HAGURUKA
Defending the rights of women and children

MAP OUT GBV SERVICE PROVIDERS AND ESTABLISH GBV VICTIMS' REFERRAL SYSTEM PATH-WAY FROM COMMUNITY TO THE NATIONAL LEVEL

By
LG Consult Ltd
December, 2018

This toolkit has been developed and designed by
Advocate Dr. Tite Niyibizi, Ph.D.

Table of content

Table of content 1
EXECUTIVE SUMMARY 2
CHAPTER I: INTRODUCTION 3
1.1. Context and background 3
1.2. Rationale of the study 4
1.3. General objective of the study 5
1.3.1. Specific objectives 5
1.4. Scope of the study 6
1.4.1. Content scope 6
1.4.2. Geographical scope 6
1.4.3. Time scope 6
1.5. Organization of the study 7
CHAPTER 2: RESEARCH METHODOLOGY 8
1.1. Research Methods 8
1.1.1. Research design 8
1.2. Population 9
1.3. Sampling techniques 9
1.3.1. Sample size 10
1.4. Description of cases 10
1.5. Research instruments 11
1.6. Ethical consideration 11
Chapter 3: Presentation, Interpretation, and Discussion of the Findings 13
1.1. Distribution of the respondents by gender 13
1.2. Distribution of the respondents by age 14
1.3. Distribution of the respondents by level of education 15
1.4. Distribution of the respondents by profession 16
1.5. Distribution of respondents by experience 17
1.6. Existing referral GBV Path Way 19
1.7. Agreement with the Convenient Referral Path-Way Involving Sexual and Domestic Violence 22
1.8. The common known path-way, efficiency of violence not involving physical harm 24
1.9. Definition of responsibility of individuals or institutions in charge of handling GBV issues 28
1.10. Sameness of referral pathway of GBV involving physical harm and GVB not involving physical harm 29
1.11. Gaps in Gender-Based Violence Issues Solving 30
CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS 32
4.1. Conclusions 32
Recommendation 33
References 35

EXECUTIVE SUMMARY

Rwanda like other countries around the world is not spared of facing challenges related to gender based violence. With respect to definition of GBV, it may be argued that there is no common understanding or a universal definition of what GBV is, however all definitions provided as results of cultural context have some aspect in common.

Many consider GBV as a synonym of violence against women, however there are differe nces between the two. For instance, the UN General Assembly (1993) defines violence against women as "*any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion arbitrarily deprivations of liberty, whether occurring in public or private life." The Rwandan Law n° 59/2008of the 10/09/2008 on prevention and punishment of gender based violence, defines GBV as "[Any]act that results in a bodily, psychological, sexual and economic harm to somebody just because they are female or male. Such act results in the deprivation of freedom and negative consequences.This violence may be exercised within or outside the household"*. Although governments and states have taken some measures of reducing such case, there has been an increment of cases of GBV as the time passes by. GBV cases are neither a particular concern of developing countries but also the developed ones. It with that regard that HAGURUKA has initiated a study in order to map out GBV service providers, assess the efficiency of the existing one, clarifying the responsibilities and finding out the gaps. To achieve these objectives, this study employed a mixed methods approach to collect the data, and a descriptive exploratory research design. The population of the study was an infinity universe, and the study used a sample of 205—200 for quantitative study and 5 for qualitative study. As for primary data, we use both questionnaire, interview and document analysis, whereas document analysis was used to gather the secondary data. With respect to findings, the study revealed that there are so many organizations in charge of GBV cases; however their staff's responsibilities are overlapping. Moreover, it was revealed that some GBV cases are not reported or reported late due to culture of silence and the existing referral system is complex. Beyond this point, participants revealed that some people do not consider GBV not involving physical harm as violence cases.

CHAPTER I: INTRODUCTION

1.1. Context and background

Gender-based Violence is a broader concept which encompasses variety meanings for any harmful act that is perpetrated against a person's will and usually based on socially ascribed — gender differences between males and females (U. N. I. F. E. M., 2008). Such acts include acts of physical, emotional and sexual violence, forced and early marriage, and sexual exploitation and abuse (G. P., & AoR, G. B. V., 2010). Several studies indicate that everyone regardless the age and gender can be a victim of gender based violence; however the most vulnerable groups are children and women (Murray and Achieng, 2011). Furthermore, (U. N. I. F. E. M., 2008) reports indicate that the types and extent of specific gender-based violence differ across cultures, countries and regions.

Gender-based violence is a global concern. Moreover, statistics of gender based violence victims significantly vary according the sex and age as the majority of victims are young and very often females. Additionally, the study carried out in Kenya indicated that sexual gender based violence is the frequent violence which is committed against women and girls not only in Kenya but across the globe (Twesigye-Bakwatsa, 2010). Moreover, the same report revealed that women are disproportionately affected by GBV and the report discloses further that violence against men generally is minimal and it stands at 3%. With reference to Tanzanian context, the report indicate that over 20% of Tanzanian women aged 15-49 years were reported having experienced sexual violence in their lifetime, nearly 40% were reported having physical violence, while 44% of ever-married women had experienced physical and/or sexual violence from an intimate partner in their lifetime (Sills, Namy, Nyoni, Rweyemamu, Salvatory, 2013). The disproportionality of percentages between male and female victims of gender based violence takes its root from a traditional culture, which engendered a gender stereotype and thus results into men's domination over women (Adhiambo, 2017). Along-side with the above, the report

indicates that although women and children are more vulnerable of sexual and all other forms of gender- based violence than men. Furthermore, poorly educated women, and economically dependent on their male partners remain more vulnerable with men being perpetrators due to unequal power between both gender (National gender and equality commission, 2017). With respect to children, they are as well vulnerable; however, the report revealed that the most exposed to gender-based violence cases are those living with disabilities whose experience that violence when separated from their carer (Donna, 2017).

Being aware and sensitive of GBV issues and inherent consequences, governments and states have taken mechanisms aiming at protecting the vulnerable groups and minimizing the risks of those underwent the violence. One among the mechanisms taken is commonly known as “a referral pathway of GBV” or a reporting system of which involves the exchange of informa t ion between entities having responsibilities of handling and managing GBV cases from the grassroots up to national level. Similarly to other countries, Rwanda as well has established a reporting system of GBV from the village where the crime may be committed up to the national level, however, there is an increment of GBV cases (Al-Tuwaijri, and Saadat, 2018).

1.2. Rationale of the study

Gender based violence acts are serious concern on the global scale. It is not a particular case for developing countries, but western countries as well are also concerned. USAID and MCSP (2017) report that domestic and sexual violence in the United Kingdom costs the country around £5.7 billion per year for criminal justice costs system, health care cost, etc.. Although gender based violence is a global issue, (Leone, 2001) argued that is the least recognized human right abuse in the world. Rwanda like other countries has adopted a referral system which involves different entities while handling GBV issues and providing services to the victims. Unfortunately, the cases of gender based violence increase day after day, while some are delayed reported or

definitely kept secret. Being that the case, it would be assumed that such attitude is due to the missing awareness of the issue among the grassroots and or lack of reporting mechanism, and ineffective referral systems that has not yet addressed the problem. It is with this regards, that HAGURUKA initiated this study in order to map out the GBV service providers in its operating regions, and find out whether the existing referral system is effectively addressing the needs of GBV victims.

1.3. General objective of the study

Any research study is undertaken to solve a problem, and without a problem to solve, the research endeavor would be useless (Saunders, Lewis, and Thornhill, 2009). The general objectives of this study as to map out GBV service providers and establish GBV victims' referral system path-way from community to the national level.

1.3.1. Specific objectives

Having realized that there is an incremental of various forms violence perpetrated against women and children in Rwandan population, HAGURUKA initiated a study aimed at attaining the following objectives:

1. Mapping out GBV service providers;
2. Assessing the efficiency of the existing referral path-way involving sexual anddomestic violence;
3. Proposing the desired referral-path way as emerged from the data;
4. Assessing the clarity of responsibilities and competences of the staff assigned to dealwith GBV issues across different organizations;
5. Identify gaps in GBV issues solving process, and suggest solutions.

1.4. Scope of the study

A research scope is defined as the study coverage which comprises both content scope, geographical scope, and time scope. Scope has to do with delimitation of the study as far as time, cost and energy are concerned. A researcher should do his/her best to set the boundaries of the study in order to make sure that he is able to optimize the objectives attainment rather widening a study which ends us fail to answer the problem being investigated. It is with that respect that this study considered the below highlighted scopes within this study.

1.4.1. Content scope

With consideration of the general aim of the study, the researcher set the boundaries are the central theme of the study as such the point that this study has to deal with were limited to— mapping out the GBV service providers, assessment of the efficiency of the existing referral path- way involving sexual and domestic violence, analyzing the clarity of responsibilities and competences of staff in charge handling of GBV issues and identifying gaps in in GBV issues solving process.

1.4.2. Geographical scope

With respect to geographical scope, this study was carried out in five districts namely Nyaruguru, Nyamagabe, and Nyanza districts in Southern province, Rulindo and Gakenke in Nothern province. The above districts were chosen are there areas where HAGURUKA focuses its interventions in relation with women and children's rights.

1.4.3. Time scope

With regards to time horizon or perspective, we distinguish two types of surveys— cross- sectional survey and longitudinal survey. They both refer to data collection time frequencies. A study is a cross-sectional study when the data of a study are collected at one point in time, whereas

a longitudinal study occurs when data are collected at different point in time. The last is undertaken to investigate the progress of a phenomenon or whether particular changes occurred over time. As for this study, it is a cross-sectional study as the data were collected once upon a time-during the year of 2018.

1.5. Organization of the study

The first chapter is an introduction to the research which encompasses the subheadings such as context and background of the study through which the historical background is shortly discussed rationale of the study—a section under which the reasons for which a study is worthy to be carried out were presented, objectives of the study, scope of the study and finally the organization of the study. As for chapter two—research methodology, this chapter is made up of sections such as research methods, research designs, population, sampling techniques, sample size, description of the case—the place where the study is carried out, research instrument, definition of the concepts, and ethical consideration. With respect to chapter three, it dealt with the findings whereby the findings presentation started with demographic variables discussion in relation with the objectives of the study, assessment of the efficiency of the existing referral path-way for GBV issues, identifying the responsibilities of the staff in charge of GBV cases across different organizations, and finding out the existing gaps in GBV issues solving process.

CHAPTER 2: RESEARCH METHODOLOGY

The current chapter discusses the methods used for data collection analysis and interpretation. It encompasses the research approaches used to gather the data, research design, population, sampling techniques, and sample size, description of the case, research instrume nts, and definition of the key concepts. Rajasekar (2013) defines research methodology as a systematic way to solve the problem and argued that research methodology is a science of studying how research is to be carried out. With that regards, due to the nature of the study, the researcher used a mixed methods approach—quantitative and qualitative research approach.

1.1. Research Methods

As far as this study aimed at measuring the extent to which the GBV service providers responds to the needs of the victims, the use of quantitative study was of worth to collect numer ica l data through which research instrument was developed from the objectives of the study (Fraenkel, Wallen, and Hyun, 2011). Along with the quantitative research methods, the researcher used qualitative research methods in as much as the study sought to explore the opinions of the respondents (Creswell, 2016). It is with that respect that (Saunders, 2012) argue that whenever a study has a descriptive and exploratory purpose it should combine both approaches—quantita t ive and qualitative approaches.

1.1.1. Research design

Kothari (2013) defines a research design as a blueprint or the overall strategy that a researcher uses to assess the meaning related to an observable phenomenon. It is with that respect that this study used qualitative research approach as it aims at exploring the opinions of one category of the respondents—victims whereas the rest categories of the respondents were surveyed with a questionnaire through which the researcher chose to use a descriptive research design.

Respectively with the data collection technique, this study used concurrent exploratory researchdesign by which both questionnaire and interviews were administered concurrently.

1.2. Population

Kotheri (2013) defines a population as a group from which the sample is drawn and about which the research findings are to be generalized. The author defines a population as synonymous with a universe and thus distinguishes two types of universes—finite universe by which the total number of the population is known, and the infinite universe by which the population size is not known. As to the case of this study, the population size was unknown, however the population targeted was the victims of five districts namely Nyamagabe, Nyaruguru, Nyanza, Gakenke, Rulindo and the officers of the key institutions most concerned with GBV issues, and involved in GBV referral pathway in respective districts. The entities and organizations as well as category of people identified to provide the information on referral pathway are health centers/hospitals, Police FSU, RIB, GBV officers , in charge of gender at district level, youth representative and others operating in the respective districts mentioned above.

1.3. Sampling techniques

In order to answer the research questions, it is doubtful that researcher should be able to collect data from all cases, and thus, there is a need to select a sample. Having constraint pertaining to unknown population, the researcher decided to use non-probability sampling as far as the use of any formula would not help to determine the sample size. It is with that respect the researcher decided to use purposive sampling and snowball sampling. Purposive or judgmental sampling is a strategies in which particular settings, persons or events are selected deliberately in order to provide important information that cannot be obtained from other choices, whereas snowball sampling uses a few cases to

help encourage other cases to take part of the study, thereby increasing

the sample size (Fraenkel, Wallen, Hyun, 2011) Purposive sampling was used when the researcher were seeking out to select the institutions most concerned with the phenomenon under the investigation. As snowball sampling, it was used during the recruitment of GBV participants who were hardly to identify as individuals who had first-hand experience with such sensitive phenomenon being investigated.

1.3.1. Sample size

With the use of purposive sampling by which the researcher administered questionna ires sought to collect quantitative data, this study used a sample of 200 participants, respectively, 5 GBV officers at district level, 4 participants taken from national women Council at district level, 5 DASSO commanders at district level, 3 gender officers at district level, 79 health advisors, one for each sector in respective districts, 77 youth representatives for each sector of the respective districts, 5 one stop center officers at district level, 5 police officers, one for each of the respective districts, 5 staffs representing Rwanda education board—RIB at district level, 5 health centers/hospital directors, on in each district mentioned above, and other key potential informa nts. Along with quantitative data, the researcher collected qualitative data through a face to face interview with GBVs. As reaching out the GBVs seems to be impossible due to the fact that the study touched their private life experience, the researcher used snowball sampling, a technique by which the researcher recruited the first participant through whom others are recruited by one another. Consequently, the entire sample used for this study was 205 participants.

1.4. Description of cases

The findings of this study result into the information provided by GBV service providers from different districts. The districts selected are, Nyamagabe, Nyaruguru, Nyanza in Southern province, whereas those of Northern Province were Rulindo, and Gakenke. They were selected

purposively due to the fact that HAGURUKA interventional activities related to women and children rights are focused in those districts. Furthermore, they were selected as the potential partners of HAGURUKA in fighting GBV issues as such were in the better position to provide the relevant information for this study.

1.5. Research instruments

The data collected for this research, were generated by two research instrume nt—questionnaire and structured interview. The questionnaire was developed from 5 research objectives and it had four components. The first component was made up of demographic variables namely gender, age, educational level and working experience were assessed to finding out the distribution of the respondents. The second component was made up of items asking about chronological ranking of referees by whom the victim would start with while reporting the violence perpetrated against him or her. The third component was made up questions asking about responsibilities of each entity in charge of providing services to GBV customer, whereas the fourth components attempted to assess the extent to which GVB customers are satisfied with the service they receive from the respective service providers.

1.6. Ethical consideration

As this phenomenon had sensitive information, the researcher first used informed consent form provided by both LG Consult, a research consultancy company contracted to carry out this research and HAGURUKA NGO initiated this study. Furthermore, the researcher took time to explain to the participants, the purpose of the study, and requested their voluntary participation in the study by signing the personal informed consent form. Respondents were assured the confidentiality of their information and anonymity of their identification as their names were

represented by codes during data analysis coding and analysis. As for data treatment, the researcherused his personal computer and it was kept safe as it was protected by a code.

Chapter 3: Presentation, Interpretation, and Discussion of the Findings

The quantitative data collected from a sample of 200 individuals of different categories were analyzed through the use of SPSS and generated tables indicating the distribution of gender of the participants, age, educational level, profession, experience, mean and standard deviation of each item measured. Along with quantitative data, qualitative data were gathered and analyzed manually.

1.1. Distribution of the respondents by gender

To begin with quantitative data, gender portion, and age distribution of the respondents was also a concerned variable as far as the majority of GBV are female, youth and children. With respect to gender variable, the research revealed that 44.5% of the respondents were male against 55.5% were female as shown by the **table 3.1** below.

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	89	44.5	44.5	44.5
	Female	111	55.5	55.5	100.0
	Total	200	100.0	100.0	

Table 3.1: Gender distribution of the respondents

With respect to the characteristics of the respondents selected, it can be argued that government and its partners have put much efforts to place many females in the positions requiring trust and strong rapport with the GBVs as far as 55/ % of the people surveyed were female. It is a positive step made to treat fairly and with justice those encountered the problem of violence at home as far as the majority of GBV are male and children. However, the number of male might

be decreased again in order to build more trust and rapport between service providers and GVBvictims.

1.2. Distribution of the respondents by age

As demographic variable, gender was important for this study for several reasons. When it comes to deal with a sensitive case as such of GBV cases, age of the officers is an important variable as those whose job duties are related to GBV cases should not only provide legal support for fair justice, but also provide emotional support to GBVs as they are vulnerable to trauma. Below is the **table 3.2,** which reflects the age distribution of the respondents.

Ages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21-30 years	10	5.0	5.0	5.0
	31-40 years	105	52.5	52.5	57.5
	41-50 years	65	32.5	32.5	90.0
	51-60 years	20	10.0	10.0	100.0
	Total	200	100.0	100.0	

Table 3.2: Age distribution of the respondents

Respectively with the age of the respondents, the research revealed that those of 21-30 years old represent 50%, 31-40 years represent 52.5%, 41-50represent 32.5%, 51-60 represent 10%. The implication of the percentages above indicates that age is considered during the employees' placement in the positions directly or indirectly related to GBV issues. However, it remains critical as far as the majority of GBVs are children, youth and young women who may not feel comfortable while reporting their experience. Although experience counts as well while providing counseling and emotional support, however the age group of 51-60 years hereby

representing 10% remains large. This argument stems from the age of victims who are usuallyyoung and who would feel open if the age of GBV officer corresponds with his or her age.

1.3. Distribution of the respondents by level of education

As far as GBV cases require a critical and deep analysis, variable education matters. With reference to categories of educational level of the individuals surveyed, the researcher set three categories namely high-school, bachelor and master degree. Those with a high school degree represent 35.5%, bachelor degree 63.5% and 1% for master degree. **The table 3.3** below indicates the distribution of the respondents by educational level.

Educational level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High-School	71	35.5	35.5	35.5
	Bachelor	127	63.5	63.5	99.0
	Master	2	1.0	1.0	100.0
	Total	200	100.0	100.0	

Table 3.3: Distribution of respondents by educational level

By looking at the table, the figures indicate that those who are in direct contact with GBV victims are schooled, which means that they are qualified to some extent to help GBV victims effectively. However, some other parameters were not considered such as areas of specializat io n. It remains a serious concern to know whether they provide consistent support as far as those cases would need legal and counseling support during the entire process of referral pathway.

1.4. Distribution of the respondents by profession

Profession was one core demographic variable as we used purposive sampling through which we targeted the key respondents who would provide the relevant information. The people surveyed were those whose job duties have closer relationship with GBV victims. With that respect, we used a wide variety of professions; however, we grouped them into eleven specific professions, which include ten specific professions and non-identified professions grouped under the category of others. This approach was used in order to triangulate the information from different informants for the sake of credibility and trustworthiness of the findings. The table 3.4 below indicates the categories of professions used.

Profession

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	GBV Officer	5	2.5	2.5	2.5
	CNF conseil national de femmes	4	2.0	2.0	4.5
	DASSO	5	2.5	2.5	7.0
	Gender Officer	3	1.5	1.5	8.5
	Health Advisor	79	39.5	39.5	48.0
	In charge of Youth	77	38.5	38.5	86.5
	One stop center	5	2.5	2.5	89.0
	Police	5	2.5	2.5	91.5
	RIB coordinator	5	2.5	2.5	94.0
	Health Center/Hospital Director	5	2.5	2.5	96.5
	Others	7	3.5	3.5	100.0
	Total	200	100.0	100.0	

Table 3.4: Distribution of respondents by professions

The individuals surveyed with respect to profession are distributed as follow: GBV officers represent 2.5% that is 5 officers, each from one of the five districts selected, 2% of national counsel for women at district level, 2.5% for DASSO commanders at district level, 1.5% for gender officers

at district level, 39.5 % for Health advisor at sector level, 38.5% for youth at sector level, 2.5% for one stop center at district level, 2.5% for police officers at district level, 2.5% for RIB coordinators at district level, 2.5% for health center/hospital directors, and 3.5% which represents non categorized professions. With regards to professionals surveyed, there is a high likelihood that the information gathered has credit as far as those are part of referral pathway circle. The only concern is to know whether, their educational training matches well with their job duties as to provide the likely needed support for GBVs.

1.5. Distribution of respondents by experience

Experience is very important in quality service delivery. It is with that respect that this study considered variable experience in order to find out whether the service providers have enough expertise to provide the required service to GBVs. Years of experience were classified into five categories with a range of ten years. The **table 3.5** below indicates the categories years of experiences used to shorten the tables and facilitate the leaders.

Experiences

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less or equal 10 years	128	64.0	64.0	64.0
	11-20 years	47	23.5	23.5	87.5
	21-30 years	13	6.5	6.5	94.0
	31-40 years	10	5.0	5.0	99.0
	41 years and above	2	1.0	1.0	100.0
	Total	200	100.0	100.0	

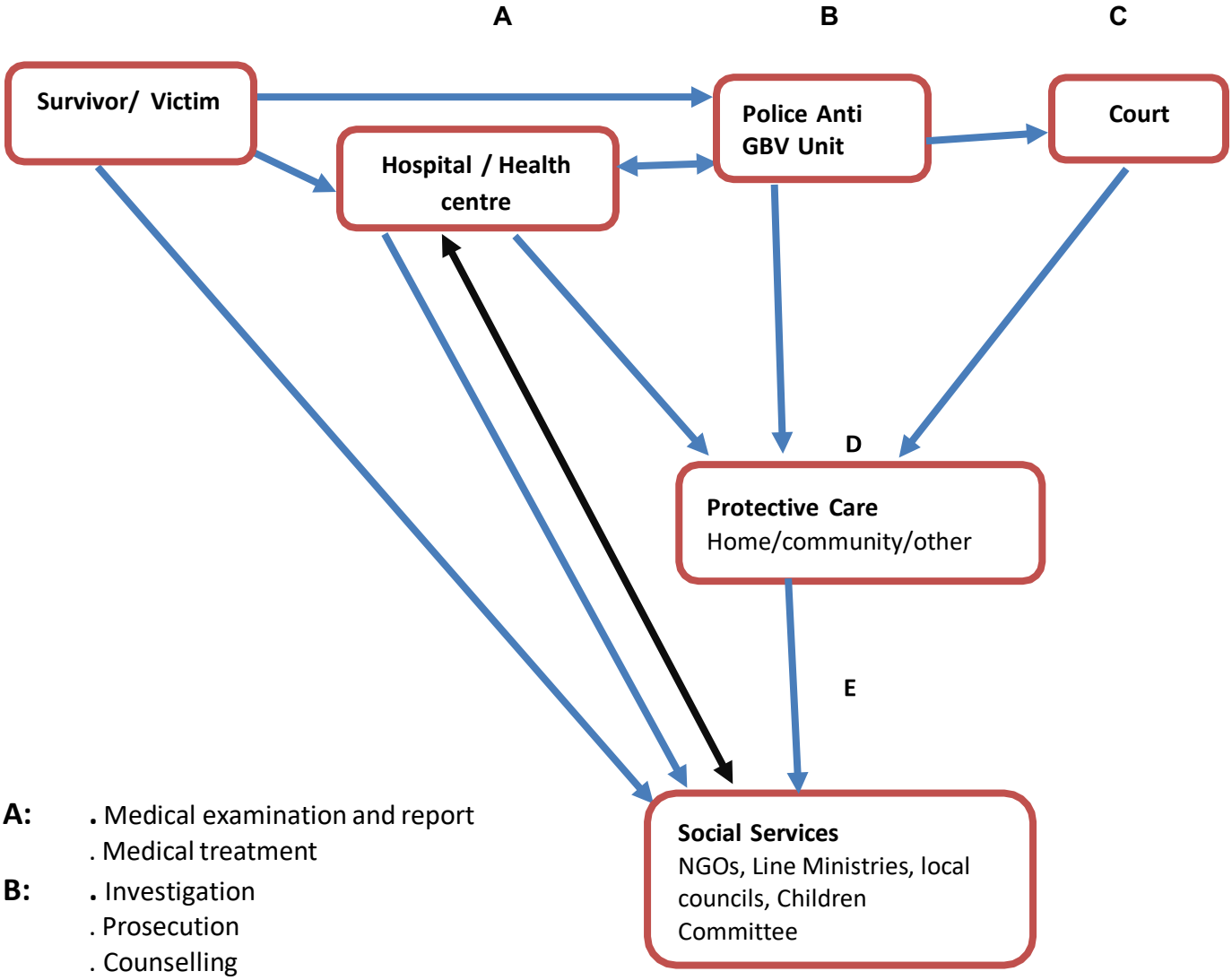
Table 3.5: Distribution of respondents by years of experience

Those with a less than 1-10 years of experience represents 64% of the total respondents, 11-20 yeas represents 23.5%, 21-30 years represent 6.5%, 31-40 years represent 5%, whereas those with 41 years and above represent 1%. The distribution of the respondents by experience looks convenient in relation effective handling cases of GBVs. This interpretation stems from the perspective client-service provider relationship. The majority of the respondents are concentrated in the group of 1-10 years of experience, which explains that they are young and thus their ages correlate with those of the clients—GBV victims as the last are usually youth, children and young women.

1.6. Existing referral GBV Path Way

REFERRAL PATH WAYS FOR WOMEN AND CHILD VICTIMS OF SEXUAL AND DOMESTIC VIOLENCE

Rape/Unlawful Canal Knowledge and serious Physical Wounding with Intent or Torture



A: . Medical examination and report
. Medical treatment

B: . Investigation
. Prosecution
. Counselling

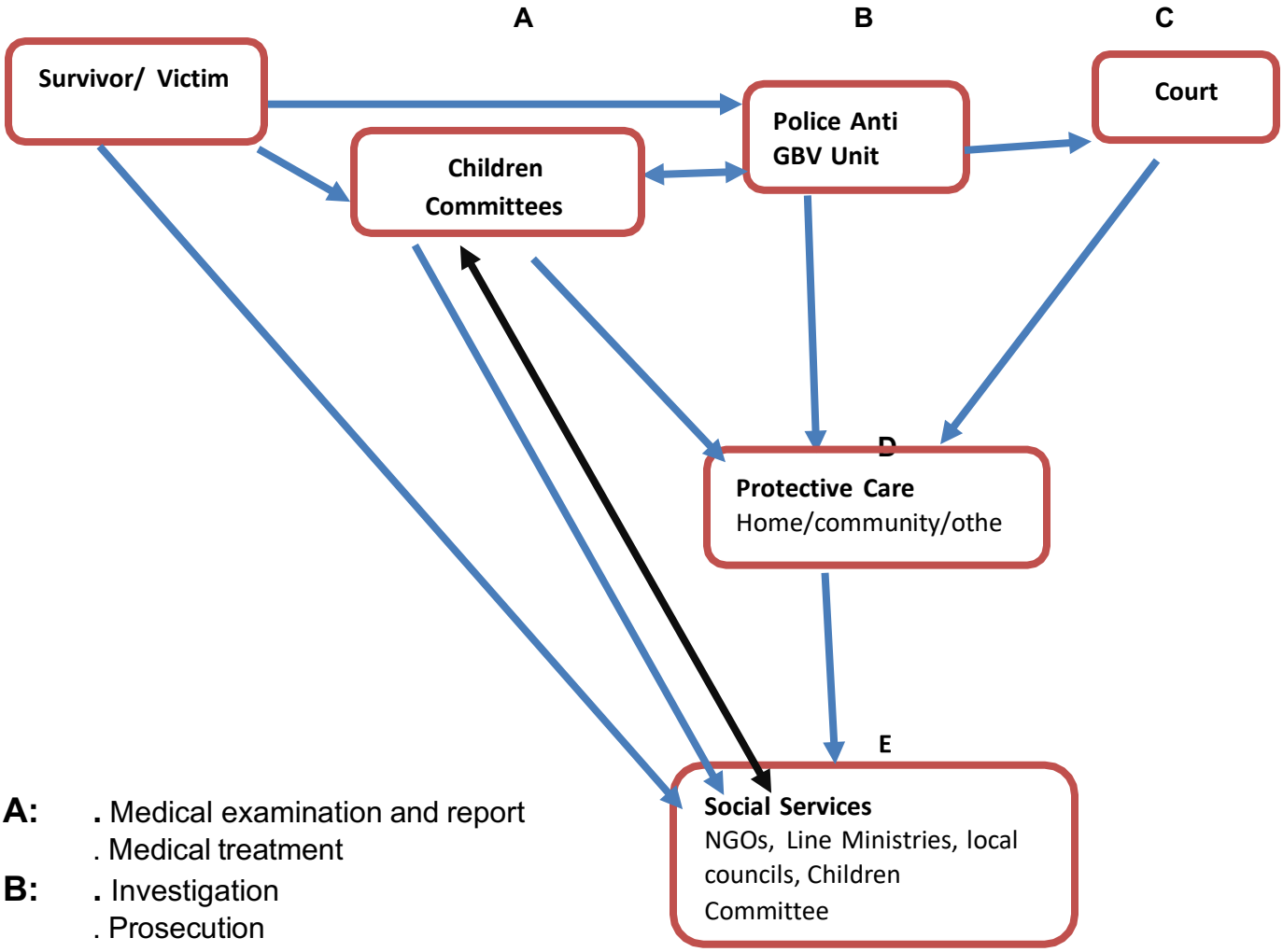
C: . Trial- Punishment of perpetrator
Protection of victim/survivor
Compensation of victim/survivor

D: . Protective Care - Free of attack, discrimination and stigmatization

E: . Counselling
. Education/skills training/gainful employment
. Shelter, medical & other needs
. Legal counsel

A & B: Isange One Stop Center

OTHER GBV THAT DO NOT INVOLVE PHYSICAL INTRUSION OR WOUNDING, e.g. forced/child marriage, fondling, indecent assault, child labor, child trafficking



A: . Medical examination and report
. Medical treatment

B: . Investigation
. Prosecution
. Counselling

C: . Trial- Punishment of perpetrator
Protection of victim/survivor
Compensation of victim/survivor

D: . Protective Care - Free of attack, discrimination and stigmatization

E: . Counselling
. Education/skills training/gainful employment
. Shelter, medical & other needs
. Legal counsel

In doing referral, the importance of minimizing further trauma to the survivors must be emphasized, and the efficiency of professionals who are in place to support them must be maximized.

The referral pathway for child or woman victim of Gender Based Violence and other forms of abuse is noted in diagram form above. The diagram denotes the referral pathways to be followed at the first point of contact i.e. when the child or woman victim of abuse first presents for help and/or to report an incident of abuse.

The first point of contact is defined as the person, in either a professional capacity or other position of responsibility/authority (Local Leader, Community Health Workers, Religious Leader, Elder etc) to whom the victim discloses details of the abuse.

A factual account of the abuse, including details of the victim, perpetrator, and what actually happened (e.g. the victim was sexually assaulted by the perpetrator) should be provided in written form by the referring agency to the National Police anti GBV Unit, and the local Government; department of Social Welfare, Gender and Children's Affairs.

If the victim requires urgent medical attention, he or she should in the first instance be referred for medical treatment to the local Health service provider (e.g. Isange One Stop Center whereby Health Service Providers and Police work in conjunction). Once this has been done the case should be reported to ensure prompt investigation of the alleged abuse.

It is important to note that there is more than one possible referral route when the victim/survivoris first reporting the incident/seeking help. For example, although the incident needs to be reported to the Police Anti GBV Unit as quickly as possible, the victim may require immediate medical attention/treatment; the reason of existing of Isange One Stop Center.

Professionals should exercise a 'common sense approach' in this regard –for instance if the victim has an open wound, or is in considerable pain and distress, medical care should be the first priority.

If there is suspicion of, or evidence suggesting victim trafficking, response services should be coordinated via National Security Services, which will in turn liaise with the Internatio nal

Organization for Migration. Details will also need to be referred to the Police Anti GBV Unit forprompt investigation.

1.7. Agreement with the Convenient Referral Path-Way Involving Sexual andDomestic Violence

Category B1 of items used in the research instrument were asking the respondents to express their opinions about how they feel convenient with the existing referral pathway in solving the GBVs issues. This category comprises 10 items, from B1 to B 10. As our measurement scales ranged from 1 to 5, the minimum mean that would confirm the response might be 2.5% for each item. However in interpreting the responses, means were contrasted with standard deviations. Thisapproach was taken as way of avoiding to be misled by means figures as far as standard deviations—distance from the mean or measure of spread out might allow us to indicate how closer or distance were the understanding of the participants on each item. It is important to note that the closer standard deviation is to the mean, the more participants' understanding or opinions are likely closer or the same, whereas the further standard deviation is to the mean, the likely participants understanding differ on the questions asked.

Descriptive Statistics

B1	N	Minimum	Maximum	Mean	Std. Deviation
B1.1. GBV victim should first ask help from hospital health center	200	1	5	3.53	1.056
B1.2. GBV victim should first ask help from police anti GBV	200	1	5	3.11	1.456
B1.3. GBV victim should first ask help from court	200	1	4	1.84	.786
B1.4. GBV victim should first ask help from protective care	200	1	5	3.64	.822
B1.5. GBV victim should first ask help from social service	200	1	4	2.15	.693
B1.6. Hospital health center and police anti GBV unity mutual	200	1	5	3.43	1.162
B1.7. Police anti GBV should first refer GBV victim to health center	200	1	5	2.45	1.111
B1.8. H. center should first refer GBV victim to police anti GBV	200	1	5	3.12	1.013
B1.9. The existing structure is known by the grassroots population	200	1	5	2.57	1.163
B1.10. The existing structure is known, however it is not efficient	200	1	5	2.66	.958
Valid N (list wise)	200				

Table 3.6.: Participants opinions about the convenient referral path ways for GBVs victims

With respect to whether victims should first ask help from hospital health centers or hospitals, the research findings revealed a moderate mean of 3.53, with a 1.056 (SD), whereas those who agreed with the statement of starting with police anti GBV have a mean of 3.11 againsta 1.456 (SD). As to whether the GVB victims should first ask help from the court, the participant s response mean was 1.84 with a 0.786 (SD). With respect to begin with GBV protective care, the mean is 3.64 against a 0.822 (SD), whereas those who argued that the GBV victims would request first a help from social service providers, the mean was 2.15 against 0.693 (SD). Those who supported the idea that police anti GBV should refer GBV victims to health center, their mean amounted to 2.45 against a 1.111 (SD), whereas those who supported the idea that health center must first refer the GBV victim to police anti GBV, their mean is 3.12 against a 1.013 (SD). With regards to whether the existing structure is well known, there was a mean of 2.57 against a 1.163 (SD). In relation of how efficient is the existing structure in solving GBV issues, the study revealed a mean of 2.66 against a 0.985 (SD).

With respect to find out whether the existing referral path-way do solve the problems of GBV victims, the study revealed that victims should first seek a help from the protective care whereby there is a high mean of 3.64 and a 0.822 (SD). Next to protective care, GBV victims would seek a help from hospital and health centers with a mean of 3.53 with a 1.056 (SD). After health centers, the participants argued that the victims would be sent to social service providers as their opinions with respect to the mean is 2.15 against 0.693 (SD) and after the social service providers, the victim should be sent to the court whereby the mean of their opinions is 1.84 with a 0.786 (SD).

As to whether the existing structure is well known by the grassroots population, the study revealed that it is not well known with a low mean of 2.57, and a 1.163 (SD). Moreover, the study

revealed that the existing structure is not efficient as their opinions were expressed with a lowmean of 2.66 against a 0.958 (SD). Respectively with the above interpretation, here below is a

proposed referral path-way from the data.

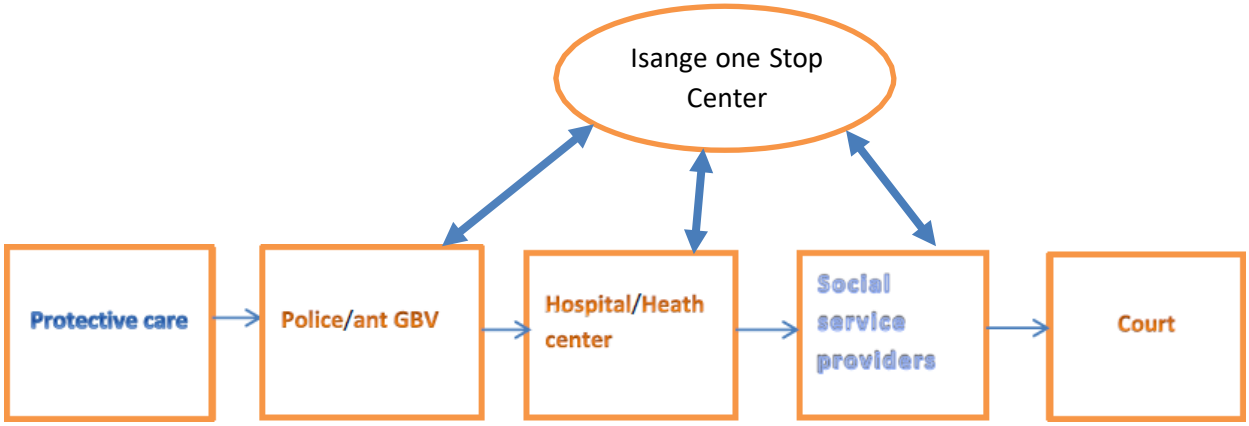


Chart 3.1: Referral path-way emerged from the data

1.8. The common known path-way, efficiency of violence not involving physical harm

The component B2 of the research instrument is made up of three categories of questions — those asking about the desired path-way, questions asking about the efficiency of the existing one and questions asking whether that path-way would be the same as the one of violence involving physical harm. With respect to the question asked if the victim would seek a help from CWS, this items earned a low mean score of 2.81 with a 1.166 (SD), whereas the question asked if the victim must first seek a help from social service providers had a mean score of 2.80 with a 1.248 (SD). With respect to question asked if CWS must refer the victim to social services provider before he/she is referred to police FSU before she is referred to social services providers, the mean score was 2.96 against a 1.188 (SD), while the question asked if CWC and social services providers must refer the victim to one another before she/he is referred to any other institution earned a mean score of 2.63 with a 1.077 (SD).

With respect to whether CWCs would refer the victims to protective care before she/he is being referred to any other institution, there was a mean score 3.27 against a 3.439 (SD), while the question asked if CWC and police FSU might refer the victim to each other and at the same time refer him/her to Protective Care earned a mean score of 2.90 with a 1.112, whereas the question asked if the path-way for violence not involving physical harm is known, the mean score was 2.77, with a 1.259 (SD). As to question asked if the existing path-way is efficient, the mean score was
3.57 against a 0.980 (SD). In regard to the question asked if the path-way used for violence involving physical harm and the one not involving physical harm would be the same; the mean score was 4.15 against 0.742. The table 3.8 below indicates the desired path-way for violence involving no physical harm, the effic iency of the existing one and the extent to which the path- way followed for GBV involving physical harm and the one not involving physical harm are alike.

With reference to the existing referral pathway for GBV involving women and children sexual domestic violence, the pathway emerged from the data differs from it as the research attempted to map GBV service providers from the data. Likewise the referral pathway not involving physical intrusion was different as well. The respondents have indicated that the existing referral pathway is complex as such the clients feel tiresome with to follow up with cases reported. This is confirmed with the statement made by a victim interviewed in one of the five districts who said " *The ways that we go through to report our cases are two complex and long to such extent that we usually leave the case in half way without following up with it up theend* (P1, P12, L.36)."

Table 3.7: Desired pathway for the violence involving no physical harm

Descriptive Statistics					
B2. Referral path-way not involving physical intrusion of or wounding	N	Min	Max	Mean	SD
Victims of domestic violence not involving physical intrusion or wounding should first seek a help from CWC	200	1	4	2.81	1.166
Victims of domestic violence not involving physical intrusion should first seek a help from **Social services** providers	200	1	5	2.80	1.248
CWS refer the victim to **Social services** before he/she is referred to Police FSU	200	1	5	2.73	.951
CWS refer the victim to **police FSU** before he/she is referred to **social services providers**	200	1	5	2.96	1.188
CWC and Social services refer the victim to one another before he/she is referred to any other institution	200	1	5	2.63	1.077
CWCs refer the victims to Protective Care before she/she is being referred to any other institution/agency or organization	200	1	22	3.27	3.439
CWC and police FSU refer the victim to each other and at the same time refer him/her **to Protective Care**	200	1	4	2.90	1.112
The grassroots population knows well this structure	200	1	5	2.77	1.259
I know well the structure and I do agree that it is efficient	200	1	5	3.57	.980
The referral path-way of handling violence not involving physical harm should be the same as the one implying sexual and domestic violence	200	2	5	4.15	.742
Valid N (List Wise)	200				

With respect to question asked if a victim should first seek a help from CWC, the research revealed that the path-way which starts with CWC is desired at around 50% as the mean score is

2.81 with a standard deviation of 1.166 (SD). This interpretation stems from the fact that the mean score is closer to 2.5 with reference to 5 Likert scales used for this study, whereas the standard deviation is moderate, which means their understanding is extent different, but much. As to whether victims would start with service providers to seek for a help, the path-way which starts with service providers is less preferred than the one which starts with CWC as the last has mean (2.80) lower than the first and a (1.248 SD) higher than the first. Concerning the question asked if CWS refer the victim to social services before he/she is referred to Police FSU, the mean score was 2.73 with a 0.951 (SD). This implies that CWS might refer the victim to social services providers, but not much preferred as there is a low mean, however, a significant number of the respondents have the same views, which is much preferred than the first two path-ways.

Concerning the question asked if CWS must refer the victim to police FSU before she/she is referred to social services providers, respondents did not appreciate much

this approach as the

mean score earned by this items is 2.96 with a 1.188 (SD). This opinion makes sense to some extent as the psychological harm may not have immediate effect as the one touching directly the body. However, as to question asked if CWC and social services refer the victim to one another before he/she is referred to any other institution, the mean score was 2.63 with a 1.077 (SD). Although the mean score and standard deviation are lower than the previous, this approach sounds important in as much as what a victim of violence not involving physical harm need first is an emotional balance, and the facts or evidences of violence can easily disappear as those of involving physical violence. As to question asked if the grassroots population knows well the path-way to follow when victimized, this items earned a low mean of 2.77 with a 1.259, which indicates that the victims do not know well the existing structure pertaining to violence involving no physical harm as far as the mean score on this item is 2.77 with a 1.259 (SD). This standard deviation is somewhat high, which implies that the victims do not have a common understanding about the way to go by whenever they want to seek for help pertaining to violence not involving physical harm.

Respectively with the question asked in relation with whether the structure is efficient, the mean score attained is 3.57 with a 0.980 (SD). This is evidence that the existing path-way is appreciated as far as the variability is too small. In the end, the question asked about whether the path-way related to violence involving physical harm and the one not involving physical harm would be the same, the mean of 4.15 attained is a very high mean with a 0.742 (SD) which indicates that the majority of the people agree that both violence involving physical harm and the one involving no physical harm would be the same.

1.9. Definition of responsibility of individuals or institutions in charge of handling GBV issues

With respect to the table 3.8 below, it is worthy to indicate that the persons asked if responsibilities of individuals and organizations in charge of handling GBV issues are well defined, the mean score on this item was 4.09—a high mean with 1.048 (SD)—a low standard deviation. This means that the majority of people agree that duties and responsibilities are well were defined, however, there is a little variation in their responses due to a moderate standard deviation of 1.048. As to question asking whether those people know well their responsibilit ies, the research revealed that they know them as the mean score was 3.71, with a 1.109 (SD), which implies that the majority of the respondents do agree on that statement. Similarly, the GBV victims are informed of what they expect from the service providers as the mean was 3.57 with a 0.793 (SD). However, the research revealed the quality service of the GBV service providers is limited in comparison of what is needed to deliver as there was a low mean of 2.60, with a 1.002 (SD),whereas, the mean score of 3.00 and a 0.99 (SD) attained indicate that responsibilities of partners overlap. The table 3.8 below indicates the extent to which responsibilities of GBV service providers are defined.

Descriptive Statistics

C1. Questions asked about definition of responsibilities of individuals/institutions in charge of handling GBV issues	N	Min	Max	Mean	SD
Our responsibilities are well defined, and are in pattern with our area of expertise	200	1	5	4.09	1.048
We all know well our responsibilities	200	1	5	3.71	1.109
Clients are aware of the service they expect to get from us	200	1	4	3.57	.793
Services that we provide are limited in comparison what is needed	200	1	5	2.60	1.002
The service that we provide overlap with those provided by our partners	200	1	5	3.00	.990
Valid N (list wise)	200				

Table 3.8: Definition of responsibilities of GBV service providers

1.10. Sameness of referral pathway of GBV involving physical harm and GVBnot involving physical harm

The components D1 of research instrument was made up questions related to the extent to which GBV officers and other people who have to deal with GVB cases are satisfied with the quality service they deliver to GBV Victims. These questions were asked in order to pinpoint the gaps reflected in the process of solving GBV issues. With respect to question asked about whether some cases are reported late or never reported due the culture of silence, there was a very high mean of 4.70, with a 6.475 (SD). Which means that a number of the respondents do agree with the statement, but there is a great variability in their responses regarding the extent to which the culture contribute to a delayed report as the standard deviation is wider (6.475). There may be other factors contributing to the delayed report along with the cultural barriers. As to professionalism required of the staff in charge of handling GBV issues, the mean score of 2.35 with a 0.883 (SD), which indicates that those people surveyed were from different professions and thus correspond well with GBV required expertise. It implies that the majority of them agree that the do have enough expertise.

Regarding the complexity of the referral system, the mean was 2.42 with a 0.969 (SD). It can therefore be concluded that the referral system is complex as far as standard deviation remain small despite of low mean. Furthermore, it can be argued that there may be lacking evidence of violence as result of a delay report and complexity of referral system as the mean score was 2.80 with a

1.022 (SD). As to question asked about the available means to solve GBV issues, the mean was 2.80 with a 1.022 (SD), which maybe one factor making the system complex. However, it is not the major factor as the distance between mean and standard deviation is somewhat long. With regards to the question whether victims are informed of their right and

responsibilities to report

GBV incidence, the research found that most of them are not aware as the mean was 3.89 with a 0.947 (SD). Majority of them do agree that victims do not know their rights and responsibilit ie s. Furthermore, research revealed that some victims are not aware of the violence committed to them particularly when are those not involving physical harm as the mean score on this item was 3.82 with a 0.544 (SD). As to customers who do not follow up with the person or institutions to which they are referred, the mean on this point was 3.63 with a 1.018 (SD), which is an indicator that they are some victims who do stop the process in half way. En the end, the study revealed that in charge of GBV issues solving do not monitor victims to check if they have received justice as the mean was 3.75 with a 0.899 (SD). The table 3.9 below indicates the gaps related to GBV issues in solving process.

Descriptive Statistics

D1. Sameness of referral pathway involving physical harm and the one not involving physical harm	N	Min	Max	Mean	SD
D1.1. Cases are reported late due to culture of silence other not	200	1	44	4.70	6.475
D1.2. I do not have enough expertise to deal with cases of gender	200	1	4	2.35	.883
D1.3. Referral system is too wide and complex	200	1	5	2.42	.969
D1.4. Cases lack evidences due to reporting delay and complex	200	1	5	2.80	1.022
D1.5. I do not have enough means to address issue immediately	200	1	5	3.09	1.166
D1.6. Victims seem to be not informed of their right and responsibilities	200	2	5	3.89	.947
D1.7. Victims are not aware of GBV violence committed against	200	2	5	3.82	.544
D1.8. Some customers are referred to other partners and don't go there	200	2	5	3.63	1.018
D1.8. I do monitor victims to check out if they have received justice	200	1	5	3.75	.899
Valid N (list wise)	200				

Table 3.9: Comparison of pathways of GBV not involving physical harm and GBV notinvolving physical harm

1.11. Gaps in Gender-Based Violence Issues Solving

The component D2 of the research instrument was intended to evaluate the quality service satisfaction of the staff in charge of GBV issues solving across various institutions. As to question whether they are satisfied with the quality service they deliver to the victims, the mean score was

3.56 with a 0.812 (SD) which is evidence that they are to some extent satisfied but not much. As to question asked if some improvements are needed, there was a high mean score of 4.01 with a 0.856 (SD). This implies that they feel the gap in the service they deliver to the GBV victims. That gap may be related to the lack of means as highlighted and expertise for some staff. Finally, it was revealed that the staff in charge of GBV issues a need support from their employing institutions as the mean was very high 4.14, with a low value of standard deviation 0.518, which is an evidence of common understanding about the need of support. The **table 3.10** below indicates the level of satisfaction of GBV staff with the quality of service they provide to GVB victims.

Descriptive Statistics

D2 **GBV staff quality service satisfaction**	N	Min	Max	Mean	SD
I am satisfied with the quality of service I do provide to the clients	200	1	5	3.56	.812
Some improvement is needed to quality service to our clients	200	2	5	4.01	.856
I do my best to meet my clients; need but I need support	200	2	5	4.14	.518
Valid N (list wise)	200				

Table 3.10. GBV Staff quality service satisfaction

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

4.1. Conclusions

This study aimed at mapping out GBV service providers and establishes GBV victims' referral system path-way from community to the national level. Along with the general objectives, the study sought to map out GBV service providers, assessing the efficiency of the existing referral path-way involving, proposing the desired pathway as emerged from the data, assessing the clarity of responsibilities and competences of the staff assigned to deal with GBV issues across differe nt organizations, and identifying gaps in GBV issues solving process and suggest solutions. While assessing the efficiency of the existing referral pathway, the researcher focused on two types of GBV—violence involving physical harm and the violence not involving physical harm in order to find out whether the participants already know the existing structure, and secondly assess if those two referral pathways should be the same or different. In relation to that, the study found participants do not know precisely the existing referral pathway pertaining to violence involving no physical harm as the statistical results mean was 2.77 with a 1.259 standard deviation. Regard the question asked if the path-way used for violence involving physical harm and the one not involving physical harm would be the same; the mean score of 4.15 and a 0.742 (SD) indicate that they are alike. It is with that regard that the result of the research indicated that the referral pathway steps should begin with protective care, police/ant GBV, hospital/health center, social service providers, and the court. As to clarity of responsibilities, the study found that the existing referral pathway is complex as indicated by a mean score of 2.42 and a 0.969 (SD). Furthermore, the study found that there existing gaps such as lack of means that would help staff in charge of GBV to deal with that case, their responsibilities are overlapping and some do not have enough expertise to solve the GBV cases.

Recommendation

To the Government—Ministry of Gender and Family

1. There might be a campaign to raise the awareness of the population as it was revealed that some cases are not reported or reported late due the culture of silence as it is evidence by a high mean of 4.70, with a 6.475 (SD).
2. Government should synchronize responsibilities of all organs in charge of GBV cases as the studies indicated that there is an overlap of responsibilities whereby the mean was 2.42 and a 0.969 (SD).
3. The study findings revealed that the existing structure is not well known by the grassroots population; therefore, there is a need to organize on regular basis awareness campaign so that the population may be aware of it as it is evidenced by a low earned a low mean of 2.77 with a 1.259 (SD).

To the Civil societies

1. It was found out that the victims do not have a common understanding about the way to go by whenever they want to seek for help pertaining to violence not involving physical harm, it is therefore recommended raise their awareness on different ways and means to use when they seek assistance in line with violence not involving physical harm

2. The research revealed that GBV service providers are limited in comparison of what is needed to deliver therefore there is a need to engage and sensitize all relevant stakeholders through an expanded stakeholder advocacy meetings involving state officials, selected service providers, community heads, police, legal officers, community leaders, CSOs, CBOs and FBOs, and the population at grassroots level etc so that they may be involved and work hand in hand for fighting against GBV.

3. It was found out that the staff in charge of GBV issues across organizations need the assistance both in terms of materials and training to enhance their efficiency, therefore, it

is recommended to put much emphasize on building their capacity so that they may delivereffectively their services

4. Finally, the population must be sensitized that any reported GBV cases must be followed up the end point where the final decision and justice is delivered rather than stopping the follow up in a half way.

References

Rwanda, U. N. I. F. E. M. (2008). Baseline survey on sexual and gender based violence in Rwanda. *Kigali: UNIFEM*.

Cluster, G. P., & AoR, G. B. V. (2010). Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings. *Gender-based Violence Area of Responsibility Working Group*.

Newman, C. J., De Vries, D. H., Kanakuze, J. D. A., & Ngendahimana, G. (2011). Workplace violence and gender discrimination in Rwanda's health workforce: Increasing safety and gender equality. *Human Resources for Health*, *9*(1), 19.

REPUBLIC OF *RWANDA*. *MINISTRY* OF *GENDER* AND *FAMILY PROMOTION*.
National Strategic Plan for *Fighting Against Gender-based Violence*. 2011-2016.

REPUBLIC OF *RWANDA*. *MINISTRY* OF *GENDER* AND *FAMILY PROMOTION*.
National Policy against Gender-Based Violence. July 2011...

USAID and MCSP (2017). Gender-Based Violence (*GBV*) *Rapid Assessment* and *Service Mapping Report* for *MCSP-supported Facilities* in *Kogi* and *Ebonyi States*, *Nigeria*

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Steven, E., & Salvatory, A. (2013). Help-seeking pathways and barriers for survivors of gender-based violence in Tanzania: Results from a study in Dar es Salaam, Mbeya, and Iringa Regions. *Dar es Salaam, Tanzania: Engender Health/Champion*.

Challenging Gender-based Violence Worldwide: *CARE's Program Evidence* - Strategies, Results, and Impacts of Evaluations 2011-2013.

Twesigye-Bakwatsa, C. (2010). Baseline analysis of the gender dimensions in the provision of agricultural services in Rwanda. *Kigali: Gender Monitoring Office and UNIFEM*.

Feasibility and acceptability of gender-based violence screening: primary health facilities in humanitarian settings: Findings from implementation among refugees in Dadaab, Kenya, Retrieved on 15/12/2018 from https://www.rescue.org/sites/defaults/files.

STATUS of GBV CASES PROSECUTED: Challenges and Strategies: Gender based violence prosecution: Presented by HABYARIMANA Angélique Inspector at the NPPA, retrieved on 1/12/2018 from : https:www. nppw. Gov.rw. fileadmin/template.

Murray, S., & Achieng, A. (2011). Gender based violence assessment Hagadera refugee camp Dadaab, Kenya.

Leone, S. (2001). Ministry of Social Welfare, Gender and Children's Affairs. *NationalPolicy on the Advancement of Women*.

Adhiambo, o. a. (2017). Effects of community policing in addressing sexual and genderbased violence in kenya: a case study of kibera slum in nairobi.

Al-Tuwaijri, S., & Saadat, S. (2018). Gender Based Violence in Fragile, Conflict, andViolence Situations.

Watts, C., & Zimmerman, C. (2002). Violence against women: global scope andmagnitude. *The lancet*, *359*(9313), 1232-1237.

Joyner, R. L., Rouse, W. A., & Glatthorn, A. A. (2018). *Writing the winning thesis ordissertation: A step-by-step guide*. Corwin Press.

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among fiveapproaches. *Health promotion practice*, *16*(4), 473-475.

Kothari, C. R. (2004). *Research methodology: Methods and techniques*. New AgeInternational.

Fraenkel, J. R., Wallen, N. E., & Hyun, H. H. (2011). *How to design and evaluate researchin education*. New York: McGraw-Hill Humanities/Social Sciences/Languages.

Appendix I. Data collection questionnaire

To Map out GBV service providers and Assess GBV victims referral system pathway fromcommunity to the national level

Section A Demographics

Kindly fill in the information about yourself by ticking the box that applies to you

1. Gender : ☐ Male ☐ Female
2. Actual age----------
3. Educational level : ☐ Primary ☐ High School ☐ Bachelor ☐ Master ☐ Doctorate
4. Profession: ……..
5. Number of years in services related to Gender based violence

Section B: Information related to research objectives and questions

Please read the following statements carefully and tick the relevant number that best represents your perceptions of each statement based on the scale provided. This section is about Gender based violence service providers perceptions about:

1. The desired structure of referrals for different services, identification of peoples' responsibilities, paths for handling GBV issues, cycle and tools (Forms from the village upto national level with reference to HAGURUKA NGO intervention zones in 5 districts)
2. Identification of the gaps, and overlaps for better programming through the creation of database showing the geographical locations of services, linkages to the referral system
3. A comprehensive assessment of GBV victim referral Pathway within the community in supporting District.
4. Identify and describe necessary steps for GBV Victim's referral pathway in place and how everyone is involved. (Community to national level.

This scale ranges from **1**=strongly Disagree (**SD**), **2**= Disagree (**D**), **3**= Neither agree nor disagree (**NA**), **4** = Agree (**A**), **5**= Strongly agree (**SA**).

B1	**GBV Referral pathway (organs and institutions)**	SD	D	NA	A	SA
With reference to referral path-ways for women/children victims of Gender Based Violence issues treatment, I do agree that the concerned agencies/institutions and organizations might be ranked as follow:						
1	A GBV victim should first ask a help from **Hospital / Health center** service providers	1	2	3	4	5
2	A GBV victim should first ask a help from **Police Anti GBV** service providers	1	2	3	4	5
3	A GBV victim should first ask a help from **Court** service providers	1	2	3	4	5
4	A GBV victim should first ask a help from **Protective Care** such as HealthCommunity Counselors (abajyanama b'Ubuzima), or educationists	1	2	3	4	5
5	A GBV victim should first ask a help from **Social services** (NGOs, Line Ministries,local councils, Children's Commission)	1	2	3	4	5
6	Hospitals/health centers and **Police Anti GBV Unit** should refer the victim to each other	1	2	3	4	5
7	**Policy Anti GBV Unit** should refer the GBV victim to the protective care/ home/community/others before he/she is referred to **Hospitals/health centers**	1	2	3	4	5
8	Hospitals/health centers should refer the victim to **Police Anti GBV Unit** before he/she is referred to **community/others**	1	2	3	4	5
9	The existing structure is known by the grassroots population	1	2	3	4	5
10	I personally understand very well this referral structure	1	2	3	4	5
11	The existing structure is known, however it is not efficient	1	2	3	4	5
B2	**Referral path-way not involving physical intrusion of wounding**					
With reference to referral path ways for women/children victims of domestic violence not involving physical intrusion or wounding (forced/child marriage, fondling, indecent assault, child labor, child trafficking, I do agree that the concerned agencies/institutions and organizations might be ranked as follow:						
1	Women/children victims of domestic violence not involving physical intrusion or wounding (forced/child marriage, fondling, indecent assault, child labor, child trafficking should first ask a help from Community/Children/Women Anti GBV Organ	1	2	3	4	5
2	Women/children victims of domestic violence not involving physical intrusion or wounding (forced/child marriage, fondling, indecent assault, child labor, child trafficking should first ask a help from Community/Children/Women Anti GBV Organ	1	2	3	4	5

3	Victims of domestic violence not involving physical intrusion or wounding (forced/marriage, fondling, indecent assault, child labor, child trafficking should first beg a help from **Social services** (NGOs, line Minister,Community/Children/Women Anti GBV Organ).	1	2	3	4	5

4	Community/Children/Women Anti GBV Unit refer the victim to **Social services** NGOs, Line Ministries, local councils, CWCs before he/she is refereed to PolicyAnti GBV Unit	1	2	3	4	5
5	CWS refer the victim to **policy FSU** before he/she is referred to **social services** **(**NGOs, Line Ministries, local councils, Community/Children/Women Anti GBVOrgan	1	2	3	4	5
6	**CWC and Social services (**NGOs, Line Ministries, local councils, Community/Children/Women Anti GBV Organ) refer the victim to one anotherbefore he/she is referred to any other institution	1	2	3	4	5
7	**CWCs refer the victims to Protective Care (**Home/community/other)before she/she is being referred to any other institution/agency or organization	1	2	3	4	5
8	**Community/Children/Women Anti GBV Unit and policy Anti GBV Unit** refer the victim to each other and at the same time refer him/her **for ProtectiveCare**	1	2	3	4	5
9	**Policy Anti GBV Unit** simultaneously refers the victim **to Community/Children/Women Anti GBV Organs, Court** for **Protective Care**	1	2	3	4	5
10	**Protective Care** (Home/community/other) only refers all the victims sent byvarious institutions and refers them to **Social services (**NGOs, Line Ministries, local councils, CWCs)	1	2	3	4	5
11	The grassroots population understands well the GBV Victim referral pathway structure and its functionality	1	2	3	4	5
12	I understand well the GBV Victim referral pathway structure and its functionality	1	2	3	4	5
13	I the GBV Victim referral pathway structure and its functionality, however it is not efficient	1	2	3	4	5
14	The structure of handling violence not involving physical harm should be the sameas the one implying sexual and domestic violence	1	2	3	4	5
C1	**About responsibilities of each institution within the GBV referral pathway**					
1	Responsibilities for institutions within the GBV Referral pathway are well defined, and are in pattern with their area of expertise (For example, are the medical care providers aware of the regal implications? Are they aware of how they must keep/collect the evidences during their action?)	1	2	3	4	5
2	All institutions within the GBV Referral pathway understand well their responsibilities,and these responsibilities are in pattern with their area of expertise.	1	2	3	4	5
3	Clients are aware of the service they expect to get from every institutions within the GBV Referral pathway	1	2	3	4	5

4	Responsibilities and services that are provide are limited in comparison of what is needed by GBV Victims	1	2	3	4	5
5	The services that are provided overlap with those provided by other partners	1	2	3	4	5

6	Responsibilities of each partner in relation with GBV are confusing to both providers and clients	1	2	3	4	5
D1	**Respondents' perceptions about the gaps related to how gender-based violence issues are handled**					
1	Cases are reported late due to culture of silence and some are not reported	1	2	3	4	5
2	I do not have enough expertise to deal with cases of gender violence	1	2	3	4	5
3	The referral systems is too wide and complex	1	2	3	4	5
4	Some cases lack the evidences due to a reporting delay and a complex referral system	1	2	3	4	5
5	I do not have enough means—financial, and equipment to address the issue immediately	1	2	3	4	5
6	Some victims seem to be not informed of their rights and the responsibilities of different institutions within the GBV Referral pathway	1	2	3	4	5
7	Some victims are not aware of gender violence committed against them and come to beg for service too late	1	2	3	4	5
8	Some customers are referred to other partners and do not go there	1	2	3	4	5
9	I do monitor victims to check out if they have received justice	1	2	3	4	5
6	Gender-based violence partners responsibilities are overlapping	1	2	3	4	5
D2	**The extent to which GBV are satisfied with the quality of service they provide**					
1	I am satisfied with the quality of service I do provide with the customers	1	2	3	4	5
2	Some improvements are needed to provide quality service to our customers	1	2	3	4	5
3	I do my best to meet my customers' needs, however I need a support from my institution	1	2	3	4	5

Thank you for taking part of this study