Research and Training
FrontiersGroup
For Evidence Based Decisions

Baseline Study: Stamping Out and Preventing Gender Based Violence (STOP GBV) in Zambia

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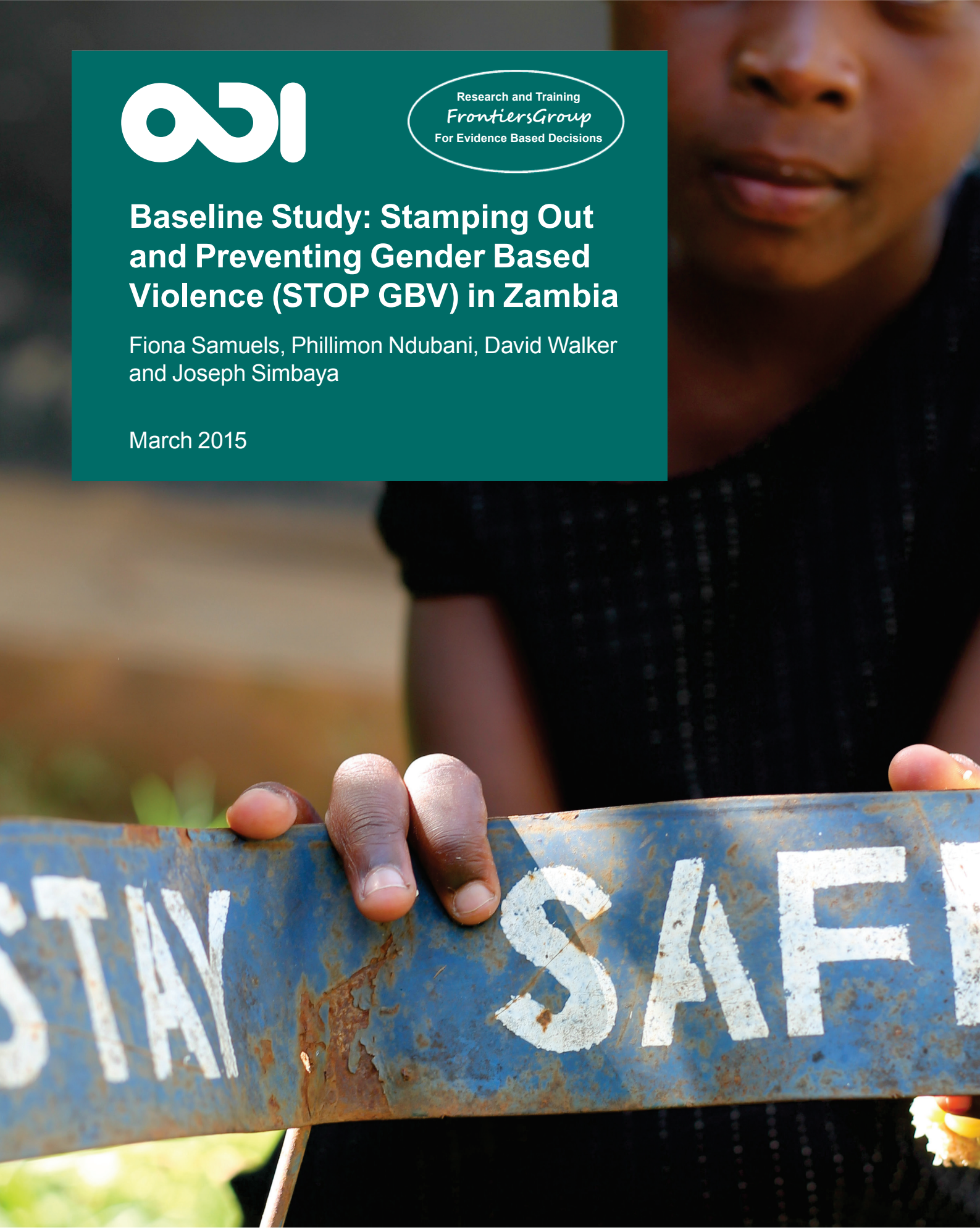

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
CSO	Central Statistical Office
DFID	Department for International Development
DHS	Demographic and Health Survey
FGD	Focus group discussion
EIGE	European Institute for Gender Equality
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
GBVSS	Gender-based Violence Survivor Support
GIDD	Gender in Development Department
HIV	Human immunodeficiency virus
ICRW	International Centre for Research on Women
KII	Key informant interview
MCTA	Ministry of Chiefs and Traditional Affairs
MCDMCH	Ministry of Community Development, Mother and Child Health
MGCH	Ministry of Gender and Child Development
MDG	Millennium Development Goal
MOH	Ministry of Health
ODI	Oversees Development Institute
OSC	One Stop Centre
PEP	Post-exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
SEA	Standard Enumeration Areas
SPSS	Statistical Package for the Social Sciences

STI	Sexually Transmitted Infection
STOP GBV	Stamping Out and Preventing Gender-Based Violence
ZDHS	Zambia Demographic Health Survey
VAW	Violence Against Women
UNFPA	United Nation's Population Fund
UNICEF	United Nation's International Children's Fund
UTH	University Teaching Hospital
USAID	United States Agency for International Development
VSU	Victim Support Unit
WHO	World Health Organization
WLSA	Women in Law for Southern Africa
WV	World Vision
ZCCP	Zambia Centre for Communication Programme

Executive summary

Gender-based violence (GBV) in various forms is commonplace in Zambia. Demographic Household Survey (DHS) data indicates that from the age of 15 years onwards almost half of all Zambian women have experienced physical violence, and a third had experienced physical violence in the 12 months preceding the survey. Factors contributing to GBV include sexual cleansing rituals, initiation ceremonies, women's economic dependence on men, socialisation of boys and girls at home and in school, inadequate laws on GBV and domestic violence, a lack of law enforcement, and intimate partner violence (IPV) (DHS, 2007).

This study provides a baseline to measure programme results, impact and long-lasting change at the end of the STOP GBV Programme led by World Vision (WV), Women and Law in Southern Africa (WLSA) and Zambia Centre for Communication Programme (ZCCP) in six districts of Zambia: Chingola, Kalomo, Monze, Mpika, Mumbwa and Nyimba. Given the focus of the STOP-GBV Programme the study focused on three main areas: GBV Survivor Services; Access to Justice; and Prevention and Advocacy.

The baseline study used secondary data review and analysis as well as collecting and analysing primary data using both quantitative and qualitative approaches: quantitative data was collected through a community survey and qualitative data through in-depth interviews with One-Stop Centre (OSC) personnel, other service providers and GBV survivors and Focus Group Discussions (FGDs) with community members. Quantitative analysis was carried out using Epi-Data and exporting the data to SPSS. All qualitative interviews, with appropriate consent, were recorded, translated and transcribed. Themes and sub-themes formed the basis of the coding structure for the transcripts, which were analysed manually. The baseline study observed relevant institutional and national requirements for ethical review: the Overseas Development Institute (ODI), through its Ethics Review Committee, ensured that the methodological tools and proposal were reviewed and approved and in Zambia both were submitted to ERES Research Ethics Committees for review and approval.

A note on definitions

This study drew on the Gender-based Violence Information Management System (GBV-IMS)[1], which identifies six forms of GBV: rape, sexual assault, forced marriage, denial of resources, opportunities or services and psychological or emotional abuse. These six forms of GBV were used as categories in the survey questionnaire, and additional sub-categories reorganised from standard DHS were used in order to leave as many options as possible for respondents to identify forms of GBV.

Findings

Description of the One-Stop Centres (OSCs) according to key informant interviews

Most of the service providers interviewed could articulate the goals and objectives of the programme in general and the OSC in particular, though they were less familiar with the various components of the programme. Both OSC staff and associated partners expressed optimism that the programme's goals and objectives would be achieved, though they pointed to a number of challenges including lack of transport, the need for shelters for survivors, limited information dissemination and issues of sustainability. Furthermore, existing protocols and guidelines were not available or easily accessible at the OSCs in all districts.

The main target group of the OSCs, according to respondents, were survivors of GBV – male and female – and were usually from lower socio-economic categories. The average number of GBV survivors seen by the OSCs

1 Gender-based Violence Information Management System, http://www.gbvims.com

was estimated at two to three per day in all districts. The reported monthly estimate based on experiences over the few weeks the OSCs had been open, ranged from 30 to 40 in all districts.

In terms of specific services the OSCs offer, the respondents outlined in detail what they and their partners provided or hope to be providing. These included (a) medical services provided by qualified health professionals, including emergency contraception and testing and treatment for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV); (b) on-going psychosocial counselling; (c) legal services – this was less clearly articulated by key informants since at the time of the study the programme activities had just started in these districts and the partners providing such services did not appear yet to be fully integrated into the OSCs; (d) information dissemination – information is provided to GBV survivors and through community sensitisation; and (e) shelter or safe houses – although all respondents knew about these shelters, they were not yet available in any of the districts.

There were mixed views concerning whether the staffing was sufficient, i.e. some thought it was adequate (e.g. in Kalomo and Mumbwa), while others believed that as the workload and demand increased, it would be insufficient. Additionally, since some of the OSCs are staffed by government employees, according to respondents, they may not be available as and when needed at the OSCs due to other government-related demands. In terms of staff training and technical capacity, in all the districts staff had attended training on various aspects of the STOP GBV programme. While they were confident in their abilities, some felt they needed more and better focused and specialised training. There was some suggestion that infrastructure was a challenge with offices being housed in containers, though this is likely to be a teething problem. In almost all the districts, the informants mentioned the problem of transport, in the absence of which they could not reach many communities with the GBV prevention and response services available at the OSCs.

All respondents reported that networking and referrals among a range of departments (health, social welfare, police (through the Victim Support Unit –VSU), the judiciary (through the courts), local council and the District Commissioner's office) were critical to effectively deal with GBV. In some districts this networking and referral appeared to be effective (e.g. Mumbwa). When this was not, it posed challenges as was pointed out in Kalomo, where one respondent felt that the hospital was not yet fully aware of the OSC and that this resulted in delayed referrals and treatment. Networking within the STOP GBV Programme and at different levels, and importantly involving the community and traditional leaders, was also seen as critical by most respondents, and was already starting to happen in many districts.

Socio-demographic description of respondents in the community survey

A total of 2,053 people participated in the baseline community survey, 58.5% of whom were female. The mean age was 31.85 years. Most respondents had received some form of formal education (96.3%). The highest (55%) proportion of respondents were in a monogamous marriage and cohabiting accounted for the lowest (0.1%). When asked about who was the main decision-maker in their household, 58% of respondents said that decisions were made by a woman and a man while 25% said the main decision-maker was a man and 17% said that it was a woman. In terms of occupation, the majority (41.1%) had no formal employment, about 21% were farmers, 15% were labourers and 23% were involved in business.

Knowledge of and attitudes towards GBV

When respondents were asked to define GBV using the GBVIMS categories, physical assault was mentioned by 81.2%, followed by rape (33.6%). Denial of resources was the next most frequently occurring definition (21.1%) followed by psychological and emotional abuse (18.8%).

Most (75.5%) had a low level of knowledge about GBV, and although men knew slightly more than women the difference was not statistically significant. Respondents in Mpika had the highest proportion of respondents who demonstrated a low level of GBV knowledge (86%) while Nyimba had a relatively high proportion who demonstrated correct or moderate knowledge (32%). A cross tabulation of knowledge level with place of residence revealed that a slightly higher proportion of rural respondents demonstrated a low level (43.8%) than those from urban areas (31.7%). The level of knowledge about GBV did not differ with education level and wealth quartile.

According to the qualitative data, definitions of GBV included women being beaten, usually by their husband; men engaging in forced sexual intercourse with young children, also referred to as rape or defilement; women being forced to have sex; mistreating and abusing children in terms of neglect or making them do hard or difficult work, and thus preventing them from studying; forced early marriage; and a broader sense of women's and rights being infringed. Reported causes of GBV included lack of harmony, love and respect, with the converse being feelings of jealousy, envy, betrayal and misunderstanding; a woman not fulfilling her expected role, including not dressing appropriately and so seen to be encouraging GBV; men not fulfilling their role as the main breadwinner; the abuse of alcohol and narcotics, mostly on the part of men but also women; early marriage, which appeared to occur in all study sites; the lack of legal recourse or punishment of the perpetrators of GBV; children being disrespectful and misbehaving; and a lack of advice, parental care and teaching regarding how to behave – all of which, according to respondents, caused GBV. Few respondents mentioned traditional ceremonies or practices more generally and in particular as fuelling GBV. Those who were asked tended to say traditional ceremonies were no longer happening and there was also a more general narrative around how nowadays people are 'not taught properly' and that while previously traditional practices had a purpose, e.g. for instructing boys and girls on how to behave in marriage, this was no longer the case and the positive aspects of these practices are slowly being lost.

Prevalence and change in the incidence of GBV

A quarter (25.4%) of respondents in the quantitative community survey felt that GBV was declining, while others either said it had not changed (19.3%) or they did not know (19.7%). When asked whether GBV was common in their community, about half (50.4%) of all respondents said it was. There were slight differences across districts with Mumbwa recording the lowest proportion of respondents who felt that GBV was increasing (35.3%) and Nyimba recording the highest (57.7%).

According to perceptions from respondents in the Focus Group Discussions (FGDs), in all districts, except for Mpika (where views were mixed), respondents saw GBV as remaining at the same level or even rising. Reasons cited included the lack of recourse and that both formal (police) and informal (headman/chief) structures were unable to control it; that children are abusing the knowledge they have gained about their rights and misbehaving, which also led to GBV; that seeing friends and (often older) family members committing GBV perpetuates it; and that population pressure has also led to an increase in GBV.

Characteristics of perpetrators and survivors

According to respondents in the quantitative community survey, about 80% of perpetrators are male with a mean age of 39.79, and the majority were married to their victim (67%). This was confirmed by respondents in the FGDs, i.e. most perpetrators were men and who were married to the victim. In at least three FGDs it was pointed out that both men and women commit GBV, but that men are reluctant to report it because of feelings of shame and humiliation and more generally an undermining of their masculinity. While there was a general sentiment that men of any age could commit GBV, it was also pointed out by FGD respondents that most perpetrators were older than the survivor, i.e. that there was an intergenerational dynamic.

According to the FGD discussions, GBV survivors tend to be women and are often younger than the perpetrator. They were often thought to be less educated and also poorer, although schoolgirls are also reported to experience GBV. Children were mentioned by respondents in all FGDs as being especially vulnerable to GBV, with orphans in particular being abused by stepmothers, among others.

Experiences of GBV

Community perceptions

According to respondents in the quantitative community survey, about a third (33.6%) reported having witnessed an incident of GBV in the previous six months. Mpika recorded the highest proportion of respondents who reported witnessing incidences of GBV (55.45%), followed by Chingola (41%) and Kalomo (37.6%). More male than female respondents reported having witnessed GBV and the difference was statistically significant (P=0.005). There were no differences among the different age groups in witnessing GBV.

About 69% of respondents felt that GBV survivors sought help, with Nyimba having the highest proportion followed by Mumbwa, and Chingola having the lowest proportion. The kind of help they sought included going to the police (51.5%), relatives (21%), community leaders (20.8%), hospital (12.2%), law courts (7.7%), place of worship (3.7%), support groups (2%), survivor services centres (1%), peer groups (0.5%) and a hotline (0.2%).

The most common form of *formal* help mentioned in the FGDs was the police, through the VSU. However, while there were some positive perceptions of the police, particularly in Mpika (e.g. that they had improved and were acting as a form of deterrent), respondents in all FGDs thought the police were ineffective for reasons ranging from being slow to react to being corrupt and only supporting those with money. Respondents also spoke about police being intimidating and lacking respect. This led to people being reluctant to go to them for support, which was also fuelled by humiliation in the case of men reporting; fear of repercussions, particularly for women; and for economic reasons on the part of women since a majority of women are economically dependent on their husband who is also often the abuser. *Informal* support for GBV-related issues was mentioned by respondents in all FGDs as being critical and ranged from that provided by family members, to that provided by the headman and chief, the church and other community-based institutions. A continuum of seeking helping emerged, starting with elders, parents/family members, and/or friends, moving to the headman or local village committee, then escalating to the chief (who can also call out the elders), and ultimately the police. There is also a sense that those who experience GBV should first go to parents, elders or traditional marriage counsellors to solve domestic issues. There were issues of corruption mentioned in relation to the headman or chief who sometimes favour certain people over others.

Experiences of survivors

Physical assault and verbal abuse were mentioned by all of the women, irrespective of age. Often beating was associated with the intimate partner abusing alcohol and was often extended to the children if the wife was not present or they happened to get in the way. Other forms of physical abuse included being locked up by a husband and being burnt by *nshima (*maize porridge*)*. In addition to beatings and verbal abuse, a number of women felt that they were not being listened to and were excluded from household decision-making processes. Two women spoke about being forced to marry – one because her family could not afford to send her to school, and the other was forced to marry her brother-in-law when her husband died, a traditional practice that is still prevalent in Zambia. Finally, two reported seeking recourse at the OSC because the fathers of their children were not supporting them appropriately. When asked what they think caused GBV, responses ranged from their husbands not supporting them to the marriage not being legally recognised resulting in the survivor facing difficulties in taking the abuser to court, to women to some extent deserving to be abused because of entrenched and internalised social norms around gendered behaviour, including violence.

Two survivors spoke about receiving help from family members (children and brother) who escorted them to the OSCs; one tried to get help from family and neighbours, but as it was not forthcoming she sought help from a friend. The other survivor said that family support was not very effective. None of the survivors spoken to mentioned going to a headman or chief. In terms of formal support, the hospital, police/VSU, court, counsellors and OSCs were mentioned, despite the sense that the police/VSU were not very effective. Two of the survivors spoke about withdrawing their charges because of pressure from their husbands and his family, but also because if the husband had to serve a prison sentence the family's livelihood would suffer.

Five survivors went to the OSCs; most had visited the centre twice, the second time being for follow-up, and most had seen a counsellor and a doctor. They were seen straight away and reported remaining there between 35 minutes to two hours. Most said that the staff treated them with respect, and they were made to feel comfortable and their privacy was maintained. All services received were free. In terms of improving the service, it was suggested that follow-up services need to be more systematic, particularly when following-up with the perpetrator, and that the time to process cases through the court system should be reduced.

Experiences from/related to children

Limited information was obtained relating to children's experiences of GBV. According to respondents, minors are taken to the police only if an agreement with the perpetrator or his family has not been reached. If the perpetrator is the child's parent or guardian, the OSC will recommend the child be removed from that environment. One of the difficulties with working with children, according to respondents, centred on delayed

reporting. In terms of staff capacity, it was felt that sexually abused children had no qualified post-trauma counsellors to treat them and that medical doctors had no specialised training to handle such cases. Similarly, psychosocial support for children had so far been provided on an informal basis by a range of different actors.

The OSC's role is to adduce the evidence of child abuse. When a child has been sexually abused, the case is handed over to the police and the OSC remains on standby to testify. In preparing a child for successful court proceedings, it was reported that the minor is counselled on how to give evidence and to speak freely without fear.

Access to and existence of GBV services and information

GBV services in general

The most frequently mentioned sources of information on preventing GBV according to respondents in the quantitative community survey were TV, radio, friends and peer education. Chingola had the highest proportion (63%) of respondents who mentioned TV as their main source of information on preventing GBV and Mumbwa had highest proportion of respondents who mentioned the radio as the main source (48%). A range of sources of information were mentioned by FGD respondents including the clinic, hospital, school, community meetings, chiefs, police stations, courts, headmen, VSUs, teachers, radio, TV and NGOs/researchers.

According to key informant interviews, there are two main channels for reporting GBV incidents: the service provider, with the main entry point being the police and the VSU and the community or primary response level with the headman, chief, and to a lesser extent neighbourhood watch groups, being the entry points.

The most commonly reported way of engaging communities in GBV interventions was through traditional structures such as the headmen and chiefs. Other mechanisms included local radio, schools and churches and, in one case (Monze) the gender-based violence committee.

STOP GBV programme

Over 90% of respondents in the quantitative community survey did not know about the STOP GBV Programme. Of the few (n=33) who did and were asked what services it provided, in all districts except Nyimba they mentioned prevention and advocacy; and in all districts except for Monze they also mentioned the OSC. Only respondents in Mumbwa and Chingola mentioned legal advice services, and only respondents in Kalomo, Mpika and Mumbwa districts (n=10) said they had participated in GBV activities related to STOP GBV. The main activity was the prevention and awareness service, which was provided in all three districts. The provision of GBV survivor services was mentioned only in Mumbwa.

The STOP GBV Programme is mainly seen to provide prevention and awareness services; respondents from Kalomo and Nyimba also mentioned the provision of GBV survivor services and Kalomo mentioned direct and indirect income support. Most of the respondents were unaware of safe houses for GBV survivors except for those from Kalomo where half (50%) of females and most males (75%) were aware of the private safe houses. Respondents who were aware of the existence of OSCs were asked about the attitude of the staff who provided services: most (84.2%, n=19) felt that the staff were polite.

Although most OSCs were not fully operational at the time of the baseline study, of the few participants who were aware of their existence (n=19), most said that local communities were involved in the activities of the programme mainly through sensitisation visits and receiving messages from support networks. When asked whether they thought the STOP GBV Programme was beneficial to their communities, all male respondents said it was, with 71.4% saying it was beneficial because it provided information on GBV, 22% because it supported GBV survivors and about 7% because it provided shelter/safe homes. Of those who thought it was not beneficial (n=17), reasons included the inappropriateness of the information provided, that services were too far away (Chingola, Kalomo, Monze) and confidentiality issues (Kalomo and Mpika).

Similar to the quantitative survey, most community members in the FGDs were unaware of the STOP GBV Programme. When it was explained to them, and in particular what the OSC did, they all liked the idea. Of those who had heard about it (i.e. the FGDs with men in Nyimba, young men in Monze, young women in Kalomo, and men in Kalomo), most knew little about it and were unclear what services were offered.

Ongoing challenges for responding to and preventing GBV

Challenges for GBV services (non-OSC)

On the *demand side*, even if services are available, GBV survivors remain reluctant to report to or seek access to the services and there is a sense that most cases go unreported. Of those who do report, most seek assistance late. Moreover, cases are often withdrawn because of family pressure on the woman.

On the *supply side*, there are three main challenges. First, infrastructure (particularly shelters) and transport were critical gaps preventing not only daily functioning of referral activities, but also longer-term sensitisation initiatives. In all the districts the safety of the survivors was not guaranteed in the absence of safe homes and shelters, with informal services such as churches and VSU offices being used to house GBV survivors. Second, most services are primarily responsive and the only preventive measures for GBV were sensitisation and community engagement, with negligible awareness of linkages with community development initiatives focusing on livelihoods, social protection, child protection, or economic strengthening activities. Finally, police capacity to manage evidence is a major obstacle in cases that proceed to prosecution.

Challenges for OSCs

On the *demand side,* although reporting is likely to increase and more perpetrators punished with the establishment of the OSCs, it was also suggested that traditional courts will continue to play a significant role since people were afraid to report to the police for fear of prosecution and because of the lengthy and cumbersome court procedures.

In addition to experiencing many of the *supply side* challenges with respect to broader GBV services, OSCs continue to face coordination challenges, funding bottlenecks affecting logistics and duplication of roles, constraints on preventive programming, and technical capacity of staff.

Conclusions, recommendations and indicators for future evaluations

The baseline study found that there is a critical need for GBV services – related both to prevention and to treatment or response. The data indicates that the STOP GBV Programme response has begun to have some positive effects, even during its inception period. In terms of the core STOP GBV Programme objectives, the response component, i.e. treatment and support to survivors, has gained more momentum than prevention in almost all the districts studied. During the fieldwork there was more evidence of medical, psychosocial, legal and safety support for GBV survivors, but limited outreach in terms of primary prevention activities including awareness-raising and improving the environment to respond to GBV.

Recommendations

- Continue to carry out sensitisation and awareness-raising on GBV, including on human rights, child protection issues and processes for redress at different levels and among different groups.
- Establish programmes specifically aimed at children, including orphans, to raise their awareness about different forms of GBV and their rights as children. OSCs require further training on child-protection referral systems.
- Ensure that awareness-raising on GBV is carried out through different media, including radio and TV programmes and through billboards and other forms of advertising.
- Build and support the capacities of informal systems of elders, headmen and chiefs to deal with GBV-related issues.
- Continue to raise awareness about the STOP GBV Programme at different levels – district and community.
- Further capacity-building and training of service providers.
- Build the capacity of the police/VSU, including empowering them to develop systems and processes to ensure accountability and transparency.
- Improve access to information and guidelines on managing GBV cases.
- Ensure logistical and infrastructure needs are met, including transport and safe houses.

- Undertake further advocacy and lobbying to tighten legal procedures and limit potential corruption to enable GBV survivors to report incidents with the assurance that due process will be followed.
- Given that poverty and women's lack of economic empowerment are underlying factors that contribute to GBV, it is critical that women are provided with or linked to organisations working on economic empowerment.

Table 1: Indicators to guide future evaluations

Key indicators to track in future evaluations/ studies	Baseline indicator	Means of collecting the information
Proportion of community members with knowledge of the STOP-GBV Programme and services	1.7%	Community survey
Proportion of community members involved in the STOP-GBV Programme	0.4%	Community survey
Proportion of community members who demonstrate correct knowledge and attitudes about GBV	Low (0 to 15 correct answers out of 45) – 75.5% Moderate (16 to 30 correct answers) – 24.4% High (31 to 45 correct answers) – 0.1%	Community survey
Proportion of community members who report receiving information on GBV in last 3 months	20.2%	Community survey
Proportion of community members who report that GBV is common in their area/community	50%	Community survey
Proportion of community members who have witnessed violent incidents or GBV in the community in the last 6 months	33.6%	Community survey
Proportion of community members who say GBV is increasing, declining, or staying the same	Increasing – 35.4% Declining – 25.3% Staying the same – 19.2%	Community survey
Proportion of community members who report that forced or early/child marriage in the area/community is very common, common, not common, non	Very Common –13.2% Common –18.9% Not common – 28.2% None – 31.9%	Community survey
Proportion of community members who are aware of the existence of community support networks that address GBV	12.6%	Community survey
Proportion of community members who report that the STOP GBV Programme is beneficial to the community	1.4%	Community survey
Proportion of community members who are aware that the programme can refer GBV survivors to shelters and safe houses	0.5%	Community survey
Proportion of community members who report that the STOP GBV Programme involve local communities in their activities	0.9%	Community survey

1 Aims of the baseline study

Gender-based violence (GBV) is pervasive in Zambia. Data from the Demographic and Health Survey (DHS) indicates that from the age of 15 years into adulthood, almost half of all women have experienced physical violence, and a third of women experienced physical violence in the 12 months preceding the survey. Factors contributing to GBV include sexual cleansing rituals, initiation ceremonies, economic dependence of women on men, socialisation of boys and girls at home and in school, inadequate laws on GBV and domestic violence and lack of law enforcement, and intimate partner violence (IPV) (DHS, 2007).

The purpose of the study is to provide a baseline from which to measure programme results, impact and long-lasting change at the end of the STOP GBV Programme led by World Vision (WV), Women and Law in Southern Africa (WLSA) and the Zambia Centre for Communication Programme (ZCCP) in six districts of Zambia: Chingola, Kalomo, Monze, Mpika, Mumbwa and Nyimba. Given the focus of the STOP GBV Programme the study focused on three main areas:

GBV survivor services

- Assess the capacity of One Stop Centres (OSCs) to provide comprehensive care to survivors of GBV
- Evaluate the referral networks, linkages and services for GBV survivors
- Assess the level of GBV competency among the health personnel
- Assess shelter and safe-house quality and capacity to care for survivors of GBV
- Assess the level of coordination within government and other GBV programmes at district level
- Assess the level of engagement of community networks to address GBV at district level

Access to justice

- Assess the capacity of GBV service providers to implement GBV laws and manage GBV cases.
- Assess the level of awareness of lawmakers, police, courts, and traditional leaders on GBV and related laws.

Prevention and advocacy

- Assess societal attitudes on and enabling factors of GBV in the area of the study.
- Assess incidence levels and the type of GBV and early marriages in the area of the study
- Access the level of awareness on GBV and child marriages within the communities in the area of the study by other stakeholders.
- Assess primary causes and the factors contributing to GBV and child marriages in identified districts.
- Assess the sources of information and methods of communication on GBV and child marriages.
- Determination of economic opportunities for vulnerable women, men and youth in the area of the study.

This brief introduction is followed by an overview of GBV globally and in Zambia. This is a summary version of the background report prepared for the study (see ODI Inception Report). Section 3 outlines the methodology used for the study. This is followed by a description of the STOP GBV Programme provided by study respondents. Section 5 provides socio-demographic and economic profiling information about study respondents based on the community baseline questionnaire. Drawing on the quantitative and qualitative data, Sections 6, 7 and 8 set out knowledge about GBV, experiences of it, and then explore issues of access to and the quality of support services more generally. Section 9 explores the challenges in relation to GBV and Section 10 ends with some recommendations and suggestions of indicators to track in future evaluations.

2 Overview of GBV globally and in Zambia

2.1 GBV as a human rights violation with adverse impacts on human development[2]

According to the United Nations Declaration of 1993, Violence against Women (VAW) – a term often used interchangeably with Gender-Based Violence (GBV) – constitutes '*a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms'* (UN, 1993). According to a World Health Organization (WHO) global survey and based on estimates from 79 countries, 30% of women reported having experienced physical and/or sexual intimate partner violence (IPV) at some point in their life. While the prevalence was lower in high-income regions such as Western Europe and in the Western Pacific, the proportion of women reporting lifetime exposure was 37% in African, Eastern Mediterranean and South-East Asia regions. When the lifetime prevalence of IPV (physical and/or sexual) and non-partner sexual violence are taken together, 45% of women in Africa are affected (WHO, 2013).

Violence against girls and women hampers countries' achievements of at least six of the eight United Nations Millennium Development Goals (MDGs) (World Bank, 2014). Often preceded or accompanied by withdrawal of resources for those being abused, violence diminishes women's access to and use of assets (e.g. natural resources, education and political voice), therefore restricting their livelihood opportunities, such as entering the labour market (World Bank, 2014). The lack of assets and opportunities contribute to household poverty and thus impede the achievement of MDG1 to eradicate poverty and food insecurity. Violence and associated sexual harassment, child abuse, early marriage and other abuse against children cuts short their chances and/or parents' willingness to send them to school, directly hampering the achievement of MDG2 of universal primary education. Violence against women and girls also directly impedes the achievement of MDG3 to promote gender equality and women's empowerment. Patriarchal gender norms and women's disempowerment trigger attitudes and forms of behaviour that lead to persistent, repeated, and severe violence against women and girls (World Bank, 2014:3). Such abuse of women directly affects the aim to reduce child mortality and improve maternal health, as set out in MDG4 and MDG5. Girls and adolescents are also highly vulnerable to trafficking, prostitution and resulting life-threatening health risks. These include HIV/AIDS and other sexually transmitted infections (STIs) that MDG6 aims to combat.

2.2 Defining GBV and VAW

There is no universally agreed definition of the violence perpetrated against women, girls, boys and men, and definitions differ according to the region, theoretical perspective and discipline (Ellsberg and Heise, 2005). The USAID Strategy to Prevent and Respond to GBV defines GBV "as violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. Gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labour; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honour" killings, and female genital mutilation/cutting."[3] GBV and VAW are often used interchangeably because this type of abuse is disproportionately inflicted by men against women and girls (EIGE, 2014). The terms 'Intimate Partner Violence' or 'domestic violence' are also used interchangeably. Although men and boys are also victims of violence, which can be perpetrated by women, GBV against women is more pervasive. When the United Nations General

[2] For further details of the literature review please see ODI Inception Report, 2014.
[3] http://www.state.gov/documents/organization/196468.pdf

Assembly passed the Declaration on the Elimination of Violence against Women in 1993, it recognised that: '*violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women* […]' (UN, 1993). The Declaration thus defines Violence Against Women as: *'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'*.

Men and women may be victims of GBV, perpetrated by same or opposite sex intimate partners and non-partners, but while men are more likely than women to experience violence inflicted by a stranger or casual acquaintance, women are more likely than men to be assaulted, injured, raped, or killed by a current or former intimate partner than by any other person (Ellsberg and Heise, 2005).

Early marriage, defined as a marriage where one or both spouses are below 18 years of age, is a prominent form of GBV facing adolescent girls around the world (ICRW and Plan, 2011). Around 33% of girls in developing countries, excluding China, are married before the age of 18 (UNICEF, 2011). Early marriage is often linked both to normative and structural factors such as poverty, lack of education, and social and religious norms and traditions (UNICEF, 2011). Of the diverse pressures on adolescent girls to enter into early marriage, many are outside the family sphere.

2.3 Impacts of GBV

Exposure to violence, as well as the acute stress it causes, can damage the health of those who experience GBV. The physical consequences include injuries, mental disorders, illnesses, cardiovascular diseases, hypertension or the development of insulin-dependent diabetes (WHO, 2013). Functional disorders are among the most common consequences of GBV in terms of the victim's physical health, i.e. ailments that have often no identifiable cause such as chronic pain (Ellsberg and Heise, 2005). Stress caused by violence experienced during pregnancy may influence women to seek an induced abortion, which in turn can place their health at risk if it takes place in unsafe conditions. Violent relationships can also trigger premature labour and birth and lead to low-birth-weight infants. The prevalence of abuse during pregnancy is between 3% and 11% in industrialised countries, with the exception of Canada and the United States of America, (USA) and between 4% and 32% in developing countries (Campbell et al., 2004).

Behavioural responses to GBV include the abuse of alcohol, prescription medication, tobacco and other drugs, which leads to further health risks. There is clear evidence that women with histories of violence consume more alcohol than those who do not (WHO, 2013). In addition, exposure to violence and traumatic events erodes victims' self-esteem, and can lead to fear and isolation, which may in turn lead to depression and suicidal behaviour (Hyde et al., 2008).

There is a growing recognition that GBV may be an important factor in women's vulnerability to HIV and STIs. Women suffering sexual violence are at greater risk of infection if they are forced to have sex or if they fear negotiating condom use. According to WHO (2013), evidence also suggests that '*men who use violence against their female partners are more likely than non-violent men to have a number of HIV-risk behaviours, including having multiple sexual partners, frequent alcohol use, visiting sex workers, and having an STI, all of which can increase women's risk of HIV'*.

From an economic perspective, all forms of violence have an impact on the ability to work and on productivity (Duvvury et al., 2013). At the individual and household level, IPV has both immediate impacts (e.g. absenteeism, poor physical and mental health, out-of-pocket expenditure health and care services, and replacement costs) and long-term impacts on education, skills and work experience.

Impacts are mediated through the interplay of an individual's capabilities (e.g. health status, stability of employment, the acquisition of skills, degree of mobility), trauma (e.g. fear might lead to psychological effects that lead to absenteeism and low productivity) and intra-household gender relations, which can both fuel and be affected by violence. For instance, loss of household income might reduce both consumption and savings, which in turn affects welfare consumption and household utility (WHO, 2013).

2.4 Prevention of and responses to GBV

Unchallenged cultural or religious barriers to admitting to, confronting or even discussing GBV combine to keep this issue a social taboo and a private matter, which impedes progress in addressing it. According to Sprechmann et al. (2013) the influence of entrenched social norms that uphold patriarchal attitudes towards women and girls presents challenges to ending GBV. For example, even in countries where GBV is prohibited by law, such acts can go unreported or unaddressed since society views GBV as acceptable and stigmatises and blames women who experience it. GBV is also often seen as a topic not to be discussed, and may even be 'invisible' to those experiencing it because it is 'deeply woven into how an individual understands who they are as a man or woman and their place in society' (Sprechmann et al., 2013: 13). According to WHO (2007), in many cultures the victims of sexual violence are prone to social stigmatisation, disbelief and are sometimes blamed for what happened to them. While men face GBV it remains even less reported than that faced by women since it is perceived as shameful and humiliating for a man to be facing GBV at the hands of a woman, and is more generally seen as undermining his masculinity.

WHO (2007) highlights the fact that victims' perceptions of sexual violence affect their subsequent responses. Typically, those who experience GBV are unlikely to seek assistance and legal support if they do not identify their experiences as GBV and acts of criminal assault. According to WHO (2007), at the global level few survivors of rape seek medical services and often go through life by avoiding thinking about the experience or engaging in the use and abuse of harmful substances. Golding et al. (1989) found that survivors of rape primarily seek support from family members, friends and members of their religious community and to a lesser extent from formal medical, mental health, legal and social services.

2.5 Overview of GBV issues in Zambia

GBV is a major health, development and human rights issue in in many African countries, particularly due to its link with HIV/AIDS (Keesbury, 2013). According to the United Nations, Zambia in particular has one of the world's highest rates of IPV and in its 2010 periodic report for CEDAW, the Zambian government acknowledged that GBV is an area of concern requiring 'immediate attention' (UN Department of Social and Economic Affairs, 2010; UN, 2010).[4] GBV, including the sexual abuse of children, has serious health implications for its victims and for their families and communities. Not only does it infringe on the sexual and reproductive health and rights of girls and women, but it is also one of the key factors of HIV infection in women and girls and affects maternal and infant mortality (UNFPA Zambia, 2013).

In the 2007 DHS, over half of Zambian women reported having experienced either physical or sexual violence, of whom around one in three experienced only physical violence, 5% experienced only sexual violence and 15% experienced both physical and sexual violence (CSO and Macro International, 2009). A 2013 World Vision survey found that 70% of ever-married women and 49% of ever-married men had experienced GBV in the last 12 months (World Vision, 2014). Urban women are more likely than their rural counterparts to have experienced emotional, physical or sexual violence (61% and 50% respectively) (CSO and Macro International, 2009). A 2013 report by UNICEF and the Population Council stated that, 'given complicated stigma and reporting issues, it is likely that these national Demographic and Health Surveys underestimate the true prevalence and incidence of violence' (Keesbury et al., 2013); nevertheless the DHS is one of the few reliable sources on GBV prevalence in Zambia.

2.5.1 Drivers of GBV in Zambia

The factors causing GBV in Zambia are numerous and are of key interest for this evaluation. Below are some of the factors identified in a USAID-funded study (USAID, 2010):

- Extreme poverty, including high levels of unemployment, which promotes property grabbing and economic abuse in relationships.
- Common belief that having sex with a child who is a virgin will cure HIV/AIDS.
- Women's extreme economic dependence on men.

[4] A 2010 report from the UN Statistics Division shows that of 83 countries with data on the prevalence of physical and/or sexual violence by intimate partners in their lifetime, only six countries have surveys reporting higher rates than Zambia: Bangladesh, Tajikistan, Uganda, Solomon Islands, Democratic Republic of the Congo and Ethiopia (The World's Women 2010: Trends and Statistics).

- Traditional and social norms that teach women to accept and tolerate physical violence, and teach men that it is normal to beat his wife.
- Various sexual cleansing practices.
- Initiation ceremonies that encourage young women to be submissive to men.
- Male domination that promotes unbalanced power relations and sexual harassment.
- Socialisation practices of boys and girls in schools and the community.
- Inadequate laws to prevent GBV and protect survivors.
- Forced early marriage, which interrupts the education of children and increases situations of extreme economic dependency and vulnerability.

2.5.2 Policy framework for dealing with GBV in Zambia

Zambia has a dual legal system based on both statutory and customary laws, and while statutory laws provide for more equality between women and men in areas such as inheritance and the control of and access to productive resources such as land and credit, the day-to-day life of most Zambians is governed by the local courts that administer customary laws (GIDD, 2008). Even if someone has been married under statutory law, customary law often overrides statutory law, such that even where the provisions of statutory law might protect someone who has experienced GBV, customary law and practice prevail. Similarly, at the local level, the families of those who have experienced GBV tend to opt for compensation through customary courts rather than pursuing criminal proceedings through the penal system (GIDD, 2008). Article 79 of the Zambian Constitution guarantees protection from discrimination and specifically states that laws and customs allowing discrimination against women are void, and Article 11 guarantees women equal status to men. Nevertheless, Article 23(4) states that where customary and statutory laws conflict, customary laws prevail and the gender equality principle does not apply in situations such as: 'adoption, marriage, divorce, burial, devolution of property on death' (World Vision, 2014).

2.5.3 STOP GBV Programme in Zambia

The United States Agency for International Development (USAID) through PEPFAR, and UK Aid through the Department for International Development (DFID), have funded Word Vision, Zambia Centre for Communication Programme (ZCCP) and Women in Law for Southern Africa (WLSA-Zambia) to implement three projects under the umbrella of the Stamping Out and Preventing Gender-Based Violence (STOP GBV) Programme for a period of five years. The three STOP GBV Programme projects are: Survivor Support (World Vision), Prevention and Advocacy (ZCCP) and Access to Justice (WLSA-Zambia).

The STOP GBV Programme work in collaboration with the Ministry of Gender and Child Development (MoGCD), the Ministry of Community Development Mother and Child Health (MCDMCH), the University Teaching Hospital (UTH), the Victim Support Unit (VSU), the Ministry of Health (MoH) and the Ministry of Chiefs and Traditional Affairs to institutionalise services for GBV survivors throughout government structures and to strengthen the quality of the GBV service referral mechanism.

The STOP GBV Programme's objectives include:

A. Survivor support
   - Strengthen GBV survivor services
   - Strengthen GBV response and coordination efforts
   - Expand the engagement of boys and young men through sports

B. Prevention and advocacy
   - Decrease social acceptance of GBV, enhance protective factors, and improve the enabling environment to respond to GBV

C. Access to justice
   - Improve access to justice for adult and child survivors of GBV by building the capacity of GBV services as well as of policy-makers, police, courts, and community leaders in GBV management and implementation of laws.

3 Methodology

3.1 Study approach

The baseline study consisted of a review of and analysis of secondary data as well as the collection and analysis of primary data. Desk reviews of secondary data from country-specific, regional and global literature on GBV comprised grey literature, peer-reviewed journal articles and books, and the policy documents of governments and international agencies. This took place as part of the inception phase of the study and a detailed literature review report was produced. Quantitative and qualitative approaches were used in collecting and analysing primary data. Quantitative data were collected through a community survey of samples of household members in the six districts. Various qualitative approaches were used to triangulate data from the quantitative survey. Figure 1 illustrates the baseline study strategy.

Figure 1: Baseline study strategy

3.2 Data-collection tools

The data-collection tools were developed by the Frontiers Group with support from ODI and were subsequently shared with WV for their input. In preparing these tools, the wider literature and the project performance monitoring and evaluation (M&E) indicators were reviewed to provide input. After the tools had been defined, they were translated into Chibemba and Chinyanja.

The two categories of tools were:

A. Quantitative
   - Community baseline survey questionnaire

B. Qualitative
   - District key informant interview guide
   - Semi-structured guide for OSC service provider personnel
   - In-depth interview guide for survivors of GBV
   - Life-history tool for GBV survivors
   - Focus group guide for community members

The details of the methodological tools can be found in Annex 1.

3.3 Quantitative

3.3.1 Site selection

The baseline survey used multi-stage cluster sampling. Standard Enumeration Areas (SEAs) as defined by the Central Statistics Office (CSO) were considered as clusters. In each district all SEAs were categorised as urban or rural. Two rural and two urban clusters in each district were randomly selected and included in the study. For each selected cluster, a cartographic map was printed and used to identify the boundaries. A total of 24 clusters were included in the baseline survey. See Annex 2 for details.

3.3.2 Recruitment strategy and sample size

The community survey was aimed at household members using a structured questionnaire. The questionnaire gathered information about community perceptions and knowledge of and attitudes towards GBV, the availability of and access to services, and views and perceptions of the STOP GBV Programme, including the OSC. The questionnaire was administered to all consenting community members aged between 18 and 65 years. Sampling frames were obtained from the Zambian CSO. In each district, an equal number of clusters or SEAs were randomly selected from a CSO list of clusters. Once the SEAs were randomly selected, each cluster was segmented into four equal parts and in each segment a random-walk method was used to select eligible households. This method involved walking from one end of the community, through the centre to the other end, counting and enumerating the households. One household was randomly selected as a starting point. We selected SEAs that were in the vicinity or communities that were benefiting from the STOP GBV Programme.

The total sample size was 2,352 across the 6 districts, with a total of 336 respondents in each districts. The teams spent approximately 10 days per district, including travel time. Once a household was selected all eligible household members aged between 18 and 65 years were listed and a *kish* grid was used to randomly select one respondent per household. This prevented selection bias and ensured that the sample was fairly distributed by sex and age groups.

3.3.3 Data processing and analysis

The research team ensured that the data were carefully managed (handling, transport and storage) throughout the study period. In addition, careful and detailed records of all interviews were maintained in each district. Epi-Data, a quantitative data-entry and processing software, was used to enter the data. To ensure the quality of the data-entry process, adequate checks were built into the design of the data-entry screens. Two clerks entered the data, validated by a researcher using a double-entry validation process built into Epi-Data, which allows for comparison of two datasets for consistency and accuracy. The data were exported to SPSS for further cleaning and analysis. Frequencies and distributions of all study variables by district and sex, age and ethnicity of respondents and chi-square tests of statistical association were undertaken. Comparison of means was achieved by using independent samples of T tests and analysis of variance (ANOVA).

3.4 Qualitative

3.4.1 Recruitment strategy, selection and sample size

To address the study objectives and to answer the principal research questions, the qualitative data-collection process focused on key informants, service providers, GBV survivors and members of the community in the sites where the quantitative survey was taking place. Qualitative sampling frames were developed in consultation with WV and following the preliminary visits to one of the six districts. Key informant interviews in each district included staff from relevant government departments (social welfare, district administration), NGOs and the Police Victim Support Unit (VSU) and STOP GBV Programme staff. The latter also helped to identify GBV survivors and community members who participated in Focus Group Discussions (FGDs) and key informant interviews.

A total of 225 respondents participated in the interviews. These included 176 FGD participants, 14 in-depth interviews with GBV survivors and 35 interviews with key informants. Slightly more females (116) than males (109) took part in in-depth interviews either as service providers or as survivors and in FGDs, as shown in Table 2. FGDs were further grouped into two categories: those with young women and young men between the ages of 18 and 24 and those with men and women aged over 25 years, with the upper age limit usually being around 60.

Table 2: Distribution of qualitative study participants

	FGDs		In-depth and survivor interviews		Key Informants	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
Chingola	13	13	0	1	4	2
Kalomo	15	14		2	5	1
Mpika	15	14	0	2	3	1
Mumbwa	15	16	1	2	2	5
Monze	15	15		3	3	5
Nyimba	15	16	1	2	2	2
Total	**88**	**88**	**2**	**12**	**19**	**16**

3.4.2 Data processing and analysis

All interviews, with appropriate consent, were recorded. The data collectors took notes during the group discussions. The interviews were subsequently transcribed and translated verbatim by the qualitative data collectors. Themes and sub-themes identified formed the basis of the coding structure for the transcripts, which were analysed manually. The transcripts were thoroughly read to identify emerging themes and sub-themes, which were then examined, referenced and grouped. This process led to the interpretation of the data and report writing.

3.5 Data-collection team, capacity building and supervision

Three field data-collection teams were formed with each team carrying out interviews in 2 districts; thus each team spent approximately 10 days on each district, or 20 days of continuous fieldwork. In each district, there were briefings on the exercise with STOP GBV Programme staff at the OSCs. The briefings also discussed the selection and participation of key district stakeholders, including methods to identify community approaches. At the end of each day the research team met to discuss the interview processes and significant emerging issues and findings. For each district visited and data collection completed, the supervisors compiled field summaries of the data-collection process, drawing on the daily debriefings.

Each field research team comprised a supervisor and seven data collectors. The role of the supervisor was to set up and manage appointments, oversee data collection and ensure quality. The supervisors also conducted qualitative interviews, provided overall supervision and compiled daily debriefing reports and district field summaries. The data collectors administered the questionnaires, some of the key informant interviews and semi-structured interviews and carried out the FGD.

A total of 21 data collectors were recruited and trained in interviewing techniques. Frontiers Group recruited 14 data collectors from the available pool of experienced research assistants, eight men and six women; WV provided seven data collectors identified and drawn from some of the partners including the CSO. The data collectors had various professional backgrounds, and most were fluent in the languages spoken in the study districts – Chitonga, Chibemba and Chinyanja.

The training of data collectors (including staff members from WV and partner organisations) took place between the 12th –15th November 2014, supported by a member of the ODI team and a member of the WV US team. The training consisted of presentations, smaller group work, role-plays and pre-testing of tools. The training equipped the data collectors with the necessary skills for collecting accurate and reliable data from both questionnaires and from qualitative approaches. It also equipped them with knowledge on how to deal with sensitive issues. The tools were pre-tested on the 15th of November and a debriefing and finalisation of the tools followed immediately.

3.6 Quality control

An important expectation and requirement for this study was to obtain good quality data. Quality-control processes started at the inception phase and continued through to analysis and report writing. Quality was maintained by ensuring that the data-collection instruments met international standards both in terms of the kinds of issues and themes to be explored and the type of questions asked. The training also ensured that all team members were aware of the key themes to be covered in the research including their sensitive nature. Role-plays and piloting of tools provided further assurance that quality would be maintained. Fieldwork supervision provided the opportunity for continued training and mentoring in order to prevent complacency and to reinforce standards. The daily briefings provided opportunities to review interesting findings, and were also spaces where challenges in relation to the data-collection tools were discussed. These daily briefings also allowed the team supervisors to carry out an informal form of quality control. Data-processing checks were built into the quantitative data processing during the data-entry phase. For the qualitative interviews, quality checks of the transcripts were made by the in-country researchers by listening to a selected number of tapes and reviewing the transcripts to ensure consistency and accuracy. While analysis and write-ups were led by the in-country research lead, who is highly experienced in conducting such processes, the ODI team supported all these processes, bringing in experience in analysis and report writing.

3.7 Ethical considerations

The baseline study was submitted for review and approval to the ODI Ethics Research Committee and to the ERES Research Ethics Committee in Zambia. Both committees approved the proposal and the data collection instruments.

All members of the research team were given guidance in research ethics to meet the highest ethical standards of data collection and analysis throughout the study. Given its sensitive nature, efforts were made to ensure that respondents were fully aware of the risks and benefits involved in participating and that confidentiality and anonymity were maintained. A process of obtaining informed consent took place using the standard information sheet and consent forms provided by ERES Ethical Review Committee. In addition, permission to conduct the study was obtained from the relevant ministries including the Ministry of Chiefs and Traditional Affairs (MCTA) and Ministry of Community Development Mother and Child Health (MCDMCH).

3.8 A note on definitions and approach use in this baseline

As outlined in section 2.2, definitions relating to GBV are not universally agreed upon given the complexity of experiences and contextual variations. Policy-makers, practitioners and researchers (particularly M&E staff) have consistently struggled to classify and analyse GBV-related data in a manner that enables comparable findings. As

a response, this programme drew on the definitions outlined in the Gender-based Violence Information Management System (GBVIMS) developed by the United Nations Population Fund (UNFPA), the International Rescue Committee (IRC) and the United Nations High Commissioner for Refugees (UNHCR) in an effort to standardise findings and to gain 'promising practice' lessons regarding its implementation.

The key advantages of the GBVIMS tool are threefold: first, it refers to six universally recognised forms of GBV; second, the categories are mutually exclusive; and third, the forms of GBV are focused on a discrete act of violence rather than the motivation for committing it. These six forms of GBV are rape, sexual assault, forced marriage, denial of resources, opportunities or services, and psychological or emotional abuse (definitions for each, as outlined by the IMS, were added to the survey tool as a footnote for continued reference during fieldwork).

These six forms of GBV were placed as categories in the survey questionnaire in both the 'Knowledge and Perception' and 'Experiences' enquiries, but included sub-categories reorganised from standard DHS templates. For example, the 'rape' category included components on cultural rites (including sexual cleansing), marital rape and defilement (among others) while the 'psychological and emotional abuse' category included elements relating to the threat of physical violence, threat of sexual violence, forced isolation, and unwanted attention/stalking. The categories also included an optional 'other' that could be used to add more colloquial and context-specific types of GBV that would later be post-coded.

While the GBVIMS tool was not fully applied in this study, largely because it is used for the intake of GBV cases rather than as a survey tool, the survey nevertheless drew on the main categories used in the tool. However, additional categories such as defilement and HIV-related cleansing were added to the tool. The decision to add sub-categories to the central IMS types of GBV was to leave as many options as possible for respondents to be able to identify forms of GBV. In practice, if a sub-category of GBV was nominated in the survey, this automatically qualified its 'parent' category as a form of GBV identified by the respondent. In addition, more components were added to take account of the sex, age and relationship of the perpetrator for each GBV case identified by the respondent. This component added significantly to the implementation time of the survey, but was considered vital for being able to fully identify the 'case context' of the type of GBV incident, as recommended in the IMS tool.

There were also separate challenges concerning whether the research was seeking 'emic' or 'etic' findings, i.e. more subjective internal perspectives in communities regarding their familiarity with and perception of GBV issues, compared to their familiarity of GBV issues as prompted by researchers. In other words, a number of questions were raised during the early stages of the research on whether the focus was more 'objective' or 'subjective' experiences of GBV at the community level. Consequently, the survey examined both dimensions – first by asking participants to define GBV (or locally defined equivalent) without any direct prompting, and second by asking participants to outline personal or witnessed forms of GBV with direct prompting (naming each type of GBV in the categories). This dual approach therefore covered both community-defined and IMS-defined dimensions of GBV.

4 Description of the One-Stop Centres

This section provides a description of the One-Stop Centres (OSCs) according to perceptions of key informants. Among other things, it outlines goals and objectives; anticipated achievements; policies and guidelines; the kind of services available and the main target groups; issues relating to staffing, resources, capacities and referral; and strengths and future challenges.

4.1 OSCs' goals and objectives

Most of the service providers interviewed could articulate the goals and objectives of the programme in general and the OSCs in particular. They emphasised the aspect of reducing GBV in the short and long run through a number of activities undertaken in collaboration with a range of stakeholders. It was mentioned that the programme aimed to fight GBV by providing adequate and correct information about services to prevent and respond to GBV. To achieve the objectives, a multi-faceted response includes survivor services, education and economic empowerment activities, as this quote below shows:

> *One of the goals is to have a decrease in the levels of GBV in our society and to look at the compounding factors, let's say women that are of low economic status, there are programmes that they can be linked to, even organizations, so that they can be stable or sustain their own livelihoods. (Nyimba)*

The informants further stated that the goals and objectives of the OSCs is to reduce the incidence of GBV over the next few years, as the quotes from service providers in Mumbwa and Kalomo show:

> *The goal is that by the year 2017 the cases of GBV should reduce to 20 or 30 per cent from 80 per cent. The objective is that we teach the upcoming boys and the girls about the cases of GBV. (Mumbwa)*

> *Three or more years from now people should have knowledge and stop this violence. There are a lot of misconceptions. If the OSC can give information that will reduce GBV – we need to sensitize, mobilize and take information to people. (Kalomo)*

4.2 Anticipated achievement of goals and objectives

The OSC staff and associated partners expressed optimism that the goals and objectives of the programme would be achieved. Many respondents felt that the objectives are achievable provided the programme receives the necessary operational and logistical support, especially transport.

> *Yes, I think they are achievable. When you have the resources it is achievable. Human resources. Police need to be there. Counsellors need to be there. We have the office here. We work as a team, we have transport. Then it is achievable. (Kalomo)*

Although they were optimistic that the objectives would be achieved, some respondents felt that there will be challenges to overcome. They believed that the programme needs concerted efforts to overcome numerous obstacles, some of which were already clear at the onset such as the lack of transport, the need for shelters for

survivors and limited information dissemination. They also raised sustainability issues, which are critical not only for the achievement of goals and objectives but also for long-term provision of the services.

> *Yes, as the programme goes on definitely the task will be more people will need to be sensitised, meaning that the centre will need adequate transport to attend to the victims of GBV and also to follow up on the patients in the communities. I think the challenges we are likely to encounter with our programme is lack of transport. (Mpika)*

> *First of all we need a house for survivors because even if we see them some of them will have to go back to the same environment and if we are not careful we might end up losing lives. So we need a safe house. Then we should start preparing the take-over of OSC by government, meaning that we should have our members of staff trained for the management of the OSC so that when our funders like World Vision pull out in the next two, three years we won't lag behind we will just continue. (Nyimba)*

While most OSC staff were aware of the objectives, they were less clear about the various components of the programme. This was most likely because the programme had only recently begun and most service providers were new to the OSCs.

4.3 Policies, guidelines and protocols

A set of questions was asked concerning the available policies, guidelines or protocols for management of GBV at the OSCs. Although there exist protocols and guidelines that could serve as reference materials, they were not available at the OSCs. Most informants said they had no protocols or guidelines for their operations. This was the case in most of the districts. In one or two instances where there were indications of their availability, the protocols were not kept at the OSC where they could be easily used.

> *Yes we have. We have a focal point person who is in charge of GBV at the hospital, this is the person who usually keeps them. (Mpika)*

In some cases it was difficult to establish whether they existed or were available because the staff were not sure or did not know about them. One informant in Kalomo alluded to the possibility of obtaining access to the guidelines through the internet, although connectivity was reported to be a problem.

> *So the challenge that we have is sometimes the internet is not good. To really download is a challenge. I tried to follow up with the district but they have not given it to me yet, so we do not have these guidelines at the moment. What we have at the moment are the health centre guidelines. And those are just about the aspect of health care. (Kalomo)*

4.4 Specific services

Working with partners, also through a system of referrals, OSCs offer a range of medical, psycho-social, and legal services to the survivors of GBV. The services also include provision of and access to safe shelters for women who are at risk of GBV. The main components of the STOP GBV programme are GBV survivor support; access to justice; and prevention and advocacy. According to study respondents, OSCs attend to and care for all forms and types of GBV:

> *The OSCs handle all forms and types of GBV cases ranging from rape, defilement, wife battery, man battery, boyfriend battery, girl battery to any other forms of GBV. (Mumbwa)*

According to key informants the OSCs have been established to make it easy for communities to access services for GBV survivors, justice and prevention support under one roof.

> *The main function of the OSC is to rehabilitate the GBV survivors so that again they become useful members of society. At the OSCs these people are offered a counselling and psycho-social counselling also for those needing medical check- up is done, those needing legal advice it is offered. (Nyimba)*

4.4.1 Medical services

Qualified clinicians and nurses at the OSCs provide all the medical services. Those who have experienced sexual abuse and rape are referred to the health centres. WV supports the capacity of the local health system to provide individual rape survivors with counselling, pregnancy testing, post exposure prophylaxis, emergency contraceptives, treatment of any sexually transmitted infection, and other medical care. To prevent pregnancy, the OSCs can prescribe and administer emergency contraception within 72 hours. In Kalomo, however, it was reported that emergency contraceptives were out of stock.

> *My major tasks is to examine the survivors medically and those sexually abused I test them for HIV, syphilis, gonorrhoea and pregnancy and see if they need to be put on medication to prevent pregnancy or HIV. For those that are assaulted by spouses, I examine them to see if they need any medication to help them in the healing of their wound and pain management. (Nyimba)*

> *We don't have medical contraceptives and we are still working on that. We are hoping by the end of tomorrow we will have them in stock. We are trying to get them, I was just at the district trying to look for them, we haven't had them since we started. (Kalomo)*

> *When the survivors of rape come to report here, we first counsel them. If it is an emergency that has happened within 72 hours we don't delay we just take them directly to the hospital. They meet the medical doctor after that, and that is when they are asked about what happened. We interview them after they come back from the hospital. (Mumbwa)*

4.4.2 Psycho-social counselling services

All the OSCs have full psycho-social counselling services offered to GBV survivors, and each one provides counselling services to meet their psychological and emotional needs. The counselling services are offered on an on-going basis from the time of first contact with the OSC to the time the patient is discharged; and at times during follow-up into the community.

> *Our goal is to ensure that the survivor is not disturbed mentally and to ensure that the person continues with her normal life, after counselling and looking at what they may need at that particular time, the survivor is assisted. (Mumbwa)*

> *Survivors receive counselling from this facility. The number of counselling sessions given to them, I think, is three sessions in a day for the survivors and counselling does not stop until we see that this person is good. (Mumbwa)*

All the OSCs have one or more counsellors with varying levels of training and competence. For example, Kalomo reported having three counsellors while Mpika had no trained counsellors.

> *We have three counsellors, two of them have done psychosocial counselling and that is kind of the best that they can have. One has done something to do with prevention of mother-to-child transmission (PMTCT). So for this one, we have encouraged her that whenever there's an opportunity, she should do the psychosocial counselling. (Kalomo)*

> *Yes especially for rape victims, yes. Yes, we have some counsellors though they are lay counsellors not really trained in counselling but counselling is done. (Mpika)*

4.4.3 Sexually transmitted infections (STIs) services

Services on STIs, including HIV prevention and treatment are also provided to GBV survivors. They provide STI-related services especially to women who have been sexually assaulted or raped. The women are screened for syphilis, gonorrhoea and HIV.

In some districts that do not have good laboratory facilities, STI presumptive and/or syndromic treatment is provided. Those districts with good laboratory facilities conduct STI testing. They collect vaginal smears that are subjected to laboratory examinations to detect STIs such as chlamydia and gonorrhoea as well as detecting the

presence of spermatozoa. For HIV prevention, PEP drugs reportedly given to GBV survivors are Atripla and Truvada. The informants indicated that PEP Antiretroviral medication to prevent HIV are taken for 28 days.

> *Yes we test them for syphilis and any other STI. If found reactive or any infections found we treat them accordingly. Yes especially for rape victims. (Mpika)*

> *I think Truvada is given. Full course of PEP drugs are given at once. Yes, most of the time it's given at once for about 29 days which is given but we haven't had such cases here. (Mpika)*

> *To prevent STI's and the spread of HIV we try to prevent pregnancy so we give emergency contraceptives and for HIV and AIDS we give ATRIPA for 28 to 30 days and for STI we give the drugs to prevent the STI. (Mumbwa)*

4.4.4 Provision of legal services

Most informants did not have a strong understanding of the legal services provided through the OSCs. Although the legal aspects form an important part of the services, informants said that very little was happening in this regard. During the fieldwork, no paralegal staff were interviewed since they did not appear to have been fully integrated yet into the OSC. In some districts, it was mentioned that follow-up on the legal process was not easy partly because the programme had just started and the OSC had not recorded many cases to be able to follow what happened to the survivors' legal processes. In Kalomo, the VSU and the paralegal staff had not yet moved to the OSC.

Some informants were aware that STOP GBV Programme staff and partners responsible for law enforcement (the VSU officers) should either be located at the OSCs or in the VSU nearby. The informants also understood that when someone who has experienced GBV comes to the OSCs, the police open a file that they subsequently submit for further processing and preparation for prosecution of the perpetrator.

> *A number of survivors that we have seen, maybe about 40, we need to follow that and see whether any legal aid was provided to those people. We had one case that is still in the court but I don't know how much legal aid has been provided. They are saying that the legal people and the VSU should quickly move into this office, to make it the one-stop centre. Since we have just started, the VSU people are sometimes found here, but with the legal people, they are not yet settled. (Kalomo)*

> *Upon gathering sufficient evidence the prosecution department of the police should take the case to the courts of law, to the magistrate court. (Mumbwa)*

> *Legal care, I don't know how to say, we need to follow that and see where any legal aid was provided to those people. We had one case that is still in the court but I don't know how much legal aid has been provided in that case. We are saying that the legal officers and the VSU should quickly move into this office to make it a one-stop centre. Since we have just started, the VSU are sometimes found here, but with the legal people are not yet settled. (Kalomo)*

In terms of how long it takes to finalise the court cases, the informants were unable to make any precise statement because they said that sometimes cases are persistently adjourned. Whilst in some districts the OSC staff knew very little about what happens to the survivors after leaving the OSC, in other districts it was reported that the OSC staff ensure that survivors are referred to the police for legal prosecution through the courts.

> *Yes, we do refer them to the court. We follow them when they leave the OSC until the court. (Mumbwa)*

It was reported that the role of the Department of Social Welfare in dealing with GBV cases was mainly that of providing paralegal and psychosocial support such as counselling. However, in many districts there was no available paralegal staff.

> *Mainly we counsel those survivors, in the event that we discover that the survivor needs assistance, maybe food supplement, we supply those. (Mumbwa)*

We are also supposed to offer paralegal services, but unfortunately at the moment we don't have anybody to do that. And then we have the victim's support unit. These are the police, they try to protect the survivor and also to help the perpetrator to change for the better. (Kalomo)

4.4.5 Documentation of legal process

The informants mentioned the need to provide documentation to facilitate the legal proceedings of GBV cases. In Mumbwa, unlike in the other districts, it was reported that such documents include medical report forms and ID cards for children's under-the age of five that are used to receive free health services. They said that the under-five cards are sometimes produced to authenticate the child's age.

We have medical report and the under-five cards. They have to produce under- five cards because some lie about the age, so for us to know for sure this person is below the age of 16 years, and under 16 years is defilement. The punishment given to the perpetrator is very hard. Others do indeed provide the under- five cards but some do not because the say they have lost them. (Mumbwa)

4.4.6 Information dissemination

In addition to other sources, the OSCs serve as a major source of information. Information is provided to GBV survivors, the relatives who accompany them to the OSC and the community members to create awareness about GBV. General community sensitisation is one of the approaches used to create awareness about GBV. The key informants reported that outreach activities are conducted to sensitise communities about GBV. Sensitisation is also done within and around the OSC:

I am based at MCH, where mothers come in larger numbers; pregnant women or those who bring children to the under-five clinic. We disseminate the information about GBV. At the VCT centre, information is disseminated. You know, this is just the beginning, people need more information. (Kalomo)

The strategy we use to create awareness is that of general sensitisation. We go in the field especially when World Vision is having a meeting, they always bring on board government workers, victim support, social welfare and ministries of health and CDMCH through the district medical office. (Mumbwa)

In summary, most informants welcomed the establishment of the OSCs in the districts visited for the baseline study. They praised the OSCs for providing all the services in one place. To provide all the services, they said that the OSCs were staffed by nurses, clinical officers, police and counsellors. The informants noted that the counsellors are there to attend to the survivors; the nurses and clinical officers are there to attend to the medical conditions and problems of the survivors; the police are there to issue medical reports and to conduct investigations; and a medical doctor should be readily available to sign the medical report free of charge. Informants said how difficult it was in the past to obtain access to GBV-related services in the districts. They pointed out that, unlike now when there are the OSCs, in the past survivors had to move from one place to another in order to seek access to various GBV services that were scattered all over the district:

In the past it used to be difficult because a victim would come to a police, the police issues the medical report, then she goes to a clinic to see a doctor where some of the officials will demand for a k50, so some of the victims used to stop from there upon being told to pay k50, if that person doesn't have that's how the case will end. He observed that currently the channels of reporting are effective because survivors are not supposed to pay anything. (Mumbwa)

4.5 Shelter or safe houses

One service or facility that is still not available in all districts is the shelter or safe homes for the survivors of GBV. In very few districts were these available and the service providers were not sure or clear as to when they would be established:

No, at the moment we don't know of any safe shelter. You should refer this to social . . . social welfare office to look for that space, where these survivors that were threatened could go for safety. At the moment we don't have that in place. (Kalomo)

Many informants made the point that the OSC should be linked to safe houses. They saw the absence of safe houses as a big challenge and that most districts were in dire need of them:

> *That's another challenge we are facing here, we don't have a safe house here so refer them to social welfare. I think they have even though we haven't sent anyone there. (Mumbwa)*

> *No, at the moment we don't know of any safe shelter. You should refer to the Department of Social Welfare to look for that space where the survivors that are threatened can go for safety. At the moment we don't have that in place. (Kalomo)*

Informants in some districts said that something was being done about the problem through advocacy and the acquisition of funds and land to build the houses, although in reality nothing tangible seemed to be happening. In Mumbwa and Mpika, some informants mentioned Lusaka as a place of last resort if a survivor was desperately in need of safe shelter.

> *When a survivor is threatened, the ideal situation is we are supposed to have a place of safety as a district. So that those survivors can be moved to that place, no interference other people may be involved, but in the case that the case is very serious, we refer such cases to Lusaka to one of the homes in Lusaka, I can site one case which we had, somewhere this side, we had to get the survivor and took her to Chilanga or Linda. (Mumbwa)*

4.6 Target group and coverage

The OSC is a non-discriminatory facility designed to attend to anyone who arrives with GBV-related problems and needs. With that mandate, the OSCs target vulnerable groups of people, i.e. male and female survivors of GBV. Although men do experience GBV, it is more pervasive amongst women and are thus those in the greatest need of OSC services. The respondents said that although it was agreed that women of lower socio-economic status form the bulk of victims, GBV also affects wealthier women.

> *It is women from the grassroots. Every female is being victimised ... it is everyone as long as that person is a woman. (Mumbwa)*

Other informants indicated that men can also experience GBV (though no such cases were found by the study team). However, in a patriarchal society such as Zambia, where men are supposed to demonstrate masculine traits such as being strong, virile and not shedding tears, the informants said that it was very difficult for some men to report the abuse at the hands of their female partners for fear of stigmatisation (this was echoed in findings from the FGDs, see section 6.3). They observed that despite the greater incidence of GBV, most cases are still not reported especially in cases of physical violence against men by women.

> *Some men will think if I go to the police to go and report this matter, people will start saying 'how can a woman beat him maybe he is not strong'. There are situations where if a male youth is being abused by an older woman to them it is a victory, they cannot even come to report. They will say at least I have had sex with a big woman, it shows I am man enough. (Mumbwa)*

The OSCs focus on communities in their catchment areas. Since most are located in the district headquarters and some are attached to the district hospitals, they cater for the entire district population. This makes their target population very large both in terms of geographical coverage and the number of people they serve.[5]

On average, according to informants, the numbers of GBV survivors seen by the OSCs was estimated at two to three a day for all the districts. The reported monthly estimate based on their experiences over the few weeks since the OSCs were open ranged from 30 to 40 in all the districts. The estimates were conservative as many respondents noted that the trends were increasing.

5 The 2010 CSO data show population estimates of 218,328 in Mumbwa, 211,425 in Mpika, 254, 211 in Kalomo 195,921 in Monze, 210,073 in Chingola and 85,684 in Nyimba.

According to our statistics here, we see maybe three to four cases every day. It's on the increase. (Mpika)

We see at least two clients per day. In a month I would say about 40 clients. (Nyimba)

4.7 Resources – staffing, infrastructure, equipment, transport and technical capacity

4.7.1 Staffing

The interviews indicated that the OSCs are staffed by a range of different kinds of service providers drawn from partner organisations including government organisations/entities. These include clinical, nursing and counselling staff. Other staff are from the VSU of the Zambian police force and paralegal and legal staff from the Department of Social Welfare and judiciary. Some districts have enough staff to run the OSC while others have staff shortfalls. In Kalomo and Mumbwa, for example, it was stated that the number of staff was adequate.

I think there is enough staff. We are here, the three counsellors and we feel like the work is not that overwhelming at the moment. We have the two officers, making it five. (Kalomo)

OK there we have the one who is in charge of the OSC, the coordinator who is a clinical officer by profession, we have a doctor, police officer, nurse and us the social welfare; yes the structure is very adequate. (Mumbwa)

On the other hand, some informants also suggested that the existing numbers of staff in some of the OSCs are not adequate to cater for the increasing workload as more people get to know about the facility and its services. Similarly, once the centres become fully operational, demand will become more critical and acute. Moreover, when staff who have been oriented in GBV are assigned other tasks beyond the scope of the OSC (since they are in other government departments, e.g. the police) operations are likely to suffer. Since staff are seconded to the OSC, conflicts in work schedules are bound to arise.

I am working at the one-stop centre and also working as a nurse. It means that am working in two places. There is only one nurse here. I think we are short-staffed everywhere. My colleague here, he too is not only working on GBV, he is doing quite a lot – it's hectic – you have to be bold to say, wait a little bit, let me attend to this one, wait let me come and all that kind of thing. So that's a big challenge. (Kalomo)

The other challenge is that the survivor may come on Thursday and the same day the doctor has to be in the theatre which means the survivor has to wait until Friday. There is no other person who can sign the paper since there is only the doctor can do that. (Mumbwa)

4.7.2 Infrastructure and equipment

It was noted that the infrastructure (building, spaces and other facilities) are a challenge. In some districts, the shortage of buildings posed a big problem. Specifically in Monze, the lack of accommodation led to some components of the programme operating in containers and other locations which made it hard to observe confidentiality. In none of the districts was there any mention of equipment limitations. In Monze informants reported the problems of maintaining confidentiality:

We have a challenge with especially confidentiality. But maybe it is about the place. We are still working from outside. So, we still have problems because we have to move our clients from office to office for counselling. On our own, as the one-stop centre, we really do not have enough space. We have this container which was given to us so something is being worked on. (Monze)

4.7.3 Transport

In almost all the district, informants mentioned that transport is a problem. They said that in the absence of transport they could not reach many communities with GBV prevention and response services available at the OSCs.

I think that transport is a problem because there are times when we have to pick a survivor from a far place maybe in the bush and because of transport we cannot follow up with those cases. (Mumbwa)

We were told that the vehicle will be there, but I'm sure it hasn't yet been here, but it was purchased.. (Mumbwa)

Sometimes we used to pay cash when booking a taxi to take us to the hospital but at the moment they told us that the car is coming from Lusaka; we are waiting because that will make our work so easy. (Mumbwa)

We understand follow-ups as something that we have to do as a matter of duty by following clients to their homes. That way, even perpetrators and everybody in the community, the family, they will know that there is this service going on. We believe that can at least help to stop GBV taking place in their homes. So we have a challenge in terms of transport. We cannot be there as we would like to. (Kalomo)

4.7.4 Training and technical capacity

Staff were confident that they have the technical capacity to provide services to GBV survivors. Some of them felt adequately trained and oriented to the activities of OSC. In all the districts, the staff had attended training on various aspects of the STOP GBV programme. Generally the training sessions normally lasted for one week and were facilitated by WV. All partners, government departments and NGOs attended the training. Although the training made a big difference, some informants felt that the work they were assigned to do at the OSC was part of what they have always been doing. With this experience, they were quite confident about their technical capacity to perform their duties.

...I can say yes because this is the same job I do when am at my office, it is just a continuation. To me am comfortable maybe I don't know about others but to me I feel this is the same thing that will be done every day. Yes we have received training we had one with world vision and recently I went to last week I attended one with WLSA in Lusaka CAMZ lodge. (Mumbwa)

Although training had taken place, according to the informants further training was necessary to increase their knowledge of the different components of the STOP GBV programme as well to improve their capacity to manage and execute the tasks of the OSC. The need for training was emphasised at all the sites.

I think we need a little bit more of training and it would be good if more members of staff would be trained in this because it's really quite rampant at the moment. If the doctors can be trained in survivor support and how to take care of somebody who is specifically undergoing gender-based violence, even we need a special training. . . maybe also in child management but in general more specialisation. (Kalomo)

For OSC I am only trained to provide medical services, am not trained in providing psycho-social services, so I feel I am not well prepared for this task. Am qualified only in medical examination not in psycho-social counselling. (Nyimba)

They also pointed at that the training sessions they attended were too short and too general. They preferred more in-depth and specialised training courses.

No because I only attended two workshops, the one I had in Livingstone was for three days and the one here in Mumbwa was for five days. It was not enough for me, because I get GBV cases I think if I had more training in counselling for me to be more qualified so that I can handle these cases. Yes I have and it's was generally about GBV. The training was early this month and the previous one was in October or September. (Mumbwa)

Not really, no, ...I think we need a little bit more of training and it would be good if more members of staff would be trained in GBV because it's really quite rampant at the moment. If the doctors could be trained just in survivor support and how to take care of somebody who has specifically undergone GBV or may be a special training in child management but in general more specialisation. (Kalomo)

One of the challenges in Mumbwa, which may also pertain to the other districts, is that none of the staff at the OSC was trained in the management of sexual abuse or rape.

The facility has no one who has received any form of training on the management sexual and rape. None of us has done that. (Mumbwa)

It was also observed by some informants, notably in Kalomo, that the VSU needed more training and capacity in the area of GBV management.

With skills, I think the VSU need something more than what they have. Maybe they also need counselling skills because sometimes what I see, I would almost say 'no, please don't do that, this person has been abused'. They need the skills because sometimes they cannot differentiate between a perpetrator and a survivor. The compassion towards a survivor is what they also need. Hopefully, maybe with time they will be able to do that. There is also efficiency, to get to them and get them to do things, it is hectic. (Kalomo)

The general observation is that the OSCs in the six districts have only just been opened. Although most OSC staff have been oriented in GBV, the assessment of their technical capacity was premature. Given that most had only recently begun it was difficult to obtain realistic information regarding their technical capacities. Despite the training they had attended, most of them still wanted further training. It was also noted that there were some areas of operation that needed more orientation. Issues of supervision were also not clearly articulated, which may suggest that monitoring and quality control were not happening, or not happening systematically. It was also not clear what mechanism the programme will use for quality assurance especially since the issues of protocols and guidelines were still unclear.

4.7.5 Quality of care

The informants also brought out issues of quality of care for GBV survivors. They said that work schedules of some staff being seconded to the OSCs are too heavy and busy. They also mentioned that geographical distances and long delays negatively affect the quality of care.

At the moment for me it's not okay and needs to be improved. The police needs to be here so that the survivors won't have to go from here to the police which is about two kilometres and then they come back. If they (police) were here they (the victims) would be finished immediately without having to follow them. (Kalomo)

I think the care at the hospital needs to be improved. First in the morning they go into the wards to see in-patients. After that they come and open for the out-patients. So sometimes we find that there are long queues. Survivors and other patients will wait to be seen by the doctor. So what we do, sometimes, is that we take the survivors there so that they can be seen first. We are not quite happy with that, it needs improvement. Why not open a clinic with special duties. Here you come as a survivor but you have to wait. It is time-consuming. (Kalomo)

In some districts, it was also felt that the environment around the OSC was prohibitive to the survivors of GBV to seek support and/or they were still unaware of the OSC.

As you can see here, when you go out here it is like a rally, there are a lot of people. So for them to be attended it may take a long time. You know when one gets abused they don't want to hang around that place, they were battered, they have all these scars. (Kalomo)

Not everyone is aware of the one-stop centre. They are still afraid that it might take them a very long time for them to be treated. And also, a long time ago they used to pay some fee for the medical report to be signed. So, not everybody is aware that now these forms are free of charge. (Kalomo)

4.8 Networking, referrals and collaboration

The OSCs work with a range of district-level stakeholders to respond to the needs of GBV survivors and to prevent the occurrence of GBV at the community level. Key stakeholders include the Departments of Health and Social Welfare, the police (through the VSU), the judiciary (through the courts), the local council and the District Commissioners' office. Networking is critical in efforts to stamp out GBV and important groundwork has been carried out to develop a strong mechanism for bringing many players together, especially those from government departments, as this observation made by a service provider in Nyimba shows:

Yes we work with police VSU and also people from the court, Ministry of Justice these are also based at a one-stop centre, so when the survivor comes then the survivor will be counselled then if there will be need for police report then it will be gotten and it will be signed by me and the police officer will investigate the alleged circumstances, and the people from Justice will advise on legal technicalities of the case. (Nyimba)

The interviews revealed that teamwork is vital in the fight against GBV especially in relation to attending to the GBV survivors. In some districts it was observed that organisations working with the STOP GBV Programme were putting in a lot of effort to support the GBV response. In Mumbwa, for instance, it was noted that, highly effective relationships exist between the police, the hospital and other partners to the benefit of the survivors and communities.

I really want to say thank you to everyone who had provided input or support to this project, it has started helping a lot of people. You have a situation where a survivor comes. If they come they report to us, and it is our duty to take that person to the hospital and see to it that the doctor signs the medical report form so that we don't delay the prosecution. (Mumbwa)

There is also a lot of networking within the STOP GBV Programme and at different levels, including involving the community. However, according to many respondents, there cannot be any meaningful engagement with the community without involving traditional leaders. The same applies to the services provided by the programme. The respondents mentioned that chiefs are involved in the GBV prevention in their chiefdoms, working through traditional structures to fight GBV and to encourage the communities to avail themselves of GBV services. It was pointed out that chiefs summon their headmen and other traditional leaders to attend meetings where GBV issues are discussed. Chiefs active in these issues were found in Kalomo, Nyimba and Mumbwa.

The chief has been telling his headmen to mobilise people and disseminate message on GBV. Whenever he has meetings with his headmen, he includes prevention of GBV and messages on early marriage. (Kalomo).

The interviews revealed that in areas where networking and collaboration were not so effective this posed challenges. According to respondents, even though OSCs may be based at health centres, when the OSC is not fully integrated into the hospital system or where it is located away from the district hospital, there were often obstacles because of geographical distance, related to speedy medical attention and subsequently the conclusion of cases. This was also the case when dealing with the Department of Social Welfare. Where the Social Welfare Officer is not physically located at the OSC, there were logistical problems.

The challenge we have is maybe because we haven't done so much awareness with our partners, other clinics, and the hospital. I think the hospital staff need to be reoriented. Our clients take too much time, even if we bring them ourselves, we find a lot of red tape and bureaucracy. With the social welfare sometimes you can refer somebody there, somebody who is vulnerable in terms of finances and all that but by the time they are helped…. It takes a long, long, long time. So I think its maybe because we are new, because we need to work on it as a team in this district. (Kalomo)

The OSC has the capacity and ability to refer and transfer survivors to other services. The VSU transports the survivors to the hospital for further medical examination and signing of the medical report[6]. The OSC completes the report, which has to be sign by the medical officer.

The VSU officers have to take the survivor there and they don't just dump them but they have to wait for the referral forms and medical reports to be signed. When the whole process is done they come with them here to me. The findings of the doctors are written on the forms. (Mumbwa)

Yes they are, in cases of rape they are but the challenge is sometimes they don't even know the rapist or perpetrator. After rape we have PEP, emergency contraceptives and psychological and moral support to the victim. (Mpika)

6 This process varies from one VSU to another and depending on the availability of a OSC in the area. Thus, if the survivor goes first to the OSC, they can be transported to the VSU if needed. If they go first to the VSU then they can be transported to the OSC.

4.9 Quality of OSC – strengths/gaps

Here we briefly outline some of the strengths as well as gaps or challenges in the OSC as perceived by the key informants. Some of these are addressed again in the final recommendations.

Strengths

- In almost all districts, the OSC service providers or staff were able to refer and also escort GBV survivors to the hospital. This enabled survivors to be attended to by a doctor in a timely manner; since a delay in being attended to by a doctor risks a deterioration in the physical evidence in the case of sexual abuse, this timely consultation with a doctor is critical
- The OSCs provide all the services or referral to services under one roof.
- Networking and collaboration ensures that resources are pooled. It also makes the roles of each partner clearer and better defined which in turn is beneficial for efficiency and effectiveness.

Gaps

- In all the districts, transport was reported to be a major challenge to the timely and effective provision of GBV services. The absence of reliable transport, means that a GBV survivor often has to make their own way to hospital (either walking or though hiring a taxi); there were also reports of counsellors or VSU staff incurring their own expenses to ensure that the person is examined and the police report signed.
- In some districts there is a shortage of staff. This has created a situation where staff who are not trained or oriented on GBV services render assistance and attend to GBV survivors.
- In most districts there are no shelters and safe homes for GBV survivors. For those survivors with safety concerns in their own home and those who come from remote places, the lack of shelters is a concern
- The erratic supplies of HIV testing kits and emergency contraception were reported in some districts.

5 Description of study respondents – quantitative findings

This section provides some basic socio-demographic and economic profiling information of the respondents using data from the quantitative community baseline questionnaire.

5.1 Socio-demographic and educational background

A total of 2,053 people aged 15–92 years participated in responding to the baseline survey. More than half (58.5%) were female. The mean age was 31.85 years and the median age was 29 years. The highest proportion of respondents was in the 20–24 years age group (20.1%) followed by 25–29 years (17.9%) and 30–34 years (14.3%). Sex distribution was relatively even, with slightly more women aged 25–29 years than other age groups (see Table 3).

Table 3: Distribution of respondents by sex and age group

District.	Sex	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55+
Chingola (n=343)	Female	11.7	19.8	20.8	10.2	11.7	10.7	8.6	4.1	2.5
	Male	11.6	24	15.8	8.9	12.3	13.7	6.2	2.7	4.8
	All	11.7	21.6	18.7	9.6	12.0	12.0	7.6	3.5	3.5
Kalomo (n=341)	Female	12.7	18.1	17.6	15.7	12.3	8.8	10.3	2	2.5
	Male	14.6	27.7	12.4	13.9	9.5	6.6	6.6	4.4	4.4
	All	13.5	22.0	15.5	15.0	11.1	7.9	8.8	2.9	3.2
Monze (n=350)	Female	10.2	25.6	17.2	14	10.7	9.8	5.6	3.7	3.3
	Male	13.3	20	17	11.9	11.9	10.4	9.6	3	3
	All	11.4	23.4	17.1	13.1	11.1	10.0	7.1	3.4	3.1
Mpika (n=349)	Female	13.2	14.7	21.6	17.6	11.3	6.9	6.4	4.4	3.9
	Male	11.7	24.8	15.9	15.2	7.6	7.6	6.2	6.2	4.8
	All	12.6	18.9	19.2	16.6	9.7	7.2	6.3	5.2	4.3
Mumbwa (n=334)	Female	9.7	21.5	17.4	19	7.7	5.6	4.6	7.2	7.2
	Male	10.8	15.8	19.4	20.1	8.6	9.4	5.8	5	5
	All	10.2	19.2	18.3	19.5	8.1	7.2	5.1	6.3	6.3
Nyimba (n=336)	Female	14.1	13.5	20.5	12.4	11.9	11.4	3.2	8.1	4.9
	Male	14.6	17.9	16.6	11.9	11.3	9.3	9.3	3.3	6
	All	14.3	15.5	18.8	12.2	11.6	10.4	6.0	6.0	5.4

All (N=2053)	Female	11.9	19.0	19.2	14.8	10.9	8.8	6.5	4.8	4.0
	Male	12.8	21.7	16.2	13.6	10.2	9.5	7.3	4.1	4.7
	All	12.3	20.1	17.9	14.3	10.6	9.1	6.8	4.5	4.3

Table 4 presents the distribution of respondents by completed education level. There are no major variations by district. Overall, most study respondents had received some form of formal education (96.3%). A relatively low proportion (3.7%) had never been to school. About a third of all respondents had completed secondary school (35.3%) (combining junior and senior secondary school), followed by those who had completed primary (28.3%) education. Overall, more female respondents reported having completed primary school compared to males (34% vs 21.1%); there are no major differences according to age categories, although there is a slight increase in attendance at lower age categories. More male respondents, however, reported having completed junior secondary school (23.1% vs 22.5% for females), senior secondary school (39.9% vs 31.9% for females) and tertiary levels (12.8% vs 7.6% for females) when compared to female respondents.

Table 4: Distribution of respondents by level of education

District	Sex	None	Primary	Junior Secondary (Grades 8-9)	Senior Secondary (Grades 10-12)	Tertiary	Adult Literacy
Chingola (n=343)	Female	1.5	18.8	21.8	50.8	7.1	-
	Male	1.4	13.0	17.1	47.9	20.5	-
	All	1.5	16.3	19.8	49.6	12.8	-
Kalomo (n=341)	Female	6.9	35.3	26.5	24.5	6.9	-
	Male	4.4	22.6	25.5	38.0	8.8	0.7
	All	5.9	30.2	26.1	29.9	7.6	0.3
Monze (n=350)	Female	5.6	36.3	26.0	26.0	5.1	0.9
	Male	5.9	28.9	23.7	31.9	9.6	-
	All	5.7	33.4	25.1	28.3	6.9	0.6
Mpika (n=349)	Female	2.0	27.9	22.1	34.3	13.7	-
	Male	-	15.2	30.3	42.8	11.7	-
	All	1.1	22.6	25.5	37.8	12.9	-
Mumbwa (n=334)	Female	4.1	42.1	21.0	24.6	8.2	-
	Male	4.3	24.5	20.1	40.3	10.1	0.7
	All	4.2	34.7	20.7	31.1	9.0	0.3
Nyimba (n=336)	Female	4.3	42.7	16.2	32.4	4.3	-
	Male	2.6	21.2	22.5	37.7	15.2	0.7
	All	3.6	33.0	19.0	34.8	9.2	0.3
All (N=2053)	Female	4.1	33.8	22.4	32.0	7.6	0.2
	Male	3.0	20.8	23.2	39.9	12.8	0.4
	All	3.7	28.3	22.7	35.3	9.7	0.2

Table 5 presents the distribution of respondents by marital status. The highest proportion (55%) were in monogamous marriages and cohabiting accounted for the lowest (0.1 %). The sex distribution according to marital status was relatively balanced with slightly more males who had never been married than females.

Table 5: Distribution of respondents by marital status

		Married		Cohabiting	Never married	Divorced or separated	Widowed
		Monogamy	Polygamy				
Chingola (n=343)	Female	59.4	-	-	25.9	6.6	8.1
	Male	50.7	2.7	-	43.2	2.1	1.4
	All	55.7	1.2	-	33.2	4.7	5.2
Kalomo (n=341)	Female	56.4	6.9	-	20.1	6.4	10.3
	Male	46.0	4.4	-	44.5	4.4	0.7
	All	52.2	5.9	-	29.9	5.6	6.5
Monze (n=350)	Female	52.6	4.7	0.5	23.3	7.0	12.1
	Male	60.0	3.0	-	30.4	5.2	1.5
	All	55.4	4.0	.03	26.0	6.3	8.0
Mpika (n=349)	Female	57.8	1.5	-	27.5	8.3	4.9
	Male	58.6	0.7	-	37.9	1.4	1.4
	All	58.2	1.1	-	31.8	5.4	3.4
Mumbwa (n=334)	Female	53.8	1.0	-	24.1	7.2	13.8
	Male	52.5	2.9	1.4	33.8	8.6	0.7
	All	53.3	1.8	0.6	28.1	7.8	8.4
Nyimba (n=336)	Female	58.9	2.7	-	20.5	4.9	13.0
	Male	50.3	2.6	-	39.1	3.3	4.6
	All	55.1	2.7	-	28.9	4.2	9.2
All (N=2053)	Female	56.4	2.8	0.1	23.6	6.8	10.3
	Male	53.0	2.7	0.2	38.2	4.1	1.8
	All	55.0	2.8	0.1	29.7	5.7	6.8

5.2 Socio-economic status and household decision-making

When asked about the language in which they were most comfortable reading/writing, most of the respondents (35.7%) mentioned English followed by Bemba (20.8%) (see Table 6). This could partly be attributed to the fact that local languages are mainly taught at primary school, after which they become optional; English, on the other hand, is the official language, the medium of instruction in all schools, and is taught to everyone who attends secondary school and beyond. Less than a quarter (16.3%) could not read or write in any language. The proportion of those who were uncomfortable writing/reading in any language was highest in Mumbwa and Nyimba (21.6% and 21.7% respectively).

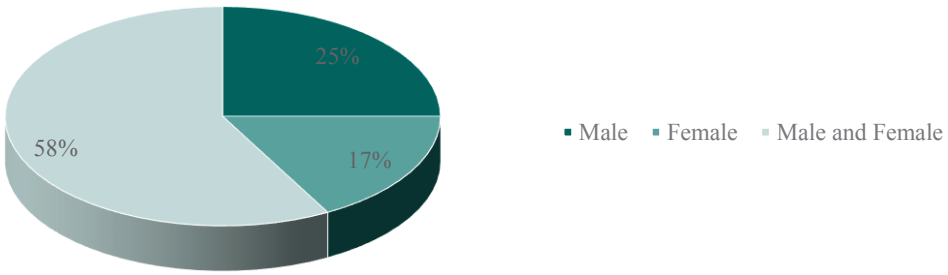
Table 6: Distribution of respondents by preferred language for reading/writing

	Chingola	Kalomo	Monze	Mpika	Mumbwa	Nyimba	All
None	5.5	20.2	23.1	6.0	21.6	21.7	16.3
Bemba	46.9	2.1	1.1	65.9	5.7	1.5	20.8
Nsenga/Chewa	0.9	0.9	0.6	0.9	12.9	36.9	8.7
Tumbuka	1.2	-	-	-	0.9	1.5	0.6
Lozi	0.3	2.3	0.3	0.6	5.4	0.6	1.6
Luvale	0.3	-	0.3	-	-	-	0.1
Lunda	1.5	-	-	-	0.3	-	0.3

Tonga	-	40.5	41.4	1.1	3.9	-	14.6
Kaonde	0.3	-	0.3	-	5.1	-	0.9
English	42.6	34.0	32.6	25.2	42.2	37.8	35.7
Chokwe	0.3	-	-	-	-	-	0.0
Ila	-	-	-	-	0.6	-	0.1
Lamba	0.3	-	-	-	-	-	0.0
Lenje	-	-	-	-	0.6	-	0.1
Mambwe	-	-	-	0.3	-	-	0.0
Mbunda	-	-	-	-	0.6	-	0.1
Ndebele	-	-	0.3	-	-	-	0.0
Zulu	-	-	-	-	0.3	-	0.0

Household decision-making is an important consideration in designing any programme with gender dimensions. The baseline survey asked questions about decision-making at the household level. When asked about who was the main decision-maker in their households, most (58%) mentioned both the man and the woman while 25% said the main decision-maker in their household was a man. Seventeen percent mentioned woman as the main household decision-maker (see Figure 2).

Figure 2: Household decision-making (N=2053)



Distribution of survey respondents by occupation (Table 7) shows that the majority (41.1%) had no formal employment, about 21% were farmers, about 15% were labourers and 23% were involved in business. Nyimba had the highest proportion of respondents in business. Distribution across districts indicates that Chingola had the highest (55.4%) proportion of people without any form of formal employment while Nyimba had the lowest (22.6%). Nyimba had the highest proportion of farmers (37.1%) and Chingola had the lowest (5%), possibly because of the more urban nature of Chingola and rural nature of Nyimba, Mpika had the highest proportion of labourers (22.9%). There are statistically significant differences between male and females with regard to occupation (except for farming P=0.13). Females are more likely to be outside of formal employment (i.e. receiving a regular salary) (48.6% compared to 30.1% for men) (P<0.001) but are more likely to be engaging in business activities (24.5% compared to 20.9% for men), which includes small-scale trading.

Table 7: Distribution of respondents by occupation

District	Sex	No formal employment	Farming	Labourer	Business
Chingola (n=322)	Female	67.7	2.1	9.0	21.2
	Male	38.1	9.0	38.1	14.9
	All	55.4	5.0	21.1	18.6
Kalomo (n=285)	Female	59.2	7.8	4.5	28.5
	Male	41.5	10.4	20.8	27.4

	All	52.6	8.8	10.5	28.1
Monze (n=318)	Female	57.7	15.4	7.5	19.4
	Male	44.4	17.1	23.9	14.5
	All	52.8	16.0	13.5	17.6
Mpika (n=332)	Female	45.7	12.7	17.8	23.9
	Male	28.9	25.9	30.4	14.8
	All	38.9	18.1	22.9	20.2
Mumbwa (n=331)	Female	34.5	33.0	8.2	24.2
	Male	17.3	38.8	23.0	20.9
	All	27.3	35.4	14.4	22.8
Nyimba (n=326)	Female	27.1	37.8	4.8	30.3
	Male	16.8	36.2	14.8	32.2
	All	22.6	37.1	9.2	31.2
Total (n=1914)	Female	48.6	18.2	8.7	24.5
	Male	30.1	23.8	25.1	20.9
	All	41.1	20.5	15.4	23.0

In addition to asking about their occupation, respondents were asked about the household's main source of income. Figure 3 shows the mains source of household income by main decision-maker in the household, i.e. male, female or both. There appears to be significant variation by site, however formal employment has a more critical role in Chingola and Mpika particularly household where men are the decision-makers. Mumbwa and Nyimba stand out as sites where self-employment is more critical than formal employment for all forms of households. Piecework is often more critical for household with male decision-makers, particularly in Monze and Kalomo. Table 1 in Annex 2 describes the main sources of household income by sex of respondent and shows that about half of the respondents (51.9%) said they were formally employed and about 30% were self-employed. Chingola had the highest (51.9%) proportion of formally employed respondents while Mumbwa had the least (21.6%). Mumbwa had the highest (63.5%) level of self-employed respondents and Chingola had the lowest (33.8%).

Figure 3: Main income sources by main decision-maker in the household

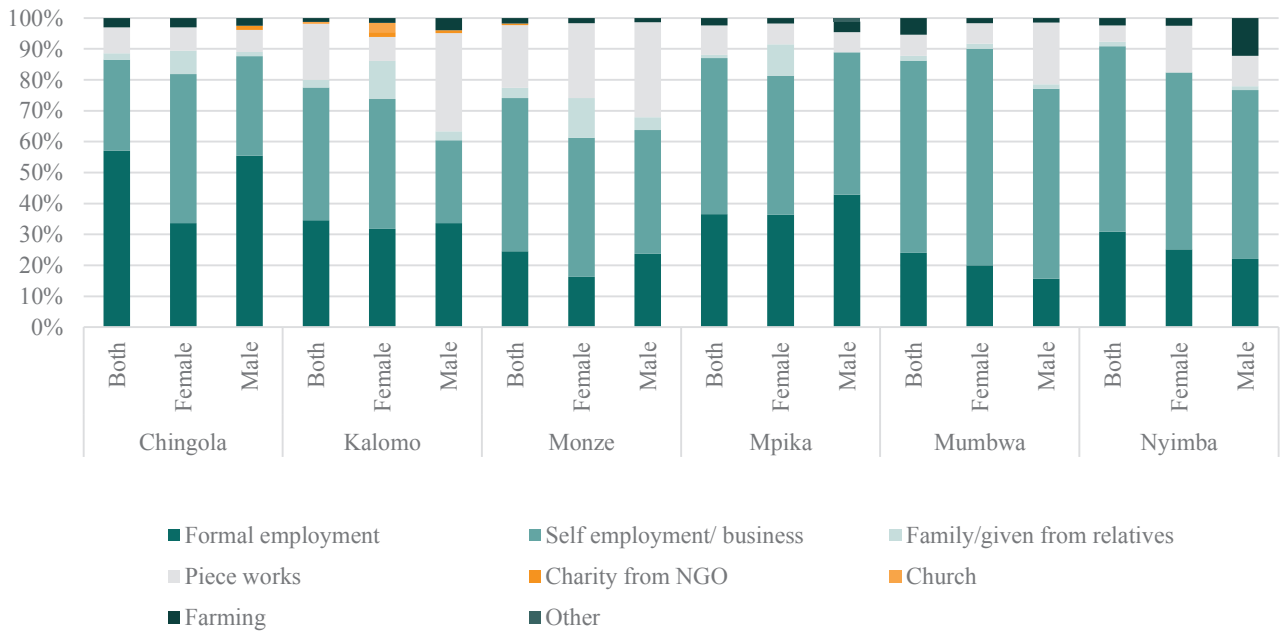
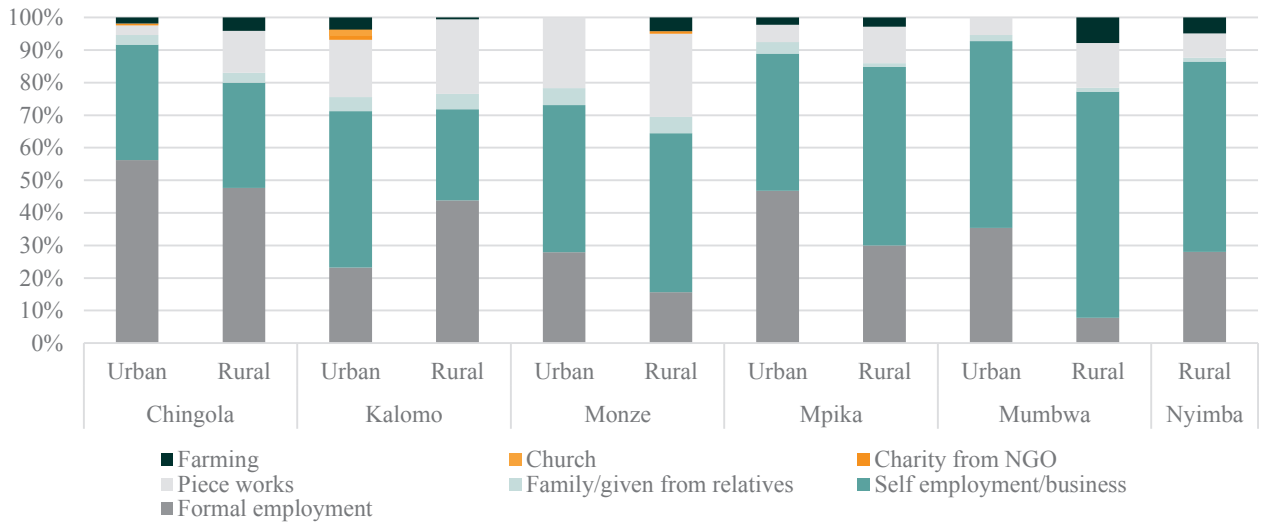


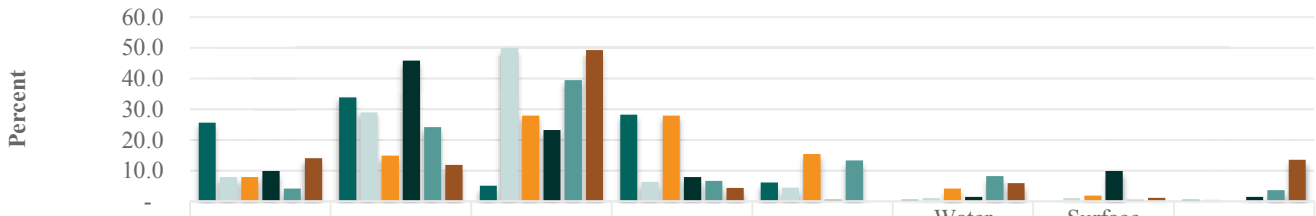
Figure 4 below shows household main income source by rural vs urban sites. As can be seen, the greatest variance is the degree of formal employment which, as can be expected, is higher in urban areas in all districts apart from Kalomo. Piecework appears to be higher in rural areas again apart from in Kalomo where the balance is more even.

Figure 4: Household main income source by rural vs urban



When asked about their main source of drinking water, since it is a good indicator of wealth, 31.8% of the respondents said that they accessed drinking water from public taps or standpipes and 24.3% had water piped to their outside yard. Figure 5 presents the distribution of respondents' source of water by district and shows that Chingola had the highest proportion (25.6%) with water piped to their dwellings, again most likely because of the more urban nature of Chingola, while Mpika had the highest proportion for piped to the yard (45.8%). Respondents from Kalomo (50%) and Nyimba (49.2%) relied largely on public taps whereas respondents from Monze and Chingola had the highest percentage of protected wells.

Figure 5: Main source of drinking water for the household (N=2047)



	Piped into dwelling	piped to yard/plot	Public tap/standpipe	Protected well	Unprotected well	Water vendor/kiosk /private tap	Surface water (river/dam	Borehole
Chingola	25.6	33.8	5.1	28.2	6.2	0.5	-	0.5
Kalomo	7.8	28.9	50.0	6.4	4.4	1.0	1.0	0.5
Monze	7.9	14.9	27.9	27.9	15.3	4.2	1.9	
Mpika	9.9	45.8	23.2	7.9	0.5	1.5	9.9	1.5
Mumbwa	4.1	24.1	39.5	6.7	13.3	8.2	0.5	3.6
Nyimba	14.1	11.9	49.2	4.3		5.9	1.1	13.5

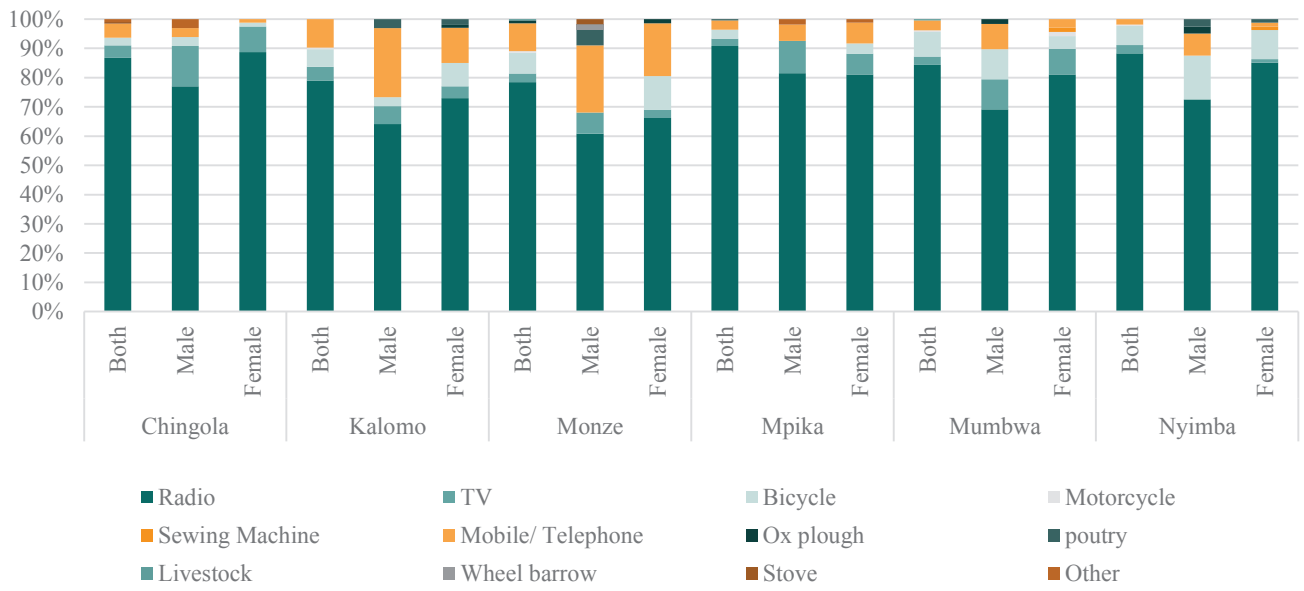
In terms of type of toilet facility used in their household approximately half (50.1%) of the respondents relied on traditional pit latrines, while a quarter of respondents mentioned pit latrine with slab, i.e. an improved version of the traditional pit latrine. About 20% said they used flush or pour flush toilets, i.e. water is poured into the toilet pan. Chingola had the highest proportion (63.6%) of households using such toilets, probably again because of its more urban nature. Traditional pit latrines were more common in Mpika (63.3%) while improved pit latrines were more commonly reported in Monze (see Annex 2, Table 2).

Respondents were also asked about the main material from which their house walls were built. More than half (62.4%) of the respondents lived in houses made of brick, with Chingola reporting the highest proportion. Mumbwa had the highest with concrete-walled houses (32.9%) but also the highest proportion of respondents from mud-walled houses and those with wooden walls were more common in Mpika. Again the fact of being urban or rural probably influences these indicators (see Annex 2, Table 3).

Respondents were also asked about the main roofing material of their dwelling. Over half of the respondents live in houses with corrugated iron roofing (62.8%) and Mpika accounted for the highest proportion of such respondents. Chingola recorded the highest proportion of respondents with asbestos roofing (61.06%) and Mumbwa had the highest for grass thatch (30.24%) (see Annex 2, Table 4).

Figure 6 shows the type of assets owned by respondents according to main household decision-maker. Radio, TV and mobile phones are the dominant type assets owned by all households across the 6 districts. Radio tends to be more common in households where women are the main decision-makers whereas mobile phones and TV are more prominent in households where men are the main decision-makers. (Table 5 in Annex 2 contains information of asset ownership by respondent sex).

Figure 6: Asset ownership by main decision-maker in the household

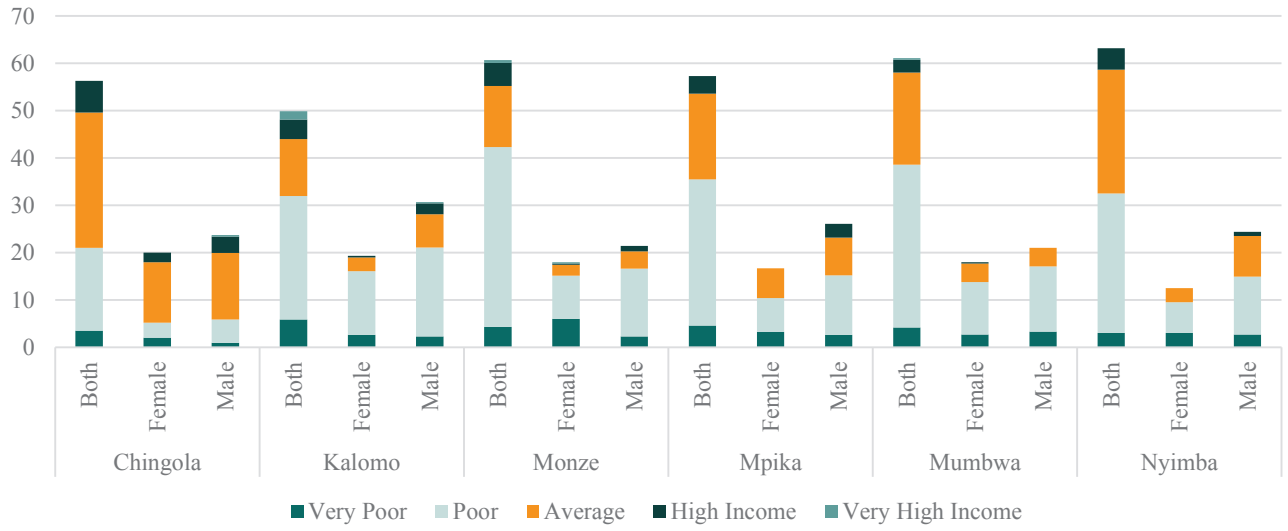


Several variables were used to compute the household wealth index. Each asset was assigned a value from 1 to 5, and included indicators such as type of toilet and the source of drinking water to compute the wealth index and to place each household in a relative wealth ranking. The minimum score for each household was 4 and the maximum possible score was 48. Overall, half of the respondents were ranked poor (50.6%), and one third (32.2%) of them were ranked average. Only about 8 percent of the respondents were ranked as well to do. Monze had the highest proportion of respondents (61.4%) ranked poor while Chingola had the lowest (25.7%). Chingola had the highest proportion for average (55.4%) and well-to-do (12.2%) households. Of all the six districts, Chingola is the most

urbanised due to the mining activities in the district. Monze has low economic activity, which might explain the low wealth index ranking of survey households.

Figure 7 shows the distribution of the wealth index by both site and type of household (lead decision-maker). The figure reveals that Chingola is an outlier in that there is a notably higher proportion of households with an 'average' wealth index. Apart from this, there is limited variance in the wealth index patterns across the sites. Comparing by types of decision-maker (male, female, or both), it can be seen that females in Nyimba and Monze have a higher proportion of females that have a 'very poor' wealth index status.

Figure 7: Distribution of Wealth Index by main decision maker and district (N=2053)



6 Knowledge of and attitudes towards GBV

This section draws on findings from the quantitative community survey and the qualitative survey, for which we draw largely on the FGDs. In each sub-section, where relevant, we first present the quantitative data followed by the qualitative data.

6.1 GBV: definitions, meanings, perceptions and attitudes

6.1.1 Quantitative data

Respondents were asked to define GBV (about 9% gave no definition). According to the main types of GBV as identified by the GBVIMS toolkit[7], physical assault was mentioned by 81.2% of respondents; within the category of physical assault, hitting was the most frequently mentioned (77.3%) A third of respondents (33.6%) identified rape as a form of GBV; while more females than males identified rape as a form of GBV, the difference was not statistically significant (P=0.161). The most frequently mentioned category of rape was defilement (16%). The next most frequently occurring definition of GBV was denial of resources (21.1%), followed by psychological and emotional abuse (18.8%), with only 9.7% of respondents mentioning sexual assault and early marriage (5%) as forms of GBV, see Table 8.

Table 8: Definitions of GBV (n=1857)

Forms of GBV	Yes (%)
Rape	33.6 (total)
Cultural rites including cleansing	0.9
Marital rape	4.5
HIV-related cleansing	0.6
Child abuse	11
Defilement	16
Sodomy	0.6
Sexual assault	9.7 (total)
Attempted rape	2.8
FGM/Circumcision	0.1
Unwanted kissing/touching	1.6
Child abuse	5.2
Physical assault	81.2 (total)
Hitting or slapping	77.3
Burning	2.3

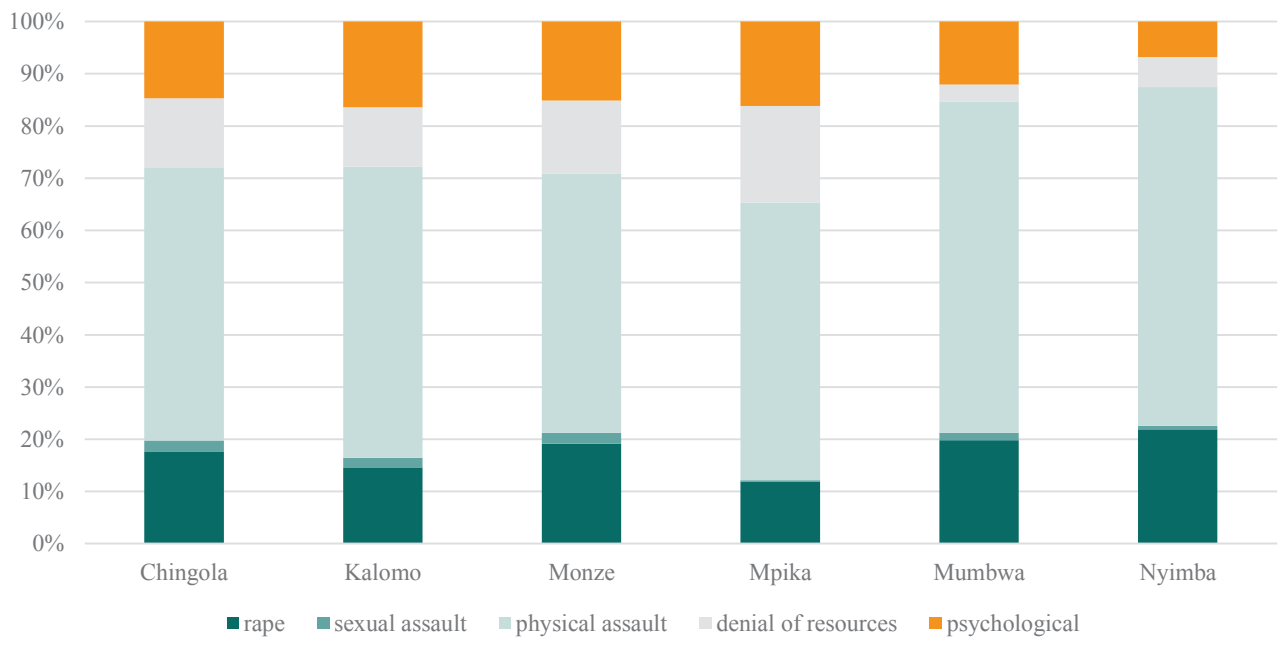
7 This table is based on the GBVIMS however additional categories were included to incorporate context specific dimensions of GBV. Thus, for instance, HIV-related cleansing is not in the GBVIMS but because it is a form of rape it was included as a sub-category of rape. Other additions include sodomy and defilement.

Choking	1.6
Forced marriage	5 (total)
Early marriage	5
Denial or resources/opportunities/services	21.1 (total)
Denial of education	7.6
Denial of health services	1.3
Denial of contraception	0.6
Denial of inheritance	1.7
Denial of right to own land	1
Denial of savings	8.9
Psychological and emotional abuse	18.8 (total)
Threat of physical violence	13.9
Threat of sexual violence	1.9
Forced isolation	1.8
Unwanted attention/ Stalking	1.2

There are no significant differences in definitions of GBV by sex ($p>0.05$), although significantly more male than female respondents defined GBV as sodomy ($p=0.04$), choking ($p=0.030$), forced marriage ($p=0.007$), early marriage ($p=0.017$), psychological and emotional violence and the threat of physical violence ($p=0.027$).

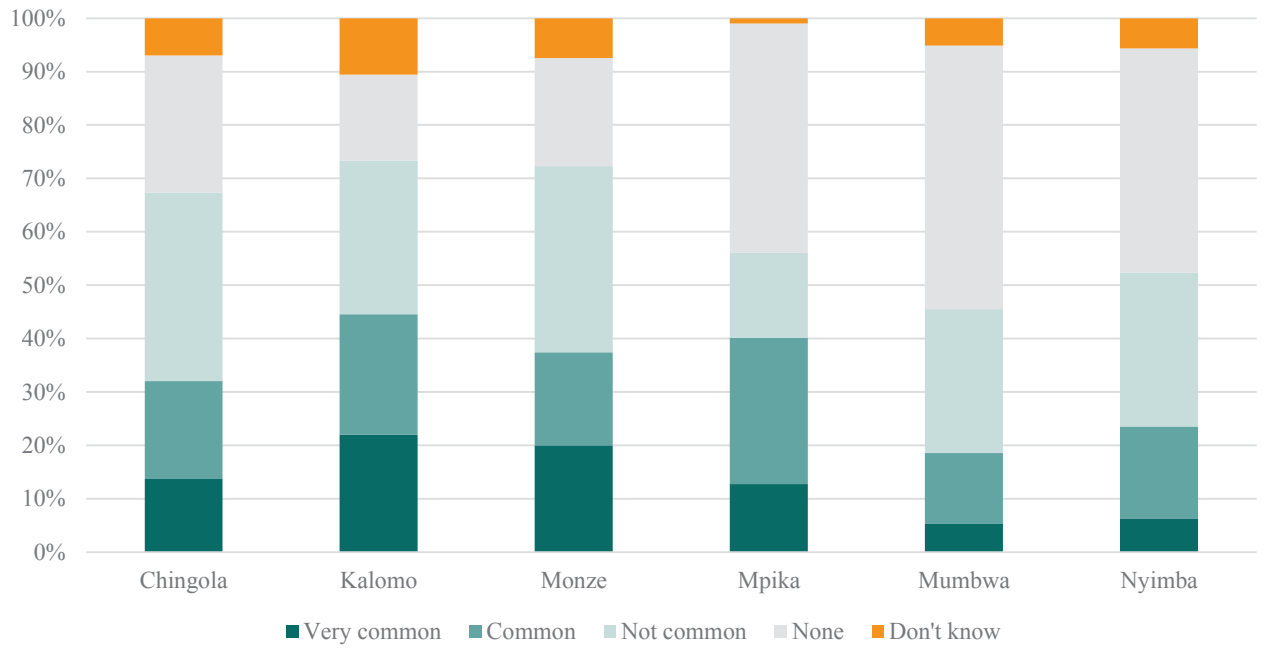
When comparing the most widely mentioned definitions of GBV across the different districts, the patterns are largely similar (see Figure 8). Similarly, when comparing rural-urban differences there is little variation in definitions of GBV, although physical assault appears to be a significantly more common response in rural areas (41.5%) when compared to urban (31.8%).

Figure 8: Definitions of GBV by district



A total of 1293 or 63% of respondents reported that girls marry below the age of 18, whereas only 23.8% of boys were seen to marry under the age of 18. When asked how common early marriage was in their communities, 32.1% said it was common or very common. Comparing responses by district, Kalomo and Mpika have the highest proportion of respondents say that early marriage is very common or common, i.e. 44.5% and 40.1%, compared to Mumbwa and Nyimba with 18.5% and 23.5%. See Figure 8. According to study respondents, early marriage occurs because of economic reasons (29%), for dowry (19.45) and because it is expected behaviour (3.8%).

Figure 9: Perceived prevalence of early marriage by district



In terms of attitudes towards GBV, a set of 7 statements were read out to respondents which they responded to using a Likert scale. Figure 10 shows the distribution by sex and by statement. What stands out is that in most cases more women than men agreed/strongly agreed that it was acceptable for a man to beat his wife in a variety of circumstances (see below); the only exception was for rape, where marginally more men than women agreed/strongly agreed that it was acceptable. Thus marginally more respondents strongly agreed or agreed that rape is never deserved (approximately 70%). According to respondents, neglecting children appears to be a greater justification for GBV than refusing to have sex, arguing with the husband or burning food. Figure 11 explores the extent to which rape is deserved if girls dress badly or misbehave by district and by sex. Overall attitudes across all districts are regressive as a majority of respondents disagree or strongly disagreed that rape is never deserved. In particular, Nyimba and Mumbwa stand out as being districts where there was the highest proportion of respondents reporting regressive attitudes. Generally, males and females have comparable attitudes across all districts with the some minor exceptions. Thus in Monze, for instance, approximately 42% of females strongly agreed or agreed that rape is never deserved compared to approximately 28% of men; and in Mpika, approximately 25% of men disagreed that rape is never deserved compared to 12% of women.

Figure 10: Attitudes towards GBV

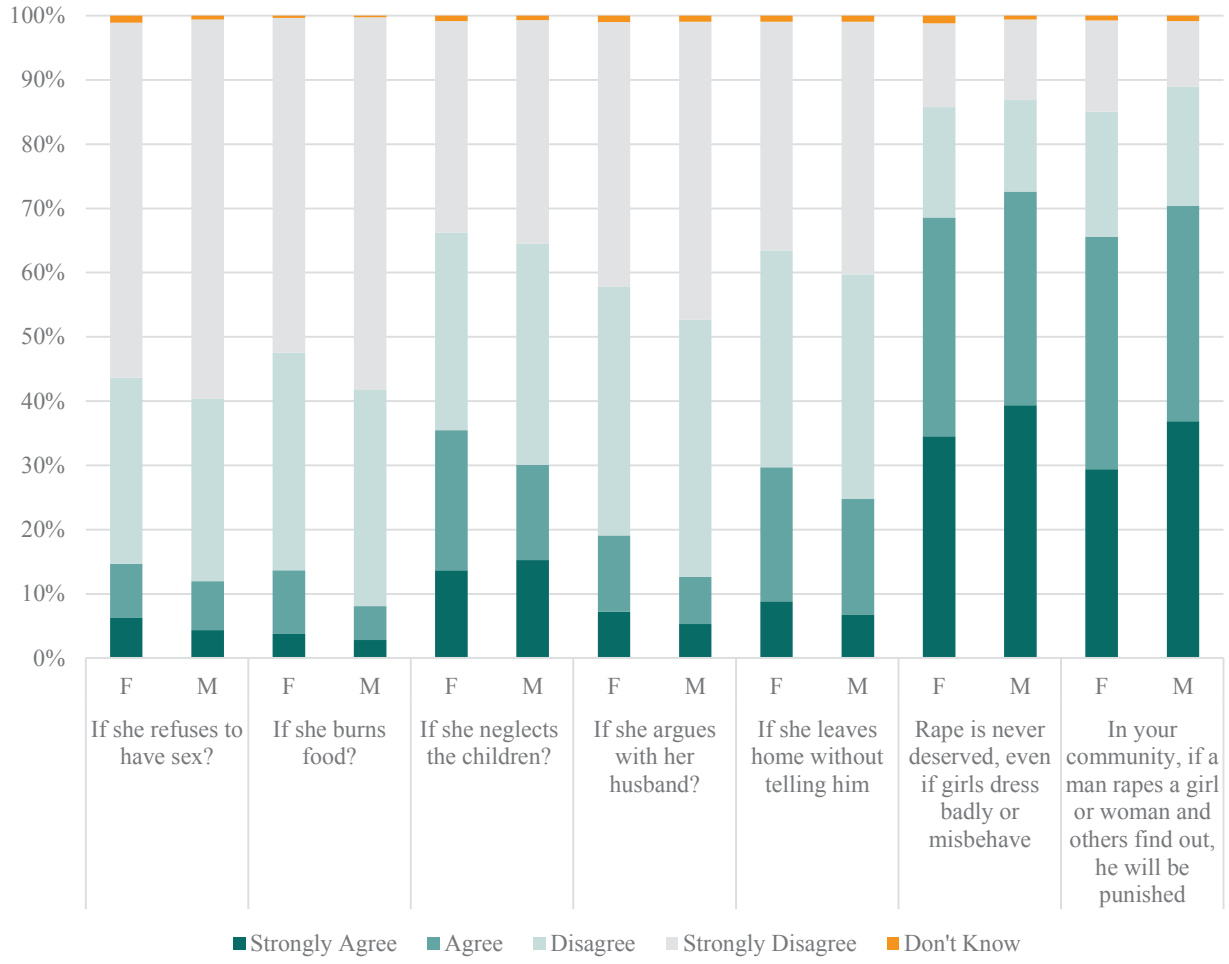


Figure 11: Attitudes towards GBV according to district and sex

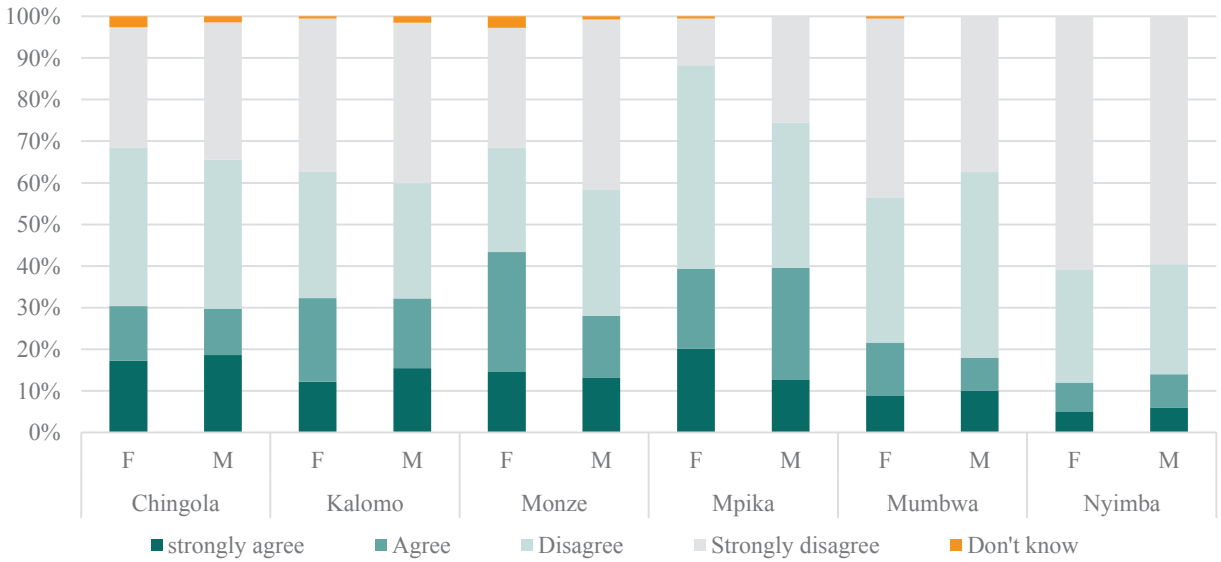


Figure 12 shows a composite knowledge and attitude index for all study participants, based on 39 variables. The range of variables included the definition of and attitudes towards GBV. Participants were asked to define GBV without any prompting. Each definition was assigned a value of 1. For the 6-scale attitude questions (see Figure 9 above), the set of possible responses was strongly disagree, disagree, agree and strongly agree (see appended questionnaire). If the favourable response reflecting correct knowledge of GBV was 'strongly agree' it was assigned the value of 2 and 'agree' was assigned the value of 1. The highest possible score was 45 and the lowest was 0. The scores were summed up for each participant and presented in three mutually exclusive categories. These were low knowledge level (0–15), moderate level (16–30) and high level (31–45). The actual scores ranged from 0 to 41. The mean score was 12.4 and the median was 13. As shown in Figure 10 most respondents had low knowledge levels and discriminatory/regressive attitudes and about a quarter were classified as having moderate knowledge levels and less discriminatory/regressive attitudes.

Figure 12: Respondents' knowledge level and attitudes

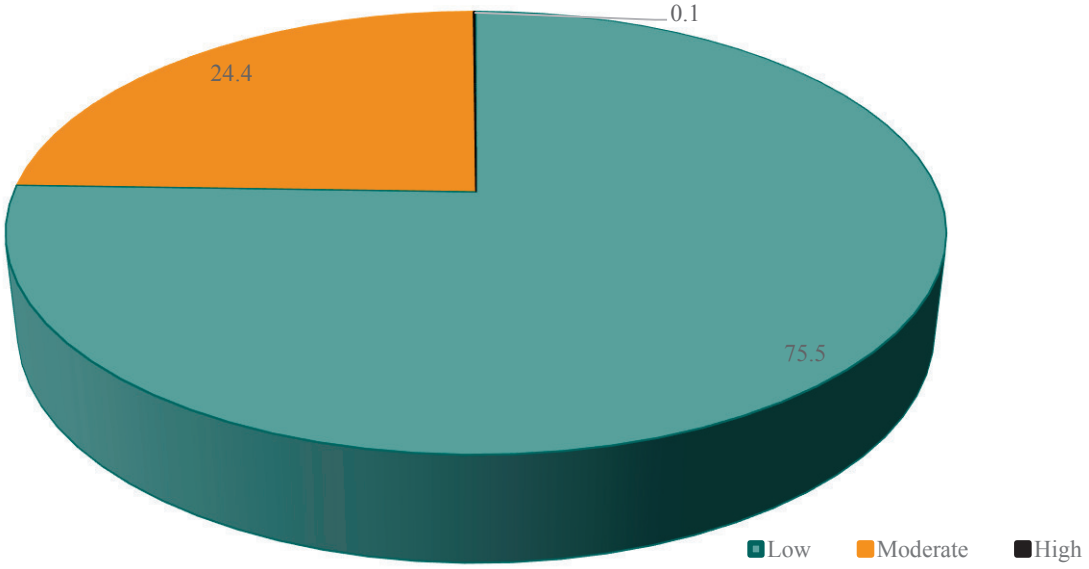


Table 9 shows the distribution of knowledge level by district and sex. More males than females demonstrated correct knowledge, but this was not statistically significant. Mpika respondents had the highest proportion of people who demonstrated low levels of GBV knowledge while Nyimba had a relatively high proportion who demonstrated correct knowledge.

When knowledge level was cross-tabulated with respondents' location, a slightly higher proportion from rural areas demonstrated low knowledge level (43.8%) than those from urban areas (31.7%). Interestingly, there was no variation by education level and wealth quartile.

The mean age for the respondents with moderate knowledge is 32.17 years while for those with low knowledge level it is 32.75 years. An independent t-test was used to test for differences in knowledge levels by age group. The results show that at the 5% confidence level, there is no statistically significant difference among the different age groups (t=-0.711, p=0.477).

Table 9: Participants' GBV knowledge by district and sex

		Low	Moderate	High
Chingola (n=343)	Female	79.2	20.8	
	Male	76	23.3	0.7
	All	77.8	21.9	0.3
Kalomo (n=341)	Female	77.9	22.1	-
	Male	76.6	21.9	1.5
	All	77.4	22	0.6
Monze (n=350)	Female	75.3	24.7	-
	Male	77.8	22.2	-
	All	76.3	23.7	-
Mpika (n=349)	Female	85.3	14.7	-
	Male	86.9	13.1	-
	All	86	14	-
Mumbwa (n=334)	Female	68.2	31.8	-
	Male	66.9	33.1	-
	All	67.7	32.3	-
Nyimba (n=336)	Female	69.7	30.3	-
	Male	64.2	35.8	-
	All	67.3	32.7	-
All	Female	76.1	23.9	-
	Male	74.7	25	0.4
	All	75.5	24.4	0.1

6.1.2 Qualitative data

A large amount of information was obtained by asking community members how they would define GBV and its causes. Although there are similarities between the quantitative and qualitative findings, what emerges from the qualitative are more nuanced and context specific descriptions and understandings of GBV and its causes. The description below uses the framing and language as provided by the study respondents and does not impose predefined categories since it is based on their understanding of GBV and its various manifestations. These definitions and explanations are also likely to vary according to a number of reasons including how the facilitator set up the discussion and introduced the topic, whether people had already received some form of sensitisation and their own experiences. Similarities were found across all FGDs, and while there were some gendered patterns, particularly in relation to the causes of GBV, in general responses did not appear to be influenced by whether the respondents were male or female, young or old or living in more rural or more urban areas.

Definitions of GBV included: women being beaten, usually by their husband; men raping young children, also referred to as defilement; women being forced to have sex; mistreating and abusing children in terms of physical abuse, neglect, forcing them to do hard or difficult work and preventing them from studying; forced early marriage; and a broader sense of women's rights being infringed. See Box 1 for the range of definitions.

Box 1: What is GBV?

Beating of women/wife

GBV is the beating of women and mistreating of children. (FGD, young women in Mpika)

...when men beat their wives then that's GBV, and also infringing on the rights of children. (FGD, women in Mpika)

GBV is the fighting between man and woman. (FGD, young women in Chingola)

If you are married then you start beating your wife or your wife starts beating you that is GBV. (FGD, young women in, Monze)

It's the beating of wives and sleeping with young children. (FGD, men in Mpika)

Rape/forcing women to have sex

When you force her [a woman] to have sex, that's GBV. (FGD, men in Mpika)

Early and forced marriage

Also marrying off children when they are still young. (FGD, women in Mpika)

GBV is the early marriages. (FGD, young men in Mpika)

It [GBV] is the abandoning of wives and marrying other women. (FGD young men in Mpika)

Child labour

... abusing your child were you just sit and send your child any how to sell by the road side ... instead of giving him/her an opportunity to go to school they give them heavy things to sell in the market and other places. (FGD, young men in Monze)

Violence is when you give a person to do something heavier than their size or age. Giving that person work which is not of her size that means violence and it is not supposed to be happening. (FGD, men in Kalomo)

... to abuse someone like if you are keeping a child and treating that child as if they are not children from your home ... you use them for abusive jobs; the time for that child to go to school is when you send them to say go to this place and by the time they come from there time for school is finished. So that is what we call GBV. (FGD, men in Kalomo)

Sending small children to go and sell at the market. Telling them you will only eat after selling if you do not sell you will not eat. (FGD, young men in Chingola)

Child defilement/rape

Sleeping within an under-age child, we have these who when they are drink and they see a child who is not properly dressed, they get the child in the house give her sweets, just like that. (FGD, young man, in Monze)

Violence is when a man sleeps with a child, that is violence. (FGD, men in Kalomo)

Child defilement and rape are also forms of GBV. (FGD, men in Kalomo)

Infringement of rights

The infringement of rights of girls or other people… This happens when the parents give the children a lot of work to do such that they do not have time to study or do something out of their own desire. (FGD, young women in Mpika).

Also to us women in marriages we are having our rights infringed you may have rights to do certain things but then a husband makes sure he infringes on you, it's even nice to be single ...we are not enjoying our full rights, there are things or jobs we can do but we are not allowed.

If you don't look after children well like you neglect them that's GBV because they have rights that's why there is what they call child protection. (FGD, men in Mpika)

People also spoke about perceived causes of GBV. These can be grouped into eight broad types (as outlined below), though clearly there are overlaps and they are not mutually exclusive, e.g. alcohol can be an important cause leading to GBV, but this same person may also be in an early marriage with a wife not fulfilling her expected roles.

Lack of harmony, love and respect and feelings **of jealousy, envy, betrayal and misunderstanding** were mentioned by many as causes of GBV, irrespective of whether the FGDs were with women or men, or with young or older people as the following quotes highlight:

> *The main reason why they find themselves [facing GBV] is because they lack love and they don't understand each other, that leads to confusion between the spouses (FGD, women in Nyimba)*
>
> *(GBV) happens because between the two there is no harmony … and the two are looking down on each other (FGD, young men in Nyimba)*
>
> *It is caused by not matching together (FGD, men in Kalomo).*

Envy was also seen to be a cause of GBV with respondents comparing themselves with their wealthier peers; in this case inequality can be seen to be fuelling GBV since a man, in trying to compete with his wealthier peers, ends up abusing his wife or intimate partner:

> *The reason why (GBV) continues is because these days we believe that a good life is all about being rich. When you look at your friends who are rich and then you say for me I don't have money … we concentrate too much on the one who is on top wanting to compete with that one. Then they start doing bad things yes (FGD, men in Kalomo).*

A very common cause of GBV results from a **woman or a girl not fulfilling her expected role or behaving appropriately,** which, according to study respondents, can in turn **encourage GBV**. While these perceptions came mostly from the FGDs with men, some women also referred to women or girls as encouraging GBV, particularly in relation to clothing (see below). Many respondents were of the view that a woman is supposed to be submissive, and to show respect to her husband, i.e. according to this perception men are the main decision-makers and power-holders in the household. Education was seen as destabilising this power dynamic since, according to some respondents when a woman is educated she tries to 'rule in the home', which leads to domestic problems including physical and other forms of abuse, as these quotes from an FGD with young men in Nyimba show:

> *Sometimes the woman is educated and the man not, so the woman tries to rule in the home which causes violence so when a man tries to ask for something from a woman, she answers rudely.*

(GBV happens) as a result of a woman trying to be equal, for example in a home….

There was also a perception that women who are 'taught' (most likely referring to being given instructions by elders on how to behave in particular in relation to their husband) will behave appropriately when married (i.e. showing respect and being submissive to their husbands) and in turn will not encourage GBV and conversely that those who are 'not taught' will encourage GBV: *You know that they are women who are taught and those who are not; those who are not would start arguing and they want to rule like a man in that case they are then beaten* (FGD, men in Mpika).

The way women and girls dressed was also perceived by many respondents, both men and women, young and old as encouraging GBV. Thus scanty or tight clothing was perceived as showing a lack of respect and therefore girls themselves were blamed for encouraging GBV.

The dress code for some girls is not very good. Some are raped because they dress inappropriately (FGD, young women in Mpika).

The girls like wearing very tight clothes and bum shorts thereby enticing the boys (FGD, young women in Chingola).

Then if you look at the way they [girls/women] dress it is shameful … a woman who doesn't dress properly … the thighs are outside you see, so all that brings problems (FGD, men in Kalomo).

Here in town the women are not respectful as compared to those in the villages. If you advise them to dress appropriately they just shout at you (FGD, men in Chingola).

According to study respondents, **men not fulfilling their role as the main breadwinner** also caused GBV. This highlights the fact that women continue to be economically dependent on men for their livelihoods and when this support is not forthcoming problems arise. Thus respondents spoke about men not sharing their earnings with their wife and spending it on things such as alcohol and other women. This cause of GBV came out primarily from the FGDs with women as the following quotes highlight:

When a man is paid the wife does not see the salary, if the woman asks then the man will start to beat the wife, so that is the type of GBV we face here (FGD, women in Nyimba).

Sometimes you remain at home looking after the home washing for him, and he has gone for piece works he comes back and he won't even give you some of his money, then the quarrel starts (FGD, women in Mpika).

When they (husbands) are working they don't give money to the wife but to the girlfriends and then they go drinking alcohol; if he does not find food he will fight with the wife which is very bad (FGD, young women in Monze).

Alcohol and smoking (drugs) was invariably seen as a cause of GBV, as the quotes below illustrate:

The issue of violence is the issue where you drink alcohol and instead of you going to sleep you start fighting because you are drunk (FGD, men in Nyimba).

Beer drinking is one of the biggest problems in this community, they allow even children under the age 18 to drink. These people do not even have self-control and can easily abuse others (FGD, young women in Mpika).

The first thing is when you go to drink and you come back drunk you start asking for fish but she cooked okra, that brings problems (FGD, men in Mpika).

It is the beer they like that causes this (FGD, women in Mpika).

The other thing is that when the men get drunk they come home and begin to beat their wives even without a proper reason (FGD, young men in Mpika).

Sometimes the drugs they take make them misbehave (FGD, young women in Monze).

As you all know smoking confuses the brain… when you look at the way this child is dressed you will think she is an old women then she starts saying come uncle. You see then as results that is an offence (FGD, men in Kalomo).

Although alcohol is not necessary for violence to occur, most respondents were in no doubt that it fuels GBV. There was a perception that drinking alcohol is widespread in these communities and starts from an early age. As the quotes above show, alcohol results in lack of control and inappropriate behaviour with intimate partners often facing the consequences in terms of physical abuse.

According to study respondents**, early marriage** was also a commonly reported form and cause of GBV. In all study sites early marriage, around the age of 14-16 appeared to be occurring and while respondents spoke about it as being very common, they also largely condemned it. Thus, men in Mpika said that early marriage created problems because people were not mature enough to be married:

Yes mainly it's the early marriages because they are not mentally mature … we have here many examples, for instance my child is married to her age mate but they are in a troubled marriage.

This sentiment was echoed by men in Chingola and in Kalomo men also felt that if early marriages stopped there would be fewer problems. There was also a perception amongst these men in Kalomo, that since marriage signifies being independent and being able to makes one's own decisions, when people are young this capacity is still lacking and they continue to need the advice of parents and others:

If you marry early they [parents/advisers] will leave you, they say 'because you have married it means you have grown up, so go ahead do what you can'. Those are problems, so early marriage is not good; if you want to achieve something in life stop early marriages, yes.

Respondents also commented that early marriage led to children (usually girls) being withdrawn from school usually for economic reasons:

Sometimes you find that children may have the desire to go school but the parents may not be in a capacity to sponsor them. As a result there may be disagreements at home. For instance girls may have ambitions to become nurses or teachers but due to lack of sponsorship their ambitions just die out (FGD, young women in Mpika).

The other problem is that the parents do not send their children to school as a result they get married early (FGD, young men in Mpika).

Similarly, if a young person gets married there is a tendency to drop out of school: A man will marry while still at school, he will stop school because he will want to be feeding the wife maybe they even have children at home (FGD, men in Kalomo).

In addition to the economic reasons that fuel early marriage, young men in Chingola thought it was occurring because sometimes women feel they will be treated better by their husbands than by their birth families. This, however, does often not turn out to be the case and they continue to be abused in their marital home: *The reason that some women marry early is because they want to save themselves from mistreatment from homes where they are staying. But they are found to be mistreated even where they are married… what contributes as well is the notion that elderly men are the ones that take good care of the women. That is why you find girls who are 16 getting involved with men who are in their 40s* (FGD, young men in Chingola).

Another reason mentioned as a cause of GBV was the **lack of recourse and that perpetrators are not punished**: *It is because there are no stiffer punishments for the perpetrators. So they keep committing the same crime* (FGD, young men in Mpika). This was echoed by men in Chingola who noted that the *police service has become so weak*.

Children being disrespectful and misbehaving was also mentioned to cause GBV. Mostly this was in relation to children not listening to their parents and their parents being unable to control them, as the quotes below highlight:

Some girls themselves they misbehave they do not follow what parents are teaching them. They begin sleeping out. They have to follow what their parents are telling them. (FGD, women in Chingola)

The problem is with us girls. They [parents] do emphasise very much on good morals but the girls do not listen … Even when the parents try to advise, the children do not listen. They are very rude in answering to their parents. When women are advising a girl to dress appropriately she would just say am not your daughter. That is why we die early leaving the elderly behind (FGD, young women in Chingola).

Similarly, in relation to schooling some respondents said that it was the children who wanted to stop, not the parents: *Sometimes the parents just fail to control their children even when the money is there to send the school* (FGD, young men in Mipka). Young men in Monze also noted that: *…every parent wants what is good for the child, they want school for their child but you find that the child has no interest for school then they see that since the child is not interested in school then let the child be doing something else*. Other respondents perceived parents to have lost power over their children because, in a sense, sensitisation had backfired: *The parents now have been rendered powerless because the children do not listen to them. They always say 'I know my rights' whenever the parents try to advise them (*FGD, men in Chingola).

Linked to the above was the sentiment that people today **lack advisers, parental care and teaching** on how to behave particularly in relation to married life and what is expected of a man and a woman, all of which, according to study respondents, can cause GBV as these quotes from an FGD with men in Kalomo show:

For other people to be found in such situations it is because they don't have people to advise them … the only thing which is causing these things to happen is because we don't have parental care and we don't have that heart of keeping others.

Sometimes others just lack teaching. So us in the community we need people to go and teach because sometimes you find a person has never been taught, never been to school, is just seated in the community, he does not know what is wrong and what is right. So people need to go round in the community and educate people on this vice.

6.2 Reported prevalence of GBV

6.2.1 Quantitative data

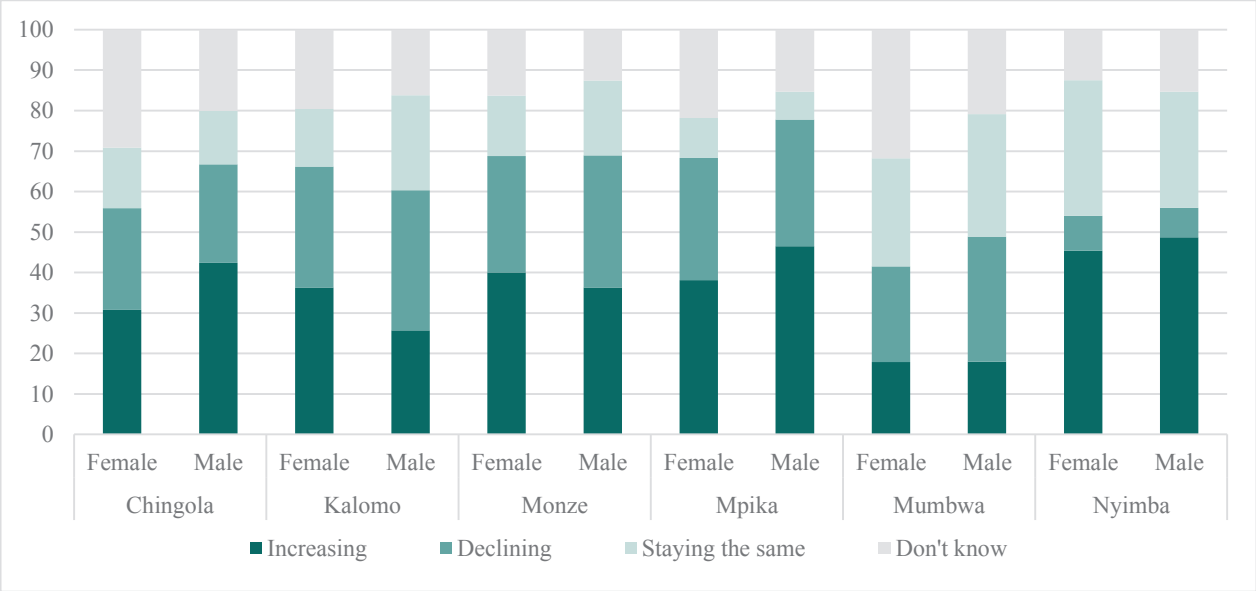
Table 10 and Figure 13 presents respondents' perceptions of whether GBV was increasing, decreasing or remained unchanged in their communities. Slightly more than a third (35.5%) of all respondents felt that GBV was increasing in their communities, 25.4% felt it was declining and others either said it had remained the same (19.3%) or they did not know (19.7%). Nyimba also stands out as a clear outlier in that it has a significantly higher proportion of respondents who declare that GBV is increasing and far fewer who declare that GBV is decreasing compared to other sites. There appears to be considerable variations across sites in terms of whether respondents consider GBV to be increasing, declining, or staying the same, e.g. in Mumbwa both men and women perceive it to be declining whereas in Nyimba both men and women perceive GBV to be increasing. By contrast, within sites there appears to be less variation by sex of respondent.

Table 10: Would you say GBV in this community is increasing, declining or staying the same? (N=2044)

District	Sex	Increasing	Declining	Staying the same	Don't know
Chingola (n=339)	Female	30.8	25.1	14.9	29.2
	Male	42.4	24.3	13.2	20.1
	All	35.7	24.8	14.2	25.4
Kalomo	Female	36.3	29.9	14.2	19.6

(n=340)	Male	25.7	34.6	23.5	16.2
	All	32.1	31.8	17.9	18.2
Monze (n=350)	Female	40.0	28.8	14.9	16.3
	Male	36.3	32.6	18.5	12.6
	All	38.6	30.3	16.3	14.9
Mpika (n=346)	Female	38.1	30.2	9.9	21.8
	Male	46.5	31.3	6.9	15.3
	All	41.6	30.6	8.7	19.1
Mumbwa (n=334)	Female	17.9	23.6	26.7	31.8
	Male	18.0	30.9	30.2	20.9
	All	18.0	26.6	28.1	27.2
Nyimba (n=335)	Female	45.4	8.6	33.5	12.4
	Male	48.7	7.3	28.7	15.3
	All	46.9	8.1	31.3	13.7
Total (n=2044)	Female	34.8	24.7	18.7	21.8
	Male	36.6	26.5	20.2	16.7
	All	35.5	25.4	19.3	19.7

Figure 13: Would you say GBV in this community is increasing, declining or staying the same? (N=2044)



When asked whether GBV was common in their community, 50.4% of all respondents answered that it was. Slight differences were observed across districts with Mumbwa recording the lowest proportion of respondents who felt that GBV was increasing in their community (35.3%) while Nyimba recorded the highest (57.7%). There is no statistically significant difference between males and females with regard to perceptions of prevalence of GBV in their communities (p = 0.282) (see Table 11). In addition, the only site in which GBV was not seen as a 'common' concern was Mumbwa, which showed community perceptions of GBV prevalence to be 5-10% lower than in other sites.

Table 11: Is GBV common in this area/community? (N=2037)

District	Sex	Yes	No	Do not know	Not sure
Chingola (n=334)	Female	44.9	39.8	15.3	-
	Male	50.7	42.8	6.5	-
	All	47.3	41.0	11.7	-
Kalomo (n=340)	Female	58.1	34.5	2.5	4.9
	Male	46.0	44.5	4.4	5.1
	All	53.2	38.5	3.2	5.0
Monze (n=349)	Female	58.1	34.9	0.9	6.0
	Male	50.0	44.8	0.7	4.5
	All	55.0	38.7	0.9	5.4
Mpika (n=344)	Female	52.5	38.2	9.3	-
	Male	55.0	35.0	10.0	-
	All	53.5	36.9	9.6	-
Mumbwa (n=334)	Female	34.4	47.2	-	18.5
	Male	36.7	48.2	-	15.1
	All	35.3	47.6	-	17.1
Nyimba (n=336)	Female	58.4	36.8	-	4.9
	Male	57.0	32.5	-	10.6
	All	57.7	34.8	-	7.4
All (n=2037)	Female	51.2	38.5	4.7	5.7
	Male	49.3	41.1	3.6	6.0
	All	50.4	39.6	4.2	5.8

There appears to be no major difference in perceptions about the prevalence of GBV by level of educational attainment (see Figure 12). However, as can be seen in Figure 15, a substantial majority (80%) of wealthier people ('very well to do') perceived GBV to be declining.

Figure 14: Perception of change in GBV by educational attainment

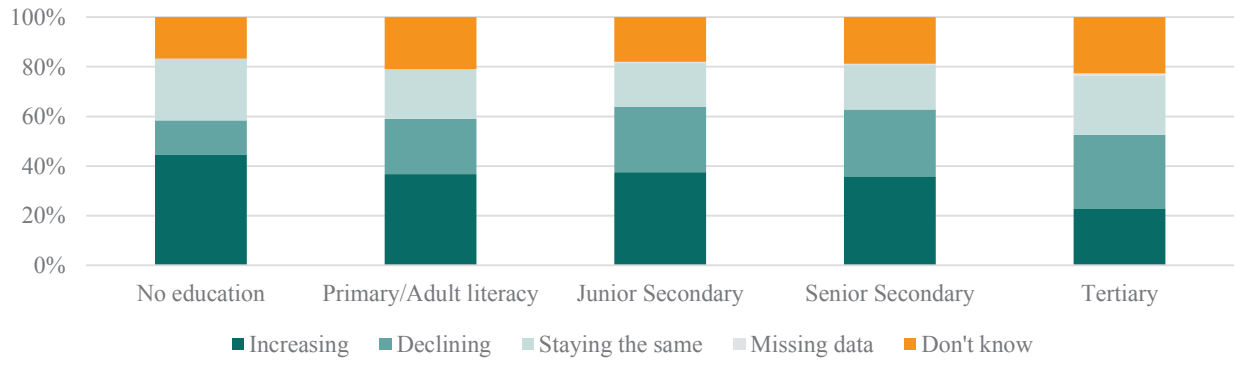


Figure 15: Perception of change in GBV by wealth index

6.2.2 Qualitative data

Similar patterns and trends as those described above can be seen when exploring the qualitative data in terms of perceptions about change in GBV. The qualitative, however, adds further depth and context to the above findings also bringing out additional insights into if, how and when GBV is changing. Thus, perceptions among community members and from respondents in all FGDs was that GBV can 'happen anytime' and in most homes (*It is difficult to tell because these cases are kept as a secret and it is embarrassing to reveal what happens in the home outside. But GBV happens in almost all the homes* {FGD, women in Chingola}). There was also a perception that when financial resources were available there was a tendency for GBV to rise. Thus for formal-sector employers, those who live in urban or peri-urban areas, as well as those receiving a pension, GBV became worse at the end of a month when they were paid their salaries.

> *It is usually during the month end because here there are miners and these miners when they get paid they do not take the pay slips home and this causes problems in the homes. Because their wives begin pressurising them about the pay slip as a result they begin fighting (FGD, young men in Chingola, and echoed by the women's FGD in Chingola).*

For those engaged in farming, GBV was heightened around harvesting periods:

> *It [GBV] usually happens during the harvest period when people sale their maize to the Food Reserve Agency (FRA). For some it is after they have collected the caterpillars and have money. They feel they can do anything they want. Sometimes they do not even listen to the advice of the parents (FGD, young women in Mpika).*

> *When the two have worked together in the field and harvested and sold the produce, but a man collects money and uses it alone, that is a recipe for violence (FGD, young men in Nyimba).*

In terms of the extent to which GBV is changing, only in Mpika did respondents see it as declining, although views were mixed. Of those who agreed that GBV was decreasing, both men and women attributed this to increasing sensitisation and also to the fear of being arrested acting as a deterrent). The following quotes from Mpika highlight how and why people think GBV is decreasing:

> *They [cases of GBV] are decreasing because of intensive sensitisation going on (FGD, men in Mpika).*

> *In the past there was a lot of infringement on the rights of children but now people have learnt and the cases have reduced. Previously parents never used to send the children to school but they send them now (FGD, young women in Mpika).*

> *It [GBV] is not a big problem these days but in the past it used to be a big problem. The people are being educated now. They are sensitized through the radio and television. And there are some organizations that come and teach on these matters (FGD, women in Mpika).*

At least now the parents send the children to school and do not marry them off at the tender age (FGD, young men in Mpika).

The change started four years ago. Because in the past you would hear that the husband and wife were fighting but nowadays we do not hear of them (FGD, young women in Mpika).

Some Mpika FGD respondents, however, felt that rates of GBV have stayed the same or were increasing:

It started long ago … It is just the same, in fact it is even increasing (FGD, women in Mpika).

The problem has been in existence for long time now and it is just increasing (FGD, young women in Mpika).

Sometimes people may think now it's better, but for you who lives with this person it's the same (FGD, women in Mpika).

The belief that GBV was mostly unchanged or increasing was echoed in all the other FGDs in all other districts, as these following examples highlight:

The GBV here has not been reducing but increasing, we can't even say it has been reducing. Beer drinking is increasing, verbal quarrelling is increasing, and the chief is not doing much about it (FGD, men in Nyimba).

I do agree because from the time we were born we found it, but now it is increasing (FGD, young women in Monze).

The problem is not reducing its just increasing. Nothing has changed concerning gender-based violence (FGD young women in Chingola).

The problem is not reducing it is just increasing. (Everyone nods their heads in agreement.)(FGD, young men in Chingola).

Because things [GBV] are happening and there is no change (FGD, women in Kalomo).

According to respondents, reasons for GBV remaining unchanged or increasing was because people perceived that there was no recourse, i.e. neither the formal (police), nor the informal (chief/headman) authorities could control it (see also section 7.2 on forms of support available): *It's too much of GBV and there is no one who is doing anything about it so that it reduces. Even when a husband commits GBV against his wife there is no one who can stop it* (FGD, men in Nyimba). As respondents in Chingola noted: *Police service it has become so weak* (FGD, men in Chingola). Similarly respondents noted that if people started being arrested GBV would decline*: If they begin arresting them the cases will reduce* (FGD, young women in Chingola).

In Chingola respondents also pointed to a possible backlash occurring, particularly in relation to teachers being unable to discipline students for fear of the students reporting them to the relevant authorities; this in turn, according to such respondents, led to students behaving badly and to potential increases in GBV: *Those days when we used to be in school the teachers would beat us in order to discipline us but these days a teacher cannot even try to beat a pupil ....because when the child misbehaves you cannot whip him or her she will report you to the human rights commission. So they behave however way they want* (FGD, men in Chingola).

It was also felt that GBV was on the increase due to peer pressure: *For others they just copy the behaviour of their friends* (FGD, women in Mpika). Similarly, it was pointed out that intergenerational transmission of GBV is occurring, also in line with existing research. Thus if a child witnesses domestic violence in their home, it is likely that they will also become a perpetrator in the future: *Because a lot of people do fight and from birth we found people fighting and we have learned to fight because of our parents who fight. Our parents fight and even us we see as though that is life* (FGD, young women in Monze).

People coming from outside the area, or perhaps increasing population pressure, also led people to suggest that this was a reason for increasing GBV: *This compound was a very peaceful in the past but now because of the people that come to live here people fight everywhere. Some are busy insulting (*FGD, men in Chingola).

Some respondents gave a more balanced perspective, suggesting that in some cases, situations or locations GBV was decreasing, but in others it was not*: These things are still happening somehow and then again these things are changing* (FGD, men in Kalomo); and they saw change happening as a result of 'people passing through', referring also to the study team.

6.3 Characteristics of perpetrators and survivors

6.3.1 Quantitative data

Respondents were asked about the demographic characteristics of the GBV perpetrators in relation to the incidents they had witnessed. About 80% of study respondents reported that perpetrators were male, there was no differences between the sex of respondents. The youngest reported age was 13 while the oldest was 80 years. The mean and median ages were 39.79 and 35 respectively. In most cases the perpetrators was the spouse (67%). Interestingly, 75% of all GBV incidents are reported to have occurred in the home and only a quarter outside the home. There were no observable differences by sex of respondent or by location/district.

The community survey did not include a question on the characteristics of survivors.

6.3.2 Qualitative data

Perpetrators

Perpetrators – gender and relationships

Qualitative findings closely mirror those found in the quantitative survey. Thus, most key informants reported that the main perpetrators of GBV are men and are most often the intimate partner of the victim. Similarly, all respondents in FGDs said it was predominantly men who were the perpetrators of GBV, whether younger and older men and women and among more rural and more urban groups. The most commonly discussed relationship of the perpetrator to the victim was that of spouse or husband.

Qualifying further, it was also widely accepted that it was men who were consuming alcohol who caused a lot of the GBV: *The ones that commit too much GBV are the drunkards and the smokers* (FGD with men in Mpika). However, men and women in the FGDs underlined that a man did not necessarily have to drink to commit GBV: *…these men they don't even drink, but every time you say something or suggest something in a home then its violence and results in you being beaten, they don't drink because if its drinking you can say, no its drinking or maybe he has smoked daga (marijuana) but he doesn't, it's that spirit he has of not wanting to be corrected..* (FGD, women in Mpika). Another respondent in the same FGD agreed: *When you say something, you are beaten, in fact it's happening even to those men that don't drink, its almost all men*. A similar sentiment was expressed by young men in Chingola: *Mostly it is men [who are perpetrators]. Because when you marry you have accepted that you will be responsible for everything, the children and the woman. So men are the ones who mistreat others.*

These last two quotes echo many of the points raised in earlier sections and will be picked up again later, i.e. that it is accepted that a man beats a woman, that he is all powerful in the home and women can do little about it, and similarly, that this is happening inside the home and should be private.

Despite the fact that most GBV perpetrators are men, in at least three FGDs – one with young women in Kalomo, one with young men in Chingola and one with young men in Monze (all more urban or peri-urban areas) – it was noted *…that both men and women are perpetrators* [of GBV] (FGD, young women in Kalomo). (Interviews with key informants also pointed to the fact that men can also experience GBV, see also section 4.6.). Women's consumption of alcohol was linked to them committing GBV, as the young men in Chingola explained: *I think it is balanced up now because women have become savages, nowadays they get drunk and beat up their husbands sometimes.* Another young man in the FGD discussion says: *It is like women have just gone crazy, nowadays most of them are drunkards.* In Monze it was suggested that women could abuse young men and then claim they had raped her if they reject her: *... if a man is working at somebody's home then they find a woman, an old woman who says she wants me, then I refuse so after I refuse she can change the statement and say he wanted to rape me and they can make me suffer for things I do not know. So I see men to be more at risk* (FGD, young men in Monze*)*. In a sense these perceptions could be pointing to the fact that the roles of men and women are changing and that perhaps women are starting to be empowered and asserting themselves. This in turn may be seen by many as challenging accepted and entrenched power dynamics and relationships between men and women and in order to

try and give meaning and explain this men resort to expressions such as 'women have gone crazy' or 'are savages' nowadays.

Despite cases of GBV against men, according to these respondents, there was a sense that these cases were not reported largely because men would feel embarrassed and humiliated, and could more generally be perceived as undermining their masculinity: *If the man reports that he is being abused by the woman, they [the police] laugh and mock him saying how can a man be beaten by a woman. So next time the man would not want to go back to the police to report* (FGD young men in Chingola). This begs the question whether violence against men is more prevalent than previously thought but is not reported because of traditional notions of what it means to be a man.

Perpetrators – age

There was a general perception from key informants that men of all ages commit GBV, as this quote from a key informant highlights: *But with regards to age group, we have from all age groups. We have perpetrators from kind of all age groups. Let me say from the age of 15 upward* (OSC manager in Kalomo). In the FGDs, responses varied according to how people were defining GBV and how the discussion had been going previously. What tended to emerge, however, was the perpetrators were often older than their victims, and as such, an intergenerational dynamic was in evidence. There was also a perception that this intergenerational dimension was more prevalent now, as the following quotes from an FGD with young men in Chingola highlight:

> *This time it is different, five years ago it was the young men in their 20s who abused young girls, but this time it is the older men in their 40s who abuse the young girls.*
>
> *I do not know, these days, maybe because it is a modern world, you find that a girl who is 16 years is having relations with a man who is 40 years. I do not know whether that is GBV because those people have agreed.*

This could be explained by the fact that poverty or inequality is more pervasive nowadays so young girls may be more actively seeking out relationships with older men in order to provide them with some form of security, since often these relationships consist of forms of payment, either in cash or in kind. Similarly, given increased accessed to consumer goods through different forms of globalisation, girls are more willing to accept different forms of abuse in order to gain access to these goods.

Young women in Kalomo also pointed to the intergenerational dimension of GBV saying: *...old people are the ones behind GBV..;* and again in Mpika women agreed that *... mostly a man will be very old compared to the women..* But, as seen in the quote above, a difference in age was also witnessed in the case of women abusing men:*... you find a woman, an old woman who says she wants me, then I refuse* (FGD, young men in Monze).

Parents as perpetrators of early marriage

Again, depending on the flow of the discussion, people commonly reported that parents were perpetrators of GBV through forced early marriages. *In the case of forced marriages the parents are the perpetrators. They are the ones that take the girl to the boy's house if she is impregnated* (FGD, young men in Mpika). Similarly, economic reasons were cited as reasons why parents force girls to marry: *Yes, sometimes because they want money they force the girls to get married* (FGD, young men, Mpika).

Survivors

Survivors - gender, age, relationships, educational, poverty status

Mirroring the above discussions around characteristics of perpetrators, survivors were most often young women: *Mostly it is the women [who are victims]. But mostly it is the young women who are between the ages of 16 to 24* (FGD, young women in Chingola). These young women were further qualified by their marital status, thus according to young men in Mpika: *Mostly the girls that are not yet married but about to get married [are victims] and are between the ages of 15 to 17 years.* Others stressed that they are beaten when they are girls and they continue to be beaten after they are married: *We are beaten as girls. When you get married you are beaten even without a reason* (FGD, young women in Chingola).

There was a sense that as a woman aged she learnt to deal better with GBV usually perpetrated by her husband:

Mostly it's young women because for us we are paramilitary, we have been tested and are now strong so we just watch young women (FGD, women in Mpika).

In terms of levels of education, there were mixed responses regarding the characteristics of female victims. Some pointed out that they were still at school*: Some of the victims are grade pupils who also range from the age of 15 to 17 years* (FGD, young men in Mpika). However, the young women's FGD in Chingola, while agreeing that victims tended to be young women (*The women are the victims but even girls of about 15 to 22 years are also victims*), pointed to the fact that most had dropped out of school: *Most of them are secondary school leavers and drop outs*. This was echoed by men in Chingola, who suggested that most female victims are not educated: *Mostly the women [are victims], especially those that are not educated.*

In terms of socio-economic status, there was a tendency for respondents to make the link between GBV and poverty, although, in fact, GBV was often perpetrated when there was money available, i.e. at the month end when people were paid and when, amongst other things, people are seen to consume more alcohol. Thus in Chingola young women mentioned that: *Most of them [victims] are of low and middle-income levels*'. Similarly young men in Nyimba suggested that those at greatest risk of GBV are those who are 'poor and uneducated'. The aspect of poverty was reinforced by responses from key informant interviews, thus according to an OSC service provider in Mumbwa: *People who have come here are poor women usually wives of farmers.* Similarly, in Kalomo the OSC manager pointed to women having no source of income and not being educated: *Yes, I would say mostly it is housewives, those who are not working and have no source of income. So far we have not had a nurse or a teacher. I think it is because of vulnerability. You see the fact that they don't have any source of income and mostly these people have not really been educated*.

In some FGDs men were seen as victims of GBV and faced physical assault from their wives – this suggests that gender roles are not in fact that rigid, and that men can be the subordinate ones in a relationship with a woman. However, such power dynamics rarely emerge in public and, as also mentioned above, men rarely come forward to report abuse perpetrated by their wives for fear of shame and humiliation: *It is not all men that beat up women some are beaten by their wives* (FGD, young men, in Chingola). This sentiment was echoed in an FGD with men in Monze. Men, and especially boys, were also seen as victims in the sense that if a girl became pregnant, her parents forced them to marry: *Yes, they are victimised in the sense that if a young man impregnates a girl he is forced to marry that girl even when he is not ready. He has no choice even if he is still in school, they just bring a girl to his home and leave her there* (FGD, young men in Mpika). In this case, both the girl and the boy are victims because expectations of acceptable behaviour are that they should marry; this usually results in one or both of them withdrawing from school.

Children as victims

Coming out very strongly in discussions were children as victims, and again, this could reflect how the discussion was going (see above on definitions of GBV). Interestingly, the sex of the children was not mentioned, the reference was always to children in general. Thus, according to young men in Chingola: *Mostly it is the women and children [who are victims]. But mostly the children are the ones that suffer the consequences of GBV.* These same men explained this as resulting from women taking out their frustrations on children because they are facing problems with their husband:

Why they [children] are mostly at risk is because of what the men teach, that women should submit to their husbands. So the women are very submissive and the men take advantage of them. And when the husband is not around the women release their frustrations on the children who are now expected to be submissive to their mothers. For example, if they burn relish (foods accompany the staple maize porridge) their mother will vent their frustrations on them.

In at least three FGDs – with men in Kalomo, young men in Chingola and women in Chingola – the category of children was further qualified and it was stressed that orphans were particularly vulnerable to GBV. Respondents in these FGDs said that orphans living with stepmothers or aunts faced a range of vulnerabilities, were often discriminated against compared to other children in the household, were made to work and were taken out of school, as the following quotes highlight:

You find [as an orphan] that I am not going to school, my cousins …they are going to school, and my fees are not being paid for. In the end I stop going to school (FGD, men in Kalomo).

Most of the cases that I have seen, they usually mistreat the orphans and stepchildren … When they get married and find that their partner has a child they begin to mistreat that child because they do not consider that child as their own (FGD, young men in Chingola).

For some who keep the orphans, the children are usually victimised, they are not free in the houses where they are being kept. Their own children are sent to better schools while the orphans are not. When it comes to feeding and clothing, their own children are given the first priority while the orphans are oppressed. Even their growing up is not properly managed (FGD, women in Chingola).

Thus what emerges from the above is that men, and often older men and husbands, are the main perpetrators of GBV; parents were also pointed out to be perpetrators of GBV in relation to early marriage. It is mostly younger women who are victims of GBV alongside children, especially orphans. According to respondents, girls can be going to school and face GBV but victims are often those who are uneducated and poor.

6.4 The role of cultural values and beliefs in perpetuating GBV

Although in 6.1 many of the themes discussed in relation to the causes of GBV touch on issues of cultural values and beliefs, and further related issues are highlighted in Section 7, in this section we draw them out further and explore traditional notions of what it means to be a man or a woman in Zambia, the causes and consequences of early marriage and traditional practices particularly regarding initiation ceremonies. We also examine how traditional practices and beliefs are seen to be breaking down and no longer fulfilling their original roles and purposes.

6.4.1 What it means to be a man and a woman in Zambia

According to many respondents, GBV can be fuelled when men or women are not adhering to expected gendered behaviour. However, because of notions regarding what it means to be a man or a woman in Zambian society, women invariably face the brunt. Thus it is widely believed that women should be submissive, especially to their husband. Similarly, it is acceptable for a man to beat his wife because, according to local beliefs, wives have to be 'controlled and disciplined'. Furthermore, some maintain that for a man to assault a woman is a sign of love:

It is the culture in which these women are brought up, they believe that even when the man beats them in that marriage, they have to persevere, they don't have to tell anyone as that is your bedroom secret (OSC service provider in Kalomo).

In some communities, there are beliefs that when a husband beats a wife that is a sign of love... (OSC service provider in Mumbwa).

A man has power, he has authority, he can do anything, but when a woman is heard having said something she is beaten (FGD, women in Mpika).

As regards to adultery, the woman who commits it should go. Because remember the saying adultery by a woman is what causes divorce, not that of a man (FGD, men in Mpika).

As will be discussed further in section 7.3, to some extent women agreed with these sentiments, as shown from the following statement:...*yes she [the wife] must be beaten if she is not properly taking care of the children ...* (35-year-old woman survivor in Monze).

Women are also expected to guard marital secrets and not to divulge them to outsiders or a third party. The quotes below highlight some of these sentiments around family honour:

When a woman is taught, she is not supposed to reveal anything that happens in the house. Even when you argue she is not supposed to take the arguments outside. If she does that, that means she has not been taught well... If a woman reveals the things that are supposed to be hidden she is embarrassing the home. If things get out of hand then she should go to the one who taught her when she was about to get married (FGD, young men in Mpika).

When they teach us women they say even when you are beaten and your eye is swollen you are not supposed to reveal outside what happened. You are to say that you just fell and then you hurt yourself. If you reveal they say you do not have respect (FGD, women in Chingola).

Dependency of women on male relatives and in particular husbands, largely because of women's limited access to resources, is prevalent in Zambia and, according to informants, creates the grounds for abuse. Most women are of low economic status and lack the resources to earn a living. Thus they are often economically dependent on their husband. Consequently, they feel they have to endure abuse since they cannot leave home as they have limited alternative means of making a living. Similarly, because of economic dependency on men, women often enter into sequential abusive relationships (see also Section 7.3).

You find that even if they are abused they think that if I leave this man how will I take care of my children so it's better I suffer for the children (OSC service provider in Nyimba).

6.4.2 Early marriage

As stated earlier, early marriage is prevalent in Zambia, often for economic reasons. As also mentioned above, there is a link between early marriage and girls dropping out or being taken out of school, often against their wishes (see also Section 7.3). Early marriage is often forced on girls by their parents so that the parents can earn money or, in southern province, cattle (bride price or *lobola)*. Despite attempts to raise awareness about the consequences of early marriage for girls in particular, including curtailing their education, challenges persist. A head teacher of a primary school, for instance, commented that whenever the school intervenes to discourage early marriage, parents get upset and warn the school authorities not to interfere:

Parents come and even tell us that you are not part of our family and if you continue putting your nose into our affairs you will see what we can do. So sometimes we sort of refrain (Head teacher in Mumbwa).

When people were asked what they thought was the ideal age for marriage, and when they wanted their children to marry, most said over the age of 20 and after they had finished school. This quote from a GBV survivor in Monze aptly sums up the general sentiment: *At least 23 or 24 or even 50 years [when she wants her children to marry]. Let's just say when you have finished school* (GBV survivor in Monze).

Although there was broad agreement that early marriages were for economic reasons and that parents were the main instigators, some key informants reported that sometimes girls themselves were responsible, and went against their parents' wishes, engaging in early sexual activity and thus also being vulnerable to GBV and particularly early marriage: *... in other cases it could be the children who are just not being obedient to their parents. Children might necessarily not be encouraged by their parents but due to lack of obedience they might end up engaging in premarital early sexual practices and eventually fall victims to GBV* (Service provider in Mpika).

6.4.3 Traditional ceremonies

Few respondents mentioned traditional ceremonies or practices as fuelling GBV. When the question was asked directly, respondents tended to say that they were no longer happening: *These days I don't hear of traditional practices. Long time ago we would hear of Ichisungu [a girl having the first periods] but we do not hear that these days; I do not know about others* (FGD, young women in Mpika). The exception was among participants in an FGD with men in Monze, where circumcision was mentioned as potentially fuelling GBV: *There [during the ceremonies] they teach a lot of things that do not make sense like smoking and drinking, that is what causes bad behaviour in the compound if you are drunk so this is not good* (FGD, young men in Monze).

Another response in relation to traditional ceremonies came from a GBV survivor who spoke about being forced to go through an initiation ceremony that she also claimed meant she had no choice but to marry early (see Section 7.3). Another survivor spoke about being forced to marry her late husband's brother. Although it was not framed as such, this points to the practice of sexual cleansing, i.e. a practice carried out on the death of a spouse to 'clean' the surviving spouse, clearly with wide ramifications in a society such as Zambia where HIV prevalence is around 12.5%.[8] Rather, this was framed as women needing support to bring up their children. This particular women in

8 http://www.unaids.org/en/regionscountries/countries/zambia

a sense faced a double form of GBV – she was forced to marry her brother-in-law, after which he abused her and eventually threw her and her children out of his house.

6.4.4 Breaking down of traditional beliefs and practices

A number of respondents were of the opinion that nowadays traditional practices were being abused and similarly, that people were 'not taught properly', all of which could potentially fuel GBV. For instance, men discussing circumcision pointed out that these ceremonies used to serve a purpose but now people were doing them 'anyhow' and often just to make money: *They are just doing them [the ceremonies] anyhow ... now they are doing it using their own rules ....yes it is business because even us the youths we take ourselves there, then those Luvales [the ethnic group that does the ceremony]make money out of us, they cannot say we have made enough money let us stop, they just continue* (FGD, young men in Monze). The same young men in Monze also doubted what girls were being taught*: As for the women,when they go to be taught in a house maybe when they come out they become prostitutes who don't spend time at home and they don't listen to their parents; but they have just been taught!* (FGD, young men in Monze). This sentiment was echoed by young men in Chingola who felt that girls were 'taught' too early resulting in them becoming sexually active, which in turn, according to them, leads to early marriage:

> *Girls, when taught about sexual practices at an early age, they become a problem ... sometimes the girls are taught at a very early age such as 12 years, so when they are taught they tend to engage in sexual activities faster as they want to practise what they have been taught ... it is one of the causes of early marriages. They know things at an early age, by the time they turn 15 they may be impregnated already... When they reach puberty they should just be taught common and general things which they are supposed know, the rest should be taught when they are about to get married (FGD, young men in Chingola).*

Similarly, a village headman in Mumbwa also pointed to the fact that while sensitization of men in GBV matters begins early, before they get married, so that when they grow up they respect their wives and marriages, nowadays it has changed and despite counselling young men no longer heed any advice. *We usually tell them when they are getting married that they should go and look after themselves very well in their homes; but these days young men don't seek advice from the elders, the only thing they do is fight each other.*

Finally, women in Chingola saw traditional practices as having meaning in the past, but now there was a breakdown, with alcohol being seen as the principal cause:

> *It is like the world is now confused; a long time ago such practices helped a lady to respect the husband and the husband respect the wife. But now that is destroyed. Beer drinking has destroyed all that. In the presence of the husband, the wife must humble herself. These days the wives insult their husbands in public which is not good. They are supposed to talk to them nicely inside the house. Even the men should be taught very much. Beer drinking has destroyed a lot of things they need to minimise on beer drinking.*

Parents were also not seen to be carrying out their parental duties: according to young men in Mpika, parents were no longer teaching their daughters how to behave: *The parents are the ones who are supposed to teach the girls those practices but since the girls are just dumped at the boys' homes without being taught, they don't even know how to take care of their husbands ... they treat their husbands as they are not supposed to, so they end up fighting (*FGD, young men in Mpika).

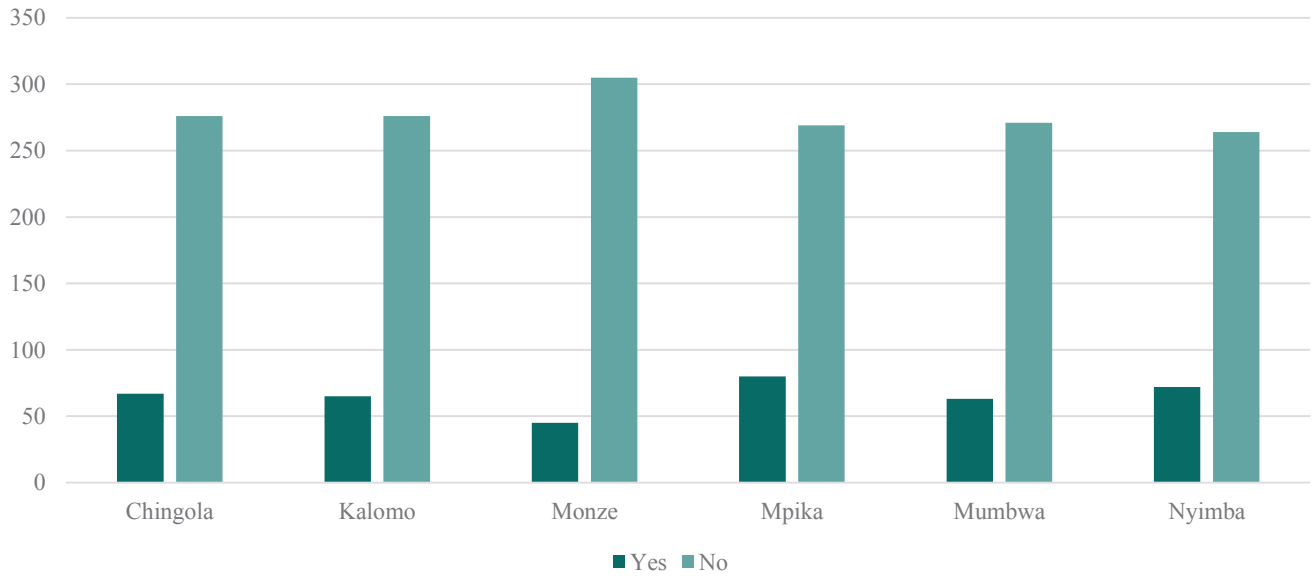
7 Experiences of GBV

In this section we focus on experiences of GBV from the perspective of community members and survivors. Thus we draw on both the quantitative community survey data, i.e. on findings on whether respondents had witnessed GBV and what forms of support they think are available, but in particular on the qualitative data. For the qualitative data we draw on the FGDs and interviews with survivors.

7.1 Kinds of GBV experienced and witnessed – quantitative data

Respondents were asked whether they had experienced GBV in the past six months prior to the study. A total of 392 (19.1%) respondents had experienced it; 23% of women reported experiencing GBV and 12.8% of men. In terms of district breakdown, as can be seen in Figure 16 Mpika has the highest reported number of people experiencing GBV (80 incidents or 32.1%); the lowest number of experiences reported is in Monze with a reported 45 cases or 14.7%. The most common form of GBV being experienced is physical assault (200 reports or 9.7%), followed by psychological abuse (6.1%) and denial of resources/opportunities and services (4.1%).

Figure 16: No. of respondents experiencing GBV in last 6 months by district



Respondents were also asked whether they had witnessed GBV in the six months prior to the study. About a third of all respondents (33.6%) reported having done so (Figure 16). As shown in Figure 17, Mpika recorded the highest proportion of respondents who reported witnessing incidences of GBV, followed by Chingola and Kalomo. More male than female respondents reported having witnessed GBV, and the difference was statistically significant (P=0.005). There were no differences among the different age groups in witnessing GBV. Mumbwa and Nyimba were shown to be the two sites with the lowest observed cases of GBV.

Figure 17: Have you witnessed incidence of GBV in past six months? (n=2037)

	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
	Chingola		Kalomo		Monze		Mpika		Mumbwa		Nyimba		Total	
Yes	37.8	44.2	36.5	38.7	24.7	26.9	48.0	62.9	16.9	22.3	21.6	23.8	31.1	36.4
No	62.2	55.8	63.5	61.3	75.3	73.1	52.0	37.1	83.1	77.7	78.4	76.2	68.9	63.6

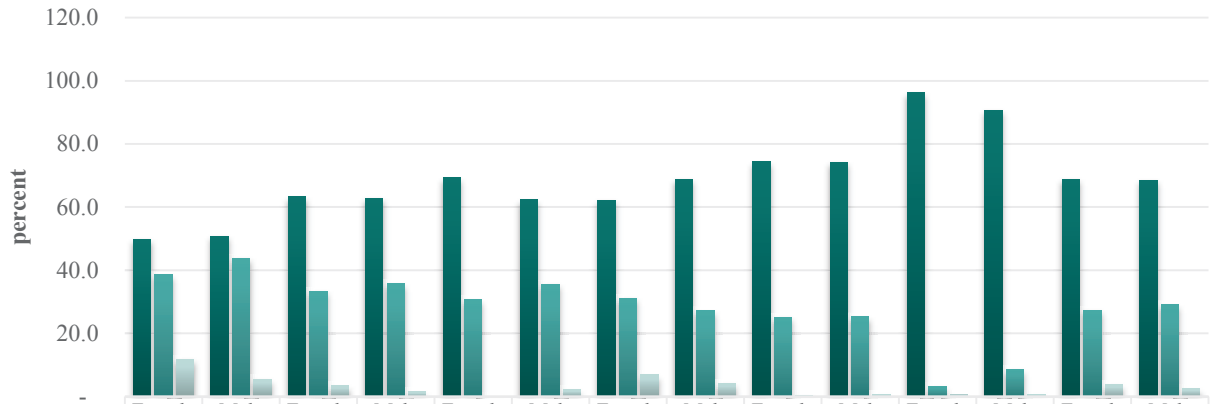
7.2 Sources of help for survivors of GBV

7.2.1 Quantitative data

When asked whether respondents felt that survivors of GBV sought help, about 69% said they did. Nyimba had the highest proportion of respondents who felt that GBV survivors sought help followed by Mumbwa. Chingola had the lowest proportion of respondents (see Figure 18).

When asked about what kind of help survivors of GBV sought, several mechanisms were mentioned. These included the police (51.5%), relatives (21%), community leaders (20.8%), hospital (12.2%), courts (7.7%), places of worship (3.7%), support groups (2%), survivor services centres (1%), peer groups (0.5) and hotline (0.2%). There were no observable differences by district, sex or age.

Figure 18: Do survivors look for help when they experience violence? (n=2049)



	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
	Chingola		Kalomo		Monze		Mpika		Mumbwa		Nyimba		Total	
Yes	49.7	50.7	63.2	62.8	69.3	62.2	62.1	68.8	74.4	74.1	96.2	90.7	68.8	68.5
No	38.6	43.8	33.3	35.8	30.7	35.6	31.0	27.1	25.1	25.2	3.2	8.6	27.4	29.1
Do not know	11.7	5.6	3.4	1.5	-	2.2	6.9	4.2	0.5	0.7	0.5	0.7	3.8	2.5

In terms of what factors enable people to recover from or respond to GBV incidents, according to study respondents, economic independence is seen as the most important (41.4%, with more women (23.5%) than men (17.9%) reporting this), followed by equality in decision-making (16.65%). Responses for other options provided were negligible (e.g. help from friends, support from public services, distance to services and trust in services).

7.2.2 Qualitative data

Based on discussions in the FGD, forms of support can be divided into formal and informal. Since much of the discussion coming from the FGDs concerned the quality of support, particularly in relation to formal support, we also explore this issue.

Formal support for GBV survivors

For all FGDs the most common type of formal help mentioned was the police through the VSU; this is also mirrored in the quantitative findings where 51.5% of respondents said that GBV survivors can seek help from the police. In addition, a few respondents mentioned the Social Welfare Department as being available to provide formal support; the courts were mentioned a few times; the District Commissioner was mentioned as a place to go to for support; in Mpika an orphanage was mentioned; and hospitals were also mentioned a few times.

Despite the police and VSU unit being mentioned by all FGD respondents, there was a sense in almost all FGDs that the police were ineffective - *Out of 100 per cent I can give them 2 per cent* in terms of effectiveness (FGD, young men in Chingola) - for reasons ranging from being slow to react to being corrupt and only supporting those with money. Respondents also spoke about police being intimidating and lacking respect. When asked about capacity of police and the VSU, it was felt that overall they had been adequately trained, but that it was the lack of resources and/or corruption that was preventing them from doing their jobs effectively. This clearly led to people being reluctant to approach the police. Interestingly, although women did perceive police as being often ineffective, most of the narratives/quotes came from men, as can be seen in Box 2. This may imply, as also suggested by some women, that women are less knowledgeable about what happens at the police/VSU, they are less exposed to them and therefore have fewer perspectives to share about them.

Box 2: Perceptions of the police and VSU

Police are slow to react / take time coming

Here police are quick to give help when animals are hit by a vehicle, but when it's a person hit they are slow that's how they work here (FGD, young men in Nymiba).

They are not fast in responding to the cases. You find that when you call them they will tell you to come to the bar where they are instead of the police station (FGD, young men in Chingola).

There are not fast in responding to the cases. When someone has beaten you and you are reporting to them, they say go and bring the person who beat you (FGD, young women in Chingola).

Lack of resources makes police/VSU ineffectual

When you have a problem they will ask you whether you have fuel for them, if you have then they will come and arrest the person (FGD, young men in Nyimba).

The police, in many cases why they don't come when called, is because they say they don't have food (FGD, young women in Kalomo).

Need money to get a response from the police and other formal support systems

If you do not have money they are very slow (FGD, young men in Chingola).

Like when GBV does happen in this village it helps if you have money. If you don't have money and GBV does happen when you go the police you have to buy fuel for the vehicle to go and get the perpetrator then that is when that person will be scared of you or maybe you go to the court and when you get the clerk to go and get that person money is required. The court and the police personnel refuse if you have no money to go and get that person. … if you don't have money then they cannot use the government vehicle until you pay them something that is when they will use it (FGD, men in Nyimba).

No, they [police] are not supportive … They even question you as to why are you reporting this case .. they are not very helpful, not until you give them some money (FGD, young women in Chingola).

Favouring rich people / those with /who bring money

No, the rich are usually favoured. The case can even turn against the poor even if the rich person is the one that is wrong … The police officers have received the training but they are corrupt. (FGD, young me in Mpika).

Yes sometimes they [police] help, sometimes they don't help properly; you will find a person who has a problem who is poor without money, they want the money instead of solving your issue. (FGD, men in Kalomo).

At the police sometimes they are not fair, when you go there you will find that they favour the person who is rich because they know they will give him something. The police respect too much those who are high class because they know that if they respect those they will able to have something... (FGD, young men in Monze).

You find that those who have money may commit those crimes more often but are not prosecuted (FGD, young men in Chingola).

… when you go to report they [police] listen properly and nicely, but when they give out the summon, before you arrive he comes with money for the police and when you sit down to talk, they will be delaying and not looking at you properly, so that is what they do mostly (FGD, men in Kalomo).

… [it doesn't matter whether you're a man or a woman] if you are poor you won't be helped, only when you are well-to-do will they help you. If you have money they'll help (FGD, men in Nyimba).

Fear of reporting to police because goes against you

But there is too much corruption in the police. People are even afraid of reporting to the police. If the officers over stay at the same police station so you find that they are the same people when you report the case it ends up turning against you (FGD, men in Chingola).

Police (and other formal structures) as intimidating and lacking respect

...like at the police they don't answer properly or when you want to go and see someone they will say what do you want, they scare you instead of welcoming ... no wonder three quarters don't go there (FGD, young men in Monze).

You go there and find that their way of answering is that very style of intimidating, they are partial even the way they address you. They just want to intimidate you so that you look confused (FGD, men in Mpika).

They are different [the police], some are respectful while others are not. Some are very rude and boastful (FGD, young women in Mpika).

The police these days they are not respectful, they are very rude (FGD, men in Chingola).

Some of us have never been to the courts or the police so how do we explain what happened, we will just be intimidated by the uniforms and will end up losing the case (FGD, women in Chingola).

Capacity/training of police

...they have been taught they know yes, it is only corruption which has disturbed them (FGD, men in Kalomo).

The police officers may have received the necessary training but some never had intentions of becoming police officers so they do not care much about how they conduct themselves (FGD, men in Chingola).

They [the police] are trained well where they get training, but coming here they change, corruption is still there (FGD, men in Mpika).

Others you find sometimes that they are not well trained but because the bosses at the top are their relatives so they just enter the service. Others went for training but are not employed; because of corruption their relatives enter the job without training (FGD, young men in Monze).

As well as facing difficulties in approaching the police because of the above-mentioned issues, a number of other concerns were raised about the reluctance to report GBV-related incidences to the police. On the one hand male victims of GBV were said to hesitate to report abuse for fear of being ridiculed: *You can't even report to the victim support unit because if you do they will look down on you, saying what kind of a man are you being oppressed by a woman?* (FGD, young men, in Mpika). This was echoed by men in Chingola and a related point was raised by young men in Chingola, asking whether the VSU was for men as well as women: *I want to ask about the VSU, is it only made for women? Because mostly I see that they only help the women. If as a man you report a case, they do not help but when a woman reports that's when they act…* Such behaviour was also experienced in Mpika, and according to men there: *When beaten by a woman you report there, they say you are foolish, how can you be beaten by a woman. They speak to confuse you and make your case to have no basis, but when a women takes a case then it has got value, it's got basis.*

Women also spoke about being reluctant to go to the police due to possible consequences, in this case in relation to shame and humiliation, but also potentially further abuse and abandonment (see also below): *You think of reporting him to VSU, then you think of the consequences then you just remain quiet … in some cases the men fear but in some cases they just get used to it, there is nothing you can do, sometimes they even buy them beer and they (the men) drink together with the people (police) who are supposed to pick them up* (FGD, women in Mpika). Another woman in the same FGD states: *There are times when a woman is really beaten then she goes to the headman and reports that she has been beaten.. then he can order vigilantes to apprehend him, the neighbourhood watch takes him straight to police, but know after that, the women will have no peace*. Similarly, in Chingola women were reluctant to go to the VSU both because they say they were laughed at, but also because they felt that such issues were private : *You find when you go to the VSU they laugh at you… Officers might be there but it is difficult to for a woman to report what happens in the home* (FGD, women in Chingola).

Economic reasons also play an important role in discouraging women from reporting their husband as a perpetrator to the VSU. A majority of women are economically dependent on their husbands and if their husband were to be prosecuted and end up in prison then the woman and her family would face severe challenges in relation to their livelihoods. As various women in the FGD in Mpika argue,

> *…Police are okay and serious (do their job), but the problem is they will arrest him, now that is a problem because who is going to fend for the children, its him who brings a tin of maize; now the home becomes cold, that's where the problem is.*

When he is taken to the police your aim is that they just caution him, not take him to prison because, that gallon of maize, who brings it?

..How do you prepare porridge for children, even his relatives will come and tell you to have to him release, so he just has to be freed.

When asked about the gender balance of the police, responses were mixed. In some cases respondents reported that there was a gender balance (e.g. FGD, men in Kalomo), in other cases there were more men than women (e.g. according to respondents in the young women FGD in Mipka), and in yet other cases, e.g. according to the young men in the FGD Chingola, there were more women than men. Only in this latter case did respondents perceive more women as being a problem: *Most of the officers are women. Can a woman apprehend strong men*? (FGD, young men in Chingola).

It is important to note that a number of positive experiences were also mentioned. Thus, for instance, respondents in an FGD with young women in Mpika felt that police had improved when compared to previously:

Previously the police were not very helpful but now they are trying to do what they can. If a woman is beaten they come to investigate and arrest the culprit (FGD, young women in Mpika).

In Mpika and Nyimba the VSU was seen to resolve cases effectively, to act as a form of deterrent and a keeper of the peace:

What happens is that they are warned that if they continue they will be kicked out of the village, so most of them change (FGD, young men in Mpika).

It helps [going to the headman or VSU] in that at least he starts to fear that next time I may be arrested and taken further ... when his friends see that he has been arrested then they learn that this is how it will be with me also, I will be taken to prison (FGD, women in Mpika).

... the help we get from the police ... when you get a call out, the person becomes scared and stops (FGD, men in Nyimba).

These days they (the police) do have transport ...when they hear the information or the case they will go there to see what is happening, what's the cause ... then he or she will be followed. If it is an assault issue then they will look at it, if it is defilement they will hand over the issue; then if you are able to be arrested or taken to court then they also advance the issue in court yes, they usually move with handcuffs (FGD, men, in Kalomo).

Finally, as pointed out, the police do help out but the problem is that when someone keeps coming back they feel there is little they can do: *but the police helping, they do help but when they see that it is too much and the same person being taken there all the time, they decide to forgive him ... they leave that person thinking he has a mental problem they just leave him to figure it out for himself* (FGD, men in Nyimba).

Informal support for GBV survivors

Informal support for GBV-related issues ranges from that provided by family members, to that provided by the headman and chief, to that provided by the church and other community-based institutions, e.g. the Community Crime Prevention Unit made up of vigilantes, as mentioned in Mpika by the men's FGD, and the neighbourhood watch committee (referred to usually as 'neighbourhood'), which can also take perpetrators to the police. According to respondents in the quantitative survey, informal support was also important for GBV survivors and included turning to relatives (21%) and community leaders (20.8%) for help.

There is a sense from most FGDs that there is a continuum of seeking help, starting with the headman or local village committee, then escalating to the chief (who can also call out the elders), and ultimately the police. The extent to which it is escalated also depends on the severity of the issue and whether the perpetrator makes any changes in behaviour, as is illustrated by the following quotes:

..where they can seek help ... with the headman first in the village you stay in. Secondly you can go to the chief and if things fail to work out, that is when you can go to the police (FGD, men in Nyimba).

Those who fight in their homes are brought to the village committee where they are advised. Some change but those who do not change are taken to the chief who punishes them by sending them to work on the fields. If they continue then they are taken to the police (FGD, young women in Mpika).

If a man is found to be frequently mistreating his wife he is taken to the village headman who will talk to him. And if he continues then he is taken to the chief who will punish him ... we start by reporting to the village headman, if it fails that is when we take the matter to the police (FGD, young men in Mpika).

Before going to the headman, the first option is to go to elders, parents, family members and/or friends for support. For women especially, and in relation mostly to problems with their husbands, the first port of call is often their mother or best friend: *Sometimes I can go to my mother or best friend; depending on how much experienced they are in such matters they would encourage me* (FGD, women in Chingola). This is echoed by male respondents from Mpika when talking about women: *Sometimes she may go to the mother and tell her of her suffering* (FGD, men in Mpika). Many expressed the sense that one should first go to parents, elders or traditional marriage counsellors to resolve domestic issues as the following quotes from women in the FGD in Chingola illustrate:

We resort to going to the parents because it is easy to explain to them and because of their experience they can help.

Usually they are advised to go to their traditional marriage counsellors who would seat them down and try to resolve the issue. They only go to court when things cannot be resolved and they just want to divorce.

More generally there is a sense that talking to parents and elders can solve certain problems and change the situation: *Some situations do change, for example if they go to parents and talk over issues properly they can change ... they can share the problem with elders who live in the neighbourhood who can solve that problem or issue* (FGD, men in Monze). However, respondents also noted that if a man turns to his parents, he may be let off easily as parents tend to be lenient, as this narrative from men in Nyimba shows: *The ones that commit too much GBV are the drunkards and smokers and after committing these cases they go to their parents for support. They have faith that even if I go to jail my family will come and bail me out. They can boast because they know that their family members will come and bail them out, they go drinking, commit GBV and boast that their family will bail them out.*

While generally going to the headman and chief acts as a deterrent and can prevent future violence, as does reporting to the VSU, it was also mentioned that it can backfire. Thus according to men in Nyimba: *When you take a complaint to the chief, he is the one in the forefront shouting at the person reporting the case. When you complain a bit they turn the case against you. So that is my complaint* (FGD, men in Nyimba). The same men also mentioned later on*: When you go to the headman the person becomes scared that maybe I'll get chased from the village and stops (the abuse). And when you go to the chief it's the same thing, you get scared that you'll get chased from the village* (FGD, men in Nyimba). Similarly, there was a sense that sometimes when cases are taken to the headman, they are not fully resolved and that perpetrators go unpunished

Likely linked to this, as was also found in the formal systems of support, is that the informal system also treats people differently according to what they can offer the headman or chief and as such is open to corruption; thus according to men in Nyimba: ... *if you have a case and go to the village headman in the night with a chicken then he'll rule in your favour and it's the same thing with the police, you bribe then to rule in your favour* (FGD, men in Nyimba).

Reporting perpetrators to the headman can also backfire for women, with a women ending up being beaten or divorced as this narrative from women in Mpika shows: *Let me say something here regarding the fear of the women, when she gets married to a paramilitary [rough man] and he says I will hurt you and your children, when it happens the woman cannot do anything, I take him to the headman then he comes back to hate me or he will divorce me, it's here where we are in slavery. Even in this village you can take him to victim support, you can take him but then the consequences are that the process is weaker and bad for you* (FGD, women in Mpika).

A number of FGD participants spoke about the church prayer and 'letting love' lead as a way to resolve problems related to GBV and should be turned to before other forms of recourse, as illustrated in the quotes below. This form of support was also mentioned in the quantitative survey where 3.7% of respondents discussed places of worship as a source of help.

> *Sometimes things end when they go for prayers and talk about it if they are Christian; so when they fight sometimes the man goes to the wife and says 'I'm sorry forgive me for everything I have done to you' ... just like that (FGD, young men, Monze).*
>
> *What we may say is let love lead because in the community when people love each other it means things will be all right (FGD, young men, Monze).*
>
> *No wonder my friends have spoken about loving your neighbour as you love yourself (FGD, young men in Kalomo).*
>
> *Some go to church when they are found in such problems (face violence) (FGD, women in Chingola).*

7.3 Survivors' experiences

There were ten interviews with GBV survivors, whose ages ranged between 17 and 50 years (two were 17, one was 18, one was 25, one was 34, three were 35 and two were 50 years of age). Six were married or divorced. Five of the women were asked specifically about their experiences at the OSCs. All except one, where the perpetrator was her brother, experienced GBV from an intimate partner or father of her child.

Below we first outline the types of GBV that was perpetrated against them, followed by their perceptions of its causes. The kinds of support they sought are then described, followed by a short section about their experiences at the OSCs (see also section 8.2). We end with a brief note about children's experiences. This information was obtained mainly from key informant interviews since the only interview with a child, the 17-year-old from Monze, did not contain detailed enough information.

7.3.1 Forms of GBV

Physical abuse. Survivors invariably mentioned beating and verbal abuse, irrespective of their ages. Beating was often associated with the intimate partner abusing alcohol as this exchange with the 50 year-old women in Monze shows:

Respondent	*What happened was that I hurt myself on the leg. I was at home and when it reached around 10 and I was preparing to go to the market, my husband came and he was very drunk and then he started talking too much and insulting me. Then he started roughing me up and when I fell down he caught me and started beating me.*
Interviewer	*So you mean he just started beating you for no reason or without anything happening?*
Respondent	*Yes he just came back from wherever he had gone and started insulting and talking, then he caught me and started beating me. Then I fell down. I fell down because he hit me with an iron bar. He beat me so bad and I realised that he hurt my leg, that's when people came and took him to the police and I was taken to the hospital.*

The man's violence against his wife was often extended to the children if the wife was not present or they happened to get in the way (see for example, survivors' experiences from Monze and Kalomo). While girls and boys were treated differently, both were exposed to it: *Both the males and the females [children] he fights with. If it's the males he even punches them but for the females he just insults them* (Woman aged 50 in Monze).

Among other things, the beatings have led women to miscarry – *When I had five children and was pregnant with the sixth, then he beat me and I had a miscarriage* (Woman aged 34 in Kalomo) – and also resulted in women being unable to work, thus affecting their livelihoods: *In October this year he beat me so after he had beaten me I got sick seriously I could even have died* (Woman aged 25 in Monze). A similar view was expressed by the 50-year-old woman from Monze, who did not want her husband to go to prison fearing this would affect her and her household's livelihood, particularly since as a result of his beating her she was now unable to work (see below).

Other forms of physical abuse included being locked up by the husband (Woman aged 25 in Monze) and being burnt by *nshima* (the local maize staple) (Women aged 50 in Monze).

Although it was difficult to get an exact response from the GBV survivors, the overall sense was that the GBV and especially the physical violence had been going on for a long time and that women face repeated assault. Thus one woman from Kalomo, who is currently aged 34 and has seven children, spoke about the beatings: *It started a long time ago. The time I had two children.* Another woman from Nyimba, who is 25 years of age and has three children, also said the beating had been going on for a long time, starting when she was pregnant with her first child. The woman from Monze also mentioned repeated beatings.

Views not respected/not part of decision-making processes. In addition to physical and verbal abuse, a number of women felt that they were not being listened to and were excluded from decision-making processes. This occurred particularly in relation to the relatively powerful position of the mother-in-law as these two accounts from the women in Monze show:

> *With my husband we used to agree on what to buy, but his mother would come and say do not listen to your wife. Do not buy what she says. Then she would get money and waste it or go with it.*
>
> *You find that when you make the budget properly then his mother would come and get the money and use it. If I talk about [it] he would say that I do not have respect for his mother and then fighting begins.*

Forced and early marriage. Two women spoke about being forced to marry. The 25-year-old woman from Monze said she had been forced to marry both her first and second husband– first her father forced her, and when he died, her uncle and mother forced her. According to this survivor, early marriage can create problems since one is not mature enough to take on the responsibilities of married life: *Getting married fast because you find that one is not matured enough to get married or to keep the marriage. But because of being forced [leads to problems]*(Woman aged 25 in Monze).

A slightly different story was told by a 35-year-old woman from Monze who, when she was widowed (she had been married for 10 years), following accepted tradition, was forced to marry her husband's younger brother. However, upon marrying, her husband started abusing both her and her children 'pouring water over them' and eventually 'chasing them' from the house. In a sense this woman faced a double form of GBV – she was first forced to get married and then when she did so, both she and her children were physically abused: *His relatives agreed that he should marry because I am a hard working woman and so that he can help me raise the children since I wasn't going to manage alone… and he was also with the idea of marrying, but to my surprise when he brought me here he started torturing me and the children as if they're not [his] nieces, he doesn't care about them. Not a single day has he ever bought something, not even a simple bathing soap or a K5 [local currency] pair of trousers.*

Women (or girls) are often forced into marriage for economic reasons. For the 35-year-old woman described above, she married the brother of her late husband so that he could help her and her children economically. For the 25-year-old respondent, when family members could not afford to send her to school after her father died, she was withdrawn from school and married. This link between early marriage and school drop-out is common (see also section 6.1). In this case, the girl tried to do something about it but to no avail: *I complained to the District Commissioner when there was the MMD government. They said they would come to talk to my parents so that I can start school. They said the money for school would come from the … there is an office where they help in terms of school… Yes that's what they said. But up to now they have not done anything* (Woman aged 25 in Monze).

Traditional practices. As discussed above, the traditional practice of marrying a sibling after being widowed had negative consequences for the 25-year-old women in Monze. Another traditional practice that appears to have had negative consequences, according to the interviews, was the initiation ceremony, *Chisungu.* According to the 25-year-old woman from Monze, she was forced to undergo this ceremony, with her grandmother making her stay in the house, where she was 'beaten and pinched'. She feels it is not a good practice and would not want her daughter to go through it, particularly since it is associated with a girl leaving school and getting married early: *... it is not a good practice because when you come out of the house it forces you to marry the girls fast* (Woman aged 25 in Monze).

7.3.2 Causes of GBV

When the survivors were asked about what they thought were the causes of GBV, responses ranged from their husband not supporting them to the marriage not being legally recognised resulting in the survivor facing difficulties in taking the abuser to court, to women to some extent deserving to be abused because of entrenched and internalised norms around gendered behaviour, including violence.

According the 25-year-old in Monze, there was no evidence or exchange of money (*nthengo* and *nthakula* – *nthengo* is the money which they pay to show that you have married well, *nthakula* is the permission for the man to take woman to his home) which showed that her marriage was recognised. Nor did she have a marriage certificate, which meant she could not report him to the police or take him to court since the union was not recognised. This, according to her, meant she could not divorce him and he could treat her however he liked.

Perhaps a more common cause of GBV, according to the survivors, arises from men not supporting their wives financially. Thus instead of using earnings to support their household, according to these women, men will spend this money elsewhere including on alcohol and other women. When the wife asks for financial support this sparks anger in the man and he responds by physically assaulting his wife, as can be seen from this quote: *When he gets paid, from January up to now, except the month of August I have not seen his salary. He does not give me money even when he gets paid money. The children at home are suffering. Then I told him 'We do not have money. Don't you have money in your pocket? Yesterday you were sharing K900s with your friends where you were building houses'. So that is when he started beating me saying I told you not to be coming here at the lodge* (Woman aged 34 in Kalomo).

Some survivors also mentioned that sometimes GBV against women can be justified when women are not behaving as is expected of them. This highlights the extent to which social norms around gendered behaviours, including violence, are entrenched and internalized. It also highlights the need for continuing awareness-raising around the rights of women and girls including the different forms of recourse:

> *Yes, like a housewife when she drinks and the man also drinks and she doesn't listen, a man is allowed to beat her though not much and I mean verbal beating not physical beating, it's always right to correct someone when they are wrong (Woman aged 50 in Monze).*
>
> *Yes, she must be beaten if she is not properly taking care of the children because children must be taken care of ... yes, if you not obedient then he can beat you, but if you are obedient he cannot (Woman aged 35, Monze).*

7.3.3 Support

Informal. Informal support refers to that provided by family, friends and neighbours. According to one survivor, because help from family and neighbours was not forthcoming when she was forced to leave her husband's home, it was her friend who helped her with food, to find work and shelter (Women aged 35 in Monze). Similarly, according to the 25-year-old from Monze, help from family members did not appear to be very effective, although her mother did talk to the man's family: *I talked to my mother who shouted at the man's family that they are letting him beat me and they are not doing anything.*

In two other cases family members were seen to be supportive: in one case, the woman's children took her to the OSC (woman aged 50 in Monze) and in the other case the woman's brother advised her to report the abuse she was facing from her husband to the VSU: *At that time we went to the victim support unit, and my brother started explaining that this person was beaten by her husband at home and she had gone to the hospital and gave a lie that she fell off an ox cart so after I heard this from pemba, I was called. He continued by saying 'I don't want this because my sister has been undergoing this for a long time now. So I want this person to come here. He should know the law. You should show him. This is not a good practice. Battering the wife like this'* (Women aged 34 in Kalomo).

Formal support structures. In terms of formal support, survivors mentioned the hospital, police/VSU, courts, counsellors and OSC. Of those who mentioned only the police/VSU, the impression was that they were not very effective. According to the 25-year-old woman from Monze, she went to the police three times to report her husband but they did not arrest him (also because they are not legally married) and as such, she feels it is not worth going back. The 35-year-old from Monze also doubted that the police could make a difference: *The reason why*

I'm saying this is because I have stayed with him and I don't think the police treatment can change his character or behaviour… so we would just be wasting time … he already did bad things to me, so even if he was jailed nothing would change, so as I'm talking right now he's drinking beer and starts from morning until the sun goes and he involves himself into fights and also doesn't care about matters of the home.

Although women may know about and turn to formal support structures for help, often they withdraw charges due to pressures from family members. According to the survivor from Kalomo, the previous year she had gone to court, but under pressure from her husband and his family, and also with the knowledge that if he went to prison, she and her children would suffer, she withdrew charges:

> *My husband just said that I should go and withdraw the case, that things would be OK, that he would change, but things did not change. ... he said he would start supporting me financially and for things needed at home. Because he was not providing for me as his wife for nine months, that is why I went to court. So that the courts may help us.*
>
> *...I don't want us to be on separation because the children can suffer. I just want people that can offer us help so that we can live better together in the home.*
>
> *... he begged me to go and withdraw the case. He wanted to resolve the issue here at home with our parents… It was my husband and his parents, they were begging me saying because with the offence that he committed he would be arrested. My parents also accepted that we just discuss the issue away from the police.*

A similar experience was described by the 50-year-old from Monze: when her children saw her husband beating her they reported it to the police and the police arrested him. She was called to the police station where she asked them to release her husband so that they could resolve the problems at home. She felt that without him her livelihood would suffer, especially since as a result of his beating her, she was now unable to walk: *When I managed to walk a bit and that was in the morning and I went to the police station to talk to the police so that they could release him ... I explained to them that since I was in that state no one was going to look for food for the home so it's better for him to come out so that he can look after the children and the food. If he went to Mazabuka [prison] it would have been hard for me to look after the kids in my state. And at home we are supposed to sit as a family and discuss*.

7.3.4 Experiences at the OSC

Two of the women discussed in the above section (the 50-year-old from Monze and the 34-year-old from Kalomo) went to the OSCs. It appears that both were referred either by the police or by the hospital. The other three survivors who had gone to the OSCs were not discussed in the previous sections partly because they appeared to face different forms of GBV and partly because they were asked about their experiences of the OSC and their experiences of GBV were not probed in depth. Thus the 17 and 18-year-olds from Mpika went to the OSC because they felt that the father of their children was not supporting them sufficiently and the 35-year-old from Monze went because she was beaten by her drunken brother (it seems it was a one-off occurrence).

The 35-year-old from Monze reported that she did not want to go to the police because it was a family matter, and saw the OSC as being a more appropriate intermediary: *Family issues are difficult. Like I said… that when I was coming here in the morning my brother came. There were a lot of relatives and they begged that we just resolve the issue at home and not have him arrested.*

Three of the survivors visiting the OSC said they were accompanied by family members: the mother went with the 18-year-old from Mpika, both parents accompanied the 17-year-old from Mpika, and the 50 year-old woman from Monze was accompanied by her son.

Most had visited the centre more than once so far (twice being common). Most had seen a counsellor and a doctor. They were seen straight away and reported remaining there between 35 minutes to two hours. All received the services free of charge and most said the staff behaved well, that they were treated with respect, were made to feel comfortable and their privacy was maintained: *The behaviour of the people at the one-stop centre is very good. And the way I have seen, if these people continue like this people will stop being violent toward each other.*

Because they are very serious. They are very good. They follow up cases ...They even came to just check up on me and see how I was doing and asked what I was thinking about the issue (Woman aged 35 in Monze).

In terms of improving the service, it was suggested that follow-up services needed to be more systematic, particularly in relation to the perpetrator: *I think they do not follow appointments because, for example, when the father to this child came he was told to come on Wednesday and when he comes, he might be told to come another day and so on and so forth. They need to stick to what they say… They just talk and make you feel as if they going to take a step further but then they end up doing nothing* (Woman aged 18 in Mpika).

Similarly, survivors mentioned that cases take a long time when they are taken through the courts, and most called for cases to go through more quickly and efficiently.

Box 3 contains a case study of a survivor of GBV. According to her story, for the past 10 years she had been regularly beaten by her husband. While she initially sought support from the headman, her parents-in-law and the church, he continued beating her, so she eventually turned to the courts. However, this also resulted in her feeling embarrassed and humiliated.

Box 3: GBV survivor in Mumbwa District

Dora (a pseudonym) lives in Mumbwa district. She originated from Zambezi district in North-Western Province. She is 50 years old and is married with 11 children. She has been married for 33 years. She studied up to grade 4 in Zambezi district but then stopped due to insufficient financial support. She is currently a farmer and has joint ownership of a plough, cows, chickens and goats.

When she experiences marital problems she goes to the village headman, her parents-in-law (her parents live far away) and the church; if the situation worsens she goes to court. She frequently seeks help when her husband has been drinking which often leads to him physically and verbally abusing her. The church provides her with moral support and encourages her to be strong. At times the church people visit her, however when they do pay a visit she says: *They will find my husband very drunk so they don't discuss anything.*

She stated that violence started in 2004 and continues to this day: *I think I was verbally abused, physically abused and I suffered from wife battering and even being chased away, my husband saying that I should go back to my father's house.* This physical abuse was also extended to the children since whenever he came home drunk he would enter the children's room to wake them up and if they did not respond he would beat them.

In September I went to court but he then pleaded with me that he has stopped. Since that time he hasn't beaten me again and he also said I should forgive him and he will stop the beer drinking, but the beer drinking has not stopped neither has the shouting when he is drunk. Since her husband was prohibited from beating her through the court order, the physical abuse stopped however, according to her, the verbal abuse continued (she also later suggested that the beating was also continuing). She went to the court because despite asking for help from the headman and her parents-in-law, it did not lead to any change in her husband's behaviour: *When I came to see the headman he said that he had enough of this case so I had to take the case to court because I was so angry with my husband.*

Although she sought recourse through the formal system, and in this case the courts, Dora was not satisfied with the consequences and reported feeling humiliated and embarrassed to have 'to drag her husband to court'. Although she did not elaborate, this humiliation and embarrassment probably arose from her having to speak in public about domestic affairs and similarly admitting in public that she was having marital problems.

A note on experiences of children

The primary understanding of how GBV affects children is with respect to child abuse and sexual and physical assault. According to respondents, minors are taken to the police only if an agreement or amicable settlement with the perpetrator or his family has not been reached. Where they reach a settlement they will not report the matter. If the perpetrator is the parent or guardian of the child, and the matter is reported to the OSC, the OSC will recommend the child be removed from that environment.

One of the difficulties with working with children, according to respondents, centres on delayed reporting: bringing a child five days after an incident of assault (either physical or sexual) undermines the prosecution of a case. Usually the parents or guardian will claim that they delayed because of transport problems, but it was also noted that the delays happen because of lack of information in the community regarding due process, and the associated costs and implications of filing a case. One respondent from the VSU in Chingola also noted that there was an unclear separation of mandates and roles between the VSU and the District Child Protection Unit (part of the Ministry of Community Development and Social Welfare). A lack of training and guidance on the referral channels and follow-up procedures therefore led to unsystematic approaches in dealing with children who had experienced physical and sexual assault.

It was also generally felt that sexually abused children had no specialised post-trauma counsellors to treat them and medical doctors attending to children were not specialised in such cases. Similarly, it was pointed out by a number of key informants that psychosocial support had so far only been provided to children on an informal basis by a range of actors, including the community service directorate coordinator, the Child Protection Unit, the school liaison officer and the person responsible for community safety.

The informants observed that children who become victims of GBV were also brought to the OSCs for care and support by parents or grandparents. The OSC's role is to collect any evidence of abuse. When a child has been sexually abused, the case is handed over to the police. The OSC remains on standby to testify and prove that the abuse had taken place.

> *Most of the time we just deal with evidence of abuse. If we suspect that a child has been abused by the parents, we hand over to the police to do the investigations but as a hospital we just provide the evidence that it occurred. If it's an assault, was the person really assaulted and what exactly has happened to the victim (Mpika).*

Some respondents noted that cases of defiled children are now being handled effectively because of collaborative efforts among partners, including the VSU. To ensure the safety of the children who are physically and sexually abused, they are referred to the Department of Social Welfare because the OSCs do not currently have safe houses or shelters. In Mumbwa, the informants said that cases of child sexual abuse are common - since the OSC was established about a month ago, they had attended to mainly cases of wife battery and child sexual abuse: *Since we started we had reached a month yesterday so we have recorded 13 cases since we opened and mostly are wife battery and defilement*.

8 Existence of and access to GBV services and information

In this section we present findings on information and services that exist on GBV at the community level, the extent to which people are aware of them, what people think about them, how cases of GBV are reported and the role of community engagement in these activities. The second part of the section focuses on knowledge of the STOP GBV Programme. We draw on findings from the quantitative community survey and the qualitative survey, including FGDs and key informant interviews.

8.1 Awareness of information sources

8.1.1 Sources of information

In all the districts there was generally lack of or limited information on GBV and related support services including the STOP GBV Programme. This was more so in rural districts such as Nyimba and Mpika. In Chingola, organisations such as ZCCP and Sport in Action were mentioned as the main sources of information on GBV. Some of the awareness-raising strategies involved outreach programmes aimed at compounds and peri-urban areas. The need for scaling up GBV prevention through sensitisation campaigns was emphasised in all the districts.

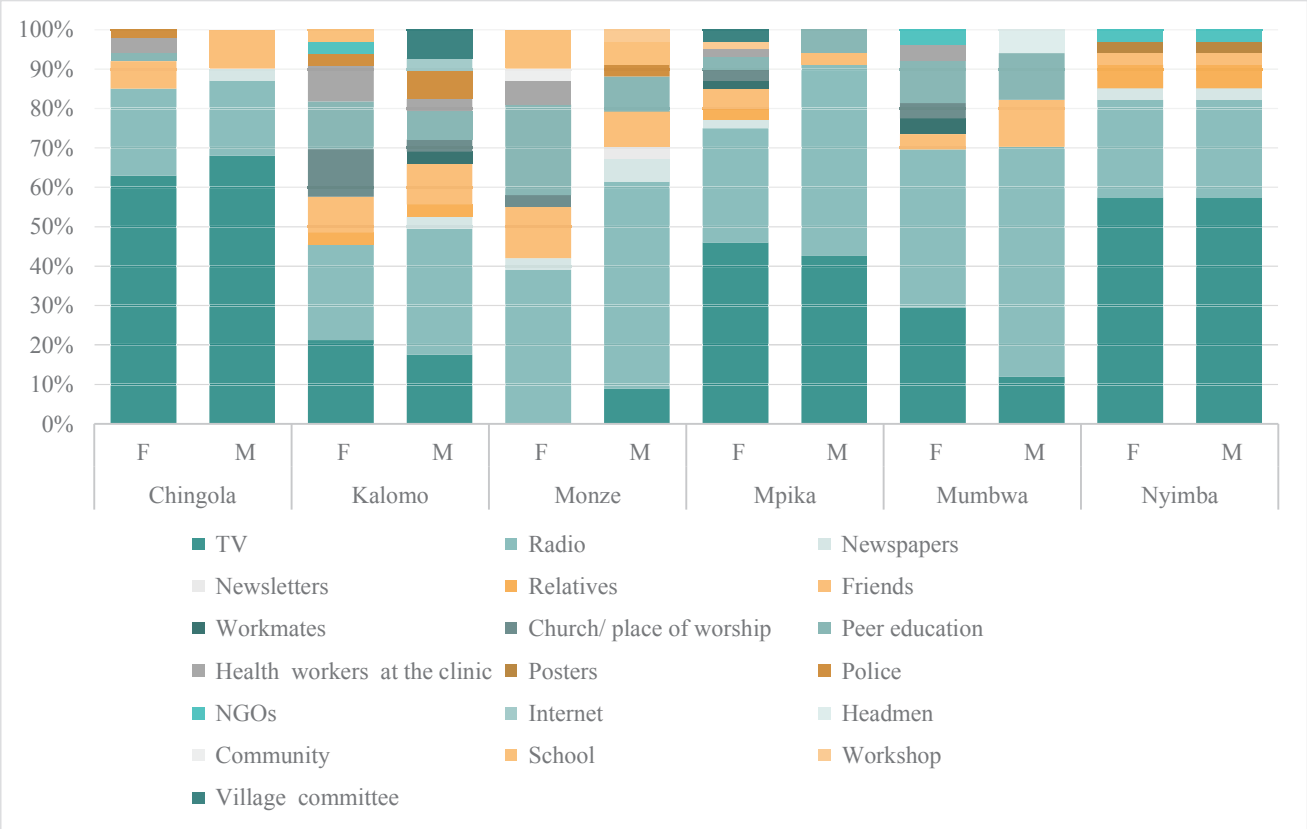
Turning to the quantitative data from the community survey, Figures 19 and 20 present the distribution of respondents by source of information on GBV prevention. The frequently mentioned sources in all the districts were TV, radio, friends and peer education. Chingola had the highest proportion (63%) of respondents who mention TV as their main source of information on GBV prevention and Mumbwa had highest proportion of respondents who mentioned the radio as the main source (48%).

Figure 19: What is your main source of information on GBV prevention? (N=385)

	Chingola (n=77)			Kalomo (n=29)			Monze (n=65)			Mpika (n=94)			Mumbwa (n=44)			Nyimba (n=76)		
	F	M	All	F	M	All	F	M	All	F	M	All	F	M	All	F	M	All
TV	63	68	65	21	17	19	-	9	5	46	43	45	30	12	23	58	58	50
Radio	22	19	21	24	31	27	39	53	46	29	49	36	41	59	48	25	25	33
Newspapers	-	3	1	-	3	2	3	6	5	2	-	1	-	-	-	3	3	13
Newsletters	-	-	-	-	-	-	-	3	2	-	-	-	-	-	-	-	-	3
Relatives	-	-	-	3	3	3	-	-	-	3	-	2	-	-	-	6	6	-
Friends	7	10	8	9	10	10	13	9	11	5	3	4	4	12	7	3	3	-
Workmates	-	-	-	-	3	2	-	-	-	2	-	1	4	-	2	-	-	-
Church/ place of worship	-	-	-	12	3	8	3	-	2	3	-	2	4	-	2	-	-	-
Peer education	2	-	1	12	7	10	23	9	15	3	6	4	11	12	11	-	-	-

Health workers at the clinic	4	-	3	9	3	6	6	-	3	2	-	1	4	-	2	-	-	-
Posters	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	3	-
Police	2	-	1	3	7	5	-	3	2	-	-	-	-	-	-	-	-	-
NGOs	-	-	-	3	-	2	-	-	-	-	-	-	4	-	2	3	3	-
Internet	-	-	-	-	3	2	-	-	-	-	-	-	-	-	-	-	-	-
Headmen	-	-	-	-	-	-	-	-	-	-	-	-	-	6	2	-	-	-
Community	-	-	-	-	-	-	3	-	2	-	-	-	-	-	-	-	-	-
School	-	-	-	3	-	2	10	6	8	-	-	-	-	-	-	-	-	-
Workshop	-	-	-	-	-	-	-	3	2	2	-	1	-	-	-	-	-	-
Village committee	-	-	-	-	7	3	-	-	-	3	-	2	-	-	-	-	-	3

Figure 20: What is your main source of information on GBV prevention? (N=385)



There appears to be no systematic causality between a person's sex and access or exposure to types of GBV-related information, including exposure to a variety of sources. However, peer education, church/places of worship, and health workers/clinic are relatively more frequently mentioned among females, whereas males tend to highlight 'radio' as a more significant source. What is significant is the very limited reference to schools as potential sources of information. In fact, schools were highlighted as relevant resources only in Monze and Kalomo – and much more by women than by men.

In the qualitative data, key informants did not mention TV as a core source of information on GBV, but emphasized community radio – such as is in Mpika (Mpika community radio) and Monze (Sky Radio and Chikuni radio). Both

key informants and participants in FGDs pointed to the role of traditional structures (chiefs and headman) as being a key source of information on GBV: *The major players are the village headmen; they are the ones that organize these meetings after receiving the message from the chief. In addition, most of the information is given to the headman then the headman takes that information to the chief, if the chief allows, then the headmen organizes the meetings which are to be attended by everyone in the community' (*FGD with girls in Mpika)(see also section 7.2 on forms of support).

FGDs from other sites, particularly Monze and Kalomo, showed a wider appreciation of sources of GBV-related information. For instance, young women in Kalomo noted that these could include the clinic, school, community meetings, or chiefs, whereas young men highlighted police stations, courts, hospitals, headmen, VSUs, teachers, radio, TV and NGOs/researchers. Feedback from Chingola suggested that communities in this site were least familiar with types and sources of GBV information (as also shown in Figures 19 and 20).

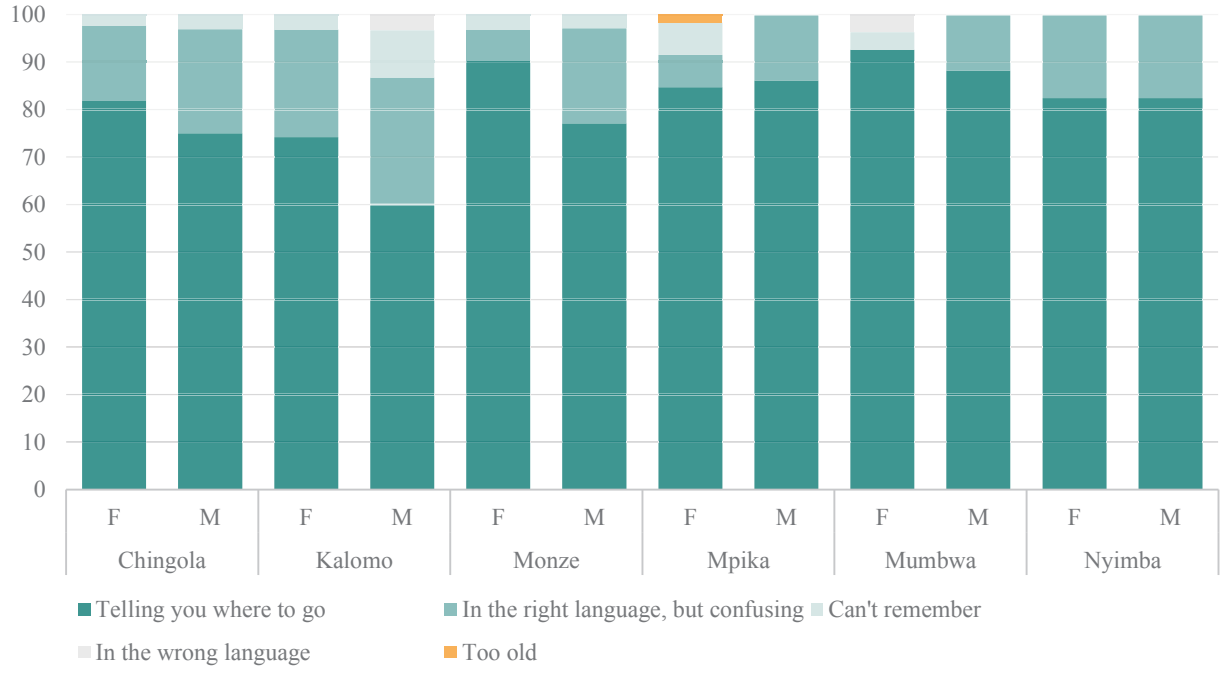
8.1.2 Quality of GBV-related information

Drawing on the quantitative community, survey Table 12 and Figure 21 present the perceptions of respondents regarding the quality of GBV information to which they had access. Around 81% of respondents felt that the GBV information to which they had access 'tells them where to go' if they were to experience or witness GBV. About 15% felt the information was 'in the right language but was confusing'. Gender-based differences across the sites were marginal, although generally men considered information to be more 'confusing', particularly in Kalomo and Monze.

Table 12: Quality of GBV information (n=410)

District	Sex	Telling you where to go	In the right language, but confusing	Can't remember	In the wrong language	Too old
Chingola (n=76)	Female	81.8	15.9	2.3	-	-
	Male	75.0	21.9	3.1	-	-
	All	78.9	18.4	2.6	-	-
Kalomo (n=61)	Female	74.2	22.6	3.2	-	-
	Male	60.0	26.7	10.0	3.3	-
	All	67.2	24.6	6.6	1.6	-
Monze (n=66)	Female	90.3	6.5	3.2	-	-
	Male	77.1	20.0	2.9	-	-
	All	83.3	13.6	3.0	-	-
Mpika (n=95)	Female	84.7	6.8	6.8	-	1.7
	Male	86.1	13.9	-	-	-
	All	85.3	9.5	4.2	-	1.1
Mumbwa (n=44)	Female	92.6	-	3.7	3.7	-
	Male	88.2	11.8	-	-	-
	All	90.9	4.5	2.3	2.3	-
Nyimba (n=68)	Female	82.4	17.6	-	-	-
	Male	82.4	17.6	-	-	-
	All	82.4	17.6	-	-	-
Total (n=410)	Female	84.1	11.5	0.4	0.4	3.5
	Male	77.7	19.0	0.5	-	2.7
	All	81.2	14.9	0.5	0.2	3.2

Figure 21: Quality of GBV information (n=410)



8.1.3 Common channels for reporting GBV

According to key informant interviews, there are largely two levels of reporting GBV incidents: the service provider level and the community or primary response level. In terms of the former, key informants (which included VSU Officers, District Administration Officers, Social Welfare Officers, OSC staff, medical professionals) uniformly said that the central entry channel for reporting GBV at the formal service level was the police and then the VSU. Beyond this, the hospital and health centres have historically been the next most important reporting channels.

> *At the moment of course it is the police. It's the police but with the coming of this one-stop centre .. at the end of the day we think we are going to have so many information received from that) (Monze).*

> *Most of the time they start through the police then come to the hospital. Yes, though we have cases where they come to the hospital first, we attend to them and then we send them for a police report which they have to get from the police itself (Mpika Health Centre).*

At the community level the main entry points are either the village headman or chief and, to a lesser extent, neighbourhood watch groups. Such entry points were more readily familiar to key informants in Monze, Mpika and Mumbwa than in Chingola, Kalomo and Nyimba;

> *The main two entry points for reporting GBV are the police and the hospitals. Sometimes we get reported cases from chiefs (Mpika).*

> *Traditional leaders – we engage them because that is where everything starts. You find that here is a case of defilement a person will report to the headman to say my daughter has been defiled and when the headman sees that all these are my people he will just sit them down. (Mumbwa)*

The interviews also showed that there were neighbourhood watch groups at the community level, although the research could not determine or triangulate the size of these or the degree to which they were active and effective:

> *Neighbourhood watch are people who assist the police... they would bring both the offender and the victim to the police (Monze).*

We have a group of people that we call the neighbourhood watch [that] helps the community by apprehending people who have committed assaults on their female partners. And the person is taken to the police. These are people we live with in village. They help us when a thief has stolen property or committed a wrong; they look for that person until they apprehend that person and take that person to the police. They handle and work well because we usually tell them that when they catch a person they should not beat that person but only take that person to the police (Mumbwa).

In Mpika, the headman also outlined that a key channel for referring GBV incidents was via teachers. Further mention of formal linkages with schools was negligible (although this gap may have arisen due to lack of probing on the subject by interviewers).

8.1.4 Community engagement in GBV interventions

According to key informant interviews, forms of community engagement exist across the six sites, but they are unsystematic and sporadic – at least in terms of the level of familiarity of the respondents. Without further investigation it is difficult to discern which sites have the widest and deepest forms of continued community engagement on GBV issues, but it appears that Monze, Mpika and Kalomo have the strongest links given their multiple media outreach (radio and posters), community education and network-building initiatives with GBV committees.

We have got two radio stations here. There is one that [facilitates] community registrations. We do call them for some programmes. Also there is a bit of communication on [GBV]' (Monze).

The gender-based violence committee ... we were having activities through the same committee. We used to go to the villages to go and sensitize. Of course, VSU was one of the stakeholders (Monze).

As already mentioned, headmen and chiefs are key entry points for community engagement:

Some maybe engage with the traditional chiefs. We do refer them back. And the chiefs tell them: 'What you are doing in your home is very wrong!' So we do referrals to the chiefs. If we see that a case can be handled by them we then refer them to the chiefs. Or to the church (Monze).

The local community actually is of help to the fight against GBV, because we have headmen involved in these issues of GBV ... headmen sometimes may even go out in the field – they get involved, even traditional leaders, the chiefs, I think in Kalomo, they are trying their best, also they are getting involved in issues of GBV (Kalomo).

In a small number of cases, schools and religious centres such as churches are considered important points for either obtaining cases through referrals from teachers, or as informal support structures. In the latter instance, some respondents explained how the limited resources for shelter facilities through the Social Welfare office had led stakeholders to consider developing informal linkages with churches to address the shortfall:

We don't have any safe homes for them. Between social welfare and the district and also the church - they are trying to work this out. I went to the social welfare and they mentioned something like that. We would really love to have such a facility. (Kalomo)

In terms of engaging men and boys in GBV interventions, according to a village headman in Mumbwa, he feels that sensitization of both men and women, but particularly men, has been going on for some time in the community: *We have got people who help us. A lot of groups and organizations like Women for Change and World Vision have taught us a lot. They teach us to unite as families but unfortunately many husbands still beat their wives. These organizations assemble men and teach them how to take care of the families and wives and also how to take care of their children.*

In Mpika, it was reported that outreach sensitisation activities in fact target mainly the men for various reasons including the fact that they are the heads of households and likely perpetrators of GBV. According to respondents, men are sensitised on the need and importance of preventing GBV by ensuring that it does not occur in communities. The informants asserted that, if men understand the importance of avoiding GBV then GBV cases can be reduced.

And because men are heads of houses, when they understand the importance of not engaging in GBV then even the young ones will be sensitized, then we will have a generation without GBV in the next 2 to 3 years. Women are usually victims and whatever they say is overshadowed if men do not participate. So the target should be men and of course women should be there also as partners (Mpika).

In Monze, the NGO, Sports in Action reported targeting men with GBV prevention messages through a number of activities including providing information to raise knowledge and awareness about the disadvantages of GBV and working with the church to mobilise and engage men. They also aim to use sport festivals and tournaments to reach out to more men, including working with male victims of GBV.

I promote sport as a tool to mobilize the young men and boys that we work with. They are our target group and I facilitate sessions with them and in the next few months we will be training a few in GBV prevention facilitation (Monze).

The churches have got men's networks. They are able to engage the men through their networks. And also there is a session that we will roll out - young men as equal partners. This curriculum is very interesting because it involves the boys. And also the boys will be involved in terms of them facilitating the process of this curriculum (Monze).

It was, however, pointed out, that it will take a long time to change male attitudes and behaviours because of entrenched social norms which allow men to control and dominate women, as this following quote highlights:

The cultural orientations of communities are a very big challenge because when you start sensitising people in certain areas, you hear the comments from the men, sometimes one man would just say 'women don't be cheated by these people, these are just people who are interested in money, they have come here to make money, so if you listen to them and implement what they are saying, you will destroy your society' (Kalomo).

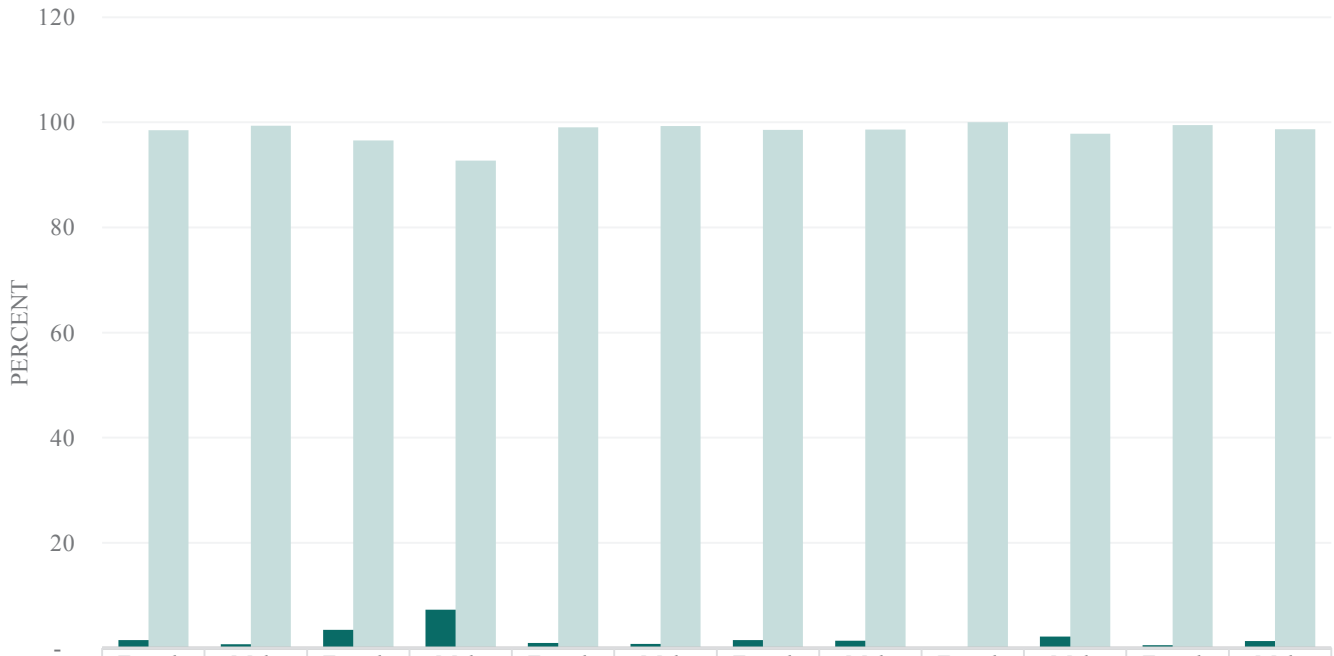
In summary, the strategies and actors engaged in raising awareness are not yet clearly mapped across actors working on GBV at the district level. A core structure is however present in the form of GBV committees that work at the community level and are housed managerially in the District Gender Sub-committees, whose mandate includes a component on sensitising local leadership, as well as broader agendas on women and girls' empowerment, which emphasise a focus on process issues as well as GBV outcomes.

8.2 Knowledge of and participation in GBV services provided by the STOP GBV Programme

8.2.1 Knowledge about STOP GBV Programme – quantitative data.

Given that this baseline study appropriately took place before most intervention activities could begin, more than 90% of respondents in the quantitative survey had not heard about the STOP GBV Programme. As can be seen from Figure 22, Kalomo had the highest proportion of respondents who had heard about the programme. There was no statistically significant difference between women and men regarding exposure to the STOP GBV Programme ($p=0.123$).

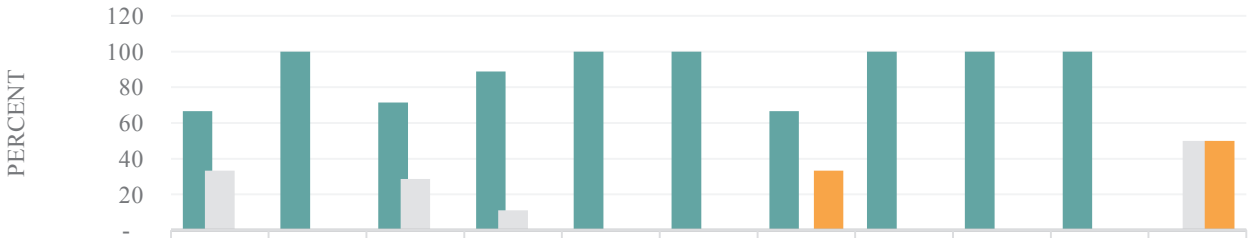
Figure 22: Knowledge about the STOP GBV Programme



	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
	Chingola		Kalomo		Monze		Mpika		Mumbwa		Nyimba	
Yes	2	1	3	7	1	1	1	1	-	2	1	1
No	98	99	97	93	99	99	99	99	100	98	99	99

Respondents (n=33) who said they had heard about the STOP GBV Programme were further asked what information it provided. Figure 23 below provides the distribution of respondents who agreed that the programme provided information on GBV and early child marriage.

Figure 23: STOP GBV Programme: information on GBV and early child marriage (n=33)



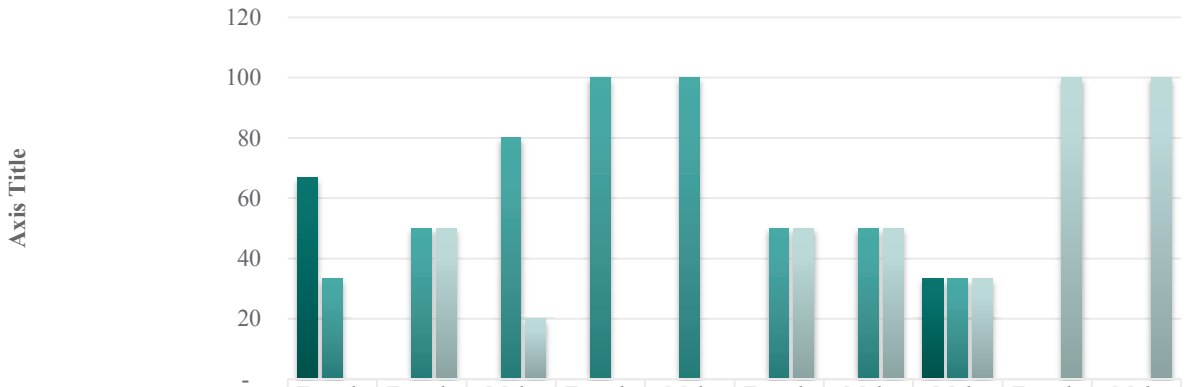
	Female	Male	Female	Male	Female	Male	Female	Male	Male	Female	Male
	Chingola		Kalomo		Monze		Mpika		Mumbwa	Nyimba	
Yes	67	100	71	89	100	100	67	100	100	100	-
No	33	-	29	11	-	-	-	-	-	-	50
Do not know	-	-	-	-	-	-	33	-	-	-	50

8.2.2 Knowledge and participation in GBV service provision – quantitative data.

When asked about the specific services the STOP GBV Programme provides, in all districts except Nyimba, respondents (n=29) mentioned prevention and advocacy and in all districts they also mentioned the OSC except

for Monze. Figure 24 shows that only in Mumbwa and Chingola respondents indicated that OSCs provide legal advice.

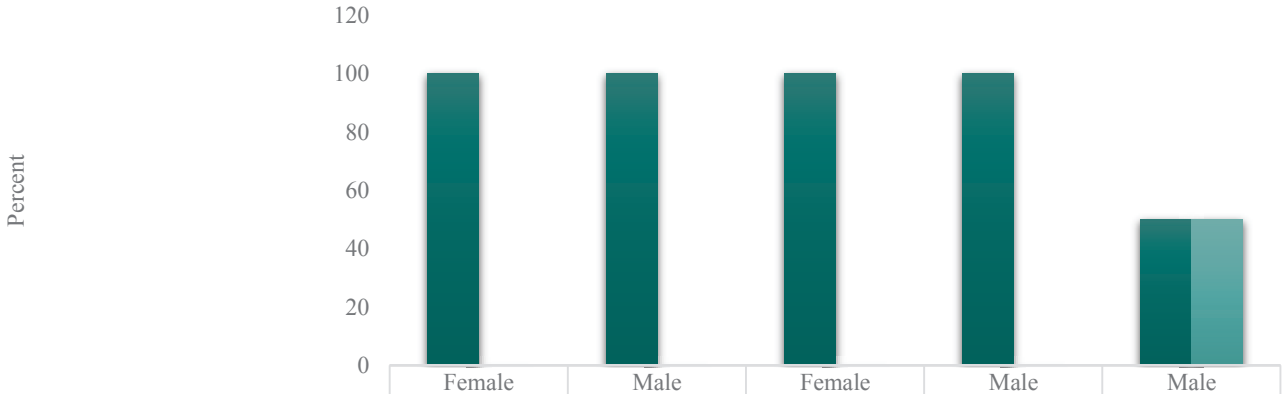
Figure 24: Services provided by the STOP GBV Programme[9] (n=29)



	Female Chingola	Female Kalomo	Male Kalomo	Female Monze	Male Monze	Female Mpika	Male Mpika	Male Mumbwa	Female Nyimba	Male Nyimba
Legal advice	67	-	-	-	-	-	-	33	-	-
Prevention and advocacy	33	50	80	100	100	50	50	33	-	-
STOP-GBV centre	-	50	20	-	-	50	50	33	100	100

Only respondents in Kalomo, Mpika and Mumbwa districts confirmed having participated in GBV activities implemented by the STOP GBV Programme, though the number was very small. The main activity was the prevention and awareness–related information, which occurred in all three districts. Provision of GBV survivor services was mentioned only in Mumbwa (see Figure 25).

Figure 25: STOP GBV Programme activities in which respondents participated (n=10)

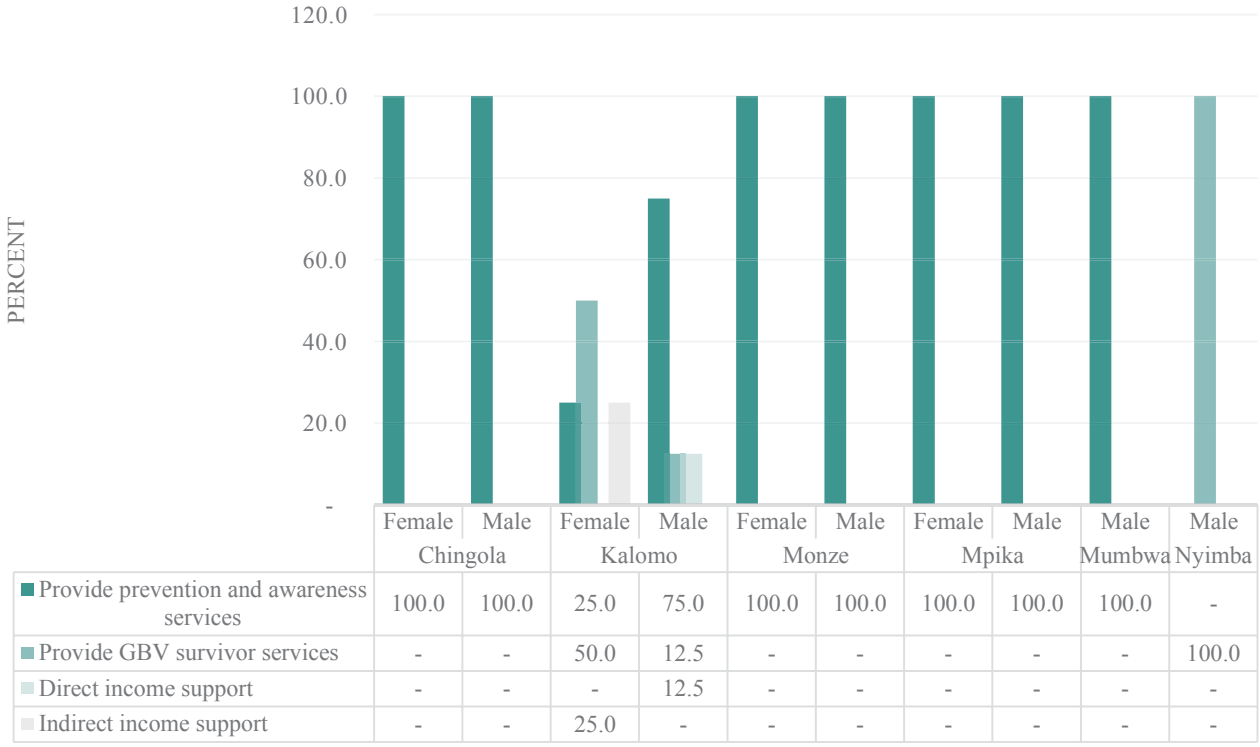


	Female Kalomo	Male Kalomo	Female Mpika	Male Mpika	Male Mumbwa
Provide prevention and awareness services	100	100	100	100	50
Provide GBV survivor services	0	0	0	0	50

As shown in Figure 26, the STOP GBV Programme is mainly seen to provide prevention and awareness services. Respondents from Kalomo and Nyimba also mentioned GBV survivor services and only Kalomo mentioned direct as well as indirect income support.

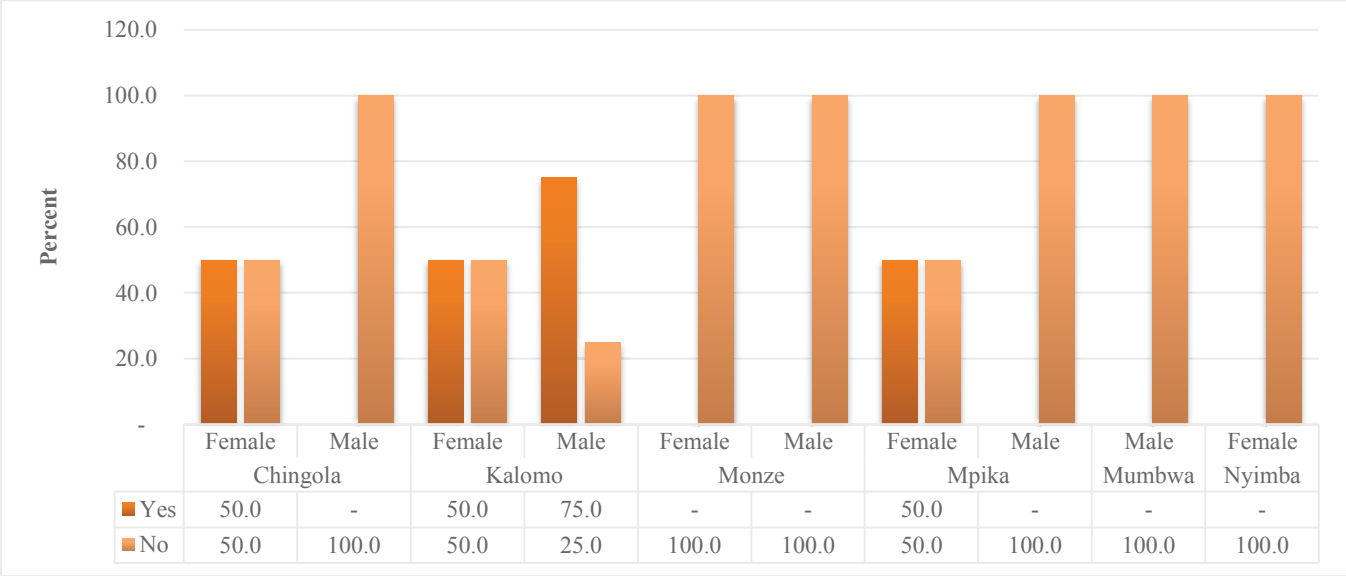
9 In some districts, also due to the small number, there both sexes did not respond to the question.

Figure 26: Activities of the STOP GBV Programme (n=24)



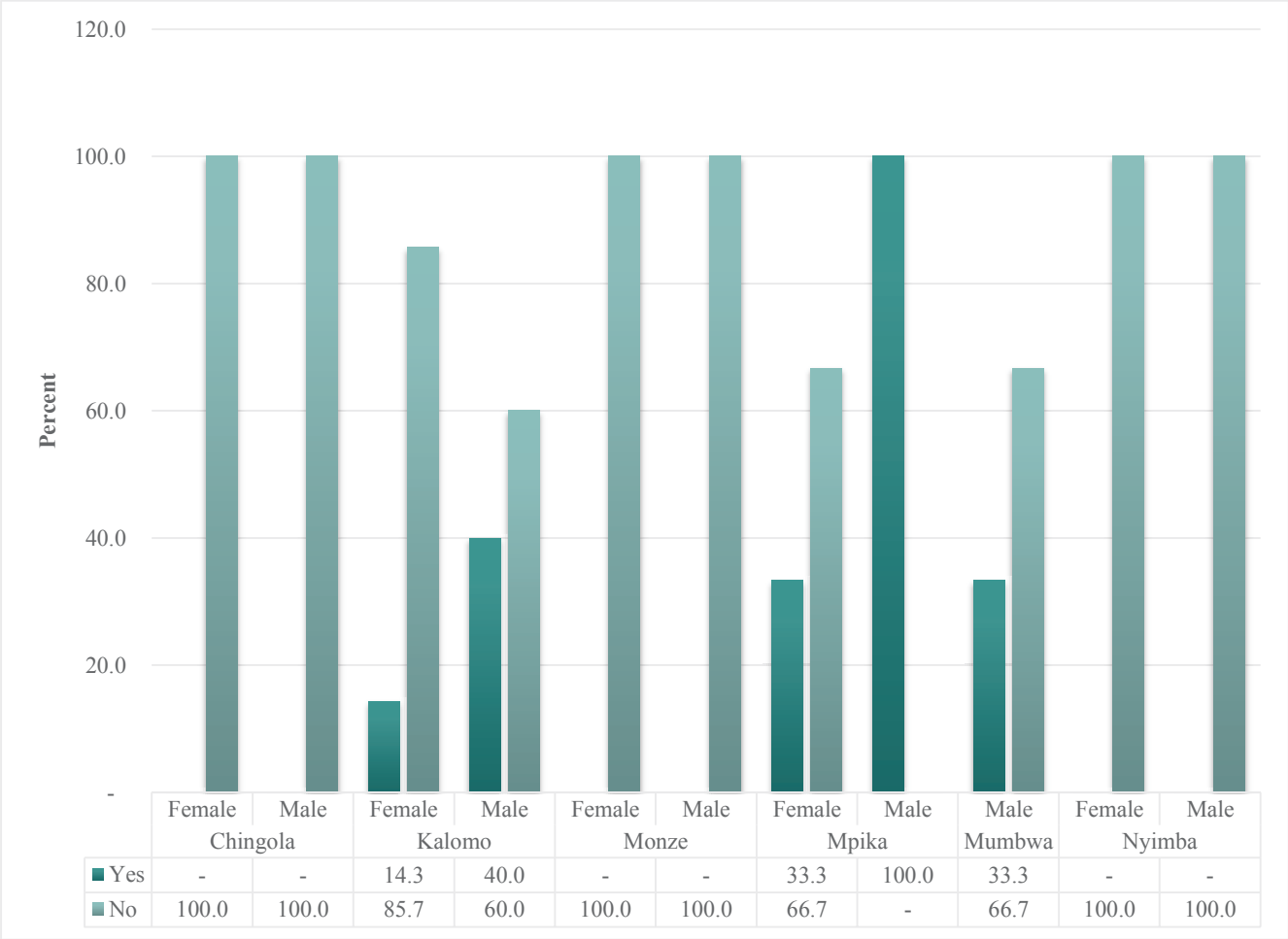
Few respondents reported participating in any of the programme activities as most districts have not yet launched their activities (see Figure 27).

Figure 27: Participation in the STOP GBV Programme activities (n=33)



Most of the respondents were not aware of private safe houses for GBV survivors except for those from Kalomo where half (50%) of females and most males (75%) were aware. When asked about whether a safe house could provide protection to the GBV survivors, most of the respondents agreed that it could, while others were not sure (see Figure 28).

Figure 28: Awareness of safe houses for GBV survivors (n=19)



	Female	Male	Female	Male	Female	Male	Female	Male	Male	Female	Male
	Chingola		Kalomo		Monze		Mpika		Mumbwa	Nyimba	
Yes	-	-	14.3	40.0	-	-	33.3	100.0	33.3	-	-
No	100.0	100.0	85.7	60.0	100.0	100.0	66.7	-	66.7	100.0	100.0

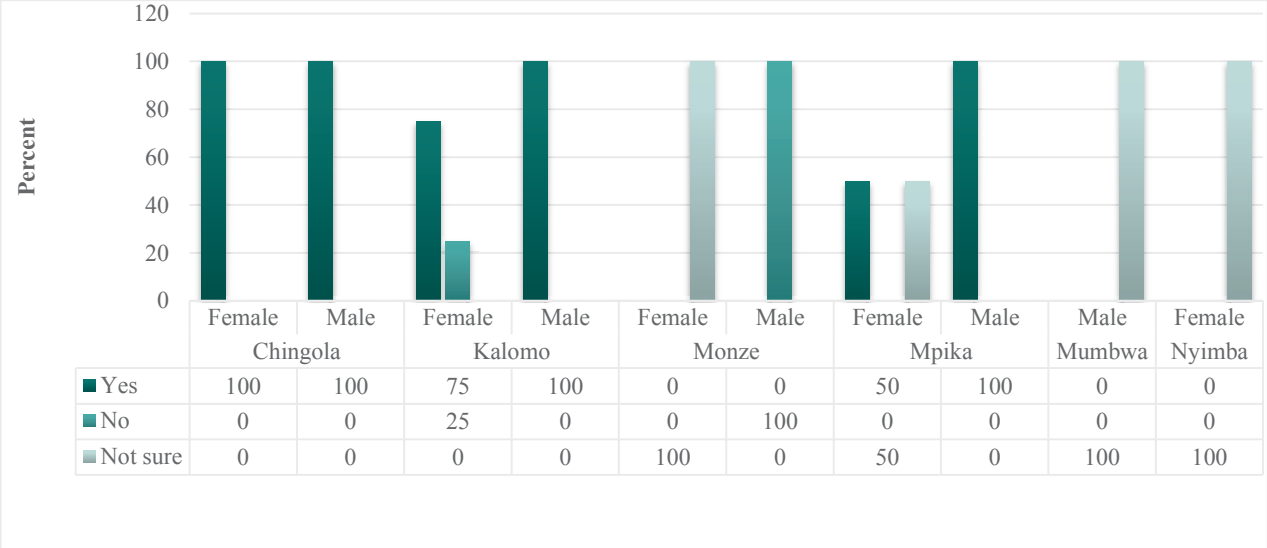
Respondents who were aware of the existence of OSCs were asked about the attitude of staff providing services. The majority (84.2%, n=19) felt that the staff were polite and about 7% that they were compassionate.

8.2.3 Community involvement in the STOP GBV Programme – quantitative data.

When asked about their perception of the nature of local community involvement in the STOP GBV Programme, sensitisation visits came out as the most prominent. Chingola and Mumbwa mentioned messages from support networks as a way in which local community is involved, consultations were further highlighted in Kalomo and Mumbwa and only Kalomo mentioned messages from leaders as another way of engaging the local community.

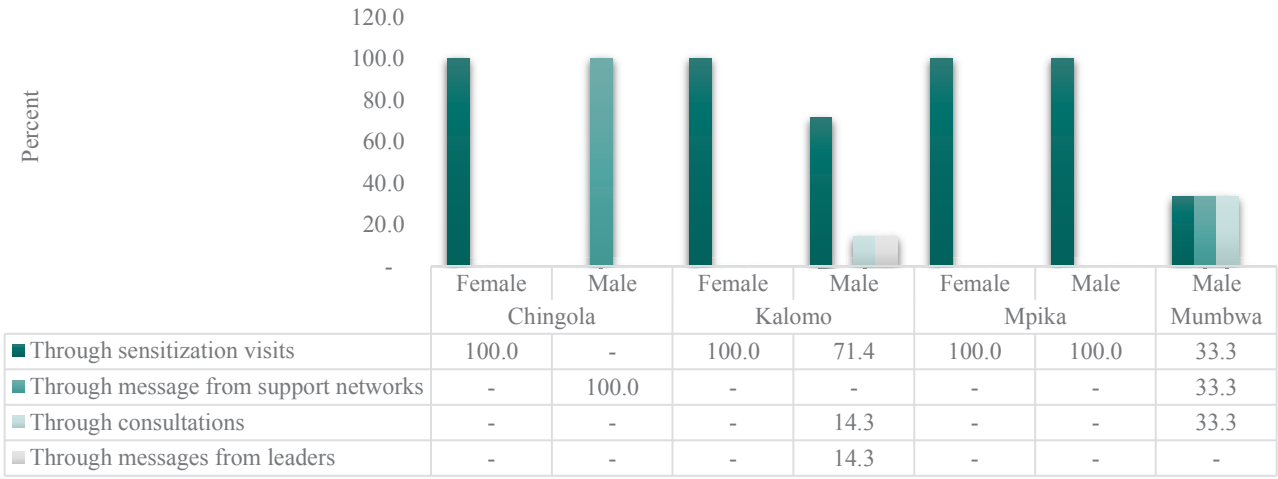
Although most OSCs were not fully operational at the time of the baseline study, the few participants who were aware of their existence (n=19), said that local communities were involved in the activities of the programme as shown in Figure 29 below.

Figure 29: Community involvement in the STOP GBV Programme (n=19)



As can be seen in Figure 30, the main type of involvement in the Stop GBV Programme in the areas where the OSCs were operational, was participation in sensitisation visits and receiving messages from support networks. It must be noted, however, that service provision in these districts had not yet taken shape as the activities awaited funding in order to commence.

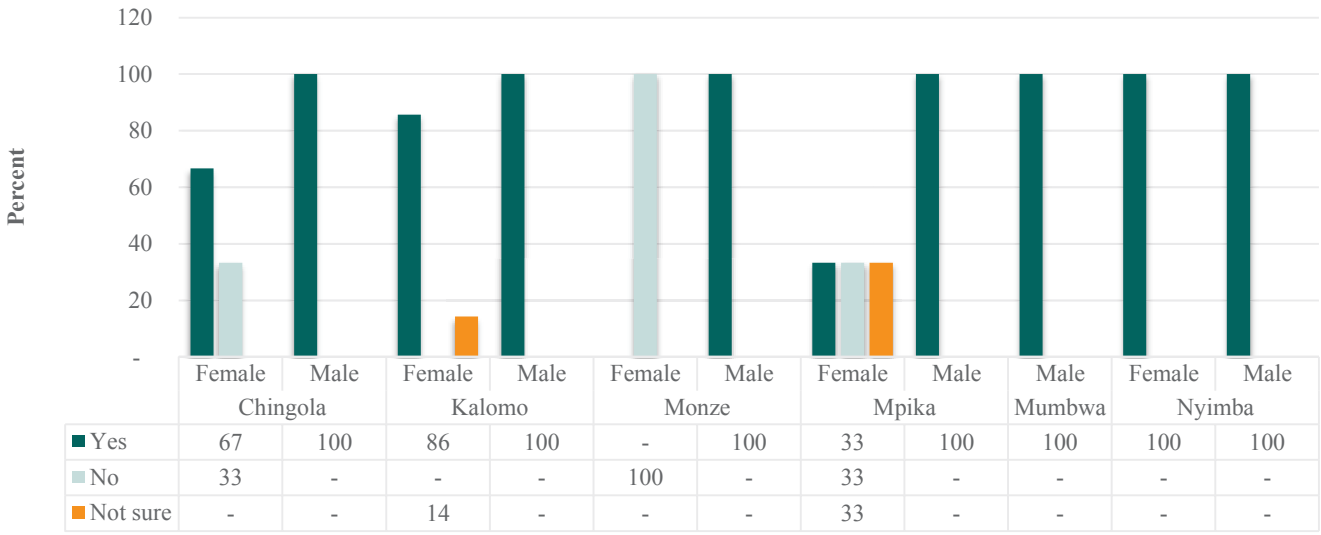
Figure 30: Kinds of community involvement in STOP GBV Programme activities (n=18)



8.2.4 Perceptions of effectiveness/quality of the STOP-GBV Programme – quantitative data

When asked about whether they thought the STOP GBV Programme was beneficial to their communities, all male respondents said they thought it was (see Figure 31). Thus male respondents were more likely to consider programme activities to be beneficial than females (p=0.032) (Fishers exact test). This could possibly be explained by the fact that men's awareness of and knowledge about the programme was higher than women's; an alternative explanation could be because women were better able to understand the broader complexities and challenges of dealing with GBV.

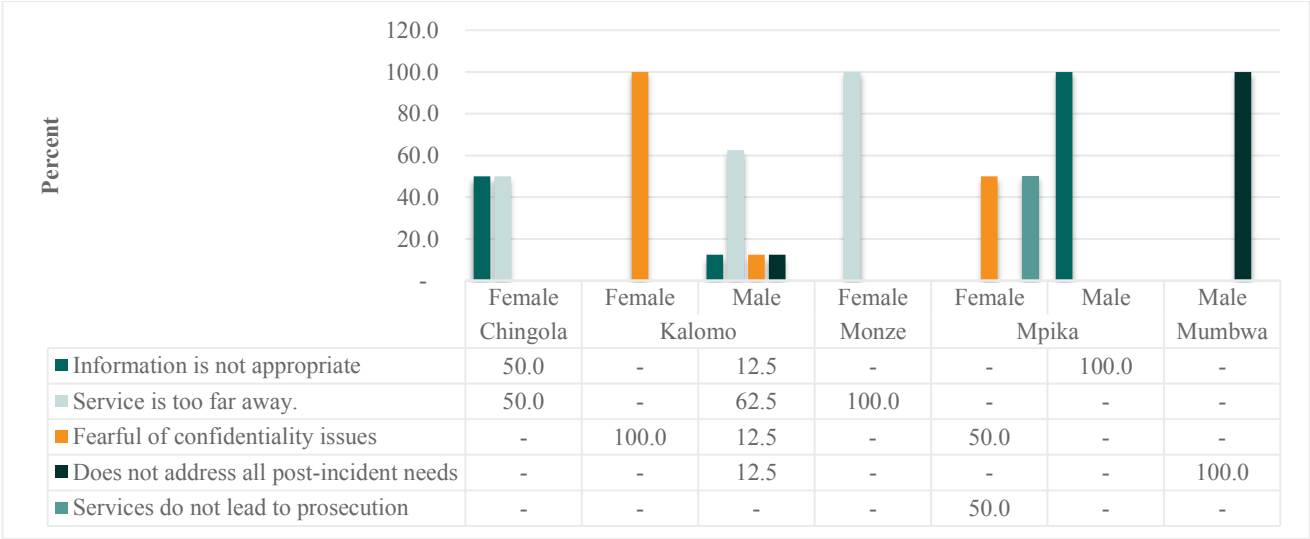
Figure 31: Perceptions of whether the STOP GBV programme is beneficial (n=33)



Almost three quarters of respondents (71.4%) said the programme was beneficial to their community as it provided information on GBV, 22% said it supported GBV survivors and about 7% said it provided shelters/safe homes.

Of those in the quantitative survey that felt that the STOP GBV Programme was not beneficial (n=17), respondents from Chingola, Kalomo and Monze felt that the information provided was not appropriate and that services were too far away. In Kalomo and Mpika respondents were fearful of confidentiality issues. Only those from Kalomo and Mumbwa felt the programme does not address all post-incident needs while only Mpika respondents felt that the programmeis not beneficial because services do not lead to prosecution (see Figure 32).

Figure 32: Why do you think the STOP GBV Programme is not beneficial? (n=17)



8.2.5 Knowledge of and engagement in the STOP GBV Programme: findings from the qualitative data.
Mirroring findings from the quantitative survey, most respondents in the FGDs were not aware of the STOP GBV Programme since operations in the districts had only started in the past month. When the programme was described, and in particularly the functions of the OSCs, respondents expressed appreciation for the initiative. Of those who had already heard about the programme (i.e. respondents in FGDs with men in Nyimba, young men in Monze, young women in Kalomo, and men in Kalomo), the majority had limited information regarding the kinds of services offered. Perhaps the men in Nyimba appeared to have more knowledge, as the quote below suggests:

There is World Vision. They also go to traditional leaders. We have a committee here that takes care of GBV cases and we even go to the headman when need be and we really help … World Vision took us for training to the workshop and then they said you can go out to teach others ...Yes we have [heard of the STOP GBV Programme], it's at the chief's place (FGD, men in Nyimba).

As already seen in Section 7, some survivors had experiences of the OSC and while generally they viewed them positively, here were also some concerns mostly about issues of transparency.

When asked about community engagement in the STOP GBV Programme, according to respondents from the qualitative study, while in some districts community members including headmen, pastors, and school teachers have already been mobilised and included in the promotion of anti-GBV messages, and in all the districts community counsellors have been engaged, community involvement has not yet reached its full potential. There is general awareness, also consistent with the programme documents, that there are clear plans and strategies to mobilise and involve communities in the prevention of GBV.

They have engaged volunteers who have done psycho-social counselling; these people also sensitise the community about services being offered here (Nyimba).

The key informants also acknowledged that one of the services provided by the STOP GBV Programme partners is information dissemination and general community sensitisation is among the approaches used to create awareness about GBV.

The strategy we use to create awareness is that of general sensitisation. We go in the field especially when World Vision is having a meeting; they always bring on board government workers, the victim support unit, social welfare and ministries of health and CDMCH through the district medical office (Mumbwa).

9 Challenges in responding to and preventing GBV

In this section we pull together a number of challenges in terms of supply and demand, drawing mostly on key informant interviews. We identify challenges in relation to GBV services more generally and then in relation to the OSCs (see also Section 4). These are revisited in the final recommendations.

9.1 Challenges for GBV services (non-OSC)

First, in terms of **demand**, even if services are available, GBV survivors are reluctant to report to or seek access to the services and there is a sense that a large majority of cases are unreported:

> *The challenge is that although a number of people have been reporting these cases, the majority still don't report so there is serious need to conduct a lot of sensitisation in these communities (Mumbwa).*

Of those who do report, it was noted that most survivors seek assistance late, both those facing sexual and physical assault: some survivors only report after two weeks, by which time physical evidence from the assault will have been lost. Similarly, cases of child defilement are not reported in a timely fashion. These delays can be caused by transport problems but also because of parents not being aware of the need to report early. Similarly, even if cases are reported, they are often withdrawn, with women facing pressure from family members to do so.

> *Mostly people come late... maybe a woman was sexually assaulted, maybe a month ago, that's when they come ... there is no physical evidence for you to tie the alleged circumstances to what you found. Even for the assault cases where a male or female who have been assaulted, sometimes they come when their wounds have healed so it's very hard for you to ascertain because no wound or physical evidence can be linked to the alleged circumstance (Nyimba).*

> *When somebody is being battered. and we say 'this is a very good case, let's go to the judge', but the victim just comes and says: 'No, I don't want this person to go to jail..I have got children with him. He's the breadwinner'. So if he goes to jail maybe they'll have a lot of problems at home (Monze).*

There are three main challenges in relation to **supply**. First, infrastructure (particularly shelters) and transport were routinely seen to be critical gaps preventing not only the daily functioning of referral activities, but also longer-term sensitisation initiatives. In all the districts the absence of safe homes and shelters meant that the safety of survivors could not be guaranteed, with churches, VSU and police offices often being used as temporary accommodation for the GBV survivors.

> *One of the most painful challenges I have seen in our district is lack of transport; if we had sufficient transport, specifically for GBV, I think we would have done tremendous work, because it's painful to receive a victim, all the way from Mapatizya, but then you have that challenge of transport and can do little (Kalomo).*

> *Initially, we were supposed to have shelters through social welfare. ...They don't have at the moment. At this time we tell them just hang around there, at the police station, temporarily (Monze).*

Second, the majority of services are primarily responsive. The only preventive measures for GBV referred to by study respondents were sensitisation and community engagement initiatives. There was also limited awareness of the potential for broader community development initiatives focusing on livelihoods, social protection, child protection, or economic-strengthening for preventing GBV in the medium to longer term.

Finally, and related to earlier points on making complaints and reporting incidents in a timely manner, police capacity to manage evidence, particularly DNA-related evidence, is a major obstacle in cases that proceed to prosecution.

> *…. There are times when the court is facing challenges. It's lack of evidence in that case. It's also a challenge there in the court (Monze).*

> *The gaps are there, when it comes to the issue of evidence collection, I think we are still behind, because they are certain investigations where we need cameras, certain investigations were you need even fingerprints, … they are certain cases where we need do swabbing you know that one is mostly done in the hospital, but in sexual offences there are certain scenes of crime where we need to collect evidence there and then, but you find that you may lack some equipment, so you will have no option but to rely on what you feel will make you have a good case in court (Kalomo).*

9.2 Challenges for OSCs

With respect to **demand**, the reporting of GBV cases is likely to increase and more perpetrators punished with the arrival of the OSC in the districts, as shown by this quote below:

> *So with the new centre, the one-stop centre here in Kalomo, I think many people that we have talked to will be more open now. So this is a good thing. We are going to be free rather than being pushed by the police here and there (Kalomo).*

Respondents also suggested that the traditional courts will continue to play a significant role for some time to come because of lengthy and cumbersome procedures for accessing and completing the court cases through the judiciary system. In many districts, the service providers at the OSC were not aware of any cases that had clearly been taken forward in a court of law. In one district, the medical officer had been called to testify but did not know whether the case had been concluded. Thus it appears that procedures for legal support are lengthy, disjointed and sometimes information is missing or not shared.

In addition to many of the **supply challenges** outlined above with respect to broader GBV actors, and although OSCs are still in their infancy, a number of early constraints are appearing. These include management and coordination challenges, funding bottlenecks which affect logistics, overlapping roles, constraints on preventative programming and technical capacity of staff. Management procedures are currently reactive, and although there is a general awareness that guidelines exist, management decisions and activities are verbal and tacit rather than routed through clear management systems and processes. While there are many partners working together to reduce GBV, there was no clear coordination including the necessary processes and mechanisms for achieving coordination. In Kalomo, for instance, obstacles to efficient referrals included the distance between the OSC and other facilities, limited staff capacity and delays because of bureaucracy. These constraints also contributed to OSC affiliates (e.g. legal advisers, visiting VSU officers) from regularly attending OSC offices in person. The following quotes from Kalomo highlights this lack of coordination among different stakeholders as well as delays in obtaining services at the hospital, Social Welfare Department and police stations:

> *The challenge that we have especially in referrals to the hospital is that our clients take too long to be attended to. Just within the hospital system, it is a challenge maybe because we have not done much awareness especially at the hospital. I think the hospital staff need to be reoriented. Even when we bring them ourselves, we find a lot of red tape and bureaucracy (Kalomo).*

> *With the social welfare, sometimes you can refer somebody there, somebody who is vulnerable in terms of finances ..but by the time they are helped it will be … It takes a long, long, long time. All these are challenges. So maybe because we are new but we need to work together as stakeholders (Kalomo).*

> *The other challenge is in terms of the police. We always have the police here but there are times when they are not here. Maybe they are short staffed. Every time they have a meeting then we don't have anybody here. That means we have to take the survivors to the police station, bring them back here and take them back again. And also for here, as members of staff, we don't just deal with GBV, I am working in the OPD [Out-Patient Department] as well (Kalomo).*

For those OSCs that are primarily government-led, understaffing and role-duplication affect the provision of services and efficiency: *I am working at the one-stop centre and I am also working as a nurse. So it means that I am working in the two places. There is only one nurse here. I think it's short-staffed everywhere* (Monze).

The government-led OSCs have also faced operational constraints in processing funding allocations within short timeframes: *From the time we started we have not received any funding. Not because World Vision is not giving it to us but because we have problems with the district. They are not comfortable with World Vision giving salaries to the one-stop centre officer. They would rather want the money going into their account and then we start claiming from the district office. So we have a challenge. I've been going to the districts, maybe you find that the accountant that needs to approve it is not there, like I've been doing this for the past two weeks. Going, coming back, the people from World Vision actually came in to sort this out that but when I went there this morning they still said 'we have a problem', they still want to talk to the people of World Vision. So that for me it is a really big challenge* (Monze).

With respect to preventive programmes, the STOP GBV Programme has a prevention and advocacy component that is focused on individuals and communities. At present, according to study respondents, it appears that little is happening in this area as most respondents continued to refer to the need to embark on educational and sensitisation campaigns. This can be seen by the fact that currently many people, including those in need of GBV response services, are unaware of the facility and its location. OSC linkages with longer-term economic-strengthening initiatives were also rarely mentioned:

> *One of the challenges that we are likely to face as we go forward is that inasmuch as certain cases will be followed and pursued through to the courts, I think issues of divorce, looking at a wife who has no job and means of getting resources to feed the family and herself, will be a challenge for us because once the marriage has ended then what follows for that person, how does she look after her children? I think that will be a challenge that we will have in future (Mpika).*

In some districts, such as Kalomo, some of the police and the paralegal officers had not yet established themselves. This, according to study respondents, made the services disjointed and referrals were not taking place as efficiently as they should be.

In terms of OSC staff technical capacity, most could not provide a comprehensive definition of GBV, tending to focus on dominant and visible forms of GBV, such as physical assault. Some are able to identify economic deprivation and psycho-social violence in addition to physical and sexual violence. A critical gap also relates to the handling of child-protection cases and liaising with the various bodies at district level on child-specific issues.

10 Conclusions, recommendations and indicators

This final section briefly explores the extent to which the current interventions focus on prevention versus responses. A set of recommendations is then provided, based on the discussions with key informants and from the qualitative interviews (FGDs and survivor interviews). Finally, we suggest a number of key indicators that can be tracked as the programme progresses.

10.1 Prevention vs. response

As already mentioned, almost half of all women in Zambia have experienced physical violence since the age of 15 and one-third of women had experienced physical violence in the 12 months preceding the 2007 Zambia Demographic and Health Survey (ZDHS). The major factors behind GBV include extreme poverty, unemployment, and women's heavy economic dependence on men. Traditional norms that teach women to accept and tolerate violence, and teach men that it is normal to beat his wife, are also among the major factors leading to GBV in Zambia, as are sexual cleansing practices and forced early marriage, which, among other things, interrupt the education of children.

The baseline study has found that there is a critical need for GBV services – related both to prevention and to treatment or response. The data indicate that the STOP GBV response has begun to have some positive effects, even during its inception period. In terms of the core STOP GBV objectives, the response component has gained more momentum than prevention in almost all the districts studied. During the fieldwork there was more evidence of medical, psycho-social, legal and safety support for GBV survivors, but limited outreach in terms of primary prevention activities including awareness-raising and improving the environment to respond to GBV.

Thus, there is evidence of determination and group work with both governmental and non-governmental stakeholders coming together to implement GBV services and improve response and coordination capacity. The engagement of men and boys via Sport in Action is underway to various extents across the sites, although there currently appears to be limited understanding of how its activities fit into a broader theory of change on GBV and engaging men on issues of masculinity. In terms of access to justice, partnerships with police VSUs are strong, which is critical given that these are currently the main entry point used by GBV survivors to report incidents. Paralegal capacity and team presence in the OSCs is mixed, while VSUs themselves continue to face systemic challenges regarding case and evidence management. Perhaps more challenging is the prevention and advocacy component of the STOP GBV Programme. Community mobilisation, education and sensitisation will need to be intensified and scaled up to create awareness in the target populations.

Critical challenges across the three core STOP GBV objectives in relation to demand are underreporting and limited primary response structures (i.e. community or neighbourhood watch groups), often based on misunderstandings or mistrust of formal systems and implications of reporting. In terms of supply, key gaps include shelter and transport, funding bottlenecks, role-overlaps (particularly in government-run OSCs) and the technical capacity of staff (particularly in terms of their familiarity with their roles and responsibilities vis-à-vis the wider case-management system).

Below we identify a number of more specific recommendations, some of which no doubt the STOP GBV team is already planning.

10.2 Recommendations

- Given that GVB remains an ongoing challenge in Zambia, it is critical that the STOP GBV Programme partners, led by the World Vision office in Zambia with support from World Vision US, continue with sensitisation and awareness-raising on GBV more generally, including on human rights and processes for redress at different levels and among different groups of people including:
  - headmen and chiefs
  - youth and women's groups
  - men and boys parents
  - schools/teachers to sensitise in the classroom
  - churches to sensitise their congregations
  - the police at different levels, particularly on evidence management

- A key factor which inhibits women from reporting abuse by their spouses, as identified in this baseline study, is the fear that if their spouses are prosecuted, they and their households will suffer economically. An important strategy for tackling these underlying or structural drivers of GBV is to provide economic empowerment opportunities for women. Approaches could include: skills building programmes, providing start-up capital or in-kind contributions to develop income generating activities and/or encouraging community based credit and savings schemes. While facilitating such activities may not be in the remit of the STOP GBV Programme, linking women to such complementary programmes and projects is critical. Thus World Vision staff in Zambia need to improve the linkages and coordination between the STOP GBV Programme and other organisations offering such programmes; district level linkages and coordination could also be made by the STOP GBV Programme partners working at district level including the OSC manager.

- Another factor inhibiting women from reporting abuse by their spouses and further fuelling it, as also identified in the baseline study, are notions around what it means to be a man or a woman in Zambian society, where, for instance, a women is supposed to be submissive, and where it is acceptable for a man to beat his wife. This notion is also to a certain extent sanctioned by women, as is the idea of not airing problems in public. At the same time, men are also reluctant to come forward and report when they are being abused because of notions of what it means to be a man. Continued and ongoing awareness-raising by the STOP GBV Programme staff, supported by World Vision Zambia and US is critical here, also linking and coordinating with organisations at national and district level working on similar issues. Important approaches and strategies to address this could include:
  - Working with girls and women to empower them to recognise when they are being abused and when their rights are being violated and what recourse they have
  - Working with boys and men to, on the one hand raise their awareness about the rights of women but also about their own rights and that reporting abuse should not be seen as a threat to their masculinity
  - Working with community leaders and other respected community members (e.g. elders, teachers, religious leaders) to think through the appropriate language and messaging in order to get across notions of the importance of respecting women, that violence in any form cannot be sanctioned and ensuring that traditional practices and beliefs are represented in their original meaning/intention and used to support an anti-GBV stance rather than fuel it.

- Given that informal systems of recourse are often the first port of call for GBV-related cases, as shown in this study, working with these informal systems to strengthen them is critical. Thus building and supporting the capacities of elders, headmen and chiefs to deal with GBV-related issues, needs to be a key component of the STOP GBV Programme and carried out by the STOP GBV Programme partners. This is particularly in terms of secondary prevention such as intervening in escalating tensions thereby also limiting not only GBV incidence, but also longer-term livelihood impacts in the case of prosecution or family separation. Raising the awareness amongst this group of people of the kinds of services available for potential GBV-related cases, including the OSCs and VSU, is a further important part of this approach, as is ensuring that they are aware that these service providers also need to be held to account, to ensure that the services they

provide are impartial and transparent. A high standing and respected community member is well placed to play such a role.

- Findings show that GBV is often associated with pay days and harvest time when there is more cash circulating and when there is also more alcohol being consumed. As such particular strategies and messaging needs to be developed around this both by the World Vision staff in Zambia and the STOP GBV Programme staff:
  - Working with employers to raise their awareness so they in turn can raise the awareness of their employees, is a possible strategy. Such awareness-raising messaging could include and range from: the need to curb men's violence towards their spouses, increasing understanding on the rights of spouses, to the importance of carefully managing their salaries, perhaps also handing some over to their spouses and/or setting up a bank account[10]. On the latter, employers could be encouraged to start paying salaries directly into bank accounts, thus perhaps also stemming the alcohol consumption and often linked violence that tends to be associated with having cash in hand. Such messages need to be re-emphasised on a monthly basis, during every payment day, perhaps at the point of receipt of payment. The distribution of leaflets and other information about GBV (e.g. kinds and location of services) and also perhaps about financial management and planning can also be done during payment days.
  - For those with no formal employers and who are engaged in selling their own produce, working with transport companies, leaders of cooperatives and others who act in some form of intermediary capacity to raise their awareness is another strategy. The approach can be similar to that described above; however the timing of the messaging would need to coincide with the harvest periods and other times when farmers access services through cooperatives and/or other intermediaries, e.g. when being loaned seeds or other inputs.
  - Working with brewery companies and owners of bars is another strategy for targeting men. Such stakeholders could support the distribution of information and awareness-raising, again strengthening these messages at month end and harvest time. They could also support referral processes, even prior to a violent event taking place, warning the relevant authority (e.g. VSU staff) if they, for instance, identify a patron who may be drunk and aggressive.

- Early marriage (often due to economic reasons) appears to be a root of many GBV related challenges in Zambia and is also linked to school-drop out, particularly for girls. A multi-pronged approach is necessary here, working with a range of different stakeholders. The World Vision staff in Zambia need to lead this approach working in particular with educational authorities and other NGOs and programmes at national and District level focusing on the economic empowerment of women:
  - Economic empowerment of women in particular is critical (see above), as this may have knock-on effects on both keeping girls in schools and delaying their marriages
  - Working with schools and teachers to encourage children to stay in school and to proactively encourage parents/guardians (e.g. through Parent and Teacher Associations {PTAs}) not to withdraw their children from school
  - Working directly with parents/guardians raising their awareness of the importance of education and the dangers of early marriage (including GBV and health-related)

- Given that children and particularly orphans are vulnerable to GBV, programmes specifically aimed at children are necessary in order to raise their awareness about different forms of GBV and their rights as children.
  - One important strategy for reaching children is through schools - World Vision staff in Zambia need to work closely with the educational authorities so that messages around GBV can go through schools and teachers.
  - Children's and youth clubs is another strategy for reaching children and adolescents –and working with youth leaders and raising their awareness so they in turn inform their peers is one approach as is having a GBV survivor who is willing to speak out attend club meetings and speak about their experience; many

[10] Mobile banking is also a growing phenomenon in certain countries and could be explored here.

of these clubs are linked to schools so again it is critical that World Vision staff in Zambia working alongside STOP GBV Programme staff at district level liaise with educational authorities.
    - A particular focus on reaching out-of-school children or adolescents is necessary – STOP GBV Programme staff working with community leaders to help identify these children is one approach, additionally working with their parents/guardians is important.

- In order to reach a large section of the population, awareness-raising on GBV needs to be carried out through a range of different media, including radio and TV programmes and through billboards and other forms of advertising. Increased use of community radio stations can be particularly effective in reaching local communities with appropriate and culturally relevant messages on GBV response and prevention. Programmes aimed at children and adolescents are a particularly effective means of reaching this target population – programmes can be interactive and include drama and caller question and answer sessions. World Vision staff in Zambia as well as the STOP GBV Programme staff in particular could be tasked with exploring the opportunities to work with different forms of media at national level. If appropriate, given also that some radio stations are active at community and district level, the OSC managers could also be the focal point for such activities.

- Given that there was varying degrees of awareness of the programme, also because of its relative infancy, there is need to continue to raise awareness about the STOP GBV Programme at different levels
    - Continue to ensure that all key stakeholders at district level are aware of the programme, attend joint training sessions and other joint meetings on a regular basis to ensure rapid and relevant responses. Entry points for such discussions include the District Gender Sub-Committees. This would be carried out both by World Vision staff in Zambia and also implementing partners. These awareness raising sessions need to take place on an ongoing basis, particular when new staff come into the Districts; the need for such awareness raising sessions should be monitored by the OSC managers.
    - Continue / reinvigorate community awareness and sensitisation sessions on the STOP-GBV Programme as well as about GBV issues more generally – supported by the Word Vision staff in Zambia and the OSC managers, community level volunteers need to be supported to continue spreading the messages about the STOP GBV Programme; other cadres of volunteers could be identified and trained (e.g. youth and women); additionally, means of getting the messages out through other community based fora and institutions could also be considered (e.g. through schools, traditional community ceremonies and events, through local radio [see above]).

- Respondents identified some gaps in knowledge and information about a range of issues related to GBV, as such further capacity-building and training of service providers is necessary. This would be carried out by World Vision staff in Zambia, but drawing on specialist expertise when and if necessary. This specialist expertise could come from within Zambia but also from outside, depending on availability. In some cases all service providers linked to the STOP GBV Programme could be trained, on other occasions the training could be aimed at specific cadres of people. Ongoing and refresher training on certain aspects would also be needed, e.g. in case protocols for managing GBV cases may change; also if new staff join the team additional training and mentoring would be needed. In terms of areas of training, the following could be considered:
    - STOP GBV Programme and components, including rights-based principles and language
    - protocols for managing GBV cases
    - dealing with child-protection cases and child sexual abuse in particular, including appropriate child referral processes and systems
    - laboratory skills in terms of forensic evidence and analysis
    - counselling children/minors
    - monitoring and quality-control mechanisms

- Several limitations were identified in terms of the capacity of the police/VSU, including around their abilities and associated processes to promote transparency. As such, supporting building the capacity of the police / VSU at different levels is necessary and would include:

- Empowering them to develop systems and processes to ensure accountability and transparency – given the relatively sensitive nature of this process, national level commitment needs first to be sought and this would like be a combination of World Vision staff in Zambia and US as well as the donors and other steering groups or committees working on such issues. Once this commitment is obtained, external training on how to develop accountability and transparency process and systems could be sought.
- Where police officers are men, supporting the inclusion of more women police officers – again, given the sensitive nature of this activity, discussions at national level need to take place and would likely include World Vision staff in Zambia and US as well as the donors and other steering groups or committees working on such issues. A longer term perspective and approach might also include working with training institutes to encourage them to recruit more women.
- Improving the circulation of police officers and paralegals in OSCs and hospitals to enable GBV cases to be reported directly and efficiently – national level commitment is needed for this to happen, thus again World Vision staff in Zambia and others can lobby and work with national level police authorities. At District level, the OSC manager, supported by World Vision staff in Zambia, also needs to liaise closely with the District and Provincial head of police to ensure that this circulation can be improved; mechanisms to ensure this might include developing a transparent time-table and schedule for the circulation of police officers and paralegals in OSCs and hospitals, with check-in and check-out procedures.

- There appeared to be relatively little information and access to appropriate guidelines and protocols for dealing with GBV. As such, there is need to improve access to such guidelines and protocols, which may be relevant to all STOP GBV Programme staff and their partners, but could also be tailored to specific cadres.
  - Best practice guidelines and protocols for managing GBV cases need to be made available (including written guidelines and decision-tree charts) – World Vision staff in Zambia and the US could collate these documents and make them available to the STOP GBV Programme staff and partners.
  - Guidelines and protocols could be tailored (language and content) for a Zambian audience and specific cadres – the Word Vision staff in Zambia could lead this process, also liaising with appropriate Zambian partners to ensure that the language and context is appropriate.
  - Guidelines and protocols should be easily available and accessible to those using them (e.g. make copies, keep in a central location, etc.) – the OSC manager should be in charge of these guidelines making them available in each District also raising the awareness of their existence to relevant line ministries (MOH, MGCH, MCDMCH) and cadres of staff.
  - Improve the information flow between different departments (e.g. health, police and judiciary) – key to information flow at District level are the OSC managers; for this flow to happen at District level, higher level commitment is also necessary, and here the lobbying work of the World Vision staff in Zambia is necessary (see also below).

- Given the challenges related to infrastructure and other logistical processes, these need to be strengthened and the following needs to be considered:
  - Ensure that adequate and reliable transport is available to enable staff to carry out their work effectively – the STOP GBV Programme needs to either supply vehicles/motorbikes and fuel, provide funds so that staff can hire appropriate vehicles as and when needed or/and come to some agreement with partner line departments so that they can share vehicles.
  - Ensure that petty cash budgets are topped up – the World Vision staff in Zambia need to work closely with the OSC managers in each District to firstly make medium term forecasts for possible cash needs, to then ensure that there is petty cash available when needed and finally that it is constantly topped up so as to avoid any delays in case of an emergency.
  - Ensure that safe houses and/or shelters are established as rapidly as possible, and that interim informal practices are agreed upon by all stakeholders – until these shelters are fully established through the STOP GBV programme, World Vision staff in Zambia in conjunction with the OSC manager in each District need to make formal arrangements, also in writing, in each District, on a case by case basis, regarding where GBV survivors can be housed. In certain districts a facility may already exist which could accommodate them, in others a temporary arrangement can be arrived at; critical is that the GVB survivor does not need to travel a long distance.

- Ensure that infrastructure related to and providing GBV services at community level do not change when a new headman or chief comes into power – World Vision staff in Zambia, working closely with the OSC manager in each District, need to encourage the headmen or chief that if they are no longer in power, they either need to allow their structures still to be used or make alternative arrangements. Involving other respected members and elders in the community in such an issue could also facilitate this process.

- Further advocacy and lobbying work is needed in order to tighten legal procedures and limit potential corruption so as to enable GBV survivors to report incidents with confidence that due process will be followed without undue family pressure from family (this also applies to minors). An advocacy and lobbying plan should be developed by the STOP GBV Programme staff or other World Vision staff in Zambia responsible for this area of work. The plan should include:
  - the kinds of actions the STOP GBV programme staff can undertake and those that are more appropriate to partners and other stakeholders; for instance for national and high level advocacy activities, working through steering groups or committees which may include donors and other NGOs, may be more appropriate.
  - key targets for this advocacy work – these would include working with the key representatives of the legal system, including traditional leaders, as well as with the police force, through the appropriate channels
  - a time-scale– advocacy and lobbying activities should be carried out on a continuous basis, but should also link to key moments either at national level or international events; again, it would be the task of the advocacy officer within the World Vision office in Zambia or directly linked to the STOP GBV Programme to to identify these key moments.

10.3 Indicators to guide future evaluations

Below we suggest some indicators that would be useful to track in future evaluations.

Key indicators to track in future evaluations/ studies	Baseline indicator	Means of collecting the information
Proportion of community members with knowledge of the STOP-GBV Programme and services	1.7%	Community survey
Proportion of community members involved in the STOP-GBV Programme	0.4%	Community survey
Proportion of community members who demonstrate correct knowledge and attitudes about GBV	Low (0 to 15 correct answers out of 45) – 75.5% Moderate (16 to 30 correct answers) – 24.4% High (31 to 45 correct answers) – 0.1%	Community survey
Proportion of community members who report receiving information on GBV in last 3 months	20.2%	Community survey
Proportion of community members who report that GBV is common in their area/community	50%	Community survey
Proportion of community members who have witnessed violent incidents or GBV in the community in the last 6 months	33.6%	Community survey
Proportion of community members who say GBV is increasing, declining, or staying the same	Increasing – 35.4% Declining – 25.3% Staying the same – 19.2%	Community survey
Proportion of community members who report that forced or early/child marriage in the area/community is very common, common, not common, non	Very Common –13.2% Common –18.9% Not common – 28.2% None – 31.9%	Community survey

Proportion of community members who are aware of the existence of community support networks that address GBV	12.6%	Community survey
Proportion of community members who report that the STOP GBV Programme is beneficial to the community	1.4%	Community survey
Proportion of community members who are aware that the programme can refer GBV survivors to shelters and safe houses	0.5%	Community survey
Proportion of community members who report that the STOP GBV Programme involve local communities in their activities	0.9%	Community survey

References

Campbell J, Garcia-Moreno C, Sharps P. (2004) 'Abuse during pregnancy in industrialized and developing countries', *Violence against Women* 10(7): 770-789.

CARE (2013) 'One-stop model of support for survivors of gender-based violence: lessons from CARE Zambia'. : CARE.

Central Statistical Office (CSO) and Macro International Inc. (2009) 'Zambia Demographic and Health Survey 2007'. Calverton, MD: CSO and Macro International Inc.

Duvvury et al. (2013) *Intimate partner violence: Economic costs and implications for growth and development*. Washington, DC: World Bank.

European Institute for Gender Equality (EIGE) (2014) 'What is Gender-Based Violence?' Available at: http://eige.europa.eu/content/what-is-gender-based-violence

Gender In Development Division (GIDD) (2008) 'National Action Plan on Gender-Based Violence (2008–2013). Lusaka: GIDD.

Golding, J. M., Siege, J. M., Sorenson, S. B., Burnam, M. A., and Stein, J. A. (1989) 'Social support sources following sexual assault', *Journal of Community Psychology* 17(1): 92-107.

Hyde, J. S., Mezulis, A. H., and Abramson, L. Y. (2008) 'The ABCs of depression: integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression', *Psychological Review* 115(2): 291.

ICRW (International Center for Research on Women) and Plan South Asia (2011) 'Asia Child Marriage initiative: Summary of Research in Bangladesh, India and Nepal'. New Delhi: Plan South Asia.

Keesbury, J., Onyango-Ouma, W., Undie, C., Maternowska, C., Mugisha, F., Kageha, E. and Askew, I. (2012) 'A Review and Evaluation of Multi-Sectoral Response Services (One-Stop Centres) for Gender-Based Violence in Kenya and Zambia'. Nairobi: Population Council.

Overseas Development Institute (ODI) (2014) 'Baseline Inception Report. Stamping Out and Preventing Gender Based Violence (STOP GBV) in Zambia'. London: ODI.

Population Council (2010) *RAPIDS Evaluation Final Report: 2005-2009 Key Findings.* PLACE: Population Council.

Sprechmann S., Christie K. and Walker, M. (DATE) 'Challenging Gender-Based Violence Worldwide: CARE's Program Evidence. Strategies, Results and Impacts of Evaluations 2011-2013'. PLACE: CARE International.

USAID (2010) 'USAID/ Zambia Gender-Based Violence Programming Evaluation'. Lusaka: USAID.

World Bank (2014) Protecting Women From Violence Database. Available at: http://wbl.worldbank.org/data/exploretopics/protecting-women-from-violence

World Vision (2013) *Gender Equality Policy.* PLACE: World Vision.

World Vision (2014) *Gender-Based Violence Survivor Support: Baseline Report.* Lusaka: World Vision Zambia

Annexes

Annex 1: Study tools

STAMPING OUT AND PREVENTING GENDER BASED VIOLENCE (STOP GBV) IN ZAMBIA

Community Baseline Survey Questionnaire

Instructions

- To be administered by the Research Assistants (RA).
- To be administered at the Community.
- To be administered to a respondent who has been living in the HH for more than 6 months.
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement.
- Circle the code corresponding to the response and fill the code of the response in the space provided against each question.

Introduction
My name is……..I work for Frontiers Group, a research organization based in Lusaka. We are conducting a baseline study on gender based violence in Zambia. The purpose of this study is to provide a way to measure program results, impact and long lasting change at the end of the project in six districts in Zambia. We are gathering views to help us better understand GBV Projects and to identify ways of improving the interventions. We are also asking questions about your ideas, attitudes, knowledge and behaviours, and whether you have heard of/know about the GBV and the project in this district.

Questionnaire No.: [__|__|__|__]
Date of Interview (dd/mm/yyyy): [__|__/__|__/__|__|__|__]
District: 2Kalomo 3Monze [__] 4 Mpika 5 Mumbwa 6 Nyimba
Compound/Village: SEA [__□__] CSA [__□__] House Number [__□__□__□__□__] Research Assistant [__□__]

10.3.1 SECTION 1: DEMOGRAPHIC INFORMATION

QID	Question	Response options/codes	Coded response	Skip pattern
101	Sex of respondent	Female **1** Male **2**	[__]	
102	How old are you? What is your birthday (dd/mm/yyyy)?	[__|__] [__|__/__|__/__|__|__|__]	[__|__]	
103	What is your current marital status?	Married monogamously **01** Married polygamously**02** Cohabiting (Not married but living with partner) **03** Never Married **04** Divorced or separated **05** Widowed **06**	[__|__]	
104	What is your highest educational grade/level that you have completed? (Completed Grades)	None/Never attended school **00** Primary 1 **01** Primary 2 **02** Primary 3 **03** Primary 4 **04** Primary 5 **05** Primary6 06 Primary 7 **07** Junior Secondary 8 **08** Junior Secondary 9 **09** Secondary 10 **10** Secondary 11 **11** Secondary 12 **12** University level **13** Adult literacy **14** College/Vocational **15**	[__|__]	
105	What is your ethnic group?	Bemba **01** Nsenga/Chewa **02** Tumbuka **03** Lozi **04** Luvale **05** Lunda **06** Tonga **07** Kaonde **08** Namwanga/Mambwe **09** Other **66** Specify_____	[__|__]	
106	Which language do you converse with **most** of the time?	Bemba **01** Nsenga/Chewa **02** Tumbuka **03** Lozi**04** Luvale**05** Lunda **06** Tonga **07** Kaonde **08**	[__|__]	

		English **09** Namwanga/Mambwe**10** Specify_____		
107	Which languag	None**00** Bemba **01** Nsenga/Chewa **02** Tumbuka **03** Lozi**04** Luvale**05** Lunda**06** Tonga **07** Kaonde**08** English **09** Specify_____	[__|__]	
108		Christian Catholic **01** Christian Protestant **02** Muslim **03** Buddhist **04** Hindu **05** Other (specify……) **06** _____	[__|__]	
109	How long have you lived in the compound/vil	_____ Years	[__|__]	
Section 2: Household Composition				
201	Who currently makes the most decisions in the household? MAN CAN BE: FATHER, BROTHER, UNCLE, GRANDFATHER ETC. WOMAN CAN BE: MOTHER, SISTER, AUNT, GRANDMOTHER ETC. **SELECT ONE ONLY**	Man and Woman **01** Woman, no man **02** Man, no woman **03**	[__|__]	
202	What is your position in the family? **SELECT ONE ONLY**	Wife **01** Husband **02** Son **03** Daughter **04** Mother **05** Father **06** Uncle **07** Aunt **08** Sister **09** Brother **10** Nephew **11** Niece **12** Grandfather **13** Grandmother **14** Any other **66** Specify_____	[__|__]	
203	How many altogether are you at this household (household size)	Number_____	[__|__]	
204	Not including yourself, how many adults live in this household (18 years of age or older)?	Number_____		
205	How many are women and how many are men?	Men_____ Women_____		

206	How many children live with you (17 years or younger)?	Number _____	[__|__]	
207	Are you living in the household with people who are not part of your family?	Yes **1** No **2**	[__|__]	
208	How many dependents are staying in this household? **(if None write 00)**	Number_____	[__|__]	
209	What kind of work do you do? (circle all mentioned)	**Yes** **No** No Work **1** **2** Farming **1** **2** Labourer **1** **2** Business **1** **2** Other **1** **2** Other _____		
210	What is your household's **main** source of income?	None **01** Formal Employment **02** Self Employment/Business **03** Family/Given from relatives **04** Piece works **05** Charity from NGO **06** Church **07** Any other **66** Specify_____		
211	Does your household have any of the following items? **CIRCLE ONE OR MORE AS APPROPRIATE**	**Yes** **No** Radio **1** **2** Television **1** **2** Bicycle **1** **2** Motorcycle **1** **2** Sewing machine **1** **2** Mobile/telephone **1** **2** Ox plough **1** **2** Oxen/donkey-drawn cart **1** **2** Car/truck **1** **2** Refrigerator **1** **2** Poultry **1** **2** Livestock **1** **2** Wheelbarrow **1** **2** Stove **1** **2** Other **1** **2** Other specify_____		
212	What is the ***main source of drinking water*** for the household? CIRCLE ONE	Piped into dwelling **01** Piped to yard/plot **02** Public tap/standpipe **03** Protected well **04** Unprotected well **05** Rain water **06** Water vendor/kiosk **07** Surface water (river/dam) **08** Other specify_____ **66**		
213	What type of toilet facility does the household use?	Flush or pour flush toilet **01** Traditional pit latrine **02** Pit latrine with slab **03** VIP **04** No facility/bush **05**		

		Bucket latrine **06** Other specify_____ **66**		
214	What is the **main** material of the wall of your house made of?	Bricks walls **01** Concrete brick walls **02** Iron sheet walls **03** Grass walls **04** Reed walls **05** Mud walls **06** Wood walls **07** Other specify_____ **66**		
215	What is the **main** material of the roof of your house made of?	Tile roof **01** Asbestos roof **02** Iron sheet roof **03** Grass roof **04** Reed roof **05** Other specify_____ **66**		
216	Please tell me if you think it is difficult or easy for you to utilize the following services in the community: • Police • Health centre • Education • Religious services • Legal aid • Psychosocial assistance • Other_____	Difficult Easy 1 2 1 2 1 2 1 2 1 2 1 2 1 2		
SECTION 3: KNOWLEDGE AND PECEPTION ABOUT GBV				
301	What do the words gender-based violence mean to you? ASK 'GBV OR GENDER-BASED VIOLENCE' FIRST. THEN WAIT FOR RESPONSE. NO RESPONSE, THEN TRANSLATE BROADLY ONLY [CHECK AT SITE FOR BEST BROAD DEFINITION IN LOCAL DIALECT] SEE ENDNOTE I FOR GUIDANCE **DO NOT PROMPT** **CIRCLE AS APPROPRIATE**	**Yes No** **RAPE 1 2** Cultural rites–including cleansing **1 2** Marital rape **1 2** HIV-related cleansing **1 2** Child abuse **1 2** Defilement **1 2** Sodomy **1 2** **SEXUAL ASSAULT 1 2** Attempted rape **1 2** fgm/c **1 2** Unwanted kissing or touching **1 2** Child abuse **1 2** **PHYSICAL ASSAULT 1 2** Hitting or slapping **1 2** Burning **1 2** Choking **1 2** **FORCED MARRIAGE 1 2** Early/child marriage **1 2** **DENIAL OF RESOURCES, OPPORTUNITIES/SERVICES 1 2** Denial of education **1 2** Denial of health services **1 2** Denial of contraception **1 2** Denial of inheritance **1 2** Denial to own land **1 2** Denial of savings **1 2**		

		PSYCHOLOGICAL AND EMOTIONAL ABUSE 1 2 Threat of physical violence **1 2** Threat of sexual violence **1 2** Forced isolation **1 2** Unwanted attention/ stalking **1 2** Don't know **1 2** Other **1 2**		
302	Is gender-based violence common in this area/community?	Yes **01** No **02** Do not know **99**		
303	Have you yourself experienced GBV?	Yes **01** No **02**		**If No, Skip to 306**
304	What were the type or types of GBV that you experienced in the past 6 months Circle one or more as appropriate SEE ENDNOTE I FOR GUIDANCE **PROMPT EACH TYPE OF GBV**	**Yes No** **RAPE 1 2** Cultural rites–including cleansing **1 2** Marital rape **1 2** HIV related cleansing **1 2** Child abuse **1 2** Defilement **1 2** **SEXUAL ASSAULT 1 2** Attempted rape **1 2** fgm/c **1 2** Unwanted kissing/touching **1 2** Child abuse **1 2** PHYSICAL ASSAULT **1 2** Hitting or slapping **1 2** Burning **1 2** Choking **1 2** FORCED MARRIAGE **1 2** Early/child marriage **1 2** **DENIAL OF RESOURCES, OPPORTUNITIES, SERVICES 1 2** Denial of education **1 2** Denial of health services **1 2** Denial of contraception **1 2** Denial of inheritance **1 2** Denial to own land **1 2** PSYCHOLOGICAL AND EMOTIONAL ABUSE **1 2** Threat of physical violence **1 2** Threat of sexual violence **1 2** Forced isolation **1 2** Unwanted attention **1 2**	[__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__]	
305	Do you know who has committed this act or acts outlined above?	Yes **01** No **02** Do not know **99**	[__|__]	
306	What was the gender, age and relationship of the perpetrator in each case? **[Relationship codes]** Spouse **1** Partner 2 other family members **2** peers **4**	**Incident 1** Male **01** Female **02** **Age** ___ Relationship _____ Location _____ **Incident 2** Male **01** Female **02** **Age** ___	[__|__] [__|__] [__|__] [__|__]	

	co-worker **5** stranger 6 prefer not to say **7** Other_____**66** **[Location codes]** Home **01** Workplace **02** School **03** Community **04** On the Road **05** Don't know **99**	Relationship _____ Location _____ **Incident 3** Male **01** Female **02** Relationship _____ Location _____ **Age** ___ **Incident 4** Male **01** Female **02** **Age** __ Relationship _____ Location _____ **Incident 5** Male **01** Female **02** Relationship _____ Location _____ **Age** ___ **REPEAT AS REQUIRED**	[__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__]	
306	Have you witnessed any violent incidents or GBV in the community in the past 6 months?	Yes **01** No **02**		**If No, Skip to 310**
307	What type or types of GBV have you witnessed in the past 6 months **CIRCLE ONE OR MORE AS APPROPRIATE** **SEE ENDNOTE I FOR GUIDANCE** **PROMPT EACH TYPE OF GBV**	**Yes No** **RAPE 1 2** Cultural rites – inc. cleansing **1 2** Marital rape **1 2** HIV related cleansing **1 2** Child abuse **1 2** Defilement **1 2** **SEXUAL ASSAULT 1 2** Attempted rape **1 2** fgm/c **1 2** Unwanted kissing/touching **1 2** Child abuse **1 2** **PHYSICAL ASSAULT 1 2** Hitting or slapping **1 2** Burning **1 2** Choking **1 2** **FORCED MARRIAGE 1 2** Early/child marriage **1 2** **DENIAL OF RESOURCES,OPPORTUNITIES, SERVICES 1 2** Denial of education **1 2** Denial of health services **1 2**		

		Denial of contraception **1** **2** Denial of inheritance **1** **2** Denial to own land **1** **2** **PSYCHOLOGICAL AND EMOTIONAL ABUSE** **1** **2** Threat of physical violence **1** **2** Threat of sexual violence **1** **2** Forced isolation **1** **2** Unwanted attention **1** **2**		
308	Do you know who has committed this act or acts?	Yes **01** No **02** Do not know **99**		
309	What was the gender, age and relationship to the perpetrator in each case? **[Relationship codes]** Spouse **1** Partner 2 other family members **2** peers **4** co-worker **5** stranger 6 prefer not to say **7** Other_____**66** **[Location codes]** Home **01** Workplace **02** School **03** Community **04** On the Road **05** Don't know **99**	**Incident 1** Perpetrator: Male **01** Female **02** Survivor: Male **01** Female **02** Age of perpetrator ___ Age of survivor ___ Relationship _____ Location _____ **Incident 2** Perpetrator: Male **01** Female **02** Survivor: Male **01** Female **02** Age of perpetrator ___ Age of survivor ___ Relationship _____ Location _____ **Incident 3** Perpetrator: Male **01** Female **02** Survivor: Male **01** Female **02** Relationship _____ Location _____ Age of perpetrator ___ Age of survivor ___ **Incident 4** Perpetrator: Male **01** Female **02** Survivor: Male **01** Female **02** Age of perpetrator ___ Age of survivor ___ Relationship _____ Location _____ **Incident 5** Perpetrator: Male **01** Female **02** Survivor: Male **01** Female **02** Relationship _____ Location _____ Age of perpetrator ___ Age of survivor ___ **REPEAT AS REQUIRED**	[__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__] [__|__]	

			[__|__] [__|__] [__|__] [__|__] [__|__] [__|__]	
310	Would you say GBV in this community is increasing, declining, or staying the same?	Increasing **01** Declining **02** Staying the same **03** don't know **99**	[__|__]	
311	What are the main factors that enable people to respond or prevent GBV incidents? **CIRCLE 3 ONLY** **DO NOT PROMPT, WE ARE SEEKING PERCEPTIONS**	**Yes No** Economic independence from perpetrator **1 2** Equality in decision-making in HH **1 2** Help from friends **1 2** Know they will not be stigmatised **1 2** Public services to support **1 2** Community disagrees with GBV **1 2** Distance to service is near **1 2** Trust services to respond **1 2** Other **1 2** Specify_____	[__] [__] [__] [__] [__] [__] [__] [__]	
312	What are the main community responses when GBV occurs? CIRCLE MULIPLE AS REQUIRED	**Yes No** Perpetrators taken to police **1 2** Cases usually not reported **1 2** community dialogue **1 2** taken to headman/ chief **1 2** taken to local court **1 2** discuss as families **1 2** case taken to religious leader **1 2** Taken to health services **1 2** Taken to GBV response centre **1 2** Other **1 2** Specify_____	[__] [__] [__] [__] [__] [__] [__] [__] [__] [__]	
313	Do survivors of GBV look for help when they experience violence?	Yes **1** No **2** Do not know **7**	[__]	**If No, skip to 401**
314	What kind of help do they look for?	**Yes No** Police **1 2**	[__]	

	CIRCLE ONE OR MORE AS APPROPRIATE	Relatives **1** **2** Hospital **1** **2** Place of worship **1** **2** Hotline **1** **2** Survivor service centre **1** **2** Community leaders **1** **2** Peer Group **1** **2** Support Group **1** **2** Court **1** **2** Other **1** **2** Specify_____	[__] [__] [__] [__] [__] [__] [__] [__] [__] [__]	

SECTION 4: INCIDENCE OF GBV (INCLUDING EARLY MARRIAGES)

401	At what age do girls/women **usually** first get married in this community?	Less than 12 **1** 12-15 years **2** 16-18 years **3** 19 and above **4**		
402	At what age do boys/men **usually** first get married in this community?	Less than 12 **1** 12-15 years **2** 16-18 years **3** 19 and above **4**		
403	How common is forced or early/child marriage in the area/community? OUT OF 10 GIRLS IN THE COMMUNITY, HOW MANY WILL MARRY EARLY? [0 none 1-3 Not common/ 4-6 common/7-10 very common]	Very common **1** Common **2** Not common **3** None **4** don't know **99**		**If 4 or 99, skip to 501**
404	Why do these forced or early/child marriages happen? CIRCLE ONE OR MORE	For economic freedom **01** Dowry for the family **02** Expected role of girl **03** I don't know **99** Other **66** Specify_____	[__|__]	
405	Who are the main perpetrators of forced marriage? **Record Verbatim**	Record Verbatim _____ Age:	[__|__]	

SECTION 5: ATTITUDES TOWARDS GBV

	Please, state whether the following statements are true or false.			
501	When hit/beaten by a husband, a wife should not report the husband to the police	True 1 False 2	[__]	
502	When hit/beaten by his wife, a man should not report the wife to police	True 1 False 2	[__]	
503	A man can have extra marital affairs, but not a woman	True 1 False 2	[__]	
504	If you heard about a case of GBV occurring in your community, would you report the case?	Yes **1** No **2** Not sure **3**	[__]	
	I am going to read a series of statements and I want you to tell me if you think it is ever acceptable for a man to beat his wife in the following situations.			

505	If she refuses to have sex	strongly agree **1** agree **2** disagree **3** strongly disagree **4** don't know **5**	[__]	
506	If she burns the food	strongly agree **1** agree **2** disagree **3** strongly disagree **4** don't know **5**	[__]	
507	If she neglects the children	strongly agree **1** agree **2** disagree **3** strongly disagree **4** don't know **5**	[__]	
508	If she argues with her husband	strongly agree **1** agree **2** disagree **3** strongly disagree **4** don't know **5**	[__]	
509	If she leaves home without telling him	strongly agree **1** agree **2** disagree **3** strongly disagree **4** don't know **5**	[__]	
510	Rape is never deserved, even if girls dress badly or misbehave towards boys	Strongly disagree **1** Disagree **2** Agree **3** Strongly agree **4** Don't know **5**	[__]	
511	In your community, if a man rapes a girl or woman and others find out about it, he will be shunned	Strongly disagree **1** Disagree **2** Agree **3** Strongly agree **4** Don't know **5**	[__]	
SECTION 6: EXISTING GBV SERVICES				
601	What facilities/organizations/options exist for helping survivors of gender-based violence in this district? ***Circle one or more***	**Yes No** Police **1 2** Relatives **1 2** Hospital **1 2** Place of worship **1 2** Hotline **1 2** Survivor service centre **1 2** Community leaders **1 2** Friends **1 2** Support Group **1 2** Court **1 2** Specify_____		
602	From what source can you learn about GBV services?	Y N		

	Please tell me all that you can remember. **CIRCLE ONE OR MORE**	a) TV **1** **2** b) Radio **1** **2** c) Newspapers **1** **2** d) Newsletters **1** **2** e) Relatives **1** **2** f) Friends **1** **2** g) Workmates **1** **2** h) Church/place of worship **1** **2** i) Peer educators **1** **2** j) Health workers at the Clinic **1** **2** k) Any othe Specify _____		
603	In the community where you live, are you aware of existence of community support networks that address GBV?	Yes **1** No **2**		
604	If, Yes how do the community networks address GBV?	Support through counselling **1** Engage in technical/ livelihood advice **2** Rotational savings support **3** Other_____**66**		
				SE
701	Have you received any information on GBV in the past three months?	Yes **1** No **2** don't know 66		**If No, skip to 801**
702	What is your ***main*** source of information on GBV Prevention?	TV **01** Radio **02** Newspapers **03** Newsletters **04** Relatives **05** Friends **06** Workmates **07** Church/place of worship **08** Peer educators **09** Health workers at the Clinic **10** Billboards **11** Leaflets **12** Posters **13** Specify_____		
703	Do you thin	Yes **01** No **02**		
704		telling you where to go **01** in the right language, but confusing **02** in the wrong language **03** too old **04** can't remember **05** **Don't know 99** **Other 66**		

SECTION 8: EXPOSURE TO WORLD VISION ONE-STOP GBV PROJECTS				
801	Have you hea	Yes **1** No **2**		
802	If yes, what specific services do the STOP-GBV projects provide?	STOP-GBV centre **01** Legal advice **02** Prevention and advocacy **03** Other_____**66**		
803	What is the project doing in your community?	Provide GBV survivor services **1** Provide legal services 2 Provide prevention and awareness services 3 Direct income support 4 Indirect income support 5 Other Specify _____66		
804	Does the STOP GBV Project provide information on GBV and early child marriages?	Yes 1 No 2		
805	Have you ever participated in any of their activities?	Yes **1** No **2**		
806	Which activities?	Provide GBV survivor services **1** Provide legal services **2** Provide prevention and awareness services **3** Other Specify _____		
807	Do you think that this project is beneficial to your community?	Yes **1** No **2** Not sure **3**		**If No, skip to 809**
808	Which way is it ***most*** beneficial? **Single response only**	Provides information on GBV **01** Supports GBV survivors **02** Provides Shelter/safe home**03** Other **66** Specify _____		
809	Why do you think it is not beneficial?	Information is not appropriate **01** Service is too far away **02** Fearful of confidentiality issues **03** Services do not lead to prosecution **04** Does not address all post-incident needs **05**		
810	Generally, what is the attitude of STOP GBV staff?	Polite **1** compassionate **2** Indifferent **3** Don't know **99**		
811	Are you aware that the project can refer survivors of violence to shelters and safe houses?	Yes **1** No **2**		
814	Do you feel that a safe house can provide protection to the GBV survivors?	Yes **1** No **2** Not sure **99**		
816	Do the STOP GBV projects involve local communities in their activities?	Yes **1** No **2** Not sure **99**		
817	How are the local communities involved?	Through sensitisation visits **1**		

		Through consultations **2** Through messages from leaders **3** Through message from support networks **4** Not sure **66**		

STAMPING OUT AND PRVENTING GENDER BASED VIOLENCE (STOP-GBV) IN ZAMBIA

Key Informants Interview Guide for stakeholders

Instructions

- To be interviewed by two Research Assistants (RA)
- Check how long respondent has been in the community or in their position – make judgement
- To be administered to relevant stakeholders and partners these will include: Manager of the OSC (One Stop Center), one representative of VSU handling GBV issues, Gender Focal Point Persons (District/Province), one Village Headman/woman, manager of GBV officer of one NGO implementing GBV services in the district, and others as appropriate.
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement. An introductory paragraph is provided below.

  I work for Frontiers Group, a research organization based in Lusaka. We are conducting a baseline study on gender based violence in Zambia. The purpose of this study is to provide a baseline to measure program results, impact and long lasting change at the end of the project in six districts in Zambia. We are gathering views to help us better understand STOP- GBV Projects and to identify ways of improving the interventions. We are asking questions about your ideas, attitudes, knowledge and behaviours, and whether you have heard of/know about the GBV and the project in this district.

- Audio record the interview and take notes of any visual and non-verbal communication as well as top-line issues and headlines.

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- Audio record the interview and take notes of any visual and non-verbal communication as well as top-line issues and headlines.

RESPONDENT'S DETAILS (***This section may be completed immediately after consent***)			
ID01	Province:	ID02	District:
ID03	Location:	ID04	Community
ID05	Respondent's Type:	Institutional Affiliation:	
ID06	Interviewer:	Date of interview:	
	Interview start time:	Interview end time:	

Section A: General views about GBV in the district

1. What do the words gender based violence mean to you?
2. Does GBV occur in this district?
   a. Which kinds of GBV occur here?
   b. Which kinds are most common and why?
   c. How often does it (do they) happen? (daily, weekly, monthly, rarely, etc)
   d. Is the incidence increasing or decreasing? Why? How do you know it is increasing? Since when?
   e. Are people reporting incidences of GBVs in the district? If yes, since when? Have the reports been increasing, since when and why? If no, why not?

3. What are the major causes of GBV in the area? What factors influence or continue to sustain GBV? (probe: eg. poverty, low levels of education, some cultural beliefs and values, alcoholism, exposure to media/poor role models, etc.)

4. Who are the main perpetrators of GBV? Why?

5. Who are the main victims of GBV? (according to age, gender, socio-economic status, tribal grouping, etc. etc.)

6. What are some of the cultural beliefs and values that influence GBV in this district?
    a. are they changing at all?
    b. who are the people who maintain these beliefs and values?

Section B: GBV information and services in the district

7. What are the main sources of information on GBV in this area?
    a. What strategies are used to create awareness?
    b. Who are the major players in information dissemination?

8. What GBV services exist in the district (government, NGO, community) (Probe: since when, where/how work, target group, what services provide, etc.)
    a. How effective do you think these services have been?
    b. Are these services mostly responsive (after the incident) or are they preventative? Please give examples.

9. What are the commonly used channels for reporting GBV? How effective do you think these channels have been?

10. Are members of the local community involved in GBV prevention, response, awareness raising, etc.? Are there community networks for preventing GBV?
    a. Who is involved (age, gender, position)? What do they do? Who do they target? How effective are they?

11. What legal facilities or personnel exist for victims/survivors of GBV and for punishing perpetrators? (*e.g., court, local/traditional, or civil authorities*)

12. Do you or your organization deal with GBV issues?
    a. What kind of work / services related to GBV do you/your organization do? Who is your target group? Do you do awareness raising activities? (if yes, which kind, how often, etc.)
    b. How often do you or your organization deal with GBV cases? How many cases per week/month do you deal with?
    c. From what individuals or organizations do you typically receive or send reports of GBV?

13. What are some of the challenges that you or your organization face in **responding** to GBV? How do you think these challenges could be addressed?

14. What are some of the challenges that you or your organization face in **preventing** GBV? How do you think these challenges could be addressed?

Section C: STOP GBV Project (To a STOP GBV project staff member and other district level staff, can probe for further details for staff member, can also start with this if a STOP GBV project staff member)

15. Describe the main components of the STOP GBV Project that you are involved with/that you know about? What are the goals and key objectives of the project?

16. To what extent do you think the goal and objectives STOP GBV Projects will be achieved by the end of the projects? Why do you think so?

17. Are you or your organization working with STOP GBV projects? How? In what way? Since when?

18. What specific services does the STOP GBV Project provide? Could you list the services? (Probe: Who are the target group, who accesses the services, what is the coverage? Numbers of people who access on a daily/weekly/monthly basis, etc.)

19. (In particular for the GBVSS project within the STOP GBV Program, in relation to the services they provide, are buildings, spaces and facilities adequate?
    a. Are shelters and safe house adequate to provide care for survivors of GBV?
    b. Is there enough space, privacy, how about cooking and sanitation facilities, etc.?

20. In your opinion, what technical resources are currently available at the OSCs? What do you think of these resources? (Probe: funding, equipment, etc).

21. In your opinion, what human resources are currently available at the OSCs? What do you think of these resources? (Probe: are they adequately trained, are they able to maintain confidentiality, etc.)

22. Are you aware of policies, guidelines and protocols (national and institutional) that have informed the implementation of the OSCs projects? Provide copies

23. How are STOP GBV activities managed and coordinated at the district and local community levels? Who ensures that you or your organization works in a coordinated way with STOP GBV projects?

24. Do STOP GBV projects work with local communities? How does the project work with traditional leaders and other district stakeholders?

25. What is your understanding of the way OSCs work with law enforcement (police, courts) agencies?
    a. How are they involved?
    b. Do you feel that they are trained to deal with GBV cases?
    c. What are some of the specific roles of each of them?

26. In general, do you think survivors who report to OSCs services receive quality clinical care?
    a. What are the gaps in these services?
    b. What are the strengths?
    c. What can be improved?
    d. How well do they address the medical needs of children?

27. In general, do you think that the survivors who report to the OSCs are referred to and receive necessary support from the police?
    a. What are the gaps in these services?
    b. What are the strengths?
    c. What can be improved?
    d. How well do police handle cases involving children?

28. In general, do you think that the survivors who report to OSCs receive the support they need to be able to successfully pursue their case in court?
    a. What are the gaps in these services?
    b. What are the strengths?
    c. What can be improved?
    d. How well do the projects prepare children (and their parents) for successful court hearings, including both the collection of evidence and court appearances?

29. In general, do you think that the survivors who report to the OSCs receive the psychosocial support they need to recover?
    a. What are the gaps in these services?
    b. What are the strengths?
    c. What can be improved?
    d. How well do the projects address the needs of children and their parents?

30. What are some of the challenges this project is likely to face going forward?

Closing

That is all of our questions for now. Does anyone have anything they would like to add or do you have any questions for us? As we told you in the beginning, our discussion today is meant to help us learn about the concerns that you have for GBV in your community.

Thank-you for your co-operation

STAMPING OUT AND PRVENTING GENDER BASED VIOLENCE (STOP GBV) IN ZAMBIA

Focus Group Discussion Guide for Community Members
(Men, Women, Youth)

Instructions

- To be conducted by at least 2 Research Assistants (Facilitator and Note taker)
- To be administered to mobilized community members in every district
- To be administered ideally to 1 group of men, 1 group of women, 1 group of female youth and 1 group of male youth (between ages of approximately 18-24)
- The same basic tool will be used for all age and gender groups as this will provide comparable information; where relevant, and post piling, questions will be tweaked accordingly
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement. An introductory paragraph is provided below.
- Audio tape the group discussions, but given difficulties in capturing group discussion, rigorous notes must also be taken. Photos of any visual material should also be undertaken.

My name is……..I work for Frontiers Group, a research organization based in Lusaka. We are conducting a baseline study on gender based violence in Zambia. The purpose of this study is to provide a way to measure program results, impact and long lasting change at the end of the project in six districts in Zambia. We are gathering views to help us better understand GBV Projects and to identify ways of improving the interventions. We are also asking questions about your ideas, attitudes, knowledge and behaviours, and whether you have heard of/know about the GBV and the project in this district.

RESPONDENT'S DETAILS (***This section may be completed immediately after consent***)			
ID01	Province:	ID02	District:
ID03	Location:	ID04	Community
ID05	Respondent's Type: Women / Men/ Youth (M) / Youth (F) [circle]		
ID06	Facilitator:	Date of FGD:	
	Interview start time:	Interview end time:	

Section A: General Questions about GBV in the locality

1. What do you understand by gender-based violence? Or, in this community, what do people think gender-based violence is?

2. Do you think GBV is a problem in this community/district?

    a. If so, why? Since when?

    b. Has it changed over time? Why, how?

3. What forms does GBV take here?

- When does GBV occur in this community/area?
- Where does GBV occur in this community/area?
- In your view, who are the perpetrators of GBV? (probe: e.g. people in authority, family members, others)
- Which groups do you think are most at risk of GBV and why do you think these groups are more at risk? (Disaggregated by age, education level, poverty, orphan status, etc.)
- Where did they get support?

4. What kinds of cultural practices exist that you think might be harmful to women, men, girls and boys in this community? (for each cultural practice probe why does it continue? Who supports these cultural practices? What happens if someone disobeys the cultural practice?) What would happen if it didn't continue (if talk about marriage, at what age/stage do girls and boys get married in this community?)?

[Participatory Safety Mapping Exercise (if have time and once piloted to see if works): Participants outline the most important services and locations for them –household, schools, hospitals, market etc. They then discuss and highlight the TOP 3 risk areas where GBV occurs and why.]

Section B: GBV Services [note - Questions on One-Stop services come later]

5. What GBV services are available in this area or community?
   - Ask people to list services
   - Are there places for victims/survivors of GBV to go to when their life is in danger?
   - What legal facilities or personnel exist for survivors of GBV and for punishing perpetrators? (*e.g., court, local/traditional, or civil authorities*)?
   - Is the local police involved in GBV services? What are the specific services? Does the police station have the ability to transport or accompany victims/survivors for further services? If no, how do victims/survivors access the services? What kind of system is in place for reporting security issues or abuse?

6. What do you think of these services?
   - Are they helpful? If yes, which ones and in which way? What are their benefits? (to individual and community)
   - If they are not helpful/useful, which ones, and why?
   - Are people able to access them? If no, why not? Which kinds of people are able to access and which kinds are not?
   - How are you treated by the staff who provide the services? Do you think they have sufficient training? Is there a good gender balance? Are they respectful/polite? Do they stigmatise? Etc.

7. What are the main sources of information on GBV and forced or early/child marriages
   - What strategies are used to create awareness?
   - Who are the major players in information dissemination?
   - How are the local communities involved?

Section B: One Stop Center (OSC) Specific Questions (if not already mentioned above in list of services)

8. Do you know about the OSC in the area?
   - If yes, where are the STOP GBV services located? Is this convenient?
   - What specific GBV services do the OSC provide?

9. Are the services adequately staffed and who works at these centres? Do STOP GBV Projects work with other stakeholders including the local communities? How do the projects work with local communities?
   Probe: How do they work with traditional leaders and civic organisations?
   Who else is involved in GBV in this community?
   Who does the project network with?
   Who does the facility refer GBV cases to?

10. What do you see as the major strength of STOP GBV projects?
    Probe: Adequacy and competence of personnel
    Quality of services,
    Availability of infrastructure and equipment etc
    Client satisfaction

11. What are some of the limitations of STOP GBV Projects?
    Probe: Gaps, constraints and challenges that need to be addressed moving forward.

Closing
That is all of our questions for now. Does anyone have anything they would like to add that we have forgotten?

Do you have any questions for us?

As we told you in the beginning, our discussion today is meant to help us learn about the concerns that you have for GBV in your community.

If you have any concerns about our discussion today regarding GBV issues, we can advise you accordingly.

Thank you for your participation

STAMPING OUT AND PRVENTING GENDER BASED VIOLENCE (STOP-GBV) IN ZAMBIA

In-depth Interview Guide for Survivors of GBV

Instructions

- To be interviewed by either by research supervisors or by Research Assistants (RA) experienced with conducting highly sensitive interviews
- To be administered to survivors of GBV when and if possible. Assistance from OSCs and medical centres will be sought to identify respondents.
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement. An introductory paragraph is provided below.
  I work for Frontiers Group, a research organization based in Lusaka. We are conducting a study on gender based violence in Zambia. The purpose of this study is to provide a baseline to measure program results, impact and long lasting change at the end of the project in six districts in Zambia. We are gathering views to help us better understand the STOP- GBV Projects and to identify ways of improving the interventions. We are asking questions about your experience about GBV and STOP GBV project in this district.
- Audio-record the interview and take notes of any visual and non-verbal communication.

RESPONDENT'S DETAILS (***This section may be completed immediately after consent***)			
ID01	Province:	ID02	District:
ID03	Location:	ID04	Community
ID05	Respondent's Type:	Institutional Affiliation:	
ID06	Interviewer:	Date of interview:	
	Interview start time:	Interview end time:	

Section A: Socio-demographic characteristics

- Sex
- Age
- Marital status, if married for how long, age of marriage
- Do you have children? If yes, number?
- Educational level
- Place of residence
- Can you describe to me what happened to you that made you visit the OSC?

Section B: First Visit to OSC

Now, if it is ok with you, I would like to begin by talking about your first visit to the one-stop center.

- Do you remember the day of the week that you went to the OSC? What time of day was it? Did you go on your own? If no, who accompanied you?

- When you arrived, who welcomed you? What did they tell you? What did you do? Where did you go?

- What was the reason you sought care at the OSC?

- Who told you to go there to seek care? How did you know to go there to seek care?

- Did you delay in going to use the service? Yes/No – why, and for how long?
- How long did you have to wait before you received services?
- Did this seem like it was too long or just the right amount of time?
- What happened next, can you mention to me the different steps that you were taken through from beginning to end?
- In total, how much time did you spend in the OSC from beginning to end of your first visit?
- Were you asked to pay for any services?
- What services and how much?
- How did the staff behave towards you? Did they make you feel at ease/comfortable? Did you feel that the visit and the use of your information was adequately confidential?

Section C: Experience with medical care

Now I would like to ask you some questions about the medical care you received from the OSC.

- During your first visit to the OSC, were you referred for medical care?
    - Where was the medical care provided? Did you feel the room protected your privacy?
    - Were you referred to a doctor at any time during your first visit to the OSC?
    - How did the doctors and nurses behave towards you? (Probe: Were they polite, hurried, respectful, indifferent, etc.)
    - During your first visit, did you receive any drugs?
      If so, what did the staff say were drugs that you were give?
      (If reason for visit was sexual assault, ask: Did you receive a drug called emergency contraception (EC) which is used to prevent pregnancy?)
    - (If reason for visit was sexual assault ask: Did you receive a drug to prevent HIV transmission (called PEP)?
      Probe:How long did it take you to visit the centre after sexual assault?
      Did the provider take enough time to explain how the drug works?
      Did the provider take enough time to explain its side effects?
      Did you experience any side-effects? What were they?
      For how long did you have to take the drug?
    - After the first visit, did you return to the OSC and the hospital for any additional services?
    - What services were they? How many times have you returned?
    - Did you feel that all of your physical injuries were adequately recorded?
    - How would you like the referrals from OSC to health/police/paralegal services improved?

Section D: Experience with counseling services

Now I would like to ask you some questions about the counseling and social services you received from the OSC.

- During your first visit to the OSC, did you meet with a counselor?
    - Where did you meet with the counselor? Did you feel the room protected your privacy?
    - Did you feel that the counselor was respectful to you?

- Did you feel that it was safe for you to go back to your own home at the time of your first visit to the OSC? (Probe: If no, why not, if yes, why?). If no, were you given re-settlement alternatives, or information about other facilities for support?

- What services did the counselor provide during your first visit?
  - **Probe**: counseling, referrals to other services, provided clothes/food, etc.

- During your first visit, were you invited to participate in survivors groups? Yes/No
  - If yes, how many survivors' group meetings have you attended? What do you do/discuss during these survivors group?
  - Do you feel that survivors' groups are useful for the participants? (Probe: if no, why not, what would want to see done differently? If yes, why?)

- Have you ever returned to the OSC for any additional social services or counseling (apart from survivors' groups)?
  - How many return visits have you made to see social services or counseling?
  - What services did you receive?

- How would you like the counseling and social services you received from the OSC improved?

Section E: Experience with Police services
Now I would like to ask you some questions about the police services you received from the OSC.

- During your first visit to the OSC, did you meet with a VSU officer or were you referred to a VSU officer? If not on the first visit, did you ever meet with a VSU officer? (if no, skip this section)

  - Where did you meet with the VSU officer? Did you feel the room where you met with the VSU officer protected your privacy?

  - Did the VSU officer take a statement from you?

  - How did they VSU officer behave towards you? (Probe: where they respectful, polite, etc.) Were there any barriers? (If no response – probe for issues such as payments or suggestion of payments to facilitate the service)

  - Were you given a police medical report form for the doctor to sign?
    - Did the doctor sign the report form?
    - Was the signed report form returned to the police?
    - If not, did you keep the form? Why?

  - Did you decide to pursue the case in court? Why or why not? Was any 'informal arbitration' or out-of-court settlement negotiations suggested? If so, what were these?

  - To the best of your knowledge, did the police:
    - Ever visit the scene of the crime?
    - Take a statement from other witnesses?
    - Take a statement from the perpetrator?

  - Was the perpetrator arrested? How long was the perpetrator in the cell?

  - After the first visit, did you return to the OSC to meet with the VSU officer?
    - Did you meet with the VSU officer at the police station?
    - How many times?
    - What was the purpose of these meetings?

  - How would you like the police services you received from the OSC improved?

Section F: Experience with legal services
Now I would like to ask you some questions about the legal services you received from the OSC.
- During your first visit to the OSC, did you meet with a paralegal?

- Where did you meet with the paralegal? Did you feel the room protected your privacy?

- What services did the paralegal provide? Did the paralegal explain all the legal options available to you in your situation?

- How did the paralegal behave towards you? (Probe: were they respectful, polite, etc.?)

- Did you decide to take your case to court? Why or why not?
    - If yes, do you feel that you were adequately prepared for court by the paralegal?
    - Do you think that the police collected enough evidence to adequately prosecute the case?
    - What was your experience of the court hearing? (intimidating, fair, etc.).
    - Were you happy with the outcome?
    - What could have been done to improve your experience with the court?

- How would you improve the legal services provided at the OSC?

- Were you referred by any care provider in the OCS to any additional services that not offered at the OSC?
    - What were these services?
    - Did you seek them?
    - Why or why not?

- Overall, are you happy with the care and services provided to you at the OSC?
- Do you have any recommendations for improving services?
- Do you have any other comments?

Closing
That is all of our questions for now. Does anyone have anything they would like to add or do you have any questions for us? As we told you in the beginning, our discussion today is meant to help us learn about the concerns that you have for GBV in your community.

Thank-you for your co-operation

STAMPING OUT AND PRVENTING GENDER BASED VIOLENCE (STOP-GBV) IN ZAMBIA

Life history tool
(GBV survivors – different age, socio-economic status)

Instructions

- To be conducted by Research Assistants (Facilitator and Note taker)
- Check how long respondent has been in the community (> 3 months)
- To be administered to GBV survivor in every district
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement.
- Audio tape the interview and record take notes of any visual and non-verbal communication.

RESPONDENT'S DETAILS (***This section may be completed immediately after consent***)			
ID01	Province:	ID02	District:
ID03	Location:	ID04	Community
ID05	Respondent's Type:	Institutional Affiliation:	
ID06	Interviewer:	Date of interview:	
	Interview start time:	Interview end time:	

Section 1: Socio-demographic details background:

- Age, marital status (if in polygamous union, probe number of wives), age, where they live, age of marriage, number of children
- Living arrangements, since when living here, where were before, why moved, etc.
- Educational level, reached what level, where, reasons for leaving education, etc.
- [seek broad overview on life history and associated challenges – economic status, perception of vulnerability, experience of risk and degrees of resilience]

Section 2: Occupation/livelihood and assets

- Main occupation, livelihood, if paid, how much, what do with money, etc.
- Migration history if relevant
- What assets do you own? What assets does your spouse/household own?

Section 3: Support structure/social networks

- Who do you turn to for support? (friends, relatives, etc.)
- What kind of support do they give? (Financial, emotional/psychological, etc.)
- Do you support anyone? How do you support them?
- Are you a member of any support group? If yes, when/how often do you meet, what do you do, how many are you, etc. If no, why not?
- How has support changed over time? Since when? Is it more or less? Which kinds are more, which kinds are less? Why?

Section 4: Decision making and cultural/traditional practice

- Who makes decision in your household? (about how many is spent, whether health /other services are accessed, etc.). Has this changed over time? If yes, how has changed?
    - Do you make any decisions? If yes, what kinds of decision? Has this changed over time? If so, why and since when?
- Who decided what age you should marry?
    - Were you happy about this, if not why not? Did you do anything about it? If not, why not? If yes, what did you do?
- What age would you like your daughter/son to get married? And why this age?
- Who decided whether you should continue education or not?
    - Were you happy about this, if not why not? Did you do anything about it? If not, why not? If yes, what did you do?
- Until what age would you like your daughter/son to continue education to? And why this age?
- Have you undergone any initiation ceremonies?
    - Who decided that you should go through these?
    - Were you happy about this, if not why not? Did you do anything about it? If nt, why not? If yes, what did you do?
- Would you want your daughter to go through the initiation ceremony?
    - If yes, why? If no, why not?

Section 4: GBV experience and history

- Can you tell me when you first started experiencing GBV?(**and say that this can include physical, sexual and verbal abuse, as well as early marriage, sexual exploitation and FGM/C in the home, school, community or workplace)**
    - What form did this GBV take?
    - How often were you facing this?
    - How long did it continue for?
    - If stopped, why stopped? If stopped and then started, why? If changed, why /what changed to?
    - Who was the perpetrator? Was it always the same person? If more than one person, who were they?
    - Why do you think this started happening? (probes: poverty, alcohol, peer or family pressure, etc.)
- How did this make you feel? Did your feelings change overtime? If yes, how and why?
- What did you do about it?
    - If nothing, why nothing?
    - When did you start doing something about it? What was the trigger?
    - If talked to friends/relatives, what kind of friends/relatives, what did they advise you?
- If sought help from services:..
    - which services, when did you start accessing services, how did you find out about them, who told you about them?
    - how did accessing the services make you feel?
    - did you face any challenges in accessing the services?
    - have you changed since accessing the services? If yes, how have you changed?
    - Do you know more about your rights than before you accessed the service? Give examples

Closing

That is all of our questions for now. Do you have anything else you would like to add or do you have any questions for us? As we told you in the beginning, our discussion today is meant to help us learn about the concerns thatyou have for GBV in your community.

Thank you for your participation

STAMPING OUT AND PREVENTING GENDER BASED VIOLENCE (STOP-GBV) IN ZAMBIA

Semi-structured Guide for STOP GBV Service Provider Personnel

Instructions

- To be interviewed by the Research Assistants (RA).
- To be administered to various categories of STOP GBV Projects personnel.
- Explain the purpose of the study and politely request respondent for permission to proceed as detailed in the Informed Consent Statement.
- Audio record the interview and take notes of any visual and non-verbal communication.

Introduction

My name is……..I work for Frontiers Group, a research organization based in Lusaka. We are conducting a baseline study on gender based violence in Zambia. The purpose of this study is to provide a baseline to measure program results, impact and long lasting change at the end of the project in six districts in Zambia. We are gathering views to help us better understand STOP- GBV Projects and to identify ways of improving the interventions. We are asking questions about your ideas, attitudes, knowledge and behaviours, and whether you have heard of/know about the GBV and the project in this district.

RESPONDENT'S DETAILS (***This section may be completed immediately after consent***)			
ID01	Province:	ID02	District:
ID03	Location:	ID04	Community
ID05	Respondent's Type:	Institutional Affiliation:	
ID06	Interviewer:	Date of interview:	
	Interview start time:	Interview end time:	

Section A: General Understanding of GBV issues

31. What do the words gender-based violence mean to you?

32. How do you rate the incidence of GBV in this community? Would you say GBV is increasing or decreasing? What factors contribute to the increase/decrease

33. What are the major causes of GBV in this area?

34. Who are the main perpetrators of GBV in this area?

35. Who are the main victims of GBV in this area? (probe: age, gender, poverty levels, etc.

36. What factors influence or continue to sustain GBV?

37. What are the goals and key objectives of the STOP GBV projects? Please, describe their main components?

38. Can you mention the core services that STOP GBV projects provide?

39. How many GBV survivors does this facility/you see per day? What are they main forms of GBV faced by survivors who come to this facility? (**may only be relevant to One Stop Centers)**

40. Which of the three STOP GBV projects do you work for? What specific job or tasks do you perform?

41. What types or cases of GBV do you handle? How often do you handle these cases of GBV? How many per week or month?

Section B: Technical capacity of personnel

42. Do you feel adequately trained for this job? Why?

43. Have you received training on the work you are doing? If so, what was the training about, who provided it, when was it, and how many days did it last?

44. Do you work with other service providers (NGOs, government departments, health facilities, legal, victim support unit (VSU), psychosocial (social welfare)) on the issue of GBV? If so, how?

45. Does the service have mechanisms to refer survivors to other services? If yes, what services and where are these services located? How do you provide the referral? How do you ensure that the service is provided at the reference point?

46. What are some of the challenges that you face in responding to GBV? How do you think these challenges could be addressed?

47. Are there places for survivors of GBV to go to when their life is in danger? Do you refer such clients to shelters or safe places?

48. Does the local police station/VSU have the ability to transport or accompany survivors for further services? If no, how do survivors access the services?

49. Is post-exposure prophylaxis (PEP) provided to survivors?
    If yes, ask: What PEP regimen is prescribed?
    Is the full course of PEP drugs given all at once?
    - three- day starter pack then all of remaining drugs
    - All drugs given at one time
    - seven-day supply given
50. In case of rape, are survivors referred to relevant services? If yes, what services are offered to the survivor after rape by the health center?
    - None
    - Emergency contraceptives (or morning-after pill)
    - Pregnancy test
    - Abortion counselling/information
    - Other _____
51. Are STI related services offered? If yes, what STI-related services do you offer the survivor after rape?
    - None
    - Give prophylactic treatment (Ask what the treatment is)
    - Refer to an STD/STI clinic
    - Send swab to lab to test for STIs
52. Is it possible for survivors to receive counselling in this facility? If yes, how many counselling session, etc. If no, where do you refer to?

53. Do you refer to other service providers, VSU and courts? Where are the people referred to (NGOs, support groups)? *(Try to get the names of the institutions.)*
    How do you follow-up on survivors once they have left the health facility?
54. Have you or anyone else at this facility received formal training on the management of sexual violence/rape?
    If yes, ask: how many different trainings have you attended, and who provided the trainings?

55. Does this facility have protocols/guidelines for the management of GBV?
    If yes, ask: Where do you keep them? [*Ask to see them*.]
56. Who makes the decision when reporting a case of GBV to the police *(health care providers, the survivors/victims of the violence, parent/guardian)?*

57. What do you do if you have a suspicion that a parent or guardian is involved in the GBV of a child? How do you proceed with managing the safety needs of that child?

58. What are some reasons that girl or women survivors of GBV may not be able to access OSC services?
    Fear of being identified as survivors

Distance to health facility
No female staff
No availability of confidential treatment
Lack of trained staff
Don't know
Other – If "other," please specify:

59. How does the facility work with local communities?
    Probe: How does the project work with traditional leaders and civic organisations?
    Are there any mobile outreach activities?
    Who else is involved in GBV work in this community?
    Who are part of the local networks?

60. What kind of documentation is required to facilitate legal proceedings and investigations? What are the major challenges experienced? What is the time period that it takes to finalize a case, and why?

61. What are some of the challenges that STOP GBV project is likely to face in its implementation?

Closing
That is all of our questions for now. Does anyone have anything they would like to add or do you have any questions for us? As we told you in the beginning, our discussion today is meant to help us learn about the concerns that you have for GBV in your community.

Thank-you for your co-operation

Annex 2: Additional socio-demographic and wealth related data

Table A1: Household's main source of income

District	Sex	None	Employment		Family/ given from relatives	Piece works	Charity from NGO	Church	Farming
			Formal	Self					
Chingola (n=343)	Female	0.5	55.8	32.5	2.5	5.6	-	-	3.0
	Male	-	46.6	35.6	3.4	11.0	0.7	-	2.7
	All	0.3	51.9	33.8	2.9	7.9	0.3	-	2.9
Kalomo (n=340)	Female	1.0	30.9	40.2	5.4	19.6	-	1.5	1.5
	Male	2.2	36.5	32.8	2.9	20.4	1.5	-	2.9
	All	1.5	33.1	37.2	4.4	19.9	0.6	0.9	2.1
Monze (n=350)	Female	0.5	20.0	49.8	5.6	21.9	0.5	-	1.9
	Male	-	27.4	41.5	4.4	25.2	-	-	1.5
	All	0.3	22.9	46.6	5.1	23.1	0.3	-	1.7
Mpika (n=348)	Female	-	43.1	44.6	3.9	4.4	-	-	3.4
	Male	-	31.0	53.8	-	13.8	-	-	1.4
	All	-	38.1	48.4	2.3	8.3	-	-	2.6
Mumbwa (n=334)	Female	-	24.6	63.6	1.5	6.2	-	-	4.1
	Male	-	17.3	63.3	1.4	14.4	-	-	3.6
	All	-	21.6	63.5	1.5	9.6	-	-	3.9
Nyimba (n=336)	Female	1.1	30.3	56.2	2.2	7.0	-	-	3.2
	Male	1.3	24.5	59.6	-	7.9	-	-	6.6
	All	1.2	27.7	57.7	1.2	7.4	-	-	4.8
All (N=2051)	Female	0.5	34.0	47.7	3.6	11.0	0.1	0.3	2.8
	Male	0.6	30.6	48.0	2.0	15.3	0.4	-	3.2
	All	0.5	32.6	47.8	2.9	12.8	0.2	0.1	3.0

Table A2: Type of toilet facility used by household

District	Sex	Flush or pour flush toilet	Traditional pit latrine	Pit latrine with slab	VIP	No facility/bush
Chingola (n=343)	Female	68.0	18.8	13.2	-	-
	Male	57.5	27.4	15.1	-	-
	All	63.6	22.4	14.0	-	-
Kalomo (n=340)	Female	5.4	60.3	32.4	1.0	1.0
	Male	8.1	59.6	29.4	2.9	-
	All	6.5	60.0	31.2	1.8	0.6
Monze (n=350)	Female	6.0	52.1	38.6	2.3	0.9
	Male	5.2	36.3	54.8	2.2	1.5
	All	5.7	46.0	44.9	2.3	1.1
Mpika (n=341)	Female	23.0	59.0	18.0	-	-
	Male	7.1	69.5	23.4	-	-
	All	16.4	63.3	20.2	-	-
Mumbwa (n=334)	Female	8.7	61.0	26.7	3.6	-
	Male	6.5	61.2	27.3	4.3	0.7
	All	7.8	61.1	26.9	3.9	0.3
Nyimba (n=336)	Female	18.4	50.3	14.1	15.7	1.6
	Male	28.5	46.4	14.6	9.9	0.7

	All	22.9	48.5	14.3	13.1	1.2
Total (n=2044)	Female	21.3	50.3	24.2	3.6	0.6
	Male	19.3	49.9	27.0	3.3	0.5
	All	20.5	50.1	25.3	3.5	0.5

Table A3: Main material of the wall of the house

District	Sex	Bricks wall	Concrete brick walls	Iron sheet walls	Grass walls	Reed walls	Mud walls	Wood walls
Chingola (n=343)	Female	79.7	12.7	0.5	-	-	7.1	-
	Male	71.9	21.9	2.7	0.7	-	2.7	-
	All	76.4	16.6	1.5	0.3	-	5.2	-
Kalomo (n=340)	Female	65.7	15.7	0.5	0.5	-	17.6	-
	Male	73.5	15.4	-	-	-	11.0	-
	All	68.8	15.6	0.3	0.3	-	15.0	-
Monze (n=350)	Female	62.3	16.7	-	-	-	20.9	-
	Male	61.5	18.5	-	0.7	0.7	18.5	-
	All	62.0	17.4	-	0.3	0.3	20.0	-
Mpika (n=348)	Female	74.4	18.7	0.5	-	-	6.4	-
	Male	76.6	17.2	0.7	-	-	4.8	0.7
	All	75.3	18.1	0.6	-	-	5.7	0.3
Mumbwa (n=334)	Female	32.3	35.4	-	-	-	31.3	1.0
	Male	41.7	22.3	-	-	0.7	35.3	-
	All	36.2	29.9	-	-	0.3	32.9	0.6
Nyimba (n=336)	Female	52.4	22.2	-	-	-	25.4	-
	Male	57.0	20.5	-	-	-	21.9	0.7
	All	54.5	21.4	-	-	-	23.8	0.3
Total (n=2,051)	Female	61.4	20.1	0.3	0.1	-	18.0	0.2
	Male	63.7	19.4	0.6	0.2	0.2	15.6	0.2
	All	62.4	19.8	0.4	0.1	0.1	17.0	0.2

Table A4: Main roofing material of household

District	Sex	Tile	Asbestos	Corrugated iron	Grass	Reed
Chingola (n=339)	Female	1.53	67.86	29.59	1.02	-
	Male	4.20	51.75	43.36	0.70	-
	All	2.65	61.06	35.40	0.88	-
Kalomo (n=340)	Female	-	6.37	70.10	23.53	-
	Male	-	5.88	76.47	17.65	-
	All	-	6.18	72.65	21.18	-
Monze (n=350)	Female	0.47	8.84	67.91	22.79	-
	Male	-	7.41	66.67	25.93	-
	All	0.29	8.29	67.43	24.00	-
Mpika (n=347)	Female	0.50	20.79	70.30	8.42	-
	Male	-	9.66	84.14	6.21	-
	All	0.29	16.14	76.08	7.49	-
Mumbwa (n=334)	Female	-	14.87	55.38	29.74	-
	Male	1.44	11.51	54.68	30.94	1.44

	All	0.60	13.47	55.09	30.24	0.60
Nyimba (n=336)	Female	-	7.03	68.65	24.32	-
	Male	-	7.95	70.86	21.19	-
	All	-	7.44	69.64	22.92	-
Total (n=2046)	Female	0.42	20.80	60.48	18.30	-
	Male	0.94	15.78	66.08	16.96	0.24
	All	0.64	18.72	62.81	17.74	0.10

Table A5: Assets owned by household (N=1993)

	Chingola (n=330)			Kalomo (n=329)			Monze (n=336)			Mpika (n=336)			Mumbwa (n=330)			Nyimba (n=332)		
	F	M	All	F	M	All	F	M	All	F	M	All	F	M	All	F	M	All
Radio	18	19	18	19	18	19	21	18	19	19	24	21	20	19	20	18	19	18
Television	18	16	17	15	13	14	10	10	10	17	16	16	11	10	10	11	10	11
Bicycle	5	6	5	13	12	12	13	15	14	7	8	8	13	14	14	12	15	13
Motorcycle	0	0	0	2	2	2	2	1	1	0	-	0	1	2	1	2	1	1
Sewing machine	2	1	2	2	2	2	1	1	1	1	1	1	1	1	1	1	1	1
Mobile/ telephone	17	18	18	23	19	21	22	19	21	22	22	22	18	15	17	18	16	17
Car/truck	5	5	5	2	2	2	2	3	2	4	3	3	2	2	2	2	3	2
Refrigerator	14	13	14	4	6	5	4	4	4	12	10	11	3	4	4	6	5	6
Poultry	2	2	2	4	5	4	6	7	7	3	4	3	9	9	9	9	7	8
Livestock	0	1	1	3	5	4	6	6	6	1	1	1	7	7	7	6	6	6
Wheelbarrow	4	4	4	4	4	4	3	4	4	3	3	3	4	4	4	3	3	3
Stove	15	15	15	5	4	5	3	4	3	11	9	10	5	5	5	8	7	8
Ox plough				3	4	4	5	6	6	0	-	0	3	3	3	3	4	3
Oxen/donkey-drawn cart				1	3	2	2	2	2	0	-	0	2	4	3	1	2	2

Annex 3: Study locations in each district

DISTRICT	WARD NAME	CSA NO.	CLUSTER NUMBER	AREA SETUP
MONZE	MANUNGU	03	808128101032	URBAN
	MONZE URBAN	01	808128182011	URBAN
	CHOONGO EAST	04	808127071043	RURAL
	CHOONGO EAST	07	808127071072	RURAL
KALOMO	CHOONGA 1	10	804120092061	URBAN
	CHOONGA 2	06	804120092104	URBAN
	MAYOBA	02	804120101021	RURAL
	NAMWIANGA	06	804120111061	RURAL
NYIMBA	NYIMBA A	02	307052072011	URBAN
	NYIMBA B	04	307052072042	URBAN
	LWEZI	01	307052051011	RURAL
	KALIWE	01	307052072011	URBAN
MUMBWA	MUPONA 1	04	105010062041	URBAN
	MUPONA 2	11	105010062113	URBAN
	MUMBA 1	10	105010051102	RURAL
	MUMBA 2	05	105010051052	RURAL
CHINGOLA	CHIKOLA	03	202016212042	URBAN
	CHIKOLA	01	202016202012	URBAN
	MUSENGA	01	202016111013	RURAL
	LULAMBA	05	202016141051	RURAL
MPIKA	MUSAKANYA	02	603100132031	URBAN
	MUSAKANYA	16	608100132171	URBAN
	CHIMBWA	01	608100111072	RURAL
	LWITIKILA	07	608100121073	RURAL

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