

A LIFE FREE FROM VIOLENCE:

An evidence-based value proposition for CARE's Gender-Based Violence programming in the Great Lakes region



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February 2018

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List of Acronyms

ADA	Austrian Development Agency
AMwA	Akina Mama wa Afrika
BCC	Behaviour Change Communications
BEE	Better Environment for Education
COCAFEM	Concertation des Collectifs des Associations Féminines de la Région des Grands Lacs
CSC	Community score-card
CSO	Civil society organisation
DFJ	Dynamique des Femmes Juristes
DFID	Department for International Development
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EMB	Engaging Men and Boys
GBV	Gender based violence
GBV IMS	Gender based violence Information Management System
GED	Gender Equality and Diversity
GEWEP II	Gender Equality and Women's Empowerment Programme II
GDP	Gross Domestic Product
GLAI	Great Lakes Advocacy Initiative
IEC	Information Education Communications
INGO	International non-governmental organisation
JoT	Journeys of Transformation
MANU	Mwanmke Amani na Usalama (Women, Peace and Health)
MIGEPROF	Ministry of Gender and Family Promotion
NUWEP	Northern Uganda Women's Empowerment Programme
PEP	Post-exposure prophylaxis
PIIRS	Project and Programme Information and Impact Reporting System
PSEA	Prevention of Sexual Exploitation and Abuse
RMM	Role Model Man
RWAMREC	Rwandan Men's Resource Centre
RWC	Refugee Welfare Committee
SAA	Social Analysis and Action
SAFPAC	Supporting Access to Family Planning and Post Abortion Care

SRMCH	Sexual, Reproductive, Maternal and Child Health
SS4G	Safe Schools for Girls
VAWG	Violence against women and girls
VSLA	Village Savings and Loans Association
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commission for Refugees
UNSCR	United Nations Security Council Resolution
UWOPA	Uganda Women Parliament Association
WEE	Women's Economic Empowerment
WFP	World Food Programme
WSF	Women's Space Facilitator

Executive Summary

Gender-based violence (GBV) is one of the most widespread abuses of human rights which takes place in all societies to varying degrees irrespective of age, sex, religion, class or caste. Although GBV affects both sexes, the majority of victims are women and girls. GBV is both an extreme form of discrimination and a mechanism for oppression and domination, which stems from unjust and unequal power relations, and which is perpetuated and reinforced by deeply rooted social norms. CARE's global 2020 Program Strategy identifies the need to address GBV as a vital aspect of the organisation's strategic approach for strengthening gender equality and women's voice.

In the Great Lakes countries of the Democratic Republic of Congo, Uganda, Burundi and Rwanda the incidence of physical and sexual violence experienced by women and girls is very high, with the proportion of women aged 15 – 49 who reported experiencing physical and/or sexual violence in their lifetime ranging from 43.9% in Rwanda (2014 DHS) to 46.7% in Burundi (2016 DHS) to 56.6% in DRC (2014 DHS) to 62.2% in Uganda (2011 DHS). The prevalence of GBV in the Great Lakes region has been exacerbated by a history of conflict in all four countries at different points of time. Other drivers of GBV in the region include: discriminatory social norms and customary practices which define and perpetuate the subordinate status of women and girls; women and girl's limited agency; poverty and governance failures and the weak implementation of existing legal and policy frameworks for GBV prevention and response. This report presents the findings of a consultancy commissioned by CARE's regional management unit for Eastern, Central and Southern Africa to draw together an evidence-based value proposition documenting experiences and learning from CARE's GBV programming in the Great Lakes region. The process for the consultancy involved a review of programme documents, a series of 23 interviews with CARE programme staff from the four country offices and the region and a further 7 interviews with staff from five partner organisations (see Annex 1), and field visits to projects in Uganda, Rwanda and Burundi.

In 2017 CARE was involved in implementing 19 long-term development projects that directly focused on addressing GBV across the four countries of the Great Lakes region, together with several projects addressing GBV in the humanitarian context in Uganda. The GBV components of the 19 long term development projects reached 213,755 direct participants in 2017, of whom 115,951 were women, and a further 191,122 direct participants were reached through the GBV component of CARE Uganda's emergency response for refugees from South Sudan and host communities in West Nile (the humanitarian response project)¹. A total of 2,849,889 people were indirectly reached by the GBV interventions of these projects in FY 2017, of whom over 80% (2,300,000) were reached by means of a range of IEC interventions, including peer sharing and radio programmes, through the UNFPA's United Nations Joint program on GBV in Uganda.

CARE's programming experiences in Uganda, DRC, Rwanda and Burundi over the past 10 years provide the basis for defining an emerging, evidence-based 'model' to prevent and respond to GBV in the Great Lakes region. This model brings together five key elements or programming approaches under the proposed "branding" acronym of 'POWER', which are:

- **P**romoting women and girls' economic, social and political empowerment;
- **O**rganising and engaging men and boys (EMB) to challenge gender inequitable social norms and practices;
- **W**orking with communities to facilitate community dialogue, activism and action;
- **E**ngaging with local-level duty bearers and service providers for strengthened capacity, coordination, resourcing and accountability;
- **R**eaching and influencing decision-makers through advocacy and partnerships at national, regional and international levels.

¹ PIIRS data for FY 2017.

Evidence from CARE's GBV programming in the Great Lakes region suggests that the integrated implementation of these five elements or approaches is effective in addressing and transforming the unequal power relations between men and women and different groups or social categories that are the underlying causes of GBV, and which are often exacerbated in conflict situations. The POWER model supports progress towards gender equality by facilitating changes in the personal agency of women and men; in their interpersonal relationships at household and community levels; and in the structures and institutions (including social norms) that shape women's and men's opportunities, choices and behaviours. It involves working at multiple levels with individuals, households, communities, local-level duty bearers and service providers, and with civil society and government partners, institutions and decision-makers at the national, regional and international levels.

CARE's humanitarian programming for GBV prevention and response in the West Nile refugee settlements has incorporated four key elements of the POWER model, namely the approaches of: engaging men and boys, including as clients with their own specific needs; generating community activism against GBV through community dialogue, awareness-raising and action; promoting access to services through case management (e.g. healthcare, psychosocial support, police referrals); and engaging in advocacy and partnerships with other organisations involved in the humanitarian response, including the Government of Uganda, UNHCR, protection agencies and other INGOs. The adaptation of the Role Model Men (RMM) model developed under the Northern Uganda Women's Empowerment Program (NUWEP) has been a key strategy for CARE Uganda's GBV programming in the humanitarian context. This has involved a focus on addressing male youth's psychosocial support needs, for example through activities such as community theatre, and emphasizing the need to adapt to cultural diversity in new settings where daily activities are not defined. The work with refugee RMM is still at a relatively early stage, but is recognised by partners, women refugees who have witnessed the activities of the RMMs, and programme staff as a strength of CARE's emergency response.

CARE Uganda's emergency response has also involved the establishment of a network of community-based facilitators trained to facilitate community dialogue and awareness-raising activities, to support referrals and to provide some basic counselling to GBV survivors; capacity-building with Health Centres to promote access to services by GBV survivors; the establishment of infrastructure (lighting, latrines and appropriate shelter) for improving security and reducing the risk of GBV for women and girls based on Participatory Safety Audits; and awareness-raising with local leaders on GBV issues and legislation. To date CARE's programming for humanitarian response in the West Nile has not included a VSLA component, although CARE is providing some support for small enterprise development and cash for work to GBV survivors and refugee youth at risk of GBV, and another consortium partner (Mercy Corps) is implementing VSLA activities in some (but not all) of the sectors of the settlements covered by CARE interventions.

Programme staff and participants identified the need for CARE to incorporate programming to promote refugee women's economic empowerment and to empower them to have more voice in recognition of the linkages between poverty and GBV in the refugee settlements. In recognition of the need for alternative economic empowerment approaches in an emergency response setting where the funding cycles are too short for the full VSLA cycle and/or where refugees have limited capacity for saving, CARE Uganda is also advocating for the use of cash transfers linked to VSLAs, which would target women and girls engaging in transactional sex, as a strategy for reducing the risk of GBV in humanitarian response settings. A recent proposal incorporating a VSLA component has been approved by UNFPA to support the continuation and extension of CARE Uganda's humanitarian response in West Nile across all 8 refugee hosting districts in West Nile. CARE's experience from DRC which has shown that IDPs who have fled conflict often manage to continue VSLA activities in the temporary camps where they seek shelter suggests that the inclusion of VSLA activities is likely to be a positive and viable extension of CARE Uganda's GBV programming in the humanitarian context.

Key learning points identified in this review regarding CARE's overall approach for GBV programming in Great Lakes region are that: i) Programmes aiming to address the root causes of GBV need to work at multiple levels and adopt gender-synchronized approaches; ii) Programming to challenge and change discriminatory social norms and practices starts from within by building gender committed and competent organizations both in CARE and with local CSO partners; iii) A holistic approach for addressing GBV requires a flexible and context-specific balance between prevention and response – that balance will differ between long-term development and humanitarian interventions; and iv) The 'POWER' model provides an integrated framework for GBV prevention and response which can be adapted to different contexts, including in situations of conflict

Key learning points identified regarding the specific programming approaches of the POWER model are:

On Promoting women and girls' economic, social and political empowerment:

- Programming for effective GBV prevention and response involves empowering women and girls economically, as well as strengthening their agency and building social networks and leadership capacity.
- The majority of VSLAs manage to sustain their savings and credit activities even under conditions of extreme insecurity.
- Programming for GBV prevention and response at scale in the Great Lakes region needs to address the specific needs of adolescent girls (and boys) for information on issues of gender and gender equality, including GBV and SRH, and for support in accessing services and building healthy relationships with their peers, their families, and their communities.

On Engaging Men and Boys:

- Economic incentives provide a key entry point for GBV programming with women and men.
- EMB initiatives need to target adolescent boys, youth and single men as well as men in couples and opinion leaders.
- EMB approaches are an important element of CARE's GBV prevention and response programming, but it is critical that women are also actively involved and have a voice in processes of dialogue and action with and by engaged men and boys.
- Understanding GBV as the outcome of unequal power relations is potentially transformative, providing it is based on a process of meaningful participatory analysis and reflection by and with programme participants.

On community dialogue and activism: Combining context-appropriate approaches for promoting women and girls' empowerment, EMB and community activism provides a strong foundation for sustainable social change to address GBV.

On engaging duty-bearers and service providers:

- Changing the mind-sets and behaviours of Opinion Leaders is key for creating an enabling environment for effective GBV prevention and response.
- Traditional and religious leaders are a particularly important target group for creating an enabling environment for GBV prevention and response.
- It is also critical to support women and girls in taking up leadership roles in local governance structures at different levels so that they are able to influence processes of decision-making and resource allocation relating to GBV prevention and response, and to participate in holding duty bearers and service providers accountable.

On advocacy and partnerships:

- Working in partnership with local NGOs is an effective strategy for civil society capacity-building and extending outreach but can present challenges for programme quality, reporting and learning.
- Bringing voices, experiences and evidence from the grassroots level into debates at the various levels up to the national and regional levels provides a strong foundation for advocacy on GBV issues.

- Effective advocacy on GBV at the national and regional levels requires compelling evidence based on credible data and rigorous analysis.

Based on examples of the ongoing scale-up of CARE's programming approaches for GBV prevention and response and potential opportunities for future scale up identified by programme staff and partners, three key scale-up pathways have been identified as potential mechanisms for significantly increasing the scale and impact of CARE and partners' programming to prevent and respond to GBV. These pathways to scale are:

1. Implementation of proven models at scale: This pathway involves integrating CARE's evidence-based model for GBV programming into existing and future programmes by government, NGOs (including CARE), UN agencies and the private sector, leading to change at scale.
2. Working in alliances at multiple levels with social movements for women and men involved in advocacy and activism to stop GBV.
3. Advocacy and lobbying campaigns at national, regional and international levels to influence enactment and implementation of laws and policies with a view to closing the "implementation gap" and holding the various parties accountable, with a focussed agenda on Women, Peace and Security

Partners interviewed across all four countries consistently highlighted the effectiveness of CARE programming approaches such as VSLA, EMB and the use of SASA! for community mobilisation and awareness-raising for GBV prevention and response. Partners also recognised CARE's expertise in promoting gender transformative programming focussing on challenging and changing social norms and power relations as a strength. Another widely identified strength of CARE's programming was the organisation's commitment to building the capacity of civil society for addressing GBV by working through partners. However, partners consistently identified the need to strengthen the documentation, reporting and communication of CARE's programming approaches and impacts, as an area for improvement of CARE's GBV programming. Partners in DRC and Burundi also identified the need for CARE to strengthen its programming for GBV response and promoting resilience given the changing conditions due to problems of insecurity in those politically volatile contexts.

Findings from a recent review of evidence on Violence Against Women and Girls (VAWG) and interventions to prevent carried out by the DFID-funded What Works global programme provide a striking external validation of the approaches proposed in the POWER model. The What Works review concluded that there is reasonable evidence for the effectiveness of group-based relationship-level interventions working with males and females; group-based microfinance combined with gender-transformative approaches; community mobilisation interventions to change social norms; and interventions that target boys and men (alongside women and girls) through group education combined with community mobilisation.

1. Context

1.1 Gender-based violence as a human rights issue

Gender-based violence (GBV) is defined by CARE as “...a harmful act or threat based on a person’s sex or gender identity. It includes physical, sexual and psychological abuse, coercion, denial of liberty and economic deprivation whether occurring in public or private spheres”.² It is one of the most widespread abuses of human rights which takes place in all societies to varying degrees irrespective of age, sex, religion, class or caste. Although GBV affects both sexes, the majority of victims are women and girls. The World Health Organization estimates that 1 in 3 women will experience physical or sexual violence by a partner or sexual violence by a non-partner within their lifetime³. Forms of GBV include domestic violence, intimate partner violence, child marriage, forced marriage, forced pregnancy, “honour” crimes, female genital mutilation, femicide, sexual and other violence perpetrated by someone other than an intimate partner (also referred to as non-partner violence), sexual harassment (in the workplace, other institutions and in public spaces), trafficking in women and violence in conflict situations⁴. GBV also includes various traditional harmful practices, all widely practiced in the Great Lakes, such as wife inheritance, widow cleansing, all of which are widely practiced in the Great Lakes region and which contribute to the spread of HIV and other sexually transmitted infections. Negative coping mechanisms such as transactional or survival sex and commercial sex are also considered forms of GBV, which are widely present as well in the Great Lakes. As such GBV is both an extreme form of discrimination and a mechanism for oppression and domination, which stems from unjust and unequal power relations, and which is perpetuated and reinforced by deeply rooted social norms. It is also driven by poverty and conflict.

The impacts of GBV on survivors and their families and communities are physical, psychological and emotional, social and economic. Survivors of sexual violence have been found to be three times more likely to suffer from depression, and six times more likely to experience post-traumatic stress disorder than others⁵. GBV has also been linked with poorer physical health for survivors – particularly sexual, reproductive and maternal health – including increased risk of HIV and AIDS⁶, maternal mortality and higher rates of miscarriage. Households in which women are subjected to GBV have higher rates of child mortality and poorer child health and nutrition⁷. Girls and boys subjected to GBV in and outside of school can be deprived of the chance to continue their education. GBV also leaves deep scars on societies that it affects, in terms of psychosocial trauma, community cohesion and stigmatization of survivors, and development outcomes⁸. The societal impacts of GBV include significant direct and indirect economic costs. Conservative estimates of lost productivity from domestic violence range from 1.2 per cent of GDP in Brazil and Tanzania to 2 per cent of GDP in Chile, with an estimated productivity loss of 1.6 per cent of GDP for Uganda⁹.

CARE’s global 2020 Program Strategy¹⁰ identifies the need to address GBV as a vital aspect of the organisation’s strategic approach for strengthening gender equality and women’s voice. The global program strategy includes

² CARE (2015) *CARE GBV Strategy*

³ http://www.who.int/reproductivehealth/publications/violence/VAW_Prevalence.jpeg?ua=1

⁴ United Nations (2015) *The World’s Women 2015 – Trends and Statistics*. UN Department of Economic and Social Affairs, New York, 2015: 232 pp.

⁵ World Health Organization. (2005) “WHO Multi-Country Study on Women’s Health and Domestic Violence against Women”. Cited in *CARE GBV Strategy*.

⁶ Dunkle, et al (2004). “Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.” *The Lancet*, Volume 363, Issue 9419, Pages 1415 – 142. Cited in *CARE GBV Strategy*.

⁷ World Bank: <http://siteresources.worldbank.org/INTGENDER/Resources/andymorrison.ppt>

⁸ CARE (2015) *CARE GBV Strategy*

⁹ Duvvury et al (2013). Intimate partner violence: Economic costs and implications for growth and development. The World Bank Group. www.worldbank.org/gender/ agency.

¹⁰ The CARE 2020 Program Strategy articulates the organisation’s role, identity and programmatic focus towards realizing its vision of “a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security”. CARE (undated) *Working for Poverty Reduction and Social Justice: The CARE 2020 Program Strategy*.

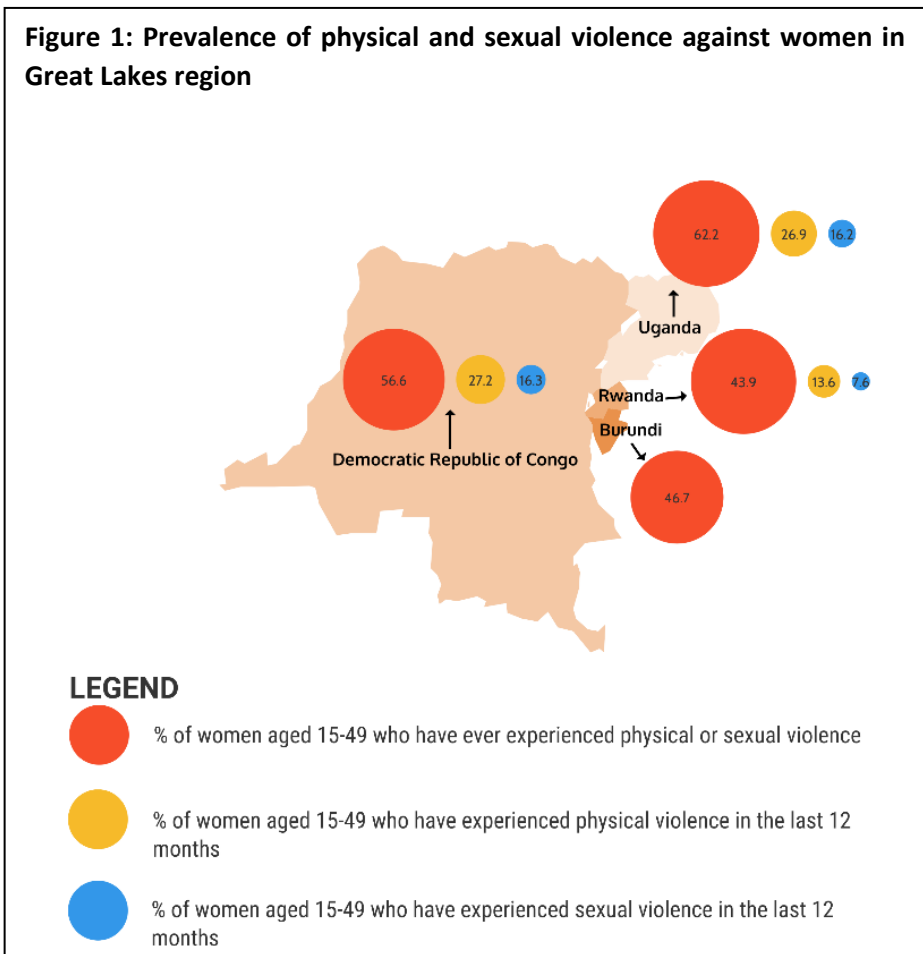
a commitment to ensure that 100 million women and girls exercise their rights to sexual, reproductive and maternal health and a life free from violence as one of four global outcomes against which the progress of CARE’s work will be measured. As such GBV has been identified as an issue that requires both focused programming in its own right and integration across all of CARE’s work.

1.2 GBV in the Great Lakes region

The incidence of physical and sexual violence experienced by women and girls is high in Africa and the rates reported in the Great Lakes countries of the Democratic Republic of Congo, Uganda, Burundi and Rwanda are among the highest on the continent¹¹. The available Demographic and Health Survey (DHS) data show the proportion of women aged 15 – 49 experiencing physical and/or sexual violence in their lifetime ranged from 43.9% in Rwanda (2014) to 62.2% in Uganda (2011)¹². In addition to the high prevalence of physical and sexual violence in the Great Lakes countries (see Figure 1) women in those countries are widely subjected to other forms of GBV, including economic and emotional violence. In DRC, many husbands do not allow their wives to meet friends (41%)

or try to limit their wives’ contact with their families (27%), and 30% of working women state that their income is mainly controlled by their husbands¹³. In Burundi, almost a quarter of women have little or no influence on decisions regarding their health care, and 43% do not participate in decision-making regarding important purchases for the household. In Rwanda, over one-quarter of women (26%) say that decisions regarding important household purchases are usually made by their husband alone. In Uganda, early marriage, although diminishing, is still a significant problem: 40% of women between the ages of 20-24 were married by the age of eighteen, while 10% were married by the age of fifteen.

Figure 1: Prevalence of physical and sexual violence against women in Great Lakes region



¹¹ United Nations (2015)

¹² DHS data sources: République du Burundi, Enquête Démographique et de Santé Burundi 2016, May 2017; Republic of Rwanda, Rwanda Demographic and Health Survey 2014-2015, March 2016; République Démocratique du Congo, Enquête Démographique et de Santé (EDS-RDC) 2013-2014, September 2014 ; and Republic of Uganda, Uganda Demographic and Health Survey 2011, August 2012. Note: Available 2016 DHS data for Burundi does not report experience of physical or sexual violence in 12 months prior to survey.

¹³ The law in DRC stipulates that married women need their husbands’ permission to work, to open a bank account, to obtain credit, to start a business or to travel.

While there are important contextual differences between the countries of the Great Lakes region, the following common underlying causes or drivers of high rates of GBV have been identified¹⁴:

Discriminatory social norms and customary practices which define and perpetuate the subordinate status of women and girls in all spheres of daily life: The dominance of patriarchal value systems in Uganda, Rwanda, Burundi and DRC mean that women and girls are disadvantaged in terms of access to opportunities and services (including education and health services), ownership and control of economic assets, participation in household decision-making and public life. In all four countries there is a pervasive gender stereotype whereby men are expected to 'control' their wife, by means of violence if necessary, and to take on sole responsibility for providing for their families. Practices of early socialisation for boys and girls ensure that the resultant gender-based inequalities are widely accepted by women and men alike. Traditional and religious leaders play important roles in influencing the extent to which these customary social norms and practices can or cannot be challenged and changed.

Poverty as a critical factor shaping women and girl's vulnerability to GBV and men's violent behaviours: Economic deprivation based on gender is a form of GBV in itself which acts to increase women and girl's (financial) dependency in abusive relationships, thereby increasing women's vulnerability to other forms of GBV. Poverty can also force women and girls into behaviours for meeting basic needs that place them at increased risk of GBV. At the same time poor men who feel they are losing face because they are unable to meet societal pressures for them as the breadwinners of their households may revert to violence out of frustration or as an alternative way of asserting and proving their masculinity. This tendency is particularly strong during displacement.

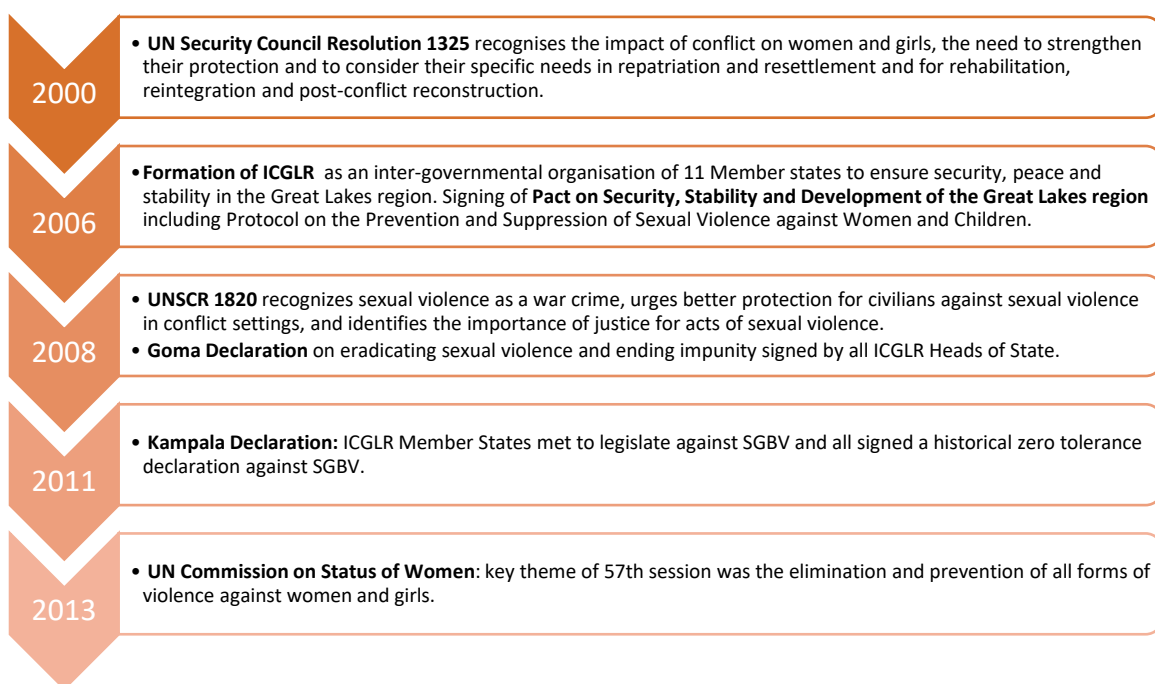
Women and girl's limited agency in terms of knowledge, capacities, aspirations and confidence: Many women and girls lack information about and awareness of their rights, as defined by existing legislation and policies for GBV prevention and response, and existing support mechanisms. Women and girl's access to and understanding of information on their legal rights in terms of inheritance, ownership of land and property, SRH and other family issues also have a bearing on their vulnerability to GBV in its different forms. Women and girl's subordinate position in society and lack of self-esteem also prevent them from taking action to claim their right to a life free from violence. The lack of understanding of their rights and what constitutes a violation of these rights and of GBV and GBV-related legislation and structures in wider society (i.e. the absence of an enabling environment) also limits the extent to which women and girls and their husbands or families are able to seek support for ending the cycle of exploitation, abuse, deprivation and violence.

Conflict: The prevalence of GBV in the Great Lakes region has been exacerbated by a history of conflict in all four countries at different points of time, with conflict ongoing in Burundi and in several provinces of DRC including North Kivu, South Kivu, Ituri, Kasai central, Tanganyika. Conflicts in the region have caused displacements of large numbers of people, huge losses in terms of lives and livelihoods, the disruption of service provision, and have – in some instances (e.g. DRC and South Sudan) - been characterised by the widespread use of sexual violence as a weapon of war. The normalisation of violence as a means of survival in conflict and post-conflict settings increases the risk and incidence of GBV by reinforcing existing harmful practices and inequalities in society (e.g. alcoholism) and undermining social cohesion and community support systems. The massive population displacements caused by conflict in the region (e.g. DRC has XXX of displaced people and Uganda as 1,4 million refugees) increase the risks of GBV because the response by humanitarian actors does not match the scale of the tragedy, and because displacement leads to increased risk factors and serious protection issues, including the risk of trafficking.

¹⁴ CARE (2015) *Gender-based violence Program Strategy – CARE in the Great Lakes sub-region: Burundi, Democratic Republic of Congo, Rwanda and Uganda.*

Governance failures and weak implementation: All four countries of the Great Lakes region are signatories to CEDAW and members of the ICGLR and, as such, have committed to tackling/ addressing GBV under the terms of a series of international agreements, which include the UN Resolutions 1325, 1820 and the Goma and Kampala Declarations (see Figure 2). In line with these commitments all four countries have established national legal and policy frameworks for the prevention of GBV, including the development of National Action Plans for implementing UNSCR 1325¹⁵. While there has been some progress on the implementation of those frameworks (e.g. the establishment of One-stop centres in Rwanda, Burundi and Uganda) the implementation gap, i.e. the difference between what women and girls experience on the ground in terms of GBV prevention and response and what the legal and policy context was designed to ensure they experience, persists to a large extent¹⁶. Factors contributing to the implementation gap vary from country to country but generally include: limited funding for the relevant national level institutions and government departments responsible for GBV prevention and response (the “gender machinery”), limited awareness and understanding of the legal and policy frameworks among duty-bearers and service providers, and problems of weak coordination of, governance failures by, and a lack of commitment to and accountability for the enforcement of the existing legal instruments by those actors. Consequently, GBV continues to be a part of day-to-day life for millions of women and girls across the Great Lakes region and progress towards addressing the impunity of perpetrators has been limited.

Figure 2: Summary of Key International Agreements relating to GBV signed by GL countries



2. Scope of the review of CARE’s GBV programming in the Great Lakes

The purpose of the learning review was to draw together an evidence-based value proposition documenting experiences and learning from CARE’s GBV programming by the four country offices (Uganda, Rwanda, DRC and Burundi) in the Great Lakes region. As such, the consultancy was designed to explore the over-arching learning questions:

¹⁵ The NAPs for Uganda however ran from 2011 to 2016, while that for Burundi ran from 2012 to 2016.

¹⁶ CEWIGO/ DGF (2017) *Deepening Advocacy on Women, Peace and Security – a CSO Monitoring Report. Monitoring the implementation of the National Action Plan for UNSCR 1325 and UNSCR 1820 and the Goma Declaration in Uganda.*

- What do the CARE country offices of Burundi, DRC, Rwanda and Uganda do well in their SGBV programming?
- What do others in the country/ region do well and where CARE should learn from the programming experiences of others?
- What are some of the failures or weaknesses that CARE has found in its SGBV programming and/or the work of others in the GL region (including consideration of advocacy)?
- What are the major points of learning for CARE to move forward with its GBV programming in the GL region?
- What can the organization do to accelerate the scale and quality of impact to reach the current target of 7 million girls and women in the GL region?

The process for the consultancy involved:

- i) A focussed review of documents provided by programme staff from each of the four country offices;
- ii) A series of 23 interviews with CARE programme staff from COs and the region and a further 7 interviews with staff from five partner organisations (see Annex 1); and
- iii) Field visits to projects in Uganda - CARE's humanitarian response in West Nile, Rwanda - the *Indashyikirwa* project, and Burundi - a community visit to meet with members of a VSLA group and *Abatangamuco* (engaged men).

As the learning review focussed primarily on exploring the experiences and perspectives of CARE programme staff, and so included a relatively limited number of interviews conducted with partners and external stakeholders, the analysis of external and partner perspectives presented in this report is not extensive.

3. The Reach of CARE's current GBV programming in the Great Lakes

PIIRS data for the 2017 financial year show that CARE was implementing 19 long-term development projects directly focused on addressing GBV across the four countries of the Great Lakes region in that year, together with six projects with a direct focus on addressing GBV in the humanitarian context which together made up CARE Uganda's emergency response with refugees and asylum seekers from South Sudan and host communities in West Nile. These were all projects being implemented in rural settings. The GBV interventions of the 19 long term development projects reportedly reached 304,688 direct participants, of whom 191,104 were women, while a further 191,122 direct participants were reached through CARE Uganda's emergency response for refugees from South Sudan and host communities in West Nile (see Table 1).

The total number of people indirectly reached by the GBV interventions of these projects in FY 2017 was 3,411,995, of whom over 65% (2,300,000) were reached by means of a range of Information Education Communications (IEC) and Behaviour Change Communications (BCC) activities such as peer sharing and radio programmes through UNFPAs led United Nations Joint program on GBV in Uganda. The method of calculation of numbers of people indirectly reached by other projects varied from project to project. Some projects such as the Every Voice Counts and Win Win projects in Burundi did not report indirect participants due to overlap in their targeting of direct participants with other programmes. Several projects, e.g. CARE Burundi's Joint Programme for adolescent SRH, and the GEWEP II interventions in Rwanda and Burundi calculated the number of indirect participants as the number of direct participants multiplied by the average size of household. Interventions working with youth in schools (e.g. *Sisi vijana* in Burundi and DRC, and the BEE and SS4G projects in Rwanda) calculated numbers of indirect participants as including the classmates, siblings, teachers and parents of boys and girls participating directly in project activities.

Table 1: Summary of PIIRS data on CARE's GBV programming in the Great Lakes region in FY 2017

Country	Project/Initiative Name	Duration	Budget (USD)	Direct ppts (GBV): n. total	Direct ppts (GBV): # women & girls	% of direct ppts (GBV) women & girls	Indirect ppts (GBV): # total
Burundi	Addressing roots causes/Nyubahiriza ¹	2016 - 2020	1,927,030	0	0	0	0
Burundi	Every Voice Counts	2016 - 2020	2,567,435	16,309	10,389	63.7%	0
Burundi	Joint programme for adolescent SRH	2015 - 2020	7,342,603	2,251	1,085	48.2%	11,255
Burundi	Gender Equality Women's Empowerment Programme II	2016 - 2020	5,716,244	9,824	9,235	94.0%	53,050
Burundi	A Win-Win for Gender, Agriculture and Nutrition: Testing a Gender-Transformative Approach from Asia in Africa	2016 - 2019	2,578,671	10,572	6,555	62.0%	64,297
Burundi	Wotro research project: Young Burundians agency regarding sexual relations and decision making ¹	2016 - 2019	41,087	0	0	0	0
Burundi	<i>Sisi vijana</i> initiative	2013 - 2016	1,073,341	7,466	2,912	39.0%	49,854
DRC	MAWE TATU	2015 - 2019		2,294	1,755	76.5%	22,294
DRC	GEWEP II	2016 - 2020	2,472,112	7,021	477	6.8%	42,126
Rwanda	Learning for change (L4C): Strengthening Women's Voices in East Africa	2016 - 2019	533,415	36	19	53%	0
Rwanda	Every Voice Counts	2016 - 2020	2,354,786	3,457	2,627	76.0%	2,556
Rwanda	GEWEP II & Literacy for Empowerment	2015 - 2020	4,023,856	86,940	68,623	79.0%	286,902
Rwanda	Indashyikirwa "Agent For Change" Project	2014 - 2018	4,821,973	3,957	2,129	53.4%	275,206
Rwanda	Better Environment for Education (BEE)	2016 - 2018	870,013	44,822	24,856	55.5%	136,802
Rwanda	Safe Schools for Girls (SS4G)	2015 - 2020	1,437,650	54,326	30,803	56.7%	165,762
Uganda	GEWEP II	2014 - 2018	880,053	2,200	0	0.0%	1,125
Uganda	SRMCH (Improving Access to Reproductive, Child and Maternal Health in Northern Uganda)	2014 - 2017	386,667	7,831	2,349	30.0%	53,800
Uganda	Digital Sub-Wallets for Increased Financial Empowerment of Women	2016 - 2019	798,062	4	4	100.0%	16
Uganda	UNFPA United Nations Joint program on GBV	2017 -	160,000	45,378	27,227	60.0%	2,300,000
Uganda	Emergency response for refugees, asylum seekers from South Sudan and host communities in West-Nile	2017 - 2018	3,466,939	191,122 ²			
TOTAL				495,810	186,762		3,465,045

¹ New project in start-up phase of implementation which has not yet started working with participants in the field

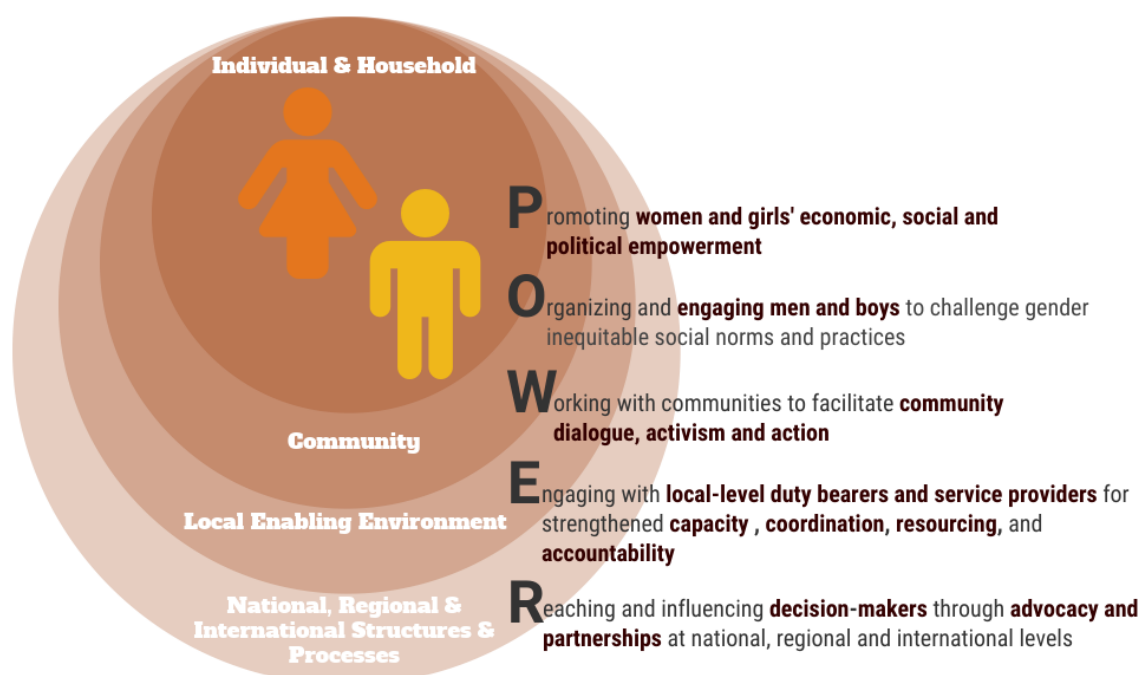
² Data provided by country office rather than from PIIRS FY 2017 reporting.

4. CARE’s GBV Programming Model for the Great Lakes Region

CARE’s programming experiences in Uganda, DRC, Rwanda and Burundi over the past 10 years provide the basis for defining an emerging, evidence-based ‘model’ to prevent and respond to GBV in the Great Lakes region. This section will give an overview of this suggested model and its key elements: subsequent sections will examine each element in detail. There are advantages to ‘branding’ this model, in the way that other programmatic models within CARE are branded (see for example the SuPER principles CARE uses to describe its approach to food and nutrition security). One possible such approach for branding – based around the ‘POWER’ acronym - is offered here: but CARE may want to consider working with branding and communications experts to develop this.

The ‘POWER’ model (see Figure 3) brings together five key elements or programming approaches. The evidence examined during this review suggests that the integrated implementation of these elements or approaches is effective in addressing and transforming the unequal power relations between men and women and different groups or social categories that are the underlying causes of GBV, and which are often exacerbated in conflict situations. The model supports progress towards gender equality by facilitating changes in: the personal agency of women and girls and men and boys; their interpersonal relationships at household and community levels; and the structures and institutions (including social norms) that shape women’s and girls’ and men’s and boys’ opportunities, choices and behaviours. It involves working at multiple levels with individuals, households, communities (where communities may include IDPs, refugees and host communities), local-level duty bearers and service providers, and partners and decision-makers at the national, regional and international levels. It is being adapted in all four countries for youth-focussed programming with girls and boys in and out of school.

Figure 3: The ‘POWER’ GBV programming model for the Great Lakes Region



As such, the programming approaches of the POWER model maps to the four domains of change of the socio-ecological model presented in CARE's global GBV strategy¹⁷. Beyond this, the POWER model also aligns with the core domains of CARE's long-standing women's empowerment framework – agency, relations and structure – and is thus supported by many years of programming experience across the CARE world. The programming approaches identified as key elements of the POWER model are also consistent with the emerging evidence and learning being generated by the DFID-funded What Works to Prevent Violence Against Women and Girls global programme¹⁸.

4.1 Promoting women and girls' economic, social and political empowerment

The socially-defined subordinate status of women and girls in many countries puts them at risk of GBV, with marginalised groups such as refugees and IDPs often being particularly vulnerable. Approaches to promote women and girls' economic, social and political empowerment are therefore at the centre of CARE's programming to prevent and respond to GBV. These approaches start with the formation of groups of women, which can be Village Savings and Loans Associations (VSLAs), or women farmers groups, Farmer Field Schools, WASH committees or women's CBOs etc. CARE then works with these groups to promote positive changes in women's agency, in their relations with others – including men, and in the structures (i.e. legal, policy and institutional environment) that define their rights and the opportunities open to them. CARE programming interventions often combine activities to promote economic empowerment with women's leadership capacity-building and accompaniment. Strengthening women and girl's agency by increasing their access to information about their rights, and the services that should be available to them, and supporting women and girls to participate and take on leadership roles at different levels, from the local to national, so that they are able to influence processes of decision-making and resource allocation are important aspects of CARE's programming to empower women and girls to live lives free from violence.

The VSLA programming approach (see Box 1 overview) is a key element of CARE's programming to address GBV in the Great Lakes region. This approach has been found to provide an effective and sustainable way of promoting women and girls' empowerment by increasing women and girls' access to economic assets, enabling the development of income generating activities, promoting solidarity among women VSLA members, and contributing to women's increased influence in household decision-making and participation in public life at the community level and beyond. VSLA projects and programmes are currently being implemented at scale in all four countries of the region. For example, the second phase of the NORAD-funded Gender Equality and Women's Empowerment Programme (GEWEP II) being implemented until 2020 in Rwanda, Burundi and DRC (as well as in Mali, Niger and Myanmar) with four cross-cutting thematic focus areas of strengthening civil society, women's economic empowerment and entrepreneurship, women's participation in decision-making processes and men's engagement in transforming gender norms, is working with almost 16,000 VSLAs representing a combined membership of 328,366 women¹⁹. Over the period 2014 – 2015, the Northern Uganda Women's Empowerment Programme (NUWEP) implemented by CARE Uganda as a post-war recovery and development programme with a particular focus on the elimination of GBV has worked with over 3000 VSLAs, representing a combined membership of 60,800 women²⁰.

¹⁷ CARE (2015) *CARE Gender-Based Violence Strategy*. CARE International, March 2015.

¹⁸ What Works (undated) *A global programme to prevent violence against women and girls: A Summary of the Evidence*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/337599/summary-evidence-research-agenda-C.pdf

¹⁹ Data from GEWEP II 2016 Annual Report produced by CARE Norway. The total number of VSLAs by country is: 10,142 groups in Burundi, 620 in DRC and 5,027 in Rwanda, which numbers include VSLAs established under previous NORAD-funded initiatives in those countries.

²⁰ CARE International in Uganda (2016) *Annual Report Financial Years 2014 - 2015*

Box 1: The VSLA approach

CARE's VSLA programming approach was launched in Niger in 1991 based on a traditional system of group savings. By 2016, 200,000 CARE VSLAs in 35 countries had mobilised 5 million members more than 70% of whom were women. These groups had generated more than 350 million financial transactions a year, creating millions of dollars in annual savings and with a loan repayment rate of 99%.

The VSLA approach is based on the voluntary formation of groups of 20 - 30 self-selected participants who make regular savings contributions by purchasing shares to a loan fund from which any of the members can borrow. Loans are paid back with interest, causing the fund to grow. The VSLA also creates a social fund based on regular equal contributions by all members, which is kept separate from the loan fund, and which provides small but important grants to members in distress. All transactions are carried out at regular (i.e. weekly or fortnightly) meetings in front of members. The cycle of savings and lending is time-bound and does not last more than one year. At the end of the agreed period of 9 – 12 months, the accumulated savings and interest are shared out amongst the membership in proportion to the amount each member has saved over the course of the cycle. In this way the VSLAs, which are autonomous and self-managing, provide simple savings and loans facilities in communities that do not have access to formal financial services.

Source:http://www.care.org/sites/default/files/documents/vsla_25years_final_20sept16.pdf

An important strength of the VSLA approach as a mechanism for tackling GBV is that it provides an economic incentive for women's participation, which can reduce the extent of a woman's dependency on relationships with violent male partners or relatives. As women VSLA members become economically empowered and are more able to contribute to their households, the economic benefits of their participation in the VSLA are also recognised by their husbands and male relatives, which can lead to more supportive intra-household relationships and the increased influence of women on household decision-making. Attendance at regular VSLA meetings also provides women with opportunities to build social relationships with other women, to benefit from experience-sharing and peer-to-peer learning, and to develop their communications and leadership skills. These benefits in terms of social and political empowerment and solidarity are highly valued by women VSLA participants. In this way the VSLA offers a safe space for women who are experiencing violence in their households to discuss their problems and seek the support of their peers. As such, as well as being an effective programming approach for WEE, VSLA membership also provides an entry point and programming platform for addressing a range of women's rights issues, including SRH and GBV, and for promoting women's leadership both within and beyond the group, in what is known as CARE's VSL+ programming approach.

Evaluations of large-scale VSLA programmes implemented by CARE in the Great Lakes region over the past 5 – 10 years²¹ have found the positive impacts of VSLA membership for women to include:

- Increased levels of material well-being/ decreased poverty as evidenced by improvements in food security, asset ownership and participation in and diversification of IGAs;
- Improved psychosocial well-being, including increased self-esteem and confidence;
- Improved relationships both within and beyond the household, including reductions in the % of women experiencing violence in their households, the strengthening of women's social networks and improved social recognition within their communities;
- Increased participation in public life, from increased attendance and active participation in community meetings, through to women successfully seeking election to local leadership positions.

The fact that most VSLAs become self-sustaining by the end of the first savings cycle and go on to continue and develop their activities is powerful evidence of the positive benefits of the approach for participants.

²¹ See for example the final evaluation report of the Kirumara II project in Burundi (De Boodt 2012) and the final evaluation of the Isaro project in Rwanda (CARE International in Rwanda, undated).

Examples of spontaneous replication of the approach, whereby VSLA members go on to establish and support new VSLAs without external assistance, have also been consistently reported across the Great Lakes region.

CARE's GEWEP II is supporting VSLAs in Burundi and DRC to organise into networks as a way of strengthening capacity for collective representation and voice, and providing the VSLA networks with training on governance, women's leadership, gender and rights-based approaches. In Burundi, GEWEP supports 54 communal advocacy networks (in which VSLA members participate) to develop relations with communal authorities and contribute to local development. Several of these networks have also been linked to provincial focal points of the Ministry of Gender to support specific women's cases of GBV²². In Goma, DRC, after strengthening VSLA member's capacities on leadership, GEWEP noticed the emergence of a potential women social movement as 10 VSLA networks and 136 VSLA (6 456 women) formed a coalition to promote the VSLA approach, support women's political participation and advocate for women's rights. CARE DRC is also using the VSLA approach as a platform to build resilience of communities, by linking communities to each other through mutual assistance agreements as an approach linking humanitarian and long-term development that could potentially be replicated in other contexts (see Box 2).

The VSLA approach has also been adapted for programming with adolescent girls often as part of SRH interventions. Understanding the demography of the Great Lakes region and the prevalence of GBV among girls and youth has led to growing recognition within CARE country offices of the need for programming to address the specific SRH issues and needs of adolescent girls with an integrated focus on GBV prevention and response. For example, teenage pregnancy can be a starting point for GBV as pregnant girls are often excluded from school and stigmatized by their families and communities, which can lead them to adopt risky behaviours to meet basic needs. In Rwanda, the Safe Schools for Girls and Better Environment for Education projects are designed to equip adolescent girls with life skills in terms of SRH behaviour so that they have the knowledge and capacity for good decision-making around sexuality and healthy relationships. Both projects include a VSLA component, as a mechanism for encouraging regular school attendance and enabling girls to meet their own economic needs, so that they are less likely to engage in risky behaviours which expose them to sexual exploitation. In Burundi, CARE is currently implementing a large-scale programme jointly with UNFPA, Rutgers World Population Fund and CordAid which is promoting comprehensive sex education and access to SRH services for adolescents and youth based on the World Starts With Me (WSWM) curriculum²³. The Joint Programme targets youth in and out of schools across eight provinces of Burundi and includes a VSLA component for working with adolescent girls who have dropped out of school.

However, evidence from Rwanda, Uganda and Burundi also shows that VSLA membership in itself does not necessarily enable women and girls to achieve lives free from violence and that some women who become economically empowered through the VSLA actually experience increased levels of violence in their households, as a result of prevailing social norms relating to gender roles²⁴. The final evaluation of the Kirumara II project in Burundi concluded that *"it is the decision of the man to abandon domestic violence which is the determining factor (of whether a household is free of violence), hence the importance of efforts for raising men's awareness"*²⁵. CARE's learning from the implementation of VSLA programming at scale has therefore

²² CARE Norway (2016) *Gender Equality and Women's Empowerment Programme II, 2016 – 2019: 2016 Annual Report*. Programme document: 37pp.

²³ "The Worlds Starts With Me" (WSWM) is a comprehensive program that combines sexuality education with learning IT skills ... to help young people to address sensitive issues around love, sexuality and relations. The issues vary from the development of their bodies to pregnancy, contraceptives, HIV and sexual abuse. See <https://www.rutgers.international/what-we-do/comprehensive-sexuality-education/depth-world-starts-me>

²⁴ CARE International in Rwanda (2012) *Mind the Gap: Exploring the Gender Dynamics of CARE Rwanda's Village Savings and Loans (VSL) Programming*.

²⁵ De Boodt, K. (2012)

highlighted the need to accompany and integrate VSLA with other programming elements, particularly engaging men and boys, in initiatives for prevention and response to GBV. This learning has informed the development of CARE's Engaging Men and Boys approach, which is the second key element of the POWER model.

Box 2: Adapting the VSLA approach to promote community resilience

In 2016, CARE DRC started using the VSLAs as a platform for the strengthening resilience of individuals, families and communities, as an approach to link humanitarian and long-term development programming. The community resilience component has involved linking communities to each other, supporting the emergence of VSLA networks, and pairing VSLA networks from crisis affected areas with networks in host communities. The host communities will welcome VSLA members from crisis affected areas in times of displacement. So far, 70 families have been identified from host communities. To strengthen the capacities of the host community, 40 families have been given support to start income generating activities. CARE DRC programme staff identified several compelling examples of host communities providing support in the form of shelter, food and medical care to people displaced by recent incidents of conflict in North Kivu.

In Goma, a coalition of 10 VSLA networks and 136 VSLAs has been formed to promote the VSLA approach, support women's political participation and advocate for women's rights. Local-level advocacy initiatives by this coalition have resulted in increased access to land by internally displaced and vulnerable women, and some cases of the prevention of GBV specific to female widows. However, CARE DRC's experiences have also highlighted the issue of ensuring the security of VSLA funds as a growing and critical factor for the sustainability of the approach.

Source: GEWEP II Annual Report 2016

4.2 Organizing and Engaging Men and Boys (EMB) to challenge gender inequitable social norms and practices

CARE's programming approaches for Engaging Men and Boys (EMB) are based on the recognition that achieving real and lasting progress towards gender equality requires proactive work with men and boys alongside women and girls. Programming experiences across all four countries in the Great Lakes region consistently demonstrate the complementary value of integrating EMB approaches with women and girls' empowerment programming to address the discriminatory social norms and behaviours that cause GBV.

In Burundi, CARE's EMB programming has focussed largely on supporting the emergence of a social movement of rural men known as the *Abatangamuco* ("those who shine light"). The *Abatangamuco* are a group of rural men who have decided to change the way they live in their families and with their wives, ending abusive and oppressive practices and instead collaborating with their wives in all aspects of family life²⁶. They use testimonies, theatre, personal consultations and other peer-to-peer activities to convince other men to make the same changes and, potentially, join the organisation and contribute their testimonies to the group's activities. The central argument for change as made by the *Abatangamuco* is that traditional Burundian ideals of masculinity are counterproductive for efforts to achieve other ideals – such as prosperity, status and harmony. If a man becomes a member of the *Abatangamuco*, he must commit to no longer using force against his wife, not to try and force the family to do as he says, no longer to spend money that belongs to the family without consulting with his wife, and to contribute to all aspects of work in the family even if the tasks are traditionally considered "women's work". Since the identification of the first *Umutangamuco* during an appreciative enquiry process by CARE Burundi in 2006, the movement has grown to have a membership of 4,326 *Abatangamuco* couples and is now registered as a formal organisation.

²⁶ Wallacher, H. (2012) *Engaging Men: The Abatangamuco and Women's Empowerment in Burundi*. Peace Research Institute Oslo (PRIO) Research paper: 51pp.

In Rwanda, EMB programming began with a pilot initiative developed by CARE in 2010, in partnership with global research and activism organisation Promundo and the Rwandan Men's Resource Centre (RWAMREC)²⁷, to develop and test an intervention for engaging men in a couple-focused process designed to respond to men's doubts and resistance regarding women's participation in WEE initiatives²⁸. From this intervention, the Journeys of Transformation (JoT) couple-based training curriculum emerged, which was piloted with 30 couples from vulnerable households over 16 weeks. The JoT training engaged couples in discussions about household dynamics, health and gender-based violence through a combination of men-only sessions and couple sessions²⁹.

Findings of baseline and follow-up research carried out with participant couples and a comparison group showed a range of positive impacts of the training³⁰. Impacts included:

- Improvements in the economic situation of participant households (increased incomes) with men becoming more supportive of their wives' economic activities through the VSLA and expressing increased recognition of women's economic roles and contribution to the household;
- Changes in the sharing of care work with men collaborating more with their wives in household chores and becoming positively engaging in childcare;
- Increases in shared planning and decision-making within the household for economic activities and family planning and positive changes in family dynamics with reduced conflict and violence;
- Increased understanding by women and men of violence and the laws relating to gender equality.

The JoT couples-based training has since been implemented at scale by CARE Rwanda in the Isaro programme and in phases I and II of the Norad-funded GEWEP - interventions designed and implemented to promote women's empowerment and address GBV through a gender-synchronized approach combining VSLA and EMB activities. Engaged men from these interventions have formed Men Engage Clubs, as structures to help men to sustain the changes they have committed to making in their lives. The Men Engage Clubs also support engaged men in reaching out to help other men and women from their communities and the surrounding areas to change their behaviours. A concern has however been raised that women's voices are absent from the Men Engage clubs and that there is a risk of the clubs promoting engaged men's status rather than gender equality³¹.

The JoT curriculum is also a key element of the DFID-funded *Indashyikirwa* project being implemented by CARE Rwanda and partners as an initiative designed specifically to prevent intimate partner violence (see Box 4)³². Programming by CARE DRC through the GEWEP II and the *Mawe Tatu* project is also gender-synchronized to include EMB activities by means of the establishment of Men Engage groups for the husbands of women programme participants involved in VSLAs.

In Uganda, CARE's EMB programming began in 2010 with a pilot initiative designed to mobilise men and boys to understand and support concepts of positive masculinity and gender equality as part of NUWEP, using the

²⁷ Promundo is a global NGO promoting gender justice and preventing violence by engaging men and boys in partnership with women and girls (see <http://promundoglobal/about/>). RWAMREC is a Rwandan NGO which aims to address issues of negative masculine behaviours and gender inequalities to promote healthy families, men's welfare, women's rights and men's well-being (see www.rwamrec.org).

²⁸ Slegh, H., G. Barker, A. Kimonyo, P. Ndolimana and M. Bannerman (2013) *'I can do women's work': reflections on engaging men as allies in women's economic empowerment in Rwanda*. *Gender and Development*, 21:1, pp15-30.

²⁹ Slegh, H., P. Pawlak and G. Barker (2012) *Journeys of Transformation: A training manual for engaging men as allies in women's economic empowerment*. CARE International in Rwanda and Promundo – US.

³⁰ Slegh et al. (2013)

³¹ Kimonyo, A. (2015) *Final Evaluation Report on Engaging Men Initiative*. Consultancy report for CARE International in Rwanda: 34pp.

³² CARE International in Rwanda, Rwanda Women's Network and RWAMREC (2015) *Indashyikirwa – Agents of Change: A Community-based GBV prevention project*. Project document: 17pp.

'Journeys of Transformation' (JoT) manual that had been developed by Promundo and CARE Rwanda³³. Based on discussions with community members, the programme identified Role Model Men (RMMs) who were trained to become active as change agents in their communities and to engage in communications and advocacy related activities. The selected RMMs included both men who were already practicing positive masculinity and men who had been in violent or unstable/ vulnerable households but who were willing to change. Each RMM was expected to provide peer-to-peer facilitation support and male mentoring to ten neighbouring households identified as being vulnerable to psychosocial problems (e.g. a history of GBV, alcohol abuse, extreme poverty, post-traumatic stress from conflict etc.) by convening regular reflection meetings to discuss issues concerning gender relations such as shared care giving, households resource management, decision-making on SRH, violence and alcoholism. To date 642 RMM, who are working with over 6,420 households across eight districts, have been trained through NUWEP.

Since 2015 CARE Uganda has worked with a local CSO to adapt the RMM approach to promote men's positive involvement in sexual, reproductive, maternal and child health (SRMCH) in three districts of Northern Uganda. The SRMCH project has been designed to respond to knowledge and information gaps on issues of sexuality and the potential role of men in supporting SRMCH. 100 RMM have been trained on simplified community SRMCH modules, developed in partnership with district health departments, and have reached 6,000 men across the project working area. Results reported for the SRMCH project include: increased knowledge among men of the importance of supporting their wives to access SRMCH services; improved family relationships and reduced violence; a greater than 50% increase in the numbers of mothers and husbands seeking ante-natal and post-natal care in Gulu district; and increased uptake of family planning services and antiretroviral therapy³⁴.

The EMB approaches developed by CARE across the four countries all involve mobilising men to reflect on their own personal experiences to build understanding of and support for concepts of positive masculinity. The rationale for this is that men who embrace concepts of positive masculinity will be able to build more harmonious and gender equitable relationships in their households and communities, thereby contributing to development of an enabling environment for gender equality and ending GBV. In all four countries, EMB programming has also emphasized the establishment of mechanisms to provide peer support for engaged men. However, the degree of focus on engaging men and women together in their couples has varied across different countries and different programmes. For example, the *Abatangamuco* movement developed as a movement that focussed primarily on engaging men in changing their negative behaviours, with women's role in the movement initially being largely confined to witnessing and testifying to those changes, rather than being agents of change themselves³⁵. By contrast, the JoT curriculum developed by CARE Rwanda and Promundo was designed specifically for use with couples and facilitating couple-based dialogue continues to be the primary focus of CARE Rwanda's EMB programming approach.

An in-depth analysis of the comparative value and relative impacts of these variations of the EMB programming approach has not yet been carried out specifically for the Great Lakes region³⁶. In 2015 however, a Men Engage Learning Initiative was carried out for a sample of CARE's EMB interventions in Africa, Asia and Latin America and the Caribbean, which included field-based community analyses in Uganda, Rwanda, Tanzania and Niger³⁷. The learning initiative meta-analysis reported changes in the behaviours of engaged

³³ CARE International in Uganda (undated) *Northern Uganda Women Empowerment Programme (NUWEP): Engaging Men and Boys Model*. Programme technical brief: 8pp.

³⁴ CARE International in Uganda (2016) *Annual Report Financial Years 2014 - 2015*

³⁵ De Boodt, K. (2009) *Final evaluation of the Abatangamuco*. Consultancy report for CARE International in Burundi: 26pp.

³⁶ CARE Burundi had planned to undertake a piece of action research comparing the *Abatangamuco* and Journeys of Transformation initiatives in Burundi in collaboration with the World Bank but this study was postponed due to the political crisis of 2015.

³⁷ Wu, D., R. Baron, S. Martins, R. Shannon (2016) *Man in the Mirror: Reflections on men and boys engaging gender work in development*. CARE International report: 21 pp.

men at individual, household and community levels which contribute to reducing GBV (e.g. reduced consumption of alcohol, increased sharing of household decision-making, and men acting as counsellors and educators within their communities), and which were consistent with programming experiences and findings from programme evaluations from the Great Lakes region.

However, CARE's programming experiences also show that there are challenges associated with the EMB approach: engaged men often experience negative reactions, resistance and backlash to their changed attitudes and behaviours, which challenge traditionally accepted social norms³⁸. Poverty is also a factor that can cause men to go back to their previous negative behaviours, or to abandon participation in EMB initiatives – as illustrated by the challenge of drop-out reported for Men Engage groups from the *Mawe Tatu* and GEWEP interventions in DRC³⁹. Concerns have also been raised about the tendency of some RMM to adopt a quasi-evangelical approach in advocating to address GBV, using religious references which can exclude other groups, and which promote solutions to previously violent relationships that focus on preserving the marriage rather than listening to women's needs and preferences. An external analysis of CARE's EMB work has also identified tensions relating to engagement work with men and boys including tendencies for the reification of "good" masculinity and rewarding men as champions if they provide even tokenistic support for initiatives promoting gender equality⁴⁰. These issues highlight the need to facilitate deeper consideration and more meaningful analysis and understanding of the underlying power dynamics that enable couples to negotiate and create healthy relationships within families and communities as a critical part of EMB programming interventions.

CARE's work on EMB is nonetheless widely recognised by donors, partners and programme staff as a particular strength of the organisation's programming to prevent and respond to GBV in the Great Lakes region. The EMB approach is now being adapted for programming with youth, as for example in the *Sisi vijana* project being implemented in Burundi and DRC to promote support for gender equitable social norms and reduced tolerance of GBV among young men and women aged 13 -23. CARE Uganda's EMB approach of working with Role Model Men is also being adapted and scaled up (see Section 7) as part of CARE's interventions on SRH and GBV prevention and response as part of the humanitarian response to the influx of refugees from South Sudan who have settled in the West Nile region⁴¹. CARE's experiences to date from gender synchronized programming based on the VSLA and EMB approaches have resulted in increasing recognition of the importance of building a supportive enabling environment for addressing GBV to ensure the sustainability of changes for women and men at the individual/ personal and household levels. The third programming approach of the POWER model therefore focuses on facilitating community dialogue, activism and action as a critical element of that process. The approach of facilitating community dialogue, activism and action in turn links to the fourth programming approach of engaging with local-level duty-bearers and service providers to ensure their support for communities taking action against GBV (see section 4.4).

4.3 Working with communities to facilitate community dialogue, activism and action

CARE's experiences from programmes such as NUWEP and GEWEP and from initiatives with the *Abatangamuco* in Burundi and RMMs in Uganda show that men, women and couples who have experienced positive changes in their relationships and lives are often motivated to try and help others change. However, their effectiveness in doing so depends to a large extent on gaining the support of the wider community, as part of a process of creating an enabling environment for social change. Building on this recognition, programming interventions in all four Great Lakes countries include activities to facilitate community dialogue,

³⁸ Kimonyo, A. (2015 b) *Cross-country learning on Engaging Men: The Case of Rwanda*. Consultancy report for CARE International in Rwanda, November 2015: 33pp.

³⁹CARE Nederland (2017) *Programme Mawe Tatu Revised Narrative Annual Plan for the period of 01/06/2017 – 31/05/2018*. Unpublished programme document: 17 pp.

⁴⁰ Duriesmith, D. (2017) *Engaging men and boys in the Women, Peace and Security Agenda: Beyond the "Good Men" Industry*. Paper 11/2017, LSE Centre for Peace, Women and Security working paper series.

⁴¹ CARE/ UNFPA (undated) *Empowering Women and Girls through CARE's Role Model Men (RMM) approach*. Briefing note: 3pp.

activism and action for prevention and response to GBV based on the use of participatory methodologies such as Social Action and Analysis (SAA) and SASA! (see Box 3). CARE's youth-focussed programming interventions in the Great Lakes region also include community outreach activities with the parents of the adolescent girls and boys participating in those projects, as well as with community leaders and teachers.

The SAA and SASA! methodologies both involve processes of facilitated reflection to enable communities to explore and challenge restrictive social norms. The SASA! methodology developed by the Ugandan NGO Raising Voices has however been more widely taken up in CARE's programming for GBV prevention and response in the region, while the SAA methodology has been used mostly in SRH programming. Interventions such as NUWEP in Uganda, the *Mwanamke, Amani na Usalama* (MANU) project in DRC and the *Indashyikirwa* project in Rwanda are using the SASA! methodology to train community volunteers to facilitate community mobilisation based on awareness raising and dialogue on GBV and gender equality issues at community events and forums. For example, the Women's Space Facilitators (WSFs) trained by the *Indashyikirwa* project in Rwanda hold regular discussions on topics such as the management of household economic resources, alcohol consumption, family planning which are open to all community members. They raise gender equality and GBV issues at community meetings such as the Parents Evening forums, which are held by local leaders to discuss community development processes. The WSFs (and community volunteers with equivalent functions in some of CARE's other interventions which are promoting community mobilisation and activism) also play a role in facilitating GBV referrals, by linking survivors to the relevant service providers, and providing informal counselling and mediation support.

Box 3: Overview of SASA!

SASA! (the Kiswahili word for "now") is a community mobilization methodology developed by Raising Voices - a Ugandan NGO - for addressing the link between violence against women and HIV/AIDS by exploring the central question "How are you using your power?" The SASA! methodology provides an approach for changing the social norms that perpetuate women's vulnerability to violence and HIV. It is structured around four stages of community mobilization that enable organisations to effectively and systematically facilitate a process of behaviour change in the community. The four stages of change are:

- **Start:** During this first phase, violence against women and HIV/AIDS are introduced as interconnected issues and community members begin to foster *power within* themselves to address these issues.
- **Awareness:** In the second phase, community members experience a growing awareness about how communities accept men's use of *power over* women, fueling the dual pandemics of violence against women and HIV.
- **Support:** Throughout the third phase, community members discover how to support the women, men and activists directly affected by or involved in these interconnected issues, by joining their *power with others*'.
- **Action:** In the fourth and final phase, community members explore different ways to take action, using their *power to* prevent violence against women and HIV.

Source: <http://raisingvoices.org/sasa/>

CARE Rwanda's *Indashyikirwa* project (see Box 4) incorporates a particularly strong focus on promoting community activism in support of broader social change at the community level. The project does this by providing additional activism skills training based on the use of SASA! techniques to selected couples who have completed the JoT couples-based training curriculum, and who are willing to become activists in their communities advocating for the prevention of GBV. The project is the subject of a rigorous ongoing impact evaluation being conducted through the DFID-funded What Works consortium⁴². The *Indashyikirwa* impact evaluation has included a randomized control trial across three time-points with intervention and control couples, designed to assess key risk factors for Intimate Partner Violence (IPV) and the prevalence of IPV. The

⁴² The What Works to Prevent Violence Against Women and Girls Programme is a £25 million flagship programme from the UK Department for International Development (DFID), which ... supports primary prevention efforts across Africa, Asia and the Middle East, that seek to understand and address the underlying causes of violence, and to stop it from occurring. (See <http://www.whatworks.co.za/about/about-what-works>).

impact evaluation has also involved qualitative research to track the project's implementation, to understand how the project interventions work in different contexts and to assess whether and why interventions are influencing change⁴³. The results of the impact evaluation are expected to become available in July 2018. Preliminary analysis however suggests that there is significant evidence of the impact of *Indashyikirwa* on women's economic, personal and relationship empowerment, and on preventing IPV. The process research with couples suggests the majority have made significant household investments using the curriculum stipend, and due to greater joint decision-making⁴⁴. The project is also anticipated to have an impact on the wider community level for couples who did not participate in the JoT training but who were subsequently targeted by community activists.

Overall, CARE's programming experiences suggest that the SASA! methodology provides an effective mechanism for enabling communities to identify ways of addressing GBV issues by and for themselves in both long term development interventions and in the humanitarian context with refugee populations⁴⁵. CARE's programming approach of promoting community dialogue, activism and action for GBV prevention and response based on the use of SASA! and other participatory methodologies is also an important mechanism for supporting women's leadership development, as women often take on key roles in those processes as community facilitators and case managers. In doing so, they gain skills, confidence and recognition within their communities as well as providing role models for other women to emulate, as part of the community-wide process of social change.

So far therefore we have seen that CARE's experience in the Great Lakes strongly supports the integration of three elements – promoting women and girl's economic, social and political empowerment through VSLA and other approaches, addressing harmful norms through engaging men and boys, and facilitating community dialogue, activism and action – in effective GBV programming at the community level. The next two sections will examine how complementing this community-level programming with additional elements can both enhance its effectiveness, and potentially enable the multiplication of impact to a far greater scale.

Box 4: The *Indashyikirwa* programme

The *Indashyikirwa* programme is a 4 year (2014-2018) IPV prevention programme coordinated by CARE International Rwanda, implemented by Rwanda Men's Resource Center (RWAMREC) and Rwanda Women's Network (RWN), and funded by DFID Rwanda. The programme is being implemented across 7 districts, in 14 sectors of Eastern, Western and Northern Provinces of Rwanda. 14 additional sectors receive standard VSLA programming and serve as the control area. The programme works with couples recruited from CARE's micro-finance village savings and loans associations (VSLAs) through a 5 month curriculum to help couples build skills to prevent IPV and support healthy, equal relationships. A sub-set of trained couples have been further supported to diffuse what they learned in their communities through activism with neighbors. To help facilitate community-level change, the programme has also trained opinion leaders to more effectively prevent and respond to IPV, and established 14 women's safe spaces (one in each intervention sector) to educate women about their rights, accompany women who wish to report abuse or seek services, and advocate for both prevention of IPV and improved services for survivors of IPV.

Source: <http://www.whatworks.co.za/about/global-programme/global-programme-projects/evaluations-and-research/item/54-indashyikirwa-agents-of-change-for-gbv-prevention>

⁴³ <http://www.whatworks.co.za/about/global-programme/global-programme-projects/evaluations-and-research/item/54-indashyikirwa-agents-of-change-for-gbv-prevention>

⁴⁴ Stern, E. and Nyiratungu, R. (2017) A Process Review of the *Indashyikirwa* Couples Curriculum to Prevent IPV and support Healthy, Equitable Relationships in Rwanda. *Social Sciences* 6, 63: 13 pp.

⁴⁵ CARE's experience is consistent with the reported effectiveness of the SASA! methodology in other contexts. For example, a rigorous evaluation of a project implementing SASA! in Uganda found that its use had generated significant shifts in gender norms related to IPV, with a 52% reduction in past-year experience of physical IPV among women (Abramsky et al. 2012; Kyegombe et al. 2014).

4.4 Engaging with local-level duty bearers and service providers for strengthened capacity, coordination, resourcing and accountability

Policy and legal frameworks for prevention and response to GBV have been developed in all four countries of the Great Lakes region - in line with international commitments of UNSCR 1325, UNSCR 1820 and the Kampala Declaration⁴⁶ - and these frameworks define responsibilities for a set of 'duty bearers' with the state structures in all four countries, as well as – in theory – channelling resources to support specific capacities at different levels. Progress on the implementation of these frameworks has however been variable⁴⁷ and the incidence of GBV remains widespread, together with persistent problems of impunity and survivors' limited access to services, even in countries such as Rwanda where there exists a high level of apparent political commitment to addressing GBV. Among local level duty bearers and service providers, capacity constraints, including lack of awareness and understanding of the relevant policy and legal frameworks, limited resources, and poor coordination are often key limiting factors on the effective provision of services for GBV prevention and response. The fourth element of the POWER model therefore reflects the focus of CARE's programming on promoting an enabling environment for GBV prevention and response through engagement with local level duty-bearers and service providers. This element builds on and extends the programming approach of facilitating community dialogue, activism and action discussed previously.

In practice this programming element means that CARE and CARE partners work with opinion leaders (i.e. people who hold influence in their communities, which includes local government representatives, cultural and religious leaders, service providers, people working in the media, sports personalities etc.) often using training methodologies such as SASA! to build awareness and understanding of concepts of GBV and gender equality. In programmes focussing on GBV prevention - such as NUWEP in Uganda or the *Indashyikirwa* project in Rwanda - these activities are designed to promote changes in leaders' attitudes and mindsets to enable them to support communities in taking action against GBV. The process of engaging opinion leaders in this way is often linked to local-level advocacy initiatives being raised by community members.

CARE interventions designed to strengthen GBV response also incorporate trainings with service providers that promote awareness-raising and support technical capacity-building to ensure the quality of care provided to survivors (which can be psychosocial support, medical care, protection and legal aid and/or support for their socio-economic reintegration). For example, the Supporting Access to Family planning and Post-Abortive Care (SAF-PAC) intervention in DRC and Uganda includes trainings of health facilities' staff on the Minimum Initial Services Package for Reproductive Health (MISP) in Crisis Situations, covering the clinical management of rape, and administration of Post Exposure Prophylaxis and emergency contraceptives, which is used as an entry point to family planning and post-abortion care services.⁴⁸

CARE's programming experiences in the Great Lakes region show that promoting an enabling environment for GBV prevention and response also requires the strengthening of linkages between communities and local government and service providers. Community support networks to link survivors with duty-bearers and service providers have been established by various interventions in the region to meet this function. Examples include: the GBV case managers of the Great Lakes Advocacy Initiative; the Women's Rights Activists (WRAs) of the MANU project in DRC; the Community Volunteers in CARE Uganda's humanitarian response programming; and the *Indashyikirwa* WSFs. Local leaders, programme staff and partners consistently report

⁴⁶ WayFair Associates (2013) *The Great Lakes Advocacy Initiative (GLAI) Final Evaluation*. Unpublished consultancy report prepared for CARE Norway: 94 pp.

⁴⁷ See, for example: CEWIGO/ DGF (2017) *Deepening Advocacy on Women, Peace and Security – a CSO Monitoring Report. Monitoring the implementation of the National Action Plan for UNSCR 1325 and UNSCR 1820 and the Goma Declaration in Uganda*.

⁴⁸ The Minimum Initial Service Package (MISP) is a series of crucial actions required to respond to reproductive health needs at the onset of every humanitarian crisis. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff. See: <https://www.unfpa.org/resources/what-minimum-initial-service-package>

that the presence of these community-based structures contributes positively to improved communications, responsiveness and coordination of GBV prevention and response at the local level. Women taking up roles in these community support networks in some cases go on to take up leadership roles within and beyond their communities - a tendency which CARE recognises provides as a mechanism for strengthening women's voice in local level processes of decision-making and resource allocation for GBV prevention and response.

In a few interventions promoting an enabling environment for GBV prevention and response has also involved the establishment of actual physical spaces, where community volunteers are able to engage with survivors and community members. For example, the *Indashyikirwa* project has established Women's Spaces where the WSFs organise community dialogues, develop and implement advocacy messages, provide GBV referral services and organize monthly review and planning meetings. CARE Uganda is similarly planning to create Women and Girls' Centers to support the GBV prevention and response activities by community volunteers and CARE staff as part of its humanitarian response in the West Nile and South West refugee settlements. The intention of these structures is to provide a private and safe space where women and girls feel physically and emotionally safe, where they can report and seek support services on GBV, interact socially and access information. In the context of the humanitarian response with refugees from DRC and South Sudan, the need to provide equivalent spaces for men and boys, who may also be victims of GBV and/or in need of psychosocial support, has also been identified. While the existence of these spaces offers greater confidentiality and security for survivors and community volunteers, the question of their sustainability in the absence of external funding has yet to be fully addressed. In Uganda the intention is to situate the Women and Girls' centres in close proximity to existing health facilities to enable their long-term management by the health facility staff.

Other activities undertaken by CARE interventions to support effective engagement with duty-bearers and service providers have included:

- The production and dissemination of popular versions of key policies and legislation on GBV to promote the accessibility of this information for opinion leaders and communities. This has been a focus of CARE Burundi's work with COCAFEM.
- Use of the Community Score Card (CSC) process (see Box 5) to promote and increase the monitoring of GBV service delivery by citizens and civil society and to increase the accountability and responsiveness of services providers and local leaders in CARE Rwanda's *Umugore Arumva* ('A woman is listened to') project⁴⁹, and in the Every Voice Counts project being implemented by CARE in Burundi and Rwanda.
- Working in partnerships with local CSOs which have specialist technical capacity for providing quality care to survivors. For example, in DRC CARE works with the Dynamique des Femmes Juristes (DFJ) – a feminist CSO led and predominantly staffed by women with legal expertise – on the implementation of GEWEP II. DFJ has established structures for providing legal support to GBV survivors. Although GEWEP II does not have funds for legal support activities, the partnership with DFJ facilitates referral of survivors to access those structure.

Box 5: The Community Score Card (CsC) model

The Community Score Card (CsC) is a participatory process designed to engage citizens in assessing and giving feedback on the quality and effectiveness of the public services they receive. It aims to improve citizen participation and collective action for improved service delivery. The CSC process engages both 'Service Users' (citizens) and 'Service Providers' in a discussion around the issues that affect service delivery and to develop joint action plans.

Source: Chambers, V. (2016) *ODI Policy Brief*.

⁴⁹ The Umugore Arumvwa (UA) project was a two year project (2013-2015) which aims to contribute to the fight against Gender Based Violence (GBV) by strengthening the voice of the citizens and civil society networks and improving the accountability of responsible authorities in preventing Sexual and Gender Based Violence. (see Chambers, V. 2016)

Examples of positive changes in the quality of engagement by local government and service providers on GBV issues that have been associated with CARE GBV programming interventions in the Great Lakes region include:

- In Uganda, district level action plans to address GBV have been developed by 6 districts of Northern Uganda. This process has involved translation of Uganda’s national action plan on the implementation of UNSCR 1325 and 1820 and the Goma Declaration to reflect the specific contexts of those districts. The existence of these district level action plans means that activities to prevent and respond to GBV receive higher priority in district planning processes and are more likely to be funded⁵⁰. Several of the districts concerned are reported to have since made budgetary allocations for GBV prevention and response activities.
- In Rwanda, the issue of health centres charging GBV survivors for medical treatment was identified through the *Indashyikirwa* Women’s Spaces and raised with district authorities. Advocacy by the WSFs and Rwanda Women’s Network (the partner organisation supporting the activities of the Women’s Spaces) resulted in a directive from the District Council that what was an ‘informal policy’ intended to discourage violence should be abandoned to enable survivors of GBV to claim their right to free medical treatment. The issue has since been taken up by the project with the Ministry of Gender Equality and Promotion of Family as an advocacy issue that needs to be addressed at the national level.
- In three communes in Burundi, the *Abatangamuco* are running sessions on concepts of gender equality, gender roles and GBV for couples who are applying for the civil registration of their marriages and they are working to include these sessions in the official policy requirements of what couples need to do before marriage⁵¹.
- In DRC, the VSLA network in the town of Goma, with the support of CARE’s local partner, successfully lobbied for a reduction in the charges levied by local authorities for the civil registration of marriages. The registration of marriage is an important mechanism for the protection of women’s rights, as women whose marriages are not registered do not have rights of inheritance.

4.5 Reaching and influencing decision-makers through evidence-based advocacy and partnerships at national, regional and international levels

The fifth element or key programming approach of the POWER model focuses on reaching and influencing decision-makers through evidence-based advocacy and partnerships at national, regional and international levels. This element is vitally important for promoting the implementation, and – where appropriate – reform, of existing policies and legislation relating to GBV, and for multiplying the impact of CARE’s programming for GBV prevention and response. This programming approach is critical to support the reach, impact and sustainability of the four other programming approaches of the POWER model that seek to promote changes for individuals, households, communities and with duty bearers and service providers.

CARE’s understanding of advocacy as “... *the deliberate process of influencing those who make decisions about developing, changing and implementing policies*”⁵² includes implicit recognition of the need for working in partnership with others. Working in partnership has become a central strategy for CARE programming in the Great Lakes region over the past 7 years. Most of CARE’s programming interventions for GBV prevention and response in the region are now being implemented largely through partner organisations rather than by direct delivery. The nature and quality of CARE’s partnerships with local and national CSOs has therefore become a key determinant of the quality of the organisation’s programming. Working in partnership has meant that CARE’s role has shifted to focus increasingly on capacity-building with partners to ensure programme quality

⁵⁰ CARE Uganda (2016) *Contribution, Attribution: CARE’s 10 year long effort in advocating for Uganda’s National Gender-Based Violence Policy*. Process documentation, CARE International in Uganda: 10 pp.

⁵¹ CARE Norway (2016) *Gender Equality and Women’s Empowerment Programme II, 2016 – 2019: 2016 Annual Report*. Programme document: 37pp.

⁵² CARE International (2014). *The CARE International Advocacy Handbook*. CARE International, Geneva: 44 pp.

and facilitate learning, coordinating activities by and with a range of different partners, and convening or supporting alliances for higher-level advocacy initiatives.

Capacity-building with local and national CSO partners is widely recognised as a strength of CARE's programming by partners, donors and programme staff. It has been an important factor contributing to the progress and achievements of CARE's engagement in advocacy initiatives on GBV issues at the national level and beyond. The Great Lakes Advocacy Initiative (GLAI) implemented by CARE with local partners in Rwanda, Uganda, Burundi and DRC piloted a GBV Information Management System and built the capacity of community activists and local partners to use data from the GBV IMS for advocacy, thereby focussing the attention of the public and decision-makers on the high incidence of GBV and its serious consequences for survivors. By facilitating linkages and working in partnership at multiple levels GLAI brought evidence and voices from the grassroots level into national debates which influenced changes in policy and policy implementation in all four countries⁵³. Experience from GLAI has informed an ongoing focus on strengthening linkages between local and national level advocacy processes in CARE's GBV programming. For example, in Burundi CARE is supporting the development of women's advocacy networks to represent issues identified by community groups at commune and provincial level.

CSOs and CSO network partners supported by CARE during GLAI have continued to play active roles in advocating on GBV issues in their countries since the end of the project in 2013. For example, in Uganda CARE is an active member of the GBV coalition – an alliance of INGOs and CSOs – which is monitoring the progress of implementation of Uganda's National Action Plan on UNSCR 1325, 1820 and the Goma Declaration and which has played a key role in the development of Uganda's 2016 National Policy on GBV. In Rwanda, the CSO GBV network established during GLAI⁵⁴ is also involved in monitoring the implementation of these international commitments and advocating for the inclusion of GBV activities and indicators in district development plans and annual performance contracts⁵⁵.

Other strengths of CARE's programming in terms of reaching and influencing policy-makers on GBV issues at the national level identified by this review include:

- Building strong working relationships with national government and development partners to promote the uptake of CARE programming approaches. For example, in Burundi the Ministry of Gender has requested capacity-building support for the roll out of the VSLA programming approach through local government structures at the provincial level. In Rwanda, CARE has signed an MoU with MIGEPROF to guide collaborative working and a representative from the Ministry is a member of the steering committee for the *Indashyikirwa* project. In Uganda, CARE has been consulted by the Ministry of Gender on the development of the ministry's policy for engaging men and boys and is a member of the Financial Inclusion Technical Working Group (TWG) chaired by the Ministry of Finance.
- Working with women parliamentarians as potential champions for change on issues of gender equality and GBV. Examples include CARE Uganda's lobbying of Uganda Women Parliament Association (UWOPA) for the development of Uganda's National GBV policy, and CARE Burundi's advocacy with women parliamentarians concerning the development of the Law on GBV that was enacted in 2016.

⁵³ WayFair Associates (2013).

⁵⁴ The CSO GBV network in Rwanda is coordinated by Pro-Femmes /Twese Hamwe - a national civil society umbrella organization established in 1992. Profemmes currently represents 57 civil society organizations aimed at the advancement of women, peace and development in Rwanda.

⁵⁵ Initiative Performance Consult Ltd. (2015) *Final Report of the Endline Evaluation: Umugore Arumvwa "A Woman is Listened to" Project*. Consultancy report for CARE International in Rwanda: 80 pp.

- Maintaining an active presence on relevant technical working groups and engaging with government and civil society to raise awareness of CARE’s GBV programming approaches during events such as the 16 days of activism, International Women’s Day etc.

There are fewer striking examples of CARE’s achievements in terms of advocacy and partnerships for addressing GBV at the regional and international levels. The need to strengthen CARE’s engagement at these higher levels was consistently recognised by programme staff, particularly for addressing sensitive issues of governance and women’s rights in the politically volatile contexts of DRC and Burundi. However, CARE is recognized to have made a significant contribution through GLAI to the lobbying done by CSOs across the region to influence the development of the 2011 Kampala Declaration⁵⁶. CARE’s participation in this process included active engagement in national consultation processes and attendance by GLAI programme staff from Burundi, Uganda and Rwanda at the Regional CSO Experts meeting in Arusha, Tanzania which was convened in preparation for the summit. Data from the GBV IMS piloted through GLAI was used to demonstrate the scale and impacts of GBV as a problem requiring deliberate and focused attention across the region. Several of the key resolutions included in the Kampala Declaration, including those on one stop centres and zero tolerance, were based on CSO contributions. Key factors that enabled CARE’s contribution to this process included: the availability and use of flexible funding to convene and support stakeholder meetings and to ensure CARE’s active presence in those forums, as well as the availability of compelling evidence from grassroots level programming.

CARE is now working to define a regional advocacy agenda focussing on the three proposed priorities of:

1. Domestic violence;
2. Barriers to women’s economic participation and decision-making; and
3. Sexual violence.

The region has supported a consultancy to conduct a mapping of key GBV stakeholders at the national and regional levels⁵⁷ and to identify GBV-related policies and guidelines presenting opportunities for CARE to move forward on programming to deliver the Life Free from Violence IGS. The further development of the regional advocacy agenda in the coming months is likely to build on the value proposition articulated here through a process of reflection and discussion with programme staff from the four country offices and the regional management unit.

⁵⁶ The Kampala Declaration was signed by the Heads of State of the International Conference of the Great Lakes Region (ICGLR) in December 2011 and committed those states to fast-track the prevention of GBV, to end impunity and to ensure the provision of support to survivors.

⁵⁷ Fate Consulting Ltd. (undated). *Great Lakes GBV External Landscape Mapping Final Report*. Consultancy report prepared for CARE Great Lakes: 40 pp, and CARE Great Lakes (undated) *GBV Landscape Report – Complement to Fate Consulting Report*.

5. CARE's GBV programming for Humanitarian Response in the Great Lakes Region

Since 2014, CARE Uganda has been responding to the South Sudanese refugee crisis with interventions in SRH and GBV prevention, care and support in Rhino settlement in the West Nile Region, which response was later expanded to Imvepi and Bidibidi settlements. CARE Uganda's GBV programming in this humanitarian context has involved a series of projects funded by UNFPA, the Czech Republic, ECHO, Norad, GAC and the Austrian Development Agency (ADA)⁵⁸. During FY 2016 CARE also implemented two projects in eastern DRC which were categorised as humanitarian response interventions and which focussed on promoting SRH. These projects were the Aid Match project, which aimed to improve access by adolescents in the town of Goma to modern methods of contraception, and the SAFPAC project, which is being implemented to promote improved access to family planning and post-abortion care across four sites of intervention in North Kivu⁵⁹. The 2017 PIIRS data however reported that the Aid Match and SAFPAC projects were not directly addressing issues of GBV, which seems surprising given the high incidence of sexual violence in the DRC context and its linkage with SRH⁶⁰. While the Aid Match project has now closed, the SAFPAC project has recently developed an action plan for integrating GBV response into the project's implementation strategy, which has involved training on GBV for project staff, updating project materials and tools for communications and data collection and the inclusion of activities focussing on GBV with health services providers and communities.⁶¹

In the West Nile region of Uganda, CARE is working to respond to the needs of refugees, the majority of whom are women and children, who have fled the conflict in South Sudan which has involved the widespread use of sexual violence as a weapon of war. Many of the women and girl refugees arriving in the West Nile refugee settlements have suffered sexual abuse and violence sometimes both in South Sudan and in Uganda. Unaccompanied women and girls are particularly vulnerable to harassment, exploitation and violence in crowded refugee settlements where insufficient access to food, water and other items for meeting basic needs often forces women and girls to adopt risky behaviours, including transactional and commercial sex⁶². Many also face maternal and reproductive health problems. Men and boys arriving in the refugee settlements have often also experienced trauma both as perpetrators and victims and so have their own needs for SRH and PSS services. Changing gender roles in the socially unstable settings of the settlements, where men have limited opportunities to provide for their families and/or where women may become the breadwinners for their households, can also lead to negative behaviours such as alcohol and substance abuse, which increase the risk of GBV.

In the context of the West Nile refugee settlements, CARE's humanitarian programming for GBV prevention and response has incorporated four key elements of the POWER model, namely the approaches of: engaging men and boys; facilitating community dialogue, awareness-raising and action; promoting access to services (e.g. healthcare and psychosocial support); and engaging in advocacy and partnerships with other organisations involved in the humanitarian response, including the Government of Uganda, UNHCR and other INGOs. The adaptation of the RMM model developed under NUWEP has been a key strategy for CARE Uganda's

⁵⁸ CARE International in Uganda (2016)

⁵⁹ CARE International in DRC (2017) *Rapport d'Evaluation du Projet AIDMATCH implementé dans la ville de Goma (RD Congo)*.

Unpublished project document : 93 pp ; CARE International in DRC (undated) *Work-Plan CARE SAFPAC Phase 3*. Unpublished project document.

⁶⁰ Data reported in 2017 for the Aid Match project showed that 6.3% of male youth (n = 320) and 20.7% of female youth (n = 466) interviewed for the project endline survey had experienced rape in the 12 months prior to the survey. *Ibid*.

⁶¹ While CARE's other GBV programming interventions in eastern DRC (i.e. GEWEP, *Mawe Tatu* and MANU) are categorised as long-term development projects, programme staff based in Goma consistently commented that the ongoing insecurity in eastern DRC means those projects also need to be able to address issues of humanitarian response in response to the changing conditions of that conflict-affected context.

⁶² CARE/ UNFPA (undated) *Empowering Women and Girls through CARE's Role Model Men (RMM) Approach*. *Briefing note*.

GBV programming in the humanitarian context⁶³. This has involved a focus on addressing male youth's psychosocial support needs, for example through activities such as peer support, community theatre, and emphasizing the need to adapt to cultural diversity in new settings where daily activities are not defined. To date 42 refugee RMM have been trained who have reached over 4,336 men in Rhino Camp settlement. The work with refugee RMM is still at a relatively early stage, but is recognised by partners, women refugees who have witnessed the activities of the RMMs, and programme staff as a strength of CARE's emergency response. Based on the recognition that many refugee households are headed by women who are exposed to violent men outside their household, CARE Uganda is now planning to support the refugee RMM to reach out to other men organised into men's groups or so called "Male Action Groups", and to promote collaboration on positive masculinity between refugee and host community men and boys. A deliberate effort is being made to adapt the methodology to adolescent boys and young refugee men in the settlements.

CARE Uganda's emergency response has also involved the establishment of a network of community-based facilitators based in the refugee and host communities who are trained to facilitate community dialogue and awareness-raising activities, to support referrals and to provide some basic counselling to GBV survivors. Information desks have been set up in the refugee settlements to facilitate the reporting of GBV cases by survivors to community volunteers, but some of these desks are located in open public spaces. In recognition of the need to ensure greater confidentiality and security of the reporting and referrals process for both survivors and the community volunteers, CARE is now supporting the construction of Women's Spaces in the settlements as buildings dedicated for use in GBV prevention and response. At the same time as supporting the Community Volunteers in awareness-raising activities, CARE Uganda is also working with local leaders from the Refugee Welfare Councils (RWCs) and from host communities to promote understanding and awareness of the different forms of GBV and the legislation existing in Uganda to address it.

In terms of promoting access to services by GBV survivors: CARE Uganda's emergency response has included capacity-building activities with Health Centres on the use and distribution of PEP kits, emergency contraception (through training on MISP as mentioned above) and dignity kits; training with Police and Health sector workers on the Government of Uganda Standard Operating Procedures for GBV case management and referral; and the provision of psychosocial support to GBV survivors by programme staff – including activities with youth (e.g. community theatre and sport). Programming activities to promote an enabling environment for GBV prevention in the refugee settlements have involved the use of Participatory Safety Audits bringing together refugee and host communities to jointly identify areas or activities that present risks to the entire community and specific gendered risks for men and boys and women and girls. A participatory process of discussion and analysis by refugees, host community representative and other key protection actors then enables the development of a joint safety plan specifying contributions from the diverse actors involved. Actions specified in these plans may include the installation of solar lighting at high-risk locations (e.g. water points and markets), the construction of additional latrines in public spaces, the design and construction of improved shelters for people with special needs (a category which includes women survivors of GBV), the organisation of community patrols in certain areas, the clearance of undergrowth from paths where girls might be attacked etc.. These activities for improved security were highlighted by CARE programme staff and the Community Volunteers in Rhino camp as a positive contribution to reducing the risk of GBV for women and girls.

Implementation of CARE's humanitarian response in the West Nile settlements has been carried out in partnership with other organisations (including Oxfam, Mercy Corps, Save the Children, Dan Church Aid) with each partner taking on responsibility for different components of response. CARE has provided training on integrating GBV response into the activities of consortium partners implementing WASH and livelihoods

⁶³ *Ibid.*

interventions. CARE has also advocated with partners and the government of Uganda for the adoption of the Prevention of Sexual Exploitation and Abuse (PSEA) code of conduct to provide a framework for ensuring respectful and safe working relationships with refugees, women and the communities involved in the emergency response, and has provided trainings on Gender in Emergencies and PSEA to both CARE staff and the staff of other agencies.

To date CARE's programming for humanitarian response in the West Nile has not included a VSLA component, although CARE is providing some support with small enterprise development and various types of cash for work to refugee youth at risk of GBV and GBV survivors, and another consortium partner (Mercy Corps) is implementing VSLA activities in some (but not all) of the sectors of the settlements covered by CARE interventions. Programme staff and participants identified the need for CARE to incorporate programming to promote refugee women's economic empowerment and to empower them to have more voice in recognition of the linkages between poverty and GBV. While programme staff recognised the potential challenges of implementing VSLA in the unstable social context of the refugee settlements, they suggested that the experiences of partners such as Mercy Corps currently implementing VSLA interventions in those settlements could inform the adaptation of the VSLA approach by CARE to the West Nile context. The community volunteer interviewed during the field visit to the Rhino Camp settlement mentioned that women in the camp have independently set up their own system of group-based rotational savings using cooking oil and other foodstuffs that are provided as part of the monthly ration by the World Food Programme (WFP)⁶⁴. This comment suggests that there is potentially demand for VSLA activities from the refugee community in Rhino settlement which hosts the more established, less recently-arrived refugees who tend to have greater capacity for saving. CARE's experience from DRC which has shown that IDPs who have fled conflict often manage to continue VSLA activities in the temporary camps where they seek shelter suggests that the inclusion of VSLA activities is likely to be a positive and viable development of CARE Uganda's GBV programming in the humanitarian context. A recent proposal incorporating a VSLA component has now been approved by UNFPA for the continuation of CARE Uganda's humanitarian response to reach all 8 refugee hosting districts in West Nile. CARE Uganda is now scaling up its humanitarian GBV programming in the South West and is targeting Congolese refugees.

In recognition of the need for alternative economic empowerment approaches in an emergency response setting where the funding cycles are too short for the full VSLA cycle and/or where refugees have limited capacity for saving, CARE Uganda is also advocating for the use of cash transfers linked to VSLAs, which would target women and girls engaging in transactional sex, as a strategy for reducing the risk of GBV in humanitarian response settings. This approach would involve the provision – for a defined time period - of a cash transfer amount based on the Minimum Expenditure Basket and topped up by an amount for saving to recipients who would be organised into VSLAs.

⁶⁴ Interview with CARE Community Volunteer, Grace Atek, in Rhino Camp settlement, 9/01/2018.

6. Learning from CARE's GBV programming in the Great Lakes region

CARE's contribution to tackling GBV in the Great Lakes region over the past ten years has been significant and innovative. Key learning points identified in this review regarding CARE's overall approach for GBV programming in Great Lakes region are:

Programmes that aim to address the root causes of GBV need to work at multiple levels and adopt gender-synchronized approaches. Promoting changes in attitudes and behaviours and the establishment of an enabling environment that supports the rights of women, girls, men and boys to live free from violence requires interventions that work with women, girls, men and boys as individuals, in households and in their communities, with local government structures and civil society allies and at national and regional levels. In humanitarian response settings interventions need to be designed and implemented to address the particular needs of groups such as IDPs, refugees and high-risk youth, as well as targeting the general population of host communities.

Programming to challenge and change discriminatory social norms and practices starts from within by building gender committed and competent organizations both in CARE and with local CSO partners. CARE programme staff and partners consistently referred to CARE's internal organisational culture as an important foundation for effective GBV programming. Staff who had been trained on JoT and SASA! methodologies spoke of changes in their personal values and behaviours due to the trainings. They recognised that this allowed them to "walk the talk" when facilitating gender-transformative programming with communities and other programme stakeholders. Organisational capacity-building initiatives such as CARE's GED initiative and the Learning for Change project in Rwanda and Uganda have contributed to this internalisation of ideas and values in support of gender equality.

A holistic approach for addressing GBV requires a flexible and context-specific balance between prevention and response – that balance will differ between long-term development and humanitarian interventions. CARE is widely seen as an organisation that focusses strongly on GBV prevention (as exemplified by the *Indashyikirwa* project in Rwanda), but the organisation also has an important role to play in programming for GBV response. Programme staff involved in CARE Uganda's humanitarian response to the South Sudanese refugee crisis identified the need to extend and strengthen GBV response activities to address survivors' needs (e.g. for healthcare and psychosocial support) as a complement to the GBV prevention work that CARE is undertaking in the refugee settlements, and to incorporate activities to promote the economic empowerment of refugee women and men to cover their basic needs as part of the overall humanitarian response. Similarly, programme staff and partners in DRC and Burundi identified the need for CARE to incorporate humanitarian response work into its ongoing long-term development programming on GBV as necessary to meet the changing demands of the highly insecure contexts in which they are working.

The 'POWER' model provides an integrated framework for GBV prevention and response which can be adapted to different contexts, including in situations of conflict. The model recognises the need to address power relations at multiple levels through the five key programming approaches by empowering women and girls; encouraging men and boys to use their power positively in building healthy relationships that promote gender equality; enabling the voices and perspectives of less powerful/ marginalised groups (including women and girls) to be heard in processes of community dialogue and action; and similarly promoting increased responsiveness and accountability of duty-bearers and service providers at local and national level to the communities, households and individuals they work with and for. The focus of the model on facilitating reflection, dialogue and the negotiation of mutually respectful and beneficial relationships at all levels make it potentially highly relevant as a programming framework in situations of conflict which are characterised by extreme imbalances in the power relations between men and women, people of different social and ethnic affiliations, communities etc. CARE's ongoing and future programming for GBV prevention and response in the

Great Lakes region offers considerable scope for learning as to what works in addressing GBV in conflict and post-conflict settings.

Key learning points identified regarding the specific programming approaches of the POWER model are:

On Promoting women and girls' economic, social and political empowerment:

Programming for effective GBV prevention and response involves empowering women and girls economically, as well as strengthening their agency and leadership capacity. CARE has developed a range of programming approaches for women's economic empowerment, including the VSLA approach which has proven to be a key element of CARE's GBV programming at scale in the Great Lakes region.

The majority of VSLAs manage to sustain their savings and credit activities even under conditions of extreme insecurity. CARE DRC has experience of adapting the VSLA approach to promote resilience in conflict-affected communities in eastern DRC, where VSLAs have continued operating in IDP camps based on a shortened 5-6 month saving cycle. However, the security of VSLA funds is a growing and critical factor for the sustainability of progress achieved by VSLA members. More learning is needed to support the development of an approach for addressing the security issues encountered by VSLAs in conflict settings. In Uganda, CARE is planning to incorporate a VSLA component into the scale-up of its humanitarian programming with refugees in West Nile and South West Uganda, while also providing support for shorter cycle economic empowerment approaches such as IGA and small enterprise development and cash for work. The emergence of endogenous food-based savings groups organised by women refugees themselves in Rhino Camp settlement clearly suggests there is likely to be considerable demand for an adapted VSLA initiative there.

Programming for GBV prevention and response at scale in the Great Lakes region needs to address the specific needs of adolescent girls (and boys) for information on issues of gender and gender equality, including GBV and SRH; and for support in accessing services and building healthy relationships with their peers, their families and their communities. This learning point reflects the demographic reality of the Great Lakes region in which all four countries are characterised by very young populations, together with CARE's understanding that discriminatory social norms are rooted in socialisation practices experienced from early childhood onwards.

On Organising and engaging men and boys (EMB) to challenge gender inequitable social norms and practices:

Economic incentives provide a key entry point for GBV programming with women and men. Poverty is recognised as an important causal factor for GBV. One of the great strengths of the VSLA approach is that it provides a strong economic incentive for women to meet regularly, which is valued by both women and their male relatives and which promotes high rates of attendance at regular VSLA meetings. CARE's experiences of engaging men in the Northern Uganda and the West Nile refugee camps and DRC highlight that men in those highly insecure contexts are often unable to support their families and also need opportunities for socio-economic development. CARE DRC's experience from the *Mawe Tatu* project suggests that in the absence of any economic incentive for men to participate in weekly trainings it can prove difficult to retain men in Men Engage clubs leading to rates of drop-out that limit the effectiveness of the approach. By contrast, the *Indashyikirwa* project which paid a stipend to couples participating in the JoT training over a period of 20 weeks experienced little or no drop-out.

This raises a question as to how CARE - an organisation that focuses on promoting women's empowerment - could or should consider ways of providing economic incentives to the men and boys being engaged to support of gender equality. In Burundi, the registration of the *Abatangamuco* as a formal organisation which now operates as a CSO working in partnership with CARE, means that its members can now receive payment for their activities. In Uganda, CARE pays a stipend to RMMs in the humanitarian sector to cover the opportunity costs of their engagement in community mobilisation and awareness-raising activities, in line with the stipends paid to community volunteers. In DRC CARE programme staff are discussing the option of establishing VSLAs

for the Men Engage clubs. This thinking is consistent with the approach being taken by the *Sisi vijana* project where youth VSLAs provide an entry point for engaging boys with the adapted version of the JoT training curriculum.

EMB initiatives need to target adolescent boys, youth and single men as well as men in couples and opinion leaders. Much of CARE's EMB programming over the past ten years has focussed on engaging men in couples - particularly men who are the wives of women VSLA members - and men who are in positions of influence and leadership. However, recognition of the role of socialisation practices in perpetuating gender norms has led to increased investment in gender-synchronized programming targeting the adolescents and youth (boys and girls), who are the men and women of tomorrow. CARE Uganda's experience of working in post-conflict and refugee settings in Northern Uganda and West Nile has also highlighted the need for EMB programming targeting single men, who may be mobile and living independently.

EMB approaches are an important element of CARE's GBV prevention and response programming, but it is critical that women are also actively involved and have a voice in processes of dialogue and action with and by engaged men and boys. Evaluations of EMB initiatives in Burundi and Rwanda have noted the tendency for men's voices and experiences to be more dominant in the *Abatangamuco* movement and in the Men Engage clubs established in Rwanda. By contrast, the adapted JoT and SASA! curriculum developed by the *Indashyikirwa* project encourages men and women in *couples* to understand and discuss their relationships in terms of power balance/ imbalance, based on the premise that all individuals, men and women, can use power both positively and negatively in everyday situations. It would be useful for CARE to build a deeper understanding of how the different EMB approaches that have developed in Burundi, Rwanda and Uganda (i.e. the *Abatangamuco* movement, the JoT couples' curriculum and the RMM) compare in terms of their effectiveness for supporting people to overcome predefined stereotypes, gender roles and/or prejudices that contribute to GBV⁶⁵.

Understanding GBV as the outcome of unequal power relations is potentially transformative, providing it is based on a process of meaningful participatory analysis and reflection by and with programme participants. Programme participants, staff and partners of the *Indashyikirwa* project in Rwanda highlighted that understanding GBV as the outcome of unequal power relations had been a very important learning from their participation in the project. This understanding was identified as a key factor that had helped couples participating in the *Indashyikirwa* project to build healthier relationships as the basis for living free of violence.

On Facilitating community dialogue, activism and action:

Combining context-appropriate approaches for promoting women and girls' empowerment, EMB and community activism provides a strong foundation for sustainable social change to address GBV. GBV programming interventions that are implemented by means of a community-based approach, and which work with and build on existing community structures, ensure ownership of the change process by the people involved and so are more likely to be self-sustaining and self-replicating. In the words of one of the *Indashyikirwa* Field Supervisors: *"The value of this approach is that the village will own the actions of fighting GBV. Those actions will not be brought by CARE or DFID but because they themselves will have developed them. They will do it with you or without you if you give them the notion"*⁶⁶.

On Engaging with duty bearers and service providers for strengthened capacity, coordination, resourcing and accountability:

Changing the mindsets and behaviours of Opinion Leaders is key for creating an enabling environment for effective GBV prevention and response. Interventions that work at the individual, household and community

⁶⁵ The What Works consortium has also highlighted an evidence gap in terms of the lack of research into the effectiveness of complex and multi-component interventions to transform masculinities or change social norms.

⁶⁶ Interview with Marietta Utamuvuna, *Indashyikirwa* Field Supervisor, 12/01/2018.

levels are not enough to stop GBV. Opinion leaders (including local government, traditional and religious leaders) and service providers are key partners and play key roles in supporting communities and their members in tackling GBV. Changes in the personal values and behaviours of these opinion leaders provide the foundation for them to commit to and engage in actions to prevent GBV within their respective areas of work. Such actions reinforce and amplify positive changes taking place at the individual, household and community levels through the combination of approaches to promote women and girls' empowerment, EMB and community activism.

Traditional and religious leaders are a particularly important target group for creating an enabling environment for GBV prevention and response. CARE DRC programme staff and partners emphasized the need to scale up and intensify EMB initiatives with traditional and religious leaders in communities targeted by CARE programming in eastern DRC. Traditional and religious leaders in DRC and other Great Lakes countries are highly influential in their communities, where literacy rates are often low, and yet are often resistant to concepts of gender equality, which are considered to reflect external, Western ways of thinking.

It is critical to support women and girls in taking up leadership roles in local governance structures at different levels so that they are able to influence processes of decision-making and resource allocation relating to GBV prevention and response, and to participate in holding duty bearers and service providers accountable.

On Reaching and influencing decision-makers through advocacy and partnerships at national, regional and international levels:

Working in partnership is an effective strategy for civil society capacity-building and extending outreach but can present challenges for programme quality, reporting and learning. CARE's programming through local partners is recognised as an area of organisational strength. Delivering transformative gender programming by working in partnership involves challenging civil society partners to be self-critical of their own biases relating to concepts of gender equality and GBV so that they also have the capacity to "walk the talk" in terms of their internal organisational cultures, and this has been a focus of CARE's Learning 4 Change initiative. It also means that CARE has a reduced direct presence in the field and is largely reliant on partner reporting to understand the progress and achievements of programming at that level. This was identified by donors and CARE programme staff as a challenge both in terms of ensuring the timeliness and quality of reporting, and for maintaining a culture of organisational learning. The need to strengthen systems and processes for understanding and documenting programming experiences by CARE and partners (see below) was widely recognised.

Bringing voices, experiences and evidence from the grassroots level into debates at the national level and beyond, with specific attention to girls and youth, provides a strong foundation for advocacy on GBV issues. There are numerous examples of effective local level GBV advocacy initiatives emerging from CARE's programming in the Great Lakes region. In some cases, issues relating to GBV that have been raised in local-level advocacy initiatives (for example by VSLA networks in Burundi or the Advocacy working groups in Northern Uganda) have influenced or are influencing processes of dialogue and decision-making at higher levels. However, the need to strengthen advocacy at national levels and to establish a clearly defined regional advocacy agenda that would help mainstream advocacy as an integrated element of programming rather than as a specialist add-on function was identified by programme staff in all four countries.

Effective advocacy on GBV at the national level and beyond requires compelling evidence based on credible data and rigorous analysis. The experience from GLAI of having consistent and credible data from the GBV IMS which could be used for lobbying regarding the content of the Kampala Declaration illustrates this learning point. Programme staff and partners interviewed for this review consistently highlighted the need for better documentation and communication of CARE's programming experiences and learning to support CARE's wider

and more effective engagement in evidence-based advocacy. Partnerships with research institutions (such as for example, the *Indashyikirwa* research partnership with the What Works consortium) can potentially provide a way of partially addressing this gap, but clearly will only be possible for a limited sample of CARE's programming interventions. This learning point therefore indicates the need for CARE to invest in the wider strengthening of internal organisational systems and processes for monitoring, evaluation and learning by, with and through the programme staff and partners who are involved in field-based programming. Capacity-building for more effective MEL relating to CARE's GBV programming will require careful consideration of questions concerning: what data to collect, how and from where; how to present and interpret data to enable the more effective communication of CARE's programming results.

7. Scaling Up and Moving Forward

Various examples of the ongoing scale-up of CARE's programming approaches for GBV prevention and response were identified by programme staff and partners interviewed for this review, as well as potential opportunities for future scale up (see Table 2). Based on these examples, the following **pathways to scale** have been identified as potential mechanisms for significantly increasing the scale and impact of CARE and partners' programming to prevent and respond to GBV:

- 1) Implementation of the proposed POWER model at scale:** This pathway involves integrating CARE's evidence-based model for GBV programming into existing and future programmes by government, NGOs (including CARE), UN agencies and the private sector, leading to change at scale. This will include:
 - Expanding the geographical coverage of CARE's GBV programming with partners from government, civil society, bilateral and multilateral institutions. The recognised effectiveness of CARE's programming approaches for promoting women and girl's empowerment, EMB and community activism has led to demand from local and national government bodies, UN agencies and civil society partners to partner with CARE in new programming initiatives. CARE programming approaches are currently being scaled up with UNFPA and UN Women in Uganda and Burundi, and with the World Bank in Rwanda. In Rwanda, the potential scope for scale up with and through local government also appears high, given the focus of government attention on GBV as a priority issue at the national level.
 - Integrating approaches for GBV prevention and response into interventions being implemented by CARE in other programmatic areas such as education and SRH. There may be significant potential to increase the reach and impacts of CARE's work on GBV in the Great Lakes region by integrating or mainstreaming GBV programming approaches into programmes that focus primarily on other sectors, as illustrated by the recent development of a plan for integrating GBV prevention and response activities into the CARE DRC SAFAPAC project or the integration of GBV into the GATES financial inclusion E-wallet project in Uganda. The establishment of a regional cross-country learning platform as a forum for programme staff and partners to share experiences and learning on the progress and achievements of CARE's GBV programming would support the operationalisation of this pathway.
 - Promoting the uptake of CARE programming approaches by other stakeholders outside of CARE programmes, which could include integrating approaches tested at the local level into national level programmes or translating national and international commitments into local-level action plans. The examples identified by programme staff suggest that there has already been significant uptake of CARE programming approaches by national government in Uganda, by CSO partners, and by the FAO in Burundi. CARE's understanding of the reach and impacts of these initiatives is however limited as the country offices have yet to establish systems for monitoring or documenting processes of secondary scale-up.

- 2) Working in alliance with social movements for women and men involved in advocacy and activism to stop GBV:** This pathway involves working at multiple levels. At the grassroots level CARE will seek to support and strengthen the VSLA and Men & Boys Engage networks that have emerged as structures for local level advocacy and activism, and which have the potential to link to national and international level EMB and feminist movements. CARE will also support national and regional women’s rights organisations to strengthen their influence in promoting the development and implementation of national policies and strategies for GBV prevention and response. CARE’s work with women’s rights organisations will include promoting linkages with grassroots and local level solidarity groups and networks to ensure that the voices of marginalised groups are represented and heard in national processes of dialogue and decision-making. Programming experiences in Burundi and Uganda indicate that this pathway could contribute substantially to the future scale-up of CARE’s GBV prevention work, although there is a need for more data and documentation of the reach and impacts that have been achieved by the activities of such networks to date.
- 3) Advocacy and lobbying campaigns at national and regional levels to influence enactment and implementation of laws and policies:** CARE has the potential to play an important role in generating evidence and learning to influence the improved implementation of laws and policies and resourcing of services for closing the “implementation gap” which has been identified as a challenge for tackling GBV in the GL region. Strengthening CARE’s advocacy work at the national and regional levels as a multiplier for the impacts of CARE’s GBV programming will require the effective communication of CARE’s learning through interaction with national and regional forums for policy dialogue and planning (e.g. working groups at national level, contacts with regional umbrella organisations such as COCAFEM). This scale-up pathway will involve working with women’s movements at national and regional levels, as for example in the forthcoming collaborative initiative with COCAFEM to address GBV experienced by women engaging in cross-border trading between DRC, Rwanda and Burundi. This pathway could also involve CARE in supporting the establishment and facilitation of learning platforms in collaboration with partners, following CARE Uganda’s experience of co-facilitating a women and leadership in emergencies learning platform with UN Women⁶⁷.

⁶⁷ UN Women (undated) *Women’s Leadership, Empowerment, Access and Protection: South Sudan Refugee Response in Uganda*. UN Women Brief.

Table 2: Examples of ongoing scale-up and opportunities for future scale up of CARE programming approaches for addressing GBV

Pathway to scale	Examples of ongoing and potential future scale-up
<p>1. Implementation of proven models at scale</p> <ul style="list-style-type: none"> - By expanding geographical coverage of CARE’s GBV programming with partners (including government, UN agencies, CSOs) 	<p>Ongoing scale-up: A recently approved joint programme to expand an integrated package of GBV prevention and response activities, including promoting the engagement of men and boys in SRH programming will be implemented by CARE and UNFPA for five years from 2018 across 8 districts (including 34 refugee settlements) in Uganda.</p> <p>Ongoing scale-up: In January 2018, the World Bank began implementation of a one-year project with CARE Rwanda to roll out the couple curriculum and training for Opinion Leaders developed by the <i>Indashyikirwa</i> project across 4 additional districts in Rwanda’s Southern Province.</p> <p>Future opportunity: In Rwanda, there has been considerable interest in and demand from local government at village and sector levels for the roll-out of the <i>Indashyikirwa</i> couple-based training module in sectors not currently being covered by the project.</p>
<ul style="list-style-type: none"> - Mainstreaming gender and GBV thinking into projects/ interventions being implemented by CARE and partners in other sectors (e.g. education, SRH); 	<p>Ongoing scale-up: In DRC, CARE is implementing the SAF PAC III project across 5 health zones (<i>zones de santé</i>) in North Kivu to promote family planning and post-abortion care with the goal of contributing to the reduction of maternal mortality. In November 2017 the project team developed a plan for integrating GBV response activities into its implementation with health service providers and at the community level and into project M&E systems.</p> <p>Ongoing scale-up: In Uganda, the new 5 year framework agreement funded by ADA will focus on integrating WEE and GBV programming. The new 5 year DANIDA funded framework focuses on promoting resilience while mainstreaming gender and GBV thinking into the programme implementation approach.</p>
<ul style="list-style-type: none"> - By promoting uptake of CARE programming approaches by other stakeholders (including national and local government structures, CSOs) 	<p>Previous scale-up: In Uganda, the development of a national GBV database by Uganda’s Ministry of Gender in 2015 - 2016 involved scaling up the GBV IMS that had been piloted by CARE with UNFPA funding in Northern Uganda. CARE was also actively involved in the development of the Standard Operating Procedures for the national GBV IMS.</p> <p>Ongoing scale-up: In Burundi, the FAO is implementing CARE’s VSLA programming approach through a 3 year EU-funded project to promote increased resilience for crisis-affected rural populations. The PRO ACT project is targeting 15,000 vulnerable households across 5 provinces.</p> <p>Future opportunity: In Burundi, the Ministry of Gender has requested capacity-building support from CARE to enable delivery of the VSLA programming approach through the provincial structures of the CDFC (the Provincial Committee for Family and Community Development). CARE has recently given a Training of Trainers on the VSLA approach to 27 members of staff of the Ministry (18 from the CDFC and 9 senior ministry staff).</p> <p>Future opportunity: In DRC, the Provincial Ministry of Gender in North Kivu has expressed interest in integrating the <i>Sisi vijana</i> training materials into national curriculum on Comprehensive Sex Education.</p>
<p>2. Support for/ alliance with social movements for women and men involved in advocacy and activism to stop GBV</p>	<p>Ongoing scale-up: Men Engage groups are emerging spontaneously (i.e. without any direct facilitation inputs or support from CARE) in communities where CARE’s GEWEP is being implemented in Rwanda and DRC. Similarly CARE programme staff reported the spontaneous emergence of VSLAs in Burundi and DRC.</p>

	<p>Ongoing scale-up: At the request of the provincial authorities in several provinces, the <i>Abatangamucyo</i> in Burundi are now involved in providing training on gender and healthy relationships to couples planning to register their marriages.</p> <p>Future opportunity: CARE’s collaboration with COCAFEM on addressing GBV experienced by women engaging in cross-border trade from DRC to Rwanda and Burundi.</p>
<p>3. Advocacy, messaging and media campaigns</p>	<p>Previous scale-up: CARE Burundi worked with women parliamentarians and a coalition of CSOs to advocate for the enactment of the specific law on GBV in Burundi, which was passed in 2016.</p> <p>Ongoing scale-up: In Uganda, CARE has been consulted by the Ministries of Gender and Health on the development of policies for Engaging Men and Boys and SRH and is supporting the Ministry of Gender on the elaboration of the new UNSCR 1325 NAP.</p> <p>Ongoing scale-up: Lobbying by advocacy groups established under NUWEP regarding the incidence and causes of GBV in Northern Uganda resulted in the enactment of district-level ordinances to address issues of alcoholism in several districts in Northern Uganda. CARE Uganda has also supported the development of district-level action plans for implementation of UNSCR 1325 in Gulu District. The fact that some districts in Northern Uganda are now including allocations (albeit small allocations) for addressing GBV in their budgets represents a significant step forward that reflects growing recognition of the importance of GBV by local government and commitment to addressing the problems.</p>

8. Partner and External Perspectives on CARE's GBV programming

The process of evidence-gathering for the development of this value proposition included eight interviews with partner organisations across the four countries, including national NGOs, an umbrella organisation (COCAFEM) and UNFPA. Partners were asked for their views concerning the strengths of CARE's GBV programming and areas for improvement. Partners interviewed across all four countries consistently highlighted the effectiveness of CARE programming approaches such as VSLA, EMB and the use of SASA for community mobilisation and awareness-raising for addressing GBV. Several partners also recognised CARE's expertise in promoting gender transformative programming focussing on challenging and changing social norms and power relations as a strength. Another widely identified strength of CARE's programming was the organisation's commitment to building the capacity of civil society for addressing GBV by working through partners. Overall, the consensus opinion among the respondents from partner organisations was that CARE makes a significant, positive contribution to addressing GBV in the Great Lakes countries and is a good partner to work with.

In response to the question as to the weakness or areas for improvement of CARE's GBV programming, partners consistently identified the need to strengthen the documentation, reporting and communication of CARE's programming approaches and impacts. Partners in DRC and Burundi also identified the need for CARE to strengthen its programming for GBV response and promoting resilience given the changing conditions due to problems of insecurity in those politically volatile contexts. Box 6 presents some illustrative examples of the view of partners concerning both the strengths and areas of improvement for CARE's GBV programming in the Great Lakes region.

Box 6: Reported Strengths (S) of CARE's GBV programming and Areas for Improvement (AI)

Programming approaches (S): *"CARE stands out for the Men Engage work which they have been doing since 2008. CARE's contribution (to GBV programming) is also through VSLA which is excellent and SASA. CARE is recognised for its long-term development programming but also makes a good contribution in the humanitarian context."* UNFPA, Uganda.

Programming approaches (S): *"CARE's strength is that its programmes are tackling gender issues and the VSLA approach is a good model for promoting the socio-economic reintegration of women and tackling GBV."* Congomen, DRC

Advocacy & partnerships (S): *"CARE's strength is in convening and creating safe spaces for reflection, as for example in terms of work with COCAFEM in DRC. CARE is strong on advocacy and working with partners because it supports organisation either by funding or as strategic partners. However, few people know this because CARE focuses on implementation through partners".* AMWA, Uganda.

Capacity-building of local organisations (S): *"CARE encourages the growth of local NGOs – some have developed from CBOs to national NGOs. There are sometimes problems in terms of reporting and underspend by local partners. CARE needs to choose which organisations to work with and when and to build their capacity for reporting and financial management so that working through partners doesn't complicate programme implementation."* UNFPA, Uganda

Partnership (S): *"CARE's strength in terms of work on GBV is working with partners who have presence and expertise on the ground and giving value and room to work to those partners, while at the same time supporting them. CARE has that strength – of working through empowering and positive partnerships. We have seen them involve us on many issues – they value our engagement with processes of strategic planning and programme design. Many donors try to do that but CARE is a step forward. We feel we are contributing to CARE's global goal".* RWAMREC, Rwanda

Reporting & documentation (AI): *"One of CARE's biggest weaknesses is reporting and documenting results. When you go on the ground you see their work but other organisations produce better reports."* UNFPA, Uganda

Documentation (AI): *“We do good programming but we don’t see it being so well documented – CARE’s gap is our gap. We have to document (our experience) to sell it. We have amazing stories but they are here on my small computer”.* RWAMREC, Rwanda

Communications (AI): *“CARE does many things but does not publicise its achievements very much. You need to increase your participation in the discussion spaces of the technical clusters and networks”.* UNFPA, Burundi.

Strengthening response (AI): *“CARE’s GBV programming could be strengthened by including elements of response alongside work on prevention and awareness-raising. ... We need a model for community action that will provide alternative conflict resolution mechanisms”.* DFJ, DRC

Findings from the DFID-funded What Works to Prevent Violence Against Women and Girls Global Programme provide a useful external perspective on the relevance and potential effectiveness of the POWER model for CARE’s GBV programming proposed in this report. The What Works programme focusses on Intimate Partner Violence and aims to identify effective strategies for prevention, i.e. preventing violence from ever occurring by addressing the root causes or established risk factors for violence⁶⁸. The programme supports national and international non-profit organisations working in DFID priority countries to fund innovative approaches to preventing violence. It is also undertaking operations research and impact evaluations of promising existing interventions to assess their effectiveness or, if proven effective, to better understand the economics of scale up. As noted previously, the impact evaluation of CARE Rwanda’s *Indashyikirwa* project is being undertaken by the What Works consortium.

To inform the priorities for innovation grants and research under the What Works programme, the Consortium has undertaken a review of the evidence on VAWG and interventions to prevent it. A key finding of the What Works evidence reviews is that *“In terms of prevention interventions ... there is fair evidence to recommend: group based relationship-level interventions working with males and females, such as Stepping Stones; group based microfinance combined with gender-transformative approaches such as IMAGE; community mobilisation interventions to change social norms; interventions that target boys and men (alongside women and girls) through group education combined with community mobilisation; and parenting programmes”*⁶⁹. A systematic review of 58 reviews conducted by World Bank to synthesize evidence on the effects of 290 VAWG prevention interventions similarly identified promising evidence of the effectiveness of approaches involving community mobilisation, group-based training – both in terms of empowerment training for women and girls and training for women and men together, and economic empowerment interventions based on microfinance in combination with gender equality training⁷⁰. The findings from both the What Works and World Bank evidence reviews therefore support the relevance of the CARE programming approaches of VSLA, EMB and facilitating community activism.

In terms of scalability the What Works evidence review notes that even for interventions that have been found to be effective in addressing violence and that have been replicated little is known about their value for money (VFM) and how to take them to scale. However, the review concludes that: *“Current evidence on effective interventions point to the importance of participatory group-based intervention delivery, larger scale social norm and community mobilisation approaches, as well as the value of structural level changes. Group-based participatory interventions that engage over time with women, men, girls and boys could possibly best be scaled up as add-ons to large-scale programmes in various sectors, such as such as education, economic development, social welfare and health, with potentially low incremental cost. By addressing the multiple*

⁶⁸ A summary of the evidence and research agenda for **What Works: A Global Programme to prevent violence against women and girls**. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/337599/summary-evidence-research-agenda-C.pdf

⁶⁹ *Ibid*, page 5.

⁷⁰ Arango et al (2014) *Gender Equality and Development: Interventions to prevent or reduce violence against women and girls: A systematic review of reviews*. World Bank.

economic and health needs of their beneficiaries, such an approach could enable existing investments to be leveraged for greater impact on VAWG prevention. Community level mobilisation intervention models delivered by a local NGo may be more efficiently expanded through replication by other similar organisations. This 'franchise' model has been used to scale up community-focused HIV programmes to good effect". This conclusion is also consistent with CARE's experiences and the programming model that is emerging for the organisation in the Great Lakes region.

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Annex 1: List of Respondents

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2	Sandra Achom Ronald Mutanda	CARE CARE	GBV Humanitarian specialist Programme Manager	Uganda
	Josephine Atek Kenneth Masa	CARE CARE	Psychosocial support worker GBV project officer	Uganda
3	Janephar Taaka	CARE	Psychosocial Support Specialist – Learning 4 Change	Uganda
4	Doreen Komuhangi	UNFPA	Program Analyst - GBV and Humanitarian	Uganda
5	Eunice Musiime Patience Ayebazibwe	Akina Mama wa Afrika (AMWA)	Executive Director Programme Officer	Uganda
6	Elizabeth Katusiime	CARE	Advocacy Coordinator	Uganda
7	Rose Amulen	CARE	Women's Leadership specialist	Uganda
8	Ronald Ogal	CARE	EMB specialist	Uganda
9	Sidonie Uwimpuhwe	CARE	Coordinator – Vulnerable Women Programme	Rwanda
10	Lea Liliame Niyibizi Janvier Kubwimana	CARE CARE	<i>Indashyikirwa</i> Programme Manager GEWEP Programme Manager	Rwanda
11	Andrew Ndahiro	RWN		Rwanda
12	Olive Uwamariya	CARE	Advocacy Thematic Lead	Rwanda
13	Ritha Nyiritunga Bosco Rudasingwa	RWAMREC	Programme Coordinator Field Supervisor - GEWEP	Rwanda
14	Theo Twahirwa	CARE	Director of Programme Quality & Learning	Rwanda
15	Mariette Utamvuna	CARE	<i>Indashyikirwa</i> Field Supervisor	Rwanda
16	Sam Kalinda	CARE	SS4G and BEE Programme Manager	Rwanda
17	Domitille Ntacobakimvuna	CARE		Burundi
18	Generose Nzeyimana	CARE	Great Lakes Regional Advocacy Advisor	Burundi
19	Josee Ntabahungu	CARE	GEWEP Programme Coordinator	Burundi
20	Ninon Ndayikengurukiye	CARE	Advocacy and Communications advisor	Burundi
21	Jean Nimubona	CARE	EMB specialist	Burundi
22	Jimmy Mategeko	CARE	National Programmes Coordinator	Burundi
23	Nicole Nyangolo Jeanne Bitsure	COCAFEM	Director of Programmes Director of Advocacy	Burundi
24	Oswald Muderwa Chishugi	UNFPA	GBV Sub-sector Interagency Coordinator	Burundi
25	Dr Jacqueline Ninunzi	CARE	WSWM Programme Coordinator	Burundi
26	Alexis Kisubi	CARE	MANU, <i>Sisi vijana</i> & GEWEP Programme Manager	DRC
27	Felicien Cigoha Theophile ***	CARE CONGOMEN	EMB specialist	DRC
28	Jean Makelele	CARE	<i>Mawe Tatu</i> North Kivu Programme Manager	DRC
29	Blaise Kibiswa	CARE	SAFPAC Community engagement and Advocacy specialist	DRC
30	Pacifique Faradja	DFG	Programme Officer	DRC
31	Rose Vive	CARE	<i>Mawe Tatu</i> Programme Coordinator	DRC