Integrated GBV Prevention and Response to the Emergency Needs of Newly Displaced Women, Men, Girls, and Boys in Borno State, North-East Nigeria

FINAL EVALUATION REPORT

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European Union
Civil Protection and
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The project, funded by EU humanitarian aid, supports 7,894 newly displaced women, men, girls and boys in Borno state, Northeast Nigeria

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ACRONYMS

AOG	Armed Organized Group
CARE NG	CARE Nigeria
COVID-19	Corona Virus
DME	Data Management Evaluator
DVA	Domestic Violence Act
ECHO	European Commission Civil Protection and Humanitarian Aid
EQ	Evaluation Question
FGD	Focus Group Discussion
FHH	Female Headed Household
GBV	Gender Based Violence
GBVIMS	Gender Based Violence Information Management System
IDI	Individual in-depth Interviews
IDP	Internally Displaced Person
IE	Investigative Evaluator
INGO	International Non-Governmental Organization
IPV	Intimate Partner Violence
KII	Key Informant Interview
LE	Lead Evaluator
LGA	Local Government Area
M&E	Monitoring and Evaluation
OM	Outcome Mapping
PII	Personal Identifiable Information
QCA	Qualitative Comparative Analysis
RRS	Risk Rating Scale
RMS	Risk Mitigation Strategy
RMP	Risk Mitigation Plan
SAA	Social Analysis and Action
SEMA	State Emergency Management Agency
SRHR	Sexual and Reproductive Health and Rights
ToR	Terms of Reference
UNHAS	United Nations Humanitarian Air Service
VSLA	Village Savings and Loan Association
WGFSS	Women and Girls Friendly Safe Spaces

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EXECUTIVE SUMMARY

OVERVIEW

Violence against women is an age long psychological and social issue deep rooted in Nigerian societies (Arisi, 2011). This is an appalling human right violation and has assumed endemic nature in Nigeria to the extent that a number of women who were victims of violence thought they deserve it (Gender in Nigeria Report, 2017). It has become an everyday occurrence in the country. Amnesty International (2017) reported that countless women and girls in Nigeria particularly in the north east are subjected to violence by some members of their families and their communities. These women of all ages and from all socio economic groups, living in rural or urban communities are affected directly by the gender based violence. Violence persists because discriminatory laws condone and even legalizes certain forms of violence against women in Nigeria.

Sexual violence was seen as a shameful act that dishonors the family's name, young girls are pushed out to be married early mostly in the camps as the parent seek favor from new relatives and require space in the tent. These factors that contribute to this high rate of violence against women in Nigeria which includes the fact that, violence against women is seen as a 'private' matter to be dealt with by the family. It is often regarded as a fact of married life that must be tolerated. In addition, Nigeria is failing to implement her obligations under international law. Women generally were not granted a seat in decision making except for some specific issues for which women leaders are involved although, very limited or non-active in the community Gender Based Violence (GBV) is pervasive in northeast (NE) Nigeria society, which supports male supremacy and grants men power and control over women in both domestic and public spheres.

BACKGROUND

Under the European Commission Civil Protection and Humanitarian Aid (ECHO) funding with support of CARE France, CARE Nigeria to implement a Gender Based Violence in Emergencies project. The project was implemented in Bama and Ngala Local Government Areas (LGAs) – Northeast, the goal of the project was to contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in North-eastern Nigeria.

The project had six expected results:

- R 1. GBV prevention, care, and response services available and accessible to newly displaced individuals and vulnerable host community members at risk of or affected by GBV.
- R 2. Awareness, knowledge, and application of humanitarian principles and SEA prevention and response principles improved among humanitarian actors and security forces.

The intervention was anticipated to reach about a total of 7,832 project participants. The global objective of the project was To contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in northeastern Nigeria. The specific objective of the project was to enhance

the access of newly displaced, vulnerable women, men, girls, and boys to life-saving GBV prevention and response services through coordinated, principled humanitarian support and community-based prevention activities.

EVALUATION SCOPE

The geographical scope of the evaluation is Bama and Ngala LGAs of Borno State, NE Nigeria. The technical scope of the evaluation was to assess the relevance, efficiency, effectiveness, coordination, and impact/sustainability of the project in light of its objectives and provide recommendations for future programming. Furthermore, the evaluation assessed how the project ensured accountability to affected groups considering the commitments of the Core Humanitarian Standard.

EVALUATION METHODOLOGY

To deliver on these evaluation objectives, the external evaluation team adopted a multi-tier evaluative approach i.e. Outcome Harvesting (OH), Outcome Mapping (OM) and Most Significant Change (MSC) methodologies. Outcome Harvesting (OH) collects ("harvests") evidence of what has changed ("outcomes") and, then, working backwards, determines whether and how an intervention has contributed to these changes. This has proven to be especially useful in complex situations when it is not possible to define concretely most of what an intervention aims to achieve, or even, what specific actions will be taken over a multi-year period.

EVALUATION SAMPLING

Sample sites will be selected through a stratified multi-stage cluster sample design. Strata will be selected at the LGA level, and will include key characteristics and factors expected to impact progress towards outcome (i.e. sex, geographic location, etc.). For the sampling of households for the evaluation survey; the team adopted of a snowball approach (i.e. respondent referral survey) to ensure each engaged respondent was a target beneficiary of the project. This approach was quite effective given the limited time allowed for field data collection (i.e. 5 days) as well as the prevailing precarious security situation in Ngala and Bama LGAs. By adopting the snowballing approach to sampling, a team of field enumerators conducted daily Key Informant Interviews (KIIs)/household surveys based on informed guidance from project beneficiaries.

To prevent gender bias the field enumerators were instructed to source alternative interviews based on an established protocol i.e. enumerators shall make accommodations for prioritizing a near-equal ratio of beneficiaries for field interviews e.g. enumerators shall interview a female respondent after a male respondent, and vice-versa. The Data Management Evaluator (DME) also routinely examined respondents interviewed (i.e. respondent locations, and last names) to ensure variability of the sampled population. This measure ensured that no portion of sampled population was left out. To ensure that the evaluation team limits respondent referral bias (i.e. respondents linking to only relatives, neighbors, or close associates); each enumerator was provided with a randomized list of 200 beneficiaries per assigned location. Enumerators were then directed to only reach out to beneficiaries captured on their assigned

list. While the technical evaluators took notes on referrals given by each respondent that had relocated to other areas of the target LGAs or had relocated away from the target LGAs or simply could not be found.

Evaluation Sample Frame

Based on this projection, a final evaluation sample frame of 416 beneficiaries was established.

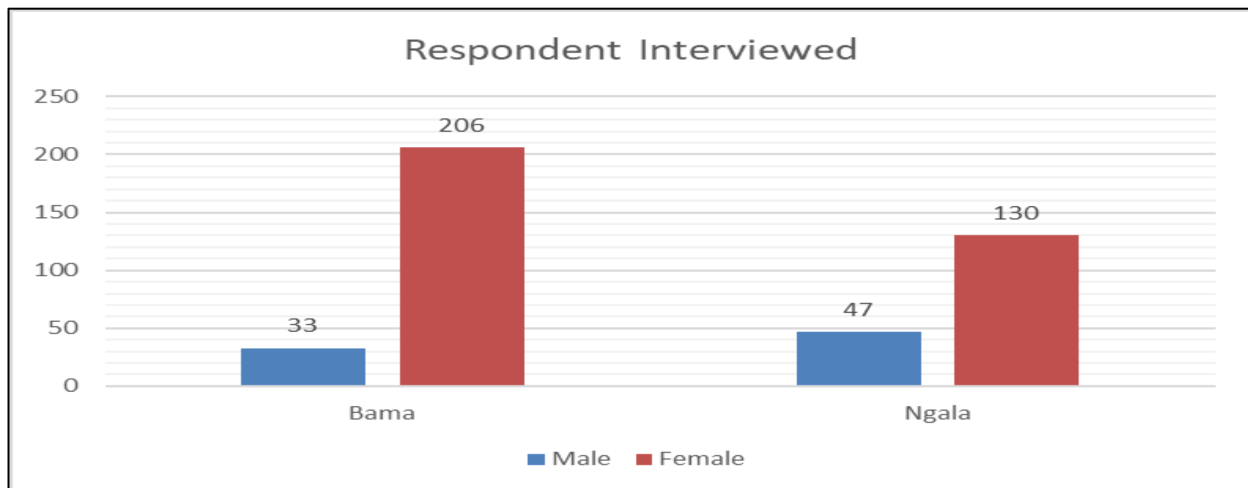
Bama LGA – 239 respondents (33 Males and 206 Females)
Ngala LGA – 177 respondents (47 Males and 130 Females)
Total – 416 respondents (80 Males and 336 Females)

Each field enumerator was provided with a randomized list of project beneficiaries (i.e. based on the consolidated list of 1000 beneficiaries in each LGA as provided by CARE NG). The dual-sampling approach mitigated potential challenges locating respondents because of frequent displacements common with both locations and persistent conflict.

Over the five (5) day period, each field enumerator interviewed a minimum of five (5) respondents per day and twenty-five (25) at the end of the data collection exercise. Strategically, a randomized buffer list of 200 beneficiaries (i.e. 100 beneficiaries per LGA) was generated, containing randomly selected beneficiaries in proposed sample LGA sites and reserved for replacement should any or a combination of the following situations arise:

- If, by chance, the enumeration team were unable to reach a respondent for interview.
- A selected respondent was not willing to participate in the interview; and/or
- A selected respondent relocated from the known location for unknown reasons.

Figure 1. Interviewed Beneficiaries (Bama and Ngala)



The quantitative assessment data indicates that 82% of the respondents were females and 13% in Bama while 77% of the respondent were female and 26.5% were males in Ngala. These respondents were reached via snow balling approach from a project implementation database shared from the ECHO project. The respondents interviewed were majorly IDPS; a total of 88.8% (75.6% female and 13.2% male project participants) were from the IDP camps and 9.5% females were from the host community within

Bama; compared to Ngala which had 74.8% female and 25.2% male responses from IDPs and 31.6% female and 68.4% male response from the host community. 65.8% females and 22.2% females and 12.2% males from IDP camps in Ngala

EVALUATION DATA QUALITY ASSURANCE

Prior to the commencement of field data collection, the LE developed a Risk Mitigation Plan (RMP) itemizing potential challenges and risks associated with data quality for field activities. This ensured timely reporting and effective assessment of field data collection by respective evaluators. The RMP also adopted mitigation strategies and reviewed probability ratings for each identified risk. For this reason, the RMP consisted of two sections: i.e. Risk Rating Scale (RRS); and Risk Mitigation Strategy (RMS). The RRS assigned corresponding risk ratings captured in the RMP. The impact of each identified risk was scaled according to the probability of its occurrence across a four-code color scheme (i.e., low, medium, high, and critical). The RMP was also updated on an ongoing basis, to respond to changing scenarios or encountered challenges by the technical team. The LE revised the RMP to accommodate noted changes to identified data collection risks (Annex).

CHALLENGES ENCOUNTERED

A number of challenges were encountered during the conduct of the final evaluation study. These were addressed by the evaluation team:

- **Insecurity**: The field enumeration team in Ngala LGA, had to conclude data collection abruptly on the final day due to an Armed Organized Group (AOG) attack across the border in Fotokol in Cameroon on October 10th, 2020. Although the security situation was slightly better in Bama, field enumerators were constantly guided to complete daily interviews before 4pm for safety reasons.
- **Non-responsive respondents**: Beneficiaries within the Internally Displaced Persons (IDPs) camps often complained of hunger and lack of Non-Food items (NFIs) during interviews. Hence, they were less willing to spend time answering questions from the enumerators; and would rather go elsewhere in search of food. The engagement of local enumerators provided by SEMA was helpful in mitigating this situation. As the team was able to get the support of community leaders and stakeholders to convince beneficiaries within the IDPs camps to participate in Key Informant Interviews (KIIs).
- **Relocated beneficiaries**: A minor challenge faced by the evaluation team during field data collection; was the relocation of project beneficiaries (i.e. based on the consolidated list of project beneficiaries provided by CARE). The team were routinely informed of relocated beneficiaries and had to resort to the randomized buffer list to move on with the field interviews.
- **Social distancing measures**: Due to the corona virus pandemic, the evaluation team had to take robust measures to ensure the safety of all respondents and field enumerators. Therefore, interviews were conducted with face masks and adequate social distance maintained at all times during data collection. Hence, field data collection focused mainly on one-on-one interviews with beneficiaries and stakeholders; as the option for Focus Group Discussions (FGDs) was not explored. Furthermore, the evaluation team deployed an online survey (Microsoft forms) tools to retrieve responses from the CARE Nigeria team.

DATA CLEANING

Furthermore, to check for data entry errors, the evaluation team periodically reviewed a sample of uploaded data questionnaires and checked to see if individual entries were entered correctly. The Lead Evaluator (LE) and Data Management Evaluator (DME) both handled additional data cleaning processes i.e.

- **Missing data**: Scanning through the uploaded field data, the DME examined uploaded evaluation questionnaires to search for missing data; which may occur if a respondent declined to answer a question, or a field enumerator failed to ask or record a respondent's answer or skipped entry of a response.
- **Inconsistent data**: The DME also looked at individual generated survey data, to ascertain the consistency of recorded responses. For example, a respondent might say that she never accesses GBV services and then report that certain project activities were most useful. The LE took steps to reconcile such inconsistencies by referencing the isolated questionnaires, if possible develop a rule about sorting such dataset i.e. noting which response to accept.

QUALITATIVE COMPARATIVE ANALYSIS (QCA)

Qualitative Comparative Analysis (QCA) is a methodology that enables the analysis of multiple cases in complex situations. It can help explain why change happens in some cases but not others. QCA is good at addressing questions around why some interventions worked and not others. This is particularly useful for evaluations where people are interested not just in the results of a project or program, but also in how and why those results were achieved. QCA can therefore be used to help decide whether and/or how projects or programs could be scaled up or replicated (Baptist and Befani 2015). When used for the purpose of evaluating project outcomes, QCA is a methodology for learning.

The methodology does not include any inherent processes for measuring change. Instead, its main focus is on generating lessons and recommendations. Basically, QCA is a methodology identified patterns across multiple cases to better understand why some changes happen and others did not. When used for this evaluation, QCA information outputs was used to identify outcomes for each project objectives and identify the presence or absence of potential contributory factors to improve onward project design, planning and performance in the future.

KEY EVALUATION FINDINGS

Beneficiary awareness

The evaluation survey showed that beneficiaries in both intervention LGAs were aware of GBV issues and referral pathways facilitated by the project. There was an increase in the awareness of beneficiaries from the mid-term evaluation; as more respondents were more likely to make a report on GBV related incidences (i.e. sexual violence, sexual exploitation, domestic violence, sexual harassment, and forced marriages). Based on analyzed evaluation data, of the total number of beneficiaries interviewed, the following project activities were most effective in increasing beneficiary GBV knowledge e.g. Use of GBV champions - 87.5% (Ngala 32.9% and Bama 54.6%), Sensitization activities – 91.5% (55.5% in Bama and 36% in Ngala) and provision of livelihood assistance – 66.8% (43.5% in Bama and 23.3% in Ngala).

At the final evaluation, awareness amongst beneficiaries was greater in Bama than Ngala; as project-driven sensitization activities emerged as the predominant means by which beneficiaries were informed of GBV issues and accompanying referral pathways by the project. In spite of CARE Nigeria not having an on the ground presence in Ngala at the time of the final evaluation study (i.e. due to the lack of fundng for GBV interventions since August 2020); interviewed beneficiaries remained knowledgeable of GBV issues and referral pathways.

Accessed GBV related services

In both Bama and Ngala LGAs, beneficiaries in all five (5) communities (i.e. Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, and IDP Camp Ngala) indicated low access to services among females at the final evaluation period i.e. 100% of men accessed GBV related services in Bama compared to 73% of men in Ngala. On the other hand, Only 18% of interviewed female respondents accessed GBV related services in Ngala and no respondent accessed services in Bama LGA. Examining this further, analyzed data showed that 54.2% of male respondents did not access services in Bama compared with 23.3% in Ngala. The situation was reverse among female respondents in Bama, as 45.8% did not access services in Bama and 76.7% in Ngala.

The analyzed data also showed fewer beneficiaries in both intervention LGAs were likely to make reports of GBV related abuses. However, there was a higher potential for beneficiaries in Bama to report GBV related cases of abuse than beneficiaries in Ngala. For example, 45.2% of male respondents stated that they were interested in reporting cases of GBV compared to 54.8% of female respondents. On the other hand, in Ngala, no men were willing to make GBV related reports; while all women were open to making such reports (100%). The details in methods of reporting GBV experienced in the communities showed there is need for more awareness and outreach activities to log such GBV complaints in Ngala especially among men and encourage more reports in Bama.

Factors affecting Women/Girls Particiaption in GBV related activities

To examine the accessibility of GBV related services among respondents, the evaluation data also examined the existing factors that affected the participation of women/girls in GBV related activities in both intervention LGAs. The quantitative data revealed that female respondents in Bama were more likely to not participate in GBV related actiivties than women/girls in Ngala. This was due to a number of notable issues, but the prevalence of early marriage was the most prevalent reason given by female repsondents in Bama (46 responses). This was closely followed by the lack of livelihood support (38 responses) and early pregenancy (37 repsonses).

Mental health and SRHR issues also were mentioned as likely reasons among female respondents in Bama. On the other hand, female respondents in Ngala reported low self-esteem and exposure to GBV as core reasons for not participating in GBV related activities.

Ease of reporting GBV related issues

When considering the ease of reporting GBV services and accessing related services among beneficiaires, the evaluation findings showed that there was a preference for face-to-face engagement (85.2% of beneficiaries in Bama and 14.8% of beneficiaries in Ngala) and use of Help desk services (68.6% of beneficiaries in Bama and 31.4% of beneficiairies in Ngala). Among survey respondents, the analyzed data showed that majority of beneficiaries could freely make GBV related reports through designated feedback channels. For example, the quantitative assessment data showed that 58% of beneficiaries in Bama had no reservations making reports of GBV related issues compared to 42% of respondents in Ngala LGA. Among the most frequently adopted service options (help desk services and in person consultations), male beneficiaries in Bama frequently used these two service options (15.8% for help desk services and 13.5% for in-perosn consultations). However, in Ngala more men used the help desk services (39.1%) than in-person consultations (9.7%).

Adequacy of GBV related services

Collated responses from stakeholders show that majority of respondents (53.3%) in Ngala state that GBV related services were not adequacy; although reverse is the case in Bama; where respondents agree that GBV related services were adequate. On the other hand, project beneficiaries clearly state that GBV related services were adequate across intervention LGAs in Bama and Ngala respectively. In Bama, 13.8% of men and 86.2% of female confirmed the adequancy of GBV related services provided by the project. In Ngala, 73% of men and 27% of women also confirmed the adequancy of GBV related services provided by the project. More so, the number of survivors who received an appropriate response to GBV was 303 persons (i.e. Female 308 perosns and Men 5 persons).

Beneficiary perception of services provided

At the baseline, there were no services providd by the project; hence collectively, interviewed beneficiaries had a positive perception of services provided by the ECHO GBV project in Bama and Ngala. For example, 42.5% of respondents in Bama (Male – 17% and female 25.5%) recorded being highly satisfied in their perception of services provided by the project. In Ngala, beneficiary feedback showed that 19.4% of male respondents and 80.6% of female respondents were satisfied with services provided. No beneficiary was not satisfied with the services provided by the project. Stakeholders also had a positive perception (47% of respondents) of the services and 53.3% of stakeholders rated the services provided by the project as being good in Bama and Ngala Local Government Areas (LGAs).

Capacity Strengthening Activities

The ECHO GBV project successfully conducted a number of capacity building activities for stakeholders and beneficiaries in Bama and Ngala. The quantitative data highlighted the high percentage participation of stakeholders in several training sessions i.e. GBV trageted training (Bama 35.7% and Ngala 64.3%), GBV targeted workshops (Bama 36.4% and Ngala 63.6%), self reflection sessions (38.5% and 61.5%). Collated responses from the field survey among beneficiciaries showed that the project successfully conducted multiple training sessions i.e. GBV targeted training (79.4% and Ngala 20.6%), livelihood assistance (Bama

100% and Ngala 0%), IGA/PSEA (Bama 5% and Ngala 95%) and Psycho-Social Support (Bama 98.6% and Ngala 1.4%).

Quality of Monitoring and Evaluation (M&E) System

The established Monitoirng and Evaluation (M&E) system deployed ofr the ECHO GBV program consisted of a MEAL plan, logical framework workplan for activity reporting, output tracker and beneficiary database. As MEL functions were handled by a team consisiting of a MEAL Coordinator, MEAL officer and two (2) data clerks. A key limitation of the MEAL system was the limited utilization of evidence and project data for onward adaptive management improvements. For example, the project did not have an established learning agenda, with corresponding learning questions and supportive learning activities. This was evident in the absence of reflective learning opportunities, which could have been conducted after each assessment study i.e. baseline, midline and end line assessment studies. Furthermore, there were no targetd studies to examine the emrging findngs from each assessment study.

Project Effectiveness

The ECHO GBV project was most effective in strengthening GBV awareness across target communities in Bama and Ngala LGAs. This was achieved mainly through the implementation of these activities:

- **Community awareness raising on GBV**: Both stakeholders and beneficiaries alike recognized the importance of ongoing community awareness raising and sensitization events on GBV. Such project activities should be sustained to encourage community ownership of project activities. For example, the project also conducted mass awareness-raising reaching 5,045 (3,410 F and 1,635 M). In total 14,473 (7621 F, 6852 M) were reached.
- **Mobilization and training of GBV champions**: To embed sustainability measures for future project activities, the mobilization and training of GBV champions is essential. GBV champions can also drive community-level awareness raising and sensitization of returnees and IDPs beyond the project's implementation period.
- **Establish and support GBV vigilant committees**: When dealing with issues related to GBV, communal coordination and support was integral to the success of project activities i.e. creating safety in numbers. Trained GBV champions readily supported these vigilant committees in Ngala and Bama LGA.
- **Create and operate safe spaces**: The creation and operation of safe spaces for community-level engagement, eased referral pathway services and remains an effective implementation approach; which should be extended in future design iterations. This should ideally extend to support women solidarity groups and organizing further case management training to GBV champions and vigilant committee members to effectively make use of created safe spaces.

Knowledge of Gender-Based Violence (GBV)

At baseline, a striking 61.7% of interviewed respondents stated that GBV cases were common in the community, majorly in the camps (Arabic camp, ISS camp, and GSSSS camp) with 44.5%, followed by host community members with 13.1%, then refugees with 3,5% and finally 0.6% of returnees. Also, 35.3% of respondents stated that GBV cases were not common (5.3% from host community members, 29.2% from

IDPs, 0.6% from refugees and 0.2% from returnees), while 3.1% of respondent "did not know" if GBV was either increasing or reducing.

At midline, all interviewed beneficiaries did report an increasd in their knowledge of the ECHO GBV program (Bama – Male 24.4% and Female 75.6%, Ngala – Male 70% and Female 30%). At the final evaluation, quantitative data revealed that all interviewed stakeholders had participated in GBV awareness trainijgn provided by the program (40% in Bama and 60% in Ngala). Therefore, the project's engagement of stakeholders in GBV awareness training improved their social awareness through the sensitization of community members on GBV and further engagement of GBV protection networks (vigilantes and champions).

The project successfully conducted multiple training sessions for stakeholders on GBV, PSEA and humanitarian standards and also community awareness for the security forces. For example, the adoption of the Social Analysis and Action (SAA) manual during training sessions; was used to advocate for the reduction/elimination of sexual violence. Community leaders and security operatives also acknowledged the usefulness of training sessions as a viable means of increasing GBV awareness and sensitization of community members.

Participative approach to improved quality of integrated GBV services

Promoting community based mobilization and sensitization efforts remain key to community entry, ownership and program sustainability. Project activities should be driven by local actors and complimented by project personnel through training sessions. For example, the role of GBV vigilantes and champions cannot be over-emphasized in creating vocal community centered-advocates on GBV issues i.e. in connecting women, girls, boys and men to information services; as well as promoting the use of GBV awareness messages.

The project promoted active coordination among humanitarian actors by ensuring that GBV related services were user friendly. According to the end line evaluation study conducted by CARE Nigeria, the project implemented activities such as case management, and psychosocial support services to the participants, overall case managing a total of 313 (308 F, 5M) cases, and providing Psycho-social Support (PSS) to more than 3000 males and females. This was achieved through the implementation of the following community based activities i.e.

- Involving and training community members;
- Use of local language to disseminate information during sensitization events to increase awareness of GBV related issues;
- Successfully employed the GATHER model to implement activities in the establishment of Women and Girls Friendly Safe Spaces (WGFSS). This approach was particularly effective in linking GBV survivors to necessary services. Note: The GATHER approach to counseling (Greet, Ask, Tell, Help, Explain, and Return) documents effectiveness in Family Planning (FP) programs. The more of the GATHER elements a counselor uses, the more satisfied clients are with their care and the more likely they are to use contraception.

- Provided alternative compliant and feedback mechanisms for beneficiaries and stakeholders.

Involvement and coordination of actors

The project promoted active coordination among humanitarian actors by ensuring that GBV related services were user friendly. This was achieved through the implementation of the following community based activities i.e. involving and training community members; use of local language to disseminate information during sensitization events to increase awareness of GBV related issues; successfully employed the GATHER model to implement activities in the establishment of Women and Girls Friendly Safe Spaces (WGFSS). This approach was particularly effective in linking GBV survivors to necessary services. The ECHO-GBV project also provided alternative compliant and feedback mechanisms for beneficiaries and stakeholders.

CONCLUSION

The baseline assessment study showed that women in Ngala and Bama generally were not granted a seat in decision making except for some specific issues for which women leaders with limited or non-active participation in community sensitization. The conflict has contributed to a vicious cycle of GBV as women, men, girls and boys in dire situations resorted to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. With improved awareness and sensitization on GBV information among beneficiaries and stakeholders alike, it is clear that the project successfully met the needs of the intervention communities in Ngala and Bama despite complex security challenges withing a humanitarian crisis situation. Based on feedback from beneficiaries, the following project activities should be considered for strengthening the GBV project achievements i.e. setting up child friendly spaces, distribution of dignity kits, continue sensitization on GBV issues as well as livelihood support for women groups and promote continuous inter-agency coordination efforts.

KEY RECOMMENDATIONS

The following recommendations are proposed for future implementation i.e.

- Any follow-on design iterations of the project should further consolidate the promotion of active humanitarian actor coordination to sustain effective referral pathways for target beneficiaries especially in under-accessed locations and vulnerable populations in Ngala. For example, in Ngala 88% of stakeholders and14.1 % of beneficiaries felt services provided by the project were not adequate. Compared to Bama LGA where 99.6% of beneficiaries and 100% of stakeholders acknowledged the adequacy of services provided by the project.
- Strengthen existing options for beneficiary feedback and compliant mechanisms to encourage more women and girls to continue active use of these options. Hence there is a need to ensure strict confidentiality for all engagements. This is especially important to avoid any obvious appearance that may expose the nature of such complaints by target beneficiaries.
- The use of complaint and feedback mechanism is extremely low among men and boys in both intervention communities. Therefore, future design iterations should prioritize the development of inclusive and more culturally appropriate complaint and feedback mechanisms for men and boys

in target intervention communities. Men and boys must also feel safe to make reports of GBV cases; without the fear of stigmatization or harsh rehearsals from security operatives.

- To promote knowledge retention and active participation of project beneficiaries, the project should continue the engagement of GBV champions and vigilantes to provide follow-up support to build on completed training session. Therefore, promoting knowledge retention among beneficiaries may be supported through community socialization events, spot checks, provision of livelihood assistance and monitoring referral support services. Specifically, the project needs to organize a refresher training for target beneficiaries in Ngala to increase entrepreneurship and community ownership to take responsibility for their wellbeing.
- To strengthen the M&E system, the development of a project centred learning agenda should be prioritized to enable the utilization of documented evidence and project data for reflective learning. This may also extend to the development of an Evidence and Learning Catalog to provide a knowledge repository to promote action learning and effective knowledge management.

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SECTION 1. INTRODUCTION

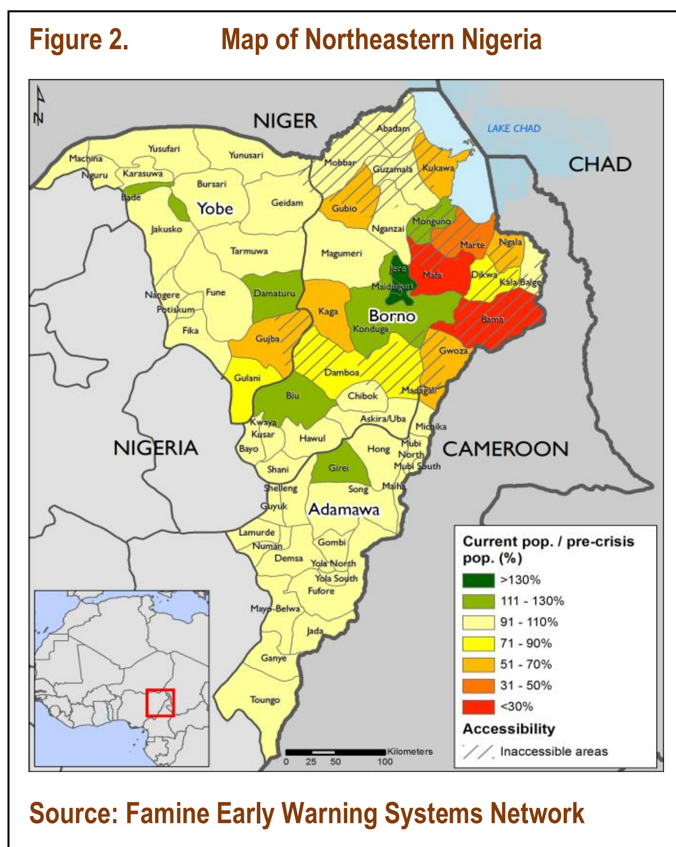
1.1. Overview

Sexual violence is seen as a shameful act that dishonors the family's name, young girls are pushed out to be married early mostly in the camps as the parent seek favor from new relatives and require space in the tent. Women generally are not granted a sit in decision making except for some specific issues for which women leaders are involved although, very limited or non-active in the community Gender Based Violence (GBV) is pervasive in northeast (NE) Nigeria society, which supports male supremacy and grants men power and control over women in both domestic and public spheres.

The conflict has also maintained a vicious cycle of GBV as women, men, girls and boys in dire situations resort to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. The fear, shame and stigma associated to GBV significantly weight on the mental health conditions, socio-economic situation and access to GBV services. Humanitarian actors are already present in the area. But GBV services access and quality are quite poor.

CARE International in Nigeria engaged the services of an evaluation team with experience in the end of project evaluation of humanitarian programs in conflict-affected areas to undertake a thematic evaluation of the CARE project integrated Gender Based Violence (GBV) prevention and response to the emergency needs of newly displaced women, men, girls, and boys in Borno State, North-East Nigeria'.

Figure 2. Map of Northeastern Nigeria



Source: Famine Early Warning Systems Network

The purpose of the evaluation was to generate learning and evidence on the extent to which the project has:

- Targeted internally displaced persons (IDPs) and other vulnerable categories of people pertinent to the project rationale and objectives;
- Supported timely, relevant and effective delivery of GBV services (prevention and response) to target populations;
- Delivered results in-line with the project results framework;

- Been able to effectively monitor project activities through a 'remote management model'- particularly within the COVID-19 period.

The evaluation put forward evidence that will contribute to the management of relief programs and to CARE humanitarian approach more broadly. The evaluation findings shall also contribute to the common evidence base on humanitarian practice in a somewhat unique context, as well as strategies on how to build resilient within a complex humanitarian crisis.

1.2. Background

Under the European Commission Civil Protection and Humanitarian Aid (ECHO) funding with support of CARE France, CARE Nigeria to implement a Gender Based Violence in Emergencies project. The project was implemented in Bama and Ngala Local Government Areas (LGAs) – Northeast, the goal of the project was to contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in North-eastern Nigeria. At the end of the project it is expected that:

- GBV prevention, care, and response services are available and accessible to newly displaced individuals and vulnerable host community members at risk of or affected by GBV and
- Awareness, knowledge and application of humanitarian principles and Sexual Exploitation and Abuse prevention and response principles is improved among humanitarian actors and security forces.

1.3. Evaluation Purpose and Objectives

The purpose of this final project evaluation was to ensure accountability and identify lessons learned and best practices so as to feed into the decision making process of the project stakeholders, including the donor, beneficiaries, and Government counterparts. The specific objectives of the end of project evaluation are primarily:

- To assess progress made towards the achievement of results at the outcome and output levels; include the sustainability of the outcomes of the project, beyond the project lifetime. Also to provide evidence-based information on performance of the project against the intervention logic and existing project and program indicators
- To assess performance in terms of the following criteria: Appropriateness of design; relevance of results; sustainability (where relevant); transparency and accountability; effectiveness, efficiency of resource allocations, and validity of design/relevance of the project
- To identify and to document lessons learned and provide evidence-based recommendations for guiding subsequent humanitarian programming or similar future interventions.
- To assess how the project ensured inclusion of vulnerable and marginalized communities and engaged with affected population and communities;
- To assess how the project contributed to coordination efforts for improved GBV response.

1.4. Scope of Evaluation

The geographical scope of the evaluation is Bama and Ngala LGAs of Borno State, NE Nigeria. The technical scope of the evaluation was to assess the relevance, efficiency, effectiveness, coordination, and impact/sustainability of the project in light of its objectives and provide recommendations for future

programming. Furthermore, the evaluation assessed how the project ensured accountability to affected groups considering the commitments of the Core Humanitarian Standard. Building on this, the evaluation team ensured that all data collected from field locations were disaggregated by sex and age to examine the gaps between men and women related to the impact of the project.

1.5. Evaluation Questions

The following evaluation questions were answered by the final evaluation study i.e.

1.5.1. Relevance

The evaluation team looked at the design of the project and assessed the extent to which the stated project objectives addressed the identified problems or stakeholder needs:

- How has the project design (outcomes, outputs and activities) been relevant to addressing underlying causes of the identified problems?
- What alternative strategies would have been more effective in achieving its objectives?

1.5.2. Efficiency

- How has the project been efficient in allocating and managing resources (funds, human resources, time, expertise etc.) to achieve outcomes? Were the management capacities adequate- i.e. management of personnel, project properties, communication, relation management with elders, community leaders, other development partners, etc.?
- Do the results achieved justify the costs (human resources, time, energy, money, materials)? If not, why not? Have project funds and activities been delivered in a timely manner? If not, why not?
- Was there a clear understanding of roles and responsibilities by all parties involved?
- Has the project received adequate technical and administrative support from ECHO, CARE France, and CARE Nigeria?
- How far and in what ways the project was able to strengthen local non implementing partners, communities, government, youth groups (and other relevant groups) and provide suggestions to further improve their capacities.
- Review and assess the quality of the project monitoring and evaluation system, specifically: Assess the appropriateness of the indicators and also assess the robustness of the monitoring protocol and approaches in quantitative and qualitative data collection and compilation by project staff based on the log frame indicators.

1.5.3. Effectiveness

The effectiveness of the ECHO project was assessed through an examination of these lines of inquiry i.e.

- How the project was perceived by relevant stakeholders (Local leaders and community members) in light of achieving its planned objectives?
- How has the project been effective in achieving its planned activities and outcomes? If not, why?

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- Which were the strengths in the project implementation and what are the constraints and challenges faced? How has the project mitigated these challenges?
- How gender and protection have been mainstreamed into project activities and what was the impact of the project on gender equity and related issues
- How have the approaches/modalities followed by the project been effective in ensuring inclusion of vulnerable and marginalized communities?
- Have the approaches/modalities followed by the project been effective in engaging with the communities affected by the crisis? How and why?

1.5.4. Impact/Sustainability

- What are the planned and unintended effects, direct and indirect, positive and negative, of the project on the living conditions of the populations in the targeted area?
- What were the linkages between activities such as linkages between the women solidarity groups and livelihood assistance that allow to maximize the effected of the project?
- Evaluate the sustainability of the project achievements such as GBV committees, sensitization tools, level of capacity building of the staff, partners community leaders and other actors, reduction of GBV incidence, appropriation of the project by the beneficiaries;
- To what extent do the positive changes resulting from the project continue after the end of the action? In particular, through the replication of training activities and continuity of the GBV committees.
- Make proposals for strengthening the achievements of the project. Coordination
- Is the level of involvement and coordination of actions with other actors including local authorities, NGOs, Technical Services present in the area adequate?
- Is the level of collaboration through the sharing of information (technical, financial, logistics) and good practices adequate?
- What is positive and negative impact of inter-agency coordination efforts? To what extent does the project contribute to improved collective response on the GBV and SEA vulnerabilities in targeted locations?

1.5.5. Accountability

- Are the beneficiaries informed about the activities of the project?
- The situation / participation of girls and women, especially those heads of household?
- Are the existing monitoring and accountability mechanisms used and adapted to the context? If not, how can they be improved?
- Do the beneficiaries know the complaint and feedback mechanism? What are its limits? Do they use them? What feedback do they have on this mechanism?

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1.6. Literature Review

1.6.1. Addressing Gender Based Violence

Violence against women is widespread and may affect women of any age, class, race, religion, sexuality, or ability. Factors which may increase women's vulnerability to some types of violence include age, disability, and poverty. Across all forms of violence and abuse, women are most at risk from men they know. Significant numbers of women experience more than one type of violence. Prevalence surveys which address violence against women in all its forms may yield more information than 'single-issue' surveys about the meaning and impact of violence in women's lives.

Few studies have been designed specifically to record the experiences of marginalized groups of women, including black and minority ethnic women, women with disabilities, lesbian, women working in prostitution and homeless women. Attempts to document the experiences of marginalized groups of women must go beyond merely ensuring their 'inclusion', numerically speaking, in general, population studies.

Violence against women has a significant impact on the health and socio-economic status of women. It affects the health and wellbeing of children and young people who witness violence against their mothers and other women. The costs to society of responding to violence against women, and the overall economic impact, are high and measurable. However, there is a need for improved data collection systems across all agencies involved in responding to women who have experienced violence.

Although there has been an increase in the number and range of services available to women who have experienced violence, there is relatively little evaluative research. The available research suggests that women value advocacy and support and want service providers to be more proactive in offering these.

Research into interventions tends to focus on discrete aspects of violence against women, reflecting how service providers and policymakers compartmentalize women's experiences. Although some comparative analysis has been undertaken, no studies were identified which evaluated interventions to respond more broadly to women's incidents of violence. Research on violence against women cuts across academic boundaries and is found in several fields, including law, social sciences and health. This is a reflection of the diverse range of responses violence against women demands.

However, multidisciplinary research is rare, and consequently, opportunities for 'cross-fertilization' are missed. Services for children and young people affected by violence against women are still relatively scarce. Although not addressed directly in this review, an initial trawl of the literature identified little research on effective interventions. The existing body of research focuses primarily on the impact of domestic abuse on children and young people.

It is acknowledged that the involvement of women survivors of male violence in contributing to the development and design of services increases effectiveness and accountability. In describing the acts of abuse perpetrated by different men, at other points in their lives, women survivors of male violence consistently make the connection between child abuse, rape, domestic violence and commercial sexual exploitation.

There are demonstrable links between different forms of violence against women, like the violence, the consequences of it, and the interventions required. Whether or not these links are made visible in policy and practice is to some extent governed by how far violence against women is regarded as symptomatic

of broader gender inequalities in society, and how far initiatives to tackle violence against women are located within this context.

1.6.2. The Global Context of Gender-Based Violence

There have been significant advances in understanding and addressing violence against women and girls globally in the last ten years. After decades of advocacy and programming by women's movements and feminist activists, violence against women and girls is now widely recognized as a fundamental violation of human rights, and a severe development and public health issue.

This has resulted in increasing financial investments and several conventions, policies and frameworks to address violence against women, including through the Sustainable Development Goals. There is now also a consensus that unequal gender power relations and discrimination against women and girls are root causes of violence against women, and the Ecological Framework has become the standard framework for understanding the drivers of violence across multiple levels.

While the scale of the issue of violence against women and girls is immense, there is increasing evidence that rates of violence can be reduced within programmatic timeframes, and several key elements to effective prevention programming have been identified. However, more evidence is needed from low- and middle-income countries, particularly from Asia and the Pacific. The next big questions remain around what works to prevent violence against women and girls in different cultural contexts, how to ensure an intersectional approach, how to continue to support local women's movements, and how to address and respond to violence against women and girls on a large scale in a sustainable way.

1.6.3. Addressing Violence against Women

Records indeed have it that violence within the family in Nigeria has reached alarming proportions. Reports of beating, torture, acid attacks and killing of women in the family or relationships are regular features in the media and documented reports. The pages of most Nigerian newspapers are replete with instances of women who were beaten or hurt by their husbands.

The Nigerian Television Authority (NTA) has interviewed many women victims, the National Orthopedic Hospital, Igbobi, Lagos, as well as Lagos University Teaching Hospital (LUTH) have reported such cases too. Public testimonies before the Civil Resources Development and Documentation Centre Tribunal in Enugu and Abuja since 1996 have revealed other harrowing cases of wife battering in Nigeria.

Shija reports that here in Nigeria, an average of 300–350 women are killed every year by their husbands, former partners, boyfriends, or male relations. Most times the incidences are considered family feuds, which should be treated within the family. Most police refuse to intervene and advice the victims to go back home and settle "family matters". Domestic violence affects women in Nigeria irrespective of age, class, educational level and place of residence. Nigerian law and custom categorizes a woman as an object who is not quite human.

Gender-based violence is perhaps one of the most terrifying illustrations of inequality between male and female. Women are more at risk from violence than men in all sectors of the society. This is because of the differential access to prestige, power, control of materials resources, freedom to obtain knowledge

and other basic needs of life among the gender. Violence against women is entrenched in the family, institutionalized by the social structure and driven by patriarchal arrangement, or class/gender stratification.

The family which has been regarded as the ideal basic unit of the society where there is support, love, understanding and care, has turned out to be and can be the most oppressive institution for serious violence, hostility and conflicts. Yet according to Nwankwo, the law still ignores the gravity of the problem.8 Domestic violence constitutes a violation of women's human rights. It contravenes the fundamental rights provisions contained in the constitution: for instance, the right to life and all the basic civil and political freedoms including freedom of association, assembly, expression and worship and freedom from discrimination.

The United Nations sponsored Convention for the Elimination of Discrimination against Women (CEDAW) was adopted by UN General Assembly in1979 and is often called a bill of human rights for women. It calls on governments that signed the treaty to remove all forms of discrimination against women to ensure women's equal access to political and public life, education, health, and employment and to protect their reproductive rights. In 1979 Nigeria signed the convention and in 1985 ratified it without reservations.

Other conventions that address the specific rights of women include the convention for the suppression of the traffic in persons and the convention on consent to marriage, the minimum age for marriage and the registration of marriages. In spite of these, one problem with these protections is the long, technical and cumbersome procedures necessary to enforce these human rights.

The change was not immediate as, years after political majority rule, the legacies of institutionalized violence remain in the treatment of many and the acceptance of violence as a legitimate, and primary means of settling disputes" (City of Edinburgh Council, 2002). In a study on overcoming endemic violence against women, it was acknowledged that abuse and violence against women have been with us for the duration of recorded history and appears to be a universal phenomenon relating to women's general status in particular communities. When violence is referred to as "endemic", it conveys the premise that it is widespread, familiar, and deeply entrenched in most societies (Bindel and Kelly, 2014).

The study explains that statistics relating to violence against women are notoriously difficult to establish mainly due to under-reporting and gives reasons such as the acceptance of such violence as normative by individuals and the authorities, lack of confidence in the police, the shame women experience in describing assaults particularly of a sexual nature, economic dependence on abusers, fear of future reappraisals and the difficulty in obtaining convictions.

1.6.4. Understanding Gender-Based Violence

The feminists are of the view that victims of intimate violence are less likely to define their victimizations as criminal acts, and as such women and men come to view violence by intimates as less severe than violence by strangers. This is even though stranger violence could be less extreme. Victims view intimate relationships as private and legal, intervention into them are seen as an accusation of failure, a source of

embarrassment and shame, and as a cause of breakdowns in those relationships. Feminists explain that its acceptance reinforces offenders in their use of violence in intimate settings and victims in their reluctance to invoke the law against intimates who attack them

Sexual violence in particular places a limit on a woman's ability to protect herself against infection such as HIV, pregnancy and unwanted sexual acts, among other unwanted things. In this manner, a woman's rights are not fully exercised. These views of violence against women limit the impact of HIV prevention strategies that emphasize the use of condoms and abstinence and do not take violence into account. These strategies tend to fail to achieve their intended goals because women, who are victims of violence, are often unable to negotiate and enforce these life-saving strategies. Violence, or its perceived threat, seems to be a strong deterrent to adopting prevention measures, and have grave implications for the risk associated with HIV/AIDS in young people in particular.

Nigerian women have been subjected to various forms of domestic violence throughout history. Domestic violence in its physical, emotional and psychological contexts constitutes torture of women, an attack on their integrity and a grand design to undermine their humanity. Efforts by the international community are trailing domestic ones to alter the situation. Although there are some remarkable changes in attitudes, but there still exist great disparities. It is argued, can only be fought if a worldwide and collective approach to the problem is evolved. One of the future directions in the fight against violence against women in Nigeria is to create or raise awareness of women’s rights in the police and judiciary and promote public information campaigns in the news media to provide support to women’s organizations and provide improved knowledge and statistics from case studies. Equally important, it is necessary to educate women about their human rights.

The United Nations has already adopted an international bill on the rights of women. International and local agencies such as Department for International Development (DFID), women Empowerment against Violence (WEAVE), National Coalition against Domestic Violence (NCADV), and several others are working in this same direction. Sexual violence in particular places a limit on a woman's ability to protect herself against infection such as HIV, pregnancy and unwanted sexual acts, among other unwanted things. In this manner, a woman's rights are not fully exercised.

These views of violence against women limit the impact of HIV prevention strategies that emphasize the use of condoms and abstinence and do not take violence into account. These strategies tend to fail to achieve their intended goals because women, who are victims of violence, are often unable to negotiate and enforce these life-saving strategies. Violence, or its perceived threat, seems to be a strong deterrent to adopting prevention measures, and have grave implications for the risk associated with HIV/AIDS in young people in particular.

1.6.5. Prevalence of Gender-Based Violence

The incidence of Gender Based Violence (GBV) is growing astronomical with the activities of the insurgency in the North East. From forced and early marriages to the physical, mental or sexual assault on a woman, nearly 3 in 10 Nigerian women have experienced physical violence by age 15 (NDHS 2013). The United Nations Fund for Population Activities (UNFPA) targeted areas of interventions is to improve

the gender-based violence policy environment at national and state levels. The Fund works with a variety of partners to provide survivors with medical, reproductive health services and/or psychosocial care as part of our commitment to rehabilitate women and girls who have been abused and to help them overcome their ordeal.

The Ministry of Women Affairs and Social Development and United Nations Population Fund (UNFPA) shows that "28% of Nigerian women aged 25-29 have experienced some form of physical violence since age 15." Also, the risk of violence varied based on marital status as "44% percent of divorced, separated or widowed women since age 15, while 25% percent of married women or those living with their spouses have experienced violence." In addition, a report from UNFPA shows that nearly "3 in 10 Nigerian women have experienced physical violence by age 15."

1.6.6. Correlates of Gender Based Violence

Nigeria is a highly religious country with Christianity, African Traditional Religion and Islam being the major belief systems. Religious leaders are held in high esteem with fear, respect and love. Thus, religion plays a major role in the life of the people. The patriarchal system in the country enforces violence against women as a tool for correcting behavior and exerting male dominance, especially in marriages. Religious bodies play major roles in shaping beliefs and perceptions in the country. Thus, it no surprise that religious bodies play a role in encouraging such practices. For example, there are religious ideologies on women being inferior to men, the perception of women as "unclean" and the portrayal of virtuous women as "submissive", all of which endorse GBV. Also, the frown on divorce by some religious sects makes it further difficult for women to leave abusive marriages.

Surprisingly, these acts of violence are even perpetuated by the religious leaders who are revered and feared. The report by premium times with the headline "Islamic Cleric rapes 16-year-old, but claims she's his wife" is a clear example. In a country where these religious leaders are revered and feared, who will put them in check? It is rather ironic the way women are addressed on such issues. Women are told to be prayerful and hopeful for a change in situations where they report such cases. Also, women are told to cover up and hide their bodies because the perpetrators "just don't come themselves". They are further told to keep quiet and refrain from making the men angry. There are ridiculous solutions because in north-east of Nigeria society, where women are known for covering up and being "submissive", cases of GBV are high. According to a situation report from UNPFA, "6 out of 10 females reported to have experienced one or more forms of GBV in the North East, where sexual violence and GBV prevalence has increased by 7.7% since the conflict with Boko Haram began."

1.6.7. Help-Seeking Behavior

The women exposed to physical and sexual violence in the north east about 39.7% reported that they sought help to stop the perpetrator from hurting them again. Rates of help seeking are geographically patterned by state (range: 12% to 65%). State-level development, measured by the Human Development Index (z-score), is positively associated with help seeking (OR=1.30, 95% CI 1.05 to 1.61), after adjusting for individual-level characteristics.

State-level prevalence of violence against women (z-score) is negatively associated with help-seeking (OR=0.68, 95% CI 0.55 to 0.84), suggesting that service providers who may target their programs to areas

with high prevalence of violence, may need to simultaneously address barriers to help seeking. Few individual-level characteristics are also associated with help seeking, including wealth, marital status, employment status, ethnicity, history of witnessing domestic violence and relationship to perpetrator. Efforts to support female survivors of violence should consider broader social and contextual determinants that are associated with help-seeking behaviors.

1.6.8. Conceptual Framework Gender-Based Violence

The framework within which violence against women is understood as it stems in part from women's and girl's subordinate status in society recognizes that violence directed against a person is done so based on his or her gendered identity. It generally derives from cultural and social norms that imbue men with power and authority over women (Bindel, 2014). Bossy and Coleman (2016) are of the view that there is complexity with identifying perpetrators of GBV as unequivocally "male". However, it may be true that the perpetrator's gender does differ critically from that of the victim with overwhelming regularity. It is noted that identifying perpetrators solely by their gender is an inadequate way to honestly explain the myriad forms of behavior that together can be called GBV, and also cannot explain the fact that women are differently vulnerable to GBV, while men in diverse relations to its perpetuation.

Gender identities are shaped through violence as our identities as men and women were stitched together in violent times, realized against brutal conditions (UNICEF, 2014). Cambell (2017) identifies an unspoken assumption that masculinities are by nature, violent, and that violence is a natural part of everyday life. It is through this concept that we glean an understanding of how women "s subordination to men is socially constructed, by reinforcing male power and the beliefs of women" s inferiority. The background characteristics of the respondents will likely affect their experience of violence. The background characteristics of the respondents will likely affect whether or not they seek help after experiencing violence (Greene, Robles, Stout, and Suvilaakso, 2013). The background characteristics of the respondents will likely affect where they seek help from after experiencing violence.

1.6.9. Conclusion and Recommendations from Baseline for the ECHO project

The conflict has also maintained a vicious cycle of GBV as women, men, girls and boys in dire situations resort to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. The fear, shame and stigma associated to GBV significantly weight on the mental health conditions, socio-economic situation and access to GBV services. Humanitarian actors are already present in the area. But GBV services access and quality are quite poor. The findings show also that the humanitarian assistance should be improved regarding respect of safety and dignity of the communities. Key recommendations

- Strong GBV awareness is needed to engage communities and change social norms (stigmatization).
- To encourage existing positive coping mechanisms.
- To strongly reinforce the knowledge on the accessible and available GBV services and encourage coordination between the actors.
- Vigilance on the safety, accessibility and participatory approach while delivering the activities expected in the project.
- Community-based mitigation plans to be supported within the budget possibilities.

SECTION 2. EVALUATION METHODOLOGY

The final evaluation study employed a mixed-methods approach to collect, analyze, and triangulate quantitative and qualitative data to answer specific lines of enquiry (study scope) revised from the desk review conducted by the Lead Evaluator (LE). This section provides information on the adopted methodology and approach.

2.1. Description of Evaluation Methodology

To meet these objectives and provide useful insights from the above-mentioned evaluation questions; the final evaluation employed a multi-tier methodology approach as shown in Table below.

Table 1. Evaluation Methodology

Evaluation Methods	Evaluation Tasks
Outcome Harvesting (OH)	**Desk Study**: Primary Data Review
	Deep Dive: Secondary Data Review
	Develop Inception Report
Outcome Mapping (OM)	Interview of Key Program Staff, Stakeholders and Beneficiaries
	Data Review and Analysis
Most Significant Change (MSC)	Establish Casual Linkages
	Develop Final Report
	Develop Knowledge Products
	Presentation: Validation and Dissemination Meeting

2.1.1. Outcome Harvesting

Outcome Harvesting (OH) collects ("harvests") evidence of what has changed ("outcomes") and, then, working backwards, determines whether and how an intervention has contributed to these changes. This has proven to be especially useful in complex situations when it is not possible to define concretely most of what an intervention aims to achieve, or even, what specific actions will be taken over a multi-year period. This informed the selection of this evaluation approach by the LE to deliver on the objectives of the final evaluation study. This is the first evaluation tier to be employed by the LE.

The outcome harvesting process will incorporate a desk study review of primary data from CARE Nigeria regarding program reports. Leading from this, the evaluation team proceeded to conduct a deep dive to review secondary data (via a literature review) on specific GBV program areas in Nigeria and Borno

specifically. Broadly speaking, the outcome harvesting process will documented key findings along the following lines of enquiries i.e.

- **Learning from what works**: what was achieved from the activities planned, what worked well/what the success factors were, key lessons learned, key adaptations to leverage success/achieve greater CARE Nigeria program outcomes for achieving greater results.
- **Learning from what did not work**: what was not achieved from the activities planned, what did not work well/what were the challenges/bottlenecks, key lessons learned, key adaptations/course corrections to address challenges/bottlenecks to achieve expected outcomes in relation to CARE Nigeria program expected results.

2.1.2. Outcome Mapping

Outcome mapping (OM) is a methodology for planning and assessing projects that aim to bring about 'real' and tangible change. It has been developed with international development in mind and can also be applied to projects (or program) relating to evaluation communication, policy influence and research uptake. This approach is especially useful for evaluating the ECHO sponsored intervention. The OM process commenced with interviews with identified respondents and stakeholders (i.e. based on established lines of enquiries outlined in the evaluation matrix). The evaluation team also surveyed CARE Nigeria program stakeholders during respondent interviews (e.g. online surveys). Output from this analysis stage (visuals and data) was used by the evaluation team to further showcase documented program outcomes from the final evaluation findings.

2.1.3. Most Significant Change

The Most Significant Change (MSC) technique is a form of participatory monitoring and evaluation. It involves the collection and selection of stories of change, produced by program or project stakeholders. Upon collation of field data by the evaluation team analyzed both qualitative and quantitative data to identify the MSC achieved by CARE Nigeria during the implementation period of the program in Nigeria (Borno). This was achieved through a comparative analysis of baseline, mid line and final evaluation findings across both intervention LGAs. All evaluation findings (visuals, data, and narrative contents) was used to explain CARE Nigeria program outcomes for each Evaluation Question (EQ). The evaluation team focused on clearly showcasing examples where CARE Nigeria program successfully delivered on its core objectives of the final evaluation study.

2.2. Evaluation Sampling Approach

Sample sites were selected through a stratified multi-stage sample design. Strata was selected at the LGA level, and included key characteristics and factors expected to impact progress towards outcome (i.e. sex, geographic location, etc.).

2.2.1. Snowball Sampling Approach

For the sampling of households for the evaluation survey; the team adopted of a snowball approach (i.e. respondent referral survey) to ensure each engaged respondent was a target beneficiary of the project. This approach was quite effective given the limited time allowed for field data collection (i.e. 5 days) as

well as the prevailing precarious security situation in Ngala and Bama LGAs. By adopting the snowballing approach to sampling, a team of field enumerators conducted daily Key Informant Interviews (KIIs)/household surveys based on informed guidance from project beneficiaries.

To prevent gender bias the field enumerators were instructed to source alternative interviews based on an established protocol i.e. enumerators shall make accommodations for prioritizing a near-equal ratio of beneficiaries for field interviews. For example, field enumerators were mandated to interview a female respondent after a male respondent, and vice-versa. The Data Management Evaluator (DME) also routinely examined respondents interviewed (i.e. respondent locations, and last names) to ensure variability of the sampled population. This measure ensured that no portion of sampled population was left out.

To ensure that the evaluation team limits respondent referral bias (i.e. respondents linking to only relatives, neighbors, or close associates); each enumerator was provided with a randomized list of 200 beneficiaries per assigned location. Enumerators were then directed to only reach out to beneficiaries captured on their assigned list. While the technical evaluators took notes on referrals given by each respondent that had relocated to other areas of the target LGAs or had relocated away from the target LGAs or simply could not be found.

2.2.2. Sampling Frame

Each field enumerator was provided with a randomized list of project beneficiaries (i.e. based on the consolidated list of 1000 beneficiaries in each LGA as provided by CARE NG). The dual-sampling approach mitigated potential challenges locating respondents because of frequent displacements common with both locations and persistent conflict. Over the five (5) day period, each field enumerator interviewed a minimum of five (5) respondents per day and twenty-five (25) at the end of the data collection exercise. Based on this projection, a proposed final evaluation sample frame of 500 beneficiaries was proposed.

- **Bama LGA** – 239 respondents (33 Males and 206 Females)
- **Ngala LGA** – 177 respondents (47 Males and 130 Females)
- **Total** – 416 respondents (80 Males and 336 Females)

Strategically, a randomized buffer list of 200 beneficiaries (i.e. 100 beneficiaries per LGA) was generated, containing randomly selected beneficiaries in proposed sample LGA sites and reserved for replacement should any or a combination of the following situations arise:

- If, by chance, the enumeration team were unable to reach a respondent for interview.
- A selected respondent was not willing to participate in the interview; and/or
- A selected respondent relocated from the known location for unknown reasons.

Therefore, the evaluation team ensured that the adopted evaluation sample frame of 250 respondents per LGA incorporated reasonable levels of certainty that the findings would be representative for the target population i.e.

- Reasonable ability to generalize the intervention's effectiveness to similar contexts;
- Reasonable ability to generalize the insights into what works and why for similar contexts.

2.3. Ethical Considerations

Due to the dynamic situation in which CARE operate, as well as the potentially life threatening nature of the issues involved, the evaluation team adhered to strict ethical and security guidelines. The evaluation team successfully leveraged their extensive experience conducting evaluative surveys and monitoring activities across multiple donor funded projects in the Northeastern Nigeria. Furthermore, the evaluation team adhered to CARE Nigeria Code of Conduct (C&C) guidelines at all times.

Specifically, the evaluation team adhered to the following ethical considerations:

- **Informed Consent**: This was communicated prior to the commencement of each interview. Respondents' consent was secured for all interviews and when this was not given, the enumerators proceeded to the next identified beneficiary.
- **Do No Harm**: In conducting evaluation activities, the team maintained a robust understanding of the impact of aid on existing Northeast crisis, especially its interactions within a target LGA context, with technical guidance provided by CARE Nigeria to limit or prevent unintended negative effect e.g. adhering to the Borno State government directive on engaging community based enumerator.
- **Confidentiality**: Measures were taken to ensure the strict confidentiality of collated data by the enumerators. The Data Management Evaluator (DME) ensured absolute compliance in this regard.
- **Anonymity**: No Personal Identifying Information (PII) was taken during the field data collection exercise.
- **Voluntary Participation**: No respondent or beneficiaries was placed under duress to participate in conducted field surveys.
- **Cultural Sensitivity**: The evaluation team engaged a mixed team of field enumerators, to ensure ease of reaching female beneficiaries and vice-versa.
- **Independence**: The evaluation has been external, and measures were be put in place to prevent bias.
- **Usefulness:** The evaluation findings were articulated clearly and in a way that maximizes the potential for these findings to inform decision-making.
- **Representativeness**: Evaluations strived to include a wide range of beneficiaries/ stakeholders.
- **Gender Sensitiveness**: The evaluation was gender sensitive and also, wherever possible, assessed the intended or unintended effects of the project on gender relations.
- **Conflict Sensitivity:** The evaluation was conflict sensitive and also, where possible, tried assess the intended or unintended effects of the project on the conflict.

2.4. Data Sources and Data Collection.

2.4.1. Desk Study Review

The evaluation team conducted a preliminary desk review of primary and secondary data sources i.e. internal and external documents. This involved collating findings from the CARE Nigeria project documents aligned to the evaluation questions. This was followed by a secondary review of project

documents upon completion of field data collection to examine outliers identified from the data analysis process.

2.4.2. Literature Review

As part of the Outcome Harvesting (OH) process, the evaluation team conducted a literature review to curate current knowledge including substantive findings, as well as theoretical and methodological contributions to the evaluation questions. The literature review put forward a theoretical basis for each study objective outlined in the Terms of Reference (ToR) document.

2.4.3. Field Survey

The evaluation team deployed the ODK collect platform for field data collection i.e. developed questionnaires were uploaded on the ODK collect app platform (https://www.getodk.org/); which will enable remote near-real time monitoring of field data collection by the evaluation team across both locations, as well as offer close coordination support mechanisms by the DME to address potential data quality issues. Fieldwork occurred in Ngala and Bama, conversing Gambaru A, Gambaru B, Ngala, Kasugula, Shehuri, Mairi and Hausari, as well as GSSSS camp, Arabic and ISS camp during the period of 6th to 11th October, 2020.

Team composition comprised of field enumerators supervised by respective technical evaluators (i.e. Investigative evaluator and Data management evaluator), each field enumerator was tasked with administering the beneficiary and stakeholder evaluation questionnaires in Ngala and Bama LGAs. Since the midline evaluation, security situation in both locations have significantly deteriorated, with Ngala only being accessible by scheduled United Nations Humanitarian Air Service (UNNHAS) helicopter flights.

Table 2. Engagement of Evaluation Team

SN	Description of Tasks	Lead Evaluator	Investigative Evaluator	Data Management Evaluator
		Level of Effort (Days)	Level of Effort (Days)	Level of Effort (Days)
1	Desk Study and Literature Review	1	1	0
2	Development of Evaluation Matrix and Questionnaires	1	0	1
3	Develop Inception Report	1	1	0
4	Conduct Data Collection	5	5	5
5	Conduct Data Analysis	2	1	2
6	Develop KM Products	2	0	0
7	Develop Final Evaluation Report	2	1	0
8	Final Dissemination Meeting	1	1	0
Total		**16**	**10**	**8**

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Therefore the Lead Evaluator (LE) and Data Management Evaluator (DME) had to coordinate daily field data collection exercises remotely via WhatsApp communications with field enumerators. All field enumerators were provided with routine technical support throughout the entire field data collection exercise.

Figure 3. Community Leader, Bama, Borno

Courtesy: Sahab Umar Ibrahim

However based on prevailing security challenges and insistence by the Borno State government that NGOs/INGOs shall engage Local Government Area (LGA) based enumerators for their field activities (i.e. localization of project activities).

The evaluation team engaged LGA based field collectors, especially in Ngala where locations were only accessible by helicopter flights due to insecure land routes. To this end, both technical evaluators handled daily data cleaning, flagged incomplete forms and conducted assurance checks on updated forms by field enumerators.

2.4.3.1. Field Deployment and Data Collection

Upon approval of the evaluation questionnaires, the LE developed a field deployment roster to guide data collection and supervision by assigned technical evaluators for each sample location. Each technical evaluator directly supervised five (5) field enumerators in each LGA to handle field data collection. Field data collection occurred concurrently to deliver on the final evaluation within the fifteen (15) days allocated timeframe as outlined in the ToR i.e. field data collection shall be conducted over five (5) days.

Table 3. Field Deployment

Borno State	Evaluation Team	Field Enumeration Team
Bama	Data Management Evaluator	Field Enumerators (x5)
	Lead Evaluator	
Ngala	Investigative Evaluator	Field Enumerators (x5)

Over a 5 day period, a team of field enumerators (alongside a technical evaluator) were successfully deployed to conduct data collection in Ngala and Bama. The LE and DME coordinated a one-day remote training session for both set of enumerators via WhatsApp. This was done to ensure that each enumeration team were conversant with the developed evaluation tools (i.e. questionnaires). Each

enumerator used ODK collect via mobile devices provided by CARE Nigeria to access downloaded evaluation questionnaires. The evaluation team engaged mainly State Emergency Management Agency (SEMA) approved enumerators trained by CARE Nigeria based in each LGA; field enumerators were most knowledgeable in the use of mobile-app collection platforms and did not require extensive training due to their familiarity of the local context.

2.4.3.2. Timeframe of the Evaluation

The evaluation took place in October 2020 period and was articulated around the following main period/activities:

- **September 15th**: Signing of evaluation contract
- **September 25th**: Desk study and literature review
- **September 30th:** Development of evaluation matrix and design of evaluation questionnaire
- **October 2nd**: Submission of inception report
- **October 5th**: Enumerator training + pilot testing of the forms
- **October 6th - 11th**: Data collection in Ngala and Bama LGAs.
- **October 11th – 13th**: Final data entry and cleaning database
- **October 13th - 16th**: Report development
- **October 16th:** Evaluation report submission

2.5. Key Demographics.

This section provides a breakdown of demographic profiles of completed evaluation interviews for each respondent category (i.e. stakeholders, beneficiaries, and program staff) for data collection activities in Ngala and Bama LGAs, Borno. The breakdown of interviewed beneficiaries is highlighted in Table 4. Below.

Table 4. Key Demographics (Beneficiaries)

Respondent Category		Male	Female	Total
1	Bama LGA	33	206	239
2	Ngala LGA	47	130	177
Total		80	336	416

The breakdown of interviewed stakeholders is highlighted in Table 5. Below.

Table 5. Key Demographics (Stakeholders)

Respondent Category		Male	Female	Total
1	Bama LGA	4	9	13
2	Ngala LGA	2	0	2
Total		6	9	15

The breakdown of interviewed program staff is highlighted in Table 6. Below.

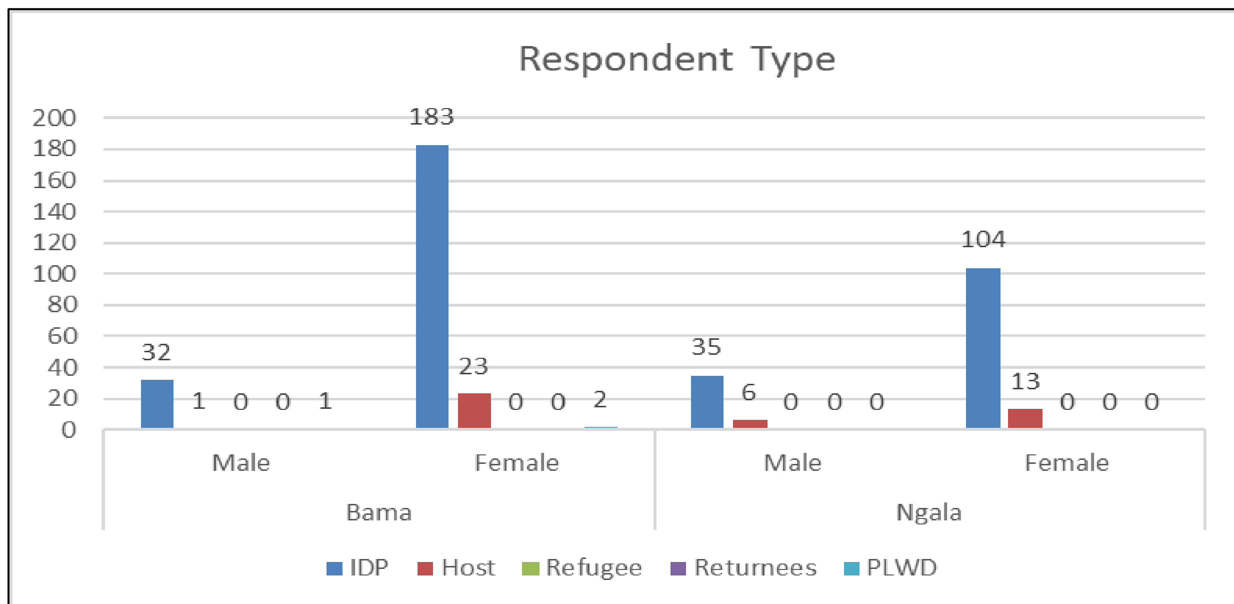
Table 6. Key Demographics (Program Staff)

Respondent Category		Male	Female	Total
1	Program Management	0	3	3
2	Monitoring and Evaluation	1	0	1
3	GBV/Social Protection	0	0	0
4	Others	0	0	0
Total		1	3	4

Across both intervention LGAs, majority of beneficiary respondents (354 persons – 67 male and 139 females) were Internally Displaced Persons (IDPs); while host community beneficiaries accounted for 42 persons (36 females and 6 males) received responses. Generally, IDP respondents were more willing to provide information on the GBV response project in both locations, compared to host community beneficiaries. This may be due to an increased sense of security and related comfort of host community beneficiaries, unlike IDPs who have an increased vulnerability from not being permanently settled in both intervention LGAs.

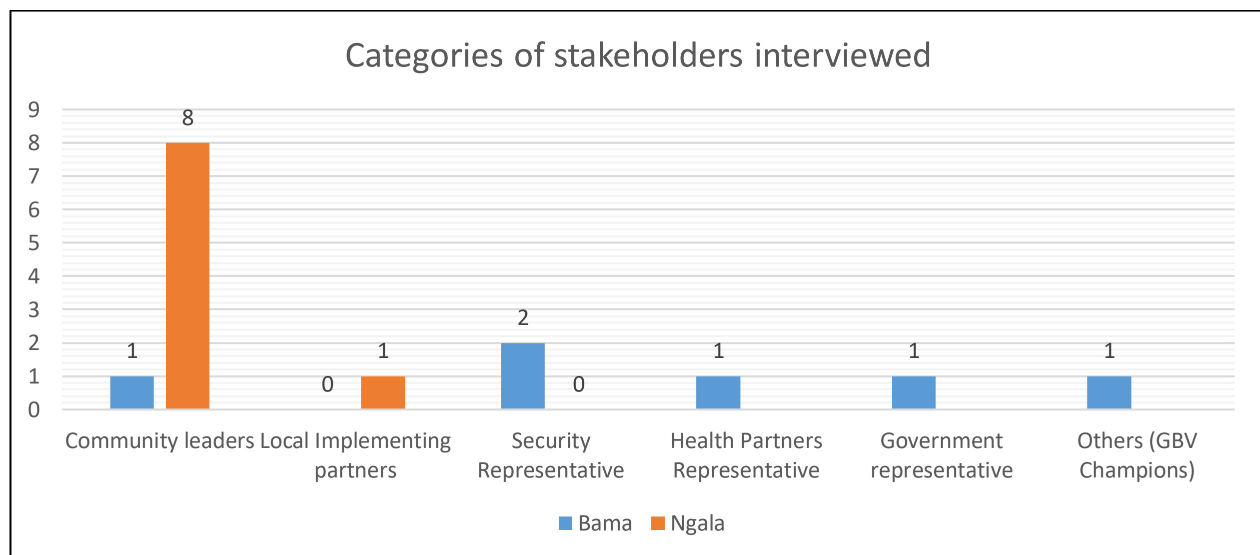
IDPs were therefore more willing to speak up and seek GBV related services wherever available. An examination of the implemented activities by the project in host communities and IDPs can provide useful insight into this response pattern. On the other hand, a review of interviewed stakeholders by the field enumeration team showed that community leaders were more willing to provide information on the ECHO GBV project. The evaluation team had limited success in engaging other stakeholders i.e. implementing partners, government representatives and health partners.

Figure 4. Beneficiary respondent category (Bama and Ngala)



The quantitative assessment data indicates that 82% of the respondents were females and 13% in Bama while 77% of the respondent were female and 26.5% were males in Ngala. These respondents were reached via snow balling approach from a project implementation database shared from the ECHO project. The respondents interviewed were majorly IDPS; a total of 88.8% (75.6% female and 13.2% male project participants) were from the IDP camps and 9.5% females were from the host community within Bama; compared to Ngala which had 74.8% female and 25.2% male responses from IDPs and 31.6% female and 68.4% male response from the host community. 65.8% females and 22.2% females and 12.2% males from IDP camps in Ngala.

Figure 5. Category of interviewed stakeholders (Bama and Ngala)



2.6. Data Analysis Methods

2.6.1. Qualitative and Descriptive Analysis

Data analysis was conducted using updated field questionnaires from field enumerators for each LGA to provide a contextual analysis of collated respondent feedback, draw lessons learnt, identify challenges and proffer recommendations. By triangulating different feedback sources from respondents, the evaluation team will be able pinpoint relevant responses per respondent group to answer each study question. After field data collection has been completed and the DME finalized quality control reviews, The DME created the data sets for analysis and reporting.

The Lead Evaluator (LE) also worked with the respective technical evaluators' data to ensure the data was cleaned, summarized and ready for use in informing and supporting the narrative report. Particular emphasis was given to identifying the differences between men and women; as the qualitative/descriptive analysis was sex disaggregated.

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2.7. Development of Risk Mitigation Plan

Prior to the commencement of field data collection, the evaluation team developed a Risk Mitigation Plan (RMP) itemizing potential challenges and risks associated with data quality for field activities. This protocol was used by the evaluation team as a reference guide to ensure timely reporting and effective assessment of field data collection by field enumerators. The RMP also highlighted respective mitigation strategies and probability ratings for each identified risk. For this reason, the RMP will consists of two sections: i.e. Risk Rating Scale (RRS); and Risk Mitigation Strategy (RMS).

Figure 6. Risk Rating Scale (RRS) - Sample

RISK SCALE	RISK PROBABILITY				
		REMOTE	OCCASSIONAL	PROBABLE	FREQUENT
	SIGNIFICANT	CRITICAL	CRITICAL	CRITICAL	CRITICAL
	MATERIAL	HIGH	HIGH	CRITICAL	CRITICAL
	MARGINAL	MEDIUM	MEDIUM	HIGH	HIGH
	NEGLIGIBLE	LOW	LOW	MEDIUM	MEDIUM

The RRS assigned corresponding risk ratings captured in the RMP. The impact of each identified risk was scaled according to the probability of its occurrence across a four-code color scheme (i.e., low, medium, high, and critical). As a reference guide, the RMP was routinely updated on an ongoing basis, to respond to changing scenarios or encountered challenges by the technical team.

The LE revised the RMP to accommodate changes to identified data collection risks (Annex).

SECTION 3. MAJOR LIMITATIONS

3.1. Challenges Encountered

A number of challenges were encountered during the conduct of the final evaluation study. These were addressed by the evaluation team:

- **Insecurity**: The field enumeration team in Ngala LGA, had to conclude data collection abruptly on the final day due to an Armed Organized Group (AOG) attack across the border in Fotokol in Cameroon on October 10th, 2020. Although the security situation was slightly better in Bama, field enumerators were constantly guided to complete daily interviews before 4pm for safety reasons.
- **Non-responsive respondents**: Beneficiaries within the Internally Displaced Persons (IDPs) camps often complained of hunger and lack of Non-Food items (NFIs) during interviews. Hence, they were less willing to spend tie answering questions from the enumerators; and would rather go elsewhere in search of food. The engagement of local enumerators provided by SEMA was helpful in mitigating this situation. As the team was able to get the support of community leaders and stakeholders to convince beneficiaries within the IDPs camps to participate in Key Informant Interviews (KIIs).
- **Relocated beneficiaries**: A minor challenge faced by the evaluation team during field data collection; was the relocation of project beneficiaries (i.e. based on the consolidated list of beneficiaries provided by CARE). The team were routinely informed of relocated beneficiaries and had to resort to the randomized buffer list to move on with the field interviews.
- **Social distancing measures**: Due to the corona pandemic, the evaluation team had to take robust measures to ensure the safety of all respondents and field enumerators. Therefore, interviews were conducted with face masks and adequate social distance maintained at all times during data collection. Hence, field data collection focused mainly on one-on-one interviews with beneficiaries and stakeholders; as the option for Focus Group Discussions (FGDs) was not explored. Furthermore, the evaluation team deployed online survey (Microsoft forms) tools to retrieve responses from the CARE Nigeria team.

3.2. Data Cleaning

To check for data entry errors, the evaluation team periodically reviewed a sample of uploaded data questionnaires and checked to see if individual entries were entered correctly. The evaluation team handled additional data cleaning processes i.e.

- **Missing data**: Scanning through the uploaded field data, the DME examined uploaded evaluation questionnaires to search for missing data; which may occur if a respondent declined to answer a question, or a field enumerator failed to ask or record a respondent's answer or skipped entry of a response.
- **Inconsistent data**: The DME also looked at individual generated survey data, to ascertain the consistency of recorded responses. For example, a respondent might say that she never accesses GBV services and then report that certain project activities were most useful. The LE took steps to reconcile such inconsistencies by referencing the isolated questionnaires, if possible develop a rule about sorting such dataset i.e. noting which response to accept.

SECTION 4. DATA ANALYSIS, QUALITY AND RESULTS

4.1. Data Quality Assurance

4.1.1. Data Quality Assurance

The evaluation team has proposed a robust mixed-methods assessment approach to address each EQ and aligned with the objectives of the project for effective storytelling with data. The evaluation team will combine the right visuals and narrative content with the right data, to develop a data story that can influence and drive change. This addresses the "so what?" for every research i.e. setting out a viable action plan to implement the findings for the evaluation study as well as facilitate sustainable uptake by respective stakeholders. The data cleaning and analysis process will involve the review of conducted data collection activities by digesting what happened and determining how it could relate to corrective actions.

Through the application of descriptive analysis, a train of evaluation findings will be developed to show linkages between EQs and baseline survey findings to ascertain the quality of end line evaluation findings (i.e. clearly showing attribution of program outcomes). Upon the completion of data collection from all categories of respondents and triangulation of responses, the evaluation team will also review all data points for quality standards i.e. completeness, uniqueness, timeliness, validity, accuracy and consistency.

Table 7. Data Quality Standards

DQA Standards	Definition
Completeness	The proportion of stored data against the potential of "100% complete.
Uniqueness	Nothing will be recorded more than once based upon how that thing is identified. It is the inverse of an assessment of the level of duplication.
Timeliness	The degree to which data represent reality from the required point in time.
Validity	Data are valid if it conforms to the syntax (format, type, range) of its definition.
Accuracy	The degree to which data correctly describes the "real world" object or event being described.
Consistency	The absence of difference, when comparing two or more representations of a thing against a definition.

By triangulating different feedback sources from respondents, the evaluation team will be able pinpoint relevant information to answer each Evaluation Question (EQ) as a comparison from preliminary baseline and midline survey findings. The evaluation team adopted a Data Quality Assurance (DQA) checklist showing definition standards i.e. used to complement the Risk Mitigation Strategy (RMS) to address encountered challenges during field data collection. Analyzed data will then be reviewed to highlight pivot points in order to create a bridge between program implementation and decision-making. Additional data quality assurance measures are highlighted in subsequent sections below.

4.1.2. Qualitative Comparative Analysis (QCA)

The Qualitative Comparative Analysis (QCA) is a method for understanding how causal factors (or "conditions") combine to produce a given outcome. QCA merges in-depth knowledge of cases with

quantitative Boolean algebra in order to reduce a complex array of diverse cases into a logically simple and robust solution. Set theory provides the theoretical bases for QCA; cases are conceived and evaluated in terms of their membership (or non-membership) in various sets, represented numerically with membership scores ranging from 0 (fully out of the set) to 1 (fully in).

QCA is a methodology that enables the analysis of multiple cases in complex situations. It can help explain why change happens in some cases but not others. QCA is good at addressing questions around why some interventions worked and not others. This is particularly useful for evaluations where people are interested not just in the results of a project or program, but also in how and why those results were achieved. QCA can therefore be used to help decide whether and/or how projects or programs could be scaled up or replicated (Baptist and Befani 2015). When used within M&E, QCA is a methodology for learning. The methodology does not include any inherent processes for measuring change. Instead, its main focus is on generating lessons and recommendations.

The QCA employs two parameters of fit: consistency and coverage. High consistency scores indicate that a certain factor (or combination of factors) frequently results in a given outcome. In set theoretic terms, the outcome would be a subset of the causal factor, signaling a "necessary" relationship: the outcome is not possible without the causal factor, but the factor alone is insufficient to produce the outcome. High coverage scores indicate that many cases with a shared outcome are represented by a certain factor (or combination of factors).

In set theoretic terms, the factor would be a subset of the outcome, signaling a "sufficient" relationship: the outcome will occur if the factor is present, but the outcome can occur without the factor. QCA seeks to identify combinations of factors that are consistent with the outcome, while also having a robust representation (or coverage) among available cases. In other words, QCA helps us identify which factors are strongly linked to the outcome ("necessary"), which factors are most effective in producing the outcome ("sufficient"), and which combination of factors, all together, make the difference for success, and under what circumstances.

Basically, QCA is a methodology identified patterns across multiple cases to better understand why some changes happen and others did not. When used for this evaluation, QCA information outputs was used to identify outcomes for each project objectives and identify the presence or absence of potential contributory factors to improve onward project design, planning and performance in the future. As the final analysis stage of the multi-tier approach, all evaluation findings (visuals, data, and narrative contents) shall be used to explain the program outcomes for each Evaluation Question (EQ). The evaluation team will focus on clearly showcasing examples where CARE Nigeria and programs successfully delivered on its core objectives of the final evaluation study.

4.1.3. Data Analysis Plan

The evaluation matrix served as the foundation for an overall analysis plan, guided by your evaluation questions. Finalized evaluation questionnaires had embedded probing questions identified in the evaluation matrix and sequenced to ensure collated responses for each respondent group (through online surveys and informant interviews) could be used to triangulate findings in both intervention LGAs. For example,

the evaluation harvested feedback from CARE Nigeria staff on completed project activities and progress milestones; while simultaneously retrieving same information from target beneficiaries in each LGA.

The evaluation team also conducted an initial desk review of CARE Nigeria GBV project documents, supported by a follow-on literature review to curate current knowledge including substantive findings, as well as theoretical and methodological contributions to the evaluation questions (i.e. as part of the Outcome Harvesting process). Collated data was then analyzed (descriptive and qualitative comparative analysis) to determine the extent to which consolidated responses could be linked to overall evaluation findings i.e. casual linkages from baseline, midline and final evaluation.

The evaluation team analyzed uploaded field data to identify the Most Significant Change (MSC) achieved by CARE Nigeria during the implementation period of the program in Borno. This was achieved through a comparative analysis of baseline and end line evaluation findings across both intervention LGAs. Thereafter, all evaluation findings (visuals, data, and narrative contents) were used to explain CARE Nigeria program outcomes for each Evaluation Question (EQ).

SECTION 5. KEY EVALUATION FINDINGS

5.1. Relevance

5.1.1. Project Design

When reviewing the design of the ECHO GBV project, the evaluation study examined the types of activities implemented across target communities in Bama and Ngala LGAs. The quantitative data showed that the project implemented a variety of activities and based on feedback provided by interviewed respondents (416 persons, Male –239 and Female - 177), these activities were utilized by target beneficiaries. Table 8 outlines the percentage of interviewed respondents that confirmed benefitting from implemented GBV related services/activities in Bama ana Ngala respectively.

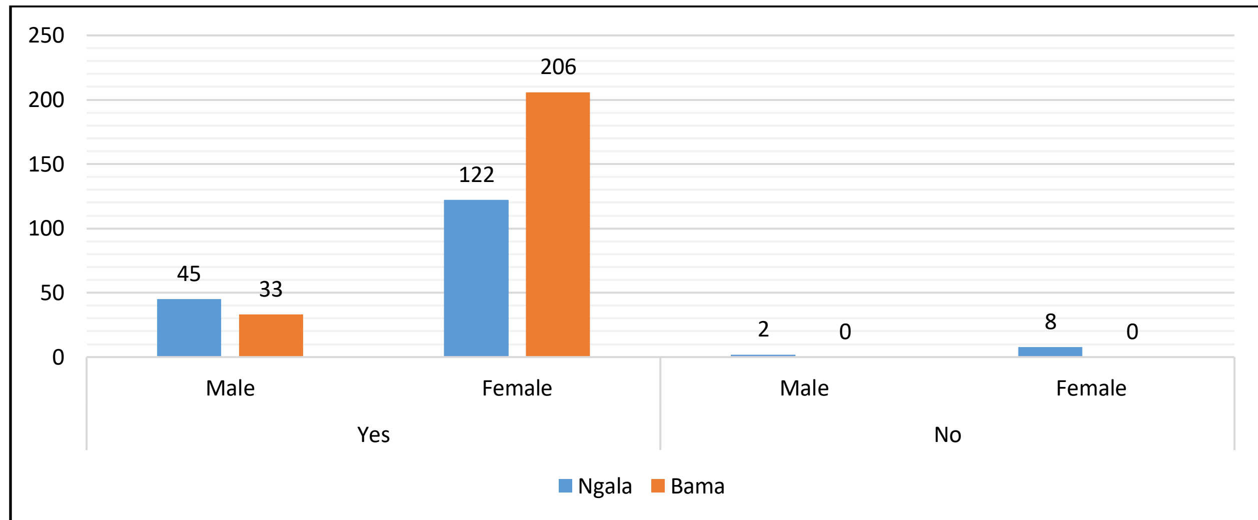
Table 8. Implemented project activities

SN	Implemented Project Activities	Bama	Ngala
1	Sensitization activities	59%	41%
2	Raising GBV awareness	62%	38%
3	Provision of material support	80%	20%
4	Safety and security	98%	2%
5	Connecting women/girls to information services	82%	18%
6	Distribution of dignity kits	57%	43%
7	Referrals	61.6%	38.4%
8	Psycho-social support and counselling	20%	80%
9	Material needs	88%	12%
10	GBV Survivor linkages to health services	52,8%	47.2%
11	Livelihood support	65.2%	34.8%

More importantly, when considering the relevance of implemented acties in terms of addressing underlying causes of identified problems in target communitiies, a majority of interviewed beneficiaries confirmed that GBV related services provided by the project met their emergency needs. For example, in Bama, 13.8% of men and 86.2% of female confirmed that provided GBV services met their emergency needs. In Ngala, 73% of men and 27% of women also confirmed the adequancy of GBV related services provided by the project.

The end line evaluation findings also showed that the number of survivors who received an appropriate response to GBV was 303 persons (i.e. Female 308 perosns and Men 5 persons).

Figure 7. GBV services meeting beneficiary emergency needs



5.1.2. Knowledge of Gender-Based Violence (GBV)

At baseline, a striking 61.7% of interviewed respondents stated that GBV cases were common in the community, majorly in the camps (Arabic camp, ISS camp, and GSSSS camp) with 44.5%, followed by host community members with 13.1%, then refugees with 3,5% and finally 0.6% of returnees. Also, 35.3% of respondents stated that GBV cases were not common (5.3% from host community members, 29.2% from IDPs, 0.6% from refugees and 0.2% from returnees), while 3.1% of respondent "did not know" if GBV was either increasing or reducing.

At midline, all interviewed beneficiaries did report an increasd in their knowledge of the ECHO GBV program (Bama – Male 24.4% and Female 75.6%, Ngala – Male 70% and Female 30%). At the final evaluation, quantitative data revealed that all interviewed stakeholders had participated in GBV awareness trainijgn provided by the program (40% in Bama and 60% in Ngala). Therefore, the project's engagement of stakeholders in GBV awareness training improved their social awareness through the sensitization of community members on GBV and further engagement of GBV protection networks (vigilantes and champions).

The project successfully conducted multiple training sessions for stakeholders on GBV, PSEA and humanitarian standards and also community awareness for the security forces. For example, the adoption of the Social Analysis and Action (SAA) manual during training sessions; was used to advocate for the reduction/elimination of sexual violence. Community leaders and security operatives also acknowledged the usefulness of training sessions as a viable means of increasing GBV awareness and sensitization of community members.

5.1.3. Knowledge of the ECHO-GBV program

Beneficiary knowledge and awareness of ECHO-GBV program was significant as all respondents clearly identified different activities implemented by CARE Nigeria. For example, surveyed respondents confirmed

that they participated in multiple training sessions on GBV, Child Marriage, Psychosocial support, Child protection, Livelihood, SRHR, and skill acquisition. Beneficiaries also showed increased knowledge on the protection focus and readily identified existing referral pathways in Bama. This was not the case in Ngala, where respondents were not able to readily identify referral pathways.

5.2. Efficiency

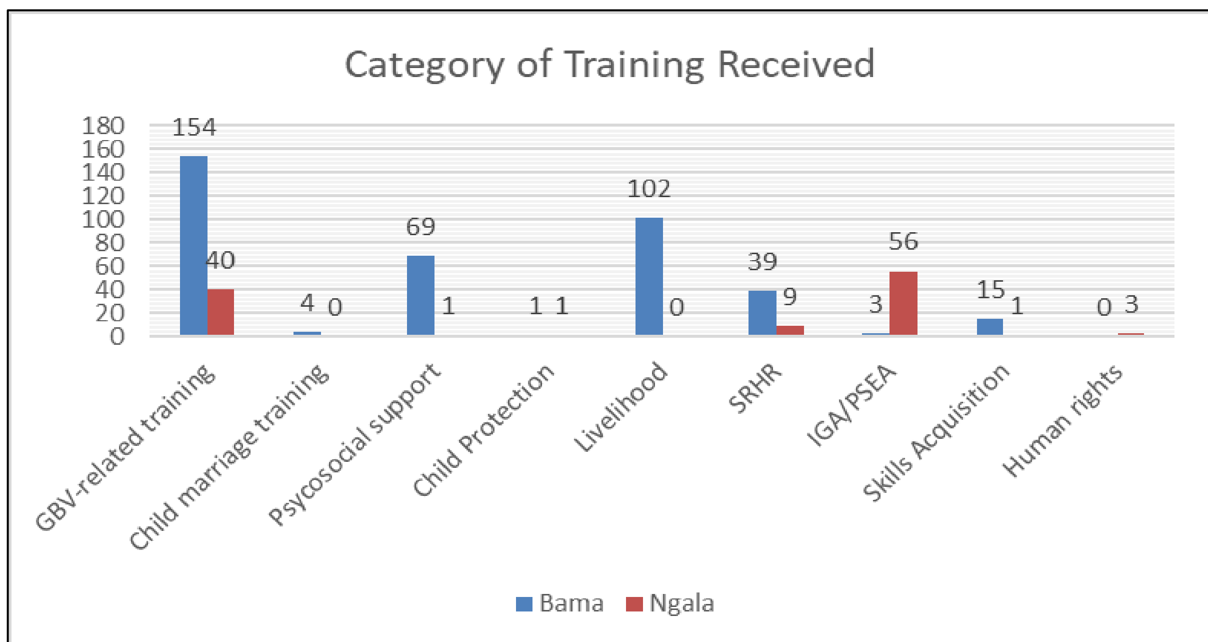
5.2.1 Clarity of Responsibilities

The quanitative data showed that interviewed stakeholders in Ngala (60%) and Bama (40%) displayed a clear understanding of their roles and responsibilities related to the implementation of the ECHO GBV project. This also translated to the positive perception of the project by stakeholders in Bama (40%) and Ngala (60%) respectively.

5.2.2. Technical and Adminstrative Support

When reviewing the nature of technical and administrative support required by the project, responses from interviewed program staff were evenly recorded (50% agreed that the project received adequate support and 50% urged further support for future GBV project iterations). Specifially, the ECHO GBV project was the first GBV project implemented by the Nigeria country office, and hence there was limited in-country operational model to adopt or replicate; as the project also required a robust staffing plan to ensure technical coverage. Going forward, it is imperative that future GBV projects are properly staffed and additional Techncial Assistance (TA) support should leverage CARE's extensive networks to address any intevention gaps.

Figure 8. Types of training received



Project beneficiaries also confirmed that they received different type of training from CARE Nigeria through the ECHO GBV project. GBV related training (154 responses) and livelihood assistance (102 responses) training were the most referenced sessions among interviewed respondents in Bama; while IGA/PSEA and GBV related training sessions were highlighted by project beneficiaries in Ngala LGA.

Interestingly, when asked about the type os trainings received, interviewed respondents associated PSEA training with IGA activities, as beneficiaries felt by being empowered through IGA, they in turn were more protected against Sexual exploitation and abuse (SEA). This may suggest that there were prevailing economic drivers to GBV cases in Ngala, especially with the COVID-19 pandemic that further restricted the activities of vulnerable households and eliminated livelihood options for rural communities.

5.2.3. Capacity Strengthening Activities

The ECHO GBV project successfully conducted a number of capacity building activities for stakeholders and beneficiaries in Bama and Ngala. The quantitative data highlighted the high percentage participation of stakeholders and beneficiaries in several training sessions i.e. GBV tragted training, GBV targeted workshops, self reflection sessions among stakeholders; and livelihood assistance, IGA/PSEA and Psycho-Social Support (PSS) among beneficiaries.

Table 9. Capacity Building Sessions Received by Stakeholders

SN	Capacity Building Sessions	Bama	Ngala
1	GBV Targeted Training	35.7%	64.3%
2	GBV Trageted Workshop	36.4%	63.6%
3	Self Reflection Sessions	38.5%	61.5%

Table 10. Training Received by Beneficiaries

SN	Training Received	Bama	Ngala
1	GBV Targeted Training	79.4%	20.6%
2	PSS	98.6%	1.4%
3	Livelihoods	100%	0%
4	IGA/PSEA	5%	95%

5.2.4 Quality of Monitoring and Evaluation (M&E) System

The established Monitoirng and Evaluation (M&E) system deployed ofr the ECHO GBV program consisted of a MEAL plan, logical framework workplan for activity reporting, output tracker and beneficiary database. As MEL functions were handled by a team consisiting of a MEAL Coordinator, MEAL officer and two (2) data clerks. A key limitation of the MEAL system was the limited utilization of evidence and project data for onward adaptive management improvements. For example, the project did not have an established learning agenda, with corresponding learning questions and supportive learning activities.

This was evident in the absence of reflective learning opportunities, which could have been conducted after each assessment study i.e. baseline, midline and end line assessment studies. Furthermore, there were no targetd studies to examine the emrging findngs from each assessment study.

5.3. Effectiveness

5.3.1. Project effectiveness

The ECHO GBV project was most effective in strengthening GBV awareness across target communities in Bama and Ngala LGAs. This was achieved mainly through the implementation of these activities:

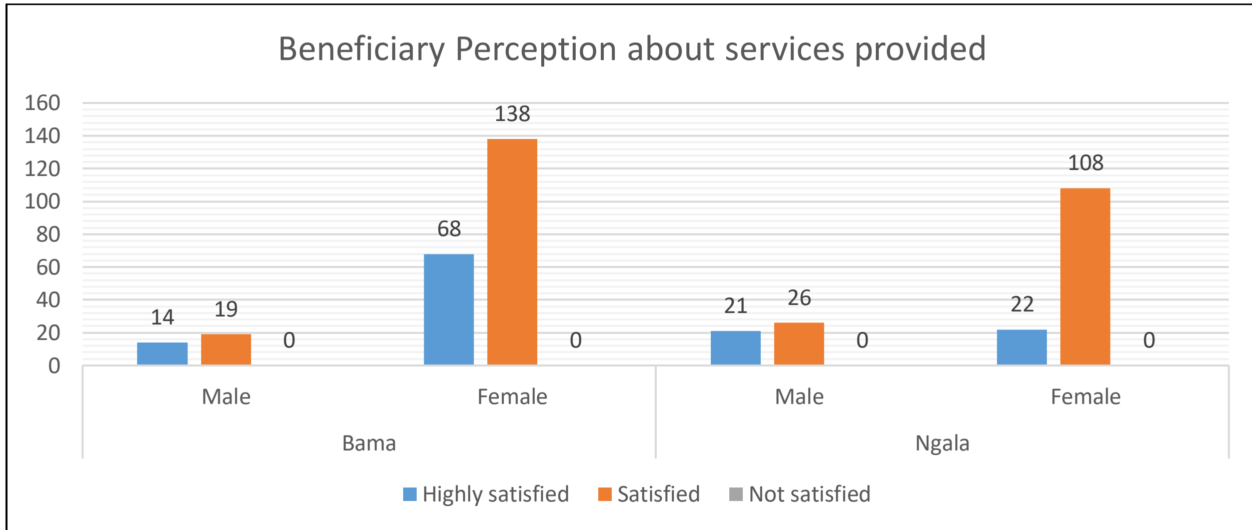
- **Community awareness raising on GBV**: Both stakeholders and beneficiaries alike recognized the importance of ongoing community awareness raising and sensitization events on GBV. Such project activities should be sustained to encourage community ownership of project activities. For example, the project also conducted mass awareness-raising reaching 5,045 (3,410 F and 1,635 M). In total 14,473 (7621 F, 6852 M) were reached.
- **Mobilization and training of GBV champions**: To embed sustainability measures for future project activities, the mobilization and training of GBV champions is essential. GBV champions can also drive community-level awareness raising and sensitization of returnees and IDPs beyond the project's implementation period.
- **Establish and support GBV vigilant committees**: When dealing with issues related to GBV, communal coordination and support was integral to the success of project activities i.e. creating safety in numbers. Trained GBV champions readily supported these vigilant committees in Ngala and Bama LGA.
- **Create and operate safe spaces**: The creation and operation of safe spaces for community-level engagement, eased referral pathway services and remains an effective implementation approach; which should be extended in future design iterations. This should ideally extend to support women solidarity groups and organizing further case management training to GBV champions and vigilant committee members to effectively make use of created safe spaces.

5.3.2. Beneficiary perception of services provided

At the baseline, there were no services providd by the project; hence collectively, interviewed beneficiaries had a positive perception of services provided by the ECHO GBV project in Bama and Ngala. For example, 42.5% of respondents in Bama (Male – 17% and female 25.5%) recorded being highly satisfied in their perception of services provided by the project. In Ngala, beneficiary feedback showed that 19.4% of male respondents and 80.6% of female respondents were satisfied with services provided.

No beneficiary was unsatisfied with the services provided by the project. Stakeholders also had a positive perception (47% of respondents) of the services and 53.3% of stakeholders rated the services provided by the project as being good in Bama and Ngala Local Government Areas (LGAs).

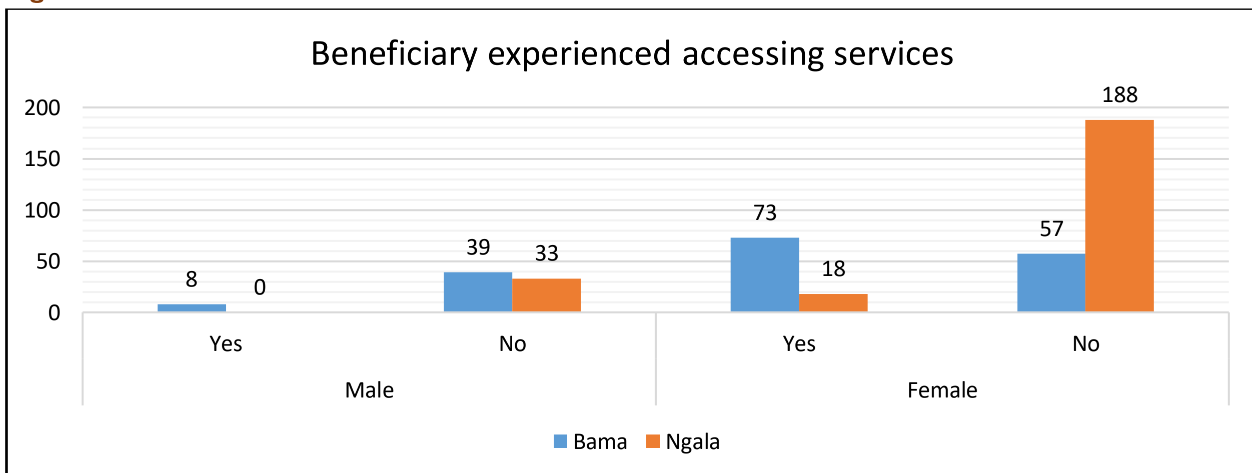
Figure 9. Beneficiary perception of services provided



5.3.3. Accessed GBV related services

In both Bama and Ngala LGAs, beneficiaries in all five (5) communities (i.e. Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, and IDP Camp Ngala) indicated low access to services among females at the final evaluation period i.e. 100% of men accessed GBV related services in Bama compared to 73% of men in Ngala. On the other hand, Only 18% of interviewed female respondents accessed GBV related services in Ngala and no respondent accessed services in Bama LGA. Examining this further, analyzed data showed that 54.2% of male respondents did not access services in Bama compared with 23.3% in Ngala. The situation was reverse among female respondents in Bama, as 45.8% did not access services in Bama and 76.7% in Ngala.

Figure 10. Accessed GBV related services



The analyzed data also showed fewer beneficiaries in both intervention LGAs were likely to make reports of GBV related abuses. However, there was a higher potential for beneficiaries in Bama to report GBV related cases of abuse than beneficiaries in Ngala.

For example, 45.2% of male respondents stated that they were interested in reporting cases of GBV compared to 54.8% of female respondents. On the other hand, in Ngala, no men were willing to make GBV related reports; while all women were open to making such reports (100%).

Interview with GBV Champion Leader, Bama LGA, Borno

Courtesy: Sahad Umar Ibrahim

The details in methods of reporting GBV experienced in the communities showed there is need for more awareness and outreach activities to log such GBV complaints in Ngala especially among men and encourage more reports in Bama.

5.3.4. Achievement of planned activities and project outcomes?

The quantitative assessment data indicates the beneficiary emergency need were met in Bama among females were 86.2% and 13.8% amongst male respondents compared to 73.1% in Females and 26.9% in males of Ngala. For example, a total of 6,487 persons were reached by the implementation of specific GBV prevention measures at the end of the implementation phase of the project (end line evaluation records). Against the project target of 7,500 persons, the project was unable ot reach 1,013 persons.

However, the quantitative date did reveal that more female beneficiaries (206 in Bama and 122 in Ngala) reported that the ECHO GBV program met their emergency needs compared to male beneficiaries (45 in Ngala and 33 in Bama). Interestingly, 8 female respondents in Ngala stated that their emergency needs were not met by the project; unlike the situation in Bama, where all interviewed beneficiaries were satisfied with the project. The analyzed data shows that there remains a demand for GBV related services and referral pathways in Ngala. Since CARE Nigeria had no presence in Ngala at the time of the evaluation study due to insecurity; it is clear that project beneficiaries still seek support for emergency needs.

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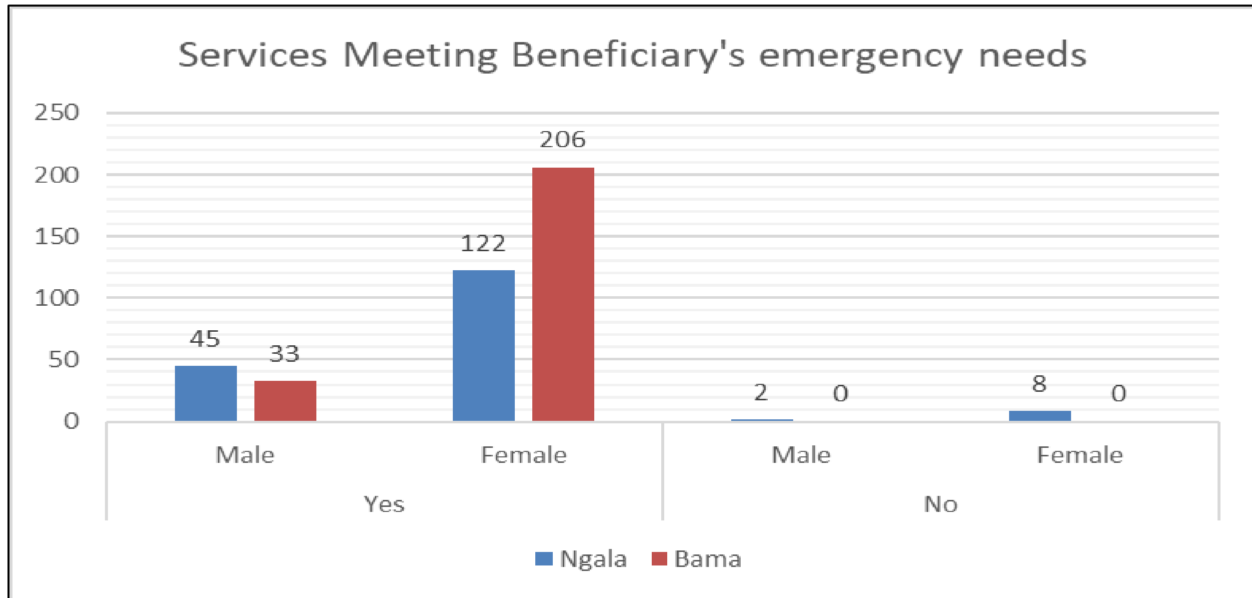
Figure 11. Meeting beneficiary emergency needs



5.4. Accountability

5.4.1 Beneficiaries awareness

The evaluation survey showed that beneficiaries in both intervention LGAs were aware of GBV issues and referral pathways facilitated by the project. There was an increase in the awareness of beneficiaries from the mid-term evaluation; as more respondents were more likely to make a report on GBV related incidences (i.e. sexual violence, sexual exploitation, domestic violence, sexual harassment, and forced marriages).

Based on analyzed evaluation data, of the total number of beneficiaries interviewed, the following project activities were most effective in increasing beneficiary GBV knowledge e.g. Use of GBV champions - 87.5% (Ngala 32.9% and Bama 54.6%), Sensitization activities – 91.5% (55.5% in Bama and 36% in Ngala) and provision of livelihood assistance – 66.8% (43.5% in Bama and 23.3% in Ngala).

At the final evaluation, awareness amongst beneficiaries was greater in Bama than Ngala; as project-driven sensitization activities emerged as the predominant means by which beneficiaries were informed of GBV issues and accompanying referral pathways by the project. In spite of CARE Nigeria not having an on the ground presence in Ngala at the time of the final evaluation study (i.e. due to the lack of fundng for GBV interventions since August 2020); interviewed beneficiaries remained knowledgeable of GBV issues and referral pathways.

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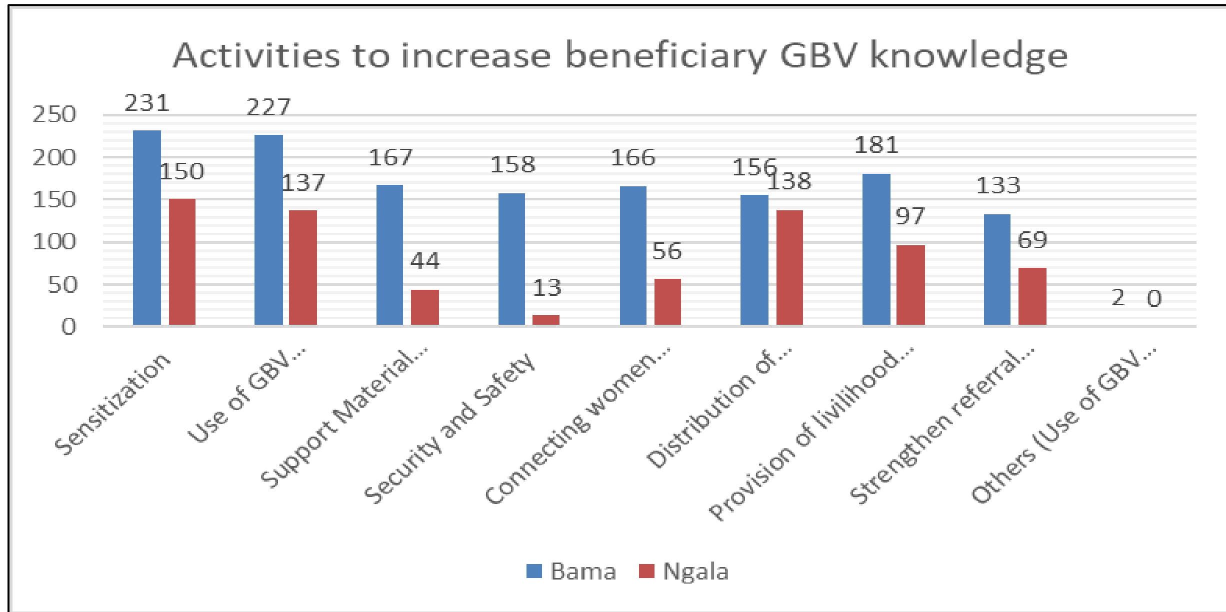
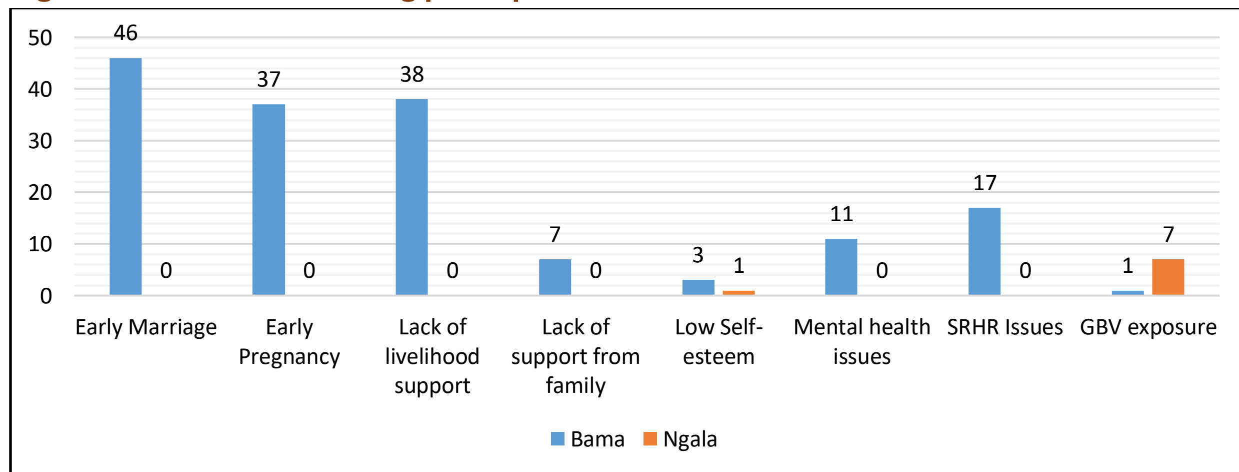
Figure 12. Beneficiary Awareness of GBV issues and referral pathways



5.4.2 Factors affecting Women/Girls participation in GBV related activities

To examine the accessibility of GBV related services among respondents, the evaluation data also examined the existing factors that affected the participation of women/girls in GBV related activities in both intervention LGAs. The quantitative data revealed that female respondents in Bama were more likely to not participate in GBV related actiivties than women/girls in Ngala. This was due to a number of notable issues, but the prevalence of early marriage was the most prevalent reason given by female repsondents in Bama (46 responses).

Figure 13. Fators affecting participation of Women/Girls in GBV related activities



This was closely followed by the lack of livelihood support (38 responses) and early pregenancy (37 repsonses). Mental health and SRHR issues also were mentioned as likely reasons among female respondents in Bama. On the other hand, female respondents in Ngala reported low self-esteem and exposure to GBV as core reasons for not participating in GBV related activities.

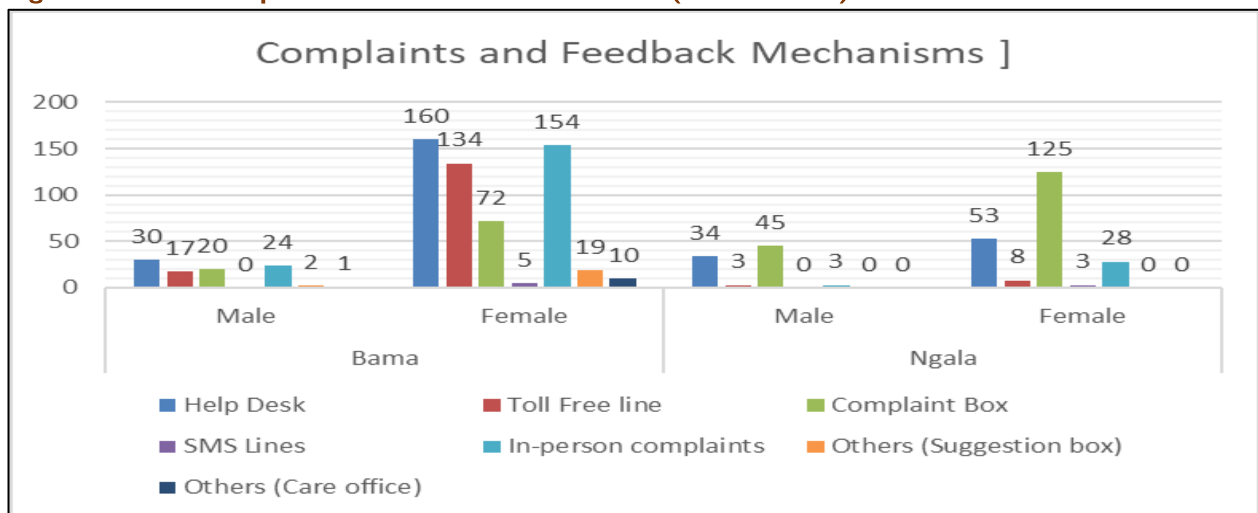
5.4.3 Ease of reporting GBV related issues

When considering the ease of reporting GBV services and accessing related services among beneficiaires, the evaluation findings showed that there was a preference for face-to-face engagement (85.2% of beneficiaries in Bama and 14.8% of beneficiaries in Ngala) and use of Help desk services (68.6% of beneficiaries in Bama and 31.4% of beneficiairies in Ngala). Among survey respondents, the analyzed data showed that majority of beneficiaries could freely make GBV related reports through designated feedback channels. For example, the quantitative assessment data showed that 58% of beneficiaries in Bama had no reservations making reports of GBV related issues compared to 42% of respondents in Ngala LGA. Among the most frequently adopted service options (help desk services and in person consultations), male beneficiaries in Bama frequently used these two service options (15.8% for help desk services and 13.5% for in-perosn consultations). However, in Ngala more men used the help desk services (39.1%) than in-person consultations (9.7%).

5.4.4 Complaint and feedback mechanism

Project monitoring data was used to inform evidence-based decision-making monitoring data through GBVIMS (case management database) was used to inform decision making in aspect of intervention scale. The project, through its accountability systems strengthened referral systems through meetings and feedback session held in the target communities.

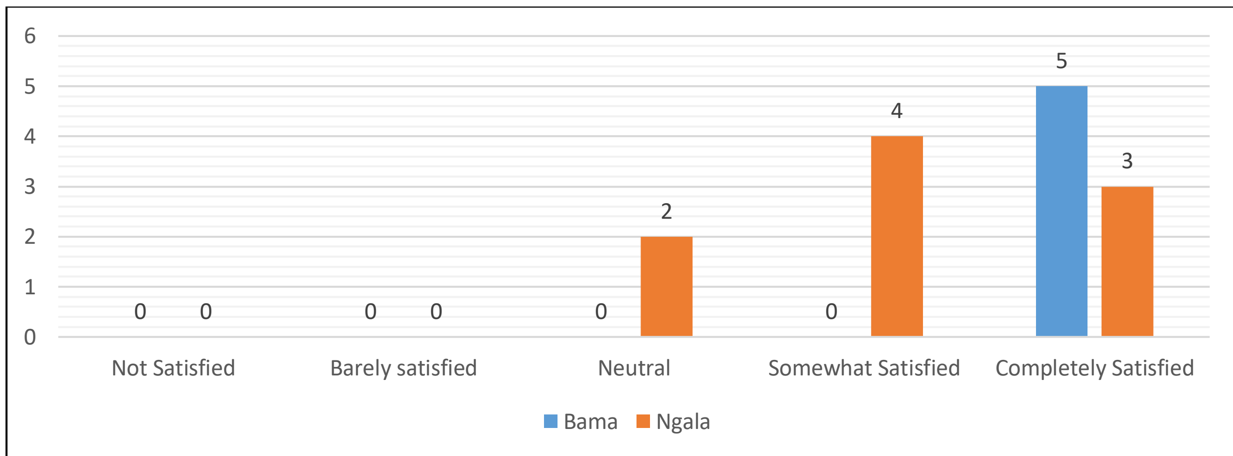
Figure 14. Compliant and feedback mechanisms (Beneficiaries)



Furthermore, among survey respondents, the analyzed data showed that majority of beneficiaries could freely make GBV related reports through designated feedback channels. For example, the quantitative

assessment data showed that 58% of beneficiaries in Bama had no reservations making reports of GBV related issues compared to 42% of respondents in Ngala LGA. The use of toll-free lines to make reports was also recorded as a frequently used feedback mechanism among beneficiaries mainly in Bama LGA.

Figure 15. Stakeholder satisfaction with complaints and feedback mechanisms



As beneficiaries in Ngala LGA made use of mainly physical feedback systems (e.g. complaint boxes, help desk and in-person complaints), this is because telecommunication network coverage is virtually non-existent and erratic at best. Most beneficiaries employ the use of cross-border network providers from Cameroon. Feedback from project stakeholders showed a clear satisfaction rating for established complaints and feedback mechanism utilized by beneficiaries in both intervention areas. All stakeholders in Bama LGA were completely satisfied with the existing complaints and feedback mechanism put in place by the project.

5.5 Impact and Sustainability

5.5.1. Project Linkages

Women need to be supported to be independent with improved livelihood options e.g. the project linked women in solidarity groups to Village Savings and Loan Associations (VSLA) to increase women empowerment. Weekly VSLA meetings with women and post distribution monitoring, further strengthened project linkages among project beneficiaries.

5.5.2. Sustainability of the project achievements

The project recorded a number of major milestones through the course of implementation in both target interventions LGAs i.e.

- The project successfully consolidated solidarity groups and reduction of negative coping mechanism e.g. transactional sex, provision of GBV awareness and referral systems. As the end

line evaluation findings showed that 71% (36% F, and 35%M)[1] of the target population reported an improved feeling of safety and dignity.

- Conducting regular capacity building sessions to support door to door awareness sensitization on GBV issues in the community. This in turn created awareness and fostered dialogue on GBV across target communities.
- Additional training support should be provided to beneficiaries and community actors e.g. protection mainstreaming and GBV in emergency; GBV minimum standards and IASC guidelines; and psychosocial support training.

5.5.3. Proposals for strengthening project achievements

Based on feedback from beneficiaries, the following proposals should be considered for strengthening the GBV project achievements i.e.

5.5.3.1. *Child friendly space:*

Building on the establishment of the Women and Girls Friendly Safe Spaces (WGFSS), the project should explore the creation of child friendly spaces. The follow on ECHO project should establish and strengthen a network of high-quality, child friendly FP/RH providers around strategic areas to offer referral services to the young persons. These could include primary healthcare nurses, Propriety Patent Medicine Vendors (PPMVs) community pharmacists, depot holders, and community health extension workers.

Project Beneficiaries in Bama, Borno

Courtesy: Halima Abba

5.5.3.2. *Basic Contraceptive Technology (BCT) training*

BCT training should be conducted for the pre-qualified SRHR service providers using state certified master trainers. In order to bond with the child friendly spaces, the providers should be purposively encouraged to participate in demand generation activities such as outreaches and infusion of SRHR into the skills and livelihood curriculum to encourage entrepreneurship for those young persons cared for within the spaces. For example, when reviewing the factors that affected the participation of women/girls in GBV related

[1] Figure shown has been approximated to a whole number, the actual figure is 70.8% (35.5% F and 35.3% M)

activities especially in Bama LGA, early pregnancy and marriages were prominent among collated responses.

5.5.3.3. Health/medical care for GBV survivors

Survivors, especially female survivors, living with and/or having experienced violence may need medical treatment for injuries and mental health services as well as sexual reproductive health services, such as sexually transmitted infections (STI) and HIV testing, prenatal care, contraceptive counseling and provision of methods and other relevant treatment for other common health consequences of GBV. For survivors of sexual violence the essential components of medical care - as defined by international protocols - are: documentation and treatment of injuries, collection of forensic evidence, evaluation for STI and HIV/AIDS and preventive care, evaluation for risk of pregnancy, prevention of pregnancy, psychosocial support, counseling and follow-up. Follow-on GBV support interventions may consider extending the provision of immediate health medical care for GBV survivors i.e. as part of the comprehensive GBViE services.

Field Enumeration Team in Bama, Borno

Courtesy: Ibrahim Musa

5.5.3.4. Continued Sensitization on GBV issues

Sensitization on GBV issues requires informed Consent for GBV Survivors. This involves the approval or assent, particularly and especially after thoughtful consideration. Informed consent is voluntarily and freely given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action; and according to the circumstances can be verbal or written. For example, based on analyzed evaluation data, of the total number of beneficiaries interviewed, the following project activities were most effective in increasing beneficiary GBV knowledge e.g. Use of GBV champions - 87.5% (Ngala 32.9% and Bama 54.6%), Sensitization activities – 91.5% (55.5% in Bama and 36% in Ngala) and provision of livelihood assistance – 66.8% (43.5% in Bama and 23.3% in Ngala).

Therefore, the continued provision of these services should be done through culturally-sensitive, multisectoral care, including health and medical care, mental health and psychosocial support, security/police services, legal assistance, case management, education and vocational training opportunities, and other relevant services. The sensitization on GBV issues requires a referral Pathway

which is a flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance and legal/justice support.

5.5.4. Involvement and coordination of actors

The project promoted active coordination among humanitarian actors by ensuring that GBV related services were user friendly. This was achieved through the implementation of the following community based activities i.e. involving and training community members; use of local language to disseminate information during sensitization events to increase awareness of GBV related issues; successfully employed the GATHER model to implement activities in the establishment of Women and Girls Friendly Safe Spaces (WGFSS). This approach was particularly effective in linking GBV survivors to necessary services; and provided alternative compliant and feedback mechanisms for beneficiaries and stakeholders.

SECTION 6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The baseline assessment study showed that women in Ngala and Bama generally were not granted a seat in decision making except for some specific issues for which women leaders with limited or non-active participation in community sensitization. The conflict has contributed to a vicious cycle of GBV as women, men, girls and boys in dire situations resorted to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. At the mid-term assessment period, evaluation findings revealed that progress was made in the provision of GBV related services, increased awareness and access to referral pathways; as survivors of sexual violence more openly discussed incidents in their communities. Project beneficiaries also readily accessed project services and provided feedback via established protocols. they now have information at their doorsteps about GBV and where to access services from.

With improved awareness and sensitization on GBV information among beneficiaries and stakeholders alike, it is clear that the project successfully met the needs of the intervention communities in Ngala and Bama despite complex security challenges withing a humanitarian crisis situation. Based on feedback from beneficiaries, the following project activities should be considered for strengthening the GBV project achievements i.e. setting up child friendly spaces, distribution of dignity kits, continue sensitization on GBV issues as well as livelihood support for women groups and promote continuous inter-agency coordination efforts.

6.2. Recommendations for future implementation

The following recommendations are proposed for future implementation i.e.

- Any follow-on design iterations of the project should further consolidate the promotion of active humanitarian actor coordination to sustain effective referral pathways for target beneficiaries especially in under-accessed locations and vulnerable populations in Ngala. For example, in Ngala 88% of stakeholders and14.1 % of beneficiaries felt services provided by the project were not adequate. Compared to Bama LGA where 99.6% of beneficiaries and 100% of stakeholders acknowledged the adequacy of services provided by the project.
- Strengthen existing options for beneficiary feedback and compliant mechanisms to encourage more women and girls to continue active use of these options. Hence there is a need to ensure strict confidentiality for all engagements. This is especially important to avoid any obvious appearance that may expose the nature of such complaints by target beneficiaries.
- The use of complaint and feedback mechanism is extremely low among men and boys in both intervention communities. Therefore, future design iterations should prioritize the development of inclusive and more culturally appropriate complaint and feedback mechanisms for men and boys in target intervention communities. Men and boys must also feel safe to make reports of GBV cases; without the fear of stigmatization or harsh rehearsals from security operatives.
- To promote knowledge retention and active participation of project beneficiaries, the project should continue the engagement of GBV champions and vigilantes to provide follow-up support to build on completed training session. Therefore, promoting knowledge retention among

beneficiaries may be supported through community socialization events, spot checks, provision of livelihood assistance and monitoring referral support services. Specifically, the project needs to organize a refresher training for target beneficiaries in Ngala to increase entrepreneurship and community ownership to take responsibility for their wellbeing.

- To strengthen the M&E system, the development of a project centred learning agenda should be prioritized to enable the utilization of documented evidence and project data for reflective learning. This may also extend to the development of an Evidence and Learning Catalog to provide a knowledge repository to promote action learning and effective knowledge management.

ANNEXES

ANNEX 1. EVALUATION STAFFING AND MANAGEMENT

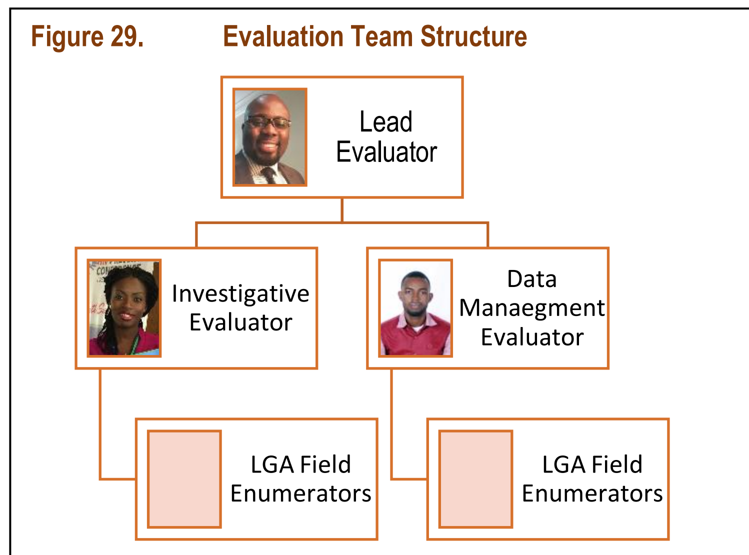
Annex 1.1. Staffing Plan

Annex 1.1.1. One-Team Partnership Approach.

The Lead Evaluator (LE) was supported by suitably qualified evaluators at different stages of the final evaluation study. The technical team consisted of an Investigative Evaluator (IE) and a Data Management Evaluator (DME) to provide field based supervisory functions during data collection across all sampled respondents. Throughout the evaluation process, the team was tasked to deliver on specific tasks and deliverables. This ensured comprehensive professional review and technical oversight across board.

Field deployment for data collection was handled by the IE and DME for assigned target Local Government Areas (LGAs), and the LE provided routine technical coordination and second-tier data management support. The LE also directed coordination and management support across board.

Figure 29. Evaluation Team Structure



The external evaluation team worked together, coordinating across responsibilities and functions, through weekly conference calls. The LE also provided feedback to CARE NG i.e. brief on evaluation progress status; and had a debrief meeting with CARE NG upon completion of field data collection by a team of ten (10) enumerators.

To ease communication, the LE set up a WhatsApp group to facilitate timely feedback among team members and discuss any potential challenge encountered. The evaluation team also collaborated closely with the logistics, procurement and security personnel from CARE NG to ensure a seamless execution of all planned external evaluation tasks.

Annex 1.2. Key Personnel

The consultancy engagement was led by the Lead Evaluator (LE) working with a team of technical of technical evaluators.

Annex 1.2.1. Lead Evaluator (LE) – Augustus Emenogu

As a Monitoring and Evaluation, Research, Learning, and Adaptation (MERLA) Expert, Augustus has established effective results-based M&E systems and developing consolidated databases for field surveys and research studies on multiple donor-funded projects in Nigeria, Sri Lanka, Thailand, Myanmar, and the United Kingdom e.g. World Bank, USAID, OFDA, FFP, OTI, EU, DFID, ECHO, OCHA, Government of Nigeria, Commonwealth Secretariat, UNDP, UNMC, UNICEF, AWDF, Global Fund, Qatar Foundation, and the Ford Foundation. Specifically, Augustus has led multiple evaluation studies on different donor funded initiatives i.e.

- **Head of Evidence and Learning (MST)** - As the Head of Evidence and Learning with Save the Children (SCI) Myanmar, I ensured consistency and quality in research as well as the use of evidence in MST Cluster (Myanmar, Sri Lanka, and Thailand); by providing oversight of MEAL in the MST Cluster. The Head of REALM role Institutionalizes evidence uptake and learning practices to inform adaptive management processes to lead the development of systems, processes, and country capability for quality research and MEAL for MST Cluster.
- **Monitoring and Evaluation (M&E) Support Evaluator** - worked in a 2-member evaluation team to evaluate the 4-year USAID OFDA Information Management Support for Humanitarian Assistance Program in Nigeria. iMMAP has been providing information management (IM) support, since 2016, to nine (9) humanitarian sectors responding to the crisis in north east Nigeria, with a grant from the United States Agency for International Development, Humanitarian Bureau of Assistance (USAID/BHA).
- **Principal Evaluator**- Served as the Principal Evaluator with CBM International supervising and managing the end line research study to explore perceptions of persons with disability towards the inclusiveness of health services in Nigeria (FCT and Nassarawa) for the Seeing is Believing (SiB) Program (USD2M). Had the primary responsibility for ensuring the quality and timely delivery of all evaluation task(s) and providing final approval of all field visit plans, draft deliverables, and all reports prior to their submission.
- **Deputy Chief of Party (DCOP)** - Held a leadership role within a fast-paced environment with a focus on increasing productivity and efficiency levels. Tasked with leading technical functions related to a third-party monitoring system on the USAID OFDA/FFP Nigeria Monitoring Project (USD15M); which was used to monitor trends related to programs in Nigeria implemented by Management Systems International (MSI).
- **Monitoring, Evaluation and Learning (MEL) Advisor** – Led the conduct of Political Economy Analysis of Six Urban WASH Utilities) with RTI international on USAID E-WASH (USD60M).
- **Social Scientist Evaluator** – Handled two (2) evaluation research components (i.e. government investments and sustainability) for USAID Feed the Future (FTF) Final Performance Evaluation (across 5 intervention states) while engaged by Devtech Systems Inc. (USD15M).
- **Deputy Monitoring and Evaluation (M&E) Manager** – Led the conduct of cluster evaluations, case study assessments and got approval for 112 final evaluations (across 4 intervention states) for USAID/OTI North East Regional Initiative (NERI) program (USD 75M) implemented by Creative Associates International.

- **Monitoring and Evaluation (M&E) Advisor** – Led the design, operationalization and conduct of a Randomized Control Trail (RCT) across 7 research pilot states for USAID Reading and Access Research Activity (RARA) implemented by Mott MacDonald (USD11M).
- **Programs and M&E Coordinator** – Led the design and conduct of Baseline Survey of Out-of-School Children (OOSC) across 23 intervention states as sponsored by the Qatar Foundation and implemented by Oando Foundation.

Education Background

- PG Cert. Disaster Management and Humanitarian Aid, Deakin University, Australia
- M.Sc. Environmental Management, Geographic Information System (GIS) and Climate Change, Coventry University, The United Kingdom
- B.Sc. Urban and Regional Planning, University of Technology, Minna, Nigeria.

Annex 1.2.2. Investigative Evaluator (IE) – Joy Tebu

As a Monitoring Evaluation and Learning (MEL) Expert, Joy has developed key performance indicators and familiar with specific procedures and established effective results based M&E systems and developing consolidated databases for field surveys and research studies on multiple donor funded projects like Bill and Melinda Gates, DFID, PSI, Global Fund, USAID and World Bank. She has successfully managed projects in various states and communities with culture and ethnical diversity of Nigeria. Joy is also a certified database manager who has successfully developed/coordinated the customization of forms on the health information system used in preparation of annual, quarterly and monthly work plans and budgets for program implementation. For example, Joy has developed various unconventional approaches in monitoring and evaluating processes that recognizes the expertise, capacity, and intelligence powering the grassroots response to family planning, Maternal and child Health, HIV/AIDS and TB in Nigeria.

Joy has developed various unconventional approaches in monitoring and evaluating processes that recognizes the expertise, capacity, and intelligence powering the grassroots response to family planning, Maternal and child Health, HIV/AIDS and TB in Nigeria. For example, in her current role, Joy supports the conduct of all DAI MEL activities on the USAID/DAI UAH project in Lagos and Kano State, Nigeria. The program works to improve the health and well-being of urban, low-income adolescents, ages 15 to 19, by increasing voluntary family planning uptake, situating family planning within a broader, more holistic context that encompasses by enhancing youth life skills for healthy living and future planning.

Joy Led the development of project Monitoring and Evaluation tracker for implementing training/workshops and/or designing training modules e.g. Led the start-up development indicators and performance indicator Reference Sheets (PIRS) of the AMEL plans within 90 days of project award and all data collection tools including Management Information System (MIS) on the project specific data base TAMIS.

Education Background

- PhD. Public Health (in-view), Walden University, USA.
- M.PH Public Health, University of Roehampton, London.
- M.Sc. Development Studies, Bayero University, Kano, Nigeria
- PG. Diploma. Education, Federal College of Education

- PG. Diploma in Development Studies, Bayero University, Kano, Nigeria
- B.Sc. Biochemistry, University of Jos, Plateau, Nigeria.

Annex 1.2.3. Data Management Evaluator (DME) – Maxwell Onuoha

Maxwell is a Monitoring and Evaluation specialist with 8 years' hands-on experience of leading and delivering excellent public health programs and intervention across malaria, tuberculosis, HIV and emergency response in Nigeria. Maxwell is skilled at project management, skilled in research, capacity building, data analysis, and visualization, strategic planning, monitoring and evaluation, leading and coordinating teams, multitasking and seeing the big picture. As a skilled Data Management Evaluator (DME), Maxwell has successfully led data management functions on multiple donor funded initiatives working across different thematic sectors e.g. WASH, Health, Nutrition, Food Assistance and Protection, HIV/AIDS, Tuberculosis, Malaria, Public Health etc. across Nigeria. Furthermore, Maxwell also develops project indictor performance tracking templates, data collection matrix, data analysis maps and research protocols to enable GPS-tracking for intervention activities.

Education Background

MSc. Medical Biochemistry University of Nigeria, Nsukka, Enugu, Nigeria
BSc. Applied Biochemistry Nnamdi Azikwe University, Anambra, Nigeria

Annex 1.3. Team Structure

Annex 1.3.1. Lead Evaluator (LE) role and responsibilities.

The LE served as the evaluation manager/team leader leading and managing all formative technical review of CARE NG task order deliverable and was the primary liaison with CARE NG staff. He also had primary responsibility for ensuring the quality and timely delivery of all evaluation task(s) and coordinated the delivery of technical deliverables among the technical team. With guidance from CARE NG, the LE finalized all evaluation tasks including field visit plans, data risk analysis protocols and led the technical development of final evaluation study report for onward submission.

Annex 1.3.2. Investigative Evaluator (IE) role and responsibilities.

The Investigative Evaluator (IE) conducted technical review of CARE NG documents as well as supported data collection via interviews with identified respondent/stakeholder groups. The IE provided primary data quality assurance guidance during field data collection with remote support from the LE.

Annex 1.3.3. Data Management Evaluator (DME) role and responsibilities

The DME assisted in analyzing quantitative/qualitative data from CARE Nigeria field data collection activities. This extended to the development of different statistical data analysis options for preparing reports by the LE, with a focus on incorporating effective data visualizations in those reports and ensuring a clear/concise narrative. The DME provided a systems-level review of data quality; along with Management Information System (MIS) support to the evalua

ANNEX 2. EVALUATION MATRIX

Theme One: Relevance

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
How has the project design (outcomes, outputs and activities) been relevant to addressing underlying causes of the identified problems?	To what extent did the project design address identified problems?	What activities were implemented to strengthen GBV awareness in target communities?	CARE NG Staff/ Beneficiaries/Stakeholders
		What was the resultant change in social norms (stigmatization) as a result of the project activities?	CARE NG Staff
		How did the project encourage existing positive coping mechanisms?	CARE NG Staff/ Beneficiaries/Stakeholders
		What was done to reinforce the knowledge of target beneficiaries on the accessible and available GBV services in target communities?	CARE NG Staff/ Beneficiaries/Stakeholders
		How did the project encourage coordination between the actors	CARE NG Staff Beneficiaries/Stakeholders

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		How the project ensure active vigilance on the safety, accessibility and participatory approach while delivering the activities expected in the project	CARE NG Staff/ Beneficiaries/ Stakeholders
What alternative strategies would have been more effective in achieving its objectives?	How successful were the strategies implemented in achieving project objectives	In your opinion, did the strategies implemented contribute to achieving project objectives?	CARE NG Staff
		What factors contributed to the performance of the strategies implemented?	CARE NG Staff
		Do you think any of the implementation strategies were successful?	CARE NG Staff Beneficiaries/ Stakeholders
		What other strategies do you think that would have been more effective to achieve project objectives	CARE NG Staff/Beneficiaries/Stakeholders

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
Theme 2: Efficiency			
Evaluation Questions	**Sub-Evaluation Questions**	**Probing Questions**	**Respondent Category**
How has the project been efficient in allocating and managing resources (funds, human resources, time, expertise etc.) to achieve outcomes? Were the management capacities adequate- i.e. management of personnel, project properties, communication, relation management with elders, community leaders, other development partners, etc.?	To what extent did achieved outcomes justify project allocations and resource management?	Where the right resources available for project implementation?	CARE NG Staff
		Was the budgetary allocations in line with the project design?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		Where the capacities of the management adequate manage personnel, project properties, communications and stakeholders?	CARE NG Staff
		Is any pending financial commitment from CARE on this project?	CARE NG Staff
		How were the management accountable for the project resources available to them?	CARE NG Staff
		What were the mechanisms put in place to ensure accountability	CARE NG Staff
Do the results achieved justify the costs (human resources, time, energy, money, materials)? If not, why not? Have project funds and activities been delivered in a timely manner? If not, why not?	To what extent did the achieved results justify project costs?	Were project activities implemented according to planned timelines?	CARE NG Staff
		What adjustments were made (Course corrections or adaptive management measures)?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		Was all the allocated cost in line with the budgetary provisions in the project design?	CARE NG Staff
		Did the project have adequate human resource and monetary provision to achieve desired results?	CARE NG Staff
Was there a clear understanding of roles and responsibilities by all parties involved?	How all stakeholders involved in this project achieve a clear understanding of roles and responsibilities?	As stakeholder in this project, do you have an understanding of your roles and responsibilities?	Beneficiaries/Stakeholders
		Have you discussed with each stakeholders what their roles and responsibilities are on this project?	CARE NG Staff
		Are there factors that creates little or no understanding of your roles and responsibilities as stakeholders?	Beneficiaries/Stakeholders

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
Has the project received adequate technical and administrative support from ECHO, CARE France, and CARE Nigeria?	To what extent has the project received technical and administrative support	From whom do you get your technical support?	CARE NG Staff
		Who provided you with administrative support while you implement this project?	CARE NG Staff
How far and in what ways the project was able to strengthen local non implementing partners, communities, government, youth groups (and other relevant groups) and provide suggestions to further improve their capacities.	To what extent has this project worked with local non-implementing partners, communities, government, youth groups	Does this project work with local non-implementing partners, communities, government, and youth groups?	CARE NG Staff
		What efforts have you put to strengthen the capacities of these groups?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		As a local non-implementing partner, community representative, government representative, and a member of the youth group, are you aware of the activities of this project?	Beneficiaries//Stakeholders
		Has this project contributed in strengthening your capacity?	Beneficiaries/Stakeholders
	To what extent did this project provide capacity building for non-implementing partners, communities, government, youth groups?	Do you have capacity building program targeted at the stakeholders affected by your project?	CARE NG Staff, Beneficiaries/Stakeholders
Review and assess the quality of the project monitoring and evaluation system, specifically: Assess the appropriateness of the indicators and also assess the	How effective was the monitoring and evaluation system in facilitating performance based indicators	Was there an established project M&E System? What were the core components?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
robustness of the monitoring protocol and approaches in quantitative and qualitative data collection and compilation by project staff based on the log frame indicators.	for (qualitative and quantitative) data collection.		
		How was project monitoring data used to inform evidence based decision making for adaptive management?	CARE NG
		What data quality assessment protocols was developed for the project?	CARE NG
		What accountability feedback mechanisms were utilized by the project?	CARE NG Staff/Beneficiaries
Theme Three: Effectiveness			
Evaluation Questions	**Sub-Evaluation Questions**	**Probing Questions**	**Respondent Category**
How the project was perceived by relevant stakeholders (Local leaders and community members) in light of achieving its planned objectives?	What is your perception about	As a community leader, what is your perception of this project's activities?	Beneficiaries/Stakeholders

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		Are you well informed about the work that this project does?	Beneficiaries/Stakeholders
		Have you or anyone you know benefitted from this project's activities?	Beneficiaries/Stakeholders
		Did you experience any challenges accessing this project's activitie	Beneficiaries/Stakeholders
		What is your perception about this project activities as a beneficiary?	Beneficiaries/Stakeholders
How has the project been effective in achieving its planned activities and outcomes? If not, why?	To what extent has the project implemented its planned activities?	Have you implemented all the planned activities in this project? if not, why?	CARE NG
		What project activities or approaches were most effective in securing positive outcomes and why?	CARE NG
Which were the strengths in the project implementation and what are the constraints and challenges	What key lessons can be leveraged from the project during implementation?	Please elaborate on identified strengths and encountered challenges from the project's implementation?	CARE NG

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
faced? How has the project mitigated these challenges?			
	To what extent was implementation of project activities affected by constraints and challenges?	What challenges and constraints were encountered during project implementation?	CARE NG
		Did these challenges or constraints hinder the implementation of planned activities? If yes, Why?	CARE NG
		How were encountered challenges mitigated by the project?	CARE NG
		How did the project document and incorporate beneficiary feedback to address service access challenges?	CARE NG
		What did you do to mitigate such challenges faced by beneficiaries?	CARE NG

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
How was gender and protection mainstreamed into project activities and what was the impact of the project on gender equity and related issues?	To what extent has gender and protection being mainstreamed into project activities?	Did your project integrate gender and protection issues in its activities?	CARE NG
		Are these services available to beneficiaries in an easily accessible manner?	CARE NG
		What mechanisms did you put in place to make these services user friendly?	CARE NG
		Did you receive gender-based and protection-based services from this activity?	CARE NG
		Did you experience any challenges while accessing these services?	CARE NG

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
How have the approaches/modalities followed by the project been effective in ensuring inclusion of vulnerable and marginalized communities?	Did the project implementation influence gender equity and social inclusion of vulnerable and marginalized communities?	If you experienced any gender-based issues, will you come to this project to access service?	Beneficiaries/Stakeholder
		What will the project do differently to make you access their services more?	Beneficiaries/Stakeholder
		As a community leader, are you aware of the gender and protection services provided for by this activity?	Beneficiary/Stakeholder
Have the approaches/modalities followed by the project been effective in engaging with the communities affected by the crisis? How and why?	To what extent did the project increase institutional engagement with communities affected by crisis?	How did the project engage communities affected by the crisis?	CARE NG Staff
		How effective were adopted approaches and modalities in engaging communities affected by the crisis? What this effective? If so, how was this achieved? If not, why?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		How can the project better engage communities affected by the crisis?	CARE NG Staff/Stakeholders
		How were these communities selected?	CARE NG Staff
		Do you have any recommendations to improve the selection or targeting criteria for target populations and communities?	CARE NG Staff
Theme Four: Impact and Sustainability			
Evaluation Questions	**Sub-Evaluation Questions**	**Probing Questions**	**Respondent Category**
What are the planned and unintended effects, direct and indirect, positive and negative, of the project on the living conditions of the populations in the targeted area?	How were the living conditions of target population influenced by the project?	What expected outcomes were attained by the project?	CARE NG Staff
		Were these planned outcomes direct or indirect? List	CARE NG Staff
		What unintended outcomes on the living conditions of the target populations emerged as a result of implemented project activities? List	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		Were these unplanned outcomes negative or positive? Please give reason for answer.	CARE NG Staff
What were the linkages between activities such as linkages between the women solidarity groups and livelihood assistance that allow to maximize the effect of the project?	How did the project maximize linkages among women solidarity groups to facilitate livelihood assistance support?	How were women solidarity groups engaged and supported by the project?	CARE NG Staff
		Was the project able to establish and maximize linkages of women solidarity groups for livelihood assistance? If so, how was this achieved? If not, why?	CARE NG Staff
Evaluate the sustainability of the project achievements such as GBV committees, sensitization tools, level of capacity building of the staff, partners community leaders and other actors, reduction of GBV incidence, appropriation of the project by the beneficiaries;	To what extent are any results likely to be sustained after the project ends?	What might affect the participation of girls and women especially those heads of households in a future project?	CARE NG Staff/beneficiaries/Stakeholders

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Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
To what extent do the positive changes resulting from the project continue after the end of the action?		What supports are needed to sustain existing women solidarity groups?	CARE NG Staff/ beneficiaries/Stakeholders
		What are the existing priority GBV capacity building needs of staff?	CARE NG Staff
In particular, through the replication of training activities and continuity of the GBV committees.		How can the project replicate or scale up training activities and promote continuity of GBV committees?	CARE NG Staff/ Beneficiaries/Stakeholders
Make proposals for strengthening the achievements of the project. Coordination	What revisions should be adopted to amplify project achievements?	What design options should be considered for future project iterations?	CARE NG Staff
Is the level of involvement and coordination of actions with other actors including local authorities, NGOs, Technical Services present in the area adequate?	How adequate was the level of involvement and coordination among key actors during project implementation?	Were key actors (NGOs, local authorities) actively involved in project coordination effects? If so, how? If not, why?	CARE NG Staff/Stakeholders/Beneficiaries

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Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
		Were technical services adequate in target intervention areas? If so, how? If not, why?	CARE NG Staff, Beneficiaries, Stakeholders
Is the level of collaboration through the sharing of information (technical, financial, logistics) and good practices adequate?		What best practices were employed by the project to facilitate information sharing and promote adequate collaboration (technical, financial and logistics)	CARE NG Staff
What is positive and negative impact of inter-agency coordination efforts? To what extent does the project contribute to improved collective response on the GBV and SEA vulnerabilities in targeted locations?	How did the project contribute to improved GBV and SEA response?	What positive or negative effects on inter-agency coordination efforts can be attributed to the project?	CARE NG Staff
		What project activities supported improved response to GBV and SEA vulnerabilities	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
Theme Five: Accountability			
Evaluation Questions	**Sub-Evaluation Questions**	**Probing Questions**	**Respondent Category**
Are the beneficiaries informed about the activities of the project?	How were beneficiaries informed of project activities?	List communication channels employed to inform beneficiaries of project activities	CARE NG Staff
The situation / participation of girls and women, especially those heads of household?	To what extent were girls and women, especially female headed households engaged by the project?	How were girls and women especially those heads of household targeted by the project?	CARE NG Staff
		What informed the targeting criteria for girls, women and female headed households?	CARE NG Staff
Are the existing monitoring and accountability mechanisms used and adapted to the context? If not, how can they be improved?	To what extent did the project adapt existing monitoring and accountability mechanisms?	Did this project establish and adapt monitoring and accountability mechanisms to the context? If so, how was this done?	CARE NG Staff
		What alternative monitoring and accountability mechanisms can be utilized by the project for future interventions?	CARE NG Staff

Evaluation Questions	Sub-Evaluation Questions	Proposed Probing Questions	Respondent Category
Do the beneficiaries know the complaint and feedback mechanism? What are its limits? Do they use them? What feedback do they have on this mechanism?	To what extent did the use of complaint and feedback mechanism increase among beneficiaries?	Are you are aware of the complaints and feedback mechanism provided by this project?	Beneficiaries/Stakeholders
		Have you utilized any of the complaints and feedback mechanism provided by this project?	Beneficiaries/Stakeholders
		Were reported concerns addressed by the project?	Beneficiaries/Stakeholders
		Are you are aware of the complaints and feedback mechanism provided for you by this project?	Beneficiaries/Stakeholders
		Are you satisfied with the available feedback mechanisms adopted by the project?	Beneficiaries/Stakeholders

ANNEX 3. EVALUATION QUESTIONNAIRES

3.1. Program Staff Questionnaires (PSQ)

Program Staff Questionnaires (PSQ)			
Questionnaire Code: (PSQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location:			
Consent			

Interview Prompt

[At the start of the interview, please say the following]

“It is a pleasure to meet you. My name is [Insert Name]. I/We are here to collect your views on the implementation of the Integrated Gender Based Violence (GBV) Prevention and Response to the Emergency Needs of Newly Displaced Populations in Borno State. We work as part of an independent evaluation team engaged by CARE International Nigeria that is working to obtain information on behalf of the Project’s sponsors.

The purpose of this interview is to gather information on the services offered at this location and to better understand GBV prevention and response needs. The interview is estimated to last 45 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get.

We will not ask personal questions, only about the services you receive from the CARE International Nigeria. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future.

Are you willing to participate in the interview? Yes or No

No Harm Principle

Evaluators will adhere to these three Protection Principles:

1. Evaluators will not further expose people to physical hazards, violence or other rights abuses.
2. Evaluators will not undermine any beneficiary’s capacity for self-protection.
3. Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.

The Program Staff Questionnaire (PSQ) is divided into five (5) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on GBV response emergency needs of displaced populations in Borno State.

- Section 1: Demographic and Background Information
- Section 2: Relevance
- Section 3: Efficiency
- Section 4: Effectiveness
- Section 5: Impact and Sustainability
- Section 6: Accountability

Photos shall ONLY be taken when instructed. Please note that children should not be photographed, nor can they provide informed consent.

Section 1	**Demographic and Background Information**	
SN	Questions	Response Options
1	Age (record age at last birthday)	Insert response
2	Gender	Choose relevant option 1 = Male 2 = Female
3	Respondent Category	Choose relevant option 1 = Program Management 2 = M&E 3 = GBV and Social Protection 4 = Others
Section 2	**Relevance**	
SN	Questions	Response Options
	What activities were implemented to strengthen GBV awareness in target communities?	Select all that apply • Protection Risk Assessment Baseline • Link to existing referral systems with defined confidential referral pathway.

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SN	Questions	Response Options
4		• Case Management Training for CARE staff • Case management services to GBV survivors and their families • Establish and operate safe spaces • Psycho-social to GBV survivors and their families • Survivors with in-kind materials support • Set-up and train community GBV vigilant committees • Mobilize and train GBV champions • Community awareness raising on GBV • Support women solidarity groups • Monitor GBV incidents and report to relevant groups
5	Was there a change in social norms (stigmatization) as a result of the project activities?	Choose option 1 = Yes 2 = No 3 = Do not know or Not Sure
6	If 5 = Yes, how was this achieved	Insert response
7	If 5 = No, why?	Insert response
8	What did this project do to increase the knowledge of target beneficiaries on the available GBV services in target communities?	Select all that apply • Sensitization • Use of GBV awareness messages • Provision of support materials

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SN	Questions	Response Options
		• Initiate safety and security measures • Connecting women and girls to information services • Distribution of relevant dignity kits to women and girls • Provision of livelihood support • Strengthen referral systems to connect at risk groups
9	Are these services available to beneficiaries in an easily accessible manner?	Choose option 1= Yes 2 = No
10	If No = 9, Provide main reason for inaccessibility of services If Yes = 9, Skip to Question 11	Insert response
11	What mechanisms did the project put in place to make these services user friendly?	Insert response
12	How did the project encourage coordination between the stakeholders and beneficiaries?	Insert response
13	How did this project ensure active vigilance on safety, and accessibility while delivering the activities expected in this project?	Insert response

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SN	Questions	Response Options
14	In your opinion, did adopted strategies contribute to achievement of project objectives?	Choose option 1 = Yes 2 = No
15	If 14 = Yes Provide most effective strategy If 14 = No, Skip to Question 16	Inset response
16	Why did the strategies not contribute to the project objectives?	Insert response
Section 3	Efficiency	
SN	Questions	Response Options
17	Were the right resources available for this project's implementation?	Choose option 1 = Yes 2 = No
18	Capacities of the management were adequate to manage personnel, project properties, communications and stakeholders?	Choose option 1 = Yes 2 = No
19	If 18 = No Identify most significant gap	Insert response
20	What capacity development support should be prioritized for future projects?	Insert response

SN	Questions	Response Options
21	Is there any pending financial commitment from CARE on this project?	Choose option 1 = Yes 2 = No
21	If 20 = Yes Give reason for pending financial commitments, If No, skip to Question 22	Insert response
22	What mechanisms did this project put in place to ensure accountability?	Insert response
23	Were project activities implemented according to planned timelines?	Choose option 1 = Yes 2 = No
24	If 23 = No Why were timelines not adhered to?	Insert response
25	Did the project engage community stakeholders and humanitarian partners?	Choose option 1 = Yes 2 = No
26	If 25 = Yes Select all options that apply	Select all that apply 1 = Local NGOs 2 = INGOs

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SN	Questions	Response Options
		3 = UN Agencies 4 = Security Agencies 5 = Health Service Providers 6 = Women groups 7 = Youth groups 8 = Others
27	If 26 = Others Provide name of engaged partners not provided above	Insert response
28	What activities were conducted to strengthen the capacities of these groups?	Insert response
30	Was there an established project M&E System?	Choose option 1 = Yes 2 = No
31	If 30 = Yes Provide main components of project M&E system?	Insert response
32	In 30 = No Why was a project M&E system not established or developed?	Insert response

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SN	Questions	Response Options
33	How was project monitoring data used to inform evidence based decision making for adaptive management?	Insert response
Section 4	**Effectiveness**	
34	How did the project document and incorporate beneficiary feedback to address service access challenges?	Insert response
35	What did the project do to mitigate challenges faced by beneficiaries?	Insert response
36	How did the project identify and select target communities for intervention?	Insert response
37	Do you have any recommendations to improve the selection or targeting criteria for target populations and communities?	Insert response
Section 5	**Impact and Sustainability**	
SN	Questions	Response Options
38	What expected outcomes were attained by the project?	Insert response
39	Was the project able to establish and maximize linkages of women solidarity groups for livelihood assistance?	Choose option 1 = Yes 2 = No
40	If 39 = Yes How were linkages established and maximized by the project?	Insert response

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SN	Questions	Response Options
41	If 39 = No What alternative options should be explored?	Insert response
42	What might affect the participation of girls and women especially those heads of households in a future project?	Insert response
43	What additional supports are needed to sustain existing women solidarity groups?	Insert response
44	What are the existing priority GBV capacity building needs of staff?	Insert response
45	Did this project work with GBV committees?	Choose option 1 = Yes 2 = No
46	If 46 = Yes What support was most effective in engaging GBV committees?	Insert response
47	How can the project sustain and promote continuity of GBV committees?	Insert response
48	Do you think that the integrated GBV prevention and response services provided were adequate in target intervention areas?	Choose option 1 = Yes 2 = No
49	If 48 = Yes What was a major milestone achieved by the project?	Insert response
50	If 48 = No	Insert response

SN	Questions	Response Options
	What additional GBV prevention and response service options should be prioritized in future projects?	
51	Was the project successful in improving response to GBV and SEA vulnerabilities among target beneficiaries?	Choose option 1 = Yes 2 = No
52	If 51 = Yes How was this achieved?	Insert response
53	If 51 = No What could have been done differently?	Insert response
54	List communication channels employed to inform beneficiaries of project activities	Insert response
55	What informed the targeting criteria for girls, women and female headed households?	Insert response
56	Did this project establish and adapt monitoring and accountability mechanisms to the context? If so, how was this done?	Choose option 1 = Yes 2 = No
57	If 56 = Yes How was this achieved?	Insert response
58	If 56 = No Why was this not done?	Insert response

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SN	Questions	Response Options
59	What alternative monitoring and accountability mechanisms can be employed in future projects?	Insert response

3.2. Beneficiary Questionnaires (BQ)

Beneficiary Questionnaires (BQ)			
Questionnaire Code: (BQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location:			
Consent			

Interview Prompt

[At the start of the interview, please say the following]

"It is a pleasure to meet you. My name is [Insert Name]. I/We are here to collect your views on the implementation of the Integrated GBV Prevention and Response to the Emergency Needs of Newly Displaced Populations in Borno State. We work as part of an independent evaluation team engaged by CARE International Nigeria that is working to obtain information on behalf of the Project's sponsors.

The purpose of this interview is to gather information on the services offered at this location and to better understand GBV prevention and response needs. The interview is estimated to last 40 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get.

We will not ask personal questions, only about the services you receive from the CARE International Nigeria. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future. Are you willing to participate in the interview?

- **Evaluators will adhere to these three Protection Principles:**
    4. **Evaluators will not further expose people to physical hazards, violence or other rights abuses.**
    5. **Evaluators will not undermine any beneficiary's capacity for self-protection.**

6. **Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.**

The Beneficiary Questionnaire (BQ) is divided into six (6) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on GBV response emergency needs of displaced populations in Borno State. Photos shall **ONLY** be taken when instructed. Please note that children **should not** be photographed, nor can they provide informed consent.

- Section 1: Demographic and Background Information
- Section 2: Relevance
- Section 3: Efficiency
- Section 4: Effectiveness
- Section 5: Impact and Sustainability
- Section 6: Accountability

Section 1	**Demographic and Background Information**	
SN	**Questions**	**Response Options**
1	Age	Insert response (Age at last birthday)
2	Gender	Choose option 1 = Yes 2 = No
3	Beneficiary Type	Choose relevant option 1 = Host 2 = IDP 3 = Refugee 4 = Returnee 5 = Person living with disability
Section 2	**Relevance**	

SN	Questions	Response Options
4	Are you aware of any project activity implemented in this Local Government Area?	Select all that apply 1 = Sensitization 2 = Use of GBV awareness messages 3 = Provision of support materials 4 = Initiate safety and security measures 5 = Connecting women and girls to information services 6 = Distribution of relevant dignity kits to women and girls 7 = Provision of livelihood support 8 = Strengthen referral systems to connect at risk groups 9 = Provision of psychosocial support and counseling 10 = Provision of material needs (food and non-food items) 11 = Linkage of GBV-survivors to health services
5	Did the project help you meet your emergency needs?	Choose option 1 = Yes 2 = No
6	If 5 = Yes How was this done? Then skip Question 7	Insert response
7	If 5 = No How can the project help you in the future?	Insert response
8	What did this project do to increase your knowledge about GBV services in your community?	Choose all that apply • Sensitization • Use of GBV awareness messages • Provision of support materials

		• Initiate safety and security measures • Connecting women and girls to information services • Distribution of relevant dignity kits to women and girls • Provision of livelihood support • Strengthen referral systems to connect at risk groups
9	In this project, did you observe any other group of people that participated in the implementation of the activity?	Choose all that apply • IOM • Security • Health personnel • Government • UNFPA • Community leaders
10	Which of the following activities were implemented by the project?	Choose all that apply • Engagement of women solidarity groups • Engagement of GBV champions • Activation of GBV survivors group • Raising GBV awareness messages • Training of GBV Vigilante Committee • Distribution of dignity kits • Linkage of GBV survivors to women solidarity groups
11	What other activity do you think should be implemented by the project?	Insert response

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Section 3		Efficiency
SN	**Questions**	**Response Options**
12	As stakeholder in this project, do you have an understanding of your roles and responsibilities?	Choose option 1 = Yes 2 = No
13	If 12 = Yes What is your role? Then skip Question 14	Insert response
14	If 12 = No Are there any reasons why you do not know your role or responsibilities?	Insert response
15	Did you receive any training from this project?	Choose option 1 = Yes 2 = No
16	If 15 = Yes What main training did you receive? Then skip Question 17	Insert response
17	If 15 = No What training would you like to receive?	Insert response
18	As a GBV beneficiary how did you report any problem to the project?	Choose all that apply • Help Desk • Toll free lines • Complaints box

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SN	Questions	Response Options
		• SMS Lines • In-person complaints
Section 4	**Effectiveness**	
SN	**Questions**	**Response Options**
19	Did you experience any challenge while accessing the services provided by this project's activities?	Choose option 1 = Yes 2 = No
20	What is your perception about this project activities as a beneficiary?	Choose option • Very Satisfied • Satisfied • Not satisfied
21	If you experienced any gender-based issues, will you come to this project to access service?	Choose option 1 = Yes 2 = No
22	If 21 = Yes Why would you choose this project? Then skip Question 23	Insert response
23	If 21 = No What will the project do differently to make you access their services more?	Insert response

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Section 5		Impact and Sustainability
SN	**Questions**	**Response Options**
24	What might affect the participation of girls and women especially those heads of households in a future project?	Insert response
25	How can the project provide extra support to existing women solidarity groups?	Insert response
26	Were project services adequate for you?	Choose option 1 = Yes 2 = No
27	If 26 = Yes Which specific services were you satisfied with? Then skip Question 28	Insert response
28	If 26 = No Why were accessed project services not adequate?	Insert response
Section 6		**Accountability**
SN	**Questions**	**Response Options**
29	If you have a complaint about the project or project staff, do you know where to go?	Choose option 1 = Yes 2 = No
30	Do you feel comfortable reporting?	Choose option

		1 = Yes 2 = No
31	Have you personally reported or given feedback?	Choose option 1 = Yes 2 = No
32	If 31 = Yes Was any action taken?	Choose option 1 = Yes 2 = No

3.3. Stakeholder Questionnaires (SQ)

Stakeholder Questionnaires (SQ)			
Questionnaire Code: (SQ/State/LGA/00_)		Time Start	
Date of Interview:		Time End	
Field Visit Location:			
Consent			

Interview Prompt

[At the start of the interview, please say the following]

"It is a pleasure to meet you. My name is [Insert Name]. I/We are here to collect your views on the implementation of the Integrated GBV Prevention and Response to the Emergency Needs of Newly Displaced Populations in Borno State. We work as part of an independent evaluation team engaged by CARE International Nigeria that is working to obtain information on behalf of the Project's sponsors.

The purpose of this interview is to gather information on the services offered at this location and to better understand GBV prevention and response needs. The interview is estimated to last 40 minutes. Your participation in this interview is completely voluntary. It is your choice whether to participate or not. There are no right, or wrong answers and you can refuse to answer any question and can terminate this interview at any time. Non-participation will not affect the services/benefits that you usually get.

We will not ask personal questions, only about the services you receive from the CARE International Nigeria. Information collected will be kept in a secure location, and only be used to inform better service delivery. However, even if information you provide is used in the report, this does not mean that the issues raised will lead to immediate changes in the future. Are you willing to participate in the interview?

- **Evaluators will adhere to these three Protection Principles:**
    7. **Evaluators will not further expose people to physical hazards, violence or other rights abuses.**
    8. **Evaluators will not undermine any beneficiary's capacity for self-protection.**
    9. **Evaluators will manage sensitive information in a way that does not jeopardize the security of the informants or those who may be identifiable from the information.**

The Stakeholder Questionnaire (SQ) is divided into six (6) sections based on identified research questions. Data will be collected via the conduct of Individual In-depth Interviews (IDIs) on GBV response emergency needs of displaced populations in Borno State. Photos shall **ONLY** be taken when instructed. Please note that children **should not** be photographed, nor can they provide informed consent.

- Section 1: Demographic and Background Information
- Section 2: Relevance
- Section 3: Efficiency
- Section 4: Effectiveness
- Section 5: Impact and Sustainability
- Section 6: Accountability

Section 1		**Demographic and Background Information**
SN	**Questions**	**Response Options**
1	Gender	Choose option 1 = Yes 2 = No
2	Respondent Type	Choose relevant option 1 = Community leader 2 = Government representative 3 = Local Implementing Partner 4 = Women solidarity group 5 = Representative of Person living with disability
Section 2		**Relevance**
SN	**Questions**	**Response Options**
3	Did you participate in GBV awareness training by this project?	Choose option 1 = Yes 2 = No

4	If 3 = Yes Recall any GBV services promoted by the project?	Insert Response
5	How did the project support the monitoring of GBV related issues?	Choose All Options that Apply 1 = Active vigilance on Safety 2 = Active vigilance on Accessibility 3 = Promoted Participatory Approaches
6	As a stakeholder, do you think that the activities implemented by this project were successful?	Choose option 1 = Yes 2 = No
7	If 6 = Yes What in your opinion made the project successful? Then skip Question 8	Insert Response
8	If 6 = No What can the project do differently to address this?	Insert Response
Section 3		**Efficiency**
SN	**Questions**	**Response Options**
9	Did CARE talk to you about your roles and responsibility as a stakeholder?	Choose Option 1 = Yes 2 = No
10	If 9 = Yes How was this done?	Insert Response

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11	On this project, what responsibilities did you perform?	Insert Response
12	Are there factors that stopped or limited you from performing your responsibilities as a stakeholder?	Choose option 1 = Yes 2 = No
13	If 12 = Yes Please list these factors?	Insert Response
14	Did this project provide capacity building for you?	Choose option 1 = Yes 2 = No
15	If 14 = Yes What capacity building did this project provide for you? Then skip Question 15	Choose All Options that Apply • GBV targeted trainings • GBV targeted workshops • Engaging men and boys on self-reflections • Trainings on accountability • Trainings on humanitarian principles • Awareness raising
16	If 14 = No What type of capacity building support would you like to receive from the project?	Insert Response
17	As a stakeholder, are you aware of the complaints and feedback mechanism available on this project?	Choose option 1 = Yes 2 = No

18	If 17 = Yes Please, list the complaints and feedback mechanism you know that were provided.	Insert Response
Section 4	Effectiveness	
19	As a stakeholder, what is your perception about the activities implemented by this project?	Choose Option 1 = Poor 2 = Bad 3 = Fair 4 = Good 5 = Excellent
20	As a stakeholder, are you aware of the gender and protection services provided for by this activity?	Choose Option 1 = Yes 2 = No
21	What should the project to increase stakeholder collaboration?	Insert Response
22	How do you think that the project should better engage communities affected by the crisis?	Insert Response
Section 5	**Impact and Sustainability**	
23	What might affect the participation of girls and women especially those heads of households in a future project?	Insert Response
24	As a stakeholder, were you involved in the project's coordination efforts?	Choose Option 1 = Yes

		2 = No
25	Were services provided by the project adequate in target intervention areas?	Choose Option 1 = Yes 2 = No
26	If 25 = Yes Which service was most needed? Then skip Question 27	Insert Responses
27	If 25 = No Which services should the project improve?	Insert Responses
Section 7		**Accountability**
28	Are you satisfied with the complaints and feedback mechanisms provided by the project?	Choose option 1 = Yes 2 = No
29	If 28 = Yes Please rate your level of Satisfaction, on a scale of 1 – 5. With 5 as the highest score of satisfaction.	Rate Level of Satisfaction 1 = Not Satified 2 = Barely Satisfied 3 = Neutral 4 = Somewhat Satisfied 5 = Completely Satisfied
30	If 28 = No What can be done to improve your level of service satisfaction?	Insert Response

ANNEX 4. RISK MITIGATION PLAN (RMP)

Potential Risk	Mitigation Strategy	Risk Rating
Security	In Northern Nigeria, security preparedness requires a daily assessment of violence, threats and road closings. Few roads in the region are safe for consistent travel and cell phone and internet connections are unreliable. The evaluation team will take strict preventive safety measures e.g. maintaining contact and maintaining a diary of security emergency contacts. The evaluation team will also work with CARE NG security contacts and local security agencies for assistance when visiting conflict-prone areas as needed.	**Critical**
Data Reliability	To address this concern, the technical evaluators will conduct primary data quality assessment of collated data, and will provide direct support during field data collection. The evaluation team will engaged trained GBV volunteers identified by CARE NG, to ensure engaged enumerators are knowledgeable of the GBV in Emergency Project. This will also eliminate the need to conduct rigorous training for field data collectors will conduct rigorous training of field data collectors within the restricted timeframe. With support from CARE NG, the evaluation team will organize meetings with target persons to facilitate ready access to respondents and offer an opportunity to receive feedback on specific challenges encountered in the field.	**Low**
Covid-19	The Corona virus pandemic has had far reaching impacts on all facets of life; and until a viable vaccine is available all necessary precaution must be taken. To this end, the evaluation team will ensure adherence to social distancing protocols by the World Health Organization (WHO) during the conduct of evaluation activities and tasks. During all IDIs, the evaluation team will ensure the use of face masks for both interviewees and facilitators; as well as encourage the use of hand sanitizers; while maintaining appropriate social distance among respondents. Technical evaluators will also ensure that engaged enumerators maintain appropriate social distancing during field data collection, while employing the use of face masks.	**Critic1al**
Use of Primary and Secondary Data	The triangulation of data will be driven by the evaluation team using primary data provided by the ECHO GBV in Emergencies Project (i.e. desk study) and secondary data derived supplementary resource materials (i.e. deep dive) as well as reference all suitable data sources.	**Low**
Data Validity	The Risk Mitigation Plan (RMP) will guide field data collection and documentation. When necessary, the evaluation team will also maintain updated data quality worksheets to ensure effectively data assurance and cleaning.	**Critical**

Potential Risk	Mitigation Strategy	Risk Rating
Privacy Concerns	As a component of protection against security and privacy concerns, the evaluation team will adhere to "Do No Harm" protocols during all data collection activities. This includes informed consent as well as minimizing collection of personally identifiable information (PII).	**Medium**
Culture and Language Barrier	The evaluation team member possesses extensive professional experience in the Northeast local language skills. If a situation arises where the local dialects differ then the team will engage a community member as a translator. The lead evaluator will ensure language challenges are minimized and will conform to existing culturally sensitive issues during the conduct of field data collection activities.	**Low**
Logistics	The evaluation team will coordinate field activities leveraging on CARE NG established networks and resources to facilitate effective logistics planning. Each Individual In-depth Interview (IDI) will serve as referral to associated respondents that could be easily reached and also be conversant with the subject matter being researched by the evaluation team.	**Medium**
Non-response	Data collection and survey instructions will be developed to guide field activities regarding use of evaluation findings.	**Medium**

ANNEX 5. MOST SIGNIFICANT CHANGE (MSC) MATRIX

Most Significant Change (MSC) Matrix	
Knowledge and perception of GBV (Change in Social Norms)	
Baseline	During the Focus Group Discussion (FGD) session held with men and boys, the table above shows the list of organizations present and are functional in their locations. Quite a few organizations are actually providing GBV services. The level of participation of health worker in delivering GBV responses play a striking role in a community that is infringed by male dominancy. Health facilities report rape as the most common type of violence women and girls receive services for. Abortion, Counselling, antenatal care, blood pressure, medical examination and treatment were listed as the services provided in the health facility.
Midline	When asked "what does GBV mean to you?", there was no shortfall of answers. Only 6% of respondents to the open-ended question with an "I don't know". To keep the quality and authenticity of the responder's perception of GBV, a word cloud was generated to depict the wordings used via the respondent. Rape had the highest occurrence with 10.6% of all respondents, followed by harassment with 8.2%, 6% of respondents said "I don't know", 4% mentioned early marriage, 3% mention both child abuse as well as sexual abuse. During the KII, respondents also had some things to say about what GBV means to them; it is clear that the majority of the respondent on both qualitative and quantitative surveys understood what GBV was. To dive in further, a question was asked: is GBV common? It can be noticed from the chart below that majority of the respondent, a striking 61.7% said "yes" to GBV is common in the community, majorly in the camps (Arabic camp, ISS camp, and GSSSS camp) with 44.5%, followed by host community members with 13.1%, then refugees with 3.5% and finally 0.6% of returnees. Also, 35.3% of respondents said GBV is not common (broken into 5.3% from host community members, 29.2% from IDPs, 0.6% from refugees and 0.2% from returnees), while 3.1% of respondent "did not know" if GBV was either increasing or reducing. A follow-up would be, have you or anyone you know experienced GBV in the last 6 months? Because of the sensitivity around discussion around GBV, knowing how leader and community influencers frown from such discussion, the direct question which is have you experienced GBV? the response was not solicited, as it is also culturally inappropriate. Enumerators were trained to engage respondent on this question with care, to not come out as interrogating but to be observant, noting the responders' behavior, if he/she is free to speak about her personal experience, a listening ear should be given and at the end of the day's briefing, that should be discussed. Regardless, from the total respondent to "do you or someone you know experience GBV in the last 6months?": 49% of respondents answered "yes", 47% answered "no" while 5% were not sure and answered, "I don't know".
End-Line	**Beneficiary perception of services provided** Collectively, interviewed beneficiaries had a positive perception of services provided by the ECHO GBV project in Bama and Ngala. For example, 42.5% of respondents in Bama (Male – 17% and female 25.5%) recorded being highly satisfied in their perception of services provided by the project. In Ngala, beneficiary feedback showed that 19.4% of male respondents and 80.6% of female respondents were satisfied with services provided. No beneficiary was not satisfied with the services provided by the project. Stakeholders also had a positive perception (47% of respondents) of the services and 53.3% of stakeholders rated the services provided by the project as being good in Bama and Ngala Local Government Areas (LGAs).

Most Significant Change (MSC) Matrix	
Knowledge of the ECHO-GBV Program	
Baseline	Overall, 77.9% and 50% of respondents in Ngala and Bama respectively confirmed the presence of humanitarian response and actors. On the other hand, 12.2% and 28.1% of respondents in Ngala and Bama responded "No" to the presence of any humanitarian actors in their respective LGAs. Furthermore, 9.9% and 21.8 % respondents in Ngala and Bama tend not to even know about the presence of humanitarian actors in their locations. On the whole, the respondents that said "Yes", listed the following humanitarian agencies; Alima, IOM, CARE2 , Danish Refugee Council, MSF, FHI360, Mercy Corp, INTERSOS, UNICEF, WFP, UNHCR, Red Cross, CHAD, SIF, UNFPA, WHO and Solidarities International as the organizations providing services in their LGAs. Through FGD, they also went further to mention services provided like Food distributions and NFI, Health services, Shelter, for IDPs, Psycho social support and WASH for both areas.
Midline	The majority of respondents knew about the ECHO-GBV project as can be seen by the chart above. The same respondents were asked what services/activities the ECHO-GBV Program provided. The figure below shows the distribution of a multiple-response question from respondents who agree on the set activities as being carried out by the Program. For example, 0.14% of respondents who chose others mentioned sensitization and awareness-raising on GBV prevention and response.
End-Line	**Enhanced Access to GBV humanitarian support and community-based prevention services** When asked about the benefits of the ECHO-GBV program to their communities, the majority of respondents, 90% (31% female, and 10% male in Bama and also 35% female and 14% male in Ngala) thought it was beneficial to them. The majority of the responses came from female respondents because the majority of the ECHO-GBV participants are women. Among respondents with a positive perception of the ECHO-GBV program activities, the provision of information on GBV (82%), support to GBV survivors (67%) and providing a safe home for survivors (12%) were the main reasons behind their positive perception of the project. There were also beneficiaries who felt that the information provided by the project was not appropriate, as services were too far from their homes/communities and expressed concerns on the actual confidentiality of such services. Few respondents in Ngala LGA stated that not all post-incident needs were addressed by the project as services did not lead to persecution.

Most Significant Change (MSC) Matrix	
Perceptions of effectiveness/quality of the ECHO-GBV Program	
Baseline	Out of 7063 responders, 8.50% (5.3% females and 3.2% males) in Bama and 15.70 % (11.6% female and 4.1% male) in Ngala responded "Yes" that humanitarian assistance is safe and accessible. And 0.6% (0.4% females and 0.2% males) in Bama and 3.6 (1.4% females and 2.1% males) in Ngala responded that they are involved in decision making (participatory manner). In total the current humanitarian assistance is delivered in a safe, accessible and participatory manner for 14.20% of respondents.
Midline	When asked about whether they thought the ECHO-GBV Program was beneficial to their communities, the majority of respondents, 90% (31% female, and 10% male in Bama and also 35% female and 14% male in Ngala) thought it was beneficial to them. The majority of the responses came from women respondents because the majority of the ECHO-GBV participants are women. Of the respondent who mentioned the ECHO-GBV Program was beneficial, the majority mention it was beneficial because it provides information on GBV (82%), others mentioned it was because it supports GBV survivors (67%) and some mentioned it provides a safe home for survivors (12%). Of those that felt the ECHO-GBV project was not beneficial, respondent felt that the information provided was not appropriate, also that services were too far, others were fearful of confidentiality issues, some group also said it does not address all post-incident needs and then lastly; services do not lead to persecution.
End-Line	Collectively, interviewed beneficiaries had a positive perception of services provided by the ECHO GBV project in Bama and Ngala. For example, 42.5% of respondents in Bama (Male – 17% and female 25.5%) recorded being highly satisfied in their perception of services provided by the project. In Ngala, beneficiary feedback showed that 19.4% of male respondents and 80.6% of female respondents were satisfied with services provided. No beneficiary was not satisfied with the services provided by the project. Stakeholders also had a positive perception (47% of respondents) of the services and 53.3% of stakeholders rated the services provided by the project as being good in Bama and Ngala Local Government Areas (LGAs).

Most Significant Change (MSC) Matrix	
Project Effectiveness	
Baseline	Although the integrated GBV program at this point was not yet to start, the baseline assessed here if the general humanitarian assistance was delivered in a safe, accessible and participatory manner. At baseline, the integrated GBV project prevention and response activities had not yet started; therefore, these data inform only on the humanitarian assistance in general. In an attempt to get a clearer understanding of the context, safety and dignity were taken as separate components, and an individual question was asked on each: Has your safety been affected by humanitarian assistance? And Do you feel that your dignity is respected when you access a humanitarian service?
Midline	Shortly after the baseline, ECHO organized a training on the use of its protection mainstream guidelines, for all organization implementing an ECHO-funded project. The guideline contains a series of 21 questions and guidelines on how to calculate the output/responses. The midline assessment questions are meant to inform the protection mainstreaming indicators. For this survey, the questions were modified to also provide data on specific indicator 1 as well as indicator 2. At baseline, all activities leading to the impact indicators had not yet begun therefore, the outcome was not measured and was zero (0).
End-Line	The ECHO GBV project was most effective in strengthening GBV awareness across target communities in Bama and Ngala LGAs. This was achieved mainly through the implementation of these activities: • **Community awareness raising on GBV**: Both stakeholders and beneficiaries alike recognized the importance of ongoing community awareness raising and sensitization events on GBV. Such project activities should be sustained to encourage community ownership of project activities. • **Mobilization and training of GBV champions**: To embed sustainability measures for future project activities, the mobilization and training of GBV champions is essential. GBV champions can also drive community-level awareness raising and sensitization of returnees and IDPs beyond the project's implementation period. • **Establish and support GBV vigilant committees**: When dealing with issues related to GBV, communal coordination and support was integral to the success of project activities i.e. creating safety in numbers. Trained GBV champions readily supported these vigilant committees in Ngala and Bama LGA. • **Create and operate safe spaces**: The creation and operation of safe spaces for community-level engagement, eased referral pathway services and remains an effective implementation approach; which should be extended in future design iterations. This should ideally extend to support women solidarity groups and organizing further case management training to GBV champions and vigilant committee members to effectively make use of created safe spaces.

Most Significant Change (MSC) Matrix	
Objective 1: To enhance the access of newly displaced, vulnerable women, men, girls, and boys to life-saving GBV prevention and response services through coordinated, principled humanitarian support and community-based prevention activities	
Baseline	Not applicable
Midline	Program participants, who had been engaged in the project for its lifetime were asked: When you received assistance in the past 6 months did you feel safe while going to receive assistance, waiting for assistance and coming back to your home after assistance? And Did you feel that you were treated with respect by NGO staff during the intervention in the past 6 months? During training, enumerators were told what safe/safety and dignity meant in the context: Safety – describes the condition of being protected against physical and psychological harm, while dignity – describes the fact that people have a right to be valued, respected and receive ethical treatment. This unfortunately was not the orientation at baseline, therefore the emphasis was placed on the understanding of the terminologies.
End-Line	**Accessed GBV related services** In both Bama and Ngala LGAs, beneficiaries all five (5) communities (i.e. Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, and IDP Camp Ngala) indicated low access to services among females in Ngala compared to Bama LGA. Only 29.3% of females in Bama actually accessed services compared to 7.2% of females in Ngala LGA. The analyzed data also showed fewer beneficiaries in both intervention LGAs were likely to make reports of GBV related abuses. However, there was a higher potential for beneficiaries in Bama to report GBV related cases of abuse then beneficiaries in Ngala. More females (54.8% and 45.2%) in Bama were likely to report cases of GBV; while 37.6% females and 62.4% males had no interest in reporting cases of GBV abuse. The details in methods of reporting GBV experienced in the communities showed there is need for more awareness and outreach activities to log such GBV complaints in Ngala and encourage more reports in Bama. **Ease of reporting GBV related issues** Among survey respondents, the analyzed data showed that majority of beneficiaries could freely make GBV related reports through designated feedback channels. For example, the quantitative assessment data showed that 58% of beneficiaries in Bama had no reservations making reports of GBV related issues compared to 42% of respondents in Ngala LGA.

Most Significant Change (MSC) Matrix	
Objective 2: Deliver integrated GBV services and through a participative approach combining community based prevention and specialized services of GBV response, including case management, psychosocial support, and material support delivered based on needs assessed on a case-by-case-basis, and linked to SRH services already provided in the area of operation with UNFPA funding.	
Baseline	Not applicable
Midline	When asked do you know anyone who has been consulted by aid workers on what your needs are, 49.1% and 43% of female respondent in Bama and Ngala said "yes", followed 18.5% and 34% of male respondent in Bama and Ngala who also answered "yes", more details can be seen in Table 3a above. Table 3b also shows responses on the appropriateness of assistance received in the past 6 months; the majority of the respondent answered "no" in Bama 52.8% female and 21.1% male, while in Ngala, the majority answered "yes" seen by 43.1% female and 31.4% male respondents. Table 3a and 3b show that although the majority of respondents agreed on participation in decision making around programming, not all agree on the appropriateness of its intervention.
End-Line	**Adequacy of GBV related services** Collated responses from stakeholders show that majority of respondents (53.3%) in Ngala state that GBV related services are not adequacy; although reverse is the case in Bama; where respondents agree that GBV related services were adequate. On the other hand, project beneficiaries clearly state that GBV related services were adequate across intervention LGAs in Bama and Ngala respectively. This positive feedback accounted for 78.4% of responses from interviewed beneficiaries for both men and women. Promoting community based mobilization and sensitization efforts remain key to community entry, ownership and program sustainability. Project activities should be driven by local actors and complimented by project personnel through training sessions. The role of GBV vigilantes and champions cannot be over-emphasized in creating vocal community centered-advocates on GBV issues i.e. in connecting women, girls, boys and men to information services; as well as promoting the use of GBV awareness messages.

Most Significant Change (MSC) Matrix	
Objective 3: Promote coordination with other actors though safe, confidential, and effective referral pathways	
Baseline	Not applicable
Midline	In both Bama and Ngala, all 5 communities (Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, IDP Camp Ngala) indicated a change in the incident of sexual violence, to get a clearer picture of the change in the incident, the proportion of the total in the community who have not witnessed sexual violence was measured using this question: Have you or know anyone who has been sexually abused within the last 6 months? And What would you say is the status of GBV in this community? Thus, 70% of the respondent during the mid-line survey reported that the incident of GBV and sexual violence has declined within the last 6 months. However, about 30% of respondents lamented that they are aware of cases of sexual violence in the communities although, 14% of the alter group could not have ascertained if the status of sexual violence is declining or not.
End-Line	**Involvement and coordination of actors** The project promoted active coordination among humanitarian actors by ensuring that GBV related services were user friendly. This was achieved through the implementation of the following community based activities i.e. involving and training community members; use of local language to disseminate information during sensitization events to increase awareness of GBV related issues; successfully employed the GATHER model to implement activities in the establishment of Women and Girls Friendly Safe Spaces (WGFSS). This approach was particularly effective in linking GBV survivors to necessary services. The ECHO-GBV project also provided alternative compliant and feedback mechanisms for beneficiaries and stakeholders.

<table>
<tr><th colspan="2">Most Significant Change (MSC) Matrix</th></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Objective 4: Contribute to improving the quality of service delivery while reducing risks emanating from insufficient awareness and knowledge about humanitarian principles among humanitarian staff, volunteers and security actors</td></tr>
<tr><td>Baseline</td><td>Not applicable</td></tr>
<tr><td>Midline</td><td>All staff trained on GBV, Case management and GBV referral pathway have shown an increased knowledge on the protection focus and can indicate the referral pathway effectively. Follow-ups to these training were conducted through spot checks and monitoring. Likewise refresher training was also conducted.</td></tr>
<tr><td>End-Line</td><td>In both Bama and Ngala LGAs, beneficiaries all five (5) communities (i.e. Bama host community, Ngala host community, Gambaru host community, IDP Camp Bama, and IDP Camp Ngala) indicated low access to services among females in Ngala compared to Bama LGA. Only 29.3% of females in Bama actually accessed services compared to 7.2% of females in Ngala LGA. The project promoted active coordination among humanitarian actors by ensuring that GBV related services were user friendly.

This was achieved through the implementation of the following community based activities i.e.
Involving and training community members;
Use of local language to disseminate information during sensitization events to increase awareness of GBV related issues;
Successfully employed the GATHER model to implement activities in the establishment of Women and Girls Friendly Safe Spaces (WGFSS). This approach was particularly effective in linking GBV survivors to necessary services.
Provided alternative compliant and feedback mechanisms for beneficiaries and stakeholders.</td></tr>
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ANNEX 6. EVALUATION TERMS OF REFERENCE

Overview

Sexual violence is seen as a shameful act that dishonors the family's name, young girls are pushed out to be married early mostly in the camps as the parent seek favor from new relatives and require space in the tent. Women generally are not granted a sit in decision making except for some specific issues for which women leaders are involved although, very limited or non-active in the community Gender Based Violence (GBV) is pervasive in northeast (NE) Nigeria society, which supports male supremacy and grants men power and control over women in both domestic and public spheres.

The conflict has also maintained a vicious cycle of GBV as women, men, girls and boys in dire situations resort to negative coping mechanisms including 'survival sex'/transactional sex, forced/early marriage. The fear, shame and stigma associated to GBV significantly weight on the mental health conditions, socio-economic situation and access to GBV services. Humanitarian actors are already present in the area. But GBV services access and quality are quite poor.

CARE International in Nigeria engaged the services of an evaluation team with experience in the end of project evaluation of humanitarian programs in conflict-affected areas to undertake a thematic evaluation of the CARE Project 'Integrated Gender Based Violence (GBV) prevention and response to the emergency needs of newly displaced women, men, girls, and boys in Borno State, North-East Nigeria'. The purpose of the evaluation is to generate learning and evidence on the extent to which the project has:

- Targeted internally displaced persons (IDPs) and other vulnerable categories of people pertinent to the project rationale and objectives;
- Supported timely, relevant and effective delivery of GBV services (prevention and response) to target populations;
- Delivered results in-line with the project results framework;
- Been able to effectively monitor project activities through a 'remote management model'-particularly within the COVID-19 period.

The evaluation will provide evidence that will contribute to the management of relief program and to CARE humanitarian approach more broadly. The evaluation findings are also expected to contribute to the common evidence base on humanitarian practice in a somewhat unique context, as well as strategies on how to build resilient within a complex humanitarian crisis.

Background

Under the European Commission Civil Protection and Humanitarian Aid (ECHO) funding with support of CARE France, CARE Nigeria to implement a Gender Based Violence in Emergencies project. The project was implemented in Bama and Ngala Local Government Areas (LGAs) – Northeast, the goal of the project was to contribute to the protection of the lives of vulnerable women, men, girls, and boys most affected by the crisis in North-eastern Nigeria. At the end of the project it is expected that:

- GBV prevention, care, and response services are available and accessible to newly displaced individuals and vulnerable host community members at risk of or affected by GBV and
- Awareness, knowledge and application of humanitarian principles and Sexual Exploitation and Abuse prevention and response principles is improved among humanitarian actors and security forces.

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Evaluation Purpose and Objectives

The purpose of this final project evaluation is to ensure accountability and identify lessons learned and best practices so as to feed into the decision making process of the project stakeholders, including the donor, beneficiaries, and Government counterparts. The specific objectives of the end of project evaluation are primarily:

- To assess progress made towards the achievement of results at the outcome and output levels; include the sustainability of the outcomes of the project, beyond the project lifetime. Also to provide evidence-based information on performance of the project against the intervention logic and existing project and program indicators
- To assess performance in terms of the following criteria: Appropriateness of design; relevance of results; sustainability (where relevant); transparency and accountability; effectiveness, efficiency of resource allocations, and validity of design/relevance of the project
- To identify and to document lessons learned and provide evidence-based recommendations for guiding subsequent humanitarian programming or similar future interventions.
- To assess how the project ensured inclusion of vulnerable and marginalized communities and engaged with affected population and communities;
- To assess how the project contributed to coordination efforts for improved GBV response.

Evaluation Ethics

Due to the dynamic situation in which CARE operate, as well as the potentially life threatening nature of the issues involved, it is essential that the evaluation team adhere to strict ethical and security guidelines. The evaluation team has extensive experience conducting evaluation and monitoring activities across the Northeast across multiple donor funded projects. Therefore, the evaluation team shall adhere to CARE Nigeria Code of Conduct (C&C) guidelines at all times. More specifically, the team will ensure adherence to the evaluation criteria below

- **Independence**: The evaluation shall be external, and measures shall be put in place to prevent bias.
- **Usefulness**: Evaluation findings shall be articulated clearly and in a way that maximizes the potential for these findings to inform decision-making.
- **Representativeness**: Evaluation shall strive to include a wide range of beneficiaries/ stakeholders.
- **Gender Sensitiveness**: Evaluation will be gender sensitive and also, where possible, try to assess the intended or unintended effects of the project on gender relations.
- **Conflict Sensitivity**: Evaluation will be conflict sensitive and also, where possible, try to assess the intended or unintended effects of the project on any conflict triggers.

Scope of Evaluation

The geographical scope of the evaluation is Bama and Ngala LGAs of Borno State, NE Nigeria. The technical scope of the evaluation is to assess the relevance, efficiency, effectiveness, coordination, and impact/sustainability of the project in light of its objectives and provide recommendations for future programming. Furthermore, the evaluation will assess how the project ensured accountability to affected groups considering the commitments of the Core Humanitarian Standard. The evaluation team shall ensure

that all data collected from field locations are disaggregated by sex and age to examine the gaps between men and women related to the impact of the project.

Evaluation Questions

The following evaluation questions would be answered by the final evaluation study i.e.

Relevance

The evaluation team will look at the design of the project and assess the extent to which the stated project objectives address the identified problems or stakeholder needs:

- How has the project design (outcomes, outputs and activities) been relevant to addressing underlying causes of the identified problems?
- What alternative strategies would have been more effective in achieving its objectives?

Efficiency

- How has the project been efficient in allocating and managing resources (funds, human resources, time, expertise etc.) to achieve outcomes? Were the management capacities adequate- i.e. management of personnel, project properties, communication, relation management with elders, community leaders, other development partners, etc?
- Do the results achieved justify the costs (human resources, time, energy, money, materials)? If not, why not? Have project funds and activities been delivered in a timely manner? If not, why not?
- Was there a clear understanding of roles and responsibilities by all parties involved?
- Has the project received adequate technical and administrative support from ECHO, CARE France, and CARE Nigeria?
- How far and in what ways the project was able to strengthen local non implementing partners, communities, government, youth groups (and other relevant groups) and provide suggestions to further improve their capacities.
- Review and assess the quality of the project monitoring and evaluation system, specifically: Assess the appropriateness of the indicators and also assess the robustness of the monitoring protocol and approaches in quantitative and qualitative data collection and compilation by project staff based on the log frame indicators.

Effectiveness

The effectiveness of the ECHO project would be assessed through an examination of these lines of inquiry i.e.

- How the project was perceived by relevant stakeholders (Local leaders and community members) in light of achieving its planned objectives?
- How has the project been effective in achieving its planned activities and outcomes? If not, why?
- Which were the strengths in the project implementation and what are the constraints and challenges faced? How has the project mitigated these challenges?

- How gender and protection have been mainstreamed into project activities and what was the impact of the project on gender equity and related issues
- How have the approaches/modalities followed by the project been effective in ensuring inclusion of vulnerable and marginalized communities?
- Have the approaches/modalities followed by the project been effective in engaging with the communities affected by the crisis? How and why?

Impact/Sustainability

- What are the planned and unintended effects, direct and indirect, positive and negative, of the project on the living conditions of the populations in the targeted area?
- What were the linkages between activities such as linkages between the women solidarity groups and livelihood assistance that allow to maximize the effected of the project?
- Evaluate the sustainability of the project achievements such as GBV committees, sensitization tools, level of capacity building of the staff, partners community leaders and other actors, reduction of GBV incidence, appropriation of the project by the beneficiaries;
- To what extent do the positive changes resulting from the project continue after the end of the action? In particular, through the replication of training activities and continuity of the GBV committees.
- Make proposals for strengthening the achievements of the project. Coordination
- Is the level of involvement and coordination of actions with other actors including local authorities, NGOs, Technical Services present in the area adequate?
- Is the level of collaboration through the sharing of information (technical, financial, logistics) and good practices adequate?
- What is positive and negative impact of inter-agency coordination efforts? To what extent does the project contribute to improved collective response on the GBV and SEA vulnerabilities in targeted locations?

Accountability

- Are the beneficiaries informed about the activities of the project?
- The situation / participation of girls and women, especially those heads of household?
- Are the existing monitoring and accountability mechanisms used and adapted to the context? If not, how can they be improved?
- Do the beneficiaries know the complaint and feedback mechanism? What are its limits? Do they use them? What feedback do they have on this mechanism?

ANNEX 7. EVALUATION REFERENCES

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