Essential Gender Based Violence Prevention and Services Project

End of Project Report

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Acroynms and Abbreviations

CAG	Community Action Group
COWLHA	Coalition of Women Living with HIV & AIDS
CVSU	Community Victim Support Unit
DHS	Demographic and Health Survey
GBV	Gender-Based Violence
M&E	Monitoring and Evaluation
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
SAA	Social Action and Analysis
SASA	Start Awareness Support Action
SRGBV	School Related Gender Based Violence
TA	Traditional Authority
TWG	Technical Working Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSLA	Voluntary Savings and Loan Associations
WOLREC	Women's Legal Resources Centre
WOJAM	Women Judges Association of Malawi
YONECO	Youth Net and Counselling

Executive Summary

Gender-based violence (GBV) against women is acknowledged worldwide as a violation of basic human rights. Increasing research has highlighted the health burdens, integrational effects, and demographic consequences of such violence.[1] In Malawi, lifetime experience of GBV among women aged 15-49 is substantial: 34% of women in Malawi have experienced physical or sexual violence, and the percentage has increased since 2004. Only 40% of all women who have experienced any type of physical or sexual violence sought help to stop the violence—49% have never sought help or told anyone about the violence they experienced. The most common source of help was a woman's own family; fewer than 10% sought help from the police.[2] Relatively few cases brought to the police ever proceed to trial, and most Malawians prefer to access community or informal forms of justice.

In 2016, former United States President Barack Obama selected Malawi as one of the first focus countries for U.S. interagency GBV prevention and response programming. With support from the U.S. Department of State, EngenderHealth launched the Essential GBV Prevention and Services Project in Malawi in 2017, with the overall goal of decreasing GBV incidences and increasing the coordination of multi-sectoral responders in the districts of Blantyre, Chiradzulu, Mzimba, and Kasungu. Over the course of the project period, EngenderHealth and project partners rolled out GBV prevention, care, and support interventions reaching women and girls, men and boys, traditional leaders, religious leaders, and members of the justice sector. The project was the first GBV program in Malawi and delivered impact and learnings that can inform social and health programs in-country and beyond. For example:

- Through approaches such as Social Action and Analysis (SAA) and Start Awareness Support Action (SASA) Faith, leaders went through a process of self-reflection, individual and community action planning, and follow-up. At the end of the project period, these leaders not only became an important source of GBV support but were seen as key in changing harmful traditional practices such as child marriage.
- Service providers indicated that gender sensitization trainings were successful and there is some evidence to show their effectiveness in changing attitudes. However, these trainings need to be taken to scale and fully evaluated to determine direct links to reducing GBV.
- Women's economic empowerment activities received positive feedback from participants. However, evidence that demonstrates increased earnings mitigate GBV needs to be further explored.

In the report that follows, the project results, impact, and learnings are further discussed.

[1] United Nations. 2006. *Secretary-General's In-depth Study on All Forms of Violence against Women*. New York, USA: United Nations Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N06/419/74/PDF/N0641974.pdf?OpenElement

[2] National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

Context and Background

Despite advances in gender equality over the last decade, Malawi ranks 145/188 on the Gender Inequality Index, reflecting high levels of inequality in reproductive health, women's empowerment, and economic activity. The Government of Malawi recognizes the problem of GBV and acknowledges its impact on vulnerable groups, gender equality, and poverty reduction efforts.[3] The government is committed to preventing and responding to GBV through a variety of actions, including laws, policies, international commitments, programs, and services. The Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) is the government institution tasked with coordinating Malawi's national GBV response and has made meaningful strides in recent years. Yet despite these efforts, GBV remains a problem for Malawian women. According to the 2015-16 Malawian Demographic and Health Survey (DHS), 34% of women have experienced physical violence since age 15, and 20% have experienced sexual violence. Almost half of ever-married women have experienced spousal violence, with the most common type of spousal violence being emotional violence (30%), followed by physical violence (26%), and sexual violence (19%).[4] Malawi also has a high rate of child marriage. The UNICEF National Traditional Practices Survey (2019) report revealed that 9% of the women interviewed were married before the age of 15 years, while 42% were married before the age of 18 years (as compared to their male counterparts at the rates of 1% and 6% respectively), further indicating gender imbalances.[5]

With support from the U.S. Department of State, EngenderHealth launched the Essential GBV Prevention and Services Project in Malawi in 2017, with the overall goal of decreasing GBV incidences and increasing the coordination of multi-sectoral responders in the districts of Blantyre, Chiradzulu, Mzimba, and Kasungu. To address the underlying barriers to GBV, the socio-ecological model was used for addressing GBV through a multi-sectoral approach that created synergy between prevention and response interventions. The project's activities sought to increase the level of primary prevention efforts by targeting the root causes of GBV (e.g., harmful traditional practices, and rigid social, cultural, and gender norms); build the leadership of women and girls to demand their right to live free from violence and seek health and social services; engage with men and boys to challenge negative notions of masculinity and patriarchal social norms that perpetuate the use of violence; and strengthen the link between informal and formal justice sectors. To maximize community ownership and overall sustainability, EngenderHealth worked with local organizations and networks to implement interventions across the focus areas, with our role being focused on technical assistance, networking between the local partners, and refining interventions based on evidence and learnings from the implementation sites. Partners under the project included Tovwirane, Youth Net and Counselling (YONECO), Women's Legal Resources Centre (WOLREC), Coalition of Women Living with HIV & AIDS (COWLHA), World Education, and Women Judges Association of Malawi (WOJAM).

3 Ministry of Gender, Children, Disability and Social Welfare. 2014a. DRAFT National Plan of Action to Combat Gender-Based Violence in Malawi (2014–2020). Lilongwe, Malawi: government of Malawi.
4 National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.
5 UNICEF. *National Traditional Practices Survey*. 2019. Malawi available at: https://www.unicef.org/malawi/media/1546/file/Traditional%20Practices%20in%20Malawi:%20Survey%20Report.pdf

Project Results and Learnings

The Essential GBV Services project has demonstrated great successes and learnings over the implementation period. A brief summary of these learnings, as supported from findings from the baseline and endline surveys, are summarized below.

Engagement of traditional authority (TA) leaders and religious leaders is key to address harmful traditional practices, attitudes, social norms, and behaviors that perpetuate GBV.

A key component of the project was the active engagement of community-level leaders to address factors that perpetuate GBV. During the first year of the project, EngenderHealth worked with local project partners to conduct participatory dialogue sessions to identify locally-specific harmful traditional practices, beliefs, and general social norms that normalize GBV. By identifying drivers of GBV together with community leaders, such as traditional and religious leaders, the project was able to engage influential individuals from the outset who would later help to address these harmful traditional practices. A total of 160 TA leaders were trained to participate and co-facilitate dialogue meetings across the four districts. Harmful traditional practices, identified through formative research, included: initiation ceremonies which sometimes involve 'sexual initiation' of girls and forced circumcision of boys; norms requiring 'widow cleansing' following the death of a husband; and beliefs that paying dowry (lobola) provides automatic power to the husband and his family over the woman, which is mostly abused and encourages men's superiority over women. These beliefs were further supported by the project baseline assessment (N=653), which revealed that only 23% of respondents agreed to a statement that 'men/boys are equal to women/girls.' In addition, agreement to this statement was slightly lower among male respondents as compared to female respondents (20.6% versus 29%, respectively).

To address these harmful traditional practices and beliefs, EngenderHealth supported implementing partners to engage community leaders through on-going reflective dialogue sessions, using the participatory gender transformative approaches SAA and SASA Faith. The project worked with community leaders to develop commitments and action plans to facilitate and monitor change. A quote provided from a community member suggests some positive change.

Community and traditional leaders held various meetings in their communities to fulfill the commitments in their action plans. For example, six group village headmen from Kampingo Sibande in the Mzimba district formed GBV committees of 10 members (four men and six women). These GBV committees held small group sessions with community members to discuss harmful traditional practices that promote GBV, and supported referrals of GBV cases. These activities may have helped promote positive changes in attitudes and perceptions of GBV within the community, as evidenced by a population-based household study that was implemented across the four districts at the end of the project in October 2019. The endline survey revealed that 68% of respondents reported they had noted changes in customs and cultural practices that perpetuate GBV. Furthermore, there were few differences between male and female respondents (72% and 66%, respectively). Across the four districts, reported changes were highest in Chiradzulu (84%), followed by Blantyre (73%), Kasungu (66%), and Mzimba (65%). Among those that reported such changes, respondents commonly cited positive changes

> "Through awareness and sensitization campaigns, many men have started realizing that beating a woman, among other things that they were doing to their wives, is violence. More importantly, because women are now aware of where to report GBV cases, men are now afraid to conduct such acts looking at stiffer punishments that are offenders have already received."
>
> **CAG – TA Wimbe**

in their community, in terms of early childhood marriage (78%), forced marriage (67%), and wife inheritance (36%). Fewer respondents cited changes in the practices of virginity cleansing (21%), hyena customs (20%), obtaining a bonus wife (8%), and/or wife swapping (4%). Some of the communities, led by TA leaders, are currently practicing modified traditional practices and have put in place by-laws that aim to reinforce the modified practices and deter others from performing the harmful practices. The endline survey demonstrated overwhelming support for the traditional leaders, with respondents citing they were available (93%), accessible (98%), and functional (98%). Similar findings were observed for religious leaders, where respondents cited they were available (80%), accessible (95%), and functional (96%). These findings highlight the need to engage community leaders early and often through participatory processes to change perceptions and address harmful traditional practices.

Engage communities to create support structures for survivors of GBV. The project included numerous efforts to mobilize communities to change norms, facilitate referrals, and address harmful traditional practices through local GBV committees/groups as described above. One example of an outcome of the mobilization was the establishment of 86 safe homes/safe spaces to accommodate survivors of violence in need of immediate shelter. These safe houses are meant to provide shelter for GBV survivors while they await support from the District Social Welfare Officers, law enforcement, etc. Use of pooled community funds, resources, and efforts to construct or refurbish safe spaces demonstrate a level of commitment for the survivors. In addition, community volunteers provide hosting services for survivors staying in the space. To support the volunteers running the safe houses, the project conducted a series of capacity building trainings and supportive visits which enabled the volunteers to provide support and guidance to the survivors. In addition, the traditional leaders and community action group members for each traditional authority acknowledged their responsibilities to ensure the safety of survivors. While the establishment of the safe houses demonstrates community-led commitment and support for survivors, these initiatives should be paired with an intensive package of community activities. The endline survey demonstrated that only 17% of participants were aware of these safe homes. This was highest in Kasungu (38%), followed by Mzimba (35%), Blantyre (14%), and Chiradzulu (12%). Of those who were aware of the safe homes, women and girls reported greater knowledge (64%) as compared to men and boys (37%). The more community members who are aware of support options such as safe houses, the greater the opportunity for survivors to seek support.

Linking economic empowerment for young women and girls offers potential for larger impact in the GBV space. In the final year of the project, 737 young women and girls were selected through a rigorous process to participate in a series of economic empowerment activities, including vocational skills training and GBV sensitization sessions. In line with the project's aim to be gender transformative and inclusive, the project enrolled 13 young women with a physical disability. To ensure young women in remote areas were aware of the opportunity, EngenderHealth conducted nine meetings to increase awareness of this initiative (with a total of 491 participants [378 women, 113 men]), promoted the opportunity in community mobilization activities, ran radio jingles, and provided printed materials.

The project successfully graduated all 737 young women from vocational skills programs. The project actively encouraged women to select a vocation that challenged gender stereotypes, such as masonry, carpentry, bricklaying, electrical installation, tailoring, and basic electrical repair. The women and girls selected for the training were from poor backgrounds, within the required age group, at risk of GBV, and demonstrated genuine interest to be trained and a willingness to put the skills to use. EngenderHealth complemented the vocational training with basics on GBV, using SAA approaches such as pile sorting, value clarifications, gender box, etc. In addition, 144 spouses of the young women participated in sessions to foster male engagement and further prevent intimate partner violence. Evidence from the endline survey suggests that among the 546 women and girls that were interviewed,

only 7% of these participated in an economic empowerment program. Of these women (N=41), 86% agreed with the statement that "Following the training, I developed my knowledge and skills in financial management." Agreement to other statements addressing the perceptions of the training are also promising, with most women and girls agreeing that after the training, they had increased skills and knowledge on gender, GBV, and empowerment (79%), and were in a better position to participate in financial decisions in the household (86%). These findings suggest that while the economic empowerment program demonstrated positive results, the need to scale project activities is necessary to ensure greater reach of vulnerable women and adolescent girls. Quotes from some of those that participated in the project also highlighted several positive outcomes.

> "Since I started making cakes, samosa and scones my life changed. When business is going on well, I make almost MK10,000 ($13) on a good a day or MK8,000.00 ($11) on a bad day. My life has really improved. Right now, I am able to pay for school fees for my child instead of asking my husband or parents. I am even able to save some money."
>
> **Economic Empowerment Trainee-Kampingo Sibande**

The project transformed the lives of 68 men and 669 women, totaling 737 young people (100% achievement of target), through empowerment with vocational skills which they utilized to establish skill-based businesses. Through this initiative, the project reached an additional 3,685 people (immediate family members) who directly depend on the trained young people. Furthermore, the trained young people were able to trickle down their skills to an average of three people each, thereby broadening the reach of the project and multiplying its effect in fostering resilience to GBV through economic empowerment.

As part of the economic empowerment activities, EngenderHealth supported women who received the vocational training to access voluntary savings and loan associations (VSLAs). The project supported 5,065 women members of the VSLA groups who come from communities surrounding the targeted 43 community secondary schools. In addition, there were 981 male members, for a total of 6,046 members (121% achievement of target). The endline survey revealed that 37% of the respondents were currently a member of the VSLA groups, and of those who were not members, 22% of married respondents cited that their spouse was. This was higher than what was observed at the baseline, where only 17% reported being a member and 7% of married respondents cited that their spouse was. The endline data also found that 30% of the respondents who were involved in the VSLA group were male and 41% were women. Participation was highest in Mzimba (48%), followed by Blantyre (39%), Chiradzulu (34%), and Kasungu (26%). The endline data also reveal that those participating in the VSLA groups cited promising outcomes of this participation, including support to: 1) purchase school uniforms for kids (60% as compared to 49% at baseline); 2) purchase additional food (61% as compared to 40% at baseline); and 3) increased financial freedom (60% as compared to 31% at baseline). That said, several challenges were identified by respondents in the endline survey that were part of the VSLA groups, including conflicts within the groups (54%), loss of friendships due to disagreements (63%), and loss of property for failing to pay back a loan (61%). Several mechanisms were identified to address these challenges, including discussions with group leaders (as cited by 40% of participants), or mediation from a non-member (21%). Very few respondents reported leaving the group (12%) or that the group was discontinued (9%).

Respondents identified several means to improve the quality of the VSLA groups, including better guidelines (57%) and convening more routine meetings (47%). Of additional interest is the finding that 57% of members reported that both spouses contributed towards the VSLA savings, and 22% cited that it was solely the wife. When asked who controls funds from the VSLA in the household, 66% cited both spouses, which is higher than what was observed at baseline (38%). Only 10% cited this was the husband at endline, compared to 20% of respondents at baseline. Among married respondents that were interviewed at the endline study, 88% cited that the VSLA program had a positive effect on their marriage, which was slightly higher than what was reported at baseline (81%). Quotes from participants illustrustrates positive reflections of the VSLA program:

> "Currently, husbands are respecting us as compared to previous years. They know that we have money, and if they chase us away, they are chasing away money."
>
> **VSLA member-Simlemba**

The evidence suggests some promising project findings as illustrated through the endline study. In short, project activities may have increased awareness of GBV in the communities, resulting in positive changes in attitudes, and increased economic empowerment for women. It is acknowledged that such beliefs and changes in behavior may then lead to a reduction in violence due to the money the women bring home. However, an important learning is that despite some positive project findings, this does not necessarily indicate that the root cause of GBV has been addressed or that a gender transformative shift has taken place in the attitude of both men and women. A true gender transformative change would mean attitudinal changes, including an absence of all forms of violence, irrespective of the earning capacity and contribution of women or men. A gender transformative change process requires time, and the project did not have the advantage of long-term implementation in the specified geographies. As a suggestion for continuing to reap the dividend of this project, we would recommend a focused gender transformative lens intervention with all stakeholders, to challenge and change the root causes and attitudes around GBV.

> "I am an example of one of those people that have managed to get nice pieces of cloth through the VSLA. At the beginning, my children and I used to wear rags and we were ridiculed in the community but now, our levels of poverty have decreased"
>
> **VSLA participant-Simlemba**

Interventions that address School Related Gender-based Violence (SRGBV) provide additional opportunities to strengthen the GBV response. At the TA level, the project engaged the surrounding communities—as well as guardians/parents of the students—to address SRGBV and create an enabling environment for students to actively engage in the efforts for the elimination of GBV in schools. Activities included training the implementing partners on the 'My Dreams, My Choice' curriculum (100% achievement of the target); training 20 trainers on the GoTeachers-Plus curriculum (100% achievement of the target), which resulted in 500 teachers being trained (83% achievement of the target). Community Action Groups and parent/guardian groups within the project districts took action and nullified 198 child marriages. The girls were later reintegrated into school.

The project also initiated GBV prevention efforts in tertiary institutions, one of the first in Malawi. It engaged students, lecturers, and other key staff associated with the welfare of students at Lilongwe University of Agriculture and Natural Resources (LUANAR). The project was the first to facilitate the development of a GBV orientation package which has been adopted by other institutions (Bunda College, Natural Resources College) wanting to take action in addressing GBV. At the closure of the project, the package had been mainstreamed as an integral part of the routine student orientation package of participating colleges. Furthermore, the three colleges of the university established anti-GBV clubs which champion sensitization and peer support on GBV issues. At Bunda College, the project supported the review of its gender policy and guidelines to ensure that it was GBV sensitive. At Natural Resources College, the project provided technical support in the development of their gender policies, ensuring that issues of GBV were included and articulated.

Project Activities Overview

Over the three-year project period, EngenderHealth and its implementing partners rolled out interventions to strengthen coordination of GBV, improve engagement between actors to enable a more systematic response to GBV, and reached men, women, and young people with messages in communities and educational settings. Many interventions embodied SAA and SASA Faith approaches, which foster community, individual-level reflection, dialogue, and collective action to address norms and behaviors that perpetuate GBV. Other interventions focused on ensuring survivors of violence had recourse to a functional legal system.

Below is a description of the main project interventions over the three-year period, along with key achievements against targets, woven in with findings from the endline survey. This information is presented together to allow for a comprehensive reflection on the project's achievements. A list of indicators with baseline and endline targets is provided in the Performance Management Plan in Annex A.

Objective 1: To strengthen coordination of GBV prevention and response in civil society organizations and government.

Strengthened coordination of stakeholders at the national and district levels to improve GBV programming: The project targeted key structures instrumental in the design, delivery, and oversight of GBV work in Malawi. At the national level, the project revitalized and engaged the GBV Technical Working Group[6] (TWG) which was not functional at the start of the project. EngenderHealth supported the development of clear terms of reference and helped re-energize membership and discussion at this key national forum. Further, EngenderHealth supported the TWG secretariat (Department of Gender) to develop mechanisms for sustainable functioning of the TWG and its subcommittees. This included development of a joint work plan that enables tracking of GBV work, and allows for harmonization of resources on GBV work across other relevant TWGs. In addition, the TWG started reporting on various interventions (and associated results) executed by implementing partners across the country.

At the district level, the program revamped the TWG and other committee functions, enabling implementing partners to work collaboratively with district-level stakeholders in responding to GBV

[6] GBV TWG is comprised of key departments and civil society organizations responsible for technical support in development of GBV-related policies, strategies, and programs. At the national level, it is recognized as one of the important structures that provides technical advice to parliamentary committees of Gender and GBV.

issues and cases. Prior to this, there were suggestions that referrals were difficult, as exemplified by a statement from a child protection worker.

> There is no government hospital here, the only available one is private and about 15kms away and the court usually does not accept medical reports from private hospitals. Court's usually require referral letters from public hospitals so it's a big challenge to easily address other forms of violence especially that of rape and involving major bleeding.

Child Protection Worker- Kampingo Sibande

In addition, monitoring and supportive supervision visits that were conducted jointly with district TWGs served as opportunities to share these tools, reinforce best practices for referral structures, and share lessons learned between national and district-level bodies (e.g. Department of Gender). Joint routine monitoring visits with District Gender Officers, District Health Officers, and District Social Officers helped to strengthen multi-sectoral coordination and supported continuous improvements to the GBV response.

Capacity building for key district officers on their roles in addressing GBV: At the beginning of the project, the Government of Malawi had already recruited District Gender Officers who had assumed their positions without orientation on their roles or responsibilities. The project consultative meetings with stakeholders determined the need to orient District Gender Officers so they could support project implementation and continue interventions after the project's closure. The project trained 39 District Gender Officers and District Social Welfare Officers (98% achievement of target) on existing GBV tools, monitoring and referral systems, and data collection and analysis, and facilitated a participatory session in which they explored gender and how they can support community-driven actions to reduce GBV. The training was beneficial as it helped the officers develop professional networks to facilitate the rollout of community-level activities. Furthermore, the training helped the officers understand the complexity of the project and develop strategies to support local implementing partners for effective community mobilization.

Commitment of key stakeholders at the national, district, and community levels: At the national and district levels, the secretariat offices (Gender Offices) developed a plan to sponsor routine quarterly meetings on a rotational basis. At the community level, members were trained in resource mobilization initiatives that enabled them to raise funds to cover logistical needs during the meetings.

Strategic selection of community members in committees and capacity-building initiatives: The project conducted a needs assessment in each of the four districts to establish influential groups to lead GBV prevention and response efforts in their communities. Criteria for selection into the groups included: affiliation with key practices that perpetuate GBV, ability to influence members of the community, and broad social support and standing in the community. The groups, which varied by location, included chiefs, religious leaders, initiation counselors, and community workers. For example, in Chiradzulu, the groups included leaders of traditional dancers (Angaliba or Nyau), a cadre that was identified as critical in Kasungu. The participatory approach to the needs assessment is an approach embodied in SAA methodology, as these groups and individuals would then become key players in changing the local response to GBV throughout the project. A key achievement included a training with 229 religious leaders (286% achievement of the target), community faith-based representatives, and

support group members on gender foundations, GBV, and how religious institutions can prevent and respond to GBV using the SASA Faith methodology.

The project introduced the selected groups to gender sensitization and GBV trainings, which enabled them to understand issues of gender and GBV, understand their different and complementary roles, as well as the importance of good coordination in delivering their duties. In Mzimba and Blantyre, this initiative led to the establishment of networks which champion the work of volunteers. Members of the influential groups did a lot of outreach work to change attitudes. For example, chiefs who were members of the influential groups reached 8,063 people with GBV messages (323% of target).

The endline study revealed that 71% of respondents knew where a GBV survivor could report a case, and there were few notable differences according to gender or district. Increases for a number of indicators/groups were observed between the baseline and endline survey in terms of where GBV cases could be reported: village chiefs (72% at baseline versus 85% at endline), community survivor support units (21% at baseline versus 49% at endline), schools (5.7% at baseline versus 67% at endline), and community workers (10% at baseline versus 40% at endline). These findings reinforce the importance of engaging influential groups at the community level to further increase the number and types of avenues where a GBV case can be reported.

Strengthened referral systems through training and improved tools: The project supported the development and dissemination of harmonized reporting and referral forms which made it easier to report and follow-up on cases, instead of continued reliance on the separate reporting and referral tools used in previous years by the Department of Social Welfare and Health, which made it difficult to trace cases. Over the course of the project period, EngenderHealth developed and printed 512 simplified referral manuals (256% achievement of the target) for use by community activists and local leaders. The District Monitoring and Evaluation Officer is an active member of the district-level GBV TWG and leads the consolidation and analysis of the data generated from the forms. The District Monitoring and Evaluation Officer is responsible for sharing data analysis during TWG meetings and other programming fora, to foster learning and understanding about GBV and the case management continuum at the district level.

To further strengthen the referral pathways, key stakeholders at the district level were trained on effective referral systems and the new tools. The district and community stakeholders were encouraged to conduct routine review meetings in which they analyzed progress, identified weaknesses in the system, and explored mechanisms for improving the referral pathway. The stakeholders demonstrated commitment and made an effort to coordinate and improve the overall referral pathway. Due to persistent limited resources in the district offices, some communities and district offices had to use their personal resources to assist women to move between various service points and access care.

That said, several indicators on referrals were not met. Only 30 national meetings were held with key stakeholders to assess and clarify the referral pathways, and ensure the availability and accessibility of these referral pathways at the national and district levels for GBV survivors, meeting only 50% of the target. In addition, a key outcome was to orient and popularize GBV referral tools for use by community network members and service providers (such as community leaders and members, village heads, Community Based Educators, and SASA groups). While 153 people were reached by this activity (96% achievement of the target), only 12 GBV survivor cases (6% achievement of the target) were subsequently referred.

Objective 2: To strengthen linkages between and among multisectoral actors and improve overall legal response to GBV Objective

The project improved the overall legal response to GBV in the four implementation districts. The following are some of the key interventions implemented with partners to address the multisectoral response, with a focus on legal services for survivors.

Access to justice for survivors: The project facilitated the establishment of community response structures such as Community Action Groups (CAGs) to be the focal points for reporting GBV cases at the community level. CAGs are comprised of volunteers who are influential members of the community, such as traditional leaders, religious leaders, child protection workers, and community policing members. Their role includes facilitating the referral of survivors of GBV to different service providers, follow-up of cases, and supporting people at high risk of GBV to seek refuge in safe places. These structures mediate cases between the formal and informal justice systems. Throughout the project, 8,284 people were reached by the CAGs (166% achievement of the target), and 24,710 people were reached by Community Activists (247% achievement of the target).

Strengthened capacity of community victim support units as first responders to GBV: The project made efforts to ensure that the performance of Community Victim Support Units (CVSUs)[7] was enhanced. The CVSUs play a fundamental role in community-based response and referrals to GBV. The project conducted targeted orientations with 147 Victim Support Unit members (45 women, 102 men) in the two implementing districts of Mzimba and Chiradzulu. Following the training, the project notes that the CVSUs intensified efforts on GBV response as well as community awareness raising. For instance, the CVSUs for Mzimba district handled 10 GBV cases and facilitated referrals of cases to the police (including one case of sexual and gender-based violence, or SGBV).

CVSUs reached 2,830 (81% achievement of target) community members with awareness-raising messages on GBV and negative social norms. The CVSUs also reached key and vulnerable populations (KVPs), as well as women living with disabilities. KVPs and women with disabilities are at an increased susceptibility for GBV, and therefore the project worked closely with the CVSUs in each district to strengthen their response and referral mechanisms while working with KVPs. The project facilitated a two-day targeted orientation with faith leaders, traditional leaders, and CBOs on the Disability Act of 2012 and other key recently enacted legislation. The project also supported CBOs at the district level, with a plan to continue activities after the project ends.

Mobile courts and fast-tracking of GBV cases: The project conducted stakeholder mapping to identify the areas in which mobile court services were not available. After the mapping, the project provided support to set up mobile court services in the areas with no access to court services. EngenderHealth and project partners worked with the CAGs and TAs to organize and raise awareness of the mobile courts. The project worked closely with the justice system to bring mobile courts to the communities and nearer to the survivors.

Community members have increased knowledge on the importance of reporting GBV-related cases, and referral points for incidences of GBV. Data from the baseline and endline surveys reveal some positive shifts over the project duration. When respondents were asked the question, 'Where can GBV survivors in this community get legal service assistance?,' only 7% cited mobile courts at baseline, as compared to

[7] CVSU is the official name of the unit as per Malawi systems, and is not a term EH uses in its own work. Therefore throughout this project, and all engagements with various stakeholders as well as in this document, we have consistently used the term survivor.

30% at the endline, and there were few differences between gender or district. Among respondents that cited mobile courts, an increasing percentage of respondents believe that mobile courts are needed in the community (31% at baseline versus 58% at endline). When asked about their perceptions towards the utility of mobile courts, several positive increases were observed over time. Respondents cited that mobile courts 1) provide quick access to legal services by GBV survivors in report settings (37% at baseline versus 80% at endline); 2) will help increase the rate of reporting among GBV cases (24% at baseline versus 69% at endline); 3) encourage the community to volunteer information that can lead to arrest of perpetrators (19% at baseline versus 70% at endline); 4) increase the number of convictions (15% at baseline versus 63% at endline); 5) improve community awareness of GBV (12% at baseline versus 64% at endline); and 6) will enhance community participation in GBV prevention through the formal legal system (13% at baseline versus 61% at endline). With the project, 64 mobile courts/circuits were conducted (80% achievement of target). Additionally, reporting of GBV cases improved, which led to the handling of 241 cases (60% achievement of target) through the mobile court initiative. Furthermore, the handling of court services through mobile courts in the communities may have proven to be a strategic deterrent for potential or current abusers. The formal justice initiative was complemented by the implementation of by-laws by traditional courts, for GBV cases other than SGBV and physical violence, providing holistic coverage for varying needs of justice services by survivors of GBV.

Improved gender-sensitization of the judicial system: Drawing on international human rights standards, the project conducted an assessment and review of minimum standards of care for GBV survivors who engage the judicial system. Women Judges Association of Malawi (WOJAM) consolidated the review findings into Court Guidelines for Dealing with Gender Based Violence Cases, which will be presented to the Chief Justice for adoption as a national standard across the Malawi judicial system. In addition, the project conducted gender sensitivity training of the magistrates, as well as other court actors (clerks, police, paralegals), prior to rollout of the mobile courts to ensure gender sensitivity in the conduct and delivery of justice. The training reached 30 justice actors (50% achievement of target), of whom six were women. Gender sensitivity training for the judiciary focused on identifying gender issues, stereotypes, and bias in courtroom management, sensitivity of the language used for sexual violence, evidence and procedure in sexual and gender-based violence cases, remedies and sentencing principles in sexual and gender-based violence cases, and judicial reasoning and judgment writing in sexual and gender-based violence cases. The training was insightful to many judicial officers, who admitted to previous instances of reinforcing gender stereotypes and subjecting GBV survivors to re-victimization during judicial processes. The project, through WOJAM, has since identified four judicial focal points in the four implementation districts to monitor the conduct of GBV cases under the judicial system (especially during the mobile courts) and ensure adherence to principles of gender sensitivity as per the training.

Conducted an assesment of judicial services and needs for GBV services: To inform the mobile court intervention, the project conducted an assessment and mapping of current—as well as unconcluded or stagnant—GBV cases within the courts of the four implementation districts. The assessment, led by WOJAM, revealed that GBV continues to be on the rise in Malawi despite various programmatic efforts, policies, and legislative interventions. The report revealed that gender-based violence is significantly felt by vulnerable groups like women and children, especially those living in rural areas. The assessment indicated that sexual violence (especially defilement) and physical violence are common GBV incidences reported to the courts that remain unaddressed. The assessment also noted specific disconnects in the links between health and the judicial system. For example, in Kampingo Sibande, Mzimba district, there is no police or public health facility (the nearest hospital is a private clinic which is 15km away). When volunteers go to private clinics with rape cases, there are challenges with taking the cases to court—courts only accept reports from public health facilities. The absence of a

public health facility remains a challenge in Kampingo Sibande, and has resulted in a coordination gap between communities, volunteers, courts, and health facilities. The assessment further noted gaps in terms of knowledge and skills in managing GBV-related cases amongst court actors, including magistrates.

As supported by the endline findings, it is important to note that gender transformative change takes time and one-off gender sensitization trainings do not lead to lasting impact. There is a need to consistently and persistently have these reflective dialogues and discussions with the judiciary, community gatekeepers, women, men, and all stakeholders, so that they continue to reflect and change their personal perceptions of gender, GBV, and survivors. The complexities of mainstreaming a GBV response within the legal framework requires continued support to ensure sustainability. Initiatives which are part of the legal framework or policy guidelines are more likely to continue (mobile courts, etc.) but initiatives which are not mainstreamed into policy (like the gender sensitization of judiciary players, safe house construction and maintenance by community groups, etc.), may be difficult to sustain in the long run. This project initiated gender transformative change to end GBV, but more needs to be done to sustain, continue, and persist on these crucial steps initiated by the project.

Objective 3: To increase the number of men and women reached by GBV prevention programming to address social and gender norms, and justification and normalization of GBV

A significant component of the project was to engage the gatekeepers and perpetrators of harmful gender norms and practices in order to change their mindset and actively change those practices from within. Framed in the socio-ecological model, the project reached spouses, traditional leaders, educators, religious leaders, and the media to maximize reach. Below is a description of key interventions for the key target groups.

Interventions to address harmful traditions, behaviors, and social norms that perpetuate GBV, especially for women and girls in the wider communities: The project was successful in partnering with religious and traditional leaders to challenge cultural and social norms that support violence, discrimination, and harmful practices. TA leaders and religious leaders in Malawi are enforcers of customary law and reinforce customary by-laws through formally recognized penalties. Their social power can either reinforce a harmful customary law or change these social norms and practices. During the project, implementing partners engaged 229 leaders (286% achievement of target) in trainings and campaigns to raise awareness of GBV. The traditional and religious leaders were trained using the SASA Faith and SAA curriculums. These curricula focused on helping the religious and traditional leaders reflect upon their personal biases and stereotypes around gender, GBV, and survivors, and attempted to challenge and change these perceptions. The SASA sessions included panel discussions with expert speakers from the Survivor Support Units of the Malawi Police Services headquarters, post-trauma care service providers, social workers, and magistrates appointed by WOJAM. As a result of these trainings, 94 GBV cases were responded to, achieving 94% of the project target. During the project period, we trained 517 (517% achievement of the target), CAGs, CVSUs, youth groups, and CBOs on the SASA approach, to mobilize around changing negative social norms to prevent and respond to GBV at the community level. We also conducted monthly community SASA sessions through trained SASA facilitators, reaching 4,161 people in the community (69% achievement of the target). The use of SASA Faith proved useful in changing social norms as it challenged prevailing norms and practices using people's existing religious beliefs. It enabled people to reflect on their own faith and reconsider their actions. The training included sessions on gender sensitization, understanding the root cause of GBV, creating action plans to prevent and respond to GBV in one's community, and identifying and building the capacity of champions among the traditional and religious leaders. All key gatekeepers went through robust capacity building which enabled them to support

the change process. Gatekeepers were also trained on monitoring for progress, as well as exposed to best practices through learning visits and implementation of routine review meetings. That said, given the short project implementation time, changing deep rooted social norms was a challenge, as exemplified by the following quote.

> Changing cultural practices and beliefs which they are used to is difficult. It is not possible to convince a person just in a day to change their cultural practices and beliefs by telling them that what they have been doing in their entire lives is bad. There is need more time to achieve and see significant results.
>
> **TA leaders- Kampingo and Chindi**

Male engagement: Over the course of the project, 77 men were trained to be male champions (96% achievement of target). Trained champions also attended quarterly follow-up trainings. These male champions reached 20,797 people with messaging to raise awareness about GBV (54% achievement of target). Male champions also conducted awareness campaigns with community members, especially men and boys, using community theatre and other techniques to challenge negative notions of masculinity. They were able to reach 477 community members (60% achievement of target) using these methods.

Some notable customs which have been addressed include: Chokolo is mostly practiced in Mzimba and Simlemba in Kasungu. This is a practice where a man forcefully takes custody of his late brother's wife/wives as his own wife. This is practiced under the social norm that identifies women as weaker and requiring the support of a man, and to maximize the value of the dowry the family has paid for. This custom is harmful as it infringes on the rights of women to choose partners, and they are put at high risk of contracting sexually transmitted infections, including HIV. While the baseline and endline surveys did not specifically address this issue, a series of statements were administered to address these social norms between a married couple. Very few differences were observed over time, which is understandable given the time between the two surveys was just over a year, and deeply engrained social norms are challenging to change in a short time period. That said, what was promising at the endline is that many respondents showed favorable responses. For example, 86% agreed with the statement 'A woman's consent must be considered when it comes to her marriage,' and only 8% agreed with the statement 'Men have the right to have sex with their partners even if their partners do not want to have sex.' Additional analysis by gender revealed few differences between men and women in their responses to these statements.

Continued schooling for girls and preventing early, child, and forced marriages: The data presented previously suggests there is some evidence that for the school-related economic empowerment initiative, some guardians and parents of students were able to save funds and access loans from the village banking initiative which enabled them to afford school fees for their children. This may imply a reduction in school dropouts and minimize the risk of forcing young girls into early marriages as a way of transferring the responsibility of raising their children.

Fostering a GBV-free environment in the targeted schools: The project aimed to foster a GBV-free environment in the targeted schools. EngenderHealth supported 43 'Protect Our Youth' (POY) clubs (108% achievement of the target), and trained 84 (37 men and 47 females) POY club peer facilitators (105% achievement of the target). A total of 2,044 students were reached through these clubs (160%

achievement of the target), and of those 34% were female. The activities aimed to improve functional response systems and give students strategies to eliminate social practices that perpetuate SRGBV. The establishment of 43 mother groups (108% achievement of the target) was a necessary activity to deter girls from dropping out of school due to early marriages, and other social factors such as poor menstrual hygiene. In addition, the project held a one-day training with mother groups on GBV prevention and responses, which was attended by 60 participants, representing a 233% achievement of the target. That

> Despite that referral mechanisms have been established students tend to report more cases of lesser impact and that of more impact are rarely reported due to fear of being mocked by friends or punished. For instance, it is so easy to report [a GBV case] when they have been touched on the breasts rather than to report a case of being raped.
>
> **Head teacher- Euthini secondary school**

said, a quote from a head teach suggests that while efforts are in place to reduce school based violence, severe cases may be under-reported.

Furthermore, it is recognized that to truly address and eliminate GBV issues, a complementary approach, that includes community and system level interventions is necessary. A quote from a headteacher exemplifies this.

> School is just a smaller entity of the larger community. Much as teachers can do their best, these children come from homes or communities where change also needs to be emphasized. Yes, as teachers we can do our part but if parents are not aware of these GBV issues it will be difficult to change most of these children because they feel that this is the normal way of living because their parents say so.
>
> **Head Teacher-Euthini Secondary school**

Empowered young women, girls, and boys with vocational skills as a means for reducing vulnerability to GBV: The project reached 737 vulnerable adolescents and youth (68 men, 669 women) between the ages of 18 and 30 by training them on vocational skills. Courses included bricklaying, carpentry, house electrical installation, cookery, tailoring, hair styling, and soap making. Furthermore, the trained participants trickled down their skills to other community members, which led to an increase in the reach for the project. The objective of this activity was to increase self-esteem, and improve self-confidence and decision making. Through trainings from experts and interactions with colleagues from other districts, the project's goal was to ensure participants would appreciate cultural and behavioral diversity, and participants would develop short- and long-term plans for their businesses.

The project produced short documentaries, where beneficiaries were interviewed and asked to describe how the project benefited their lives. Their stories, which are available online, illustrate how the project helped improve the women's self-esteem. Several of those interviewed describe how the project helped them acquire a sustainable income. As a result of this training, they are in a better position to purchase essential goods and support their families. One woman described how her social status has been elevated from 'the unknown' to 'important.' The additional income was also described by one of the interviewees as helping her become an equal partner in decision making.

Evaluation Findings

EngenderHealth Malawi commissioned an endline study for the Essential Gender-Based Violence Prevention and Services project, implemented across four project-supported districts. The endline study aimed to evaluate the impact of project interventions and provide recommendations for improvement of future programming. The endline study was a cross-sectional household survey, implemented among girls, boys, women, and men aged 15-49, to address their knowledge of gender and GBV, as well as their experience and awareness of harmful traditional practices and negative social norms. Results were compared with a similar baseline cross-sectional survey that was conducted in 2018.

The household study collected data from 653 respondents at baseline (65% female) and 944 at endline (62% female). The age composition at baseline was as follows: 6% aged 10-14 years old, 7% aged 15-16 years old, 13% aged 17-19 years old, 14% aged 20-24 years old, and 60% aged 25 or older. At endline, the age composition was as follows: 2% aged 10-14 years old, 4% aged 15-16 years old, 8% aged 17-19 years old, 14% aged 20-24 years old, and 72% aged 25 or older. It is noteworthy that a slightly larger number of respondents at endline were from an older cohort. The majority of respondents were married (59% at baseline and 62% at endline) as opposed to single (29% at baseline and 20% at endline). At baseline and endline, over 90% of respondents had attended school and 77% could read and write. The key findings are presented throughout this end-of-project report.

In addition, the team collected qualitative data from key informants and used a participatory approach with community members. The primary data is available if needed.

Lessons Learned, Challenges and Recommendations

Lessons Learned

Building on the project's successes and learnings described above (pages 3-7), and the findings from the endline evaluation, the following are additional insights and lessons learned.

Trainings offered as part of the project on gender, norms, and referrals are often viewed positively by participants and stakeholders. There is also some evidence that these trainings are effective at improving social norms and services for survivors. However, these trainings need to be taken to scale and thoroughly evaluated through an impact assessment to determine the extent they lead to a reduction in GBV.

Effective prevention for GBV requires challenging and changing the root cause of gender inequality at both the individual and collective levels to gain critical mass. Any effort which aims to challenge and then change root causes needs to engage groups at every level of the socio-ecological model (family, TAs, religious leaders, police, judiciary), to enable individual members of that group to better understand and change their individual behaviors and practice positive behaviors as a group.

Male engagement is important to help partners, fathers, brothers, and spouses challenge and change negative notions of masculinity. The absence of violence does not mean equal gender power dynamics. Interventions with men need to delve deeper to understand the reason for the absence of violence. For example, there is some evidence that women may experience a reduction in violence by their husbands because they bring home income. However, a reduction in violence is not guaranteed—in interventions with both women and men, the absence of violence has not been found to correspond with a woman's income.

Key and vulnerable populations remain difficult to reach and to mainstream in Malawi, such as people with disabilities. The GBV response mechanism needs to mainstream the needs of the vulnerable groups and people with disabilities, to promote equitable access to screening, response, and treatment.

Challenges

1. For GBV to be eliminated from these communities, there is a need to consistently and persistently have reflective dialogues and discussions with the judiciary, community gatekeepers, women, men, and all stakeholders, so they continue to reflect, challenge, and change their personal perceptions around gender, GBV, and survivors. The complexities of mainstreaming the GBV response within the legal framework requires continued support to deepen engagement and support processes and people to change in the longer term.

2. In a similar manner, to truly change entrenched norms and harmful practices, interventions need to be scaled up and greater emphasis placed on community engagement, which should reach across all components of the socio-ecological model. Our data show that despite several efforts, awareness at the community level of certain activities, such as safe houses, was low. Similarly, while the project strengthened referral systems at the district level, community-level referral cases were low.

3. Stakeholders at the district and community levels pointed to limited availability of resources (transportation and meals). Despite local efforts to cover basic logistical needs for their work and meetings, there were insufficient resources under the project to fully cover these expenses. This led to some volunteers pulling out or skipping planned activities as they could not afford the cost. Furthermore, local structures often failed to reach out to more distant areas to address and follow-up on cases due to limited availability of transportation money, and district-level stakeholders also failed to conduct frequent and effective monitoring visits and follow-up on issues in hard-to-reach areas. For

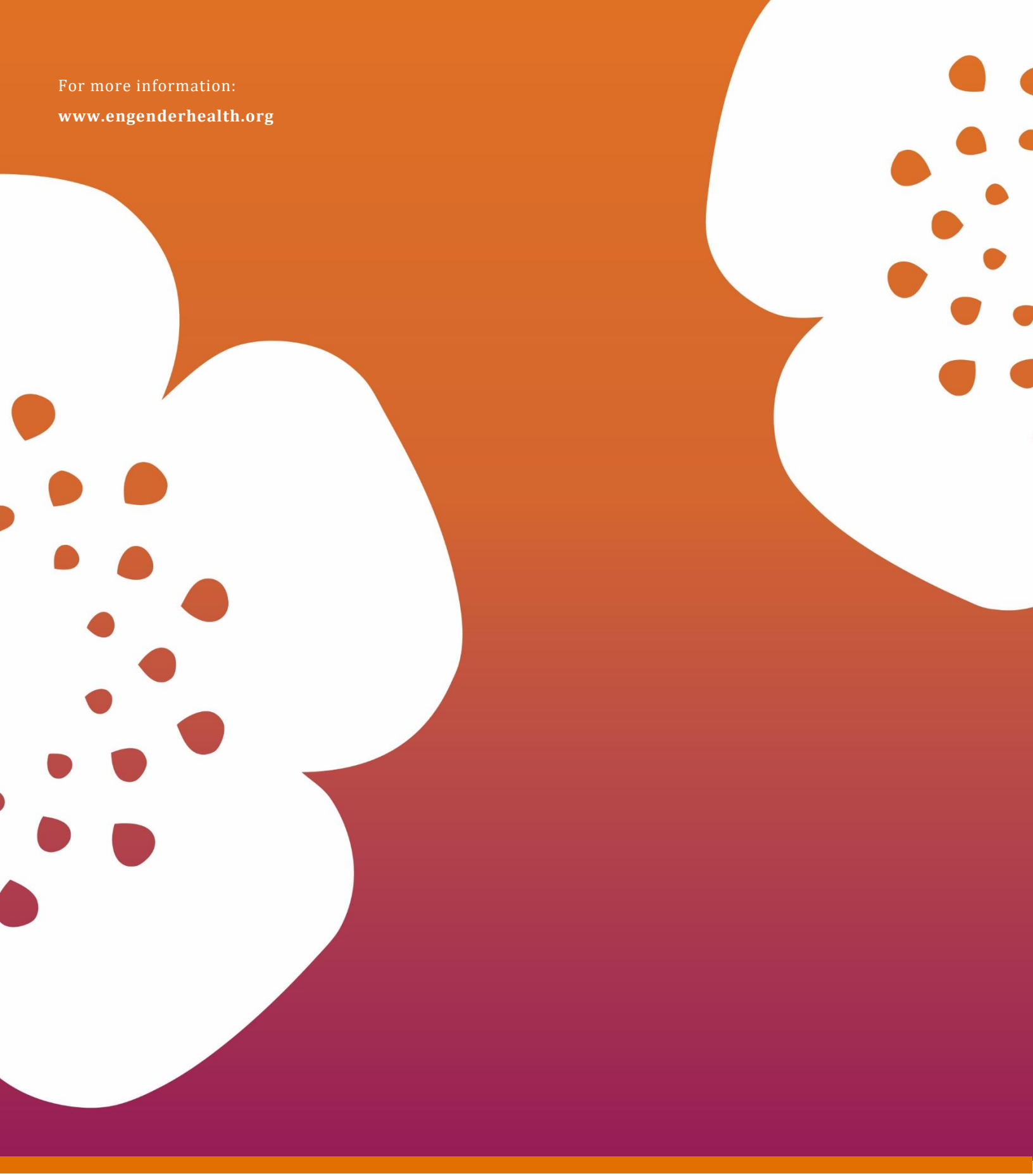
example, in Kasungu, some services that require the intervention of chiefs are available only after payment has been made. This includes the ability to access village tribunals for GBV-related civil cases, where the complainant is required to pay in order to meet the chief. Due to poverty, some people/survivors fail to acquire services through village tribunals, which in turn prevents them from receiving relevant support.

Additional Recommendations

1. GBV awareness should be paired with economic empowerment programs which include key life skills (such as negotiation and communication skills) to empower women and girls to have positive discussions around challenging and changing gender power dynamics. The economic empowerment programs should be complemented with trainings in other soft skills, such as business management, so participants can set up their own businesses. These economic empowerment activities should also be paired with male engagement and larger community sensitization, to mitigate the risk of GBV due to the changing status of women in the community.
2. Future projects should continue to engage and support local structures such as Community Based Volunteers (CBVs), TA leaders, and religious leaders, to ensure a change in the GBV space. This should include financial support for logistics and activity implementation. Also, national-level structures such as the GBV TWG need to be further supported to ensure coordination across US government projects, and other donor projects that engage in this space.
3. More support is needed for the communities that have demonstrated commitment in establishing safe homes, so they can realize their goal. Limited financial and technical support may be a demotivating factor for the sustainability of the initiatives. There is a need to advocate for the safe home initiative to be scaled up to other areas of the country through policy interventions.

For more information:

www.engenderhealth.org



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