Cordaid BUILDING FLOURISHING COMMUNITIES

FINAL EVALUATION REPORT

Project title :	**Stability - 3G (Gender and Community Guarantee, One-Stop Centres and SRH Essential Commodities Supply Chain Management)**
Location:	**North Kivu: Karisimbi, Kirotshe and Mweso health zones. South Kivu: Kalehe, Kamituga and Ruzizi health zones. DR CONGO**
Customer (lead) :	**CORDAID**
Partners of execution :	**Heal Africa, iPeace, LPI, PAP RDC and SOS SIDA**
Directed by :	**Victim's Hope DRC**
Sector:	**Sexual and Reproductive Health**

March

Royaume des Pays-Bas

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The contents of this report are the responsibility of the consultant and do not necessarily reflect the views of Cordaid.

Authors of the Victim's Hope DRC team report :
- **Junior Habimana**, Country Director
- **Yves Badesire**, Head of Evaluation
- **David Willy**, Statistical Analyst
- **Trésor Luvale**, Data Management and GIS

Cabinet information :
Contacts: +243 990 094 448/826163250
Email : victimeshope2004@gmail.com
Website: www.victimshopedrc.org
Address: AV. MICHOMBERO, C/ de Bagira, Bukavu
South Kivu in DR Congo

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Acronym

ABA	American Bar Association
AGR	Income-generating activities
APN	Access Point Name
APS	Psychosocial Assistant
AS	Health area
WITH	Village Savings and Credit Association
BAT	Technical Support Office
CAD	Distribution Axis Committee
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CS	Health Centre
CTMP-PF	Permanent Multisectoral Technical Committee for Family Planning
DRC/RDC	Democratic Republic of Congo/République Démocratique du Congo
FOSA	Health training
GCA	Supply Chain Management
HEAL	Health-Education-Community Action-Leadership
HRM	Regional Military Hospital
IMA	Interchurch Medical Assistance
LPI	Living Peace Institute
OECD	Organisation for Economic Co-operation and Development
OSC	One Stop Center
PEC	Support
PEP	Post Exposure Prophylaxis
PNC	Congolese National Police
PNSM	National Mental Health Programme
PNSR	National Reproductive Health Programme
S3G	Stabilisation, Gender and Community Guarantee, Guichet Unique, Managing the supply chain for sexual health drugs
SDSR	Sexual and Reproductive Health and Rights
SSRAJ	Sexual and Reproductive Health of Adolescents and Young People
TdC	Theory of Change
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSBG	Sexual and gender-based violence
VH	Victim's Hope
ZS	Health zone

I. EXECUTIVE SUMMARY OF THE EVALUATION

The S-3G project was funded by the Embassies of the Kingdom of the Netherlands (RNE) in the Great Lakes region with the aim of contributing to stability through the prevention of and response to sexual and gender-based violence (SGBV) and the improvement of sexual and reproductive health and rights (SRHR) in eastern DRC, specifically in the provinces of North and South Kivu.

This intervention took place in 24 health areas in 6 health zones in the two provinces of the Democratic Republic of Congo. These are the health zones of Karisimbi, Kirotshe and Mweso in North Kivu and Kalehe, Ruzizi and Kamituga in South Kivu. Since 2020, this project has been implemented by a consortium made up of Cordaid and Heal Africa, as well as implementing partners including SOS SIDA, IPeace, LPI and PAP RDC, with the support of technical partners ARQ International, PNAM and the North and South Kivu Health Division.

In order to understand how this project was implemented to achieve its objectives and to assess its impact on the beneficiary communities, a final evaluation has been commissioned, the results of which will be used by Cordaid and its partners to inform decisions on improving similar programmes in the future.

In order to meet this final evaluation objective, a qualitative methodological approach was used, involving semi-structured individual interviews with key informants, i.e. government technical services involved in the project and S-3G project implementation staff, and focus group discussions with beneficiaries.
To assess community satisfaction with the project, focus groups were held with the various community groups set up through the S-3G project. All these categories were used to assess the change and success stories of the programme within the community.

I.1. Relevance:

The S-3G project, implemented through 8 One Stop Centres and 24 health centres aimed at contributing to stability in the two provinces, was deemed relevant by members of the community and community leaders in the health zones. The activities relating to prevention, response to sexual and gender-based violence (SGBV) and improving sexual and reproductive health and rights (SRHR) have met the needs of the community.
Through this project, the technical capacities of healthcare providers in the areas supported have been strengthened. The project has also met the needs of health staff by providing a multi-sectoral response. The community members we met said that they had been consulted before the project activities were implemented, so that their needs relating to SGBV and sexual and reproductive health and rights could be met.

I.2 Consistency:

The activities carried out by Cordaid and its partners were consistent with the needs expressed by VSBG and the SRHR.

This project, funded by the Embassy of the Kingdom of the Netherlands (RNE) in the Great Lakes region and implemented by a consortium made up of Cordaid (lead organisation), Heal Africa (expertise in One

Stop Centres) and ARQ International (technical assistance in mental health and psychosocial support), was consistent with other interventions implemented in the areas by other partners. There was good coordination of activities during implementation by the various implementing partners in the field. The project was implemented in accordance with the standards and guidelines of the Ministry of Health and the national protocols governing activities relating to SGBV and SRHR. Complementarity and collaboration in the supply chain for RH/FP inputs and PEP KITs, as well as in legal and judicial care, with other NGOs working in the zones, was experienced throughout the implementation period. The Panzi Foundation set up mobile courts in Kamituga, and the American Bar Association (ABA) set up mobile courts in Kalehe. IMA supplied PEP kits in both provinces (North and South Kivu). UNFPA supplied contraceptives to North Kivu, as did Chemonics/USAID, which supplied contraceptives to South Kivu, and the Global Fund/Cordaid project offered PEP kits in both provinces (North and South Kivu) in support of the S-3G project. Collaboration also extended to the Office of the Adviser to the Head of State on the fight against GBV at the Office of the President of the Republic, through support for the draft law on the prevention and repression of GBV.

I.3 Efficiency:

Based on the results of the surveys, the majority of beneficiaries had a positive perception of the S3G project's activities. The project has contributed to stability, prevention and the response to sexual and gender-based violence, as well as improving reproductive health and sexual rights in the two provinces. The project has made it possible to limit the risk of conflict in the community thanks to the services offered in the intervention zones through community mobilisation and legal and judicial support. *Before the S-3G project, there was an upsurge in conflicts between the victim's family and that of the alleged perpetrator, but also the children born of rape were a source of conflict within the victim's family," explains a respondent interviewed during the survey. Thanks to the S-3G project, the perpetrators of rape and violence have been brought to justice and some have been convicted, while the victims have received care and been reintegrated into society. This has considerably reduced conflict within the community," he continues*. According to the results of CORDAID's final report (2023), 75% of SGBV survivors stated that they had regained stability in their daily activities, whereas the initial figure was 36%. This represents a difference of 39%, giving an average variation of 108% improvement compared with the baseline study.

I.4. Efficiency:

Efficiency seeks to understand how the project's resources were used to achieve the expected results. The project's financial, material and organisational resources were used rationally to achieve the planned results. Overall, the key informants interviewed commented on the efficiency of the S-3G project. According to them, the resources were managed rationally, enabling the expected results to be achieved within the time allowed.

I.5. Impact:

The S-3G project has produced positive results, according to key informants and beneficiaries.
According to the results obtained, this project has had a positive impact in the two intervention provinces. This impact was felt by SGBV survivors, staff at the health facilities benefiting from the activities and the community itself.

Free support was provided to victims of SGBV through a multi-sectoral response. This support has enabled survivors to set up income-generating activities to help them recover economically and socially. An average of 83% of survivors were satisfied with the socio-economic reintegration package. Health workers said they had improved their services through the capacity-building they received during the implementation of the S3G project. They said that they had been able to treat survivors in favourable conditions with the inputs they had received free of charge from the S3G project, and they also mentioned the rehabilitation of the one-stop centres that had been set up and were operational in the various health zones. According to the responses of the community members surveyed, good governance and community mobilisation have had a positive impact on their community. A number of victims' cases have been pleaded, while the awareness-raising campaigns have brought about a positive change in attitudes to the consideration and perception of gender-based violence issues.

According to the project's final report, 80% of community leaders are already adopting positive attitudes to gender and SRH. At the start of the community discussions, 72% of men in North Kivu and 82% of men in South Kivu agreed that changing nappies, bathing babies and feeding children were tasks for women. This percentage fell to 15% and 20% respectively in North and South Kivu. 54% of men in North and South Kivu said that women deserved to be beaten at certain times. After the intervention, this percentage was reduced to 13% and 8% in North and South Kivu respectively.
All the approaches implemented by the S-3G project have strengthened the stability and well-being of survivors through the prevention of and response to sexual and gender-based violence (SGBV) and the improvement of sexual and reproductive health and rights (SRHR).

I.5. Sustainability:

8 one-stop centres rehabilitated and equipped in the 6 health zones in compliance with standards of over 80% quality score[1] were deemed sustainable within the community. The health workers have shown that the capacity-building they received through this project will continue to provide a solid basis in the future for offering quality care to the various cases of SGBV victims within the health facilities.
The community reported effects that prove the sustainability of the project in the intervention zones. Community members have shown that they will continue to raise awareness of SGBV in the community despite the end of the project, because they have received this training for the well-being of the community. The capacity-building acquired by the health providers, the operational CSOs, the availability of RH/FP inputs in the facilities, the operational AVECs and the youth CBOs are achievements that will help to ensure the project's sustainability.

I.6. Cross-disciplinary aspects:

In its strategy, Cordaid is committed to implementing its projects using an approach based primarily on community involvement. The intervention has effectively contributed to reducing gender inequalities within the community. Women and young people, who have always been marginalised and whose rights continue to be violated as a result of customs and harmful practices, have been heavily involved in activities to combat these inequalities. Members of the community have been given pride of place in the fight against sexual and gender-based violence in the areas where the project is being implemented. Thanks to Heal Africa's expertise in the multi-sectoral response to SGBV using the one-stop centre approach, the beneficiaries felt that they were sufficiently involved, without discrimination based on gender, custom or social background.

1 *Score Card evaluation mission report in the six health zones of North and South Kivu of the S-3G project, November 2022.*

21% (18/85) of women among managers trained in evidence gathering in the two provinces, 58% (38/66) of women among providers offering services for survivors have been traumatized (Cordaid annual report February 2023). According to the multisectoral response to SGBV, of the 2,151 cases identified, 63% (1,348) are women, 36% (782) are girls, 0.6% (12) are boys and 0.4% (9) are men[2] . This shows that the majority of SGBV cases in the communities covered by this project affect women.

The data collected through interviews and group discussions show that the project has been more inclusive, taking into account all sections of the community through the different approaches it has put in place.

[2] 2023 01 23_S3G_Annual_Report_Second_Year_draft, Page 10.

II. PRESENTATION OF THE PROJECT

II.1 Introduction to the project

With sexual and gender-based violence on the rise in the DRC, most of this violence is linked to the recurrent insecurity in the east of the country. The main aim of the S-3G project in the east of the Democratic Republic of Congo, funded by the Ministry of Foreign Affairs of the Kingdom of the Netherlands as part of its Great Lakes Countries programme, is to contribute to stability, health and well-being in the east of the Democratic Republic of Congo (DRC) by preventing and reducing sexual and gender-based violence (SGBV) and improving the sexual and reproductive health and rights (SRHR) of women and girls. This project is being implemented by Cordaid and Heal Africa through local implementing organisations as well as state services and members of the communities concerned by the project in 24 health areas in 6 health zones in the provinces of North Kivu (Karisimbi, Kirotshe and Mweso health zones) and South Kivu (Kalehe, Ruzizi and Kamituga health zones) in the Democratic Republic of Congo. The project was implemented through 8 One Stop Centers (including the Congolese National Police Hospital in Bukavu and the Regional Military Hospital in Goma) and 24 health centres in the 6 health zones mentioned above.

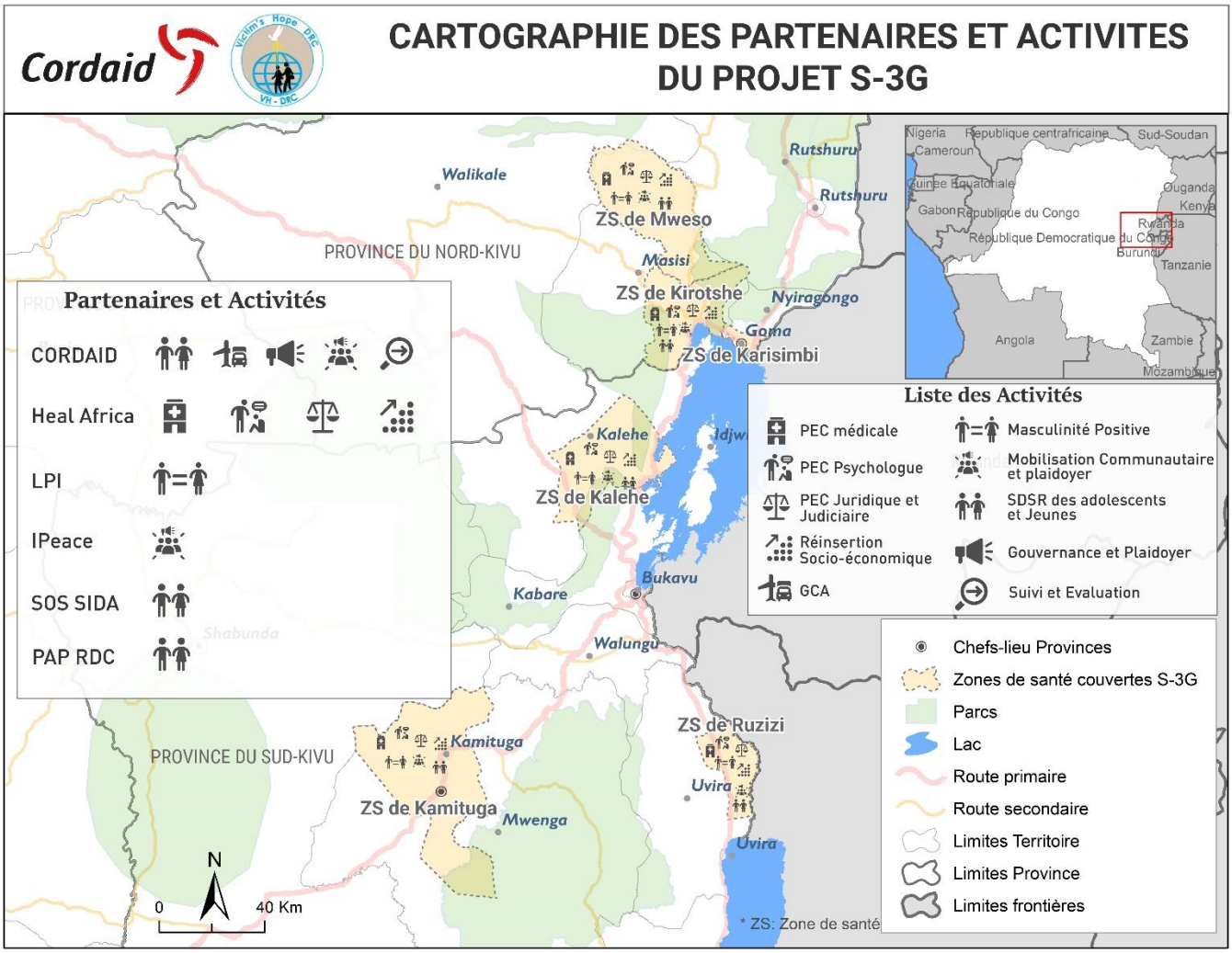
The S-3G project has used four main channels to achieve its objectives in order to contribute to stability, health and well-being in the east of the Democratic Republic of Congo:

1. **Multi-sectoral response to SGBV**: Creation of one-stop shops offering comprehensive case management (medical, psychosocial, legal and judicial support and socio-economic reintegration);
2. **Strengthening the healthcare system**: SRH services adapted to women and young people with a solid supply chain for SRH and SGBV products;
3. **Governance and advocacy**: Strengthen the effectiveness of provincial coordination and governance with regard to GBV, to enable those involved in the fight against GBV to implement strategies to prevent and respond to (S)GBV.
4. **Community mobilisation**: Promote gender transformation processes, reduce stigmatisation and obtain broad community support for the protection of SGBV survivors.

II.2 Project implementation

II.2.1. Map of approaches and implementation partners

Figure 1: Map of S-3G approaches and partners



II.2.2 Computer graphics

4,304 survivors received medical assistance and psychosocial support and recovered their physical and psychological balance.

430 survivors were socio-economically reintegrated through 55 AVEC groups set up in the 24 health areas. 209 beneficiaries, including 202 (96.6% in South Kivu), have increased their self-confidence and are contributing to individual and household resilience.

1,096 people (including 792 women and 304 men) visited the 8 CSOs in North and South Kivu. 610 survivors were identified (including 574 women and 36 men). 289 complaints were lodged, including 132 in North Kivu and 157 in South Kivu. 553 people received legal advice, including 431 women and 122 men, and 39 cases are currently before the various courts. 79 judgements have already been handed down, including 25 in North Kivu and 54 in South Kivu.

54 football matches were organised, with 625 players (referees and players) taking part, including 229 women and 396 men. Some 4,719 people were made aware of the various issues involved in combating SGBV.
384 community members have been involved and trained in positive masculinity and equity, and 21,237 other parents and religious leaders have been reached through 1,080 awareness-raising sessions (report February 2023).

73 awareness-raising sessions with members of the protective communities, involving 120 participants, 65 men and 55 women. Some 19,195 people reached by the awareness messages (7,013 men, 10,423 women, 863 boys and 896 girls).

III. OBJECTIVES OF THE EVALUATION

3.1 General objective

The general objective of this evaluation is to assess the project's achievements, the results obtained and their impact on the community and institutions, drawing lessons and good practices in order to make recommendations to improve future interventions.

3.2 Specific objectives

Specifically, this assessment seeks to :

- Assess the progress made in implementing the intervention, highlighting strengths and weaknesses and analysing the factors that have positively or negatively affected the achievement of results;
- Examine the effectiveness and efficiency of the project in achieving its planned results (in relation to its objective and outcomes);
- Assess the relevance and sustainability of the project's results ;
- Evaluate change for survivors (especially with a focus on mental health / socio-economic reintegration);
- Assess the perceived change in the gender transformation process compared to the results of the initial project evaluation.
- Assess the significant changes in organisational SGBV capacity over the last two years and to what extent and how the project has contributed to these changes.
- Reflect on the Theory of Change (ToC) as the basis for this project: was the theory complete with all the relevant assumptions and conditions?
- Evaluate the delivery mechanisms and partnership strategy to achieve the outcomes and reporting arrangements and make proposals for future collaboration.
- Suggest areas for improvement for the next phase

3.3 Scope

Of the 6 beneficiary zones of the S-3G project in the provinces of South and North Kivu, 5 health zones were visited for data collection because of their accessibility and security. The Mweso health zone in North Kivu was excluded because of insecurity following ongoing clashes between the FARDC and M23 rebels during data collection.

In South Kivu province, this assessment covered the RUZIZI, KALEHE and KAMITUGA health zones, while in North Kivu, the KARISIMBI and KIROTSHE health zones were visited. In the Kirotshe health zone, only one health area was visited (SAKE), which was considered to be accessible from a security point of view. This evaluation covers the entire project implementation period from December 2020 to March 2023.

3.4 Assessment criteria

The survey was carried out in accordance with the Cordaid evaluation standards and the OECD guidelines defining the evaluation criteria. The following criteria were applied: Relevance, Coherence, Effectiveness, Efficiency, Sustainability, Impact and Transversality. [3]

[3] TDR OF THE FINAL EVALUATION OF THE S3G_I PROJECT

IV. METHODOLOGICAL APPROACH

IV.1 Assessment approach

To carry out this evaluation, a participatory approach was adopted involving all the parties involved in the implementation of the project.

Cordaid and its implementation partners were involved in providing input into the design of the data collection tools and the report to ensure that the results contained in the report are valid and reflect the reality of the implementation context.

The survey was carried out in accordance with Cordaid's evaluation standards and based on OECD guidelines defining evaluation criteria with the participation of all stakeholders including implementing partners, key leaders and beneficiary communities. The evaluation will use a qualitative data collection method to assess the results of the intervention, the quality of implementation and Cordaid's performance, and to make recommendations for a future programme cycle or similar projects.

IV.2 Data collection methods

IV.1 .1 Literature review

A review and analysis of the documentation and data from the S3G programme shared by Cordaid was carried out. These documents enabled us to gain a better understanding of the project's implementation, achievements, bottlenecks, results and impact on the community. In addition, this document review facilitated the development of data collection guides for this evaluation, based on the different approaches used to implement the project's activities. The document review also made it possible to assess the extent to which the objectives had been achieved, the quality and quantity of the services provided, the difficulties encountered and the action taken.

This basis was used to report on the evaluation and formulate recommendations based on the lessons learned from the project.

IV.2.2. Primary data collection

Qualitative data was collected through a series of semi-structured interviews and focus groups in a participatory and inclusive manner. The interviews and focus groups were conducted by interviewers (day labourers) and supervisors under the direct coordination of the Field Coordinator, using **semi-structured interview guides validated by Cordaid**.

The qualitative methodology consisted of collecting opinions and views from key informants (KIIs) in the area and direct beneficiaries of the project grouped in discussions (FGDs). This method was enriched by collecting data on the changes brought about by the project in the area and direct observations by the field team.

The study population consisted of young girls and boys aged 15-24 and adults aged 25-69. A guide (protocol) was developed for each group, covering the key questions according to the project activities and the OECD evaluation criteria.

The key informant guides (KII) were tailored to the categories of respondents targeted at different levels, while the focus group guide was tailored to the intervention package and to gender (Girls, Boys, Men and Women).

IV.2.2.1. Targeted interviews with key informants

Semi-structured individual interviews (KII) were conducted in 24 of the 32 health facilities supported by the project, including health staff, managers of 8 one-stop shops and women from 5 safe houses in the health zones (Mweso being under M23 control). For both towns, the types of respondents interviewed were staff from Cordaid, Heal Africa, SOS SIDA, PAP RDC, LPI, IPeace, the Ministries of Health and Gender, PNSM, PNSA and PNSR.

Table 1: Types of key informants interviewed

N°	Types of key informants	Planned	Number Achieved
1	MCZ/Nurse Supervisors	5	5
2	Safe house advisers	5	5
3	Psychologists	7	4
4	PSAs/Senior nurses	7	11
5	WITH	7	4
6	S3G Staffs	14	13
7	Strategic players	15	14
Total		**60**	**56**

Of the 60 interviews planned, 56 were successfully completed, i.e. 93.3% of the key informants, and 4 (6.7%) could not be contacted. Of the latter, 3 psychologists could not be contacted (43%), 3 AVEC members (43%), 1 staff member (7%) and 1 strategic player (6.6%).
It should also be noted that 11 of the 7 planned PSAs were achieved, i.e. 157%.

IV.2.2.2. Group discussion

Based on the evaluation criteria and research questions, four group discussion guides were developed and validated by Cordaid before the actual data collection in the field. The group discussions were conducted with the beneficiaries of the project activities by a facilitator and a note taker. The focus groups were made up of 6-10 people. A total of 25 focus groups were planned for this evaluation, with 5 FGDs per Health Zone, including 1 FGD with the Nehemia and WASI committees, 1 FGD with parents and religious leaders, 1 FGD with young people, 1 FGD with the wives of resilient men and 1 FGD with resilient men.

Table 2: Category of respondents in the focus groups

Province	Health zone	Nehemiah Wasi		Parents Leaders		Young people		Resilient men's wives		Resilient men		Total	
		Planned	Directed	Planned	Directed	Planned	Directed	Planned	Directed	Planned	Directed	Planned	Directed
North Kivu	Karisimbi	1	1	1	1	1	1	1	1	1	3	5	7
	Kirotshe	1	0	1	0	1	1	1	0	1	0	5	1
SOUTH KIVU	Kalehe	1	1	1	1	1	1	1	0	1	1	5	4
	Ruzizi	1	1	1	1	1	1	1	1	1	1	5	5
	Kamituga	1	1	1	1	1	1	1	1	1	1	5	5
Total		**5**	**4**	**5**	**4**	**5**	**5**	**5**	**3**	**5**	**6**	**25**	**22**

Of the 25 FGDs planned, 22 (88%) were successfully carried out. 3 FGDs, i.e. 12%, were not carried out due to the security situation in the Kirotshe health zone following the clashes that took place in the vicinity of Sake, on the one hand, and on the other, the delay in sharing contacts with certain respondents,

in particular resilient men, the wives of resilient men, members of the Nehemia committees, as well as parents and religious leaders.
In the Karisimbi health zone, we carried out 7 FGDs instead of 5, i.e. 140%, because 3 FGDs of resilient men were carried out instead of the planned 1, i.e. 300%.

IV.3. Limitations of the assessment

IV.3.1 Inaccessibility :

Data collection was hampered by security restrictions which reduced the evaluation zones from 6 to 5. The Mweso health zone, in the grip of clashes between the FARDC and M23 rebels, was not assessed. The precarious security situation in certain health areas in the Kirotshe health zone also meant that the teams were unable to visit the entire zone.
This led to an increase in the sample in other areas, such as Karisimbi, where 7 FGDs were interviewed instead of the 5 initially planned.

IV.3.2 Unavailability of respondents :

As the assessment areas were highly agricultural, and the security situation was precarious, some respondents were unavailable and reluctant to take part in the data collection. The interviewers, working with the supervisors, tried to convince them by explaining the purpose of the mission. In some areas, the beneficiaries forced the teams to comply with the timing of the survey, while in others, they were unprepared for the project evaluation team's visit to the area.

IV.3.3. Respondents' wait-and-see attitude : The project beneficiaries were expecting a new phase of the project. The data collection team provided as many explanations as possible on the objectives of this survey in order to reduce the respondents' tendency to be hesitant, which could influence their answers in the exchanges.

IV.4. Data analysis and quality assurance

IV.4.1. Data transcription

All the data collected through the semi-structured interview guides and group discussions were transcribed by the data collection team. Transcription involved converting the audio recordings of the interviews or discussions into text format. All recordings were transcribed verbatim (i.e. word for word). The data from the various guides was first summarised in a Word file according to the various Development Assistance Committee (DAC) criteria aplied for this evaluation before being migrated to Excel to facilitate analysis using MAXQDA software.

IV.4.2. Data analysis

All this data was cleaned and synthesised in an Excel file so that it could be integrated into the MAXQDA 2022 software to analytically extract the necessary information according to each research section and the evaluation criteria. The MAXQDA qualitative analysis software was used, as it is one of the most comprehensive and extremely versatile, as well as user-friendly and intuitive, software packages in the CAQDAS (Computer Assisted Qualitative Data Analysis Software) family. Respondents' views and opinions were grouped into frequencies and percentages to answer the evaluation criteria questions. Analyses of scorecard evaluation data were also integrated to supplement this qualitative data.
Analyses of data from score card evaluations carried out by CORDAID have also been incorporated to supplement this qualitative data.

IV.4.3. Data quality assurance

Data collectors were trained in best practice to ensure good interviewing and the best facilitation of focus group discussions. The data collection tools were explicitly used during this training. Interview and focus group guides were developed with guidance from the facilitator to ensure that the same process was used by all facilitators during interviews and focus groups. During the training, the guides were translated into local languages to facilitate understanding between respondents and interviewers during data collection, and interviewers were given tools for formulating probing questions to ensure that respondents understood them correctly and were able to provide correct answers. In addition to the notes taken during the discussions and interviews, a recording was made to ensure that the transcriptions were accurate and that only the respondents' answers were noted in the transcripts. The note-taker was the main transcriber, while the facilitator carried out a second reading to confirm that the transcripts accurately reflected the results of the discussions that had taken place. A second quality control check was carried out by the supervisor, before a final read-through by the evaluation lead to perform the final clean-up and ensure that the responses were consistent with the evaluation questions and criteria before proceeding with the analysis.

IV.5. Ethical considerations

IV.5.1. Safeguarding considerations

All members of the evaluation team complied with Cordaid and VH-RDC policies on child protection and the fight against sexual abuse and exploitation (Child Safeguarding, PSEA, etc.). The VH code of conduct was explained to all the members of the evaluation team before they signed it and before they went into the field. During the training of data collectors, all team members were fully briefed on the ethical considerations of evaluation, including working with children and safeguarding issues and issues of sexual abuse and exploitation.

IV.5.2. Free and informed consent

The participation of individuals in this evaluation was declared strictly voluntary. Measures were taken to ensure respect for the dignity and freedom of each person invited to participate. Verbal informed consent was obtained prior to interviews and group discussions with all participants. Respondents were not required to answer all questions. An opportunity to refrain from answering questions that made them uncomfortable was followed during the interviews. The interviewee was assured that he or she could end the interview at any time that he or she no longer felt comfortable with the interview . The coordination team ensured that confidentiality was maintained throughout the evaluation process.

IV.5.3. Data storage and security

All data including recordings were stored in password-protected devices accessible only by the evaluation team. The data collected has been anonymised and stored securely in a password protected secure folder. All data remains the property of Cordaid and no copies will be retained by VH after the end of this contract.

V. RESULTS OF THE EVALUATION

V.I. DEMOGRAPHIC DATA

The data below presents the demographic characteristics of the beneficiaries of the S-3G project in the provinces of North and South Kivu, in the DRC. This evaluation concerns exclusively qualitative data, which was collected in the Kamituga, Kalehe, Ruzizi, Karisimbi and Kirotshe zones. The beneficiaries were grouped during focus group discussions, taking into account their marital status, main activities, age group and level of education.

V.1.1. Sex and age of respondents

Table 3: Gender of FGD participants

	South Kivu			North Kivu			%
Gender	**Kalehe**	**Ruzizi**	**Kamituga**	**Kirotshe**	**Karisimbi**	**Total**	
Female	12	8	16	3	13	52	39%
Male	17	15	18	5	25	80	61%
Total	29	23	34	8	38	132	100%

This table shows that out of 132 people interviewed in the FGDs, 52 (39%) were women and 83 (61%) were men. It should be noted that the Kirotshe health zone has a low representation of respondents due to the recurrent insecurity in this health zone. The FGDs for the women of resilient men were not surveyed in the Kirotshe and Kalehe health zones. In the Ruzizi health zone, only two women were surveyed in the FGD for the women of resilient men, even though the criteria for organising FGDs require at least 6 people. This explains the 39% participation of women in the FGD.

Table 4: Age disaggregation of participants by health zone

AGE GROUP	SOUTH KIVU			NORD-KIVU			%
	KALEHE	RUZIZI	KAMITUGA	KIROTSHE	KARISIMBI	TOTAL	
15-24 years old	6	10	9	5	7	37	28,6%
Aged 25-34	7	3	4	3	7	24	18,6%
35-44 years old	11	3	9	0	18	41	31,7%
45-54 years old	3	7	6	0	5	21	16,2%
Age 55-69	2	0	3	0	1	6	4,6%
TOTAL	29	23	31	8	38	129	100%

This table shows that the 35-44 and 15-24 age groups were most affected by the surveys. It should also be noted that in the Kamituga health zone, 3 respondents in the female and male groups did not give their ages. This is what differentiates the sex table from the age table.

V.1.2. Marital status of respondents

Table 5: Marital status of respondents

Marital status	South Kivu			North Kivu			%
	Kalehe	Ruzizi	Kamituga	Kirotshe	Karisimbi	Total	
Single	5	8	9	5	7	34	26%
Married	24	15	25	2	30	96	73%
Divorced	0	0	0	0	0	0	0%
Widow(er)	0	0	0	0	1	1	1%
Total	29	23	34	7	38	131	100%

The table shows that 73% of respondents were married, while 26% were single. There were also 1% widows. One person did not give their marital status, which shows a difference between the two tables (sex and marital status).

V.1.3. Main activities carried out by respondents

Table 6: Respondents' main activities

PROFESSION	SOUTH KIVU				NORTH KIVU				GENERAL TOTAL
	KAMITUGA	KALEHE	RUSIZI	TOTAL	KARISIMBI	KIROTSHE	MWESO	TOTAL	
CULTIVATOR	11	11	5	**27**	0	1	0	**1**	**28**
COUTURIER	1	5	0	**6**	1	1	0	**2**	**8**
GOLDEN CREATOR	2	0	0	**2**	0	0	0	**0**	**2**
TEACHER	4	6	2	**12**	5	0	0	**5**	**17**
NURSE	4	1	2	**7**	0	0	0	**0**	**7**
MENAGERE	0	1	0	**1**	8	0	0	**8**	**9**
STUDENT	3	1	5	**9**	5	3	0	**8**	**17**
RECO	0	2	0	**2**	0	0	0	**0**	**2**
JOURNALIST	0	0	3	**3**	0	0	0	**0**	**3**
MERCHANT	5	0	0	**5**	7	0	0	**7**	**12**
VILLAGE CHIEF	0	1	0	**1**	0	0	0	**0**	**1**
COORDINATOR	0	1	0	**1**	0	0	0	**0**	**1**
CIVIL SERVANT	2	0	0	**2**	1	0	0	**1**	**3**
PASTEUR	3	0	0	**3**	2	0	0	**2**	**5**
ENTREPRENEUR	0	0	0	**0**	3	3	0	**6**	**6**
SOUDIERE	0	0	0	**0**	1	0	0	**1**	**1**
JOINERY	0	0	0	**0**	1	0	0	**1**	**1**
ELECTRICIAN	0	0	0	**0**	1	0	0	**1**	**1**
JOBLESS	1	0	0	**1**	2	0	0	**2**	**3**
MOTARD	0	0	1	**1**	0	0	0	**0**	**1**
TECHNICIAN	0	0	0	**0**	1	0	0	**1**	**1**
TOTAL	36	29	18	**83**	38	8	0	**46**	**129**

For most of our respondents, the main activity carried out remains farming (28/129), followed by teaching (17/129) and student work (17/129).

We met with a wide range of beneficiaries, who were involved in over 15 different activities, including schoolchildren, motorcyclists, diggers, journalists, housewives, nurses and pastors. This is further proof of the inclusion of this S-3G project during implementation.

V.2. THE RELEVANCE OF THE PROJECT

Relevance seeks to understand the extent to which the objectives and design of the project's interventions meet the needs of the beneficiaries and the policies of the country, the target area, and its impact on the target group in relation to reproductive health and gender-based violence.

V.2.1. Result 1: Multisectoral response to SGBV

According to the HRP 2022, gender-based violence (GBV) and serious violations of children's rights remain a critical issue. Between January and September 2021, a total of 74,275 cases of GBV were reported, compared with 43,003 cases in September 2020, an increase of 80%. Women and girls are more affected than men (94% of the total).

In the provinces of South and North Kivu, the trend in cases of gender-based violence (GBV) and serious violations of children's rights also remain major problems. Women and girls are the most affected (94% of cases). Incidents of GBV are mainly reported in the eastern provinces most affected by the humanitarian crises, including North Kivu (15,954 cases, i.e. almost 21% of the total) and South Kivu (9,136 cases, i.e. 12% of the total)[4] . The following forms of GBV were recorded: rape (51% of the total), psychological and emotional violence (15%), physical assault (11%), sexual assault (10%), forced marriage (7%), denial of resources and opportunities (6%), and sexual abuse and exploitation (3%)[5] (HNO RDC 2022 & 87).

This sharp increase in cases of GBV is thought to be due to a resurgence in the deteriorating security situation in South and North Kivu and Ituri, as well as the activism of armed groups and their pursuit by the FARDC. It should also be added that the state of siege has only worsened the situation in the two provinces of North Kivu and Ituri since 21 May 2021[6] .

In line with the standards and principles of the humanitarian plan (SO 1&2 PRH 2022)[7] , the Gender Stability and Community Guarantee, One-Stop Centres and SRH Essential Commodities Supply Chain Management "S-3G" project seeks to contribute to stability, health and well-being in the east of the Democratic Republic of Congo (DRC) by preventing and reducing sexual and gender-based violence (SGBV) and improving the sexual and reproductive health and rights (SRHR) of women and girls in the health zones of Kamituga, Kalehe, Ruzizi (in South Kivu) and Mweso, Karisimbi and Kirotshe (in North Kivu).

The S-3G project identified 2,151 cases of SGBV, including 1,177 (948 cases of rape and 229 other cases of SGBV) in North Kivu and 974 in South Kivu (649 cases of rape and 325 other

[4] *Cumulative report from 2018 to 2020 on the scale of gender-based violence in the DRC.*

[5] *HNO RDC 2022,* *https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/hno_2022_drc_20211222.pdf*

[6] Détérioration de la situation sécuritaire accentuée par l'état de siège, https://information.tv5monde.com/afrique/rdc-apres-un-d-etat-de-siege-quel-bilan-l-est-du-pays-455618#:~:text=Le%206%20mai%202021%2C%20il,%2DKivu%20et%20l'Ituri.&text=D%C3%A9but%202021%2C%20122%20groupes%20arm%C3%A9s%20s%C3%A9vissent%20dans%20la%20r%C3%A9gion.

[7] DRC Humanitarian Response Plan 2022, **https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/hrp_2022-_janvier-v2-finale-web.pdf**

cases of SGBV). The province of North Kivu accounts for 55% of cases, due to the atrocities caused by the conflicts in most of the territories, which only encourage acts of rape and violence against women and girls.

This project is aligned with the Sustainable Development Goals (SDGs), including Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Goal 5 (Achieve gender equality and empower all women and girls) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, ensure access to justice for all, and build effective, accountable and inclusive institutions at all levels).
In addition to this, the S-3G project is in line with the RNE multi-annual strategy for the Great Lakes 2019-2022 and the Netherlands "Sexual and reproductive health and rights, including HIV/AIDS, through the prevention and management of SGBV. It falls under the heading of social progress and will contribute directly to achieving the impact of a "lasting and equitable peace between the sexes to contribute to stability".8

This project was implemented in accordance with the national policy to combat gender-based violence (SNVBG), as adopted in 2009 and evaluated in 2015.9
The government strategy which seeks to promote social equality and inclusion, increase resilience (people and systems) and strengthen the social contract between governments and their societies.

The project's interventions have been of vital importance in the community, as a number of survivors who were unable to access healthcare due to a lack of resources have been able to access free holistic care thanks to the project (medical, psychosocial, socio-economic, legal and judicial).
According to health facility managers, the project's activities have met priority needs:

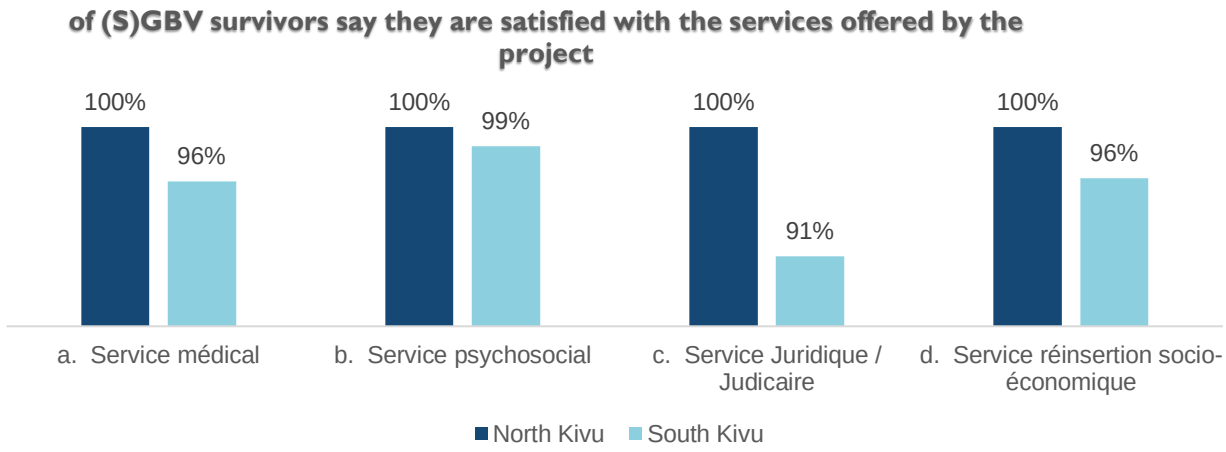
- Capacity building for service providers
- Free access to medical, legal and psychological services
- Socio-economic reintegration through AVEC

The S3G project was deemed relevant by beneficiaries in the health zones of North and South Kivu. 42.2% of opinions collected in focus groups showed that this project implemented by Cordaid in the 6 health zones met the needs of the community. This is in line with output 1.1.1, which showed that 96% of SGBV survivors received holistic support in the intervention zones according to their specific needs, and 99% of them said they were satisfied with the services they received as part of the holistic support (Cordaid report March 2023).

[8] 3G stability proposal Oct 2020.en.fr, Page 15

[9] National strategy to combat gender-based violence (SNVBG) of the DRC 2015.

Figure 2: Percentage of SGBV survivors who say they are satisfied with the services provided by the project



According to Cordaid's final report (March 2023), SGBV survivors stated that they were satisfied with the holistic care service at the health facility level. This is in line with the opinions of 6 key informant providers interviewed during the final evaluation.

As part of the capacity-building programme, psychologists from the one-stop centres and the project, as well as the National Mental Health Programme (PNSM) team from two provinces, attended a 4-day training course on stress monitoring and mentoring organised by ARQ International.
11 people, including 8 psychologists from structures supported by the project and the PNSM team in North and South Kivu, and 3 from Heal Africa, benefited from this training.
The level of stress linked to post-rape trauma was assessed in 86 providers and PWAs using the mentoring and monitoring tool for stress and burnout. Of these, 76 showed a need for support and 22 did not. 32% returned to normal after receiving 3 sessions.

"In the past, survivors could go round and round to get the appropriate care, and this exposed them to a number of risks, including stigmatisation and stereotyping. And others could even be influenced by their environment to drop out of care. Thanks to this project, with its innovative One Stop Centre approach, where we randomly pick up files and see internal referrals, we can see that people have benefited from holistic care. As coordinator of the PNSR, I'm delighted to have seen holistic treatment in a single unit. Testimonial from a technical partner involved in implementing the S-3G project". 10

According to a doctor in charge of the zone, *"today, everything that was difficult in the health structures is now a reality, because we no longer need to transfer every case of SGBV to Panzi hospital, but we can manage some and refer only certain complicated cases".*

According to an executive from the Gender Division in North Kivu, the project has strengthened the resilience of the SVS and empowered women. "From *the moment we take charge to the moment we receive the materials, you will see that there is a circuit that is respected not only to protect or secure the confidentiality of cases for the beneficiaries or survivors, but also to strengthen the resilience of those*

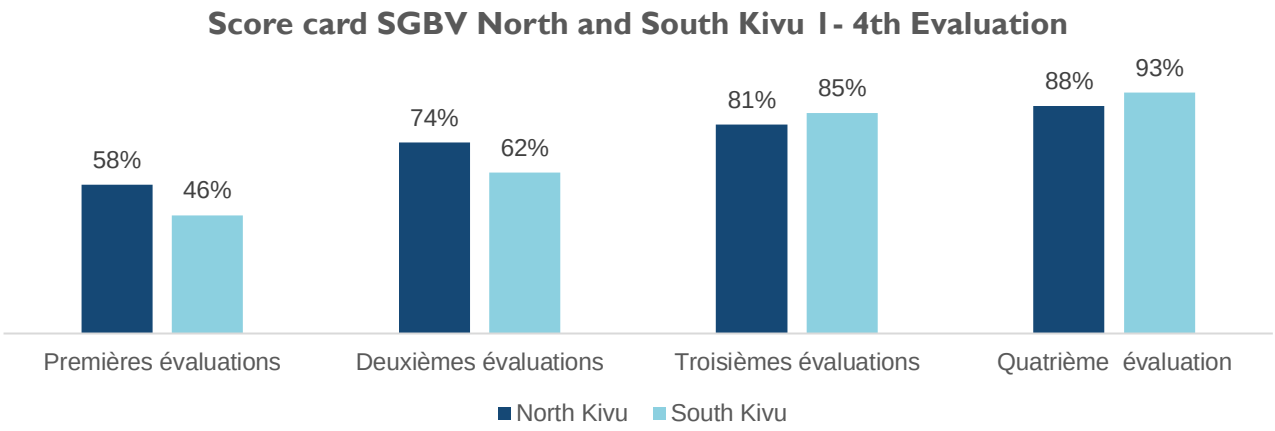
[10] KII with informant with a PNSR technical partner

who were targeted to receive the materials. To strengthen resilience, the project has set up IGAs, vocational training and AVECs".

According to the key informants interviewed, the project was relevant to the beneficiaries; 12 of the key informants interviewed felt that the IGAs met the needs of the beneficiaries in terms of socio-economic reintegration.

SGBV card score from first to fourth assessment

Figure 3: Score card SGBV



This graph shows how far the card scores have progressed from the first to the fourth evaluation. For the province of North Kivu, the score rose from 58% for the first evaluation, 74% for the second evaluation, 81% for the third evaluation and 84% for the fourth evaluation. For the province of South Kivu, the score rose from 46% for the first evaluation, 62% for the second evaluation, 85% for the third evaluation and 93% for the fourth evaluation. This increase in the curve from the first to the fourth evaluation for the facilities in these six health zones evaluated, including 3 in North Kivu and 3 in South Kivu, can be explained by compliance with the various recommendations and action plans given to the different facilities during the different visiting missions.

V.2.2. Outcome 2: Strengthening the health system

According to a member of a health facility we met in Kamituga, before the S-3G project intervened, reproductive health needs and knowledge about sexual and gender-based violence did not seem to attract the attention of the local authority at community level. Yet these needs had a social, health and economic impact on the community. Health workers showed a lack of supervision and care for victims of sexual and gender-based violence.

With the arrival of the S-3G project, memorandums of understanding were signed with the central offices, which opened the doors to support.

The needs identified by the health facilities with the support of the health zones and health zone divisions were covered by the project. Building the capacity of healthcare staff in the 25 health facilities to care for survivors, referrals, supplies of medicines and a number of inputs are real needs that were affecting the capacity of the health facilities to provide quality services and care for survivors.

25 youth corners have been equipped with functional audio-visual equipment in the 6 health zones. Capacity-building for health workers in 6 health zones met the needs of providers in the area of sexual and reproductive health care for young people.
During the evaluation, interviewees confirmed the availability of FP inputs and PEP kits at health facilities, which corroborates the data found in Cordaid's March 2023 final report (data from the last quarter, December 2022 to February 2023).

Figure 4: Availability of SRH products in South Kivu

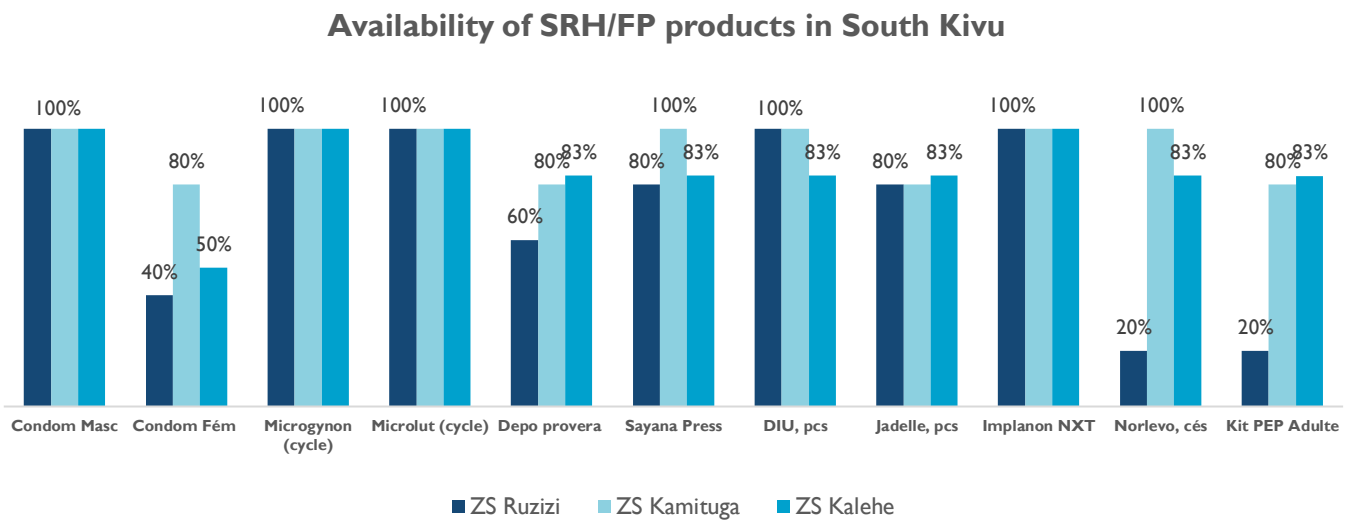
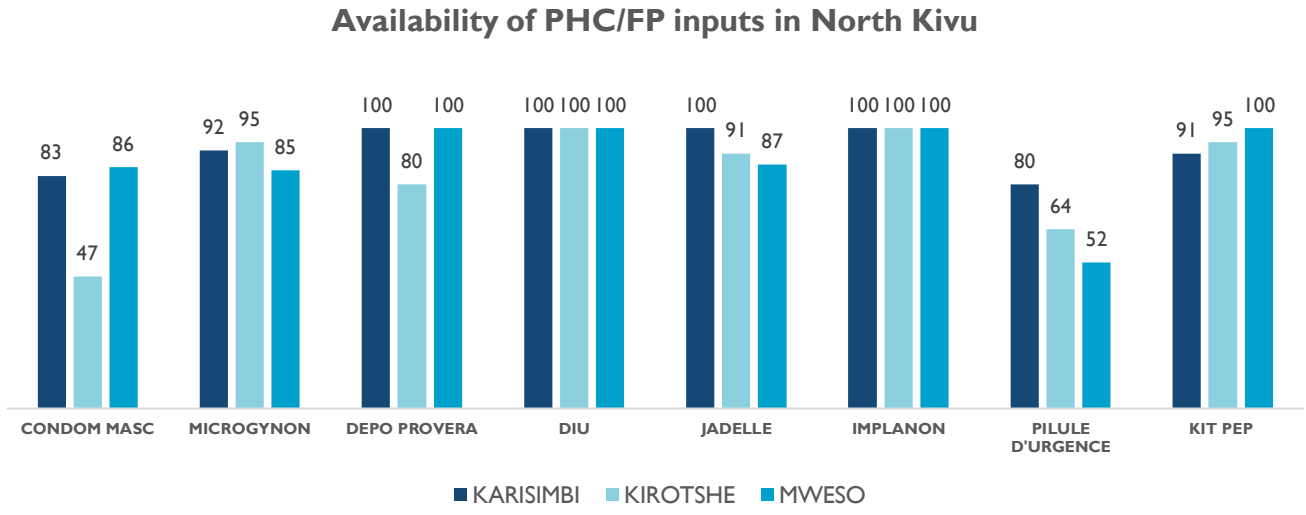


Figure 5: Availability of SRH products in North Kivu



According to a young participant in the group discussion who was a member of the Nehemia group in Kamituga, *"Yes, the reproductive health (RH) and GBV system in health facilities is adapted to the needs of women and girl survivors of SGBV because of the economic context in which we live. We live in an area where the main activity is gold digging, and the second activity in the area is selling sex in the mining areas, with all the possible consequences of catching STIs, HIV AIDS and unwanted pregnancies. The S-3G project has really got*

to the heart of our problems, with community members starting to protect themselves before having sex, even though the project has only reached 4 health areas. Condoms are available in health centres free of charge".[11]

It should be noted that at the time of the baseline assessment, the data relating to the availability of SSR and KIT PEP products was as follows:

- In terms of the proportion of health facilities with RH/FP products available on the day of the visit, the overall availability of contraceptive methods in the two provinces was 61% in South Kivu and 63% in North Kivu in the health zones surveyed.
- With regard to the availability of PEP Kits, the overall average availability in the 6 health zones is 55%.

The proportion of health facilities with SRH/FP products and PEP kits in North and South Kivu in the last quarter of the third year of the project was as follows:

- SR/FP products are 87.7% in North Kivu and 92.9% in South Kivu.
- Kit PEP is 95.3% in North Kivu and 61% in South Kivu.

The availability of RH/FP products and PEP kits has improved in both provinces. This improvement is due to the IPM (Informed Push Model) approach using the CAD (Comite d'Axe de Distribution) strategy for transporting products to the last kilometre of delivery.

V.2.3. Outcome 3: Governance and advocacy on SGBV

The specific objective of governance and advocacy on sexual and gender-based violence is to strengthen the effectiveness of provincial coordination and governance on gender-based violence in order to enable those involved in the fight against gender-based violence to put in place strategies to prevent and respond to gender-based violence.

According to Cordaid's final report (March 2023),

- The project supported the "Strategic Alliance for Advocacy" platform in submitting and validating the draft law on the prevention and repression of GBV with the office of the Advisor to the Head of State on the fight against SGBV.
- Integrating the "One Stop Center" approach into national policy on responding to sexual violence.
- Reinsertion of the Design Purchases budget line in the judicial decisions of the 6 decentralised territorial entities
- Adoption of a co-payment system with preferential rates for sexual and reproductive health care for young people and adolescents.

All these results corroborate the statement made by a manager from the North Kivu Provincial Gender Division, contacted on the day of the evaluation: "There have been improvements in the advocacy framework. We were talking to the Head of State's principal advisor on sexual violence about the law on repression and reparation for victims of sexual violence. The law is already on the table in parliament, and we're just waiting for the result. At provincial level, we have a budget line for the CTMP. The project provides technical support for CTMP meetings and its sub-committees, and the disbursement of funds for the purchase of contraceptives is monitored by the advocacy sub-committee.

[11] Source: Secondary data-Discussion group, group members Néhémie Kamituga

In terms of coordination, the S-3G project has achieved :

- Helping the two gender divisions to draw up their priority activity plans, so two priority action plans have been set up for two provinces
- Carrying out performance evaluations of the gender divisions,
- Helping divisions draw up roadmaps,
- To support the organisation and holding of synergy meetings between the community players involved in the project.
- Provide technical and financial support to the gender working groups in the two provinces to coordinate the gender division.
- Organising joint missions to monitor project activities under the lead of the Ministry of Gender.
- Support project steering committee meetings under the lead of the Ministry of Gender.

V.2.4. Result 4: Community mobilisation

The community living in the east of the country lives in a context of armed and inter-community conflicts, making the climate favourable to the proliferation of cases of sexual violence on the one hand, and on the other, customs and certain other religions continue to disregard the value and rights of women and girls.
This situation is compounded by the low level of access to knowledge and information for many community members.
The S-3G project has responded to different needs by using a variety of ways and means to bring knowledge of family planning and reproductive health, as well as sexual and gender-based violence, within the reach of the community.
Football matches were used, the media (radio), religious leaders and other members of the community were involved to raise awareness and reach more people, but also through the advertising that was produced.

In the baseline evaluation of the S-3G project, the proportion of individuals who stated that men and women did not often discuss aspects of SGBV in their community was 51.7%. At the final evaluation, out of 47 people interviewed, 14 women and 33 men, i.e. 100%, stated that women participated and were involved in decision-making in their households.
33 of the men (100%) said they were involved in various household tasks. (Drawing water, sweeping the yard, doing the laundry, arranging the bed, changing the baby's nappies, etc.).
This corroborates the results of the final report (Cordaid March 2023), in which 81% (174) of the wives of male members of resilient men's networks said that they had improved their level of decision-making in their household, out of 216 women interviewed.
89% (320) of community members who received coaching are committed to positive masculinity and gender equity out of 360 coached.
This positive improvement in the community's perception of women's involvement in household decision-making and men's participation in household chores is due to the various awareness-raising sessions on positive masculinity conducted by the partner LPI for men in the various health zones supported by the project.

Table 7: Results of pre- and post-test indicators

Description of the indicator	PRE TEST		POST TEST	
	OK	DISAGREE	OK	DISAGREE
1) Women who become pregnant without being married are considered free women and lose the respect of the community.	62%	30%	49%	44%
2 Unmarried women who are poor and have sex in exchange for food are entitled to the same respect as everyone else.	35%	60%	48%	47%

This table shows that negative perceptions of women are declining. For the first indicator, 30% in the pre-test disagreed with the statement that a woman who becomes pregnant without being married is considered a free woman and loses the respect of the community, whereas in the post-test 44% disagreed, a difference of 14%. For the second indicator, 35% agreed that an unmarried woman who is poor and has sex in exchange for food is entitled to the same respect as anyone else, whereas in the post-test 48% agreed, a difference of 13%.

Community mobilisation to combat gender-based violence through the creation of protective communities, mass and door-to-door awareness-raising campaigns and the production of radio programmes.

A woman from the WASI group said, *"Before the S-3G project came along, we were just standing by watching our daughters being tortured by the boys who raped them, and their families could give us just a few goats or nothing at all and we would keep quiet, if not force the girl to go to her husband against her will, while the girl was still suffering inside, but through the awareness-raising and guidance we've received, we now know that it's punishable and we know where we can get support in the event of this kind of problem".*

A man who took part in the focus group of resilient men in the Karisimbi health zone expressed his satisfaction with the relevance of the project in the area, saying: *"We can say that the project has achieved 100% of its objectives and has enabled men to change their behaviour and have a positive attitude towards women, because before the project, men considered women to be slaves in the home. Even when it came to managing property and inheriting family assets, and even in some families, women were not allowed to eat at the table with the men. But this project has made a major contribution to changing this behaviour.*

Table 8: Community perception of pregnant and unmarried survivors

Description of the indicator	Positive perception	Negative perception	Initial level n=30
How do you perceive a woman who has become pregnant without being married as a result of rape?	16(80%)	4(20%)	20
As regards the stigmatisation of girls and women who are victims of rape, how does this manifest itself in your community?	4 (40%)	6(60%)	10
	20 (67%)	10 (33%)	30

Analysis of this table shows that 67% of respondents to the final evaluation have a positive perception of women and girls who have been raped and become pregnant, compared with 33% who have a negative perception. Compared with the baseline study, 59.6% of respondents had a negative perception, compared with 33% in the final study, giving a regression proportion of 55.4%. These results are the fruit of the various community awareness-raising activities carried out by the project's stakeholders in the health zones supported.

V.3. THE PROJECT'S EFFECTIVENESS

This criterion was examined in order to assess the extent to which the project has already achieved its initial objectives. By looking at the summary of achievements in the results framework, it is possible to confirm that the project's objectives have been achieved. The specific objectives achieved are assessed at :

Strategic area 1. Multi-sector response to SGBV

Table 9: List of Axis 1 indicators

	Objectively verifiable indicator	Baseline	Target	% progress since start against target	Full completion of the project
Intermediate results 1	of (S)GBV survivors say they are satisfied with the services offered by the project	63%	85%	99%	84%
	% of survivors of (S)GBV say they have regained stability in their daily activities		50%	150%	75%
Results Immediate 1.1	of survivors of (S)GBV who receive holistic assistance in intervention areas based on their specific needs		100%	92%	92%
Product 1.1.1	# One-stop centres meeting the standard of over 80% quality score	0	8	100%	8
	# new SGBV cases reported in one-stop centres	TBD	1243	135%	1681
	# Transit houses installed, functional and efficient	0	6	100%	6
	# service providers trained (CSO medical and psychosocial care)	TBD	19	105%	20
	# trained legal clinic staff	TBD	10	80%	8
Product 1.1.2	# WITH installed	0	50	110%	55
	# survivors who are members of AVEC and who create and/or	0	125	302%	378

	strengthen an IGA with the support of AVEC				
Product 1.1.3	# Developed and functional Hotline entry points	0	24	88%	21
	of complaints handled	0	1	100%	1
	# community members trained in hotline operations	0	48	250%	120
Product 1.1.4	of healthcare organisations displaying the complete checklist with manuals, SOPs and clinical tools	0	100%	100%	100%
Results Immediate 1.2	% clinical providers who improve and maintain quality in their work with survivors of (S)GBV (to be verified with ARQ)	60%	85%	76%	68%
Product 1.2.1	# of clinical providers enrolled in the mentoring programme	0	76	71%	54
	% Clinical providers who actually take part in mentoring courses	0	80%	110%	88%

This table shows the results achieved from the start to the end of the project. Compared with the targets set out in the results framework, an average of 93.6% of the objectives for this strategic area have been achieved. This is due to the various activities carried out by the project at community level and in health facilities. The One Stop Centre approach was judged to be effective insofar as it enabled survivors to access all services in the same place.

This corroborates the statement made by a nurse interviewed during the evaluation: "*The one-stop-shop approach is very important because it allows survivors to have holistic care and with this approach survivors are spared a lot of shuttling and are also spared the stigma of the community*".

According to the chief medical officers interviewed, the S-3G project has effectively met the needs not only of the health facilities but also of members of the community. One of them said "the use of the one-stop centre is an innovation where survivors receive all services in one place, it's really encouraging and it's this approach that has enabled survivors to respond effectively to their needs and also to our satisfaction as healthcare staff".

In terms of legal and judicial support, 223 cases were recorded in North and South Kivu during the implementation of the S-3G project, 145 complaints were lodged, and a total of 79 judgements, including 54 in South Kivu and 25 in North Kivu, were handed down since the start of the project. Taking into account the context and functioning of the judicial system in DR C, this result is a significant advance for the two years of project implementation.

Strategic priority II. Strengthening health systems

Table 10: List of Axis II indicators

	Objectively verifiable indicator	Baseline	Target	% progress since start against target	Full completion of the project
Interim result 2	% of health facilities that are improving the quality of care for survivors of SVBG	49,00%	80%	106%	85%
	% of health facilities that are improving the quality of care they provide to SSRAJ clients	37,00%	80%	106%	85%
	% of health facilities that demonstrate good stock management of medicines with a score of over 80%.	52,00%	76%	132%	100%
Results Immediate 2.1	% health facility staff improve their knowledge of SGBV and SRH services for adolescents	TBD (See post-training test)	80%	94%	75%
Product 2.1.1	# key health centre staff trained in gender-sensitive and youth-friendly SRH services	0	48	135%	65
	# Clients using family planning and contraception services in 24 health centres in six health zones (>75% women)	TBD	65619	95%	62045
	% spaces adapted to young people, equipped with functional audio/visual equipment	0	100%	100%	100%
Product 2.1.2	# new SGBV cases reported in health facilities excluding one-stop shops	0	3730	70%	2623
	# service providers trained (CS / medical and psychosocial PEC)	0	57	84%	48
Results Immediate 2.2	of PSPs with zero stock-outs of SRH / FP and (S) GBV products one year after the start of the programme for products available at provincial level	TBD	75%	113%	84%
Product 2.2.1	# of providers trained in SCM at BCZ and FOSA level	0	270	105%	284

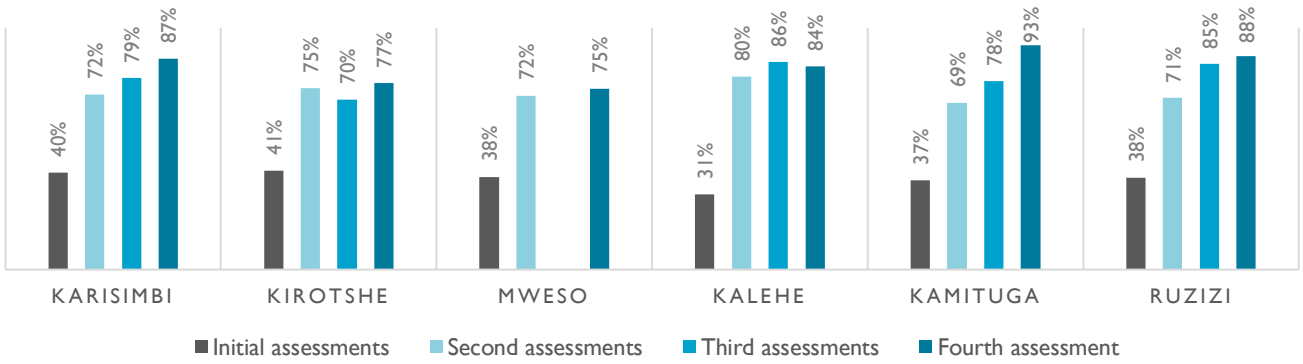
	Number of days SSR/PF and SGBV products were out of stock at the zonal pharmacy	9	0%	#DIV/0!	0.73
Product 2.2.2	% of PPSs in the targeted health zones are supplied by IPM 1 year after the start of the programme.	0	100%	100%	100%
	Number of DACs installed and operational	0	35	106%	37
Product 2.2.3	# of functional CTMP Logistics and Info sub-committee	0	2	100%	2

This table shows the results achieved for strategic axis 2, with an average of 93%. It should be noted that these results are due to the various activities that the project has put in place and which have been the basis for achieving the results. The key indicators for this area are the availability of inputs (FP and PEP kits) in health facilities. It should be pointed out that the availability of inputs is due to the IPM approach, which has been operational and which has ensured that the facilities do not run out of inputs following the activities of the members of the CAD (Distribution Axis Committee) who transport the inputs from the health zone to the various care facilities.

During the evaluations, the nurse in charge of one of the facilities stated that the inputs were available in the facilities: "*This project has contributed to the prevention of unwanted pregnancies among young people and to birth spacing thanks to the availability of the relevant inputs in the health facilities, in particular PEP kits and condoms, but also thanks to the community awareness-raising sessions*".

According to a health worker we met: *"Before the project, we were able to record 17 to 20 births per quarter, but now we can't even manage 05. You already find the girls chasing away the boys who are taking advantage of them, telling them: I no longer agree with your practices, because everything you're looking for in me I've already been taught at the centre. That's how even the rate of teenage pregnancies is reduced here.*

Figure 6: SRH quality assurance assessment, North and South Kivu health zones



Source: Report on the evaluation and analysis of the SGBV and SSRAJ card scores and the survivors' satisfaction survey on the service offered by the project, February 2023.

On the basis of these analyses reflected in this graph, a significant change was observed between the first evaluation and the fourth evaluation carried out by the project. This analysis shows that all the structures

doubled their score performance, ranging from an average score of 37.5% (first evaluation score) to 84% (fourth evaluation score). This shows the excellent performance of the S-3G project's contribution to quality assurance of the Sexual and Reproductive Health and Rights of Adolescents and Young People (SRHR) in the 6 health zones benefiting from the S3G project. The Kirotshe and Mweso health zones were ranked last in terms of performance. This could be due to the security situation, which remains precarious in these two zones and which does not provide a favourable working environment for the proper implementation of a better health system and for ongoing monitoring.
According to some of the strategic players we met (PNSA, PNSM, Gender and Health Divisions, BAT, Ministry of Gender and Health), the system is adapted because the service providers were selected beforehand and were able to provide holistic care for survivors and train all age groups of young people and women in reproductive health to their complete satisfaction.

In an interview with the Ministry of Gender in North Kivu, he confirmed the effectiveness of the health system, saying: "*Yes, because the service providers have confirmed this to us, and you should know that they are the ones who are most concerned. When we visited the Karisimbi health zone, we found victims who were benefiting from this service, because my field team made quarterly visits*.

As for the Ministry of Health in South Kivu, "*the availability of PEP kits, contraceptives and family planning methods, without stigmatising the support provided, was comprehensive. Access to information on sexuality is also part of the success of the S-3G project's health reinforcement system*".

Strategic area III. Governance and advocacy on GBV

Table 11: List of indicators for Axis III

	Objectively verifiable indicator	Baseline	Target	% progress since start against target	Full completion of the project
Interim result 3	# GBV policies that are changing to improve the lives of survivors		3	0	0
	of advocacy activities carried out		80%	102%	82%
	# of stakeholders involved in GBV activities		90	76%	68
Immediate result 3.1	Number of state structures with a functional VMS data management system	0	2	100%	2
Product 3.1.1	# full assessment carried out	0	4	75%	3
	# action plan for priority activities	0	1		0
Product 3.1.2	# customer needs assessments	0	4	50%	2
Immediate result 3.2	% of stakeholders involved in the fight against (S)GBV who take initiatives to promote gender equity through coordination actions	0	80%	125%	100%
	of customers benefiting from services who say they were referred by partner organisations	0	75%	24%	18%

Product 3.2.1	# coordination meetings involving health centre staff, women's groups and community representatives	0	96	75%	72
	# stakeholders involved in advocacy activities	0	90	76%	68
Product 3.2.2	# reference lines set up and functional	0	72	100%	72
Product 3.2.3	#Roadmap drawn up	0	2	100%	2
Immediate result 3.3	Level of involvement of the government (including decisions taken during implementation) in implementing actions to combat GBV	TBD	2	100%	2
Product 3.3.1	# Capacity building plan for DPGFE divisions	0	6	67%	4
Product 3.3.2	# Provincial (S) database on GBV supported and operational	0	2	100%	2
	# Learning data report / Documents of successes and best practices produced and disseminated	0	14	14%	2
Immediate result 3.4	% community leaders who adopt positive attitudes towards gender and SRH	TBD [Pre and post test]	100%	100%	100%
	% of advocacy actions carried out by women's rights organisations that resulted in	0	1	#DIV/0!	0
Product 3.4.1	# community leaders involved in gender promotion activities, SRHR and the fight against (S)GBV	0	480	73%	355
	# of women members of women's rights organisations who are involved in advocacy activities	0	60	200%	120

In view of this table, activities relating to governance and advocacy on sexual and gender-based violence were carried out at an average rate of 71.2%.
However, certain specific objectives, such as :

- Number of state structures with a functional VSBG data management system: 100%.
- Number of provincial SGBV databases supported and operational: 100%.

These two specific objectives corroborate the statement made by an executive from the gender division in North Kivu: "*Yes, the interventions have made a positive contribution. If I can stay at the level of advocacy, thanks to this project there have been changes in the budget lines for the commune of Goma. When the budget was drawn up, they included a budget line for the purchase of contraceptives, which didn't exist before. In data collection, we have received technical support, we have strengthened the capacity of the gender focal points and*

data collection service providers, and we have provided the division with tablets for data collection, to show that nothing can become a bottleneck in achieving the objectives".

Strategic area IV. Community mobilisation

Table 12: List of indicators for Axis IV

		Objectively verifiable indicator	Baseline	Target	% progress since start against target	Full completion of the project
55	Interim result 4	% populations in the intervention areas who adopt positive attitudes in relation to gender.	18.5% on average have a negative perception of gender (R.2.34 to R.2.37)	10%	89%	89%
55	Immediate result 4.1	% of community members with positive attitudes towards gender and SRH	15%	80%	92$	74%
56	Product 4.1.1	of women of men members of resilient men's networks who say they have improved their level of decision-making in their household	TBD	50%	161%	81%
57		of community members committed to positive masculinity and gender equity	0	70%	127%	89%
58		# community focal points (Codesa- SGBV) trained in prevention, protection and response to SGBV.	0	120	100%	120
59		% community members (parents, religious leaders) involved in the SRHR of adolescents and young people	0	60%	157%	94%
60	**Product 4.1.2**	Percentage of members of community structures involved in the prevention, warning, guidance and protection against GBV at the local level (Néhemie, WASI and the youth association).	0%	60%	69%	42%

61		# A safe, functional space for young people	0	24	104%	25
62		# youth associations supported that demonstrate a high level of capacity score	0	20	120%	24
63	**Immediate result 4.2**	% community members improving their knowledge of GBV and SRHR	77%	85%	97%	83%
64	**Product 4.2.1**	# of radio programmes broadcast	0	48	150%	72
65		# volunteer counsellors with access to the "Rape Counseling" application and trained in its use	0	120	96%	47 68

The table shows that an average of 95.25% of planned activities have been completed. This achievement is due to the various activities carried out by the project at community level, which were successfully completed.

On the day of the evaluation, we affirm that the project has worked on negative perceptions of gender and in the promotion of the sexual and reproductive health rights of adolescents and young people. The testimonies below corroborate the results shown in the table above.

Testimony of a member of the OCB met and interviewed in Kamituga: *"Our area is still a young town, before it was given this town renown, it was under the sway and predominance of ancestral custom (to be called a man you have to go and see KIMBILIKITI for rites) but since this endowment, these customs have started to change. Many of the 15-20 year olds who had undergone training under the S-3G project had gone to see KIMBILIKITI and were considered to be very powerful. They couldn't be sent to mill, knead, cook, sweep, etc. These jobs were reserved only for his sisters. But thanks to this project, these young people have understood that housework is not just for girls, even though they have been introduced to these different customary practices. Thanks to a lesson entitled "Are boys different from girls?", these young people are now starting to knead, sweep, etc. It's a bonus for this project, because we're seeing a change in behaviour".*

Testimony of a woman interviewed in Kamituga*: "Before, we didn't even discuss it, he would come and tell me he needed to make love and I couldn't even discuss it; but now, he's starting to prepare me and if I'm not ready, I tell him and then he understands me".*

Testimony of a woman interviewed in Kamituga *Before, our husbands couldn't help us with certain household chores, which were reserved for us women alone because of customary rules, but thanks to this project, our husbands have changed. They often sweep the yard, help us spread and unshade the cassava, and give food to the children too.*

Testimony of a resilient man from Kalehe *"For me, as a resilient man, this sentence cannot be taken too much into consideration because it is not only the man who must have a say in the home or in society, the woman's opinion must be taken into consideration to avoid this imposition. The man must avoid imposing his ideas on his partner in order to prioritise peace and family harmony but also for the family to flourish. The man must avoid imposing his ideas on his partner in order to prioritise peace and family harmony but also for the family to flourish".*

V.4. THE EFFICIENCY OF THE PROJECT

The project began with the baseline study, which involved the beneficiaries in determining their needs. The evaluation found that the needs analysis was well done and that the necessary resources were available to meet them. The various stakeholders were involved, especially in determining the activities to be carried out in the respective project areas.

Generally speaking, according to key informants and some of the project's direct and indirect beneficiaries, the project's resources were used rationally to achieve the project's objectives, as the expected results were achieved within the allotted time with the resources allocated to the project. The activity schedule was impacted by several external factors already listed above, but adjustments were made to maintain the achievement of results.

The members of the implementation staff met as part of this evaluation showed that the project's resources were allocated to the project's activities while focusing on the priorities and expected results, which enabled the project's objectives to be achieved.

During the mid-term evaluation, it was reported that there was a problem with referring young people to STI services. The latter do not fully provide STI care, and the cost is often beyond the means of these young people, who are often students and wish to be treated without their parents' knowledge. This discourages some young people of limited means. What's more, the cost of consulting young people in the care facilities, although reduced to 80%, is an obstacle for a section of young people from poor families. Despite this, the financial resources provided have enabled all the project's activities to be carried out successfully to date.

During the final evaluation, there was a clear improvement in access to STI treatment services for young people in health training. This improvement is due to the preferential rate resulting from the project's lobbying of nurses in the various health centres supported by the project.

A young person from Kamituga explains: "*The various awareness-raising sessions have helped to reduce the use of self-medication for STIs. Before this project, when a young person was infected with an STI, he couldn't go to hospital for treatment, so they would take a glass of the local drink (Kanyanga) with chloramphenicol as a remedy, but to no avail. But thanks to this project, young people have started going to the health centres for treatment, and there has now been a significant reduction in the number of STIs in Kamituga*.

V.5. THE IMPACT OF THE PROJECT

The S-3G project aimed to improve the stability, health and well-being of girls and women in eastern DRC by reducing SGBV and meeting the needs of the population in terms of SGBV and SRHR.
Following various assessments, it was observed that :

- Access to holistic care thanks to the installation of OSC,
- Good care for survivors of sexual violence and young people by strengthening the capacity of healthcare providers
- A positive change in community perceptions of social relations between men and women (an average regression of 55% compared with the baseline study);
- Easy access to the SSR for young people and adolescents
- Referral and counter-referral (community to health centre, health centre to CSOs, CSOs to tertiary structures).

All these results corroborate the statements made by various people interviewed during the final evaluation:
Before the S-3G project, there was an upsurge in conflicts between the victim's family and that of the alleged perpetrator, but also the children born of rape were a source of conflict within the victim's family," explains a respondent interviewed during the survey. Thanks to the S-3G project, the perpetrators of rape and violence have been brought to justice and some have been convicted, while the victims have received care and been reintegrated into society. This has considerably reduced conflict within the community," he continues.

According to a health worker we met: *"Before the project, we were able to record 17 to 20 births per quarter, but now we can't even manage 05. You already find the girls chasing away the boys who are taking advantage of them, telling them: I don't agree with your practices any more, because everything you're looking for from me I've already been taught at the centre. That's how even the rate of teenage pregnancies is reduced here.*

According to an AVEC president in Kamituga: *"The greatest success of the S-3G project is the existence of AVEC in our community, which has healed many hearts because once stressed, plus the financial crisis, this led men to bump into their wives every time. With this AVEC we are already developing a life together, the problem of one has become the problem of the other, we borrow money to pay back and the stresses no longer seem to exist.*

V.6. SUSTAINABILITY OF THE PROJECT

The capacity-building acquired by health providers, operational CSOs, the availability of RH/FP inputs in facilities, operational AVECs and youth CBOs are all achievements that will help to ensure the sustainability of activities.

The issues of improving the health and well-being of women survivors of SGBV and adolescents in terms of sex education and reproductive health are still there, and the mechanisms put in place will not stop.
During the final evaluation of the project, community members showed that they would continue to raise awareness of SGBV in the community despite the end of the project because they had received this training for the well-being of the community.

Statement from an SOS SIDA staff member: *"Yes, some will follow, for example, at community level we have trained supervisors who are members of the community. We used local labour, the supervisors are from the health areas, and the young people affected by this project are from the community. Last December, an exit workshop was held at which all the supervisors and CBO managers made commitments to ensure that the project's achievements, including awareness-raising and sex education sessions, are sustained*.

Statement by a doctor at the Goma military hospital*: "Yes, the effects of the project will continue because it is already a success. The service is already in place and the staff have already been trained to administer appropriate care to survivors and will continue to do so.*

This same category of respondents demonstrated their arguments by saying that sustainability would be conditioned by the recovery of costs for the care of survivors in certain structures.

This is the case of the statement made by the nurse at the Methodist Health Centre, which can be summed up as follows: "*Yes in*
At the health centre, we'll continue to provide medicines, but this time we'll pay for them. In short, the services will be available, but people will start paying for them.

In other facilities, however, examinations are free, but some services are chargeable (legal services and psychological care). In Kamituga, however, the service providers have developed strategies for referring cases to the PANZI Foundation for legal and judicial support.

The project has been implemented in the hospital and as long as the hospital exists, the activities will continue but with suffering. As for the services that will disappear, we can see that legal support has already disappeared, even before the end of the project. Now all we do is refer cases to the Panzi Foundation, with Cordaid's authorisation.

The community leaders interviewed during the evaluations showed that the change in community behaviour through awareness-raising and training, which has even changed social norms and laws, will not only be sustainable but also long-lasting. This is justified by :

- Capacity-building for health workers, which is a valuable addition to their knowledge of the job they do every day
- Income-generating activities through AVEC will be sustainable
- A change in certain customary norms regarding the consideration of women in decision-making within society, with the integration of positive masculinity.

These are significantly positive effects that will be long-lasting within the community.

Sustainability of project results: For the respondents interviewed during this evaluation, the Village Savings and Loans Associations set up by the project, and the training materials made available to Safe House, can continue with the subsidies granted to the survivors, which have enabled them to develop income-generating activities with small businesses and livestock. These funds will enable them to continue to pay their membership fees and keep these economic structures running. AVEC members have been given skills that will help them manage their economic, family and social activities and that will serve them throughout their lives.

Although the members of the community we met were certain of the sustainability of the project through the IGAs set up, a significant proportion thought the opposite. According to them, the amounts

injected into the AVEC vary between 20 USD for the individual IGAs and 400 USD for the collective ones and do not reflect the local reality, and cannot continue to serve them, and also the lack of conscience of certain members, who after having been served, no longer return for the deposit. Data from the document review show that the average value of shares purchased is 828,423.7 CFA francs in North Kivu and 892,183.33 CFA francs in South Kivu.
Another opinion was that medical care for survivors will continue even after the project. However, for some of the Titulaires we met, they ensure this sustainability but fear that stocks of inputs will run out, that trained staff will be transferred and that care will have to be paid for after the project.

For other respondents, the sustainability of the project is ensured through several training courses offered to community activists, religious leaders, community members involved in Nehemia committees, youth CBOs, groups of resilient men and resilient women, who remain people living in the communities who have been empowered and who will continue the fight against SGBV through awareness-raising. The rehabilitated One Stop Centres will also continue to welcome community members to continue holistic care.

Factors favouring sustainability: The factors favouring the sustainability of the interventions of this project are that the implementation was done by local organisations whose staff are implemented within the same communities and who have the confidence of the community and to whom the beneficiaries can turn for advice for the continuity of their activities. Religious leaders, young people, women and community activists have played an important role in the implementation of this project's interventions and are members of the community who have the trust of their leaders (members of the community) and who will continue with their civic and religious duties to raise awareness among members of their respective groups on the promotion of women's rights at no cost whatsoever.

Factors hindering sustainability: Some of the effects of this project will not be able to continue for a long time or survive beyond the end of the project. Legal and psychological care will not be able to continue after the end of the project because their continuity requires funds that neither the health service providers nor the Health Division will be able to obtain to continue offering this package of services to victims of sexual and gender-based violence. The persistence of insecurity in the intervention zones, with a consequent increase in cases of rape and violence against human rights and women's rights in particular, could reduce the project's efforts to zero by creating high demand and overflowing health facilities.

Statement by a leader in Kamituga on the sustainability of the project: "*Applying what has been learnt in training, in particular good personal hygiene practices, gender equality, being an ambassador for change within society, honouring commitments made during training, recharging one's batteries in terms of personal development*".

Table 13: Participants' views on the sustainability risks of the S3G project

RISKS						
NEHEMIE	PARENT LEADERS	RESILIATED MEN	OCB	SERVICE SUPPLIER	SAFE HOUSE	WITH
No confidentiality War	-Community relaxation in the commitments made, -Transfer of care staff -War	-War, -Rotation of trained health workers, -Discouragement	-Political instability, - insecurity -Shortage of inputs, -unavailability of care	-Absence of lawyers and psychologists, -lack of inputs, especially	Lack of further awareness-raising by the NEHEMIE group,	Breakage of inputs, especially

	-Breakdown of STI treatment inputs, -Unavailability of services at facility level			antibiotics for young people, -security -War	-Failure of WASI to supervise girls in trade apprenticeships -war	PEP kits

V.7. WEAKNESSES RAISED BY PARTICIPANTS IN THE EVALUATION

- According to the observations made in the field during data collection, socio-economic reintegration seems to be one of the approaches that did not meet with the satisfaction of the beneficiaries, followed by legal and judicial support. In some of the areas surveyed, there were multiple AVECs in the same community (AVEC 1 and AVEC 2) set up by the same project. This created conflict within the community, and some respondents criticised the strategy used by the S-3G project in implementing these savings and loan activities. According to them, when members of AVEC groups were told that this group was for you, some received loans and no longer came back with the money to repay the loans granted, which currently weakens the groups. And afterwards, some others will create their own groups, that's how there are multiplications of AVEC in the same community. And those who remain with the groups founded by the S-3G project and who still show some stability say that when the project comes to an end, they will leave too. Another factor that has led to the weakness of the socio-economic reintegration component is the amount given for reintegration, around $20 for individual IGAs and $400 for collective IGAs. According to some of the participants we met, the sum ($20) allocated to individual activities is insignificant compared to the current cost of living and cannot enable a survivor to start up any profitable income-generating activity.
- Poor coverage of health areas in the intervention zones.
- Conflicts between men trained without their wives,
- Stigmatization created by the insufficient amount of money available to reintegrate survivors into their households,
- Lack of involvement from the parents of the children involved in the project, which led to misunderstandings between the children and their parents.

V.8. LESSONS LEARNED

- This section seeks to analyse the lessons learned during the planning, management and implementation of this project which can be capitalised on by Cordaid to enable it to make improvements for future projects and Cordaid's strategy. According to some health facilities, the bonus intended for them was insufficient to encourage them to carry out their activities properly. One facility, for example, received $200 for 17 staff. As for some HPAs, they felt that channelling their bonus through their hierarchical superiors was not a very encouraging approach, as it is often a source of conflict between subordinates and superiors, and they encouraged individual payment instead. These service providers say that they were not consulted on this issue in order to gather their views.
- The implementation of the One Stop centre ! approach is contributing to survivors' satisfaction with the care they receive and is gradually helping to bring about change in the fight against GBV in the areas concerned, as it uses new holistic care strategies in a single unit and strengthens survivors' confidence in confidentiality. This approach could serve as a basis for other partners in the intervention areas.
- The installation of community groups in the S-3G project intervention zones has been a great success for the project in the SGBV prevention and reproductive health process. This strategy brings together religious leaders, young people and men, all of whom are considered to be key players in the promotion of women's rights. They have a major role to play in eradicating harmful practices caused by backward customs, and are responsible for encouraging people to change their attitudes.
- According to some of the resilient men they met, it was necessary to organise the training sessions as a couple and not each group separately to encourage discussions between the couples. For some, their wives accused them of vagrancy when they went to the resilient men's training sessions.
- Support for the organisation of the youth corners and Safe House is a factor that has motivated community leaders to become more involved in awareness-raising. This has encouraged community leaders to organise more meetings to discuss issues of rape and reproductive health. For some respondents, the provision of working materials and a start-up fund was a motivating factor and would attract their commitment.
- The availability of visibility, according to some respondents came at the end of the project, and for so much this should be available from the beginning to strengthen community acceptance.
- There have been gradual changes in the attitudes of the stakeholders, with new knowledge leading to the adoption of new attitudes through the introduction of new practices in the daily lives of the stakeholders concerned (discovery of care, autonomy, social integration, socio-economic empowerment of women, group work, discovery of one's own body, responsible sexual attitudes, integration into family life, application of contraceptive methods, combating STIs).
- Talking about gender-based sexual violence is no longer a myth but a reality, unlike the secrecy that community members used to keep about it. Among young people, children, adults and other leaders, there is plenty of evidence of denunciation, especially by men.

VI. CONCLUSION AND RECOMMENDATIONS

VI.1 Conclusion

Relevance

The S-3G project implemented through the One Stop Center in the 24 health centres aimed at contributing to stability in the two provinces was deemed relevant by community members and leaders in the area. The activities relating to prevention, response to sexual and gender-based violence (SGBV) and improving sexual and reproductive health and rights (SDSRSDSR) have met the needs of the community.

Efficiency

The S3G project was judged to be effective because it achieved its expected results by around 90%. The One Stop Centre approach has been judged to be effective in that it enables survivors to benefit from all the services in one place.

Efficiency

Generally speaking, the project's resources were used rationally to achieve the project's objectives, as the expected results were achieved in the time available with the resources allocated to the project.

Impact

The S3G project has had a positive impact, with a positive change in negative perceptions of social relations between men and women (an average regression of 55% compared with the baseline study) and access to holistic care thanks to the establishment of CSOs.

Durability

The community has provided evidence of the project's sustainability in the intervention zone. Community members have shown that they will continue to raise awareness about GBV in the community despite the end of the project, because they have received this training for the well-being of the community. The capacity building acquired by the health providers, the operational CSOs, the availability of RH/FP inputs in the facilities, the operational CBOs and the youth CBOs are achievements that will contribute to ensuring the sustainability of the project. It should also be noted that the use of local labour is an element that will ensure the sustainability of the project.

VI.2 Recommendation

Based on the results of discussions with key informants in the field, implementing partners and beneficiaries, a number of recommendations were made for improving Cordaid's future programming.

For Cordaid

1. The aim is to give victims of sexual violence peace of mind and help discourage the culture of impunity for those who abuse women and girls, especially in a context where cases of sexual violence are recurrent,
    - *It is very important to organise mobile court hearings in all the intervention zones to try the perpetrators and to plead for more flexible legal procedures, which often discourage victims.*

2. Some men feel that when women are able to provide for the family, it diminishes men's power and influence in the family sphere. This can lead to domestic violence and undermine the progress already made in changing behaviour.
    - *Intensifying awareness-raising among couples and involving men in activities is relevant to preventing any domestic violence that may arise in the home when men and women do not have the same understanding.*

3. The socio-economic reintegration component seems to be the one that has not been well appreciated by the beneficiaries. The amounts injected do not reflect the local reality, which is why the members of the AVEC have become lax.
    - *The evaluation team recommends carrying out a market study before the start of the reintegration programme in order to meet the needs of survivors in accordance with local realities, but also to develop strategies that can lead to the sustainability of the AVECs that have been set up.*

For the financial backer

1. The health service providers, while praising the efforts made by Cordaid and the donor, the Embassy of the Kingdom of the Netherlands, feel that the coverage in terms of the number of health areas sprayed by the interventions of this project is not sufficient, as there are several health areas in the same health zones and other health zones which are still heavily affected and which need the intervention package provided by this project.
    - *Health service providers recommend integrating new health areas and, why not, new health zones in order to reach many GBV survivors and other vulnerable people.*

For government departments

A. DPS

2. During interviews with some healthcare providers, they were concerned about the return of stock shortages in health facilities. The DPS, via BAT/PNSR, is the regulatory body for the supply chain of essential and generic medicines at provincial level (North and South Kivu),
    - *The evaluation team recommends that TAOs/NRHPs make inputs available in the health zones and monitor their use.*

B. BCZs

1. According to some respondents to the evaluation, one of the factors hindering the sustainability of S-3G project activities is the change and reassignment of health facility staff who have benefited from capacity building thanks to the S-3G project.
    - *The team of evaluators recommends that the BCZs not only ensure the stability of the providers who have received training in their health facilities, but also encourage them to organise sessions for members of the health facilities to share and transfer the skills they have received.*

C. FOSA

1. According to some respondents to the evaluation, the fear of continuity in the legal and judicial handling of SVS at the level of CSOs

The evaluators recommend that healthcare providers refer any cases that have expressed a need for legal and judicial support to other projects with the same objectives in the health zones (Heal Africa in North Kivu, Fondation PANZI in South Kivu, etc.).

VII. APPENDICES

Appendix 1: The different transcriptions
Appendix 2: Start-up report
Appendix 3: Collection tools
Appendix 4: S-3G intervention map.