USAID | DEMOCRATIC REPUBLIC OF CONGO
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USHINDI Project & Women's Leadership

Overcoming sexual and gender-based violence

in Eastern D. R. Congo

ANNUAL REPORT – Year Four

October 2013 – September 2014

Implemented by IMA World Health with ABA Rule of Law Initiative, CARE, Children's Voice, HEAL Africa, Panzi Foundation, PPSSP, Save the Children
Cooperative Agreement No. # AID-623-A-10-00012-00

Figure 1. Singing and dancing at a Youth Club meeting in Mwenga, South Kivu

(Note child friendly space in background at the Safe House)

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List of Acronyms

ABA	American Bar Association
ABA ROLI	American Bar Association Rule of Law Initiative
AGR	Activités Génératrices de Revenus (Income Generating Activities)
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Care
AS	Aire de Santé (Health Area)
BCC	Behavior Change Communication
BCZS	Bureau Central de Zone de Santé (Central Health Zone Office)
CBO	Community Based Organization
CD	Country Director
CDE	Convention relative aux Droits de l'Enfant (Convention for the Rights of Children)
CoP	Chief of Party
CODESA	Health and Development Committees (Comité de Développement Sanitaire)
CS	Centre de Santé (Health Center)
CV	Children's Voice
CYP	Couple Year Protection
DCoP	Deputy Chief of Party
DQA	Data Quality Assessment
DRC	Democratic Republic of Congo
ECZS	Health Zone Team (Equipe Cadre de Zone de Santé)
ECP	Emergency Contraceptive Pill
F	Female
FARDC	DRC Armed Forces (Forces Armées de la République Démocratique du Congo)
FAT	Famille d'Accueil Transitoire (Temporary Foster Family)
FBO	Faith Based Organization
FDLR	Democratic Force for the Liberation of Rwanda (Force Démocratique pour la Libération de l'Rwanda)
FP	Family Planning
FY	Fiscal Year
GBV	Gender Based Violence
HA	Health Area
HC	Health Center
HEAL Africa	Health, Education, community Action, Leadership development
HGR	General Referral Hospital (Hôpital General de Reference)
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HZ	Health Zone
IGA	Income Generating Activities
IMC	International Medical Corps
IP	Implementing Partner
IR	Intermediate Result
IT	Infirmier Titulaire (Head Nurse in a Health Center)
LQAS	Lot Quality Assurance Sampling
M	Male
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCZ	District Health Officer (Médecin Chef de Zone)

MoG	Ministry of Gender
MoH	Ministry of Health
MoJ	Ministry of Justice
MONUSCO	Mission of United Nations for the Stabilization of Congo (Mission de l'Organisation des Nations Unies pour la Stabilisation du Congo)
MTE	Mid-Term Evaluation
ND	No data
NGO	Non-Governmental Organization
OCHA	Office for Coordination of Humanitarian Affairs
OFDA	Office for Foreign Disaster Assistance
OPJ	Officier de la Police Judiciaire (Court Officials)
RPR	Rapid Plasma Reagin
PEP	Post Exposure Prophylaxis
PDH	Positive Deviance Hearth
PF	Panzi Foundation
PHC	Primary Health Care
PPR	Performance Plan & Report
PPSSP	Programme de Promotion des Soins de Santé Primaires (Program for the Promotion of Primary Health Care)
RECO	**Re**lai **Co**mmunautaire (Community Health Worker)
RECOPE	**Ré**seau **Co**mmunautaire de **P**rotection de l'**E**nfance (Community Network for Child Protection)
RH	Reproductive Health
ROI	Règlement d'Ordre Intérieur (bylaws)
SGBV	Sexual and Gender Based Violence
SNIS	Système National d'Information Sanitaire (National Health Information System)
STI	Sexually Transmitted Infections
SV	Sexual Violence
ToT	Training of Trainers
TP	Technical Partner
UNFPA	United Nations Family Planning Association
USAID	United States Agency for International Development
USG	United States Government
USHINDI	We Will Overcome
VCT	Voluntary Counseling and Testing
VSLA	Village Savings and Loans Associations
WLP	Women's Leadership Project
WS	Wamama Simameni (Women's Safe Houses and Empowerment Centers)

Project Contacts

Organization: IMA World Health	Date: Oct 31, 2014
Address	**Contact Persons**
IMA World Health, USA 500 Main Street, PO Box 429 New Windsor, MD 21776-0429	IMA Headquarters: Tracey Stevens Chief Financial Officer Email: TraceyStevens@imaworldhealth.org Tel : +1-410-635-8720 ; Fax : 410-635-8726 IMA Headquarters: Susan Duberstein Director of Programs Email: SusanDuberstein@imaworldhealth.org Tel: +1-410-635-8720; Fax: 410-635-8726
IMA World Health, Kinshasa, DRC No. 14 Ave. Sgt. Moke DRC/Safricas Kinshasa/Gombe, DRC	Contact Person Kinshasa: Scott Shannon Deputy Country Director Email: ScottShannon@imaworldhealth.org Tel.: +243 814 913 713
IMA World Health, Goma, DRC Quartier des Volcans Rue Lyn Lusi, No. 73 Goma, DRC	Contact Person Goma: Steven W Brewster Chief of Party Email: SteveBrewster@imaworldhealth.org Tel: +243 820 476 065
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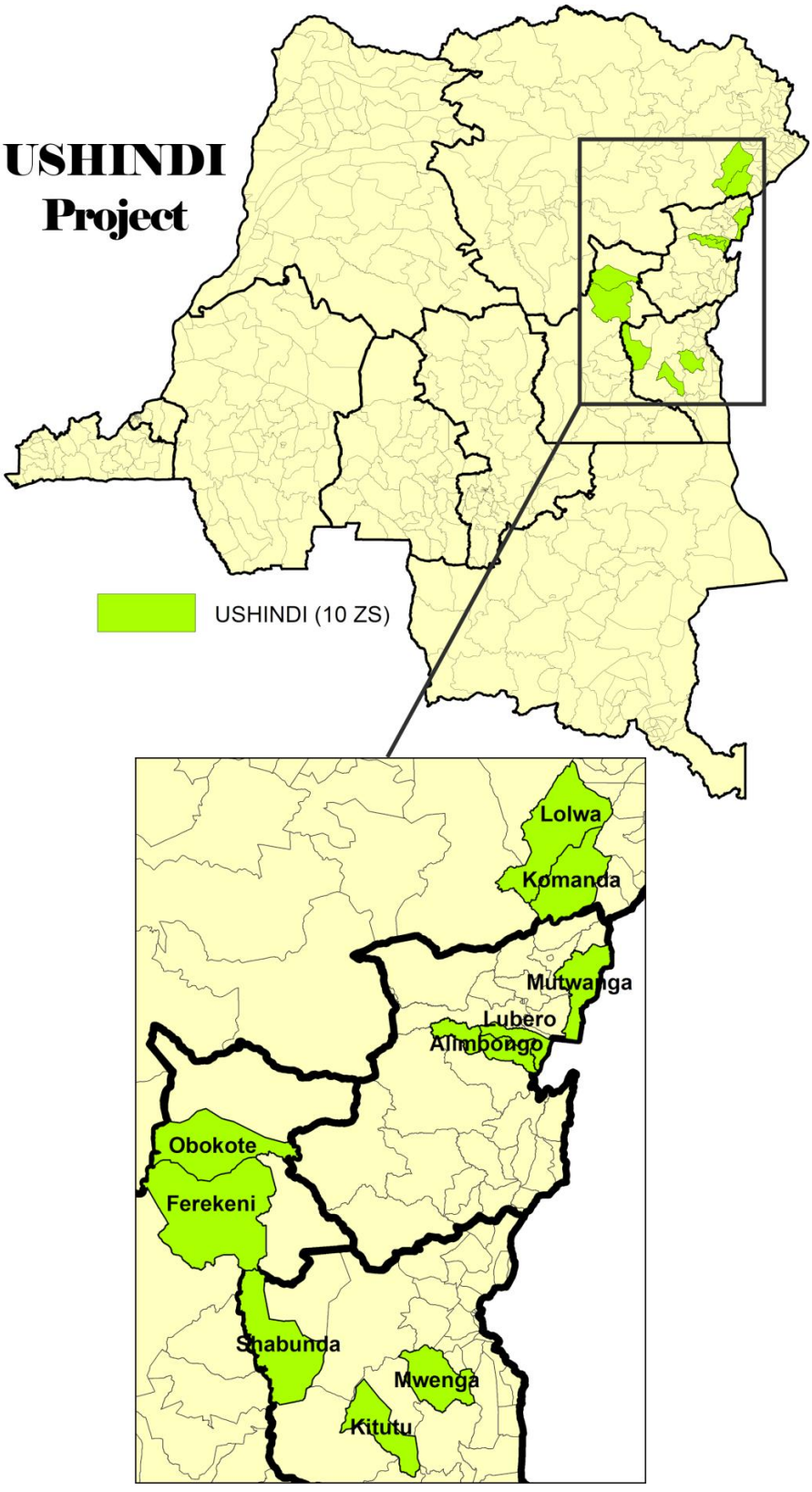
Period Covered by this Report:	October 1, 2013 – September 30, 2014

Map of Intervention locations

Figure 2 Map of intervention areas



Important Note: Conventions vary but in this report ***SGBV*** will refer to all forms of Sexual and Gender Based Violence; ***SV*** will refer to Sexual Violence only; and ***GBV*** will refer to other forms of Gender Based Violence, i.e. not directly sexual.

I Summary

The "Overcoming Sexual and Gender Based Violence in Eastern DRC" USHINDI program implements holistic approaches to combat Sexual and Gender Based Violence (SGBV) in the Eastern Democratic Republic of Congo by: 1) increasing access to timely and quality services for individuals affected by SGBV; 2) improving the quality of services and interventions for individuals and communities affected by SGBV; and 3) reducing the vulnerability of individuals to future acts of abuse and violence.

In addition, the Women's Leadership Project, which was a two-year (2013-2014) supplemental program to Ushindi, contributed to promoting women's empowerment through better control of their reproductive cycle as well as community outreach on women's rights and good governance and leadership.

Table 1. Population by HZ

Project Assisted Health Zones		
Province	**Health Zone**	**Population**
Orientale	Lolwa	42,138
	Komanda	78,501
Maniema	Obokote	73,874
	Ferekeni	60,444
Nord Kivu	Mutwanga	183,973
	Lubero	213,548
	Alimbongo	184,739
Sud Kivu	Shabunda	90,020
	Kitutu	75,233
	Mwenga	80,601
TOTAL		**1,083,071**

The project is implemented under the direction of IMA World Health with three Implementing Partners (HEAL Africa, Panzi Foundation and PPSSP) and four technical partners (The American Bar Association, Save the Children, CARE and Children's Voice). The Ushindi project covers 10 Health Zones, 108 health districts and 1,118 villages with a total beneficiary population of 1,083,071 people.

1. Highlights

Budget Constraints

In FY14, the project received approximately $600,000 less than budgeted, forcing the reduction of several activities such as supervision and training. The new funds for the year also arrived late causing a delay in other activities. In addition, the project was informed in April of a further reduction in the final year of the project of another $1.4 million for a total budget reduction of approximately $2M. This caused, as an immediate consequence, substantial changes in strategies and planning in order to accommodate the shortfall.

Steps were taken immediately to plan for reduction in the number of partners and assisted Health Zones. For the former, Save the Children and Children's Voice were informed of the end of their contract as of the end of the fiscal year and, for the latter, planned closures were announced for three Health Zones (Obokote, Ferekeni and Shabunda). The partners were chosen based on having the least impact

on survivors and the only remaining technical partner will be ABA. Even ABA will have to close their activities at the end March due to insufficient funds. These three HZs were dropped due to higher costs because of how remote they are. Fortunately, alternative partners were found to continue many of the activities in these HZs to minimize the impact on the population.

These actions required a descoping that was approved by USAID to reduce both the numbers of partners and HZs as well as many indicators to accommodate the lower budget. A list of activities that were (or are to be) cut, reduced or problematic is given in the section on challenges.

There are very important issues worth noting here – the ability to implement the recommendations from both the Mid-term Evaluation and the USAID assessment is greatly reduced and/or no longer possible, as is the ability to carry out an end-line/impact evaluation.

Recommendations from the MTE

Following the August 2013 mid-term evaluation, a number of key recommendations were implemented and included:

- An integrated exit strategic plan was developed by Ushindi partners with the support of key local actors, including youth clubs, SGBV-committee members (called Noyaux Communautaires or simply Noyaux) and local authorities.
- Additional training was organized to strengthen the skills, practice and collaboration among social actors for sustainable and long-lasting change. Field visits were conducted by Ushindi implementing and technical partners, as well as by USAID staff, to provide technical support to field staff, strengthen partnerships with local key actors and evaluate progress toward the project's achievements.
    - The field visits noted significant progress of 87% toward the project's expected results and encouraging outcomes in decreasing[1] Sexual and Gender Based Violence (SGBV) incidents by 13% compared to FY3 (i.e., from 5,828 In FY3 to 5,065 of FY4).
    - They also noted increased interest, ownership and involvement of community members and authorities to support community-based structures, e.g., Noyaux and VSLA, to empower both women and men to alleviate vulnerabilities to SGBV and a collective capacity to respond to unmet essential needs, including equal access to income-generating opportunities.

"Noyaux communautaires" (Community Core Groups)

Discussion groups in the field began with Noyaux members on a strategy for sustainability. A first draft of community bylaws (ROI[2]) was developed to improve their functioning. Internal systems were enhanced and are in the final phases of elaboration. In addition, the members received an orientation on integrating their action plans to promote community ownership and sustainability by the Noyaux. Participative meetings were held with all partners to arrive at a common vision and to develop an

[1] Although it is difficult to differentiate between decreases in numbers of incidents reported and actual incidents, it is likely that there was an actual decrease in most areas based on field staff's perceptions.
[2] Règlement d'Ordre Intérieur

operational plan to extend SGBV prevention and Women's Leadership for Noyaux households and communitywide.

Additional comments on the success of the Noyaux are available in a special section 4.4 in this report. The comments are some results from an ad hoc study.

Behavior Change Communication activities

New BCC tools to improve community involvement in conflict resolution and women's leadership were contextually adapted, printed and distributed to all safe houses. IMA/Ushindi participated actively in mass campaigns against SGBV, initiated by local and international organizations:

- One Billion Rising for Justice (V-Day): Bukavu, February 2014;
- *We Will Speak Out*: Kinshasa, March 2014 and USA, April 2014;
- *Amani Peace Festival*: Goma February 2014;
- Global Summit to End Sexual Violence in Conflict: London, June 2014; and
- *One Peace Day* festival: Goma, September 2014.

These events permitted Ushindi to share its project strategies and accomplishments with a large number of people at national and international levels.

Diagnostic of socio-economic reintegration activities (VSLA and micro-projects)

Field trips were carried out by our VSLA project officer to evaluate needs and increase technical capacity and products to existing VSLA and supported local organizations. New guidance was provided to improve VSLA implementation. Health Zone-based training of partners was conducted for priority topics identified during project evaluations. Topics included improved data collection tools, preparation of micro-plans, improved support from local authorities, entry of VSLA financial operations and registration of additional VSLA groups.

Local partner financial audit

An external auditing firm was chosen to verify project conformity to donor procedures and contractual obligations. Generally, the auditors found that the partners were in conformity with rules and regulations. Some practical advice was provided to partners based on partner-specific findings.

Logistics

New motorcycles were supplied to each safe house to improve staff mobility for supervision. Also, new laptops were provided to each safe house to improve data tracking and evaluation. Visits were carried out to the nine project-supported safe houses to provide staff with technical guidance on management of medicines, medical supplies and nonfood items provided by the project.

2. Selected achievements by Intermediate Result (IR)

2.1. IR1: Increased Access to Quality and Timely Care and Treatment Services

The Year 4 annual target was to reach 5,793 beneficiaries in the 10 HZ; 87% (5,065) of this target was achieved.

- 83% (4,883) of the annual target of 5,973 beneficiaries received psycho-social support.
- 73% (2,679) of the annual target of 3,476 received access to medical services.
- 56% (1,517) of the annual target of 2,715 received legal assistance.
- Empowerment of vulnerable people included:
  - 9,771 VSLA registrations representing 219 % of the target (4467)
  - 962,589 loans representing more than 100% of estimated target
  - 3,562 members of Incoming Generating Activities (IGA)
- 77% (20) of the original 26 supported micro-projects are operational.
- 136% (312,361 of 229,999) of the targeted population was reached through public awareness messages on Behavior Change Communication (BCC).
- 873 focus groups brought together 13,429 civilians, military and police to discuss SGBV in their communities, the importance of the use of medical services in less than 72 hours after a rape and the correct application of the law concerning SGBV incidents.
- 5,183 discussion forums brought together 98,046 participants, including men, women and children to discuss women's and children's rights, the prevention of early marriages and social reintegration of survivors of sexual violence.
- 318 advocacy sessions were held with 1,396 local authorities to obtain their support for activities concerning the prevention of SGBV in their administrative district or military/police units.
- 7,785 births and 1,143 marriages were registered with local authorities.

2.2. IR2: Increased organizational and community capacity to respond to SGBV (BCC) and the reintegration of the survivors

Ushindi reinforced the technical capacity of service providers, community agents and community committee members (Noyaux).

- 176% (3653) of an annual target of 2,070 service providers and other local players (school leaders, Ushindi staff, community leaders and representatives of community groups) participated in refresher training sessions to reinforce their skills on the prevention of SGBV in schools, management of temporary foster families, IGA management, the clinical management of cases of sexual violence and psychosocial support to adults and children survivors. Although this is somewhat low due to cash flow issues during the first part of this year, it is has been accelerated since March.
- Delivery of essential drugs (PEP kit) to health facilities.
- Regular provision to the 9 Ushindi bases of food and non-food items to help survivors of SV
- Reinforcement of field supervision by the IPs.
- Health care payments for 2,679 survivors and other vulnerable people.
- 955 people newly registered in 45 literacy circles

2.3. IR3: Improved ability of communities and individuals to lead and participate in community-based social integration and economic recovery activities

- 108 local Core Community Groups (Noyaux[3] communautaires, sometimes called SGBV committees) with more than 2,500 active members were instrumental in outreach to, and reintegration of, survivors.
- 45 Temporary Foster Families (FAT[4]) were supported and responded to the social needs and protection of 41 children survivors.
- 12 RECOPEs[5] (community networks for the protection of children) were active in all intervention sites.
- 108 youth clubs with 3,313 adolescent members are active in BCC messaging and the peaceful resolution of conflicts between children and parents.
- 20 community organizations were assisted to run micro-projects that generated profits for their individual members as well as contributing to a social fund for vulnerable people of their Health Areas (HA).
- 415 VSLA began their new cycle and assisted 635 survivors to increase the economic capital of their households and the social power of their members.

2.4. IR 4: Strengthened community's ability to prevent SGBV

- Noyaux (Core Community Groups) members and youth clubs organized :
  - 2,926 community outreach sessions
  - 2,150 focus groups
  - 2,774 discussion forums
  - 494 parenting skills sessions
- Several high profile international mass media days or events were celebrated with themes on human rights or no tolerance for SGBV, such as :
  - 16 Days of Activism
  - V-Day – "One Billion Rising for Justice"
  - International Day of the Woman
  - Day of the African Child
- Several meetings with partners and field trips for supervision for strategic planning, monitoring and evaluation of activities, data quality control, technical assistance and contract adherence.

3. Positive trends

➢ The active involvement of Noyaux members in prevention is noted through the many testimonies of both male and female members as well other as community members who emphasize that more families now respect shared household management, equality of gender roles and the noticeable reduction of both physical violence and denial of resources.

[3] Noyaux means core community groups
[4] **F**amilles d'**A**ccueil **T**ransitoire
[5] **Ré**seaux **Co**mmunautaires de **P**rotection de l'**E**nfant

- The noyaux structure forms a promising beginning as a community based mechanism for sustainability as well as a potential platform for other development activities.
- The active involvement of children in communication activities for behavior change is an encouraging sign of change that could improve project sustainability, including promotion of messages to lower the risk of long-term violence, active listening of their peers and promotion of advocacy of children's rights at school and in their villages.
- 70% of rape cases were able to return to their normal state of functioning.
- BCC messages contributed to women disclosing information to Ushindi lawyers about domestic violence committed by their partners.
- The savings and credit dynamics of economic interest groups (VSLA) and micro-credit projects increases access to loans, generates benefits for basic needs of the household (food, medical care, home improvement) and strengthens social cohesion. The VSLAs are highly appreciated even by non-members, which led to the birth of many self-created VSLAs.
- The strong involvement of members of women's and youth groups (VSLA, Youth Clubs, RECOPE, FAT) in raising awareness of victims' rights in cases of sexual violence and family mediation reassures survivors and encourages them to use the available services, reduces stigma and reinforces their social reintegration.
- The existence of a referral system to various services is known and applied by all stakeholders and survivors.

4. Performance Plan and Report (PPR) progress

The PPRs are:

- PPR1. Number of people benefiting from USG-supported social services – for more detailed information, see pages 9-24
- PPR2. Number of service providers trained[6] who serve vulnerable persons – for more detailed information, see pages 25-26
- PPR3. Facilities offering social services strengthened – for more detailed information, see page 26

The following table provides a very brief overview of PPR achievements.

Table 2. Global PPR progress

	FY14 Target	FY14 Achieved	FY14 Progress	Total Targets	Total Achieved	% Total Progress to date
PPR1. Beneficiaries	5,793	5,065	**87%**	24,187	22,073	**91%**
PPR2. Service providers	2,070	3,653	**176%**	7,286	15,811	**217%**
PPR3. Organizations	572	848	**148%**	572	848	**148%**

[6] As defined by person-training sessions, i.e. the total # of people participating in training sessions

Remarks: Annual progress for PPR1 (number of people benefiting from USG-supported social services) was a little short of its target for this point in the year at 87%. There is some concern that this may be partially due to funding gaps. PPR2 (number of service providers trained who serve vulnerable persons) is well over its target at 176%. PPR3 (facilities offering social services strengthened) is now at 148% of total targets with the new VSLAs spontaneously created over the last year.

The following page has a more detailed snapshot of progress on the PPRs at Year 4. All PPRs and most sub-indicators are either met or ahead of project's total targets.
See Annex A for more detail.

Figure 3.
Leader of a Mwenga Noyaux making a point

Figure 4. PPR progress to date

Indicator Title	FY 14 Targets			Fy14 Annual achievement			FY 14 annual progress	LoP TOTAL targets (revised)	Achieve-ments - 2010-2014	Year 1-4 progress
Program Element Indicators by Implementing Mechanism	Male	Female	Total	Male	Female	Total				
PPR1. Number of people benefiting from USG-supported social services (SGBV)	**630**	**5,163**	**5,793**	**545**	**4,520**	**5,065**	**87%**	**24,187**	**22,073**	**91%**
Dissagregated by SGBV incidence										
People reporting a SGBV incident	186	3,413	**3,599**	**30**	**2,610**	**2,640**	**73%**	**16,310**	**13,961**	**86%**
Other people reporting a GBV Incident/other vulnerability	444	1,750	**2,194**	**515**	**1,910**	**2,425**	**111%**	**7,878**	**7,998**	**102%**
Total	**630**	**5,163**	**5,793**	**545**	**4,520**	**5,065**	**87%**	**24,187**	**22,073**	**91%**
Dissagregated by age										
Children (< 18)	220	1,744	**1,964**	**122**	**1,713**	**1,835**	**93%**	**9,647**	**7,720**	**80%**
Adults (>18)	410	3,419	**3,829**	**423**	**2,807**	**3,230**	**84%**	**14,540**	**14,353**	**99%**
Total	**630**	**5,163**	**5,793**	**545**	**4,520**	**5,065**	**87%**	**24,187**	**22,073**	**91%**
Dissagregated by type of service										
People receiving health support	288	3,187	**3,476**	**73**	**2,476**	**2,549**	**73%**	**16,952**	**13,180**	**78%**
People receiving psychosocial support	630	5,163	**5,793**	**496**	**4,312**	**4,808**	**83%**	**23,963**	**21,806**	**91%**
People requesting legal support	534	2,181	**2,715**	**220**	**1,297**	**1,517**	**56%**	**10,936**	**13,520**	**124%**
People receiving legal support - GBV	435	2,206	**2,317**	**200**	**651**	**851**	**37%**	**9,665**	**6,666**	**69%**
People receiving legal support - SGBV	154	831	**985**	**20**	**646**	**666**	**68%**	**4,296**	**4,326**	**101%**
Cases taken to court	45	348	**394**	**66**	**549**	**615**	**156%**	**1,794**	**2,669**	**149%**
**Number of judgements*	8	130	**138**	**3**	**157**	**160**	**116%**	**1,320**	**437**	**33%**
**Number of mediation achieved*	182	397	**579**	**88**	**314**	**402**	**69%**	**2,324**	**1,992**	**86%**
Survivors enrolled in VSLA groups for socio-economic reintegration support	432	1,728	**2,159**	**22**	**985**	**1,007**	**47%**	**8,169**	**3,489**	**43%**
Other beneficiaries										
**Number of people who have completed VSLA cycle of 12 months*	893	3,574	**4,467**	**2,581**	**9,883**	**12,464**	**279%**	**12,526**	**25,438**	**203%**
**Number of people assisted by social fund*	143	1,284	**1,427**	**2,969**	**3,700**	**6,669**	**467%**	**6,521**	**17,146**	**263%**
**Number of beneficiaries of IGA/micro project*	807	1,499	**2,307**	**875**	**2,687**	**3,562**	**154%**	**9,785**	**9,155**	**94%**
**Number of people who completed literacy trainings*	41	959	**600**	**19**	**360**	**379**	**63%**	**4,783**	**2,858**	**60%**
WLP - New acceptants receiving Family Planning services	313	5,948	**6,261**			**8,686**	**139%**	**21,288**	**22,576**	**106%**
Outreach & Public Awareness	**58,743**	**172,651**	**229,774**	**129,061**	**183,169**	**312,230**	**136%**	**924,917**	**1,515,311**	**164%**
Community leaders engaged in BCC activities	217	506	**723**	**3,292**	**1,663**	**4,955**	**686%**	**2,960**	**22,187**	**750%**
Community members reached by BCC activities	38,070	152,281	**190,351**	**86,724**	**138,242**	**224,966**	**118%**	**770,585**	**1,264,620**	**164%**
School children involved in BCC activities	18,274	19,796	**38,070**	**38,040**	**43,169**	**81,209**	**213%**	**145,508**	**225,380**	**155%**
People in uniforms involved in BCC activities	2,183	68	**630**	**1,005**	**95**	**1,100**	**175%**	**5,865**	**3,124**	**53%**
WLP - Community leaders educated on Women's Rights	180	1,620	**1,800**	**17,531**	**39,395**	**56,926**	**3163%**	**5,400**	**111,872**	**2072%**
WLP - Women and Men of reproductive age educated on FP	55,724	57,998	**113,722**	**23,508**	**51,631**	**75,139**	**66%**	**227,444**	**157,467**	**69%**
PPR2. Number of service providers trained who serve vulnerable persons	**1,010**	**1,060**	**2,070**	**2,161**	**1,492**	**3,653**	**176%**	**7,286**	**15,811**	**217%**
Health service providers	81	81	**162**	**107**	**149**	**256**	**158%**	**162**	**580**	**358%**
Psychological counselors	-	126	**126**	**9**	**45**	**54**	**43%**	**126**	**436**	**346%**
BCC for Community volunteers	135	135	**270**	**1,013**	**515**	**1,528**	**566%**	**270**	**4,356**	**1613%**
OPJ,Paralegal	265	5	**270**	**51**	**47**	**98**	**36%**	**270**	**272**	**101%**
Community leaders	162	108	**270**	**160**	**137**	**297**	**110%**	**270**	**395**	**146%**
Child Protection skills for school directors	126	126	**252**	**54**	**89**	**143**	**57%**	**252**	**540**	**214%**
Leaders of women's associations	-	233	**233**	**20**	**10**	**30**	**13%**	**233**	**203**	**87%**
Community Supervisor and mobilizer of VSLA	15	15	**30**	**135**	**47**	**182**	**607%**	**30**	**415**	**1383%**
Micro enterprise supervisors	15	15	**30**	-	-	-	**0%**	**104**	-	**0%**
VSLA approach and micro project for leaders				**135**	**47**	**182**		**4,301**	**4,537**	**105%**
Community mobilizers	12	8	**20**	**209**	**133**	**342**	**1710%**	**20**	**342**	**1710%**
Literacy Trainers	10	15	**25**	-	-	-	**0%**	**25**	**29**	**116%**
TOT Counselors- Child protection	14	18	**32**	**94**	**86**	**180**	**563%**	**32**	**364**	**1138%**
RECOPE	90	90	**180**	**88**	**37**	**125**	**69%**	**138**	**287**	**208%**
Leaders on gender & justice			-	-	-	-		**251**	-	**0%**
Parenting skills for couples			-	-	-	-		**432**	**2,387**	**553%**
Foster Families and Counselors	-		-	**72**	**45**	**117**		**200**	**400**	**200%**
Children's club Counselors	45	45	**90**	**14**	**105**	**119**	**132%**	**90**	**200**	**222%**
Ushindi IP staff	40	40	**80**	-	-	-	**0%**	**80**	**68**	**85%**
WLP -.Family Planning for health providers			-			-		**310**	**259**	**84%**
WLP - Democracy and Governance for Community Mobilizers			-			-		**300**	**351**	**117%**
PPR3. Number of USG-assisted organizations and/or service delivery systems strengthened that serve vulnerable populations: organisations, Health										
Total			**572**	**0**	**0**	**848**	**148%**	**572**	**848**	**148%**
Centres de sante			**108**			**108**	**100%**	**108**	**108**	**100%**
CBO, NGO/groups& associations created with Ushindi's support			**464**			**740**	**159%**	**464**	**740**	**159%**

II Ushindi program achievements by intermediate results (IR)

1. IR1: Increased Access to Quality and Timely Care and Treatment Services

During the reporting period, 5,065 survivors of sexual violence and other forms of gender based violence, as well as a small number of other vulnerable people, benefited from Project Ushindi's social services as described in the following sections.

1.1. Number of people benefiting from USG supported services

PPR1. NUMBER OF PEOPLE BENEFITING FROM USG-SUPPORTED SOCIAL SERVICES

Table 3. Beneficiaries by sex & age

	Child			Adult	Total	%
	0-5 yrs	6-11 yrs	12-17 yrs			
Male	19	30	73	423	545	***11%***
Female	87	143	1,482	2,808	4,520	***89%***
Total	106	173	1,555	3,231	5,065	***100%***
%	***2%***	***3%***	***31%***	***64%***	**100%**	

Remarks: During FY 2014, Ushindi partners provided assistance to 5,065 survivors amongst whom 89% were female and 11% of male. By age group, children represent 36% compared to 64% for adults. This proportion of child survivors of SGBV has remained virtually unchanged throughout the project. Children between 12 and 17 years old comprise 31% of the total of all assisted survivors and 85% of all children. This is undoubtedly due to their increased vulnerability being adolescents.

Table 4. Beneficiaries by civil status

Marital status	M	F	Total	%
Single	197	2,421	2,618	**52%**
Married	296	1,271	1,567	**31%**
Divorced	6	104	110	**2%**
Widowed	4	198	202	**4%**
Cohabitation	42	526	568	**11%**

Remarks: The distribution of beneficiaries by marital status shows that 52% are single with most of these (63%) being girls under 18 years of age. The 48% "other than single" groups include 31% married, 2% divorced, 4% widowed and 11% living in cohabitation[7]. ***It is noteworthy that a single woman is more likely to be a victim of sexual violence than any other category and is twice as likely to be a victim as a married woman.***

[7] Called "occupés" (= busy) in French, in this case it means couples that are neither married by civil authorities nor according to tradition and signifies couples temporarily living together, especially itinerant business people and artisanal miners.

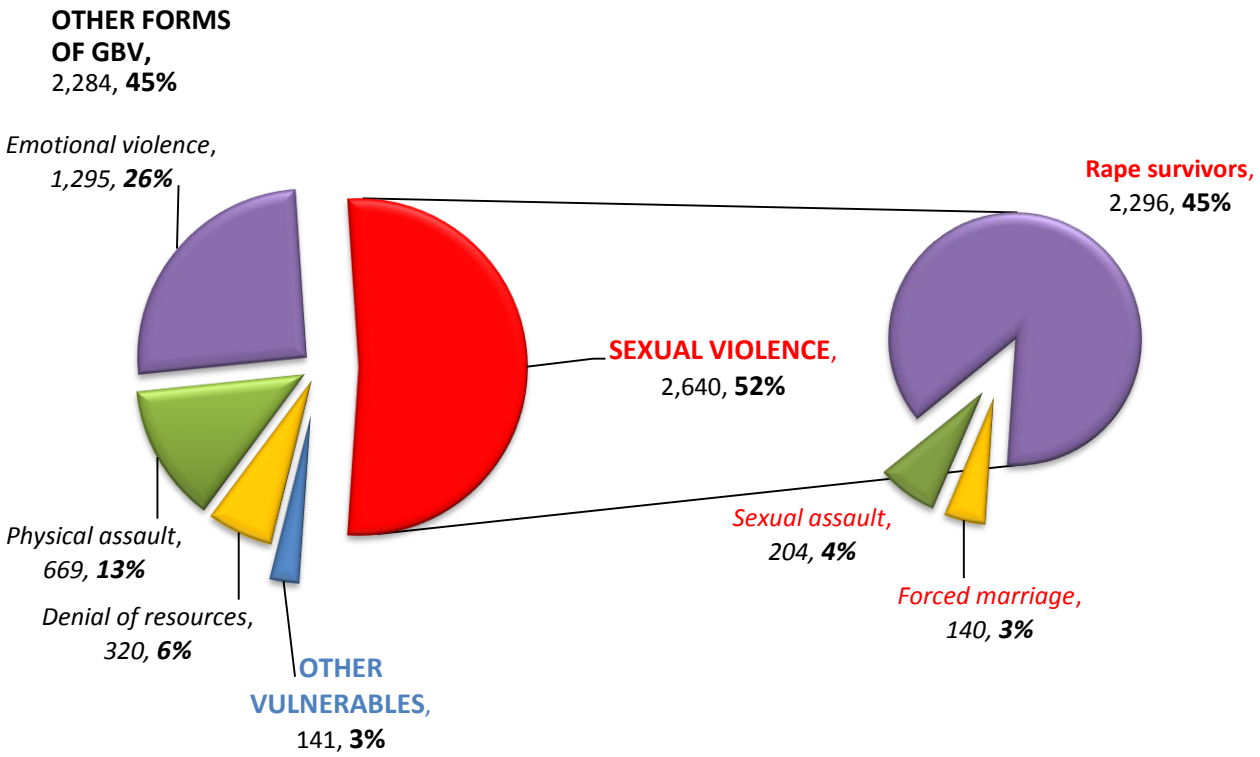
Table 5. Distribution of beneficiaries by violence type and annual targets

Indicator	FY14 Targets			FY14 Achievements			FY14 Progress
	M	F	Total	M	F	Total	
# of people benefiting from social services	**630**	**5,163**	**5,793**	**545**	**4,520**	**5,065**	**87%**
# reporting a SV incident	186	3,413	3,599	30	2,610	2,640	**73%**
# reporting other GBV Incident or vulnerability	444	1,750	2,194	515	1,910	2,425	**111%**

Remarks: During the reporting period, 87% (5,065) of the target (5,793) for beneficiaries benefited from social services within Ushindi-assisted health zones. Of the projected 3,599 sexual violence incidents that were anticipated, 73% (2,640) were reported and received assistance. Similarly, it was projected that there might be 2,194 incidents of other types of Gender Based Violence (GBV) of which 111% (2,640) were reported and received assistance. These levels of service provision are an encouraging sign of the widespread acceptance and public awareness of messages disseminated by Noyaux about sexual violence and specific laws to address incidents of SGBV. There has been a synergy of many players, including civil society, legal resources and social services in supported community structures such as health centers and legal aid clinics.

Figure 5. Noyaux and Safe House staff meeting in Obokote

Figure 6. Distribution of SGBV incident type

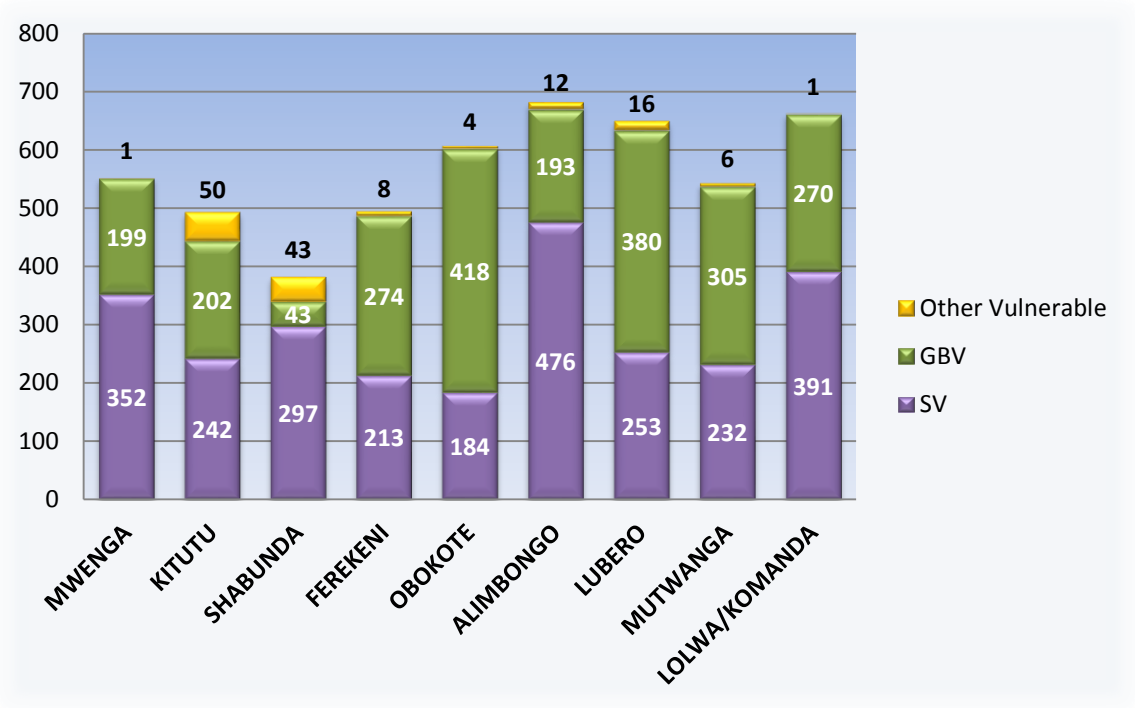


Remarks: Of the 5,065 survivors assisted, 2,640 of the cases (52%) were for Sexual Violence (SV), 45% represented other forms of GBV and 3% were linked to other types of reproductive health problem such as prolapses and fistulae. The most prevalent incidents were rape (45%), emotional violence (26%) and physical assault (13%).

Among the 2,640 cases of sexual violence, 2,296 (87%) were incidents of rape, 204 (8%) involved sexual assault and 140 (5%) were linked to forced marriage.

Considering only cases of other forms of Gender Based Violence, 57% declare to have been (or continue to be) victims of emotional violence, 29% claimed physical assault and 14% consulted services for problems related to denial of resources.

Figure 7. Distribution of Incident Type by Health Zone



Remarks: The above chart shows the distribution of the 5,065 SGBV survivors. The greatest number of cases comes from Alimbongo with 681 cases, Lolwa–Komanda with 662 and Lubero with 649. Those HZs are generally considered to be less stable due to activism of local militia, sporadic fighting by FARDC or presence of displaced populations. The higher rate of GBV incidents observed in Obokote and Ferekeni HZs may be explained by increased awareness by community-based campaigns conducted with traditional chiefs to encourage survivors to seek legal support and mediation.

Table 6. Distribution of cases by sex and incident type by HZ

Health Zone	SV Male	SV Female	Other GBV Male	Other GBV Female	Vulner Male	Vulner Female	Total
Lolwa-Komanda	1	390	48	222	0	1	**662**
Mutwanga	4	228	56	249	0	6	**543**
Lubero	**14**	239	73	307	0	16	**649**
Alimbongo	7	469	53	140	0	12	**681**
Obokote	0	184	120	298	0	4	**606**
Ferekeni	2	211	79	195	0	8	**495**
Shabunda	0	297	27	16	0	43	**383**
Kitutu	2	240	28	174	0	50	**494**
Mwenga	0	352	31	168	0	1	**552**
TOTAL	**30**	**2,610**	**515**	**1,769**	**0**	**141**	**5,065**

%	1%	51%	10%	35%	0%	3%	100%

Remarks: 51% of all cases are SV incidents against women but ***note that nearly one-fourth (23%) of all other forms of GBV are against men*** (515 out of 2,279). Note as well the unusually high number of SV cases against men in Lubero (14). The HZs with the most sexual violence incidents are Lolwa–Komanda and Alimbongo followed by Mwenga and Shabunda where women and young girls have been reportedly sexually abused by local militia in remote villages. The lower numbers of SV in Ferekeni and Obokote is reportedly linked to a culture of silence. Other factors that discourage reporting incidents of SV include a judiciary system that condones forced marriage or marriage-by-rape. Noyaux members are addressing this matter by disseminating messages concerning Congolese law and SGBV, promoting the benefits of medical care within 72 hours and emphasizing the rights of children.

Some of the information from the previous chart can also be visualized using the following maps.

Figure 9. Rape Incidence

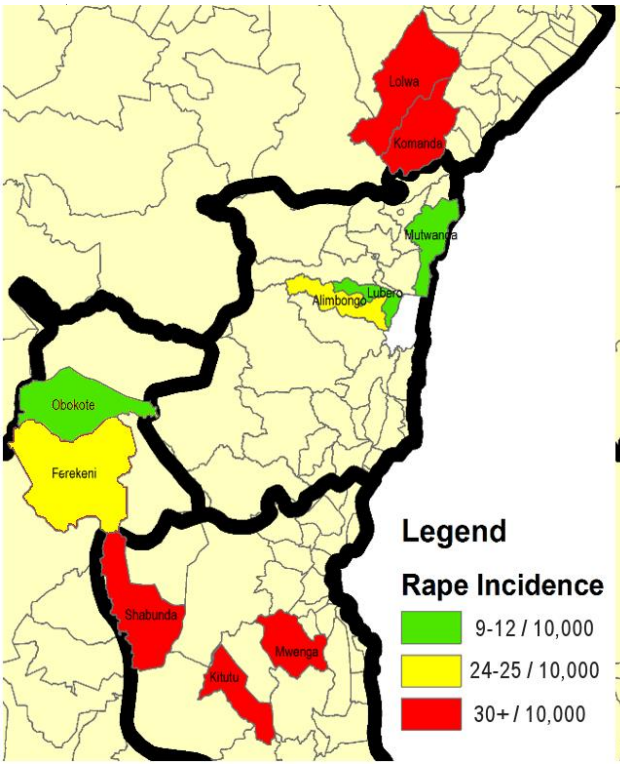
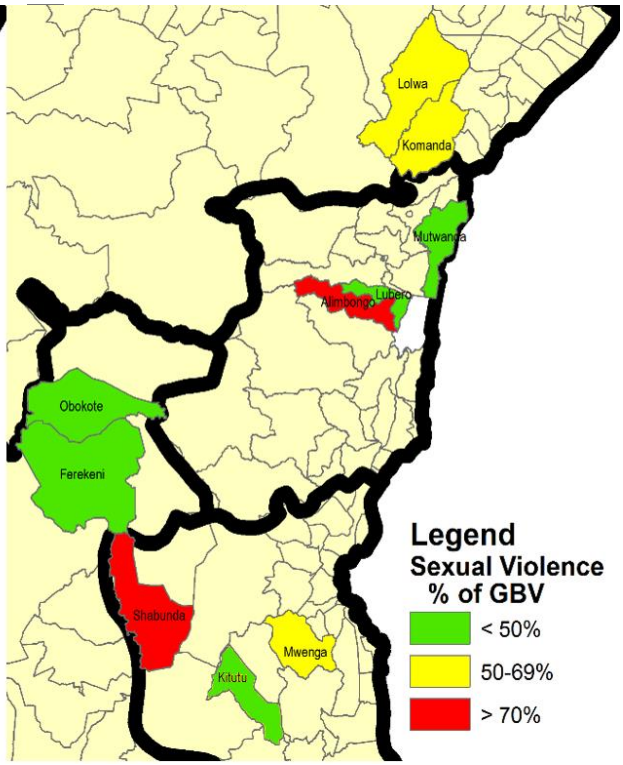


Figure 9. Map of Sexual Violence as a % of all cases of SGBV



Rape incidence (i.e., the number of rapes per 10,000) shows that the highest incidence is in Lolwa-Komanda and the three HZs in South Kivu as shown in the map at left. In comparison, the percentage of rapes with respect to all forms of SGBV is demonstrably worse in Alimbongo and Shabunda, as shown in the map at right. The "convergence" of these two maps indicates that the greatest problem concerning rape is probably in Shabunda HZ followed by Alimbongo, Mwenga and Lolwa-Komanda. Comparatively, Mutwanga, Lubero and Obokote appear to be relatively better than other HZs in this regard.

Table 7. Distribution of types of incidents by age and violence type

Types of Incidence	Children				Adults				Total	
	M	F	S/Total	%[8]	M	F	S/Total	%[8]	#	%[9]
SV incidents										
SV sub-total	**7**	**1,466**	**1,473**	**56%**	**23**	**1,144**	**1,167**	**44%**	**2,640**	**52%**
Rape survivor	*5*	*1,229*	*1,234*	*54%*	*13*	*1,049*	*1,062*	*46%*	*2,296*	*45%*
Sexual aggression	*2*	*111*	*113*	*55%*	*6*	*85*	*91*	*45%*	*204*	*4%*
Forced marriage	*0*	*126*	*126*	*90%*	*4*	*10*	*14*	*10%*	*140*	*3%*
Other GBV incidents										
GBV sub-total	**115**	**236**	**351**	**15%**	**400**	**1,533**	**1,933**	**85%**	**2,284**	**45%**
Emotional violence	*45*	*124*	*169*	*13%*	*257*	*869*	*1,126*	*87%*	*1,295*	*26%*
Physical assault	*59*	*99*	*158*	*24%*	*84*	*427*	*511*	*76%*	*669*	*13%*
Denial of resources	*11*	*13*	*24*	*8%*	*59*	*237*	*296*	*93%*	*320*	*6%*
Other vulnerable people										
Other vulnerable	**0**	**10**	**10**	**7%**	**0**	**131**	**131**	**93%**	**141**	**3%**
TOTAL	**122**	**1,712**	**1,834**	**36%**	**423**	**2,808**	**3,231**	**64%**	**5,065**	**100%**

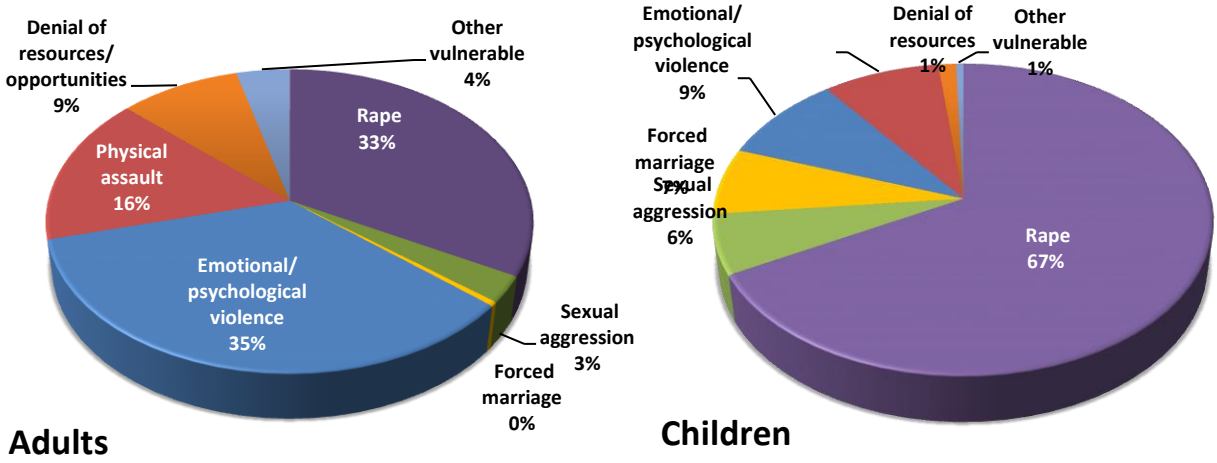


Figure 10. SGBV incidence - Children & Adult

[8] Note that this % represents the % of child (or adult) cases for this kind of incident, e.g. 56% of all reported SV cases were children and 44% were adults.
[9] This is the % of all cases, e.g. SV incidents represent 52% of all cases (2.640).

Remarks: Of 5,064 beneficiaries, 52% (2,640) were cases of Sexual Violence while 45% (2,284) were other cases of Gender Based Violence and 2% was of other vulnerable people.

Considering only Sexual Violence cases, 87% were rapes. Children were more affected by SV at 56% of all SGBV cases compared to 44% for adults, whereas adults were more often victims of other forms of GBV comprising 85% of the cases compared to 15% for children. For rape cases, children were more often victims at 54% compared to 46% for adults. For forced marriage, 90% were under 18.

Considering only other forms of GBV, 57% were emotional or psychological, which were much more common with adults at 87% than children at 13%. Physical assault comprised 29% of these kinds of cases and again is more common with adults at 76%, compared to 24% for children. Denial of resources or opportunity constituted 14% of these cases, the vast majority of which were adults at 93%.

Note I: TYPES OF INCIDENTS BY AGE

Distribution of types differs greatly between adults and children.

Adult *incidents are nearly equal between* ***rape at 33%*** *and* ***emotional violence at 35%,*** *with physical assault at 16%.*

Children*, however, were mostly* ***rape victims at 67%,*** *followed by emotional violence, physical assault and forced marriage at only 9, 9 and 7 percent respectively.*

Although a small percentage of all cases at 4%, sexual aggression (which includes sexual harassment and forced prostitution) is more common amongst children at 55% compared to 45% adults. Early or forced marriage was of course more common amongst children at 90% compared to 10% adults.

Figure 11. Profile of alleged assailants

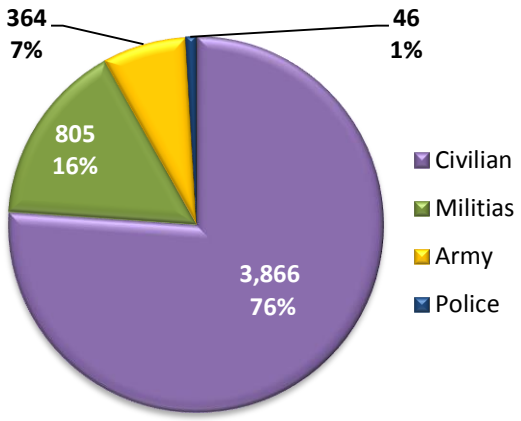


Table 8. Profile of civilian assailants

	Total	%[10]
Farmer	**3,043**	**60%**
Student	**465**	**9%**
Merchant	142	3%
Teacher	119	2%
Health care providers	34	1%
Political leaders	30	1%
Religious leaders	23	0%
Humanitarian	9	0%
Lawyers, paralegal	1	0%
TOTAL	3,866	76%

[10] These are the percentages compared to ALL assailants. cfr. Figure 6.

Remarks: Of the 5,081[11] alleged assailants, civilians represented (76%), followed by militias and rebels (16%), military (7%) and police (1%). Although police were at just 1%, they are not to be discounted given their role in assuring the protection and security of the population.

Farmers formed the biggest percentage (60%) of total assailants and 79% of the civilian total. Militias are still second at 16%, but ***students are third at 9%*** (465 cases is very concerning), the FARDC soldiers at 7% (177), followed by businessmen and teachers at 3% and 2% and the rest at 1% or less each.

It is also interesting to note that women form a fairly significant percentage of the alleged assailants/perpetrators with an average of nearly one-third (32%) of all perpetrators across all professions. Those professions with the highest percentage of women are humanitarians (67%), religious leaders (48%), militias (44%), merchants (42%) and police (39%). However, it should be noted that the first categories, humanitarians and religious leaders, represent very low sample sizes and are less than 1% of all perpetrators.

These figures underline the fact that most SGBV incidents are committed by well-known perpetrators (e.g., neighbors, classmates and friends). It is generally well-known that more SGBV incidents occur in the bush or in remote villages late at night than those perpetrated by armed gangs and/or elements from national security forces such as the FARDC or PNC.

1.1.1. Number of people benefitting from psychosocial support

Table 9. Psychosocial services

Psychosocial Support	Male	Female	Total	%
Total # of cases	545	4,520	**5,065**	100%
Received Active Listening/Counseling	536	4,347	**4,883**	96%
Received Home Visit	447	3,860	**4,307**	85%
Family Mediation facilitated	114	907	**1,021**	20%

Remarks: The psycho-social case reports indicate that 96% of the cases received active listening and counseling. 85% of cases include home visits (a figure that includes cases from previous months), and 20% were supported with family mediation for more effective reintegration.

[11] There are more assailants than victims because in some cases there is more than one assailant.

Table 10. Survivors re-established from SGBV-related mental trauma

Health Zone	Cases[12]	Re-established	%
Lolwa Komanda	659	618	**94%**
Mutwanga	538	533	**99%**
Lubero	635	340	54%
Alimbongo	651	384	59%
Obokote	596	403	68%
Ferekeni	494	198	40%
Shabunda	380	258	68%
Kitutu	480	152	32%
Mwenga	481	259	54%
TOTAL	**4,914**	**3,145**	**64%**

Remarks: 97% (4,915) of the 5,065 cases identified and accompanied by counselors received one or more services including active listening and family mediation for social rejection or for people facing stigma and discrimination due to rape incident. Others received donations of food and non-food item to resolve social issues. Of the 4,914 survivors benefiting from psychosocial support, 64% of those were declared recovered and deemed to have no need for further psychological services.

The combination of various therapeutic methods such as active listening and counseling, relaxation exercises, occupational therapy, home visits and family mediations resulted in an average of 64% of the survivors declaring (and as witnessed by the psychosocial counselors) that they had recovered psychologically and had reintegrated socially. Psychological assistance was considered concluded when the signs of stress or trauma had largely disappeared and the survivor was able to return to the normal activities that they had engaged in prior to the incident. Frequent behavioral problems that the survivors experienced and sought help for, included: feelings of shame, fear or rejection, disturbed sleep, loss of self-esteem, sadness and suicidal feelings, amongst others. Recovery was indicated by the re-establishment of a feeling of comfort, self-confidence, peaceful sleep, the hope for a better future and especially the personal motivation to return to the everyday activities that were carried out before the traumatic incident.

The highest percentage of successful re-establishment was in Mutwanga at 99% and Lolwa-Komanda at 94%. This high level of recovering survivors is probably due to several factors, such as local security, excellent public awareness campaigns and the active engagement of the Noyaux members. Additional investigations should be conducted in these health zones for lessons learned and best practices.

On the other hand, health zones with recovery rates of less than 50% should be investigated to seek explanations for their lower rates. These weak performance scores might be linked to certain

[12] Note that these are the cases that requested/received psycho-social help (97% of all cases)

external obstacles such as insecurity, work in the fields, transport costs, impracticable roads/paths, fear of stigmatization and social rejection. They could also be linked to internal weaknesses such as problems in follow-up reporting of cases and/or the more limited technical capacity in certain remote health areas. The Ushindi project will strive to address and correct these problems during quality-control supervision and with follow-up training of psychosocial counselors to emphasize quality monitoring, proper completion of case charts, case notification and improved recognition of trauma signs for post-SGBV cases.

However, some of these differences may be due to differing IP procedures or practices regarding more severe (usually SV cases) and less severe cases.

Table 11. Rape survivors - Emotional recovery

Health Zone	# clients identified	# new rape cases	# recoveries	% rape survivors recovered[13]
Lolwa-Komanda	662	366	343	**94%**
Mutwanga	543	209	212	**101%**
Lubero	649	177	112	**63%**
Alimbongo	681	399	260	**65%**
Obokote	606	79	67	**85%**
Ferekeni	495	153	67	**44%**
Shabunda	383	291	225	**77%**
Kitutu	494	210	68	**32%**
Mwenga	552	282	153	**54%**
TOTAL	**5,065**	**2,166**	**1,507**	**70%**

Remarks: Psycho-social accompaniment, including active listening, emotional support or trauma-related counseling, and social support, was provided by health area counsellors and psychologists to 2,165 new rape-survivors. This group represents 43% of 5,065 clients recovering from emotional signs and mental disorders/symptoms related to rape. The best recovery score from rape-related mental disorder was observed in Mutwanga HZ with 101% (including some cases from the end FY13), followed by 94% in Lolwa-Komanda, 85% in Obokote, 77% in Shabunda, 65% for Alimbongo, and 63% in Lubero.

Good scores may be explained by the increased knowledge and positive attitude among community members to end stigma and discrimination surrounding sexual violence. They have been involved in helping survivors reach existing adequate social services as is the case for Mutwanga, Lubero, Alimbongo, Lolwa–Komanda and Shabunda. On the other hand, the positive trend of post-rape trauma recovery may also be explained by an improved security context and easier access to psychosocial and medical support as might be the case for Obokote and Lolwa-Komanda. Discussion with field staff about a lower rate of post-rape and emotional recovery in some health zones could

[13] Note that some of these recoveries could be from a previous year and thus could go beyond a 100%.

be linked to security concerns especially among IDPs living in non-stable security context, among those living in a stigmatizing environment or by those exposed to repetitive violence by a close perpetrator. Psychologists and counsellors do their best to adapt specific techniques to help survivors exposed to repetitive incidence of sexual violence and to those living in non-stable zones, but constraints remain as home visits by service providers are limited.

It is interesting to note that the recovery rate for SV related cases is somewhat higher than other forms of GBV (70% to 60%). Possible explanations include: some survivors in this category may not see the need for counseling and so do not continue to use the services and the counselors are not able to follow up and, in the cases of domestic abuse, women are in more of a chronic situation where they are not as easily able to recover because the abuse is ongoing.

1.1.2. Number of people benefiting from medical care

Survivors had access to 108 health facilities (90 Health Centers/HC, 10 General Reference Hospitals and 8 Reference Health Centers/RHC) and were supported with medicine as well as additional treatment in facilities where medical staff was trained in the clinical management of sexual violence. Of the 5,065 cases identified by psychosocial services, 53% (2,679 cases) sought medical services in 108 supported health facilities. Among 2,679 cases registered in supported health facilities, 84% were rape survivors; 11% presented physical trauma; 4% had vaginal prolapses; and 2% were fistulae.

Table 12. Type of SGBV cases seeking medical care by HZ

Health Zone	Clients reporting	Rape	Physical trauma	Fistula	Vaginal prolapse
Lolwa-Komanda	367	365	1	1	0
Mutwanga	215	212	2	1	0
Lubero	241	186	39	13	3
Alimbongo	472	437	23	8	4
Obokote	185	85	97	1	2
Ferekeni	249	153	87	2	7
Shabunda	324	278	7	2	37
Kitutu	310	230	22	17	41
Mwenga	316	298	17	0	1
TOTAL	**2,679**	**2,244**	**295**	**45**	**95**
% of Total[14]	**100%**	**84%**	**13%**	**2%**	**4%**

Remarks: From a total of 2,679 people who received medical care, rape incidents were highest in the HZs of Alimbongo (437), Lolwa-Komanda (365), Mwenga (298) and Shabunda (278). These HZs include many villages under the control of local militia members, have experienced recurrent fighting between armed groups or have reported increased human right abuses and/or

[14] Note that the total percentages exceed 100% because a survivor can have more than one kind of medical issue.

vulnerable/displaced families. Thousands of women and young girls have reportedly experienced rape in these HZs as a weapon of war by more than one militia. Others reportedly have been forced to have sex and early child marriage by known perpetrators, including neighbors, friends and soldiers.

Rape cases were also reported from remote health areas of Bunyatenge, Kasugho, Kalimba in Lubero territory, and in most health areas of Kalole and Lulingu Health Zones bordering Ushindi-supported health clinics of Mugembe, Kassa, Makese, Tchombi in Shabunda HZ, and in Kalambi, Kitagana, Ngando, Buziba and Kilambwigali in Mwenga HZ. Many cases registered in Kitutu HZ are actually from the neighboring Kalole HZ where PEP kits were not available. In some cases, people walked for 3 to 5 days to reach the health clinics of Kagelagela, Kokelokelwa, Mela, Byonga and Mapale in order to access Ushindi's social services.

The high number of rape cases observed in Lolwa-Komanda HZ was primarily registered among IDPs from Mambasa territory who were fleeing the Morgan and Cobra Matata militia. Those IDPs were hosted by the health centers of Pekele, Mabukulu, Manya in Lolwa HZ.

Fistula cases and prolapses were registered among vulnerable women without access to adequate reproductive care.

Most (60%) of Ushindi-supported health clinics in Shabunda, Mwenga, and Alimbongo HZs lack adequate infrastructure, medical equipment, permanent skilled medical staff and geographical accessibility. Basic health kits distributed by Ushindi project to 75% of targeted health clinics increased the rate of primary health care attendance in 2011-13, but did not cover the needs for renovation and equipment of health facilities.

Table 13. Emergency care for rape cases

Health Zones	# of Rapes	Rapes reported <72 h.		PEP kits received		ECP	
		#	%	#	%[15]	#	%[16]
Lolwa-Komanda	365	234	**64%**	234	100%	221	94%
Mutwanga	212	160	**75%**	158	99%	132	83%
Lubero	186	87	**47%**	87	100%	66	76%
Alimbongo	437	239	**55%**	239	100%	233	97%
Obokote	85	32	**38%**	32	100%	29	91%
Ferekeni	153	109	**71%**	109	100%	108	99%
Shabunda	278	44	**16%**	44	100%	22	50%
Kitutu	230	41	**18%**	40	98%	30	73%
Mwenga	298	159	**53%**	159	100%	90	57%
TOTAL	**2244**	**1,105**	**49%**	**1,102**	**100%**	**931**	**84%**

[15] Note that this is the % of PEP kits given to cases who reported in <72 hours
[16] The % of ECP given to cases reporting in <72 hours

Remarks: Amongst all SGBV cases receiving medical care, 83% (2,244) were rape cases amongst which 49% (1,105) arrived in less than 72 hours of the incident. 99.7% (1,102) of cases reporting in less than 72 hours received PEP[17] kits and 84% received an Emergency Contraceptive Pill (ECP). Note that the 51% (1,139) who reported their incident after 72 hours received Voluntary Counseling and Testing services (VCT) for STIs and HIV as well as STI prophylaxis for 69% of the 1,139 cases. Health Zones of Ferekeni, Mutwanga, Mwenga, Alimbongo, Obokote, Lubero, and Lolwa-Komanda distributed STI doses to more than 95% of the patients who were not eligible for PEP kits based on WHO's protocol for STI treatment.

In general, the percentage of rapes reported within 72 hours is low. This can lead to an under-utilization of PEP kits. Mutwanga and Ferekeni HZs actually meet the target of 70% followed by Lolwa-Komanda with 64%. Best practices should be verified in those areas and applied to the other HZs. It is speculated that improved reporting may be due to more active Noyaux and their successful public outreach. Also, an ad hoc survey will be conducted to try to identify the actual reasons for the delay in each HZ. The PEP kit goal was 80% and so all HZs are well above that (100% nearly everywhere). Similarly, the use of ECP is generally very good except for Shabunda HZ where its usage is 50%, yet that was still a significant progress compared to 21% registered during the previous semester.

1.1.3. Number of people benefiting from legal assistance

During the reporting period, the survivors of sexual violence and other forms of gender based violence had access to three types of legal services – individual counseling, accompaniment in the judicial process and mediation in the nine legal clinics established in the HZs, as well as in different courts.

1.1.3.1 Legal advice

Every survivor requesting legal counsel received specific advice according to their case to clarify their particular issues, the advantages and disadvantages of pursuing their case legally and, if deciding to pursue it, the need for consent and a decision to be accompanied or not in the judicial process.

[17] PEP kit = Post Exposure Prophylaxis against HIV and other STIs

Table 14. Legal Assistance by sex and type of incident

Legal aid clinic	SV			GBV			TOTAL
	M	F	S/Total	M	F	S/Total	
Lolwa-Komanda	0	148	**148**	16	70	**86**	**234**
Mutwanga	16	130	**146**	2	52	**54**	**200**
Lubero	2	128	**130**	11	117	**128**	**258**
Alimbongo	1	45	**46**	53	74	**127**	**173**
Obokote	0	41	**41**	7	40	**47**	**88**
Ferekeni	1	36	**37**	4	72	**76**	**113**
Shabunda	0	45	**45**	26	21	**47**	**92**
Kitutu	0	31	**31**	22	67	**89**	**120**
Mwenga	0	42	**42**	59	138	**197**	**239**
TOTAL	20	646	**666**	200	651	**851**	**1,517**
%	1%	43%	**44%**	13%	43%	**56%**	**100%**

Remarks: Among 5,065 cases assisted by USG-funded social services, 30% (1,517) requested legal aid. Of those persons seeking legal aid 56% were cases of GBV and 44% were SV survivors.

1.1.3.2 Accompaniment in judicial proceedings

During FY14, the lawyers based in the HZs initiated complaints with police stations, followed them through the courts and facilitated mediation for domestic disputes as well as denial of rights. By the end of March 2014, the staff based in the legal clinics had accomplished the cases as shown in the table below.

Table 15. Forms of legal aid supplied to survivors

Indicators	FY14 Annual Achievements			
Numbers of…	**M**	**F**	**Total**	**%**
People benefiting from social services	545	4,520	5,065	
Requesting legal support	**220**	**1,297**	**1,517**	**30%**
Receiving legal support - GBV	200	651	851	17%
Receiving legal support - SV	20	646	666	13%
Cases taken to court *(% of all legal support)*	66	549	615	**41%**
Judgments *(% of cases taken to court)*	3	157	160	**26%**
Mediations achieved *(% of all GBV cases)*	88	314	402	**47%**

Remarks: Among 1,517 cases requesting legal aid from the nine Ushindi-supported legal aid clinics, 41% consented to have their cases taken to court or trial with the lawyers. Judgments were obtained for 26% of the cases taken to court. Mediation was facilitated by lawyers for 402 cases of other GBV issues, representing 47% of those cases. These included denial of access to household resources, opportunities or emotional support; refusal of heritage or abandonment of children by parents and siblings; and children in conflict with their parents or neighbors. These were resolved with generally satisfactory results with mutual agreement to put an end to their differences and promote a lasting reconciliation between the two parties.

Note II: OBSTACLES TO LEGAL INTERVENTIONS

Backward cultural practices, a tradition of silence with the practice of amicable settlements between parties in conflict for even felonies such as rape, early and unjustified release of prisoners by the judges and the lack of indemnity payments to the survivors, these all affect the use of the legal clinics and the willingness of the survivors to pursue legal proceedings through to judgment.

25% of the survivors of sexual violence received appropriate legal advice, including details of the Congolese laws concerning sexual violence as well as the advantages and disadvantages of making a legal case. 49% (327 of 666 cases) soliciting legal assistance accepted to register a formal complaint with only 12% having so far led to a judgment.

1.1.3.3 Legal advice on human rights violations

During the reporting period, the staff of ABA ROLI assigned to the nine legal clinics gave legal advice to 1,352 people (645 women and girls, 747 men and boys) on problems linked to, but not limited to, human rights, inheritance, amicable agreements and family disputes.

Table 16. Human rights-related counseling

Health Zones	YOUTH			ADULT			Sub Total		TOTAL
	M	F	S/TOT	M	F	S/TOT	Male	Female	
Lolwa-Komanda	2	7	**9**	35	39	**74**	37	46	**83**
Mutwanga	13	35	**48**	68	58	**126**	81	93	**174**
Lubero	24	46	**70**	50	58	**108**	74	104	**178**
Alimbongo	50	55	**105**	58	85	**143**	108	140	**248**
Obokote	37	24	**61**	72	28	**100**	109	52	**161**
Ferekeni	15	21	**36**	27	28	**55**	42	49	**91**
Shabunda	5	11	**16**	61	31	**92**	66	42	**108**
Kitutu	4	12	**16**	67	52	**119**	71	64	**135**
Mwenga	49	4	**53**	70	51	**121**	119	55	**174**
TOTAL	199	215	**414**	508	430	**938**	707	645	**1,352**
%	15%	16%	**31%**	38%	32%	**69%**	**52%**	**48%**	**100%**

Remarks: Besides legal assistance for survivors of SGBV, the lawyers based in the nine legal clinics, in collaboration with citizen legal activists and local staff, received 1,352 people seeking legal advice.

Those include 48% women and girls and 52% men and boys. Most of these related to public infractions such as theft, land tenure, calumny and public insults. These legal counseling sessions were highly appreciated because they reinforced the community's level of basic knowledge and understanding of what constitutes a public infraction and of the penal code, increased the confidence and use of the Congolese judicial system and reduced the number of cases resolved privately in the case of sexual violence. Legal advice on human rights has tended to reduce the idea of vengeance and popular justice as a way to resolve conflicts by the community, with sometimes dire consequences.

The HZ lawyers also led mass campaigns in the villages and on community radio. Note that budget reductions did not allow for all of the supervision trips originally planned.

1.2. Establish/supply service delivery systems: health centers, safe houses, legal clinic

In order to improve access to quality services, IMA World Health supplied 108 health facilities with medicine and essential supplies as well as paying the medical bills of the survivors.

The Implementing Partners/IPs (Heal Africa, PPSSP and the Panzi Foundation) continued to supply the nine bases with food and other consumables, office supplies and maintenance supplies for their vehicles and motorcycles (18 motorcycles and 4 Land Cruisers) so that the facilities might provide a comfortable environment for psychosocial support and offer quality services to the beneficiary population as well as ensuring supervision and monitoring activities.

For the emotional needs of the children, eight "*paillottes*[18]" were put up by the community to be used as recreation spaces and modestly equipped with game kits in Mutwanga, Lolwa, Komanda, Alimbongo, Obokote, Ferekeni, Mwenga and Kitutu HZs.

In the nine Ushindi bases, ABA continues to strengthen the legal clinics with office supplies, transport subsidies (for supervision and training) and food for those survivors and their caretakers who are pursuing legal cases in the courts.

[18] Thatch covered hangars built of traditional materials

2. IR2: Increased organizational and community capacity to respond to SGBV (BCC) and the reintegration of the survivors

2.1. Number of service providers and community stakeholders trained

PPR2. NUMBER OF SERVICE PROVIDERS TRAINED WHO SERVE VULNERABLE PERSONS

Due to the partial and limited availability of funds during Year 4, capacity building of key players was limited to reinforcing formative supervision of psychosocial service providers, management committees of VSLAs and local stakeholders involved in the protection and promotion of children's rights. As a result, a series of four training sessions (see table below) were organized in health Zones assisted by Save the Children, HEAL Africa and PPSSP to improve the knowledge and professional practices of 412 (16%) of the originally intended 2,430 participants. The distribution of the participants by topic resulted in 38 psychosocial agents being trained in life skills and psychosocial accompaniment of children, 87 safe house agents and representatives of the temporary host families trained on the importance and management of their charges, 55 counselors and key staff of safe houses trained in psychosocial accompaniment of the SGBV survivors; 29 nurses and doctors trained in clinical management of acts of sexual violence, and lastly 165 school teachers trained on the prevention of sexual violence in schools.

Table 17. Training of Service Providers and Local Animators

Training title by profile of participants	Participants		
	M	F	Total
Behavior Communication and change against SGBV for Community Volunteers	1,013	515	**1,528**
Behavior Communication and change in SGBV for teachers and students	112	53	**165**
Socio-economic support to survivors of SGBV: VSLA approach and micro project for VSLA and CBO leaders	135	47	**182**
Child protection and sexual violence DRC laws for Health service providers	39	6	**45**
Psychosocial support for children victims of SGBV and maltreatment	9	45	**54**
Psychosocial support for adult rape victims for psycho-social counselors	5	50	**55**
Organizing a child friendly space ToT for psychosocial counselors	14	105	**119**
Child life skills ToT for Children's club	42	62	**104**
Child protection DRC law ToT for Community Child protection Team (RECOPE)	49	31	**80**
Transitory Fostering family (FAT) for couples and counselors	72	45	**117**
Prevention of SGBV and existing Ushindi services for community leaders, religious leaders and CBOs	80	62	**142**
Clinical management of rape for skilled medical staff	72	23	**95**
SGBV general knowledge, community behavior change in SGBV and responses for local leaders (traditional, religious)	190	123	**313**
Child protection and legal framework for protection	49	31	**80**
TOTAL	**1,881**	**1,198**	**3,079**

Remark: Following the recommendation of the Mid-Term Evaluation and to prepare for the exit strategy to intensify, Ushindi partners organized various training sessions in all the Health Zones. A total of 3,079 people were trained, with 61% (1,881) men and 39% (1,198) women, to update knowledge, hone skills and share field experiences. The sessions were oriented to improve their ability to initiate and conduct SGBV prevention activities, provide quality care to needy survivors and correctly manage VSLA and Income Generating Activities (IGA).

To ensure that project sustainability, Ushindi partners are transferring progressively all community-based activities for SGBV prevention and women's empowerment to different Noyaux committees. In addition, Health Zones will be handling provision of social care and support to survivors under the supervision of Implementing Partners.

See also Annex B for TraiNet details.

2.2. Number of organizations' delivery systems strengthened

***PPR3.** FACILITIES OFFERING SOCIAL SERVICES STRENGTHENED*

This project component concentrates on systems strengthening initiatives that reinforce the capacity of health centers, safe houses, legal clinics and other social service structures to remain functionally operative and provide services to survivors of SGBV. These structures include the creation of opportunities for SGBV survivors to engage in livelihood activities. During the past year, project assistance has notably made the following contributions in this area:

- 108 targeted health facilities received essential medicine and other medical supplies as well as training on SGBV themes and interventions to provide appropriate medical care to survivors; training and contraceptive products were also provided for family planning.
- 108 Community Core Groups (Noyaux) have been equipped with awareness-raising tools for SGBV prevention, the promotion of women's rights, and promotion of family planning. Noyaux members have also, in response to a MTE recommendation, worked on drafting bylaws and action plans to reinforce the sustainability of their project accomplishments.
- 715 VSLAs are continually monitored by field agents and re-insertion focal points in order to strengthen the ability of village committees to improve their performance and to extend these activities into other villages.
- 108 Youth Clubs received material, recreational space and training to help provide safe environments for children and to implicate them in community outreach for SGBV and children's rights, especially amongst their peers.
- 12 RECOPEs (community networks for child protection) received material and training to continue to provide advocacy for children's rights and issues as well as help identify vulnerable children.
- 45 Temporary Foster Families (FAT) have been provided with food and supplies to provide transitional care for 41 child survivals of SGBV.

- 20 Micro-projects and production units were supported operationally. Six previously supported projects are no longer operational due to two of them having encountered technical difficulties (machines breaking down) and four have become bankrupt.
- 9 safe houses have been stocked with food, supplies and fuel in order to provide care for SGBV survivors and to facilitate program supervision and reporting.

2.3. Legal Awareness and Outreach program

Lawyers from various clinics facilitated discussions concerning the positive and negative effects related to using judicial services to pursue issues of sexual violence. These discussions were attended by a total of 3,423 (39% youth and 61% adult) participants (see table below) that included para-jurists, members of community core groups, members of youth clubs, schools authorities and local health zone staff.

Table 18. Awareness-raising concerning laws related to Sexual Violence and Sexism

Health Zone	YOUTH			ADULT			TOTAL
	M	F	S/Total	M	F	S/Total	
Kitutu	92	41	**133**	84	65	**149**	**282**
Mwenga	8	12	**20**	11	17	**28**	**48**
Shabunda	204	132	**336**	361	470	**831**	**1,167**
Lubero	173	165	**338**	8	4	**12**	**350**
Alimbongo	8	6	**14**	61	42	**103**	**117**
Ferekeni	13	2	**15**	61	19	**80**	**95**
Obokote	8	13	**21**	35	15	**50**	**71**
Mutwanga	186	183	**369**	39	49	**88**	**457**
Lolwa-Komanda	36	44	**80**	144	234	**378**	**458**
TOTAL	728	598	**1,326**	804	915	**1,719**	**3,045**
%	24%	20%	**44%**	26%	30%	**56%**	**100%**

3. IR3: Improved ability of communities and individuals to lead and participate in community-based social integration and economic recovery activities

3.1. Local discussions and programs create awareness of the consequences of SGBV

During the year, members of various community groups (e.g., Noyaux, Youth Clubs, RECOPE, VSLAs and local organizations), with the support of the community mobilization advisors and lawyers from legal clinics, led several participatory communication sessions for Behavioral Change Communication (BCC), via forums and focus groups. These sessions analyzed and discussed root causes of SGBV, needs of survivors and paths to solutions, each according to the local context in the HZs supported by Ushindi.

3.2. Women and youth groups engaged in discussion

Women, men and adolescents (as members of Noyaux), VSLAs, Youth Clubs or RECOPEs organized several discussion groups with 6 to 15 people (focus groups) or larger with up to 25 members (discussion forums). In total, 5,183 group meetings were held with active participation of 98,046 civilian and uniformed participants to discuss the impact of SGBV on the individual and collective lives of people. Participants gathered in three groupings: 1) groups of the same sex (male, female); 2) mixed group of different ages (children and adults); and 3) various professions (civil and military or police). There were more women than men involved in discussions by about two to one. See IR4 for more details.

3.3. Psychosocial assessment of survivors realized

The evaluation of the psychological state of survivors benefiting from psychosocial support is a continuous process and precedes any integration of the individual into the different economic groups. Monitoring of their psychological state is done during community follow-ups (home visits and to the Health Centers/HC, family mediation) carried out by the counselors as well as during the monthly technical meetings at each of the nine Ushindi bases.

Table 19. Types of psychosocial care

Psychosocial care of clients (survivors)	#	%
Identified survivors	5,065	
Access to active listening and psycho-emotional support	4,883	96%
Home visits	4,307	85%
Declared/determined to have returned to their usual state/activities	2,329	47%
Family mediation	1,021	20%
Integrated into VSLAs (survivors of rape)	678	30%[19]

Remarks: The follow-up of those who were assisted and accompanied psychologically and emotionally is illustrated in the table below. In total, 47% of 5,065 survivors were reported recovered from their symptoms and were able to return to normal activities. Others estimated to 20% (678 persons) chose to join VSLA groups and some became community leaders to participate in awareness-raising activities on the empowerment of women. Care of other survivors not yet fully returning to normal activities is underway.

[19] This is the percentage of rape survivors (1,147) who are integrated into the VSLAs, i.e. 678 (in VSLAs)/2,296 (all rape survivors), and includes survivors integrated into unsupported VSLAs (spontaneously created).

3.4. Market analysis

During Year 4, no specific analysis or market study was carried out because the results of the first study in Year two were able to initiate the first phase of support to 26 micro-projects, 20 of which are currently in progress. However, the VSLA and local organizations implicated in the socio-economic reintegration activities are assisted by field agents in 108 Health Areas (HA) who analyze regularly the opportunities and risks during supervision visits and monitoring meetings.

3.5. Economic empowerment by socio–economic activities: VSLA, IGA

To reinforce the economic and social capital of women, thus contributing to the reduction of their vulnerability to sexual violence and especially to denial of resources and opportunities, the Ushindi Project supports economic interest groups with technical support (training, supervision and "operational" kits[20]) for VSLAs and provides kits for processing agricultural products as well as some capital funding for small businesses.

3.5.1. Village Savings & Loan Associations (VSLAs)

This intervention is an initiative of self-managing groups of 25 members living in the same area, all motivated to save small amounts weekly, and to grant themselves credit from the fund of which each member has bought a share. At the end of the annual cycle for each VSLA, the members divide up the dividends according to the shares that each has purchased and can then go on to the next cycle.

The project objective is to have 432 VSLAs, i.e. with four VSLAs in each of the 108 targeted Health Areas (HA). Currently a total of 720 VSLA groups with 17,795 members exist of which 415 (58%) are directly supported by the project, and community members generated 305 additional VSLA on their own (see table below). This "explosion" of VSLA was described in the Success Story in the previous report and is further discussed in an additional Success Story at the end of this report.

SUCCESS STORY:

Note III: Viva la VSLA

***See Section V**: The VSLAs have become so popular in some communities that new VSLAs are popping up on their own.*

The training of field agents in improved reporting of VSLA activities began in April 2014 in all project-assisted health zones.

[20] The office supplies and other material needed to start up the VSLA

Table 20. VSLA and Membership by Health Zones

Partner	Health Zone	Total # of VSLA	Membership # in VSLA			Mean VSLA size		Initial # of VSLA	Spont[21] VSLA created	% Inc
			M	F	Total					
PPSSP	Lolwa-Komanda	70	285	1,295	1,580	23		48	22	46%
	Mutwanga	62	398	1,349	1,747	28		44	18	41%
	S/Total	**132**	**683**	**2,644**	**3,327**	**25**		**92**	**40**	**43%**
Heal Africa	Lubero	116	511	2,999	3,510	30		48	68	142%
	Alimbongo	174	647	4,156	4,803	28		48	126	263%
	Obokote	53	447	739	1,186	22		48	5	10%
	Ferekeni	58	455	814	1,269	22		48	10	21%
	S/Total	**401**	**2,060**	**8,708**	**10,768**	**27**		**192**	**209**	**109%**
Panzi Foundation	Shabunda	64	484	919	1,403	22		48	19	40%
	Kitutu	56	275	813	1,088	19		48	16	33%
	Mwenga	67	218	991	1,209	18		35	21	60%
	S/Total	**187**	**977**	**2,723**	**3,700**	**20**		**131**	**56**	**43%**
TOTAL		**720**	**3,720**	**14,075**	**17,795**	**25**		**415**	**305**	**73%**
			21%	**79%**	**100%**					

Remarks: VSLAs have been so popular that there was a 73% increase in the total number of VSLAs. These 305 new VSLAs were spontaneously created by the communities themselves but have only limited support from the project due to budget limitations and so are a cause of concern (if for example, they are set up and functioning properly according to model norms). The structure of these committees is similar to those initially supported by the project albeit with a somewhat higher proportion of women to men (83% to 17% compared to 79% to 21%).

The particularly large increases in number of VSLAs in Lubero and Alimbongo bear investigation to determine what factors produced such a favorable environment for VSLA creation there. This also parallels higher average VSLA sizes in North Kivu with 30 in Lubero, 28 in Alimbongo and Mutwanga, compared to South Kivu with lower average rates of enrollment in Mwenga at 18 and Kitutu at 19.

The higher membership enrollment in North Kivu could be explained by the fact that members have a deeper understanding of VSLA's benefits in generating profits and increasing household welfare and social cohesion. In addition, testimonies and success stories collected from VSLA members note that Lubero, Alimbongo and Mutwanga are much more accessible with a fertile soil and dynamic population animated by the culture of transforming local opportunities for individual and community self-sufficiency, and where for decades many of the men and women conduct prosperous small businesses and agriculture. On the other hand, the Health Zones of Mwenga and Kitutu have limited accessibility to fertile soil, suffer from insecurity, have worse roads and

[21] # of VSLA spontaneously created by villages, not directly supported by project.

thousands of young people are more engaged in artisanal mining rather than other local opportunities such as agriculture.

Table 21. Products generated by VSLA (Ushindi supervised)

VSLA Products	Amount	Ave	Notes
# of initial VSLA groups	415		Created/supervised by Ushindi
# of members of initial VSLAs	9,771	25	In original 415 VSLAs
# of shares purchased by members	962,589	98	Ave # of shares/member
Net Value of savings (in USD/$)	$427,391	$44	Ave savings/member
Value of savings in other forms (goods convertible to $)	$19,629	$2	Ave savings in goods/mem
# of loans granted (from VSLA funds)	15,443	1.6	Ave # of loans/member
Value of loans granted from VSLA funds	$373,405	$24	Ave value of loans/member
Balance unpaid from loans by members	$45,289	$109	Ave value loans unpaid/VSLA[22]
Amount in $ from solidarity funds	$43,671	$105	Ave amount of funds pd/VSLA
# of members assisted by solidarity fund	8,557	5	Ave amount of funds/member assisted[23]

Remarks: VSLAs that are directly supervised by the project have collectively generated a financial force equivalent to USD $490,691. This includes the net value of VSLA shares of $427,391 in cash, $19,629 savings in other forms and contributions for mutual support (the solidarity fund) of $43,671. From these resources, 962,589 shares with a value of $447,020 ($427,391 in cash and $19,629 in other forms) were put into savings representing an average of $46 per member. 15,443 loans were granted worth $373,405 with an average value of $24 per VSLA members. According to the local market analysis, the sum is generally considered sufficient for the start-up of a small business based on trade involving farm produce, paying school fees, renovating/or building houses or to resolve other social needs in several villages.

In addition, $43,671 in solidarity funds was given to 8,557 members with an average cash value of $5, coupled with provision of goods such as bundles of firewood and foodstuffs as support to families affected by various types of crises, (e.g., illness, death in the family, loss to fires or loss of seeds) or to celebrate a marriage or birth.

[22] This represents about 12% unpaid per VSLA however some of these could have been paid back after the close of the annual cycle.
[23] 88% of all VSLA members received social assistance from the solidarity fund.

Table 22. Products generated by supported VSLA groups by HZ

VSLA output/ HZ	Lolwa /Komanda	Mutwanga	Lubero	Alimbongo	Obo-kote	Fere-keni	Shabunda	Kitutu	Mwe-nga
# of original VSLAs	48	44	48	48	48	48	48	48	35
# VSLA members	1,105	1,206	1,435	1,384	1,079	1,042	777	1,057	686
# of shares (total)	85,875	147,648	197,728	288,889	79,217	32,168	19,323	51,408	60,333
Average # of shares/person	**78**	**122**	**138**	**209**	**73**	**31**	**25**	**49**	**88**
Net Value of savings (in USD/$)	58,949	61,553	85,782	51,739	9,251	17,662	19,384	61,457	61,616
Value of savings in other forms (goods convertible to USD)	2,902	510	-	175	-	2,513	12,095	1,179	255
Average value of shares ($)	**0.69**	**0.42**	**0.43**	**0.18**	**0.12**	**0.55**	**1.00**	**1.20**	**1.02**
Average net value of savings/member ($)	**56**	**51**	**60**	**38**	**9**	**19**	**41**	**59**	**90**
# of loans granted (total)	1,223	1,689	2,810	2,202	379	538	2,315	3,693	594
Average # of loans/member	**1.1**	**1.4**	**2.0**	**1.6**	**0.4**	**0.5**	**3.0**	**3.5**	**0.9**
Value of loans ($)	37,341	49,349	79,721	43,209	6,004	8,397	13,762	109,283	26,340
Average value of loan/loan ($)	**31**	**29**	**28**	**20**	**16**	**16**	**6**	**30**	**44**
Average value of loans/member	**34**	**41**	**56**	**31**	**6**	**8**	**18**	**103**	**38**
Balance unpaid by members ($)	2,842	12,853	21	6,284	-	238	168	18,810	4,072
Average unpaid loan/VSLA ($)	**59**	**292**	**0**	**131**	**-**	**5**	**4**	**392**	**116**
Amount in $ from solidarity fund	5,482	4,825	4,042	5,202	1,943	1,537	4,514	4,152	11,975
Average amount of solidarity fund/VSLA ($)	**114**	**110**	**84**	**108**	**40**	**32**	**94**	**87**	**342**
# of members assisted by the solidarity fund	1,055	1,312	1,022	1,196	443	526	701	381	1,921
Average amount of solidarity fund/assisted member ($)	**5.2**	**4.0**	**4.0**	**4.4**	**4.4**	**2.9**	**6.4**	**10.9**	**17.5**
% of all VSLA members assisted by solidarity fund	**95%**	**109%[24]**	**71%**	**86%**	**41%**	**50%**	**90%**	**36%**	**280%[24]**

Remarks: There is considerable variation between HZs on the details of their VSLAs. Average savings per member varies from $9 (Obokote) to $90 (Mwenga); average value of loans per member from $6 (Obokote) to $103 (Kitutu); average net unpaid balance on loans per VSLA from completely paid (Obokote) to $392[25] (Kitutu); and average social assistance per assisted member (solidarity fund) from $2.90 (Ferekeni) to $17.50 (Mwenga). Some of this variation is probably due to local economic

[24] This means that, on average, each VSLA member received more than one social assistance from the group. In the case of Mwenga, each member received nearly 3.

[25] Although this rate and that of Mutwanga are exceptionally high, it is thought to be a problem of misunderstanding by some VSLAs the difference between outstanding loans (that are late but eventually paid off) and uncollectable loans. As noted the new VSAL coordinator is investigating the problem and will try to differentiate in future diagnostics between late payments and losses.

conditions (such as Ferekeni and Obokote), but others are probably due to variations in the quality of the local IP's program. The new socio-economic advisor is currently investigating these variations.

3.5.2. Opportunities created for survivors to engage in livelihood activities

Data also indicate (as shown in the table below) that an estimated 635 survivors of sexual violence have actively participated in supported VSLAs[26] and received financial assistance from VSLA members after the annual sharing of dividends. There is considerable variation between HZs. Lolwa-Komanda, Mutwanga and Alimbongo are being investigated for best practices, but some of the differences are probably due to difficulties of the reporting structure given the confidentiality of survivor membership in VSLAs[27]. At least 30% of rape survivors have been participating in socio-economic reintegration activities.

Table 23. Survivors of sexual violence integrated into VSLAs

Health Zone	# of VSLA Members	Survivor of Rape in VSLA			%
		M	F	Total	
Lolwa-Komanda	1,105	0	189	**189**	**17.1%**
Mutwanga	1,206	0	258	**258**	**21.4%**
Lubero	1,435	0	13	**13**	0.9%
Alimbongo	1,384	3	116	**119**	**8.6%**
Obokote	1,079	0	7	**7**	0.6%
Ferekeni	1,042	0	2	**2**	0.2%
Shabunda	777	0	34	**34**	4.4%
Kitutu	1,057	2	5	**7**	0.7%
Mwenga	686	0	13	**13**	1.9%
TOTAL	**9,771**	**3**	**632**	**635**	**7.3%**

3.5.3. Income Generating Activities (IGA)

Of the 26 micro projects which have been financed since the beginning of projects, 20 projects (summarized in the table below) are currently operational with 1,933 beneficiaries. IMA has recruited an expert in "re-insertion" to provide assistance to local NGOs and VSLA in management practices relating to the specific production units supported by the project.

[26] At least an additional 43 survivors are participating in spontaneous VSLAs although it is impossible to know actual numbers.

[27] VSLAs are not supposed to know who amongst their membership is a survivor and, in fact in most cases, probably do not. There is therefore some difficulty in reliably collecting this information and the numbers are thought to be much higher.

Table 24. Micro-Projects and members by HZ

Partner	Health Zone	Micro Projects Operating	People Enrolled in IGA		
			M	F	Total
PPSSP	Lolwa-Komanda	5	210	459	669
	Mutwanga	3	55	138	193
	S/Total	**8**	**265**	**597**	**862**
Heal Africa	Lubero	2	0	0	0
	Alimbongo	3	41	911	952
	Obokote	2	0	0	0
	Ferekeni	2	0	29	29
	S/Total	**9**	**41**	**940**	**981**
Panzi Foundation	Shabunda	1	28	50	78
	Kitutu	1	0	0	0
	Mwenga	1	0	12	12
	S/Total	**3**	**28**	**62**	**90**
TOTAL		**20**	**334**	**1,599**	**1,933**

Examples of the successful undertakings included the following:

- A motorized pirogue at Kowe 1 (Ferekeni HZ) has generated funds to purchase a phone that was needed for communication in that isolated area;
- A mill in Kitutu HZ has resulted in the creation of a fish farm and support to schooling of 7 children;
- A cassava mill at Bulongo (Mutwanga HZ) has allowed members to purchase a rice huller and land; and
- Small commerce at Nzenga (Mutwanga HZ) made it possible for members to purchase land.

Of the six projects which are non-operational, two are non-functional due to machinery breakdowns (problems with parts) and lack of competent technicians. The other four projects that became bankrupt due to internal management problems included a restaurant in Shabunda HZ, vegetable gardening in Mwenga HZ, a soap factory in Lubero HZ and a depot for fresh produce in Lubero HZ.

3.6. Formal education & literacy circles

3.6.1. School reentry for vulnerable children

Girls' education today is very important in the promotion of gender equity, poverty reduction and especially the increase of economic capital in households. Project Ushindi remains convinced that good governance and Congolese leadership depend on girls' education being on the same level as boys. Within the framework of preventing sexual violence, potential early marriages, juvenile delinquency, Ushindi encourages the reentry of children into schools. Although the project paid school feels for some vulnerable children in 2013, this was not feasible in 2014 due to budget cuts.

3.6.2. Literacy circles

This activity started with project payment of alphabetizers, but now continues thanks to initiatives of certain trained volunteer members of Community Core Groups who have opted to serve their communities without remuneration in order to sustain this important activity. Nevertheless, the voluntary approach is not appreciated by a number of literacy teachers, which has affected the quality and quantity of this activity. Sessions for 2014 were launched in October 2013 for six to nine months to accommodate time allocated for the cultivating season. The cumulative number of participants based on partial data from 6 of the 9 intervention sites indicates that 955 individuals are registered (see table below) in 45 literacy circles and that among them 379[28] completed the program with success.

Table 25. Enrollment in literacy circles

Health Zone	Enrollment in Literacy Circles		Total
	M	F	
Lolwa-Komanda	15	81	**96**
Mutwanga	45	201	**246**
Lubero	-	-	**0**
Alimbongo	10	226	**236**
Obokote	-	-	**0**
Ferekeni	13	221	**234**
Shabunda	-	-	**0**
Kitutu	4	102	**106**
Mwenga	3	34	**37**
TOTAL	**90**	**865**	**955**

[28] However, the majority of the rest are expected to complete the cycle as well. Some circles started later for various reasons and won't complete their cycle until November or December.

3.7. Couples trained in parenting skills

There was no classic training during this period. However, reinforcement sessions of the local Core Community Groups provided an opportunity for the partners to do more capacity building of their members. Therefore, 494 meetings with members committed to parenting skills met to benefit 6,095 members in sharing their experiences and responsibilities as parents, as well as those of their children, in order to reduce violence within the family and with neighbors.

4. IR 4: Strengthened community's ability to prevent SGBV

This component of project Ushindi builds on other SGBV prevention methods to strengthen the capacity of community leaders and structures to prevent SGBV. It also includes advocacy for women's and children's rights.

4.1. Local discussions and awareness programs create awareness of the consequences of SGBV

As emphasized above, community structures (community core groups, youth clubs, VSLAs, RECOPE) received technical support to help them organize discussion groups to analyze risk factors for SGBV and factors limiting women's self-determination. The discussions took place in homogeneous and heterogeneous groups which resulted in the development of awareness-raising actions, public debate, prevention messages and related responses. The resulting actions for prevention of SGBV and promotion of women's initiatives lead to the organization of a number of key activities.

Table 26. Individuals in discussion sessions

Type of Discussion	# of sessions	Participants		Total
		M	F	
Focus Groups	2,150	9,919	15,299	**25,218**
Forum discussion	2,774	25,427	41,306	**66,733**
Parenting Skills	494	3,060	3,035	**6,095**
TOTAL	**5,418**	**38,406**	**59,640**	**98,046**
%		39%	61%	100%

A total of 5,418 sessions were organized that included focus groups, discussion forums and discussions between model couples. A total of 98,046 participants attended these discussions, including members of community core groups, youth clubs, and Champion Couples as shown above and detailed in the following tables.

Table 27. Discussion forums by HZ

Health Zone	# Discuss Forum	# of leaders		Total
		M	F	
Kitutu	243	3,050	3,679	6,729
Mwenga	103	1,083	1,313	2,396
Shabunda	235	1,422	1,500	2,922
Lubero	225	1,919	4,571	6,490
Alimbongo	940	5,900	16,769	22,669
Ferekeni	533	6,702	6,599	13,301
Obokote	269	2,957	2,785	5,742
Mutwanga	102	984	1,774	2,758
Lolwa-Komanda	124	1,410	2,316	3,726
TOTAL	2,671	25,427	41,306	66,733
%		38%	62%	100%

Table 28. Focus Groups by HZ

Health Zone	# Focus group	Participants		Total
		M	F	
Kitutu	222	891	1,556	2,447
Mwenga	0	637	775	1,412
Shabunda	182	872	1,076	1,948
Lubero	243	898	1,811	2,709
Alimbongo	363	1,377	3,125	4,502
Ferekeni	535	3,439	3,672	7,111
Obokote	233	845	1,813	2,658
Mutwanga	101	359	418	777
Lolwa-Komanda	139	601	1,053	1,654
TOTAL	2,018	9,919	15,299	25,218
%		39%	61%	100%

Table 29. Parenting skills (Champion Couples) by HZ

Health Zone	# Parenting skills sessions	# of leaders		Total
		M	F	
Kitutu	23	217	218	435
Mwenga	0	0	0	0
Shabunda	16	24	28	52
Lubero	45	852	792	1,644
Alimbongo	84	578	587	1,165
Ferekeni	201	363	402	765
Obokote	90	561	543	1,104
Mutwanga	19	303	303	606
Lolwa-Komanda	16	162	162	324
TOTAL	494	3,060	3,035	6,095
%		50%	50%	100%

4.2. Community level awareness campaigns

Community structures supported by Ushindi include 108 youth clubs, 108 community core groups, 435 VSLA and 12 child protection networks (RECOPE). These groups collectively organized 61,603 mass community awareness-raising sessions in villages, including during international commemorative days. A total of 312,361 individuals participated of which 72% were community members, 26% were primary or secondary school staff (and students) and 2% were local leaders. These participants followed the SGBV prevention messages and how to maximize the utilization of services that respond to the needs of SGBV survivors as well as related interventions such as

alphabetization, schooling, reproductive health services and VSLA that collectively target self-determination of women (see table below).

Table 30. Awareness-raising on SGBV and women's rights

People engaged in BCC	M	F	Total	%
# of leaders	3,292	1,663	**4,955**	1.6%
# of community members	86,724	138,242	**224,966**	72.0%
# of school children/ student	38,040	43,169	**81,209**	26.0%
# of people in uniform	1,154	77	**1,231**	0.4%
TOTAL	**129,210**	**183,151**	**312,361**	100%

4.3. Women–led or child–led community groups strengthened

The awareness-raising sessions related to protection and respect for the rights of children contributes to an apparent reduction in the number of early marriages. Similarly there have been significant increases in marriage and birth registrations. This has included an increase in the declaration of monogamous marriages with civil authorities which help to prevent conflicts in inheritance issues in case of the death of one of the parents. The public awareness-raising has also helped to clarify instructions for the orientation of children to appropriate and available services in cases of sexual violence.

The involvement of parents and authorities in the promotion and respect of children and women's rights is reflected in the increased access to medical care. For example, PEP kits were made available to 316 of 609 survivors of child rape. In addition, there have been new registrations of 1,143 marriages and 7,785 births. Anecdotally, members of youth clubs have noted that the number of cases of children being mistreated has decreased, particularly in households of the members of Noyaux and their neighbors due to their increased knowledge of the rights of children.

A total of 108 Youth Clubs, 415 VSLA and 20 women-led IGA/CBOs are supported by the project to get women and children actively involved in BCC activities and socio–economic reintegration. Women's membership is 9,042 in the VSLAs[29] and CBOs out of a total membership of 11,704 and children's membership is 3,313 in the Youth Clubs.

They meet in discussion groups, conduct advocacy sessions and play a role in family mediations to facilitate peaceful resolution of conflict between couples and between children and their parents.

4.4. Noyaux

Noyaux have been one of the fundamental building blocks of the Ushindi approach. They have ensured large coverage of BCC messages, as well as comprehensive identification of SGBV cases, and

[29] Only supported VSLAs but an additional 6,632 are in the self-generated ones.

give the best hope for sustainability of both prevention and mitigation of cases through community ownership

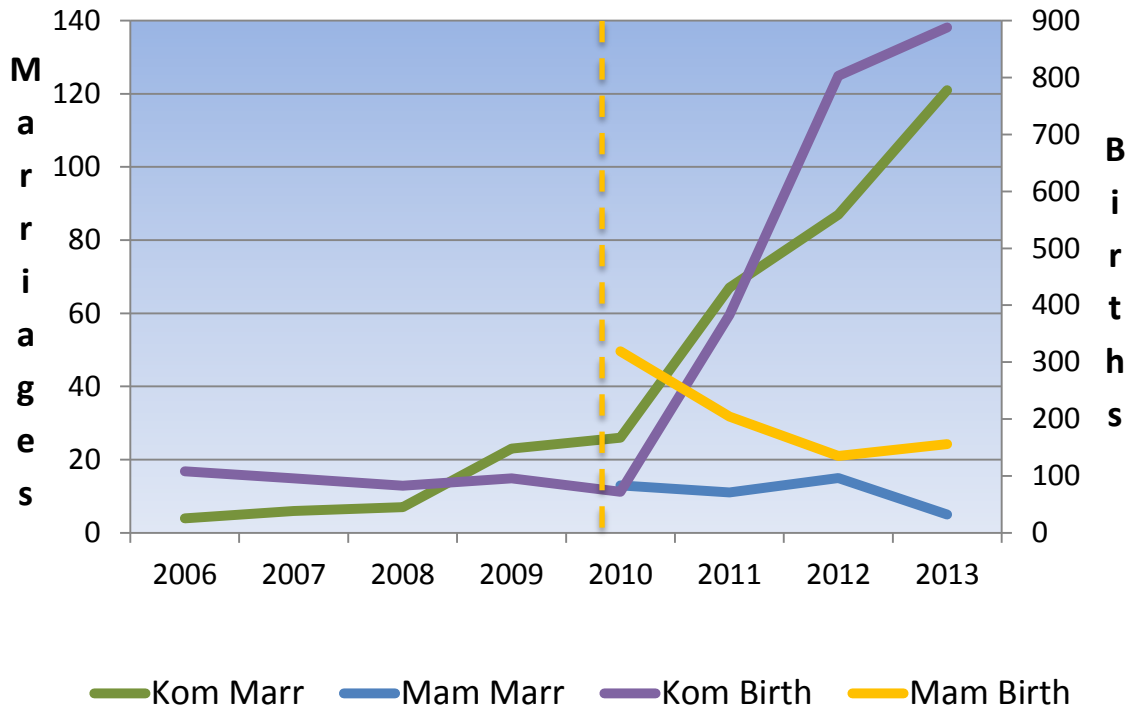
Following are a couple of concrete examples of the viability of the Noyaux as well as a more detailed plan for sustainability through them. See also the MTE follow-up (Section IV.3).

Noyaux as agents of change

A set of common messages from Ushindi and the Noyaux concerns women's and children's rights. One of the messages to promote these rights is to register marriages and births with the local authorities. Frequently, neither is registered but is rather considered traditionally accepted. This, however, often leaves women and children unprotected if problems arise.

The Noyaux have been very active in promoting registration. So the project verified birth and marriage registration both in the 4 years leading up to the project start as well those registered in neighboring Health Zones, compared to the data from Ushindi HZs in the first four years of the project. Although data was not available from civil authorities in many cases, the following two charts show 1) a specific case of two neighboring sites where one was assisted by Ushindi and the other was not and 2) a summary of some of the global findings.

Figure 12. Births & Marriages in Komanda and Mambasa HZ (2006-2013)[30]



[30] Presented at the Third International Symposium on Health Systems Research in Cape Town (9/30 – 10/3). See Annex E for full presentation.

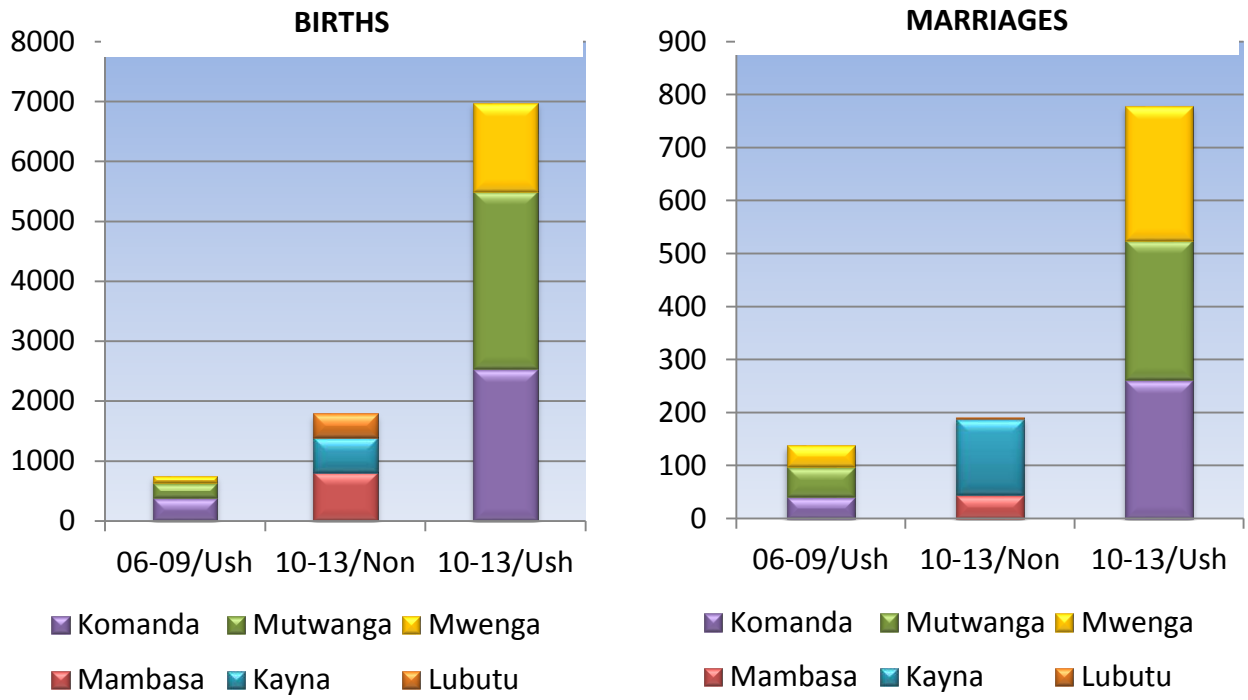
(Komanda Marriages Mambasa Marriages Komanda Births Mambasa Births)

Remarks: It is clear from the graph that there was a very large increase (6-8 times) in the number of births and marriages registered both comparing the records in Komanda before and after the project start date as well as comparing Komanda to the neighboring HZ of Mambasa since the project began.

Registered marriages in Komanda from 2006 to 2009 varied from 4 in 2006 to 23 in 2009 whereas after the project started it went form 26 in 2010 to 121 in 2013. Births were all less than 100 registered per year before project start up but then went from 72 in 2010 to 888 in 2013. Whereas Mambasa registered fewer than 15 marriages per year from 2010 to 2013 and births varied from 319 to 135.

In the following chart, 3 Ushindi assisted HZs (Komanda, Mutwanga and Mwenga) and 3 neighboring non-assisted HZs (Mambasa, Kayna and Lubutu) are compared for marriage and birth registrations. The columns represent the cumulative totals of registrations for years 2006-2009 (before project start-up) for the 3 Ushindi HZs as well as the years 2010-2013 for both the 3 Ushindi assisted HZs and the 3 non-assisted HZs. The results are significant for both cases.

Figure 13. Births & Marriages in 3 Ushindi HZs and 3 non-Ushindi HZs



Noyaux as agents of development and ownership

During various field trips it was observed that many Noyaux were taking on additional development activities outside of Ushindi's mandate. These seem to be an interesting gauge of the level of their

commitment to change in the community and their own development. An ad hoc survey was done to see what some of those other activities consist of.

Table 31. Non-Ushindi activities carried out by Noyaux

HZ	Noyaux	Sector	Activity
Mutwanga	Halungupa	Health, Infra	LWF – built Health Center
Mutwanga	Mwenda	Ag, IDP	AAA – market gardening, new seeds
Mutwanga	Nzenga	Infra, Ag	AAA – road building, maintenance
Komanda	Bamande	Health, Infra	Comm – building Health Post
Lolwa	Pekele	Ag	Comm – group field preparation
Lubero	Kisima	Legal	Comm – boundary dispute mediation
Lubero	Mubana	Ag	FAO – comm field for new cassava stock
Lubero	Kasamala	Ag	Comm – revive potato & hog farming
Lubero	Kasugho, Kagheri	Ag, priv sect	ESCO – introduction of new cacao variety
Alimbongo	Alimbongo	Legal	Comm – boundary mediation/advocacy
Mwenga	Kasika, Kitamba	Health	HZ – mass campaign WASH & vacc

Remarks: This small sample notes a diversity of activities undertaken by the various Noyaux, from infrastructure work (roads, HCs) to agricultural endeavors to health campaigns to helping IDPs to mediating boundary disputes[31]. They have done this with various groups such as Lutheran World Federation, FAO, Agro-Action Allemande, the HZ itself as well as their own initiatives (Comm = Community).

Note IV: NOYAUX POTENTIAL

These results show great promise in furthering the capacity of Noyaux to do other kinds of program assistance as representatives of the community, as well as demonstrating clear ownership of their own development. It also indicates a real potential for sustainability of the work begun in Ushindi.

III Women's Leadership Project – Key Achievements

Final Summary

The Women's Leadership Project (WLP) was a two-year (2012-2014) add-on project to USHINDI, which reached completion in June 2014. The goal of the program was to further enhance women's capacity for self-determination and leadership and was designed to follow two key strategies:

[31] In fact, this is a crucial problem for peace building in the Eastern Congo.

- Promote women's self-determination through community action to facilitate the promotion of democracy, gender equity and social justice along with women's leadership and participation in decision making at home and within community organizations.
- Promote key behavior changes in favor of reproductive health and family planning, highlighting the values of birth spacing.

These key strategies were implemented by strengthening the capacity of community organizations already created and supported by Ushindi to carry out further advocacy. Through training and mobilization, the VSLAs, literacy circles, core community groups (Noyaux), and youth groups became further empowered to promote progress in gender equity, social justice and women's leadership within their communities. Operationally, this was carried out by the addition of a women's leadership counselor in each health zone to instigate a cascade of training and to work together with these community groups and alongside the network of health area counselors and Ushindi safe houses.

The strengthening of family planning services also required close partnership with the head nurses from each Health Area and the leadership team of each Health Zone in raising the capacity of health facilities to provide the reproductive health services for which the project advocated.

The total population in the targeted health zones was 1,083,071.

1. Key Achievements

The training of local leaders and health service providers.

Community leaders and mobilisers were trained in cascade fashion across project sites on communication techniques to promote women's leadership, gender equity and modern family planning practices highlighting the value of birth spacing.

Together with the ministry of health, clinical staff was trained in the practice of modern contraceptive technology including counseling, prescription and management of long-term contraceptive options as well as the collection and documentation of data regarding use of family planning methods. Once staff was trained, the resources needed for provision of FP services were distributed to the health facilities.

Community-Wide Advocacy

The trained leaders and community mobilisers carried out public awareness activities throughout community organizations and other structures developed by Ushindi. The five major themes were: 1) women in leadership, 2) family planning, 3) DR Congo's political organization 4) democracy, good governance and conflict resolution, and 5) the electoral process in DR Congo.

In addition to the smaller forums and community organization discussions, a series of messages through mass campaigns was also introduced over 16 days surrounding the International Day of Women. These included distribution of pamphlets and posters with key messages.

Introduction of family planning services in the health facilities.

Contraceptive products along with community education tools and administration tools were provided to all the Health Zones which then provided contraceptive options to the population free of charge.

2. Synthesis of Intermediate Results (IR)

PPR 1. Number of people benefiting from USG-supported social services

- 22,137 new acceptors received contraceptive therapy from supported Health Zones, but it was not possible to evaluate accurately due to poor data at the HZ level. Even so it appears that the number of new acceptors would have approximately doubled between 2012 (before the project started) and 2014 (extrapolating the data from the first five months to the end of the year).
- 52,660 of community organization members and VSLA received sensitization messages about women in leadership within the 108 health areas.
- 111,872 local leaders were taught and sensitized concerning the rights of women which was well above its target.
- 157,467 women and men of reproductive age were educated on Family Planning at 69% of its target
- Of the 415 VSLA created and followed by the project, 90% have women leaders
- The members of the 415 VSLA were all provided teaching on good governance, and 75% of the associations have a set of internal regulations.
- 79% of VSLA members are women.
- Of the 955 learning participants within literacy circles, 865 or 91% were women.

PPR 2. Number of service providers trained who serve vulnerable persons

- 259 health service providers, representing 84% of the targeted providers, received training in women's leadership and family planning.
- 351 community mobilisers, representing 117% of the targeted number were trained in women's leadership, democracy and good governance.

PPR 3. Number of USG-assisted organizations and/or service delivery systems strengthened

- 100% or all 108 health centers in the USHINDI health zones, received training and support in the development of women's leadership and family planning.
- 828 Community Based Organizations[32] were supported by the project, namely 720 VSLAs and 108 core community groups (Noyaux) representing 149% of the target.

3. Impact

An informal series of 52 focus groups was held in 7 of the assisted interventions sites with 206 men and 297 women for a total of 503 participants. Groups were chosen in various combinations: only men, only women, mixed, same with girl and boys, Noyaux members, VSLA members, religious leaders, non-members, etc.

[32] The increased number of CBO associations achieved largely has to do with the spontaneous formation of new VSLAs during the course of the project as successful VSLAs often encouraged replication with the help of established VSLAs.

The following table gives a résumé of some of the common themes that came out of these groups. There are many positive comments although often qualified with "some" or other similar terms. Negative findings are noted in red.

For the full final report see Annex G.

Table 32. Some impact results of Women's Leadership (from focus groups)

Signs of positive changes observed within households			
#	Applicable situations	Women's position prior to the Women's Leadership Project	Positive changes noted in certain households touched by the Women's Leadership project
I. Concerning women's role and decision-making authority in the democratic process and resolution of conflicts			
1	Management of household goods	Women were systematically excluded from decisions which were made by husbands themselves or with participation of male relatives.	Women are participating in decision-making on whether to buy and sell land or livestock as well as discussing uses of a husbands' salary.
2	Family Reunions for decision making	Women were excluded	Women are participating in decision making regarding marriages, baptisms, other ceremonies and decisions to move not only in their homes but in their in-law's families
3	Decisions regarding their children.	Women did not have a say in the big decisions affecting their children. That was done by the father and his brothers.	• Women participate in concerning their children particularly with regards to educating them and giving equal opportunity to girls. In some cases it has gone so far that mothers have been able to get their adolescent daughters who have already been married and had children to come back to them for education. • When young girls are impregnated, parents are no longer automatically accepting that they be married to the men who have impregnated them but are insisting that the girls continue their education. • Parents discuss with their children choices regarding school, study tracks, vacations, etc. to come to a mutual agreement.
4	Registration of marriages and children as well as questions of inheritance.	It was not common practice in many places to register marriages and children legally. Women were not allowed to participate in discussions concerning inheritance	• The population has welcomed the message to register their marriages and children legally but are encountering several barriers: - Women's families are not always available to receive the required dowry - Husbands have not always been able to pay off the dowry - Some men still desire to practice polygamy. - Special fees affixed to the dowry are making it difficult for some men to meet the cost, e.g. fee for virginity and fee for school fees that the family has already paid for their daughter • Children are being registered by common agreement of husband and wife • Women are being allowed to participate in discussions of inheritance and their voices are being heard.
5	Access to information and education	Men would not accept that their wives return to school Women themselves did not want to return to school thinking it was the domain of men and that their place was only caring for children, household chores and tending fields	• Women have freedom to join literacy circles • Women who received primary school education desire to return to school but are often ashamed of doing so. • Some women who have had secondary education are returning to school without shame and are being supported by their husbands. • Some are being prevented by their husbands who: - Are afraid that an educated spouse may neglect them if they get a higher level of education or financial independence by getting hired. - Are jealous that their wives may begin relationships with their professors. - If they have paid for school fees in the dowry then they and their families expect the wife to work hard to pay for the husbands' ability to be educated. - Accuse their wives of preferring nice clothes than getting the dowry paid off.

Signs of positive changes observed within households			
#	Applicable situations	Women's position prior to the Women's Leadership Project	Positive changes noted in certain households touched by the Women's Leadership project
			- Don't approve of the character of their wives. - Don't have the capacity to find other childcare if the wife returns to school - Have difficulty financing the cost of education.
6	Access to positions of authority	Before USHINDI it was rare to see women in positions of authority. There was one female sector chief but she was often opposed by the men.	•There have even been new cases of women becoming village chiefs •Women are sometimes preaching in churches •Women are being nominated for president of some community organizations. •There are now some women ordained as pastors in the Kimbanguist church •Some women are planning to run for office in the next election
7	Community Participation	Women were not interested in community development, but occupied themselves solely with working the fields and household work.	•Currently women are heavily involved in community development •Women are particularly engaged in pursuing reduction in GBV and in working towards healthier villages.
8	Management of public goods	Before USHINDI management of public affairs was a men's affair	•Women now participate in public affair decisions including construction committees for building markets, roads, water access points, footpaths, schools and health centers.
9	Creating political parties and associations.	Before USHINDI, there was no understanding of political associations FEREKENI. The men thought that women would talk too much, argue and lie. They were also jealous and worried about infidelity of women were to get involved in political parties.	• Women are creating their own political associations • There are examples of women belonging to different political parties then their husbands who have accepted it. • Some women are ambitiously seeking to run for office in the next elections and have good support from men in the community • Some women are even being allowed to participate in religions that differ from their husbands without impediment.
10	Conflict management over inheritance rights and rituals surrounding a death.	Women often suffered under oppression from the women in their family of in-laws at the death of a husband and were often left out entirely of inheritance and death-rites ceremonies.	Today women participate in conflict resolution over questions of inheritance and other ceremonial rites surrounding death. Certain oppressive practices surrounding the death of a husband are diminishing and pastors preach against such practices
II. Concerning women's decision-making authority about their own reproductive health and family planning			
11	Marriage choice	Forced marriage was the norm. Some places had 0 legally registered marriages.	Today women have a choice in their marriages and rarely are forced into unwanted marriages.
12	Sexual relations among married couples and sexual exploitation.	• Husbands routinely forced their women to have sexual relations leading as well to physical abuse even in front of children. • Women and their daughters often submitted to sexual advances from their chiefs or other leaders.	• Women are having a say in decisions over sexual relations and that is diminishing physical abuse according to comments from children within focus groups. • Unfortunately sexual exploitation continues in the community at the hands of numerous leaders—chiefs, pastors, teachers and women often remain silent until or unless a pregnancy results.
13	Child spacing	• People had no concept of child spacing • People believed they should leave the number of children they had up to God's will.	Some women are taking action on spacing out their pregnancies, but much work on education of men still needs to take place as there is often still resistance on the part of men. They sometimes voice concerns about infidelity if their wives are practicing contraception.
14	Infidelity within marriages and self-protection against HIV	Marital infidelity and polygamy were particularly prominent in FEREKENI	Men are no longer commonly taking minor girls as concubines. However, women still are not able to voice their opinions concerning infidelity and their husbands' concubines. They have no power to protect themselves against STIs and HIV/AIDS.

IV Monitoring, Follow-Up & Evaluation

1. On-going M&E

In the course of FY14, the Ushindi coordination team and the consortium partners carried out the following activities and field trips:

- Presentation of Year 3 results to stakeholders in the 10 Health Zones
- Routine supervision of the 10 HZs supported by the project
- Formative supervision, including DQAs in all HZs
- Missions to monitor the quality of psychosocial interventions based on USAID recommendations after an evaluation in into Obokote HZ
- Active participation in monthly inter-cluster meetings for social protection, multi-sectoral SGBV assistance and Data Mapping in order to exchange experience with other partners
- Participation in meetings of social protection meeting with other USAID partners in Kinshasa
- Participation in the visits by U.S. government delegations in support of SGBV programs
- Participation in SGBV prevention campaigns in Kinshasa, Washington and London
- Organization of the monthly strategic planning meetings with the partners and staff in Goma
- Follow-up supply/inputs management in all HZs
- Elaboration and dissemination of draft bylaws and strategic guidelines for increasing the sustainability of Community Core Groups (Noyaux)

2. Work plan evaluation

The implementation of activities planned for Year Four improved considerably compared with what had been accomplished by the end of the first semester of 2014. Implementation of planned activities increased from 73% to 91% (i.e., an increase of more than 18%). This improvement is due in large part to trips to Health Zones made by the new VSLA expert to reinforce socio-economic reintegration and also to activities by Children's Voice to improve BCC activities in collaboration with Safe House staff.

During the second semester of the current financial year, the movements of armed groups in North and South Kivu did not hinder the implementation of field activities. On the other hand, the condition of the road during the last rainy season did hamper the work of Panzi to visit Kitutu and Mwenga HZs and of HEAL Africa to visit Ferekini HZ.

In anticipation of phasing out Ushindi assistance in the HZs of Ferekini, Obokote and Shabunda, several joint missions between IMA and implementing partners have taken place in those Health Zones and included meetings with Safe House staff, HZ management teams and selected Noyaux.

See Annex C for more detail.

3. Mid-Term Evaluation (MTE) Follow-Up

Implementation of a Sustainability Strategy based on Noyaux

A key recommendation of the mid-term evaluation (August 2013) was to concentrate on the strengthening of Community Noyaux as key structures offering the most favorable opportunities for

sustaining project achievements over the long term. During the past year, the following actions have been accomplished:

- Development of model operating standards (ROI: Règlement d'Ordre Intérieur) to assist Community Noyaux in defining their objectives, key actors and operational strategies.
- Organization of internal meetings with partners to discuss and improve the proposed operating standards.
- Incorporation of opinions and consideration from partners and validation of the proposed strategy and draft ROI during a coordination meeting held in Goma
- Realization of joint missions with Implementing Partners to brief safe house staff on the project's sustainability strategies including the proposed ROI for Noyaux.
- Organization of participative meetings with Noyaux members in targeted health areas for awareness-raising of Noyaux concerning the proposed ROI.
- Restructuring of selected Noyaux based on the logic as defined in the proposed ROI.
- Preparation of micro-plans by Noyaux members with technical support from Safe House staff for their respective areas of expertise.
- Strengthening mechanisms for skill transfer and partnership between implementing partners and community structures (e.g., Noyaux, VSLA and Youth Clubs) and with various offices of key partners (e.g., Division of Gender, Women, Family and Children).
- Reinforcement of collaboration between community structures with local leaders and the other stakeholders.

4. USAID Assessment

Although the original field visit was carried out in May 2013, significant budget cuts came soon afterwards making several of the recommendations difficult. The final report, received in December 2013, was reviewed by staff and IPs in January and February and discussions undertaken as to how best implement them given that the budget for FY14 was already well begun and funds allocated to other tasks. The staff agrees that all the recommendations are important for improving processes and psycho-social care if the work is able to continue in the future.

It was decided however to hire a local consultant to review the recommendations with a focus on current best practices within the IPs to see if some improvements might be easily transferrable. Although the consultant was hired in April, they did not start until late May and, by that time, the latest budget cuts were announced (50% for the final year) which made many of their suggestions moot as even the simplest require some kind of meetings and or trainings, if not outside consultation.

Although project staff agrees that the suggestions were mostly very good and built well on best practices, they are still difficult in the current situation to implement. For various reasons the final version has been delayed, mainly due to rewrites. With only a few months left in the project, it would be further quite challenging to do any kind of meaningful supervision even if funds were available to do coordination meetings and/or trainings.

Therefore, the project will continue to share the suggestions and ideas between Implementing Partners and ask them to take them into consideration. In addition, project staff will work on elaborating documents based on the suggestions - as feasible -with the idea of eventually implementing them should more funds or new projects become available.

An executive summary is available in Annex F. Note that the best practices sections provide a very good basis for future project design and/or improvements.

V Challenges

The funding gap for this and next fiscal year constitutes the biggest challenge to the project and impacts the ability to follow up on the strategy for sustainability and community ownership as well as the following activities:

- Realization of an end-line assessment to evaluate the impact of the interventions.
- Improvement of the quality of psychosocial services in the field according to the recommendations of the USAID monitoring visit, some of which would require additional resources.
- Follow-up on MTE recommendations.
- Restructuring of the Noyaux according to the sustainability strategy and related training of local stakeholders.
- Organization of in-zone meetings to exchange experiences between different community structures (Noyaux) within each HZ.
- One time evaluation of the Noyaux and VSLAs in Shabunda, Obokote and Ferekini to evaluate the degree to which why took ownership and continue the activities after Ushindi's departure.
- Training and monitoring of village agents to extend and assist the VSLAs in villages yet to be covered.
- Reinforcement of the capacity of the reinsertion coordinators at the safe houses to improve operations of the micro-projects begun in Year 3.
- Continuation of the improvement in the data collection system for the socio-economic activities and the realization of some small research activities to measure the impact of VSLAs on the population.
- Reinforcement of the integration of survivors and other vulnerable people in VSLAs to ensure a more durable assimilation.
- Support for school reinsertion activities for child survivors and other vulnerable children.
- Acceleration the number of judgments rendered and executed in the HZs in order to close out the dossiers in process in the courts before the end of the project.
- Closer field supervision of project activities by IP program staff and the safe house team.
- Improve ownership of specific project interventions by the relevant state players (BCZ for the MoH and the various offices of the ministry of Gender, Family and Children).
- Improvement on the overall database and data collection system.

In addition, the project has the following challenges:

- Security for project activities in certain Health Areas due to the presence of armed groups (Kasugho and Kagheri in Lubero and Bunyatenge, Bingi and Kaseghe in Alimbongo; and in South Kivu, Ngando in Mwenga)[33]
- Changing societal norms and behaviors towards women's roles remains a constant challenge in the remote regions of Eastern DR Congo
- Limited geographic accessibility in the Health Zone of Kitutu
- Poor road conditions that are made worse by the rains frequently interferes with planned activities
- Weak community participation and sense of volunteering for non-formal adult education (literacy circles)

VI Security situation in Ushindi's areas of intervention

Throughout this year, the security situation was relatively better than last period with only 7 of the 108 Ushindi health areas (compared to 14 last year) having the presence of armed groups. All Ushindi areas were relatively calm. A few cases of spontaneous insecurity were reported in some Health Zones; however, these cases did not significantly affect project implementation.

In North Kivu, there are a variety of active armed groups including: FDLR, Mai-Mai and PARECO. The most affected Health Areas in North Kivu were Kasugho and Kagheri in the Health Zone of Lubero; Bunyatenge, Bingi and Kaseghe in the Health Zone of Alimbongo. The defeat of the M23 by the FARDC in the territories of Rutshuru and Nyiragongo had greatly improved access by road to Lubero from Goma. However, that deteriorated in the second half of the year due to banditry in Virunga National Park. Military operations between the FARDC and the ADF-NALU in Oicha, Mbau and Kamango seem to be nearly over although some reports still talk about rebel holdouts in the surrounding forests. Much of the population has, however, retuned and kidnapping has been greatly reduced.[34]

In South Kivu, FDLR and Rai Mutomboke are present. The affected Health Areas are Bubila and Chombi in the Health Zone of Shabunda and Ngando in the Health Zone of Mwenga.

In Maniema, the Health Zones of Ferekeni and Obokote are usually calm although many of the Health Areas are very inaccessible due to poor roads. However there was a civil disturbance in the HZ of Ferekeni in March which temporarily caused the suspension of project activities in that HZ.

In Oriental Province, the Health Zones of Lolwa and Komanda remained relatively quiet[30]. However, armed groups are known to be circulating in the neighboring areas.

Even in areas affected by armed groups, the return of state authority has taken place. The courts are now operational in Shabunda, Lubero and Lubutu which have contributed to a more rapid management

[33] And now all of the PPSSP zones

[34] Note that this changed drastically in October after the close of the FY and the ADF-NALU has become perhaps even more vicious than before with several massacres already greatly affecting the movements of PPSSP in their HZs.

of dossiers introduced into the justice system; which helps to reinforce the use of these systems by the survivors of sexual violence.

No Ushindi staff has been affected during this period.

VII Outlook for Year 5

The final year, the project will continue providing support to routine activities linked to service delivery to the survivors. In addition, implementation will focus on the consolidation of project exit strategies in the targeted Health Areas to support community-based structures, including Noyaux and Youth Clubs. All project and safe house staff missions for project coordination and support of activities will be focused on this operational vision. With these strategies in mind, and within the budget constraints, the following activities are proposed:

- Share the achievements of the year 4 with stakeholders at all levels;
- Organize a coordination meeting to capitalize on best practices;
- Conduct financial audits and Data Quality Assessments with implementing partners;
- Lead missions to collect information related to impact changes observed at the community level;
- Operationalize the bylaws for the Noyaux;
- Transfer the responsibility for VSLA activities to association members that have been conducted by project staff in the past;
- Participate in various interagency meetings, including those with USAID; and
- Prepare the final project report.

VIII Success Stories

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SUCCESS STORY

Never Too Late for Mediation

Kasereka Chrison and Mme Mbambu hold the signed mediation agreement (shown below).

Photos: Project Ushindi

Map showing Mutwanga health zone

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www.usaid.gov

Kasereka Chrison and his wife Mbambu were officially married for many years. Together they created a family with six children and lived in the Zenga health area of Mutwanga health zone. However, in 2001 M. Kasereka decided, for reasons not known to this author, to leave his wife. And when he left, he took with him the control of family property, including houses, fields and land plots. Mme Mbambu was left to fend for herself and her children without any regular support or inheritance.

Mme Mbambu did not, at that time, realize that she had rights to the family property that they had shared and developed during their marriage. However, thanks to the Ushindi project and information provided to her via her Community Noyaux, Mme Mbambu learned of her legal rights as wife and of the inheritance rights of her children. She also informed that she could obtain free legal advice as the legal clinic located in the Ushindi-supported Safe House of Mutwanga health zone.

It was at the legal clinic in March 2013 that she met with Ushindi's lawyer Bernard Mulumba. Advocate Mulumba is affiliated to Beni judiciary system through Ushindi's technical partner, the American Bar Association (ABA), to defend causes of GBV survivors in Ruwenzori sector. He recommended that Mme Mbambu first try to establish an action of mediation with her ex-husband. Through a member of the community Noyaux and through Mulumba's wife, M. Kasereka was contacted and invited to join a process of mediation. However while this invitation was received by M. Kasereka, the later declined to join the mediation process.

In response to this rebuff at mediation, Mme Mbambu was obliged to pursue other legal options. As a result, M. Mulumba contacted the local Police and to intervene and hear both parties in the conflict. It was at that time that M. Kasereka began to understand (or to admit) that his children had inheritance rights, even after he decided that he did not want to live in union with their mother.

As a result of this contact and discussion, M. Kasereka accepted to enter into a mediation process. That process moved quickly and concluded with the joint signing of a mediation agreement in which M. Kasereka officially gave his wife a field of the village of Kalehene, a plot of land in Kasindi and a store/boutique in Mutwanga that she could use as income for her support and for the education of their children. Mme Mbambu and the six children have subsequently thanked Ushindi project for this successful mediation, and the re-establishment in their rights.

It is always sad to see marriages broken and children abandoned. However, on a more positive note, it is encouraging to know that the "happy ending" of this story is just one of several hundred mediations which the Ushindi project has helped to facilitate.

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SUCCESS STORY

Viva la VSLA!

Photos: Project Ushindi.

Mme Nobi Neema, Umoja VSLA, Ofay, Komanda HZ

Mme Kahindo Devota, Neema VSLA, Idohu, Komonda HZ

Mme Jeanette Katungu, Akili Ni Mali VSLA, Kaseghe, Alimbongo HZ

Mme Kavira Kanza, VSLA Amani, Kaseghe, Alimbongo HZ

Mme Kahindo Kalimboa, VSLA Wasinja, Kangahuka, Mutwanga HZ

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A previous report described Ushindi's "explosion" of Village Savings & Loans Associations. The project goal is to create 432 VSLA. By the end of year three, 467 VSLA had been created. This year that number has increased to 746 with 9,771 enrolled members. Below we document a few close-up and personal success stories provided by VSLA members.

The Beignet Baker: Mme Nobi Neema, mother of five, has been an active member of the Umoja VSLA in Ofay health area of Komanda HZ for two years. Thanks to a micro-credit of 18,000 FC ($20) she began producing and selling beignets (local doughnuts). She credits this activity with helping cover certain household expenses, and also in increasing her confidence and self-worth in the eyes of her husband, who now, she reports, engages her more fully in important decision-making for their household.

The Manioc Miller: Mme Kahindo Devota is now in her 4th year of participation and currently president of Neema VSLA in the Idohu health area of Komanda HZ. She used her first microcredit of 45,000 FC ($50) to start a hair salon. With her second loan of 200,000 FC ($222) she started selling manioc flour. She was able to reimburse that loan, including 10% interest, within four months! She and her husband have now purchased land and materials to build a store.

The Rabbit Raiser: Mme Jeanette Katungu has been a member of the Akili Ni Mali VSLA for two years. Her first microcredit allowed her to begin selling beer. With a second microcredit of 16,000 FC ($18) she purchased two rabbits which, as rabbits will do, soon became 13 rabbits. She recently sold 5 rabbits at $8 each! Thanks to these activities this mother of 7 children has been able to re-establish food security for her family.

The Roofers: Mme Kavira Kanza is a three-year member of VSLA Amani in the health areas of Kaseghe in Alimbongo HZ. She used her first microcredit of 50,000 FC ($55) to begin selling pharmaceutical products. She expanded that commerce with a second loan and, along with her husband's income from a separate VSLA, was able to purchase materials for a new roof for their house. She is now contemplating a new kitchen!

The Coffee Connoisseur: Mme Kahindo Kalimboa is a member of the VSLA Wasinj in the health area of Kangahuka in Mutwanga HZ. She used her microcredit to begin a cross-border export of coffee to Uganda – an occupation normally reserved for men due to the start-up capital required. Her success in this endeavor has allowed her to feed her children and send them to school.

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SUCCESS STORY

A Story of Hope and Espoir

Photos: Project Ushindi.

This is the story of "Espoir", a 30 year-old woman and mother of four from Dima health area, Shabunda HZ.

Marie Salumu, psychological advisor for Dima health area, Shabunda health zone

Map showing Shabunda HZ

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This is the story of "Espoir"(not her real name), but in her own words:

When I think about it, I realize that I almost died. My husband had abandoned me following an incident when he struck me because I had been raped. I lost my self-esteem, my dignity as a woman, and my hope for living, I considered myself to be dead, and a very poor death at that. Today, however, my personal well-being and functions as a woman have been revived by Ushindi (We will Overcome!). In particular my thanks go to the intensive assistance which I received from the local community, at Dima health center, at Shabunda Hospital and the whole way to Panzi hospital.

After 6 months of care at Panzi, I returned home in good health, just has happy and pretty as I was before my marriage. My husband received me at the foot of the plane having been persuaded by the psychosocial advisor who convinced him that I was returning from Panzi in good health, without risk of any infection. We embraced fully each other and with tears of joy returned to our home where our life began again just as it did on the first day of our marriage.

I consider all that has happened as a miracle and incommensurable fruit of services from project Ushindi. Without this assistance my home would have dissolved as I had been profoundly torn soul from body, ripped meat from bones, without hope, and isolated from the rest of society. I would no longer have had this infant whom you see me now holding. I might have technically remained "living", but it would have been without a woman's image and confidence to face any man on the earth. Miraculously my husband has re-accepted me.

My son, our only boy following his three sisters, is, therefore, a great gift, a comfort after all this suffering, both physical and moral. His father and I have given him the name of « Samitamba » which means "Fibers among girls." That is our way of saying that he should treat all girls (women) as his own sisters and never to harm them. Coming back to my case, I am absolutely functional and fully revived as though nothing happened. And I am one among many women whom Ushindi as revived. I think that all women living in Shabunda health zone, those having experienced or not experienced rape, warmly welcomed the arrival of Ushindi. The women of Shabunda have indeed been helped and healed by its services.

Marie Salumu, (her real name), psychological advisor for Dima health area in Shabunda HZ, added this comment to Espoir's story:

I did not know that it was possible to heal without applying medicine! Yet my holistic training from Ushindi has shown that this is not a myth. We have cured so many women, our sisters, of moral or physical suffering without medications. Each Ushindi advisor has become an important person, a key referrer, and community leader within her respective health area. People now listen to us, which contributes considerably to the success of our actions and mediations. We are overcoming!

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SUCCESS STORY

Marriage before God and Local Authorities

Photos: Project Ushindi.

A historic marriage in Bamande health area of Lolwa health zone

Twelve couples registering their marriages in Bamande health area of Lolwa HZ

Map showing Lolwa health zone

A number of health zones in Province Oriental include a significant pygmy population. The health zone of Lolwa, for example, is one such health zone assisted by project Ushindi, where respect for and adaptation to the local pygmy culture must be taken into consideration.

By tradition and custom the pygmy population has never put much stock in registering their marriages officially with local authorities. For centuries, they have contented themselves with their traditional "marriage" practice that consists of occasionally exchanging sisters between two families.

With the arrival of the Ushindi project, and the work of implementing partner PPSSP (Program for Promotion of Primary Health Care) these customs are slowly changed. As part of its project activities PPSSP disseminated behavior change communication (BCC) messages through the community-based Noyaux that included information about the rights of the women and children, including their right to have a legal and registered identity and marriage. These messages were also disseminated into the scattered camps of the local pygmy population.

After internalizing these messages, and having now understood the importance of having marriages legalized, twelve couples in the Bamande health area of Lowla health zone decided to legalize their marriages before God and before the front door of the local office for registration of marriages.

The celebration of these religious and civil marriages created excitement and involvement by the community at large. For example, local Noyaux committee members contributed food, clothes and money to support the celebrations. Local civil authorities also made a significant contribution to these weddings by providing certificates of marriage free of charge.

Religious leaders, including priests and pastors in the Bamande area have expressed appreciation for Ushindi interventions that go beyond developmental to include spiritual growth among ostracized and marginalized populations. And this story is not ending here. A number of new couples have already begun to follow ecumenical teaching for additional upcoming wedding celebrations.

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SUCCESS STORY

Women of Reflection and Action

Improving Reflection and Action

Diplomed: Tina Odondi Nasi, Sidonie Kasiene, Bahati Ngereza & Osako Salumu

Photos: Project Ushindi.

Maman Mapasa, Village Market Chief

Women building a new Health Post

Mme. Mado, Musombola Village Chief

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Ushindi and *Women's Leadership* have significantly impacted Ferekeni and Obokote health zones. Recent focus groups with 169 women and men were conducted in four health areas of those HZs. Many key changes since the start of Ushindi were noted by participants, (e.g., women are now more involved in the management of domestic property, and participate more fully in family meetings, including distribution of inheritance. Forced marriages and precocious pregnancies have decreased with girls saying in school and women marrying at a later age. Couples, both women and men, now act officially to register marriages and births. Additional highlights from this work are noted below.

1) Improved capacity for reflection and action: When Ushindi began most women had a low level of respect within the community. Today, many women have improved their capacities and evolved into respected community leaders who are sought for mediation of dissensions and general advice (e.g., dealing with harmful funeral customs.)

2) Promoting the education of the women: Girls were often expected to be satisfied with married domestic life without completing their studies. Four married women, thanks to Ushindi, returned to school and completed their studies. They have, in turn, led other women back to school and encouraged their daughters to complete their studies rather than rushing into early marriage.

3) Women in Positions of Responsibility: Thanks to her experience in a VSLA, Maman Mapasa (Obokote HZ) learned good governance and management, and was elected as chief of the local market. She uses this position an opportunity to organize Saturday morning meetings with traders to speak about family planning, women in property management and leadership in religious activities. She and her spouse have been selected to be a "Couple Champion".

4) Eagerness for Health Care: Given the long distance between Ferekeni and Fikiri health centers, the women of Pukwanyama VSLA reflected and then took action to initiate building a durable health post with their VSLA savings – a good example of *Health for All and by All.*

5) Women in Power: Madame Mado was recently inaugurated as the Village Chief of Musombola in Ferekeni HZ. From that position she has taken action to promote kitchen gardens, community sanitation and reducing SGBV. She and her spouse are also a "Couple Champion".

IX Annexes

Annex A. Global PPR

See attached

Annex B. TraiNet

See attached

Annex C. Work Plan Evaluation

See attached

Annex D. EMMP

ENVIRONMENTAL MONITORING AND MITIGATION PLAN AND REPORT

An EMMP either should be included in or developed for (1) **all IEEs** that have at least one "Negative Determination with Conditions" and (2) all Environmental Assessments (EAs). If the EMMP is not developed as part of the IEE, the implementing partner should usually lead development of the EMMP, subject to review and oversight by the MEO and C/AOTR. In all cases, the tasks identified in the EMMP are incorporated into the implementing partner's Work Plan, budget, and reporting.

The following EMMP format is recommended. It can be adapted, as necessary.

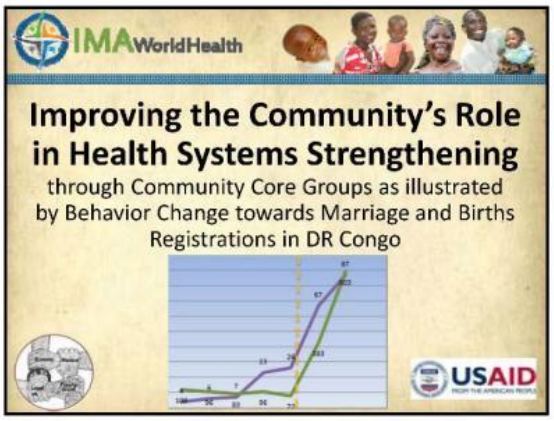
A. ENVIRONMENTAL MONITORING AND MITIGATION PLAN (EMMP) TEMPLATE

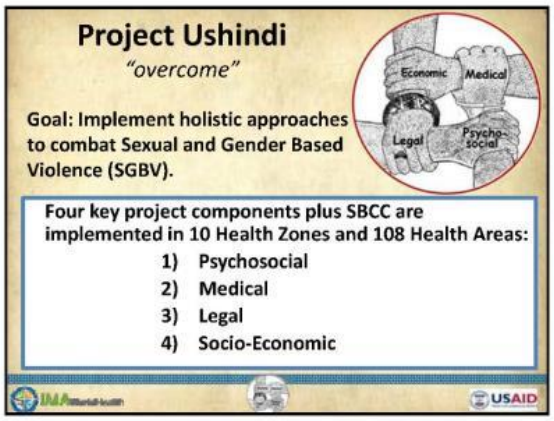
Activity Title: Overcoming Sexual and Gender Based Violence in the Eastern Congo.
Implementing Partner: IMA World Health

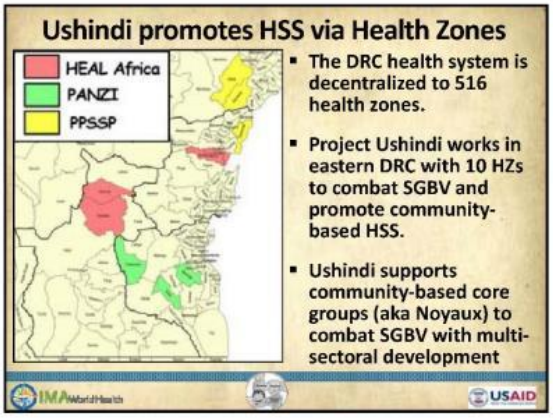
Activity	Mitigation measure(s)	Monitoring indicator(s)	Monitoring and Reporting Frequency	Party (ies) responsible.
List all activities in IEE that received a "negative determination with conditions."	If mitigation measures are well-specified in the IEE, quote directly from IEE	Specify indicators to (1) determine if mitigation is in place and (2) successful.		If appropriate, *separately* specify the parties responsible for mitigation, for monitoring and for reporting.
Providing medical care to SGBV survivors, including administration of Post-Exposure Prophylaxis, which includes antibiotics to treat sexually transmitted diseases, HIV prevention, emergency contraception and referral to medical care	Medical waste will be disposed of according to accepted norms, national policy and the Medical Waste Disposal Plan (developed in Y2 of the project) by the assisted medical facilities. Training was provided in Y2.	Assisted health facilities will have a disposal plan in place and these plans and their utilization will be verified during field visits by both the Implementing Partners and project staff.	When field visits take place, a short form will be filled out, signed by the supervision staff and sent to central IP office with copies to the Ushindi office and the local health authorities.	The Implementing Partners program managers have immediate responsibility for monitoring and reporting, with Ushindi M&E oversight. The MoH is responsible for mitigation with project assistance to the extent possible.

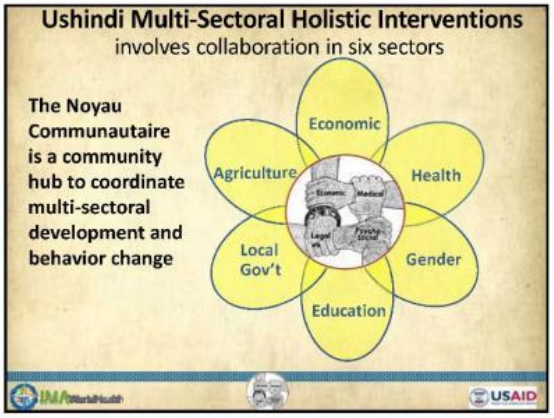
Annex E. Presentation of some Noyaux results at the Third International Symposium on Health Systems Research at Cape Town SA, Oct. 3 2014

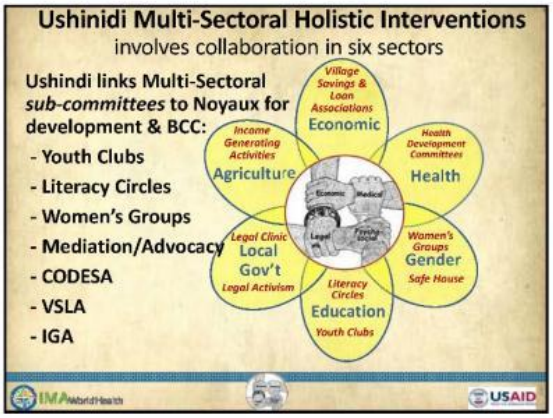
Improving the Community's Role in Health Systems Strengthening











1

Improving the Community's Role in Health Systems Strengthening

Strength in Numbers

- Each Ushindi-assisted HZ has 12 Noyaux to cover 60-100% of the HZ's Health Areas.
- The collective Noyaux "*voice of the people*" represents a significant local force for advocacy and multi-sectoral coordination for systems development and behavior change communications.

Examples of Cross-Sectoral Integration

Sector	Activity
Health, Infrastructure	Helped build Health Center & Health Post
Ag, IDP	Market gardening, new seeds
Infra, Agriculture	Road building, maintenance
Agriculture	Community field for potato & cassava
Legal	Boundary mediation/advocacy
Economic	Big "explosion" of Village Savings & Loan
Behavior Change	Marriage and Births Registrations

An "Explosion" of Village Savings & Loans

- Ushindi helped create 4 VSLA in each Health Area for a total of 432 VSLA.
- Keen community interest has led to the bottom-up creation of many more VSLA in some Health Areas, (e.g., 30 new VSLA in Bunyakondomi Health Area of Lubero HZ.

Noyaux and Behavior Change

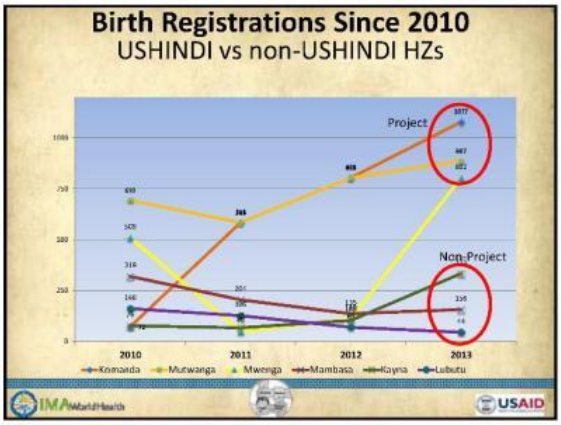
- BCC is promoted as a cross-cutting tool in all the Noyaux sub-committees and sponsored activities
  - Youth Club community-based theater
  - Public-Service Announcements with community radio
  - Advocacy of local gov't to support registration procedures
  - Promotion of Honorable Life Champions
- Regional and local campaigns to promote Marriage and Birth Registration was a key point for Ushindi's BCC efforts.

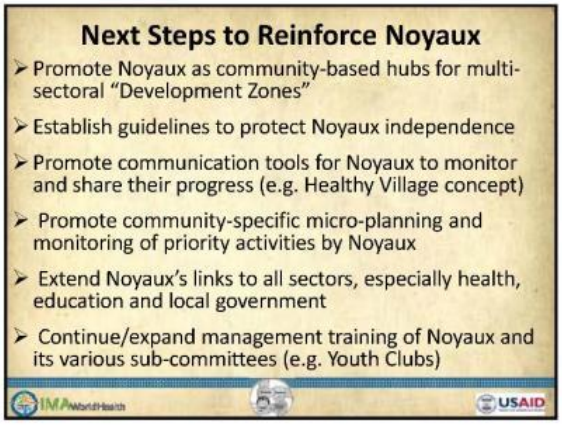
Increased Marriage & Birth Registrations
Komanda Health Zone

Increased Marriage & Birth Registrations
Mwenga Health Zone

2

Improving the Community's Role in Health Systems Strengthening





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Annex F. Consultant's report summary for USAID recommendations

Executive Summary

In May 2013, a general assessment of IMA's USHINDI project was conducted the Victims of Torture (VoT) Program to 1) Assess its mental health component; 2) Determine if economic strengthening should be evaluated across USAID-funded projects; and 3) Confer with the mission regarding future programming. The assessment proposed the following six recommendations:

1) Strengthen monitoring of problems and survivor functionality to measure need and impact;
2) Improve supervision;
3) Improve staff care, particularly of counselors;
4) Expand training/supervision capacity for coordinators and for counselors;
5) Review VSLAs to determine their service to survivors, especially the very poor; and
6) Set up a database to track changes in the survivor population.

Following the VoT assessment, IMA engaged a consultant to conduct additional research to 1) assess the applicability of recommendations #1-#5; 2) identify best practices within USHINDI related to those recommendations; 3) suggest additional actions for implementing the recommendations; and 4) suggest next steps within existing resource constraints. The process included 49 semi-structured key informant interviews with psychosocial actors at all programmatic levels, including health areas, health zones, implementing partners and IMA project staff. Here follows a summary of the key points related to each recommendation.

USAID Recommendation #1: Strengthen monitoring of problems and functioning of survivors as indicators of need and impact

The assessment found that Ushindi's M&E system provides excellent monitoring of the numbers of survivors and the types of services they receive. However, execution fluctuates due to varied interpretation of monitoring terms and procedures. While the counselors appear to know which cases are more severe, this is not readily documented from "current case files" for possible referral.

Best Practices found among the implementing partners for this topic included:

- Best practice 1.1: Heal Africa – the inclusion of narrative and a discharge statement
- Best practice 1.2: PPSSP – developing a tool to assess symptoms (in Swahili)
- Best practice 1.3: PPSSP – reworking the follow-up form and including it in case files

Based on the above recommendation and best practices the following actions are suggested:

- Clarify all terms in monitoring tools on ensure a common understanding, including separate sections for internal and external referrals;
- Establish standard operating procedures for end-of-the month open cases, for internal referrals within Ushindi and external referrals to partners;
- Revise the follow-up form to standardize terminology/practices for intake and discharge and include space for more detailed assessment of symptoms;
- Ensure completion of follow-up forms and their inclusion in the case files, including data collection on termination of services; and

- Provide refresher training for counselors on note-taking and follow-up forms (in Swahili) to be used at the community/health area level.

USAID Recommendation #2: Improve supervision

Best Practices found among the implementing partners for this topic included:

- Best practice 2.1: Heal Africa - two day validation meetings
- Best practice 2.2: PPSSP - Closer relationship between level 2 and 3
- Best practice 2.3: PPSSP - development of supervision tools
- Best practice 2.4: Heal Africa – MH resources

Based on this recommendation and best practices the following actions are suggested:

- Provide further training and capacitation, especially in child counseling and mediation, and, preferably as separate training sessions for Principal Counselors;
- Provide Principal Counselors regularly with simple and short training materials that they can use when training counselors (see Best Practice #2.4);
- Expand the IP's monthly meetings to two days to provide more opportunity for discussing case details, addressing problems, and providing additional interactive training;
- Improve and standardize psychosocial supervision protocols used by PCs to include more case discussion, quality assessment checklists (see Best Practice #2.3), data verification and personalized on-the-job training; and
- Strengthen links between IPs and HZ with quarterly meeting to improve monitoring and technical capacity building for training/supporting health area volunteers.

USAID Recommendation #3: Improve staff care, particularly of counselors

Best Practices found among the implementing partners for this topic included:

- Best practice 3.1: Heal Africa and Panzi Foundation – support during difficult mediations
- Best practice 3.2: PPSSP - fewer counselors need support

Based on this recommendation and best practices the following actions are suggested:

- Increase Noyau awareness of and support for the difficult work of community counselors;
- Provide counselors with self-care training, (e.g., stress management, asking for help);
- Provide further training PCs to recognize distress signs and trauma in counselors; and
- Encourage stress-relief group activities, (e.g., nature walks, social activities and exchange visits with other counselors and/or health zones.)

USAID Recommendation #4: Expand training/supervision capacity for coordinators and for counselors

Best practice 4.1: PPSSP - putting "in-house" experience to good use.

Since USAID-funding will end in June 2015, and no additional funding has been identified, it is recommended that IMA limit efforts to reinforce what is already in place, including points 1, 2, 3 and 5 of this document. However, if additional funding should become available that might support the integration of mental health elements into the psychosocial pillar, then the following actions for implementation should be considered:

- Provide basic training on mental health for all actors involved in the project;
- Periodically send HZ-based staff concise mental health resources for training counselors;
- Develop a mental health referral protocol that describes local MH services (governmental and non-governmental), criteria for referral, and a post-discharge assessment visit; and
- Research the effectiveness and acceptability of Ushindi's psychosocial approach, including a determination of the proportion survivors with severe mental issues.

<u>USAID Recommendation #5</u>: Review Village Savings and Loan Associations (VSLAs) to determine how well they serve survivors, particularly those who are very poor

Best practice 5.1: Panzi Foundation – encouraging the most vulnerable to join a VSLA.

Based on this recommendation and best practice, the following actions are suggested:

- Improve the monitoring to have reliable data survivor participation in VSLAs;
- Increase the number of VSLAs to include the most vulnerable as members;
- Reinforce counselor's knowledge on the VSLA's and t socio-economic reintegration, including setting up IGAs and drawing up an IGA plan; and
- Provide person-specific micro-credits for survivors who accept to join a VSLA (Best Practice 5.1.

Annex G. Women's Leadership Final Report

USAID | DEMOCRATIC REPUBLIC OF CONGO
FROM THE AMERICAN PEOPLE

Intervention

Women's Leadership Project

Overcoming sexual and gender-based violence

in Eastern D. R. Congo

FINAL REPORT

July 2012 – June 2014

USHINDI
Women's Leadership Project
C.A. No: AID 623-A-10-00012-00

IMA World Health

IMA World Health

USAID FROM THE AMERICAN PEOPLE

1. Introduction

1.1. Summary

The Women's Leadership Project (WLP) was a two-year (2012-2014) add-on project to USHINDI, which reached completion in June 2014. The goal of the program was to further enhance women's capacity for self-determination and leadership and was designed to follow two key strategies:

- Promote women's self-determination through community action to facilitate the promotion of democracy, gender equity and social justice along with women's leadership and participation in decision making at home and within community organizations.
- Promote key behavior changes in favor of reproductive health and family planning, highlighting the values of birth spacing.

These key strategies were implemented by strengthening the capacity of community organizations already created and supported by USHINDI to carry out further advocacy. Through training and mobilization, the VSLA's, literacy circles, core community groups (noyaux), and youth groups became further empowered to promote progress in gender equity, social justice and women's leadership within their communities. Operationally, this was carried out by the addition of a women's leadership counselor in each health zone to instigate a cascade of training and to work together with these community groups as well as alongside the network of health area counselors and USHINDI safe houses.

The strengthening of family planning services also required close partnership with the head nurses from each health area and the leadership team of each health zone in raising the capacity of health facilities to provide the reproductive health services for which the project advocated.

The total population in the targeted health zones was 1,083,071.

1.2. Key Achievements

i. The training of local leaders and health service providers.

- Community leaders and mobilisers were trained in cascade fashion across project sites on communication techniques to promote women's leadership, gender equity and modern family planning practices highlighting the value of birth spacing.

- Together with the ministry of health, clinical staff was trained in the practice of modern contraceptive technology including counseling, prescription and management of long-term contraceptive options as well as the collection and documentation of data regarding use of family planning methods. Once staff were trained, the resources, needed for provision of FP services, were distributed to the health facilities.

ii. Community-Wide Advocacy

- The trained leaders and community mobilisers carried out sensitization activities throughout community organizations and other structures developed by USHINDI. The five major themes were: 1) women in leadership, 2) family planning, 3) DR Congo's political organization 4) democracy, good governance and conflict resolution, and 5) the electoral process in DR Congo.

- In addition to the smaller forums and community organization discussions, a series of messages through mass campaigns were also introduced over 16 days surrounding the international day of women. These included distribution of pamphlets and posters with key messages.

iii. Introduction of family planning services in the health facilities.

- Contraceptive products along with community education tools and administration tools were provided to all the health zones which then provided contraceptive options to the population free of charge.

Awareness-raising on Family Planning

Launching the "We Will Speak Out" Campaign

One Billion Rising for Justice" against Impunity

Playing for Change – Singing for Peace

1.3. Synthesis of Intermediate Results (IR)

PPR 1. Number of people benefiting from USG-supported social services:

- 22,137 new acceptors received contraceptive therapy from supported health zones
- 52,660 of community organization members and VSLA received sensitization messages about women in leadership within the 108 health areas.
- 111,872 local leaders were taught and sensitized concerning the rights of women.
- 157,467 women and men of reproductive age were educated on family planning
- Of the 467 VSLA created and followed by the project 90% have women leaders
- The members of the 467 VSLA were all provided teaching on good governance and 75% of the associations have a set of internal regulations.
- 76% of VSLA members are women.
- Of the 955 learning participants within literacy circles, 865 or 90.5% were women.

PPR 2. Number of service providers trained who serve vulnerable persons

- 259 health service providers, representing 84% of the targeted providers, received training in women's leadership and family planning.
- 351 community mobilisers, representing 117% of the targeted number were trained in women's leadership, democracy and good governance.

Trainees	Overall target			Overall achievements			
	Male	**Female**	Total	**Male**	**Female**	Total	Percentage
WLP- Family Planning for health providers	264	47	310	**155**	**104**	259	84%
WLP Democracy and Governance for Community Mobilizers	120	180	300	154	197	351	117%
Total	**384**	**227**	610	**309**	**301**	610	
	63%	**37%**		**50.6%**	**49.4%**		

PPR 3. Number of USG-assisted organizations and/or service delivery systems strengthened

- 100% or all 108 health centers in the USHINDI health zones, received training and support in the development of women's leadership and family planning.
- 854 community organizations were supported by the project, namely 746 VSLAs and 108 core community groups (noyaux communautaire)

Organization / Institution	Target	Achievement	Percentage
Health Centers	108	108	100%
CBO, NGO/groups& associations supported	575	854*	149%
Total	683	932	140%

* the increased number of CBO associations achieved largely has to do with the spontaneous formation of new VSLAs during the course of the project as successful VSLAs sometimes encouraged replication with the help of established VSLAs

2. Women's Leadership Program achievements by intermediate results (IR)

IR1.1 Number of people trained to provide advocacy for women's leadership, gender equity, good governance and the democratic process in DRC.

- 351 community mobilisers, representing 117% of the targeted number were trained directly in women's leadership, democracy and good governance. This was the start of a cascade of education/sensitization which ultimately led to 215,577 people educated on the same subjects.

IR1.2 Number of individuals receiving education and sensitization messages across all topics.

Table2. People involved in WLP& PF- related BCC activities

	Year 1			Year 2			
Sensitization	**M**	**F**	**Total**	**M**	**F**	**Total**	**G.Total**
# men and women at reproductive age educated on PF services	25,924	56,404	82,328	23,508	51,631	75,139	15,7467
# men and women educated on WLP	20,803	34,143	54,946	17,531	39,395	56,926	111,872
# of people educated on DR. Congo's political organization	109	177	286	1,352	2,159	3,511	3,797
# of people educated / sensitized on Governance, Democracy and conflict resolution (members VSLA, CBO, HC)	20,919	32,798	53,717	17,447	32,541	49,988	103,705
# community mobilizers/ volunteers educated on FP and leadership	8,040	2,839	10,879	6,608	4,342	10,950	21,829
# of community volunteers educated on electoral processes	51	92	143	1,395	2,405	3,800	3,943
# of community member supported structures sensitized on WLP, FP and governance	14,006	18,947	32,953	9,892	9,815	19,707	52,660
Total	89,852	145,400	235,252	77,733	142,288	220,021	455,273

Remark. 455,273 men and women were sensitized / educated on various themes related to empowering women's leadership, including women's participation as active decision-makers at different levels including households as well as local organizations and positions in government. At the same time, advocacy was made regarding equal access and opportunity to receive health care, education and inheritance.

IR2 Reproductive Health and Family Planning Services Promoted and Provided

2.1 Access to Family planning services

2.1.1 Over the course of the project, 157,467 people of reproductive age received education on family planning. Of this group, 69% were women and 31% were male. Education reached 47.5% of the expected number of reproductive aged women (estimated at 21% of the population.)

2.1.2 Of those receiving education on FP, 27,105 accepted referrals to a health center for family planning services. Of this group, 76% were female and 24% were male.

2.1.3 Data on new acceptors of family planning obtained from the national database were as follows:

Year	2012 (baseline)	2013	2014
# of new acceptors	10, 018	13, 890	8,686 (20,846)*

- *The data for 2014 only includes the first 5 months of the year after which the women's leadership program came to an end. If the same rates are extrapolated out for the full year, the number of new acceptors would likely have been around 20,000 or double the baseline new acceptors.

Where there exists complete data for baseline and the first full year in which the program was functioning (6 health zones) a similar story appears:

		MUTWANGA	KOMANDA -LOLWA	OBOKOTE	LUBERO	ALIMBONGO	FEREKENI
2012	# Women at reproductive age	36,591	208,825	15,595	41,830	42,254	13,762
	New acceptants	812	3,016	311	3,113	2,492	275
	% new acceptants	2.2	1.4	2.0	7.4	5.9	2.0
2013	# Women at reproductive age	37,689	25,334	16,063	43,084	43,522	14,175
	New acceptants	1,084	3,446	884	2,680	3,954	1,053
	% new acceptants	2.9	13.6	5.5	6.2	9.1	7.4

2.1.4 The total couple years of protection provided during the project was 32,143 and is summarized on table 4 on the following page.

2.1.5 The total number of health workers trained to provide family planning services was 259, or 84% of the targeted number.

Table 4. Couple year protection by HZs (number of estimated prevented pregnancies among women at reproductive age)

Health Zone		Mutwanga	Lolwa-Komanda	Obokote	Ferekeni	Lubero	Alimbongo	Kitutu	Mwenga	Shabunda	Total
Women at reproductive age 21% of total population		38,634	25,334	15,514	12,693	44,845	38,795	15,799	16,926	18,904	227,445
Method	Calculation factor / method	CYP	CYP	CYP	CYP	CYP	CYP	CYP	CYP	CYP	CYP
Vasectomy	12.5	0	0	0	0	0	25	0	0	0	25
Tubal Ligation	10	1,830	30	50	0	0	1,970	1,830	220	0	5,930
COC	0.067	22.3	77.4	35.6	0.2	0.01	35.2	22.4	10.3	33.6	237
POP	0.067	8.3	53.3	2.8	0	0	18.0	8.3	13.2	1.6	106
DMPA	0.25	263.3	597.8	176.8	1.8	0.4	278.8	263.3	108.5	82.8	1,773
DIU Med	3.8	15.2	3.8	3.8	0	0	288.8	15.2	34.2	0	361
Jadelle	3.5	945	805	612.5	10.5	36.8	1,935.5	945	24.5	0	5,315
Norplan	3.5	0	0	0	0	0	0	0	28	10.5	39
Implanon	3.5	0	0	0	0	0	0	0	38.5	0	39
Condom, Male	0.007	4.5	10.1	8.2	1.6	0.01	14.2	4.5	3.8	0.01	47
Condom, Female	0.007	0.9	0.8	0.9	1.8	0.01	0.6	0.9	3.8	0.7	10
MAO confirmed	2	0	0	344	166	332	540	0	136	30	1,548
Cycle beads	2	532	1,880	224	0	0	1,194	532	530	0	4,892
DIU Inert	3.8	0	72.2	0	0	0	10,602	0	1,113.4	34.2	11,822
Total		3,622	3,530	1,459	182	369	16,902	3,622	2,264	193	32,143

3. Observations, Challenges and Lessons Learned

3.1. Positive signs in the field

- Women are increasingly noted to be participating in decision-making processes in the USHINDI zones. This includes household and property management issues, input to child education decisions, and inheritance issues as well as leadership in community organizations.
- Traditional chiefs have been recruited to encourage the elimination of certain cultural practices and power structures that violate women's rights, such as sexual rites with virgin girls younger than 14 years and forced marriages of adolescent girls.
- Increased interest and use of family planning services especially in certain zones where the community leaders and mobilisers took family planning messages to heart.
- An awakening of understanding regarding the benefits of women's leadership and the role that providing education to women can play in facilitating women's leadership. This has led to many efforts in advancing women's literacy and re-enrolling young mothers in schools.
- The women of one church in Bulongo dismantled a local brothel and placed adolescent girls back into their families.
- Religious leaders and men in the population have participated in advocating for family planning.

3.2. Challenges

- Limited support from the state regarding women's leadership and family planning issues.
- Limited availability of some contraceptive products in certain health zones.
- Some resistance to certain family planning methods in certain local churches.
- Limitations in access to legally register marriages and children in some areas.
- Insecurity due to the activity of armed rebel groups in some targeted areas.
- Entrenched cultural practices in some areas that hinder acceptance of women's leadership and family planning principles.

3.3. Lessons Learned

- Women and/or couples demonstrated a definite preference for long-acting contraception—either the implants or injected medroxyprogesterone. Implants were clearly the preferred method though unfortunately not always available in the health structures.
- Men are being convinced about the benefits of family planning and birth spacing as well as accepting the potential reintegration to family and community of sexually violated women that previously may have been shunned for life
- Women are joining community foundations that provide them with social support
- The access of women to financial resources through the VSLA has not only increased their social status, but also their overall sense of well-being in family and community.
- VSLAs have proved to be an ideal vehicle for education and sensitizing women and men on issue pertaining to women's leadership and family planning