CARE International in Rwanda

Sexual and Gender-Based Violence Advocacy Strategy 2009 - 2013

[Acronyms and Executive Summary]

1. Introduction

Advocacy is a technique used to influence for change. It is a deliberate action taken to influence a decision-maker with the aim of changing a certain law/policy or structure.

1.1 Organisational Context

CARE International in Rwanda's mission is to work alongside communities to enable them to overcome underlying and specific causes of poverty, achieve positive lasting change and live with dignity. CARE emphasizes women, who make up at least 70% of its impact group.

The ISARO program of CARE in Rwanda builds on the POWER[1] project and aims to achieve gender equality through the promotion of women's social, economic, and political rights. ISARO is mainly funded by Norad via CARE Norway. The Great Lakes Advocacy Initiative (GLAI) and Public Policy Information Monitoring and Advocacy (PPIMA) project are two components of ISARO funded by CARE International-UK and Norwegian People's Aid (NPA), respectively.

The ISARO program mainly targets the poor and marginalized women already enrolled in existing VS&L (Voluntary Savings and Loans) groups, and who were selected based on participatory vulnerability assessments conducted at community level; as well as other vulnerable people, mostly women, who are not VSL members. These women include the following: particularly poor women (belonging to the poorest categories according to the Government of Rwanda's classification)[2]; women who are heads of households and who are caretakers for Orphans and Vulnerable Children (OVC); women living with HIV; and women who are part of the historically marginalized population in Rwanda (the Batwa). ISARO also serves as the anchor project for the implementation of the PPIMA project led by Norwegian People's Aid (NPA) and GLAI.

The PPIMA project is a civil society strengthening initiative aimed at promoting active and effective citizen participation in Rwanda's national processes of policy formulation, implementation and management. The goal of this project is that "Rwandan government policies, plans and budgets at national and local levels are pro-poor and are utilized effectively to reduce poverty and improve wellbeing for the poor in Rwanda." The project will work through the local implementing partners of the ISARO program for community-level monitoring

[1] POWER project (Promoting opportunities for women empowerment In Rwanda) started in January 2006 with the main purpose of improving access the of 30,000 extremely poor people, 80% of whom are women, to sustainable socio-economic opportunities and participation in decision-making processes at household and community levels. The POWER project ended in 2008.

[2] According to the National Integrated Living Conditions Survey 2005/6 poverty among female and widow headed households are higher than average.

and reporting on the delivery of public services. The PPIMA project will also work to empower communities, particularly women, through civic education.

GLAI is a regional initiative composed of three CARE country offices (CARE-Rwanda; CARE-Burundi; and CARE-Uganda). The initiative is aimed at contributing to the implementation of international humanitarian and human rights standards that protect the rights of women and girls in post-conflict and conflict situations, as set forth in UNSCR 1325 and the complementary UNSCR 1820. The initiative includes GBV advocacy activities implemented within ISARO, as well as national, regional, and international level advocacy around GBV.

The inclusion of PPIMA and GLAI in the ISARO program serve to complement the GBV prevention efforts of ISARO by contributing targeted strategies around GBV response, governance, and grassroots advocacy.

1.2 Legitimacy in taking the advocacy approach

CARE Rwanda is well placed to undertake advocacy on GBV issues. In 2009, we celebrated our 25th anniversary of work in Rwanda, and we have a strong record of programming in women's empowerment and tackling GBV. CARE Rwanda's revised Long Range Strategic Plan (LRSP) for 2008-2015 identifies gender inequality as a root cause of poverty. In the plan, CARE Rwanda commits itself as an organisation to prioritising relationship-building with government and local authorities for influencing meaningful change, seeking women's participation in decision-making bodies, and raising awareness of women's and girl's rights. The GoR has created a space for CSOs to participate in Rwandan society in just this way through the Vision 2020 Umurenge. Since extremely poor women and girls are the target impact group identified by the LRSP process, CARE Rwanda has also pledged to tackle the socio-cultural barriers contributing to women's social vulnerability and marginalization, including the harmonisation of GBV awareness across programs.

While all of CARE-Rwanda's programs focus on women's empowerment and capacity building, there are currently 5 projects addressing the issues of GBV and women's rights, which are ISARO, GLAI, PPIMA, CAVA and Higa Ubeho. These projects can all serve as strategic platforms for collecting evidence from the grassroots level and communicating it to the national level for policy change. CARE Rwanda is also driven towards GBV advocacy as a strategy for achieving women's empowerment and gender equity as a result of information already gathered from community members, local partners, and victims of GBV; through our ongoing work with local communities, partners and authorities, some key issues around national GBV prevention and response have already been identified as areas requiring focused advocacy. [Linkage between GoR and CARE Rwanda?]

For example, GLAI Rwanda has established a local structure of case managers in each sector of the six districts where GLAI operates. The case managers provide immediate support to victims of GBV, through basic counseling, referrals, home visits, and follow ups. Case managers also

collect evidence from the victims of GBV, which is analyzed quarterly to identify trends and gaps and are incorporated into the advocacy strategy.

Additionally, being a member of the multi-country Great Lakes Advocacy Initiative (GLAI), which focuses on GBV issues throughout the Great Lakes region, provides the opportunity for additional funding and expertise as well as the possibility of influencing international policy.

1.3 Advocacy capacity in CARE Rwanda

It should be noted that advocacy is a relatively new approach for CARE Rwanda, and as such internal capacity is not fully developed. Furthermore, the context of Rwanda, whilst sharing some commonalities with neighbouring countries, has a specific political context in which civil society should not challenge government but work with the existing political agenda; such a context needs to be fully considered in defining an advocacy platform, choosing activists, and identifying the target audience. Progress in advocacy will necessarily start small, as we develop our advocacy credibility and confidence, through considered interventions.

1.4 How this strategy was developed

This strategy was developed through a series of consultations, policy and law analysis, desk reviews and consultative meetings with GBV service providers (such as the police, community activists) and duty bearers (local authorities) to identify the socio-cultural factors that contribute to GBV in Rwanda, to identify potential barriers/challenges to the implementation of the new national law on the prevention and punishment of GBV crimes, and to identify potential areas for GBV advocacy by CARE-Rwanda. The research and focus groups culminated in a three day workshop in August 2010 involving CARE staff and partners. Input and feedback has been incorporated from GLAI case managers; CARE Rwanda programme staff including from GLAI, PPIMA, and ISARO; partner organisations including COPORWA, ADENYA, UNIFEM, Action Aid, FACT and Rwanda Women's Network; and advocacy staff from CARE Burundi, CARE Uganda, and CARE UK.

It is a working document and will be reviewed and developed as CARE Rwanda's advocacy capacity, research, and evidence base develops.

1.5 Roles and responsibilities

CARE Rwanda's Policy and Advocacy Manager (GLAI focal person) and Gender Mainstreaming Specialist are responsible for coordinating finalization of the strategy, with strategic guidance of the Assistant Country Director Programmes, which will include the utilisation of the internal Gender Task Force as a mechanism for finalization and sharing of the strategy. Monitoring the implementation of the advocacy strategy will primarily be the responsibility of the Policy and Advocacy Manager, who will work together with staff in the ISARO program, including PPIMA, and the Higa Ubeho project to collect and track data on the implementation of the strategy and to report on its successes and challenges.

1.6 A note on terminology – Victim or Survivor?

In the context of Rwanda, when we use the term 'survivor' we usually mean in the context of the 1994 genocide. Grassroots activists make the distinction of GBV by referring to people who have experienced GBV as 'victims'. After internal and external consultation and discussion, CARE Rwanda has decided to use the term 'victim'.

1.7 The context of GBV in Rwanda

Rwanda has an enabling environment at the political level compared to other countries, and is highly ranked as a country that has made great efforts to address gender inequality. The current government of Rwanda has ratified international and regional conventions and put into place national laws and strategies to address gender and other forms of inequality. Amongst others, the government of Rwanda ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1981, and the International Conference of Population and Development (ICPD) in 1994.

On the national front, the GoR has passed various laws and policies for the protection and promotion of women's Human Rights including: the national Gender law; the national gender policy; the national GBV law for the prevention and punishment of GBV; and the national policy on violence against women and children.

The Rwandan Constitution (June 4th, 2003) promotes gender equity and guarantees 30% representation of women in all government institutions from the highest to the lowest leadership positions. Currently the proportion of women in the national parliament is the highest in the world, at 56%.

Notwithstanding women's political progress in Rwanda, there remains grave levels of gender-based violence. Rwanda society, like others, is characterised by a patriarchal social structure that underlies the unequal social power relations between men and women, boys and girls. This has translated into men's dominance, and women's subordination and economic dependence on them. Gender inequalities are not seen as unjust, but as part of respected social norms.

There is a general lack of reliable data on GBV in Rwanda, but recent studies[3] have highlighted the following:

- 31% of women have experienced physical violence since the age of 15
- 37% of married women experienced domestic violence
- Domestic violence among married women increased with number of children: 22% for women with no children vs. 38% for women with at least 5
- 31% of married women reported having forced intercourse with their husbands
- 36% of women reported being forbidden by their husbands to speak to other men
- 37% of women reported that they were forced to tell their husbands where they had been and with whom

[3] 2005 Demographic Health Survey, Baseline Survey on Sexual and Gender-Based Violence in Rwanda'—UNIFEM (2008)

- 33% of women were forbidden access, by their husbands, to the household income to meet basic household needs
- 12.3% of women stated that their husbands attacked their children or separated the children from them
- Amongst victims of GBV, only 16% had consulted a lawyer, 10% had consulted a physician, and 18% had reported the case to the police
- 39% of victims reported suffering psychological trauma requiring professional assistance

2. The strategy

2.1 Vision, Goal and Objectives

Vision

CARE has a vision of Rwanda where women and girls live in freedom from gender-based violence.

Goal

Reduction in women's and girls' vulnerability to GBV through the protection of their basic rights and the improvement of policies and legal frameworks.

Domains of change

1. Improved access, availability and quality of services for GBV victims.
2. Existence of a functional legal system that protects vulnerable women and girls from GBV at all levels.
3. Active coalition of civil society actors at national and regional levels that advocate for the prevention of and response to GBV.

Impact groups

Through consultation with representatives of two community partners (COPORWA and ADENYA), and building on the experience of the 72 case managers who work directly with victims in communities, the two impact groups have been defined as:

- Vulnerable women – including married women, 'illegally' married women, and historically marginalised women.

- Girls – including adolescent girls, girls from birth to 12 years, and girls living in step families.

Rationale for Domains and Impact Groups

2.2 Key objectives

It is recommended that the strategy take place in two stages – the first stage (Domain of Change 1) will begin at local level, with GLAI activists playing a key role, and centre around the improvement of services. Building on this, and after investing in the capacity of staff, in building relationships, and in developing the network of GBV service providers, the advocacy will expand to include Domain 2, to be carried out at national level through the influencing of legislation and policy development and their implementation. GLAI will actively seek to establish a network of civil society organisations involved in GBV advocacy (Domain 3) concurrently with both stages of the strategy as a support to the activities in Domains 1 and 2.

Domain of change (1): Accessibility, Availability and Quality of Services

Advocate for a measurable and enduring improvement in the availability, accessibility and quality of frontline services for victims of GBV, to include:

- Improved capacity of police to respond to GBV victims including the following:
  - Increased geographic distribution of Police or other police structures such as 'community policing' structure
  - Improved technical capacity of Police officers, despite frequent transfers, to respond to and handle cases of GBV (including documentation, interrogation, psychosocial support, follow up, gender-sensitivity, confidentiality, willingness to collaborate, knowledge of laws and how to apply them, and appropriate referral techniques; availability of gender desks in all police stations.)
- Increased access of victims to effective legal services for case registration and court representation including the following:
  - Increased availability of free legal services for victims, such as free representation
  - Improved technical capacity of existing legal services established by government (including improvements in their understanding and implementation of the laws and in providing legal guidance to victims).
- Health centres that are better equipped (human, material, and technological) to respond to the needs of victims including the following:
  - Advocating for health centres at sector level to be able to respond to and treat all cases of GBV such that this technical capacity (medical, psychosocial, etc., but also staff knowledge as to how to orient the victim in terms of reporting, evidence collection, existence of a GBV desk, etc.) is not restricted to hospitals located at the district level which is much further away
- Increased government resources allocated to GBV response including the following:
  - Advocacy at the national level of the GoR to increase its allocation of funds to national gender response, e.g. investing money into services, including temporary shelters for victims providing clothing and food, using evidence collected by the PPIMA project through community score cards and the monitoring of government expenditures.
  - Availability of financial services for GBV victims (including availability of financial support for victims to access medical care, medication, legal services, and to register their case)

- Reduced impunity through the following:
  - Review of cultural and legal barriers to justice (including victim refusal to report; lack of coordinated response to perpetrator flight; corruption of local authorities, police, and courts; incomplete linkages between service providers, e.g. police and health centres; lack of qualified personnel to handle GBV cases; frequent transfers of trained service providers; lack of an independent justice system; incomplete enforcement of the existing laws and court decisions by local authorities, police, and courts; and other cultural and historical impediments to justice and vulnerabilities to violence at the community and government levels. Poverty also contributes to impunity by making services, including legal services inaccessible.)
  - Advocacy around the identified causes of impunity.
  - Support for current attempts to develop performance contracts for local civil servants, such as police officers, recognized by the government, which include indicators for GBV.

Rationale:

During the advocacy development process, the local authorities and activists acknowledged that the new GBV law represents a tremendous step in terms of the punishment of GBV in Rwanda, but several challenges as far as the practical implementation of the law were also noted. Many victims of GBV in Rwanda 'suffer in silence' and do not have access to basic frontline services such as adequate healthcare, counselling, police, and justice systems. According to the GLAI Rwanda baseline study, only 19% of the volunteer GBV Case Managers who were surveyed feel services meet most of the needs of the GBV victims. The barriers to these services are based around three major factors – availability, accessibility and quality.

Availability – There is an overall lack of local services for victims of GBV in Rwanda. The distribution of health centres and hospitals is inadequate, often meaning victims have to walk for several hours to receive medical attention. For example, in GLAI Rwanda's baseline study, only 40% of surveyed Case Managers report that health facilities offer specialised services for the care of child victims, and only 69% stated that health facilities supply necessary HIV medicines, such as PEP kits. In general, only 59% of respondents felt that health facilities had adequate equipment and supplies for treating and managing GBV cases. 31% indicated that local police do not have enough staff to handle GBV cases, and only 31% of Case Managers felt police had adequate logistics to follow up on a case. Community members report that the GBV focal point in the local police force is often forced to work over a very wide area and is thus often simply unavailable when needed by victims [needs more info on legal access]. What is more, 75% of GLAI Case Managers are currently providing food, clothes, and shelter to victims, since these are unavailable through public services.

Accessibility – Financial barriers to accessing services mean that many women are simply unable to seek medical care, or report the attack to the police, much less follow a judicial procedure through the courts. First, women's financial dependence on their husbands or partners (often the perpetrators of GBV) renders them unwilling or unable to report the attack. Second, seeking medical help and reporting a crime to police can take many hours or days, and

women do not have the resources to pay for transport, accommodation, or medical fees, and furthermore cannot afford to take time away from productive work in order to access services. In particular, historically marginalised people, who are most likely to live in extreme poverty, are often furthest from services and face particular challenges in access.

Corruption, particularly within the police force and among local authorities, can also prevent a case from being pursued. CARE community case managers report that if the perpetrator is well known in the community, victims are discouraged from pursuing a case. Reports of lost documents and long delays in cases being transferred to court are common. Case managers also report difficulty accessing the police at night when victims most often seek assistance.

Quality – Even when GBV victims overcome the barriers of availability and access, the quality of the services they receive is inadequate to meet their needs. Response mechanisms are slow and ineffective. It is widely reported among victims that police officers do not have the level of training to deal sensitively and appropriately with women who are reporting GBV, and that local authorities do not have adequate understanding of GBV law to implement it properly. In the baseline study, only 31% of surveyed case managers indicated that police had adequate resources to follow up on GBV cases. 40% of respondents did not report confidence that local government staff possess sufficient capacity, defined as a set of skills, necessary to respond to GBV cases. Health centre staff also do not have the training or equipment to meet the needs of victims at sector level, so they are often referred to the hospital located at the higher district level, which adds an extra journey of several hours to the ordeal of most victims.

A high turnover of staff in all local services, with staff often transferred to other posts with no notice, means that following up on cases is often almost impossible. Impunity, perpetrators found not guilty, or the release or escape of prisoners, presents a further challenge. When perpetrators are not brought to justice it leads to a lack of deterrent for other potential perpetrators, and also the re-insertion of the perpetrator into the same home as the victim, thus perpetuating the cycle of violence.
Without equitable access to available, good quality frontline services, GBV victims are unable to rebuild their lives.

Key interventions:

The following is not an exhaustive list, rather a set of guidelines for advocacy interventions, which can be adapted as the advocacy campaign progresses.

CARE Rwanda will work with identified partner organisations and local activists to campaign for improved access, availability, and quality of services. This will mainly be based at a local level and will include:

- Expanding the network of Case Managers across 6 districts/77 sectors from 69 to 154, by August 2011.
- Identifying and training 12 grassroots activists across 6 districts.

- Training Case Managers on GBV case management.
- Training activists in GBV advocacy skills and community mobilization
- Building and facilitating a Community Activism Forum for local activists (see Section 3 – Implementing the Strategy for further details)
- Introducing activists to key actors in local authorities
- Supporting activists to build links with local CSOs and actors in GBV prevention and services.
- Engaging media as key partners on dissemination of information on GBV and advocacy efforts.
- Development of a GBV services referral system.
- Development of a community-based GBV response system building on anti-GBV committees.

When the Case Managers have received training, and are in receipt of ongoing necessary support, they will:

- Analyze data
- Collect data on GBV
- Orient GBV victims to available medical, legal, and financial services
- Provide basic psychosocial counseling to GBV victims
- Do conflict mediation

When the grassroots activists have received training, and are in receipt of ongoing necessary support, they will:

- Identify with communities and Case Managers trends of GBV in local area
- Monitor issues
- Build relationships with local actors
- Communicate evidence to leaders at village, cell, sector and district level
- Participate in and influence community and sector-level meetings
- Influence agendas of strategic local meetings
- Mobilize communities in support of the advocacy aims
- Facilitate dialogues at community level with officials
- Lobby local representatives
- Provide a link between communities and decision makers
- Undertake representation at higher level where appropriate; this could include national and international levels.

Through carrying out the above roles, activists will become known as a key figure in the community in the response to GBV.

Key Actions:

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This will be the basis for a more focused strategy specifically for GLAI on our advocacy goals.

The GLAI project in Rwanda will contribute the following actions to the achievement of CARE in Rwanda's goals in Domain of Change (1): Services.

1. Sensitization of community members, including victims, perpetrators, and local leaders, by Case Managers and Grassroots Activists to GBV laws; the rights of women and girls; and the forms of GBV including sexual, physical, psychological, and economic.
2. Capacity Building of local anti-GBV structures, including the training of CSOs, CNF representatives, local authorities, anti-GBV committees, service providers, and other strategic structures.

Expected Outcome:

GLAI Rwanda's key actions will result in an increased knowledge, understanding, and implementation of the rights of women and girls and of GBV laws among victims, community members, local leaders, CSOs, service providers and other local structures.

Domain of change (2): Improved legal framework

Advocate for a functional legal system and policies that protect vulnerable women and girls from GBV at all levels. This will be achieved through:

- The implementation of article 10 of the national GBV law (Preventing Violence and catering to the victims of GBV), including:
  - The establishment of a ministerial order, which is necessary for the support of GBV victims to provided as it is stipulated in article 10.
  - Victims of violence against women should benefit from a permanent program of support and assistance to alleviate the suffering and the consequences resulting from the violence suffered by female victims of GBV. The government must put in place financial and material resources for their care and social reintegration.
- A sound, gender-sensitive policy to accompany the law and ensure its meaningful implementation, including the following:
  - All forms of GBV should be clearly specified and identified in the law/policy to avoid being vulnerable to arbitrary interpretation (Policy Analysis (PA) 15).
  - The legislature must take into account all the social strata of the population. Legislation must be adapted to the socio-economic needs of all social groups that constitute the population of Rwanda. For example, the rights of historically-marginalized women and girls, such as compensation for denial of the right to landlordship, must be assured (PA 23, 20-1).
  - Some Labour Code provisions must be subject to amendment or be accompanied by measures protecting the rights of women, such as provisions in Article 68, which discriminate against women, and in Article 66, which insufficiently remunerate women during maternity leave (PA 20).

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This enables us to create an M&E plan based on our key actions.

- Texts of laws and policies should be popularized and applied without gender-based discrimination, for example succession law should be applied equally to widows and widowers and to male and female children with regard to the establishment of a Succession Council and the rights of usufruct (PA 23, 10-3).

Rationale

The GoR has adopted a number of international laws and policies around gender equity and the elimination of GBV. These include, but are not limited to, UN security resolution 1325, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and nationally the 1992 family code, the land bill, and the succession law. The Rwandan GBV Law of 2009 demonstrates most strongly the government's commitment to tackling GBV and to promoting gender equality. It is a very welcome step forward, paving the way for a coordinated response to GBV. However, Article 10 paragraph 3 of the law provides that "an order of the Prime Minister would determine the modalities for prevention and response to gender-based violence by the state organs. These methods of prevention and response should include mechanisms for reception, relief, advocacy, care, and assistance to victims…. Although the source of hope, that order has not yet been put in place" (Policy Analysis 14-15).

A year after the GBV law was introduced, CARE's work at the grassroots level with GBV victims demonstrated that the implementation of the law is both piecemeal and inconsistent. Only 53% of GLAI GBV Case Managers felt that the GBV law criminalised all sexual violence, according tot he baseline study. Local authorities do not have a full understanding of the law or how to implement it, and as such women continue to fall victim to GBV in great numbers, and are not able to fully exercise their rights. The recent GLAI baseline study also reveals cultural tensions at the root of implementation issues, indicating that cultural interpretations of GBV among law enforcers, as well as victims and perpetrators, conflict with the formal meaning of the GBV law and lead to impunity and failure to enforce. The study's findings demonstrate challenges to enforcement especially around economic and psychological GBV. For Rwanda's GBV law to reach its full potential in reducing GBV, it needs to be part of a wider policy framework with women at the heart.

Key interventions

Further work needs to be completed to fully analyse existing laws and policies, and hence this list represents simply a list of guidelines for interventions at national level.

- Build relationships with CSOs
- Train local case managers, activists, CSOs, and authorities on specific aspects of GBV law and related policies using IEC and TOTs strategies
- Facilitate a wide network of advocacy actors on GBV, including NGOs, UN structures, university student groups, key allies and interested individuals

- Analyse data from local activists
- Conduct research/policy analysis
- Analyse trends
- Monitor media for coverage of GBV issues
- Provide a link between national decision making bodies and grassroots
- Facilitate creative community-level dialogues between duty bearers (authorities, anti-GBV committees) and rights holders (community members) on legal prevention and response to GBV
- Ensure representation at national level forums
- Communicate evidence to national leaders
- Influence agenda of strategic meetings to include GBV
- Build relationships, especially with MIGEPROF, MINISANTE, MINIJUST
- Organise and participate in campaigns
- Lobby parliamentarians and the Prime Minister for policy on GBV and full implementation of GBV law, including regular training of political and technical staff at every level.

Domain of Change (3): Active coalition of civil society actors

Establish an active coalition of civil society actors at the national and regional levels that advocate for the prevention of and response to GBV. This will be achieved through:

- Building and fostering strategic relationships with government institutions.
- Facilitating a wide network of advocacy actors on GBV
- Communicating grassroots evidence to national leaders and decision-makers
- Participating strategically in national decision-making bodies and/or meetings
- Facilitate connections among a strategic and operational coalition of civil society actors aimed at national and regional advocacy for the prevention of GBV and the protection of GBV victims

Rationale

A study of Rwandan civil society by P. Gready suggests that networks and coalitions of CSOs may be particularly advantageous and effective within the Rwandan political context. An informal structure of local, national, and international groups amplifies the message of the coalition through the significance of numbers while fostering and reinforcing the comparative skills and assets of various members. These complementary advantages includes the position of some member organisations as already embedded in the political process; thus, the network benefits from established relationships and steady means of dialogue with political and government actors.

GLAI's baseline study indicates that there are limited efforts at the national level to build networks and coalitions which support services for GBV victims and sensitisation of communities. No network focused specifically on advocacy for policy change on GBV issues

exists, however. Coordination of services at the grassroots, national, and regional levels is also needed.

Most GLAI Case Managers interviewed for GLAI's baseline study (88%) reported being involved in advocacy for the implementation of laws that address GBV while 65% had participated in advocacy to challenge cultural norms that promote GBV in their communities. However, qualitative evidence indicates a lack of capacity for advocacy and an insufficiently detailed knowledge of advocacy and how to practice it among identified community partners and Case Managers. Inclusion of both local and international NGOs within a national coalition of CSOs allows the opportunity for capacity-building of local CSOs in advocacy skills and knowledge of GBV-related law.

Key Interventions

- Build and foster strategic relationships with government institutions
- Facilitate a wide network of advocacy actors on GBV, including local, national, and regional, including other CARE COs in GLAI project
- Generate a formal coalition, including TORs with each collaborating CSO
- Establish regular meetings to share evidence and plan joint activities
- Collectively communicate grassroots evidence to national leaders and decision-makers
- Participate strategically as a coalition in national and regional decision-making bodies and/or meetings
- Organise and participate in national and regional campaigns

[Campaigns messages – to be developed by activists, early 2012]

3. Implementing the strategy

Key to implementing the strategy is to facilitate a network of activists, to build the internal advocacy of CARE in Rwanda and its local partners, and to carry out sound research to ensure that advocacy is based on evidence. This section lays out some of the steps necessary to build towards success in the advocacy goal.

3.1 Building advocacy capacity in CARE Rwanda

It has been recognised that capacity to carry out advocacy within CARE Rwanda is still limited. Specifically, capacity to carry out policy analysis has been augmented in the form of a consultancy. Existing staff who have an advocacy component to their roles, whether local or national, can build up their capacity through strong networking. This can either be externally by building links with advocacy staff in other NGOs and local partners or through internal CARE International networks, such as the CI-Women Peace and Security network. Staff of the ISARO program will also attend trainings on GBV advocacy, such as with the Kampala-based NGO Raising Voices.

3.2 Developing a network of activists

As described in Section 2 (above), a network of local activists with links to the Case Managers, GBV victims, local communities and authorities will connect to a coalition of local, provincial, and (as experience and capacity builds) national CSOs working at the national and regional level. Appendix 1 shows the structure of the activist network, and the links between local and national level.

Taking into account the specific national context, GLAI Rwanda will choose activists who are living in the community and actively involved in the existing decision-making structures. As the link between community members and decision makers, activists will collect and synthesize data from case managers and community analysis in order to communicate this evidence to service providers, local authorities, and members of community and sector-level meetings. In consultation with strategic partners, GLAI Rwanda has identified representatives from the National Women's Council (CNF) and the National Youth Council (CNJ) as potential grassroots activists. Two activists, one male and one female, will be trained in each of the six districts of Rwanda's Southern Province, for a total of six.

Once MOUs are signed, the 12 activists will be trained on GBV, gender, laws, policies, policy analysis, identifying trends and gaps within the policy and legal framework, lobbying and advocacy and data collection. For effective exchange of ideas, experiences and information, a network for activists will be created and with facilitation and support from CARE, members will meet regularly (quarterly) to exchange experience and draw recommendations and ways forward.

As activists gain momentum in advocacy efforts, additional CSOs and international NGOs will be identified on the local and national levels of Rwandan society by case managers, activists, and CARE staff. MOUs and the institution of regular meetings, forming an expanding coalition that will maintain a coordinated effort on the prevention of GBV, safety of GBV victims, and advocacy on GBV issues will be facilitated by the Policy and Advocacy Manager. The three objectives of the GBV Advocacy CSO Network will be 1) to act as a learning and sharing platform, 2) to identify gaps on GBV prevention, protection, and care/support, and 3) to develop an action plan for advocacy.

CARE will advocate for a clearly defined, effective framework of partnership between government and civil society organizations to lead a countrywide fight against gender-based violence (Policy Analysis 23). CARE will work with local, national, and regional networks and alliances to lobby national governments and their officials, regional, and intergovernmental bodies to effect change at the policy level. Lobbying will be done through formal and informal meetings, the media, and indirectly by working with people or organizations that can persuade or exert pressure on those responsible for bringing about change. The aim of lobbying is to influence the policy process by working closely with individuals in political and government offices.

3.3 Identifying allies and opponents

In moving towards the advocacy goal, and ultimately in having an impact on vulnerable women and girls in Rwanda, it is necessary to both build alliances and recognise opponents. The following list needs to be reviewed and expanded as implementation proceeds for each individual domain of change.

Allies

International allies include CARE International (especially USA, UK, Norway), who can help to raise the issues within international forums and can bring media attention, and international donors and structures such as DFID, World Bank, NORAD, USAID, SIDA, CIDA.

National allies include (but are not limited to) politicians who are passionate about addressing GBV, religious and community leaders, media outlets, celebrities and prominent Rwandans, including CNF and CNJ representatives, universities, high schools, student associations, teachers, educational leaders, Action Development Forums, and NGOs, including the Rwandan Men's Resource Centre (RWAMREC).

Allies for Domain of Change (1): Accessibility, Availability and Quality of services:
Numerous collaborators in the work of CARE community case managers have thus far been identified, with the most important including local village authorities, Executive Secretary of the Cell, CNF, the police, and the Official over Social Affairs at the sector. Importance is based on frequency of interaction over cases, however, and does not necessarily entail being a true ally in the cause, as will be demonstrated below in Opponents for Domain of Change 1. Other collaborators range from abunzi, community mediators, and family elders to NGOs, such as AJEPRODHO, AMI, and Haguruka, to religious leaders and organisations to youth and school anti-GBV clubs.

Opponents

In any advocacy campaign, there will be those who oppose the changes we are trying to achieve, either for financial or moral reasons. It is necessary to reflect on why they oppose the change, and look for opportunities to positively influence them. Opponents include some traditional leaders, some religious leaders, parts of the Government (which has an inconsistent level of commitment to tackling GBV), local police, local service providers, and chiefs of families.

Opponents for Domain of Change (1): Accessibility, Availability and Quality of services:
Those opposing the work of case managers in some cases and sectors include the family of the perpetrator, the perpetrator, the victims themselves when they refuse to report, other community members, local authorities, the police, courts, and health centres. These individuals oppose case management work for various reasons, including cultural, financial, relational, and structural causes. Some categories of opponents are also strong allies in different contexts and situations, especially within small communities where individuals are likely to act on complex

and interconnected motivations.

3.4 Identifying and working with targets

For each intervention, it is necessary to identify who is being targeted, and analyse how they can be influenced. This includes examining who is that person influenced by and accountable to, and how those networks can be infiltrated. Appendix 2 is an example of an influence map for targeting the Prime Minister. Similar mapping exercises should be carried out for each intervention/target.

Politicians at the local and national level are targeted as key decision makers and sometimes adversaries in this strategy. The following guidelines shall be used to relate to politicians:

1. CARE and partners shall learn as much as possible about the politician before initial contact. This will be done through review of biography and reading of any local papers and constituent brochures if available. The purpose is to understand if the politician is sympathetic to the issue or if the politician needs to be won over. One of the ways of winning the politician is to identify some of their accomplishments and be prepared to applaud.
2. The next thing to do is to recognise and value the 'gatekeeper' roles. These are people who have influence on the politician's decision making. It is important to sell gatekeepers on the value of the politician meeting with representatives of CARE and partners. The best times to meet with politicians are usually during session days.
3. The representatives of CARE and partners should position themselves as a resource to staff or the 'gatekeeper' and the politician. The advocates should position the GBV advocacy issues in the context of public interest or issues that concern the voters in the politician's constituency. It is important to sell the advocacy information as a useful resource for the politician to respond to queries and concerns.
4. Finally, the GBV advocates shall briefly provide information the politician needs to understand the issue and the concern. It is not good to assume the politician is knowledgeable about the issue because it is almost impossible to be fully informed about all issues. The strategy proposes the use of policy briefs, background information, case studies, fact sheets, brochures, and leaflets for face-to-face meetings with decision makers.

3.5 Popular mobilisation and using the media

Often the success of an advocacy campaign relies on raising the issue among the public, and causing a public call to action or outcry. This can be achieved through a variety of techniques, including the following:

- Using international days to raise the issue in the consciousness of the public

CARE will join forces with others for activities and public actions on International Women's Day and during the 16 Days of Activism Against Gender Violence, with the aim of showing public concern about GBV, and to raise the profile of a specific advocacy ask.

- Using the media

The media is a crucial partner for building mass public support for CARE's GBV advocacy. Planned campaigns are expensive so it is important for CARE and the partners to remain alert for opportunities to initiate or respond to media interest. CARE will develop pro-active relationships with journalists by giving them information they can use. The investment made in building relationships with editors and journalists could lead to the publication of articles that will inform a wider general public, including some of the specialized interests CARE intends to reach. One of the best ways to establish this kind of relationship is to arrange regular briefings with reporters, journalists, and media executives. Other ways include orientation seminars for journalists, in-country site visits for influential journalists, arranging interviews with high-profile people on GBV, and regular dissemination of up-to-date information and data. CARE also plans to incorporate some representation of women journalists in the GBV advocacy network called for by Domain of Change 3.

A key strategy at the local/community level will be to facilitate discussions between local authorities and the media in order for journalists to hold leaders accountable for GBV issues. CARE needs to acquire information on toll-free numbers for key media where community members and activists can anonymously report gaps and successes in implementation of GBV laws, policies, and services at the grassroots level.

Section 4: Measuring Success [to be extracted from WEP M&E Plan

Section 5: Advocacy Sustainability Plan