



**Integrated Government and Community-based Strategy
for Prevention and Response of Violence against Women
and Girls in South Sudan**

Evaluation Report

9th December, 2013

Submitted to ARC – South Sudan

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ABBREVIATIONS

ARC	American Refugee Committee
CMR	Clinical Management of Rape
CPN	Village Protection Network
DG	Director General
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
KII	Key informant Interview
MoSD	Ministry of Social Development
MoH	Ministry of Health
NGO	Non-Governmental Organization
RoSS	Republic of South Sudan
SAJP	Safety Access and Justice Program
SOPs	Standard Operating Procedures
SPU	Special Protection Unit (Police)
UNMISS	United Nations Mission in South Sudan
UNTF/UN Women	United Nations Trust Fund to End Violence Against Women
VAWG	Violence Against Women and Girls

ACKNOWLEDGEMENT

This report draws heavily from data and information from collected during the end of project evaluation of the ARC- UN Women program on Gender-based violence in South Sudan conducted between July and August 2013.

Many thanks go to the team of 20 Evaluation Assistants for their hard work in gathering data for this evaluation in Wau and Yei. Most of all, special thanks go to the over 700 respondents, key informants and community resource persons who made this study possible.

Special thanks go to the ARC South Sudan team and ARC Headquarter staff for their thoughtful and dedicated support throughout the evaluation team's fieldwork and report writing process. These individuals include: Hilde Bergsma, Moses Makuach, Betty Akello, Mary Dutke, Simon Kuka, Evas Kasiime, Lauren Bienkowski, and Anjali Dotson.

I am also honored and humbled to have the opportunity of serving ARC in South Sudan in this meaningful capacity.

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EXECUTIVE SUMMARY

Introduction

The extent of the problem of gender-based violence (GBV) in South Sudan, a country recovering from decades of conflict, is enormous, with widespread cases of GBV being reported throughout the country. However, capacity of the government and civil society organizations to respond to problem of GBV is lacking and the presence of services to protect and assist survivors of violence have been severely limited in scope and coverage. Against this background, in September 2011, the American Refugee Committee (ARC) with support from the United Nations Trust Fund to End Violence against Women administered by UN Women implemented an “Integrated government and community based strategy for Response and Prevention of Violence against Women program” in South Sudan. The overall goal of the project was to improve the quality of response services for survivors of gender based violence in five States of South Sudan. At the closure of the program in July 2013, ARC commissioned an evaluation to assess the efficiency, effectiveness, cost-effectiveness, relevance, coverage and sustainability of the GBV program and to identify lessons, challenges, strengths and weakness encountered during implementation.

Methods

The evaluation adopted a cross-sectional study design with a representative sample of 613 heads of households from ten randomly selected Payams in the States of Central Equatoria (Yei) and Western Bahr el Ghazal (Wau). The evaluation team utilized a culturally-sensitive approach, using standard quantitative and qualitative evaluation methodology, including a desk review of program documents, analysis of GBVIMS database, interviews with key informants, including community leaders, police, religious and clan leaders, health workers, ARC staff, WHO, and Ministry of Social Development personnel, and facilitation of focus group discussions with community members. Analysis of quantitative data was by descriptive statistics using SPSS version 17 while qualitative data was thematically analysed.

Findings

The project has mobilized and raised the public’s awareness about the harmful effects of gender-based violence and the negative consequences of GBV through local community based peer educators and case managers. Awareness and knowledge of GBV was generally high, with 81% of surveyed community members aware of two response providers in their community. Fifty-nine percent of community members correctly mentioned at least three forms of GBV, and 60% of respondents were knowledgeable of the impacts of GBV in the community.

Overall, 61% of respondents knew at least two negative impacts of GBV in the community. While access and utilization of psychosocial support and case management services has been greatly improved through women’s centers, it appears that healthcare and security services through the police are still difficult to access due to lack of survivor-centered standards and practices, including illegal fees charged at health facilities and Police Special Protection Units. At least 48.3% of respondents said that rape survivors had to pay a fee in order to receive medical care. A summary of program planned targets versus achievement is shown in Table 1.

Capacities to respond to GBV have been strengthened at different levels of the community. At least three quarters of respondents report that they would have enough confidence to speak out or advocate for women and girls whose rights are being violated, while 85 percent of the respondents report that they would have confidence to report to the police or other service providers for help if their rights

were violated. These surprising figures must be analyzed in the context where actual practices and other studies, including other ARC assessments, show that women and girls often choose not to report or seek help due to fears of retribution, rejection from her family and community, and not receiving confidential, compassionate services. From this particular assessment, it appears that some stigma surrounding disclosure and reporting of GBV has reduced with 72 percent of women and men stating that they would be willing to disclose and report to relevant authorities for action if they experienced abused. One strategy that seemed particularly effective was to establish and manage women's centers in cooperation with local women's groups to raise awareness on GBV, offer case management and psychosocial support services, and promote women's support groups and networks where possible.

The GBV Working group has seen many more CBOs and INGOs, UN bodies, such as Safer World, SIHA, UNPOL and Kids Alive International joining the working groups with great enthusiasm to bring change to the women and girls who suffering from violence. The Working Group has provided a forum to more effectively share information and best practices including successful strategies, successes and challenges in gender-based violence integration into agency efforts. The Working Group has also provided an opportunity to discuss improvements to program development and implementation.

Five hundred and twenty-eight (528) survivors of GBV sought assistance from ARC [Upper Nile=91 (Dec 2011-Dec 2012) + 96 cases (Dec 2011-Feb 2013); WBeG = 341 cases (May 2011 – May 2013)]. According to GBVIMS statistics, referral to the health care services for reported GBV cases is still quite low. The reason for this is unclear, whether women were not choosing health services or if options were not being explained clearly enough. Additionally, few survivors sought justice, and the few who did seek resolution through the formal courts did not often receive an outcome during the course of the project.

Despite a limited number of services accessed by survivors, the establishment of a multi-sectoral approach through capacity building of various key stakeholders in GBV prevention and response must not be underestimated. Reports for services are increasing as awareness of and trust in services is increasing, but access to health, legal and security services are still constrained by costs of transportation for victims, lack of confidence in services, and the non-availability of other referral services such as livelihoods and educational activities that would address long term needs of the GBV survivors. The support provided by ARC in the overall coordination and advocacy efforts among multi-sectoral service providers in the government and NGOs, especially at the State, county and community levels, is widely acknowledged.

Conclusion

This evaluation has demonstrated that the program objectives are slowly being achieved through the established multi-sectoral approach. The program has creatively engaged government structures and communities to effectively respond to GBV issues by transforming attitudes and norms to the benefit of the entire society. However, GBV continues to have a severe effect on the health, social, and emotional well-being of women and girls. It is the team's hope that ARC and all concerned GBV actors in South Sudan- Ministries, Donors, and NGOs continue their support for GBV initiatives in South Sudan over the long-term.

Table 1: M&E Indicator Tracking Table for the ARC-UN Woman program in RoSS, 2013¹

Assessment level	Indicator	Planned target	Actual achievement	Assessment methodology	Source of data	
Impact	Percentage of GBV survivors reporting to ARC or partner staff for assistance is increased by 15%	Increase of 15%		Document/data review	GBVIMS	
	At least 15% of all reported rape cases reporting within 72 -120 hours and receiving appropriate emergency medical care	15%	No data in GBVIMS	Document/data review	GBVIMS	
	Percent of individuals that reported experiencing violence from an intimate partner in the last 12 months (gender disaggregated) ²	No target	21.5% M=16.7%, F=21.8%	Document/data review	GBVIMS	
	Percent of individuals reporting at least two negative impacts of GBV/violence in the community	No target	61%	Individual interviews	Sampled community members	
Outcome	% of survivors satisfied with ARC- supported services	No target	No data in GBVIMS	Client exit interviews	GBV Survivors	
	% of health facilities providing CMR that utilize quality of care monitoring tools	No target	No data found	Individual interviews	Health facility staff	
	% post test score of CMR focal point participants in CMR guidelines training	No target	No data	Document review	ARC training reports	
	% of reporting GBV survivors receive quality psychosocial support and are referred to other GBV services (legal, protection/security, medical and psychosocial support services) in line with the their wishes	No target	100%	Document/data review	GBVIMS	
	% of community members aware of 2 response providers in their community	No target	81.6%	Individual household interviews	Sampled community members	
	Inputs	GBV Standard Operating Procedures (SOPs) finalized and endorsed by government and civil society actors	SOPs adopted	Achieved at State level: Wau and Yei	Document review	ARC project staff
		# of Community Support Group' (CSG) members trained on training on GBV risk reduction strategies, survivor-centered approaches, and referral mechanisms	No target	Data missing in progress report	Document review	ARC training reports
		At least 80% of the focal point participants in the CMR guidelines training score 70% or higher in the a post-training evaluation.	80%	Data missing in progress report	Document/data review	ARC training reports
% of ARC and implementing partner staff receive post training evaluation scores of 80% or higher related to caring for survivors of GBV		No target	Data missing in progress report	Document review	ARC training reports	
% of agencies/bodies representing psychosocial, security, legal, and health sectors participating in regular coordination meetings to review SOP utilization		No target	Data missing in progress reports	Document review	ARC project staff	
Non-identifying data is shared with GBV working group on a monthly basis		Not target	100% of cases anonymous	Document review	GBVIMS	

Note: Indicator Table was extracted from the TOR.

¹ Most of the Indicators had no baseline targets.

² Denominator: Total Number of GBV survivors captured in the GBVIMS database.

1.0 BACKGROUND AND CONTEXT

1.1 Introduction

The two decades of war in the Republic of South Sudan (RoSS) forced over four million people from their homes and claimed the lives of more than one million people. The conflict has also taken a heavy toll on the already inadequate social services that existed prior to the war. The United Nations Mission in Sudan (UNMIS) estimates that from 2005-2009, more than 2.2 million refugees and internally displaced persons (IDPs) returned to homes in South Sudan, including 247,612 refugees and IDPs in the first six months of 2009 alone. In the same year, nearly 400,000 people were displaced internally due to conflicts within South Sudan. The prolonged nature of the conflict in South Sudan has not only led to the collapse of infrastructure and governance structures, but has also exacerbated gender disparities and violence against women and girls (VAWG). It has created new security risks for women including disruption of community and family structures, presence of arms, weakened legal and security institutions, and heightened tensions related to displacement^{3,4}. As a result, the presences of services that protect and assist survivors of violence were severely limited. Local organizations and government service providers lacked the training and expertise to appropriately handle and refer GBV cases. International organizations who implemented a range of programs in some communities had severely limited geographic reach.

The extent of the problem and need for Gender-based Violence (GBV) to be addressed in South Sudan is enormous. For instance, a 2009 study revealed that at least 4 out of 10 South Sudanese women reported experiencing GBV over the course of one year,⁵ . The most commonly reported forms of GBV at that time; included physical violence (47%), psychological abuse (44%), economic violence (denial of resources, services, and opportunities) (30%), and sexual violence (13%)⁶. Evidence collected from interviews in a 2011 report revealed that 59% of surveyed women reported GBV in the home and 19% reported GBV in the community⁷. Reports from human rights groups indicate that there is evidence of extensive domestic violence, sexual harassment, and sexual assault in South Sudan⁸.

Since the Comprehensive Peace Agreement (CPA) was signed in 2005, the RoSS has struggled to put in place basic services. However, progress has been challenging and slow. Return and continued conflict have put further strain on delivery of services. It has only been recently that there is more attention and coordination around issues related to gender equality and gender-based violence. However, as this topic is still relatively new on the government's agenda, the security and justice actors still struggle with their understanding and application of laws pertaining to women and responsibilities to uphold them. Within the health sector there is limited understanding of GBV response and prevention among different key players and capacity to manage GBV cases is lacking. As a result, access to protection and support services to GBV survivors of violence is severely constrained by lack of an appropriate GBV framework and guidelines at national level. Previous initiatives by other NGOs on GBV have been severely limited geographic reach.

In an effort to improve national capacity to prevent and respond to GBV among refugees, IDPs, and other conflict-affected populations in South Sudan, ARC with support from UN Women developed and implemented a program dubbed "Integrated Government and Community Based Strategy for Prevention and Response of Violence against Women and Girls in South Sudan". This program aimed at mounting an effective response to

³ Elia L. *Fighting gender-based violence in South Sudan*. 2007. Accessed on 11-12-2011
<http://www.fmreview.org/sites/fmr/files/FMRdownloads/en/FMRpdfs/FMR27/full.pdf> [webcite](#)

⁴ Elia L. *Sexual violence: weapon of war, impediment to peace*. 2007. Accessed on 11-12-2011
<http://www.fmreview.org/sites/fmr/files/FMRdownloads/en/FMRpdfs/FMR27/full.pdf> [webcite](#)

⁵United Nations Development Fund for Women (UNIFEM) in collaboration with SATIMA Consultants Ltd: *Gender-based Violence and Violence Against Women: Report on Incidence and Prevalence in South Sudan*. 2009.

⁶ Ibid.

⁷ UNHCR, UNFPA: *Gender-based Violence and Protection Concerns in South Sudan*. 2011.

⁸ *Human Rights Watch and Amnesty International Briefing Paper*. South Sudan: A Human Rights Agenda; 2011. Accessed on 3-10-2013
<http://www.hrw.org/news/2011/06/30/south-sudan-human-rights-agenda> [webcite](#)

GBV in South Sudan that would ultimately lead to improved social, emotional and physical wellbeing of the GBV survivors. Furthermore, ARC recognizes the need to prevent and respond to gender-based violence in bridging the transition from relief to development, with an emphasis on building resilient communities that do not condone violence or discriminate against survivors. Specifically, the program aimed at achieving the following outcomes:

- a) At community level, the program aimed to increase awareness and knowledge of benefits of available services for GBV survivors;
- b) Establish a clear and functioning referral system to increase survivor's access to comprehensive services
- c) Increased access and uptake of quality services (especially health care) by GBV Survivors using a multi-sectoral approach to service delivery;
- d) Availability and use of GBV Standard Operating Procedures in program states, Clinical Management of Rape Survivors Guidelines finalized and adopted by Ministry of Health, improved commitment and skills of key government and civil society actors to implement the GBV SOPs,
- e) Functional GBV Information Management System (GBVIMS) established. The key beneficiaries of this GBV program were women and girls who had experienced violence in the five States of project implementation.

ARC anticipated 800,000 women and girls in 5 States would have access to survivor-centered, multi-sectoral services if they chose as well as increased empowerment through improved decision-making power and access to information and opportunities.

1.2 Rationale for the Evaluation

As part of the project design, ARC planned to conduct an evaluation exercise at the end of the project period to assess the efficiency, effectiveness, relevance of the program and the outcomes and impact made in the different target communities. The overall purpose of the evaluation was to assess program performance in accomplishing the terms and objectives of the respective funding agreement between ARC and UN Women. Findings from this exercise will provide key lessons for future programming as well as serve as baseline information for the key indicators for future similar projects. Specifically the evaluation will aim at the addressing the following specific objectives:

1.3 Evaluation Objectives

1. To benchmark project high level indicators (outcome, impact) as entrenched in the program the log frame
2. To identify the intended and unintended outcomes as well as key challenges that were experienced during implementation of the program;
3. To evaluate the cost-effectiveness, relevancy and appropriateness of ARC project approach to the needs of the target beneficiary groups.
4. To Assess project strengths and limitations and lessons learned from the implementation of the ARC-UN Women GBV program
5. To assess the internal and external factors that influenced (positive and negatively) ARC's performance and operations

This report summarizes the methods and findings from the evaluation. The final parts summarize evidence on evaluation theme, recommendations that are actionable and specific to each programmatic theme and the conclusion.

2.0 EVALUATION APPROACH AND METHODOLOGY

2.1 Evaluation approach and design

Guided by the terms of reference for this assignment, the M&E consultant used a mix of approaches and data collection techniques deemed most appropriate for the purpose. The evaluation utilized participatory research methodologies involving a cross section of the various stakeholders at all levels. A participatory approach was ensured by involving ARC South Sudan Program staff and a team of local evaluation experts (identified by ARC) in the planning and execution of the assessment. The evaluation adopted a mixed cross sectional study design utilizing both quantitative and qualitative methods of data collections. The evaluation design was primarily informed by standards promoted by the World Health Organization ethical and safety recommendations that seek to minimize harm during GBV research.

2.2 Study population

Women aged 15 years and/or men aged 18 years and above who provided the required information and were available during the study period July and August 2013 were enlisted in the quantitative individual household survey. The secondary study population included GBV program stakeholders at community, country, state and national level who either took part in the GBV program implementation or was therefore deemed knowledgeable about GBV issues in South Sudan.

2.3 Sample size estimation

In total, a representative sample of 613 household heads was studied. The distribution of the randomly samples Payam and Bomas is summarized in the table below.

Table 2: Sample size for the quantitative household survey

State	County	Payam	Sample	Percent
Central Equatoria State (Yei)	Lainya	Lainya	67	10.9
		Lujulo	116	18.9
	Yei	Yei	56	9.1
		Otogo	66	10.8
Western Bahr el Gazal state (Wau)	Wau	Wau Western	72	11.7
		Wau north	66	10.8
		Nazareth	1	0.2
	Wau Municipality	Wau South	88	14.4
		Jur River	Marial Bay	45
			RocRoc Dong	36
States = 2	Counties = 6	Payams = 10	Sample = 613	100.0

2.4 Sampling

From the five States⁹ where GBV program was implemented, two of the States namely Western Bahr el Gazal State and Central Equatoria State were intentionally selected to represent areas where the GBV program implementation was predominantly active. A list of all Payams and Bomas was generated to constitute the sampling frame. In view of the resources available for field work, minimum of 10 Bomas in each state where conveniently enlisted for the survey. In each of the selected Boma, only households with eligible respondents were interviewed. If the eligible household head was not present, the next household was enlisted. For the purpose of this survey, only one eligible woman or man from each selected household was interviewed.

2.5 Data collection techniques

Below is an overview of the techniques used to gather data/information:

⁹ Central Equatoria State – Yei, Western Bahr el Gazal – Wau, Northern Bahr el Gazal – Aweil, Upper Nile State – Malakal and Warrap State – Kuajok

- a) **Desk review:** desk review included the preparatory project proposal on which basis the project was established. Training manuals, the GBVIMS database, program narrative and financial reports have also been reviewed. In addition, the main documents listed in the Terms of Reference – South Sudan National Gender Policy, State/County level GBV SOPs (Standard Operating Procedures, and monitoring plan and indicators. However, no previously evaluation and annual reports of the project were available.
- b) **Household individual survey** - using a pre-coded questionnaire to collect data on program effectiveness, coverage, outcomes and sustainability.
- c) **Key informant interviews** – held with 14 GBV stakeholders namely: ARC program staff, GBV focal points of collaborating partners such as staff at WHO, Ministry of Gender, and Social Development community leaders, religious leaders and clan chiefs, as well as teachers, health workers and the police. Interviews with key stakeholders using interview guides prepared by the Consultant are provided in an annex.
- d) **Focus group discussions** –thirteen (13) focus group discussions (comprising 8 to 10 participants) were held with women and youth groups, school children (girls and boys) and GBV case managers from purposively selected communities. These aimed at gaining a deeper understanding of the program achievements, limitations, weaknesses and lessons. See Annex for FGD participants.

2.6 Measurements

In this evaluation, the following variables were measured: socio-demographic characteristics of the respondents; awareness, knowledge and perceptions of GBV; response and handling of GBV cases and level of community empowerment/capacity built by the program.

2.7 Data management and analysis

Data from the household survey questionnaires were entered into the computer in one record form using Epi Data 3.1 version (www.epidata.com) and exported to SPSS version 17 for descriptive statistical analysis. Quantitative data is presented using descriptive statistics: frequencies, means and proportions. All qualitative data was transcribed verbatim, translated from local languages (Arabic, Dinka and Kakwa) into English. Texts were coded and clustered along themes and sub-themes for subsequent manual analysis. Key phrases or statements are quoted verbatim in the report.

2.8 Quality control and ethics

The evaluation was guided by WHO's *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*¹⁰ For purposes of quality enhancement and learning, the development of evaluation tools was developed by the consultant with support from the South Sudan country office and ARC HQ . The questionnaire was reviewed by the team of trained data collectors identified by ARC and revisions were made accordingly. The tools were pre-tested and further adjustment made. All community interviews were conducted in the local language and in a confidential manner to ensure comprehension of questions and respect of respondent's privacy. Appropriate information on referral for GBV support services for individuals responding to the questions was offered by the interviewer. Participant feedback was anonymous. . The consultant and team leaders supervised the data collection exercise and held daily meetings with the field team to review the day's work for completeness, identify challenges and plan for the next day's interviews. All data collected was stored in a locked filing cabinet and carefully monitored. During the consent process, the purpose, benefits and risks of the study were explained to respondent. Informed verbal consent was obtained from each respondent after the consent form had been read. Participation in the assessment was entirely voluntary.

¹⁰ World Health Organization (WHO), 'Ethical and safety recommendations for researching documenting and monitoring sexual violence in emergencies' 2007, http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

3.0 RESULTS

3.1 Socio-demographic characteristics

Quantitative survey: Overall, 28.7% of the respondents were male while 71.3 percent were female, a finding that solely depended on chance. Of the 613 respondents, 77.5 percent were married compared to 12.1 percent who were single, 3.8 percent widowed, 4.4 percent divorced and 2.2 percent separated. Most of the households (74.1 percent) were headed by males compared to 25.9 percent households headed by females. The mean age of the respondents was 30 years (SD 10 years) while the mean age at first marriage was 19 years (SD 4 years) and lower for women marrying at 18 years of age (SD 3 years) compared to 23 years for men (SD 5 years) on average.

With regard to education attainment, 27% of respondents had never attended formal education at all, 48.6% percent had attained primary education, 2.7% had attended secondary education while only 1.7 percent had attended post-secondary or tertiary education. Education significantly varies with sex with 52.4 percent of men compared to 39.2 percent of women having attended primary education. The majority of the respondents were Christians with Catholics constituting the majority (55.6%) followed by the Anglican (30.9%), Muslim (12.3%) and Pentecostal (1.0%). In terms of ethnicity, main ethnic groups were the Kakwa (22%), Dinka (22%), Keliko (10%) and Balanda (9.6%) while the rest constituted over 30 small ethnic groups. Slightly less than a half of the married people (48 percent) worked in another state (distant) from where their families live. There were no significant difference between sex of respondent and having a spouse working in a distant state.

3.2 Program achievements

Program achievements were measured in terms of contribution of the ARC efforts in meeting the planned outcomes of GBV program under the following domains: (1) awareness and knowledge of GBV and benefits of available services for GBV survivors; 2) having a functioning referral system to increase survivor's access to comprehensive services including access to quality health care by GBV survivors; (3) a functional GBV Information Management System (GBVIMS) established; (4) availability and use of GBV Standard Operating Procedures in program states government and civil society actors; (5) finalization and adoption of Clinical Management of Rape Survivors Guidelines finalized and adopted by Ministry of Health; and (6) improved commitment and skills of key government and civil society actors to implement the GBV SOPs.

3.2.1 Awareness creation and Knowledge about GBV

a) Awareness about forms of GBV

In this survey, knowledge and perceptions about GBV was assessed by asking if the respondents knew of someone in the community who had experienced the following acts of violence (rape, sexual assault, sexual exploitation, physical violence, female genital mutilation conflict resulting from property rights or financial and power relations in a home, abuse of women with disability, and mistreatment of widows over property inheritance) in the past 12 months preceding the survey.

Table 3: Findings from this survey revealed that 76 percent of the respondents had ever witnessed or seen an act of violence/inhuman treatment in their community, primarily affecting women and girls, in the past one year. Cases of GBV that were reported as most commonly seen in the community were physical abuse, sexual assault, and abuse resulting from misunderstandings about money and property in a home. The fact that more than half of the respondents are able to mention or see acts of GBV is demonstrates that some level of awareness has been created through the GBV interventions and that there appears to be a perception that VAWG is a regular occurrence, harming thousands of women and girls.

Table 3: Awareness about different forms of violence against women and girls

Percentage of men and women who, in response to prompted questions, say knew of someone in the community who had experienced the some acts of violence in the past 12 months preceding the survey, by county

Characteristic	Proportion of responses by county						Overall
	Jur River	Lainya	Morobo	Wau	Wau Municipal	Yei	
Ever heard of any women who was forced into sex by anyone	46.3	56.1	56.1	42.5	37.5	54.9	49.4
Knows of any young girl who has been sexually abused (by anyone)	58.0	58.2	60.0	47.9	37.5	60.3	55.0
Knows of any girl or a woman who has undergone genital mutilation	16.0	3.2	5.4	23.3	0.0	6.6	13.2
Knows of any woman or young girl who has been forced to sell sex for money	54.3	47.8	48.6	45.6	75.0	42.6	47.4
Knows of any child who has been selectively malnourished or starved to death by family members	27.5	24.6	22.6	22.2	12.5	21.0	22.9
Knows of any woman who reported forced sex with her male partner against her will	33.3	43.9	41.6	32.6	0.0	31.4	34.9
Knows of any woman who has been beaten/battered	82.7	64.6	65.8	73.5	100.0	59.5	69.9
Knows of any women who were mistreated by their sexual partner due to a misunderstanding about family property	69.1	68.2	62.6	67.6	62.5	58.2	65.0
Knows of any young girl or woman who have been trafficked	45.7	55.2	60.5	35.8	12.5	47.5	45.9
Knows of any women who were mistreated by her sexual partner due to a misunderstanding about managing money	81.0	56.7	61.4	70.2	100.0	59.7	66.8
Knows of any women who were mistreated by her sexual partner due to a misunderstanding about power relations	55.	43.3	44.7	46.9	37.5	44.6	46.6
Knows of any women with disability who have been sexually abused	49.4	43.3	30.4	32.6	0.0	39.0	36.5
Knows of any girls under the age of 18 who have been sexually abused	56.8	64.6	55.4	50.7	50	64.4	56.6
Knows of any widow who was mistreated by family members of deceased husband in regards to property inheritance	71.6	56.1	56.8	65.1	50.0	51.7	60.6

b) Knowledge of GBV support services

In order to assess awareness on GBV, respondents were asked if they were aware of ARC's presence and any other organizations or government departments that provide GBV response and prevention services in the in the community. Overall, 64 percent of the respondents had heard about ARC as an organization working in their community. Sixty nine percent of the respondents knew of an organization and or department where GBV survivors can be handled.

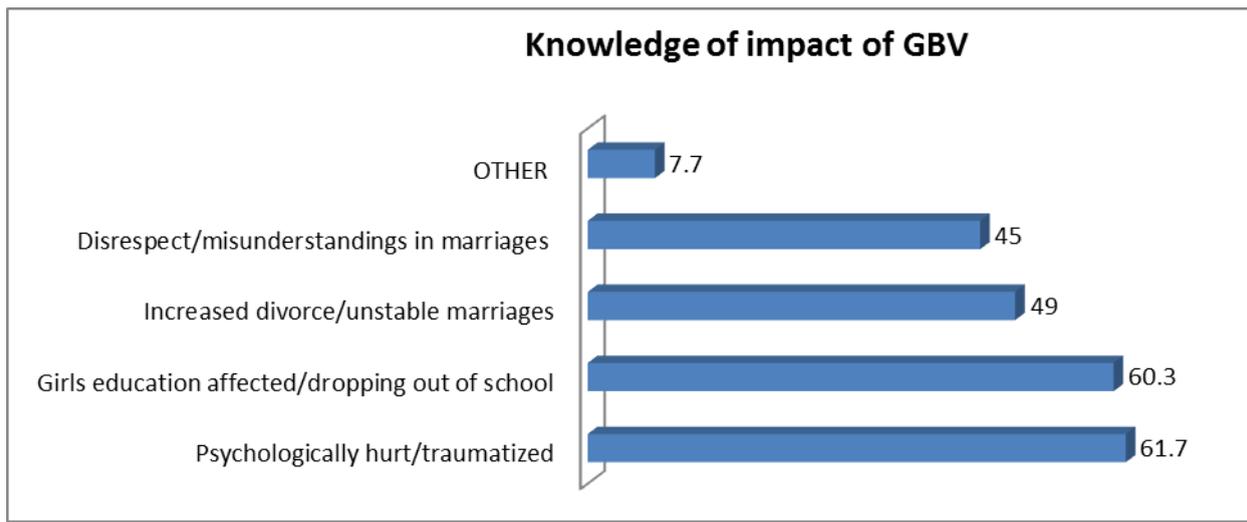
Asked which organizations or departments that handle issues on violence against women and girls in this community, the majority (63.1 percent) of the respondents mentioned government/police, followed by ARC (54.4 percent), other NGOs (21 percent) and traditional leaders/sultans (9.6 percent). Only 5 percent of respondents mentioned hospitals as places handing GBV cases. Seventy one (71 percent) had received messages about Gender Based Violence messages in the past one year preceding the survey, which implies that awareness creation on GBV was relatively high.

However, findings from key informant interviews with key national stakeholders revealed that the RoSS is confronted with other pressing health priorities and that GBV perhaps may not be a priority at least in the short run. In the future, ARC should consider integrating GBV programs into national reproductive health programs to ensure that this project becomes a reality.

c) Knowledge of Impact of GBV

One of the key outcome indicators for this program was increase the proportion of people who know at least two negative impacts on GBV. Respondents were asked to mention the negative impacts that violence against women and girls is likely to have in the community. Figure 1: About 62% of the respondents mentioned psychological trauma, followed by negative impact on girl education, divorce /unstable marriages.

Figure 1: Proportion of respondents with knowledge of impact of GBV



Alleged Perpetrators of GBV

Analysis of data from the GBVIMS revealed that the majority of the alleged perpetrators of GBV were males at 91.3%. The majority of the alleged perpetrators of GBV were aged 26 to 40 years (46.8%) followed by the age group 18 to 25 years (20.8%). However, 13.8 percent of the alleged perpetrators did not were of unknown age.

Relationship between type for GBV and relationship of the alleged perpetrator

We further analyzed the relationship between the type of GBV reported and the relationship of the alleged perpetrator to the GBV survivor. Overall, the perpetrators of GBV were Husbands/intimate partners/former partners of the GBV survivor (21.7%), family other than spouse or caregiver (21%) or unknown (16.5%) or persons without relationship with the survivor. The majority (27%) of the alleged perpetrators of rape had no relationship with the survivor or was unknown similar to sexual assault where the majority of perpetrators (21%) were unknown.

The alleged perpetrators of physical violence were mainly Husbands/intimate partners/former partners of the GBV survivor (59%) and a family member other than the spouse or caregiver (17%). Forced marriages were mainly perpetuated by a family member (44%) and primary caregivers of the GBV survivor (24%). Similar findings are obtained for denial of family resources in which 60% of the perpetrators were Husband/intimate partner/former partner and family other than spouse or caregiver.

3.2.2 Access to GBV support services

Our analysis of data from the GBVIMS system indicates that between the period May 2011 and May 2013, at least 341 GBV incident cases had been directly reached with GBV support services as reflected in the GBVIMS database in Western Bahr el Gazal state. Data on Yei State is missing in the database.

Of the 341 cases handled, the majority of survivors were females (94.4%). Table 4: The most common cases of GBV reported were rape (42%), followed by physical assault (26%), forced marriage (14.75), and sexual assault (10.1%). Other cases in which less than 10 percent of the GBV survivors had experienced; included denial of resources (3.2%) and psychological abuse (4.4%). Findings revealed that forced marriages, rape and psychological abuse were more common in females than male.

Table 4: In terms of location of GBV incident, analysis of the GBVIMS data revealed that almost all reported rape cases and sexual assault cases occurred in the bush and 34.8% of rape cases occurred in the home. Survivors of reported rape were primarily single (53.9) or divorced (30.8%).

The above findings are similar to findings from the household survey where respondents said the most common cases of GBV handled by the GBV support structures were physical violence (62.5%) and sexual abuse (52.1%). During the community FGDs with men, most participants said forced marriages and sexual assault were very common in the communities, and most oftentimes the alleged perpetrators were family members, especially the family or clan heads.

"Once a clan head has decided, no other person in the family/clan can oppose his opinion" an FGD participant in Greater Yei asserted during an FGD.

Table 4: Incident cases of GBV handled by the ARC GBV program (source: GBVIMS data – May 20011-May 2013)

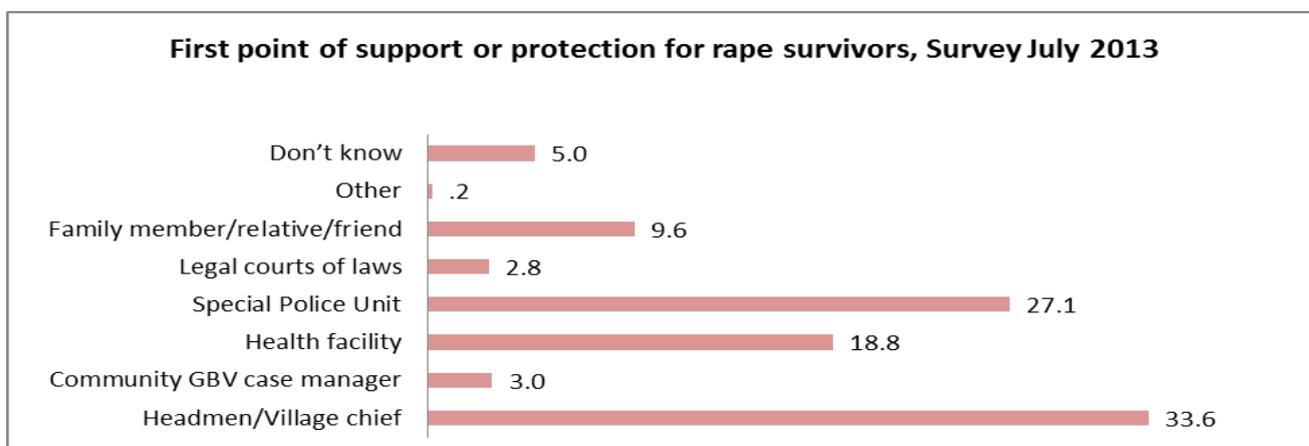
Incident cases of GBV handled by the ARC GBV program							
Characteristic	Forced marriage	Physical assault	psychological/emotional abuse	Rape	Sexual assault	Denial of resources	Total (N)
Sex							
Male	1 (5.6)	9(50.0)	0(0.0)	2(11.1)	5(27.8)	1(5.6)	18
Female	45(15.1)	73(24.4)	14(4.7)	131(43.8)	27(9.0)	9(3.0)	299
Civil marital status							
Divorced	1(7.7)	2(15.4)	2(15.4)	4(30.8)	3(23.1)	1(7.7)	13
Married	10(10.9)	47(51.1)	5(5.4)	17(18.5)	10(10.9)	3(3.3)	92
Single	33(17.1)	27(14.0)	7(3.6)	104(53.9)	19(9.8)	3(1.6)	193
Widowed	0(0.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1
Other	3(20.0)	4(26.7)	0(0.0)	5(33.3)	0(0.0)	3(20.0)	15
Location of incident							
Bush	0(0.0)	0(0.0)	0(0.0)	8(80.0)	2(20.0)	0(0.0)	10
Home	41(20.1)	58(28.4)	11(5.4)	71(34.8)	16(7.8)	7(3.4)	204
Street	2(3.4)	12(20.7)	1(1.7)	35(60.3)	8(13.8)	0(0.0)	58
Unknown	1(6.3)	6(37.5)	2(12.5)	4(25.0)	2(12.5)	1(6.3)	16
School	1(25.0)	1(25.0)	0(0.0)	0(0.0)	2(50.0)	0(0.0)	4
Workplace	0(0.0)	0(0.0)	0(0.0)	3(75.0)	0(0.0)	1(25.0)	4
Other	0(0.0)	0(0.0)	0(0.0)	3	0(0.0)	1(25.0)	4
Overall (n,%)	46(14.5)	82(25.9)	14(4.4)	133(42.0)	32(10.1)	10(3.2)	317

3.2.3 Strengthening the GBV Referral pathway.

In a bid to strengthen the functionality of the multi-sectoral referral pathway, social workers from the MoSD and community case managers from CBOs were trained on the case intake form, case management and referral skills including use of the GBVIMS that was set up to capture data from all the States. ARC together with MoSD further managed to place social workers in safe women’s centers, Wau teaching hospital and police Special Protection Units in the two states.

Analysis of the referral pathway data from the GBVIMS (n=341) revealed that the majority of GBV survivors were referred from the Police as first point of contact (25.8), followed by community or camp leaders (21.9%), self-referral (20.3%), and health or medical service points (11.8%). The above findings slightly differ from the household survey findings in which the majority of respondents (33.6%) said that GBV survivors sought support from the village headman or chief (also called Sultan) as first point of report/contact, followed by Police (27.1%) and health care facilities (18.8%) as shown in Figure 4 below.

Figure 2: First point of support for rape survivors, ARC Household Survey, July 2013

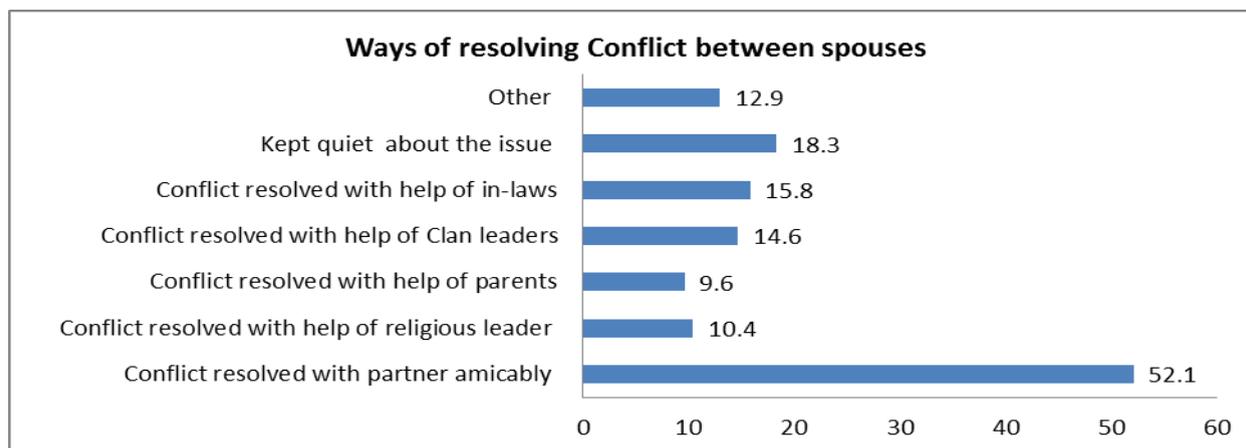


In terms of referrals, results reveal that majority of GBV cases managed by ARC were referred to Police or other security services (82.6%), followed by medical services (65.8%), and legal services (57.1%). In terms of service provision by the referring agency, services mostly commonly provided to GBV survivors were psychosocial services, medical, and safety planning, including to safe shelters where appropriate and available. Further analysis of the GBVIMS data showed that referral services that were largely unavailable but desired by survivors includes livelihoods/vocational training, safe house/shelter, and practical security services and solutions. In addition, support services received prior to reporting to ARC were also minimal for GBV cases recorded in the GBVIMS.

a) Resolving of Conflicts within the community

Figure 2: Findings revealed that slightly over half of spousal conflicts were reportedly resolved amicably between husband and wife, while 18 percent of the aggrieved parties in the marriage conflict kept quiet about the issue. Religious and clan leaders played an important role in resolving family conflicts, with 15 percent of spouses in conflict having their issues resolved with the help of a religious leader.

Figure 3: Ways of resolving conflict between spouses, ARC Survey, 2013



Justice in handling GBV cases

Despite improvements noted in the protection systems, reporting and handling of reported cases reported were not fully resolved or concluded. According to interviews with the community members, the judicial courts are not exercising equal justice for both poor and rich people (meaning those who have the money bribe the system) cases of GBV reported by poor people are never handled properly and court only favors the rich. According to the interviews with the community members, some GBV cases still took long to be settled in the courts. As far as handling GBV cases are concerned, the community focus group discussions noted that gender differences exist.

"It takes 6 months to pass judgment; women's rights are not recognized by our government since the signing of the CPA. Women are not well protected in the traditional courts; men are favored; women are not listened to by these courts" (FGD Woman participant, Roc Roc Dong- Eastern bank)

Community Support groups

Finding from the household survey revealed that 27 percent of the respondents belonged to Community Support Groups (CSGs), which are involved in preventing violence against women and girls. Of those who belonged to a support group, only 48 percent reported ever having a sensitization or awareness session on violence against women and girls in their community.

3.3 Program Coverage

Review of program progress report for the period 1st November – 31st May 2013 reveal that activities under this project were implemented in the five of States of South Sudan namely: Central Equatorial (Yei), Western Bahr el Ghazal (Wau), Northern Bahr el Ghazal (Aweil), Upper Nile (Malakal) and Warrap (Kuajok)¹¹. Financially, this project largely supported the programs of WBeG and Central Equatoria. Some activities in Aweil and Malakal were implemented with financial support from other donors other than UN women. It was also noted that beneficiary communities had limited involvement in the identification of their needs, planning and design of project activities.

3.3.1 Recommendations

The initial spread of the GBV program in five states and the subsequent scale down to two States points to shortfalls in the project design. In future, ARC should ensure consider narrowing coverage of its GBV programs to a few program sites if impact is to be demonstrated. A mapping on GBV prevalence and support services may greatly help ARC to effectively plan program sites where greatest need is needed.

¹¹ It had been communicated to the donor that ARC closed programs in Warrap State by beginning 2012

3.4 Relevance and appropriateness of the program

Our findings from this evaluation reveal that the GBV program is still relevant to the priorities and policies of the needs of the target population, government of Republic of South Sudan, ARC and UN Women. The problem of GBV is still enormous and GBV cases are increasingly being reported as revealed by the ARC GBV IMS database. The program objectives fit well within the three key result areas of the UN Women on: 1) enhanced women Leadership and participation in gender responsive governance; (2) increased access to women's empowerment and opportunities; (3) Improved protection and security for women and girls. Increased women's access education opportunities will be cross-cutting and supports all the three pillars.

In addition, ARC GBV program is relevant to the Government of South Sudan commitment to strive for gender equality in the country as enshrined in the country's 2011 Transitional Constitution of the Republic of South Sudan and the South Sudan Development (SSDP 2011/13) and the National Gender Policy (2012). All these legal and policy frameworks affirm government's commitment to building a country that is just and free from all forms of discrimination and violence. The ARC GBV response program complements these efforts by supporting the operationalization of national GBV policies and guidelines that will ultimately lead to improvement in prevention of GBV. Indeed, the role ARC has played in bringing hope for GBV survivors is widely acknowledged by most stakeholders in Wau and Central Equatoria State (Yei). The project is thus highly needed to help decrease and mitigate the occurrence of GBV.

3.4.1 Recommendations

While this program has shown significant progress in increasing awareness and access to GBV support and protection services; full recognition of GBV at national level will depend on continuity of the GBV programs and continual advocacy by ARC and other GBV actors in South Sudan.

3.5 Program efficiency

The evaluation teams established that the implementation of the GBV program followed standard accounting and procurement procedures consistent to the international accounting standards. Checks and balances were instituted, and supervision and financial monitoring undertaken to ascertain that inputs were being used rationally and as per agreed purpose. The total funds available for the UNTF Program in South Sudan was US dollars 997,982. As at June 30th, 2013 (which corresponds to the end of program), a total of USD 917,462 (92% of total available funds) had been spent.

Although the numbers GBV incidents reported per month were steadily increasing, the evaluation team reasons that they are generally low and not commensurate with the capacity built at community level and awareness created. The small numbers reported in the GBVIMS may further imply that more targeted and improved capacity-strengthening efforts should continue in order to build trust and confidence in services for those women and girls who are seeking assistance.

Interviews with ARC staff involved in project implementation revealed that the area of operation was large for the available human resources. The abrupt closure of the project that shortened the implementation period by 4 months did not allow planned activities to be carried out. For instance, staff said there was insufficient time for training activities on GBV to be completed in Yei. Yet reasons for early project closure were not clearly communicated to program managers and officers in field offices. In addition, staff also expressed that they were under pressure to make up for the lost time, whereas laying a firm foundation for sustainability and appropriate exit was not adequately done in favour of meeting the set targets. In spite of the above challenges, interviews with ARC field staff revealed that the program would have achieved its intended program outputs if was not for early closure of the project.

The unforeseen closure of the GBV program in all the five states left many community members and stakeholders in doubt of continued work on GBV in the area where ARC placed a central role in GBV response.

For instance, inadequate funds to support the operation led to the closure of the main office in Western Bahr el Gazal state (Wau) which interrupted program operations and activities. No clear communication on project closure was sent out to ARC field teams and stakeholders in implementing States.

3.5.1 Recommendations

The high staff turn-over rate associated with this program could also have grossly retarded the efficiency of the program. In future, ARC should put in place mechanisms and strategies for retention of competent staff. A good tradeoff between input costs and expected outputs should be clearly articulated during design of future projects. ARC future programs should attempt to develop realistic budgets to ensure efficient and effective implementation of community programs in South Sudan. The absence or lack of execution of an exit strategy has future implications on acceptability of ARC future programs in the future. ARC South Sudan management should be reviewed to streamline reporting and communication processes, with the goal of improving efficiency.

3.6 Program effectiveness

Effectiveness has been measured by assessing the extent to which ARC attained the intended project outcomes namely: increased awareness and knowledge of benefits of available services for GBV survivors; uptake of GBV support services especially health care, establishment of a clear and functioning referral system to increase survivor's access to comprehensive services including a functional GBV Information Management System (GBVIMS), and adoption of SOPs and CMR guidelines by the by government and civil society. Below is a brief analysis of the different program aspects.

3.6.1 Increased awareness and knowledge of GBV

Based on the GBV program logic (refer to Summary evaluation table in the TOR), the key impact indicators for this project are specified as follows: Percent of individuals reporting at least two negative impacts of GBV/violence in the community; rape survivors reporting to ARC and receiving appropriate emergency care before 72 to 120 hours; and percent of individuals that reported experiencing violence from an intimate partner in the last 12 months (gender disaggregated). Overall, 61% of respondents knew at least two negative impacts of GBV/violence in the community.

Other positive results included increased awareness of GBV issues among the various target groups – police, NGO practices relevant public state sectors officials as well as community's capacity to recognize and report GBV cases. From the focus group discussions and key informant interviews with ARC staff, it would appear that cases of GBV have reduced. However, in the absence of a baseline and given that ARC was not the only player in GBV response in South Sudan, attribution of the observed impact or change to ARC cannot be resolved.

Furthermore, the GBV program has empowered communities by improving the level of confidence in reporting GBV cases that occur in the community. At least three quarters of the respondents have enough confidence to speak out or advocate for women and girls whose rights are being violated, with 85 percent of the respondents reporting confidence to report to police or any structure for help if their rights were violated. The stigma surrounding disclosure and reporting of GBV has reduced with 72 percent of women and men willing to disclose and report to relevant authorities for action if they were abused by my spouse.

3.6.2 Quality of health care to GBV survivors

Quality of health care for survivors of rape was measured in terms of access, timeliness and availability of the service at the health facility. Review of the progress report for the period November 2012 to May 2013 (and only report availed to the evaluation team), revealed that 287 GBV survivors directly benefited from the program in its second year. Cumulative data on year one is not reported in the progress reports. Most of them received

State/Location	GBV cases handled
Wau	85
Yei	44
Aweil	127
Malakal	31
Total	287

medical care and psychosocial support, from psychosocial support, case management and referral services provided through both the ARC-MoSD Women's Center and ARC Peer Educators. Referral of cases to Police was noted to a challenge, as the majority of cases were referred directly to traditional courts where compensation offers are made for cases such as rape. Also, some

of the survivors came late for medical care due to final challenges as well as delays in negotiation with the offender's side.

In the household survey, 48.3% of the respondents said that rape survivors paid a fee in order to receive medical care while 39 percent of respondents said rape cases received free medical care. The above findings were further supported by views from some ARC program staff who, during the interviews, agreed that at some point GBV survivors were charged a fee for medical care in the early phase of the project. However, this practice was stopped after intervention by the State authorities. During focus group discussions, similar views were held by adolescent girls in Alel chock village who also affirmed that some health workers at the hospitals asked for money for medical care /examination from rape survivors. It was also found that the police asked GBV survivors to pay a fee in order to be issued with the Form 8. The illegal levying of fees for medical care or **form 8** to survivors of rape is violation of the national health policy on provision of free and universal care for all Sudanese. The fee may have constrained the quality of services but also e negating the effectiveness of the referral pathway.

3.6.3 Satisfaction with services for Survivors of Rape

This project aimed at having at least 75% of survivors of Rape expressing satisfaction with services. Satisfaction was to be measured using an exit interview to monitor client satisfaction with multi-sectoral response services. Our findings revealed that the GBVIMS did not capture any data on satisfaction with the services provided to the GBV survivors and as such it was difficult for the evaluation team to assess satisfaction by the latter. Furthermore, it was found that client exit Interviews to client satisfaction at the women's centers or health facilities were not carried out during project implementation. However, according to household interviews, only 55 percent of the respondents said they were not satisfied with the manner in which survivors of rape were handled in the community. In future, client satisfaction surveys should be conducted as part of the routine M&E activities for the GBV program and use such data to inform quality improvement in service delivery.

3.6.4 A functional GBV coordination system

The project has been partly successful in instituting a well-coordinated GBV Working Group that has been central to improving service delivery for GBV survivors at the state level. Key stakeholders have included Ministry of Sports, Youth and Social Welfare, MoH, MoE and the local officials such as local judges, chiefs, religious leaders, teachers and elders that played a big role in changing the negative cultural practices. This blending has led to improvement in access of services especially the Police form 8 that has been a night mare to the survivors of GBV in the States. Local NGOs in Yei such as WOPHA (Widow Orphans & People Living With HIV/Aids, (Raise Women Hope), Yei Women Association, and Lainya Women Association have actively participated in the meetings concerning GBV at the county and community levels.

3.6.5 Development and adoption of GBV Standard Operating Procedures (SOPs) and Clinical Care for Sexual Assault Survivors Protocol

Evaluation findings revealed that Clinical Management of Rape Guidelines for the health sector response to GBV are now being rolled out at the State level, in both Wau and Yei respectively. For instance in Yei, SOPs for Lainya County was endorsed by the department of Gender and Social Welfare and several copies of SOPs printed and distributed to partners in the county. However, commitment by the central level actors especially ministry of health and social welfare has is slowly being achieved. Interviews with ARC staff and national stakeholders reveal that advocacy for adoption of the guidelines was not effectively sustained at the national level but significant achievements have taken place at the State and County levels.

3.7 Cost-effectiveness

In the absence of cost data and a clearly measurable quantitative outcome for this program, the use of cost-effectiveness analysis was not practical. For example, there was no disaggregated cost data for key cost-centers such as workshops, trainings, meetings, medical care, and community awareness activities. There was also absence of an accurate data of corresponding numbers for beneficiaries reached in all project locations and cost data of the equivalent of the non-monetary contributions by other stakeholders to the GBV program. However, a glance at the project direct total cost revealed that project was not cost-effective in view of the GBV cases versus the level of resource investment.

3.7.1 Recommendations

In future, ARC should endeavor to capture cost data to aid future cost-effectiveness analysis studies. The M&E framework should be strengthened to include possible measures for cost-effectiveness and approaches to be used.

3.8 Sustainability

To assess the likely sustainability of ARC GBV program's key activities, outputs and outcomes, the evaluation team explored mechanisms put in place to continue nurturing key project activities after ARC pulls out of South Sudan. Key positive core aspects of sustainability identified included: Establishing and/or strengthening GBV protection structures and GBV case managers and equipping various stakeholders – health centres, police and CBOs with the necessary GBV tools and equipment to manage GBV cases. The established community structures such as the informal judicial system for handling GBV cases are good practices for sustainability. The tools that have been developed and rolled out and are in use at women's centres, police and health facilities at the State and county levels are provide further prospects for sustainability of the program. However, findings from key informant interviews with key national stakeholders revealed that the RoSS is confronted with other pressing health priorities and that GBV perhaps may not be a priority at least in the short run.

3.8.1 Recommendations

In future, ARC should consider integrating GBV programs into national reproductive health programs to ensure that this project becomes a reality. In addition, continued advocacy is needed especially at to push the GBV agenda especially at the national level. Efforts to sustain and consolidate achievements at the State and County level in both Western Bahr el Gazal state (Wau) and Yei should be strengthened through continued technical support and development of a sustainability plan.

Also, future projects of this nature should build on the Payam and Boma development plans to ensure that there is significant commitment to sustain the benefits accruing after the implementation of the project. Furthermore, all intended stakeholders should actively participate in the project design. This will increase effectiveness and efficiency of strategy development, resource allocation and detailed planning for sustainability.

4.0 FACTORS THAT INFLUENCED ARC'S PERFORMANCE AND OPERATIONS

- a) The program was constrained by both technical and financial capacity to effectively manage the program as evidenced by the ARC GBV project staff turn-over and restructuring process by the South Sudan government that led to the departure of key GBV program focal persons in the Police and health sectors. This was compounded by the inefficient recruitment systems at ARC south Sudan to ensure staff replacement and program continuity. Thus operations in Western Bahr el Gazal state (Wau) stopped upon closure of the main office. For instance, in Malakal, it took a period of four months to replace the GBV Project manager in charge.
- b) The inter-communal conflict erupted in December 2012 between the population of Wau between different tribes that was politically instigated led to the killings and political unrest. This consequently disrupted implementation of program activities leading to a scale down of our community activities following government banning of any gatherings that may further fuel or promote retaliation between the fighting the fighting tribes. It was difficult for the volunteers and assistants to reach the troubled areas in the state.
- c) The presence of military in in some of the northern states especially those neighboring Darfur watered down some of efforts put in place to improve GBV response and protection systems in the project areas. Women and girls suffered sexual abuse, the number of rape cases increased day by day in specific at the height of the military police and SPLM. The influence on military on GBV is a foreseeable event that ARC should have mitigated at the inception phase of the program by involving and engaging with the military commanders, as far humanitarian principles can allow, in the planning and implementation of GBV awareness activities in the area.
- d) The changing environment in South Sudan cannot be underestimated. The program was affected by the raising inflation and this partly affected the program and operations. However, some budget alignment was made to surmount the effects. Most of the projects that co-funded staff salaries had closed down which ultimately affected staff motivation. Given that South Sudan is generally an expensive country compared to other countries in the East African region, ARC program budgets should have an inbuilt annual inflation factor to be avoid significant changes in program costs in future.

5.0 LESSONS LEARNT, WEAKNESSES AND STRENGTHS

5.1 Assistance to GBV survivors

Medical care and police support services are still limited. The Partnership and networking between health centers and the police department has made it easier for the improvement in accessing services, especially the police form 8 that has been a challenge for the survivors of GBV in the state. The actors agreed and form 8 was photocopied and supplied at the different police posts where the forms were supposed to be, to avoid money being asked from survivors. Lack of transport was consistently cited by service providers as a major obstacle, along with lack of awareness about the urgency of obtaining medical care. There is still much advocacy to be done around Form 8, so that survivors have the option to access healthcare only, and not the police, if they so choose.

5.2 Capacity for GBV stakeholders

The good working relationship ARC has had with the beneficiary community structures - community leaders, community volunteers, women's associations and the youth groups and the media laid a soft ground for the GBV program to acceptability and ownership of the program aspects. On the other hand, capacity for community structures at Payam and Boma levels has not been adequately built to cascade trainings and

continue awareness on GBV in the project areas beyond. The existing GBV case managers and Boma leadership were not adequately supported with resources.

5.3 Coordination of the GBV response

The multi-stakeholder cluster approach to coordination of GBV prevention and response activities has been central to improving service delivery for GBV survivors at the State and Payam levels. Through the monthly meetings, different GBV response actors in the areas of health, security and psychosocial support created a better platform for articulating GBV strategies and addressing implementation challenges which partly contributed to synergy of program results. ARC strengthened the functionality of the multi-sectoral referral pathway which was being up dated on a quarterly basis. ARC together with MoSD further managed to place social workers in women's centers, Wau teaching hospital and SPUs.

5.4 Integration of GBV services

This GBV program was implemented as a standalone project and did not effectively link with other programs that address reproductive health needs and livelihoods of most GBV survivors. Women and girls in South Sudan are very vulnerable because of low or no education, which exposes them to further violence. Vocational education and livelihoods programs would help them in recovering and regaining their hope in life.

5.5 Protection and Referral system

The effectiveness of GBV case managers, police and health workers in sustaining a referral system for access to GBV services has mainly depended on the ARC support to partners in terms of logistics (forms, guidelines and tools) and monitoring and support supervision of GBV response activities. In the absence of ARC's central role in the referral system, it is indeterminate if the collaborating government departments - police and health (midwives) will sustain referral of GBV survivors for legal, protection and medical services in a confidential, timely and competent manner. Information from national level stakeholders indicated that the government of the RoSS does not have adequate funding and yet GBV sounds may not be one of the top national priorities for health sector at least not in the short term.

5.6 Data management and analysis

There is no doubt that the establishment of GBVIMS was timely as it promotes safe and ethical data collection, storage, analysis, and sharing. This GBVIMS system enabled the project to track GBV survivor demographics, support services accessed as well as help in assessing program effectiveness in providing care and achieved key results. The GBVIMS was functional in Wau. Statistics were regularly shared on a monthly basis with other GBV WG members. However, some inconsistencies in recording of data were observed and these could affect data quality.

5.7 Strengthening the M&E component

This particular project did not have clear outcome and impact indicators that reflect changes at population level. The program documents available to the evaluation team were limited, particularly in the areas of training, capacity building, and progress reports. Reporting could be strengthened with more detailed narratives and clearer targets and an effective staff supervision system to ensure adherence to reporting schedules. In future, ARC should develop a comprehensive M&E plan with outcome and impact indicators on GBV that reflect regional and global indicators on GBV to enhance comparability of program results across different countries.

6.0 LIMITATIONS

Due to budgetary and time constraints, the evaluation team stayed in South Sudan for only 10 days to conduct the individual interviews and household survey in over 600 households in Wau and Yei. The evaluation coincided with the dissolution by the President of executive arm of government (Cabinet) of the republic of South Sudan which caused a three-day unrest that sparked off intertribal conflicts especially in Wau while operations in Juba were temporarily disrupted. This posed difficulties for scheduling interviews with those affected, particularly government officials and key staff from partner organizations.

The evaluation period coincided with closure of a number of ARC projects and the amount of work to be done both at field and at country office level was quite immense. This evaluation was conducted at a time when the program was left with 10 days to closure (closed on July 31, 2013), which posed challenges in effectively managing teams in the field. At the time of the evaluation, key ARC program staff on this project had left the organization while the remaining few staff were in the mood of project shut-down. This limited the participation of some key staff that had left ARC and hence undermining the depth of information obtained. Nonetheless, the evaluation team worked tirelessly to achieve the evaluations targets and objectives.

Although the data collectors were largely experts of Sudanese origin and conducted interviews in the local language, some information might have been lost along the process of data capture, translation and transcription. Social and cultural norms that surround gender based violence coupled with discomfort and fear of freely sharing information about GBV especially sexual abuse may have affected the responses of community focus group participants and key informants. However, we strongly believe that the use of simplified tools, pre-testing of tools and trained data collectors surmounted this bias. Efforts were made to include female researchers on the evaluation team so as to cater for respondents' gender preferences during interviews.

Data for all the project locations/States was not captured in the GBVIMS. Only data for Western Bahr el Gazal state (WBeG) was recorded in the GBVIMS. No data for Yei is captured in the GBVIMS that was available to the team. The incompleteness of data in part limited our comprehensive analysis of the program effectiveness in terms of actual GBV cases reached in all project States. The GBVIMS is a relevant and should be incorporated throughout all of ARC's programming, with staff well trained on all IMS functions.

Despite the above shortcoming, the evaluation team strongly believes that the use of the mixed methods in this evaluation significantly improved the validity of the evaluation findings.

7.0 CONCLUSION

The findings of this evaluation suggest that ARC GBV program in the RoSS has to great extent established a multi-sectoral referral pathway and the capacity of GBV actors at the State level. The capacity of protection structures has been built to intervene in family conflicts and these provide a valuable entry point for action on GBV issues. Communities are aware that domestic violence exists as a problem, and that violence is not an acceptable way of resolving conflicts. ARC should also increase further support for gender based violence initiatives in South Sudan. The support should encompass many of the lessons learnt and work towards sustaining awareness-raising, respond to the gaps identified with respect to capacity and coordination of GBV actors and structure in South Sudan.

5.0 ANNEXES

ANNEX 1: TERMS OF REFERENCE

Terms of Reference (TORs) of External Evaluation

Geographic Area(s)	
Project name	Integrated Governmental and Community Based Strategy for Response and Prevention of Violence against Women in Southern Sudan
Project Period	October 2011 – October 2013
Activity	End -of-Program Evaluation
Program location (States)	
Primary Methodology:	The methodology shall include but not limited to; <ol style="list-style-type: none"> 1. Key informant interviews (KII) 2. Review of Secondary information 3. Representative household survey 4. FGDs with men, women boys and girls 5. Household interviews
Evaluation Start and end dates:	July 10 -September 05, 2013
Anticipated Evaluation Report release date:	September 05, 2013

1. Background and Context

Two decades of war in South Sudan forced over four million people from their homes and claimed the lives of more than one million people. The conflict also took a heavy toll on the already inadequate social services that existed prior to the war. While the Republic of South Sudan (RoSS) has struggled to put basic services in place since the CPA was signed in 2005, progress has been challenging and slow. Return and continued conflict have put a further strain on services. UNMIS estimates that from 2005-2009, more than 2.2 million refugees and IDPs returned to homes in South Sudan, including 247,612 refugees and IDPs in the first six months of 2009 alone. In the same year, nearly 400,000 people were displaced internally due to conflicts within South Sudan. Additionally, since October 2010 more than 300,000 returnees from north Sudan have returned to South Sudan.

Displacement increases the risk of women and girls experiencing violence as traditional social support and protection mechanisms break down and there is an increase in the presence of armed actors. Given the prolonged nature of the conflict in South Sudan, the collapse of infrastructure and governance structures, and the rapid return of refugees and IDPs, local capacity failed to meet the protection needs of women and girls. About two years back, there was no strong initiative or coordination from the RoSS on women and girl's needs and issues, coupled with little understanding within the security and justice sector on laws pertaining to women and responsibilities to uphold them. Even within the health

sector there was little understanding about responsibilities to treat survivors. As a result, the presences of services that protect and assist survivors of violence were severely limited. Local organizations and government service providers lacked the training and expertise to appropriately handle and refer cases. International organizations who implemented a range of programs in some communities had severely limited geographic reach. In response to the above situation, ARC designed a two year project (2011-2013??) whose overall goal was to improve the quality of response services for survivors of gender based violence in 5 States of South Sudan.

The key beneficiaries of this project were the women and girl survivors of violence who will directly benefitted from improved multi-sectoral response services in the 5 States of project implementation. Based on a UNIFEM 2009 study in South Sudan, 41% of all women and girls in South Sudan had experienced GBV in the past year. Based on this prevalence data, ARC anticipated around 800,000 women and girls survivors of violence in 5 States to benefit from the availability of improved multi-sectoral response services and reduced community stigma associated with seeking help. Secondary beneficiaries included community members reached with awareness raising messages on the benefits and availability of multi-sectoral services as well as messages promoting a reduction in violence against women and girls. Awareness raising activities engage male and female community members equally.

2. Project main activities and expected results and to achieve them

The overall goal of the project was to improve the quality of response services for survivors of gender based violence in 5 States of South Sudan. Such States are Central Equatoria, Western Bahr el Ghazal, Northern Bahr el Ghazal, Warrap and Upper Nile. However, those 5 States became soon 4 as Warrap program closed few months after the beginning of UNTF for lack of funds. Of those 4 States the ones implementing activities directly under the UNFT support are mainly Western Bahr el Ghazal and Central Equatoria. However also Upper Nile and Northern Bahr el Ghazal programs have been implementing most of the activities of the project and reported to UNTF. Key expected outcomes included:

- Survivors of GBV access quality, multi-sectoral response services
- Survivors of rape receive quality health care according to RoSS Clinical Management of Rape Survivor Guidelines
- GBV Standard Operating Procedures in place in 5 States
- Improved commitment and skills of key government and civil society actors to implement the GBV SOPs
- A functional GBV Information Management System (GBVIMS) established
- Community is aware of benefits of available services for GBV survivors
- Clinical Management of Rape Survivors Guidelines finalized and adopted by Ministry of Health

Note: Detailed evaluation indicators in Annex 1 below.

3. Purpose of the evaluation

As part of the project design, ARC International planned to conduct an evaluation exercise at the end of the project period to assess the outcomes and impact made in the different target communities. The end-of- program evaluation will assess whether the project was successful in realizing its strategic objectives as outlined above. Furthermore, apart from measuring the efficiency, effectiveness and relevance of the program, the evaluation exercise will also assess aspects related to lessons learned as well as program sustainability. Findings from this exercise will provide key lessons for future programming as well as serve as baseline information for the key indicators for future similar projects. Overall it is expected that the consultant/ evaluator intentionally aims to measure the high level indicators (outcome, impact) and not outputs whose details are well document in the program reports.

4. Evaluation objectives and scope

The main objective of this Evaluation study is to assess the extent to which the program objectives were achieved, facilitate self-analysis of overarching lessons learned (what went well and what did not go well), and make recommendations that will influence future interventions or programming. Specifically the evaluation will aim at the following specific objectives:

- Measure the projects high level indicators (Outcome, Impact) as indicated in the program the log frame and;
- Identify and document key lessons learned, project strengths and weaknesses, intended and unintended outcomes as well as key challenges that were experienced during implementation of the program;
- To evaluate the cost-effectiveness, relevancy and appropriateness of ARC project approach to the needs of the target beneficiary groups.
- To assess the internal and external factors that influenced (positive and negatively) ARC's performance and operations?

5. Evaluation Questions

Key evaluation questions under this exercise will include (but not limited to):

- To what extent were stated project goal, impact, outcomes and outputs achieved and how?
- What external factors have contributed to the achievement or/and failure of the intended outcomes and the project goal? And how and to what extent?
- What key lessons were learned?
- Where there any unexpected results?

6. Evaluation Methodology

The evaluation exercise will employ both qualitative and quantitative data collection methods. These shall include but not limited to interviews, documentation, site visits/observation, and meetings with ARC, UN organizations local leadership, beneficiaries and other NGOs and stakeholders. The consulting team will sign the American Refugee Committee indemnity forms and child protection protocol before commencing data collection. The Consultant will be expected to provide a detailed methodology and data analysis plan that includes the following:

- Data collection instruments, protocols and procedures,
- Sampling procedures,
- Procedures for analyzing quantitative and qualitative data,
- Data presentation/dissemination methods.

The involvement of the beneficiaries (the vulnerable) and implementers at all stages of this evaluation exercise is preferred. The preliminary findings are expected to be shared with the beneficiaries who, among others will validate the findings but also give input in the recommendations.

Development of evaluation data collection tools will be done by the consultant with the involvement of the monitoring and evaluation team, with support from ARC HQ and S.Sudan country office for purposes of learning and quality enhancement. Evaluation tools will reflect gender aspects including appropriate disaggregation of data where applicable and utilization of gender sensitive questions and approaches. The review and signing off of all the data collection tools may be done remotely, pending amendments to be done during the training of enumerators/data collection team, testing and validation of tools. For more details on source of data, please refer to annex 1 below.

Evaluation Partner	Role
American Refugee Committee	Hiring of Consultant / evaluation design. Transport expenses for the consultant and travel team to support the exercise while in S.Sudan. Working space for the consultant. Hiring and payment of the enumerators. Stationary and other related cost inputs.
Line Ministries	Providing information on their partnership with ARC to implement the program.
Project Staff	Provision of all required project documents for review / facilitation of evaluators' access to villages and target groups. Recruiting enumerators

Monitoring and Evaluation Sector	Checking of evaluation methods quality / Selection of consultants
Logistics/ Supply Chain	Hiring of evaluators / facilitate contraction of evaluators
Other ARC Sudan Support Departments	Provision of logistics, supplies, equipment, transfer of funds
Community Leaders	Facilitation consultant acceptance into villages, facilitate meetings and data collection in the community
Consultant	Provision of services in designing, data collection, & reporting, training of enumerators. Facilitation of meetings and data collection in the community

7. Evaluation Ethics

In terms of evaluation policy, the evaluation team will refer of the United Nations Evaluation Group (UNEG) '*Ethical Guidelines for Evaluation*'¹² and/or of the World Health Organization (WHO) '*Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*'¹³.

Annex 1

Summary Evaluation Table: Indicators and sources of data.

Assessment level	Indicator	Assessment methodology	Source of data
Impact	GBV survivors reporting to ARC or partner staff for assistance is increased by 15%	Document/data review	GBVIMS
	At least 15% of all reported rape cases <i>reporting within 72 -120 hours</i> and receiving appropriate emergency medical care	Document/data review	
	Percent of individuals that reported experiencing violence from an intimate partner in the last 12 months (gender disaggregated)	Document/data review	GBVIMS
	Percent of individuals reporting at least two negative impacts of GBV/violence in the community	Individual interviews	Sampled community members
Outcome	% of survivors satisfied with ARC- supported services	Client exit interviews	GBV Survivors
	% of health facilities providing CMR that utilize quality of care monitoring tools	Individual interviews	Health facility staff

¹²United Nations Evaluation Group (UNEG), 'Ethical Guidelines for Evaluation', June 2008. Available at: <http://www.unevaluation.org/ethicalguidelines>

¹³ World Health Organization (WHO), 'Ethical and safety recommendations for researching documenting and monitoring sexual violence in emergencies' 2007, http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

	% post test score of CMR focal point participants in CMR guidelines training	Document review	ARC training reports
	% of reporting GBV survivors receive quality psychosocial support and are referred to other GBV services (legal, protection/security, medical and psychosocial support services) in line with the their wishes	Document/data review	GBVIMS
	% of community members aware of 2 response providers in their community	Individual interviews	Sampled community members
Inputs	GBV Standard Operating Procedures finalized and endorsed by government and civil society actors	Document review	ARC project staff
	# of Community Support Group' (CSG) members trained on training on GBV risk reduction strategies, survivor-centered approaches, and referral mechanisms	Document review	ARC training reports
	At least 80% of the focal point participants in the CMR guidelines training score 70% or higher in the a post-training evaluation.	Document/data review	GBVIMS
	% of ARC and implementing partner staff receive post training evaluation scores of 80% or higher related to caring for survivors of GBV	Document review	ARC training reports
	% of agencies/bodies representing psychosocial, security, legal, and health sectors participating in regular coordination meetings to review SOP utilization	Document review	ARC project staff
	Non-identifying data is shared with GBV working group on a monthly basis		

ANNEX 2: LIST OF SAMPLED COMMUNITIES (SIMPLE RANDOM)

Names of PayamS and Bomas in Wau County and Jur River County				
County	Payam	Boma	Sampled	
Wau	Wau county	Bagari	Nazareth	
		Wau North	New site	
		Bessellia	Gezira	
		Wau south	Jebel Kher	
	Jur River County		Marial Bai	Korokorong
				Bazia Gedid
				Alelchoke
				Hai Jezira
				Daraja
				Shika Hadid
Yei				
Yei River	Otogo	Otogo	Goja, Logo	
	Mugwo			
	Yei	Yei	Minyori, Yei Mission	
Lanya	Lainya	Lainya	Lukorbanga, Lugwili	

	Kupera		
	Wuji		
	Gulumbi		
	Panyume	Panyume	Morjoame, Panyume
	Kimba		
	Udabi		

ANNEX 3: EVALUATION TOOLS



Consent Form

Introduction

Hello. My name is _____, and I am a Researcher with the American Refugee Committee (ARC). Over the past two years, ARC has been implementing a program on Gender Based Violence aimed at improving the wellbeing and welfare of women and girls in their communities in South Sudan. This program has been implemented in partnership with government, other NGOs and Community Structures. The program covered five states which include: Central Equatoria, Western Bahr el Ghazal, Northern Bahr el Ghazal, Warrap and Upper Nile. We are here to undertake an assessment of what the ARC program on improving welfare of women and girls (reducing violence against women or girls) has been able to achieve or benefit you, your families and the community and also able to identify areas of improvement in the future. Your responses will help ARC to understand how it can support government and communities to prevent and respond to violence against women and girls in the future.

Over the next few minutes to one hour, I will ask you some questions to respond to. Your honest answers to the questions will provide accurate information that may be useful for planning by the government and ARC. There is no right or wrong answers as we want information based on your experiences, observations and feelings about the violence against women. Please feel free to ask for clarifications where needed. All your answers will be completely confidential and your name will not be collected in order to protect your identity. . Your participation in this study is entirely voluntary and you can choose not to answer any individual question that you are not comfortable with. However, we hope that you will participate in this assessment since your views in various components of this study are very important.

Risks: There are no risks to you if you participated in this assessment. However, if you choose to participate and would like to speak with someone and receive confidential support, you can speak with me or another ARC counselor. Please also know you can choose not to complete the interview at any time.

Potential Benefits: There are no immediate benefits to you from this study. However, the findings of this study will help ARC and government to raise more funds to improve the welfare of girls and women, which may be of benefit to you or your community.

Subject consent: I have been explained the purpose, risks and benefits of the study and I have understood. By signing this consent form, I voluntarily accept to participate in this study.

Study Number. _____

Signature of Interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED _____ (Continue with interview)

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED _____

(End the interview and bring the form with you)

AMERICAN REFUGEE COMMITTEE – SOUTH SUDAN

QUESTIONNAIRE FOR THE VIOLENCE AGAINST WOMEN AND GIRLS

HOUSEHOLD SURVEY

Respondents: Heads of Household - Women aged 15 to 49 years of age and adult men (aged 18 years and above)

Project: Integrated Governmental and Community Based Strategy for Response and Prevention of Violence against Women in South Sudan

State:	County	Payam	Boma
Household number:	Team Code:	Interviewer's Name:	
Date of Interview:	Checked by(Team leader):	Interviewer's Code:	

Directions: Please answer all questions by circling the number of your choice(s) or writing in the spaces provided where applicable. Do not leave any question unattended to.

The questionnaire will be filled by the numerator.

No	QUESTIONS	CODING CATEGORY	CODE (For office use)
SECTION A : SOCIO-DEMOGRAPHIC DATA			Write here
A1	Sex of the head of household (this person may be different from the respondent)	1 – MALE 2 – FEMALE	<input style="width: 40px; height: 20px;" type="text"/>
A2	Sex of Respondent (the person being interviewed)	1 – MALE 2 – FEMALE	<input style="width: 40px; height: 20px;" type="text"/>
A3	Age of Respondent (in completed years)		<input style="width: 40px; height: 20px;" type="text"/>
A4	Marital status of the Respondent?	1=Married 2=Widowed 3=Divorced 4= Separated 5=Single	<input style="width: 40px; height: 20px;" type="text"/>
A5	If married, type of marriage	1=Monogamous 2=Polygamous	<input style="width: 40px; height: 20px;" type="text"/>
A6	If married, age at first marriage (in completed years)		<input style="width: 40px; height: 20px;" type="text"/>
A7	If married, does your spouse work in a state different from where you live?	1 = YES 2 = NO	<input style="width: 40px; height: 20px;" type="text"/>
A8	If ever married, who chose your partner?	1. Self 2. Parents 3. Relatives 4. Other (specify)	<input style="width: 40px; height: 20px;" type="text"/>
A9	Highest level of education attained by the Respondent	1. None 2. Primary 3. Secondary 3. Tertiary 5. Other (specify).....	<input style="width: 40px; height: 20px;" type="text"/>
A10	Highest level of education attained by the head of household (ASK IF HEAD OF HOUSEHOLD IS NOT THE RESPONDENT)	1. None 2. Primary 3. Secondary 3. Tertiary 5. Other (specify).....	<input style="width: 40px; height: 20px;" type="text"/>
A11	Religion of the Respondent	1=Catholic 2=Anglican 3=Muslim 3=Pentecostal 4. Other (Specify)	<input style="width: 40px; height: 20px;" type="text"/>
A12	Main occupation of the Respondent	1=Peasant farmer 2=Employed/salaried 3=Self employed 4=Unemployed 5=Other (specify).....	<input style="width: 40px; height: 20px;" type="text"/>
A13	Ethnicity/clan/tribe of the respondent?		<input style="width: 40px; height: 20px;" type="text"/>

SECTION B : EXPERIENCES AND PERCEPTIONS ABOUT VIOLENCE AGAINST WOMEN AND GIRLS			
B1	In the past one year, are there any acts of violence/inhuman treatment that you have observed or seen happen in this community?	1 = YES 2 = NO 9 = DON'T KNOW	<input type="checkbox"/>
B2	Please could you tell us the types/forms of violence against women or girls that occur in this community? <i>Please circle multiple responses</i>	1=Sexual assault/harassment 2=Rape 3=Emotional/verbal/psychological 4=Physical abuse/injuries 5=Economical/deprivation of money 6=Early and forced marriage 7=OTHER; (<i>Pls. Specify</i>) _____ 9= DON'T KNOW	
B3	If yes, which categories of people are most affected by such acts of violence in this community? <i>Please circle multiple responses</i>	1=Women 2=Girls 3=Boys 4=People with Disability 5=Orphans 6=Men 7=Other(specify)_____	
B4	What are the main causes of violence against women and girls in this community? <i>Please circle multiple responses</i>	1=Protesting of spousal decisions 2=Power relations between husband and wife 3=Families where women are more educated than men 4=families where women have more money than men 5=Alcoholism 6=Unavailability of parents at home 7=Other (specify)_____	
B5	Who do you think are the main perpetrators (offenders) of violence against women and girls in this community?	1=Men 2=Women 3=Boys 4=Uncles 5=Other(specify)_____	
B6	Overall, how would you rate/perceive the situation of violence against women and girls in this community?	1= High 2= Moderate 3= Low	<input type="checkbox"/>
SECTION C: RESPONDING AND HANDLING OF VIOLENCE AGAINST WOMEN AND GIRLS CASES			
C1	Are there any measures/structures in place to address the issues of violence against women and girls in this community?	1 = YES 2 = NO 9 = DON'T KNOW	<input type="checkbox"/>
C2	If yes to C1, can you mention the different structures or systems which respond or handle cases of violence against women and girls? <i>Please circle multiple responses</i>	1=Headmen/Village chief/Leader 2.=Community GBV case managers 3=Health care facilities 4= Police (Special Police Unit) 5=Legal courts of Laws 6=Family member/relative/ friend 7=Other (specify..... _____ 9= DON'T KNOW	
C3	Which cases of violence against women and girls are commonly handled by the structures (traditional or official) in this community? Give examples. <i>Please circle multiple responses</i>	1=Sexual abuse 2=Emotional/psychological 3=Child abuse 4=Physical violence/beating 5=Economical/conflict arising from money 6=OTHER; (<i>Pls. Specify</i>) _____ 9= DON'T KNOW	
C4	Where does a survivor of Rape go first for support or protection?) (circle only one response)	1=Headmen/Village chief/Leader 2= Community VIOLENCE AGAINST WOMEN AND GIRLS case managers 3= Health care facilities 4= Police (Special Police Unit) 5= Legal courts of Laws 6= Family member/relative/ friend 7= Other (specify..... _____ 9= DON'T KNOW	
C5	What services do the survivors of Rape receive when taken to the health facility? <i>Please circle multiple responses</i>	1= Health Worker always asks for a Police Letter 2= Don't give treatment without Police Letter 3= Gives treatment to Rape survivor straight away 4= Health Worker provides psychocial counselling and guidance 5= Health worker refers case to Police 7=Other (specify..... _____ 9= DON'T KNOW	
C6	Are the medical services to survivors of Rape provided free of charge at the health facility?	1 = YES 2 = NO 9 = DON'T KNOW	<input type="checkbox"/>
C7	How long does it normally take for the community or family members to seek or refer survivors of Rape or Violence for medical treatment?	1= LESS THAN 72 HOURS (3 days) 2= LESS THAN 96 HOURS (4 days)	<input type="checkbox"/>

		3=LESS THAN 120 HOURS (5 days) 4=Other (specify) _____	
C8	Overall, are you satisfied with the manner in which cases of violence against women and girls/Rape have been handled in this community?	1=YES 2=NO 9=DON'T KNOW	<input type="checkbox"/>
SECTION D: PREVALENCE OF VIOLENCE AGAINST WOMEN AND GIRLS Restrict the Responses to the past 12 months (ONE YEAR) to avoid past stories that took place during the last 20 years of Civil War.		<i>Circle the appropriate response</i>	
D1	In the past one year, have you heard of any women who was forced into sex by anyone – say sex by a stranger or a close relative or fellow worker?	1 – YES 2 – NO 9 – DON'T KNOW	
D2	Do you know of any young girl who has been sexually abused (by anyone) in this community?	1 – YES 2 – NO 9 – DON'T KNOW	
D3	Do you know of any girl or a woman who has undergone genital mutilation in this community?	1 – YES 2 – NO 9 – DON'T KNOW	
D4	Do you know of any woman or young girl who has been forced to sell sex for money in this community?	1 – YES 2 – NO 9 – DON'T KNOW	
D5	What are the main reasons that may lead women and girls of this community to sell sex?	1=Money/livelihoods 2=Sexual pleasure 3=Idleness/having nothing to do 4=When girls don't stay with parents 5=Harsh treatment at home 6=Parents unable to meet girls basic needs 7=Its culturally normal 8-Other (specify) _____	
D6	Do you know of any child who has been selectively malnourished or starved to death by family members in this community?	1 – YES 2 – NO 9 – DON'T KNOW	
D7	Do you know of any woman who (say) had sex with her male partner against her will or when not ready for the sexual act?	1 – YES 2 – NO 9 – DON'T KNOW	
D8	Do you know of any woman who has been beaten/battered, slapped or physically punched by her male sexual partner?	1 – YES 2 – NO 9 – DON'T KNOW	
D9	Do you know of any women who were mistreated by their sexual partner due to a misunderstanding about family property?	1 – YES 2 – NO 9 – DON'T KNOW	
D10	Do you know of any young girls or women who have been taken from their home/villages to towns or other places for housekeeping services or other work in other states or outside the country?	1 – YES 2 – NO 9 – DON'T KNOW	
D11	Do you know of any women who were mistreated by her sexual partner due to a misunderstanding about managing money?	1 – YES 2 – NO 9 – DON'T KNOW	
D12	In the past one year, Do you know of any women who were mistreated by her sexual partner due to a misunderstanding about power relations?	1 – YES 2 – NO 9 – DON'T KNOW	
D13	Do you know of any women with disability who have been sexually abused in this community?	1 – YES 2 – NO 9 – DON'T KNOW	
D14	Do you know of any girls under the age of 18 who have been defiled or sexually abused in this community?	1 – YES 2 – NO	

		9 – DON'T KNOW
D15	Do you know of any widow who was mistreated by family members of deceased husband in regards to property inheritance – land, animals, building, household assets?	1 – YES 2 – NO 9 – DON'T KNOW

SECTION E: OUTCOME and IMPACT ASSESSMENT

E1	Have you ever heard about the American Refugee Committee?	1 – YES 2 – NO 3 – DON'T REMEMBER	<input type="checkbox"/>
E2	What are the negative impacts that violence against women and girls is likely to have in the community? <i>Please circle multiple responses</i>	1=Psychologically hurt/traumatized 2=Girls education affected/dropping out of school 3=Increased divorce/unstable marriages 4=Disrespect/misunderstandings in marriages 5 - OTHER; <i>(Pls. Specify)</i> _____ (Multiple responses allowed)	
E3	In the past 12 months, do you remember receiving or hearing messages regarding on violence against women and girls?	1 – YES 2 – NO 3 – DON'T REMEMBER	<input type="checkbox"/>
E4	If yes to E3, what are the main channels of communication through which you hear or receive information on violence against women and girls? <i>Please circle multiple responses</i>	1=RADIO 2=TELEVISION 3=VIDEO SHOWS/PLAY BACKS 4=COMMUNITY VOLUNTEERS 5=POSTERS/LEAFLETS 6=COMMUNITY SENSITIZATION SESSIONS 7 - OTHER; <i>(Pls. Specify)</i> _____ (Multiple responses allowed)	
E5	In the past 12 months, Have you ever participated in any violence against women and girls prevention and response campaigns in this community?	1 – YES 2 – NO 9 – DON'T KNOW	<input type="checkbox"/>
E6	Are you aware of any organization and or department where survivors of Rape/violence against women and girls can be handled?	1 – YES 2 – NO 9 – DON'T KNOW	<input type="checkbox"/>

Adolescent Girls Focus Group Discussion Guide

**Adapted from the GBV AoR Assessment Tools and IRC Assessment Toolkit*

Location:

Date of FGD:

Duration (start time and end time):

Name of moderator:

Name of note-taker:

Participant summary (include # of women or men):

Age range of respondents:

Introduction:

My name is _____ and this is my colleague _____. We work for _____. *(Please give brief information about what kind of work ARC does.)*

We would like to ask you some questions about the issues affecting girls and women in your community so that we can better understand your needs and concerns about these groups.

We are not asking for your specific stories, so please do not use any names. We are asking about things that you have heard of or know to be happening. The questions we are going to be asking you today are about the way that you live every day. If you feel uncomfortable at any time, you can leave. Participation in the discussion is completely voluntary, and you do not have to answer any questions that you do not want to answer.

We are not offering anything other than listening; there will be no other direct benefits related to this time we spend together today. We do ask that everyone be respectful when others speak, and, sometimes, the facilitator may interrupt the discussion but only to make sure that everyone has the opportunity to speak if they would like.

We do not need your names and will not be writing your names down. We also will not present any other potentially identifying information in anything that we produce based on this conversation. We will treat everything you say today with respect, and we will only share the answers you give as general answers combined with those from all the people who speak to us.

We ask that you keep everything confidential too to protect the privacy of all of the women. Please do not tell others what was said today. In fact, if people do ask, you could say that you were speaking about the health problems of women and girls.

_____ is taking notes to make sure that we do not miss what you have to say. Is this OK with you?

We really want to hear what you have to say, and I would like you to answer my questions however you want. There is no wrong answer to any question.

I expect our discussion to last for a maximum time of one-and-a-half hours to two hours. Do you have any questions before we begin?

First I would like to ask you some general questions about life, or the way you live in your community or in this area.

1. How are young people spending their time in this community? Are they in school? Are they working?
2. What do adolescent girls do for entertainment in the evening? Adolescent boys? Men?
3. What problems do young girls or young women face in this community? (*Ask for specific examples*)

4. What are the challenges or problems that girls and young women face when they move around in this area?

PROBE: What are the known areas that are dangerous in this community (or in this area) where women and girls are more likely to experience violence or abuse (water points, homes, going to the field, going to and from school, in schools, or going to town, etc.)? *Ask for specific locations*

[If certain types of gender-based violence have not come up, use the following. If it has come up and you have the answers you need, then skip to the next relevant question]

5. **Without mentioning any names or indicating anyone**, can you tell me what kinds of incidents of violence against girls take place in your community? (*Ask for specific types of violence*)

PROBE: When and where does sexual violence occur in this community/area?

PROBE: How is the problem of sexual violence now? How is it different from last year and previous years?

6. **Without mentioning any names or indicating anyone specific**, who are the perpetrators of sexual violence? (**PROBE:** people in authority, family members, teachers, security forces such as police, military?) How about for other types of violence/abuse against women and girls that you mentioned?

7. What happens to people who commit these acts of violence against girls?

PROBE: Are they punished? If so, how?

8. **Without mentioning any names or indicating anyone specific**, which group(s) of girls and young women feels the most insecure or more likely to experience violence, including sexual violence? Why?

Which group(s) of girls and young women feels the most secure? Why?

9. Are there ever times when girls or young women have to provide sexual favours or acts to meet their basic needs (school fees, protection, food, housing, health care, etc.)?

10. Who is considered powerful in this community? What gives people power in this community? (**PROBE:** land/property, spiritual leadership, position of authority, money, having a job, guns, ...)

11. **Without mentioning any names or indicating anyone specific**, can you give any examples of how young girls are likely to engage in sexual relationships with people who are influential or powerful in the home or in this community?

PROBE: When this type of thing happens, are girls ever pushed into doing this by anyone (such as family members)?

[If the following issues have not come up, use the following questions to explore areas that have not been mentioned]

12. What other types of violence affect girls or young women in this community/area?

PROBES:

- *At what age/stage do girls and boys get married in this community? Has this changed this year as compared to previous years?*

PROBE: Is there ever any pressure for girls to get married against their will?

- *What about violence between married couples or intimate partners?*
 - *Can you describe any situations when men and boys say things to girls that make them uncomfortable?*
 - *Can you describe times when girls are forced or made to leave the community to find new work or other opportunities?*
-

Now I would like to ask you a few questions about possible incidents and what happens after violence and abuse take place. (You can ask these questions outside the context of the story if you feel it would give you more in-depth answers)

Case Study 1: A 14-year-old girl has just come home from school, and her teacher comes to her house soon after she arrives and brings her a gift. She is at home alone. The teacher tells her how well she is doing in school and that he can help her with her studies anytime. The teacher then starts to touch her and grab her. Then, he pressures her to have sex with him.

Case Study 2: A 21-year-old young woman is going to collect water as the sun is going down. She has been at home much of the day with a sick child, but she must get water for her family. As she is walking on the road, 2 men approach her and start to say things that make her uncomfortable. Then, they grab her, take her behind a tree, and force her to have sex with them.

13. If a young girl (or the young girl in the story) suffers violence, is she likely to tell anyone about it? Who is she likely to talk to (family members, other women, health workers, community leaders, police/security or other authorities or anyone else)?

PROBE: What might keep a girl from telling other people or getting help?

14. How comfortable are girls (or the young woman/girl in the story) in seeking help from the service providers in the area (**PROBE:** health workers, police, etc...)?

15. What do you think is the most important thing for a person to do after she experiences sexual violence or rape?

16. If you were going to seek health services in this area where would you go? (**PROBE:** health centre, traditional healer, faith healer) Please describe any barriers or difficulties that someone might face.

17. What could be done to help girls or young women feel more comfortable getting help from the health clinic? At the police station? For Psychosocial or emotional support?

18. **Without mentioning any names or specific stories**, how does the family treat a girl (or the girl / woman in the story) who was the victim of rape or sexual assault? How does the community treat her?

PROBE: Is there a time when the community might say that the violence is her fault? If the community does sometimes see it as her fault, then is there a time where she might be punished? If so, how?

PROBE: How might her family or community support her?

19. What is done to help survivors of sexual violence in this community? What do you think would stop violence against women and girls from happening in your community?

Closing

That is all of my questions for now. Thank you for your time and your answers / contributions.

Do you have anything you would like to add? Do you have any questions for us? Do you have any questions that you think should be asked of other groups?

As said in the beginning, our discussion today is meant to help us learn about the concerns that you have for women and children in your community.

Please remember that each of us agreed to keep this discussion to ourselves. If anyone would like to speak to me or ___(person taking notes) in private, we are happy to talk to you.

Thank you again for your help.

Key Informant Interview Guide

for ARC Staff and Collaborating partners

1. What were the specific needs that the GBV response and prevention program aimed to address in the five states of South Sudan?
2. What criteria were identified and used to make a decision to respond or not to respond in specific localities?
3. What specific approaches or strategies did ARC use in addressing GBV issues at household level, institutional levels, workplaces, and the rest of the communities in the country?
4. Which partners did you collaborate with on the GBV program and what roles did each of them play?
5. How appropriate and effective were the strategies in ensuring that the GBV interventions were relevant and delivered on time as planned?
6. To what extent did the assistance seek to strengthen the capacities of local communities to lead the response, reduce vulnerability and meet their own needs?
7. What resources have been invested (human, financial, technical) to achieve the defined outputs and outcomes?
8. To what extent did ARC ensure optimum efficiency with respect to use of the different resources?
9. What were the internal and external enabling factors that helped ARC to effectively implement and achieve program goals?
10. Would you say that the GBV program was too ambitious to be achieved given that it did not adequately cover the original 5 states as planned? Please give reasons.
11. What aspects of the GBV program would you consider sustainable and why?
12. What actions are needed to ensure an effective GBV response in this country?

AMERICAN REFUGEE COMMITTEE

End of GBV program Evaluation in South Sudan

Project: Integrated Governmental and Community Based Strategy for Response and Prevention of Violence against Women in South Sudan

Lead Consultant: Dr. Mulekya Francis, ARC/Makerere University School of Public Health, Kampala, Uganda; Telephone +256772 672 355; Email: francisbmf@yahoo.co.uk

Name of Payama _____ Boma/Cluster _____

Moderator _____ Recorder _____

Language _____ Date : _____ Time:Start _____ End _____

Introduction

(To be read out to the FGD participants by the Interviewer)

We are a team of Evaluators from ARC undertaking an assessment of ARC program on Gender Based Violence aimed at responding and preventing violence against women in the Republic of South Sudan. The study assesses the extent to which the ARC GBV program has helped reduce violence against women in this community, the kind of structures/systems that are in place to respond to GBV issues, what challenges still exist in handling of GBV perpetrators and GBV survivors as well recommendations for improving GBV interventions in the community. It is hoped that the findings will inform and guide ARC and government of the Republic of South Sudan in designing strategies to further prevent and respond to GBV in this community/country. You were identified from the community purposively as people with useful information on the GBV programs implemented in your community.

In order to discuss easily, we need to introduce our selves to one another, by mentioning your first name. We are grateful you have accepted to be here with us as we try to understand the issues of violence against women (including girls) and ways in which the problem can be reduced. Feel free and give us your opinions. Everyone has their own thinking that may differ from the rest; so let us respect that. We are voice recording and taking notes to be able to keep track of all that is being discussed. The discussion will take about two hours to last. Your participation in this exercise is entirely voluntary. Your name will not appear anywhere in the report or publications. All information in this discussion will be kept confidential.

We ask you not to reveal anything that might be heard from other group members. Even though we will ask people in the group not to reveal anything to others, we will not guarantee this.

Potential Benefits: There are no immediate benefits to you from this study. However, the results of the study will be used to help identify gaps in social services for GBV survivors and development of an effective strategy on GBV in your community. ARC is fundraising for GBV interventions in South Sudan for continuity of services in your community.

Costs or Payments: You will be given transport refund and refreshments (soda and simple snack) during the focus group discussion. No payments will be made to Key Informants.

Moderator Consents on behalf of the group by signing this form:

Name of Moderator: _____

Signature: _____

Date: _____

GUIDE QUESTIONS

Knowledge and prevalence of GBV

1. What would you say about acts of violence against women and girls in this community over the past 2 years? (Probe for where GBV occurs, perpetrators and reasons that increase their risk or vulnerability of women and girls to GBV.
2. What are the main sources or channels of communication through which you learn or hear messages on GBV in this community? (Probe for Radio, Community leaders/GBV Volunteers, Police, etc)

Reporting System

1. Where do you report cases of GBV? Engage them in ranking the persons they would report to first and why? Probe for the explanations.
2. Do you think all cases of GBV that occur in this community are reported? If No, what could be reasons for under reporting or non-reporting?
3. What are the strengths and weaknesses in the reporting system for GBV cases that you see in this community?

Protection Systems, Process and Outcomes

1. Where do victims/survivors of GBV in this community get care and support services from? (probe for Protection centres, families, religious and other support systems in the community e.g family courts, police, etc) Find out the traditional sources, health centres and challenges in getting health services.
2. How long does the process of handing a case of GBV take to have a judgement passed when reported to the existing protection/support systems? Probe for duration of handling cases at family court level, Police or Probation office, etc. Moderator asks participants to give specific cases where cases of GBV took long to be resolved, without mentioning names of victims/survivors.
3. What are your feelings about the protection services received from these traditional courts? Find out whether they are satisfied with the protection services.

Formal and informal protection structures

1. Can you share with us (me) experiences of GBV that have occurred in this community in the past one year without mentioning actual names and how the case was handled (Request the group members to share such experiences and record the story)
2. Which structures/ NGOs/Agencies are involved in responding to GBV issues? Probe for any formal/traditional/family/clan/religious court system?
3. What is good/bad about the process of getting justice in the formal courts? Moderator, find out the factors at family, community level and within the courts that frustrate getting justice?
4. As a community, are satisfied with the manner in which GBV cases have been handled by the structures above?

Recommendations

1. What do you think needs to be done to ensure that GBV cases receive the protection and fairness in the courts of law?
2. What do you think should be done to improve your access to formal justice? Probe for roles in making justice delivered?
3. What do think can be done to reduce or stop occurrence of GBV as a practice in this community? List responsibilities for each of the following actors
 - a. Reduce GBV at the following levels
 1. Family
 2. Community
 3. Local leaders
 4. Service providers e.g Government and NGOs
 - b. Improve GBV protection mechanisms at the following levels
 1. Family
 2. Community
 3. Local leaders
 4. Service providers e.g Government and NGOs

Key Informant Interview Guide for Protection Services, Law enforcement and access to Justice (Judiciary, Police, Political Leadership, Probation and welfare)

Introduction and General Information

1. Can you tell me your name and your title?
2. Tell me about what you do in this office in relation to GBV protection?
3. Can you briefly comment on the situation and welfare of women in this community?

GBV Reporting

1. Tell me about the status of GBV in this area? Probe for magnitude and request for statistics, if available, quote the source document
2. Could you share practical experiences on how GBV cases have been handled in this state/community and what lessons you have learnt from them?
3. Do you think cases of GBV are adequately reported to your office? Probe for challenges in reporting, documentation and verification of reports.
4. How important are these reports in service delivery? Probe for linkages and barriers to accessing services(health, formal justice)
5. What do you think need to be done to improve on reporting cases of GBV in this community?

GBV Service Delivery

1. What are services/ interventions on GBV are currently implemented in this area?
2. What you consider to be the impact of the ongoing GBV response interventions in this community? (Probe for impact at family level, community and government level)? What is your comment on the relationship with other actors in protection of GBV? Probe for challenges and opportunities in the network of actors?
3. What do you think needs to be done to improve the situation of GBV in regard to protection of GBV survivors in this community?

Section 5: Recommendations

1. What do think can be done to reduce or stop occurrence of GBV as a practice in this community?
List responsibilities for each of the following actors
 - a) Reduce GBV at the following levels
 - 1) Family
 - 2) Community
 - 3) Local leaders
 - 4) Service providers e.g Government and NGOs

Key Informant Guide for Cultural/Opinion leaders/Clan/Community Elders/Religious Leaders

1. Can you please tell me about yourself and what you do.
2. What acts/behaviors/statements do you consider as acts of GBV/violence against women? Probe for historical trends regarding violence against women and girls
3. What factors do you think could promote GBV against women in this community? Are there any socio-cultural factors or practices do you think can reduce GBV in this community?
4. In the event that a women experiences GBV/domestic violence, how do you settle such cases in this community? Give examples of cases handled in the past two years and who settles them.
5. What do you consider in determining justice in cases of GBV?
6. Where are cases of GBV reported and who reports the cases?
7. What challenges do GBV survivors face in the process of reporting?
8. Do you have linkages with the Local Council or family Courts/Police /Probation and Welfare?
9. What do you think should be done to improve protection and prevent GBV cases in the community?

Key Informant Interview Guide for Health Managers/ Workers

Introduction and General Information

1. Can you tell me your name and your title?
2. Tell me about what you do in this facility in relation to GBV
3. Can you briefly comment on the situation and welfare of women in this community

GBV occurrence in the community

1. What are the main types of GBV you receive or handle at this facility? (Rape, Sexual assault, Physical injuries, Alcohol related injuries, etc)
2. Who are the persons mainly affected? (age group, sex,
3. Which places or community do these cases mainly come from and why?
4. How far from the facility do the cases generally come from?
5. What do you think are the main causes of violence against women in the community you serve?
6. What are some of the negative impacts of GBV in catchment community of your health facility?

GBV Case management and referral

1. Where are the GBV survivors referred from to this facility? Probe for specific persons who refer the cases to the facility?
2. What specific support and treatment services do you offer to GBV survivors at this facility and in the community? (probe for medical interventions, awareness and health education, etc)
3. Have you or your health care team received any training on how to manage GBV cases?
4. Where do you refer GBV cases that you have managed?
5. Which structures and partners have you closely worked with in managing GBV cases?
6. Do you have any specific guidelines or tools you use for reporting GBV cases

Challenges and lessons learnt

1. What are the strengths and weaknesses in the reporting system for GBV cases that you see in this community?
2. What are the challenges you face in the referral and management of GBV survivors at your facility?
3. What strategies have worked well or not worked well for you in managing and referring cases of GBV?
4. What do you think should be done and by who?
 - a. To prevent GBV in the community or in your catchment zone?
 - b. To improve case management of GBV?
 - c. To improve Justice in handling of reported GBV cases?