Report

Enhancing women's influence in local governance with community scorecards

CARE Rwanda's experience

Victoria Chambers

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Key messages

- This report explores the use of the community scorecard (CsC) model in two projects within CARE Rwanda's vulnerable women's programme. It examines how the model was implemented in each of the projects; the key outcomes of the initiatives; and how these have contributed to improving the quality of gender-based violence service delivery and enhancing women's role in local governance processes.
- The findings indicate that the CsC is not a one-size-fits-all solution with regard to improving developmental outcomes. It is a flexible guide or tool that can and should be adapted to the distinct contextual and operational environment in which it is implemented and based on the objectives and changes it intends to produce.
- Entry points and the mechanisms by which they are implemented are key when implementing a CsC. Decisions on these need to be considered carefully against the project objectives and the broader context.

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Abbreviations

CA	Community Animator
CM	Case Manager
CsC	Community Scorecard
DFID	Department for International Development
EU	European Union
FGD	Focus Group Discussion
FO	Field Officer
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
Isaro	Isaro/PPA Governance PPA4 programme
JADF	Joint Action Development Forum
MIGEPROF	Ministry of Gender and Family Promotion
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development Corporation
NWC	National Women's Council
ODI	Overseas Development Institute
PPA	Programme Partnership Agreement
RWN	Rwanda Women's Network
UA	Umugore Arumwa. 'A Women is Listened To'
UK	United Kingdom
VWP	Vulnerable Women's Programme
VSLA	Village Savings and Loan Association

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1. Introduction

The community scorecard (CsC) has become internationally recognised as an effective social accountability tool for building and strengthening citizen collective action for improved service delivery. CARE has more than a decade of experience of applying scorecards, starting with CARE Malawi in 2002 and then through applying the approach in different sectors and to different issues in various country programmes.

Since 2009, CARE Rwanda has been involved in several projects that have used the CsC to monitor the delivery of gender-based violence (GBV) services and strengthen citizen participation and voice in local governance processes and decision-making. Supported by CARE International UK, CARE Rwanda initially adapted the CARE CsC with the aim of increasing women's participation and voice in local governance processes and initiatives within the framework of the Isaro/Programme Partnership Arrangement (PPA) 4 (Isaro) governance project. It has since been integrated into the Umugore Arumwa, 'A Woman Is Listened To', (UA) project as a means of enhancing community collective response to GBV and thus contributing to strengthening the voice of citizens in local GBV service delivery. The overall objective of both of these projects is in line with that of the CARE Rwanda Vulnerable Women's Programme (VWP) to increase women's participation in decision-making at the same time as improving the quality of GBV services.

CARE Rwanda commissioned the Overseas Development Institute (ODI) to conduct this study in order to explore how and why use of the CsC approach has affected the delivery of GBV services and affected women's participation and voice in local GBV service delivery and thus local governance. The research aims to assess how the CsC has operated within both projects and to reflect on the implications of this for women's role in local governance and service delivery. In doing this, it aims to understand whether and how the CsC has enhanced women's voice and agency, seeking to identify the features that have constrained or enabled this.

1.1 Analytical approach

The key question for this research is, 'What can we learn from CARE Rwanda's use of the CsC in projects/programmes in order to enhance women's agency, voice and participation in local governance in Rwanda?' In order to unpack this question, this research explores two dimensions.

First, it looks at how the CsC model was implemented in each of two projects. By focusing attention on the process and implementation approach of the CsC in the two initiatives, the study aims to identify any variations and adaptations to the model. This is in order to understand how project design and implementation decisions interacted with and aligned with (1) the wider context – the operating environment – and (2) the specific rationale and objective of the projects.

Second, it documents the key outcomes and impacts of the CsC initiatives in both projects in order to examine how each project has contributed to improving the quality of GBV service delivery and how this has helped enhance women's agency, voice and participation.

We then analyse findings from these two dimensions to identify the contextual factors and the features of design and implementation that have influenced how the CsC has contributed to the projects' intended results. In this way we can reflect on what we can learn from these two projects with respect to the use of the CsC for CARE Rwanda, CARE more broadly and peers, in particular with regard to programming aimed at improving service delivery.

1.2 Rwanda gender-based violence and women's rights context

Local governance and service delivery

The current Rwandan governance context is characterised by a strong state, with a disciplined political leadership committed to achieving inclusive development objectives. This is achieved through coherent and top-down policy direction with strong performance monitoring systems that provide incentives for good performance and sanctions for poor performance. Policy direction and performance systems also include bottom-up feedback – for instance through *ubudehe*, a national poverty reduction eradication initiative, and *umuganda* (public community works). Top-down performance pressure and citizen participation and engagement in processes like *ubudeh*e have both been equally important in contributing to Rwanda's progress and top-down policy drive has been a critical ingredient of grassroots progress (Chambers and Golooba Mutebi, 2012).

Rwanda has also demonstrated a strong commitment to decentralised structures, albeit within a strong central state framework. In practice, district authorities function relatively autonomously from the centre; they have control

over their budgets and make decisions about how funds are raised, allocated and spent; they are responsible for producing their own district development plans (albeit in strong alignment with national plans and priorities); and they facilitate collaborative arenas within which citizens can input into these processes. In addition, district authorities exercise administrative control of service delivery facilities (such as schools and hospitals), and make decisions around staffing issues.

District local authorities (and their lower administrative levels – sectors, cells and villages) are answerable to locally elected councils at the various administrative levels. The district mayor is elected from within such a council. Responsibility for monitoring and supervising basic development and service delivery objectives (i.e. in health) is shared by local authorities and public service providers, although this is undertaken within policy frameworks enacted and enforced from the central level. Collaborative spaces that bring together these technical and administrative providers exist and function, although the lines of accountability tend towards central government rather than citizens and citizens are yet to use these spaces to raise their concerns, opinions and views. The Joint Action Development Forum (JADF) is responsible for the coordination of development partners (international and national) at the district and sector level and ensures development assistance is in line with the district development plan and coherent to national and sector policies.

A number of mechanisms have been introduced to enable citizens to participate in local development planning processes and action and through which they can in theory hold local leaders and service providers to account for the services they deliver (*imihigo*[1], *ubudehe*, etc.). While these spaces for popular participation exist, they have been fostered in a framework of top-down, centrally driven policies and within an arena whose boundaries have been defined by the central government. There are concerns that local leaders and service providers are most accountable to their immediate hierarchy and that this reduces the space for fostering downward accountability to the needs and concerns of the local population. As a result, the local population's willingness and capacity to challenge local leaders and service providers may be constrained. So, while existing collaborative spaces do provide very real arenas in which citizens can and do participate and influence the implementation of state policies that affect them, there is a need to recognise that citizens are yet to take full advantage of these arenas to independently shape local governance agendas.

Overall, there are strong accountability mechanisms, particularly for upward accountability of performance of service providers, built into service provision, from the local to the national level. These are enforced, dominated by and strongly embedded in the central government national development framework and performance management system.

Gender-based violence

Over the past decade, the Rwanda government has progressively made gender equality a key national development policy. The government sees GBV as a threat to Rwanda's economic development and recognises that, to continue along its current path, preventing and responding to GBV must be a priority at all levels. This is for several reasons. First, it recognises that GBV reinforces existing inequalities in society, which prevent victims from contributing to the country's development. Second, the significant cost to the state in terms of the resources required to respond to the social, economic, physical and psychological consequences of GBV (i.e. public health expenditure) diverts resources away from the development agenda.

The national GBV policy recognises that GBV is fed by a number of factors, including the presence of certain cultural beliefs and traditions, social exclusion and issues related to socioeconomic development. It identifies the entrenched idea of distinct gender roles as one of the main obstacles to combating GBV and also the misunderstanding of 'gender' as pertaining to women alone. It also recognises that negative cultural beliefs are a key challenge; for example, many acts of GBV, such as domestic violence, spousal rape and denial of property rights, are perceived as 'normal' within the family (MIGEPROF, 2011).

However, despite the existence of a generally strong legal framework that protects women, and political will to support the empowerment of women at the policy level, challenges remain. GBV persists and remains prevalent in Rwandan society. According to the Rwanda 2010 Demographic and Health Survey, 41.2% of women (aged 15-49) had experienced physical violence at least once since the age of 15, and of those currently married 95.4% reported that this took the form of domestic violence by a husband or partner. In order to address this challenge, the government has recently highlighted GBV as one of its top governance priorities.

Rwanda has a legal and policy framework that recognises the right of women to be equal partners in the country's development and that supports prevention of and response to GBV. The country has ratified a number of international commitments, which have been translated into domestic law, and these have been accompanied by national policies and implementation mechanisms to

1 Imihigo is a performance contract designed to provide incentives to local government leaders to implement and meet local and national development targets. The concept of *imihigo* refers to the traditional practice of warriors making public pledges to their kings to engage in specific accomplishments. It was revived in 2005. Annual district performance contracts (*imihigo)* are signed between the president and district mayor as and are based on a clear set of national and local priorities and specific targets, selected by the district, backed by measurable performance indicator targets. Performance is evaluated on an annual basis and the mayor must report back on the progress towards the objectives directly to the president during a public meeting.

Box 1: Rwanda's legal and policy framework for GBV

International commitments

- International Conference of the Great Lakes Region
- UN Universal Periodic Review
- UN Security Council Resolution 1325 National Action Plan

Legal and policy framework

- The Law on Matrimonial Regimes, Liberalities and Successions (1999), which specifies that women have the same rights to inheritance as men
- The Organic Law Determining the Use and Management of Land in Rwanda (2005), which determines equal rights of the wife and the husband to their land and prohibits any discrimination in matters relating to ownership or possession of rights over the land based on sex
- The National Policy on Violence Against Women and Children (2007)
- The National Gender Policy (2010), which highlights guidelines on which sector policies and programmes integrate gender issues
- The National Policy Against GBV (2011), which engages in prevention, response and evidence-building on GBV

National institutions

- The Ministry for Gender and Family Promotion (MIGEPROF), which works across government from within the Office of the Prime Minster
- The National Council of Women (NWC), a constitutional body established to promote women's participation in national development and governance
- The Gender Monitoring Office, is a governmental body that monitors, advises and advocates for gender equality in all institutions in the country

ensure enforcement of women's legal entitlements and compliance with GBV laws. A number of institutions have been set up to support implementation of the legal and policy framework, with vertical links from the national to the village level. In keeping with government policy to ensure the participation of citizens in national development processes, village-level committees have been created to play a key role in ending GBV (such as anti-GBV committees) (see Box 1).

There is no common understanding or universal definition of what GBV is and it can mean many things to different people. In this report, we use Rwandan law and policies to define GBV and to identify how it manifests itself within society.

Rwanda Law 56/2008 of 10 September 2008 on the prevention and punishment of GBV defines acts that can be sanctioned by law as:

> *[Any] act that results in a bodily, psychological, sexual and economic harm to somebody because they are male or female. Such act results in the deprivation of freedom and negative consequences. This violence may be exercised within or outside the household.*[2]

The National Policy Against GBV (2011) expands on this by identifying four major forms of GBV:

- economic violence: denial of economic rights to property, succession, employment or other economic benefits
- physical violence: the intentional use of physical force with the potential to cause harm, injury, disability or death
- sexual violence: act of forcing another individual, through violence, threats, deception, cultural

2 In addition, Law 51/2007 of 20 September 2007, determining the responsibilities, organisation and functioning of the Gender Monitoring Office, defines GBV as 'any behaviour aimed at sexual relations or any other sexual behaviour which affects the dignity of a male or female victim whether such behaviour may be from a superior work place, school or whether from families as well as from elsewhere'.

expectation, weapons or economic circumstances, to engage in sexual behaviour against her or his will
- psychological violence: trauma to the victim caused by acts, threats of acts or coercive tactics; these threats are often related to sexual or physical violence

1.3 Methodology

The subject of analysis for this research is the CsC component of the two projects, Isaro and UA. The study was based on a limited desk review of key project documents and primary research findings. For each of the CsC initiatives, fieldwork visits at the sector and cell level were undertaken within one selected district where the scorecard had been delivered and where there were opportunities to interact with key participants in the project. On the basis of discussions with CARE Rwanda, Ruhango and Gakenke districts were selected as field sites for the Isaro governance initiative and UA project studies, respectively.[3] This selection was based on the availability of CARE country office staff to collaborate in the research and the logistic feasibility of the fieldwork given time constraints. The field visits were used to understand how the CsC component had been implemented in practice and how target participants experienced the CsC work to collect evidence of outcomes and impact and to understand why and how these had been achieved.

Primary data collection was undertaken from 25 March to 3 April 2015 by a researcher from ODI working alongside CARE programme staff in Ruhango district and with CARE and Haguruka programme staff in Gakenke. The researcher was reliant on the quality of CARE documentation and the availability of CARE staff to help identify key stakeholders. The fieldwork drew significantly on the tacit knowledge of CARE country staff, particularly those who had been closely involved in implementation of UA and Isaro.

The fieldwork used a mix of semi-structured interviews and focus group discussions (FGDs) with key stakeholders in each of the selected fieldwork locations. In total, 19 individual interviews were conducted (9 for the Isaro governance initiative and 10 for the UA project) with local government officials (at all levels: district, sector, cell and village), public service providers (health centre and police), and national partners involved in the CSC initiative, representatives from community level organisations (such as NWC), community mediators (*abunzi*) and beneficiaries.

Two FGDs were held for each CsC project with community representatives who had facilitated the scorecard process: community animators (CAs) and cluster representatives for UA and case managers (CMs) and village savings and loans association (VSLA) representatives for Isaro. In addition, an FGD was held with *abunzi* in the UA project. In each of these cases, efforts were made to ensure participants were representative of the gender make-up of the groups they were representing. For example, the UA project had one female and one male CA per village; as a result, we tried to ensure the focus group represented a 50/50 split of men and women.

It is important to note here that the purpose of this study was not to undertake a full evaluation either of the individual projects or of their scorecard components. Rather, the focus was on identifying key outcomes and impacts of the two CsC processes as a means of understanding what contextual factors and features of the design and implementation of the CsC made these possible. While the research sought to triangulate findings, evidence of outcomes and impact was based on the perceptions of change expressed by key stakeholders during qualitative interviews. Finally, it is important to note that all the interviews were undertaken with people who had been involved in some way with either the UA project or with the Isaro governance initiative CsC processes; this limits what we can say about how sustainable these outcomes and impacts are or will be.

The timing of the research is also important. While the research was undertaken two years after the Isaro governance initiative scorecard process had taken place, in the case of UA the process was still ongoing: the interface meetings had been completed only in September 2014, six months previously. This has implications for the conclusions that can be drawn about future effects and whether any observed outcomes for women and girls are sustained.

3 In Gakenke district, Cyabingo and Kivuruga sectors were visited; in Ruhango district, the field visits concentrated on Ruhango sector and Buhoro cell.

2. Approach of the community scorecard initiatives in the two projects

This section gives an introduction to the CARE Rwanda VWP, its theory of change and the rationale for the use of the CsC as a tool. It then provides a brief overview of the rationale and objectives of the two projects that are the focus of this study and the specific purpose of using the CsC as a component of their project activities. The section then reflects on the key stages of the respective scorecard approaches and highlights where these have been adapted and aligned to the contexts and objectives of the respective projects.

2.1 Overview of the programme and projects

CARE Rwanda Vulnerable Women's Programme

The development of the CARE Rwanda VWP began in 2009. Both the Isaro and the UA projects sit within the overall strategy of this programme, directly contributing to the aspired overall objectives: 'To ensure that vulnerable Rwandan women are socially and economically secure and exercise and enjoy their rights by 2020'.

The VWP is centred around a theory of change that highlights the need for change in three domains of women's lives: their increased use of socioeconomic opportunities and quality services; a social environment that encourages women to participate in decision-making and claim and enjoy their rights; and duty bearers ensuring an appropriate legal framework to protect women's rights. The programme's strategic goal reflects the recognition that the underlying causes of women's poverty and vulnerability include economic and social factors and also those related to the legal and policy framework. VWP documentation highlights the following:

- Poverty limits women's access to basic services and socioeconomic opportunities.
- Patriarchy results in limited decision-making power for women regarding sexual and reproductive health, family planning, the household's finances, etc. and leaves them vulnerable to GBV.
- A strong link exists between poverty and women's social position: women's lower income and access to (financial) resources is both a consequence and a cause of their lower social position.
- Insufficient awareness, capacities and accountability mechanisms prevent the effective implementation of the legal framework.
- This contributes among others to higher vulnerability to GBV and women being unable to exercise their rights related to access to and inheritance of land.

The VWP recognises that, while Rwanda has strong performance-based systems, there are challenges and gaps in the implementation of existing policy and legal frameworks. It also reflects the fact that Rwandan society is subject to cultural norms that in practice prevent Rwandan women from being able to enjoy the rights they are entitled to.

The VWP theory of change accepts that achieving its strategic goal is a long-term process of change and assumes that, in order to achieve lasting impact on vulnerable women's lives, multidimensional change in all three of these domains (social, economic and institutional) is necessary. The pathways of change reflect the ways CARE Rwanda aims to contribute to bringing about change in each of these domains (see Table 1).

Table 1: CARE Rwanda – pathways of change

Pathways of change	Isaro
P1: Financial resources P2: Health P3: Food security and nutrition P4: Water, sanitation and hygiene	1. Vulnerable women increasingly use socioeconomic opportunities and quality services
P5: Exercising rights P6: Engaging men P7: Civic participation and leadership P8: GBV prevention and response	2. The social environment allows and encourages vulnerable women to participate in decision-making and claim and enjoy their rights
P9: Advocacy P10: Grassroots activism	3. Duty bearers ensure an appropriate and operational legal framework that protects the rights of vulnerable women

The CARE CsC is one of several models the VWP uses to achieve change (see Box 2). Given the recognition within the VWP theory of change that women's poverty and vulnerability stem from accountability challenges and collective action problems related to social norms, the CsC tool was considered an appropriate model for the programme's aims. A growing evidence base indicated that the CsC could contribute to improvements in service delivery through bringing actors together to solve problems. Moreover, previous use of CsC in Rwanda had been well received by local authorities and appeared to suit the enabling environment.

A brief overview of the two projects under the VWP that contain CsC components is set out below.

Box 2: The community scorecard

The CsC is a participatory process designed to engage citizens in assessing and giving feedback on the quality and effectiveness of the public services they receive. It aims to improve citizen participation in decision-making, transparency and accountability, while at the same time improving the quality of service delivery to the citizens. These objectives are in line with the domains of change identified in the VWP theory of change.

Source: CARE Rwanda VWP.

Isaro governance initiative

The Isaro governance initiative was a UK Department for International Development (DFID) PPA-funded three-year (2011-2014) project anchored to the Isaro project, funded by the Norwegian Agency for Development Corporation (Norad), which aimed to promote women's economic and socio-political empowerment. The Isaro project was built on CARE's experience with VSLAs and had four main pillars of activity: training of VSLAs in governance challenges and opportunities; building the capacity of VSLAs to engage with local authorities; building the capacity of local government institutions to respond to women's concerns; and a social accountability/citizen oversight process drawing on CARE's CsC experience.

The Isaro governance initiative focused on the latter of these activities, and was the focus of this study. The objective of the initiative was to enhance women's voice and influence in local development planning and public decision-making through women's oversight of services.

A pilot was carried out by CARE in Gisagara district from 2011 to 2012 and the project was subsequently rolled out to two other districts (Nyanza and Ruhango) in 2013, by a national partner, Rwanda Women's Network (RWN). RWN had previous experience implementing the CARE CsC approach under the Public Policy Information Monitoring and Advocacy project, and the strategy for implementing the Isaro governance initiative CsC was to use pre-existing VSLAs as an entry point.

Umugore Arumwva 'A Woman Is Listened To'

The UA project is a two-year (2013-2015), European Union (EU)-funded, CARE Rwanda project in collaboration with CARE Netherlands. It aims to contribute to the fight against GBV by strengthening the voice of citizens and civil society networks and the accountability of responsible authorities in preventing sexual and gender-based violence (CARE Rwanda, 2014).

The project has three key objectives: (1) building the capacity of duty bearers and responsible authorities to implement Rwanda's international commitments to end GBV; (2) increasing the capacity of national civil society to effectively monitor the implementation of these commitments; and (3) increasing the capacity of communities to advocate effectively for action where those commitments are not being met. In order to achieve these objectives, the project has several pillars of activity, including the training of local leaders in Rwanda's GBV commitments and the legal and rights framework related to GBV; the facilitation of a CsC process to ensure service providers are accountable to citizens; and the strengthening of civil society capacity to advocate for change when there is a deficiency in the services delivered to citizens(CARE Netherlands, 2012).

The CsC was a key activity implemented under the second strategic objective. It was introduced as an instrument to increase the monitoring of GBV service delivery by civil society and to increase service provider accountability and responsiveness.

The UA project is implemented by two national implementing partners, Haguruka and RWN, in Gakenke and Gatsibo districts, respectively. The focus on this analysis was on the CsC process undertaken in Gakenke district under Haguruka, a local non-governmental organisation (NGO) formed in 1991 that has expertise in legal aid and legal education on GBV and strong experience working on sexual and gender-based violence.

2.2 Variations in the community scorecard implementation approach

The scorecard approach in both the Isaro governance initiative and the UA project adhered broadly to the main stages of the CARE CsC model as set out in the CARE generic CsC toolkit: (1) preparation; (2) community problem identification and scoring exercises undertaken by citizens; (3) separate scoring exercise undertaken by service providers/ local leaders; (4) interface meeting held between the two (see Box 2); and (5) follow-up on the agreed action plan.

However, the way the two CsCs were implemented in practice differed in a number of distinct ways – in particular with respect to the objectives of the projects themselves, the mechanism by means of which the activity was implemented and the levels at which the intervention took place. These are discussed below and summarised in Table 2.

First, the **Isaro governance initiative and the UA project CsC objectives** were different. While both projects focused on reducing GBV, the Isaro governance initiative CsC was used primarily as a vehicle to enhance the quality and performance of service delivery related to GBV issues. This focused on ensuring service providers were sensitive and responsive to citizens/service users' feedback. The UA project, meanwhile, had a greater focus on enhancing citizen mobilisation around the causes of GBV and collective problem-solving to aid prevention and bring about behavioural change in relation to GBV and GBV service delivery.

Second, the **entry point for local implementation** differed in the two cases. The Isaro governance initiative used CARE's flagship VSLA model to facilitate the

Box 3: Stages of the CARE community scorecard

- Preparation/input tracking: process of gathering information about the community's entitlements and the 'inputs' budgeted for in relation to a service. The community then has an opportunity to compare this with what has actually been received.
- CsC with the community: process whereby citizens score the service in question against indicators they have developed themselves, based on the issues that concern them most
- CsC with service providers: opportunity for service providers to raise and discuss issues from their perspective and to assess their own performance
- Interface meeting: when service users and providers come together to discuss their scores and the recommendations arising from them. A joint action plan is produced that sets out mutually agreed, achievable actions to improve service delivery in the village. These are then monitored and followed up locally. A second scoring process and interface meeting after an agreed period of time serves to show the progress made vis-à-vis the action plan
- Follow-up meetings with higher levels of decision-makers: to ensure these actors take note of the aggregated results of the different CsCs in the villages in their area, and to allow them to take into account these results in their decision-making.

Source: Care Rwanda VWP

scorecard process, engaging existing VSLA[4] members as a segment of service users/consumers of existing GBV services in their localities to spearhead its rollout. This was because the anchor project used the VSLAs to provide women with socioeconomic opportunities. In contrast, the UA project used decentralised community-level structures – that is, village committees – as an entry point to elect community animators and peer facilitators at the village level. This was because the project identified limited local-level implementation of GBV commitments, inaccessibility of available GBV services and non-supportive attitudes of local leaders as a key factor in continuing high levels of GBV. These village structures (unlike the VSLAs) are formal, in the sense that they are created and their function is regulated by the state with a strong upward accountability line, but they are not financed by the state and are in theory voluntary.

Third, **the level of intervention at which the CsC took place** differed. The Isaro governance initiative focused on the GBV service delivery arena and its related service providers (health centre staff, police officers, local authorities at various administrative levels, etc.). As features of the GBV service delivery arena are addressed at the cell level, which is also the lowest administrative level for service delivery monitoring, the initiative focused at that level. The UA project, on the other hand, began its process at the village level. This was informed by the focus and objective of the project, which was designed to implement GBV commitments at the local level. It did this through a number of strategies but notably by focusing on reducing social acceptance of GBV, increasing awareness of women's rights, reducing women's economic dependence on men and ensuring that at the lowest levels services were accessible to citizens and duty bearers were responsive to GBV victims.

Fourth, **the role assigned to the targeted beneficiaries** in the two projects differed. In the Isaro governance initiative, the VSLAs were treated as constituencies of potential users or consumers of the GBV service delivery system and were targeted as representative users of GBV response services. This was in contrast with the UA project, which engaged the community more broadly as a constituency to address the issue of GBV and targeted citizens as contributors to the prevention and fight against GBV. The gender balance in the VSLAs and among UA project community representatives also differed. The VSLAs working within the Isaro governance initiative were required to have a minimum of 80% female membership and thus the Isaro target group was specifically women. The UA project targeted men and women equally, requiring an even gender balance between its CAs and peer facilitators.

2.3 Implications of adopted approach – community scorecard adaptations

These differences in the implementation approach had implications for how the CsC was implemented in practice. Our research signalled a number of ways in which the process was adapted as a result of this. Below, we explore three key ways in which the CsC processes were adapted.

Services and service providers

The different level of intervention and role assigned to the targeted beneficiaries of the two CsCs had implications for both **the GBV 'services' addressed within the scope of the process and the 'service providers' targeted.**

In the Isaro governance initiative, the CsC participants were perceived to be potential users or consumers of the formal GBV service delivery response system. In this case, the 'services' addressed within the process were those provided by facilities such as the health centre, the police station and the cell or sector office. The service providers targeted were contractual professionals and civil servants (health workers, police, sector-level staff) with formal mandates enforceable through central government performance mechanisms such as *imihigo*.

UA project participants, on the other hand, included a broader range of citizens at the village level whose objective was to address the causes of GBV. The 'services' examined focused on more local-level preventative GBV service delivery mechanisms such as local counselling services, community mediation mechanisms and the village committee. As a result, the UA project CsC 'service providers' were more typically 'local leaders' delivering services through associative structures and committees. These power holders were typically volunteer local leaders with no mandatory and enforceable contractual performance obligations. In fact, the UA project scorecard undertaken by service providers (see Figure 1 on page 15) is entitled 'Amanota ya bayobozi' in Kinyarwanda, which means 'leaders' scorecard' and refers to a much broader perception of public authority than the term is typically ascribed in social accountability literature (see Box 4).

4 VSLAs are self-selected autonomous and self-managed groups made up of 15-30 members who pool their savings into a fund from which members can borrow. CARE introduced the VSLAs in the early 1990s as a tool to enhance solidarity among the most poor and vulnerable women in impoverished communities. Membership is open to both women and men, but in the context of the Isaro women's empowerment project, at least 80% of VSLA members should be female. The *purpose* of a VSLA is, principally, to provide savings and simple insurance facilities in a community that does not have access to formal sector financial services, but when the amount of money saved is sufficient, any member can borrow from this source and must repay the loan with interest. This allows the fund to grow.

Box 4: Social accountability and perceptions of public authority in Rwanda

Social accountability typically refers to the actions citizens take to influence public officials (both elected and appointed) and to hold them to account for how they manage public resources and carry out their responsibilities. It also refers to the actions public officials take in response to these actions (Domingo et al., 2015).

As a social accountability mechanism, the CsC process enables citizens to engage with the state, and a typical scorecard processes assumes interaction will take place with providers of defined public services, such as police officers, health workers and local government officials.

However, in Rwanda, who the population perceives as being 'public authorities' appears to be broader than elsewhere, yet at the same time does not include informal authority structures.

Public authority rests exclusively with formal representatives of the state, whether these are public civil servants who are employed by the state or formal structures (including village-level representatives of various associative and community structures who would elsewhere be considered local civil society).

This had further implications for how the input tracking was carried out in the two CsC cases. In the Isaro governance initiative, input tracking focused on identifying what GBV services existed at specific facilities to respond to GBV cases in relation to national standards and whether they had sufficient budgeted resources. For the UA project, input tracking focused on mapping existing local mechanisms, resources and mandates to address the causes of GBV and prevent their occurrence – for example what measures local authorities have at their disposition to ensure both girls and boys go to school (as not allowing girls to go to school is defined as a cause of GBV) and what they can do to reduce alcohol abuse (a common cause of physical and sexual GBV).

Community engagement

The different entry points for local intervention used in the two CsC initiatives and the roles assigned to beneficiaries had implications for how scorecard facilitators were selected and appointed and how the community engaged with the scorecard process and expressed their concerns.

Although both projects held up the principle of gender parity, the UA project CsC was facilitated by two elected CAs in each village (one man and one woman) working alongside an employed field officer (FO) from the national partner organisation, Haguruka, whereas the Isaro governance initiative CsC process was facilitated by two CMs (one man and one woman) from each cell. The CMs were supported by two peer facilitators (one man and one woman) from each of the three VSLAs selected per cell in the two sectors and with CARE staff.

Whereas UA project CAs were elected by the target community at a village meeting held by the implementing organisation to explain the scorecard process, Isaro governance initiative CMs were already VSLA members acting as peer facilitators yet selected based on agreed criteria. UA project CAs were elected on set criteria and on the basis of their status within the local community (opinion leaders) and the extent to which they could influence community members and local leaders. They were therefore not necessarily familiar with GBV issues. Isaro governance initiative CMs on the other hand had worked on CARE-supported initiatives on GBV and family planning for several years and had experience engaging with local service providers and authorities. Along with CARE staff, it was the CMs who selected the three VSLAs from each cell to participate in the process. The VLSAs then appointed the peer facilitators based on agreed criteria.

Problem identification

The role assigned to beneficiaries and the level and mechanism of intervention had implications for how problems were identified, how indicators were selected and the form the scoring took.

A process of **participatory problem identification and analysis** was a key step in both the UA project and the Isaro governance initiative scorecards, and in both cases prioritised problems were the basis for the development of indicators used to undertake scoring exercises. However, the different processes by means of which problems were identified meant the scope of issues raised differed dramatically in the two cases, and as result so did the indicators and what the scoring exercise evaluated in practice.

Within the Isaro governance initiative, scorecard problems were identified with respect to the issues users encountered in the **delivery of GBV-related services** at the cell level (such as lack of privacy and intimacy for GBV victims when accessing public services). In contrast, in the UA project, problems were identified as those **GBV issues most affecting the community** at the village level (such as domestic abuse and non-consensual sex), which were then compiled at the cell level in an additional step.

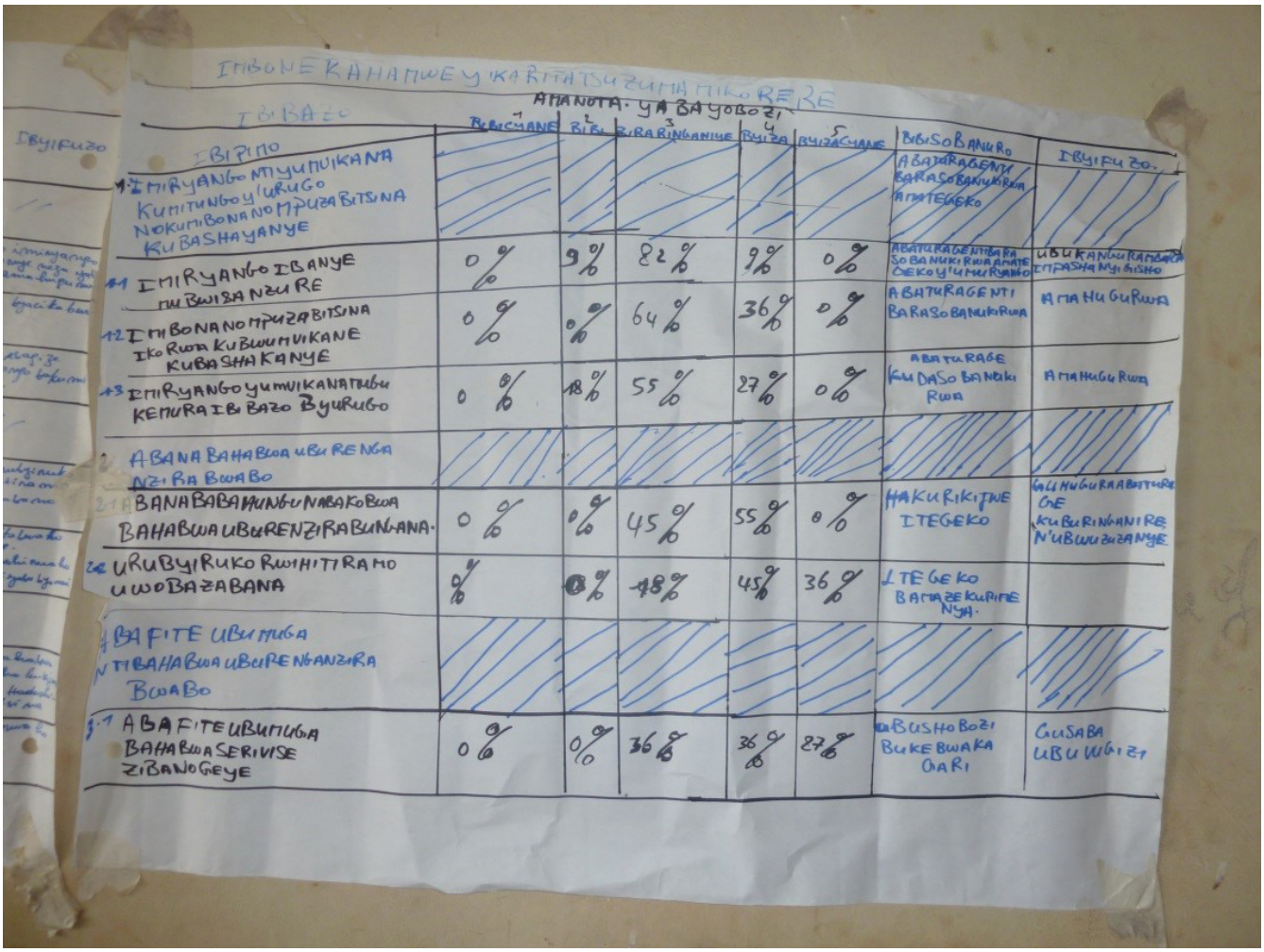
The **types of indicators used in each programme differ** because they reflected whether the nature of the problem was defined in terms of (1) service delivery and service providers' capacity to improve GBV services or (2) GBV-related issues affecting communities and local leaders' capacity to respond to and prevent them. In the Isaro governance initiative, indicators related to specific features of the services provided along the GBV service delivery chain, whereas in the UA project indicators typically described what a community not experiencing the specific

GBV issues identified would look like. For example a major problem prioritised as a GBV issue affecting local village households in the UA project scorecard was 'conflict within families'. This was an all-encompassing term used to refer to households in which couples were experiencing communication and cohabitation issues but also to households in which instances of sexual and domestic violence as well as 'economic' violence were prevalent. In the cells we studied, the indicator evaluated during the scoring was 'families living in harmony'.

The different ways in which problems were identified and the corresponding type of indicator used in the two projects meant **the scoring process for the Isaro governance initiative and the UA project was very different** both for beneficiaries and for 'service providers'.

- In the Isaro governance initiative, the **service providers undertook a self-assessment to evaluate their own performance** *vis-à-vis* the indicators highlighted in the matrix designed by the community related to service delivery modalities. In parallel, target constituents for the Isaro governance initiative CsC (members of VSLAs) undertook a restricted community scoring exercise in which they gave **performance scores to evaluate users' satisfaction with the services delivered** to them by the service providers.
- The UA project scorecard does not score service providers *per se*; rather, it scores the state of well-being or vulnerability of a cell with respect to the identified GBV problems, from the perspectives of both intended beneficiaries and local leaders. The score given to a particular indicator reflects the frequency with which the indicator is present in a particular cell. Although they are undertaken separately, the scoring exercise undertaken by each group is therefore exactly the same. Figure 1 shows what the scorecard in the UA process looks like. Yet, although beneficiaries are thus evaluating their community rather than service providers, indirectly the process has the potential to evaluate local leaders where they have a responsibility to reduce GBV and when the ensuing discussion on how to respond to the issues raised translates into services that are not being currently provided.

Figure 1: An example of UA project scoring by local leaders



The scoring process in both projects allowed for a community dialogue on what mechanisms (in the UA project) and services (in the case of the Isaro governance initiative) exist for resolving issues related to GBV at different levels of local government, and who is responsible for them. However, notably, the individual scorecards in the UA project process explicitly recorded reflections on the causes of each of the problems identified and the potential strategies for resolving them – highlighting priority areas for actions. Discussions related to any critique of the service providers and the services they provide were reserved for this space rather than being part of the actual evaluation and scoring process. For example, one interviewee explained that the village might give a score of 30% for 'families living in harmony', which would mean 70% of village households were experiencing conflict. This would prompt them to ask why, to examine the causes of the conflict and to ask who was responsible for resolving them.

Both programmes had an **interface meeting** step during which the community and service providers came together to exchange respective scorecards on both sides and looked for strategies to resolve the mutually agreed issues. At the end of this meeting, a joint score was agreed on and a plan of action was established to improve services. However, whereas in the Isaro governance initiative the action plan focused on corrective actions (responsibility) by public workers and civil servants, in the case of the UA project the focus of the action plan was more on local-level problem-solving by the population through associative structures.

Table 2: Variations in Isaro governance initiative and UA project processes and implementation

Process variations	Isaro	UA
Objective	Improved quality and performance of formal GBV services	GBV prevention and behaviour change
Entry point	VSLAs	Formal/associative community structures
Level of intervention	Cell level	Village level
Role assigned to beneficiaries	Potential users of GBV services	Citizens who can respond to and contribute to the prevention of GBV
Targeted group	Vulnerable women	Men and women
Implementation adaptations	**Isaro**	**UA**
Services targeted	GBV services provided at formal facilities (health centre, police station, etc.)	Local preventive GBV service delivery mechanisms (community mediation, counselling, etc.)
Service providers	Mandated professionals/civil servants subject to performance evaluations	Local leaders delivering services through associative structures and committees
Input tracking	Identifies which GBV services exist and whether they have resources	Mapping existing local mechanisms, resources and mandates to address the causes and prevent GBV
Scorecard facilitators	Cell-level CMs + peer facilitators (selected from existing VSLAs)	FO + village-level CAs elected by community
Problem identification	Problems with the delivery of GBV-related services	GBV issues most affecting the community
Indicators	Features of the GBV services provided	
What is evaluated during scoring by whom?	Service providers self-assess their own service performance and community representatives evaluate users' satisfaction with the services	Local leaders and community representatives evaluate state of well-being or vulnerability of a community with respect to the identified GBV problems

3. Key outcomes and impacts of the community scorecard

This section provides a summary of the key outcomes and impact of the Isaro governance initiative and the UA project scorecards as identified by a range of stakeholders (local authorities, service providers, local CsC facilitators and beneficiaries) involved in both processes. The outcomes and impacts could not always be independently evaluated as part of this analysis, but, where possible, findings were triangulated to ensure accuracy. The overview of outcomes and impacts documents tangible changes, benefits or other effects (expected or unexpected), as well as the broader change and effects observed that respondents in the study consistently highlighted.

It is important to note that this study was not intended to be a comprehensive evaluation of the impact of the two projects; nor was it the purpose of the report to compare the two. Rather, the focus was on better understanding the processes by means of which results have been made possible in the two cases; *how and why* the CsC project has contributed to improving the quality of GBV service delivery; and *how in turn* this has contributed to improvements in women's agency, voice and participation, paying particular attention to the agency of participants and relations between citizens and service providers.

Moreover, it is difficult to attribute outcomes and impacts directly to the scorecard process. First, the CsC initiatives studied as part of this research were only one component of several mechanisms implemented as part of the wider projects they were part of. Second, these wider projects themselves were built on a wide range of complementary government and development partner interventions and training and other tools and mechanisms working towards similar objectives.

Below, we describe key ways in which the two CsC projects have contributed to GBV service delivery and consider how this has helped improve women's agency, voice and participation. Table 3 presents an overview of these outcomes and impacts.

3.1 Improvements in service delivery

According to a number of stakeholders, the **scorecard process has achieved a number of tangible outcomes** that better meet the needs of GBV victims. In the case of the Isaro governance initiative, these typically include better facilities for receiving GBV victims at health centres, police stations and local authority offices. In the UA project, they include the provision of mediation services at the village level for couples living with GBV and greater involvement of local authorities in GBV prevention.

Isaro governance initiative and improved delivery of GBV services

The setting-aside of a room at Nyarurama health centre in Ruhango sector is one example of improved service delivery in the Isaro governance initiative CsC. Before, GBV victims were not accorded any privacy when seeking assistance and had to air their problems in public. There was also an absence of dedicated staff to address their concerns and ensure they were seen promptly. During the CsC interface meeting, the health centre director agreed to make provisions to rectify the issue; less than a month later, the health centre management committee made a decision to provide a separate room for GBV victims and ensure there was a GBV trained nurse available at all times to counsel victims. Struggling with available rooms, they combined two HIV treatment rooms (for antiretroviral treatment and prevention of mother-to-child transmission) into one to free up space). Representatives of the constituents for the Isaro governance initiative scorecard process confirmed that the health centre had prepared a room specifically for GBV victims, and one case manager remarked that the room even had beds in it. Target local authorities and community representatives in the Isaro governance initiative scorecard process agree health staff now treat GBV victims better.

This issue was raised frequently in the Isaro governance initiative CsC with respect to various service providers, including the police, cell authorities and health centres. In response to a criticism levelled against local cell authorities in Buhoro that there was no anonymity for GBV victims, a decision was taken to renovate the cell offices. The cell office had always existed but was not equipped to receive visitors appropriately. Following the scorecard process, the cell village committee organised for the office to be repainted and equipped with tables and chairs. The population contributed to the cost of doing up the room and providing the materials (i.e. a desk, sofas etc.)

Improved relations between service providers and users

A key element of this improvement in service delivery in the Isaro governance initiative CsC is an observed attitude change among service providers towards the beneficiaries, as a **result of improved relations between the community and services providers, including local authorities.**

Service providers involved in the Isaro governance initiative CsC interviewed for the study frequently noted that, despite being initially reluctant, they found the CsC process **was a positive experience and they felt their status within the community had improved.** On the other hand, CMs involved in the Isaro governance initiative CsC process claimed that, through the CsC, service providers had realised they worked for the population and had an obligation to take their needs/opinions into account. Increased visits by local authorities and service providers to community representatives in their villages were an example used to substantiate this claim and were frequently raised as something that beneficiaries appreciated. This appears to have opened up new space for dialogue, which has contributed to overcoming the gap between service providers, local authorities and the local community. Before the CsC, interaction between service providers and the population at village level was limited or absent. When community members needed to seek help from the local authorities or the police, the onus rested on them to visit the relevant service providers. For example, the police were criticised during the scorecard process for rarely venturing into villages to investigate GBV crimes and speak to those involved, despite requests from victims to do so. According to a Ruhango police inspector, the police now make regular visits to villages, and this permits them to obtain information about domestic violence cases At the sector level, the police have increased the meetings they have with the community with the goal of preventing GBV.

The way local authorities have improved their treatment of GBV victims is an example of this. Isaro governance initiative informants indicated that, before the CsC, local authorities often did not take victims seriously but that, since the scorecard, there had been an improvement in their attitudes towards GBV issues and in the assistance provided to victims. For example, in one village, the village head had routinely asked for payment to intervene in family conflict issues. In another case, *abunzi* were accused of deliberately delaying the hearing of GBV cases in return for payment. In both cases, VSLA members noted that these practices stopped following the CsC.

Interviews with a range of formal service providers (professional civil service functions) supported this suggestion, indicating they felt a greater sense of accountability towards citizens. However, this was largely linked to performance monitoring mechanisms, incentives and sanctions. For example, one police officer said, 'I have to put food on the table and so I need to get promoted.' She also noted that, if the population did not like the service individual police officers provided, the latter could be transferred and even lose their job. In this respect, citizen feedback through the CsC acts as an incentive for service providers to improve their performance as a means of gaining satisfaction, the praise of the service users and promotional prospects with higher pay.

Nonetheless, this behaviour change was also reported among voluntary service providers such as the *abunzi* and NWC committees. A member of a village NWC committee said, 'Before we thought that our responsibility was to donors because they give us resources. We hadn't thought that we had a responsibility towards the population'.

Box 5: Local changes in health insurance regulations

One of the issues highlighted by the Isaro governance initiative scorecard process was the limited level of health care treatment covered by health insurance. General health insurance regulations state that injuries sustained as a result of violence are not covered by the health insurance scheme. This meant it was difficult for GBV victims to receive treatment for their injuries (. The local authorities discussed this during meetings and took the decision to ensure that the insurance would cover this sort of injury in the future. Although this was not in line with the broader national framework of health insurance policy, local authorities signalled that they had a certain amount of room for manoeuvre to make decisions about this at the district level.

Source: Isaro governance initiative field notes.

3.2 Greater awareness about gender-based violence rights and services

A key outcome identified by informants in both CsC initiatives is that citizens are better informed about their rights and obligations with respect to GBV, the responsibility that local authorities and service providers have towards them and which institutions are in charge of particular services.

UA project informants (both men and women) claimed they had a greater awareness of legal rights relating to GBV and the channels they can use to assert these rights. They consistently demonstrated their knowledge of these rights referring to women's equal inheritance rights, women's entitlement to equal control of household resources under the marriage contract, women's right to consensual sex within marriage, the illegality of domestic violence and girls' equal rights to attend school.

In the case of the Isaro governance initiative, interviewees reported that they were better informed about the GBV services they are entitled to and where to access them and were clearer about procedures for reporting GBV.

This can be seen as an outcome related to the change in service provider practice the Isaro governance initiative CsC has brought about. An important aspect to this is the **improved communication from service providers to users about their services**, which means the population is better informed about their role and functions. In Buhoro cell, the local authorities have put up public notices to inform the population which services are available on which days and have provided telephone numbers on which cell staff can be reached. The police in Ruhango sector have done the same: clients can phone the complaints line if they are not happy with the service they receive. This reflects a change in practices on behalf of the providers of GBV services.

The CsC process has also enabled service providers to better inform users about the correct procedures to follow when reporting GBV cases. For example, one problem users highlighted during the CsC was of the police releasing GBV suspects from prison without charge. During the interface meeting, the police informed the population of the separation of responsibilities between the police and the judicial system and the obligations that limit the time they can hold a suspect before the courts charge them. This information has encouraged citizens to use the right procedures in reporting GBV cases and understanding why past reported cases have not been dealt with accordingly.

An increased awareness of what GBV is, how it manifests itself and the impact is has on victims and on society more broadly was also consistently raised by participants in both the Isaro governance initiative and the UA project.

When asked to define GBV, nearly all informants from both CsC initiatives described the four types of GBV espoused in the Rwanda government definition. Isaro governance initiative VSLA representatives who participated in an FGD claimed that the CsC had made them realise they lived with sexual, economic, physical and emotional violence on a daily basis. This was also the case for almost all participants involved in the UA project scorecard. UA project informants consistently noted that before the CsC men and women had been unaware that they had been subjected to GBV; many men did not know they were committing GBV, particularly in relation to economic and sexual violence, and women were unaware of their rights. This general recognition by women that they had been living with GBV is an important outcome, which it can be argued can contribute to increasing women's agency.

A common reflection from UA project informants when discussing this change was that before the CsC both men and women accepted the *status quo*, in which a woman was considered the property of her spouse; a women was economically dependent on her husband; and he had the right to beat her and have sexual relations with her at will. There was general consensus that this was 'normal' and part of Rwandan 'culture'. As a result, women felt unable to raise these issues and, as one male local authority representative put it, 'Husbands were not bad they were just ignorant and unaware'.

The UA project CsC's implementation approach meant the scorecard was much more focused on how GBV could be prevented, and this generated discussion around the causes of GBV. Through this process, 'conflict within families' came up as a major problem affecting local village households. This term was used to refer to married couples with communication breakdowns and cohabitation issues as well as those experiencing sexual and domestic abuse and 'economic' violence. Although sexual violence included rape of women and young girls, it was mainly mentioned in reference to non-consensual sex between couples – married or not. Domestic violence within the home was also raised as an issue, with women more often the victims but cases of men being victims of domestic abuse were also flagged. Economic violence, was, unexpectedly, raised consistently both as a widespread form of GBV (with women being identified as victims) but also as a driver of other forms of GBV. For example socioeconomic factors and mismanagement of household assets and resources, as well as alcohol abuse, were noted as causes of other forms of GBV (i.e. physical and psychological).

Although the process is challenging, there was general consensus among UA project respondents that mentalities are beginning to change and that there is a general perception that families are 'living in greater harmony'. The increased awareness of men, in the case of the UA project CsC, is a critical step forward in challenging the social acceptance and tolerance of GBV and changing relations between men and women.

3.3 Action resulting from increased awareness

There is evidence to indicate that community members have achieved a greater sense of awareness around their rights relating to GBV issues. However, more importantly, there is evidence to suggest they are using knowledge of their entitlements in relation to GBV service delivery to claim these rights.

In the Isaro governance initiative, this was typically expressed in terms of women's increased demands with respect to GBV services. An important aspect of this is that, through the CsC process, community representatives not only better understand the GBV services the community is entitled to receive but also, because of improved relations with local authority structures and service providers, are prepared to claim these rights if the services received are not satisfactory. A female police officer reported that before the CsC women had been intimidated in speaking to the police, which prevented them from voicing their issues and seeking help, but that since the CsC more women were coming forward. An Isaro governance initiative local authority representative echoed this, highlighting that before the CsC the population thought of themselves as beneficiaries and not as people who could reclaim and demand things – exercising their rights in relation to access to services. VSLA respondents were clear that they would have no problem contacting a village head's superior if an issue they brought to his attention was not satisfactorily addressed. Service providers are aware of this and that their work is being monitored.

In the UA project, informants claimed women were increasingly discussing issues they had felt unable to raise before, and that there had been a shift in the extent to which women demand their rights. UA project respondents reported that there was much greater willingness to discuss GBV, with previously taboo subjects such as non-consensual sex being more openly discussed. Women have begun speaking up about the abuse they are subjected to within the confines of their marriage and couples are publicly sharing their testimonies about how their lives have changed for the better; this reflects change at the agency level. Furthermore, UA project FGDs indicated that, while previously women had been scared to approach the local authorities, they now think nothing of going to see their village head to reclaim their rights, for example when their husbands try to sell their joint assets without their consent.

Women's increased confidence

UA project and Isaro governance initiative respondents consistently reported that women were more confident than they used to be.

During an FGD with UA project CsC representatives, one CA said there had been a major change in women; they now have more self-confidence and give their opinions publicly on issues, which they did not before. Others participating in the FGD showed clear support for this assessment, and this was repeatedly echoed by local leaders, who agreed women were more confident today. During the UA FGDs, several participants qualified women's increased confidence by saying women were now brave enough to speak and take up leadership positions, although they did not refer specifically to women's leadership role in the prevention and response to GBV. Yet another of the men said, 'If you are seeing them [women] here today it is because things have changed!' Similarly in the Isaro governance initiative, one interviewee alluded to this increased confidence in women by noting that, because women now know they have rights, they are no longer scared to engage with local authorities to demand their rights.

Increased trust of local authorities by community members

This increased confidence is part a more generalised outcome of the scorecard process that affects both men and women. Many of the stakeholders interviewed made reference to how much the scorecard process had been appreciated by community members and how citizens more generally had become more confident in sharing the problems they face generally and raising them with local leaders. During FGDs, community members frequently asserted that the process had built up villagers' self-esteem and that they were no longer afraid of speaking about things that were not working and confronting local leaders about the issues. Previously, community members were said to have avoided contact with local leaders.

An important aspect to this is that citizens feel local authorities now take their opinions seriously, are concerned about their welfare and will act to support them. This has been possible through improved relations with community representatives and local leaders built up by the scorecard facilitators. In an FGD, UA cluster representatives noted how cell local authorities now trusted them and encouraged villagers to address their problems to them; they said this gave them the assurance that the local authorities cared about what happened to them. Likewise in the Isaro governance initiative process, VSLA participants have grown to trust the CMs.

Local leaders agree the population is becoming more forthright about raising issues. One Isaro governance initiative district authority representative said that before, when the local authorities visited the population, no-one ever asked any questions and people were generally reluctant to give their opinion, but this had changed since the scorecard process. UA project respondents expressed a similar sentiment, indicating that service providers and local authorities were unaware of some of the challenges the population was facing. In both processes, then, the CsC opened up a space for dialogue and the exchange of ideas, which has strengthened feedback loops from citizens by providing them with a platform in which they can raise issues. This is particularly important for addressing GBV,

given stigma and perceptions of the issue that mean people typically keep quiet about it.

Women's increased confidence to engage on issues related to GBV can be seen as an extension of this and a result of their involvement in the scorecard process, as CMs, CAs, peer facilitators and cluster representatives and in positions where they have had to engage with local leaders and service providers. Women who participated as scorecard facilitators in the Isaro governance initiative reported that the process had been a very positive experience and they were keen to be involved in similar processes in the future.

When one participant was asked whether this increased confidence among women had extended to within the family, her response was, 'Can a woman who is capable of addressing herself to the district and sector local authorities be scared to talk to her husband? I don't think so!' This response speaks to the hierarchical social culture of Rwandan society and highlights the extent to which public authority dominates private authority.

3.4 Perceived reduction in GBV

Nearly all UA project and Isaro governance initiative informants reported that there had been a **reduction in all types of GBV since the scorecard process**. However, it is important to note that these reported outcomes were based on the perceptions of key stakeholders as relayed during key informant interviews and FGDs. Although every effort was made to triangulate these reports, they could not be independently evaluated. In addition, it is important to note that it is difficult to attribute outcomes and impacts directly to the scorecard process.[5]

In the case of Isaro, the service providers interviewed (health workers and police) indicated that the number of GBV cases reported had reduced and that prevention measures had been effective at addressing potential GBV before it escalates. UA project service providers had a similar perception and often cited the same reasons, indicating that the focus on addressing the underlying cause of GBV was preventing GBV from getting out of hand.

UA project service providers (local leaders) consistently reported that instances of domestic violence and non-consensual sex within marriage had substantially reduced and women had more equal access to household resources than before the CsC. Discussions with UA project community representatives supported this perception of change. The main reasons explaining the perceived reduction in GBV incidence appear to be improved relationships at the household level as a result of informed awareness and knowledge on GBV; increased agency of women, who have less fear of reporting cases of GBV; and the strong commitment of public authorities to addressing GBV.

An interesting finding of the study was that in both the Isaro governance initiative and the UA project, service providers and beneficiaries consistently reported improvements related to economic GBV. They highlighted women's increased right to seek employment and to uphold their inheritance rights (particularly succession of land) and their greater access to and participation in decision-making concerning household income as a major outcome of the CsC process.

The government's inclusion of, and the importance it gives to, economic GBV has been crucial in shaping this popular understanding of GBV (see Section 1.2 and Box 1). It has underlined the importance of increasing women's access to resources (employment, inheritance, household resources and assets, etc.) and decision-making power within the home and thus addressing unequal power structures in the household as a key element of the fight against GBV.

In the case of Isaro, respondents' comments referring to women having greater rights over the use of household resources were typically given during discussions around women's increased access to credit and income-generating activities. Given that these features are integral components of the VSLA, it is difficult to argue that this was a result of the CsC process alone. Nonetheless, the improved relationship of women with GBV service providers – in which women have been able to influence the way services are provided through targeted feedback on what works and what does not – can be attributed to the CsC process.

In the UA project, women's unequal access to the **management and ownership of household assets and the financial benefits derived from them was a key problem highlighted during the CsC process.** Men were described as typically having sole control over household assets (i.e. livestock, land, harvested goods), with women excluded from their ownership and decision-making on how assets were used and the use of any income accruing from their sale . Economic violence – where women are refused access to the control and ownership of productive assets – emerged as one of the key obstacles identified by local stakeholders during the CsC problem identification phase. Overcoming economic GBV requires changing fundamental gender power relations, but addressing it can contribute enormously to resolving other forms of GBV (physical, psychological and sexual).

UA project local leaders and community representatives reported that since the CsC there had been a radical change in how household resources were controlled, with claims that men now understand women have the right to an equal share of the household resources and that they consult their wives in household decision-making processes. When questioned on this subject, female CAs were emphatic that this was the case (see Box 4 for an example). In the UA project, a key element in this change

5 Although progress reports on the two projects corroborate this study's findings on reductions in GBV incidence.

appears to have been the components of the wider programme and in particular the extensive training on GBV and its legal framework in Rwanda to a wide range of services providers and local authorities in addition to the scorecard facilitators and local community members.

UA project service providers said challenging cultural norms around economic GBV during the CsC had met resistance, some of which persists, but despite this there was general consensus among respondents that a process of behavioural change had begun. During FGDs, UA community representatives noted that husbands who had previously prevented their wives from working were now encouraging them to do so. One man demonstrated this change by saying, 'Before a woman had to wait for her husband to buy her a *pagne* now she can sell tomatoes and buy it herself'. UA local authority representatives also recognised this shift towards greater acceptance of women contributing to family income. It is again difficult to attribute these changes solely to the CsC, but it seems plausible it has contributed to improved relationships at household level, which has enabled women to better negotiate their private space.

Box 6: Example of economic empowerment

One woman told us that, before the scorecard process, her husband used to say the bananas harvested from their land were his. She noted that this was because he had inherited the land on which their banana trees were growing and so he considered it was his alone and not 'theirs' as a married couple. As bananas can be sold for a higher price than the sweet potatoes that they grow on their land, he insisted on keeping the harvest for his own purposes, typically selling it and using the money to buy drink. His wife was left with the much cheaper sweet potatoes. She said that, since the scorecard, her husband has changed. Now, when her husband sells the bananas, he brings the money home and they decide together what to do with it.

Source: UA project field notes

3.5 Broader impact on services

During the course of our interviews, several references were made to the way in which the impact of the CsC has contributed to broader effectiveness. Some of these are discussed below.

One of the most important impacts observed at the broader level has been the **sustained interest and commitment of local communities and service providers to scorecard-inspired processes.** This is important because it speaks to the potential support that exists for the CsC process beyond the scope of the project interventions. In the case of the Isaro governance initiative, community mediators in Buhoro cell claimed they had been undertaking regular monthly self-evaluations since the scorecard process to ask what they could do to improve their services. Likewise, the Nyarurama health centre director said that they were in the process of designing a satisfaction survey to get feedback on their family planning services. Inspired by the scorecard, the survey will ask users where they have experienced obstacles and ask them to make propositions for improvements.

In addition, local authorities have expressed an interest in taking up the CsC as an avenue for gathering citizens' feedback on a variety of issues. Stakeholders across the spectrum voiced their desire to expand scorecard processes beyond that of GBV and, in the case of the Isaro governance initiative scorecard, at least one village head indicated that he would like to reuse the format to identify and resolve other problems facing his villagers.

Another example of how the CsC process has had a broader impact can be seen in the extension of better services in specific sectors beyond the scope of their GBV-related services. For example, a police inspector in Ruhango sector claimed all users had benefited from their improved customer services, put in place to respond to criticism of the way GBV victims were received. Similarly, the Buhoro cell executive secretary noted that service improvement initiatives such as putting up notices benefited the community's citizens more broadly.

Finally, in the UA project, there was evidence that the **CsC process provided a platform for other groups of citizens to voice their concerns in relation to service delivery** in general, in particular disabled people and young people. During the problem identification phase of the process, a number of non-GBV-related issues arose, including the isolation and discrimination disabled people felt they suffered with respect to delivery of services. Since the CsC process, the disabled cluster has formed a strong channel for influencing public authorities. Before the process, disabled people did not receive support to pay their health insurance; following the scorecard process, they successfully lobbied for change and now local authorities pay their insurance. In addition, disabled people now participate in community meetings, receive appropriate services and are less isolated within society.

3.6 The impact on women's voice and influence?

The research into the CsC component of the two projects indicates that the CsC has contributed to enhancing women's voice and influence in local governance and service delivery in Rwanda in several ways. These are summarised below.

In both cases, the CsC has provided women with a forum to express their own views and preferences and influence decision-making. In the Isaro governance initiative, this been through the capacity to hold service

providers to account for the services they provide. In contrast, for the UA project, this has been made possible through women receiving new information on their entitlements and government responsibilities and through the process of interacting with public officials.

The UA project focus on tackling social norms has been particularly important in generating information and space in which these rights can be discussed. The UA implementation approach also ensured no restrictions on women's ability to speak freely: separating community members into clusters (i.e. men, women and the disabled) during the problem identification phase permitted women anonymity and provided a space in which they could speak openly and with confidence.

However, how much women's voice can influence decision-making depends on how those in power respond to requests. The following evidence supports the proposition that **women have had influence** throughout the two CsC processes**.**

Community representatives claim that, since the Isaro governance initiative CsC process, they are better informed about GBV services available to the community and this has translated into increased monitoring of these services as there is a mechanism to hold providers to account when the service is not adequate.

As described above, since the CsC process, women and other community members (scorecard facilitators) have increasingly sought out the services of local authorities with respect to GBV (service providers for Isaro and local leaders for the UA project). In both cases, local authorities are witnesses to more active monitoring of their activities with respect to GBV than before. Moreover, women attested to increased capacity to negotiate their entitlements with officials and providers.

Women's credibility and standing in the community have improved through participation in the CsC, particularly for those who have been involved as scorecard facilitators. Facilitators from both projects feel they have gained the respect of, and are taken more seriously by, local authorities and community leaders. In both projects, this is expressed in the way local authorities legitimise scorecard facilitators. In the case of the UA project, local authority support to the CAs has provided them with the legitimacy to act as local community mediators. The Isaro governance initiative CMs have gained credibility as experts in the field of GBV.

As described in detail above, **women have gained in confidence and skills** through their participation in the scorecard processes.

The scorecard has also **enabled women to make use of existing national accountability mechanisms** to seek the implementation of existing legal entitlements with respect to gender equality and equity.

Finally, both the UA and the Isaro CsC programmes have helped women's efforts to hold public authority figures to account. This has influenced local public decision-making on how resources are allocated and used and how services are provided. Service providers and local leaders have been made more aware of and have become more responsive to the specific needs of women and girls.

Table 3: Summary of CsC achievements

	GBV service delivery	GBV awareness	Relations	Impact on women	Broader impacts	Perceived reduction of GBV
Isaro	Improved delivery of GBV services at formal facilities	Users better informed about GBV services and where to access them	Improved relations between service providers and community, including local authorities	Increased confidence of women to engage on GBV-related issues	Service providers are undertaking self-evaluation processes	Reportedly fewer GBV incidences owing to effective prevention measures
	Greater accountability of service providers to service users	Users understand procedures for reporting GBV	Improved communication from service providers to users about their services	Women express their views and hold service providers to account on GBV services	Implementation of scorecard-inspired processes (i.e. citizen feedback surveys) by service providers and local authorities	Women's improved access to household resources owing to increased access to credit and income-generating activities
	Reduction in GBV cases at facilities (in particular physical GBV)	Increased demand for GBV services	Greater engagement of women with service providers	Women have greater access to income-generating activities	Improved services beyond the scope of GBV-related services	
	Strong commitments of public authorities to address GBV	Monitoring of GBV services by community representatives		Status of female CMs has improved		
UA	Provision of local-level support services to potential GBV victims	Greater awareness of legal GBV rights and how to negotiate these entitlements (men and women)	Improved relations between community and local leaders	Women speak more freely about GBV they face	CsC process has provided a platform for other groups of citizens to voice their concerns in relation to service delivery (i.e. disabled and youth)	Reduction in instances of domestic violence and non-consensual sex within marriage
	Increased reporting of GBV cases (especially economic)	Community members recognise GBV is an issue	Increased trust in local authorities	Increased confidence of women to engage with local leaders on GBV-related issues		Effective prevention of escalation of GBV cases owing to focus on addressing underlying cause
	Greater involvement of local leaders in GBV response and prevention	Willingness to discuss previously taboo subjects (i.e. non-consensual sex)	Engagement of women with local leaders	Women have greater input into decisions concerning household resources		Women's improved share of and control of productive assets (i.e. land, livestock, harvested produce)
		Challenge to cultural norms around GBV issues	Improved relationships at household level	Women have access to income-generating activities		Women's increased involvement in decision-making processes regarding household assets
		Monitoring of GBV in community by community representatives and local leaders		CAs receive support and legitimacy from local leaders		Greater acceptance of women contributing to family income

4. What explains the outcomes?

Here, we identify the main factors that explain the observed outcomes and impacts of the Isaro governance initiative and the UA project CsC components described in Section 3 in order to draw lessons from their experience and consider their programming implications. The focus here is on the contextual factors and features of design and implementation that have enabled the CsC to contribute to improvements in GBV and have an impact on women, in particular with respect to changing practices and the behaviour of service providers. We discuss both of these below.

4.1 Contextual factors

A number of contextual features of the Rwandan political economy have been important in ensuring women have been able to participate meaningfully in the scorecard processes. First, in Rwanda, the presence of a **functioning legal system and public service at the subnational level**, in which decentralised administrative and technical structures exist and function at all levels and are subjected to **strong performance monitoring mechanisms**, as are sector-specific service delivery infrastructure, has created an enabling environment in which national gender policy can be implemented.

The **government's prioritisation of GBV has also been crucial**. The provision of a GBV legal and policy framework, accompanied by national policies and implementation mechanisms to ensure enforcement of women's legal entitlements and active encouragement of women's participation in civic, public and associative life, has been key in ensuring GBV laws are complied with and in promoting behavioural change. Both the Isaro governance initiative and the UA project CsCs have strongly leveraged these institutional factors.

Second, coherent professional incentives to service providers and local leaders to implement state policy and improve local services promote a genuine sense of accountability in terms of improving GBV services on the one hand and addressing the problems facing the community on the other. Aligning the CsC with **existing local governance structures and processes and accountability mechanisms** is a key factor explaining the outcomes of the CsC in the two projects. This was a deliberate strategy for both projects and was explicitly linked to their overall objectives – behaviour change in the case of the UA project and improved service delivery in the Isaro governance initiative.

Third, **government commitment to promoting community participation in local development processes** has been equally important, and in particular the requirement that local governance structures have at least 30% of female committee members. The extensive participation of citizens, and by extension women, in local associations, cooperatives and community fora at the lowest levels means the local population is familiar with working collectively through these types of local governance structures. Moreover, although involvement in these local structures is voluntary, in practice participation at public village meetings is considered obligatory and often enforced by local leaders. This facilitates men's acceptance of women's involvement in these meetings. The context is very effective at giving women voice.

In both the UA project and the Isaro governance initiative, the habit of participating in committee meetings has ensured broad participation and has thus facilitated the **identification of problems that are genuinely salient for the local population and especially women.** This was especially the case for the UA scorecard, whose intervention level enabled the community the freedom to identify problems more broadly, beyond the boundaries of the national service delivery system. The result was a much more locally driven problem identification process leading to a broader reflection of the nature of GBV. The local population reflected on what GBV meant to them, what problems they were facing and what they could do about them. This went beyond the realms of service delivery focused on by the Isaro governance initiative and lent itself more naturally to discussion around how the causes of GBV could be addressed rather than the provision of GBV services *per se*. The public authorities being held to account were 'local leaders' who were, for the most part, voluntary yet elected representatives of the various committees and local structures mentioned above (village heads, community mediators, etc.)

Two more important institutional factors have been key in efforts to bring about rapid behavioural change within the scope of the CsC.

First is the relationship between public and private spheres of authority in Rwanda. The rural population are generally highly tolerant of public intrusion into their private lives. In practice, this means public authority often takes precedent in the private sphere, and local authorities/leaders have power within individual households. This **socio-cultural hierarchy means enforced change in public arenas can be rapidly diffused in private arenas.**

Second is the passive nature of Rwandan society towards government policies and priorities. There is general acceptance among the rural population that the political class knows what is best for them. Given their deference to public authority, the imposition of an enforced GBV law, alongside an effective information campaign, has been sufficient for the population to adhere to its requirements. As one informant remarked, 'GBV policy is a national programme and it's not our position to challenge it'. The two CsCs took these two factors into account and undertook a conciliatory and consensus-building approach to identified issues rather than a confrontational one – improving relations towards problem-solving.

The extent to which both community members and service providers understood the CsC was a non-confrontational evaluation to find solutions and not an evaluation to criticise and ascribe blame to particular individuals/services was noted by a large majority of our interviewees as being a key element in the outcomes, particularly in the Isaro governance initiative. The reasons for this are two-fold.

First, a major challenge noted by the community facilitators involved in the Isaro governance initiative processes was the initial reticence of local authorities and service providers to be evaluated by a less educated rural peasantry. This is understandable in the Rwandan local service delivery arena. However, the focus on feedback helped mitigate their concerns, and many reported that they felt the process had opened up a 'safe' arena for dialogue and was a good opportunity for them to know what the population thought of them, crucially without the involvement of the state.

Second, given the deferential nature of the Rwandan community *vis-à-vis* local leadership as well as the cultural context, confrontational engagement with service providers would have discouraged community members from participating. Beforehand, community members were scared of sharing information with local leaders and afraid of challenging service providers, but the CsC provided a space in which community members were able to raise issues – and the fact that many of them have been resolved has increased trust in this area.

On a general level, then, the political will to address GBV and a state that has the capacity to ensure local service providers and local authorities take the process seriously, combined with the meaningful participation of local community members and women who have been encouraged to speak out, have enabled the scorecard to make progress in enhancing women's voice and influence in Rwanda. In particular, rapid behavioural change, which has altered gendered power structures to give women greater access to control and ownership of household assets, has been critical. However, it is important to recognise that the scorecard process is just one mechanism that has contributed to this change, and it has been able to build on complementary government processes and interventions.

It is also important to note that, although women's voice and influence have been improved, this does not mean the change was brought about *because of* women's voice and influence. In Rwanda, women have not lobbied public officials to demand a change to their rights; they have used the scorecard process as a mechanism to ensure public officials preserve and honour the rights they have been told they have. The public information and training component of the scorecard has thus been critical as an instrument for opening up a public forum in which GBV issues can be discussed and in which local people are informed of their rights and obligations in this regard, alongside an awareness of the incentives in place to ensure they are respected (including sanctions). The scorecard process works well in the Rwandan context in bringing about changes within these incentive structures.

4.2 Project implementation strategy

Below we draw attention to key features of the design and implementation of the two CsC processes and their variations, which are important in explaining the observed outcomes and impacts of the scorecard process and how women have experienced these.

The strategy to align the information and sensitisation campaigns of the wider Isaro governance and UA projects with government policy positions and prioritisation of gender and GBV has been a decisive factor behind the outcomes and impacts achieved by the CsC components of the respective projects. In both the Isaro governance initiative and the UA project, **information campaigns and extensive training in GBV** have been key in the process and implementation approach.

The UA project has made a concerted effort to train a large number and breadth of people at the lower decentralised level. This has been extremely helpful in clarifying the law for a number of duty bearers.[6] The large number of people who have received training on the current GBV legal framework in Rwanda and what this means for them in practice have contributed greatly to the

6 For example, civil affairs officers uphold the law at the local level and it is their responsibility to ensure women receive what their marriage contracts legally entitle them to. In addition, information campaigns have been successful in educating local community members through a variety of local participatory institutions.

scale and rapidity of the behavioural changes observed within the context of the UA CsC.

A key element in the UA project CsC approach also has been **its focus on tackling social norms –** for example cultural beliefs around what constitutes GBV. Findings from recent research indicate that efforts to tackle gender inequality through economic empowerment programmes are unlikely to result in a significant increase in power for women, unless they are explicit about tackling harmful sociocultural norms around gender privileges and control (Domingo et al., 2015). The human rights approach of the UA project is explicit about trying to (1) tackle gender inequality through changing social norms and (2) ensure legal entitlements are respected. As a result, the UA project CsC focused heavily on the prevention of GBV. This was in contrast with the Isaro governance initiative CsC, which, although concerned with behavioural change, concentrated its main efforts of enhancing women's agency through their involvement in decision-making processes around the quality of the delivery of GBV services. This affected the implementation approaches of the two CsC with regard to which services and service providers they targeted and how community problems were identified.

The collaboration of CARE staff and implementing partners was important in getting service providers' buy-in. In the Isaro governance initiative process, CARE underlined the objectives of the scorecard and showed that the process was not about evaluating them but about trying to identify how services are provided, and was an opportunity to explain to the community what their rights and obligations were with respect to GBV. In the UA project, Haguruka officially launched the process with the local leaders and introduced them to the CAs.

5. Learning and implications for programming

Below we draw on the findings of this study to draw out what can be learnt from these two projects with respect to the use of CsCs both for CARE Rwanda and for CARE more broadly or other development actors, in particular with regard to GBV.

5.1 Learning for future use of community scorecards in CARE Rwanda programming

The study of the Isaro governance initiative and UA project CsCs clearly highlights that, even under the umbrella of the same programme, scorecard approach implementation can vary significantly in practice. This reflects a number of key elements, including the specific project objectives, the experience of the partners implementing the project and how this shapes their perception of the nature of the problem and the unique strategies they put in place to overcome specific obstacles.

CARE Rwanda's experience with the VWP shows that, in general, the CsC model is not a rigid and one-size-fits-all process but rather acts as a generic flexible guide meant to be adapted to reflect the specific implementation context in which the process is being carried out. The CsC is a process that can help achieve different objectives in line with citizen engagement to support the effective delivery of target developmental outcomes. Hence, the CsC is likely to be heavily shaped and influenced by existing external and operational contexts rather than merely lending itself as a quick fix to issues of poor service delivery.

The Isaro governance initiative and the UA project CsC experience underlines the fact that it not just the national socio-political context that shapes the adaptation of CsC programmes but more importantly the conditions and objectives for which a CsC is being used. Variations in the CsC methodology depend not only on the contextual factors of the operating environment but also on the specific features of the design and implementation of the scorecard approach.

The approach to CSC implementation is also dependent on the pursued objectives of the implementing project. The nature and experience of implementing partners are also important in this respect. For example, in the case of the UA project, the observed adaptations to the CsC process were the result of Haguruka filtering and processing the project objectives through its own human rights approach experience, rather than through a deliberate decision to adapt the process.

This suggests the approach to implementation will affect how target participants experience the CsC and the nature of outcomes and impacts. In the case of the UA project, a rights-based approach has been effective at mobilising communities and encouraging problem-solving to support GBV prevention measures and behavioural change. In the case of the Isaro governance initiative, an approach focusing on the responsiveness of service providers to citizen feedback has been effective at enhancing the quality and performance of service delivery.

The choice of entry points for a scorecard process – the mechanisms and the level at which they are implemented – is also key. This is informed by both the socio-political and operational context and the deliberate choice made by those planning to implement the CsC. In the UA, working through existing local governance structures at the village level has provided an effective forum through which to identify locally salient problems with respect to GBV and promote behaviour change that challenges gendered socio-cultural norms. Meanwhile, working through VSLAs has been effective for the Isaro governance initiative at bringing about change in service provision and improving women's access to financial assets and services critical to well-being. However, in both cases, this required careful engagement and building links with local leaders in communities, as well as within local state and service provision institutions.

In Rwanda's context, the features of how the Isaro governance initiative and the UA project scorecards were implemented, given their approaches, were well tailored to achieving effective change. The implementation approaches were shaped to take into account the prevailing socio-political and operational contexts and were in line with their target objectives. Seeking buy-in from local officials, community leaders and service providers (crucial in the Rwanda civil society arena), adopting a

non-confrontational approach, aligning with national targets and priorities and linking to existing mechanisms for national dialogue were key factors in improving engagements and outcomes. This points to the need to clearly define the target (sought) objectives when planning to incorporate a CsC mechanism into a programme.

5.2 Learning from the CARE Rwanda Vulnerable Women's Programme community scorecard experience

The following may be relevant to CARE programmes or other development stakeholders who may want to use the CsC to address the issue of women' voice, agency and influence in local governance and service delivery:

- The CsC is not a one-size-fits-all solution to improving developmental outcomes. Rather, it needs to be applied as a flexible tool that can and should be adapted to the distinct contextual and operational environment in which it is implemented and based on the objectives and changes it intends to produce.
- The specific objective of a project will shape the design and implementation approach of a CsC initiative.
- Entry points and their mechanisms are key when implementing a CsC. Decisions on these need to be considered carefully against the project objectives and the broader context.
- The operational conditions of a CsC are critical and will affect programming implications. The background and approach of implementing partners will help with filtering and processing the project objectives, adapting the process even when these decisions are not deliberate.

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