COUNTERING GENDER BASED VIOLENCE IN EASTERN DEMOCRATIC REPUBLIC OF CONGO

BASELINE REPORT

TASKING 059

Contract No. GS-10F-0033M/AID-0AA-M-13-00013

MAY 2019

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DISCLAIMER

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IMA INDICATORS

ACRONYMS

CBTH	Community-Based Trauma Healing
DRC	Democratic Republic of Congo
GBV	Gender-based violence
HZ	Health zone
IE	Impact evaluation
IPV	Intimate partner violence
SFCG	Search for Common Ground
GBV	Gender-based violence
SV	Sexual violence

EXECUTIVE SUMMARY

This report presents key results from a baseline survey implemented in selected villages in Eastern Democratic Republic of Congo (DRC) during fall 2018. The baseline is part of a randomized Impact Evaluation (IE) of a program that aims to change norms around Gender Based Violence. The impact evaluation assesses the impact of selected aspects of the *Tushinde Ujeuri* program to reduce gender-based violence, coordinated by IMA World Health and implemented by several partners including Panzi Hospital, Heal Africa, ABA Rule of Law Initiative and Search for Common Ground.

The field experiment tests the effectiveness of Community-Based Trauma Healing (CBTH) as a core approach to change norms and behavior around gender-based violence (GBV), and particularly intimate partner violence (IPV) as well as sexual violence (SV) more broadly. The evaluation randomly selects 80 villages from a list of 160 villages across 3 health zones in Eastern DRC to receive the CBTH program. The IE assesses impacts on perceived norms, and individual attitudes and behaviors (self-reported and observed). Moreover, the IE aims to assess whether and how these interventions affect the uptake of services provided to survivors of GBV through the health area-level service delivery of the *Tushinde Ujeuri* program.

This baseline survey was collected in all 160 villages that are part of the Impact Evaluation across Walikale, Katana, and Nyangezi Health Zones, and in an additional 32 avenues in the semi-urban Karisimbi Health Zone[1]. The data reported below presents results across all 192 villages. We also report on four core indicators relevant to IMA's monitoring and evaluation plan, namely (i) prevalence of GBV, (ii) gender equality, (iii) attitudes towards GBV and (iv) attitudes towards barriers to accessing GBV services.

The results from the baseline survey reflect the harsh realities that decades of conflict have brought to this region. Political instability and other hardships have wrought changes at both the village and individual level. Villages reported extremely high levels of social and economic shocks in the past five years, including drought, flooding, crop failure and disease outbreak. Witnessing or experiencing war-related abuses was extremely common. More than half of respondents reported having witnessed or experienced at least one conflict-related event. Respondents also reported high exposure to sexualized violence related to conflict. Over 22% of all respondents report having witnessed rape or sexual abuse of a woman; 9% of all respondents report having witnessed rape or sexual abuse of a man and 10% report having personally experienced sexual abuse by an armed group.

A core indicator of GBV relates to Intimate Partner Violence (a first component of IMA indicator 1). Over half of all ever-partnered women surveyed reported having experienced IPV at some point in their lives (53.4%), a number that is well above the regional average for Sub-Saharan Africa. Over a third of women (38.9%) reported experiencing IPV in the past 12 months. The survey also examined women and men's experiences with sexual violence committed by a non-partner. One-fifth of women and one in twelve men reported being ever raped by a non-partner. Again, these numbers are much higher than the regional victimization rate for women in Sub-Saharan Africa, where in the past year, 14.6% of women and 6.4% of men reported experiencing sexual violence.

[1] These 32 additional avenues in Karisimbi Health Zone were included in the baseline data collection as a precaution in case accessibility or safety issues prevented the implementation of the CBTH intervention in Walikale. More detail is provided in the Sample section below.

Almost one-third of men and 13% of women report perpetrating physical IPV against a partner in their lifetime. Roughly one in seven men have reported ever forcing someone other than their partner to have sex against their will, and 4% of men reported doing so in the past year. Just over six percent of women report ever forcing someone to have sex against their will, and 3% reported doing so in the past year.

A second core indicator of GBV relates to non-partner sexual violence (a second component of IMA indicator 1). One-fifth of women (20.5%) and one in twelve men (8.23%) reported being ever raped by a non-partner. Again, these numbers are much higher than the regional victimization rate for women in Sub-Saharan Africa, which is 14%. In the past year, 14.6% of women and 6.4% of men reported experiencing sexual violence.

The survey assessed individuals' own attitudes toward the acceptability of GBV, as well as individuals' beliefs about the attitudes of others in their community (IMA indicator 2 and 3). In general, there exists a sizable gender gap in attitudes; women hold less accepting attitudes towards GBV while men have more permissive attitudes. The most common barriers to accessing GBV services differed slightly for family versus non-family perpetrators of GBV. However, in general, the most commonly reported problems were not having money for transport or for services fees, and not knowing where to access services.

Individuals participating in the research had high levels of depression and anxiety as well as PTSD – an outcome that is expected given the high levels of trauma reported elsewhere in the survey. Across all health zones, a significantly larger proportion of women report anxiety and depression and PTSD than men.

There are stark gendered differences in many of the outcomes assessed for this project, including but not limited to: access to education, access to income-generating activities and resilience and mental health outcomes. There is also substantial variation among health zones in a number of outcomes, including literacy, employment, mental health outcomes and perceptions of security. This highlights the importance of disaggregating these data to gain a more nuanced picture of how outcomes may vary across populations.

There are strong and significant links between the GBV outcomes and exposure to war-related violence. Women who have witnessed or experienced war-related events are more likely to be victims of IPV. Men who witnessed war-related events are more likely to report perpetration of IPV and SV. These results suggest a strong link between exposure to political conflict and perpetration of violence within the home. These findings are particularly striking given the extremely high-levels of war-exposure reported in the survey.

Finally, there were strong links between certain measures of poor social cohesion and men's perpetration of different forms of IPV. Men who report worse relations with neighboring villages are also more likely to report perpetrating SV and IPV.

Taken together, these results suggest that violence within communities – including IPV and other forms of GBV – are highly associated with individuals' experiences with the conflict, and are also associated with measures of social cohesion. Addressing the underlying trauma of conflict and trying to rebuild trust and social cohesion may provide an avenue to addressing some of the underlying mechanisms that propagate violent behaviors in highly war-affected areas.

We summarize the key findings from the baseline survey below:

- Exposure to witnessing or experiencing war-related abuses was extremely common. More than half of respondents reported having witnessed or experienced at least one conflict-related event.
- Individuals participating in the research had high levels of depression and anxiety as well as PTSD. Across all health zones, a significantly larger proportion of women report anxiety and depression and PTSD than men.
- Over half of all ever-partnered women surveyed reported having experienced IPV at some point in their lives. One-fifth of women and one in twelve men reported being ever raped by a non-partner. These numbers are higher than the regional victimization rate for women in Sub-Saharan Africa.
- Men who witnessed war-related events were more likely to report perpetration of IPV and SV.
- War-related experiences are highly and significantly associated with higher odds of women reporting IPV victimization.
- Men who reported more mistrust and resentment of neighboring communities also had higher odds of perpetrating IPV and sexual violence against non-partners.

1. INTRODUCTION

USAID's Counter Gender-Based Violence (C-GBV) program known as *Tushinde Ujeuri* in Swahili) in the Democratic Republic of the Congo (DRC) seeks to:

1. promote positive gender norms, power-relations and attitudes to address a core driver of GBV;
2. respond to survivors' medical, emotional, and legal needs; and
3. reduce stigma to enhance reintegration of survivors.

Tushinde Ujeuri builds on the previous 5-year program "Overcoming Sexual and Gender Based Violence in Eastern DRC" (known as *Ushindi* in Swahili), which has implemented a holistic approach to supporting survivors of Sexual and Gender Based Violence (SGBV) through the integrated delivery of psychosocial, medical, legal and economic services to survivors and their communities. While there is an overwhelmingly positive perception of the holistic service delivery approach for survivors of GBV among implementing partners, and suggestive evidence from an independent study to confirm this (Amisi 2016), far less is known about the effectiveness of preventative strategies.

During a scoping trip conducted by the research team in 2017, implementing partners identified two key factors *driving* both the incidence of GBV and perpetuating stigma among survivors: (i) "traditional culture and norms", and (ii) exposure to, and fallout from, conflict-related traumatic events.[2]

Partners also pointed to the importance of sensitization efforts in the form of trainings, workshops and "Social and Behavior Change Communication" (SBCC) campaigns conducted as part of *Ushindi* in creating awareness about specific issues relating to GBV, and the program services. It is an open question as to whether these efforts lead to enduring changes in attitudes, norms and behaviors so as to prevent future incidence of GBV, and which types of efforts are most effective in doing so. This mirrors an overall dearth of empirical evidence from interventions oriented towards primary prevention of GBV (Ellsberg 2015).

The proposed impact evaluation (IE) seeks to narrow this evidentiary gap by evaluating a trauma healing strategy for GBV prevention in a post-conflict context. The program, Community Based Trauma Healing (CBTH) involves explicitly addressing post-conflict trauma resulting from, among other things, systematic rape in the past, indigenous conflict, internal displacement and inheritance conflicts through community *detraumatisme* sessions that bring together potential victims, perpetrators, traditional leaders and faith-based leaders.

Principal Investigators for this evaluation are Jocelyn Kelly, Sarah Khan, and Maarten Voors. The research protocol for this study was approved by the NORC Institutional Review Board (IRB00000967), Project Number 7554.059.01, IRB Protocol Number 18.08.13 on 09/10/2018.

[2] See Kelly, Khan and Voors. "Scoping Trip Report". December 7, 2017.

2. BACKGROUND

GBV is one of the most pervasive and harmful forms of violence globally. It encompasses any form of violence that is perpetrated on a person as a result of their gender identity. Men, women, boys and girls can all be victims as well as perpetrators of GBV. However, global evidence suggests that the great majority of GBV victims are women and that men have higher rates of GBV perpetration than women.

Thirty-five percent of women globally report being victims of physical or sexual abuse during their lifetime and one-third of women who have been in a relationship have experienced physical or sexual violence from a partner. Globally, one out of every five women will become a victim of rape or attempted rape during her lifetime, and intimate partner violence (IPV) is the most common form of violence against women. Sequelae of sexual abuse include injury and death as well as poorer mental and reproductive health outcomes, including unintended pregnancy; physical harm; increased vulnerability to sexually transmitted diseases, and HIV.

United States Government Definition of Gender-based Violence

Violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

GBV has many forms; a complex interplay of risk factors that contribute to this form of violence. While the types and causes of GBV may vary from one context to another, a number of multi-country research efforts have begun to uncover some of the mechanisms underlying GBV. Unequal power relations between men and women, harmful gender norms and beliefs, experiences with violence in childhood, and drug and alcohol abuse are some of the factors that are consistently associated with GBV.

There is also a link between political instability and increased rates of GBV. Research from Uganda, Thailand, Cote d'Ivoire and Liberia has found that women who are subject to higher levels of conflict-related abuses also report higher levels of IPV victimization during and after conflict. Exposure to political violence and to human rights abuses has been linked to higher rates of IPV perpetration among men in conflict and post-conflict settings. Thus, personal experience with conflict-related abuse appears to enhance vulnerability to IPV.

Relatively little systematic information is available about the factors associated with men's perpetration of sexual violence, particularly in war-affected areas. Rates of perpetration vary greatly from context to context – reinforcing the finding that social norms and gendered inequalities, as well as other factors, can affect levels of violence across the globe. Men's reports of perpetrating physical IPV vary from 42% in South Africa to 22% in India. Reports of non-partner rape vary from 9% in Chile to 37% in South Africa.

The United Nations Multi-Country Study on Men and Violence in Asia and the Pacific is one of the most comprehensive efforts to examine the prevalence and risk factors of GBV perpetration among men (Fulu et al, 2013). This study found that a number of factors are linked to sexual violence perpetration, including: having more sexual partners, seeking transactional sex, using physical violence against female partners, men's own victimization and low socioeconomic status.

While the UN study included two post-conflict sites, this was not a focus of their study. Indeed, very little is known about why men perpetrate rape in active conflict settings. Yet, data suggests that war may increase the rates of sexual victimization among women. It is therefore particularly important to understand how experiences related to political conflict may be associated with men's perpetration of sexual violence.

The data presented here suggest links between political instability and GBV, although practitioners and policy makers are still working to fully understand these links and how to address them. The *Tushinde Ujeuri* project attempts to directly address the harmful gender attitudes, norms and practices that may underlie perpetration of IPV and other forms of GBV. This evaluation aims to strengthen this effort by more fully examining how political conflict and war-abuses may be linked to the perpetration of multiple forms of GBV, and particularly IPV.

3. PLANNED IMPACT EVALUATION DESIGN

The proposed IE assesses the impact of Community Based Trauma Healing (CBTH) as a strategy to address GBV in a post-conflict context. During the scoping trip, partners repeatedly mentioned conflict-related factors as contributing both to the incidence and prevalence of GBV, and the stigmatization of survivors of GBV. This activity has not been previously implemented as part of *Ushindi*, although it has been implemented by Catholic Relief Services in other parts of the DRC. The Search for Common Ground (SFCG) Technical Strategy Document for CBTH is used as a reference to highlight the main components of this activity.

3.1 LEVEL OF IMPLEMENTATION AND COMMUNITY SELECTION

CBTH activities will be implemented at the village level in three Health Zones of Eastern DRC: Nyangezi, Katana and Walikale. Within these three Health Zones, CBTH will be implemented in 2 of 4 randomly selected villages within each of 40 study Health Areas, creating a study sample of 160 villages with 80 villages receiving the CBTH treatment.

The choice of Health Zones was based on IMA World Health's (IMA) objective to "Identify CBTH beneficiary geographic entities according to geographical accessibility and security context: for this project, the implementing partner will target at least 3 to 5 CBTH beneficiary communities per health area. The choice will also be guided by the communities most affected by the post-conflict trauma (massive rape in the past, high scale / prevalence of sexual and gender-based violence, indigenous conflict and internally displaced persons, inheritance conflicts, rejection of marginalized people, mistrust between local communities and the security forces or institutions supposed to protect them etc.)".

3.2 DESCRIPTION OF CBTH INTERVENTION

This programmatic description draws on a design developed by implementing partner Search for Common Ground (SFCG) to outline the objectives and the related activities that will constitute the CBTH intervention:

OBJECTIVE 1: TO STRENGTHEN THE COMMUNITY CAPACITY TO SUPPORT TRAUMA HEALING PROCESS

Result 1.1: Community trauma healing facilitators have increased capacity to support the community-based trauma healing process. The approach around this result is grounded in the idea that communities will be supported to select and train trusted interlocutors to become CBTH facilitators (called healing companions) to then steward healing activities in communities. The following activities will be undertaken in each CBTH community:

- **Activity 1.1: Participatory, community-led identification of facilitators -** Working with NORC as per the IMA agreed plan, SFCG will implement this action in 80 villages of the selected health zones of NYANGEZI, KATANA in South Kivu and WALIKALE in North Kivu. To cover the 80 villages, SFCG will retain 80 local facilitators here called THC (Trauma Healing Champions). To build trust, the THCs will be nominated by the community. SFCG will set a list of criteria including but not limited to:
  - Be a member of the community
  - Deserve trust from the community members
  - Facilitation skills
  - Gender balance (they will work in pair of man/women)

- Sensitivity of local identity with representation where needed
- Knowing the conflict issues and GBV issues that affect the community welfare
- Be a leader for the community (doesn't mean with official responsibility) but an accepted person that draw persons around its vision
- Effort to include victims of: past rape, indigenous conflict, internal displacement and inheritance conflicts, traditional leaders and faith-based leaders, taking into account all sensitivities
- Be able to read and write to use the facilitation guide and fill out to data collection sheets

SFCG will convene a public forum in each health area where these criteria will be explained before the community proceeds with selection of their THC. Prior to this selection forum, SFCG field assistants will sensitize different people in the community to explain the approach and the purpose of the public forum so that everyone is prepared and all groups have a chance to participate and to tolerate others' participation.

- **Activity 1.2: Training manual designed covering trauma healing, conflict resolution, and community facilitation techniques -** Following the selection of the THCs, SFCG will assess their knowledge and skills to design/update the training manual. On this basis, SFCG's training department will design the training manual with support from an in-house or external trauma healing expert (either from SFCG Burundi or from COPA that also supported CBTH in the SEEC program). The training manual will cover knowledge around CTH, GBV, Conflicts and violence and interrelations between all these and finally facilitation technics adapted to community level. SFCG will involve NORC in the design/adaptation of the training manual to ensure that learning since the start of the project is captured.
- **Activity 1.3: Training of THCs on trauma healing, GBV, conflict resolution and community participatory facilitation techniques -** To train the 80 THCs, SFCG will conduct 7 experiential training workshops gathering together 10-12 persons per training workshop. Each training will last 5 days, including 3 days of practical learning and 2 days of application of the learning, facilitating sessions and being assessed by the other participants and the trainers. Participants will re-try their session until the other participants and the trainer are fully satisfied and the participant has adequate self-confidence to lead a trauma healing session. Over the course of the project, 4 months following the training and in the 12th month of the project, SFCG will conduct 3 refresher trainings (1 Katana for 36 THC, 1 in Nyangezi for 20 THC and 1 in Walikale for 24THC) with the aim of refreshing the skills of the THC, understanding common issues and updating the facilitation materials where required.
- **Activity 1.4: CBTH facilitated sessions -** The 80 THCs will be deployed within the 80 villages targeted in the 40 health areas. One trauma healing (TH) session will be conducted in each village per month leading to a total of 960 CBTH sessions with the goal of reaching a target population of 19,200-24,000 persons, including 50% women and 40% youth below 35 years. The THC will work in peer groups, each one moving to the village of his peer to co-facilitate with him/her.

  Each TH session will bring together 20-25 persons. At the beginning groups could be based on identity, for example sessions for women themselves, without men; depending on progress sessions could be opened to person of different sex, or different generation (mixed groups). Each session will be conducted during three days. Participants will select the times that work for them to attend the meeting 2-3 hours each day.

Using the facilitation guide developed by SFCG, the THC will facilitate the session to enable participants themselves to identify incidents that affect their personality and causes them trauma. They will also help participants understand the signs of trauma, think about healing and solutions, and understand psychosocial services and other forms of support that exist in the community or near the community. Gender and conflict issues and all other trauma-related factors will be discussed. The facilitator will foster open dialogues using the skills they acquired so all participants feel comfortable to share throughout the session.

These sessions will also be as engaging as possible. For instance, trauma healing through stories drawn from myths, legends or the Bible (according to the faith of the participants) will be read during the group discussions to inspire, nourish hope, and provide relief. There is evidence, including from an experiment attempted in many areas of the DRC, that in areas with strong oral tradition and for participants with a low level of education, stories have the capacity to captivate participants who identify themselves to them, to provoke sharing of personal experiences and to nurture personal motivation to surpass oneself.

Participants requiring additional support will be referred as appropriate. For example, mediation and dialogue will be facilitated for victims of crimes, burdened by the fact that the perpetrator is known but has not faced justice, and who would like to talk to the perpetrator as part of their healing. If a judicial or medical response is required, the person will be referred to appropriate resources as part of the consortium's holistic response. If a societal norm is the cause of the trauma, mediation by traditional leader could be conducted, etc.

OBJECTIVE 2: INFORM AND MOBILIZE COMMUNITIES AROUND THE TRAUMA HEALING SENSITIVITY AND SURVIVORS' REINTEGRATION

Result 2: The population of the targeted villages have increased knowledge about trauma healing and survivors feel their communities are more positively engaged for their effective reintegration

- **Activity 2.1: Trauma healing and conflict resolution community celebrations -** SFCG will organize in the target areas, at times identified with the communities, occasional cultural public events. These events could take the form of festivals, such as traditional celebrations including dances, drums, music, shared meals, etc. SFCG will discuss the content with the community to make sure this is a community proposed (led) initiative. GBV and conflict issues will be subtly integrated into the event while emphasizing enjoyment and community cohesion: edutainment. Once a quarter between the 5th and the 17th month, SFCG will support such an activity within each health area, bringing together 500 persons. A total of 160 community events will be organized with a goal to reach 80,000 persons with balanced gender and youth participation.

  Problems underlined during sessions will be weaved in these celebrations in combination with fun and enjoyment for a large public to raise community awareness, value the victims, and mobilize community engagement to overcome trauma healing issues and establish secure space for survivors.

  SFCG will also encourage voluntary and spontaneous testimonies of former victims as part of the trauma healing approach. Some trauma victims who have been accompanied through a community-facilitated process could testify about the value of community support and the resulting changes to their lives. They will be given room to highlight the contribution of family members, neighbors, colleagues, and friends who helped them or are helping them overcome the tough traumatic situation.

These testimonies will not be compelled but instead will be welcomed when individuals express interest in sharing their experiences with community members. For the sake of the impact evaluation, only individuals from the treatment villages will be admitted to these events.

- **Activity 2.2: Trauma healing through art using de-traumatization participatory theatre -** SFCG has been supporting communities to use participatory theater for more than ten years in the most remote parts of the DRC. Participatory theater is an opportunity for the audience to learn, understand, and contribute to the solution on serious matters, all while having fun. Learning from the use of participatory theater for conflict transformation, SFCG is developing the "theater of de-traumatization" approach that will be utilized to build compassion and restore a sense of joy for the victims of conflicts and the community.

  SFCG will train the community facilitators on organizing participatory theater shows within communities, with the support and monitoring of Project Assistants. Facilitators will form six production teams comprised of 5-6 members each. The six production teams will prepare and deliver participatory theater productions within each of the 80 selected villages on a quarterly basis, bringing together 100 persons per production each time. Between the 4th month and the 16th month of the project, a total of 320 participatory de-traumatization theater productions will be delivered within the targeted villages of the 40 health areas, bringing together a total of 32,000 persons. Of the participants, 60% are expected to be females and 30% to be children.

  Finally, to be able to address secondary trauma, it will be important for facilitators themselves to be connected to available counseling services within the *Tushinde Ujeuri* program. They should also be trained identifying and referring severely affected trauma healing session participants to these services. For example, Cilliers et al (2016) found that a community reconciliation intervention in Sierra Leone improved social trust in treatment communities but worsened individual psychological wellbeing. In this regard, the holistic service delivery approach of the *Tushinde Ujeuri* program, which provides community healing interventions in the presence of psychological services to deal with and address potential negative psychological consequences is especially promising.

3.3 HYPOTHESIS

The impact assessment tests the hypothesis that CBTH activities will:

1. Improve attitudes and promote positive norms around GBV.
2. Decrease GBV incidence.
3. Increase the uptake of psychological, legal and health services provided under *Tushinde Ujeuri.*

This baseline report serves to present descriptive statistics, examine associations between key variables and undertake regression modeling to better understand the relationship between conflict-related variables and key outcomes for this project, including different forms of GBV.

4. SAMPLE

4.1 SELECTION OF STUDY AREA

The intervention areas for the *Tushinde Ujeuri* program include health areas (aires de santé) across five health zones in the North Kivu and South Kivu provinces of Eastern DRC. The first four columns of Table 1 below provide additional information about these five health zones.

The study sample for the IE (two rightmost columns of Table 1) comprises a total of 40 health areas within three largely rural Health Zones (Nyangezi, Katana and Walikale) out of the five in which the *Tushinde* program is taking place. Given the largely rural settings of USAID programs in Congo, the USAID Mission has greater interest in learning what works in rural settings, which led to the exclusion of the semi-urban Karisimibi health zone. Nonetheless, baseline data was collected in Karisimbi and we will report baseline results from across four Health Zones.[3] In addition, and in consultation with the implementing partner, the Bunyakiri health zone was excluded from the survey sample due to accessibility concerns (an escort for the field teams would be required to gain access).

Table 1: Intervention Areas

PROVINCE	HEALTH ZONE	CHARACTERISTICS	PROGRAM	BASELINE SURVEY		IMPACT EVALUATION	
			HEALTH AREAS	HEALTH AREAS	TOTAL VILLAGE CLUSTERS*	HEALTH AREAS	TOTAL VILLAGE CLUSTERS*
North Kivu	Karisimbi	Semi-Urban	16	8	32	0	0
North Kivu	Walikale	Rural & Access Issues	14	12	48	12	48
South Kivu	Katana	Rural and Accessible	18	18	72	18	72
South Kivu	Nyangezi	Rural & Accessible	12	10	40	10	40
South Kivu	Bunyakiri	Rural & Access Issues	27	0	0	0	0
Total			**87**	**48**	**192**	**40**	**160**

* For this study (and by extension for the baseline survey), 4 village clusters were selected in each selected health area.

4.2 TREATMENT ASSIGNMENT

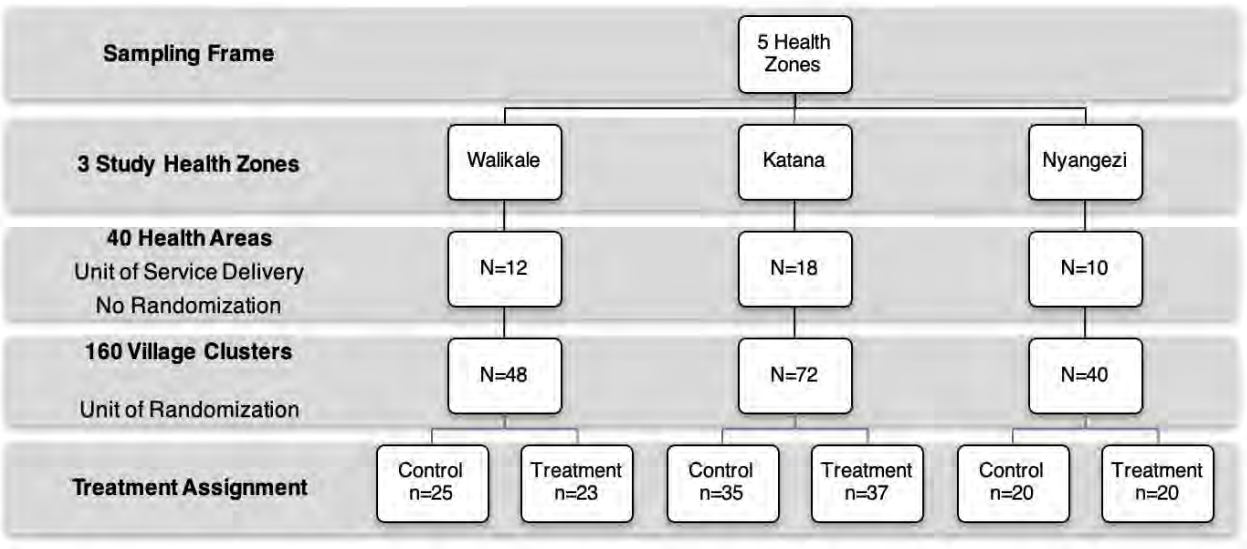
The random assignment procedure proceeded in two stages. First, within each of the three selected health zones, IMA and its implementation partners created a list of 40 health areas that met three criteria: they are receiving *Tushinde Ujeuri* interventions, they are relatively accessible, and they are not anticipated to present major security risks that might undermine or interrupt program and evaluation implementation. Within this subset of health areas, 160 eligible villages were identified by IMA and its implementation partners on the basis of their accessibility, relative security, population size and household count, and a limited presence of other projects that might contaminate any impact of the intervention. In each health area, they identified on average four villages. The baseline survey was conducted in these villages during fall 2018, before they were randomly assigned to the treatment or control group. Within each health area, approximately two villages were randomly

[3] Baseline data was collected in Karisimbi both in order to provide better coverage for the IMA indicators and to serve as a backup for the IE in case the security and accessibility conditions change in one of the other three health zones selected for the IE.

assigned to receive the CBTH program, while the other two were assigned to not receive the intervention.

The Stata Package "randomize" (Kennedy and Mann, 2017) was used to assign these 160 villages to either receive the CBTH intervention (treatment) or no CBTH intervention (control). The health areas were randomized in blocks, meaning 50% of villages in each of the 40 health areas across 3 health zones (Katana, Nyangezi, Walikale) were assigned to receive the CBTH intervention. Figure 1 shows the overall distribution of villages by health zone and treatment status.

Figure 1: Experimental Sample



4.3 RESPONDENT SELECTION

Within each of the 192 villages selected for the baseline survey, field teams used a "random-walk" methodology to randomly select households. Enumerators interviewed every 3rd household on the right in rural areas and every 5th household on the right in semi-urban areas, starting from a pre-determined village landmark (market, administrative building, well, tree, etc.) Prior to the start of daily data collection, the team supervisor was in charge of dispersing enumerators around the village so that they could cover all the area and that the sample would not be confined to a small portion of the observation area.

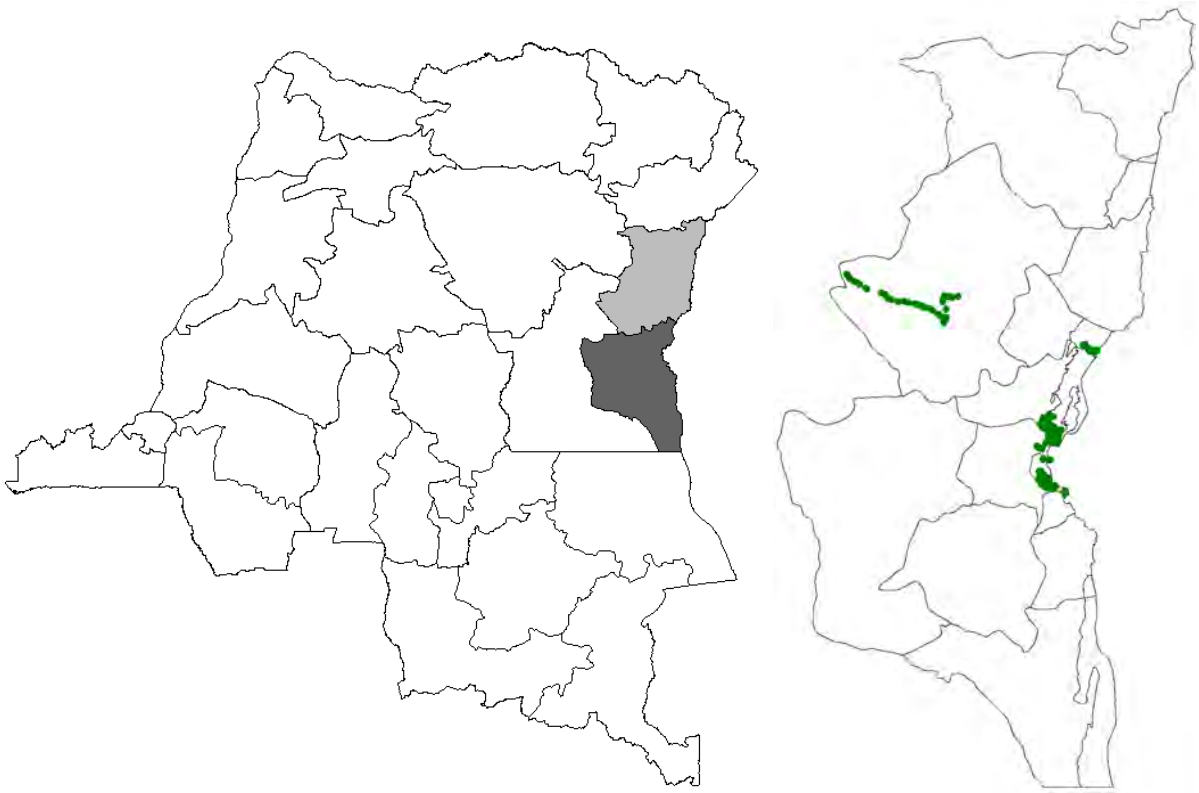
In each selected household, enumerators interviewed a random adult respondent (age 18 or over) selected from within the household (using a kish-grid method programmed on the tablet). As per the programming, and to ensure the highest level of responsiveness on sensitive topics, female enumerators only interviewed female respondents and male enumerators only interviewed male respondents.

5. BASELINE DATA COLLECTION STRATEGY

5.1 DATA COLLECTION

The baseline data collection, which occurred in fall 2018, comprised of both household and community-level surveys. The household survey was administered to a target of 20 households per village across all 192 villages. Of these, the 160 villages in the Katana, Nyangezi and Walikale health zones were part of the IE sample, while the remaining 32 villages in Karisimbi were not. Within each household, one randomly chosen adult household member was interviewed. The final sample comprises 4,223 respondents (of which 3,678 are in our experimental sample, split equally across treatment and control locations). Figure 2 displays a map with the location of the villages included in the baseline survey. The community survey was conducted with village chiefs in each of the 192 villages and aimed to capture information about each community and its characteristics, as well as the perspective of the community leaders. Note that this document reports on data from all communities and households surveyed, including those that are not part of the IE sample.

Figure 2: Map indicating location of baseline villages in Eastern DRC



6. KEY FINDINGS

6.1 RESPONDENT CHARACTERISTICS

This section presents relevant background characteristics of the individual respondents and households interviewed in the baseline household survey. Background characteristics may be predictive of psychosocial wellbeing and GBV-related outcomes. In addition, the intervention may also affect beneficiaries with different background characteristics differently.

6.1.1 RESPONDENT GENDER AND AGE

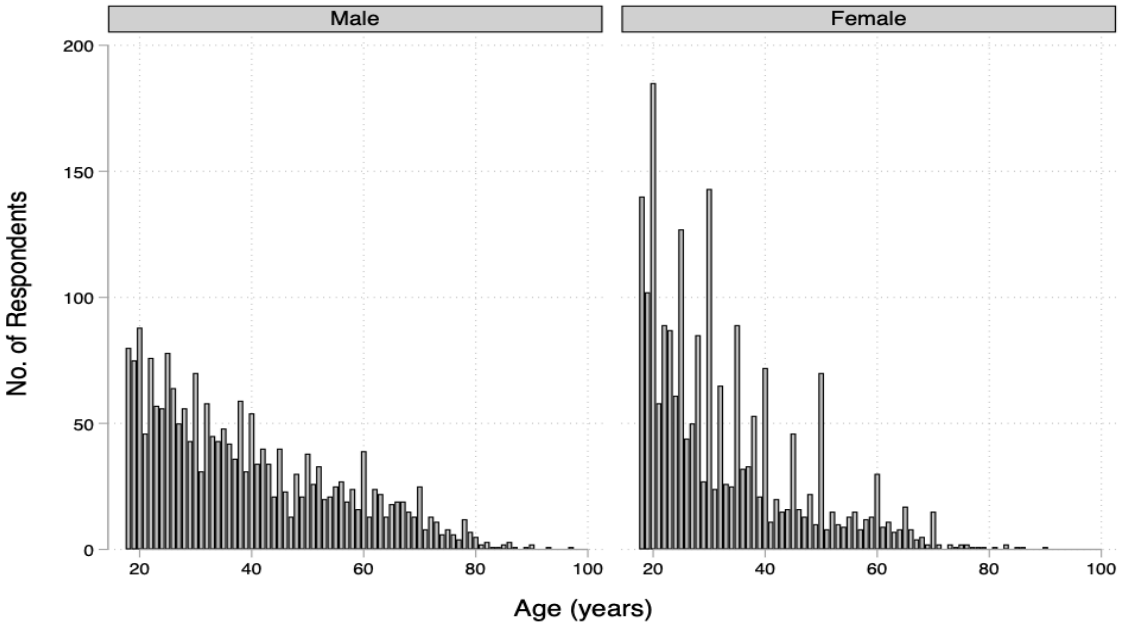
The respondents of the baseline household survey were almost equally divided into females and males. Of the total 4,223 respondents surveyed, 50.1% were female and 49.9% were male (Table 2).

Table 2: Gender Breakdown of Household Survey Sample

	PERCENTAGE	N
Male	49.9	2,109
Female	50.1	2,114
Total	100	4,223

The average age of respondents is 35.9 years, with the youngest respondent being 18 and the oldest 97. Female respondents in the sample are younger, with an average age of 32.8 years, while male respondents have an average age of 39.0 years. Figure 3 shows the distribution of age by gender in the sample. Note the spikes in the age distribution at the 5 and 10-year marks (more pronounced for female respondents) which are typical of survey data, as respondents tend to round up self-reported age.

Figure 3: Age distribution, by gender



6.1.2 RESPONDENT EDUCATION AND LITERACY

Nearly half of respondents (47%) did not complete any form of formal education and only 16% of respondents completed secondary school or higher. On average, male respondents had higher education levels, as only 35% of males did not complete any formal education and 22% completed secondary school or higher. Of the female respondents, 59% did not complete any level of formal education and only 10% attained secondary education or higher (Table 3).

Table 3: Level of education

LEVEL OF EDUCATION	MEN (%)	WOMEN (%)	TOTAL (%)
None	265 (12.6)	717 (33.92)	982 (23.3)
Primary, not completed	477 (22.6)	534 (25.3)	1011 (23.9)
Primary, completed	207 (9.8)	142 (6.7)	349 (8.3)
Secondary, not completed	697 (33.1)	503 (23.8)	1,200 (28.4)
Secondary, completed	316 (15.0)	170 (8.0)	486 (11.5)
College, not completed	60 (2.8)	22 (1.0)	82 (1.9)
College, completed	63 (3.0)	21 (1.0)	84 (2.0)
Higher than college	23 (1.1)	4 (0.2)	27 (0.6)
Missing	1 (0.1)	1 (0.1)	2 (0.1)
Total	**2,109 (100)**	**2,114 (100)**	**4,223 (100)**

In addition to education, literacy was also measured in the survey sample by asking whether the respondent is able to write a simple message, e.g. "It is hot today", in *any language*. By this measure, just over half of all respondents were literate, but substantially fewer women (42%) than men (68%) (Table 4).

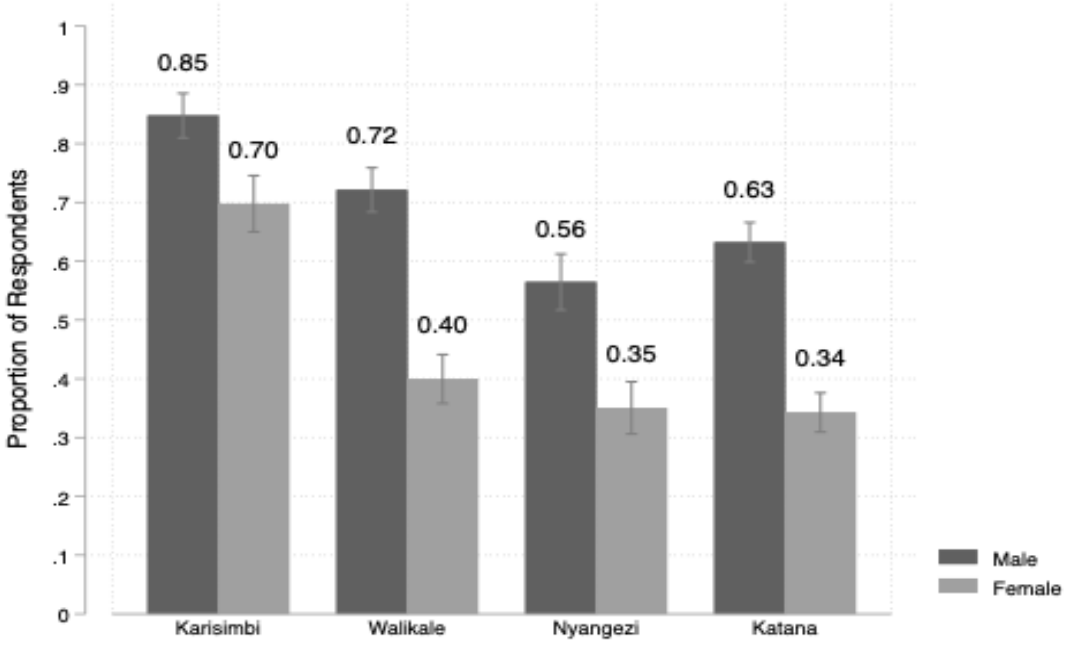
Table 4: Literacy, by gender

	PERCENTAGE	N
Male	67.8	2,109
Female	41.8	2,114
Total	54.8	4,223

Importantly, there was substantial geographical variation in educational attainment and literacy in the sample. In Karisimbi (mostly urban sites surveyed), 77% of respondents were literate, while in Walikale, Nyangezi and Katana only 56%, 45% and 49% of the respondents were literate,

respectively. The gender gap in literacy was also less pronounced in Karisimbi relative to the other health zones (Figure 4), although it still exists.

Figure 4: Proportion of respondents who are literate, by zone and gender



Note: Proportion is a value between 0 and 1. For example, 0.85 implies 85% of men in our sample in Karisimbi are literate.

6.1.3 INCOME, ASSETS AND EMPLOYMENT

HOUSEHOLD

Table 5 reports the primary sources of income for households in the sample. A majority of respondents' households primarily live from agriculture, farming or livestock rearing. Trading was the second most commonly reported primary source of income.

Table 5: Household's primary source of income

	MEN COUNT (%)	WOMEN COUNT (%)	TOTAL COUNT (%)
Agriculture/Farming/Livestock	1,076 (51.0)	1,169 (55.3)	2,245 (53.16)
Trading	301 (14.3)	345 (16.3)	646 (15.3)
Private firm employment	160 (7.6)	138 (6.5)	298 (7.1)
Civil Service	120 (5.7)	99 (4.7)	219 (5.2)
Fishing	117 (5.6)	66 (3.1)	183 (4.3)

	MEN COUNT (%)	WOMEN COUNT (%)	TOTAL COUNT (%)
Any Mining	29 (1.4)	19 (0.9)	48 (1.1)
Military employment	15 (0.7)	24 (1.14)	39 (0.9)
Other	275 (13.0)	228 (10.8)	503 (11.9)
Missing	16 (0.8)	26 (1.2)	42 (1.0)
Total	**2109 (100)**	**2114 (100)**	**4223 (100)**

Table 6 below reports on the monetary income earned by the household as a whole and by the individual respondents in the past month. The mean individual income of survey respondents was 77,331 CDF (Congolese franc). Of all male respondents in the sample, 33% were currently personally engaged in a job or activity from which cash income was earned. For the female respondents, this was 15.5%.

Table 6: Household and individual income

	N	MEAN	SD	MIN	MAX
Wealth score based on assets and dwelling status	4,223	0.29	0.15	0	0.87
Household income flow (CDF in last month)	4,223	68,769.9	98,162.2	0	600,000
Individual Respondent Income (in CDF/month)	1,022	77,331.1	108,236.8	0	1,600,000

Notes: outliers, values above 99th percentile, are removed.

Figure 5 below shows the mean wealth score disaggregated by zone and gender. We see that Walikale has the lowest mean wealth score compared to the other health zones. In all zones, women earned less than men but the difference was most pronounced in Walikale and least pronounced in Karisimbi.

Figure 5: Mean wealth score by zone and gender

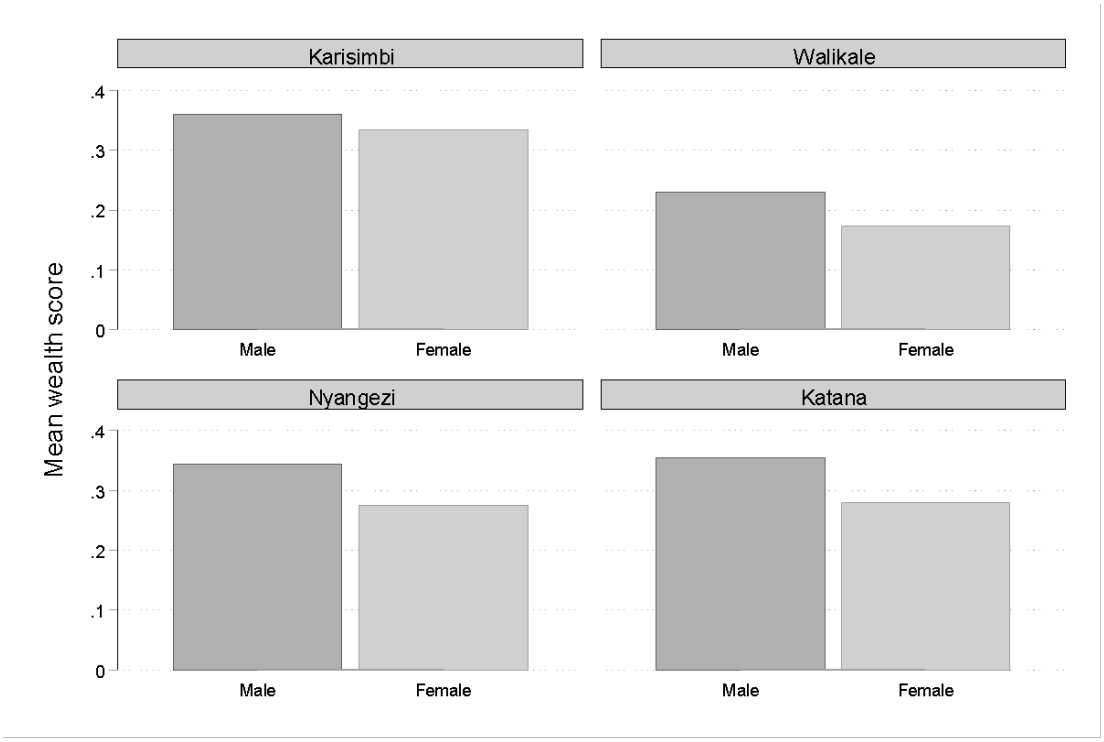


Table 7 below describes the occupation of survey respondents. Overall, we see that the majority of respondents described farming and tending livestock as their primary occupation (43.6%), with trading as the second most common occupation (11.8%). However, a significant percentage of respondents (14.9%) reported being unemployed. Women were more likely than men to report working in agricultural activities and in trading. Men more commonly reported being unemployed than women.

Table 7: Individual primary occupation

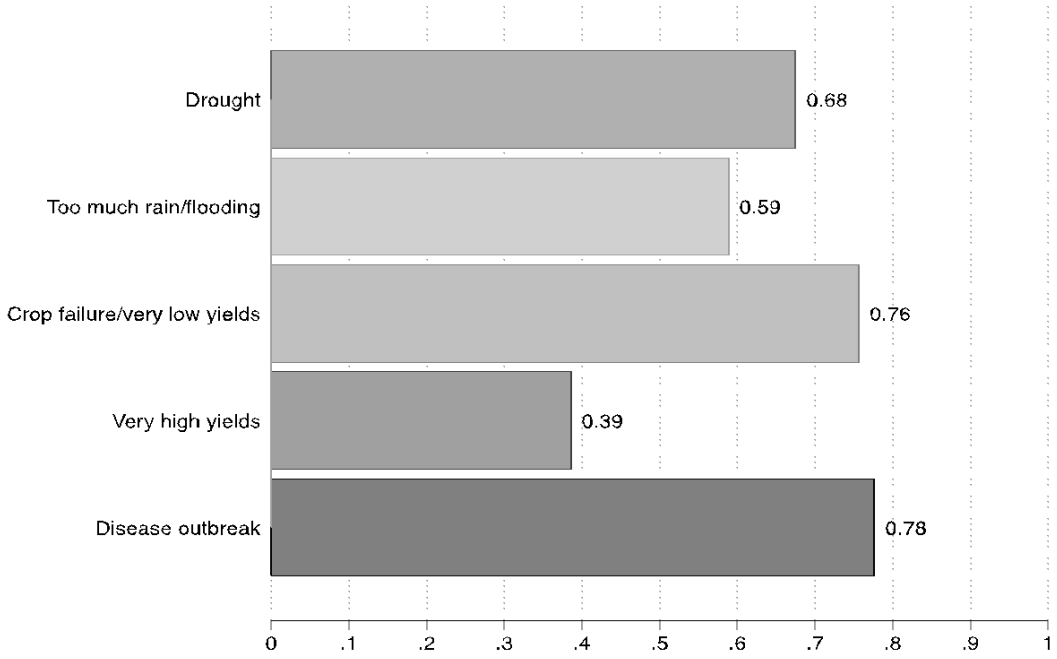
PRIMARY OCCUPATION	MEN COUNT (%)	WOMEN COUNT (%)	TOTAL COUNT (%)
Agriculture/farming/livestock	796 (37.7)	1,043 (49.34)	1,893 (43.6)
Trading	210 (10.0)	290 (13.7)	500 (11.8)
Unemployed	349 (16.6)	279 (13.2)	628 (14.9)
Other unskilled work	149 (7.1)	32 (1.5)	181 (4.3)
Student	124 (5.9)	79 (3.7)	203 (4.8)
Fishing	113 (5.4)	14 (0.7)	127 (3.0)
Private firm employee	96 (4.6)	55 (2.6)	151 (3.6)

PRIMARY OCCUPATION	MEN COUNT (%)	WOMEN COUNT (%)	TOTAL COUNT (%)
Teacher	72 (3.4)	25 (1.2)	97 (2.3)
Civil Service	61 (2.9)	10 (0.5)	71 (1.7)
Mining	42 (2.0)	5 (0.2)	47 (1.1)
Other skilled Work	41 (1.9)	7 (0.3)	48 (1.1)
Religious leader	25 (1.2)	1 (0.1)	26 (0.6)
Military	14 (0.7)	1 (0.1)	15 (0.4)
Retired	7 (0.3)	1 (0.1)	8 (0.2)
Housewife / househusband	1 (0.1)	224 (10.6)	225 (5.3)
Missing	9 (0.4)	48 (2.3)	57 (1.4)
Total	**2,109 (100)**	**2,114 (100)**	**4,223 (100)**

6.1.4 ECONOMIC SHOCKS

The survey measures community-level shocks that may have affected villages in the last 5 years through surveys with community leaders. The surveys reveal overall high levels of exposure, with a majority of villages having experienced drought, flooding, crop failure and disease outbreak. Figure 6 below shows the proportion of villages that experienced economic shocks in the past five years. Seventy-eight percent of villages reported disease outbreak, making this the most common form of shock, followed closely by crop failure or low crop yield (76%) and then drought (68%.) The very high reported levels of community shocks emphasize how common it is for village to experience extreme stressors in the survey area.

Figure 6: Proportion of villages having experienced various types of economic shocks in the past 5 years



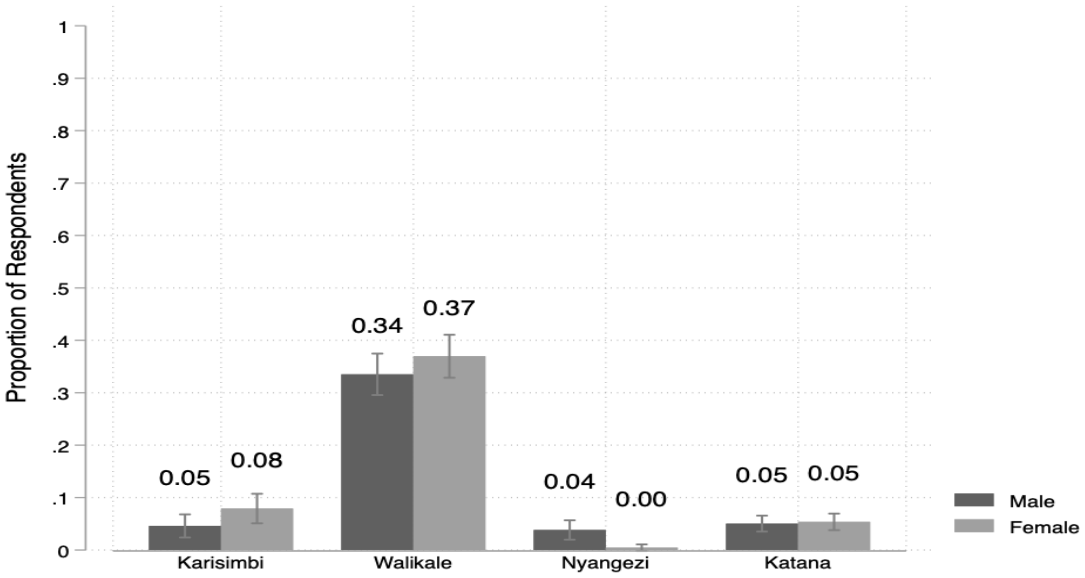
Note: Proportion is a value between 0 and 1. For example, 0.68 implies 68% of villages in our sample experienced a drought.

6.2 CONFLICT AND DISPLACEMENT

The survey measures levels of past and current displacement as well as exposure to conflict and conflict-related events in the population using individual questions asked to respondents, as well as through the community-level survey conducted with the village chief in each of the villages.

A majority of respondents in the household survey (52.5%) report that they have been displaced sometime over the course of their lives as a result of armed conflict; 12.4% of respondents report that they are currently displaced. These levels are not significantly different for men and women. There is however geographical variation in current displacement levels, with most of the displacement concentrated in Walikale (Figure 7).

Figure 7: Proportion of respondents who are currently displaced, by health zone and gender

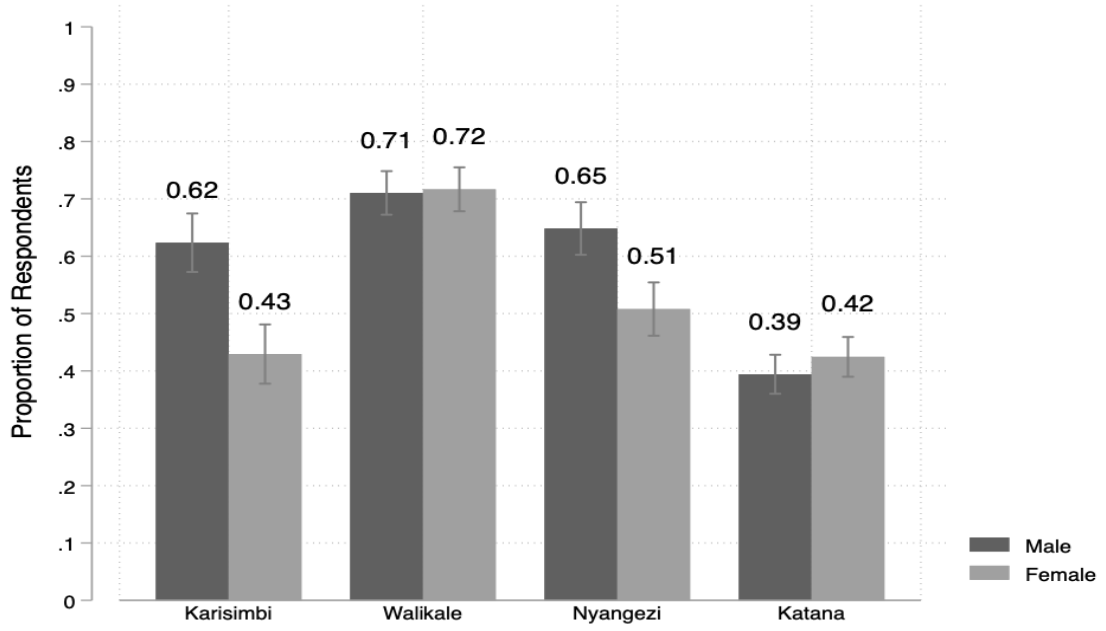


Note: Proportion is a value between 0 and 1. For example 0.05 implies 5% of males in our sample in Karisimbi are currently displaced.

Respondents were asked whether they have witnessed as well as personally experienced a number of different conflict-related events at any point in their lives. Exposure to these events either by witnessing or personally experiencing them may be a source of present trauma for respondents, which has direct relevance for the CBTH programming.

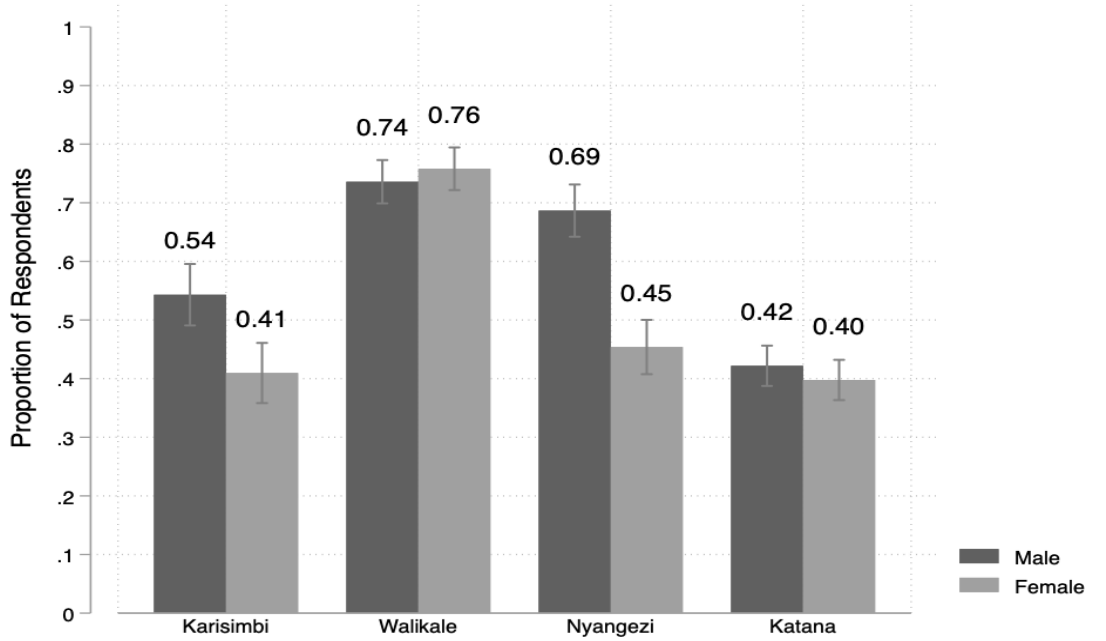
We constructed binary summary measures to assess whether respondents witnessed and experienced *any* conflict-related events to assess the levels of exposure among the population. The distribution of these measures by gender and health zone is visualized below in Figures 8 and 9. Overall, the rates of exposure are high, as more than half the respondents reported having witnessed and experienced at least one conflict-related event. Exposure seems to vary by region, with the highest levels of exposure in Walikale, followed by Nyangezi. While there are differences in exposure by gender in Karisimbi and Nyangezi, with women being less likely to report exposure to conflict events, this pattern does not hold in the other two health zones.

Figure 8: Proportion of respondents who witnessed at least 1 conflict-related event, by health zone and gender



Note: Proportion is a value between 0 and 1. For example, 0.62 implies 62% of males in our sample in Karisimbi have witnessed at least 1 conflict-related event.

Figure 9: Proportion of respondents who personally experienced at least 1 conflict-related event, by health zone and gender



Note: Proportion is a value between 0 and 1. For example 0.54 implies 54% of males in our sample in Karisimbi have personally experienced at least 1 conflict-related event.

This section also reports disaggregated exposure by *type* of conflict event witnessed or experienced and by gender in the Tables 8 and 9 below. This is important since the type of traumatic event experienced may have implications for later outcomes of resilience and post-traumatic stress.[4]

There is some evidence of gendered experiences of conflict events in these comparisons. Table 8 shows the proportion of respondents *witnessing* types of conflict events by gender. Men are more likely to have witnessed harassment, the assassination of a *non*-family member, and the sexual abuse of other men. On the other hand, women are more likely to have witnessed the assassination of a family member.

Table 8: Proportion of respondents reporting witnessing types of conflict events, by gender

	(1) MALE MEAN/SE	(2) FEMALE MEAN/SE	T-TEST DIFFERENCE (1)-(2)
Pillaging/Property Destruction	0.429 [0.011]	0.421 [0.011]	0.008
Harassment/Torture	0.367 [0.010]	0.329 [0.010]	0.037**
Assassination of family member	0.207 [0.009]	0.242 [0.009]	-0.035***
Assassination of other person	0.340 [0.010]	0.270 [0.010]	0.070***
Rape/Sexual abuse of woman	0.228 [0.009]	0.213 [0.009]	0.015
Rape/Sexual abuse of man	0.098 [0.006]	0.082 0.006]	0.016*
N	**2,109**	**2,114**	

Note: The value displayed for t-tests are the differences in the means across the groups.

***, **, and * indicate significance at the 1, 5, and 10 percent critical level.

Table 9 shows the proportion of respondents experiencing types of conflict events by gender. Men are more likely to have personally experienced being forced to pay cash or goods, being physically beaten and being forced into labor by armed group. Women are more likely to have had their house destroyed, to have been sexually abused and to have been forced to kill another person.

In terms of absolute levels of exposure to conflict-related sexual violence, more than 22% of all respondents report having witnessed rape or sexual abuse of a woman, 9% of all respondents report having witnessed rape or sexual abuse of a man, and 10% report having personally experienced sexual abuse by an armed group.

[4] In a study of gender differences in resilience among US veterans Portnoy et al (2018) find that women exhibit lower levels of resilience, however these differences are insignificant once accounting for the fact that women are more likely to experience sexual abuse, inter-personal violence and military sexual trauma.

Table 9: Proportion of respondents reporting personally experiencing types of conflict events, by gender

	(1) MALE MEAN/SE	(2) FEMALE MEAN/SE	T-TEST DIFFERENCE (1)-(2)
Forced to Flee	0.355 [0.010]	0.368 [0.010]	-0.013
Abducted by Armed Group	0.163 [0.008]	0.167 [0.008]	-0.004
House Destroyed	0.237 [0.009]	0.269 [0.010]	-0.033**
Looting or Theft	0.370 [0.011]	0.348 [0.010]	0.022
Forced to pay cash/goods	0.328 [0.010]	0.228 [0.009]	0.100***
Physically beaten	0.241 [0.009]	0.176 [0.008]	0.065***
Sexually abused	0.086 [0.006]	0.115 [0.007]	-0.029***
Forced labor	0.289 [0.010]	0.157 [0.008]	0.132***
Forced to beat other	0.080 [0.006]	0.074 [0.006]	0.006
Forced to kill other	0.032 [0.004]	0.055 [0.005]	-0.024***
N	**2,109**	**2,114**	

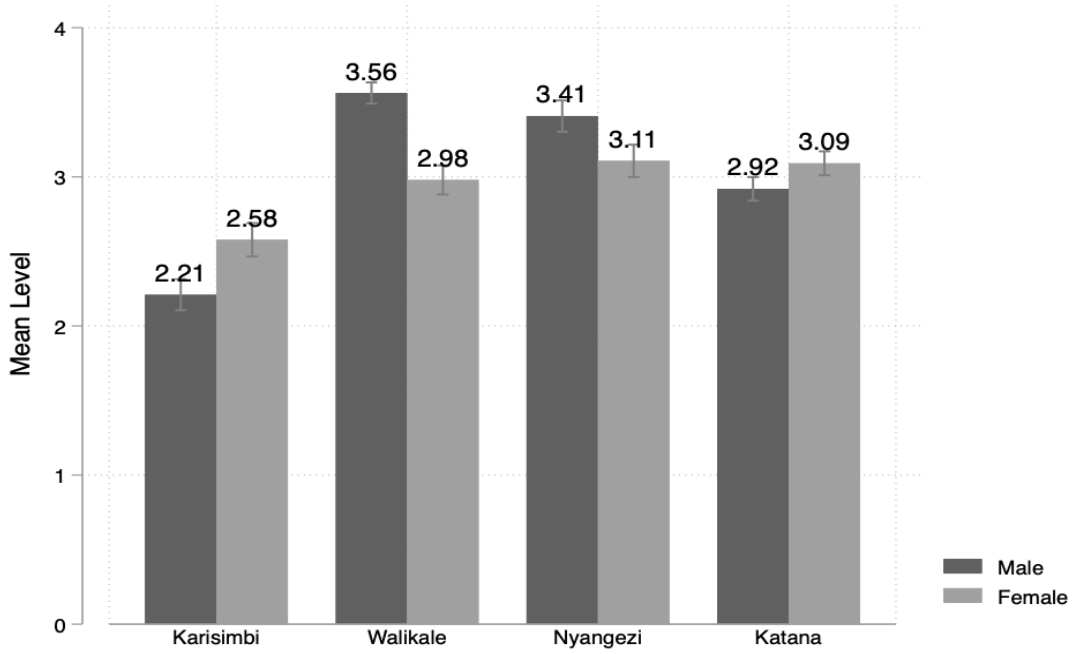
Note: The value displayed for t-tests are the differences in the means across the groups.
***, **, and * indicate significance at the 1, 5, and 10 percent critical level.

6.3 SECURITY, DISPUTES & GROUP RELATIONS

In addition to explicitly conflict related events, respondents are also asked about disputes in their community, with other individuals, and their perceptions of security and inter-group relations.

When asked to think about the security situation in their village or community, around 36% of respondents reported feeling very unsafe or unsafe, and this did not appear to differ significantly by gender. A 5-point measure of perceived safety was constructed, where 1 is very unsafe and 5 is very safe, and the average perception of safety by region and gender is visualized below in Figure 10. Respondents in Karisimbi appear to have the lowest evaluation of safety. In Walikale and Nyangezi, women seem to have lower perceptions of safety than do men, but this is reversed in the case of Karisimbi and there are no significant gender differences among respondents in Katana.

Figure 10: Mean perceived safety in community, by health zone and gender

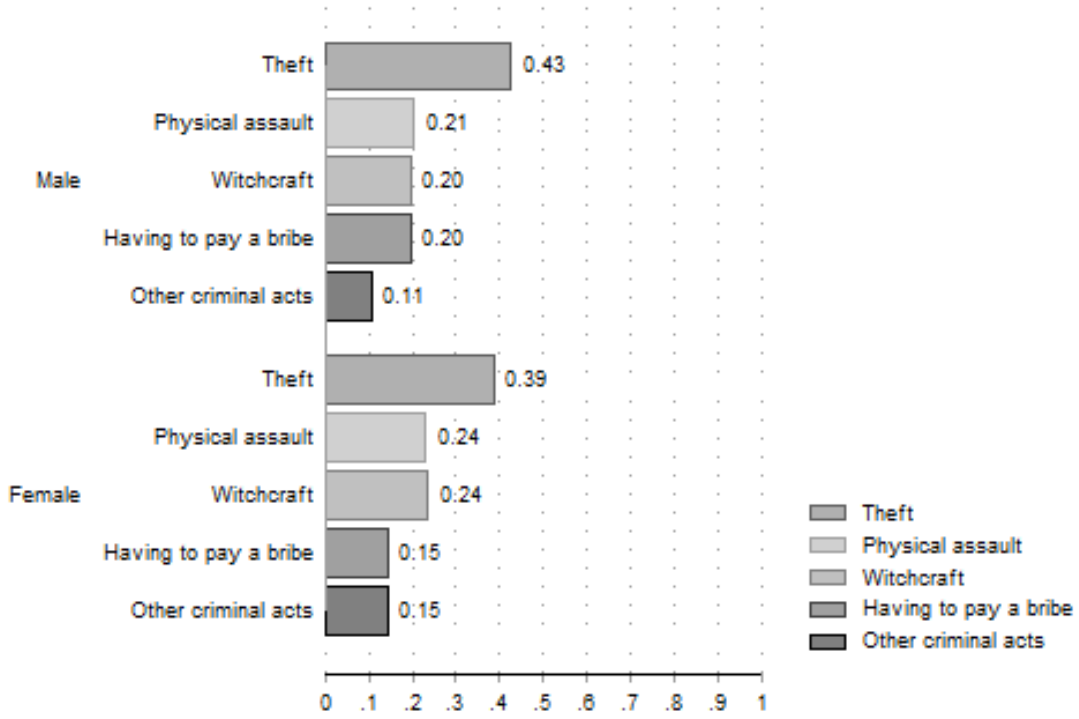


Note: question is coded on a 5-point scale of perceived safety where 1 is very unsafe and 5 is very safe

Twenty percent of respondents report having been personally involved in a conflict/dispute with another individual from the same or another community in the past year; among the 850 individuals reporting involvement in a conflict(s), 80% (N= 673) reported that at least one of these disputes turned violent. However, it is not possible to conclusively interpret whether this indicates that a large majority of inter-personal disputes turn violent, or if individuals are more inclined to say "yes" to having experienced a dispute if it led to violence.

The survey also asked respondents to report whether their household has fallen victim to non-conflict related insecurity in the form of theft, physical assault, witchcraft, forced bribe payment, and other criminal acts. Figure 11 presents the distribution of respondents reporting exposure to such events during the past 12 months. Both men and women report theft as the most common form of non-conflict related insecurity, followed by physical assault, witchcraft, having to pay a bribe and other forms of criminality.

Figure 11: Proportion of households facing exposure in last 12 months, by event type and gender



Note: Proportion is a value between 0 and 1. For example in the figure 0.41 implies 41% of respondents in our sample experienced theft during previous year.

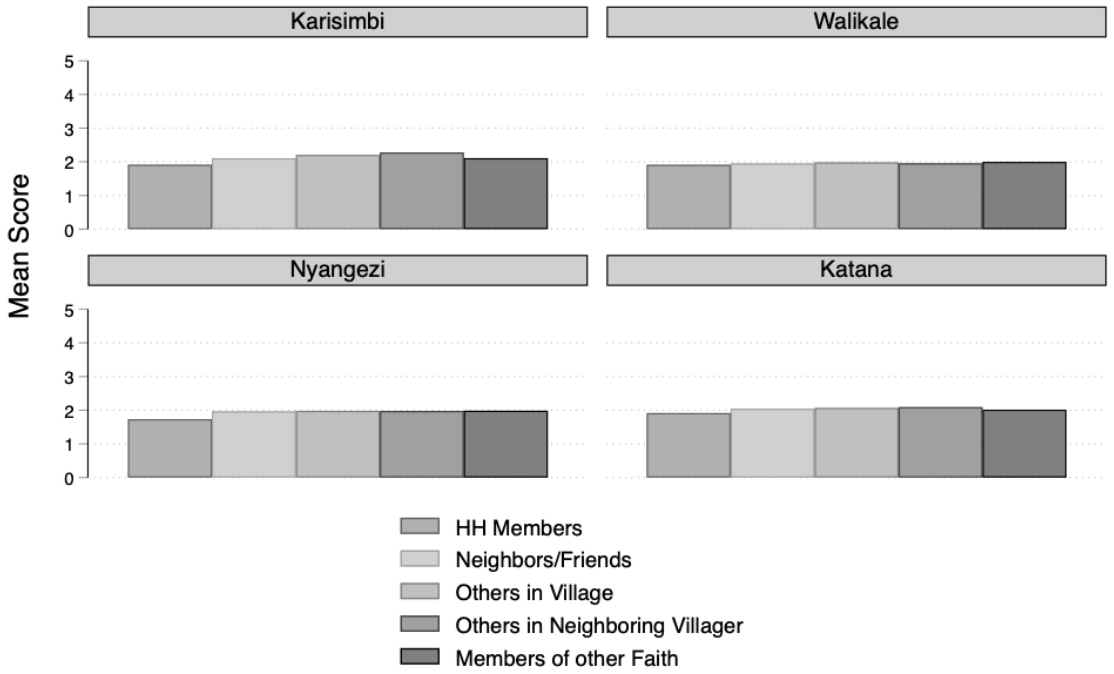
GROUP RELATIONS

To assess social cohesion, the survey asked respondents about their own perception of the quality of relations with others in and outside their village. Respondents are asked to rate relations with members of their household, friends and neighbors, others in the village, neighboring villages, other religious groups and ethnic groups other than their own on a 5-point scale.

- 1 – Very Good
- 2 – Good
- 3 – Neither good nor bad
- 4 – Bad
- 5 – Very bad

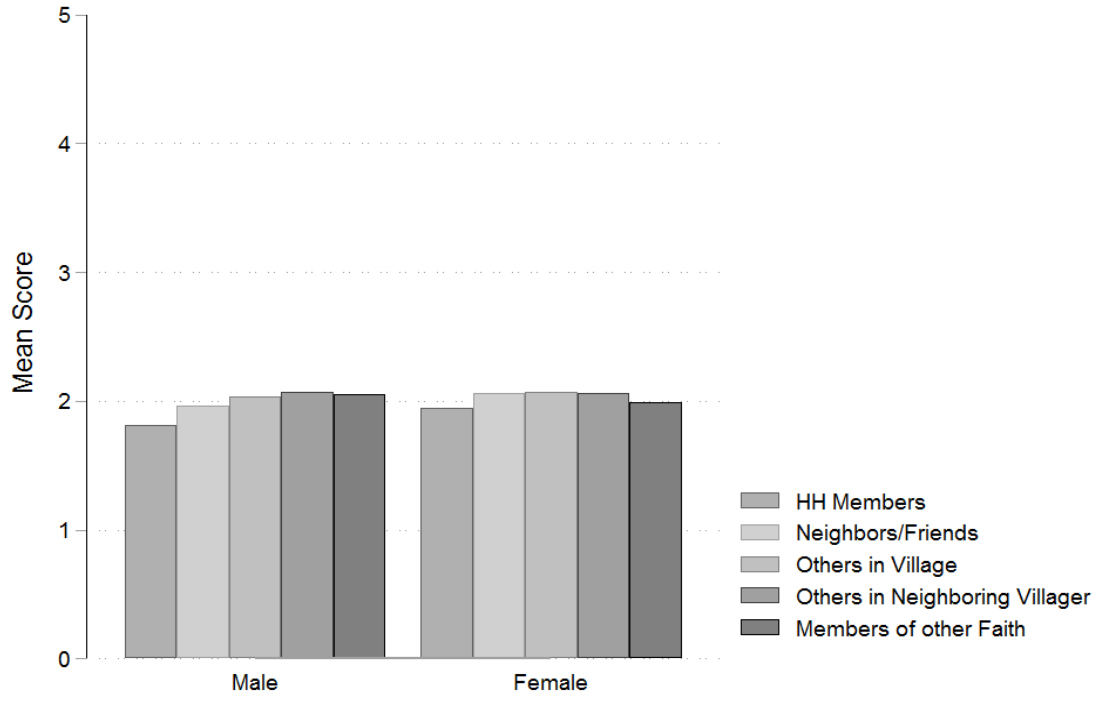
There was low variation across these measures; i.e. on average there is no significant difference in a respondent's rating of their relations with their household members and with other religious groups for example. Very few respondents rate relations with any group as bad or very bad, or even neutral (Figures 12 and 13), and little variation is seen across health zones, or between men and women.

Figure 12: Respondent rating of relations with others, by health zone



Note: Respondents rate relations on a scale of 1 (Very good) to 5 (very bad)

Figure 13: Respondent rating of relations with others, by gender



Note: Respondents rate relations on a scale of 1 (Very good) to 5 (very bad)

6.4 MENTAL HEALTH, TRAUMA AND RESILIENCE

The CBTH intervention is expected to help participants cope with trauma and have positive impacts on individual well-being and community resilience. The survey assessed baseline levels of these outcomes in the population using a number of standard psychometric scales that have been validated in a number of contexts.

6.4.1 DEPRESSION, ANXIETY, PTSD

To assess depression, anxiety and PTSD, this analysis draws on the methodology outlined by Bass et al (2013) from a mental health project in eastern DRC and uses the Hopkins Symptom Checklist (25 items) and Harvard Trauma Questionnaire (16 items).

Respondents report the frequency of symptoms in the past month on a 4-point scale:

- 0 – Not at all
- 1 – A little
- 2 – Moderately
- 3 – A lot

We generated an average score of the 25 items and 16 items respectively (with each item weighted equally) for each individual respondent, which ranges from 0 to 3, with higher scores indicating worse symptoms. Following Bass et al (2013) we used a cutoff to determine prevalence of depression, anxiety, and PTSD in the population: "An average HSCL-25 score of 1.75 or higher and an average PTSD Checklist score of 1.75 or higher were considered to be predictive of clinically significant depression or anxiety and PTSD, respectively, on the basis of data from other conflict-affected populations"

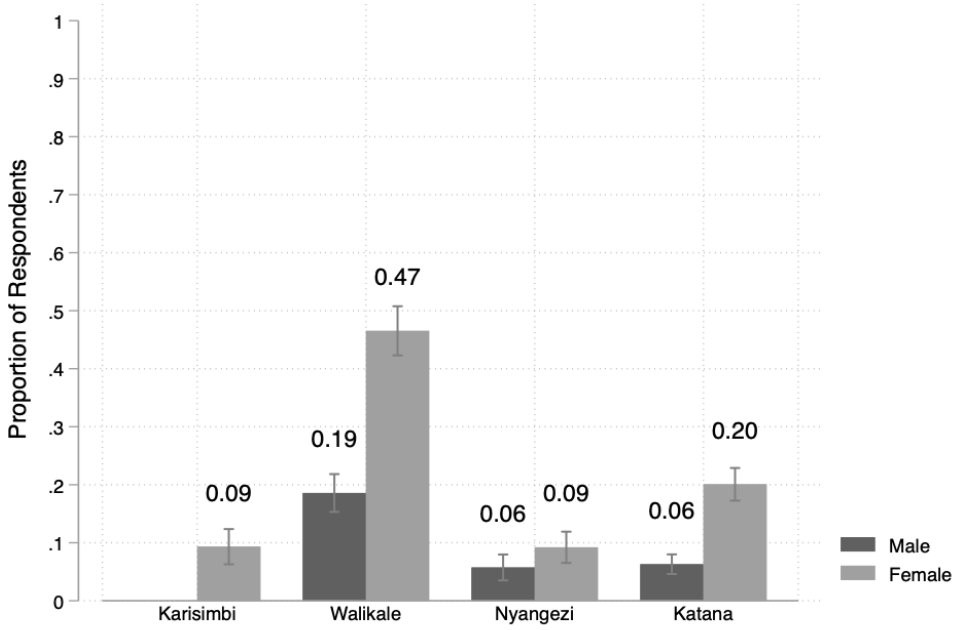
Table 10: Depression, Anxiety and PTSD Checklist Items in Survey

HOPKINS SYMPTOM CHECKLIST 25 (HSCL-25)		HARVARD TRAUMA QUESTIONNAIRE
DEPRESSION	**ANXIETY**	**PTSD**
1. Feeling low in energy, slowed down	1. Suddenly scared for no reason	1. Recurrent thoughts or memories of the most hurtful or terrifying event
2. Blaming yourself for things	2. Feeling fearful	2. Feeling as though the hurtful or terrifying event is happening again
3. Crying easily	3. Faintness, dizziness or weakness	3. Recurrent nightmares about the event
4. Loss of sexual interest or pleasure	4. Nervousness or shakiness inside	4. Feeling detached or withdrawn from others
5. Poor appetite	5. Heart pounding or racing	5. Unable feel emotions
6. Difficulty falling asleep, staying asleep	6. Trembling	6. Feeling jumpy, easily startled
7. Feeling hopeless about the future	7. Feeling tense or nervous	7. Difficulty concentrating
8. Feeling sad or blue	8. Headaches	8. Feeling on guard

HOPKINS SYMPTOM CHECKLIST 25 (HSCL-25)		HARVARD TRAUMA QUESTIONNAIRE
DEPRESSION	**ANXIETY**	**PTSD**
9. Feeling lonely	9. Spells of terror or panic	9. Feeling irritable or having outbursts of anger
10. Thoughts of ending your life	10. Feeling restless, can't sit still	10. Avoiding activities that remind of the traumatic or hurtful event
11. Feeling of being trapped or caught		11. Inability to remember parts of the most traumatic or hurtful events
12. Worrying too much about things		12. Feeling as if you don't have a future
13. Feeling no interest in things/less interest in daily activities		13. Avoiding thoughts of feelings associated with the traumatic or hurtful events
14. Feeling everything is an effort		14. Sudden emotional or physical reaction when reminded of most hurtful/traumatic events
15. Feelings of worthlessness		15. Feeling no interest in things/less interest in daily activities
		16. Difficulty falling asleep, staying asleep

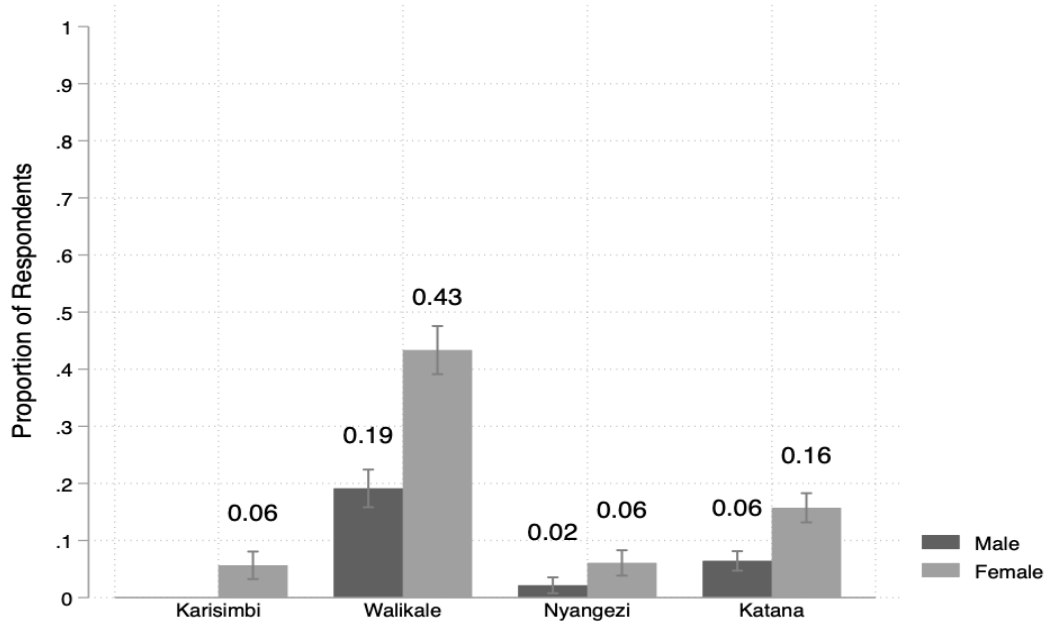
Figure 14 shows the proportion of the sample population that is above the 1.75 score cutoff on the depression and anxiety scales. Across all health zones, a significantly larger proportion of women is above the cutoffs for both scales. Notably, the proportion of male and female respondents reporting high scores on depression, anxiety and mental health is substantially greater in Walikale (more than 30% of all respondents) compared to other health zones. Figure 15 shows the proportion of the sample population that is above the score cutoff for PTSD, which shows very similar patterns to the depression and anxiety scores. Walikale has a notably higher burden of PTSD than other health zones, with women in Walikale showing the highest rates of PTSD in the sample. In all health zones, women have worse PTSD outcomes than men.

Figure 14: Proportion of respondents with scores above cutoff for depression and anxiety symptom checklist, by gender and health zone



Note: Proportion is a value between 0 and 1. For example in the figure 0.09 implies 9% of females in our sample in Karisimbi have scores above cutoff for depression and anxiety symptom checklist.

Figure 15: Proportion of respondents with scores above cutoff for PTSD symptom checklist, by gender and health zone



Note: Proportion is a value between 0 and 1. For example in the figure 0.06 implies 6% of females in our sample in Karisimbi have scores above cutoff for PTSD.

6.4.2 SELF-EFFICACY AND RESILIENCE

This survey used a number of psychometric scales and other measures to triangulate the measurement of what is often looked at as a hard-to-define concept: resilience. This survey looked

at in-group and out-group attitudes, measures of self-efficacy, measures of individual resilience and measures of community resilience to build a comprehensive picture of this multifaceted concept. Self-efficacy, while related to resilience, represents a distinct measure related to a person's ability to accomplish undertakings – this characteristic can help determine how one would approach tasks and challenges and overcome difficulties (Bandura, 1982). It also relates to belief in one's ability to control one's own social environment (American Psychological Association, no date). On a distinct but related note, resilience represents the process of adapting to one's circumstances in the face of trauma, threat, and adversity. It can be manifested at the individual and community level. The approach used here was to build on resilience scales used in a previous USAID project in the Philippines (NORC, 2018) while also adding additional measures.

We constructed scales for self-efficacy, individual resilience, and community resilience from three different sets of questions shown in Table 11. Respondents were asked to respond to each of the questions on a 5-point scale:

- 0 – Strongly Disagree
- 1 – Somewhat Disagree
- 2 – Neither Agree nor Disagree
- 3 – Somewhat Agree
- 4 – Strongly Agree

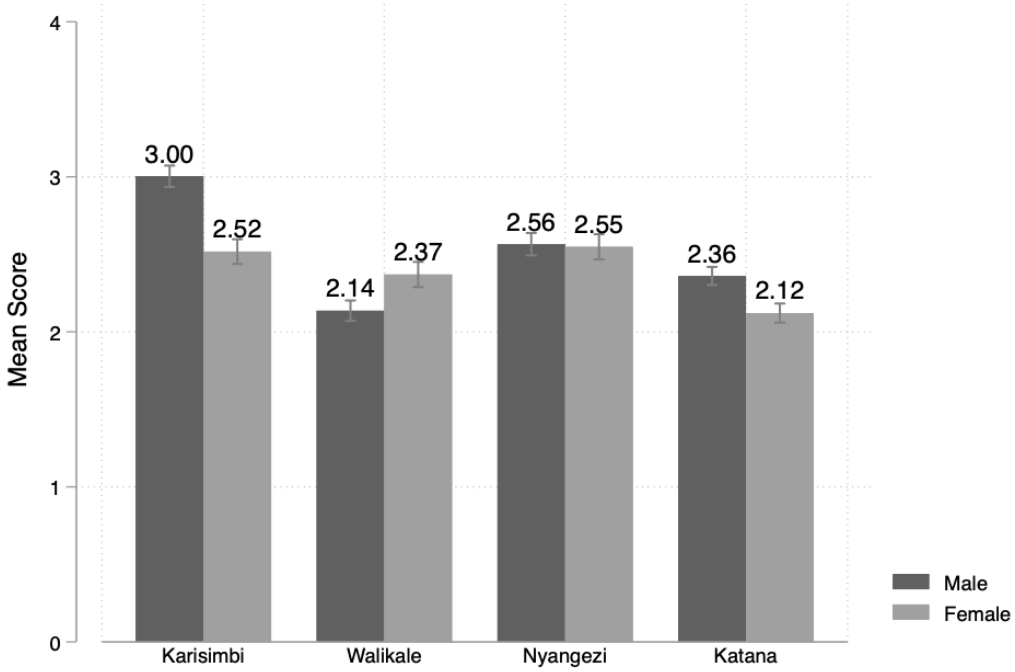
We generated an average score for each scale respectively (with each item weighted equally) for each individual respondent, which ranges from 0 to 4, with higher scores indicating greater self-efficacy and higher resilience.

Table 11: Self-Efficacy and Resilience Survey Items

SELF-EFFICACY SCALE	INDIVIDUAL RESILIENCE SCALE	COMMUNITY RESILIENCE SCALE
1. I can manage to solve difficult problems if I try hard enough	1. I feel that I belong in my community	1. People in my community feel like they belong to the community.
2. I can deal with unexpected events.	2. I know where to go if I need help	2. People in my community have hope for the future.
3. I can handle unexpected situations.	3. I cooperate with people around me	3. People in my community help each other.
4. I can remain calm when facing difficulties	4. I have people in my life who I can respect	4. My community treats people fairly no matter what their background is.
5. If I am in trouble, I can usually think of a solution	5. Spiritual beliefs are a source of strength for me	5. My community has effective leaders.
6. Even when things are tough, I am able to succeed	6. If I am hungry, I can usually get enough food to eat	6. People in my community discuss issues so they can improve the community.
	7. I think it is important to help out in my community	7. People in my community work together to improve the community.
		8. My community keeps people informed about important news
		9. People in my community trust the leaders

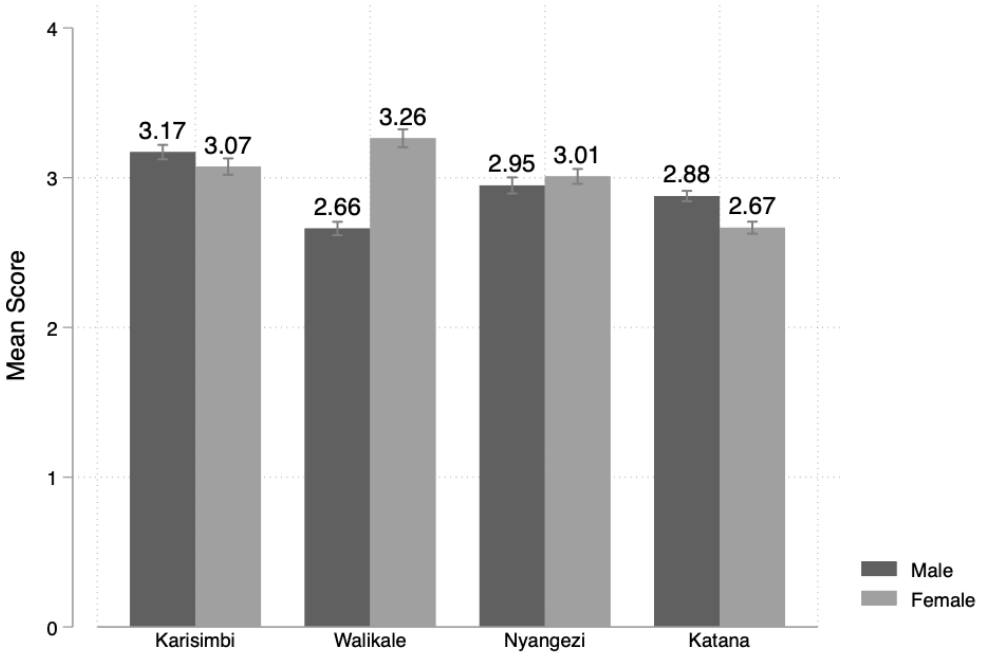
Figures 16, 17, and 18 show the distribution of scores on these measures by gender and health zone. For self-efficacy, individual resilience and community resilience, there is a pattern of gender differences with women consistently scoring lower than men on these measures in Katana which is reversed in Walikale with women consistently scoring higher than men.

Figure 16: Mean self-efficacy score, by health zone and gender



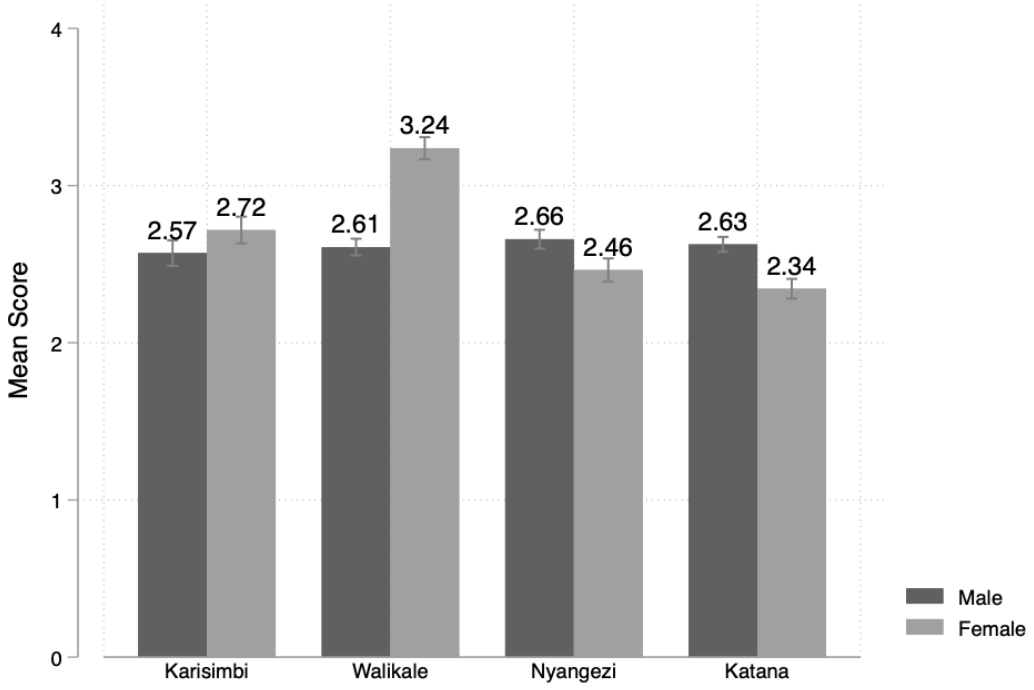
Note: Figure reports mean score on 6 item self-efficacy scale

Figure 17: Mean individual resilience score, by health zone and gender



Note: Figure reports mean score on 7 item individual resilience scale

Figure 18: Mean community resilience score, by health zone and gender



Note: Figure reports mean score on 9 item community resilience scale

6.5 PREVALENCE OF GBV

IMA Indicator 1: G1.1 Prevalence rate of GBV among women, men, and children in target geographic areas

Preventing and responding to GBV is a core goal of the *Tushinde Ujeuri* project. The baseline survey, therefore, assessed two key types of GBV perpetration and victimization: sexual violence by a non-partner as well as IPV. The war trauma section also asked about experiences of being a victim or being forced to perpetrate sexual violence by an armed group. All respondents (both women and men) were asked whether they personally had experienced various forms of sexual violence or IPV in the past 12 months (past-year violence) and at any point in their lives (ever violence).

Note that the statistics below in 6.5.1 through 6.5.3 are broken down by perpetrator, namely sexual violence by 1) an intimate partner and 2) any non-partner, including by armed groups which is analyzed separately as it is particularly relevant for conflict experience. This was done because the first type is limited to women who have had an intimate partner (the survey question is asked only to those who were ever married or partnered); while the second type of sexual violence is not conditional on partner status. As such, pooling the two estimates together would not be meaningful.

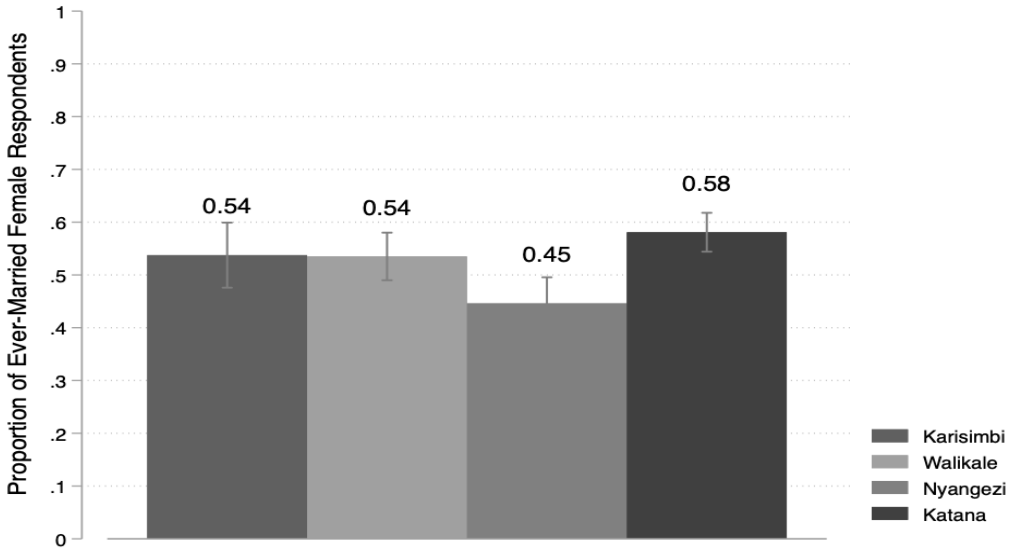
6.5.1 INTIMATE PARTNER VIOLENCE

Intimate partner violence among ever-partnered women was measured through the conflict tactics scale (CTS) and included acts of physical or sexual violence perpetrated by a partner. Ever-partnered women were asked to report the frequency (Never, Sometimes, or Often) with which their current or most recent partner engaged in a set of actions. For respondents reporting that a behavior took place Sometimes or Often, the survey asked a follow-up as to whether the partner had perpetrated the action in the last 12 months.

Over half of all ever-partnered women surveyed reported having experienced IPV (either physical or sexual) at some point in their lives (53.4%). This was well above the regional average for Sub-Saharan Africa, which is 39.9% according to Demographic and Health Survey (DHS) data. Over a third of women (38.9%) reported experiencing IPV (either physical or sexual) in the past 12 months.

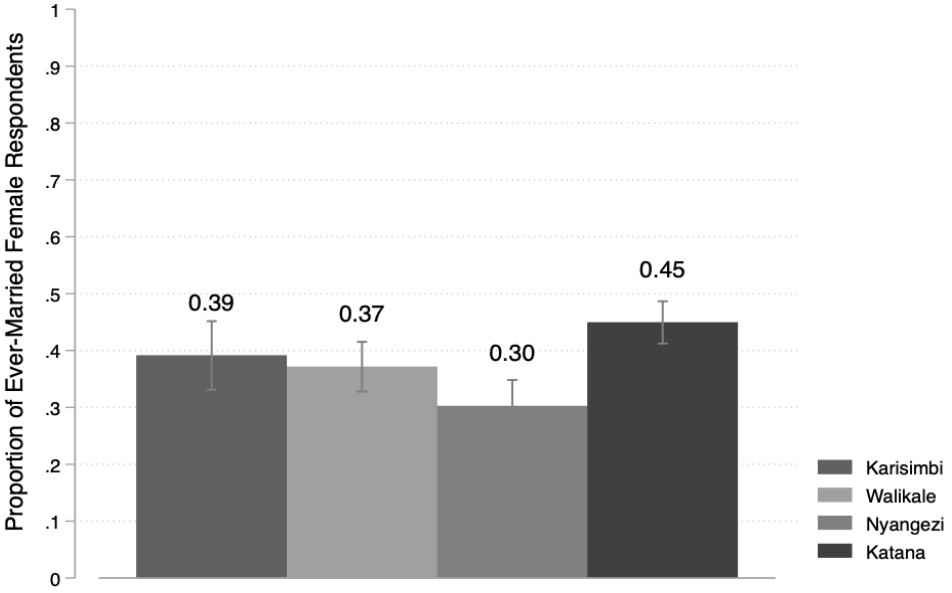
Figures 19 and 20 report the proportions of ever-partnered female respondents reporting experiencing IPV at some point in their lives and in the last 12 months, by health zone. The only significant regional differences are between Nyangezi (lowest prevalence rates) and Katana (highest prevalence rates).

Figure 19: Proportion of ever-partnered women having ever experienced IPV (physical or sexual), by health zone



Note: Proportion is a value between 0 and 1. For example in the figure 0.54 implies 54% of ever-married females in our sample in Karisimbi have experienced IPV in their lifetime

Figure 20: Proportion of ever-partnered women having experienced IPV (physical or sexual) during the last 12 months, by health zone



Note: Proportion is a value between 0 and 1. For example in the figure 0.39 implies 39% of ever-married females in our sample in Karisimbi have experienced IPV in the last 12 months.

6.5.2 NON-PARTNER SEXUAL VIOLENCE

The survey also examined women and men's experiences with sexual violence committed by a non-partner. Those people who answered yes to the following question were coded as having experienced sexual violence perpetrated by a non-partner, "At any time in your life, as a child or as an adult, has anyone ever forced you in any way to have sexual intercourse or perform any other sexual acts when you did not want to?"

One-fifth of women (20.5%) and one in twelve men (8.23%) reported being ever raped by a non-partner. Again, these numbers are much higher than the regional victimization rate for women in Sub-Saharan Africa, which is 14%. In the past year, 14.6% of women and 6.4% of men reported experiencing sexual violence.

6.5.3 SEXUAL VIOLENCE BY AN ARMED GROUP

While war-related sexual violence was covered in a separate section, it is also worth revisiting here. More than one in ten women (11.4%) and one in twelve men (8.61%) stated they had experienced sexual violence at the hands of armed groups. This statistic speaks to the heavy burden of armed group violence on the population surveyed for this project.

6.5.4 PERPETRATION OF IPV AND NON-PARTNER SEXUAL VIOLENCE

Almost one-third of men (28.5%) and 12.5% of women report perpetrating physical IPV against a partner in their lifetime. Roughly one in seven men (14.6%) have reported ever forcing someone other than their partner to have sex against their will, and 4% of men reported doing so in the past year. Just over six percent of women (6.7%) report ever forcing someone to have sex against their will, and 2.8% reported doing so in the past year.

6.6 ATTITUDES TOWARDS GENDER EQUALITY

IMA Indicator 2: IR 1.2.1 Percentage of target population reporting increased agreement that males and females should have equal access to social, economic and political opportunities

Note here that we cannot report on change statements due to the program, as is implied by the indicator, because this report is a baseline. Rather here we report on the level of agreement in the sample. In the endline survey, and by comparing across villages with and without the program, we will capture any changes.

The survey assessed respondents' attitudes towards gender roles and gender equality in various domains by asking them to state the extent to which they agree with the following statements:

1. Changing diapers, giving a bath, and feeding kids is the mother's responsibility.
2. A woman's role is taking care of her home and family.
3. The husband should make the final decision about all major household purchases.
4. A man should have the final word about decisions in his home.
5. A woman should obey her husband in all things.
6. When jobs are scarce, men should have more right to a job than women.
7. Women should have the same rights as men to own and inherit land.
8. Men make better political leaders than women, and should be elected rather than women.

The first 5 items correspond to the Domestic Chores and Daily Life Items in the Gender Equitable Men (GEM) Scale used to "measure attitudes toward gender norms in intimate relationships or differing social expectations for men and women". The last 3 items measure attitudes towards equality of economic and social opportunity and are adapted from survey items in the Afro-barometer.

Respondents were asked to rate each statement on a 5-point scale:

- 1 – Strongly Disagree
- 2 – Somewhat Disagree
- 3 – Neither Agree nor Disagree
- 4 – Somewhat Agree
- 5 – Strongly Agree

We generated an index by averaging responses to the 8 statements (with each item weighted equally) for each individual respondent, thus ranging from 0 to 40. A higher score denotes **less** equitable attitudes (Statement 7 is recoded so that higher values indicate disagreement). A respondent would score 0 if they strongly disagree with all inequitable statements and would score 40 if they strongly agree with each one. The second row rescales this to range 0 to 1 to allow for comparisons across tables.

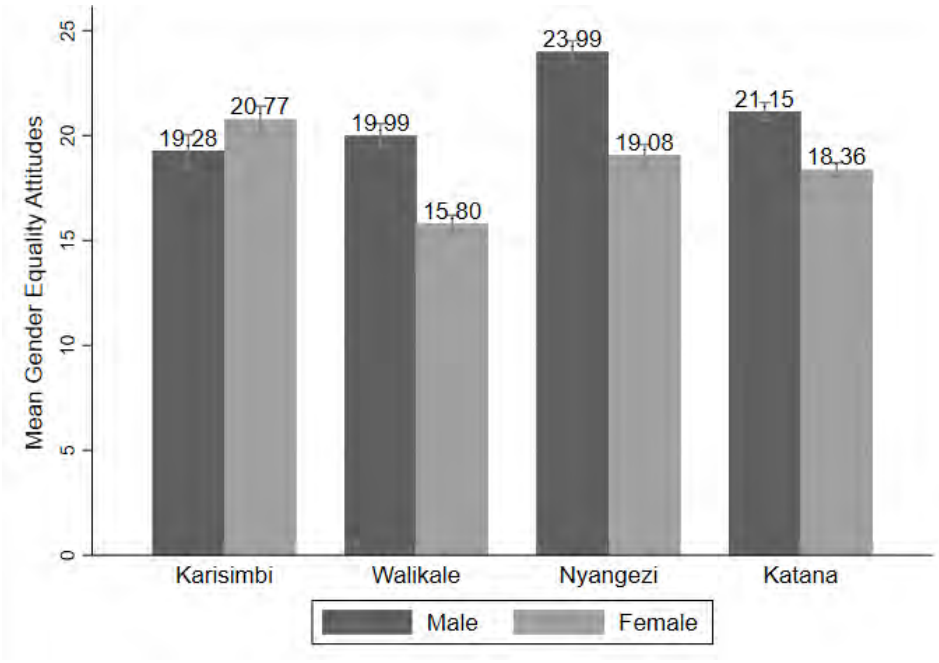
Table 12: Index of attitudes towards gender equality in different domains

	MEAN	SD	MIN	MAX
Gender equitable attitudes (out of 40)	19.7	6.19	0	40
Gender equitable attitudes (rescaled to 0-1)	0.49	0.15	0	1
Gender equitable attitudes (men only)	21.1	6.61	0	40
Gender equitable attitudes (women only)	18.3	5.38	0	39

Note: Minimum value of 0 represents most favorable towards gender equality, maximum value of 40 (or 1) represents least favorable towards gender equality

Figure 21, showing variation by health zone and gender, reveals that overall, respondents in Katana and Nyangezi seem to hold slightly less favorable views on gender equality. In all regions except for Karisimbi (where this is no significant difference), there is a gender gap in attitudes towards equality where women seem to hold more favorable views towards gender equality.

Figure 21: Gender equitable attitude index, by health zone and gender



Note: Min value of 0 represents most favorable towards gender equality, max value of 40 towards least favorable

6.7 ATTITUDES AND NORMS AROUND GBV

IMA Indicator 3: IR 1.2.4 Percentage of target population that views GBV as less acceptable after participating in or being exposed to USG programming.

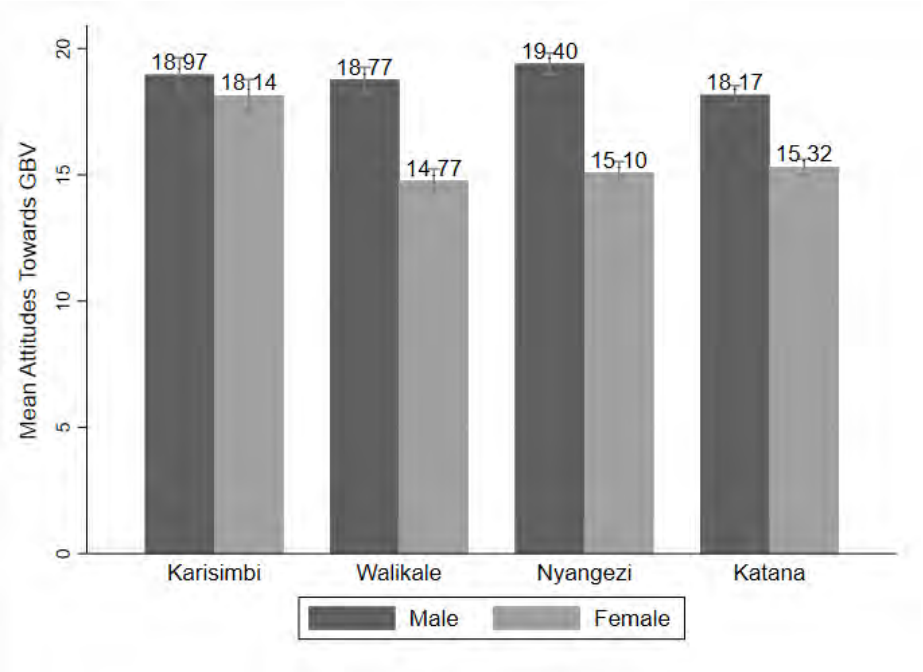
The following section assesses the acceptability of GBV among the sample through questions about individually held attitudes, as well as questions pertaining to respondents' beliefs about the attitudes and behaviors of others. Note that, as this stage, we cannot report on any change in the perception of GBV due to the program (as is implied by the indicator). Rather, we report here on the perception levels in the sample at baseline. Once the endline survey is completed, we will capture any changes in perception by comparing across villages with and without the program.

On individual attitudes, respondents were asked about the extent to which they agree with the following 6 Violence Domain Items of the Gender Equitable Men (GEM) Scale:

1. There are times when a woman deserves to be beaten.
2. A woman should tolerate violence to keep her family together.
3. It is alright for a man to beat his wife if she is unfaithful.
4. A man can hit his wife if she won't have sex with him.
5. If someone insults a man, he should defend his reputation with force if he has to.
6. A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.

We generated an index by averaging the responses to the 6 statements (with each item weighted equally) for each individual respondent, which ranges from 0 to 30. A higher score denotes **greater acceptance of GBV**. A respondent would score 0 if they strongly disagree with all statements indicating acceptability of GBV and would score 30 if they strongly agree with each one.

Figure 22: Index of acceptability of GBV, by health zone and gender



Note: Min value of 0 represents least accepting of GBV, max value of 30 represents most accepting

As Figure 22 shows, there do not seem to be substantial differences across regions in men's attitudes towards acceptance of GBV. However, in Karisimbi there is no gender gap in accepting attitudes and women report generally more accepting attitudes than in the other health zones. In the other three health zones, there is a sizable gender gap in attitudes whereby women hold less accepting attitudes towards GBV.

In addition, the survey asked respondents to report their beliefs about the attitudes of others in their community. Specifically the survey asked each respondent to think of 5 men and 5 women in their community and ask them how many of these men and women would agree with the following statements:

- There are times when a woman deserves to be beaten, and
- A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.

We averaged the responses to construct a measure of each respondent's perception of other men and women's beliefs. Overall it appears that respondents believe men to be more accepting of GBV than women – on average respondents think that 2.2 men but only 1.75 women would agree with these statements. At the same time, female respondents seem to perceive both other women and other men to be more tolerant of GBV than do male respondents (Table 13).

Table 13: Index of attitudes and norms towards GBV

	N	MEAN	SD	MIN	MAX
GBV Acceptability (out of 30)	4,223	17.2	5.49	0	30
GBV Acceptability (rescaled to 0 - 1)	4,223	0.57	0.18	0	1
GBV Acceptability (men only)	2,109	18.7	5.44	0	30

	N	MEAN	SD	MIN	MAX
GBV Acceptability (women only)	2,114	15.6	5.10	0	30
Norms (men)	4,223	2.03	1.09	0	5
Norms for men (men only)	2,109	1.78	1.03	0	5
Norms for men (women only)	2,114	2.29	1.09	0	5
Norms (women)	4,223	1.75	1.21	0	5
Norms for women (men only)	2,109	1.78	1.03	0	5
Norms for women (women only)	2,114	2.29	1.09	0	5

Note: For acceptability Min value of 0 represents being most acceptable of GBV (strongly agree to all statements), max value of 30 (or rescaled to 1.)

Norms indicate how many out of 5 men/women in a respondent's surrounding are accepting towards GBV.

6.8 AWARENESS OF GBV-RELATED SERVICES ACCESS

IMA Indicator 4: IR 2.3.2 Percentage of target population reporting disagreement with identified barriers to accessing GBV-related community services

A key objective of the *Tushinde Ujeuri* program is to raise awareness and uptake of GBV services. The baseline study used a 6-point scale to assess possible barriers to access to GBV-related services. The six barriers were: "Doesn't want family to know"; "No money for transport"; "Doesn't know where to get help"; "Doesn't want others to know"; "No money for fees"; and "Doesn't think services will help". Respondents reported more barriers to seeking services for GBV if the perpetrator was a family member (2.53) compared to a non-family member (2.36). Interestingly, men reported more barriers to service seeking than women for both family and non-family perpetrators (Table 14). Figures 23 and 24 show number of indicated barriers to GBV-services by health zones and gender.

Table 14: Barriers to accessing GBV-related services

	N	MEAN	SD	MIN	MAX
Barriers to GBV service access no family (out of 6)	4,223	2.36	1.93	0	6
Barriers to GBV service access no family (women only)	2,114	2.26	1.93	0	6
Barriers to GBV service access no family (men only)	2,109	2.46	1.92	0	6
Barriers to GBV service access family (out of 6)	4,223	2.53	1.93	0	6
Barriers to GBV service access family (women only)	2,114	2.39	1.92	0	6
Barriers to GBV service access family (men only)	2,109	2.67	1.92	0	6

Note: Indicates how many out of 6 possible barriers to access to GBV-related services are identified by respondents.

Figure 23: Number of indicated barriers to access GBV-related services if perpetrated by a family member, by health zone and gender

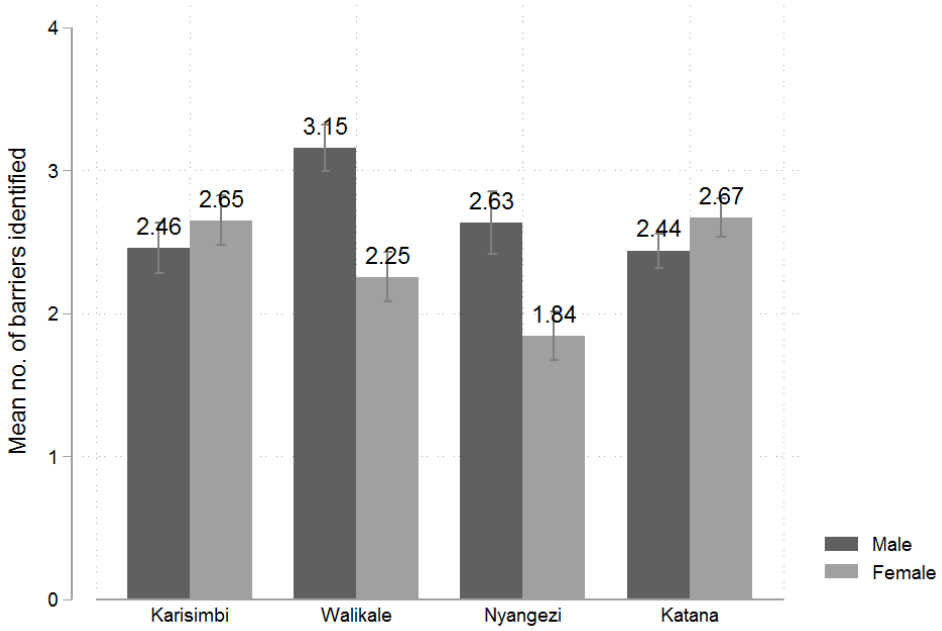
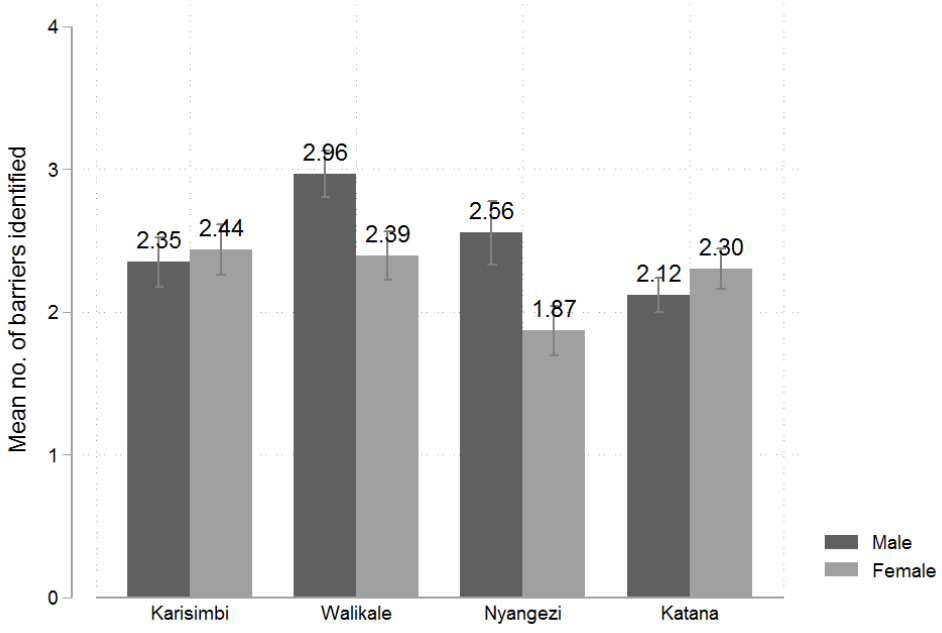


Figure 24: Number of indicated barriers to access GBV-related services if perpetrated by non-family member, by health zone and gender



The most common reasons for not seeking services for GBV perpetrated by a non-family member were: *no money for transport*, followed by *doesn't think services will help* and *doesn't know where to get help* (Table 15). For family GBV perpetrators, the most common reason for not seeking services was no money for transport, followed by no money for fees and doesn't know where to get help (Table 16).

Table 15: Barriers to access to GBV-related service if perpetrated by non-family member

	MEAN	MIN	MAX
Doesn't want family to know	0.40	0	1
No money for transport	0.48	0	1
Doesn't know where to get help	0.45	0	1
Doesn't want others to know	0.28	0	1
No money for fees	0.43	0	1
Doesn't think services will help	0.47	0	1

Table 16: Barriers to access to GBV-related service if perpetrated by family member

	N	MEAN	SD	MIN	MAX
Doesn't want family to know	3776	0.38	0.49	0	1
No money for transport	3776	0.54	0.50	0	1
Doesn't know where to get help	3776	0.49	0.50	0	1
Doesn't want others to know	3776	0.27	0.44	0	1
No money for fees	3776	0.49	0.50	0	1
Doesn't think services will help	3776	0.48	0.50	0	1

7. RISK FACTORS FOR GBV VICTIMIZATION AND PERPETRATION

This section aims to better understand the factors, such as demographics, war exposure, norms etc., associated with the perpetration and victimization of both non-partner sexual violence and IPV. The following analysis focuses on three main GBV variables (i) IPV victimization among women (ii) Men's perpetration of IPV and (iii) Men's perpetration of non-partner sexual violence.

First, we examine the relationship between the levels of these three GBV outcomes at the village level to see whether villages where IPV victimization of women is high also have higher levels of perpetration by men, both in terms of IPV and non-partner sexual violence. Indeed, the village-level correlations between these measures are high (see Table 17)—in villages where women reported higher levels of IPV, men perpetration of IPV and non-partner sexual violence is also higher. The village-level correlation between women experiencing IPV and men's perpetration of IPV is 0.38 and between women experiencing IPV and men's perpetration of non-partner sexual violence is 0.45. Both of these correlations are highly statistically significant. It is not surprising that in villages where men's perpetration of IPV is high, men's perpetration of non-partner sexual violence is also high—the correlation is 0.55 and is highly statistically significant. These results suggest that there could be community-level factors that affect the experiences and behaviors of individuals within the same communities in a similar way. These factors could be observed ones such as the demographic composition of the population (age distribution, ethnic composition, etc.) or unobserved ones such as norms regarding and/or tolerance for GBV.

Table 17: Village-Level Correlation Between GBV Measures

	IPV VICTIMIZATION AMONG WOMEN	MEN'S PERPETRATION OF IPV
Men's perpetration of IPV	0.380***	
Men's perpetration of non-partner sexual violence	0.451***	0.550***

Note: *** p-value ≤ 0.01

Next, we explore the correlation between the three GBV outcomes with known contributing factors related to individual experiences regarding conflicts, perceptions of social relations, demographic characteristics and attitudes, and partner behavior. Given that there are several potential contributing factors, we use multivariate regression analysis.

Specifically, we use a linear probability model with village fixed effect that allows for examining the contributing factors by comparing individuals within the same village. This is especially important because of the likely village-level effects on the outcome measures described above. In addition, we include the following contributing factors in the regression model: war exposure (witnessing or experiencing conflict related events), within and between village social relations (ranging from very good to very bad), whether a respondent experienced a personal conflict with someone else, respondent age, marital status, if primary occupation is farming, religion, whether the respondent had abusive parents, whether they have gender inequitable attitudes, and (for female respondents) whether husbands use alcohol or drugs.

Finally, we run three regression models, one with each of the three outcome measures as dependent variables. We include the same contributing factors, as listed above, for each of the three regressions. We present the regression results for women that experienced any form of IPV, IPV

perpetration by men, and non-partner sexual violence perpetration by men in Columns 1, 2, and 3, respectively of Table 18 and describe them below.

7.1 IPV VICTIMIZATION AMONG WOMEN

The regression model for examining the correlations between IPV victimization among women with various contributing factors includes responses from and information on 1,560 female respondents from the baseline survey. Of the women in our sample, over 53% report having experienced physical or sexual IPV in their lives (Column 1, Table 18).

Women exposed to war-related experiences were significantly more likely to be victims of IPV compared to women who had fewer war-related experiences. Specifically, women who have witnessed or experienced conflict events are about 6% more likely to report IPV victimization. However, both of these correlations are weakly statistically significant, at the 10% level. These results highlight how personal experiences with conflict may put women at greater risk of violence within the home.

Some background characteristics, such as age, marital status, and experience with violence in childhood are also important contributing factors. Younger women are 2% more likely and women in polygamous marriages are 12% more likely to report they have experienced any form of IPV, and both correlations are statistically significant at the 5% level. Women who had an abusive father (who they witnessed beating their mother or those women who were beaten themselves when young) are 13% more likely to report IPV victimization and this relationship is highly statistically significant, at the 1% level.

Not surprisingly, women with husbands with alcohol and drug abuse problems are more likely to report IPV victimization. The correlations between alcohol and drug use by husbands and IPV victimization are quite large and highly statistically significant at the 1% level. Women who report their husband drinks are 23% more likely to report having experienced IPV, and those with husbands that use drugs are 20% more likely to report having experienced IPV.

Other contributing factors included in the regression model were not statistically significant.

The factors we found to be statistically significant align with the existing literature on IPV victimization. Globally, risk factors for GBV include younger age, education level, wealth, experience of or witnessing of violence previously, and alcohol or substance abuse (Abramsky et al., 2011; Hindin et al., 2008; Jewkes, 2013, Linos et al., 2013; WHO, 2013; WHO, 2014). For IPV specifically, having more children under five in the household and attitudes condoning domestic violence by victim and perpetrator are also risk factors (Jewkes, 2002; WHO, 2013).

7.2 MEN'S PERPETRATION OF IPV

The regression model for examining the correlations between men's perpetration of IPV with various contributing factors includes responses from and information on 2,030 male respondents from the baseline survey. Of the men in our sample, about 29% report to have "hit, slapped, kicked, or done anything else to hurt their current or previous wife/husband or girlfriend/boyfriend physically" (Column 2, Table 18).

Similar to the results for women, men who witnessed war-related events are about 9% more likely to report perpetration of violence against women, compared to men that did not, suggesting a strong link between exposure to political conflict and perpetration of violence within the home. In

addition, social relations with neighboring villages also seem to be an important factor contributing to perpetration of IPV. Men that report worse relations with other (nearby) villages are about 6% more likely to report IPV perpetration. Both of these correlations are highly statistically significant at the 1% level. Men who had a personal conflict with someone in the year preceding the survey were also more likely, by about 6%, to report IPV perpetration and this correlation is statistically significant at the 5% level.

Background characteristics, such as age, marital status, and experience with violence in childhood are also important contributing factors. Older men are slightly more likely (by 1%) to report IPV. Compared to single men, married men (by about 7%) and those in polygamous marriages (by about 16%) are more likely to report they hurt their partner(s). Also, men who had an abusive father are 12% more likely to report IPV perpetration. These results are in line with the finding above that women in polygamous marriages are more likely to report experiencing any form of IPV.

Also, men who hold gender inequitable norms, such as "I strongly agree there are times when a woman deserves to be beaten" are 12% more likely to report they hurt their partner and this is highly statistically significant at the 1% level. We did not observe similar results for women; therefore, women's attitude did not have any correlations with them reporting IPV victimization. This suggests that for perpetrating men, women's views regarding equitable gender norm is not so important.

Finally, Muslim men are 13% more likely to report IPV perpetration compared to Christian men and this is weakly statistically significant at the 10% level. Other contributing factors included in the regression model were not statistically significant.

7.3 MEN'S PERPETRATION OF NON-PARTNER SEXUAL VIOLENCE

The regression model for examining the correlations between men's perpetration of non-partner sexual violence uses the same sample of the 2,030 male respondents as in the model above. Of the men in our sample, 10% answered "yes" to the question "Have you forced someone OTHER THAN your current or previous wife/husband or girlfriend/boyfriend to have sex with you when she did not want to?" (Column 3, Table 18). These respondents were coded as having perpetrated non-partner sexual violence.

Unlike the previous two sets of results, war-related experiences were not a contributing factor for men to perpetrate non-partner sexual violence. However, men who report worse relations with other (nearby) villages are about 8% more likely to report perpetrating sexual violence. Men who had a personal conflict with someone in the year preceding the survey were also about 6% more likely to report perpetrating sexual violence. Both of these correlations are highly statistically significant.

Other factors contributing to men reporting perpetrating sexual violence are similar to those that we found to have contributed to men's reports of IPV perpetration: Compared to single men, married men are about 5% more likely to report they perpetrated sexual violence, while Muslim men are about 13% more likely compared to Christian men, both statistically significant at the 5% level. Also, men who had an abusive father are about 7% more likely and men who hold gender inequitable norms, such as "I strongly agree there are times when a woman deserves to be beaten" are about 9% more likely to report sexual violence, both results being highly statistically significant at the 1% level.

Table 18: Correlates of IPV

	(1) EXPERIENCED ANY FORM OF IPV (EVER MARRIED FEMALE)	(2) IPV PERPETRATION (MEN)	(3) SEXUAL VIOLENCE PERPETRATION (MEN)
Witnessed Conflict Events (1=yes)	0.056* (0.032)	0.088*** (0.025)	0.029 (0.020)
Experienced Conflict Events (1=yes)	0.062* (0.033)	-0.035 (0.025)	-0.004 (0.020)
Inter-village relations are bad (1= very good – 5 = very bad)	0.036 (0.027)	0.004 (0.021)	0.009 (0.017)
Intra-village relations are bad (1= very good – 5 = very bad)	-0.015 (0.027)	0.057*** (0.022)	0.075*** (0.017)
Own village is worse off than neighboring villages (1= much better – 5 = much worse)	0.007 (0.011)	0.005 (0.010)	-0.012 (0.008)
Personal Conflict (last year) (1=yes)	0.034 (0.032)	0.057** (0.024)	0.058*** (0.019)
Age (years)	-0.002** (0.001)	0.001* (0.001)	0.000 (0.001)
Married/cohabiting (1=yes)		0.074*** (0.027)	0.053** (0.022)
Married polygamous (1=yes)	0.117** (0.046)	0.155*** (0.046)	0.029 (0.036)
Divorced or widowed (1=yes)	-0.006 (0.036)	0.065 (0.063)	0.079 (0.049)
Main occupation if farming (1=yes)	0.016 (0.032)	-0.036 (0.023)	0.011 (0.018)
Protestant (1=yes)	0.049 (0.030)	-0.030 (0.022)	0.012 (0.018)
Muslim (1=yes)	0.046 (0.120)	0.130* (0.074)	0.134** (0.059)
Other (1=yes)	0.054 (0.045)	0.034 (0.034)	0.032 (0.027)
Abusive father when young (1=yes)	0.133*** (0.026)	0.123*** (0.024)	0.068*** (0.019)
Gender inequitable attitude (1=yes)	-0.028 (0.036)	0.122*** (0.021)	0.085*** (0.017)
Husband uses alcohol (1=yes)	0.232*** (0.027)		
Husband uses drugs (1=yes)	0.199*** (0.054)		
Respondent gender	FEMALE	MALE	MALE
Village Fixed Effects	YES	YES	YES

	(1) EXPERIENCED ANY FORM OF IPV (EVER MARRIED FEMALE)	(2) IPV PERPETRATION (MEN)	(3) SEXUAL VIOLENCE PERPETRATION (MEN)
Observations	1,560	2,030	2,030
Mean of Dependent Variable	0.534	0.285	0.106

Notes: i) OLS regressions; ii) significance levels indicated by * p < 0.10, ** p <0.05, *** p < 0.01; ii) standard errors in parenthesis; iii) specifications include village fixed effects; iv) Column 1, female respondents only; v) Column 2 and 3, male respondents only.

8. CONCLUSIONS

A foundational goal of this research was to understand the baseline levels of different forms of GBV that affect communities in the project areas. The survey asked a number of questions to assess GBV perpetration and GBV victimization. For victimization, the survey assessed lifetime IPV, past-year IPV for women, as well as lifetime SV and past-year SV for women and men. For perpetration, the survey assessed perpetration of IPV and SV among women and men.

Over half of all ever-partnered women surveyed reported having experienced IPV at some point in their lives, a number that is well above the regional average for Sub-Saharan Africa. Over a third of women (38.9%) reported experiencing IPV in the past 12 months. The survey also examined women and men's experiences with sexual violence committed by a non-partner. One-fifth of women and one in twelve men reported being ever raped by a non-partner. Again, these numbers are much higher than the regional victimization rate for women in Sub-Saharan Africa. In the past year, 14.6% of women and 6.4% of men reported experiencing sexual violence.

Almost one-third of men and 13% of women report perpetrating physical IPV against a partner in their lifetime. Roughly one in seven men has reported ever forcing someone other than their partner to have sex against their will, and 4% of men reported doing so in the past year. Just over six percent of women report ever forcing someone to have sex against their will, and 3% reported doing so in the past year.

Another core goal of this research was to better understand the norms and beliefs related to GBV and GBV help seeking in this area. The survey assessed individuals' own attitudes toward the acceptability of GBV, as well as individuals' beliefs about the attitudes of others in their community. In general, there exists a sizable gender gap in attitudes; women hold less accepting attitudes towards GBV while men have more permissive attitudes. Overall it appears that respondents believe men to be more accepting of GBV than women. At the same time, female respondents seem to perceive both other women and other men to be more tolerant of GBV than do male respondents.

Related to GBV help-seeking, overall men reported more barriers to accessing GBV services on average than women. The most common barriers to accessing services differed slightly for family versus non-family perpetrators of GBV. However, in general, not having money for transport or for services fees, and not knowing where to access services were common problems.

There are stark gendered differences in many of the outcomes assessed for this project, including but not limited to: access to education, access to income-generating activities and resilience and mental health outcomes. There is also substantial variation among health zones in a number of outcomes, including literacy, employment, mental health outcomes and perceptions of security. While all health zones included in this survey have been highly affected by conflict, Walikale stood out as a site with higher levels of displacement, lower levels of literacy, and higher levels of depression and anxiety than other health zones. There were significant geographic and gendered differences among many outcomes, suggesting the importance of disaggregating this data to gain a more nuanced picture of how outcomes may vary across populations.

There are strong and significant links between the project outcomes – IPV and SV – and exposure to war-related violence. Women that witnessed or experienced conflict are 6% more likely to report IPV victimization. These results highlight how personal experiences with conflict may put women at greater risk of violence within the home. Men who witnessed war related events were more likely to report perpetration of IPV and SV, suggesting a strong link between exposure to political conflict and perpetration of violence within the home.

In addition, there were strong links between certain measures of poor social cohesion and men's perpetration of different forms of IPV. Men who report worse relations with other (nearby) villages are more likely to report perpetrating SV and IPV.

Taken together, these results suggest that violence within communities – including IPV and other forms of GBV – are highly associated with individuals' experiences with the conflict, and are also associated with measures of social cohesion. Addressing the underlying trauma of conflict and trying to rebuild trust and social cohesion may provide an avenue to addressing some of the underlying mechanisms that propagate violent behaviors in highly war-affected areas.

We summarize the key findings from the baseline survey below:

- Exposure to witnessing or experiencing war-related abuses was extremely common. More than half of respondents reported having witnessed or experienced at least one conflict-related event.
- Individuals participating in the research had high levels of depression and anxiety as well as PTSD. Across all health zones, a significantly larger proportion of women report anxiety and depression and PTSD than men.
- Over half of all ever-partnered women surveyed reported having experienced IPV at some point in their lives. One-fifth of women and one in twelve men reported being ever raped by a non-partner. These numbers are higher than the regional victimization rate for women in Sub-Saharan Africa.
- Men who witnessed war-related events were more likely to report perpetration of IPV and SV.
- War-related experiences are highly and significantly associated with higher odds of women reporting IPV victimization.
- Men who reported more mistrust and resentment of neighboring communities also had higher odds of perpetrating IPV and sexual violence against non-partners.

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APPENDIX A: INTERVENTION TIMELINE

We include the expected timeline of the impact evaluation below. A key element of the impact evaluation is to include the collection of data, as part of the data collection for the impact analysis, which will contribute to the monitoring and evaluation needs of the implementing partners.

- September 2017-2018. Develop research design with partners
- September 2018. Finalize research design (see Kelly, Khan and Voors (2018) Impact Evaluation Design: Changing Norms around Gender Based Violence in Eastern Democratic Republic of Congo)
- September/October 2018: Baseline data collection
- October 2018: Assign Treatment (blocked cluster randomization, using replicable procedure in STATA/R)
- January 2019: Program CBTH activities commence by SFCG and partners
- Continuous: Monitoring
- Spring 2020: Endline data collection
- Spring 2020: Analyses and impact report and results presentations

APPENDIX B: MEMO ON POPULATION-LEVEL ESTIMATES OF THE BASELINE REPORT

July 9, 2019

PURPOSE AND NOTES ON METHODOLOGY

This memo reports population-level estimates for certain key indicators on which IMA relies for its M&E activities. These IMA indicators were originally presented and discussed in Sections 6.5 to 6.8 of the baseline report for the sample households included in the impact evaluation study. For the baseline study, we randomly selected 20 households each from 192 villages, irrespective of village population size, from 48 Health Areas (HAs) in 4 Health Zones[5] (HZs). In this memo, we reproduced the IMA indicators by weighting the village-level estimates appropriately to reflect that the responses to baseline survey represent different proportions of population in different villages. As such, **the IMA indicators reported in this memo are the population averages for the 192 villages that were included in the study**. Note that we can "weight up" the sample averages reported in the baseline study to population averages of the 192 villages because the study sample is a random sample of the population in the 192 villages included in the study.[6]

However, note that this approach does not provide population averages for either the North Kivu and South Kivu Provinces as a whole or the four HZs as a whole or the 48 HAs as a whole in which the 192 villages surveyed are located. This is because the selection of villages within the HAs were not random—the criteria for the villages to be included in the sampling frame were accessibility, relative security, population size and household count, and a limited presence of other projects that might contaminate any impact of the intervention. This has two implications:

(1) We do not have the statistical ability to weight the sample estimates to all villages (192 plus the ones that are not selected) in the 48 HAs, and

(2) The population-level estimates presented in this memo for the 192 villages may not represent the population-level estimates for all villages (192 plus the ones that are not selected) in the 48 HAs had we been able to calculate them. This is specifically likely because of the non-randomness in the village selection—the villages that were not selected for the study were less accessible and less secure and thus are likely to have worse outcomes on GBV.

Nonetheless, absent the appropriate sampling strategy, the estimates presented in this memo are the best available population-level estimates for the 192 villages in the 48 HAs in the 4 HZs in South Kivu and North Kivu Provinces. We recommend that IMA exercises caution in using these estimates. Specifically, given the possibilities in #2 above, the estimates presented here are likely to be lower-bound estimates compared to the estimates that would include all villages (192 plus the ones that are not selected).

[5] Namely Karisimbi, Walikale, Katana, and Nyangezi.

[6] The weight is calculated as the inverse probability of being selected for the survey in the village. This probability is calculated by dividing the sample size in each village by the population size of that village.

TABLES AND CHARTS FOR POPULATION-LEVEL ESTIMATES

IMA Indicator 1: G1.1 Prevalence rate of GBV among women, men, and children in target geographic areas

Figure 1. Proportion of ever-partnered women having ever experienced IPV (physical or sexual), by health zone, at the population-level[7]

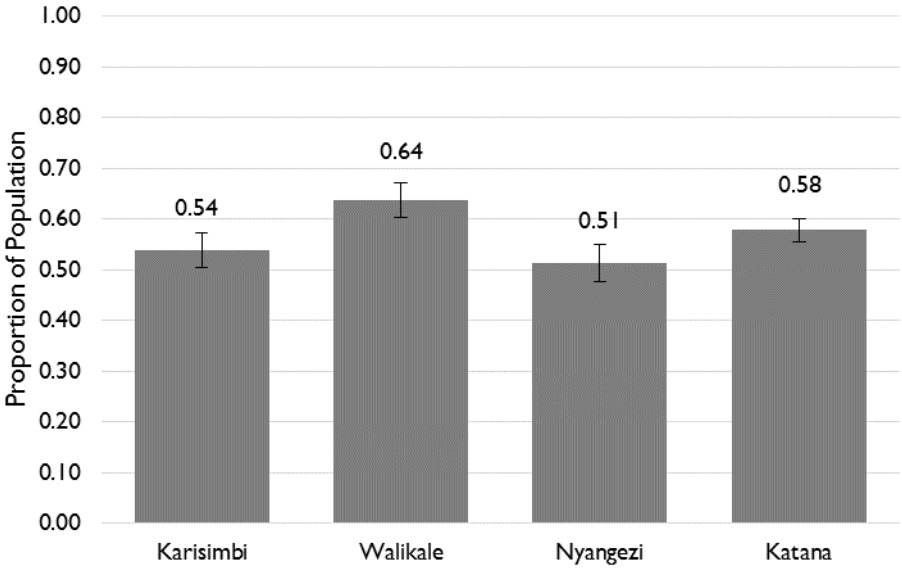
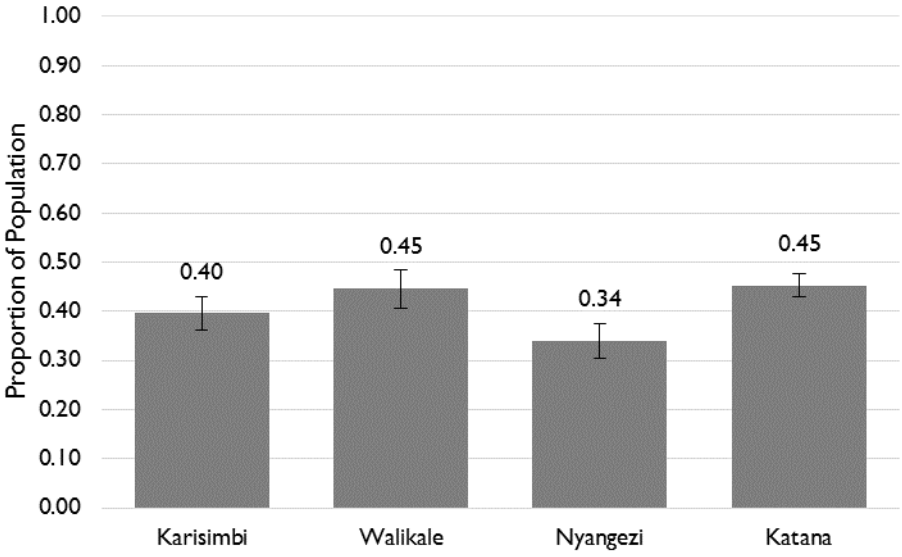


Figure 2. Proportion of ever-partnered women having experienced IPV (physical or sexual) during the last 12 months, by health zone, at the population-level[8]



[7] Population-level version of Figure 19 in the baseline report.

[8] Population-level version of Figure 20 in the baseline report.

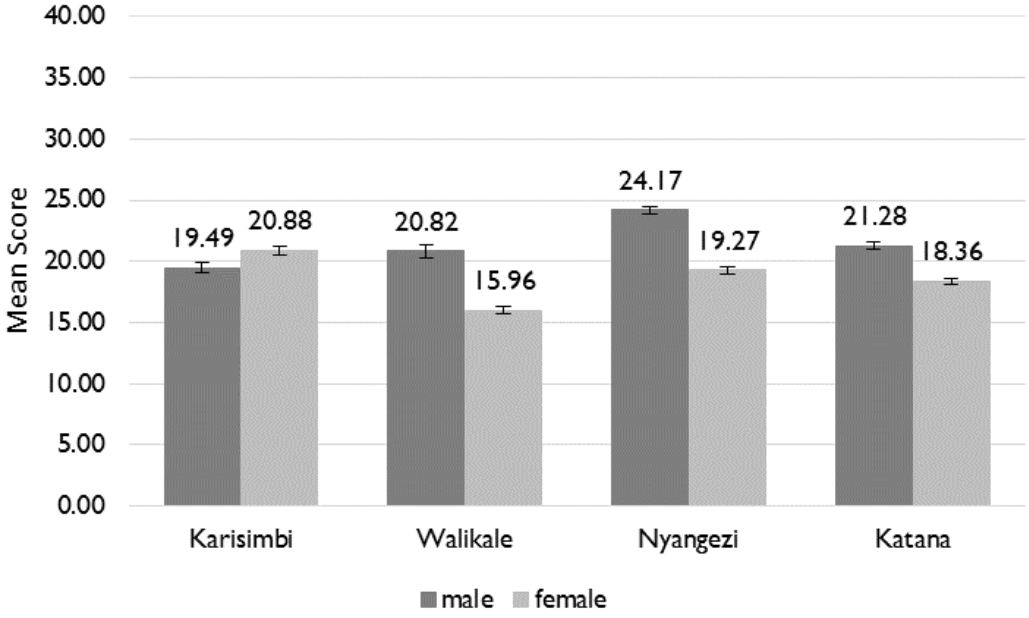
IMA Indicator 2: IR 1.2.1 Percentage of target population reporting increased agreement that males and females should have equal access to social, economic and political opportunities

Table 1. Index of attitudes towards gender equality in different domains (population-level)[9]

	MEAN	SE	MIN	MAX
Gender equitable attitudes (out of 40)	20.1	0.13	0	40
Gender equitable attitudes (rescaled to 0-1)	0.50	0.00	0	1
Gender equitable attitudes (men only)	21.4	0.19	0	40
Gender equitable attitudes (women only)	18.7	0.15	0	39

Note: Minimum value of 0 represents most favorable towards gender equality, maximum value of 40 (or 1) represents least favorable towards gender equality

Figure 3. Gender equitable attitude index, by health zone and gender, at the population-level[10]



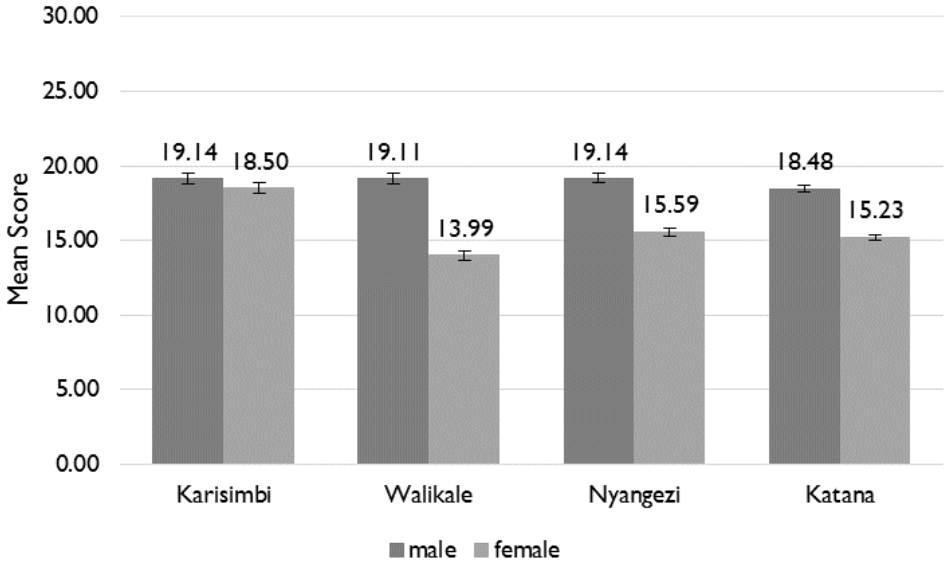
Note: Min value of 0 represents most favorable towards gender equality, max value of 40 towards least favorable

[9] Population-level version of Table 12 in the baseline report.

[10] Population-level version of Figure 21 in the baseline report.

IMA Indicator 3: IR 1.2.4 Percentage of target population that views GBV as less acceptable after participating in or being exposed to USG programming.

Figure 4. Index of acceptability of GBV, by health zone and gender[11]



Note: Min value of 0 represents least accepting of GBV, max value of 30 represents most accepting

Table 2. Index of attitudes and norms towards GBV (population-level)[12]

	N	MEAN	SE	MIN	MAX
GBV acceptability (out of 30)	4223	17.4	0.11	0	30
GBV Acceptability (rescaled to 0 - 1)	4223	0.6	0.00	0	1
GBV acceptability (men only)	2109	18.9	0.16	0	30
GBV acceptability (women only)	2114	15.8	0.15	0	30
Norms (men)	4223	2.0	0.02	0	5
Norms for men (men only)	2109	1.8	0.03	0	5
Norms for men (women only)	2114	2.3	0.03	0	5
Norms (women)	4223	1.7	0.02	0	5
Norms for women (men only)	2109	1.8	0.03	0	5
Norms for women (women only)	2114	2.3	0.03	0	5

For Acceptability, Min value of 0 represent being most acceptable of GBV (strongly agree to all statements), max value of 30 being least acceptable of GBV (strongly disagree to all statements). Norms indicate how many out of 5 men/women in a respondents surrounding are acceptable towards GBV.

[11] Population-level version of Figure 22 in the baseline report.
[12] Population-level version of Table 13 in the baseline report.

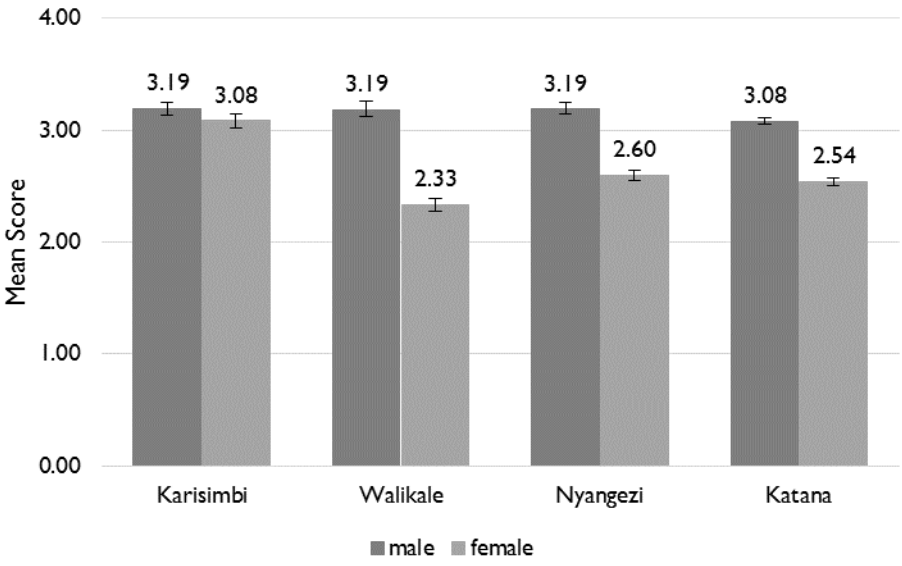
IMA Indicator 4: IR 2.3.2 Percentage of target population reporting disagreement with identified barriers to accessing GBV-related community services

Table 3. Barriers to accessing GBV-related services (population-level)[13]

	N	MEAN	SE	MIN	MAX
Barriers to GBV service access no family (out of 6)	4223	2.43	0.04	0	6
Barriers to GBV service access no family (women only)	2114	2.38	0.06	0	6
Barriers to GBV service access no family (men only)	2109	2.48	0.06	0	6
Barriers to GBV service access family (out of 6)	4223	2.60	0.04	0	6
Barriers to GBV service access no family (women only)	2114	2.51	0.06	0	6
Barriers to GBV service access no family (men only)	2109	2.70	0.06	0	6

Indicates how many out of 6 possible barriers to access to GBV-related services are identified by respondents

Figure 5. Number of indicated barriers to access GBV-related services if perpetrated by family member, by health zone and gender, at the population-level[14]



[13] Population-level version of Table 14 in the baseline report.

[14] Population-level version of Figure 23 in the baseline report.

Figure 6. Number of indicated barriers to access GBV-related services if perpetrated by non-family member, by health zone and gender, at the population-level[15]

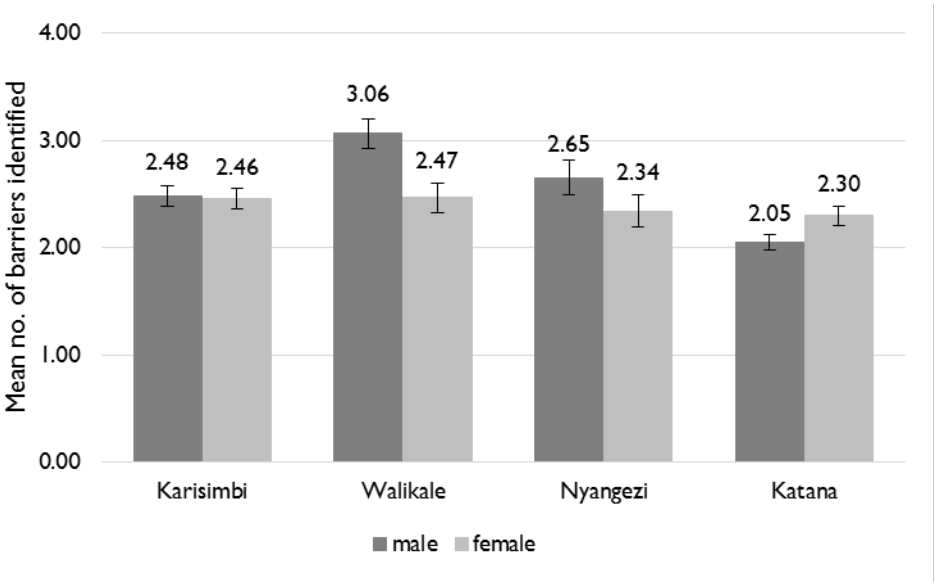


Table 4: Barriers to access to GBV-related service if perpetrated by non-family member

	N	MEAN	SE	MIN	MAX
Doesn't want family to know	3734	0.39	0.01	0	1
No money for transport	3734	0.50	0.01	0	1
Doesn't know where to get help	3734	0.46	0.01	0	1
Doesn't want others to know	3734	0.27	0.01	0	1
No money for fees	3734	0.45	0.01	0	1
Doesn't think services will help	3734	0.48	0.01	0	1

Table 5: Barriers to access to GBV-related service if perpetrated by family member

	N	MEAN	SE	MIN	MAX
Doesn't want family to know	3776	0.38	0.01	0	1
No money for transport	3776	0.57	0.01	0	1
Doesn't know where to get help	3776	0.51	0.01	0	1
Doesn't want others to know	3776	0.28	0.01	0	1
No money for fees	3776	0.50	0.01	0	1
Doesn't think services will help	3776	0.49	0.01	0	1

[15] Population-level version of Figure 24 in the baseline report.

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