Assessment Title:	**Burundi Sexual Violence Assessment**
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Date(s)	August 21–September 3, 2011
Trip name/description	Sexual Violence Assessment
Country/city	Burundi, Bujumbura
Trip type	Field research/Assessment
Program supporting your travel	RESPOND
Trip objectives	In August/September a needs assessment was conducted in Bujumbura, Burundi, to identify which laws, policies and activities exist to prevent and respond to sexual violence.

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ACRONYMS AND DEFINITION OF KEY TERMS

ABUBEF	Association Burundaise pour le Bien-Etre Familial (Family Welfare Association of Burundi)
ACORD	Agency for Co-operation and Research in Development
ADDF	Association pour la Défense des Droits des Femmes (Association for the Defense of Women's Rights)
AFJ	Association des Femmes Juristes du Burundi (Association of Women Lawyers)
AIDS	Acquired Immune Deficiency Syndrome
APFB	Association pour la Promotion de la Fille Burundaise/ Association for the promotion of the Burundian Girl
APRODH	Association pour la Protection des Droits Humains et des Personnes Détenues/ Association for the Protection of Human Rights and Detained Persons
Art	Article
AsF	Avocats sans Frontières/Lawyers without Borders
BCC	Behavior Change Communication
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CDF	Centre de Développement Familial/Family Development Centre
CNLS	Conseil National de Lutte contre le SIDA/National Anti-AIDS Council
DV	Domestic Violence
FAWE	Forum for African Women Educationalists
GBV	Gender Based Violence
GOB	Government of Burundi
IASC	Inter Agency Standing Committee
IEC	Information, Education and communication
ICGLR	International Conference on the Great Lakes Region
IRC	International Rescue Committee
JPO	Judicial Police Officer (OPJ: Officier de la Police Judiciaire)
MSF	Médecins Sans Frontières (Doctors Without Borders)
MoH	Ministry of Health
MinJust	Ministry of Justice
NGO	Non-governmental Organization
PEP	Post Exposure Prophylaxis
PNSR	National Reproductive Health Programme
PMTCT	Prevention of Mother-To-Child Transmission
RH	Reproductive Health
STI	Sexually Transmitted Infection
UDHR	Universal Declaration of Human Rights
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation

Definition of Key Terms

Violence Against Women is any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[1]

Gender-Based Violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.[2] Gender-based violence experienced by women and girls includes, but is not limited to: battering, marital rape, sexual violence, dowry-related violence, female infanticide, honor crimes, early marriage, forced marriage, female genital cutting, sexual harassment in the workplace and educational institutions, commercial sexual exploitation, trafficking of girls and women, and violence perpetrated against domestic workers.

Sexual violence is any act that violates the sexual autonomy and bodily integrity of women and children under international criminal law, including, but not limited to[3]:

- Rape;
- Sexual assault;
- Grievous bodily harm;
- Assault or mutilation of female reproductive organs;
- Sexual slavery;
- Enforced prostitution;
- Forced pregnancy;
- Enforced sterilization;
- Harmful traditional practices, inclusive of all behavior, attitudes and/or practices that negatively affect the fundamental rights of women and children, such as their right to life, health, dignity, education and physical integrity, as defined in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa;
- Sexual exploitation or the coercion of women and children to perform domestic chores or to provide sexual comfort;
- Trafficking in, and smuggling of, women and children for sexual slavery or exploitation; enslavement by the exercise of any or all of the powers attaching to the right of ownership over women and includes the exercise of such power in the course of trafficking in women and children;
- Forced abortions or forced pregnancies of women and girl children arising from the unlawful confinement of a woman or girl forcibly made pregnant, with the intent of affecting the composition of the identity of any population or carrying out other grave violations of international law, and as a syndrome of physical, social, and psychological humiliation, pain and suffering and subjugation of women and girls;
- Infection of women and children with sexually transmitted diseases, including HIV/AIDS; and
- Any other act or form of sexual violence of comparable gravity.

[1] United Nations Declaration on the Elimination of Violence Against Women.
[2] Guidelines for Gender-Based Violence in Humanitarian Settings. Focusing on Prevention and Response to Sexual Violence in Emergencies. 2005
[3] The Protocol on the Prevention and Suppression of Sexual Violence against Women and Children, 30th June 2006.

1. EXECUTIVE SUMMARY

At the request of USAID Burundi, EngenderHealth carried out a needs assessment of the state of sexual violence prevention and response to inform its current and future sexual violence programming.

Burundi's discriminatory legislation, stereotypes and prejudice against women all contribute to attitudes that value girls less than boys, impede girls' education, and also put women in a secondary position within their homes. They also contribute to the exclusion of women from inheriting land and obtaining jobs, and participating in decision making at all levels. This deeply entrenched gender inequality has provided an enabling environment for high levels of sexual violence. The civil war in Burundi exacerbated this violence, which continues today, with near total impunity.

Data on the prevalence of sexual violence are available, but not collected in a coherent and coordinated manner. There is also significant underreporting of violence due to a number of factors. First, discussion about sex is taboo in Burundian society. As sex is not talked about, neither is sexual violence. Second, stigmatization of the victim can lead to her exclusion from her family home. As well, the acceptance and normalization of the crime, the ignorance of the fact that sexual violence is a crime, the lack of victim protection, the lack of access to legal services, the distrust of the police and negative attitudes from service providers in general discourage victims from denouncing the crime. Widespread impunity discourages women to trust and use the legal system. All these factors need to be taken into consideration when looking at the high percentage of sexual violence against children, including children of a young age. According to all interviewees sexual violence is more likely to be denounced when it affects children, than adults.

Even though Burundi has ratified most international and regional legal instruments that guarantee equality between men and women, national legislation is inadequate to guarantee this right. A key example is the law on inheritance, which vehemently discriminates against women. The current draft gender-based violence bill, a major instrument to prosecute perpetrators of sexual violence, has not yet been approved by parliament. As well, the revised Penal Code has an article on sexual violence, but is not fully implemented as illustrated by the judicial system's failure to punish rape, in particular that taking place between a husband and wife.

The Government of Burundi's response to sexual violence is weak. The Ministry of National Solidarity, Human Rights and Gender's National Directorate of the Promotion of Women and Gender Equality, does not assume its coordination role due both to lack of technical skills and financial resources. The provincial structures of the Ministry are the "Centres de Développement Familiaux", should in principal coordinate issues surrounding gender- based violence, including data collection. These centers, however, have neither a formal strategy, nor terms of reference to undertake this function. Furthermore they lack the resources necessary to carry out this function, and thus suffer from high staff turnover and inconsistent services provision.

Limited access to and questionable quality of healthcare, including emergency contraception, post-exposure prophylaxis, and treatment for sexually transmitted infections, deter women from seeking medical assistance in cases of sexual violence. Even if women and girls seek medical support, most Health Centers can only provide emergency contraception and medication for sexually transmitted infections. This is exacerbated by the fact that some health facilities are not well-stocked with PEP and rape kits. Furthermore, only government doctors in hospitals can provide PEP and issue a health certificate, the latter of which is necessary for denouncing sexual violence as a crime and bringing a criminal charge against the perpetrator of the violence. Forensic evidence collection also remains a problem since Burundi does not possess the capacity to conduct DNA tests.

The Unité de Protection des Mineurs et des Mœurs is the arm of the Burundian National Police Force that also deals with gender issues. It has focal points at the provincial level and a team of 11 officers in Bujumbura. The officers of the Unit have only had limited training and are too few in number to deal with cases of sexual violence in a systematic way. Most police officers are men who call into question whether women and girls who present themselves to police stations have actually been victims of sexual violence. The police have no protocol or written procedure to guide how they attend to survivors of sexual violence. As a result, Police officers seem to have a tendency to encourage victims to withdraw their complaint. They also lack a formalized referral pathway to refer the victim to other services.

If a survivor does actually succeed in registering a complaint with the police, and her case reaches the court, it is highly likely that the judicial process will take years to complete. The likelihood that a verdict against the perpetrator will be reached is low unless the survivor is represented by a civil society organization. It is worth noting that the state currently does not offer legal aid assistance. Even though there are condemnations of perpetrators, legal aid lawyers lament that the verdicts are often not enforced and that the perpetrators usually go free.

Burundi has numerous civil society actors that address sexual violence. Awareness-raising surrounding the existence of sexual violence and the need to prevent and respond to it exists. Whereas few organizations offer medical services, there are a number of organizations that provide legal assistance to survivors of sexual violence and also some that make available psychosocial support. There are few identifiable efforts to deal with the socio economic reintegration of survivors of sexual violence.

Civil society organizations claim to undertake a multitude of interventions in the area of information, education and communication (IEC) and behavior change communication (BCC), thus leaving the impression that all Burundians are aware of sexual violence and that each community has a network of community leaders and activists who engage on gender based violence issues and sensitize the communities. However, these claims have to be treated with caution since no IEC materials and hardly any training materials were made available during the assessment to show what was used to facilitate said activities.

A mechanism to coordinate activities, in particular a sexual violence referral pathway amongst the different service providers, does not exist. Multiple international donors[4] are haphazardly funding numerous local CSOs and INGOs[5], which makes for a very fragmented and chaotic environment for sexual violence prevention and response. These donors do not always coordinate their efforts. This has created an environment where national associations organize their activities around certain problems with short term funding, rather than focusing on developing a coherent, organized and coordinated response to sexual violence.

Table 1 Summary of Key Findings and Recommendations:

Macro-Level Recommendations

- Improve sexual violence data collection and mapping of service providers to have a better understanding and better documentation of the scope and prevalence of sexual violence, and the efforts to prevent and respond to it.

[4] Among the international donors cited during the assessment were: USAID, KFW, the Belgium Cooperation, the Swiss Cooperation, the European Union, GTZ, UN agencies, BPRB, MSF Belgique, the Netherlands, the Norwegian government, CRS, Trocaire, 11-11-11…

[5] FHI, IRC, IMC, Pathfinder, CARE, Handicap International.

- Advocate for evidence-based policy recommendations and laws to prosecute sexual violence offenders
- Improve coordination among different actors' activities and programs to better serve survivors of violence, augment prevention efforts, and maximize resources and impact
- Develop a comprehensive, long-term, multi-sectoral strategy (such as the SEED framework) to address and prevent GBV/SV. This would include multiple components, including advocacy, capacity building, community education and BCC, male involvement, broader community engagement, and public/private partnerships.
- Develop protocols and training for health and security actors (as part of a broader sexual violence)
- Foster increased community engagement and BCC to address cultural and gender norms that perpetuate sexual violence and gender inequality.
- Augment resources (human and financial), in particular to key government agencies coordinating sexual violence prevention and response.

Key Challenges	Recommendations
Factors Contributing to the Perpetuation of Sexual Violence	
▪ Rampant gender inequality	▪ Develop behavioral change communication initiatives to dismantle gender stereotypes and prejudices.
▪ Loss of traditional values and traditional mechanisms to deal with sexual violence within the family and/or at the community level	▪ Conduct discussions and round tables with traditional leaders and community leaders (authorities)
▪ Lack of political will to address gender inequality	▪ Host special round tables and lectures with and for law enforcement institutions
▪ A legislative environment that does not facilitate gender inequality, as well as combat sexual violence	▪ Advocacy with senior-level policymakers to take a stand against gender discrimination and SV
National Legislative and Policy Framework	
▪ The new Penal Code Procedures, draft GBV law, and draft Inheritance Law have not been adopted.	▪ Advocate for the application of penal code provisions on marital rape and the adoption of the draft GBV law, the draft Inheritance Law and the Penal Procedural Law
▪ Extremely low prosecution rate of marital rape	▪ Support the simplification of the penal code and disseminate it at all levels: the police, justice system, and social workers
▪ Advocate for the reparations to survivors of sexual violence are not sufficiently regulated in the existing legal structure	▪ Advocate for increased political commitment to ensure reparations to survivors of SV
▪ Discriminatory provisions in other existing national legislation	▪ Advocate for increased political commitment to gender equality and sexual violence, partnered with increased support for the visibility and

	capacity of the Ministry of Solidarity and Gender.
▪ Burundi has not ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women as well as the optional protocol on Women's Rights of the African Charter of Human and People's Rights	▪ Advocate for the ratification of the Optional Protocol to CEDAW
▪ Inadequate attention to sexual violence in national planning and strategy documents	▪ Advocate and provide technical support to encourage augmented budget allocations for sexual violence in key national-level strategies and planning documents, including the National HIV Strategic Plan and the Cadre Stratégique de la Croissance et de la Lutte contre la Pauvreté – Deuxième Génération (GPRSP II)
Research and Data on Sexual Violence	
▪ Lack of reliable data on the prevalence of sexual violence due to severe underreporting, and inconsistent and incoherent data collection and analysis efforts	▪ Provide support for the revision of the current data collection tool (in progress); Support an extensive mapping exercise/baseline study on sexual violence services provision and an assessment of the quality of services to survivors of sexual violence in the four PEPFAR provinces; Carry out a Knowledge, Attitude and Practice study on sexual violence; Support the inclusion of a full set of GBV questions in the next Demographic Health Survey
▪ Insufficient coordination in data collection due to problems in the "Centres de Développement Familiaux" (CDF)[6]	▪ Provide assistance to the Ministry of National Solidarity, Human Rights and Gender (MSNDPHG)/Direction General de la Promotion de la Femme et Egalité de Genre to improve coordination through the CDF of key stakeholders engaged in sexual violence data collection
▪ Confidentiality issues with respect to the data collection tool used at the national level	▪ Provide support to the Ministère de la Solidarité Nationale, des Droits de la Personne Humaine et du Genre and its partners to ensure confidentiality of the victims of SV during data collection

[6]As outlined below

Sexual Violence Prevention and Response	
Health Services Provision	
▪ Insufficient integrated health services for survivors of violence	▪ Encourage the improved quality of health services to victims of SV by ensuring the availability of integrated services (Maternal and Child Health and Family Planning services)
▪ Lack of systematic training of doctors and nurses on GBV and SV specifically	▪ Support the training of medical staff (doctors and nurses) on the clinical management of rape and sexual violence
▪ Lack of consistent availability of key medications for survivors of sexual violence in health centers and hospitals	▪ Ensure availability of medications (PEP, emergency contraception, antibiotics for STIs), and increased number of doctors.)
▪ No protocol on the clinical management of rape and other forms of sexual violence	▪ Develop a national level protocol on Clinical Management of rape and victims of SV
▪ Lack of a referral pathway between health centers, hospitals and other service providers (police, legal aid, psychosocial assistance)	▪ Develop a National referral pathway system that could be used by health care providers, police, legal and psycho-social aid workers and partners
▪ Traditional birth attendants, midwives, and key local-level healthcare providers are not part of the prevention and response to SV in Burundi	▪ Support programming to engage traditional birth attendants and midwives to prevent and respond to SV
Psychosocial Support Gaps	
▪ Lack of coordination and a standard methodology for providing psychosocial support to survivors of violence	▪ Conduct a mapping on activities of the different organizations providing psychosocial support to survivors, including the training that different service providers have received, and the methods that they use to provide those services; Support the collaboration of different actors, including the establishment of a referral pathway between service providers.
▪ Lack of materials and training for counselors working specifically with survivors of SV	▪ Support the development of standardized training materials and training of service providers.
Security Services	
▪ Inconsistent and insufficient training of police combined with the lack of a protocol on addressing the needs of survivors of sexual violence	▪ Support the development of training materials and training of the police, in particular the Police Gender Focal Points (GFP)
▪ GBV and SV are not specifically included	▪ Advocate for the inclusion of training on SV

into the curricula for the training of police.	into the overall police training curricula
▪ Lack of female police officers.	▪ Increase the number of female police officers recruited in the force by offering incentives
▪ Negative attitudes of police towards women and sexual violence, paired with the poor reputation of the police, which discourages women and girls from reporting violence.	▪ Support to the Unité de Protection des Mineurs et des Moeurs, which is responsible for addressing SV (possibly providing support for an audit of current existing human resource capacity and financial resources)
▪ Poor reputation of the Force de Defense Nationale (Army).	▪ Support the creation of a SV unit within the army; train military doctors and nurses on SV and how to care properly for survivors; In partnership with high ranking officers in the army, develop an action plan for addressing SV and its implications for the FDN and the population at large
Legal Redress	
▪ Few Women judges and magistrates	▪ Increase the number of females university students going to law school by offering incentives such as scholarships
▪ Lack of training of magistrates and judges in SV and gender issues	▪ Advocate for and support the inclusion of SV into law curricula and specifically training for judges
▪ Legal aid workers are not fully aware and properly trained on SV issues and thus cannot provide the needed support to the victims	▪ Support the training of more legal aid providers
Integrated Services for Survivors of Sexual Violence	
▪ At present no One-Stop center exists in Burundi (though one is planned in Gitega province) for survivors of GBV. Through an ad-hoc referral pathway, several organizations collectively provide medical, legal, and psychosocial support.	▪ Support the replication of the Centre Seruka integrated model for caring for survivors in other provinces. ▪ Support the creation of women's shelters in all provinces
Information, Education and Communication (IEC) and Behavioral Change Communication to Address Sexual Violence	
▪ Very few organizations undertaking behavioral change initiatives have any concrete IEC materials to support their work	▪ Support behavioral change communication interventions and messaging and materials development for existing interventions
▪ Very few organizations have interventions targeting men and focusing on changing	▪ Involve men, youth and religious leaders in order to change social norms around SV at the

social norms	community level
▪ Only one national level NGO works with school teachers and students on SV	▪ Work with teachers to change their behaviors and not just to train them on teaching sexual education; Develop a life-skills module for girls in school (primary school where they are the most numerous)
▪ There are many players in the field of SV in Burundi, all developing their own materials and messages with no quality control	▪ Ensure proper development and pretesting of harmonized messages and materials surrounding SV for communities
▪ Many organizations throughout Burundi (local and international) work with "relais communautaires" in the provinces. Yet very few organizations have the needed IEC resources and materials to support this work	▪ Develop proper materials for focal points and other "relais communautaires" at the colline level
▪ Journalists often publish SV victims names when reporting on the issue	▪ Train journalists on SV so they are sensitized to the issue in their reporting
GBV and Sexual Violence Coordination	
Small funding/projects, the diversity of actors on the donor side, as well as on the implementing side, the lack of coordination amongst actors all lead to fragmented, incoherent and probably contradictory responses to GBV and sexual violence.	
▪ No proper coordination mechanism among NGO sexual violence service providers.	▪ Advocate for a coordinated response protocol and training for key health, police, and justice actors.
▪ No coherent and formalized coordination mechanism for donors on GBV.	▪ Support coordination mechanisms on GBV and SV among donors and national and international actors
▪ No lead Ministry to coordinate SV services provision.	▪ Advocate for the naming of one ministry to coordinate the activities of governmental and non-governmental actors and institutions working on SV in Burundi.
▪ The CDFs in place in the provinces receive little or no support from the GOB	▪ Support to the MSNDPHG to develop a coherent approach with Centres de Développement Familiaux (CDF), by supporting the formulation of a strategy, as well as Terms of Reference, for the CDFs.

2. BACKGROUND

Burundi is a landlocked country in the Great Lakes region of Eastern Africa. Its size is just under 28,000 km², with a population of 8,038,618.[7] Burundi is divided into 17 provinces, 129 communes, and 2,908 collines[8]. Provincial governments are structured according to these boundaries. Since 2005 a "conseil collinaire" is elected in every colline, consisting of 5 members. Next to the elected "conseil collinaire" there are 135 Abashingandahe, traditional leaders at colline level, who derive their power from their authority within the community. Burundi is one of the ten poorest countries in the world, with a per capita GDP of US 401[9].

Burundi is emerging from a long and difficult period of civil war that killed thousands of people. During this period, sexual violence was used as a weapon of war. The perpetrators have not been systematically punished. Because of this impunity for crimes committed during the conflict, perpetrators of sexual violence are often undeterred, confident that they will not face punishment. Of even greater concern is the role of Burundian culture in perpetuating sexual violence.

In a recent survey, ACORD and Oxfam gauged the attitudes of the general population regarding gender-based violence against women and girls. The survey discovered that many Burundians, in particular those with low levels of education, do not value girls and boys equally. For example, 57 percent of respondents stated that "a family without a husband (man) becomes despicable, not respectable." As a result, the women [and girls] of these families become highly vulnerable to all forms of gender-based violence.

Sexual violence is one of the multiple causes of the increase in new cases of HIV/ AIDS in Burundi. Burundi has a low-prevalence, generalized HIV/AIDS epidemic that continues to be a major public health threat. National health information systems are weak and provide little reliable recent data on HIV/AIDS. The most recent study includes the National HIV Survey conducted by the National AIDS Council (NAC) in 2007. UNAIDs and the World Bank have also conducted similar, albeit dated studies. Currently, Burundi is awaiting the final results from a second DHS which was conducted in 2010.

The 2007 NAC survey showed an adult HIV prevalence of 2.9 percent, with a higher prevalence in urban and peri-urban areas (4.6 percent and 4.4 percent respectively) than in rural areas (2.8 percent), where 90 percent of the population lives. According to the Ministry of Public Health and the Fight Against AIDS (MOHA), HIV prevalence in rural areas quadrupled between 1989 (0.6 percent) and 2002 (2.5 percent). The NAC reported roughly equal HIV prevalence among women (2.9 percent) and men (2.8 percent), although further studies are needed to confirm these figures.

The available data suggest that the main drivers of the epidemic include heterosexual transmission through multiple concurrent partnerships (MCP), including transactional, intergenerational, and commercial sex; low condom use; and weak knowledge about HIV. In the NAC survey, only 22.6 percent of young people (ages 15-24) and 18.6 percent of adults (ages 25-49) reported using condoms during paid sex. More than 70 percent of youth reported having had at least one casual sexual encounter in the previous 30 days, with only 11.8 percent using condoms. Only 10.7 percent of survey participants knew three ways to prevent HIV infection (condoms, fidelity, and abstinence). Only 17.3 percent had ever received an HIV test. Four-fifths (82 percent) knew that ARVs could prevent mother-to-child HIV transmission.

[7] According to the 2008 census
[8] Analyse de la Situation de l'Enfant et de la Femme, Burundi, mai 2009, UNICEF, GoB
[9] UNDP International Human Development Indicators (2008 PPP)

HIV prevalence among commercial sex workers (CSWs) nationally is estimated at 38 percent, with higher prevalence in rural areas (46 percent) than in the capital, Bujumbura (29 percent). This is perhaps due to high mobility near borders with other high-prevalence countries. Other Most-At-Risk Populations (MARPs) may include truckers, the military, and men who have sex with men (MSM); although no reliable data to substantiate these hypotheses are available. Injection drug users (IDU) are not identified as a MARP due primarily to a lack of data.

GBV as an HIV risk factor features prominently in the Global Health Initiative Strategic Framework and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). GBV, and in particular sexual violence, put women and girls at greater risk of HIV infection through multiple pathways.[10]. Women who have been raped face the obvious risk of infection from their assailant. The risk of HIV is further exacerbated by the reluctance of women and girls to report having experienced sexual violence because of the social stigma associated with rape; which often results in women not receiving any care or follow-up, including post-exposure prophylaxis, even where it is available.[11]

3. ASSESSMENT OBJECTIVES AND METHODOLOGY

3.1 Assessment Objectives

The Assessment has the following three key objectives:

1. To conduct an analysis of sexual violence (SV) in Burundi including how it affects HIV, other sexually transmitted diseases (STIs) and unwanted pregnancies. The analysis will include reviewing BCC targeting young girls and family communication, procurement of PEP kits for health centers, and training of community health workers, teachers, and facility health workers to evaluate the capacity of screening for and addressing risks for SV, including providing or referring SV victims for emergency health care, emergency contraception, PEP, care, counselling on SV and social and legal services.

2. EngenderHealth/RESPOND will provide recommendations to the USG on a longer-range initiative to address social and gender norms conducive to SV. Recommendations will aim at improving the response and protection systems for victims of SV. This includes identifying and building relationships with possible partners. A critical component for the activity will be reviewing the capacity of institutions and staff, especially police and heath care workers, and possibly in future years targeting other staff in public administration and civil society by finding a partner to work with the Ministries of National Solidarity, Repatriation of Refugees, National Reconstruction and of Justice and Keeper of the Seals, as well as relevant civil society organizations (CSOs), religious leaders, the private sector, and women's associations, to develop a strategy for BCC, advocacy, and policy analysis and reform.

3. Based on the analysis, EngenderHealth/RESPOND will provide recommendations to improve the current USG sexual violence interventions, which also contribute to the broader GHI requirements. Raising awareness of existing and pending GBV legislation (including legislation or guidelines specific to SV) is critical. Guidelines, linkages, and referrals between institutions and response-systems need to be identified, strengthened and perhaps created to support implementation of the new legislation and provide protection for victims of SV.

[10] Campbell et al. 2008. http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_Gender_Spolight_Gender-based_violence.pdf

[11] Mary Ellsberg and Myra Betron. AIDSTAR-One | SPOTLIGHT ON GENDER Preventing Gender-Based Violence and HIV: Lessons from the Field. 2011

3.2 Assessment Methodology

The assessment team consisted of one EngenderHealth employee and one external consultant. The assessment was carried out in Bujumbura, with support from the USAID Program Assistant, Jean-Claude Niyongabo.

For two weeks (August 22nd to September 2nd, 2011), the team reviewed relevant documents, completed site visits, met with key Burundian Government decision makers, Burundian civil society representatives and representatives of international NGOs, UN Agencies and bilateral donors.[12]

Gathering of documentation and Desk Review

Both prior and during the assessment, the team collected documents, including draft legislation, policy documents, strategies, research reports, some data, and training materials. An external consultant conducted a desk review in preparation for the trip, which was subsequently continued throughout the assessment.

Interview guide for key informants

Questions were divided into the following blocs[13]:

- Introduction
- Legislation and policies
- Attitudes and perceptions regarding GBV and SV
- Data and statistical information about SV
- Services and organizational approach to SV

Specific interview questions were developed for the Police, Ministry of National Solidarity, Human Rights and Gender, Ministry of Justice, and Ministry of Public Health and the Fight against AIDS.

Site visits

Due to the short duration of the assessment mission, the assessment team had the opportunity to visit only few sites:

- Hospital Prince Régent Charles, Bujumbura
- Family Development Center, Bujumbura Rural
- Health Center Maramvya, Bujumbura Rural
- Centre Seruka
- Voluntary Counseling and Testing Center of the Force de Défense Nationale, Centre Akabanga (Burundian army)

4 FACTORS CONTRIBUTING TO THE PERPETUATION OF SEXUAL VIOLENCE IN BURUNDI

4.1 Culture, Tradition and Attitudes

[12] Meeting Agenda in the Annex C.
[13] The full interview guide is in Annex D.

According to the Burundian CEDAW Report (2007), the inferior political, economic, and social status of Burundian women derives from the patriarchal organization of society.[14] Furthermore, according to the Centre Seruka (2010) in the aftermath of the war, the predominance of female headed households, the status of Burundian women, the economic situation and an erosion of traditional values all contribute to the persistence of SV against women in social groups[15].

Colonization and Christianization have had a large impact on traditional Burundian society, community structure and values. With respect to sexual violence (SV), traditionally communities had very strict and effective mechanisms to deal with perpetrators, thus resulting in the exclusion of perpetrators from the community. Collines were lead by a group of traditional Chiefs, the Abashingandahe. They were chosen as community leaders on the collines. They still exist today but their power has been taken away by the elected officials put in place by the Government of Burundi, which has an impact on their ability to influence the prevention and response to sexual violence. Now at the colline level, there is a group of 5 "chefs collinaires" who are elected by the population. It is unclear what kind of relationship exists between the elected chefs collinaires and the Abashingandahe.

SV is strongly linked to a larger context of gender inequality in Burundi. The inferior status of women within the family and in Burundian society, values and cultural beliefs favor the submission of the woman. The basic, structural causes for sexual violence in Burundi lie in inherent gender inequality derived from a patriarchal system. Girls are less valued than boys to the extent where a woman can be chased away from her community if she gives birth only to girls. Unequal access to formal education and high dropout rates of girls, especially in rural areas, remain a problem, even though the overall rate of girls with primary schooling has improved significantly in the last decade. In 2005, 54.3 percent of girls had primary schooling, and in 2009, 89.7 percent had primary schooling.[16] Early pregnancy and the excessive household chores contribute to a higher illiteracy rate amongst women and girls. Women are also economically disadvantaged in part due to the large burden of household tasks paired with unequal access to remunerated job opportunities. [17]

Inequality exists on all levels of interaction between men and women. Women have no decision making power within households, property is usually owned by men and men also have full power and "ownership" over the children. Even though women cultivate the land, they have no right to own or to inherit it. Lastly, inequality and disempowerment of women is also reflected in sexual relations. Women cannot refuse sex, nor negotiate the manner in which sex occurs.[18]

Sex and sexuality related issues are a taboo, in Burundian society and not talked about within families nor in schools. Traditionally it was an aunt, and in some cases the mother, who used to educate girls regarding sexuality, but this tradition has since been lost. Today, families assume children get this education in schools and that their children are better informed than they are, which results in no one talking to children about sexuality or HIV prevention. There is a life skills program in schools; however, it does not include these issues and is not taught with the proper methodology. It is very difficult to talk about sex in Burundian society, especially when men and women are together. When this is the case, women will not talk at all and be embarrassed; and girls will not talk about it for fear of "getting a reputation". "Having sex", "rape" and other words referring to sex are circumscribed with other words. "Gufata Kunguvu",

[14] Burundi CEDAW Report, 2007.
[15] Centre Seruka, Annual Report 2010.
[16] République du Burundi. Cadre Stratégique de Croissance et de Lutte Contre la Pauvreté (CLSP I 2007-2008). Evaluation de la Performance et de l'Impact. October 2010.
[17] Politique Nationale de Genre 2011-2025
[18]Tearfund. A View on the Current Situation Regarding Sexual Violence in Burundi: The Role of the Church and Possible Avenues for Intervention. 2010.

which is the term used in Kirundi to talk about a rape and does not have any sexual connotation. It means "take by force".

In the same way that Burundians do not talk about sex, they also do not talk about sexual violence. This contributes to the prevalence of sexual violence. The stigmatization of rape victims, including husbands chasing their wives who have been raped from their home, and the lack of victim protection contribute to reluctance to report sexual violence and ultimately to its impunity. As well, social norms that stipulate that "a man is not a real man unless he beats his wife" and "if not the husband who else would discipline a woman?"[19] also contribute to the prevalence of sexual violence and gender-based violence.

4.2 Harmful Traditional Practices

The perception of the inferior status of the woman is reinforced by certain customs, such as the dowry and the right of the man to "correct" his wife. Linked to the dowry, women become part of the family of their husbands and are obligated to obey their mother-in-laws in the absence of their husbands, and sometimes even to have sexual relationships with other male members of the family.[20]Some specific forms of SV that take place in the Burundian context are forced sexual relations before giving birth (*Kubangura*), forced sexual relations after childbirth (*Gukanda*), forced sexual relations between a woman and her father-in-law (*GuteraIntobo*), forced sexual relations between a woman and her brother-in-law (*GushingaIcumu*), and rape of widow by making threats to her safety (*Kukibikira*).[21] It did not become clear in the course of the interviews to which extent they are still practiced.

4.3 The Impact of the War

According to interviews with key informants, "War had an impact since the rule of law was missing for a long time and people did what they wanted. This continues to influence Burundian society even today."[22] SV against women was considered by several of the interviewees as a consequence of the armed conflict (even though all informants indicated that it was present to some extent even before the war). The war in Burundi exacerbated this violence and displaced large populations of women and girls to communities often with no common, shared social norms, or with new social norms where violence was acceptable. Women suffered from rape, which was used as a weapon of war, and from other brutalities, massacres and looting, forced enlistment and forced displacement.

4.4 Impunity

The Ministry of Justice cites the release of the perpetrators of sexual violence by police as a key factor contributing to the impunity of sexual violence. Impunity was mentioned by many of the interviewees as a major factor contributing to the perpetuation of SV. Impunity can be attributed to the trivialization of SV by law enforcement personnel and the judiciary, as well as to corruption among them. SV cases often receive no follow up unless a civil society organization has provided legal assistance. Furthermore, survivors fear the repercussions of reporting sexual violence and thus have a tendency to withdraw their complaints. If they withdraw their complaint, according to the current legislation, the criminal procedure is then terminated.

[19] Quotation from interviewees.
[20] "Le phénomène de violences basée sur le genre au Burundi", Conférence des Evêques catholiques du Burundi, and interview with Edouard Nsanzintwari
[21] ACORD and Oxfam. Rapport du Sondage CAP (Connaissance Attitudes et Pratiques) sur Les Violences Basées sur le Genre. August 2009.
[22] Interview with FAWE.

Key Challenges	Recommendations
Factors Contributing to the Perpetuation of Sexual Violence	
▪ Rampant gender inequality	▪ Develop behavioral change communication initiatives to dismantle gender stereotypes and prejudices.
▪ Loss of traditional values and traditional mechanisms to deal with sexual violence within the family and/or at the community level	▪ Conduct discussions and round tables with traditional leaders and community leaders (authorities)
▪ Lack of political will to address gender inequality	▪ Host special round tables and lectures with and for law enforcement institutions
▪ A legislative environment that does not facilitate gender inequality, as well as combat sexual violence	▪ Advocacy with senior-level policymakers to take a stand against gender discrimination and SV

5 NATIONAL LEGISLATIVE AND POLICY FRAMEWORK

5.1 International and Regional Law

Burundi has ratified and/or incorporated into national law all of the key international normative documents including those on the equal rights of women, on gender-based violence and sexual violence as well as those on the rights of the child.[23]

However, Burundi has not yet ratified the Optional Protocol to Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). By ratifying the Optional Protocol, a State recognizes the competence of the Committee on the Elimination of Discrimination against Women, the body that monitors States parties' compliance with the Convention, to receive and consider complaints from individuals or groups within its jurisdiction.

At the regional level, The International Conference on the Great Lakes Region (ICGLR) has adopted a protocol and model legislation in the areas of Prevention and Suppression of Sexual Violence against Women and Children. With the entry into force of the Pact on Security, Stability and Development in the Great Lakes Region, the Protocol on Sexual Violence has the force of law, meaning that there is a strong legal basis for full implementation of the Programme of Action for Eradicating Sexual Violence.

The legislation is the first of its kind in the region to establish international standards to address the crime of SV taking place during and after conflict. Under the Protocol, Heads of State and Governments have committed themselves to setting up regional mechanisms to protect women and children and to provide legal and material assistance for survivors of sexual violence. The legislation establishes links between the crime of sexual violence and the offences of trafficking; slavery, genocide and war crimes. The protocol further incorporates preventive aspects as encapsulated in such statutes as CEDAW, the African Union (AU) and UN Convention on the Rights (UNCRC) of the Child. Counseling procedures are also

[23] For more information, See Annex E.

stipulated as part of the rehabilitation of victims of sexual violence. The protocol also advocate for maximum sentencing as per the domestic legislation of individual states.

5.2 National Law

The Burundian Constitution

Burundi ratified without reservation by Decree-Law No. 1/006 the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW, as well as the UNCRC and other international human rights instruments, are ratified in the 2005 Constitution of Burundi, Art 19[24]. In Art 13 the Constitution of Burundi further guarantees that "all Burundians are equal in value and dignity. All citizens are entitled to equal rights and to equal protection under the law. No Burundian shall be excluded from the social, economic or political life of the nation on account of her/his race, language, religion, gender, or ethnic origin".

The Penal Code

The 2009 revisions to the **Burundian Penal Code** (Law Number 1/05 April 2009) establish rape, sexually slavery, forced prostitution, forced pregnancy, forced sterilization, and other generalized and systematic acts of SV against civilians as crimes against humanity.[25] Sentences specifically for perpetrators of rape are the following:

- 5-25 years (and a fine of 50.000 to 100.000 francs) for cases of rape without any of the other conditions present listed in the bullets below.
- 15-25 years (and 5200 francs) for rape committed against minors, and committed by family members, teachers, service providers, or religious figures.
- 20-30 years (and 100,000 to 500,000 francs) if a gang rape has taken place, a weapon was used, the victim was physically or psychologically impaired, younger than 12 years of age, or the rape was committed in public.
- Punishment of life in prison if the perpetrator committed rape knowing that he had a sexually-transmitted disease, killed the victim, committed the act against a child of 12 years of age or younger, or if the rape was proceeded or accompanied by torture or other heinous acts.
- 8 days (and a fine of 10,000 to 50,000 francs) if marital rape was committed.

The revisions to the penal code also address other similar crimes that often accompany sexual violence, including voluntary homicide, voluntary corporal lesions, kidnapping (of both adults and children), abortion, adultery, incest, domestic violence, forced prostitution and hustling. The revisions to the penal code also establish that mothers (and fathers) who abandon their children without any motive for more than two months are subject to two months in prison (and a fine of 25,000-50,000 francs). These revisions do not take into consideration the case where mothers are forced to abandon their homes due to the risk or occurrence of sexual and/or other forms of gender-based violence.

[24]"The rights and duties proclaimed and guaranteed inter alia by the Universal Declaration of Human Rights, the International Covenants on Human Rights, the African Charter on Human and Peoples' Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child shall form an integral part of the Constitution of the Republic of Burundi. These fundamental rights shall not be limited or derogated from, except in justifiable circumstances in the general interest or for the protection of a fundamental right".

[25]République de Burundi. Loi NO 1/05 du 22 Avril 2009 Portant Révision du Code Pénal Burundais. http://www.unhcr.org/refworld/country,,NATLEGBOD,,BDI,,4c31b05d2,0.html

Penal Procedural Code

The revised Penal Procedural Code (PPC), which regulates the procedural implementation of the 2005 Penal Code (PC), has not yet been adopted. Even though the revised PC is applied by courts, the procedure still follows the old procedural code. The revised PPC will introduce important elements for the pursuit of sexual violence cases. Currently only the victim can file and follow a complaint. The new PPC allows, in case the victims withdraw the complaint, an association to follow up on the victim's behalf with the victim's consent. Also, Health Centers will be authorized to do a first forensic evidence check that then will be accepted by the court[26].

According to the Ministry of Justice, the Minister will present the CPC to the Council of Ministers soon. Apparently the delay was caused by the need to translate the French version into Kirundi.

Draft Bill on Gender-Based Violence in Burundi

"Where specific sexual crimes laws are in place, the wide discretion by courts is largely minimized and stricter sentencing is observed."[27]

In addition to the revisions to the PC, Burundi is currently considering a draft bill on SV. With UN Women and UN Action Against Sexual Violence[28] support (via OHCHR, and UNICEF), Mr. Gaspard Kabura[29], the National Coordinator of the International Great Lakes Region Conference and the President of the Monitoring Committee for the Adoption of a Specific Law on SV in Burundi submitted the draft bill for the Prevention, Protection, Repression and Reparation for GBV to the Ministry of National Solidarity, Human Rights and Gender on 24 June 2011. The proposed bill forms part of efforts to incorporate clauses on sexual violence from the Pact on Security, Stability and Development in the Great Lakes Region into Burundian national law.[30]

The proposed bill would help in the prosecution of perpetrators of SV. Compared to the PC, that requires strict corroboration of rape or other SV crimes, the bill recognizes the impracticality of strict corroboration or the imposition of a high burden of proof on the survivor. The Bill on GBV is also important since in addition to the regulations on SV in the PC, it regulates all forms of GBV, as well as victim reparations and evidence collection, as part of the special procedure foreseen in the code, according to the Protocol of the ICGLR. This protocol should be domesticated in Burundi which could be accomplished simply by adopting that law.

It is important to note that all interviewees were very skeptical about the adoption of the Bill. Many indicated that the adoption was being "blocked" due to a lack of political will.

[26] Currently only certificates issued by doctors are accepted.
[27] ACORD. Making the Law Count: A Five Country Judicial Audit. 2009.
[28] UN Action against Sexual Violence in Conflict (UN Action) united the work of 13 UN entities with the goal of ending sexual violence in conflict. It is a concerted effort by the UN system to improve coordination and accountability, amply programming and advocacy, and support national efforts to prevent sexual violence and respond effectively to the needs of survivors.
[29] Mr. Kabura could not be reached for an interview
[30]The Pact on Security, Stability and Development in the Great Lakes Region. The Pact was signed by all member countries forming part of the Great Lakes National Conference on 15 December 2006.

Draft Law on Inheritance, Matrimonial Regimes[31]

"With regard to succession — an area that is still governed by custom — men and women do not have the same rights of inheritance, especially with regard to land. As for the inheritance of other property, girls and boys now inherit equal shares of their parents' property. Unfortunately, the Government recognizes that this jurisprudence has not been sufficiently publicized."[32]

Women in Burundi cannot inherit land. Civil society has advocated for many years to change this situation. A draft law on inheritance, matrimonial regimes and gifts, would give women the right to inherit. There exist strong doubts among key civil society actors that the law will be passed. Sensitization sessions have been organized by the General Directorate for the Promotion of Women (MSNDPHG), but had to be halted due to resistance and threats from some communities.

Legal Gaps

Although the Constitution of Burundi integrates CEDAW and other international instruments, laws to implement the principles contained in these international texts are incomplete or insufficient.

Key Challenges	**Recommendations**
National Legislative and Policy Framework	
▪ The new Penal Code Procedures, draft GBV law, and draft Inheritance Law have not been adopted.	▪ Advocate for the application of penal code provisions on marital rape and the adoption of the draft GBV law, the draft Inheritance Law and the Penal Procedural Law
▪ Extremely low prosecution rate of marital rape	▪ Support the simplification of the penal code and disseminate it at all levels: the police, justice system, and social workers
▪ Advocate for the reparations to survivors of sexual violence are not sufficiently regulated in the existing legal structure	▪ Advocate for increased political commitment to ensure reparations to survivors of SV
▪ Discriminatory provisions in other existing national legislation	▪ Advocate for increased political commitment to gender equality and sexual violence, partnered with increased support for the visibility and capacity of the Ministry of Solidarity and Gender.
▪ Burundi has not ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women as well as the optional protocol on Women's Rights of the African Charter of Human and People's Rights	▪ Advocate for the ratification of the Optional Protocol to CEDAW
▪ Inadequate attention to sexual violence in	▪ Advocate and provide technical support to

[31] Loi sur l'héritage, les régimes matrimoniaux et les libéralités
[32]Government of Burundi CEDAW Report. 2007

national planning and strategy documents	encourage augmented budget allocations for sexual violence in key national-level strategies and planning documents, including the National HIV Strategic Plan and the Cadre Stratégique de la Croissance et de la Lutte contre la Pauvreté – Deuxième Génération (GPRSP II)

5.3 National Policy and Strategy Documents

The following National Policy and Strategy Documents address GBV and sexual violence to varying degrees of success:

- **Burundian CSLP.** The CLSP addresses GBV largely through the window of improved HIV services, in particular with a focus on access to PEP for survivors of sexual violence.

- **National Gender Policy**, 2011-2025, Ministère de la Solidarité Nationale, des Droits de la Personne Humaine et du Genre.

- **National Strategy to Fight Gender Based Violence**, January 2009, Ministry of National Solidarity, Human Rights and Gender: The Government of Burundi developed a 2009 National Strategy to Combat Gender-Based Violence. One of the key achievements of the strategy is its identification of the major challenges to preventing and responding to gender-based violence in several key sectors (health, justice, education, security, health, and social rights). Moreover, the strategy also enumerates key actions necessary to address those challenges. The National Strategy to Combat Gender-Based Violence has been finalized but not yet validated. At the time of the assessment mission, it was unclear at which stage in the process the document was, and why it had not yet been validated. The UN Trust Fund to End Violence against Women has funding for the implementation of the strategy. The Strategy is accompanied by a 2010-2012 National GBV Plan, which spells out in greater detail the actions that will be carried out, and by whom (national and local-level institutions), to address the gaps identified in the Strategy.

- The **2011-2015 National Health Plan** pays very little attention to sexual violence. Specifically, there is no mention made of sexual violence in the diagnostics portion of the document, and no allocations in the budget that would seemingly address sexual violence. One key area of potential support at the policy planning level would be to the Ministries of Health, Public Security, and Justice towards more gender-responsive planning and budgeting (in particular in their respective Medium-Term Expenditure Frameworks).

- The **2010-2014 National Reproductive Health Strategy** focuses specifically on developing educational programs to prevent sexual violence, making available rape kits, and on reinforcing care for survivors of sexual violence. It is not clear, however, to what extent this strategy has been implemented. [33]

- The new **Strategic Plan for HIV/AIDS 2011-2015**, includes very little mention, if any at all, on sexual violence.

[33] République de Burundi – Ministère de la Santé Publique et de la Lutte Contre le Sida - Programme National de Santé de la Reproduction. Plan Stratégique de Santé de la Reproduction 2010-2014. 2010. http://pnsrburundi.org/images/stories/PLAN_STRATEGIQUE_du_07_Janvier.pdf

6 RESEARCH AND DATA ON SEXUAL VIOLENCE

6.1 Characterization of Sexual Violence

Popular comprehension of the actual nature and prevalence of SV is limited to "a girl being raped by a stranger"[34]. In reality, perpetrators of SV are mostly family members; usually husbands/partners of the victim. Rape in marriage finds no recognition in Burundian society[35] and is punishable with only eight days in prison according to the new Revised Penal Code[36]. The short prison sentence highlights that even the state does not acknowledge the gravity of the crime of marital rape.

In general, SV takes many forms in Burundi, including forced sex/rape, marital rape, unwanted touching, grabbing sexual parts of the body, inserting objects into someone's private parts, refusal to have protected sex, forced prostitution, forced marriage, and defilement.[37]

The NGO Report to the Committee on the Elimination of All Forms of Discrimination of Women "Violence against Women in Burundi", 2008, characterizes violence within the family and the community as follows: Within the family, gender-based violence takes the form of: SV – mainly incest, marital rape and sexual harassment, physical and verbal domestic violence and economic violence. Within the community, sexual violence and especially rape are also widespread. Examples include rape by close friends and neighbors, especially of young girls or women living alone, sexual harassment in the workplace and especially in the context of unregulated domestic work; physical violence, trafficking and forced prostitution. Finally, numerous cases of state violence against women have been reported, for example: violence committed by agents who abuse of their position and authority, sexual violence or other violations linked to the non-separation of male and female detainees and to the failure to provide adequate facilities and care required by pregnant or breastfeeding women detainees, arbitrary arrests and detentions following marital disputes or based on illegal grounds (the fact of being out late or dressing in a certain way).

Sexual violence in schools

Teenage pregnancy is one of the reasons that compel girls to drop out of schools. The MoH has a reproductive health program in schools, but sex and HIV/AIDS education are not part of the school curricula and teachers usually are reluctant to address the subject since sex is a taboo in schools as it is in Burundian society in general.[38]The Forum of African Women Educationalists – Burundi chapter (FAWE) and the Association for the Promotion of the Burundian Girl (APFB) have projects to include awareness-raising with respect to HIV/AIDS prevention in schools.

Most CSOs mentioned SV in schools as a problem. Both anecdotal evidence and formal data collection efforts show that teachers are often the perpetrators of SV against students. Girls have the tendency not to talk about the incident and are likely to be forced by teachers to have sexual relations in order to pass the grade. "The girls do not file complaints in case of SV." Quite a few parents try to arrange a wedding between the teacher and their child or to try to get financial compensation from the teacher once the crime has taken place. However, the stigmatization suffered by young girls still remains and the child and the

[34] Interview with CARE
[35] Associations providing legal aid never have cases of marital rape
[36] Compared to 5, 15, 25 or even 30 years for other forms of rape
[37] CARE's Great Lakes Advocacy Initiative (GLAI). Gender-Based Violence: An Advocacy Guide for Grassroots Activists in Burundi. 2010.
[38] FAWE, interview

mother are often then rejected by their community. According to FAWE, there are more cases of SV in semi-urban areas and in provinces close to Bujumbura (e.g.: Bubanza, Cibitoke) and areas that have a cultural mix and are close to the forest, where rebels hide. The school is also a potential source of SV against girls who are often raped by their classmates or neighbors.

Profile of Sexual Violence Perpetrators

Since the end of the war, data as well as all interviewees suggest that perpetrators are largely known to the victim[39]. SV perpetrators are often neighbors, relatives, and other community members of the victim. Furthermore, current data points to perpetrators of violence targeting youth, and even children, of both sexes in increasing numbers.[40] CARE International reports that "Rebels and military personnel are no longer the primary perpetrators in communities where CARE works; survivors of sexual violence report that the majority of attacks are committed by members of their extended family, teachers, and household domestic staff. This reflects a general breakdown in social norms."[41]

Whereas the Ministry data reveal that 23.41 percent of perpetrators of GBV are spouses, hardly any concrete data on rape within marriage are available. Human rights organizations such as the Association for the Protection of Human Rights and Detained Persons (APRODH) claim that cases of marital rape are hardly ever reported.

6.2 Sexual Violence Data Collection

The available data are inadequate to capture the breadth and depth of GBV and SV in Burundi. It can be assumed that current existing data and statistics regarding SV are not representative of the problem. Data are scarce, and even when collected in Counseling Centers, they are not collected in a systematic and coherent way[42] and often not reconciled or analyzed. One of the major obstacles to collecting representative data is the silence that surrounds SV. Sex is a taboo in Burundian society and not talked about at family level or at school. Furthermore, a victim of SV is exposed to stigmatization and repercussions[43] such as exclusion from her family by her father or husband. Unmarried girls or women who experience sexual violence do not stand a chance of getting married. Many organizations mentioned that women fear the repercussions of denouncing the perpetrator. In any case, it is still the woman who is blamed for SV and often also accused of having brought "malediction" over the family. It was mentioned several times that gender inequalities are so entrenched and normal in Burundian society that SV is just simply not talked about, often accepted and in most cases trivialized. In this light, all existing data has to be considered with caution as most adult women do not report SV.

The Ministry of National Solidarity, Human Rights and Gender, with support from various actors, including UNWOMEN, UNFPA and UNICEF, has put in place a GBV data collection system, which is implemented largely through the decentralized Centres de Développement Familial[44](CDF) in each of Burundi's 17 provinces. The Ministry has placed social workers in each commune who are theoretically responsible for data collection and coordination of local service providers. The data are collected from medical centers and police stations as well as civil society organizations. Due to insufficient materials and

[39] Not men in uniform as formerly during the conflict
[40]Tearfund. A View on the Current Situation Regarding Sexual Violence in Burundi: The Role of the Church and Possible Avenues for Intervention. 2010.
[41]Zicherman, Nona. Addressing Sexual Violence in Post-Conflict Burundi. Forced Migration Review. 2007.
[42] One of the centers had no questionnaires for attending victims and for further data reference available.
[43] According to all interviewees as well as main strategy documents, e.g.: National strategy on GBV
[44]Family Development Centers

financial resources, these social workers cannot cover all collines. The Ministry is trying to put in place a community network « Imboneza»[45] to assist survivors of GBV.

The CDF's staff collect and register data from all service providers in each province, except from the province of Makamba, where The International Rescue Committee (IRC), a major service provider in the area, does not feed its case data into the national system.[46] The Centre Seruka and APRODH as well as other associations also independently collect and report data on cases of GBV. The field assessment has made it clear that there is a general weakness in the coherence of data collection due to the multitude of interventions and players. Furthermore, the degree of overlap between the data from the Ministry and the data from the various associations engaged in data collection is not clear. As well, there are concerns from civil society regarding the confidentiality of the data, including the transmission of data to the national level where all data are entered into a centralized data system. As well, it is important to highlight that the person responsible for the data entry at the central level left the Ministry[47]months ago and that all hard copies of the data have been accumulating as they await entry.

Problems regarding the quality of the data were identified in the Annual Report of the MSNDPHG on GBV and confirmed through the interviews. They include: irregularity or a quasi absence of data collection tools (questionnaires), irregular field work by social workers who are responsible for data collection (due to a lack of means for transport), insufficient salaries and personnel to cover all provinces and a lack of training of many actors on how to use the data collection tool. Currently the data collection tool is being revised with support from UN WOMEN together with IRC and UNFPA.

In 2010, the Ministry registered 3,951 cases of all forms of GBV, 94 percent of which took place among women or girls. The average age of women and girls survivors of GBV was 22.4 years of age, and that of men and boys was 22.6 years of age. The Ministry registered 2,447 cases of rape, 96 percent of which took place among women or girls. The average age of victims of rape is notably younger than the overall age of GBV survivors; female survivors are on average 16.8 years of age and male survivors are on average 14.9 years of age. It is worth noting that nearly 20 percent of registered victims of rape are girls under 10 years of age, and 69.8 percent of all victims are women and girls under 30 years of age. Survivors of rape from Bujumbura Mairie, Bujumbura rural, Bururi, Kayanza, and Kirundo are generally younger than those from other provinces. This is possibly attributable to both male and female migration to urban areas where social protection systems are not well-established.

Most victims of GBV are either single females (52.2 percent) or married females (23.9 percent). It is important to note that widows are also vulnerable to GBV and rape (5 percent of victims), even if they represent a smaller proportion of the overall pool of survivors.[48] Most victims (women and girls) of violence have no schooling (53 percent) or only primary schooling (34 percent)[49].

The data reveals that SV is the most common form of reported GBV, followed by psychological violence, physical violence, and socio-economic violence. Of course, those other forms of violence often go unreported. Also, those forms of violence are not mutually exclusive. SV is often accompanied by psychological violence, and socio-economic violence often takes place at the same time as physical violence. The most commonly reported consequences of GBV are medical and "psychological"

[45]République du Burundi, Ministère de la Solidarité Nationale des Droits de la Personne Humaine et du Genre. Rapport Annuel sur les Violences Basées sur le Genre 2010
[46] IRC has raised issues regarding the data collection tools and the handling of data with respect to confidentiality
[47]Apparently due to lack of funding of the salary.
[48] République du Burundi, Ministère de la Solidarité Nationale des Droits de la Personne Humaine et du Genre. Rapport Annuel sur les Violence Basées sur le Genre 2010
[49]This likely matches overall education trends for the female population as a whole.

consequences, HIV/AIDS, vaginal tearing, and vaginal flushing. Again, these data should be interpreted with some caution due to the overlapping nature of the reporting categories.

Centre Seruka documented and provided support to 1,397 survivors of SV in 2010 and 1,488 in 2009, an average of 116 and 124 survivors per month, respectively. The Centre provided support largely to women and girls from Bujumbura Mairie, Bujumbura Rurale; though it also furnished assistance to women and girls from neighboring provinces such as Bubanza and Bururi.

According to the Centre Seruka data, 18 percent of survivors of violence were less than 5 years of age, 25 percent of survivors 5-12 years of age, 20 percent of survivors 13-17 years of age, and 35 percent of survivors 18 to 45 years of age. In general, nearly 65 percent of survivors were less than 17 years of age, and 99 percent of survivors were less than 45 years of age. Most survivors are single women. It is worth noting that 82 percent of survivors came to the center within 72 hours to receive PEP treatment. 97 percent of cases that arrived within 72 hours received the ARV treatment; those that do not receive it were already known to be HIV positive even before they were raped.

Key Challenges	**Recommendations**
Research and Data on Sexual Violence	
▪ Lack of reliable data on the prevalence of sexual violence due to severe underreporting, and inconsistent and incoherent data collection and analysis efforts	▪ Provide support for the revision of the current data collection tool (in progress); Support an extensive mapping exercise/baseline study on sexual violence services provision and an assessment of the quality of services to survivors of sexual violence in the four PEPFAR provinces; Carry out a Knowledge, Attitude and Practice study on sexual violence;Support the inclusion of a full set of GBV questions in the next Demographic Health Survey
▪ Insufficient coordination in data collection due to problems in the "Centres de Développement Familiaux" (CDF)[50]	▪ Provide assistance to the Ministry of National Solidarity, Human Rights and Gender (MSNDPHG)/Direction General de la Promotion de la Femme et Egalité de Genre to improve coordination through the CDF of key stakeholders engaged in sexual violence data collection
▪ Confidentiality issues with respect to the data collection tool used at the national level	▪ Provide support to the Ministère de la Solidarité Nationale, des Droits de la Personne Humaine et du Genre and its partners to ensure confidentiality of the victims of SV during data collection

[50]As outlined below

7 SEXUAL VIOLENCE PREVENTION AND RESPONSE

At present, there are no GBV Standard Operating Procedures to delineate specific procedures and agreements among organizations providing sexual violence services. This includes the lack of a plan of action (and GBV referral pathway) and a delineation of individual organizations' roles and responsibilities in GBV prevention and response. As well, there is no stand-alone GBV referral pathway to assist survivors of violence with finding and obtaining psychosocial and medical support, legal redress, security services, shelter, and socio-economic reintegration. Governmental agencies and non-governmental organizations provide services on an individual basis, largely without coordinating with other agencies operating in the same or related areas.

7.1 Health Services for Survivors of Sexual Violence

The health sector in Burundi is generally underfunded. Medical personnel are also not sufficiently trained and survivors have a difficult time accessing health centers due the long distances that they must travel to reach them. According to the PNSP, the majority of citizens have to travel about 5 km to access a health center, but the real barrier to access is the high costs of health care. Even though theoretically victims of SV have the right to access free health care, in practice they are often obliged to pay for costs associated with the exam or treatment of ailments.

Key issues related to the provision of medical treatment to survivors that have been identified in the literature are the lack of rape kits for examining survivors of violence, and also the lack of training of the larger Burundian medical community on the clinical management of rape. As well, medico-legal certificates (with the exception of at Centre Seruka where they are free) are often too costly for most survivors. According to MSF, "sometimes, medical-legal certificates, which can be used as evidence in court, are rejected unless they are signed by a government doctor. To obtain a signature, a victim must pay up to 15,000 francs (15 USD), which is unaffordable for many Burundians."[51] Lastly, it is unclear to what extent medical services are generally available to repair obstetric fistula, resulting from the act of rape itself or from the process of childbirth (where rape survivors have become impregnated by their perpetrators).

There are 45 district hospitals headed by doctors (for every hospital there is an estimated 150.000 to 200.000 people) and at the commune level, the population has access to health centers (700 in total). Those centers are only staffed with nurses who provide basic services to the population and then refer the patients to the district hospitals. In cases of SV, the nurses at the health centers cannot collect forensic evidence, nor can they give a medical certificate that confirms that a rape has taken place. The system is such that a nurse can provide emergency contraception to the victim (when it is available at the health center), as well as a regimen of antibiotics to prevent and treat STIs. However, only a medical doctor can provide PEP and a medical certificate that can be used as evidence in court. Some "decentralized" health centers are able to provide ARVs, but it was unclear how many there are and where they are located.

During a visit to the Centre Seruka in Bujumbura, which treats and accompanies victims of SV, key informants indicated that the doctor in charge was providing medical certificates. Victims of violence, however, still must be referred to a public hospital in order to receive another medical certificate, this time signed by a government doctor. According to the practitioners at the Prince Regent Hospital[52], some victims are referred to them from the Centre Seruka days after the rape. At this point, it may be too late for the doctor to observe any lesions on the victim.

[51] Médecins Sans Frontière. Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims. 2009. http://www.doctorswithoutborders.org/publications/reports/2009/MSF_Shattered-Lives_Sexual-Violence.pdf

[52] Centre de prise en charge ambulatoire des PVVIHs and the Gynecology Department.

Furthermore, no DNA tests are possible in Burundi which makes it difficult for a victim of SV to prove the identity of the perpetrator, or in the case of teenage pregnancy, the identity of the father. Often by the time a woman who was raped reaches the hospital, too much time has elapsed to collect forensic evidence. Physical/geographical accessibility to provincial hospitals and even to health centers is a problem in some areas.

If a victim of SV reaches a hospital, she is directed to the HIV ward to receive the PEP treatment as this is the case at the Prince Régent CharlesHospital. Usually, the victim is then transferred to the gynecology department to receive a pelvic exam, emergency contraception and the treatment for STIs. The assessment team observed, however, that in the Prince Régent Charles Hospital, there is no emergency contraception available on-site. As a result, victims of violence are referred to the community health center across the street or to the ABUBEF (the local IPPF affiliate).

According to one interviewee, public hospitals are not prepared to help victims of SV, a situation that is even worse in the provinces. In theory, the cost of treatment for a victim of SV is free. The health center or the hospital is supposed to treat the victim and then send the bill to the Ministry of National Solidarity, Human Rights and Gender to be reimbursed. In practice, this does not take place.

The Direction Générale de la Promotion de la Femme et de l'Egalité du Genre indicates that their annual budget is sufficient to treat 2 rape victims, per year, per province.

As mentioned previously, in health centers where there are no doctors, the victims need to be referred to district hospitals. These hospitals are often out of stock of medicines, including ARV and medications to cure opportunistic infections. For instance, the Prince Régent Charles Hospital currently does not have the proper PEP treatment for children.

Capacity of health personnel regarding the treatment of survivors of SV

GBV and SV are not part of the medical training that doctors and nurses receive in medical school and nursing school respectively. Health care providers are not trained to recognize the signs of SV in cases where the victim does not openly mention having experienced violence. According to the Direction Générale de la Promotion de la Femme et de l'Egalité du Genre, doctors and nurses in health posts and hospitals generally know about the 72 hours limit for PEP and emergency contraception after rape. However, one third of all health facilities are managed by religious organizations, where contraception is not made available.

According to the Director of the PNSR, Burundi has not had any shortage of contraceptives in the past 5 years[53]. However, it was not possible to verify if the health centers at the commune level were indeed properly stocked. Furthermore, emergency contraception is not included on standard procurement list.

A training module for health care workers exists (and seems to be widely used by various actors) and will be revised in the near future in collaboration with key health partners. The Center Seruka is collaborating with the MoH in training doctors on RH and SV issues.

Five years ago, the school of midwifery opened and there are 20 students per level. The training lasts for 2 years and includes classes on GBV and SV most specifically. However, the new graduates do not end

[53] According to one NGO the reason for this is a lack of demand since people are not informed about the different possibilities of contraception.

up working at the health centers or in the hospitals. Most of them can be found working for the PNSR or local NGOs.

During the assessment, none of the CSOs interviewed mentioned working with the Traditional Birth Attendants (TBAs) at the Colline level. TBAs exist in Burundi and are indeed working closely with the health centers from which they receive a financial incentive to bring young mothers to deliver there instead of in their homes.

Sexual Violence Referral Pathway

The interviews elucidated that referrals from health centers/hospitals to police hardly ever take place: "medical health personnel do not think of doing this. They do their medical work and do not go any further." The first place for a victim to go is, according to interviewees, either a health center or a local association, which then refers or accompanies the victim to seek proper medical care, judicial or psycho-social support. There are no real coordination mechanisms in place among and between CSOs working in the field of SV, but they do manage to collaborate as best as they can and to refer victims to the proper outlet to receive the necessary and appropriate support (medical, psycho-social and judicial).

Currently no protocol exists for health personnel on the clinical management of rape and other forms of sexual violence. The Ministry of Health is, with the assistance of UNFPA, KFW and the USAID/ROADS Project, in the process of developing a protocol on how to treat survivors of SV, which should be ready by early December 2011. No formal referral pathway has been established between the different service providers. The visit to the Prince Regent Hospital indicates that to the contrary, survivors of violence are often transferred from one service to another and sometimes even outside the health facility to receive further treatment.

With the exception of one medical service provider, Centre Seruka, it is unclear whether other providers adhere to international standards for medical treatment of sexual violence survivors. These standards include the IASC Caring for Survivors of Sexual Violence in Emergencies, and the WHO Clinical Management of Rape Guidelines.

Training materials

A training manual on GBV[54] is available for healthcare workers and seems to be widely used, including for the training of SV focal points at the provincial level and training of CSOs. UNICEF also claimed that the manual was used for police training. The manual will be revised in the near future.

The IRC has developed a training module[55]. The aim is to have this included into the national training curriculum that is based on the 2002 National Protocol. UNFPA also financed the development of a guide on SV to be used at the community level for sensitization[56].

The National Directorate of Reproductive Health, MoH

The National Directorate of Reproductive Health, Ministry of Health is tasked with sexual violence and health; however, maternal health and family planning take priority. The Directorate collaborates with

[54] Manuel de formation pour la prise en charge globale des victimes de violences sexuelles à l'attention du personnel de santé », Ministère de la Sante Publique, République du Burundi, 2004
[55] Soins Cliniques pour les Survivants d'agressions sexuelles, IRC, 2009
[56] Though The Direction Générale de la Promotion de la Femme helped to develop it, no one was able to provide a copy.

national NGOs, especially with the Centre Seruka. The Directorate is engaged especially in resource mobilization for medications, and capacity building in the provinces, in collaboration with Seruka.

Key organizations providing medical care to survivors

Center Seruka: Located in Bujumbura, the center is (the) key player in medical care for survivors of SV. The work of the center is outlined below under "integrated health services"

The Association Nturengaho provides medical care to survivors of violence[57].

Pathfinder International has mobile teams to guarantee that people have access to testing and treatment as well as contraception.

UNFPA provides funds to cover salaries of organizations like Nturengaho and Seruka and medication to the MOH (emergency contraception and PEP) and also to the above mentioned NGOs.

Key Challenges	Recommendations
Health Services Provision	
▪ Insufficient integrated health services for survivors of violence	▪ Encourage the improved quality of health services to victims of SV by ensuring the availability of integrated services (Maternal and Child Health and Family Planning services)
▪ Lack of systematic training of doctors and nurses on GBV and SV specifically	▪ Support the training of medical staff (doctors and nurses) on the clinical management of rape and sexual violence
▪ Lack of consistent availability of key medications for survivors of sexual violence in health centers and hospitals	▪ Ensure availability of medications (PEP, emergency contraception, antibiotics for STIs), and increased number of doctors.)
▪ No protocol on the clinical management of rape and other forms of sexual violence	▪ Develop a national level protocol on Clinical Management of rape and victims of SV
▪ Lack of a referral pathway between health centers, hospitals and other service providers (police, legal aid, psychosocial assistance)	▪ Develop a National referral pathway system that could be used by health care providers, police, legal and psycho-social aid workers and partners
▪ Traditional birth attendants, midwives, and key local-level healthcare providers are not part of the prevention and response to SV in Burundi	▪ Support programming to engage traditional birth attendants and midwives to prevent and respond to SV

[57] During the visit of the Center no access to the medical chamber was possible since the key for the room could not be found. The association also had no more copies of the data collection tool (questionnaire for victims) available.

7.2 Counseling and Psychosocial Support to Survivors of Sexual Violence

Most of the associations that work with survivors of violence mention counseling as a component of their programs. However, it is not clear how this counseling is carried out or what kind of training counselors have. A training manual exists with a section on counseling of victims of violence. It is directed at health care workers but is also apparently used by other service providers, including those providing psychosocial support. However, it could not be verified if this was the material used to provide formal training to counselors. It is likely that counseling takes place in function of the knowledge and attitudes of the individual counselor rather than based on standardized professional norms and coherent training. Organizations providing services include the following:

Organization	Services Provided
The Conférence des Evêques Catholiques de Burundi	Attends to victims of human rights violations[58] in 6 counseling Centers in 6 Dioceses (out of 8) awareness sessions at the community level. The Counseling Centers attend to people in distress, mainly traumatized by the war and/or victims of SV. Many women who come to the Centre have not talked about the SV within their families. They were referred by either a medical facility or an Association. The Centre listens, counsels, and proceeds to therapy, incl., at times, family therapy and follows up with home visits in severe cases.
Nturengaho Organization	Provides psychosocial support to adolescent victims of SV in Bujumbura Mairie.
ADDF	Provides counseling to survivors of violence in Bujumbura Mairie, Bujumbura Rural, Gitega, Bubanza, Muyinga, Karusi, Rutana, Makamba, Bururi and Mwaro.
Association pour la Promotion de la Fille Burundaise (APFB),	Addresses the socio economic reintegration needs of survivors in Bujumbura Mairie and Kayanza
SWAA Burundi	Provides psychosocial monitoring for survivors of sexual violence in Bujumbura, Muyinga, Ruyigi, Gitega, Kayanza, and Ngozi.
International Medical Corps	Provided from 2007 to 2010 psychosocial assistance to survivors in Bururi, Makamba and Rutana provinces in Southern Burundi.

Other organizations that have mentioned engaging in some kind of counselling are: Center Seruka, IRC, and CDF. Details on the scope of these services were not available during the course of the assessment.

Key Challenges	Recommendations
Psychosocial Support Gaps ▪ Lack of coordination and a standard methodology for providing psychosocial support to survivors of violence	▪ Conduct a mapping on activities of the different organizations providing psychosocial support to survivors, including the training that

[58] **"**Counseling (Ecoute), healing the memory (guérison des memoires) and prevention of human rights violations."

	different service providers have received, and the methods that they use to provide those services; Support the collaboration of different actors, including the establishment of a referral pathway between service providers.
▪ Lack of materials and training for counselors working specifically with survivors of SV	▪ Support the development of standardized training materials and training of service providers.

7.3 Security Services to Prevent and Respond to Sexual Violence

The police have a Unité de Protection des Mineurs et des Mœurs et du Genre at the national level with 11 members in Bujumbura and a focal point in every province and commune. It is unclear, however, how many focal points were trained and where they are located. Focal points are knowledgeable in the penal code and have been trained in GBV and SV. (The contents of the training are not clear since the training manual was not available during the assessment.) A training of the units is being planned for October, financed by UN Agencies. UNICEF suggested that some members of the Unit were trained with the help of the training manual directed to health workers. Awareness-raising sessions led by various organizations are taking place at the level of collines, where police are said to participate.

The police work in partnership with NGOs, like the Centre Seruka, ADDF, Œuvre Humanitaire pour la Protection et le Développement de l'Enfant en Difficulté OPDE, APRODH and Nturengaho. According to the interview with the police, the police refer or even accompany the victim to the centers of the association. However, very few victims come to the police (compared to associations and centers). One of the reasons is that they do not trust male police officers and only 2.8 percent of the police are women. Another reason is that victims are not aware that there is a law that protects them, so they go for medical treatment but do not denounce the crime. Further, the police acknowledge that most victims coming to the station are children accompanied by their parents (90 percent)[59].

Interviews with civil society and judicial audits[60] reveal that the police are not sufficiently equipped to respond to the needs of SV survivors. There is insufficient knowledge that SV is a crime, as well as little empathy and capacity to deal with survivors of SV, particularly in terms of sensitivity and confidentiality. Most prosecutions of perpetrators fail as a result of inadequate investigations, in particular weak evidence collection and preservation. The inadequate resources availed to the police sector hinders their ability to respond to SV as well as other crimes."

Another constraint is the lack of capacity to obtain forensic evidence, which is needed to confirm the occurrence of SV and reveal the identity of the alleged perpetrator. Health Centers, staffed with nurses only, cannot issue a medical certificate and hospitals are not always equipped to carry out tests that could prove the identity of the perpetrator. There is no capacity to carry out a DNA test in Burundi.

"Forensic examination, specimen collection, analysis and documentation provide the link between the health and the criminal justice system. These are crucial elements in securing a successful prosecution and appropriate sentencing. The lack of availability of health services in most of the regions of the audit greatly compromises the physical, mental and emotional well being of survivors of SV. Most patients

[59] No data is available since all computers at the police crashed last year
[60] Making the Law Count, ACORD, 2009

and/or survivors of SV were drawn from very remote communes. Most of the health centers reviewed for this audit reveal that health personnel are not well equipped (in terms of skills and equipment) to manage the full range of consequences related to SV."[61]

According to one interviewee, in most instances, survivors of SV have to withstand pressure exerted by the Judicial Police Officers (JPOs) for them to withdraw their complaints and accept an out-of-court arrangement, which is not forbidden by the law. "We also follow up with police. We facilitate and cover certain costs like transportation and medical costs. In the police, it depends on the OPJ as to whether the case receives follow up or not. There is a general problem with judicial actors and their awareness. Sometimes police officers mediate cases."[62]

The police capacity and will to attend to survivors of violence is limited. Several of the interviewees raised the issue of corruption within the police, as well as attitudes within the police force that are not favorable towards victims of SV. Legal aid associations enumerate several problems regarding working with police, including the problem of corruption, the dropping of cases by the victim due to pressure, lack of capacity and professionalism and understanding of the issues (attitudes), as well as "trivialization" of sexual violence.

In cases where the police do not want to investigate, the victim has the opportunity to file the complaint at the level of the parquet. The parquet will then send it back and order the police to investigate. Another problem is the lack of victim and witness protection, and the fear of many victims fear reprisals. Currently there is no protocol that lays out the steps how to attend to a victim of SV.

Key Challenges	Recommendations
Security Services	
▪ Inconsistent and insufficient training of police combined with the lack of a protocol on addressing the needs of survivors of sexual violence	▪ Support the development of training materials and training of the police, in particular the Police Gender Focal Points (GFP)
▪ GBV and SV are not specifically included into the curricula for the training of police. ▪ Lack of female police officers.	▪ Advocate for the inclusion of training on SV into the overall police training curricula ▪ Increase the number of female police officers recruited in the force by offering incentives
▪ Negative attitudes of police towards women and sexual violence, paired with the poor reputation of the police, which discourages women and girls from reporting violence.	▪ Support to the Unité de Protection des Mineurs et des Moeurs, which is responsible for addressing SV (possibly providing support for an audit of current existing human resource capacity and financial resources)
▪ Poor reputation of the Force de Defense Nationale (Army).	▪ Support the creation of a SV unit within the army; train military doctors and nurses on SV and how to care properly for survivors; In partnership with high ranking officers in the army, develop an action plan for addressing SV and its implications for the FDN and the

[61] Making the Law count, ACORD, 2009
[62] Interview with AFJB.

	population at large

7.4 Legal Assistance and the Redress for Survivors of Sexual Violence

As outlined above, despite the existence of unreliable sexual violence data, one can safely conclude that there is a high prevalence of sexual violence in all regions of Burundi. Nonetheless, arrests and convictions of perpetrators are limited as most women and girls do not denounce SV, and in cases where they do denounce it, there is a lack of judicial follow up/treatment by the relevant court.

The NGO report prepared by OMT and ACAT Burundi on Violence against Women[63]lists a range of obstacles at the judicial level that affect the legal protection of women, in particular victims of gender-based violence: The trivialization of these crimes by Burundian society in general, and in particular by agents of the police and judiciary; the fear of stigmatization and reprisals; the ignorance of the aggressor's identity, especially when it is a member of armed forces or organized crime groups; the very high cost of police and judicial services and medical certificates; the widespread corruption worsened by an excessive length of judicial proceedings; the lack of deontological control of the judiciary; economic dependence and de facto judicial incapacity; and limitations on women's ability to initiate judicial proceedings without her husband's agreement.

Another key challenge is the court process of judging cases, which takes an excessively long time, at times up to 5 or 10 years[64]. "In operational terms, the weak court infrastructure such as inadequate computer skills, traditional methods of recording evidence in writing, inadequate courts, few magistrates and judges are all factor against efficient prosecution."

From the colline, where the complaint is lodged, it is treated by the Police Judiciaire (part of the Ministry of Public Security), then depending on the gravity of the case, it is forwarded either to the provincial court or to the magistrates at commune level. Most SV cases go to the province.

No state organized and funded legal aid system exists as of yet in Burundi. The result is that victims of SV rely on the assistance of associations for legal and judicial aid. Several civil society organizations focus their support on legal and judicial assistance to victims of SV: ADDF, AFJB, and APRODH. Their services include listening ("Ecoute"), counseling and orientation, as well as legal aid and accompanying the victim until the end of the legal procedure with the help of legal aid clinics and lawyers hired punctually for certain cases. The associations appear to have a referral system, to certain partner organizations, e.g. Centre Seruka, TPO Health Net, CAFOB, and Nturengaho, who also work in collaboration with Avocats sans Frontières.

According to associations providing legal and judicial victim support, victims often drop their complaint also because of lengthy judicial procedures. Associations like APRODH, ADDF and AFJB lobbied the judiciary to give priority to cases of sexual violence. The courts are very slow and there is a backlog of cases. According to APRODH, detainees can wait 2, 3 and up to 4 years before their case is dealt with by the court[65].

An additional problem raised by some of the legal assistance associations is that survivors usually have to carry the costs of the judicial procedure, unless they "win the case" and the verdict clearly states that the

[63] NGO Report on Violence against Women In Burundi, CEDAW, January 2008; OMT, ACAT Burundi
[64]Making the Law Count, ACORD 2009
[65] According to APRDH there are 12.000 prisoners, only 4.500 of them with verdict.

perpetrator has to carry the costs (which often is not the case). Also, survivors hardly ever receive reparations.

Organization	Services Provided
APRODH	Works in cooperation with other organizations to identify cases of SV. Once the case is submitted, the observers follow up with the magistrate at the provincial level. Since 2008 APRODH has addressed approximately 400 SV cases. APRODH has worked with the judiciary to ensure that SV cases gain more weight and become a priority.
AFJB	Offers legal aid and judicial assistance via fixed and mobile legal aid clinics and also offers basic services including listening, counseling and orientation and mediation for cases of non-violent disputes. AFJB gives basic legal advice and refers the victim to the responsible/relevant structures of the legal system. When the case enters the justice/ judicial system, lawyers accompany the case, advising the woman and representing her in front of the court. AFJB also selects cases that can be precedent setting and thus assist other women in similar situations. The victims are referred to AFJB by their partners – e.g. Centre Seruka, TPO Health Net, CAFOB, Nturengaho. The AFJB also works in collaboration with Avocats sans Frontières
Avocats sans Frontières (AsF)	Offers legal assistance to rape victims. AsF has 4 Centres d'Ecoute (Bujumbura, Gitega, Ngozi, Makamba) with each Centre being staffed with an advocate and a lawyer. From these provinces mobile legal aid clinics operate in the communes, twice a month (boutique ou caravanes juridiques). The lawyers who travel use an office from the local administrator or an Association where he /she can receive victims of SV (also any of the other issues that AsF addresses). They have approximately 30 lawyers who assist them with specific cases and who get paid by AsF. Victims sometimes come to the Centre even before they go to health facility, usually referred by an Association. Victims are usually informed about their potential exposure to HIV infection. The police hardly ever refer victims. Evidence collection is a problem since no DNA tests can be conducted in Burundi. According to AsF the condemnation rate is about 30 percent. The real problem, however, is the execution of the condemnations since verdicts can be read in

	absence of the perpetrator, but perpetrator will never be caught/imprisoned, since neither the police nor justice system makes an effort to catch them. AsF works specifically with Centre Seruka, APRODH, ADDF and Nturengaho.
ADDF	Has an Office/ Center in Bujumbura where victims of SV are attended to, receive legal advice and are referred to legal and medical services. ADDF attends to 7-10 victims per day and can provide lodging for 10 women at a time. ADDF has 3 psychologists and 4 lawyers and refers women for medical care to the hospital (to a woman gynecologist). Most cases of violence that ADDF addresses are rape, rape within marriage/relationships and women who have been chased away from their homes.

Legal Aid Community Awareness Raising

Most of the (legal aid) associations listed above have selected and then trained activists who serve as paralegals in communities (50 percent men) to raise awareness about SV; the causes and consequences of SV; how to file a complaint, and how to tackle victim stigmatization. However, it seems that the CSOs themselves do the training and there is little quality control.

Ministry of Justice

The MINJUST has nominated a focal point (FP), who is the FP for Gender and Juvenile Justice GJJFP and represents the Ministry in the Sectoral Group Justice (SGJ) and follows up on all issues emerging from the SGJ meetings. The GJJFP also participates in other meetings regarding gender, within the Ministry and with partners and in organizing training[66] (e.g. participated in organizing training for GJJFP (3) at the level of all 17 provincial courts (tribunal de grand instance) and 2 GJJFP at the level of the Parquet.

These judges and magistrates are supposed to address SV as a priority. The MINJUST organized this training. Once discovered that these trainings were of poor quality and held without a training manual, the United Nations Development Programme (UNDP) initiated measures to support the development of training material. Based also on the evaluation of what has been accomplished thus far, the GJJFP will be retrained.

The MINJUST has no data compiled on sexual violence at the central level, even though the parquet and courts submit to them monthly reports. The GoB CEDAW Report 2007 presents the rate of women's participation in the judiciary, 2004-2005 as follows: In senior posts in the relevant departments, there are 5 women and 48 men - women account for 9.4 per cent of the total.

[66] Note that no training manual was used. The training was held by interventions from various individuals.

Key Challenges	Recommendations
Legal Redress	
▪ Few Women judges and magistrates	▪ Increase the number of females university students going to law school by offering incentives such as scholarships
▪ Lack of training of magistrates and judges in SV and gender issues	▪ Advocate for and support the inclusion of SV into law curricula and specifically training for judges
▪ Legal aid workers are not fully aware and properly trained on SV issues and thus cannot provide the needed support to the victims	▪ Support the training of more legal aid providers

7.5 Integrated services for Victim of Sexual Violence

The Centre Seruka

The Seruka initiative started in 2003, with support from MSF-Belgium, with the goal to provide integrated medical and psychological assistance to victims of rape and to improve the prevention of SV**.**

From the opening of the Centre in September 2003 until December 2010, 9,983 victims of SV received support. Of these victims, 60 percent knew their aggressor but only 22 percent filed a complaint. Only a few of those who filed a complaint had a court procedure. Since 2011, Seruka also began offering legal and judicial assistance with an onsite lawyer starting on September 1, 2011, and also by referring victims to APRODH. As well, the center offers temporary shelter for victims of violence. Since 2006, most of the victims (63 percent) have been minors, of which 17 percent were children below 5 years of age and 32 percent from 0 to 13 years of age. The coordinator of the center also explains that married women, raped by either their husband or someone else, do not want this to be known to others and thus do not seek help.

Centre Seruka is open 24/7. Approximately 120 survivors of SV are treated at the center each month, with victims coming from all provinces. Seruka asks for victims to present themselves within 72 hours, in order to give them PEP, emergency contraception, hepatitis and tetanus vaccination, as well as antibiotics to treat STIs. Most victims arrive at the center within that time limit. The victim is asked to return for follow up examinations after 1, 6 and 12 months. Many victims, however, do not return after their first visit.

Centre Seruka receives funding from UNFPA, UNICEF, UNWOMEN, the Belgium Cooperation, and the Swiss Cooperation and works in partnership with the MoH (for medication and vaccines) and the MSNDPHG, as well as a number of associations (nearly all representatives of Associations mentioned Seruka as a partner).

Centre Seruka also conducts health promotion activities in some provinces, mostly Bujumbura and Bujumbura Rural, to sensitize the communities on SV. The center collaborates to this end with local organizations that have offices in the provinces. As well, the Centre Seruka staff also train, in support of and in collaboration with the MoH, doctors and nurses from 8 provinces, offering them also a two-week internship at the center to gain practical experience.

Center "Gitega" (Province Gitega)

The center, soon to be opened, will offer integrated services for victims of SV, and serve as a One Stop Center in Gitega Province. The center will be supported by the GoB and the UN, to offer medical treatment for survivors, as well as additional training on the clinical management of rape, and a referral pathway for survivors of rape. Moreover, the training of doctors, and nurses on the clinical management of rape will take place in eight provinces within the same initiative.

Even though supported by various donors including UN Agencies, several budget issues, including the funding of the salary of the coordinator of the Centre, have not been resolved and have delayed the opening of the Center.

Key Challenges	Recommentations
Integrated Services for Survivors of Sexual Violence ▪ At present no One-Stop center exists in Burundi (though one is planned in Gitega province) for survivors of GBV. Through an ad-hoc referral pathway, several organizations collectively provide medical, legal, and psychosocial support.	▪ Support the replication of the Centre Seruka integrated model for caring for survivors in other provinces. ▪ Support the creation of women's shelters in all provinces

7.6 Information, Education and Communication (IEC) and Behavioral Change Communication to Address Sexual Violence

Nearly all of the organizations visited during the course of the assessment undertake sexual violence BCC activities and have claimed that they have developed messaging and materials to support their interventions. However, these organizations could not provide the IEC materials that they use. As well, there is little to no coordination of these activities even if organizations work in the same province. The team identified a real gap that could lead to misinformation and confusion due to incoherent and contradicting messages. Furthermore, every organization working at the community level has a network of volunteers that act as "Gender Focal Points". According to the interviewees, all of the focal points are leaders in their communities; they are members of local women organizations, parents/teachers organizations, or religious leaders. Those volunteers resemble "activists" organized in a network to combat SV at the community level. What also transpired was the fact that every CSO and INGO had a very wide network of focal points. In other words, they can be a focal point for 3-4 organizations working in the same commune. This has implication on many levels:

- The focal points are being counted multiple times by all the CSOs working in the province
- The focal points are stretched thin as they are supposed to work for many different organizations having different mandates (Clinical support, psycho-social and judicial support)
- Given that they are not remunerated, it is important to question how efficient they can be given the possible necessity of engaging in other income generation priorities

It is also not clear at all to what extent these activists were trained, what material was used for their training (the team never saw any material), and what kind of supporting materials they have when they sensitize the populations at the colline level. All organizations interviewed mentioned that they were using training and sensitization of the communities as the main strategies for their work on SV in the

provinces. IRC, CARE and Pathfinder were using known approaches[67] to sensitize communities and to attempt to transform social norms. Except for Pathfinder, the assessment team did not find an organization working directly with men to try to change their behaviors and prevent SV. This is a real gap. Finally, it is of utmost importance to harmonize the training of the focal points and how they respond and accompany victims of SV, to ensure that the "sensitization" sessions for the community are carried out properly and in accordance with existing international standards.

Some of the activities/organizations involved in IEC and BCC

Organization	Services Provided
International Rescue Committee (IRC)	Since Dec 2010 IRC is involved in behavior change activities/community mobilization with a special project "SASA", developed by "Raising Voices". IRC has volunteers that create awareness in the communities.
CARE International	CARE's Project GiriJambo in Bujumbura and Bubanza aims to prevent SV, ensure access to services and to promote human rights. The support material currently used is "SASA"
Centre Seruka	Conducts health promotion activities in some provinces, mostly in Bujumbura and Bujumbura Rural, in order to sensitize the communities on SV. The center collaborates to this end with local organizations that have offices in the provinces.
FAWE	Conducts sensitization sessions with students and teachers on sexuality and reproductive health issues, HIV/AIDS prevention and SV.
ADDF	Conducts groups in 14 provinces, are present in all communes with 15 focal points per commune. The FP sensitizes communities. ADDF and sometimes specific partners (individuals/experts) trains trainers (3 per province) who train FP in provinces for which they have a special module (which was not available).
APRODH	Organizes awareness/sensitization at community level to change behavior and address gender equality
APFB	Engages in HIV/AIDS prevention through sensitization activities, which include a focus on GBV, especially for girls, in Bujumbura and all communes. The Association started the initiative "Club STOP SIDA" (sensitization in schools), with the assistance of UNFPA, UNDP, and UNWOMEN.
Pathfinder International	Currently is using a special methodology (HIM[68]) to change men's behavior. The project is at the very beginning of its implementation (trainers were trained and action plans to create community networks were drafted). Funding for the project is limited.
FHI	Works through "community animators (who are part

[67] Healthy Images of Manhood and Sasa.
[68] Healthy Images of Men (HIM)

	of the PNSR network) to sensitize populations around the health centers. These animators sensitize FP and do home visits to reach a wider number of men with FP messages. FHI also works with peer educators (volunteers). They receive the same training as the community networks.
UNFPA	Financed the development of a guide on SV for use at the community level for sensitization. The Direction Générale de la Promotion de la Femme helped to develop the guide, though no final copy was made available to them. Moreover, no one has a copy of the guide and could explain how it was used and by whom.
CDF	Works with communes, the community networks and more specifically with "community leaders" on gender issues.

Sexual Violence Awareness Raising Campaigns, including the Media

Every year several partners engage in an awareness campaign of 16 days of Activism Against Violence Against Women at the beginning of November. Each year the theme is different: in 2010 the focus was on the fight against impunity and in 2009 on engaging men in combating violence against women. The campaign also offers an opportunity for actors to meet and discuss gender issues in general. UNWOMEN and other UN Agencies are the main funders of this campaign.

According to some key informants, the media landscape has become more diverse in the last five years and increasingly report on GBV. These include both print media and radio. Radio stations, including Radio Publique Africaine, Bonesha, and Isanganiro, address key social issues, including gender inequality and GBV. "Promomedia", an NGO of journalists, with the help of SYFIA (an International NGO for journalists, funded by EUD) developed in February 2011 a four-page Inlay dealing with gender inequality and GBV and a bimonthly magazine of 300 examples. The magazine is distributed by women's associations in the communes and to schools to target teachers with the aim that they use the articles as didactic materials. Media coverage, however, may not always be undertaken in a victim-sensitive way. One organization reported that different media outlets provide the names of the victim and the alleged perpetrators.

Key Challenges	**Recommendations**
Information, Education and Communication (IEC) and Behavioral Change Communication to Address Sexual Violence	
▪ Very few organizations undertaking behavioral change initiatives have any concrete IEC materials to support their work	▪ Support behavioral change communication interventions and messaging and materials development for existing interventions
▪ Very few organizations have interventions targeting men and focusing on changing social norms	▪ Involve men, youth and religious leaders in order to change social norms around SV at the community level
▪ Only one national level NGO works with school teachers and students on SV	▪ Work with teachers to change their behaviors and not just to train them on

	teaching sexual education; Develop a life-skills module for girls in school (primary school where they are the most numerous)
▪ There are many players in the field of SV in Burundi, all developing their own materials and messages with no quality control	▪ Ensure proper development and pretesting of harmonized messages and materials surrounding SV for communities
▪ Many organizations throughout Burundi (local and international) work with "relais communautaires" in the provinces. Yet very few organizations have the needed IEC resources and materials to support this work	▪ Develop proper materials for focal points and other "relais communautaires" at the colline level
▪ Journalists often publish SV victims names when reporting on the issue	▪ Train journalists on SV so they are sensitized to the issue in their reporting

8 COORDINATION OF SEXUAL VIOLENCE PREVENTION AND RESPONSE

8.1 GBV and Sexual Violence Standard Operating Procedures and Referral Pathway

The lack of GBV Standard Operating Procedures and referral pathway are indicative of larger coordination issues with respect to GBV prevention and response not only at the level of service provision, but also at the level of national and local government planning and budgeting. At the national level, various ministries are involved in SV and GBV issues: The Ministry of Health, The Ministry of Solidarity and Gender, the Ministry of Public Security, The Ministry of Education, and The Ministry of Justice.

This multi-sectoral approach is of utmost importance in the prevention and response to SV. However, after meeting with the various GOB actors, it seemed that the environment was chaotic and that there was a lack of coordination and resources allocated to GBV. Furthermore, even though the Ministry of Solidarity and Gender has been officially assigned the role of coordinating GBV and SV, it is not clear whether the Ministry is best placed to play this coordination role, and also whether the human and financial resources have been allocated to it to this end.

8.2 GBV and Sexual Violence Coordination

The MSNDPHG, specifically the **General Directorate for the Promotion of Women and Gender Equality** has the coordinating function for gender equality. However, since the MSN and the MDPHG merged, it has become more difficult for the directorate to fulfill its functions due to a certain disempowerment that the directorate has had to face. For instance, the coordination of the FDC, which used to be under the directorate is not under the cabinet of the Ministry. Also, the directorate has a very small budget which manly consists of budget line items for salaries rather than for activities.

Even though a referral pathway exists between the **various civil society organizations and NGOs**, they lack coordination and a platform to coordinate interventions. Moreover local NGOs and Associations in

Burundi generally have limited human resources, lack coherent data collection and information sharing. Insufficient funds and short term planning/projects limit sustainability of activities.

Donor coordination is weak and happens mainly through participation in sectoral working groups, with some of them functioning better and more regularly than others. 50 percent of the national budget in Burundi comes from international aid at the national level. Since 2007, the Comité National de Coordination des Aides (CNCA), which falls under the 2nd vice-president, coordinates this aid. The secretary general is also from the GOB. There are a series of working groups, each lead by a specific donor. The groups cover issues such as education, health, agriculture, justice, private sector. They meet monthly and are attended by members of the donor community, ministry representatives, as well as representatives from the CSOs. Each committee has a strategic plan. Attendance at the meetings varies from one group to the next.

According to UN-WOMEN, **UN agency and international NGO** coordination meetings in the area of gender have been held for the past 4 years in an informal way between different partners, including various ministries, national and international NGOs and UN Agencies on a monthly basis. The primary focus of these meetings is on awareness-raising campaigns, the exchange of experiences, and the delineation of advocacy issues (e.g. impunity and access to services). The MSNDPHG has the coordination function for these meetings. Recently a Sectoral Working Group was established to address gender issues in the CLSP II. [69]

The United Nations Development Framework (UNDAF) and the **UN Programme for the Provision of Integrated Services to Survivors of GBV and other Marginalized and Vulnerable Groups** support government ministries and NGOs to address some of the aforementioned coordination issues. The activities supported by the various UN Agencies are reflected in the Annual joint plan of the UNDAF. "Assistance to Victims of GBV and Other Marginalized and Vulnerable Groups". The programme brings together key United Nations agencies (UNICEF, UNFPA, UN-Women, UNDP, OHCHR, UNESCO, UNHCR, WHO and WFP) to support the Burundian Ministries of Justice, Public Security, Health, Educational Planning, and the Interior, and local decentralized administrations and elected leaders, religious NGOs dedicated to service provision.

The Programme began in 2010 and focuses on supporting improved national GBV coordination, planning and policy systems (including a GBV referral pathway, data collection, and budgeting and planning in the Burundian Poverty Reduction Strategy); augmented local GBV planning, budgeting, and services provision capacity; and improved security sector and judiciary capacity to document and prosecute cases of GBV. The Programme responds to GBV prevention and response priorities (medical, justice, education, security, and socio-economic and psychosocial support) identified in the 2009 National GBV Strategy and 2010-2012 National GBV Plan.

The progress of the Programme has been slow thus far, in large part due to senior-level staffing changes within most of the aforementioned ministries, as well as upheaval during and after the 2010 national, provincial and local elections.[70] As a result, some key coordination issues remain unaddressed, including the GBV referral pathway. Successes thus far include support for a proposed draft GBV bill to the Ministry of Gender for eventual adoption into law, and the establishment of an Integrated Center for the Prevention and Response to GBV. Though not operational as yet[71], the Center will provide integrated, coordinated emergency healthcare to survivors of violence (included post-exposure prophylaxis),

[69] The first meeting was held in July 2011 and the next meeting is scheduled for September 2011.
[70] In the last 18 months, there have been three changes of minister at the Gender Ministry, two changes at the Ministry of Justice, two changes at the Ministry of Health, and one change at the Ministry of Public Security.
[71] In the last 18 months, there have been three changes of minister at the Gender Ministry, 2 changes at the Ministry of Justice, 2 changes at the Ministry of Health, and 1 change at the Ministry of Public Security.

followed by socio-economic reintegration, psychosocial support, shelter, food support, and legal assistance.[72]

The Role of the Centres de Développement Familiaux (CDF)

CDFs have been established in all provinces except Makamba and are located hierarchically under the Cabinet of the MSNDPHG. Every commune has a social worker and at the colline level and a group of women "Imboneza" works with the CDFs on a voluntary basis. The CDF are tasked with coordinating all the SV activities at the provincial level.

As outlined in a baseline study on the situation of CDFs[73], three major challenges were identified in the proper strategic and operational management and thus the functioning of the Centers:

- There is no official document outlining the mission and vision of the centers. Terms of reference and planning, monitoring and evaluation tools do not exist.
- Human resources: Salaries are not paid regularly, which results in high staff turnover.
- The low level of Ministry control and harmonization of CDFs does not allow for an efficient coordination of the partners that work with CDFs. The reason for this lies partly in the instability of the institutions that that have been responsible for CDFs on the one hand, and on the other in the limited budget and weak logistical capacity.

Activities of the CDFs vary, depending largely on donor support and can include: assistance to victims of violence, alphabetization of adults, technical assistance to Women's' Associations, conflict resolution. Target groups are preferentially women. On a daily basis, CDFs at the provincial level struggle with a lack of resources, partner coordination, lack of registers (books), insufficient infrastructure and a lack of human resource capacity.

Partners of CDFs are national and international NGOs and Associations, governmental and intergovernmental organizations and UN Agencies. A formal and regular mechanism of communication between the MSNDPHG and partners does not exist. Partner assistance is often directed to a specific CDF and it is not clear what the selection criteria are. Sometimes partners seem to decide unilaterally which CDF to support. Since the Ministry has neither strategy nor an operational plan for CDFs, CDFs receive only punctual support from donors, which makes it difficult to guarantee continuity and coherence in activities as well as efficiency in coordination at communal and provincial level.

The baseline study also shows that CDFs have a great potential in specific areas, especially in child protection, GBV and mediation through its geographic coverage and dynamic network of women "Imboneza". It was also noted that social assistance plays an important role in preventing and responding to GBV.

The results of the baseline show that CDFs have real potential as a community based structure that has representation all over Burundi. However, a strategy needs to be developed and the operation of the CDFs needs to be standardized.

During the mission, one of the CDFs that was mentioned by several donors as being quite well functioning was that of Bujumbura Rural. However, a field visit to the center created some doubts

[72]To-date, the GOB has provided a building for the center, which UNDP is currently in the process of furnishing. Due to a lack of full funding, the center will start by providing only priority services. UN agencies will come together during the week of 15 August 2011 to review the project and the priorities for the remainder of the year

[73] Project d'appui a la structure: "Centres de Développent Familial (CDF)". Mai 2001, MSNDPHG, supported by GIZ and ZFD

regarding the level of functioning of the center. In particular, there was no collaboration between the CDF and the local health clinic (in the same neighborhood). Inputs in the Registry were few, some wrongly dated and some statements and comments inappropriate. According to the coordinator, CDF Bujumbura Rural offers counseling and referral to the reference hospitals, as well as to the justice system. The CDF Bujumbura Rurale collaborates with Centre Seruka.

Key Challenges	**Recommendations**
GBV and Sexual Violence Coordination	
Small funding/projects, the diversity of actors on the donor side, as well as on the implementing side, the lack of coordination amongst actors all lead to fragmented, incoherent and probably contradictory responses to GBV and sexual violence.	
▪ No proper coordination mechanism among NGO sexual violence service providers.	▪ Advocate for a coordinated response protocol and training for key health, police, and justice actors.
▪ No coherent and formalized coordination mechanism for donors on GBV.	▪ Support coordination mechanisms on GBV and SV among donors and national and international actors
▪ No lead Ministry to coordinate SV services provision.	▪ Advocate for the naming of one ministry to coordinate the activities of governmental and non-governmental actors and institutions working on SV in Burundi.
▪ The CDFs in place in the provinces receive little or no support from the GOB	▪ Support to the MSNDPHG to develop a coherent approach with Centres de Développement Familiaux (CDF), by supporting the formulation of a strategy, as well as Terms of Reference, for the CDFs.

Annex A Scope of Work

USAID/Burundi
Gender Assessment
Scope of Work – FINAL Draft June 20, 2010

I. TITLE

Activity: USAID/Burundi Gender Assessment

II. PERFORMANCE PERIOD

PEPFAR/Burundi is planning on implementing an assessment of the state of prevention and response activities on sexual violence (SV) at the national and provincial levels over a period of two weeks. The assessment will inform current and future gender based programming and activities in FY 12. The assessment will be implemented in the summer of FY 11.

III. FUNDING SOURCE

USAID/Burundi PEPFAR funding

IV. JUSTIFICATION AND OBJECTIVES OF THE ASSIGNMENT

Gender inequity and gender-based violence (GBV, heighten HIV risk across age and socio-economic groups. GBV includes physical, emotional, economic and sexual violence, but the focus of this assessment will be specifically on sexual violence due to its prevalence and impact on women in Burundi. Sexual violence is defined as "coercing or attempting to coerce any sexual contact or behavior without consent. It includes, but is certainly not limited to marital rape, attacks on sexual parts of the body, forcing sex after physical violence has occurred, or treating one in a sexually demeaning manner"[74]. It is understood that sexual violence can occur in the household, school, workplace, and almost any environment and that perpetrators of violence are often persons close to the victims, such as family, partners, friends, peers, co-workers, teachers and neighbors. Sexual violence can be perpetrated against adults, adolescents, and children. The assessment will include but is not limited to sexual violence in all of the contexts mentioned above.

According to UNICEF's Situation Analysis of Children and Women in Burundi (2009), 19 percent of children had their sexual debut before age of ten, 35 percent at ages 10-14, and 35 percent at ages 15-19. In 21 percent of cases, the partner was a parent or a family friend, and only 19 percent of those surveyed used condoms during their first sexual intercourse. One in five (19 percent) reported that sexual violence had occurred in their school. Project data and anecdotal evidence suggest that other factors contributing to high-risk behavior include alcohol abuse and poverty.

Other sources reveal that in 2010, at least 2,330 rapes were committed in Burundi, the majority of victims were women. A recent study by the Ministry of National Solidarity and Gender also notes 3,707 other cases of violence based on gender. These gender-based rapes and acts of violence usually committed in homes, at the workplace, at school, or in the fields, according to the study which states that perpetrators use "cunning, strength, weapons or abuse of authority." The following data illustrates that the situation is not improving. From 2004 to November 2007, the Seruka Center managed by Doctors without Borders

[74] Adapted from US Department of Justice

Belgium (MSF) has recorded 5,466 cases of sexual violence, an average of 1,366 victims per year and 27 victims per week. In 2005, the League Iteka and MSF reported 1791 cases of sexual violence, an average of 34 casualties per week.
In 2006, these two organizations have reported 1,930 cases of sexual violence, an average of 37 victims per week, a number higher than previous years. In the same year, a study of the gender unit of ONUB said that 60 percent of rapes reported involved minors and 24 percent of rape victims are under the age of eleven. These statistics represent only those cases where the victim has reported the crime. Many casualties remain unreported due to various constraints, and especially the fear of reprisals.

Laws and policies regarding GBV are poorly enforced. Reporting remains repressed in crimes of rape and sexual violence in Burundi. Human rights activists argue that impunity blocks the fight against rape and sexual violence. Advocates argue that a number of recorded cases are disregarded by the police despite evidence in their files such as photos and testimonials. During investigations, survivors are often intimidated. Stringent provisions on rape and sexual harassment exist in the new code of Burundi but are rarely applied.
Access to post-exposure prophylaxis kits (PEP) to prevent HIV transmission in cases of sexual violence is minimal. In FY 2011 PEPFAR will provide limited support for the procurement of PEP kits. Furthermore, PEPFAR will provide technical assistance to the GOB to identify policy gaps and develop strategies to strengthen education about and enforcement of laws and policies. Longer-term efforts will target public education curricula, and gender and social norms. In addition, the USG will explore opportunities for private public partnerships in the coffee industry to reach the thousands of female workers with messaging, GBV services, and other focused interventions.

Objectives:

9 EngenderHealth/RESPOND will conduct an analysis of SV in Burundi including how it affects HIV, other STIs and unwanted pregnancies. The analysis will include reviewing BCC targeting young girls and family communication, procurement of PEP kits for health centers, and training of community health workers, teachers, and facility health workers to evaluate the capacity of screening for and addressing risks for SV, including providing or referring SV victims for emergency health care, emergency contraception, PEP care, counselling on SV and social and legal services.

10 EngenderHealth/RESPOND will provide recommendations to the USG on a longer-range initiative to address social and gender norms conducive to SV. Recommendations will aim at improving the response and protection systems for victims of SV. This includes identifying and building relationships with possible partners. A critical component for the activity will be reviewing the capacity of institutions and staff, especially police, armed forces (including DOD funded activities) and heath care workers, and possibly in future years targeting other staff in public administration and civil society by finding a partner to work with the Ministries of National Solidarity, Repatriation of Refugees, National Reconstruction and of Justice and Keeper of the Seals , as well as relevant CSOs, religious leaders, the private sector, and women's associations, to develop a strategy for BCC, advocacy, and policy analysis and reform.

11 Based on the analysis, EngenderHealth/RESPOND will provide recommendations to improve the current USG SV interventions which also contribute to the broader GHI requirements. Raising awareness of existing and pending GBV legislation (including legislation or guidelines specific to SV) is critical. Guidelines, linkages, and referrals between institutions and response-systems need to be identified, strengthened and perhaps created to support implementation of the new legislation and provide protection for victims of SV.

V. BACKGROUND

Burundi is emerging from a long difficult period of civil war that killed thousands of people. During this period, sexual violence was used as a weapon of war. The perpetrators have not been systematically punished. Because of this impunity for crimes committed during the conflict, perpetrators of sexual violence are often undeterred, confident that they will not face negative repercussions.
More concerning is the role of the Burundian culture in understanding and perpetuating violence against women, including sexual violence.

In a recent survey, ACORD and Oxfam gauged the attitudes of the general population regarding gender-based violence against women and girls. For many Burundians, particularly those with low education, girls and boys are not perceived the same way. The survey discovered that popular assertions devalue girls and women. For example, 57 percent of respondents stated that "a family without a husband (man) becomes despicable: not respectable." This means that the widowed women (single women who have families) becomes at high risk of gender-based violence including sexual violence.
Sexual violence is one of the multiple causes of the increase in new cases of HIV / AIDS in Burundi.

Burundi faces a low-prevalence generalized HIV/AIDS epidemic that continues to be a priority public health threat. National health information systems are weak and provide little reliable recent data on HIV/ AIDS. Recent studies include a national HIV survey conducted by the National AIDS Council (NAC) in 2007, and older studies by UNAIDS and the World Bank. More than 23 years after the first DHS, Burundi is awaiting final results from a second DHS which was conducted in 2010.
The 2007 NAC survey showed an adult HIV prevalence of 2.9 percent, with higher prevalence in urban and peri-urban areas (4.6 percent and 4.4 percent) than in rural areas (2.8 percent), where 90 percent of the population lives. According to the Ministry of Health and the Fight Against AIDS (MOHA), HIV prevalence in rural areas quadrupled between 1989 (0.6 percent) and 2002 (2.5 percent). The NAC reported roughly equal HIV prevalence among women (2.9 percent) and men (2.8 percent), although further studies are needed to confirm these figures.

Available data suggest that main drivers of the epidemic include heterosexual transmission through multiple concurrent partnerships (MCP), including transactional, intergenerational, and commercial sex; low condom use; and weak knowledge about HIV. In the NAC survey, only 22.6 percent of young people (ages 15-24) and 18.6 percent of adults (ages 25-49) reported using condoms during paid sex. More than 70 percent of youth reported having had at least one casual sexual encounter in the previous 30 days, with only 11.8 percent using condoms. Only 10.7 percent of survey participants knew three ways to prevent HIV infection (condoms, fidelity, and abstinence). About 17.3 percent had ever received an HIV test. Four-fifths (82 percent) knew that ARVs can prevent HIV transmission from mother to child, and a WHO study in 2010 showed that 43 percent of men were circumcised.

HIV prevalence among commercial sex workers (CSWs) nationally is estimated at 38 percent, with higher prevalence in rural areas (46 percent) than in the capital, Bujumbura (29 percent), perhaps due to high mobility near borders with other high-prevalence countries. Other most-at-risk populations (MARPs) may include truckers, the military, and men who have sex with men (MSM), although no reliable data is available. Injection drug use (IDU) is not identified as an important factor; no data exists.

VII. METHODOLOGY

Gender Assessment and Recommendations

This assessment team should review relevant documents, complete site visits, meet with key Burundian Government decision makers, civil society representatives and other relevant stakeholders. The

assessment team will present a methodology to the HIV/AIDS Team Leader before the assessment begins. The methodology should include the following:

- Meet with USAID/Burundi Mission for a briefing prior to beginning the assessment
- Meet with relevant ministries and institutions involved in gender based issues
- Meet with relevant NGOs and key stakeholders, including UN and other donors
- Review of existing legislation, policy, and protocol for SV cases
- Select areas of intervention and specific target groups for highest impact
- Define recommendations for capacity building/training
- Prepare an action plan/recommendations for the way forward in FY 12 and estimate the level of effort required for budgetary purposes.
- Provide a debriefing on the findings and recommendations and prepare a succinct assessment and recommendations report.

VIII. TEAM PERSONNEL QUALIFICATIONS, SKILLS AND LEVEL OF EFFORT

The assessment team will consist of two consultants. For site visits a USAID/Burundi staff member will accompany the team throughout the assessment.

In general, the assessment team members should have the following requirements:

- Experience in GBV programming which preferably includes HIV prevention programming
- Assessment experience
- Excellent writing and communication skills
- French conversational fluency.

ESTIMATED LEVEL OF EFFORT (LOE)
The following is the estimated LOE for the assessment team members who will work in close collaboration with the USAID/Burundi team:

Assessment and Recommendations

Task/Deliverable	**Estimated LOE for two consultants**
Background lit review	5 days
Development of interview tools	2 days
Trip preparation	2 days
Travel to Burundi	4 days
Assessment Trip	24 days in country
-Briefing with USAID/PEPFAR Heath team	
-Conduct site visits and key informant interviews	
Return travel	4 days
Submit Final Report within 2 weeks (including recommendations)	8 days
Total LOE	49 days

IX. DELIVERABLES AND PRODUCTS

Succinct and comprehensive assessment report that includes the state of activities in regards to SV in Burundi, obstacles and challenges to SV programming, and recommendations for concrete prioritized list

of interventions to assist in programming decisions to improve the overall policy environment and services in regards to SV.

X. RELATIONSHIPS AND RESPONSIBILITIES

A detailed schedule for the assessment will be drafted prior to the team's arrival in Burundi. A USAID vehicle will be provided for travel in Burundi and site visits.

XI. MISSION CONTACT PERSON(S)

USAID/Burundi: Donatien Ntakarutimana
HIV/AIDS Team Leader
Bujumbura, Burundi

USAID/Burundi: Jim Anderson
USAID Country Representative
Bujumbura, Burundi

XII. COST ESTIMATE A cost estimate will be provided by EngenderHealth prior to the start of the assignment.

Annex B Matrix of NGOs Interviewed Working on Sexual Violence in Burundi

Service/Association	Donors	Medical	Psychosocial/ counseling	Legal	BCC/ IEC	Collaboration
Centre de Développement Familiale (CDF)	UNICEF (Itega, Ruyigi, Karuzi) IRC, UNWOMENU NFPA		x	x	x	Seruka , AsF, ADDF, AJB
Association pour la Défense des Droits des Femmes (ADDF)	Trust Africa, Cordaid (Ireland), DFID		Bujumbura	Bujumbura	Bujumbura	APRODH, Seruka, CDF
Association des Femmes Juristes du Burundi (AFJB)	UNWOMEN, UNFPA, UNHCR, Trocaire, Coalition N-S, 11-11-11 (Belg. NGO)			Bujumbura Muyinga And mobile legal clinics		Seruka, TPO HealthNet, CAFOB, Nturengaho, AsF
Association pour la Promotion de la Fille Burundaise APFB)	UNFPA, UNDP, UNWOMEN				Bujumbura	Pathfinder
Association pour la Protection des Droits Humains et des Personnes Détenus (APRODH)	Trocaire, Swiss Cooperation, Belgium Cooperation			(Offices) in all provinces	(Offices) in all provinces	ADDF, Nturengaho, AFJB
Nturengaho	UNFPA, Swiss Cooperation	Bujumbura Ngozi	Bujumbum bura Ngozira		Bujumbura, Ngozi	Seruka, ADDF, CAFOB, Ligue Iteka, CNLS, ABUBEF, FAWE, UNFPA
Conférence des Evêques Catholiques du Burundi (CECB)	CCItaly, Dutch Cooperation		In 6 Dioceses	x		APRODH, Ligue iteka, AsF
Seruka	Belgium Cooperation UNICEF, UNFPA, UNWOMEN, Belgium Cooperation, Swiss Cooperation (formerly	Bujumbura	Bujumbura	Bujumbura (from 1.09.2011 on)	Bujumbura Bujumbura Rurale	MoH, APRODH, AFJB

Service/Association	Donors	Medical	Psychosocial/ counseling	Legal	BCC/ IEC	Collaboration
	MSF-Belgium and French Embassy)					
Forum for African Women Educationalists (FAWE)	Belgium Cooperation UNICEF, UN-WOMEN UNFPA				Karuzi, Ngozi, Muyinga	MinEdu, ADP, APFB, AFJB, Nturengaho
Promomedia	EU, SYFIA				All provinces	Women's Associations, schools
Avocats sans Frontières (AsF)	Belgium Cooperation, DFID			Bujumbura Gitega, Ngozi, Makamba		Seruka, APRODH, ADDF and Nturengaho
CARE	Norway, EU				Bujumbura, Bubanza	APRODH
International Rescue Committee (IRC)	Belgium Cooperation		CDF Mukamba & BujRur		CDF Mukamba& BujRur	
Family Health International (FHI)					Kayanga, Muyenga and Kirundo (peer educators, community networks) and training of health workers	
Handicap International (HI)	EU, Swiss Cooperation, Oak Foundation, UNHCR				Bujumbura	ADDF, Associations des Personnes Handicapées, CNLS
International Medical Corps (IMC)					Makamba, Rutana, Bururi	MoH, DP, CDF
Pathfinder	USAID EastAfrica	Muyinga, Kayanza			Muyinga	IntraHealth , APFB (Stop SIDA), Seruka

Annex C: Meeting Schedule/Contact List

SEXUAL VIOLENCE ASSESSMENT

*Meetings Schedule for Engender**Health's** Esther Braud and Independent Consultant Viktoria Perschler*
August 22 - September 2, 2011
Bujumbura, Burundi

Date	Time	Person(s) met	Position	Organization	Contact Information
August 22, 2011	9:30	Dr. Donatien Ntakarutimana Jean-Claude Niyongabo	Program Dev. Specialist (Health) Program Dev. Assistant	USAID/Burundi	• 22 20 7097 • 22 20 7334
	11:00	Marie-Josée Kandanga	Program Officer	UN Women-Burundi	• 22 30 1303 (office) • 77 052 518 (Cell) E-mail: marie.josee.kandanga@unwomen
	15 :00	Ms. Tamah Murfet	GBV Program Officer	IRC, Burundi Office	• 78 429 377 (Cell)
August 23, 2011	8 :00	Dr. George Gahungu	Director	MOH's National Reproductive Health Program	• 22 22 2838 (Office) • 79 959 182 (Cell)
	9:30	Mamadou Ndiaye	Program Officer	IMC, Burundi Office	• 79 238 004 E-mail: mndiaye@internationalmedicalcorps.org
	11 :00	Pierre-Claver Mbonimpa	Founding President and Legal Representative	Association burundaise pour la Protection des Droits Humains et des Personnes Détenues (APRODH)	• 79 923 135 E-mail: • aprodh@hotmail.com • Mbonimpa50@yahoo.fr
	11:30	Marceline Ndabateyinzigo	Director	Centre de Développement Familial (CDF), Bujumbura Rural	• 78 918 131
	15:00	Christine Nsabiyumva	Focal Point for the protection of minors and	National Police	• 79 726 100 E-mail: kirisina70@yahoo.fr

Date	Time	Person(s) met	Position	Organization	Contact Information
			morals		
August 24, 2011	8 :00	Amédée Ndagijimana	Legal Advisor at CAJAK and former Ligue Iteka's Gender Focal Point	CAJAK (Centre d'Assistance Juridique et d'Action Citoyenne)	• 79 910 028 or 79 585 453 E-mail : karikurubucome@yahoo.fr
	9 :30	Jimmy Mategeko	GBV Program Officer	CARE Int., Bdi Office	• 79 920 022 E-mail : Jimmy.Mategeko@co.care.org
	11 :00	Bakary Sogoba Lucia Soleti	Head, Child Protection Program Child Protection Officer	UNICEF Burundi	• 22 20 2050 (Off.) or 79 985 095 (Cell.) • 22 20 20 51 (Off.) or 79 234 142 (Cell.)
	15 :00	Christa-Josiane Karirengera	Coordinator	Initiative SERUKA pour les Victimes de Viol (ISV)	• 22 25 0353 (off.) or 77 780 661 (Cell.) E-mail : centreseruka@gmail.com
	16 :30	Ben Bradley	Regional Director	Heartland Alliance	• 79 223 854 E-mail: bradley@heartlandalliance.org
August 25, 2011	8 :00	Edouard Nsanzintwari	Program Coordinator	Conférence des Evêques Catholiques du Burundi, CECAB	• 79 911 197
	9 :00	Yves Nindorera Raphael Manirakiza	Program Officer Expert Support for the Coordination of Health Partners	Belgian Cooperation	• 79 323 363 E-mail: ynindo@yahoo.com • 77 767 520 E-mail : Raphael.Manirakiza@diplobel.fed.be
	10:30	Béatrice Nijebariko	National Coordinator	Forum for African Women Educationalists, FAWE	• 77 745 999 or 79 990 088 E-mail: fawe-burundi@onatel.bi
August 26, 2011	8 :00	Janvière Sabushimike Emma Gakobwa	National Coordinator Bujumbura Office Coordinator	Association Nturengaho	• 79/78 410 084 • 78 825 294 E-mail : gakobwaemma@yaho.fr
	9 :30	Alphonsine Bigirimana	Coordinator	Association des Femmes Juristes du Burundi (AFJB)	• 22 24 3733 E-mail : afjuristesbu@yahoo.fr

Date	Time	Person(s) met	Position	Organization	Contact Information
	11 :00	Zénon Nicayenzi	Senior Founding Member	Association Abashingantahe (Wisemen)	• 79 931 070
	15 :00	Mrs. Soline Rubuka	National Coordinator	Collectif des Associations Féminines et ONGs au Burundi (CAFOB)	• 22 21 8409 (off.) or 79 569 576 (Cell.)
August 29, 2011	9:00	Mr. Joseph Mujiji	President	Coalition des Hommes contre les violences faites aux Femmes CHOVIFE	• 22 23 8204 (Off.) or 77 735 336 (Cell.)
	11:30	David Bigirimana	Vice-President	Association pour la Défense des Droits de la Femme (ADDF)	• 22 24 8731 E-mail: addf91@yahoo.fr
	15 :00	Mrs. Seconde Nizigiyimana	Program Development Specialist (DG)	USAID/Burundi	• 22 20 7129 (Off.) or 79 999 149 (Cell.)
	16 :30	Ms. Sophie Monseur	Program Officer	Delegation of European Union	• 22 22 3426
	17 :45	James Anderson	Country Representative	USAID/Burundi	• 22 20 7272 (Off.) or 79 935 565 (Cell.)
August 30, 2011	10 :30	Ms. Anne-Marie Bariyuntura	Program Assistant (Gender)	UNFPA	• 22 20 5854 (Off.) or 78 866 677 (Cell.)
	11:00	Mr. Salvator Doyidoyi	Focal Point for Criminal Justice System	Ministry of Justice	• 78 844 605
	13:00	Ms. Mireille Niyonzima	President and Legal Representative	Association pour la Défense des Droits de la Femme (ADDF).	• 79 920 744 E-mail: milair2002@yahoo.fr
	15 :30	Mr. Désiré Nshimirimana Mr. Jacques Bukuru	Executive Secretary Legal Representative	SYFIA/PROMOMEDIA	• 79 360 455 E-mail : deshimir@yahoo.fr
August 31, 2011	10 :00	Ms. Laetitia Twagirimana	Director General	Ministry of National Solidarity and Gender	• 79 580 657

Date	Time	Person(s) met	Position	Organization	Contact Information
	16:00	Ms. Patricia Ntahorubuze	Program Assistant (Gender)	UNDP	• 78 821 594
	16:00	Mrs. Ingrid Kanyamuneza	Legal Aid Coordinator	Avocats Sans Frontières	• 22 24 16 77 (Off.) or 79 952 082 (Cell.)
September 1, 2011	8:30	Dr. Martin Ngabonziza	Country Director	Family Health International, FHI	• 22 25 5881 (Off.) or 79 990 707 (Cell.)
	10:00	Mr. Tanou Diallo	Country Director	Pathfinder International	• 22 25 8647 (Off.) or 79 215 215 (Cell.)
	10:30	Dr. Scholastique Manyundo	Head Of HIV/AIDS Department	Hôpital Prince Régent Charles (HPRC)	• 22 22 5100
	11:30	Dr. Chloé Ndayikunda	Head Of Gynecology Department	Hôpital Prince Régent Charles (HPRC)	• 22 22 5100
September 2, 2011	8:00	Firmat Nizirazana	Centre AKABANGA	Ministry of Defense and Former Combatants	• 22 25 6666
	8:15	Come Niyongabo Fulgence Ndagijimana Audace Ntezukobagira	Program Coordinator HIV/GBV Program Coordinator Urban Refugees Program Coordinator	Handicap International	• 78 725 213 • 78 725 217 • 78 725 221
	14:30	Marceline Ndabateyinzigo Benjamin	Director Head	• CDF Buj. Rural • CDF Maramvya	• 77 918 131
	17:00	Dr. Jean Rirangira	Permanent Executive Secretary	Conseil National de Lutte contre le SIDA (CNLS)	• 22 24 5302 (Off.) or 79 927 623 (Cell.)

Annex D: Key Informant Questionnaire

Sexual Violence Assessment
Burundi

Interview Questions for Key Informants

Introduction

We would like to thank you for your time. The USAID Mission here in Burundi requested that EngenderHealth conduct an assessment of the current state of sexual violence prevention and response. We will be meeting with government ministries, national civil society organizations and non-governmental organizations, and international organizations in order to learn more about how different sectors respond and deal with this issue. Part of the focus of the assessment is on the response of the health and police/justice sector providers to sexual violence. We are also very interested to hear about your views and experiences in general when it comes to this pressing matter.

We will use all of the interviews to help us get a general picture of this issue and based on that, we will prepare a report with some recommendations on areas where USAID could have an impact when it comes to sexual violence. It is possible that this may also lead to some EngenderHealth programmes on this issue but that is something we will learn more about only further on down the line. Please note that any point during the interview, you can indicate that information you provide should not be shared with others or attributed directly to you. This interview should not take long. Thank you in advance for your time**.**

Standard Questions:

1. How does your organization understand the meaning of "Sexual Violence"? [Does it include rape, sexual harassment, molestation of minors, child marriage, forced sexual relations before childbirth (*Kubangura*), forced sexual relations after childbirth (*Gukanda*), forced sexual relations between a woman and her father-in-law (*Gutera Intobo*), forced sexual relations between a woman and her brother-in-law (*Gushinga Icumu*), and rape of widow by making threats to her safety (*Kukibikira*)]?

<u>Legislation and Policies</u>

1. The 2009 revisions to the Penal Code criminalize sexual violence, and other forms of gender-based violence. There is also a proposed law on the books on gender-based violence, which is currently under consideration. What has been the process for the creation of this legislation that deals with sexual violence? How were laws drafted and presented? Which ministries or organizations played a key role? Were women's rights organizations involved?

2. How have the revisions to the Penal Code been interpreted and put into practice by your organization? By the larger community?

3. Are there any laws, policies and strategies in place to promote equality between women and men [Including for example, the Draft La Loi sur la Succession, the Stratégie National Stratégie de Lutte Contre les Violence Basées sur le Genre, le Plan d'Action Triennal de Mise en Œuvre de la Stratégie National de Lutte contre Les Violences Basées sur le Genre] ?

4. How do you think that they relate to the issue of SV? Will they reduce sexual violence or improve the response to it once it has taken place?

5. In your opinion are ministry budget allocations sufficient for the implementation of the laws, regulations and strategies on sexual violence mentioned above? [What about in the GPRSP [Cadre Stratégique de Croissance et de Lutte contre la Pauvreté –CSLP], the Ministry of (Reproductive Health and Justice's National Strategies?]

6. What are the constraints to more effective budgeting at the national and local levels for sexual violence?

7. With the relatively recent decentralization of the health system, does the budgeting for the health sector, as well as for security and justice sectors take place at the local level or still at the national level? [Is health budgeting truly decentralized or only deconcentrated]?

Attitudes and Perceptions Regarding SV

1. What is your impression about SV in society? Why does SV take place? Which customs, traditions, religious beliefs have an impact on SV? **Examples**: What are common reasons men and women give for sexual violence? How is consent perceived? Can a woman claim she was raped by her husband?

2. In your experience, what are the most common forms of sexual violence? Is it usually accompanied by violence? By infection with HIV?

3. What do you think is the common Burundian man's and woman's perception of SV? Do they think that it is to be expected, normal or acceptable?

4. To the best of your knowledge, what is the general state of awareness of HIV? Are perpetrators of sexual violence ever known to use condoms?

5. Do women and girls generally seek help when they have experienced sexual violence? From whom do they first seek help? How do those individuals or institutions usually respond?

6. How do families/parents typically deal with violence in the home?

7. Is there traditional justice?

8. Do the present laws and policies have a deterrent effect on sexual violence?

9. What are the attitudes of your service providers (health staff, social workers, police, teachers, prosecutors) towards SV?

10. How do you think the relatively recent political conflicts in Burundi affect SV? What kind of services or programming exists for former fighters?

11. How do men and women perceive power within relationships in Burundi? Do men generally hold more power within the household? Could you give examples of how that plays out? How do economic opportunities affect this?

12. How do the media influence the issue of gender equality and violence against women? What kind of news coverage do you recall about these issues? How could media be used as a positive force?

Data and Statistical Information about SV

1. Could you tell me about the different types of existing data and datasets [base de données] on sexual violence in Burundi? [Ministry of Gender and Health database, Centre Seruka, APRODH]

2. Could you tell me about the process of data collection that the Ministry of Gender and Human Rights employs in its database? In your opinion, what are the limitations of that process and the data collected? Do you have any suggestions on how to improve it?

3. Are there any other data collected at the national level on SV including with respect to attitudes toward SV and the prevalence of SV? At the provincial or local [commune] level? Are there any large studies that you are aware of regarding the prevalence of SV and the response to SV? Could you tell me how we can get a copy of the results of the study and who carried it out?

4. If not mentioned, are there specific data and/or information about SV among teenagers [date rape, gf/bf violence, school violence]?

5. If not mentioned, are there data and/or impressions about SV between teenagers and adults [i.e., sugar daddies, teachers]?

6. We have heard of increasing cases of sexual violence against children (under 10)? Could you tell us more about this?

7. Are there studies about gender norms or attitudes [ex HIV and Gender]?

Services and Organizational Approach to SV

1. Which services are you aware of for survivors of SV? Which support services exist for woman and girls who have experienced sexual violence [health, psychological, social]? Women's shelters? If so, how many and who runs them? How are they funded?

2. Are you aware of any sexual violence prevention efforts? If so, which?

3. Which awareness raising efforts exist in Burundi to promote gender equality? How successful do you feel they have been? Could you share some examples? How are they funded?

4. Is there a special branch or branches in your organization (or in the government) for gender-based violence/ sexual violence? What do they do? If not, how is the issue dealt with when it presents itself?

5. How does your organization collaborate with other organizations (e.g., Ministries, UN Agencies, police, civil society, women's rights organizations, etc.)?

6. Are there gender equality policies in your organization?

7. Are there specific policies in your organizations to deal with SV? Sexual harassment? What are they? Any specific to sexual harassment in workplace and schools?

QUESTIONS FOR SPECIFIC ORGANIZATIONS:

Police

1. Have the police received training about rape and sexual violence, specifically with respect to how register and investigate complaints? Forensic training? Proper Investigation techniques?

2. Do the police put in practice proper investigative techniques for sexual violence (respectful, not degrading, prompt, impartial, and thorough)?

3. Are there clear procedures for the police to deal with SV complaints? What are they? (Does it include. a Code of Conduct?) Are police aware of, and adhere to a code of conduct?

4. Are there any gaps in training and capacities? What are they? Are there any efforts that you know of to build this capacity?

5. What are the biggest challenges for police to support survivors of sexual violence?

6. Are survivors of rape taken to the hospital? Is there forensic evidence collection?

7. What percentage of officers are women on the police force? Do they occupy positions of seniority?

8. In your experience, with whom do survivors of sexual violence most prefer to speak - men police officers or women police officers?

9. Do police refer survivors to other service providers? To which ones? Do police need more information or training on how and to where to refer cases?

10. What kind special structures, if any, are in place to deal with child survivors of SV?

11. Are there any data of the incidence of violence committed by the police themselves?

12. Where is forensic evidence collected? As part of evidence collection, do women have the option of having medical exams performed by a woman doctor? Are the staff trained on how to get evidence from children?

13. Are the costs of the medical-legal certification prohibitive for survivors of violence?

14. Are there costs associated with the investigative work of judiciary police officers [official de la police judicaire] that impede their investigations or for which survivors are obliged to pay [i.e. stationery, transportation]?

Ministry of Human Rights and Gender

1. Are there any formal or informal women's shelters in Burundi? Who runs them? [N.B. It appears that only Centre Seruka has a formal system to address the temporary shelter needs of survivors of violence].

2. What exactly do the shelters do? How do the women access them? Are there referrals from health and/or justice sector?

3. The Ministry of Human Rights and Gender collects data on gender-based violence at the national level. Could you tell us more about the process of data collection, and some of the challenges of carrying it out, in particular in rural areas?

4. Are there any large studies that you are aware of regarding prevalence of SV and the response to SV? How can we get a hold of the results of the study? Who carried it out?

5. How does the Ministry of Gender relate to other ministries and agencies on sexual violence, in particular with the Ministry of Justice, Ministry of Public Safety, and the Ministry of Health?

6. Could you tell us a little bit about the "Programme Intégré Appui à la Prise en Charge Globale des Victimes des VBG et les Autres Groupes Marginalisés et Vulnérables" that you are implementing in partnership with multiples agencies of the United Nations? What is the Ministry's role? How is the implementation going thus far?

7. The Ministry is planning to undertake sexual violence prevention activities in schools. Are there any other initiatives that the Ministry is responsible for on SV prevention?

8. What about training other ministries and institutes regarding the upcoming gender-based violence law? If not, who is?

9. Could you tell us a little about the implementation of the revised penal code, the new draft gender-based violence law, and the draft new inheritance law?

Ministry of Justice

1. How adequate is current legislation to deal with SV?

2. Is there any pending process/any example of a process whereby a woman or a child victim's parents brings a charge against her assailant?

3. Are there any data available on the rate of prosecution and [adequate] punishment of perpetrators vs. impunity? What is it?

4. How would you describe what an investigation [type of, responsibility, quality, etc] of cases of SV looks like?

5. Would you describe how criminal proceedings [rules of evidence and procedure] take place? Are they gender sensitive, prone to re-victimize, respect of dignity, etc. [victim confidentiality, simplification of procedures, etc.]?

6. What remedies exist for victims of violence? [e.g., access to justice, reparation for harm suffered, restitution, compensation, rehabilitation, guarantees for non repetition and prevention, etc.]

7. What training programs exist for judicial personnel addressing issues of SV? [judges, prosecutors, etc.]

8. Is there coordination with police/health posts/legal aid to assist survivors of SV?

9. What is the availability of legal aid (including free legal aid)?

10. How often are judicial/police systems accessed in the majority of the country?

11. What are the biggest impediments for the justice system to handle cases? [supplies, proper documentation of cases, secure filing cabinets, training, security of judges, secure and humane detention facilities with separate holding areas for women, men, and children]?

12. Do people utilize traditional or customary laws? If so, how are those in terms of SV? How are most cases of sexual violence resolved?

13. What type of awareness-raising on sexual violence would it be useful to conduct in partnership with traditional leaders? What should it focus on? Are there meetings or other fora where traditional leaders gather, and where awareness-raising could take place?

Health/HIV/AIDS

1. What are the health policies regarding SV? Are rape kits widely available? Is emergency contraception and PEP widely made available to survivors?

2. Do survivors know that they must receive PEP within 72 hours of exposure?

3. Do survivors return to health centers for follow-up visits to their initial visit? Why or why not?

4. Are there specific trainings for health service providers on SV? Are their protocols regarding intake of victims of rape or suspected sexual violence?

5. Are there specific health centers responsible for receiving victims of SV? Are there protocols for attending to victims of SV in the public health system? Have there been trainings on these protocols? If so, how often and what has been the content? Could we get a copy of the manual?

6. Where is forensic evidence collected? Do women have the option of having the exam performed on them by a woman doctor? Are the staff of the centers trained in how to obtain evidence from children?

7. Is there any data available on HIV/AIDS incidence and the intersection between SV and HIV?

8. How would you describe the existing referral mechanisms regarding SV [health posts, hospitals, police..]?

Health Posts and Other Health Services Providers

1. Which post or center personnel are available to deal with SV?

2. Are health professionals sufficiently trained in the clinical and psychological management of SV?

3. Are trained (local) health care professionals on call 24 hour/day? [Apparently only at Centre Seruka]

4. Are female health providers available to serve female survivors (optimal)?

5. What are the general conditions of health posts [including privacy to attend to SV]?

6. How willing are health personnel to serve victims of SV?

7. Are rape kits available in health posts? Are they readily available? What do they include?

8. How available is post exposure prophylactic of HIV transmission (PEP)?

9. How available are drugs used to treat STIs, hepatitis B? Vaccinations?

10. Is HIV/AIDS counseling readily available? How is personnel trained?

11. Are referral hospitals known and available and close by?

12. Do health centers refer survivors to other services – psychosocial support, socio-economic reintegration, legal services?

13. Are there services to repair obstetric fistula? Are they sufficient? Do survivors know how to access to them? Can they afford to access them?

14. Do health professionals know how to prepare the medico-legal certificate? Do they charge for the certificate?

15. Are there other service providers who refer survivors to your post/clinic? Do they pay for any of the costs associated with the exam or treatment?

16. To which laboratories do you send specimens for analysis? Are there any issues with the laboratories? Who pays for laboratory costs? Are survivors expected to pay for lab costs?

17. To the best of your knowledge, can survivors afford the costs of the transportation, medicines, and other costs necessary for treatment [beyond PEP, which should be free]?

18. Who are the key actors in the community who encourage survivors of violence to seek treatment? Are there any programs that you know of that work with those key actors?

P

Ministry of Education

1. What are policies regarding gender equality in schools?

2. How prevalent is sexual violence and harassment in schools? When is a girl/young woman or boy/young man most vulnerable to sexual violence [on the way to school, during the school day, after the end of classes on school premises]?

3. How is sexual violence dealt with in schools? Do teachers have basic information about how to deal with sexual violence when a student reveals that it has taken place, in particular on how not to re-victimize the student [GBV protocol for education settings]?

4. Do school staff members ever take students to get medical treatment? Do students any receive any form of counseling or advice? From whom?

5. What type of training do teacher and school staff receive regarding sexual violence and harassment?

6. Are there gender equality promotion activities and prevention activities around SV?

National or International Organization Involved in SV

1. What activities/services related to SV and HIV/AIDS do you conduct/provide?

2. What type of collaboration do you have with other structures (Government/NGO/etc)? Do you refer cases of sexual violence to other service providers? If so, which ones?

3. What suggestions do you have for better collaboration and coordination among service providers? And with policymakers? [establishment of a referral pathway, Standard Operating Procedures, improved gender-responsive budgeting, improved overall budget execution]?

4. In your view, which national organizations are best cut out to undertake awareness raising or behavioral change communication projects? Why?

5. In which regions [provinces, communes] does your organization work? Does it provide the same services in all regions/offices? Is there unmet demand for services?

6. [If an international organization]How long has your organization been in Burundi? Is the organization incorporated in Burundi?

7. [If an international organization]What was the process of setting up the field office like? Any persons to recommend (Lawyer, etc.)?

8. [If an international organization]What is it like to work in Burundi (Government regulations, labor laws, bureaucracies, any corruption)?

9. What is your relationship like with government structures? What is your impression of working with them?

IEC/BCC

1. Are there specific organizations that raise awareness about the causes and consequences of sexual violence?

2. Who do those organizations target? Survivors? The families of survivors, including spouses? Community leaders? Policymakers?

3. In your opinion, which types of awareness raising activities are most effective? At what level should they be carried out? By whom [men's associations, traditional leaders, journalists association, theatre groups]?

4. What are the key messages should they deliver? Whom should they target?

WHAT KIND OF RECOMMENDATIONS WOULD YOU LIKE TO MAKE FOR PREVENTING OR RESPONDING TO SEXUAL VIOLENCE?

Closure

Thank you for your time. **Do you have any questions for us?** Do you have anything to add? Could you recommend anyone who you think we should talk to while we are here about these themes? Thank you again for your time.

Annex E: International Human Rights Conventions Ratified or Signed by Burundi
International Normative Structures

Burundi has ratified and/or incorporated into national law largely all of the key international normative documents on the equal rights of women, and on sexual violence. The following is a list of those international and regional documents, by the year that they were adopted by the United Nations, United Nations Security Council, or by other key international stakeholders such as the African Union and the International Conference on the Great Lakes Region (ICGLR)

International Documents to which Burundi is a signatory

- Convention on the Prevention and Punishment of the Crime of Genocide (1948)
- Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1948)
- United Nations Declaration of Human Rights (1948)
- Convention Relating to the Status of Refugees (1951)
- Declaration of the Rights of the Child (1959) – ratified as a decree/law no. 1/032 on 16 August 1990
- International Covenant on Civil and Political Rights ICCPR (1966) – ratified as a decree/law no 1/009 on 14 March 1990
- International Covenant on Economic, Social and Cultural Rights (1966) – ratified as a decree/law no 1/008 on 14 March 1990
- Optional Protocol of the International Pact on Civil and Political Rights (1966)
- Protocol Relating to the Status of Refugees (1967)
- Declaration on the Elimination of Discrimination against Women (1967)
- Organization of African Unity, Convention Governing the Specific Aspects of Refugee Problems in Africa 1969
- Convention on the Elimination of al Forms of Discrimination Against Women CEDAW (1979) – ratified as a decree/law no 1/006 on 4 April 1991
- Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984) – ratified as a decree/law no 1/006 on 31 December 1992.
- Beijing Platform and Declaration on the Elimination of Violence Against Women (1995)
- Convention on the Rights of the Child (1989)
- Rome Statute on the International Criminal Court (1998) – Ratified on 21 September 2004
- Protocol to Prevent, Suppress and Punish Trafficking of Persons, especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (2000)
- Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (2000)
- Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (2001)
- The United Nations Security Council Resolution 1325 on Women, Peace and Security (2001)
- The United Nations Security Council Resolution on Sexual Violence in Conflict 1820 (2008)
- The United Nations Security Council Resolution 1888 on Sexual Violence in Conflict (2009)
- The United Nations Security Council Resolution 1889 (to strengthen the implementation of UNSCR 1325) (2009)
- The United Nations Security Council Resolution 1960 (to establish a monitoring, analysis and reporting mechanism on sexual violence) (2010)

Africa Regional:

- African Charter on Human and People's Rights (1981) – ratified by decree/law no 1/029 on 28 March 1989

- African Charter On The Rights And Welfare Of The Child - Oau Doc. Cab/Leg/24.9/49 (1990), *Entered Into Force* Nov. 29, 1999.
- African Charter on Human and People's Rights – Protocol on the Rights of Women in Africa ("Maputo Protocol") (2003)
- African Union Solemn Declaration on Gender Equality in Africa (2004)
- International Conference on the Great Lakes Region (Protocol on sexual violence) (2006)
- Goma Declaration (2008)

Annex F: Documents Consulted

ACAT and OMCT. Les Violences Contre les Femmes au Burundi: Rapport Alternatif Soumis par l'ACAT Burundi et l'OMCT – Comité pour l'Elimination de la Discrimination à l'Egard des Femmes 40e session. January 2008.

ACORD. Faire Valoir la Loi. Burundi: Un Audit sur les Pratiques Judicaires en Matière de Violence Sexuelle. March 2010

ACORD and Oxfam. Rapport du Sondage CAP (Connaissance Attitudes et Pratiques) sur Les Violences Basées sur le Genre. August 2009.

Agence France Presse. Burundi Slates Truth and Reconciliation Panel for 2012. 2011. http://reliefweb.int/node/437453

Association pour la Protection des Droits Humains et des Personnes Détenues. (APRODH) Rapport Annuel 2010. 2010.

CARE's Great Lakes Advocacy Initiative (GLAI). Gender-Based Violence: An Advocacy Guide for Grassroots Activists in Burundi. 2010.

Centre Seruka. Rapport Annuel 2010. 2010.

Inter-Agency Standing Committee. Guidelines for Gender-Based Violence in Humanitarian Settings. Focusing on Prevention and Response to Sexual Violence in Emergencies. 2005.

Inter-Agency Standing Committee. Caring for Survivors of Sexual Violence in Emergencies. 2010. http://www.rhrc.org/resources/index.cfm?type=guideline

Inter-Agency Standing Committee. IASC Guidelines for Addressing HIV in Humanitarian Settings. 2010. http://www.aidsandemergencies.org/cms/

Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergencies. 2007. http://www.rhrc.org/resources/Guidelines%20IASC%20Mental%20Health%20Psychosocial.pdf

Inter-Agency Working Group on Reproductive Health in Crises. Inter-Agency Field Manual on Reproductive Health in Emergency Settings. 2010. http://www.iawg.net/resources/IAFM%202010/IAFM2010thanks.pdf

Inter-Agency Working Group on Gender and Humanitarian Action. GBV Resource Tool: Establishing GBV Standard Operating Procedures. (SOP Guide). 2008. http://www.interaction.org/document/iasc-gbv-standard-operating-procedures

International Conference on the Great Lakes Region. ICGLR Moves Forward in Assisting Survivors of Gender-Based Violence. 30 June 2011. http://icglr.org/spip.php?article140

International Conference on the Great Lakes Region. Pact on Security, Stability and Development in the Great Lakes Region. December 2006. http://www.internal-displacement.org/8025708F004BE3B1/(httpInfoFiles)/60ECE277A8EDA2DDC12572FB002BBDA7/$file/Great%20Lakes%20pact_en.pdf

http://www.icglr.org/IMG/pdf/Framework_for_durable_solutions_to_the_Humanitarian__Social_and_Environmental_Issues_in_the_Great_Lakes_Region.pdf

International Rescue committee. Clinical Care for Sexual Assault Survivors. 2008. http://clinicalcare.rhrc.org/docs/facguide.pdf

Médecins Sans Frontières. Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims. 2009. http://www.doctorswithoutborders.org/publications/reports/2009/MSF_Shattered-Lives_Sexual-Violence.pdf

Oxfam. Rapport du Sondage CAP sur les Violences Basées sur le Genre. August 2009.

PEPFAR. Burundi FY 2011 Country Operational Plan (COP)

Radio Télévision Nationale Burundi. La Loi Couvrant Tous Les Aspects de Traitement Juridique du Problème de la Violence Basée sur le Genre. June 2011. http://www.rtnb.bi/index.php?option=com_content&view=article&id=1753:la-loi-couvrant-tous-les-aspects-de-traitement-juridique-du-probleme-de-la-violence-basee-sur-le-genre-&catid=8:societe&Itemid=9

Reliefweb. Briefing Kit for Burundi and Women. Compiled on 30 July 2011. 2011.

Reliefweb. Displaced women in Bujumbura risk HIV rather than hunger. 26 April 2011 http://reliefweb.int/sites/reliefweb.int/files/reliefweb_pdf/briefingkit-47dd085e23b1bd2b9d4bfbb730e4c98b.pdf

République of Burundi. Cadre Stratégique de la Croissance et la Lutte contre la Pauvreté – Deuxième Génération. Version – 18 July 2011

République de Burundi. Cadre Stratégique de Croissance et de Lutte Contre La Pauvreté (CLSP I. 2007-2009). Evaluation de la Performance et de l'Impact. October 2010.

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