Mid Term Review

Gender Based Violence Prevention and Response Project UNFPA and Swiss Agency for Development and Cooperation

Paro Chaujar, 13 April 2018

ABSTRACT

This is a report of the Mid Term Review conducted by a team of external consultants appointed by SDC to review progress of its UNFPA implemented project on GBV and to provide recommendations for way forward in the context of the new federal structure in Nepal. The team of consultants includes: Mr. Krishna Prasad Sapkota, Ms. Indu Tuladhar and Ms. Paro Chaujar (Team Leader)

Table of Contents

Acronyms

APEIRON	Alleviate Poverty Empowering Women in Rural Areas of Nepal
CBO	Community Based Organization
CDO	Chief District Officer
CMC-Nepal	Centre for Mental Health and Counselling Nepal
CMO	Community Mobilization Officer
CPSW	Community-based Psychosocial Workers
DDC	District Development Committee
DWC	Department of Women and Children
DFID	Department for International Development UK
DHO	District Health Office
FCHVs	Female Community Health Volunteers
FGD	Focus Group Discussion
GBV	Gender-Based Violence
GEEGBVDCC	Gender Equality, Ending Gender Based Violence District Coordination Committee
GG	Girls Group
GoN	Government of Nepal
IP	Implementing Partners
MoHP	Ministry of Health and Population
MoWCSW	Ministry of Women, Children and Social Welfare
MTR	Mid-Term Review
NGO	Non-Government Organization
OCMC	One-Stop Crisis Management Centres
OPD	Out-Patient Department
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Development Goals
SFSP	Social Financial Skills Package
ToR	Terms of Reference
ToT	Training of Trainers
UNFPA	United Nations Population Fund
WC	Women's Cooperative
WCO	Women and Children's Office

Executive Summary

All women and girls have the right to live a life of dignity, free from discrimination and violence. It is for this vision that the United Nations and governments across the world have committed to achieving gender equality and empowering all women and girls (UN SDG 5). A broad agreement has been reached in terms of what it takes to end all forms of discrimination and violence against women—more vigorous efforts, including legal frameworks, to counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms.

Ending violence against women requires effective and coordinated efforts for both prevention and response. This has been the conceptual framework applied by UNFPA and Swiss Agency for Development and Cooperation (SDC) in designing the Gender Based Violence Prevention and Response project (GBV project) in Nepal 2016-2018. The project is implemented in three districts—Okhaldhunga, Udayapura (Province 1) and Sindhuli (Province 2).

The overall goal of the GBV project is to reduce the prevalence of GBV through the effective empowerment of women and men and through prevention and response interventions by more responsible and capable government agencies. The expected outcomes of the project were designed for results expected at the level of rights holders—Outcome 1: Men and women in working districts increasingly prevent, report and address gender-based violence; and at the level of duty bearers—Outcome 2: Duty bearers respond effectively to gender-based violence in the working districts and increasingly at national level. A team of 5 NGOs and 2 INGOs were contracted for implementation of the various elements of the project in the three project districts.

A mid-term review of this project was commissioned to assess progress of the project so far, and make recommendations for the way forward, particularly in the context of changed structure of governance in Nepal and its implication on the project.

This is the most exciting and dynamic phase of the project when after initial delays and hiccups caused by changing governance structures in Nepal, the project interventions have caught speed and initial results are able to indicate which innovations are promising and those that need to be modified. The mid term review has concluded that the project remains relevant in the context of new structure of governance and there is need to modify its target groups to include the local governments. Gains made under the project in the area of strengthened response mechanisms can immediately be linked with the local government structures and institutionalized through effective evidence-based advocacy. There will be need for continuous support to local governments as they adopt and institutionalize the response mechanism demonstrated effectively in this project.

In the medium and long term, the project will need to expand its scope from exclusive focus on GBV to broader goals of gender equality and women's empowerment, not only because it is a more effective strategy to achieve results envisaged in the project but also because in the new set up of local governments, gender issues are being looked at as part of an entire social sector and there is greater potential to integrate gender equality and women's empowerment agenda across the social sectors. This is different from the previous centralized approach where it was extremely challenging to design and implement integrated projects with different central ministries that tended to work in silos.

While the project has made significant gains in strengthening capacities of duty bearers and is making good progress towards an effective and efficient response

mechanism, there are gaps in the achievement of results in the area of prevention and those will need to be addressed going forward. Project management and monitoring, which have also recently become more diligent with hiring of more competent staff, will also need to be strengthened for more effective and efficient results.

Relevance

The GBV project continues to be relevant to the needs and priorities of the intended beneficiaries. FGDs with women, girls and men confirmed that project interventions on prevention and response work are relevant and critical for them. The project has also demonstrated its relevance and usefulness for service providers—hospital staff (Doctors, Nurses) shared that the training have been useful for them since they are now able to identify and refer cases of GBV from their OPD. Case managers, counselors at OCMC as well as the CPSWs reported that the training and mentoring was relevant to their work and helped them understand and carry out their roles and responsibilities. Police reported that their attitude towards women survivors has changed—they have become more "civil" in their response to women survivors and know about and are able to refer survivors to OCMC. The project has created a demand for interventions for prevention and response among community members, and service providers alike, as demonstrated by the increase in number of women seeking services and support.

Relevance of both outcomes and most outputs remains critical but interventions on prevention need to be made more relevant to behaviour change learning needs of the communities and outcomes related to service providers need to be re-targeted to include local government and its structures. Specific concerns are: Output 1.1 that deals with enabling Women's Cooperatives to establish women's and girls CBOs to address GBV will need to be revised, since Women's Cooperatives are unlikely to remain the fulcrum of local government's interventions on gender and GBV, other CBOs such as the *tola sudhar samiti* may become more relevant. Output 1.2 on engaging men and boys was and continues to be relevant but is under represented in the project.

The most befitting component of the project includes the appointment and mentoring of trained community based psychosocial workers in the communities, and case managers and outreach counselors in the hospitals in the districts. The least appropriate interventions have been those with couples and with members of the women's cooperatives. The inappropriateness stems from the lack of clarity on their roles and in the design and execution of interventions to mobilise them as change agents. Training content has not been developed based on needs assessment and selection of trainers has not been prudent but more driven by convenience and miscalculated assumptions (that women's cooperatives are the most sustainable CBO to work with and that husbands of members of GBV watch groups/other men will be available and will come forward for couple's trainings that address their marital conflict).

Some issues that are relevant but missed in the project design are those related to (i) the prevalence of alcohol use and its link with (increased propensity) for violent behaviours. The beneficiaries, including men have repeatedly raised the issue of alcohol abuse and the need for interventions to address this. Similarly, women beneficiaries across the districts and service providers have repeatedly stressed on the need for interventions for improved financial autonomy of women to enable them find alternatives to dependence on husband/in-laws that prevents them from resisting, negotiating or opting out from abusive relationships. Lastly, and this has been a shortcoming of service centres across Nepal, often survivors have dependent children

and the inability of service centres to host women along with their dependent children is a deterrent to accessing services of the centres (except in Kathmandu centre).

Finally, *in order for the project to continue to be relevant to the governance structure* in Nepal, local governments and its bodies need to be included as target groups under the project. The elected representatives, including mayors, deputy mayors, and council/ village assembly need to be included in capacity strengthening interventions, both for building perspectives as well as in actual support to them for carrying out their roles and responsibilities and building leadership among women representatives.

Effectiveness

The review has been held at 24 months of the 36-month project but most interventions have only completed 3-14 months. Expectedly then, at mid term, monitoring data collected by UNFPA indicates that partial set of results, mainly at the completion of activities (input) or at best output levels, appear to be on track for achievement.

The main gain made in the project is that gender-based violence is no longer as closeted as before; survivors are aware that they can report and that they have a trained psychosocial worker who listens to them; and more experienced case managers who can help them heal and assess their options. Service providers are gradually becoming sensitive (police, hospital/health post staff), and there is improved coordination between different referral points.

An assessment of the likelihood of achievement of planned results indicates that outcome (1) related to increased actions by women and men to prevent, report and address GBV is set for partial achievement. While seeking help has increased because of improved outreach, the project needs to adjust its strategies for empowering men and women to be able to critically examine and challenge social norms and change their behaviours. Interventions with boys have not yet been initiated and the pilot of interventions with men through couples training has not yielded desired results. Men who have received training have not acknowledged their role as perpetrators but have embraced the idea of them being equally "victims" in marital discords ("my wife was constantly grumpy, unhappy and angry and after the training she has calmed down and therefore I do not get aggressive with her"). The curriculum and method for working with men to help them critically reflect on toxic male behaviours as an offshoot of patriarchy need to be revised to address more resilient forms of patriarchy (expectations of normative female behaviour for instance).

Outcome 2 on the other hand (related to strengthened response mechanism) has highest likelihood of being achieved with sustained inputs and handholding as well as advocacy with MoHP as well as local governments to adopt the most effective components within their institutional mechanisms (the CPSW and Case Managers).

An assessment of the quality of outputs indicates a mixed bag of good quality, not satisfactory and satisfactory quality across outputs. *Outputs that may be rated as "good quality"* are those related to provision of adequate medical and psychosocial services by trained personnel in hospitals and communities (Output 2.3). Where sustained training and mentoring is provided to actors selected on the basis of their job description, ability and motivation, actors are able to deliver more effectively on their results (for instance CPSW, Case Managers). The outputs that have "satisfactory quality" are the ones related to establishment of functioning service centres (Output 2.2)—where previously there were no provisions of safe homes for women, safe homes have been established and trained staff have been appointed. There are concerns about the service centres not able to host dependent children and address

the need for financial empowerment of women that keeps it from achieving "good quality" status.

The outputs with less than satisfying results are those related to engaging men and boys, Output 1.2 (for reasons shared earlier) and outputs are those related to building capacities of WCO, police, lawyers (Output 2.1) and building capacities of women's cooperatives are also partially satisfactory. While there may be some staff of WCO and members of women's cooperatives who have demonstrated leadership and mobilized communities successfully, these are exceptions. Project interventions with these institutions have not been successful because of miscalculated design. Modalities of behaviour change and empowerment through short duration trainings have not worked well. A lesson emerging from the project is that selection of candidates for social change needs to be carefully based on their capabilities, motivation and potential for being change agents (older couples for instance have not turned out to be most suitable agents of change); trainings need to be preceded by a training needs assessment (ToT of Women's Cooperatives and training of couples, for instance. Curriculum followed in information sessions with women members of cooperatives for instance, is limited to providing information on types of violence, reproductive health and not so much to develop critical reflection on social norms and how to challenge and change them, as well as how to influence others to do the same (ToT).

Efficiency

It is too early to make an assessment of cost efficiency but one can look at the *comparative investment in different elements* and the results that are emerging. Assessment of budget allocation indicates that significantly higher investments have been made for components related to response than for prevention. Over 60 per cent of budget allocated to implementing partners was allocated for interventions to strengthen response. While it could well be that some interventions cost more than others, it may be worth reviewing the allocation for intended/unintended bias or presumption about the comparative investment for the two components. Lower allocation for prevention work and poorer results in outcomes related to prevention may be correlated.

The project has been affected by delays at two points in its implementation. One at the very beginning of the project where staff were only hired by the 6th months and implementing organizations by the 8th and 9th months. These are attributable to internal systems and processes of UNFPA for recruitment of staff and for contracting NGO partners, which ideally should have been built into the project design and timeline and budget. The other set of delays was caused due to the federalization process (elections) and subsequent lack of clarity on flow of funds from aid agencies to different levels of government. UNFPA did find an alternative—channeling funds through NGO implementing partners but again the internal process of formalizing this arrangement took long and there was cascading delay in implementation of project activities since NGOs also received their funds for quarter 3 and 4 towards the end of the year. UNFPA is confident to make up for this delay and the resultant under-spending of 45 per cent with a 6-month no-cost extension of the project.

This is a complex project in terms of its implementation structure—several agencies have been hired for different elements that are implemented in the same communities or settings. And there seem to be some tension between partners on perspectives being communicated in the communities and with the different actors. It is to be expected that different agencies may have different perspectives on GBV and how best to address it. But for the sake of a common project with common results and a common set of beneficiaries, it is important that a common perspective on GBV is defined and messages delivered to communities and actors are consistent. A very

simplistic kind of tension that is apparent is between what is considered a "confrontationist" or "radical" approach vs. a "reconciliatory" approach in the case of domestic violence, for instance. While UNFPA is aware of these differences, the impact of such difference in approach on beneficiaries and project outcomes has not been sufficiently understood and addressed.

Part of this disagreement could be resolved through mechanisms for collaboration and partnership between different partners that UNFPA will need to facilitate. Knowledge products developed in the project (various curriculum, for instance) will need to be consistent and mechanisms for exploring linkages, harmonizing messaging and bringing different elements together need to be developed. Otherwise the project is at risk of delivering outputs in silos by sub-contracted vendors. At the district level as well, in the absence of clearly defined structures and mechanisms for ensuring collaboration and synergy, depending on initiative and experience of individual staff, there is more collaboration in some places (Okhaldhunga) than others (Udayapura). However, district level collaboration by implementing staff has little meaning when there is lack of collaboration and consistency in design and execution at the level of decision-makers.

There are indications that project team are not receiving the kind of leadership, guidance and encouragement that is required for fulfilling their roles. An extreme example is where staff have reported that they are prevented from carrying out monitoring visits in the field, which has serious implications for management of a multi-partner project and facilitation of synergy between multiple components.

What's working: Strategies on response mechanism

- ✓ Strategies to improve and strengthen response mechanism have worked.
- ✓ Providing community based psychosocial workers who are available in the community and who focus on "listening" and provide the first source of support to survivors in a confidential and non-threatening manner has been successful. They have also successfully linked communities with service providers, particularly trained case managers at OCMCs.
- ✓ Providing trained case managers in hospitals and training hospital staff (Doctors and Nurse) on GBV has helped increase identification of cases, referrals and in provision of appropriate and trained response to survivors.
- ✓ Home visits by Case Managers and Outreach Counselors have been crucial for improving women's access to OCMC services, especially given that women affected by violence rarely visit facilities as a first step.
- ✓ Where UNFPA field staff (CMO) are motivated and have training and experience in working on GBV, effectiveness and efficiency of project interventions is better than where the staff is not trained and experienced.
- ✓ Engaging girls with sustained inputs over a period of a year has helped in their own personal development and strengthened their ability to negotiate for their rights within their homes.

What is not working: Strategies on prevention

- ☒ Strategies for engaging men to prevent and address gender-based violence are not working and strategy for engaging boys is yet to be developed. Strategies for empowering women through ToT of representatives of women's cooperatives has not worked, the training content and duration has been insufficient to develop their

critical understanding and ability to transfer this knowledge and inspire behaviour change in others.

☒ Making women's cooperatives the fulcrum of the project. While it is understandable and desirable that the project works with the WC in order to be aligned with the GoN structures for women's empowerment, limiting outreach for social mobilization through them has not worked. Primarily concerned with savings and credit, the outreach of WC is limited to women from their own ethnic backgrounds (relatively homogenous group) and they have been unable to move beyond their traditional role of recruiting for, and managing savings and credit group.

☒ In the absence of a clear perspective on gender-based discrimination and GBV as offshoots of patriarchal ideology, implementers such as CPSW or trainers of couples (or others in the community) are at risk of conveying unclear messages including those that suggest a tolerance of male toxic behaviours.

☒ Infrequent monitoring and monitoring systems that lack a results framework and mechanisms for generating lessons and feeding them into the project affect program quality and efficiency.

Recommendations

Efforts for both, prevention and response are critical in achieving the vision of all women and girls living a life of dignity, free from discrimination and violence. And the efforts need to be comprehensive. Improving information on sexual and reproductive health rights alone will not prevent violence against women and behaviour change elements focused on women and not including men will not go far in ending abusive behaviours of men. It is also important to recognize the link between prevention and response—multisectoral services (medical and psychosocial support) can help both survivors and perpetrators of GBV to avoid repeat incidence of violence.

The MTR team recommends that project for prevention and response on GBV must be continued in Nepal and particularly as local governments take on the role of to prevent and respond effectively to GBV, such a project must be continued with strengthened strategies. The project needs to make some modifications for the remaining period of the current project period and the second phase of this project needs to be re-designed based on lessons learnt from the current phase, specifically in terms of focus on prevention work.

<u>To improve program effectiveness</u>

Within current phase:

i. A common perspective building exercise needs to be undertaken as a first step and the project design and execution reviewed as a program of interconnected and interdependent elements that have a common perspective, language and objective.
ii. Review all trainings under the project for the appropriateness and sufficiency of their training materials to address gender-based violence. All knowledge products need to be reviewed collectively and a common set of products needs to be owned, implemented, monitored and fed back into the project (continuous monitoring of what's working, what's not).
iii. Develop a strategy for prevention that includes engaging women and girls, men and boys (including youth aged 16-24) in critical reflection of social norms and how to challenge and change them.

iv. Mentoring and interventions on capacity development at health centres in communities needs to be strengthened. Female Community Health Volunteers are closely linked with these health centres and need to be included in the project as a target for improved outreach.

For the next phase:

v. Expand focus of project to address women's empowerment in general, specifically developing leadership among women and developing their financial autonomy. While UNFPA may be able to address the former with current set of partners, the latter may require brining in other partners or linking beneficiaries of the project with other initiatives that work on financial autonomy.

For improved management and monitoring of the project

i. UNFPA to develop mechanism for ensuring collaboration, consistency and synergy across different project components and partners. Clear strategy and mechanism for collaboration between different partners need to be developed at the central level as well as at the level of implementation. A mechanism such as project advisory committee comprising senior representatives of all implementing partners could be established for more meaningful partnership for the project (and not just contractual relationship between UNFPA and individual partners).
ii. Develop a robust results-based monitoring framework that enhances learning and feedback. Improve data management, providing consistent templates for reporting at all levels. Establish clear guidelines for frequency and objectives of monitoring by project staff that are aligned with results framework
iii. Review project organogram and ensure appropriate leadership and guidance is provided and roles and responsibilities are clearly communicated to all staff with clear lines of reporting. Organize training for staff on GBV and skills that they may need in carrying out their roles. UNFPA will need to build its own capacities and capacities of partners to work with the local government, while ensuring that these team members are also either experienced in, or provided with training, on gender, GBV, etc.

For working with local governments

Within current phase:

i. UNFPA could make representations to all municipalities in the project, and orient them on gender inequality, women's empowerment and GBV and support development of their plans for fiscal year 2018-2019. Build common perspective and messaging on work GBV before orienting local governments.

ii. Advocate for integration of specific components in the municipalities' plans for the upcoming fiscal year—specifically the CPSW and OCMC. Offer to match funds for CPSW and maintain funding of Case Managers until MoHP is able to finance. The policy brief on "importance of and best approaches to mainstream psychosocial support in the multisectoral response and prevention of GBV" could be developed specifically for this purpose. Success of this initiative will help achieve the result expected under this output and indeed for the outcome, and pave way for the next phase of deepened engagement with the local governments.

For the next phase:

iii. Engage with and support municipalities in developing a comprehensive program on prevention and response on GBV. A capacity needs assessment of the municipalities will be required and capacity development interventions designed accordingly. Municipalities' capacity development needs are not restricted to GBV or gender and they may need support more broadly on organization development, planning and managing their work. They are required to develop their own laws, policies, standards, regulations and indicators. The social development section of local government needs to be equipped with situation analysis and supported to manage and use data to plan their interventions.

1. Introduction

1.1. This is an external review of the Gender-based Violence Prevention and Response Project 2016-2018, (GBV project), funded by the Swiss Agency for Development and Cooperation (SDC) and implemented by UNFPA in Nepal.

The review was scheduled at the beginning of the third and final year of this project, specifically in the context of assessing adaptability of the project with the new federal structure adopted by Nepal while the project had just completed 18 months. The purpose of the review is to make an overall assessment of the achievements by the GBV project with a special focus on its processes, outputs and outcomes, and to make recommendations for the design of the next phase of the project. The review had the following objectives:

A. Evaluate the relevance, effectiveness and efficiency of the project and identify the main lessons learnt and best practices.
B. Propose major elements of a relevant project design for the new federal structures, which creates meaningful linkages to other projects of UNFPA and SDC.

Terms of Reference for the review are attached as Annex 1.

This chapter provides an overview of the project design.

1.2 Current phase of the project runs from February 2016 to December 2018 and it is being implemented in 3 locations that previously were categorized as districts: Udayapura, Okhaldhunga and Sindhuli. With Nepal adopting a federal structure for governance in July 2017, project location now falls under 17 municipalities of 2 states: Province 1 (including municipalities from Udayapura and Okhaldhunga) and Province 3 (including municipalities from Sindhuli). The total budget for the 3-year project is $ 2,961,015

1.3 The **overall goal** of the GBV project is to reduce the prevalence of GBV through the effective empowerment of women and men and through prevention and response interventions by more responsible and capable government agencies. The expected outcomes of the project were designed for results expected at the level of rights holders (Outcome 1) and at the level of duty bearers (Outcome 2):

Outcome 1: Men and women in working districts increasingly prevent, report and address Gender-based Violence
Outcome 2: Duty bearers respond effectively to gender-based violence in the working districts and increasingly at national level

1.4 The project design aligned itself with the **legal and policy framework on GBV** in Nepal and sought to strengthen the existing structures that were vested with the responsibility for addressing GBV, namely the Ministry of Women, Children and Social Welfare and the Ministry of Health and their line agencies at the local levels (then, districts): Women and Children Offices in districts and Women's Cooperatives established and supported by them in the villages, as well as, hospitals and health centres in districts with specific focus on setting up and supporting One Stop Crisis Management Centres in hospitals and an outreach mechanism for the same.

1.5 The project design sought to address the following **gaps** that were identified in the area of prevention and response for reducing GBV:

- The capacity of Women and Children Offices (at the districts) is not adequate to meet the demands of their mandate
- Very few Women's Cooperatives have GBV Watch groups
- Men are not sufficiently engaged
- Limited psychosocial support is available for survivors of GBV
- Inadequate (response) Services for GBV survivors [in the 3 selected districts there were no One Stop Crisis Management Centres for survivors of violence nor service centres (shelter homes)]
- Police and lawyers are not gender sensitive to provide effective service to GBV survivors
- Coordination in districts is weak and limited resources are under-utilized
- Lack of awareness among women and girls on women's rights
- Weak implementation of laws and policies

1.6 **Intervention strategies** adopted for addressing the gaps and meeting the results were as follows:

a) At the *micro level,* support women's cooperatives (WCs) in villages in order to establish functioning GBV watch groups and adolescent girls groups (as per national guidelines) and men's networks. In addition to strengthening WC for the above, the project planned to conduct trainings for couples, to engage husbands of members of GBV watch groups. Systematic multi media campaigns focusing on the role of men in fighting GBV were also planned.
b) At the *meso level*, professionalize the services for GBV survivors in the districts, including services by hospitals/OCMC, shelters, police and for legal aid. Referral from individual level to household to service providers along continuum of referral to district and national levels were planned to be strengthened. A key addition to existing services were to be introduced- counselors for outreach services would be appointed at OCMC, initially to be paid for by the project, and subsequently through advocacy by UNFPA, included as regular hospital staff (in line with National Health Sector Program 2015-2020).
c) At the *macro level*, evidence-based advocacy in relation to psychosocial care with the MoHP and in relation to lessons learnt about the different approaches for GBV prevention with the Department of Women and Children (DWC). An action research was planned to assess what interventions work.

1.7 The project design acknowledged possible implications of upcoming decision on **federal structure** on the project strategies, specifically, the possibility of WCO being dissolved. It was assumed the Women's Cooperatives and their GBV watch groups in the communities as well as Service Centers, hospitals and police will continue to function under transition as well as under new structure and hence focus on strengthening these was underlined. The project document was explicit in evolving the project as and when the new structure gets implemented, in particular to contribute to the capacity building and strengthening of the new structures that emerge.

1.8 The project aimed to **directly benefit**
a) Approx. 1000 GBV survivors through comprehensive, functioning services
b) Approx. 18,500 community members (17,000 women/girls and 1,500 men/boys) trained and actively fighting against GBV

c) Approx.120,000 households directly engaged with by trained community members

Secondary beneficiaries of the project:

a) 350 health staff; 300 police staff; 200 VDC secretaries and staff of DDC and 45 WCO staff.

1.9 The project was designed along the following **theory of change** (see picture below):

When women reflect on gender norms, they have an improved understanding of their rights and begin to report instances of violence to and invite the support of groups, service providers or local authorities, leading to surge in reported cases as violence becomes less acceptable socially;

And,

When men reflect on gender norms, their own behavior towards women changes and they actively discourage violence against women;

And

When service providers including hospitals and OCMCs, police, women and children's office and coordination mechanism for services and referrals are strengthened, women survivors receive better quality services and there is prompt action against perpetrators

Then, incidence of violence reduces.

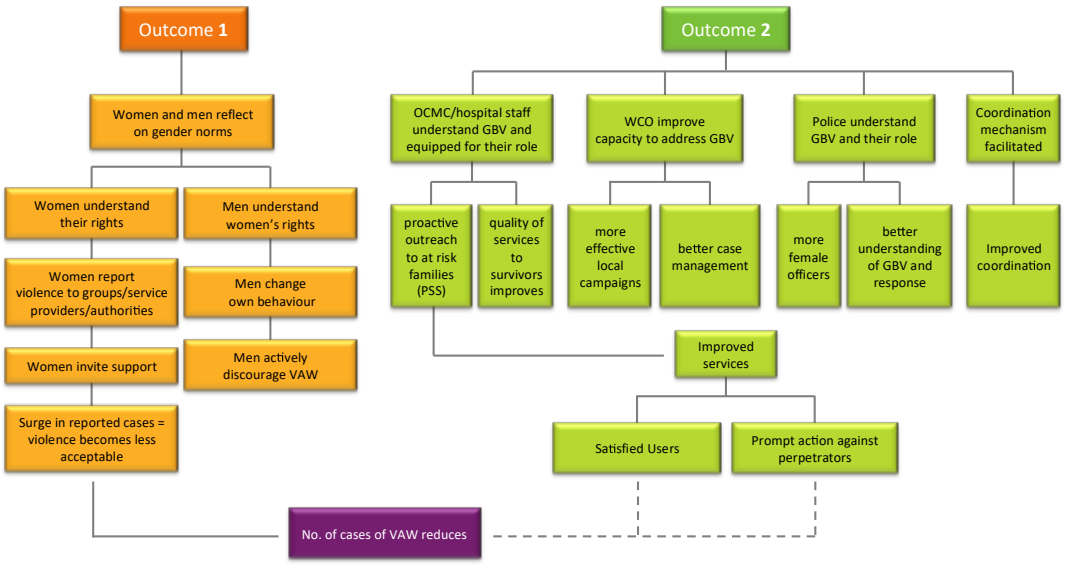
1.10 UNFPA partnered with 7 NGOs (2 of which are international NGOs) to implement the various elements of the project. 3 of these were already partners of UNFPA under other projects (WOREC, Restless Development and JHPIEGO) and the remaining were selected through a bidding process. Existing training manuals developed by the Government of Nepal were used in some of the capacity building interventions while new modules were developed for other interventions:

Intervention	Partner organization	Training materials
1. Strengthening capacities of WCO and WC as trainers to improve understanding, awareness and action by women and men in communities	WOREC (since October 2016)	*Sanjivani* module of the GoN for Women's Cooperatives
2. Strengthening capacities of girls groups to improve understanding and action by girls	Restless Development (since October 2016)	*Rupantaran* module of the GoN for adolescent girls
3. a. Training couples to improve understand and action by men b. Training Community Psychosocial Workers c. Training Case Managers and Counselors of OCMC	CMC-Nepal (since August 2016)	New manuals were developed New manuals were developed New manuals were developed
4. Training of staff of hospitals, health centres	JHPEIGO (since September 2016)	Existing manuals of JHPIEGO

5. Establishment and running of shelter services, training and mentoring staff of shelters	APEIRON (since January 2017)	Existing manuals of APEIRON
6. Mass media programs: Radio, TV, web series, edutainment *mela*, BCC materials	Sancharika Samuha (since September 2017)	N/A
7. Action research on what's working, what's not	CREHPA (since September 2017)	N/A

In order to increase the level of engagement and ownership from the government, some funds for logistics, coordination and monitoring were provisioned with WCO and funds related to OCMC with the DDC. Until June 2017, DWC and WCO were engaged in managing funds for safe houses by the women's cooperatives, for organizing girls groups (logistics and mobilization for training, and provision of seed grants) and for monitoring implementation of the project. The DDC was channeling funds for OCMC to the hospitals. After Nepal adopted the new federal structure, agreements with DWC were put on hold and WCO's role in the project was transferred to WOREC for Udayapura and Sindhuli and to CMC-Nepal for Okhaldhunga. Funds that previously flowed to and for activities of women's cooperatives and girls' groups were channeled through these two NGOs under the new arrangement. Funds for OCMC were also routed through implementing partners.

The **theory of change** of the project design may be depicted as follows:



2. Process of MTR

The Mid Term Review was initially conceptualized as an evaluation of the project. Given that there have been several delays in the implementation of this project and most activities have barely completed a year since they were initiated, this exercised was reframed as a mid-term review. As such, this is not an end of project or end of phase evaluation but more of an assessment at mid term to check the course of project with a specific purpose of exploring pathways for next phase given the changed context of governance in Nepal.

The assessment of results in the absence of an end line means that conclusive assessment of achievement of results cannot be made, rather an assessment of whether project is moving towards the results has been done. This assessment is based on feedback from the various partners and stakeholders as well as through impressions gathered from on-site visits. Data where collected by the various partners/stakeholders and shared with consultants has been used.

The MTR was conducted between February and March 2018 by a team of three consultants: Paro Chaujar (Team Leader), Indu Tuladhar (Nepal expert on policy and legal framework) and Krishna Prasad Sapkota (ex-Parliamentarian of Nepal and expert on local governance). Apart from consultations in Kathmandu, the team travelled to 2 of the 3 project districts—Okhaldhunga and Udayapura.

The MTR involved[1]: (i) desk review of project documents, annual reports, work plans of implementing partners and existing monitoring reports; (ii) consultations with primary project holder—UNFPA, its senior leadership and project team at the central office and in two districts where field visits were made—; (iii) consultations with all I/NGO implementing partners of UNFPA; (iv) consultations with representatives of MoHP and DWC; (v) consultations with teams of other organizations that are working on GBV, including UNICEF, CARE-Nepal and Asia Foundation. (vi) Consultations/ focused group discussions with members of women's cooperatives; GBV watch groups; girls group; couples who have received training; CPSW; OCMC Case Managers and Counselors; staff of district hospitals and health centres; district coordination committee on GBV (Okhaldhunga only) and police officers (vii) Consultations with elected representatives of wards and municipalities, members of judicial committee, chief administrative officers. The MTR team decided not to interview women survivors as beneficiaries also some women beneficiaries may have been part of consultations in groups.

Initial findings of the MTR after completion of all consultations and field visits were presented to UNFPA and SDC.

[1] See Annex 2 a and b for detailed list of consultations held for MTR

3. Findings

3.1. Relevance

- Project is relevant to the context of GBV in Nepal: GBV is highly prevalent in the country and the focused districts of this project
- Project is relevant to the Government of Nepal, the provisions in Constitution of Nepal, legislation and national plan of action on GBV
- National reports have recommended comprehensive and systematic intervention on prevention and response
- Prevention and response, both are identified as priorities by beneficiaries
- The GBV project has created a demand for interventions for prevention and response among community members and service providers alike.
- Beneficiaries (women and girls) report that they appreciate the information received on GBV but it needs to be shared with men and boys and with all members of the communities (not just targeted groups under this project)
- Beneficiaries also report that sustained inputs are needed for changing behaviour and that 2-5 days "trainings" are not sufficient
- Project was designed to match the pre-federal structure and needs to be re-aligned to match the new federal structure: strategies for working with municipalities

3.1.1. Relevance to the needs and priorities of the intended beneficiaries

Prevention and response interventions on GBV continue to be relevant to the needs and priorities of the intended beneficiaries—survivors, women, girls, men and boys in the community. Although the MTR team did not interview survivors, FGDs with women, girls and men (as part of FGD with couples) as well as interviews and consultations with service providers along the continuum of referral, from CPSW to health posts, hospitals, police, and OCMC staff—all **confirmed that the need to work on prevention and response for intended beneficiaries are relevant and critical**. Both men and women, and girls have reiterated the need for interventions with men and boys and with broader members of the communities (rather than limited to members of the women's cooperatives).

In addition to being relevant to the intended beneficiaries, **the project has demonstrated its relevance and usefulness for service providers.** Representatives of police staff who received training under the project, as well as hospital staff (Doctors, Nurses) shared that the training have been useful for them since they are now able to identify and refer cases of GBV from their OPD. Case managers, counselors at OCMC as well as the CPSWs reported that the training and mentoring was relevant to their work and helped them understand and carry out their roles and responsibilities.

The action research report and reports from NGO implementing partners confirm the relevance of the project for beneficiaries. In fact **this project has created a demand for interventions for prevention and response among community members and service providers alike as demonstrated by the increase in number of women seeking services and support.**

3.1.2. Relevance of outcomes and outputs as specified in the ProDoc

The outcomes and outputs of the project continue to remain relevant, except for Output 1.1, which focuses on training women's cooperatives. For the rest, some need to be modified to include new targets in light of the new local government structure. Output related to development of critical understanding of discrimination and violence in prevalent social norms among women and men, girls and boys needs to be introduced in the project.

Results	Relevance
Outcome 1 (rights holders): Men and women in working districts increasingly prevent, report and address gender-based violence	Relevance continues, significant increase in reporting and referral; prevention work needs to be focused more
Output 1.1: Women Cooperatives[2] (WC) have established functioning GBV watch groups and adolescent girls groups to address gender-based violence	• Relevance of WC is likely diminished in the new local government structure • Scope of work of GBV WG is changed in the context of CPSW and perhaps in context of new local governments • Girls Group remains relevant, not necessarily through mentoring by WC, rather through CPSW • WC does not seem to be the most fit CBO for influencing social change • The assumption of ToT with WC needs to be re-examined
Output 1.2. Men and boys have the capacity to engage in the prevention of and response to gender-based violence	Continues to be relevant but project interventions have not included boys and miscalculated strategy for including men (through couples training)
Output 1.3. CSOs, media and research organizations engaged in evidence based advocacy for an improved response to GBV by GoN actors at district and national level	Continues to be relevant. Is very recently introduced. To remain relevant, needs to include local government as actors/target
Outcome 2: Duty bearers respond effectively to gender-based violence in working districts and increasingly at national level.	Relevance continues, needs to be re-targeted in context of new structure (duty bearers to include municipality structures), more service providers need to be included (ex FCHV)
Output 2.1: Women and Children Development Offices, police, and legal service providers have been enabled to prevent GBV and respond to GBV	• Remains relevant, interventions for prevention need to be redesigned and focused • Needs re-targeting to include municipality offices/sections and in light of WCO/DWC dismantling
Output 2.2: Women Service Centers have been established and are functional in the working districts, with links to capable referral safe houses in Kathmandu	• Remains relevant • District safe houses need to be more responsive to needs of survivors-dependent children and need for financial autonomy currently not addressed • Management of service centres is likely to fall under more than one municipality, may or may not continue to be managed by WC as municipalities take on this role. There will be need to support development of cooperation

	agreement between municipalities for management of service centres
Output 2.3: Health facilities in the working districts have the capacity to provide adequate medical services and community based psychosocial case management for GBV survivors and their families	• Remains relevant, need to include health line management at municipalities
Output 2.4: MoWCSW and MoHP are supported with evidence to develop policies and plans	• Needs re-targeting, local governments need to be supported with evidence and ideas for their policies, law and plans • Ministries at the state level also become relevant now: Social Development Ministry is now responsible for women's empowerment and they have the exclusive power to make criminal and civil procedures related legislation, guidelines etc. Ministry of Health at the state level will be responsible for hospital management. • Exact role of MoWCSW not clear yet, not for provincial government either. As their roles emerge, specific output can be planned

3.2. Relevance of each component for prevention and response to GBV

Components for rights holders	Relevance
ToT for women's cooperatives	• This CBO loses its relevance in the current set up. In the new federal set up (with the dismantling of the DWC and WCO), the Women's Cooperatives may or may not be made part of the local government structures. Municipalities are planning different local level groups for "social issues". • They could remain relevant as any other CBO in the communities that needs information and behavior change interventions but not as trainers • The ToT model with WC has not been relevant: content, duration and strategy • WC are not relevant to poorest women and those that are not able or interested in savings and credit. Daily wage earning women are not participating in WC
WC as mobilisers and supervisors of CPSW	• As above. More relevant to link CPSW with local government structure
GBV Watch Groups	• There does not seem to be a clear plan for the role of GBV watch group. None of the GBV WG seem to have developed any action plans on GBV and their monthly meetings (if at all) tend to focus on savings and credit. • In this project, with the introduction of CPSW, the scope of GBV WG is revised and now limited to identifying and connecting survivors with CPSW • Their roles are likely to be redefined by local governments
Training of couples	• Objective of working with couples is not clear • Intervention could be relevant insofar as couples are provided with counseling for their own relationship. • But not as agents of change in the way it is being done
Girls group	• Creating and mentoring girls groups for prevention and response, remains relevant

	• For program to have continued relevance, interventions with girls need to be dynamic and constantly respond to emerging needs and priorities of the girls. There is risk that this intervention could end up being more relevant to and limited to WC agenda of younger recruits into their cooperatives (savings and credit) • The Rupantaran training module needs to be reviewed for its relevance and effectiveness in prevention and response
Engaging men and boys	• This remains a crucial and relevant component but is missing. Men are included as recipients of training as part of couples and as service providers (male officers in the police and male members of the BAR association) • Boys have not been reached out to yet • Intervention relevant to boys and to the theme of prevention and response needs to be designed. • The *Rupantaran* training module needs to be reviewed for its relevance and effectiveness in prevention and response
Components for duty bearers	

Advocacy with Governments	• Project not yet relevant to local government structures, interventions with municipalities need to be added, with special focus on social development sector and judicial committees
	• Advocacy and support to ensure that women's rights receive adequate state support along all structures is crucial, focus seems to be diminishing:
	  • At the **national level** the Ministry of Women is being restructured to reduce number of officers. DWC is dismantled and there is no provision for senior level officers, all asked to move to local levels (negotiations ongoing)
	  • At the **provincial level**, Women's Development Section is combined with "Social Security" under the Education Division. There are no provisions for senior roles here, only section officer and women development inspector.
	  • At the **local level**, matters related to women's empowerment and protection are clubbed together with several other themes including education and health in the social development sector. Women's issues not on priority of municipalities visited

Community Based Psychosocial Workers	• Most relevant of all components • Demonstrated relevance through increased referral and reporting of cases • *Siddhicharan* Municipality has hired their own psychosocial worker, indicating scope for institutionalizing CPSWs

Health care system	• Case Managers and outreach counselor at OCMC
	  • Continued relevance, demonstrated through increased referral
	• Hospitals, PHC, Health Posts
	  • Continued relevance, especially with OCMC institutionalized and referral pathways
	• FCHV seems a relevant component but is missing as target in the project

Service Centres/ Shelter Homes	• Continue to be relevant, previous challenges remain – limited duration of hosting survivors and lack of facilities for supporting women to become financially independent (except in Kathmandu) and lack of responsiveness to women with dependent children (except in Kathmandu) • Role of WC in "managing service centres" may become less relevant as local governments choose their own mechanisms

Training for police and lawyers	• Trainings are relevant, training not conducted in 1 out of 3 districts • Combining training lawyers with police is not relevant to their different training needs, roles and capacities • To stay relevant in new structure, project needs to include police department established by the local governments
Other components	
Action Research	• Action Research is relevant for identifying what is working and what is not but report so far is not providing nuanced information. To become relevant to this project, the Action Research needs to be re-thought urgently
Mass media campaigns	• Mass Media targeted interventions could be relevant have only very recently been initiated • To ensure relevance, the objectives of the initiatives need to be clearly aligned with project objectives and messaging needs to be consistent with other components of the project (messages being conveyed through various training manuals to various audiences). • Consider relevance of online portal-how many in the target have access

3.2.1. Relevant issues that are not addressed by the project

Consequences of federalization

A significant change during the course of the project has been the adoption of the new federal structure and establishment of local governments that have now replaced the previously tier of “districts”. The project’s initial focus was on strengthening capacities of advocating with the previous local and national structures responsible for addressing GBV (WCO, CDO, DDC, MoWCSW and MoHP).

The project now needs to include as its target group, the structures and local authorities emerging from the new structure- The Mayors and Deputy Mayors, Ward Chairs, Council of Municipality and the Village Assembly. The Judicial Committee and the specific department or unit on “social sector” at the municipalities will need to be included in capacity strengthening initiatives. Strengthening understanding on GBV and capacities to develop action plans, local policies, allocation of resources would be relevant for the local government now.

While it will be important to support and strengthen the capacities of elected women representatives to understand, prioritize and plan appropriate interventions for their municipalities, it will be crucial to include male elected representatives to improve the programs relevance to engaging with men and boys. Besides, women elected representatives need capacity enhancement in areas beyond GBV or other themes/sectors—on their leadership and ability to negotiate in a male dominated structure.

According to a recent capacity needs assessment of elected women representatives, across literacy/levels of education, elected women representatives articulated need for training and inputs on: financial and budget management (39.5%), leadership and women empowerment (15.8%), information on Constitution and laws (13.2%), skill development (12.1%), different programmes (11.6%) and “other” (7.9%). During the course of this MTR, consultations with elected women and men representatives

confirmed that some of them need support in program and planning for GBV, in interpreting the Local Government Act. In some cases, elected women representatives specifically asked for support in understanding the role of the Judicial Committee and their own role within it, specifically vis-à-vis cases of GBV, some of which were already being referred to them and which they have "addressed". Some NGOs, such as WOREC have already started working with elected women representatives (not under this project) and in at least one municipality where consultations were held for the MTR, the Deputy Mayor has appreciated the intervention.

Other relevant issues

The other relevant issues that are identified in the MTR as missing in this project are related to alcoholism, financial autonomy of women and working with girls and boys through schools. These are not new issues that emerged during the course of this project but are relevant to prevention and response.

While violence in the state of inebriation and alcoholism are only manifestations of root causes of violence against women, the use of alcohol is certainly viewed by men and women and girls as problematic, creating nuisance and aiding violence. To remain relevant to the needs of the beneficiaries, the project may need to consider some interventions to address this manifestation.

Similarly, lack of financial autonomy is a well-known barrier to women escaping violent domestic lives. This is not to suggest that women who are financially autonomous are not subjected to violence. At present, the project is only able to provide support for enabling women to become financial autonomous through the shelter support in Kathmandu. These are for what are considered the "worst" cases. This service needs to be made more widely available at the district level, through linkages with other projects/initiatives if not within the scope of this project. With the decentralized governance, there is greater scope for providing such integrated services.

Most women survivors of domestic violence have dependent children and the inability of district service centres to host women with their children is a barrier to women accessing these services. To be relevant to women who need shelter support, service centres need to be responsive to dependent children.

An institution that is relevant to prevention efforts and which is also indicated in UNFPA strategy on *Engaging Men and Boys, Communities and Parents to End Violence against Women, Child Marriage and Other Harmful Practices in Nepal,* is schools. Not only are schools most relevant because of the greater potential for institutionalizing interventions, with Nepal having near complete secondary school attendance, chances of excluding certain children is minimized. One of the implementing partners (CMC-Nepal) already has experience of working with girls and boys in schools on GBV and their experience could be harnessed for including work with schools.

3.3. Effectiveness

At the time of the mid term review, this 36-month project had completed 24 months since signing of the agreement between SDC and UNFPA and about 3-14 months since the different interventions were initiated. Some planned activities had not yet been initiated (work with boys, for instance). Expectedly then, at mid term, monitoring data collected by UNFPA indicates that partial set of results, mainly at the completion of activities (input) or at best output levels, appear to be on track for achievement. See Annex 3 for a matrix on progress vis-a-vis all planned results.

As a result of the project, GBV is out in the open, survivors are aware that they can report and have a trained psychosocial worker who listens to them, and more experienced case managers who can help them heal and assess their options. Service providers are gradually becoming sensitive (police, hospital/health post staff), and there is improved coordination between different referral points.

3.3.1. Extent of achievement of results of the project

Based on the progress made so far, at mid term, it appears that the outcome pertaining improved services by duty bearers is more likely to be achieved than those related to empowering women and men to prevent and report.

Achievement of Outcomes

Result	Likelihood of achievement
Outcome 1: Women and men in the working districts increasingly prevent, report and address gender-based violence • % of women and girls who have the knowledge on all forms of GBV and know when and where to seek health care following violence. • % of men and boys who believe that violence against women and girls is acceptable reduced by 50% • # of men and boys who have taken action to prevent GBV increased by 50% every year • GBV is increasingly being reported (plus 5% per year) • Possession of vital documents (by girls and women in focus VDCs increased by 15% every year	Partial achievement expected • Increased efforts by men and women to prevent GBV are unlikely to be achieved since there has been little focus on prevention • Increased reporting and redress can be expected to be achieved • Increased knowledge on where to seek care can be expected to be achieved • Changed perception and behaviour among men and boys cannot be expected since there were negligible interventions with them. Any change may not be attributable to the project
Outcome 2: Duty bearers respond effectively to gender-based violence in the working districts and increasingly at national levels • # of health service delivery points that have adhered to the Clinical Protocol on GBV	Highly likely to be achieved at the district levels • Adherence to Clinical Protocols likely to be achieved, with continuous monitoring and mentoring by JHPIEGO. Equal focus needed on centres in communities and district

• 70% of GBV survivors who sought assistance have improved their well-being[3] • Percentage of GBV survivors who are satisfied with the quality of GBV services[4] • # of GBV cases that were prosecuted by law • MOHP guidelines and strategy on psychosocial and mental health services as an integral part of the OCMCs available	• Improved wellbeing of survivors as currently defined can be expected to be achieved. • Given that services were not available in the past, it can be expected that survivors are satisfied with quality of services • Data on prosecution needs to be assessed • At the national level, MoHP likely to more fully integrate OCMCs but need to be engaged

3.3.2. Quality of achievement of outputs

Output 1.1: Women Cooperatives have established functioning GBV watch groups and adolescent girls groups to address GBV

Quality assessment: Not satisfactory

A main reason for the lack of success of this component is that sustained training, mentoring and follow-up has not been provided to the members of the Women's Cooperatives. While selected members have received ToT from qualified trainers, the large numbers of women have not been reached out to by qualified trainers but through a ToT approach whereby women have been provided with very short duration trainings (5 days) to be able to deliver what qualified trainers have delivered to them. Besides, there has been no mentoring or follow up of the ToT. Besides, the WC itself does not emerge as the most suitable group to rest the project's outreach on.

In terms of numbers, this output has been achieved. Trained WC members have provided GBV watch group members with information and mobilized girls to form groups. As indicated from monitoring data of UNFPA (see Annex 3), most GBV watch groups were established before the project was initiated. Whether these groups are functioning to address GBV is unsure.

As part of this project, trained members of the WC have indeed conducted sessions with GBV WG to transfer their knowledge gained from the *Sanjivani* module on gender, GBV and reproductive health. There is however no monitoring or assessment of the relevance and effectiveness of the training module in preventing and responding to GBV nor of the impact of ToT with WC and neither on the quality of sessions conducted by the WC members and its impact on GBV watch groups. At best GBV WG report that they identify cases and refer them to CPSW, beyond that, their role and contribution in this project is unclear.

Consultations with members of women's cooperatives and GBV watch group reveal that neither have developed a strategic plan of action for mobilizing communities and their interactions with community members outside of their groups is sporadic and around events such as observance of women's day. When asked about what messages they give in the communities, they said they inform community members about the types of gender based violence, that men and women can be equally victims

3 Improved well-being: improved relationships with family members and other significant persons, emotional situation, health, economic situation if relevant

4 Target/milestone: Develop GBV related community score cards for police, WCOs, Bar Association/ government attorney, hospital/OCMC/Safe house

of it and that men should not be violent towards their wives—rather simplistic messaging. How can such strategies lead to behaviour change? Increased information about services, perhaps yes, but not behaviour change.

What defines a functioning GBV WG is not clear, and the one indicator for a functioning WG (implement action plan) is neither achieved nor likely to be achieved since they have not yet made an action plan. There are reports of GBV watch groups not meeting regularly since provisions for snacks for their meeting have been removed from this project. Motivation of some (if not all) GBV watch groups for participating in this project seems to be diminishing. During the MTR consultations, no GBV watch group talked about mobilising communities-holding regular meetings with wider community members although this was highly recommended by all (that the "training" on GBV needs to be provided to all members of the community). GBV WG members as well as members of women's cooperatives shared that community members would rather pay attention to messages given by "outsiders" than by members of their own communities.

WC members have shared that they do not feel competent to transfer knowledge they gained in 5 days of ToT to pass it on to the other members of the WC or with the GBV WG or with the broader community. To expect that they would also transfer this knowledge and mobilise communities to prevent GBV seems far-fetched. Monitoring report shared by WOREC as well as the Action Research report confirms that the approach of training WC members as trainers for other women needs rethinking.

To be a trainer who facilitates behavior change one needs to be able to critically reflect on social norms and how they influence behavior and also learn how to influence others to critically reflect and adapt new behaviours. This kind of change rarely comes about as a result of 5 day training. Intervention for prevention need to be based on a good understanding of how social norms influence behaviours, what it takes to change behavior and provide sustained inputs for the same. Also, by design, are members of the WC best suited (qualified, capable) to be trainers and do they have access to the poor and marginalized women?

WC have also mobilized girls to form groups and one member of the WC is appointed to oversee their interventions. While all groups have been formed, there needs to be an assessment of the criteria of selection of girls and ascertain why there is negligible representation of out-of-school girls in these groups.

Notwithstanding the concern with representation, the high potential for working with girls in groups is evident. The method for mobilizing the girls and engaging with them is more effective that the method for mobilizing women (and men). A girl with leadership abilities and motivation is selected and trained as a facilitator for other girls using the manual adopted by the GoN for engaging with adolescents, called *Rupantaran.* The facilitator then conducts sessions with her girls groups (of about 20 girls) once a week for 2 hours for 54 weeks of the year. A similar modular approach spread over a longer period of time for engaging women and men and boys could be considered.

The *Rupantaran* module itself needs to be reviewed for its suitability for preparing girls for GBV prevention and response. While it is understandable that the project needed to be aligned with GoN program on adolescents and its prescribed training module on Social and Financial Skills, i.e. the *Rupantaran* module, this module is far more focused on developing financial skills and being "good citizens" than on critical reflections on social norms, learning new behaviours, including negotiating and advocating for their space.

Engaging girls seems to be one of the most promising elements of the project- girls shared experiences of how it has changed their own thinking and understanding and also enabled them to negotiate more equitable treatment for them at home (girls mostly shared examples of segregation and restriction imposed on them during menstruation). It helps that their mothers are members of Women's Cooperatives and the content of *Rupantaran* was familiar for at least one parent.

Consultations with girls groups during MTR reveal that once the curriculum of *Rupantaran* is completed, they are a bit lost about planning their activities. They do conduct "meetings", at which they mostly engage in collecting weekly savings and making decisions on giving credit to one of the members. In the absence of mentoring of the girls by capable facilitators, this highly potential agent of change for self and community (prevention, resistance and response) could stagnate and get restricted to a savings and credit group, early recruits for the women's cooperatives.

The girls shared that they wanted to understand more about gender dynamics, sexuality and about what they could do. They are required to develop a plan of action but without capable facilitation this may not get done. The reason for developing girls groups is that they be able to "address" GBV –how they may do that is something they will need facilitation for. UNFPA is already implementing a Comprehensive Sexuality Education program for adolescent girls and boys including in the project districts. Perhaps a review of *Rupantaran* and CSE module (and some others that focus on gender equality, power dynamics in relationships and violence) could be done with a view to make a more effective module.

Output 1.2: Men and boys have acquired the capacity to engage in the prevention of and response to GBV

Quality assessment: Poor

This is probably the weakest element in the project since it has been undermined. There is no clear explanation for why men and boys were not engaged as a priority in this project despite that fact that project document clearly identified this area as a gap:

> There is a need to engage men, and particularly boys, to reflect on harmful and unequal masculine norms and attitudes in order to bring about significant shifts. Further analysis of the NDHS 2011 on Women's Empowerment and Spousal Violence in relation to health outcomes in Nepal has concluded that strategically engaging men and boys in the process of women's empowerment to help reduce the incidence of gender-based violence, including spousal violence, is crucial for attaining gender equality.
>
> *Gender Based Violence Prevention and Response Project, Project Document, UNFPA, 2016*

There seems to be an insufficient understanding on approaches for engaging men and boys. There are 3 components in the project design for engaging men and boys:

- "6 initiatives" with CSOs for engaging men and boys and the only reference to this is the media events with implementing partner Sancharika Samuha, which have been conducted towards the end of 2017. Are media events and programs sufficient to build capacity of men and boys to prevent and respond to GBV?
- Training 1000 couples, including 500 men (husbands) of members of Women's Cooperatives, with the intention of including them as social agents along with WC

members to promote behaviours that will reduce spousal violence. Training method included a manual that was specifically developed for this intervention and training was conducted for groups of couples over 3 full days. As a design, this seems to exclude couples who are employed and/or those that cannot afford to leave work for 3 full days. Besides, the idea that behaviours can change after a 3-day group "training" seems implausible.

Monitoring reports suggest and the MTR confirms that the WC who were responsible for identifying the 1000 couples, could not identify and mobilise 1000 couples for this initiative. This number was based on the number of GBV watch group members who are being mobilized in this project. The idea was that husbands of GBV watch groups will be mobilized to join the efforts through couples training and these trained husbands would support their wives (and thereby the GBV watch group's efforts) in preventing and responding to GBV cases. UNFPA reports that due to high male outmigration they were unable to mobilise 1000 couples. Does this mean that a majority of members of the GBV watch groups are wives of migrant workers?

Of the 290 couples that received the training, majority were older—only 1 member in each of the couples' groups who were consulted for MTR were younger (under 40) the others were over 50-60 years old. Although the original intention was to enroll younger couples for this program, project partners report that they found it hard to find younger couples due to high male out migration in the areas. This explanation needs to be verified. One reason for this could be that the modality of the training (full day commitment for 3 days) is difficult to expect from young working couples. Older couples, husbands of WC members (who also tend to be older women) are easier to mobilise and give their time than younger couples. Or are GBV watch members generally older and therefore only older couples were mobilized?

Consultations with couples during the MTR revealed that rather than engaging men in reflecting on harmful and unequal masculine norms and attitudes the sessions have in fact emboldened men's perception of normative behavior expected of women. Men reported that the training has helped reduced tensions in their relationships because women had become "calmer", were "less angry" and therefore men responded with calm as well. Women's aggression and demanding nature were shared as reasons for disharmony, aggression and violence by men against their wives. There was no evidence of a critical understanding of norms and behaviours.

While such interventions are able to communicate that physical violence is inappropriate and against the rights of women and probably influence individual men's (physically violent) behaviours, they rarely question male privilege and attendant expectations of female submissiveness that are more resilient forms of patriarchy (than physical violence). Evaluations of interventions with couples, specifically to develop role model men have noted that while the "role model men" can have impact on changing gender attitudes and behaviours of individual men, but underlying patriarchal values are often more difficult to dislodge if broader social, political and economic dynamics are not addressed[5].

A combination of poor design and execution renders this initiative ineffective in engaging men and is in fact at risk of causing more harm to women.

5 USAID 2015: Working With Men and Boys to End Violence Against Women and Girls. Approaches, Challenges and Lessons

- Training of 300 boys to take action to prevent violence against women

This activity has not been initiated. UNFPA and its implementing partners share that this activity was not initiated because they were not clear about the nature of precise intervention.

It is possible that the mobilization of girls group was far more easy and convenient for members of the WC than mobilization of boys, which against raises the question of relevance and appropriateness of the role given to Women's Cooperatives by this project.

The use of "training" as an approach needs to be rethought for all elements in the project design for community mobilization. What is required is sustained facilitation with women and girls, men and boys, to critically reflect on discrimination, inequality and social norms and behaviours that promote and condone violence in relationships.

UNFPA already has a tried and tested global package for working with adolescents to address violence (among other things)- Comprehensive Sexuality Education. And there are several initiatives that have successfully engaged boys and men in Nepal, (including Reflect model by CARE), South Asia and different parts of the world. Indeed, UNFPA's own strategy document on engaging with men and boys "*Engaging Men and Boys, Communities and Parents to End Violence against Women, Child Marriage and Other Harmful Practices in Nepal*[6]*",* suggests strategies for the same and could have been adopted for this project.

Output 1.3: CSOs, media and research organizations have engaged in evidence-based advocacy for an improved response to GBV by GoN

Quality assessment: Uncertain

The strategy for evidence-based advocacy with GoN does not appear clear. Other than the action research on what's working and what's not, it is not clear how the project intends to collect evidence for backing policy. The Action Research is an important activity but it was started in late 2017 and its initial summary report is missing nuanced information. The method for Action Research may need to be reviewed to ensure that it is robust. A critical area that was envisaged to be tested was engaging men and boys, this activity is unlikely to be initiated till mid 2018 given that its strategy and approach has not been developed at the time of this MTR. The Action Research may not be able to assess all elements of the project and provide the robust evidence that will be needed for policy advocacy.

Mass media interventions are also expected to feed into evidence-based advocacy but it is not clear how this is planned to be achieved. Edutainment *Mela*, radio and TV programs can be useful tools for generating awareness but how exactly these contribute to policy advocacy is uncertain. Public event, such as the one organized by Sancharika Samuha in Okhaldhunga, where local authorities were confronted with 6 specific cases could serve to advocate for these specific cases—there is some data to indicate that a redress of a couple of cases was expedited as a result of the public hearing and its subsequent telecast on television. However, without sustained and strategic advocacy at all levels, one off events can at best serve individual cases and not address at policy level.

[6] UNFPA and International Centre for Research on Women (ICRW), January 2014.

Observing of key milestones in women's rights movement such as International Women's Day, International Day of the Girl Child and 16 days of activism on violence against women are powerful tools to strengthen solidarity among women and girls' group and for mobilizing broader public opinion. They can also be used effectively for evidence based advocacy but so far there is no evidence of the same in this project. Stakeholders and women and girls organizations did observe these events but it is not clear how these events targeted policy and what kinds of evidence were used.

Output 2.1: Women and Children Development Offices, police, and legal service providers have been enabled to prevent GBV and response to GBV

Quality: Partially satisfactory

While trainings were held with WCO and police (except in Udayapura), no training has been held with legal service providers yet. Where police have been trained there seems to have been an increased understanding and better critical self-reflection but whether that has translated in better quality and responsive services to survivors is yet to be assessed.

Similarly, the impact of training WCO needs to be monitored and assessed. According to implementing partners WCO do not show ownership of this project and not all staff are capable of being trainers. While there has been better response from WCO in Sindhuli, the response in Udayapura has been poor. During the MTR consultations with GEEGBVDCC, the WCO present was not informed about the different funds available for supporting survivors and how they could mobilize it (neither was the CDO active on this).

A key gap identified in the project document was that "coordination in districts is weak and limited resources are under-utilized". While coordination between different actors along the referral pathway in Okhaldhunga seemed good but even here the fact that the GEEGBVDCC members, in particular the WCO and CDO were not abreast with resources available and how they could mobilise the various funds, the gap of under utilization could continue.

Legal service providers have not been provided with training yet and there seems to be a disagreement between UNFPA and implementing partner on the roll out of this activity, with UNFPA suggesting that lawyers and police be trained together and implementing partner advising for separate training. The latter makes more sense given the difference in roles and capacities of the two service providers.

With the new structure and dismantling of the WCO, a new approach may be required. The WCO may be appointed by local governments to continue to focus on women's issues including GBV and trained and competent WCO could be mobilized in the project for advocating for appropriate policy and program by local government.

Output 2.2: Women Service Centers have been established and are functional in all working districts, with links to capable referral safe house Kathmandu

Quality: Satisfactory

Given that absence of service centres was an identified gap that the project sought to fill, establishment of service centres in all districts is one of the most significant achievements of the project. Access to and use of Service Centre has reportedly increased and so have referrals to and from OCMC and service centres (an analysis

of what is most common pathway and why would be useful for understanding what's working better and why). Quality of services, responsiveness to needs of all survivors, dealing with threat by perpetrators and including provisions for women with dependents remain challenging issues. There are also issues related to "control" exerted by WC members over staff of the service centres (withholding funds, etc.). Service centre staff must receive regular mentoring and support, including for self-care. Once in 3 months visits by APEIRON staff may not be sufficient.

> Only one service centre was visited as part of the MTR and at the time of the visit there were no users. The in-charge of the service centre valued the training she had received and found it useful in her work. The location of the service centre however seems problematic (isolated) and there is little to engage survivors with meaningfully during their stay (except for company and sharing with staff of service centres and entertainment by TV). There has also been an incidence of threat by perpetrator (husband), which has prevented the service centre to re-host a survivor. The survivor also has children and has been advised by service centre that her needs will be best met by the Kathmandu shelter but she has not taken up this offer yet. Service centre in-charge is following up through the CPSW with the survivor and has learnt that the husband has restricted mobility of the survivor and while he is not beating her anymore, he does not allow her any outside interactions. In the face of such threats, the service centre in-charge also fears for her self.

Referral to Kathmandu service centre is also increasing and that has allowed for survivors to take their dependent children with them. User satisfaction survey with survivors at the Kathmandu service centre indicates satisfaction of users. There is need to assess how centres decide on referrals to Kathmandu, how many survivors have rejected the option of going to Kathmandu and how many survivors are coming back repeatedly to the centres.

Output 2.3: Health facilities in the working districts have built up the capacity to provide adequate medical services and community based psychosocial case management for GBV survivors and their families

Quality: Good

The project has successfully filled the gap of lack of OCMCs by establishing OCMCs in the 3 districts and equipping them with qualified case managers as well as training general staff of the hospital on clinical protocols. One of the most effective strategies employed in the project is the appointment of trained Community Based Psychosocial Workers in the communities.

A main reason for the success of this component is that sustained training, mentoring and follow-up has been provided to the staff of OCMC and CPSW, by qualified staff of the implementing partners.

Case Managers and Outreach Counselors: Consultations with case managers and counselors in both Okhaldhunga and Udayapura suggests that they have increased number of cases being referred to them through the CPSW in the field as well as through OPD in the hospital and that a significant number of survivors are approaching the OCMC directly (this may need more examining, what was the source of their information). Case Managers report that they feel competent to provide psychological support to survivors and intervene with perpetrators as well. For complex or unusual cases they seek support from CMC-Nepal over the phone or refer to CMC-Nepal. The

outreach counselors play an important role in traveling to the communities and identifying and referring cases. Case managers take turns to travel to communities.

Hospital staff: Consultation with hospital staff in both districts suggests that there is vast difference in the quality of response by hospital staff. While in Okhaldhunga, the motivation and engagement of wide range of hospital staff and their close working relationship with OCMC staff, GEEGBVDEE, JHPEIGO mentor and UNFPA community mobilization officer was evident, in Udayapura this was missing. The doctor who has received ToT in Udayapura for instance, had not transferred the knowledge and skills to new recruits in the hospital after the trained staff had moved to other hospitals. Hospital staff will need (have asked for) regular refresher training and inputs and specific training on medico-legal aspects of the service, including forensics.

Mentoring and interventions on capacity development at health centres in communities needs to be strengthened. Female Community Health Volunteers are closely linked with these health centres and are relevant to outreach and for linkages but have been so far excluded. They need to be included for improved outreach.

Community Based Psychosocial Workers: Consultations with CPSW reveal that the training they received has not only helped them personally but has also enabled them to provide psychosocial counseling to survivors. Some CPSW have been survivors themselves and the training they received helped them heal and in fact some have said that they have blossomed in this role.

Trained CPSW have proven to be far more effective agents of change and support for survivors that the GBV WG. The approach of addressing survivors has changed dramatically with the introduction of this strategy and members of the GBV watch groups who were consulted for the MTR acknowledge and appreciate this shift. GBV watch groups mention that their earlier strategy used to be to call a “public meeting” on the cases of GBV and attempt to address it, without a focus on confidentiality and addressing psychosocial needs of the survivors. With the CPSW, not only have such public discussions on individual cases reduced (if not completely stopped) but also the focus has shifted to survivor’s wellbeing by trained CPSW rather than “intervention” by GBV watch group members. The provision of psychosocial first aid has potentially served interests and needs of survivors more than any other intervention (and this needs to be explored and verified through action research). CPSW are playing an effective role in linking survivors with services of the OCMC/shelter homes. In Okhaldhunga and Udayapura, the CPSW are also referring community members to community mental health project run by CMC-Nepal (under another project funded by TEAR Australia)

This change was appreciated and acknowledged by members of WC and GBV watch groups as well. Although there are reports that in some communities there is growing resentment of the CPSW being hired on honorarium for the same work the GBV WG used to do for “free” before. There is need to address this simmering discontent.

There is need to review the socio-political perspective that is being disseminated to CPSWs and through them to survivors and others. Interventions to address gender inequality and power dynamics have always been a complex, multilayered, reflective and evolving process. The clarity of perspective on gender inequality and power dynamics crucial. In the absence of a clear perspective on gender-based discrimination and GBV as offshoots of patriarchal ideology, implementers such as CPSW or trainers of couples (or others in the community) are at risk of conveying unclear messages including those that suggest a tolerance of male toxic behaviours. “Women and men are equally responsible for ensuring harmony in the relationships”,

are benign statements that in the context of “counseling” couples where the man is abusive could give the message of tolerating toxic male behaviours. Such misplaced understanding will completely contradict the objective of the intervention. Also gender-based violence has been sometimes misinterpreted as any violence committed against either gender, with CPSW and couples being referred or intervening in cases of water dispute or road construction dispute between any man and woman in the community as cases of *gender-based* violence.

Another concern about the CPSW component is that the success of this approach has meant that the workload on CPSW is far greater than what was imagined and has required women to give up on their household chores and other economic activities. Also, the terrain demands long and arduous travel and the compensation for meeting their travel and incidental costs is not sufficient and could deter CPSW from traveling to the farthest and most inaccessible areas. The strategy is at risk of perpetuating unpaid care economy for women and needs to be addressed at the earliest.

Local governments are appreciating the CPSW intervention and one result is that CPSW are being asked to (or expected to) take on cases other than or not related to gender-based violence such as drug abuse (*Sundarpur* Municipality) or for general mental health (*Triyuga* Municipality). The demand for psychosocial intervention in communities is high and it is likely that the CPSW focus could be moved beyond GBV and that will need to be carefully considered given the work load, training and capacity of current set of CPSW.

The CPSW are anchored with (and are accountable to) the Women’s Cooperatives and this is structurally challenging given the role that WC have played and have the capacity to play and the recent restructuring. In fact this may be an opportune time to look for institutionalizing CPSW within the social sector of the local governments and anchor them with local government/hospitals.

Output 2.4: MoWCSW and MoHP are supported with evidence to develop policies and plans

Quality: Cannot be assessed

Most of the activities under this output have not yet been implemented and are planned for 2018. So far it appears that documentation by different implementing partners is expected to feed into the policy briefs that are to be presented to the government. Initially planned for the MoWCSW and MoHP, these now need to be presented to the local governments as well, if not more importantly. As the terms of reference for the federal and state structure of these Ministries becomes clearer, specific targeted advocacy with them will need to be planned.

Timing is crucial for policy advocacy. It is best done before governments make their plans and budgets for the year, which for the duration of this project would be June 2018. The policy brief on “importance of and best approaches to mainstream psychosocial support in the multi-sectorial response and prevention of GBV” could be developed specifically for municipalities and on priority presented for their consideration for FY 2018-2019. Given the positive indications from the components of CPSW, case managers and hospitals/health centres in general, institutionalizing CPSW and case managers could be the core advocacy message. Success of this initiative will help achieve the result expected under this output and indeed for the outcome.

During consultations with the DWC and MoHP for the MTR, it appeared that while DWC was informed about the project activities, the MoHP was not aware of the various trainings that were being provided to staff of the hospitals under this project. The representatives asked for greater engagement with them and sharing of lessons so they can include in the guidelines they are currently revising for the OCMCs. The MoHP has also proposed a strategy to work with schools on GBV by placing a trained nurse in each school (as per Health Policy). This initiative could be considered for the second phase of this project (see more under recommendations).

3.3.3. Monitoring system and the knowledge management

Monitoring: For providing technical support to district line agencies and implementing partners in carrying out their work and monitoring and knowledge management at the district level, UNFPA has appointed, in each district, Community Mobilization Officers (a misnomer) in each of the 3 districts. There are 2 full time staff at the head office for the leadership, management and coordination of the project. A look at the monitoring visits made by UNFPA staff indicates that there has been inconsistent monitoring in the field, with some project locations visited more frequently and some not visited at all. See Annex 4 for timeline of monitoring visits.

One reason for inconsistent monitoring within and across districts is reportedly the lack of permission for staff to go for field visits. Project staff have reported that there is an environment of discouraging staff from making field visits and often the cost of field visits (DSA, for instance) is cited as a reason for not grating permission to staff to travel. As a result, the communities that are close to the duty station of the staff are visited more often than those that are far. Ironically, it is the farthest and more difficult to reach communities that are usually marginalized and it is these communities where the interventions have not been frequently monitored.

Apart from the inconsistency in frequency of monitoring, there seem to be gaps in the quality of monitoring being done. The primary purpose of monitoring is learning and feedback into the project loop. A clear and results based monitoring system does not seem to be in place. Templates for reporting from partners also for instance do not match the results framework on the project and there is tendency to report on inputs and not outputs and use of outputs (ToT held for 900 people, but no information on the quality of the ToT and how the participants used that training). This kind of activity based reporting is also reflected in annual reports of UNFPA that are unable to provide nuanced reflections. Some partners have reported that when they have provided their own internal monitoring reports and made suggestions for changes, those suggestions have not been accepted. At least one partner is not even making any monitoring visits (RD) and the task of monitoring their component of the project and reporting to the implementing partner is given to UNFPA field staff, which does not make sense.

Project staff have also indicated that they have not been trained on GBV nor other components of the project so they are at a loss on what they should be monitoring and reporting on. Those staff that come with experience and background in GBV are able to use their previous knowledge to steer the project, those that do not, are not able to do as well.

For a project with multiple implementing partners, a comprehensive oversight and steering of different elements is critical and that requires a robust monitoring system, which seems to be lacking. UNFPA reports that data gathered in the project is inconsistent across sources and partners. One reason for this could be that reporting templates are not harmonized, aligned with results framework. Recently an RBM toolkit has been attempted but it is at best a compilation of the various formats being used by different implementing partners and not a comprehensive framework that is aligned with the project results.

Knowledge Management: There are different knowledge products being produced/used/generated in the project- training curricula for women members of cooperatives, for girls, for couples, for CPSW, for case managers, for hospital staff and so on. There is however no evidence of collaboration between different developers of these products (implementing partners) to ensure common perspective and messaging.

While one of the implementing partners has expertise on gender inequality, gender based violence; others have expertise in psychosocial counseling, clinical protocols and so on. The end beneficiaries of all these products are the same women and girls who are survivors or at risk of violence. Consultations in communities as well as with different implement partners indicates that there are different perspectives and messages being conveyed in communities, which is detrimental to the project objectives.

As discussed earlier, perspective building is also an on-going process and not bringing together all implementing partners to build knowledge together and learn from the various aspects together (perhaps joint review) has been a lost opportunity. In the recent months UNFPA has provided more opportunities for partners to meet and collaborate (annual review and planning meeting) but even these were not built into the program design from the beginning.

At mid term, the recommendation is that all knowledge products need to be reviewed collectively and a common set of products needs to be owned, implemented, monitored and fed back into the what's working, what's not kind of knowledge management.

A large part of the success of the project depends on successful evidence based advocacy with the government. In the absence of a strong knowledge management component, robust evidence will be hard to generate. The action research, as discussed earlier has potential to generate such systematic evidence but in the absence of collaboration and a strong monitoring by UNFPA, the anchoring of lessons is unlikely.

3.3.4. Exclusive focus on GBV and effectiveness of the project

The project's exclusive focus on GBV and within that more focus on response (identifying cases, referring for services, providing services) that prevention (facilitating critical reflection on social norms, learning new behaviours for men and women, boys and girls) is limiting its ability to achieve its results. While increased reporting and prosecution may reduce the incidence of violence to some extent (although there is evidence that increased severe prosecutions are deterrent for survivors to complain), these are not at all sufficient for changing mind-sets and norms. Prevention work is more long term and requires consistent and capable facilitation. A look at the allocation of resources in this project also indicates that significantly larger share of the budget was invested in the response component than in the community mobilization/prevention component (see under Efficiency section below)

The exclusive focus on GBV has rarely shown results and the Commission on the Status of Women has asserted the importance of promotion of gender equality, women's empowerment and their enjoyment of human rights as crucial elements of any prevention intervention. Ensuring women's economic autonomy and security, increasing their participation in decisions in homes, communities and public life and governance, are all essential to effective prevention.

During consultations with women and girls in communities and with local authorities on how can violence be prevented, there were agreements of the following components: economic autonomy of women, leadership of women and changing the

mindset and behaviours of men. The former could be addressed through linkages with other initiatives and the latter two should be addressed within the current project design.

UNFPA states in its Annual Report 2017 that in order to reduce resistance from community members, discussions on GBV in communities should "emphasize gender equality approaches rather than more explicit discussions of GBV victims and perpetrators, as this tends to create greater resistance". While it is important that this gap has been realized, it needs to be understood that this is not simply a matter of how discussions in communities proceed so as to reduce resistance, but it is about actually implementing interventions that further gender equality, economic autonomy of women and strengthening women's leadership (see also under 4.2.4). Critical reflections on social norms and how to change them need to be focused equally with women and girls and men and boys.

There is an opportunity to redesign the project for its next phase with the local governments who are looking at gender and within it GBV as part of a broader social sector approach, including education and health. This could be an advantage if used strategically to mainstream gender and GBV through health system (already demonstrated well by this project in terms of response) and education system (working with young girls and boys to critically reflect on social norms and challenge harmful behaviours). Youth will be another important category for the local governments (although focus might be on gainful employment/livelihoods).

3.3.5. Synergies with other interventions

There is no evidence of synergy with other UNFPA/UN or SDC interventions. In fact there are clear areas where good practices or knowledge products from UNFPA existing projects in Nepal could be brought into this project (CSE for instance), but have not been done.

Similarly, while both UNICEF and UNFPA work with the DWC, WCO and Women's Cooperatives on GBV prevention, there is little exchange of ideas or working together, especially in preparation and re-strategizing in the context of the new federal structure. UNICEF for instance, has developed "adaptation plans" for its 12 focused districts on GBV intervention that outlines how they would proceed during the period of transition, including working with WCOs to help them influence plans and work of the municipalities. UNICEF also worked with DWC and WCO and submitted annual work plans of WCOs to the local governments, making presentations of their work and has mapped where WCO in all 35 districts (where UNICEF originally worked before federalization) have been placed and shared the information with the DWC.

UNFPA has not yet developed its strategy for working with the local governments and this needs to be prioritized. Representations by project staff need to be made to all local government in project locations. In Okhaldhunga, where the CMO has taken initiative, at least the local governments are more aware of the UNFPA project but in Udayapura this was not the case.

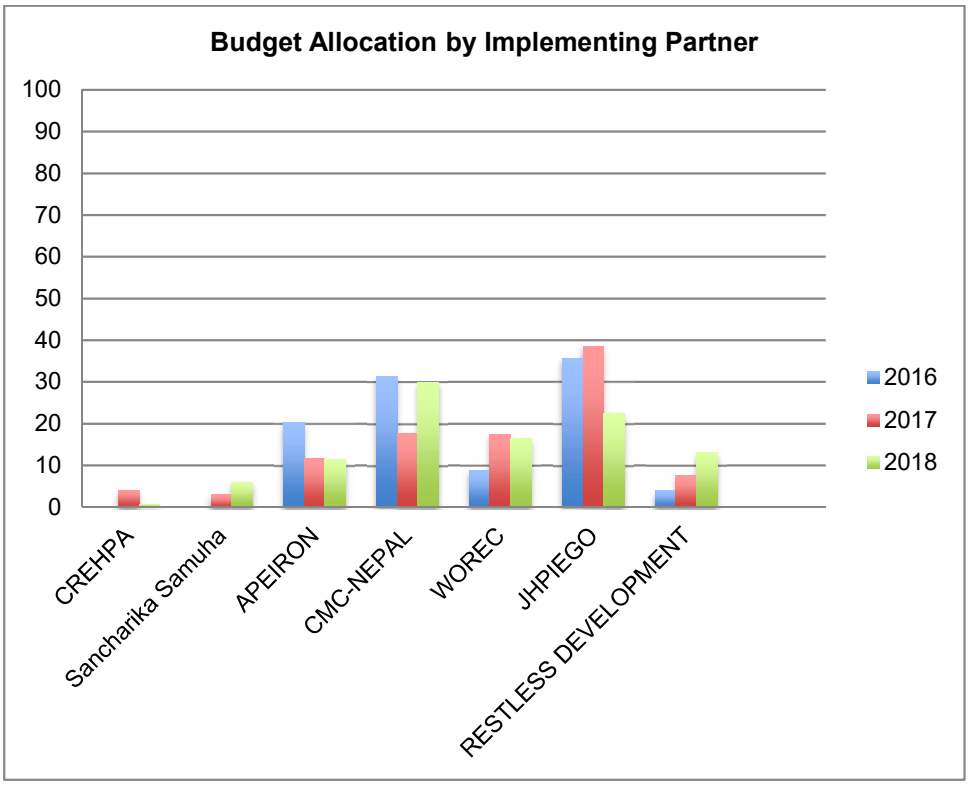
3.4. Efficiency

3.4.1. Cost efficiency and relation between cost and quality

It is too early to make an assessment of cost efficiency but one can look at how the comparative investment in different elements and the results that are emerging. From the chart below[7], it appears that allocation is significantly higher for components related to response than for prevention (WOREC, Sancharika Samuha and Restless Development). Over 60 per cent of budget allocated to implementing partners was allocated for interventions to strengthen response.

While it could well be that some interventions cost more than others, it may be worth reviewing the allocation to assess intended or unintended bias or presumption about the comparative investment for the two components. While an effective response mechanism is crucial and can contribute to prevention, without investments in preventative work to change social norms, patriarchal attitudes and behaviours are unlikely to change.

Lower allocation for prevention work and poorer results in outcomes related to prevention may be correlated.



3.4.2. Factors contributing to delays in project implementation

The project has been affected by delays at two points in its implementation. One at the very beginning of the project where staff were only hired by the 6th months and implementing organizations by the 8th and 9th months. These are attributable to internal

[7] This is a quick assessment based on budget related data shared by UNFPA. A more detailed assessment by inputs could be more useful and is recommended for future planning.

systems and processes of UNFPA, which ideally should have been built into the project design and timeline and budget. See Annex 5 for operational milestones in the project.

While UNFPA was already working in Udayapura and Sindhuli prior to the signing of the agreement with SDC, it had to seek and obtain approval from the Ministry of Federal Affairs and Local Development to implement the project in Okhaldhunga. This approval and agreement with DDC in Okhaldhunga was signed in August 2016, only after this the activities in the district could be initiated.

The other set of delay was caused during the elections for local governments where field activities were disrupted for few weeks and then after the local governments were set up and WCO were dismantled. Dismantling of the WCO and DDC meant that the funds that were previously flowing through DWC and MoHP (cost of trainings of WC, GBV watch groups and girls groups, payment of salaries to OCMC staff and CPSW) and activities that were the responsibility of the WCO and DDC were stopped and UNFPA had to find other ways to channeling the same.

Activities that were suspended for three months were those where WCO was responsible for logistics/ operational aspects—training WC, GBV WG, police, Bar, DDC DAO staff training, and establishment of 2 new safe houses. Suspension lasted 3 months. With the uncertainty in roles and channel of funding from international organizations, for all levels of government in Nepal, UNFPA proposed that budgets that were previously routed through DWC and DDC would now be channeled through existing implementing partners- WOREC's work plans were revised to include fund flow for Udayapura and Sindhuli while CMC-Nepal's work plans were revised to include fund flow for Okhaldhunga. This adjustment was made in October in the work plans and funds for third quarter were disbursed to partners in November along with funds for the 4th quarter, which were also delayed. This delay had cascading effect on regular activities of partners (they had no funds). After work plans were revised in October, it took one more month for CMC-Nepal and WOREC to sign agreements with WC to enable fund transfer from WOREC and CMC-Nepal to WCs. Despite the delay in fund disbursement, partners were able to spend majority of the funds by end of 2017.

Given the initial delay by 6 months and the fact that the possibility of dismantling of the DWC was expected (reference Project Document), perhaps an alternative could have been planned earlier.

Apart from the above-mentioned operational factors that caused delays, some delays can be attributed to lack of clarity on strategy and method. For instance, due to lack of clarity, the interventions with boys were not initiated. Another factor could be lack of sufficient planning and preparedness. For instance, the module for ToT of WC members and curriculum for training couples was developed or finalized before conducting a training needs assessment. Some of these factors could have been avoided had partners participated in the design of the project and its planning (what preparedness is required).

The project was looking to experiment with a few new and unfamiliar elements (couple's training) but on other elements, there is a body of experience and resource already among the existing partners and others in Nepal (or within the region). These could have been harnessed in designing and planning of the project.

Primarily as a result of the delays, the project has unspent 45 percent of the budget allocated for 2016-2017 and UNFPA is confident of utilizing the unspent amounts within the third and last year of the project with a no-cost extension of 6 months (to make up for the 6 month initial delay).

3.4.3. Project management

With multiple partners

The project is implemented with multiple implementing partners; both local and international NGOs that have specific work plans and look at specific elements of the project but also addressing the same beneficiaries or targets. For instance, representatives of Women's Cooperatives receive training from WOREC on gender GBV and RH, from CMC-Nepal on psychosocial skills relevant to GBV work, from CMC-Nepal as and for couple's training and from APEIRON on management of safe houses. In hospitals, regular staff receives training from JHPIEGO on clinical protocols while Case Managers and Counsellors receive training from CMC-Nepal. CPSW (who are also members of women's cooperatives receive training on psychosocial work from CMC-Nepal and on documentation from WOREC.

If managed well, as a collaboration, with consistency in perspectives and messaging, and appropriate selection of targets (for e.g. who among the WC is trained for what) such a multi-partner project could well add value to the project. If not, it could end up compromising results for targets and beneficiaries.

If implementing partners do not have a similar perspective on gender-based discrimination, patriarchy and its impact on violence and implications for psychosocial work (which is likely the case), the target groups being mobilized and trained to work together in this project: members of women's cooperatives, CPSW, Case Managers, hospital staff, police, could be receiving mixed messages.

Besides, different elements of the project need to be working in cooperation with each other. Where such cooperation is facilitated and supported, results have been better (Okhaldhunga) while where such cooperation is not facilitated, results have been compromised. At least in one case, OCMC staff have reported that they do not have good collaboration with the service centre managed by WOREC. WOREC staff of the centre do not allow OCMC Case Managers to be involved in cases that are being hosted at the WOREC service centre. And given WOREC's history of work in the district (Udayapura), the police also directly refer survivors to WOREC's centre rather than the OCMC. Such lack of coordination could dilute project's effectiveness and efficiency.

The project does not seem to have been anchored and facilitated as one program, rather as a set of different interventions implemented by different organizations. UNFPA senior management holds partners responsible for the lack of collaboration whereas, as the primary holder of this project who has recruited the various partners, the responsibility for ensuring collaboration, consistency and synergy rest with UNFPA. At the district level as well, in the absence of clearly defined structures and mechanisms for ensuring collaboration and synergy, depending on initiative and experience of individual staff, there is more collaboration in some places (Okhaldhunga) than others (Udayapura).

Perhaps the project could benefit from a mechanism that promotes a more meaningful partnership for the project (and not just contractual relationship between UNFPA and individual partners). A common perspective building exercise needs to be undertaken as a first step and the project design and execution reviewed as a program of interconnected and interdependent elements that have a common perspective, language and objective. UNFPA may also review whether fewer partners can implement the project. For instance, could CMC-Nepal also run program for girls and boys, they also have expertise and experience of working with both, girls and boys, and that too in schools (which is essential for institutionalizing the work on changing

social norms with children, a strategy that is already proposed by UNFPA in strategy paper on addressing GBV). CMC-Nepal also has the ability and wherewithal to monitor and provide sustained inputs in the field.

Within UNFPA

Internal organizational management of UNFPA seems to be weak. The organogram of the project has changed frequently with uncertainty on leadership of the project among staff at UNFPA (and also to SDC). Staff have reported a lack of guidance and leadership while at the same time discouragement for initiative. Clear lines of communication between project staff, leadership and implementing partners are not established with project staff's communication with partners frequently overruled without their engagement by senior leadership. The project is at risk of festering discontent and lowering motivation of staff. Staff who were hired with clear commitment on part of UNFPA to help build their capacities on GBV report that they have not received any opportunities for capacity development and that affects their ability to contribute more meaningfully in their roles.

Capable and experienced leadership is crucial for a complex multi partner project where UNFPA is expected to provide technical leadership and management and steering of the various components as part of a whole.

It appears that internal systems at UNFPA are also partially responsible for inefficient management. For instance, while the field staff report to project coordinator at the central office, they need permissions from regional office for their travel to the field for monitoring. The role of regional development coordinator is not clear and staff report that they are frequently denied permissions to travel to the field for monitoring.

Even though there is an M&E officer looking after this project, there is not yet a robust results-based monitoring framework that is applied by all implementing partners consistently. This framework should have been established at the very beginning of the project.

3.4.4. UNFPA's interaction with different levels of government

UNFPA has some degree of interaction with the DWC and MoHP, namely through annual review meetings that are conducted with them. The MoHP however felt that they would like to be more engaged, be informed about the various trainings and lessons learned in the project so they may include good practices in their policy and plans. They were pleased to hear the MTR team's feedback on the progress made under the project with the OCMCs and the CPSW.

At the local level however, UNFPA has had no interactions in Udayapura and some informal interactions in Okhaldhunga. UNFPA awaits joint UN strategy on working with local governments. However, in the meantime, some representation could have been made to the local governments, introducing the project, its partners. It has been now 7 months since the local governments were established and there have been no strategic interactions with them by the project.

4. Conclusions

4.1. Lessons learnt

What is working?

i. Strategies to improve and strengthen response mechanism have worked because:

- ✓ Service providers have been appointed along referral continuum: from CPSW in community till Case Managers in OCMC
- ✓ Service providers along continuum have been provided with training that is helping them in their work and making them more accessible to survivors. For instance, not only staff of hospitals in the districts but also health posts in the communities are being trained
- ✓ Trained service providers: CPSW and OCMC Case Managers receive regular mentoring and supervision
- ✓ Home visits by Case Managers and Outreach Counselors have been crucial for improving women's access to OCMC services, especially given that women affected by violence rarely visit facilities as a first step.
- ✓ Engaging hospital staff meaningfully and providing them with training is crucial for identification of passive survivors (patients that come with "regular" complaints to OPD, for instance) the success of OCMC
- ✓ Women and girls who participate in WC, GBV WG and GG are aware of service providers and linked by CPSWs

Where sustained training and mentoring is provided to actors selected on the basis of their job description, ability and motivation, actors are able to deliver more effectively on their results (for instance CPSW, Case Managers)

ii. Providing community based psychosocial workers who are available in the community and who focus on "listening" and provide the first source of support to survivors in a confidential and non-threatening manner has been successful strategy to encourage women to break the silence and seek support. CPSW emerge as the most effective and efficient input in this project—leading to improved help seeking behaviour among survivors, including along the referral continuum by successfully linked communities with service providers, particularly trained case managers at OCMCs

iii. Providing trained case managers in hospitals and training hospital staff (Doctors and Nurse) on GBV has helped increase identification of cases, referrals and in provision of appropriate and trained response to survivors

iv. District level coordination between different implementing partners and actors is working better in Okhaldhunga than in Udayapura, primarily because of facilitation of coordination by the more experienced CMO in Okhaldhunga than Udayapura.

v. Engaging girls with sustained inputs over a period of a year has helped in their own personal development and strengthened their ability to negotiate for their rights within their homes. This is a group with high potential for changing social norms and will need continued mentoring and support from capable facilitators to grow into a solidarity group for each other and for continued evolution of their understanding of harmful social norms and how to challenge and change them.

What is not working?

i. Strategies for empowering women and men to prevent and address gender-based violence is not working because:

- ✓ There is insufficient understanding of what it takes to change behaviours of women and men, girls and boys. The theory of change for the project proposed that when women and men reflect on social norms, then change happens. In practice, the project miscalculated how reflection on social norms can be facilitated. Strategies such as 5 days of training representatives of women's cooperatives to influence other women have not been successful in reaching out and communicating behaviour change with other women (other members of the WC, GBV watch groups or other women in the community). Similarly strategy of engaging men through mobilising couples for "training" has not yielded desired results. Facilitating critical thinking on social norms is a complex and evolving process and cannot be achieved in a 3, 5 or 12 day "training". A modular, consistent and capable facilitation over a period of time and experiences supports change in perspective, understanding and behaviours, not short infusions of information.
- ✓ Men and boys have not been engaged meaningfully and effectively to enable them to challenge and change toxic masculinities. Focusing interventions for prevention and behaviour change among women and girls will not reduce violence against them perpetrated by men and boys if men and boys are not made responsible for their behaviours.
- ✓ Sustained inputs and mentoring has not been provided to trained agents of change—women members of cooperatives and GBV watch groups and girls groups, as is evident from the lack of plan of action and clarity with these groups about their exact role and how they are to fulfill it.

ii. Modality of behaviour change and empowering through short duration trainings do not work if most suitable agents of change are not carefully selected on the basis of their capabilities, motivation and potential for being change agents (older couples for instance) and if existing training modules are applied without a training needs assessment (ToT of Women's Cooperatives and training of couples, for instance). Curriculum followed in information sessions is limited to providing information on types of violence, reproductive health and not so much to develop critical reflection on social norms and how to challenge and change them, as well as how to influence others to do the same (ToT)

iii. Making women's cooperatives the fulcrum of the project when they understand their primary identity as that of a savings and credit group, their outreach is limited to women from their own ethnic backgrounds (relatively homogenous group) and where their experience of mobilising other women has been limited to recruiting for the savings and credit groups—has not yielded the result empowering women and girls. Even though it was necessary for the project to work with WC to be aligned with the GoN program and strategy on women's empowerment, making WC the only source of outreach and mobilization has not worked. It is perhaps also one factor why men and boys have not been mobilized under this project. Women's cooperatives can be part of the project as one of the targets but not as the only source of outreach and mobilization.

iv. In the absence of a clear perspective on gender-based discrimination and GBV as offshoots of patriarchal ideology, implementers such as CPSW or trainers of couples (or others in the community) are at risk of conveying unclear messages

including those that suggest a tolerance of male toxic behaviours. “Women and men are equally responsible for ensuring harmony in the relationships”, are benign statements that in the context of “counseling” couples where the man is abusive could give the message of tolerating toxic male behaviours. Such misplaced understanding will completely contradict the objective of the intervention.

v. Infrequent monitoring and monitoring systems that lack a results framework and mechanisms for generating lessons and feeding them into the project affect program quality and efficiency.

vi. Multi-partner projects without sufficient opportunities for building common perspective, understanding and synergies are at risk of undermining project results.

4.2. Recommendations

The MTR team recommends that project for prevention and response on GBV must be continued in Nepal. The current project needs to make some modifications for the remaining period of the current project period and the second phase of this project needs to be re-designed based on lessons learnt from the current phase, specifically in terms of focus on prevention work.

To improve program effectiveness

i. A common perspective building exercise needs to be undertaken as a first step and the project design and execution reviewed as a program of interconnected and interdependent elements that have a common perspective, language and objective. UNFPA may also review whether fewer partners can implement the project. For instance, could CMC-Nepal also run program for girls and boys, they also have expertise and experience of working with both, girls and boys, and that too in schools (which is essential for institutionalizing the work on changing social norms with children, a strategy that is already proposed by UNFPA in strategy paper on addressing GBV). CMC-Nepal also has the ability and wherewithal to monitor and provide sustained inputs in the field.

ii. Develop a strategy for prevention that includes engaging women and girls, men and boys (including youth aged 16-24) in critical reflection of social norms and how to challenge and change them. UNFPA already has a tried and tested global package for working with adolescents to address violence (among other things)- Comprehensive Sexuality Education. And there are several initiatives that have successfully engaged boys and men in Nepal, (including Reflect model by CARE), South Asia and different parts of the world. Indeed, UNFPA’s own strategy document on engaging with men and boys “Engaging Men and Boys, Communities and Parents to End Violence against Women, Child Marriage and Other Harmful Practices in Nepal ”, suggests strategies for the same and could have been adopted for this project.

   Include an output in results framework on development of critical understanding of discrimination and violence in prevalent social norms among women and men, girls and boys

   Expand package for training and mobilization to include more materials on gender, power, sexuality, (toxic) masculinities/femininities and violence prevention and response

iii. Expand focus of project to address women’s empowerment in general, specifically developing leadership among women. With the trend in local governments

clubbing together gender issues with other social sectors such as education, health and employment, there is an opportunity here to embed GBV interventions with and within broader interventions for gender equality and women's empowerment. Explore how project can link with other initiatives to promote women's financial autonomy

iv. Review all trainings under the project for the appropriateness and sufficiency of their training materials to address gender based violence

All knowledge products need to be reviewed collectively and a common set of products needs to be owned, implemented, monitored and fed back into the what's working, what's not kind of knowledge management.

Rupantaran module itself needs to be reviewed for its suitability for preparing girls for GBV prevention and response. There is far more emphasis on developing financial skills and being "good citizens" than on critical reflections on social norms, learning new behaviours, including negotiating and advocating for their space. Consider other modules being used for girls and boys include module by UNFPA on CSE, CMC- Nepal's module, modules being used by other partners in other projects.

Put on hold the *couple's training* program, conduct an extensive review of the intervention in broader consultation with other partners and experts and either redesign interventions for couples or explore other more effective ways of engaging men (see (i) above). In the interim, continue to provide support to couples through CPSW as required.

Put on hold the *ToT for Women's Cooperatives* and continue to provide them and GBV watch groups with information and engaged in referral loop through CPSW. Re-allocate resources to interventions of strengthening capacities of local governments (see below). In the meantime develop curriculum/modules for critical reflection on social norms and review and modify *Sanjivani* or introduce a newer model

Review training modules for health service providers, including hospitals, health centres, OCMC and CPSW for clarity of perspective on gender inequality and for ensuring that health service provision, including psychosocial services, address gender inequality, discrimination and do not unwittingly embolden perception of normative behavior expected of women.

Review the modality of training of trainers, focus on identifying and developing capable facilitators and social mobilisers and provide them with meaningful, sustained inputs and mentoring (like for CPSW). These could be social mobilisers or facilitators that are being hired and or mobilized by local governments under the current set up, or mobilisers that implementing partners use as part of their other projects (both CMC- Nepal and WOREC develop a team of trained community mobilisers)

v. Mentoring and interventions on capacity development at health centres in communities needs to be strengthened. Female Community Health Volunteers are closely linked with these health centres and are relevant to outreach and for linkages but have been so far excluded. They need to be included for improved outreach.

vi. Increase the number of CPSW and bring them on board as full time paid workers along the line of government employed social mobilisers. The new batch of CPSW should be selected by the local governments.

For improved management and monitoring of the project

iv. UNFPA to develop mechanism for ensuring collaboration, consistency and synergy across different project components and partners. Clear strategy and mechanism for collaboration between different partners need to be developed at the central level as well as at the level of implementation.

v. Develop a robust results based monitoring framework that enhances learning and feedback. Improve data management, providing consistent templates for reporting at all levels. Establish clear guidelines for frequency and objectives of monitoring by project staff that are aligned with results framework. Monitor use of outputs, such as training, review training curricula, selection of trainers and audience for training (age, scope for change and scope for being change agent)

vi. Review project organogram and ensure appropriate leadership and guidance is provided and roles and responsibilities are clearly communicated to all staff with clear lines of reporting. Organize training for staff on GBV and skills that they may need in carrying out their roles. Establish clear monitoring plans with frequency, coverage, content and learning agenda specified. Review controls in administrative processes for monitoring visits and make them more efficient.

vii. UNFPA will need to build its own capacities and capacities of partners to work with the local government, while ensuring that these team members are also either experienced in or provided with training on gender, GBV, etc.

For working with local governments

A large part of the success of the project depends on successful evidence based advocacy with the government. With the new federal structure emerging, targets for advocacy will need to evolve too. In the immediate future, the project needs to focus on working with local governments while continuing to engage with the Ministries at the central level and explore collaboration with the state (Social Development Ministry). Timing is crucial for policy advocacy. It is best done before governments make their plans and budgets for the year, which for the duration of this project would be June 2018. While UNFPA awaits joint UN strategy on working with local governments, the following actions are recommended for the remaining period of the project:

Immediate next steps:

i. UNFPA could make representations to all municipalities in the project, and orient them on gender inequality, women's empowerment and GBV and support development of their plans for fiscal year 2018-2019. Build common perspective and messaging on work GBV before orienting local governments.

ii. Advocate for integration of specific components plans of municipalities for upcoming fiscal year—specifically the CPSW and OCMC. Offer to match funds for CPSW and maintain funding of Case Managers until MoHP is able to finance.

iii. The policy brief on "importance of and best approaches to mainstream psychosocial support in the multisectoral response and prevention of GBV" could be developed specifically for municipalities and on priority presented for their consideration for FY 2018-2019. Given the positive indications from the components of CPSW, case managers and hospitals/health centres in general, institutionalizing CPSW and case managers could be the core advocacy message.

Success of this initiative will help achieve the result expected under this output and indeed for the outcome.

Medium term and next phase

There is an opportunity to redesign the project for its next phase with the local governments who are looking at gender and within it GBV as part of a broader social sector approach, including education and health. This could be an advantage if used strategically to mainstream gender and GBV through health system (already demonstrated well by this project at least in terms of response) and education system (working with young girls and boys to critically reflect on social norms and challenge harmful behaviours). Youth will be another important category for the local governments (although focus might be on gainful employment/livelihoods).

iv. Strengthen capacities of local governments.

- The project now needs to include as its target group, the structures and local authorities emerging from the new structure- The Mayors and Deputy Mayors, Ward Chairs, Council of Municipality and the Village Assembly. The Judicial Committee and the specific department or unit on "social sector" at the municipalities will need to be included in capacity strengthening initiatives.

- Strengthening understanding on GBV and capacities to develop action plans, local policies, allocation of resources would be relevant for the local government now. Also, since the Assembly gives mandate to municipalities, interventions with assembly are important.

- The Local Government Act (Section 12) specifies that every Tola (neighborhood) should be organized into a *Tola Vikas Samiti* (Neighborhood Development Committee). This could be considered as one mode for implementing the GBV project, perhaps in the next phase.

- Among the list of legislation that local governments are required to enact, two are specifically relevant to GBV 1) *Melmilap* (Reconciliation) and arbitration/ mediation Act; 2) Emergency Fund establishment and implementation/operation Act. There is also a requirement for municipalities to enact a "Protection" Act, although it is not yet clear whose protection and whether protection of children and women is included and if social protection is also included in this. In addition, municipalities need to develop legislation for operations of the Judicial Committee. The GBV project could provide support to the municipalities in the development of these legislation.

- The social development section of local government needs to be equipped with situation analysis and supported to manage and use data to plan their interventions. At the moment some staff of WCO are included in the social development section and they might have varying degrees of capacities but beyond this, there are no trained persons at the municipalities who are ready to plan and implement GBV/gender related work. In some municipalities elected representatives may have a background in law or may have been trained under various programs. So there is need to conduct a capacity needs assessment of members of the municipalities and plan for their capacity development accordingly.

v. While it will be important to support and strengthen the capacities of elected women representatives to understand, prioritize and plan appropriate interventions for their municipalities, it will be crucial to include male elected representatives to improve the programs relevance to engaging with men and boys. Besides, women elected representatives need capacity enhancement in areas beyond GBV or other themes/sectors—on their leadership and ability to negotiate in a male dominated structure.

vi. Municipalities capacity development needs are not restricted to GBV or gender they need support more broadly on organization development, planning and managing their work. They are required to develop their own laws, policies, standards, regulations and indicators. Both men and women elected representatives shared with the MTR team that they need support and help in developing these. One deputy mayor specifically asked for help in understanding laws pertaining women and GBV so she may address cases accordingly (there is some confusion on the scope of judicial committees intervention on GBV). Capacity building interventions for municipalities must be able to respond to these needs of the municipalities as well. For instance, the gender equality and GBV capacity enhancement program can include workshops on perspective building as well as support the municipalities in developing laws, policies, standards, regulations and indicators in the gender thematic area.

Annex 1: Terms of Reference

External Review of Gender-based Violence Prevention and Response Project

1. The Project

The Gender-based Violence Prevention and Response Project, short GBV project, phase I from January 2016 to December 2018 is based on a contract between the Swiss Agency for Development and Cooperation SDC with UNFPA. The project responds to the high prevalence of GBV and the lack of appropriate response mechanisms and services in Nepal. The overall goal of the GBV project is to reduce the prevalence of GBV through the effective empowerment of women and men and through prevention and response interventions by more responsible and capable government agencies.

Outcome 1: Men and women in working districts increasingly prevent, report and address gender-based violence

Outcome 2: Duty bearers respond effectively to gender-based violence in working districts and increasingly at national level

UNFPA implements the projects in three districts of Nepal, Sindhuli, Udayapura and Okhaldhunga. In these districts, the project supports women's cooperatives (WCs) to establish functioning GBV watch groups, adolescent girls groups and men's networks. The WCs are CBOs set up and capacitated by the district Women and Children Development Offices (WCOs). The project helps them to implement the national guidelines according to which WCs must form GBV watch groups at ward level and groups for girls. Men in strategic positions as well as young men are also involved in project activities.

A strong emphasis of the project is on strengthening government services for the prevention of and response to GBV. One Stop Crisis Management Centres (OCMCs) were established at the district hospitals and staff of hospitals and health posts were trained to respond to GBV affected persons. Each district now has a safe house for GBV survivors. Trainings were provided to police personnel. The link between government services and the GBV victims/survivors is being made by a) Community Psychosocial Workers (CPSWs) who are members of the WCs and the GBV Watch Groups and b) the outreach psychosocial counselors based in the OCMCs.

UNFPA implements the project mainly through Government and NGOs implementing partners. One district based staff and 2 staff at the Kathmandu office of UNFPA support the project implementation.

The project started in January 2016; the intervention was fully operational on the ground after April 2017. While the achievements since and in just a few months are impressive, it has also become apparent that the exclusive focus on GBV may be too narrow and possibly even counterproductive. The evaluation will thus not only review past achievements but will be forward looking in terms of scope and operational modality of the project. The evaluation therefore will make recommendations as to how the intervention could be broadened from a standalone project to an intervention more integrated in and aligned with other initiatives for the empowerment of women.

Since the beginning of the project, the state structure has changed. The local governments have to take on many functions in relation to the empowerment and protection of women and on GBV in particular. All these activities will be part of the wider social services, a sector that has to be established and enabled to fulfill its functions.

Moreover, the functions, reporting and accountability mechanism of sectorial line ministries (e.g. health) in relation to the sub-national governments has not been defined yet. A basic system of planning, monitoring, budgeting and reporting of development interventions is yet to be established by local governments. It is unclear and has to be explored how government services will incorporate GBV prevention and response, including empowerment of women and men.

The next phase of the GBV project will have to take all this into consideration and contribute to strengthening the new federal structures particularly the social development sector at the local level.

2. **The purpose of the external review and related key questions:**

The purpose of the external review is to make an overall assessment of the achievements by the GBV project with a special focus on its processes, outputs and outcomes, and to make recommendations for the design of the next phase of the project. Hence, the external evaluation will have the following objectives:

C. Evaluate the relevance, effectiveness and efficiency of the project and identify the main lessons learnt and best practices.

D. Propose major elements of a relevant project design for the new federal structures, which creates meaningful linkages to other projects of UNFPA and SDC.

The related guiding questions under each objective of the review are:

Relevance:

- To what extent are the outcomes and outputs as specified in the ProDoc still valid for prevention of and response to GBV?
- How relevant is each component for prevention and response to GBV?
- Is the program relevant in relation to the needs and priorities of the intended beneficiaries?
- Have relevant issues emerged over the last years that are not addressed by the project?

Effectiveness:

- To what extent have the outputs and outcomes of the project been achieved or are likely to be achieved by the end of the phase?
- What were the major factors influencing the achievement/non-achievement of the outcomes and outputs?
- How could the effectiveness of each component be enhanced, particularly the work with men and boys, and the scope of Women Cooperatives and GVB Watch Groups?
- Beyond the quantitative target set in outcomes and outputs, what is the quality[8] of the services provided?
- How does the monitoring system and the knowledge management approach support the effectiveness and quality development of the project?
- How does the project set-up, i.e. the exclusive focus on GBV promote/limit the effectiveness of the project?
- How has UNFPA been able to create synergies with other UNFPA/UN Agencies and/or SDC interventions?
- How many people are benefitted by the project intervention?
- What are the real differences that the project has made on the lives of the targeted beneficiaries in the very short time of the first phase?
- What results not mentioned in the ProDoc were achieved.

Efficiency:

- To what extent were the activities carried out by UNFPA cost-efficient? What is the relation/relevance between the cost and quality?
- What relevant factors have contributed to delays in project implementation and how can they be avoided/adjusted?

[8] Quality: Major indicators of quality for each service will have to be identified by the evaluators based on the monitoring framework and in consultation with project stakeholders.

- What are the pros and cons of the implementation modality of UNFPA and the management of the project (UNFPA's management of the project; modality with a number of implementing partners at the central and local level, GoN),
- What is UNFPA's interaction with the federal and provincial level governments and local CSOs and networks of women and discriminated groups?

3. Recommendations for the design of the next project phase

- What are the lessons learnt from the current phase of the GBV project?
- What are the recommendations for the next phase in terms of
    - Entry points for the work on GBV/scope of the work when adopting a broader empowerment focused approach and if possible create synergies with other SDC interventions (employment/income and migration)
    - Relevant components/types of interventions and services
    - Strengthening of local government capacities and collaboration with all levels of government in terms of social service delivery and women's empowerment; including the type of expertise and human resource required for project implementation in Palikas
    - Project implementation modality and partnership approach
    - Project management , including project steering

4. Methodology and scope of work

The review team will propose the methodology and discuss and agree it with SDC Nepal, and with UNFPA. The external review team is expected to conduct individual interviews, Focus Group Discussions and meetings/workshops with the major stakeholders (see the list of stakeholders below) and onsite field visits. The initial findings shall be presented towards the end of the review in a meeting with stakeholders.

Specific tasks and methods:

- Review reference documents to be familiar with the nature of the GBV project and its contribution in addressing the issues related to GBV in Nepal (see list of reference documents attached) and hold preliminary discussions with SDC and UNFPA.
- Consult, discuss and verify findings with stakeholders in Kathmandu and in Udayapura and Okhaldhunga districts. Potential stakeholders to be consulted are:
    - Partner organizations
    - Sample Palikas: elected representatives, chairs/mayors and deputy chairs/deputy mayors; Chief Administrative Officers, Women Development Officers, Public Health Officers and Police Officers, coordinators of Judicial Committees
    - Responsible ministry at federal and provincial level
    - UNICEF, UN Women and development partners with GBV programmes
    - UNFPA
    - Beneficiaries
    - SDC
- Conduct consultation workshops to consolidate the findings.
- Sharing of preliminary findings with SDC and UNFPA
- Sharing of findings with key stakeholders

5. The Review Team

The review will be conducted by an international consultant acting as the team leader and one or two Nepali consultant acting as member of the external review team.

Expected competencies for the team leader

- Sound experience in evaluation of development projects; analysis of project management
- Strong background in gender issues, women's empowerment, GBV
- Understanding of governance structures in a federal system
- Good understanding of UN organizations
- Knowledge/experience in South Asia
- Excellent analytical and report writing skills in English.

Expected competencies for the team member (s):

- Sound understanding of the federal governance system in Nepal and issues related to the state restructuring process; very good understanding of capacity issues and functions at the local and provincial level
- Sound understanding of community structures, social mobilization processes and community institutions working in GBV and women's empowerment in Nepal
- Good understanding of GBV, gender and social inclusion
- Sound experience in evaluation of development projects.
- Excellent analytical and report writing skills in English.

6. Time Frame and estimated working days for lead consultant

The review will take place from xx February, 2018 to xx March, 2018. The number of days for completing assignment is estimated at 27 days including travel, preparation, finalizing the report and debriefing.

Activities	**Days**	
	International consultant	**National consultant**
Preparatory work (Review of relevant documents, work plan, report structure etc.); preparation of mission plan and methodology	1.5	1.5
Onsite visit and interaction with beneficiaries and local stakeholders in Palikas of 2 districts; interactions with provincial ministry	10	10
Meetings, Interviews and Focus Group Discussions with partner organizations, stakeholders, UNFPA and SDC in Kathmandu	4	4
Analysis and writing of draft report	4	1
Presentation of the draft report/debriefing	0.5	0.5
Finalizing the report	2	1
Sharing of findings to key stakeholders	0.5	0.5
Debriefing with SDC and discussion of next steps	0.5	0.5
International travel	2	
Total	**25**	**19**

7. Reporting and deliverables

The lead consultant shall submit the following documents:

- Evaluation work plan including approach/methodology before the start of the mission.
- Final report of **maximum 30 pages including an executive summary (4-5 pages) to SDC and excluding annexes**. The report should be submitted as soft copy within two weeks after the end of mission.

8. Roles and Responsibilities:

- The consultant/s work closely with SDC (Barbara Weyermann/Manohara Khadka).
- UNFPA will arrange for logistics and prepare field itinerary for the consultants.
- Consultants are responsible for the assignment as per the finalized TOR and meet the expected objectives of the assignment.

9. Reference documents to be consulted:

- Project Document and Agreement
- All YPOs and semi-annual/annual reports
- All study reports
- All reports from partner organizations
- Operating guidelines, monitoring guidelines, communication guidelines; contracts with partner organizations etc.
- Swiss Cooperation Strategy (2018-2021); UNFPA Country Programme Action Plan 2018-2022
- Local Governance Act and all other acts and guidelines which are relevant for the federal structure.
- Relevant gender and social inclusion acts, policies and frameworks of government and development partners

Annex 2 a: Itinerary for MTR consultations in project locations in Udayapura and Okhaldhunga

Date	Groups met with	Person (s) to meet/visit
9-March - 18	Kanchan Women Cooperatives (Rauta)	Executive Committee Members of WC
	GBV-Watch Group members of above	GBV-Watch Group Members
	Meeting with elected representatives of Rautamai Rural Municipality and Judicial Committee	Gajendra Khadka (Chair), Kumari Thakuri (Vice Chair)& Judicial Committee members
10-Mar-18	Meeting with Namuna Women Cooperatives (Triyuga)	Gayatra Dhungana (WC President), Tara Bhattarai (Secretary) and Executive Committee Members
	Meeting with GBV Watch Group of above	GBV Watch Group Members of Namuna WC
	FGD with Girls Group (Triyuga)	SFSP session observation of Apsana Khatun (SFSP Facilitator) and Laxmi Ghimire (SFSP Facilitator)
	FGD with trained married couples (Triyuga)	At least five trained couples
11-Mar-18	Visit to OCMC Udayapura, FGD with OCMC staff and meeting with Doctors and other staff	2 Case Managers and 1 Psychosocial Counselor, DPHO, Medical Superintendent, Staff Nurse
	Meeting with elected representatives of Triyuga Municipality and Judicial Committee	Baldev Chaudhary (Mayor), Devi Kumari Chaudhary (Dy. Mayor and 2 other Judicial Committee members, Taranath Kafle (CAO)
	FGD with CPSWs	
	Meeting with Trained Police personnel	Nabaraj Bhatt (SP), Uma Gurung (Police cell), Surendra Lamsal and other available trained police personnel
	Visit SaMi Counseling Center of SDC	Sonam Rai (Sami-District Coordinator) and Visit CDO
13 March, 2018	Travel to	
	Meeting with Mahila Beli Chameli Women Cooperative (Molu Rural Municipality)	Executive Committee Members
	Meeting with GBV-WGs of above	At least 10 GBV-WG Members from Beli Chameli WC
	Meeting with elected representatives of Molu Rural Municipality and Judicial Committee	Mayor, Dy. Mayor and other Judicial Committee Members, Chief Administrative Officer, Women and Children Section staff
	Meeting with trained married couples	5 Trained married couples from Harkapur
	Meeting with GGs	Girls group of ward 2 of Harkapur
14 March, 2018		
	Visit to OCMC Okhaldhunga Consultations with Case Managers and Psychosocial Counselors; and with hospital staff (Doctors, Nurses from hospital and health posts)	Sajana Rai, Kumari Tamang and Chhatra Khatri
	Brief meeting with DHO	

	Meeting with safe home staffs and management committee	Dhankumari Thapa, Pemdoma Sherpa and the management committee of safe house
15 March, 2018	FGD with trained married couples, Siddhicharan Municipality	At least 5 trained married couples from Siddhicharan Municipality
	Meeting with elected representatives of Siddhicharan Municipality Team and Judicial Committee	Mohan Shrestha (Mayor), Ichha Kumari Gurung (Dy. Mayor), trained Palika members Binok KC (CAO), Binod Shrestha, Kedar Babu Basnet, Dan Bahadur Baniya, Aita Bahadur
	Meeting with trained police personnel and Women and Children Service Centre	Mr. Dashrat Chaudhari, Incharge of women and Children Service center of district police office and other trained police
	Meeting with 10 CPSWs from different area	10 CPSWs
	FGD with GEEGBVDCC	Gender Equality, Ending GBV District Coordination Committee

Annex 2 b: Consultations held in Kathmandu

5th March	Meeting with UNFPA and SDC (at UNFPA) - **Introduction of the project by UNFPA** - **Methodology presentation by the Evaluation team followed by discussion, including expectation by UNFPA from the evaluation**
	Meeting with SDC - Discussions of evaluation plan/questions etc. - Introduction to SDC strategy and other relevant projects
6th Mar	**Consultation meeting all implementing agencies/partners** (APEIRON, JHPIEGO, CMC-Nepal, WOREC, Restless Development, Sancharika Samuha) - Each partner presented key results/achievements and challenges, followed by discussion
	Meeting with UNFPA project staff - Understand project organogram, roles and responsibilities of each staff, reflections by individual staff - Meeting with Kristine Blokhus, Deputy Representative UNFPA CO
7th March	**Meeting with other organizations that have projects on GBV** - CARE GBV Programme team (Dr Bisika Thapa) - UNICEF GBV project team (Ms. Yoko Kobayashi and her team) - Asia Foundation Deputy Country Representative (Ms. Nandita Baruah)
19 Mar	**Individual meetings with implementing partners:** Restless Development WOREC CMC-Nepal CREHPA
20 Mar	**Meeting with GoN representatives** - DWC (Department of Women and Children)- Ms Mamata Bisht) - MoHP (Dipendra Raman Singh, Division Chief Public Health Administration and M&E)
22 Mar	Meeting with Dr. Renu Rajbhandari, WOREC

Annex 3: Progress against planned results

Legend: Green: Set for achievement; Orange: Requires significant effort for achievement/Uncertain; Red: Not set to be achieved/Needs to be changed. Grey: Not enough information at MTR

Results	Indicators	MoV	Progress
Goal: The prevalence of gender-based violence is reduced through the effective empowerment of women and men and through prevention and response interventions by more responsible and capable government agencies	Reduction of spousal violence by half in programme area	Baseline and end line survey report	To be assessed during end line
	Reduction of incidence of all forms of GBV in programme area	Further analysis of existing national data sets	To be assessed during end line
	Increased allocation of budget for GBV prevention and response at national and decentralized level	UNFPA Outcome 3 tracking study	Outcome 3 tracking study of UNFPA awaited
Outcome 1: Women and men in the working districts increasingly prevent, report and address gender-based violence	Percentages of women and girls who have the knowledge on all forms of GBV and know when and where to seek health care following violence.	Baseline and end line survey report (including annual FGD in focus VDCs) KA	To be assessed during end line FGDs currently being assessed by CREHPA as part of action research.
	Percentage of men and boys who believe that violence against women and girls is acceptable reduced by 50% in programme focused VDC.	Baseline and end line survey report (including annual FGD in focus VDCs)	As above
	Number of men and boys in programme area who have taken action to prevent GBV increased by 50% every year	Baseline and end line survey report (including annual FGD in focus VDCs); WC reports	As above
	GBV is increasingly being reported (plus 5% per year)	OCMC monthly reports; IP's monitoring reports; District Police and WGs reports	As above Initial reports collated by OCMCs indicate that from the establishment of OCMC till end of 2017, 274 cases (85% female survivors) were reported to OCMCs
	Possession of vital documents (birth certificate, citizenship and marriage certificate) by girls and women in focus VDCs increased by 15% every year	Baseline and end line survey report; Vital Registration System, VDC data; WC reports	To be assessed during end line Annual Report 2017 of UNFPA indicates drop in birth registration by 40 and 73 percent in 2 of 3 districts, and increase in marriage registration by over 500% in one district. Needs further assessment, including for attribution to this project

Results	Indicators	MoV	Progress
Output 1.1: Women Cooperatives (WC) have established functioning GBV watch groups and adolescent girls groups to address GBV	180 GBV watch groups and 54 adolescent girls groups established	Meeting minutes, GBV WG and Girls Circle's periodic report	270 GBV WGs established, 90 in each district 54 adolescent girls groups established and comprising 700 girls
	At least 1000 GBV WG members and 2,000 adolescent girls group members trained on GBV and women's rights have implemented action plans (50% of the trained persons are from marginalized communities)	Training reports including profile of participants. Training follow-up report of WC	1700 GBV WGs oriented on Gender/GBV and RH using *Sanjivani* module 700 girls received *Rupantaran* training No evidence of action plans developed by GBV WG (neither in Annual Report, nor in MTR)
	60 members of WCs provided with TOT on GBV prevention and response have oriented GBV WG members	Training reports with pre and post-test assessment; Observation reports by project staff and trainers on capacity of WC member trainers	UNFPA Annual report 2017: 157 WC members trained as trainers; 1700 WG members oriented by trained WC members
	60 members of WC trained in psychosocial first aid have reached out to GBV survivors and their families at risk of violence	PSFA training completion report with profile of participants; Case documentation; GBV WG reports	60 members of WC trained in psychosocial first aid and appoints as CPSW
Output 1.2: Men and boys have acquired the capacity to engage in the prevention of and response to GBV	1,000 trained couples (members of the GBV watch groups and their husbands) have increased their knowledge on women's rights and GBV by 80%	Training report with pre-post test result including participants profile	290 married couples have been trained. Additional 321 individuals (x women and y men, not married to each other but from the same family) were also trained. Pre-post test results not available MTR indicates widespread misunderstanding on GBV and perspective on gender and women's rights weak among trained husbands. At risk of harming women's interest and protection.
	300 trained adolescent boys implemented action plans to challenge gender inequality	Training report with pre-post test result; Action plan and its implementation report	Intervention not initiated, planned for 2018.
	Number of initiatives implemented by CSOs in collaboration with WCs on engaging men and boys	CSO Report	None

Results	Indicators	MoV	Progress
	Number of political leaders trained on their role in fighting GBV	Meeting reports; follow-up reports	One orientation held for 19 political leaders (M=16,F=3) in Sindhuli. None in other 2 districts
Output 1.3: CSOs, media and research organizations have engaged in evidence based advocacy for an improved response to GBV by GoN actors at district and national level	Action research report on effectiveness of three of the project approaches produced and disseminated[9]	Action research reports Dissemination plans	Action research only initiated in end of 2017
	FM radios regularly broadcasted on women's rights and men's engagement in fighting GBV	Key messages on GBV and women's rights, FM coverage report	Initiated end of 2017 2 Public Service Announcements aired on 2 FM channels in all 3 districts.
	Multi media campaign conducted	Campaign report	1 public hearing in alcoholism and domestic violence in Okhaldhunga and aired on TV and YouTube 2 episodes on aired on TV 2 Edutainment *mela* one each in Sindhuli and Udayapura in November 2017
	Women's Rights Groups at district level organized advocacy events	Advocacy event report	In each district International Women's Day was observed under leadership of WCO approx. 3000 (1000 in each district) people participated in the event In Udayapura, 426 girls from GG, observed International day of a Girl Child (facilitated by WOREC) 16 Days of Activism against GBV/VAW observed in all 3 districts. 9 WC in Udayapura, 3 WC in Okhaldhunga and x in Sindhuli.
	CSOs provided evidence of gaps in the implementation of the policy framework and advocated for change	CSO report including event celebration report	1 public hearing that included local authorities
Outcome 2: Duty bearers respond effectively to gender-based violence in the working districts and increasingly at national levels	Number of health service delivery points that have adhered to the Clinical Protocol on GBV	Baseline and end line survey report Health service progress report;	To be assessed at end line. NGO reports indicate: 35 Health facilities adhering to the protocol: 13 in Okhaldhunga (11 health posts, 2 hospital including mission hospital) 11 in Sindhuli (10 health posts and 1 hospital) 11 in Udayapura (2 hospitals including in Katari and 9 health posts)

[9] Engaging men and boys, lessons learnt from different approaches to engage with WC/GBV WGs and one more to be decided on the second year of the project

Results	Indicators	MoV	Progress
	70% of GBV survivors who sought assistance have improved their well-being[10]	Case documentation by psychosocial counselors	55% survivors serviced by OCMC improved wellbeing (23% improved by 5 to 7.5 points and 32 improved by 7.5-10 point scale)
	Percentage of GBV survivors who are satisfied with the quality of GBV services[11]	Baseline and end line survey report (including analysis of client exit interviews)	To be assessed at end line Initial client exit interviews for 20 survivors who received services of Safe House in Kathmandu indicates 80% reported "highly satisfied" and 20% reported "satisfied". Assessment of satisfaction of clients of district based safe houses not available.
	Number of GBV cases that were prosecuted by law	Police and court records	To be assessed at end line Current official data indicates reduction in prosecution in Okhaldhunga by 16% and Sindhuli by 29% and increase in prosecution in Udayapura by 195%. Needs to be analyzed, including for attribution
	MOHP guideline and strategy on psychosocial and mental health services as an integral part of the OCMCs available	GoN Document	MOH has set up 29 OCMCs in fiscal year 2073/74. MOH authorized OCMCs to include mental health and psychosocial counseling services and also made provision for referral funds and costs for assistance to unaccompanied survivors.
Output 2.1: Women and Children Development Offices, police, and legal service providers have been enabled to prevent GBV and response to GBV	45 WCO staff have acquired good understanding of gender issues including women's rights, GBV and Reproductive Health	Training report with pre-posttest result	Evidence not documented. NGO report indicates capacities and motivation of WCO staff are widely different, even after training. This output indicator needs to be revised in the context of restructuring of local government.
	Number of Women Cooperative members and managers trained by WCO staff on GBV in non-focus VDCs	WCO report	Information not available.
	Number of watch groups formed by WCO in non-focus VDCs	WCO report	No information available on how many new WG were formed by WCO under this project
	Quarterly district coordination meetings convened and decisions implemented	Meeting minutes with actions points followed up	Quarterly meeting of Gender Equality and Ending GBV District Coordination Committee (GEEGBVDCC) in all three project districts

10 Improved well-being: improved relationships with family members and other significant persons, emotional situation, health, economic situation if relevant

11 Target/milestone: Develop GBV related community score cards for police, WCOs, Bar Association/ government attorney, hospital/OCMC/Safe house

Results	Indicators	MoV	Progress
			Information on decisions made and implemented not available.
	At least 300 police, district attorney staff, Bar Association members and social mobilizers have been trained to respond to GBV survivors sensitively and adequately	Training report with pretest and post test results including training participants profile; WC Training follow up report	77 police officers trained from 2 districts Pre-post test results not available "Sensitive" and "adequate" response not assessed No training yet for police in Udayapura No training for district attorneys or BAR members yet
	At least 50 staff of DDC and DAO trained on GBV prevention and response	Training report with pre rest and post test results; Training follow up report	96 staff from DDC and VDC secretaries received training Pre, post test results not available Need to review this indicator in the context of restructuring
Output 2.2: Women Service Centers have been established and are functional in all working districts, with links to capable referral safe house Kathmandu	At least 15 staff of Women Service Centres (safe houses) trained on provision of GBV services to GBV survivors in 3 district level safe houses	Training completion report with pre and post test results	12 participants trained (including safe house in-charge, WCO staff, safe house management committee members and WC members from 2 districts) No training in Sindhuli yet Average 80% increase in knowledge assessed at post training
	At least 3 Service Centers set up and functional in 3 districts	Monthly progress reports	All 3 safe houses established and functional
	Number of cases referred to and from OCMCs/district hospital and safe house	OCMC/district hospital and safe house report	274 cases referred to 4 OCMC 142 cases registered at all 3 safe houses 37 cases (with 22 dependents) referred to Kathmandu safe house
	Staff of referral safe house in Kathmandu strengthened their capacity to deal with complex cases	Training report; NGO report on Shelter	20 cases were referred to safe house in Kathmandu 13 were reintegrated within their communities 3 were re-settled Assessment of capacity related to complex cases not available
Output 2.3: Health facilities in the working districts have built up the capacity to provide adequate medical services and community based psychosocial case management for GBV survivors and their families	45 trainers and 228 health workers trained on "Clinical Protocol on Gender based Violence"	Training completion report with pre and post test results and participant profile	94 health workers (48 women, 46 men), including five doctors, four nurses, 33 auxiliary nurse midwives and 52 paramedics have received first batch training in 2016. Of these 83 received blended learning in 2017. 45 participants of them (38 women and 7 men), including 18 doctors and 27 nurses were trained as trainers by end of Aug 2017

Results	Indicators	MoV	Progress
	6 staff of district hospital/OCMC acquired certificates of psychosocial counselors.	Psychosocial counselors Certificates	6 case managers hired at the OCMCs (2 in each district) already had certificates when they were hired They have received further training and mentoring under this project.
	At least 1,000 GBV survivors receive community level case management services	Case documentation report	355 survivors received community level case management through outreach counselors from the 3 OCMCs
	Number of GBV survivors who received appropriate services (disaggregated by types of services by trained health workers)	OCMC monthly progress report; health service reports	108 survivors received consultation and treatment by psychiatrist 351 survivors received medical and/or legal services through OCMC
Output 2.4: MoWCSW and MoHP are supported with evidence to develop policies and plans	At least 5 policy briefs based on good practices in programme districts	5 good practice document	No policy briefs prepared as of MTR Planned for 2018
	DWC and all 75 WCOs oriented on the experience of the project	Review meeting minutes	Not yet Needs to be reviewed in the context of restructuring OCMC. Review and Planning Workshop held with MoHP
	A comparative study of OCMC/district hospitals with/without psychosocial outreach workers completed and policy brief developed	Comparative study report and policy brief	Not yet Planned for 2018

Annex 4: Monitoring visits by project personnel (July 2016-March 2018)

SN	Name of the Women's Cooperatives	2016									2017										2018	
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Udayapura																						
1	Nari Kalyan Savings & Credits Cooperatives, Girls groups/circles, Katari Municipality																					
2	Jalpadevi Mahila Multipurpose Cooperative, Sirise, Katari Municipality																					
3	Munal Mahila Savings and Credits Cooperatives, Risku, Katari Municipality																					
4	Chandrawati Mahila Multipurpose Cooperative, Lekhani, Katari Municipality																					
5	Namuna Mahila Savings & Credits Cooperatives, Girls Groups(GG)/Circles(GC),Triyuga Municipality																					
6	Usha Kiran Mahila Multipurpose Cooperative, Triyuga Municipality																					
7	Shanti Mahila Multipurpose Cooperative, Bhalayodanda, Udayapurgadi Rural Municipality																					
8	Kanchan Mahila Multipurpose Cooperative, Rauta, Rautamai Rural Municipality																					

9	Nawa Durga Multipurpose Cooperative, Girls Groups/Circles, Sundarpur, Chaudandigadi Municipality																							
10	Shree Bhetghat Mahila Savings and Credits Cooperatives, Tapeshwori, Belakha Municipality																							
Sindhuli																								
1	Pushpanjali Mahila Multipurpose Cooperative, Dudhali Municipality																							
2	Santoshi Mahila Savings and Credits Cooperatives, GGs/GCs, Harshai, Dudhauli Municipality																							
3	Sagarmatha Mahila Savings and Credits Coop, Hatpate, Dudhauli Municipality																							
4	Suryamukhi Mahila Savings and Credits Coop, GGs/GCs, Nipane, Dudhauli Municipality																							
5	Pragatisheel Mahila Bikash Krishi Cooperative, Kamalamai Municipality																							
6	Jalakanya Mahila Savings and Credits Coop, Jalakanya, Kamalamai Municipality																							
7	Bhagawati Mahila Savings and Credits Coop, dandi Gurase, Kamalamai Municipality																							
8	Sunaulo Bihani Mahila Savings and Credits Coop, Hariharpurgadi Rural Municipality																							
9	Marine Baraju Mahila Savings and Credits Coop, Bastipur, Ghyanlekh Rural Municipality																							
10	Deepmala Mahila Savings and Credits Coop, Jhanajholi-Ratamata, Sunkoshi Municipality																							
	Okhaldhunga																							

1	Sidhdhi Charan Mahila Savings and Credits Coop, GGs/GCs, Siddhicharan Municipality																						
2	Mahila Uththan Savings and Credits Coop, narayansthan, Siddhicharan Municipality																						
3	Kamana Multipurpose Cooperative, ketuke, Manebhanjgyang Rural Municipality																						
4	Mahila Ekata Savings and Credits Coop, Waksa, Manebhanghyang Rural Municipality																						
5	Namuna Savings and Credits Coop, Belakhu, Sunkoshi Rural Municipality																						
6	Mahila Udhyamsheel Savings and Credits Coop, Sisneri, Sunkoshi Rural Municipality																						
7	Beli Chameli Mahila Savings and Credits Coop, GGs/GCs, Harkapur, Molung Rural Municipality																						
8	Pragatisheel Savings and Credits Coop, Shreechaur, Molung Rural Municipality																						
9	Sagarmatha Mahila Multipurpose Cooperative, Diyale, Chisankhugadi Rural Municipality																						
10	Mahila Milan Savings and Credits Coop, Khijiphalate, Khijidemba Rural Municipality																						
UNFPA CO																							
1	Ram Prasad Dahal																						
2	Pratibha Rijal																						

Annex 5: Operational milestones in the project

	Milestones	2016												2017											
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1.	Contract signed between SDC and UNFPA																								
2.	First tranche received																								
3.	Project staff hired (project officer, 3 CMO's)																								
4.	Community Mobilization Officers deployed in the districts																								
5.	Project Coordinator hired and joined																								
6.	GBV Specialist (IUNV) joined																								
7.	Women Cooperatives assessed through external consultants																								
8.	Second tranche received																								
9.	Partnership signed with APEIRON																								
10.	Partnership signed with JHPIEGO*																								
11.	Partnership signed with CMC-Nepal																								
12.	Partnership signed with WOREC*																								
13.	Partnership signed with Restless Development*																								
14.	Partnership with DDC Udayapura was ongoing																								
15.	Partnership with DDC Sindhuli was ongoing																								
16.	UNFPA requested DWC to provide working station to CMOs																								
17.	DWC directed WCO to provide working station to CMO																								
18.	Partnership signed with DDC Okhaldhunga																								
19.	Partnership signed with CREHPA																								
20.	Partnership signed with Sancharika Samuha																								
21.	Contract signed with SW Nepal for Baseline Survey																								
22.	Baseline report finalized																								
23.	Annual Progress Report 2016 submitted to SDC																								

24.	Half Yearly Report 2017 submitted to SDC																								
24	Annual Progress Report 2017 submitted to SDC																								
25	OCMC Established in Rumjatar District Hospital, OKH																								
26	OCMC Established in SDL																								
27	OCMC Established in UDP																								
28	OCMC Established in Mission Hospital, OKH																								
29	Partnership discontinued with DDC OKH, SDL & UDP																								
30	Agreement signed with WCs through CMC-Nepal in OKH																								
31	Agreement signed with WCs through WOREC in UDP																								
32	Agreement signed with WCs through WOREC in SDL																								
33	Safe houses started in Sindhuli and Udayapura (Katari)																								

*UNFPA had ongoing partnerships with these NGOs. Elements of the GBV project were added to the ongoing partnership agreements on the months indicated in this timeline.