THE SURVEY REPORT ON

THE STATUS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS AND PROVISION OF SERVICES TO UNDER-18 FEMALE VICTIMS OF SEXUAL VIOLENCE AT 7 ISANGE ONE STOP CENTERS IN RWANDA

August 2019

The survey on the Status of Sexual and Reproductive Health Rights and provision of services to under-18 Female Victims of sexual violence at 7 Isange One Stop Centers in Rwanda

Report produced by Oxfam in Rwanda

In collaboration with Kacyiru Hospital

Supported by the Scottish Government

Conducted by Dr. Etienne Rugigana, University of Rwanda, School of Public Health

Executive Summary

In Rwanda, the legal and policy framework to both prevent and respond to gender-based violence and child abuse is robust. It is mainly composed of (but not limited to) a National Policy against Gender-Based Violence, a National Integrated Child Rights Policy, Law No. 59/2008 of 2008 on prevention and punishment of gender-based violence and Law N°54/2011 and the addendum N°71/2018 of 31/08/2018 on rights and protection of the child against violence

The policy against GBV established Isange One Stop Centers (since 2009) as a multi-sector and holistic endeavor to support gender-based violence victims., providing psychosocial, medical, forensic and legal services to adult and child survivors of gender-based violence and child abuse occurring in the family or in the community at large.

In 2017, Oxfam Rwanda won a grant funding for a project titled "Claiming Sexual and Reproductive Health Rights in Rwanda" (CSRHRR). One of the objectives of the project is "to build the capacities of health care providers at Isange One Stop Centres for high quality services and empowering victims of sexual and gender-based violence for reduction of GBV incidence."

In the above scope, CSRHRR commended the "Survey on the Status of Sexual and Reproductive Health Rights and Provision of Services to under-18 female victims of Sexual Violence at 7 Isange One Stop Centers (IOSC) in Rwanda, namely: Isange OSC Kacyiru Hospital, IOSC Remera-Rukoma, IOSC Kabgayi, IOSC Gitwe, IOSC Kabutare, IOSC Gisenyi and IOSC Shyira.

Four techniques were used to collect data, namely a desk review, a questionnaire, key informants' interviews and focus group discussions

The key findings are as follow:

- ✓ A total of 1951 under-18 female victims of sexual violence were received by the IOSC between January 1st, 2018 and December 31st, 2018. Isange One Stop Center at Kacyiru Hospital received and assisted 46.1% of the surveyed sample while the 6 peripheral Isange OSC account for 53.9% of victims of sexual violence under 18 years of age.

- ✓ Most (67.95%) of under-18 female victims of sexual violence were aged 10-17 years, a sizable proportion (19.41%) were aged 5-9 years while under 5-year-old victims represent 13%. The majority (50.8%) of the victims was in primary schools

- ✓ The main type of sexual violence reported by surveyed victims is the penetration of penis in vagina (78% of victims); followed by the sexual violence of level 1 (38.1% of victims) and sexual touching (29.4% of victims).

- ✓ The consequences of sexual violence to under-18 females include unwanted pregnancies (24.4%), risky behaviors manifested as follows: 69.8% of victims dropped out school, 6.1%

of victims have been involved in prostitution, 5.8% and 4.2% respectively presented depression and anxiety, while 2.4% had experienced suicidal thoughts and ideations. Other consequences were related to sexual transmitted infections including HIV. 8.5% of victims were affected as follows: 6% with STI, 1.6% with HIV and 0.5% with Hepatitis C.

- ✓ In the study, 81.9% of perpetrators are known by the victims: neighbors (51.7%), friends (23.2%), or a family member (8.6%), and strangers were 16.2%. Furthermore, 33.8% of rapes took place in the victim's home, 28% occurred in perpetrator's residence while 14.3% of victims were raped in the bush.
- ✓ Risk factors associated with perpetrators committing rape include alcohol consumption (42%), drug consumption (12%) and incidents of mental health (7.5%). On the other hand, risk factors associated with the victim includes low socioeconomic status and poor parental supervision.

- ✓ Protective factors are related to access to information and services on reproductive health as well as awareness of the legal framework (law on GBV and law on abortion). Generally, respondents had poor awareness of the legal framework while for health professionals of Isange OSC, the level of awareness was fair. In addition, victims don't understand clearly the judiciary process and think that perpetrators are not adequately punished. 72% of under-18 female victims of sexual violence reported not having information or access to the use contraceptives while 82% reported that they had the right to be consulted/treated by the doctor or the nurse that they have chosen.

- ✓ In our study, findings showed that 476 (24.4%) victims had unwanted pregnancies. Among them, 240 (50.4%) victims requested assistance for a safe abortion while 145 (30.5%) victims were refused assistance of abortion by medical services.

- ✓ With regards to legal services provided to the victims at IOSC, only 49.7% of perpetrators have been arrested and 49.2% has been taken to court. Furthermore, 35.3% of perpetrators went to jail.

- ✓ Considering the utilization of health services available to 7 IOSC, victims appreciated and rated the quality of service they received at all Isange OSC as high. However, health professionals in Isange OSC expressed the need for refresher training in gender-based violence.

- ✓ Further research should explore and provide insights on these themes: "Sexual violence and HIV infection among under-18 females: a retrospective study in all Isange One Stop Centers"; "Survey on outcomes of Judicial Process with regards to perpetrators".

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List of Abreviations and Acronyms

ASRH: Adolescent sexual and reproductive health

CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women

CSRHRR: Claiming Sexual and Reproductive Health Rights in Rwanda

CSA: Child sexual abuse

DHS: Demographic and Health Survey

GBV: Gender-based violence

GoR: Government of Rwanda

HIV: Human immunodeficiency virus

IOSC: Isange One Stop Center

ICRP: Integrated Child Rights Policy

IPPF: International Planned Parenthood Federation

MDG: Millennium Development Goals

MIGEPROF: Ministry of Gender and Family Promotion

MOH: Ministry of Health

RIB: Rwanda Investigation Bureau

RWAMREC: Rwanda Men's Resource Center

SDG: Sustainable Development Goals

SPSS: Statistical Package for the Social Sciences

SRHR: Sexual and reproductive health rights

STI: Sexual transmitted infections

UN: United Nations

UNCRC: United Nations Convention on the Rights of the Child

UNICEF: United Nations Children's Fund

UNFEM: United Nations Development Fund for Women

UNFPA: United Nations Population Fund

WHO: Word Health Organisation

Chapter One: Introduction

1. Background

Sexual and reproductive health and rights or SRHR refers to the right to have control over and decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination and violence[1].

Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability[2].

Sexual and Reproductive Health Rights (SRHR) are based on various legal instruments at international, regional and national levels. In Cairo, Egypt, the International Conference on Population and Development (ICPD) in 1994 recognized the reproductive and sexual needs and rights of individuals and called for universal access to sexual and reproductive health services by 2015.

Twenty years later, the Cairo goals were recorded as an unfinished agenda and a High-Level Task Force for ICPD extended policy recommendations beyond 2014, with the vision of a world where all women and men, adult and young, have equal opportunities, freedoms and choices to forge their own life aspirations and destinies[3].

In 2002, the UN General Assembly Special Session on Children recognized the need to develop and implement health policies and programs for adolescents that promote their physical and mental

[1] *Sexual and reproductive health and rights – a crucial agenda for the post-2015 framework*

IPPF's Vision 2020 report; 2014

[2] *Lancet Commission Lancet 2018; 391: 2642–92 Accelerate progress—sexual and reproductive health and rights for all*

[3] *Policy Recommendations for the ICPD Beyond 2014: Sexual and Reproductive Health & Rights for All*

health[4].

In 2003, the Committee of the Convention on the Rights of the Child issued a General comment recognizing the special health and development needs and rights of adolescents and young people[5].

Other supporting instruments are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the right to health—a concept included in various international agreements such as the Universal Declaration of Human Rights and the international Millennium Development Goals (MDG), which include indicators to reduce pregnancy rates among 15–19 year old, increase HIV knowledge, and reduce the spread of HIV among young people[6].

Two targets of the globally adopted 2030 Agenda for Sustainable Development explicitly mention sexual and reproductive health. Target 3.7—under the health goal— states, "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs". Target 5.6—under the gender equality goal—aims to, "Ensure universal access to sexual and reproductive health and reproductive rights"[7]

In the scope of the international SRHR framework, the Africa continent has developed legal instruments including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, guarantees comprehensive rights to women including the right to take part in political processes, to social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation[8]. Previously, the African Charter on Rights and Warfare of the Child was adopted in 1990 and implemented since 1999.

Rwanda is a signatory to the various mentioned international and regional conventions, declarations and/or treaties. In addition, the Constitution of the Republic of Rwanda (2003) reaffirms the adherence to the principles and commitments of the various ratified international and regional instruments. Following the above rationale; the Government of Rwanda has set milestones to address gender-based issues in general, including the National Policy against GBV together

[4] United Nations. Resolution adopted by the General Assembly [on the report of the Ad Hoc Committee of the Whole (A/S-27/19/Rev.1 and Corr.1 and 2)] S-27/2. A world fit for children 2002. 11 October 2002 Twenty-seventh special session.

[5] United Nations. Convention on the Rights of the Child. General Comment No. 4 (2003). Adolescent health and development in the context of the Convention on the Rights of the Child

[6] Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1999), General Recommendation No. 24; United Nations, Human Rights Council (2011)

[7] Sexual health and its linkages to reproductive health: an operational approach; WHO 2017

[8] The Maputo Protocol of the African Union: An instrument for the rights of women in Africa; gtz 2006

with its strategic plan, and particularly the rights and needs of children are addressed through the Integrated Child Rights Policy; the Strategic Plan for the Integrated Child Rights Policy (ICRP) in Rwanda in (2011-2016), and laws related to GBV and children's rights have been promulgated including; Law N° 21/05/2016 of 20/05/2016 relating to Human Reproductive Health; Law No 59/2008 of 10th September 2008, on the Prevention and Punishment of Gender-based Violence; Law No 13/2009 of 27th May 2009, regulating Labour in Rwanda. Law n° 54/2011 of 14/12/2011and the addendum n°71/2018 of 31/08/2018 relating to the Rights and Protection of the Child.

National policy against GBV highlights the necessity of interventions for prevention and response to GBV, including the creation of Isange One Stop Centers (in 2009) as a multi-sector and holistic endeavor to support victims of gender-based violence[9].

Isange is a Kinyarwanda word that means "Feel at home". The first Isange OSC was set up in July 2009 at Kacyiru District Hospital, founded with the support of Imbuto Foudation, under the advocacy of H.E the First Lady Madam Janet Kagame, in partnership with the Ministry of Health, Rwanda National Police and One UN Rwanda particularly UNICEF, UNIFEM and UNFPA. Other implementing partners include Ministry of Justice and MIGEPROF.

The main mission of Isange OSC is to provide timely, affordable high quality services to child abuse victims as well as and gender-based violence victims.

The centre operates 24/7, a free phone hotline for help, protection from further violence, investigation of crimes, medical and psychosocial care and support and collection of forensic evidence. The center also has provisions for emergency contraception, HIV prophylaxis, STI prevention, and other necessary medications and medical interventions.

In 2012, Kacyiru Isange One Stop center scooped the United Nations Public Services Award (UNPSA) for its efforts in fighting Sexual and Gender Based Violence (SGBV). The award dubbed "Promoting Gender Responsive Delivery" of Public Services was in recognition of Isange holistic services to GBV and child abuse victims

Following that successful piloting of the Kacyiru Isange OSC Model in Rwanda, Rwandan Government's Seven-Year Programme (2010-2017) recommended to establish Isange one Stop Center in every district hospital in Rwanda[10].

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[9] *National Policy against Gender- Based Violence Document, Ministry of Gender & Family Promotion, Kigali, July, 2011.*

[10] *((www.police.gov.rw/news, Rwanda National Police, Partners to launch a countrywide awareness campaign against GBV and Child abuse under Isange One Stop Center Model; 2014)*

National Scale up of Isange One Stop Center Model in Rwanda 2013-2015 of Isange One Stop Center Model in Rwanda 2013-2015, A joint Programme, between The Government of Rwanda, One UN Rwanda and funded by the Royal Netherlands Embassy, November 2013, Kigali, Rwanda)

The original IOSC programme design was devised after a workshop that took place in May 2009. The workshop was facilitated by staff members from UNFPA and UNICEF and brought together 20 people from the Rwanda National Police Gender Desk, Kacyiru Police Hospital, the Ministry of Gender and Family Promotion (MIGEPROF), and the Ministry of Justice (MINIJUST). The two-day workshop succeeded in developing a common vision for the IOSC. The original program design details an overall approach to responding to and following up with victims and highlights the roles and responsibilities of each sector including the medical, psychosocial, and police aspects.

To further enhance service delivery in responding to GBV, the Ministry of Health in close collaboration with the different partners established nine One-Stop Centers in the following districts hospitals: Gicumbi, Rusizi, Ngoma, Nyagatare, Rubavu, Gakenke, Bugesera, Muhanga and Gasabo. From 2011 to 2017, under the scale up programme, Isange was so far established in 44 hospitals across the country as part of the grand programme to replica them in all district hospitals. The move will see anti-GBV services increased up to 500 Isange One Stop Centres, with at least one in every health center, at sector level.

2. Key Terms and Definitions

Reproductive Health

The United Nations International Conference on Population and Development in Cairo in 1994, defines "Reproductive health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well- being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[11]

[11] *WHO. Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Geneva: World Health Organization, 2004.*

Reproductive rights[12] rest on the recognition of human rights of all individuals and couples to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and the right to attain the highest standard of reproductive health. They also include: the right to make decisions concerning reproduction, free of discrimination, coercion, and violence; the right to privacy, confidentiality, respect, and informed consent; the right to mutually respectful and equitable gender relations

Sexual health is defined as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[13]

Sexual health implies that all people have access to: counselling and care related to sexuality, sexual identity, and sexual relationships[14]; services for the prevention and management of sexually transmitted infections, including HIV/AIDS, and other diseases of the genitourinary system

Sexual rights[12;13] are human rights and include the right of all persons, free of discrimination, coercion, and violence, to: achieve the highest attainable standard of sexual health, including access to sexual and reproductive health services[15]; seek, receive, and impart information related to sexuality; engage in consensual sexual relations; choose whether, when, and whom to marry; pursue a satisfying, safe, and pleasurable sexual life, free from stigma and discrimination.

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but

Lancet 2006; 368: 1595–607 : Sexual and Reproductive Health

[12] *The Lancet Commission: Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission; Lancet 2018; 391: 2642–92*

[13] *WHO. Sexual health and its linkages to reproductive health:an operational approach. Geneva: World Health Organization, 2017*

[14] *World Association of Sexology. Declaration of sexual rights. 2014. http://www.worldsexology.org/wp-content/uploads/2013/08/ declaration_of_sexual_rights_sep03_2014.pdf*

[15] *UN. Beijing declaration and platform for action. New York, NY: United Nations, 1995: 93–97*

not limited to home and work[16]. Sexual violence includes all forms of sexual abuse and sexual exploitation of children.
Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when a person is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.

Rape (Sexual Assault): Sexual violence includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape.

There are 3 levels of sexual assault[17] following the gravity of physical injuries:

Level 1: Any form of sexual activity forced on another person (i.e., sexual activity without consent), or non-consensual bodily contact for a sexual purpose (e.g., kissing, touching, oral sex, vaginal or anal intercourse). Level 1 sexual assault involves minor physical injury or no injury to the victim.

Level 2: A sexual assault in which the perpetrator uses or threatens to use a weapon, threatens the victim's friends or family members, causes bodily harm to the victim, or commits the assault with another person (multiple assailants).

Level 3: (Aggravated sexual assault) A sexual assault that wounds, maims, or disfigures the victim, or endangers the victim's life.

Child Sexual Abuse (CSA)

The World Health Organisation (WHO) defines CSA as "the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society[18]." The term CSA includes a range of activities like "intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing

[16] World Health Organization. Violence against women – Intimate partner and sexual violence against women. Geneva, World Health Organization, 2011.
[17] Sex Information and Education Council of Canada (SIECCAN); sieccan@web.ca
[18] Guidelines for medico legal care for victims of sexual violence. Geneva: World Health organization; Child Sexual abuse. updated 2003. Available from: Whqlibdoc.who.int/publications/2004/924154628x.pd

children to adult sexual activity or pornography, and the use of the child for prostitution or pornography[19].”

Gender-based Violence

The UN General Assembly (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion arbitrarily deprivations of liberty, whether occurring in public or private life[20]".

“Gender-based violence[21] reflects and reinforces inequalities between men and women and compromises the health, dignity, security and autonomy of its survivor. It encompasses a wide range of human rights violations . . . Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, result in death.

Gender

Gender refers to the roles and responsibilities of men and women that are created in our families, our societies and our cultures. The concept of gender also includes the expectations held about the characteristics, aptitudes and likely behaviors of both women and men (femininity and masculinity). Gender roles and expectations are learned. They can change over time and they vary within and between cultures. Systems of social differentiation such as political status, class, ethnicity, physical and mental disability, age and more, modify gender roles. The concept of gender is vital because, applied to social analysis, it reveals how women’s subordination (or men’s domination) is socially constructed. As such, the subordination can be changed or ended. It is not biologically predetermined nor is it fixed forever[22].

Sex

Sex describes the biological differences between men and women, which are universal and determined at birth[22].

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[19] *Putnam FW; Ten-year research update review: child sexual abuse. J Am Acad Child Adolesc Psychiatry. 2003 Mar; 42(3):269-78*

[20] *1993 UN Declaration on the Elimination of Violence against Women, art. 1.*

[21] *UNFPA (2007). Ending Widespread Violence Against Women. http://www.unfpa.org/gender/violence.htm*

[22] *http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/BSP/GENDER/PDF/1.%20Baseline%20Definitions%20of%20key%20gender-related%20concepts.pdf*

3. Rationale

Child and adolescent sexual abuse is a global problem[23]. An estimated 19.7% of females universally have faced sexual abuse before the age of 18[24], while the highest prevalence rate of child sexual abuse was seen in Africa (34.4%)[24-25]

At some time in their lives, 1 in 6 women have experienced an attempted or completed rape; more than half occurred before the woman was 18, and 22% before age 12. Worldwide, by age 18, 1 in 4 girls will be sexually assaulted[26].

Sexual abuse towards children is the most prevalent form of SGBV in Rwanda[27]. A baseline survey (RWAMREC) found that 31 % of respondents declared having heard (in their communities) of cases of sexual abuse against children in the last 12 months[28]. According to the Rwanda National Police records, cases of child sexual abuse or violence against children aged between 8 and 18 constituted 75 % of all cases of domestic violence[29].

Findings from a recent national survey[30] (2015-2016) on violence against children and youth reveals that 12% of 13-17-year olds girls reported sexual violence in the last 12 months, and of the young women (18-24 years) who reported having been sexually abused before the age of 18, approximately one third reported that their first experience of sexual intercourse had been unwanted.

Taking into account the magnitude and consequences of GBV and child sexual abuse, National Policy on GBV and ICRP set up a framework which defines standards of practice, roles and

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[23] Mannat Mohanjeet Singh & al; an epidemiological overview of child sexual abuse; J Family Med Prim Care. 2014 Oct-Dec; 3(4): 430–435.

[24] Wihbey J. Global prevalence of child sexual abuse. Journalist Resource. [Last on Aug and Updated on 2011 Nov 15]. Available from: Journalistsresource.org/studies/./global-prevalence-child-sexual-abuse

[25] Behere PB, Mulmule AN. Sexual abuse in 8 year old child: Where do we stand legally? Indian J Psychol Med. 2013 35:203–5. Available from:www.ijpm.info/article.asp?issn = 0253-7176;year 35;Behere . [PMC free article] [PubMed] [Ref list]

26 Tjaden, P. and Thoeness, N. (2000). Prevalence, Incidence and Consequences of Violence Against Women: finding from the National Violence Against Women Survey. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/183781.pdf

[27] National public Prosecution Authority, Child rape in Rwanda: an analytical overview, Kigali, September 2009, p. 37.

28 RWAMREC; Baseline Study on GBV, May 2013

[29] National Police Records, October 2006

30Rwanda Ministry of Health (MOH). 2017. Violence Against Children and Youth: findings from National Survey, 2015-16. Kigali, Rwanda.

responsibilities of various actors for an efficient and effective response to GBV and child abuse.

In the framework, Isange One Stop Centers play a key role in providing psychosocial, medical, forensic and legal services to victims of gender-based violence and child abuse occurring in the family or in the community at large.

The Policy emphasize the necessity of collecting reliable data regularly in relation to GBV, in order to inform evidence-based decisions. It is in this scope Oxfam Rwanda through "Claiming Sexual and Reproductive Health Rights in Rwanda (CSRHRR) commissioned "The survey on the status of sexual and reproductive health rights and provision of services to under-18 female victims of sexual violence at 7 Isange One Stop Centers in Rwanda".

Claiming Sexual and Reproductive Health Rights Project:

In 2017, Oxfam Rwanda was successfully awarded a four year and half grant funding from the Scottish Government through the Scottish Government Development Programmes for a project titled "Claiming Sexual and Reproductive Health Rights in Rwanda" aimed at" increasing awareness for positive change in social attitudes, cultural norms that discriminate against women in targeted communities, building the capacities of health care providers at Isange One Stop Centres for high quality services and empowering victims of sexual and gender-based violence for reduction of GBV incidence."
The project is implemented in partnership with the Rwanda Interfaith Council on Health (RICH), a network of religious organizations[31] created in 2003 with the aim to promote participation of religious-based organizations in health activities. RICH and OXFAM's strategic partnership is based on the belief that achieving gender justice is critical in ending poverty and challenging inequality, not only for women and girls, but also for other community members given potential influence and real ability of religious organisations to reach a larger population.

The project specifically targets 1,000 victims of sexual and gender-based violence who reported to Isange One Stop Centres; 120 health care providers at Isange One Stop Centres; 1,000 agents of change; 1,000 champions (men and women) and 15,000 community members (indirect beneficiaries) in 6 selected beneficiary districts of Rwanda namely Huye, Ruhango, Muhanga and Kamonyi in Southern Province and Rubavu and Nyabihu in Western Province.

[31] *RICH is composed of six confessional groups, namely the Catholic Church, the Anglican Church of Rwanda, the Protestant Council of Rwanda, the Evangelical Alliance of Rwanda, Rwanda Muslim Community, and the Fédération des Eglises Protestantes Reformées au Rwanda (FEPR).*

4. Conceptual framework[32]

Figure 1: WHO conceptual framework of sexual health with its linkages to reproductive health

The framework presented above seeks to fully describes the components of sexual health, as well as its linkages to reproductive health, to place these two distinct but intertwined concepts on an equal footing.

At the ***centre of the framework*** is the ultimate objective of sexual health: the attainment of physical, emotional, mental and social well-being in relation to sexuality.

The foundation of guiding principles: These are six crucial, cross-cutting principles (shown at the base of the illustration) which must be incorporated into the design of all sexual health (and reproductive health) interventions and which can also serve as evaluation criteria against which these interventions should be assessed.

The rosette of sexual and reproductive health interventions: the two groups of interventions are depicted on contrasting colours of the intertwined ribbons of a rosette – blue for sexual health and

[32] *WHO. Sexual health and its linkages to reproductive health:an operational approach. Geneva: World Health Organization, 2017*

orange for reproductive health – to show that they are distinct yet inextricably linked.

The climate of social-structural factors: The surrounding shading in the graphic framework represents the existing cultural, socioeconomic, geopolitical and legal environment that forms the context for people's lives in different settings, and which influences sexual health interventions and outcomes.

IOSC conceptual framework or Model of Services Provision

(customized from Isange One Stop Center Standards Operating Procedures Manual)

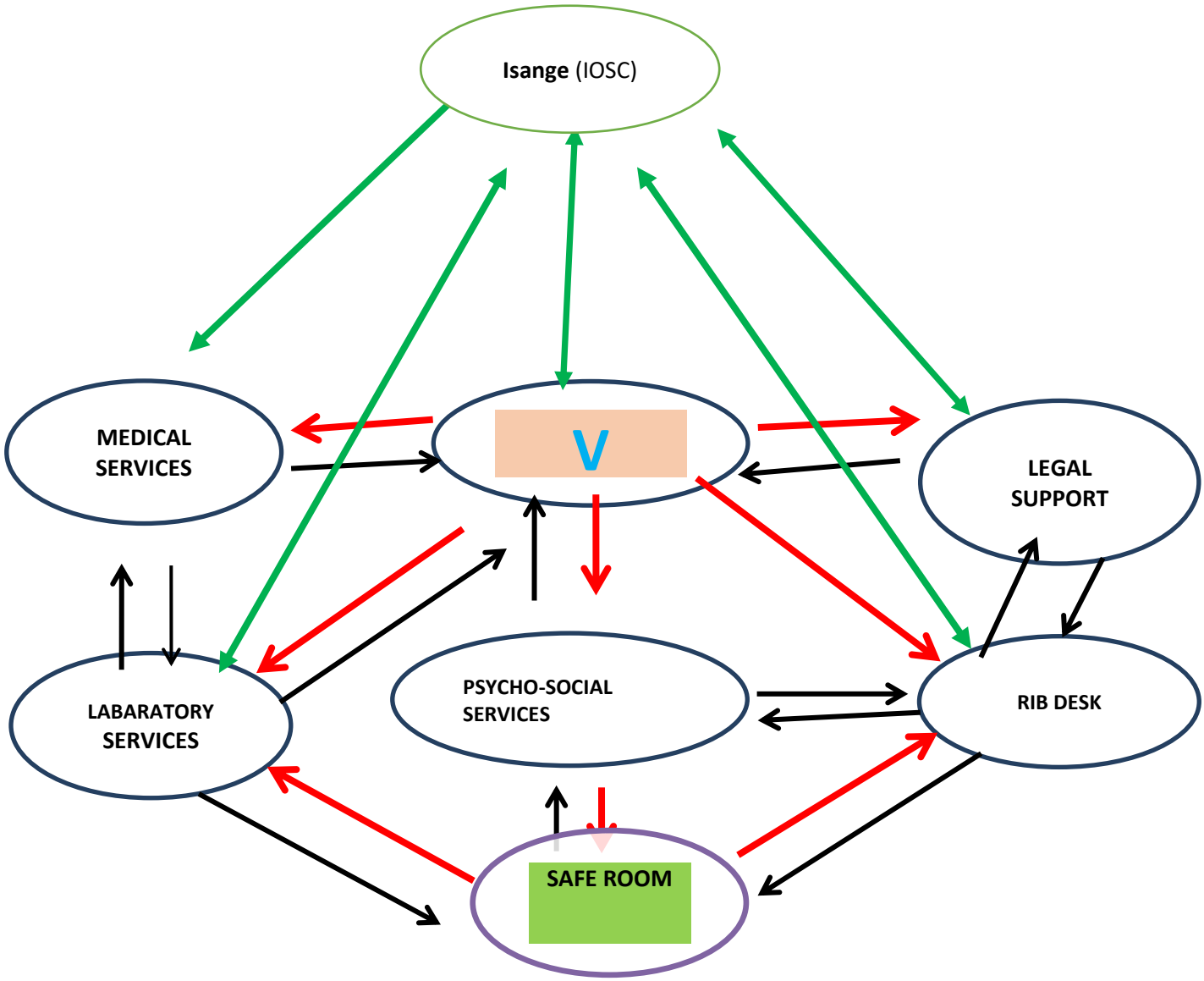

Figure 2: Isange One Stop Center Model of Service Provision

The IOSC framework is a model for integrated care and support, providing medical, psychosocial, forensic and legal services to the victims of sexual violence. The IOSC framework reflects the components of the WHO framework for operationalizing sexual health and its linkages to reproductive health.

5. Objectives of the Survey on Sexual and Reproductive Health Rights

5.1 Global objective

Assess the status of service delivery for under-18 female victims of sexual violence at 7 Isange One Stop Centers in Rwanda.

5.2 Specific objectives

- Describe the determinant patterns of sexual violence and other forms of violence to female victims under 18 years.
- Identify potential risks and protective factors of sexual violence for females under 18 years.
- Assess the knowledge and utilization of health services available for under-18 female victims of sexual violence and other forms of GBV.
- Understand under-18 female victims' perceptions about the quality of services received from Isange OSC.
- Understand the current level of knowledge of service providers in managing and supporting victims of GBV.
- Identify areas for further research.
- Make recommendations on improving and enhancing interventions to better identify, treat and prevent sexual violence against under-18 females and related health consequences.

Chapter Two: Methodology

Four techniques were used to collect data, namely the desk review, the questionnaire, key informants' interviews and focus group discussions.

2.1 Desk review

This technique enabled the researcher to gather and make use of various specialized reports, scientific works from peer-reviewed journals as well as activity reports from health institutions dealing with issues related to or associated with children and youth sexual abuse.

In the same way, the researcher analyzed legal and regulation texts as well as public policies related to GBV and child rights protection. The desk review was aimed at equipping the researcher with a general overview of GBV and sexual violence, to gain a deep understanding on how sexual health is linked to reproductive health. The desk review explored, but was not limited to, the following documents:

International policies, treaties, conventions or declaration and reports

- United Nations, General Assembly (1993), Declaration on the Elimination of Violence Against Women
- United Nations. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
- UN. Beijing declaration and platform for action.
- UN. Report of the International Conference on Population and Development, Cairo, September 1994
- United Nations. Resolution adopted by the General Assembly: A world fit for children 2002.
- United Nations. Convention on the Rights of the Child.
- African Charter on Rights and Warfare of the Child
- The Maputo Protocol of the African Union
- WHO: World Report on Sexual Violence
- World Association of Sexology. Declaration of sexual rights. 2014
- WHO Social determinants of sexual and Reproductive Health
- WHO multi-country study on women's health and domestic violence
- Report of the Gutmacher-Lancet commission on sexual and reproductive health and rights
- WHO. Sexual health and its linkages to reproductive: an operational approach
- World Health Organization. Violence against women – Intimate partner and sexual violence against women.

Rwandan laws and policies relating to GBV and violence against children and youth

- National Policy against Gender-based Violence Document
- National Strategic Plan for Fighting Against Gender- based Violence 2011-2016.
- National Integrated Child Rights Policy, August 2011.
- The Strategic Plan for the Integrated Child Rights Policy
- 2003 Policy on Orphans & Vulnerable Children (OVC).
- Official Gazette of the Republic of Rwanda n°14 of 06/04/2009, Law No. 59/2008 of 2008 on prevention and punishment of gender-based violence.
- Official Gazette of the Republic of Rwanda n°26 of 25/06/2012, Law N°54/2011 and n°71/2018 of 31/08/2018 on rights and protection of the child against violence.
- Official Gazette of the Republic of Rwanda, special of 27/05/2009 Regulating Labor in Rwanda.
- Official Gazette of the Republic of Rwanda n°37 of 12/09/2016, Law governing persons and family.

2.2 Quantitative methods

2.2.1 Target population

Under-18 female victims of sexual violence attending 7 Isange One Stop Centers for care and management

Setting/Sites: Isange OSC Kacyiru Hospital, Isange OSC Remera-Rukoma Hospital, Isange OSC Kabgayi Hospital, Isange OSC Kabutare Hospital, Isange OSC Gisenyi Hospital, Isange OSC Shyira Hospital

2.2.2 Inclusion criteria

- Being a victim of sexual violence
- Under 18 years
- Female
- Availability of consent or ascent form of the mentioned victim

2.2.3 Exclusion criteria

- Victims of other forms of gender-based violence which are not sexual violence
- Victims above 18 years
- Absence of consent or ascent form of the mentioned victim
- Male victims

2.2.4 Study design

It is a descriptive cross-sectional retrospective study using both quantitative and qualitative methods.

2.2.5 Sampling of IOSC facilities

It is purposive sampling taking into account the first established IOSC at Kacyiru Hospital, and 6 IOSC supported identified by OXFAM in Southern and Western provinces. These IOSC include Remera-Rukoma, Kabgayi, Gitwe and Kabutare in Southern Province; Shyira and Gisenyi in Western Province.

2.2.6 Sampling of victims of sexual violence

The sampling of victims of sexual violence was done through the sampling of the data collection tool namely "the patient sexual assault forensic examination form."

All under-18 female victims of sexual violence received by the Isange One Stop Center were enrolled in the study.

2.2.7 Data collection tool and techniques

We designed a data collection tool (in Annexes) using "the patient sexual assault forensic examination form" which served to collect information on the victim at Isange OSC. The information includes: social demographics, information on sexual assault, victim medical and gyneco-obstetrical history, findings on general examination, information on patient post assault activities and findings from the laboratory.

2.2.8 Training of data enumerators

A total of 16 enumerators were hired and trained on the following topics:

- The purpose and the implementation steps of the study
- Overview on child abuse
- Highlighting the components of "the patient sexual assault forensic examination form"
- Importance of maintaining confidentiality

4 enumerators surveyed Kacyiru IOSC while each of the remaining 6 IOSC had 2 enumerators for data collection. All enumerators were required to have demonstrated a proven experience in working in a GBV domain or as a psychological counselor.

2.2.9 Field work

Each enumerator had had an authorization letter from the overall IOSC coordinator to submit to the 6 IOSC coordinators to allow them to perform data collection

At the end of each day, the principal investigator reviewed the files surveyed for completeness and accuracy.

2.2.10 Data analysis

The statistical package SPSS was used for data management and analysis.

Chi-square test was used to reveal the level of association between the covariates and the outcome variable (victim of sexual violence). Univariate analysis with frequencies was done for the outcome variable and all independent variables. Bivariate analysis was plotted for all covariates with the outcome variable.

2.2.11 Limitations of the study

The limitations of the study are linked to its nature: as other cross-sectional retrospective studies, it is prone to recall bias or misclassification bias and cannot determine causation, but only association. However, the advantage is that the study has assessed the burden of sexual violence on under-18 victims in order to inform the planning and allocation of health resources. In the retrospective data collection, the information on risk factors to sexual violence is only available for perpetrators.

2.2.12 Ethical considerations

The study proposal was submitted for ethical clearance at the University of Rwanda, College of Medicine and Health Sciences, School of Public Health (UR-CMHS-SPH) Internal Review Board (IRB). Only victims who signed a consent or assent form were considered for data collection and anonymity (no name indicated on the data collection tool) was guaranteed.

While using qualitative methods, for this purpose, the researchers observed a set of measures to comply with ethical standards during the whole process of the study. These are:

- We sought and obtained formal consent from each informant before interviewing them or engaging in discussions;

- We informed respondents that they had the right to refuse any participation in the study

We guaranteed confidentiality regarding any information given and promised to use it exclusively for the research purpose. Such measure was intended to gain cooperation and trust between the researcher and the respondents.

2.2 Qualitative methods

We conducted both key informant interviews (KII) and focus group discussions (FGD) to explore broadly the sexual and reproductive health and rights of under-18 females in the communities surrounding the 7 IOSC surveyed.

The survey was carried out during the period from January 2018 to December 2018.

Purposively, we took 2 days in mid-year to enroll all victims attending the 7 IOSC for FGD. A counsellor from the 7 IOSC tracked the victims or their parents for FGD on the chosen days.

KII and FGDs were conducted in non-intimidating, non-public settings to maintain privacy, and again, ensure that the participants felt comfortable expressing their views on these sensitive questions. FGDs were facilitated by experienced counsellors from Isange OSC Kacyiru, at the Psychologist office of surveyed IOSC. In each IOSC, 2 FGDs were conducted, one targeting girls aged 10-17, the other targeting parents for under 10 years. Each FGD was composed by 6 participants. A note taker reported and recorded the discussions. A total of 14 FGDs were conducted in the 7 IOSC surveyed. A questionnaire guide was designed, and questions were related to circumstances of rape, reactions of the victim after the rape, utilization of IOSC services, satisfaction about assistance received, opinion on judiciary process, etc.

Key informant interviews (5):

In order to gain deep understanding of sexual violence amongst under-18 females, we selected a number of resource persons who deals with sexual violence issues on a daily basis, as follows:

District Hospital & IOSC (3)

- In charge of emergencies at district hospital
- Clinical psychologist at IOSC
- In charge of mental health at IOSC
- In charge of maternity department

Administrative district staff (2)

- In charge of Gender in district
- In charge of justice (MAJ)

In depth interviews were conducted by the ‘in charge of mental health’ and the psychologist. The ‘in charge of mental health’ interviewed the Psychologist, the ‘in charge of maternity’ and the ‘in charge of emergencies at district hospital’. The psychologist interviewed the ‘gender and justice officers at district level’. Conversations took place at the interviewee’s workplace. An interview questionnaire guide (Annexes) was designed for every position and included the roles and responsibility of the officer with regard to sexual violence, the kind of assistance he/she provides to the victim, challenges, areas of improvement, etc.

Qualitative data analysis

For FGD and KII, Atlas software was used to process entered scripts, pulling data from different stakeholders together under key topics and subtopics to identify crosscutting trends and themes which help in supplementing interpretation given to quantitative data.

The information (perceptions, experiences, attitudes, practices or testimonies on sexual violence) from qualitative data analysis was triangulated with the results interpretation of the quantitative cross-sectional retrospective study in the 7 IOSC and the trends of the literature review on sexual violence.

The context of social ecological model (SEM) helped the researcher to understand various interactions occurring with the victim of sexual violence.

The Social Ecological Model[33] (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations. There are five nested, hierarchical levels of the SEM: individual, interpersonal, community, organizational, and policy/enabling environment. The most effective approach to public health prevention and control uses a combination of interventions at all levels of the model. The below provides a brief description of each of the SEM levels.

Table 1: Description of Social Ecological Model (SEM) Levels

Factors	Definitions
Intrapersonal	Characteristics influencing individual behavior such as knowledge, attitudes, personality traits and beliefs
Interpersonal	Family, friends, peers providing social identity and support with role definition
Institutional/ Organizational	Rules and regulations, policies, informal structures, that may promote or constrain recommended behavior
Structural	Socioeconomic conditions, cultural context of society enabling or serving as a barrier for healthy behavior
Public Policy	National laws which regulates or support proper actions and practices for prevention, early detection, treatment, care and support

Conceptual framework adapted from AkinaShrestha, 2012.

[33] https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx

Chapter Three: Findings and Discussion

3.1 Socio-demographics characteristics

3.1.1 Distribution of under-18 female victims of sexual violence according to IOSC site

A total of 1951 under-18 female victims of sexual violence were received by the IOSC between January 1st, 2018 and December 31st, 2018. Kacyiru IOSC has the highest number of victims (n=900) while Shyira IOSC has the lowest number of victims (n=118). Graph 1 highlights the distribution of victims according IOSC site.

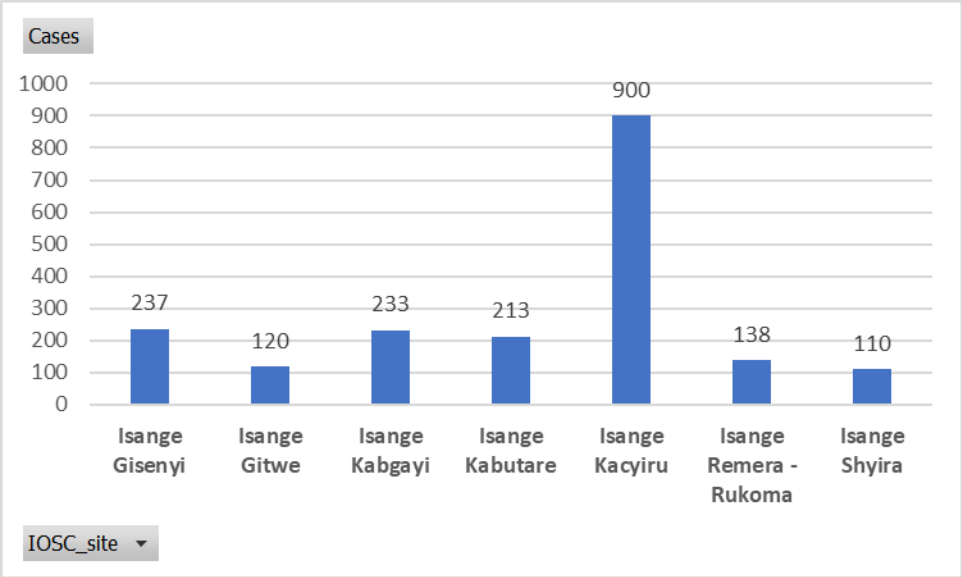

Figure 3. Distribution of under-18 female victims of sexual violence received according to IOSC site

Isange One Stop Center at Kacyiru Hospital received and assisted 46.1% of the surveyed sample while the 6 peripheral Isange OSC account for 53.9% of victims of sexual violence under 18 years of age. During the period from January 2018 to December 31, 2018. This can be explained by the fact that Isange OSC at Kacyiru Hospital was the first pilot IOSC established in the country that provided holistic care for victims of gender-based violence while assisting victims in arresting and bringing to courts the perpetrators[34]. From then, it was a king of referral center for GBV victims countrywide.

From 2010, IOSC Kacyiru provided a complete holistic package with sufficient skilled health professionals. In addition, it is providing services free of charge available 24 hours a day and comparatively with 2010, the ISOC services of the Kacyiru Hospital, were full of sufficient staff,

Nyamwasa.D. Prise en charge holistique des victimes de la violence conjugale: une étude retrospective de 243 cas colligés à I sange One Stop Center, Hôpital de Police de Kacyiru, Kigali, Rwanda. RMJ Vol.72 (2); June 2015: 8-9

the service was and remain available 24 hours, 7 days a week. Comparatively, the other 6 IOSCs, were established in 2011 and started to offer the holistic package in 2016 (except IOSC Gisenyi which started to offer the holistic package in 2012). In addition, the 6 peripheral IOSC services are only available during working hours (7h00 a.m-17h00 p.m.).

3.1.2. Presentation of the victims according their age range

Most (67.95%) of under-18 female victims of sexual violence were aged 10-17 years, a sizable proportion (19.41%) were aged 5-9 years while under-5 victims represent 13%.

The youngest victim was 1-year-old; the oldest victim was 17-year-old while the mode (the value/age that appears most often) is 16 years.

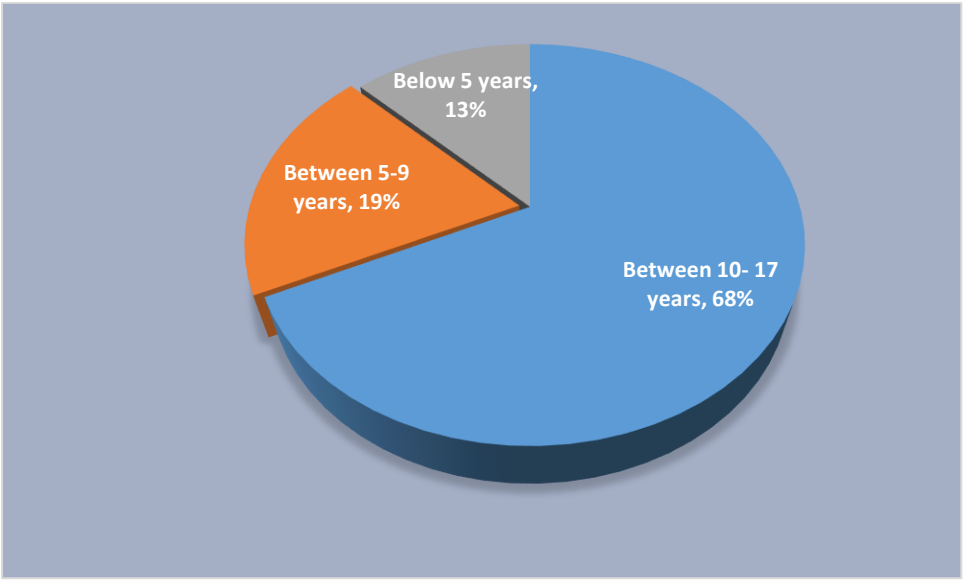

Figure 4. Age interval of under-18 female victims of sexual violence

The national integrated child rights policy defines a child as any person under 18 years.

Statistics related to sexual violence corroborate our findings: worldwide, up to 50% of sexual assaults are committed against girls under 16 years[35]; furthermore, the records from Quebec Police in 2013 reveals that 61.8% of females[36] aged 12-17 years were victim of sexual violence. In a national survey on violence against children conducted in Swaziland, among all females

[35] *UN Women (2010), Fact Sheet: Violence against Women and the Millennium Development Goals*.

[36] *Ministère de la sécurité publique du Québec (2015). Statistiques 2013 sur les infractions sexuelles au Québec. Québec Gouvernement du Québec*

experiencing some form of sexual violence prior to age 18, approximately 44.1% reported one incident in their lifetime, while 55.9% reported two or more incidents in their lifetime[37]

In 2001, it was reported by the South African Police Services[38] that children are the victims of 41 % of all rapes reported in the country and NGOs stated 50% of South Africa's children will be abused before the age of 18. Similarly, in Zimbabwe, a rural hospital examined 324 rape cases between 1983 and 1990, of who 43% was under 16 and 9% under 12 years old[39].

3.1.3 The level of education of the victims

The majority (50.8%) of the victims was in primary schools, 25% were not educated (or were not attending formal education system) and the other group of 23% was in secondary school mainly in lower level. There was the few of victims who were in upper level secondary school (1.1%).

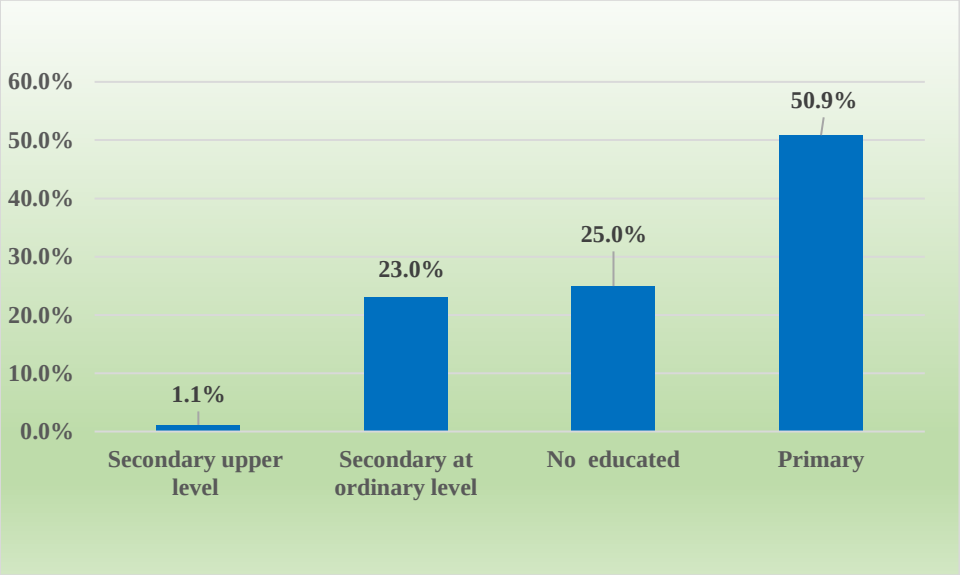

Figure 5. Level of education of under-18 female victims of sexual violence

[37] *United Children's Fund*

[38] *Kevin Lalor; Child sexual abuse in sub-Saharan Africa: a literature review Child Abuse & Neglect 28 (2004) 439–460*

https://en.wikipedia.org/wiki/Sexual_violence_in_South_Africa

[39] *Meursing, K. & al. (1995). Child sexual abuse in Matabeleland, Zimbabwe. Social Sciences and Medicine, 41(12), 1693–1704.*

Sexual Violence against under-18 females can compromise educational achievements if they have an early pregnancy or face stigma in their community. It is worth to note a significant proportion (25%) of girls who are not attending formal education either due to these consequences or for some, the age school is not yet reached. In the uneducated group there are all categories of age, there 33 children who are 10 to 14 years od, 138 who are 15 to 17 years, 89 children who are 5 to 9 years and 222 children are below 5 years.

3.1.4. Presentation of victims according to their occupation

More than 52% of under-18 female victims of sexual violence are students. The proportion of unemployed and farmers are respectively 39% and 4.6%. A painful observation is that these unemployed victims dropped out of school. Only 1.1% mentioned that they are employed (they are most likely housemaids). However, these are children and can not be in the employment market according to Rwanda labor law[40].

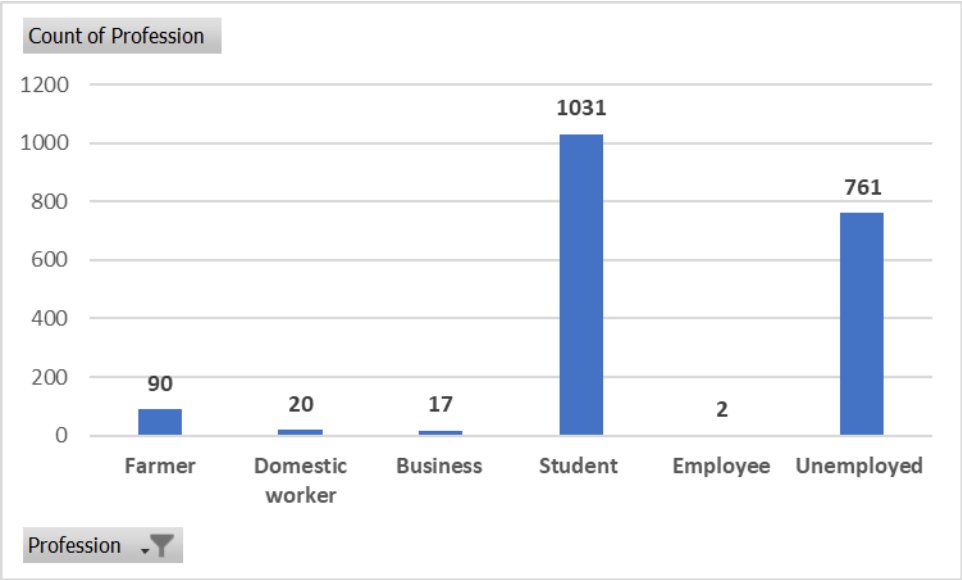

Figure 6. Occupation of victims

[40] *Official Gazette of the Republic of Rwanda, special of 27/05/2009 Regulating Labor in Rwanda*

3.2. Patterns of sexual violence experienced by under-18 females attending 7 IOSC

The main type of violence reported by surveyed victims is the penetration of penis in vagina (78% of victims); followed by level 1 sexual violence (38.1% of victims) and sexual touching (29.4% of victims). The rarest form of violence reported is the penetration of penis in mouth and penetration of penis in anus with 1.1%, 1.2% respectively. It is possible that a victim may have undergone more than one form of sexual violence. Sexual violence level 1 is often accompanied with minor injuries (see page 15 for the explanation of different levels).

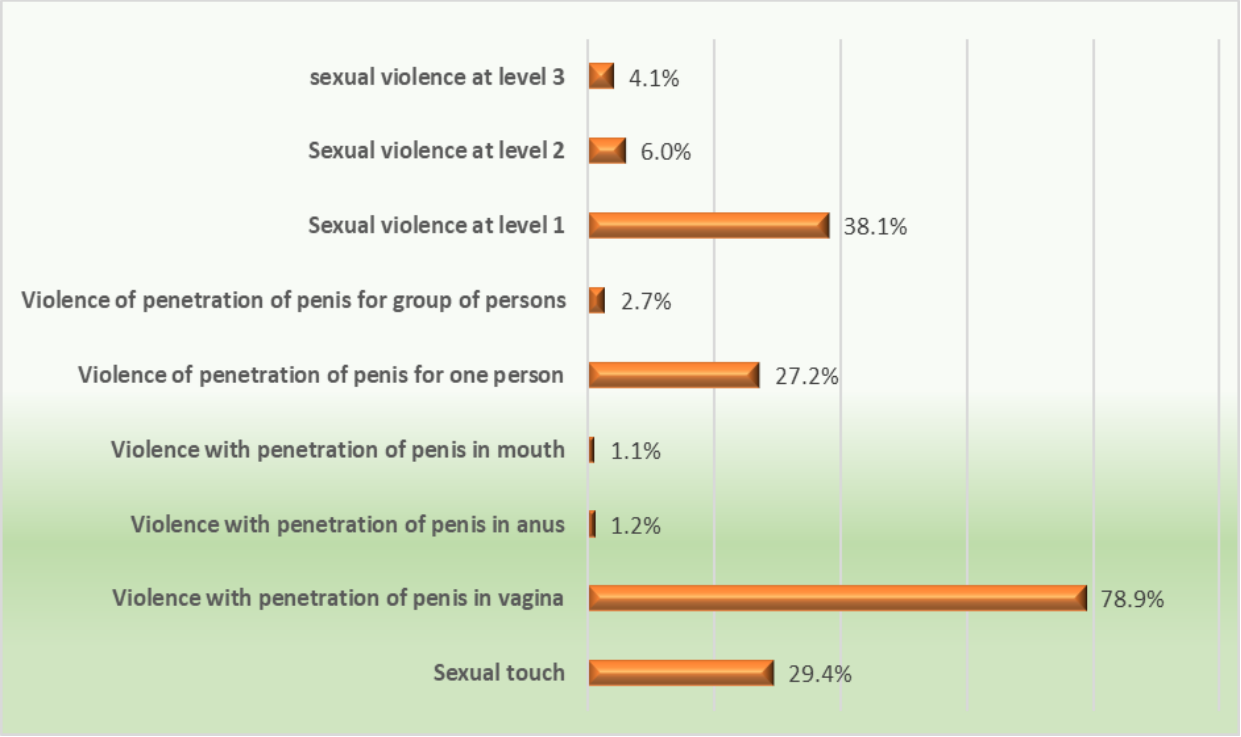

Figure 7. Forms of sexual violence experienced by under-18 females.

Sexual violence is the predominant pattern of child sexual abuse in Africa, and the common form is the violence with penetration of penis in vagina. In a review of publications about non-consensual sex, 18% of 15–19-year-olds in Nigeria and 16 % of 15–19-year-olds in Haiti had had non-consensual penetrative sex.[41] These trends are lower compared to our findings mainly due to the methodology: our study is a health facility-based records study while the review is related to population based study.

[41] *Jejeebhoy SJ, Bott, S. Non-consensual sexual experiences of young people in developing countries: an overview. In: Jejeebhoy SJ, Shah I, Thapa S, eds. Sex without consent. Young people in developing countries. London: Zed Books, 2005: 3–45.*

3.3. Consequences of sexual violence on under-18 females in Rwanda

3.3.1. Physical and Obstetrical consequences

After coerced sexual intercourse, various consequences can occur depending on the circumstances of rape. In the surveyed sample, there are 476 cases of unwanted pregnancies, 310 victims present 1st degree perineal tear and 146 present permanent partial disability. The age group 10 to 17 years is the most affected with 1038 cases.

Table 2. Physical and obstetrical consequences of the victims after the rape

The victim presents with a permanent partial disability	146	16.3%
The victim presents with a total permanent disability	15	1.7%
The victim was impregnated	476	24.4%
The victim presented with a vulva contusion	163	18.2%
The victim presented with anus tearing	39	4.4%
The victim presented with 1st degree perineal tear	310	34.6%
The victim presented with 2nd degree perineal tear	29	3.2%
The victim presented with 3rd degree perineal tear	19	2.1%
The victim presented with 4th degree perineal tear	26	2.9%

3.3.2 Risky Behaviours

In the literature, child and adolescent sexual-assault victims are at risk for a range of negative outcomes[42], including rape-related ano-genital injuries, major depressive episode, comorbid post-traumatic stress disorder, substance abuse, eating disorders, delinquency, and revictimization. The most common consequence of sexual violence is unintended pregnancy. According to a 2012 World Health Organization (WHO) fact sheet on adolescent pregnancy, it is estimated that 16 million adolescent girls give birth every year most in low and middle-income countries.

In our study, 24.4% of victims had unwanted pregnancies. In a national survey on violence against children and youth, among young women who had experienced unwanted completed sex in childhood, 48% reported unwanted pregnancy as a result[43]. This trend is higher than our findings and it reflects a proportion which is not attending health facilities for assistance. Another study in Ethiopia[44] found that among adolescents who reported being raped, 17% became pregnant after rape.

Sexual abuse during childhood is associated with high–risk behaviors later in life, including alcohol and drug use, early consensual sexual experience, and a high number of partners[45].

In our study, among 377 victims who presented risk behaviors after the rape, 69.8% dropped out of school, 6.6% were stigmatized, 6.1% have been involved in prostitution, 5.8% and 4.2% presented respectively depression and anxiety, while 2.4% had experienced suicidal thoughts and ideations.

The table below shows the spectrum of risk behaviors presented by under-18 female victims of sexual violence.

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[42] *Danielson CK, Adolescent Sexual Assault: an update on literature; Curr Opin Obstet Gynecol. 2004 Oct;16(5):383-8.*

[43] *Rwanda Ministry of Health (MOH). 2017. Violence Against Children and Youth: findings from National Survey, 2015-16. Kigali, Rwanda.*

[44] *Behere PB, Sathyanarayana Rao TS, Mulmule AN. Sexual abuse in women with special reference to children: Barriers, boundaries and beyond. [Last cited on 2014 Aug 09];Indian J Psychiatry. 2013 55:316–19. Available from: http://www.indianjpsychiatry.org/temp/IndianJPsychiatry554316.1837618_050616.pdf. [PMC free article] [PubMed]*

[45] *Fergusson DM, Horwood LJ, Lynskey MT. Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. Child Abuse Negl 1997; **21:** 789–803.*

Table 3. Risky behaviors presented by the Victims of sexual violence

Risky Behavior	Frequency	Proportion
School dropout	263	69.8%
Suicidal thoughts and ideation	9	2.4%
Alcohol abuse	7	1.9%
Drug abuse	8	2.1%
Prostitution	23	6.1%
Stigma	25	6.6%
Nightmares	3	0.8%
Depression	22	5.8%
Anxiety	17	4.5%
Total	377	100%

3.3.3 Chronic Diseases

In our study, victims were tested for sexual transmitted infections including HIV. A total of 167 victims (8.5%) were affected as folow: 117 with STI, 31 with HIV, 9 with Hepatitis C and 10 with Hepatitis B. For HIV, 24 victims aged 10-17 years were infected, while 7 victims aged 5-9 years were infected. For STI, 92 victims aged 10-17 years were infected while 18 victims were 5 to 9 years old.

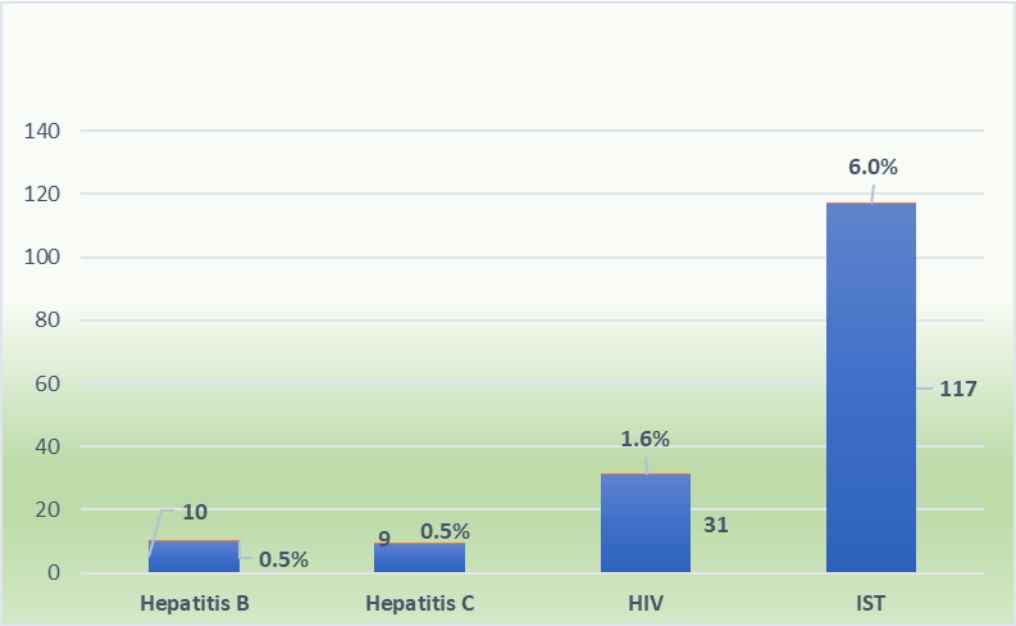

Figure 8. Infections contracted by victims after sexual violence

A recent study in Uganda found that adolescents who reported coerced first intercourse were more likely to to report one or more genital tract infections[46]. Similarly, a study in a township in Cape Town, South Africa found that women who had experienced coercisive intercourse were significantly more likely to have more sexually transmitted infections (STIs)[47]. Another study in South Africa has shown the increase of HIV incidence in raped women[48] .

[46] *Kisekka, M. N., & Otesanya, B. (1988). Sexually transmitted diseases as a gender issue: Examples from Nigeria and Uganda.*

[47] *Ann Moore, Coerced First Sex among Adolescent Girls in Sub-Saharan Africa: Prevalence and Context*

[48] *BL Meel Afr Health Sci. 2005 Sep; 5(3): 207–212.*

3.3.4. Relationship between the victim and the perpepretor

Sexual abuse against under-18 females are committed by a friend (intimate partner), a neighbor, a stranger[49] (unknown by the victim) or a close member of the family.

In our study, a total of 1399 (71%) victims did not have any family relationship with the perpetrator while 115 (7.5%) victims did have family relationship with the perpetrator as follow: 59 (3.8%) victims were raped by their cousins, 28 (1.8%) by their uncles., 21(1.4%) by their fathers and 7 (0.06%) by their stepfathers. The response rate at the question was 78.4% (n=1529)

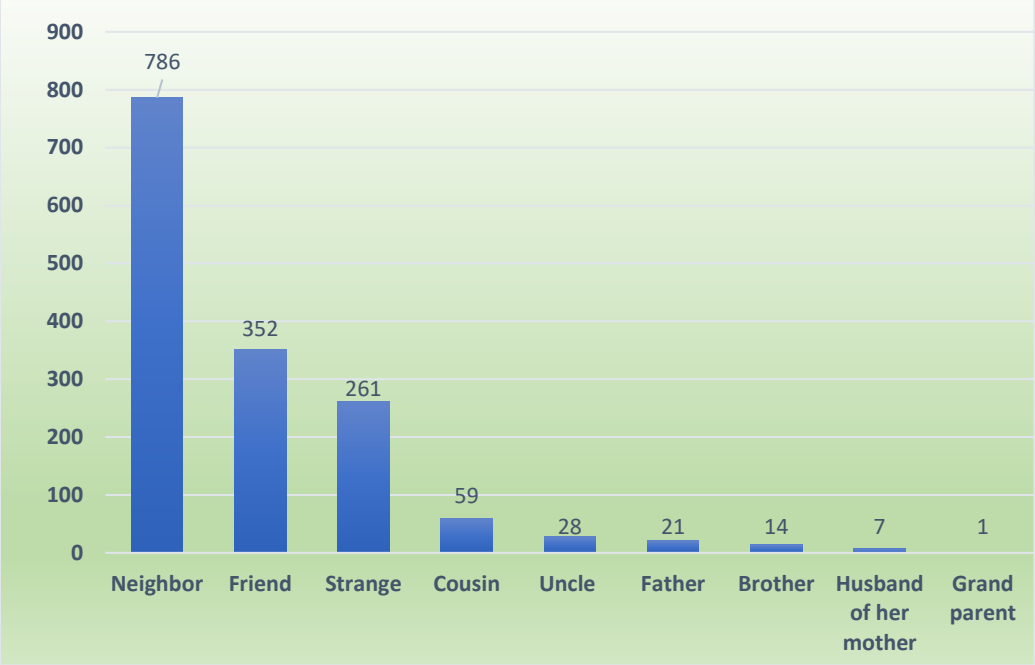

Figure 9. Relationship between the victim and the perpetrator

In the literature, records over a five-year period from the South African police[50] indicated that in 83% of sexual abuse cases, the perpetrators were known to their victims. This trend is similar to the findings of our study: 81.9% of perpetrators are known by the victims while we take into account friends, neighbors and family members.

In a national survey on violence against children in Swaziland, amongst incidents of sexual violence that occurred prior to age 18, 35.6% were perpetrated by a husband or boyfriend, 27.1% were perpetrated by a man/boy from the victim's neighborhood, 15.7% were perpetrated by a male relative other than a father, stepfather or husband, and 10.1% were perpetrated by a stranger. In our study, 17% of rapes are perpetrated by strangers while neighbors are responsible for 51.4% of sexual assaults.

[49] . *F Meinck, (http://dx.doi.org/10.1136/jech- 2015-205860).*
[50] *(https://www.wnd.com/2001/12/12139/#RYA5OHjzrkySJtWW.99)*

Findings from adolescents and parents focus groups discussions reflect the results from quantitative methods. Below are some significants quotes:

One victim revealed: *"He was a neighbor. My parents asked me to bring things there, he then raped me and no one could hear me because there was no one else in the house."*

Another victim added: *"For me, I knew him because he used to come to visit my parents. We used to talk on the phone. He lived in town, and he asked me to pass by to see his new place. He then closed the door. That is how it happened."*

"He was married to my mother, he forced me to have sex with him when my mother was not around. He told me that he would kill me if I disclose anything." (adolescent odd)

"He was the husband of my grandma." (adolescent odd)

"For me, he was my teacher." (adolescent odd)

The information provided by the victims themselves was complemented by that of the parents. A mother of another victim revealed that the offender was the kid's uncle: *"He was my brother in law who did the rape, it means he is the uncle of the child",* the mother adds

With regards to the place of rape, some authors estimate that about 40% of sexual assaults take place in the victim's own home. Another 20% occur in the home of a friend, neighbor, or relative[51]. Similarly, in our study, 615 (33.8%) rapes took place in the victim's home, 509 (28%) happened in perpetrator's residence while 261(14.3%) were raped in the bush. The response rate at the question was 93.2% (n=1818).

[51] *Greenfeld, L.A. (1997). Sex offenses and offenders: An analysis of data on rape and sexual assault (NCJ 163392). Washington DC: U.S. Department of Justice.*

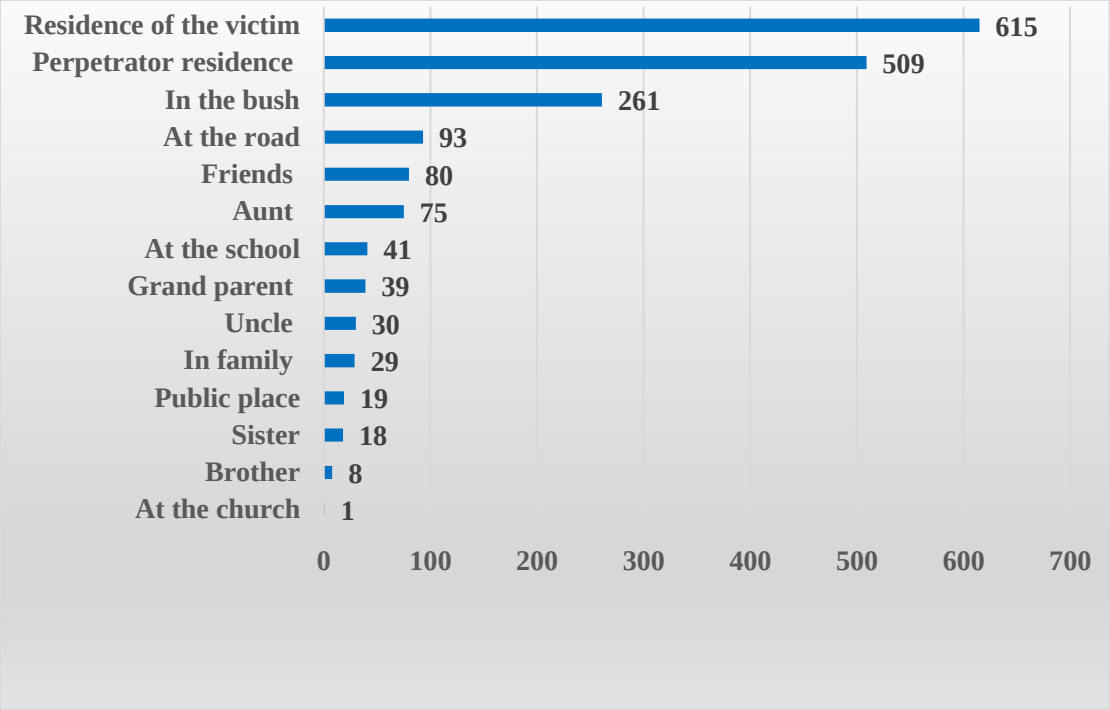

Figure 10. The place of sexual violence

In the Rwanda national survey on violence against children and youth[52], findings from young women and girls suggest that females are most likely to experience sexual violence on the street, followed by in their own home or the perpetrator's home. 10% of first incidents of sexual violence reported by young women had taken place in schools. In our study, only 2.2% of rapes occurred at school.

In another National Survey on Violence Against Children in Swaziland[53], amongst incidents of sexual violence that occurred prior to age 18, 32.9% occurred in females' own home, 22.8% occurred in the house of a friend, relative, or neighbor, 19.1% occurred in a public area or open field, 10.0% occurred in a school building or on school grounds, and 9.5% occurred on the way to or from school.

[52] [52]*Rwanda Ministry of Health (MOH). 2017. Violence Against Children and Youth: findings from National Survey, 2015-16. Kigali, Rwanda.*

[53] *Unicef; Findings from a National Survey on Violence Against Children in Swaziland 2007*

3.4. Contributing factors to sexual violence for females under 18 years

3.4.1. Risk factors

Factors increasing men's risk in committing rape[54] include individual factors like alcohol and drug consumption, psychological factors (sexually violent men have been shown to be more likely to consider victims responsible for the rape and are less knowledgeable about the impact of rape on victims[55]) as well as community factors such as poverty and social environment.

In our study, risk factors associated with perpetrators include alcohol consumption (42%) and drug consumption (12%), incidents of mental health (7.5%) and excessive libido (38.5%). The response rate to the question was 39.4% (n=769)

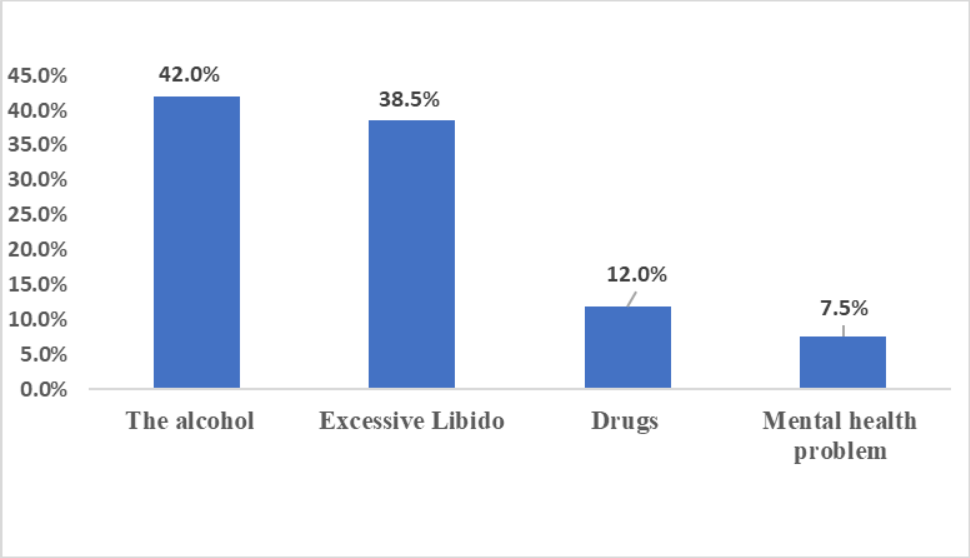

Figure 11. Risk factors associated with committing rape

On the other hand, some factors increase the vulnerability of under-18 females to become victims of sexual violence; especially family factors including low socioeconomic status and poor parental supervision. In out study, quotes from focus group discussions with adolescents reflect the poverty background in which the victims live:

"He gave me sweets and promised to assist me if I get pregnant. He was a neighbor and he was my uncle (a brother to my father)."

"For me, he used cassava bread and soup…I used to comfortably go to his house and eat. Then he scared me, telling me that since there is a witch in his family, that I should have sex with him, otherwise, bad things would happen to me. It then kept happening repeatedly."

[54] *https://enacademic.com/dic.nsf/enwiki/10071320*

[55] *Drieschner K, Lange A. A review of cognitive factors in the aetiology of rape: theories, empirical studies and implications. Clinical Psychology Review, 1999, 19:57–77.]*

"For me I didn't know him. As you know people are going to town, moving from one place to another, looking for a job. That is how we met and then he raped me."

"For me, because he had a shop, I used to go there and he gave me things like soda and biscuits; he had promised to buy me a phone as well. I went to his home and it happened"

3.4.2. Protective factors

Challenges in meeting sexual and reproductive health needs include inadequate access to health information and services, as well as the ignorance of the legal context, laws and policy related to the situation or rights of the victims. The study explored the level of awareness of victims in relation to laws and policies on GBV and abortion, as well as their awareness on the use of contraceptive methods and reproductive health services[56]. Access to health information and services is a key protective factor. Legal and policy reforms such as abortion law and revitalizing social norms, and it is crucial that adolescents and their parents are informed about the process and their rights.

3.4.2.1. Victims know about the prevention law on sexual violence

The law on prevention and punishment of GBV crimes has been promulgated by the government of Rwanda in order to prevent GBV and protect its victims in general; the proportion of under-18 female victims of sexual violence surveyed who were aware of the existence of GBV law varies according to the IOSC sites. The sites which have the highest proportion of awareness are Gitwe (100%) and Kabgayi (96.1%), and the lowest is Kacyiru (42.7%) and Remera Rukoma (44.2%).

[56] *Sexual health and its linkages to reproductive health: an operational approach; WHO 2017*

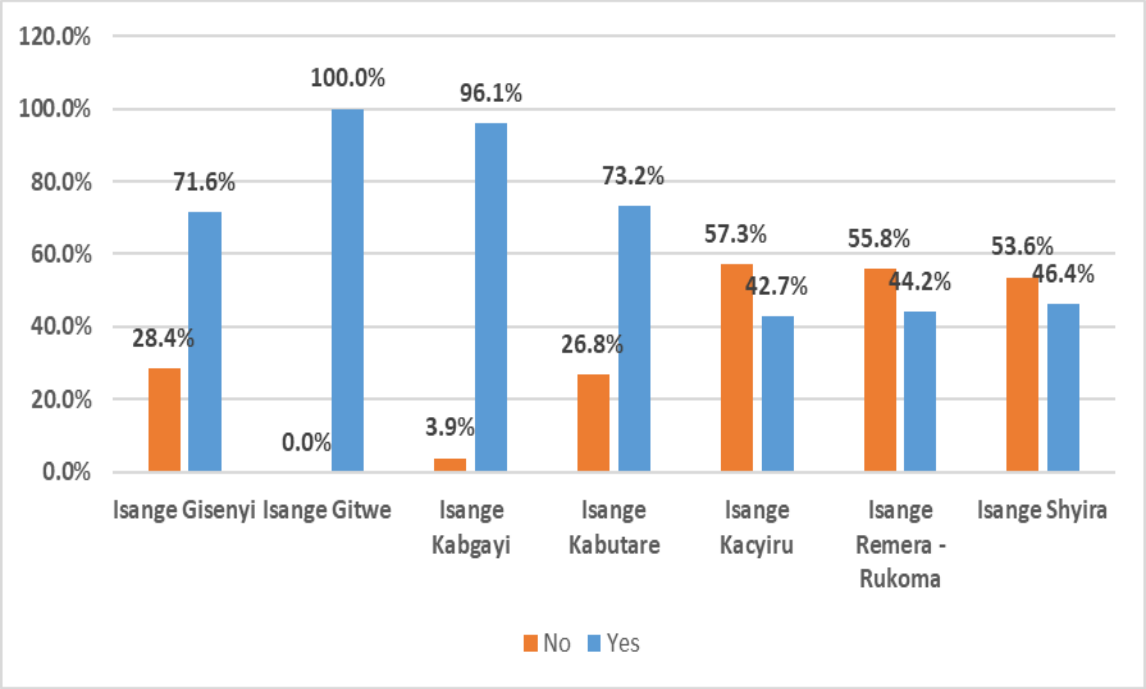

Figure 12. Level of awareness amongst victims about the GBV law.

However, findings from FGD highlights the lack of knowledge (by participants) of the law on the Prevention and Punishment of Gender-based Violence crimes. In fact, there was no quote recorded from participants where they had heard about the GBV law, and some adolescents had little or nany quote from participants is recorded about having heard about the law on GBV, rather some adolescents had little or indecipherable information on the abortion law.

Furthermore, in depth interviews with the gender and judiciary access point officers at district level reaffirms that a lot of victims are not bringing their complaints to the appropriate services.

"A lot of victims are not aware of their rights" (odd from MAJ.

"There is a culture of keeping it a secret in Rwandan and sometimes these children are scared to disclose who raped them. You find many of them above 12 years of age, approximately 70% who are impregnated and are not assisted in prevention" (odd from District Gender officer.

However, respondents from FGDs were more aware of the existence of abortion law.

"Yes, I think that law is helpful especially when the kid is for example 12 years old. This law eliminates the risk and problems that the kid might have when giving birth." (a mother odd)

"If the kid is still in school, this law would help the victim to have an abortion and stay in school." (a mother odd)

"Yes, first of all, it is so sad to have sex with someone you are not in love with, no negotiation between you and him, and finally he impregnates you and there was no pleasure in the sexual relationship. For me if I get the authorization through that law; I can ask for medical assistance for abortion because it is unpleasant to have an unplanned pregnancy." (an adolescent odd)

"You might be a student and get pregnant. Abortion would allow you to avoid dropping out of school" (an adolescent odd)

Some health providers were aware of the abortion law, but they didn't have enough information on how the law should be implemented.

"We know that the government has approved the law on abortion, but we don't have any information about putting it into practice" (Odd from Psychologist at Isange OSC)

3.4.2.2 The victims are aware that the perpetrator should be punished

Legal assistance is part of the package of services that GBV victims can benefit from at the IOSC. The majority of victims attending IOSC Gitwe (100%), IOSC Kabgayi (96.1 %), IOSC Kabutare (73.24%), IOSC Gisenyi (71.68%) are aware that the perpetrator can be punished. Victims received at IOSC Kacyiru had a low level of awareness and limited information about the law (42.71 %).

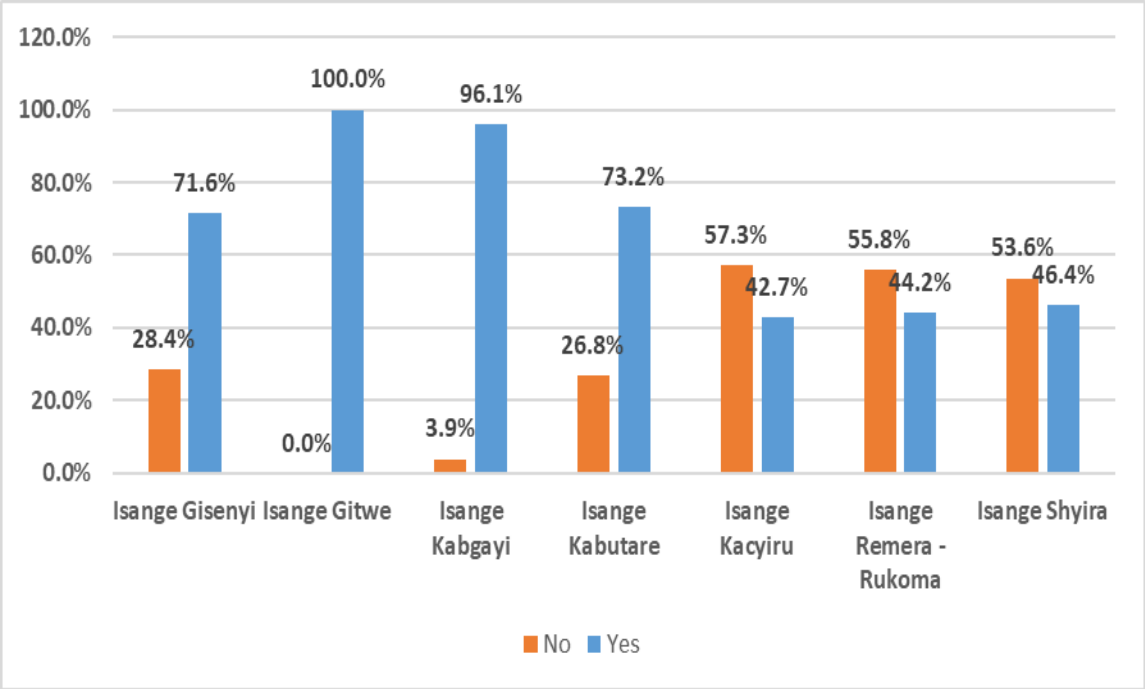

Figure 13. Level of awareness amongst victims that the perpetrator might be punished

In addition, FGD findings revealed that participants have limited understanding of the legal process and think that perpetrators are not adequately punished.

"We thought that if we delay, the perpetrator can disappear, it is the reason why I have called DASSO and took him to the police but I was surprised because after a little while he was released." (A mother odd)

"After reporting the case, the perpetrator spent around one month in prison and then was released. When I went back to the police, they asked me to come with the copy of investigation from Gakenke police but now I have given up." (A mother odd)

"Yes, it is worth it to punish the perpetrator for what he has done…" (A mother odd)

"We didn't negotiate with him because, we have reported the case to the authorities "(A mother odd)

"For me, he was in jail and I went to visit him. He then begged me to forgive him and promised to help me. They released him and he didn't fulfill his promise. When they tried to arrest him again, they didn't find him." (An adolescent odd)

"For me, I didn't know the perpetrator, but I reported it to my parents who helped me to trace the perpetrator and his family so that they can help us. When I met the perpetrator, he said that he didn't know me. Then his family said that their boy couldn't have done such things. I approached the authority and they put him in jail. But they said that they arrested him without proof that he raped me, so they asked us to inform them after giving birth. We did all that, and they asked to wait for 2.5 months so that they can do a blood test. After giving birth, we went to Mageragere prison and they told us that they had released him. I asked how they did that without doing the blood test to prove whether he was the father or not" (An adolescent odd)

The quotes above reflect the frustration of victims or their parents on the outcomes of the legal process.

3.4.2.3 Level of awareness of Reproductive Health Information

The increase in cases of unwanted pregnancies amongst young girls is generally due to the lack of adequate knowledge about reproductive health yet children engage in unprotected and unpredicted coercive sex at a tender age.

In our study, the victims mentioned having benefited from awareness or information on reproductive health prior to the consultation at Isange services. The victims received by IOSC Gitwe are most likely to be aware of RH issues as represented by 98.3% of them; followed respectively by IOSC Kabgayi with 91.4%. and IOSC Shyira with 88.7%. IOSc Kabutare presents the lowest proportion of victims who had RH information (56.3%) while in IOSC Kacyiru, only 64.9% of under 18 years' girls have been informed on RH issues. Below is a quote from FGD which reflects the support received by victms.

"When we got to Isange, we attended sessions that taught us about reproductive health" (An adolescent odd).

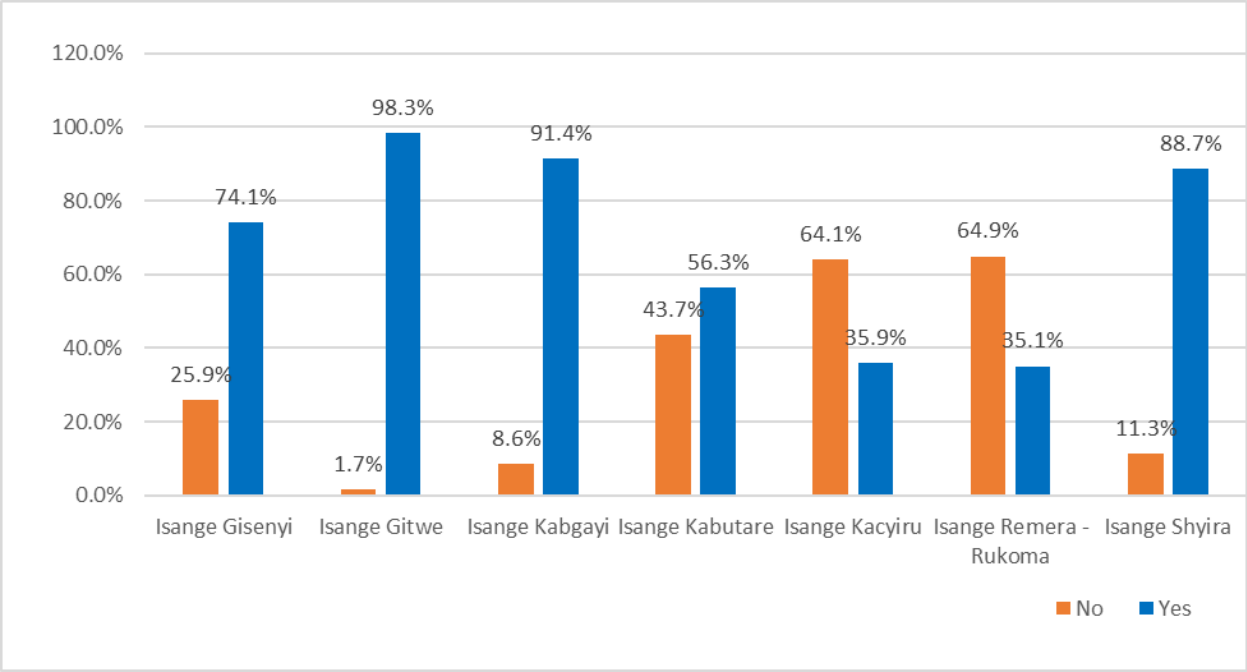

Figure 14. Level of awareness amongst victims of reproductive health

3.4.2.4 Level of awareness and the use of contraception.

According to the definition[57]; contraception is the use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse.

A range of people have an influence on adolescents' access to information and services, including peers, parents, family members, teachers, and healthcare providers.

On the other hand, there are judgmental attitudes about sexual activity, especially for those who have sex outside of marriage and sexually active girls. In fact, cultural and legal norms in Rwanda allow for sexual intercourse and childbearing and rearing only in marriage, with the minimum legal age for marriage being 21 years[57]

Use of contraceptives to prevent unwanted pregnancy is low amongst Rwandan youth. Only 1.9% of women aged 15-19 years and 18.5% of women aged 20-24 years were using a modern contraceptive method at the time of the DHS Survey[58]

In our study, 72% of under-18 female victims of sexual violence reported not having information about or access to contraceptives, either as a result of social norms or parental advice.

[57] *Adolescent Sexual Reproductive Health and Rights Policy: MOH, 2011*

[58] *NISR Rwanda Demographic and Health Survey 2015*

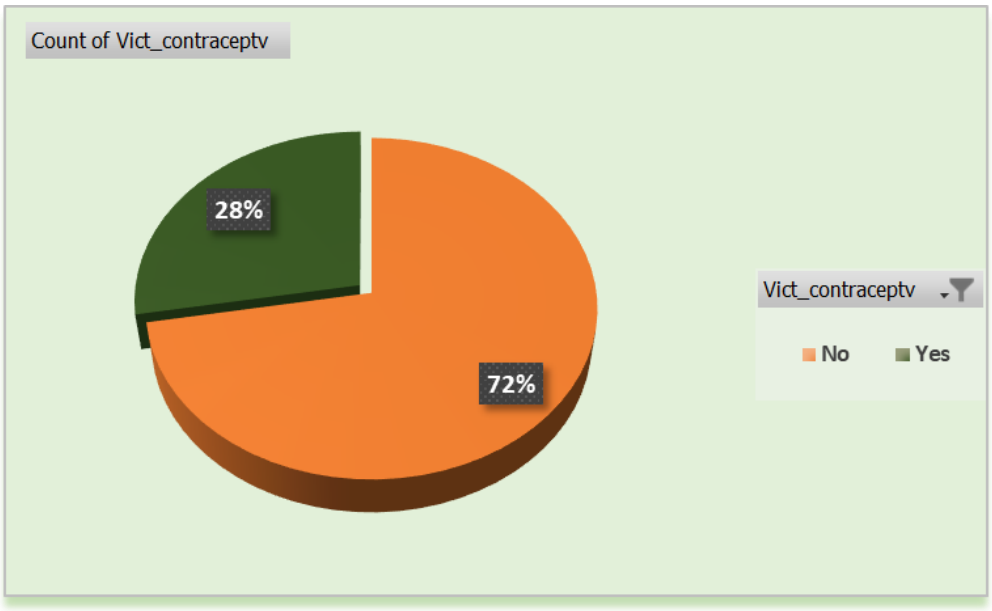

Figure 15. Level of awareness amongst victims about using contraceptives

Findings from FGDs reveal that victims receive comprehensive information, mainly from Isange OSC.

"We have been advised about various ways such as using contraceptive tubes, using condoms, etc…" (An adolescent odd).

"For example, I gave birth when I was still in school. It held me back in terms of my goals. After I got here, they gave us advise on how to behave in order to prevent it from happening again. I personally decided to wait and get pregnant legally." (An adolescent odd).

"Before I got help from Isange, I thought all my dreams were over. But the advice from Isange helped me to decide to wait to have sexual intercourse" (An adolescent odd).

3.5. Utilization of health services available for under-18 female victims of sexual violence

3.5.1 Right for the victim to choose the health professional of their choosing.

Most of the surveyed victims (88%) reported that they had the right to be consulted/treated by the doctor or the nurse that they have chosen.

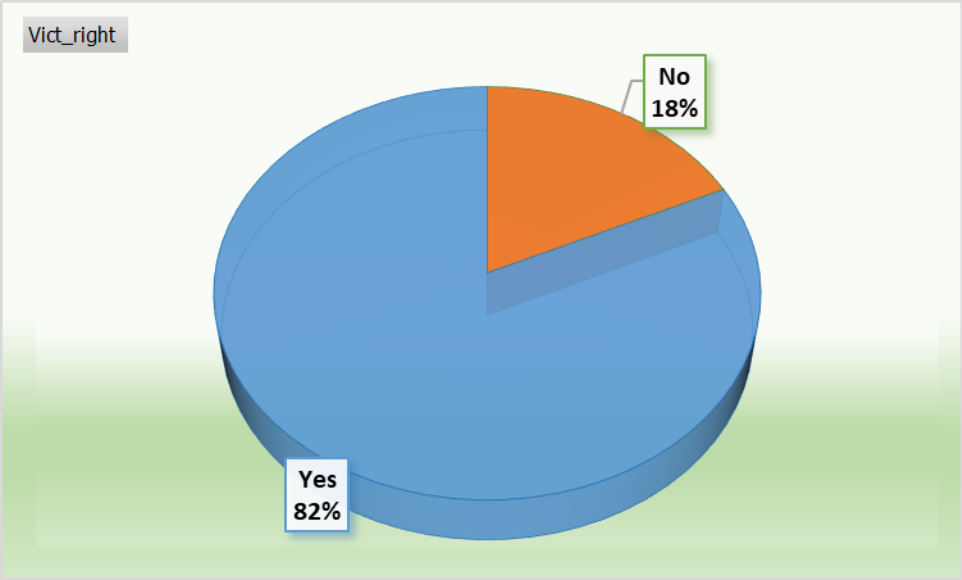

Figure 16. Proportion of victims who had chosen their own health professional.

3.5.2 Right to medical assistance and safe abortion for the victims

Rwanda reformed its law relating to Human Reproductive Health in 2016, and in October 2018, the Rwandan government removed the requirement of court approval and the second doctor's permission for a legal abortion. These changes came into effect with Ministerial Order No.002/MoH/2019 on 8 April 2019, which outlines the conditions to be satisfied for a medical doctor to be able to approve and provide abortion care; some of the determinant reasons to seek an abortion include; in the case that the pregnant person is very young, in the case that the pregnancy is a result of incest (up to second cousins), in the case that the pregnancy is a result of rape and also in the case that the pregnancy is a result of forced marriage.

In our study, 476 victims (24.4%) had unwanted pregnancies. Among them, 240 victims (50.4%) requested assistance in having a safe abortion. 145 victims (30.5%) were refused assistance to abortion by medical services. In fact, many abortions were denied because the judiciary process (court) took too long to come to a decision.

'In charge of maternity' interview confirms the trend.

"Yes, they come into maternity for delivery; but none come into obtain an abortion" (in charge of Maternity odd).

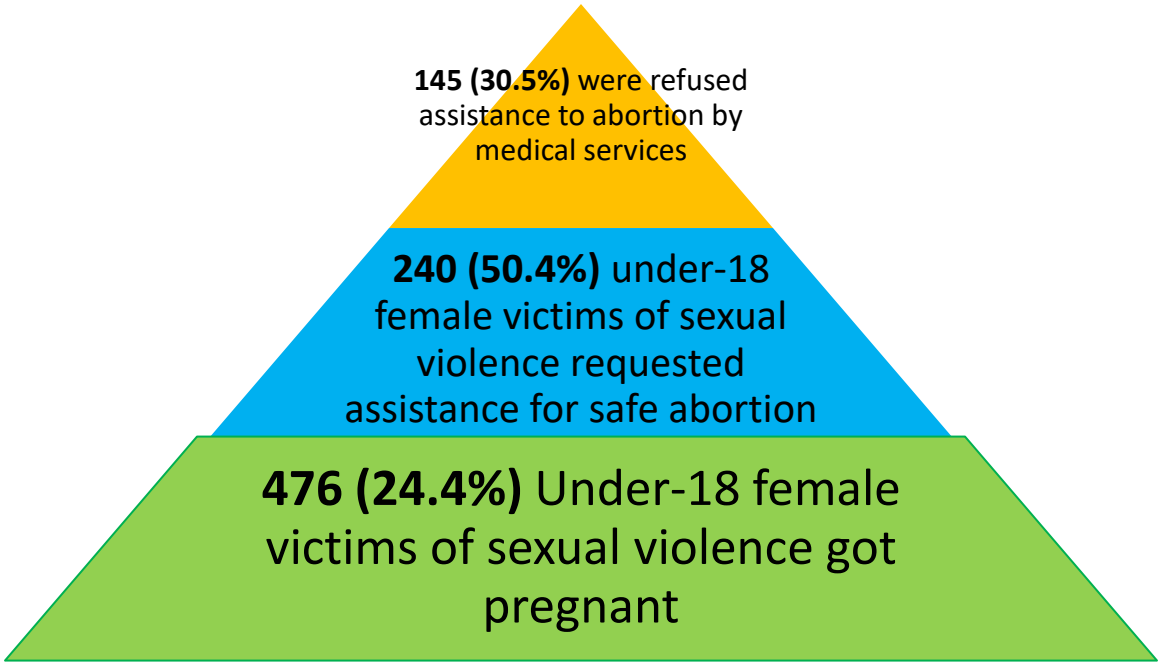

Figure 17. Medical assistance to victims for safe abortion

3.6. Services available at IOSC for under-18 female victims of sexual violence

Regarding service provision at Isange One Stop Centers, all IOSC offers the required holistic package including psychosocial, medical, police and legal services for victims of gender-based violence and child abuse occurring in the family or in the community. These services are free of charge in all IOSC surveyed, available 24 hours in Kacyiru IOSC whilst in the other 6 IOSC, these services are available during official working hours. All IOSC surveyed also have provisions for emergency contraception, HIV prophylaxis and STI prevention.

However, the health professional at the other 6 IOSC who is in charge of GBV, is in charge of mental health as well. Thus, these are overwhelming responsibilities. In addition, the psychologist is available during official working hours and is off during the weekend.

Quotes from indepth interviews with health professionals at Isange IOSC reflects the services offered:

"The doctor does the medical consultation and ask for laboratory exams; then, he gives the post exposure prophylaxis and emergency contraceptive pills to avoid the unplanned pregnancy, and then after refers the victim to the IOSC" ('In Charge of Emergencies service' at District Hospital)

"The psychologist is available on working days, at the weekend they do not work, and because of having a position in two departments, sometimes he might not be available on working days as well, due to the activities organised in the department of mental health "(Psychologist)

With regards to the training needs, health professionals in Isange OSC expressed the necessity of refresher courses in gender-based violence.

> *"We did not receive any training" ('In Charge of Emergencies services' at District Hospital).*

> *"Yes, we have been trained but it is not enough" (Psychologist).*

3.6.1 Prevention services targeting under 18 years' girls' victims of sexual violence

With regards to prevention, 82.7% of victims attending IOSC services received HIV post exposure prophylaxis within 72h; 79.8% of victims received STI prevention within 48h and 51.4% received emergency contraception. The proportion of victims receiving additional prevention services including HVB prevention, prevention of tetanus and Hepatitis B prevention are respectively 37.4%; 43.8%; & 42%.

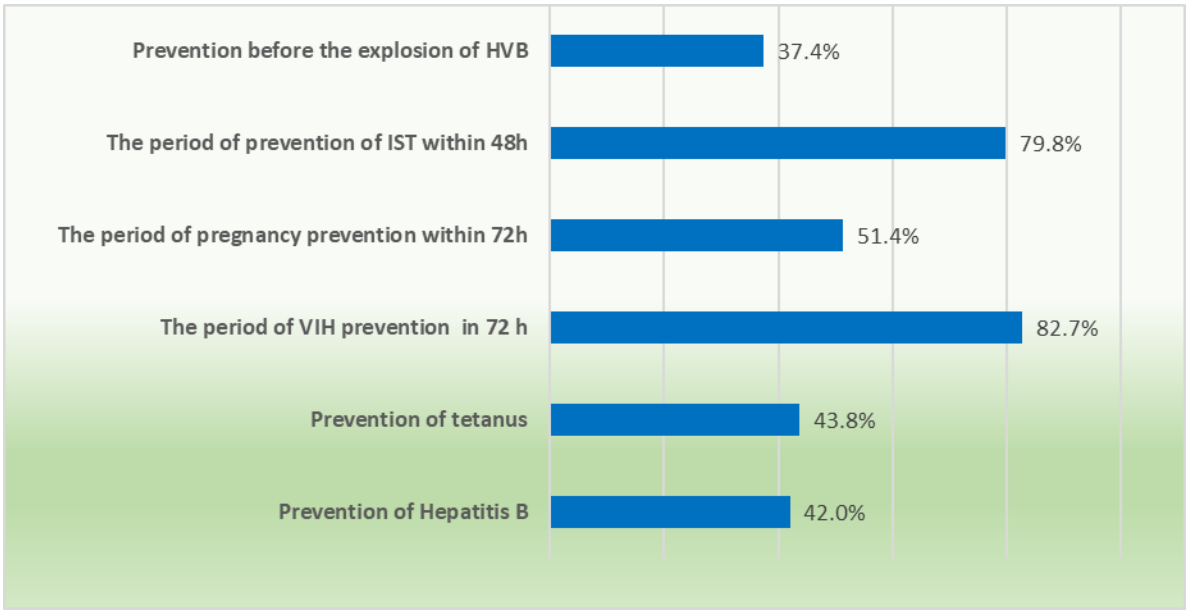

Figure 18. Level of utilization of prevention services at IOSC by victims of sexual violence

The quotes below from adolescents in the FGDs reflect the assistance received at Isange OSC:

A victim female reported:" *For me, after it happened, my parents took me to the hospital and they did tests. Then, they gave me pills. I later went to the police, to get the offender arrested, but he escaped. They then referred me to Isange, and they give me pills to help with pregnancy and medicines to prevent me from contracting HIV. They stayed close to me and they made me feel confident and had hope again."*

"*For me, they taught me how to count my menstrual month in order to avoid unwanted pregnancy. (adolescent odd)*

"After the rape, we have been trained about reproductive health here at Isange". (adolescent odd)

"We have been taught how to behave and they taught us about our body transformation and the way to avoid unwanted pregnancy" (adolescent odd)

3.6.2 Psychosocial support services offered to under-18 victims of sexual violence

The rationale of the establishment of IOSC was to offer medical, forensic, legal and psychosocial support to GBV victims.

95.5% of surveyed victims received the counseling services and 91.4% got follow-up appointments after being received by the IOSC. A sizable proportion of victims (33.4%) have been kept in the safe room while 60.4% of victims benefited from group therapy.

Table 4. Psychosocial support services offered to the victims at Isange OSC

Type of service	**Frequency**	**Percentages**
Counseling for the victim	1841	95.5%
Group therapy (IEC session)	1164	60.4%
The victim was kept in safe room	644	33.4%
Security measures for the victim	1635	84.8%
The victim received a follow-up appointment	1761	91.4%

The victims of sexual violence indicated that a wide range of services were offered. Among others, education on reproductive health, post-violence counseling, and medical and legal services were mentioned.

For those who were aware of Isange, they said that they immediately reached out to the centre for help as one of the respondents reported: *"I had heard of it, but I didn't know where it was located"*

In contrast, another respondent added that she went immediately to the centre. According to the parent whose child experienced sexual violence, she says, *"After I heard what happened, I urgently came here to Isange One Stop Center because I know that after reporting the case to Isange they would be in charge of what willhappen after."*

Another female victim reported:" *For me, after it happened, my parents took me to the hospital and they did tests. They then gave me pills. I later went to the police, to get the offender arrested, but he escaped. They then referred me to Isange, and they give me pills to help with pregnancy and medicines to prevent me from contracting HIV. They stayed close to me and they made me feel confident and had hope again."*

Some reasons behind the delay to reach out to Isange OSC were revealed by the participants. Among others, ignorance of the victims' parents and fear and shame to reveal that they have been violated. Asked why she did not reach out immediately to Isange OSC, one of the victims said, "*Because I was so afraid of revealing it. Also, after I got there, I didn't know what services they offer, but after I joined, they gave me a lot of support untll now*". The fear factor was identified as the most common reason for delaying in attending Isange OSC. In addition, ignorance has been identified, however it was not commonly indicated.

"I didn't know Isange, however, when I went to the health center, they referred me to Isange" (Adolescent odd)

"For me, I knew it from my cousin who had been raped before" … (Adolescent odd)

"many people don't know that Isange exists. There are many girls who face sexual violence but don't know about Isange." … (Adolescent odd)

3.6.3 Satisfaction with the services provided at Isange One Stop Centre and suggestions for improvement

The respondents in FGDs highlighted the importance of Isange OSC and stressed that they were satisfied with the services offered.

For instance, the victims reported:

"Before joining Isange, I lost hope and didn't want to continue my education. But Isange stayed close to me and helped me to recover and gain back hope for the future." Adds a female who was a victim of sexual violence.

Another victim added: "*What I can add is, they have been like parents to us. It is beyond what we imagined. I was worried that I wasn't going to do my A level tests. But they helped me to realize that pregnancy doesn't mean the end of education."*

Another victim relied heavily on the Isange One Stop Centre as there was nowhere else to go for help.

"I was happy. I thought I was going to drop from school… But the district helped me through Isange OSC."

Several suggestions were provided by the participants for improvements in the services at Isange. The most common of the suggestions provided emphasized sensitization and education to raise awareness in the community about Isange one stop centres. One of the victims stressed *"I would*

request Isange to partner with schools so that teachers teach students about reproductive health. Information about Isange should also be communicated in community works."

"Isange should bring its services to health centers, because raped girls go to health centers for basic help" (another adolescent odd)

3.6.4. Knowledge of services providers in managing and supporting victims of GBV

Many service providers who were contacted during the interviews acknowledged that laws on GBV and abortion were important for the victims of sexual violence. However, there was not a clear understanding on how these laws can be implemented.

One of the providers reported: *"Regarding abortion, I have heard that a person is allowed to do abortion when 2 people involved are close family members, or if the pregnancy happened by force." ('In charge of Emergencies at District Hospital')*

Another respondent complemented by saying: *"For me, I know that when the girl is still in school and young, when the pregnancy is dangerous for the girl, then abortion can be considered." ('In charge of Maternity at District Hospital')*

"We know that the government has approved the law of abortion but we do not have any information about putting the law into practice." (Psychologist)

3.6.5. Legal services offered to the victims at Isange OSC

MAJ (Maison d'Acces a la Justice) are judicial access points based at districts, put in place to offer legal assistance to poor citizens. In the context of Isange OSC services provisions, the MAJ assist, counsel, represent and plead, to all courts of law, for the victims of sexual violence and for GBV victims in general. In addition, they have the role of disseminating laws to local communities as well.

MAJ are available twice a month at IOSC to hear the complaints of victims and to have a common understanding on the legal process.

Indepth interviews with MAJ revealed challenges reflected in these quotes:

"We work with IOSC day by day, when they send us the victims who need to go to court, especially for compensation, we help them, especially for those who are poor, until the end of the accusation in the court. Here there are barriers we often meet because there are some who are sent by IOSC but do not reach us because they do not know the location of the district well." (MAJ Odd)

"Victims are delaying revealing the circumstances and evidence of rape…" (MAJ Odd)

"One judiciary access point is not enough because sometimes we receive a lot of complaints and we are not able to follow up on them timely; and sometimes we are not able to go into the community to solve urgent issues due to a lack of means of transport." (odd from MAJ)

Consequently, the assertions above may explain why the time required for cases to be adjudicated through the legal system can be very lengthy and sometimes, the victims are not kept informed on the progress.

Collaboration between legal services and gender services at district level

The gender officer assistance to the victim of sexual violence include the counselling of the victim, accompaigning the victim at Isange OSC service at district hospital, facilitate the transport fees when the victim goes back home, provide food to the victim when she is in the safe room and to ensure that all services required by the victims at Isange OSC are offered.

At household level, assistance to the victims of sexual violence include regular visits at home and counselling, and assistance in community reintegration while combating stigma in community.

Gender officer works closely with MAJ through "inteko z'abaturage"/community mediation and assisting the victms in setting up small income generating projects.

"When we receive a victim, we first send her to Isange where she can get comprehensive assistance, sometimes there are some victims who come back saying that they did not have justice, for example when the perpetrator is not arrested…, we refer the victim to the MAJ for follow up in judicial process" ('Gender officer at district level')

"Sometimes, the victims complain that they didn't receive assistance at justice level or they are not satisfied at all. For example, a victim mentioned that the perpetrator was released from prison in a few days and she has not been informed how the trial went…" (Gender officer at district level)

However, some of the victims mentioned poor assistance:

"We didn't receive financial support from the gender office, they promised it but they didn't provide it."

With regards to legal services provided to the victims at IOSC, only 49.7% of perpetrators have been arrested and 49.2% has been taken to court. Furthermore, 35.3% of perpetrators went to jail; some disappeared (36.4%) after committing the sexual violence while 13.8% of perpetrators were released after a short period kept at the police station.

Table 5. Legal services provided to the under 18 years' girls' victims of sexual violence

The legal services	Frequency	Percent
The perpetrator has been arrested	744	49.7%
The perpetrator has been taken to court	736	49.2%
The perpetrator has disappeared	545	36.4%
The center has provided a lawyer to the victim	375	25.1%
The victim didn't have a lawyer	380	25.4%
The perpetrator is released	207	13.8%
The perpetrator has been punished	529	35.3%

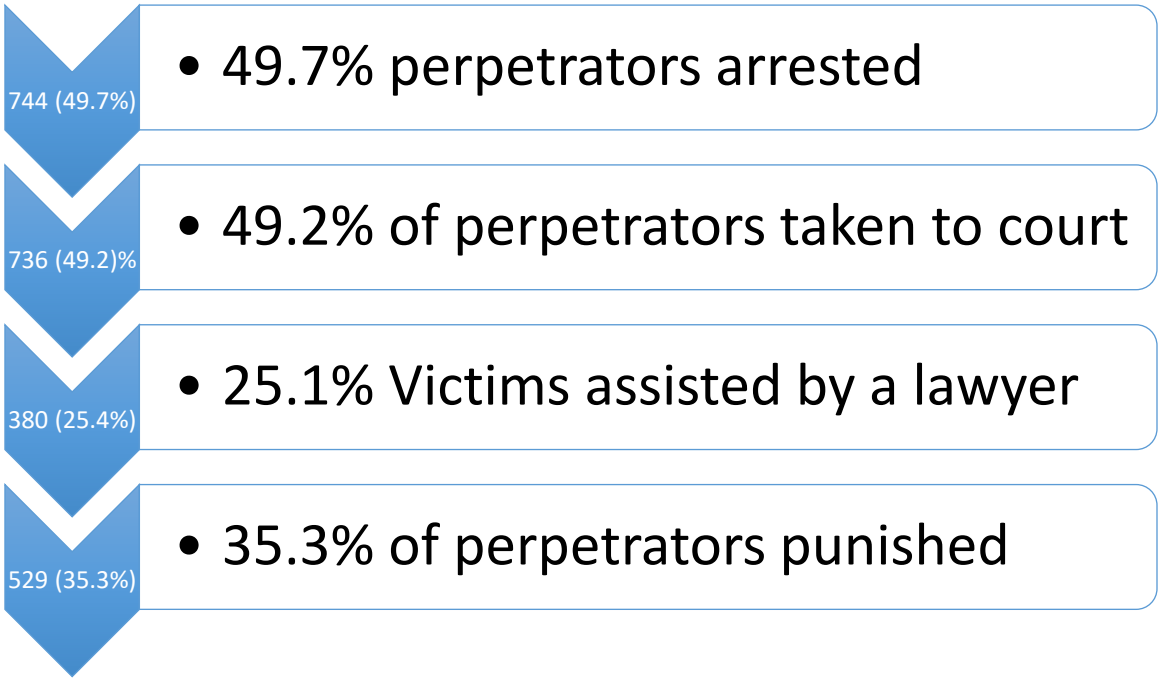

Figure 19. Process and outcomes of assistance in legal services for sexual violence victims

3.6.6 The financial support to victims at IOSC

All IOSC surveyed are providing financial support to under-18 female victims of sexual violence like other GBV victims including transport fees (92.9%), free of charge medical, psychosocial and legal services.

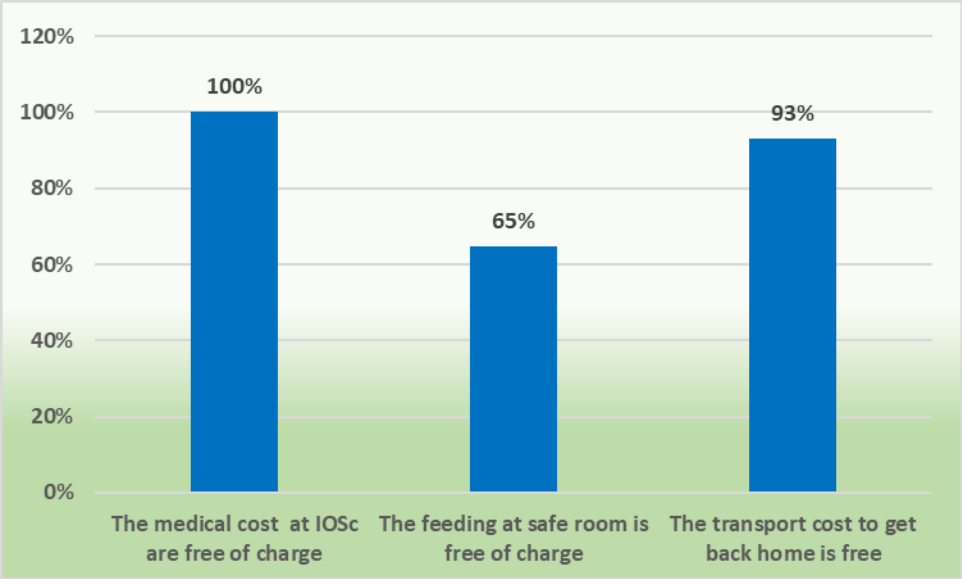

Figure 20. Level of financial support to victims of sexual violence

Chapter Four: Conclusion & Recommendations

The findings from the survey on the status of sexual and reproductive health and rights and the provision of services to under-18 female victims of sexual violence at 7 Isange One Stop Centers in Rwanda show that victims appreciated services received at the 7 Isange OSC, however there is still a need to strengthen awareness interventions in the community with regards to sexual violence and adolescents' rights on reproductive health.

The findings of the survey lead to these recommendations:

- For the peripheral 6 Isange OSC, each center should have at least 2 trained health professionals; one in clinical psychology and counselling, another one in mental health. (Currently, at peripheral level, very often, there is one psychologist, the other one is a nurse).
- Capacity building of health professionals working in Isange OSC, especially organizing in-service training on various themes/topics related to their routine work; including gender-based violence (GBV awareness, HIV/AIDS and GBV, multisectoral prevention and response to GBV, etc.), behavior change communication, participatory methods and team building and team work.
- Organize session of awareness on the abortion law for the district hospital health professionals
- Increase the number of judicial access points (MAJ) based at district level and ensure that they receive training on dealing with sexual violence victims.
- A team composed of the gender officer at district, the judicial access point at district and the psychologist at Isange should plan together activities to implement at community level. These interventions should include awareness campaigns on sexual violence in the communities and in schools, education on adolescent reproductive health should be regular (at least twice a month).
- Effectively engage in (continue) awareness raising campaign to sensitize communities and parents about all aspects related to minors unwanted pregnancies, in order to contribute to their prevention, to encourage the education of pregnant and parenting girls, help them to access SRH services and reduce stigma and discrimination through empathy and support.
- Establish mechanisms for tracing girls who dropped out school due to unwanted pregnancies, through all level of community administrative channel; from Isibo to Umudugudu, then to Akagali (Cell). In his monthly report, the Community Health Worker should highlight the number of under 18 years' girls who got unwanted pregnancies.
- Capacity building on Child rights and Adolescents-Sexual Reproductive Health in schools: debates should be organized at all schools to give teenagers a platform to express their views and opinions on the theme, and clubs for anti - teenage pregnancy should be formed at all schools.
- Develop linkages between schools and health services as part of efforts to reduce unwanted

pregnancies and support pregnant and parenting adolescents

- Encourage and support school health services (SHS) that offer on-site contraception and counselling services as part of efforts to reduce early and unintended pregnancies

- Deliver curriculum-based comprehensive sexuality education (CSE) in schools prior to and after puberty to prevent early and unintended pregnancies

Further research should explore and provide insights into these areas:

- Sexual violence and HIV infection among under-18 females: a retrospective study in all Isange One Stop Centers
- Interventions to prevent sexual violence and their impact to adolescent reproductive health in Rwanda
- Survey on outcomes of judicial process with regards to perpetrators of sexual violence
- Survey on the patterns of sexual violence in schools

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