Health Services for Survivors of Gender Violence in Rwanda

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GENDER-BASED VIOLENCE, and more specifically, violence against women, remains a public health issue in many countries, negatively impacting women's psychological and physical security and resulting in inequities in health status and health service access.

IN 2008, IntraHealth's Twubakane Decentralization and Health Program assessed the readiness of the political/legal environment, the health system and the community to respond to violence against women in Rwanda. At five study sites in Kigali, researchers met with and collected data from 38 health care providers, 40 antenatal clients, 117 participants in community focus groups, 14 key informants and 27 representatives of community organizations offering services to help victims of gender-based violence.

"**I COULD NEVER** reveal the violence done to me…That would be shameful, But also, I don't have confidence in the health facility personnel; they'd divulge my secrets. It's better just to keep quiet!"

— Client Focus Group Respondent

Assessment Results

A variety of psychological, cultural, socioeconomic, physical and institutional barriers often keep women in Rwanda from taking advantage of existing services that can assist victims of gender-based violence. Secrecy, shame, silence and impunity perpetuate the violence.

Health care providers have positive attitudes about caring for victims, though they lack knowledge about violence against women. Too, existing service delivery protocols and client education materials are lacking and often do not respond to the needs of women who have suffered from violence.

Interestingly, the politico-legal environment offers opportunities to integrate a response to violence against women into antenatal care, but policy gaps result in victim-unfriendly services.

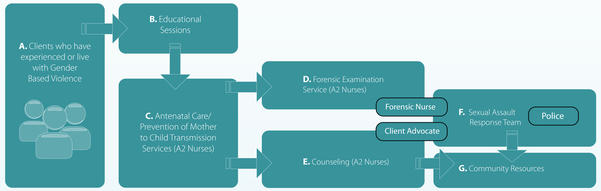
- According to current Sexual Violence policy protocol, only forensic physicians are permitted to perform the forensic documentation of cases of abuse and to prescribe post-exposure prophylaxis. Unfortunately, forensic doctors are scarcely found in rural facilities, thus creating an access barrier for poor and rural women.
- Cases of sexual assault must be substantiated by a witness, or by the perpetrator's own confession. This makes it exceedingly difficult for victims to bring abuse claims forward, thus victims lack trust in the system.
- Standard operating procedure for police dealing with gender-based violence communicates distrust of the victim. For example, police are trained to "test for any alcohol content to prove that the victim was sober and can be relied upon on the account of his/her allegations."

Recommendations

To promote gender equity in health, we recommended activities at the national policy, health facility and community levels to eliminate obstacles to service access and create better health outcomes for women. These should include:

- Reforming health policy, training health care providers to better respond to violence against women, and developing more victim-friendly protocols and materials for screening, counseling and referring victims
- Promoting partnerships between communities and health facilities for improved survivor support and referral
- Sensitizing police officers and improving officer training to better respond to violence against women
- Mobilizing communities to prevent violence against women and promote women's financial independence.

Additionally, we recommended that the Rwanda Ministry of Health adopt a decentralized service model that delegates services to more accessible cadres in the health workforce and creates linkages with the justice system and economic, legal and social support in the community. In such a model, a client (A) who visits a health center and has experienced violence will first be provided with educational materials at an information session conducted by health center staff (B). She may then be seen by an A2 nurse for antenatal care and/or services to prevent the transmission of HIV from mother to child (C). At this stage, she may be referred to forensic examination services (D) or counseling services (E), both conducted by A2 nurses. For victims of sexual violence, a sexual assault response team (F) consisting of a forensic nurse, a client advocate and the police will offer further assistance. The client may then be referred to community-based resources (G) to receive legal, economic or psychosocial support.



"**THERE IS TOO MUCH** impunity for violence: One of my best friends is regularly beaten by her husband but each time she reports this to the authorities, they don't follow through and her husband ridicules her even more."

— Community Focus Group Respondent

ABUSED WOMEN ARE MORE LIKELY TO HAVE an unintended pregnancy than women who are not abused. Violence against women is also a barrier to women's access to HIV testing, FP, compliance with ART, and proper infant feeding. [1]

WOMEN EXPOSED TO SPOUSAL VIOLENCE ARE 50% more likely to experience at least one episode of fetal loss compared with women not exposed to abuse. Recurrent fetal mortality is associated with all forms of spousal violence. [2]

MORE THAN 25% of Rwandan women had experienced sexual violence during the five years prior to a recent study; more than 12% had been victims of at least one act of physical violence; and more than 13% had been victims of psychological violence. [3]

1. Alio AP, Nana PN, Salihi HM. Spousal Violence and potentially preventable single and recurrent spontaneous fetal loss in an African setting: cross sectional study. The Lancet, Vol. 373, Issue 9660. Pp. 318-324. January 2009.
2. Hindin M, Kishor S, Ansara DL. Initimate partner violence among couples in 10 DHS countries: predictors and health outcomes. DHS Analytical Studies 18. USAID, 2008.
3. Institut National de la Statistique du Rwanda (INSR) and ORC Macro. Rwanda demographic and health survey 2005. Calverton, Maryland: INSR and ORC Macro, 2006.