REPUBLIC OF RWANDA

REPORT ON THE FINAL EVALUATION OF THE PROJECT FOR THE NATIONAL SCALE UP OF THE ISANGE ONE STOP CENTER MODEL IN RWANDA

Kigali, December 22, 2016

By RAD Consult Ltd.

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LIST OF ACRONYMS

BPFA	Beijing Declaration and Platform of Action
CA	Child Abuse
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CSOs	Civil Society Organizations
EKN	Embassy of the Kingdom of the Netherlands
FBOs	Faith Based Organizations
GBV	Gender Based Violence
GERAS	Global Evaluation Reports Assessment
GMO	Gender Monitoring Office
GoR:	Government of Rwanda
IOSC	Isange One Stop Centre
IP	Implementing Partner
JADF	Joint Action Development Forum
MIGEPROF	Ministry of Gender and Family Promotion
MINIJUST	Ministry of Justice
MoH	Ministry of Health
NCC	National Commission for Children
NCHR	National Commission for Human Rights
NEPAD	New Partnership for Africa's Development
NGO	Non-Government Organisation
NISR	National Institute of Statistics of Rwanda
NWC	National Women Council
NYC	National Youth Council
OSC	One Stop Centre
RNP	Rwanda National Police
SDGs	Sustainable Development Goals
ToC	Theory of change
ToR	Terms of Reference
UDHR	Universal Declaration of Human Rights
UN WOMEN	United Nations for Women
UNCHR	United Nations High Commission for Refugees
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations for Children Funds

I. INTRODUCTION

1.1. Background of the project

The "National Scale up of Isange One Stop Centre (IOSC) model in Rwanda" is a joint programme between the government of Rwanda represented by Ministry of Gender and Family Promotion (MIGEPROF), Ministry of Health (MOH), Ministry of Justice (MINIJUST), Rwanda National Police (RNP) and One UN represented by UN Women, United Nations Development Programme (UNDP), United Nations for Children Funds (UNICEF), United Nations Population Fund (UNFPA) and United Nations High Commission for Refugees (UNHCR).

The joint programme focuses on the three strategic priorities:

1. Upscaling the IOSCs from 6 to 23 centres and provision of holistic services to prevent and respond to Gender Based Violence (GBV) and child abuse (CA);
2. Promoting behaviour change through public awareness and education in relation to laws and policies on GBV and CA;
3. Strengthening institutional frameworks for effective coordination, monitoring and evaluation as well as information management for evidence based planning and policy advocacy.

The programme is entirely funded by the Dutch Embassy.

The main goal of the programme is to ensure "Changed attitudes and behaviour in relation to GBV and CA; GBV&CA crimes are reported and multidisciplinary services provided to victims; and GBV&CA has reduced".

The programme is formulated around three main outcomes and six outputs as elaborated in section 3.1.4 of this report. The following strategies were developed to achieve the project goal and results:

1. Ensuring well-functioning IOSCs to provide high quality holistic service to prevent and respond to GBV and CA;
2. Promoting behaviour change through public awareness and education in relation to laws, policies on GBV and CA;
3. Strengthening institutional frameworks for effective coordination, monitoring and evaluation as well as information management for evidence based planning and policy advocacy.

The programme aimed at strengthening six of the already existing nine centres and setting up 17 new centres.

1.2. The IOSC model

The initial phase of the IOSC programme started in 2009 as a pilot project between the One UN in Rwanda and the RNP to target the then high incidence of GBV occurring in the country. GBV is a global phenomenon and a violation of human rights that need a concerted effort to be addressed. The model was designed to provide comprehensive response, care, and support services to survivors of GBV and CA. The model seeks to provide a unique multi-sectoral and interdisciplinary service by

providing a wide range of assistance to adult and child survivors of GBV occurring within the family and the community at large under a single roof. Services include psychosocial, medical, police and legal services, which have ensured the conviction of a substantial number of perpetrators. The centres also have provisions for emergency contraception, Human Immunodeficiency Virus (HIV) prophylaxis, Sexually Transmitted Infections (STIs) prevention, and other medications. The programme's awareness component focuses on community level prevention measures through sensitization and has led to a greater understanding of GBV and CA issues in communities throughout the country, leading to increased confidence in the IOSC model by victims and their families seeking an end to GBV and CA.

The IOSCs initiated by RNP provide a holistic response to GBV under one roof, to minimise the risk of re-victimisation, spoilt evidence and delayed justice. The centres provide free, 24-hour medical, psychosocial/counselling, legal and safe house services to the victims. Toll free telephone lines that facilitate quick emergency reporting, information access and rapid response to GBV cases are some of the facilities provided to IOSCs for more efficiency. It was widely recognised that quality services, conviction of perpetrators and sustained community awareness-raising help build the resilience of victims and their families including prevention of future violence and abuse.

1.3. Purpose and objective of the evaluation

After more than seven years of operation, a full-scale evaluation of the IOSC model nationwide is warranted to assess the extent to which the objectives of the programme established at the outset have been achieved.

This evaluation is in line with article 8 of the joint project document signed between the One UN Rwanda and the Government of Rwanda (GoR) in June 2014. The evaluation will also be used to inform any additional programming planned by the GoR and the international community both in Rwanda and in other similar country contexts.

The overall objective of the evaluation is to assess the extent to which the joint initiative achieved set objectives and met the needs of its intended beneficiaries and document any resulting changes (intended and unintended).

The specific objectives are to:

1. Determine the effectiveness of the IOSC model in addressing the short and long-term issues of GBV and CA through a multi-sectoral approach taking into consideration the health, legal and psycho-social outcomes on victims/survivors. This will include an analysis of the overall strategy and approaches of the IOSC related to data collection and knowledge generation and dissemination to analyse the different approaches used by each partner in the joint intervention and assess their respective effectiveness and efficiency – intended and unintended, positive and negative, as well as the major factors that influenced the project's achievements.

2. Identify good practices learned (identifying strengths and weaknesses) on both operational and management issues of IOSC implementation (cost-effectiveness) and make recommendations.
3. Develop or uncover and assess the Theory of Change (ToC) for the IOSC model and strategy considering the proposed recommendations that allows adjustment of the intervention logic.
4. Determine the sustainability of the IOSC model based on the phasing out/ end of donor funding.

II. EVALUATION METHODOLOGY

2.1. Approach

While the end-term evaluation of the IOSC project measured the achievement of results in line with planned outputs, outcomes and impact, there was a need to focus on the context in which these were (not) achieved and key factors that led to the current situation. The proposed methodology therefore considered the contextual local environments in which the project was implemented. The evaluation analysed the socio-cultural, economic and political aspects of the sampled IOSCs and how these have affected the project's implementation.

In line with the guidelines presented in "Integrating Human Rights and Gender Equality in Evaluations" by UNEG (2014) the evaluation team integrated human right and gender concepts, standards, values and principles into its approach:

- analysing how the intervention advances the rights of the target population, particularly women and marginalised individuals/groups;
- identifying and analysing the inequalities, discriminatory practices and unjust power relations that are central to development problems;
- ensuring that rights holders' voices (specially of the groups mentioned above) are heard and their views considered;
- reinforcing the capacity of the duty bearers to fulfil their obligations and responsibilities;
- strengthening accountability mechanisms and "promote more transparent review and dialogue on competing or alternative values or theories";
- monitoring and advocating for compliance with international standards on HR & GE.

Based on the qualitative and quantitative natures of the project's indicators, the evaluators used mixed methods for data collection to allow a combination of conventional methods (review of documentation, semi-structured interviews, and survey questionnaire) with participatory methods (focus group discussions and testimonials).

A desk review of documentation was conducted at the beginning of the project's evaluation, prior to different meetings. This review provided a solid understanding of the project design, its implementation and progress. The evaluators reviewed the following key documents:

- The project document: this is a key document providing a better understanding of the project's design and planned impact, outcomes and outputs as well as related planned activities.
- Annual work plans: this document provided an understanding of the actual results on yearly basis;

- Progress reports: quarterly narrative and annual reports were key for the evaluation team to get a better understanding of the implementation progress and related good practices, lessons and challenges from the implementation management team's point of view.
- Other documents like project's briefs and publications.

Semi-structured interviews: they were conducted with several project stakeholders including but not limited to Government partners (central and local), Civil Society Organisations (CSOs), participating UN Agencies, District Hospitals, the Donor, GBV victims and local communities. At central level interviews were conducted for the members of the Evaluation Reference Group representing the MoH, MIGEPROF, MINIJUST and RNP. On the side of donors interviews were done with the UNWomen Country Representative and the First Secretary in charge of Security, Justice and Good Governance at the Embassy of the Netherlands.

At decentralised level individual interviews were conducted for concerned staff working in the hospital hosting IOSC and in the District. In the hospital interviewed staff included the Director or his/her Deputy, the Accountant and the M&E Officer. At the district level the following attended the individual interviews: Vice-Mayor in charge of Social Affairs, Professional in charge of Gender and Family Promotion, District M&E Officer, Coordinator of National Women Council, Coordinator of National Youth Council, Representative of CSOs and Representative of Faith-Based Organizations.

Focus Group Discussions were used with key project stakeholders and beneficiaries to get their collective point of view and complement information collected using other techniques. Three focus group discussions were conducted at the level of each IOSC, one for female GBV victims, another for male GBV victims and another one for professionals serving in IOSC. The list of participants in the focus group discussions and individual interviews is in Annex 2.

Survey in surrounding communities: a survey was conducted in the communities surrounding the IOSC. The target population aged 18 years and above was selected randomly and gender parity among respondents was considered. It is noteworthy that enumerators were instructed to seek consent from respondents before they started interviews. The following were given a special attention as major areas of the survey:

Field survey: the questionnaire (see Annex 3) was distributed to respondents at the level of each the 10 IOSC selected based on the following criteria: 2 old IOSC, 4 newly established IOSC, 2 IOSC within the proximity of a refugee camp and 2 others near the borders serving neighbouring countries among other beneficiaries. Thus, the following IOSC were selected for each Province:

- Kigali City: Kacyiru in Gasabo District (old) & Kanombe in Kicukiro District (new);
- Eastern Province: Nyagatare in Nyagatare District (serving neighbouring countries) & Kibungo in Ngoma District (old);
- Northern Province: Ruhengeri in Musanze District (new) & Kinihira in Rulindo District (new);

- Southern Province: Kigeme in Nyamagabe District (proximity with a refugee camp) & Remera Rukoma in Kamonyi District (new);
- Western Province: Gisenyi in Rubavu District (serving neighbouring countries) & Kibuye in Karongi (proximity with a refugee camp).

Sampling method/sample size: the sample size for GBV and CA survey was calculated using two formulas below. Firstly the sample size was calculated from an infinite population, and 576 respondents was obtained by the formula below, and the sample size obtained was further rounded up to 600 respondents to minimize errors and bias and to account for non-responses cases.

Formula for the infinite population

$$ss = \frac{Z^2 \times P(1-P)}{M^2} \times D$$

Where:
SS= Sample Size for infinite population
Z = Z value equal to 1.96 for 95% confidence level
P = population proportion 25% (0.25)
M = Margin of Error at 5% (0.05)
D= Design Effect of 2

Formula for finite population

$$Ss = \frac{SS}{1 + \frac{(SS-1)}{Pop}}$$

Where:
SS= Sample Size for Infinite Population
Ss =Sample size for finite population
Pop = Population of **3,672,412** beneficiaries

The sub sample in each stratum (district) was calculated based on the total population of each district as indicated in the table below. The district with a higher population size therefore had big sample size: the formula for calculating the subsample is:

$$S = \frac{P}{PT} x\, Ss$$

Where S = Sample in each stratum (District),
P = Number of people in each district,
PT = Total population,
Ss = Total sample size

Table 1: Sampling Stratum per District/Associated IOSC

District names	Population	IOSC	Sample size per district
Gasabo	529,560	Kacyiru	86
Kicukiro	318,561	Kanombe	52
Ngoma	336,928	Kibungo	55
Nyagatare	465,855	Nyagatare	76
Musanze	368,267	Ruhengeri	60
Rubavu	403,662	Gisenyi	66
Karongi	279,135	Kibuye	46
Kamonyi	340,501	Remera-Rukoma	56
Nyamagabe	341,491	Kigeme	56
Rulindo	288,452	Kinihira	47
Total	**3,672,412**	**-**	**600**

The use of mixed methods by combining quantitative (questionnaire analysis, matrices for ranking and prioritizing, statistical analysis) with qualitative methods (interviews, focus group discussions and observations) maximised the collection of required information for evidence-based findings and triangulation of the evaluation findings from various sources of information. The evaluation also used a participatory approach, which encouraged the active involvement of the programme's stakeholders throughout the evaluation.

Filled questionnaires in the 10 selected districts amounted to a total of 637 respondents including 321males and 316 females, which led to an additional of 37 questionnaires as compared to the 600 that were initially planned. This additional was considered as it was found not statistically a problem for the methodology used. Table 2 below shows the number of males and females respondents for each district.

Table2. Proportions of sampled districts

District	Sex		Total	Percentage	
	Male	Female		Male	Female
Gasabo	45	44	89	14	14
Kamonyi	27	36	63	8	11
Karongi	27	25	52	8	8
Kicukiro	22	31	53	7	10
Musanze	31	31	62	9	10
Ngoma	28	31	59	14	10
Nyagatare	45	36	81	14	11
Nyamagabe	37	23	60	12	7
Rubavu	33	37	70	10	1112
Rulindo	26	22	48	8	7
Total	**321**	**316**	**637**	**100**	**100**

Source: Evaluation survey, December 2016.

The survey was conducted in 8 days by 8 enumerators at the rate of 10 questionnaires per day by each enumerator.

Study limitations

The following were found to be the major limitations of this study:

- In some districts participants in focus group discussions especially the GBV victims were not many due to lack of transport which was not planned in the study budget. In actual fact it was thought that GBV victims could be easily found in the communities surrounding the visited IOSCs but the field reality revealed that majority of them came from far.
- Several resource persons especially the Directors of visited hospitals and the JADF Representatives and some other professionals in districts were not available during the field work, as they were attending the Governance Academy course that took longer time than the planned 2 days for the field.
- GBV and finance related data in the visited IOSCs are not recorded in a harmonized way, which complicated a bit the analysis process.

2.2. Evaluation process

This evaluation was carried out by a team of consultants from Rwanda Accuracy Development (RAD) Ltd on behalf of the Government of Rwanda and One UN through UNWOMEN. The team included:

1. Augustine Kimonyo: Team Leader
2. Paul Sijssens: International M&E Expert
3. Donnah Kamashazi: Gender and Human Rights Expert
4. Gad Runezerwa: Gender and Development Expert

After the approval of the inception report, the next two weeks were allocated to the field work in the 10 selected districts and interviews with project partners at central level as indicated in Table 3 below:

Table 3: Summary of the evaluation process

Date	Activity
7 – 14 November 2016	Development of the inception report
16 November 2016	Approval of the inception report (meeting on the inception report)
17 November 2016	Incorporation of inputs from the meeting
18 November 2016	Submission of the final inception report
18-22 November 2016	Interviews with key partners at central level Training of data collectors
23 November 2016	Interviews and focus group discussions with Remera –Rukoma Hospital and IOSC staff, key partners at district level, GBV victims and survey with local community members
25 November 2016	Interviews with Kanombe hospital and IOSC staff, key partners at district level, focus group discussion with GBV victims and survey with local community members
27 November 2016	Travel to Karongi, Rubavu and Nyagatare
28-29 November 2016	Interviews and focus group discussion with Kibuye, Gisenyi and Nyagatare hospital and IOSC staff, key partners at district level, GBV victims and survey with local community members
30 Nov- 01 December 2016	Interviews and focus group discussions with Kinihira hospital and IOSC staff, key partners at district level, GBV victims and survey with local community members

2 December 2016	Interviews with Kacyiru IOSC staff and survey with local community members
5 December 2016	Interviews and focus group discussion with Kinihira hospital and IOSC staff, key partners at district level, GBV victims and survey with local community members
6-13 December 2016	Preparation and submission of the draft evaluation report

III. FINDINGS

Findings are described in relation to the five standard evaluation criteria as defined by the Development Assistance Committee (DAC) of the Organisation of Economic Co-operation and Development (OECD): relevance, efficiency, effectiveness, impact and sustainability.

3.1. Relevance

Relevance is the extent to which the project is suited to the priorities and policies of the country (and to a lesser extent to those of the donor), the appropriateness of the project to the problems, needs and priorities of its target groups/beneficiaries, and the quality of the design through which the objectives are to be reached.

3.1.1. Consistency of the project objectives with GoR policies and strategies

The programme goal of the upscaling of the IOSC model is:

"changed attitudes and behaviour in relation to GBV and CA, GBV&CA crimes are reported and multidisciplinary services provided to victims and GBV &CA has reduced".

The programme goal is thereby consistent with the importance given by the GoR to reduce GBV and CA.GoR has shown a solid commitment to promoting gender equality and ending GBV and CA in line with existing related institutional frameworks. At the highest levels, the government has created policies and enacted laws to fight GBV and CA. It is a signatory to several conventions including the Universal Declaration of Human Rights (UDHR), the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW), the Sustainable Development Goals (SDGs), the UN Security Council Resolution 1325, the New Partnership for Africa's Development (NEPAD), Beijing Declaration and Platform of Action (BPfA), African Charter on Human and Women's Rights, Maputo Declaration to name a few.

Not only is the GoR's commitment shown in policies, strategies and plan, H.E. the President of the Republic and the First Lady have both repeatedly spoken against GBV and CA and have called for action.

The national policy against GBV of 2011 specifically mentions that "the existing One-Stop Centres provide critical support to victims of GBV and can be used as a model for integrated care and support. The One Stop Centres provide short-term emergency accommodation to victims who fear to return home or who need intensive support and time to come to terms with what has happened to them. Most of them do return to their family or community without delay and the Centre provides continued psycho-social support to them within their communities. This much-needed support also offers a chance for victims to access legal aid as part of an integrated package".

In Programme No.7 of the 2010-2017 7-year Government Programme, paragraphs 47 and 48 stipulate that One-Stop Centres will be put in place in every Community Health Centre, and that anti-GBV Committees at all levels will be empowered to totally eradicate GBV in Rwanda.

The national strategic plan against GBV (2011-2016) indicates that the Ministry of Health will lead the scale up of the One-Stop Centres.

The National Policy for Orphans and Other Vulnerable Children (2003) provides several strategies related to CA, including (i) reinforcement of the application of the law protecting children from abuse and exploitation, (ii) Provision of medical, social and legal assistance to affected children and (iii) Establishment of prevention and reporting mechanisms.

National Integrated Child Rights Policy (2016) states that abuse, exploitation and violence against children are intolerable. Children will be protected from abuse, exploitation and violence. Children will be protected in their homes, be it with or without parents; in schools, in communities; in their place of work; in prisons; in institutions; on the streets - wherever they may be.

It is the policy of the GoR to ensure that children's rights are met through the provision of basic needs and services for all children in the country, and protect them from abuse and exploitation.

The government will undertake specific measures for prevention of and response to sexual abuse through community based support mechanisms (such as the GBV/CP committees) that are appropriately linked to medical, legal and social support. Parents, guardians and caregivers have the obligation of protecting their children against all forms of abuse and whoever doesn't fulfil his/her obligation, will be brought to justice.

3.1.2. Consistency of the project objectives with other stakeholders' policies and strategies

The mandate of UN Women is to accelerate the United Nations' goals on gender equality and the empowerment of women. UN Women partners with Governments, UN agencies, civil society organisations and other institutions to advocate for ending violence, increase awareness of the causes and consequences of violence and build capacity of partners to prevent and respond to violence. It also promotes the need for changing norms and behaviour of men and boys, and advocate for gender equality and women's rights. UN Women supports expanding access to quality multi-sectoral responses for survivors covering safety, shelter, health, justice and other essential services. One of the UN Women programmes in Rwanda is to collaborate with other UN agencies such as UNFPA and UNICEF to provide holistic services to gender based violence survivors through one-stop centres. UN Women Rwanda will also play a key role in humanitarian assistance by providing technical assistance to prevent and respond to GBV in refugee camps.

Gender is an important cross-cutting issue in the multi-annual strategic plan (MASP 2014-2017) of the Embassy of the Kingdom of the Netherlands. It is observed that gender inequality remains a serious issue. Traditional patriarchal stereotypes regarding the role and responsibilities of women and men persist in the family and in the wider community, leading to violence against women and lack of educational and employment opportunities. Due attention will be given to gender based violence and the way police and legal aid institutions can become more efficient and sensitized on this subject. Outcome 4 of the MASP reads "improved human rights situation for vulnerable groups". One of the outputs is "support to the fight against Gender Based Violence in Rwanda in

close cooperation with UN Women, UNICEF and bilateral donors active in the theme (Germany and Belgium), focusing on sensitisation and training of the Rwandan police.

3.1.3. Response to the needs of the target groups

Before establishment of IOSCs, the hospitals that hosted GBV victims were facing a challenge of providing comprehensive and quality support to the victims. The issue remained a reality until the establishment of IOSCs that responded to the inequities and observed gaps in the hospitals in handling GBV cases.

It is evident that IOSCs, assessed as part of the evaluation, demonstrate significant broadness and scope of their objectives. IOSCs have broadly focused on service delivery to GBV victims through a holistic approach (multi-dimensional services at one centre), which is viewed by beneficiaries as a positive aspect of the overall model.

The multi-dimensional services offered to GBV victims include medical treatment, psychological support, legal services and social reintegration. Apart from the medical response that was provided in hospitals that hosted GBV programmes before the establishment of IOSCs, the three other services came as an added value to respond to the specific needs of GBV victims and abused children.

The relevance of IOSCs lies in the fact that GBV victims are provided with medical services to prevent from contamination of HIV/AIDS and other sexually transmitted diseases in cases of rape and unwanted pregnancies among others.

3.1.4. Intervention logic

The project is structured along three outcomes, each with two outputs, as shown in Table 4. In the project document, several activities are defined for each output.

Table 4. Overview of programme outcomes, outputs and activities

Programme outcomes	Programme outputs	Activities
Outcome 1: All GBV and CA victims/survivors in Rwanda including refugees have access to holistic and timely services through the OSC model	**Output 1.1:** Appropriate medical, psychosocial, forensic and legal services provided to victims/survivors of GBV and CAin line with established protocols	• Put in place at each IOSC a multidisciplinary team • Legal assistance to GBV and CA victims • Develop/update comprehensive guideline/protocols on prevention and response to GBV and CA • Set up follow up mechanisms for victims of GBV and CA
	Output 1.2: The Capacity of new and existing IOSCs and other service providers in prevention, delivery of integrated response and	• Harmonisation of MDIIT training manual • Review multi-disciplinary ISOPs • Set up 17 new IOSCs • Organise study tours for IOSC staff and technical team to learn best practices • Provide training on MDIIT and forensic evidence skills

	follow-up of GBV and CA strengthened	to the multidisciplinary team and technical staff for forensic investigation • Provide performance-based contracts to 3 additional staff to speed up handling and follow-up of GBV cases
Outcome 2: GBV and CA cases are reduced through changed attitudes and behaviour among communities and institutions	**Output 2.1:** Awareness and knowledge of community members on how to prevent respond to and monitor GBV and CA increased	• Develop and disseminate information and communication material on GBV and CA for awareness raising • Conduct intensified anti-GBV and CA public awareness campaigns • Provide incentives to community structures for prevention and response and timely reporting of GBV and CA cases • Develop and conduct awareness raising programmes targeting GBV and CA perpetrators • Set up annual awards for districts for their outstanding performance in addressing GBV and CA • Train media representatives on GBV and CA prevention and timely reporting • Train men and boys as change agents to prevent and respond to GBV and CA • Set up toll free hotlines to report GBV cases in all IOSCs • Conduct training on GBV, human rights, gender roles, gender quality and empowerment of women
	Output 2.2: Social reinsertion systems for GBV and CA victims/survivors is improved at community and refugee camps levels	• Support reinsertion of most vulnerable victims within community through vocational training, start-up tools, micro-finance, etc.
Outcome 3: An effective management and coordination system for GBV and CA is strengthened at all levels	**Output 3.1:** Management systems for IOSC strengthened	• Conduct baseline survey on GBV an CA in the country • Develop integrated preventive measures and communication strategy according to baseline data findings on GBV, domestic violence and CA • Support creation of centralised GBV and CA data collection and information management system for all IOSC • Train IOSC staff on the use of data collection, management and reporting
	Output 3.2: Coordination strengthened at national and decentralized levels for effective OSC delivery	• Organise coordination meetings at national level for the SC and TC • Organise national launching of IOSC • Equip the technical staff with laptop and communication fees • Hiring of a national coordinator • Conduct a project audit • Conduct endline evaluation • Train partners on project management and UN

		reporting system

The programme logic is quite comprehensive and well structured. The division in three outcomes is logical: (i) comprehensive care to victims, (ii) reduction of GBV & CA and (iii) effective management and coordination.

On the other hand, the programme is a mix of two fundamentally different elements:

1. Project elements. These are temporary activities necessary for the initiation or establishment of an expanded network IOSCs. This is the core of the project: scaling up the IOSC model. Examples of this type of activities are recruitment, induction and training of staff, rehabilitation of infrastructure, purchase of basic equipment.
2. Recurrent elements. These are activities that are not limited to the scaling-up phase of the programme, but will continue for as long as the IOSCs are operational. Examples of this type of activities are support to reinsertion of victims, annual awards, data collection and dissemination. Topping up of staff also belongs in this category.

The mix of project and recurrent elements is an indication that the system of IOSC is not (yet) fully integrated in national structures and is seen as an external project, with an externally funded project staff and recurrent costs funded by the project.

3.1.5. Risks and mitigation

In the project document, several risks were identified:

Delay in start up

As elaborated below (Section 3.2.1) this risk materialised. The project started with an effective delay of seven and half months and ended 13 months later than anticipated. The mitigation measures to maintain regular contact with stakeholders and implementing partners did not prevent the delays, but prevented further delays in the course of programme implementation.

Limited capacity of IOSC staff and services not accessible

Mitigation measures of capacity strengthening and awareness raising were effective. The capacity of the IOSC has reached a satisfactory level and services are easily accessible.

High IOSC staff turnover

The mitigation measure was to extend training on GBV and CA to a wider selection of staff to assure an adequate pool of trained staff.

Deep seated gender norms and stereotypes impede target groups' receptivity to awareness activities

The project aimed to engage men, boys and FBO leaders to make them partners and champion in changing mind sets and increase awareness on human, children's and women's rights.

Stakeholders not willing to share information and lack of complete data on GBV

To mitigate this risk, the project set up a systematic information system

Involvement of key stakeholders involved in the design process

Four government institutions (the Ministry of Health, Ministry of Gender and Family Promotion, Ministry of Justice and Rwanda National Police) were involved in the project design process on one hand and the Netherlands Embassy and UNwomen on the other. However, consultations revealed that involvement of stakeholders was done at central level but failed to consider the role of the implementing partners including the district and hosting hospital. More importantly was the lack of the voice of GBV victims, men and women, which would serve to mainstream gender and human rights dimension in the designing of the project. This limited the level of ownership of the IOSC programme by concerned implementing partners and beneficiaries.

3.2. Efficiency

Efficiency measures the outputs, qualitative and quantitative, in relation to the inputs.

3.2.1. Timeliness of implementation

The project followed a phased approach, with four financial tranches.

The project was scheduled to run for 24 months, from 1 December 2013 until 30 November 2014. However, the project started with a series of delays. Programme funds were transferred to UNWomen from One UN in March 2014 and the last government institution signed the project document only in June 2014. This in turned delayed the recruitment of the project coordinator, so effectively the project started on 14 July 2014. With a delay of seven and half months. Because of the delays, a no-cost extension of 13 months was granted, up to 31 December 2016.

Delays in terms of transfer of budget from UNwomen/Ministry of Health to IOSCs were highlighted, through consultations, as another challenge.

It was also noted that the baseline survey was only conducted in 2015 (baseline report: August 2015). This can hardly be considered a baseline, as it was conducted close to the original end date of the programme.

3.2.2. Cost efficiency

The progress report 2014 outlines the following delivery rates:

1. Delivery rate in terms of the funds received by UNWOMEN (718,192 USD): according to reports from Implementing Partners (IPs), the delivery rate excluding committed funds is 45% and the delivery rate including committed funds is 62.35%. That is out of 718,192 USD received, 323,835 USD were fully spent (giving 45%) and when we include the committed funds we have 447,804 USD spent and committed (giving 62.3%).

2. Delivery rate in terms of IPs capacities to deliver: Partners received from UNWOMEN a total sum of 472, 313.60 USD and have spent 253,262 USD (giving 53.6% without committed funds) and when we include committed funds of 123,969 USD (we have 79.9%). (See tables below).

The funds received as the first instalment payment were for the following planned activities that can be grouped under the following categories:

- Studies and capacity building activities;
- Sensitization and awareness creation on the ill effects of GBV and CA;
- Direct support to GBV and CA victims;
- Improvement of the capacities of the IOSCs to provide quality services timely
- Improve the coordination and management of the IOSC Program activities in the country.

Table 5 gives a breakdown of the funds received by One UN in 2014. Table 6 shows how the funds disbursed by One UN were used by the IPs.

Table 5. Use of Funds received by One UN in 2014

Description	USD
Contribution received by One UN Fund	725,447
1% Administrative Agent's fee	7,254
Amount received by UN Women	718,192
7% management costs	50,273
Balance	667,919
Amount disbursed by UN Women to IPs	472,314
Funds used by UNWOMEN for training of IPs	20,000
Balance remaining with UN Women	175,605

Table 6. Use of funds by Implementing Partners in 2014

Implementing Partner	Amount Received (USD)	Amount Spent (USD)	Funds committed (USD)	Balance without committed funds	Bank balance including committed funds
MIGEPROF	104,347	17,718	45,713	40,917	86,630
MINIJUST	45,801	45,758		423	43
Ministry of Health	196,129	151,033	43,377	45,096	1,719
Rwanda National Police	126,037	39,053	34,879	52,104	86,983
Total	**472,314**	**253,562**	**123,969**	**138,159**	**175,374**

The delivery rate at the end of December 2015 was up to 82.68% and the breakdown of expenditures is presented in Table 7 below. Table 8 shows how the funds disbursed by One UN were used by the IPs.

Table 7. Use of Funds received by One UN per 31 December 2015

Description	USD
Contribution received by One UN Fund	3,099,638
1% Administrative Agent's fee	30,996
Amount received by UN Women	3, 068,643
7% management costs	214,805
Balance	2, 853,838
Amount disbursed by UN Women to IPs	2, 406,502
Funds used by UNWOMEN for IOSC official launch, IP training, Programme Monitoring and programme audit	206,712
Balance remaining with UN Women	240,624

Table 8. Use of funds by Implementing Partners in 2015

Implementing Partner	Amount Received (USD)	Amount Spent (USD)	Funds committed (USD)	Delivery rate
MIGEPROF	365,425	316,093	49,333	86.50%
MINIJUST	150,424	150,424	0	100%
Ministry of Health	1,516,809	1,418,217	98,593	93.50%
Rwanda National Police	373,844	268,190	105,654	71.74%
Funds not yet transferred to IPs	447,336	206,712	240,624	
Total	**2, 853,838**	**2,359,635**	**494,203**	**82.68%**

Financial management by UN Women has been efficient. As the fund management agency, it has been keeping funding of each IP until it reached a delivery rate of at least 80% before releasing a new instalment. All funds have been audited annually. All financial audits have been clean, except for one case when one of the IPs was not able to provide all supporting documents on time. Although this resulted in a qualified audit, the documents were produced later, showing that there were no irregularities in the use of project funds.

By far the largest share of the budget was allocated to MoH. This is in line with the major budget items that were implemented by MoH: rehabilitation of infrastructure, equipment for the IOSCs, staff top-ups, training, and support to reinsertion. It is noteworthy that contracted IOSCs facilities were not equally equipped. Much as the majority of visited IOSCs have similar structures in terms of physical facilities some have two safe rooms for men and women others do not have. Consultations rooms are generally occupied by medical doctors but in some IOSCs they are shared with GBV Officers/Coordinators. The evaluation team did not have the expertise to assess value for money of construction works, but could verify that infrastructure was rehabilitated as planned and is in full use. It is worth mentioning that gender dimension was taken into account in rehabilitation activities as the bulk of IOSCs have two safe rooms one for males GBV victims and another for females. Gender was also considered in recruitment of police officers as there is a couple of staff, one male and one female, to ensure privacy, confidentiality and safety of GBV victims.

Some observations in relation to value for money are:

- For each IOSC, printer/copiers are budgeted at USD 5,162 each. This seems high and results in a budget of USD 118,726 on printer/copiers only;
- For study tours, tickets to Europe and per diem were budgeted at USD 2,300 and USD 300 each, which seems high.

The evaluation team further has questions about the performance contracts (top-ups) with three staff at each IOSC. On the one hand there is a feeling of frustration among the staff who do not receive hardship allowance and communication fee as the latter are only allocated for the positions of GBV Officer and the two Police Officers. On the other hand there is an issue of sustainability, which is elaborated in Section 3.5.2.

Another important issue was observed under the budget component of 'support to the most vulnerable GBV victims'. It was realised that no criteria to determine the most vulnerable GBV victims were established. The most critical gap observed in terms of budget implementation was that the bulk of the disbursed budget was more on response to GBV cases than prevention. As matter of fact no budget line was planned for raising awareness and disseminating IOSCs' services among the district communities. This was also highlighted during consultations with different resource persons.

3.2.3. Monitoring of activities

The Ministry of Gender and Family Promotion serves as the Overall National Coordinator of IOSCs while the Ministry of Health and Rwanda National Police jointly coordinate the implementation. The Ministry of Health receives information from IOSCs through the hospital data management system (HMIS) that organises data from grassroots level to the central level. The police staff report directly to the National Coordinator of IOSCs within the Rwanda National Police. However, there is a coordination gap between the central and decentralised levels given that the district, which is supposed to coordinate interventions implemented within its circumscription, does

not have a room within the above-mentioned reporting channels. This was highlighted during consultations with different resource persons at district level.

Monitoring of activities in line with IOSCs remains a challenge. In fact, there is lack of harmonisation of used indicators by the different IOSCs visited and stakeholders, districts included, which impacts on recorded and reported data both at decentralised and central levels.

As shown in Section 3.1.4 above, the programme was structured in a logical framework, with indicators at output level. The indicators are mostly SMART (specific, measurable, assignable, realistic and time-related).

Unfortunately, the study to establish the baseline for the indicators was only done in 2015 (report August 2015), which means that the baseline data was established when the project was more than halfway, rather than at the start. This makes it virtually impossible to measure the change that can be attributed to the project.

In the 2014 report, progress was reported by Outcome and output. In the 2015 progress report the indicators were used for reporting progress.

3.3. Effectiveness

Effectiveness measures the contribution made by the project's results/outcomes to the achievement of the project purpose.

3.3.1. Achievement of planned results

A sizable number of planned interventions have been implemented as planned. They include rehabilitation of physical structures of IOSCs, staffing of IOSCs, fees for hardship allowance and communication for GBV Officers and Police Staff, follow up mechanisms and support for the most vulnerable GBV victims.

The main achievements reported in 2014 were as follows:

1. Improved capacity of 11 IOSCs to provide multidisciplinary services to GBV and Child Abuse victims;
2. Increased access of 2,263 GBV and CA victims to multi-disciplinary services;
3. Increased access of nearly 400 Most Vulnerable Victims (MVVs) to legal services;
4. The process of the development of comprehensive guidelines/protocols on the prevention and response to GBV and Child Abuse in Rwanda launched;
5. Increased sensitivity of over 20,000 women, men, boys and girls on the ill effects of GBV and Child Abuse;
6. Enhanced awareness and knowledge of community members on how to prevent and respond to GBV and CA as well as on early detection of GBV and child abuse incidents through a two months country wide campaign on GBV and child abuse;
7. Increased sensitivity of over 1,000 female and male GBV and Child Abuse perpetrators on the ill effects of gender based violence and child abuse;

8. The process of engaging men and boys as change agents launched;
9. Strengthened coordination and management of the IOSC Program;
10. Improved capacities of implementing partners on results based management (RBM).

The achievements reported in 2015 are given in Table 9.

Sections 3.3.2 to 3.3.4 will analyse the achievements of results per outcome, using information collected through surveys and consultations as part of the evaluation.

Table 9. Achievements reported in 2015

Programme outcomes	Programme outputs	Indicator	Baseline	Targets	achievements
Outcome 1: All GBV and child abuse victims/survivors in Rwanda including refugees have access to holistic and timely services through the OSC model	**Output 1.1:** Appropriate medical, psychosocial, forensic and legal services provided to victims/survivors of GBV and child abuse in line with established protocols	Number of victims/survivors and refugees, disaggregated by sex and age receiving medical, psychosocial, forensic, and legal services	372 (Gihundwe OSC in 2013)	8,555 victims (for 23 district hospitals)	6,649 GBV and CA victims of have accessed appropriate medical, psychosocial, forensic and legal services from IOSCs and among them 92% are women.
		Number of alleged perpetrators of GBV and Child Abuse that are taken to court, including perpetrators of violence against refugees, disaggregated by age and sex.	6,840 perpetrators in 2011	10% increase	2,513 GBV and CA cases were brought to court in 2015. Among those 1,338 are for minors. These cases combined with the ones registered in 2014 totalling 1990, give a total of 4,503 cases which have been brought to court from the start of the programme to December 2015
	Output 1.2: The Capacity of new and existing OSCs and other service providers in prevention, delivery of integrated response and follow-up of GBV and Child Abuse strengthened	No. of people trained on MDIIT model disaggregated by sex and age	105	294	In 2015, 90 service providers including police officers, GBV officers, Social workers and psychologists have been trained in Multidisciplinary Investigative and Intervention Team (MDIIT) model making a total of 195 staff trained.
		No. health facilities supported with the establishment/ renovation and stocking of OSCs supplies	2	23	16 IOSCs were established namely IOSC Butaro, Gakoma, Gihundwe,Kabgayi, Kacyiru, Kigeme, Kinihira, Muhororo, Ngarama, Nyagatare, Nyanza, Rwamagana, Ruhengeri, Kibungo, Kibuye and Kinazi.
		Number of IOSCs adequately equipped according to standards	2	23	16 established/upgraded IOSCs were fully equipped and multidisciplinary team available to provide holistic services to GBV&CA victims making 69.5% of the total IOSCs to be established under this programme.
		No. of refugee camps with access to OSCs	**1**	**6**	4IOSCs provide GBV&CA services to refugees in addition to the host community.

					These are: IOSC Gakoma, Nyanza, Kibuyeand Kigeme. Initially IOSC Gisenyi was also providing services to Congolese refugees when they were still in Nkamira transit centre before being shifted to Kigeme and Mugombwa.
Outcome 2: GBV and child abuse cases are reduced through changed attitudes and behaviour among communities and institutions	**Output 2.1:** Awareness and knowledge of community members on how to prevent respond to and monitor GBV and Child Abuse increased	GBV& child abuse knowledge products	**No**	**Yes**	A document entitled "Isange Rwanda's Holistic Approach to Gender Based Violence and Child Abuse" was produced in 2015 that explains How the Isange One Stop Centre came about and its role in GBV response and prevention. In addition, SOPs and GBV guidelines were also produced as guiding tools for GBV service providers countrywide In addition, a training module "Nozimibanire" (Improve your relationship) was also produced and utilised for engaging men in GBV&CA prevention and response.
		Number of victims/survivors (including refugees) of sexual violence disaggregated by age and sex seeking emergency contraception STDs and HIV post-exposure prophylaxis within 48 hours.	F: 949; M: 65 (2013 – 8 months)	25% increase	4543 victims of sexual violence (4,405 females and 138 male) have been provided with emergency PEP in 2015 making 68.3% of the total victims who sought services at IOSCs in 2015 but more than three times the programme target when looking at 2015 data only but it is more than five times when combined the 2014&2015 data.
	Output 2.2: Social reinsertion systems for GBV and child abuse victims/survivors is improved at community and refugee camps levels	Protocols on social re-insertion of victims established	No	Yes	In order to avoid duplication, the reinsertion process follows the existing social protection protocols mainly that of Ubudehe programme
		No. of victims of GBV and child abuse disaggregated by age and sex appropriately	0	30%	1,054 victims of GBV and CA have been visited and discussions on strategies with local authorities to ensure that the most vulnerable victims are not re-victimised were

		reintegrated			held. As a result, 824 Victims have been identified as the most vulnerable and were provided with socio economic support in line with government pro-poor programmes including health insurance, cows, pigs, goats, start-up capital and school material and school fees for children in schools. The makes 78.2% of all the victims follow up by the IOSCs social workers.
		Extent to which survivors/victims are satisfied with reintegration package	**0**	60% of reintegrated victims	The perception survey has not yet been conducted
Outcome 3: An effective management and coordination system for GBV and child abuse is strengthened at all levels	**Output 3.1:** Management systems for IOSC strengthened	IOSC baselines established through survey in year One	No baseline	Baseline available	The baseline was conducted in 2015
		Database for collection management of data on GBV are in place and used	0	23	The IOSCs use the Health Management Information system (HMIS)
		Proportion of partners who signed and implementing the SOPs	0	80%	16 IOSCs (69.6%) use SOPs for standardization of procedures and service delivery.
	Output 3.2: Coordination strengthened at national and decentralized levels for effective OSC delivery	No. of coordination meetings conducted per year	1national, 0 decentralised	2 national, 2 decentralized	2steering and five technical committee meetings were held in 2015 at central level while at decentralised level, 2meetings were also held one with district hospitals during the joint field visit and another one during the advocacy campaign bringing together community members, central and local government officials, security organs such as police, army and District Administration Security Service Organ (DASSO) to discuss on how to prevent and respond to GBV and CA and early detection of GBV and child abuse incidents.
		OSC Communication strategy in place	Not existing	Communication strategy in place	SOPs and GBV guidelines have been produced
		No. joint monitoring visits per year	2	2	One Joint monitoring field visit has been conducted

3.3.2. Achievements of Outcome 1

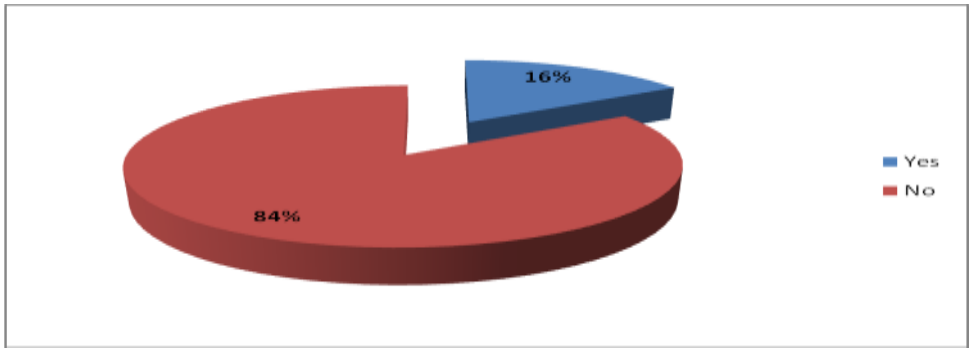
Outcome 1: all GBV and CA victims/survivors in Rwanda including refugees have access to holistic and timely services through the IOSC model.

Important achievements in line with this outcome have been registered. They include:

(**1) GBV awareness of the general population** probably due to the synergised efforts among the different stakeholders, IOSCs included, in anti GBV campaigns. Based on the findings from the survey, it was found that a very significant number of surveyed populations within the ten selected districts (91.5%) were found to have a good understanding of GBV and can differentiate it from other forms of violence. This GBV awareness is an excellent opportunity to facilitate access to IOSC though it would be difficult to assess exactly the extent to which ISOCs have contributed for this level of awareness.

However, much as the general population proved to be aware of GBV and related issues, it was found that a significant number of respondents (84%) in the survey were not aware of the existence of IOSC in their districts, as illustrated by Figure 1 below.

Figure 1 Awareness on existence of IOSC



The limited awareness on the existence of IOSCs is also confirmed by the level of which GBV victims can use IOSCs when seeking assistance as shown in Figure 2 below.

Figure 2. Representation of channels likely to be used by GBV victims for help as perceived by respondents.

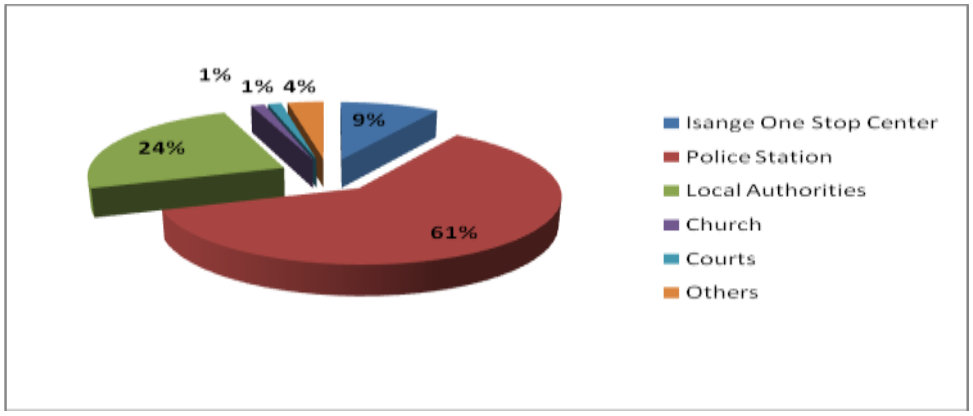


Figure 2 indicates that most GBV victims are likely to seek assistance from the police. This has been confirmed during focus group discussions with GBV survivors, most whom reported that they came to IOSC as referred by the police station from their community. This led to the observation that most GBV survivors prioritise justice over their health status. Consequently, this reduces their chances to get medical evidence which is very critical to facilitate courts procedures. Also, the delayed arrival at IOSCs limits the chances of prevention against HIV/AIDS and other sexually transmitted diseases and unwanted pregnancies among others.

(2) Access to holistic and timely services through IOSCs

Concerning access the latter is constrained by the long distance to be covered by GBV victims as so far the established IOSCs are hosted in district hospitals which are generally located far from populations residing in different sectors making the district. Additionally, the channel mostly used by the GBV victims to seek help, which is the police, prevents them from directly accessing medical assistance which they mostly need for preventive measures. Equally important is the issue of limited staff in IOSCs. So far only three staffs including two police officers and one GBV officer, are permanently employed in IOSCs. The others including medical doctor and psychologist/Mental Health Officer are appointed to IOSCs but spend more time in attending to other patients in the hospital. Equally important is the Legal Officer who so far has not been recruited or appointed across the visited IOSCs. To bridge the gap of Legal Officer some IOSCs are working closely with the MAJ staff to address legal matters. For some other IOSCs collaboration with MAJ staff remains inexistent. Due to this absence of Legal Officer in IOSCs GBV and the limited collaboration between IOSCs and MAJ, GBV and CA victims are generally happy with the medical and psychological assistance they get but are very frustrated given that access to legal services that remains a daunting challenge for them.

It is worth mentioning that though GBV and CA victims are generally happy with the provided medical and psychological assistance, there is still the issue of medical evidence that requires a special attention. In fact, medical expertise has so far failed to prove the link between the proved evidence and the suspected perpetrator. This is one of the major factors leading to rather proving the suspected perpetrator innocent. According to focus group discussion with GBV victims, this kind of situation is very frustrating to the and it does not end there as it affects the rest of the community members who opt for not reporting GBV and CA cases as they realize that perpetrators are not punished for the crimes they committed. Based on the above it appears that access to holistic and timely help as needed by the GBV victim remains unsettled challenge.

3.3.3. Achievement of Outcome 2

Outcome 2: GBV and CA cases are reduced through changed attitudes and behaviour among communities and institutions. As shown in Table 10 below cases of GBV as baselines varied between 1.5% and 11.7% for very high, 2.2% and 16.7% for high, 18.8% and 26.5% for low, 17.3% and 27. 5 for very low and 27.8% and 53% for none.

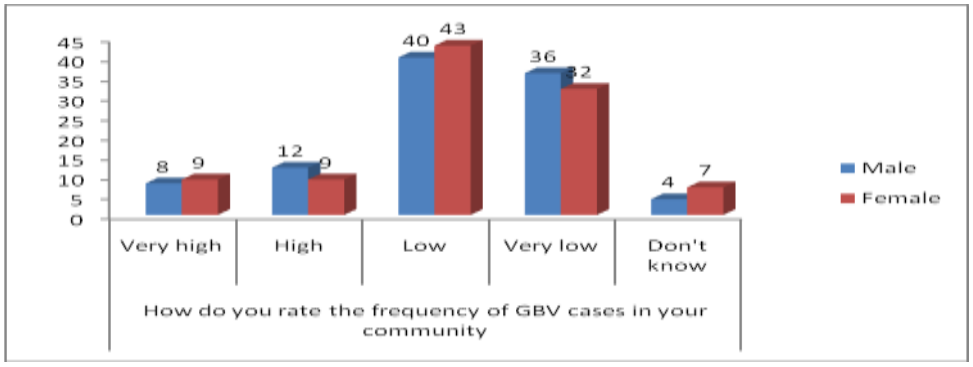
Table 10. Level of GBV and CA in the community (Baseline 2015)

Level of GBV in the community	Respondents perceptions on GBV types awareness					
	Very high	High	Low	Very low	None	Total
Hitting as a GBV in the community	11.7%	15.2	26.5	18.8%	27.8%	100%
Insult as a GBV in the community	7.3	16.7	26.5	17.3	32.1%	100%
Rape as a GBV in the community	3.7	6.0	22.0	26.2	42.1%	100%
Resource deprivation as a GBV in the community	4.3	13.8	25.0	21.3	35.5%	100%
Restrictions/denial of freedom as a GBV in the community	2.8	7.3	23.0	23.5	43.3%	100%
Sexual deprivation as a GBV in the community	3.5	6.7	19.5	17.3	53%	100%
Isolation from friends as a GBV in the community	2.5	3.3	20.0	23.7	50.5%	100%
Early marriage as a GBV in the community	1.5	4.8	19.2	27.5	47%	100%
Forced marriage as a GBV in the community	0.8	2.2	18.8	26.7	51.5%	100%

Source: Baseline survey primary data 2015

As per the current status, cases of GBV are perceived as very high at the rate of 9%, high at 10%, very low at 34%, low at 41% and 6% for Don't know, as shown in Figure 3 below.

Figure 3. Prevalence of GBV in the community



Observation from the baseline and the current situation on cases of GBV indicate that GBV in general remains present in the community. Figure 4 below confirms the existence of GBV cases in the community as it portrays lived realities from perceptions by answering to the question of knowing whether the respondent has heard or met a GBV victim.

Figure 4. Cases of GBV and CA heard or met

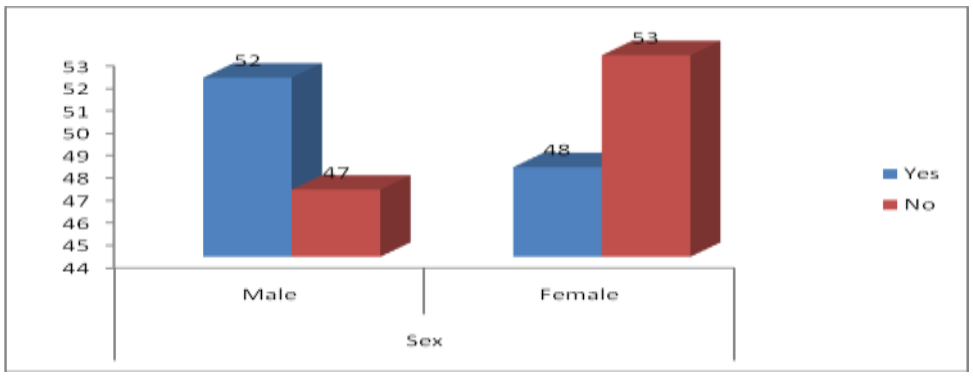


Figure 4 shows that cases of GBV are still high considering that ideally nobody should be subjected to GBV or CA. It is noteworthy that women are among the majority of GBV victims as perceived by the surveyed population. In fact, 50% of respondents said that the GBV victims heard or met were females while males GBV victims represented 13%. Discussions held with both male and female GBV victims highlighted that even though males remain the minority among the GBV victims very few of them are reported. Interesting enough is that even though women remain the majority among the GBV victims, they are less informed about cases of GBV compared to men as indicated in Figure 4.

So no change as such has taken place due to the following major reasons as stressed during consultations with different resource persons: firstly attitude and behaviour fuelling GBV are still alive among the communities. This is illustrated by the culture of silence around GBV issues especially when they involve family members. GBV victims mostly women fear reporting a relative or husband to protect the name and unity of the family and to some extent to avoid economic implications that may arise from the husbands' imprisonment. This is a very important gender issue that starts with the socialization process that dictates young females to suffer in silence when they are married (e.g. when beaten by the husband) to avoid family dislocation. Another gender aspect in this is the economic dependence of females upon males, which again

sustains domestic discrimination of which females are majority among the victims. Another gender issue is the fact that very few men are reporting their cases as GBV victims to avoid stigmatization by other men who would look at them as not real men. So they prefer to hide their cases and suffer in silence for the sake of manhood. Secondly the issue of impunity of GBV perpetrators is discouraging reporting GBV cases as the GBV and CA victims feel it is a waste of time.

In refugee camps, it was found that two major reasons are underlying cases of GBV and CA. Firstly the style of their housing, very closed and small houses, which is leading to promiscuity that fosters GBV cases especially rape leading most of time to unwanted pregnancies for both female adults and minors victims. Secondly the culture of 'reconciliation' among the GBV perpetrator and GBV and CA victim is constraining reporting which affects mostly the victim who powerlessly suffers the consequences.

3.3.4. Achievement of Outcome 3

Outcome 3: an effective management and coordination system for GBV and CA is strengthened at all levels. In terms of programme management, MIGEPROF is the coordinating body from the Government and has one IOSC programme Coordinator who is managing the project on daily basis while the other IPs have IOSC focal points who ensure the programme management and coordination. The capacity of IOSC programme staff in Result Based Management (RBM) has been enhanced through a five-days refresher training in RBM held in May 2015 which was attended by 35 staff working in IOSCs, as highlighted in the donor report, January-December, 2015. The training aimed to help programme staff ensure timely and quality programme management and reporting. It was also a good opportunity for IOSC staff to share experiences of addressing GBV and CA challenges using RBM approaches.

It is noteworthy that the Steering Committee bringing together the Implementing Partners and the Donors meets four times per year as reported by the National Coordinator of IOSCs. However, the reality in the field reveals that there is no reporting link between IOSCs and MIGEPROF together with MINIJUST. The coordination mechanism between IOSCs, districts and other stakeholders both at central and decentralized levels is not clear. Consultations revealed that the overall coordination is operating at central level dealing with IPs but there is no link between the central level and the decentralized level.

At the level of IOSCs it is important to mention that the fact that they are embedded within the district hospitals provides basis for easy management and coordination. However, there is a common issue, except the IOSC of Kacyiru, which is the uncompleted structure that affects both the management and coordination of the project implementation. In fact according to the planned structure the following staffs were supposed to be in place: Coordinator, Medical Doctor, GBV Officer, Police (2 staffs), Legal Officers (2), Psychologist/Mental Health and Social worker. It is worth mentioning that due to shortage of medical doctors in the country, one doctor from the existing staff of the hospital is appointed to IOSC to serve whenever needed but he/she is not a fulltime staff member one of IOSC. So far only the GBV Officers and two police officers are employed in IOSC on fulltime basis. Others are outsourced from the hosting hospital which is affecting the response time for the GBV victim as they are expected to attend to other cases of patients in the hospital.

Concerning the management of IOSCs project the following were observed as major obstacles: firstly limited communication between the IPs at central level and IOSCs. For example the three staffs in IOSCs are not informed about the reasons underlying the delayed transfer of hardship staff allowance and communication fee. This delay affects their performance and thus impacts on achievement of planned results. Secondly no single planning tools (e.g plan of action) associated with the outcomes of the project was in place. Their activities are more informed by GBV and CA victims who daily approach them for help. Given the above management and coordination of IOSC project remains a serious challenge.

3.4. Impact

Impact is defined as the effect of the project on its wider environment (change). This involves effects resulting from the project on the local social, economic, environmental and other development indicators. Note that these effects can be both intended and unintended, as well as positive and negative.

3.4.1. Changes caused by the project

The IOSCs project brought in a series of changes including the new services offered by hosting hospitals such as police and strengthened counselling. Much as all the needed staffs have not been in place but the few working in IOSCs have changed the old structure of concerned hospitals. Also the rest of hospital staffs are aware of the newly provided services through ISOCs and are informing their neighbours on the existence of the mentioned services.

3.4.2. Effect of the project on the beneficiaries

The IOSC project has impacted on beneficiaries' lives due to the combined services offered in one place. In fact GBV and CA victims have received preventive treatment to avoid HIV/AIDS and other sexually transmitted disease as well as unwanted pregnancies which was an important change positively affective their lives both for victims and communities as this was not done before. Beneficiaries have a new image of police within IOSCs who are more perceived as protectors and care givers compared to the police outside IOSCs perceived as custodians of punitive measures for committed crimes.

3.5. Sustainability

Sustainability is the likelihood of a continuation of benefits produced by the project after the period of external support has ended.

3.5.1. Affordability of services/results at the completion of project

The main investment by the project was rehabilitation of infrastructure and equipment for the IOSCs. Once the project is finished there is no immediate need for further investment. Since the investments were made in existing infrastructure, owned by the local government and supported by the MoH, it is expected that the investments can be maintained as part of regular maintenance by the mentioned institutions.

Another project activity was staff training and community sensitisation. Since the staff trained is government-employed personnel, it is expected that these staff will continue to operate at the IOSCs and the investment in people can be sustained.

Other payments by the project include staff top-ups and support to reinsertion. These are expenditures that are not part of regular government procedure and their continuation is doubtful.

3.5.2. Embedding in local structures

The project of upscaling of IOSCs was implemented by four government institutions, and all interviewed staff members at the headquarters and at the IOSC are confident that the system of IOSCs is therefore fully integrated in the government structure. The evaluation team does not fully agree with that observation. While the upscaling project is a joint operation, that cannot be said yet of the IOSCs is fully integrated within the hosting hospital. The upscaling is managed like a project, with a project coordinator, project funds and typical project expenses, like top-ups. The IOSCs as such are integrated in district hospitals, but they are not yet fully integrated in the government structure, including the government budget. Positive steps were made, but in a next phase still more emphasis is needed to make the IOSCs, and their coordinating nature, part of a permanent management structure.

IV. THEORY OF CHANGE

The IOSC project theory of change was uncovered as inspired by the mentioned project outcomes which show the expected change and the how to achieve it. In fact the IOSC project came as a response to the issue of high incidence of GBV and CA as reflected in Outcome 1: All GBV and child abuse victims/survivors in Rwanda including refugees have access to holistic and timely services through the OSC model. The expected main change of the IOSC project is reflected into Outcome 2: GBV and child abuse cases are reduced through changed attitudes and behaviour among communities and institutions. This outcome is embedded with both needed change "GBV and child abuse cases are reduced" and ways or strategies to attain it "changed attitudes and behaviour among communities and institutions". Other strategies to achieve the above mentioned change are included in the Outcome 3: An effective management and coordination system for GBV and child abuse is strengthened at all levels.

In a nutshell the above three outcome reflect the theory of change[1] which inspired the IOSC project under assessment. The framework below provides details on the different components making the theory of change within the context of IOSC project.

Problem areas to be addressed		**Impact**
▪ Majority of Rwandans between 15-49 years have experienced physical and sexual violence (DHS 2010) ▪ Reported sexual violence cases are domestic (intimate) in nature ▪ Of all abused women, only 42% seek help while the majority remained silent. 53% of women survivors of violence seek help from neighbours, 22% seek help from their family, 21% from others (health centres, hospitals etc.); only 7% go to the police ▪ Most survivors of GBV do not access comprehensive services like the psychosocial, health, justice, security ▪ Most of the perpetrators go unpunished ▪ Limited collaboration and coordination among the key stakeholders (police, health, legal, community)		▪ Decreased incidences of GBV and CA ▪ Changed attitudes and behaviours among community members and institutions.
		

[1] This Theory of Change did not exist in his form, but was constructed by the evaluation team, based on literature review, exchange with project stakeholders and internal discussion.

Causes		Outcomes
▪ Communities are not sensitised on prevention and response to gender and sexual violence as well as its punitive consequences ▪ Cultural and religious beliefs sustaining unequal power relations/inequalities between men and women ▪ Negative masculinity ▪ Misunderstanding of gender and human rights principles ▪ Limited knowledge of law and rights ▪ Alcoholism		▪ Increased number of reported cases of GBV and child abuse including those in refugee settings ▪ Increased knowledge of the court procedures and processes at the community levels ▪ Effective coordination of all stakeholders in the area of prevention and response to GBV and CA ▪ Increased numbers of GBV and CA perpetrators brought to court and their cases concluded including giving remedies to survivors ▪ Created communities networks to prevent and fight GBV and CA ▪ Increased numbers of survivors re-inserted into their communities.
Assumptions ▪ Negative attitudes and lack of knowledge will be reversed through targeted sensitisation ▪ More perpetrators are brought to justice and are convicted due to the holistic approach of the IOSCs ▪ More GBV and CA victims report and seek care, because IOSCs provide a more conducive environment ▪ Survivors can re-integrate in the community after treatment and having reported their cases ▪ Sensitisation, together with more effective application of the law, results in reduction of GBV and CA		

Looking at the designing and implementation of the IOSC project, it appears that the above Theory of Change was not followed as such. In fact more efforts were put on response and less attention was accorded to causes of GBV and CA. This can be seen through limited prevention related interventions as compared to response. For example, the breakdowns of budget sent to visited IOSCs indicate that money was solely used for hardship allowance and communication for concerned IOSC staff, follow up mechanisms and support to the most vulnerable victims. Nothing was planned for prevention activities which would play a pivotal role in addressing causes underlying GBV and CA. Apart from the fact that limited attention was given to causes of GBV and CA, it is worth noting that it is too early to expect an impact resulting from the implementation of IOSC project given that it started in 2014.

V. CONCLUSIONS

5.1. Relevance

The project is highly relevant to the policies and strategies of the GoR. IOSCs are mentioned by name in the national policy against GBV of 2011 as critical support to victims of GBV and to be used as a model for integrated care and support.

The project is equally relevant to the mission of UN Women and One UN. The mandate of UN Women is to accelerate the United Nations' goals on gender equality and the empowerment of women and it has been supportive of IOSCs to provide holistic services to gender based violence survivors.

The project is also relevant to the donor, the Government of the Netherlands, as it deals with human rights and the support to vulnerable people. The Netherlands is especially supportive of including the justice aspect in the IOSC. It contributes to prevention and prosecution of perpetrators.

The project directly responds to the needs of the target groups, victims and survivors of GBV and CA. The multi-dimensional services offered to GBV victims include medical treatment, psychological support, legal services and social reintegration.

The programme logic is quite comprehensive and well structured, but contains a mix of project elements and recurrent elements. This is an indication that the system of IOSC is not (yet) fully integrated in national structures, with externally funded project staff and recurrent costs funded by the project.

5.2. Efficiency

The project has suffered some delays, especially at the start. There was an effective delay of seven and half months. Therefore a no-cost extension of 13 months was granted. After the initial delays the project picked up a fair speed.

Financial management by UN Women has been efficient. As the fund management agency, it has been keeping funding of each IP until it reached a delivery rate of at least 80% before releasing a new instalment. All funds have been audited annually, mostly resulting in clean reports.

Monitoring of activities turned out challenging. The study to establish the baseline for the indicators was only done in 2015. The evaluation also noted a lack of harmonisation of used indicators by the different IOSCs visited and stakeholders, districts included, which impacts on recorded and reported data both at decentralised and central levels.

5.3. Effectiveness

The project has been effective in delivering planned inputs and outputs. Joint services to GBV and CA victims are offered in newly rehabilitated centres by multidisciplinary staff, including physical and mental health, justice and police. Staff has been trained and motivated, community awareness activities were undertaken. Coordination structures were set up.

In turn of outcomes, mixed results were measured. A high understanding of GBV was measured, but awareness of the existence of IOSCs was small among the population. Only 9% of

respondents chose an IOSC as first entry point to report GBV cases. Access to IOSC is limited due their relative scarcity (for many victims at long distances from their households). It was also found that it remains complicated to get sufficient proof for successful court cases against GBV and CA perpetrators, which is very likely to sustain impunity.

According to respondents, and in comparison to the baseline, there is no measurable change in the incidence of GBV and CA in the community given that the baseline was conducted last year August, 2015.

Management and coordination capacities were strengthened, but challenges remain at the level of the IOSCs.

5.4. Impact

Large scale, systematic and sustainable impact, like a reduction in the incidence of GBV and CA, could not yet be measured by the evaluation. However, the project already had an impact on those victims that made use of the services of the IOSCs. They have received appropriate treatment and were able to receive medical as well social economic support but less effort are made to provide legal assistance. However, majority of GBV cases for both male and female victims remain unreported due to limited efforts in tackling the gender norms sustaining the silence around GBV.

It is expected that the project in the long run will have a significant impact, through the separate status of comprehensive care to GBV and CA victims and raised awareness among hospital staff and police. Another noted impact, intended or not, is a positive change of image of the police.

5.5. Sustainability

The fact that the IOSCs are housed at (local) government hospitals and staffed by government personnel enhances the chances for sustainability. Only one more step needs to be taken to ensure sustainability: to manage the IOSC not as a project, but as a regular government service, fully integrated in government structures.

VI. GOOD PRACTICE AND LESSONS LEARNT

Several lessons and good practice have been learnt during the lifetime of the project, which can be beneficial for future implementation, or for a similar follow-up project.

The approach itself of providing holistic care combining medical, psychological, legal and social support in one place with full respect and dignity of the GBV and CA victims has proved to be a good practice.

The work of serving in IOSCs is more than a usual work, as it requires a high dose of passion and commitment to effectively respond to the needs of GBV and CA victims on due time.

Joint approach brings expertise from different partners, influence and power but challenging at coordination level.

Despite a noted risk of delays at start-up of the project, this risk materialised and apparently could not be prevented. It was learnt that some delays seem to be inevitable and stringent mitigation measures are needed.

Capacity strengthening was an important element of the project. It is important that different implementing partners, each from their own technical or organisational background, reach the same level of information to enable joint programming and implementation.

It is important that all implementing partners are fully aware of their own and each other's role and responsibility in the programme and that all are aware of the procedural requirements. Joint implementation of the programme has enabled project partners to learn from one another and to build strong collaboration and information sharing.

Smooth collaboration of all partners is required to be able to provide full time service at the IOSCs. Addressing GBV with a multi-interdisciplinary approach helps to build a cohesive strategy that enables the implementation of activities and achievement of desired outcomes.

Timely reporting of GBV and CA incidences is crucial for timely response and avoidance of spoiling of evidences as well as prevention of GBV and CA victims from contamination of HIV and other STIs.

A good collaboration with different institutions involved in legal support services such as RNP, NPPA, Supreme courts, etc. facilitate the process of ensuring justice to GBV and CA victims.

VII. RECOMMENDATIONS

The IOSC model is showing that it has the potential to be a major element in the fight against GBV and CA, and as an instrument for care of GBV and CA victims. It is therefore recommended to continue with the established centres and to expand their numbers.

For the IOSCs to be more effective in the prevention of GBV and CA it is important that more cases are brought to justice and that more perpetrators are prosecuted successfully. The system of collection of evidence needs therefore to be further improved.

It is recommended that the coordinating function of the IOSCs is fully fledged through recruitment of IOSC Coordinator among other needed staff to link with the National Coordinator who also should be recruited or appointed.

More inputs are needed to increase awareness and prevention which would balance the response part that is so far given more attention in visited IOSCs.

Based on the job descriptions, work plans for IOSC staff are recommended, which specifies the amount of time required to work at sector or household level.

Joint approach needs to be strengthened at local level through joint planning among concerned stakeholders and/or organs to effectively address both prevention and response to GBV and CA.

Collaboration between MAJ and IOSCs should be clarified and uniform to more effectively tackle the issue of limited access to justice by GBV and CA victims.

It is recommended to avoid temporary salary top-ups to motivate staff. This only works temporarily and cannot be sustained. Each IOSC needs to be assigned a budget to allow field work.

ANNEXES

Annex 1. LIST OF CONSULTED RESOURCE PERSONS

DISTRICT/INSTITUTIONS	NAMES	POSITION
UNWOMEN	Fatou Lo	UNWOMEN Country Representative
UNWOMEN	Schadrack Dusabe	National Program Officer
UNWOMEN	Carine Uwantege	
UNWOMEN	Deodata Mukazayire	M&E Officer
Netherlands Embassy	Vasco Rodrigues,	First Secretary Security, Justice and Good Governance
Police Forensic Laboratory	Dr. Nyamwasa Daniel	Director of Police Forensic Laboratory and former Director of Kacyiru Police Hospital
MIGEPROF	Mugabo Geoffrey	IOSC Program Coordinator
MINIJUST	Urujeni Martine	Division Manager Community Justice/
RBC	Claude Rubayita Hodari	SGBV/M&E Officer
Kamonyi	Bernadette Harerimana	GBV Officer/Coordinator
Kamonyi	Akimana Teta Safari Philemon	Police Officers/IOSC
Kamonyi	Semana calpephore	Chief account /Remera Rukoma Hospital
Kamonyi	Dr. Patrick Ruremesha	Hospital Administrator
Kamonyi	Monique Dusenge	Psychologist/Mental Health
Kamonyi	Murerwa Marie	Gender Officer
Kamonyi	Nkurunziza Jean de Dieu	Executive Secretary Rukoma sector
Kamonyi	Bizimana Emmanuel	Director of Groupe Scolaire Remera Rukoma
Kamonyi	Mazuru Innocent	Social Affairs Officer at Rukoma Sector
Kamonyi	Bizimana Jerome	Faith Based Representative
Kamonyi	Nyirandabaruta Esther Niyoyita Sarah Ntambabazi Safira Vastiya Nyiramuligo Niyompano Chantal	Focus Group Discussions with GBV survivors
Kicukiro	Ezekiel Kavura Mutesi Catrine Sifa Clemence	GBV Officer / Coordinator Psychologist Police
Kicukiro	Kwizera Annet	M&E Officer

Kicukiro	Nsanzimfura Silver	Teacher at Groupe Scolaire Camp Kanombe
Kicukiro	Rutangira Eugenie and Kananura Cyprien	Married couple victims of GBV
Kicukiro	Kagaba Sophie	Social Affairs at Village level
Kicukiro	Niyigena Jean de la Croix	Youth Representative at Village level
Kicukiro	Vuguziga Dorcella Nyiraneza Marie Uwihoreye Chantal Nyiraneza Florence Dushimumuremyi Leonie	Focus Group Discussions with GBV survivors
Rubavu	Seugo Michel	District MAJ Coordinator
Rubavu	Nzakizwanimana Etienne	District Assistant MAJ Coordinator in charge of GBV
Rubavu	Nakabonye Epiphanie	IOSC Coordinator and GBV Officer
Rubavu	Angelique Mugirazina	Police at IOSC
Rubavu	Patrick Nizeyimana	District Representative of NYC
Rubavu	Inspector Nyiraneza Solange	Community Policing
Rubavu	Ishimwe Pacifique	District NWC Coordinator
Rubavu	Cyurinyana Vestine	CSOs Representative
Rubavu	Uwampayizina Marie Grace	Vice Mayor Social Affairs
Rubavu	Irankunda Janviere Ahishakiye Roselyne	Survivors of GBV
Musanze	Justine Giraneza	MAJ Coordinator
Musanze	Ngaboyisonga J. Claude	MAJ GBV and CA Officer
Musanze	Uwamariya Marie Claire	Vice Mayor Social Affairs
Musanze	Nicolas Murenzi	District Gender Officer
Musanze	Pastor Matabaro Jonas	Representative of FBOs
Musanze	Umukundwa Alice	IOSC Coordinator and GBV Officer
Musanze	Nyirandahiriwe Christine	IOSC Police officer
Musanze	Bora Liliane	IOSC Police officer
Musanze	Francoise Uwamahoro	Psychologist
Musanze	Joyeuse Mukasharangabo	Accountant Ruhengeri Hospital
Musanze	Nyirantezimana Clementine	Representative of CSOs
Gasabo	Dr. Nyamwasa Daniel	Former Kacyiru Hospital Director / Director of Police Forensic Laboratory
Gasabo	Shafiga Murebwayire	IOSC Coordinator
Gasabo	Insp. Charles Rweru	Head of Mental Health
Gasabo	Elyse Uwase	GBV Officer
Rulindo	Gasanganwa Marie Claire	Vice Mayor Social Affairs

Rulindo	Musonera Leopold	Representative of Police
Rulindo	Gasana Rwangeyo Desire	MAJ Representative
Rulindo	Ingabire Claudine	Gender Officer
Rulindo	Jean de Dieu Rugiriyaremye	District Youth Representative
Rulindo	Uwingabire Lea Mukamusoni Modestine Philemon Musafiri Ntibarikure Paul Anastase Mbarushimana Kanyange Phoibe Dr. Kamariza Marie Aimee	GBV Officer /Coordinator Police Officer IOSC Police Officer IOSC M&E Accountant Hospital Administrator Medical Doctor/ IOSC
Rulindo	Hakizimana Gerard Nzabonimana Laurent	Focus Group Discussions with men survivors of GBV
Rulindo	Mukankurunziza Beatrice Uwamahoro Vivine Uwinema Clementine Mukagahutu Annociate	Focus Group Discussions with women survivors of GBV
Nyamagabe	Mujyawayezu Prisca Byukusenge Irene	Vice Mayor Social Affairs MAJ GBV Officer
Nyamagabe	Boniface Habumugisha Bizimana Bertin Bizimana Jean Baptiste Dr. Nzirorera Ildephonse Uwamahoro Eugenie	Police Officer IOSC/Kigeme GBV Officer / Coordinator Mental Health Medical Doctor/ Deputy Director of Kigeme Hospital Accountant
Nyamagabe	Uwamahoro Alice Nyirahirwa Jeanine Uumuhoza Josiane Bamurange Assumpta	Focus Group Discussions with women GBV victims
Karongi	Viateur Nshimiyimana Marie Chantal Nyirakamana Francoise Uwamariya Alphonse Mahangayiko Jean Baptiste Sagahutu Murindangabo Aimable Udatsikira Heritien Twambajemariya Jeanne D'Arc Akimana Laurence Mutabazi Innocent Egide Muragijimana Uzamukunda Esperance Dr. Patrick Nsangano	Police Officers /IOSC GBV Officer/Coordinator Mental Health M&E JADF Gender Officer District NWC MAJ Coordinator MAJ GBV Officer Hospital M&E Accountant Medical Doctor
Karongi	Nyirakarazima Kazigiriza	Focus Group Discussions with women

	Mukasine Belancie Nyiramajigija Veronique Bakuramutsa Dancile Ahishakiye Venancie	GBV victims

Nyagatare	Dr. Tresor Ingabire Marius	Assistant Hospital Director
Nyagatare	Jean Paul Habonangenda	Hospital Data Analyst
Nyagatare	Nina Gaju	Hospital Chief Accountant
Nyagatare	Agnes Nakato	Gender Based Violence Officer and Isanga one stop center coordinator
Nyagatare	Marie Gorethe Uwibambe	Legal representative Isange one stop center
Nyagatare	Mayor	Mupenzi
Nyagatare	Vice mayor social affairs	Domitille Musabyemariya
Nyagatare	Vice mayor economic affairs	Didas Kayitare
Nyagatare	Director of Public health	Eliah Kamanzi
Nyagatare	Director of Social Development	Thomas Habumuremyi
Nyagatare	Gender and Family Promotion Officer	Jane Mbabazi
Nyagatare	MAJ Coordinator	Maitre Evariste Rwamukwaya
Nyagatare	MAJ assistant Coordinator	Mary Mirembe
Nyagatare	Glass root Gacaca Courts and GBV	Charles Munyaneza
Ngoma	Hosptial Director	Dr. Namanya William
Ngoma	Gender Based Violence Officer and Mental Health Officer	Genevieve Muhimpundu
Ngoma	Clinical Psychologist	Francoise Uwizeye
Ngoma	Legal Officer	Console Ingabire
Ngoma	Legal Officer	Joy Turanezerewe
Ngoma	JADF District Representative	Gedeon Hakuzwimana
Ngoma	MAJ Representative	Desire Nshuti
Ngoma	MAJ Representative	Mediatrice
Ngoma	Representative National Women's Council	Chantal Mukalutesi
Ngoma	Representative of National Youth Council	Augustin

List of survivors

DISTRICT	NAMES
Nyagatare	Christine Kagoyire
Nyagatare	Laurence Mukabahizi
Nyagatare	Batamuriza Anociatha
Ngoma	Rosette Umubyeyi
Ngoma	Charlotte Musaga
Ngoma	Christine Uwange
Ngoma	Francoise Nayituriki
Ngoma	Marie Solange Mukalulinda

Annex 2: Evaluation framework with unpacked questions

Evaluation question	Unpacked questions	Source of information
Relevance		
Are the project objectives consistent with, and supportive, of GoR policies and strategies?	• What are the relevant GoR policies and strategies regarding GBV and CA? • What are the objectives of the project? • How do the project objectives support GoR policies and strategies?	GoR policies Project document Project progress reports
Does the project respond to the needs of the target groups?	• What are the project target groups? • What are the needs of the project target groups? • How does the project respond to the needs of the target groups?	Survey, Interviews, FGDs
Is the intervention logic clear and logical?	• What is the project intervention logic? • Is it clear and logic?	Project document Project progress reports
Are the risks and assumptions holding true? Are risk management arrangements in place?	• Are risks and assumptions described in the project documents? • Are risks and assumptions still valid? What measures are taken to mitigate identified risks? • Are there any lessons learnt from risk management?	Project document Project progress reports
How were key stakeholders involved in the design process?	• Were stakeholders involved in project design? • How were they involved? • Are there any lessons learnt from stakeholders involvement in project design?	Interviews, FGDs
Efficiency		

Are activities implemented as scheduled? If there are delays how can they be rectified? Are a work plan and resource schedule available and used by the project management?	• Are there a clear implementation schedule and work plan? • Are there deviations from the implementation schedule (delays)? • If there are delays , is the project taking action to rectify them? • How is project expenditure in relation to planned expenditure? • What is done to rectify any deviation from the planned expenditure? • Are there any lessons concerning planning and budgeting?	Project progress reports Interviews, FGDs
Are inputs provided/available at planned cost (or lower than planned)?	• Are procurement procedures in place? • How do costs for input compare to estimated (unit) costs? • How can deviations be explained?	Project progress reports Interviews, FGDs
How well are activities monitored by the project and are corrective measures taken if required?	• Is there a monitoring system in place? • Are there SMART indicators for input, output, outcome and/or impact? • Is there reporting against indicators? Are there corrective measures if results for indicators are behind schedule?	Project progress reports Interviews, FGDs
Effectiveness		
Have the planned results to date been achieved? What are the major factors influencing the achievement or non-achievement of the objectives?	• What are actual achievements versus planned results? • What are the reasons for any deviation from planned results?	Project progress reports Survey, Interviews, FGDs
What is the likelihood of the project objectives to be achieved?	• Is the project on schedule of achieving the planned objectives? • What is the likelihood of the project objectives	Project progress reports

	to be achieved?	Interviews, FGDs
Impact		
What has happened as a result of the project or what is likely to happen?	• What changes have already occurred or are expected to occur because of the project?	Project progress reports Interviews, FGDs
What real difference has the project made to the beneficiaries?	• What has changed for the beneficiaries because of the project (positive and/or negative)? • Are there good practices or lessons learnt?	Survey, Interviews, FGDs
How many people have benefitted?	• Who has benefitted from the project? (distinguish between different types of stakeholders) • How many people have benefitted? (distinguish between different types of stakeholders)	Project progress reports Interviews, FGDs
Sustainability		
Are the services/results affordable for the stakeholders (local government) at the completion of project?	• How will services/results of the project be sustained after completion of the project? • Who will be responsible? • Who will finance it?' • Will it be affordable? • Are there good practices or lessons learnt?	Interviews
How far is the project embedded in local structures?	• Is the project embedded in existing local structures? How? • Are there good practices or lessons learnt?	Survey, Document review Interviews
To what extent are relevant stakeholders actively involved in decision-making concerning project orientation and implementation?	• Are stakeholders involved in project decision making and implementation? (specify stakeholders) • Are there good practices or lessons learnt?	Interviews, FGDs

What support has been provided by the relevant national or local government?	• What support has been provided by the relevant national or local government?	Interviews, FGDs

Annex 3: Consulted documents

UNEG: Integrating Human Rights and Gender Equality in Evaluations. August 2014

UNWomen: Global Evaluation Report Assessment and Analysis System (GERAAS). January 2015

Government of Rwanda and One UN: National Scale up of Isange One Stop Centre Model in Rwanda 2013-2015. Project Document. November 2013

Government of Rwanda: National Scale up of Isange One Stop Centre Model. Progress report January – December 2014. November 2014

Government of Rwanda: National Scale up of Isange One Stop Centre Model. Donor report January – December 2015.

Government of Rwanda: IOSC programme plan for 2 years.

Fountain Publishers: Isange. Rwanda's Holistic Approach to Gender Based Violence and Child Abuse. 2015

Government of Rwanda / Ministry of Health: Multidisciplinary Treatment of Victims of Gender-based Violence and Child Abuse. Protocol. April 2015

Government of Rwanda / Ministry of Gender and Family Promotion: Gender Based Violence and Child Abuse Baseline Survey report. August 2015

Government of Rwanda / Ministry of Gender and Family Promotion: Guidelines on Prevention of/and Response to Gender Based Violence and Child Abuse in Rwanda. 2015