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Victims of Torture Fund Evaluation of the IRC Gender-Based Violence Program in the Democratic Republic of the Congo

May 2009

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Danuta Lockett and Paul Bolton

May 8, 2009

Acronyms

AED	African Centre for Human Rights Education (Action pour Education aux Droits
CBO	community-based organization
CIP	Centre d'Intervention Psychosocial
COOPI	Cooperazione Internazionale
DRC	Democratic Republic of the Congo
FDLR	Forces Democratiques de Liberation du Rwanda
FRCD	Congolese National Army
GBV	gender-based violence
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome (AIDS)
IRC	International Rescue Committee
JHU	Johns Hopkins University
NGO	nongovernmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
STD	sexually transmitted disease
TA	technical support or assistance
USAID	U.S. Agency for International Development
VTF	Victims of Torture Fund

Introduction

The USAID-Victims of Torture Fund (VTF) seeks to promote the treatment of survivors of torture and trauma. From 2002 to 2008, the Fund has contributed more than $9 million to programs designed to assist girls and women who have been victimized by the decade-long armed conflict in eastern Democratic Republic of the Congo (DRC). Since 2002, the USAID mission has awarded $6,056,020 to the International Rescue Committee (IRC) program to assist survivors of sexual and gender-based violence (GBV) in the Kivus. USAID's other partner, the Cooperazione Internazionale (COOPI), has managed projects on sexual and gender-based violence since 2003 in Ituri, and since 2004 in Maniema.

The USAID mission requested that VTF evaluate recent progress under the IRC program, focusing on the period from 2007 to the present, which corresponds roughly to the following agreement periods:

- May 2006 – April 2008
    - 2006 (Cost extension) $1,618,000
    - 2006 (Incremental Funding) $400,000
- May 2008 to May 2009
    - 2008 (Cost extension) $1,187,924

The VTF team, comprised of Drs. Danuta Lockett, consultant and adviser to the Fund, and Paul Bolton, head of the VTF's grant to Johns Hopkins University (JHU), was in the DRC from April 6 through April 15, 2009 to evaluate the South Kivu-based IRC program. In addition to assessing progress, the team considered ways the Fund can continue to play a strategic role in addressing the needs of survivors in eastern Congo. During the visit, Dr. Bolton also provided another round of technical support to IRC on evaluating the psychological well-being of beneficiaries.

This report is divided into sections on (1) IRC evaluation findings, (2) recommendation for continued VTF engagement in DRC, and (3) a summary of technical assistance to IRC under VTF's agreement with JHU.

IRC Evaluation Findings

Using the original design and plan stipulated in the May 2006 proposal and agreement, the team hoped to determine IRC's progress in meeting stated goals and objectives. However, during the course of the evaluation it became clear that IRC has evolved and refined the original plan in substantial ways. Consequently, the team decided that the evaluation should shift its purpose from whether IRC has carried out its original plan to how well IRC has adapted the program to fit realities on the ground and whether, in hindsight, those adaptations were appropriate. When examining progress, the team also referred to the results of the 2005 VTF assessment, which identified the need for IRC to improve oversight of its partners and to measure outcomes at the beneficiary, as well as partner level.

Programming Challenges

The operating environment continues to present challenges to programming in eastern DRC. Flare up and pockets of instability are expected to continue in the Kivus. Increasingly, the Democratic Liberation Forces of Rwanda's (Forces Democratiques de Liberation du Rwanda [FDLR]) presence in South Kivu is a menace, and violence is expected to increase as the Congolese National Army (FRDC) mounts campaigns to splinter and defeat the FDLR. Incidents of sexual violence related to military action are expected to increase as well. The prospect of escalating violence looms over the territories as humanitarian agencies prepare for worse possible scenarios. While IRC has shifted its strategy to a long-term recovery program, it is likely that programs should continue to be prepared to respond to emergency needs.

Another constant challenge is the capacity of local partners to deliver services. Governance, management, and technical depth of partners' staff varies, despite best of intentions and oversight. High staff turnover plagues several organizations, making it difficult to retain IRC-trained counselors, as an example. Other organizations, such as IRC's legal partner the African Centre for Human Rights Education (Action pour Education aux Droits [AED]), have been embroiled in internal conflict causing IRC to shift its strategy. An increasing number of local NGOs, reportedly around 400 in the Kivus according to a recent survey from the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), are proclaiming interest in GBV. Only a few, however, are viewed seriously enough to be part of the core GBV coordination group. Similarly, more international NGOs are interested in GBV issues, and a number offer a referral and case management model similar to IRCs.

The success of a small-grants program, such as IRCs, depends on the reach and ability of local service providers. Although more organizations locally claim GBV capacity, IRC's experience points to just a few that are able to deliver services. AED, IRC's legal partner, is not operational in all of the GBV program sites, for example, limiting the ability of NGOs to refer clients interested in legal services.

Access continues to be an issue. Poor infrastructure makes it physically difficult and expensive to reach affected areas, particularly during the wet season. Numerous areas remain insecure and/or inaccessible by road, impeding the ability of local organizations to reach beneficiaries and for beneficiaries to reach the services to which they are referred.

Program Refinements

Overall, the team noted that IRC has greatly tightened the management and technical supervision of its partners. There is more direction and standardization of service provision. IRC has reduced the number of local NGO partners from fourteen to five with good track records, and the number of community-based organizations (CBO) from twenty-five to nineteen. At the same time, it has deepened the technical support and monitoring of partner performance. This includes standardization of the types of services that partners provide. Currently, all four of the partners (not including AED) focus on the provision of psychosocial services, whereas in the past, the nature of services varied greatly with much discretion on the part of the partners. Similarly, IRC

has expanded the size of subgrants to its NGO partners in recent months to test their capacity to advance and broaden services. See Appendix B for a map of programming sites.

The program has also built links with women's associations, identified as CBOs, to foster community advocacy and build opportunities for socio-economic integration. IRC has also boosted and deepened trainings of its partners and engaged IRC staff in more technical oversight and assistance. IRC-GBV staff has incorporated those refinements into a new draft logframe, which is being rolled out for 2009 onwards.

A budget analysis comparing IRC's distribution of resources by areas for the period 2006 to 2008 to that of 2008 to 2009 indicates the organization's shift in programming priorities. Greater resources are being dedicated to staff monitoring, technical assistance, training, and the provision of subgrants to GBV partners:

Shift in the Distribution of Resources by the International Rescue Committee from 2006-2009		
Resource	**2006-2008**	**2008-2009**
Personnel	18 percent	30 percent
Capacity building	4 percent (mainly psychosocial and community education)	15 percent (43 percent psychosocial, 26 percent medical, 15 percent community education, 15 percent institutional capacity building)
Advocacy	3 percent	10 percent
Direct support/funding to partners	• 35 percent CBOs, psychosocial and legal • 40 percent fistula repair. Funded by USAID- Safe Motherhood (not VTF). Money channeled to Panzi and Health Africa by the IRC-GBV program. This component ended in April 2008 and is now managed by USAID's partner, Engender Health.	45 percent • CBOs-8 percent • Psychosocial-30 percent • Legal-7 percent • Medical: 0 percent Note: Only capacity building trainings are provided by IRC-GBV. All drugs and equipment are provided by IRC Health or other medical INGOs. IRC-GBV covers the cost of medical care of survivors where services are not free. This money is included in the subgrant amount awarded to psychosocial partners and is relatively minimal when compared to the entire budget.

Specific Program Findings

1. *Fewer, higher-quality NGO partnerships have resulted in a more manageable, streamlined program.* IRC staff is more focused on technical support and management oversight. The

result is more direction and standardization of partner interventions and better knowledge of what partners are doing, especially in the psychosocial and medical fields. The resulting deepening of capacity of four NGO partners is being tested by IRC's recent 30 percent increase in the size of grants. So far, the evidence suggests that local partners are up to the task of managing larger grants.

2. *Increased technical support to partners has improved their capacity to deliver services and monitor results, especially in the psychosocial area.* Services are better defined, trainings expanded, and quality criteria developed for oversight by NGO supervisors and IRC staff. Knowledge levels are tested after training and quality checklists maintained (see Appendix C for example). A new partner's intake and action plan was redesigned and introduced in 2008, for example, to improve counselors' ability to assess the needs of beneficiaries and make referrals. IRC has evolved several instructional and analytical tools in the areas of advocacy (action plans development for NGO partners and CBOs), situational analysis, and case management tracking forms.

3. *CBOs are increasingly becoming an important service delivery arm for IRC, although they are distinct from IRC's NGO partners.* Some CBOs are stronger or more active than others. They evolve out of community needs and their membership strength, reach, standing, and capacity can vary greatly, making some more reliable than others. However, IRC finds they are an important complement to NGO partners where their work overlaps. Also, in areas where local partners are not working, CBOs may be the sole outlet for services. On average, CBOs receive $3,000 to implement psychosocial and socio-economic activities, and $1,000 for advocacy campaigns. IRC has increased the CBO implementation cycle from six to ten months so they can properly develop activities. IRC is proceeding cautiously in finding ways to strengthen CBOs without destroying their organic and voluntary nature.

4. *IRC's quality criteria are comprehensive, appropriate, and measurable.* For example, NGO partner supervisors and IRC staff utilize quality criteria checklists developed in 2007 to rate the provision and quality of services being provided by counselors in individual, group, and family mediation sessions. A threshold of practices must be in evidence to receive a quality score. Similarly, partner supervisors utilize a quality criteria checklist to ensure that survivors are receiving quality care at the different medical sites. See appendix for an example of a quality criteria checklist for psychosocial care.

5. *Training has been an important component of IRC's strategy to strengthen the capacity of NGO partners and CBOs in the areas of psychosocial interventions, health, and advocacy.* Starting in 2007, the GBV program expanded the training of NGO partner counselors from one week-long session, which included the topics of case management, individual and group counseling techniques, and family mediation, to quarterly week-long sessions on each of those training topics. A session on psychosocial approaches with adolescents and children is planned in May 2009.

   In 2008, IRC revised the holistic psychosocial training for CBO partners and expanded the training by a day. A greater emphasis was placed on identifying common problems and exchanging potential solutions among participants. Additionally, IRC reinforced the training component on how to refer women to specialized services delivery with a special emphasis on the importance of accessing services within seventy-two hours of the time of sexual assault. The GBV staff work closely with IRC Health to train health staff and community

workers in the four health zones. In 2008, IRC provided training to AED in case management and principles guiding work with survivors of sexual assault. In the last three years, IRC has developed new trainings for CBOs in women's leadership (includes a session with local leaders on how to involve women more directly in decision making), advocacy, and adult literacy, and revised a unit on HIV/AIDS and STDs. Literacy trainings are done with the help of an outside consultant from a local NGO, which trains the identified CBO teachers in an adult literacy curriculum. Training in HIV/AIDS and STDs has also been very positively received, and community education sessions with youth and local leaders are carried out by IRC staff with participation from the CBO. CBOs have asked for family planning training, which IRC hopes to address during the next implementation phase. See Appendix D for a summary of trainings provided in the 2006 to 2009 period.

6. *Reporting requirements are clear and data collected by NGOs and IRC staff are collated monthly into a database showing progress on outputs and indicators.* The data feed into quarterly reports to USAID. The amount of information collected by NGO partners is extremely detailed. The data descriptors are included in Appendix E with a sample quarterly summary of statistics.
7. *Shifting the delivery of medical services for survivors of sexual assault in 2006 into its larger primary health care package strategically helped refocus staff attention to improving the quality of GBV programming.* GBV staff is collaborating with IRC Health in training staff and community workers in the South Kivu health zones. IRC Health implements a free healthcare policy for survivors of sexual assault. The GBV program covers the cost of care under NGO subgrants where services are not free.
8. *Not all local NGOs have an active legal partner in their zones, limiting the range of services it can offer beneficiaries.* Most victims of sexual violence ask for legal action to protect themselves from further assault. Additionally, many other victims of gender abuses seek legal assistance in civil matters related to property rights, inheritance claims, and child custody. The range of assistance that IRC's legal partner, AED, has provided since 2005 includes provision of information on a woman's legal rights, arbitration of civil claims, and assistance in civil and criminal cases. An evaluation of AED in 2007 showed important gaps in AED's internal referral system. IRC attempted to rectify that gap through training. However, recent management upheaval within AED has affected its ability to deliver services. IRC is contemplating a more strategic review of the legal component to better define the nature of services possible and expand partners to broaden access in the future.
9. *IRC has attempted to deepen the level of advocacy at the community level beyond raising awareness of rights by pilot testing six- to eight-month advocacy campaigns designed by three NGO and three CBO partners.* IRC staff trained partners in the dynamics of advocacy and how to structure campaigns on issues of importance to the community. Partners developed action plans to address the key problems they identified. Early results appear promising, especially the ability of partners to mobilize local leaders. A report of final results will be available in June 2009.
10. *Socio-economic integration is now largely being implemented through the CBOs, while IRC examines how best to re-engage local NGOs in socio-economic activities.* Previously, beneficiaries had access to community fields rented in the name of the NGO, and were able to share the proceeds after the harvest. However, in 2008 IRC suspended funding for that

activity because participation criteria were vague and the distribution of income from sales unclear. NGOs were not able to clearly demonstrate who benefitted and how. Alternatively, IRC supports the purchase of land in the name of CBOs. CBOs identify the most vulnerable members of their group to work the fields and to participate in livestock rotations. The harvest from those fields is sold collectively at local markets and the proceeds are split among the beneficiaries. IRC is reviewing its overall socio-economic integration strategy to improve options. Among the activities being considered is the introduction of a household kit for beneficiaries who meet vulnerability criteria, and a review of experiences in other IRC country programs where socio-economic activities are being implemented.

Suggested Improvements

- In the future, IRC should update its operational logical framework and performance monitoring reports to align more closely to shifts in programming when such shifts occur. The fact that this was not done should not diminish IRC's notable achievements in refining the program since 2006.
- IRC should be encouraged to continue to examine ways of expanding its socio-economic and legal interventions to provide better options for referrals. IRC intends to examine ways legal interventions can be broadened beyond criminal prosecution to civil actions that address women's legal rights. Similarly, IRC is interested in examining ways community protection mechanisms can be extended to women to protect them against perpetrators, when legal options are limited. IRC is planning to expand economic support beyond the provision of inputs (seeds and tools, for example) to income-generation activities that have the potential for more sustainable outcomes.
- A curriculum for support groups, which NGO partners are evolving, is needed, as IRC recognizes. Interest in forming support groups is growing, but few formalized mechanisms on structure and process are used.
- Recruitment and turnover are enduring challenges for the program and need to be addressed more systematically. This appears to be a larger challenge for IRC than for other organizations, due to the perception that IRC provides more training but lower salaries than other like organizations.
- To date, efforts at impact assessment have focused solely on the psychosocial aspects of the program. Future efforts need to be structured to include socioeconomic, legal, and advocacy areas.
- The revised version of the logframe (a draft version of which was viewed by the assessment team) should be completed, particularly the sections referring to indicators and means of verification. IRC should use its internal monitoring and evaluation capacity at its headquarters as a resource for the program.
- IRC recognizes the importance of including men as part of the solution to gender-based violence, as it has done in advocacy campaigns. A more articulated view of how men can be included in community-level campaigns and integration efforts would be helpful, fully understanding the need to maintain the privacy of women who have been sexually violated.

Recommendation for Continued VTF Engagement in DRC

Some improvements in function are expected after beneficiaries receive medical care and economic assistance. Feeling well, returning to function, and having the financial means to survive arguably are foremost in aiding recovery. However, not all individuals achieve this with existing interventions. Counselors who work for IRC's four local partners that deliver psychosocial services stated informally that 70 percent of their caseload shows signs of medium-level trauma, and 10 percent shows high levels of symptoms. Counselors believe that they are able to clearly differentiate between symptoms of stress (which resolve when stress is reduced, through improved security, general counseling, and support programs that address social and economic recovery) and symptoms of trauma in their beneficiaries (which do not resolve with improvements in one's situation, but require specific psychological treatments).

Under present circumstances, counselors point out that they need more specialized training in interventions that can address the symptoms of trauma. Currently, IRC training encompasses broad-level skills in active listening, family mediation, and case management (identifying needs, making referrals, and following up), but does not include trauma treatment. This broad approach is likely effective in addressing stress, but not sufficient for reducing some of the persistent symptoms of trauma.

Meanwhile, there appears to be a growing interest among other organizations in South Kivu in implementing programs similar to IRC's program that addresses the psychosocial needs of survivors or refers individuals to such psychosocial programs. However, few resources are available to cultivate that growing interest in a responsible manner.

Currently, VTF has an agreement with Johns Hopkins University (JHU) to design, monitor, and evaluate psychosocial programs. The original intent of that agreement was to identify promising interventions in the torture and trauma fields, and to promote effective programming by measuring the effectiveness of those interventions in collaboration with VTF's implementing partners. Previous assistance to IRC was fashioned under this type of agreement.

There are many interventions being promoted by numerous organizations and practitioners today, but few have solid evidence behind them to suggest that they are effective. The Fund was created to help treat survivors and to promote the training of providers in promising interventions. Through a state-of-the-art review, JHU has identified several evidence-based interventions that address the mental and psychosocial problems of torture survivors and are suitable for use by local NGO providers working in low-resource environments at the community level. Two of those interventions are currently being tested under JHU supervision in a torture treatment program being implemented in Iraq by a VTF-financed NGO. JHU is monitoring the effectiveness of the interventions, applying a more rigorous version of the evaluation methods so far used with IRC (See Chapter #3, below).

Note: Contents redacted…..

Summary of Technical Assistance to IRC under VTF's Prior Agreement with JHU

Since November 2005, JHU faculty (at that time working at Boston University) has provided technical assistance to the IRC-GBV program in eastern DRC. That assistance began with a workshop on program design provided to IRC staff, staff of their local partners, and other interested organizations working in that region including COOPI/CIP (Centre d'Intervention Psychosocial). Using those skills, IRC subsequently developed a program logframe for its GBV activities including program monitoring and evaluation. IRC, JHU faculty, and USAID also agreed on terms of reference for a more complete program of technical support for program monitoring and evaluation subsequent to that initial design activity. That included the following activities:

1. A qualitative study of how GBV survivors view their own needs.
2. Development of a quantitative instrument to assess those needs and to assess survivors' ability to function (since restoration of function is a major concern of the Fund). This includes local testing of the instrument.
3. Testing and finalization of the instrument. Training of IRC-GBV program staff in the supervision of data collectors and the management of the resulting data. The latter includes training in a data entry and management software program, and in basic analysis using that program.
4. Training of local partner staff in its use, specifically those staff acting as counselors and directly providing services to GBV survivors.
5. Implementation of the instrument into the program regimen. Counselors interview new program participants using the instrument. They then interview them again after participation in the program—months later and/or at the end of their participation.
6. JHU would work with the IRC data management staff to manage and analyze the data to determine program impact.

Compared to other technical support on program design, monitoring, and evaluation (for example in Indonesia and Iraq) provided by JHU to VTF partners, this TA is more limited in its scope and therefore in its ability to yield data from which to draw conclusions. Normally instrument testing includes assessment of instrument accuracy. However, in that case only the feasibility of the instrument (i.e., whether interviewers could use it and whether interviewees understood it) was assessed. Local accuracy therefore remains unproven. In addition, there was no control group to compare what would have happened if participants had not received the program. That factor is important since the likelihood is that other factors in the environment (or even just the passage of time) would affect whether problems and function improved. Therefore, if there were changes in the instrument between pre- and post-intervention assessments it would remain uncertain how much of that change (if any) was due to the program itself. Finally, both pre and post assessments were done by the program staff, which normally introduces a bias in that the participants are more likely to report improvements due to a desire to please the counselor.

Those limitations came about because IRC staff was unwilling to expend the additional resources required for implementing JHU's standard approach of program design, monitoring, and evaluation. In addition, there was recognition on both sides—IRC and JHU—that the program interventions themselves were changing even as they were being implemented. Therefore, it would not be clear at the end exactly what interventions were being assessed. It was therefore decided to accept the ultimate results of the impact assessment as being suggestive only, rather than providing proof of impact.

Multiple delays were experienced in implementing that approach, so that only now are JHU and IRC completing the impact assessment. As of the writing of this report, JHU faculty has completed a very preliminary comparison of the mean problem and function scores at pre- and post-intervention interviews. The preliminary findings are as follows:

1. On recruitment into the IRC program, GBV survivors showed unusually high rates of psychosocial problems and of dysfunction—substantially higher than those of other trauma-affected populations we have assessed.
2. After prolonged exposure to the IRC program, the severity of those problems and of dysfunction showed large improvement, as measured by comparing mean scores pre-intervention with those from interviews conducted after exposure to the program.

Much more detailed analysis is needed. However, given the analysis so far, and taking into account the limitations described above, results suggest that the IRC program is more likely than not to have had a significant effect on GBV survivors. Further analysis and conclusions will be provided in an upcoming final report on that activity.

APPENDIX A: List of Interviews

International Rescue Committee GBV Staff

GBV Coordinator (IRC/DRC-Bukavu) - Sara Moseley
GBV Technical Advisor (IRC/NY) - Karin Wachter
North Kivu GBV Coordinator - Jennifer Melton (IRC/Goma)
Community Based Organization Supervisor - Marlene Bahizire
Community Based Organization Officers (3)

- Julie Gubanja
- Gisele Moella
- Joelle Mulangala

NGO Technical Capacity Unit Supervisor - Claude Kitumaini
Technical Counselor in Psychosocial Support (2)

- Claudine Rusara
- Eugenie Katagata

Technical Counselor in Medical Care/Referral - Daniel Kitumbi
Advocacy and Community Education Supervisor - Oswald Chishugi
Technical Counselor in Community Education - Jessy Kabessa
Technical Counselor in Community Educaiton - Anicet Bukarumi

UEFA

Coordinator - Aldofina Muley
Project Head - Piero Kiesse
Supervisor - Adili Amani
Counselors - Christine Bujiriri, Ceute Kavuo, Furaha Waluka

ANAMAD

Coordinator - Chiza Bambona
Project Head - Adrien Kakola
Supervisor - Safari Buguma
Counselors - Annie Buvigi, Nabushaku Lanishaso, Josephine Buholo

ADIF

Coordinator - Jeanne Safari
Project Head - Desire Kalwira
Supervisor - Fanny Mweze
Counselors - Iragi Rwizibuka, Cinesha Cibalonza, Marie Jeanne Msimire

PSVS

Coordinator - Pascal Bwemere
Project Head - Amini Mwasangala
Supervisor - Furaha Batachoka
Field Supervisor - Aimee Birinowa

AED

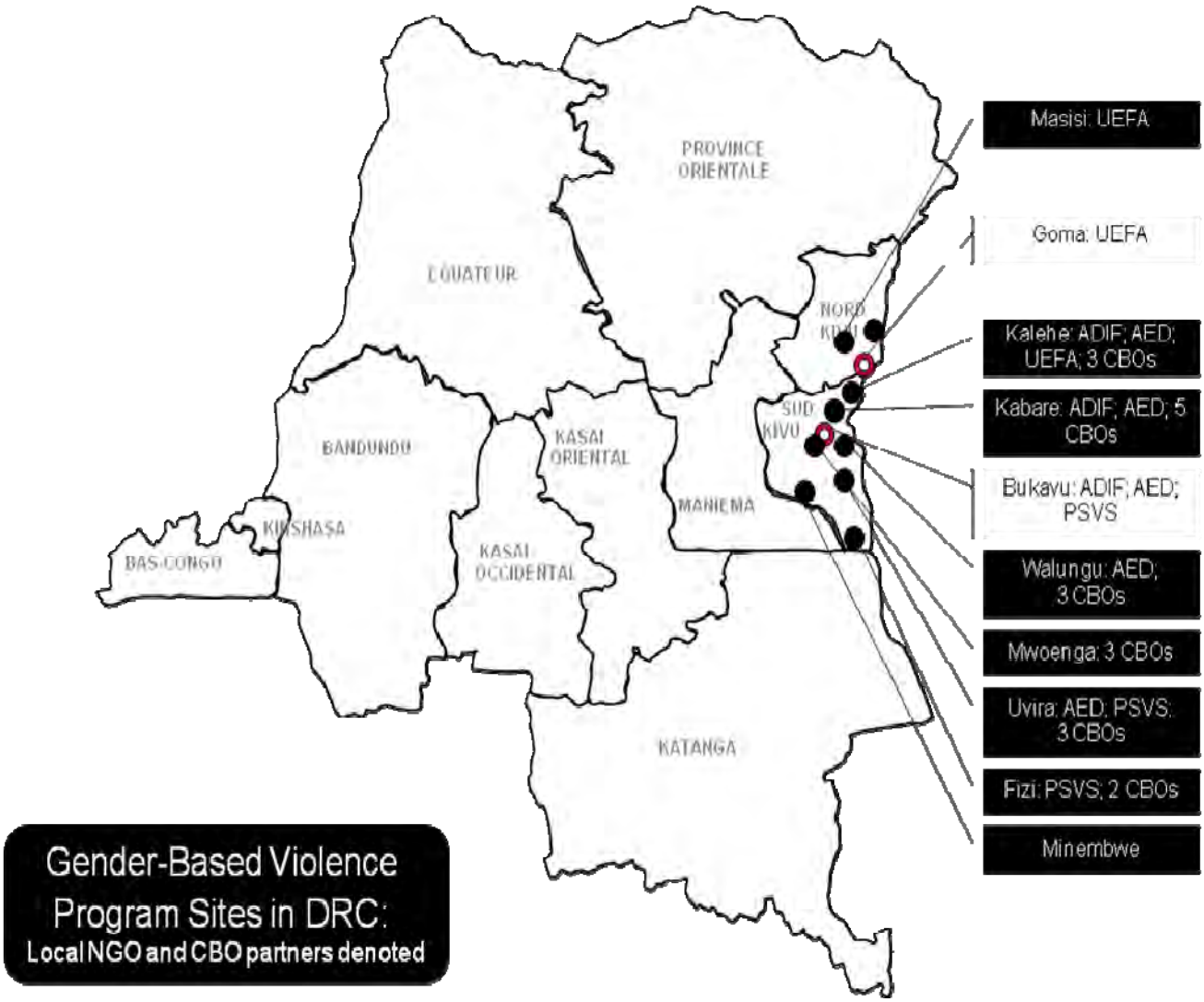
CFK-Women's Association located in Kamanyola
Met with 18 of association's 500 + members, visited agricultural fields.

COOPI - Cooperazione Internazionale
Coordinatrice Psychosociale/Protection RDC - Elena Lucchetti

Malteser
Country Director - Ursula Salesse

Panzi Hospital
Medical Director - Dr. Denis Mukwege Mukengere
PMU-Project Manager Victims of Sexual Violence Project - Maria Bard

APPENDIX B: MAP of IRC-GBV Programming Sites/DRC



APPENDIX C: Counseling Checklist

Checklist pour évaluation d'une séance de Counselling

1) Les pondérations ont été déterminées essentiellement à partir des normes contenues dans le projet sphère.

2) L'observateur attribue une note de 0 à 5 pour chaque catégorie. La note attribuée augmente au fur et à mesure que la qualité du service augmente. L'observateur donne une note de 0 ou 2 lorsque le service ne répond pas à la norme de qualité minimale définie (4, bon). L'observateur donne une note 4.5 ou 5 lorsque la qualité du service dépasse la norme de qualité minimale définie. Une fois la note attribuée, l'observateur la multiplie par l'indice de pondération pour obtenir le total pour la catégorie. L'observateur additionne les totaux de chaque section pour obtenir la note finale. La note finale qui assure que le service est de qualité est de 80 percent (équivalent de notes ' bon' pour toutes les catégories).

		Mauvais	Passable	Bon	Très bon	Excellent	
	Pondération	0	2	4	4.5	5	Total
1. Cadre (environnement)	10						
Environement favorable (sécurisé, privé et sans distractions).	1.00						
Moment approprié (pour la conseillère et la cliente).	1.00						
2. Accueil	15						
La conseillère se présente (Salue la cliente, parle d'elle-même, son rôle, garantit la confidentialité).	1.00						
Position physique de la conseillère convenable (met à l'aise la cliente).	1.00						
La conseillère engage la cliente dans la conversation.	1.00						
3. Ecoute	30						
La conseillère écoute plus qu'elle ne parle.	1.50						

La conseillère utilise des questions ouvertes et précises.	1.50						
La conseillère résume les questions et problèmes discutés.	1.50						
La conseillère réagit adéquatement aux émotions de la cliente.	1.50						
4. Partage de l'information	25						
La conseillère donne une information claire et simple.	1.67						
La conseillère laisse à la cliente la possibilité de réagir.	1.67						
La conseillère répète les renseignements clés pour éviter les malentendus.	1.67						
5. Résolution des problèmes	20						
La conseillère encourage la cliente à identifier les problèmes et à proposer ses propres solutions.	1.33						
La conseillère aide la cliente à opérer un choix parmi les solutions proposées.	1.33						
La conseillère définit avec la cliente le système de suivi.	1.33						
Note totale (percent)							

Observations et Recommandations:

Date:
Conseillère observée:
Observateur:

APPENDIX D: Training Matrix 2007 to 2009

DATES				Participants			Partenaires beneficiaires								Resultats tests				Observations
															Pre	Post			
Du	Au	LIEUX	THEMES	H	F	Total	ADIF	AED	ANAMAD	PSVS	UEFA	RECO	CODESA	FOSA	<60	>60	<60	>60	
	March	**Bukavu**	**Community Education**																
Du 17 au	20 mars 09	Goma	**Technique de mediation familiale (incluant des notions sur le VIH-SIDA et la prise en charge legale des VVS)**	**3**	14	17	0	0	0	0	17	0	0	0	13	3	1	15	Le CP n'a pas participe au pre et post-test
Du 3 au	6 mars 09	Bukavu	**Technique de mediation familiale (incluant des notions sur le VIH-SIDA et la prise en charge legale des VVS)**			23	13	0	0	10	0	0	0	0	18	5	1	22	
	February	Itombwe	**Prise en charge medico-sanitaire des victimes de violences sexuelles, la gestion des outils CPLVS, les concepts selon la nouvelle loi sur les violences sexuelles en RDC**																
Du 25 au	27 Fevrier 09	Minembwe	**Prise en charge medico-sanitaire des victimes de violences sexuelles, la gestion des outils CPLVS, les concepts selon la nouvelle loi sur les violences sexuelles en RDC**			38	0	0	0	0	0	0	0	38	26	5	5	26	Les participants retardataires au pre-test ne passent pas le pre et post-test
	Feb	Kalehe	**Des rappels sur la prise en charge medico-sanitaire des victimes de violences sexuelles, la gestion des outils CPLVS, les concepts selon la**																

			nouvelle loi sur les violences sexuelles en RDC															
Du 29 au	29 Janv.09	Kabare	**Des rappels sur la prise en charge medico-sanitaire des victimes de violences sexuelles, la gestion des outils CPLVS, les concepts selon la nouvelle loi sur les violences sexuelles en RDC**			17	1	1	0	0	0	0	0	0	5	7	1	11	Idem
Du 2 au	3 fevrier 09	Kabare	**Gestion de cas et systeme de reference**			45	0	0	0	0	0	45		0	22	9	6	25	Idem
Du 23 au	24 Janvier 09	Kalehe	**Gestion de cas et systeme de reference**			35	1	1	1			35		0	15	14	15	16	Idem
Du 19 au	20 janv.09	Bukavu	**Gestion des cas** (pour les membres et animateurs des noyaux AED)			20	0	20	0	0	0	0	0	0	19	0	7	12	Idem
	Oct	Bukavu	**Advocacy**																
Du 21 au	24 Oct.08	Bukavu	**Techniques de counseling individuel et collectif**			22	12		0	0	10	0	0	0	21	1	17	5	
Du 14 au	17 Oct.08	Bukavu	**Techniques de counseling individuel et collectif**			18	0	0	9	9	0	0	0	0	18	0	14	4	
Du 25 au	28 Aout 08	Bukavu	**Developpement des materiels d'IEC**																
Du 19 au	21 aout 08	Goma	**Formation psychosociale** (Generalites sur les violences, Notions sur le traumatisme, la gestion des cas, les techniques de counseling individuel et collectif, les outils du volet psychosocial et			22	0	0	10	0	11	0	0	0	20	1	3	15	une personne n'a pas fait le post test

			l'outil de fonctionnalite/BOSTON)																
Du 29 au	31 Juillet 08	Bukavu	**Formation psychosociale** (Generalites sur les violences, Notions sur le traumatisme, la gestion des cas, les techniques de counseling individuel et collectif, les outils du volet psychosocial et l'outil de fonctionnalite/BOSTON)			19	9	0	0	10	0	0	0	0	17	1	15	4	
			Trainings Below - Phase VI -- 2007-2008																
			Leadership et promotion du genre			29	8	0	7	9	5	0	0	0	29	0	17	12	Deux pre et post test etaient administres (pour chacun des themes)
Du 25 au	28 Fev.08	Bukavu	**Plaidoyer**			29	8	0	7	9	5	0	0	0	24	5	10	19	
Du 17 au	17 Oct. 07	Sange	**Remise a niveau des nouvelles conseilleres recrutees au PSVS sur** les etapes de l'accompagnement psychologique, le counseling et les activites de groupe et sur les outils de gestion psychosociale	0	4	4	0	0	0	4	0	0	0	0	4	0	2	2	

Du 19 au	22 Nov.07	Bukavu	**Prise en charge psychosociale** (generalites sur les violences, Processus de prise en charge psychosociale des VVS, Notions sur les techniques de counseling, les techniques de mediation familiale, La strategie du volet psychosocial, revision des notions sur le traumatisme, amenagement sur certains outils de gestion du volet)	0	18	18	10	0	0	8	0	0	0	0	15	2	6	11	
Du 26 au	29 Nov.07	Goma	**Prise en charge psychosociale** (generalites sur les violences, Processus de prise en charge psychosociale des VVS, Notions sur les techniques de counseling, les techniques de mediation familiale, La strategie du volet psychosocial, revision des notions sur le traumatisme, amenagement sur certains outils de gestion du volet)	2	17	19	0	0	11	0	8	0	0	0	19	0	12	7	
Du 8 au	10 oct. 07	Kabare	**Education communautaire**	24	19	43	0	0	0	0	0	43		0	43	0	25	18	
Du 26 au	28 sept.07	Kalehe	**Education communautaire**	30	3	33	0	0	1	0	0	32		0	33	0	18	15	
DU 13 au	18 aout 07	Kalehe	**Prise en charge medico-sanitaire des victimes de violences sexuelles et sur les IST-VIH/SIDA**			13	1	0	1	0	0	0	0	13	7	6	2	11	Ces deux formations etaient organisees conjointement avec le programme sante
Du 20 au	25 aout 07	Kabare	**Prise en charge medico-sanitaire des victimes de violences sexuelles et sur les**			22	0	0	0	0	0	0	0	22	18	4	3	19	

			IST-VIH/SIDA															

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APPENDIX E: Selected Database Summary- Clients Assisted by IRC Psychosocial and Legal NGO Partners, per Service, September-November 2008

		Number of clients receiving services, September-November 2008											
NGO Partner	**Geographic Location (Province)**	Total Clients Served this Quarter[2]	Newly Identified Clients this Quarter[3]	Total Number of Clients Served to Date in Phase 7	**Psycho-Social Support**	**Family Mediation**	**Medical Care**	**Socio-Economic Activities**	**Legal Reference**	**Legal Assistance**	**# People Who Participated in Comm. Education**		
											TOTAL	**Hommes**	**Femmes**
ADIF	Kabare and Kalehe Territories (South Kivu)	695	174	901	624	18	132	517	2	0	2855	1817	1559
AED	Bukavu and periphery; Fizi, Mwenga, Uvira, and Walungu Territories (South Kivu)	22	43	25	0	7	0	0		22	490	0	0
ANAMAD	Kalehe Territory (South Kivu)	89	80	183	89	5	59	8	10	0	2172	1032	1140
DOCS HEAL	Goma and periphery; Masisi, Lubero, Rutshuru, and Walikale Territories (North Kivu)		-	0	-	-	-	-	-	-	0	0	0
PANZI	Fizi, Kabare, Kalehe, Mwenga, Uvira, and Walungu Territories (South Kivu)	0		0									
PSVS	Fizi and Uvira Territories (South Kivu)	397	128	537	356	7	108	91	1	0	2938	1456	1482
SOPROP				0									
UEFA	Goma and periphery; Masisi and Rutshuru Territories (North Kivu)	260	219	407	176	7	224	18	0	0	3758	3232	2117
TOTAL		**1463**	**644**	**2053**	**1245**	**44**	**523**	**634**	**13**	**22**	**12213**	**7537**	**6298**

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