



TWUBAKANE

Decentralization and Health
Program in Rwanda

STUDY ON THE READINESS OF THE POLITICAL, LEGAL, HEALTH AND COMMUNITY SYSTEMS
TO RESPOND TO GENDER-BASED VIOLENCE IN THREE DISTRICTS OF THE CITY OF KIGALI

Kigali, May 2008

TABLE OF CONTENTS

Table of Contents	2
List of tables	5
List of figures	6
Acknowledgement	8
Acronyms and abbreviations	9
Summary	11
I. INTRODUCTION.....	22
1.1. Context of the study, political and programmatic justification.....	22
1.2. Defining GBV.....	23
1.3. Objectives	24
II. METHODOLOGY.....	25
2.1. Research systems and techniques	25
2.2. Sampling strategies and selection of sites for the study.....	25
2.3. Interviewees' characteristics	27
2.4. Selection and training of data-collecting agents	28
2.5. Pretest of data-collecting tools.....	28
2.6. Data collection	29
2.6.1. Level 1: Assessing the readiness of the policy environment to respond to GBV	29
2.6.2. Level 2: Assessing the readiness of the health system to respond to GBV	29
2.6.3. Level 3: Assessment of the community support system.....	30
2.6.4. Contact with local authorities	31
2.6.5. Organization of on-field team members and supervision	31
2.7. Data analysis.....	31
2.8. Dissemination of results.....	31
2.9. Limitations	31
III. RESULTS.....	32
3.1. Level 1: Assessing the readiness of the policy environment	32
3.1.1. General findings on the policy environment related to GBV	32
3.1.2. Key informants' perceptions on the dissemination of laws and policies.....	33
3.1.3. Key informants' perceptions on the enforcement of laws and policies.....	33
3.1.4. Obstacles and gaps perceived by key informants	34
3.1.5. Key informants' perceptions on the role of the health sector in managing GBV	35
3.1.6. Key informants' perceptions on available services and existing resources in the health sector	36
3.1.7. Key informants' perceptions on meeting needs at the health care sector level to improve GBV management.....	36

3.1.8. Key informants’ perceptions of obstacles women must overcome when they seek GBV services within the health sector	37
3.1.9. Key informants’ perceptions on the people who need GBV services the most and the people who have the most limited access to these services.....	38
3.1.10. Key informants’ perceptions on the link between GBV/HIV/AIDS and the integration of GBV services in ANC/PMTCT service delivery.....	39
3.1.11. Readiness to manage GBV with laws and policies	40
3.1.12. Findings	44
Conclusions on the readiness of the policy environment to respond to GBV	46
3.2. Level 2: Assessing the readiness of the health sector to manage GBV.....	47
3.2.1. Findings on providers’ knowledge related to GBV	48
3.2.2. Findings on the providers’ attitudes and beliefs.....	50
3.2.3. Perceptions and experiences of providers on the integrated management of GBV in ANC/PMTCT services.....	55
3.2.3.1. Referring victims of violence	56
3.2.3.2. Health services support system for victims of violence	56
3.2.3.3. Perceptions on the victims’ readiness to report the acts of violence they experienced	57
3.2.3.4. Providers’ perceptions on the risk of violence for ANC/PMTCT clients	57
3.2.3.5. Providers’ knowledge of existing laws and regulations	58
3.2.3.6. Providers’ perception on the government’s and the community’s role in the management of GBV	59
3.2.3.7. Existing GBV services in health facilities.....	59
3.2.3.8. Existing treatment for GBV victims	59
3.2.3.9. Providers’ perceptions on a possible integration of GBV into ANC/PMTCT services.....	60
3.2.3.10. Providers’ opinion on the need for a good integration of GBV in ANC/PMTCT service delivery ...	61
3.2.3.11. Perceptions on the clinical management of rape.....	62
3.2.4. Current practice related to GBV.....	62
3.2.5. Assessing the readiness of health facilities to manage GBV: Availability of key components to support GBV service delivery.....	63
3.2.6. Assessment of the health system by ANC services’ clients.....	66
3.2.6.1. Perception and experience of violence by ANC clients	66
3.2.6.2. Management of violence by the victims	67
3.2.6.3. Perception on the assistance provided to victims of violence	68
3.2.6.4. Assessing the assistance provided by the facilities to the victims of physical abuse.....	68
3.2.6.5. Assessing the assistance provided by the facilities to rape survivors	69
3.2.6.6. ANC clients’ suggestions on the role of providers in rape cases	69
3.2.6.7. Victims’ readiness to talk about their experience and seek the help of providers	70
3.2.6.8. Risk of violence perceived by an ANC/PMTCT client, perceptions on the actions to be taken by providers	71
3.2.6.9. Role of the government and the community in responding to GBV	74
Conclusions on the readiness of the health system to manage GBV.....	75
3.3. Level 3: Assessing the readiness of the community to manage GBV.....	76
3.3.1. Support from the community organizations.....	76
3.3.1.1. Types of clients served and GBV management	76
3.3.1.2. Directly available services	77
3.3.1.3. Referrals from the organizations.....	78

3.3.2. Collaboration and coordination	78
3.3.2.1. Current situation	78
3.3.2.2. Suggestions for the best coordination mechanism	79
3.3.2.3. Suggestions regarding the best coordination framework for GBV management	80
3.3.3. Community members' perceptions on GBV.....	82
3.3.3.1. Community's perceptions on the support provided to victims of GBV or domestic violence	84
3.3.3.2. Community perceptions on the integration of GBV services in the health facilities.....	85
3.3.3.3. Community perceptions on the providers' role towards victims of domestic violence.....	86
3.3.3.4. Community perceptions on the obstacles to overcome to access GBV management services in the health facilities	86
3.3.3.5. Community perceptions on the moments an ANC/PMTCT client is likely to experience violence ..	88
3.3.4. Conclusions on the community environment	90
IV. Conclusions and strategic recommendations for each level	91
4.1. Conclusions and recommendations on the readiness of the policy environment to respond to GBV	91
4.2. Recommendations on the readiness of the health system to respond to GBV	96
4.3. Recommendations on the community environment.....	99
4.4. Final conclusions	103
V. References.....	104

LIST OF TABLES

Table 1: Health facilities selected in order to assess their readiness to respond to GBV	26
Table 2: The people we interviewed, by category and by health facility	27
Table 3: Participants' characteristics (n=14).....	32
Table 4: Type of interviewed providers by health facility and district.....	48
Table 5: Percentage of providers (n=38) with correct answers on the GBV knowledge test in all five health facilities	50
Table 6: Mode regarding the attitudes of providers in the five health facilities	52
Table 7: Types of violence and times when ANC clients are at risk, according to providers	58
Table 8: Types of available support at the community organizations level in three districts (n=24).....	65
Table 9: Number of ANC respondents by health facility	66
Table 10: Types of violence and moments of risk assessed by ANC/PMTCT clients ...	71
Table 11: Role to be played by the government and the community.....	74
Table 12: Number of participants in the focus groups in the community by health facility, age group and district.....	82

LIST OF FIGURES

Figure 1: Average score on providers' knowledge of GBV in five health facilities (percentage of correct answers).....	49
Figure 2: Average score in providers' beliefs by health facility (n=5).....	53
Figure 3: Average score on providers' beliefs related to GBV by health facility	54
Figure 4: Ranking of health facilities according to providers' beliefs and knowledge	55
Figure 5: Percentage of key elements available in the facilities in order to respond to GBV.....	63
Figure 6: Percentage of organizations managing GBV, by type of GBV and in three districts.....	64
Figure 7: Percentage of organizations providing some kind of assistance related to GBV	65
Figure 8: Risks of violence in the path of an ANC/PMTCT client	73

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Laura Hoemeke, Twubakane program director

ACRONYMS AND ABBREVIATIONS

%	: Percentage
+	: Plus
AIDS	: Acquired Immunodeficiency Syndrome
ANC	: Antenatal Care
ARV	: Antiretroviral
BCC	: Behavior Change Communication
CHF	: Community Health Facilitator
CNF	: National Women’s Council
CNJ	: National Youth’s Council
COC	: Combined Oral Contraceptives
DHSR	: Demographic and Health Survey, Rwanda
FFRP	: Rwanda Women Parliamentary Forum
FOSA	: Health Facility
FP	: Family Planning
GBV	: Gender-Based Violence (including sexual violence)
GDD	: Focus Group
HC	: Health Center
HIS	: Health Information System
HIV	: Human Immunodeficiency Virus
i.e.	: That is
IEC	: Information, Education, Communication
INSR	: Rwandan Institute of Statistics
IntraHealth	: IntraHealth International Incorporated
IPPF	: International Planned Parenthood Federation
IUD	: Intra-Uterine Device
MIGEPROF	: Ministry of Gender and Family Promotion
MINALOC	: Ministry of Local Authority, Community Development and Social Affairs
MINIJUST	: Ministry of Justice
MININTER	: Ministry of Internal Security
MINISANTE	: Ministry of Health
NGO	: Non-Governmental Organization
NHRC	: National Human Rights Committee
OVC	: Orphans and Vulnerable Children
PEP	: Post Exposition Prophylaxis
PEPFAR	: US President’s Emergency Plan for AIDS Relief
PLH	: People Living with HIV/AIDS
PMTCT	: Prevention of Mother-to-Child Transmission of HIV
PoP	: Progestogen-Only Pill
STI	: Sexually-Transmitted Infections
SV	: Sexual Violence

TRAC : Rwanda Treatment and Research AIDS Center
TWG : Technical Work Group
Umudugudu : The smallest Administrative Unit in Rwanda
UNICEF : United Nations Children's Fund
USAID : United States Agency for International Development
VCT : Voluntary Counseling and Testing

SUMMARY

In order to support an initiative to improve the quality and utilization of antenatal care and prevention of mother-to-child transmission of HIV (ANC/PMTCT) services through an integrated response to gender-based violence (GBV), Twubakane, in collaboration with USAID, assessed the readiness of the policy environment, the health system and the community to respond to GBV at ANC/PMTCT service sites and in the community. This readiness assessment was conducted in five health facilities in the city of Kigali. Three of them are Catholic-affiliated (Biryogo, Kicukiro and Masaka). The other two are public (Gikomero and Kacyiru).

Using eight data-gathering tools, the assessment team met with 235 people, including 38 providers, 40 women using ANC services, 117 participants in the community discussion groups, 14 key informants (from the policy environment dealing with GBV/ANC/PMTCT) and 25 representatives or officials from organizations involved in the response to GBV.

Findings, conclusions and recommendations

Assessing the readiness of the policy environment to respond to GBV

Information at this level was provided by interviewees or informants working at the governmental and local levels, as well as in the private sector and in NGOs. Also, these informants helped us identify legal/political documents and resources related to GBV.

Twenty-four laws, policies, strategies and protocols dealing with GBV have been analyzed. Some of these laws have been implemented while others are still in the works or about to be implemented.

Among these documents, 18 have been evaluated with one main and six related criteria applied in order to establish the appropriateness of each document in responding to GBV. The purpose of the main criterion is to decide if the document is helpful to female victims, children and GBV services clients. The six related criteria are presented as follows:

- I) Does the document identify the types of violence that are considered a crime and does it mention the punishment incurred?
- II) Does the document cover all types of GBV as they occur in Rwanda?
- III) Do health care providers have to inform the police of each case of GBV they treated?
- IV) Does the document include a national follow-up system for epidemiological purposes?
- V) Does the document require that only physicians can perform a forensic examination and deliver a certificate related to this examination?

VI) If the document is a law, a policy or a protocol related to the health sector, does it explicitly mention the term GBV and responses to all types of GBV?

Analyzing these texts according to quality, accessibility and utilization criteria show that the policy environment is a very diverse one and that it can respond to GBV. Certain documents, however, should be reviewed and completed in order to help the health sector provide services and facilitate their access to GBV victims. Also, because most laws and policies dealing with GBV only highlight sexual violence, there is a need to raise awareness among people so that they acknowledge the existence of several types of GBV, including physical, emotional or economic violence, as various groups of interviewees reported these types of violence.

Interviewees tend to slightly disagree on how the texts should be disseminated. For some of them, official bulletins, seminars and workshops are efficient dissemination devices. However, according to other key informants we met, popularizing these documents is even today a difficult task as official bulletins cannot always reach the people they are intended to and because seminars and workshops are too limited.

In general, laws and policies are not always implemented; therefore GBV victims are not aware of laws that could protect them, even though relevant institutions are supposed to design implementation strategies for each law.

A few innovative measures have been taken as far as authorities are concerned, including a police emergency number and the placement of police officers in charge of GBV in each district. An agent dealing with violence against children is also now working at the Ministry of Gender and Family Promotion (MIGEPROF) and the response to GBV has been integrated into performance contracts (“*imihigo*”). In the private sector and civil society, national and international organizations are supporting initiatives to prevent or respond to all types of GBV.

The lack of data and resources gathering systems in this area is considered a major obstacle. Other issues such as the lack of victim support and awareness among providers and the community should also be addressed.

All interviewees agree that there is a link between GBV and HIV/AIDS.

On the policy environment level, it has been found that efforts have been made to design laws, policies and strategies responding to GBV. All of these elements could help improve the capacity of providers and health facilities to offer better GBV services at ANC/PMTCT service sites if they were standardized, more detailed and implemented effectively. Here are our recommendations in order to achieve this goal:

- I. The MIGEPROF should implement a multi-sector mechanism in order to coordinate responses to GBV through:

- a. A National Coordination Steering Committee including the MIGEPROF, Ministry of Health (MINISANTE), Ministry of Justice (MINIJUST), Ministry of Internal Affairs (MININTER)/ The National Police Force, Haguruka and other organizations leaders responding to GBV
 - b. A technical committee or support group which would be created by the MINISANTE or the National AIDS Control Commission (CNLS) to integrate GBV into ANC/HIV/AIDS services.
2. Relevant ministries (including the MIGEPROF, MINISANTE, MINIJUST, MININTER, Ministry of Local Authority, Community Development and Social Affairs (MINALOC) and the Parliament should:
- a. Update, complete and standardize laws related to GBV and design efficient strategies to help implement and disseminate them through:
 - Seminars and workshops with law-makers, lawyers, local authorities, health facilities, the national police force and other opinion leaders in every district
 - Training programs
 - Official bulletins and ministerial guidelines
 - b. Update laws related to GBV, especially the ones related to evidence in order to make them more relevant to the actual challenges victims encounter
 - c. In collaboration with the Twubakane program, enhance the technical expertise on GBV laws and strengthen it with a day-long training intervention.
3. The MINISANTE should consider GBV as a public health issue and implement a policy which addresses all types of GBV women endure at different stages of their lives by:
- a. Highlighting victim-oriented services which focus on GBV prevention and care, in addition to ANC/HIV/AIDS/family planning (FP) services
 - b. Developing criteria in order to design an appropriate GBV law and improve victim-oriented services
 - c. Planning free services for all types of GBV
 - d. Highlighting decentralization of the financing intended to be used to respond to GBV in the community
 - e. Letting A2 nurses (with formal training) provide expertise in HIV Post Exposure Prophylaxis at the health facility level
 - f. Designing a code of good practice for providers.

4. In order to initiate the actions mentioned above, the Twubakane program will help organize a workshop with stakeholders involved in HIV/AIDS/PMTCT services and identify an efficient political strategy to address GBV in the health sector.
5. The MINISANTE, MIGEPROF, in collaboration with the MININTER/the police and other legal organizations will:
 - a. Design a protocol to respond to other types of GBV such as domestic violence
 - b. By 2009-2010, standardize the response protocol to sexual violence in addition to a policy responding to GBV in the health sector.
6. Before developing that policy, the MINISANTE should revise existing documents listed below to make them more victim-oriented and relevant to GBV survivors. It should also improve access to GBV services. The existing documents include:
 - a. The response protocol to sexual violence
 - b. The learning guide on sexual violence.
7. The MINISANTE should make sure that information related to GBV problems is integrated in the Health Management Information (GESIS) indicators and that it is used to improve the prevention and follow-up of GBV.
8. The results of this study must be disseminated on a large scale. In order to do so, the Twubakane program will organize a meeting to disseminate the results nationally and locally among the targeted population. This will allow us to discuss the best strategies with stakeholders and partners in order to improve the quality of and access to GBV services at ANC/PMTCT service sites at the local level, starting with three districts of Kigali.
 - a. Twubakane will propose a multi-sector action plan in order to support a decentralized response to GBV. This framework is designed in accordance with The National GBV Policy and Reproductive Health Policy. In this context, it is recommended that health leaders collaborate with legal authorities, non-governmental organizations (NGOs), including Haguruka, the National Women Council and Pro-Femmes. In addition, the response to GBV must be integrated in the MINISANTE approach.
 - b. Twubakane will provide technical and financial support to districts and other local entities to integrate the response to GBV in their development plans and in the performance contracts (*imihigo*).
 - c. Twubakane will organize a workshop for stakeholders involved in GBV and PMTCT services in order to implement strategies for an integrated response to GBV in health systems, the community and the health facilities in which the study was conducted (Gasabo, Nyarugenge and Kicukiro). The workshop will also include an open forum to identify challenges and opportunities in confronting psychological, socio-cultural and evidence issues related to GBV crimes.

9. The MINISANTE and the decentralized authorities should work more closely with the police regarding the gathering of evidence, prosecution of GBV perpetrators as well as prevention of GBV. This will help strengthen the interaction between the health and legal systems so that they can respond to GBV. The Twubakane program will collaborate with the police and other partners in order to:
 - a. Identify practices and needs related to GBV in the legal system
 - b. Adopt GBV-oriented curricula based on the national police needs
 - c. Provide joint awareness programs intended for the legal and health systems as well as other public authorities (including law-makers, public prosecutors and police officers/lieutenants)
 - d. Help design and/or update a protocol and/or manual intended for police officers to help them respond to GBV. This protocol/manual should be in keeping with the one intended for health providers.
 - e. Provide the police department with additional support materials
 - f. Finance the planning and coordination of meetings with the Urgent Response Team based in the health facilities and social services and with other key partners at the community level.
10. In order to encourage GBV victims to seek help from the police, the department should:
 - a. Hire more female officers
 - b. Identify a “Victim’s Rights Defender” who would ensure access to information, protection against potential reprisals and referral to other community services and who could finance transportation fees related to the services the victim might need.
11. The MIGEPROF should provide a Kinyarwanda translation of the law related to the prevention and repression of GBV and rapidly forward it to its main users.
12. The MINIJUST should create a protection mechanism for victims who dare to speak out about the conjugal violence they suffered (including rape by a conjugal or intimate partner).

Assessing the readiness of the health system to respond to GBV

The readiness of the health system to respond to GBV has been assessed by using a knowledge and attitudes questionnaire of 38 providers that we met in five health facilities. We also used discussion groups which included 36 of the 38 providers as well as the inventory of resources available at the health facilities. Finally, we looked at potential GBV services, and we took the perceptions of ANC clients and members of the community into account.

1. It has been found that the level of knowledge and general awareness of gender and GBV issues is low: among the 38 providers, the average score was 35%.
2. After reviewing the scores given to providers regarding their knowledge, attitudes and opinions and the scores given to health facilities regarding their equipment, supplies, available surface as well as the services offered by them, it appeared that none of these sites were able to respond to GBV at the time the study was conducted.
3. However, all the providers who took part in the discussion groups think that the integration of GBV in ANC/PMTCT services is possible. It would help meet all the needs of clients at the same time and in the same place.
 - a. Providers recommend the implementation of a special GBV service offering extensive support in human resources and materials.
4. Key informants, ANC/PMTCT clients, health providers and the community generally agree that the response to GBV should be decentralized.
 - a. Forensic examination as well as other responses to GBV should be available at the health care center level.

According to the providers and health facilities' clients, ANC/PMTCT clients may suffer from violence at different moments, at the health facility level and in the community. These risks may vary according to the type of violence, and they can increase when the victim has been diagnosed with HIV. However, the response to GBV currently provided by the health facilities we visited is still in an embryonic state.

- a. The Twubakane program therefore provides a decentralized model for GBV services at the health facility level along with short-term and long-term recommendations. In the short-term, Twubakane will collaborate with relevant authorities to help:
 - Organize a workshop with stakeholders involved in GBV and PMTCT services in order to implement strategies for an integrated response to GBV in health systems and in the community
 - Design and translate a training curriculum, consisting of different units that can be taught separately, and organize in-service training for the providers
 - Design policies for the providers' workplace environment as well as clinical protocols to identify and manage GBV at PMTCT sites
 - Develop, assess and disseminate materials related to behavior change communication (BCC) strategies for GBV
 - Support local partnerships between NGOs and health facilities to improve education in the community.

Using **the inventory assessing the capacities of health facilities** to respond to GBV, we found that:

5. All five health facilities have a private examination room, but very few of them have the required materials to appropriately respond to GBV (25% at the most of what is required). Therefore, at the time the study was conducted:
 - a. None of the health facilities had all the materials and equipment required or even the essential resources to constitute a rape kit for rape survivors.
 - b. Emergency contraception and PPE were not available at any of the health facilities.
6. It is necessary to gather more data at the health facility level.
 - a. GBV-focused meetings should be held in order to enhance the quality of services and to improve the health system.
 - b. Before or during awareness-raising sessions and training interventions, the Twubakane program should:
 - Start the training intervention in health facilities where providers have a better understanding and knowledge of GBV issues: 1) Gikomero, 2) Biryogo, 3) Kicukiro. Learn lessons from this experience through a follow-up and then continue interventions in 4) Kacyiru and 5) Masaka
 - Work with the partners supporting the five health facilities and supply them with the required materials in order to respond to GBV.
 - c. The Twubakane program will help design and implement a recording and follow-up system for GBV cases in the five health facilities where the study was conducted.

Readiness assessment of the community to respond to GBV

The following conclusions were, for the most part, drawn from the ideas and views of the 117 participants who were involved in the community discussion groups near the five health facilities we visited.

- I. It has been found that communities, who are aware of violence, have numerous ideas to address the issue, but they are not aware of what resources are available in their neighborhoods. Therefore:
 - a. GBV-related issues should be addressed by the community at all administrative levels: from the villages (*umudugudu*) to higher authorities.
 - b. Providers' first contact with victims as well as their capacities should be improved to better integrate GBV issues in the health facilities.

2. Each district has resources available for the community to respond to GBV but no organization provides shelter to GBV victims. However, people we interviewed in these organizations highlighted the fact that it was an essential need. That is the reason why:
 - a. PROFEMMES and Haguruka, who have a keen interest in that issue, should advocate for such measures at the local government and stakeholder level in order to finance the building of a transit shelter for GBV violence in Kigali.
 - b. USG and PEPFAR should provide the shelter with materials and equipment once it is built.
3. It has been found that victims do not usually resort to these services. This can be explained by cultural, psychological, external and institutional factors. Therefore:
 - a. Action should be taken to help women overcome these obstacles and to encourage them to use health and GBV services.
 - b. The legal, health and education sectors, along with local authorities, should collaborate with the civil society, the media, the clergy and the Ministry of Social Affairs in order to develop BCC strategies that would address GBV and its consequences on health services, victims, women's human rights and socio-cultural standards. In that respect, awareness should be raised on the availability of free GVB services at the health facilities.
 - c. Local authorities should collaborate with other contributors to raise awareness of GBV among the population. Such programs would include:
 - The dissemination of laws, policies and rules related to GBV
 - Discussions in the community
 - Awareness and education campaigns related to the prevention and elimination of GBV (e.g. from November 25 to December 10, every year, during the "16 days of activism" period). These should:
 - Help older women in rural areas identify GBV and refer GBV victims to relevant services rather than encouraging them to keep silent and put up with violence
 - Help men reflect on various topics related to reproductive health (e.g. the fact that gender attribution biologically depends on the father), their involvement in family planning, the prevention and treatment of HIV/AIDS and PMTCT, as well as the consequences of GBV
 - Allow Twubakane to organize training interventions and BCC sessions, in collaboration with the police, the National Women's Council (CNF), the National Youth's Council (CNJ) and other opinion leaders.

These interventions/sessions will help prevent GBV in the community using tools developed by “Raising Voices” (a Ugandan NGO) in collaboration with IntraHealth.

- d. The Twubakane program will help districts:
 - Adopt a coordinated action plan in which all sectors take action in their field of activity and work together to support GBV victims and punish perpetrators
 - Mobilize financial and human resources to build transit shelters for GBV victims
 - Collaborate in a multiservice center intended to provide psychological, social and economic support using the District’s Initiative Support (DIF) grant
 - Strengthen women’s socio-economic capacities through:
 - Employment
 - Microcredit programs
 - Income-generating activities
 - Helping dependent women, who dropped out of school because of various types of violence, have access to job training and complementary classes
4. According to the majority of participants who attended the group discussions, an ANC/PMTCT client runs a higher risk of suffering from violence when she is asked to go back to the health facility along with her husband, who already rejected her and refused to go with her the first time around. The victim therefore suffers from a dual form of violence:
 - a. First, she is rejected by the provider who will not care for her unless she’s accompanied by her husband.
 - b. Then, she is rejected by her partner (husband or intimate partner) who might refuse to go with her, or even worse, brutalize her in different ways and eventually hit her.
5. A minority of interviewees suggested alternative ways to respond to GBV:
 - a. Centralizing services supporting victims of GBV in only one place (e.g. legal, psychological and material support). This would make sense for two reasons:
 - This would allow victims to have access to various services and speak out more about the form of violence they face.
 - The number of organizations addressing GBV is increasing, and it is becoming difficult to have a real follow-up on their activities.

- b. Other interviewees would like to develop exchange mechanisms between organizations addressing GBV issues. This would allow them to exchange information and solutions to problems usually encountered with GBV. This system could easily be justified as it is easy to implement. It is also more realistic and cost-effective.

Community Support

6. In three districts, it has been found that several types of GBV were covered by various community services available for the victims.
 - a. However, the capacity of these services to meet the victims' specific needs as well as their quality and their referral mechanisms is unknown.
 - b. No organization can provide shelter to GBV victims.
7. There is no documented system approach regarding referrals to other services (within the health facility or other organizations). Many interviewees said they referred victims by making a call, writing a note or accompanying them to other services.
8. The community's perception of the integration of GBV services to the health facilities can be summarized as follows:
 - a. The majority of interviewees highlight the need to improve the quality of the providers' first contact with the victims as well as their professional skills.
 - The first contact should occur with a well-trained, mature, female provider.
 - A specific service including several providers should be created in order to anticipate a shortage in staff.
 - GBV victims should have free and unconditional access to these services.
 - These services should be decentralized at all levels.
 - The capacities of health facilities should be strengthened in order to perform an on-field follow-up of the victims.
 - b. Concrete referral and counter-referral mechanisms should be implemented between relevant authorities in order to respond to GBV.
 - The collaboration between community organizations and the health sector and the coordination of their interventions can be noticeably improved.
 - c. PROFEMMES (which is represented at the district level) in collaboration with Twubakane and with the Community Health Workers should:
 - Strengthen the capacity of its members at the district level to mobilize the community

- Adapt and multiply the tools necessary to mobilize the community in the three districts.
9. Strengthening women's capacities is of utmost importance as it would allow them to be morally and financially independent from the perpetrator. Therefore:
- a. The health facility and the community structures involved in the response to GBV should enhance victims' access to income-generating activities, microcredit programs and formal employment.
 - b. Twubakane will support this initiative within its intervention area through quality assurance programs and its partnerships with several organizations.
10. NGOs that are offering support to GBV victims use the health facilities as a key component of their collaboration process while many providers we interviewed do not have the contact information for these facilities. This could be seen as a one-way partnership and a lack of collaboration. Therefore:
- a. Coordination and communication between the health facilities, community organizations and districts should be increased through periodical meetings or the creation of a committee/coalition at the district level which would include public sector organizations' representatives, NGOs, the civil society, faith-based organizations and the Ministry for Social Affairs.
 - b. The Twubakane program will disseminate a "List of Community Resources related to GBV" in NGOs, at the district level and in health facilities.

I. INTRODUCTION

1.1. CONTEXT OF THE STUDY, POLITICAL AND PROGRAMMATIC JUSTIFICATION

The Twubakane Decentralization and Health Program, which is financed by USAID/Rwanda, is implemented by IntraHealth International, RTI, Tulane University, the Payson Center for International Development and Technology Transfer and other partners. This program stretches over five years (from 2006 to 2010) and is aimed at strengthening the capacities of local authorities in decentralized structures in order for them to be able to meet the needs of the population and promote community health services. Twubakane's global goal is to improve access to quality health care and use of reproductive health services in health facilities and communities while strengthening the capacity of local authorities—as well as the community's—in order to enhance health care service delivery at decentralized levels.

This program resulted from the partnership between the US Government, represented by USAID, and the Rwandan Government, represented by the Ministry of Local authorities (MINALOC) and the MINISANTE. Twubakane also works in collaboration with the Rwandan Association for Local Government Authorities (RALGA), EngenderHealth, VNG (The Dutch International Cooperation Agency) as well as Pro-Femmes.

The draft of the *national policy responding to violence against women and children* (1) referred to several recent studies, which showed the extent of GBV and its different forms in Rwanda (p.9).

A study by the MIGEPROF (2) showed that more than 25% of women had suffered from sexual violence during the five years prior to this study; that more than 12% of women had been victims of at least one act of physical violence (i.e. slaps in the face, punches, kicks); and that more than 13% had been victims of psychological violence.

According to the demographic and health survey (DHS) conducted in 2005 (3), most acts of violence against women within the community are perpetrated by their husbands or their former partners. A little over half of women (51%), who reported the acts of violence they suffered from, had been victims of domestic psychological violence (including insults, verbal threats, deprivation of freedom and health care and confiscation of money). Thirty-one percent of them had been victims of domestic physical violence, with a frequency of two to three times a year. The DHS shows how serious this type of violence is: 17% of women reported an injury or a broken bone after suffering from domestic physical or sexual violence over the past twelve months. However, only 8% of them sought help in health centers or hospitals. This highlights the fact that health providers are not consulted in proportion to the extent of GBV occurring in the community.

The national policy draft also showed that among the 3,000 rape cases registered by the police between 2005 and 2006, 78% of victims were under 18 years old. In this policy, it is mentioned that children and teenagers, who had been interviewed, have identified three main types of violence: physical, sexual and psychological violence. Their drawings showed that most acts of violence they experienced took place at home, in the community, in the woods and in the fields.

The link between HIV and GBV is a global challenge, and it should be considered a priority as it has a considerable impact on children and women (4). In Rwanda, the last UNAIDS/WHO report (5) showed that 57% of people living with HIV/AIDS were women. Women are prime targets for violence and HIV. The US President's Emergency Plan for AIDS Relief (PEPFAR) can help them by supporting activities aimed at changing standards and practices encouraging violence against women and by preventing or reducing physical, sexual, emotional and economic (material) violence after women have been declared HIV-positive. The PEPFAR can also help strengthen the links between the clients in PMTCT services and the community members, as well as social services providers. Finally, it can improve the policies and legislation aimed at preventing and punishing GBV crimes (6).

The objectives of Twubakane and the political orientations we mentioned above are the bases for this study. More precisely, one of the objectives is to improve the quality and use of ANC/PMTCT services through integrated GBV services as part of the coordination of multi-sector actions at the community level, in addition to community mobilization and advocacy at the political and legal levels. The results from our study should provide the information necessary in order to develop a multi-sector response to GBV on several levels. It should also provide a decentralized model for the integration of GBV services within ANC/PMTCT service delivery. This model should be based on needs, perceptions and recommendations of providers, clients, communities and partners at the national level.

In order to better develop and implement this initiative, Twubakane conducted a qualitative and quantitative study on the response to GBV through ANC/PMTCT services in the districts of Nyarugenge, Kicukiro and Gasabo in the city of Kigali between July and October 2007. A systemic approach is required in order to develop an appropriate response to GBV. That is why we studied the readiness of the following systems to respond to GBV:

- The political and legal environment in charge of the implementation of GBV aid services
- The health system in order to identify the institutional reforms of the health services that would help health facilities and providers meet the needs of clients suffering from GBV
- The community support system that would prevent GBV or help implement an appropriate response to GBV.

1.2. DEFINING GBV

Although there are several definitions of GBV, we will use the one we found in the Senate's draft policy on the prevention and repression of GBV: *"Gender-based violence is an act of physical, psychological, sexual or economic violence perpetrated against someone on account of gender. Such acts of violence may result in freedom deprivation and other harmful consequences. This type of violence can occur domestically or elsewhere"*.

GBV may occur in the household, in the community and within institutions. The national draft policy on violence against women and children states that *"domestic violence (by a spouse or partner) can include the deprivation of economic freedom, as well as isolation. This type of violence can have harmful consequences on women's safety, health and well-being."* (8)

These definitions enable us to take into account a rather wide range of violence forms as well as victims from various age groups and marital status.

GBV may target women and men, as well as girls and boys, insofar as “social mechanisms confining girls and women to roles of secondary importance can also automatically limit boys and men to mannish activities” (9, 10). Thus violence is seen by some as a way to impose a relation of subordination (11).

1.3. OBJECTIVES

The global objective for this study is to assess the readiness of the political, legal, health and community systems to respond to GBV at the ANC/PMTCT services level and within the community in five health facilities of the city of Kigali.

The specific objectives of this study are structured on three levels, which include:

1. Level 1: Assessing the readiness of the policy environment to respond to GBV

Analyze implemented policies, strategies and legislation regarding the response to GBV in Rwanda. Integrate GBV prevention devices in decentralization and health policies and strategies. Disseminate new laws, policies and strategies related to the prevention of GBV.

2. Level 2: Assessing the readiness of the health system to respond to GBV

Analyze the perceptions of health providers regarding their role and their readiness to deliver services responding to GBV and determine their needs in order to better respond to GBV in their service pack

Assess the knowledge, the beliefs and the practice of health providers regarding GBV

Assess the capacity of health facilities to deliver GBV services

Analyze the perceptions of clients regarding their needs, the possible course of action for GBV victims and the role of providers in assisting them.

3. Level 3: Assessing the readiness of the community to respond to GBV

Define legal, psychological, economic and social services available for GBV victims at the community level and identify possible collaborations between these services and the health facilities

Analyze the perceptions of community members regarding GBV and the individual role of health centers and others in the prevention of GBV.

II. METHODOLOGY

2.1. RESEARCH SYSTEMS AND TECHNIQUES

This study is aimed at describing and analyzing GBV through qualitative and quantitative approaches. Eight data collecting tools have been developed for informants and key institutions. You will find them in the appendices of the report.

All the data collecting tools created and tested by IntraHealth in Armenia (12) have been adapted and tested by IntraHealth/Twubakane according to the study's specific objectives in Rwanda. They were, then, reviewed by various committees: a specially implemented steering committee, the PMTCT technical work group, the CNLS research committee and the national ethics committee. After receiving the proper certifications and the necessary recommendations by the National Institute of Statistics, the Ministry of Health (MINISANTE), CNSL and the ethics committee, the tools were pretested after the training of data-collecting agents had taken place. They were, then, finalized.

2.2. SAMPLING STRATEGIES AND SELECTION OF SITES FOR THE STUDY

Sites have been selected according to the USAID intervention program and its related projects. The sites include five health facilities located in Kigali: Biryogo, Kacyiru, Kicukiro, Gikomero and Masaka.

USAID financed this study and suggested that it take place in the city of Kigali as a pilot zone. The American agency for international development also suggested the following criteria in order to select the health facilities to be sampled:

Most health centers in this study must be supported by USAID and/or partner organizations.

In order to reflect the differences in physical and social setting, typical to the sampled area, and considering the essentially urban setting of the city of Kigali, two health centers in semi-rural areas were also selected as part of the sample.

The sample sites were selected in the three districts of Kigali: Nyarugenge, Kicukiro and Gasabo.

In addition in order to select the following sites, the technical steering committee based its decision on the level of attendance in the facility and the appropriate number of providers to ensure they could take part in the focus groups (six to ten providers in each group):

Table 1: Health facilities selected in order to assess their readiness to respond to GBV

District	Health facility	Status	Setting	Aid agency
Nyarugenge	HC Biryogo	Aggregated HF	Urban	FHI
Kicukiro	HC Kicukiro	Aggregated HF	Urban	UNICEF
	HC Masaka	Aggregated HF	Semi-rural	EGPAF
Gasabo	HC Kacyiru	Public HF	Urban	VCTI
	HC Gikomero	Public HF	Semi-rural	EGPAF

- ❖ In each health facility, we asked available providers to take part in individual interviews. When necessary, we randomly chose available providers during the investigators' visits.
- ❖ Regarding community surveys, the consultant and the Twubakane technical steering committee identified, in each health facility, the categories of informants that had to take part in the focus groups. We decided to use such samples, so that opinion leaders could meet and enrich the discussions. In collaboration with local authorities and health facilities' leaders, appointments were organized according to the time and place that were the most convenient for the participants. These participants include:
 - Local authorities, police
 - Community health workers
 - Young students
 - Children who have dropped out of the school system
 - Journalists, human rights activists, trade union leaders
 - National council for youth at a decentralized level

Overall, contacts had been made ahead of time and the investigators went out into the field, knowing exactly the category of informants they would meet there.

In that respect, the sampling includes several levels:

- A reasoned sampling approach has been chosen for the city of Kigali and the five health facilities.
- A simple random sampling has been used for community participants and women seeking ANC services.

- The snowball approach has been adopted for interviewees in tool 7 (which describes the legal, economic, psychological and social services, as well as the aid services available in the community for GBV victims). This approach enabled us to gather information in a different way, as one informant gave us information about someone he worked with and/or about participants working in the same field. The same approach has also been used in Tool 1 in order to identify the policy makers, who are the most competent to provide information about the policy environment regarding GBV.

The data collection process took place from July 13-August 18, 2007 for tools # 2, 3, 4, 5, 6 and 8 (in the health facilities and the surrounding communities) and from July 23-October 27, 2007 for tools # 1 and 7 (which were conducted after appointments with policy makers and NGO leaders had been made.).

2.3. INTERVIEWEES' CHARACTERISTICS

The study targeted 234 interviewees, who could be divided as follows: 117 came from the community surrounding the health facilities, 40 women using ANC services, 14 informants from the policy system, 27 representatives from NGOs and associations focusing on GBV and 38 health care providers, who answered the questionnaires or took part in individual interviews. It is important to note that 36 of the providers mentioned above also took part in the focus groups.

The following table shows the most important socio-demographic characteristics of the participants we interviewed over the course of the study.

Table 2: The people we interviewed, by category and by health facility

Participants met	Tools used	District and Health Facility					TOTAL	%
		Nyarugenge	Gasabo		Kicukiro			
		Biryogo	Gikomero	Kacyiru	Kicukiro	Masaka		
Social worker	Individual questionnaire (# 4)				1		1	0.4%
Social worker Voluntary Counseling and Testing (VCT)	Individual questionnaire (# 4)				1		1	0.4%
Nurse (A1)	Individual questionnaire (# 4)			2	1		3	1.3%
Nurse (A2)	Individual questionnaire (# 4)	8	6	6	5	8	33	14.1%
S/Total providers' individual questionnaires		8	6	8	8	8	38	16,2%
ANC clients	Focus groups (#2)	8	8	8	8	8	40	17,1%
Community	Focus groups (#8)	19	24	24	26	24	117	50,0%
Providers' focus groups*	Focus groups (#3)	8	7	8	7	6	36	15,4%
S/Total by health facility		35	38	40	42	40	195	83,3%

Participants met	Tools used	District and Health Facility					TOTAL	%
		Nyarugenge	Gasabo		Kicukiro			
		Biryogo	Gikomero	Kacyiru	Kicukiro	Masaka		
Key informants (political and legal levels)	Individual interview (# 1)						13	5,1%
Organizations focusing on GBV	Individual interview (# 7)	7	15		5		27	11,5%
TOTAL by district		42	93		87		235	100,0%

* 36 out of the 38 providers, who took part in the individual interviews and who were in the health facility on the day of the interview, also took part in the focus groups.

NB: Tools # 5 and # 6 are inventory forms, which are filled out by the investigator using existing materials (# 6) and registers (# 5) with the help of the health facility leader or his/her assistant.

We can notice that informants at the community level represent more than half of the people we interviewed (59.69%).

2.4. SELECTION AND TRAINING OF DATA-COLLECTING AGENTS

Among all the investigators, who applied at the Twubakane/IntraHealth office, we appointed the ones with a solid experience in terms of qualitative and quantitative surveys. Therefore, eight investigators, including four men and four women, took part in a six-day training session. After they completed their training and the pretest, six investigators were selected and two substitute investigators (one man and one woman) were told they would be called in replacement if need be.

The training session was facilitated by our consultant and supported by professionals from Twubakane/IntraHealth and from Capacity Project/IntraHealth. This participative training session covered themes related to gender and violence as well as techniques aimed at conducting qualitative surveys using interviews and focus groups. Other themes like approaches for quantitative surveys, sampling techniques and the selection process of on-field participants were also covered. During the training, role plays were also organized in order to help interviewers (investigators) become more acquainted with the content of data-collecting tools as well as the methodology they had to use.

2.5. PRETEST OF DATA-COLLECTING TOOLS

Regarding the interviewees at the community level, the two-day pretest took place in the health facilities of Kabusunzu and Rubungo and in their surrounding areas. Each investigator had the opportunity to become more familiar with the tools that were used during this evaluation session. The pretest of Tool #1 (policy makers) and #7 (partner organizations) was conducted by the survey's coordinator. She had to submit them later on to the key informants in those categories. Comments and discussions about the pretest helped us readjust our logistical organization so that we could set up meetings in a timely fashion with all the categories of informants we had to meet.

In addition, the pretest helped us assess the capacity of the data-collecting team and to advise its members when necessary. The tools have also been reviewed and finalized according to the results we gathered during the pretest.

2.6. DATA COLLECTION

Eight data-collecting tools have been used on three different levels (see appendix 1):

2.6.1. LEVEL 1: ASSESSING THE READINESS OF THE POLICY ENVIRONMENT TO RESPOND TO GBV

“Interview with policy and legal stakeholders” (Tool #1): Interviews were conducted with partners and key informants that had been identified by the technical steering committee and in the final report titled “Initiatives to protect women’s legal rights” by Chemonics International regarding the prevention of GBV in Rwanda (13). After reviewing the laws, policies or strategies related to health, we proceeded to an analysis using the “GBV laws/policies/strategies assessment form” that we added to the interview guide. The purpose of this analysis was to determine criteria, which could help us better respond to GBV (see explanations in 3.1).

2.6.2. LEVEL 2: ASSESSING THE READINESS OF THE HEALTH SYSTEM TO RESPOND TO GBV

Some arrangements had been made with health facilities’ leaders before we submitted the four following tools in order to avoid disrupting their usual activities:

Guide for focus groups with ANC/PMTCT clients (Tool #2): Five focus groups included a sample of clients seeking ANC services at the health facility. The collected information is useful as it helps us improve the quality and use of ANC/PMTCT services and develop the GBV service package. The focus groups gathered while clients were waiting for their test results and after they talked to ANC/PMTCT service providers. This way, we did not disrupt the service delivery at the health facility. The providers were not involved in the selection of participants for the focus groups. They only facilitated the meeting between ANC clients and the investigators. The providers were informed, long in advance, of us conducting interviews in their services. Each focus group included eight people.

Guide for focus groups with ANC/PMTCT service providers (Tool #3): In each health facility mentioned in table 2 (above), a group of six to ten ANC/PMTCT service providers (A2 nurses) took part in the focus groups. Together, they talked about GBV detection, common methods to respond to GBV in health facilities and the capacities of these facilities to offer services related to that matter. The discussions helped providers identify moments when an ANC/PMTCT client was likely to experience violence. It also enabled them to suggest ways to integrate responses to GBV in ANC/PMTCT services. In addition, these providers took part in an individual interview in order to assess their knowledge of GBV using a **Questionnaire about Knowledge and Beliefs related to GBV (Tool #4)**, and to assess their personal readiness to respond to this particular kind of violence.

Clinic/client review form (Tool #5): A clinic data/statistics review form was filled out in the facilities with the managers in order to assess providers' GBV practice in each of the five health facilities we had selected (detection of violence and transfers/referrals to community support services).

Finally, in each of the five health facilities, we submitted an **inventory to assess facilities' readiness to manage GBV (Tool #6)**. The inventory was conducted in collaboration with the facility managers or the service providers' immediate supervisor. The purpose of this tool was to assess the adequacy and readiness of the facility environment to support the detection and management of GBV. The inventory took place after the facilities' managers had filled out an individual questionnaire regarding the providers' knowledge and beliefs related to GBV (tool #4). A checklist of equipment, supplies and materials for clinical management of rape survivors to be filled out by the managers was added at the end of the inventory to assess the level of equipment in the health facility.

2.6.3. LEVEL 3: ASSESSMENT OF THE COMMUNITY SUPPORT SYSTEM

Two tools were used at this level:

The GBV Resource Scanning Guide (Tool #7) was what we used for the individual interviews with the community organizations providing legal, economic, psychological and social services and assistance to victims of GBV in Kigali. These organizations were identified by key informants and were found in the report titled "Initiative to protect women's legal rights in Rwanda" by Chemonics International (see above).

Interview guide for focus groups with community members (Tool #8): The purpose of this tool was to explore community perceptions about GBV and the role of individuals, health centers and others in the community in addressing violence against women. This information will be used to improve the quality and use of ANC/PMTCT services, to develop a GBV service pack, to create communications messages for social change campaigns and to promote a supportive policy and legal environment in which to address GBV.

The focus group with community members, which included 8 to 12 participants, gathered in areas surrounding the five selected health facilities. These groups included representatives from women's and employers' associations, newspapers, the government, the police and local governments, clergy, educators as well as members of the local community of all ages, who could be reached through faith-based organizations and public authorities. Some of the groups only included men while others only included women. Some of the groups consisted of mixed younger participants, associations' representatives or public and private institutions. Three focus groups were organized in the areas surrounding the sampled health centers. We ensured that participants in these groups belonged to the different categories we mentioned earlier. We also made variations in the categories from one site to the other.

In order to recruit participants for the focus groups, we identified a key community member, who helped us invite individuals based on the criteria we developed for each site (gender, age, socio-economic level, education, close location, etc.). We usually used a local authority within the community. The data-collecting process per se took place under the direct supervision of the consultant and was based on the meetings that were organized by the study's coordinator.

The focus groups that included the providers always took place after the individual interviews. Indeed, as the interviews dealt with the providers' individual knowledge, they would have created a bias in the focus groups. It is important to note that an explanation of GBV was given by the facilitator prior to the actual focus group meetings.

2.6.4. CONTACT WITH LOCAL AUTHORITIES

Before starting the entire process, Twubakane/IntraHealth had met the requirements of the Rwandan Institute of Statistics (INSR), CNLS and the ethics committee, which later authorized the study. Twubakane/IntraHealth managers in Kigali contacted the relevant authorities and officials before sending over investigators. Authorities have welcome and supported us all along the process.

2.6.5. ORGANIZATION OF ON-FIELD TEAM MEMBERS AND SUPERVISION

During the on-field investigation process, the investigators were accompanied by the consultant and/or the study's coordinator. Working this way enabled us to overcome challenges that are inherent to on-field activities and to propose immediate solutions to problems we encountered.

2.7. DATA ANALYSIS

After the data-collecting process was over, guidelines were given to the investigators for them to check and manually count the questionnaires that had been appropriately filled out. Then, they sifted through the answers they received in order to separate them by types of informants and to analyze them with a specifically developed analytical device. Regarding the questionnaires about providers' knowledge, we used an answer key card that we developed long before the data collection took place. The qualitative data analysis was done using the analytical device that we created and was entered in Word. The quantitative data and the participants' socio-demographic characteristics were entered in Access and were then transferred to SPSS to create graphs and tables in Excel.

2.8. DISSEMINATION OF RESULTS

The results from the study have been validated by a smaller committee including the main partners (approximately 15 of them). Afterwards, a larger dissemination workshop was planned after the document had been finalized, based on the feedback from the validation workshop, which lasted two and a half days.

2.9. LIMITATIONS

The small size of the sample (five health facilities) prevents us from making comparisons based on statistics and from generalizing the results to the whole country.

III. RESULTS

3.1. LEVEL 1: ASSESSING THE READINESS OF THE POLICY ENVIRONMENT

Brief methodological introduction

We wanted to know if the policy environment in Rwanda was ready and willing to respond to GBV within the health sector, especially in ANC/PMTCT services. We analyzed policies and used a guide to conduct interviews with policy and legal stakeholders and with key informants in the policy environment, who are involved in the prevention of GBV. Through these analyses and interviews, we aimed at assessing the integration of GBV in health and decentralization policies and strategies, as well as the dissemination program for regulations, policies and strategies related to GBV.

The information we collected with the interview guide came from parliamentarians, public institutions representatives focusing on human rights, executives from MIGEPROF, MINIJUST and MINISANTE (and related institutions such as CNLS and TRAC), as well as private institutions' representatives involved in the prevention of GBV in the policy environment, as shown in the following table.

Table 3: Participants' characteristics (n=14)

Informants	Number
Government level	10
Province level	1
Private sector	1
NGOs	2
Total	14

The fourteen participants came from the following institutions: National Police Force (1); MINISANTE (1); MIGEPROF (1); CNLS (1); Treatment and Research AIDS Center (1); Parliamentarians (3); MINIJUST (1); National Council for Human Rights (1); CNF (1); Chargé of social affairs in Nyarugenge district (1); Former secretary at the CNF (currently working in the private sector) (1); Haguruka (1).

3.1.1. GENERAL FINDINGS ON THE POLICY ENVIRONMENT RELATED TO GBV

Many initiatives have been developed, and lots of efforts have been made lately in order to implement laws and policies related to GBV in Rwanda. They are a direct consequence of the better understanding of the "gender" concept. Indeed, after the Beijing conference in 1995 and others that followed, many women rights activists in Rwanda decided to raise awareness among the country's leading institutions about the importance of gender consideration in the development process. This led to changes in policies and laws and resulted in the 2003 Constitution emphasizing gender equity.

We surveyed several levels of the policy environment with the help of key informants. The interview guide was based on seven main topics: a) the health sector's role in the management of GBV; b) the available services and resources; c) the shortcomings in service delivery and resources that should be corrected; d) obstacles for women and GBV services' clients in health facilities; e) links with HIV/AIDS; f) existing regulations and GBV types ruled by these regulations as well as their dissemination and their enforcement; g) the importance (according to the participants) of the laws identifying GBV; h) gaps and obstacles in laws and policies responding to GBV. The participants focused on the topics they were the most familiar with, based on their training or their experience.

3.1.2. KEY INFORMANTS' PERCEPTIONS ON THE DISSEMINATION OF LAWS AND POLICIES

Regarding the dissemination of the texts and documents mentioned above, the interviewees told us that the *Rwandan Official Gazette* as well as various seminars and workshops were good dissemination channels. Others think that some structures are available in a few sectors, but they do not have concrete dissemination mechanisms, as it is the case for decentralized health services.

Some laws have been made more accessible to more people by adapting their style and translating them in the public's mother tongue. It has been the case for the code of family and property written by MIGEPROF in 2002. *There is a need to use the same approach on GBV, particularly for the draft law and policy on GBV whose adoption by competent authorities is pending.*

However, many key informants we met believed that the popularization of laws and policies was not widespread due to the fact that the *Official Gazette* does not always reach the relevant people and also because the number of seminars and workshops is still limited.

3.1.3. KEY INFORMANTS' PERCEPTIONS ON THE ENFORCEMENT OF LAWS AND POLICIES

Overall, the participants we interviewed believed that *laws and policies are rarely enforced in spite of a few measures aimed at correcting these shortcomings*. Many GBV victims are not aware of laws protecting them and do not know what course of action they can take, even though, according to the parliamentarians we met, an enforcement strategy is supposed to be developed every time a law is adopted.

Also, the health policy and the strategic plan from the MINISANTE include the management of victims of sexual violence (counseling and treatment), even though, in practice, it is not enforced. This statement is highlighted by the fact that providers in five health facilities said that standards and protocols for the diagnostic and management of GBV were unavailable (See following section: Level 2, Health System).

A few innovative strategies have recently been launched, such as a police hotline, the placement in each district of a police officer in charge of GBV, who works in collaboration with the health facilities, the placement of an agent in charge of violence against children at the MIGEPROF as well as the integration of GBV prevention in the performance contracts of decentralized institutions (*imihigo*).

3.1.4. OBSTACLES AND GAPS PERCEIVED BY KEY INFORMANTS

The first obstacle that was reported to us is the lack of data-collecting and documentation systems about the extent of the GBV phenomenon, which prevents a better follow-up on the management of this type of violence.

Through interviews with key informants, we noticed that GBV awareness, although recent, is quite significant. In that respect, the most relevant institutions have confirmed their need for new laws and the revision of existing regulations in order to prevent GBV: for instance laws specifically targeting domestic violence, trafficking in children as well as legal aid for women and children who are the most vulnerable to violence, a law regulating GBV within the health system and emphasizing the good practice of providers and a law focusing on violence against prostitutes. These changes have been demanded by the Ministries of Health, Justice, Gender and Family Promotion, the National Human Rights Committee and the Rwanda Women Parliamentary Forum (FFRP).

The list of laws and policies that we analyzed shows that the legal response to GBV is well underway. According to some participants, this response should be strengthened and completed (as mentioned in the section above). A female informant emphasized the fact that no law condemns polygamy, even though it fosters GBV against children and wives.

These findings prove that it is necessary to reconsider certain types of violence as crimes and to include them in laws.

According to key informants, the economic obstacles are linked to the lack of financial, human and material resources that could help the victims. These resources are desperately lacking in decentralized institutions, although they must face most of the problems related to GBV (immediate assistance, referral and others). Therefore, they must advocate for better services.

Regarding the gaps and obstacles in providers' service delivery, the participants gave us the following examples:

- The lack of understanding of the “gender” concept and GBV by providers, when their expertise is needed, particularly in the case of sexual violence
- The social and cultural environment as well as economic dependency which encourage the victims of sexual violence to remain silent and, therefore, protect perpetrators (NB: This perception was also detected in the focus group with the community).

At the health facility level, the participants mentioned the following obstacles:

- The lack of equipment and materials, which could lead providers to refer victims to different services, although these women cannot cope with the burden of being transferred to a district hospital or another referral hospital

- The low quality and quantity of GBV providers: Men sometimes have to examine female rape survivors, which could be a problem for the victims.
- Poor organization/communication between services within health facilities or health centers
- Lack of health facilities, making it difficult to access them
- Insufficient funds, which prevent providers from spending enough time following up on victims of sexual violence
- There are also gaps in the legal framework. A law on medical responsibility aimed at preventing providers from perpetrating violence and GBV should be developed. In that respect, one of our informants mentioned that talks had been initiated with the MINISANTE in order to implement such a law.

Socio-cultural obstacles revolve around traditional behaviors and the fact that men can treat women as they wish. One of the female representatives of the CNF also revealed that *“many young girls believe that reporting acts of sexual violence they experienced will make it hard for them to find a husband. They worry a lot about gossip.”* That is why the participants suggested *the elaboration of appropriate strategies for BCC in order to promote people’s rights and a specific program for GBV management.*

This also means human rights education should be integrated in formal and non-formal educational systems. It should focus on mutual respect, introduce the main aspects of GBV and detect what fosters gender-based stereotypes in order to better tackle them.

3.1.5. KEY INFORMANTS’ PERCEPTIONS ON THE ROLE OF THE HEALTH SECTOR IN MANAGING GBV

Interviewees described the following responsibilities for the health sector:

- Treatment of GBV victims: According to most participants, it includes physical and psychological treatments, which are equally important. A few participants also mentioned follow-up procedures and access to special care units. The most knowledgeable participants also referred to PEP.
- Counseling is the second type of assistance which is required of health services. Interviewees find it as crucial as physical treatment.
- Development of information, education, communication (IEC) programs: These programs should be included in every service (not only in ANC services).
- Free health care and medical expertise

- Finally, the health sector must work in collaboration with other public institutions (MINALOC, MIGEPROF, MINIJUST and the police) and the community.

Here is what a participant had to say about the role of the health sector in managing GBV: *“The health sector has a great role to play in the prevention of GBV. People tend to trust health workers more than anyone else. Therefore, the level of trust towards them is higher than the level of trust between the population and the legal system or even human rights committees. A woman will find it easier to talk to a health care provider than to her husband. It will be the same for a young girl, who would rather talk to a health worker than to her parents.”*

3.1.6. KEY INFORMANTS’ PERCEPTIONS ON AVAILABLE SERVICES AND EXISTING RESOURCES IN THE HEALTH SECTOR

The treatment of victims is the service that is mentioned most often by interviewees. Other services were also mentioned depending on the participant’s experience in one of the following topics (see table 16 in appendix 4 “Perception of responsibilities and tasks to be undertaken by health providers/by type of interviewee”).

- Counseling and psychological support
- First diagnostic-enabling appropriate referral to legal or medical services
- Detection of GBV and related diseases
- PEP
- Free health care services for victims of sexual violence.

A senior executive at the MINISANTE indicated that available resources in health facilities were also available for GBV clients. He also said that raising awareness among victims of sexual violence, so that they would seek related services at CHK (Kigali Hospital), resulted in an increasing number of clients. The fact that the districts did not have enough money to pay for the bills for the GBV services provided by CHK had a negative impact on these services. *This shows that it is necessary to find a way to finance GBV services at decentralized levels while providing free health care for the different types of GBV.*

3.1.7. KEY INFORMANTS’ PERCEPTIONS ON MEETING NEEDS AT THE HEALTH CARE SECTOR LEVEL TO IMPROVE GBV MANAGEMENT

Regarding services that should be offered, we received the following suggestions:

- Set up useful, specific and affordable GBV services
- Recognize the seriousness of GBV and raise awareness of it among providers

- Follow up with GBV victims, especially the poorest ones
- Encourage victims to seek GBV services
- Train providers so that they can provide counseling services
- Allow time for prevention/integrate IEC in GBV service delivery/work with the community.

Interviewees also expressed needs in terms of resources:

- The lack of human and material resources, which is linked to the next two elements:
- The lack of funding in health services and the country's high level of poverty and the fact that services are not free, although the law states otherwise
- The lack of skilled providers and female providers/no counselors/the fact that only physicians can prescribe PEP and other GBV treatments and that there is only one trained forensic physician in the country
- The fact that physical health care has to be paid for (in addition to sexual violence).

3.1.8. KEY INFORMANTS' PERCEPTIONS OF OBSTACLES WOMEN MUST OVERCOME WHEN THEY SEEK GBV SERVICES WITHIN THE HEALTH SECTOR

While some of the aforementioned gaps and obstacles are up to the women themselves to overcome, many others are directly linked to the fact that the health facilities themselves turn away or discourage women from seeking GBV services.

Some victims go to the health facilities later than they should and, therefore, cannot be appropriately taken care of:

- Women do not report the GBV they experienced because they are afraid of becoming marginalized in the community and in their family. Reporting GBV could lead to more severe cases of violence.
- A woman wants to be tested for HIV but her husband does not want her to; or a woman is HIV+ and blamed by her husband for it.
- Some providers denigrate women by saying *they had lost their virginity before they experienced sexual violence*.

Obstacles can also be explained by cultural factors and the fact that women are not always aware of their rights. Out-of-court settlements can also occur between a victim and a perpetrator (public figure) or between parents when a child is raped.

- A woman in Gasabo told us: *“If my husband raped me or molested me, I would rather find an amicable agreement with him than lodge a complaint against him at the police station.”*
- Another woman said: *“The love you feel towards your husband sometimes prevents you from reporting the violence he puts you through.”*

The behaviors described below encourage a “culture of silence” for the victim and a “culture of complete impunity” for perpetrators.

- Poverty limits access to health care, as referring a patient can be expensive for the victim.
- Fear of reporting incidents to male providers or police officers.
- Unwelcoming providers
- Providers do not ensure the confidentiality of the information they receive.
- The health workforce is not appropriately trained, which results in the low quality of services and explains why women do not seek GBV services.

3.1.9. KEY INFORMANTS’ PERCEPTIONS ON THE PEOPLE WHO NEED GBV SERVICES THE MOST AND THE PEOPLE WHO HAVE THE MOST LIMITED ACCESS TO THESE SERVICES

According to the interviewees, women need GBV services the most, as they are the most vulnerable target, as highlighted by the following examples:

- Poor women, with no education, financially dependent and coming from rural areas
- Young girls, who have been raped, especially the ones who have been raped by a relative or a neighbor
- Female teenagers, who have been raped by their teachers or other men
- Genocide survivors, who have experienced multiple acts of sexual violence and who are HIV+
- Victims of sexual violence, who got contaminated by HIV before or after the genocide
- Women exposed to STI/HIV/AIDS

- Prostitutes
- Employees raped by their employers

Women in the various categories mentioned above are also the ones who have the most limited access to GBV services. However, many informants told us that the main problem was that GBV services were either poorly delivered or do not exist in some health facilities.

3.1.10. KEY INFORMANTS' PERCEPTIONS ON THE LINK BETWEEN GBV/HIV/AIDS AND THE INTEGRATION OF GBV SERVICES IN ANC/PMTCT SERVICE DELIVERY

All the people we interviewed admitted that there is a link between GBV and HIV/AIDS. They gave concrete examples of women, who are the most at risk:

- Poor HIV+ women and prostitutes (who are often battered when they ask for the money they are owed or when the client discovers they are HIV+)
- Women in HIV discordant couples
- HIV+ young girls (who are considered prostitutes, whereas young men are treated compassionately)

There are two categories of women seeking GBV services:

- The women who seek treatment because they are afraid of AIDS and the ones who are referred to the health facility by the police.

In order to improve this situation, here is what the interviewees suggested:

- Integrate GBV services in ANC/PMTCT service delivery (encourage counseling and IEC, help the victims become economically and nutritionally independent and promote micro-projects with support groups)
- Educate society, so that people living with HIV are not discriminated against because of their gender
- Reach HIV+ women to give them advice and help them make decisions related to family planning. Raise awareness of existing services for the prevention and management of GBV.

Also, an employee from the MINISANTE admitted that *integrating GBV services in ANC/PMTCT services could help detect GBV cases.*

All the informants we met mentioned that GBV could only be managed if they were reported. An interviewee also emphasized the fact that GBV could result in unwanted pregnancies and increase the risk of HIV and STI contamination. Some informants added that the integration of GBV services could encourage couple counseling.

3.1.11. READINESS TO MANAGE GBV WITH LAWS AND POLICIES

During the study, existing laws and policies as well as strategies in every sector have been compiled. In some cases, we even collected drafts and laws pending adoption, finalization or enactment. The key informants we contacted also shared their views regarding existing documents and the ones that were being developed.

Informants helped us localize existing laws and policies, as some of them were deeply involved in their enforcement or their development process. Some could remember the exact names of laws and policies while others were able to refer us to relevant ministries and to the institution in charge of the publication of laws and decrees. Protocols and standards were brought to our attention by interviewees working in services related to the MINISANTE.

Here are the laws and policies related to GBV/ANC/PMTCT mentioned by the informants we interviewed:

- Protocol for the management of sexual violence (MINISANTE)
- Learning guide (by the MINISANTE): Sexual Violence
- Strategic draft plan of the Rwandan government on violence against women and children
- Draft law on reproductive health
- Ministerial decree # 20/13 of 3/31/2006 from the MINISANTE regarding the medical management of sexual violence (written in Kinyarwanda)
- Guide for the management of people living with HIV in Rwanda
- Law #27/2001 regarding the children's rights and protection against violence
- Provider's guide for the psychological and social management of people living with HIV/AIDS
- Training course for trainers related to gender issues and HIV/AIDS
- Training course on the management of victims of sexual violence
- National policy on violence against women and children

- National Plan for the Prevention of HIV 2005-2009
- National multi-sector strategic plan against HIV/AIDS 2005-2009
- Health Policy
- National Policy on Reproductive Health
- National policy against HIV/AIDS
- National Policy on Gender
- Draft law on GBV prevention and repression
- Revision draft of the penal code
- Protocol for the management of sexual violence.

A key female informant brought the following documents to our attention:

- The international human rights conventions, especially the ones regarding the protection of children and women. Indeed, according to the article 190 of the Rwandan constitution of 06/04/2003, these conventions prevail over national laws, provided that they have been ratified by Rwanda.

She also mentioned:

- The civil and political rights pacts
- The Convention on the Elimination of all Types of Discrimination Against Women
- The penal code: she mostly focused on article 10, as it specifies that non-profit associations can bring in a civil action to ask for damages on behalf of the victims they are assisting or in the case victims choose not to take action.
- The civil, commercial, social and administrative code: our informant focused on article 185, which specifies that children in conflict with the law should be represented by a lawyer all along the procedures and that if parents cannot pay for one, the public prosecutor's office will have to find one. Although the article does not directly refer to GBV victims, we believe it gives us an opportunity to advocate for the legal representations of these people, as most of them are traumatized.

By “readiness” of the policy environment, we mean its willingness to integrate, enhance the quality of and access to and/or the utilization of client-oriented GBV (and PMTCT) services. We based our work on the recommendation from the Draft National Policy on Violence against Women and Children (14), particularly the section dealing with health, in which it is specified that the health sector must ensure the availability of medical services “favorable to women and children” (including assistance and counseling services) (p. 19).

In order to identify the legal documents, laws and policies that are favorable to women and children and which can regulate the GBV services meeting their needs, we had to determine several criteria. We were helped in that mission by an international expert in GBV (15):

Global criterion: Is the law or policy favorable to women, children and victims so that the provider can offer services that meet their needs?

- I. Sub-criterion 1: Do policy instruments on GBV clearly mention the type of violence, which is defined as a crime, and the related punishment?
- II. Sub-criterion 2: Do these instruments reflect the entire range of violence, which is experienced in the country?
- III. Sub-criterion 3: Do providers *have to* notify legal authorities or to provide a report outside of the health service in which they work?

Explanatory note: In some countries, providers have to report acts of violence, as they are convinced victims never would do so themselves (because of adverse social consequences they might face, potential reprisals from the perpetrator, loss of means of subsistence, negative impact on their children and a lack of trust in the legal system).

Despite the importance of the factors we mentioned above explaining why victims keep silent, we believe that it is of crucial importance that the information shared with the health system remains confidential. Having providers report acts of violence (maybe against their will) can also result in the victim fearing multiple consequences. The victim should have the right to decide where, when and with whom she wants to report the violence she experienced.

- IV. Sub-criterion 4: Is a national follow-up of GBV planned/required by law as part of a disease surveillance system?
- V. Sub-criterion 5: Does the policy/protocol require an examination of the victim by a physician forensic expert?

Explanatory note: Requiring a forensic expert, who is a physician, can be a very tedious procedure as this kind of expertise is rare and almost unavailable for the victims. It can result in long waits, unforeseen expenses and does not encourage GBV victims to seek such services. Providers should, therefore, be trained to provide these tasks and enhance access to and utilization of these services.

- VI. Sub-criterion: If it is a policy/protocol related to health, reproductive health, HIV/PMTCT, does it actually mention the term GBV (for instance, does it include the management of the several types of violence and a range of appropriate services responding to GBV?)

N.B: These criteria are not limitative. Their use is not aimed at assessing or passing a permanent judgment on a document. However, these criteria helped us identify factors fostering the quality of, the access to and the utilization of services that are favorable to women and children. They were used as landmarks in the important discussion about the readiness of the policy environment to respond to GBV in Rwanda. They also helped us think about the gaps that should be filled in order to integrate GBV services into ANC/PMTCT service delivery.

In the end, the criteria turned out to be useful for the identification of some elements in the policy environment, which encourage or prevent a response to GBV in Rwanda and the implementation of client-oriented GBV services.

The criteria are applied on two levels:

1. A (draft) law, a (draft) policy or an individual protocol: a law or a policy that includes all or most of the criteria we mentioned above is considered as an instrument encouraging the management of GBV in ANC/PMTCT services and fostering an environment that is favorable to the integration and the quality of GBV services.
2. The policy level as a whole: an environment that includes all these criteria shows its readiness to integrate useful and accessible GBV services in ANC/PMTCT service delivery.

N.B: See the analyses conducted with these criteria and the detailed discussions in appendix 2.

3.1.12. FINDINGS

We found out that there is a wide range of useful documents related to GBV.

- The policy environment includes all the criteria that encourage the management of GBV as well as the quality of and the access to these services.
- Generally speaking, there are no standards for the definitions and types of GBV that we found in the documents. For instance, the definitions of rape and sexual harassment are different in the draft policy on GBV prevention and repression and in the penal code.
- Some texts provide very good suggestions for an integrated response to GBV in ANC/PMTCT services that is favorable to women and children:
 - a. The national draft policy on violence against women and children: it provides a good political framework to take action and meet relevant objectives in the health sector. It also gives a vision of GBV that includes all the range of GBV experienced in Rwanda. It is important to note that, in the section related to the objectives of the health sector (4.5.2.3), the French version of the policy focuses on sexual violence even though it mentions other types of GBV. In addition, the terms “GBV and violence against children” are used in the English version.
 - b. The draft strategic plan on GBV and violence against children emphasizes the link between HIV/AIDS and GBV: “HIV/AIDS and the extreme level of poverty increase the impact of GBV in the community and, at the same time, contribute to the existence of GBV.” It says that mechanisms should be implemented in order to ensure that citizens can live a life free of physical and sexual abuse while accessing property, health care, education and justice. It stresses the fact that particular attention should be given to the enforcement of existing laws related to GBV and provides priority strategies for an integrated response to GBV.
 - c. The National Reproductive Health Policy: it also provides a good political framework for actions to be taken and objectives to be met within the health sector. This policy mentions two types of violence (sexual and domestic) and defines objectives and strategies to prevent sexual violence. Some of its goals have been met, such as the development of guidelines to prevent sexual violence and the integration, to a certain level, of GBV management in the minimal service package available in health centers. But other goals still need to be reached.
 - d. The draft law on Reproductive Health (RH) follows some of the recommendations from the policy we mentioned above. This draft law deals with the general aspects of sexual violence, with a particular focus on violence against children, as well as psychological and economic violence, which could result from pregnancy. These types of violence are considered an offense (or a crime in some cases). However, the content of the draft law is not as extensive as the policy’s in the sense that it does not mention domestic violence.

- e. The National Multi-sector Strategic Plan against HIV/AIDS 2005-2009 (by TRAC) recognizes the link between HIV and several types of GBV: *“In order to reduce the impact of AIDS, we must fight the discrimination against people living with HIV, improve the legal protection of women, boys and girls against rape, physical abuse and exploitation”*(p. 41). It also provides a central strategy: *“Reduce the social and economic impact of HIV/AIDS”* (see 4.2.3). It also focuses on the protection of women against GBV: *“Protecting women against sexual and domestic violence, as well as sexual harassment”*(p. 61).
- f. The guide for managing people living with HIV in Rwanda: This guide has the great merit of mentioning rape and the ways of preventing HIV and pregnancy (by prescribing PEP and emergency contraception methods).
- g. The training course for trainers in gender issues and HIV/AIDS describes all types of GBV and related health care services. It is the only training course that focuses on all the forms of violence (physical violence, assault and battery, use or threat of using weapons). The provider’s guide for psychological and social management of people living with HIV (by TRAC) directly refers to sexual violence. It is the first extensive guide mentioning counseling for HIV concordant or discordant couples (thus decreasing the risk of GBV linked to the test results). Therefore, it encourages the integration of GBV services in the health sector.

The policy environment also highlights some factors that could be an obstacle to the GBV service delivery, the access to and use of services responding to sexual violence that are favorable to women and children. Here are these obstacles:

- a. The management protocol for sexual violence limits medical expertise and the prescription of PEP by physicians only, which creates obstacles for poor women and peasants, who live far from district hospitals, as the women cannot pay for transportation and other expenses related to the use of such services.
- b. The Learning Guide on sexual violence: this guide emphasizes hymen rupture as a proof of sexual violence and, therefore, seems to deny the possibility that sexually active individuals, married or single, may also be raped. It also does not take into account the fact that a man or a boy may also be raped. Also, there are very serious types of sexual violence for which there are not any physical evidence.
- c. A key informant told us: *“There is very little understanding for GBV issues during forensic examinations of sexual violence: It may happen that there is no physical evidence proving that a woman experienced sexual violence and litigators can use that factor to deny that an act of violence occurred. There are shortcomings in the way physicians conduct forensic examinations. Physicians should write their report according to facts that were reported to them and based on the discussion they had with the victim. They should not write: ‘No visible signs, occurrence of sexual violence remains possible,’ as such a diagnosis results in a misunderstanding between the providers and the judges. Training is, therefore, necessary.”*

Generally, sexual violence is included in legal documents although certain types of GBV (physical, psychological and economic violence) are widely reported in various studies (16, 17). A key female informant from the police department emphasized the under-reporting of GBV as GBV cases that are not related to sexual violence are not reported. They are actually not considered as GBV by authorities and society as a whole. However, all types of GBV should legally and equitably be responded to in order to be better managed. In addition, in numerous cases, the various types of violence are intertwined. Also, the results we gathered from the focus groups with providers, clients and community members that are documented in sections 2 and 3 of this report show the different types of GBV, the moments at which violence is most likely to occur during ANC/PMTCT service delivery, how the different forms of violence can be linked, as well as the frequency of domestic violence and physical abuse.

However:

- The penal code addresses several types of GBV but does not mention domestic violence.
- The draft law on the prevention and repression of GBV, in its most recent version, does not explicitly recognize domestic violence and physical abuse. Also, it does not provide sufficient details on the evidence necessary for the police, the judges, the lawyers and the prosecutors to prove that an act of GBV occurred.
- Moreover, Article 38 of the draft law on the prevention and repression of GBV (“Punishment incurred for false reporting of GBV”) can result in discouraging victims from reporting the acts of violence they experienced. The punishment incurred for false reporting is in proportion with the punishment that would be given to an actual perpetrator. This seems to be aimed at preventing false reporting. However, given the quantity of evidence already necessary to ascertain an act of sexual violence (medical expertise, testimonies from the witness and the perpetrator) and the possible stigmatization of victims, it is very likely that the victim will not take any chances. Even a truthful report could be considered a wrongful allegation because of the lack of visible physical evidence, the lack of detailed information regarding the reliability of GBV evidence, the cross-examination of witnesses and the perpetrator’s denial. In addition, GBV (such as domestic, psychological and sexual violence) generally occurs in the private circle. It is, therefore, extremely difficult to get someone to testify.

This law was specifically developed for managing all types of GBV and is considered a reference. It would be more favorable to the victims if an article regarding domestic violence was added and if articles related to the burden of proof were revised and became more explicit. Moreover, a law favorable to the victims should not discourage anyone from reporting crimes and offenses.

CONCLUSIONS ON THE READINESS OF THE POLICY ENVIRONMENT TO RESPOND TO GBV

We found out that, on the legal and policy level, Rwanda is starting to have at its disposal a wide range of useful legal documents, policies and strategies regarding GBV and HIV/PMTCT. However, there are obstacles that need to be overcome in order to appropriately integrate GBV management within the health sector.

Among these obstacles, we found: the non-harmonization of legal documents, discrepancies in the definitions of GBV aspects and types, the fact that some laws and policies are not favorable to GBV victims, the insufficient dissemination and popularization of laws and policies, the lack of consideration of GBV as a public health issue and the lack of appropriate policies in that area. Such policies should define:

1. Client-oriented services for treatment and prevention
2. Criteria to appropriately respond to GBV within the health sector
3. Necessary material, financial and human resources
4. Integration of pre-service and in-service training and GBV awareness-raising campaigns among providers
5. Decentralization of victim-focused services, including PEP and medical expertise
6. Collaboration with central partners and community members
7. Systematic and standardized documentation and registration of information related to GBV, as part of the Health Information Management System (GESIS).

Furthermore, as key informants recognize the link between GBV and HIV, they should support a coordinated response to GBV both at the community and health sector levels and advocate for a more appropriate legal environment. This approach should result in recommendations aimed at correcting the shortcomings we mentioned above.

Overall, if existing documents and strategies were harmonized, more detailed and effectively enforced, GBV policies could help improve the capacities of providers and health facilities to deliver client-oriented GBV services within ANC/PMTCT services.

Detailed recommendations and concrete propositions aimed at making up for the gaps we found in the policy environment, as well as Twubakane's and other partners' contributions are introduced in section 4 of this report.

3.2. LEVEL 2: ASSESSING THE READINESS OF THE HEALTH SECTOR TO MANAGE GBV

In order to assess the readiness of this sector, we focused on:

1. Health care providers and how to meet their needs in order to better respond to GBV in their service package (i.e. assessing their knowledge, beliefs and practices related to the management of GBV)
2. The readiness and the capacities of health facilities to provide GBV services, as well as the availability of resources for people living with HIV in the community

3. The clients' perceptions on their own needs, possible courses of action for victims of violence and the role of health care providers in assisting GBV victims.

Therefore, the study team used the following tools: “The interview guide for focus group with PMTCT service providers (Tool #3)”; “the questionnaire on providers’ knowledge and beliefs related to GBV (Tool #4)”; “the clinic record review form to assess providers’ GBV practice (Tool #5)”; and “an inventory to assess facility readiness to manage GBV (Tool #6)” including an extra form titled “Equipment and supplies for the management of Rape victims” and an “Interview guide for focus group with ANC/PMTCT clients (Tool #2)”.

We also used the information we found in the “GBV Resource Scanning Guide (Tool #7)”.

Table 4: Type of interviewed providers by health facility and district

DISTRICT	Health Facility	Type of providers				TOTAL
		Social worker	Social worker VCT	Nurse (A1)	Nurse (A2)	
NYARUGENGE	BIRYOGO				8	8
GASABO	GIKOMERO				6	6
	KACYIRU			2	6	8
KICUKIRO	KICUKIRO	1	1	1	5	8
	MASAKA				8	8
TOTAL		1	1	3	33	38

We noticed that the great majority of interviewed providers—33 out of 38—were A2 nurses. Only the health facilities of Kacyiru and Kicukiro have A1 nurses. We also noted that A2 nurses account for 87% of providers and are the first ones to give orientations to ANC clients when they arrive in the facility.

3.2.1. FINDINGS ON PROVIDERS’ KNOWLEDGE RELATED TO GBV

The results below have been collected with a questionnaire on knowledge and beliefs filled out by 38 providers, under the supervision of a facilitator who provided explanations when necessary.

Questions were asked to the providers in order to assess their knowledge of GBV. Providers were asked about the management of GBV by the policy environment, the definitions of violence against women, their perceptions on the prevalence of GBV and aspects related to the management of GBV. Six to eight providers were interviewed in each facility.

Each provider was graded by the number of correct answers s/he had. We calculated an aggregate score in order to find an average grade for each health facility. Providers in the Kicukiro health facility got the highest average score with 38.3% (see figure 1 below)—even if 38% cannot really be considered “high.” The average score for all the facilities was 35.5%.

In addition, it appeared that providers in every facility knew the types of violence and the reasons for domestic violence more than any other topic (84.2%). More than half of providers (60.5%) could identify a referral community service or an organization at the district level. One provider (2.6%) was able to describe precisely the warning signs and the way one can assess the risk of violence for a client. Two providers (5.3%) were able to clearly explain the conditions under which emergency contraception should be prescribed to a client who just experienced violence.

Generally, providers are aware of the different aspects of GBV but they lack knowledge in the identification and treatment of this type of violence. The level of knowledge slightly varies from one health facility to another (see table 5 below).

Figure 1: Average score on providers' knowledge of GBV in five health facilities (percentage of correct answers)

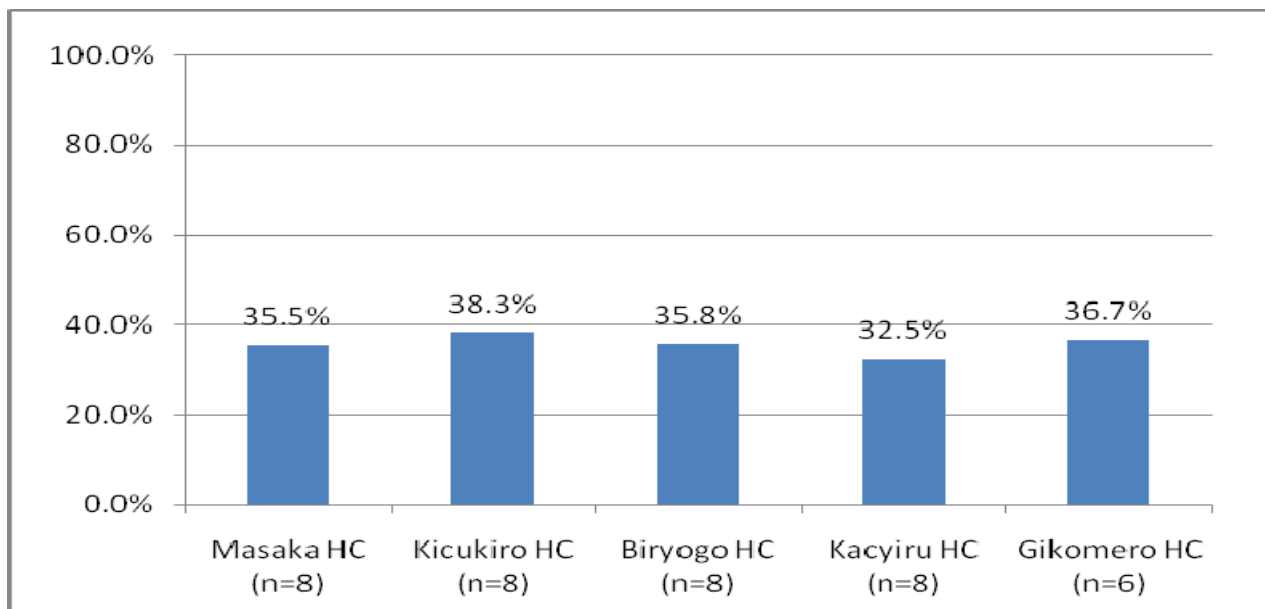


Table 5: Percentage of providers (n=38) with correct answers on the GBV knowledge test in all five health facilities

Questions	Percentage of correct answers
Laws and policies responding to GBV	44.8
Types of violence	84.2
Warning signs of violence	2.6
Assessing the risk of violence	2.6
Ensuring safety of women at risk	13.2
Appropriate prescription of emergency contraception	5.3
Ensuring confidentiality and safety in violent relations	10.5
Reasons for not reporting violence/reasons for continued violence	84.2
Availability of a referral agency at the community level for GBV services	60.5
Myths related to GBV	50.0
Global extent of violence	34.2
GBV prevalence in the city of Kigali	13.2
Total	35.5

3.2.2. FINDINGS ON THE PROVIDERS' ATTITUDES AND BELIEFS

After assessing the providers' knowledge, we studied their readiness to deliver quality GBV services. In order to do so, we asked them questions related to their perceptions and feelings towards different aspects of violence against women. It was determined as follows:

- Do providers blame the victims? (The less they blame, the more willing they are to respond GBV.)
- Do they consider men responsible for acts of violence? (If so, they are ready.)
- Can providers be declared competent to respond to GBV? (If providers believe they are competent, they are ready.)

I) The most frequent score (mode):

For each question we asked, we calculated a mode in order to see the answers that were most frequently given by the providers in each health facility (see table 6). For each question, we asked the providers to tell us to what extent they agreed with the answers we suggested. It ranged from one to five (1 – Entirely agree, 2 – Agree, 3 – Do not know, 4 Disagree, 5 – Entirely disagree).

- Apart from the Gikomero health center, health providers in the five health facilities most often agreed that women were responsible for the violence they experienced because of their behavior (mode=2). In the Masaka health center, providers most often agreed that there are times when the use of violence by men against women can be justified (mode=2).
- There two modes according to which men can be judged responsible for acts of violence: in Masaka and Biryogo, providers agree that men are not responsible for their actions. Providers in these facilities entirely agree with the following statement: “A man who rapes a woman cannot control his behavior.” On the contrary, providers in Kicukiro and Gikomero most often entirely disagree with this statement.
- A majority of providers in the five facilities agreed on the fact that they are competent to respond to violence against women. They mostly agreed with all the statements in this category.

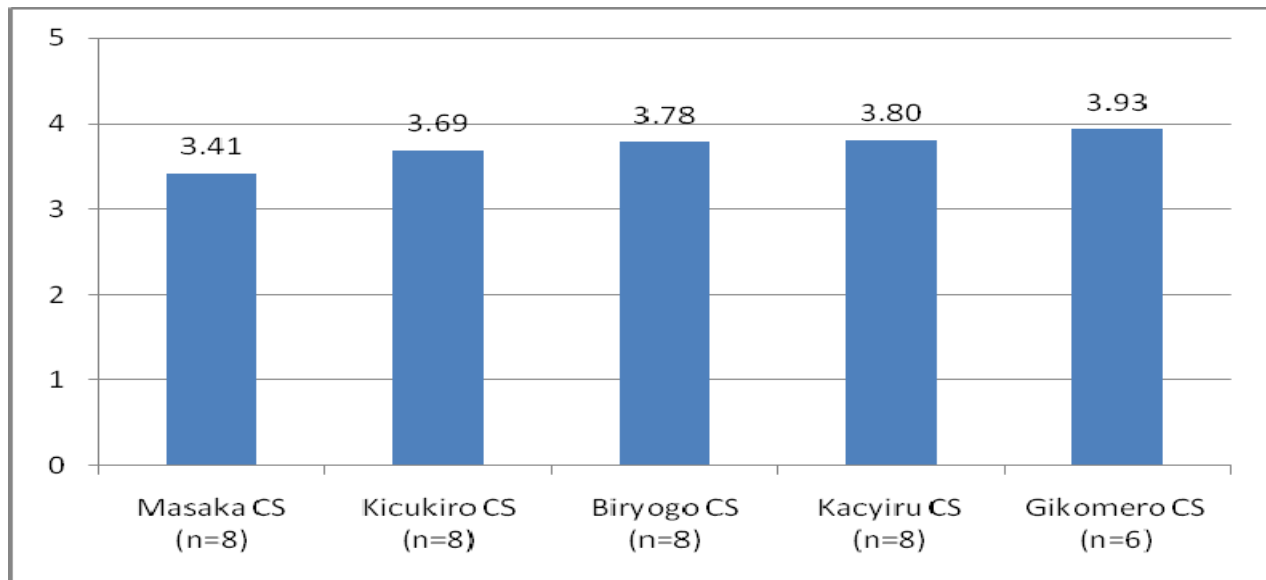
Table 6: Mode regarding the attitudes of providers in the five health facilities

Attitudes	Health Facility					
	Masaka HC (n= 8)	Kicukiro HC (n= 8)	Biryogo HC (n= 8) Kacyiru HC (n=8)	Gikomero HC (n=6)	Total	(n= 38)
On blaming the victim						
A woman who is beaten and who does not leave an abusive relationship must really approve, otherwise she would just leave.	5	5	4	5	4	5
A woman provokes her partner's violence because of her own behavior,	2	2	2	2	4	2
There are times when a husband is justified in beating his wife.	2	5	5	5	5	5
On considering men responsible						
A man who forces a woman to have sex cannot control his behavior.	1	5	1	3	5	1 and 5
On considering health care providers competent to respond to violence						
Preventing, detecting and managing (e.g. treatment, education and referral) intimate partner/conjugal violence is not part of a health service provider's job.	5	2	4	1	5	5
Most health service providers do not have time to inquire into suspected cases of intimate partner/conjugal violence.	5	4	2	5	5	5
I would not feel comfortable discussing intimate partner/conjugal violence with my clients.	5	1	5	5	5	5
Asking clients about violence in their intimate relationships would offend them.	2	4	5	5	5	5
I do not believe I can help victims of violence improve their situations.	5	4	4	5	5	5
Violence against women is really a family matter and not a matter for public health policy.	5	4	5	5	5	5

2) Average score:

In order to calculate the average score on providers' beliefs in each facility and find a trend in their answers, we decided that the highest score possible would be 5 (see figure 2). Providers in the Gikomero health facility showed the highest level of readiness (to respond to GBV), with an average score of 3.93.

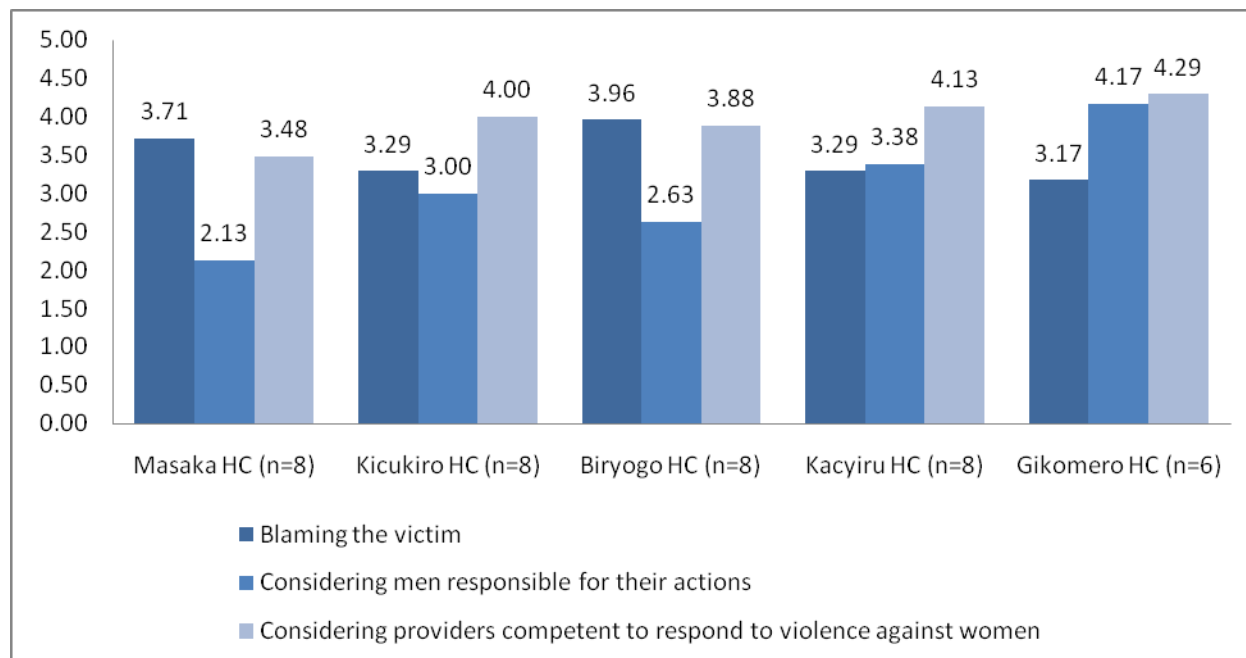
Figure 2: Average score in providers' beliefs by health facility (n=5)



The data we gathered in each facility shows that:

- Generally, providers have a rather positive attitude in providing support for victims of violence. A further investigation on the average answers to individual questions, their frequency and the types of GBV helps us identify specific gaps to be filled through training sessions (see figure 3).
- Regarding the section titled “blaming the victim,” the Biryogo health facility got the highest average score (3.96) among all health facilities as providers there believe women should not be blamed for the violence they experience.
- Regarding the section titled “considering health providers competent to respond to violence against women,” the Gikomero health facility got the highest average score (4.29) among all health facilities. Providers in this facility also believed men should be considered responsible (highest average score 4.17). The Masaka health facility got the lowest average score (2.13).

Figure 3: Average score on providers' beliefs related to GBV by health facility

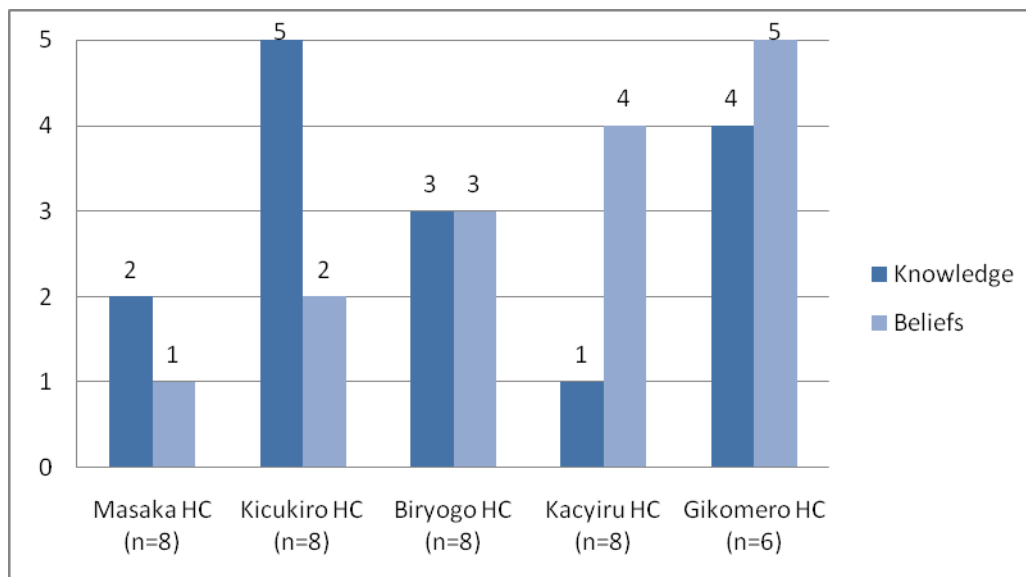


Synthesis on the readiness of health providers to respond to GBV based on the scores they got on the beliefs and knowledge test

In order to determine the level of readiness to manage GBV in each health facility, we had to assess the general knowledge and beliefs of the providers, so we decided to rate every healthy facility. The best performing one would get the highest score (5) and the worst performing one would get the lowest (1). The results show that:

- The Gikomero health facility displays the highest level of readiness in terms of beliefs and ranks second in terms of knowledge.
- Although the Kicukiro health facility globally ranks second and got the best average score in terms of knowledge, providers there do not perform as well in terms of beliefs.
- On the contrary, the Kacyiru health facility ranks second among the best performing health facility in terms of beliefs, but providers do not perform as well in terms of knowledge.
- The Biryogo health facility ranks third in terms of knowledge and beliefs.
- The Masaka health facility has the lowest level of readiness in terms of knowledge and beliefs (2).

Figure 4: Ranking of health facilities according to providers' beliefs and knowledge



The Gikomero health facility boasts the highest level of readiness to respond to GBV in terms of knowledge and beliefs. It is important to note that, despite the ranking, each facility seems to be facing challenges in these two areas. There is still an important gap between the providers' knowledge and their beliefs. These gaps can be filled through training sessions and awareness-raising campaigns.

3.2.3. PERCEPTIONS AND EXPERIENCES OF PROVIDERS ON THE INTEGRATED MANAGEMENT OF GBV IN ANC/PMTCT SERVICES

As we mentioned in the section related to methodology, 36 providers participated in 5 focus groups (8 in Biryogo, 7 in Gikomero, 8 in Kacyiru, 7 in Kicukiro and 6 in Masaka).

Overall, the providers considered violence as a combination of different acts, the most important one of them being physical abuse (men beating women). Rape was also identified by a great number of providers. Other forms of violence were also mentioned:

- Deprivation of fundamental rights
- Men not providing food to their own family
- Insults and public disrespect towards women, as well as distrust and disdain shown by husbands to their wives
- Sexual relations without mutual consent
- Men abandoning their families

- Men rejecting family planning
- Husbands preventing their wives from seeking ANC services and treatment
- Ill-treatment of women, who only gave birth to girls
- STI/HIV/AIDS contamination due to HIV+ men's unwillingness to use condoms
- Jealousy

According to providers' testimonies and based on their experience, some women are not fully aware of the violence they face, or they resign themselves to it. According to some health workers, that would explain why so many battered women keep silent and do not report violent incidents.

Providers we met in the focus groups revealed that some victims could, through counseling and mediation, manage to peacefully fix problems with their husbands. The person who is responsible for the conflict, then, has to ask for forgiveness. Others choose a different course of action and ask health providers to intervene, sometimes looking for financial aid.

According to most providers, almost all types of violence against women are perpetrated by their husbands, who are often under the influence of alcohol or encouraged by tradition. Violence could also be a consequence of unfaithfulness and hatred towards "older women" (*kumurambirwa no kumuzinukwa*).

3.2.3.1. Referring victims of violence

Victims can be referred to other providers or organizations for the following services:

- Hospitals (for medical examination in the cases of rape and serious injuries)
- Local authorities (for administrative assistance): *"Lately, a wounded woman came here and we treated her. She complained that her husband kicked her out from their house so he could live with his girlfriend. We referred her to basic authorities that could work on her case,"* a nurse in Gasabo told us.
- Social workers (for psychological and material assistance, including health care costs)
- Haguruka (for legal assistance)

3.2.3.2. Health services support system for victims of violence

The providers we interviewed unanimously said that as soon as a battered woman or a rape survivor comes to a health facility, the first thing to do is to mend possible physical wounds and to make a first diagnostic, which could help them fill out the medical report.

Some providers revealed that, in the case of domestic violence, they ask the husband to come in order to conduct mediation. Others inform administrative authorities and the police force.

A great number of providers believe that they have the right to enforce medical privilege when it comes to domestic violence. As a nurse in Kicukiro told us: *“I looked after a woman, who had an abortion because her husband was beating her, but she did not want anyone to know. One day, her family asked me if she actually had had an abortion for that reason, so they could file a complaint against the perpetrator. I said I had no idea.”*

Providers are actually debating whether they should alert the police regarding GBV cases. Most providers believe it is their duty to do so, while some say they can choose not to.

According to providers, there are two reasons why a health worker may not look after a victim of violence: the lack of competence and the willingness to preserve the evidence. Apart from that, most providers said nothing should keep them from looking after victims of violence.

3.2.3.3. Perceptions on the victims’ readiness to report the acts of violence they experienced

According to most providers, who took part in the focus groups, victims of violence who dared to talk to them felt relieved afterwards. A nurse in Kicukiro was pleased to notice how satisfied these women were: *“When we give them enough time to share their stories and to welcome appropriate advice, they feel relieved and they tell us how much they appreciate our assistance. Some of them just come by to thank us.”*

In the focus groups, some providers told us that victims of violence trust them and have no problem sharing their stories with them. However, some health workers added that some patients would rather keep things secret, as they are afraid their husbands will end up knowing they talked to someone. According to providers who are trusted by women, victims are still in shock when they share their experience with them.

Some victims are reluctant to talk to a provider, who would lack compassion and understanding. Some women are afraid they might have to reveal the name of the person responsible for their pregnancy. This is true for women living without a socially recognized partner (single mothers, widows, divorced or separated women).

Health providers who took part in the focus groups in the five health facilities said they tried to create a positive environment with their clients in order to foster dialogue. Discussions with health workers show their readiness to look after victims of violence and to improve communication.

3.2.3.4. Providers’ perceptions on the risk of violence for ANC/PMTCT clients

According to providers, who took part in the focus groups in the different health facilities, ANC/PMTCT clients are at risk at different times. These risks may vary according to the types of violence involved and they worsen when the victim is HIV+. The different types of violence and the moments at which they are likely to occur are illustrated in the following table:

Table 7: Types of violence and times when ANC clients are at risk, according to providers

Types of violence	Times when clients are at risk
<ul style="list-style-type: none"> Preventing a woman from seeking ANC services or refusing to accompany her to these services 	<ul style="list-style-type: none"> After one or both spouses have been declared HIV+
<ul style="list-style-type: none"> Physical abuse, insults and lack of respect, psychological trauma 	<ul style="list-style-type: none"> After the gender of the child has been declared (especially in the case of a girl) if the woman has had an ultrasound (sonogram) at the hospital After giving birth (especially to a girl) After seropositivity has been confirmed
<ul style="list-style-type: none"> Lack of respect during the victim's admission in the facility, insults from providers 	<ul style="list-style-type: none"> Anytime During pregnancy, during labor and after delivery (the risk increases for women who do not have a socially recognized partner)
<ul style="list-style-type: none"> Failure to provide substitution nutrition to replace breastfeeding by an HIV+ mother Requesting an HIV+ mother to breastfeed a child so that people around cannot suspect the couple's seropositivity, even though the mother opted for artificial nutrition right after she gave birth. 	<ul style="list-style-type: none"> After giving birth While breastfeeding
<ul style="list-style-type: none"> Forced sexual intercourse (requested by the husband) HIV+ husband refusing to use a condom (in HIV discordant couples) 	<ul style="list-style-type: none"> After HIV test Anytime, especially when the husband is under the influence of alcohol

3.2.3.5. Providers' knowledge of existing laws and regulations

Through the focus groups, we realized that providers' knowledge of laws and regulations was vague, if not very limited. Indeed, the questions we asked them on these topics were meant to clearly identify the legal documents they were the most comfortable with, but the answers we got from them revealed they were not quite aware of the appropriate laws.

Some providers (in Masaka, Gikomero and Biryogo) even admitted they had no clue. Others say they heard about the punishments incurred for the health workers who do not report the cases of violence they observe. One of the providers in Gikomero told us what he knew about this procedure: "I heard that health workers who fail to properly look after a rape survivor will be fined 10,000 Rwandan Francs". Workers also mentioned that there are free services intended for victims of violence. According to some interviewees in Kicukiro, Biryogo and Kacyiru, rape can result in life imprisonment. Providers must also notify the police every time they register a rape case.

3.2.3.6. Providers' perception on the government's and the community's role in the management of GBV

Providers in health facilities we visited insisted on the importance of mobilization/awareness of the community regarding GBV. According to respondents, this approach should be used on all layers of the population and at every administrative level. It should range from the villages (*Umudugugu*) to other local authorities and, finally, be adapted to health workers in the facilities. They added that government officials in charge of gender issues should take actions in order to raise awareness and disseminate policies, laws and regulations related to GBV.

The government is also expected to develop legal documents related to GBV. It should pay close attention to their enforcement, create centers for GBV-related services and implement easily accessible communication mechanisms, especially in rural areas.

3.2.3.7. Existing GBV services in health facilities

Overall, the management of GBV is still at an embryonic stage:

- Only two health facilities (Masaka and Kacyiru) out of the five we surveyed admitted providing counseling services to help the victim relax.
- Only one health facility (Kicukiro) assesses the risks of violence for the victim.
- Two health facilities conduct a physical examination: providers in Masaka test the victims for HIV upon their request while health workers in Gikomero test victims when they have reasons to believe they might have been infected.
- Regarding safety issues, providers in Gikomero refer the victims to the police department, after reporting that they have been raped, while health workers in Biryogo said they write a report that they forward to the police department.
- Only the facilities in Gikomero and Biryogo provide IEC/BCC activities through educational discussions. However, Gikomero only focuses on FP while Biryogo deals with various topics other than GBV.

3.2.3.8. Existing treatment for GBV victims

Regarding the documentation of the victims' wounds intended for the legal system, the majority of providers revealed that their health facilities did not have the appropriate equipment and supplies. Some health workers reminded us that primary health facilities (*centres de santé*) were not legally competent to provide such expertise. These perceptions are confirmed by the assessment of the facilities' capacities and the analysis of the country's policy environment.

Regarding the confidentiality of data related to the treatment of victims of violence, all the providers we met told us that professional secrecy in that matter was well-kept.

According to many providers, the first challenge they face in the treatment of rape survivors is linked to the fact that they are *not legally competent to deliver an official document that could help the victim obtain justice as quickly as possible, although they are the first ones to detect cases of violence, document them and to make a diagnostic*. That is why some vulnerable women find the examination process so burdensome and eventually decide not to press charges against the perpetrators of violence. These perceptions are corroborated by the analysis of the policy environment. They show the necessity of decentralizing legal competence so that health facilities can provide a medical certificate.

3.2.3.9. Providers' perceptions on a possible integration of GBV into ANC/PMTCT services

According to all providers in the focus groups, the integration of GBV services into ANC/PMTCT service delivery is *possible and beneficial*. Indeed, this integration would benefit women *by providing all the services they need in one same place*. This will also help services complement each other while providing workers with new diverse skills and raising awareness among women coming for ANC/PMTCT services (direct availability of IEC/BCC services). Here are the different types of services that should be integrated:

a) Counseling, HIV screening, physical examination and assessment of GBV risk

All health facilities agree that these activities can be added to ANC/PMTCT service delivery. Responsibility for these activities would fall upon providers and people in charge of counseling services. The main advantage that providers emphasized is that victims could be looked after during their first visit at the health facility.

The possible challenges resulting from such an approach are the same in every health facility: limited human resources and lack of sufficient infrastructures enabling systematic GBV counseling of all ANC/PMTCT clients. This could lead to an increase in workload and working hours as well as exhaustion for health providers and paramedical staff.

Moreover, it could make women impatient and bored and also make them lose precious time if they are not interested or directly concerned by the importance of GBV. Finally, health facilities should be extended in order to appropriately offer these services.

According to providers, physicians in addition to nurses should be responsible for the medical examination.

b) Planning for the client's safety

Providers in health facilities unanimously agree that this task can be integrated into their current activities. One of the key advantages at the ANC/PMTCT level would be the timely referral of the client to other services or institutions. According to providers, one of the challenges would be that women could get into an argument with their husbands, which could then result in an increase in domestic violence.

c) IEC/BCC activities

The providers in the five health facilities all agree that the integration of IEC/BCC in their daily GBV related tasks is a good thing. It would only require for them to be properly trained and to have enough time.

3.2.3.10. Providers' opinion on the need for a good integration of GBV in ANC/PMTCT service delivery

According to the majority of providers, the integration of GBV services requires the creation of a specific service within each health facility. Its mission would be to:

- Admit GBV victims in the facility and manage their cases
- Supervise, follow up, monitor and coordinate GBV-related activities
- Ensure appropriate work conditions for the health workers

Regarding the description of tasks performed by providers, some important elements have been suggested:

- Nurses should be welcoming when they admit the clients before treating, testing, referring and advising them.
- Counselors should carefully listen to the clients, encourage women to share their experience, visit them at home and transfer them to other competent jurisdiction (police, justice, local authorities).
- Physicians should admit clients quickly and give them background information on GBV services, medical expertise and other services involving their specific technical skills.

The purpose of supervision would be to coordinate the activities, their monitoring and evaluation, the quality of services offered and the safety of health care providers.

Training sessions will be required at all levels, including for providers that will not be directly involved (receptionists, etc.).

However, the participants noted that this approach requires prior improvements:

- Training sessions for providers in the service and in-service education opportunities (training internships, availability of literature related to GBV)

- Provide the service with tools, equipments and infrastructures that are adapted for a quick, discrete and confidential admission of clients.

In order to facilitate the integration of GBV services, the great majority of providers believe that IEC/BCC activities should be widespread in the community and related to active organizations (ASC, PAQ, religious groups, CNF, associations protecting and promoting women's rights, CNJ, etc.).

At the health facility level, providers believe that the best time to talk about GBV and detect it among women using ANC services is *when they first arrive to the facility, during their first contact with a health provider*. This would help determine other possible referrals, if need be. This could be applied to other services such as child delivery, postpartum care, inoculations, ARV treatments and neonatal care.

All providers agree that HIV+ women deserve particular attention in every step of the process, as they are afraid of experiencing violence once they go back home.

3.2.3.11. Perceptions on the clinical management of rape

The providers in each facility agreed that *services for the clinical management of rape survivors should be offered* in their health centers. However, according to health workers, only three facilities (Kacyiru, Masaka and Kicukiro) plan on offering these services.

Through the questionnaires, we found out that, at the time of the study, none of the five health facilities offered such services.

3.2.4. CURRENT PRACTICE RELATED TO GBV

A clinic record review form was filled out by each investigator through interviews with the facility manager or an experienced health care provider in order to identify what the current practices were in terms of GBV management in the health facilities we visited. We particularly focused on the detection and the referral of GBV clients. Among the five investigated health facilities, three are Catholic (Biryogo, Kicukiro and Masaka) and two are public (Gikomero and Kacyiru). (See appendix 4, "Availability of providers and health care services.")

None of the health facilities had data available regarding the detection of GBV in ANC, postpartum care, FP and referral services for the twelve months prior to the study (July 2006 – June 2007).

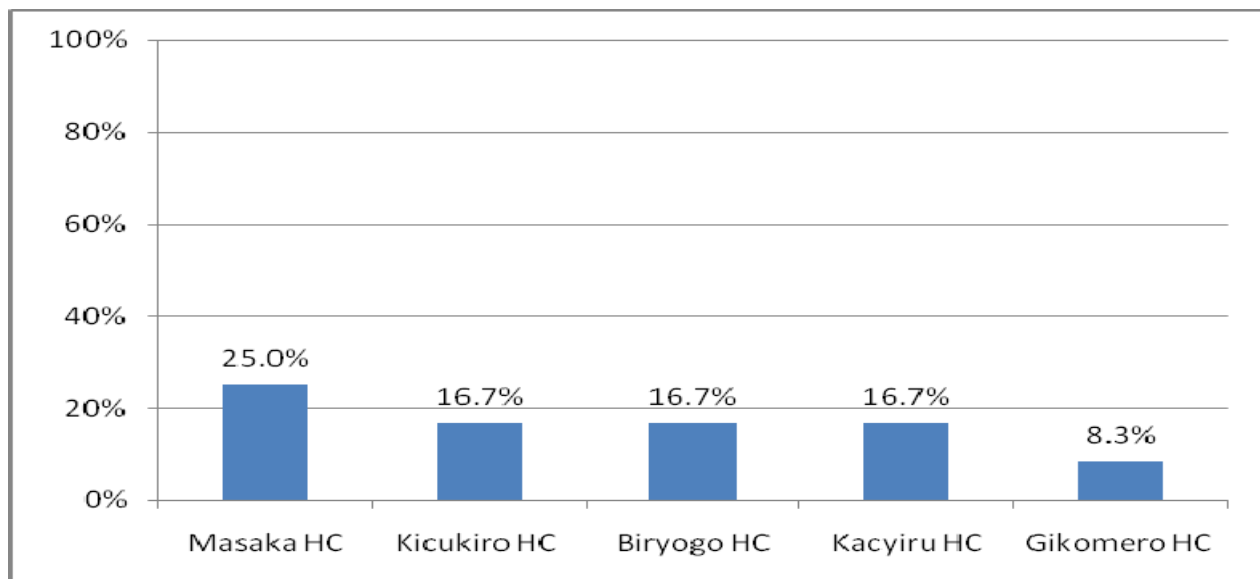
As we found out during our inventory and while consulting the facilities' registries, GBV incidents are poorly recorded by health facilities. For instance, we noticed a few inconsistencies between the data in the facilities' registries and the ones that were sent to the MINISANTE (such as HIS reports). Some providers were reluctant to show their registries, while others were trying to recall data without any kind of reference. *Well-documenting and recording every service offered by the facility is an important need for the facility that providers have to meet.*

3.2.5. ASSESSING THE READINESS OF HEALTH FACILITIES TO MANAGE GBV: AVAILABILITY OF KEY COMPONENTS TO SUPPORT GBV SERVICE DELIVERY

In each sampled health facility, the data-collecting agent consulted the registries to assess the availability of equipments and other necessary supplies in order to support GBV service delivery, including sexual abuse. A complete list of these elements can be found in appendix I (Inventory assessing the capacities of the health facilities). Twelve key components were selected and used to assess the facilities' readiness to respond to GBV based on their availability. The results from this analysis can be found in table 17, appendix 4. In addition, a percentage of available equipments and supplies was calculated for each health facility (see figure 5 below).

Overall, we could not find all twelve elements in the facilities. The Masaka health facility had the highest level of equipment with 25% of all the necessary elements, while Gikomero had the lowest (8.3%). All facilities have a private consultation room available. Except for Gikomero, all the other facilities had the necessary equipment for "Post-Exposition Prophylaxis."

Figure 5: Percentage of key elements available in the facilities in order to respond to GBV



The availability of a rape kit in the facility was a major element in the list. Given the number of key elements necessary for the rape kit to be complete (n=33), each facility was evaluated according to the number of elements available. A complete list of elements for the rape kit can be found in table 18, appendix 4.

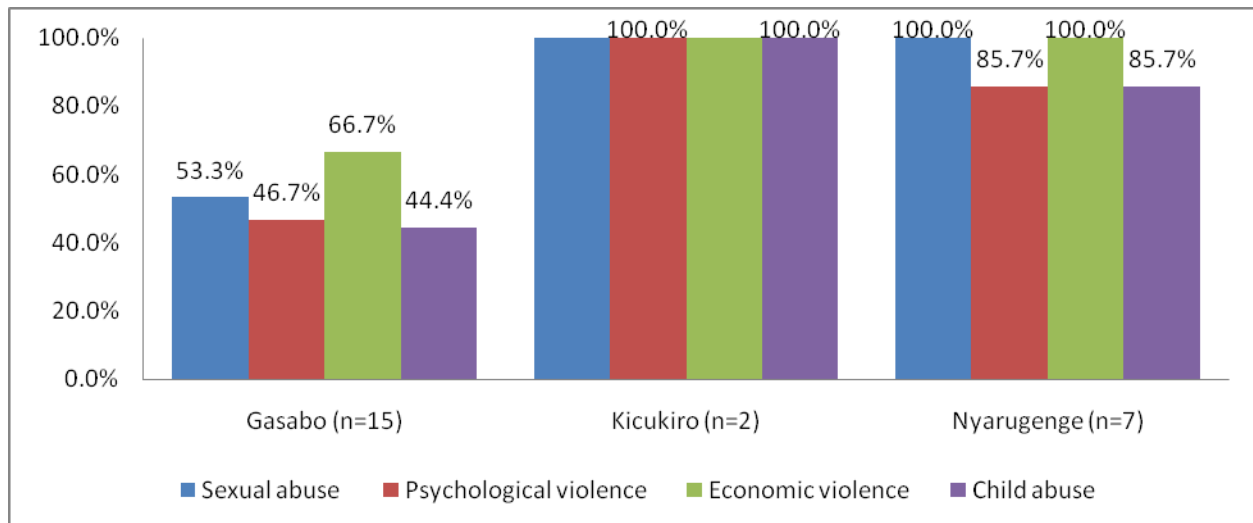
We could not find health facilities with all the required materials/equipments/resources constituting this kit, i.e. none of the facilities were quite ready to manage rape cases. The Masaka health facility had the highest number of elements (75%), followed by Kicukiro (66%), Biryogo and Kacyiru (63.7%) and Gikomero (57.6%).

Availability of resources in the communities surrounding the health facilities

The readiness of health facilities to manage GBV was also determined by the readiness of the surrounding community to respond to GBV through its available resources. Many community organizations have been interviewed in order to identify the resources that are available for GBV clients and providers by using the “GBV Resource Scanning Guide (Tool #7).” These organizations were identified after a first assessment by the Women’s Legal Rights Initiative (2006), and their selection was based on the quality of their intervention in Kigali. Thus, 24 organizations were interviewed in three districts: Nyarugenge (Biryogo health facility), Kicukiro (Kicukiro and Masaka health facilities) and Gasabo (Gikomero health facility). Each organization was carefully studied in order to understand the types of violence it dealt with and the types of services it could provide to the clients. Individual interviews were, therefore, conducted with community organizations offering legal, material (financial), psychological and social assistance to GBV victims in the city of Kigali.

Overall, we noticed that in every district, community services were available for GBV victims (see figure 6 below). However, it is important to note that, although these services exist, their ability to meet the clients’ specific needs as well as their quality and their referral mechanisms are yet unknown.

Figure 6: Percentage of organizations managing GBV, by type of GBV and in three districts



The 24 organizations were also evaluated based on the types of available services for victims of violence. The list of services includes social, psychological and housing services, as well as legal, medical and financial assistance (for a detailed description, see table 20, appendix 8: “*Type of specific assistance provided to GBV victims by organizations in several districts of Kigali*”).

- In each district, all types of support were available in at least one of the interviewed organization.
- In Gasabo, two of the organizations, which also welcome clients coming from other districts, had all six services available for clients (AVEGA and World Vision).

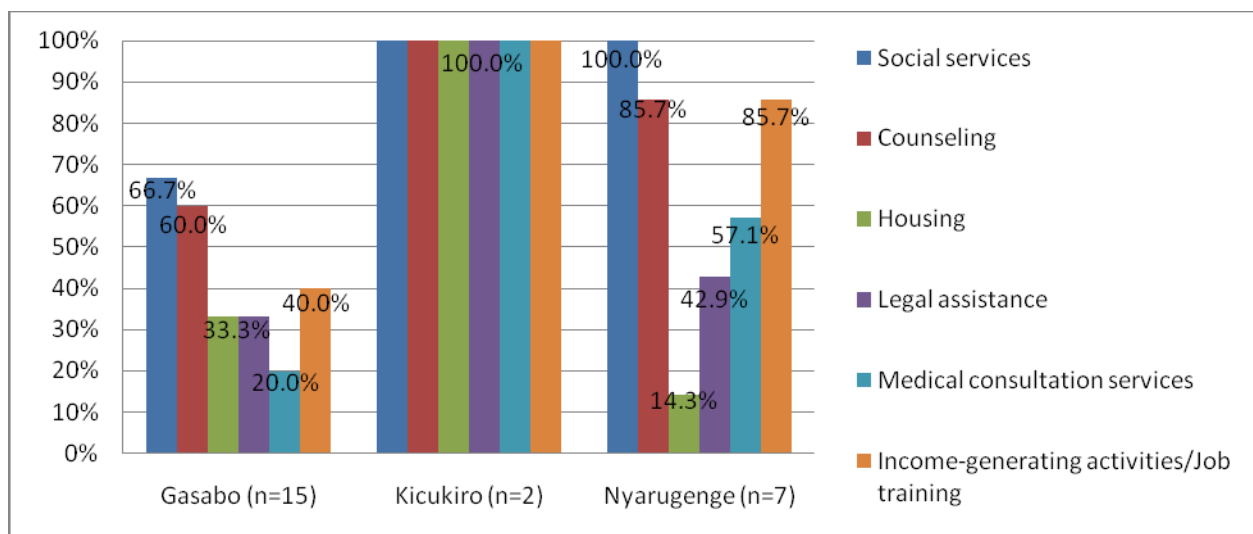
- In Kicukiro, two identified organizations also offered the six services mentioned above.
- In Nyarugenge, none of the organizations we interviewed had all of these services available.

The support services for GBV victims were available in each district for at least four different types of violence (see table 8 below). In addition, a range of services were delivered by these organizations, thus offering more choice to providers, who refer clients to available services at the community level. Although some organizations support the building of homes for genocide victims or for orphans and vulnerable children (OVC), this kind of housing is not available for clients facing a high risk of violence.

Table 8: Types of available support at the community organizations level in three districts (n=24)

District	Social services	Counseling	Housing	Legal assistance	Medical consultation	Income-generating activities/job training
Gasabo (n= 15)	10	9	5	5	3	6
Kicukiro (n= 2)	2	2	2	2	2	2
Nyarugenge (n= 7)	7	6	1	3	4	6
Total (n= 24)	19	17	8	10	9	14

Figure 7: Percentage of organizations providing some kind of assistance related to GBV



However, the durability of these organizations, the number of clients they can assist for each kind of services they offer, as well as their capacity to provide these services to the people who need them have not been assessed yet.

3.2.6. ASSESSMENT OF THE HEALTH SYSTEM BY ANC SERVICES' CLIENTS

We computed data that we gathered from the focus groups with ANC services' clients in five health facilities. Eight women in each facility (40 women total) took part in the focus groups. In order to select them, we asked the ANC services' manager or another provider in charge of these services to gather, on the day ANC consultations usually take place, all ANC clients with the team of female investigators. This team explained the purpose of the study to the clients and tried to convince them to be part of it. The clients, who agreed and who were available, were then divided into groups according to the villages they came from. Our investigators randomly picked eight women from different villages in order to get diverse perspectives on the area they studied.

Table 9: Number of ANC respondents by health facility

District	Health Facility	ANC	TOTAL by district
NYARUGENGE	BIRYOGO	8	8
GASABO	GIKOMERO	8	16
	KACYIRU	8	
KICUKIRO	KICUKIRO	8	16
	MASAKA	8	
TOTAL		40	40

3.2.6.1. Perception and experience of violence by ANC clients

According to the women we interviewed (especially the ones in Kicukiro and Kacyiru), violence has several characteristics, the main one being the deprivation of women's fundamental rights (right to express their opinion in their family or in the community, participation in the decision-making process related to family matters...). They also emphasized the various constraints that women have to face and that put their health at stake, thus reducing their contribution to socio-economic development to housework and domestic chores. One woman we met in Masaka told us:

“My husband doesn't want me to have a source of income. He forced me to quit my well-paying job, and he doesn't want me to have any kind of income-generating activity. He wants me to stay home to take care of the kids and do the housework.”

During discussions on this topic, women shared diverse experiences of violence with us and described the ill treatment they received from men:

- Men who refuse family planning, ANC services, voluntary testing of HIV and the use of condoms; one woman in Nyarugenge told us: “My husband used to wear condoms, but one day he tore one into pieces. He threatened me by saying there were many women out there who would agree to sleep with him without him wearing a condom.”
- Men who abide by the traditions and who reject their wives’ views and ideas
- Men who mistreat women who only give births to girls: a woman in Gasabo said her husband became furious and insulted her when he realized she gave birth to a girl. He even refused to give a gift to his wife, even though it is a tradition for new mothers.
- Men who force women into having sex while they are under the influence of alcohol
- Irresponsible men who neglect their family duties (feeding their family, caring for them...), those who abandon their families in order to spend time with prostitutes... These situations can, then, result in women having sexual relations for money in order to survive.
- Men who are violent with their wives and children—we actually received an extreme testimony by a client in Masaka: “*One of my neighbors had been beaten by her husband. Her own family did not take care of her and forced her to go back to him. A few months ago, as nobody seemed to understand what she had to go through, she committed suicide*”.

According to most women, men are responsible for the violence they put women through. However, according to some respondents, especially in Gikomero, in-laws can be considered responsible for the acts of violence that occur after the husband or the wife passes away or when children are deprived of their inheritance.

Some respondents, particularly in Kicukiro, said that women who cannot sexually satisfy their spouses are often victims of physical, emotional and economic violence. One client in Biryogo reported what her brother-in-law said about his wife he abandoned: “*I cannot feed a woman who cannot please me sexually. She’s very dry and she did not perform ‘gukuna’ (18)*.”

3.2.6.2. Management of violence by the victims

Victims manage violence in very different ways. Most victims look for support from their friends and relatives in order to open up and share their experience. Others keep silent, resign themselves and become repressed.

According to testimonies we received in Gikomero, some victims of violence share their stories with anyone who can provide counsel and guidance, including administrative institutions and health care providers.

Respondents in Kacyiru added that victims of violence confide their grief to women's associations, such as "Women for Women." This NGO has its headquarters in Kacyiru and provides assistance to women in that area. A few women in Masaka also told us about an extreme, shocking and unfortunate "course of action" for these victims: suicide.

These various testimonies show that people are aware of violence and that they understand some of its consequences for the victims.

3.2.6.3. Perception on the assistance provided to victims of violence

Overall, according to clients who took part in the discussion, assistance to victims of domestic violence is practically nonexistent if not unknown for some people at the community level. Indeed, 87% (34 out of 39) women said they did not know institutions or organizations which could support victims of domestic violence.

Moreover, some women emphasized the assistance provided by community health workers, basic authorities, neighbors, in-laws, friends and acquaintances, as well as organizations and associations like Haguruka. The same phenomenon can be observed in each health facility, especially in Kacyiru, where Women for Women was mentioned (in Kimihurura, an area close to Kacyiru) and in Biryogo, where women told us about the "ICYUZUZO" center, an organization advising victims and providing social and financial support, which is located in an area close to Biryogo.

Some women we interviewed mentioned the important role played by health care workers, basic authorities and law enforcement officers who help victims on a daily basis.

These testimonies show that there is an urgent need to inform clients and the population about the resources that are available in the community.

3.2.6.4. Assessing the assistance provided by the facilities to the victims of physical abuse

Regarding the assistance provided by the health facilities to victims of physical abuse, almost all women who took part in the discussions gave the same answers. Here are the services that are available for battered wives in the facilities, by order of importance:

- Treatment of wounds and pain and, if necessary, transfer to a hospital with broader competence (N.B: An investigator visited two district hospitals in the city of Kigali and he found out that they were not well-prepared to respond to GBV.)
- In rape cases, survivors are tested for STI and HIV (essential for the survivor and the perpetrator) and counseled.
- Contact with the police force to arrest the perpetrator. Not only do the police catch the perpetrator, they also arrest people who contributed to the assault or did not prevent it from happening or failed to assist a person in danger.

- Advice is given to the husbands who are responsible for the acts of violence and requires that they have their wives looked after. This was particularly emphasized in Masaka and Kacyiru.

3.2.6.5. Assessing the assistance provided by the facilities to rape survivors

A large majority of women told us that, in addition to cleaning the wounds, the providers test the victims for HIV/AIDS. The health workers also make contact with the police in order to have the perpetrator arrested. A woman in Kacyiru told us the following story: *“When my daughter got raped, the provider took care of her right away and contacted the police in order to have the perpetrator arrested. He’s still in prison today.”*

Some cases of negligence have, however, been detected, as one person in Biryogo told us:

“My daughter got raped so we took her to the nearest health facility. After being admitted, she was examined but nobody told us anything. We had to wait a month before someone finally told us the test results had been lost and that my daughter had to go back to the facility for a new examination. My husband was outraged, especially since the perpetrator had been released.”

3.2.6.6. ANC clients’ suggestions on the role of providers in rape cases

Here are the suggestions in order of importance: examine the patient thoroughly and make a diagnostic, look after the victim and counsel her. Some women think the victims should be referred to local authorities and to the police department. Health centers are expected to take good care of the victims (through treatment, counseling and HIV testing).

However, it is important to note that some providers are accused by ANC clients (in Kicukiro) of not keeping professional secrecy, which could traumatize the victims. Clients also claimed that providers were rude to women and threatened the ones who could not describe the pain they felt.

The women we met suggested providers should be specifically trained to respond to acts of violence. Thus, they would offer better services and appropriate counseling, in order to help the victims manage the situation. This suggestion is in keeping with the providers’ declarations in the previous sections. They also want quick access to relevant services (police and administrative institutions), testing (for the victim and the perpetrator), as well as treatment of pain caused by violence.

According to many women who took part in the focus group, providers in charge of rape survivors management should *create a confidential environment, in which victims would feel more secure and where they could receive technical advice and assistance in specific areas of expertise.*

ANC clients voiced their concern about several negative aspects:

- Lack of professional secrecy by the provider

- Providers reprimanding the victim when they find out that the client has not revealed her/his experiences of violence
- Victims feeling traumatized as they have to recall and share experiences of violence
- Dealing with providers who desperately lack understanding.

All these suggestions show how important it is to find a decentralized response to GBV at the health facility level in a positive and confidential environment.

3.2.6.7. Victims' readiness to talk about their experience and seek the help of providers

We attempted to know how open victims of violence were when sharing their experiences and if they could break the silence on GBV. ANC clients revealed that providers, due to their responsibilities and trustworthiness, have a special status. Therefore, the women trust them and feel they can share their stories with them. However, some women were deeply concerned about the fact that some of the providers do not always keep professional secrecy. One woman told us: "I cannot ever tell anyone about the violence I experience! Not only am I ashamed of it, but I cannot trust providers at health facilities as they would tell everyone my secrets. I'm better off keeping things to myself!"

- We found out that violence against women is commonplace. We can observe some differences in the attitudes of women who share their experience and the ones who keep silent or resign themselves. Resignation is linked to Rwandan traditions that prevent women from voicing their opinion and encourage them to accept life as it is and not to report any incidents of violence they might face. Indeed, when women tell their aunts or another trustworthy person about the domestic violence they experience, here is what they are told:

"Keep holding on! That's what marriages are made of. Don't leave your husband and keep things secret" (*niko zubakwa, ntuzahave cyangwa ngo umene ibanga ry'urugo*).

- Some women can be discouraged after hearing such advice. Not abiding by such rules requires a lot of courage and determination. This shows that the extent of violence is a lot more serious than what it seems, as many victims choose to listen to such advice and carry on with their daily life when they are actually suffering on the inside.
- There is quite a dilemma related to the providers' role. While the large majority of ANC clients globally appreciate what they do and trust them, other clients remained concerned about their failure to keep things secret. Moreover, many providers conduct mediation between the victims and the perpetrators and they, sometimes, feel the need to contact the police department in order to report the violence they observed. This could ruin the victim's effort to break the silence and thus increase her sufferings. Indeed, health facilities are not always prepared to conduct mediation between the victim and the perpetrator (sometimes the husband) and this situation, like the referral to the police and local authorities, can have disastrous consequences.

Our female informants reported that providers were moved by the victims' stories and that they paid very close attention to them in order to make them feel better and counsel them. Others added that providers encourage victims to break the silence. Moreover, clients in Kicukiro and Gikomero mentioned that providers there test violent husbands for HIV and ask them to come in the facility in order to inform them and counsel them. Health workers also encourage women to talk to their friends and relatives (Kicukiro) and ensure the confidentiality of the victims they refer to the police department (Biryogo).

The clients that took part in the focus groups highlighted the fact that providers had to manage the victim by providing appropriate counseling. The perceptions we detailed above show that clients are ready to have their case managed at the health facility level, but they are still concerned about the quality of services there. In a nutshell, clients would be willing to break the silence if confidentiality was ensured in the facility and if providers had the appropriate skills. Clients are concerned about the fact that providers are sometimes indiscrete and do not welcome them in a proper manner, thus preventing victims from opening up to them.

3.2.6.8. Risk of violence perceived by an ANC/PMTCT client, perceptions on the actions to be taken by providers

According to the participants in the focus groups, an ANC/PMTCT client is at risk at various times. The risks vary and sometimes worsen with HIV testing. The types of violence and the critical times for their occurrence are listed in the table below.

Table 10: Types of violence and moments of risk assessed by ANC/PMTCT clients

Types of violence	Moments of risk
<ul style="list-style-type: none"> • Husband refusing to provide food, shelter and clothes for his wife • Husband leaving his family 	<ul style="list-style-type: none"> • During pregnancy • After delivery
<ul style="list-style-type: none"> • Preventing a woman from seeking ANC services and refusal to go seek these services with her 	<ul style="list-style-type: none"> • After one of the two spouses has been tested HIV+
<ul style="list-style-type: none"> • Physical abuse, insults and lack of respect, psychological trauma 	<ul style="list-style-type: none"> • After ANC consultation, after the ultrasound when the child's gender has been confirmed (especially for a girl) • After delivery (especially for a girl) • After seropositivity has been confirmed
<ul style="list-style-type: none"> • Forced and unprotected sexual intercourse 	<ul style="list-style-type: none"> • After delivery • Anytime

Types of violence	Moments of risk
<ul style="list-style-type: none"> • Preventing an HIV+ mother from feeding her baby with substitution nutrition instead of breastfeeding • Requesting an HIV+ mother to breastfeed her non-infected child so that the family circle does not suspect the couple's seropositivity 	<ul style="list-style-type: none"> • After delivery • During breastfeeding
<ul style="list-style-type: none"> • Providers giving up on pregnant women, not looking after them 	<ul style="list-style-type: none"> • During pregnancy, labor and delivery (the situation gets worse for women without a socially recognized partner)
<ul style="list-style-type: none"> • HIV+ husband refusing to wear a condom 	<ul style="list-style-type: none"> • After testing • Anytime, especially under the influence of alcohol
<ul style="list-style-type: none"> • Transmission of HIV to the child 	<ul style="list-style-type: none"> • During "forced" breastfeeding although the mother is HIV+, if the mother chose artificial (substitution) nutrition for her baby • When the baby is delivered at home (as women are sometimes afraid of mandatory testing for pregnant women)
<ul style="list-style-type: none"> • Disappointment and loss of self-esteem 	<ul style="list-style-type: none"> • Different moments

According to the clients we interviewed, these types of violence are commonplace. However, when a woman is tested HIV+ this situation increases the violence her husband puts her through. A woman in Masaka testified on that topic:

“After my neighbor was tested HIV+, her husband took everything with him and left her and her children in an acute state of poverty.”

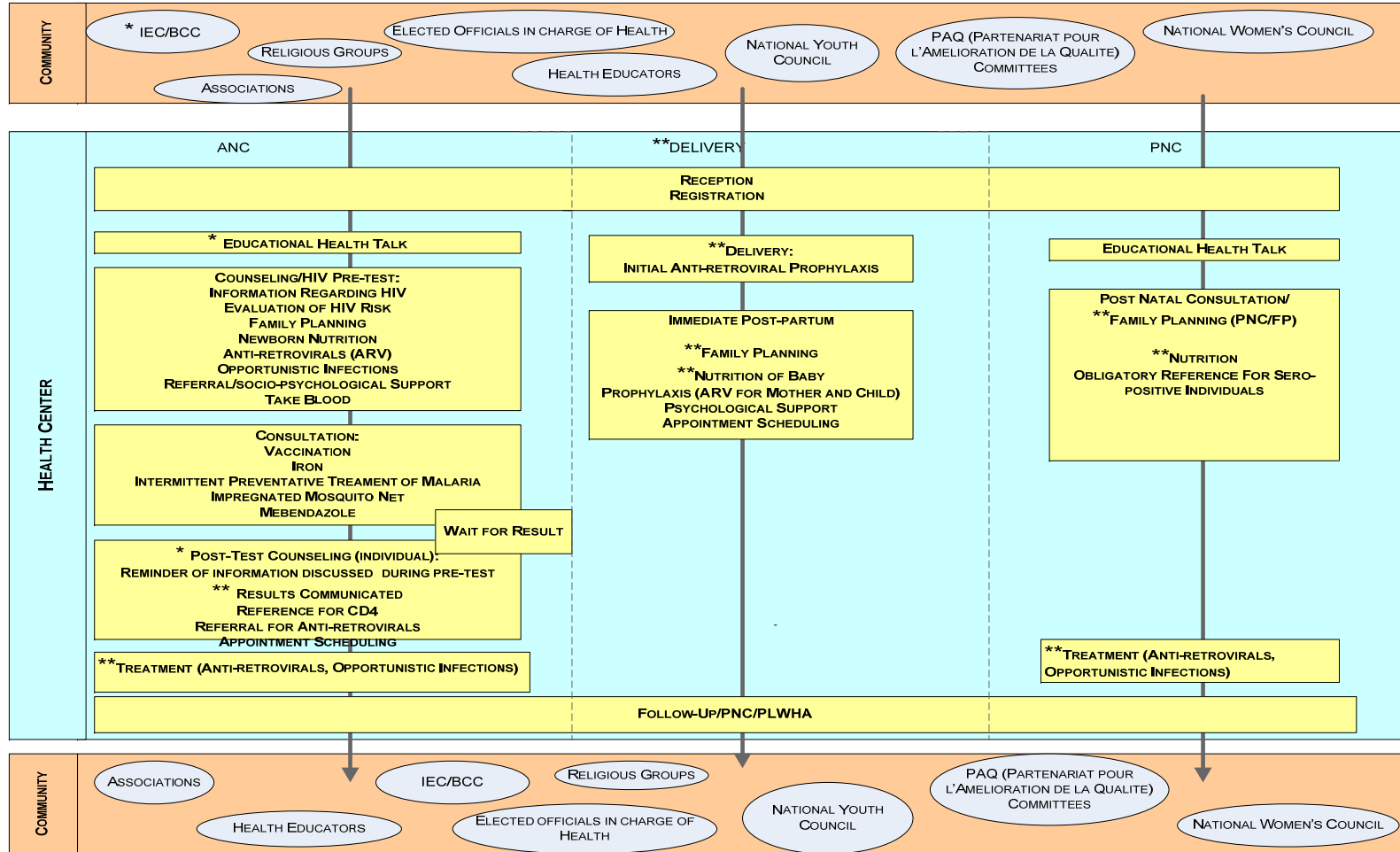
Respondents also mentioned that the best time to provide counseling to the clients would be during the couple's first visit to the health center or during the first ANC consultation. Other times have been suggested: after the child delivery, during the child's inoculations, when giving the results for HIV testing and during the conversations prior to HIV testing.

After analyzing the data regarding the risk of GBV for ANC/PMTCT clients, we found out that there are specific moments when providers should consider GBV detection and management a priority. These moments are shown with an asterisk in figure 8 below:

Figure 8: Risks of violence in the path of an ANC/PMTCT client

WHEN* TO ADDRESS MOMENTS** OF RISK IN THE PATH OF AN ANC/PMTCT CLIENT

TWUBAKANE PROGRAM, EVALUATION OF MANAGEMENT OF GENDER BASED VIOLENCE, APRIL 2008



3.2.6.9. Role of the government and the community in responding to GBV

ANC clients who were involved in the focus groups gave us their vision on the role to be played by the government and the community in the general management of and response to GBV. The following table highlights the opinions of the large majority of women we met in the five facilities.

Table 11: Role to be played by the government and the community

Role of the Government	Role of the community
<ul style="list-style-type: none"> • Organize awareness-raising meetings among all levels of the population in order to break the silence • Increase GBV training, especially for men, as they are often the perpetrators • Implement strict measures (laws and regulations) in addition to punishment for GBV perpetrators and ensure laws are enforced • Make health providers available in villages (<i>umudugudu</i>= the smallest administrative unit) • Implement a quick follow-up system of GBV victims in villages • Support and strengthen the capacities of women's associations through micro-credits 	<ul style="list-style-type: none"> • During every meeting, raise awareness on the importance of GBV and raise this issue at every meeting at the community level and in health facilities. • Stay away from drugs and alcoholic beverages • Publicly denounce violence among honest and upright men in village meetings. Speak up about rape and suggest social punishments in addition to usual legal action • Show sympathy to the victims of violence and encourage them to share their stories with others (friends and relatives) • Break the silence that benefits the perpetrators of violence within the community • Set up associations and clubs for GBV management at the village level • Create jobs for women in order to make them more independent.

CONCLUSIONS ON THE READINESS OF THE HEALTH SYSTEM TO MANAGE GBV

We drew the following conclusions from our visits in the five health facilities:

The five facilities are not equally ready to respond to GBV. Indeed, after analyzing the knowledge and beliefs of providers, it globally appeared that some were more prepared than others. Gikomero boasts the highest level of readiness while Masaka has the lowest.

When we examined the availability of elements necessary for an appropriate GBV management, we noticed that most facilities lacked many of them. However, the Masaka health facility had the highest percentage of these key elements (25%) and the Gikomero facility had the lowest (8.3%).

Based on our visits in 24 organizations across 3 districts, we found out that there is a range of services available for GBV victims. However, their capacity and quality do not meet the specific needs of the victims, and the referral mechanisms are still deficient. A few gaps should also be filled by the organizations—for instance, none of them provides shelter to victims of violence, and none of them deals with rape for non-married victims or even physical abuse.

Several recommendations have been made in order to help the health sector integrate victim-oriented and community-supported GBV services as well as an appropriate policy environment. You can find these detailed recommendations in the last section (4) of this document.

3.3. LEVEL 3: ASSESSING THE READINESS OF THE COMMUNITY TO MANAGE GBV

Brief methodological introduction

The study's objectives at this level were to identify how the community resources could be made available to the health facilities in order to respond to GBV. One of the objectives was also to study the perceptions of community members regarding GBV and the role of individuals and health centers in preventing this type of violence.

We used the GBV resources scanning guide (tool #7) for individual interviews with community organizations which provide legal, material (economic), medical, psychological and social assistance for GBV victims in the city of Kigali (N.B: Part of these results can be found in section 2, "Availability of resources in the communities surrounding the facilities").

3.3.1. SUPPORT FROM THE COMMUNITY ORGANIZATIONS

The data introduced in this section was gathered among 24 participants (NGOs, associations and projects) dealing with GBV in three districts of Kigali. Fifteen participants are based in Gasabo district, seven in Nyarugenge and two in Kicukiro. However, it is important to note that the actions taken by 22 out of 24 (92%) of these participants are equally spread out in all three district and in other regions across the country. This shows that the scope of action is larger than the district, where the associations are based. "Women for Women" and the François Bagnoud Association were the only two participants that did not cover all three districts (See appendix 9, table 20: Specific type of assistance for GBV victims provided by organizations in the districts of Kigali).

3.3.1.1. Types of clients served and GBV management

In general, organizations we interviewed in Kigali look after various groups, including widows, orphans and vulnerable children, in addition to married women experiencing any kind of violence and people living with HIV/AIDS. Although some participants target the people they serve by age groups, it is important to note that all age groups are usually taken care of. Many participants focus on victims from a low socio-economic background with a low level of education. Only three organizations do not offer free services.

Only a few participants said they particularly focused on GBV, especially FACT (which provides a hotline 24 hours/7 days), We-ACTX and Haguruka, which provides legal assistance to the victims of different types of violence (women and children).

- The participants we met offered various services in order to respond to different types of violence and help clients from various backgrounds: domestic violence, sexual abuse (in addition to rapes and other forms of violence that occurred during the genocide, domestic rape, house employees raped by their employers, young girls raped by their foster parents);

- economic violence, including women deprived of their rights to property in their original or new family, violence against stepchildren; women who are put through violence by a partner who does not help with the household expenses or who refuses to pay for child support in the case of a divorce, or even for his children's tuition (these situations often result from alcoholism); married women who are unemployed; married women who cannot get out of a violent relationship because they are financially dependent: young girls who cannot pay for their tuition and end up dropping out of school; emotional abuse, child abuse (during the genocide and in foster homes after the genocide); children raped by their stepfathers, visitors, neighbors, teachers, relatives, other children in the foster homes, etc.

Some women do not want to be insulted any longer, so they want to find another place to stay, but they could be exposed to prostitution by living alone and could be the target of ill-intentioned men looking for sexual relations. Therefore, instead of substituting one problem by another, they choose to stay in their violent relationship.

3.3.1.2. Directly available services

The participants generally offer diverse services, including:

- Counseling, psychological, financial and material support
- Legal, nutritional, medical and educational management
- Strengthened capacities after training victims for small jobs, such as dressmaking, carpentry, welding, mechanics, soap and basket making
- Income-generating activities, such as agriculture, farming, modern mill installation.

All our interviewees said that there was no house or shelter where women, young girls and children could go to if they were facing domestic violence. None of the organizations provides shelter for GBV victims, although participants all insisted on the importance of meeting this need.

Some organizations reported that some victims could find shelter at local authorities. Others mentioned that when the situation becomes unbearable and unmanageable, police officers temporarily place the husband (perpetrator of violence) into custody, even though it could increase the risk of GBV in the future. Some organizations (Pro-femmes, Haguruka, We-Actx, RRP+) have been thinking about building shelters but they could not gather sufficient financial resources to do so. Some interviewees told us about places (in Kenya) where such shelters could be found and the locations of which are only known by social workers in order to prevent men from finding their wives. The need for such structures is emphasized in the following testimony:

“Once a victim has been looked after and has received psychological support, it is really hard for her to go back to her partner, share the same house, sleep in the same bed and eat at the same table.”

3.3.1.3. Referrals from the organizations

We took into account the referrals made in the city of Kigali, especially since 93% of the participants admit the clients irrespective of where they live or come from.

Forty-eight percent of the participants we interviewed (11 out of 24) told us GBV-related services were linked to their organization, and they provided the names of the partner organizations they work with. Almost all of them refer victims to health facilities and sometimes interact with each other.

Very few participants gave their opinion on the capacity and the quality of the partner organizations, saying they did not have enough data to assess them.

None of the partners has an actual PMTCT program available. Victims in need of such services are referred to health facilities.

Information regarding referrals is not systematic and not well-documented. Many respondents revealed they only made a phone call, left a post-it note or walked the victim to referral services (Benimpuhwe and Mbwirandumva). Only Rwanda Women Network, the Cor-Unum medical center, SWAA Rwanda, Icyuzuzo and FACT document the referrals they make in detailed forms. As for AVEGA, it documents the number of referrals by the number of invoices that has to be paid. Haguruka expects feedback from referred victims when they come back from GBV services to tell them what happened.

3.3.2. COLLABORATION AND COORDINATION

3.3.2.1. Current situation

In general, collaboration and coordination never occur. The organizations we visited refer victims to health facilities or other partner organizations without formally notifying them where the victim is coming from. There is no reciprocity; collaboration, in this case, is a one-way street. According to the interviewees in these organizations, victims are most often referred to health facilities (transfer/referral, insurance payment), followed by local authorities.

Most of the organizations are part of a coalition, network or forum. Pro-femmes/Twese Hamwe come first, followed by the NGO forum on AIDS. However, according to almost all respondents, there is no coordination program facilitating the complementary nature of the services offered to the victims regarding GBV/PMTCT, either at the national or local level.

Nevertheless, one of the respondents told us about a strategic national plan draft on violence against women and children developed by the MIGEPROF. This interviewee actually had the opportunity to take part in a workshop introducing this project.

Then, we found out that this project defined collaboration mechanisms, such as a national coordination committee, which will ensure the national coverage of GBV services across the country. This project still has to be disseminated and adopted by all the relevant authorities. Apart from that, the organizations lamented on the fact that no coordination framework is yet available and that it is impossible to know who does what, where, when and how.

3.3.2.2. Suggestions for the best coordination mechanism

The study's objectives were to find out what coordination mechanisms the organizations recommended and to localize institutions responsible for coordinating the implementation of GBV management activities. We aimed at understanding the coordination process at every level of the development sectors, with a special focus on the health sector and PMTCT services.

Most organizations recommend the creation of a committee including partner organizations' representatives (public sector, NGOs, civil society and religious groups). This would be a sub-commission of the already existing "gender cluster." This framework would help exchange ideas, centralize information, refer victims, supervise activities, provide technical assistance and strengthen capacities. It would also coordinate the mobilization of resources and the synergy between the organizations.

Some of the organizations we interviewed suggested the decentralization of the coordination process at the district level, with a particular focus on social affairs. UNIFEM is keeping a keen eye on this topic, as it plans to implement a coalition of NGOs that focus on GBV in order to create a synergy between the organizations.

Few organizations defined a specific mechanism for the health and PMTCT sectors. As it is the case for the groups implemented by CNLS, the organizations suggested the creation of a coordination mechanism for GBV/HIV services either by the MINISANTE or CNLS. The same approach would be used to integrate health facilities with PMTCT services.

As for choosing the institution responsible for coordinating the implementation of GBV management activities, the interviewed organizations suggested a joint committee including the Ministries of Health, Justice, Gender and Family Promotion, in addition to the police force and a couple organization leaders with GBV expertise (including Haguruka).

As for the health and PMTCT sectors, the MINISANTE and CNLS have once more been designated by the organizations to coordinate the implementation of GBV-related activities.

Regarding the mechanisms required for the collaboration between the organizations and the documentation of referrals, here is what they suggested:

- Facilitate the organization of meetings to share success stories and encourage mutual assessment in order to reduce the gap between the facilities and the communities (*guhuza*)

- Find out how roles could be shared and maximize the use of existing potential to ensure a better complementarity and assess the impact of achievements
- Encourage experience sharing
- Increase advocacy
- Develop on-field training to ensure sustainable improvement, despite the lack of resources
- Develop online (and phone) solutions to encourage feedback and monthly on-field follow-up to foster dialogue with the client
- Make transportations available in order to better reach clients and relevant policy makers.

3.3.2.3. Suggestions regarding the best coordination framework for GBV management

We found out that victims of violence had to go to several different places in order to receive counseling, legal and financial assistance, as well as other kinds of support. However, they often do not have enough money, time and freedom to go to these places and end up not using these services. In order to improve the access to such services, taking into account the gaps in the collaboration and coordination between existing GBV services, we suggested two different frameworks to the interviewees. The participants then had to decide which one was the most feasible.

1. The first model suggested the centralization of GBV support services, such as legal, psychological and material assistance in one place, so that the victim can easily access these services without having to travel from one facility to another (for instance, a multiservice “Family Advocacy Center”).
2. The second model was meant to strengthen the systems used to share information, solve problems and refer GBV victims to other organizations.

The participants did not show a particular preference for one of the two models. They find pros and cons to both. A slight majority believes the first model is better. Here are their arguments:

- It looks like the most efficient one, even though it requires a lot of support.
- It helps the victims access many services in one same place.
- If the services are efficient, they will help victims open up and share their experience.
- Individual organizations depend on the funding given by outside donators.

- There are similar centers in South Africa (Sara Baartman Center) and in Kenya. GBV services are accessible in both.
- This model could help victims meet different kinds of providers.
- The number of organizations focusing on GBV is growing, which makes their follow-up harder.
- Information sharing (as it suggested by the second model) is not convenient. It would be very difficult to implement it and to enforce it.

Three interviewees even suggested the integration of this multi-dimensional GBV management service in the health facilities. They justify their decisions by the fact that it would prevent the stigmatization of victims as the clients would be among other patients. In addition, this model is sustainable as the facilities' life expectancy is longer than the organizations' (closing, lack of funding).

Also, a few guidelines were given to ensure this centralization model would work well:

- Service providers should be competent and have the necessary resources. They have to ensure the confidentiality of the victims so that violent partners or husbands cannot find them.
- Several centers should be created where their presence is needed the most.
- Once the model has been implemented, its programs should be linked to existing ones at the local level.
- Priority should be given to services that are not available in any organizations.
- Supporters for this centralization model highlighted the fact that it was a high-scale process that should be implemented for the long run and with considerable resources.

Respondents opting for the second model, strengthening mechanisms in order to share information linked to the referral of GBV victims also gave us a few arguments to justify their decision:

- This model is easier to implement. It is also more realistic than the first one and not as costly.
- It emphasizes training, information sharing, norms and standards development, the implementation of adequate referral systems based on the mapping of the organizations focusing on GBV and the creation of an assessment committee.
- Organizations have their specificities and clients have a right to choose.
- Organizations focus on what they do best.

- Victims mostly need psychological and financial assistance as GBV often results from women's dependence.
- There is a need to support existing structures and to conduct a thorough study on what should be improved.

A coordinated response to GBV is necessary at the national, local and community levels. It should help share information and introduce who does what, as far as GBV is concerned. It should also standardize different approaches where necessary. Finally, it should encourage the integration of GBV services in health service delivery and improve the management of GBV victims at the community level.

At the district and community levels, a coordinated (multi-sector) action framework would be useful in order to support GBV victims and address the impunity of GBV perpetrators. Such a coordinated model in the community will support a decentralized response to GBV in the health facilities, as described in section 2. In that matter, we recommend that health managers work in collaboration with the legal system and the police force as well as NGOs including Haguruka, the National Council for Women and Pro-femmes.

3.3.3. COMMUNITY MEMBERS' PERCEPTIONS ON GBV

For this section, we used Tool #8: Interview guide for focus group with community members. Our goal was to examine the opinions and ideas of community members located near the health facilities we investigated. We targeted different groups, some of them having more influence in the community (members of women's organizations, local authorities, executives from the government and the private sector, representatives from media groups, the police department, religious leaders, educators, etc.). Others were regular citizens, including young illiterate girls and boys (like the ones we met in Masaka for instance).

The following table shows how the participants in the focus groups can be divided (by gender, age group and health facility).

Table 12: Number of participants in the focus groups in the community by health facility, age group and district

District	Facility	Age group	Gender		Total
			Female	Male	
Nyarugenge	Biryogo	21-25	4	3	7
		26-30	2	1	3
		31-35	1	1	2
		36-40	1		1
		61-82		6	6
		Total	8	11	19
Gasabo	Gikomero	26-30	1	4	5

District	Facility	Age group	Gender		Total
			Female	Male	
		31-35		2	2
		36-40		1	1
		41-45	1		1
		46-50	1	1	2
		51-60	3	3	6
		61-82	3	4	7
		Total	9	15	24
	Kacyiru	21-25	2		2
		26-30	5	2	7
		31-35	2		2
		36-40	6		6
		41-45	3		3
		46-50	2	1	3
		Total	20	4	24
	Kicukiro	Kicukiro	21-25	7	6
26-30			2	3	5
31-35			2	1	3
41-45				2	2
46-50			1	1	2
51-60			1		1
Total			13	13	26
Masaka		13- 15	4	3	7
		16- 20	3	5	8
		21-25	1	1	2
		26-30	2	1	3
		31-35		2	2
		Total	11	13	24
		Grand total	61	56	117

3.3.3.1. Community's perceptions on the support provided to victims of GBV or domestic violence

According to the majority of respondents in the communities surrounding the health facilities we visited, the communities should contribute to the management of GBV-related problems at all administrative levels (from the villages to higher institutions). Among others, the participants mentioned the following groups: health centers, the police, NGOs, religious groups, women's organizations, etc. A farmer in Gikomero told us what he thought religious groups could do to help: "GBV should be included in the premarital teachings." According to the participants, all these groups have a role to play in order to:

- Mobilize, raise awareness and train providers on GBV
- Create anti-GBV clubs and associations
- Prevent polygamy and unfaithfulness
- Implement centers for psychological support, follow-up and treatment of GBV victims
- Strengthen the capacities and increase the knowledge on GBV, through training at the local authority level
- Collaborate with local health managers in order to report hidden cases of violence
- Develop and enforce laws to discourage GBV perpetrators and punish them
- Set up surveillance measures in order to tackle the main causes of violence: alcoholism, drugs, ignorance due to cultural traditions, irresponsibility of men in the household, etc.

A woman in Kicukiro said: *"Too many GBV crimes go unpunished. One of my best friends is beaten by her husband on a regular basis, but every time she reports it to local authorities, nothing is done to help her and her husband traumatizes her even more."*

Other actions could be taken at the community level but, according to the respondents, these would have to be supported by higher state institutions. For instance:

- Implementing centers to manage and counsel GBV victims
- Strengthening the capacities of health centers (well-trained providers, appropriate level of equipment) and improve their accessibility
- Developing documents aimed at training, raising awareness and mobilizing people on GBV

- Organizing and facilitating discussions and conferences on GBV (with radio and TV broadcast)
- Strengthening women’s capacities and independence.

However, some older participants we met in Gikomero did not agree on the fact that breaking the silence on domestic violence was a good thing. One woman told us: *“It is not culturally accepted to talk about couples’ issues. How could I tell someone what’s happening between the sheets?”* Another one added: *“In life you’ve got to be brave and keep holding on. If somebody raped me, I would not tell anyone.”*

3.3.3.2. Community perceptions on the integration of GBV services in the health facilities

The participants tended to share the same views regarding the integration of GBV management in the health facilities.

Thus, the large majority of participants mainly insisted on the improvement of victims’ admission and providers’ skills. On the one hand, some suggested GBV-managing responsibilities should be given to specific, well-trained and older providers who could listen to the victims and counsel them (preferably a woman). On the other hand, some participants suggested the creation of a specific service including several providers in order to anticipate staff shortage (NB: These views are in keeping with ANC/PMTCT clients and providers). Other ideas regarding the integration of GBV have been introduced:

- Provide unconditional and free access to GBV services
- Decentralize GBV services at the basic administrative level (*umudugudu*)
- Strengthen the health facilities’ capacities to raise awareness on GBV issues
- Encourage and support the implementation of clubs, associations and other organizations focusing on GBV prevention
- Strengthen communication across the media through different tools (hotline with the police department and health centers)
- Develop educational material on GBV in order to raise awareness on that issue and get the message through via literacy programs
- Prevent disparities and socio-economic inequities between men and women (through close collaboration with religious groups)
- Propose the creation and the implementation of a support fund for GBV victims
- Ensure exemplary professional conduct of health providers within the facilities

- Show educational videos about GBV
- Set up concrete collaborative mechanisms between competent institutions managing GBV cases.

3.3.3.3. Community perceptions on the providers' role towards victims of domestic violence

The purpose of the study was to examine the expectations of the community regarding the role that providers play in the management of victims of domestic violence. We found out that the views of community members mostly resemble the ones expressed by ANC clients (see section 3.2.). Here is a further description of their role:

- Psychological and medical management
- Encouraging opportunities to raise awareness on this issue and increase training
- Exemption from expenses related to examinations, consultations and possible referrals due to GBV
- Writing a medical report and submitting it to competent authorities and institutions as soon as possible
- Including GBV topics in educational discussions in order to help people prevent this type of violence
- Mobilizing and raising awareness among women to help them break the silence on GBV
- Accompanying victims to competent institutions so that they receive the appropriate form of assistance
- Asking the victim to raise awareness among others so they can seek help in health centers.

3.3.3.4. Community perceptions on the obstacles to overcome to access GBV management services in the health facilities

According to the participants in the focus groups, GBV victims do not seek help for the following reasons. They are introduced in order of importance in figure 11, appendix 8, "Community-identified factors affecting the use of GBV management services."

1. **Shame and acute sense of decency** and fear of tarnishing their family's reputation. This behavior is partly linked to the Rwandan cultural tradition, according to which a dignified woman can remain silent in the face of the most outrageous acts (rape for instance).

If she decides to share her experiences, she would be called “Birihanze” (literally, bizarrely indiscrete). As one woman in Gikomero put it:

- “Older folks tell young women not to betray the person they sleep with (even if they have been raped).”
- Similarly, a retired man in Biryogo said: “A rape victim is afraid of being stigmatized, as her family circle will consider her untrustworthy or promiscuous.” Victims would rather keep an awful secret than face the social consequences of its revelation. To an extent, some victims would rather talk to very close friends so that their stories remain confidential.

2. **Fear of the consequences after denouncing the perpetrators.** This can be partly linked to women’s economic dependence towards their husband. The relation of subordination to the husband and the unconditional respect women must show as well as the fear of being divorced/separated/repudiated are other reasons why they keep silent. According to a 22 year-old student in Kicukiro: “It sometimes happens that a woman is reluctant to file a complaint against her husband, as she is afraid he would be imprisoned and would not be able to provide her with means of subsistence.” A sales woman in her forties added that women love men no matter what the circumstances are, and that is why they do not report the acts of violence they experience.
3. **Ignorance and illiteracy.** These factors can explain why women and the general population do not know where they can seek help/file a complaint, etc. As a result of the lack of information on the free services that are offered to GBV victims, some women may trust witchcraft and/or traditional medicine rather than modern health services or administrative institutions in order to solve the problems they face.
4. **External factors.** The difficult access to and location of health centers, local authorities that become accomplices instead of responding to violence, insufficient or inexistent mechanisms to train, mobilize, and raise awareness, the lack of shelters for economically dependent victims.

According to the community members we met over the course of the study, there are other barriers and obstacles preventing the use of these services in health facilities:

1. Husband refusing to accompany his wife or provide the transportation she needs to access GBV services
2. Poor admission of victims by providers, especially for women living on their own (single-mothers, divorced, widowed...)
3. Non-reliable medical results leading to a lack of respect and denigration of health services
4. Poor treatment of the patient due to the results from the ANC consultation (repeated pregnancy with girls) and unwanted and unplanned pregnancies

5. Lack of trust in health workers: this is true for men, who do not want their wives to be looked after by a male provider or by female clients who are afraid of being raped by a provider.

These risks of violence and their consequences may be faced by women during ANC/PMTCT consultations and their seriousness may vary depending on the moments at which they use these services.

3.3.3.5. Community perceptions on the moments an ANC/PMTCT client is likely to experience violence

We asked the following question to community members, as we did with ANC clients: *Are there particular moments when an ANC client is more likely to experience violence?* According to a large majority of participants in the focus groups, ANC/PMTCT clients are likely to experience different types of violence at different times. Looking at the classic structure of ANC service delivery, the first moment of risk for a client is when providers ask her to come back to the facility with her husband, although he does not want to and has already said no once before. The client therefore experiences a dual kind of violence: first from the provider who refuses to look after her because she came unaccompanied and second from her husband (partner) who can not only refuse to go with her but also brutalizes her in different ways just because she asked.

The risk of violence worsens after the results of HIV tests have been given and when the woman is declared HIV+. According to almost all participants irrespective of the health facility, when a woman is tested HIV+ and her husband is HIV- (or simply does not want to be tested), violence is most likely to occur. The husband accuses his wife of being unfaithful, or even of being a prostitute, and sometimes jumps to the conclusion that their child is not his. In most cases, the woman is subject to physical and emotional violence, and she is repudiated. A young leader in Masaka added that a woman who has been tested HIV+ feels desperately lonely and distraught unless her husband shows some understanding (*Umugore basanzemo SIDA we ntaho aba ari, keretse iyo afite umugabo umwihanganira*).

A woman also faces violence when results from the ANC consultation show they are expecting a daughter (although the husband was hoping for a son), in which case, she will experience insults and mockery and will not be congratulated after giving birth. A woman may also experience violence when she is forced by her husband to breastfeed her baby, even though it has been contraindicated by her physician. Such a behavior is sometimes used to hide the couple's seropositivity.

Other testimonies revealed that many women can be put through violence by their husband when he refuses to feed them (as well as their children) and when he first learns his wife is HIV+. Some men tell their friends and family about this situation, which can result in more stigmatization and discrimination.

Other moments of risk can occur after postnatal consultations when husbands reject family planning and force women into having sexual intercourse. This situation results in unwanted pregnancies or HIV contamination for the woman (if her husband is HIV+). All these examples show how strong male domination can be and how women end up being controlled by them. All participants in the focus groups said the husband was responsible for these acts of violence, followed by the providers and the community.

Table 13, on respondents' perceptions on the moments when the victim is the most at risk, summarizes all the views from providers, clients and the community and the area for which they agree there is a risk of GBV.

Table 13: Moments of risk by type of respondents

Risks of GBV for a woman	Providers in ANC/PMTCT services	ANC/PMTCT female clients	Community members
After one of the two spouses has been confirmed HIV+	■	■	■
After ANC consultation and confirmation of the child's gender	■	■	■
During breastfeeding (when a woman is forced to breastfeed by her husband, even though it has been contraindicated by providers – behavior aimed at hiding the couple's seropositivity)	■	■	■
Anytime , especially under the influence of alcohol	■	■	
During pregnancy (by partners) during labor and after delivery	■	■	
During pregnancy (by providers) during labor and after delivery (the situation is worse for women without a socially recognized partner)	■	■	
During delivery at home (fear of mandatory HIV testing for pregnant women)		■	
After ANC consultation when the husband rejects family planning methods and forces his wife into having sex			■

3.3.4. CONCLUSIONS ON THE COMMUNITY ENVIRONMENT

The study showed that community members are aware of the support available for GBV victims at the health facility level. In addition, their recommendations made perfect sense. This proves that the understanding of GBV is increasing. However, the fact that women insufficiently seek GBV-related services has been emphasized in all focus groups.

The study also documented the psychological, socio-economic and institutional factors affecting the use of ANC/PMTCT services, including future GBV management services, as well as the moments of risk for women, either when they use the services or during their pregnancy, during labor or after delivery. Therefore, there is a need for a coordinated effort at different levels to overcome the obstacles preventing victims of violence to use GBV management services.

It is important to note that NGOs use health facilities as their prime collaborators. However, many interviewed providers do not know their whereabouts, which implies that collaboration is still at an embryonic stage and does not work both ways. Coordination and communication should, therefore, be enhanced between the health facilities, the community organizations and the districts through periodical meetings or the creation of a committee at the district level, including public organizations' representatives, NGOs, civil society as a whole, as well as religious groups and local institutions in charge of social affairs.

Despite the fact that GBV awareness is growing among the communities we surveyed, there are still cultural factors affecting the use of ANC/PMTCT services and preventing women from breaking the silence about GBV. That is the reason why a coordinated effort is necessary at different levels to overcome obstacles that keep women from using health services, including GBV management services. Detailed recommendations on community mobilization in order to increase the commitment of its members in the response to GBV can be found in section 4 at the end of the final report.

IV. CONCLUSIONS AND STRATEGIC RECOMMENDATIONS FOR EACH LEVEL

4.1. CONCLUSIONS AND RECOMMENDATIONS ON THE READINESS OF THE POLICY ENVIRONMENT TO RESPOND TO GBV

After analyzing the policy environment we came to the following conclusions:

GBV awareness in Rwanda is well underway. Many laws and sector policies already exist in that area. If they were harmonized, more detailed and effectively enforced, these (existing or pending enforcement) legal documents could help improve the providers' and health facilities' capacities so that they could provide GBV management services that would be favorable to women and children as part of ANC/PMTCT service delivery.

That is why we recommend:

- I. The implementation of a central multi-sector coordination mechanism in order to harmonize GBV interventions at the national level by the MIGEPROF: a strategic plan draft on the management of GBV is actually being developed by this Ministry. Coordination at the national level could also be strengthened with:
 - a. A national coordination and steering committee that would be responsible for the availability of GBV services, the dissemination of policies, laws and strategies, the coordination of interventions and the harmonization of GBV management methods (such as training protocols and curricula): This joint committee would include MIGEPROF (as a leader), the MINISANTE, the police, Haguruka, as well as a couple of GBV-focused organizations' leaders.
 - b. A technical committee or group created by the MINISANTE or CNLS for the integration of GBV services in ANC/PMTCT/AIDS service delivery
 - c. The creation, at the district level, of a (multi-sector) community-coordinated action framework supporting a decentralized answer to GBV in the health facilities: it is recommended that health managers work in collaboration with legal structures, NGOs (such as Haguruka), the National Council for Women, Pro-femmes, and that the response to GBV is integrated into the MINISANTE's approach.
2. The update and harmonization of existing GBV laws and policies by the relevant ministries (MIGEPROF, MINISANTE, MINIJUST, MININTER, MINALOC) and the Parliament (including domestic violence, violence against women, children, house employees and prostitutes, as well as child trafficking and other types of violence experienced in Rwanda).

Also, the update of the draft law on the prevention and repression of GBV should be considered in order to make it more victim-oriented. Some measures should also be taken in order to punish people, who fail to report GBV acts they know of. This process should be accelerated as many people are waiting for such a law to become available.

Similarly, the laws against the discrimination of women should be enforced in order to better respond to GBV (1977 penal code art. 354 punishing adultery).

Twubakane could also contribute to the technical expertise of GBV laws and support the organization of an awareness-raising campaign and a one-day training intervention.

3. The finalization of GBV laws and policies by the relevant ministries (MIGEPROF, MINISANTE, MINIJUST, MININTER, MINALOC and all the ministries focusing on educational, cultural and youth programs) and the implementation of dissemination and enforcement strategies in every sector for existing and pending laws, policies and instructional material through the following channels:
 - a. Seminars and workshops for lawmakers, lawyers, local, medical and health authorities, the national police force and opinion leaders and the district level
 - b. Training curricula
 - c. Ministerial guides and policies
4. The MINISANTE should consider GBV a public health issue and will implement a “Policy responding to GBV in the Health Sector,” which will be in keeping with the National Policy on Violence against Women and Children in order to manage all types of GBV by:
 - a. Emphasizing client-oriented services, GBV integration in FP, ANC/PMTCT and HIV/AIDS services along with preventive and curative care services
 - b. Agreeing on criteria of an appropriate GBV law for the health sector, particularly in women-, children- and victim-oriented services and enforcing standardized policies. For instance:
 - The client-oriented minimal service package
 - The non-obligation of providers to report GBV orally or in writing to the police
 - Collecting data on the need for an epidemiological follow-up
 - Conditions for medical expertise in order to facilitate victims’ access to facilities.

- c. Providing unconditional free services for every type of GBV (with referral to local authorities and the police): in that respect, the ministerial guidelines on the free access to rape management services should also be revised.
 - d. Developing a code of good conduct for providers
 - e. Aiming at the decentralization of medical expertise and the prescription of PEP by A2 nurses trained at the facility.
 - f. Emphasizing the decentralization of targeted financing in order to better manage GBV cases as part of the community coordinated action framework
5. To launch the initiatives mentioned above, Twubakane could help organize a workshop with GBV stakeholders within the health sector and HIV/AIDS/PMTCT services in order to identify elements of a strategic policy addressing GBV and the ways to implement it at a decentralized level.
 6. In the medium-term (one or two years), it will be necessary to harmonize the protocol for the management of sexual violence in addition to the development of a policy addressing GBV issues within the health sector, starting with domestic violence. Such a protocol should be developed by the MINISANTE in collaboration with the Ministries of Internal Affairs (police), Justice, local authorities, social affairs, as well as MIGEPROF. This would help provide a standardized training to health workers and would facilitate the integration of victim-focused activities in the service package available at health centers (including psychological support services, confidential advice, safety planning and counseling).
 7. Before developing a GBV policy for the health sector, the MINISANTE should revise the following documents so that they can be more favorable to women and children, more client-oriented and also ensure an easier access to GBV services: revise the protocol on the management of sexual violence and the learning guide about sexual violence, after considering the psychological and social needs that should be met at the health center. The emphasis on the burden of proof for the victim should also be reconsidered (hymen rupture).
 8. The MINISANTE should ensure that information regarding GBV issues and regular follow-up of victims is integrated into indicators from the health information management system that the facilities are in charge of. The MINISANTE will use this data in order to provide better follow-up in the management of GBV.
 9. As it is often the case in similar studies, it is necessary to disseminate the results on a large scale. In order to do so, Twubakane will organize a meeting aimed at disseminating the results through the nation in collaboration with the districts that were targeted by this study. This will help stakeholders and partners to discuss the best strategies to respond to GBV and improve the access to quality GBV management services in ANC/PMTCT service delivery at the district level.

Twubakane will support the districts and other local institutions in order to integrate the response to GBV in their development plans and in the performance contracts (*imihigo*), including technical assistance and decentralized financing.

10. The forensic examination of GBV survivors requires an efficient collaboration between the health and the legal sector (in order to properly handle the samples taken from the victims) and coordination between various partners to deliver the necessary evidence. There is a need to strengthen multi-sector interaction to respond to GBV. Given the specific role of the police in the research of evidence, the investigation on perpetrators and the prevention of GBV, it is highly necessary for the MINISANTE and the decentralized institutions to work closely with this institution.

Twubakane can work in collaboration with the police and other partners to identify practices and needs in order to respond to GBV at the legal level by:

- a. Adapting GBV curricula in relation to the needs of the Rwandan police
 - b. Raising awareness through joint programs between the legal and health system as well as other public authorities (particularly judges, public attorneys, police officers/inspectors)
 - c. Developing a protocol or a manual for GBV management intended for police officers and in relation to the one given to health providers (if it does not already exist).
 - d. Giving additional material support to the police (fix up the interrogation room to ensure confidentiality, improve the equipment, IEC/BCC material and supplies), coordinating finances and planning meetings with the emergency response team based in the health facility (see recommendation in section 2 below), social services and other key partners in the community.
11. In order to encourage GBV victims to contact law enforcement services, the police should:

- a. Hire more female police officers (as one high-ranked police executive focusing on GBV mentioned, after the validation of the study's results)
- b. Identify a defender of the victim's rights, responsible for ensuring access to information, providing protection against possible retaliation and suggesting referral to other community services
- c. Create, at the district level, a compensation program for victims (like a payment of damages) to pay for their transportation fees and other costs related to the services they might need after surviving GBV.

12. The MIGEPROF requested the translation of a law regarding the prevention and the repression of GBV in a language that is spoken by everyone and demanded that it be sent to the prime users (i.e. health facilities, basic authorities, support organizations, population). The following are legal documents that have already been translated in Kinyarwanda:
- a. Job aid on GBV (definitions, types, examples, consequences, how to prevent GBV)
 - b. Women's economic rights related to the 1999 law on inheritance and donations, which, unlike traditional sayings, enable women to come into an inheritance both in her original family and in her new one (after getting married)
 - c. Another part of the family code also dealing with inheritance (translation from sections a, b and c of this law that single or widowed women needed after the genocide; the translations have been provided by two NGOs supporting women).
 - d. African unity's declaration of Heads of State and Government on gender equity and a translated version of the CEDAW intended for the MIGEPROF.
13. The Ministry of Justice is encouraged to develop a mechanism for the protection of women who dare to report acts of domestic violence (rape by husband or partner). For instance, a restraining order can be issued by a judge to prevent the perpetrator to get anywhere close to the victim and ensure that he would financially assist his wife (and their children) while under protection.
14. Twubakane will organize a three-day workshop for GBV and PMTCT stakeholders in order to plan the implementation of GBV management strategies in the health and community systems and in the health facilities of the three districts we studied (Gasabo, Nyarugenge and Kicukiro). This workshop will also include an open forum to identify challenges and opportunities to assess the psychological, social and cultural particularities of GBV and the evidence related to this type of violence.

4.2. RECOMMENDATIONS ON THE READINESS OF THE HEALTH SYSTEM TO RESPOND TO GBV

Given the low score received by the health facilities regarding providers' knowledge and beliefs (overall 35%), the lack of key elements in the health facilities to offer GBV services (level of necessary equipment: max. 25%, min. 8%) and given the gaps we noticed in community organizations, which do not meet the needs of GBV clients, as well as the lack of coordination between the various interventions, here is what we recommend:

The policy-makers' expectations at the national, health facility and community levels show the need for a decentralized, holistic and coordinated support. The focus groups with ANC clients proved that GBV is a widespread phenomenon and that women are likely to experience violence during ANC/PMTCT service delivery. However, victims do not always open up to providers or authorities for diverse reasons, including the culture of silence, lack of information on their rights and the community resources available for them and the fear of reprisals. Therefore:

- 1) We recommend the decentralization of medical expertise and the prescription of PEP for victims of sexual violence in order to help them get all the services they need at the nearest facility. In order to better respond to the needs of sexual violence victims, providers and health facilities should be equipped and appropriately supplied to make a diagnostic and give the appropriate medical expertise, enabling the justice system to gather all the necessary evidence as soon as possible to prove the perpetrator's guilt. The MINISANTE should consider it a priority to adopt a "decentralized model for the management of GBV in ANC/PMTCT services and at the health facility level" (see figure 10 at the end of the report), which, in the short or long term, would meet the clients' needs for a minimal service package related to GBV while reflecting providers', clients' and communities' recommendations. It would also be harmonized with the National Health Policy. In this client-oriented holistic model, the most important needs to be met are: the necessity to include all types of GBV experienced by the victims; health and safety; and (regarding sexual violence) the protection of the victims against a second trauma and the opportunity to receive PEP and forensic examination in the facility by a provider who does not have to be a physician (for instance, a specifically-trained A2 nurse).

This GBV service package at the facility level would be part of broader community-coordinated action framework, whose key elements are as follows:

- a. (Short-term) At the first consultation in ANC/PMTCT services, A2 nurses educate the victims on the prevention of all types of GBV, their harmful consequences, human rights, the availability of services to manage that form of violence (including PEP) and the free access to related services.
- b. (Short-term) During the first ANC consultation, A2 nurses admit the client, ask her questions, test her for HIV, assess her risk of experiencing GBV (notice if there is a relation between these two elements), examine the client, documents facts in a report, prescribe emergency contraception when necessary and, if need be, refer the client to:

- i. The legal, psychological and financial community resources
 - ii. In-depth counseling services in the same health facility by a (specifically trained) A2 nurse, who also helps with the planning of the client's safety.
- c. (Medium-term: 1-2 years) In the case of sexual violence, the client is referred to the emergency response team in charge of that type of violence. It includes three members: a forensic nurse, a client's defender and a police officer.
- i. In the forensic unit, there are two A2 nurses in the same health facilities who are trained to respond to GBV and who are available for victims 24/7. These specialized providers proceed to the medical and gynecological examination of the victim and take samples before they document the aggression. The victim is also tested and treated before the medical examination certificate is signed. It is then given to the client. The victim may also receive treatment for STIs as well as PEP and emergency contraception. If the victim's case goes to trial, these nurses may testify. The nurses work closely with the victim's defender.
 - ii. This person can be an A2 social worker, a health worker who received in-depth counseling training or—if there is a shortage in staff—a community member appointed by the health facility to serve as a member of the emergency response team. The defender also psychologically supports the client and acts as a link between her, the providers, the community resources and sometimes the police. S/he plans the client's safety, looks for a place where the victim can stay, if necessary and if available, and helps her access financial assistance in order to take the case to trial. S/he plays an important role in creating a link with the third member of the team.
 - iii. The police officer is specifically trained in GBV issues. S/he leads the investigation with the victim's consent (unless she's a minor) and works in collaboration with the rest of the team.
- 2) If the forensic expert is not yet available, the client's defender and the police should work as a team in order to maximize the coordination between the health facility and the community services at the district level (for instance, by setting up a reward program for the victim).
- 3) Given the moments when ANC/PMTCT clients are most likely to experience violence (see table 13 Moments of risks by types of respondents), it is necessary to integrate HIV testing and the prescription of emergency contraception in FP services as well as in maternal and antenatal care services. These services can, therefore, help refer clients who are the most likely to experience violence to specialized providers in the health facility (see figure 9 above "when to address moments of risk in the path of an ANC/PMTCT client").

A response to GBV should also be integrated into the premarital teachings, where such services exist in order to raise awareness among young couples on their individual rights and conflict resolution in a marriage without resorting to violence.

- 4) The community health agent should also refer GBV victims to health facilities.
- 5) The PAQ teams are also encouraged to hold meetings focusing specifically on GBV management services and make suggestions to improve the management of this type of violence within the health system.
- 6) Before implementing the integration of GBV services at the decentralized level, the reorganization of services should be discussed in order to integrate a response to GBV. A reorganization of tasks within the facility is also necessary in order to take the integration of GBV into account. The recruitment of new staff might be an imperative in overwhelmed health facilities. However, appointing specialized providers for GBV management in each facility is also possible.
- 7) Awareness should also be raised among health workers.
- 8) The inventory of the facilities' capacities shows a lack of basic equipment, which could otherwise help them offer GBV services to their clients. These gaps should be filled.

Before or while raising awareness among providers, Twubakane should work with partners supporting the five facilities we surveyed in order to equip them with the appropriate material, so that they can properly manage GBV victims, such as:

- a. A GBV management protocol (for all forms of violence, including the management of sexual violence)
- b. A registry for community resources to facilitate the referral of victims to financial, legal, and psychological support services and the police
- c. Laws and policies to educate the clients
- d. A simple documentation system for GBV information
- e. Medical material (rape kit, PEP, emergency contraception)
- f. IEC/BCC material, to be developed and disseminated in the facilities and among community health agents in order to support information and counseling sessions (brochures and posters)

Twubakane will develop, test, multiply and disseminate educational material intended for the providers and community health agents in the five facilities.

- 9) The results tend to prove that the MINISANTE should develop an in-service training course for the prevention and management of GBV.
 - a. Twubakane will translate, use or facilitate the use of a training course on the prevention and management of GBV intended for ANC/PMTCT providers which could be implemented in the facilities through half-day or three-day-long learning sessions.
 - b. Twubakane will train providers on GBV issues, equipment and supervision in the health facilities with the highest level of readiness in knowledge and beliefs (1/ Gikomero, 2/ Biryogo, 3/ Kicukiro) with a follow-up to reflect on the lessons learned (followed by 4/ Kacyiru and 5/ Masaka). However, discussions should be held with the partners supporting these sites to assess the policy and management environment's willingness to make this initiative a success.
 - c. Periodical meetings should be held with health providers, the police, and the client's defender in order to strengthen the coordinated response to GBV.
- 10) In the longer-term, there is a need to integrate GBV management in the current medical and nursing sciences curriculum or in some training sessions given to providers (especially those working in reproductive health, HIV/AIDS, FP, OBGYN and social services).
 - a. In nursing and medical sciences programs, awareness would be raised among all GBV services providers.
 - b. Then, a GBV management training course should be developed with clients as a main focus, including testing, physical examination, counseling, referral and documentation.
- 11) In order to respond to the risks of violence against ANC/PMTCT clients, health facilities must try different strategies to communicate test results to couple. For instance, in Uganda, the AIDS information center developed a procedure in which results have to be official before starting post-test counseling. In addition, PMTCT service providers should consider sharing the husband's results first.

4.3. RECOMMENDATIONS ON THE COMMUNITY ENVIRONMENT

It is important to notice that community members are aware of the available support at the facility level for victims of violence. In addition, their suggestions aimed at improving existing services make perfect sense. This proves that they are already aware of GBV. However, the fact that very few victims seek GBV services has been emphasized in the focus groups and during the interviews.

This study documented the psychological, socio-economic and institutional factors that are affecting ANC/PMTCT service delivery, including future GBV services (see figure 11, appendix 5) as well as the moments of risk on the path of ANC services' clients or before pregnancy, during labor and after delivery.

A multi-level coordinated effort is, therefore, necessary to overcome the obstacles that prevent victims of violence from using health services, including GBV management services.

At the district and community level, a multi-sector coordinated action model is recommended in order to support GBV victims and to address the impunity of GBV perpetrators in the community. Such a model will help support a decentralized response to GBV at the health facility level, as we explained in section 3.3.2.2. In order to develop this model, it is recommended that health managers work in collaboration with the police, the legal system and NGOs, such as Haguruka, the National Council for Women and Pro-femmes.

- 1) The communities told us they needed a multi-service center for psychological and financial support linked to GBV. In addition, several key informants recommended the construction of shelters for GBV victims.
 - a. Twubakane was asked to encourage the districts to mobilize financial and human resources in order to create counseling centers (or to collaborate with other districts to create one in the city of Kigali.) This center could include a client's defender coordinating the various community GBV services.
 - b. Pro-femmes/Twese Hamwe and Haguruka are encouraged to advocate among local authorities and donators in order to finance a shelter for GBV victims in the city of Kigali.
 - c. USG and PEPFAR should make arrangements in order to equip a shelter for GBV victims once it is build.
 - d. Local authorities are encouraged to work in collaboration with other stakeholders in order to mobilize the population and prevent and eradicate GBV. This can be done through the dissemination of laws, policies and regulations related to GBV; education campaigns on the prevention and eradication of GBV (for instance during the 16 days of activism from Nov. 25 to Dec. 10); and community discussions.
- 2) Contributors in the civil society, local authorities, the justice, health and education systems, religious groups, the media and social affairs should find a common communication channel, particularly through community meetings, to discuss GBV, women's human rights as well as zero-tolerance policies regarding GBV. They can also:

- 3) Organize campaigns intended for older women in rural areas in order to help them identify GBV and help victims find a way out of the violence they are put through. This can be done by referring GBV victims to the health facilities (or any other competent authority) rather than encouraging them to resign themselves to violence.
 - a. Organize campaigns targeting men, insisting on their involvement in FP, HIV/AIDS, PMTCT and reproductive health services. Among other things, these campaigns should focus on the fact that men are responsible for their child's gender. It should also focus on alcoholism and on the harmful consequences of GBV.
 - b. Raise awareness among the population on all types of GBV (not only sexual violence); laws preventing GBV and protecting individuals; the importance of breaking the silence and the community's responsibility for preventing such violence and punishing perpetrators; and the availability of free and accessible GBV services in health facilities. This awareness-raising campaign, aimed at increasing the demand for and use of GBV-related services, should not take place prior to the training of providers and the implementation of protocols and procedures in health facilities.
 - c. Pro-femmes, in collaboration with Twubakane, is encouraged to strengthen the capacities of its partner organizations in order to mobilize the community (in all age groups). Action should be taken (like the "raising voices" or "stepping stones" approaches) in order to promote change in standards and social relations through dialogue between men and women of all ages. The "stepping stones" community dialogue aims at "reconciling those who are reluctant to social change and those who would like to see it happen" so that men and women are both involved in the transformation of standards and behaviors related to gender (19). Pro-femmes should focus on this task with the collaboration of the community health agents.
 - d. Twubakane is encouraged to work in collaboration with Pro-femmes in order to adapt and multiply the tools necessary for the mobilization of the community in all three districts.
- 4) Numerous participants in the focus groups emphasized how important it was to strengthen women's capacities so that they could become more independent (both emotionally and financially) from the perpetrator of violence. The health facilities and community structures that are involved in GBV management should improve victims' access to: income-generating activities (for instance, by increasing collaboration with farmers' cooperatives or NGOs, such as Heifer International); micro-credit (through organizations like Duterimbere); and formal employment to enhance women's independence.

In addition to income-generating activities, a referral program for victims of violence should help them have access to job and/or craft training as well as remedial classes for those who dropped out of school because they experienced violence.

Twubakane is encouraged to support this initiative in its area of intervention through PAQ teams and in collaboration with organizations that specialize in that matter.

- 5) It is important to note that NGOs that assist GBV victims put the health facilities first in their collaboration while many interviewed providers do not know their whereabouts, which means that the collaboration can still be improved or that it is not mutual. Coordination and communication between health facilities, community organizations and the districts should be increased through periodical meetings or via the creation of a stakeholders' committee at the district level. This coalition would include various public organizations, NGOs, civil society as a whole (religious groups and social affairs institutions within the district).

Twubakane is encouraged to disseminate the “registry of community resources related to GBV” among NGOs at the district level and in health facilities

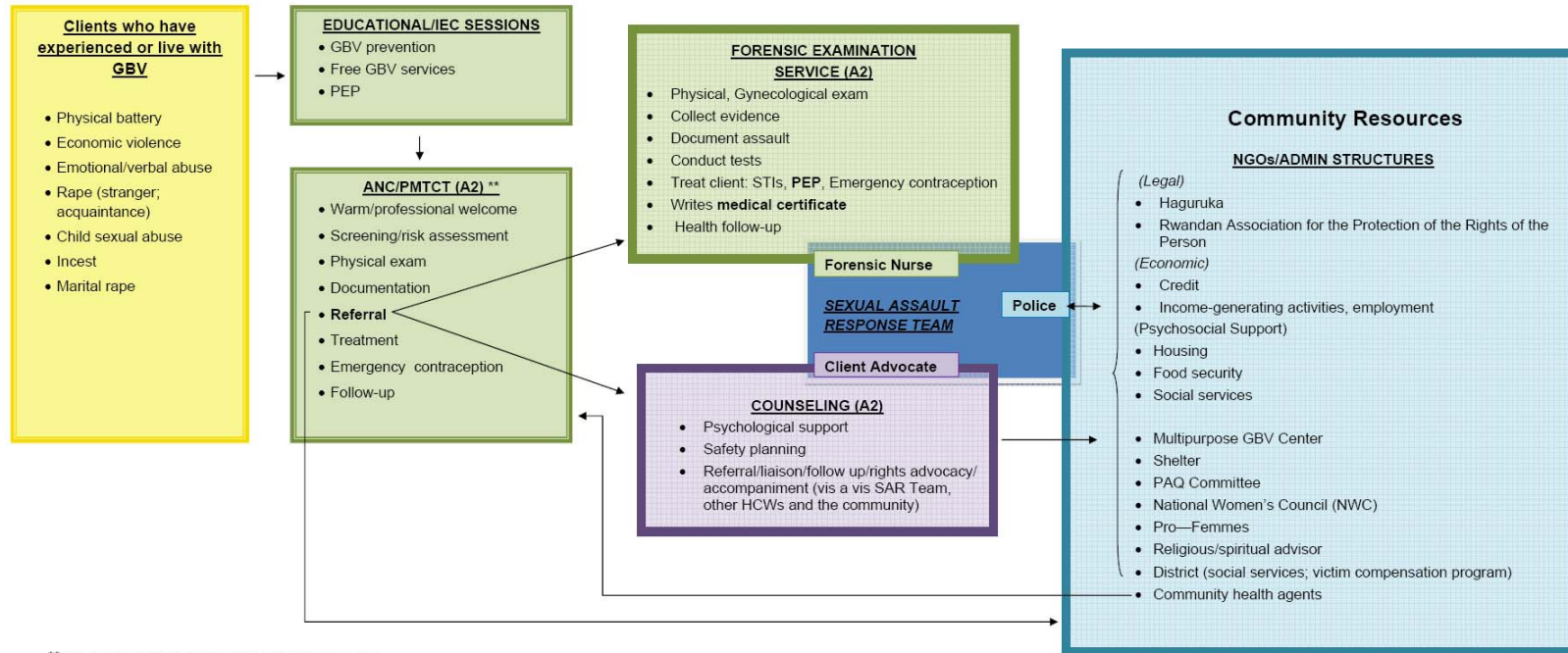
- 6) Despite growing awareness on certain types of GBV among the surveyed communities, there are still social and cultural factors affecting the use of ANC/PMTCT services and preventing the victims from speaking up (see figure 11, appendix 5 “Community-identified factors affecting the use of services”). Therefore, priority should be given to BCC for all types of GBV and to the stigmatization of GBV victims. It is important to note that, according to the focus groups, women seem to be considered responsible for the child's gender, even though it has been scientifically proven that men are. Highlighting this fact should be a central part of the BCC strategies. This could help decrease violence against women who usually give birth to only one particular gender.

Twubakane is encouraged to work in collaboration with the health communication center, CHAMP and USAID in order to develop BCC strategies based on the study's results, so that the communities can prevent GBV, reduce victims' stigmatization and support the use of ANC/PMTCT services (through TV or radio broadcast).

4.4. FINAL CONCLUSIONS

Finally, based on the three levels of the study, we recommend a client-oriented GBV service package in the health facilities as presented in figure 10 below:

Decentralized Model for GBV/ ANC/PMTCT Integration at Health-Center Level



** Other moments of risk/opportunities to respond:
 - Antenatal: HIV test results - FP/Condom use
 - Delivery: Sex of child (girl) - Post-partum: infant feeding
 - ARV treatment

*Client Advocates can also be based in the health center, NGO, Police or Social Services

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