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Stopping Abuse and Female Exploitation in Zimbabwe: Endline Report

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Tetra Tech International Development – Stopping Abuse and Female Exploitation in Zimbabwe: Endline Report

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This document has been approved for submission by Tetra Tech International Development Project Director, based on a review of satisfactory adherence to our policies on:

- Quality management;
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- Personnel recruitment and management;
- Performance Management and Monitoring and Evaluation (M&E)

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Project Director

Signature:

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Acronyms

CBT	Cash-based transfer
DHS	Demographic and Health Survey
ELU	Evaluation and Learning Unit
FCDO	Foreign, Commonwealth & Development Office
FQOL	Family quality of life
GALS	Gender Action Learning System
GBV	Gender-based violence
GCBC	GBV Community-based Clubs
GDPR	General Data Protection Regulation
IDI	In-Depth Interview
IGA	Income Generating Activities
IP	Implementing Partner
IPV	Intimate partner violence
ISAL	Internal Savings and Loans
LNOB	Leave No One Behind
MICS	Multiple Indicator Cluster Survey
MRCZ	Medical Research Council of Zimbabwe
NGO	Non-Governmental Organisation
RAG	Red, Amber, Green
SADC	Southern African Development Community
SAFE	The Stopping Female Abuse and Exploitation Programme
SDG	Sustainable Development Goal
TISAL	Toose Internal Savings and Loans
ToC	Theory of Change
USD	United State Dollar
VAWG	Violence Against Women and Girls

WEAI	Women's Empowerment in Agriculture Index
WFP	World Food Programme
WHO	World Health Organisation
WRO	Women’s Rights Organisation
ZHARP	Zimbabwe Humanitarian and Resilience Programme
ZimLAC	Zimbabwe Livelihoods Assessment Committee
ZIMSTAT	Zimbabwe National Statistics Agency

Executive Summary

Abstract

The Stopping Abuse and Exploitation Programme (SAFE) Evaluation Learning Unit (ELU) Endline Study assesses changes in key outcomes of the SAFE programme - a gender-based violence (GBV) prevention and response initiative implemented in three districts of Zimbabwe. Using a longitudinal, mixed-methods design, the study primarily relies on quantitative data to measure change over time among women who participated in Cohorts 1 and 2, with qualitative insights from Cohort 3 to contextualise findings. The evaluation focuses on changes in intimate partner violence (IPV), household wellbeing, gender norms, and women's empowerment, in line with the SAFE Theory of Change (ToC).

The quantitative endline results present a mixed picture. The most consistent and significant improvements were observed in household wellbeing. These include greater household ability to meet essential needs, increased men's contributions to domestic labour, and improved joint decision-making among couples. These changes were particularly prominent where women participated in the programme alongside their male partners, reinforcing the importance of couple-based interventions.

However, changes in GBV-related outcomes were more nuanced. While some women reported reductions in IPV severity, particularly in specific districts and cohorts, overall IPV prevalence slightly increased from baseline - most notably in Chiredzi and among Cohort 2 participants. Emotional and controlling behaviours also remained high. These findings align with earlier qualitative studies showing that while relationship dynamics improved for some, deeper gender norms around power, infidelity, and sexual rights remained largely unchanged.

The endline also shows improvements in gender-equitable attitudes and increased opposition to early marriage. However, progress on empowerment indicators was limited or negative. For example, women's reported agency in decision-making declined overall, and normative barriers to help-seeking remained persistent.

Economic stress emerged as a key factor influencing IPV outcomes. Households experiencing worsening food insecurity reported higher levels of IPV, while women in food secure households were more likely to take out larger and more frequent Toose Internal Savings and Loans (TISAL) loans. Although greater loan engagement was associated with improved ability to meet needs and reduced IPV acts, the study found no evidence that TISAL loans reduced food insecurity. In fact, qualitative data suggest that loans were often diverted to cover basic needs - particularly in Chiredzi, where economic shocks, drought, and inflation seem to have exacerbated vulnerability.

Exposure to Toose's gender-transformative sessions yielded mixed results. While some outcomes - such as improved conflict resolution and reduced corporal punishment - suggested positive shifts, other findings were less straightforward. Some women exposed to IPV-focused sessions reported higher IPV prevalence. This may reflect greater awareness and reporting, or in some cases, backlash from partners as a result of challenging harmful norms.

Overall, the quantitative endline results suggest that the SAFE model contributed to important gains in family wellbeing and collaboration but faced clear limitations in reducing IPV and transforming gender norms at scale. These findings support the value of combining social and economic empowerment approaches, but also underscore the need for longer implementation timelines, stronger normative content, and adaptations for contexts marked by deep poverty and food insecurity.

Introduction

This report presents the findings from the Endline Study conducted as part of the SAFE programme.

The SAFE programme aims to prevent and respond to GBV, specifically IPV, in Chiredzi, Chikomba and Mwenezi districts in Zimbabwe, through a social and economic empowerment intervention, also known as 'Toose'. IPV is the most reported form of GBV in Zimbabwe and includes physical, sexual, economic, and emotional abuse by an intimate partner.

Tetra Tech leads the programme's ELU which seeks to strengthen the evidence base on what works to prevent and respond to violence against women and girls (VAWG).

The SAFE programme

The programme's primary aim was to reduce the perpetration of IPV, largely driven by economic insecurity and social norms. To deliver on the ToC, SAFE adopted an economic and social empowerment approach, worked at individual, relationship, and community levels, and was publicly framed as a family wellbeing programme. Central to the SAFE ToC was the synergetic effect of the economic and social empowerment activities benefiting couples, where a new cash stream was used to create an impetus for families to engage in joint visioning and planning. Newly acquired financial stability was also expected to decrease family financial stress and have the potential to directly impact on violence perpetration.

SAFE contained both prevention and response components. The GBV prevention component was framed as a family well-being programme, using gender transformative social and economic empowerment approaches, which operated at both household and community levels. The intervention was piloted in communities in focal wards in three districts: Chikomba (rural), Mwenezi (rural) and Chiredzi (urban). SAFE Communities has implemented SAFE in three consecutive cohorts to enable learning and adaptation to be integrated into subsequent cohorts.

The implementation components under SAFE are referred to as the TOOSE (adapted from the Shona word "Tose" meaning "together") model. This includes an economic empowerment component, a social empowerment component and a response component. In addition, cash-based transfers (CBT) were layered onto the programme in Chiredzi.

The Endline Study

The purpose of the Endline Study is to quantitatively measure changes in outcomes and impacts (according to the SAFE ToC) among SAFE beneficiaries in Cohorts 1 and 2 by measuring these at endline and comparing them against baseline. The study also qualitatively explores impact on Cohort 3 participants, including on men. Because the endline does not include a comparison group, the endline data alone does not provide evidence on causality (see limitations).

More specifically, the study's purpose is to:

- Provide an estimate for the change in IPV among programme beneficiaries;
- Strengthen any claims in relation to the testing and validation of the intervention model;
- Strengthen our understanding of the potential for and usefulness of SAFE scale-up;
- Fill evidence gaps in our evaluation design (i.e. Cohort 3 impact and impact on men);
- Provide the precedent for future studies to further explore the impact, including the counterfactual and causality;
- Give insights into the contribution of the intervention, by a) comparing quantitative endline data against quantitative baseline data, and b) combining quantitative endline data with qualitative endline data, and qualitative data from the longitudinal cohort study.

The discussion section also brings together ELU and programme data, including from the endline evaluation, the qualitative cohort study (Deep Dive 2 and Deep Dive 5), the Process Level Study (Deep Dive 4) and the Summative Evaluation, to present possible hypotheses to explain endline results according to the three pillars of the prevention triad, and the underlying operational foundations.[1] This is presented in the discussion section.

Methods

The Endline Study (conducted in 2024) is a longitudinal study that tracked participants from the quantitative Baseline Study conducted in 2022, allowing for measurement of change over time.

It is a mixed-methods study with qualitative and quantitative components, with a stronger emphasis on quantitative research. The study involves a large quantitative survey (1,037 women were interviewed at endline)[2] complemented by qualitative in-depth interviews with Cohort 1 participants and their partners and GBV Community-based Clubs (GCBC) volunteers (74).

[1] A tool designed by the Prevention Collaborative to useful tool for interpreting evaluation findings across three programme elements: programme model, context and population, and implementation quality (see the coding and analysis section).
[2] Although less women were interviewed at endline than at baseline, the endline achieved sample at the district-level is sufficient to detect mean pre-post differences of 0.20 standard deviations or larger in the distribution of any continuous variable, with a statistical power of 80% at the 95% confidence level.

The baseline and endline studies were designed to measure impact, outcome and output indicators based on the programme ToC. This is useful to understand the different pathways of change, however, this approach has limitations since the ToC was significantly updated in 2023 (see below).

Limitations

Adaptations to the Theory of Change: The baseline and endline studies were designed to measure impact, outcome and output indicators based on the programme ToC. This ToC was updated in 2023 in line with the programme's adaptive approach. There are some gaps in understanding given that the baseline and endline studies were designed with a previous ToC version in mind. This is especially the case for the Outcome 3 pathway, which previously focused on reduced tolerance of IPV among focal communities.

Children: We have included insights pertaining to children throughout this report. These are based on perceptions of adult household members who participated in the programme. Children were not directly targeted by the programme, and therefore also not included in this study.

Men: By sampling women only for the endline, the study does not quantitatively measure endline outcomes and impacts for men. However, these issues have been explored through the qualitative longitudinal cohort study. The qualitative component of this Endline Study also sampled a small number of men in Cohort 3, which helps us understand the intervention's effect on men's lives in Cohort 3.

Control/ comparison group: Because the Endline Study does not include a comparison group, the endline data alone does not provide evidence on causality – it does not tell us with certainty whether a reduction or increase in IPV and other key outcomes is a result of the intervention, or the result of other influencing factors, or a combination of those (attribution).[3][4] However, it should be noted that the aim of this Endline Study was not meant to isolate impact quantitatively, its aim was rather to map changes in key outcome and impact indicators. In an effort to understand causality, using the ToC as the guiding framework.

Differences in selection into the intervention in urban and rural areas: There were different modalities of selection into the intervention in the programme's urban district (Chiredzi) versus its rural districts (Chikomba and Mwenezi), with profiling in Chiredzi being based on a profiling exercise to determine vulnerability. This is not believed to have had significant impacts on the findings given that food insecurity was lowest among beneficiaries in Chiredzi at baseline when compared with the other two districts. Although, differences in selection and recruitment into the intervention should be kept in mind.

External shocks: The Endline Study was conducted during a severe El Niño drought year, which affected large parts of Zimbabwe. This environmental shock had significant socio-economic consequences, particularly related to food security and livelihoods. These external stressors may have influenced household dynamics, levels of stress, and economic insecurity, all of which are known drivers of IPV and other forms of GBV. As such, the drought may have impacted both the lived experiences of participants and the outcomes measured at endline.

Timing of data collection relative to programme exposure: The Endline Study took place 1–2 years after most participants completed the SAFE programme. This time lag may have affected participants' ability to recall specific programme components - such as attendance, who accompanied them to Toose sessions, or the content of particular modules - and could therefore have implications for the accuracy of retrospective data. Additionally, the gap between programme completion and data collection means that some observed outcomes may reflect longer-term impacts, while others may have diminished over time. Both possibilities should be considered when interpreting the findings.

Timing of CBT exposure: In April/ May 2024, six months prior to the endline data collection, many Toose participants were removed from the CBT programme. Unaware of this change in programme exposure, the evaluation team was unable to mitigate for it through its methodological approach by recording possible termination in the endline survey. This means that the endline dataset is unable to measure the extent to which termination of CBT impacted on endline outcomes.

Desirability bias and reliability of personal accounts of GBV: Social desirability bias in research is the tendency for participants to present reality in line with what they believe to be socially acceptable. GBV-related issues are sensitive. As a result, people, especially vulnerable populations, and young people, may have been unwilling to talk or

[3] However, the summative study explores influencing factors that strengthen our understanding of contribution and give some insights into the attribution of the intervention.
[4] Current evidence suggests that a rigorous mixed-methods evaluation approach is the most appropriate to evaluate a pilot intervention, particularly one that has not been previously tested for the reduction of IPV. Following confirmation of evidence of effective intervention implementation and positive intervention impact, recommendations for scale-up could be made with future plans to conduct an experimental study, such as a Randomised Control Trial (RCT).

to express their views in a sincere and accurate manner – this may have happened at baseline as well as endline. This could have created a bias towards 'socially acceptable' views and underreporting of occurrences and severity of violence. Our instruments, forms and protocols were designed to minimise such biases as much as possible. Despite this, interview biases cannot be fully eliminated and must be kept in mind when analysing and interpreting the data.

High level summary of endline evidence

The Endline impact and outcome evidence presents a complex picture, highlighting both significant progress and some persistent challenges in addressing GBV and promoting household wellbeing. The study highlights:

- Strong positive impacts on household wellbeing (e.g. improved ability to meet needs, joint decision-making, and men's contribution to domestic labour).
- Reductions in IPV severity but limited change in overall IPV prevalence, controlling behaviours, and corporal punishment.
- Improvements in attitudes around gender equality and early marriage, though normative and empowerment outcomes showed mixed or modest change.
- Variability in impact by district, cohort, economic stress levels, and participation structure (e.g. women attending Toose with partners).
- Lessons on sequencing, facilitation, norm change, sustainability, and participatory approaches.

The table below summarises endline impact level measures by district, using a Red, Amber, Green (RAG) rating. For instructions on how to interpret the colours, see *Section 2.3.4.*

RAG rating for impact level measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Impact						
Past year prevalence IPV (binary)						
Emotional IPV						
Economic IPV						
Physical IPV						
Sexual IPV						
Severe IPV 1						
Severe IPV 2						
Number of acts of IPV						
Controlling behaviours						
Corporal punishment against children (women)						
Corporal punishment against children (men)						
Perceptions of reduction of early marriage						
Family wellbeing / quality of life						

Discussion of combined evidence from ELU evidence base

The discussion section synthesises and interprets the findings of the endline evaluation in light of the SAFE ToC and the wider evidence base generated throughout the programme. It examines the extent to which change has occurred across different domains and present possible hypotheses to explain endline results according to the three pillars of the prevention triad, and the underlying operational foundations.[5]

[5] A tool designed by the Prevention Collaborative to useful tool for interpreting evaluation findings across three programme elements: programme model, context and population, and implementation quality (see the coding and analysis section).

Understanding change: pathways of change

Overall, the evidence suggests that the TOC pathway to change linked to household wellbeing has led to stronger and more consistent positive outcomes, particularly in economic and social empowerment. The evidence on progress in gender norms and women's empowerment is more variable.

First, SAFE led to strong positive impacts on household wellbeing, with notable improvements in economic and social empowerment outcomes. Households participating in the programme experienced an increased ability to meet essential needs, stronger shared household visions, greater joint decision-making among couples, and increased contributions by men to domestic labour.

Qualitative insights from earlier ELU studies show that households feel more financially resilient, with greater stability in income sources, improved financial planning, and more strategic spending decisions that balance immediate needs with long-term investments. They also suggest that couples are engaging in more open discussions about roles and responsibilities, fostering a more participatory household environment.

At the same time, progress was more modest in some aspects of collaborative relationships, such as joint economic planning. However qualitative evidence from earlier studies shows that discussions around household finances have become more inclusive, with more households engaging in collective decision-making, particularly in male-headed households, where children are increasingly contributing insights based on their exposure to financial tools and market trends.

Second, some women experienced significant reductions in IPV severity. However, the programme did not impact overall levels of IPV prevalence, controlling behaviours, and corporal punishment against children. Encouragingly, there were improvements in gender-equitable attitudes and growing opposition to early marriage. Qualitative insights reinforce these findings and suggest that reductions in IPV severity may be linked to improvements in economic stability and reductions in some of the key drivers of violence, such as household financial stress and alcohol use.

Yet some challenges persist. For example, women's agency in decision-making did not improve and physical IPV continues to be justified in some cases among SAFE participants. Earlier qualitative ELU studies also showed that sexual IPV remains a concern: while awareness of sexual violence has increased, entrenched norms around men's conjugal rights and women's sexual obligations continue to shape household dynamics, with sexual coercion often linked to concerns about infidelity or other perceived threats to male authority. Additionally, more survivors are aware of available support, yet some still face normative barriers to seeking help, such as concerns about family stability or social repercussions.

In parallel, qualitative studies show that while acceptance of emotional IPV has declined, this has not always translated into more equitable gender norms. Instead, these shifts seem to prioritise household harmony over challenging gendered power imbalances. Nonetheless, the programme's focus on power dynamics has contributed to meaningful changes in household relationships, particularly in how men engage with their children. There have been notable improvements in how men perceive and exercise power within their families, leading to greater reflection on non-violent approaches to conflict resolution and discipline.

These findings highlight both the programme's successes and the ongoing need for targeted efforts to further shift social norms and support sustainable change in IPV.

Understanding change: influencing factors

Evidence form this endline evaluation study highlights a nuanced picture of change, with variations across districts and key economic and programmatic factors shaping outcomes. These insights offer valuable learning for strengthening GBV prevention and response efforts in similar contexts.

1) **District-level changes:** The impact of SAFE varied across districts, with encouraging trends in some areas and challenges in others. In Chikomba and Mwenezi, there were significant reductions in sexual and severe IPV, controlling behaviours, and corporal punishment against children. In Chiredzi, however, increases in IPV and controlling behaviours were observed. While the reasons for these increases are not fully clear, qualitative findings suggest that rising food insecurity and economic shock in Chiredzi may be at play. Encouragingly, in Chikomba, where IPV reductions were observed, there were also improvements in household economic stability and collaborative decision-making - suggesting that strengthening economic security and household relationships is an important pathway to change.
2) **Economic factors:** Economic security emerged as a significant factor in IPV outcomes. Women in households where food security improved or remained stable were less likely to report IPV, whereas those experiencing

greater food insecurity at endline reported increased IPV across all measures. While SAFE's economic activity, TISALs, did not fully mitigate economic shocks, an association was found between women taking multiple loans and reduced severity of IPV - suggesting that access to financial resources may contribute to lowering stress-related triggers of violence. These findings reinforce the importance of integrating economic empowerment initiatives into GBV prevention programming.

3) **Participation in Toose with partner versus other family members:** How women participated in Toose also influenced outcomes. Women who attended Toose sessions with their partners reported experiencing fewer acts of IPV, improved household economic stability, greater knowledge of conflict resolution, and more progressive attitudes toward child marriage. In contrast, when women attended with another family member rather than their partner, there was an association with worsened peaceful conflict resolution practices among men. These findings suggest that engaging couples together in gender-transformative discussions may be more effective in shifting relationship dynamics than engaging women separately.

1) **Exposure to gender transformative Toose sessions:** Findings on Toose sessions focusing on gender norms and IPV were mixed, requiring careful interpretation.
   a) Negative impacts: Participation in sessions on IPV and power dynamics was associated with improved conflict resolution practices between partners and a reduction in women's use of corporal punishment against children.
   b) Positive impacts: Some women who attended IPV-focused sessions in Cohort 3 reported increased experiences of IPV and controlling behaviours. While this could indicate a rise in violence, an alternative explanation is that women's increased awareness of IPV led to greater recognition and reporting at endline - particularly if violence was previously normalised or underreported. It is also possible that increased knowledge of IPV empowered women to challenge harmful norms, which in some cases may have triggered resistance from partners.

These findings are challenging to explain. It is possible that increased IPV among women exposed to Toose sessions on IPV is reflecting women's greater knowledge of IPV at endline, leading to increased reporting in the endline survey. Given that women attending gender transformative sessions is associated with improved conflict resolution practices with partners, it is possible that IPV has in fact reduced at endline and we are seeing the impacts of under-reporting at baseline. However, it is also possible that exposure to these sessions has increased IPV risks, for example, if greater knowledge of IPV has led women to challenge their partners or resist violence.

Interpretation across the three elements of the prevention triad

The discussion section draws from ELU and programme data, including from the endline evaluation, the qualitative cohort study (Deep Dive 2 and Deep Dive 5), the Process Level Study (Deep Dive 4) and the SAFE Summative Evaluation, to present possible hypotheses to explain endline results according to the three pillars of the prevention triad, and the underlying operational foundations.

The SAFE endline findings must be interpreted within the broader context of Zimbabwe's economic and political instability, the COVID-19 pandemic, and programme-level constraints. COVID-19 and national elections disrupted implementation and reduced timeframes, particularly for Cohort 3. Economic shocks, including inflation and food insecurity, undermined the effectiveness of income-generating activities and limited loan repayment among TISAL members.

Adaptations to the Toose curriculum improved relevance but introduced variation across cohorts, complicating impact evaluation. The emphasis on household wellbeing rather than women's empowerment helped drive community engagement but may have limited gender transformative outcomes. Implementation quality was affected by budget cuts, reduced TISAL coverage, and challenges in facilitator training, though improvements were made in later cohorts. Community cadres, particularly GCBCs, played a key role in programme delivery and GBV response.

Taken together, these factors may help explain the mixed results observed - stronger outcomes for household wellbeing and collaboration, and weaker or inconsistent outcomes for women's empowerment and IPV reduction.

See *Section 9* for a more comprehensive discussion.

Conclusions: making sense of the evidence

The conclusions section brings the endline results into conversation with earlier studies - both qualitative and quantitative - to make sense of patterns across time, geographies, and study designs. In doing so, it highlights where there is consistency across evidence sources, where findings diverge, and what this means for the overall effectiveness and limitations of the SAFE model.

Across all studies, the SAFE model appears to have been most effective in improving family wellbeing, including household economic security, emotional relationships, parenting, and family functioning. These were among the strongest and most consistent findings at endline, and the qualitative Endline Study confirms that family unity and improved household relations were among the changes most valued by participants themselves. This aligns with SAFE's decision to frame the intervention around family wellbeing, rather than directly targeting GBV or women's empowerment, a strategy which was found to increase buy-in and participation among both men and women. It also reflects the mutually reinforcing relationship between SAFE's economic and social empowerment components, which together helped foster greater collaboration, visioning, and practical support within the household.

The SAFE studies also appear to suggest that CBT has been successful in mitigating economic stress and supporting economic outcomes, although limitations in the endline data make it challenging to make conclusions. The endline data suggests that ability to meet basic needs has not changed in Chiredzi. However, previous ELU studies and SAFE monitoring data paint a different picture, finding that during the programme timeframes, CBT in Chiredzi allowed households to use vouchers or cash for food, strengthening their ability to direct money into TISAL savings than could then be converted into loans and income generating activities (IGAs). These divergences may be due to several factors, including endline data collection being conducted one year after the programme's completion and six months after termination of CBT for some households, and due to worsening food insecurity in Chiredzi.

There is also evidence that SAFE contributed to improved awareness of GBV and availability of services, particularly through the work of GCBCs and Musasa. Participants' confidence in supporting survivors increased, perceived barriers to access declined, and actual help-seeking behaviour improved across some indicators. However, normative barriers - such as shame, stigma and fear of consequences - persisted, and in some cases increased. This was particularly the case among women exposed to certain diffusion activities, such as Toose community conversations and GCBC sessions, echoing earlier concerns that diffusion had, at times, reinforced the idea that women are responsible for managing conflict and preventing violence. This was also seen in the community-level study, where women described giving advice to others on how to behave to avoid violence - advice which often emphasised compliance, silence, and self-sacrifice.

Similarly, although there were improvements in household joint decision-making and a notable increase in men's contributions to household labour, these shifts have not translated into stronger decision-making power or greater agency for women. In fact, several empowerment indicators - such as women's perceived ability to make decisions about things and their value - declined. These patterns have been observed throughout SAFE's evaluation cycle. Earlier studies found that behaviour change often remained conditional on practical benefits to the household, and that power remained concentrated with men. Despite changes in behaviour, underlying attitudes and norms - particularly around gender roles, infidelity, and male authority - were more resistant to change.

This may help explain one of the key endline findings: the overall increase in IPV prevalence. While severity and frequency of IPV decreased in some cohorts and districts, overall prevalence rose slightly but significantly from baseline, driven largely by trends in Cohort 2 and in Chiredzi. However, the endline findings also suggest that IPV may have been mitigated in cases where women had stronger engagement in Toose activities, particularly the economic empowerment components. The data shows a strong association between number of loans taken and reduced IPV acts and between improved food security and reduced IPV. Conversely, when food security worsened, IPV tended to rise. These findings are consistent with earlier evidence that linked economic stress to IPV risk, and suggest that under the right conditions, SAFE's model may offer some protective effects.

Despite this potential, the endline findings also raise important questions about the limits of the TISAL model - SAFE's main economic intervention - in contexts of heightened economic vulnerability. The data show that food insecurity significantly worsened over the programme period, particularly in Mwenezi and among households experiencing economic shock. Although a greater number of TISAL loans is associated with improved ability to meet essential needs and reduced IPV acts, there is no evidence that TISAL loans improved household food security. In fact, women in the most food secure households at endline had also taken out the most loans, suggesting that food security may be a precondition for effective engagement in TISALs, rather than an outcome. Qualitative evidence also indicates that some women diverted loans to cover basic needs like food and healthcare, and that worsening economic conditions and droughts limited business success and loan repayment. In this context and from an economic empowerment standpoint, TISALs may not be well suited to the poorest or most food insecure households, and their impact appears constrained where broader structural drivers of economic vulnerability remain unaddressed. These findings echo concerns raised in earlier studies and suggest a need to reassess the sufficiency of the TISAL approach in such settings.

While some of the endline findings may appear unexpected at first glance - such as the increase in IPV prevalence or modest shifts in women's empowerment - these results are not necessarily surprising when viewed against the broader body of evidence generated throughout the programme cycle. Earlier studies, including the qualitative endline, process study and summative evaluation, have consistently highlighted both the strengths and limitations of the SAFE model. These include the persistence of patriarchal gender norms, the practical but conditional nature of behaviour change, and the challenges of achieving normative transformation in a short implementation window. As such, the trajectory observed at endline is broadly in line with earlier findings: improvements in wellbeing, communication, and household collaboration often coexisting with more modest or inconsistent changes in gender norms, power dynamics and help-seeking behaviour. The endline findings therefore reinforce rather than contradict the earlier body of evidence and help to further clarify where SAFE has been most effective, and where further adaptation may be needed.

These findings also make sense when viewed through the lens of each study's methodology. The endline evaluation, the only study with a quantitative design, provides population-level estimates of change over time but cannot on its own explain why or how change occurred, or establish causality. It uses direct, structured questions to measure IPV, which, while potentially more sensitive, are also likely to produce more accurate prevalence estimates due to standardised interviewing techniques. In contrast, the qualitative longitudinal cohort study focused on understanding the processes and mechanisms behind change, offering rich insight into participants' experiences but with a smaller, non-representative sample. It used a more indirect approach to exploring experiences of violence, in line with ethical and safeguarding considerations. As a result, there were likely fewer disclosures of IPV and these often emerged in more generalised or contextualised terms and were not always framed as personal experiences.

The qualitative evidence tends to present a more positive picture of IPV change, with participants more frequently describing improved relationships and reduced conflict. This difference may be partly explained by the smaller and non-representative sample, as well as the more open-ended questioning, which may be less likely to elicit disclosures of violence. These methodological differences underscore the importance of drawing on both qualitative and quantitative evidence. The quantitative data provides measurable estimates of what has changed, while the qualitative data helps to unpack how and why change has - or has not - occurred. Together, they offer a more complete and nuanced understanding of programme impact.

The process study examined the quality of implementation and contextual factors that shaped outcomes, while the community-level study explored the reach and effects of diffusion activities beyond direct participants. Finally, the summative evaluation brought these threads together, synthesising evidence across the evaluation cycle.

Each study, by design, captured different dimensions of the programme, and while their findings vary in emphasis and depth, they are broadly consistent. Together, they present a coherent picture of SAFE's impact: a programme that fostered positive shifts in wellbeing and household dynamics, but which faced persistent challenges in transforming gender norms and reducing violence at scale, particularly in a context shaped by poverty, food insecurity and entrenched patriarchal attitudes.

Overall, the SAFE model appears to have delivered change through multiple, mutually reinforcing pathways - economic, relational and community-based - but with limitations where prevailing social norms and external structural conditions (such as poverty, insecurity and male migration) presented barriers. This is reflected in the ToC: the outcome areas where evidence is strongest are those focused on economic stress and household wellbeing. Outcome areas focused on gender norms, power, and violence appear only partially supported. These findings are important not only for understanding the legacy of SAFE, but for informing future iterations of similar models aiming to reduce GBV and promote gender equality in complex, resource-constrained settings.

Recommendations

1) **Support further experimentation of Toose to find an appropriate balance between household wellbeing and women's empowerment to achieve the desired impact on IPV.** The endline evaluation suggests that while focusing on wellbeing may be linked to positive impacts on family quality of life as measured through the endline evaluation, a more deliberate focus on women's empowerment may be required if Toose is to be successful in reducing IPV. This does not require abandoning the programme's focus on family and household wellbeing but could be strengthened through several different approaches. One is elevating the elements of the SAFE ToC related to women's empowerment from output to outcome level, including women's negotiating power within the household and, ultimately, agency. Another is by strengthening the Toose manual content on power to support reflection on the fact that sharing power does not mean losing it and integrating more experiential content on households practicing power balance in relationships. See the ELU combined Deep Dive 4 and Deep Dive 5

Recommendations Annex for several ways to strengthen both the content and facilitation of the Toose curriculum in line with this.

4) **Focus on couples and prioritise men's participation to strengthen impact.** The endline evaluation results suggest that change in impacts and outcomes were stronger when women participated in Toose with their male partners, and that the participation of other family members may have diluted impact. Future roll out of Toose should focus on the intervention as a couple's intervention and build in stronger incentives for the participation of male partners to strengthen impact.
5) **Integrate stronger content on sexual IPV, jealousy and (perceived or real) infidelity to address persisting triggers of violence.** SAFE ELU studies have consistently identified jealousy, infidelity (whether perceived or real) and refusal of sex as key triggers of conflict and IPV. The endline evaluation has also found that an increase in men's controlling behaviours is accounted for by partners accusing women of being unfaithful, suggesting that the programme has not been successful in addressing these triggers of violence. The Toose manual's focus on strengthening the quality of relationships may not be a sufficient mechanism to address these triggers. While the introduction of explicit IPV content into the manual may support more change in reducing justifications for IPV, future implementation should consider introducing additional content to more specifically address sexual IPV, and triggers associated with infidelity.
6) **Develop guidance and modalities to support peer facilitators to share consistent Toose messaging through diffusion, including in gender transformative ways.** SAFE ELU studies have suggested that community diffusion is a promising modality for extending the scope and reach of Toose messaging; however, some challenges were identified, including in relation to male peer facilitators' comfort and ability to share challenging messages, and the distortion of messages when shared widely. Future implementation of Toose community diffusion activities should produce clear guidance and other support modalities for peer facilitators and others diffusing messages to enable them to tackle challenging conversations in gender transformative ways that do not reproduce gender stereotypes. Programmes should also develop guidelines for community diffusion to enable mainstreaming of community messaging and mitigate the risk of distortion.
7) **Extend implementation timelines to support gender transformative change.** The eight-month cohort cycle may be too short to support deeper normative shifts, particularly those related to power dynamics, decision-making, and violence. Findings across SAFE studies suggest that behaviour change often remained conditional or instrumental, and that shifts in gender norms were limited or uneven. The persistence - and in some cases reinforcement - of patriarchal norms, as well as mixed findings on IPV, suggest that longer timelines are likely needed to allow for more sustained engagement, reflection, and gender transformative change.
8) **Expand and re-sequence the Toose curriculum to strengthen impact and mitigate risks**. It may be necessary to expand both the length and content of the Toose social empowerment curriculum to ensure it provides sufficient depth and structure to support meaningful transformation. SAFE evaluation evidence suggests that key sessions - particularly those on IPV and power - may have been introduced too late in the cycle, limiting opportunities for reflection, reinforcement and behaviour change. The process study identified cases of backlash and male dominance in TISALs, including men taking control over women's profits. These risks may be exacerbated when social empowerment does not precede economic engagement. Re-sequencing sessions on power and gender dynamics earlier in the cycle, and adding structured follow-up activities, could help mitigate harm and build stronger foundations for empowerment. This could enhance impact and reduce risks such as backlash or misinterpretation.
9) **Strengthen facilitation of the Toose curriculum for more effective delivery.** To ensure the content described above is delivered effectively, future implementation should invest in ongoing mentoring and capacity building of both IP and peer facilitators. The process study and summative evaluation both highlighted that some facilitators struggled to deliver accurate or gender-transformative messages, and that male facilitators in particular faced challenges engaging men on sensitive topics. In some cases, this led to reinforcement of harmful norms, especially in discussions around sexual consent or marital rights. Integrating more experiential learning on power-sharing and decision-making, alongside stronger facilitator support systems, could help ensure messages are consistently and safely delivered. This would require additional time and resources but is aligned with global good practice - for example, What Works Phase I found that interventions were more effective when curricula were delivered over 40–50 hours across weekly sessions. Recommendations to strengthen facilitation through ongoing mentoring and capacity building of both IP facilitators and peer facilitators have been made at various points (for example, in the Deep Dive 4 process study and the Summative evaluation) during the programme and these recommendations have been adopted. Future roll out of Toose should ensure that adequate time and budget is built in to support facilitator training and mentoring over time.

10) **Pilot future adaptations of Toose with stronger focus on social norms and behaviour change.** The SAFE ELU Deep Dive 4 and Deep Dive 5 studies made recommendations for Toose to strengthen its focus on social norms and behaviour change; however, this was out of scope of the 2024/ 2025 programme extension. Previous and current evaluation findings suggest that some elements of the intervention insufficiently address the status quo around gender norms and may be reinforcing some patriarchal norms. The programme has taken important steps in the right direction, including integrating more gender transformative content into Cohort 3. However, there are persistent findings that lead to questions about whether significant shifts in social norms are possible through short, wellbeing focused interventions. Future iterations should reflect on this question and which adaptations are required to reduce the risk of harm while maximising impact.
11) **Reassess the appropriateness of the TISAL model in contexts of food insecurity.** Endline findings highlight a strong relationship between food insecurity and increased IPV and show that TISALs alone may not be sufficient to reduce economic vulnerability in highly food insecure settings. Households experiencing food insecurity were less likely to take out loans or benefit from them, and there was no evidence that TISAL loans reduced food insecurity. Instead, women with greater food security were more likely to access more and larger loans. In Chiredzi, where the TISAL model was paired with cash-based transfers, both food insecurity and IPV prevalence still increased - suggesting that CBT alone may not be enough to offset economic stress in some contexts. Qualitative data also shows that households often diverted loans to basic needs, limiting their use for income generation. Nevertheless, SAFE evaluation evidence has consistently shown that the Toose model worked best when its social and economic components were combined, with each reinforcing the other to strengthen household collaboration, visioning, and wellbeing. Future iterations should reassess the appropriateness of the TISAL model for the poorest households and explore more robust or sustained economic interventions in settings where food insecurity is high, potentially including combinations of livelihood support, longer-term cash assistance, or targeted social protection.
12) **Explore alternative methodological approaches to supporting learning and adaptation cycles within prevention programmes and ensure that these are sequenced effectively with implementation cycles.** The evaluation approach, which focused predominantly on a series of qualitative deep dive studies conducted throughout the programme timeframes, provided useful insights to support adaptation. However, there were several challenges in making the most of the comprehensive data and learning generated by the programme. A key challenge was short timeframes between implementation cohorts, making it challenging to sequence studies and adaptations. Another challenge was the inability to conduct separate baseline and endline studies for each implementation cohort due to resource constraints. Future roll-out of adaptative programmes such as SAFE, should ensure that sufficient time is built into implementation cohorts and cycles to make the most of evaluation data and learning.

1. Introduction

This report presents the findings from the quantitative Endline Study conducted as part of the Stopping Female Abuse and Exploitation (SAFE) programme.

The SAFE programme aims to prevent and respond to gender-based violence (GBV), specifically intimate partner violence (IPV), in Chiredzi, Chikomba and Mwenezi districts in Zimbabwe, through a social and economic empowerment intervention, also known as 'Toose'. IPV is the most reported form of GBV in Zimbabwe and includes physical, sexual, economic, and emotional abuse by an intimate partner.

Tetra Tech leads the programme's Evaluation and Learning Unit (ELU), which seeks to strengthen the evidence base on what works to prevent and respond to violence against women and girls (VAWG).

The remainder of this section presents a brief overview of the SAFE programme and its operating context. The report then consists of the following sections:

- **Section 2** introduces the Endline Study, including its purpose, objectives and scope and the approach and methods used.
- **Section 3** presents insights on participant engagement with different intervention components.
- **Section 4** presents findings at the impact level, including IPV prevalence and family wellbeing.
- **Sections 5, 6, 7 and 8** present findings at the outcome level. Each section presents one outcome pathway from the SAFE Theory of Change, covering a total of four outcome pathways.
- **Section 9** presents our discussion, which synthesises and interprets the findings of the endline evaluation in light of the SAFE Theory of Change and the wider evidence base generated throughout the programme.
- **Section 10** presents conclusions, drawing together the key findings from across the SAFE evaluation cycle to help the reader make sense of the findings.
- **Section 11** discusses recommendations.

1.1. Context

As is the situation globally, GBV in Zimbabwe is endemic. The country has a high prevalence of GBV with one in three women experiencing lifetime prevalence of GBV and the phenomenon occurring across all socio-economic and cultural backgrounds and regions of the country. GBV is rooted in gender inequality, the abuse of power and harmful norms. The 2019 Multiple Indicator Cluster Survey (MICS) shows that close to 40% of women and girls in Zimbabwe experience physical violence in their lifetime and 12% experience sexual violence. Prevalence of physical violence among women and girls in Zimbabwe is 10 percentage points higher than the average global prevalence rate of 30%.[6]

Further context on GBV in Zimbabwe drawn from national and international datasets from the Zimbabwe National Statistics Agency (ZIMSTAT) and the United Nations and other multi-lateral agencies is provided in *Annex 1*.

1.1.1. The SAFE Communities programme

Overview

The programme's primary aim is to reduce the perpetration of IPV, largely driven by economic insecurity and social norms. To deliver on the Theory of Change (ToC) SAFE adopts an economic and social empowerment approach, works at individual, relationship, and community levels, and is publicly framed as a family wellbeing programme. Central to the SAFE ToC is the synergetic effect of the economic and social empowerment activities benefiting couples, where a new cash stream is used to create an impetus for families to engage in joint visioning and planning. Newly acquired financial stability is also expected to decrease family financial stress and have the potential to directly impact on violence perpetration.

[6] Zimbabwe National Statistics Agency and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

SAFE contains both prevention and response components. The GBV prevention component is framed as a family well-being programme, using gender transformative social and economic empowerment approaches, which operate at both household and community levels. The intervention is piloted in communities in focal wards in three districts: Chikomba (rural), Mwenezi (rural) and Chiredzi (urban).

The actual implementation components under SAFE are referred to as the TOOSE (adapted from the Shona word 'Tose' meaning "together") model. This includes an economic empowerment component, a social empowerment component and a response component, each presented below. All components were complemented by two key programme strategies and approaches: a Leave No One Behind (LNOB) framework, and a comprehensive learning and adaptation approach.

Prevention: economic empowerment component

The economic component consists of the participation of women (and some men) in Internal Savings and Loans (ISAL) groups in all the districts. In Chiredzi, the programme layers Toose onto the World Food Programme's (WFP) Zimbabwe's Urban Cash Assistance programme, a cash-based transfer (CBT) intervention funded by Foreign Commonwealth Development Office's (FCDO) Zimbabwe Humanitarian and Resilience Programme (ZHARP) in Chiredzi and implemented in partnership with Plan International. While the majority of ISAL participants are women, SAFE has also piloted male ISAL groups to enhance men's engagement with the programme. A total of 2,076 people were enrolled into ISALs across the three domains and cohorts of the programme (see *Table 1*).

Table 1: Number of ISAL participants in the programme

	Cohort 1		Cohort 2		Cohort 3	
District	Women	Men	Women	Men	Women	Men
Chikomba	293	28	280	42	42	14
Chiredzi	285	38	265	56	42	14
Mwenezi	284	35	245	57	42	14
Subtotal	**862**	**101**	**790**	**155**	**126**	**42**
Total	**963**		**945**		**168**	

Prevention: social empowerment component

The prevention approach is an adaptation of the GALS (Gender Action Learning System) model,[7] initially developed by Oxfam. It was originally designed to promote household gender equality within agricultural development programmes and is simple and scalable. SAFE adapted it to focus on reducing GBV by adding tools borrowed from effective GBV prevention interventions tested through FCDO's What Works to Prevent Violence Against Women and Girls Global Programme.

Toose drew from a co-facilitation model whereby SAFE Communities' implementing partners (IPs) facilitated the social empowerment Toose curriculum for Cohort 1 and recruited Toose participants to become Toose peer facilitators who co-facilitated subsequent intervention cohorts alongside IP facilitators and rolled out community activism activities.

A GBV prevention manual was developed and field-tested with Cohort 1 and has gone through additional iterations in Cohorts 2 and 3. The Cohort 3 version of the Toose manual contained eight sessions of three hours each, gathering 14 ISAL participants (predominantly women) and their partner or other family member (28 people in total).[8] The eight sessions covered topics equipping participants to vision and plan as a family, and critically examined gender norms, income and expenditures patterns, and triggers and root causes of violence. It also equipped participants with simple tools to promote harmonious families, including good communication and sharing positive time.

GBV Response

Complementing the prevention work is an ethical minimal response package, led by local Zimbabwe IP Musasa, that speaks to the increased demand for services through the Toose intervention whilst strengthening sustainable community level response support. The programme focuses on two key strategies: (1) Strengthening community-based response and increase demand generation through GBV Community-based Clubs (GCBCs), composed of trained community members who are tasked to strengthen referrals, accompany survivors to services and raise

[7] GALS is a community-led empowerment methodology that uses principles of inclusion to improve income, food and nutrition security of vulnerable people in a gender-equitable way. It positions poor women and men as drivers of their own development rather than victims, identifying and dismantling obstacles in their environment, challenging service providers and private actors. It has proven to be effective for changing gender inequalities that have existed for generations, strengthening negotiation power of marginalized stakeholders and promoting collaboration, equity and respect between value chain actors. (Oxfam Novib, 2014)
[8] The final Toose social empowerment manual after a fourth implementation cohort not covered under this evaluation contains 10 sessions.

awareness of GBV; and (2) contributing to the delivery and quality of the package of non-governmental direct services to survivors in SAFE districts, including shelters.

Promoting community level change

SAFE takes two approaches to promoting change at the community level whilst strengthening the enabling environment. Firstly, structured diffusion of Toose messages takes place whereby Toose peer facilitators diffuse Toose messages in both formal community events and informal social interactions. Second, unstructured diffusion occurs when any Toose graduate shares information and messages about the programme with family and community members. SAFE also trains key influencers and gatekeepers, with the aim of creating an enabling environment for women and men to change by creating public support for the shift in gender relations being promoted by the Toose approach and encouraging influential community members to amplify their voices in support of greater gender equality and non-violent intimate partner relationships. This involves key influencers participating in the Toose training or participating in a shortened three-day session exploring gender, masculinity and GBV.

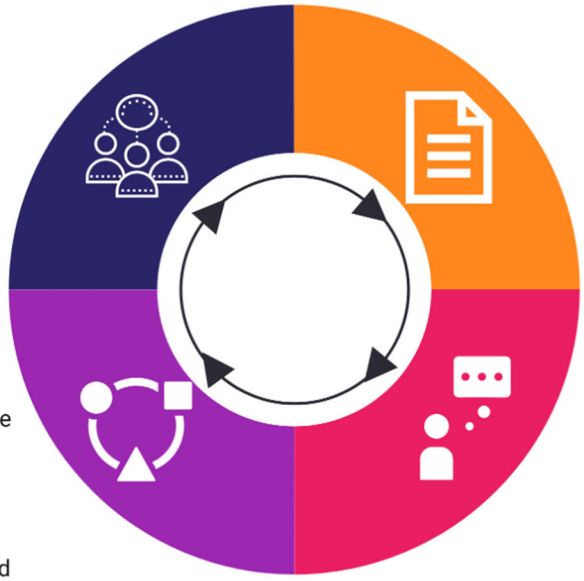
Leave No One Behind framework

LNOB principles are central to the implementation of SAFE. An LNOB framework was developed, which promotes the participation of women with disabilities and vulnerable women from different family structures (widows, wives of migrants or other women head-of-households). The LNOB strategy was developed in 2019, adapted over implementation and finalised in 2022.

Learning and adaptation approach

SAFE Communities implemented SAFE in three consecutive cohorts to enable learning and adaptation to be integrated into subsequent cohorts. The programme's learning and adaptation approach consisted of four phases, including: (1) cohort-based implementation, (2) triangulation of various sources of evidence, (3) reflection through structured programme workshops and (4) adaptations to programme components, including curricula, content and modalities (see *Figure 1*).

Figure 1: SAFE Learning and adaptation cycles



1 DOING

SAFE was implemented in three cohorts over a period of up to eight months each, with space inbetween cohorts to allow for evidence, reflection and adaptation cycles.

2 EVIDENCE

Multiple sources of evidence were used to design the intervention and test it over three cohorts, including: global and national evidence reviews, formative research, monitoring, independent evaluative and research studies and IP practice-based knowledge.

4 ADAPTATION

Adaptations were made to enhance impact and effectiveness in subsequent cohorts. This was accompanied by capacity building of implementing partners to support implementation of adapted approaches.

3 REFLECTION

At the end of each cohort, the programme conducted structured learning and adaptation workshops with programme partners to share lessons learnt from evidence, practice, experiences, successes and challenges.

1.1.2. The SAFE Evaluation and Learning Unit

The SAFE ELU seeks to strengthen the evidence base on GBV in Zimbabwe by iteratively testing the effectiveness of the SAFE programme; informing programme adaptation; optimising delivery to maximise the impact of Toose on women and girls in Zimbabwe; helping to explain what is working to prevent and respond to violence against women and girls, including how and why; and contributing to the wider GBV knowledge base, both nationally and internationally.

The SAFE ELU's overarching evaluation has three objectives:

1) The **learning** component of the evaluation design focuses on informing programme design, learning about what is working (and not working), and why, and informing subsequent programme adaptation, during both the inception and implementation periods.
2) The impact component of the evaluation design seeks to test and validate the intervention model through the measurement of its impact on violence against women and girls and on primary and intermediate outcomes in the SAFE theory of change and understand why impact has occurred or not.
3) The scale up component of the evaluation design seeks to understand possibilities for scaling up the SAFE intervention if it is observed to be effective and impactful.

1.1.3. The SAFE Theory of Change

The SAFE ToC finalised in July 2021 (*Annex 2*) was revised in April 2023 *(Annex 3*). The impact statement of the ToC is *Reduced prevalence of GBV in SAFE focal wards and improved family wellbeing*, which is expected to be delivered through five outcomes, four of which are addressed in this report (Outcomes 1-4).

Outcome 1 is *Households are able to manage economic stress*. This outcome is expected to be delivered through the development of income generating activities (IGAs) supported by ISAL groups and coverage of basic needs through CBT in Chiredzi. There are important links to Outcome 2 through the development of shared visions to improve household wellbeing, and women having greater financial independence and increasing their negotiating power in the household through greater economic contributions.

Outcome 2 is Intimate partners and family relationships are more gender equitable, do not seek to control individuals and do not resort to violence to resolve conflict. Outcome 2 is expected to be delivered predominantly through the Toose manual, including intimate partners' greater cooperation, more gender equitable behaviours in the household and increased relationship quality (feeling loved and respected, and spending positive time together).

Outcome 3 is *Members of focal communities express a desire to live the Toose way*. This outcome is delivered through structured and unstructured diffusion of Toose messages and tools at community level, and awareness raising about GBV and available services through GCBCs.

Outcome 4 is *Increased access to essential GBV services by women and adolescent girls*. This outcome is expected to be delivered through the reduction in barriers to survivors accessing GBV response services, including women and girls recognising GBV as a harmful practice and GCBCs supporting women and girls to access available GBV services.

Outcome 5 is the *SAFE model and its effectiveness is well documented for learning and replication by other actors,* with a focus on internal and external learning and dissemination of the Toose package.

The central hypothesis of SAFE's ToC is that to reduce IPV and other forms of GBV, changes are needed at both the household level (Outcomes 1 and 2) and community level (Outcome 3). These are the main points of intervention for SAFE, which focuses on prevention through reducing economic drivers of violence, addressing harmful social and gender norms that shape how women, men, boys, and girls are expected to behave, and reducing tolerance and acceptability of GBV. Providing survivors of violence with access to essential services is a vital component of an ethical approach to GBV prevention. SAFE's approach therefore seeks to enable survivors of violence to access the services they need by tackling critical barriers and improving quality of services (Outcome 4). To maximise the impact of SAFE in focal wards and elsewhere in Zimbabwe, evidence is needed of an effective intervention model that can be packaged and replicated (Outcome 5).

It should be noted that the baseline was designed before the ToC was updated in 2023. The baseline and endline studies were therefore designed to measure impact, outcome and output indicators based on the original programme ToC from 2021. The discussion section of the report uses key findings to interrogate the ToC assumptions and pathways and draws from the most recent ToC. However, it should be noted that there are some gaps in understanding given that the baseline and endline studies were designed with a previous ToC version in mind.

2. The Endline Study

2.1. Purpose, scope and objectives of the study

The purpose of the Endline Study is to quantitatively measure changes in outcomes and impacts (according to the SAFE ToC) among SAFE beneficiaries in Cohorts 1 and 2 by measuring these at endline and comparing them against baseline. The study also qualitatively explores impact on Cohort 3 participants, including on men. More specifically, its purpose is to:

- Provide an estimate for the change in IPV among programme beneficiaries;
- Strengthen any claims in relation to the testing and validation of the intervention model;
- Strengthen our understanding of the potential for and usefulness of SAFE scale-up;
- Fill evidence gaps in our evaluation design (i.e. Cohort 1 impact and impact on men);
- Provide the precedent for future studies to further explore the impact, including the counterfactual and causality;
- Give insights into the contribution of the intervention, by a) comparing quantitative endline data against quantitative baseline data, and b) combining quantitative endline data with qualitative endline data, and qualitative data from the longitudinal cohort study.

To achieve these aims, the study has five objectives. Namely, to understand:

1) Change in prevalence of GBV among SAFE beneficiaries since baseline;
2) Change in household dynamics among SAFE beneficiaries since baseline, including decision making, gendered division of labour, economic planning, and forms of communication and conflict resolution;
3) Change in attitudes towards GBV and GBV response among SAFE beneficiaries since baseline;
4) How different intervention components and adaptations affected change;
5) The sustainability of change, and of the different programme components.

In doing so, the study explores the differences in the findings across the SAFE intervention districts. The study pays particular attention to the heterogeneity of experiences between target beneficiaries of the SAFE Communities intervention in rural and urban areas and between beneficiaries who received CBT assistance (Chiredzi) and those who did not (Mwenezi, Chikomba). The study also analyses, where relevant, intervention impact for beneficiaries' intersectional characteristics including age and disability. The qualitative component pays attention to differences between men and women, and to differences between SAFE participants and their partners.

2.2. Research questions

The study is guided by eight Endline Study questions that are based on the relevant overarching SAFE ELU evaluation and learning questions, in particular the impact evaluation and learning questions, which were devised in consultation with SAFE Communities and the FCDO at the start of the programme. The Endline Study questions both respond to the study objectives outlined above and contribute to the overarching SAFE ELU evaluation and learning questions, which all ELU activities contribute towards answering.

1) To what extent does SAFE improve family wellbeing through reducing household economic stress, improving gender equitability of intimate partner and family relationships, and increasing access to essential GBV services?
2) What unintended outcomes (both positive and negative) are evident as a result of the SAFE programme?
3) To what extent does SAFE improve key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?
4) To what extent and how far does SAFE reduce prevalence of different types of GBV among SAFE Communities beneficiaries?
5) To what extent does SAFE address the prevailing attitudes towards GBV, including GBV response, among SAFE beneficiaries?
6) Which components and adaptations of the intervention led to change? What change is associated with each activity and adaptation, including Cohort 1? What is the added value of CBT?

7) To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?
8) To what extent is the change measured sustainable? How sustainable is each activity?

2.3. Approach and methods

2.3.1. Research approach and methods

The Endline Study is a longitudinal study that tracked participants from the quantitative Baseline Study conducted in 2022, allowing for measurement of change over time.

It is a mixed-methods study with qualitative and quantitative components, with a stronger emphasis on quantitative research. The study involves a large quantitative survey complemented by qualitative in-depth interviews (IDIs). The quantitative component includes an anticipated 1,245 household surveys with women from cohorts 1 and 2 across the three SAFE implementation districts (see *Section 2.3.2* and *Annex 4* for the sampling approach and breakdown).

Since the Baseline Study only sampled from cohorts 1 and 2, the endline survey also exclusively sampled from cohorts 1 and 2. However, the qualitative component supplemented this with 74 IDIs, of which 60 were conducted with male and female participants from Cohort 3 and their partners, and 14 with GCBC volunteers. Further details on sampling can be found in *Section 2.3.2* and *Annex 4.*

Because the Endline Study does not include a comparison group, it does not measure the counterfactual. As a result, the endline data alone does not provide evidence on causality – it does not tell us with certainty whether a reduction or increase in IPV is a result of the intervention, or the result of other influencing factors, or a combination of those (attribution).[9,10] However, the combination of primary qualitative data, particularly focused on contribution of different programme elements, strengthens this study's design and partly mitigates against not having a formal counterfactual.

Survey

The anticipated survey sample was 1,245 household surveys with women aged 18 years and over in SAFE Communities' implementation wards. We did not sample children and men because these were not sampled at baseline for several reasons. These are discussed in *Annex 4*. The endline survey tool is included in *Annex 5*.

In-depth interviews

We conducted 60 IDIs with men and women in Cohort 3 to ensure a comprehensive understanding of the community and household dynamics within the intervention areas and across all intervention cohorts. Because cohorts 1 and 2 have been well represented in our evaluation design, this qualitative component of the Endline Study primarily focused on Cohort 3 Toose participants and their partners, which our evaluation has generated limited evidence on because of the timing of implementation. We also conducted 14 interviews with GCBC volunteers (one per intervention ward) to better understand the GBV response component of the programme. The endline IDI tools for women and men in Cohort 3, their partners, and GCBC members can be found in *Annexes 5, 6, 7 and 8.*

Roles and responsibilities

The Endline Study was conducted by the SAFE ELU, led by Tetra Tech International Development in collaboration with Q Partnership and affiliation with the University of Zimbabwe, both based in Harare. All data collection with women was undertaken by female enumerators/interviewers and with men by male enumerators/interviewers, recruited by Q Partnership. The enumerators and interviewers were trained by Tetra Tech's Gender Advisor based in Harare and Q Partnership. The Gender Advisor also conducted monitoring of data collection activities.

[9] However, the summative study explores influencing factors that strengthen our understanding of contribution and give some insights into the attribution of the intervention.
[10] Current evidence suggests that a rigorous mixed-methods evaluation approach is the most appropriate to evaluate a pilot intervention, particularly one that has not been previously tested for the reduction of IPV. Following confirmation of evidence of effective intervention implementation and positive intervention impact, recommendations for scale-up could be made with future plans to conduct an experimental study, such as a Randomised Control Trial (RCT).

Pre-test

The survey and qualitative interview tools were pre-tested in one district, with all data collectors administering the tools with a selection of women and men from beneficiary communities who were not included in the endline sample. The SAFE ELU and Q Partnership team then conducted a debrief with data collectors, leading to some minor adjustments to the tools and additional training.

2.3.2. Sampling and achieved sample

Survey

The endline household survey sample was intended to reproduce the baseline sample as much as possible. We recontacted each adult woman who participated in the household survey at baseline, using the personal information they shared at baseline. This information was stored securely on paper forms by our research partner Q Partnership, who used this data to recontact respondents by phone and/or in the field and ask them if they would like to participate in the endline survey. Respondents who did not provide any contact detail information at baseline, or who refused to participate in another survey at the time, were not recontacted. For details of our tracking system and sampling approach, see *Annex 4.*

At baseline, we interviewed 1,245 women, which was just over the target number of 1,200 women (400 per district). With an attrition buffer of 20% calculated on the target sample (1,200), the endline minimum threshold for attrition while retaining power in the sample was a target sample of 960 women. At endline we surveyed 1,037 women, of whom 958 (77%) were classified as successfully recontacted and retained in the endline sample, with a loss of 287 women overall (see *Table 2*). While this appears to represent an attrition rate of 23%, given we oversampled at baseline, the actual attrition rate based on the baseline target sample is 20%.[11] Consequently, the endline achieved longitudinal sample at the district-level allows us to detect mean pre-post differences of 0.20 standard deviations or larger in the distribution of any continuous variable, with a statistical power of 80% at the 95% confidence level.[12]

Table 2: Completed interview vs target by district

District	Target baseline sample	Actual baseline sample	Endline sample	Matched/ retained	% Successfully recontacted (against actual sample)	% Successfully recontacted (against target sample)
Chikomba	400	411	334	311	76%	78%
Chiredzi	400	419	359	330	79%	83%
Mwenezi	400	415	344	317	76%	79%
Total	**1,200**	**1,245**	**1,037**	**958**	**77%**	**80%**

In depth interviews

For the IDIs, we sampled a) men and women participants from Cohort 3; b) their partners; and c) GCBC volunteers.

We sampled both Cohort 3 participants and their partners to understand impact among women and men who participate fully, and their partners, who participate partially, in the programme. Participants are full beneficiaries of the programme as they participate in all components of the prevention intervention (both economic and social empowerment) but their partners only participate in the social empowerment component. Of the 74 intended IDIs, all 74 were completed (see *Table 3* below). For details of our sampling approach, see *Annex 4.*

[11] Reasons for attrition include migration, death and failure to match unique IDs between the baseline and endline samples (see the Endline Fieldwork Report for further details).
[12] A difference of 0.2 standard deviations is a standard measure of a "small-size effect" according to the widely adopted guidelines suggested by Cohen (1988). Confidence levels of 95% are the most widely used benchmark in social sciences while a statistical power of 80% or higher is usually considered good standard. In practice, our district-level samples are able to detect a 0.15 shift in standard deviations with an 82% statistical power and a 0.20 shift with a 91% statistical power (calculations made for Chikomba where the attrition rate is highest – for the two other districts, statistical power is marginally higher).

Table 3: Achieved IDI sample across districts and participant types

Group	Chikomba		Chiredzi		Mwenezi		Category Total
	Female	Male	Female	Male	Female	Male	
GCBC Focal	5	0	1	3	5	0	14
Cohort 3 Beneficiaries	7	3	6	4	7	3	30
Cohort 3 Partners	3	7	4	6	3	7	30
Total	**15**	**10**	**11**	**13**	**15**	**10**	**74**

Potential attrition bias

Although the attrition rate achieved across the three districts does not exceed the baseline target of 20%, even low levels of attrition may create biases when comparing baseline and endline samples across time. This happens when respondents are not lost at random or, in other words, when respondents that can be recontacted are slightly different than the average respondents. For example, the most fragile populations may have migrated for work or other reasons, which may result in an endline sample that is, on average, "better-off" than the baseline sample. *Table 4* below shows the levels of key variables at baseline, comparing the complete baseline sample to the recontacted and lost samples.

Table 4: Attrition bias

Variable	Complete sample	Recontacted	Lost	p-value
Age (mean)	42	43	38	0.00***
Disability rate (baseline)	12%	11%	16%	0.02**
Had partner in last 12 months	81%	81%	81%	0.99
Food insecurity scale	4.2	4.2	4.4	0.08
IPV prevalence	47%	45%	53%	0.06
Controlling behaviours prevalence	54%	53%	59%	0.08

The right column shows the p-value of the student's t-tests of statistical significance between the recontacted and lost samples. Only age and disability rates have p-values lower than 5%. This implies that the recontacted sample is significantly older and fewer have disabilities than the lost sample. While there are differences between the total sample and lost sample on measures of IPV and controlling behaviours, the differences between the total and recontacted samples are minimal and not significant. This suggests that while there is some attrition bias in the endline sample, this is likely to have had minimal impact on key outcome findings of the evaluation.

2.3.3. Coding and analysis

The data collected was systematically analysed, triangulated, and synthesised by the SAFE ELU team, incorporating longitudinal analysis techniques to assess changes and trends over the duration of the study.

The outcomes measured through the endline survey data were compared with those from the baseline survey data (see *Annex 4* for a description of how variables were created). This comparison was made through calculating the difference between endline and baseline variable levels, using paired statistical testing on recontacted women. Different statistical tests were used to check the robustness of results: i) Student's tests of equality of means, ii) Wilcoxon signed-rank test of equality of medians, and iii) McNemar's tests (for binary variables only). P-values lower than 5% were flagged, although absolute differences in levels were also analysed in themselves, especially for sub-samples of smaller size. Statistical tests were run on the overall sample as well as on a variety of subgroups defined by the values and levels of key sociodemographic variables and potential IPV triggers[13]. Tests were also run across categories of key exposure questions to assess the effect of different activities of all dimensions of gender-based

[13] These are: Cohort, District, Disability status, Age category, Food insecurity at baseline, Food insecurity at endline, Experience of unexpected loss of income or assets in the past 12 months (at endline), and Partner having worked away from home in the past 12 months (at endline)

violence[14]. Further, exposure questions were tabulated across the key sociodemographic variables listed above to exhibit the respondents' levels of exposure to different SAFE activities according to the subgroups to which they belong.

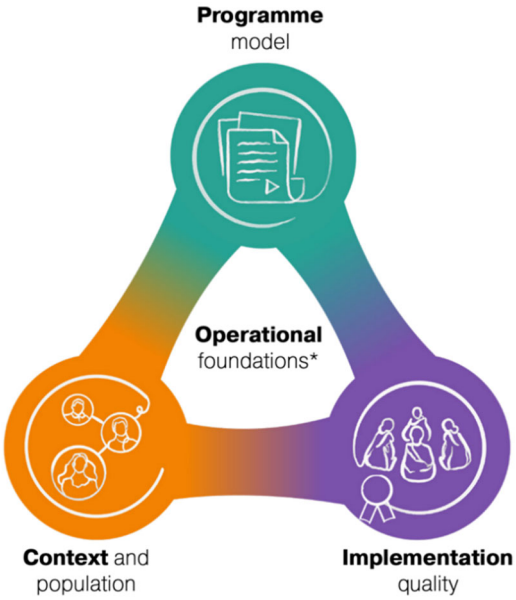
The qualitative data was coded using Dedoose software, using a team of two data coders. A coding framework was established based on the qualitative tools, and the coders were trained to ensure consistent application of the coding framework. A pilot phase was conducted where all coders coded the same transcripts and raised issues or inconsistencies, which were discussed among the team. The first batch of coding was thoroughly quality assured and any inconsistencies were discussed with the coding team. A thematic analysis of general trends was undertaken, and attention was given to differences between men and women, Toose participants and partners of participants, and between districts.

The analysis, triangulation and interpretation of endline quantitative and qualitative findings draws from secondary data, including from other SAFE ELU studies, programme monitoring data and national and international literature. This comes together in the discussion section of the report where the results are framed around the Prevention Triad (see *Figure 2*) , which is a useful tool for interpreting evaluation findings across three programme elements:

1) The **programme model** includes the theory of change, the components that make up the intervention model, materials and curricula, the length, intensity and sequencing of interventions, and the programme's contribution to mechanisms to reduce violence.
2) **Implementation quality** refers to the planning and logistics for rolling out an intervention, including recruitment and capacity of staff, facilitators and other field workers, selection of and engagement with participants, and how programme's respond to challenges.
3) **Context and population** refer to the characteristics of the setting in which a programme is implemented, and the need to ensure that interventions are fit for context and populations.

At the centre of the Prevention Triad sits the basic operational foundations that are critical for programme success, including organisational capacity, partnerships, appropriate budget and adequate timeframes for implementation.

Figure 2: Prevention Triad



Source: Prevention Collaborative

Working with qualitative data

Because the data is collected using open and indirect questions as part of semi-structured interviews, not all responses/interviews are the same and therefore comparable; every interview looks slightly different. It also means that responses tend to be complex, lengthy and need to be coded and analysed individually and then, interpreted by the researcher. Further, unlike quantitative data, qualitative data is descriptive and expressed in terms of language rather than numerical values, so it cannot be measured or counted. For this reason, it would not be appropriate to provide percentages or quantities in large scale qualitative research. In line with this, the qualitative sections in this report do not provide percentages or numerical values. It does, however, give rough indications of prevalence of data or proportion of participants, using terms such as 'a few', 'most', 'a handful' etc.

[14] These are: Number of TISAL loans taken, having participated in Toose session with partner, having participated in Toose session during the second half of 2023, having participated in Toose session on different forms of power, having participated in Toose session on IPV, having attended Toose community conversation, having worked as peer facilitator, having participated in GCBC (Musasa) session, having been supported by GCBC (Musasa) member, and Having accessed a Musasa service. This list only includes questions that could discriminate between sufficiently large parts of the sample (i.e., when they could be used to create categories of at least 50 respondents each).

2.3.4. Ethics and safeguarding

The study was designed alongside a robust ethical protocol in alignment with the SAFE Ethical Framework.[15] The ethical protocols ensured that:

1) Informed consent was obtained from all participants;
2) Safeguarding processes and reporting mechanisms were followed;
3) 'Do no harm' principles were respected, including minimising distress and establishing appropriate mechanisms for handling distress;
4) GBV referral mechanisms were in place and accessible for survivors;
5) Confidentiality and privacy were maintained;
6) Data protection protocols were compliant with General Data Protection Regulation (GDPR) commitments;

The Endline Study proposal was submitted and approved for ethics approval to both the Medical Research Council of Zimbabwe (MRCZ) and the Research Council of Zimbabwe (RCZ). Our affiliation partner, the University of Zimbabwe, supported the application for ethical approval.

For details on obtaining district level fieldwork permissions, please refer to the Endline Ethical Approval Proposal. Full details of the ethical and safeguarding protocols and procedures can be found in *Section 2.4* of the proposal or *Annex 4* of this report.

2.3.5. Dissemination of results

In the lead up to completion of the final endline evaluation report, the SAFE ELU and programme partners have disseminated both preliminary and more comprehensive endline findings in a number of fora and with different stakeholders. These include several national dissemination events with the presence of government, civil society and local partner stakeholders, and beneficiaries of the programme from local communities, including Toose peer facilitators, Toose champions (graduates) and GCBC members. The SAFE ELU also presented the endline results in the programme's Cohort 4 Learning and Adaptation workshop, with a smaller set of internal stakeholders, including programme IPs and beneficiaries from communities in Chiredzi (the only district covered under Cohort 4).[16] The endline results have been shared through several online events, including in an international webinar to celebrate 16 Days of Activism, through a targeted learning session with the Prevention Collaborative and as a final presentation to the programme's Reference Group. Results have been disseminated in written form through two briefs, one summarising key programme learning to date and the other summarising the impact of the programme, both drawing from the endline results[17].

[15] This SAFE Ethical Framework is fully compliant with a range of key frameworks and guidelines, including: the SAFE Safeguarding Framework; instructions on Institutional Review Board (IRB) ethics review submissions to the Medical Research Council of Zimbabwe; the World Health Organisation (WHO) Ethical and safety recommendations for intervention research on violence against women (2001, and updated in 2016); the Child Protection Monitoring and Evaluation Reference Group Ethical principles, dilemmas, and risks in collecting data on violence against children (2012); the guiding concepts and principles set out in FCDO's Evaluation Policy (2013), FCDO's Research Ethics Guidance (2011), FCDO's Ethical guidance for research, evaluation and monitoring activities (2019) and FCDO's Digital Strategy 2018 to 2020: doing development in a digital world; the HM Government Involving Disabled People in Social Research Guidance by the Office for Disability Issues (2011); and the General Data Protection Regulation (2018).
[16] While the ELU's endline evaluation did not cover Cohort 4 implementation, the SAFE ELU's presentation of endline results at the Learning and Adaptation workshop was framed as supporting ongoing adaptation and learning across the programme.
[17] See https://intdev.tetratecheurope.com/projects/safe-zimbabwe/

2.3.6. Limitations

Adaptations to the theory of change

The baseline and endline studies were designed to measure impact, outcome and output indicators based on the programme ToC. This ToC was updated in 2023 in line with the programme's adaptive approach. The discussion section of the report uses key findings to interrogate the ToC pathways to change and draws from the most recent ToC. However, it should be noted that there are some gaps in understanding given that the baseline and endline studies were designed with a previous ToC version in mind. This is especially the case for the Outcome 3 pathway, which previously focused on reduced tolerance of IPV among focal communities. The new pathway in the revised ToC focuses on focal communities' desire to live 'the Toose way' instead. Although this Endline Study explores the former version of the pathway, the latter was explored in the SAFE ELU qualitative community impact study. For more examples of changes to the ToC, see *Annex 3*.

Children

We have included insights pertaining to children throughout this report. These are based on perceptions of adult household members who participated in the programme. Children were not directly targeted by the programme, and therefore also not included in this study.

Men

By sampling women only for the endline, the study does not quantitatively measure endline outcomes and impacts for men, limiting a quantitative endline impact assessment only to impacts and outcomes among women. However, these issues have been explored through the qualitative longitudinal cohort study, which included women from the baseline and, where relevant, their male partners. The qualitative component of this Endline Study also sampled a small number of men in Cohort 1 (male beneficiaries and male partners of female beneficiaries) as well as their male partners, which helps us understand the intervention's effect on men's lives in Cohort 3.

Control/ comparison group

Because the Endline Study does not include a comparison group, it does not measure the counterfactual (i.e., what would have happened in the absence of the programme). As a result, the endline data alone does not provide evidence on causality – it does not tell us with certainty whether a reduction or increase in IPV is a result of the intervention, or the result of other influencing factors, or a combination of those (attribution).[18][19] However, it should be noted that the aim of this Endline Study was not meant to isolate impact quantitatively. Its aim was rather to map changes in key outcome and impact indicators in an effort to understand causality, using the ToC the guiding framework. The combination of primary qualitative data and integration of secondary data from ELU and programming evidence, particularly focused on contribution of different programme elements, strengthens this study's design because it improves the accuracy, reliability and depth of this ToC based approach.

Differences in selection into the intervention in urban and rural areas

Due to the different modalities of implementation in different districts, with CBT implemented in Chiredzi's urban context but not in the programme's two rural contexts, there are some differences in selection procedures. Participants in Chikomba and Mwenezi self-selected into the Toose intervention. While participants also did so in Chiredzi, they had first undergone a rigorous profiling exercise implemented by WFP to determine the most vulnerable households eligible for CBT. This means that the baseline beneficiary population in Chiredzi was likely different in composition from the population in the other two districts, with some potentially higher indices of vulnerability. This is not expected to have had significant impacts on the data given that SAFE baseline households in Chiredzi were less food insecure at baseline than the other two districts.

[18] However, the summative study explores influencing factors that strengthen our understanding of contribution and give some insights into the attribution of the intervention.
[19] Current evidence suggests that a rigorous mixed-methods evaluation approach is the most appropriate to evaluate a pilot intervention, particularly one that has not been previously tested for the reduction of IPV. Following confirmation of evidence of effective intervention implementation and positive intervention impact, recommendations for scale-up could be made with future plans to conduct an experimental study, such as a RCT.

External shocks

The Endline Study was conducted during a severe El Niño drought year, which affected large parts of Zimbabwe. This environmental shock had significant socio-economic consequences, particularly related to food security and livelihoods. The drought led to a massive crop failure and heightened food insecurity. Despite receiving average rainfall across most of the main maize planting areas in late December and early January 2024, most of the country experienced a dry spell, lasting more than 30 days, in February 2024. Poor rainfall led to partial or complete crop failure in most parts of the country - 40% poor and 60% written-off. The 2024 Zimbabwe Livelihoods Assessment Committee determined that 7.6 million people (50% of the total population) in the country faced food insecurity as a result of the drought, with 1.7m people in urban areas and 5.9m in rural areas likely to be food insecure by the peak of lean season from January to March 2025. This is double the number of food insecure population from the last lean season.

These external stressors may have influenced household dynamics, levels of stress, and economic insecurity, all of which are known drivers of IPV and other forms of GBV. As such, the drought may have impacted both the lived experiences of participants and the outcomes measured at endline.

Timing of data collection relative to programme exposure

The Endline Study took place 1–2 years after most participants completed the SAFE programme. This time lag may have affected participants' ability to recall specific programme components - such as attendance, who accompanied them to Toose sessions, or the content of particular modules - and could therefore have implications for the accuracy of retrospective data. Additionally, the gap between programme completion and data collection means that some observed outcomes may reflect longer-term impacts, while others may have diminished over time. Both possibilities should be considered when interpreting the findings.

Timing of CBT exposure

In March and April of 2024, the entire caseload in Chiredzi went through a CBT reprofiling exercise. In April/ May, the new caseload came into effect. Many Toose participants from Cohorts 1, 2, and 3 were removed from the CBT programme before data collection for the endline began. This information was not shared with the SAFE ELU until after endline data collection took place, and so possible termination of exposure to CBT was not recorded in the endline survey. This means that the endline dataset is unable to measure the extent to which termination of CBT impacted on endline outcomes.

Desirability bias and reliability of personal accounts of GBV and attendance

Social desirability bias in research is the tendency for participants to present reality in line with what they believe to be socially acceptable. GBV-related issues are sensitive. As a result, people, especially vulnerable populations, and young people, may have been unwilling to talk or to express their views in a sincere and accurate manner – this may have happened at baseline as well as endline. This could have created a bias towards ‘socially acceptable’ views and underreporting of occurrences and severity of violence. Women who experience violence may not be willing to share their experiences due to feelings of shame and/or fear of retaliation from perpetrators. For example, if the bias took place at baseline and, at endline, participants felt more confident speaking about GBV, this could lead to the data suggesting an increase in IPV when in fact the estimates of IPV prevalence were lower than they should have been. A way to mitigate this is to use population data such as MICS or Demographic and Health Survey (DHS) data and compare this against the study’s prevalence rates. However, when comparing with DHS data, the baseline prevalence rates of IPV were higher than the national average. Therefore, underestimates of prevalence at baseline are possible but not likely.

In addition, as demonstrated in previous studies, participants may have more knowledge of what constitutes socially acceptable behaviours and attitudes. Social desirability bias can also happen at the end of a programme due to people’s desire for programming to continue, particularly if they perceive the programme to be beneficial to them or their community.

In relation to attendance, there could be recall bias in remembering whether or not participants attended a session on IPV or power more than a year ago, how many sessions participants attended, and who they brought to the sessions.

Our instruments, forms and protocols were designed to minimise such biases as much as possible, drawing on our teams’ expertise, international standards, and best practices. The fieldwork teams received training to familiarise themselves with the purpose and specificities of the interview guides, and how to ensure the confidentiality of interviewees. Despite this, interview biases cannot be fully eliminated and must be kept in mind when analysing and interpreting the data.

2.4. Reporting of results

The following sections of the report present results in relation to participant engagement with different components of the programme, and impact and outcome level change in line with the four main pathways to impact in the SAFE ToC. Where results refer to being significant, this means that they are statistically significant and that there is 5% or less probability that the results occurred by chance (p=<0.05) in a bilateral hypothesis testing. Throughout the report, the strength of the statistical significance of findings is depicted in graphs through the number of stars: *p=<0.05; **p=<0.01; ***p=<0.001. At the start of each section reporting on impact and outcome pathways in the SAFE ToC, key measures are illustrated through a red, amber, green (RAG) rating as depicted below. RAG ratings are compiled across all impact and outcome measures in *Annex 9.*

Table 5: RAG Rating Breakdown

Significant change in wanted direction (p=<0.05)	Insignificant change in wanted direction (p=0.06–0.1)	No change (p>0.1)	Insignificant change in unwanted direction (p=0.06–0.1)	Significant change in unwanted direction (p=<0.05)

3. Engagement with the intervention

Key findings

- The large majority of women sampled in the endline survey (95%) had taken at least one loan from a Toose Internal Savings and Loan (TISAL) group. Factors associated with having had taken out a loan include exposure to Toose social empowerment sessions, Cohort 1 and Toose community conversations. These results may suggest that engagement with social empowerment and community diffusion activities have strengthened engagement with economic activities. However, causality, directionality and temporality of this finding cannot be established; it is also possible that the reverse is true and that stronger engagement in TISALs led to enhanced engagement with social empowerment components.
- The number of loans taken out by women appears lower in Mwenezi than in other districts, and among women with a disability. Taking out loans is also associated with food security and lower age, which may suggest that greater household food security frees up household resources to contribute to TISAL savings and benefit from loans. The size of loans also appears lower in Mwenezi and is also associated with age and food security such that a larger number of loans has been taken out by women in younger age groups and those with higher food security. The most common reason for taking out loans is to cover school fees and to direct towards business activities and IGAs. The qualitative Cohort 1 findings echo these survey results.
- Survey results show that 49% of women brought their partner to Toose sessions and 88% brought other family members. Participation with partners was most common in Chiredzi, with much less participation of partners in the other two districts. The Cohort 1 qualitative data shows similar trends.
- Attendance of social empowerment sessions was lowest in Chiredzi (mean of 6.8 sessions) and highest in Mwenezi (mean of 7.7 sessions). The Cohort 1 qualitative data suggest a different trend: attendance was lower in Chikomba and higher in Chiredzi and Mwenezi.
- Almost eight in ten respondents said they attended a Toose community conversation, although this was higher in Mwenezi and lower in Chikomba. This was echoed in the Cohort 1 qualitative interviews. Overall, happy families and visioning and planning were the messages most listened to. The most common platforms used to facilitate Toose community conversations were community meetings, followed by church and community gardens.
- Almost half of women had participated in a GCBC awareness raising session in the community, and exposure to sessions was greater in Chiredzi and Mwenezi. Only 13% of respondents stated that a GCBC member had provided direct support to them and this was echoed in the Cohort 1 qualitative data.
- When asked which elements of the programme Cohort 1 respondents were most likely to take forward, most respondents across all districts said participating in TISALs, saving and working hard on maintaining and further expanding their IGAs, and collective visioning, planning, and decision making. Other commonly mentioned elements include communicating effectively with partners and children and fostering family unity.
- When asked about the sustainability of TISALs, most respondent said their groups (or their partners' groups) were still functioning. However, many groups experienced challenges, such as drop-outs and inconsistent attendance, mostly from members with debts who were unable or unwilling to repay these. This was true for all districts but more so for Chiredzi and Chikomba.

Before presenting impact and outcome level findings of the endline evaluation, it is useful to understand how respondents engaged with and participated in the programme. The endline survey measured women's engagement with different elements of the programme and included some measures of perceptions of programme quality. Key findings related to engagement are outlined below according to the four core components of the programme: economic activities, social empowerment, community diffusion and GBV response. Relevant findings from the qualitative Cohort 1 interviews are also presented below.

3.1. Economic activities

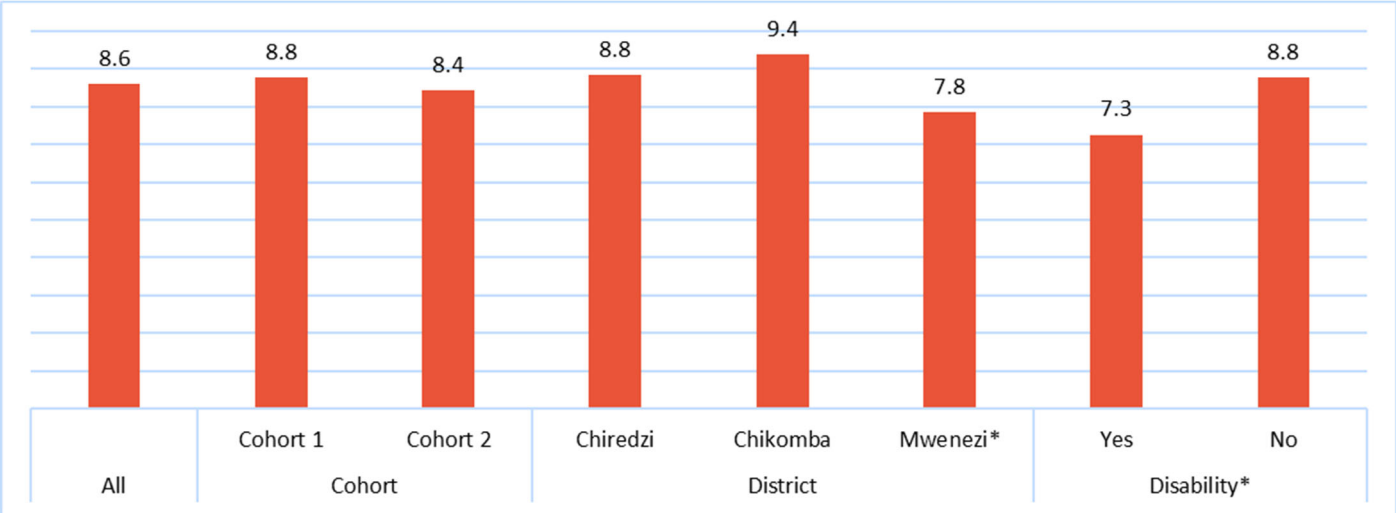
The endline survey measured how many loans women had taken out from their TISAL groups since startup to understand if the number of loans was associated with economic empowerment outcomes.[20] The large majority of

[20] According to the programme logic, TISALs are the main vehicle for household economic wellbeing outcomes through savings and loans directed towards IGAs.

women sampled in the endline survey (95%) had taken at least one loan from a TISAL group and this proportion was consistent across both cohorts and all three districts, and regardless of whether women had a disability or not. In relation to exposure to the Toose social empowerment component of the programme, several elements of exposure are significantly related to taking out TISAL loans. A larger proportion of women took out at least one loan when having participated in Toose social empowerment sessions with a partner (99% versus 91% of women who participated with another family member, p=0.001). Having taken out a loan was also associated with participation in Cohort 1 sessions (97% of women versus 90% who did not participate in Cohort 1 sessions, p=0.001) and participation in Toose community conversations (97% of women versus 88% of women who had never attended a Toose community conversation, p=0.001). These results may suggest that engagement with social empowerment and community diffusion activities have strengthened engagement with economic activities. However, causality, directionality and temporality of this finding cannot be established; it is also possible that the reverse is true and that stronger engagement in TISALs led to enhanced engagement with social empowerment components. In either case, these results would be in line with findings from other SAFE ELU studies that have found that the economic and social empowerment components of the programme are mutually reinforcing.[21]

Women participating in the endline survey reported a mean number 8.6 TISAL loans since their TISAL started up,[22] although the mean was significantly lower among women in Mwenezi and among those with a disability (see *Figure 3*). The number of loans taken out is correlated with age, with larger number of loans being taken out by women in younger age groups (see *Figure 4*). Taking out loans is also associated with food security, with a significantly larger mean number of loans taken out among women in the most food secure households at endline (9.5 mean loans, p=0.001) when compared with women in medium food secure and food insecure households (7.7 mean loans in each group). This may suggest that greater household food security frees up household resources to contribute to TISAL savings and benefit from loans, which is in line with the findings from the ELU's Deep Dive 3 study on the social and economic empowerment benefits of the programme's economic activities.

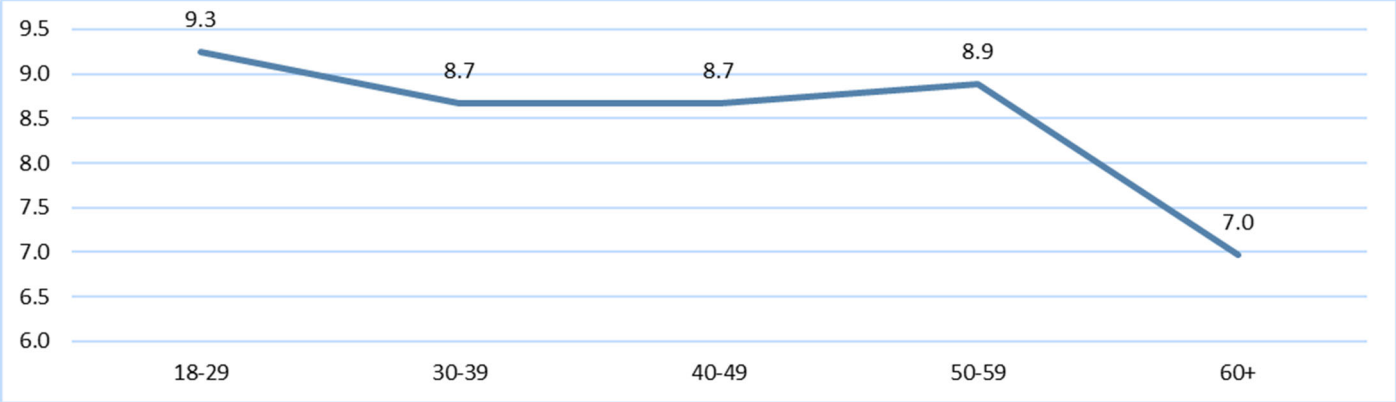
Figure 3: Mean number of TISAL loans taken out since TISAL start up, by cohort, district and women's disability status



[21] For example, as outlined in the ELU's Summative Evaluation, cash from the CBT programme in Chiredzi and new income streams from TISALs in all three districts created opportunities for couples and other household members to practice skills and behaviours shared in the social empowerment training, including joint decision making, visioning and planning.

[22] With a range of between zero and 41 loans.

Figure 4: Mean number of TISAL loans by age



Box 1: Qualitative insights on number of loans, loan size and use of loans in Cohort 3

In the qualitative Cohort 3 interviews, taking out loans frequently or monthly and taking out loans sporadically (one to three times) were both most commonly mentioned, and participants were just as likely to mention these (17 reports of frequently or monthly and 18 reports of one to three loans). Taking out four to six loans was mentioned nine times, and taking out seven to eight loans was mentioned four times, across all districts. Frequent or monthly borrowing was more likely in Chiredzi (10 reports), while sporadic borrowing was more likely in Mwenezi (nine reports). In Chikomba, the distribution was more equal.

When asked about the largest loan taken out, responses were also mixed. Most respondents said their largest loan was between USD100-250 (11 reports), followed by USD50-100 or USD250-500 (both seven reports). There were four reports of USD10-50 and one report of USD900. In Chikomba, participants were more likely to take out larger loans than smaller loans. In Chiredzi, this was equally spread, while in Mwenezi participants were more likely to take out smaller loans. This is in line with the survey data on Cohorts 1 and 2 presented above. The distribution between men and women was also relatively equal, with some men and women taking out small loans, while others took out medium and large loans.

When asked about the use of loans, respondents overwhelmingly said they used the loans to launch, maintain or expand their IGAs, for example the purchase of stock feed and livestock. Loans were also used for household necessities, such as groceries, and home improvements, mostly in Mwenezi, and the payment of school fees, mostly in Chiredzi. These results echo the survey data for Cohorts 1 and 2. Emergency costs, such as funerals and hospital bills, were mentioned a handful of times.

Women were asked about the size of the largest loan they had taken out, with a total mean of USD 166 reported. While there were no differences in largest loan size between cohorts, there were significant differences between districts, with a mean of USD202 recorded in Chiredzi, USD200 in Chikomba and USD95 in Mwenezi (p=0.001). Much like for number of loans taken, the size of loans is associated with age, with younger women taking out larger loans than older women (see *Figure 5*). The mean size of largest loans taken is also associated with food security, with significantly higher value of loans taken among women in the most food secure households (USD197) than those in medium food secure households (USD147) and food insecure households (USD102). Mean loan size is also significantly higher among women who attended Toose with a partner (USD180) than those who attended with another family member (USD151) (p=0.01).

Figure 5: Mean size of largest loan (USD) by age

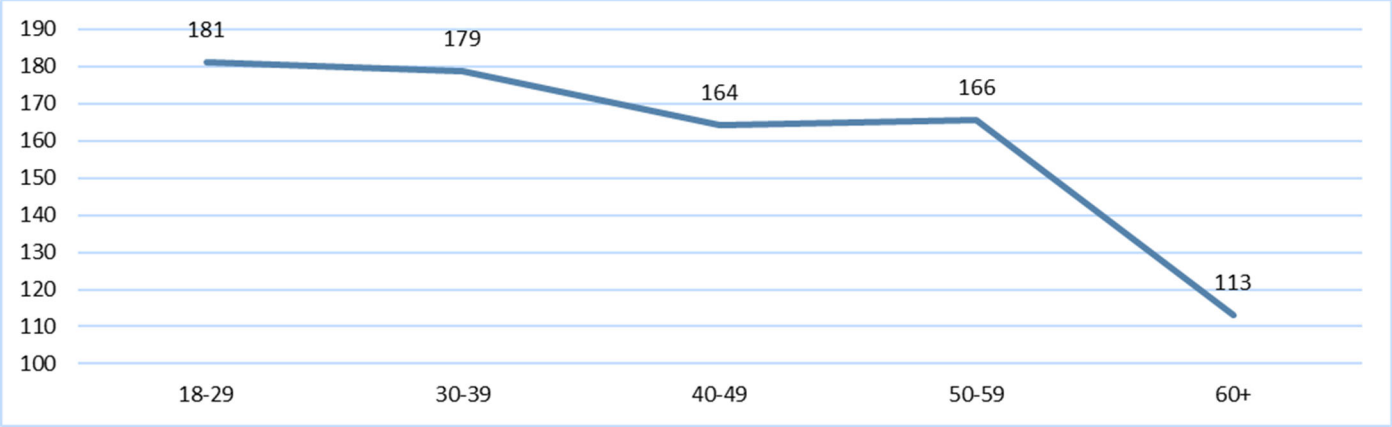
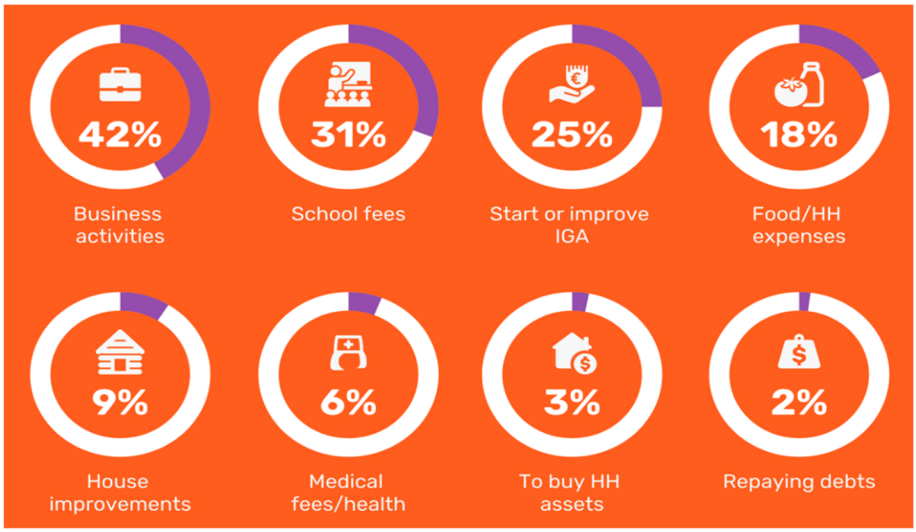


Figure 6: Main reasons for taking largest TISAL loans



Respondents used loans for several reasons, the most common being to cover school fees and to direct towards business activities and IGAs.[23] Almost two in ten women used loans for food or household expenses (see *Figure 6*). There were substantial variations in the use of loans across the districts. The use of loans for food and household expenses was much more common in Mwenezi (27% of respondents) than in Chiredzi or Chikomba (14% of respondents in both districts). Using loans to pay for school fees was more common in Chiredzi (43%) than in Chikomba (22%) or Mwenezi (27%). Using loans for business activities was much higher in Chikomba (61%) than in Chiredzi (26%) and Mwenezi (39%); however, using loans to start or improve IGAs was more common in Chiredzi (40%) than Chikomba (14%) and Mwenezi (19%). This may be explained by differences in characteristics associated with the urban/ rural nature of the three districts. For example, use of loans for school fees is more common in Chiredzi and this may be because school fees in urban areas are significantly higher than in rural areas.

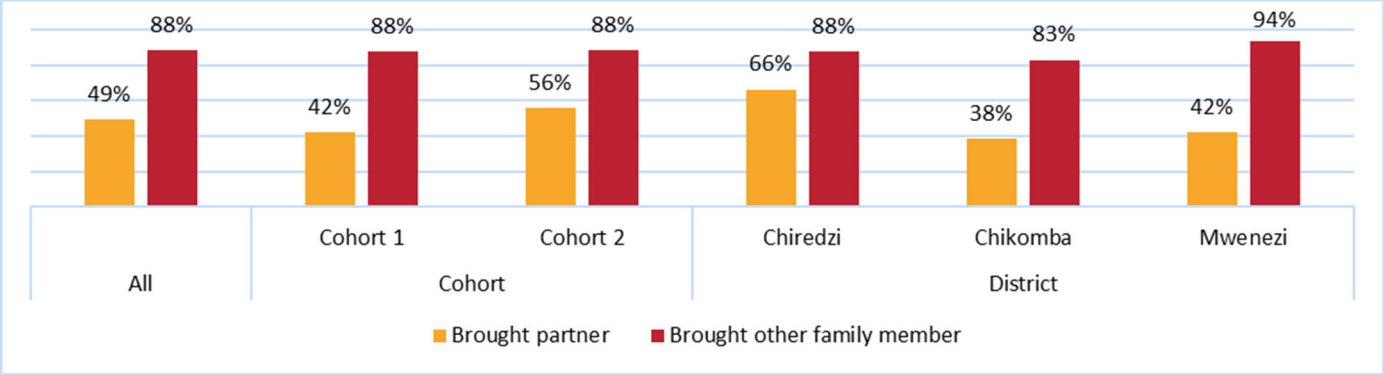
3.2. Social empowerment

The endline survey captured whether women participated in Toose social empowerment sessions with their partner or with other family members, although it should be noted that a positive response to both questions was possible given that women could bring different family members to different Toose sessions. Consequently, the proportions for attendance with partners or other family members do not necessarily add up to 100%. The endline data shows that 49% of women brought their partner to Toose sessions and 88% brought other family members (see *Figure 7*). Participation with partners was most common in Chiredzi, with much less participation of partners in the other two districts. Other family members mainly included children, particularly daughters, with some women also bringing parents, in-laws, siblings, grandparents, uncles or aunts. The findings related to whom was invited to participate in Toose sessions alongside women suggest that both their partners and other family members participated. The endline qualitative data also suggests that both partners and other family members participated in Toose sessions, with more than one family member sometimes participating (see *Box 2*). This is in line with the findings from the SAFE ELU's

[23] Note that both 'business activities' and 'IGAs' were included as response options; however, the survey tool did not make explicit differentiation between these two response options when presented to participants.

process-level study (Deep Dive 4), which found that in cases where male partners were not able to attend a Toose session, facilitators encouraged women to bring another family member. The process study also found that participation of other family members was not necessarily consistent or uniform, with different family members sometimes coming during different sessions.

Figure 7: Women's participation in Toose social empowerment sessions with partners and other family members, by cohort and district



Endline survey respondents were asked how many Toose social empowerment curriculum sessions they had attended, with a mean of seven sessions attended across the whole sample with the majority of respondents stating that they had attended seven, eight or nine sessions (23%, 41% and 12% respectively). Attendance was lowest in Chiredzi (mean of 6.8 sessions) and highest in Mwenezi (mean of 7.7 sessions) with women in Chikomba attending a mean of seven sessions. Women's mean number of sessions attended was significantly higher when they participated in Toose with a partner (7.5) than when they did so with another family member (6.9) ($p=0.001$).

Seven in ten survey respondents stated that they had participated in additional Toose sessions in 2023. A third of respondents said that they had participated in a Toose session on different forms of power, and attendance was most common in Mwenezi (45%) and least common in Chikomba (22%). A slightly larger proportion of respondents (38%) said that they had participated in a Toose session on IPV, with participation greatest in Mwenezi (58%) and lower in Chiredzi (27%) and Chikomba (28%). Other session topics included refreshers on economic and business topics, including on budgeting, planning, visioning and successful IGAs, and some respondents also referred to sessions being conducted to monitor progress and understand the impacts and sustainability of Toose.

Box 2: Qualitative insights on engagement with social empowerment sessions in Cohort 3

Most participants appear to have attended most Toose social empowerment sessions but very few appear to have attended all. In Chikomba, respondents were more likely to attend fewer sessions, while in Chiredzi and Mwenezi they were more likely to attend more sessions, although respondents mentioned a range of numbers between six and twelve when asked about the total number of sessions. This differs from the survey findings, which suggest that attendance was lowest in Chiredzi instead.

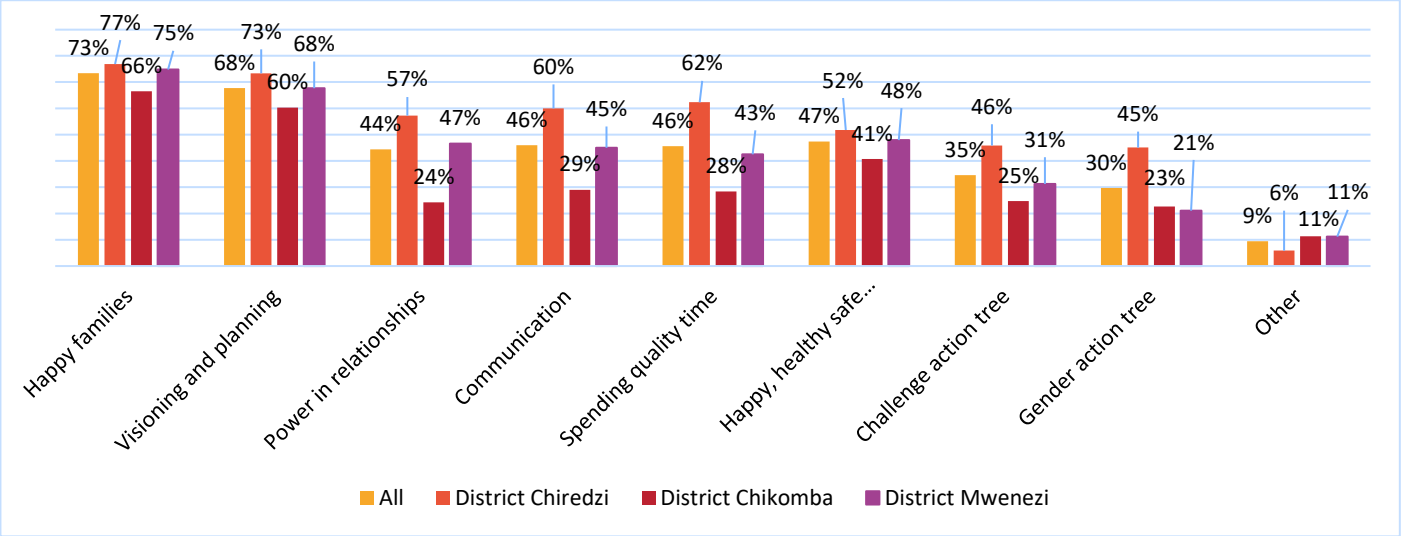
Attending most sessions was equally true for men and women but partners of participants were more likely to miss a significant number of sessions, especially in Chikomba. This was also true for both female and male partners. Some completed all sessions (this was more likely in Chiredzi and Mwenezi); however, others also said they joined towards the end of the programme and therefore only attended a few sessions.

Participants were most likely to bring their partner to the sessions. In Chiredzi, all participants said they brought their partner, while in Chikomba and Mwenezi a handful of participants brought their children alongside their partner, or another family member instead of their partner, e.g., parents, a sister- or brother- in-law, or children. This echoes the survey findings, which suggest that participation with partners was most common in Chiredzi. Bringing children and a partner was not always done consistently; for example, in some cases the partner only attended when available.

3.3. Community diffusion

The endline survey asked several questions to measure respondents' exposure to community diffusion activities, which were led predominantly by Toose peer facilitators who shared a variety of Toose messages and tools.[24] Almost eight in ten respondents (78%) said that they had attended a Toose community conversation, although a higher proportion had done so in Mwenezi (93%) and a lower proportion had done so in Chikomba (63%). Respondents were asked what they had heard about during Toose community conversations. Overall, happy families and visioning and planning were the messages most listened to, with just under half of those who had attended a community conversation also hearing about power in relationships, communication, spending quality time together and happy, healthy, safe relationships (see *Figure 8*). Around a third of respondents had heard reference to Toose tools, including the challenge action tree and gender balance tree. These figures did not differ across cohorts, but there were some district variations. For example, a larger proportion of women in Chiredzi than the other districts heard about messages related to relationship dynamics, including power, communication, quality time together and safe and healthy relationships.

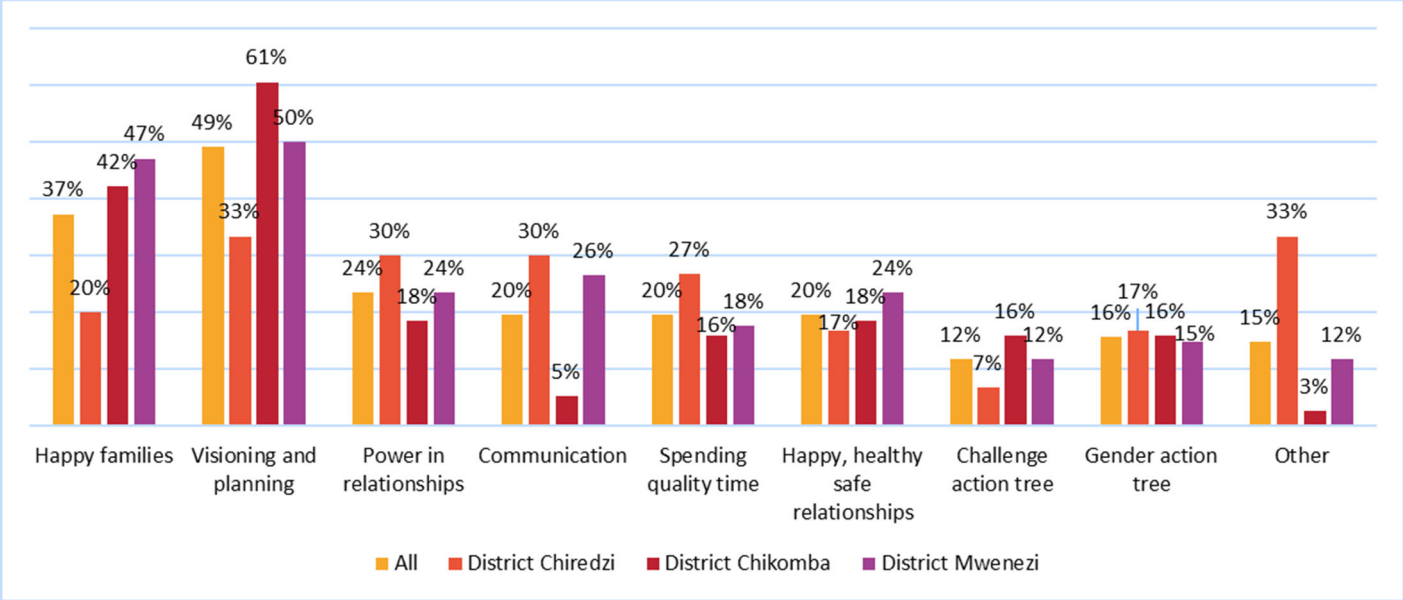
Figure 8: What respondents heard during Toose community conversations, by district



Respondents were also asked in the endline survey whether they had worked as a Toose peer facilitator, with 79 women saying that they had. Of these women, 91% said that they had facilitated a Toose community conversation (n=72). When asked, however, about whether respondents had shared messages at community conversations, 102 women said they had done so suggesting that messaging was not only shared by peer facilitators but also by Toose champions. When asked which topics people found most interesting in community conversations, visioning and planning and happy families were the most popular sessions, particularly in Mwenezi and Chikomba (see *Figure 9*). Of those respondents who said 'other' topic, this included community conversations about alcohol and drug abuse, GBV, financial management and IGAs.

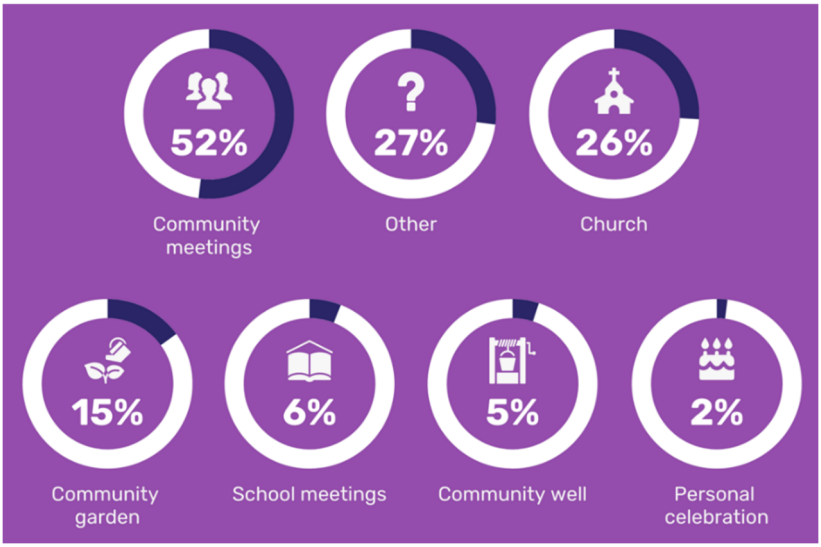
[24] While the programme shared a suite of tools and messages with Toose peer facilitators, the facilitators themselves chose which messages to share with community members depending on their own comfort and interest, and the audience, setting or time allocated for diffusion.

Figure 9: Perceptions from those facilitating Toose community conversations about which topics were most interesting to community members, by district



The most common platforms used to facilitate Toose community conversations were community meetings, followed by church and community gardens (see *Figure 10*). Other platforms included homes, community halls, funerals and stadiums. Using church as a platform was most common in Chikomba (42%) and least common in Mwenezi (9%), and community meetings were most common in Mwenezi (74%) and least common in Chiredzi (30%). Community gardens were popular in Mwenezi (24%) and Chikomba (18%) with no respondents describing community garden platforms in Chiredzi.

Figure 10: Platforms used to facilitate Toose community conversations



Box 3: Qualitative insights on engagement with community diffusion in Cohort 3

When asked about organised community level conversations about Toose, most respondents in Chikomba and Chiredzi said they did not attend these conversations, and some were unaware of their existence. In Mwenezi, respondents were more likely to attend community conversations about Toose. Notably, several participants, especially in Chiredzi and Mwenezi, said they instigated or participated in informal community conversations in which they would spread Toose messages to other community members. For example, while selling chickens to customers or attending a funeral.

3.4. GBV response

The Endline Survey asked respondents about whether they had participated in or accessed a GCBC or Musasa GBV response activities. Almost half of women (45%) had participated in a GCBC awareness raising session in the community, and exposure to sessions was greater in Chiredzi (54%) and Mwenezi (52%) than in Chikomba (29%). When asked about which topics they heard about in GCBC sessions, the most common ones were IPV (82%), how to access help, including referrals (49%), child marriage (44%), Musasa (36%) and sexual and reproductive health (34%). Other topics included violence against children, how to report GBV cases and drug abuse. Almost three quarters of respondents who had been to a GCBC session (72%) spoke to others about they had heard, mainly partners (30%), daughters (30%) and sisters (12%), with small proportions of women speaking to other family members. In relation to the 'other' (specify) response category, women shared that they had spoken to friends, neighbours, community members, church members and workmates about topics shared by GCBCs.

Only 13% of respondents stated that a GCBC member had provided direct support to them and there was very little difference between the districts on this measure. Of those who had received support from a GCBC member (n=124), 80% had received counselling, 21% had been accompanied to services and 17% had received 'other' types of support, mainly financial assistance or transport to access services. Almost all women who received support from GCBCs were very satisfied (83%) or satisfied (12%) with the support they received, and this was consistent across the three districts. Very few women in the survey sample shared that they had accessed Musasa services (11%), including psychosocial counselling (7%), mobile services (5%), shelters (1%) or an 'other' service (2%) (mainly financial assistance or legal advice). All women who had accessed a Musasa mobile service or shelters said that the quality of the service was very good or good, and 93% and 95% of women who had accessed psychosocial support services or other types of services (respectively) said that the quality of services was good or very good.

Box 4: Qualitative insights on help seeking and access to services in Cohort 3

In the Cohort 3 qualitative data, many respondents complimented the GCBC teachings on violence and said violence (IPV, child marriage, child abuse) in their communities had significantly reduced as a result. Very few people spoke about violence in their own household or family.

Similar to the survey findings above, when asked if participants received direct support from GCBCs, participants in Chikomba overwhelmingly said they never personally did, with only one second-hand report. However, according to GCBC reports in Chikomba, many community members in Chikomba received assistance. For example, one GCBC volunteer accompanied two underage mothers to seek child maintenance from the father. Another volunteer reportedly counselled several couples in one of the villages in Chikomba. It is possible the Cohort 1 qualitative sample did not include women or men who accessed these services. In Chiredzi and Mwenezi, a handful of participants described personal interactions with GCBCs. GCBC volunteers in Mwenezi and Chiredzi confirmed assisting with cases such as rape cases. Other types of assistance include providing emotional support, referring survivors to other services, and raising awareness and encouraging couples to join Toose.

The findings for Musasa were similar. When asked if participants received direct support from Musasa, participants in Chikomba overwhelmingly said they never personally did, with only one second-hand report. Although still limited, participants in Chiredzi and Mwenezi were more likely to share experiences of accessing Musasa services.

3.5. Sustainability

Although sustainability was not a primary focus of this study (it was not measured in the quantitative survey), the Cohort 3 qualitative interviews asked respondents which elements of the programme they were most likely to take forward. This provides some insights into the sustainability of the programme components and results.

Box 5: Qualitative insights on sustainability in Cohort 3

When asked which elements of the programme respondents were most likely to take forward, most respondents across all districts said participating in TISALs, saving and working hard on maintaining and further expanding their IGAs, and collective visioning, planning, and decision-making. Other commonly mentioned elements include communicating effectively with partners and children and fostering family unity. Sharing responsibilities for household labour, prioritising relationships with children and living in peace without violence were also mentioned but only in a handful of cases.

When asked about the sustainability of TISALs, most respondents said their groups (or their partners' groups) were still functioning. However, many groups experienced challenges, such as drop-outs and inconsistent attendance, mostly from members with debts who were unable or unwilling to repay these. This was true for all districts but more so for Chiredzi and Chikomba.

The few groups that terminated, did so for similar reasons. For example, one TISAL group in Chiredzi was terminated because a member reportedly owed more than USD400 and was unable or unwilling to pay their debt. In a handful of cases, TISAL groups were still functioning but temporarily paused for similar reasons.

Groups that are still fully functioning appear to be driven by a) members' incentives to achieve their goals and their transformative success stories; b) adherence to group constitutions to avoid being penalised; and c) group cohesion, whereby some groups have reportedly become like families, supporting each other in times of needs. In Chiredzi, there were several reports of field agents continuing to visit and support the TISAL groups.

4. Impact: Reduced prevalence of GBV and improved family wellbeing

Key findings:

- There was an increase in IPV prevalence at endline (50%) since baseline (45%), no change in the severity of IPV (from 17% to 16% for measure 1 and 17% to 14% for measure 2) and a reduction in the mean number of IPV acts, with significant variations in these findings according to different factors.
  - IPV increased in Cohort 2 and stayed the same among women in Cohort 1, although the severity of IPV and number of IPV acts reduced among women in Cohort 1 while staying the same in Cohort 2. IPV prevalence increased in Chiredzi, although the severity of IPV and the mean number of acts of IPV have not changed. IPV prevalence has not changed in Chikomba, but the severity of IPV and the mean number of IPV acts decreased significantly. No significant changes were observed in any IPV measure in Mwenezi.
  - There are several characteristics that are strongly associated with variations in IPV change between baseline and endline, particularly economic factors. The evaluation observed reductions in IPV prevalence, the severity of IPV and the number of IPV acts among women whose households' food security improved or stayed the same at the endline. In contrast, the endline evaluation also found increases in IPV, the severity of IPV , and the number of IPV acts when women's household food security has worsened at the endline. The results suggest that stronger engagement with Toose economic activities through a larger number of TISAL loans taken is significantly associated with a reduced number of IPV acts at the endline, suggesting that loans may help to mitigate the economic drivers of IPV.
  - Changes in IPV prevalence are also associated with exposure to Toose social empowerment, but in some unusual directions. An increase in any IPV at the endline is associated with women's participation in sessions on different forms of power and IPV; however, the number of IPV acts reduced regardless of women's engagement with these Toose sessions. It is possible that increased IPV among women exposed to Toose sessions reflects women's greater knowledge of IPV at the endline, leading to increased reporting; however, it is also possible that exposure to these sessions has increased IPV risks.
- In the Cohort 3 qualitative data, respondents rarely mentioned reduced IPV prevalence as an effect of the programme. Other effects (e.g., intimate relationships, communication, decision-making, family wellbeing, household economic security) were much more commonly mentioned. Participants were more likely to mention improvements in the prevalence of IPV when asked about GCBCs and other response actors, such as Musasa. However, they usually referred to their wider communities or other households, not their own households.
- Partners' controlling behaviours have also increased at the endline (57%, from 52% at baseline), although, much like for IPV, this increase is only observed in Chiredzi. An increase in controlling behaviours is mainly observed for partners accusing women of being unfaithful, which is in line with ELU and programme evidence that infidelity, whether perceived or real, is a key trigger of IPV.
- There was no change in the prevalence of corporal punishment against children at the endline overall, but there are district-level variations. Changes in corporal punishment appear to be associated with food security, with reductions in corporal punishment observed for women whose food security improved at endline 48%, from 61% at baseline).
- The Endline Survey is not able to measure change in child marriage; however, the findings show significant improvements in perceptions that child marriage has reduced, particularly in Mwenezi, and these improvements are associated with exposure to different components of the intervention, particularly participation in community diffusion activities, GCBC awareness raising activities and participation in Toose sessions on power and IPV. This is supported by the Cohort 1 qualitative evidence.

Family wellbeing improved significantly across four sub-scales of the Family Quality of Life scale, including satisfaction with family interactions, parenting, emotional relationships and material wellbeing. These improvements were consistent across cohorts and districts, although with some weaker results in Chikomba. Similar changes were observed in the Cohort 1 qualitative data.

Table 6: RAG rating for impact level measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Impact						
Past year prevalence IPV (binary)						
Emotional IPV						
Economic IPV						
Physical IPV						
Sexual IPV						
Severe IPV 1						
Severe IPV 2						
Number of acts of IPV						
Controlling behaviours						
Corporal punishment against children (women)						
Corporal punishment against children (men)						
Perceptions of reduction of early marriage						
Family wellbeing / quality of life						

4.1. Prevalence of IPV[25]

IPV is multifaceted and includes different types: emotional, economic, physical and sexual IPV. IPV can also be perpetrated with different levels of severity or frequency. To capture these nuances, the IPV prevalence findings are presented according to four different measures in line with recent evidence that traditional binary indicators of IPV may conceal more subtle variations in intervention impact.[26] A description of the four measures of IPV used are summarised in *Box 6* (see *Annex 4* for details on the measures used in the endline survey).

Box 6: Measures of IPV

- Binary measure of IPV: Report of any act of IPV in the past year at least once versus no IPV. Includes emotional, economic, physical and sexual IPV.
- Severe IPV1: What Works measure of any act of physical or sexual IPV in the past year more than once or the experience of two or more different types of physical or sexual IPV at any frequency (Dunkle et al, 2020).
- Severe IPV2: Measure of any of the four items of severe physical IPV or any item measuring sexual IPV in the past year (Chatterji et al. 2023).
- Number of IPV acts: The number of different acts of physical or sexual IPV in the past year (between 0 and 9).

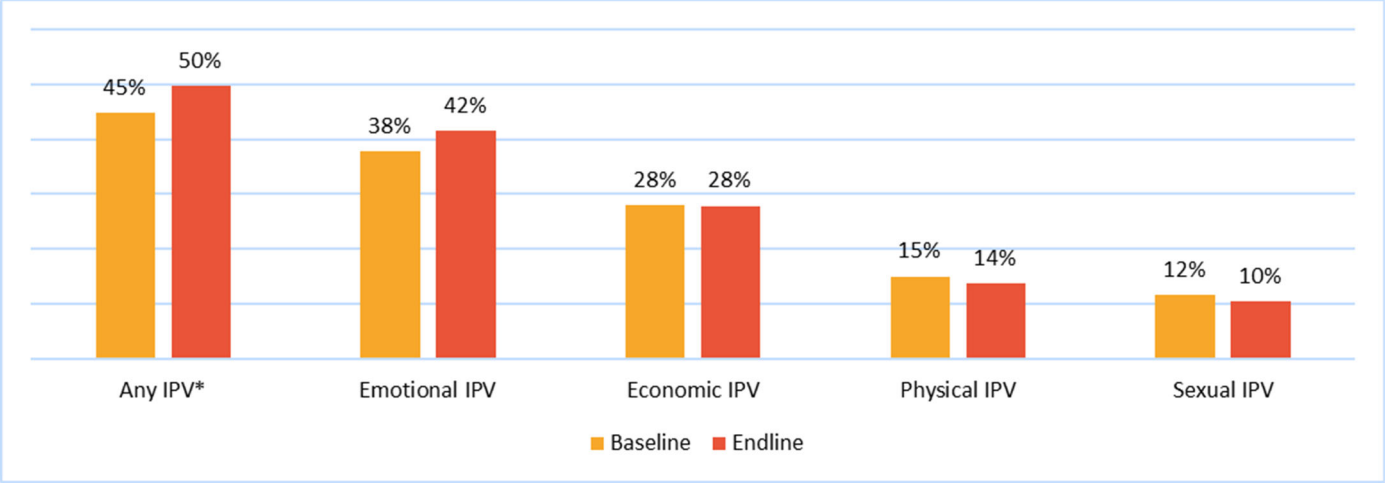
Binary measure of IPV

There has been a significant increase in any type of women's past-year IPV experience between baseline (45%) and endline (50%), comprising an 11% increase overall, mainly driven by an increase in emotional IPV. Economic IPV, physical IPV and sexual IPV either remained stable or decreased slightly (although these changes were not significant). (see *Figure 11*).

[25] See the survey tool in Annex 5 for the questions used to measure IPV including: emotional IPV (questions 5.6-5.15); economic IPV (questions 5.16-5.21); physical IPV (questions 5.22-5.35); and sexual IPV (questions 5.36-5.39).

[26] Chatterji, S. et al. (2023) Optimizing the Construction of Outcome Measures for Impact Evaluations of Intimate Partner Violence Prevention Interventions. Journal of Interpersonal Violence, 38(15-16): 9105-9131.

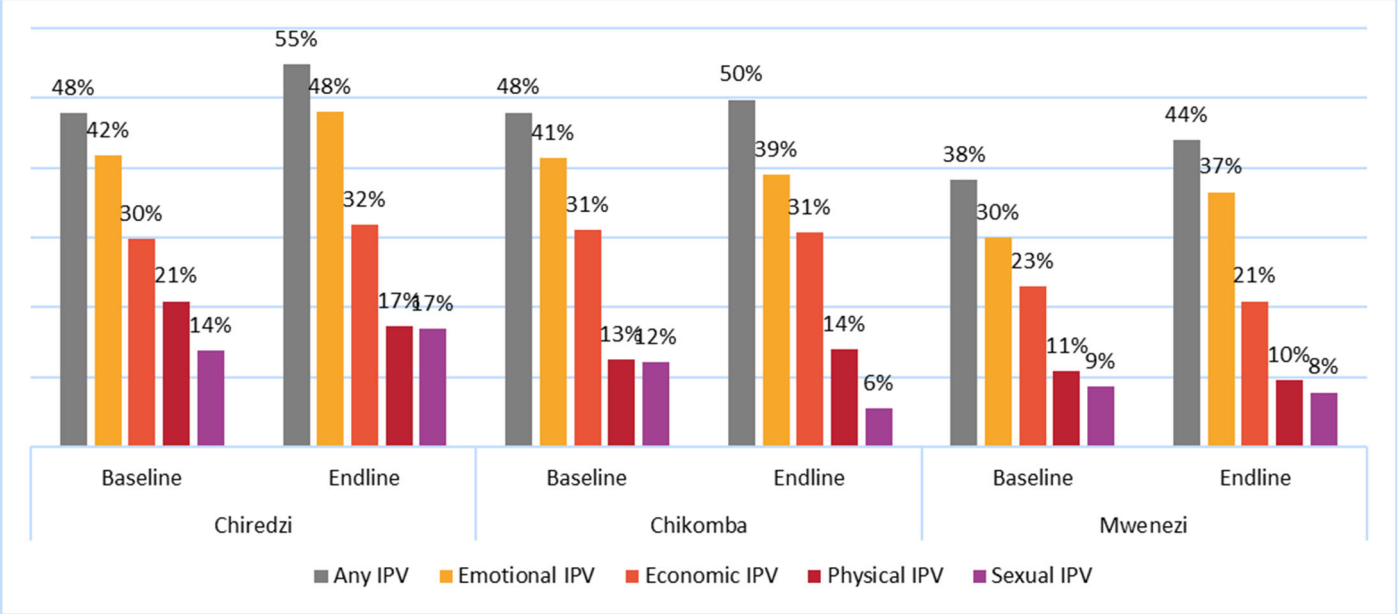
Figure 11: Baseline and endline past-year IPV prevalence by type of IPV



When disaggregating IPV by implementation cohort, a significant increase in IPV between baseline (42%) and endline (50%) was only observed in Cohort 2 (p=0.02) and this was mostly accounted for by an increase in emotional IPV in Cohort 2 from 35% to 42% (p=0.03). The only significant decrease in IPV was observed for sexual IPV among women in Cohort 1, with a 36% reduction from 14% to 9% (p=0.04).

When examining IPV by district, it is evident that prevalence of any IPV has increased slightly across all three districts (see *Figure 12*); however, this increase is only significant in Chiredzi where IPV prevalence increased from 48% to 55% (p=0.05). This finding in Chiredzi is mostly accounted for by a small albeit insignificant increase in emotional IPV, with a similar trend found in Mwenezi for emotional IPV. There were no significant changes in emotional, economic, physical or sexual IPV with the exception of a significant decrease in sexual IPV from 12% at baseline to 6% at endline in Chikomba (p=0.01).

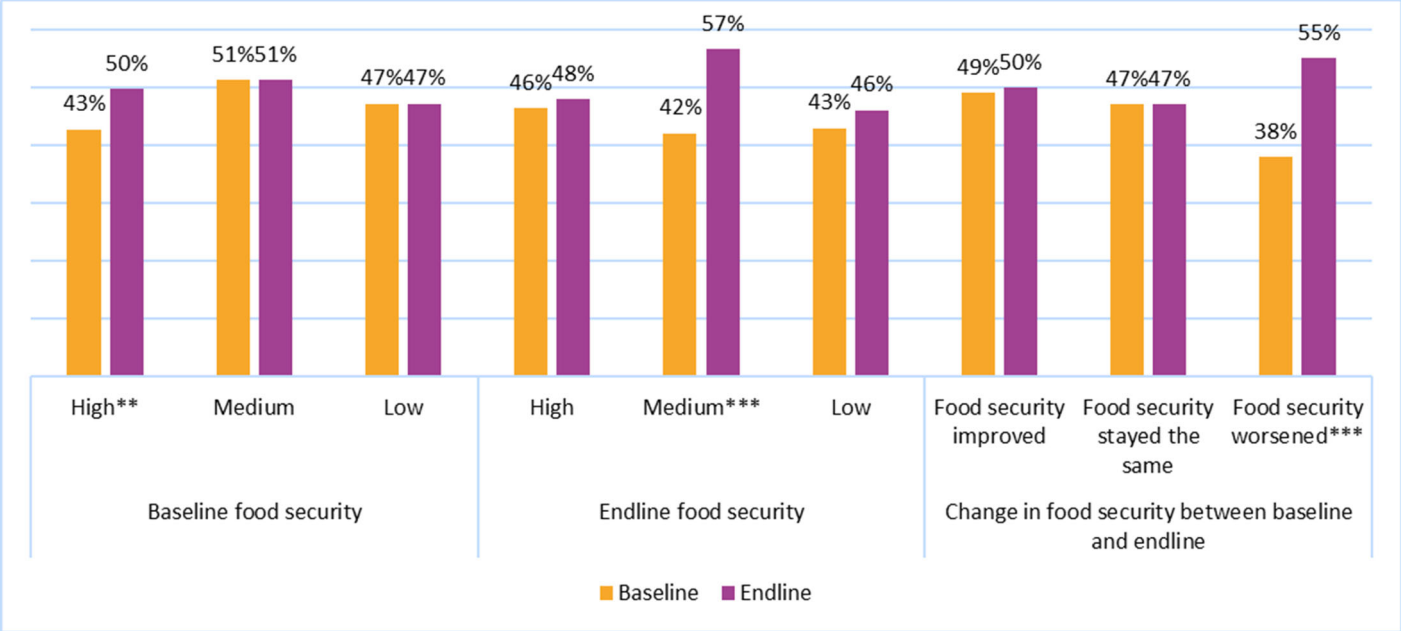
Figure 12: Baseline and endline past-year IPV prevalence by type of IPV and district



There are a few notable differences in IPV prevalence according to women's individual characteristics. Any IPV increased significantly by 5% percentage points for women without a disability (p=0.04) and by 13% percentage points for women with disabilities (from 38% at baseline to 51% at endline) although this increase was not significant, potentially due to the small sample size of women with a disability at endline (n=118). Changes in IPV prevalence are also associated with women's age. Any IPV increased slightly at endline across all age categories, but this increase was only significant for women aged 30-39 years, where there was an increase from 46% at baseline to 54% at endline (p=0.02).

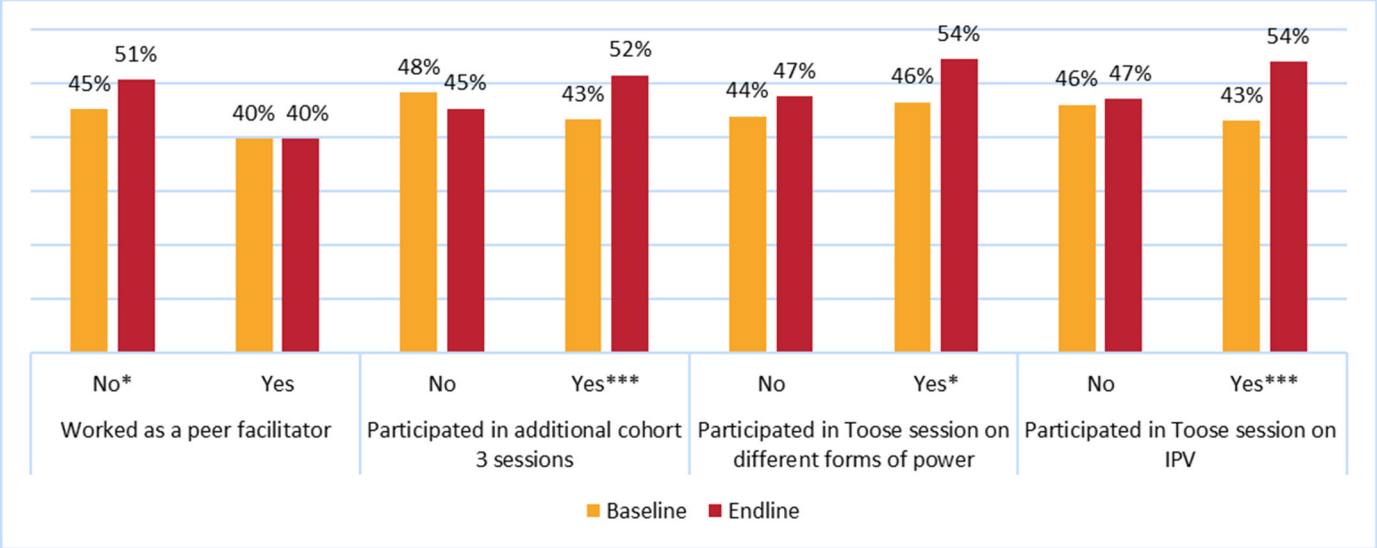
There are also some differences in IPV prevalence between baseline and endline according to women's household economic factors. Any IPV increased from baseline to endline (46% to 53%, p=0.04) among women whose household experienced economic shock in the past 12 months while staying the same for those women who did not experience economic shock. When disaggregating baseline and endline prevalence of any IPV by household food security at baseline, a significant increase in IPV at endline was observed for women who were food secure at baseline and those who had medium food security at endline (see *Figure 13*). This pattern held for emotional IPV but not for other types of IPV. Notably, when looking at change in food security over time, IPV prevalence increased significantly only among those women whose households' food security had worsened at endline. There was no change among women whose food security improved or stayed the same. **These findings suggest that an increase in IPV at endline has been influenced by economic shock and worsening food security, with no change in IPV observed among women without these worsening economic outcomes**.

Figure 13: Baseline and endline past-year IPV prevalence by baseline and endline food security, and change in food security between baseline and endline



Past-year IPV prevalence was also analysed according to variables measuring **women's exposure to intervention activities.** There was no significant difference in patterns of IPV prevalence between baseline and endline according to whether women attended Toose sessions with their partner or with another family member, or according to the number of loans they took out from TISALs. However, there were significant differences according to other factors, including women's participation in specific Toose sessions. IPV increased significantly at endline among women who had been exposed to additional Cohort 3 sessions in 2023, and those who had attended Toose sessions on different forms of power and IPV (see *Figure 14)*. Further, while there was no change in IPV among women working as Toose peer facilitators, there was a significant increase in IPV among those women who did not work as peer facilitators (p=0.02). These findings may suggest a number of things. **It is possible that exposure to Cohort 3 sessions, including the session on IPV, increased women's knowledge of GBV**, leading to more honest or informed reporting of IPV experience. However, it is **also possible that exposure to these sessions has increased IPV risks** for some women (see *Section 9*) for a discussion about these possibilities).

Figure 14: Baseline and endline prevalence of any past-year IPV by exposure to Toose social empowerment curriculum sessions



Two measures of severe IPV

Overall, there was a slight reduction in severe IPV between baseline and endline when using the two different measures of severe IPV, although these were not significant; however, there was a significant reduction in severe IPV in Cohort 1 and in Chikomba when using the second measure of severe IPV (see *Figure 15*).

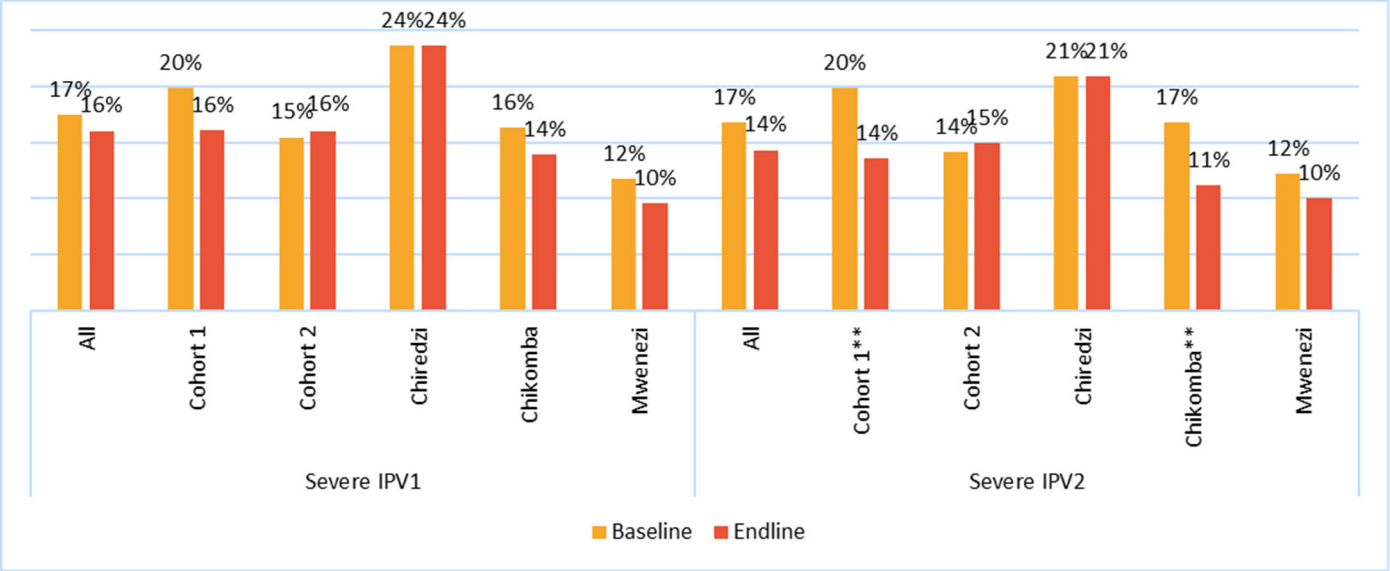
Box 7: Qualitative insights on IPV prevalence in Cohort 3

Instead of asking about the prevalence of IPV; the research instruments utilised open questions about the effects (positive and negative) of the Toose curriculum and the programme as a whole. When asked about the effects of the programme, most respondents mentioned changes in other output, outcome and impact measures (e.g., intimate relationships, communication, decision-making, family wellbeing, household economic security – further discussed below) but not in prevalence of IPV, suggesting this was not the main impact for Cohort 3 participants.

Changes in IPV were only mentioned in a handful of cases; in Chiredzi and Chikomba there were two explicit mentions of reduced violence in the household, while in Mwenezi there were three explicit reports of reduced violence and an additional four reports of fewer violent fights between partners. For example, a woman in Mwenezi said she and her husband were less likely to chase each other down the streets, throwing bricks at each other when in disagreement. In Chikomba, a woman said her husband is no longer violent because he fears the GCBCs in their community, and facing legal consequences. GCBC presence and being reported to authorities acting as a deterrent to perpetrators was also mentioned in other districts.

Participants were more likely to mention improvements in prevalence of IPV when asked about GCBCs and other response actors, such as Musasa. However, they usually referred to their wider communities or other households, not their own households. In all districts, a handful of men and women spoke about a reduction in GBV in their communities, including IPV and child abuse (further discussed in *Section 3.4*), when asked about the impact of GCBCs. In Mwenezi, participants specifically mentioned a change in perceptions towards violence, with violence now being regarded as “shameful” or “backward” in their communities.

Figure 15: Baseline and endline past-year severe IPV prevalence according to two measures of severe IPV, by cohort and district



For the first measure of severe IPV, there were no variations according to women's individual or household characteristics, with the exception of endline household food security. The results suggest that severe IPV (Measure 1) decreased among women whose households had high food security at endline and increased among women whose households experienced medium food security at endline (see *Figure 16*). When examining IPV against change in women's household food security between baseline and endline, it is evident that severe IPV decreased significantly among women whose household food security improved or stayed the same, and severe IPV increased among women whose household food security worsened. Similar trends are observed for the second measure of severe IPV, but results are only significant for reduction of severe IPV among women with high food security at endline and among those whose food security stayed the same at endline (see *Figure 17*). Much like the first measure of severe IPV, an increase in severe IPV (Measure 2) was observed among women in households with worsening food security. **These results echo the findings for the binary measure of any IPV and suggest that increase in severe IPV is influenced by worsening food security**.

Figure 16: Baseline and endline past-year severe IPV prevalence according to severe IPV (Measure 1) by endline household food security and change in food security between baseline and endline

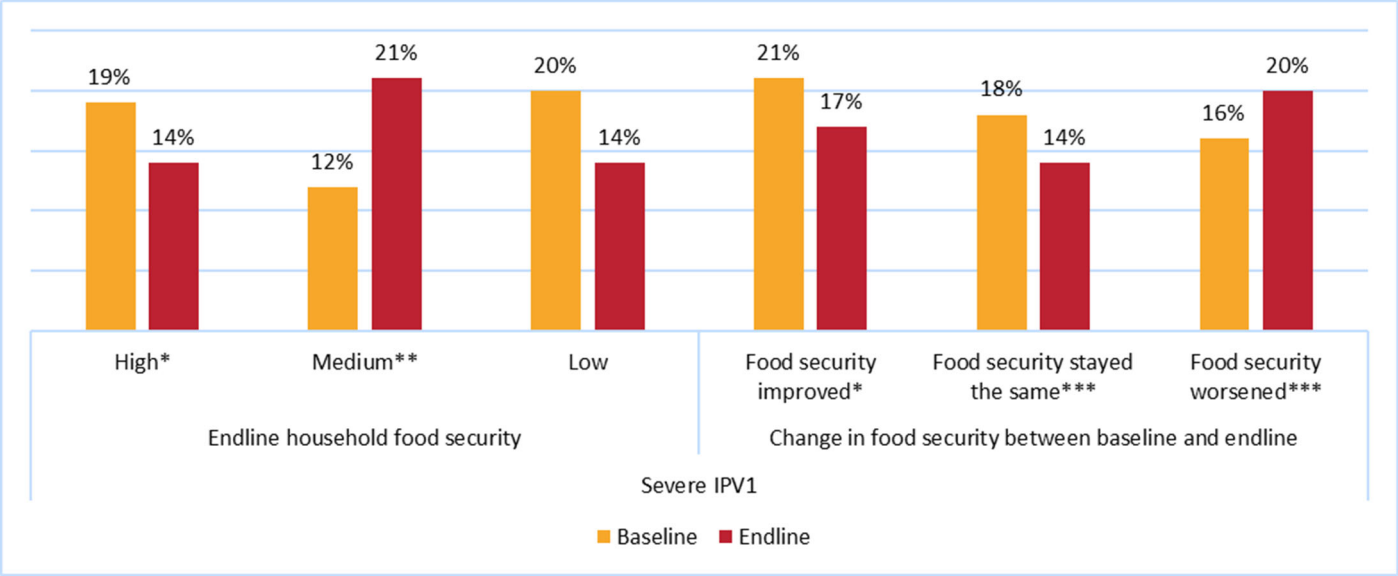
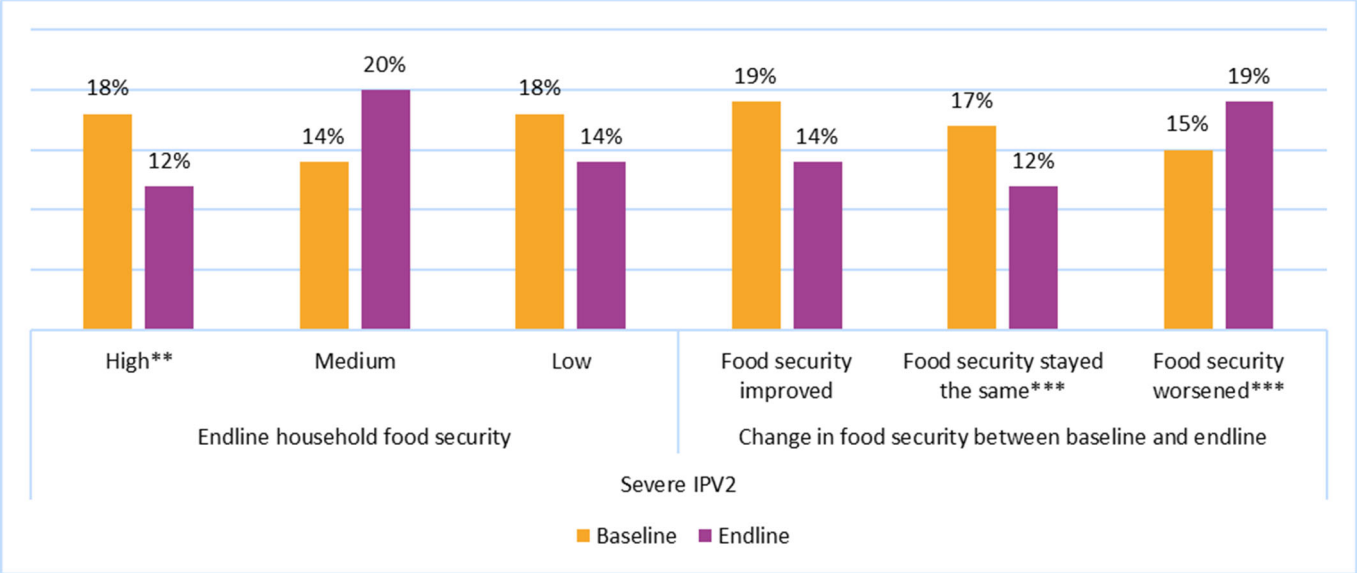


Figure 17: Baseline and endline past-year severe IPV prevalence according to severe IPV (Measure 2) by endline household food security and change in food security between baseline and endline

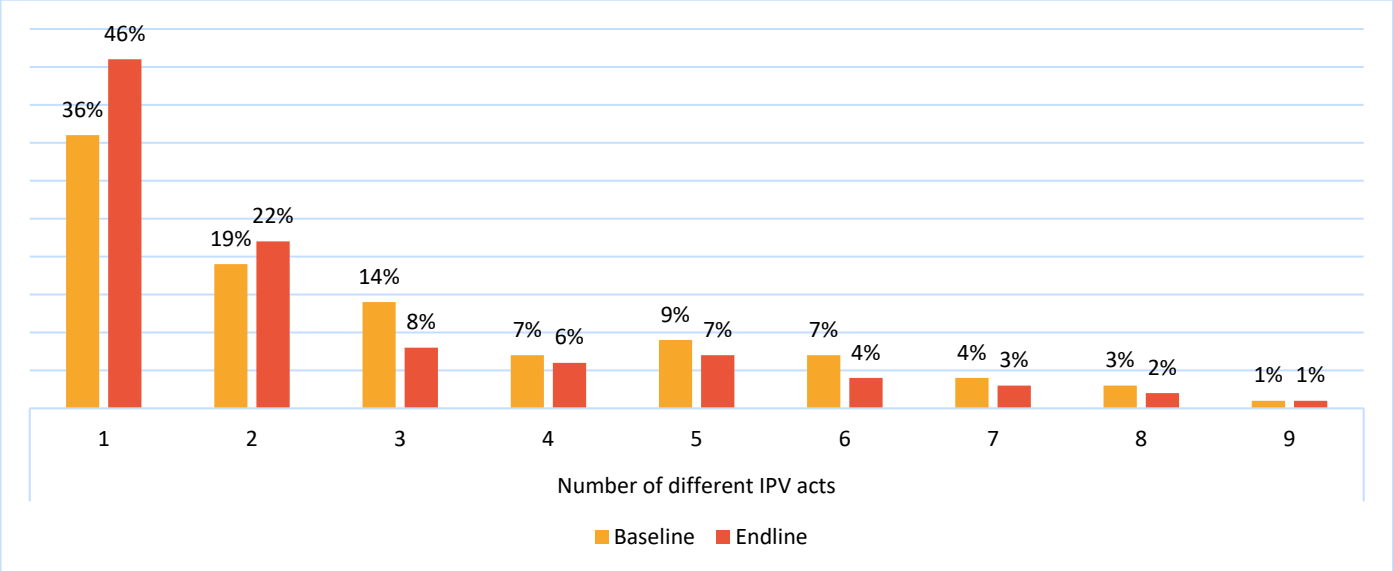


When using the second measure of severe IPV, there was a significant reduction in severe IPV among women whose partners worked away from home in the past year, from 18% to 11% (p=0.05), with no change observed among women whose husbands stayed at home. There were no other notable variations in results for severe IPV, for either of the two measures, nor according to women's exposure to different intervention components or elements.

Number of IPV acts

While an increase in IPV prevalence was observed at endline overall, with a small but insignificant reduction in severe IPV, the pattern in results is reversed when examining the number of different physical or sexual IPV acts women experienced in the past year. *Figure 18* depicts the distribution of the number of women experiencing one to nine IPV acts at baseline (n=143) and endline (n=136), with a reduction in mean number of IPV acts per affected woman from 3.1 at baseline to 2.46 at endline (p=0.001).[27] On the full scale of 0 to 9 IPV acts, the mean number of acts also reduced significantly between baseline (0.58) and endline (0.44) (p=0.01), although the magnitude of this reduction is small overall.

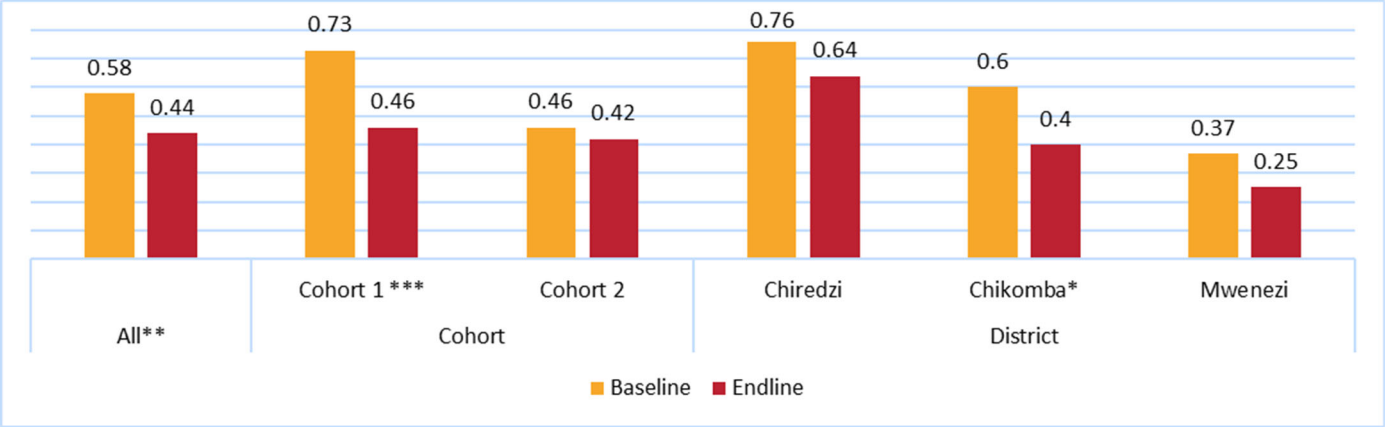
Figure 18: Number of women at baseline and endline who experienced one to nine different physical or sexual IPV acts in the past year



[27] *Figure 18* does not include the sample of women who experienced zero acts of IPV at baseline (n=605) and endline (n=600).

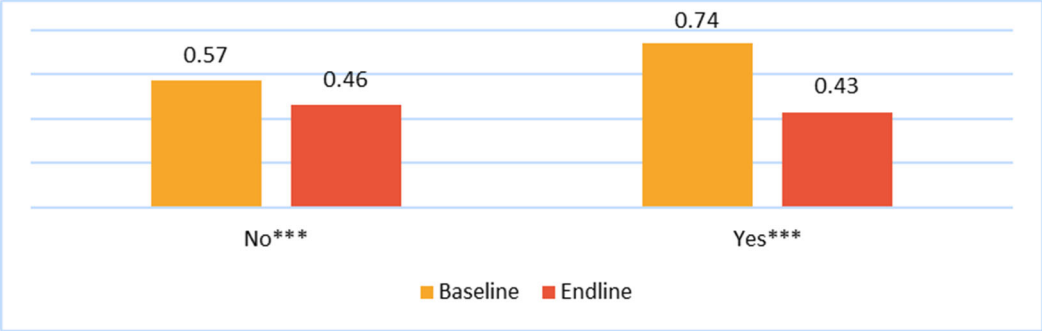
The significant reduction in number of IPV acts holds for women in Cohort 1 and in Chikomba (see *Figure 19*), mirroring the results for the second measure of severe IPV presented in the previous section. While there was a reduction in mean number of IPV acts in Chiredzi and Mwenezi, these reductions were not significant.

Figure 19: Baseline and endline mean number of acts of physical or sexual IPV in the past year by cohort, district, and individual characteristics



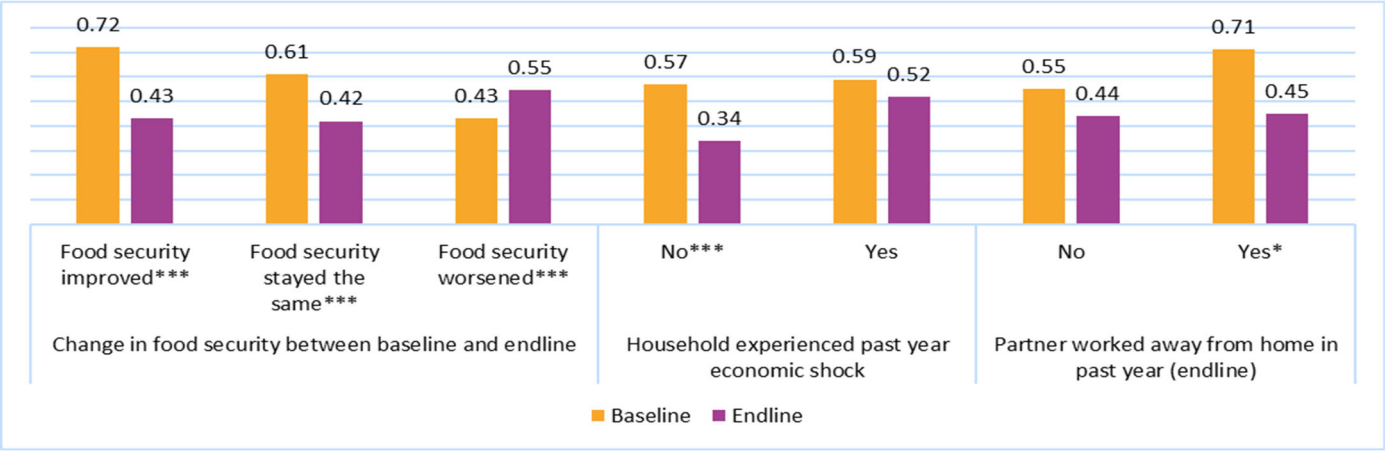
There was a significant reduction in number of IPV acts among women both with and without a disability at endline, although the reduction was larger for women with a disability (see *Figure 20*).

Figure 20: Baseline and endline mean number of acts of physical or sexual IPV in the past year by disability



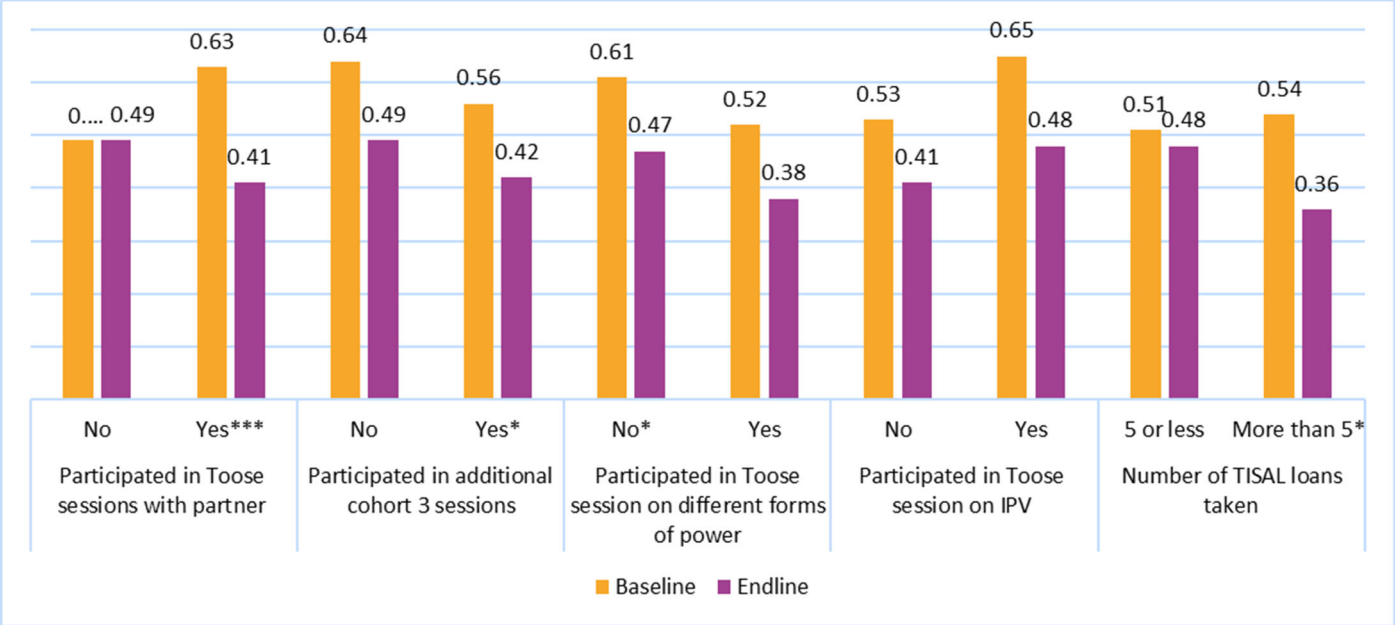
The results also indicate a significant reduction in the number of acts of physical or sexual IPV according to economic factors, including among women whose households did not experience economic shock in the past year and among women whose household food security had improved or stayed the same at endline. There was a corresponding significant increase in mean number of acts of IPV among women whose household food security had worsened at endline (see *Figure 21*), **emphasising again the role of worsening economic trends in increases in IPV**. There was also a significant reduction in mean number of acts of physical or sexual IPV among women whose partners worked away from home in the past year.

Figure 21: Baseline and endline mean number of acts of physical or sexual IPV in the past year by household factors



When examining the mean number of acts of physical or sexual IPV by intervention exposure, there are some notable results. There was a significant reduction in mean number of IPV acts among women who participated in Toose sessions with their partner with no corresponding change for those women who participated with another family member, highlighting the **importance of male partners' participation in social empowerment sessions** (see *Figure 22* . There was also a significant reduction in mean acts of IPV among women who had taken more than five loans from their ISAL group with no change observed among women who had taken five or fewer loans, which may suggest that **number of loans have helped to mitigate economic drivers of IPV**.[28] Mean number of IPV acts reduced across the other types of intervention exposure linked to specific Toose sessions in *Figure 22* (Cohort 3 sessions, different forms of power and IPV), with only some of these results being significant. However, the uniformity in these results suggests that exposure or lack of exposure to these sessions is not likely to be responsible for variation in IPV results.

Figure 22: Baseline and endline average number of forms of physical or sexual IPV in the past year by intervention exposure

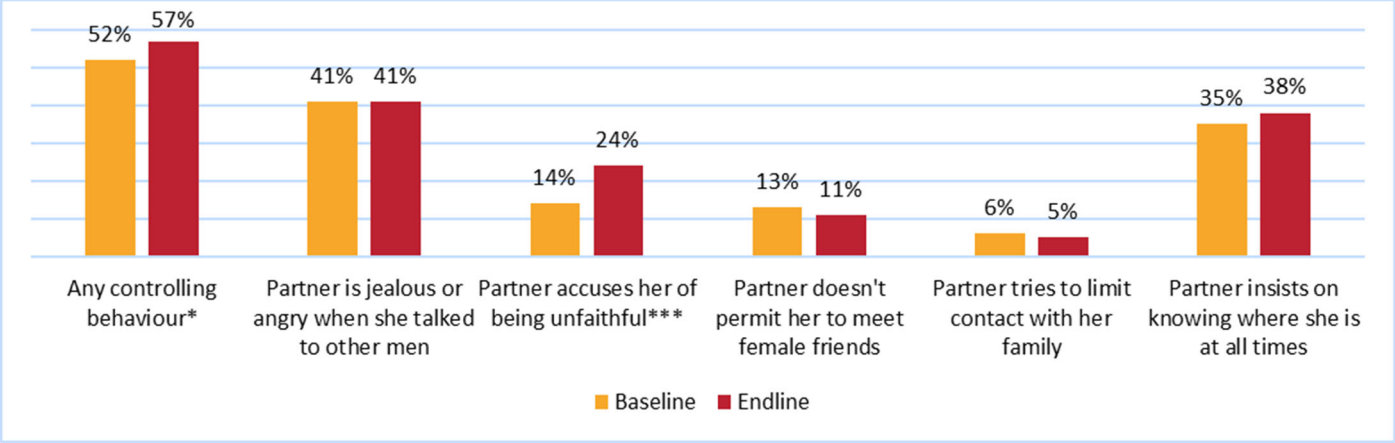


4.2. Prevalence of controlling behaviours

There is a significant increase between baseline (52%) and endline (57%) in women's reports of partners having controlling behaviours (see *Figure 23*). When examining the results according to type of controlling behaviour, **the increase in prevalence is driven mainly by one type of behaviour, women's partners accusing them of being unfaithful, with the prevalence of other behaviours staying the same at endline**. This is an important finding given that perceived or real infidelity is a strong driver of conflict, as identified in both SAFE Communities formative research and various SAFE ELU studies.

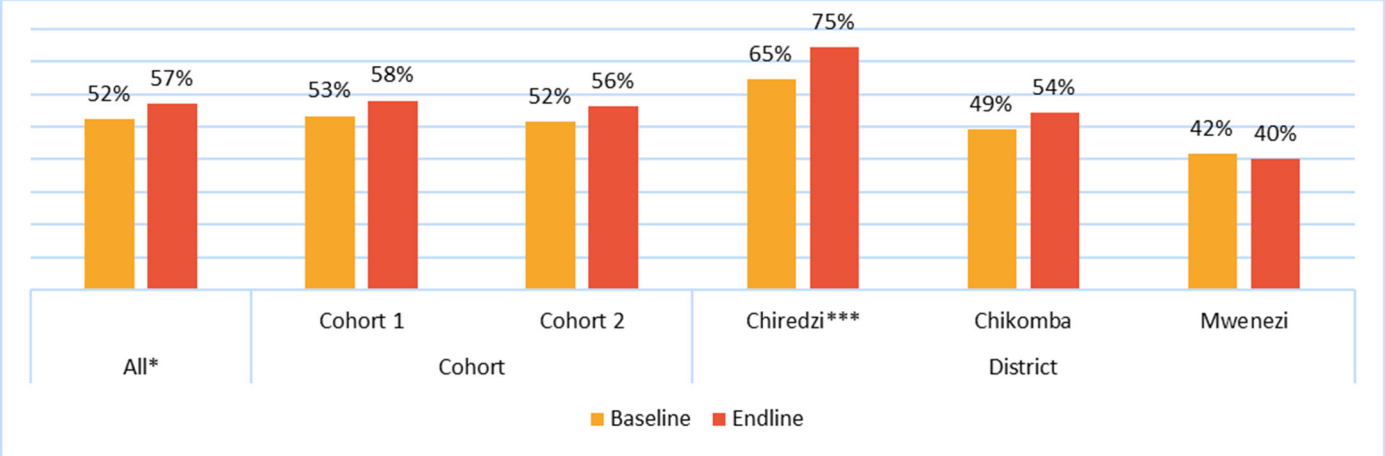
[28] A binary variable was created dividing the sample into two roughly equal groups based on number of loans, with five representing the intermediary number.

Figure 23: Baseline and endline past-year prevalence of partners' controlling behaviours by different types of behaviours



There was no change in controlling behaviour overall by implementation cohort (see *Figure 24*), although there were some variations according to the different types of behaviours. An increase in partners accusing women of being unfaithful was observed in both Cohort 1 (16% at baseline and 25% at endline, p=0.001) and Cohort 2 (13% at baseline and 23% at endline, p=0.001). There was also an increase in partners insisting on knowing where women were at all times in Cohort 2 (33% at baseline and 40% at endline, p=0.001) with no change on this measure observed in Cohort 1. There were also some district-level variations, with a significant increase in overall controlling behaviours observed in Chiredzi but not in the other two districts (see *Figure 24*). This increase is mainly accounted for by a larger proportion of women reporting that their partner accused them of being unfaithful in Chiredzi (16% at baseline and 33% at endline, p=0.001) and a similar increase was observed in Chikomba (12% at baseline and 20% at endline, p=0.001). Further, a larger proportion of women in Chiredzi stated at endline that their partner insisted on knowing where they were at all times (38% at baseline and 52% at endline, p=0.001). No other district trends were observed.

Figure 24: Baseline and endline past-year prevalence of partners' controlling behaviours by cohort and district



Much like the findings for IPV prevalence, partners' controlling behaviours are associated with food security. Controlling behaviours increased significantly from 52% at baseline to 59% at endline among women who were the most food secure at baseline and from 53% to 63% among those who were most food secure at endline (see *Figure 25*). These results are largely driven by district effects: Chiredzi is the district where women reported the highest food security and where controlling behaviours increased the most and within Chiredzi food secure households are those where controlling behaviours increased the most (by 11 percentage points). It is interesting to note, however, that unlike the findings for IPV, which are sensitive to changes in food security between baseline and endline, controlling behaviours from partners increased significantly regardless of whether women's household food security improved, stayed the same or worsened at endline (see *Figure 26*).

Figure 25: Baseline and endline past-year prevalence of partners' controlling behaviours by baseline and endline food security

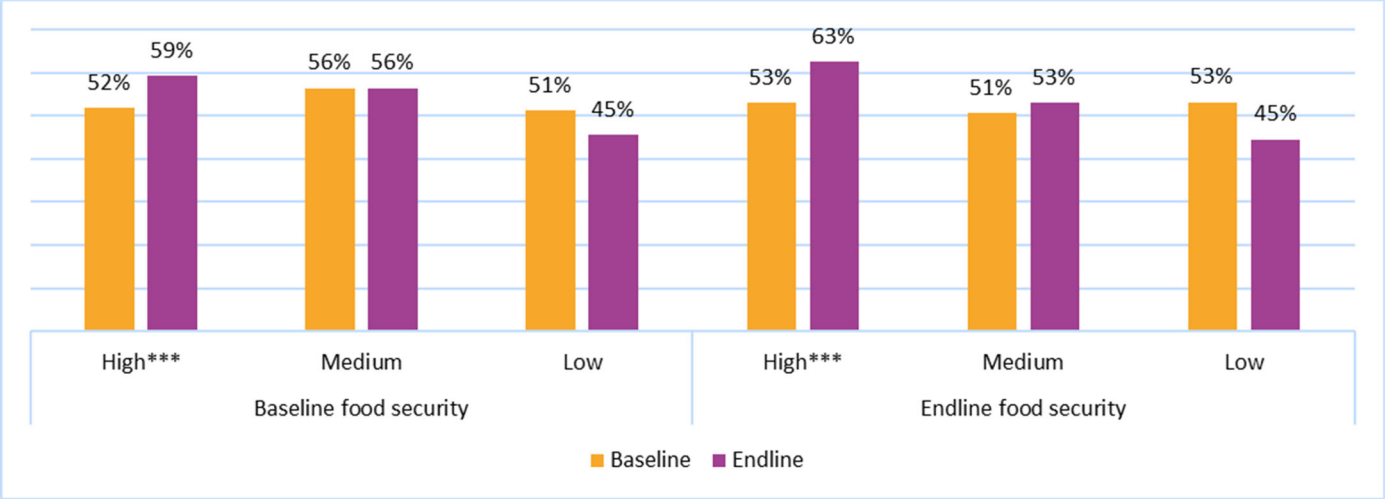
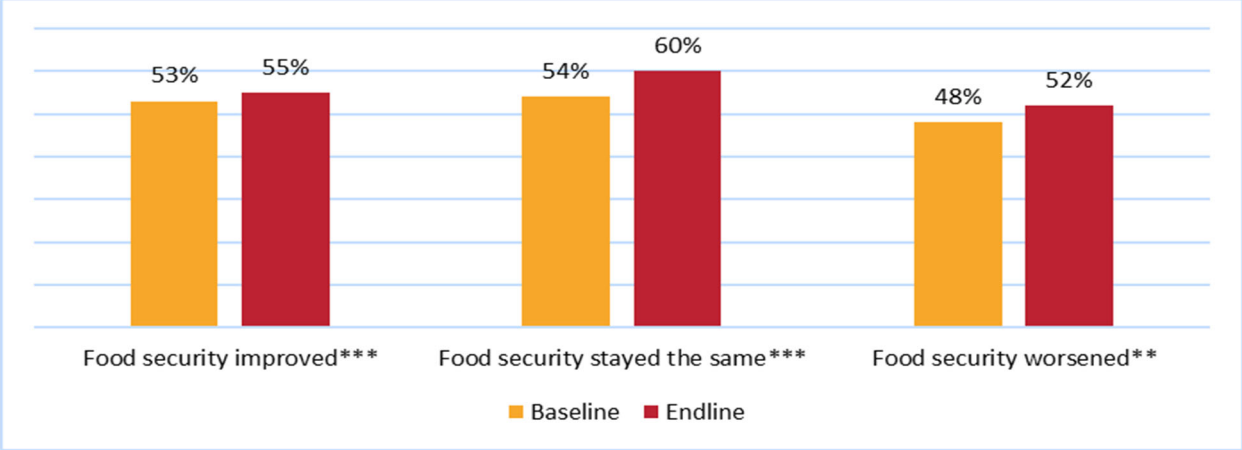


Figure 26: Baseline and endline past-year prevalence of partners' controlling behaviours by change in food security between baseline and endline



The findings related to controlling behaviours according to women's exposure to intervention activities largely mirror the results for any IPV. The endline results indicate a significant increase in controlling behaviours at endline among women who had been exposed to additional Cohort 3 sessions in 2023 (49% had experienced controlling behaviours at baseline and 55% at endline, p=0.02), including a Toose session on IPV (47% at baseline and 55% at endline, p=0.03).

Box 8: Qualitative insights on controlling behaviours in Cohort 3

As with the data on prevalence of IPV, the Cohort 3 qualitative dataset contains limited data on controlling behaviours because this was not explicitly questioned. However, the study did utilise open questions with relevant probes about changes (positive or negative) as a result of the Toose curriculum and the programme as a whole. Although there were no explicit reports of changes in controlling behaviours, the dataset contains a few reports from men and women sharing their experience with the 'power' Toose session. In both Chiredzi and Mwenezi, two men and two women said the session helped them understand the danger of exerting too much power over their partner. This was not mentioned in Chikomba.

4.3. Prevalence of corporal punishment

Overall, there is no change at endline in women's use of corporal punishment against a child in the past year and this holds across both cohorts (see *Figure 27*). When disaggregating the data by district it is evident that there has been a significant increase in women's use of corporal punishment in Chiredzi and significant reduction in Mwenezi. The same pattern was observed in women's reports of their partners' use of corporal punishment in the past year (see

Figure 28). When examining women's use of corporal punishment against their individual and household characteristics and intervention exposure, the only significant findings were related to food security. There was a reduction in corporal punishment from 61% at baseline to 48% at endline (p=0.02) for those women who were most food insecure at baseline, and a reduction from 56% to 48% for those who had medium food security at endline (p=0.04).[29] Further, while corporal punishment decreased from 58% to 50% for women whose household food security improved at endline, it increased slightly among women whose food security stayed the same or worsened.

Figure 27: Baseline and endline past-year prevalence of women's use of corporal punishment against a child

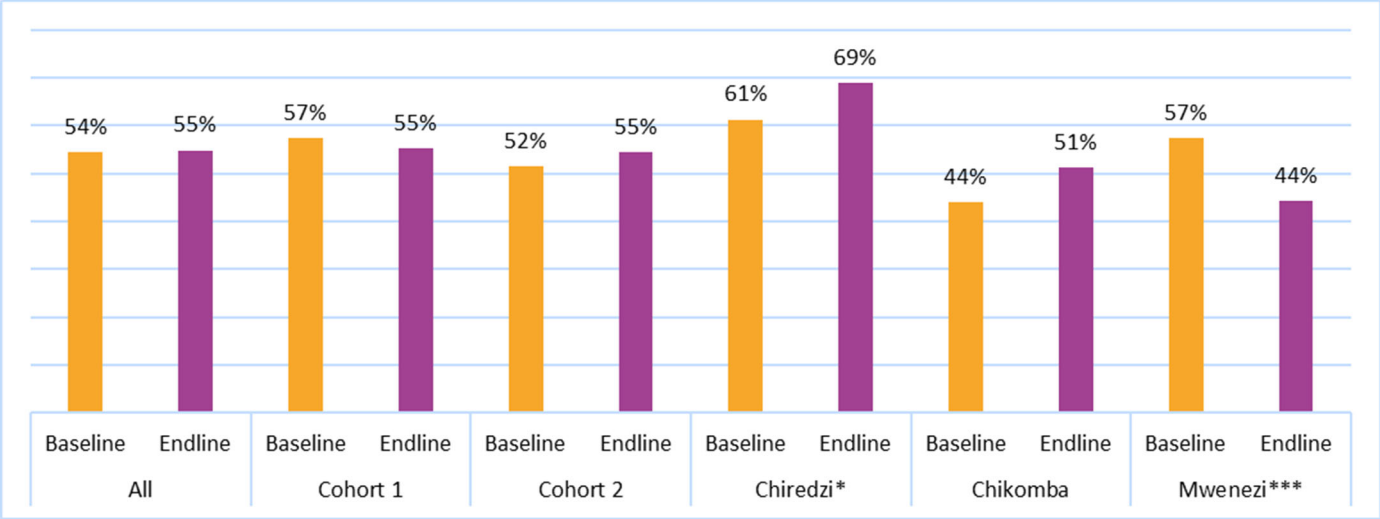
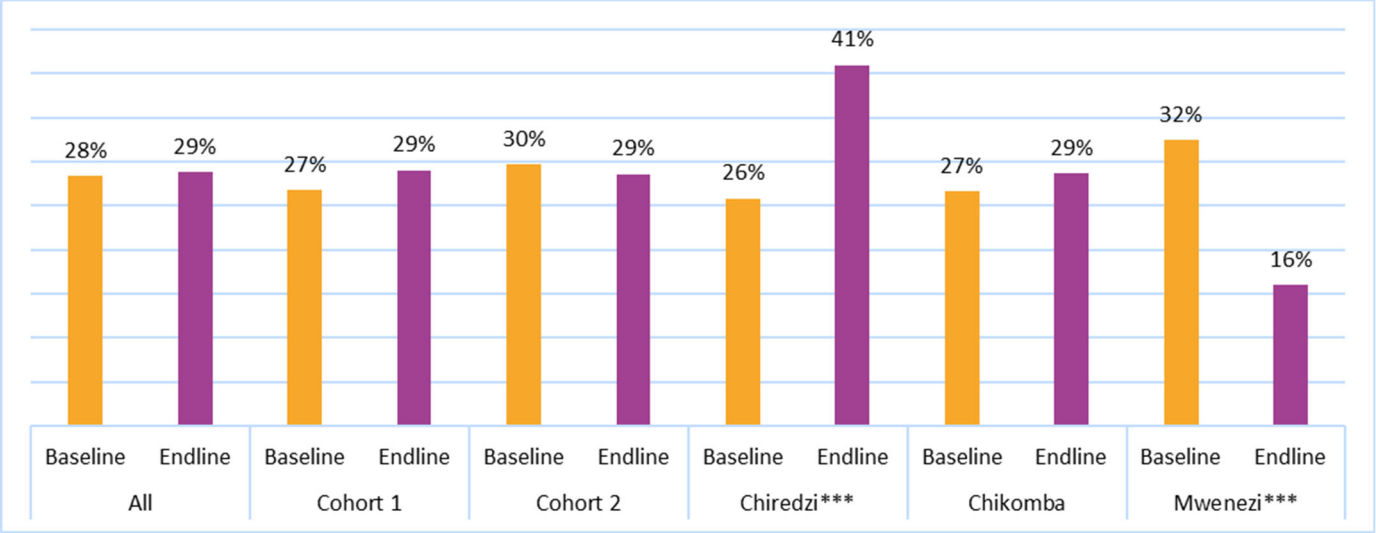


Figure 28: Baseline and endline past-year prevalence of women's partners' reported use of corporal punishment against a child



The results for corporal punishment are curious given the results of other ELU studies that have suggested that an unintended positive impact of Toose has been improved relationships with children. This is also reflected in other findings in the Endline Study, including positive impact on the parenting sub-scale of the family quality of life scale (see *Section 4.5* of the report) and positive results related to children identified in the Cohort 3 qualitative data (see *Box 9*). It is possible that the unexpected endline quantitative results are linked to under-reporting of corporal punishment against children at baseline.

[29] Partners' use of corporal punishment according to female respondents cannot be analysed by men's individual characteristics given that men did not participate in surveys and individual data for men was not collected.

Box 9: Qualitative insights on corporal punishment in Cohort 3

The Cohort 3 qualitative data paints a different picture from the survey data, with almost all participants, men and women, describing a more positive relationship with their children since joining the programme. This includes men and women who report having reflected on their use of power over or projection of anger onto their children and having changed this since participating in the programme. For example, one female participant in Mwenezi said she no longer behaves authoritarian towards her children. These changes were observed across all districts in the Cohort 1 qualitative data and are consistent with findings of other SAFE ELU qualitative studies. There were very few responses that suggest a misinterpretation of Toose teachings in relation to children. For example, only one man in Chiredzi described his children being more obedient as positive change. One woman in Mwenezi said the programme taught children to be more obedient to not provoke their parents into using violence. Changes in relationships with children are further discussed under 'family wellbeing' below.

4.4. Child marriage

The baseline and endline surveys are unable to measure the prevalence of child marriage but did measure respondents' perceptions of prevalence of early marriage in their community. There has been a significant increase in respondents' perceptions at endline that very few girls marry before the age of 18 in their community, with a corresponding decrease in the proportion who think that many girls marry before age 18 (p=0.001) (see *Figure 29*). It is notable, however, that over 50% of respondents at endline perceive many girls in the community to be marrying before the age of 18.

This finding is largely driven by change among Cohort 1 respondents and respondents in Mwenezi, a significantly smaller proportion of whom perceive many girls marrying at an early age at endline (see *Figure 30*). However, perceptions that many girls are marrying before age 18 are significantly more common at endline in Chikomba.

Figure 29: Baseline and endline perceptions of the number of girls marry before age 18 in the community

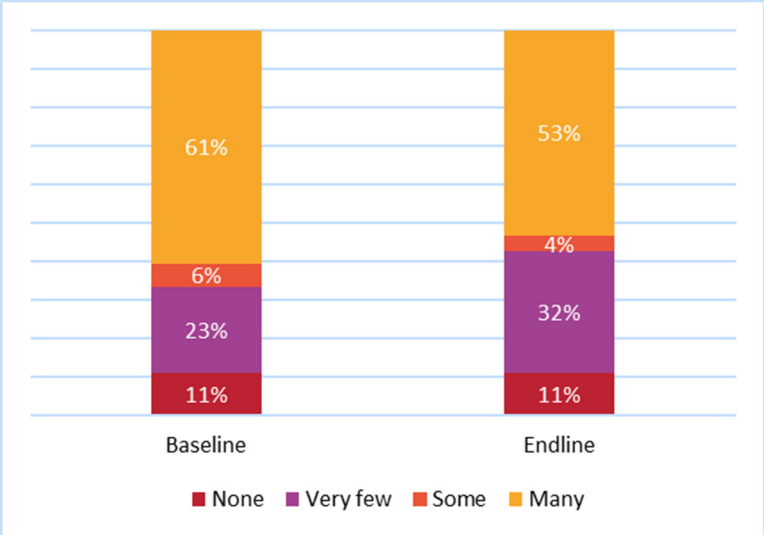
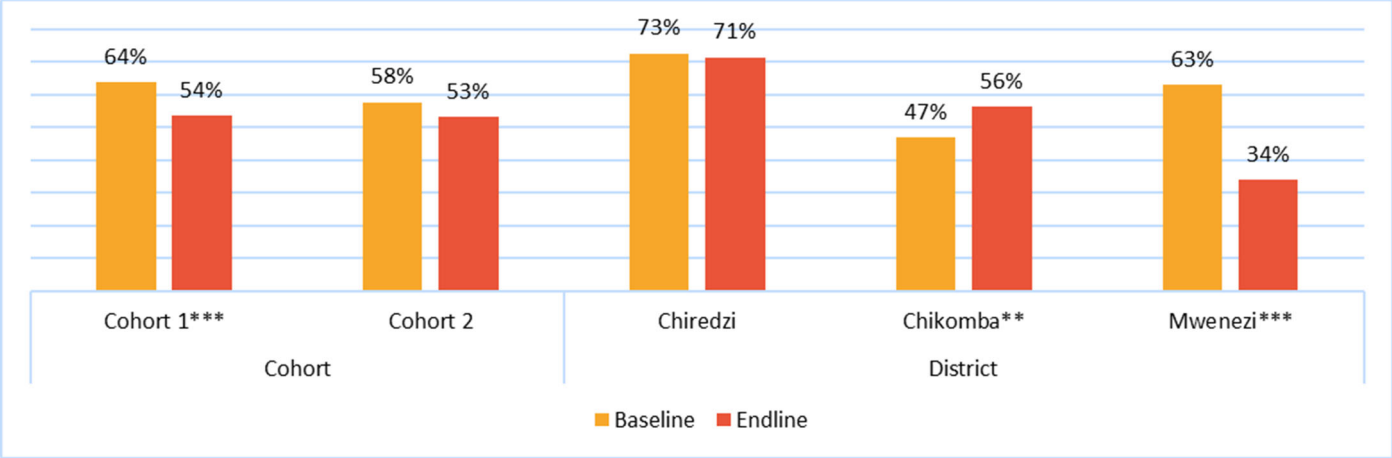
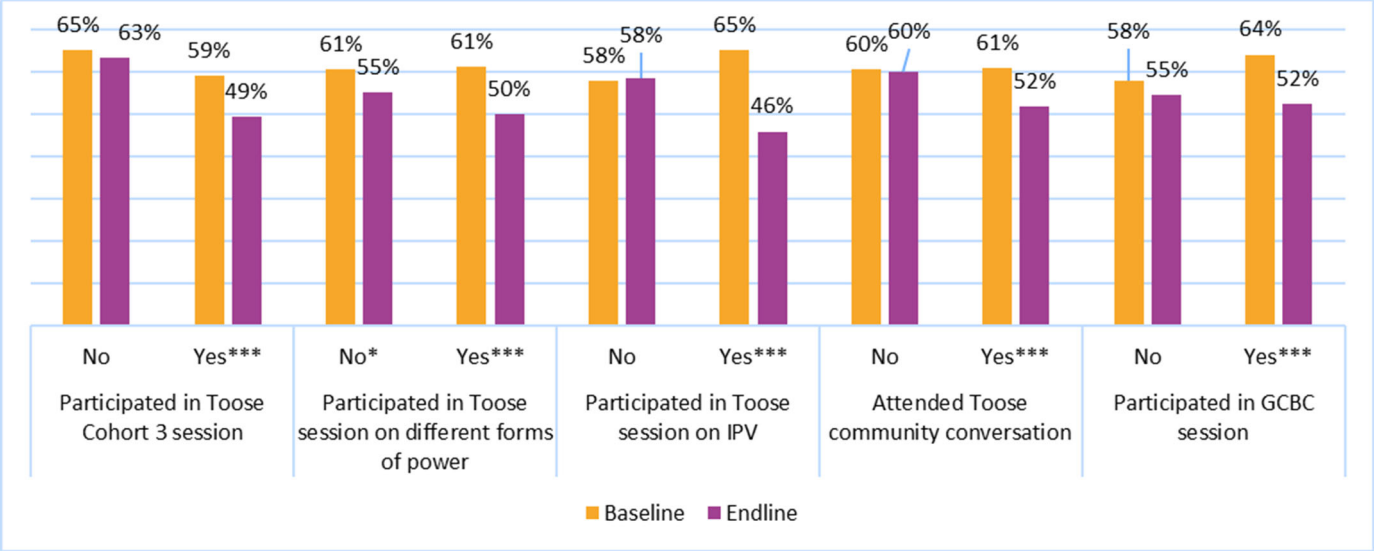


Figure 30: Baseline and endline perceptions that many girls marry before the age of 18 in the community, by cohort and district



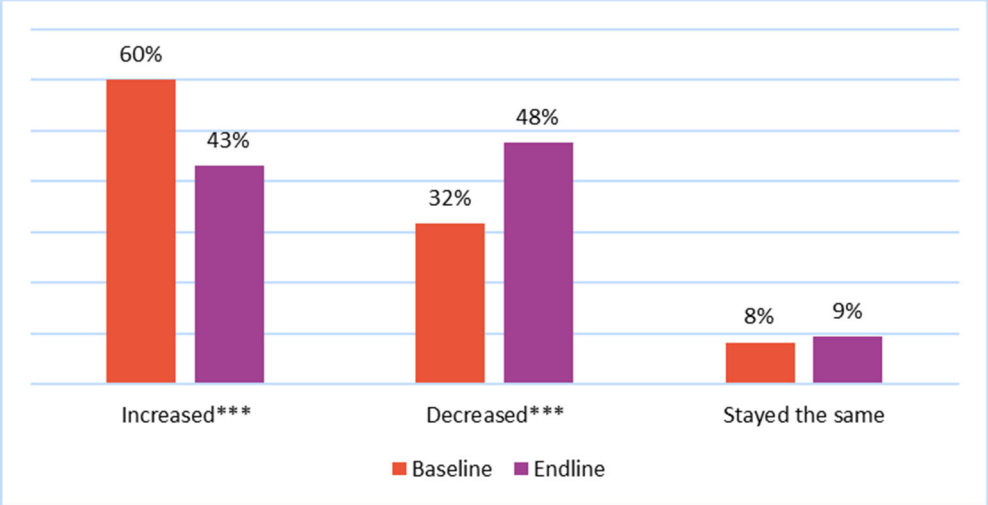
When exploring intervention exposure, it is notable that diminishing perceptions of many girls marrying before 18 years of age are strongest among women who had been exposed to different Toose intervention elements, including Cohort 3 Toose sessions in general, Toose sessions on different forms of power and IPV, and among those women who had attended a Toose community conversation or GCBC awareness raising session (see *Figure 31*).

Figure 31: Baseline and endline perceptions that many girls marry before the age of 18 in the community, by intervention exposure



Respondents were also asked whether child marriage in their community had increased, decreased or stayed the same in the past year, with a significant reduction in the proportion of respondents perceiving an increase in child marriage, and a corresponding increase in the proportion of respondents feeling that child marriage is decreasing (see *Figure 32*). Diminishing perceptions that child marriage is increasing were observed across all three districts, but particularly in Mwenezi, where 55% of respondents at baseline and 26% at endline felt that child marriage had increased in the past year (p=0.001). This trend holds across all individual and household characteristics and regardless of level of intervention exposure.

Figure 32: Baseline and endline perceptions that child marriage has increased, decreased or stayed the same in the past year



While it is not possible to test the extent to which child marriage has actually decreased and, if so, whether Toose had any impact on this, the quantitative findings certainly suggest that there are widespread perceptions of reduced prevalence of child marriage, particularly in Mwenezi. Associations between perceived reductions in child marriage and engagement with GCBCs in particular echo other results from ELU studies, which have emphasised perceptions that GCBC activities have been instrumental in raising awareness about the harms of child marriage.

Box 10: Qualitative insights on child marriage in Cohort 3

In the Cohort 3 qualitative data, a handful of participants in each district described improvements in child marriage prevalence in their community. In most cases, this was specifically attributed to GCBC awareness raising activities. The association between perceived reductions in child marriage and engagement with GCBCs echoes the survey results above as well as other results from ELU studies.

For example, a woman in Chiredzi said GCBC awareness campaigns have successfully educated community members on the risks associated with early marriage, which is now less likely. When asked for an example of positive change in relation to children, a male participant in Chiredzi said he decided to assist his daughter when she became pregnant, instead of "sending her away for this mistake". It is possible but unclear if he was referring to early marriage. A GCBC volunteer in Mwenezi reported seeing a positive shift in members of the Apostolic sect, allowing their daughters to complete high school education as a result from their work in the Apostolic community. In Chikomba, a GCBC volunteer confirmed they observed a decrease in child marriages. GCBC volunteers in Mwenezi explained that early marriages were a problem, especially in December because young girls would be enticed with material items by "border jumpers" (men who migrated to South Africa for labour purposes). To combat this, GCBC volunteers went around schools in Mwenezi to educate young girls on the dangers of early marriage and the importance of education. Similar initiatives were undertaken in Chikomba and Chiredzi.

In the Cohort 3 qualitative data, we also observed a handful of reports in each district of reductions in child abuse, including sexual, physical and neglect. In each district, several participants said the presence of GCBCs reduced child abuse, either because it acted as a deterrent or because the GCBCs (sometimes in collaboration with Musasa) directly intervened in cases of child abuse. For example, a woman in Chikomba said a case of child sexual abuse was brought to light by GCBC volunteers and handled swiftly, while the victim received appropriate support.

However, GCBC volunteers also warned that young girls were still experiencing various types of violence. For example, sexual violence, and economic and emotional manipulation, mostly at the hands of much older men, but sometimes also emotional and physical abuse at the hands of parents or stepparents. Another example they provided was sexual or economic exploitation by male employers, such excessive workload without pay.

4.5. Family wellbeing

As noted in *Annex 4,* family wellbeing was measured using a Family Quality of Life (FQOL) scale with four sub-scales capturing wellbeing related to family interactions, parenting, emotional relationships and material wellbeing. *Table 7*

contains baseline and endline scores on a scale of 1 to 5 with 1 meaning very dissatisfied and 5 meaning very satisfied with a range of elements related to the sub-scales. Women's reported family quality of life was significantly higher at endline (p=0.001) on all four sub-scales of the FQOL scale. The sub-scale with the largest improvements is the parenting sub-scale where a 0.5 point increase in the average sub-scale score was observed, compared to 0.2 - 0.3 for the other sub-scales. However, improvements on the other subscales were significant.[30] Significant improvements in all four quality of life sub-scales held across both cohorts and in Chiredzi and Mwenezi, although only for two sub-scales (parenting and material wellbeing) in Chikomba.

[30] Note that all scores across sub-scales are comparable given they represent average dissatisfaction or satisfaction with different elements of family quality of life on a 1-5 point scale.

Table 7: Baseline and endline FQOL scores on four sub-scales, disaggregated by cohort and district

		All	Cohort		District		
			1	2	Chiredzi	Chikomba	Mwenezi
Family interactions	Baseline	3.9	3.9	4.0	3.8	4.1	4.0
	Endline	4.2***	4.1***	4.2***	4.1***	4.1	4.4***
Parenting	Baseline	3.5	3.4	3.6	3.4	3.6	3.5
	Endline	4.0***	3.9***	4.1***	3.9***	3.9***	4.2***
Emotional	Baseline	3.2	3.1	3.3	3.3	3.1	3.2
	Endline	3.4***	3.3***	3.5***	3.5**	3.1	3.6***
Material	Baseline	3.4	3.3	3.5	3.2	3.5	3.5
	Endline	3.6***	3.5***	3.7***	3.3***	3.6**	3.7***

Significant improvements in family quality of life were observed across multiple individual and household characteristics and elements of intervention exposure, with a few exceptions:

- Improvements in the family interactions subscale were not significant for women with a disability, women aged 60+ or for women who did not attend a Toose community conversation
- Improvements in the emotional subscale were not significant for women with a disability, those who had medium food security at baseline, and those who did not participate in Toose sessions with a partner, nor among those who did not attend a Toose community conversation or an awareness raising sessions by GCBCs. Further, household emotional wellbeing was reported to have worsened significantly among women aged 60+.
- Improvements in the material subscale were not significant for women with a disability, those aged 30-39 years or 60+ years, those who had medium food security at baseline and those who did not attend a Toose community conversation.

Box 11: Qualitative insights on change in family wellbeing

The Cohort 3 qualitative data contains many reports of improvements in family wellbeing and quality of life, including in the sub-scales presented in Table 6 above. Positive change is mostly reported on three levels; improved quality of intimate partner relationships, improved quality of relationships with children, improved family dynamics or interactions. All change at these three levels appears to be driven by improved household economic dynamics, and/or improved communication, but to a lesser extent by more equitable relationships. To illustrate this, a women in Chiredzi said an increase in household income meant her children were able to take snacks and drinks to school, which made them happy, and this in turn contributed to a happier family.

Improvements in the quality of relationships with partners was mentioned most often. This includes reports of increased harmony, love, communication and intimacy. A more equal sharing of labour burden was also mentioned here but less commonly. For example, a male participant in Chikomba said his relationship with his wife has blossomed because of the programme, and it is now filled with laughter and meaningful quality time. A woman in Mwenezi disclosed she used to be under-weight and experienced restless nights as a result of marital conflict about money. Since participating in the programme, she has become financial independent and no longer argues with her spouse. She reports having gained healthy weight and being at peace, and feels her wellbeing benefitted greatly.

Improvements in family dynamics and improvements in relationships with children were roughly equally common. Male and female participants spoke about spending more quality time together as a family, creating more time for play, and experiencing happier home environments. Engaging in open communication with children, involving them in important conversations, and creating a safe environment for them sharing their concerns and experiences were also commonly mentioned. For example, a woman in Chikomba explained that, because of open communication, her children feel more comfortable sharing their struggles, and about school and friendships.

5. Outcome 1 pathway: Household are able to manage economic stress

Key findings:

- Food security has worsened overall (from 4.2 at baseline to 4.7 at endline), but this only holds in Cohort 1 and Mwenezi. In the Cohort 1 qualitative interviews, some respondents spoke about challenges that give insight into the factors in communities that may have contributed to the survey findings on food insecurity. For example, customers failing to pay for goods bought on credit due to worsening economic conditions and hunger, droughts that severely impacted agricultural activities, and challenges in repaying loans due to slow or limited success with small businesses. In Chiredzi, there were more reports of a worsening economic environment than in other districts.
- Despite food security worsening at endline, household ability to meet essential needs has improved among women in Cohort 1 and Chikomba, with no change in ability to meet needs in contexts where food security worsened at endline. Participants in the Cohort 1 qualitative interviews, in particular in Chiredzi, disclosed struggling to repay TISAL loans because they had to divert their income to urgent basic needs, such as primarily healthcare and school fees.
- Based on the qualitative Cohort 1 data on food security and ability to meet basic needs, participants in Chiredzi do not seem to have better outcomes than participants in Chikomba and Mwenezi. However, when asked if and how cash vouchers helped participants in Chiredzi, most participants said the vouchers helped cover food expenses or school fees and thereby free up money to participate in TISALs.
- There was no change in household joint economic planning overall, except in Chikomba where there has been a significant increase in planning at endline. The Cohort 1 qualitative data however suggests that joint economic planning is widespread across all districts.
- Women's economic outcomes are associated with several economic measures, with economic shock being linked to worsening food security, and ability to meet essential needs associated with strong food security at endline. Women's level of engagement in economic activities may have strengthened some economic outcomes but not all, with the number of
- Number of TISAL loans taken out has no relationship with food security but is significantly associated with meeting essential needs and engaging in household joint economic planning.

Table 8: RAG rating for outcome pathway 1 measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Outcome Pathway 1 - Ability to manage economic stress						
Household food security						
Household ability to meet essential needs						
Household joint economic planning						

5.1. Food security

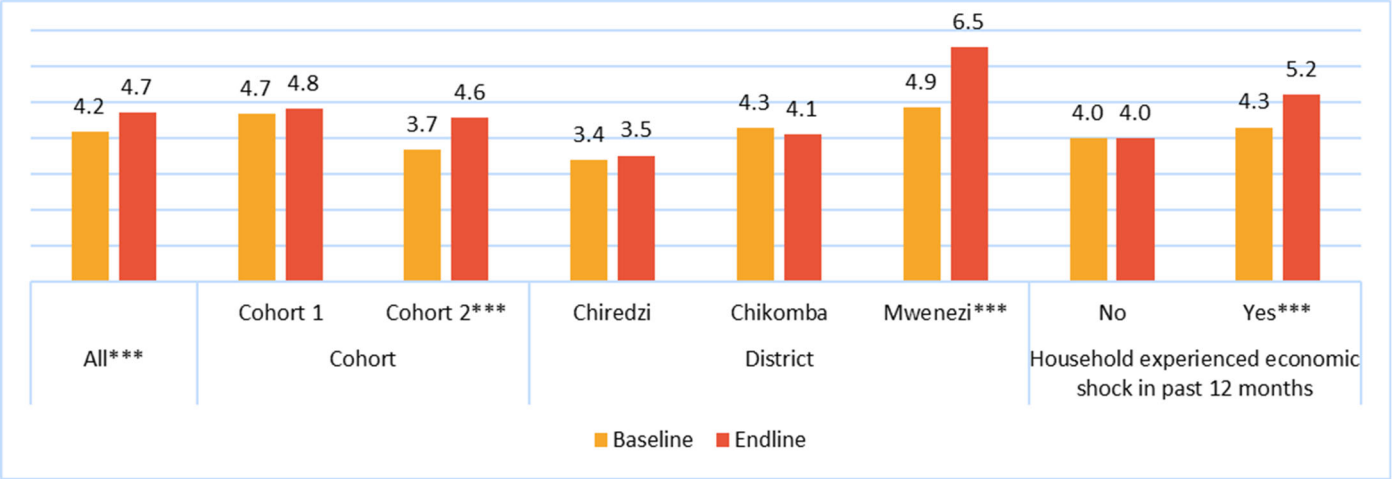
The endline findings suggest that household food insecurity, measured on a scale from three to 12,[31] has worsened significantly at endline, increasing from a score of 4.2 to 4.7. However, mean scores remain low overall, indicating low food insecurity at both baseline and endline. When disaggregated by implementation cohort and district, worsening food insecurity was only significant for Cohort 2 and in Mwenezi (see *Figure 33)*. Food insecurity also worsened significantly among women whose households experienced economic shock in the past year, defined as a sudden loss of income or assets, with a large increase between baseline and endline in the proportion of households that had

[31] Low scores mean low food insecurity and high scores mean high food insecurity.

experienced past-year economic shock (from 33% to 57%). It is possible that the El Niño drought was at play, which affected large parts of Zimbabwe during the year of endline data collection. This environmental shock had significant socio-economic consequences, particularly related to food security and livelihoods.

The relationship between food insecurity and economic shock is also visible through the coping strategies that women's households engaged in to handle a sudden loss of income or assets in the past year. There has been an increase between baseline and endline in coping strategies related to food, including reducing the proportion of meals (from 8% to 15%) and reducing the number of meals per day (from 4% to 16%). There was also an increase between baseline and endline in the proportion of women borrowing money as a coping strategy for economic shock (from 7% to 30%), which may be related to increased borrowing from TISAL groups. However, there does not appear to be a relationship between food insecurity and women's engagement with TISALs, with household food insecurity increasing significantly regardless of how many loans women took from TISAL groups, suggesting that borrowing is not necessarily easing food insecurity for women's households.

Figure 33: Baseline and endline food insecurity scores by cohort, district and whether household experienced economic shock in the past 12 months



Box 12: Qualitative insights on food security in Cohort 1 and the added value of CBT in Cohort 3

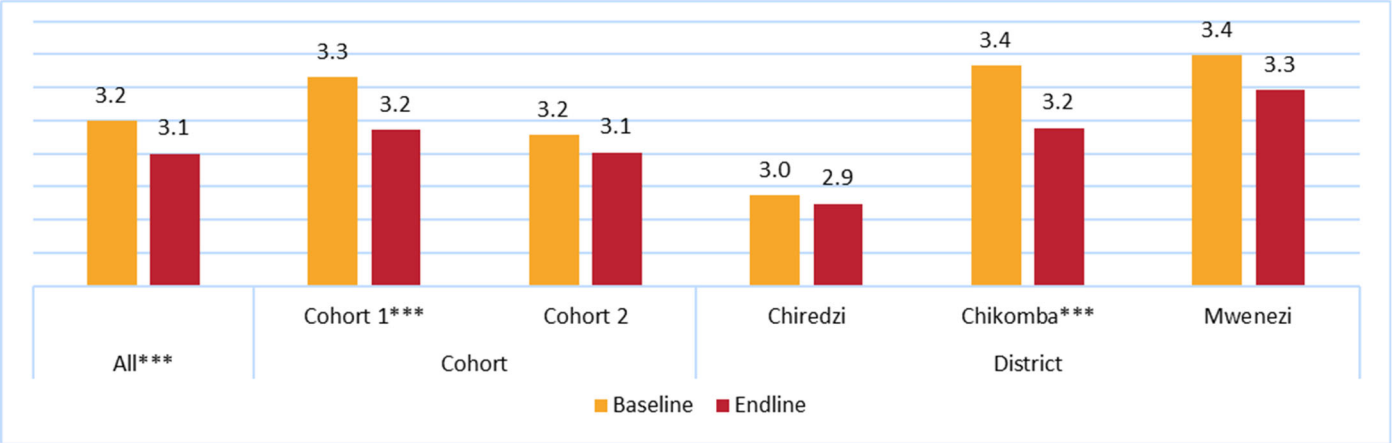
Although the Cohort 3 qualitative dataset does not contain data on food security specifically, we found some data that helps understand the wider context. Participants were asked about challenges in participating in TISALs and repaying loans. Although almost all participants reported few to no challenges, a handful of men and women spoke about challenges that give insight into the factors in communities that may have contributed to the survey findings on food insecurity described above. In Mwenezi and Chiredzi, some participants spoke about customers failing to pay for goods bought on credit due to worsening economic conditions and hunger, while others failed to repay loans on time. Other participants said that increased competition (when other TISAL members trading in the same goods sold these at the same time) caused a downturn in sales, and that droughts severely impacted agricultural activities. In Chikomba, a handful of participants reported challenges in repaying loans due to slow or limited success with their small businesses. One female TISAL group in Chikomba has had to temporarily halt their activities because of outstanding debts from several of its members. Several other groups experienced the same (see *Box 5*). In Chiredzi, there were more reports of a worsening economic environment than in other districts.

Based on the qualitative Cohort 3 data on food security and ability to meet basic needs, participants in Chiredzi do not seem to have better outcomes than participants in Chikomba and Mwenezi. However, when asked if and how cash vouchers helped participants in Chiredzi, most participants said the vouchers helped cover food expenses or school fees and thereby free up money to participate in TISALs. It also ensured participants were able to avoid spending their TISAL revenues on food and rather invest these in IGAs for example. A handful of participants also said they allocated part of the money to food and the rest to TISAL contributions. Participants praised the flexibility the cash awarded them, when compared to food vouchers.

5.2. Ability to meet essential needs

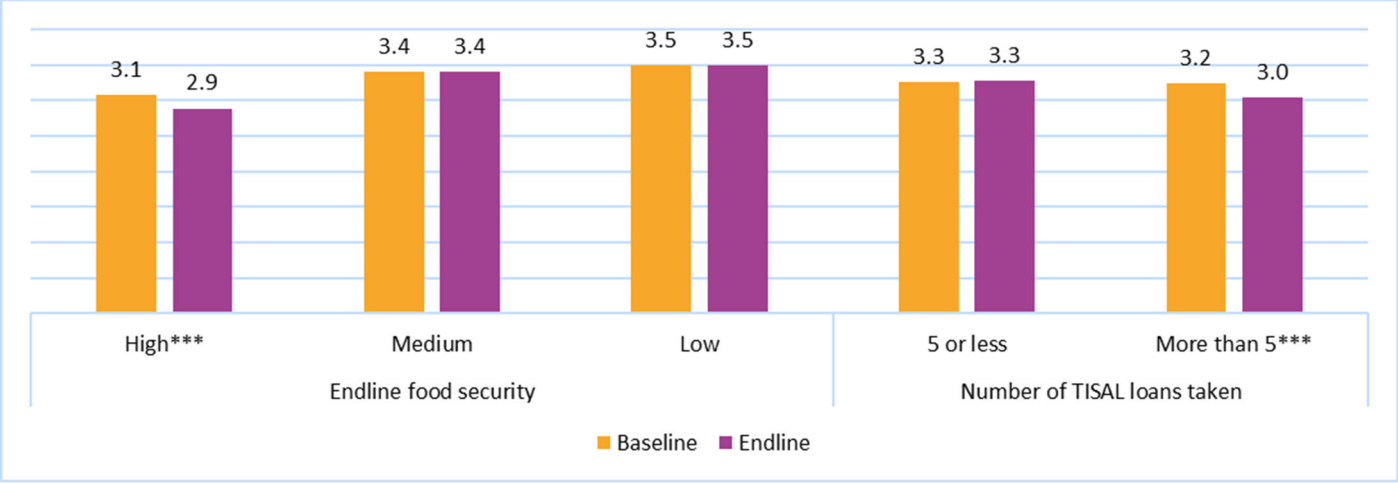
Despite an increase in household food insecurity overall, the evaluation results suggest that household ability to meet essential needs in the past month according to women's priorities has improved. On a scale of 1 to 4, with 1 indicating that households are able to meet all needs and 4 indicating they are able to meet very few or no needs, mean scores decreased significantly at endline indicating improved essential needs met. However, the magnitude of this change overall is small (dropping from 3.2 to 3.1) (see *Figure 34*). When disaggregating these results by cohort and district, the finding was only significant in Cohort 1 and in Chikomba. The result was also only significant among women aged 50-59 years (p=0.01).

Figure 34: Baseline and endline ability to meet essential needs, by cohort and district



Ability to meet essential needs appears to be related to economic factors. Women's improved ability to meet essential needs only held among women who were the most food secure at endline (see *Figure 35*). Further, the proportion of women whose households had essential needs met increased significantly for those who had taken out more than five TISAL loans (p=0.001) while staying the same for those who took five or fewer loans. This may suggest that larger number of loans has helped households to meet essential needs, although causality or temporality cannot be established as it is also possible that being able to meet essential needs allows people to take out and repay more loans.

Figure 35: Baseline and endline ability to meet essential needs by endline food security and mean number of TISAL loans taken



Box 13: Qualitative insights on ability to meet basic needs in Cohort 3

The qualitative Cohort 3 data provide some insights into other economic factors that may have contributed to the small magnitude of the food security changes presented above. In Chiredzi, in particular, participants disclosed they struggled to repay TISAL loans because they had to divert their income to urgent basic needs, such as primarily healthcare and school fees. There were many reports of participants failing to repay loans, for various reasons,

including drought and a worsening of economic conditions, theft of raw goods, accidents, business losses, and diversion to basic needs (mostly healthcare). This was also mentioned in Chikomba and Mwenezi, but to a lesser extent than in Chiredzi.

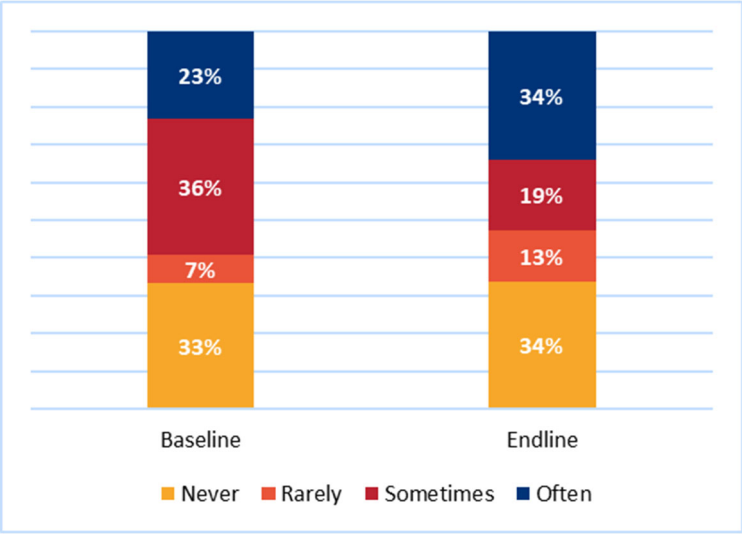
Despite challenges with loan repayment, most participants reported improvements in household income when asked about the impact of the programme on their lives, echoing the survey results. Improvements in household income was one of the most reported benefits of participation in the programme, often leading to significant improvements in living conditions. This was especially the case when asked about TISAL participation, and true across all cohorts. For example, participants reported being able to pay school fees, home improvements, purchase large household items, such as plasma TVs and freezers, and afford sufficient meals.

5.3. Household joint economic planning

On a scale of 1 to 4, with scores representing frequency with which household members worked together to develop economic plans in the past 12 months, there was no difference between baseline (2.5) and endline (2.5) scores.[32] When looking at the breakdown of response categories, it is evident that there was an increase in the proportion of women between baseline (23%) and endline (34%) who stated that their household often worked together to develop economic plans in the past 12 months, but with a corresponding increase in the proportion of those who never or rarely did so (40% at baseline and 47% at endline) (see *Figure 36*). Variations in the frequency of household economic planning were only observed in Chikomba, where scores measuring the frequency of household planning increased from 2.3 at baseline to 2.8 at endline (p=0.001) and among women who had taken out more than five TISAL loans (scores of 2.6 at baseline and 2.8 at endline, p=0.04).

The results on household joint economic planning should be read with caution. The survey question asked: “In the past 12 months, how often have you and your household members worked together to come up with a plan to increase household income or assets?” The frequency with which this kind of planning was done is not necessarily a good proxy for household collaboration. The question may also have been confusing for respondents if the terminology of 'working together to come up with a plan to increase household income or assets' was not how the programme content was framed.[33]

Figure 36: Baseline and endline frequency with which respondents and their household members worked together to increase household income or assets in the past 12 months



Box 14: Qualitative insights on household joint economic planning in Cohort 3

The Cohort 3 qualitative data paints a positive picture, although it should be noted the interviews did not explore frequency like the survey did. Household economic planning appeared to widespread among Cohort 3 participants.

[32] A score of 1 means never and a score of 4 means often.
[33] The baseline survey, from which the endline was adapted, was designed and fielded prior to the completion of the Toose social empowerment curriculum. While some key concepts and terminology were known at this time, such as the concept of shared visioning (see further below), and thus easily translated into appropriate language for the survey, the more generic framing of household planning may not have aligned well with programme content.

Although it is unclear what the frequency of the reported planning was, this often resulted in improvements in living standards. Respondents overwhelmingly attributed this to the programme. For example, a woman in Chikomba said economic planning enabled them to build a toilet, reducing exposure to disease due to poor hygiene. Others said they were finally able to pay their children's school fees as a result. There were no reports of a decrease in the frequency of planning, as suggested by the survey results.

6. Outcome 2 pathway: Intimate partner and family relationships are more gender equitable and do not resort to violence to resolve conflict

Key findings:

- There was a small but significant improvement at endline (81%, from 76% at baseline) in respondents' ability to identify assertive communication as the most appropriate way to resolve a conflict, although knowledge was already high at baseline.
- Despite improvements in knowledge about the most appropriate way to resolve a conflict, there has been no change at endline in the frequency of women's use of peaceful ways of resolving conflict with their partner in the past 12 months. However, frequency of using peaceful conflict resolution methods was also high at baseline.
- According to women in Chiredzi, there was a significant reduction in their partners' use of peaceful conflict resolution methods (3.0, from 2.8 at baseline) and the opposite was observed in Mwenezi (3.4, from 3.2 at baseline), where women reported significant increases in their partners' peaceful conflict resolution. This is associated with men's participation in Toose and women's exposure to additional Cohort 1 sessions. The Cohort 1 qualitative results suggest that Cohort 1 participants and their partners in Mwenezi have better knowledge of non-violent conflict resolution and its benefits or value than those in other districts. The Cohort 1 qualitative data also found one or two cases of apparent misinterpretation of Toose teachings in each district. This was true for both programme participants and their partners
- The endline results show a significant increase in the proportion of women (85%, from 55% at baseline) reporting that their household had agreed on a shared vision for improving family quality of life and this result is consistent across both cohorts and all three districts. Despite this positive result, there was no significant change in the extent to which households had worked towards achieving this shared vision for improving family quality of life. Similar to the survey results on cohorts 1 and 2, shared family planning and visioning was widespread among participants in the Cohort 1 qualitative data. When asked about the positive impacts of Toose participation, most participants said they were more likely to make plans for improving quality of life and their family's future, together as a household. This was mostly mentioned in relation to the household's economic standing.
- Despite an increase in women's decision making alone or jointly with their partner on several measures of decision making, women's inputs into the decision-making process reduced significantly. Women's feelings that they are able to make their own decisions about things they value if they wanted to have also reduced significantly at endline. These results suggest that there was positive impact in relation to the main objective of Toose in relation to decision making, which is to strengthen women's joint decision making with partners and other household members. However, this joint decision making is not necessarily translating into women's strengthened agency within their households. This is supported by findings from the qualitative Cohort 1 data.
- There was an increase at endline in women stating that their partner helps them with household labour. Change is observed specifically in relation to male partners providing some help to women, rather than tasks being shared equally or done together. The Cohort 3 qualitative data show a similar picture to the survey results, one that confirms findings from previous qualitative ELU studies.

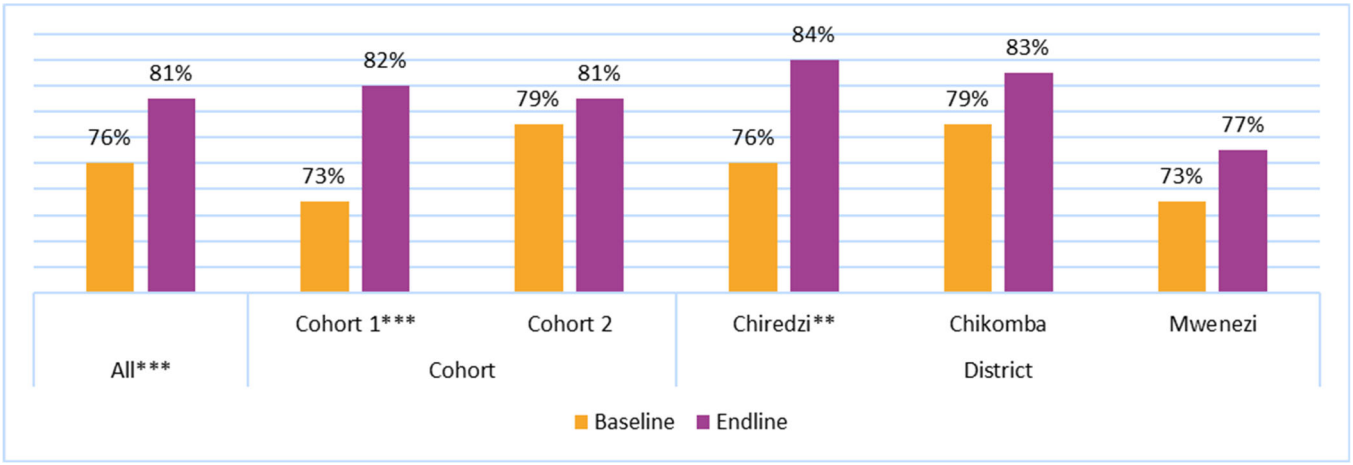
Table 9: RAG rating for outcome pathway 2 measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Outcome Pathway 2 - Gender equitable, cooperative and non-violent relationships						
Knowledge of positive conflict resolution methods						
Peaceful conflict resolution practices with partner						
Partner's peaceful conflict resolution practices with women						
Agreement on shared family vision for wellbeing						
Worked towards achieving this vision for wellbeing						
Women's sole or joint decision making						
Women's agency in decision making						
Men contributing more to household labour						

6.1. Intimate partner conflict resolution

There has been a small but significant improvement at endline in respondents' ability to identify assertive communication as the most appropriate way to resolve a conflict (76% at baseline and 81% at endline, p=0.001), although knowledge was already high at baseline. Increased knowledge about assertive communication was highest in Cohort 1 and in Chiredzi (see *Figure 37)*. Knowledge about assertive communication is also associated with age: knowledge increased between baseline and endline among younger women aged 18-28 years (69% at baseline and 84% at endline, p=0.001) and 30-39 years (76% at baseline and 84% at endline, p=0.001), while not changing significantly among women in older age groups. When analysing knowledge by exposure to Toose intervention components, significant increase in knowledge was consistent regardless of exposure with the exception of women who did not participate in Toose sessions with a partner and who did not participate in Cohort 1 sessions, and those who did not attend a Toose community conversation.

Figure 37: Baseline and endline identification of assertive communication as the most appropriate way to resolve a conflict



Despite improvement in knowledge about the most appropriate way to resolve a conflict, there has been no change at endline in the frequency of women's use of peaceful ways of resolving conflict with their partner in the past 12 months. However, frequency of using peaceful conflict resolution methods was high at baseline. On a scale of 1 to 4, with 1 representing never using peaceful conflict resolution methods and 4 representing often using such methods, the baseline and endline mean scores were both 3.2. This finding holds across both cohorts and all three districts. The only factor significantly associated with women's more frequent use of peaceful conflict resolution methods with partners is whether women participated in a Toose session on different forms of power (baseline and endline scores of 3.2 and 3.3, p=0,001) or a Toose session on IPV (baseline and endline scores of 3.2 and 3.4, p=0.001). These findings linking positive conflict resolution with exposure to Toose sessions on power and IPV are curious, particularly given that exposure to these sessions was also associated with increased IPV at endline.

Women were also asked about the frequency with which their partner used peaceful conflict resolution methods in the past 12 months. While there were no significant differences at endline overall or by cohort, there were significant differences according to district. According to women in Chiredzi, there was a significant reduction in their partners' use of peaceful conflict resolution methods (from 3.0 at baseline to 2.8 at endline, p=0.001) and the opposite was observed in Mwenezi where women reported significant increases in their partners' peaceful conflict resolution (from 3.2 at baseline to 3.4 at endline, p=0.01). When analysing partners' conflict resolution by exposure to intervention elements, women reported a significant reduction in their partners' peaceful conflict resolution when partners did not participate in Toose, and when women did not participate in additional Cohort 1 sessions, sessions on different forms of power or sessions on IPV (scores were 3.1 at baseline and 2.9 at endline for all cases, p<0.05).

Box 15: Qualitative insights on intimate partner conflict resolution in Cohort 3

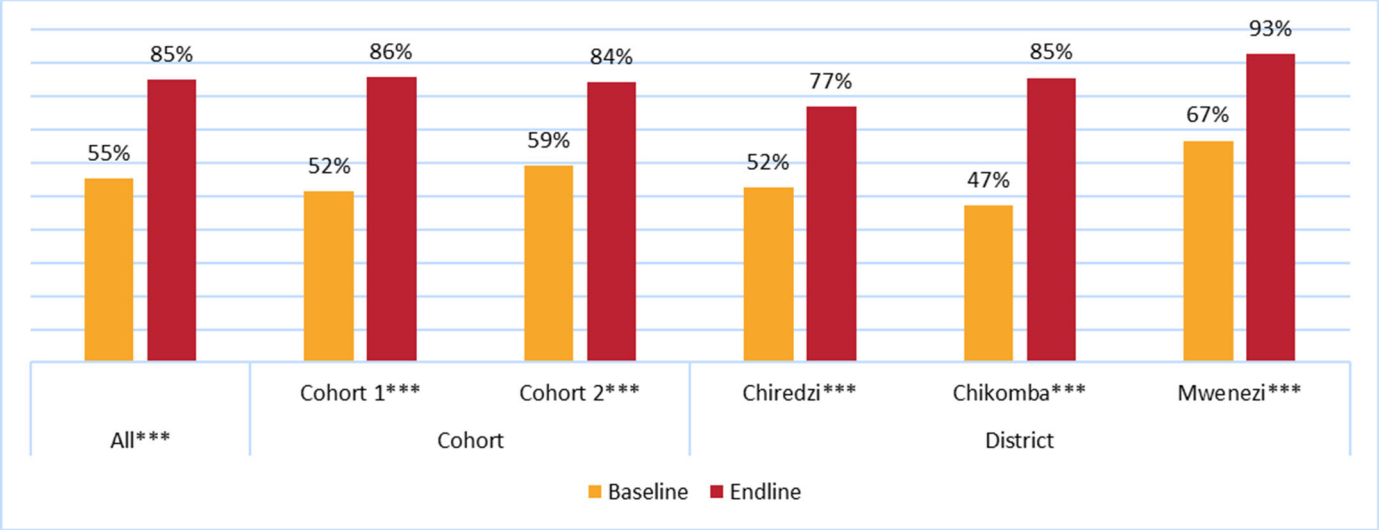
In the Cohort 3 qualitative data, almost all participants reported improvements in communication and conflict resolution, with a few variations across districts. When looking at the nature of the responses, Cohort 3 participants and their partners in Mwenezi appear to display better knowledge of non-violent conflict resolution and its benefits or value. They provided more specific examples and shared about the precise Toose sessions that benefitted their communication and conflict resolution. For example, a woman recalled learning that respectful communication, along with the willingness to forgive and reconcile, is key to resolving conflicts constructively. She also noted that, when conflicts are addressed in a fair and just manner, it fosters trust and understanding between partners, and that expressing emotions and resolving disagreements peacefully strengthens relationships, reduces tension, and promotes emotional well-being for both individuals. These findings support the survey results on the increase in partners' use of peaceful conflict resolution. In Chikomba and Chiredzi, participants were just as likely to report non-violent conflict resolution, but the nature of the responses suggests less knowledge of these methods and their value.

In each district, we found one or two cases of apparent misinterpretation of Toose teachings. This was true for both programme participants and their partners. In Mwenezi, a woman said Toose helped her become better at detecting her husband's moods and responding appropriately to avoid violence. In Chiredzi, a woman stated submitting to her husband, not talking back or raising her voice, as an example of positive change. In Chikomba, one man said his wife has become more submissive as a result, and another man reported his wife being more willing to carry out household chores, such as fetching him bath water. In Chikomba, a woman also said there was greater harmony between her and her husband but only when he was sober. His demeanour would change drastically when intoxicated with alcohol.

6.2. Shared family vision for wellbeing

The endline results show a significant increase in the proportion of women reporting that their household had agreed on a shared vision for improving family quality of life and this result is consistent across both cohorts and all three districts (see *Figure 38*). The result also holds across all factors, including respondents' individual and household characteristics and exposure to intervention elements. Despite this positive result, there was no significant change in the extent to which households had worked towards achieving this shared vision for improving family quality of life. On a scale of 1 to 4, with 1 meaning not at all and 4 meaning to a high extent, scores on working towards achieving shared visions were 2.9 at both baseline and endline. This was consistent across women's individual and household characteristics, with the exception of women in Chikomba, women with a disability and women aged 50-59 years, among whom significant increases were observed in working towards a shared vision. In relation to intervention exposure, there was a significant increase in working towards shared visions among women who did not participate in Toose sessions on different forms of power (p=0.001) and a decrease in achieving shared visions among those who did participate in sessions on power (p=0.001).

Figure 38: Baseline and endline proportion of respondents whose household agreed on a shared vision for improving family quality of life



Box 16: Qualitative insights on shared family vision in Cohort 3

Similar to the survey results on Cohorts 1 and 2, shared family planning and visioning was widespread among participants in the Cohort 3 qualitative data. When asked about the positive impacts of Toose participation, most participants said they were more likely to make plans for improving quality of life and their family's future, together as a household. This was mostly mentioned in relation to the household's economic standing. Participants overwhelmingly attributed this to the programme and, in many cases, this reportedly resulted in improvements in living standards. For example, a woman in Mwenezi recalled that family planning and visioning allowed them to purchase additional livestock (one cow and two goats), pay school fees and buy food. Family planning and visioning was also mentioned in relation to family wellbeing but to a lesser extent.

6.3. Women's decision making

The baseline and endline surveys included several different measures related to women's decision making in their households about economic matters. The main measures used were drawn from standardised items such as those commonly used in population surveys like the DHS, which ask about whether women make decisions alone or together with their partner, or if their partner makes the decisions alone. These survey items were supplemented with additional questions from the Women's Empowerment in Agriculture Index (WEAI) that ask about how much input women have in decision making and the extent to which they feel they can make personal decisions about these issues if they want to. These additional questions seek to move beyond final decision making and explore the process of decision making, including the extent to which women can input into and make personal decisions about things they value. These elements of decision making are recognised in the literature as important indicators of women's agency, of which joint or final decision making is not necessarily an accurate proxy.[34]

The endline results related to women's decision making alone or jointly are largely positive. In relation to decisions about earnings, there has been no change in women's decision making about their own income use, which was already high at baseline. However, there has been a significant increase in the proportion of women deciding alone or jointly with their partner about how their partners' income is used, making major household purchases, how to spend household savings and whether to take out a loan. As outlined in *Table 10*, these results vary across cohort and district with stronger improvements observed for Cohort 1, when compared with Cohort 2, in relation to decisions about using income. Women's sole or joint decision making about their partners' income also increased significantly in Chiredzi while staying the same in the other two districts although joint decision making was already common at baseline in Chikomba and Mwenezi. Other non-significant findings in *Table 10*, including for spending household savings in Chiredzi and taking out loans in Chikomba and Mwenezi need to be read with caution given small sample sizes within these categories.

[34] Donald, A. et al. (2017) Measuring Women's Agency. Policy Research Working Paper 8148. World Bank Group.

Table 10: Women's baseline and endline decision making alone or jointly with their partner

Type of decision	Time point	All	Cohort		District		
			Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
How her earnings will be used	Baseline	90%	87%	93%	88%	89%	93%
	Endline	92%	93%***	91%	92%	91%	93%
How partners' earnings will be used	Baseline	75%	68%	79%	70%	78%	78%
	Endline	84%***	83%***	84%	81%**	85%	86%
Making major household purchases	Baseline	65%	67%	64%	65%	62%	69%
	Endline	83%***	83%***	83%***	83%***	77%***	88%***
How to spend household savings	Baseline	78%	79%	77%	71%	80%	78%
	Endline	91%***	93%***	89%***	71%	94%***	93%***
To take out loan	Baseline	77%	76%	77%	75%	79%	79%
	Endline	89%***	88%*	90%*	93%***	75%	86%

Despite an increase in women's decision making alone or jointly with their partner on several measures of decision making as outlined above, the endline results suggest that women's inputs into the decision-making process have reduced significantly. This result is observed overall, and across both cohorts and all districts, with the exception of inputs into decisions about spending household savings in Chiredzi (see *Table 11*). It is also observed across different individual and household characteristics of respondents and across different levels of intervention exposure.

Table 11: Women's baseline and endline ability to input into decision making[35]

Type of decision	Time point	All	Cohort		District		
			Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
How her earnings will be used	Baseline	2.7	2.7	2.8	2.7	2.7	2.8
	Endline	2.5***	2.5***	2.5***	2.5***	2.5***	2.5***
How partners' earnings will be used	Baseline	2.5	2.4	2.5	2.4	2.4	2.6
	Endline	2.2***	2.1***	2.2***	2.2***	2.2***	2.3***
Making major household purchases	Baseline	2.6	2.6	2.6	2.6	2.5	2.6
	Endline	2.4***	2.4***	2.4***	2.3***	2.3***	2.5***
How to spend household savings	Baseline	2.6	2.7	2.6	2.4	2.7	2.7
	Endline	2.5***	2.5***	2.5*	2.4	2.5*	2.5***
To take out loan	Baseline	2.7	2.7	2.8	2.7	2.8	2.6
	Endline	2.2***	2.3***	2.2***	2.2***	2.4*[36]	2.1*[37]

Women's feelings that they are able to make their own decisions about things that they value if they wanted to have also reduced significantly at endline for all four categories of decision making measured (see *Table 12*). There are a few notable differences in this result, mainly in Chikomba, where we see that reduction in women's ability to make their own decisions about how to spend household savings is not significant and where ability to make their own decisions about taking out loans has increased significantly.

[35] Average score between 1 and 3, with 1 indicating no or very little input and 3 indicating input into most or all decisions.
[36] Note that despite endline change being significant, the sample size was small (n=28) and so this result should be read with caution.
[37] Note that despite endline change being significant, the sample size was small (n=29) and so this result should be read with caution.

Table 12: Women's baseline and endline feelings that they can make their own decisions[38]

Type of decision	Time point	All	Cohort		District		
			Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
How her earnings will be used	Baseline	3.7	3.7	3.7	3.6	3.6	3.7
	Endline	3.5***	3.5***	3.5***	3.5*	3.4***	3.5***
Making major household purchases	Baseline	3.5	3.5	3.5	3.5	3.5	3.5
	Endline	3.0***	3.0***	3.1***	2.9***	3.1***	3.2***
How to spend household savings	Baseline	3.4	3.3	3.4	3.2	3.4	3.4
	Endline	3.2**	3.3	3.2**	2.9	3.2	3.2*
To take out loan	Baseline	2.9	2.9	2.8	2.7	2.9	3.0
	Endline	2.6***	2.6***	2.6***	2.2***	3.2**	2.5***

The results suggest that there has been positive impact in relation to one of the objectives of Toose which is to strengthen collaborative relationships in households and encourage women's joint decision making with partners and other household members. However, this joint decision making is not necessarily translating into women's strengthened agency within their households. This is supported by findings from the qualitative Cohort 3 data presented below.

Box 17: Qualitative insights on women's decision making in Cohort 3

In the Cohort 3 qualitative interviews, both male and female participants reported improvements in shared decision making when asked about the impact of the programme on their lives. This was true across all districts, however it was less frequently mentioned than other changes, such as improved economic planning and family wellbeing. Although the qualitative interviews did not specifically ask about types of decisions like the survey did, decision making was most commonly mentioned in relation to TISAL activities; taking out loans, determining IGA type and other ways to allocate the loans, repayment, etc. This was true for both male and female programme participants, who reported involving their partner in decision making regarding TISAL activities. There was no mention of women's sole decision making in the Cohort 3 qualitative data.

We found a few statements (in less than 5% of all research participants) that suggest the change in behaviour may not be accompanied by a change in attitudes. For example, one male participant said he gave his wife the authority to make decisions in his absence, and one female participant said she now supports her husband as the head of the household. The partner of a female TISAL participant said his wife is the primary decision-maker for household matters and therefore only consults him or major expenses. The partner of a male TSIAL participant noted that her husband is the sole decision maker when it comes to spending the TISAL loans because he considers his participation in the TISAL "his programme".

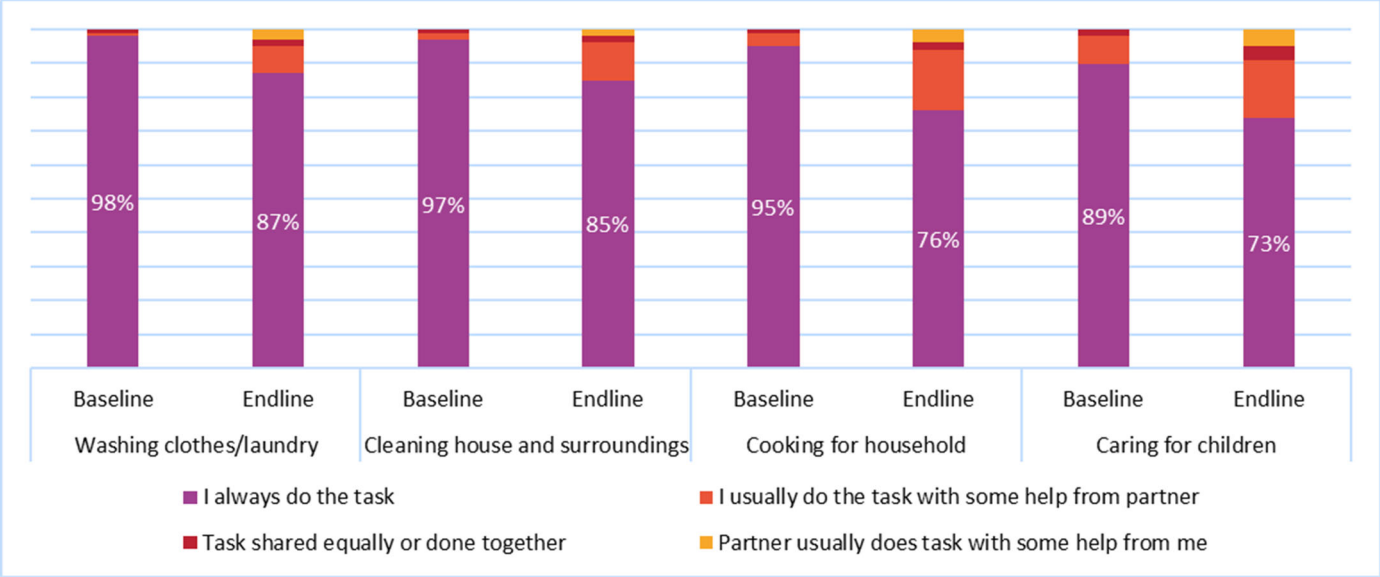
In Mwenezi however, responses were more likely to suggest attitudinal change than in the other two districts. For example, several men and women here spoke about the benefits of shared decision making in relation to gender equality, in line with the Toose teachings.

6.4. Shared responsibilities for household labour

There has been an increase at endline in women stating that their partner helps them with household labour (see *Figure 39*) and this is significant (p=0.001) for all four tasks included in the survey although change is greatest in relation to men's contribution to caring for children. The significant increase in men's support with household labour holds across both cohorts and three districts (with the exception of cleaning house/surrounding in Chikomba), and also across women's individual and household characteristics and exposure to intervention components. As presented in *Figure 38,* change is observed specifically in relation to male partners providing some help to women, rather than tasks being shared equally or done together.

[38] Average score between 1 and 4, with 1 indicating not at all and 4 indicating to a high extent.

Figure 39: Baseline and endline distribution of household tasks



Box 18: Qualitative insights on shared responsibilities for household labour in Cohort 3

The Cohort 3 qualitative data show a similar picture to the survey results above, one that confirms findings from previous qualitative studies. Almost all participants' reported men were more likely to help their partners with household tasks. As with the survey findings described above, this is mostly in relation to men assisting women, although there were a few mentions of partners carrying out tasks together. In many cases, this was presented as men assisting with women's tasks, suggesting the behavioural change is not necessarily accompanied by attitudinal change. In a handful of cases, men's support also appeared conditioned, for example limited to women being occupied or pregnant, or limited to specific tasks such as gardening.

This was not in all cases, however. A significant number of men and women in Chiredzi and Mwenezi described their division of tasks as more "gender equal" or "gender blind", or said the division was based on needs rather than gender.

7. Outcome 3 pathway: Communities in focal wards have reduced tolerance to IPV and other forms of GBV

Key findings:

- Justification for violence reduced significantly at endline for three circumstances. These three scenarios are all related to norms associated with women deviating from their gendered roles and challenging men's hierarchy and control, which was found in previous ELU studies to be key triggers of IPV. When analysing these findings by district, significant reductions in justification of physical IPV hold in Mwenezi (goes out without telling him), Chiredzi (she disobeys him) and across all districts (if she argues with him). There was no significant change in women's justifications for violence when women are unfaithful to their partner, which is the circumstance garnering most agreement both at baseline and endline. There are some variations in results on justification for violence according to respondent characteristics and exposure to Toose.
- Few women at baseline stated that they would consider marriage before the age of 18 for any of their daughters and at endline this figure dropped to 0%. Although the Cohort 1 qualitative interviews did not specifically explore attitudes related to early marriage like the survey did, a handful of participants said they welcomed the GCBC messages about rejecting early marriage and child abuse. They also noted that community members appear fearful to engage in harmful practices such as early marriage for fear of being reported to the authorities or facing legal consequences. Although the latter does not necessarily indicate a change in attitudes, some respondents described this as positive change.
- There was a significant increase in women's gender equitable attitudes at endline on a scale measuring attitudes related to household gendered roles and responsibilities (2.3 at baseline and 2.7 at endline). Agreement with specific statements related to household gender roles suggest that attitudes have become more gender equitable particularly in relation to men's roles in the household and to a lesser extent in relation to women's roles in the household. The Cohort 1 qualitative data support these findings. Many participants spoke about the importance of men assisting with women's tasks in the household, but some of these reports assumed that household tasks are the woman's responsibility.

Table 13: RAG rating for outcome pathway 3 measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Outcome 3 pathway - reduced tolerance to GBV						
Justification for physical IPV						
Attitudes related to early marriage						
Gender equitable attitudes						

7.1. Justification for physical IPV

The endline results suggest that overall, there has been no change in women's attitudes related to justification for violence in different circumstances, although there was a significant reduction in justification in Chiredzi (see *Figure 40*). When exploring specific circumstances in which women justify physical IPV, it is clear that justification was low at baseline for most circumstances and has reduced significantly at endline for three circumstances: when she goes out without telling her partner, if she argues with him and if she disobeys him (see *Figure 41*). These three scenarios are all related to norms associated with women deviating from their gendered roles and challenging men's hierarchy and control, which was found in previous ELU studies to be key triggers of IPV. When analysing these findings by district, significant reductions in justification of physical IPV hold in Mwenezi (goes out without telling him), Chiredzi (she disobeys him), and across all districts (if she argues with him). It is notable that there has been no significant change in women's justifications for violence when women are unfaithful to their partner, which is the circumstance garnering most agreement both at baseline and endline.

Figure 40: Baseline and endline justification of physical IPV in any of 7 circumstances by cohort and district

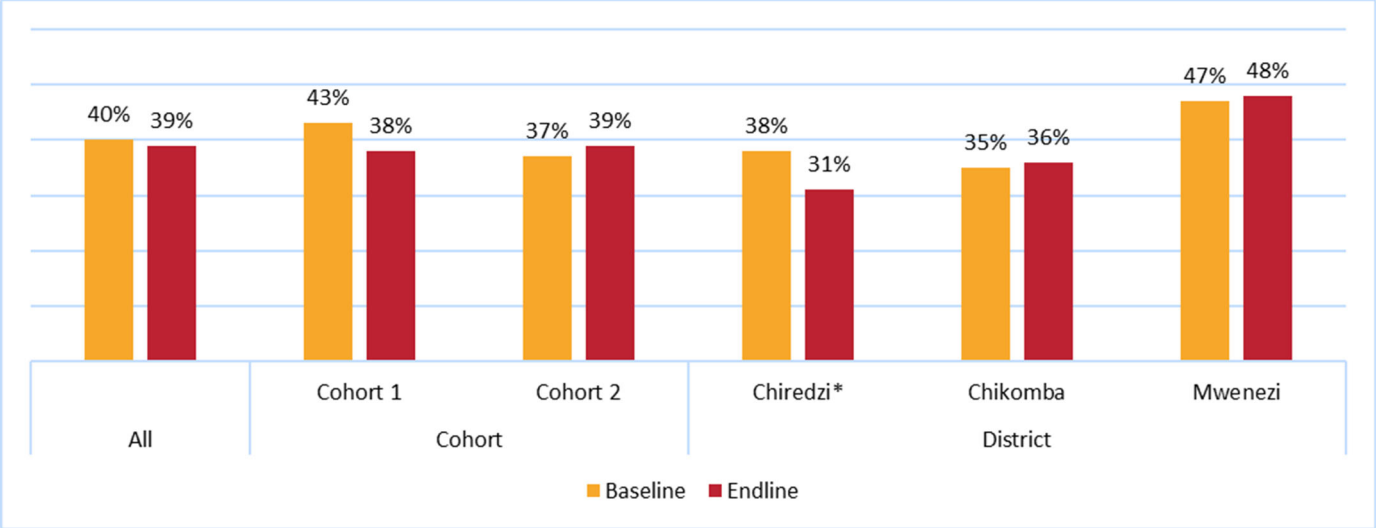
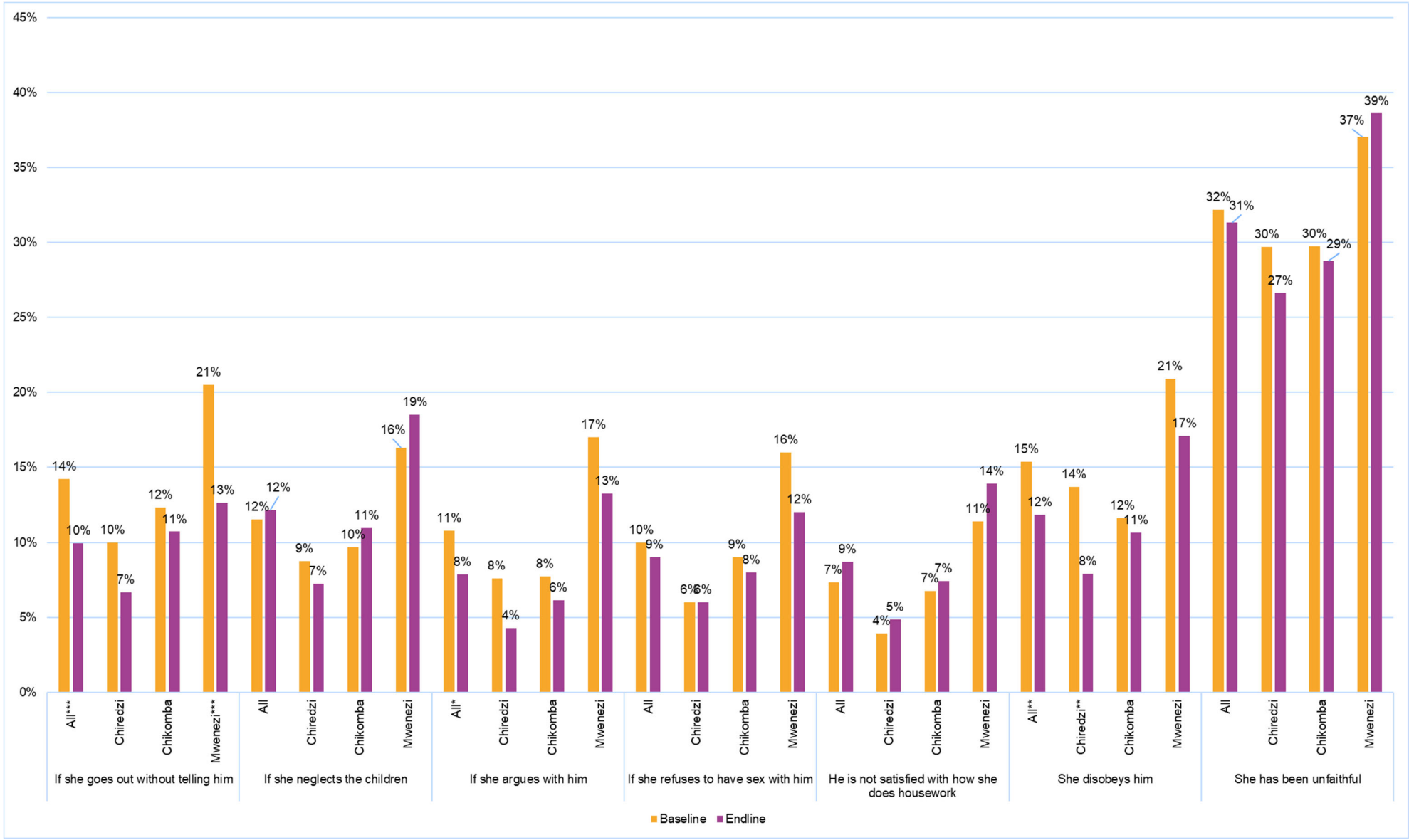


Figure 41: Baseline and endline agreement with statements related to justification for a man beating his wife



There are some variations in results on justification for violence according to respondent characteristics and exposure to Toose.

- Age: Reduction in agreement with physical IPV in any of the seven circumstances was significant among women aged 30-39 years (41% at baseline and 34% at endline, p=0.02) with smaller, non-significant reductions observed for women in other age groups. In relation to specific circumstances, significantly reduced justification for violence when women disobey their partner (p=0.03) or refuse to have sex with them (p=0.02) was observed for women aged 18-29 years. Significantly reduced justification for violence when women go out without telling their partner was also observed among women in the 18-29 and 30-39 age groups.
- Participation in Toose with partner: There was a significant reduction in justification for physical IPV among women who participated in Toose sessions with their partner in relation to two circumstances: when she goes out without telling him (14% at baseline and 9% at endline, p=0.001) and if she disobeys him (14% at baseline and 10% at endline, p=0.03).
- Exposure to community diffusion: There were significant reductions in justification of violence for women who attended a Toose community conversation in relation to agreement with two circumstances: when women go out without telling their partner (16% at baseline and 10% at endline, p=0.001) and when women disobey their partner (16% at baseline and 11% at endline, p=0.001).

7.2. Attitudes related to early marriage

At baseline, only 1% of women stated that they would consider marriage before the age of 18 for any of their daughters and at endline this figure dropped to 0%. Similarly, very few women at baseline (2%) said they thought their partner would consider early marriage for a daughter, reducing to 1% at endline. There was also a significant increase in the average age that respondents suggested would be a good age for girls to marry, from 21.5 years at baseline to 21.7 years at endline (p=0.03).

Box 19: Qualitative insights on attitudes towards early marriage in Cohort 3

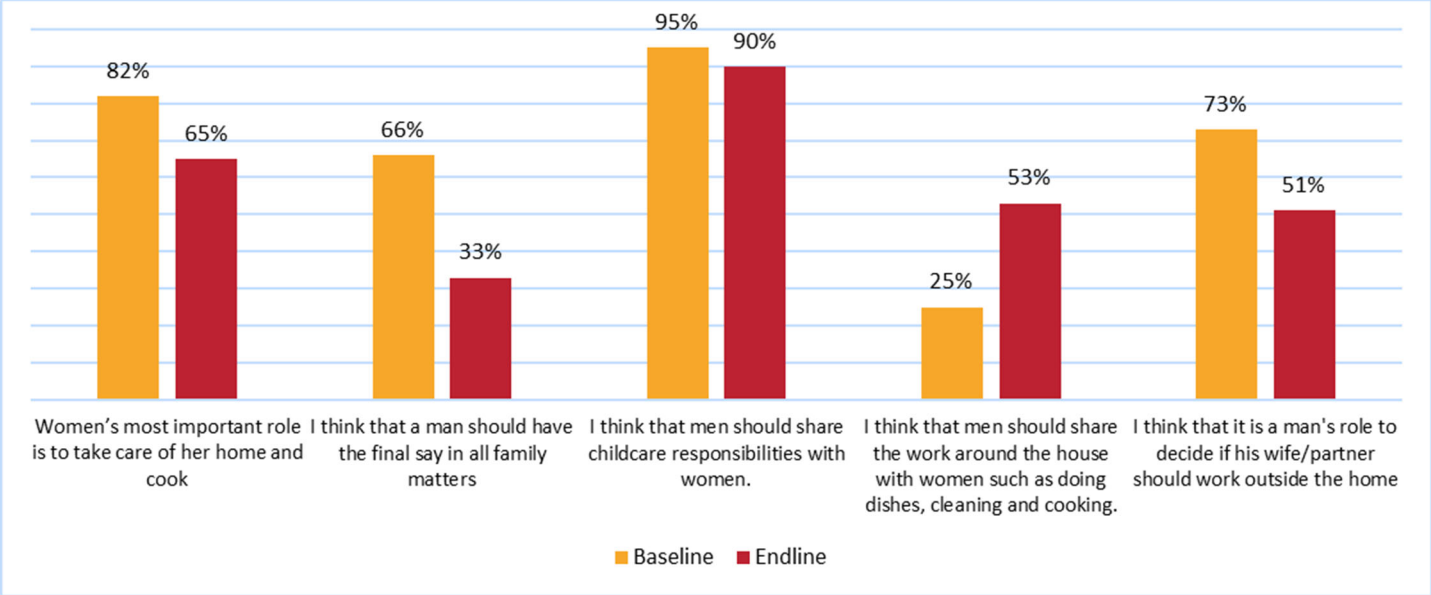
Although the Cohort 3 qualitative interviews did not specifically explore attitudes related to early marriage like the survey did, a handful of participants said they welcomed the GCBC messages about rejecting early marriage and child abuse, among other things. They also noted that community members appear fearful to engage in harmful practices such as early marriage for fear of being reported to the authorities or facing legal consequences. Although the latter does not necessarily indicate a change in attitudes, some respondents described this as positive change. This supports the survey results presented above.

7.3. Gender equitable attitudes

There was a significant increase in women's gender equitable attitudes at endline on a scale measuring attitudes related to household gendered roles and responsibilities (2.3 at baseline and 2.7 at endline, p=0.001).[39] This finding held across both cohorts, all three districts, women's individual and household characteristics, and regardless of level of exposure to intervention activities. As highlighted in *Figure 42*, women's baseline and endline agreement with specific statements related to household gender roles suggest that attitudes have become more gender equitable particularly in relation to men's roles in the household and to a lesser extent in relation to women's roles in the household.

[39] Scale scores range from 1 to 4, with higher scores indicating more gender equitable attitudes.

Figure 42: Baseline and endline agreement with statements related to gender roles in the household



Box 20: Qualitative insights on gender equitable attitudes in Cohort 3

The Cohort 3 qualitative data support these findings. Many participants spoke about the importance of men assisting with women's tasks in the household, but some of these reports assumed that household tasks are the woman's responsibility. A handful of responses also suggest that men might be more willing to assist their partner because this supports her ability to contribute to the household's income, either through IGAs or TISAL participation. However, as presented in Box 18 a significant number of men and women (especially in Chiredzi and Mwenezi) described their division of tasks as more gender equitable, said the division was based on needs rather than gender, or on family wellbeing considerations. For example, a woman in Chiredzi said her husband sometimes cooks to allow the family to rest. Several participants also referred to Toose teachings, such as the importance of "avoiding power over other family members", when describing their division of labour.

8. Outcome 4 pathway: Increased access to essential GBV services by women and adolescent girls

Key findings:

- The survey shows a small but significant decrease in the proportion of women who knew of no services (from 12% to 8%), and a significant increase in knowledge of counselling services (from 33% to 56%) and legal counsel services (grom 9% to 17%). However, there was a reduction in the proportion of women who had knowledge about the other types of services asked about in the survey and there was a significant increase in women stating that they knew of 'other services' (0% to 26%). These results are curious and may suggest that there are growing perceptions of some services not being stable or available.
- The endline findings show survivors' increased help-seeking, with a significant reduction in the proportion of survivors who told nobody about the violence (50% to 39%). There was a significant reduction at endline in the proportion of women without a disability who told nobody about the violence they experienced. Despite improvements in survivors' help-seeking overall, there was little change in access to services.
- It is notable that the increase in survivors not accessing services at endline is significant among those who did not participate in Cohort 3 Toose sessions, or Toose sessions on power or IPV. Similar results were observed for survivors' exposure to GBV response activities, with significant increases in not accessing services observed among survivors who had not participated in GCBC awareness sessions, not been supported by a GCBC and not accessed a Musasa service. The results suggest there may be a relationship between GCBC and Musasa exposure and survivors' improved access to GBV services, although these trends are not significant. These results may suggest that participation in Toose sessions and exposure to GCBC and Musasa activities have been protective.
- In the Cohort 1 qualitative interviews, participants in Chikomba overwhelmingly said they never personally received direct support from GCBCs or Musasa. However, according to GCBC reports in Chikomba, many community members in Chikomba received assistance. In Chiredzi and Mwenezi, a handful of participants described personal interactions with GCBCs.
- At endline, the figures on barriers that were already low at baseline dropped even more or stayed approximately the same. The only exception was the proportion of survivors who did not access services because they could not afford service fees, which dropped significantly (from 48% to 0%), suggesting that affordability barriers reduced substantially. However, the survey results also show some increases in other barriers, including those associated with denial of the problem or lack of need or want of services, or normative barriers associated with stigma, blame or fear of negative repercussions, although not all of these are significant. There are some variations in changes to barriers to service seeking according to survivors' individual and household characteristics, and also according to intervention exposure.
- There was a very large and significant increase in the proportion of women who said they would not face any challenges accessing services if they experienced violence in the future (from 21% to 70%). The perceived barriers to service-seeking among all women sampled for the survey are quite different to the actual barriers that survivors reported facing after experiencing violence, particularly in relation to normative barriers. While there is a reduction in perceived normative barriers across the whole sample, these barriers appear to still be restricting some survivors from accessing services. In the Cohort 1 qualitative interviews, GCBC volunteers also highlighted several barriers to the continuation of their activities, which threaten access to services for women who may experience violence in the future.
- There was a significant increase between baseline and endline in women's confidence supporting survivors of violence (from 65% to 75%). There were some differences according to intervention exposure and district. There was also a significant increase in the proportion of respondents who said that they were very likely to support a woman or girl who had experienced violence to access support from services. Despite increased confidence and intentions to support survivors, there was no significant change between baseline and endline in the proportion of women surveyed who had actually provided support to a survivor in the past 12 months. However, this should

be read with caution as respondents may not have provided support because they had not encountered cases of violence.

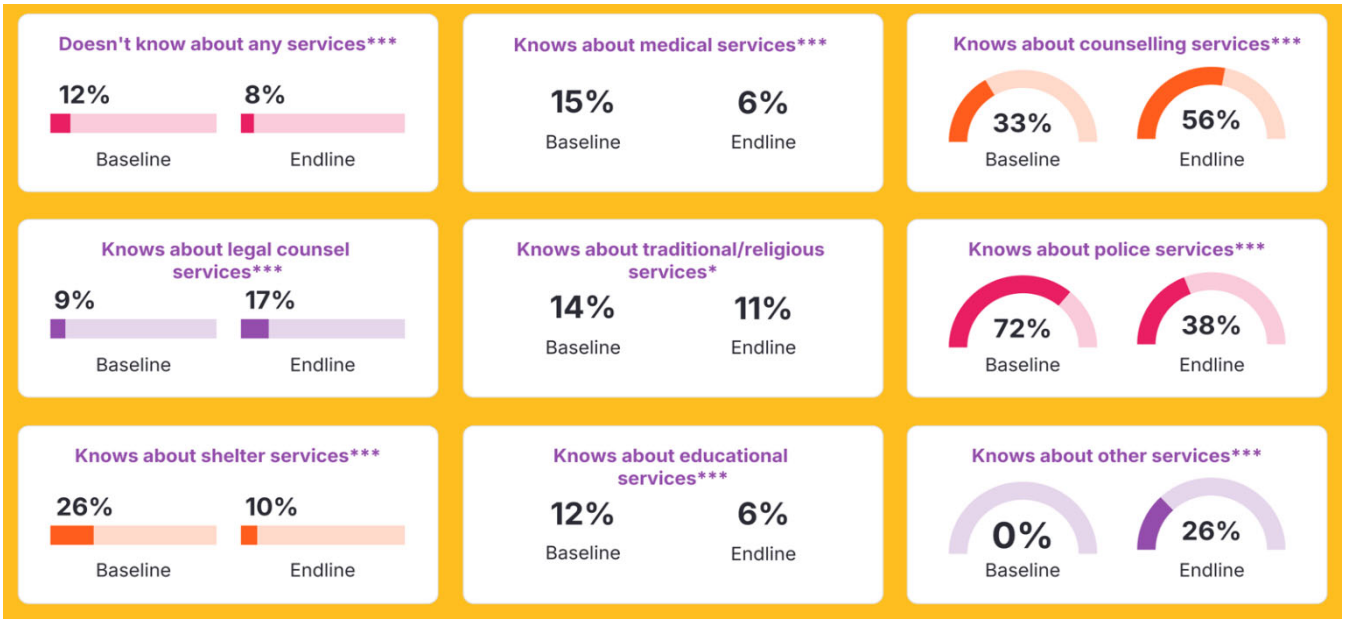
Table 14: RAG rating for outcome pathway 4 measures by cohort and district

Measure	All	Cohort		District		
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi
Outcome 4 pathway - access to essential GBV services and help seeking						
Knowledge of any GBV services (all women)						
Help-seeking (survivors)						
Access to services (survivors)						
Accessibility/travel barriers (survivors)						
Cost/affordability barriers (survivors)						
Normative barriers - didn't think it was problem (survivors)						
Normative barriers - afraid of divorce (survivors)						
Perceptions of challenges to access to services (all women)						
Perceptions of accessibility/travel barriers (all women)						
Perceptions of cost/affordability barriers (all women)						
Perceptions of normative barriers - afraid of divorce (all women)						

8.1. Knowledge of GBV services

All women in the baseline and endline samples were asked about their knowledge of services that support women and girls who experience violence in their community. The results show a small but significant decrease in the proportion of women who knew of no services, and a significant increase in knowledge of counselling services and legal counsel services (see *Figure 43*). However, there was a reduction in the proportion of women who had knowledge about the other types of services asked about in the survey, including medical, traditional/religious, police, shelter and educational services. There was a significant increase in women stating that they knew of 'other services' although the survey did not measure which ones these included. These results are curious and may suggest that there are growing perceptions of some services not being stable or available.

Figure 43: Women's baseline and endline knowledge of different types of GBV services that support women and girls who have experienced violence

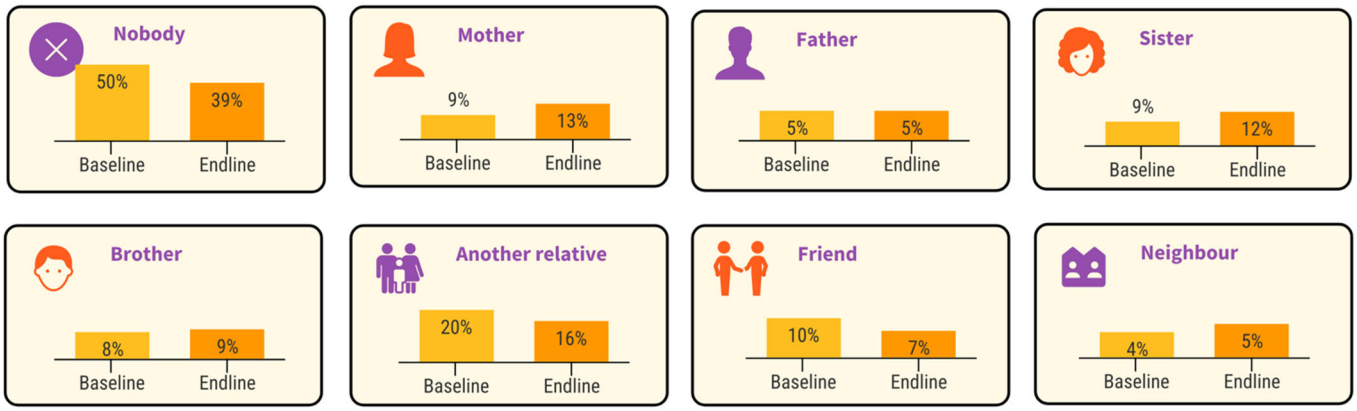


Change in knowledge about some of the services presented in *Figure 43* are consistent across respondent characteristics and intervention exposure, including increased knowledge of counselling services and decreased knowledge about police services and shelter services. But there are some notable differences, particularly in relation to women not knowing about any services. For example, when disaggregating the findings by district, the proportion of women who did not know of any service decreased significantly only in Mwenezi (from 19% at baseline to 10% at endline, p=0.001). Lack of knowledge was already low at baseline in the other two districts (9% in Chiredzi and 7% in Chikomba) and remained that way at endline (7% in Chiredzi and 7% in Chikomba). The proportion of women who knew of medical services reduced significantly in Chikomba (from 22% to 3%, p=0.001) and Mwenezi (from 12% to 3%, p=0.001) but stayed the same in Chiredzi (12% at baseline and 13% at endline). The proportion of women who knew about legal counsel increased significantly in Chiredzi (from 15% to 38%, p=0.001) and Mwenezi (from 2% to 6%, p=0.01) while decreasing in Chikomba (from 11% to 5%, p=0.001).

8.2. Help seeking and access to services

Women who reported having experienced IPV in the past year were asked if they spoke to anybody about the violence they had experienced. The endline findings show survivors' increased help-seeking, with a significant reduction in the proportion of survivors who told nobody about the violence (from 50% at baseline to 39% at endline, p=0.03) (see *Figure 44*). There were small increases in the proportion of survivors who talked to their mother or sister, and small reductions in speaking with friends or another relative (i.e., not those asked about in the survey), with no change observed across other types of people. There was, however, a significant increase between baseline (5%) and endline (11%) (p=0.03) in the proportion of survivors who told another person. When asked to elaborate on this 'other' response, women noted a range of people including their children, aunts, uncles and grandparents, and their brother-in-law, sister-in-law or mother-in-law. Other people that survivors talked to about the violence included religious leaders, elders and GCBCs (referred to as 'Musasa community people').

Figure 44: Help seeking by survivors of past 12-month IPV



When observing changes between baseline and endline help-seeking by survivors' characteristics and intervention exposure, there are some notable differences. The increase in help-seeking was greatest in Mwenezi and was significant, where 33% of survivors at endline told nobody about the violence compared with 56% at baseline (p=0.03), although the changes in the other districts were not significant (see *Figure 45*). In relation to intervention exposure, improved help seeking was greatest, and significant, among those survivors who participated in Cohort 3 sessions and sessions on power, and those who attended a Toose community conversation or were supported by a GCBC (see *Figure 46*).

Figure 45: Baseline and endline proportion of survivors who told nobody about the violence they experienced, by district

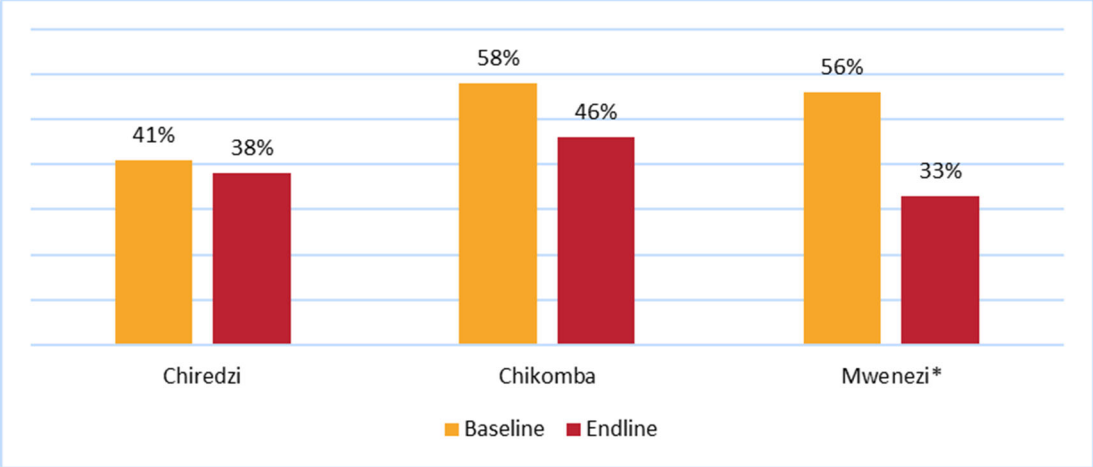
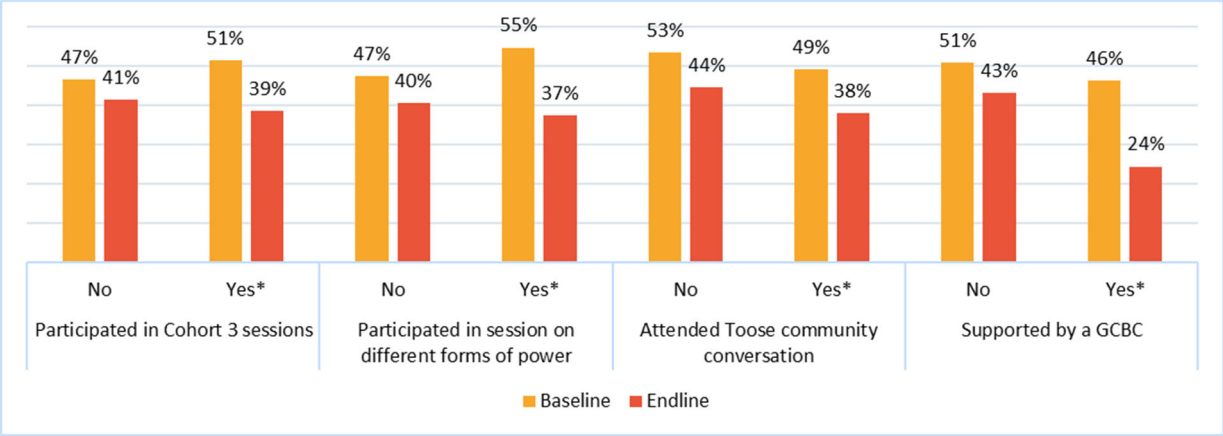
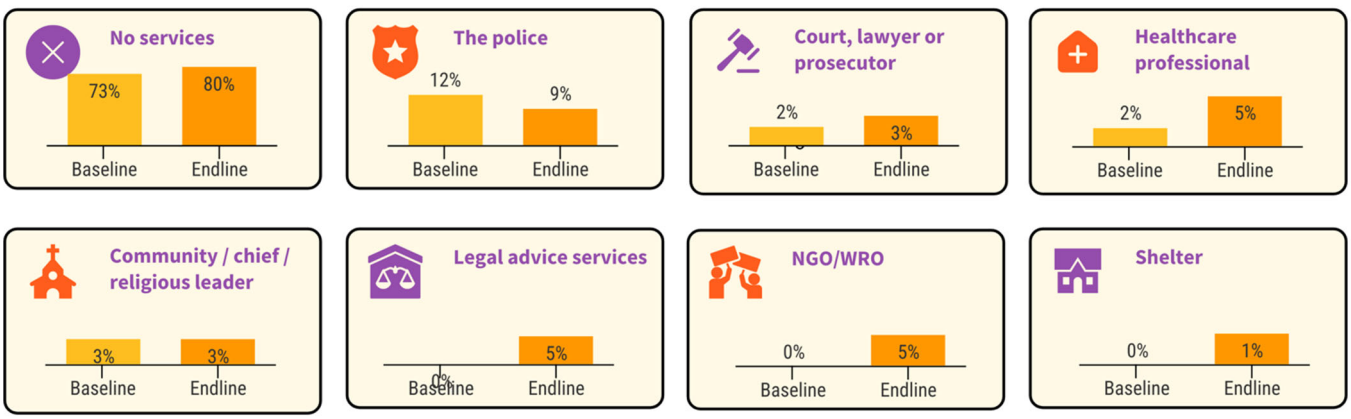


Figure 46: Baseline and endline proportion of survivors who told nobody about the violence they experienced, by Toose and GCBC intervention exposure at endline



Despite improvements in survivors' help-seeking overall, there was little change in their access to services. There was an increase between baseline (73%) and endline (80%) in the proportion of survivors who did not access any service for the violence they experienced, although this increase was not significant (see *Figure 47*). The endline results show a small increase in access to healthcare services, legal advice and Non-Governmental Organisations (NGOs)/ Women's Rights Organisations (WROs), and a small decrease in accessing police services and no change in access to other services, although none of the changes depicted in *Figure 47* are significant.

Figure 47: Access to services by survivors of past 12-month IPV



There are some variations in access to services according to district. While there is an increase in accessing no services between baseline and endline in Chiredzi and Chikomba (see *Figure 48)*, this increase is only significant in Chikomba (p=0.03). In contrast, access to services has improved slightly in Mwenezi, although this change is not significant. It is notable that the increase in survivors not accessing services at endline is significant among those who did not participate in Cohort 3 Toose sessions, or Toose sessions on power or IPV, with no change observed among survivors who did participate in these sessions. Similar results were observed for survivors' exposure to GBV response activities, with significant increases in not accessing services observed among survivors who had not participated in GCBC awareness sessions, not been supported by a GCBC and not accessed a Musasa service (see *Figure 49*). The results in *Figure 49* also suggest that there may be a relationship between GCBC and Musasa exposure and survivors' improved access to GBV services, although these trends are not significant. These results may suggest that participation in Toose sessions and exposure to GCBC and Musasa activities have been protective.

Figure 48: Baseline and endline proportion of survivors who did not go to any services because of the violence they experienced, by district and Toose intervention exposure at endline

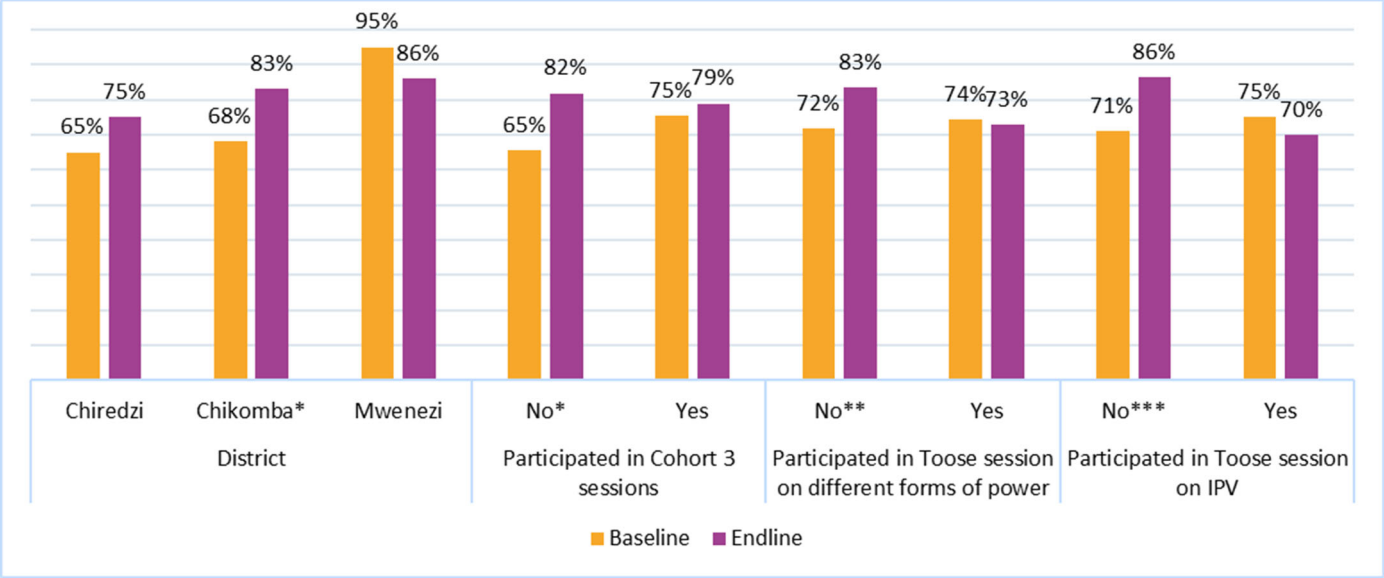
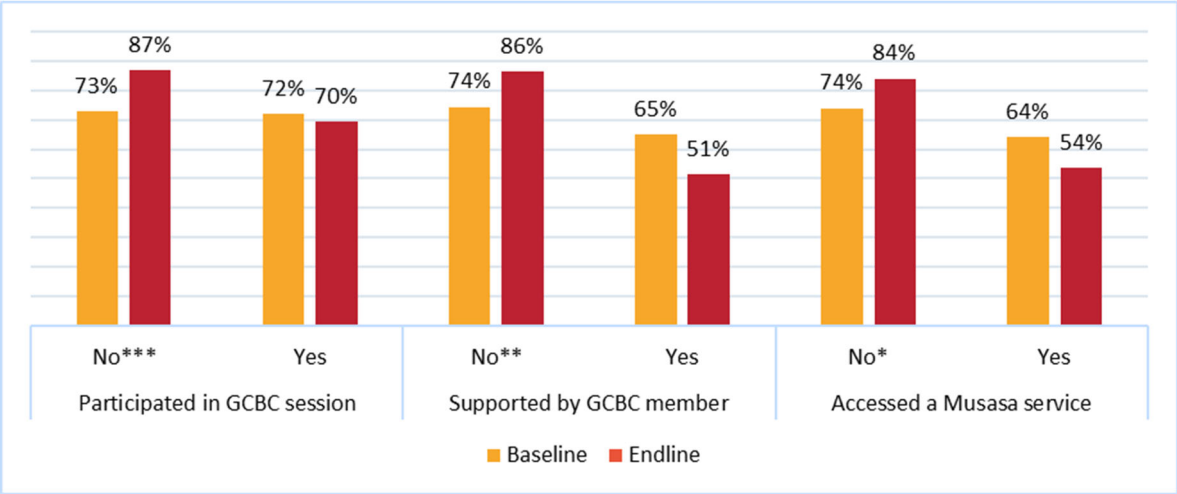


Figure 49: Baseline and endline proportion of survivors who did not go to any services because of the violence they experienced, by GCBC intervention exposure at endline



Box 21: Qualitative insights on help seeking and access to services in Cohort 3

As discussed in *Box 4*, when asked if participants received direct support from GCBCs, participants in Chikomba overwhelmingly said they never personally did, with only one second-hand report. However, according to GCBC reports in Chikomba, many community members in Chikomba received assistance. For example, one GCBC

volunteer accompanied two underage mothers to seek child maintenance from the father. Another volunteer reportedly counselled several couples in one of the villages in Chikomba.

In Chiredzi and Mwenezi, a handful of participants described personal interactions with GCBCs. In Chiredzi, a woman said she accompanied her sister, a survivor of violence, to obtain a peace order that would allow her to divorce her abusive husband. A man said GCBC volunteers helped his daughter who recently gave birth and was left to care for the child alone. GCBC volunteers helped them access legal help and file a court case. The court ruled that the father of the child was required to financially support the child. Another man said he sought help from GCBCs because of marital conflict, and was offered counselling, improving his relationship with his wife. In Mwenezi, a woman said she and her husband were counselled by GCBCs because her husband used to verbally abuse her when intoxicated with alcohol. This significantly improved her situation. Another woman, living with a disability, said she was encouraged to participate in programme activities. GCBC volunteers in Mwenezi and Chiredzi confirmed assisting with such cases, among others (see *Box 4*).

The findings for Musasa were similar. When asked if participants received direct support from Musasa, participants in Chikomba overwhelmingly said they never personally did. While still limited, participants in Chiredzi and Mwenezi were more likely to share experiences of accessing Musasa services. In Chikomba, one male participant and one male partner commended the counselling services he received from Musasa, while another woman praised the support her sister received in obtaining a peace order against her husband. A female participant said she accompanied a friend who stopped receiving child maintenance from the father. In Mwenezi, one female participant said she received marital counselling, while another female participant commended the counselling she received when she fell into a depression as a result of her adult-onset disability. She explained that Musasa assessed her situation and provided her with assistive devices.

8.3. Barriers to accessing services (survivors)

In the endline survey, women who had experienced violence in the past year and who did not access any services were asked why not. Accessibility and quality of service barriers were already reported to be very low at baseline, with between 0-3% of baseline survivors who did not access services stating that they did not do so because they didn't know where to go, could not afford transport or felt nobody could help, or that services were too far to travel. At endline these figures dropped even more or stayed approximately the same. The only exception was the proportion of survivors who did not access services because they could not afford service fees, which dropped from 48% at baseline to 0% at endline (p=0.001), suggesting that affordability barriers have reduced substantially.

In contrast, the evaluation results show some increases in barriers, including those associated with denial of the problem or lack of need or want of services, or normative barriers associated with stigma, blame or fear of negative repercussions, although not all of these are significant. There was a significant increase in the proportion of survivors who did not access services because they did not think the violence was a problem (see *Figure 50*), and who were afraid of being divorced or abandoned (see *Figure 51*). There was also a significant increase in the proportion of survivors who did not access services because of another reason (from 17% at baseline to 31% at endline, p=0.02). In endline open-ended responses to clarify which reasons (n=116), about a third of respondents referred to having solved the problem within the family or with the help of family members, with some of these responses also mentioning wanting to keep the violence a secret, including to avoid community gossip. Only one respondent said that she had learned from Toose not to share household secrets with outsiders. Other reasons given were related to couples having resolved the problem, women having forgiven their partner, problems being perceived to be minor or fear of negative consequences (e.g., losing livelihoods, partners being arrested).

Figure 50: Baseline and endline proportion of survivors who did not go to any services because of denial of problem or lack of need/ interest in services

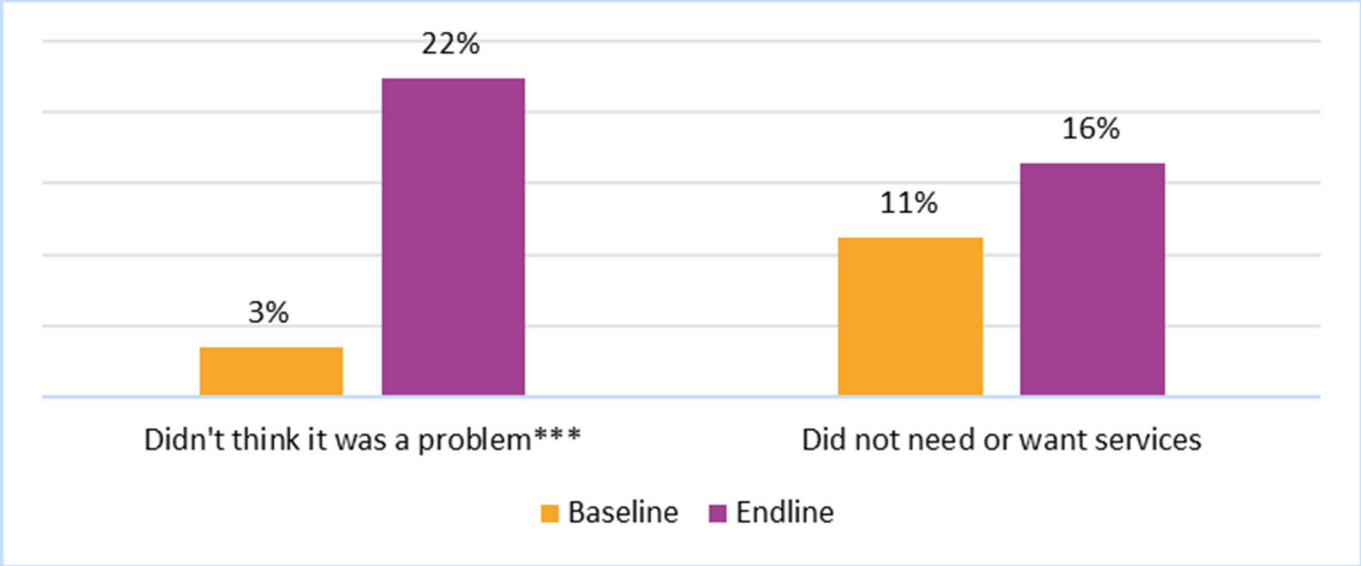
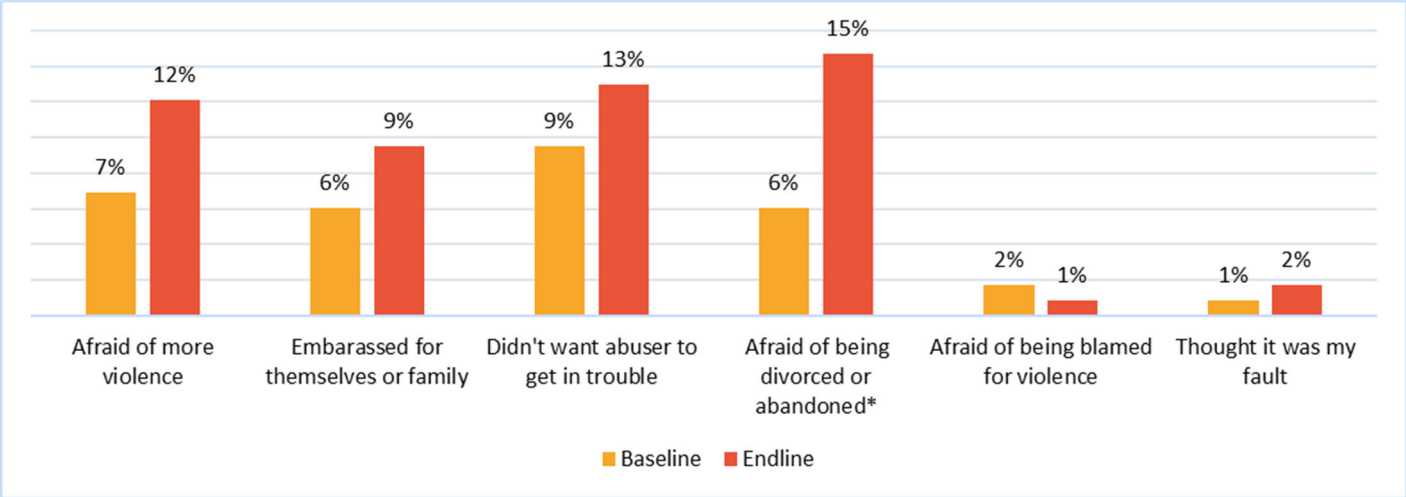
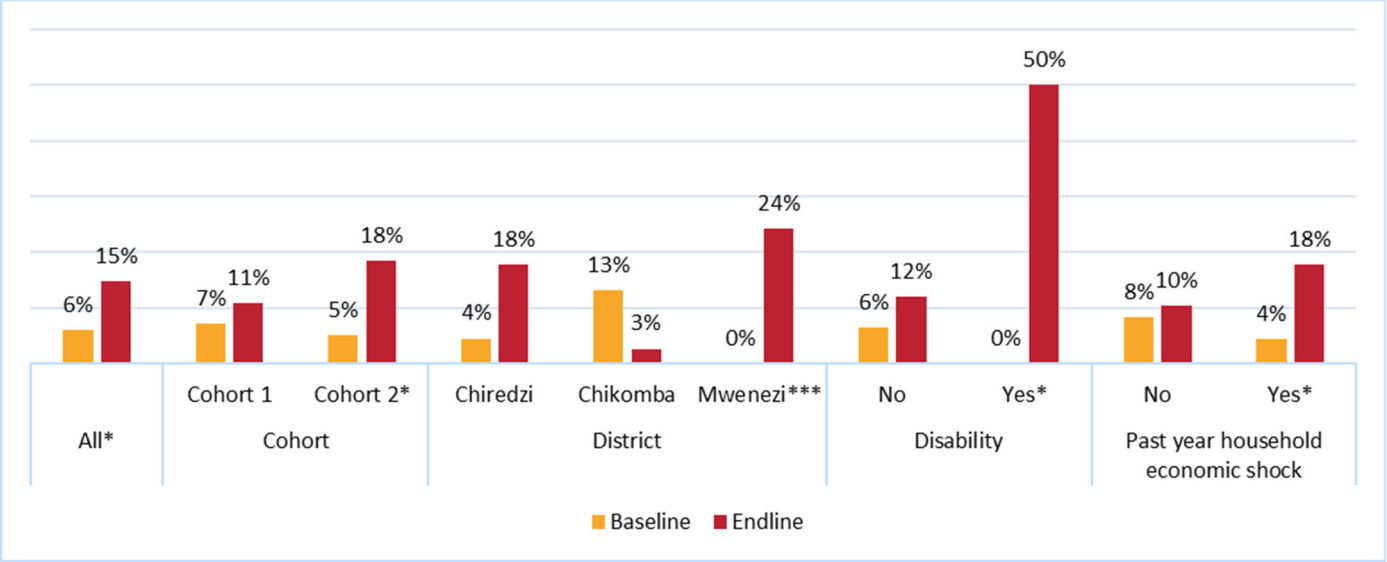


Figure 51: Baseline and endline proportion of survivors who did not go to any services because of normative barriers, including stigma, blame or fear of negative repercussions



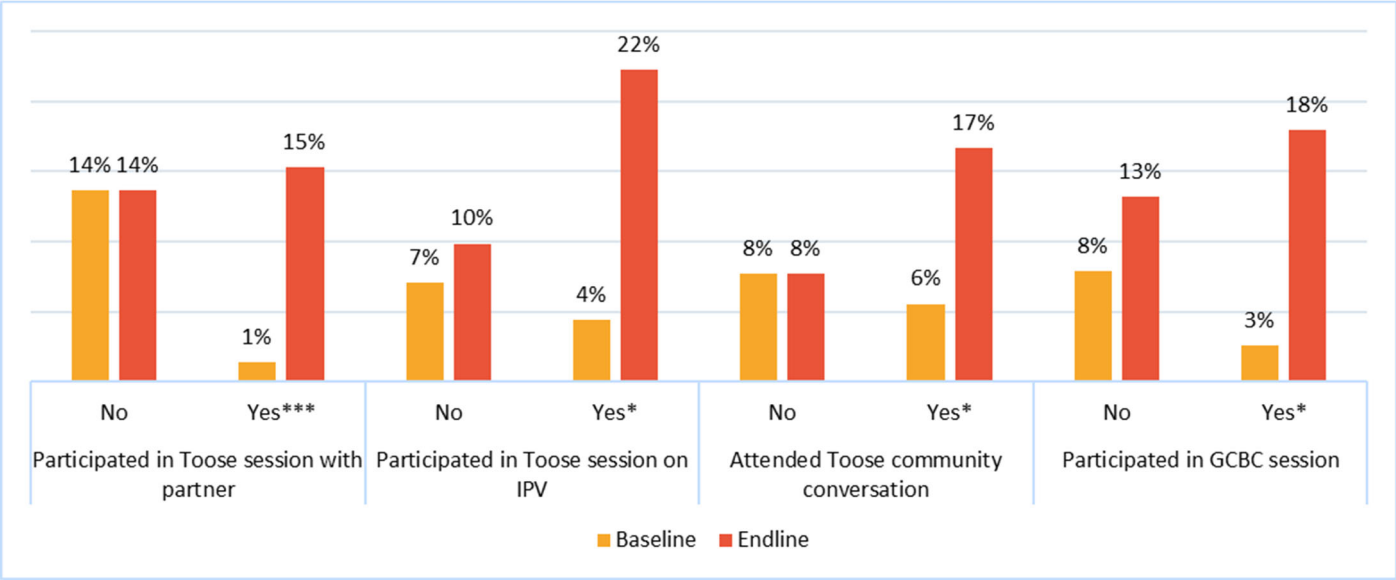
Some results related to barriers to service seeking are consistent across survivor characteristics and levels of intervention exposure, including increased beliefs that the violence was not a problem, and a decrease in inability to afford service fees. However, there are some variations in changes to barriers to service seeking according to survivors' individual and household characteristics, particularly in relation to not needing or wanting services, or because of fears of negative repercussions. For example, a significant increase in survivors not accessing services because they didn't want or need to, was observed in Chiredzi (from 7% at baseline to 31% at endline, p=0.001) but not in the other two districts. Other notable findings are related to survivors' fears of being divorced or abandoned, with a significant increase in these fears at endline in Cohort 2, in Mwenezi, and among those with a disability or whose households experienced past-year economic shock (see *Figure 52).* The result for survivors with a disability should be read with caution given it is based on a sample of only eight survivors. The significant increase in fears of divorce or abandonment among survivors who experienced economic shock highlight the role of economic stress in locking women into violent relationships. This may also explain a significant increase from baseline (6%) to endline (31%) in survivors' lack of service use because of fear of more violence among those who were the most food insecure at baseline (p=0.04). An increase was also observed among younger women aged 18-29 (0% at baseline and 23% at endline, p=0.01).

Figure 52: Baseline and endline proportion of survivors who did not go to any services because they were afraid of being divorced or abandoned, by cohort, district, disability and past year household economic shock



There are also some variations according to intervention exposure. For example, the increase between baseline and endline in the proportion of survivors who said they did not access services because they were afraid of more violence was significant among survivors who had not participated in a GCBC awareness raising session (5% at baseline and 16% at endline, p=0.03). In contrast, fear of more violence reduced among survivors who had attended a GCBC session (10% at baseline and 5% at endline) although this reduction was not significant. While this pattern in results suggests that exposure to GCBC sessions has been protective, the results related to survivors' fear of being divorced or abandoned suggest the opposite. There was a significant increase between baseline and endline in the proportion of survivors fearing divorce or abandonment among those who participated in Toose with a partner, participated in a Toose session on power, attended a Toose community conversation and participated in a GCBC session (see *Figure 53*). There was no significant change, however, among survivors who had not been exposed to these intervention elements.

Figure 53: Baseline and endline proportion of survivors who did not go to any services because they were afraid of being divorced or abandoned, by intervention exposure



Survivors who did seek help for the violence they experienced in the past year were asked why they sought help. There are very small sample sizes for these results, which is likely why there are few significant differences between baseline and endline. The only significant finding is an increase in the proportion of women from baseline (0%) to endline (36%) who said they sought help because they were threatened by a perpetrator (p=0.04). However, based on a sample of only 11 survivors, this result needs to be read with caution. Similarly, while the evaluation observed

increases in the proportion of survivors who sought help because they could not endure the violence anymore (45% at baseline and 64% at endline) and because they received a referral (9% at baseline and 18% at endline), these changes are not significant.

Box 22: Qualitative insights on barriers to accessing services in Cohort 3

Of relevance to the survey results are three cases of women in Mwenezi who disclosed experiencing violence but not reporting the perpetrator. One survivor said she was reluctant to report her husband while two other survivors said they felt shared responsibility for their husband's violence perpetration, upon reflection. This may confirm the findings on normative barriers discussed above and below.

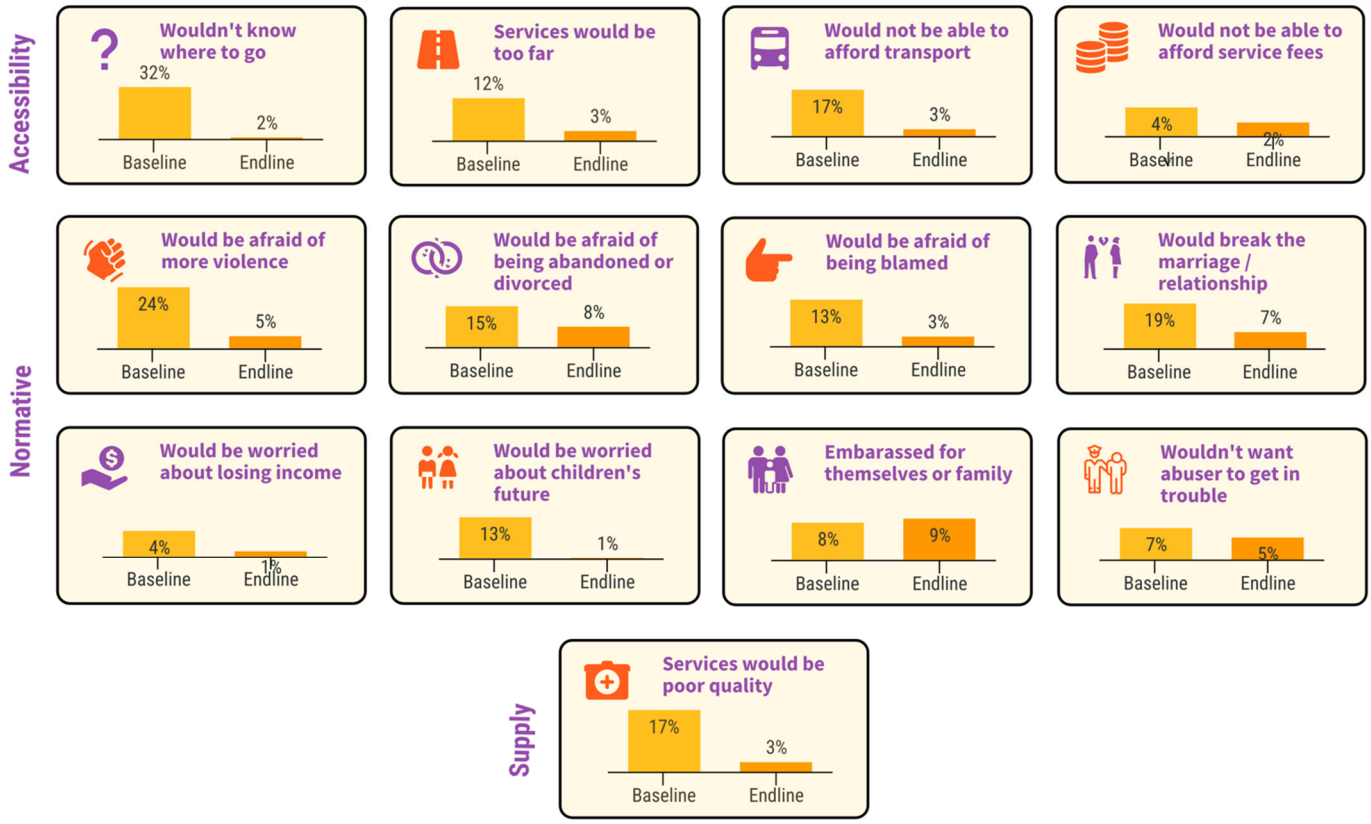
A GCBC volunteer in Chikomba reported that the parents of an underage pregnant girl refused to report the man who impregnated her to the police. Their reasoning was that the case was unlikely to be successful because of corruption among police staff. Here, a GCBC volunteer also disclosed that some community members continue to protect perpetrators, allowing them to continue to perpetrate violence. It was not clear what type of violence this report relates to.

GCBC volunteers also reported several challenges with providing services to survivors and/or facilitating access to services. In all districts, limited resources to cover transportation costs proved challenging, often leaving survivors stranded or unable to reach safe spaces. Pushback from men or community members was also mentioned in all districts, often based on wrong perceptions of GCBCs and Musasa, although this appears to have improved over time. For example, in Chiredzi, a GCBC volunteer said that community members initially thought Musasa's aim was to break up marriages. Transportation challenges did not appear to improve over time.

8.4. Barriers to accessing services (all women)

The previous section reports on barriers to help- and service-seeking among women who had experienced violence in the past 12 months. The survey also asked all respondents about any challenges they felt they might face accessing services if they experienced violence. There was a very large and significant increase in the proportion of women who said they would not face any challenges accessing services (21% at baseline and 70% at endline, p=0.001) and this result held for all characteristics and types of intervention exposure. When asking about specific types of barriers, there was a significant reduction in all four accessibility barriers measured in the survey, including knowledge of where to access services, distance to access services and affordability or transport or service fees (see *Figure 54*). There was also a significant reduction in the supply-level barrier (perception of poor-quality services) and most normative barriers measured by the survey, including barriers related to fear of negative repercussions, except for respondents' embarrassment for themselves or their families or fear of abusers getting into trouble. The perceived barriers to service-seeking among all women sampled for the survey are quite different to the actual barriers that survivors reported facing after experiencing violence, particularly in relation to normative barriers. While there is a reduction in perceived normative barriers across the whole sample, these barriers, particularly fears of abandonment and divorce, appear to still be restricting some survivors from accessing services.

Figure 54: Baseline and endline proportion of women who perceive barriers to access to GBV services, including accessibility, normative and supply barriers



Box 23: Qualitative insights on barriers to & sustainability of accessing services in Cohort 3

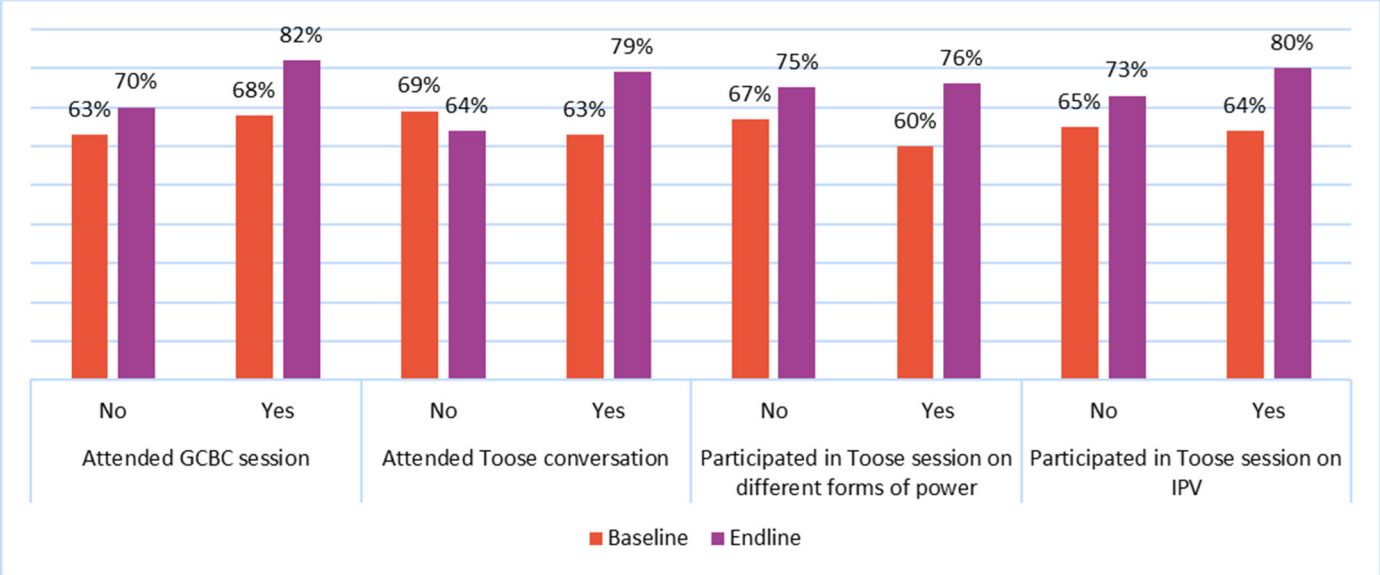
GCBC volunteers raised several barriers to the continuation of their activities, which threaten access to services for women who may experience violence in the future. Since the completion of the programme, volunteers have struggled to maintain momentum and engagement from community members without financial resources. Motivation among GCBC volunteers has also decreased, with less participation reported in Chiredzi. In Mwenezi, participation has continued despite the discontinuation of funding; volunteers appear to have the knowledge on how to continue without financial resources.

The lack of resources for transportation of survivors appears to have worsened but own transportation has also become a challenge. One GCBC volunteers requested bicycles so they could reach more survivors in Chiredzi. A lack of resources for airtime was mentioned as a challenge to the efficiency of service delivery. Volunteers noted they require sufficient airtime to keep communication channels open at all times. In Chikomba, the deterioration of uniforms was mentioned as an obstacle to effectively engage with communities.

8.5. Supporting survivors

There was a significant increase between baseline and endline in women's confidence supporting survivors of violence. On a scale of 1 to 4, with 1 being very confident, women's confidence improved from a mean of 1.45 at baseline to a mean of 1.34 at endline (p=0001). This change is mostly accounted for by an increase in strength of confidence with 65% of respondents at baseline and 75% at endline stating that they were very confident. There were some variations by district. There was no significant change in confidence in Chikomba where confidence was already strong at baseline: 76% of respondents in Chikomba said they were very confident at baseline, increasing to 80% at endline. However, there were significant increases in respondents being very confident in Chiredzi (59% at baseline and 69% at endline, p=0.001) and Mwenezi (59% at baseline and 78% at endline, p=0.001). There were some differences according to intervention exposure. Differences between baseline and endline confidence supporting survivors increased among women who had attended a GCBC awareness raising session, attended a Toose community conversation, participated in a Toose session on different forms of power or attended a Toose session on IPV (see *Figure 55*).

Figure 55: Baseline and endline proportion of women who reported being very confident supporting survivors by intervention exposure



There was also a significant increase in the proportion of respondents who said that they were very likely to support a woman or girl who had experienced violence to access support from services: from 71% at baseline to 82% at endline (p=0.01). While this increase was observed across all three districts, these differences were not significant. There were, however, significant differences according to intervention exposure, with increased likelihood of encouraging service-seeking found to be greater among women who had been exposed to a GCBC awareness session, a Toose community conversation, a Toose session on different forms of power or a Toose session on IPV (p=<0.05).

Despite increased confidence and intentions to support survivors, there was no significant change between baseline (47%) and endline (45%) in the proportion of women surveyed who had actually provided support to a survivor in the past 12 months. This result was consistent across the three districts and across different levels of intervention exposure; however, it should be read with caution as respondents may not have provided support because they had not encountered cases of violence. Among those women who did support survivors in the past year (n=249), there was an increase in the proportion who had comforted a survivor (from 57% to 69%, p=0.001) or encouraged a survivor to access services (from 41% to 51%, p=0.02), no change in the proportion who had accompanied a survivor to a service (from 14% to 12%) and a significant decrease in those who had spoken with the perpetrator or his family (from 21% to 13%, p=0.02). There are some variations across the districts. For example, significantly increased comforting was observed in Chikomba but not in the other two districts, while significantly increased encouragement to access services and significantly decreased intervention with the perpetrator or his family were only observed in Chiredzi.

9. Discussion

This section synthesises and interprets the findings of the endline evaluation in light of the SAFE Theory of Change and the wider evidence base generated throughout the programme. It examines the extent to which change has occurred across different domains - economic wellbeing, gender dynamics, violence prevention and service access - and explores why change has or hasn't taken place. The discussion draws on ELU and programme data to identify patterns, enablers, and limitations, considering context, implementation quality, and the design of the intervention itself. By analysing trends across cohorts, districts, and participant characteristics, it provides a deeper understanding of the programme's pathways to change and their plausibility.

9.1. Synthesis of results

Annex 9 contains a summary of key endline impact and outcome measures according to the report's red, amber and green (RAG) rating that depicts negative change, no change and positive change, including across a selection of sample and exposure characteristics. The results show a complex picture with a range of different results that appear to be related to two important components of the programme ToC:

- **Wellbeing and collaborative relationships**: Overall, at impact level, there are strong results related to household wellbeing, which is the primary underlying logic of change in the ToC. There are corresponding positive changes at outcome level related to both economic and social empowerment outcomes, particularly those outcomes related to collaborative household relationships. These include household ability to meet essential needs, developing household shared visions, couples' joint decision making and men's greater contribution to household domestic labour. There are some outcome measures related to collaborative relationships that do not appear to have improved, including household joint economic planning and working towards shared visions.
- **GBV, women's empowerment and social norms**: Overall, at impact level, there are poor results or no change related to prevalence of IPV, controlling behaviours and corporal punishment against children. However, the evaluation has identified reductions in IPV on some measures of IPV severity or frequency and increased perceptions that child marriage has reduced. At outcome level, there are improvements in women's gender equitable attitudes (related to women's and men's roles) and attitudes towards early marriage. However, there are several other outcome areas where we see limited or even negative change, including a reduction in women's agency in decision making and no change in justification of physical IPV or peaceful conflict resolution practices with partners. It is also telling that there has been an increase in survivors' lack of help seeking because of normative barriers, including because they didn't feel the violence was a problem or because of fear of divorce or punishment.

It appears from these results that the pathways to change related to household wellbeing are linked to stronger results, with less positive results observed mainly for elements of the ToC involving normative and empowerment outcomes. In addition to these trends, the endline evaluation has identified a number of complexities associated with change, including district variations, potential enablers of change and factors that may have impeded change.

- **District level changes**: Negative impact-level change is concentrated in Chiredzi, where there was an increase in any IPV, partners' controlling behaviours (particularly around accusations of women's infidelity) and women's and men's perpetration of corporal punishment. There may be several reasons for these results. At endline, there was a worsening of male partners' peaceful conflict resolution practices (according to women), which may be related to increased IPV. Further, increases in IPV in Chiredzi are mainly for Cohort 1. While CBT in Cohort 1 consisted of food vouchers, there was a shift to cash in Cohort 1, which may mean that increased IPV, controlling behaviours and men's non-peaceful conflict resolution is associated with a new injection of cash into households. However, this is a hypothesis that the endline evaluation cannot test, and there was no evidence of increased conflict over cash in the qualitative data. Another possible driving factor for results observed in Chiredzi is the termination of CBT among some Toose households approximately six months prior to endline data collection, although it is not possible to identify which households had CBT terminated (see section 3.3.6 on study limitations). This could have impacted on increased food insecurity, diversion of TISAL funds to essential needs and an increase in IPV (see section 12.2 below for additional details on increasing food insecurity trends in Chiredzi in 2024).

- No increases in GBV were observed in Chikomba and Mwenezi and some reductions were observed, including a reduction in sexual IPV, severe IPV and partners' controlling behaviours in Chikomba, and a reduction in corporal punishment against children in Mwenezi. It is noticeable that in Chikomba, there was an improvement in households' ability to meet essential needs, increased household joint economic planning and increased household work together to achieve their shared vision for wellbeing.
- **Economic factors**: The results suggest that a very significant factor influencing change, particularly at impact level, is heightened food insecurity, with no change in IPV and reduced severity of IPV observed for women whose households' food security improved or stayed the same. Conversely, increased IPV was observed on all measures of IPV for women suffering from greater food insecurity at endline. The endline results suggest that while the programme's main economic activity, TISALs, do not appear to have mitigated economic trends towards heightened food insecurity, there is an association between reductions in severe IPV and higher number of loans taken from TISALs. The evaluation cannot establish the causality of these associations. It is possible, in line with the programme's logic, which taking out larger number of loans reduces household stress, mitigating economic drivers of severe IPV. However, it is also possible that women who experience less severe IPV are more productive in their engagement in TISALs.
- **Participation in Toose with partner versus other family members**: Whether women participated in Toose with their partner or other family members appears to have influenced the direction of change for a number of endline measures. Notably, women attending Toose sessions with their partner (as opposed to another family member) is associated with reduction in the number of acts of IPV women experienced in the past year, increased household ability to meet essential needs, women's stronger knowledge about conflict resolution methods and better attitudes towards child marriage. In contrast, women bringing another family member to Toose sessions was associated with women's partners' worsening of peaceful conflict resolution practices. These findings suggest that impacts and outcomes related GBV and conflict resolution are stronger when women engage in the intervention with their partner.
- **Exposure to gender transformative Toose sessions**: There are mixed and sometimes what seems to be contradictory findings related to women's participation in gender transformative Toose sessions, including sessions on different forms of power or IPV.
  - Negative impacts: Women's participation in a Cohort 3 Toose session on IPV is associated with increased prevalence of IPV (any IPV), emotional IPV and partners' controlling behaviours.
  - Positive impacts: Women's participation in a session on IPV is associated with women's reduced perpetration of corporal punishment against children with lack of attendance being associated with higher prevalence of perpetration. Women's participation in a session on IPV or different forms of power is associated with more peaceful conflict resolution practices with their partner, and women not attending these sessions is associated with the worsening of men's conflict resolution practices.

These findings are challenging to explain. It is possible that increased IPV among women exposed to Toose sessions on IPV is reflecting women's greater knowledge of IPV at endline, leading to increased reporting in the endline survey. Given that women attending gender transformative sessions is associated with improved conflict resolution practices with partners, it is possible that IPV has in fact reduced at endline and we are seeing the impacts of under-reporting at baseline. However, it is also possible that exposure to these sessions has increased IPV risks, for example, if greater knowledge of IPV has led women to challenge their partners or resist violence.

9.2. Interpretation across the three elements of the prevention triad

The discussion section draws from ELU and programme data, including from the endline evaluation, the qualitative cohort study (Deep Dive 2 and Deep Dive 5), the Process Level Study (Deep Dive 4) and the SAFE Summative Evaluation, to present possible hypotheses to explain endline results according to the three pillars of the prevention triad, and the underlying operational foundations.

Context and population

COVID-19

The SAFE programme was launched at the end of 2019, a few months before the start of the COVID-19 pandemic, which led to various challenges including the pausing of programme design and implementation to focus on evidence building on the effects of the pandemic on GBV in Zimbabwe. The SAFE ELU's Deep Dive 4 study identified other knock on effects of the pandemic on the earlier phases of the programme, including during the inception period.

Lockdowns limited SAFE Communities' ability to travel to districts and wards to do capacity building with IPs, sometimes relying on online modalities for engagement.

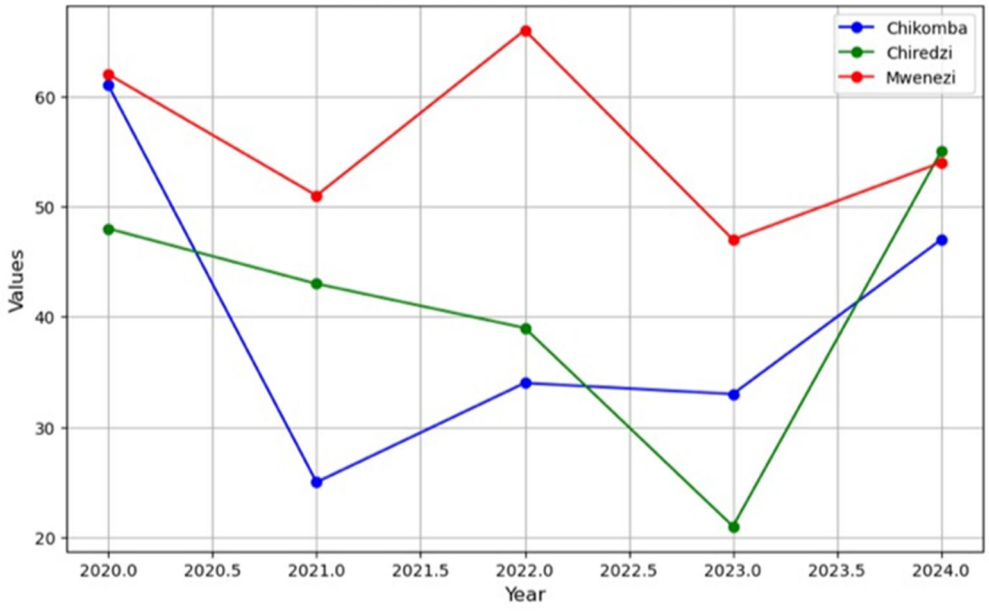
In relation to implementation, the Deep Dive 4 study found that the pandemic also had a negative impact on TISAL groups as economic productivity was reduced. Most TISAL group members relied on informal business and during the pandemic they were not allowed to travel, prohibiting access to markets to sell products, negatively impacting business opportunities. There was also a poor market for selling produce which resulted in some TISAL members making losses as it took longer than usual to sell products and therefore longer to make returns. Door to door selling was also not possible, further constraining the potential for TISAL members to maintain or increase the profitability of their IGAs. This affected the programme by delaying the progress of establishing IGAs and therefore making it more difficult for TISAL members to repay loans in full and on time.

Wider economic context

Other SAFE ELU studies, particularly the process level study, have emphasised the extent to which economic instability in Zimbabwe, including from inflation and fluctuating exchange rates, has impacted negatively on the operation of TISALs. External economic trends reduced both the ability of TISAL members to repay loans and the likelihood of loans being spent on IGAs.

The endline qualitative data also highlighted how the wider economic context in Zimbabwe has negatively impacted on those participating in the intervention. In Mwenezi and Chiredzi, participants spoke about customers failing to pay for goods bought on credit due to worsening economic conditions and hunger, and some participants failed to repay TISAL loans on time. Some also said that competition caused downturn in sales and that droughts severely affected agriculture. There were more reports of a worsening economic environment in Chiredzi than in other districts. In Chiredzi, several participants disclosed that they struggled to repay TISAL loans because they had to divert their income to urgent basic needs, including healthcare. Many cases arose of failure to repay loans, for various reasons, including drought, theft of raw goods, accidents, diversion to basic needs and business losses. National data reflects these findings, with food insecurity having been high in Mwenezi for some time but worsening substantially in Chiredzi in 2024 (see *Figure 56*). These trends may have been exacerbated by the termination of CBT among some Toose households in Chiredzi.

Figure 56: Trends in food insecurity (2020-2024)



Source: Rural Zimbabwe Livelihoods Assessment Committee (ZimLAC), WFP Zimbabwe

The qualitative data clearly illustrates how these wider economic trends in Zimbabwe have affected household economic stress and food insecurity. Both the quantitative and qualitative endline data suggest that this may have limited intervention impact, particularly in relation to IPV and the economic drivers of violence among the most vulnerable populations.

Wider political context

During 2023, while SAFE Communities was rolling out the third cohort of implementation, Zimbabwe had national elections, with pre-election processes hampering a number of programme activities. One of the most significant negative impacts of the elections was the pausing of SAFE programme activities, reducing the implementation time for roll out of Cohort 3. Consequently, a shorter implementation period needs to be kept in mind when assessing the impact of Cohort 3 activities. The election period also affected the delivery and operation of TISALs and IP meetings. This mainly affected when and where TISALs could meet with SAFE IPs but also affected how IPs had to present themselves within the community. Restrictions on meetings and mobility during the election period also affected the progress and profitability of TISALs. Meetings were sometimes disrupted although in most instances meetings simply had to be rearranged or held at different locations as TISALs could not gather as normal. Elections also reduced the mobility of TISAL members, which prevented them from having access to places where they would normally buy and see produce.

Inclusive programme approach

The Toose intervention is primarily targeted towards couples, but in line with a family-focused approach the programme's LNOB strategy emphasised the inclusion of women in female-headed households, women with migrant partners working away from home and women in polygamous unions. In addition, the programme paid significant attention to inclusion of people with disabilities. While the programme encouraged inclusion of women from diverse family, household and relationship backgrounds, the Toose social empowerment manual was not adapted to be inclusive of these diversities. Subsequently, both SAFE Communities monitoring data and ELU data found that some groups struggled to engage with Toose sessions, particularly those more explicitly tailored for couples. The ELU's Deep Dive 4 study also found that women often brought other relatives (e.g., mother-in-law, adolescent children) to Toose sessions even when they had a male partner, on the request of facilitators who urged them to bring any family member in the absence of a male partner. It also found that the participation of other family members was not necessarily uniform or consistent, with different members sometimes coming during different sessions. The quantitative and qualitative data from the endline evaluation also confirm this. This means that not all the Toose social empowerment curriculum sessions were necessarily delivered to the same people or sets of people, which may have diluted impact. As noted in the previous sub-section of the report, some endline outcomes are stronger when women participated in Toose with their partner rather than another family member.

Programme model

The theory of change focus on household wellbeing

The Toose intervention is communicated outwardly to communities and stakeholders as a family and household wellbeing intervention, and this is the explicit focus of the ToC with family wellbeing being one of the expected impacts of the programme. While women's empowerment does feature at lower levels of the ToC, through an output related to women's negotiation of power in their households, this is not a central feature of the ToC and does not feature at outcome or impact level.

The ELU's Deep Dive 4 study and Summative Evaluation found that the decision to focus on family wellbeing rather than women's individual empowerment has helped to generate interest and buy-in from communities and increase the relevance and acceptability of the intervention. This approach has also reduced the risk of alienating or generating resistance from men and has been linked to various positive behaviours including spending quality time together, collaboration and setting shared visions for household success and joint decision making. However, the studies also found that an emphasis on household wellbeing may have limited empowerment outcomes for women. The results of the Deep Dive 4 study suggested that insufficient explicit attention to women's empowerment may have inadvertently reproduced rather than challenged the status quo in relation to women's and men's gendered roles and responsibilities and may have led to some examples of backlash from men and their attempts to assert control over women, and reproduction of patriarchal norms.

This evidence from past studies may explain why we see certain patterns in the data, as outlined in the previous sub-section of the report on the synthesis of results. The results of the endline evaluation point towards more positive impact related to household wellbeing and collaborative relationships, and weaker and sometimes negative results related to GBV, women's empowerment outcomes and social norms.

Economic interventions

Given the wider economic challenges noted above, the question emerges of whether the TISAL approach, as the main vehicle for reduction of household economic stress, is sufficient to reduce IPV. Due to funding cuts in the early phases of the programme (see further below), plans to implement a stronger economic intervention were not possible

and TISAL groups became the main modality for delivering economic empowerment for women (with the addition of CBT in Chiredzi). However, the Deep Dive 4 study highlighted the significance of the wider economic context in negatively influencing economic intervention outcomes. The study found that TISAL members often struggled to repay loans in full or on time, with inflation and unstable currency exchange rates within the multi-currency system in Zimbabwe also impacting negatively on loan repayment and profitability of IGAs. The Deep Dive 4 study also found that during periods of economic uncertainty, TISAL members were more likely to use TISAL loans for consumption purposes rather than IGAs. The process-level study found that the TISAL model did not benefit all members equally or in the same way, with poorer TISAL group members struggling to make contributions and often using loans to cover basic needs, including food.

Various iterations of the Toose social empowerment curriculum

Given the adaptative nature of the intervention, significant adaptations were made to the Toose curriculum across the three cohorts covered by this evaluation. Through the programme's learning and adaptation approach, triangulated learning about what was working well and what needed to be improved was fed back into curriculum adaptations, some of which were quite substantial. While this approach leads to strengthened intervention content, it poses some challenges for evaluating impact as different cohorts of women and men have been exposed to different intervention content. This challenge is relevant not just for the social empowerment curriculum but for other components of the programme that went through various phases of adaptation, including economic activities.

One important adaptation was the addition of a curriculum session on IPV. Programme evidence generated during the implementation of cohorts 1 and 2 suggested that the Toose social empowerment curriculum would benefit from additional and more targeted content on IPV. This was subsequently introduced into the Cohort 1 Toose social empowerment curriculum and rolled out in 2023, including with a separate cohort of TISAL members, with additional sessions (including on IPV) also rolled out with some women and men from cohorts 1 and 2. Given the short period for Cohort 3 implementation, including due to the political challenges noted above, the programme completed implementation shortly after completing the Toose social empowerment component of the programme, with potentially insufficient time to support Toose participants with some of the challenging content raised in the IPV sessions, which was sequenced at the end of the curriculum. This may be responsible for some of the findings related to increased IPV among women who had participated in the session on IPV, although the endline evaluation data cannot confirm this.

Bringing visioning into TISALs

The core Toose conception of visioning (working with family members to develop and achieve visions for household wellbeing and success) was originally introduced in the Toose social empowerment sessions in Cohort 1. The introduction of this concept was sequenced differently in Cohort 2 and introduced into TISAL training at the start of Cohort 2 implementation. The results of the ELU's Summative Evaluation and Deep Dive 4 study emphasised how this adaptation strengthened the effectiveness of both TISAL groups and IGAs. Visioning was using as an aspirational process and planning tool for income generating projects and was also key in creating aspirational visions for the groups, including leading to stronger governance arrangements. The ELU results also found that the introduction of visioning into the economic activities supported the mutually reinforcing relationship and benefits between the economic and social interventions. These adaptations may have contributed to stronger results observed for change related to family wellbeing.

Implementation quality

Facilitation of Toose social empowerment sessions

Community peer facilitators (Toose graduates from Cohort 1) shared facilitation responsibilities with IPs during the second and third cohorts of the programme after completing Cohort 1. The ELU's Deep Dive 4 study found that there were two critical factors that influenced success in facilitation. The first was whether facilitators had gone through their own transformative journey of change. Some male facilitators in particular described how going on their own journey of change had impacted positively on their own relationships, including shifting power in their own intimate relationships. The second factor influencing facilitation was the strength of training, ongoing support and mentoring. The programme encountered some challenges with this factor including difficulties recruiting skilled peer facilitators; poor facilitator comprehension of earlier versions of the Toose manual, which were described as too complex; and turnover of facilitators and challenges providing refresher training to new peer facilitators, in part due to resourcing issues. These challenges may have led to some dilution of intervention impact among women in the earlier cohorts of the programme (those sampled for the endline survey). Although it should be noted that these challenges were ironed out in cohorts 2 and 3, including through stronger training and clearer, more simplified Toose manuals.

Facilitation of gender transformative messaging

Peer facilitators also rolled out structured diffusion of Toose messaging during Cohort 1 implementation. The ELU's Deep Dive 4 study found that messages about happy families, different forms of power and visioning were popular, and that peer facilitators found learning about power to be particularly personally transformative. They also suggested that conversations about power were also sometimes controversial, particularly among men. Several ELU studies have found that some male peer facilitators struggled to share gender transformative messaging with other men in both Toose social empowerment sessions and during community diffusion activities due to persisting norms around masculinities. For example, male peer facilitators shared challenges related to diffusing Toose messages with men who were resistant to topics that challenged the status quo, such as men sharing household labour with women, men having 'power over' others or men refraining from drinking alcohol. In at least a few examples from EL evaluative studies, some peer facilitators appeared to reproduce traditional gender narratives in their messaging rather than gender transformative ones, including when sharing messages about topics such as sexual consent in relationships.

Community cadres

The SAFE programme drew extensively from the use of community cadres to support intervention implementation. The ELU's Summative Evaluation found that the engagement of community cadres was a strong factor driving success, particularly in the community diffusion and response elements of the programme. Toose peer facilitators, TISAL Field Agents and GCBCs were grounded in their local communities and had the necessary expertise to navigate the social and cultural landscape of the programme and trouble shoot challenges. They were also able to make any necessary adaptations to approaches to align with local norms, such as developing appropriate approaches to incentivise participant engagement. GCBCs were also selected by local community members in some districts and wards, through a transparent voting process, enhancing trust and accountability. GCBCs, in particular, have been critical in supporting GBV response outcomes and GBV awareness raising, with exposure to GCBC awareness raising sessions in the community found to be associated with several positive outcomes in the endline evaluation. Multiple ELU studies have also identified strong perceptions that GCBC awareness raising has led to a reduction in early marriage.

Operational foundations

Appropriate budget

The SAFE programme has experienced significant budget cuts throughout programmatic timeframes, starting with budget cuts during the COVID-19 pandemic. These budget cuts affected the scale, scope and momentum of the programme. For example, when SAFE started, four districts (two rural and two urban) were considered but this had to be limited to three (removing one urban district). Budget cuts also affected the number of TISAL groups generated by the programme. Cohort 1 started with 23 groups per district, Cohort 2 had 23 groups per district and Cohort 3 only had four TISAL groups per district. Funding challenges also affected the scope of the economic component of the intervention, as noted above, although the programme did strengthen economic activities to attempt to enhance impact. For example, in Cohort 1, the main focus of the programme was on grafting Toose onto TISALs, with assumptions that this would be sufficient for the productive generation of savings and loans. However, additional features were built into TISALs in subsequent cohorts, including TISAL training and other types of training to enhance the productive impact of groups and their development of IGAs. However, a question remains about whether these activities were sufficient to mitigate the economic drivers of IPV.

Timeframes for implementation

Finally, the short timeframes for implementation may have influenced programme impact. The implementation length of each cohort spanning approximately eight months, in order to go through the programme's learning and adaptation cycle, may have not been sufficient to fully embed the social and economic empowerment elements of the intervention.

9.3. Reflections on the SAFE Theory of Change

The SAFE Summative Evaluation synthesised SAFE ELU and programme data to analyse the extent to which evidence supported change pathways in the ToC. We have drawn from this synthesis and adjusted it in alignment with the new evidence generated from the endline evaluation.

The Outcome 1 pathway to change through household management of economic stress is partially supported, but with some limitations in terms of women's empowerment.

Previous programme evidence has suggested that SAFE improved wellbeing at the household and individual levels and that this was taking place through reduction of household economic stress and improving the quality of relationships. Evidence from previous ELU studies suggested that households were better able to manage economic stress through improvements in income and savings, more inclusive household economic discussions and greater cooperation between partners. However, a key assumption that TISALs could be adapted to be viable for very poor households has not fully held across the programme learning cycle, with poorer households often struggling to make contributions and loans repayments and using loans for productive purposes.

The findings of the endline evaluation suggest that stronger economic outcomes are associated with stronger social empowerment outcomes on a number of different measures, and that challenges in this pathway to change are related mostly to wider economic trends outside the programme's control, including heightened food insecurity, coupled with limitations in the extent that TISALs can mitigate these wider trends.

Previous ELU studies identified a specific gap in this pathway to change, in relation to women having negotiating power in the household. Past programme evidence suggested that the extent to which women did achieve stronger negotiating power depended partly on the extent to which they could generate income, and the importance of that income to the household. The results of the endline evaluation appear to suggest that women's agency in decision making about economic issues has worsened, even though joint decision making with partners has improved. These findings are aligned with observations presented in *9.2* that while wellbeing and collaborative relationships have improved, women's empowerment outcomes have been more modest or limited.

The Outcome 2 pathway to change through gender equitable and non-violent relationships is only partially supported.

Previous ELU and SAFE Communities evidence synthesised in the Summative Evaluation found that women and men in couples felt supported, loved and united, and felt that their communication and conflict resolution had improved. This appeared to be leading to a reduction in IPV, albeit with some attitudes and behaviours rooted in persisting and sometimes reinforcing patriarchal gender norms. Consequently, where couples perceived positive conflict resolution happening, this was sometimes grounded in women's silence or subservience to men. Similarly, in some cases where quality of relationships were described as improving, including sexual relationships, this was based on women acquiescing to the perceived conjugal rights of men, or out of fear of men's infidelity or violence.

The endline evaluation has mixed findings in relation to this outcome pathway. They suggest that there has certainly been change in knowledge (e.g., about positive conflict resolution) and agreement and understanding about core programme elements such as shared visioning for family wellbeing. However, these changes have not necessarily translated into concrete behaviours, including peaceful conflict resolution, working towards shared visions or, ultimately, GBV. One exception in behaviour change is men’s contribution to household labour, which increased at endline, although programme evidence to date has suggested that these behaviours have not necessarily translated into normative change around gender roles and responsibilities.

These findings suggest that while there have been some positive changes in gender equitable relationships and the quality of relationships, this has not necessarily led to less violence in relationships. It is challenging to say why this has taken place, but it may be related to the ELU evidence noted above on persisting and sometimes reinforcing gender norms. This may suggest that shifting gender norms is required for this pathway to change to be viable.

The Outcome 3 pathway to change through community wide adoption of the 'Toose way' is mostly supported.

As noted previously in the report, the SAFE ToC was adjusted mid-programme, and the ToC focus under this pathway shifted away from gender equitable attitudes and reduced tolerance for violence (attitudinal and normative measures) and towards more focused outcomes related to Toose community diffusion. However, given that the endline evaluation measured change against the original outcomes in the ToC, both previous and current iterations of this outcome pathway are discussed here.

According to the Summative Evaluation findings, focal points diffusing messages about Toose were successful at encouraging the wider adoption of Toose, including through their own personal example of change. Community members were familiar with Toose tools and concepts and understood the changes they needed to make to adopt the 'Toose way'. However, there was some distortion of what it meant to embody and live the 'Toose way'. Much like what occurred in Outcome 2, change was sometimes rooted in persisting and sometimes reinforcing patriarchal gender norms.

The endline evaluation findings suggest that there have been some improvements in attitudinal change, particularly in relation to gender equitable attitudes. However, justification for physical IPV persists, particularly in relation to perceptions of women's infidelity, suggesting that norms surrounding the justification of IPV have remained more static. Attitudes related to child marriage, however, appear to have improved.

These findings, across both versions of the ToC, suggest that while some positive attitudinal change has occurred, including in relation to gender equality, more rooted patriarchal social norms have not necessarily shifted as much.

The Outcome 4 pathway to change to increased access to essential GBV services is mostly supported.

Previous ELU studies and programme data have suggested that lack of affordability and lack of accessibility of services were significant barriers that SAFE was being able to reduce through strengthened access to response services, including mobile services, and drawing from GCBC community cadres for support, accompaniment and awareness raising. The endline evaluation supports these findings and shows improvements in reducing accessibility and affordability barriers in particular.

The programme evidence suggests that there has not been positive change in relation to addressing the normative barriers preventing help seeking. Previous ELU studies found that while there was greater recognition of GBV as harmful, some attitudes justifying violence persisted and may have been amplified through community diffusion messages that put the onus on women to avoid violence. The ELU's Community level impact study also found that some distortion was happening in relation to help seeking, with some perceptions circulating that women should handle conflict directly with their partner and not involve others outside the household. This may have reproduced the norm that violence is a private family matter. The endline evaluation has also identified some persistence or worsening of normative barriers, including increased proportions of survivors who did not seek services because they felt the violence was not a problem or because they were concerned about negative repercussions. The finding of survivors' increased fear of divorce or abandonment if they seek help for GBV among those participating in Toose community conversations and GCBC sessions may be linked to the findings above from the Community impact study indicating some persisting norms related to violence being a private matter.

10. Conclusions: making sense of the evidence

This section draws together the key findings from across the SAFE evaluation cycle to provide a holistic interpretation of what the programme has achieved, how change happened, and where challenges remain. It brings the endline results into conversation with earlier studies - both qualitative and quantitative - to make sense of patterns across time, geographies, and study designs. In doing so, it highlights where there is consistency across evidence sources, where findings diverge, and what this means for the overall effectiveness and limitations of the SAFE model.

Across all studies, the SAFE model appears to have been most effective in improving family wellbeing, including household economic security, emotional relationships, parenting, and family functioning. These were among the strongest and most consistent findings at endline, and the qualitative Endline Study confirms that family unity and improved household relations were among the changes most valued by participants themselves. This aligns with SAFE's decision to frame the intervention around family wellbeing, rather than directly targeting GBV or women's empowerment, a strategy which was found to increase buy-in and participation among both men and women. It also reflects the mutually reinforcing relationship between SAFE's economic and social empowerment components, which together helped foster greater collaboration, visioning, and practical support within the household.

The SAFE studies also appear to suggest that CBT has been successful in mitigating economic stress and supporting economic outcomes, although limitations in the endline data make it challenging to make conclusions. The endline data suggests that ability to meet basic needs has not changed in Chiredzi. However, previous ELU studies and SAFE monitoring data paint a different picture, finding that during the programme timeframes, CBT in Chiredzi allowed households to use vouchers or cash for food, strengthening their ability to direct money into TISAL savings than could then be converted into loans and IGAs. Given that endline data collection was conducted one year after the programme's completion and six months after termination of CBT for some households, and during a period of drastically worsening food insecurity in Chiredzi, it is possible that the endline is picking up on wider downward trends.

There is evidence that SAFE contributed to improved awareness of GBV and availability of services, particularly through the work of GCBCs and Musasa. Participants' confidence in supporting survivors increased, perceived barriers to access declined, and actual help-seeking behaviour improved across some indicators. However, normative barriers - such as shame, stigma and fear of consequences - persisted, and in some cases increased. This was particularly the case among women exposed to certain diffusion activities, such as Toose community conversations and GCBC sessions, echoing earlier concerns that diffusion had, at times, reinforced the idea that women are responsible for managing conflict and preventing violence. This was also seen in the community-level study, where women described giving advice to others on how to behave to avoid violence - advice which often emphasised compliance, silence, and self-sacrifice.

Similarly, although there were improvements in household joint decision-making and a notable increase in men's contributions to household labour, these shifts have not translated into stronger decision-making power or greater agency for women. In fact, several empowerment indicators - such as women's perceived ability to make decisions about things they value - declined. These patterns have been observed throughout SAFE's evaluation cycle. Earlier studies found that behaviour change often remained conditional on practical benefits to the household, and that power remained concentrated with men. Despite changes in behaviour, underlying attitudes and norms - particularly around gender roles, infidelity, and male authority - were more resistant to change.

This may help explain one of the key endline findings: the overall increase in IPV prevalence. While severity and frequency of IPV decreased in some cohorts and districts, overall prevalence rose slightly from baseline, driven largely by trends in Cohort 2 and in Chiredzi. However, the endline findings also suggest that IPV may have been mitigated in cases where women had stronger engagement in Toose activities, particularly the economic empowerment components. The data shows a strong association between number of loans taken and reduced IPV acts, and between improved food security and reduced IPV. Conversely, when food security worsened, IPV tended to rise. These findings are consistent with earlier evidence that linked economic stress to IPV risk, and suggest that under the right conditions, SAFE's model may offer some protective effects.

Despite this potential, the endline findings also raise important questions about the limits of the TISAL model - SAFE's main economic intervention - in contexts of heightened economic vulnerability. The data show that food insecurity significantly worsened over the programme period, particularly in Mwenezi and among households experiencing economic shock. Although a greater number of TISAL loans is associated with improved ability to meet essential needs and reduced IPV acts, there is no evidence that TISAL loans improved household food security. In fact, women in the most food secure households at endline had also taken out the most loans, suggesting that food

security may be a precondition for effective engagement in TISALs, rather than an outcome. Qualitative evidence also indicates that some women diverted loans to cover basic needs like food and healthcare, and that worsening economic conditions and droughts limited business success and loan repayment. In this context and from an economic empowerment standpoint, TISALs may not be well suited to the poorest or most food insecure households, and their impact appears constrained where broader structural drivers of economic vulnerability remain unaddressed. These findings echo concerns raised in earlier studies and suggest a need to reassess the sufficiency of the TISAL approach in such settings.

While some of the endline findings may appear unexpected at first glance - such as the increase in IPV prevalence or modest shifts in women's empowerment - these results are not necessarily surprising when viewed against the broader body of evidence generated throughout the programme cycle. Earlier studies, including the qualitative endline, process study and summative evaluation, have consistently highlighted both the strengths and limitations of the SAFE model. These include the persistence of patriarchal gender norms, the practical but conditional nature of behaviour change, and the challenges of achieving normative transformation in a short implementation window. As such, the trajectory observed at endline is broadly in line with earlier findings: improvements in wellbeing, communication, and household collaboration often coexisting with more modest or inconsistent changes in gender norms, power dynamics and help-seeking behaviour. **The endline findings therefore reinforce rather than contradict the earlier body of evidence and help to further clarify where SAFE has been most effective, and where further adaptation may be needed.**

These findings also make sense when viewed through the lens of each study's methodology. The endline evaluation, the only study with a quantitative design, provides population-level estimates of change over time but cannot on its own explain why or how change occurred, or establish causality. It uses direct, structured questions to measure IPV, which, while potentially more sensitive, are also likely to produce more accurate prevalence estimates due to standardised interviewing techniques. In contrast, the qualitative longitudinal cohort study focused on understanding the processes and mechanisms behind change, offering rich insight into participants' experiences but with a smaller, non-representative sample. It used a more indirect approach to exploring experiences of violence, in line with ethical and safeguarding considerations. As a result, there were likely fewer disclosures of IPV and these often emerged in more generalised or contextualised terms and were not always framed as personal experiences.

The qualitative evidence tends to present a more positive picture of IPV change, with participants more frequently describing improved relationships and reduced conflict. This difference may be partly explained by the smaller and non-representative sample, as well as the more open-ended questioning, which may be less likely to elicit disclosures of violence. These methodological differences underscore the importance of drawing on both qualitative and quantitative evidence. The quantitative data provides measurable estimates of what has changed, while the qualitative data helps to unpack how and why change has - or has not - occurred. Together, they offer a more complete and nuanced understanding of programme impact.

The process study examined the quality of implementation and contextual factors that shaped outcomes, while the community-level study explored the reach and effects of diffusion activities beyond direct participants. Finally, the summative evaluation brought these threads together, synthesising evidence across the evaluation cycle.

Each study, by design, captured different dimensions of the programme, and while their findings vary in emphasis and depth, they are broadly consistent. Together, they present a coherent picture of SAFE's impact: a programme that fostered positive shifts in wellbeing and household dynamics, but which faced persistent challenges in transforming gender norms and reducing violence at scale, particularly in a context shaped by poverty, food insecurity and entrenched patriarchal attitudes.

Overall, the SAFE model appears to have delivered change through multiple, mutually reinforcing pathways - economic, relational and community-based - but with limitations where prevailing social norms and external structural conditions (such as poverty, insecurity and male migration) presented barriers. This is reflected in the ToC: the outcome areas where evidence is strongest are those focused on economic stress and household wellbeing. Outcome areas focused on gender norms, power, and violence appear only partially supported. These findings are important not only for understanding the legacy of SAFE, but for informing future iterations of similar models aiming to reduce GBV and promote gender equality in complex, resource-constrained settings.

11. Recommendations

1) **The endline evaluation confirms that SAFE has had important outcomes, for example in household wellbeing, improved relationships, and community-level GBV awareness.** However, the results also raise questions about the appropriateness or sufficiency of the current model to shift gender norms or reduce IPV at scale - especially within short timeframes and in contexts of high food insecurity. The recommendations below are intended to inform future adaptations and scaling decisions. The SAFE ELU do not recommend direct replication of the current model without these adaptations. Instead, we suggest that future implementation of SAFE should be tailored to the specific context and objectives, with particular attention to gender norms, economic vulnerability, and time required for transformative change.
7) **Support further experimentation of Toose to find an appropriate balance between household wellbeing and women's empowerment to achieve the desired impact on IPV**. The endline evaluation suggests that while focusing on wellbeing may be linked to positive impacts on family quality of life as measured through the endline evaluation, a more deliberate focus on women's empowerment may be required if Toose is to be successful in reducing IPV. This does not require abandoning the programme's focus on family and household wellbeing but could be strengthened through several different approaches. One is elevating the elements of the SAFE ToC related to women's empowerment from output to outcome level, including women's negotiating power within the household and, ultimately, agency. Another is by strengthening the Toose manual content on power to support reflection on the fact that sharing power does not mean losing it and integrating more experiential content on households practicing power balance in relationships. See the ELU combined Deep Dive 4 and Deep Dive 5 recommendations annex for several ways to strengthen both the content and facilitation of the Toose curriculum in line with this.
8) **Focus on couples and prioritise men's participation to strengthen impact**. The endline evaluation results suggest that change in impacts and outcomes were stronger when women participated in Toose with their male partners, and that the participation of other family members may have diluted impact. Future roll out of Toose should focus on the intervention as a couple's intervention and build in stronger incentives for the participation of male partners to strengthen impact.
9) **Integrate stronger content on sexual IPV, jealousy and (perceived or real) infidelity to address persisting triggers of violence**. SAFE ELU studies have consistently identified jealousy, infidelity (whether perceived or real) and refusal of sex as key triggers of conflict and IPV. The endline evaluation has also found that an increase in men's controlling behaviours is accounted for by partners accusing women of being unfaithful, suggesting that the programme has not been successful in addressing these triggers of violence. The Toose manual's focus on strengthening the quality of relationships may not be a sufficient mechanism to address these triggers. While the introduction of explicit IPV content into the manual may support more change in reducing justifications for IPV, future implementation should consider introducing additional content to more specifically address sexual IPV, and triggers associated with infidelity.
10) **Develop guidance and modalities to support peer facilitators to share consistent Toose messaging through diffusion, including in gender transformative ways**. SAFE ELU studies have suggested that community diffusion is a promising modality for extending the scope and reach of Toose messaging; however, some challenges were identified, including in relation to male peer facilitators' comfort and ability to share challenging messages, and the distortion of messages when shared widely. Future implementation of Toose community diffusion activities should produce clear guidance and other support modalities for peer facilitators and others diffusing messages to enable them to tackle challenging conversations in gender transformative ways that do not reproduce gender stereotypes. Programmes should also develop guidelines for community diffusion to enable mainstreaming of community messaging and mitigate the risk of distortion.
11) **Extend implementation timelines to support gender transformative change.** The eight-month cohort cycle may be too short to support deeper normative shifts, particularly those related to power dynamics, decision-making, and violence. Findings across SAFE studies suggest that behaviour change often remained conditional or instrumental, and that shifts in gender norms were limited or uneven. The persistence - and in some cases reinforcement - of patriarchal norms, as well as mixed findings on IPV, suggest that longer timelines are likely needed to allow for more sustained engagement, reflection, and gender transformative change.
12) **Expand and re-sequence the Toose curriculum to strengthen impact and mitigate risks**. It may be necessary to expand both the length and content of the Toose social empowerment curriculum to ensure it provides sufficient depth and structure to support meaningful transformation. SAFE evaluation evidence suggests

that key sessions - particularly those on IPV and power - may have been introduced too late in the cycle, limiting opportunities for reflection, reinforcement and behaviour change. The process study identified cases of backlash and male dominance in TISALs, including men taking control over women's profits. These risks may be exacerbated when social empowerment does not precede economic engagement. Re-sequencing sessions on power and gender dynamics earlier in the cycle, and adding structured follow-up activities, could help mitigate harm and build stronger foundations for empowerment. This could enhance impact and reduce risks such as backlash or misinterpretation.

13) **Strengthen facilitation of the Toose curriculum for more effective delivery**. To ensure the content described above is delivered effectively, future implementation should invest in ongoing mentoring and capacity building of both IP and peer facilitators. The process study and summative evaluation both highlighted that some facilitators struggled to deliver accurate or gender-transformative messages, and that male facilitators in particular faced challenges engaging men on sensitive topics. In some cases, this led to reinforcement of harmful norms, especially in discussions around sexual consent or marital rights. Integrating more experiential learning on power-sharing and decision-making, alongside stronger facilitator support systems, could help ensure messages are consistently and safely delivered. This would require additional time and resources but is aligned with global good practice - for example, What Works Phase I found that interventions were more effective when curricula were delivered over 40–50 hours across weekly sessions. Recommendations to strengthen facilitation through ongoing mentoring and capacity building of both IP facilitators and peer facilitators have been made at various points (for example, in the Deep Dive 4 process study and the Summative evaluation) during the programme and these recommendations have been adopted. Future roll out of Toose should ensure that adequate time and budget is built in to support facilitator training and mentoring over time.
14) **Pilot future adaptations of Toose with stronger focus on social norms and behaviour change**. The SAFE ELU Deep Dive 4 and Deep Dive 5 studies made recommendations for Toose to strengthen its focus on social norms and behaviour change; however, this was out of scope of the 2024/ 2025 programme extension. Previous and current evaluation findings suggest that some elements of the intervention insufficiently address the status quo around gender norms and may be reinforcing some patriarchal norms. The programme has taken important steps in the right direction, including integrating more gender transformative content into Cohort 3. However, there are persistent findings that lead to questions about whether significant shifts in social norms are possible through short, wellbeing focused interventions. Future iterations should reflect on this question and which adaptations are required to reduce the risk of harm while maximising impact.
15) **Reassess the appropriateness of the TISAL model in contexts of food insecurity.** Endline findings highlight a strong relationship between food insecurity and increased IPV and show that TISALs alone may not be sufficient to reduce economic vulnerability in highly food insecure settings. Households experiencing food insecurity were less likely to take out loans or benefit from them, and there was no evidence that TISAL loans reduced food insecurity. Instead, women with greater food security were more likely to access more and larger loans. In Chiredzi, where the TISAL model was paired with cash-based transfers, both food insecurity and IPV prevalence still increased - suggesting that CBT alone may not be enough to offset economic stress in some contexts. Qualitative data also shows that households often diverted loans to basic needs, limiting their use for income generation. Nevertheless, SAFE evaluation evidence has consistently shown that the Toose model worked best when its social and economic components were combined, with each reinforcing the other to strengthen household collaboration, visioning, and wellbeing. Future iterations should reassess the appropriateness of the TISAL model for the poorest households and explore more robust or sustained economic interventions in settings where food insecurity is high, potentially including combinations of livelihood support, longer-term cash assistance, or targeted social protection.
16) **Explore alternative methodological approaches to supporting learning and adaptation cycles within prevention programmes and ensure that these are sequenced effectively with implementation cycles**. The evaluation approach, which focused predominantly on a series of qualitative deep dive studies conducted throughout the programme timeframes, provided useful insights to support adaptation. However, there were several challenges in making the most of the comprehensive data and learning generated by the programme. A key challenge was short timeframes between implementation cohorts, making it challenging to sequence studies and adaptations. Another challenge was the inability to conduct separate baseline and endline studies for each implementation cohort due to resource constraints. Future roll-out of adaptative programmes such as SAFE should ensure that sufficient time is built into implementation cohorts and cycles to make the most of evaluation data and learning.

Annex 1: GBV in Zimbabwe (further context)

As is the situation globally, GBV in Zimbabwe is endemic and has been declared an emergency by the government. The country has a high prevalence of GBV with one in three women experiencing lifetime prevalence of GBV and the phenomenon occurring across all socio-economic and cultural backgrounds and regions of the country. GBV is rooted in gender inequality, the abuse of power and harmful norms. The 2019 MICS shows that close to 40% of women and girls in Zimbabwe experience physical violence in their lifetime and 12% experience sexual violence. Prevalence of physical violence among women and girls in Zimbabwe is 10 percentage points higher than the average global prevalence rate of 30%.[40]

IPV is one of the most common forms of violence against women, including in Zimbabwe, and includes physical, sexual, economic, and emotional abuse by an intimate partner. IPV occurs amongst all socio-economic, religious, and cultural groups and consequences of IPV include negative physical and mental health impacts.[41] The 2019 MICS found that 49% of ever-married adolescent girls and women aged 15-49 had experienced any type of IPV in their lifetime, and the prevalence of past-year IPV was 28%. The survey also found that physical and emotional IPV are the most common forms of IPV in Zimbabwe.[42] Reports by civil society organisations reflect that IPV is one of the most prevalent forms of GBV. In 2019, the Musasa Project alone recorded 32,344 cases of GBV; one of the most common types was IPV.[43]

Child marriage is also common in Zimbabwe despite being criminalised by the Constitution of Zimbabwe and the Marriages Act. There has been a large focus on ending child marriage[44] in line with the Sustainable Development Goals (SDGs)[45] and the Marriages Bill and Child Justice Bill, which state that the age of marriage for both boys and girls is 18.[46] In the 2019 MICS study, one in three women aged 20-24 reported that they married before the legal age of 18 and 5% married before the age of 15. The survey also found that child marriage was more common in rural areas and among women with low educational attainment or who were poor.[47]

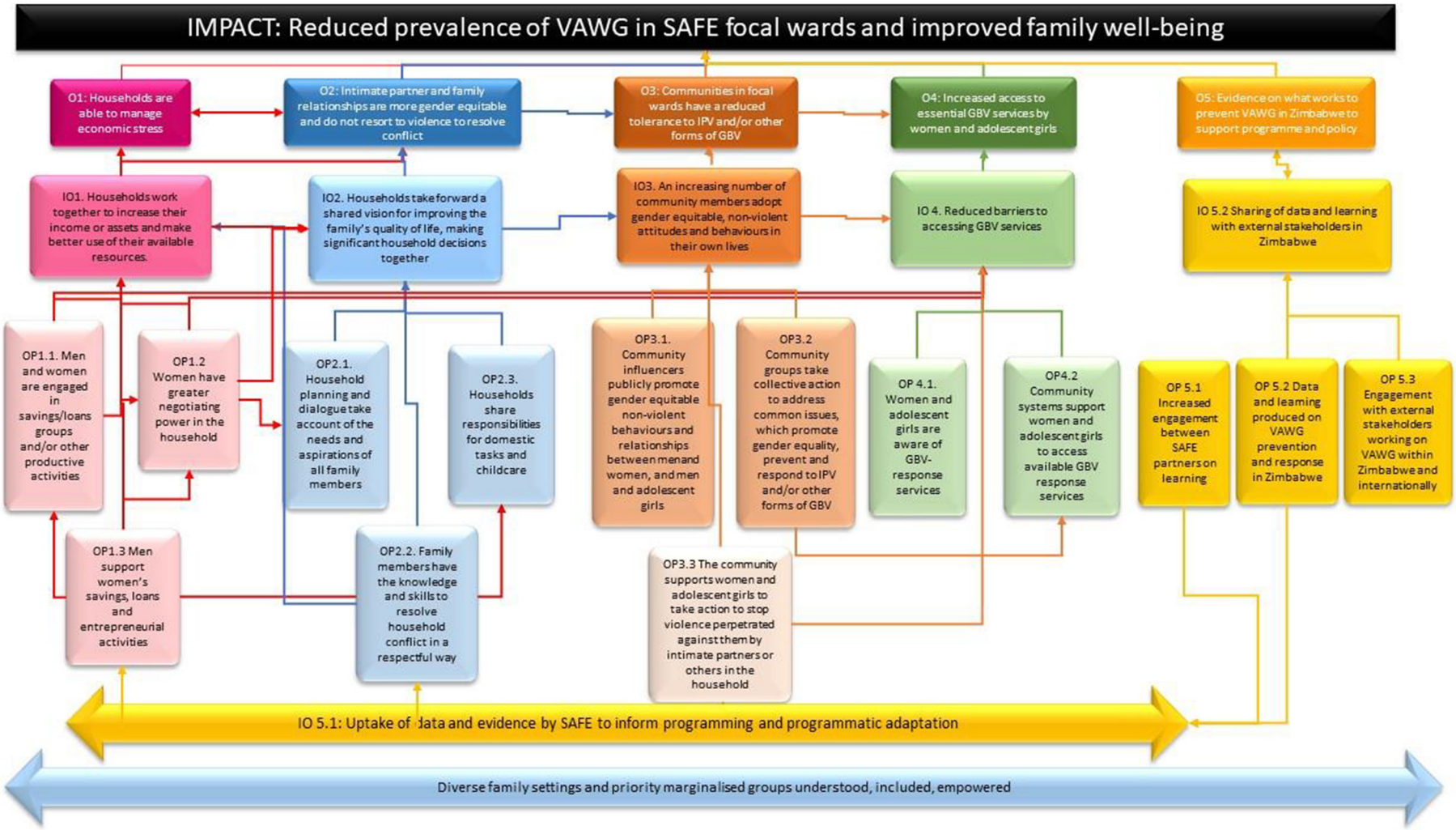
The Government of Zimbabwe acknowledges that GBV and harmful practices are a serious breach of human rights, a major barrier to women's involvement in decision-making, a significant constraint to women's participation in economic and social activities, and a hindrance to the country's development goals. The GoZ has also pledged to eliminate GBV and harmful practices by signing international, continental, and regional instruments on GBV and Gender Equality such as the Convention on the Elimination of All Forms of Discrimination Against Women, the Beijing Platform for Action, the SDGs, and the Southern African Development Community (SADC) Protocol on Gender and Development, 2008 (revised in 2016). In 2021, the Government of Zimbabwe committed itself to ending GBV by officially launching the first ever High-Level Political Compact on Ending Gender Based Violence and Harmful Practices (2021-2030), among others.

Although significant progress has been made towards the reduction and ultimately elimination of GBV and harmful practices, significant challenges remain. These include among others: insufficient implementation of GBV related laws and policies owing to weak accountability mechanisms; human and financial resources capacity constraints among GBV stakeholders and service providers; pervasive patriarchal values, attitudes, and practices; inadequate funding of the GBV national response; weak coordination of the national GBV response; and limited awareness of GBV laws, rights and availability of services leading to poor help-seeking behaviour.[48]

It is within this context that FCDO funded SAFE, a four-year programme to target the worst forms of abuse and exploitation of women and girls in Zimbabwe.

[40] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.
[41] WHO (2012) Understanding and addressing violence against women: Intimate Partner Violence. World Health Organization.
[42] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.
[43] Musasa Project Annual Report, 2019.
[44] For more detailed information on commitments made by Zimbabwe, see https://www.girlsnotbrides.org/child-marriage/zimbabwe/
[45] SDG 5 Gender Equality target 5.3 ending child marriages; S78(1) of the Constitution of Zimbabwe [Chapter 20].
[46] S78(1) of the Constitution of Zimbabwe [Chapter 20].
[47] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.
[48] UNFPA Zimbabwe | Zimbabwe National GBV strategy 2023 to 2030

Annex 2: First version of SAFE Communities programme theory of change

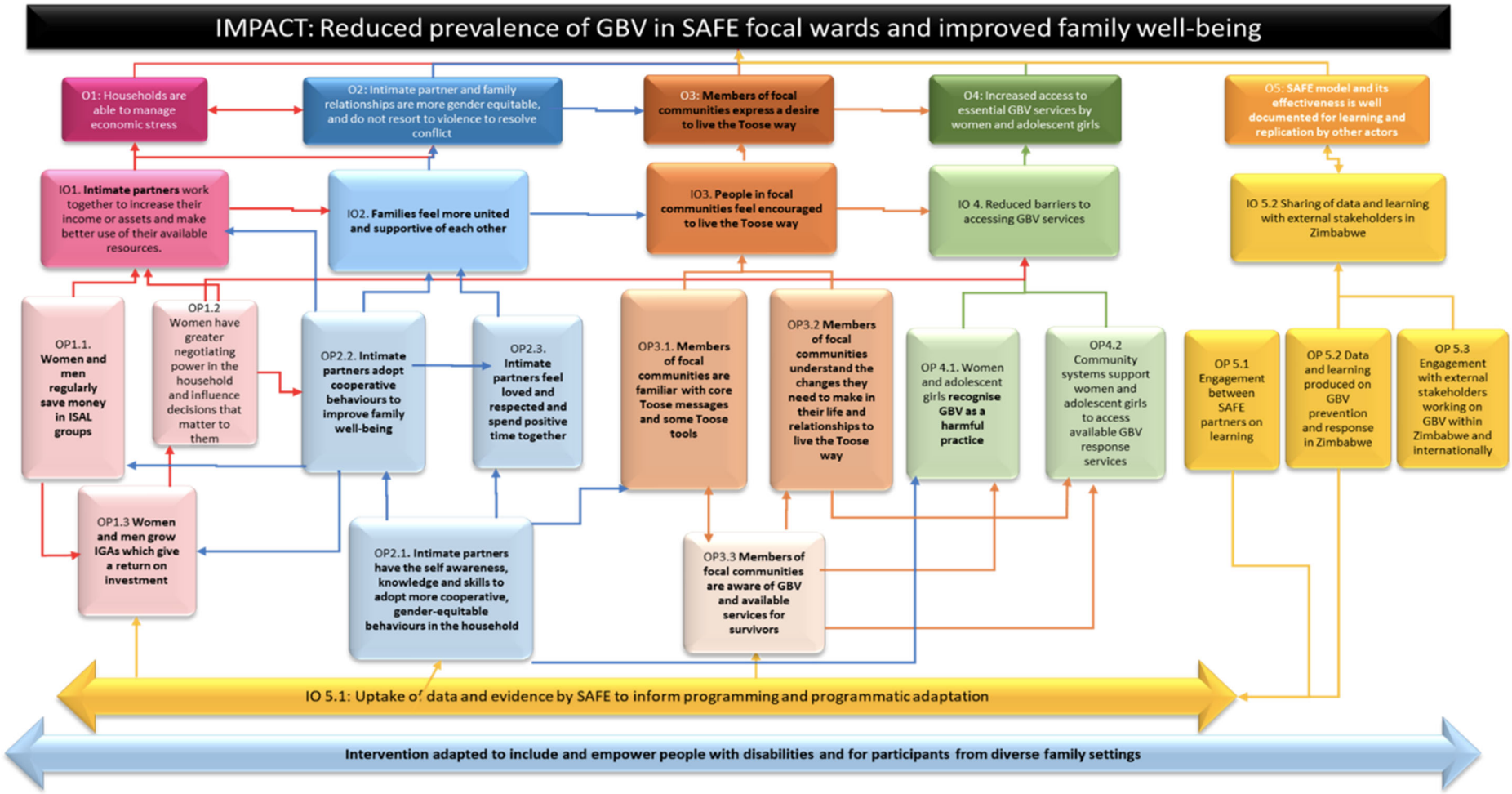


Annex 3: Revised version of SAFE Communities programme theory of change

SAFE Theory of Change: Update April 2023

Experience from Cohorts 1 and 2, as well as evidence generated through SAFE's baseline and subsequent deep dive studies have suggested the need for some adjustments to SAFE's Theory of Change. The proposed changes and how we have addressed them are set out in the table below. In addition to these, revisions to the ToC have tried to reflect a more accurate understanding of how change is happening under Outcome 2, which has emerged through SAFE's qualitative monitoring. Following the table, we present the updated Theory of Change diagram and narrative.

Proposed change to be made	Source of proposed change	Action
Recognise the extent to which we can address stigma against survivors	Baseline	New assumption added under Outcome 4
Recognise the need for a power shift across multiple domains to achieve gender equality	Deep Dive 2	Captured in Outputs 1.2 and 2.2. Is that proportionate and appropriate?
Reflect the importance of family members feeling valued, cared for and respected	Deep Dive 2 Learning and Adaptation Workshop, July 2022	Included in TOC diagram and in causal pathway for Outcome 2
Recognise that current approach to ISALs may not contribute to reduction in household economic stress for more vulnerable, food insecure people	Deep Dive 3	Included in assumptions under Outcome 1
Be more explicit about the need for change at the individual level to catalyse change at the couple level.	Learning and Adaptation workshop, July 2022	Some adjustments made under Outcomes 1 and 2 and their associated causal pathways to draw out emphasis on individuals (women and men/intimate partners) and how these catalyses change as a couple and family
Reflect changes to community level approach, including: • Redefine the overall objective of SAFE's community level work to something more realistic given the available resources. • Focus on diffusion only.	Learning and Adaptation workshop March 2023	Outcome 3 and its causal pathway reformulated with a focus on diffusion by Toose participants/champions.
Ensure the importance of discussion of Toose content outside of Toose sessions is reflected as an essential part of the change process.	Learning and Adaptation workshop, July 2022	This is reflected in Outcome 2 causal pathway.
Revisit ToC assumptions to ensure they are relevant and practically acknowledge contextual risks, in particular related to the potential impact of the cost-of-living crisis on the programme's outcomes	Annual Review 2022	Assumptions updated to reflect key contextual factors e.g., cost of living and forthcoming elections.


IMPACT: Reduced prevalence of GBV in SAFE focal wards and improved family well-being
O1: Households are able to manage economic stress
O2: Intimate partner and family relationships are more gender equitable, and do not resort to violence to resolve conflict
O3: Members of focal communities express a desire to live the Toose way
O4: Increased access to essential GBV services by women and adolescent girls
O5: SAFE model and its effectiveness is well documented for learning and replication by other actors
IO1. Intimate partners work together to increase their income or assets and make better use of their available resources.
IO2. Families feel more united and supportive of each other
IO3. People in focal communities feel encouraged to live the Toose way
IO 4. Reduced barriers to accessing GBV services
IO 5.2 Sharing of data and learning with external stakeholders in Zimbabwe
OP1.1. Women and men regularly save money in ISAL groups
OP1.2 Women have greater negotiating power in the household and influence decisions that matter to them
OP2.2. Intimate partners adopt cooperative behaviours to improve family well-being
OP2.3. Intimate partners feel loved and respected and spend positive time together
OP3.1. Members of focal communities are familiar with core Toose messages and some Toose tools
OP3.2 Members of focal communities understand the changes they need to make in their life and relationships to live the Toose way
OP 4.1. Women and adolescent girls recognise GBV as a harmful practice
OP4.2 Community systems support women and adolescent girls to access available GBV response services
OP 5.1 Engagement between SAFE partners on learning
OP 5.2 Data and learning produced on GBV prevention and response in Zimbabwe
OP 5.3 Engagement with external stakeholders working on GBV within Zimbabwe and internationally
OP1.3 Women and men grow IGAs which give a return on investment
OP2.1. Intimate partners have the self awareness, knowledge and skills to adopt more cooperative, gender-equitable behaviours in the household
OP3.3 Members of focal communities are aware of GBV and available services for survivors
IO 5.1: Uptake of data and evidence by SAFE to inform programming and programmatic adaptation
Intervention adapted to include and empower people with disabilities and for participants from diverse family settings

SAFE's Impact

The expected impact of SAFE is: Reduced prevalence of GBV in SAFE focal wards and improved family well-being.

A reduction in prevalence is in line with the program's focus on prevention, with the programme's work on access to essential services being a secondary focus required as an ethical programming approach. The term prevalence is used in the impact statement given that program targets will be to reduce the proportion of women and girls who report violence.

The emphasis given in GALS+ to improving quality of life suggests that improved economic and emotional well-being for households in targeted communities is a realistic programme impact.

Intended outcomes and their causal pathways

SAFE's theory of change has five intended outcomes. These are presented below, with their associated intermediate outcomes and outputs. For each, we present their pathway of change and the underlying assumptions. We also assess the strength of evidence underlying the pathway.

Outcome 1: Households are able to manage economic stress

This outcome has one intermediate outcome and three outputs:

- Intermediate outcome: Intimate partners work together to increase their income or asset and make better use of their available resources (link to intermediate Outcome 2)
- Output 1.1: Women and men regularly save money in ISAL groups
- Output 1.2: Women have greater negotiating power in the household and influence decisions that matter to them (Link to intermediate Outcome 2)
- Output 1.3: Women and men grow IGAs which give a return on investment

The problem statement for Outcome 1's pathway of change is that insecure livelihoods place households under severe economic stress, leaving them with insufficient food and unable to meet other essential costs like school fees. Economic stress strains intimate partner relationships and leads to conflict over the allocation of household resources, which often results in violence in the household. It also leads to harmful coping strategies, including alcohol abuse by men, pulling children out of school, transactional relationships, and child marriage, many of which either trigger violence or place individuals at greater risk of violence.

The logic for this pathway of change is that:

- **If** women and men are provided with technical support, seed funding and financial literacy training, **and**
- Women and men attend Toose sessions where they are assisted to develop a shared vision to improve their family's wellbeing (Link to Outcome 2), **and**
- Husbands, as well as other men in their family and/or community, support their wives/partners in their savings and entrepreneurial activities, (output 1.3, link to Outcome 2) **and**
- [In Chiredzi], households receive cash transfers to meet their basic needs,
- **Then** women and men will save regularly in an ISAL group **and**
- They will invest loan money into IGAs which give a return on investment, **and**
- They will increase income and assets available to the household, **and**
- Through their IGAs, women will have greater financial independence, **and**
- By contributing to the family income, women will increase their negotiating power within the household (output 1.2) (link to O2) **and**
- Women will influence the household economic decisions that affect them or matter to them (intermediate Outcome 1, link to Outcome 2), **and**
- Households will be able to make better use of the resources they have available to meet their basic needs (intermediate Outcome 1) **and**
- Households will be better able to manage economic stress without resorting to the use of harmful coping strategies and by reducing the strain placed on intimate and family relationships (Outcome 1).

The assumptions underpinning this pathway of change are:

- ISALs can be adapted to be viable for very poor sections of the community

- Women's domestic responsibilities do not prevent them from dedicating time to productive activities & women's participation in ISALs and IGAs do not become an additional burden to childcare and other domestic roles.
- Women and men with disabilities are able to participate in ISAL groups and they can identify viable IGAs which are compatible with their disability/support needs
- Backlash to women's increased economic activity can be successfully managed and does not undermine intervention effects
- The cost of living crisis in Zimbabwe does not undermine the ability or willingness of individuals to engage in ISALs and IGAs or the effectiveness of ISALs in assisting household economic resilience.
- IGAs income will contribute to the reduction of harmful and negative household coping strategies.

There is good evidence to show that improving household economic security, including through cash transfers, can reduce the occurrence of different forms of violence in the household.*49* However, it is possible that, without cash transfers (Chikomba and Mwenezi), ISALs alone may not be sufficient to alleviate economic stresses, especially amongst the poorest. There is also evidence to suggest that men's support for women's entrepreneurial activities needs to be cultivated to avoid backlash.

Outcome 2: Intimate partner and family relationships are more gender equitable, do not seek to control individuals and do not resort to violence to resolve conflict

This outcome has one intermediate outcome and three outputs.

- Intermediate outcome: Families feel more united and supportive of each other
- Output 2.1: Intimate partners have the self-awareness, knowledge and skills to adopt more cooperative, gender-equitable behaviours in the household
- Output 2.2: Intimate partners adopt cooperative behaviours to improve family well-being
- Output 2.3: Intimate partners feel loved and respected and spend positive time together

The problem statement for this pathway of change is that economic and social realities are challenging established gender norms for men and women, resulting in household conflict and violence. Conflict and violence arise when men are no longer able to reliably provide for their families, undermining their ability to fulfil their expected gender roles, as ascribed by prevalent norms. Men feel their established position as head of household is compromised, which leads to frustration, and a tendency to re-assert their power by exerting violence against their partner, in contexts where it is normalised and considered as an acceptable behaviour. Women are left to 'make ends meet', sometimes resorting to transactional relationships to do so, which fuels the frustration of men. This situation also leads women to resent their partner for not conforming with traditional provider male role, which sometimes translates into sarcasm, further frustrating the man[50]. Limited trust and poor communication skills between intimate partners exacerbates the situation. In financially insecure households, adolescent girls sometimes resort to transactional relationships or early marriage as coping strategies.

The logic for this pathway of change is that:

- **If** intimate partners participate in Toose sessions together, **and**
- They reflect on and discuss their Toose learning at home with each other, and other family members, **and**
- They act on their Toose learning with their partner and other family members, **and**
- They are able to access financial resources to meet household expenditure needs (link to output 1.3), **and**
- They feel supported by their communities (link to IO 3)
- **Then** intimate couples will have a deeper understanding and empathy for the aspirations and challenges their partner faces, **and**
- Individuals will modify their own harmful behaviours and be more supportive to his/her partner, **and**
- Intimate partners will adopt more cooperative behaviours to improve family well-being, for example, developing a shared vision to improve family well-being, planning together, taking important household decisions together, sharing responsibility for household chores and childcare (output 2.2), **and**

[49] What Works Evidence Review 2020
[50] SAFE Formative Research, June 2021

- Other family members, especially children will be consulted about, and involved, in efforts to improve family well-being, **and**
- Intimate partners will spend more positive time together (output 2.3) and with their children, **and**
- Intimate couples will feel valued, loved and respected (output 2.3), and
- Intimate couples will have a deeper intimate relationship, **and**
- Families will feel more united and supportive of each other (IO 2), **and**
- There will be fewer conflicts between intimate partners and family members, but where they do occur, they will be resolved through respectful discussion (Outcome 2), **and**
- Families will be more gender equitable.

The assumptions underpinning this pathway of change are:

- Men are willing to engage in Toose facilitated sessions and in using Toose at the household level
- Couples involved in Toose sessions are willing and able to share the Toose tools and learning with other family members and enable their involvement in the change process within the household
- Toose adopts a language that is meaningful and appropriate at the community level and does not provoke negative reaction or backlash.
- Both women and men are willing to step out of their traditional gender roles and give space to their partner to adopt new and different roles
- SAFE is able to adapt the Toose approach to be relevant in households with atypical structures e.g., female-headed households, polygamous households, and to provide more direct support to women with disabilities.
- Contextual factors - COVID pandemic, elections etc - do not undermine the ability of Toose groups to meet
- Not all households are characterised by use of violence to resolve conflict, affecting results that can be achieved

The strength of the evidence for this pathway is good overall, but with some important gaps. There is good evidence that couples' interventions are effective in reducing GBV (What Works Evidence Review, 2020).

Outcome 3: Members of focal communities express a desire to live the Toose way

This outcome has one intermediate outcome and three outputs:

- Intermediate outcome: People in focal communities feel encouraged to live the Toose way
- Output 3.1: Members of focal communities (non Toose participants) are familiar with core Toose messages and some Toose tools
- Output 3.2: Members of focal communities understand the changes they need to make in their life and relationships to live the Toose way
- Output 3.3: Members of focal communities are aware of GBV and available services for survivors

The problem statement for this pathway of change is that social and cultural expectations of men and women, boys, and girls, perpetuate gender inequality and allow intimate partner violence and other forms of GBV, including child marriage, to continue unchecked.

The logic of the pathway of change is that:

- **If** Toose participants/ champions share Toose core messages with people in their social networks, **and**
- Toose champions/ peer facilitators discuss and promote Toose core messages at community meetings, **and**
- Toose participants/ champions role model their new Toose behaviours, **and**
- Toose champions/ peer facilitators familiarize others in the community who have not participated in Toose sessions with key Toose tools, **and**
- District officials and community influencers publicly endorse the Toose way of living in focal communities, **and**
- GCBCs raise awareness of GBV and available services for survivors in focal communities,
- **Then** growing numbers of people in focal communities who have not been involved in Toose sessions will be familiar with core Toose messages, **and**
- Growing numbers of people in focal communities who have not been involved in Toose sessions will understand the changes they need to make in their life and relationships to live in the Toose way, **and**

- Growing numbers of people in focal communities, especially women and adolescent girls, will be aware of GBV and the services available for survivors (link to outputs 4.1 and 4.2), **and**
- A growing number of people in focal communities will feel encouraged to live in the Toose way, **and**
- A growing number of people who have not been involved in Toose sessions will express a desire to live in the Toose way (link to intermediate outcomes 1, 2 and 4).

The assumptions underpinning this pathway of change are:

- Toose core messages can be simplified for onward communication by Toose participants in communities, and an emphasis on IPV retained.
- Toose champions have the confidence and skills to communicate Toose messages at community meetings
- Toose participants and champions will be willing to publicly role model their new behaviours and will not be sanctioned by others for their new behaviours
- Other contextual factors - COVID pandemic, elections etc - do not crowd out the issues Toose focuses on
- Communities do not see the SAFE programme as an interference in their cultural and traditional systems

There is **good** evidence that community-level interventions tackling the norms and beliefs that sustain partner violence work to prevent GBV when they work through multiple entry points, with sufficient intensity over a long period and are supported by well-designed manuals and well-trained community volunteers engaging with both men and women, as well as with opinion influencers/leaders (including religious and traditional leaders and state actors).[51]

Outcome 4: Increased access to essential GBV services by women and adolescent girls

This outcome has one intermediate outcome and two outputs:

- Intermediate Outcome: Reduced barriers to accessing GBV response services
- Output 4.1: Women and adolescent girls recognise GBV as a harmful practice
- Output 4.2: Community systems support women and adolescent girls to access available GBV response services

The problem statement for this pathway of change is that there are strong social and economic barriers, which prevent women and girls from accessing GBV response services. IPV and other forms of violence are seen by many as normal, something which women and adolescent girls should bear in silence. In seeking help, a woman risks losing her husband, and critically his financial support for herself and their children, making it almost impossible to survive. There are practical barriers to accessing services too: women and adolescent girls are often not aware of the available services, and they are often far away, making it difficult to travel to them. The quality of services can be poor, and coordination between services makes referrals patchy.

The logic for this pathway is that:

- **If** women and adolescent girls know about different forms of GBV and available services for survivors (Output 3.3), and
- Women and adolescent girls recognise GBV as a harmful practice which undermines their wellbeing and their family's (Output 4.1), **and**
- Women and adolescent girls perceive available NGO-led GBV services as supportive, **and**
- Family members or friends support women and adolescent girls to access available GBV services (link to Output 3.3), **and**
- GCBCs are well established in the community and known to be a key access point to services for survivors of violence**, and**
- Prevailing family and community attitudes do not force women and adolescent girls to remain silent about the violence they experience (link to Intermediate Outcome 3 and Outcome 3), **and**
- **Then** there will be fewer barriers, which prevent women and girls from accessing the services they need (intermediate outcome 4), **and**
- More women and adolescent girls will seek assistance from available GBV services (Outcome 4).

[51] What Works Evidence Review, 2020

The assumptions underpinning the pathway are:

- Stigma associated with being a survivor of violence and seeking help cannot be fully addressed by SAFE and will persist to some degree, affecting women and adolescent girls' decision-making about accessing services
- A range of essential GBV response services are available in focal districts and are of adequate quality
- SAFE's prevention and response work is well integrated so that one supports the other
- Access to services does not become politicised.

Despite the limited robust evidence of the effectiveness of the approaches proposed in improving women and girls' use of services, it can be reasonably assumed that decreasing barriers to services and encouraging demand will improve service uptake, if activities are implemented with sufficient quality by Musasa. It would be unethical to increase awareness of GBV and encourage women to access services without ensuring that essential services are available and of sufficient quality.

Outcome 5: SAFE model and its effectiveness is well documented for learning and replication by other actors

This outcome has two intermediate outcomes and three outputs:

- Intermediate outcome 5.1: Uptake of data and evidence by SAFE to inform programming and programmatic adaptation
- Intermediate outcome 5.2: Sharing of data and learning with external stakeholders in Zimbabwe
- Output 5.1: Engagement between SAFE partners on learning
- Output 5.2: Data and learning produced on GBV prevention and response in Zimbabwe
- Output 5.3: Engagement with external stakeholders working on GBV within Zimbabwe and internationally.

The problem statement for this pathway of change is that there is limited available evidence on effective approaches to preventing GBV in Zimbabwe. The evidence that is available may not be up-to-date or relevant for the Zimbabwe context or may not be accessible or understood in a way that meets the needs of practitioners, donors and policymakers in Zimbabwe. Evidence is needed of an effective intervention model that can respond to and prevent intimate partner violence and other forms of GBV in Zimbabwe.

The logic for this pathway is that:

- **If** data and learning is generated on drivers of violence against women and girls and pilot interventions are designed to address these (through formative research and a Baseline Study) (Output 5.1), **and**
- Deep dive studies and monitoring data generate timely insights into what is working on the programme and what is not, **and**
- Relevant **external** stakeholders working on GBV in Zimbabwe and internationally also share data and learning on what works to prevent and respond to GBV with SAFE partners (Output 5.3), **and**
- Internal programmatic channels and mechanisms are established to share, understand and unpack this data and learning in an effective way so that it informs programme adaptation (Output 5.1)
- **Then** data can be used by SAFE to inform programming decisions and adapt its pilot interventions to strengthen its intervention model (Intermediate Outcome 5.1) **and**
- The SAFE intervention model will be well tested and documented for sharing with external stakeholders in the GBV community in Zimbabwe and internationally (Intermediate Outcome 5.2), **and**
- External stakeholders will have the opportunity to draw from and potentially replicate SAFE experience in their own efforts to combat GBV in Zimbabwe and internationally (Outcome 5).

The assumptions underpinning this pathway are:

- Stakeholders in Zimbabwe and elsewhere are willing and able to engage with and share learning and evidence with SAFE partners;
- There is an effective coordination mechanism with which to identify and engage external stakeholders in Zimbabwe and internationally through the SAFE programme;
- That coordination and engagement with stakeholders is led and maintained by the FCDO-funded post due to limited resources to do so by SAFE programme partners;
- Data and learning generated through SAFE is relevant, timely and understandable by SAFE programming teams to inform intervention design and adaptation;

- SAFE programme teams and downstream partners have the sufficient capacity, skills and resources to first, make use of the data and learning and second, to implement changes in programme design accordingly;
- SAFE programme teams and downstream partners are not constrained in being able to adapt their programme outputs based on emerging data and learning;
- SAFE's documentation of its model and effectiveness is done in a way that aids external stakeholders to use and replicate the experience;
- Tackling GBV remains a priority internationally with resources to invest in prevention activities continuing to be available.
- All other assumptions and contextual factors underpinning other pathways to change in SAFE's intervention model remain constant.

The strength for this pathway of evidence is **promising**. Evidence from the recent *What Works to Prevent Violence against women and girls Lessons on Research Uptake* (May 2021) suggests that investment and scale up of evidence-based policies and programmes for GBV prevention and response in the Global South is inadequate. It suggests that combining the generation of new knowledge (Output 5.1), stakeholder and donor engagement (output 5.3), and information dissemination and uptake (intermediate outcome 5.1) is needed to produce knowledge and awareness of GBV and how to prevent and respond to it (Outcome 5). It suggests that the existing barriers to achieving this are **knowledge gaps** in the forms of GBV and how to prevent these effectively, that key stakeholders are **limited in their ability and interest** to interpret and use evidence on GBV to make key programming decisions, that there is **low political will and understanding** of GBV prevention, making it difficult to advocate for evidence-based GBV prevention, and **limited funding** allocated to evidence generation for GBV prevention.

Confidentiality assurances and data protection

We have implemented several processes to ensure compliance with our GDPR commitments to the FCDO around the transfer and storing of data. These are mirrored in our consultancy and sub-contractor agreements, which our team have signed up to. All data is stored on our secure drives meeting our stringent requirements around data protection. Audio recordings will be kept in secure storage by our data collection partner in Zimbabwe, Q Partnership.

Further details on this are listed below.

- Data protection – as defined by the Data Protection Act 2018 – involves the secure handling of data and associated data, and the correct level of anonymisation of data sources. In line with this:
- All data will be stored securely in a manner proportionate to the type of participant groups and the volume and the sensitivity of records involved as collation takes place.
- All identifiers (address, telephone and names) will be stored separately and linked by a project key. They will be archived and released for use only for data linkage that has been approved by the participant and relevant ethical bodies (e.g. RCZ), and for re-contact, where permission has been given.
- All identifiers (such as name, date of birth, location) will be removed from all internal analytical products.
- All identifiers and potentially disclosive information (such as unusual combinations of occupation and location) will be removed from external products in a manner proportional to the risk of identification and sensitivity of context; and
- Where vulnerable groups are identified in the population, supervisors will take appropriate steps to ensure that all recording and transmission of information is managed correctly and that any verbatim notes or open-coded information in the relevant records are not transmitted or stored incorrectly – in other words to enforce normal best practice.

With our survey data collection application, COSMOS, data is protected throughout the collection and transfer process, including end-to-end encryption, allowing us to protect sensitive data. The COSMOS software running on survey devices is password-protected. Once survey data has been collected and verified by fieldwork supervisors, it is saved on the device and cannot be modified. Upon network availability, collected data will be automatically uploaded to the secure COSMOS remote database owned and managed by Tetra Tech. For the qualitative data collection, interviews will be audio recorded on password protected audio recording devices and at the end of the day supervisors in the field will upload audio recordings onto our research partner Q Partnership's secure online drive. Once uploaded, the data will be verified by Q Partnership staff in the main office in Harare and backed up on Tetra Tech's secure SharePoint. Once the data has been fully uploaded and backed up, supervisors will be instructed to delete audio files from recording devices.

All notes, audio files, data transcripts and consent forms will be stored in a safe server with access limited to authorised project staff working on the study. Given the longitudinal nature of the study, we will collect contact details for tracking participants. To ensure full anonymity of the survey, the personal characteristics of respondents will be recorded separately on paper, converted into a digital file, and both paper and digital copies will be stored securely by our research partner (in locked cabinets in the case of paper copies, and in password protected files in the case of digital copies). We will separate the contact details from the survey data by using unique IDs for the contact information that will also be used for the survey data uploaded on COSMOS. A separate file mapping the ID to the original identification information will be kept separately in the safe storage site. Transmission between project parties will involve only de-identified data. At the end of the study, all electronic files (and hard copies, where these have been made) will be archived for five years in a secure site. At the end of five years, a decision should be made to destroy the data. If the decision is not to destroy the data, the storage will continue for another five years.

The analysis and interpretation of findings is equally important, and all researchers are ethically obliged to ensure that findings from the research are properly presented and interpreted in the final study report. This means consulting and validating the findings with relevant stakeholders including SAFE Communities, the FCDO and Q Partnership to ensure these are sensitive and appropriate and will not bring about harm to research participants.

Annex 4: Methodology

Mapping of study questions against SAFE Evaluation and Learning questions

Study questions	Corresponding E&L questions ELU
1. To what extent does SAFE improve family wellbeing through reducing household economic stress, improving gender equitability of intimate partner and family relationships, and increasing access to essential GBV services?	• How far has SAFE changed attitudes, practices and underlying norms related to GBV in communities where it operated? • How far has SAFE reduced incidence of GBV? • Who changed – did we reach those women and girls most at risk of violence / the men most strongly supportive of violence?
2. What unintended outcomes (both positive and negative) are evident as a result of the SAFE programme?	• What unintended outcomes (both positive and negative) are evident as a result of the SAFE programme?
3. To what extent does SAFE improve key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?	• How far has SAFE changed attitudes, practices and underlying norms related to GBV in communities where it operated? • How far has SAFE reduced incidence of GBV? • Who changed – did we reach those women and girls most at risk of violence / the men most strongly supportive of violence?
4. To what extent and how far does SAFE reduce prevalence of different types of GBV among SAFE Communities beneficiaries?	• How far has SAFE reduced incidence of GBV? • Who changed – did we reach those women and girls most at risk of violence / the men most strongly supportive of violence?
5. To what extent does SAFE address the prevailing attitudes towards GBV, including GBV response, among SAFE beneficiaries?	• How far has SAFE changed attitudes, practices and underlying norms related to GBV in communities where it operated? • Who changed – did we reach those women and girls most at risk of violence / the men most strongly supportive of violence?
6. Which components and adaptations of the intervention led to change? What change is associated with each activity and adaptation, including Cohort 1? What is the added value of CBT?	• Why did the change occur: what component or element(s) of the intervention caused the change? What else influenced the change? What are the differences across context?
7. To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?	• To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required?
8. To what extent is the change measured sustainable? How sustainable is each activity?	• What issues affect the sustainability of different activities and what needs to change to ensure the programme can continue to be effective and can be replicated or adapted to achieve the overall outcomes and impact? To what extent are the outcomes from the programme likely to be sustainable?

Methods and sample

Survey

The anticipated sample for the endline survey was 1,245 household surveys with women aged 18 years and over in SAFE Communities' implementation wards. We did not sample children and men because these were not sampled at baseline for several reasons:

- **Children**: SAFE beneficiaries enrolled in the intervention are adults. In addition, collecting data with children on sensitive topics related to the experience of violence poses several ethical challenges.

- **Men**: The main focus of the baseline (and endline) study was to measure the impact statement of the ToC (reduction in IPV), and this is best measured through women's reported past 12-month experience of IPV rather than men's reported past 12-month perpetration of IPV. In addition, at the time of baseline data collection, SAFE had recruited women but not yet their male partners (or other male household members) into the intervention. This posed methodological challenges as male partners of female beneficiaries were not all expected to participate in the intervention, limiting the ability of the endline survey to sample male beneficiaries. There were also ethical concerns about sampling men for the survey given the sensitive nature of the survey questions, and the heightened risk of male backlash IPV or other forms of violence against women.

By sampling women only for the endline, the study does not quantitatively measure endline outcomes and impacts for men, limiting a quantitative endline impact assessment only to impacts and outcomes among women. However, these issues have been explored through the qualitative Endline Study, which included women from the baseline and, where relevant, their male partners (MP). The qualitative component of this study also sampled a small number of men in Cohort 1 (male beneficiaries and male partners of female beneficiaries), which helps us understand the intervention's effect on men's lives in Cohort 1. This is further discussed in 'in depth interviews' below.

The survey included questions about:

- **The socio-demographic profile of households**. Characteristics include household income and economic status, access to resources and assets and household food security. In addition, participants were asked about their perceptions of their family's quality of life drawing from the FQOL scale.
- **The socio-demographic profile of individual respondents**, including age, educational attainment, marital and family status, and individual economic characteristics including participation in income generating activities, access to savings and loans and participation in household decision making. This also includes disability status which was measured using the Washington Group on Disability Statistics short set of questions.
- **Individual attitudes** related to gender equality, acceptability of GBV, the justification for and tolerance of GBV and help seeking was measured through attitudinal scales, which include the Gender Equitable Men Scale (GEMS), and the DHS set of questions on justification for physical IPV. Questions related to attitudes about early marriage have also been included in the survey, drawing from recommended global indicators.
- **Help seeking behaviours and access to services** for women who report having experienced GBV in the past 12 months was measured through a number of sources, including items adapted from the World Health Organisation (WHO) multi-country study on women's health and domestic violence, and the Demographic Health Survey (DHS) domestic violence module.
- **Household decision making** was measured through items on women's participation in decision making about important household decisions (i.e., herself, her partner, herself jointly with her partner), derived from the DHS. Additional questions aimed at understanding women's role in negotiating decision making have been derived from the Women's Empowerment in Agriculture Index (WEAI).
- **Gendered household roles and responsibilities** was measured through an adaptation of the IMAGES survey on gendered division of household labour.
- **Additional known risk factors for IPV** beyond those demographic measures identified above for participants, was also measured. These include:
  - Male partner's alcohol use and severity of alcohol use (adjusting the Alcohol Use Disorders Test (AUDIT)).
  - Participation in transactional sex or sex work
  - Self-reported depression or anxiety, drawing from additional items from the long version of the Washington Group disability questions.
- **Past 12-month prevalence of IPV experience** was measured, including severity of IPV. Prevalence of IPV experience was measured by using the corresponding set of questions on physical, sexual, and emotional IPV in the WHO multi-country study on women's health and domestic violence and supplemented with additional questions on economic IPV developed and used in FCDO's What Works to Prevent Violence Against Women and Girls Global Programme. Additional questions were asked to establish whether the IPV occurred in the last month.
- **Communication and conflict resolution** between women and her male partners and/or other household members was measured through a number of items and scales, including the negotiation sub-scale of the Conflict Tactics Scale, and a vignette related to communication in conflict resolution developed from couples' curricula from which SAFE training content was derived.

- **Perceptions of the prevalence of early marriage** in the community and norms and beliefs around early marriage.
- **Level of exposure** to SAFE activities.

Further details about measures, tools and the creation of key variables, and the expected direction of change for these variables, are included in the table below.

Measure	Tool(s) used	Development of variable	Expected direction of change
Demographic variables			
Disability	Washington Group Short Set (WG-SS) with additional affect items from the extended short set.[52]	Coded as disability if respondents says 'a lot of difficulty' or 'cannot do at all' on any of the six items in the WG-SS.53	---
Impact variables			
Any IPV	Emotional, physical and sexual IPV were measured through an adjusted version of the WHO Multi-Country Study on Women's Health and Domestic Violence (WHO MCS).[54] Economic IPV was measured through items adapted from the Multi-Country Cross Sectional Study (MCCS) in Asia and the Pacific.[55]	Binary measure of IPV (yes/no), if respondent reports experience of at least one IPV act once in the past year.	Decrease
Severe IPV 1		Binary measure of severe IPV (yes/no) if respondent reports experience of any act of physical or sexual IPV more than once or two or more different IPV acts at any frequency.[56]	Decrease
Severe IPV 2		Binary measure of severe IPV (yes/no) if respondent reports experience of any of the four acts of severe physical IPV or any sexual IPV act.[57]	Decrease
Number of IPV acts		Continuous measure of number of physical or sexual IPV acts experienced in the past year, on a scale of 0 to 9.	Decrease

[52] The survey measured six functional domains from the short-set vision, hearing, mobility, cognition, self-care, communication) in addition to affect items (depression and anxiety) from the Washington Group Extended Short Set. See WG-ES.
[53] Feeling anxious or depressed is coded separately to the other disability measures.
[54] The WHO MCS was adapted in FCDO's What Works to Prevent Violence Against Women and Girls Global Programme. See for example Gibbs, A., Dunkle, K. & Jewkes, R. (2018) Emotional and economic intimate partner violence as key drivers of depression and suicidal ideation: A cross-sectional study among young women in informal settlements in South Africa. PLOS ONE.
[55] The MCCS was adapted in FCDO's What Works to Prevent Violence Against Women and Girls Global Programme. For the MCSS, see Jewkes, R. et al. (2017) Women's and men's reports of past-year prevalence of intimate partner violence and rape and women's risk factors for intimate partner violence: A multi-country cross-sectional study in Asia and the Pacific. PLOS Medicine.
[56] Dunkle, K. et al. (2020) Effective prevention of intimate partner violence in Rwanda through a couples training: a randomized controlled trial of Indashyikirwa in Rwanda. BMJ Global Health, e002439.
[57] Chatterji, S. et al. (2023) Optimizing the Construction of Outcome Measures for Impact Evaluations of Intimate Partner Violence Prevention Interventions. Journal of Interpersonal Violence, 38(15-16): 9105-9131.

Measure	Tool(s) used	Development of variable	Expected direction of change
Controlling behaviours	Set of questions about intimate partner controlling behaviours from the DHS Domestic Violence Module.[58]	Binary measure of controlling behaviour (yes/no), including at least one instance of controlling behaviour in the past year	Decrease
Household wellbeing	Four sub-scales from an adjusted FQOL scale.[59]	Values for each sub-scale consist of scores on a range of 1 to 5, with 1 indicating strong dissatisfaction and 5 indicating strong satisfaction.	Increase
Outcome variables			
Food insecurity	Household module from the Household Hunger Scale[60]	Values of the three food security questions are summed, with scores on a range of 3 to 12, with higher values indicating higher food insecurity.	Decrease
Justification of physical IPV	Seven items adapted from the five-set from the Demographic and Health Survey, with additional items added in line with similar surveys in the region (e.g. What Works)	Binary variable of any justification of physical IPV if respondent justifies any of the seven items.	Decrease
Gender equitable attitudes	Adapted from GEMS (Gender Equitable Men Scale), with a focus on attitudes related to men and women's role in the household, particularly in relation to financial matters and division of labour	Average score on a scale of 1-4 indicating agreement with gender equitable statements (higher scores=more gender equitable attitudes)	Increase
Joint decision making	Demographic and Health Survey questions about household decision making	Binary variable of sole/joint decision making with partner versus partner or another person makes decisions	Increase
Women's inputs into decision making	Women's Empowerment in Agriculture Index (WEAI)	Scores measuring making personal decisions if she wanted to, and having inputs into decision making	Increase
Use of non-violent conflict resolution	Negotiation subscale of the Conflict Tactics Subscale	Average score on a scale of 1-4 indicating frequency of non-violent conflict resolution behaviours (higher	Increase

[58] Ibid.
[59] The original Beach Center Family Quality of Life Scale (FQOL) has five sub-scales, including a sub-scale related to disability developed to test satisfaction in families with children with disabilities. The disability sub-scale was removed from the SAFE Endline Study given the target population was not families with children with disabilities.
[60] See guidance for the Household Hunger Scale.

Measure	Tool(s) used	Development of variable	Expected direction of change
		scores=more frequent positive behaviours)	

In-depth interviews

We conducted 60 interviews with men and women in Cohort 1 to ensure a comprehensive understanding of the community and household dynamics within the intervention areas and across all intervention cohorts. Because cohorts 1 and 2 have been well represented in our evaluation design (most ELU studies have sampled from Cohort 1 and 2 Toose participants), this qualitative component of the Endline Study primarily focused on Cohort 1 Toose participants and their partners, which our evaluation has generated limited evidence on because of the timing of implementation. We also conducted 14 interviews with GCBC volunteers (one per intervention ward) to better understand the GBV response component of the programme. More specifically, we:

- **Sampled men and women from Cohort 1** who were not sampled for the baseline, enhancing our understanding of the intervention's effects over time. In doing so, we targeted:
  - Twenty women participating in TISALs and their male partners (total: 40); and
  - Ten men participating in TISALs and their female partners (total: 20).
- **Sampled 14 GCBC volunteers** to better understand the GBV response component of the programme, which our evaluation has generated limited evidence on. We randomly sampled 1 GCBC per ward (for more details, see below).

The IDIs add methodological rigor in assessing impact by complementing the quantitative survey and providing a qualitative dataset that helps address gaps in the baseline data regarding men's perspectives and experiences, as well as enhance understanding of the intervention's effects over time by including Cohort 3 participants.

The IDIs with Cohort 1 Toose participants include questions about**:**

- **Participation in different intervention activities**, including TISALs, Toose sessions and community dialogue activities;
- Changes as a result of participation in different intervention activities, including TISALs, Toose sessions and community dialogue activities;
- **Sustainability of different intervention activities**, including TISALs, Toose sessions and community dialogue activities;
- Interaction with GCBCs and GBV response services;
- **Changes in participant's lives** since participating in Toose (positive or negative).

The IDIs with cohort GCBC volunteers include questions about:

- Ways in which GCBCs raised awareness about GBV;
- Impact and sustainability of GCBC activities on the communities GCBCs work in;
- Linkages between the prevention and response components of the programme;

Both the household surveys and IDIs were undertaken by our research partner, Q Partnership, in Zimbabwe.

Sampling approach

Survey

The endline household survey sample reproduced the baseline sample as much as possible. We recontacted each adult woman who participated in the household survey at baseline, using the personal information they shared at baseline. This information was stored securely on paper forms by our research partner Q Partnership, who uses this data to recontact respondents by phone and/or in the field and ask them if they would like to participate in the endline survey. Respondents who did not provide any contact detail information at baseline, or who refused to participate in another survey at the time, were not recontacted.

Baseline sample size calculations were initially based on a maximum attrition rate of 20%. This means that our longitudinal analysis maintains a statistical power of 85% at a 95% confidence level provided that at least 80% or more of baseline respondents were successfully recontacted and completed the endline survey as they did at baseline. The attrition rate was monitored throughout the fieldwork and several attempts were made to recontact baseline respondents. We did not seek to replace or substitute respondents because of the limited value of this for the Endline Study, and because the final attrition levels did not exceed the 20% target, which imply that the recontacted sample is statistically powerful enough to detect small differences in key variable levels between baseline and endline.

Sample details

The baseline sample with adult women beneficiaries was equally split across Cohorts 1 and 2 and equally split across the three districts of intervention. The target and actual number of surveys achieved by cohort, district and ward are shown in the table below. The different number of TISALs sampled across wards within the same district reflects the number of ISALs per ward targeted by the programme that included a sufficient number of women beneficiaries, based on information shared by the programme team at baseline.

	COHORT 1				COHORT 2			
	No. TISALs sampled	Number of surveys per ISAL	Target number of surveys	Actual number of surveys	No. TISALs sampled	Number of surveys per TISAL	Target number of surveys	Actual number of surveys
Chikomba								
Ward 18	4	10	40	40	4	10	40	31
Ward 23	4	10	40	40	4	10	40	48
Ward 27	5	10	50	50	5	10	50	43
Ward 28	5	10	50	54	5	10	50	42
Ward 16	2	10	20	20	2	10	20	44
Mwenezi								
Ward 2	4	10	40	45	4	10	40	43
Ward 3	4	10	40	40	4	10	40	39
Ward 8	3	10	30	30	3	10	30	42
Ward 11	4	10	40	40	4	10	40	42
Ward 12	5	10	50	50	5	10	50	44
Chiredzi								
Ward 3	4	10	40	45	4	10	40	54
Ward 4	5	10	50	50	5	10	50	59
Ward 5	6	10	60	60	6	10	60	52
Ward 8	5	10	50	50	5	10	50	52
TOTAL	60	-	600	610	60	-	600	635
TOTAL across cohorts			Target: 1,245				Achieved: 1,245	

Our intended sampling approach at baseline was meant to follow a two-stage clustered design. First, TISALs (clusters) would have been selected within SAFE wards, based on the lists provided by the SAFE Communities team. Second, female respondents would have been randomly selected within the members of the previously selected TISALs.

Upon receiving the sample lists, we noticed that the total number of SAFE beneficiaries was only nominally larger than our intended sample. As such, we adjusted our sampling approach to include all listed beneficiaries, understanding that refusal or attrition would likely result in us meeting our intended sample. This was a way to avoid

the practical and ethical difficulties of having to exclude only a few TISAL members from the sample, while maximising cluster size (number of respondents per TISAL), hence the statistical power of our survey.

The final achieved sample slightly exceeded the target: 614 completed household surveys were used in our analysis of Cohort 1 data, and 631 surveys were used for Cohort 2, for a total overall sample size of 1,245 surveys.

All beneficiary women identified by the programme were eligible to be included in the household survey sample, whether they were single, part of female-headed households or had a partner (and whether this partner participated in the programme activities or not). The household survey sample was therefore representative of the entire population of SAFE beneficiaries. Similarly, women from marginalised groups or at risk of marginalisation (widows, women with disabilities, survivors of violence, etc.) were included in our sample without being considered subgroups because they did not form analytical units of sufficient size from which to draw any statistically meaningful findings.

In-depth interviews

For the IDIs, we sampled a) men and women participants from Cohort 1; b) their partners, and c) GCBC volunteers.

We sampled both Cohort 1 participants and their partners to understand impact among women and men who participate fully, and their partners, who participate partially, in the programme. Participants are full beneficiaries of the programme as they participate in all components of the prevention intervention (both economic and social empowerment) but their partners only participate in the social empowerment component.

While the majority of TISAL participants are women, SAFE has also piloted a small number of male only TISAL groups to enhance men's engagement with the programme (see the table below for the number of TISAL participants in Cohort 1). We are therefore sampling from both women and men TISAL participants. However, because the programme has recruited more female TISAL participants, we are sampling more women than men (see discussion below).

Cohort 3		
District	Women	Men
Chikomba	42	14
Chiredzi	42	14
Mwenezi	42	14
Subtotal	126	42
Total	168	

Each participant group was sampled using a unique sampling approach. The sample sizes were proportionate but not representative of the population size. For example: we sampled more women than men participants from Cohort 1 because there are more women than men comprising primary beneficiaries. However, the sample size is not exactly matched to the number of women and men participants. Similarly, for the IDIs with GCBC volunteers we sampled one GCBC volunteer per ward, which is not exactly matched to the number of GCBC volunteers per ward. More specifically:

Twenty women who participated in Cohort 3 and their male partners (total: 40) were sampled in two ways:

a) Women were randomly sampled from a TISAL participant list provided by SAFE Communities but those who participated in our Deep Dive 4 process study were excluded. They were contacted and asked to participate in the study. If they agreed, they were asked if they would consent to their male partner also participating in the study. If they disagreed, they were not interviewed and we selected a different female participant.
b) For those women that consented to their partners being invited to the study, we contacted their male partners. If the male partner disagreed, we did interview him and his partner and we selected a new couple. Those who participated in the community study were excluded.

Ten men who participated in Cohort 1 and their female partners (total: 20) were sampled in two ways:

a) Men were randomly sampled from a TISAL participant list provided by SAFE Communities but those who participated in the community study were excluded. They were contacted and asked to participate in the study. If they agreed, they were asked if they consented to their female partner also participating in the study. If they disagreed, they were not interviewed and we selected a different male participant.

b) For those men that consented to their partners being invited to the study, we contacted their female partners. If the female partner disagreed, we did not interview her and her partner and we selected a new couple. Those who participated in the community study were excluded.

14 GCBC volunteers were sampled randomly and targeted from a participant list provided by SAFE Communities. We sampled one GCBC per intervention ward (the programme operates in 14 wards) but we also excluded GCBC volunteers that participated in the ELU Deep Dive 4 study to reduce the risk of overburdening participants and ensure an equal split between male and female GCBC volunteers. The distribution of this split across wards was done randomly.

Tracking approach

In line with its longitudinal approach, the ELU used a comprehensive tracking system at baseline to enable follow up of respondents at endline. At baseline, each respondent was given a unique numerical identifier. During baseline data collection, we recorded full details of participants, including (for each unique numerical identification code): participant's name, address, and phone number. These details were recorded separately to any data collected and only unique identifiers were recorded in surveys and IDIs.

For the endline, we sought to survey the same respondents from the baseline using the information from the tracking system developed during baseline data collection. We worked with the SAFE Communities programme teams to obtain updated participant lists and cross-check the personal information provided by participants during the baseline as some time had passed since. Any inconsistencies were resolved with the interviewees before the interview. Participants whose individual information could not be matched across the baseline tracking system and the updated lists were be included in our endline survey sample.

The SAFE Communities IPs were no longer present in the districts but, following agreements with the SAFE Communities team, they were paid by Tetra Tech to assist in reviewing the sample list for any changes and mobilising participants.

Coding and data analysis

The data collected was systematically analysed, triangulated, and synthesised by the SAFE ELU team, incorporating longitudinal analysis techniques to assess changes and trends over the duration of the study.

The outcomes measured through the endline survey data were compared with those from the baseline survey data (see *Annex 4* for a description of how variables were created). This comparison was made through calculating the difference between endline and baseline variable levels, using paired statistical testing on recontacted women. Different statistical tests were used to check the robustness of results: i) Student's tests of equality of means, ii) Wilcoxon signed-rank test of equality of medians, and iii) McNemar's tests (for binary variables only). P-values lower than 5% were flagged, although absolute differences in levels were also analysed in themselves, especially for sub-samples of smaller size. Statistical tests were run on the overall sample as well as on a variety of subgroups defined by the values and levels of key sociodemographic variables and potential IPV triggers.[61] Tests were also run across categories of key exposure questions to assess the effect of different activities of all dimensions of gender-based violence.[62] Further, exposure questions were tabulated across the key sociodemographic variables listed above to exhibit the respondents' levels of exposure to different SAFE activities according to the subgroups to which they belong.

The qualitative data was coded using Dedoose software, using a team of two data coders. A coding framework was established based on the qualitative tools, and the coders were trained to ensure consistent application of the coding framework. A pilot phase was conducted where all coders coded the same transcripts and raised issues or inconsistencies, which were discussed among the team. The first batch of coding was thoroughly quality assured and any inconsistencies were discussed with the coding team.

[61] These are: Cohort, District, Disability status, Age category, Food insecurity at baseline, Food insecurity at endline, Experience of unexpected loss of income or assets in the past 12 months (at endline), and Partner having worked away from home in the past 12 months (at endline)
[62] These are: Number of TISAL loans taken, having participated in Toose session with partner, having participated in Toose session during the second half of 2023, having participated in Toose session on different forms of power, having participated in Toose session on IPV, having attended Toose community conversation, having worked as peer facilitator, having participated in GCBC (Musasa) session, having been supported by GCBC (Musasa) member, and Having accessed a Musasa service. This list only includes questions that could discriminate between sufficiently large parts of the sample (i.e., when they could be used to create categories of at least 50 respondents each).

Annex 5: SAFE Endline Survey Tool for Women

Section	Q No.	Question	Response options	Code	Logic skips
0. Pre-survey information	Note: survey times, dates, device name and GPS coordinates will be recorded automatically by the data collection software.				
	0.0	Respondent ID	_____		
	0.1	District	Chikomba Chiredzi Mwenezi	1 2 3	
	0.2	Ward Number	_____		
	0.3	Village name	_____		
	0.4	Enumerator name	_____		
	0.5	Supervisor name	_____		
1. Household characteristics		First, I would like to ask you some questions about your household.			
	1.3	Is the head of household male or female?	Male Female Don't know Refusal	1 2 98 99	
Household economy	1.4	Does your household have? (Select all that apply)	Electricity through interconnected grid Electricity off-grid (generator/isolated system) Radio Refrigerator Television Non-mobile telephone Mobile telephone Bicycle Motorbike/scooter Car Truck Computer Animal-drawn cart	1 2 3 4 5 6 7 8 9 10 11 12	

Section	Q No.	Question	Response options	Code	Logic skips
				13	
	1.5	Does your household own any livestock, herds, other farm animals, or poultry?	Yes No	1 2	
	1.6	Does any member of this household own any land that can be used for agriculture?	Yes No	1 2	If 2, go to 1.8
	1.7	Who owns this land?	I own the land My partner owns the land My partner and I own the land jointly Another household member owns the land Another household member and I own the land jointly	1 2 3 4 5	
Household food security	1.12	In the past month (4 weeks), did it happen that there was no food to eat of any kind in your house because of lack of resources to get food?	Never Rarely Sometimes Often	0 1 2 3	
	1.13	In the past month (4 weeks), did it happen that you or any household member went to sleep hungry because there was not enough food?	Never Rarely Sometimes Often	0 1 2 3	
	1.14	In the past month (4 weeks), did it happen that you or any household member went a whole day and night without eating anything at all because there was not enough food?	Never Rarely Sometimes Often	0 1 2 3	
Basic needs	1.15	I would like to ask you about your household's ability to meet its most basic needs, such as securing food, paying for housing, hygiene and medical costs, schooling costs for children, or other things that your household sees as its most essential needs. In the past month (4 weeks), to what extent was your household able to meet its most essential needs?	Able to meet all needs Able to meet most needs Able to meet some needs Able to meet very few or no needs Don't know Refusal	1 2 3 4 98 99	
Response to economic shock	1.16	In the last 12 months, has your household experienced any unexpected loss of income or assets?	Yes No	1 2	If 2, go to 1.18

Section	Q No.	Question	Response options	Code	Logic skips
	1.17	What did the household do to compensate for this loss of income and/or assets? (Select up to five things you did to compensate)	Rely on less preferred, less expensive food Borrowed food, helped by relatives Purchased food on credit Consumed seed stock held for next season Reduced the proportion of the meals Reduced number of meals per day Skipped days without eating Some household members migrated Sold durable household goods Sent children to live with relatives Married girl(s) Removed girl(s) from school Removed boy(s) from school Reduced expenditures on health and education Spent savings Gathering food Sold or consumed livestock Sold agricultural tools, seeds, or other inputs Worked for food only Sold crop before harvest Rented out land Sold land Borrowed money Other	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 97	
	1.18	If your household had an emergency and needed 10 USD, how easy would you say it would be to find the money?	Very difficult Somewhat difficult Fairly easy Very easy	1 2 3 4	
Family wellbeing		Now I would like to ask you some questions about how satisfied you are with certain parts of your family life. Your family may include different people, such as a partner, parents, parents-in-law, children, aunts, uncles, grandparents. We are interested in knowing about those family members who live in your household. Please think about your satisfaction with your family life over the past 12 months. How satisfied are you that:			
	1.19	Your family enjoys spending time together	Very dissatisfied Dissatisfied Neither Satisfied	1 2 3 4	

Section	Q No.	Question	Response options	Code	Logic skips
			Very satisfied Don't know Refusal	5 98 99	
	1.20	Your family has the support it needs to relieve stress	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.21	Your family members have friends or others who provide support	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.22	Your family members help the children with schoolwork and other activities	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.23	Your family members talk openly with each other	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.24	Your family members teach the children how to get along with others	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	1.25	Your family solves problems together	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.26	Your family members support each other to accomplish goals	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.27	Your family members show that they love and care for each other	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.28	Your family has outside help available to take care of special needs of all family members	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.29	Adults in your family teach the children to make good decisions	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.30	Your family gets medical care when needed	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied	1 2 3 4 5	

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	98 99	
	1.31	Your family has a way to take care of expenses	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.32	Your family is able to handle life's ups and downs	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.33	Adults in your family have time to take care of the individual needs of every child	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.34	Your family feels safe at home, work, school, and in the neighbourhood	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
		Overall, how satisfied are you with your family relationships with:			
	1.35	Your husband/partner	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Not applicable (no partner)	1 2 3 4 5	

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	97 98 99	
	1.36	Your children	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.37	Other family members living in your household	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.38	Other family members living outside of your household	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
2. Individual characteristics		I would now like to ask some questions about you.			
	2.1	How old are you? [enumerator instruction: Enter age in years. If the respondent is unable to tell her exact age, ask her if she is closer to 20, 30, 40, 50, 60, 70 or older, and enter the corresponding number.]	_____ years Don't know Refusal	 98 99	
Marriage and relationship status	2.8	Have you ever been married?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99 GO TO 2.11
	2.11	What is your current relationship status?	Single Married	1 2	If 1, 5, 6, 98 or 99 Go to

Section	Q No.	Question	Response options	Code	Logic skips
			Boyfriend (cohabiting) Boyfriend (not cohabiting) Widowed Divorced or Separated Don't know Refusal	3 4 5 6 98 99	2.19 If 3 or 4 Go to 2.16
	2.12	If married, is this a civil, customary or religious marriage?	Civil Customary Religious Other (specify) _____ _____ Don't know Refusal	1 2 3 4 98 99	
	2.13	If married, is this a polygamous marriage?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 2.16
	2.14	How many other wives does your husband have? (Insert number)	_____		
	2.17	Has your partner been working away from home in the past 12 months?	Yes No Don't know Refusal	1 2 98 99	If 1, Go to 2.19
	2.18	For how many months in the past 12 months has your partner worked away from home?	Less than a month 1-3 months 4-6 months 7-9 months 10 -12 months Don't know Refusal	1 2 3 4 5 98 99	
Early marriage	2.1.NEW	Since 2022, how many girls in your household married before the age of 18?	_____ Don't know Refusal	 98 99	
	2.25	What do you think is a good age for a woman or girl to get married for the first time?	_____ years	 98	

Section	Q No.	Question	Response options	Code	Logic skips
		[enumerator instruction: enter age in number of years]	Don't know Refusal	99	
	2.26	Would you ever consider a marriage before the age of 18 for one of your daughters? [Even if they do not have a daughter, ask respondent to imagine if they had one]	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 2.28
	2.27	In which circumstances would you consider marriage for a daughter under the age of 18? [Don't read out and select all that apply]	If she had a boyfriend If she was pregnant If the family/household was having economic problems To collect bride price (lobola) To ensure that she was economically taken care of Other (specify)_____ Don't know Refusal	1 2 3 4 5 6 7 98 99	
	2.28	Do you think your partner would consider marriage for a daughter under the age of 18? [Even if their partner does not have a daughter, ask respondent to imagine if they had one]	Yes No Not applicable (no partner) Don't know Refusal	1 2 97 98 99	If 2, 97, 98 or 99, Go to 2.30
	2.29	In which circumstances do you think your partner would consider marriage for a daughter under the age of 18? [Don't read out and select all that apply]	If she had a boyfriend If she was pregnant If the family/household was having economic problems To collect bride price (lobola) To ensure that she was economically taken care of Other (specify)_____ Don't know Refusal	1 2 3 4 5 6 7 98 99	
	2.30	Approximately how many girls do you think are married before the age of 18 in your community?	None Very few Some Many		

Section	Q No.	Question	Response options	Code	Logic skips
			All Don't know Refusal		
	2.31	In your opinion, has the practice of marrying girls before the age of 18 increased, decreased or stayed the same in your community in the last year?	Increased Decreased Stayed the same Don't know Refusal		
Economic characteristics	2.32	In the last 12 months, have you received any of the following?	Remittances Government allowance (pension, disability benefit) Assistance from charity	1 2 3	
	2.33	Have you participated in any of the following activities over the last 12 months?	No activity Agriculture and sales of crops Livestock and sales of animals Brewing Fishing Unskilled wage labour Skilled labour Handicrafts/artisanal work Use of natural resources (firewood, charcoal, bricks, grass, wild foods, honey, etc.) Petty trading Seller, commercial activity Worked as an employee for salaries, wages Begging Other	0 1 2 3 4 5 6 7 8 9 10 11 12 97	If no activity, Go to 2.37
	2.37	Who usually decides how your earnings will be used?	I decide My partner decides My partner and I decide jointly Another household member decides Another household member and I decide jointly Not applicable (don’t earn money)	1 2 3 4 5 97	If 97, Go to 2.41

Section	Q No.	Question	Response options	Code	Logic skips
	2.38	How much input do you have in making decisions about how your earnings will be used?	No input or input in few decisions Input into some decisions Input into most or all decisions		
	2.39	To what extent do you feel you can make your own decisions regarding how your earnings will be used?	Not at all Small extent Medium extent To a high extent		
	2.40	Would you say that the money that you earn is more than what your partner earns, less than what he earns, or about the same?	More than my partner Less than my partner About the same Partner has no earnings Don't have a partner Don't know	1 2 3 4 5 98	If 5, Go to 2.44
	2.41	Has your partner engaged in any paid work or productive activities over the past 12 months?	Yes No	1 2	If 2, Go to 2.44
	2.42	Who usually decides how your partner's earnings will be used?	I decide My partner decides My partner and I decide jointly Other	1 2 3 97	
	2.43	How much input do you have in making decisions about how your partner's earnings will be used?	No input or input in few decisions Input into some decisions Input into most or all decisions		
	2.44	Who usually makes decisions about making major household purchases?	I decide My partner decides My partner and I decide jointly Another household member decides Another household member and I decide jointly	1 2 3 4 5	
	2.45	How much input do you have in making decisions about major household purchases?	No input or input in few decisions Input into some decisions Input into most or all decisions		
	2.46	To what extent do you feel you can make your own decisions regarding major household purchases?	Not at all Small extent Medium extent To a high extent		
	2.47	Does your household have any savings?	Yes No	1 2	If 2, go to 2.49

Section	Q No.	Question	Response options	Code	Logic skips
	2.48	If yes, where did you put your savings?	In house (in your house or that of a family member/friend) Bank account Credit union ROSCA (Rotating Credit and Savings Association) SACCO (Savings and Credit Cooperative Organization) Other	1 2 3 4 5 97	
	2.49	Who usually makes decisions about how to spend the savings of your household?	I decide My partner decides My partner and I decide jointly Another household member decides Another household member and I decide jointly	1 2 3 4 5	
	2.50	How much input do you have in making decisions about how to spend savings?	No input or input in few decisions Input into some decisions Input into most or all decisions		
	2.51	To what extent do you feel you can make your own decisions regarding how to spend household savings?	Not at all Small extent Medium extent To a high extent		
	2.54	Who made the decision to take this/these loan(s)?	I decided My partner decided My partner and I decided jointly Another household member decided Another household member and I decided jointly	1 2 3 4 5	
	2.55	How much input did you have in making the decision to take this/loan(s)?	No input Some input A lot of input	1 2 3	
	2.56	To what extent do you feel you can make your own decisions regarding taking a loan?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.57	Thinking about the different savings, loans and income generating activities you have engaged in over the last 12 months, how supportive would you say your partner has been of your participation in these activities?	Very supportive Somewhat supportive Somewhat unsupportive Very unsupportive Not applicable, no activities	1 2 3 4 5	If 5, Go to 2.59

Section	Q No.	Question	Response options	Code	Logic skips
			No applicable, no partner Don’t know Refusal	6 98 99	
	2.58	And how supportive would you say other household members have been of your savings, loans and income generating activities over the last 12 months?	Very supportive Somewhat supportive Somewhat unsupportive Very unsupportive Don’t know Refusal	1 2 3 4 98 99	
	2.59	In the past 12 months, how often have you and your household members worked together to come up with a plan to increase household income or assets?	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	If 1, 98 or 99, Go to 2.63
	2.60	Which household members were involved in working together with you to come up with plans? [Don’t read out - select all that apply]	Husband/partner Mother/father Mother/father-in-law Son/daughter Brother/sister Other household members Don't know Refusal	1 2 3 4 5 6 98 99	
	2.61	Were any adolescent girls in the household involved in planning?	Yes No	1 2	
	2.62	Would you say that female or male household members have been more involved in planning, or would you say it has been about the same?	Female members more involved Male members more involved About the same Don't know Refusal	1 2 3 98 99	
	2.63	In the past 12 months, has your household agreed on a shared vision for improving family quality of life?	Yes No	1 2	If 2, Go to 2.68
	2.64	Who in your household was involved in agreeing on this shared vision? [Don’t read out - select all that apply]	Husband/partner Mother/father Mother/father-in-law Son/daughter Brother/sister Other household members Don't know	1 2 3 4 5 6 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	2.65	Were any adolescent girls in the household involved in agreeing on the shared vision?	Yes No	1 2	
	2.66	To what extent do you feel your household has worked towards achieving its shared vision?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.67	Would you say that female or male household members have worked more towards achieving this vision, or would you say it has been about the same?	Female members have worked more Male members have worked more About the same Don't know Refusal	1 2 3 98 99	
Functional difficulties		Now I would like to ask you some questions about difficulties you may have doing certain activities because of a health problem.			
	2.68	Do you have difficulty seeing, even if wearing glasses?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.69	Do you have difficulty hearing, even if using a hearing aid?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.70	Do you have difficulty walking or climbing steps?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.71	Do you have difficulty remembering or concentrating?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	2.72	Do you have difficulty (with self-care such as) washing all over or dressing?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.73	Using your usual language, do you have difficulty communicating, for example understanding or being understood?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.74	How often do you feel worried, nervous or anxious? Would you say it is:	Daily Weekly Monthly A few times a year Never Don't know Refusal	1 2 3 4 5 98 99	
	2.75	How often do you feel depressed? Would you say it is:	Daily Weekly Monthly A few times a year Never Don't know Refusal	1 2 3 4 5 98 99	
3. Gender equitable attitudes and justification/ tolerance for VAWG		In this community and elsewhere, people have different ideas about families and whether there are situations where a man can use violence with his partner. In these questions we would like to learn from you what you think about some of these issues. There are no right or wrong answers, please answer honestly. Your answers will not be shared with anyone you know or used publicly.			
		Sometimes a man does not like the things his wife or partner does. I am going to ask you, in your opinion, if a man is justified in hitting or beating his wife or partner in any of the following situations. Please respond if you strongly agree, agree, disagree or strongly disagree with the statements.			
	3.1	A man is justified in beating his wife/partner if she goes out without telling him	Strongly agree Agree Disagree Strongly disagree Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	3.2	A man is justified in beating his wife/partner if she neglects the children	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.3	A man is justified in beating his wife/partner if she argues with him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.4	A man is justified in beating his wife/partner if she refuses to have sex with him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.5	A man is justified in beating his wife/partner if he is not satisfied with the way she does the housework	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.6	A man is justified in beating his wife/partner if she disobeys him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.7	A man is justified in beating his wife/partner if he finds out that she has been unfaithful	Strongly agree Agree Disagree Strongly disagree Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
		Now I would like to ask your opinion on some statements about what YOU think about relations between men and women. Please respond if you strongly agree, agree, disagree or strongly disagree with the following statements.			
	3.8	Women's most important role is to take care of her home and cook	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.9	I think that a man should have the final say in all family matters	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.10	I think that men should share childcare responsibilities with women.	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.11	I think that if a man works, he should give his money to his wife/partner	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.12	I think that men should share the work around the house with women such as doing dishes, cleaning and cooking.	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.13	I think that if a woman works, she should give her money to her husband/partner	Strongly agree Agree Disagree Strongly disagree Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	3.14	I think that it is a man's role to decide if his wife/partner should work outside the home	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
4. Couple and family dynamics		Now I would like to ask you some questions about you and household work. First, I'd like to ask you about who usually does household tasks – you, your partner or both together.			
Gendered division of household labour	4.1	Washing clothes/laundry	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task Not applicable (no partner) Don't know Refusal	1 2 3 4 5 6 98 99	If 6, go to 4.2. For all other responses, go to 4.3
	4.2	Washing clothes/laundry	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.4
	4.3	Cleaning the house and surroundings	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me	1 2 3 4	Go to 4.5

Section	Q No.	Question	Response options	Code	Logic skips
			My partner always does the task Don't know Refusal	5 98 99	
	4.4	Cleaning the house and surroundings	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.6
	4.5	Cooking for the household	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.7
	4.6	Cooking for the household	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.8
	4.7	Providing daily care of children	I always do the task I usually do the task with some help from my partner Task shared equally or done together	1 2 3 4	Go to 4.9

Section	Q No.	Question	Response options	Code	Logic skips
			My partner usually does the task with some help from me My partner always does the task Don't know Refusal	5 98 99	
	4.8	Providing daily care of children	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	
Managing conflict in relationships		No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things or just fight because they are in a bad mood or for some other reason. Couples also have different ways of settling their differences. I am going to describe a hypothetical scenario of a conflict that might happen within a couple, and I will ask you about the best way to resolve it.			
	4.9	Maida is upset that her husband Tendai earned some money and spent it on alcohol rather than contributing the money to household needs, like food and school costs for the children. I am going to read out some things that Maida might say to Tendai to deal with the conflict, and I would like you to tell me which is the best way.	You are a drunk! You come home and don't bring any money to help our family. Other wives have real husbands who support them! When you make decisions like this, it upsets me because I feel that it hurts our family. Oh well, I suppose we will just have one meal a day now that we don't have enough money for food.	1 2 3	
		Now I am going to read out a list of things that might happen when you have differences with your partner. Please tell me how many times you did each of these things in the past year (12 months), and how many times your partner did them in the past year (never, rarely, sometimes or often).			(If no partner in past 12 months, go to 4.25)

Section	Q No.	Question	Response options	Code	Logic skips
	4.10	I showed my partner I care even though we disagreed	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.11	My partner showed care for me even though we disagreed	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.12	I explained my side of a disagreement to my partner	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.13	My partner explained his side of a disagreement to me	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.14	I showed respect for my partner’s feelings about an issue	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.15	My partner showed respect for my feelings about an issue	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	4.16	I said I was sure we could work out a problem	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.17	My partner said he was sure we could work out a problem	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.18	I suggested a compromise to a disagreement	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.19	My partner suggested a compromise to a disagreement	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.20	I agreed to try a solution to a disagreement my partner suggested	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.21	My partner agreed to try a solution I suggested	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	4.26	In the last 12 months, how valued and respected have you felt by other household members?	Very valued and respected Somewhat valued and respected Somewhat unvalued and un-respected Very unvalued and un-respected Don't know Refusal	1 2 3 4 98 99	
5. Experience of VAWG		The next questions are personal and may be uncomfortable to answer. Women like you may experience violence by strangers or people they know well, such as a romantic partner. I am going to ask some questions about this because we want to learn more about what women experience in their lives. I want you to speak freely and remember that everything you say will be confidential, and you can skip any questions that you don't feel comfortable answering. [Enumerator guidance: Ensure that there is auditory privacy and that there are no other people in the interview location who can overhear the following questions]			
		First, I am going to ask you about common situations faced by women. Think about the last 12 months, and please tell me if these situations apply to your relationship with any current or former husband/ boyfriend/ partner.			
	5.1	He (is/was) jealous or angry if you (talk/talked) to other men?	Yes No Not applicable (no partner in last 12 months) Don't know Refusal	1 2 3 98 99	If 3, go to 5.40
	5.2	He (accuses/accused) you of being unfaithful?	Yes No Don't know Refusal	1 2 98 99	
	5.3	He (does/did) not permit you to meet your female friends?	Yes No Don't know Refusal	1 2 98 99	
	5.4	He (tries/tried) to limit your contact with your family?	Yes No Don't know Refusal	1 2 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.5	He (insists/insisted) on knowing where you (are/were) at all times?	Yes No Don't know Refusal	1 2 98 99	
		In any relationship there are good times and bad times, I now want to ask you about some of the bad times. Can you please tell me if any current or past husband, boyfriend or partner has done any of the following things in the past 12 months?			
	5.6	Insulted you or made you feel bad about yourself?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.8
	5.7	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.8	Belittled or humiliated you in front of other people?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.10
	5.9	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.10	Threatened you by saying they will leave you or divorce you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.12
	5.11	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.12	Threatened to hurt you or someone you care about?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.14
	5.13	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.14	Done things to scare or intimidate you on purpose, for example by the way he looked at you, by yelling and smashing things?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.16
	5.15	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.16	Stopped you from getting a job, going to work, trading or earning money?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.18
	5.17	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.18	Taken your earnings from you when you didn't want him to	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.20

Section	Q No.	Question	Response options	Code	Logic skips
	5.19	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.20	Spent money on things for himself when he knew there was not enough money for food or school fees or other essential household expenses?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.22
	5.21	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.22	Slapped you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.24
	5.23	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.24	Pushed you, shook you or threw something at you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.26
	5.25	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.26	Twisted your arm or pulled your hair?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.28
	5.27	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.28	Punched you with his fist or with something that could hurt you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.30
	5.29	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.30	Kicked you, dragged you or beat you up?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.32
	5.31	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.32	Tried to choke you or burn you on purpose?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.34

Section	Q No.	Question	Response options	Code	Logic skips
	5.33	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.34	Threatened or attacked you with a gun, knife or other weapon?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.36
	5.35	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.36	Forced you physically or with threats to have sexual intercourse with him when you didn't want to?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.38
	5.37	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.38	Forced you physically or with threats to perform any other sexual acts you did not want to do?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.40
	5.39	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
6. Actions taken by VAWG survivors		(Enumerator guidance: The following questions should be asked of any woman disclosing any instance of physical or sexual violence in the last 12 months, whether from a husband/partner/boyfriend or another person in or outside of the family, or any instance of emotional or economic violence from a partner)			(If no experience of violence in past 12 months, go to 7.1)
		You have shared with me that in the past 12 months you have had some experiences of people trying to hurt you or force you to do things you didn't want to do. Now I would like to talk to you about any support you may have received after experiencing these things in the past 12 months.			
	6.1	In the last 12 months, who in your family or community have you talked about the violence you experienced? [DO NOT READ OUT] [Select all that apply]	Nobody Mother Father Sister Brother Other relative Husband / boyfriend / partner Teacher Employer Community chief/leader, or religious leader Friend Neighbour Other person (specify who) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 98 99	
	6.2	In the past 12 months, did you ever go to any of the following services for help? (READ EACH OUT AND SELECT ALL THAT APPLY) Any other services?	Police Court/lawyer/prosecutor Healthcare professional (Doctor, nurse, or other) Social services Legal advice service NGO / women's organisation Shelter Community chief/leader, or religious leader Other (specify) _____ Did not go to any services	1 2 3 4 5 6 7 8 9 10 98	If 10, continue. If 98 or 99, Go to 7.1 For all other responses Go to 6.4

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	99	
	6.3	What are the reasons you did not seek any help? [DO NOT READ OUT] [Select all that apply]	Did not know where to go Afraid of more violence or getting in trouble Embarrassed for self or my family Did not want abuser to get in trouble Too far to travel Afraid of being abandoned or divorced Afraid of being blamed for violence It was my fault that the violence happened Did not think it was a problem Could not afford transport Could not afford service fees Did not need / want services No one could help me / felt it was useless Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 14 98 99	For all – Go to 7.1
	6.4	What were the reasons that made you go to these services for help? [DO NOT READ OUT] [Select all that apply]	Received a referral Encouraged by friends/family Encouraged by other people from the community Could nor endure the violence anymore Was badly injured Was threatened by perpetrator Was thrown out of home Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 98 99	
7. Knowledge of VAWG services		Now I would like to ask you a few questions about services and support for survivors of violence in your community.			

Section	Q No.	Question	Response options	Code	Logic skips
	7.1	Overall, what services do you know of that support women and girls who have experienced violence in your community? By violence, I mean any type of physical or sexual violence from a partner, family member or any other person, or emotional abuse from a partner. Violence may also include forced or early marriage of girls. [DO NOT READ OUT] [Select all that apply]	I don't know any services Counselling services Medical services Legal counsel Traditional/religious services Police services Educational programs Shelter Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 98 99	
	7.2	How confident are you of how to support a woman or girl who has experienced violence?	Very confident Somewhat confident Somewhat unconfident Very unconfident Don’t know Refusal	1 2 3 4 98 99	
	7.3	How likely is it that you would encourage a woman or girl that you know who has experienced violence to seek support from services?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know Refusal	1 2 3 4 98 99	
	7.4	In the past 12 months, have you provided any type of support to a woman or girl who has experienced violence?	Yes No Don’t know Refusal	1 2 98 99	If 2, Go to 7.6
	7.5	What type of support did you provide? [DO NOT READ OUT] [Select all that apply]	Comforted her Spoke with the perpetrator or his family Encouraged her to access services Accompanied her to a service Other (specify) _____ Don’t know Refusal	1 2 3 4 5 98 99	
	7.6	How likely would you be to seek help or support from family or friends if you experienced violence?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	7.7	How likely would you be to seek help or support from services if you experienced violence?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know Refusal	1 2 3 4 98 99	
	7.8	Are there any challenges you feel you would face in accessing services if you experienced violence, and what would these be? [DO NOT READ OUT] [Select all that apply]	No challenges Would not know where to go Would be afraid of more violence or getting in trouble Would be embarrassed for self or my family Would not want abuser to get in trouble Too far to travel Would be afraid of being abandoned or divorced Would break my marriage/relationship Would be worried about the future of my children Would be worried about losing income Would be afraid of being blamed for violence Would not be able to afford transport Would not be able to afford service fees Poor quality of services Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 98 99	
8. Risk behaviours		Next I would like to ask you about sexual relationships with somebody other than your primary partner. No one else will know your answers so please feel free to answer openly and honestly. There are no right or wrong answers.			
Transactional sex and sex work	8.1	In the past 12 months, how often have you had sex with a non-primary partner because he provided you with, or you expected that he would provide you with, food, cosmetics,	Never Rarely Sometimes Often Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
		clothes, transport, cash or other things that you needed?	Refusal	99	
	8.2	And in the past 12 months, have you participated in sex work? By sex work, we mean an activity through which you engage in sex with people with whom you share little to no emotional intimacy, in exchange of money or things of value.	Yes No Don't know Refusal	1 2 98 99	
Alcohol use		I would like to ask you some questions about your use of alcohol. Remember that your answers will remain confidential.			
	8.3	In the past 12 months, how often have you drunk alcohol?	Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times a week Don't know Refusal	1 2 3 4 5 98 99	If 1, 98 or 99, GO TO 8.5
	8.4	How often in the last 12 months have you quarrelled with a husband //boyfriend/ partner about your drinking?	Never Once More than once Not applicable (no partner in last 12 months) Don't know Refusal	1 2 3 4 98 99	If 4, go to 9.1
	8.5	In the past 12 months, how often has your husband / boyfriend / partner drunk alcohol?	Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times a week Don't know Refusal	1 2 3 4 5 98 99	If 1, 98 or 99, GO TO 9.1
	8.6	How often in the last 12 months have you quarrelled with your husband/ boyfriend/ partner about his drinking?	Never Once More than once Don't know Refusal	1 2 3 98 99	If 1, Go to 9.1

Section	Q No.	Question	Response options	Code	Logic skips
	8.7	Why did you quarrel? (Don't read out - select all that apply)	Partner spending money on alcohol Partner became violent when drunk Other (specify) _____ Don't know Refusal	1 2 3 98 99	
9. Intergenerational effects of violence		Now I want to ask some questions about your children and also your experience growing up.			
	9.3	In the last 12 months, how often did your husband/ partner punish your children by smacking or beating them?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	9.4	In the past 12 months, how often did you punish your children by smacking or beating them?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
10. Exposure to interventions		We are about to finish the interview. I just want to ask you some questions about activities that may have been happening in your community recently.			
	10.4	In the last 12 months, have you seen or heard the slogan "Love shouldn't hurt"?	Yes No Don't know Refusal	1 2 98 99	If no, skip next question
	10.5	If yes, where did you see or hear it? [Don't read out and select all that apply]	TV Radio Celebrity songs Celebrity videos Digital/social media Outdoors (billboards, posters, flyers etc) Community dialogues Neighbourhood Watch Other Don't know Refusal	1 2 3 4 5 6 7 8 9 98 99	
	10.1.NEW	Have you ever taken a loan from a TISAL (Toose ISAL)?	Yes No	1 2	If no, skip next three questions

Section	Q No.	Question	Response options	Code	Logic skips
	10.2.NEW	How many loans have you taken since the TISAL (Toose ISAL) started up?	_____ Don't know Refusal	 98 99	
	10.3.NEW	What was the size of the largest loan you have taken?	_____ USD Other currency, please specify amount and currency: _____		
	10.4.NEW	What were the main reasons that you took this/these loan(s)? (Select three maximum)	Food/household expenses Repaying debts School fees Family celebration/ceremony House improvements Medical fees/health Business activities To buy household assets Emergency/economic shock To start or improve an income-generating project To cover funeral costs Other	1 2 3 4 5 6 7 8 9 10 11 97	
	10.5.NEW	How many Toose sessions have you participated in? (Probe: approximate number is fine if respondent cannot recall the exact number of session)	_____ Don't know Refusal	 98 99	
	10.6.NEW	Did you bring any household member with you to the Toose sessions?	Yes No	1 2	If no, skip next question
	10.7.NEW	Which household members did you bring? (Select all that apply)	Partner Mother Father Son Daughter Mother-in-law Father-in-law Brother Sister Uncle Aunt Grandmother	0 1 2 3 4 5 6 7 8 9 10 11	

Section	Q No.	Question	Response options	Code	Logic skips
			Grandfather Co-wife (if in polygamous marriage) Other (specify) _____ Don't know Refusal	12 13 97 98 99	
	10.8.NEW	In the second half of 2023, did you participate in any Toose sessions?	Yes No	1 2	If no, skip next question
	10.9.NEW	What did the sessions cover?	Different forms of power Intimate partner violence Other (specify) _____ Don’t know Refusal	1 2 97 98 99	
	10.10.NEW	Have you attended a Toose community conversation?	Yes No	1 2	If no, skip next question
	10.11.NEW	What did you hear during this community conversation?	Happy families Visioning and planning Power in our relationships Communicating and listening to each other Spending quality time together Happy, healthy, safe relationships Challenge action tree Gender action tree Other (specify) _____ Don’t know Refusal	1 2 3 4 5 6 7 8 97 98 99	
	10.12.NEW	Did you work as a peer facilitator in Toose?	Yes No	1 2	If no, skip next question
	10.13.NEW	Have you facilitated a Toose community conversation?	Yes No	1 2	If no, skip next three questions
	10.14.NEW	What subjects did you cover? (Select all that apply)	Happy families Visioning and planning Power in our relationships Communicating and listening to each other Spending quality time together Happy, healthy, safe relationships Challenge action tree	1 2 3 4 5 6 7	

Section	Q No.	Question	Response options	Code	Logic skips
			Gender action tree Other (specify) _____ Don't know Refusal	8 97 98 99	
	10.15.NEW	What subjects people found most interesting? (Select up to three subjects)	Happy families Visioning and planning Power in our relationships Communicating and listening to each other Spending quality time together Happy, healthy, safe relationships Challenge action tree Gender action tree Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 97 98 99	
	10.16.NEW	Which platforms did you use for community conversations?	Church Community meetings Community garden Health care centre Community well School meetings Personal celebrations (e.g. birthday) Other (please specify) _____	1 2 3 4 5 6 7 97	
	10.17.NEW	Have you participated in any GCBC (GBV Community-Based Club) (Musasa) session in your community?	Yes No Don't know Refusal	1 2 98 99	If no, skip next three questions
	10.18.NEW	What did you hear in that session?	Early marriage Sexual and reproductive health Intimate partner violence How to access help (including referrals) About Musasa Other (specify) _____ Don't know Refusal	1 2 3 4 5 97 98 99	
	10.19.NEW	Have you ever talked to anyone about what you have heard at the GCBC session?	Yes No Don't know	1 2 98	If no, skip next question

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	10.20.NEW	To whom did you talk about what you have heard?	Partner Mother Father Son Daughter Mother-in-law Father-in-law Brother Sister Uncle Aunt Grandmother Grandfather Co-wife (if in polygamous marriage) Other (specify) _____ Don't know Refusal	0 1 2 3 4 5 6 7 8 9 10 11 12 13 97 98 99	
	10.21.NEW	Did a GCBC (GBV Community-Based Club) (Musasa) member ever support you?	Yes No	1 2	If no, skip next two questions
	10.22.NEW	What support did they provide?	Counselling Accompanied me to services Other (please specify)	1 2 97	
	10.23.NEW	How did you feel about the support you received?	Very satisfied Satisfied Unsatisfied Very unsatisfied Don't know Refusal	1 2 3 4 98 99	
	10.24.NEW	Since 2022, have you accessed any of the following Musasa services?	Musasa mobile services Shelters Psychosocial counselling Other (specify) None of them Don’t know Refusal	1 2 3 97 0 98 99	If None of them or Don’t know or Refusal, skip next question

Section	Q No.	Question	Response options	Code	Logic skips
	10.25.NEW	What was the quality of that service?	Very good Somewhat good Somewhat poor Very poor Don't know Refusal	1 2 3 4 98 99	Ask for each type of service selected above
	10.26.NEW	How did you hear about Musasa?	GCBC Toose champion Toose peer facilitator Community leader Government focal person Family member Neighbour or friend Other (specify) _____ Don't know Refusal _____	1 2 3 4 5 6 7 97 98 99	
11. Closing section	11.1	That concludes our questionnaire. Would you give consent for one of our researchers to contact you again in the following weeks to invite you to participate in a follow up interview?	Yes No	1 2	
	11.2	Overall, how comfortable did you feel answering the survey questions today?	Very comfortable Somewhat comfortable Somewhat uncomfortable Very uncomfortable Don't know Refusal	1 2 3 4 98 99	
	11.3	At any point during the interview, were you afraid that someone might hear your answers and hurt you in any way because of what they heard?	Yes No Don't know Refusal	1 2 98 99	
	11.4	Did my asking you any questions about violence make you feel upset because the violence reminded you of a past experience?	Yes No Don't know Refusal	1 2 98 99	
	11.5	Did you find it upsetting or stressful to answer any of these questions?	Yes No Don't know Refusal	1 2 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
		I would like to thank you very much for helping me. I appreciate the time that you have taken. I realise that these questions may have been difficult for you to answer, but it is only by listening to people like you that we can really understand about the issues faced by people in your community. Sometimes the questions I have asked might remind you of times when you, or people you know, have experienced difficulties in life and you may think that you would like to talk to someone about this. This might be now or at any time in the future. I have a list of organisations here that provide various types of services that may be of interest to you. Please contact them if you need help or wish to find out more information about what they offer. You can contact them whenever you would like to. Do you have any questions you would like to ask me?			

Annex 6: SAFE Endline IDI tool for Cohort 1 participants

Topic guide for the study

This guide is for women or men who participated in COHORT 3 of the SAFE (Toose) Programme, including in female-only or male-only TISAL groups

Section	Timings and notes
Introduction and pre-briefing script	
To be read by interviewers to the participant before starting the discussion alongside the consent form. <u>Consent form to be signed prior to starting the interview.</u> Hello, my name is _____ and I work for Q Partnership, on behalf of the SAFE Evaluation and Learning Unit. Thank you for agreeing to be here today. You have been invited to participate in this research because we would like to ask about your experiences with the Toose programme, which has been working with some communities in Zimbabwe to help them improve family wellbeing. We would like to ask you some questions to find out about your experiences participating in Toose, including TISALs, Toose sessions and community activities.	5 minutes
Overview	
1. Firstly, can you tell me how you came to know about Toose and why you enrolled in the programme? • What did you hope to achieve through your participation?	5 minutes
TISALs	
I would like to ask you a few questions about your participation in a TISAL group. **2.** When the TISAL group started, was there any kind of training to support the group? • What was the most useful component of that training? • Can you share an example of something you did with the things that you learned from the training? **3.** Can you tell me about any other forms of support and how useful these were? • (Probe are seed funding or support from Field Agents) **4.** How many loans did you take out from the TISAL? • What was the largest loan you took out? • What did you typically spend loans on? • Did you face any challenges paying back loans? How did you overcome these? **5.** Did you develop any income generating activities or projects as a result of taking out loans? Can you please describe these? • Which projects were most successful and least successful and why? **6.** Did you face any challenges participating in the TISAL? How did you overcome these challenges? • (Probe around economic challenges, mobility challenges, and whether partners or other family members supported participation) **7.** Can you share an example of a positive change that happened in your life as a result of your participation in a TISAL group? • What do you think was responsible for this positive change? **8.** Are there any negative changes that happened in your life because of your participation in a TISAL group? • What do you think was responsible for this negative change? **9.** Is your TISAL group still operating now that Toose field agents are no longer supporting? • (If Yes) What has helped the TISAL to continue operating? • (If No) Why do you think the TISAL stopped operating? **10.** [*Only for respondents in Chiredzi*] Did cash vouchers received from WFP/Plan make any difference in your participation in TISAL groups?	25 minutes

• (Probe around how cash vouchers were used and whether these were directed towards TISALs in any way)	
Toose sessions	
Now I would like to ask you some questions about Toose. **11.** Firstly, can you tell me whether you completed all seven Toose sessions? • If not, what prevented you from attending? **12.** Which family member (or members if more than one) did you invite to participate in Toose with you? • (Probe around whether the same member attended all sessions or if different members attended sessions) **13.** How many sessions did your family member(s) attend? • Was there anything that prevented them from attending? **14.** Which Toose session did you find the most important or useful? Why? **15.** Can you give me an example of a positive change that happened in your life as a result of your participation in Toose sessions? **16.** Are there any negative changes that happened in your life because of your participation in Toose sessions? **17.** Is there anything you learned in Toose that you continue to use in your everyday life? • Is there anything that you used to do because of Toose but that you don't really do anymore?	20 minutes
Community conversations	
I would like to ask you about Toose activities in your community. **18.** Did you attend any Toose activities at the community level, including community conversations? • Where were these activities held? • What were the key Toose messages or tools shared at the activities? • Which community activities do you think have been most successful? Why? **19.** Can you share an example of positive change you have observed in your community as a result of Toose community activities? • What do you think has been most responsible for this change? **20.** Are there any examples of negative change you have observed in your community because of Toose community activities? • What do you think has been most responsible for this change? **21.** Are there any Toose messages that continue to be shared in your community? Which ones?	10 minutes
GCBCs and GBV response	
I would like to ask you about other activities in your community. **22.** What do you know about the work of GCBCs (GBV community-based clubs) in your community? • What has been their main role? • What messages have they shared with community members? • Can you share an example of positive change in your community resulting from the work of GCBCs? • Were there any negative changes resulting from their work? **23.** Did a GCBC member ever help you directly? • (If Yes) Can you describe how they helped you? What was the outcome of this help? **24.** (If respondent mentions accessing Musasa services) Which services, did you access? • Can you tell me about the quality of those services? • How could they be improved?	10 minutes
Overall impact and sustainability	
24. Overall, since Toose started, have you experienced any changes in your life in the following areas? These could be positive or negative. (Where changes are mentioned, probe around what these changes look like) • Your household's economic status • The quality of your relationship with your children	10 minutes

- Women's and men's contribution to planning and decision making in the household
- Women's and men's division of household labour
- The quality of your relationship with your partner
- Conflict and communication in your relationship with your partner

25. To what extent has Toose contributed to the changes you have described?
    - Which elements of Toose were most responsible?
    - Were there any other programmes or people working in your community that also helped these changes to happen? Can you describe these?
26. Thinking of the future, which elements of Toose can you imagine taking forward in your everyday life?

Wrap up and close	
I've asked you a lot of questions and I thank you for your patience. Before I go, is there anything I haven't asked that you think is important for us to know about the topics we have discussed today? Do you have any questions for me? THANK YOU AND CLOSE	5 minutes Wrap up interview, summarise next steps and close

Annex 7: SAFE Endline IDI tool for partners of Cohort 1 participants

Topic guide for the study

This guide is for women or men who are partners of those who participated in TISALs in COHORT 1, 2 or 3 of the SAFE (Toose) Programme. These women and men may have participated in Toose sessions but were not primary beneficiaries of TISALs.

Section	Timings and notes
Introduction and pre-briefing script	
To be read by interviewers to the participant before starting the discussion alongside the consent form. Consent form to be signed prior to starting the interview. Hello, my name is _____ and I work for Q Partnership, on behalf of the SAFE Evaluation and Learning Unit. Thank you for agreeing to be here today. You have been invited to participate in this research because we would like to ask about your experiences with the Toose programme, which has been working with some communities in Zimbabwe to help them improve family wellbeing. We would like to ask you some questions to find out about your experiences participating in Toose, including Toose sessions and community activities. Your partner may also have participated in TISALs and we would like to hear about any observations you have about this.	5 minutes
Overview	
1. Firstly, can you tell me what you know about Toose? **2.** How did you feel when your partner enrolled in the Toose programme? • Did you have any concerns about their participation? • Did you have any hopes about their participation?	5 minutes
TISALs	
I would like to ask you a few questions about your partner's participation in a TISAL group. **3.** How many loans has your partner taken out from the TISAL? • What was the largest loan they took out? • What did they typically spend loans on? • Did they face any challenges paying back loans? How did they overcome these? **4.** Have you engaged at all in household decisions made about how to spend loans taken from your partner's TISAL? • How has this decision making taken place? **5.** Did your partner develop any income generating activities or projects as a result of taking out loans? Can you please describe these? • Have you engaged at all in any of these projects? • Which projects were most successful and least successful and why? **6.** Can you share an example of a positive change that happened in your household as a result of your partner's participation in a TISAL group? • What do you think was responsible for this positive change? **7.** Are there any negative changes that happened in your household because of your partner's participation in a TISAL group? • What do you think was responsible for this negative change? **8.** Is your partner's TISAL group still operating now that Toose field agents are no longer supporting? • (If Yes) What has helped the TISAL to continue operating? • (If No) Why do you think the TISAL stopped operating? **9.** [*Only for respondents in Chiredzi*] Did cash vouchers received from WFP/Plan make any difference in your partner's participation in TISAL groups? • (Probe around how cash vouchers were used and whether these were directed towards TISALs in any way)	25 minutes

Toose sessions	
Now I would like to ask you some questions about Toose. **10.** Firstly, can you tell me whether you participated in Toose sessions with your partner? • Did you attend all the Toose sessions? If not, what prevented you from attending? • Which Toose session did you find the most important or useful? Why? **11.** Can you give me an example of a positive change that happened in your or your family's life as a result of your participation in Toose sessions? (If they didn't participate in Toose, ask about change resulting from Toose in general) **12.** Are there any negative changes that happened in your or your family's life because of your participation in Toose sessions? (If they didn't participate in Toose, ask about change resulting from Toose in general) **13.** Is there anything you learned from Toose that you continue to use in your everyday life? • Is there anything that you used to do because of Toose but that you don't really do anymore?	20 minutes
Community conversations	
I would like to ask you about Toose activities in your community. **14.** Did you attend any Toose activities at the community level, including community conversations? • Where were these activities held? • What were the key Toose messages or tools shared at the activities? • Which community activities do you think have been most successful? Why? **15.** Can you share an example of positive change you have observed in your community as a result of Toose community activities? • What do you think has been most responsible for this change? **16.** Are there any examples of negative change you have observed in your community because of Toose community activities? • What do you think has been most responsible for this change? **17.** Are there any Toose messages that continue to be shared in your community? Which ones?	10 minutes
GCBCs and GBV response	
I would like to ask you about other activities in your community. **18.** What do you know about the work of GCBCs (GBV community-based clubs) in your community? • What has been their main role? • What messages have they shared with community members? • Can you share an example of positive change in your community resulting from the work of GCBCs? • Were there any negative changes resulting from their work? **19.** Did a GCBC member ever help you directly? • (If Yes) Can you describe how they helped you? What was the outcome of this help? **20.** (If respondent mentions accessing Musasa services) Which services, did you access? • Can you tell me about the quality of those services? • How could they be improved?	10 minutes
Overall impact and sustainability	
24. Overall, since Toose started, have you experienced any changes in your life in the following areas? These could be positive or negative. (Where changes are mentioned, probe around what these changes look like) • Your household's economic status • The quality of your relationship with your children • Women's and men's contribution to planning and decision making in the household • Women's and men's division of household labour • The quality of your relationship with your partner	10 minutes

- Conflict and communication in your relationship with your partner

25. To what extent has Toose contributed to the changes you have described?
    - Which elements of Toose were most responsible?
    - Were there any other programmes or people working in your community that also helped these changes to happen? Can you describe these?
26. Thinking of the future, which elements of Toose can you imagine taking forward in your everyday life?

Wrap up and close	
I've asked you a lot of questions and I thank you for your patience. Before I go, is there anything I haven't asked that you think is important for us to know about the topics we have discussed today? Do you have any questions for me? THANK YOU AND CLOSE	5 minutes Wrap up interview, summarise next steps and close

Annex 8: SAFE Endline IDI tool for GCBCs

Topic guide for the study

This guide is for members of GBV community based clubs (GCBCs) engaged in the SAFE programme's GBV response component.

Section	Timings and notes
Introduction and pre-briefing script	
To be read by interviewers to the participant before starting the discussion alongside the consent form. Consent form to be signed prior to starting the interview. Hello, my name is _____ and I work for Q Partnership, on behalf of the SAFE Evaluation and Learning Unit. Thank you for agreeing to be here today. You have been invited to participate in this research because we would like to ask about your experiences with the SAFE (Toose) programme, which has been working with some communities in Zimbabwe to help them improve family wellbeing and respond to gender-based violence. We would like to ask you some questions to find out about your experiences supporting communities to access GBV services and raising awareness about GBV as part of the SAFE programme, and the impact of these activities.	5 minutes
Introduction	
1. Firstly, can we start with you introducing yourself and telling me about your role in a GCBC? • What are the main activities of GCBCs? 2. What kind of training and support did you receive to be a GCBC member? • What was the most useful part of the training? • Can you share a story about a time that you used the knowledge and skills you gained to help somebody in your community?	5 minutes
Impact of activities	
I would like to hear more about how you have helped people to access Musasa services. (remind participant that we don't want to know names or any information that might identify individuals) 3. Which kinds of services did you help people to access? (probe around, counselling, shelters, justice) • What was your role in helping people to access these services? • How did the SAFE programme help you in your role? • Did you face any challenges helping people to access services? 4. Can you tell me more about the support the GCBC provided for adolescent girls to access services? • Which kinds of problems did adolescent girls need help with? • How did you respond to these problems? 5. Can you share with me a story or example that illustrates the most significant positive change that has happened as a result of community members' access to Musasa services? 6. Now can you share with me a story or example that illustrates change that might not be that positive? I would like to hear more about the awareness raising activities you have conducted in your community. 7. Can you share some examples with me of how the GCBC raised awareness about GBV in your community? • Which types of GBV did you share information about? • What did awareness raising activities look like? (Probe around formal meetings, informal engagements)	25 minutes

• Which messages did you share? (Probe around whether any messages were related to Toose) 8. I would like to hear more about awareness raising on early marriage. What were some of the main messages you shared about early marriage? • Can you share any examples of how awareness raising on early marriage changed the lives of adolescent girls? 9. Can you share with me a story or example that illustrates the most significant positive change that has happened as a result of GCBC's awareness raising activities? 10. Now can you share with me a story or example that illustrates change that might not be that positive?	
Linkages between prevention and response	
I am aware that there were other parts of the programme, including Toose activities such as TISALs and Toose sessions. 11. To what extent did the GCBC collaborate with people supporting Toose? This could be the NGOs supporting Toose, or people in your community (e.g., Toose Champions, Peer Facilitators, TISAL field agents, TISAL members)? • What was the nature of the collaboration? • Can you share any positive things that emerged from the collaboration? • Were there any challenges with the collaboration? 12. Did the GCBC interact in any way with GBV survivors participating in TISALs? • Did GCBCs play any role in supporting survivors to access TISALs? • Did you observe any positive impacts of survivors' participation in TISALs? • Did you observe any negative impacts of survivors' participation in TISALs?	10 minutes
Sustainability	
13. We are aware that SAFE's community activities ended some time ago. To what extent has your GCBC continued its activities in the community? • Can you share some examples of things that the GCBC has continued to do? • Are there things that the GCBC is no longer doing? Why? 14. What are the factors that have allowed GCBCs to continue? 15. What are the factors that have made the continuity of GCBCs challenging? 16. Other than funding, what more could be done to support GCBCs to continue operating?	10 minutes
Wrap up	
I've asked you a lot of questions and I thank you for your patience. Before I go, is there anything I haven't asked that you think is important for us to know about the topics we have discussed today? Do you have any questions for me? THANK YOU AND CLOSE	5 minutes

Annex 9: RAG rating of key measures according to sample characteristics and exposure

Key measures are illustrated through a red, amber, green (RAG) rating as depicted below.

Significant change in wanted direction (p=<0.05)	Insignificant change in wanted direction (p=0.06–0.1)	No change (p>0.1)	Insignificant change in unwanted direction (p=0.06–0.1)	Significant change in unwanted direction (p=<0.05)

Measure	All	Cohort		District			Endline food security			Toose with partner		Toose session on power		Cohort 3 IPV session	
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi	High	Med	Low	No	Yes	No	Yes	No	Yes
Impact															
Past year prevalence IPV (binary)															
Emotional IPV															
Economic IPV															
Physical IPV															
Sexual IPV															
Severe IPV 1															
Severe IPV 2															
Number of acts of IPV															
Controlling behaviours															
Corporal punishment against children (women)															
Corporal punishment against children (men)															
Perceptions of reduction of early marriage															
Family wellbeing / quality of life															
Outcome Pathway 1 - Ability to manage economic stress															
Household food security															
Household ability to meet essential needs															
Household joint economic planning															
Outcome Pathway 2 - Gender equitable, cooperative and non-violent relationships															
Knowledge of positive conflict resolution methods															

Measure	All	Cohort		District			Endline food security			Toose with partner		Toose session on power		Cohort 3 IPV session	
		Cohort 1	Cohort 2	Chiredzi	Chikomba	Mwenezi	High	Med	Low	No	Yes	No	Yes	No	Yes
Peaceful conflict resolution practices with partner															
Partner's peaceful conflict resolution practices with women															
Agreement on shared family vision for wellbeing															
Worked towards achieving this vision for wellbeing															
Women's sole or joint decision making															
Women's agency in decision making															
Men contributing more to household labour															
Outcome 3 pathway - reduced tolerance to GBV															
Justification for physical IPV															
Attitudes related to early marriage															
Gender equitable attitudes															
Outcome 4 pathway - access to essential GBV services and help seeking															
Knowledge of any GBV services (all women)															
Help-seeking (survivors)															
Access to services (survivors)															
Accessibility/travel barriers (survivors)															
Cost/affordability barriers (survivors)															
Normative barriers - didn't think it was problem (survivors)															
Normative barriers - afraid of divorce (survivors)															
Perceptions of challenges to access to services (all women)															
Perceptions of accessibility/ travel barriers (all women)															
Perceptions of cost/affordability barriers (all women)															
Perceptions of normative barriers - afraid of divorce (all women)															