IMPLEMENTATION OF NATIONAL GBV POLICY IN KARONGI, NYAMASHEKE, RUSIZI AND RUTSIRO DISTRICTS

A study Report

Kigali, 02 August 2017

Disclaimer

This publication was prepared by Pro-Femme/Twese Hamwe. The research study was supported by the Ikiraro Cy'Iterambere Programme, funded by the UK government, SIDA, USAID and SDC. The Programme is managed by Palladium Rwanda LTD. The views expressed in this publication do not necessarily reflect the views of the Ikiraro Cy'Iterambere Programme, Palladium Rwanda LTD or the donors.

Table of Contents

List of Tables

List of Figures

LIST OF ACCRONYMS

CEDAW	Convention for the Elimination of Discrimination Against Women
CHW	Community Health Workers
CSOs	Civil Society Organizations
FGDs	Focus Group Discussions
GBV	Gender Based violence
GMO	Gender Monitoring Office
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICGLR	International Conference on the Great Lakes Region
JADF	Joint Action Development Forum
MAJ	Maison d'Accès à la Justice
MIGEPROF	Ministry of Gender and family Promotion
MINALOC	Ministry of Local Administration
MINEDUC	Ministry of Education
MINIJUST	Ministry of Justice
MoH	Ministry of Health
NCC	National Children Commission
NPPA	National Public Prosecution Authority
NWC	National Women Council
PFTH	Pro-Femmes/Twese Hamwe
RDF	Rwanda Defense Forces
RNP	Rwanda National Police
SSR	Security Sector Reform
ToR	Terms of Reference
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	Fonds de développement des Nations Unies pour la Femmes
UNSCR	United Nations Security Council Resolution

ABSTRACT

The overall goal of this study was to examine the status of implementation of the national GBV Policy with a particular focus on the identification of the major implementation gaps. The study used both quantitative and qualitative approaches and covered four districts of the western province, namely Karongi, Nyamasheke, Rusizi and Rutsiro. The main methods of data collection were desk review, survey questionnaire to which **312** people responded, **35** interviews with key informants and **8** focus group discussions to which **93** people from various categories of the Rwandan population participated in total.

The broad key finding is that the national GBV Policy is satisfactorily being implemented. The policy sets an operational framework that enables various actors to intervene against GBV. Noticeable efforts are related to prevention of, response to cases of GBV and coordination and monitoring of various GBV interventions. The study shows however that some gaps and challenges pertaining to the implementation of the national GBV Policy are persistent and that the impact of various interventions are yet to materialize in some areas as specifically summarized below.

- Activities that aim at raising awareness of the population on GBV and corresponding instruments are implemented at the community level by actors from various sectors, including community structures, the police, health sector, justice and non-government actors in the four districts. Despite coordination efforts at the district level through JADF, the study suggests imbalance between districts in terms of coverage by anti-GBV interventions at the expense of Rutsiro;
- Community meetings, media (radio particularly), the health sector and police are the most important sources of information about GBV and GBV instruments;
- Overall, awareness about the national GBV Policy is very high (93.2%), but there is statistically significant difference by sex in

favor of men due to sociological and cultural reasons. Indeed division of labor penalizes women while offering men with more chance to have access to various social networks;

- If awareness is high, knowledge about GBV is mixed. The study findings shows that no single respondent (quantitative survey) mentioned economic violence among the forms of GBV. The same was observed with reference to the referral process in case of GBV many respondents having just a general idea about what to do and where to go in case of GBV;
- The study noticed remarkable progress in relation to the implementation of the national GBV Policy provisions with regard to protection of victims of GBV, medical services and justice. Illustratively, there is a GBV desk in each police station, a comprehensive service package is provided to victims of GBV by the Isange One Stop Centers free of charge and under the same roof and the judicial system has introduced significant reforms, including a special GBV unit within the NPPA and measures to consider GBV part of the priority cases. The MAJ significantly contributes to access to justice among the victims of GBV through orientation and legal conclusions;
- However, despite this progress, there are still serious gaps and challenges that affect effective implementation of the national GBV Policy. For instance, only few health facilities have a staff specifically in charge of GBV (17%) contrarily to the provisions of the national GBV Policy. The majority of the Isange One Stop Centers themselves face issues of limited resources that affect the quality of services and health centers are not well equipped. In addition, there are few staff with appropriate skills to respond effectively to cases of GBV. Due to limited resources, follow up of victims of GBV by health structures after they are back to their respective communities is not done due to limited resources;
- Judges and other judicial service providers with specific training in GBV are only few and there is no comprehensive permanent

plan for capacity building of the personnel within the judicial system as provided for by the national GBV Policy;

- Due to lack of popular education on GBV evidence preservation and insufficiently equipped laboratories in the four districts, proof to support access to justice for victims of GBV is still a serious obstacle that affects access to justice for victims of GBV, but also deterrence of this violence;
- Community reporting of GBV cases is still low due mainly to cultural traditions and beliefs. The capacity of the four districts to collect quality GBV data, treatment and reporting is low as well;
- The role of community structures and members in the process of reintegration of GBV victims is yet to be defined.

In relation to gaps in the implementation of the national GBV Policy, the following recommendations are formulated.

TO MIGEPROF

- Develop a program for families' active engagement in GBV prevention and response efforts;
- Avail the GBV training manual to all the schools in Kinyarwanda, French and English;
- Train teachers and school managers on gender equality and GBV;
- Develop and avail guidelines for the local level leaders and communities on their role in the process of reintegration of GBV victims;
- Develop strategies to increase men engage in community structures on GBV such as *Umugoroba w'ababyeyi.*

TO MINALOC

- Ensure interventions against GBV, particularly by non-state actors are fairly distributed between districts with special focus to remote districts;
- Sensitize community members to play an active role in the reintegration of victims of GBV;
- Avail capacity building opportunities at local level (closer to the communities) in order to increase women's attendance and participation;

TO MINEDUC

- Establish anti-GBV clubs in all educational structures, particularly primary and secondary schools;

TO MINISTRY OF HEALTH

- Improve health technical equipment for quality evidence on GBV cases;
- Train GBV focal persons at health centres on how to handle GBV cases;
- Decentralize the Isange One stop Center to closer health facilities to ease accessibility by the victims of GBV;
- Organize follow up visits to victims of GBV after they are back to their respective homes for a more successful reintegration.

TO THE JUDICIARY AND MINIJUST

- Develop a comprehensive and permanent plan for capacity building of judicial service providers, including investigators, prosecutors, judges and lawyers;
- Train specialized judicial service providers on GBV, related GBV law and related topics;
- Educate the public on the preservation of evidence of GBV.

TO THE DISTRICTS OF KARONGI, NYAMASHEKE, RUSIZI AND RUTSIRO

- Establish and strengthen community structures where they are not and ensure men's involvement in activities of prevention of and response to cases of GBV;
- Sensitize the population to join anti-GBV structures and play active role for prevention and reporting of cases of GBV;
- Strength the M&E activities to monitor the functioning of *Umugoroba y'Ababyeyi* and other community initiatives that help to foster a conducive environment for prevention and reporting of GBV cases;
- Engender District Development Plans by including activities pertaining to gender equality, the prevention and response to GBV and budget;

- Train in charge of M&E on GBV data collection, analysis and reporting;

TO FAMILIES

- Insert in family performance contracts "*Imihigo*" activities pertaining to the prevention of and fight against GBV;

TO CIVIL SOCIETY ORGANIZATIONS

- Train selected community leaders from the four districts on GBV law, policy, other relevant instruments, GBV reporting mechanism and the referral process;
- Advocate for the increase of district budget allocated to anti-GBV activities;
- In collaboration with the justice sector, conduct community-based campaigns on preservation of evidence of GBV in the four districts;
- Monitor on regular basis the functionality and of the established anti-GBV community structures.

AREAS FOR FURTHER RESEARCH

- GBV status among People With Disabilities and other marginalized groups;
- The role of Faith Based Organizations in the prevention and fight against GBV;
- Examine barriers to family participation in GBV prevention and response efforts.

Chap. I: GENERAL INTRODUCTION

11. Introduction

The Government of Rwanda has achieved a lot in terms of prevention and response to cases of Gender Based Violence (GBV) as evidenced by the policy and legislative environments of the country. In addition to laws and policies, the country has established an institutional framework for the implementation of relevant legal and policy provisions. However, translation into effect of these policies and laws into effects has remained less documented, leaving knowledge gaps on the policy implementation, the challenges in place and advocacy strategies that need to be put in place. This study particularly focuses on examining the status of implementation of the National Policy against Gender Based Violence (GBV policy) adopted in 2011.

1.2 Study objectives

From the Terms of Reference (ToR), this study aims at providing Pro-Femmes/Twese Hamwe (PFTH) with evidence-based information on the GBV Policy, as well as other related policies and legal instruments implementation gaps in Rwanda.

More specifically, the study aims at:

- ✓ Documenting and analyzing the current status of implementation of the GBV policy and related laws in four selected districts, namely Karongi, Nyamasheke, Rusizi and Rutsiro;
- ✓ Identifying the key gaps and challenges in relation to proper implementation of the GBV policy and laws in the selected districts;
- ✓ Identify and highlight key advocacy issues for a better implementation of GBV policy and relevant laws in the four districts and elsewhere;
- ✓ Formulate recommendations to relevant partners and stakeholders on what to do for a better implementation of GBV policy and related laws

1.3 The concept of Gender Based Violence

The term "Gender-Based Violence" has gained momentum over the last four to five decades. It refers to violence that targets individuals or groups on the basis of their gender. The United Nations' Office of the High Commissioner for Human Rights' Committee on the Elimination of Discrimination against Women (CEDAW) defines Gender Based Violence as "violence that is directed against a woman because she is a woman or that affects women disproportionately".[1] This includes acts that inflict physical, mental or sexual harm or suffering, the threat of such acts, coercion and other deprivations of liberty. Together with "sexual violence" and "violence against women", "gender-based violence" is used interchangeably.

This does not mean that all acts against a woman are gender-based violence, or that all victims of gender-based violence are female. The surrounding circumstances where men are victim of sexual violence could be a man being harassed, beaten or killed because they do not conform to views of masculinity that are accepted by society. Violence against women is defined by the UN Declaration on the Elimination of Violence against Women, adopted by the General Assembly on 20 December 1993, as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". It is a form of gender-based violence and includes sexual violence.

The Declaration states in its introduction that "…Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men". **Sexual violence** includes sexual exploitation and sexual abuse.

[1] http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm, Accessed May 05, 2017.

It refers to any act, attempt, or threat of a sexual nature that result, or is likely to result in, physical, psychological and emotional harm. Sexual violence is a form of gender-based violence.

Gender based violence occurs in both the 'public' and 'private' spheres. Such violence not only occurs in the family and in the general community, but is sometimes also perpetuated by the state through policies or the actions of agents of the state such as the police, military or immigration authorities. Gender-based violence happens in all societies, across all social classes, with women particularly at risk from men they know.

Table 1.1: Summary description of different types of GBV

Type of GBV	Description	Sites of GBV (spaces of socialization to gender inequality)
Physical	Overt physical abuse (includes battering, sexual assault, at home or in the workplace)	**Family**: ▪ Is one of the primary sites of gender violence.; ▪ Prepares its members for social life, forms gender stereotypes and perceptions of division of labor between the sexes; ▪ Is the arena where physical abuses (spousal battering, sexual assault, sexual abuse) and/or psychological abuses occur (Domestic violence can also take such forms as confinement, forced marriage of woman arranged by her family without her consent, threats, insults and neglect; overt control of a woman's sexuality through either forced pregnancy or forced abortion); ▪ Because violence within the family and household takes place in the home, it is often seen as a 'private' issue and information about it is lacking. **Community/society** ▪ As a group sharing common social, cultural, religious or ethnic belonging, it perpetuates existing family structure and power inequalities in family and society;
Psychological	Psychological abuse (includes deprivation of liberty, forced marriage, sexual harassment, at home or in the workplace)	
Economic	Deprivation of resources needed for physical and psychological well-being (including health care, nutrition, education, means of livelihood)	
Sexual	Treatment of women as commodities to achieve sexual	

	pleasure (includes trafficking in women and girls for sexual exploitation)	▪ Justifies the behavior of male abusers aimed at establishing control over women in the family, and supports harmful traditional practices such as battering and corporal punishment; ▪ Workplace can also be a site of violence. Either in governmental service or in a business company, women are vulnerable to sexual aggression (harassment, intimidation) and commercialized violence (trafficking for sexual exploitation). **State** ▪ Legitimizes power inequalities in family and society and perpetuates gender- based violence through enactment of discriminatory laws and policies or through the discriminatory application of the law. ▪ Is responsible for tolerance of gender violence on an unofficial level (i.e. in the family and in the community); ▪ To the extent that it is the State's recognized role to sanction certain norms that protect individual life and dignity and maintain collective peace, it is the State's obligation to develop and implement measures that redress gender violence.

Chap.II:MAJOR ACHIEVEMENTS IN RELATION TO THE FIGHT AGAINST GBV IN RWANDA

The chapter highlights Rwanda's key achievements in relation to GBV in the key areas, namely: prevention of GBV, response to GBV and support to victims of GBV.

2.1 GBV Policy overview

In 2011, the government of Rwanda adopted the GBV policy with the vision of building a Rwandan society that is GBV-free and, in the interim, to have a Rwandan society that can effectively and efficiently prevent and respond to GBV. The overall objective of the policy is to progressively eliminate gender-based violence through the development of a preventive, protective, supportive and transformative environment. From the objective above, the policy covers three strategic areas, namely: (1) prevention of GBV, (2) response to GBV and (3) coordination, monitoring, and evidence on GBV.

2.2 Achievements in the area of GBV Prevention

Rwanda has made tremendous progress in terms of prevention of GBV. Prevention efforts are evidenced by an impressive legal, policy and institutional environment summarized in the table below.

Table 2- 1: Key prevention policy and law progress

No	Law	Indicative changes/ambitions related to gender equality/SGBV
1.	The Constitution of the Republic of Rwanda of 2003 revised in 2015.	Equal right between women and men; women granted at least 30 percent of the posts in decision-making organs (art.10); 24 of the 80 seats in the Chamber of Deputies (the legislature) are reserved seats for women (art. 75); only civil monogamous marriages recognized...
2.	Law Nº32/2016 of 28/08/2016 governing persons and family	• Equality in property and inheritance rights between men and women,

	Law Nº27/2016 of 08/07/2016 governing matrimonial regimes donations and successions	boys and girls… …(art. 54 of succession law) See art 218 of family law
3.	Law N°54/2011 of 14/12/2011 relating to the rights and the protection of the Child.	Woman's right to grant her nationality to her child, even if the child's father is not of Rwandan nationality; protection of girls from forced and early marriage
4.	Law N° 43/2013 of 16/06/2013 governing land in Rwanda	Equal land right between men and women; boys and girls.
5.	Law No 59/2008 of 10th September 2008, on the Prevention and Punishment of Gender-Based Violence	Provides for the protection and relief of victims of violence; remedies for the punishment of perpetrators of domestic violence; procedures and guidelines to be followed by courts in relation to punishment, protection and compensation of victims of violence. Also provides for several women friendly measures brought up by the law, clear definition and expansion of the notion of rape…
6.	Law No 13/2009 of 27th May 2009, Regulating Labor in Rwanda	Protects workers against SGBV; protection against discrimination in the workplace based on sex and marital status; outlines maternity leave duration, breastfeeding periods; remuneration during maternity and woman's right to resume work after the maternity leave
7	Ministerial order n°002/08.11 of11/02/2014 on court fees in civil, commercial, social and administrative matters	Art 2 all actions relating to the protection of a child's rights and the fight against sexual violence are exempted from paying court fees.

	Policy documents	*Brief description of changes introduced*
1.	National Gender Policy (2010)	Promotion of gender equality and equity through a clearly defined process for mainstreaming gender needs and concerns across all sectors of development
2.	National Policy against Gender Based violence (2011)[2]	Elimination of GBV through the development of a preventive, protective, supportive and transformative environment.
3.	National Integrated Child Rights Policy (2011)	Creation of an environment in which child's development, survival, protection and participation are ensured.
4.	Gender budgeting guidelines (2008)	Provision of a framework for gender mainstreaming in the planning and budgeting processes; addressing the current deficiencies in gender budgeting, providing guidelines for budget agencies and other stakeholders to develop budgets that will address the objective of gender equality

The above policy documents are supplemented by strategic and annual action plans that set clear targets to achieve, as well as the implementation timeline and responsibility. Legal and policy changes in place in Rwanda represent themselves a decisive step towards gender equality and participate in creating a more conducive environment for the fight against GBV.

At the central level, a four fold institutional structure, known as "Gender machinery"[3], having well-defined and complementary responsibilities has been put in place to ensure translation of legal provisions and policy objectives into practice. At the grass root level, community structures

[2] The GBV Policy is presently under revision; the final version is expected to be adopted in a very near future.

[3] These are respectively the Ministry of Gender and Family Promotion (MIGEPROF), National Women Council (NWC), Gender Monitoring Office (GMO) and the National Children Commission (NCC).

such as “Inshuti z’umuryango” (friends of family) have been established from the village to the district level with the purpose to raise awareness among the population on equal rights between men and women, boys and girls, on the forms of SGBV and its consequences and on the reporting and referral process in case of rape or any other SGBV related abuse.[4]

Further initiatives bringing together men and women to discuss issues of interest, including GBV, are in place at the community level, including the ‘Parent’s evening’, or *Umugoroba w’Ababyeyi* that is becoming a prominent mechanism to prevent violent family conflicts, including those related to SGBV, report abuse and conflicts and discuss ways to handle them.[5]

Gender desks and/or gender focal points that are provided for in the Kampala Declaration are in place since 2006 within Rwanda Defense Forces (RDF) and Rwanda National Police (RNP). They mainstream gender from within, guide the implementation of related policies and procedures, and work to enhance response to SGBV.[6]

According to former UNIFEM (now UN Women), the establishment and strengthening of these desks, notably within RNP and RDF, explicitly follows Rwanda’s international and regional commitments on GBV.[7] Security Sector Reform (SSR) involving both RDF and RNP concentrated on capacity building activities, including trainings, communication and awareness raising among the uniformed personnel, and community-based approach in addition to the existing gender desks.[8]

Efforts to integrate gender into national planning and budgeting documents as stipulated in international and regional obligations to which Rwanda is part have been invested right from 2003.[9] A

---

[4]MIGEPROF, *Guidelines on the setting up of committees to fight against gender-based violence and for the protection of child’s rights, from Umudugudu to district levels*, no date.

[5] GMO, *Evaluation of the implementation of the 2009-2012 National Action Plan for the United Nations Security Council Resolution 1325 in Rwanda*, Kigali, May 2015.

[6] Rwanda National Police official website (www.rnp.gov.rw)

[7] UNIFEM, *Case study. Establishment of Rwanda National Police Gender Desk*, Kigali, 2009.

[8]See Centre for Gender, Culture and Development (Kigali Institute of Education), *Africa region security organs capacity building workshop on violence against women and girls: prevention, response and peacekeeping*, Report of a workshop, Kigali, 21-24 July, 2011.

[9] Engendering budget is explicitly provided for by the CEDAW, the Beijing Platform for Action and the Kampala Declaration on SGBV among other international agreements.

comprehensive gender mainstreaming program championed by the Ministry of Gender and Family Promotion (MIGEPROF) was conducted with the objective to integrate gender equity into the country's development agenda and processes. Since then, gender is integral part of the Vision 2020, the country's development roadmap, and its deriving five years strategy, the Economic Development and Poverty Reduction Strategy (EDPRS).

This integration of gender into the national development agenda is based on the belief that gender equality will remain an empty concept unless it is translated into concrete plans, budget programming and allocation.[10]

2.2 Achievement in the area of Response to cases involving GBV

On the chapter of response to cases involving GBV, Rwanda has equally made encouraging progress. In addition to awareness raising activities on the rights of victims of GBV, the focus was put on judicial mechanisms to ensure responsible of GBV cases are punished. Impunity for GBV is addressed by the Penal Code and the Code of Criminal Procedure of Rwanda in addition to the legal framework described above. The law on Prevention and Punishment of GBV for instance provides for zero tolerance. Special sessions such as mobile courts for cases of SGBV particularly those involving children are organized by courts. Furthermore, SGBV cases are given priority.[11]

In 2008, the National Public Prosecution Authority (NPPA) established a special unit in charge of SGBV cases to mark the importance accorded to the fight against this crime. A list of all cases of SGBV tried as well as the outcomes is published on yearly basis as a means to promote transparency and prevent further violence. Though capacity building sessions are organized,[12] studies have pointed to significant knowledge gaps among the judicial personnel, particularly regarding

[10] MINECOFIN, *Gender budgeting guidelines*, Kigali, May 2008, pp 6-7.
[11] Supreme Court Official website: www.judiciary.gov.rw
[12] See for instance Gender Monitoring Office, *Beijing +20 Rwanda country report*, Kigali, June 2014.

the understanding of SGBV [13] and the issue of evidence in cases involving rape and other forms of sexual abuse.[14]

Rwanda implements the 16 days (November 27-December 10) of activism on violence against women established by the United Nations in 1993. Bringing together actors from various sectors, the campaign aims at raising awareness on SGBV and relevant laws, including the GBV law, which improves the quality of response to cases of violence. Similarly, Rwanda organizes on annual basis the campaign "Zero Tolerance Now" as decided by the ICGLR Ministers of Gender and of Justice of the member States in July 2012.[15]

2.3 Achievement in the area of Support to victims of GBV

In order to address the rights and needs of victims of GBV, Rwanda has established recovery centers since 2009. Known under their Kinyarwanda name, the 'Isange' One Stop Centers (feel at home; feel most welcome) provide a comprehensive service package to victims of GBV, including medical, legal and psychosocial support free of charge, under the same roof. Efforts to expand the centers' services by including forensic component are underway. [16] According to the 7-year Government Program (2010-2017),[17]these centers are expected to be functional in all district hospitals of Rwanda this year (2017). As of to date, there are 43 Isange One Stop Center throughout the country.[18] However, some challenges are still undermining the functioning of these centers, such as limited funds, limited training and insufficient number of service providers.

Significant achievement under the same area is the work of the Access to Justice Bureaus, known under their French acronym MAJ (Maison d'Accès à la Justice).

---

[13] Legal Aid Forum Rwanda, *Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda*, Kigali, 2013.

[14] Pro-Femmes Twese Hamwe, *Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda*, Kigali, 2014.

[15] MIGEPROF, Official website: www.migeprof.gov.rw

[16] UN Women (Rwanda), *Evaluation of the Gihundwe One Stop Centre for survivors of gender based violence and child abuse*, March 2015.

[17] Programme No.7, paragraphs 47 and 48.

[18] Pro-Femmes Twese Hamwe (PF/TH), op. cit. 2014.

Established in 2006, MAJ operates in each district and comprises of 3 lawyers, one of whom is specifically in charge of child protection and the fight against GBV. These officers provide free legal services to the most vulnerable of society, including legal conclusions on cases involving SGBV and case orientation among other duties[19]. Legal aid is provided by numerous other CSOs.

Numerous other initiatives to address the rights and the needs of victims of GBV are underway. One of these initiatives is the introduction of the Women's Guarantee Fund in 2007. Now fully operational, the initiative aims at increasing the number of women entrepreneurs in Rwanda by providing a 75 percent guarantee for a bank or micro finance loan that a Rwandan woman takes out to start up an enterprise or a small business.[20] To date, the Women's Guarantee Fund (WGF) is operating under Business Development Funds DF, and has so far provided loans to 6 899 women.[21] Whether the fund has improved the living standards of women was beyond the focus of this study, and requires therefore a separate enquiry.

2.4 Achievement in the area of coordination and Monitoring

The above progresses have been achieved thanks to coordination and monitoring mechanisms that have been established. At the national level, a Steering Committee has been established co-chaired by MIGEPROF and MINISANTE. Other members of the committee are respectively the Ministry of Finance and Economic Planning (MINECOFIN), Ministry of Local Government (MINALOC), Ministry of Youth and Information, Communication Technology (MYICT), Gender Monitoring Office (GMO), National Women Council (NWC), Ministry of Justice (MINIJUST), Rwanda National Police (RNP), National Public Prosecution Authority (NPPA), National Children's Commission and relevant development partners represented at the highest level.

[19] Ministry of Justice, Official website: www.minijust.gov.rw

[20] Gender Monitoring Office, *Evaluation of the implementation of the 2009-2012 national action plan for UNSCR1325 in Rwanda*, Kigali, may 2015.

[21] From BDF portfolio Statistics 2016, an amount of FRW 17.100.512.615 of loan was given to women both garantee and grants included.

The Steering Committee provides overall strategic direction and meets on a biannual basis to monitor implementation of the policy's objectives, share information and coordinate activities and responses. Apart from the national steering committee, two Gender-based Violence Technical Working Groups have been established, operating under the Gender Cluster. They provide technical expertise pertaining to the policy and strategic plan objectives and report to the NSC on a quarterly basis.

At the district level, the GBV and Child Protection Committee chaired by the Vice-Mayor in charge of Social Affairs and assisted by the Gender and Child Protection Professional monitors the implementation of anti-GBV related activities in the District and collects information pertaining to challenges as well as implementation from the community level upwards. The District GBV/Child Protection Committee liaise with the Joint Action Development Forum and provide anti - GBV programming inputs for utilization in local development planning. At the lower level, coordination and monitoring mechanisms and structures have been established to ensure an effective implementation of the policy. These include the Anti- GBV and Child Protection Committees that exist from the Umudugudu level upwards, community policing committee and Community health workers.

Despite the above coordination mechanisms, evidence reveals serious coordination gaps as discussed in the findings of this study (Chapter 4)

Despite the above progress, GBV is still a prevalent phenomenon in Rwanda. It requires close examination of existing strategies to achieve a society free from GBV, hence the relevance of this study.

Chap.III: RESEARCH METHODOLOGY

This chapter describes methodological strategies used to implement this study. In this regard, the study design, the approaches, as well as the methods used for data collection and analysis are discussed. The chapter also presents the sampling strategy, the procedures for data collection, and measures taken to ensure quality among other things.

3.1 Study design

The function of a research design is to ensure that the evidence obtained enables the researcher to effectively address the research problem logically and as unambiguously as possible. In social sciences research, obtaining information relevant to the research problem generally entails specifying the type of evidence needed whether it is to test a theory, to evaluate a program, or to accurately describe and assess meaning related to an observable phenomenon. In relation to the above and to the objectives of this research, the study design is both *descriptive* and *analytical*. The implementation progress and gaps associated with GBV Policy and related instruments are firstly described, and then factors explaining the implementation status are analytically examined.

3.2 Approaches

The nature of this study imposes a mixture of quantitative and qualitative approaches. But despite some quantitative indications on the gaps associated with the implementation of the GBV policy, the approach is qualitative-dominated. Issues pertaining to implementation or non- implementation of laws are by nature qualitative. As already mentioned, due to its nature, the study mainly resorted to qualitative methods. Qualitative research is a type of scientific research that seeks to understand a given research problem or topic from the perspectives of the local population it involves. Qualitative research is especially effective in obtaining culturally specific information about the values, opinions and views, and social contexts of particular populations.[22]. In terms of "how to do it', the study was participatory in manner. In order

[22] Denzin NK, Lincoln YS (eds.). *Handbook of Qualitative Research*. London: Sage Publications, 2000:2

to come up with reliable findings, all categories of relevant informants were involved in the research process. Details regarding eligible categories of respondents are provided in the appendices.

3.3 Process

The process to implement this study project went through the following key complementary steps:

- *Planning & preparation:* The research team planed for and prepared research activities not only to assure project quality but also to build team spirit and allow effective interaction during the actual research phase. Meetings were organized to identify key potential informants (per category), to identify relevant documentation, and to discuss and understand key concepts among other things. This phase aimed at ensuring that team members had a common understanding of the process, requirements, methodology and the entire approach. The main topics included: discussing and agreeing on a common methodology; strategy and strategic planning –how best to conduct the research (data collection procedures); and devising a questionnaire and other research tools;
- *Data Collection***:** This was the actual fieldwork. It consisted of field quantitative survey involving people selected at the household level, interviews with key informants as well as focus group discussions;
- *Data processing and analysis:* For the purpose of quantitative data entry, clerks were trained on the data base entry process. Based on the questionnaire, a specific data entry application has been designed using Statistical Package for Social Science (SPSS). A mask for the data clerk to enter the data was created in this regard. After the data entry, a tabulation plan was produced to facilitate the analysis plan. The qualitative data analysis was done using the coding strategy. Answers were grouped in accordance with corresponding themes. Each researcher produced a daily summary answering the key questions to ease future drafting activities and a

final detailed report compiling diaries was produced. Not only qualitative researchers produced the reports, but also surveyors submitted reports to provide the report writing team with qualitative insights evolving from the quantitative interviews;

- *Report drafting*. This step is all about harmonizing of data and information in a unique and coherent document.

3.4 Data collection methods

Four main data collection methods were utilized, namely the desk review, the questionnaire, key informant interviews, and focus group discussions.

Desk review: This technique enabled researchers to gather and make use of various specialized reports, studies as well as any other documents specifically those dealing with GBV or related topics in Rwanda. In the same way, relevant legal and policy documents related to the theme under study have been exploited. The role of the desk review was mainly to provide the study with a literature and equip the researchers with a clear understanding of the topic under study, to gain a deep understanding of the issues involved and complement other research instruments. For instance, the survey questionnaire and interview guide themes were generated by the desk review, particularly the national GBV Policy.

The desk review made use of the following documents in addition to relevant laws, to mention but a few:

- ✓ MIGEPROF, *National Anti-GBV Policy and Strategic Plan*, Kigali, 2011.
- ✓ MIGEPROF, *Guidelines on the setting up of committees to fight against gender-based violence and for the protection of child's rights, from Umudugudu to district levels* (no date).
- ✓ Pro-Femmes Twese Hamwe. *Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda*, Kigali, 2014.

- ✓ UN Women Rwanda. *Evaluation of the Gihundwe One Stop Centre for survivors of gender based violence and child abuse*, Kigali, March 2015.
- ✓ Legal Aid Forum Rwanda, *Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda*, Kigali, 2013.
- ✓ GMO, *Evaluation of the implementation of the 2009-2012 National Action Plan for the United Nations Security Council Resolution 1325 in Rwanda*, Kigali, May 2015.

Questionnaire: A questionnaire is addressed to a group of individuals in order to collect their opinions, perceptions, knowledge and testimonies on a given phenomenon. In the context of this study, a questionnaire was addressed to various categories of informants, men and women, rural and urban resident to extract answers on a number of numerically measurable variables.

A detailed questionnaire is attached to this report. Variables like awareness about GBV policy, laws and services were measured using the questionnaire. In total, 312 have responded to the quantitative questionnaire.

Interviews with key informants: In order to gain deep understanding on the implementation gaps of the national GBV policy and related provisions as well as existing challenges, a set of resource persons were identified for research conversations. This category of people or the 'privileged witnesses' have been chosen on the basis of their expertise, their daily experience and their contact with the subject under study. Initially there was no pre-fixed number of interviews to be conducted, but a checklist of key categories of people per areas of the GBV Policy. Interviews held were rather determined according to the principle of saturation or the redundancy in the collected answers, which suggested that all aspects of the study were covered and that there were no more new elements coming out. In total, 35 interviews with key informants

were conducted in the four selected districts. People from these categories will be given priority:

- Policy makers;
- Public GBV service providers at district, sector and cell levels;
- Education specialists;
- Security officers;
- Health sector representatives;
- Justice sector representatives;
- Relevant civil society members;
- Faith Based Organizations.

Focus group Discussion (FGDs): Though desk review, questionnaire and interviews were to provide plenty of useful information, focus group discussions were to offer additional advantages: by providing an opportunity for debate, focus group discussions created an enabling environment to understand gaps related to the implementation of GBV policy. Initially, it was planned for homogenous groups of discussions to free expression given the sensitive character of the topic, but finally only heterogeneous ones were organized. The researcher team has noticed no reluctance among the participants to speak out. Focus groups were initially expected to happen after visualization of the preliminary quantitative findings, but given time constraint, they were conducted in parallel with the quantitative survey. In total 8 focus group discussions were organized, two in each of the selected districts. The total number of focus group discussions participants is 93 people of which women represent about 48%.

3.5 Sampling

Since this study is predominantly qualitative, researchers used mainly purposive sampling procedures to ensure the 'right' respondents to the questionnaire. Though respondents were selected randomly, a number of criteria (see below) were set to guide surveyors, affecting a bit the random character of the sample. In addition, districts covered have been selected purposively by PFTH, namely Karongi, Nyamasheke, Rusizi and Rutsiro.

Two sectors in each district were selected randomly, but the principle to include both rural and urban sectors was respected where feasible. The selected sectors per district are as follows

Table 3-1: Sectors covered per district

#	District	Sectors per district
1	Karongi	▪ Bwishyura ▪ Rubengera
2	Nyamasheke	▪ Ruharambuga ▪ Cyato
3	Rusizi	▪ Bugarama ▪ Gikundamvura
4	Rutsiro	▪ Gihango ▪ Kivumu

Data collectors are encouraged to cover both rural and urban areas, and to include participants representing both sexes as well as representatives of various age groups. This implies that they will have the possibility to replace some sectors by others to meet the above principle of residence representativeness.

A part from qualitative respondents, the quantitative survey intended to cover 300 respondents to be distributed equitably among districts and sector, making it 75 respondents per district. The following criteria guided identification of respondents:

- Age
- Sex
- Characteristic of residence
- Status of respondents: people who have ever been victims of any form of GBV and those who have never been.

Qualitative respondents were selected deliberately in relation to their expertise, profession and position. It was anticipated that at least 6 interviews with key informants were to be conducted in each district and at least 2 focus group per district bringing together relevant discussants. If the number of focus group was scrupulously respected, the number of interviews with key informants increased. In total, 35 interviews and 8 focus group discussions were held.

3.6 Data collection procedures

Field data collection was facilitated by PFTH in collaboration with relevant staff in the selected districts. The administration of the questionnaire was mainly indirect; meaning that the survey or interviewer was in charge of filling in the questionnaire form based on the answers provided by respondents. Identification of key informants for interviews was carried out in collaboration with PFTH technical staff to make sure relevant informants participated in the study.

3.7 Quality assurance mechanisms and ethical standards

Conducting any study requires a set of measures to assure data reliability and validity. While the two terms are essential criteria for quality in quantitative dominated research, in qualitative paradigms, these terms may be represented by credibility, neutrality or conformability, or consistency to be the essential criteria for quality.[23]

The research team leader ensured the study instruments are clearly understood by all before fieldwork starts. For this to be possible, a set of measures were implemented, including:

- ✓ The research team was acquainted with the study background, rationale and objectives;
- ✓ Recruitment of experienced research team members;
- ✓ A training of the entire research team on the methodology, questionnaire, interview guide and focus group discussion checklist was held;
- ✓ Daily supervision of field activities;
- ✓ Daily reports and summaries for both quantitative surveyors and qualitative researchers;
- ✓ Training of data entry clerks and double entry data type will also be used to avoid any errors of typing;
- ✓ Anonymous questionnaire to encourage open expression…

[23] See Lincoln, Y. S., & Guba, E. G., *Naturalistic inquiry*, Beverly Hills, CA, Sage, 1985.

From an ethical perspective, members of the research team were required to adhere to the highest ethical standards of research. To comply, the researchers had to observe a set of measures during the whole process of this study:

- ✓ An official permission introductory letter issued by PFTH was presented to every district administration before actual data collection starts;
- ✓ Participation consent was requested before interviewing respondent or engaging in discussions;
- ✓ Confidentiality was guaranteed regarding any information given to be disclosed;
- ✓ Voice recording for the purpose of data analysis required a clear prior consent from respondents where applicable.

Chap.IV: STATUS OF THE GBV POLICY IMPLEMENTATION: STUDY FINDINGS

This chapter is based on empirical findings from the four selected districts namely Karongi, Nyamasheke, Rusizi and Rutsiro. In addition to the quantitative findings, it makes use of qualitative information for sound discussions and interpretations.

4.1 Basic Characteristics of respondents

Presentation of socio-demographic characteristics of respondents is important not only for information of readers, but also for the quality of responses, particularly in terms of representativeness. The table below summarizes the basic characteristics of the study population.

Table 4-1: Distribution of the basic characteristics of the study population

Variable	Modality	Frequency	% (n=308)
District	Karongi	75	24.4
	Nyamasheke	77	25.0
	Rusizi	79	25.6
	Rutsiro	77	25.0
Milieu	Urban	96	31.2
	Rural	212	68.8
Sex	Male	150	48.7
	Female	158	51.3
Marital Status	Married	199	64.6
	Single	78	25.3
	Widowed	19	6.2
	Divorced	10	3.2
	Divorce in process	2	0.6
Age group in years	18-24	49	15.9
	25-29	46	14.9
	30-34	38	12.3
	35-39	43	14.0
	40-44	41	13.3
	45-49	30	9.7
	50-54	21	6.8

Variable	Modality	Frequency	% (n=308)
	55-59	17	5.5
	60+	23	7.5
Level of Education	Primary	153	49.7
	Vocational	11	03.6
	Secondary	53	17.2
	University	31	10.1
	None	60	19.5
Profession	None	16	5.2
	Agriculture	203	65.9
	Public servant	41	13.3
	NGO	1	0.3
	Private sector	11	3.6
	Self employed	24	7.8
	Retired person	3	1.0
	Other Job[24]	9	2.9

Source: Primary data

As already mentioned, the study was carried out in four districts purposively selected by PFTH with almost the same number of respondents (25% each) following the purposive sample selection. The majority (68.8%) of respondents are from rural settings, which is representative of the residence characteristics of the national population. More than 50% of all respondents are females (51.3%), whereas more than six out ten respondents are married (64.6%), and almost 60% are younger than 40 (57.1%). Almost a half of them have completed primary schools (49.7%), and a significant share of respondents have completed secondary school (17.2%) and tertiary (10.1%) education – shares which are greater than the national averages. Of all respondents, about 70% are working in the agriculture sector while civil servants and self-employed represent respectively 13.3% and 7.8% as detailed in the table 4-1 above.

The findings above clearly show that all the key population characteristics are represented, from the residence characteristic to sex,

[24] Other jobs include informal jobs that respondents did not want to mention.

age groups and education levels. Such an inclusive distribution of respondents is in itself an element of quality data in that the findings a representative of the variety of opinions, perceptions and experiences of various groups.

4.2 Implementation of GBV Policy in the four selected Districts

The status of the implementation of GBV policy in the four selected districts was assessed based on the key policy strategic areas, namely prevention, response/service to victims, as well as coordination and monitoring.

4.2.1 Prevention

Prevention is meant to foster a GBV hostile environment. Effective GBV prevention entails among other things raising community awareness about GBV, its forms, GBV policy, anti –GBV structures and laws.

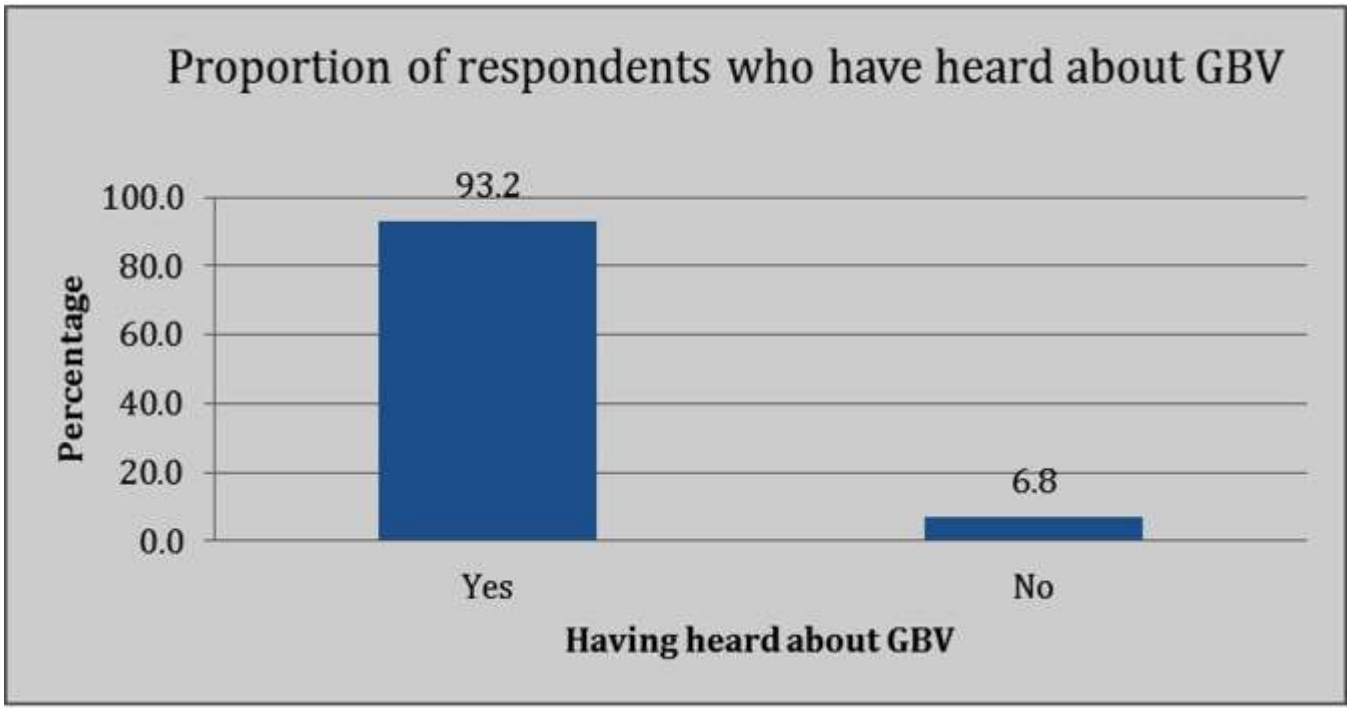
4.2.1.1 Awareness about the national policy against GBV

Awareness about GBV is the entry point for understanding the status of implementation of the national GBV policy and related instruments. There is no way one can identify and understand the policy implementation progress, gaps and challenges before answering the question whether the policy beneficiaries know and understand what GBV itself is. Indeed, popular education about what GBV is all about; constitutes an integral part of the national GBV policy objectives. This section analytically shows what the population knows about the national GBV policy and GBV itself in the selected four districts and the way they have come to know about it.

4.2.1.2 Awareness about the existence of the national GBV policy

Findings from the field show that the big majority of respondents have heard about national GBV policy. Figure 1-4 below provides details.

Figure 1-4: Respondents who have ever heard about GBV policy



Source: Primary data

The findings above clearly show that the majority of respondents have heard about the national GBV policy (93.2%). In a society where cultural norms that sometimes condone GBV are still prevalent, such a level of awareness is of great importance. Awareness the existence of a national policy against GBV is a great opportunity upon which prevention of and response to cases of GBV can be built. Whether this level of awareness is proportionately distributed per respondents' sex and residence characteristics is discussed in the paragraphs below.

The two variables (sex and residence) were considered given their importance in relation to this study's objectives. Indeed, empirical studies have already established that sex and characteristics of the residence are critical variables in trying to understand the magnitude of GBV with females constituting the majority of victims[25] and the rural resident being particularly exposed because urban dwellers are less likely to tolerate GBV.

[25] See for instance World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, 2013; United Nations Department of Economic and Social Affairs, *The World's Women 2015*, *Trends and Statistics* (Chapter 6, Violence against Women), 2015;

Table 5-4: Respondents who have ever heard about the national GBV Policy per sex

Variable	Males 149 (48.4%)	Females 159 (51.6%)	p. value
Having heard about GBV			
Yes	144 (50.2)	143 (49.8)	.016 (S)
No	5 (23.8)	16 (76.2)	

Source: Primary data

As stipulated above, the majority of respondents have heard about the national GBV policy (93.2%). However, among those who have never heard about it (about 7% of the total respondents), a big proportion is observed among females with statistically observed differences by sex (p. value= 0.016). Though the number of females who declared having never heard about GBV policy is very small compared to those who ever had, it appears non-negligible compared to males who never heard about the same policy. From qualitative insights, sociological reasons explain this difference: females are not exposed to social networks the way males are. Indeed, due to disproportionate labor division in Rwanda between males and females in favor of the former[26], women's exposure to various channels and spaces, including trainings, workshops and study tours in which different issues are discussed, including GBV, is limited. However, from the same qualitative data, women's exposure to sources of information is increasingly high due to community structures that are close to the population and whose schedules are not conflicting with women's responsibilities such as *Umugoroba w'Ababyeyi* or the 'parents' evening'.

[26] According to the Rwanda Integrated Household Living Conditions Survey (EICV) 2013/2014, males spent 43 hours per week and females spent 53 hours per week (on both domestic and economic activities, in 2013/14). But when it comes to domestic works, the difference becomes critically important with females spending 27 hours per week for 12 that men spend on the same. (EICV 2013/2014, Thematic report-economic activity, Kigali, March 2016, p. 39)

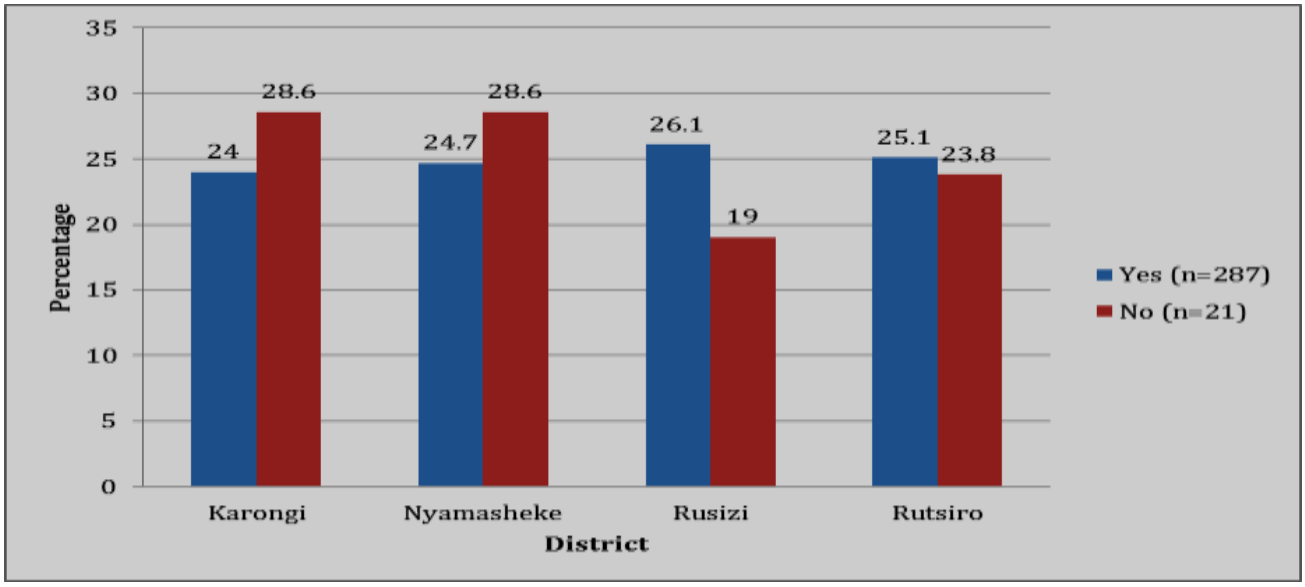
Table 6-4: Respondents who ever heard about the national GBV policy per milieu of residence.

Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	P. value
Having heard about the national GBV policy			
Yes	91 (31.7)	196 (68.3)	.313 (NS)
No	5 (23.8)	16 (76.2)	

Source: Primary data

From the findings of table 6-4 above, it appears that there are not statistically significant difference between urban and rural residents it terms of awareness about GBV (p value=0.313). This suggests that urban and rural areas are equally exposed to messages related to GBV. Likewise, there appears to be no significant difference between districts.

Figure 2-4: Awareness about the national GBV Policy per district



Source: Primary data

From figure 2-4 above, respondents from the four selected districts have almost equal access to information about the national GBV Policy. There is no significant difference in terms of awareness about the national GBV Policy between citizens of the four districts. The findings show that 308 respondents who provided a meaningful answer to this particular question (these represent 93. 18 % of the total respondents) are equitably distributed between the four districts.

4.2.1.3 Main sources of information on GBV

There are several sources of information about GBV. The findings below show that media and community meetings are the main sources of information on GBV. Their order of importance varies however when examined based on sex and milieu of residence.

Table 7-4: Main sources of GBV information by sex

Variable	Males 149 (48.4%)	Females 159 (51.6%)	P. value
Community Meetings			
Yes	113 (52.1)	104 (47.9)	.080
No	35 (42.2)	48 (57.8)	
Debates on GBV			
Yes	29 (55.8)	23 (44.2)	.193
No	119(48.0)	129 (52.0)	
Media (Radio and Television)			
Yes	96(56.1)	75 (43.9)	.005
No	52(40.3)	77(59.7)	
At School			
Yes	14(53.8)	12 (46.2)	.391
No	135(48.9)	141 (51.1)	
At Church level			
Yes	3(37.5)	5(62.5)	.371
No	145(49.7)	147 (50.3)	
Friends/ Colleagues			
Yes	4(21.1)	15 (78.9)	.011
No	144(50.5)	141 (49.5)	
At Family level			
Yes	12(41.4)	17 (58.6)	.240
No	136(50.2)	135 (49.8)	
At Work Place			
Yes	4 (57.1)	3 (42.9)	.485
No	144(49.1)	149 (50.9)	
At Club level			
Yes	2(40.0)	3 (60.0)	.513
No	146(49.5)	149 (50.5)	

Source: Primary data

From the findings above, media, namely radio and television (p. value= 0.005) and friends/colleagues (p. value= 0.011) are the main sources of GBV information for both males and females. More so, community meetings are also source of information for both males and females even though observed differences are not statistically significant (p. value=0.080). However, debates on GBV (p value=0.193) being at school (p value=0.391), at church (p. value= .371), at Work place (p value=0.084) and surprisingly at club level (p value=0.154) are not important sources of information on GBV as one would expect for both males and females with observed differences that are statistically not significant.

Table 8-4: Main Sources of GBV information by milieu of residence

Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	P. Value
Community Meetings			
Yes	74 (34.1)	143 (65.9)	.039
No	19 (22.9)	64 (77.1)	
Debates on GBV			
Yes	28 (53.8)	24 (46.2)	.000
No	65 (26.2)	183 (73.8)	
Media (Radio and Television)			
Yes	56 (32.7)	115 (67.3)	.266
No	37 (28.7)	92 (71.3)	
Friends/Colleagues			
Yes	6 (31.6)	13 (68.4)	.577
No	89 (31.2)	196 (68.8)	
At Family level			
Yes	5 (37.5)	24 (62.5)	.066
No	88 (30.8)	183 (69.2)	
At School			
Yes	13 (50.0)	13 (50.0)	.028
No	90 (29.3)	202 (70.7)	
At Church level			
Yes	3 (42.9)	4 (57.1)	.375
No	90 (30.7)	203 (69.3)	

Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	P. Value
At Work place			
Yes	46 (57.5)	34 (42.5)	.084
No	154 (42.5)	166 (51.9)	
At Club level			
Yes	0 (0.0)	5 (100.0)	.154
No	93 (31.5)	202 (68.5)	

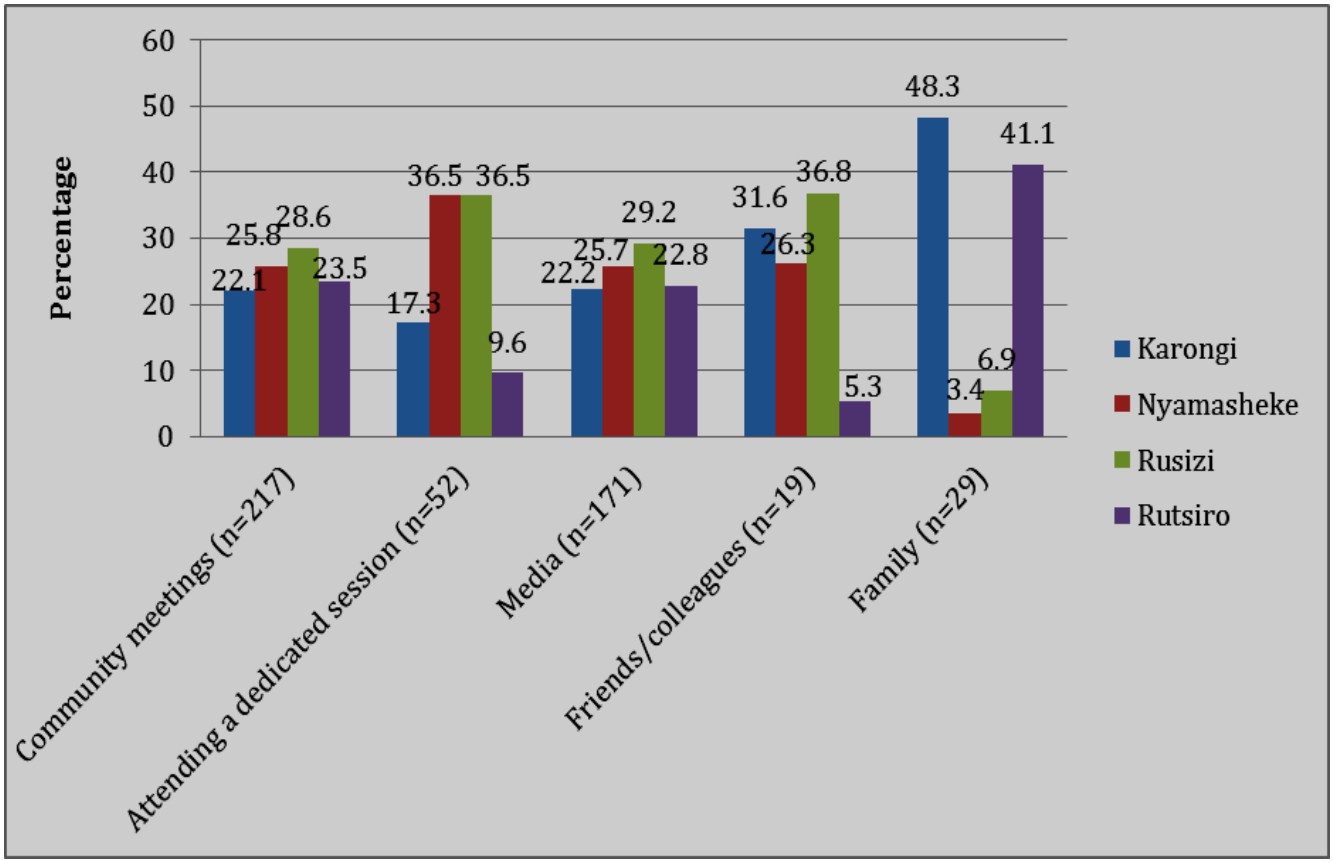
Source: Primary data

In relation to milieu of residence, community meetings are the main source of GBV information for both rural and urban areas (p value=0.039) while debates on GBV (p value=0.000) and the school (p value=0.028) are less likely to be source of information on GBV for some scientific reasons as their observed differences are statistically significant. However, media (radio and television) is the main source of information for a big proportion of respondents from both rural and urban areas even though observed differences are not statistically significant (p value=0.266). One should notice that friends/colleagues (p value=0.577), at family level (p value=0.066), at church level (p value=0.375), at work place (p value=0.084) and at club level (p value=0.154), all these opportunities are less likely to be source of information on GBV for both rural and urban areas with observed differences that are statistically not significant.

It appears clearly from section 4.2 that awareness about the national GBV policy and GBV is high. There are two main sources of awareness, respectively media and community meetings. Other social spaces that would be expected to play a crucial role in promoting not only awareness about GBV, but also understanding/knowledge about the same are visibly playing a minor role, including schools, churches and families. Given the fact that GBV is a dynamic phenomenon and that the population itself is dynamic, it is important to ensure that various channels and social spaces are active in raising awareness on GBV, particularly among the youth. It is equally important to continue to strengthen community structures such as *Umugoroba w'Ababyeyi* in that

they facilitate increased participation for women taking advantage of their proximity.

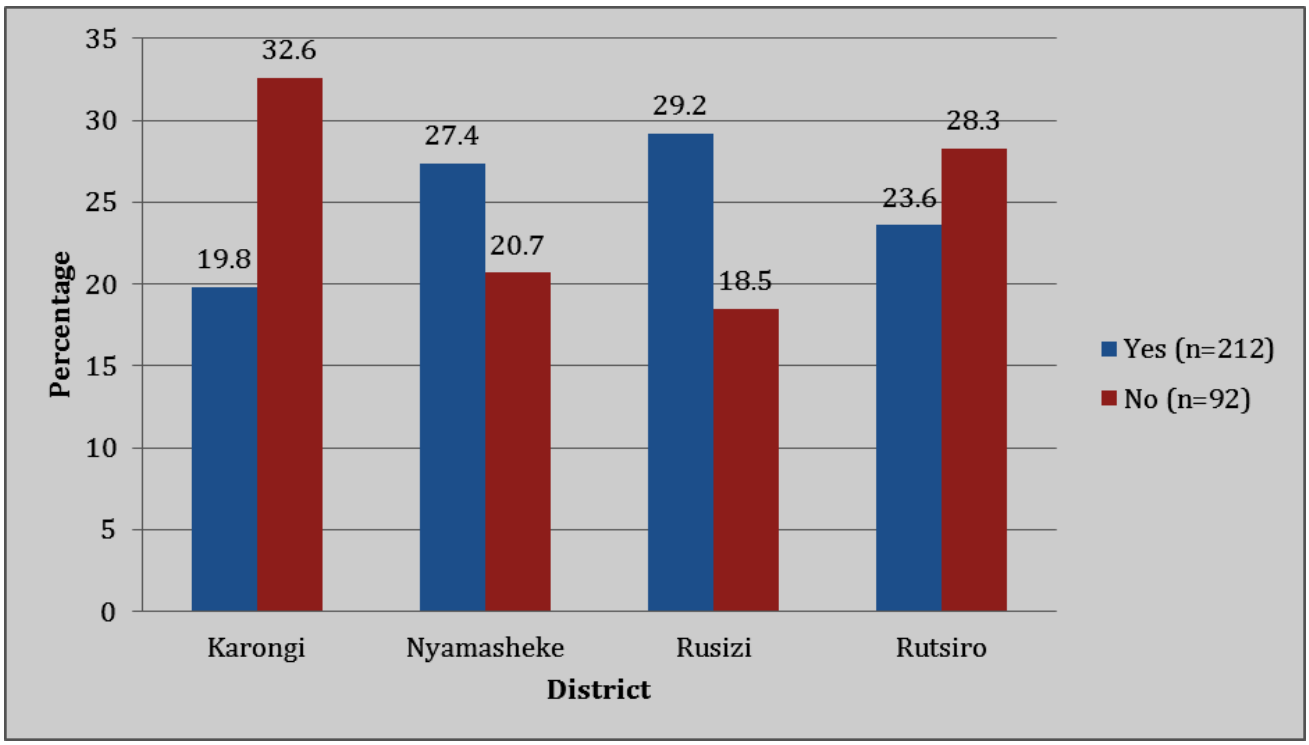
Figure 3-4: Main Sources of GBV information by district



Data disaggregated by district confirm the predominance of community meeting and media as the main sources of information.

The use of community meetings and media looks better in Rusizi compared to other districts. From qualitative information, the slight advantage of Rusizi is attributed to the active role that the Isange One Stop Center in Gihundwe hospital, formerly Humura One Stop Center that organized several meetings with communities in various sectors of the district to educate them on issues related to GBV. With regard to special sessions and friends or colleagues serving as sources of information on GBV, the district of Rusizi is once more ahead for the same reasons. District disaggregated data confirms that the role of friends and families as sources of information on GBV is small.

Figure 4-4: Discussions about GBV at the family level per districts



Source: Primary data

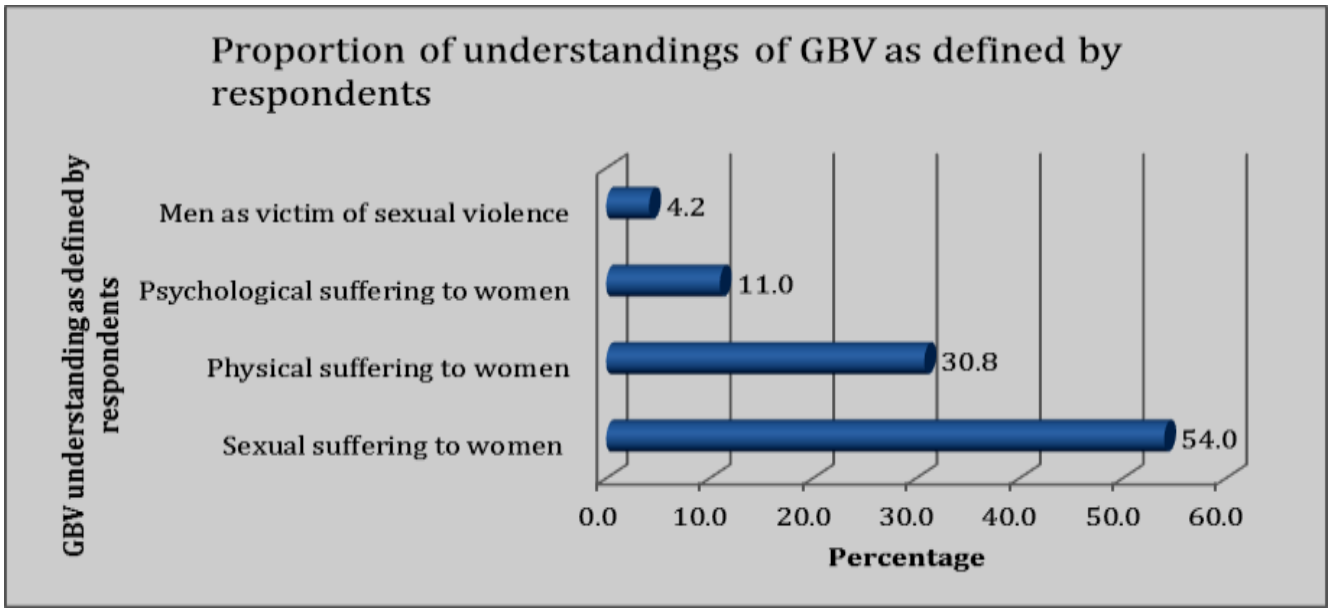
Though the role of the families in educating members on GBV is small in comparison to other channels, it is still an important source of information on the same when taken separately. Of all respondents who have provided a meaningful answer to the question whether families members held discussions about GBV (they are 304), 212 representing about 70% have responded affirmatively. The district of Rusizi and Nyamasheke have made good use of families as compared to Rutsiro and Karongi for reasons explained above. Indeed, the Humura One Stop Center used to cover both districts. The activeness of this center that was funded by UN Women, UNICEF and UNFPA under the One UN approach has contributed to engage with families and other actors around issues of GBV. However, an evaluation of Humura One Stop Center of 2015 shows that the center's services have gone lip since the end of the funding.

4.2.1.4 Knowledge/understanding of GBV

The section above has elaborated on awareness about GBV in the four selected districts. Awareness or 'consciousness' and understanding are

used interchangeably to mean the same concept, but are not synonymous. While awareness describes a state of existence or the 'heard of', understanding connotes the acquisition or achievement of some kind of intellectual clarity following a process of learning or striving the entry point of which is awareness. This section discusses understanding/knowledge of GBV by respondents. It is based on respondents' own definitions of what GBV is, its forms, causes and consequences. It uses data from the quantitative survey and information from interviews and focus group discussions conducted in the selected four districts.

Figure 5-4: GBV as understood by respondents



Source: Primary data

From the findings summarized in figure 5-4, it appears that respondents have a satisfactory understanding of what GBV is. The understanding however is not as high as the awareness is (93.2%). From the figure above, two characteristics are noticeable:

GBV is mainly inflicted on women or females in general (1) and some forms of GBV are more known than others (2). From the quantitative data above, sexual violence is better known as a form of GBV with 54% followed by physical violence (30, 8%). The popular character of sexual violence as a form of GBV was widely confirmed by focus group

discussions [27]. A non-negligible share of other respondents acknowledges the psychological violence (11%). However, the economic form of violence is totally absent from respondents' answers (quantitative), which suggests a need to raise awareness about and understanding on this form of GBV. It is also noticeable that men are not seen as victims of GBV by the majority of respondents.

From respondents' answers, the forms of GBV (above) were described as follows:

- Sexual violence implies treatment of women as commodities to achieve sexual pleasure (includes trafficking in women and girls for sexual exploitation);
- The physical violence includes battering and assault at home or in the workplace;
- Psychological violence is also seen as mainly directed against women includes threats and verbal harassments, arbitrary deprivation of liberty, whether occurring at home or in a different place.

Qualitative research has provided even more insights about GBV. From group discussions in all the four districts, poverty, cultural traditions (including negative masculinity), ignorance and religious beliefs are seen as the most important causes of GBV[28]. Among the major consequences of GBV are unwanted pregnancies, sexually transmissible diseases including HIV/AIDS, murder, divorce/separation, violation of children's rights and social stigma.

4.2.1.5 Knowledge about structures that foster an environment that prevents GBV

The study also sought to know whether respondents were aware of the structures that are chiefly concerned with prevention and the fight against GBV. From the quantitative data, local government entities are the most known and are perceived to be the most appropriate structures that foster a GBV hostile environment with regard to both sex

[27] All the definitions of GBV turn around sexual violence (group discussions held in Nyamasheke and Rusizi).
[28] Fieldwork reports, May 2017.

and milieu of residence of respondents. Paradoxically, structures such as media organs and community structures that are presented to be the main sources of information on GBV (see sub-section 3.2.2 above) seem to play a rather medium role in fostering an environment that prevents GBV, which sounds contradictory. Schools, religious confession, civil society organizations, private sector and even community clubs are considered to play only a minor role in providing the population with information on GBV as evidenced by the illustrative tables 9-4 ad 9-4 below.

Table 9-4: Structures that participate in preventing GBV according to respondents by sex

Variable	Males 149 (48.4%)	Females 159 (51.6%)	P. Value
Local Authorities			
Yes	140 (49.1)	145 (50.9)	.241
No	9 (39.1)	14 (60.9)	
Confession Organizations			
Yes	13 (48.1)	14 (51.9)	.571
No	136 (48.4)	145 (51.6)	
Media (Radio and Television)			
Yes	17 (43.6)	22 (56.4)	.320
No	132 (49.1)	137 (50.9)	
NGOs			
Yes	19 (57.6)	14 (42.4)	.175
No	130 (47.3)	145 (52.7)	
Private sector			
Yes	3 (75.0)	1(25.0)	.287
No	146 (48.0)	158 (52.0)	
Clubs			
Yes	36 (51.4)	34 (48.6)	.328
No	113 (47.5)	125 (52.5)	

Source: Primary data

Table 10-4: Structures that participate in preventing GBV according to respondents by milieu of residence

Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	P. Value
Local Authorities			
Yes	90 (31.6)	195 (68.4)	.386
No	6 (26.1)	17 (73.9)	
Confession Organizations			
Yes	11 (40.7)	16 (59.3)	.181
No	85 (30.2)	196 (69.8)	
Media (Radio and Television)			
Yes	17 (43.6)	22 (56.4)	.050
No	79 (29.4)	190 (70.6)	
NGOs			
Yes	8 (24.2)	25 (75.8)	.242
No	88 (32.0)	187 (68.0)	
Private sector			
Yes	0 (0.0)	4(100.0)	.222
No	96 (31.6)	208 (68.4)	
Clubs			
Yes	28 (40.0)	42 (60.0)	.049
No	68 (28.6)	170 (71.4)	

Source: Primary data

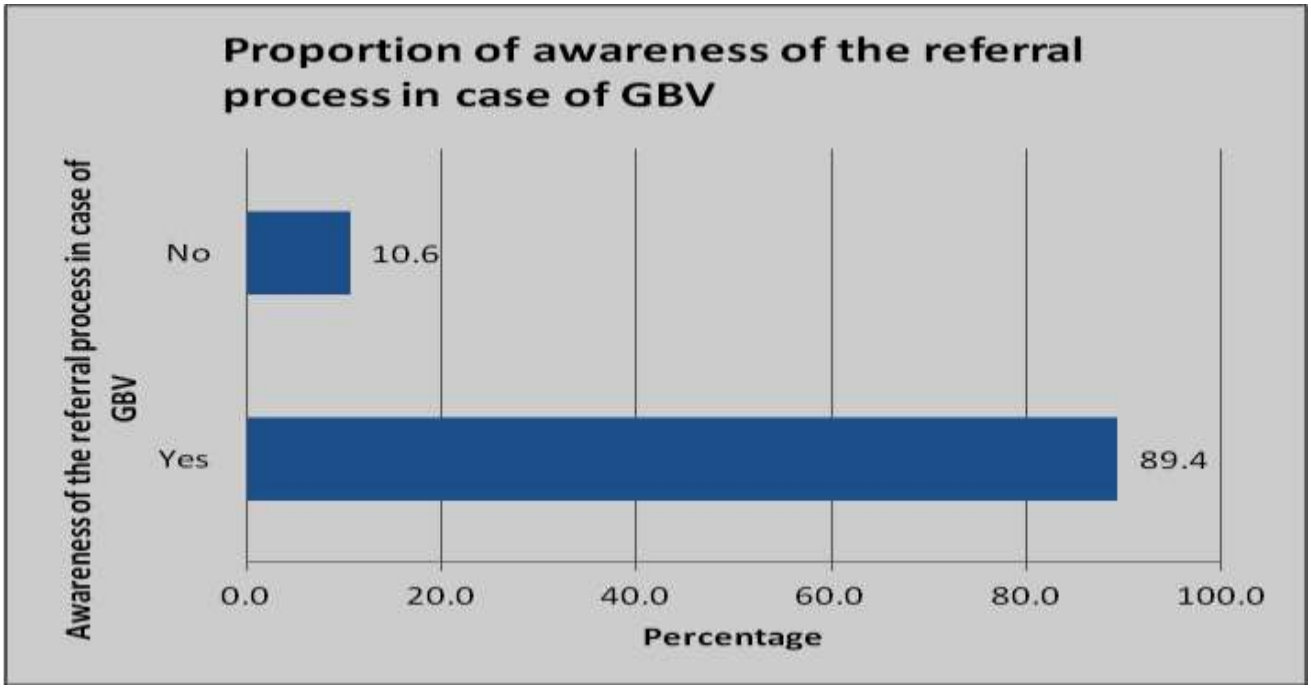
4.2.1.6 Awareness about the referral process in case of GBV

One of the key national GBV policy actions is to raise awareness on the referral process for cases involving GBV.[29] Raising awareness was expected to be done by various actors, including media, local and community structures, civil society organizations, and so forth. This

[29] MIGEPROF, *National Policy against Gender-Based Violence*, Kigali, July 2011, pp.14-15.

study sought to know how well community members are aware and familiar of the referral process using both the quantitative survey and the qualitative research.

Figure 6-4: Respondents' claimed awareness about the referral process in case of GBV



Source: Primary data

In light of the finding above, it appears that almost nine out of ten respondents are aware of the referral process in case of GBV. Disaggregated data shows that awareness of the referral process in case of GBV is very high for both males and females and for rural and urban residents given that observed differences are not statistically significant (p. value =.398). Table 11-4 and 12-4 below provide details.

Table 11-4: Claimed awareness of the referral process in case of GBV by sex

Variable	Males 149 (48.4%)	Females 159 (51.6%)	P. Value
Awareness of the referral process in case of GBV			
Yes	129 (49.4)	132 (50.6)	.398 (NS)
No	14 (45.2)	17 (54.8)	

Source: Primary data

Table 12-4: Claimed awareness of the referral process in case of GBV by residence

Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	P. Value
Awareness of the referral process in case of GBV			
Yes	84 (32.2)	177 (67.8)	.308 (NS)
No	8 (25.8)	23 (74.2)	

Source: Primary data

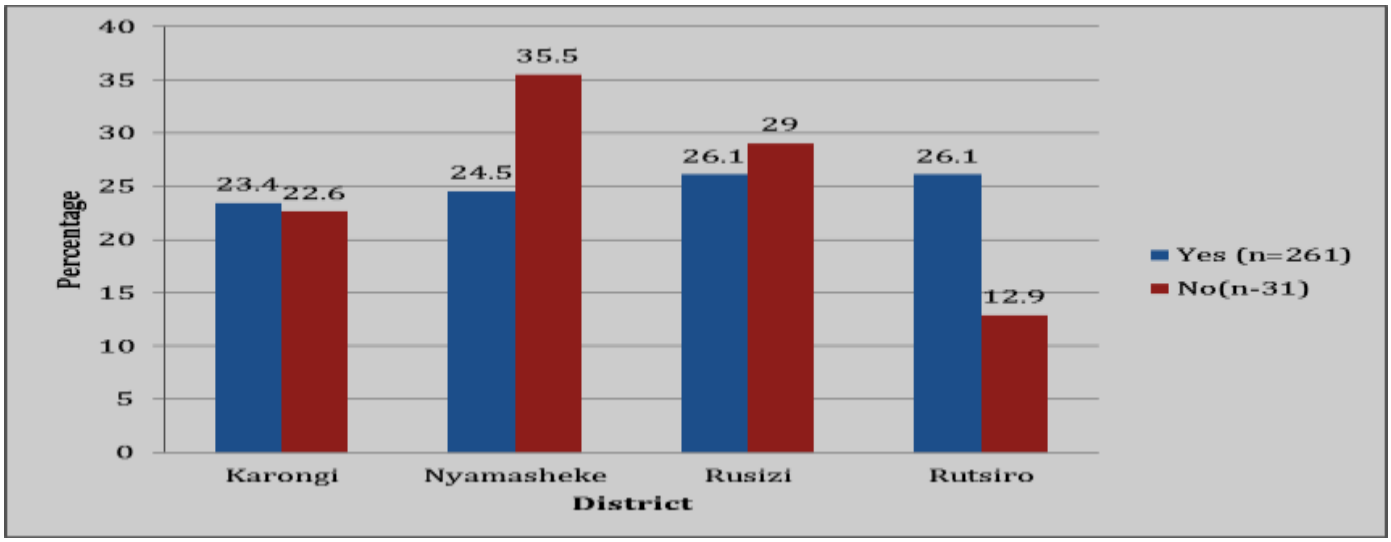
Probing questions to understand what respondents know about the referral process have provided additional insights. In case involving rape or sexual abuse, respondents would follow the following pathway in priority:

- Healthcare first not only to confirm cases, but also to ensure the victim has primary medical and psychological care; and
- Keep informed police and local authorities for further services, including protection of the victim and case documentation.

For cases involving physical violence, respondents have a slightly different order to follow:

- Keep informed police for protection of the victim;
- Keep informed local authorities for case management.

Figure 7-4: Claimed awareness about the referral process in case of GBV per district



Source: Primary data

From the findings, there is no noticeable difference between districts in terms of awareness about the referral process. Overall, it is clear that respondents in the four selected districts have general information about key services that are needed by victims of both sexual and physical violence.

Qualitative findings confirm the general character of information on the referral process in case of GBV and show that results are mixed. Some respondents have quite a clear idea about what to do in case of GBV, particularly in case of rape or any other related sexual violence. To the question on what to do in case of rape, respondents advanced various ideas. Some were vague, while others appeared to have a clear idea on what to do: "Natanga amakuru ku nzego zibishinzwe" (I can report to relevant structures) without being otherwise precise; "the most important thing is to refer the victim to health centers before evidence disappears"; or "I can report to local governments and to the police for further steps".[30] Similar ideas to refer the victims to health centers, the police and to justice were heard in almost every single group discussion. Isolated points were also heard on the necessity for the victims to preserve evidence (for instance by not taking shower or not changing the dressing).

Closer examination of qualitative findings suggests the following overall observations:

- ✓ A wide majority of community members know that GBV cases should be denounced and reported to relevant structures;
- ✓ Local government entities, the police and health structures are the most known, which shows that general information on how to refer cases of GBV, particularly rape in particular is known;
- ✓ However, the exact path to follow as defined by MIGEPROF is not known. Campaigns to raise awareness on GBV cases referral process should be as specific and detailed as possible;
- ✓ Partly for the above reason, economic hindrances, the culture and ignorance, reporting of cases of GBV is still low. Findings clearly

[30] Focus Group Discussions, Nyamasheke, 30 May 2017.

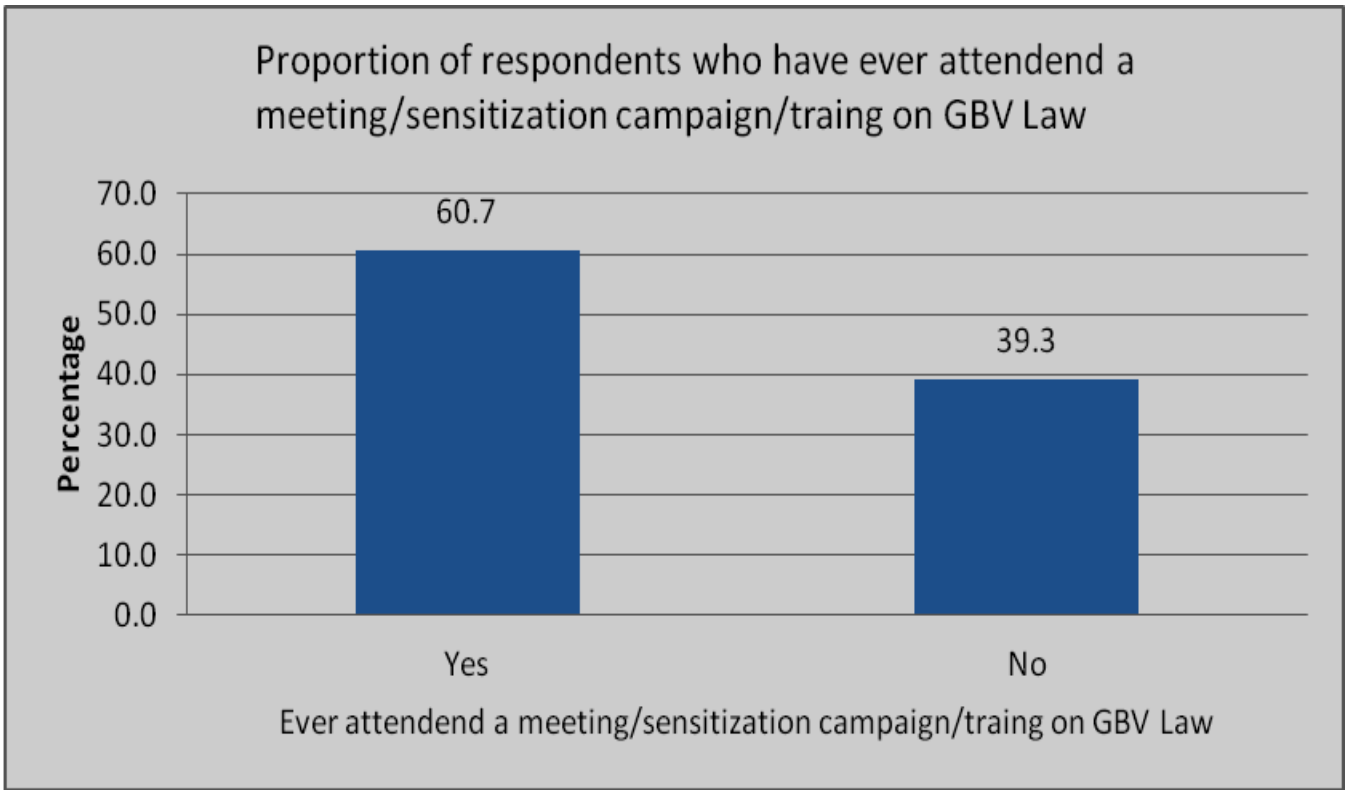
show that some families still prefer mediation not only because it provides some financial gains on the side of the victim, but also because determination to be given justice is portrayed as "exposing the victim" and hence social stigma;

- ✓ Evidence preservation is still a serious issue and will continue to constitute an obstacle for access to justice by victims because it was mentioned in a rather isolated way during fieldwork;
- ✓ Collaboration between community members and structures and various actors in the sector of GBV in the four districts appeared to happen on a rather punctual basis despite coordination by JADF offices. Strengthening ties between both sides are needed to improve the general knowledge on GBV, and particularly on the referral process;
- ✓ Ownership of the fight against GBV is still low among community members. During discussions, it was clear that "reporting cases to local authorities" was a dominant attitude. Visibly, participants consider reporting cases of GBV to local authorities enough; individual initiatives to refer or take victims to points of service, including health facilities was extremely rare in their answers.

4.2.1.7 Awareness about the GBV Law

It is quite impossible to dissociate the national GBV policy from the GBV law. The study sought to know whether respondents know something about the GBV law as well. By trying to know what they know about the law, the objective was not to measure their capacity of memorization, but the key elements of GBV as defined in the law, such as their forms and consequences. The level of understanding of the law key content is satisfactory as described in the introductory part of section 4.3. This section mainly discusses the degree of exposure to the same law.

Figure 8-4: Respondents who have attended an event at least once covering the GBV law



Source: Primary data

In light of the finding in figure 8-4, more than six out of ten respondents (60.7%) have attended a meeting/sensitization campaign/training at least once where the GBV law was either referred to or deeply discussed. Community meetings represent the biggest opportunity where GBV law and related topics were discussed. From figure 4-4, it is clearly evident that efforts to make citizens aware of GBV instruments have not yet been sufficient. The findings above are eloquently expressive on the need to strengthen awareness raising of legal and policy instruments pertaining to GBV. Findings tell us that about 4 of every 10 people in the four districts covered by the study have never had a direct opportunity to learn about the GBV law, the most important and specific legal instrument regulating this crime in the country. Considering the importance of law awareness in the change of attitudes and effective prevention of GBV, the proportion of people who have never had the opportunity to engage directly with GBV key instruments represents a significant segment of the population in the four districts.

Table 13-4: Respondents who have attended at least once an event where the GBV law was either referred to or discussed by sex

Variable	Males 149 (48.4%)	Females 159 (51.6%)	p. value
Ever attended a meeting/sensitization campaign/training on GBV law			
Yes	98 (52.4)	89 (47.6)	.050 (S)
No	51 (42.1)	70 (57.9)	

Source: Primary data

Disaggregated findings confirm gender unequal exposure to GBV instruments learning opportunities though to a lesser extent. From table 4-10 above, females are dominant among those who have never had such opportunity. Reasons behind this imbalance are related to women's domestic double burden (productive and reproductive responsibilities). Differences between rural and urban dwellers seem less important as evidenced by the findings in table 4-11 below.

Table 14-4: Respondents who have ever attended an event where the GBV law was either referred to or discussed by milieu of residence

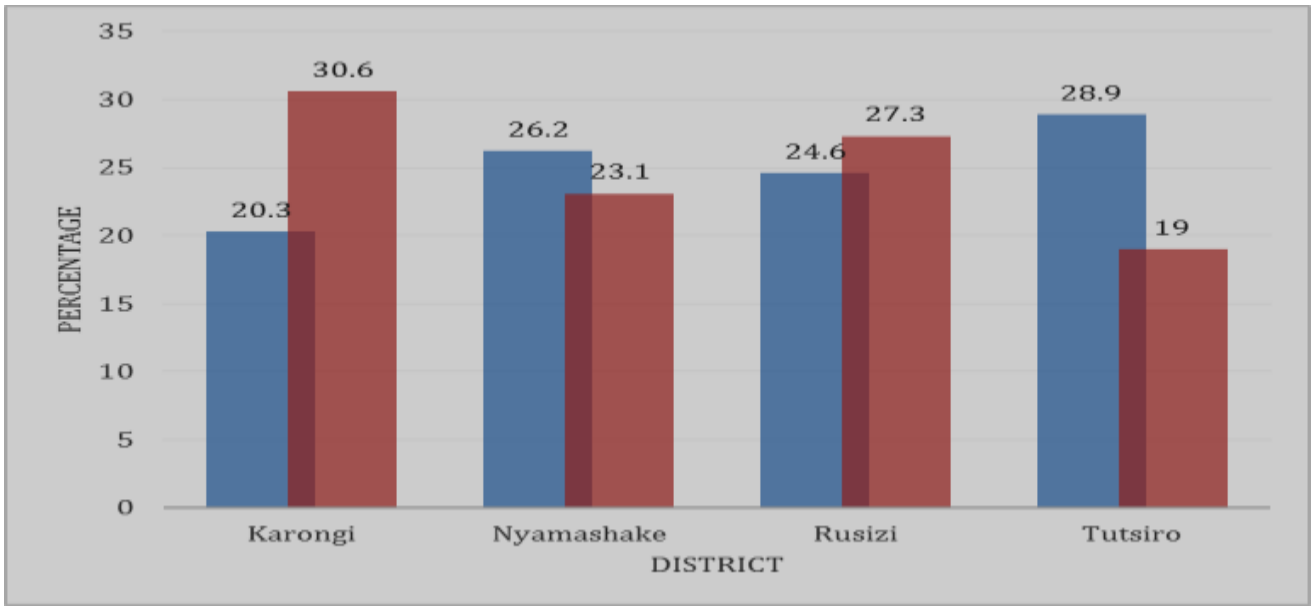
Variable	Urban 96 (31.2%)	Rural 212 (68.8%)	p. value
Ever attended a meeting/sensitization campaign/training on GBV law			
Yes	60 (32.1)	127 (67.9)	.381 (NS)
No	36 (29.8)	85 (70.2)	

Source: Primary data

In light of the findings in table 4-11, slightly more than 6 people out 10 have ever attended an event where the GBV law was directly referred to or discussed. There is no significant difference between rural and urban areas. This is probably due to the fact that community meetings are held in both areas and key media organs, particularly radio Rwanda is received in all most all parts of the selected districts.

Quantitative findings also point to mixed results regarding the frequency of meetings/events focusing on the GBV instruments. As shown in the figure 4-5 below, half of respondents indicate that such meetings are frequent while another half support the opposite.

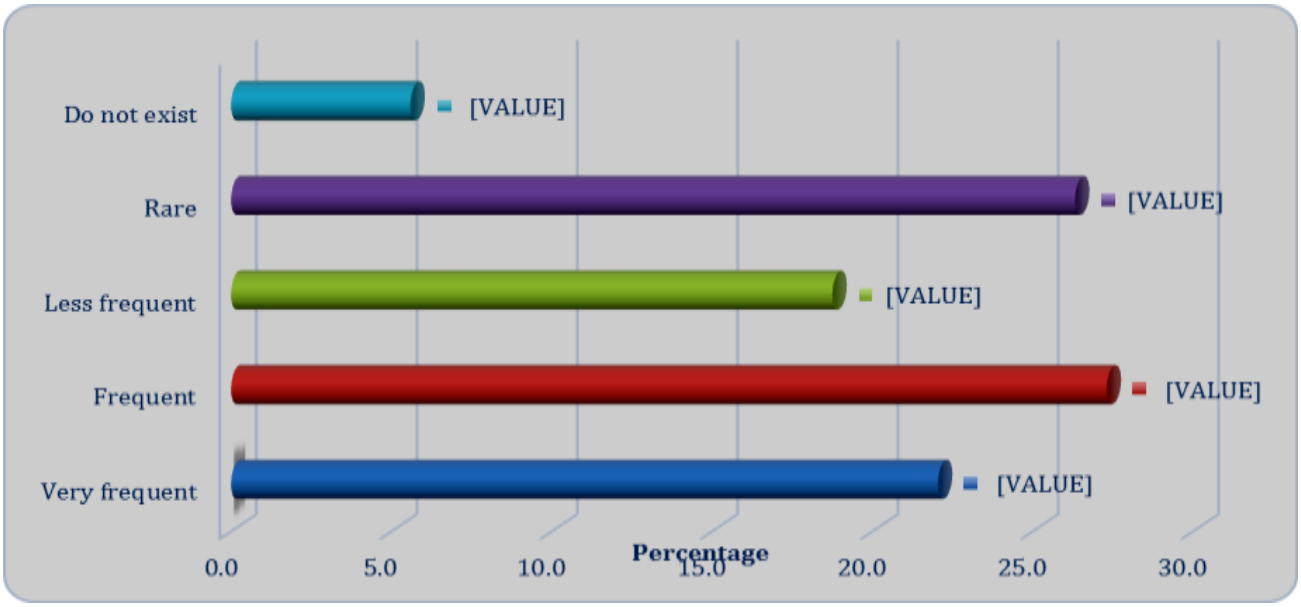
Figure 9-4: Respondents who attended an event on GBV law at least once by district



Source: Primary data

Respondents from the four districts have had the opoortunity to attend at least one session or event where the GBV law was either discussed or referred to. Overall, respondents have heard about this specific law. Compared to other districts, respondents from Karongi district appear to have had little opportunity.

Figure 10-4: Frequency of meetings/sessions on GBV instruments



Source: Primary data

In light of qualitative data, specific meetings on GBV, particularly discussions focusing on the law and policy governing GBV are rare in

ordinary community meetings. GBV is referred to in a rather subsidiary way due to competing topics on the agenda. More elaborate discussions on GBV are held during the *Umugoroba w'ababyeyi* that unfortunately only few men attend. This very promising community mechanism has remained women-dominated to the extent that some have started to call *it Umugoroba w'abagore* (evening of women).

Qualitative data also show that reference to GBV law and policy is more general. From group discussions, it appears that instruments governing GBV are just mentioned in various meetings, but are not well known of the population as summarized in the following sentence:

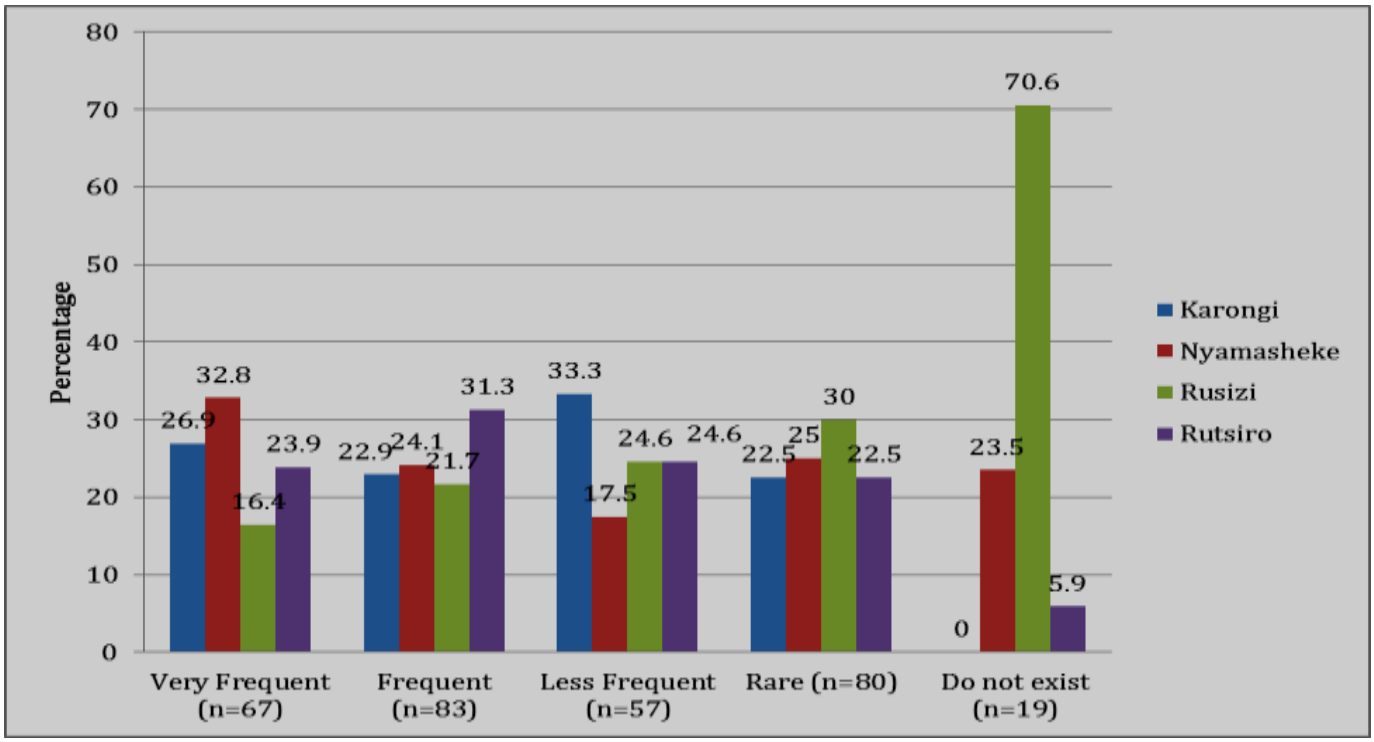
"Nta mahugurwa twigeze tubona. Iyo turi munama batubwira ko hari amategeko ahana uwahohoteye, ariko ntabwo badusobanurira amategeko n'amabwiriza ajyanye n'ihohoterwa rishingiye ku gitsina. Ahubwo rimwe na rimwe tubyumvira kuri radio naho abayobozi babitubwira ari uko byabaye, nabwo bakabicaho bahita, ntabwo twavuga ko tuzi byinshi ku mategeko arwanya ihohoterwa"[31].(We have never been trained, but leaders refer to the law on GBV from time to time during community meetings. We also get some messaged from radio stations, but we cannot say that we know much about the GBV law. We have heard about it in a more superficial way).

Similar ideas were heard in the three other districts. For instance, in Karongi district, Byishyura sector, during a focus group discussion a woman declared that they receive messages on GBV particularly during meetings of *Umugoroba w'ababyeyi* and that sometimes similar messages are shared after community works. But these messages are mainly communiqués by villages' leaders: "*Turabyumva mu mugoroba w'ababyeyi buri wa kanne wa nyuma w'ukwezi…No mumuganda banyuzamo abayobozi bakaduha amatangazo ajanye n'ihohoterwa, ariko guhugurwa nyirizina si kenshi. Mu mezi nk'atatu ashize nibwo twabihuguweho n'umushinga witwa Tubibe Amahoro*".[32] (the issue of GBV is discussed during the parents' evening. Sometimes it is referred to during the community work meetings, but a specific trainings on this

[31] Focus group discussions, Ruzisi, 01 June 2017.
[32] Focus grou discussions, Karongi, 31 May 2017.

topic are few. In the last three months we have been trained on GBV by the Tubibe Amahoro project).

Figure 11-4: Frequency of meetings/sessions on GBV instruments by district



Source: Primary data

Results about the frequency of meetings/sessions when GBV law and policies are discussed are mixed. Of all respondents, 27.1 % said that discussions on GBV instruments are frequent, while 26.1 % others respondents consider that these discussions are rare. Similarly, about 22% said that discussions about GBV are 'very frequent', another 19% expressed the opposite view. As mentioned above, qualitative information shows that GBV is referred to in various meetings, but in a more general way. There are not many focused meetings where GBV is discussed in depth. From a comparative perspective, the frequency of such meetings appear to be a bit higher in Rutsiro and Nyamasheke respectively for reasons that the study was not able to document.

4.2.1.8 Structures involved in GBV awareness raising known of respondents

Awareness about GBV implies awareness about structures/organizations that are involved in the fight against GBV. It is quite impossible to effectively combat GBV if the population does not know structures to report to in case of GBV. In this regard, the study sought to identify structures that were involved in GBV awareness raising activities. Figure 4-6 below summarizes the findings.

Figure 12-4: Structures involved in raising awareness on GBV as known of respondents

Source: Primary data

In light of the findings above, not surprisingly state institutions play a pivotal role in educating the population about GBV and GBV instruments. Among these institutions, local entities from village to the sector are the main organizers of sessions on GBV and GBV instruments in almost 40% of all cases. The ministry of health and the police are also organize such sessions and were mentioned in 10% of all cases. Other public institutions, including the Parliament, MIGEPROF, and Itorero were mentioned as organisers of GBV sessions in about 8% of sessions.

Specific non-government organizations were mentioned to play a non-negligible role in education the population on GBV. These include World Vision (6.5%) and Handicap International Rwanda (5.2%). UNFPA and

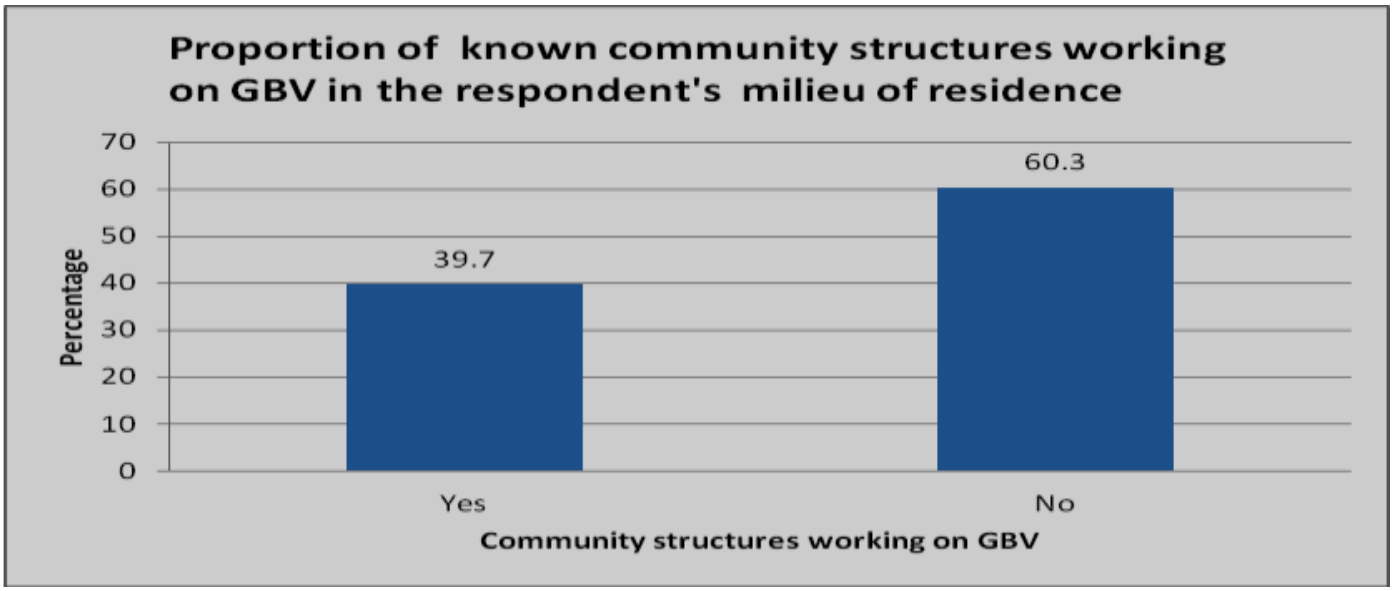
CARITAS were also mentioned though in an isolated way. Contrarily to provisions of the national GBV Policy, schools and Faith Based Organizations play a rather minor role given their proximity to the population and their core mandate. The following observations emerge from the findings above as well as from qualitative insights:

- The fight against GBV continues to be led mainly by government institutions. Though some non-government organizations are active in this area, their presence on the field was described as "sporadic" given dependence on external donors' funds;
- The national GBV Policy is not fully implemented with regard to partnership between various actors at the local level. If it is true that the coordination and coherence of interventions have improved since the establishment of the Joint Action Development Forum (JADF) at the district level in 2007, [33] it is also true that joint planning has remained a big issue, affecting therefore partnership between various actors in this area of GBV, including among public institutions. With regard to civil society organizations, dependence on development partner funding has remained a big obstacle to coherent planning, domain specialization and geographical distribution of services[34];

In relation to structures that are involved in raising awareness about GBV, the study also sought to know what respondents know about community structures doing the same and whether they are themselves members of these structures. The survey found that a huge majority of respondents are not aware of a single community structure working on GBV as evidenced by figure 13-4.

[33] Interview with Aimable Murindangabo Rwanda, JADF of the district of Karongi 31Mai 2017.
[34] Fieldwork insights from the districts of Karongi, Nyamasheke, Rusizi and Rutsiro, May-June 2017.

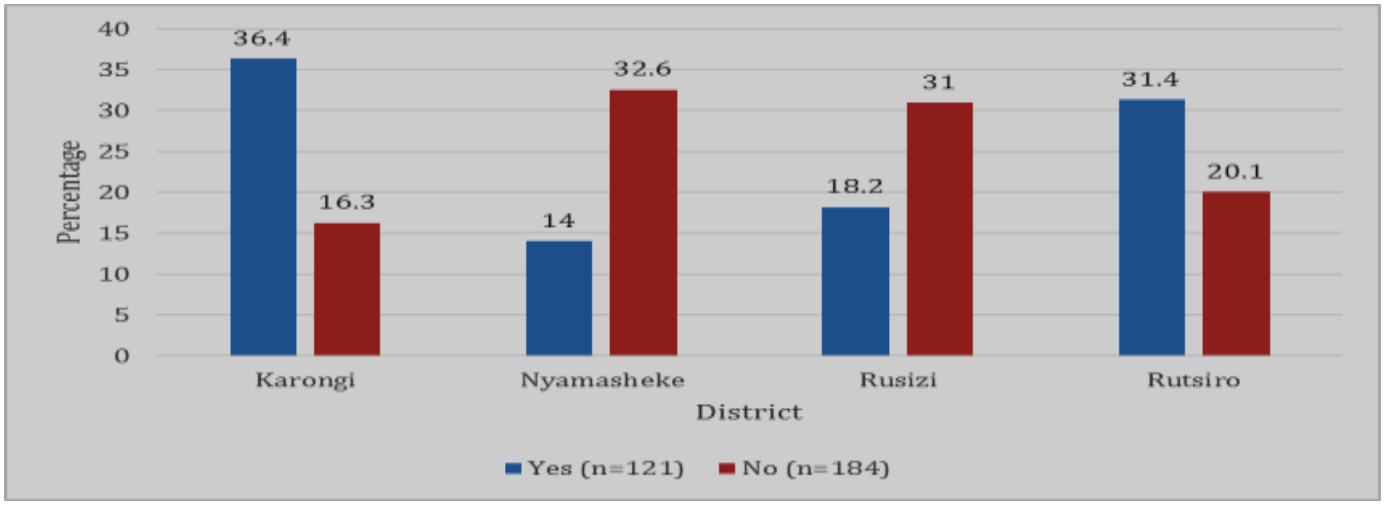
Figure 13-4: Knowledge about any community structures working on GBV in the respondents' residence area



Source: Primary data

It appears from the findings from figure 4-6 that more than 6 people out of 10 are not aware of a single community structure working on issues related to GBV. Considering that some of these structures are very popular, particularly *Umugoroba w'ababyeyi*, one would hypothesize that respondents have not understood the question. However, further findings tend to show that respondents are coherent. Indeed, only a few of them are members of community clubs and related structures working on GBV as evidenced by the findings below.

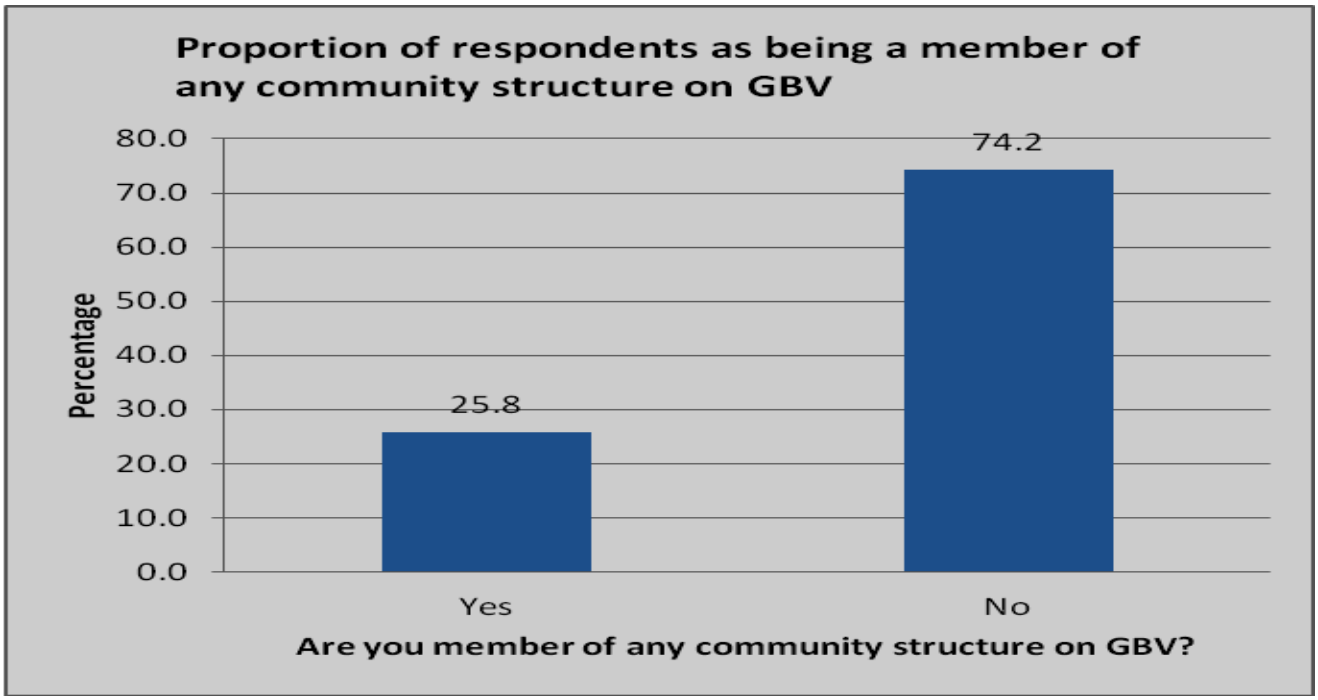
Figure 14-4: Knowledge about any community structures working on GBV



Source: Primary data

Disaggregated data confirms that slightly more than six respondents out of ten are not aware of any community structures working on GBV. From those who declared that they were aware of community structures working on GBV (they represent about 37% of the total respondents), the majorities are from Karongi and Rutsiro with 36.4% and 31.4%, respectively.

Figure 15-4: Status of membership of community structures on GBV among respondents



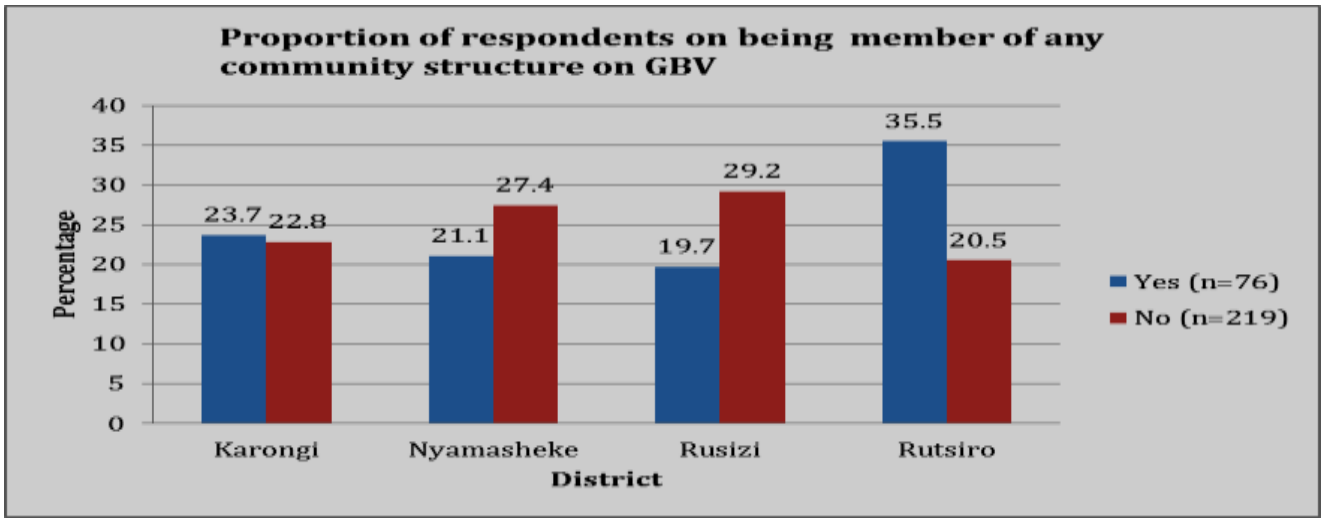
Source: Primary data

The findings above speak by themselves and this explains that: low membership to community structures explains the reason why the majority of respondents were not able to mention a single community initiative on GBV. From the findings, only less than 30% belong to a structure of the kind, which is extremely low in a context where cultural traditions still condone GBV. From experience, without a critical mass of community members determined to collectively devise strategies to prevent and fight against GBV, effective transformation towards a gender hostile special environment provided for by the national GBV Policy will bear only little fruit at best or simply fall obsolete at worst.

The findings show that community members who belong to any of the structures working on GBV play important role in the fight against GBV. Their responsibilities consist specifically of the following:[35]

- Raising community members' awareness on the GBV law;
- Mobilizing the community for the prevention of GBV;
- Training the youth on human rights and strategies to prevent GBV;
- Raising awareness of victims of GBV on the referral process and justice pathway;
- Providing information on GBV at family, community and workplace milieu.

Figure 16-4: Membership of any such community structures per district



Source: Primary data

In accordance with findings in figure 4-14 above, there appears to be a difference between districts when it comes to membership. Out of 295 respondents who have provided meaningful answers to this question, only about 26% are members of community structures on GBV. These findings expressively plead for sensitization not only to ensure community structures working on GBV are in place, but also community members adhere to them for effective prevention of and response to cases of GBV. Ownership of the fight against GBV will remain low until communities themselves are active members of such structures. For the few structures that exist or are functional, membership is a bit higher in

[35] Adapted from fieldwork survey and qualitative research, May-June 2017.

Rutsiro compared to other districts. However, efforts to establish active community structures are needed in all the four districts given that the overall membership status is still low.

4.2.1.9 Role of education structures in preventing GBV

The national GBV Policy is a multi-faceted tool whose implementation requires interventions from various sectors to ensure that Rwanda creates an environment that is hostile to GBV. Apart from local administrations that are expected to coordinate all GBV interventions and therefore play a more crosscutting role, the policy defines specific interventions to be implemented by specific sectors or institutions. Some of these interventions aim at preventing GBV by raising awareness of the population, others are aimed at responding to cases of GBV through various services.

In this regard, the national GBV Policy provides for activities aimed at preventing GBV to be implemented by the education sector, namely schools. Under its strategic area one related to prevention strategies, the policy reads that "educational institutions will promote gender equality and GBV prevention….and educate the youth on reproductive health, specifically on sexuality and biological changes".[36] Education services are also expected to provide awareness raising about GBV law, among other things.

The fieldwork research revealed mixed findings on how education is perfoming this role. From quantitative findings, only 6.2% of all respondents mentioned schools among structures that raise the population's awareness on GBV in the four studied districts. If this finding suggests a need for improvement of the role that educational structures play in the fight against GBV, it has to be understood from the methodological perspective. Indeed, the quantitative survey was conducted at the household level, not in the schools. School structures were covered by the qualitative research.

[36] National GBV Policy, p.13.

From qualitative research[37], schools and other educational structures implement a number of activities aimed at educating the youth on gender equality and GBV. The most frequently mentioned school activities include the following:

- Health clubs are operational and discuss among others sexual and reproductive health, and GBV
- Regular school meetings on sexual and reproductive health, and GBV
- GBV discussions at school level through different opportunities in addition to health clubs, particularly during school gatherings;
- Guest speakers are sometimes invited to engage with students on various issues, including GBV;
- Joint meetings between parents and schools are organized on a regular basis. Parents are reminded to be vigilant and take time to discuss issues related to GBV with their children;

Schools also implement specific, but generally punctual activities aimed at educating the youth on reproductive health and sexuality. The most popular activities include:

- Teaching students, by category of age, on specific issues on sexuality and reproductive health;
- Setting up clubs on youth sexual and reproductive health and use of media to provide useful information to the targeted segment of the population in addition to implementing the "Ni Nyampinga" program at school level;
- Promotion of girl's room at school level for adolescent girls;
- Organization of conference on youth sexual and reproductive health at school level;
- Specific courses for youth in primary 4 up to primary 6 on sexual and reproductive health;
- Drama on sexual and reproductive health;
- Existence of senior man and senior woman at school level to deal with sexual and reproductive health issues.

[37] Information discussed under this section was compiled from interviews with education staff from the four districts.

However, from the field findings, there are many things that need to be improved for schools to play a more effective school role in the prevention of GBV:

- There is no training manual on GBV at the school level. MIGEPROF's training manual needs to be popularized and distributed to every single school to ensure quality information on GBV is given to students;
- Despite the fact that teachers and school managers are naturally the main resource persons on GBV at the school level, the former are not trained on GBV, which may affect the quality of their contributions;
- Despite partnership between districts and some civil society organizations[38], specific anti-GBV clubs are not established in all schools, which explains partly the sporadic character of discussion on this issue;
- The feeling that key responsibility to prevent GBV relies with government institutions, particularly local administrations was perceptible during conversations with school leaders suggesting that ownership of the prevention and fight against GBV is low among educational structures.

4.2.1.10 Reduce vulnerability of groups most at risk from GBV

As stipulated in the GBV policy, another important means of prevention is to reduce vulnerability of groups most at risk of GBV.

Qualitative findings reveal that vulnerable groups are generally assisted through various social protection progams such as Vision 2020 Umurenge Program, Girinka and alike. These programs however, do not have a particular focus on groups particularly exposed to GBV. In addtion, it worth to mention that people with disability do not have a special consideration in relation to GBV prevention and response. For instance, with regard to sources of information about GBV as provided in Figure 4-3, the special needs of people with disability are not taken

[38] In Karongi for instance, RWAMREC, Care International and AEE were explicitly mentioned by the district director for Education

into consideration. The most popular sources of information about GBV, such as community meetings and media are designed for the general population with no specific consideration of level and type of disability. This situation worsens vulnerabilty to GBV among people with disability. There is therefore a need for further investigation to understand GBV status among this group as well as correctional measures.

4.2.1.11 Changing community attitudes and social norms on GBV

The first specific objective of the national GBV Policy is to "foster a prevention-focused environment where GBV is not tolerated".[39] One of the corresponding policy actions is to undertake activities that promote positive social norms and attitudes at the community level to ensure not only that people resist GBV, but also are active in fighting it.

From the qualitative data, there are several initiatives[40] at the local level aimed at fostering such an environment. The most noticeable are, but not limited to:

- Media programs on community radio stations to educate the populations on gender equality and against GBV;
- Regular meetings with all structures having in charge gender equality and the fight against GBV to devise strategies on how to create a GBV hostile environment and promote GBV cases reporting;
- Sensitization sessions on gender equality and GBV during community meetings;
- Sessions to raise awareness about GBV law and policy;
- Occasional trainings on gender and GBV targeting different segments of the population, particularly the youth;
- Establishment and use of community structures like *Umugoroba w'ababyeyi* and child protection committees to discuss issues of interest for community members such as security, GBV and cooperatives; and

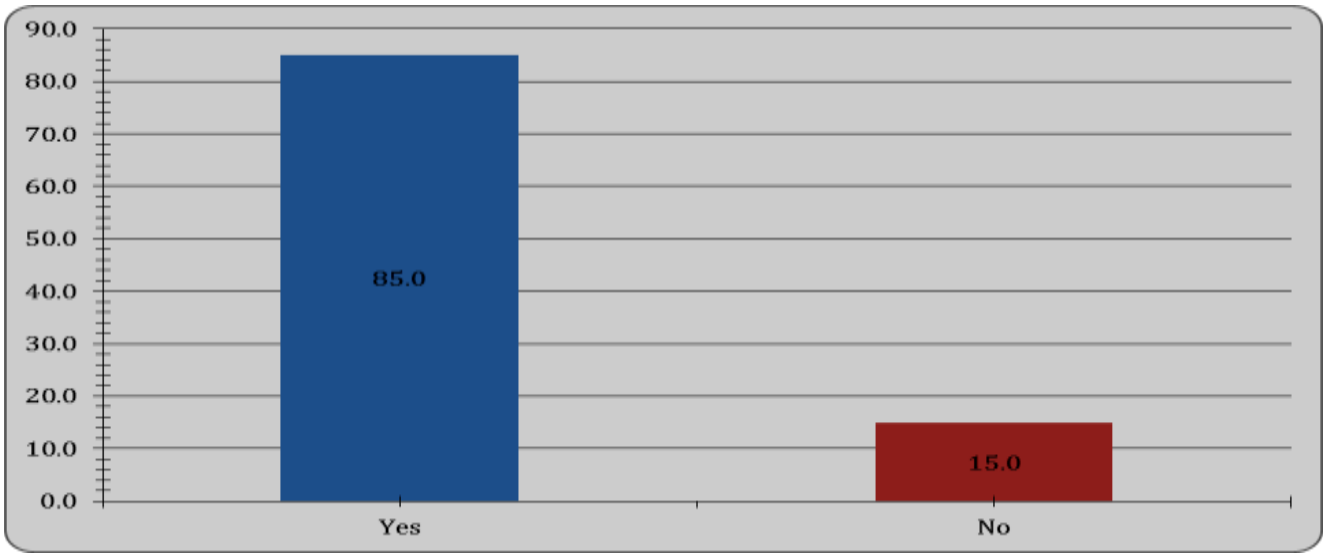
[39] See page 12 of the policy.

[40] Extracted mainly from interviews with Vice Mayors in charge of social affairs in Karongi, Nyamasheke and Rusizi, May- June 2017.

- Committees in charge of conflict management at the cell level;

Quantitative data tend to show that the initiatives above have produced positive effects as suggested by the perceptions in figure 4-6 below. Indeed, the majority of respondents think that community attitudes and social norms are positively changing towards gender equality and zero tolerance of GBV.

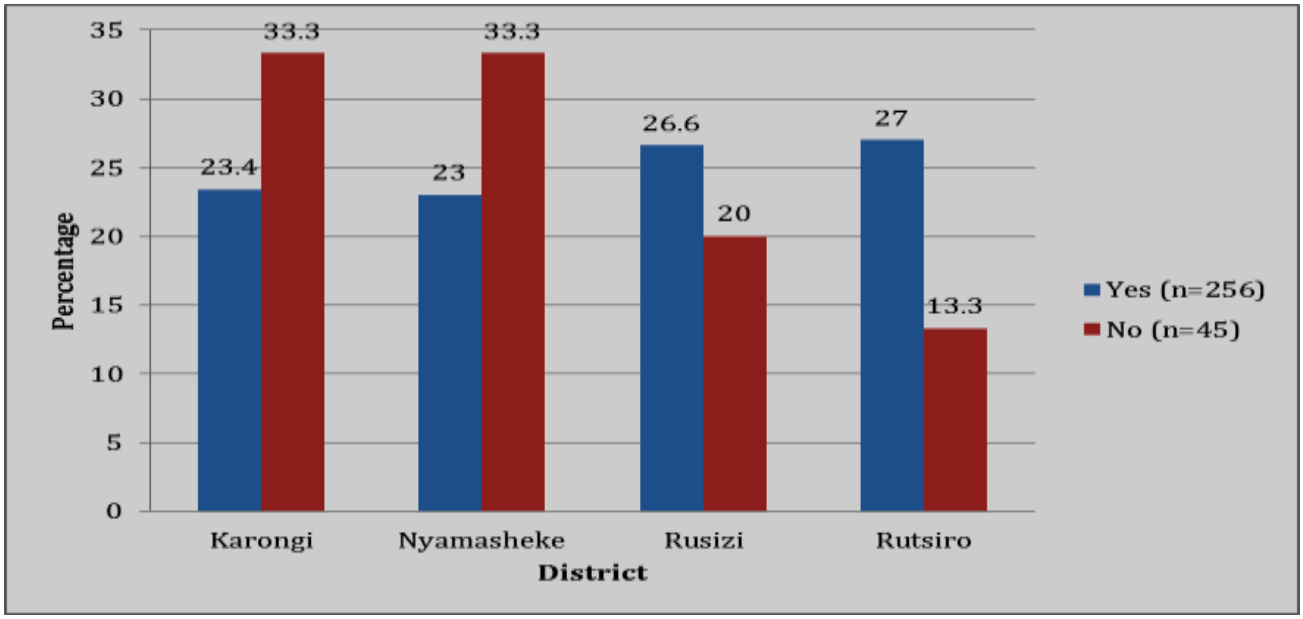
Figure 17-4: Do you think attitudes and social norms are changing against GBV?



Source: Primary data

In light of the findings above, majority of respondents think that community attitudes and social norms are progressively changing against GBV in 85% of cases. But another significant share of respondents support the opposite (15%). There is no significant difference between females and male respondents. Likewise, no significant difference between rural and urban dwellers is observed. Respondents who said that social norms are changing for better have advanced a number of independent variables that explain the changes. The figure below provides details on the same per each of the four districts.

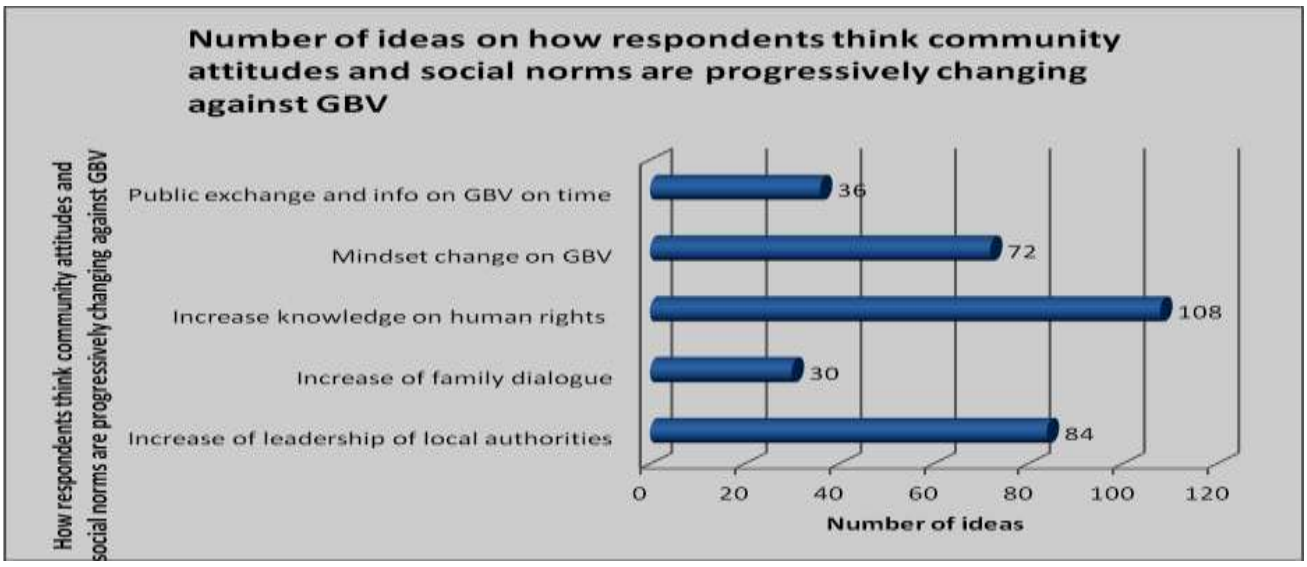
Figure 18-4: Perceptions on changes of attitudes and social norms against GBV per district



Source: Primary data

The findings above show that there is no significant difference between districts. Respondents reported perceived changes from each district. However, though respondents who did not witness any changes are relatively few (15 % of the total respondents) in general, the majority of them comes from Karongi and Nyamasheke districts with 33.3% each.

Figure 19-4: Perceived factors leading to changes of social norms and attitudes on GBV per number of respondents



Source: Primary data

In response to the question about factors explaining changes in social norms, many different suggestions were put forward. Among the survey respondents, 108 consider the increase in knowledge about human rights as the most important factor of change of social norms. Human rights awareness is respectively followed by the active role of local authorities (84) and mere mindset change against GBV (72). Also noticeable is the relatively weak role of families in the changes of social norms and attitudes that are supposedly taking place. This finding suggests the interest for various actors in this area of GBV to devise specific strategies and focus on the role of families in the fight against GBV. It is hypothetical whether any change happening without an active involvement of families will prove to be sustainable.

From qualitative insights, however, it is difficult to know how much changes have happened, and in which precise areas. One reason is the abstract nature of such changes because it is hard to accurately measure social norms and attitudes. In addition, qualitative research findings point to a number of issues suggesting that changes in attitudes and social norms in relation to gender equality and GBV are slow, if any. The issues that emerged from various group discussions and interviews with key informants in the four selected districts include, but are not limited to the following:

- Mediation of cases involving GBV is still a common practice in the region;
- If mediation is sometimes motivated by financial interests, it is also based on the families' tolerance of GBV. For instance, beating a wife is not that a big issue for some citizens;
- Reporting of cases of GBV is believed to be low compared to the prevalence of this phenomenon in the four districts. In many cases, low reporting is justified by the conviction that GBV, particularly when related to sex, will result in the victim being stigmatized, "*imiryango itinya kuvuga ibyabaye kubera kwirinda igisebo*"[41]

[41] Focus Group discussion, Rusizi, 02 June 2017.

(the families do not report GBV because they fear social stigma for the victims);

- People still consider shameful any topic related to sex due to cultural traditions, "*abantu ntabwo bari babohoka mu kuvuga ibijyanye n'igitsina kubera umuco, n'ubundi abenshi babivuga kubera ko abandi baba bababonye*"[42];
- Some people are not willing to share evidence or deliberately destroy evidence on GBV in order to close down the case.

4.2.2 Response and services to GBV Victims

One of the specific objectives of the GBV Policy is to provide an appropriate and adequate response to GBV. This includes ending impunity for GBV, promoting access to justice and other services to victims of GBV. Considering the nature of this objective, its achievement requires interventions from various sectors, mainly, justice sector, health sector and the police, among others.

4.2.2.1 Implementation of the national GBV policy by police services

From the provisions of the national GBV Policy, Rwanda national police is expected to play a key role in the prevention of and response to cases of GBV. More specifically, the police is expected to play a pivotal role in ensuring that citizens are aware about GBV and the legal process for cases involving GBV, protection of victims and so forth. The policy provides also for sustained capacity building for judicial service providers, including police officers.

The study findings show that policy provisions are satisfactorily implemented with regard to the role of the police as evidenced by quantitative findings in section 4.3.4 above.

In order to educate the population to prevent GBV, Rwanda National Police implements a series of activities. The police regularly organizes meetings with communities on security issues. GBV is part of the issues that are discussed given its prevalence and consequences. During

[42] Idem

community meetings, families are reminded of the rights of children and are encouraged to protect and promote these rights. The police provide lectures in various schools in the selected districts. During these lectures, GBV is widely discussed according to interview results. GBV law is used to raise awareness of citizens on the forms of this crime and on legal consequences associated with acts of GBV. The police attend meetings in the context of *Umugoroba w'ababyeyi* with a specific aim to convey messages on security and violence. The police also use community radio stations to educate the population against GBV in partnership with other actors, such as local administrations and non-government organizations.

Through community policing, the police have established strong ties with community structures. This collaboration is used to encourage community members to play an active role in preserving security and to report timely cases of GBV and other forms of violence. In addition to local authorities, there is a group of 5 community members in each cell working in close partnership with the police to prevent crimes and report them. The police have a staff member in charge of GBV in every police station who works closely with the Isange One Stop center. There is a toll free number for reporting of cases of violence and any other security related issues.

However, there are also noticeable gaps compared to the ambitions of the national GBV Policy:

- There is no comprehensive plan for capacity building for police officers involved in the fight against GBV;
- Reporting of cases of GBV is still low or GBV is poorly reported due either to outdated information or to lack of quality evidence;
- The number of police officers working on GBV is reasonably small compared to the size of territory they are expected to cover;
- Logistical equipment of police stations does not make it possible to effectively respond to cases of GBV.

4.2.2.2 Implementation of the national GBV policy in the health sector

The health sector is understandably crucial for the implementation of the national GBV Policy. Given that most forms of GBV are also health issues, medical facilities are expected to play a leading role in addressing the needs and rights of victims of GBV.

In addition to actual treatment of victims of GBV, the health sector in the districts of Karongi, Nyamasheke, Rusizi and Rutsiro is involved in prevention activities and, more importantly, in raising awareness of the population referral process immediately after GBV is committed. The health sector works closely with the police and judicial structures to ensure evidence for GBV is preserved and perpetrators are identified.

Every district hospital in the four districts has the Isange One Stop Center that provides a comprehensive service package to victims of GBV, particularly primary medical treatment and counselling under the same roof. Though these centers face some issues related to insufficient budget, they play a critical role in addressing urgent medical needs for victims. These centers however cannot serve effectively all the victims given difficult accessibility. Indeed, the size of the districts and economic hindrances prevent some victims from reporting for medical care. Previous studies have already shown that the Isange One Stop Centers do not provide some of the services they were initially expected to provide due to limited financial resources. In this regard follow up of victims of GBV after they have returned to their communities has remained the least performing area of the Isange One Stop Centers.[43]

In general, the health sector provides to victims of GBV the following minimum package in case of sexual violence:

- Provision of first aid and referral to hospital for effective management of the case;
- Counseling and treatment as stated in different health protocols;
- Prevention of non-desired pregnancies; and
- Quick HIV/AIDS test and prophylaxis treatment.

[43] See for instance Un Women Rwanda, UNFPA Rwanda and UNICEF Rwanda, *Evaluation of the Gihundwe One Stop Centre for survivors of GBV and child abuse*, Kigali, March 2015.

In line with the government health policy, treatment for victims of sexual violence is provided free of charge. Victims of physical and psychological violence receive the following minimum package when they report to health facilities:

- Counseling and primary treatment;
- Double referral of victims to hospital for diagnosis and case management and of perpetrator to police station;
- Informing local authorities and police for security reasons.

In general, health services provide a response that is adapted to each GBV victim's individual need as provided for by the national GBV Policy. However, health facilities do not always have the necessary equipment and skills to effectively address the needs of victims. From qualitative analysis of responses from the health sector staff, only 17% of health facilities have a specific staff in charge of GBV. The same findings show that 87% have attended, at least once, a training that has covered issues related to GBV, among other aspects. In light of the quantitative data, there is a permanent program to build capacity of service providers to assist victims of GBV. However, the researcher was not able to consult the capacity building plan. Compared to other sectors, medical and health facilities seem to have made greater progress with regard to response to cases of GBV.

At the community level, the presence of Community Health Workers (CHW) participates meaningfully in responding to cases of GBV. Indeed, CHW are actively engaged in sensitizing people on GBV as well as the referral process. Since they are community members, they also serve the first contact persons in case of GBV and other issues pertaining to their mandate. In this capacity, CHW provide local authorities with information in due time. They are key in organizing and carrying out community meetings and dialogue on GBV and by increasing awareness of GBV issues particularly among the youth. Previous studies have already suggested that CHW is more effective in addressing local health

and GBV issues compared to other community structures having similar mandate.[44]

Despite the progress above, there are still gaps in this particular area of response to GBV. The most important issues identified are as follows:

- The majority of health centers those that are closer to the population do neither have skilled staff to effectively respond and manage cases of GBV nor do they have relevant laboratory equipment. In consequence, it was estimated that 80% of cases of GBV reported to health centers are referred to district hospitals for more appropriate health care. The longer distance to district hospitals causes some GBV victims to stop seeking medical assistance.
- It was also reportedly noticed that several health centers are understaffed;
- Only few hospitals and bigger health centers have a permanent staff specifically responsible for cases involving GBV. In many health facilities, cases of GBV are referred to medical doctors and other relevant staff on the basis of their availability;
- Follow up of GBV victims after they are back to their communities is almost inexistent in all the four districts;
- Though the Isange One Stop Centers represent a huge progress in the response to cases of GBV, they face serious challenges. As of to date, there are 43 Isange One Stop Centers throughout the country.[45] However, limited funds, limited training and insufficient service providers in numbers are still undermining the functioning of these centers.

[44] See Care International Rwanda, *Sexual and gender based violence baseline study in Gakenke and Gatsibo districts*, Kigali, February 2014.

[45] Pro-Femmes Twese Hamwe, *Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda*, Kigali, 2014.

4.2.2.3 Implementation of the national GBV policy in the justice sector

The role expected form the justice sector in relation to prevention and response to GBV is obvious. GBV being a crime, justice is critical not only to rehabilitate the victim and to hold accountable the perpetrator, but also to deter violence in the interest of the entire society.

In addition to the above obvious responsibility of justice, the national GBV Policy sets clear and specific expectations for this sector. The most important policy provisions are related to the training of a critical mass of judicial service providers, particularly judges and advocates; the establishment of special court/specialized chamber/special procedures to deal with cases of GBV, visibility of cases of GBV in the public while protecting privacy of the victim and the alternative sentencing measures that hold perpetrators accountable while taking into account the best interests and social/financial needs of the victims.

Overall, the justice sector has made progress in implementing the national GBV Policy. Part of the implementation measures were initiated even before the policy was developed. Impunity for GBV is addressed by the Penal Code and the Code of Criminal Procedure of Rwanda in addition to the legal framework described above. The law on Prevention and Punishment of GBV for instance provides for zero tolerance. Special sessions such as mobile courts for cases of GBV particularly those involving children are organized as needed. Furthermore, SGBV cases are given priority.[46] In 2008, the NPPA established a special unit in charge of SGBV cases to mark the importance accorded to the fight against this crime. A list of all cases of GBV tried as well as the outcomes is published on yearly basis as a means to promote transparency and deter further violence. Though capacity building sessions are organized,[47]studies have pointed to significant knowledge gaps among the judicial personnel, particularly regarding the understanding of GBV

[46] Supreme Court Official website: www.judiciary.gov.rw
[47] See for instance Gender Monitoring Office, *Beijing +20 Rwanda country report*, Kigali, June 2014.

[48] and the issue of evidence in cases involving rape and other forms of sexual abuse.[49]

Significant achievement under the same area is the work of the Access to Justice Bureaus, known under their French acronym MAJ. Established in 2006, MAJ operates in each district and comprise of 3 lawyers, one of whom is specifically in charge of child protection and the fight against SGBV. These officers provide free legal services to the most vulnerable of society, including legal conclusions on cases involving GBV and case orientation among other duties, which improves access to justice among victims of GBV[50]. Legal aid is also provided by a number of CSOs in the four districts such as Haguruka in Nyamasheke.

The justice sector is also actively engaged in prevention and awareness raising activities, particularly through MAJ. The main activities include:

- MAJ staff are regularly invited to attend community meetings in or der to raise awareness about the GBV law and GBV itself;
- It organizes community trainings to achieve the same objectives. In Rusizi for instance12,633 community members have been traine d on GBV and GBV law,
- The same settings are used to educate about gender equality with t he aim to contribute to positive change of social norms;
- The justice sector is also active in encouraging people to report to j ustice structures whenever their rights are violated;
- It also encourages people to report information timely, particularly to local authorities and the police;
- MAJ particularly helps victims of GBV to build cases for reparations in addition to their orientation role;
- There is a plan to visit schools to engage with students on GBV and related legal instruments;
- Visits to couples are organized to help with mediation;

[48] Legal Aid Forum Rwanda, *Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda*, Kigali, 2013.

[49] Pro-Femmes Twese Hamwe, *Op. Cit.*, 2014.

[50] Ministry of Justice, Official website: www.minijust.gov.rw

- Advocacy for time conscious treatment of cases of GBV;
- General community members' education about their rights and due judicial procedure

However, despite a wide compliance with the GBV law, the justice sector faces a number of gaps that are likely to affect the quality of services it offers:

- The issue of evidence affects the rights of victims of GBV of accessing to justice. In addition to poor popular education on evidence preservation, the problem of inadequate forensic equipment does not help judges to gather evidence that goes beyond reasonable doubt;
- Limited skills for judicial personnel on issues pertaining to GBV. Judges and lawyers who work on GBV cases are selected on the basis of availability than any other criteria.

4.2.3 Coordination and monitoring of GBV interventions

As earlier stated (in chapter 2), coordination and monitoring constitute other key strategic areas on GBV policy. While assessing the status of its implementation, it is worth finding out how various anti-GBV efforts from different actors have been coordinated and monitored across the four selected districts.

Qualitative findings confirm that coordination and monitoring of GBV interventions have been improving due to the work of JADF and GBV district commissions. Likewise, development by Gender Monitoring Office of GBV indicators has significantly improved monitoring activities. However, some structural challenges have remained.

Despite the existence of JADF since 2007 in all the four districts, the study noticed a kind of imbalance in the distribution of interventions aimed at raising awareness and providing services to victims of GBV with Rutsiro being a bit behind, particularly with regard to non-state interventions. The key issues in this particular area have to do with planning that is not harmonized and is still largely funder driven. From interviews with various people, the feeling of Rutsiro being less covered by such interventions was perceptible.

Another important coordination and monitoring gap noticed was poor reporting and documentation of GBV cases. This was raised in all the four districts following low reporting from community members and limited skills for reporting and generating GBV quality documentation.

4.3 Major GBV policy implementation gaps

Sections 4.2-4.7 have dwelt on the implementation status of the national GBV Policy, identifying and discussing both progress and gaps. Overall, it appears that the national GBV Policy is satisfactorily implemented. However, there are still gaps, some of which are serious, while others appear to be relatively less important. These gaps were observed at different strategic areas of the policy. Below are the most important.

4.3.1 Identified gaps in the area of GBV Prevention

Under prevention, a lot has been done. Several sectors have mobilized to raise the population's awareness of GBV. As a result, a huge majority of respondents have heard about GBV policy, mainly during community meetings and media. A huge majority of respondents have a general idea about the referral process in case of GBV (89.4%) and 60.7% have had at least an opportunity to be trained or to attend a session where the GBV law was referred to. However, serious gaps are still noticeable in relation to GBV prevention:

- Though the level of awareness on GBV is visibly high, knowledge about the same has appeared to be too general. For instance, people who have heard about the referral process are many, but those who know clearly about the process are few as suggested by the qualitative data;
- In the same vein, knowledge about GBV is mixed. For instance, no single respondentmentioned economic violence during fieldwork;
- Though community structures such as *Umugoroba w'ababyeyi (parents' evening)* are becoming increasingly popular in educating communities on GBV, men's attendance is still reportedly very low in all the four districts to the extent that some have started renaming this mechanism *Umugoroba w'abagore*. (women's

evening). The national GBV policy's provision on men's active involvement in the prevention of GBV is yet to be realized;

- Ownership of the fight against GBV is still low. This observation is supported by a number of factors including low membership of community structures working on GBV. From the quantitative survey, less than 30% are members of such structures;
- Empirical findings clearly show that families play a little role in the fight against GBV, and yet studies have already established that most cases of GBV are committed within the family settings;
- Though educational structures are playing an increasingly active role in sensitizing the youth on gender equality and against GBV, there is no harmonized manual on GBV. In addition, the majority of school teachers and managers have never benefitted from GBV specialized training in the four districts;
- Specific anti-GBV clubs are not generalized yet in all schools in the four districts.

4.3.2 Identified gaps in the area of GBV Response

Response to cases of GBV involves a chain of service providers ranging from communities to justice sector through the health sector. Despite remarkable progress as detailed in the previous sections, the multiplicity of actors implies a number of gaps that affect the quality of response:

- Reporting of cases of GBV is still low mainly due to cultural and economic reasons. If some people face economic hindrances that prevent them from reporting, others do so because they believe reporting will expose the victim to social stigma. In addition, there is the issue of late reporting that results into poor evidence for GBV and consequently limited access to justice by victims;
- The study shows that there is no comprehensive plan to build the specific capacity of police officers working on GBV;
- In addition, given the size of territory these officers are expected to cover and having in mind the existing logistical constraints that the

study findings confirmed, the number of police personnel working on GBV is small;

- The same applies to health facilities. The findings show that only 17% of health structures have a specific staff in charge of GBV cases;
- The Isange One Stop Centers are generally located far from the majority of communities. The Isange themselves face resource constraints, which reduces their effectiveness;
- Estimates suggest that 80% of cases of GBV that are reported to health centers are referred to hospitals for appropriate medical response given that the majority of these centers are either ill equipped or do not have staff with the necessary skills;
- Follow up of victims of GBV after they are back to their respective communities has remained unaddressed in all the four districts due to budget constraints, which affects the reintegration process;
- Forensic evidence is still problematic, which affects the rights of victims of GBV in that it affects access to justice;
- The study shows that there is no comprehensive plan to provide GBV specialized training to judicial officers working on GBV cases, yet knowledge gaps have been widely documented as already mentioned.

4.3.3 Identified gaps in the area of Coordination and monitoring of GBV interventions

Although progress has been made with regard to coordination and monitoring of GBV activities, in practice, gaps related to joint planning, GBV data collection and reporting skills are still undermining the quality of prevention of and response to GBV. Inadequate coordination translates into duplication of activities and sometimes imbalanced geographical distribution of GBV interventions.

Table 15-4: Summary of GBV policy implementation gaps

S/N	Policy Strategic area	Identified Gaps
1	**Prevention of GBV**	Knowledge about GBV and GBV policy is too general and mixed
		Community participation, especially men's engagement in structures such "*Umugoroba w'Ababyeyi"*
		Ownership of the fight against GBV is still low as evidenced by low membership of community structures working on GBV.
		Reporting of cases GBV is still low mainly for cultural and economic reasons.
		Families play a little role in the fight against GBV,
		Inexistence of harmonized manual on GBV in educational structure, and school teachers and managers have never had a GBV specialized training, while Anti-GBV clubs are not present in all schools.
2	**Response and services to victims of GBV**	There is no comprehensive plan to build specific capacity of service providers (police officers, Judicial officers and health staffs) working on GBV.
		Limited police officers working on GBV and logistical constraints considering the territory coverage.
		Many people live a long way from the Isange One Stop Centers. Some of these face resource constraints, which reduces their effectiveness
		80% of cases of GBV that are reported to health centers are referred to hospitals for appropriate medical response given that the majority of these centers are either ill equipped or do not have staff with the necessary skills;

		Reintegration of GBV Victims in their communities after services is still problematic
		Forensic evidence is still problematic, which affects the rights of victims of GBV in that it affects access to justice;
3	**Coordination, Monitoring & evaluation**	Planning of activities /interventions in the area of fighting GBV is not harmonized and is still largely funders driven.
		Reporting and documentation of GBV cases remain an issue due to limited skills among for local government staffs and community members

4.4 Core Advocacy Issues

Section 4.3 above has extensively discussed the gaps pertaining to the implementation of the national GBV policy in the four districts covered by the study. While all gaps need to be addressed for effective GBV prevention and response, some of them require urgent advocacy actions given their impact. In addition, for the strategic reasons, PFTH should focus on key issues in the course of advocacy. To ease advocacy efforts, key issues are identified per intervention sector as suggested in the GBV policy. The table below summarizes key advocacy issues and sets expected results.

Table 16-4: Key advocacy Issues in four districts

#	GBV policy sector	Advocacy issues	Advocacy objectives
		Insufficient capacity to collect and report GBV information.	Empowerment of community members for quality GBV data collection and reporting.
		Low Ownership by families and community members of the fight against GBV evidenced by low attendance and membership of relevant community structures and weak men's engagement in *Umugoroba w'ababyeyi*	Community mobilization for formation of more initiatives against GBV and enrollment; Sensitization of heads of households and members for the inclusion of anti-GBV specific activities in the family *Imihigo* Men oriented sensitizations sessions on GBV; formation of small groups of interests bring together men and women such as tontines
		Low knowledge about GBV evidence preservation	Media (radio) regular campaigns on evidence preservation; capacity building (trainings) for district resource persons, including MAJ and the staff in charge of social affairs on GBV evidence
2.	**Educational structures**	Lack of harmonized training and sensitization manual on GBV	GBV training manual available in all national languages to all schools
		Teachers and school managers not having specific knowledge on GBV and related instruments	Teachers and school managers are trained on GBV, GBV law and the referral process
3.	**The police**	No comprehensive plan for capacity building of police officers on GBV case management	A comprehensive plan for capacity building for a critical mass of police officers dealing with GBV cases is available.
4.	**Health sector**	Centralization of Isange one Stop centre	The Isange one Stop centre closer to the population and

		at the district hospital and absence of staff in charge of GBV in health centers.	health centers enabled to deal effectively with GBV cases.
		Inadequate capacity building plan and equipment of health facilities for effective management of GBV cases.	A plan for capacity building for health service providers and appropriate equipment are available.
5.	**Justice sector**	Problematic evidence for rehabilitation of GBV victims and accountability of perpetrators	Quality forensic laboratories for a better access to justice of victims of GBV and deterrence of sexual violence
		No comprehensive plan for capacity building on GBV for the judicial chain of service providers	Knowledge about GBV is improved among justice service providers, access to justice is improved as well as accountability for GBV.
6.	**Local gvts/collaboration & coordination**	Less harmonized planning and imbalanced distribution of GBV interventions between districts, particularly by non-state actors	Harmonized planning and balanced GBV interventions with a particular emphasis on remote rural areas
		Insufficient capacity for GBV quality data collection, treatment and reporting and monitoring of community anti-GBV initiatives (structures)	Improved capacity and skills for GBV data collection, treatment and reporting and monitoring of community anti GBV initiatives.

Source: Adapted from primary data

GENERAL CONCLUSION AND RECOMMENDATIONS

Conclusions

The main objective of this study was to assess the status of implementation of the national GBV Policy with a particular focus on the identification of the implementation gaps. From the policy, there are three strategic areas, namely prevention of GBV, response to GBV and coordination and monitoring of GBV interventions. The policy identifies several implementation structures that can be summarized into the following key categories and whose roles are practically interconnected: communities, local administrations, educational structures, the police, and the health and justice sectors. In addition to these categories are non-state actors, including civil society organizations and the private sector.

In relation to the objective above, the study findings point to the following key trends:

- A lot of effort has been invested in raising awareness of the populations on GBV and the GBV law in the four selected districts. Community meetings and media play a pivotal role in this process, while families, faith based organizations and schools play a relatively minor role to raise awareness of populations and fight against GBV compared to the police and the ministry of health. The level of awareness of GBV is high, but knowledge is too general to the extent that respondents are not aware about some forms of GBV, particularly economic violence. In the same vein, respondents have general ideas about the referral process to follow in case of GBV;
- The study has noticed remarkable progress in relation to protection of victims of GBV, medical services and justice. Illustratively, there is a GBV desk in each police station, a comprehensive service package is provided to victims of GBV by the Isange One Stop Centers free of charge and under the same roof and the judicial system has introduced significant reforms,

- Including a special GBV unit within the NPPA and measures to consider GBV part of the priority cases. The MAJ significantly contributes to access to justice among the victims of GBV;
- Despite this progress, there are still serious gaps and challenges that affect effective implementation of the national GBV Policy. For instance, only a few health facilities have a staff in charge of GBV contrary to the provisions of the national GBV Policy; health centers are not well equipped and there are few staff with appropriate skills to respond effectively to cases of GBV. There are no comprehensive permanent plans for capacity building of the personnel within the judicial system and evidence to support access to justice for victims of GBV is still a serious hindrance;
- Community reporting of GBV cases is still low due mainly to cultural traditions and beliefs. The capacity of the four districts to collect quality GBV data, treatment and reporting is low as well.
- Disaggregated data per district in the sections above show that the implementation process of the national GBV Policy is similar in the four districts. Similar gaps and challenges were identified in all the four districts despite slight differences.

Recommendations

In relation to key study findings, the following recommendations are formulated as listed the table below:

Table 17: List of recommendations

Recommendations	Implementation responsibility
To MIGEPROF	
Develop a program for families' active engagement in GBV prevention and response efforts;	**MIGEPROF**
Avail the GBV training manual to all the schools in Kinyarwanda, French and English;	**MINEDUC**
Train teachers and school managers on gender equality and GBV;	**MINEDUC**
Develop and avail guidelines for the local level leaders and communities on their role in the process of reintegration of GBV victims;	**MINALOC**
Develop strategies to increase men engage in community structures on GBV such as *Umugoroba w'ababyeyi*	**MIGEPROF**
To MINALOC	
Ensure interventions against GBV, particularly by non-state actors are fairly distributed between districts with special focus to remote districts;	**RGB**
Sensitize community members to play an active role in the reintegration of victims of GBV	**CSO**
Avail capacity building opportunities at local level (closer to the communities) in order to increase women's attendance and participation;	**MINALOC / DISTRICT**
TO MINEDUC	
Establish anti-GBV clubs in all educational structures, particularly primary and secondary schools;	**REB / WDA**

TO MINISTRY OF HEALTH	
Improve health technical equipment for quality evidence on GBV cases	
Train GBV focal persons at health centres on how to handle GBV cases	**MINISANTE**
Decentralize the Isange One stop Center to closer health facilities to ease accessibility by the victims of GBV;	**MINISANTE**
Organize follow up visits to victims of GBV after they are back to their respective homes for a more successful reintegration	**MINALOC**
TO THE JUDICIARY AND MINIJUST	
Develop a comprehensive and permanent plan for capacity building of judicial service providers, including investigators, prosecutors, judges and lawyers;	**MINIJUST/ NPPA**
Train specialized judicial service providers on GBV, related GBV law and related topics;	**MINIJUST**
Educate the public on the preservation of evidence of GBV	**CSO**
TO THE DISTRICTS OF KARONGI, NYAMASHEKE, RUSIZI AND RUTSIRO	
Establish and strengthen community structures where they are not and ensure men's involvement in activities of prevention of and response to cases of GBV;	**CSO**
Sensitize the population to join anti-GBV structures and play active role for prevention and reporting of cases of GBV;	**CSO**
Strength the M&E activities to monitor the functioning of *Umugoroba y'Ababyeyi* and other community initiatives that help to foster a conducive environment for prevention and reporting of GBV cases;	**DISTRICT**

Engender District Development Plans by including activities pertaining to gender equality, the prevention and response to GBV and budget	**DISTRICT**
Train in charge of M&E on GBV data collection, analysis and reporting;	**District**
TO FAMILIES	
Insert in family performance contracts "*Imihigo*" activities pertaining to the prevention of and fight against GBV;	**District for follow up.**
TO CIVIL SOCIETY ORGANIZATIONS	
Train selected community leaders from the four districts on GBV law, policy, other relevant instruments, GBV reporting mechanism and the referral process;	**CSO**
Advocate for the increase of district budget allocated to anti-GBV activities	**CSO**
In collaboration with the justice sector, conduct community-based campaigns on preservation of evidence of GBV in the four districts;	**CSO**
Monitor on regular basis the functionality and of the established anti-GBV community structures.	**CSO**
AREAS FOR FURTHER RESEARCH	
GBV status among People With Disabilities and other marginalized groups	
The role of Faith Based Organizations in the prevention and fight against GBV;	
Examine barriers to family participation in GBV prevention and response efforts.	

KEY REFERENCES

Care International Rwanda, *Sexual and gender based violence baseline study in Gakenke and Gatsibo districts*, Kigali, February 2014.

Gender Monitoring Office, *Beijing +20 Rwanda country report*, Kigali, June 2014.

GMO, *Evaluation of the implementation of the 2009-2012 National Action Plan for the United Nations Security Council Resolution 1325 in Rwanda*, Kigali, May 2015.

Legal Aid Forum Rwanda, *Improving the Performance of the Criminal Justice System in Rwanda in Managing Gender Based Violence Cases: Report on the Assessment of Challenges and Capacity needs of the Criminal Justice Agencies in Managing Gender Based Violence Cases in Rwanda*, Kigali, 2013.

Lincoln, Y. S., & Guba, E. G., *Naturalistic inquiry*, Beverly Hills, CA, Sage, 1985.

MIGEPROF, *Guidelines on the setting up of committees to fight against gender-based violence and for the protection of child's rights, from Umudugudu to district levels* (no date).

MIGEPROF, *National Anti-GBV Policy and Strategic Plan*, Kigali, 2011.

MIGEPROF, *National Policy against Gender-Based Violence*, Kigali, July 2011, pp.14-15.

Pro-Femmes Twese Hamwe, *Situational awareness on services delivered to the victims of GBV and services provided in Isange One Stop Centers in Rwanda*, Kigali, 2014.

Ministry of Finance and Economic Planning (MINECOFIN), *Gender budgeting guidelines*, Kigali, May 2008.

Rwanda Integrated Household Living Conditions Survey (EICV) 2013/2014, *Thematic report-economic activity*, Kigali, March 2016.

Un Women Rwanda, UNFPA Rwanda and UNICEF Rwanda, *Evaluation of the Gihundwe One Stop Centre for survivors of GBV and child abuse*, Kigali, March 2015.

UNIFEM, *Case study. Establishment of Rwanda National Police Gender Desk*, Kigali, 2009.

United Nations Department of Economic and Social Affairs, *The World's Women 2015*, *Trends and Statistics* (Chapter 6, Violence against Women), 2015;

University of Rwanda, Centre for Gender, Culture and Development, *Africa region security organs capacity building workshop on violence against women and girls: prevention, response and peacekeeping*, Report of a workshop, Kigali, 21-24 July, 2011.

World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, 2013.

APPENDICES

A. STUDY QUESTIONNAIRE

I. ENUMERATOR identification													
Enumerator Name													
Enumerator Code								**Questionnaire Number:**					
Date									**Start Time**				
									End time				

II. ADMINISTRATIVE INFORMATION				
District	**Code**		**1. Sector**	
Karongi	**01**		**2. Cell**	
Nyamasheke	**02**		**3. Village**	
Rusizi	**03**		**4. Village**	
Rutsiro	**04**			

III. DEMOGRAPHICS							
3.1 Residence	Urban	01		**3. 2 Sex**	Male	01
	Rural	02			Female	02

3.3 Which of the following age groups do you belong to?							
18-24	01		35-39	04		50-54	07
25-29	02		40-44	05		55-59	08
30-34	03		45-49	06		60+	09

3.4 Employment Status		**3.5 Level of education attained**		**3.6 Marital status**	
Unemployed	01	Primary Only	01	Married	01
Farmer	02	Vocational training	02	Single	02
		Secondary Only	03	Widow/er	03
Public servant	03	University	04	Divorced	04
Employed in CSO/NGO	04	None	05	Separated	05

Employed in private sector	05				
Self-employed	06				
Retired	07				
Other (specify)	08				

IV. ACTUAL RESEARCH QUESTIONS

QUESTIONS TO COMMUNITY MEMBERS

N°	Questions	Answers	Code
Q1	Have you ever heard about the National Policy against Gender Based Violence?	Yes=1 Non=2	/___/
Q2	If the answer on the previous question is yes, from where did you hear about it for the first time? **(more than one answer allowed; don't exceed three)**	1 = Community meetings 2 = I attended a dedicated session 3 = Media (radio, TV….) 4 = Friends/colleagues 5 = Family 6 = School 7 = Churches 8 = Workplace 9= Community anti-GBV club 10 = Other (specify)	/___/ /___/ /___/ /___/ /___/ /___/ /___/ /___/ /___/ /___/
Q3	If you ever heard about it, what is GBV in your own understanding?	---------- ---------- ----------	
Q4	What forms of GBV do you know?	1) 3) 2) 4)	
Q5	In your opinion, which of the following organizations/structures participate in fostering an environment that prevents GBV?	1) Local Governments entities 2) Faith Based organizations 3) Media organs 4) Civil Society Organizations 5) Educational based structures 6) Community-based structures (anti-GBV clubs, Umugoroba w'ababyeyi, Umuganda…) 6) Other (specify)	/___/ /___/ /___/ /___/ /___/ /___/ /___/

Q6	Have you ever attended a meeting/sensitization campaign/training on GBV Law?	Yes=1 Non=2	/___/
Q7	If yes, which organization/structure organized it if you still remember?	1) 2)	/___/ /___/
Q8	How frequent are discussions/meetings/initiatives on GBV in your residence area?	1=Very frequent 2=Frequent 3 =Less frequent 4 = Rare 5 = Do not exist	/___/ /___/ /___/ /___/ /___/
Q9	Do you think community attitudes and social norms are progressively changing against GBV?	Yes=1 Non=2	/___/
Q10	If yes, how?	----------	
Q11	Are there community structures working on GBV in your residence area that you know?	Yes=1 Non=2	/___/
Q12	If yes, who are members of such structures?	1=Men and women 2=Predominantly women 3 =Predominantly men	/___/ /___/ /___/
Q13	Have you ever had any discussions/meetings on GBV at your family/household level?	Yes=1 Non=2	/___/
Q14	Are you member of any community structure on GBV?	Yes=1 Non=2	/___/
Q15	If yes, what is your own role in this structure?	---------- ----------	

Q16	Are you aware of the referral process in case of GBV?	Yes=1 Non=2	/___/
Q17	How would you proceed before cases of rape/sexual abuse and physical violence for instance?	a) Case of rape/sexual abuse: ---------- ---------- b) Physical violence: ---------- ----------	
QUESTIONS TO SCHOOLS/EDUCTAIONAL STRUCTURES			
Q18	What mechanisms exist at the school level to prevent and fight against GBV?	1)---------- 2)---------- 3)----------	
Q19	Have your school/university ever had a session/sessions on GBV policy and laws to raise awareness of students?	Yes=1 Non=2	/___/
Q20	Are there specific activities to raise awareness of the youth on sexuality and reproductive health? If yes, which ones?	1)---------- 2)---------- 3)----------	
Q21	What do you think should be done to ameliorate the way educational sector/structures engage in preventing and responding to GBV?	---------- ---------- ---------- ---------- ---------- ---------- ----------	
QUESTIONS TO HEALTH SERVICE PROVIDERS			
Q22	What is the minimum package that you provide to victims of GBV?	1)Victims of sexual violence:---------- ---------- 2)Victims of physical/psychological violence: ---------- ----------	
Q23	How tailored to specific needs of individual victims of sexual violence and physical violence are the existing responses at the health sector	1) Specific to individual needs 2) General responses	/___/

Q24	Does the structure for which you work have a specific staff in charge of GBV victims?	Yes=1 Non=2	/___/
Q25	Have you or your colleagues ever attended a training/workshop on how to respond to needs of victims of GBV?	Yes=1 Non=2	/___/
Q26	Is there a permanent program to build capacity of service providers to victims of GBV?	Yes=1 Non=2	/___/
Q27	What is the cost of health services for victims of sexual and physical violence?	---------- ---------- ---------- ----------	
Q28	How do health structures work communities to respond to cases of GBV?	---------- ---------- ---------- ----------	
QUESTIONS TO JUSTICE SERVICE PROVIDERS			
Q29	What measures have been taken to raise awareness of justice service providers about GBV law and policy as well as the legal process in case of GBV?	1)---------- ---------- 2)---------- ---------- 3)----------	
Q30	Is there a permanent program to build capacity of the chain of judicial system to respond effectively to cases of GBV?	Yes=1 Non=2	/___/
Q31	What mechanisms exist to ensure deterrence for GBV?	1)---------- 2)---------- 3)----------	

Q32	Are there alternative sentencing measures that hold perpetrators accountable while taking into account the best interests and social/financial needs of the victims?	Yes=1 Non=2	/___/
Q33	If yes, which ones? How do they work?	1)---------- 2)---------- 3)----------	
Q34	Are there sufficient numbers of judges and defense lawyers adequately trained to deal with GBV cases?	Yes=1 Non=2	/___/
Q35	Is there a special court/specialized chamber/special procedures to deal with cases of GBV?	Yes=1 Non=2	/___/
Q36	What measures are in place to ensure sentences on cases involving GBV are known by the public while protecting privacy of the victims?	1)---------- 2)---------- 3)----------	

B. DOCUMENT ANALYSIS GUIDE

The documentary observation will consider a number of documents in addition to GBL policy and Law. Among these documents are:

- Districts Development Plans (DDPs) and annual reports;
- Districts budgets;
- Staff performance contracts;
- CSOs and FBOs strategic/action plans;
- School curricula and extra curricula programs;
- Police reports; and
- Judicial strategic/action plans and reports.

During document analysis, focus will be put on the following areas.

Key areas	Specific aspects
Prevention of GBV	▪ Activities aimed at raising awareness on GBV and budget ▪ Baseline information and situation/context analysis
Ownership of GBV policy	▪ Incorporation of GBV policy actions into DDPs, budget documents, individual organizations action plans… ▪ Profile of actors (public, CSOs, community structures, individual men and women, girls and boys…); ▪ Initiatives taken by individuals and community structures to fight against GBV ▪ Sources of information to know the role of community structures in reporting cases of GBV;
Response and services to victims of GBV	▪ Importance of budget allocated to GBV; ▪ Human resources with appropriate trainings to deal with GBV ▪ Special procedures to deal with cases of GBV (specialized courts/chambers; prioritization, … ▪ Capacity building plans for service providers to victims of GBV; ▪ Quality and regularity of reports on GBV; ▪ Partnership (MoUs /operating standards) between various actors to achieve coherent interventions); ▪ Coordination and engagement with community structures, CSOs and FBOs

C. INTERVIEW GUIDE

C.1 With vice Mayors in charge of Social Affairs/staff in charge of social affairs

1. What strategies are in place to raise community awareness on gender, GBV, and GBV laws and policies?
2. What support is provided to communities to promote understanding of gender and positive social norms and attitudes?
3. What strategies are in place to ensure law enforcement officers continue to receive training on dealing with victims, including those with special needs?
4. What mechanisms exist to help create a family and community GBV hostile environment?
5. What mechanisms are in place to support spouses and families of imprisoned GBV perpetrators?
6. What is done to ensure rehabilitation of GBV perpetrators?
7. What strategies do exist to identify and support (including economically) groups and individuals at high risk of GBV?
8. What measures are in place to empower communities to actively participate in the reintegration process of victims of GBV?
9. What measures are in place to create a network between all organizations working on GBV and to ensure coherent interventions?
10. How well are the rights and needs of victims of GBV taken into account during the district's planning and budgeting activities?
11. What are the major challenges related to the prevention and fight against GBV in this district? What do you think are the best strategies to effectively prevent and respond to GBV?

C.2 With the district JADF

1. What strategies are in place to build a network for the fight against GBV in this district?
2. Who are the actors in this particular area of GBV in this district?
3. How well is their work coordinated? How coherent are their interventions?
4. What mechanisms are in place to ensure GBV victims rights and needs are addressed during the district planning and budgeting process?
5. What mechanisms exist at the district level to engage with families and communities to prevent and fight against GBV?
6. What are the major challenges related to the prevention and fight against GBV in this district? What do you think are the best strategies to effectively prevent and respond to GBV?

C.3 With the district Police Commander/in charge of GBV

1. What strategies are in place to raise community awareness on gender, GBV, and GBV laws and policies?
2. What does the police do to engage with communities and families over GBV issue?
3. What do you think of the quantity and quality of reporting of GBV cases in this district?
4. How is the capacity of the police to respond to cases of GBV in this district? What are the major challenges in this particular area?
5. What do you think of social norms and traditions vis-a-vis gender equality and GBV in this district?
6. How is coordination of various GBV interventions in this district?
7. What are the major challenges in relation to prevention and fight of GBV in general?
8. What do you think are the best strategies to effectively prevent and respond to cases of GBV?

C.4 With representatives of the health sector/district hospital

1. What strategies are in place to raise community awareness on GBV in the health sector?
2. How is the capacity of the health sector/hospital in this district to respond to cases of GBV? How well is the hospital/dispensary equipped to respond to cases of GBV?
3. Does the district hospital have a GBV focal point? If yes, what is his role and how well is this role performed? If no, what do you think are the reasons?
4. What is the district hospital plan to develop a critical mass of staff with appropriate training on how to deal with cases of GBV?
5. How well is the district hospital prepared to deal with cases of trauma for victims of GBV?
6. What are the major challenges in relation to prevention and fight against GBV in general and in the health sector in particular?
7. What are the best strategies to respond more effectively to cases of GBV in the health sector?

C.5 With a representative of the Justice sector/MAJ

1. What strategies are in place to raise community and justice providers' awareness on gender equality, GBV, GBV policy and laws?
2. What is the legal process in place for cased involving GBV? How well is the process known? How functional is it?
3. What strategies are in place in the sector (justice) to avail a critical mass of justice service providers with appropriate training to handle cases of GBV?
4. How are cases of GBV handled in the justice system in this district?
5. What is done to strengthen the capacity of the legal and judicial systems to process cases in a fair, expedient and just manner?
6. What is done to ensure that there are sufficient numbers of judges and defense lawyers adequately trained to deal with GBV cases?
7. What mechanisms are in place to hold GBV perpetrators accountable?
8. How is transparency of cases involving GBV as well as their outcomes promoted and how is privacy of victims protected?

9. What alternative sentencing measures that hold perpetrators accountable while taking into account the best interests and social/financial needs of the victims?
10. How does the judicial system engage with communities to ensure access to justice for victims of GBV?
11. What are the major challenges vis-à-vis provision of justice to victims of GBV and what strategies can help to respond more effectively to cases of GBV?

C.6 With a representative of the education sector

1. What mechanisms exist at the school level to prevent and fight against GBV?
2. What is done by education structures to raise awareness on GBV policy and laws among their respective students/pupils communities and to influence change of tradition and social norms?
3. Are there specific activities to raise awareness of the youth on sexuality and reproductive health? If yes, which ones? How well do they work?
4. What are the major challenges vis-a-vis prevention and response to GBV in general and for the education sector in particular?
5. What do you think should be done to ameliorate the way the education sector/structures engage in preventing and responding to GBV?

C.7 Sector/Cell Executive secretary

1. What strategies are in place to raise community awareness on gender, GBV, and GBV laws and policies?
2. What support is provided to communities to promote understanding of gender and positive social norms and attitudes?
3. What strategies are in place to ensure law enforcement officers continue to receive training on dealing with victims, including those with special needs?
4. What mechanisms exist to help create a family and community GBV hostile environment?
5. What mechanisms are in place to support spouses and families of imprisoned GBV perpetrators?
6. What is done to ensure rehabilitation of GBV perpetrators?

7. What strategies do exist to identify and support (including economically) groups and individuals at high risk of GBV?
8. What measures are in place to empower communities to actively participate in the reintegration process of victims of GBV?
9. What measures are in place to create a network between all organizations working on GBV and to ensure coherent interventions?
10. How well are the rights and needs of victims of GBV taken into account during the district's planning and budgeting activities?
11. What are the major challenges related to the prevention and fight against GBV in this district? What do you think are the best strategies to effectively prevent and respond to GBV?

C.8 With a representative of CSOs (GBV domain)

1. What strategies are in place to raise community awareness on gender, GBV, and GBV laws and policies by CSOs?
2. How do you identify and respond to the rights and needs of victims of GBV?
3. How do you work with other district partners in this area of GBV?
4. What are the major challenges vis-a-vis prevention and response to GBV in general and for CSOs in particular?
5. What strategies do you think can help to prevent and respond more effectively to cases of GBV?

C.9 With a representative of FBOs

1. What strategies are in place to raise community awareness on gender, GBV, and GBV laws and policies by FBOs?
2. What do FBOs do to prevent and respond to GBV?
3. How do you work with other district partners in this area of GBV?
4. What are the major challenges vis-a-vis prevention and response to GBV in general and for FBOs in particular?
5. What strategies do you think can help to prevent and respond more effectively to cases of GBV?

D. CHECKLIST FOR FOCUS GROUP DISCUSSIONS

1. What do you know about GBV (definition, magnitude in the district, forms, causes and consequences)?
2. Have you ever had an opportunity to be trained/learn about GBV Law and Policy? If yes, when was that and who organized the training/event? What do you know about the two instruments?
3. What do individuals, families and communities do to raise awareness about GBV in this district?
4. What would you do in case of GBV involving physical injury and rape? What do you know about the referral process?
5. How well do you think GBV cases are reported by individuals and families to relevant structures?
6. What do you think about health services to victims of GBV in your district?
7. What do you think about justice services to victims of GBV in your district?
8. What do you know about GBV evidence preservation?
9. What do you think about protection services to victims of GBV in your district?
10. How is reintegration done for victims of GBV in your community?
11. What do you think is the role of CSOs and FBOs in the prevention and response to cases of GBV and the services to victims?
12. What do you think are the major challenges in relation to prevention and response of GBV in your community?
13. What strategies can help to effectively anticipate and deal with cases of GBV?