EVALUATION REPORT
EVALUATING THE EFFECTIVENESS OF GENDER-BASED VIOLENCE PREVENTION PROGRAMS WITH REFUGEES IN CHAD

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COVER PHOTO
Refugees at Women's Center in Touloum Camp, Iriba, Chad. (Photo Credit: Sylvie Morel-Seytoux)

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ACRONYMS

ACRA	Cooperazione Rurale in Africa e America Latina
ADES	Agence Sociale pour le Développement et Education
APLFT	L'Association pour la Promotion Libertés Fondamental au Chad
CAR	Central African Republic
CARE	CARE International
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CNARR	Commission Nationale pour l'Accueil et la Réinsertion des Refugiés et des Rapatriés
CSSI	Centre de Support en Santé Internationale
DIS	Détachement Intégré de Sécurité
DoS	U.S. Department of State
DPHR	Détachement pour la Protection des Humanitaires et des Réfugiés
DV	Domestic Violence
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FLM	Lutheran World Federation
FY	Fiscal Year
GBV	Gender-based Violence
GBVIMS	Gender Based Violence Information Management System
HIAS	Hebrew Immigrant Aid Society
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
KII	Key Informant Interview
LGBTI	Lesbian, gay, bisexual, transgender, intersex
M&E	Monitoring and Evaluation
MINURCAT	United Nations Mission in the Central African Republic and Chad
NGO	Non-governmental organization
PEP	Post-Exposure Prophylaxis
PRM	Bureau of Population, Refugees, and Migration
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-based Violence
SMART	Specific, Measurable, Achievable, Realistic, and Time-bound
SOP	Standard Operating Procedure
SOW	Statement of Work
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation, and Hygiene
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

Evaluation Purpose

This performance evaluation examines the effectiveness of gender-based violence (GBV) prevention programming funded in Chad by the U.S. Department of State Bureau of Population, Refugees, and Migration (DoS/PRM) during Fiscal Years (FY) 2010-2012 (October 1, 2009 – September 30, 2012). Fieldwork conducted as part of this evaluation contributes to a one-year evaluation of GBV prevention programming supported directly by PRM or indirectly by its partner organization, the United Nations High Commissioner for Refugees (UNHCR). The purposes of the evaluation are as follows:

- Assess the effectiveness of GBV prevention programming for individuals and communities at risk;
- Identify appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings; and
- Characterize best practices and lessons learned in engaging men and boys in GBV prevention and response interventions in refugee settings.

The evaluation will provide DoS/PRM, multilateral organizations such as UNHCR, and non-governmental organization (NGO) implementers with guidance about conducting priority GBV prevention initiatives; monitoring and evaluating field-based GBV prevention programs; and engaging host country, international, and local NGOs in best practices for GBV prevention.

Evaluation Questions

The evaluation seeks to answer the following questions:

1. Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
2. Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
3. Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
4. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals specific, measurable, achievable, realistic, or time-bound (SMART)? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?
6. What factors explain intended and unintended negative or positive consequences?
7. What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?
8. To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

Program Background

The Republic of Tchad (Chad) is a land-locked north central African state bordered by Libya to the north, Sudan to the east, Central African Republic (CAR) to the south, Cameroon and Nigeria to the southwest, and Niger to the west. The country is divided into multiple regions: a desert zone in the north, an arid Sahelian belt in the center, and a more fertile Sudanese savanna zone in the south. While Arabic and French are the official languages, Chad is home to more than 200 distinct ethnic and linguistic groups. Islam and Christianity are the most widely practiced religions.

With a population of 11,452,000, Chad is among the poorest countries in the world, with approximately 55 percent of the population living below the poverty line and approximately 36 percent of the population living in extreme poverty.[1] Poverty is primarily concentrated in rural areas, where 87 percent of the country's poor reside. Chad is ranked 184 of 187 countries and territories on the 2012 United Nations Development Programme (UNDP) Human Development Index.[2]

Refugee Situation: As of September 2012, Chad hosted 288,700 refugees from Sudan and 56,700 refugees from CAR, as well as 90,000 internally displaced persons (IDPs), 91,000 returned IDPs, and 550 urban refugees and asylum seekers.[3] Refugees in Chad currently reside in 18 camps that are primarily located in the southern and eastern regions of the country bordering CAR and Sudan, respectively. The Chadian government and refugee agencies are faced with a complex situation due to the diverse backgrounds and needs of the refugee populations.

PRM programming goals in Chad include the primary prevention of GBV. Primary prevention aims to prevent violence before it happens, whereas secondary and tertiary prevention focus on response to violence that has already occurred immediately (secondary prevention) or in the longer-term (tertiary prevention).[4] Based on definitions used by the World Health Organization (WHO), Centers for Disease Control and Prevention, and United Nations, primary prevention can be understood as follows:

- Carried out before violence first occurs;
- Aims to prevent initial perpetration or victimization;
- Addresses social norms and environmental factors that contribute to violence; and
- Appears to be most successful when carried out as part of comprehensive, multi-sectoral efforts.

In Chad, the evaluation team examined GBV prevention programs implemented by three NGOs with PRM funding:

Agence Sociale pour le Développement et Education (ADES): ADES is a local NGO that has been working in refugee camps in eastern Chad since 2005. It is operational in the Am Nabak, Touloum, Iridimi, Goz

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[1] CIA - World Fact Book 2013

[2] UNDP Human Development Report 2013

[3] 2013 UNHCR Country Operations Profile – Chad. UNHCR reports IDPs and returned IDPs separately. Returned IDPs are individuals who were previously displaced inside Chad but have since returned home with UNHCR assistance. UNHCR has been assisting them to return home by escorting them to their villages of origin and providing shelter and reintegration packages.

[4] Dahlberg, L. and Krug, E. "Violence—a global public health problem," *World report on violence and health*, ed. Etienne G. Krug et al. (Geneva: World Health Organization, 2002), p3-21.

Amir, and Oure Cassoni camps and conducts GBV prevention and response activities in Oure Cassoni camp and Goz Amir camp. In each of these camps, ADES implements multi-sectoral programming that includes a variety of activities such as livelihoods promotion, environmental protection, shelter construction and maintenance, child protection, information dissemination, psychosocial and health services, and water and sanitation. ADES works closely with UNHCR, refugee groups, and other NGOs to implement these activities.

CARE International (CARE): CARE is an international NGO and UNHCR implementing partner serving refugees from CAR in the southern camps of Belom, Dosseye, and Gondje Amboko. CARE began working in these camps in 2013. Previously, CARE was supporting refugees with specific needs in the northeastern camps of Am Nabak, Touloum, and Iridimi. In addition, CARE works closely with UNHCR as well as local and international NGOs to protect children and adolescents from abuse and exploitation.

Hebrew Immigrant Aid Society (HIAS): HIAS maintains an advocacy network and community-based referral system to identify and prevent GBV and sexual exploitation and abuse; respond to sexual and intimate partner violence by providing psychosocial support to survivors; and encourage women's and girls' self-reliance, leadership, and decision-making ability in 11 of the 13 camps for Darfuri refugees in eastern Chad. HIAS trains and supports refugees to implement theater productions and radio programs to transmit awareness-raising messages and sensitization activities. HIAS also works closely with UNHCR, governmental authorities, and international and local NGOs.

Evaluation Design, Methods, and Limitations

This performance evaluation employed standard rapid appraisal methods of document review, key informant interviews (KIIs), focus group discussions (FGDs), and site visits. The Chad performance evaluation complements, and builds upon, findings from the Desk Review Report submitted to DoS/PRM in July 2013 by providing primary information on best practices, lessons learned, and directions for future programming, support, and PRM engagement. The evaluation team identified the following four categories of target groups as data sources for the field evaluation:

- **Donor/U.S. Government Partners:** DoS/PRM; DoS/N'Djamena; UNHCR in N'Djamena, Maro, Goré, Koukou, and Iriba
- **NGO Implementers:** CARE International in N'Djamena, Maro, and Goré; Hebrew Immigrant Aid Society (HIAS) in N'Djamena, Koukou, and Iriba; Association pour le Développement Economique et Social (ADES) in Koukou and Iriba
- **Local Governmental and Non-Governmental Collaborators:** Commission Nationale pour l'Accueil et la Réinsertion des Refugiés et des Rapatriés (CNARR); Détachement pour la Protection des Humanitaires et des Réfugiés (DPHR), previously Détachement Intégré de Sécurité (DIS); Centre de Support en Santé Internationale (CSSI); L'Association pour la Promotion Libertés Fondamental au Chad (APLFT); Lutheran World Federation (FLM); Cooperazione Rurale in Africa e America Latina (ACRA)
- **Beneficiaries/Program Participants/Refugee Volunteers and Committee Members:** Vigil Committee, Women Leaders Committee, Religious Leaders Committee, community mobilizers, SGBV Committee, Youth Committee, theater group, SGBV survivors, Child Protection Committee, young mothers group

For evaluation fieldwork, a purposeful sample of four refugee camps was selected as research sites. Two camps were selected in the south (Belom and Dosseye), and two camps were selected in the east (Goz Amir and Touloum). These refugee camps were selected collaboratively with DoS/PRM based primarily

upon the prevalence of GBV prevention programs being conducted by the three NGO implementers that are the focus of this evaluation. Additional factors considered in the selection of these camps include the representation of the two major refugee groups currently residing in Chad; differentiations in terms of access to natural resources, such as water and arable land; numbers of new refugee arrivals; varying proximities to host communities and the local population; and a variety of logistical, transportation, and security considerations within the operating environment.

Largely due to the highly-challenging operating environment in Chad, the team encountered numerous limitations to the evaluation: selection bias regarding the number and composition of refugee camps visited; response bias in terms of possible perceptions of and information shared by vulnerable respondent groups in the presence of security forces and PRM staff at many of the KIIs and FGDs; and logistics regarding security challenges, time constraints, and language barriers.

Evidence and Findings

Evaluation Question 1: Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?

Part I: Achievement of program activities as defined in project proposals

The evaluation team found that PRM-funded NGO implementers successfully carried out the majority of proposed program activities with a fairly even balance between prevention and response. By design, the sensitization and awareness-raising activities received more focus and attention; however, these activities tended to be more in line with internationally accepted GBV guidelines, whereas several weaknesses were noted among the response and treatment activities.

NGO implementers demonstrated noteworthy achievements in terms of progress made toward transforming socio-cultural norms, empowering women and girls, and rebuilding family and community structures and support systems. CARE's programs include conducting educational talks and skits and broadcasting radio messages to raise awareness about the consequences of FGM, early and forced marriage, and domestic violence (DV); HIAS implements trainings, drama presentations, and extensive door-to-door campaigns to educate the population on GBV dynamics, causes, and consequences. HIAS was the only one of the three NGOs evaluated that explicitly focused on strengthening community support systems and referral networks. Community mobilizers received quarterly training on how to work with GBV survivors and share information about the status of available referral services. The evaluation team was unable to obtain anything other than anecdotal information on the nature or outcome of activities beyond the number of events conducted and the number of people reached.

The team was impressed with the organization, delivery, and facilitation of programs and activities despite very limited human and financial resources. However, these limitations clearly affected the volume, diversity, and quality of services provided. The team found that most services are reaching only a fraction of the refugee population within the camps and that activities tend to look very similar in design across the NGOs—with little innovative programming, and with great variation in quality. KIIs with NGO management and FGDs with NGO staff, refugee workers, and program participants underscored the challenges that implementing partners face in accurately tracking program performance. While NGO implementers use a standardized incident report form to monitor cases of GBV, there was little evidence to suggest that additional indicators were being routinely employed to measure progress against program objectives. In the absence of a clear system to track planned versus

actual implementation of activities over the life of their projects, NGO implementers struggled to definitively report whether or not proposed activities had been successfully implemented.

Part II: Barriers and facilitators to implementing program activities

The evaluation team gathered extensive data on barriers and facilitators to program implementation through observation and examples cited by KII and FGD respondents.

Barriers

Influx of refugees: A challenge faced by UNHCR and NGO partners in Maro was the influx of more than 5,000 new refugees during the relocation and consolidation of refugees to Belom Camp due to damage sustained from flooding. UNHCR reported that it was difficult for the new arrivals to integrate into the camp system during the rebuilding period.

Widespread unmet basic needs: The life-threatening difficulties that refugees in Chad face on a daily basis—related to food, water, shelter, medical care, and education—prevent the NGO partners and refugees alike from dedicating significant focus to the issue of GBV. While GBV is tied to basic human rights, the evaluators understood from respondents that it can often seem secondary to the aforementioned basic needs. Decreased food rations in several camps were cited to increase household stress levels as hunger and competition for household resources increases. Camp leaders in Touloum shared concern about the lack of resources. In particular, they suffer from a deficient availability of water and firewood.

Refugee camp health facilities in poor repair and inadequately staffed: The team found the condition of health facilities to be very poor and was informed by numerous respondents about supply distribution breakdowns leading to lack of medicines essential to support GBV survivors, such as Post-Exposure Prophylaxis (PEP) kits and depression medication.

Lack of durable solutions/refugee apathy and loss of hope: Resources are scarce in Chad. The south is a more favorable area in terms of access to resources, land, and climate. In the north, it is much harsher in terms of livelihoods. UNHCR staff in Goz Amir reported a level of frustration among the refugees, which they believe stems from insufficient infrastructure and lack of access to secondary school and higher education, as well as lack of professional training:

Cultural barriers: Deeply-rooted cultural barriers were frequently cited as some of the most challenging obstacles to program implementation and the achievement of outcomes. According to CARE staff in Maro, before FGM became illegal, refugees used to make a big show of the ceremony with dances, parties, and celebration, but now the practice is hidden. CARE delivers trainings so that people will abandon the practice; however, no women have reported circumcisions to date. APLFT staff in Maro also commented on the difficulty of addressing the deeply-embedded cultural practice of FGM through legal channels. The practices of forced marriage and early marriage present tremendous hurdles to reaching desired GBV prevention outcomes. UNHCR Goz Amir staff members reported that parents' rationales for forced and early marriage stem from a fear that if a daughter has a relationship before marriage, it will bring a great deal of dishonor to the family.

Lack of female members in security forces: Several respondent groups noted the challenges for GBV prevention resulting from the departure of the UN Mission in the Central African Republic and Chad (MINURCAT) peacekeeping force and DIS, the Chadian government police force—each of which had

female members who were trained in issues surrounding GBV. Since July 4, 2013, these forces have been recalled leaving only the Chadian Gendarme to ensure security within refugee camps. One member of DPHR in Belom Camp expressed concern about his forces' ability to provide assistance with GBV incidents.

Lack of data-driven knowledge about GBV faced by refugees: Information on the types and prevalence of GBV in the refugee camps is extremely limited, which leads to the risk of incorrect assumptions. Very little information is available on the actual incidence or prevalence of any type of GBV.[5]

Insufficient financial resources: Nearly every NGO and Government of Chad partner cited its limited budget as a major hurdle to program implementation. DPHR Maro expressed concern about its ability to assure camp security due to its severely compromised finances. UNHCR Goré expressed concern about its ability to manage GBV as a priority in the wake of so many other competing needs. Due to budget cuts across UNHCR, the Iriba office lost funding for several positions, including an education assistant and a child protection assistant. The consequence has been recognized in adjustments to existing positions, which are now much broader in order to cover all of the needs with one person functioning as the focal point for both education and child protection.

Overlap among NGO implementers: The evaluators found an overwhelming redundancy of roles and responsibilities among the various NGO partners and refugee committees regarding the prevention and treatment of GBV within the camps. The majority of KII and FGD respondents cited conducting community sensitizations and carrying out household visits to speak with and provide advice to GBV victims and victims' families. Among others, CNARR, the GBV Committee, community mobilizers, DPHR, the Youth Committee, and refugee leaders reported engaging in these activities.

Facilitators

Partnerships with refugee community organizations: UNHCR, HIAS, and CARE all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. Collaboration with internal camp leadership committees was frequently cited by NGO staff as an effective and efficient method for distributing information and services between the community and the NGO partners. In addition, NGOs recruit staff members and volunteers from the refugee community, who are recognized by refugees as extensions of the service providers and sought out for communication about problems and inquiries about types of assistance.

Strong relationships with local communities: Many of the NGO partners cited examples of activities that they are undertaking and projects that they are pursuing in order to establish strong relationships with the local communities living around the refugee camps. As most refugees rely on natural resources as well as many services, such as medical care and education, that are located in the communities, NGO partners stressed the importance of building and maintaining positive relationships with the host community.

GBV Standard Operating Procedures (SOPs) and weekly GBV coordination meeting: These tools, developed and put in place by UNHCR, play a major role in facilitating program activities. Nearly all of

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[5] See Evaluation Question 2 for further discussion about the lack of critical data on GBV.

the NGO implementers and Government of Chad partners with whom the team met cited weekly GBV coordination meetings as a forum for sharing, learning, and supporting effective work.

Female DPHR members: Just as the lack of female security officers was cited as a barrier to effective program implementation, the presence of several remaining female officers on some security teams with whom the evaluators met appeared to be a significant facilitator for GBV prevention.

Highly-skilled refugee staff/volunteers: The evaluation team learned about the nuanced GBV prevention and treatment skills and abilities that the refugee volunteers developed through their work with the NGO implementers. In particular, the team found a strong relationship between HIAS and its community mobilizers in Goz Beida Camp.

Evaluation Question 2: Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measurable objectives? If not, how can the objectives be improved?

The design of program objectives and activities was generally not informed by comprehensive needs assessments or surveys. The NGOs neither carried out baseline surveys nor determined the incidence or prevalence of GBV within their respective refugee communities, the types of GBV experienced by refugees, the places and persons at highest risk of GBV (risk mapping), or the likely perpetrators. Information on the types of GBV refugees face is limited, which may lead to incorrect assumptions. NGO implementers' programming appears to emphasize DV over other types of GBV; however, the decision to focus resources on this area does not appear to be evidence-based. There is a lack of information about the level of GBV perpetrated by the police and other authorities, GBV committed against men and boys, the number of refugees forced by circumstances into survival sex, and the extent of needs and/or challenges faced by LGBTI refugees.

Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?

With regard to supporting positive gender relations, eradicating harmful traditional practices, and rebuilding community support structures, the team found that the HIAS and CARE programs are very much in line with international GBV guidelines. The methods these NGOs employ in their awareness-raising campaigns and door-to-door home visits exhibit the utmost regard for the refugees' traditional cultures and values while at the same time introducing ideas and concepts about GBV that appropriately and sensitively challenge these norms. UNHCR and HIAS noted that just a few years ago, women were barely involved in the committees and volunteer workers were unsettled when speaking about issues such as rape and FGM, which are now central themes in their daily prevention work.

The evaluation team found that gender balance and representation on refugee camp committees was consistent and substantive across all the camps visited. Representation of males and females within all the various community groupings was well-balanced. Groups with the greatest gender balance included GBV Committees and community mobilizers, and groups with less gender balance typically included Vigil Committees and the committees of central leaders and religious leaders—which were usually composed primarily of men. The commitment on the part of PRM-funded NGO implementers and UNHCR to have a balanced gender representation within all activities and outreach is a positive factor in terms of reaching program goals of GBV prevention and outreach while reflecting international GBV guidelines.

The team identified a lack of emphasis on combatting child abuse, despite its prevalence in the refugee community. The team met with HIAS' Child Protection Committee, which discussed its work with orphans and neglected children, as well as visited a selection of schools to hear from students about their awareness of GBV. The team found that these programs were not receiving the prioritization and attention that they warrant.

The team found that issues such as the provision of medical care and the delivery of psychosocial services were less of a priority and were not fully in compliance with international standards. The quality of the medical facilities the team observed ranged from poor to critical condition, which in conjunction with the lack of medical supplies and staff, provides very limited options for refugees to receive appropriate and quality treatment in line with international standards.

Evaluation Question 4: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals SMART? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?

Indicators used by NGO implementers to monitor program performance were weak (as noted in the July 2013 Desk Review Report). Specifically, indicators were poorly designed and often included targets. Indicators should be neutral gauges of progress that can be compared against an objective or target. When used appropriately, targets can orient NGO implementers to tasks that need to be accomplished and provide guidance for monitoring whether or not program progress is being made on schedule and if results have been achieved over time.

The majority of respondents from UNHCR and NGO implementers noted that the primary, if only, indicators they are collecting are via GBV incident report forms required by UNHCR. The form is used to log cases of GBV, including the type of GBV, but lacks information about how the case came about and how it was reported. Regarding the utility of UNHCR's incident report form, respondents widely noted that indicators are largely output oriented and capable of showing progress at the activity level, but incapable of demonstrating program outcomes. Both donors and implementers conceded that outcome measures are less frequently used because they are more difficult to assess.

One of the most apparent shortcomings of the monitoring conducted by UNHCR and NGO implementers was the complete absence of any indicators to track the incidence of FGM. While nearly all respondents spoke about the prevalence of FGM and its perceived reduction as a consequence of GBV prevention programming, none were able to report with any degree of certainty about the actual incidence rate of FGM or the connection, if any, between their program activities and the prevalence of FGM.

NGO implementers reported that PRM guidance on monitoring and evaluation (M&E) strategies was limited to the proposal submission process and that it would be helpful to receive guidance and support on indicator development. PRM is aware of the challenges in understanding the effectiveness of implementers' programs. One DoS/PRM staff member reported that UNHCR and NGO implementers do not provide PRM with substantive, evidence-based conclusions about the effectiveness of GBV prevention programs.

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?

Part I: Unexpected negative consequences

While GBV prevention and awareness campaigns and support services offer survivors encouragement and improved mechanisms to report incidents of GBV and obtain legal and other necessary assistance, they can also cause socio-cultural disruptions as communities and individuals may have differing perceptions about the role of outside assistance, legal intervention, and other services in what they consider to be family issues. NGO implementer staff across all the camps noted that programs that provide women with greater independence or legal options sometimes increase tension within the home due to the abuser's anger over lack of control, insecurity, or feeling threatened (particularly in the case of DV). Representatives of APLFT, the legal service provider, explained that some male community members perceive any legal intervention pertaining to DV, for instance, as "APLFT pushing the wife against the husband." In response, PRM-funded organizations walk a very careful line in terms of balancing their support for survivors to seek legal remedies and other services related to GBV incidents with, on the other hand, respecting and working within socio-cultural norms and community systems that are deemed acceptable within the existing ethnic, religious, and traditional community context. Given that a majority of GBV cases, especially DV, are resolved outside the court system, it is possible that the NGOs may have downplayed the legal avenue almost too much in their efforts to keep peace with the refugee communities and work within the communities' social norms and structures.

Part II: Unexpected positive consequences

The team identified one important unexpected positive consequence of PRM-funded GBV prevention programs. KII feedback from refugee communities indicated that due to GBV awareness campaigns' emphasis on decreasing forced and early marriage, the demand for long-term, quality education among both girls and women has increased greatly within refugee communities. The communities have learned about the harmful consequences of early and forced marriages, such as difficult and sometimes fatal deliveries among mothers who are children themselves or young adolescents. They have also learned that there are many opportunity costs for a girl who marries early. Refugees attributed this increased desire and appreciation for education to the GBV training and awareness campaign efforts of PRM-funded NGO implementing partners, as well as to a variety of other human rights, child protection, and social advocacy messages relayed by humanitarian organizations working in the camps. Unfortunately, this positive side effect of GBV prevention programs—significantly increased awareness and interest among girls and women to continue their education, receive higher quality education, attend secondary schools, and even obtain university degrees—has been met with the negative reality of educational offerings in or near the refugee camps.

Evaluation Question 6: What factors explain expected and unexpected negative or positive consequences?

Part I: Factors explaining unexpected negative consequences

Consequences of PRM-funded GBV programming activities can be attributed to a diverse host of factors. Internal factors that may be within UNHCR's control or the NGO implementers' control are outlined below. External factors that are outside the direct control of the organizational entity implementing the program activity are discussed under Evaluation Question 6, Part I.

Internal Factors

- Lack of long-term analysis of, and planning for, possible negative consequences of program activities on the part of UNHCR and NGO implementing partners
- Psychosocial counseling protocols that may not be adequately survivor-centered and would benefit from further refinement
- Lack of male-only support groups for men and boys to prevent and address the issue of male GBV survivors
- Missed opportunities to collect data at health centers on the number of existing and new cases of FGM in each camp, which would allow programs to be better grounded in real, more accurate data regarding the prevalence of FGM
- Some duplication among partners and committees in terms of counseling, which possibly dilutes the integrity and effectiveness of counseling efforts and increases the possibility of breaches of confidentiality due to the multiple entity involvement
- Lack of monitoring at the outcome level to provide data on whether or not prevention efforts are effective, which would provide essential feedback to inform adjustments and ongoing learning for programming

Part II: Factors explaining unexpected positive consequences

Establishment of trust with refugee communities: FGD feedback across the four camps visited by the evaluation team indicates that, overall, refugee communities believe they have a good working relationship with the implementing partners. KIIs provide evidence that the refugee communities generally trust and respect the partners' efforts in GBV prevention. This is an essential and difficult accomplishment, as UNHCR and the NGO implementers are working with diverse refugee communities with various religious, cultural, educational, and ethnic backgrounds.

Close collaboration between partners: The evaluation team found collaboration between UNHCR and NGO implementers to be exceptionally strong. There exists a clear "spirit of unity" in working on GBV issues between all of the partners who are active in the four camps the team visited. The weekly partner coordination meetings conducted to discuss ongoing GBV cases is a central component of the partners' work. This shared sense of purpose and collaborative spirit is most certainly a key factor in terms of accomplishing results.

Substantive and ongoing GBV sensitization outreach: The evaluation team found there to be a significant amount of mass sensitization on GBV being carried out, on a consistent basis and with high community turnout and participation on a voluntary basis. Continued exposure to GBV prevention messages was identified by a large proportion of the refugees who participated in the FGDs as a key factor in changing people's knowledge, attitudes, and practices over time to move away from harmful traditional practices and other forms of GBV.

Creative social messaging through theater and radio: Youth theater groups conducting GBV awareness outreach offer a dynamic and participatory approach to GBV prevention. It was reported during FGDs that this form of knowledge and advocacy outreach is particularly well-liked by the refugee communities because it simultaneously relays important messages and provides the community with some (much needed) entertainment. Also, partners have used radio programming as a creative method of introducing different topics and themes related to GBV. A specific benefit of radio programming is that it reaches both refugees and host communities. This effort to introduce creative GBV messaging has been a positive component of PRM-funded programming.

Evaluation Question 7: What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?

As described under Evaluation Question 4, the team found a consistent shortage of and, in many cases, a complete lack of data on program outcomes. As such, findings on the outcomes of GBV awareness campaigns are largely anecdotal and based on the perceptions of UNHCR and NGO implementer staff. The extent of data the team received regarding GBV awareness campaigns was in reference to the number of participants who attended various events. In most cases, those numbers were not disaggregated between males and females. Despite the absence of outcome-level data about changed knowledge, attitudes, and practices, almost every NGO implementer and refugee group the team interviewed cited a decrease in the number of GBV cases and the prevalence of various kinds of GBV, such as FGM, as a result of the activities they are implementing. However, due to a lack of outcome monitoring, respondents were unable to establish a causal line of contribution between their activities and the cited decrease in GBV incidents. It is clear that UNHCR, NGO implementers, Government of Chad partners, and refugee committees are proud of the work they are undertaking to prevent and address incidences of GBV, which may contribute to their perception that their efforts have been successful and that GBV has decreased within the camps. Unfortunately, the overarching lack of outcome-level data not only prevents the evaluation team from verifying qualitative findings, but also undermines the ability of PRM, UNHCR, NGOs, refugee groups, and Government of Chad partners from knowing whether their work has been effective.

Evaluation Question 8: To what extent have men and boys been included in GBV awareness campaigns? If they were not included, why was this? If they were, what was the impact and how was it measured? Do the GBV programs address the issue of the male survivors of sexual assault or domestic violence? If yes, how?

Part I: Male engagement in GBV awareness

Although engaging men and boys in GBV prevention and response was not an explicit objective of HIAS, CARE, or ADES programs in Chad, data collection findings indicate that engaging male heads of households in discussions on gender equality and involving men in voluntary committees to promote the rights of women and girls were key components of the NGOs' efforts to transform socio-cultural norms and rebuild family and community support structures. The evaluation team found that men and boys have been consistently included in the GBV awareness campaigns and associated activities implemented within the refugee camps in Chad. KIIs with refugee committee members and leaders across all four of the refugee camps visited by the evaluation team confirmed that the rationale for and benefits of having a balanced mix of men, women, boys, and girls in GBV-related committee activities, social mobilization efforts, awareness campaigns, and direct service provision was well understood and largely "owned" by the refugee communities. CARE, HIAS, and ADES have each played a major role in integrating men and boys into GBV awareness campaigns, activities, and other outreach efforts. NGO implementers did not, however, specifically measure the impact of male engagement.

While KII feedback provides evidence that the participation of men and boys in GBV awareness campaigns is quite consistent, the evaluation team noted that there remain thematic areas of importance to reducing the incidents of GBV. KIIs affirmed PRM's concern that humanitarian programming related to GBV places less emphasis on engaging men and boys than does programming conducted within the international development context. Among the refugee camps visited, awareness raising focuses primarily on improving knowledge and understanding regarding specific types of GBV and their harmful consequences—but without also encouraging (the very difficult and probing)

discussions that question traditional norms associated with femininity and masculinity and that reinforce positive masculine behavior. One area in particular that the evaluation team noted a significant lack of engagement and focus among the NGOs was in addressing the connection between alcohol abuse and GBV. Several refugee committee members, beneficiaries, and UNHCR and NGO staff members noted the prevalence of this problem within the camps, especially as it affects men. However, the team obtained very limited evidence about programs or activities that are combating this problem.

Part II: Male survivors of sexual assault or domestic violence

The evaluation team found that GBV programs implemented in the camps of Belom, Dosseye, Goz Amir, and Touloum do not adequately address the issue of male survivors of sexual assault or DV. This is likely due to a combination of NGO implementers' lack of knowledge with respect to the existence or possible existence of GBV perpetrated against men and boys and the socio-cultural norms of the refugee communities, which tend to strongly deny the existence of these issues and/or consider their discussion taboo. The team found that the preponderance of prevention activities and messages disseminated through awareness campaigns focused on various types of violence against women and girls and that little to no discussion of violence against men and boys was included.

Evaluation Question 9: What were the short- and long-term outcomes of PRM-funded GBV prevention?

Part I: Short-term Outcomes

The work of UNHCR and the NGO implementers assessed in this evaluation has been instrumental in ensuring that PRM achieves its humanitarian objectives and fulfills its mandate. The absence of program outcome indicators, targets, and associated baseline data did not allow the evaluation team to conduct a systematic, technical assessment of program progress and impact. However, the evaluators found two areas of programming, in particular, where NGO implementers are making noteworthy achievements: 1) substantive and ongoing GBV sensitization outreach, and 2) creative social messaging through theater and radio. These areas are discussed in detail under Evaluation Question 6, Part II.

Additional highlights of short-term achievements include the following:

- GBV referral pathways exist for survivors to access services and to obtain support
- Many refugee community members have been trained in GBV awareness and outreach techniques
- Many refugee community members have participated in/attended GBV awareness campaigns and possess increased knowledge regarding the harmful consequences of various forms of GBV
- Refugee community youth have formed GBV prevention/awareness theater groups
- In some refugee camps, there has been an increased demand for legal services, which may be linked to increased awareness regarding GBV
- Childcare facilities at schools have been established in some refugee camps to support the continued education of young mothers

Part II: Long-term Outcomes

The scope of this evaluation includes projects carried out during FY 2010-2012; as such, long-term outcomes cannot yet be assessed. However, the team's 41 KIIs with UNHCR staff, NGO implementers, and DoS/PRM staff as well as 20 FGDs with diverse refugee committees provide evidence of several positive trends occurring in the refugee communities. Note that these trends are based upon the reported perspectives of the refugees themselves—most notably by those with a long history in the

camps who have witnessed gradual socio-cultural changes in knowledge, attitudes, and behaviors within their communities over time, and who have also benefited from PRM-funded GBV prevention programming over the past several years. If current GBV prevention and support services are adequately continued, the trends below could be sustained:

- Socio-cultural environment that is becoming less accepting of harmful practices such as DV, early marriage, forced marriage, FGM, child labor, and child abuse
- Raised awareness of the health consequences and other social costs of harmful traditional practices such as FGM and forced marriage
- Social-cultural norms that are becoming more open to and accepting of positive practices such as prolonged education of girls, delayed marriage for girls, and adult education for women
- A gradual decrease in the social stigmatization of girl and women rape survivors, mothers with children born out of wedlock, and children born as a result of a rape—evidenced by increased socio-cultural compassion and community support for women and girls in these situations
- Raised awareness of the importance of women's participation in decision-making, in general

Recommendations

The evaluation team provides the following evidence-based recommendations for continued progress in GBV prevention programming:

- **UNHCR and NGO partners are encouraged to conduct long-term analyses of, and planning for, possible negative consequences of program activities**. UNHCR, HIAS, CARE, and ADES—in conjunction with other NGO implementers that provide GBV services—should carefully review each of the identified barriers to program implementation to assess whether any of them could be mitigated and/or accounted for in the design and implementation of program activities. Such an assessment could be used as a baseline for continued monitoring of the most concerning consequences or barriers.

- **HIAS, CARE, ADES, and UNHCR should combine efforts to train all refugee staff members about GBV prevention and treatment.** HIAS, CARE, and UNHCR staff should receive ADES training on mental health. ADES staff and others from NGOs and government agencies such as APLFT, CSSI, CNARR, and DPHR should receive HIAS and CARE training on GBV awareness. This step might help to address some of the weaknesses the team found in the treatment protocol and to ensure that all prevention activities are implemented following the same steps.

- **PRM and UNHCR should request that CARE, HIAS, ADES, APLFT, and camp health partners collaborate to administer a survey** (in light of their extensive access to different community members) to gather information about types of abuse, knowledge about GBV, and locations in the community that are not safe. PRM and UNHCR should support the administration of the survey, and findings should be used to inform programming.

- **NGO implementers should seek consistent, quarterly consultation with PRM/Washington and PRM/N'Djamena, as well as with public health experts based in Chad such as representatives from WHO or the Red Cross of Chad, regarding the collection of GBV-related information that will be useful in risk mapping and understanding GBV as it is experienced by refugee populations.** For example, UNHCR and NGO implementers should work with health partners to monitor the incidence and degree of FGM among patients by designing a monitoring tool to record incidences and types of FGM that present during medical examinations and deliveries.

- **HIAS, CARE, ADES, and UNHCR should elaborate a classification system for the various types of GBV and the associated steps that should be followed to handle each type.** This system would support refugee volunteers and committee members in knowing whether a particular incident should be reported to UNHCR or handled informally among community members.

- **PRM should support the identification and dissemination of validated tools for measuring the impact of GBV primary prevention programs on changing social norms that legitimize GBV.** Appropriate tools could include mapping risks of GBV, mapping networks of influential individuals and groups to engage in changing norms that legitimize GBV, and tools to measure individual and community readiness for change in humanitarian settings.

- **UNHCR and NGO implementers should investigate the reportedly overwhelming trend of DV cases being resolved at the family or community level (rather than by means of local legal systems)**. The assessment would require a careful, systematic, and confidential analysis of the outcomes of previous DV cases, primarily from the point of view of survivors; a review of existing GBV social awareness campaign curricula and messaging goals; and a review of GBV counseling protocols and referral networks.

- **UNHCR is encouraged to work with NGO partners and refugee committee leaders to ensure that roles and responsibilities for GBV prevention are not duplicated.** UNHCR and NGO implementers would benefit from streamlining their referral and counseling systems to eliminate existing duplication among partners and committees, as it may be diluting the integrity and effectiveness of counseling efforts, as well as increasing the possibility of breaches of confidentiality.

- **PRM should encourage UNHCR and NGO implementers to greatly expand income-generating opportunities for refugee communities.** Models such as the microcredit programs that are currently in place provide continued focus on strategies for self-reliance, especially for girls and women at risk of GBV. If funds are not available from PRM, UNHCR and its partners should collaborate with other donors that focus on livelihoods to increase the GBV prevention aspects of these activities.

- **UNHCR and NGO implementers should increase discussions and questioning of traditional norms associated with femininity and masculinity within their GBV prevention awareness campaigns—while at the same time reinforcing positive masculine behavior that decreases GBV within the refugee community.** For instance, sensitization theater groups could expand their skits to include messages that suggest ways men can decrease GBV incidents toward women (e.g., taking on the role of collecting firewood, given that GBV assaults are common during this task, which requires women to walk long distances away from the refugee camps).

- **All PRM- and UNHCR-funded partners implementing GBV prevention activities should routinely collect confidential feedback from survivors about their levels of satisfaction and perceptions about quality of treatment and services received.** This kind of information could also be built into PRM’s requests for monitoring data from grantees on a quarterly basis.

EVALUATION PURPOSE AND QUESTIONS

Evaluation Purpose

This performance evaluation examines the effectiveness of GBV prevention programming funded in Chad by DoS/PRM during FY 2010-2012 (October 1, 2009 – September 30, 2012). Fieldwork conducted as part of this evaluation contributes to a one-year evaluation of GBV prevention programming supported directly by PRM or indirectly by its partner organization, UNHCR. The purposes of the evaluation are as follows:

- Assess the effectiveness of GBV prevention programming for individuals and communities at risk;
- Identify appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings; and
- Characterize best practices and lessons learned in engaging men and boys in GBV prevention and response interventions in refugee settings.

The evaluation will provide DoS/PRM, multilateral organizations such as UNHCR, and NGO implementers with guidance about conducting priority GBV prevention initiatives; monitoring and evaluating field-based GBV prevention programs; and engaging host country, international, and local NGOs in best practices for GBV prevention.

Evaluation Questions

The evaluation seeks to answer the following questions:

1. Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?
2. Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
3. Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
4. Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals SMART? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
5. Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?
6. What factors explain intended and unintended negative or positive consequences?
7. What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?
8. To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
9. What were the short- and long-term outcomes of PRM-funded GBV prevention programs?

PROGRAM BACKGROUND

Chad Country Background

The Republic of Tchad (Chad) is a land-locked north central African state bordered by Libya to the north, Sudan to the east, CAR to the south, Cameroon and Nigeria to the southwest, and Niger to the west. The country is divided into multiple regions: a desert zone in the north, an arid Sahelian belt in the center, and a more fertile Sudanese savanna zone in the south. While Arabic and French are the official languages, Chad is home to more than 200 distinct ethnic and linguistic groups. Islam and Christianity are the most widely practiced religions.

With a population of 11,452,000, Chad is among the poorest countries in the world, with approximately 55 percent of the population living below the poverty line and approximately 36 percent of the population living in extreme poverty.[6] Poverty is primarily concentrated in rural areas, where 87 percent of the country's poor reside. Chad is ranked 184 of 187 countries and territories on the 2012 UNDP Human Development Index.[7]

Refugee Situation: As of September 2012, Chad hosted 288,700 refugees from Sudan and 56,700 refugees from CAR, as well as 90,000 IDPs, 91,000 returned IDPs, and 550 urban refugees and asylum seekers.[8] Refugees in Chad currently reside in 18 camps that are primarily located in the southern and eastern regions of the country bordering CAR and Sudan, respectively. The Chadian government and refugee agencies are faced with a complex situation due to the diverse backgrounds and needs of the refugee populations.

Since the 2011 signing of the Darfur Peace Agreement, the political and security situation in Chad has improved, and a joint Chadian-Sudanese border monitoring force has been in place. Nevertheless, a majority of the Sudanese refugees in Chad are unable to return home due to ongoing instability in some parts of Darfur.[9] Likewise, due to volatile conditions in CAR, large-scale voluntary returns are unlikely. Because the situation in this area remains tense, there is a possibility of an additional influx of CAR refugees into Chad.

The presence of a large population of refugees from Sudan and CAR weighs heavily on the country's resources. In eastern Chad, where the climate is semi-arid, Sudanese refugees put a strain on already scarce natural resources, which leads to tensions with host communities. In southern Chad, where the climate is tropical, flooding regularly destroys refugees' homes and crops. This has hampered UNHCR's efforts to improve the self-reliance of CAR refugees and made them more vulnerable to malnutrition. The government's restriction of refugee movements, mobility, and integration in some regions has also served as a barrier to the attainment of refugee self-reliance.

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[6] CIA - World Fact Book 2013
[7] UNDP Human Development Report 2013
[8] 2013 UNHCR Country Operations Profile – Chad
[9] 2013 UNHCR Country Operations Profile – Chad

Sexual and Gender-based Violence (SGBV) in Refugee Camps: For more than a decade, UNHCR has been working in Chad in partnership with approximately 10 UN agencies and 16 NGOs to support refugee populations throughout the country, focusing primarily on food security, child protection, legal rights, prevention and response to SGBV, healthcare, primary and secondary education, and overall security. With respect to SGBV, assessments carried out as part of the UNHCR Chad 2012-2016 SGBV Strategy revealed:

> "*Though under-reported, SGBV is widespread in Chad, including in the refugee and IDP camps in Eastern and Southern Chad. The forms of SGBV that are most documented in the refugee camps and IDP sites in Chad are DV, female genital mutilation (FGM), child marriage, and other forms of SGBV, such as denial of resources. Reported incidents of rape are not high, however given the social stigma associated with sexual violence, as well as the prevailing impunity (often the traditional resolution in rape cases is to marry the survivor to the perpetrator, or even pay a fine herself), it is likely that such cases are under-reported*."[10]

In response, UNHCR has been providing SGBV prevention and programs that include sensitization campaigns, trainings, confidential identification, referral mechanisms, and reporting.

Government Response to SGBV: The Government of Chad launched its National SGBV Strategy on December 8, 2011, which presents an opportunity for UNHCR and other organizations to advocate for a stronger legal framework to address SGBV in the country, as well as in the refugee camps. The document emphasizes that "refugees and displaced persons are a priority in the fight against SGBV in Chad, given that rates of SGBV are high in the humanitarian zones where legal structures are the weakest."[11] Although Chad ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995, it has not ratified either the Optional Protocol to CEDAW or the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Positive reforms, however, include the adoption of Law No. 06/PR/2002 of April 15, 2002, which "prohibits FGM, early marriage, DV, and sexual violence."[12]

It is important to note the legal dualism that prevails in Chad, given that the constitution recognizes traditional and customary rules as having the status of laws. UNHCR reports that "SGBV is overwhelmingly resolved by traditional leaders without consideration for national laws which punish DV, rape, and other forms of SGBV, and thus impunity prevails in most cases and perpetrators usually only pay a fine."[13]

Moving forward within this context, UNHCR's 2012-2016 strategy in Chad focuses on the following objectives:

- Education for girls and women
- Protection of children strengthened
- Community mobilization strengthened and expanded

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[10] SGBV Strategy 2012-2016: UNHCR Chad
[11] SGBV Strategy 2012-2016: UNHCR Chad
[12] Africa for Women's Rights: Chad (2013)
[13] SGBV Strategy 2012-2016: UNHCR Chad

- Peaceful coexistence with local communities promoted
- Risk of SGBV is reduced and quality of response improved
- Self-reliance and livelihoods improved
- Making prevention and response mechanisms inclusive and accessible to all persons of concern from age, gender, and diversity perspectives
- Engaging men and boys in the fight against SGBV

Program Response

PRM programming goals in Chad include the primary prevention of GBV. Primary prevention aims to prevent violence before it happens, whereas secondary and tertiary prevention focus on response to violence that has already occurred immediately (secondary prevention) or in the longer-term (tertiary prevention). Based on definitions used by the World Health Organization, Centers for Disease Control and Prevention, and United Nations, primary prevention can be understood as follows:

- Carried out before violence first occurs;
- Aims to prevent initial perpetration or victimization;
- Addresses social norms and environmental factors that contribute to violence; and
- Appears to be most successful when carried out as part of comprehensive, multi-sectoral efforts.

In Chad, the evaluation team examined GBV prevention programs implemented by three NGOs with PRM funding:

Agence Sociale pour le Développement et Education (ADES): ADES is a local NGO that has been working in refugee camps in eastern Chad since 2005. It is operational in the Am Nabak, Touloum, Iridimi, Goz Amir, and Oure Cassoni camps and conducts GBV prevention and response activities in Oure Cassoni camp and Goz Amir camp. In each of these camps, ADES implements multi-sectoral programming that includes a variety of activities such as livelihoods promotion, environmental protection, shelter construction and maintenance, child protection, information dissemination, psychosocial and health services, and water and sanitation. ADES works closely with UNHCR, refugee groups, and other NGOs to implement these activities.

CARE International (CARE): CARE is an international NGO and UNHCR implementing partner serving refugees from CAR in the southern camps of Belom, Dosseye, and Gondje Amboko. CARE began working in these camps in 2013. Previously, CARE was supporting refugees with specific needs in the northeastern camps of Am Nabak, Touloum, and Iridimi. In addition, CARE works closely with UNHCR as well as local and international NGOs to protect children and adolescents from abuse and exploitation.

Hebrew Immigrant Aid Society (HIAS): HIAS maintains an advocacy network and community-based referral system to identify and prevent GBV and sexual exploitation and abuse; respond to sexual and intimate partner violence by providing psychosocial support to survivors; and encourage women's and girls' self-reliance, leadership, and decision-making ability in 11 of the 13 camps for Darfuri refugees in eastern Chad. HIAS trains and supports refugees to implement theater productions and radio programs to transmit awareness-raising messages and sensitization activities. HIAS also works closely with UNHCR, governmental authorities, and international and local NGOs.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

Evaluation Design and Data Collection Methods

This performance evaluation employed standard rapid appraisal methods of document review, KIIs, FGDs, and site visits. The Chad performance evaluation complements, and builds upon, findings from the Desk Review Report submitted to DoS/PRM in July 2013 by providing primary information on best practices, lessons learned, and directions for future programming, support, and PRM engagement. The evaluation team identified the following four categories of target groups as data sources for the field evaluation:

- **Donor/U.S. Government Partners:** DoS/PRM; DoS/N'Djamena; UNHCR in N'Djamena, Maro, Goré, Koukou, and Iriba
- **NGO Implementers:** CARE International in N'Djamena, Maro, and Goré; Hebrew Immigrant Aid Society (HIAS) in N'Djamena, Koukou, and Iriba; Association pour le Développement Economique et Social (ADES) in Koukou and Iriba
- **Local Governmental and Non-Governmental Collaborators:** Commission Nationale pour l'Accueil et la Réinsertion des Refugiés et des Rapatriés (CNARR); Détachement pour la Protection des Humanitaires et des Réfugiés (DPHR), previously Détachement Intégré de Sécurité (DIS); Centre de Support en Santé Internationale (CSSI); L'Association pour la Promotion Libertés Fondamental au Chad (APLFT); Lutheran World Federation (FLM); Cooperazione Rurale in Africa e America Latina (ACRA)
- **Beneficiaries/Program Participants/Refugee Volunteers and Committee Members:** Vigil Committee, Women Leaders Committee, Religious Leaders Committee, community mobilizers, SGBV Committee, Youth Committee, theater group, SGBV survivors, Child Protection Committee, young mothers group

Sample Selection

For evaluation fieldwork, a purposeful sample of four refugee camps was selected as research sites. Two camps were selected in the south (Belom and Dosseye), and two camps were selected in the east (Goz Amir and Touloum). These refugee camps were selected collaboratively with DoS/PRM based primarily upon the prevalence of GBV prevention programs being conducted by the three NGO implementers that are the focus of this evaluation. Additional factors considered in the selection of these camps include the representation of the two major refugee groups currently residing in Chad; differentiations in terms of access to natural resources, such as water and arable land; numbers of new refugee arrivals; varying proximities to host communities and the local population; and a variety of logistical, transportation, and security considerations within the operating environment.

Document Review

The evaluation team conducted a document review for the Chad field evaluation in conjunction with work performed for the July 2013 Desk Review Report. The review included the following sources:

- Guidelines on global GBV prevention and response in humanitarian settings;
- Publications and reports on best practices and lessons learned for GBV prevention; and

- Proposals, reports, program evaluations, and indicator data submitted by the NGO implementers.

Key Informant Interviews

The evaluation team conducted in-person KIIs in Chad from November 6-23, 2013. The team identified key informants from each of the target groups described above based on input and guidance from PRM staff in Washington, DC and Chad, NGO implementers, and UNHCR Chad. The evaluation team conducted a total of 41 KIIs, including 21 group and 20 individual interviews, reaching 97 respondents (69 males and 28 females). The team conducted the KIIs on an individual basis or in groups to maximize efficiency, depending on circumstances, appropriateness, and availability of resources. In total, the team interviewed 27 DoS/PRM and UNHCR staff; 32 NGO implementer staff (CARE, HIAS, and ADES); and 38 staff from local collaborators, governmental entities, and other services providers and donors. Annex III: Evaluation Contacts and Key Informants contains a comprehensive list of respondents. The KIIs were structured around the nine evaluation questions and aligned with the three directives in the Statement of Work (Annex I). Interviews were semi-structured and based upon the questionnaire presented in Annex II: Data Collection Instrument. Interviews combined both closed- and open-ended questions. The evaluation team developed a series of sub-questions to complement the nine SOW questions, which allowed for deviations from the established script to pose follow-up questions and explore additional areas of inquiry. Gathering information from some of the key informants required more than one interview; follow-on interviews enabled the team to deepen inquiries, particularly as data collection and analysis proceeded during the course of fieldwork.

Focus Group Discussions

The team conducted FGDs with groups of individuals who were either: a) refugee committee members or NGO volunteers; b) local collaborators; c) direct beneficiaries of NGO implementers, such as recipients of GBV treatment services; d) participants in awareness-raising activities; or e) beneficiaries of training programs, including community leaders, teachers, and students. FGDs were organized to include individuals who possess unifying characteristics that might distinguish their responses to interview questions from those of other groups with different characteristics. Key characteristics included sex, age, refugee status (ensuring a mix of new arrivals versus refugees living in the camps for many years), and exposure to specific program interventions. The team conducted 20 FGDs with a total of 293 participants (150 females and 143 males) located in Belom Camp (88 participants), Touloum Camp (77 participants), Goz Amir Camp (90 participants), and Dosseye Camp (38 participants). FGD participants represented the following groups:

- GBV Committee
- Vigil Committee
- Young mothers receiving microcredit training
- Camp Leaders Committee
- Religious Leaders Committee
- Youth Leaders Committee
- Students
- Teachers
- Youth Theater Group
- Child Protection Committee
- Survivors of SGBV
- Block (Neighborhood Community) Leaders

- Community mobilizers
- Women Committee Leaders

The evaluation team facilitated the FGDs by adapting the evaluation questions presented in Annex II: Data Collection Instrument. Additionally, FGDs with recipients of services provided by NGO implementers focused on the following topics: perceptions of the services offered; changes in knowledge resulting from participation in programs; and perceptions of the value and impact of services or support offered.

Site Visits and Direct Observation

The evaluation team conducted site visits and direct observation of GBV prevention and service facilities within the refugee camps of Belom, Dosseye, Goz Amir, and Touloum. In addition, the team visited relevant service sites operated by NGOs and other donors throughout Maro, Goré, Koukou, and Iriba. Site observations included visiting refugee community centers, women's centers, primary schools, health centers, maternity wards, youth centers, childcare facilities for young mothers on school grounds, food distribution centers, refugee collection centers, refugee marketplaces, water pump facilities, and vocational/skills-building facilities, among others.

Limitations

Selection Bias

The evaluation team visited 4 of 18 refugee camps throughout Chad: two in the south, and two in the east. While the sample selection was reasonable based on established criteria and limitations of time and budget, the sample size is small compared to the actual number of refugee camps receiving PRM-funded services. Consequently, evaluation findings cannot be generalized to the overall refugee population in Chad. This purposeful sample supports the collection of information-rich cases that will provide readers with in-depth findings about evaluation questions as they relate to specific groups and individuals who took part in the evaluation. Thus, the evaluation findings are useful for informing decisions and future programming in these specific camps.

A majority of FGDs conducted by the evaluation team included refugee committee members and leaders.[14] Randomly selected refugees who are not actively involved in camp committees or who do not hold camp leadership roles or NGO positions were not often represented in the FGDs. Obtaining feedback from a combination of refugee committee leaders, refugee NGO staff, and refugees less involved in committees or NGOs would have provided a more balanced account of beneficiary perspectives regarding the quality, accessibility, and relevance of GBV prevention efforts and services. It is likely that the refugees most engaged in community leadership structures are also the most educated and informed. In comparison to others in their communities, they may be more aware of (and more

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[14] Each of the camps visited during the evaluation employed a similar committee structure for leadership and representation of refugees, including committees of religious leaders, women leaders, neighborhood leaders, and youth leaders, among others. Committees are composed of elected officials who serve a term period of approximately two years. In addition to the internal camp committees, each of the NGOs operating in the camp was supported by either paid or volunteer groups of refugees who typically comprised the majority of that NGO's staff. Examples include the SGBV Committee, community mobilizers, and youth theater group, among others.

likely to take advantage of) GBV prevention services offered by NGO implementers. The imbalanced representation of participants in the FGDs may have biased the evaluation findings to be more positive about PRM-funded GBV prevention programming.

Time constraints prevented the evaluation team from interviewing many new refugee arrivals, who are less integrated into refugee community and leadership structures and, as a result, less aware of existing GBV prevention efforts and services. To overcome this limitation, the team particularly encouraged feedback from new refugee arrivals participating in the FGDs to ensure that their unique perspectives and contextual circumstances were incorporated into the evaluation findings.

Response Bias

A potential limitation faced by the evaluation team relates to response bias that may occur if respondents think that providing or withholding certain information may lead to various consequences (e.g., additional funding or continued participation in training activities, decreased funding streams or support, or threats to personal safety or well-being). Furthermore, key informants may hesitate or self-censor in KIIs and/or FGDs in which donor staff observe or participate.

Due to the restricted timeframe, the evaluators were not able to interview refugee beneficiaries on a one-on-one, confidential basis. This would have been optimal for gathering in-depth perspectives on sensitive topics or service needs; in a group setting, such perspectives may not have been fully disclosed by beneficiaries. To overcome this limitation, the evaluation team conducted select FGDs as female-only or male-only to encourage open communication on sensitive topics. Interviewees were also consistently assured and reminded that their responses would remain anonymous.

The security situation in Chad required the evaluation team to be accompanied by an armed military unit. While security personnel typically maintained a physical distance (either standing guard outside a building or sitting in a discreet location), the armed unit remained only several feet away from the evaluation team and interview respondents during some KIIs and FGDs. It is possible that the presence of the armed guards affected the respondents' comfort levels during the KIIs and FGDs, as well as the type of information that they shared with the team.

Finally, it should be noted that PRM representatives were present during all of the team's initial interviews with NGO implementers in N'Djamena, site visits to two UNHCR field offices, and several other KIIs. While it is possible that the presence of PRM staff—as well as their active involvement in the KIIs and FGDs—may have biased interviewees' responses, the majority of KIIs and FGDs were conducted exclusively and independently by the evaluation team. The team consistently provided interviewees with assurances of anonymity and confidentiality as the foundation to establishing an open, trusting environment for discussion and data collection.

Logistical Challenges

Logistical circumstances hindered the evaluation team's ability to achieve optimal and balanced exposure to relevant staff from each of the three PRM-funded NGO implementers that comprise the focus of this evaluation:

- Evaluation findings reflect a lack of data obtained from ADES representatives. The team experienced difficulty establishing a connection with ADES staff both prior to embarking on fieldwork and subsequent to arriving in Chad. ADES was not available to engage with the team

to the same extent as were CARE and HIAS. The evaluation team did meet with ADES staff in Koukou and Iriba; however, only ADES' operations in Goz Amir Camp (located in Koukou) included work on GBV prevention.

- CARE's work on GBV prevention in the northern camps of Touloum, Am Nabak, and Iridimi during FY 2010-2012 was intended to be a focus of this evaluation. However, CARE closed its operations in the north and established new operations in southern camps in late 2012. The evaluation team was unable to collect data from any of the CARE representatives who implemented GBV prevention programs in the north. To mitigate this limitation, the team inquired about CARE's work during KIIs with UNHCR and other NGO staff operating in these three camps. Furthermore, the team met with CARE staff to assess their work in the southern camps of Belom and Dosseye.

- In comparison, a long-time HIAS staff member accompanied the evaluation team during its visits to Goz Amir and Touloum camps. The team spent a significant amount of time with this individual and informally collected substantial data about HIAS' programs. This individual was thoroughly briefed on the evaluation and helped the team to navigate challenges with arranging meetings and interpretation in the south.

The evaluation team was limited by language and interpretation challenges throughout the data collection period. KIIs and FGDs conducted with NGO refugee staff, refugee committee members, and beneficiaries were conducted in local languages, and interpretation was often into French and of poor quality. The team encountered a number of instances when interpretation was not available for FGDs and KIIs. When necessary and where possible, the evaluators conducted a number of KIIs and FGDs without the assistance of an interpreter, while simultaneously leading the KIIs and FGDs. This situation placed considerable time constraints on the evaluation team members.

The security context in Chad generally, and at certain camps such as Touloum specifically, required that time spent in each camp be limited to daylight hours and that the evaluation team travel with NGOs in convoys at specified times. Such constraints significantly limited the team's ability to spend optimal time conducting each KII or FGD and sometimes prevented the team from meeting with certain groups. Due to the highly sensitive nature of the topics covered in the evaluation, coupled with the need for interpretation (often in multiple languages), the time required to establish trust with respondents was quite substantial. Despite these challenges, the evaluation team utilized its time as expeditiously as possible, establishing strong rapport and conducting productive exchanges with interviewees.

EVIDENCE AND FINDINGS

Evaluation Question 1: Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?

Part I: Achievement of program activities as defined in project proposals

The evaluation team found that PRM-funded NGO implementers successfully carried out the majority of proposed program activities with a fairly even balance between prevention and response. By design, the sensitization and awareness-raising activities received more focus and attention; however, these activities tended to be more in line with internationally accepted GBV guidelines, whereas several weaknesses were noted among the response and treatment activities.

NGO implementers demonstrated noteworthy achievements in terms of progress made toward transforming socio-cultural norms, empowering women and girls, and rebuilding family and community structures and support systems. CARE's programs include conducting educational talks and skits and broadcasting radio messages to raise awareness about the consequences of FGM, early and forced marriage, and DV; HIAS implements trainings, drama presentations, and extensive door-to-door campaigns to educate the population on GBV dynamics, causes, and consequences. HIAS was the only one of the three NGOs evaluated that explicitly focused on strengthening community support systems and referral networks. Community mobilizers received quarterly training on how to work with GBV survivors and share information about the status of available referral services. The evaluation team was unable to obtain anything other than anecdotal information on the nature or outcome of activities beyond the number of events conducted and the number of people reached.

The team was impressed with the organization, delivery, and facilitation of programs and activities despite very limited human and financial resources. However, these limitations clearly affected the volume, diversity, and quality of services provided. The team found that most services are reaching only a fraction of the refugee population within the camps and that activities tend to look very similar in design across the NGOs—with little innovative programming, and with great variation in quality. KIIs with NGO management and FGDs with NGO staff, refugee workers, and program participants underscored the challenges that implementing partners face in accurately tracking program performance. While NGO implementers use a standardized incident report form to monitor cases of GBV, there was little evidence to suggest that additional indicators were being routinely employed to measure progress against program objectives. In the absence of a clear system to track planned versus actual implementation of activities over the life of their projects, NGO implementers struggled to definitively report whether or not proposed activities had been successfully implemented.

ADES

Reflecting on ADES' program objectives during the 2010-2012 period covered by this evaluation, the team noted the extensive and possibly overambitious scope. While it is likely that ADES did not seek to implement each of these activities in every camp and/or community in which it worked, the list of objectives below requires staff with a tremendously wide range of skills, as well as a generous budget. Though the team was unable to interview ADES leadership in Chad or to gather a substantial amount of data pertaining to their operations, it appears that they may be overextended.

ADES 2010-2012 Program Objectives

1. Registration and establishment of profiles
2. Impact on the host communities
3. Improved access to education
4. Program management and coordination
5. Protection of children strengthened
6. Risk of GBV is reduced and quality of response improved
    - Participation of community in GBV prevention and response enabled and sustained
    - Information dissemination on GBV established and sustained
    - Victim/survivor referral mechanisms established and sustained
    - Training on GBV prevention and response delivered
    - Secure and confidential reporting system established
    - Counselling provided
    - Advocacy for women's rights and gender equality conducted
7. Services for groups with special needs strengthened
8. Shelter and infrastructure improved
9. Health of the population improves or remains stable
10. Supply of potable water increased or maintained
11. Population lives in satisfactory sanitary conditions
12. Better protection of natural resources and the shared environment
13. Improved self-reliance and livelihoods

Due to the site visit sample selection, the team was only able to visit two ADES offices and meet with a total of five staff members to discuss their operations in Koukou and Iriba.[15] Program activities implemented by ADES' Iriba office focus on education in local communities as well as on environmental and water, sanitation, and hygiene (WASH) issues in the refugee camps. Through these programs, ADES provides refugees with firewood rations and addresses the problem of reforestation in the areas where trees are harvested for firewood. ADES also distributes energy efficient stoves and sensitizes the community about the importance of managing their wood use due to the scarcity of natural resources.

In Koukou, ADES' activities focus on two primary areas: WASH and health. ADES operates with approximately 67 staff members in Koukou, with four staff members dedicated to health issues and nine community mobilizers who have been trained in psychosocial assistance. The community mobilizers are in close communication with the community and work within their respective neighborhood blocks to identify GBV cases and provide assistance. One ADES staff member reported, "We see a lot of DV because they come in for social assistance and psychological assistance." ADES provides support to individuals with issues such as "epilepsy, depression, schizophrenia, psychosis, nervousness, alcohol and drug addiction, and the mentally retarded. There is a clinic, and they get a treatment plan and we follow that patient until he/she has stabilized." Respondents reported that they see approximately three to four GBV cases each week. During the period of January-October 2013, they received 73 cases of GBV with 25 cases of DV, 14 unwanted pregnancies, seven incidents of psychological violence, nine incidents of conjugal violence, and two cases of attempted rape.

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[15] The town of Iriba is the base for ADES' operations in Touloum, Iridimi, and Ouri Cassoni camps. Only ADES' operations in Goz Amir Camp, located in the town of Koukou, included work on GBV prevention.

ADES, unlike many of the other NGO service providers, delivers counseling to refugees who suffer from alcoholism and drug addiction. ADES includes alcohol prevention messages in its sensitization programs, and mobilizers connect individuals in the community with the appropriate services. ADES health workers deliver the majority of their services in Goz Amir Camp, where there is a special unit in the health center for psychological support. Mobilizers conduct home visits for refugees with mental health issues who are unable to access the health center. ADES compiles a list of the medications it requires, and UNHCR is responsible for procuring supplies. However, respondents explained that frequent disruptions in the pipeline and shortages of medicines are major problems. This evaluation finding was widely reinforced by statements from several refugee committee members and program participants with whom the team met. ADES is in charge of family planning and dispensing contraception; however, staff reported that they have run out of female contraception, which was also echoed as a problem among a number of female respondents across the various FGDs conducted at Goz Amir Camp. The team also learned of the difficulties that non-married refugee women face in obtaining female contraception from ADES staff: "We are only giving oral contraception to married couples for family planning. But if a girl who is single comes and wants contraception, we will give it to her, but it might cause problems."

ADES reported approximately six births per day at the camp, and staff saw more than 900 births during January-November 2013. When women begin their prenatal visits, ADES provides counseling about family planning and consults them about long-lasting methods of birth control, such as Depo-Provera. ADES staff reported that as a standard practice, following a woman's tenth delivery, ADES strongly encourages mothers to begin using this type of contraception. The team inquired with ADES about the prevalence of FGM among women delivering at the health center. Respondents were unable to confidently report on the incidence of this practice but shared the following statement: "Before they came to the camp, they practiced FGM. But after 2006 and 2007 and the sensitization, the excision decreased… since 2010, 2011, and now if they do it, it is hidden and it has diminished quite a bit. APLFT is in the camp, and people know [FGM] is illegal."

During KIIs and FGDs with refugees in the camp, the team found it difficult to obtain any information about ADES' services and interaction with the community. In Goz Amir Camp, respondents emphasized an overwhelmingly stronger familiarity with HIAS, UNHCR, and the other NGO implementers, than with ADES. Nonetheless, ADES reported that staff members participate in the GBV coordination meeting with NGO partners on a weekly basis.

CARE

CARE is not funded directly by PRM, but receives funding for GBV prevention activities from UNHCR. CARE's GBV prevention work focuses on awareness-raising about GBV, as well as improvements to GBV response. Among CARE's program objectives, only one targets GBV.

CARE 2010-2012 Program Objectives

1. Impact on host communities improved
2. Risk of GBV is reduced and quality of response improved
    - Mass awareness and specific support programs aimed at reducing the occurrence and improve the response to violence based on gender
3. Protection of children is strengthened
4. Community security management systems strengthened
5. Supply of potable water increased or maintained
6. Population has optimal access to education

7. Nutritional well-being improved
8. Population has sufficient basic domestic and hygiene items
9. Population lives in satisfactory sanitary conditions
10. Services for groups with specific needs strengthened
11. Level of self-reliance and livelihoods improved

One of the team's most significant findings from data collection activities in the south relates to the extensive scope of CARE's activities. The team found that due to such a wide variety of responsibilities coupled with limited staff and resources, it appeared that CARE's GBV activities were not reaching a significant portion of the refugee community and also were not integrating training and messaging about GBV to the fullest extent possible. One of CARE's primary activities, which the team learned about through KIIs and FGDs, was the microcredit work with young mothers in both Belom and Dosseye camps. With young mothers as the target participant group, the intention of this activity is twofold in that it provides training on GBV to a high-risk population as well as gives the young mothers a means to improve their livelihood opportunities. In Dosseye, CARE engaged 60 young mothers in a three-day microcredit and GBV training. The team found this to be a remarkably small number of program participants, which was further winnowed down in later stages of the activity. Furthermore, young mothers who participated in the FGD in Belom Camp reported that the training they received from CARE only focused on microcredit and did not include information about GBV. The evaluators inquired with program participants in both camps, and few were able to explain what they had learned about GBV during their training experiences. One young mother recounted, "during the training, we were advised by CARE on the fact of getting married early and when there is separation between men and women, the women will suffer with the baby." Based on the young mothers' performance following the training, CARE selected 30 of the initial 60 participants to continue in the program by receiving microcredit assistance. The evaluators were unable to definitively ascertain how participant performance was measured or identify the basis upon which participants were selected to proceed in the activity. However, it was noted by UNHCR that CARE's budget may have been the limiting factor.

The evaluation team met with the GBV Committees in Belom and Dosseye camps, which had been formed and supported by a predecessor organization but are now under the purview of CARE. Working on behalf of CARE, the GBV Committee is responsible for carrying out extensive awareness-raising activities within the camps. The committee members informed the evaluators about the main types of GBV they focus on including DV, forced marriage, early marriage, FGM, early pregnancy, and rape.

> *"We have two types of sensitization – every week on Tuesday and Sunday. On Sundays in the church we have sensitizations and we give advice. In the camp there are eight churches and… when the pastor is finished with his sermon, he gives the committee members some time to explain GBV and give advice about GBV. Many people go to the church and they can discuss these topics with people who didn't go to church. The same happens in the mosque. On Tuesday we have a meeting and we call people here and discuss these topics. We send someone to tell the population that we will work today on a specific topic and we ask the population to come and listen to what we will talk about. Usually we receive about 100 people and then they separate themselves between young people and men and women."*

The team also met with GBV Committee members from Dosseye Camp, who provided an account of the home visits they routinely conduct: "When we go to one family we gather the people in the family and we start by presenting ourselves to them. We tell them the aim of our visit and then we explain the consequences of GBV, for example: if a woman and her husband are fighting, what will be the

consequence; if a man beats his children, what will be the consequence; if the daughter gets married before the normal age, what will be the problem."

The team conducted a FGD with the youth group from Dosseye Camp, whose members have received training on GBV from UNHCR, APLFT, and CARE. Their spokesman provided the following account of how they undertake GBV prevention work:

> *"Each week on Wednesdays we project films to make people understand the situation and we make theater to show the bad sides of getting abortion, getting married early, and violence. First we start by organizing dances – the theater group beats drums to attract everyone in the camp. If the people hear the music they are obliged to come and see what is happening. We also project movies on the wall and sometimes we go to each quarter to sensitize people."*

According to CARE representatives in N'Djamena, CARE's work has just recently started to focus on GBV: "CARE started working on gender in the southern camps in March 2013. In 2012, CARE worked in the Iriba camps doing GBV work. This work has been phased out. I think it was an intentional choice for UNHCR to work with local partners because of budget cuts. We have another program in the south on reproductive health; there are some aspects of this work that relate to GBV, but it's not direct." UNHCR noted that the transition from APLFT to CARE managing the GBV prevention programs in the southern camps of Belom and Dosseye has been challenging and that greater coordination between the partners is needed:

> *"We need some additional support with the coordination between the partners on GBV prevention activities – sharing resources and information, for example. If there is a case of GBV, CSSI and UNHCR are informed and we document the case, but then it could take two months before CARE and APLFT get involved. At the beginning – the work with APLFT and CARE – there has been some big confusion and tension between them when CARE took over their work on GBV. CARE even took some of APLFT's staff, so this is confusing about who is doing what and who is responsible for what."*

As cited in the Limitations section of this report, due to CARE's recent transition out of the northeastern camps of Touloum, Am Nabak, and Ouri Cassoni, the evaluation team was unable to observe the NGO's work in this area or to speak with staff who were in charge of implementing the programs. Nor did CARE staff in N'Djamena have information about the GBV prevention programs that had been implemented in the northeastern camps during FY 2010-2012. In an effort to learn about CARE's work in these camps, the evaluation team inquired with other NGO partners as well as with refugees. Some of these respondents noted that the scope of CARE's portfolio was rather ambitious and that it struggled to assemble sufficient resources to carry out all of its proposed activities.

HIAS

HIAS receives direct funding from PRM for GBV prevention activities and is also funded by UNHCR for GBV and other activities. HIAS' GBV prevention work focuses on child protection, advocacy, community outreach, and training.

HIAS 2010-2012 Program Objectives

1. To promote and support the well-being of vulnerable children through developmental and recreational activities in the camps and by training and educating parents on children's rights.
2. To maintain a sustainable advocacy network and community-based referral system to identify, prevent, and respond to SGBV and sexual exploitation and abuse (SEA).

3. To improve mechanisms for protection and conflict resolution and promote long-term peaceful coexistence through training and sensitization of refugees and host community members.
4. To respond to sexual violence and intimate partner violence by providing psychosocial support to survivors.
5. To encourage women's and girls' self-reliance, leadership, and decision-making ability in the community.

HIAS' programs focus on transforming socio-cultural norms, rebuilding support systems, and improving accountability systems to maintain an advocacy network and community-based referral system for identification, prevention, and response to GBV in the Bredjing, Treguine, and Goz Amir camps. Although program documents and objectives cite psychosocial response services for GBV survivors as primary activities, the evaluation team was not provided with information on these activities and it did not appear that they represented a significant area of emphasis for HIAS operations in these camps.

HIAS engages with and conducts outreach among various groups of refugees in the camps to spread its messages about GBV prevention and treatment. Specific GBV prevention activities include theater groups, radio programs, door-to-door awareness raising and community engagement, mass sensitizations, discussions with teachers and students, and organization of men's and women's groups, among others. A HIAS representative in Goz Amir Camp explained: "We have FGDs with students – girls and boys. We pass the message to the director and Jesuit Refugee Services who works at the school and we tell them that we want to come and have a FGD with the girls from this age to this age. HIAS gives the categories and then the school chooses the participants for the FGDs."

The team conducted FGDs with teachers and students in Goz Amir Camp to investigate the extent to which teachers are integrating lessons about GBV into their curriculum and to examine the prevalence of understanding about GBV among the students. Teachers reported unanimously that they do share messages about GBV with their students on topics including rape, HIV and AIDS, FGM, and early marriage. One teacher shared that skits are used to help children learn the messages. A male teacher reported, "HIAS supports us and HIAS told us about the rights of women and the rights of children."

In speaking with students, the team found a discrepancy with what the teachers reported regarding the inclusion of GBV prevention lessons in their teaching. While all of the students were familiar with HIAS, they unanimously reported that their teachers do not talk with them about topics such as early and forced marriage; none of them had participated in the theater skits described by the teacher. In addition to their lack of exposure to these important topics at school, the students reported that they also had not participated in the sensitization campaigns in their blocks, which HIAS reports to be conducting on a regular basis. The students agreed that these issues are important and reinforced that no one had talked with them about these issues before.

HIAS has a theater group that performs both in the camp and in the local community. The theater group also collaborates with the group producing the radio dramas, which typically air once per week and focus on a rotating GBV theme every three months. Unfortunately, budget limitations have constrained HIAS' ability to consistently develop and produce the radio dramas, which are rather expensive to implement.

Part II: Barriers and facilitators to implementing program activities

The evaluation team gathered extensive data on barriers and facilitators to program implementation through observation and examples cited by KII and FGD respondents.

Barriers

Natural disasters: At Belom Camp in southern Chad, UNHCR and NGO partners reported challenges that they and the refugees have faced due to extensive flooding on an annual basis. According to UNHCR Maro staff members, "flooding has destroyed the refugees' farms for the last four years and has made the refugees much more vulnerable. They are at an abject level of poverty; before they were self-sufficient." Belom Camp was constructed by combining the two former camps of Moula and Yanamou, which sustained extensive flood damage and were rendered uninhabitable. UNHCR staff highlighted related challenges for programming: "The problem of consolidating those camps was that all of the former committees were uprooted and not functioning so that all of the refugees were in a totally new area with no resources, and we had to start over from the beginning to rebuild the camp and put the committees back in place again."

Influx of refugees: An additional challenge UNHCR and NGO partners in Maro faced was the influx of more than 5,000 new refugees during the relocation and consolidation of refugees to Belom Camp. UNHCR reported that it was difficult for the new arrivals to integrate into the camp system during the rebuilding period: "Most of them were illiterate and it was hard for them to understand what we were expecting from them. With more than seven different languages, we often didn't know if the translation was correct, which made it hard to communicate, and this put us behind a bit because the new refugees had to adapt." Another UNHCR staff member explained that, "UNHCR does have a working group for GBV – the last meeting took place in September, but we were too busy dealing with the new refugees coming into the camp – we have to mobilize our resources to deal with more pressing issues, so we didn't have time to meet in October."

Widespread unmet basic needs: The life-threatening difficulties that refugees in Chad face on a daily basis—related to food, water, shelter, medical care, and education—prevent the NGO partners and refugees alike from dedicating significant focus to the issue of GBV. While GBV is tied to basic human rights, the evaluators understood from respondents that it can often seem secondary to the aforementioned basic needs.

Decreased food rations in several camps were cited to increase household stress levels as hunger and competition for household resources increases. UNHCR Iriba shared the following concerns:

> *"In this zone there is very little water; it's a desert and it's very difficult for the refuges to cultivate. They depend on humanitarian assistance for approximately 80 percent of their food needs. This year, there was only one month of rain and the seeds they planted did not germinate so they are feeding them to the livestock. At the same time, in March the World Food Programme (WFP) reduced the ration from 2100 kcal to 1700 kcal, and in December they will reduce it further to 1300 kcal."*

Camp leaders in Touloum shared concern about the lack of resources. In particular, they suffer from a deficient availability of water and firewood. Refugees obtain water from a shared well with the local population, which is located outside the camp at a distance of four to five kilometers. To locate firewood, women often travel more than 30 kilometers and are still unable to gather sufficient quantities. Women expressed concern with the distances they must travel to obtain these needed resources, citing examples of GBV that often occur during their journeys.

Refugee camp health facilities in poor repair and inadequately staffed: The team found the condition of health facilities to be very poor and was informed by numerous respondents about supply distribution breakdowns leading to lack of medicines essential to support GBV survivors, such as PEP kits and depression medication.

Lack of durable solutions/refugee apathy and loss of hope: Resources are scarce in Chad. The south is a more favorable area in terms of access to resources, land, and climate. In the north, it is much harsher in terms of livelihoods. UNHCR staff in Goz Amir reported a level of frustration among the refugees, which they believe stems from insufficient infrastructure and lack of access to secondary school and higher education, as well as lack of professional training: "There aren't a lot of durable solutions for them. They are losing hope because they don't see a lot of opportunities. Resettlement is the only possible durable solution. They cannot go back to their home, they are not allowed to integrate into the local community, and they aren't allowed to leave the camp to live." According to UNHCR staff members in Iriba, despite the fact that the majority of Sudanese refugees in the eastern camps are of the same ethnicities as the local Chadians, with whom they share cultural values and similar cultural practices, the Government of Chad does not permit local integration. The evaluation team learned that this is not the case for CAR refugees in the southern camps, who are able to obtain Chadian nationality.

At the same time, UNHCR shared that refugees now seem used to receiving assistance and when they are asked to participate in activities, they expect to be paid. UNHCR thinks this mentality is blocking refugees from building their own capacity and taking action to reach durable solutions.

Cultural barriers: Deeply-rooted cultural barriers were frequently cited as some of the most challenging obstacles to program implementation and the achievement of outcomes. A high-level UNHCR official described the cultural practice of FGM:

> *"It's very difficult to challenge FGM in the community because… they don't think they're doing anything wrong. Culturally it's an honor to be excised… it's a shame for a young girl to not be excised… in the young girl's mind it's a good thing. The victims are not really victims so that makes it very difficult because they are willing to do it… all of these young girls are totally willing to be excised. Now they are avoiding the boundaries of the camp by going outside to get excised. Some are even saying that they will go home to their country to do it because it is illegal in Chad. First we need to have them understand that this practice is very bad for the girls, and then maybe they will be able to report to us so that we can know the extent of the issue. We don't even know what the impact is."*

According to CARE staff in Maro, before FGM became illegal, refugees used to make a big show of the ceremony with dances, parties, and celebration, but now the practice is hidden. CARE delivers trainings so that people will abandon the practice; however, no women have reported circumcisions to date. Even when women seek medical help due to complications with circumcision, they do not disclose the identities of the people who performed the procedure: "When women go through the FGM practice they take an oath to never denounce the practitioner, so even when three cases were presented medically, the girls would not come forward with information about who had performed their circumcision."

APLFT staff in Maro also commented on the difficulty of addressing the deeply-embedded cultural practice of FGM through legal channels:

> *"Traditional practices like circumcision are very difficult to address; people are not reporting this for the court to judge the case. The laws are not very useful for reinforcing our work. It's important to*

> *change the mentality of the population. We know in Chad there are a lot of social difficulties, the people in the village are not very educated, so it's very difficult to change their mentality. At the same time, it's important to work within the law and building the law. There are already laws on early marriage and forced marriage, FGM, DV, child abuse – these can be used, but the big challenge is the weight of the traditional behavior on society. The laws can be applied but the great need is to change the behavior."*

The practices of forced marriage and early marriage present tremendous hurdles to reaching desired GBV prevention outcomes. According to members of the Women's Committee in Dosseye Camp, even if a girl explains to her parents that she does not love a man, they will not accept her plea. UNHCR Goz Amir staff members reported that parents' rationales for forced and early marriage stem from a fear that if a daughter has a relationship before marriage, it will bring a great deal of dishonor to the family. They also shared that Sudanese men prefer to marry virgins and young girls because they believe that it increases their chances of having many children. Additionally, a young girl who has been under the oversight of parents is perceived to be less likely to speak out against her husband and easier to control.

Despite the presence of NGOs in each of the camps—such as APLFT, whose staff members possess extensive experience in the rule of law—the team found that the majority of refugees they spoke with expressed a preference for solving problems among themselves. UNHCR and NGO partner staff confirmed this finding by sharing that even criminal issues that should normally be taken to court are managed at the camp level by community leaders. Sometimes criminal issues and even murder are managed without any involvement of legal forces. According to a representative from APLFT:

> *"Generally we receive information very late after it happens. If a case is tried informally, usually the perpetrator is made to just pay a fine to the family of the victim. There is an inclination to solve the problem informally because there is a lot of shame for the woman who is the victim; to avoid this very uncomfortable situation, people prefer to take care of it with a 'backstage' arrangement. They also know that sometimes the legal response is a long process and uncertain, but the backstage action is short and gets taken care of right away."*

UNHCR Maro reported that, in some instances, even the GBV Committee prefers to advise the community about how to handle a problem rather than bring it to APLFT. UNHCR expressed the concern that certain refugee leaders do not understand UNHCR's function. Additionally, UNHCR shared that there is a perception among refugee community members that it is trying to incite wives against their husbands and that the agency creates many problems between husbands and wives. According to the GBV Committee in Belom Camp, "when the committee sees that it's a simple problem, they can work it out on their own; but if it is a difficult problem, they send it to the partners to assist." The evaluators witnessed this type of statement frequently, where an incident of GBV was classified as small or insignificant versus major or significant. The team was unable to obtain a clear delineation of how cases are classified and addressed.

UNHCR staff in Iriba raised the issue of dowry-related GBV. The prevalence of dowry payments is high, likely due to poor families' incentives to marry their daughters for financial gain. When a husband pays a dowry for a woman, staff expressed that there is no way she can divorce him unless she repays the money that was paid to her family—no matter how many years have passed. The extensive reach of the dowry among family members, particularly to brothers of the woman, means that even a severely abused woman seeking a divorce will be strongly encouraged to remain with her husband due to the financial ramifications for her family. As one respondent framed it, "the family will put chains on the

woman to force her to stay with her husband – even the husband's family will menace her and give her a lot of problems."

Social stigma attached to rape: The evaluators interviewed young mothers at Belom Camp who reported several incidents of rape occurring among women who go to the bush in search of firewood. One woman shared that women who experience rape in the bush do not report their cases because they know that people in their community will laugh at them, so they prefer not to say anything. The Women's Committee in Dosseye Camp explained that there is a greater reluctance to report cases of rape committed within the same family as compared to extra-familial cases. According to the head of the Refugee Committee in Goz Amir Camp:

> *"Many women have been raped, but it is very shameful for them to report. They may tell someone but ask that person not to share the information because it is very shameful so they keep it as a secret. Rape is happening in the bush; a woman can work eight hours in the bushes alone and she meets many who want to rape her. She doesn't want to tell anyone because she doesn't want to make any problems with her community or the society outside the camp. At the last meeting of the Security Committee, we discussed this issue and said that it is very important for women who go more than 10 kilometers in the bushes to have protection – we discussed this with UNHCR and CNARR and asked them for protection. The women who go to get firewood should go with two men so that if anyone tries to rape them. Those who go to very far agricultural sites, there should be a kind of protection for them."*

Near total impunity for perpetrators of GBV: The evaluation team obtained fewer than five examples of cases in which perpetrators of DV were jailed. On the opposite extreme, the team heard repeated examples of perpetrators who "paid a fine" or were "scolded for their actions" as a form of punishment. UNHCR staff in Iriba reported that when camp leaders go to regulate or resolve a problem, if it is a case between a husband and wife, they will only speak with the husband and make the wife wait outside. The husband may then pay a fine and that is often the end of the issue.

Lack of viable legal system: The evaluation team obtained a great deal of information about the lack of a viable legal system to address incidents of GBV among refugee communities in Chad. Of the cases that are reported to APLFT, few make it to court and those that are prosecuted often experience multiple postponements, delays, and low rates of conviction. APLFT does support the legal system and prosecution of cases with efforts such as training, transportation, and translation for court cases. However, difficulties working through the existing legal system remain a key challenge in GBV prevention. According to APLFT, many victims are not satisfied with the legal response. First, the court is often very far from the camp—in some cases, more than 100 kilometers—so after the judgment, the victim does not follow up to request the civil reparation to which she is entitled. Although APLFT and some of the other NGO partners offer transportation assistance to the victims, they are often unwilling to travel to the court because the distance is too far. APLFT in Maro reported that of the four cases that have been brought to court, three of the perpetrators have been jailed but none of the victims have come back to claim their civil reparations.

An added challenge to applying the law to persecute perpetrators of GBV is the fundamental lack of education among the refugee population about their rights. An APLFT staff member reported: "It's very difficult because the population isn't well informed about their rights. There is no structure in place to support the law and the refugees feel very much like strangers in Chad and they don't have a voice.

There are no tribunals here and it's very difficult to give legal assistance to the GBV victims; it's not easy to bring them to Abeche where the court is… to have the case tried."

Lack of female members in security forces: Several respondent groups noted the challenges for GBV prevention resulting from the departure of the UN MINURCAT and DIS, the Chadian government police force—each of which had female members who were trained in issues surrounding GBV. Since July 4, 2013, these forces have been recalled leaving only the Chadian Gendarme to ensure security within refugee camps. One member of DPHR in Belom Camp expressed concern about his forces' ability to provide assistance with GBV incidents: "Between men and women, it is very difficult to force the issue of GBV because there are a lot of secrets; but between women and women it is much easier to gain information about GBV. Since we are all men it is difficult if we see some cases, the women refugees will not talk with us."

Overlap among NGO implementers: The evaluators found an overwhelming redundancy of roles and responsibilities among the various NGO partners and refugee committees regarding the prevention and treatment of GBV within the camps. The majority of KII and FGD respondents cited conducting community sensitizations and carrying out household visits to speak with and provide advice to GBV victims and victims' families. Among others, CNARR, the GBV Committee, community mobilizers, DPHR, the Youth Committee, and refugee leaders reported engaging in these activities:

- CNARR, Maro: "We visit the household to follow up on the victim and also council the parents of the victims and give them advice about the victim."
- GBV Committee, Belom Camp: "We are working on the topics of excision, early marriage, and forced marriage. It is the role of the committee to train and sensitize the entire population in the camp."
- DPHR, Dosseye Camp: "When there is an incident of GBV in the camp… we go with the partners together to listen to the girl and then we take her and we talk with the girl and listen to her together with the partners. We also listen to the man who has done this raping and after listening to him we prepare a report and send it to our leaders."
- Youth Committee, Dosseye Camp: "The youth group is targeted for all of the work to organize ceremonies and provide sensitization to all people in the camp."
- HIAS Community Mobilizers, Goz Beida Camp: "We work on violence against women and we help people when they have problems. We have meetings and we talk in blocks about violence against women. We were working on GBV first, and the GBV Committee just formed recently. We have all been trained to protect children and how to help if there is any violence against women or in the family members if a woman has been beaten by her husband we know how to help her. If there are any problems in the camp we bring the problems from our block and we report to our seniors and we visit again to the victims."

Lack of data-driven knowledge about GBV faced by refugees: Information on the types and prevalence of GBV in the refugee camps is extremely limited, which leads to the risk of incorrect assumptions. Very little information is available on the actual incidence or prevalence of any type of GBV.[16] Key informants

[16] See Evaluation Question 2 for further discussion about the lack of critical data on GBV.

interviewed by the evaluation team believe that DV is the most common form of GBV, but they had limited knowledge about the incidence and prevalence of other forms of GBV within the refugee population. UNHCR maintains quarterly statistics on reported GBV cases; the evaluation team's review of these statistics revealed confusing terminology and a lack of analysis of certain critical factors.

NGO staff lack of training and comfort with lesbian, gay, bisexual, transgender, intersex (LGBTI) issues: Another barrier is the lack of comfort among many of the UNHCR and partner staff with issues such as homosexuality, which the evaluation team found is not receiving adequate attention in the NGO implementers' GBV prevention work.

Insufficient financial resources: Nearly every NGO and Government of Chad partner cited its limited budget as a major hurdle to program implementation. DPHR Maro expressed concern about its ability to assure camp security due to its severely compromised finances, which only allow the organization to purchase 20 liters of gas per week. Belom Camp is divided into two sections (Belom I and Belom II), which are separated by a distance of approximately 2.5 kilometers. DPHR often responds to incidents and conducts patrol by foot, which requires that staff walk between the two sections more than eight times per day—often precluding them from actively responding to every security breach. Refugee leaders in Touloum Camp underscored the implications of DPHR's budget shortages, stating that DPHR is often unable to respond to reported incidents due to a lack of transportation.

UNHCR Goré expressed concern about its ability to manage GBV as a priority in the wake of so many other competing needs: "In terms of GBV as a priority – it is among the top priorities, but it has to be understood within the limits of the existing resources and we have a limited budget. Especially now that we have newcomers and they need access to water, to food, to healthcare, to education… GBV is one of the key areas that the office focuses on along with education and child protection, and that's the reason why we have three working groups on each of these topics."

Due to budget cuts across UNHCR, the Iriba office lost funding for several positions, including an education assistant and a child protection assistant. The consequence has been recognized in adjustments to existing positions, which are now much broader in order to cover all of the needs with one person functioning as the focal point for both education and child protection.

PRM/UNHCR alternate funding cycles: PRM and UNHCR's alternating annual funding cycles were cited by CARE and HIAS as presenting substantial barriers to effectively implementing program activities. Respondents explained that the timing does not allow them to design activities to effectively complement what they are doing with funding from the other donor. They cited needing to lay staff off and then hire them back again as well as having to stop some activities in the middle of implementation to wait for funding to come through. One HIAS staff member stated, "If we could have a proposal for two or three years, it would allow us to concentrate more on long-term goals, but each year we have to start over again."

HIAS also reported that while the number of camps in which it works and the programming it implements has continued to expand, its budget has decreased each year: "We started with PRM funding in three camps (Bredign, Treguine, and Goz Amir) in 2011 and then we added Djabal in 2012, and Farchana and Gaga in 2013. This year, in 2014, we are adding five more camps with GBV activities. Here we have seven staff, in Iriba there are three, and in Gareda there are three. We have budget constraints, but we have to satisfy the needs of the refugees."

Facilitators

Partnerships with refugee community organizations: UNHCR, HIAS, and CARE all work closely with refugee community organizations, which have been appreciative and supportive of their efforts. Collaboration with internal camp leadership committees was frequently cited by NGO staff as an effective and efficient method for distributing information and services between the community and the NGO partners. In addition, NGOs recruit staff members and volunteers from the refugee community, who are recognized by refugees as extensions of the service providers and sought out for communication about problems and inquiries about types of assistance. According to DPHR in Dosseye Camp: "There is no difference between our role and the roles of the partners. We work together, we share ideas, and we talk about how to help different people. Starting at 5:00pm, the partners are no longer in the camp, so if something happens after 5:00pm we listen to the victim and then we talk with the partners. We don't have any problems with our partners; we share information so that we can really solve these problems."

Strong relationships with local communities: Many of the NGO partners cited examples of activities that they are undertaking and projects that they are pursuing in order to establish strong relationships with the local communities living around the refugee camps. As most refugees rely on natural resources as well as many services, such as medical care and education, that are located in the communities, NGO partners stressed the importance of building and maintaining positive relationships with the host community. In Maro, where UNHCR was forced to relocate the refugee camp due to widespread damage sustained from flooding, CNARR explained to the evaluators that extensive negotiations were held with the local authorities to identify land where the new camp could be built. To appease the tension between the local community and the refugees, UNHCR and CNARR agreed to build schools in the village to compensate the local community for the loss of their lands.

The evaluators interviewed Lutheran World Federation (FLM) staff in Goré, who reported that they include approximately 30 percent of participants from the surrounding village in each of their programs to cultivate collaboration and build respect. For example, in 2013, FLM gave 35 percent of its farming cows to the local community to help prepare the land; of the 35,000 trees cultivated at its nursery, FLM gave 10,000 to the local community. FLM also gave the host community 10 chariots. FLM believes that these actions all help to reduce the violence between the host community and the refugee population.

GBV Standard Operating Procedures (SOPs) and weekly GBV coordination meeting: These tools, developed and put in place by UNHCR, play a major role in facilitating program activities. Nearly all of the NGO implementers and Government of Chad partners with whom the team met cited weekly GBV coordination meetings as a forum for sharing, learning, and supporting effective work. Many respondents appreciated the meetings as a time to discuss specific cases and receive input and guidance from the other partners about how best to address challenging incidents of GBV. The meetings are also a helpful opportunity to reinforce roles and responsibilities to ensure that each partner is fulfilling its role with regard to both ongoing cases and new cases that were identified the week before.

Female DPHR members: Just as the lack of female security officers was cited as a barrier to effective program implementation, the presence of several remaining female officers on some security teams with whom the evaluators met appeared to be a significant facilitator for GBV prevention. According to a female officer with DPHR in Goré: "We are always at the camp with the women and they come to us to explain what is going on because we are the GBV focal points." A male officer explained, "Women hide a

lot of information from DPHR, so our focal points speak with them and bring us the information. We can't pose questions directly to them because the young girls are scared to share their secrets."

Highly-skilled refugee staff/volunteers: The evaluation team learned about the nuanced GBV prevention and treatment skills and abilities that the refugee volunteers developed through their work with the NGO implementers. In particular, the team found a strong relationship between HIAS and its community mobilizers in Goz Beida Camp: "Rape is a very difficult case. If I hear that a woman has been raped and the victim didn't inform us, when I go to see her I won't ask her this because she won't respond to this question. So the first visit…, I just say that I have come to say 'hello' and 'how are things going.' In the second visit I tell more about who I am, what I do, how I can help and also assure her that I won't tell her secret to anyone. In this case I am building comfort with the victim."

HIAS staff cited the positive experiences and cooperation they have with their collaborators, which provides the incentive and motivation to wake up every morning: "The beneficiaries are so positive that we want to help them and they get out there and come to the community center and come for the meetings, and the leaders are always available – apart from once or twice, they are always there to listen and hear what you want to say and people can actually sit down and discuss and come up with a solution – they are always willing to participate." Specifically, HIAS appreciates the support it receives from UNHCR and PRM staff who take the time to visit HIAS' projects in the field to provide feedback and guidance. The opportunity to engage with someone external to the project can open the space for suggestions and feedback to make program improvements. HIAS also cited appreciation for the technical support that it receives from UNHCR in the field as being critical to the success of its activities.

Evaluation Question 2: Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measurable objectives? If not, how can the objectives be improved?

The design of program objectives and activities was generally not informed by comprehensive needs assessments or surveys. The NGOs neither carried out baseline surveys nor determined the incidence or prevalence of GBV within their respective refugee communities, the types of GBV experienced by refugees, the places and persons at highest risk of GBV (risk mapping), or the likely perpetrators. Information on the types of GBV refugees face is limited, which may lead to incorrect assumptions. NGO implementers' programming appears to emphasize DV over other types of GBV; however, the decision to focus resources on this area does not appear to be evidence-based. There is a lack of information about the level of GBV perpetrated by the police and other authorities, GBV committed against men and boys, the number of refugees forced by circumstances into survival sex, and the extent of needs and/or challenges faced by LGBTI refugees.

During fieldwork, the team learned about only three needs assessments or surveys that implementers conducted in relation to GBV prevention programming. HIAS conducted a needs assessment among its target beneficiaries, which was implemented between August 2010 and July 2011. In October 2013, UNHCR Koukou and its partners conducted two participatory needs assessments at Goz Amir Camp: one with the first wave of refugees who arrived approximately 10 years ago, and one with newly-arrived refugees. UNHCR reported that Goz Amir Camp had received approximately 2,000 arrivals since early 2013 and commented that their integration had been more smooth compared to the first group of refugees.

The team conducted an extensive FGD with UNHCR staff in Goz Amir, who reported that the situation regarding GBV was not urgent or grave in Goz Amir Camp: "It's fairly stable; there are problems but there aren't a ton of problems. We don't have a lot of reporting of serious cases, but there are some serious issues. We believe GBV is widespread in the camp and linked to the persistence of harmful traditional practices. We think that there is a problem with reporting in the more serious cases – they report the cases that are less grave." The team interpreted the uncertainty in UNHCR's above comment, in conjunction with other findings, as a reflection of the need for a stronger evidence base and routine monitoring systems.

The team was unable to obtain information about the number of refugees forced by circumstances into survival sex—another common form of GBV in humanitarian settings. The absence of information about incidences of GBV perpetrated against men and boys also underscores the lack of comprehensive surveys and assessments that UNHCR and NGO implementers have conducted to learn about the prevalence and types of GBV experienced by refugees. One NGO implementer reported: "The biggest problem is poverty – it brings girls to be prostitutes for money, when the parents have nothing and they can't assist their girls, they are obliged to resort to prostitution." UNHCR, however, stated that "There are definitely some cases of survival sex, but capacity to address the problem is very low." A comment from one APLFT staff member illustrates how the pervasive lack of data-driven programming by NGOs can manifest in precarious ways: "Compared with women, men do not have as many types or cases of GBV. Maybe when there is violence in the family – with fighting against the wife, women can hit a man and he would also be wounded. We don't have homosexuality."

The incidence and prevalence of GBV perpetrated by the police and other authorities is unknown. One APLFT staff member in Maro shared, "It's not only the refugees [who are perpetrating GBV]; they have now received training and sensitization so they are better than the local population who did not receive the training and sensitization." When asked about whether it had heard about any instances of the security forces perpetrating GBV, the GBV Committee responded, "They are human, the police, so it is possible that they are doing it."

Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?

International guidelines encourage transformation of socio-cultural norms to support positive gender relations and mobilization of populations to end harmful social norms and traditional practices. The importance of rebuilding or creating family and community support structures that uphold respect for the equal rights of all members of the community is also emphasized. Specific GBV prevention strategies outlined in Inter-Agency Standing Committee (IASC) and UNHCR guidelines include mobilizing the community to establish a system for survivors to access safe shelter if places of residence are unsafe; establishing community-based protection activities and mechanisms to prevent abuses in places where children gather for education; conducting routine spot checks and discussions with community members to reduce exposure to sexual violence due to poor shelter conditions or inadequate space and privacy; and working with host communities, local authorities, and other partners to reduce tensions relating to scarce resources. To fully involve the refugee community, guidelines recommend supporting community leaders to continuously strengthen prevention strategies by maintaining GBV risk awareness, engaging in problem-solving discussions, and supporting community groups to share information about GBV risks and incidents through formal and informal networks with stakeholders engaged in GBV prevention.

With regard to supporting positive gender relations, eradicating harmful traditional practices, and rebuilding community support structures, the team found that the HIAS and CARE programs are very much in line with international GBV guidelines. The methods these NGOs employ in their awareness-raising campaigns and door-to-door home visits exhibit the utmost regard for the refugees' traditional cultures and values while at the same time introducing ideas and concepts about GBV that appropriately and sensitively challenge these norms. UNHCR and HIAS noted that just a few years ago, women were barely involved in the committees and volunteer workers were unsettled when speaking about issues such as rape and FGM, which are now central themes in their daily prevention work.

The evaluation team found that gender balance and representation on refugee camp committees was consistent and substantive across all the camps visited. Representation of males and females within all the various community groupings was well-balanced. Groups with the greatest gender balance included GBV Committees and community mobilizers, and groups with less gender balance typically included Vigil Committees and the committees of central leaders and religious leaders—which were usually composed primarily of men. The commitment on the part of PRM-funded NGO implementers and UNHCR to have a balanced gender representation within all activities and outreach is a positive factor in terms of reaching program goals of GBV prevention and outreach while reflecting international GBV guidelines.

The important practice of maintaining survivor confidentiality, which is one of the bedrocks of international GBV guidelines, was widely discussed as a high priority in the provision of GBV services and support among respondents. Several refugee committee members and volunteers expressed particular regard for upholding this essential principle:

> *"Some people call HIAS agents and talk with us secretly. Others don't talk about it, but we hear that someone has been raped even though the victim didn't come to tell us. In this case we go to talk with her and tell her not to be worried; we explain that there are many people like you. We always talk with her alone and we keep the secrets of victims. Women don't tell us that they have been raped, but they say that they went to the bush to get firewood and someone took my clothes or my axe, so we understand that she has been raped. In this case I tell a woman colleague to talk with the victim."*

The team found that the NGOs are working toward the full involvement of the refugee community and supported groups (DV victims, in particular) to share information about incidents through formal and informal networks. The team also found that NGOs and Chadian governmental partners are striving to institute good practices in line with international GBV guidelines within the domain of refugee protection. One CNARR respondent in Maro reflected on his experience during the registration process for new refugees and shared some of the good practices followed to ensure the protection of young girls and single women:

> "*If there is a new girl who is 17 years old or younger, she is considered at risk and it's important that we follow this girl. We identify young girls, particularly those who come to the camp without any members of their family – we are obliged to follow them. We need to see who the girl will live with. We cannot accept that these girls live alone or live with a group where there are many boys and men; we prefer to settle her with a family that has children, for her not to feel alone. And then we tell UNHCR about these girls so they can follow them. Also women who come without their husbands and who live alone are considered at risk. For these cases, we try to see if we can put these women together and separate them from the men*."

NGO implementers in Chad have developed many of their programs and designed several of their activities to conform to a selection of the aforementioned best practices as outlined in IASC and UNHCR

guidelines. At the same time, the evaluators identified cases where programs and activities fall short of meeting established guidelines and do not conform to international standards. Specifically, the team found that NGOs have not been able to successfully mobilize the community to establish a system for DV survivors to access safe shelter if places of residence are unsafe. HIAS noted that it did operate a safe house at one point in time, but that the safe house created more problems within families than it alleviated and the property was therefore appropriated for another purpose.

The team identified a lack of emphasis on combatting child abuse, despite its prevalence in the refugee community. The team met with HIAS' Child Protection Committee, which discussed its work with orphans and neglected children, as well as visited a selection of schools to hear from students about their awareness of GBV. The team found that these programs were not receiving the prioritization and attention that they warrant. Further, the team found that none of the sensitization messages or awareness-raising campaigns incorporated messages about child abuse or child sexual abuse. When asked about the problem of child abuse among refugee children in Belom Camp, one member of DPHR noted: "The poor people [refugees] in Chad cannot help but abuse their children because they have nothing; they are obliged to have their children to work for them to have something to eat. We can say something to the parents when we see this, but what about the times when it's happening and we're not there? There are Chadian laws that prevent people from using children like animals."

The team found that issues such as the provision of medical care and the delivery of psychosocial services were less of a priority and were not fully in compliance with international standards. The quality of the medical facilities the team observed ranged from poor to critical condition, which in conjunction with the lack of medical supplies and staff, provides very limited options for refugees to receive appropriate and quality treatment in line with international standards.

Though the team was only able to meet with ADES in one of the four camps it visited, there was an overarching lack of recognition among respondents about the importance of psychosocial treatment. Furthermore, few respondents expressed familiarity with ADES as a primary service provider, whereas HIAS, CARE, UNHCR, and other NGO implementers like APLFT clearly had established profiles in the refugee community.

Codes of conduct are important for protecting refugees from humanitarian aid workers, including refugee staff members, who engage in abusive or exploitative behavior. None of the NGOs or refugees with whom the team met mentioned the use of complaint mechanisms to ensure accountability. One HIAS staff member expressed interest in receiving feedback from program participants: "Why can't we be assessed by our beneficiaries? I don't know how we could do it. It is something for us to get feedback from those we are assisting to see how they perceive us. It would help us to improve our delivery rather than having just external assessments… And how will we respond to their assessment? If they say that something is not okay, what will be our limit? Will we take it into account and truly change, or will we just continue the business as usual?"

In light of the high rate of DV reported within the refugee communities, the team was surprised by the absence of an approach to work with, and rehabilitate, repeat offenders. One staff member from APLFT in Maro noted the need to focus on training rather than pursing the traditional method of handling perpetrators with formal prosecution. "Going to jail is not the solution. We would prefer to have trainings in order to let refugees know that it is not good to perpetrate GBV." Many respondents among the NGO implementers noted the poor handling of perpetrators through the application of local and

informal “justice” mechanisms, which reinforces the likelihood of continued abuses. UNHCR Iriba explained how the majority of DV cases are treated within the camp:

> *“We ask them how they want it to be handled. There are two ways: through mediation and legal action, using APLFT; or maybe it can happen at the family level and in this case we wouldn’t hear about it. For the mediation we have the refugee leaders, men and women, but in general men are the ones who are discussing and talking. When it becomes a specific GBV case, it’s the men who are handling it. The leaders call the husband to talk and if he is the one who is behaving badly then they advise him or ask him to pay for tea for everybody (as his punishment).”*

UNHCR Iriba described the Community Mediation Committee, which is composed of both refugees and members of the local community. This committee is in charge of settling problems that arise outside of the refugee camp and involve the local community, such as incidents of GBV related to firewood collection. While the existence of such a committee represents best practice, the team learned that the methods the committee is using to settle cases are neither gender-inclusive nor victim-responsive. In particular, the lack of any protocol to guide the mediation process is a significant shortcoming. While HIAS described its role in supporting the victim to decide who to invite into the mediation room and what they can do, based on UNHCR’s account, the team found the mediation process to be short of reflecting international GBV guidelines and standards:

> *“The woman is called into the mediation – before this didn’t happen, but now that APLFT is involved it is happening more often. APLFT is in the meeting and is a kind of lawyer for the woman. There are very few cases that go before judgment. The female members of the committee may show up, but their opinions are not really being given or heard. Even the survivor would not like a woman to solve the case; there is some resistance here because the female victim may see the women on the committee also as victims so how can they help solve the case and women are also seen as non-trustworthy. But in some other contexts, the women understand women’s issues and what other women are suffering, so you would want to come and intervene and know what she is feeling. The final decision will come from the man – they are the decision-makers.”*

Evaluation Question 4: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs? Are the indicators in the project proposals SMART? How can proposal indicators be improved? Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?

Indicators used by NGO implementers to monitor program performance were weak (as noted in the July 2013 Desk Review Report). Specifically, indicators were poorly designed and often included targets. Indicators should be neutral gauges of progress that can be compared against an objective or target. When used appropriately, targets can orient NGO implementers to tasks that need to be accomplished and provide guidance for monitoring whether or not program progress is being made on schedule and if results have been achieved over time.

The majority of respondents from UNHCR and NGO implementers noted that the primary, if only, indicators they are collecting are via GBV incident report forms required by UNHCR. The form is used to log cases of GBV, including the type of GBV, but lacks information about how the case came about and how it was reported. Once UNHCR receives a form, information is uploaded into a database where cases are tracked according to the referral network. Within the database, each case receives an identification

number along with a description about how the case was handled and treated, where it currently stands, whether or not it is closed, and the required next steps. If the survivor experiences another incident, UNHCR can reopen the case and continue logging information. UNHCR noted that health partners—who are among the limited staff working in the camps that interact with certain types of GBV such as FGM, psychosocial trauma, and physical violence—are not required to report directly to UNHCR about GBV. Only HIAS and CARE, UNHCR's GBV partners, use the incident report form. Regarding the utility of UNHCR's incident report form, respondents widely noted that indicators are largely output oriented and capable of showing progress at the activity level, but incapable of demonstrating program outcomes. Both donors and implementers conceded that outcome measures are less frequently used because they are more difficult to assess.

According to one staff member from UNHCR Goz Amir: "Our indicators are difficult because they are predominantly outputs and quantitative. What are these really telling us about the work we're doing and the capacity we're building? It's very crude information… we don't have much information about attitudes or the quality of our work." Another UNHCR staff member from Maro noted, "The main type of indicators we have are output oriented: number and types of GBV, number of trainings, etc. Then we compare these numbers with previous years." An illuminating comment from another UNHCR staff member: "We don't have a specific form to track indicators for prevention work; we're just tracking how many people we've reached, but nothing about whether the sensitization work actually had any effect on changing people's attitudes and behaviors. We aren't even counting the number of men versus women who are participating in the sensitizations every time, this only happens sometimes."

One of the most apparent shortcomings of the monitoring conducted by UNHCR and NGO implementers was the complete absence of any indicators to track the incidence of FGM. While nearly all respondents spoke about the prevalence of FGM and its perceived reduction as a consequence of GBV prevention programming, none were able to report with any degree of certainty about the actual incidence rate of FGM or the connection, if any, between their program activities and the prevalence of FGM. The team conducted a KII with a representative from APLFT in Maro, which highlighted the near complete lack of informed understanding about FGM:

> *"It's difficult to confirm whether it's happening or not – they hide it. There are two or four groups that are in charge of doing this [FGM]. There are some cases in the camp, but it is hard to tell who is performing them. There has been an intervention in Maro since 2002, so it's been 10 years already. We see a reduction in certain cases [of GBV] – like excisions. You could see this happening in the villages before, but now it is never visible. I think that the cases have reduced. It's not just that they're hiding it; they are scared about what might happen to them."*

HIAS informed the team that it does not have any indicators to track FGM prevalence: "We are able to talk about FGM, but are we really able to have an impact on it? The health partners are not tracking this information systematically; they are only really keeping track of cases when there is a complication. Knowing how rampant this practice is, I am not satisfied by the number of reports we get – I know it is happening much more."

Another key area of programming about which NGO implementers lack comprehensive data is the prevalence of girls attending school. While awareness campaigns and sensitization activities focus on the detriments of early and forced marriage in terms of girls' lack of access to education, NGO implementers had not developed indicators to monitor whether or not their prevention programs were having an effect on this outcome. UNHCR staff in Goz Amir Camp commented, "The majority of refugee girls are

married early and this contributes a lot to the problem of education for girls, because once they are married they are forced to stay at home. We have to work to educate and sensitize the husband that it's better for the wife/girl to continue in school. This is happening more now than before, but we don't see fewer earlier marriages." HIAS reported that it tries to measure the effect of its sensitization activities in this domain by speaking with teachers about the number of girls who report to their instructors that their parents are trying to marry them off, but who prefer to remain in school.

Typically, effective GBV prevention programming should lead to an upward trend in reported cases, which indicates increased awareness. However, possibly due to the lack of effective indicators for routine program monitoring, several respondents reported that their programming was effective because of the reduced number of GBV cases reported. This trend was observed among refugee committee members, NGO implementers, and UNHCR staff. Along these lines, HIAS reported: "We think that the work we are doing with door-to-door visits has a lot more impact than the mass sensitizations. [We know this because] we look at the number of violence [incidents] and the number of married couples; this is how we know if our work is working or not… we are seeing that the number of cases of GBV is reducing a little between 2011 and 2013."

NGO implementers reported that PRM guidance on M&E strategies was limited to the proposal submission process and that it would be helpful to receive guidance and support on indicator development. PRM is aware of the challenges in understanding the effectiveness of implementers' programs. One DoS/PRM staff member reported that UNHCR and NGO implementers do not provide PRM with substantive, evidence-based conclusions about the effectiveness of GBV prevention programs.

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and how?

Part I: Unexpected negative consequences

While GBV prevention and awareness campaigns and support services offer survivors encouragement and improved mechanisms to report incidents of GBV and obtain legal and other necessary assistance, they can also cause socio-cultural disruptions as communities and individuals may have differing perceptions about the role of outside assistance, legal intervention, and other services in what they consider to be family issues. NGO implementer staff across all the camps noted that programs that provide women with greater independence or legal options sometimes increase tension within the home due to the abuser's anger over lack of control, insecurity, or feeling threatened (particularly in the case of DV). Representatives of APLFT, the legal service provider, explained that some male community members perceive any legal intervention pertaining to DV, for instance, as "APLFT pushing the wife against the husband."

> *"There are certain cases that are not brought to APLFT and are just dealt with informally in the camp; the GBV Committee prefers to advise the community… Some of the difficulties we face in the camp – the position of certain refugee leaders who don't understand our function, maybe they think we are trying to incite their wives against them, or if the refugee leaders prefer to fix the problem on their own. Some people think that we are creating a lot of problems between husbands and wives."*
>
> *"It has been difficult for the community to understand that women have rights; it was not acceptable for some people to not beat their women. In Goz Beida, we had a heated meeting with some men who said, 'ok – now our wives belong to you, whatever happens to them is your fault,' and they even*

abandoned their children when we did the promotion of child rights because they said, 'they're UNHCR's children now.'"

In response, PRM-funded organizations walk a very careful line in terms of balancing their support for survivors to seek legal remedies and other services related to GBV incidents with, on the other hand, respecting and working within socio-cultural norms and community systems that are deemed acceptable within the existing ethnic, religious, and traditional community context. Given that a majority of GBV cases, especially DV, are resolved outside the court system, it is possible that the NGOs may have downplayed the legal avenue almost too much in their efforts to keep peace with the refugee communities and work within the communities' social norms and structures.

The evaluation team did not conduct an analysis of this issue; however, extensive KII feedback from the refugee community and service providers indicates that socio-cultural norms of the refugee communities visited in eastern and southern Chad strongly favor the resolution of GBV cases (most notably DV) within the confines of the family or extended family, rather than involving outside legal or other types of interventions. In Belom Camp, for instance, respondents explained that social awareness campaigns have raised refugee awareness regarding legal options to resolve GBV incidents. However, community leaders in the camp often prefer to resolve cases themselves rather than go through the local court and legal system. This continues to be a major inhibiting factor to translating increased GBV reporting into long-term resolution of GBV cases for survivors.

Part II: Unexpected positive consequences

The team identified one important unexpected positive consequence of PRM-funded GBV prevention programs. KII feedback from refugee communities indicated that due to GBV awareness campaigns' emphasis on decreasing forced and early marriage, the demand for long-term, quality education among both girls and women has increased greatly within refugee communities. The communities have learned about the harmful consequences of early and forced marriages, such as difficult and sometimes fatal deliveries among mothers who are children themselves or young adolescents. They have also learned that there are many opportunity costs for a girl who marries early—one of which is that she is often forced to stop going to school at the demand of her husband and/or due to childcare needs of a newborn. This growing demand for education has come not only from females at the primary and secondary levels, but also from their mothers who request adult education and skills training for themselves and even want their daughters and sons to obtain university education. Refugees attributed this increased desire and appreciation for education to the GBV training and awareness campaign efforts of PRM-funded NGO implementing partners, as well as to a variety of other human rights, child protection, and social advocacy messages relayed by humanitarian organizations working in the camps.

Unfortunately, this positive side effect of GBV prevention programs—significantly increased awareness and interest among girls and women to continue their education, receive higher quality education, attend secondary schools, and even obtain university degrees—has been met with the negative reality of educational offerings in or near the refugee camps. Education options are either of poor quality, unaffordable (due to the cost of tuition, school supplies, and uniforms), inaccessible (too far from the camp), or unavailable/non-existent. The evaluation team's observations of several refugee schools and KIIs with teachers and students provided evidence of high frustration with the lack of support for teachers (with pay below subsistence levels), poor infrastructure, lack of school supplies and equipment, and poor curricula. A hopeful sign, however, was the existence of several childcare facilities that could

allow young female students with babies to stay in school. Yet, only one of the facilities was fully operational—and even it lacked basic equipment and baby formula.

A male leader in Touloum Camp reported, “We need more help and we asked for this since 2004, 2005, 2006… and we need help for education, we need help in the different fields of education, we need help for the education for children. Education has stopped… now there is no secondary education and no adult education.” A female leader in Touloum Camp emphasized the causal links between lack of education and violence:

> *“I want to speak about the reason for the cases of violence. Because of violence, we arrived here from our country. This comes from uneducated people and ignorance. And from 2004 to 2008 the education was good and we were working with NGOs, but since 2008 the education has decreased. And uneducated persons cannot help and do not know how to solve the problems of violence. We need all of us here… most of us are not educated. The children under five years old are now in the street and don’t have any education – they are becoming street children. With no education, a child may be throwing rocks or fighting with neighbors. Women are the focus of the family and for this we need adult education. This is why we have violence.”*

Evaluation Question 6: What factors explain expected and unexpected negative or positive consequences?

Part I: Factors explaining unexpected negative consequences

Consequences of PRM-funded GBV programming activities can be attributed to a diverse host of factors, including factors that may be within UNHCR’s control or the NGO implementers’ control, as well as factors that are largely external, i.e., outside the direct control of the organizational entity implementing the program activity. Many items listed under external factors below are discussed in detail under Evaluation Question 1, Part II. Barriers to implementing program activities are also likely factors contributing to unexpected negative consequences.

Internal Factors

- Lack of long-term analysis of, and planning for, possible negative consequences of program activities on the part of UNHCR and NGO implementing partners
- Psychosocial counseling protocols that may not be adequately survivor-centered and would benefit from further refinement
- Lack of male-only support groups for men and boys to prevent and address the issue of male GBV survivors
- Missed opportunities to collect data at health centers on the number of existing and new cases of FGM in each camp, which would allow programs to be better grounded in real, more accurate data regarding the prevalence of FGM
- Some duplication among partners and committees in terms of counseling, which possibly dilutes the integrity and effectiveness of counseling efforts and increases the possibility of breaches of confidentiality due to the multiple entity involvement
- Lack of monitoring at the outcome level to provide data on whether or not prevention efforts are effective, which would provide essential feedback to inform adjustments and ongoing learning for programming

External Factors

- Lack of land available to refugee households to improve food security and overall livelihood security, contributing to poverty and increased levels of household stress
- Alcoholism/drinking, primarily among males, which can exacerbate DV situations and increase conflicts in the camps and with host communities
- Harmful traditional practices such as FGM, which require long periods of time for changes to occur in terms of knowledge, attitudes, and practices
- Socio-cultural norms that consider topics such as homosexuality, male rape, or male DV as taboo
- One-year funding structures that do not allow adequate time to carry out needs assessments, collect baseline data, and put into place sufficient M&E mechanisms as a means to prevent possible negative consequences through solid pre-planning and program design
- Budget cuts across the board for all partners, which inhibit the purchase of adequate supplies and equipment needed by the various GBV support committees to fully reach their optimal potential as an effective force to prevent GBV;
- Limited resources among Government of Chad partners, such as DPHR, whose salaries are not being paid; who are forced to live in harsh, poor conditions; who lack vehicles and sufficient gasoline for responding efficiently to GBV incidents; and whose force lacks an appropriate number of female members
- Lack of safe houses for female and/or male survivors of GBV
- Inadequate legal framework and legal enforcement in Chad pertaining to GBV prevention, support, and/or restitution
- Lack of funding for positive extracurricular activities for youth (boys and girls) that could serve as a preventative measure for avoiding the many negative consequences (including perpetrating GBV) of being idle and feeling unproductive, angry, or isolated
- Firewood and water locations outside of the refugee camps, requiring women and children to travel and leading to higher incidents of GBV and rape
- Lack of infrastructure—such as offices, meeting centers, and schools—which can lead to low motivation of refugee volunteers to work on delivering services to prevent GBV

Part II: Factors explaining unexpected positive consequences

Establishment of trust with refugee communities: FGD feedback across the four camps visited by the evaluation team indicates that, overall, refugee communities believe they have a good working relationship with the implementing partners. KIIs provide evidence that the refugee communities generally trust and respect the partners' efforts in GBV prevention. This is an essential and difficult accomplishment, as UNHCR and the NGO implementers are working with diverse refugee communities with various religious, cultural, educational, and ethnic backgrounds. It demonstrates that the partners are successfully balancing their efforts to introduce sensitive topics into their activities (such as addressing FGM and forced/early marriage), while at the same time, taking care to respect and work within the refugee communities' existing community structures and religious and social norms.

There were a few instances where the values and teachings of the partners "rubbed the refugees the wrong way," but only a handful compared to the overwhelmingly positive feedback. For example, one teacher reported that now that teachers have been taught not to punish schoolchildren with physical force, the students are not as disciplined and focused. Another refugee explained that sometimes the refugees feel that the partners are "taking their women" when the partners intervene in DV cases. Overall, however, it is clear that the refugees appreciate and are heavily engaged and even "own" much

of the committee work on GBV that has been initiated by the partners. Clearly, without this foundation of trust and respect between the partners and the refugee communities, it is doubtful that any positive transformations could have taken place. It is thus considered by the evaluation team to be both a key factor in sustaining the positive achievements accomplished to date, as well as to achieving future goals among PRM's collaborating partners.

Close collaboration between partners: The evaluation team found collaboration between UNHCR and NGO implementers to be exceptionally strong. There exists a clear "spirit of unity" in working on GBV issues between all of the partners who are active in the four camps the team visited. The weekly partner coordination meetings conducted to discuss ongoing GBV cases is a central component of the partners' work, and each partner uses the matrices to follow the cases and submits the standardized incident report forms to UNHCR. All the partners expressed that they are well aware of the SOPs that UNHCR has provided. There appears to be very little, if any, infighting between partner organizations. This shared sense of purpose and collaborative spirit is most certainly a key factor in terms of accomplishing results.

Substantive and ongoing GBV sensitization outreach: The evaluation team found there to be a significant amount of mass sensitization on GBV being carried out, on a consistent basis and with high community turnout and participation. For instance, 400-500 refugees attended a recent mass sensitization effort in Touloum Camp that was conducted jointly by HIAS' GBV Committee and community mobilizers. One of the reasons reported for the strong turnout was the pre-planning and advertisement that block leaders carried out one week in advance. This level of participation indicates that refugees appreciate these sensitization events, which they choose to attend on a voluntary basis. The fact that there continues to be high turnout is an indication that the sensitization efforts are being heard by many and that GBV prevention messages are being reinforced frequently. Continued exposure to GBV prevention messages was identified by a large proportion of the refugees who participated in the FGDs as a key factor in changing people's knowledge, attitudes, and practices over time to move away from harmful traditional practices and other forms of GBV.

Creative social messaging through theater and radio: Youth theater groups conducting GBV awareness outreach offer a dynamic and participatory approach to GBV prevention. The evaluation team spoke with two theater groups located in Goz Amir and Dosseye camps. It was reported during FGDs that this form of knowledge and advocacy outreach is particularly well-liked by the refugee communities because it simultaneously relays important messages and provides the community with some (much needed) entertainment. The theater groups often use humor and comedy as part of role plays and skits as a means to share messages about GBV prevention and knowledge about harmful consequences of various forms of GBV. Also, partners have used radio programming as a creative method of introducing different topics and themes related to GBV. A specific benefit of radio programming is that it reaches both refugees, such as in Goz Amir and Touloum camps, and host communities, such as in Koukou. The refugees and partners explained that they know the host community is listening to the programming, as when they meet them in the market they express their appreciation for the radio program and discuss the issues with the refugees. This effort to introduce creative GBV messaging has been a positive component of PRM-funded programming.

Evaluation Question 7: What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs SMART? How can indicators be improved for GBV awareness campaigns?

As described under Evaluation Question 4, the team found a consistent shortage of and, in many cases, a complete lack of data on program outcomes. As such, findings on the outcomes of GBV awareness campaigns are largely anecdotal and based on the perceptions of UNHCR and NGO implementer staff. The extent of data the team received regarding GBV awareness campaigns was in reference to the number of participants who attended various events. In most cases, those numbers were not disaggregated between males and females. Despite the absence of outcome-level data about changed knowledge, attitudes, and practices, almost every NGO implementer and refugee group the team interviewed cited a decrease in the number of GBV cases and the prevalence of various kinds of GBV, such as FGM, as a result of the activities they are implementing. However, due to a lack of outcome monitoring, respondents were unable to establish a causal line of contribution between their activities and the cited decrease in GBV incidents. It is clear that UNHCR, NGO implementers, Government of Chad partners, and refugee committees are proud of the work they are undertaking to prevent and address incidences of GBV, which may contribute to their perception that their efforts have been successful and that GBV has decreased within the camps. Unfortunately, the overarching lack of outcome-level data not only prevents the evaluation team from verifying qualitative findings, but also undermines the ability of PRM, UNHCR, NGOs, refugee groups, and Government of Chad partners from knowing whether their work has been effective.

A selection of quotes from a variety of groups across the camps highlights the anecdotal nature of respondents' perception of awareness campaign outcomes:

- "Since we started, there has been a big decrease in the number of cases. Last year we fought against circumcision and now it has diminished." –DPHR
- "Before in 2003 when we first came to the camp, there was no safety for us, but after they created the GBV Committee… it did some sensitization and now there is no GBV in the camp." –Young mothers
- "There are many committees and they are working well together. It is rare to hear about a GBV case in the camp now. When we were in Yarungu, (predecessor to Belom Camp) we saw many cases of excision and circumcision, but when they started the GBV and Vigil Committees here in this camp we see that these cases don't exist now… they started to give the communities advice and people do not do these things in the camp now; all is away and the GBV cases don't exist. We are living in peace and we are very happy for this." –Vigil Committee
- "The level of [GBV] is becoming less because there are trainings on these issues so things are going well now, and theater teaches people how to respect and also courses from HIAS on violence [GBV] help people to understand… and all the levels decreased." –Refugee Committee
- "When we work with families we advise men and women not to struggle and there is a change; for example, giving a daughter before the normal age into marriage doesn't exist anymore." –GBV Committee
- "Nowadays things have changed because of what we have done, everything has changed. Taking a girl by force is forbidden, violence against women has changed a bit, and women who have children start to go to school." –Youth Committee
- "Before we arrived here or at the beginning, there was some violence. Early marriage was happening, but now there is no early marriage and the NGO gave us a lot of training on this and the people have understood and there is no early marriage." –Women Leaders Committee

- The GBV Committee in Touloum Camp reported that it trained 5,073 people between January and November 2013; 417 people attended the most recent training. To conduct the training, the women gather around a microphone and disseminate messages for three hours about the prevention of GBV. When asked whether they thought their training was effective, the women unanimously stated "yes" and continued by saying, "The people who commit violence attend the training, and they tell us that the training was good and they will not commit a crime the next time."
- The team also spoke with many refugee women's committees and young mothers' microcredit groups about their personal views on certain types of GBV such as FGM. One microcredit group member explained that she was excised when she was a young girl but that, now, all girls are refusing to be excised. "Before we arrived here in this camp, excision was practiced in Amboko (a camp in southern Chad from which some refugees had relocated); but since this year, there is no case of excision in the camp because the GBV Committee sensitized everyone."

Despite the lack of outcome-level data about the awareness campaigns, the team did find that some respondents are making insightful connections between changes they are observing among refugees regarding certain cultural practices, such as FGM. DPHR reported: "Even when people are hiding themselves to do this [FGM], it demonstrates that they are aware that the practice is not good, and this is a step toward changing attitudes. A few times now, women, when they are bothered by their husbands, they go to APLFT. They are aware of their rights, and this is a demonstration that the sensitization is working. We are also seeing some fathers who are enrolling their daughters in school."

Additionally, the team's discussions with some refugee groups reflected changes in attitudes about traditional cultural practices. The team conducted a FGD with a mix of male and female members of the Refugee Committee in Goz Amir Camp, during which respondents shared personal thoughts on early marriage. One male respondent said that he refused for girls to be married at the age of 15, which is a typical age for marriage among refugees from Sudan. A young woman voiced her disagreement and explained that if a girl loves someone and wants to marry him, it is not fair for her family to refuse as the choice of when and who to marry should belong to the girl. One of the older female members of the committee voiced the opinion that girls should be married at 15 years and that it should be the choice of the parents, not the girl. Another woman asserted that girls should be married after they finish secondary and university education. One man added that many people want girls to marry when they are 14, 15, or 16 years of age, but that in many cases this kind of marriage fails. He continued:

> *"When you give [for marriage] a young child, it is not good because she doesn't respect her husband and she is too young to take care of her children. She is a child and she needs care herself, so how can she take care of her children? But sometimes the girls want to marry when they are young, so in this case what can we do as parents? If you don't marry her to him, maybe she will be pregnant. So parents are very afraid… so they marry her to the guy she wants rather than waiting and having an illegal child [unwanted pregnancy]. If she respects herself and keeps herself from sexual relationships, her parents can let her finish her education up to university and later she can find someone who she thinks is a good partner for her life and she can marry. This is one of the problems that leads parents to early marriage; they know also that it may fail but they have no choice because the daughter wants to marry the man."*

Evaluation Question 8: To what extent have men and boys been included in GBV awareness campaigns? If they were not included, why was this? If they were, what was the impact and how was it measured? Do the GBV programs address the issue of the male survivors of sexual assault or domestic violence? If yes, how?

Part I: Male engagement in GBV awareness

Although engaging men and boys in GBV prevention and response was not an explicit objective of HIAS, CARE, or ADES programs in Chad, data collection findings indicate that engaging male heads of households in discussions on gender equality and involving men in voluntary committees to promote the rights of women and girls were key components of the NGOs' efforts to transform socio-cultural norms and rebuild family and community support structures.

The evaluation team found that men and boys have been consistently included in the GBV awareness campaigns and associated activities implemented within the refugee camps in Chad. NGO implementers did not, however, specifically measure the impact of male engagement. There was evidence of the active engagement of men and boys—including male NGO staff—on many levels:

- Consistent selection and targeting of both males and females for participation in gender sensitization training opportunities
- Purposeful inclusion of men and boys on the refugee committees that carry out GBV awareness campaigns, such as the GBV Committee, Social Mobilization Committee, and Central Committee
- Targeted selection of both boys and girls to serve on youth committees that carry out GBV awareness through theater group activities such as drama performances, skits, and role plays
- Inclusion of both male and female students as focal points to work with the GBV Committee and other committees that carry out GBV awareness campaigns and activities
- Strategic targeting and outreach to men and boys who have been identified as at risk of becoming perpetrators or who have already been involved in GBV incidents, to ensure that they attend community GBV awareness campaigns and activities

KIIs with refugee committee members and leaders across all four of the refugee camps visited by the evaluation team confirmed that the rationale for and benefits of having a balanced mix of men, women, boys, and girls in GBV-related committee activities, social mobilization efforts, awareness campaigns, and direct service provision was well understood and largely "owned" by the refugee communities.

For instance, the GBV Committee that carries out GBV awareness campaigns in Belom Camp reported that male perpetrators of DV in the community tend to "listen to men's advice more than the advice of women." The committee attributed noticeable improvements in its efforts to prevent and address the issue of GBV as directly linked to its efforts to increase the number of men serving on the GBV Committee. This common understanding that, depending on the circumstances, a male or a female may be in a better position to offer advice or assistance to a survivor (through a mass GBV awareness campaign or a drama role play or a door-to-door outreach effort) was shared by a majority of the refugees with whom the evaluation team spoke. Several young mothers in Belom Camp, for instance, reported preferring to have a male (rather than a female) speak with male family members who are "drinking too much alcohol and beating them" while intoxicated—believing that, in such circumstances, a male-to-male discussion would be most helpful.

CARE, HIAS, and ADES have each played a major role in integrating men and boys into GBV awareness campaigns, activities, and other outreach efforts. For instance, CARE staff in Goré reported that the

consistent “inclusion of men in awareness campaigns and outreach is key” to success. CARE has found that in Dosseye Camp, for example, “People now see that GBV is not exclusively a women’s problem.” CARE works to ensure that both men and women are included in the committees that carry out GBV awareness activities, and that both males and females participate in all GBV trainings and awareness outreach activities.

While KII feedback provides evidence that the participation of men and boys in GBV awareness campaigns is quite consistent, the evaluation team noted that there remain thematic areas of importance to reducing the incidents of GBV. For example, addressing—and transforming—the established roles of men and boys has not yet received adequate attention or emphasis within PRM-funded GBV awareness campaigns and outreach efforts. KIIs affirmed PRM’s concern that humanitarian programming related to GBV places less emphasis on engaging men and boys than does programming conducted within the international development context.[17]

Among the refugee camps visited, awareness raising focuses primarily on improving knowledge and understanding regarding specific types of GBV and their harmful consequences—but without also encouraging (the very difficult and probing) discussions that question traditional norms associated with femininity and masculinity and that reinforce positive masculine behavior. For instance, KII feedback across all four refugee camps provided evidence that women and girls are expected to collect firewood for their households; firewood collection was strictly deemed a female role rather than a male role. At the same time, the evaluation team identified the long roundtrip walk to obtain firewood (typically far outside the camps) as the most vulnerable period in the day or night for a girl or woman to be raped. When the refugee communities were asked whether, given the frequency of female rapes during firewood collection, they had considered sending boys or men to collect firewood instead, the typical response was some uncomfortable laughter, quick head-shaking “no,” and explanations that such a change would “not be possible because firewood collection is a job for women and girls.”

One UNHCR staff member noted a positive experience during a posting with UNHCR in another country, where men were engaged in non-traditional gender roles working on GBV prevention. This individual suggested that greater attention be placed on establishing similar initiatives in Chad: “In previous operations, I had a colleague working in community services who was male – normally it is a woman; you rarely find a male head of community services – and he managed to put an association together called Men’s Association for Gender Equality. This association really had an impact on men; I think we should move to that step here, men talking about violence against women.”

One area in particular that the evaluation team noted a significant lack of engagement and focus among the NGOs was in addressing the connection between alcohol abuse and GBV. Several refugee committee members, beneficiaries, and UNHCR and NGO staff members noted the prevalence of this problem within the camps, especially as it affects men:

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[17] Annex I (Evaluation Statement of Work) states: “As part of GBV prevention, PRM has raised the importance of determining how best to engage men and boys to reduce gender inequalities and prevent violence through questioning traditional norms associated with femininity and masculinity, and reinforcing positive masculine behavior, rather than behaviors that harm women. Although more has been done in the development context on this issue, the humanitarian community still has much to learn in identifying best practices on engaging men and boys in GBV programming.”

- "I would prefer that they choose all the men in order to train them and ask them to pay home visits to talk to each family and with the men who are drinking alcohol to explain to them what GBV is." –Young mothers
- "You will see in the camp there is a lot of DV due to the alcohol consumption among the men; they sell the food received from WFP and because men are the household chiefs, they sell the food in the market and buy alcohol." –UNHCR
- "There is a big connection between alcohol consumption and GBV/DV – men often take the rations and sell them in the market to buy alcohol." –CARE

However, the team obtained very limited evidence about programs or activities that are combating this problem. UNHCR Dosseye was the only group that was aware of a program being implemented to address the problem of alcohol and drug abuse. Nonetheless, a strong connection between these harmful practices and the phenomenon of GBV was not evident in the description of the activity, underscoring the missed opportunity of engaging with men and boys through this avenue:

> *"Now we have youth who are taking drugs and drinking alcohol, so in terms of prevention CSSI is working in this domain now… because drugs and alcohol are linked with the problem of DV. The men who were sensitized, it was a random group – the message is sent out to the whole camp and then it depends on who comes to the sensitization (which is just the delivery of some key messages, it's not a training). The sensitization does not target those who are specifically drinking, but the sensitization does talk about alcohol and drugs and the problems for the family and community. The young boys who are being sensitized are those who hang around the youth centers."*

Part II: Male survivors of sexual assault or domestic violence

The evaluation team found that GBV programs implemented in the camps of Belom, Dosseye, Goz Amir, and Touloum do not adequately address the issue of male survivors of sexual assault or DV. This is likely due to a combination of NGO implementers' lack of knowledge with respect to the existence or possible existence of GBV perpetrated against men and boys and the socio-cultural norms of the refugee communities, which tend to strongly deny the existence of these issues and/or consider their discussion taboo.

Refugee FGD participants in all visited camps were specifically asked whether they were aware of any incidents of sexual assault or DV against a man or boy in their communities. The overwhelming responses were: 1) they had not heard of any cases of men or boys being sexually assaulted, 2) they did not think that sexual assault against boys or men was happening in their community, or 3) they had heard of one or two isolated cases of DV against men but argued that most of these cases were caused by the female head of household defending herself from a husband who was beating her, drinking heavily, beating her children, or depriving her and her children of food, i.e., they felt there was contextual or situational justification. When asked whether they thought it was possible that men and boys could be experiencing DV or sexual assault, a majority agreed that it is, in fact, possible. However, it was evident that this was a somewhat new or odd perspective from their vantage point because they were consistently and noticeably more hesitant and less likely to actively engage in the FGD when this particular topic was raised.

The team also explored this topic with the NGO implementers to elicit understanding about why these issues are not included in their GBV prevention and support activities. While some conversations with NGO staff exhibited an acknowledgement that GBV could be happening to men and boys, others were less confident that this type of phenomenon exists. HIAS staff shared the following perspectives:

- "The men in Chad are not really victims – it's very few in terms of what we have heard since the beginning of this year. I can talk about two cases in the camp of Iridimi: one of them is a case of a man who is being violated – he is an old man and he is handicapped and he has a mental issue and the wife is mistreating him and it was reported. The second case is of a man who is being beaten by his wife – so very minimal cases. The culture here is more male-dominated; the men oversee the women. Maybe if there were cases it would be difficult to report because they are supposed to be bigger and greater than the women. Because it is male-dominated, the women will not go against the men and the community might look down on the man because he is the head of the home."
- "I will not say that it doesn't exist; the fact that we don't get any reports doesn't mean this. I don't know how we will go about [addressing] this… maybe talking with the children in schools – a life session that such a risk exists, so then maybe as the children are aware of it they will start to talk about it."

The team found that the preponderance of prevention activities and messages disseminated through awareness campaigns focused on various types of violence against women and girls and that little to no discussion of violence against men and boys was included. For example, when inquiring with GBV Committee members in Dosseye Camp about the GBV training they received, they responded:

> *"The training mainly involved violence against women, and also we were trained on early marriage. In the training we tried to identify what kind of violence is imposed on women or girls and we tried to solve the problem… and after all of this violence is committed, what is the impact, what is the consequence on people (mainly girls and women)? Our role in the GBV Committee is mainly on early marriage and violence against women and the cases of excision. When a little girl is excised it's not good, and if you have this case of GBV we send you to the hospital – it depends on the type of violence."*

The training content described by the Dosseye GBV Committee is consistent with that of the other camps as well as with that of the sensitizations and trainings disseminated by the refugee volunteers to their community members.

Finally, the team noted the lack of emphasis the NGOs placed on combating the perpetration of GBV by members of the security forces within the camps. While several respondents noted incidents that had occurred between refugees and the DPHR forces, the primary method for reaching this group of individuals was through sensitization activities and trainings about the various types of GBV and why they are harmful. Interestingly, the majority of incidents with DPHR that were cited involved excessive use of violence against young boys. A youth group member reported, "Violence that happens to boys is mainly at the distribution place – if your papers for the food are not in order the authorities (DPHR) take you to the jail in Goré because they think you are a thief."

Evaluation Question 9: What were the short- and long-term outcomes of PRM-funded GBV prevention?

Part I: Short-term Outcomes

PRM programming goals in Chad include a particular focus on the primary prevention of GBV, which includes interventions that are carried out before violence first occurs; aims to prevent initial perpetration or victimization; addresses social norms and environmental factors that contribute to violence; and is often carried out as part of a comprehensive, multi-sectoral effort. The absence of

program outcome indicators, targets, and associated baseline data did not allow the evaluation team to conduct a systematic, technical assessment of program progress and impact. However, the team's desk review of UNHCR and NGO reporting documents, combined with direct observations and a total of 61 KIIs and FGDs with collaborators and beneficiaries, provides ample evidence that substantive progress has been made in terms of GBV prevention and support on a variety of levels. The evaluators found two areas of programming, in particular, where NGO implementers are making noteworthy achievements: 1) substantive and ongoing GBV sensitization outreach, and 2) creative social messaging through theater and radio. These areas are discussed in detail under Evaluation Question 6, Part II.

Additional highlights of short-term achievements include the following:

- GBV referral pathways exist for survivors to access services and to obtain support
- Many refugee community members have been trained in GBV awareness and outreach techniques
- Many refugee community members have participated in/attended GBV awareness campaigns and possess increased knowledge regarding the harmful consequences of various forms of GBV
- Refugee community youth have formed GBV prevention/awareness theater groups
- In some refugee camps, there has been an increased demand for legal services, which may be linked to increased awareness regarding GBV
- Childcare facilities at schools have been established in some refugee camps to support the continued education of young mothers

Part II: Long-term Outcomes

The scope of this evaluation includes projects carried out during FY 2010-2012; as such, long-term outcomes cannot yet be assessed. However, the team's 41 KIIs with UNHCR staff, NGO implementers, and DoS/PRM staff as well as 20 FGDs with diverse refugee committees provide evidence of several positive trends occurring in the refugee communities. Note that these trends are based upon the reported perspectives of the refugees themselves—most notably by those with a long history in the camps who have witnessed gradual socio-cultural changes in knowledge, attitudes, and behaviors within their communities over time, and who have also benefited from PRM-funded GBV prevention programming over the past several years. If current GBV prevention and support services are adequately continued, the trends below could be sustained:

- Socio-cultural environment that is becoming less accepting of harmful practices such as DV, early marriage, forced marriage, FGM, child labor, and child abuse
- Raised awareness of the health consequences and other social costs of harmful traditional practices such as FGM and forced marriage
- Social-cultural norms that are becoming more open to and accepting of positive practices such as prolonged education of girls, delayed marriage for girls, and adult education for women
- A gradual decrease in the social stigmatization of girl and women rape survivors, mothers with children born out of wedlock, and children born as a result of a rape—evidenced by increased socio-cultural compassion and community support for women and girls in these situations
- Raised awareness of the importance of women's participation in decision-making, in general

CONCLUSIONS AND RECOMMENDATIONS

Evaluation Question 1

Despite the numerous barriers to program implementation the team identified, NGOs were still able to carry out an impressive array of activities. Possibly as a result of the myriad challenges implementers face, the team found that some aspects of GBV prevention and treatment programs were of a lesser quality than others. The team did not review data or monitoring reports with the implementers to specifically establish whether or not they met each of their targets; however, the evaluators did gather figures from refugee committees about various activities. The team found that implementers in some camps seemed to be reaching more community members with their activities than in other camps, and that some implementers had not fully carried out all aspects of their activities. However, due to insufficient program monitoring, UNHCR and NGO implementers are at a disadvantage for providing a structured analysis about which aspects of their activities they were and were not able to achieve.

Recommendations for PRM

- **PRM should collaborate with UNHCR and NGO implementers to integrate GBV prevention-focused activities into their livelihoods strategies.**[18] At the same time, PRM-funded NGO implementers should consider a livelihoods-oriented GBV prevention strategy to engage and collaborate with livelihoods-focused NGOs—providing increased opportunities for refugees to strengthen their livelihoods as a mechanism to prevent GBV.

Recommendations for Implementers

- **UNHCR, HIAS, CARE, and ADES—in conjunction with other NGO implementers that provide GBV services—should carefully review each of the identified barriers to program implementation** to assess whether any of them could be mitigated and/or accounted for in the design and implementation of program activities.

- **HIAS, CARE, ADES, and UNHCR should elaborate a classification system for the various types of GBV and the associated steps that should be followed to handle each type.** This system would support refugee volunteers and committee members in knowing whether a particular incident should be reported to UNHCR or handled informally among community members.

- **HIAS, CARE, ADES, and UNHCR should combine efforts to train all refugee staff members about GBV prevention and treatment.** HIAS, CARE, and UNHCR staff should receive ADES training on mental health. ADES staff and others from NGOs and government agencies such as APLFT, CSSI, CNARR, and DPHR should receive HIAS and CARE training on GBV awareness. This

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[18] "Preventing Gender-Based Violence, Building Livelihoods," Women's Refugee Commission, <http://womensrefugeecommission.org/programs/gender-based-violence>

step might help to address some of the weaknesses the team found in the treatment protocol and to ensure that all prevention activities are implemented following the same steps.

- **NGO implementers should co-facilitate a GBV protection working group with UNHCR.** Guidance for such a group could be similar to that used by the UN Global Protection Cluster approach and include guiding principles.[19] The group should focus on specific activities to prevent GBV and improve response and could leverage unique strengths of the NGO implementing partners to address identified problems.

Evaluation Question 2

The lack of comprehensive needs assessments focusing on GBV or baseline assessments of program beneficiaries undermines the learning potential of PRM-funded programs in Chad. Information on GBV remains largely anecdotal and there is no accurate characterization of the problem at large. NGO implementers have a clear understanding of some aspects of GBV within the refugee community such as forced and early marriage, DV, and rape, but they have not fully explored additional forms of GBV such as survival sex and sodomy; this not only threatens the development and implementation of effective programs, but also hinders reliable understanding about the outcomes of GBV prevention programs. The lack of data for NGO implementers to use in targeting prevention efforts toward high-risk geographic areas and sub-groups results in a failure to translate knowledge into practical prevention strategies and reduces the effectiveness of GBV prevention programs. Baseline assessments are necessary to evaluate the effectiveness of programming, and mapping of available services is important to identify gaps and develop referral pathways for survivors. NGO implementers' plans and efforts to develop data collection tools and better understand their beneficiary populations are laudable. However, to maximize the benefits of this information, the efforts need to be well coordinated and findings should be used to inform the design and implementation of current and future programs.

Recommendations for PRM

- **PRM should provide financial support for an extensive situational analysis to understand the needs and priorities of refugee communities that program interventions seek to benefit.** The situational analysis should include participatory assessments to identify the protection concerns of men, women, girls, and boys. Data collected should be disaggregated by sex and age. Situational analysis should focus on risk mapping, immediate and root causes of GBV cases, and the use of international and domestic legal standards as a framework for analysis and action.

- **PRM and UNHCR should fund partnership projects to address the gaps in knowledge about GBV.** In order to develop and implement effective prevention measures and strategies, it is essential to obtain a clear understanding of the problem in a particular setting. International guidelines recommend periodic participatory assessments to gather information and understand GBV-related issues. Standardized tools are now available with the introduction of the Gender Based Violence Information Management System (GBVIMS). A ProCap or GenCap representative could assist in the development of new ways to measure GBV prevention and to

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[19] See, for example, the UN Global Protection Cluster <www.globalprotectioncluster.org/en/news-and-publications/publications.html> and the IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, pages 17-19.

coordinate this effort; UN Office for the Coordination of Humanitarian Affairs experts are free to UNHCR and will remain in-country for six months or more. Providing an advisor to assist the NGO implementers and UNHCR in developing a standardized, confidential questionnaire that includes questions about types of GBV, perpetrators, places where GBV occurs, etc. that can be distributed during home visits or health clinic visits could also help to address knowledge gaps. Other forms of participatory research, such as focus groups, are also recommended.

- **Programs that focus on healthcare, livelihoods, or other areas should be required by PRM/Washington to develop specific and measureable objectives that clearly relate to the particular GBV activities being implemented in a country, community, or region.** Additional mapping exercises of resources and GBV risk should be undertaken (ideally via a coordinated effort between UNHCR and HIAS in the east and UNHCR and CARE in the south). The GBV Prevention Indicator Compendium (Annex IV) includes examples of indicators that could be used to measure progress against these objectives.

- **PRM and UNHCR should request that CARE, HIAS, ADES, APLFT, and camp health partners collaborate to administer a survey** (in light of their extensive access to different community members) to gather information about types of abuse, knowledge about GBV, and locations in the community that are not safe. PRM and UNHCR should support the administration of the survey, and findings should be used to inform programming.

- **PRM/Washington and PRM/N'Djamena should consider providing specific resources to UNHCR and NGO implementers for program evaluation, particularly in the case of short-term funding, which is a challenge with respect to assessing effectiveness.** Dedicated funding to support evaluation designs that are implemented across the lifespan of programs and capable of assessing attribution and change over time are preferred to final evaluations that are conducted only at the end of the program period and often draw insufficient conclusions.

Recommendations for Implementers

- **NGO implementers should seek consistent, quarterly consultation with PRM/Washington and PRM/N'Djamena, as well as with public health experts based in Chad such as representatives from WHO or the Red Cross of Chad, regarding the collection of GBV-related information that will be useful in risk mapping and understanding GBV as it is experienced by refugee populations.** For example, a confidential survey that conforms to standard research guidelines and best practices could be administered to a representative sample of refugees. By developing a set of standard "risk-mapping indicators," PRM could standardize risk-mapping protocols across country programs for learning and program improvement.

Evaluation Question 3

Although HIAS and the other implementers have made considerable progress in addressing the GBV "knowledge gap," GBV prevention requires the transformation of socio-cultural norms in gender relations—a lengthy process of deepening inquiry and discussion over time. Little is known about the actual changes in knowledge, attitudes, and behaviors that have occurred due to the GBV prevention efforts of NGO implementers in Chad thus far.

Recommendations for PRM

- **PRM/Washington should convene a working group that aims to create and implement a five-year plan across all GBV prevention programming.** It became clear to the evaluation team that such a framework would be a welcomed initiative to all stakeholders in Chad. The framework should include: standardization of GBV definitions in accordance with IASC guidelines; plans for a baseline study to characterize types of GBV and their incidence and prevalence; exploration of possible research projects in partnership with UNHCR and NGO implementers to conduct in-depth examination of certain issues; and technical support and/or collaboration with M&E specialists to improve the development and reporting of GBV indicators.

- **PRM should make a concerted effort to develop and share a common understanding of what is meant by GBV prevention programming** and ensure that NGO implementers funded by PRM are clear about prevention programming approaches.

- **PRM should support the identification and dissemination of validated tools for measuring the impact of GBV primary prevention programs on changing social norms that legitimize GBV.** Appropriate tools could include mapping risks of GBV, mapping networks of influential individuals and groups to engage in changing norms that legitimize GBV, and tools to measure individual and community readiness for change in humanitarian settings.

- **PRM, in coordination with UNHCR, should provide NGO implementers with training and resources to address social norms that legitimize GBV.** NGO staff and community members, including service providers across diverse sectors in humanitarian settings, require additional training and resources to build their capacity to understand norms in the community and develop the skills to discuss and challenge those norms with influential individuals and groups.

Recommendations for Implementers

- **NGO implementers should design, implement, and evaluate GBV primary prevention programs from a social norms perspective.** Changing norms that legitimize GBV requires the collaboration of service providers across diverse sectors (e.g. health, protection, psychosocial, and livelihoods) to successfully engage influential individuals (e.g. husbands, religious leaders, youth, mother-in-laws, etc.) and groups (e.g. traditional leaders, religious leaders, peer groups) in identifying, discussing, and challenging social norms that legitimize GBV.

- **UNHCR and NGO implementers should conduct research among DV survivors** about their interest in, and support for, their husbands/partners to receive counseling and rehabilitation support.

Evaluation Question 4

NGO implementers are struggling with M&E, and the evaluation team was not able to effectively demonstrate GBV prevention program outcomes or learn from PRM-funded programs. In particular, the absence of standardized indicators used across PRM's implementing partners prevents PRM from learning about the overarching outcomes of the GBV prevention initiatives that it funds.

Recommendations for PRM

- **PRM should develop an internal results-based management system** to support the implementation of its Functional Bureau Strategy, including a logic model that demonstrates the sequence of cause-and-effect relationships between activities, outputs, outcomes, and goals. The logic model could explicitly cover GBV prevention programs, or the logic model could demonstrate how GBV prevention should be integrated into all PRM interventions.[20]

- **PRM, in consultation with UNHCR, should disseminate required GBV M&E methodologies to NGO implementers.** Required M&E methodologies should allow flexibility related to context while supporting the need for standardization of GBV indicators, timeframes, tracking of unintended positive and negative consequences, and staff accountability in humanitarian settings. Use of common M&E methodologies—including standardized indicators[21]—will enable PRM to make comparisons across settings about the impact of GBV prevention programs, thereby providing monitoring data for PRM's internal results-based management system.

Recommendations for Implementers

- **UNHCR and NGO implementers should work with health partners to monitor the incidence and degree of FGM among patients** by designing a monitoring tool to record incidences and types of FGM that present during medical examinations and deliveries. The form should record the age of the patient as well as the date at which she arrived in the camp. Additional questions about when and how the circumcision took place and who was involved might also be presented during a follow-up visit or counseling session.

- **UNHCR and NGO implementers should work with schools** to monitor the age of girls attending, age of female drop-outs, and prevalence of girls attending school who are married and/or have young children.

Evaluation Question 5

Recommendations

- **UNHCR and NGO implementers should investigate the reportedly overwhelming trend of DV cases being resolved at the family or community level (rather than by means of local legal systems)**. The assessment would require a careful, systematic, and confidential analysis of the outcomes of previous DV cases, primarily from the point of view of survivors; a review of existing GBV social awareness campaign curricula and messaging goals; and a review of GBV counseling protocols and referral networks. The assessment would fulfill the goals below:
    1. Ascertain whether or not the current trend of DV cases being resolved at the family and community level rather than via legal remedies is harmful to DV survivors.

[20] DoS institutional resources include Managing for Results: Department of State Project Design Guidebook (October 2012) and Performance Management Guidebook: Resources, Tips, and Tools (December 2011).
[21] The GBV Prevention Indicator Compendium (Annex IV) includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation.

2. Identify whether or not the existing PRM-funded GBV awareness campaign messages adequately and/or appropriately emphasize legal channels for addressing incidents of DV in particular and GBV cases in general.

- **PRM, UNHCR, and NGO implementers are encouraged to view the positive trend of an increased desire for prolonged education and improved quality of education (among girls, women, and boys in refugee communities) as a strategic "window of opportunity."** Measures that would help to meet needs in this area include: provision of additional schools for refugees; increased teacher pay (at least to subsistence levels); fully operational and equipped school-based childcare facilities in each camp; and increased teacher training and curriculum strengthening. Additional PRM funding is essential to take advantage of this strategic opportunity to improve education levels for women and girls, which will offer many positive multiplier effects to improve the lives of girls, women, and their families.

Evaluation Question 6

In general, the occurrence of unintended program consequences was the result of not thinking through possible negative or positive consequences beforehand. Several specific contextual factors were identified as contributing to unexpected program outcomes.

Recommendations for Implementers

- **UNHCR is encouraged to work with NGO partners and refugee committee leaders to ensure that roles and responsibilities for GBV prevention are not duplicated.** UNHCR and NGO implementers would benefit from streamlining their referral and counseling systems to eliminate existing duplication among partners and committees, as it may be diluting the integrity and effectiveness of counseling efforts, as well as increasing the possibility of breaches of confidentiality. Partners should also work together to develop a more refined protocol for survivor follow-up after cases have been closed.

- **UNHCR and NGO partners are encouraged to conduct long-term analyses of, and planning for, possible negative consequences of program activities** by conducting an assessment that explores each of the barriers and challenges that were identified in the Evidence and Findings section of this report. Such an assessment could be used as a baseline for continued monitoring of the most concerning consequences or barriers.

- **UNHCR and NGO implementers should review and refine psychosocial counseling protocols**, which may not be adequately survivor-centered, to ensure that practices reflect international standards and to better support survivors of GBV.

- **UNHCR and NGO partners should explore the formation of age-specific, male-only support groups for men and boys to further acknowledge the existence of, prevent, and address GBV perpetrated against males.**

Evaluation Question 7

UNHCR and NGO implementers are struggling to measure the outcomes of all programs and activities. A particular challenge that UNHCR and NGOs are facing with regard to developing indicators to measure and monitor outcomes of GBV awareness-raising activities is the widespread perception among both

implementers and beneficiaries that they are already able to identify these outcomes. The overarching lack of exposure to and training in M&E practices and principles places NGO staff, in particular, at a disadvantage in conceptualizing how they might identify outcome-level results using different and more accurate methods than the anecdotal and perceptions-based approaches they currently employ.

Recommendations

- **PRM should encourage UNHCR to work with NGO implementers to build capacity in required M&E methodologies.** NGO implementers are using multiple methods for M&E as well as diverse GBV indicators within and across countries. M&E capacity building workshops would provide NGO staff with increased understanding of required M&E methodologies and important tools to collect and report evidence about the successes of GBV prevention programs in humanitarian settings.

- **PRM should require NGO implementers to develop logic models** that link program goals to specific indicators and data collection methods (at the process, output, and outcome levels) as part of all proposals for funding.

- **PRM should require all NGO implementers to report quarterly and/or annually** on all indicators specified in logic models, including on outcome measures.

- **UNHCR and NGO implementers should dedicate time to internal staff trainings in basic M&E** as well as the development of indicators for outcome monitoring.

- **PRM, UNHCR, and NGO implementers should work together to utilize information collected for M&E purposes to inform routine program management and decision-making.**

Evaluation Question 8

Like all sensitive topics, exploring and questioning traditional norms associated with femininity and masculinity is a difficult endeavor and must be carried out with thoughtful planning and within a culturally respectful environment. UNHCR and NGO implementers are encouraged to continue working on and bolstering this particular aspect of their GBV prevention programming—applying the proven, effective methods they have used to address other sensitive topics such as FGM and forced marriage.

Recommendations for Implementers

- **UNHCR and NGO implementers should increase discussions and questioning of traditional norms associated with femininity and masculinity within their GBV prevention awareness campaigns—while at the same time reinforcing positive masculine behavior that decreases GBV within the refugee community.** For instance, sensitization theater groups could expand their skits to include messages that suggest ways men can decrease GBV incidents toward women (e.g., taking on the role of collecting firewood, given that GBV assaults are common during this task, which requires women to walk long distances away from the refugee camps).

- **UNHCR and NGO implementers are encouraged to develop engagement strategies that emphasize men as part of the solution.** Strategies should focus on the use of positive messaging to encourage men and boys to develop their potential to act as agents of change. GBV prevention programming should be tailored to each community context and engage men and

boys where they congregate. For example, groups of young men who have been trained in GBV prevention messaging could meet with other men at local places of congregation to discuss the negative impacts of alcohol on domestic relations. This male-to-male strategy of changing social norms has been implemented successfully in regions of Zambia and South Africa.

- **UNHCR and NGO implementers should integrate alcoholism prevention efforts and recovery support systems within the camps**, given that alcohol abuse is one of the primary factors that has been found to contribute to and exacerbate DV. NGO implementers should fully and consistently integrate messages regarding the negative impact of alcoholism on GBV prevalence as an integral part of GBV awareness campaign activities.

- **NGO implementers should create a safe place within each refugee community where men and boys feel they can discuss sensitive issues and reveal their anxieties and vulnerabilities.** Effective programs engage both males and females in separate age-appropriate groups with same-sex facilitators.

- **UNHCR and NGO implementers are encouraged to work toward providing refugee men and boys access to specially-designed assistance programs** to meet their needs when they have experienced sexual violence, DV, or any other form of GBV.

Evaluation Question 9

To assess the short- and long-term outcomes of PRM-funded GBV prevention programming, it is important to reflect upon DoS/PRM's mission: "provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world." The scope of this evaluation includes projects carried out during FY 2010-2012; as such, long-term outcomes cannot yet be assessed. However, the work of UNHCR and the NGO implementers assessed in this evaluation has been instrumental in ensuring that PRM achieves its humanitarian objectives and fulfills its mandate. Through PRM's funding of these programs, critical gaps in assistance to refugees in Chad pertaining to GBV prevention in humanitarian assistance and protection programs have been filled. Given that large numbers of new refugees are continually streaming into Chad from CAR and Sudan, the need for a sustained and expanded GBV programming effort becomes even more urgent.

PRM, UNHCR, and NGO implementers should work together to accomplish the recommendations below. Given that PRM is already the largest donor to UNHCR and the most active donor in eastern Chad, additional funding may not be available to implement all recommendations. As such, efforts should be made to work closely with other donors and UN agencies with similar or complementary mandates to improve GBV prevention programming.

Recommendations for PRM

- **PRM should encourage UNHCR and NGO partners to diversify GBV prevention activities** and greatly expand their use of multi-media strategies, discussion groups with men counseling men, and work with positive deviants as counselors and spokespeople for FGM prevention.
- **PRM is encouraged to consider offering a funding cycle of three to five years, recognizing that socio-cultural change requires time and comprehensive, careful planning by NGO implementers.**

- **PRM should encourage UNHCR and implementing partners to introduce a focus on traditional power imbalances and traditional gender roles as another theme of GBV awareness and prevention.**
- **PRM should encourage UNHCR and implementing partners to consider an increased focus on human rights within existing GBV awareness campaigns.** For example, all education-based programs should teach students about human rights and the connection between human rights and preventing GBV.
- **PRM should encourage UNHCR and NGO partners to address other types of GBV rarely mentioned** (e.g., survival sex, sodomy, male victims of GBV, abortion, infanticide) in their existing prevention programs.
- **PRM should encourage UNHCR and NGO implementers to greatly expand income-generating opportunities for refugee communities.** Models such as the microcredit programs that are currently in place provide continued focus on strategies for self-reliance, especially for girls and women at risk of GBV. If funds are not available from PRM, UNHCR and its partners should collaborate with other donors that focus on livelihoods to increase the GBV prevention aspects of these activities.
- **All PRM- and UNHCR-funded partners implementing GBV prevention activities should routinely collect confidential feedback from survivors about their levels of satisfaction and perceptions about quality of treatment and services received.** This kind of information could also be built into PRM's requests for monitoring data from grantees on a quarterly basis.

Recommendations for UNHCR

- **Working collaboratively with PRM, UNHCR should develop a set of standardized counseling and mediation protocols that all implementing partners should be responsible for following, which should help to improve the outcomes of treatment activities.** Given the importance of timeliness and confidentiality for counseling, UNHCR staff should provide close oversight of protocol use during weekly NGO coordination meetings. PRM and UNHCR could also request that partners monitor their own use of these protocols and provide explanations in quarterly reports about any instances in which they were unable to follow them. Such protocols could also be built into a checklist form or tool for partners, which could help to encourage their use.
- **A standardized treatment checklist should be designed and overseen by UNHCR to ensure that every survivor is offered and provided a comprehensive package of services including medical, psychosocial, legal, and economic enhancement opportunities.** PRM, in collaboration with UNHCR and/or implementing partners, could design the form and require its application as a routine monitoring tool that is submitted by grantees with quarterly reports.
- **UNHCR and its partners are encouraged to advocate for a more active presence of United Nations Population Fund (UNFPA) in Chad to support a stronger family planning focus in all GBV awareness activities.** PRM should emphasize the importance of implementing partners and UNHCR working closely with UNFPA, where possible, to incorporate a much stronger family planning focus in all GBV awareness campaigns, activities, and outreach.
- **Given the frequent arrival of new refugees into many of the camps, UNHCR should ensure continued and expanded work on GBV prevention to sustain current results and specifically target new arrivals.**

ANNEXES

Annex I: Evaluation Statement of Work

STATEMENT OF WORK

U.S. Department of State
Bureau of Population, Refugees and Migration

Evaluating the Effectiveness of Gender-Based Violence (GBV) Prevention Programs with Refugees in Chad, Malaysia, and Uganda

NATURE AND PURPOSE

The purpose of this solicitation is to obtain the services of a contractor to carry out an evaluation, lasting up to 12 months, of Gender Based Violence (GBV) programs supported either directly by the Bureau of Population, Refugees and Migration (PRM) or indirectly through one of its multilateral partners, the United Nations High Commissioner for Refugees (UNHCR) in targeted countries. The evaluation will consist of: (1) a comprehensive desk review and analysis of GBV program reporting by PRM and UNHCR; and (2) field-based evaluations in three countries (Chad, Malaysia, and Uganda) where PRM and UNHCR support GBV prevention programming. Both the desk review and the field-based evaluations should prioritize identifying: (1) the effectiveness of GBV prevention programming; (2) appropriate indicators for measuring the effectiveness of GBV prevention interventions in refugee settings and (3) best practices and lessons learned in engaging men and boys in GBV prevention interventions in refugee settings. Evaluation recommendations should include guidance that PRM can consider when: (1) writing requests for GBV proposals; (2) when reviewing GBV proposals; (3) monitoring GBV programs in the field; and (4) engaging host governments, International Organizations (IOs), and Non-Governmental Organizations (NGOs) on GBV issues. The contractor will coordinate with PRM, UNHCR, and NGOs.

BACKGROUND

PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world on behalf of the American people by providing life-sustaining assistance, working through multilateral systems to build global partnerships, promoting best practices in humanitarian response, and ensuring that humanitarian principles are thoroughly integrated into U.S. foreign and national security policy. PRM is the largest bilateral funder to UNHCR and other multilateral humanitarian responders. PRM funds NGOs to fill critical gaps in programming by UNHCR and host governments.

Preventing and responding to GBV in refugee settings is a PRM priority. PRM's Multilateral Coordination and External Relations (MCE) Office oversees PRM-supported GBV prevention and response activities. Prior to FY 2010, MCE maintained a central pot of funding for GBV prevention/response programs. On an annual basis, MCE would issue a Request for Proposals (RFP) through which NGOs could apply for any region with PRM populations of concern. After FY 2010, MCE instead made the majority of these funds available to regional PRM offices, reserving only a small amount of central funding to promote research, capacity-building, and innovation concerning GBV prevention/response in humanitarian settings. For this reason, the scope of the evaluation will be projects carried out between FY 2010 to the present.

MCE is the main source of expertise on GBV related issues for the Bureau, complemented by technical assistance from USG partners such as the Centers for Disease Control and Prevention's International Emergency and Refugee Health Branch (CDC/IERHB) and the United States Agency for International Development's Office of Foreign Disaster Assistance (USAID/OFDA).

There seems to be an inherent challenge in measuring the impact of GBV programs, particularly where prevention activities are concerned. In a humanitarian context especially, GBV interventions tend to focus on health, legal and psychosocial *response* activities, given the urgency of the situation, funding constraints by donors (PRM generally funds activities 12 months at a time, for example), and the ability to measure impact more quickly, while the understanding of how to best support and measure the impact of GBV prevention activities in humanitarian contexts continues to be a challenge. As part of GBV prevention, PRM has raised the importance of determining how best to engage men and boys to reduce gender inequalities and prevent violence through questioning traditional norms associated with femininity and masculinity, and reinforcing positive masculine behavior, rather than behaviors that harm women. Although more has been done in the development context on this issue, the humanitarian community still has much to learn in identifying best practices on engaging men and boys in GBV programming. Strong monitoring and evaluation contributes to the identification of best practices that can be promoted in future GBV prevention and response programs, and we hope that this evaluation will identify appropriate indicators for measuring the effectiveness of GBV prevention interventions, as well as best practices on engaging men and boys in GBV prevention interventions in humanitarian settings. In addition to best practices, we should learn from mistakes that we and our partners have made so they are not repeated.

Monitoring the performance of PRM partners is a responsibility shared by MCE, regional offices, PRP and PRM's Regional Refugee Coordinators based at embassies throughout the world. The Bureau's Office of Policy and Resource Planning (PRP) will oversee administration of the evaluation and be the primary point of contact. Upon award, PRP will work closely with the contractor for the duration of the evaluation. In accordance with the standards of good management and performance-based results, the contractor will be held accountable for cost, schedule, and performance results.

SCOPE OF WORK

The contractor will:

- Conduct a comprehensive desk review and analysis of selected NGO GBV projects supported by PRM and UNHCR between FY 2010-2012 with an emphasis on measuring the effectiveness of prevention interventions.
- Carry out field-based evaluations in three countries where both PRM and UNHCR fund GBV prevention programs with refugee populations. For this study, the research sites would include refugee camps in eastern Chad, refugees living in settlements in western Uganda, and neighborhoods with high concentrations of urban refugees in Kuala Lumpur, Malaysia.
- The evaluations should answer the following questions, with an emphasis on developing best practices, lessons learned, and actionable recommendations that can inform PRM supported GBV programming in the future.
    - Did partners achieve the program activities defined in their project proposals? What were the barriers and facilitators to implementing program activities?

- Were the objectives of the program based on evidence such as needs assessments or other forms of data? Were they realistic, measureable objectives? If not, how can the objectives be improved?
- Did the GBV programming conform w/ internationally accepted GBV guidelines produced by the humanitarian community? Relevant guidelines include: (1) IASC Guidelines for GBV in Humanitarian Settings; (2) UNHCR Handbook for the Protection of Refugee Women; (3) UNHCR Guidelines on the Protection of Refugee Children; (4) GBV AoR Handbook for Coordinating GBV Interventions in Humanitarian Settings; and (5) IASC Gender Handbook in Humanitarian Action.
- Are the indicators in the above guidance documents (where available) appropriate for measuring the outcomes of PRM funded GBV prevention programs? Are the indicators in the project proposals Specific, Measurable, Achievable, Realistic or Timely? How can proposal indicators be improved? Do indicators from the above guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and for what reasons?
- Were there any unexpected negative or positive consequences of PRM funded GBV programs? Did organizations address negative consequences and how?
- What factors explain intended and unintended negative or positive consequences?
- What outcomes did GBV awareness campaigns achieve? Are the indicators for these programs specific, measurable, achievable, realistic or timely? How can indicators be improved for GBV awareness campaigns?
- To what extent have men and boys been included in GBV prevention programs? If they were not included, why was this? If they were, what was the impact and how was it measured?
- What were the short and long term outcomes of PRM funded GBV prevention programs?

Fieldwork Component: Chad

- **Agence Sociale pour le Développement et Education (ADES):** ADES is a local NGO that has been operational in refugee camps in eastern Chad since 2005. It is operational in the Am Nabak, Touloum, Iridimi, and Oure Cassoni camps and conducts GBV prevention and response in Oure Cassoni camp. In each of these camps, ADES implements multi-sectoral programming that includes a variety of activities such as livelihoods promotion, environmental protection, shelter construction and maintenance, child protection, and information dissemination. ADES works closely with UNHCR, refugee groups, and other NGOs to implement these activities.

- **CARE International (CARE):** CARE is an international NGO and UNHCR implementing partner in the Am Nabak, Touloum, and Iridimi refugee camps. In these camps, CARE is responsible for providing services to groups identified as having specific needs. In addition, CARE works closely with UNHCR as well as local and international NGOs to

protect children and adolescents from abuse and exploitation. *Update: CARE is now working in the southern camps for Central African refugees only.*

- **Hebrew Immigrant Aid Society (HIAS):** HIAS maintains an advocacy network and community-based referral system to identify and prevent GBV and sexual exploitation and abuse; respond to sexual and intimate partner violence by providing psychosocial support to survivors; and encourage women's and girls' self-reliance, leadership, and decision-making ability in 11 of the 12 camps for Darfuri refugees in eastern Chad. In order to do so, HIAS partners with local radio stations and refugee groups. HIAS also works closely with UNHCR, governmental authorities, and international and local NGOs.

Annex II: Data Collection Instrument

Chad Evaluation Questions Numbered for Coding of Interviews
General/background questions to start interview
PRM/RRC/USG Other/International Org./UNHCR/NGO NGO implementers: 1. How did you become involved in the field of refugee protection? 2. What is the definition of GBV prevention that your organization uses? 3. To UNHCR: What kinds of "code words" are used by the community you work with to imply that someone has experienced GBV? 4. What information do you have about sexual violence/exploitation of men or boys in the communities you work with? 5. What do you know about GBV and gay/transgender members of the community? 6. Please provide a brief overview of the GBV prevention programming your organization supports. 7. What is your experience working on GBV either in the refugee community or otherwise? 8. What are the most critical aspects of GBV among refugees in Chad? 9. What do you know about the refugee situation in Chad? PRM's work with refugees in Chad?
Direct beneficiaries/Indirect beneficiaries/Community leaders: 10. How long have you been in Chad? 11. Are you a member of a community group or NGO committee? 12. How long have you been a participant in this program?
Evaluation Directive 1: Effectiveness of GBV Prevention Programming for Individuals and Communities at Risk – findings, best practices, lessons learned
Evaluation Question 1a: Did partners achieve the program activities defined in their project proposals?
PRM/(DC): **1.a.1** What are the main GBV prevention and treatment activities your NGO implementers have proposed to carry out this fiscal year with PRM funding? **1.a.2** Are your NGO implementers on track to achieve their proposed activities? **1.a.3** How do you determine whether or not your NGO implementers have achieved the activities defined in their proposals? **1.a.4** Were there any changes to planned activities? If so, what were the changes? **1.a.5** How were you informed about these changes? **1.a.6** How did/have the changes affect program success/achievements?
PRM/RRC NDJ: **1.a.7** What are the main GBV prevention and treatment activities your NGO implementers have proposed to carry out this fiscal year with PRM funding? **1.a.8** Are your NGO implementers on track to achieve their proposed activities? **1.a.9** How do you determine whether or not your NGO implementers have achieved the activities defined in their proposals? **1.a.10** Were there any changes to planned activities? If so, what were the changes? **1.a.11** How were you informed about these changes? **1.a.12** How did/have the changes affect program success/achievements?
UNHCR: **1.a.13** What are the main GBV prevention and treatment activities your NGO implementers have proposed to carry out this fiscal year with PRM funding? **1.a.14** Are your NGO implementers on track to achieve their proposed activities? **1.a.15** How do you determine whether or not your NGO implementers have achieved the activities

defined in their proposals?
1.a.16 Were there any changes to planned activities? If so, what were the changes?
1.a.17 How were you informed about these changes?
1.a.18 How did/have the changes affect program success/achievements?

NGO implementers (HIAS/CARE/ADES):
1.a.19 What are the main GBV prevention and treatment activities you have proposed to carry out this fiscal year with PRM/UNHCR funding?
1.a.20 Are you on track to achieve your proposed activities?
1.a.21 How do you determine whether or not you are making progress toward the achievement of the activities defined in your proposal to PRM/UNHCR?
1.a.22 Have you made any changes to planned activities? If so, what were the changes?
1.a.23 How have you informed UNHCR/PRM about these changes?
1.a.24 How did/have the changes affected the success/achievements of your program?

Direct Beneficiaries:
1.a.25 How did you learn about HIAS/CARE/ADES?
1.a.26 What is your understanding of what this program is/was intended to do?
1.a.27 What types of services do you receive from HIAS/CARE/ADES? (OR) What kind of program did you participate in?
1.a.28 How did the services meet your needs? Are there other services you would like to receive from this program? OR What did you learn from your participation in this program? (GBV Awareness)
1.a.29 How do you think that HIAS/CARE/ADES could improve its services?
1.a.30 How do you think violence against women/girls can be prevented in families/communities? Please give specific examples.
1.a.31 How does this program prevent violence against women/girls? Please give specific examples. Are there specific services received from the program that have helped to prevent violence against women and girls?

International Orgs./CNAAR/DPHR/CSSI/APLFT/Others:
1.a.32 What can you tell us about the challenges refugees in Chad face in terms of GBV?
1.a.33 Are you aware of the programs/services provided by HIAS/CARE/ADES? If yes, what is your understanding of what the program(s) is/are intended to achieve?
1.a.34 How well do you think the program has met the objectives you have identified?

Evaluation Question 1b: What were the barriers to implementing program activities?

PRM/ (DC):
1.b.1 What are some of the challenges to program implementation that you observed among the NGO implementers?
1.b.2 Do you know of instances where your NGO implementers were unable to implement their programs or activities?
1.b.3 Can you provide a specific example of a program that was unable to implement its activities?

PRM/RRC NDJ:
1.b.4 What are some of the challenges to program implementation that you observe among the NGO implementers?
1.b.5 Do you know of instances where your NGO implementers were unable to implement their programs or activities?
1.b.6 Can you provide a specific example of a program that was unable to implement its activities?

UNHCR:
1.b.7 What are some of the challenges to program implementation that you observed among the NGO implementers?

1.b.8 Do you know of instances where your NGO implementers were unable to implement their programs or activities? **1.b.9** Can you provide a specific example of a program that was unable to implement its activities?
NGO implementers (HIAS/CARE/ADES): **1.b.10** Did you experience any difficulties implementing your program activities? Please describe.
Direct Beneficiaries: **1.b.11** Did you experience any difficulties in obtaining services from the program? Describe. **1.b.12** Did you talk to the staff about the problems you were having? **1.b.13** If you told the staff about the problems you were having, how did they respond? **1.b.14** If you did not tell anyone about the problems you were having, why not?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **1.b.15** Are you aware of any difficulties that beneficiaries might have had in accessing the services of HIAS/CARE/ADES?
Evaluation Question 1c: What were the facilitators to implementing program activities?
PRM/(DC): **1.c.1** Can you identify some programs/activities that have been easiest for your NGO implementers to implement? **1.c.2** What aspects of these programs/activities made them easy to implement? **1.c.3** Can you provide a specific example of a factor or characteristic that helped to facilitate program implementation?
PRM/RRC NDJ: **1.c.4** Can you identify some programs/activities that have been easiest for your NGO implementers to implement? **1.c.5** What aspects of these programs/activities made them easy to implement? **1.c.6** Can you provide a specific example of a factor or characteristic that helped to facilitate program implementation?
UNHCR: **1.c.7** Can you identify some programs/activities that have been easiest for your NGO implementers to implement? **1.c.8** What aspects of these programs/activities made them easy to implement? **1.c.9** Can you provide a specific example of a factor or characteristic that helped to facilitate program implementation?
NGO Implementers (HIAS/CARE/ADES): **1.c.10** Which of your activities have been the easiest for you to implement? **1.c.11** What aspects of these activities made them easy to implement? **1.c.12** Can you provide a specific example of a factor or characteristic that helped you implement the activity?
Direct Beneficiaries: **1.c.13** Were there actions taken by (the NGO) to encourage your participation in the program or to make it easier for you to use their services? (Some examples might be providing interpreters, transportation, child care).
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **1.c.14** Are you aware of any actions taken by HIAS/CARE/ADES that have made it easier for program participants to access services? Please describe.

Evaluation Question 2a: Were the program objectives based on evidence such as needs assessments or other forms of data?
PRM/(DC): **2.a.1** How did the NGO implementers develop their program objectives? **2.a.2** What data or information did the NGO implementers consult in the design of their program objectives? **2.a.3** Were the objectives informed by needs assessments? **2.a.4** If needs assessments were conducted, were they conducted specifically for the program or did they already exist? **2.a.5** What evidence exists to substantiate/support the need for the program?
PRM/RRC NDJ: **2.a.6** How did the NGO implementers develop their program objectives? **2.a.7** What data or information did the NGO implementers consult in the design of their program objectives? **2.a.8** Were the objectives informed by needs assessments? **2.a.9** If needs assessments were conducted, were they conducted specifically for the program or did they already exist? **2.a.10** What evidence exists to substantiate/support the need for the program?
UNHCR: **2.a.11** How did the NGO implementers develop their program objectives? **2.a.12** What data or information did the NGO implementers consult in the design of their program objectives? **2.a.13** Were the objectives informed by needs assessments? **2.a.14**If needs assessments were conducted, were they conducted specifically for the program or did they already exist? **2.a.15** What evidence exists to substantiate/support the need for the program? **2.a.16** What kind of work do you think it would be good to expand?
NGO implementers (HIAS/CARE/ADES): **2.a.17** How did you develop your program objectives? **2.a.18** What data or information did you consult in the design of your program objectives? **2.a.19** Did you conduct any needs assessments before designing your program? -If so when? -If so, who was included in your assessment? **2.a.20** Did you include men and boys in your assessment? -If so, how? **2.a.21** What were the major findings of the assessment? **2.a.22** What other forms of information did you use to design your program? **2.a.23** Was the design informed by your prior or ongoing work in this area?
Direct Beneficiaries: **2.a.24** What kinds of problems do you think led HIAS/CARE/ADES to decide to start this program? **2.a.25** Do you know whether HIAS/CARE/ADES conducted any safety or risk mapping for this program? **2.a.26** What types of violence or harm (psychological/emotional/physical) do women/girls face in your community? **2.a.27** What types of violence do boys or men in your community face?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **2.a.28** What types of needs assessments or other analyses were conducted prior to the planning and implementation of this program?

2.a.29 What suggestions would you have about modifying the objectives of the GBV program?

Evaluation Question 2b: Were the objectives realistic and measurable?

PRM/(DC):
2.b.1 Do you think that the objectives are realistic or achievable within the timeframe of the project?
-If so, please provide a specific example?
-If so, do you have information or data that substantiates your position?
2.b.2 Are there indicators in place to measure the objectives?
2.b.3 If so, are the indicators appropriate measures for the objectives?

PMR/RRC NDJ:
2.b.4 Do you think that the objectives are realistic or achievable within the timeframe of the project?
-If so, please provide a specific example?
-If so, do you have information or data that substantiates your position?
2.b.5 Are there indicators in place to measure the objectives?
2.b.6 If so, are the indicators appropriate measures for the objectives?

UNHCR:
2.b.7 Do you think that the objectives are realistic or achievable within the timeframe of the project?
-If so, please provide a specific example?
-If so, do you have information or data that substantiates your position?
2.b.8 Are there indicators in place to measure the objectives?
2.b.9 If so, are the indicators appropriate measures for the objectives?

NGO implementers (HIAS/CARE/ADES):
2.b.10 Do you think you will achieve your program objectives are realistic?
-If so, please explain why.
2.b.11 Do you think that you will achieve your program objectives within the timeframe of your project?
-If so, please provide a specific example.
2.b.12 Do you have any information or data to show your progress to date in achieving your program objectives?
2.b.13 Do you have indicators that you use to measure your progress in achieving your program objectives?
-If so, please provide some examples.

Direct Beneficiaries:
2.b.14 Have you been asked your opinion about whether or not you think the program is effective?
2.b.15 What kind of things do you think would show that the program is working well?
2.b.16 How do you think the staff could tell if the program is working well?

International Orgs./CNAAR/DPHR/CSSI/APLFT/Others:
2.b.17 Do you believe that the objectives of this program relevant to GBV (HIAS/CARE/ADES) were/are realistic and measurable? (Discuss examples).

Evaluation Question 2c: If the objectives were not realistic and measureable, how could they be improved?

PRM/(DC):
2.c.1 Please explain why the objectives are not achievable within the timeframe of the project.
2.c.2 Has the objective always been unrealistic or unachievable, or has there been a change in the project that affected the objective?
2.c.3 Please provide a specific example that demonstrates why/how the objective is unrealistic or unachievable.
Do you have information or data that substantiates your position?
2.c.4 How would you change the objective to make it more realistic or more likely to be achieved within

the timeframe of the project?
2.c.5 What could the grantee do differently to make the objective more realistic or more likely to be achieved?
2.c.6 What other factors would need to change to make the objective more realistic or more likely to be achieved?

PRM/RRC NDJ:
2.c.7 Please explain why the objectives are not achievable within the timeframe of the project.
2.c.8 Has the objective always been unrealistic or unachievable, or has there been a change in the project that affected the objective?
-Please provide a specific example that demonstrates why/how the objective is unrealistic or unachievable.
-Do you have information or data that substantiates your position?
2.c.9 How would you change the objective to make it more realistic or more likely to be achieved within the timeframe of the project?
2.c.10 What could the grantee do differently to make the objective more realistic or more likely to be achieved?
2.c.11 What other factors would need to change to make the objective more realistic or more likely to be achieved?

UNHCR:
2.c.12 Please explain why the objectives are not achievable within the timeframe of the project.
2.c.13 Has the objective always been unrealistic or unachievable, or has there been a change in the project that affected the objective?
-Please provide a specific example that demonstrates why/how the objective is unrealistic or unachievable.
-Do you have information or data that substantiates your position?
2.c.14 How would you change the objective to make it more realistic or more likely to be achieved within the timeframe of the project?
2.c.15 What could the grantee do differently to make the objective more realistic or more likely to be achieved?
2.c.16 What other factors would need to change to make the objective more realistic or more likely to be achieved?

NGO Implementers (HIAS/CARE/ADES):
2.c.17 Please explain why your objective is not achievable within the timeframe of the project.
2.c.18 Has the objective always been unrealistic or unachievable, or has there been a change in the project that affected the objective?
2.c.19 Please provide a specific example that demonstrates why/how the objective is unrealistic or unachievable.
-Do you have information or data that substantiates your position?
2.c.20 How would you change your objective to make it more realistic or more likely to be achieved within the timeframe of the project?
2.c.21 What would you do differently in the future when developing project objectives to better-ensure that they will be realistic and achievable?
2.c.22 What other factors would need to change to make your objective more realistic or more likely to be achieved?

Evaluation Question 3: Did the GBV programming conform to internationally accepted GBV guidelines produced by the humanitarian community?
PRM/ (DC): **3.a.1** Do the activities conform to international GBV guidelines and/or standards? -If so, which ones? -Please provide a specific example. **3.a.2** What guidelines and/or standards are most relevant to your NGO implementers' programs? **3.a.3** Are there activities or aspects of the programs that could better reflect international guidelines and standards? -If so, please provide specific examples. **3.a.4** Are there activities or aspects of the programs that do not conform to international guidelines and standards? -If so, please provide specific examples. **3.a.5** Please provide some suggestions for how the programs could better conform to or reflect international guidelines and/or standards.
PRM/RRC NDJ **3.a.6** Do the activities conform to international GBV guidelines and/or standards? -If so, which ones? -Please provide a specific example. **3.a.7** What guidelines and/or standards are most relevant to your NGO implementers' programs? **3.a.8** Are there activities or aspects of the programs that could better reflect international guidelines and standards? -If so, please provide specific examples. **3.a.9** Are there activities or aspects of the programs that do not conform to international guidelines and standards? -If so, please provide specific examples. **3.a.10** Please provide some suggestions for how the programs could better conform to or reflect international guidelines and/or standards.
UNHCR: **3.a.11** Do your NGO implementers' activities conform to international GBV guidelines and/or standards? -If so, which ones? -Please provide a specific example. **3.a.12** What guidelines and/or standards are most relevant to your NGO implementers' programs? **3.a.13** Are there activities or aspects of the programs that could better reflect international guidelines and standards? -If so, please provide specific examples. **3.a.14** Are there activities or aspects of the programs that do not conform to international guidelines and standards? -If so, please provide specific examples. **3.a.15** Please provide some suggestions for how the programs could better conform to or reflect international guidelines and/or standards. **3.a.16** Which are most relevant in terms of your own guidelines?
NGO implementers (HIAS/CARE/ADES): **3.a.17** Are you aware of any international standards or guidelines that are related to your work? **3.a.18** What guidelines or standards are most relevant to your program? **3.a.19** Are there activities or aspects of your program that do not conform to international guidelines and standards? **3.a.20** Do you have ideas about how your program could better conform to or reflect international

guidelines and/or standards?

3.a.21 In what ways did you consider international GBV guidelines or standards when you were developing your program activities?

<u>Direct Beneficiaries:</u>

3.a.22 Do you believe that the program follows national and/or international standards? For example, if you told someone on the staff in the program something personal, do you trust them not to tell anyone else in your community? Do think they treat people who come to them with respect? If so, please give some examples. Do you think they understand the needs that you or others have? What kind of ways do they show that they understand your needs?

3.a.23 In your opinion, has the program helped to prevent violence against women and girls?

3.a.24 Has the program resulted in better services for women and girls who have experienced violence?

<u>International Orgs./CNAAR/DPRH/CSSI/APLFT/Others:</u>

3.a.25 Did participants have confidence in the programs because they followed national and/or international standards? Can you give examples of standards that you think the program meets?

3.a.26 In your opinion, did the GBV program implemented by HIAS/CARE/ADES improve prevention and response to GBV over time? Did the programs develop standards to support their activities?

Evaluation Question 5: Were there any unexpected negative or positive consequences of PRM-funded GBV programs? Did organizations address negative consequences and if so, how?

<u>PRM/ (DC):</u>

5.a.1 Are you aware of any negative outcomes of the project?
-If so, please provide a specific example.
-If so, how have you addressed them? How has the grantee addressed them?
-Has the grantee done anything to mitigate or prevent the outcome from happening again in the future?
-What do you think can be done differently to prevent negative outcomes in the future?

5.a.2 Did the project produce any positive outcomes that were not planned or expected?
-If so, please provide a specific example.
-What have you done to replicate this outcome?
-Has your grantee taken any action to replicate this outcome?

<u>PRM/RRC NDJ:</u>

5.a.3 Are you aware of any negative outcomes of the project?
-If so, please provide a specific example.
-If so, how have you addressed them? How has the grantee addressed them?
-Has the grantee done anything to mitigate or prevent the outcome from happening again in the future?
-What do you think can be done differently to prevent negative outcomes in the future?

5.a.4 Did the project produce any positive outcomes that were not planned or expected?
-If so, please provide a specific example.
-What have you done to replicate this outcome?
-Has your grantee taken any action to replicate this outcome?

<u>UNHCR:</u>

5.a.5 Are you aware of any negative outcomes of the project?
-If so, please provide a specific example.
-If so, how have you addressed them? How has the grantee addressed them?
-Has the grantee done anything to mitigate or prevent the outcome from happening again in the future?
-What do you think can be done differently to prevent negative outcomes in the future?

5.a.6 Did the project produce any positive outcomes that were not planned or expected?
-If so, please provide a specific example.
-What have you done to replicate this outcome?

-Has your grantee taken any action to replicate this outcome?
NGO implementers (HIAS/CARE/ADES): **5.a.7** Are you aware of any negative outcomes of your project? -If so, please provide a specific example. -If so, how have you addressed them? How has the grantee addressed them? -Have you or your grantee done anything to mitigate or prevent the outcome from happening again in the future? -What do you think can be done differently to prevent negative outcomes in the future? **5.a.8** Did the project produce any positive outcomes that were not planned or expected? -If so, please provide a specific example. -What have you done to replicate this outcome? -Has your grantee taken any action to replicate this outcome?
Direct Beneficiaries: **5.a.9** Have you had any negative (bad) experiences due to your participation in the program? (Please describe in detail). Did you make the organization/program staff aware of your experience? If so, how did they respond? How do you feel about how they responded? If you didn't tell anyone about your bad experience, why not? Has anyone asked you if you have experienced anything negative (bad) as the result of your participation in the program? **5.a.10** Were there any unexpected positive (good) things that happened as the result of your participation in the program?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **5.a.11** Were there any unexpected negative consequences of the PRM-funded GBV program? Did the organization address negative consequences? If so, to what extent and how? **5.a.12** Did you observe any unexpected positive consequences of the planning, implementation, or evaluation of the program? (Describe.)Did you observe any unexpected positive consequences of the planning, implementation, or evaluation of the program? (Describe.)
Evaluation Question 6: What factors explain any negative or unintended positive consequences?
PRM/ (DC): **6.a.1** Why do you think the project experienced positive outcomes that were not originally planned? (What caused the positive outcomes)? **6.a.2**Why do you think the project experienced negative outcomes? (What caused the negative outcomes)?
PRM/ RRC NDJ: **6.a.3** Why do you think the project experienced positive outcomes that were not originally planned? (What caused the positive outcomes)? **6.a.4** Why do you think the project experienced negative outcomes? (What caused the negative outcomes)?
UNHCR: **6.a.5** Why do you think the project experienced positive outcomes that were not originally planned? (What caused the positive outcomes)? **6.a.6** Why do you think the project experienced negative outcomes? (What caused the negative outcomes)?
NGO implementers (HIAS/CARE/ADES): **6.a.7** Why do you think your project produced positive outcomes that were not originally expected or planned?

(What do you think caused these positive outcomes)? **6.a.8** Why do you think your project produced negative outcomes? (What do you think cased these negative outcomes)?
Direct Beneficiaries: **6.a.9** You said that you did not expect ____ to happen. Why do you think that it happened?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **6.a.10 and 6.a.11** Describe your observations of the factors that influenced or caused either unexpected negative consequences or unintended positive consequences.
Evaluation Question 7a: What outcomes did GBV awareness campaigns achieve?
PRM/ (DC): **7.a.1** Among the NGO implementers/programs that conducted GBV awareness campaigns, what were the results and achievements? **7.a..**Do you have specific information or data to demonstrate the achievement? **7.a.3**Do the outcomes match your expectations? Please explain why or why not. **7.a.4** Do you think the outcomes are sustainable? **7.a.5** How could awareness campaigns be improved?
PRM/RRC NDJ: **7.a.6** Among the NGO implementers/programs that conducted GBV awareness campaigns, what were the results and achievements? **7.a.7** Do you have specific information or data to demonstrate the achievement? **7.a.8** Do the outcomes match your expectations? Please explain why or why not. **7.a.9** Do you think the outcomes are sustainable? **7.a.10** How could awareness campaigns be improved?
UNHCR: **7.a.11** Among the NGO implementers/programs that conducted GBV awareness campaigns, what were the results and achievements? **7.a.12**Do you have specific information or data to demonstrate the achievement? **7.a.13** Do the outcomes match your expectations? Please explain why or why not. **7.a.14** Do you think the outcomes are sustainable? **7.a.15** How could awareness campaigns be improved?
NGO Implementers (HIAS/CARE/ADES): **7.a.17** Among the NGO implementers/programs that conducted GBV awareness campaigns, what were the results and achievements? **7.a.18** Do you have specific information or data to demonstrate the achievement? **7.a.19** Do the outcomes match your expectations? Please explain why or why not. **7.a.20** Do you think the outcomes are sustainable? **7.a.21** How could awareness campaigns be improved?
Direct Beneficiaries: **7.a.22** Describe how your awareness about violence against women and girls was affected by participating in this program. Did your awareness result in any changes in your life? (Describe in detail.) **7.a.23** Do you think that increased awareness of violence against women and girls has resulted in any changes in the behavior of others (family members, community members including neighbors, police, military, others)? Has there been a reduction of violence, improved healthcare access, increased prosecution of cases. Improved protection as the result of the awareness-raising or other programs? **7.a.24** What other things do you think have changed as the result of more awareness about

violence against women and girls?
7.a.25 How do you know there has been a change?
7.a.26 What would you suggest to improve awareness campaigns about violence against women and girls in the future?
7.a.27 How do you think GBV awareness campaigns have influenced men and boys? Please explain.

Community Leaders:
7.a.28 Describe how your awareness about violence against women and girls was affected by participating in this program. Did your awareness result in any changes in your life? (Describe in detail.)
7.a.29 Do you think that increased awareness of violence against women and girls has resulted in any changes in the behavior of others (family members, community members including neighbors, police, military, others)?
7.a.30 How did your participation in this program assist you and your family you're your immediate needs (safety, health, protection)?
7.a.31 How did participation help you and your family over time? Have you continued to receive services, follow-up care, and support? (Or, for GBV Awareness Programs: Has there been any follow-up to the training you received?
7.a.32 What other things do you think have changed as the result of more awareness about violence against women and girls?
7.a.33 How do you know there has been a change?
7.a.34 What would you suggest to improve awareness campaigns about violence against women and girls in the future?
7.a.35 How do you think GBV awareness campaigns have influenced men and boys? Please explain.

International Orgs./CNAAR/DPHR/CSSI/APLFT/Others:
7.a.36 What outcomes do you think GBV awareness campaigns have achieved?(increased safety, reduced violence, improved healthcare for survivors, etc.?)
7.a.37 Do you think the program is likely to continue after funding has ended? If yes, how will the program supported?

Evaluation Question 9: What were the short and long-term outcomes of PRM-funded GBV prevention programs?

PRM/ (DC):
9.a.1 Are there program outcomes that you consider to be short-term versus long-term?
-If so, please explain.

PRM/RRC NDJ:
9.a.2 Are there program outcomes that you consider to be short-term versus long-term?
-If so, please explain.

UNHCR:
9.a.3 Are there program outcomes that you consider to be short-term versus long-term?
-If so, please explain.

NGO Implementers (HIAS/CARE/ADES)
9.a.6 Are there program outcomes that you consider to be short-term versus long-term?
-If so, please explain.

Evaluation Directive 2: Appropriate Indicators for Measuring the Effectiveness for GBV Prevention Interventions in Refugee Settings – findings, best practices, and lessons learned
Evaluation Question 4a: Are the indicators produced by the humanitarian community for GBV programming appropriate for measuring the outcomes of PRM-funded GBV prevention programs?
PRM/ (DC): **4.a.1** Did you provide your NGO implementers with any guidance on how to develop their indicators? **4.a.2** Do you think that the indicators your NGO implementers use are reliable and appropriate measures of project progress? **4.a.3** Are there other indicators you would like your NGO implementers to use? **4.a.4** Are there international indicators for GBV prevention that would be useful for your NGO implementers? **4.a.5** Which of your NGO implementers' indicators are most informative about their projects' progress? **4.a.6** Which of your NGO implementers' indicators are least informative about their projects' progress?
PRM/RRC NDJ: **4.a.7** Did you provide your NGO implementers with any guidance on how to develop their indicators? **4.a.8** Do you think that the indicators your NGO implementers use are reliable and appropriate measures of project progress? **4.a.9** Are there other indicators you would like your NGO implementers to use? **4.a.10** Are there international indicators for GBV prevention that would be useful for your NGO implementers? **4.a.11** Which of your NGO implementers' indicators are most informative about their projects' progress? **4.a.12** Which of your NGO implementers' indicators are least informative about their projects' progress?
UNHRC: **4.a.13** Did you provide your NGO implementers with any guidance on how to develop their indicators? **4.a.14** Do you think that the indicators your NGO implementers use are reliable and appropriate measures of project progress? **4.a.15** Are there other indicators you would like your NGO implementers to use? **4.a.16** Are there international indicators for GBV prevention that would be useful for your NGO implementers? **4.a.17** Which of your NGO implementers' indicators are most informative about their projects' progress? **4.a.18** Which of your NGO implementers' indicators are least informative about their projects' progress? -Please explain why.
NGO Implementers (HIAS/CARE/ADES): **4.a.19** Do you think that the indicators you use are reliable and appropriate measures of project progress? **4.a.20** Are there international indicators for GBV prevention that would be useful for you to use? **4.a.21** Which of your indicators are most informative about your projects' progress? -Please explain why. **4.a.22** Which of your indicators are least informative about your projects' progress? -Please explain why. **4.a.23** How did you decide which indicators to use? **4.a.24** Did you consult any international documents/guidelines/standards when developing your indicators? **4.a.25** Did you receive any guidance on how to develop your indicators? **4.a.26** Is it easy to collect the data you require for tracking your indicator?

4.a.27 Are there other indicators you would like be using that you currently are not using?
Direct Beneficiaries **4.a.28** In your opinion, what has improved in your community because of the GBV programs? Can you give specific examples (reduction of violence, healthcare access, prosecution, protection)?
Evaluation Question 4b: Are the indicators in the project proposal specific, measurable, achievable, realistic, and time-bound (SMART)? (S) Specific –Does it cover one rather than multiple activities? (M) Measurable—Can it be quantified? Can it be counted in some way? (A) Appropriate— Is the objective important to the work we are doing? (R) Realistic—Can the objective be achieved with the resources avail- able? (T) Time-bound—Does the objective give a time frame by which the objective will be achieved?
PRM/ (DC): **4.b.1.** Are you familiar with what a SMART indicator is? **4.b.2.** Please explain whether you think your NGO implementers' indicators are specific, measurable, achievable, realistic, and time-bound. -Please provide a specific example… **4.b.3.** If you do not think that your NGO implementers' indicators are SMART, how could you change/improve them to ensure that they meet these criteria?
PRM/RRC NDJ: **4.b.4** Are you familiar with what a SMART indicator is? **4.b.5** Please explain whether you think your NGO implementers' indicators are specific, measurable, achievable, realistic, and time-bound. -Please provide a specific example… **4.b.6** If you do not think that your NGO implementers' indicators are SMART, how could you change/improve them to ensure that they meet these criteria?
UNHCR: **4.b.7** Are you familiar with what a SMART indicator is? **4.b.8** Please explain whether you think your NGO implementers' indicators are specific, measurable, achievable, realistic, and time-bound. -Please provide a specific example… **4.b.9** If you do not think that your NGO implementers' indicators are SMART, how could you change/improve them to ensure that they meet these criteria?
NGO Implementers (HIAS/CARE/ADES): **4.b.9** Are you familiar with what a SMART indicator is? **4.b.10** Please explain whether you think your NGO implementers' indicators are specific, measurable, achievable, realistic, and time-bound. -Please provide a specific example… **4.b.11** If you do not think that your NGO implementers' indicators are SMART, how could you change/improve them to ensure that they meet these criteria? **4.b.12** How do you determine if your objectives have been reached? **4.b.13** What specific measures (indicators) do you use? **4.b.14** How do you actually measure the above? **4.b.15** Do you think you will be able to achieve (the specific indicators identified above)? **4.b.16** How realistic do you think it is that you achieve the indicators? **4.b.17** What time frame do you have for your indicators?
Direct Beneficiaries: **4.b.18** Do you know how the organization knows if it has achieved its objectives?

4.b.19 Does the organization collect certain information? **4.b.20** How well do you think that information demonstrates the effectiveness of the program?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **4.b.21** Are you aware of the indicators used to measure effectiveness of the programs? **4.b.22** How realistic do you believe these indicators are? **4.b.23** In your opinion, which indicators are most useful for GBV programs?
Evaluation Question 4c: How can proposal indicators be improved?
PRM/ (DC): **4.c.1** How can proposal indicators be improved?
PRM/RRC NDJ: **4.c.2** How can proposal indicators be improved?
UNHCR: **4.c.3** How can proposal indicators be improved?
NGO Implementers (HIAS/CARE/ADES) **4.c.4** How can proposal indicators be improved? **4.c.5** Do you believe the indicators in the guidance documents you utilized are appropriate for measuring the outcome of your program?
Evaluation Question 4d: Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
PRM/ (DC): **4.d.1** Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
PRM/RRC NDJ: **4.d.2** Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
UNHCR: **4.d.3** Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
NGO implementers (HIAS/CARE/ADES) **4.d.4** Do indicators from the GBV guidance documents effectively capture the impact of GBV prevention programs? Are some more useful than others and if so, for what reasons?
Evaluation Question 7b: Are the indicators for GBV awareness campaigns SMART?
PRM/(DC): **7.b.1** Are the indicators for GBV awareness campaigns SMART?
PRM/RRC NDJ: **7.b.1** Are the indicators for GBV awareness campaigns SMART?
UNHCR: **7.b.1** Are the indicators for GBV awareness campaigns SMART?
NGO implementers (HIAS/CARE/ADES) **7.b.1** Are the indicators for GBV awareness campaigns SMART?
Evaluation Directive 3: Best Practices and Lessons Learned in Engaging Men and Boys in GBV Prevention and Response Interventions in Refugee Settings – findings, best practices, lessons learned
Evaluation Question 8a: To what extent have men and boys been included in GBV prevention programs?
PRM/(DC): **8a.1** To what extent have men and boys been included in GBV prevention programs?

PRM/RRC NDJ: **8a.1** To what extent have men and boys been included in GBV prevention programs?
UNHCR: **8a.1** To what extent have men and boys been included in GBV prevention programs?
NGO implementers (HIAS/CARE/ADES): **8a.1** To what extent have men and boys been included in GBV prevention programs?
Direct Beneficiaries: **8a.1** To what extent have men and boys been included in GBV prevention programs?
Indirect Beneficiaries/Community Leaders: **8a.1** To what extent have men and boys been included in GBV prevention programs?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **8a.1** To what extent have men and boys been included in GBV prevention programs?
Evaluation Question 8b: Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
PRM/(DC): **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
PRM/RRC NDJ: **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
UNHCR: **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
NGO implementers (HIAS/CARE/ADES): **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
Direct Beneficiaries: **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
Indirect Beneficiaries/Community Leaders: **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?
International Orgs./CNAAR/DPHR/CSSI/APLFT/Others: **8.b.1** Do the GBV programs address the issue of male survivors of domestic violence or sexual assault? If yes, how?

Key Thematic Evaluation Sub-Questions For PRM, UNHCR, CARE, HIAS, ADES, and other service providers
Indicators: 1. What types of indicators do you utilize to collect data? 2. How often do you collect this data? How is this information utilized? 3. Do you feel the GBV indicators that you utilize are well defined and appropriate to the circumstances and context of the camps you service? Are there any additional indicators that you think should be added?
Confidentiality: 1. Do you feel GBV cases are handled in a confidential manner? How do you achieve confidentiality, and are there processes you would like to see improved? 2. How are you documenting GBV incidences? What kind of GBV incidence forms are utilized, and do you find they an effective mechanism to keep track of cases in a confidential manner? 3. Have you experienced any negative consequences resulting from a lack of confidentiality in service provision? If so, please provide examples. 4. Do you feel that GBV prevention and support activities/processes encourage confidentiality? Do you feel services are survivor-centered?
Sensitization Training: 1. What kind of sensitization training do you provide? 2. Could you share with us the curriculum that you utilize? 3. Do you target specific groups for sensitization training? 4. What topics are included in your sensitization training? Are there any topics that you believe should be added?
Working with Committees 1. Do you systematically include men as part of your committees? If so, what is the male/female representation among the committees you work with? 2. Do you find that having male representation is important? Please explain. 3. Do you have representation of all religious groups within the committees? How important are the religious leaders within the refugee community in terms of changing social norms?
Security in the Camps: 1. Do you feel the general security within the camps that you offer GBV services within is sufficient? If not, please explain how it could be improved. 2. What types of security measure have you found to be effective, i.e., what's working?
GBV Among Men, Boys and GLBT Community: 1. Are you aware of any GBV perpetuated against boys or men in the camps you service? 2. Do you feel the programs implemented adequately deal with GBV perpetuated against men or boys in the camps? 3. Do you provide any targeted support to those who are GLBT within the camps? If so, please explain. If not, are you aware of any GLBT individuals who need special assistance? What kind of assistance might they need that is in addition to, or different from, standard GBV messages/services?
General GBV Questions: 1. What types of GBV occur within the camps you service? 2. When do GBV incidences take place most often (day or night)? 3. Where (geographically) do most GBV incidences take place (water pumps, market places, inside the home, outside the camp while collecting fuel, while walking to school)? If there are specific places that GBV takes place, please explain why this is the case?

4. Who most often commits the act of GBV – persons living within the camp or host community individuals? 5. In your opinion, what do you think are the primary causes of GBV within the refugee communities that you serve?
Legal Framework in Chad: 1. Do you feel the legal framework in Chad is sufficient regarding the issue of GBV? If not, what should be improved? 2. From your experience, do you find that refugees prefer to deal with GBV internally within families or the community or via utilization of Chadian laws? Either way, why is this the case? What are the pros and cons of this social norm/preference? Do refugees differ in their perspectives, i.e., do males and females or older refugees versus the youth have a different perspective regarding legal interventions? 3. Do you feel your programming places adequate attention to the legal framework surrounding GBV? If not, how could it be improved? If so, please explain any positive findings.
Service Provision: 1. What are you most proud of in terms of your accomplishments in servicing refugees with GBV prevention and support activities? 2. Where they any unintended negative consequences to your work on GBV? If so, how did you resolve them? 3. Where there any unintended positive outcomes to your work on GBV? If so, please provide examples. 4. As a service provider, do you have adequate resources (financial and otherwise) to accomplish your goals? If not, what are the roadblocks in terms of resources/support needed to be successful? 5. Do you find that the services providers collaborate well together? If so, what is working well? If not, how can the service providers improve in terms of collaboration?
Key Thematic Evaluation Sub-Questions **For** **Refugee Committee Members and Beneficiaries/Participants**
Training: 1. What kind of GBV training have members of your committee received? 2. Did you find the training content to be of good quality and useful? If not, how could it be improved? 3. How often do you receive GBV training? Is the amount and content sufficient?
Resources: 1. Does your committee have adequate resources to meet your goals/objectives? If not, please explain what is needed to better support your work? 2. What (if any) incentives are you given to carry out your committee work? How important are incentives to the motivation of your committee members? 3. Do you feel you are receiving adequate positive feedback from service providers for your committee work?
Sensitization Campaigns: 1. How do you conduct sensitization training? Please explain the format and levels of involvement in the community. 2. Do you target specific community groups or individuals? If so, who is targeted and how? 3. Is there social stigma attached to being a GBV survivor? If so, is this issue being addressed/improved via GBV sensitization messages? 4. What type of sensitization do you feel works the best in your community (presentations, drama skits, small groups, one on one counseling)? Please explain why some methods work better than others. 5. Do you use posters, brochures or other visual implements to compliment your sensitization work?

Confidentiality and Cultural Competence: 1. How important do you feel confidentiality is with respect to your GBV work? 2. Do you feel the processes established and training provided by the service providers encourage the concept of confidentiality? 3. Do you find the services and support provided by CARE, HIAS and the other service providers to be culturally respectful and relevant to your community? If so, please explain. If not, how can it be improved?
Referral and Support Systems: 1. When a GBV incident occurs, how does the reporting and support service referral system work? 2. Do members of your committee trust the service providers, such as CARE, ADES and HIAS? If so, please explain how trust has been established. If not, please explain how trust between the committee and service provides might be improved. 3. In your opinion, are youth, the disabled and newly arriving refugees adequately targeted in GBV prevention and support outreach? If not, how can this be improved? 4. Are services affordable and accessible to members of your community? If not, please explain how this could be improved. 5. Are the needs of older refugees being met by current GBV interventions/supports?
Accomplishments/Results: 1. What are you most proud of in terms of accomplishments by your committee in responding to GBV? 2. Why do you believe these accomplishments occurred? Are there any lessons learned from your successes that we can share with other committees or camps? 3. What is your current focus as a committee to decrease GBV? What do you see as priorities for your committee in the future? 4. What, if any, improvements have you seen regarding GBV knowledge and support that have resulted from the GBV interventions provided by UNHCR, CARE, HIAS and ADES (among other service providers)? 5. What has not worked in terms of GBV prevention and outreach that needs attention at this time?

Annex III: Evaluation Contacts and Key Informants

DoS/PRM & UNHCR

Name	Title	Association
Kristen Frost	Office of Assistance for Africa	DoS/PRM - Washington, DC
Mary Eileen Earl	PRM Refugee Coordinator	DoS/PRM – N'Djamena
Assoumia Foulah Marie-Ange	Refugee Coordinator Assistant	DoS/PRM – N'Djamena
Ambassador James Knight	US Ambassador to Chad	US Embassy, N'Djamena, Chad
Eric Whitaker	Deputy Chief of Mission	US Embassy, N'Djamena, Chad
Mamadou Dian Balde	Deputy Representative (Protection)	UNHCR – N'Djamena
Adele Marie Kahota	Associate Country Director	UNHCR – N'Djamena
Laurent Raguin	Assistant Representative (Programme)	UNHCR – N'Djamena
Elias Forsung	Senior Field Safety Advisor	UNHCR – N'Djamena
Angela Carvajahno	Programme Officer	UNHCR - N'Djamena
Adele Kohota	Associate Community Services Officer	UNHCR – N'Djamena
Aminata Gueye	Representative	UNHCR – N'Djamena
Mamadou Fofana	Administrateur Associé Des Services Communautaires	UNHCR - Maro Field Office
Prosper Dibidibi Kabi	Head of Office	UNHCR - Maro Field Office
Yannick Georges Mbengue	Protection Officer	UNHCR - Maro Field Office
Cheikh Tidiane Pouye	Head of Sub-Office	UNHCR – Goré Sub-Office
Djamal Zamoum	Senior Protection Officer	UNHCR – Goré Sub-Office
Remadji Ngarone		UNHCR – Goré Sub-Office
Sandra Flores	Associate Protection Officer	UNHCR - Koukou Field Office
Byaina (Madi) Galopna	Associé aux Services Communautaires	UNHCR - Koukou Field Office
Lena Fransson	GBV Consultant to UNHCR	UNHCR - Koukou Field Office

Leonidas Nkurunziza	Head of Office	UNHCR – Koukou Field Office
Koula-Hodoum Dillah	Field Associate	UNHCR – Iriba Sub-Office
Fatime Abdoulaye	Assiste Service Communautaires	UNHCR – Iriba Sub-Office
Ngarguena Blaise	Protection Associate	UNHCR – Iriba Sub-Office
Madeleine Tchadi Nounouni	Senior Protection Officer	UNHCR – Iriba Sub-Office
Morron Ndodozim Joel	Field Associate	UNHCR – Iriba Sub-Office
Aime Mbaindguim	Protection Associate	UNHCR – Iriba Sub-Office
Koumial Steve	Field Associate	UNHCR – Iriba Sub-Office

PRM Implementing Partners (CARE, HIAS, ADES)

Name	Title	Association
Bonaventure Wakana	Country Director	Cooperative for Assistance and Relief Everywhere (CARE International)
Ali Namata	Assistant Country Director	CARE International – N'Djamena
Kajangu Olga	Project Manager	CARE International – N'Djamena
Richard Bizimana	South Program Coordinator	CARE International – N'Djamena
Djekombe Yabad Simon	Responsible SGBV	CARE International – Maro
Hassana Ali	Assistant Coordinateur DevCom	CARE International – Maro
Bekayo Samuel	Responsable Base/CARE Maro	CARE International – Maro
Gatsia Tounakissia	Assistant aux Programmes	CARE International - Programmes SUD, Bureau de Goré
Amsougou Tobyo	Gestionnaire DEVCOM	CARE – Goré
Lahndiguim Aime Koingar	Reponsable Protection de l'Enfant et SGBV	CARE – Goré
Gabra Belery Belerym	Asst. Charge de la Protection de l'Enfant et SGBV	CARE – Goré

Dendouba Ghislaine	Assistant Charge de la Protection de l'Enfant et SGBV	CARE – Goré
Djimangon Malon	Assistant Charge de la Protection de l'Enfant et SGBV	CARE – Goré
Marirama Godse	Gestionnaire de Base des Donnes	CARE – Goré
Joyce Kanja	Country Director	Hebrew Immigrant Aid Society (HIAS) – N'Djamena
Ernest Anda Djogo	Project Director, Chad Operations	Hebrew Immigrant Aid Society (HIAS) – N'Djamena
Thaddee Gatimatare	Psychosocial Field Coordinator	Hebrew Immigrant Aid Society (HIAS) - Koukou Djbal & Goz Amir Refugee Camps
Mahamat Tahir	Assistant GBV/Child	HIAS – Koukou
Koumguessel Mady	Assistante GBV/Child	HIAS – Koukou
Mohti Bila	Superviseur	HIAS – Koukou
Wendy Arunga	Chef de Bureau	HIAS – Iriba
Mindekem Rosine	Assistant SGBV Protection	HIAS – Iriba
Danaglee Sakalgo Alice	Assistante SGBV/Protection Enfant Camp de Touloum	HIAS – Iriba
	Assistante SGBV/Protection	HIAS – Iriba
Mbaioroum Leopold	Superviseur Service Communautaire	HIAS – Iriba
Abdel Hakhim	Director	Association pour le Développement Economique et Social (ADES) – N'Djamena
Ahmat Nil	Encadreur Sante Mental	ADES – Koukou
Dr. Kodman Mallah Mardochee	Medecin au CDS Goz Amir	ADES - Koukou
Natoiallah Ludovic	Encadreur Sante Mentale	ADES – Koukou

Nalaitaaua Victoria	Encadreur Sante Mental	ADES – Koukou
Dieudonne Vaila	Assistant Coordinateur Environement	ADES – Iriba
Haroun Abdou Laye	Chef de Bureau	ADES – Iriba

Beneficiaries

Number	Title or Description	Association
25 (17 female, 8 males)	25 GBV Committee Members	Belom Camp
24 (4 females, 20 males)	Vigil Committee Leaders	Belom Camp
18 (all female with babies or young children)	Young Mothers Receiving Micro-Credit Training	Belom Camp
7 (1 female, 6 males)	Committee Camp Leaders and Religious Leaders	Belom Camp
14 (2 girls, 12 boys) ranging in age from 15 to 21 years	Youth Committee Leaders	Belom Camp
14 (4 females, 10 males)	Central Committee Leaders and Religious Leaders	Goz-Amir Camp
19 (10 girls, 9 boys) Ages 15 - 19 in grades 6 – 9	School Students from Dar es Salaam School at Goz-Amir Camp	Goz-Amir Camp
6 (all females)	SGBV Committee	Goz-Amir Camp
8 (1 female, 7 males)	Committee for the Protection of Children	Goz-Amir Camp
13 (4 females, 9 males)	Interview with Teachers of Dar es Salaam Primary School (K-5th grade)	Goz-Amir Camp
8 (4 girls, 4 boys) Ages 16 – 24	Theater Group (Refugee Youth)	Goz-Amir Camp
22 (all females) Ages 16 and older with 8 babies	Survivors of SGBV	Goz-Amir Camp
25 (all females)	Women Leaders Committee	Touloum Camp
18 (all males)	Committee Leaders, Religious Leaders & Block Leaders	Touloum Camp

11 (all females)	SGBV Committee	Touloum Camp
12 (9 females, 3 males)	Committee of Community Mobilizers	Touloum Camp
11 (3 females, 8 males)	Vigil Committee	Touloum Camp
17 (3 females, 14 males)	Committee of Camp Leaders	Dosseye Camp
10 (5 females, 5 males)	GBV Committee	Dosseye Camp
11 (1 female, 10 males)	Vigil Committee	Dosseye Camp

Local Collaborators (Chad Governmental Entities, Donors, Service Providers not funded by PRM)

Name	Title	Association
	Sultanat	Iriba, Government of Chad
Hassan Issa Allatchimi	Secretary Permanent	Commission Nationale pour l'Accueil et la Reinsertion des Refugies et des Rapatries (CNARR)
Richard	Camp Manager	CNARR - Belom Camp
Abakar	Camp Manager	CNARR – Touloum Camp
Zakaria Souleegman	Chef de Bureau	CNARR – Touloum Camp
Ache Saleh	SGBV/Gender Focal Point)	CNARR – Touloum Camp
Deboui Viviane	Assistante Protect	CNARR – Goré
Hassane Adoum	Chef Bureau	CNARR - Goré
Mohamat Moussa Obeimi	Delegue Regionel	CNARR - Goré
2 male DPHR Officers	DPHR Officers	DPHR – Touloum Camp
11 male DPHR Offices	DPHR Officers	DPHR – Belom Camp
6 DPHR Officers (2 females, 4 males)	DPHR Officers	DPHR - Goré
Doumagoum Moto	Director	Centre de Support en Sante Internationale (CSSI)

Jean Naissengar	Assistant Director	CSSI
Kegga Sen Jaurim	Chief Nurse	CSSI – Health Center in Maro Services to Belom Camp
Sebira Alice	Assistante Psychosociale	CSSI – Health Center in Maro Services to Belom Camp
Bonkoungou Moumoumi	Attache Psychiatric	CSSI – Goré Services to Dosseye Camp
Mbakaom Ndeimcidr	Medecin	CSSI – Goré Services to Dosseye Camp
Katymio Leloum	Asst. Psycho-Sociale	CSSI – Goré Services to Dosseye Camp
Achta Auieyedgi	Assistante Psycho-sociale	CSSI – Goré Services to Dosseye Camp
Bertin		APLFT – Maro Services to Belom Camp
Ngaro Wadal Assidjim	Coordonnateur	APLFT – Goré Services to Dosseye Camp
Nicole Djimiangar	Assistant Juridiqe	APLFT – Goré Services to Dosseye Camp
Etienne	Head of APLFT	APLFT – Koukou/Goz Beida
Tourambaye Augustin	Assistant en Besoin Essential	Lutheran World Federation (FLM) – Goré
Madjitolour Samson	Assistante Securite Alimentaire	FLM – Goré
Bouzoumke Bourdanniee	Assistant Admin/Finance	FLM – Goré
Flory Apmera	Coordinateur	FLM – Goré
Michel Rija Christian	Coordinateur Programme Sud	ACRA – Goré

Annex IV: GBV Prevention Indicator Compendium

International guidelines recommend the use of standardized indicators and M&E tools across GBV prevention programs. The GBV Prevention Indicator Compendium includes more than 30 indicators produced by the humanitarian community to track GBV-related interventions in the following program areas: designing services, rebuilding support systems, improving accountability, working with legal systems, transforming norms, and monitoring and documentation. PRM-funded NGO implementers sometimes use adaptations of indicators presented in the compendium. Increased use of common indicators across programs, countries, and donors would enable more rigorous reporting and evaluation of impact. In addition, indicators that collect information about measures taken to prevent or reduce GBV would be useful in planning, monitoring, and evaluating other non-GBV-focused programs funded by PRM. Indicators in bold text are "priority" indicators. Managers should encourage NGO partners to use at least one of these indicators if relevant for each project.

Indicator	Sector, Activity	Source
Designing services		
There is a comprehensive understanding of the specific risk factors faced by women, girls, men, and boys in camp settings and this analysis is incorporated in security provisions within the camps.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Training on GBV-related issues and potential risk factors is conducted for an equal number of female and male humanitarian workers to enable them to provide support to affected persons and direct them to adequate information and counseling centers. Training one male and one female meets this indicator.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Women participate directly in decision-making on local security arrangements for the camp community.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Percentage of teachers signing codes of conduct.	Education	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
"Safe spaces" are created at the distribution points and "safe passage" schedules created for women and children head of households.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men are involved in the process of selecting a safe food distribution point.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Distribution is conducted early in the day to allow beneficiaries to reach home during daylight. *	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Food distributions are done by a sex-balanced team.*	Food distribution	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of females involved in food distribution committees.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of food distributed to women.	Food Distribution	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
24-hour access to sexual violence services.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Confidential referral mechanism exists for health and psychosocial services for rape survivors.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Staff are trained on the clinical management of rape.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of community-based workers trained in sexual violence psychosocial support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of health staff trained in sexual violence medical management and support.	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Survivors/victims of sexual violence receive timely and appropriate medical care based on agreed-upon medical protocol.*	Health & Community Services	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Percentage of reported rape cases where survivor receives post-exposure prophylaxsis for HIV (PEP) within 72 hours of incident	Health & Community Services	"United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Response.info Indicators Registry" 2014

Indicator	Sector, Activity	Source
Number of copies of resource list in local language(s) distributed in community.	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are in place to ensure income-generation activities and economic options for women and girls so they do not have to engage in unsafe sex in exchange for money, housing, food, or education—or are exposed to GBV because of being economically dependent on others.*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Both women and men participate in the identification of safe and accessible non-food item NFI distribution sites.*	Non-food items	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
NFI distribution points are monitored to ensure they are safe and accessible.*	Non-food items	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate quantities of sanitary supplies distributed to women and girls.*	Non-Food Items	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Both women and men participate in the identification of safe and accessible sites for water pumps and sanitation facilities.*	Water and Sanitation	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Adequate number of latrines for each sex constructed and have locks (Sphere standard).*	Water and Sanitation	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Improving accountability		
Proportion of key actors who participate in regular GBV working group meetings.	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Staff are aware of and abide by medical confidentiality.*	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of actors issuing codes of conduct.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

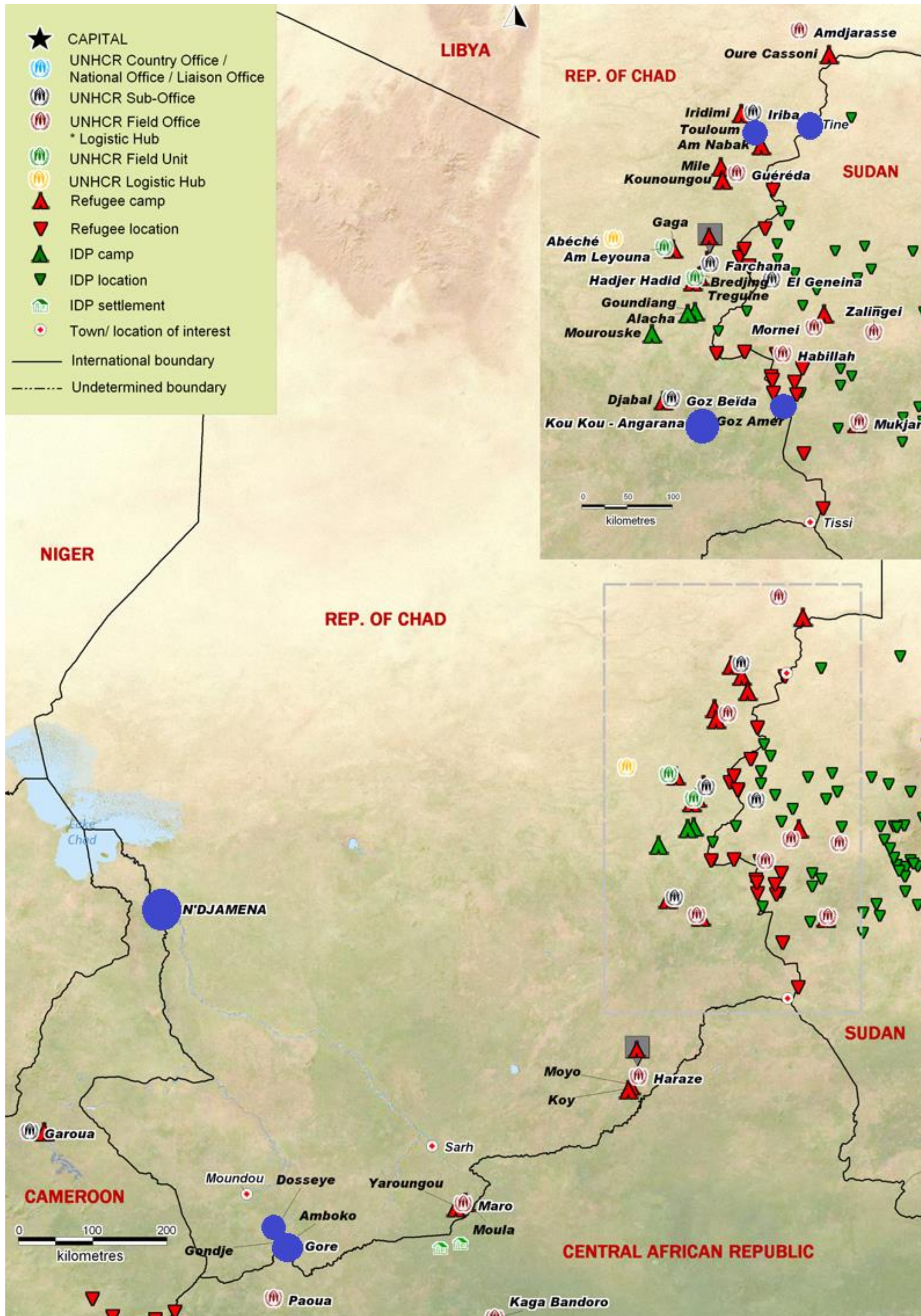
Indicator	Sector, Activity	Source
Proportion of reported sexual exploitation and abuse incidents resulting in prosecution and/or termination of humanitarian staff.	Human Resources	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Security mechanisms instituted based on where incidents occur, and monitored for effectiveness.*	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
A referral system for reporting of security and abuse incidents is operational.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Mechanisms put in place to ensure people can report any harassment or violence.*	Shelter	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Monitoring and documentation		
A mechanism is in place for monitoring security and instances of abuse.*	Registration	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Facilities and collection points are monitored to ensure they are safe and accessible (e.g. locks, lighting).*	Water and Sanitation	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
High risk security areas are monitored regularly at different times of day.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Multisectoral and interagency procedures, practices, and reporting forms established in writing and agreed by all sectors.*	Coordination	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Programs are monitored for possible negative effects of changes in power relations (e.g. rise in domestic violence due to women's empowerment).*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Regular observation visits are undertaken to distribution points, security checkpoints, water and sanitation facilities, and service institutions (e.g. schools and health centers).*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006

Indicator	Sector, Activity	Source
Reports on sexual violence incidents compiled monthly (anonymous data), analyzed, and shared with stakeholders. *	Assessment & Monitoring	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Routine spot checks and discussions with communities to ensure people are not exposed to sexual violence due to poor shelter conditions or inadequate space and privacy.*	Shelter	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Security and instances of abuse are monitored.*	Protection	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Workplaces are monitored and instances of discrimination or GBV are addressed.*	Livelihoods	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Rebuilding support systems		
Community-based plan for providing safe shelter for victims/survivors developed and used effectively.*	Shelter & Site Planning	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Transforming norms		
Informational campaigns for men and women about the health risks of sexual violence to the community.**	Health	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of IEC materials using verbal or visual messages (i.e. accessible to non-literate populations).	Information, Education, Communication	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005
Proportion of individuals who know any of the legal rights of women.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of individuals who know any of the legal sanctions for GBV.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who have been exposed to GBV prevention messages.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Proportion of people who say that wife beating is an acceptable way for husbands to discipline their wives.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010

Indicator	Sector, Activity	Source
Proportion of people who would assist a women being beaten by her husband or partner.	Community mobilization and behavior change	Gender-Based Violence Information Management System Resources, UNFPA, UNHCR, IRC, 2010
Women and men in the community, including village leaders and men's groups, are sensitized to violence against women and girls, including domestic violence.*	Protection	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Working with legal systems		
Police officers (male and female) patrol the camps.*	Camp coordination and management	"Women, Girls, Boys and Men: Different Needs – Equal Opportunities," Gender Handbook in Humanitarian Action, Inter-agency Standing Committee (IASC), 2006
Proportion of reported incidents of sexual violence where survivor/victim (or parent in the case of a child) pursues legal redress.	Protection	Guidelines on Gender-based Violence Interventions in Humanitarian Settings, Inter-agency Standing Committee (IASC), 2005

Nota bene: These indicators listed in the IASC and other guidelines are examples to follow. According to M&E best practices, the "indicators" marked with an asterisk are not truly structured as indicators, but rather as results statements, i.e. specific results that an intervention would hope to achieve through its activities. The "indicator" marked with two asterisks is an activity that an NGO might undertake to achieve a given result. Social Impact does not feel comfortable changing these indicators, as they have been produced by the humanitarian community for GBV programming. The 2005 IASC indicators are currently under review and subject to revision. In the meantime, Social Impact recommends that PRM examine the "United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Humanitarian Response.info Indicators Registry" in order to seek out adaptations of these results statements in true indicator format.

Annex V: Chad Country Map and Evaluation Locations



Annex VI: Disclosure of Conflict of Interest

Name	Erica A. Holzaepfel
Title	Evaluation Specialist
Organization	Social Impact
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(or RFTOP or other appropriate instrument number)*	RFTOP 1037-350011
DoS Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	
I have real or potential conflict of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Erica A. Holzaepfel
Date	2/10/13

Disclosure of Conflict of Interest for DoS Evaluation Team Members

Name	Sylvie Morel-Seytoux
Title	Senior Gender-based Violence Specialist
Organization	Social Impact
Evaluation Position?	☐ Team Leader ☐ Team member
Evaluation Award Number *(or RFTOP or other appropriate instrument number)*	Task Order Number: S-AQMMA-13-F0964
DoS Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Evaluating the Effectiveness of Gender-based Violence Prevention Programs with Refugees in Chad, Malaysia, and Uganda
I have real or potential conflict of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Sylvie L. Morel-Seytoux
Date	12/05/13

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