Knowledge for action: The power to make a difference!

United Nations Entity for Gender Equality and the Empowerment of Women

Name of the project: **Traditional Leaders Championing Prevention of Domestic Violence in their Communities Project in Lesotho and Malawi**

Locations of the evaluation conducted – Malawi (Phalombe, Nsanje and Blantyre Rural) and Lesotho (Leribe and Berea)

Period of the project covered by the evaluation (month/year – month/year) - 15 August 2011- 31 October 2014

Date of the final evaluation report (16 December 2014)

Name and organization of the evaluators – Holistic Development Trust

Name of the organization(s) that commissioned the evaluation - SAfAIDS

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List of acronyms and abbreviations

ART	Antiretroviral therapy
CBO	Community Based Organisation
CBV	Community Based Volunteer
CSO	Civic Society Organisation
DV	Domestic Violence
FAST	Friends of AIDS Support Trust
FBO	Faith Based Organisation
FGD	Focus Group Discussion
GBV	Gender Based Violence
GSP	Gender Support Program
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
IPV	Intimate Partner Violence
KAPB	Knowledge Attitude Behaviour and Practice
MasP	Men as Protectors
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
PLWHIV	People Living With HIV
RL	Religious Leaders
SADC	Southern African Development Community
TL	Traditional Leaders
TOT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNTF	United Nations Trust Fund
UNWOMEN	United Nations organization dedicated to gender equality and empowerment of women
VFU	Victim Friendly Unit
VSU	Victim Support Unit
WHO	World Health Organisation

Executive summary

In Malawi, HIV prevalence varies by sex, age, urban-rural residence and geographic location; and is higher among females (12.9 % vs. 8.1 %) than males. In addition, people living with HIV suffer physical, psychological and sexual violence, In Lesotho, HIV infections are higher among women than men, with less than 50% of people living with HIV aware of their status, and only 29% on retroviral therapy. Gender based violence remains one of the big challenges that women face in both Malawi and Lesotho, with domestic and sexual violence being the most common forms of violence against women. These are associated with increased risk of HIV infection in women. Both countries have adopted and are implementing National Plans to End Gender Based Violence.

The project evaluated in this document was implemented to combat socio-cultural issues related to Gender Based Violence and HIV in Malawi and Lesotho. It was implemented by SAfAIDS over 36 months from August 2011 to October 2014, and was funded by United Nations Trust Fund to End Violence against Women (UNTF) monitored through UN Women. The project used traditional leaders in targeted communities in both countries as an entry point, and took a comprehensive approach where the broader community was mobilized to challenge cultural, social and institutional practices that perpetuate violence against women and HIV. The overall goal was "to significantly contribute to the prevention and eradication of intimate violence/domestic violence against women aged 15-49 years in Lesotho and Malawi by 2015 through promoting gender equality, ensuring women's rights and reduction of harmful cultural practices that fuel violence against women".

This evaluation is an end of term evaluation where the project outcomes are being evaluated against the project objectives in order to fulfill the accountability and learning agenda. The project evaluation shows "the extent to which the project has contributed to the reduction in intimate partner violence in Lesotho and Malawi" in the targeted areas. The overall objectives of this evaluation were to:

1. Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact, with a strong focus on assessing the results at the outcome and project goals
2. Generate key lessons, working and effective models, and identify promising practices for learning
3. Generate recommendations for program scale up and advocacy, and to inform future resource investment in HIV and DV integrated prevention

The evaluation report is intended primarily for UNTF (the donor), partners and various government and non-government stakeholders to help in future planning of similar interventions.

The evaluation used a mixed approach. Structured and semi structured questionnaires were administered to randomly selected traditional leaders and individual community members. 2:3 men to women ration was applied in the sampling of individual community members. Men only, women only and mixed men and women focus group discussions were conducted in both

countries. Key informant interviews with implementing partners and other stakeholders were also held. Secondary data including project reports and other country reports like the Country Demographic and Health Survey Reports (DHS) and the Country National HIV Prevention Strategies were reviewed in the evaluation process.

The main findings of the evaluation are as follows:

- About 9 in 10 Traditional Leaders reported a decline in the prevalence of DV cases within communities ever since the start of the project, with two thirds of the TLs reporting the average number of DV cases they were handling per month in traditional courts had gone down by half between 2011 and 2014.
- The project managed to train thereby strengthening the capacity of 9 CBOs/FBOs; 6 Government Departments and 2 000 Traditional and Religious Leaders in both countries in cultural approach to addressing harmful cultural practices that promote violence against women and increase risk to HIV infection. Other important cadre trained through the project were Community Based Volunteers (45) and Men As Protectors (10 800).
- The project reached out to over 480 000 women and girls, and an estimated 316 000 men in Malawi and Lesotho through various DV and HIV prevention activities during the three year project cycle. This far surpassed project targets of 10 000 women and girls and 3 000 men respectively. The most common sources of DV messages were the radio, TLs/RLs, CBVs and printed materials, in that order.
- About 3 600 IEC material were produced and distributed between the two countries to support training of communities. IEC materials produced in Chichewa, Sesotho and English languages were useful in supporting the role of CBVs, paralegals and Traditional Leaders presiding over traditional courts in dealing with DV cases. They helped as key referral documents for these community cadres.

- Out of the TLs that received at least one DV case in the 12 months preceding the evaluation, 8 out of 10 TLs provided relevant counseling services to the couple; half of the TLs addressed couple together with relatives; two thirds of TLs referred cases to police; two fifths referred to clinics; one third of TLs referred to NGOs; one quarter referred to courts whilst another 1 in 10 referred to CBOs. There has been an increase in the proportion of TLs making appropriate referrals of DV cases to police, medical health providers, courts of law and NGOs/CBOs.
- About 8 in 10 community members in both countries indicated TLs and RLs were speaking out against domestic violence at various public gatherings and encouraging women and girls to report cases of abuse.
- Whilst all TLs in Lesotho reportedly knew cultural practices that increase risk of DV and HIV infection, only one in three TLs in Malawi knew such cultural practices. Similarly, three quarters of men and women in Lesotho compared to one quarter of community members in Malawi knew the intersection between HIV and GBV and the linkages with cultural beliefs and practices.
- The most common harmful cultural practices reported in the evaluation which includes initiation practices; wife inheritance; shaving off hair with same razor blade at funeral services; and customary practice prohibiting women from returning home for 6 months

after giving birth were all reported (by community members, religious and traditional leaders) to be dying as people are becoming more aware of the risks of HIV infection.

- Whilst there has been increased knowledge of the intersection between HIV and GBV among CBOs, FBOs, and government gender staff trained through the project, need still exists in supporting trained cadres to foster the political will and commitment from top echelons of government which includes Ministers and Permanent Secretaries to speak out against domestic violence against women and children.
- About 8 in 10 TLs and RLs in both countries have been conducting DV and HIV related awareness campaigns and meetings in communities. Whilst three quarters of TLs/RLs in Malawi were able to conduct more than one such campaign per month, only half of TLs/RLs in Lesotho were able to hold more one such campaign per month.
- Three quarters of TLs/RLs holding DV and HIV campaigns used own residence whilst 9 in 10 TLs/RLs in Lesotho conducted such campaigns at community halls/venues. Use of locally existing structures has been cost effective with wider community reach.
- About 90% and 100% of women in Malawi and Lesotho were aware that men did not have the right to control or discipline women through physical means. However, two fifths of women in Malawi believe a woman's freedom should be limited. Women and girls with little or no education were more likely to accept restrictions in their freedom by men. One third of women in Malawi believe reporting family/domestic abuse brings disrespect to the spouse.
- Of women who knew someone, witnessed or experienced DV in the 12 months prior to the survey, three quarters of women in Malawi compared to half of women in Lesotho reported DV to TLs. Another two thirds of women in Malawi compared to one third in Lesotho reported to relative/spouse. Since project inception, there has been a general increase in women now able to identify and report abuse of all forms to authorities, attributable to trainings and DV prevention campaigns. Most women reported satisfaction with services received from referrals.
- More than half the women interviewed in Malawi and over two thirds of women in Lesotho were exposed to various project materials (like posters, information sheets) about violence against women, with similar proportions reporting participating in quick chat involving project's material. Women with no education were more than two times less likely to have seen any such project materials than women with some education. This could be due to the mere lack of interest as they can not read.
- More than two thirds of men and women in Malawi compared to just about half of community members in Lesotho have seen other community members shunning violence in the 12 months preceding the survey.
- The project has resulted in modification of harmful cultural practices in some parts of Malawi such as wife inheritance, initiation practices, early marriages and polygamous marriages.

The project evaluation came up with the following main conclusions:

- The project contributed significantly towards reduction of domestic violence within target communities;

- The project has increased the capability of women and girls to realize their rights and influence decision making
- Most TLs are now actively conducting DV and HIV awareness campaigns and are now able to address DV cases
- There is increased capacity of formal and informal structures to deal with DV
- There is increased top level commitment by governments of the two countries to address GBV and HIV issues
- The project used existing community structures, making it sustainable through community ownership

Below are some of the proposed recommendations:

- Whilst the TLs have received vital training to address DV and HIV infection, there remains need for further training and replication of efforts for expansion
- The use of several platforms to disseminate DV and HIV messages was useful in educating men and women and transforming attitudes and practices. Platforms for knowledge sharing were effective and need to be replicated to other areas

- Maternal Health Knowledge gaps of HIV transmission from mother to child need to be addressed

- Women and girls continue to be worse affected by DV and HIV infection compared to men in both countries. Women still need to be empowered to access and control socio-economic opportunities.

- Girls' empowerment through Education and Health, social mobilization of parents, community members and other stakeholders to support girls learning and health are critical elements in the fight to eliminate harmful cultural norms that perpetuate DV and HIV infection in women.

In general, the project brought about some positive behaviour change within communities in the fight to eliminate harmful cultural practices that perpetuate domestic violence and increase the risk of HIV infection in women and girls. The model used by SAfAIDS was successful in establishing and strengthening local structures, formal and informal to promote prevention of DV and handle cases of abuse brought before traditional courts. Similar interventions are recommended for scale up to other previously non-target areas.

Context of the project

Malawi

Malawi is a sub-Saharan African country located south of the equator sharing international borders with the United Republic of Tanzania to the north and northeast; People's Republic of Mozambique to the east, south and southwest; and the Republic of Zambia to the west and northwest. The country is divided into three regions: the Northern, Central, and Southern Regions, with a total of 28 districts in the country. Administratively, the districts are subdivided into traditional authorities (TAs), presided over by chiefs. Each TA is composed of villages, which are the smallest administrative units, and the villages are presided over by village headmen[1].

The economy of Malawi is based primarily on agriculture, which accounts for 30% of the gross domestic product (GDP), with the major exports being tobacco, tea and sugar accounting for 85% of domestic exports. The country has an estimated population of 13.1 million people, after experiencing a rapid population growth of 32% from 9.9 million in 1998. Malawi has since adopted a National Population Policy designed to reduce population growth to a level compatible with the country's social and economic goals.

Malawi is among the ten countries with the highest HIV prevalence in the world, estimated at 12% of adults aged 15-49 years. HIV prevalence reached its peak at 16.2% in 1999 before declining and stabilizing at around 12% in 2007. The 2012 Malawi HIV estimates showed that by the end of 2012, 1, 1 million people were living with HIV, with 46,000 annual deaths. The Malawi National HIV Prevention Strategy (2009 - 2013) noted the slight decline in HIV prevalence over the years but described the decline as "shallow" adding that some behavior indicators were stagnating or worse still regressing. Specific examples cited were observations that the proportion of male youth aged 15-24 years having sex with more than one non-regular partner is high whilst on the other hand condom use with non-regular partner remains low.

About 88% of all new HIV infections in Malawi are acquired through unprotected heterosexual intercourse and 10% via mother-to-child transmission whilst the remaining 2% is transmitted through blood transfusions, contaminated medical and skin piercing instruments[2]. The majority of people being infected were observed to be those previously considered to be at low risk, like couples and partners in stable sexual relationships. HIV infection rates in the country were observed to depict gender, age, social status and geographic variations, with infection rates higher in women (12.9%) than men (8.1%), higher in urban than rural populations and higher in the Southern region compared to the rest of the regions (MDHS, 2010).

Within the context of gender, sexual and gender-based violence, gender dynamics that exacerbated risk of HIV infection were noted. WHO noted that physical, sexual, psychological or a combination of these were the most common types of violence against women in Malawi. A 2013 study titled “Patterns of Intimate Partner Violence: A study of female survivors in Malawi”

[1] Malawi Demographic and Health Survey 2010, National Statistical Office, Malawi
[2] National HIV Prevention Strategy 2009 - 2013, Republic of Malawi

showed that 13% of women experienced emotional violence, 20% experienced physical violence and 13% experienced sexual violence. The same report noted that women who cannot read were less likely to report intimate partner violence. A 2013 baseline study, funded by The United Nations Trust Fund to End Violence against Women (UNTF), on Intimate Partner Violence (IPV) among PLWHIV showed that 20% of PLWHIV suffered physical violence, 50% suffered psychological violence and 41% suffered sexual violence. The study also showed that there is an inverse relationship between women empowerment and exposure to intimate partner violence.

In response to the epidemic, the Government of Malawi, in collaboration with stakeholders developed a cocktail of policy measures which include: National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health (2003); National Plan of Action for Scaling up Sexual and Reproductive Health HIV Prevention for Young People (2008-2012); Plan for Scaling up HIV Testing and Counseling (2006-2010); Plan for Scaling up Prevention of Mother to Child Transmission of HIV Services in Malawi (2008-2012); ART Scale up Plan (2006-2010); Condom Strategy (2006); Abstinence Strategy (2008); and Mutual Faithfulness Strategy (2008-2012). Internationally and regionally, Malawi signed the United Nations Declaration of Commitment on HIV and AIDS in 2001 and the Congo Brazzaville Declaration of Commitment to Intensifying HIV Prevention in 2006, respectively. Despite notable success in guiding HIV prevention efforts, one major challenge noted with the various measures described above was their lack of optimal integration, linkage and coordination.

In addressing this gap, Malawi adopted the National HIV Prevention Strategy (2009-2013)[3]. Some of the specific interventions implemented under the specific strategy include: Behaviour change communications; Teaching of life skills education and peer education; Advocacy sessions and community based campaigns; Condom programming; HIV Testing and Counseling (HTC); Promotion of prevention of mother to child transmission of HIV; Blood safety and infection prevention; STI management; Education campaigns against stigma and discrimination due to HIV; and Work place prevention interventions, amongst other measures.

As a result of the various prevention intervention strategies implemented, substantial positive results in behaviour change were documented in population based surveys and qualitative researches. Some of the positive changes achieved were; reduction in the number of people buying sex; reduction in the number of multiple sexual partners; slight increase in the number of people using condoms; increase in the number of median age of sexual debut; increase in number of people going for HIV testing and accepting results; and universal awareness of HIV and AIDS.

However, despite positive results noted above, gaps have still continued to exist in the provision of comprehensive programming in HIV prevention and addressing drivers of the epidemic and ensuring key social groups are reached. Access to HTC and PMTCT services are still limited in some settings and to certain sub-populations as a result some people do not get tested for HIV. There is low uptake of post-exposure prophylaxis (PEP), an intervention which should be available to all who have been subject to coerced sex or occupational exposure. There are still

[3] The National HIV Prevention Strategy 2014 - 2020 has now superseded the 2009-2013 Strategy.

gender inequalities in the country showing a disempowerment of women and widespread poverty contributing to women's vulnerability to HIV and AIDS. Women and girls are also victims of gender-based violence like rape and often fail to negotiate for safe sex with partners thus exposing many women and girls to HIV infection (NHPS 2009-2013).According to the Adolescent Girls Advocacy Network, nearly half of the girls in Malawi marry before age 18, some early as 12 years. Thus these girls are forced to drop out of school, suffer consequences of child bearing and often face a lifetime of abuse at the hands of their much older husbands they did not choose to marry.

Lesotho

Lesotho is a small, mountainous kingdom situated in the southern part of Africa where it is completely surrounded by the republic of South Africa. It is divided into 10 administrative areas covering a total of just over 30,000 square kilometers, with less than 10% arable land.[4] The last national population census, estimated the country population to be just over 1, 88 million people, with 77% of the population residing in rural areas[5]. Lesotho is primarily a country of subsistence farming, with the major agricultural products being wheat, corn, sorghum, and livestock.

At an estimated 23.3%, Lesotho has the third highest HIV prevalence rate in the world after Swaziland (26.0%) and Botswana (23.4%). In Lesotho, the 2013 HIV Estimates noted the following: 71 new infections daily; 5,700 HIV infections among women aged 15-24 compared to 3,500 for men of same age group; only 29% of adults living with HIV were on antiretroviral therapy (ART) as of 2013. The Grenada Grand Anse Reef Regeneration Project (GARRP) report (year) highlighted that there were 80,000 Voluntary Medical Male Circumcisions (VMMCs) between 2012 - 2014; most of them medical. The same report noted that less than 50% of the 360,000 PLWHIV are aware of their status.

As part of measures to address the epidemic, the Lesotho government has adopted and is implementing the National HIV Prevention Strategy for A Multi-Sectoral Response to the HIV Epidemic in Lesotho 2011 - 2015, dubbed the *"National Multi-Sectoral HIV Prevention Strategy, 2011-2015".* While commitments relating to treatment, care, support, and impact mitigation remain vitally important to the national HIV and AIDS response, an intensified HIV prevention response is recognized as a top priority by the Government of Lesotho and internal and external partners[6].

Some of the key drivers of Lesotho's generalized epidemic were identified as heterosexual transmission of HIV within serial, multiple and concurrent partnerships, and vulnerability to HIV infection; low and inconsistent use of condoms during higher-risk sexual acts. Other important factors noted to have an effect on these drivers include high population mobility (men mostly) to domestic and cross-border migration; low-levels of in-depth HIV knowledge, presence of

[4] Lesotho Demographic and Health Survey 2009
[5] 2006 Population and Housing Census
[6] National Multi-Sectoral HIV Prevention Strategy, 2011 – 2015

sexually transmitted infections; alcohol and drug abuse; social and gender norms; gender inequalities and gender-based violence.

A study looking at sexual violence against women in Lesotho indicated that 61% of women reported having experienced sexual violence at some point in their life, with 40% reporting coerced sex, 50% assault, and 22% rape[4]. Findings from the Violence against Women Baseline[7] study show that 86% of the women in Lesotho have experienced some form of GBV in their life time, while 41% of the men admitted perpetration. The National Multi-Sectoral HIV Prevention Strategy for Lesotho documents the practice of harmful traditional and cultural practices that increase risk and vulnerability to HIV infection such as the practice of *chobeliso*, or eloping that involves abduction, rape, and marriage; and the practice of *ho kenela*, or wife inheritance, which places families at-risk non-consensual sex or family members are infected with HIV.

The Convention on the Elimination of all Forms of Discrimination against Women CEDAW report[8] noted that GBV in Lesotho was increasing and remained one of the main challenges facing women in Lesotho. A 2012 US Department of State Country Report for Lesotho[9], observed that between January and December 2010, about 832 cases of sexual offences against women were reported with 311 prosecutions. It further noted that domestic violence against women was widespread, while flagging an important point that "while domestic violence and spousal abuse are criminal offences defined as assault, few cases were brought to trial".

Both Malawi and Lesotho have adopted the National Action Plan to End Gender Based Violence. In both Lesotho and Malawi, culture remains an important aspect of life, and hence the project thrust to adopt a gender and cultural transformative approach to address domestic violence and HIV in both countries. It is against this background that the project was implemented to combat socio-cultural issues related to Gender Based Violence and HIV infection in both countries.

Description of the project

With funding from United Nations Trust Fund to End Violence against Women (UNTF), administered by UN Women on behalf of the UN system, SAfAIDS has been implementing a project focusing on reduction of harmful cultural practices in some targeted communities in Lesotho[10] and Malawi[11]. The 36 month project, which commenced in August 2011, and ended in October 2014, had traditional leaders as its foci given their role as custodians of culture in their respective communities.

The thrust was thus to use traditional leaders as an entry point in the fight against harmful cultural practices which have perpetuated intimate partner violence/domestic violence and HIV

[7] Lesotho Violence Against Women Baseline Study conducted by the Ministry of Gender Youth and Sports and Recreation , Lesotho Bureau of Statistics and Gender Links (GL) in 2013
[8] 11 October 2011 UN CEDAW Report of Lesotho
[9] 2011 Human Rights Reports: Lesotho (released on 24 May 2012)
[10] Berea, Leribe, Maseru, Mafateng and Mohales'hoek
[11] Mangochi, Nsanje, Phalombe, Blantyre and Dowa

against women. Broadly, the project took a comprehensive approach where the broader community was mobilized to challenge cultural, social and institutional practices that perpetuate violence against women and HIV.

Project Goal

The overall goal was "*to significantly contribute to the prevention and eradication of intimate violence/domestic violence against women aged 15-49 years in Lesotho and Malawi by 2015 through promoting gender equality, ensuring women's rights and reduction of harmful cultural practices that fuel violence against women*".

Specific Objectives

To fulfill this goal, the project adopted the following four objectives:

- Strengthening the capacity of 10 CBOs and FBOs to apply a cultural approach to addressing harmful cultural practices that promote violence against women and increase their risk to HIV
- Building the capacity of 500 traditional leaders as custodians of culture in Lesotho and Malawi to redress the historical and cultural power imbalances and harmful traditional practices that fuel violence against women and girls and increase their vulnerability to HIV.
- Mobilizing 10,000 communities in Lesotho and Malawi to unite and support Zero tolerance for domestic violence and Zero New HIV infections within their communities
- Documenting and sharing at least 4 best practices from the communities that are successfully reducing domestic violence

The following were the key expected outcomes and activities of the project:

Outcome 1: Capacity of CBOs, FBOS, and Government gender staff to address the linkages between harmful cultural practices that promote violence against women and increase their risk to HIV strengthened

a. Develop/reprint 2,000 copies of the "changing river flow" training packages for lead trainers, district trainers, traditional leaders and volunteers
b. Organize 2 (5 day) workshops for 50 lead trainers (one workshop per country)
c. Conduct 3 (3 day) workshops for 125 provincial and district trainers (3 workshops per country)
d. Conduct 10 (2 day) community meetings for 500 community based volunteers and traditional leaders)
e. Provide mentoring and support to lead trainers (2 visits per country per year)

Outcome 2: Traditional leaders (TLs) capacitated to champion prevention of domestic violence against women and HIV within their own communities

a. Conduct a baseline and post survey in each country to identify the KABP of TL/RL and political leaders, CBOs, men and women to assess their level of understanding

on the linkages between traditional laws, practices and beliefs, HIV and DV, identify harmful cultural practices

b. Develop a leadership support toolkit for use by leaders in the course of their work
c. Out of the 10 community workshops at least 5 workshops per country will target the TLs to reach at least 500 TL and RLs with relevant information
d. Organize 2 (2 day) national leadership indaba calling for Zero Tolerance towards DB and Zero New HIV infections
e. Monitor and document community/traditional court proceedings to ensure that leaders are utilizing the modern law and that women are fairly treated
f. Organize an annual Rock Awards and Calendar

Outcome 3: Capacity of women to report incidences of all forms of abuse and domestic violence in project sites increased

a. Organize a round of 10 community dialogues on Zero domestic violence and new infections per country to reach at least 10,000 people.
b. Launch Men as Protectors Campaign and set up Men as Protectors Clubs.
c. Produce and air 52 radio series per country to disseminate critical information on violence and HIV in support of the MAsPs Campaign and Zero DV Campaign through community radios in Chichewa and Sesotho to reach men, women and leaders.
d. Produce and distribute 10,000 copies of IEC materials to educate communities on DV and HIV
e. Support at least 500 community based volunteers and TLs to disseminate information on preventing GBV and HIV, identify survivors of abuse and refer and monitor traditional court systems
f. Produce 10,000 IEC including training manuals.
g. Establish a referral system for reporting Gender Based Violence (GBV)

Outcome 4: Document and share at least 4 best practices from the communities that are successfully reducing domestic violence for sharing nationally, regionally and internationally.

a. Produce 1,000 copies of Best Practice booklet.
b. Produce 1,000 copies of Best Practices video.

The primary beneficiaries of the project were women and girls between 15-49 years, while the secondary beneficiaries included the following: CBOs; TL/RL; CBVs; MAsPs; Men; Government Departments

The key implementing partners in Lesotho were: Society for Women against HIV/AIDS in Lesotho, Lesotho Network of People Living with HIV/AIDS, Phelisanang Bophelong and Lesotho Catholic Bishops Conference. In Malawi, the implementing partners were: Friends of AIDS Support Trust (FAST), Malawi Network of Religious Leaders Living and affected by AIDS (MANELERA), Gender Support Program (GSP), Chitani CBO and Kasalika Development Organization.

The major stakeholders included the following UNTF, GoM and GoL (through various institutions – Ministry of Gender, Police, Ministry of Health, and Ministry of Local Government), NGOs and CSOs

The project had a total budget of USD 1 300 216.74.

Purpose of the evaluation

The need to fulfill the accountability and learning agenda has necessitated this final evaluation. Overall, the evaluation will allow SAfAIDS and its stakeholders to fully appreciate "the extent to which the project has contributed to the reduction in intimate partner violence in Lesotho and Malawi" in the targeted areas.

The results of the evaluation will be primarily used to share lessons learnt, and inform future similar programming. The evaluation report will be shared primarily with UNTF (the donor), UN Women and various government and non-government stakeholders to help in future planning of similar interventions.

Evaluation objectives and scope

The overall objectives of this evaluation are as follows:

1. Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact, with a strong focus on assessing the results at the outcome and project goals
2. Generate key lessons, working and effective models, and identify promising practices for learning
3. Generate recommendations for program scale up and advocacy, and to inform future resource investment in HIV and DV integrated prevention

Evaluation Team

	Roles and responsibilities
Evaluation Lead Consultant	Preparation of the inception report – outlining methodology, data collection tools, among other key details embedded in this report Recruitment and capacity building of research assistants Facilitate and take part in primary data collection and secondary data review Quality assurance Facilitate data review and analysis Preparation of draft and final reports

	Presentation of final report – plenary Focal person for interaction with SAfAIDS
Data Analyst	Primarily, quantitative data analysis using SPSS and MS Excel; data triangulation; report writing and review
Research Assistants	Data collection Daily reviews of collected primary data Data entry for qualitative data, as applicable Proof reading of draft report summaries (mainly qualitative) for each country
Data entry clerk	Entry of all quantitative data generated during the survey

Brief description of work plan of evaluation team with the specific timeline and deliverables

- Inception meeting – September
- Final Inception Report (as per specified format) and data collection tools by 26 September 2014
- Primary data collection – September 28 to October 10, 2014
- Draft Evaluation Report by 27 October 2014
- Final Evaluation Report (as per specified report format) by 14 November 2014

Evaluation Questions

- The original evaluation questions from the evaluation TOR are listed and explained, as well as those that were added during the evaluation (if any).

- A brief explanation of the evaluation criteria used (e.g. relevance, efficiency, effectiveness, sustainability and impact) is provided.

Evaluation Criteria	Evaluation Questions	Data Source[12] and Data Collection Methods
Effectiveness	To what extent were the intended project goal, outcomes and outputs achieved and how?	Project proposal (log frame), status reports, KABP reports – document review

[12] The actual tools are attached

	To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached? To what extent did this project generate positive changes in the lives of the targeted women and girls in relation to specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and or girls? Please describe those changes	Community interviews – individual questionnaire, FGDs, interviews with traditional and religious leaders, implementing partner interview Beneficiary database/annual reports Interviews with beneficiaries and community structures
Relevance	To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls? To what extent do achieved results continue to be relevant to the needs of women and girls?	Implementing partner interview; community level FGD and individual questionnaire, interview with traditional leaders
Efficiency	How efficiently and timely has this project been implemented and managed in accordance with the project documents	Document review – project proposal log frame; interview with implementing partners
Sustainability	How are the achieved results, especially the positive changes generated by the project in the lives of the women and girls at the project goal level, going to be sustained after this project ends?	Interviews with implementing partners (CBOs, FBOs); community level - interviews with traditional leaders and FGDs with beneficiaries
Impact	What are the unintended consequences resulting from the project?	Interviews with beneficiaries and community structures, implementing partners

Evaluation Methodology

Sub-sections	Inputs by the evaluator(s)
Description of evaluation design	Pre-test and post-test with comparison group -takes the before/after analysis lens. However, within each country, different districts were selected.

Data sources	• Document review
	  ○ Malawi and Lesotho Demographic and Health Survey reports
	  ○ HIV/AIDS Estimates Reports for both countries
	  ○ Project description report
	  ○ Year 1, 2 and 3 reports
	• Primary data collection

• SAfAIDS staff in country, CBOs and FBO staff interviews	• Interviews with program, M&E, Finance Officers in these entities
• Individual questionnaire	• Men (42%) and Women (58%)
• Traditional and religious leaders interview guide	• Traditional Leaders and Religious Leaders (50; 19 in Lesotho and 31 in Malawi)
• Key informants key interview guide	• Referrals(judiciary (Magistrates), Ministry of Education, Ministry of Gender, Clinics, Police)
• Focus group discussions	• Men 24+ years, Women 24+ years, Men 15-24 years, Women 15-24 years, • Community based volunteers • Men as Protectors

Description of data collection methods and analysis (including level of precision required for quantitative methods,	Please refer to Annex 1

<table>
<tr><td>value scales or coding used for qualitative analysis; level of participation of stakeholders through evaluation process, etc.)</td><td></td></tr>
<tr><td>Description of sampling

• Area and population to be represented

• Rationale for selection

• Mechanics of selection limitations to sample

• Reference indicators and benchmarks/base line, where relevant (previous indicators, national statistics, human rights treaties, gender statistics, etc.)</td><td>Geographic sampling – districts, wards, villages – two districts in Lesotho (Berea and Leribe) and 3 districts in Malawi (Nsanje, Phalombe and Blantyre).

Rationale for selection

1. A 2:3 men to women ratio was applied due to the fact that women were affected the most by domestic violence and also the need to capture men's views with regards to DV and HIV issues.
2. The evaluation targeted 40 - 50% women aged between 15 - 29 years because this age cohort was amongst the most affected by DV and HIV infection.
3. The KABP baseline conducted in 2011 used a sample size of 195 in Malawi and hence for consistency, the same sample size was maintained in the endline evaluation.
4. In Lesotho, a sample size of 120 community members was selected with representation across two geographic areas (Berea and Leribe), which allows for valid baseline, endline and country comparisons.

Individual household questionnaire

a. One hundred and seventy three households (173) interviewed in Malawi while 120 households interviewed in Lesotho. Targeted households include those who are in a current or previous relationship.

<table>
<tr><td>Lesotho</td><td>Malawi</td></tr>
<tr><td>Berea – Actual=80/Planned =80 households</td><td>Nsanje - Actual=20/ Planned =78[13] households</td></tr>
<tr><td>Leribe – Actual=40/Planned =40 households</td><td>Phalombe – Actual=78/Planned=78 households</td></tr>
<tr><td></td><td>Blantyre – Planned=39/Actual 39/Planned 39 households</td></tr>
</table>

Focus Group Discussion for community members</td></tr>
</table>

[13] There was a funeral in Nsanje at the time of the interviews and hence the low number

a. Malawi
   i. 2 Male only FGDs– one in Nsanje, one in Phalombe
   ii. 4 female only – two in Phalombe (a particular focus on the 15-24 year old due to issues coming out), one in Nsanje and one in Blantyre
   iii. One combined male/female FGD – Nsanje
b. Lesotho
   i. 2 male only FGDs– one Berea, one in Leribe
   ii. 2 female only FGDs– one in Berea, one in Leribe
   iii. 1 combined male/female FGD - Berea

Insert 1: Men only interview in Berea, Lesotho

Interviews with program implementers

a. Seven CBOs and FBOs in Lesotho and Malawi were interviewed as part of the primary data collection process.

Traditional leaders

a. Interviewed 10% of the 500 targeted TLs - 19 in Lesotho and 31 in Malawi. The primary focus was on the TLs in the targeted areas (Berea, Leribe in Lesotho as well as Nsanje, Phalombe and Blantyre in Malawi.

Men as protectors interviews – through Focus Group Discussions

a. Lesotho - 2 FGDs (1 Berea and 1 Leribe)
b. Malawi - 3 FGDs (1 Nsanje, 1 Blantyre rural and 1 Phalombe)

Community based volunteers – through FGDs

a. Lesotho – one FGD each in Berea and Leribe
b. Malawi – one FGD in Nsanje, Blantyre and Phalombe

	Referrals a. 5 service providers (referral units- VSU/VFU, Gender, Judicial courts, education (as applicable) and Health) interviewed in each of the countries.
Description of ethical considerations in the evaluation	• Guarantee the safety of respondents and the research team – data collected will be used solely for the purpose of this evaluation. Respondents were not coerced to participate in the evaluation, i.e. participation is voluntary. • Apply protocols to ensure anonymity and confidentiality of respondents – no names were collected as part of the data collection process and all information collected will be treated as confidential. • Select and train the research team on ethical issues – there was a day's training in each of the two countries and ethical issues were covered as part of that training. • Store securely the collected information – all data collected was securely stored and will be handed over to SAfAIDS for safe keeping. • Issue of consent- A statement to seek consent was read to all respondents prior to the actual interviews. The consent form offered the respondents the opportunity to opt in or out of the interview. It also offered the respondents the opportunity not to respond to some questions for any reason.
Limitations of the evaluation methodology used	Sampling, by its nature, implies that not the whole population was interviewed. However, the study adopted a mixed method approach to ensure that representative data was generated during the data collection phase, complemented by secondary (mainly project) data.

Findings and Analysis per Evaluation Question

Evaluation Criteria	**Effectiveness**
Evaluation Question 1	**To what extent were the intended project goal, outcomes and outputs achieved and how?**
Response to the evaluation question with analysis of key findings by the evaluation team	**Project Goal: Significantly contribute to the prevention and eradication of intimate violence/domestic violence against women aged 15-49years in Lesotho and Malawi by 2015 by promoting gender equality, ensuring women's rights and reduction of harmful cultural practices that fuel violence against women.** The project titled *"Traditional leaders championing Prevention of Domestic Violence in their communities in Malawi and Lesotho"* has resulted in considerable reduction in the perpetration of violence against women in the target Districts of Malawi and Lesotho. Notably, through strengthening the role of Traditional Leaders, there has been increased resolve to end gender based violence by both men and women within the project target communities through challenging and abolishing harmful practices promoting violence against women and HIV infection. Traditional Leaders trained in cultural approaches to end DV have become more participatory in conducting DV and HIV prevention awareness campaigns through social gatherings and when conducting Traditional Courts, supported by trained Community Based Volunteers. The project has significantly increased communities' appreciation of harmful cultural practices promoting violence against women with some of the target communities through their TLs enacting bi-laws to eradicate such practices and promoting gender equality. The project has capacitated several organizations and institutions including state and non-state actors to respond in support of DV and HIV prevention in the target Districts. The success of the project is vastly demonstrated in several sections of this report. **Indicator 1: CBOs, FBOS, and Government gender staff better understands and able (increased confidence) to address harmful cultural practices that promote violence against women and increase their risk to HIV strengthened** Training of 9 CBOs and FBOs in Malawi and Lesotho resulted in strengthened capacity at various institutional, community and individual levels to address harmful cultural practices that fuel violence against women and increase their risk to HIV. Most community members in Malawi (76.5%) and Lesotho (72.3%) reported CBOs and FBOs to be involved in increasing knowledge through awareness campaigns on cultural approaches that promote DV against women and HIV infection. The CBOs and FBOs operational in 5 districts in Malawi and 4 districts in Lesotho managed to capacitate over 1 500 government staff in using cultural approaches to addressing GBV and HIV (*Result and Activity Report: Cycle 15)*.

Strengthened capacity of trained CBOs and FBOs was further demonstrated by the ability of some CBOs/FBOs to expand program interventions to other areas outside program focus areas with support from government and other donor funds. A specific case in Malawi is that of MANELERA which has now expanded its program activities in Mzimba District with additional support from UNAIDS. In Malawi, two CBOs and FBOs together with some trained government staff are now members of the District GBV Technical Working Groups, which serve as important advocacy platforms for influencing policy formulation on Gender Based Violence and HIV.

Indicator 2: No of capacity building materials developed & distributed to support training

Table 1: Capacity materials developed and distributed to support training[14]

Quantity Produced	Type of material produced and distributed in Malawi and Lesotho
100	Para-legal Community Handbooks for CBVs in DV and HIV Prevention in Lesotho – English Version
200	Para-legal Community Handbooks for CBVs in DV and HIV Prevention in Lesotho – Sesotho Version
100	Para-legal Community Handbooks for CBVs in DV and HIV Prevention in Malawi – English Version
200	Para-legal Community Handbooks for CBVs in DV and HIV Prevention in Malawi – Chichewa Version
1000	Mainstreaming HIV, AIDS and Gender into Culture – A community Education Handbook 1
1000	Mainstreaming HIV, AIDS and Gender into Culture – A community Education Handbook 2
1000	Inter-Linkages Between Culture, Gender Based Violence, HIV and AIDS and Women's Rights – Manual

Source : Cycle 15 Activity Report

A total of 3 600 IEC materials in Chichewa, Sesotho and English languages were produced and distributed in both Malawi and Lesotho. IEC materials were used in training of CBVs who served as paralegals as well as training of Traditional and Religious Leaders.

Indicator 3: Number of community organizations trained in the cultural approach to addressing GBV and HIV

The following 9 CBOs/FBOs were trained in the cultural approach to addressing GBV and HIV : **Lesotho**: Society for Women against HIV/AIDS in Lesotho, Lesotho Network of People Living with HIV/AIDS, Phelisanang Bophelong and Lesotho Catholic Bishops

[14] Consultants could not establish the baseline targets

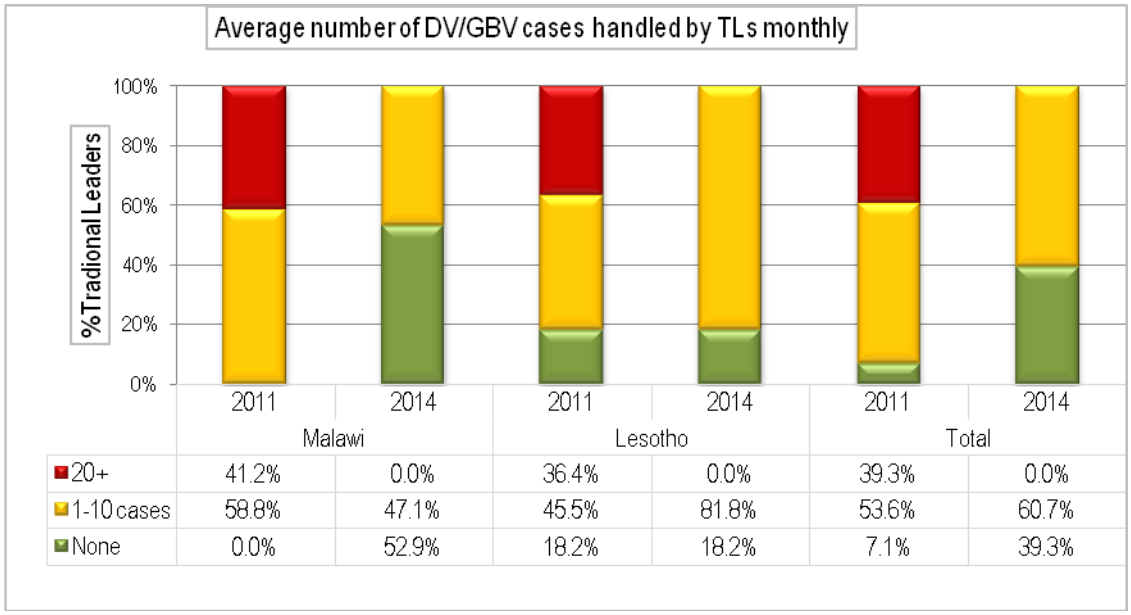
Conference. In **Malawi**-: Friends of AIDS Support Trust (FAST), Malawi Network of Religious Leaders Living and affected by AIDS (MANELERA), Gender Support Program (GSP), Chitani CBO and Kasalika Development Organization. The target was to build the capacity of 10 CBOs/FBOs.

Indicator 4: Traditional leaders bring to account GBV perpetrators via traditional courts

The majority of Traditional Leaders in Lesotho (90.9%) and Malawi (88.2%) reported a decline in the prevalence of DV cases within their communities. Before the start of the project, 58.8% of TLs in Malawi reportedly handled an average of 1 - 10 DV cases per month with the proportion dropping to 47.1% in 2014. The proportion of TLs handling more than 20 DV cases per month dropped sharply from 41.2% in 2011 to nil in 2014. Conversely the proportion of TLs who were now going for a month without handling a single DV case rose to 52.9% between 2011 and 2014.Interviews with community members and stakeholders involved showed that awareness on DV had increased and that the decline is due to an actual decrease in reported cases.

Figure 1 below shows a general decrease in both countries in the average number of DV/GBV cases per month handled by TLs currently (2014) compared to before the start of the project (2011). In this regard, the project has had two positive effects which must be distinctively noted, firstly, there has been a general decline in the prevalence of DV cases within communities and secondly, there has been an increase in the proportion of women now confidently reporting abuses of all forms. Conclusively, evidence points to a net reduction of DV cases and increased reporting on DV cases by women and girls.

Figure 1: Average number of GBV cases handled by TLs monthly



	Malawi 2011	Malawi 2014	Lesotho 2011	Lesotho 2014	Total 2011	Total 2014
20+	41.2%	0.0%	36.4%	0.0%	39.3%	0.0%
1-10 cases	58.8%	47.1%	45.5%	81.8%	53.6%	60.7%
None	0.0%	52.9%	18.2%	18.2%	7.1%	39.3%

Indicator 5: Proportion of traditional leaders identifying and redressing cultural practices which increase GBV & HIV

Most community members in Lesotho (84.7%) and Malawi (82.1%) indicated Traditional and Religious Leaders were speaking out against domestic violence. Comparing with the KABP baseline findings which show that in 2012 about 69% of the community members in Malawi reported TLs and RLs to be speaking out against domestic violence; there has been a positive increase in TLs and RLs identifying and redressing cultural practices which increase GBV and HIV infection in Malawi. This was being done mainly through public gatherings which were being used as platforms to denounce violence and encourage women to report cases of abuse.

Whilst all TLs in Lesotho reportedly knew cultural practices that increase risk of DV and HIV infection, only one in three TLs in Malawi knew such cultural practices. The situation in Malawi could be partially attributed to a combination of capacity building and or just the inherent cultures. The most common cultural practices reported by TLs included initiation practices[15] (38.6%); wife inheritance[16] (14.9%); cutting hair with one razor blade during funeral services (14.0%); and the customary practice that prohibits women from returning home for 6 months after giving birth (7.9%).

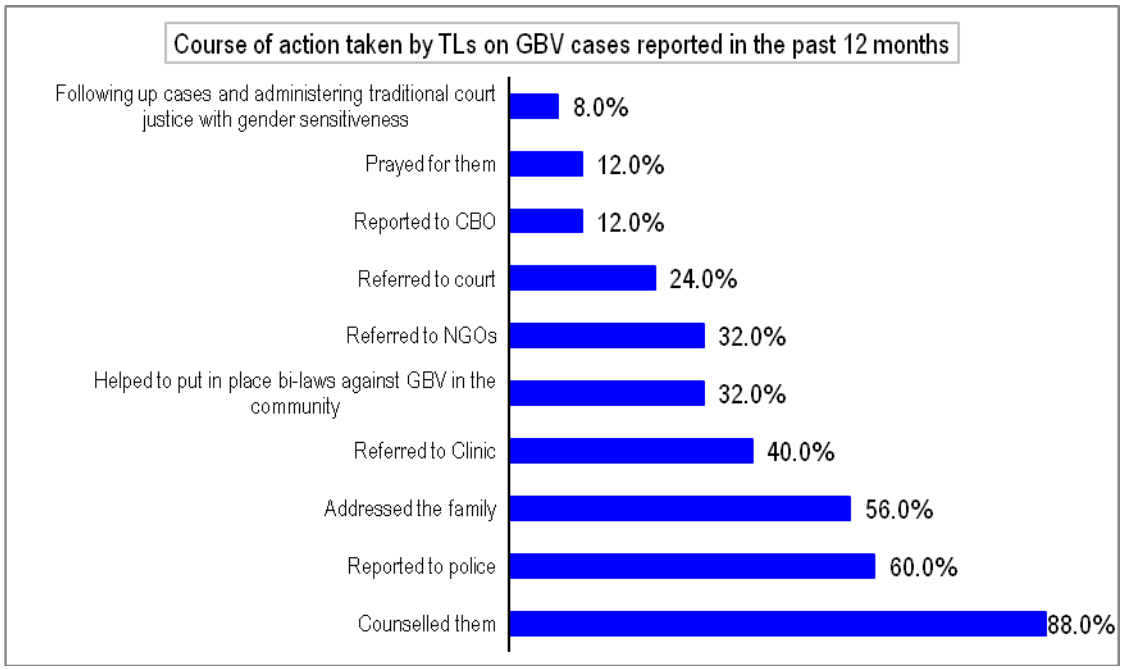
Indicator 6: Number of GBV and HIV cases referred by traditional and religious leaders

The majority of the TLs in the evaluation (96.2%) indicated they had received at least one case of domestic related violence in the 12 months preceding the survey. Of the TLs that received GBV reports, about 88% provided counseling services to the couple, whilst another 56% reportedly addressed the couple together with the extended family. The other important referrals performed by TLs on cases received include reporting to police (60.0%); referring to clinic (40.0%); referring to NGO (32.0%); referring to court (24.0%) and reporting to CBOs (12.0%). Figure 2 shows referrals performed by TLs on cases received in the 12 months preceding the survey. Referrals were based on the type of abuse suffered and appropriate remedy required. Worth noting is the involvement of of paralegals and the survivors (client centred approach).

[15] Initiation ceremonies – where girls are initiated into womanhood; they are "forced" to sleep with a man selected by the traditional leaders

[16] The practice where when a spouse dies, the brother to spouse culturally enjoys conjugal rights with the deceased's wife

Figure 2: Course of action taken by TLs on GBV cases reported in the past 12 months



Compared to the KABP Baseline findings, only 0.1% of the Traditional Leaders in Malawi reported DV cases to the police in 2011. In 2014, of the TLs that received DV cases in Malawi, 73% of TLs indicated referring at least on case to the police, whilst in Lesotho these proportions were estimated to be 40% of TLs. The findings from the "Lesotho Violence Against Women Baseline Study[17]" conducted in Lesotho indicate that only 3% and 2% of ever partnered women had reported their experiences of violence to the police and medical health providers respectively in 2012. The results show that in both countries there has been a significant improvement in the reporting of DV cases and use of referrals by trained TLs with more cases now being referred to the police, medical health providers, courts of law and NGOs/CBOs.

Indicator 7: No of trainers trained at national, district and community level

About 759 (567 males; 192 females) trainers were trained in both Lesotho (336) and Malawi (423) at national, provincial and district levels on addressing cultural imbalances and harmful practices that promote violence against women and HIV infection. This represented about 89% of the targeted trainers (850). Trained personnel were drawn from but not limited to Government Ministries of Gender, Education, the Police, Medical Health Providers and Paralegals as well as Civil Society (i.e. members from 9 CBOs/FBOs). The trained personnel in turn cascaded the trainings down to community levels where TLs and RLs were subsequently trained on cultural approach to addressing DV and HIV. This resulted in a total of 2 021 TLs/RLs being trained in

[17]The Lesotho Violence Against Women Baseline Study was conducted by the Ministry of Gender Youth Sports and Recreation, Lesotho Bureau of Statistics and Gender Links, 2013.

	Malawi (1 056) and Lesotho (965), with over 80% of these being trained during the second year of project implementation. The total number of TLs/RLs trained during the project lifecycle exceeded the project target of 500 TLs/RLs. Through individual community member interviews, it was established the majority of the community members in Malawi (72.8%) and Lesotho (80.6%) knew at least one community member that had received training in cultural approach to addressing DV and HIV. Compared to the KABP Baseline findings in Malawi (40.6%), this represented a significant increase in the proportion of community members that knew of other community member who had been trained. Education level of community member was associated with community members who knew of other trained community member (p = 0.048). Whilst 83% and 84% of community members with tertiary and secondary school levels knew someone that had been trained in cultural approach to DV and HIV, only 76% and 61% with primary and nil education respectively knew a trained community member. **Indicator 8: Increased knowledge of the intersection between HIV and GBV among CBOs, FBOs, and government gender staff** Staff from 9 CBOs/FBOs and government departments that include the Ministries of Gender, Education, the Police, Judiciary and Health received training in cultural approach to addressing DV and HIV and were themselves involved in training or TLs/RLs and communities. The impact of such trainings is evident in the changes in knowledge, attitudes, behaviour and practices taking place within the communities (demonstrated in parts of this report) which are likely to have a far reaching effect in terms of eliminating cultural imbalances that promote violence against women and increase risk to HIV transmission. Refresher training courses and enhanced knowledge sharing platforms with multi-stakeholder participation remain essential in the campaign to eliminate violence of all forms against women and girls and HIV prevention. More importantly, trained cadres need support in fostering the political will to influence domestic violence and gender policy formulation and implementation from the highest echelons of government which include Ministers and Permanent Secretaries to speak out denouncing violence perpetrated against women and children. **Indicator 9: No of traditional and religious Leaders championing HIV prevention and speaking out on the intersection between HIV, GBV, and cultural beliefs and practices** The majority of the TLs in Lesotho (83.3%) and Malawi (94.1%) of 2 021 who were trained in the cultural approach to address GBV and HIV were now confidently speaking out against domestic violence and harmful cultural practices that promote DV and HIV. Training has strengthened the resolve and willingness of TLs and RLs to address the twin epidemics. Some of the critical links reported by TLs and RLs between DV and HIV infection include cheating or marital unfaithfulness (37.5%) and transmission of HIV through sexual abuse (37.5%). All TLs interviewed in both

countries expressed confidence in their ability to address harmful cultural practices that increase risk of HIV infection within their communities. There were however lesser proportions of TLs in Lesotho (70%) than Malawi (100%) that expressed similar confidence in addressing cultural practices that promote violence against women.

Indicator 10: No of community forums where Traditional and religious leaders are discouraging GBV and HIV risk practices

Since the start of the project, most of the 2,021 TLs trained in Malawi (88.2%) and Lesotho (81.8%) have been conducting DV and HIV related awareness campaigns and meetings in the communities. About 76.5% and 55.6% of TLs in Malawi and Lesotho that conducted DV/HIV awareness campaigns were able to hold more than one such campaign per month. The majority of TLs in Malawi (76.5%) used their own place of residence for holding such campaigns whilst in Lesotho (88.9%) community halls/venue were more commonly used for DV/HIV awareness campaigns and meetings.

Indicator 11: Increased number of women who are able to define abuse of any type

Table 2: Women who agree or disagree with cultural beliefs promoting domestic violence

% women that disagree that:	Malawi	Lesotho	Total
	%	%	%
Men have the right to control or discipline women through physical means	89.8	100.0	94.1
A woman's freedom should be restricted	56.1	75.7	64.3
Physical violence is acceptable in order to resolve conflicts in a relationship like family	90.9	98.6	94.1
A man has the right to have many sexual partners	87.9	91.4	89.3
% women that agree that:	%	%	%
Couples (especially young couple) should not discuss sexual violence to outsiders.	77.8	69.0	74.1
Reporting family/domestic abuse brings disrespect to your spouse	32.0	8.5	22.0
A woman has the right to safe satisfying sex in her marriage	79.8	81.5	80.5

The majority of women surveyed in Malawi (89.1%) and Lesotho (100%) disagreed that men had the right to control or discipline women through physical means. In Malawi these proportions did not differ significantly from the KABP baseline findings (89.2%). In terms of knowledge levels, this is already a significantly higher proportion,

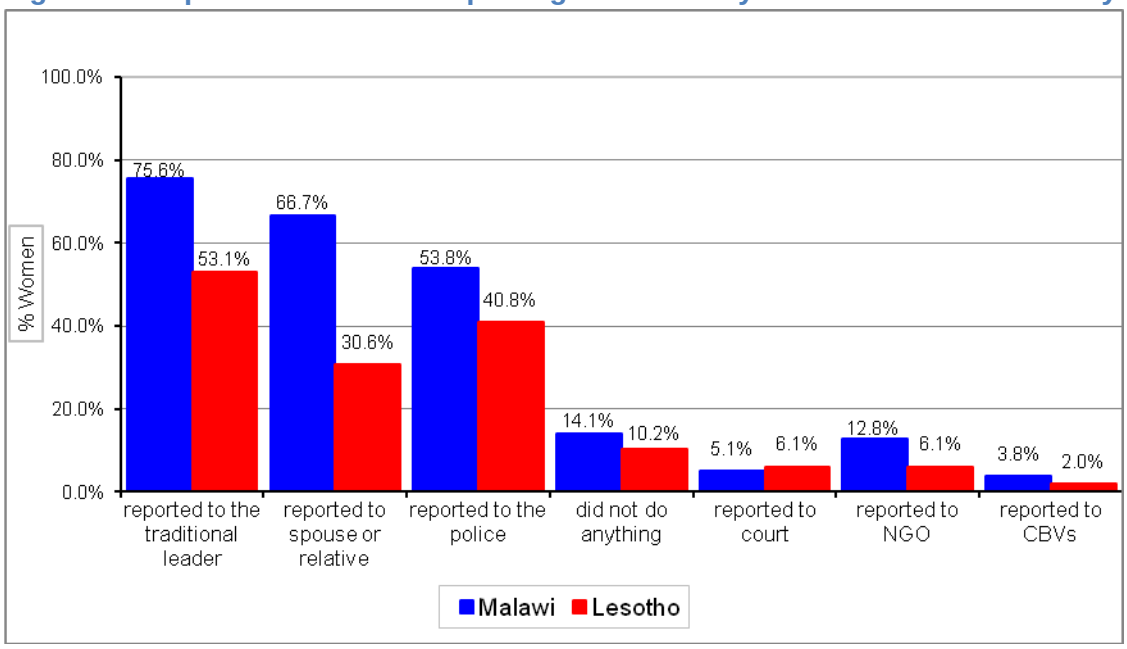
	thus the activities under this project helped cement the notion. On the other hand, there were significantly lower proportions of women in Malawi (56.1%) compared to Lesotho (75.7%) that disagreed to the notion that a woman's freedom should be restricted. This implies that about two in five women in Malawi believe that a woman's freedom should actually be restricted. Such gender attitudes which support male domination tend to promote violence against women. Education level was associated with perceptions on women's freedom being restricted (p = 0.024). Whilst 88.3%, 69.0% and 57.6% of community members with tertiary, secondary and primary school levels respectively disagreed that women's freedom should be restricted, only 40.5% of community members with no education expressed the same view. The evaluation findings indicate women and girls with little or no education were more likely to experience restrictions in their freedoms and rights compared to women with better education. These findings resonate with findings from the Lesotho Violence Against Women Baseline Study (2013), which noted that experience of Intimate Partner Violence (IPV) significantly decreased with an increase in education level. Most of the women interviewed in Malawi (90.1%) and Lesotho (98.6%) did not agree to the use of physical violence in order to resolve conflicts in a family relationship. Similarly, the majority of women in both Malawi (87.9%) and Lesotho (91.4%) disagreed that a man had the right to many sexual partners. There was however a significantly high proportion of women in both Malawi (77.8%) and Lesotho (69.0%) that still believed couples (especially young couples) should not discuss sexual violence to outsiders. The evaluation further noted that 75.3% of community members that had some exposure to DV and HIV messages from SAfAIDs indicated couples should discuss sexual violence to outsiders compared to 59.3% who had not been exposed to DV and HIV messages. The difference was statistically significant (p = 0.041) indicating DV and HIV messages disseminated to communities were having a positive impact in terms of promoting the reporting of DV cases particularly by women, who have often underreported such cases. Malawi had a further 32% of the women indicating that reporting family/domestic abuse brings disrespect to the spouse compared to 8.5% in Lesotho. In the KABP baseline, these proportions were estimated to be higher in both Malawi (69.8%) and Lesotho (51.5%). The evaluation findings show a marked decline in both countries in the proportion of women who still hold the view that reporting family/domestic abuse brings disrespect to the husband. Despite the significant improvement one in three women in Malawi continue to regard sexual violence as a private matter, an attitude that is likely hinder women and girls from reporting violence to relevant authorities. The majority of women in both Malawi (79.8%) and Lesotho (81.5%) indicated they had the right to safe satisfying sex in their marriage. The evaluation observed that 86.5% of community members that were exposed to DV and HIV messages acknowledged that women had the right to safe satisfying sex in marriage compared to 64.7% of those

that had never been exposed to DV and HIV messages. The results further demonstrate that DV and HIV messages have been very useful in increasing knowledge and awareness amongst community members in DV and HIV prevention.

Indicator 12: No of women reporting abuse of any form to relevant authority

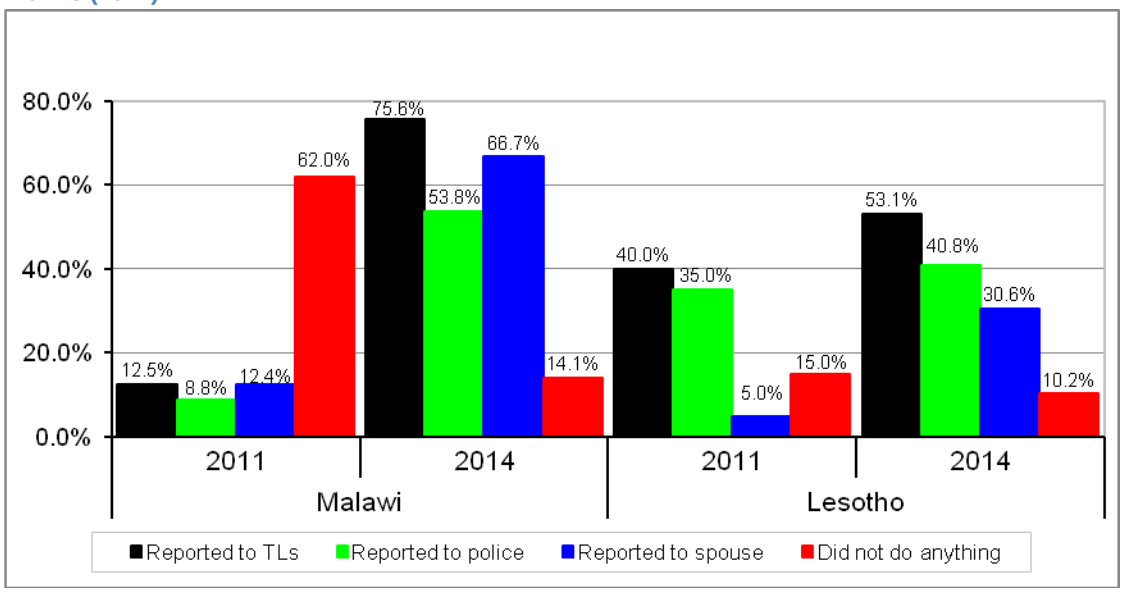
About 83.8% of the women interviewed in Malawi compared to 69.0% in Lesotho either knew someone, witnessed or experienced domestic violence in the 12 months preceding the survey. Figure 3 shows the proportion of women that reported abuse of any form to the relevant authorities.

Figure 3: Proportion of women reporting abuse of any form to relevant authority



Of the women who knew someone, witnessed or experienced domestic violence in the 12 months preceding the survey, the majority of women in Malawi (75.6%) and Lesotho (53.1%) reported domestic violence to the traditional leaders. Another 66.7% and 30.6% of women in Malawi and Lesotho respectively reported DV cases to the spouse or relative. About 53.8% of women in Malawi and 40.8% in Lesotho indicated that they reported DV cases to the police. In both countries there were fewer proportions of women that reported DV cases to the court, NGO or CBVs. However, in all instances, there were relatively higher proportions of women in Malawi than Lesotho that reported abuses to the different authorities. Figure 4 shows a comparison in trends of reporting abuse to authorities before project start (2011) and at the close of project (2014).

Figure 4: Proportion of women reporting to authority abuse of any form, Baseline (2011) vs. Endline (2014)



In the KABP baseline survey, only 8.8% of women in Malawi reported DV cases to the police whilst 12.5% reported to the traditional leaders and similarly, spouse/relative. Conversely, 62.0% of women in the baseline reportedly did nothing about the domestic violence. In 2014, there significantly higher proportions of women in Malawi reporting abuse of any form to traditional leaders (75.6%), police (53.8%) and spouse/relative (66.7%) compared to 2011. The Lesotho KABP baseline findings show that before the project started, fewer women reported DV cases to traditional leaders (40%); the police (35.0%) and spouse or relatives (5%).

In 2014, the proportion of women reporting abuse in Lesotho to traditional leaders (53.1%), police (40.8%) and spouse/relative (30.6%) had also significantly increased compared to the period before project inception. The evaluation findings indicate trainings and awareness campaigns on prevention of DV have resulted in a positive change in the practice by women in terms of opening up and reporting abuses of various forms to the relevant authorities. The significant decline in the number of women not taking action against violence perpetrated is a positive indication that women in Malawi and Lesotho are becoming more confident in the formal and informal structures available for handling DV cases.

Indicator 13: Proportion of women reporting a reduction in abuse in their own lives

Table 3: Men and women that never experienced listed DV forms in the 12 months preceding the survey

Proportion of men and women in community that never experienced the following DVs in the past 12 months				
Type of Domestic Violence	Malawi		Lesotho	
	men	women	men	women
% never pushed, slapped, hit or hurt by partner in any ways	86.4	62.7	89.2	87.8
% never hurt or threatened by partner	88.1	59.2	75.7	75.6
% never forced by partner to do something they did not want to do	88.1	76.3	86.5	85.4
% never prevented by partner you from eating or sleeping or been endangered in health in other ways	88.1	80.3	97.3	92.7

Table 3 shows the men and women in the community that never experienced the different forms of domestic violence during the 12 months preceding the survey. Whilst 87.8% of women in Lesotho reported never being pushed, slapped, hit or hurt in any ways, only 62.7% of their counterparts in Malawi reported never experiencing the same abuses. The difference in the proportions was statistically significant ($p = 0.016$). About 75.6% of women in Lesotho compared to 59.2% in Malawi indicated they had never been hurt or threatened by their partner. The difference was however not statistically significant. Analyzing through the gender lenses shows women in Malawi still experienced higher prevalence of domestic violence as indicated by the fewer proportions of women that reported never being pushed, slapped, hit or hurt (62.7%) and those reporting never being hurt or threatened by partner (59.2%) in the 12 months prior to the survey. Table 4 shows the proportion of women that have been exposed to various project materials like posters, information sheets and involvement in community activities against DV.

Table 4: % women that have been exposed to project materials within communities in last 12 months

Activity	Malawi	Lesotho	Total
% women that have seen materials (posters, sheets etc) about violence against women	53.5	70.4	60.6
% women that have been to an activity or quick chat in community looking at one of project's materials (poster, etc)	60.6	69.0	64.1
% women that have been to other activities, sessions about violence against women not organized by this project	58.6	59.2	58.8

About 53.5% of women in Malawi compared to 70.4% women in Lesotho reported having seen project materials (posters, information sheets, etc) about violence against women. The difference in proportions between the two countries was not statistically significant. However, education was associated with community members that reported seeing these project materials ($p = 0.001$). Whilst 71.4%, 64.9% and 65.4% of community members with tertiary, primary and secondary school levels saw these project materials, only 29.2% of women with no education reported seeing these materials.

A further 60.6% and 69% of women in Malawi and Lesotho reported, in the last 12 months, they had been to an activity or quick chat in the community where they looked at one of the project's material (poster, etc) and talked about violence against women and relationships between women and men. There was no relationship with age, education, marital status of profession. The evaluation also observed 58.6% and 59.2% of women in Malawi and Lesotho had also been to other activities, sessions or conversations about violence against women and relationships in the community that had not been organized by the SAfAIDS project.

Chi-square tests of association showed there was a significant relationship between women who had seen the project's materials and those that took part in community activities where violence against women and relationships were discussed ($p < 0.001$). However, similar tests of association showed there was no relationship between women who had been exposed to project materials and activities on DV and women who experienced physical violence described in Table 3 above. This implies women could still face physical violence whether or not they had been exposed to project materials; social change takes time. On the other hand, the evaluation observed that women who had been exposed to project materials were 2 to 3 times more likely to report cases of abuse to relevant authorities compared to women that had never been exposed to the project ($p < 0.001$).

Indicator 14: Women's confidence to report abuse of any form improved

Confidence in women to report abuse of any form was examined through assessing the proportions of women that had experienced DV in the past 12 months and went on to report to some authority. This excludes reporting DV cases that were witnessed or that occurred to someone else. In Malawi, 53.6% (compared to 40.0% of women at baseline) that experienced DV in the past 12 months reported to the police. A significantly higher proportion of the women that experienced DV in Malawi also reported to the Traditional Leader (76.8%) compared to 13.3% in Lesotho. The majority of women that experienced DV in Malawi (69.6%) and Lesotho (60.0%) also reported their cases to the spouse or relative. On the other hand, 9.9% of women in the survey that experienced DV did not do anything about it. As indicated in figure 4 above, generally, the findings show that women were increasingly able to report abuse of any form to relevant authorities although an estimated 1 in 10 women were still underreporting DV cases. The fact that most women that experienced DV reported to spouses or relatives suggests that violence continues to be viewed as a private matter which should not be discussed with outsiders. It is therefore important to continue exploring factors which seem to be hindering women from reporting all abuses to relevant authorities.

Indicator 15: Increased numbers of people in the community are aware of the intersection between HIV and GBV and the linkages with cultural beliefs and practices

There were significantly higher proportions of community members in Lesotho (74.0%) compared to Malawi (23.8%) that indicated the existence of a relationship between domestic violence and HIV infection. Analysis by gender revealed that about 84.3% of women compared to 69.0% of men in Malawi were aware of the relationship between DV and HIV infection. The difference was statistically significant ($p = 0.007$). On the other hand there was no significant difference between men (73.1%) and women (74.6%) in Lesotho who were aware of the intersection between HIV and GBV.

The evaluation further noted that community members that had been exposed to DV and HIV messages were more knowledgeable of the link between harmful cultural practices, GBV and HIV infection. For example, whilst 46.6% of men and women who had been exposed to DV and HIV messages were aware of the link between DV and HIV, only 21.4% knew the link amongst those that had never been exposed to HIV and DV messages. The difference was statistically significant ($p = 0.011$).

Education level of community members was found to be significantly associated with knowledge of intersection between DV and HIV ($p < 0.01$). Whilst about 75% and 71.3% of community members that attained tertiary and secondary school respectively

knew of the intersection between DV and HIV infection, only 36.2% and 11.6% with primary and no education respectively knew the intersection between DV and HIV infection. The evaluation observed that 78.8% of community members that reported an intersection between DV and HIV infection were also aware of cultural practices that promote DV whilst on the other hand, 76.4% that reported there was no intersection between DV and HIV were also not aware of cultural practices that promote DV. The relationship was statistically significant (p = 0.001). The intersection between DV and HIV was explained through such practices as rape or forced unprotected sex by spouse; partner leaving troubled marriage to seek sexual gratification elsewhere; cheating or unfaithfulness; and violent fighting leading to bleeding.

Indicator 16: Increased number of community members reporting using safer sex practices

Table 5: % men and women reporting using safer sex practices

Sexual and Gender Dynamics in the Community	Malawi		Lesotho	
	men	women	men	women
% that felt could refuse to have sex with partner if they do not feel like it?	86.3	83.7	66.0	74.6
% that have initiated a discussion about condom use with partner	63.0	50.5	75.0	66.2
% that used a condom with partner during the past 12 months	45.2	33.7	60.4	43.7
% that used a condom the last time they had sex with partner	39.7	23.5	52.8	39.4
% reporting partner had a sexual relationship with another person in the last 12 months, while being with them?	4.1	17.5	17.0	14.5
% men and women that agree to the following practices	**%**	**%**	**%**	**%**
A woman should be allowed to use contraception without her husband's permission	28.8	40.4	11.3	23.9
Women should not carry contraceptives with them	67.1	70.7	34.6	41.4
A woman can insist that her husband use a condom	72.6	73.7	67.9	81.7
A woman has the right to refuse sex	64.4	56.0	81.1	76.1

About 86.3% and 83.7% of men and women in Malawi respectively have felt they could refuse to have sex with partner if they did not feel like it compared to 66% and 74.6%

	of men and women in Lesotho respectively. A significantly higher proportion of women in Lesotho (66.2%) than Malawi (50.5%) initiated a discussion about condom use with partner in the past 12 months. Likewise, Lesotho (75.0%) had a significantly higher proportion of men than Malawi (63.0%) that initiated a discussion about condom use with partner in the same period. Age was observed to be associated with community members initiating discussion about condom use (p = 0.002). About 69.7% and 70.1% of the interviewed community members aged 18-29 years and 30-39 years respectively initiated discussion about condom use with partner compared to lesser proportions observed in community members aged 40-49 years (61.0%), 50-51 years (55.6%) and over 60 years (35.7%). Education similarly was associated with the community members that reported initiating discussion on condom use (p = 0.002). Whilst 62.7%, 71.6% and 66.7% of community members that attained primary, secondary and tertiary school levels respectively initiated discussion on condom use, only 35.7% of the community members without education initiated the similar discussion on condom use. There were significantly higher proportions of both men (60.4%) and women (43.7%) in Lesotho compared to men (45.2%) and women (33.7%) in Malawi that reportedly used a condom with partner during the 12 months preceding the survey. The differences between the two sexes were statistically significant (p = 0.011). Age, similarly was associated with men and women that reported using a condom in the past 12 months (p = 0.003). Whilst 52.5% and 54.4% of community members aged 18-29 years and 30-39 years respectively used a condom in the last 12 months, only 42.4%, 33.3% and 16.3% of members aged 40-49 years, 50-59 years and over 60 years respectively reported using a condom with partner during the same period. This suggests older couples were less likely to use condoms compared to young couples. About 52.8% of men interviewed in Lesotho compared to 39.7% men in Malawi reported using a condom the last time they had sex with partner. On the hand, lesser proportions of women in both Lesotho (39.4%) and Malawi (23.5%) reported using a condom the last time they had sex with partner. Chi-square tests show sex (p = 0.026), age (p = 0.027) and education (p = 0.031) were all associated with condom use with partner during last sexual encounter. For example, men were found to be one and half times more likely than women to have used a condom with partner in last sexual encounter. Similarly young couples were also one and half times more likely than couples aged 40 years and above to have used a condom with partner during last sexual encounter. Community members with secondary education level were two times more likely to have used a condom with partner during last sexual encounter compared to members without any education. Whilst 40.4% of women interviewed in Malawi accepted that women should be allowed to use contraception without her husband's permission, only 28.8% of their male counterparts conceded to the same view. Similarly in Lesotho, there were relatively more women (23.9%) than men (11.3%) accepting the use of contraception by a

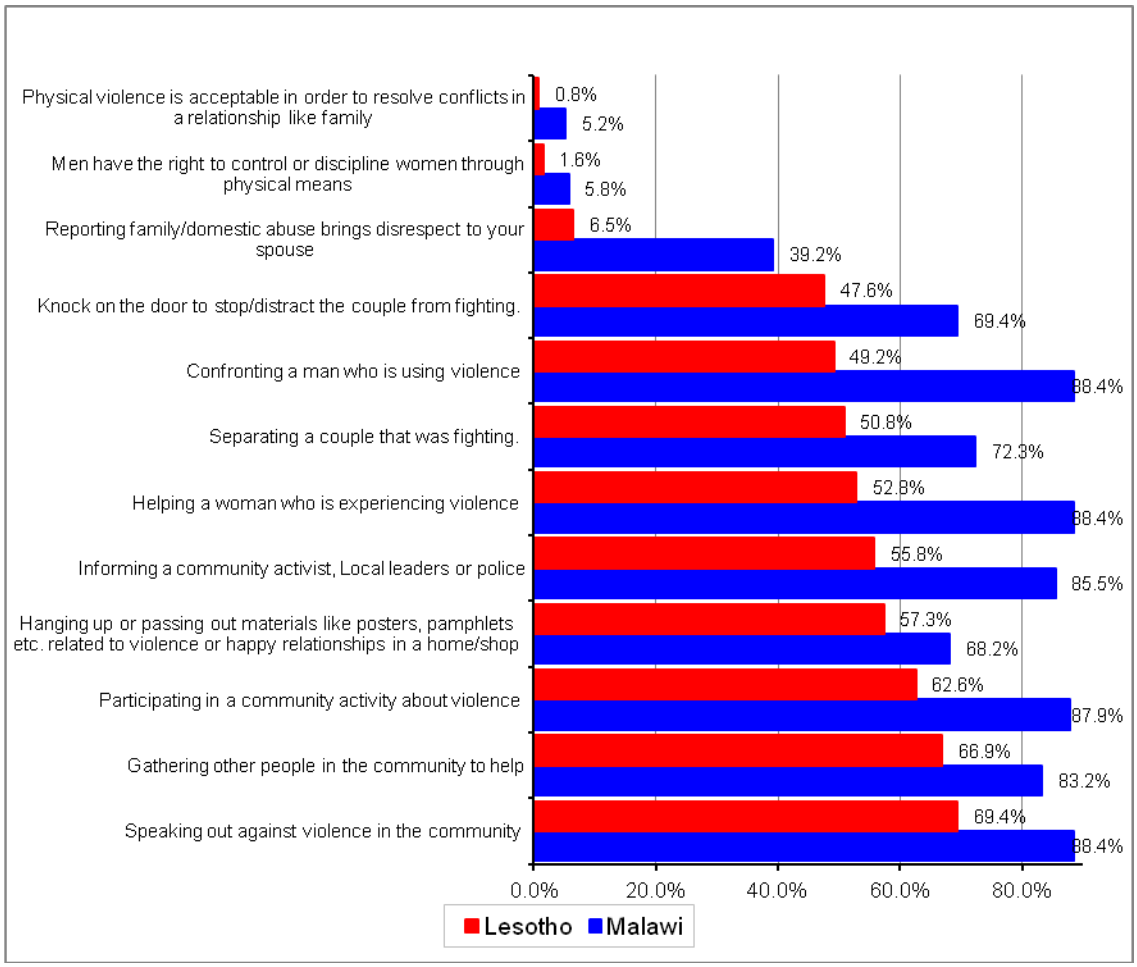
	woman without the consent of the male partner. Whilst the differences between the sexes within each country were statistically insignificant, the country variations were significant (p = 0.004). Malawi had higher proportions of community members than Lesotho that were of the view that woman should be allowed to use contraception without the husband's consent. When comparing with 2011 baseline findings, there were no statistical differences between the two time periods in both Malawi (37%) and Lesotho (18%) in the proportion of men and women who supported the view that women should be allowed to use contraceptives without the husband's consent. This indicates most men and women in the target communities have remained unchanged on the notion of women using contraceptives without husband's consent. There were significantly higher proportions of both men (67.1%) and women (70.7%) in Malawi than men (34.6%) and women (41.4%) in Lesotho that indicated women should not be allowed to carry contraceptives with them. The country differences were statistically significant. The 2011 baseline findings reported that 41% and 33.3% of both men and women in Malawi and Lesotho respectively agreed to the view that women should not be allowed to carry contraceptives. From these results it can be concluded that there had been an increase over time in the proportion of men and women who were of the view that women should not carry contraceptives with them. Age was observed to be associated with perceptions on women carrying contraceptives with them (p = 0.001). For example, whilst 64.6% of couples aged 18-29 years were of the view that women should not be allowed to carry contraceptives with them, only 51% and 42.9% of couples aged 50-59 years and above 60 years, respectively, shared the same view. In Malawi, the DHS (2010) noted the existence of considerable myths and misconceptions about condoms at community level. For example condoms are sometimes associated with promiscuity, commercial sex, or distrust of one's partner. The majority of men (72.6%) and women (73.7%) in Malawi indicated a woman could insist that her husband uses condom. Similarly, high proportions of men (67.9%) and women (81.7%) in Lesotho reported that a woman could insist that her husband uses a condom. The 2011 baseline findings reported 58.4% of both men and women in Malawi indicated women could insist that their husbands use a condom. The results suggest an increase over time in the proportion of men and women reporting women could insist husbands' use condoms. Country, age, sex and education were all not associated with the community attitudes on the issue of a woman insisting that her husband uses a condom. On the other hand, there were significantly higher proportions of men (81.1%) and women (76.1%) in Lesotho than men (64.4%) and women (56.0%) in Malawi that indicated women had the right to refuse sex. The baseline findings showed relatively lower proportions of men and women in both Lesotho (74.5%) and Malawi (49.7%) in 2011 compared to 2014 end line findings indicated women had the right to refuse sex. Although there were slightly higher proportions of men than women indicating women had the right to refuse sex, the differences were statistically insignificant (p > 0.05).

Similarly, age and education were not associated with perceptions on women's right to refuse sex. However, the country differences were statistically significant (p = 0.003) indicating that women's right to refuse sex were more readily acknowledged in Lesotho than Malawi. The results generally show that over two thirds of men and women in Malawi and Lesotho acknowledge women's right to refuse sex.

Indicator 17: Increased number of community members who shun any form of violence

The individual community interviews also sought to establish the extent to which community members were engaging in different activities in response to violence against women. Specifically, community members were asked whether they had seen any community members in the last 12 months participating in activities that shun violence against women. Figure 5 shows the proportion of community members that reported seeing other community members engaging in activities to shun violence within the community.

Figure 5: Proportion of community members who have seen other community member shun violence



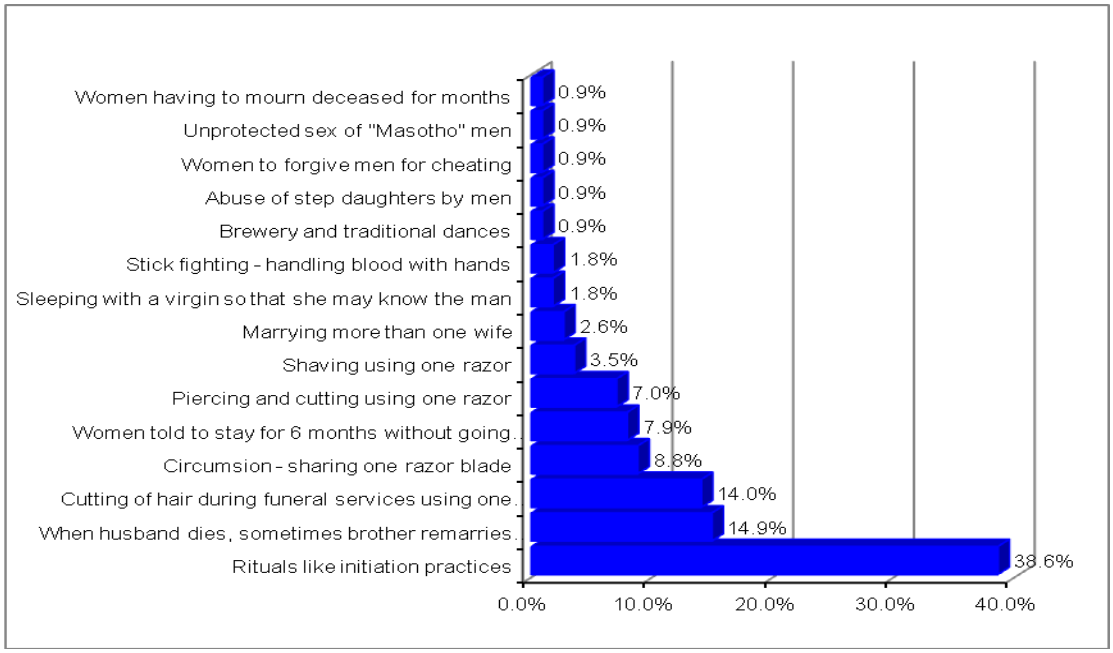
The majority of interviewed community members in Malawi (69-88%) compared to Lesotho (47-69%) had observed some community member taking part in an activity meant to shun violence against women. The activities that were reportedly undertaken by community members to shun violence against women include knocking on the door to stop/distract a couple from fighting; helping a woman who was experiencing violence; informing community activists, local leaders or police; hanging or passing out materials like posters and pamphlets; and gathering other people in the community to help amongst other activities.

Indicator 18: Community members challenging harmful cultural practices that are linked to GBV and HIV

The majority of the community members in Lesotho (74.0%) indicated the existence of a link between GBV and HIV infection compared to only 23.7% of respondents in Malawi that were aware of this link. Additionally, about 65% of community members surveyed in Lesotho knew harmful cultural practices that are linked to GBV and HIV whilst Malawi had fewer proportions (19.7%). In both cases, the differences were statistically significant ($p < 0.05$). About 85.3% of community members that reported no link existed between GBV and HIV also indicated they were not aware of the cultural practices promoting HIV infection. On the other hand, 67.4% of community members that reported a link between GBV and HIV infection were also privy of the cultural practices that promote violence against women and HIV infection. Chi-square test show the relationship between community members that reported a link between GBV and HIV and those that were aware of cultural practices which promote HIV was significant ($p < 0.05$).

Age and sex showed no association with knowledge of harmful cultural practices. Education level on the other hand was associated with knowledge of harmful cultural practices that promote HIV infection. Whilst 58.6% and 58.3% of community members with Secondary and Tertiary education respectively knew harmful cultural practices linked to HIV infection, only 32.2% and 14.0% of respondents with Primary and Nil education knew these practices. Figure 6 shows the cultural practices linked to GBV and HIV infection known to community members.

Figure 6: Harmful practices linked to GBV and HIV infection



The most common cultural practices highlighted by community members include, rituals like initiation practices; remarrying of widow by deceased person's brother; cutting of hair with one razor blade during funeral services; circumcision sharing one razor blade; women prohibited for 6 months from going home after birth; and piercing and cutting using one razor blade.

Through FGDs with men and women groups and TLs, it was established that:

- Women have traditionally been nurtured to endure abuse in intimate relationships and discouraged from reporting or discussing with outsiders issues of HIV and GBV. This culture of suffering in silence is now dying down more women in the target communities are now coming out in the open to report abuses of all forms to relevant authorities. The culture of "dying in silence" being broken down;
- People are openly discussing sex and sexuality issues, hence issue of sex after six months after birth is dying off;
- Forced marriages and early marriages going down in the target communities partly due to increased awareness of harmful cultural practices that promote GBV and HIV infection. These practices have been noted to violate the SADC Gender Protocol, the African Charter on the Rights of Women and the convention on the Rights of the Child.
- Wife inheritance practices and polygamous marriages going down
- Initiation ceremonies are dying a natural death as communities become more aware of the associated risks of HIV infection.

Indicator 19: Increase in number of Traditional court's ruling on cases with a gender sensitive eye

About 75% of TLs in Lesotho compared to 50% TLs in Malawi indicated traditional rules/regulations they were applying in traditional courts were in line with the national domestic violence policies for the country[18]. In most cases ruled over by TLs, community members found guilty of perpetrating domestic violence or violating other by-laws have been fined mostly goats, chicken and sometimes money, whilst also the rights of the survivor are observed. The use of a handbook and trained CBVs as para-legals in the court proceedings was described as very useful in ensuring upholding of survivor rights that include free decision making, confidentiality, and access to referral services and protection from further harm amongst other rights. Table 6 shows the TLs that indicated receiving DV complaints by type of survivor and person raising complaint during the 12 months preceding the survey.

Table 6: % TLs that received DV complaints, by survivor and person filing complaint, in the last 12 months

Variables		Malawi	Lesotho	Total
% TLs that received complaint of DV in the last 12 months		88.2	84.6	86.7
From whom	% women	60.0	63.6	61.5
	% men	13.3	9.1	11.5
	% both	26.7	27.3	26.9
Who filed complaint	% survivor	93.3	90.9	92.3
	% relative	6.7	9.1	7.2

About 88.2% and 84.6% of TLs in Malawi and Lesotho respectively received complaints of domestic related violence. The majority of domestic violence cases reported to TLs in both Malawi (60.0%) and Lesotho (63.6%) involved violence perpetrated against women. The survivor of the abuse in both Malawi (93.3%) and Lesotho (90.9%) was the one mainly involved in reporting their case to the TLs. The majority of TLs in both Malawi (100%) and Lesotho (91.7%) perceived women's access to TLs services in terms of DV reporting and mitigation to be the same as men.

Indicator 20: Number of women and men referred for GBV and HIV related services

The results presented in this section show the proportions of community members interviewed who were referred for DV and HIV services in the 12 months preceding the survey. Note must be taken that this is not the actual number of people referred for DV and HIV services during the project implementation period of 2011 - 2014. Table 7

[18] Note that there is no comparative baseline data

shows the proportions of community members that were referred for GBV and HIV services between 2013 and 2014 and those reporting to have accessed the service.

Table 7: Men and women that were referred for GBV and HIV service in the past 12 months

Men and Women that were referred for GBV or HIV service	Malawi		Lesotho	
	men	women	men	women
% men and women referred for GBV or HIV service (past 12 months)	30.1	36.7	35.3	35.7
% men and women referred for GBV or HIV service that received the service	100.0	100.0	83.3	80.0

About 36.7% and 35.7% of women interviewed in Malawi and Lesotho respectively were referred for GBV or HIV service during the 12 months preceding the survey. There were similar proportions of men in Malawi (30.1%) and Lesotho (35.3%) that were also referred for GBV or HIV service during the same period. Whilst all respondents in Malawi referred for GBV or HIV service managed to receive the service, about 83.3% and 80.0% of men and women in Lesotho received the service. The difference between the two countries in the proportion of men and women receiving GBV or HIV service after being referred was statistically significant ($p = 0.001$). Sex, age, marital status and education were not associated with referrals. In general, the evaluation noted that there had been an increase in the proportion of TLs who were now referring cases to police, courts and clinics (presented in other parts of this report).

Indicator 21: Proportion of referred men and women reporting satisfaction with services received

As reported earlier, most men and women that knew someone, witnessed or experienced some form of DV and reported to relevant authorities reported mainly to the Traditional Leaders, police and relatives or spouse. The evaluation sought to examine the extent to which referred survivors were satisfied with the service provided by the authority. Satisfaction was measured by respondents indicating services were easily accessible and authority was very responsive (helpful). Table 8 shows the proportion of men and women that reported satisfaction with DV and HIV services received during the 12 months preceding the survey.

Table 8: % men and women reporting satisfaction with DV or HIV service received from authority

Authority where GBV or HIV service was received	Malawi		Lesotho	
	men	women	men	women
Police	93.5	91.5	85.7	76.2
Traditional Leaders/Religious Leaders	92.3	93.8	87.1	96.3
Relatives/Spouse	80.6	87.9	71.4	75.0

	About 93.5% and 91.5% of men and women in Malawi that reported DV cases to police were satisfied with the service whilst on the other hand, lesser proportions of men (85.7%) and women (76.2%) in Lesotho reported satisfaction with service from police. The difference in proportions between women in Malawi and Lesotho reporting satisfaction with police service was statistically significant ($p < 0.05$). The majority (87-96%) of men and women in both countries were satisfied with the service they received from Traditional and religious leaders. There were relatively higher proportions of men (80.6%) and women (87.9%) in Malawi than Lesotho (71-75%) reporting satisfaction with service from relatives/spouse. Generally, the results show most men and women that received services in Malawi and Lesotho were satisfied indicating services were easily accessible and authorities were very responsive and helpful. Whilst most men and women that had been referred for DV and HIV services reported satisfaction with the services received, the evaluation could not establish whether the services had directly contributed to changes in the situations experienced by survivors. However, in one of the FGDs with women only in Berea, a typical DV case that occurred in the community involved the raping of a young girl by a young men from the same community, following which when the matter was reported to the TL and referred to the Police, it was the mother of the perpetrator who assisted in the apprehension of culprit who was taken to court and given a custodial sentence. In the past, people had a tendency of 'assisting' perpetrators if they were closely related e.g. mother harboring criminal son from law enforcers. The target community in Berea was described as now having a zero tolerance to violence especially against women and girls. In another FGD conducted with women only in Leribe District (Lesotho), a primary school teacher sexually abused a pupil and the parents felt helpless in the case until a CBV assisted the parents in pursuing the matter to police and courts following which the teacher was expelled from the school, arrested and sentenced to prison. The survivor also received some counseling and is continuing with her studies at the same school.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Community Individual Interviews ❖ FGDs (men and women groups) ❖ TLs Interviews
Conclusions	There has been strengthened capacity of government staff, CBOs, formal and informal structures to address harmful cultural practices that fuel DV and HIV infection. Trained

	cadres have become actively involved in policy formulation through participation in such forums as DV and HIV Technical Working Groups at District level. About 3 600 handbooks have been produced and disseminated in Sesotho, Chichewa and English languages. These have been very useful in training of CBVs and TLs/RLs and other community members in general and require replication for further dissemination to other areas which may not necessarily be covered by the current initiatives. There has been a significant reduction of DV cases within communities. Although physical, emotional, economical and sexual violence continue to be perpetrated, mostly against women, the average number of cases being handled by TLs per month has gone down by over half (from more than 20 to less than 10 cases per month) since the start of the project. There has been a twenty-one percent increase in the number of TLs and RLs speaking out against DV since the start of the project. Most TLs now actively conduct DV and HIV related awareness campaigns within their communities with capability of achieving more than one campaign in a given month, making use of locally available resources. About 9 in 10 TLs/RLs that have handled DV cases in the last 12 months were able to provide counseling services and referrals to police, clinics, courts, NGOs and CBOs as appropriate. Two thirds of TL's courts are now ruling cases with a gender sensitive eye and applying traditional regulations in line with national domestic violence policies, which can be directly attributed to the training received. This is being achieved through the use of the CBV paralegal manual and direct support from presence of CBVs in Traditional Court cases on DV. There has been increased visibility and participation of trained community members i.e. CBVs and MAsP within communities. These are reportedly easily accessible and very responsive. There has been increased confidence amongst TLs and RLs to address harmful cultural practices that increase risk to HIV infection and cultural practices that promote violence against women. Some TLs have now put in place by-laws aimed at eliminating harmful cultural practices promoting violence against women and HIV infection e.g.g the abolishing of child marriages in Nsanje, Malawi. Most TLs/RLs are now able to hold at least one DV and HIV related awareness campaign or meeting per month. These gatherings are quite popular in all communities and sit well within the purview of TLs' duties and responsibilities. About 8 in 10 women are now able to define abuse of any type, attributable to training and awareness campaigns, including the various platforms used by the project to disseminate DV and HIV prevention messages. However, 3 in 10 women still feel a

	woman's freedom should be restricted and this view was synonymous with girls and women that had little or no education at all. Knowledge, attitude, behavior and practices on DV and HIV prevention of community members that had been exposed to the project were higher and better than those that had never been reached by the project. In addition to general decline in DV prevalence, there has been an increase in the number of women who are now reporting DV cases to the relevant authorities especially to TLs, police and relatives/spouse. Conversely, underreporting of DV cases has gone down. Malawi, compared to Lesotho, still has relatively higher proportions of women that continued to experience physical violence in the last 12 months. More than half the women in the project targeted communities have seen printed project materials (posters, pamphlets etc.) and have been involved in community activities /sessions against violence of women not organized by the project. Women with little or no education were 2 times less likely to have accessed project material printed. Older aged couples on the other hand were more likely to have little or no education making them the marginalized group in this instance. Education level and exposure to HIV-GBV project material were both associated with increased knowledge and HIV-GBV awareness. Access to HIV-GBV materials was also associated with education. These relationships show two main things 1) Community members with higher education were better inclined to access HIV-GBV materials than those with little or no education and 2) HIV-GBV knowledge was higher amongst educated community members than those with little or no education There has been a general increase in the number of community members reporting using safer sex practices, albeit the existence of country specific variations that need closer scrutiny. For example, condom use was one and half times lower in Malawi than Lesotho. Young couples (18 - 29yrs) were more likely to initiate discussion on condom use and use a condom with partner compared to older aged couples (40 - 59yrs). Men and women attitudes differed significantly on female contraception use. There has been an increase in the number of community members seen taking part in activities to shun violence against women. Malawi had significantly higher proportions of community members than Lesotho that had been seen taking part in activities to shun violence against women. Harmful practices, although dying were still present within communities e.g. rituals like initiation practices, remarrying of deceased brother's widow, cutting hair with one razor at funeral and prohibition of women from going home for 6 months after giving birth.

	Over 50% of men and women referred for DV and HIV services accessed the service. 9 in 10 community members were satisfied with service received from police and TLs.

Evaluation Criteria	**Effectiveness**
Evaluation Question 2	**To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels?**
Response to the evaluation question with analysis of key findings by the evaluation team	**Outcome 1: Capacity of CBOs, FBOS, and Government gender staff to address the linkages between harmful cultural practices that promote violence against women and increase their risk to HIV strengthened** A multi-stakeholder approach, hinged on leveraging and wraparound funding and technical assistance has been the hallmark of the capacity building effort for CBOs/FBOs and government gender staff in the fight against GBV and HIV. SAfAIDS provided financial and technical assistance in the fight against GBV and HIV. As alluded in other sections of this report, SAfAIDS engaged government (Ministries of Gender, Education, the Police, Health, among others), while working collaboratively with the UN family (UNTF, UNAIDS, UNFPA, and UNICEF) and civil society (the 10 CBO/FBOs). SAfAIDS, thus adopted a TOT model, where a core team from across these entities (excluding the UN family) where trained on key GBV and HIV facets. The trained personnel then cascaded the trainings at community level. Additionally, the members of the TOT also participated in the various community dialogue sessions at community level. **Outcome 2: Traditional leaders (TLs) capacitated to champion prevention of domestic violence against women and HIV within their own communities** About 2,021 traditional and religious leaders (Result and activity Report, Cylce 15) in the targeted districts were capacity built in the targeted districts. Areas of capacity building[19] hinged on the key elements of both GBV and HIV (in their context), legislative instruments, counseling, handling of cases (including applicable punishment, without infringing on the rights of both the survivor and

[19] Note that there was specific training for all TLs including a leadership support toolkit. There were 10 community workshops targeting traditional leaders with relevant information

	perpetrator) as well as referrals to police and clinic. More importantly, the role of paralegals has been important in helping RL/TLs handle cases at community level. Paralegals[20] are "volunteers" in the community with some degree of schooling, usually secondary education, who were trained by SAfAIDS in a broad range of knowledge areas, notably: family law, rights of women and children, legitimate powers of law and law enforcement institutions, laws pertaining to sexual offences, land law, inheritance law, counseling techniques, court procedures, constitutional law, gender issues, the access to justice of paralegals and basic knowledge of lobbying. Thus traditional leaders, in consultation with paralegals, have been able to transform power relations and bring equality to both men and women. One member in a women-only FGD described paralegals as "our advocates", protecting women with different problems with such services as basic rights follow up and all matters pertaining to legal issues. Interviews with the VSU across the two countries showed that paralegals have played a critical role in ensuring that chiefs adhere to modern law, and that they have actively followed up on all cases referred to the police. In both Malawi[21] and Lesotho, there are designated days on which the TLs conduct community court sessions. Thus on all these days the paralegals are "ever present". "They are part of our system", said one VSU Officer in Malawi, "and we have heavily relied on them to handle some of the cases at the community level in consultation with the TL". This, he says, "has helped build the confidence of the community in the TL system. The situation is even more effective where some of the CBVs are actually paralegals as most of the cases are dealt with in a faster and effective way". Traditional Leaders preside over court cases such as emotional or psychological or economic abuse cases (from a counseling, retribution or restorative justice perspective), and refer cases such as physical abuse and rape to police, mostly because of their gravity. Paralegals document all traditional court proceedings as part of knowledge management, but more importantly, ensuring that the TLs are aligning their judgments to modern laws. In Nsanje for example, a married couple is now being selected to perform the practice of wife sexual cleansing in place of hiring a man to have sexual intercourse with a widowed woman. **Outcome 3: Capacity of women to report incidences of all forms of abuse and domestic violence in project sites increased** In Phalombe, prior to 2011, the VSU handled about 40 cases; now handling

[20] 25 CBV were trained as paralegals in each country
[21] Mondays and Fridays typically

	between 10-20 cases – reckons that this number could go down, but the project is operational in some part of district —hence the need to expand it to cover other areas. In Nsanje, prior to the project, they were handling about 35-45 per month but currently they are handling about 15 per month. In Chileka, the VSU reported that prior to the project, they were handling about 60 per month, but now currently handling about 10-15 cases. In Lunzu, about 10-15/month were being handled, but currently about 15-20 cases were being reported. The VSU attributed these changes to increased awareness and knowledge, from a number of stakeholders who have done IEC related interventions. On average, between 4-6 of the cases reported per month are taken to court, while the majority of perpetrators are fined – about MK10,000 (in Malawi). Data showed that mainly women and children were the survivors of such violence or abuse. In Lesotho, the VSU in both Berea and Leribe reported that they have been handling an average of between 5-10 cases, down from over 15 cases they handled prior to the project. Repeat perpetrators were reportedly less than 5% in both countries. Overall about 30% of the reported cases are prosecuted in Malawi, while in Lesotho; about 40-50% of the cases are reportedly prosecuted[22]. For children, it related more to guardian abuse centered around failure to provide support on food and education as well as beatings. The project through training more than 10,000 Men as Protectors and overall reaching out to more than 300,000 men with DV and HIV prevention messages has contributed reduction in violence against women and children in the project target communities. In Malawi, FGDs (with CBVs, MAsPs and community members) and KIIs (with the health personnel and police) revealed that clinics and police stations were far away, and hence it was not easy to report well in time, hence the importance of a functional traditional system for handling cases.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Project reports ❖ Focus Group Discussions ❖ Key Informant interviews
Conclusions	The capacity of 9 CBOs and 6 Government Departments has been strengthened in cultural approach to addressing linkages between harmful cultural practices that promote violence against women and increase risk to HIV infection.

[22] There is no comparative baseline data

	Financial and technical assistance provided through the SAfAIDS project has been instrumental in driving the positive results noted above. The TOT model whereby trained cadres at national, provincial and district levels cascaded the trainings to community levels needs to be sustained as it has demonstrated far reaching effects with minimal cost implications. More than two thousand Traditional Leaders (TLs) have been capacitated to champion the prevention of domestic violence against women, with the support of paralegals (Community Based Volunteers). There has been an increase in the proportion of traditional leaders presiding over court cases supported and supervised by trained paralegals with the necessary documentation of proceedings in place.

Evaluation Criteria	**Effectiveness**
Evaluation Question 3	**How many beneficiaries have been reached, primary and secondary beneficiaries?**
Response to the evaluation question with analysis of key findings by the evaluation team	

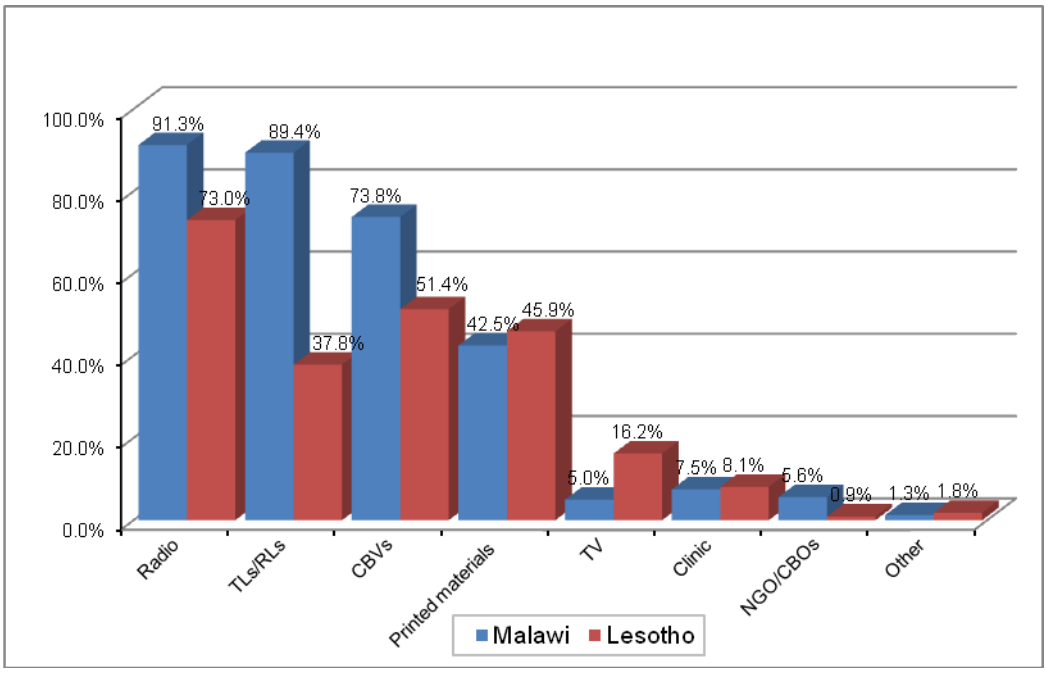
Table 9: Actual number of primary and secondary beneficiaries reached

Beneficiaries reached	Malawi	Lesotho	Total	Target
Women and Girls (15 49 years)	257,475	230,121	487,596	10,000
CBOs	5	4	9	10
TLs/RLs	1,056	965	2,021	500
CBVs	25	20	45	45
MAsPs	4,291	6,565	10,856	3,000
Men	167,359	149,578	316,937	3,000
Government Departments	6	6	6	6[23]

Table 9 shows the actual number of primary and secondary beneficiaries reached during the 3 year project implementation period. Over 480 000 primary beneficiaries (women and girls) in Malawi and Lesotho were reached during the 3 year cycle compared to about 300,000 men within the community. Nearly 11,000 men in Malawi and Lesotho were mobilized through Men As Protectors (MAsPs) activities, which far exceeded the project target of 3 000. Six government departments were capacitated and these include Gender, Education, Health, Police, Judiciary and Local Government. GBV and HIV information was disseminated through several platforms to reach out to the community. Figure 7 shows the various platforms used to share information on DV and HIV.

[23] Institutions - Gender, Education, Judiciary, Police, Health, Local Government

Figure 7: Sources of DV and HIV prevention messages received over last 12 months



Multiple response analysis shows the DV and HIV prevention messages aired on radio were accessed by 91.3% and 73.0% of men and women in Malawi and Lesotho respectively. Whilst 89.4% of community members in Malawi accessed DV messages from TLs/RLs, only 37.8% in Lesotho accessed DV messages from the same source. There were also significantly higher proportions of community members in Malawi (73.8%) than Lesotho (51.4%) that accessed DV and HIV messages from the CBVs. The other important source of DV messages were printed materials reaching out to 42.5% and 45.9% of the community members in Malawi and Lesotho respectively. Other sources accessed by fewer community members include the TV, Clinic and NGO/CBOs. Of the various sources of information on DV and HIV prevention, the radio (57.8%); TLs/RLs (15.2%); Community Based Volunteers (12.2%); and printed material (5.9%) were cited as the major sources in both countries.

The Malawi DHS 2010 noted that there were disparities in the exposure to mass media between sexes. The Malawi DHS 2010 report noted that although more than half of females (57%) listened to the radio at least once a week, more than three-quarters of men (76%) did so. The same reported further indicated that the percentage of men who are exposed to all three forms of media (newspaper, television, and radio) is about three times that of women (14% compared with 5%). These disparities are important information for programming in trying to choose optimal time for airing programme which captures a majority participation of both sexes.

	Radio: This platform was utilized in both Malawi and Lesotho ("Tseba ka AIDS"). The radio talk and phone in shows focused on GBV, violence against women and AIDS. In Lesotho, the show was aired between 8-10pm on Thursdays, while in Malawi; the program was aired between 4-5pm on Fridays[24]. The show invited different guests/stakeholders to the studio to talk about different themes – Ministry of Gender, Victims of Violence (women and girls), prostitutes on the street (in terms of their experiences and how they deal with consequences), PLWHIV and problems they encounter, private sector and the services they offer (e.g. GBV counseling, HTC etc.). The shows commenced in 2013. Nonetheless, in Lesotho a similar program had already been taking place, while in Malawi it was the first of its kind. The Lesotho program has continued to date, while the one in Malawi stopped when SAfAIDS support ended. According to the producers of the program in both countries, the radio shows had more women callers initially, but with time, men joined in and have "been contributing a lot to the discussions". Discussions showed that they were very popular programs, targeting the general population at large. Radio Lesotho reaches every corner of the country, and is also accessible in South Africa and Botswana. Hence they were also call-ins from these countries. In Malawi, Zodiac radio station is one of about 10 radio stations, but one of the popular stations. The radio producers indicated that such programs were critical in "creating a safe environment for everyone" and that "people now know where to go and report cases[25]", while highlighting that "people still need a lot of information on GBV/HIV related IEC". There was recognition that the programs should continue, although funding remains a constraint (need resources to go to the communities to conduct interviews and radio talk show programs). There were also strong views on the need to exploit the TV space to enhance coverage and catch a bigger audience. The producers also flagged the need to explore possibilities of a multi-country radio and TV program, given issues to do with migration (as women are left behind, and their spouses might not be exposed to the messages). Public community dialogue sessions: These were commonly held at the Chief's place, community centre, schools or churches. On average the TLs indicated that between 50-90% of the community participated (because of the power the TLs wield in the communities). At such sessions, TLs, RLs, CBVs, MAsPs, Government entities (Police, Ministry of Gender, Education, Health other NGOs) participated and provided GBV/HIV related IEC to the communities. Given that over 90% of the interviewed households are Christians, the church becomes an

[24] Refer to figure 7 above showing the popularity of radio as major source of DV and HIV information

[25] The word is spreading

	important platform to use/expansion. Door to Door visits: This was basically used as a direct way to address people with physical constraints (due sickness/advanced age), families that needed help with resolving disputes or issue relating to intimacy in the families etc. Door to door was also being done to make sure people take up their medication. Help line: During community dialogue sessions, CBV shared their cell phone numbers. This was meant to create a platform where survivors could call anytime if in need of assistance. While getting airtime is a challenge given the poverty situation, the community FGDs indicated that it is very effective in attending to urgent domestic violence cases on time. Schools: This was also a good platform, but not across all the program areas. There was recognition that this needs to be developed better in tandem with the Ministries of Education and Gender. Schools could potentially utilize school clubs and quiz competitions, dramas, parents' gatherings at schools etc. Nonetheless, in instances where this platform was utilized, teachers were very cooperative. In one instance in Malawi, the CBVs and MAsPs conducted a dialogue session at Ntenjela Community Day Secondary school. It was reported that several violence/abuse issues pertaining to both boys and girls came out, and the school has since requested another dialogue session, where referral units (Police, Health) will also be invited. Organized demonstration: Although this was a rare platform at community level, in one case in Lesotho, an orphaned child was murdered by an uncle he lived with. The "whole" village marched to the Police Station to report the case and "push" the police to act on this and other cases of abuse which had been reported previously. The self-policing group includes "anyone and everyone" in the community, though mostly men, who blow the whistle (as sign of a sign that there is a problem at a particular house or community point). Whenever it is blown, people start gathering at the place of the incidence, arrest the offender and bring him before TL. They are working closely with the police to report crime and violence, mostly in Malawi.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Community Individual Interviews ❖ Focus Group Discussions (FGDs) ❖ PowerPoint Presentation on "Ending HIV and Domestic Violence: Redefining the role of Leadership". SAfAIDS ❖ Result and Activity Report (Cycle 15)

Conclusions	The SAfAIDS project DV and HIV prevention activities and messages managed to surpass the targeted beneficiary groups at all geographical levels. The most common sources recognized by communities for DV and HIV prevention messages were the radio, TLs/RLs, CBVs and printed materials. This sits well with the project model which mainly promoted these information dissemination avenues. However, other population groups are marginalized by circumstances like low education levels in terms of their awareness and access to these sources.

Evaluation Criteria	**Effectiveness**
Evaluation Question 4	**To what extent did this project generate positive changes in the lives of the targeted women and girls in relation to specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and or girls? Please describe those change**
Response to the evaluation question with analysis of key findings by the evaluation team	Some of the positive changes that came from the project were: Modification of harmful cultural practices - In Malawi, for example, one woman, a widow, was being forced to be sexually cleansed by the relatives of the deceased. She reported the case to the CBVs, who took the case up with the TL and the Police. The family was summoned and the sexual cleansing ceremony was stopped. Other cultural practices promoting DV and HIV infection that are transforming include: - Wife inheritance: Typically involving one brother re-marrying widow of deceased brother as a custom to inherit wealth left behind. Increased awareness of HIV infection and spread has contributed to a decline in this practice. - Initiation practices of young men are going down although still being practiced within sections of the target communities. Of positive note are the safer practices now being adhered to at such schools such as use on one razor blade per person. In Leribe for example, Traditional Doctors have been included as part of their Initiates Curriculum the issue of HIV and Aids and as such all young men and women to be initiated go through a mandatory HIV testing and are assisted with medication where necessary. This never used to happen before. - Polygamous marriages continue to be in practice although there have been increased safe sex practices due to increased awareness of HIV prevention. - People now have the right information on GBV and HIV in Malawi

	(90.2% of survey participants) and Lesotho (91.0% off survey participants through locally established information dissemination platforms like Traditional/Religious Leaders; and Community Based Volunteers. - Women were responsible for reporting on issues to do with GBV in their areas. After the project women are now able to and know where to report cases of GBV that occur in their homes and their communities. - Men support and protect women from GBV and HIV infections by participating in Men as Protectors clubs - Decline in prevalence GBV cases since project inception - Cultural practices promoting DV and HIV infection dying down such as: forced marriages and early marriages. Early marriages reflect that the SADC Gender Protocol, the African Charter on the Rights of Women, the convention on the Rights of the Child are being violated; - People openly discussing sex and sexuality issues The SADC Gender Protocol alliance uses two yard sticks to gauge progress i.e. the SADC Gender and Development Index and the Citizen Scorecard based on perceptions. The SGDI remained stagnant at 66% from the previous year (2012). The SADC CSC shot up from 57% (2012) to 66% (2013), thus reflecting the optimism in SADC that change is coming. In Lesotho, the CSC was 80%[26], the highest in the region, as citizens felt that their government has improved in dealing with GBV. However, for Malawi, the CSC remained low at 51% (fifteen percentage points below the average in SADC, thus reflecting the amount of work that still needs to be done).
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Traditional Leaders tool ❖ Community individual tool ❖ FGDs (men and women groups**)**
Conclusions	There has been a significant decline in the practice of harmful cultural practices promoting DV and HIV infection although issues like wife inheritance, initiation practices and polygamous marriages still need to be addressed. Women are now able to report GBV issues to relevant authorities with confidence. Most women referred for GBV and HIV services are accessing the

[26] This is a 17 percentage point increase compared to 2012

	services and expressed satisfaction with their accessibility and responsiveness

Evaluation Criteria	**Relevance**
Evaluation Question 1	**To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls?**
Response to the evaluation question with analysis of key findings by the evaluation team	The project was evidence driven. KABPs were conducted in both Malawi and Lesotho prior to project implementation. In summary, both KABPs, complemented by other secondary data, showed that GBV and HIV were issues which warranted urgent attention. Secondly, evidence also showed the strong linkages between GBV and HIV. More importantly, in both countries, like most of SADC countries, both GBV and HIV were strongly rooted in culture. More importantly, the KABPs, other secondary data and dialogues at national and sub-national levels recognized the important role that TL/RLs play in the community, more so given that most of the perpetrators of GBV were men. It was with this background in mind that the project was borne, with implementation beginning in 2011. Consequently, as part of project take-off, national and district level dialogues were conducted in both Lesotho and Malawi. The focus of these multi-stakeholder dialogues was to create mutual understanding, while soliciting for ideas and possible roles that all stakeholders would play in this intervention. At the same time, this platform was utilized for stakeholder capacity building[27] on HIV and GBV issues, with a focus on the nexus between the two. This culminated in the establishment of district taskforce teams comprised principally of the SAfAIDS supported CBO/FBOs, personnel from Police, Health, Gender, in some instances Education, other NGOs like Concern Worldwide, Red Cross etc., TL/RLs, business people, among others. The principal role of these taskforces was to initially go and sensitize communities on the project focus. After sensitization[28], the taskforce then engaged communities in a phased way and facilitated approach entailing the following (summary of the SAfAIDS Culture Dialogue Model): -"Round 1 of the dialogue to break silence" - community put into groups – women[29] and men (further disaggregated by age as appropriate, custodians of culture). In these groups, the communities discussed key issues related to

[27] using the "changing river flow" training packages, capacity building was done to lead trainers, district trainers, traditional leaders and volunteers

[28] Including the roles and responsibilities of each entity in the project

[29] It was recognized that women were reluctant to flag their issues when combined with men hence the disaggregation by sex

	GBV (with an emphasis on IPV) and HIV. These groups would then be brought together (depending on circumstances), from where key themes on GBV and HIV would be flagged out. This was meant to be the first phase of flagging critical GBV/HIV issues to the community while at the same time offering an opportunity to identify the entry point in addressing these issues. -"Round 2 of dialogue to increase understanding of linkages" –bring men, women, custodians of culture and the whole community to cement earlier discussions while flagging the important GBV/HIV linkages -"Action dialogue" – mixed meetings, usually characterized by louder voices from women, while offering a window of opportunity for critical transformative issues to be flagged for everyone These important processes culminated (over a period of time) in the formation of the CBVs), while establishing working relations with the main taskforces. What followed was a series of community dialogue sessions utilizing the various platforms elaborated in earlier sections. What is critical to note here is that the focus of the taskforce and the community structures was "women", while recognizing that in most instances "men" were the perpetrators. This "later" recognition resulted in the formation of the MAsPs, whose "initial mandate" was to try and convince men to be part of this process, as their participation in the initial phases of the project were low – both in terms of presence and being aware of these critical issues. Community dialogues focused on IEC, while referral units were strengthened to be "gender" sensitive in their approaches to dealing with women. While these process issues have evolved over time, it is worth noting that the project has maintained its focus on ensuring that the needs of women and girls are addressed. Lesotho has adopted the National Action Plan to End GBV; and Malawi has the National Action Plan to End GBV; and National HIV strategic plan, which all emphasize the role of taking the family approach i.e. involving both men and women in the fight against HIV and GBV.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Key Informant interviews ❖ National Action Plan to End GBV (Malawi and Lesotho) ❖ National HIV Strategic Plan (Malawi and Lesotho)
Conclusions	The project design was informed by KABP baseline studies in both countries which revealed the magnitude and extent of GBV and HIV infection that warranted addressing. GBV and HIV infection were strongly linked to culture and the role and

	importance of TLs and RLs in addressing DV cannot be underscored. Multi-stakeholder participation throughout the project life ensured complementarities and meaningful partnerships between Government Departments and Civil society organizations.

Evaluation Criteria	**Relevance**
Evaluation Question 2	**To what extent do achieved results continue to be relevant to the needs of women and girls?**
Response to the evaluation question with analysis of key findings by the evaluation team	The following remain critical issues and hence the need for continued focus: Interviews with the 15-24 year old women, especially in Phalombe, Malawi, showed that young women still “mistrust and feel insecure” to the police. The same discussion also highlighted while they feel at easy to report to CBVs and at times even MAsPs, they still feel that the community in general “does not generally understand them”. Hence the need to take a different approach that addresses the needs of this particular group given their vulnerability to both HIV and IPV. As the information presented above shows, some TLs are still embedded in the old cultural space. Hence there is need to continue educating them and identifying key champions and exchange programs for them. The Malawi National HIV Prevention Strategy, as one of its strategic approaches in reducing risk of HIV transmission through harmful cultural practices prioritizes the building of capacity of traditional and religious leaders and other local opinion leaders to speak against harmful cultural practices, beliefs and norms that perpetuate sexual transmission of HIV while reinforcing cultural practices that are positive. As such, continued effort is critical in supporting the role and function of TLs and RLs in the fight to eliminate domestic violence and harmful cultural practices increasing risk of HIV infection in women. In the same vein, there is need to continue strengthening the role of paralegals so they can assist chiefs. Qualitative data also showed that where CBVs are also paralegals, cases are handled faster and followed up more effectively; hence future interventions might target qualified CBVs to also act as paralegals. The SADC Gender Protocol Alliance 2013 Barometer notes that “the majority of women in the SADC region are governed by customary laws that relegate them to second class citizens. Harmful gender practices continue to be justified in the name of custom, culture, religion and tradition”. Thus the role of paralegals was and remains critical in this project and communities. While there have been improvements on the HIV front in Lesotho and Malawi, the high HIV prevalence remains a critical issue affecting women and girls.

	While CBVs, MAsPs, Police and other sector staff have been trained, the information presented elsewhere in this report shows that there is still need to train more of these cadres to enhance access, while at the same time exploring opportunities for expanding into other currently non-targeted areas where GBV and HIV are still critical issues needing urgent redress. Alcoholism was cited as a big problem in both Lesotho and Malawi and an urgent issue to address as part of the efforts to fight GBV and HIV, more so from women. Given that under this program, addressing alcohol abuse was a silent component, and given its impact (from a woman and girl child perspective), it is worth investing more in this area. The establishment of CBVs and MAsPs was an important pillar of this intervention. However, focus group discussions with these entities showed that in most instances, their activities, while being complementary have been "separate", both in the spatial and temporal dimensions, and at times with a separate audience. While this has been important in enhancing coverage and addressing some of the identified barriers, it is time now to encourage women and men's groups to interact more and more so as to break communication and expectations barriers. This will also be critical in creating the trust, and giving an opportunity to survivors to freely consult with any of these groups, depending on access. The following cultural practices; the practices done on first pregnancy of a woman; rules for widowed and women mourning for a child; initiation schools – are still happening, although on the decline. They infringe on the rights of women and girls, and therefore the need to totally eliminate them.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ FGDs with men and women groups ❖ Community individual questionnaire ❖ Key Informant Interviews
Conclusions	Women and girls continue to be disproportionately affected by GBV compared to their male counterparts warranting coordinated efforts at all levels to end violence against women. Whilst training of TLs in the cultural approach to addressing DV and HIV infection has increased the knowledge levels and participation of TLs in the fight to end DV against women, there is still need to continue strengthening the role of CBVs operating as paralegals. Alcoholism and substance abuse were identified as common factors causing

	DV, hence the need to specifically address this in the project in order to have sustainable reduction of DV against women. Community Based Volunteers (CBVs) and Men As Protectors groups have been very useful in increasing awareness of DV issues within communities and need to be replicated in other geographical areas. Men as protectors were lauded as providing critical support to educating other men on DV and HIV. They are also providing counseling services. Most of them were part of the community and school development committees. They were also working closely with CBVs.

Evaluation Criteria	**Efficiency**
Evaluation Question 1	**How efficiently and timely has this project been implemented and managed in accordance with the project documents**
Response to the evaluation question with analysis of key findings by the evaluation team	The total amount disbursed to implementing partners over the 3 year period from 2012 to 2014 was US$157,738.74, accounting for 12 % of the total approved budget of US$1 300 216.74 for the entire project. On average, each organisation received about US$17,500 over the 3 year period with the exact amounts ranging from US$12,700 to US$21,030.40. In 2012 the average amount distributed per organisation was US$6,221.49 which rose to an average of US$7,000 in 2013 before receding to about US$4,300 in the third year. The financial resources provided to implementing partners through the project were useful in driving the positive results noted above. The TOT model, where initially 50 lead trainers were capacity built over a 5 day period, culminating in the training of 125 provincial and district level trainers (3 day), provided a platform for a far wider reach. The trained personnel at provincial and district level cascaded the trainings down to the community level, targeting the CBVs and TLs, among other stakeholders. This was a cheap option, as the alternative was for SAfAIDS to do all the trainings across the countries – would have been expensive both in terms of time and reach. It was also “efficient” in that it brought indigenous technical knowledge to the trainings and thus made the trainings more relevant. As highlighted in other parts of this report, the trained structures are all community based. This cuts on such costs as transport and perdiem. Had it been that the SAfAIDS was directly rolling out the interventions, costs would have been higher, while time would have been lost in transit. The use of community structures – chief’s place, community centres and halls – not only brings a sense of ownership and belonging but reduces costs

	related to space rental and the related procurements. All activities were implemented on time. Partners had received capacity building on how to plan activities, request for funding, liquidate funding utilized on time to avoid delay in activities.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	1. Expenditure Report per Partner (SAfAIDS) 2. SAfAIDs workplan 3. Annual reports
Conclusions	The project managed to surpass most of the set project targets with most indicators showing positive achievements over the three year project lifecycle. The use of CBVs, and the program approach in general targeting TLs and RLs proved successful in the target areas and can be replicated in other areas as well.

Evaluation Criteria	**Sustainability**
Evaluation Question 1	**How are the achieved results, especially the positive changes generated by the project in the lives of the women and girls at the project goal level, going to be sustained after this project ends?**
Response to the evaluation question with analysis of key findings by the evaluation team	It is worth noting that the project was hinged on community structures: CBOs/FBOs, TLs/RLs, CBVs, and MAsPs. At the same time, the project involved key government entities, notably the Ministry of Gender (and Community Development or Social Services), the Police[30], Health and in some instances, and Education. Broadly, the project worked with "development committees" at district and ward/traditional authority level, which are multi-stakeholder entities. Thus the project is well rooted at the appropriate levels to allow it to be sustained. Sustainability, in this realm, was enhanced because of the capacity building, participation in the various platforms at national (e.g. the indabas), district (through the multi-stakeholder meetings) and community level (through the community dialogues). These engagements helped bring interface between the various national/sub-national stakeholders and the communities, and thus helped create working relationship, while enhancing access for the survivors. Insert 2 shows people gathered for an Indaba on DV and HIV prevention issues in Lesotho.

[30] In Malawi, 120 prosecutors, magistrates, and social workers were trained in gender related laws in 2012, and 34 Child Justice Magistrates, 37 Probation Officers, 39 Prosecutors and 34 court clerks were trained in child justice system to strengthen provision of judicial services in all magistrates courts in Malawi. Two child friendly courts are also operational in Blantyre and Zomba area, while VSUs have been established in 34 police stations, 13 police posts and 200 support units in 300 TAs.

Insert 2: Indaba on DV and HIV prevention held in Lesotho (October 2014)

Nonetheless, a couple of issues were also flagged at district and community level. More importantly are the following issues:

1. Transport is a big challenge for Police/Health and CBVs/MAsPs and hence coverage is minimized. In the same vein, these entities also reckoned that it was difficult to make visits during the rainy season.
2. For the police (and to some extent Health), victim support systems were constrained – e.g. transport money to go back to their areas once they access services, accommodation facilities and support (e.g. blankets and food, etc.) when they come and report cases/seek services at night
3. Proper counseling and guidance when they come and report cases at a time when the trained personnel are not there

Uses of such platforms as the Chief's place, community centers, schools, churches, among others make the initiative low cost. Thus at any time, provided there is a desire, dialogue sessions can be held in the community to address GBV/HIV issues, as well as any other emerging issues. This is also made easier given the fact the CBVs/MAsPs/TLs/RLs all live in the community. Table 8 shows the proportions of community members willing to continue engaging in DV prevention activities.

Table 10: % community members likely to engage in DV prevention activities in next 12 months

Activity	Malawi	Lesotho
Participate in debates or talks in the community on violence	99.4	89.5

Talk to people in your community about ways for couples to have relationships with shared decision making	99.4	94.4
Talk to people in your community about ways to prevent violence	99.4	92.7
Try to help a woman who you know experiences violence from her husband	98.3	93.5
Try to help a man who you know uses violence against his wife	97.7	87.0
Gather other community members to help when you hear and see violence between a husband and wife.	97.7	92.7
Report violence you hear or see between a husband and wife to a community activist, LC or police or other authority?	99.4	92.6

The majority of community members in Malawi (97-99%) and Lesotho (87-94%) reported willingness to continue engaging in DV prevention activities. The differences in the proportions between the two countries were however statistically significant in all cases ($p < 0.05$). On the other hand, 9.5% of women compared to 3.2% of men were unlikely to try to help a man who they knew to be using violence against the wife. The difference was statistically significant ($p = 0.033$). In general, the high willingness of both men and women in communities to engage in DV prevention activities in the 12 months post project implementation gives indication of a solid foundation for sustainability through active community involvement.

The initiative to recognize proactive chiefs as champions of change was well received at the national indabas held in both Lesotho and Malawi. “It has acted as stimuli and we will go all the way to influence other chiefs who are still in the dark”, said one Chief from Lesotho. The initiative has thus created leading lights in the community, and given the respect that chiefs have, can only lead to better and sustained changes.

The government through the Ministry of Gender has created a platform for partners like SAfAIDS to support the fight against DV and HIV. In this realm, a number of laws and policies have been put in place, which shows a commitment on the part of the governments concerned. In Lesotho, the government now has a zero draft of the GBV policy – a critical piece for the GBV efforts in the country. More notable for Lesotho is the signing of the UN Women document by Prime Minister Motsoahae Thomas Thabane pledging

	his government's commitment[31] to fight violence against women. He made the same pledge at the SAfAIDS organized indabas in Maseru on October 1, 2014. Political will is critical in the fight against violence against women and HIV. Similarly in Malawi, the government has done the following since 2011: signed the Gender Equality Bill into Law[32] (February 2013), while the new National Gender Policy was finalized. Both countries also commemorate the "16 Days of Activism on Gender Violence", with strong multi-stakeholder participation[33], and have all ratified the SADC Gender Protocol. However, financial resource commitment by both governments is very low and hence support from partners like SAfAIDS is critical. Resource leveraging and wraparound funding is also critical for sustenance.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Community individual questionnaire ❖ Men and women FGDs ❖ Key Informant Interviews
Conclusions	The project approach of targeting CBOs/FBOs, TLs/RLs, CBVs and MAsP has been important in establishing self-sustaining community based formal and informal structures for addressing DV and HIV issues. These structures, despite being embedded in the roots of communities require some form of financial support for them to continue to operating viably. There are high proportions of community members that expressed willingness to continue with DV prevention activities. The high knowledge and awareness levels on DV prevention need to be sustained.

Evaluation Criteria	**Impact**
Evaluation Question 1	**What are the unintended consequences resulting from the project?**

[31] Entails the following commitments: Enact legislation to end impunity, bring perpetrators to justice and provide women with repatriation and remedy for violations perpetrated against them; Support the collection, analysis and dissemination of national data on prevalence, causes and consequences of violence against women and girls; Mobilize men and boys of all ages and walks of life to take a stand against violence against women and girls and fostering equality and gender solidarity

[32] The law offers protective mechanisms towards the violation of right for females and outlines explicitly the areas under which discrimination, harmful cultural practices and sexual harassment are prohibited

[33] In Lesotho, the 2013 VAW baseline showed that only 14% of women and 64% of men knew about this event.

Response to the evaluation question with analysis of key findings by the evaluation team	Protection of spouse: while the above data shows that awareness on GBV is now high, the fact that women are still not empowered economically has ushered in an element of reluctance to report cases –"if he goes to jail who will take care of children". In both Lesotho and Malawi, there were reports of women survivors who had withdrawn cases. As such two MAsP groups in Lesotho's Berea area have started household economic strengthening projects (notably chicken rearing and garden projects). There will be need to see the net effect of such HES projects and expand them accordingly. Awareness on rights has brought about a realization that there are other needs which need to be addressed. More importantly issues on food, educational support, and birth certificates for children, more so those staying with guardians. Hence most of the SAfAIDS partners have started coordination meetings with such partners as Concern Worldwide and government institutions to help address these issues, while keeping the local leadership in the picture. In Lesotho, Berea, the traditional leaders have put in place a mechanism where public bars are closed "well in time". While this affects the bar owners, this "has decreased the crime in our community". The focus on HIV, more aspects on HTC and PMTCT, has resulted in facility deliveries, thus positively influencing child birth outcomes. Former perpetrators are in the MAsP groups across the targeted areas. This has brought mixed reactions, mostly positive but in some instances women view it with suspicion. Broadly it has been viewed as a useful model hence the need to make sure the model is clear to the community. Both the CBVs and MAsP groups have been encouraging children to be in school, under the "second chance educational scheme" where early married or impregnated children have been re-admitted back into school. In Malawi, the readmitted children have taken up the role of "change agents" where they share information with other children at school based platforms such as school clubs. While the emphasis on child support, from a human rights lens, has gathered momentum, the need to focus on children who are staying with guardians has become important. It was noted that these are "children in special circumstances and requiring special needs" hence the need to address their needs as a special group. In Phalombe, Malawi, perpetrators were being released instead of being kept in custody pending trial because there are no cells to keep them for the

	stipulated 48 hours. The VSU also reported that it was difficult to take them to courts owing to transport challenges resulting in most of them being forced to pay fines only. For all the VSUs interviewed, it was noted that only two officers had been trained. In the end, when these two officers are absent from the station, and "when a survivor comes to report a case, the other officers would wait for us and this delays the process". The same was also noted in some of the clinics, where the "untrained health personnel" are not fully equipped to handle such cases resulting in survivors failing to access quality and timely service. In another case in Blantyre rural, some CBVs managed to stop two teenage girls from getting married. While they succeeded in doing so they later discovered that the girls were pregnant. The girls have since delivered, and now plan to go back to school. However, they come from poor families and hence are failing to raise money to go back to school. Interviews with the CBVs who acted on these two cases showed that the parents and the girls were now complaining that "you stopped the marriages but are you not supporting us to be in school or have food on the table". Efforts to get support from the Social Services Unit have been fruitless as they only supports orphans who have passed standard 8 to national secondary schools. This has caused problems for the CBVs concerned. While the program has not deliberately targeted school children, some CBVs have engaged schools as part of raising awareness. In Malawi, for instance, CBVs conducted a dialogue session at Ntenjela Community Day Secondary school in Nsanje. The CBVs and the school authorities highlighted that several issues to do with GBV, SRH and HIV came out, and the school children have since requested to have other dialogue sessions. The CBVs plan to bring referral units from Government departments when they conduct the next dialogue session. They are also planning to expand this model to other schools in their catchment. While both Malawi and Lesotho have been conducting traditional male circumcisions, the HIV awareness activities held by partners in the targeted areas have fostered a culture of "smart circumcisions" encompassing use of clinics for wound care and counseling, and use of one razor blade for each circumcision.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response	❖ Community Individual questionnaire ❖ FGDs for men and women ❖ Key Informant interviews

and analysis above	
Conclusions	The need to protect the spouse even in instances of violence shows the importance of economic empowerment programs. Awareness on rights has brought about a realization that there are other needs which need to be addressed. More importantly issues on food, educational support, and birth certificates for children, more so those staying with guardians. The need to train other sector staff is also an important one, so are economic empowerment started by other communities.

Evaluation Criteria	**Lessons learnt**
Evaluation Question 1	**Generate key lessons, working and effective models, and identify promising practices for learning**
Response to the evaluation question with analysis of key findings by the evaluation team	The SAfAIDS cascading TOT model adopted by the project was effective (cost wise and technically). The various government departments, CBO/FBOs and traditional leaders were trained by SAfAIDS. They in turn, trained the CBVs and later the MAsPs. Together, they helped facilitate community dialogue sessions at community level. What was more critical was that the CBVs, MAsPs and TL/RLs were rooted at the community level and used community platforms to do GBV/HIV IEC related activities. This helped cut on costs while at the same time, reaching a large number of people. The Rock Leadership Award, for TLs in recognition of the critical role they are playing, has ushered in an era of change in the communities. As alluded to earlier on, TL/RLs are the custodians of culture in both Lesotho and Malawi. Hence the concept creates “influential change agents”, a feature that will help sustain the gender transformative approach in the targeted communities. This concept is strongly complemented by the establishment of CBVs, MAsPs and training of community based paralegals to help push and sustain the transformative agenda. The role of such players as UNICEF and other UN agencies[34], Government (including Ministry of Local Government[35]) and NGOs (e.g. Concern World Worldwide[36], among others) in this agenda cannot be overemphasized. Leveraging and wraparound support is an important piece of an effective and integrated programming model.

[34] Helped with both capacity building, resources including VSU Registers and vehicles
[35] Oversee the TLs
[36] Resource leveraging, capacity building and reporting

	The evolving role of men as "change agents" in the community is evident. Qualitatively computed data showed that the percentage of men attending community dialogue sessions has been increasing since the project started[37]. Individual interviews also showed that awareness on critical GBV and HIV issues among men has increased over time. Careful attention however needs to be directed towards ensuring women are equally involved in the project. The pilot mHealth[38] platform utilized for both reporting to SAfAIDS and as a platform which survivors could use to report urgent cases is an effective platform that should be further strengthened and expanded**.** Mobile phones were given to CBVs as part of this effort. The national leadership indabas held in Lesotho (October, 2014) and Malawi (October 9, 2014), had a wider representation from both state and non state actors; community, and CSOs. The platform allowed for wider and broad based discussions, hinged on policy adoption, funding, commitments and overall implementation of the zero tolerance against GBV and zero new HIV infections. Worth noting was the recognition by stakeholders that such a platform was critical for knowledge management and knowledge sharing, while SAfAIDS was applauded for its role in documenting best practices and initiatives. If such initiatives could be expanded to district or provincial level, they could also make a significant difference, and help bring players together. The community referral system encompassing TLs, RLs, police, schools and health facilities proved to be a vital cog in this puzzle; access to survivors was enhanced. The role of CBVs, MAsPs and paralegals in this effort was also a critical piece. The capacity building of paralegals and documentation of traditional court hearings changed the scope and lens with which traditional leaders operate. Leaders realized that "now there was an eye looking at us", but more importantly, brought confidence to the community in general, and survivors in particular. The presence of CBVs as paralegals has brought more credence to the adjudication processes as they have ensured rulings are supported by the paralegals training manual. The use of a multi-thronged approach in disseminating DV and HIV information and messages has been very key to reaching out to a heterogeneous population. The radio, CBVs, TLs/RLs, printed materials have all ensured that more than 90% of the targeted communities are receiving the correct information on DV and HIV prevention with varying degrees of coverage. This approach needs to be maintained as it helps in ensuring that no population

[37] In both Malawi and Lesotho, quantitative data extracted from the qualitative interviews showed that the percentage participating in community dialogue sessions has risen from under 50% to over 80% in some of the targeted areas, depending on the day and time of the interviews

[38] Use of cell phones to collect and report on DV issues at community level, and between SAfAIDS and CBVs

	sub-groups are excluded from DV and HIV prevention interventions. Breaking silence in a community where domestic violence is regarded as a private matter is difficult. However, continuous education and knowledge sharing through the use of locally established platforms like TLs/RLs and CBVs is very useful in the fight on domestic violence against women. Additionally, CBVs have the capacity to support and complement the role of TLs and RLs but however require recognition in the form of well deserved incentives.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	❖ Community Individual questionnaire ❖ TL community tool
Conclusions	The use of community based structures in the fight against DV and HIV infection has had far reaching positive outcomes with the possibility of informing national policies on DV and gender, through lobbying, advocacy and broader information sharing. TLs being custodians of culture within communities have substantial capacity to influence knowledge, attitude and behavioral practices of community members on DV and HIV infection, hence need to continue to be supported in these initiatives

Conclusions

Evaluation Criteria	Conclusions
Overall	The project has contributed significantly towards the reduction of DV cases within communities although physical, emotional, economical and sexual abuses continue to be perpetrated, mostly by men against women in target communities within operational districts. The project has increased the capacity of women and girls to realize their rights and influence decision making within their homes and communities. Women now know their rights to participation, information and education and are increasingly becoming aware of what to do when in situations of DV. Nonetheless, there is still need to enhance women's access to and control over socio-economic opportunities. Empowerment is a key piece of the fight against IPV and HIV. Most TLs now actively conduct DV and HIV related awareness campaigns. With the support of CBVs serving as paralegals, most TLs trained through the project are now able to address various cases of DV with appropriate referrals to police, courts, clinics etc.
Effectiveness	There has been strengthened capacity of government staff, CBOs, formal and informal structures at national and sub-national levels to address harmful cultural practices that promote DV and HIV infection. The project has increased knowledge and awareness of women on what to do when in situations of abuse which has led to a marked reduction in incidences of underreporting DV cases. There has been increased capacity of formal and informal structures to deal with cases of DV within communities. Several institutions state and non-state actors are working together in the fight against DV and HIV infection.
Relevance	Despite the positive trends noted in the project areas, women and girls continue to be the worst affected by GBV and HIV infection compared to men. Concerted effort by all stakeholders including government departments and civil society to address this twin epidemic should remain high on the national agendas for both countries. TLs and other community members have received vital training in the cultural approach to addressing DV and HIV infection. There however remains the need for further and continued training of paralegals on DV issues with similar efforts replicated in other areas for expansion.

Efficiency	The project managed to surpass most of the set project targets. Most indicators showing positive achievements over the three year project lifecycle can be replicated in other areas. The use of CBVs, and the program approach in general targeting TLs and RLs proved successful in the target areas as evidenced by knowledge, attitude and behavioral changes amongst men and women in the target areas. The use of several platforms for dissemination of DV and HIV messages which include the radio, CBVs, printed materials and TLs/RLs was quite useful in educating men and women and transforming attitudes and practices of both men and women.
Sustainability	The project made use of locally existing community structures including TLs and community members trained as CBVs and Men As Protectors which makes the intervention self-sustainable through community ownership. The governments of both countries have standing policies on the prevention of DV and HIV infection. There is increased commitment at the top levels of government planning to address GBV and HIV issues. The involvement of multiple stakeholders in the fight against DV and HIV has been critical in ensuring there are complementarities which make the interventions more sustainable.
Impact	The project has resulted in a general decline in the prevalence of domestic violence cases against women in the project operational areas and increased knowledge and awareness of both men and women on DV and HIV prevention issues. Most TLs/RLs in the project area are now capable of addressing DV cases and responsible for reporting and referring cases to other relevant authorities like police, clinics and courts.
Knowledge Generation	Whilst there has been increased knowledge of cultural practices that promote GBV and HIV infection, there continues to be the need for further research to understand attitudes and practices with regards to DV and HIV prevention. The use of different information platforms for knowledge sharing was effective in reaching out to different population groups and having far reaching coverage. Indabas were instrumental in bringing together multiple stakeholders giving them a platform to share experiences.

Key recommendations

Evaluation Criteria	Recommendations	Relevant Stakeholders (Recommendation made to whom)	Suggested timeline[39] (if relevant)
Overall	The SAfAIDS TOT cascading model, was quite effective in strengthening capacity of government, CBOs/FBOs, TLs/RLs and community members to deal with issues of DV and HIV prevention. The model can be recommended for scaling up to other areas. There is need to strengthen and expand existing information sharing platforms in order to stretch the reach of the project to other villages and Districts. Women economic empowerment needs to be addressed so that women are not prohibited from being employed or earning money. Girls' empowerment through Education and Health, social mobilization of parents, community members and other stakeholders in support girls learning and health should be prioritized.	Government, NGOs, CBOs, SAfAIDS	Medium to long term
Effectiveness	Whilst the project has had a positive impact in the lives of women and girls in terms of reducing the prevalence of DV, there remains a critical need to generate and use evidence in decision making and programming at all levels. There is need to expand the community and stakeholder models to other Districts and areas not previously covered under the project. The project should continue to build synergies that allow multiple stakeholder	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term

[39] Short term=less than 1 year; medium term=>between 1-2 years

	participation including state and non state actors.		
Relevance	The evaluation showed women and young girls in marriages continue to be more vulnerable to domestic violence and hence should be prioritized in interventions aimed at eliminating DV and HIV infection. The project should target the children as they are tomorrow's people. There however must be recognition that different groups have different information needs.	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term
Efficiency	The project was quite successful in reaching out to its target population. Similar interventions need to be scaled up to other Districts. However, the project should also consider increasing budget allocations for implementing partners.	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term
Sustainability	For all the groups formed there is need to do the Group Maturity Index[40] to ascertain sustainability. Effort should also be directed towards strengthening partnerships at all levels of programming and ensuring these synergies are maintained right from grassroots levels to the top echelons of government programming. There is need to support the re-establishment of NAC for multisectoral coordination.	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term
Impact	The project has been important in increasing knowledge of government, TLs/RLs, CBO staff, and community members on DV and HIV prevention issues. There is need to replicate similar efforts to an even wider community targeting other districts. Educational support for children is recommended.	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term

[40] Its an instrument for assessing and determining maturity of a community entity in the way they bond and operate as a group to accomplish certain defined objectives/activities

Knowledge Generation	There is need to continue to gather, analyze and disseminate results giving clear details on area of strength and weaknesses for continued learning. The Indabas were quite useful in creating a platform bringing together various stakeholders to share information, knowledge and experiences on DV and HIV prevention and should be taken down to district level There is need to produce more IEC material in vernacular cognizant of varying education levels.	Government, NGOs, CBOs, SAfAIDS	Short term to Medium term

ANNEX 1: Evaluation Matrix

Evaluation criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Effectiveness	To what extent were the intended project goal, outcomes and outputs achieved and how?	CBOs, FBOS, and Government gender staff better understands and able (increased confidence) to address harmful cultural practices that promote violence against women and increase their risk to HIV strengthened No of capacity building materials developed & distributed to support training Number of community organizations trained in the cultural approach to addressing GBV and HIV Traditional leaders bring to account GBV perpetrators via traditional courts Proportion of traditional leaders identifying and redressing cultural practices which increase GBV & HIV Number of GBV and HIV cases referred by traditional and religious leaders No of trainers trained at national, district and community level Increased knowledge of the intersection between HIV and GBV among CBOs, FBOs, and government gender staff	❖ Community Individual Interviews ❖ FGDs (men and women groups) ❖ TLs Interviews

		No of traditional and religious Leaders championing HIV prevention and speaking out on the intersection between HIV, GBV, and cultural beliefs and practices No of community forums where Traditional and religious leaders are discouraging GBV and HIV risk practices Increased number of women who are able to define abuse of any type No of women reporting abuse of any form to relevant authority No of women reporting a reduction in abuse in their own lives Women's confidence to report abuse of any form improved Increased numbers of people in the community are aware of the intersection between HIV and GBV and the linkages with cultural beliefs and practices Increased number of community members reporting using safer sex practices Increased number of community members who shun any form of violence Community members challenging harmful	

		cultural practices that are linked to GBV and HIV Increase in number of Traditional court's ruling on cases with a gender sensitive eye Number of women and men referred for GBV and HIV related services Proportion of referred men and women reporting satisfaction with services received	
	To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels?	Capacity of CBOs, FBOS, and Government gender staff to address the linkages between harmful cultural practices that promote violence against women and increase their risk to HIV strengthened Traditional leaders (TLs) capacitated to champion prevention of domestic violence against women and HIV within their own communities Capacity of women to report incidences of all forms of abuse and domestic violence in project sites increased	❖ Project reports ❖ Focus Group Discussions ❖ Key Informant interviews
	How many beneficiaries have been reached, primary and secondary beneficiaries?	Number of beneficiaries, primary and secondary beneficiaries.	❖ Community Individual Interviews ❖ Focus Group Discussions (FGDs) ❖ PowerPoint Presentation

			on "Ending HIV and Domestic Violence: Redefining the role of Leadership". SAfAIDS ❖ Result and Activity Report (Cycle 15)
	To what extent did this project generate positive changes in the lives of the targeted women and girls in relation to specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and or girls? Please describe those change		❖ Interviews with beneficiaries and community structures Traditional Leaders tool ❖ Community individual tool ❖ FGDs (men and women groups)
Relevance	To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls? To what extent do achieved results continue to be relevant to the needs of women and girls?		❖ Key Informant interviews ❖ National Action Plan to End GBV (Malawi and Lesotho) ❖ National HIV Strategic Plan (Malawi and Lesotho)
			❖ FGDs with men and women groups ❖ Community individual questionnaire ❖ Key Informant Interviews
Efficiency	How efficiently and timely has this project been implemented and managed in accordance with the project documents		❖ Expenditure Report per Partner (SAfAIDS) ❖ SAfAIDs workplan ❖ Annual reports
Sustainability	How are the achieved results, especially the positive changes		❖ Community individual questionnaire ❖ Men and women FGDs

	generated by the project in the lives of the women and girls at the project goal level, going to be sustained after this project ends?		❖ Key Informant Interviews
Impact	What are the unintended consequences resulting from the project?		❖ Community Individual questionnaire ❖ FGDs for men and women ❖ Key Informant interveiws
Lessons learnt	Generate key lessons, working and effective models, and identify promising practices for learning		❖ Community Individual questionnaire ❖ TL community tool