Mid-term Evaluation report of GIRIJAMBO! Project in Bujumbura and Bubanza Provinces

For CARE Burundi

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List of Acronyms/Terms

Abatangamuco	"Those who bring light where there is darkness" . Refers to «enlightened » men who have undergone a process of internal reflection and positive behavior change in relation to sexual and gender based violence (SGBV).
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AIDS	Acquired Immune Deficiency Syndrome
APRODH	Association for the protection of human rights
CDF	Centre de développement familial (offices of the MDPPG at the commune level)
CEP	Children's Empowerment Programme
Colline	Literal translation " hill", the lowest administrative level in Burundi
GEZAHO	**"**Stop!" in Kirundi. GEZAHO, the first phase of the GIRIJAMBO! project, sought to reduce sexual violence through community based prevention and provision of medical and psycho-social services to survivors.
GIRIJAMBO!	"Express yourself!" in Kirundi
IG	Impact group
IUD	Intrauterine device
MBEI	Men and boys engaged initiative
MDPPG	Ministère des droits de la personne et la promotion du genre
M&E	Monitoring and evaluation
MSC	Most Significant Change
Nawe Nuze	Village savings and loan approached pioneered in Burundi by CARE
OPJ	Officier de la police judiciaire (judicial police)
PEP	Post-exposure prophylaxis (as protection against HIV infection)
PNSR	Programme National pour la Santé de la Reproduction (National Program for Reproductive Health)

SAA	Social Action and Analysis. An approach to working with communities that uses regular dialogue to address the links between social conditions, in particular power imbalances and women's low social position, and health challenges.
SASA!	SASA! is a Kiswahili word for "now!" and also serves as an acronym for the key components of the programme: Start, Awareness, Support, and Action. The SASA! methodology was designed by the non-governmental organization, Raising Voices to work with women and children to explore the gender aspects of power and to address the link between violence against women (VAW) and HIV/AIDS
SBVS	Synergie Burundaise contre la violence sexuelle (Burundian Synergy against Sexual Violence)
SGBV	Sexual and gender based violence
SRH(R)	Sexual and reproductive health (rights)
TOC	Terms of Change
VSL	Voluntary Savings and Loan
UCPV	Underlying cause of poverty and vulnerability
UNIFEM	United Nations Development Fund for Women
WEP	Women's Empowerment Programme

1. Purpose of the Evaluation:

CARE Burundi commissioned a midterm evaluation of the GIRIJAMBO! project. The project runs from June 2010 to May 2013. The midterm evaluation consisted of quantitative and qualitative surveys of the views of project impact group members, target groups and community members on issues related to sexual and gender based violence (SGBV). The quantitative survey targeted 265 women solidarity group members and 115 men and women on attitudes, knowledge and practices around SASA!. This was followed by a qualitative survey of project participants and stakeholders using open-ended questions, focus group discussions and Most Significant Change (MSC) exercises. The overall purpose of the evaluation was to gage the progress made by the project towards attaining its overall objective now that it is half along its implementation period. The specific objectives of the midterm evaluation were to :

- Determine to what extent the project has achieved the results that it could reasonably have been expected to achieve in the first half of the implementation period;

- Appreciate the implementation strategies of the project, in particular the voluntary savings and loan (VSL) and engaging men in women's empowerment strategies as well as issues of sexual and gender based violence;

- Document best practices and lessons learned from the first period of the project that can be used to improve future implementation.

In particular, the qualitative part of the midterm evaluation sought to answer a number of specific questions:

- Is the project on the way to reaching its overall objective? Specifically, what progress has been made in reaching each of the results set for the project?
- Are the community-based structures targeted by the project taking action to prevent and protect women from SGBV and working to change negative attitudes and behaviors that reinforce SGBV? How are they beginning to do this? What suggestions do they have so far for how this can be improved?
- Are women in the impact group (IG) beginning to see changes in terms of improved access to quality information and services in relation to SGBV in their area?
- Are women of the IG noticing that they starting to be better able to make informed choices on their sexual and reproductive health (SRH) through the transformation of socio-cultural barriers at all levels (individual, household, and community, national)?
- How well are some of the approaches working such as VSL? How appropriate and effective is the solidarity group methodology as an entry point for other activities? Engaging men (primarily through the Abatangamuco)? Are there other ways to engage men and boys that might be considered? How well is the SASA! approach working?
- What has been the involvement of various partners, in particular the government? How effective has this collaboration been? Where are the opportunities to strengthen the relationship and government involvement?

The **quantitative** data was collected by a national consultant and team of 11 surveyors over a period of 2 weeks. The **qualitative** data was collected an international consultant assisted by members of the GIRIJAMBO! project team and partners. The evaluation also had a capacity building component as CARE wanted to take this opportunity to help the GIRIJAMBO! team to reflect on the project, its objectives and strategies and find ways to

engage in reflection on our role as catalysts for development and the role we play in positively impacting the lives of the impact group. The evaluation report was prepared by the international consultant.

2. Background and Context of the GIRIJAMBO! Project:

The GIRIJAMBO! or "Express Yourself!" project is the third phase of sexual and gender based violence project that began as a one year pilot, GEZAHO I, in 2006 in Muyinga province. Phase 2 of the GEZAHO project began in 2007 in Bubanza and Bujumbura provinces. The first phases of the project sought to change community attitudes and behaviors that reinforce sexual violence while at the same time increasing access to services (medical, psychosocial and legal) for survivors. However, CARE realized during the project's second phase that women's lack of sexual and reproductive health rights was intricately linked to sexual and gender based violence because women's low social position meant that they were vulnerable to both types of rights abuse. Further, studies by CARE and other agencies in Burundi have found that both men and women have expressed significant demand for sexual and reproductive health services.

Burundi's history of sexual and gender-based violence and the related low status of women is well documented. At the end of phase 2 of GEZAHO a final evaluation was conducted, which provided several recommendations for strengthening future phases of the project. Phase 3 of the project, GIRIJAMBO! "Express Yourself" was launched in March 2010 in the same coverage area as the GEZAHO Phase 2 project -- three communes of Bujumbura province and four communes of Bubanza province -- with the overall objective to :

Contribute to CARE Burundi's Women's Empowerment Programme goal of poor and vulnerable women from rural areas (living in) dignity and fully enjoying their rights by 2015 by ensuring that women from CARE Burundi's impact group live a life free from violence, enjoy their rights and make informed choices on their sexual and reproductive health.

The project is implemented through two local partners – **APRODH** and **SBVS** who respectively provide services in legal assistance and psycho-social support to survivors of sexual and gender based violence. Both of these types of services are the crux of the project's focus. Government partners such as the Ministry of Solidarity, Human Rights and Gender/Center for Family Development and the Ministry of Health/Programme Nationale pour Santé de la Reproduction (PNSR) provide community development and health care services respectively.

The project set itself a specific objective where 6,700 women[1], by 2012, will experience improved protection[2] from SGBV and improved sexual and reproductive health rights. This would be achieved through four results each of which is summarized below.

Result 1: community-based structures would take action to protect women from SGBV and work to change negative attitudes and behaviors that reinforce SGBV.

Result 2: Women have improved access to quality information and services in relation to SGBV in 7 communes;

Result 3: Women have improved access to quality information and services in relation to SRHR in 7 communes;

Result 4: Women are able to make informed decisions on their SRHR through the transformation of socio-cultural barriers at all levels (individual, household, community, national).

[1] When we refer to women here, we refer to women belonging to the defined impact group.
[2] When we refer to protection here, we understand this to mean both prevention and response to SGBV and SRHR.

3. Evaluation Methodology & Process

The evaluation essentially consisted of two parts – an opinion survey of 265 women members of solidarity groups and a survey of 115 women (63%) and men (37%).The 265 women respondents were divided into two groups – those who are members of CARE Burundi's Impact Group and a control group of women who are not part of CARE's IG. The inclusion of a control group was intended to gage whether the IG experienced more positive changes in their lives as a result of the project[3]. The two surveys sought to solicit respondents' perceptions of changes in the incidences of and attitudes toward sexual and gender based violence and their access to sexual and reproductive health rights. The quantitative surveys used the same questionnaire tool used for the projects baseline survey in order to gage how perceptions and attitudes had changed since the start of the project. The quantitative surveys were then followed by a more in depth investigation to dig deeper into particular issues using tools such as semi-structures interviews, focus group discussion and most significant change exercises. The qualitative part of the mid-term evaluation began with a workshop that brought together the consultant and project staff to review and finalize the evaluation objectives and the main questions for which the project sought answers as well as the sample size, evaluation tools and a final plan of activities.

Before any new information was collected a number of documents were reviewed to feed into the evaluation process:

- GIRIJAMBO! project proposal
- GIRIJAMBO! baseline report
- GIRIJAMBO! log frame & M&E plan
- Detailed Implementation Plans and Annual reports
- CARE Burundi TOC & UCPV analyses

The qualitative evaluation was conducted through a series of consultative discussions with a range of project stakeholders, and impact and target group members who were able to give insights into how well it has worked over its first year. Both the stakeholder interviews and the focus group discussions were conducted using key informant interview formats with open-ended questions. Some project participants were also interviewed using the Most Significant Change tool[4]. GIRIJAMBO! staff also engaged in reflective exercises which permitted them to reflect on what changes had taken place in their own lives as a result of the project.

The table below summarizes the different sources of evidence for the qualitative study and the method used to collect the information. The approach was designed to ensure that as many categories of project stakeholders as possible were consulted and to give as complete a picture as possible of any positive and negative changes brought by the project.

[3] In fact the IGs' responses were consistently more positive than those of the control group, this suggesting that the project is indeed having a positive impact on their lives.

[4] The most significant change (MSC) technique is a form of participatory monitoring and evaluation that involves the collection of significant change (SC) stories from the field and the systematic selection of the most significant of these stories by stakeholders and project staff. The strength of MSC is its capacity to focus attention on program impact.

Key Stakeholder Category	Most Significant Change (MSC) Exercise	Key Informant Interview (individual)
CARE Staff[5] (11 in total) – Project Coordinator, Capacity Building Officer, Field Coordinators (7)	○	
APRODH & SBVS(4)		○
Family Development Center staff(3)		○
Local government – Head of Communes/Collines (2)		○
Religious leaders (2)		○
Police/judiciary (2)		○
Total	**11**	**13**

In terms of the **impact and target groups** the qualitative evaluation focused on (1) individual interviews with key actors using 2 methods – most significant change and semi-structures questions guides for interviews with key informants and (2) focus group discussions with project participants, largely through the solidarity groups, using open questions and semi-structured interview guides.

Impact & Target Groups[6]	#s of Focus Group Discussions	#s of Individual Interviews
Impact group - Solidarity groups - Individual group members	 4 n/a	
Household members (men, women)	1	
Men & women community members	1	
Community activists	2	
Health center & hospital staff		4
CDF animators		2
Abatangamuco	2	
Total	**10**	**6**

4. Analysis of Results: What Changes have occurred in the lives of GIRIJAMBO!'s Impact Group?

The first objective of the mid-term evaluation was to find out to what extent the GIRIJAMBO! project has achieved the results that it could reasonably have been expected to achieve in its first 18 months of implementation.

The project's overall objective was that b*y 2012, 6,700 women[7] (would) experience improved protection[8] from SGBV and improved sexual and reproductive health rights.* In the project document CARE proposed that this objective would be measured by (1) the percentage of women who reported having received quality services and support from the community based network set up by CARE and its partners and (2) the percentage of women who declared that they were free to make decisions regarding their sexual and reproductive health. The next sections

[5] This staff structure comes from the GIRIJAMBO! project proposal, February 2010

[6] There is likely to be significant overlap amongst the target and impact groups, therefore total numbers of individuals may actually be less than what is presented. The final numbers will be determined together with the CARE Burundi evaluation team.

[7] When we refer to women here, we refer to women belonging to the defined impact group.

[8] When we refer to protection here, we understand this to mean both prevention and response to SGBV and SRHR.

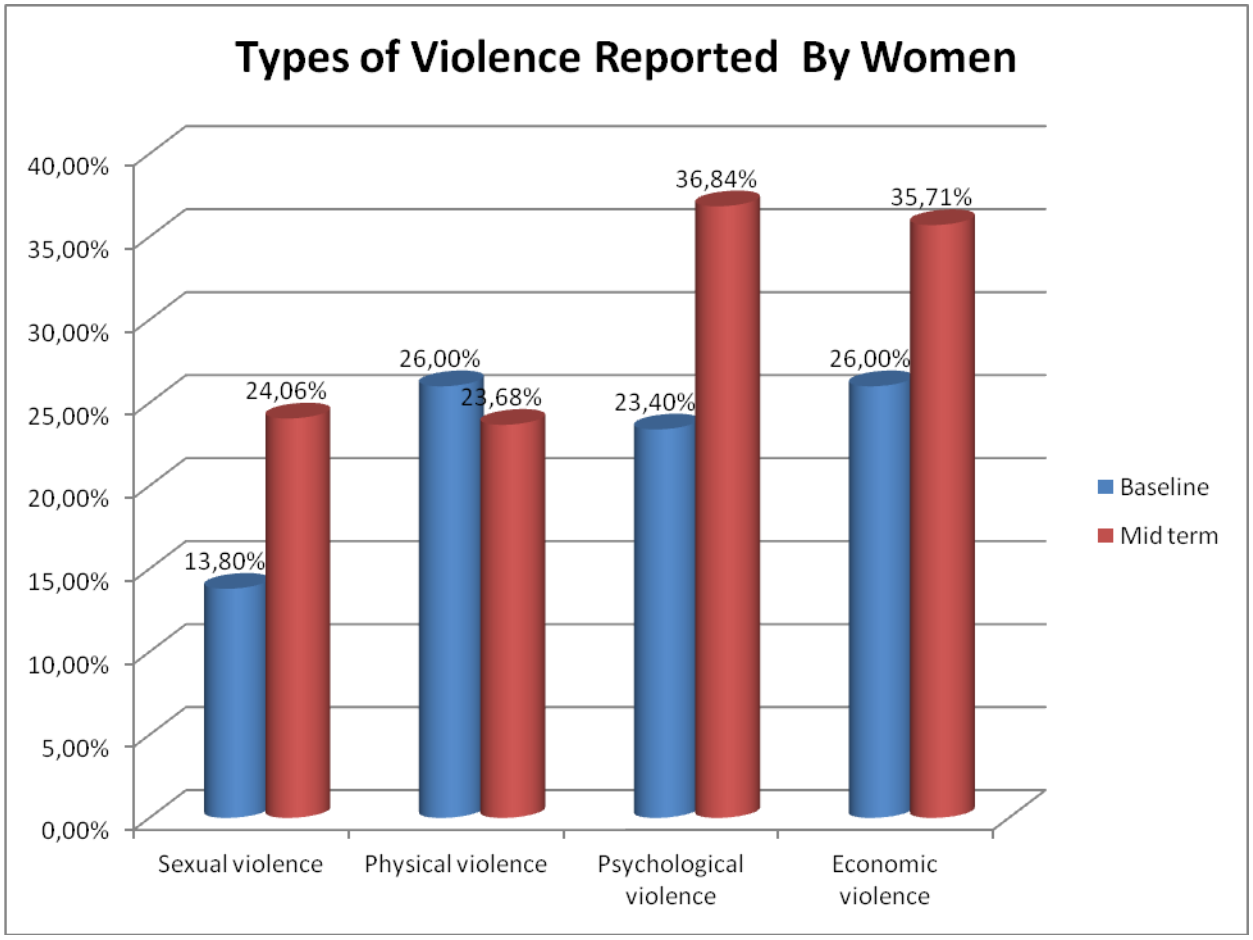
(particularly those sections on results 1 to 4) will present a detailed discussion of whether over the first six months of the project there was indeed an improvement in access and quality of services available to women victims of SGBV, and whether women are now more able to make decisions regarding their sexual and reproductive health rights.

The mid-term's quantitative survey found that a slightly higher percentage of women reported that they had experienced some form of sexual or gender based violence[9] than in the baseline survey (44% versus 40%). The qualitative survey confirmed this trend and showed that women do indeed perceive that they have better access to services through the solidarity groups and the network of providers (pyscho-social counsellors, legal representatives and quality health facilities) set up by the project.

Though there was a slight decrease in the number of women reporting physical violence[10], a higher percentage of women reported experiencing other types of violence including sexual, psychological (eg. verbal abuse or infidelity) and economic (for example men who with-hold family earnings from their partners) forms of violence. This increase is more likely due to the fact that women are now more aware of and willing to talk about the violence that they experience in their lives, rather than an actual **increase** in the **incidence** of violence. This is particularly true for sexual violence where during the in-depth conversations with key informants almost all sources claimed that the incidences of sexual and gender based violence is decreasing (though some such as CARE"s partner APRODH believe that though overall numbers of incidences are decreasing survivors are increasingly more likely to be a minor) The sections of the evaluation report on the specific results will go into more detail on the community structures that have been put in place to protect women, and the changes in community attitudes that are beginning to make these kinds of violence unacceptable.

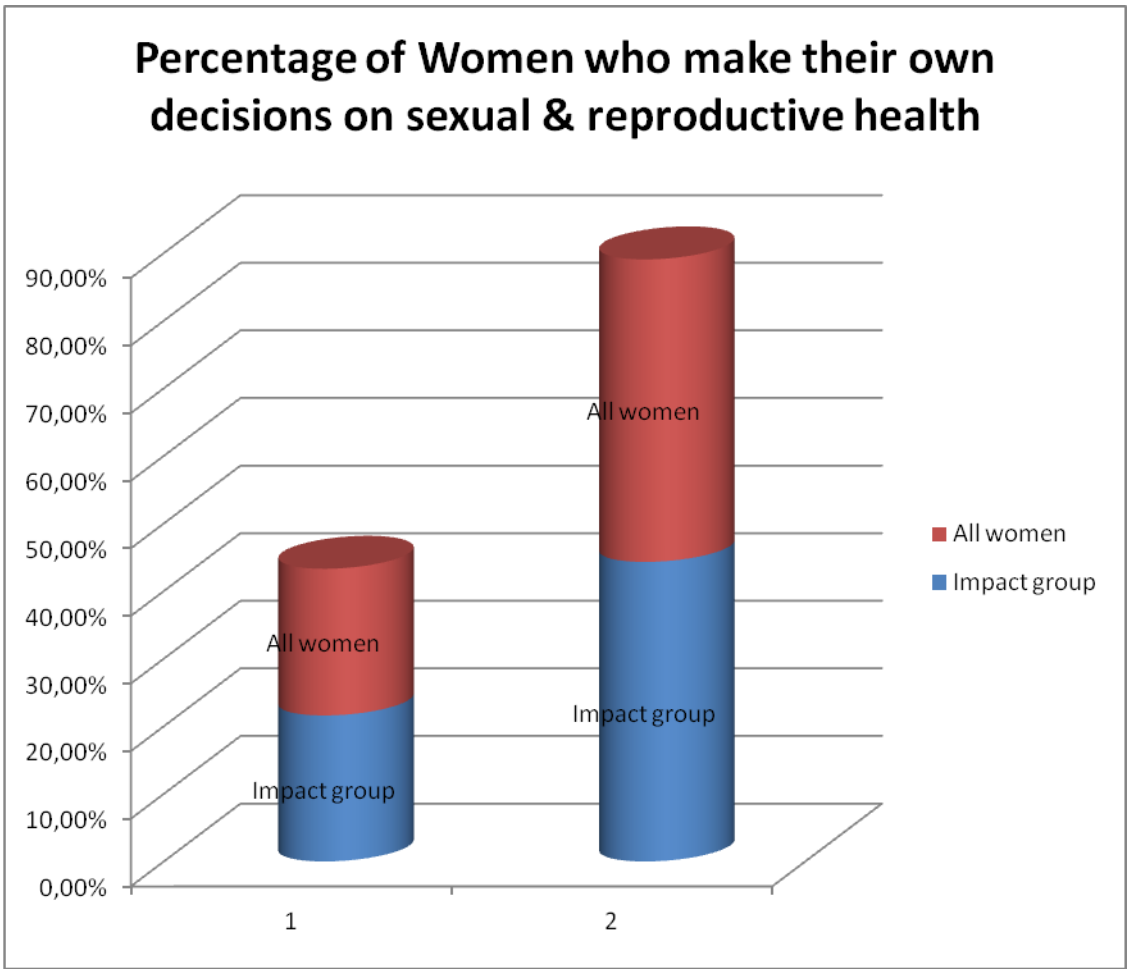
[9] The definition of gender based violence (GBV) used in this evaluation comes from the United Nations Development Fund for Women(UNIFEM). GBV is any physical, sexual, psychological and economic abuse. It cuts across boundaries of age, race, culture, wealth and geography. GBV can take place in the home, on the streets, in schools, the workplace, in farm fields, refugee camps, during conflicts and crises. GBV can range from domestic and sexual violence, to harmful practices, abuse during pregnancy, so-called honour killings and other types of femicide. Taken from: UNIFEM's UN Women E-Newsletter.

[10] The 3 percentage point decrease in physical violence is small enough that one can reasonably conclude (given the statistical probability of error) that there was no real difference between the baseline and midterm surveys in the rates at which women reported incidences of physical violence.



According to the quantitative survey results women seem now more likely to identify economic and psychological forms of violence, or verbal abuse which suggests that at least those women of the impact group who have participated in project activities may have begun to internalize some of the issues raised through the project's awareness raising and training activities.

In terms of women's ability to make decisions regarding their sexual and reproductive health, the quantitative survey found that almost twice as many women felt that they had more control (though it is not clear what the role of the partners of these women is in this new found decision-making freedom) over their sexual and reproductive health than at the time of the baseline survey. Interestingly the same proportion of women that were not in the solidarity groups reported the same as those in the solidarity group. This may be well be because the sexual and reproductive health activities target all of the population of reproductive age so that change will be seen as affecting the population in general.

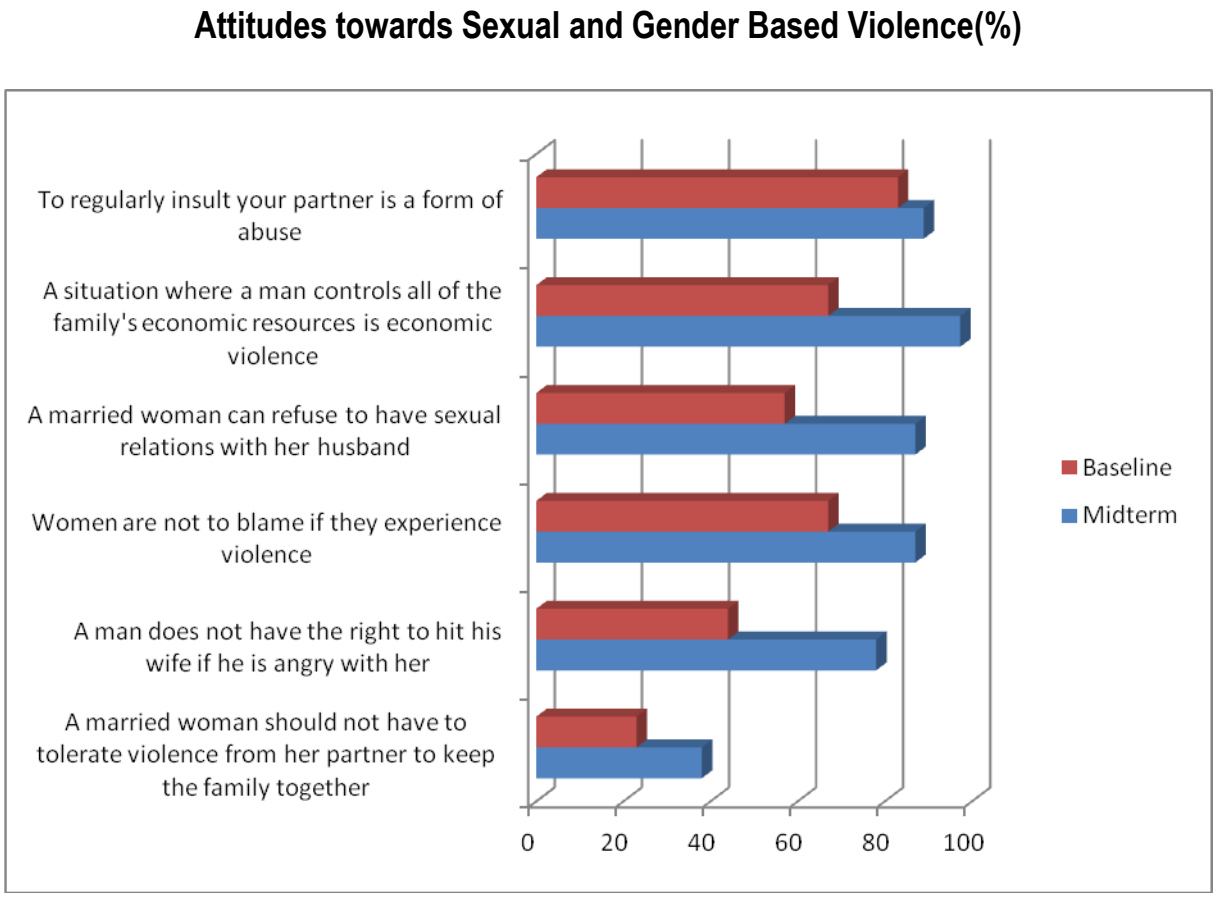


One wonders whether this means that the sexual and reproductive health component of the program has not yet had any measurable impact.

In fact the more in-depth qualitative study found that, yes, women (at least those in the solidarity groups) do seem to exert more control over decisions concerning their sexual and reproductive health but this trend has only just begun. Overwhelmingly control over women's sexuality and reproductive health still seems to rest with men. This may be in part due to the fact that the SRH component of the project is relatively new and 18 months is a very short time in which to see major changes in deeply held values on the role of women, and their sexuality and reproductive roles in the family and in Burundian society more generally. However the project has had a very promising start with the introduction of the social action and analysis (SAA) and SASA! both of which seek to redress the power imbalances at the heart of women's low social status and lack of control over their sexual and reproductive lives. The specific results sections of the evaluation report discuss progress made in more detail.

Result 1: Community-based structures are taking action to protect women from SGBV and working to change negative attitudes and behaviors that reinforce SGBV.

Indicator 1: changes in community attitudes vis-à-vis women's rights



The quantitative survey found that indeed attitudes are changing for the better. An opinion survey of women solidarity group members (summarized above) found that more women than at the time of the baseline survey understood what constituted abusive behavior in a relationship. This was confirmed by conversations held with SG members where they attested to the fact their sense of self confidence and pride has increased as a result of participating in the project. They feel that they have greater authority in their family due to their ability to help support their families and are less willing to tolerate abuse from their partners and other family members.

Similarly attitudes are changing among husbands, men in the community and community leaders. Interviews with partners of solidarity group members found that many men are beginning to appreciate the economic and social benefits of their wives' participation in the solidarity groups.

The attitudes of some local leaders are also changing and becoming more supportive. Religious leaders are also becoming more aware of the need to support survivors of sexual and gender based violence (including domestic violence) and are now more aware that they have a role to play in raising awareness that all types of gender based violence are wrong and unacceptable. In a conversation with the consultant the Curate in Musigati revealed that he

has begun to include advice on mutual respect and the rights of women to engaged couples who come for counseling prior to marriage. However these same religious leaders are a major block to women accessing modern and effective forms of contraception, as the next section of the report will discuss in greater detail.

Nevertheless lasting change on a wide scale will take much longer. For instance the Administrator of Bubanza commune revealed in an interview that most people still do not consider sexual and gender based violence to be an issue that affects the community as whole, attitudes still prevail that this is largely a "woman's issue". In the more remote areas in particular communities still hold traditional views on women's roles and are more accepting of violence against women as a normal part of family life. This is not helped by lingering attitudes of prejudice among several community leaders who were interviewed. And even some community leaders still harbor old attitudes about what sexual and gender based violence is all about. Several individuals interviewed also felt that local leaders are setting a poor example to others, in particular young men, as they continue to engage in multiple relationships (outside of legal marriage) which produce many children who then have to be fed and looked after.

Indicator 2: increase in community-level advocacy initiatives in favor of women's rights.

Since the earlier phases of the project CARE and its partners have sought to put in place a powerful network of support at the community level to enable victims and survivors of gender based violence to access services quickly and efficiently, and to increase awareness of community members of this real menace that is so deeply rooted in Burundian culture. These "structures" are composed of legal assistants, psycho-social counselors, elected community leaders (hill councils) who are supported by community activists (some of them under the tutelage of the Ministry of National Solidarity/Centers for Family Development), community role models such as the abatangamuco, and solidarity group members. These trained community operators have essentially become leaders in their communities and are recognized for the support that they provide when a crime of sexual and gender based violence occurs. There is also a significant overlap in roles as a community activist can also be a psycho-social counselor or legal assistant etc.

Together these activists offer legal, medical and moral support to survivors. The project has also done extensive outreach to inform community members of the existence of these structures so that survivors know there are sources of support and to some extent to inform potential perpetrators that their victims will no longer be powerless. Interestingly, according to conversations with project impact group members, more and more victims are turning to the solidarity groups who have now become recognized as more than a source of financial support, they increasingly play a leadership role in the community, offering moral support and advice to victims, assisting in reporting incidences, convincing families to pursue perpetrators through the legal system in order to begin combating the cycle of impunity around sexual and gender based offences.

The Legal Aides trained by APRODH have been particularly effective in helping survivors/to understand their rights; they have also supported survivors in reporting these crimes to the local "judicial police" and have even take up to the courts if the victim chooses. APRODH staff reported that in 2011 alone they had assisted in over 100 cases.

CARE's partner in the medical and psycho-social aspects of the project has over 190 community based pscyho-social counselors assigned to GIRJAMBO!, three-fourths of whom are women. The presence of female counselors is critical to building trust and to encouraging victims to come forward since most women would prefer to discuss a sexual or gender based attack with another women. According to SBVS' director, an increasing number of these counselors are young single women, a critical contribution since many of the victims of sexual and gender based violence are very young unmarried women. Effective referral systems are also in place in all of the project areas where victims can receive emergency medical care, including the post-exposure prophylaxis (PEP) s within 72 hours to prevent HIV infection. Other community "structures" such as the abatangamuco or "reformed men", the

"relais communautaires"(community agents supported by the Ministry of National Solidarity, Human Rights and Gender's Centers for Family Development) are also referring survivors to legal and medical support. The Community Animator for the CDF in Bubanza related that his office had received over 410 cases of sexual violence (396 women and 24 men) in 2011. Many of these women have received psycho-social and legal support.

The abatangamuco, an increasingly influential network of "reformed" or enlightened men, is also playing a critical role in raising awareness of sexual and gender based violence and the harmful traditional and cultural beliefs that continue to drive these trends. They use a powerful combination of public witnessing of their personal stories of positive change, through public theatre, public service radio messages, and other events to pass the message that SGBV is unacceptable. Evidence from the midterm evaluation shows that these messages are starting to have an effect and that community attitudes towards SGBV, and women's rights more generally, are starting to change positively.

These structures continue to intervene both at the grassroots and other levels to protect survivors of violence. The project continues to provide awareness raising and training for men and women in topics relating to sexual violence through public theatre and radio messages. While the change testimonies and witnessing of the abatangamuco continue to be a powerful and effective way of reaching many men and women in the communities targeted by the project, the reach of the abatangamuco is limited. Thus the project has developed a larger "men and boys engaged" strategy that seeks to engage young boys and couples as well as abatangamuco in promoting behavior change.

The project has conducted training in a number of areas in order to better empower the various members of the community structures to protect women from sexual and gender based violence. These training sessions are briefly summarized below:

In this third phase of the project[11] the project's awareness raising efforts seem to be generating real results as community leaders who were interviewed did indeed seem to demonstrate a greater awareness of gender based violence issues and more willing to support women's efforts for justice.

Result 2: Women have improved access to quality information and services in relation to SGBV in 7 communes.

The two indicators set by the project to measure progress in this result are: **percentage of survivors who use services available in case of sexual or gender based violence** and **percentage of survivors who felt satisfied by the quality of services** they received.

The project has achieved much under this result. According to project reports over 830 survivors of sexual and gender based violence received medical and psychosocial support. The above figure may actually be much higher because the CDF in Bubanza attested that in 2011 his office had received 410 cases of sexual violence, of which 396 were women and 24 men. However, the legal process remains long and cumbersome and only a limited number of cases seem to eventually reach the high courts. For instance CARE's partner ARPODH revealed that of 110 recent cases, 70 reached the « parquet » and only 20 have actually been closed. Many survivors report that they cannot afford the legal costs of prosecuting their attackers. CARE partner APRODH and the CDF (with funding from UNIFEM) appear to offer some financial support to victims through the judicial process.

The focus group discussions with the solidarity group members confirmed that women (at least those are members of the solidarity group) are indeed better informed of their rights and when they face violence they are aware of their

[11] As acknowledged earlier this project began in 2006 as GEZAHO Phase 1. It is now in its sixth year in the same geographic area.

rights and they know where to go to access medical and legal services. Women are more aware of the support that community based pyscho-social counselors can provide and are more willing to approach them. They know that a referral network is in place to provide emergency care, including PEP services within 72 hours, and community based legal assistants can help to steer them through the long legal process. From their testimonies almost all solidarity group members and community members more generally seem to now accept that sexual violence is unacceptable and that when it happens the victim is entitled to immediate medical and legal support.

Women in the solidarity group are more willing to stand up and support a survivor of violence, particularly in incidences of sexual violence. However in terms of other forms of GBV(in particular physical and psychological abuse there is much less willingness in the community to acknowledge that this is indeed a violation of women's rights. During the focus group discussions women in the solidarity group were able to identify and clearly articulate the broader issues of GBV - "economic" and even psychological violence - but, though the taboo against speaking out about sexual violence perpetrated by those outside the home has been largely broken, violence within the home, particularly physical violence, still remains a sensitive subject. Women are discouraged to speak out about this issue and those who do are seen to "betray" the family.

There is less recognition and willingness to stand up on potential violations of women's rights such as polygamy which threaten the inheritance rights of women and their children. Solidarity group members told the evaluation team that when they hear of a case of a woman being abused they will come together and go to the victims home, report the crime and help her to seek medical care and legal support.

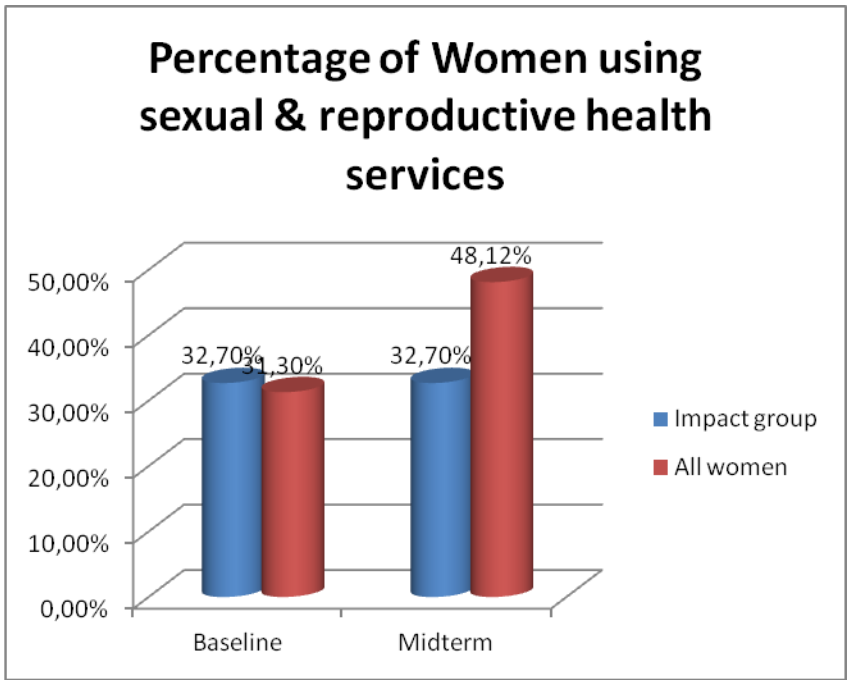
Interviews with Ministry of Health staff confirmed that the project has done an effective job in strengthening the technical capacity of health centers to provide effective medical and psychosocial assistance to survivors of sexual and gender based violence largely in line with the National Protocol[12] (including medical and psychosocial treatment and legal aid). Staff in all seven health centers (over 96 of them) have received training on psychosocial support to survivors of SGBV so that they can more effectively support survivors who come to the clinics for assistance.

The healthcare workers also participated in sessions designed to raise their awareness of the fundamental power imbalance between men and women that pervades Burundian society and the relationship between this power imbalance and the incidences of sexual and gender based violence that they see in their work. This "sensitivity training" was targeted at empowering health care workers (who presumably see victims on a regular basis) to more effectively provide care and treatment to survivors.

Result 3: Women have improved access to quality information and services in relation to SRHR in 7 communes.

The indicators defined by the project to assess the impact of this result were: **the percentage of women who use sexual and reproductive health services** and the **percentage of SRH service users who report that they are satisfied with these services**.

[12] The Burundian "National Protocol for the Treatment of Sexual Violence" meets international standards for prophylactic treatment within 72 hours, including post-exposure prophylaxis (PEP) for HIV, the treatment or prevention of other STDs, the prevention of unwanted pregnancy, the prevention of tetanus, and the suture of wounds.



The quantitative survey found that almost half of the women (48%) surveyed have used some form of sexual and reproductive health service. These services range from family planning counseling, contraception, HIV & AIDS testing, pre and post natal counseling, and delivery by a trained healthcare worker. This is a 15% increase from the baseline survey. The focus group discussions and key informant interview with partners, health workers and impact group members confirmed that sexual and reproductive health services are clearly more available and the demand for these services has increased. However, women are by far the most frequent users of the health center' services, very few men accompany their partners to seek services, though some centers have even stipulated that for any pre-natal consultations for example, that the husband must come to at least one of the four sessions according to the manager of Health Centre of Magara in Bugarama.

The sexual and reproductive health component is one of the newest aspects of the project. Since the project has only been active in the area of SHRH for 18 months much more remains to be done for the reproductive health aspects to fully take hold. Nevertheless, the achievements of the project in a short period have been remarkable. The health infrastructure available to women in the seven communes where the project works has certainly improved – the project has equipped all 7 health centers in the seven communes and a hospital in Bubanza with basic medical equipment including audiovisual equipment that is used to raise awareness and provide information on sexual and reproductive services and other health issues in the community.

The 7 health centers reached by the project and the hospital in Bubanza are now providing sexual and reproductive health services on a daily basis following a training event held for nurses on the 8 pillars of sexual and reproductive health as stipulated in the national policy of reproductive health. The results of the quantitative survey on the level satisfaction of users with the services they received is not conclusive, therefore it is not included here.

Nevertheless, despite the increase in demand for SRH services, survey respondents identified several barriers to fully accessing these services including the long distances that women must travel to get to health centers, shortages of some types of contraception, such as implants, in some health centers (for example in Magara and Kabezi) and even when these were available the health center staff were not sufficiently trained in their use.

Other social barriers include resistance from male partners, deeply held religious convictions that are sometimes in contradiction with the use of "modern" methods of contraception and rumors and misinformation regarding certain methods of contraception that discourage use among many couples.

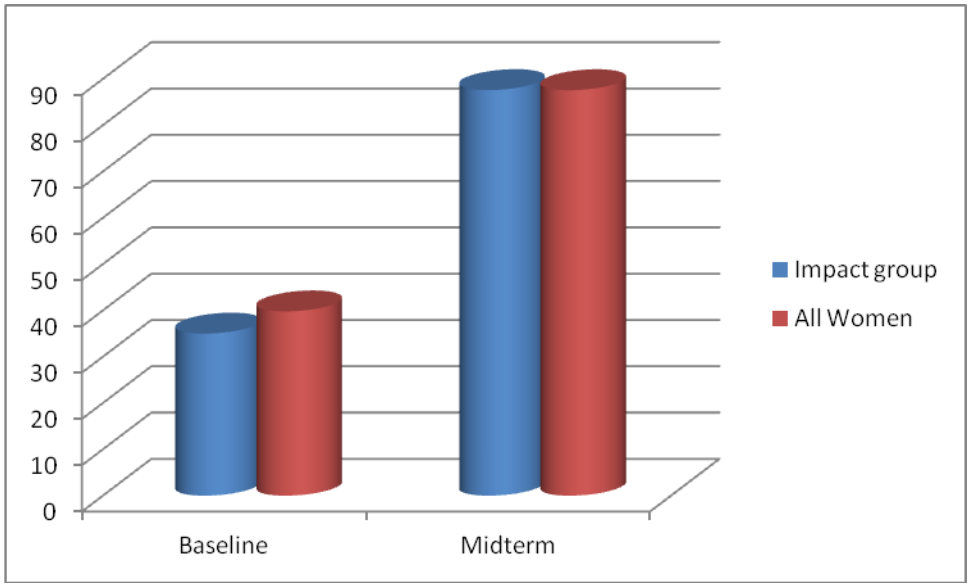
Result 4: Women are able to make informed decisions on their SRHR through the transformation of socio-cultural barriers at all levels (individual, household, community, national).

The indicators developed for this result were: the **percentage of women who said they were able to make their own decisions on their sexual and reproductive health rights** and **changes in community attitudes vis-à-vis women's sexual and reproductive health rights.**

The quantitative survey found a remarkable increase in the percentage of women who felt that they have significant say in their sexual reproductive health rights (88% now versus 35% at the time of the baseline). This trend was confirmed by the qualitative survey. Over 400 women members of solidarity groups have been trained on life skills (i.e. communication and negotiation and decision making, self-esteem, sexuality and health issues) and during the survey many of them testified to the changes that this training and support has brought to their lives.

Many women reported that thanks to the project activities (in particular because of their participation in the solidarity groups, and the training they received in Social Analysis and Action (SAA) and SASA! and "model couples") they now have more self-esteem and are better able to manage/negotiate sexual relationships with their partners.

Percentage of Women able to make their own Sexual & Reproductive Health decisions (%)



Though this aspect of the project is another one of the newest but significant progress has been made. The project has trained a number (850 so far) of community leaders and engaged men (including 390 women) on sexual and reproductive health rights. Community facilitators and engaged men have been engaged in many types of awareness raising activities promoting SRHR all sponsored by the project. These include home visits, community meetings and VSL weekly meetings. The project has also used SAA an approach enabling community member to

better identify links between social factors and SRHR, and then develop measures on how to address these factors accordingly.

Community views and attitudes vis-à-vis women's sexual and reproductive health rights are changing but very slowly. Many of those interviewed acknowledge that though there has been some improvement there is still widespread expectation that a woman's primary function in a marriage or union is to procreate. Strong taboos against childlessness and infertility remain rife in Burundi. When couples are unable to conceive the women are routinely blamed and many still expect to be abandoned in favor of another who can bring children into the world, preferably sons. These deeply held beliefs and practices continue to challenge any attempts at population control through family planning and undermine women's social position in the society.

However, the biggest threat by far to the spread of many forms of contraception is the religious institutions, in particular the Catholic church, which categorically bans the use of "modern" forms of contraception.

One particularly striking example was mentioned by solidarity group members in Musigati; members related an incident where the local Curate has preached that any woman using modern contraception is a essentially committing murder. This kind of intense pressure from one of the most respected institutions in the lives of most Burundians must weigh heavily on the minds of couples who want to change their reproductive behaviors but find it impossible to get the support to do so.

5. Interpretation : Assessment of Strategies – what is working? What needs to be changed?

The two principal strategies of the project has been the **empowerment of women through the solidarity group or "nawe nuze" approach** and the **engagement of men and boys in the fight for the rights of women and girls** (in particular the fight against sexual and gender based violence and in promotion of sexual and reproductive health). In addition to these cross cutting strategies the project has also used approaches such as social analysis and action and SASA! which have been tested and proved successful in engaging couples to tackle the difficult issues of sexuality and reproductive health. The newest strategy being tested primarily in the area of reproductive health is that of "model couples". SAA, SASA and the "model couples" cut across all of the project's and activities are intended to bring about positive impact in all aspects of the project including raising awareness and preventing sexual and gender based violence and promoting sexual and reproductive health rights. The SAA, SASA! and care couples model are all embedded within the women's empowerment and engaging men and boys' strategies.
The strong and weak points of each of these strategies and approaches and their contribution to the project achieving its goals will be explored in this section of the evaluation report.

<u>Nawe Nuze "Solidarity Group"</u> :

The project has demonstrated that the solidarity group approach is a very effective and powerful methodology for empowering women economically, socially and even politically. So far, according the latest project reports, the project has created 384 solidarity groups with 6,975 women members. Many of the women attest to a clear increase in self confidence and pride and a sense of having greater respect and authority in their family

The Story of Augustin Ndabigengesere, Giko Colline, Shari2, Bubanza Province
Augustin is a member of the Nawe Nuze group in Giko Colline, Bubanza province. Augustin believes that since joining the group, his life has changed significantly. Before he lived « illegally » with his wife. His three children's births were not officially registered. This self-confessed former « slave to beer » was frequently violent to his wife and did not share any of the money he earned with her. After a while his wife could take it no longer and ran away back to her family. When the project came to his community Augustin joined a Nawe Nuze group. As he attended more NN meetings Augustin began to realize just how unacceptable his behavior towards his family was. Soon after he legalized his marriage to his wife and registered his children's births. Now Augustin shares everything with his family– he works together with his wife in the field and he contributes to the household expenses. Every week he, like all the other members of his SG, saves 400 francs(28 US cents). He was able to borrow 10,000 francs (US$7.00) which the family has used to meet many needs. His wife is also a member of a solidarity group and she now is more financially independent and can buy what she needs. The family is now much happier and his wife has even become a role model for other women in the community.

due to their ability to contribute to the family's resources. Women in the solidarity group also attest to feeling more valued, having a higher sense of self-worth and independence. As one group member noted «we no longer have to beg our husbands for money ». Importantly men in the community have also attested to the positive impact that membership in the solidarity group has had on their families. Many men are also increasingly joining solidarity groups or forming their own groups.

Women solidarity groups members also attest that they now have some place to express themselves and discuss problems (in many instances these may be problem related to domestic violence) that they may be facing at home. In cases where the women SG members feel that the situation is above their ability to deal with it themselves they reported that they feel empowered to refer these cases to the appropriate judicial or medical authorities.

The last evaluation pointed out that the livelihood needs of SGBV survivors were being met to a large extent by the solidarity group approach and related activities, i.e. practical needs such as savings and loans but that there was still a necessity to address other practical needs for survivors, such as ensuring access to SRH services for HIV and AIDS treatment. The expansion of the solidarity group's activities into areas such as counseling and informal group therapy indicates that the group is beginning play a greater role in helping survivors to come to terms with their experiences. The SG is also playing a major role in raising awareness and in the prevention of violence against women.

Women solidarity group members are increasing their political and advocacy visibility. The administrator of Bubara in Magara district remarked that for the first time he himself saw the power of women organizing in honor of International Women's Day, an indication of the emerging power of the women of Burundi in the public sphere. However much more needs to do be done to expand the role of women in the solidarity groups from agency level empowerment to more advocate for higher level strategic and public policy level changes. The potential for this level of empowerment is there – many women in communities served by the project have already been elected to local office (some even as head of the hill councils). The consultant met with one such woman who is both the head of her local hill council and president of her solidarity group. The project should encourage women with such capacity to exert more influence in their communities in favor of the rights of women.

Women are also developing the self-confidence to challenge polygamy and "informal" marriage. However while most of the solidarity group members are seeing a clear benefit from the project it is not clear to what extent the proejct is positively impacing the lives of other women in the community. The bulk of the project's efforts focused on solidarity group members and, though the quantitative survey's control group suggests that at least in the area of SHRH there is not much difference in the impact of the project on non solidarity group members, more investigation is needed to come a clear conclusion on this point. This leads to the question of whether the project is in fact reaching the most vulnerable. Solidarity groups around the world are necessarily self selecting because their first objective is to create sustainable financial services for its members. As a result they must establish and stick to often stringent rules regarding basic financial and entrepreneurial capacity. But one migth ask if by self selecting the SGs (and by extension the project) are in fact discriminating against the most vulnerable members of the community who often are not able to meet the requirements of a microfinance program. It must be said that a number of project activities, such as the witnessing of the abatangamuco, the community outreach and awareness raising the referral network and the SHRH activities, are available to ALL members of the community but the main strategies for the empowerment of women–the SGs – limits the ability of the project to empower all women in a given community.

One major weakness of the project's use of the solidarity group approach is the neglect of young (largely unmarried) women. The evaluator found it difficult to get clear answers on the exact level of outreach of the project to young women. This particular demographic is among the most vulnerable to sexual and gender based violence

yet project activities seem to largely miss most of them. Many are likely to be overlooked by the self-selecting solidarity groups and while the other project activities such as community awareness raising are positive, these efforts are diffuse and do not sufficiently target young women. There is significant potential for GIRIJAMBO! to learn from and engage with CARE Burundi's Children's Empowerment Programme to better address the needs and vulnerabilities of young unmarried women (15 to 22 years).

Engaging Men through the Abatangamuco

The project acknowledges that for the empowerment of women to be effective and sustainable, engaging men and (increasingly) boys is critical. The project has therefore adopted a strategy of "Engaging men and boys" largely through the Men and Boys Engaged Initiative. The principle vehicle of the strategy is the *abatangamuco* (in Kirundi "those who bring light to where there is darkness"), a social movement of men and women who have experienced profound change in their lives influencing their attitudes and behaviors. In fact the abatangamuco is a strategy used across all projects within CARE Burundi's Women's Empowerment Programme. Now in its 3rd year, there are several generations of *abatangamuco* and allies among local government administrations that challenge traditional norms and values concerning women. *Abatangamuco* discuss issues concerning alcoholism, gambling, domestic violence and polygamy with communities in order to facilitate a forum for men and women to discuss their struggles. Couples have begun to work together to share their stories of positive change in their households and groups of *abatangamuco* now work together to share stories with their communities.

The Abatangamuco approach has been very convincing and largely successful. The witnessing of the couples really seems to touch people and bring out emotions from the stories of deep change. The fact that much of the testimony is done by couples makes the people even more convinced of the sincerity of the change in the men and the relationship between the couple. The project has brought an innovation to the abatangamuco approach whereby an abatangamuco couple may "adopt" five other couples who they would support in their journey to changing their relationship(of course the couple has to take the step towards changing). These five 'model couples' would then work with 5 other couples (25 in total) in a multiplier effect. This aspect of the strategy works more directly on the issues of joint decision making within a couple and on relationships of power within the couple. This is particularly important to the success of the sexual and reproductive health component of the project where decisions on reproductive health are more effectively taken by the couple. So far 160 model couples have been selected and trained. Each couple is currently mentoring another 5 couples. The model couple approach is promising and should be expanded once the initial pilot phase is concluded.

In order to improve prevention efforts on violence against women and HIV/AIDS, CARE is also working in partnership with Raising Voices (a Ugandan NGO) to integrate the SASA! approach in the activities of the GIRIJAMBO! project. SASA! is a methodology that helps to promote change in social norms by influencing change in knowledge, attitudes, abilities and behavior that reinforce violence against women and women's vulnerability to HIV/AIDS. The project has piloted the SASA! approach across its work with all community members(Activists, leaders, couples, etc.). The strength of the SASA! approach is that it addresses the issue of power in relationship between men and women –the issue at the center of many of the issues that couples face. If couples can better understand the dynamics of power then it's a big step in recognizing and resolving the issues. Though it is still in the pilot phase SASA! approach is beginning to bring positive results and should be scaled up for the remainder of the project.

Sexual and Reproductive health strategies

The SRH education and awareness raising activities are still quite a recent area of focus for the project and discussions with project impact and target groups uncovered much disinformation and misunderstanding about SRH services and in particular "modern" contraceptive measures. Some beneficiaries claimed to have heard that certain methods lead to sterility, excessive weight gain among women etc. Other beneficiaries in focus group discussions wondered why the project was not also providing intrauterine devices (IUDs) for men (a clear indication that there is not a complete understand of what constitutes modern forms of contraception). If these reflections come from solidarity group members and those closely associated with the project one can imagine how much misinformation exists among members of the community who are not closely affiliated with the project. Even some health professions interviewed showed a lack of accurate information. Much more work needs to be done by the project in increasing awareness of SRH.

The project should consider a review of its SHRH approach. Part of this revision should include examining other 'modernized' natural family planning methods that could help couples to make choices engage in family planning methods that are in line with their values and religious beliefs. Georgetown University's Institute of Reproductive Health is at the forefront of this effort and has made significant strides using approaches such as the Standard Days Method (SDM) and Fertility Awareness Method (FAM)[13]. CARE should further explore these options and consider contacting Georgetown University to explore possible collaboration on these issues.

6. Sustainability

Some of CARE's cross cutting work has reinforced GIRIJAMBO!'s impact. For example the advocacy strategy of training women to run for public office has meant that the emergence of women leaders who can support the project and act as role models for women, in particular young girls. The project could make greater use of these women in future encouraging them to take on a greater leadership role in community awareness raising for change and in local government decision-making.

Nevertheless there are real questions as to how the provision of services will continue after the end of this project. It is not clear that CARE's government or civil society partners will have the means to continue financing these activities after the current funding is finished unless the project were to receive funding for a further phase. Already the Ministry of National Solidarity, Human Rights and Gender/Family Development Centers has expressed concern about their own financial situation and would like more direct financial and budgetary support from CARE in order to continue its basic outreach activities.

The future of the Nawe Nuze solidarity group approaches also raises questions. It is understood that CARE Burundi seeks to develop Nawe Nuze as a model that others may follow. However, the future of the existing solidarity groups is not clear – how will they sustain the services that the currently receive from the project. Will they consider

[13] Fertility awareness-based methods (FAMs) are ways to track ovulation — the release of an egg — in order to prevent pregnancy. Also referred to as "natural family planning." One type of FAM is the Standard Days Method(SDM), essentially a calendar based method which allows a woman to keep track of her menstrual cycle. Most women who use the SDM use "cyclebeads" which help to keep track of their most fertile periods of the month.

a fee for service approach similar to that used by the solidarity groups of MMD movement that was started by CARE Niger? These questions should be answered as soon as possible since only 18 months remain in the current phase of the project , not a long time to make decisions and put mechanisms in place for a transition.

7. Challenges :

Legal environment:

The legal context continues to be a challenge that the project will have to address in order to fully address the abuse of women's rights. For example the inheritance laws continue to systematically discriminate against women though there has been a revision to the law pending for over 12 years. CARE has engaged in advocacy at the headquarters level along with consortia of other civil society organizations with as yet no successful outcome. In fact the law has actually been met with reservations by many in the rural communities because families (men and women) worry about its practical application – how will already small parcels be divided when there is so much pressure already on the land? Some CARE staff wonder whether these "practical" questions do not also hide deeper feelings that women should not have title to land.

Deep rooted cultural traditions:

Another major challenge to the success of the project is the deeply held traditional values that contribute to women's low social status, abuse of their rights and, eventually, violence. The project has made great strides in tackling these attitudes and traditions, however they are very slow to change. The project is at a critical phase were gains could be reversed if a sustained effort is not made to consolidate these gains. Several respondents during the qualitative evaluation raised this concern that culture and tradition is so overwhelming that is a real threat to the sustainability of the project's impacts.

Powerful religious institutions/influences:

After the extended family the church arguably exerts the most influence on the lives of most Burundians. As such religious leaders could constitute a major block on project progress particularly in the area of sexual and reproductive health. The report has already discussed how this intense pressure can cause women who would otherwise be willing to adopt modern methods of contraception to opt out. It these issues are not tackled they will have serious implications for the sustainability and expansion of the project's impact.

8. Recommendations: How do we apply lessons learnt?

The project has made remarkable progress in a very short time. As an evaluation of an earlier phase found, the model of service for sexual and gender based violence and SRH is one that is perhaps unique in all of Africa. That is a remarkable achievement for Burundi. Further the project has generally sought to take on board the lessons learned over the years and integrate these into its activities. The project has also worked with the same partners over the years developing a strong relationship of trust and camaraderie that is remarkable. One can see very little distinction between the staff of CARE and that of its partners. Project staff have received significant amounts of training and professional development in a number of new approaches that have strengthened the project such as SASA!, engaging men(including innovations such as the care groups). The project has also brought on board such innovations as the 'model couples'.

However the biggest concern about the program is that its biggest efforts seem to be missing a major section of CARE Burundi's impact groups – young women (both married and single) between ages 14 to 22 years. The concentration of much of the project's efforts on the solidarity group means that potentially only a fraction of the women of reproductive age in any community are SG members. Young women and girls are less likely to be invited to join the group or less likely to feel empowered in the presence of older more experienced women if they do join the group. Of course the project does reach the community more generally through the testimonies of the abatangamuco and the awareness raising activities of the community activists, but these activities are less intense and therefore their impact may not be as profound in terms of behavior change.

Target young people, in particular young women, aged 15 to 22 years

The project should improve its capacity to work with young people –both as survivors of sexual violence and in prevention activities that targeting behaviors and choices that impact on their sexuality and reproductive health. To reach the very vulnerable age group of young women (and men) a separate cadre of youth educators could be formed among the youngest SG and community members to promote sexual and reproductive health rights.

Part of the issue seems to be that the division between the WEP and CEP is somewhat artificial particularly in relation to young rural girls who are among the most vulnerable to sexual violence and violation of their rights. Other ways of reaching young (largely unmarried) girls should be explored such as peer education groups, animation clubs and techniques; the Children's Empowerment Program would be an excellent source of support in this initiative though the fact that the two programs are located in completely different geographic areas does makes coordination and synergies a challenge. The project should build on its community outreach efforts with youth by taking advantage of "spaces" where young people congregate to increase awareness of these issues and services. The project could start by conducting ongoing operational research to better understand the concerns and needs of young women in the area of SGBV and sexual and reproductive health rights. This can be done, as suggested in the 2009 SRH strategy quite simply by staff developing 1 or 2 "research questions" to explore with groups of young women in the project areas. GIRIJAMBO! can draw extensively on the work of the Children's Empowerment Programme. In fact this evaluator suggests that the two programs urgently look at building synergies and setting a priority of working in the same areas. Targeting youth, particularly young women, in Burundi should be an urgent priority, not only are they among the most vulnerable to sexual and gender based violence (young women), they are a major segment of the population. If efforts to address violence and abuse of rights are to take root in Burundi young people must be at the center of our strategies.

Continue to expand the engagement of men and focus more closely on engaging couples

At the same time that the project expands the involvement of young women and girls the project should also continue to expand the participation of men beyond the Abatangamuco, particularly young men by finding them in those places where they meet and through peer educators to engage them in the prevention of SGBV and so eliminate violence in a new generation of families.

This expansion has begun with the piloting of the "model couples" approach, itself a kind of peer educator approach. The project should expand the « model couple » CARE can continue in this vein by expanding this approach based on the lessons learned of the first 18 months.

Particularly in the sexual and reproductive health rights component, the project should further develop the model couples approach. Project staff can begin by simply conducting a participatory review of the approach with project

participations and partners with a few key questions to guide discussions. The results of this review should provide the project with lessons learned on what is working and where there is a need for the approach to be strengthened. The review should also examine how the approach can be more closely and clearly aligned with both SAA and SASA approaches. It is clear that the "model couples" are trained in the SASA methodology along with all the other project "activists" but the question of how SASA can support the expansion and extension of the model couple approach needs to be further examined.

Engage with Religious leaders:

Religious leaders are among the most influential in the lives of Burundians. Religious leaders have significant potential to influence the success of GIRIJAMBO!'s sexual and reproductive health goals as well as sexual and gender based violence, therefore the project should regard them more as potential partners and less as barriers, particularly in the area of SRHR but also in sexual and gender based violence. CARE Burundi's strategy should find strategic ways of engaging with this powerful block. Project staff have already begun this collaboration by organizing training and awareness raising sessions for local religious leaders. However CARE Burundi should consider developing a comprehensive strategy starting with engagement at the highest (national) level between CARE Headquarters and religious institutions. This will facilitate the project's work at the field level and help the local religious more receptive and foster a more effective collaboration. This process may begin with a strategizing session with CARE Burundi senior staff and partners followed by discussions with religious leaders at a senior level. Depending on the outcomes of these initial meetings CARE Burundi and partners would work with religious leaders at the commune level and lower to begin addressing many of the root causes of SGBV and to promote women's sexual and reproductive health rights.