedback received in Bugobe.

3. Men are key partners for changing community attitudes and ensuring the empowerment of women. The male discussion groups increased awareness around women's rights and gender roles while nurturing a community environment which is more tolerant of women's economic and social environment. This creates an increased sense of safety for women and facilitates change as gender roles shift.
4. Implementation of programming through local community partners is also best practice for sustaining program activities during period of insecurity. Local community partners can maintain a presence in communities when international agencies cannot. This can make the difference in local communities accessing essential services. Thus, it is important to build partnerships and the capacity of these local partners.

5. Psychosocial support and psychosocial education (i.e. life skills) is a key compliment to socio-economic and social reintegration activities. Psychosocial support and psycho-education facilitate understanding that makes the individual and the community around the individual more available to learn and retain the skills taught as part of socio-economic activities. This increases the positive impact of social reintegration activities on the individual and the sustainability of these activities.

6. Community education determines whether a service will be accessible to survivors or beneficiaries, even more so than the quality of the service. Ongoing and consistent resources and training must be devoted to community education to ensure accessibility of the service.

7. Socio-economic activities and models, such as VSLA, can also promote social cohesion and good governance within communities.

7. Recommendations

This report has provided an overview of the outcomes and activities which speak to each of the objectives of the ESPOIR project. The body of the report lists the strengths and challenges according to each of these objectives. From this, the following recommendations have been formulated to address the challenges. The recommendations below are organized according to the project objectives:

Objective 1: GBV survivors in North and South Kivu gain access to timely care and treatment services

1. Facilitate regular Lessons Learned workshops between the North and South Kivu teams so that the teams are able to learn best practices from each other and benefits from each other's innovation.

2. Consider more overlap and joint working between IRC/ESPOIR staff and Rapid Response to Population Movement (RRPM) teams so that ESPOIR staff benefit from the same training and coordinated planning as the RRPM teams. This can be cascaded down to training, identifying and supporting community based organizations and community partners in emergency response and planning so that there is the least disruption of services possible during periods of instability and insecurity. Some of this is already happening in North Kivu but can be increased in both provinces.

3. Disaggregate monitoring data regarding sexual violence from other forms of gender based violence. Different forms of gender based violence require different responses and approaches to prevention. For example, responding within 72 hours of an incident is most critical for sexual violence survivors. It is difficult to track this response time for sexual violence survivors if monitoring data also includes varied response times for other forms of gender based violence. Monitoring the various types of gender based violence separately can also help to inform program design, prevention activities and how to prioritize community education activities.

Objective 2: Service providers have improved capacity to respond effectively to GBV and facilitate the recovery of survivors in emergency and post conflict settings

4. Support community based organizations to use some portion of generated income to maintain an organizational budget, which would include funding to maintain activities and to pay a stipend to the psychosocial assistants.

5. Consider formation of VSLA-like groups for community structures such as health, community leaders, legal assistance and other service providers in the referral pathway. This may help facilitate the sustainability of their activities once project resources are no longer available. This may also promote necessary social cohesion to motivate and retain the various actors in continuing to provide services.

6. Implement child and/or youth specific programming which can access vulnerable and survivor children and youth. The current research study will provide more information on what the current barriers are and recommendations for overcoming them. Children and youth survivors have specific needs and appear to experience a different level of vulnerability and stigma. Coordination and integration with child protection programming will help to address ESPOIR objectives for the specific child and youth survivor context.

Objective 3: Key stakeholders have improved capacity to lead and participate in community based social integration and economic recovery activities that include strengthening community response to and prevention of GBV

7. Include organizational capacity building along with building of technical knowledge of community structures to implement project activities. In addition, include organizational leadership in all aspects of technical training (i.e. psychosocial support training). This would ensure the sustainability of these community structures, promote better governance and incorporate the technical knowledge at the leadership level so that organizational technical capacity is not strictly dependent on the retention of members who have been trained in a particular technical skill (i.e. psychosocial assistants). This would help to increase the overall sustainability of project activities.

8. Consider building the capacity of local health centre staff and the local health zones to provide direct psychosocial support and provide training and quality assurance for the provision of psychosocial support by the women-led community based organizations / psychosocial assistants. Building the technical capacity of the health structures to provide and train in psychosocial support, creates more sustainability, increased coordination and additional quality assurance checks for the provision of psychosocial support. This would mean that health centre staff and the health zones would be trained and monitored by psychosocial officers the same as the psychosocial assistants and community based organizations. After the end of the project, the health structures, the community based organizations and the psychosocial assistants could establish a psychosocial support working group to provide peer support, coordinate refresher training and quality assurance checks. This would lessen the dependency on individual psychosocial assistants to sustain the provision of psychosocial support and increase local resources for psychosocial support training within the community

9. Consider building the organizational capacity of the police by organizing gender based violence sensitivity training for police and recommending background screening criteria for the recruitment of police. Direct training rather than relying on police leadership to cascade training to police officers can help increase GBV awareness and decrease informal arrangements being made when survivors register complaints brought against perpetrators. Background screening can help to reduce the incident of former perpetrators being recruited as police officers.

10. Consider providing "training of trainer" training as well as facilitators training to facilitators of the male discussion groups so that training can potentially be cascaded to male discussion group participants who may be interested in facilitating future groups.

11. Encourage the substantial involvement of government authorities and key ministries (i.e. Ministry of Social Affairs, the Ministry of Gender, Family and Children, the Ministry of Health and the Ministry of Justice and Human Rights) at the national, provincial, territory and community level in project implementation. Expand the current focus of capacity building efforts for government authorities to include being able to monitor and provide technical support for project activities after the end of the project. This can be done by: (a) including representatives from the key ministries at various levels of government in training provided by the project; (b) creating an externship for key government authority personnel with the ESPOIR project where staff from Department of Social Affairs, the Office of Gender, Family and Children, and the Health Zone would receive the same training as IRC staff implementing the project and would work side by side with IRC staff implementing the project (i.e. field officers, program managers, etc.). This would facilitate government partners gaining practical experience and learning about the day to day implementation and operation of the ESPOIR project.

12. Consider co-locating Community Driven Reconstruction (CDR) programming with ESPOIR project sites. IRC operates a large CDR program in the eastern provinces of the Democratic Republic of Congo. Community Driven Reconstruction is a methodology that allows community to be drivers and owners of their own reconstruction and recovery through establishing community governance structures that stress choice and accountability. It is based upon community-driven development (CDD) models pioneered by the World Bank and community development/local governance initiatives under USAID and UNDP among others, but adapted for the specific context of conflict affected environments. It provides funds for implementation of community projects focused on building community infrastructure, contracted to the private sector and monitored by civil society groups[53]. As stated under lessons learned, co-location of multi-disciplinary programming can help to address multi-systemic development issues such as governance which can increase positive outcomes for project beneficiaries and communities.

[53] International Rescue Committee – Post Conflict Development Initiative (February 2007). Lessons Learned on Community Driven Reconstruction – Version 1 (Revised Draft).