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FINAL REPORT OF THE PROJECT FOR AFRICAN UNION SUPPORT TO THE PREVENTION AND RESPONSE TO SEXUAL VIOLENCE IN THE CENTRAL AFRICAN REPUBLIC

AFRICAN UNION MISAC-CAR, JULY 2015

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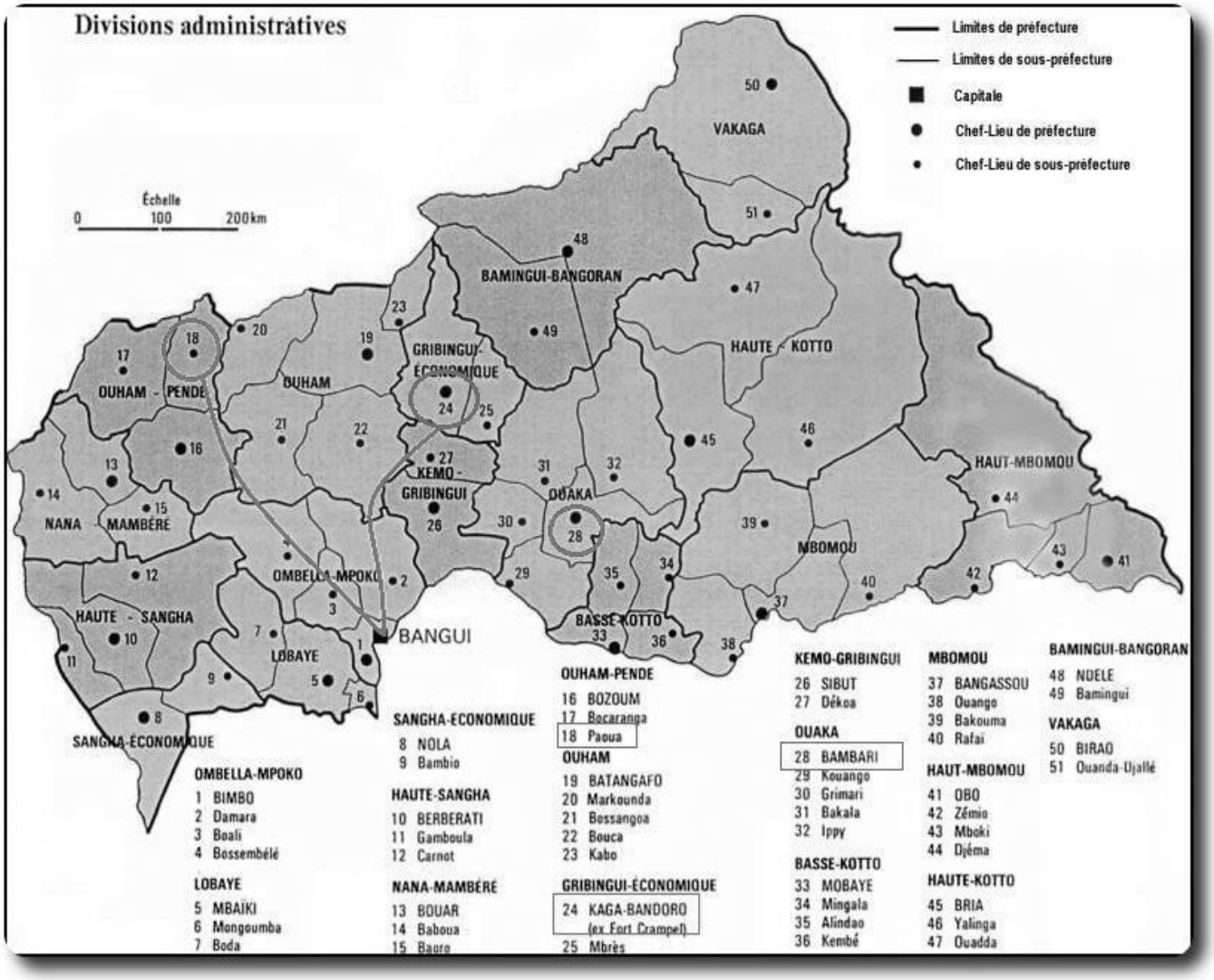


LIST OF ABBREVIATIONS & ACRONYMS

AIDS Acquired Immunodeficiency Syndrome
AMTSL Active Management of the Third Stage of Labour
ARI Acute Respiratory Infection
ARV Anti-retroviral
AU African Union
BCC Communication for Behavioural Change
CAR Central African Republic
CASWME Central African Survey for Welfare Monitoring and Evaluation
CBA Competency-Based Approach
CBO Community Based Organization
CEDAW Convention on the Elimination of all forms of Discrimination Against Women
CEMAC Central African Economic and Monetary Community
CFSVA Comprehensive Food Security and Vulnerability Analysis
CRC Convention on the Rights of the Child
DDR Disarmament, Demobilization and Reintegration
DHS Demographic Health Survey
DOT Directly Observed Therapy
EFA-FTI Education For All Fast Track Initiative
EHSEP Education and Health Sector Emergency Project
EmONC Emergency Obstetric and Neonatal Care
EPI Expanded Programme on Immunization
ESSP Education Sector Support Programme
EU European Union
GDP Gross Domestic Product
GPHC General Population and Housing Census
HDI Human Development Index
HF Health Facilities
HIMO Highly Labour-Intensive Work
HIPC Heavily Indebted Poor Countries
HIPC Heavily Indebted Poor Countries Initiative
HIV Human Immunodeficiency Virus
HLI High Labour Intensive
ICASEES Central African Institute of Statistics, Economic and Social Studies
IEC Information Education Communication
IMCI Integrated Management of Childhood Illnesses
IMR Infant Mortality Rate
IPD Inclusive Political Dialogue
JPN National Youth Pioneers
LB Live Births
LDC Lead Developed Countries
MDA Doctors of Africa

MDGs Millennium Development Goals
MFP Multi-Functional Platform
MICS Multiple Indicator Cluster Survey
MISAC AU Mission for the CAR and Central Africa
MISCA African-led International Support Mission in the Central African Republic
NACC National AIDS Control Committee
NAPA National Adaptation Programme of Action
NER (Primary Education) Net Enrolment Rate
NESDP National Education Sector Development Policy
NESS National Education Sector Strategy
NGO Non-Governmental Organisation
ODA Official Development Assistance
OVC Children Orphaned and Made Vulnerable by HIV/AIDS
PALU Pan African Lawyers Union
PEP HIV Post-Exposure Prophylaxis
PMTCT Prevention of Mother-to-Child Transmission of HIV/AIDS
PNC Prenatal Consultation
PoNC Postnatal Consultation
PRGF Poverty Reduction and Growth Facility
PRSP Poverty Reduction Strategy Paper
PSW Psychosocial Workers
RECO Community Relays
RESEN National Education System Evaluation Report
RECO Community Relays
RESEN National Education System Evaluation Report
RUECA Census of Economic Units in the Central African Republic
SGBV Sexual and Gender-Based Violence
SGBV Sexual and Gender-Based Violence
SLCRA Survey on Living Conditions in Rural Areas
SLCUA Survey on Living Conditions in Urban Areas
SPFS Special Programme for Food Security
SRH Sexual and Reproductive Health

TCP Self-Employed

UNDP United Nations Development Programme

UNFPA United Nations Population Fund

UNGASS United Nation General Assembly Special Session

UNHCR Office of the United Nations High Commissioner for Refugees

UNICEF United Nations Children's Fund

UNS United Nations System

VSV Victims of Sexual Violence

VTC Voluntary Testing Centre

WHO World Health Organisation

WFP World Food Programme

1. CONTEXT OF INTERVENTION & PRESENTATION OF PROJECT

Since the tragic events of 2013, the Central African Republic (CAR) has continued to suffer from the consequences of the complex crisis. Among other things, the state of decay of national infrastructure, the weak redeployment of the State and its deconcentrated and decentralized services in the provinces, the disintegration of social cohesion and the socio-economic fabric, continue to impact negatively on the welfare of the Central African people, particularly that of women and girls. Although there has been a relative improvement in the security situation in the territory as a whole, which has facilitated the partial return of displaced persons, it is still precarious and rather volatile. In fact, the opposing forces, the «ex-Seleka» and the «Antibalaka» militia, despite having signed, under the auspices of the international community, an «agreement on the cessation of hostilities», remain heavily armed and their continued massive presence across the country perpetuates the «virtual» partition of the territory of the Central African Republic.

Concerning the issues of gender-based violence, in addition to pre-existing and chronic gender disparities in the CAR, the crisis has increased «gender specific» vulnerabilities.

The vulnerabilities concern, among other things, issues involving physical security, education, reproductive health, nutrition, food insecurity, unequal access to economic opportunities, gender-based violence, etc. The gender disparities are increased by the aphasia of the decaying Central African State institutions. In a post-conflict context like that prevailing in the CAR, the dependency and lack of socio-economic prospects of women and girls, increases their vulnerability and exposes them to sexual violence, physical abuse, forced marriages, sexual servitude, and other forms of gender-based violence. The destruction of means of subsistence and limited mobility due to insecurity has resulted in negative coping mechanisms such as paid sex and occasional prostitution, adopted particularly by women and girls. It has also resulted in another phenomenon, namely, the pervasiveness of sexual violence against women and girls, which is still and continues to be one of the most important gender issues in terms of negative impacts on this segment of the population of the CAR. It is against this backdrop that the Project *«African Union Support to the Prevention and Response to Sexual Violence in the Central African Republic»* was implemented.

1.1. Project Description

The Project entitled «African Union Support to the Prevention and Response to Sexual Violence in the Central African Republic» aims at providing support to victims of sexual violence. Against the background of deficiencies in State authority and action, the Project is geared towards providing assistance and protection to victims of sexual violence (the majority of whom are women and children) through: (i) medical, psycho-

social and legal support – (ii) building existing national capacities in these three areas – (iii) supporting communities to develop mechanisms to prevent and respond to sexual violence. The Project is an innovative initiative of the AU, due mainly to contracting with exclusively African institutions, namely, the NGO « *Doctors of Africa*» for the medical, psycho-social care and community resilience aspects, and «*Pan African Lawyers Union*» for the legal aspects, but also providing assistance to the Mission for the institutional support aspects, as well as support for the reactivation of the judiciary and criminal justice system in the CAR, particularly concerning the legal response to cases of sexual violence.

1.1.1 Principal Project Strategies and Activities

They are as follows:

- ➔ Deployment in the CAR of a pool of African experts specializing in providing care and support to victims of sexual violence;
- ➔ Building of a specialized health centre in Kaga Bandoro (and rehabilitation of the Paoua health centre;
- ➔ Provision of specific medical consumables and supplies for the care of victims of sexual violence (HIV Post-Exposure Prophylaxis Kit, ARV drugs, molecular tests for sexually transmitted infections, etc.);
- ➔ Direct support (medical, psycho-social, legal and socio-economic) to victims of sexual violence;
- ➔ Strengthening community resilience to prevent and respond to sexual violence;
- ➔ Development of a network of community relays to monitor the reintegration of victims.

1.1.2 Strategic Approach of the Project

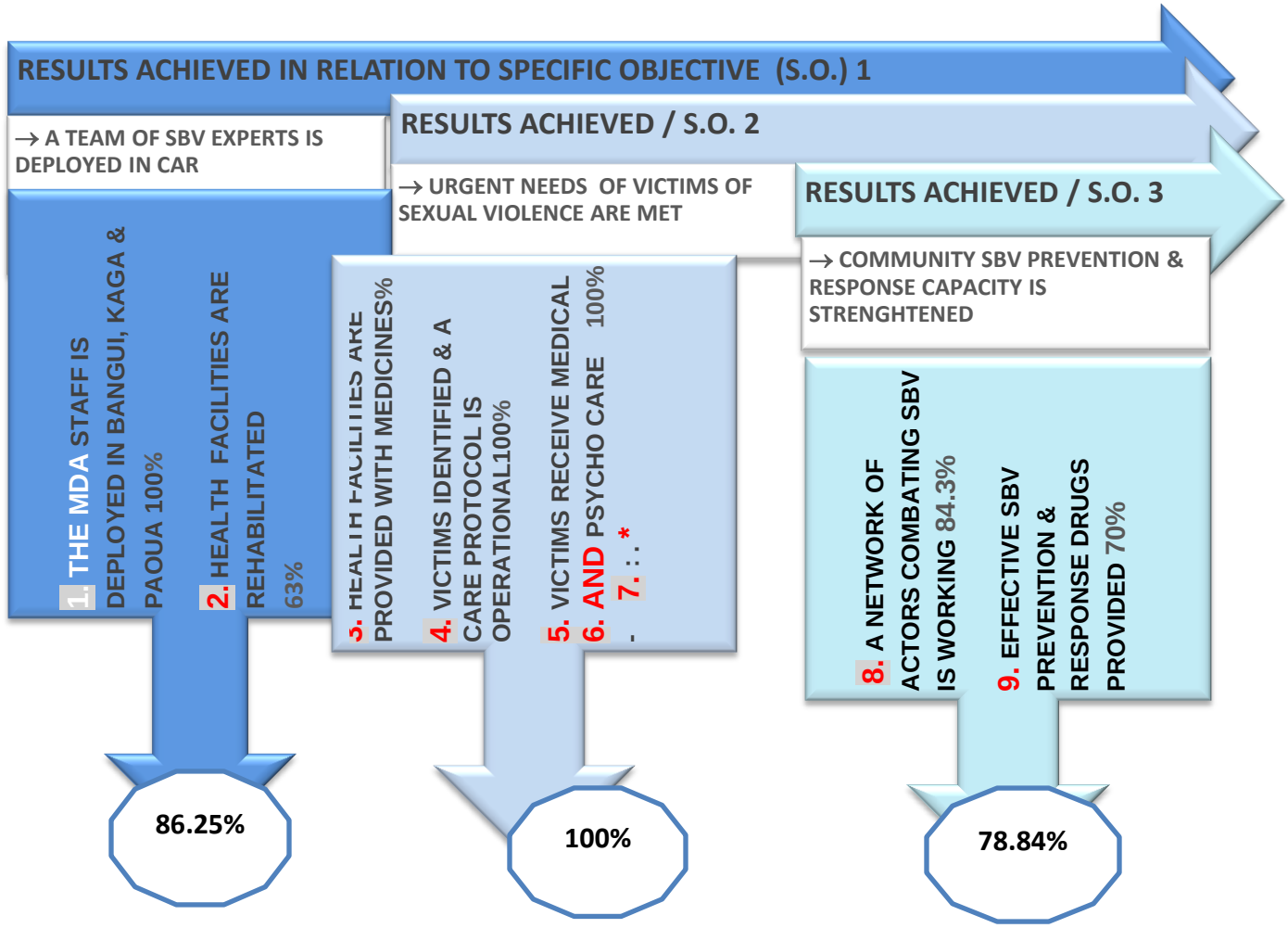
The Project adopts the «develop, manage and transfer» approach. Within a context of weak national institutions, it aims at substantially building national capacities through their inclusion in all stages of project implementation (formulation, implementation and management). National ownership would therefore be ideal during the transfer of prerogatives at the end of the project, which is to run initially for six (6) months (eventually renewable based on the good performance of the Project).

After a six (6) months implementation period from December 2014 to June 2015, this End of Activity Report aims at highlighting the results obtained in correlation with those initially expected from the Project.

2. RESULTS ACHIEVED IN RELATION TO PROJECT EXPECTED OBJECTIVES

The main objective of the support project to provide care and response to sexually based violence (SBV) in CAR consisted in taking direct care of 1000 (one thousand) victims of sexual violence. To contribute to achieving this primary objective, the following three (3) specific objectives were outlined: **(i) deployment of international and national expertise on SBV in three (3) CAR prefectures; (ii) response to the urgent needs of victims of SBV; and (iii) building the capacity of communities in the prevention and response to SBV**. A total of nine (9) strategies were developed for the three (3) specific objectives. These nine strategies were broken down into field activities (see table of activities in Appendix) that were conducted (in Bangui, Kaga Bandoro and Paoua) over a period of six (6) months or a total of nineteen (19) weeks. The graphic chart below highlights the results obtained by specific objective. Performance indicators (completion rate) measuring the respective levels are here expressed as a percentage (%).

Graphic chart No. 1



As can be seen, the completion rates for the various activities planned under the project (over a period of six (6) months) are relatively high, ranging from 63% to 100%. The activities carried out exhaustively (100%) are those falling under strategies: **1** *"Deployment of a team of experts from the NGO MDA in Bangui, Kaga Bandoro and Paoua";* **3** *"Provision of health facilities with medicines and medical consumables";* **4** *"Identification of victims of sexual violence and establishment of a care protocol";* **5** "*Medical care for victims of sexual violence*"; and **6** "*Psychological care for the victims*".

Despite the high completion rates, certain activities were not completely carried out. Such activities were related to:

- **Strategy 2** *"Rehabilitation of health facilities"* which was implemented up to **63%**. In fact although most health facilities (in Bangui, Kaga Bandoro and Paoua) where victims were treated were rehabilitated to improve functionality and hygiene in the premises, construction work at Kaga Bandoro Health Centre and the rehabilitation of Paoua Health Centre could not be executed. However, certain processes relating to these activities were completed; they include the open invitation to tender (particularly through the publication of calls for submission in three (3) CAR national dailies), receipt of application files, rating of files and finally the selection (by a commission composed of the Jurist, Gender Adviser, Head of Administration at MISAC, Logistics Officer and Accountant of the NGO MDA, and an independent external expert). A company was selected to construct the Kaga Bandoro Health Centre (see award report in annex). The award report was sent to the headquarters of the African Union in Addis Ababa for approval. Regarding the rehabilitation of Paoua Health Centre, no candidate fulfilled the conditions and it was decided not to award the rehabilitation contract to any of the bidders and relaunch a new invitation to tender;

- **Strategy 7** *"Economic empowerment of women".* This empowerment strategy was **planned** in the project, but only for issues related to capacity building rather than direct funding of victims;

- **Strategy 9** *"Establishment of sexual violence prevention and response* **mechanisms**". Of the five (5) activities under this strategy, only the *"establishment of a reference and counter reference system for victims"* was partially completed to the tune of fifty percent (50%). Although the reference and counter reference system established by MDA remains effective so far (particularly through listening units and health workers mobilized by the project), the *sustainability* of such a system over a limited period of six (6) months will be difficult. In a context of decline of the State in the Central African Republic and collapse of its health system, the deployment of such a system obviously requires much more time.

2.1 RESULTS ACHIEVED UNDER STRATEGIC OBJECTIVE 1: "DEPLOYMENT OF A TEAM OF SGBV EXPERTS IN BANGUI, KAGA BANDORO AND PAOUA"

The achievement of this objective revolved around the following two (2) strategies: deployment of staff of the NGO Doctors of Africa (MDA) and rehabilitation of health facilities.

2.1.1 INSTALLATION OF A POOL OF EXPERTS IN SGBV CARE

The project enabled the deployment and provision of international experts composed of members of the NGO Doctors of Africa/*Médecins d'Afrique* (MDA) and the construction of three (3) "intervention bases" in the capital Bangui, in the town of Kaga Bandoro (Centre, in Nana Gribizi Prefecture) and finally in the town of Paoua (North-West, in Ouham Pende Prefecture). As shown in the table below, apart from the administrative, financial and logistics staff, the NGO MDA deployed a pool of dozens of medical and paramedical experts specialized in management and response to sexual and gender-based violence.

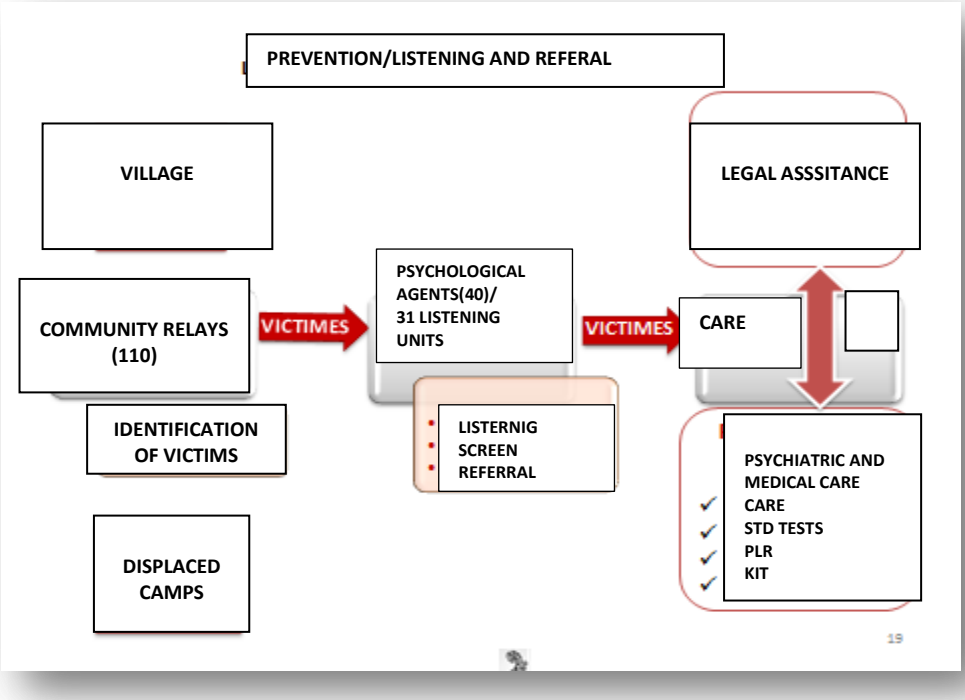
Table 1: Distribution of Human Resources Recruited for the Project

TYPE OF HUMAN RESOURCES	BANGUI # PLAYERS	KAGA BANDORO # PLAYERS	PAOUA # PLAYERS	TOTAL
⇨ State Doctors at	2	-	-	2
⇨ State Doctors at	8	-	-	8
⇨ MDA Doctors at	2	-	-	2
⇨ MDA Doctors at	2	1	1	4
⇨ State Midwives	14	1	-	15
⇨ MDA Midwives	-	1	1	2
⇨ State Nurses	14	1	1	16
⇨ MDA Nurses	-	1	-	1
⇨ MDA Psychologists at	2	1	1	4
⇨ Mission Head	1	-	-	1
⇨ Focal Point	1	-	-	1
⇨ Project Coordinator	1	-	-	1
⇨ Financial Officer	1	-	-	1
⇨ Assistant Financial Officer	1	-	-	1
⇨ Logistic Officer	1	-	-	1
⇨ Assistant Logistic	1	-	-	1
⇨ Assistant Administrative &	1	1	1	3
⇨ Secretary Accountant	1	0	0	1
⇨ Driver	3	0	0	3
⇨ Guards	6	2	2	10
⇨ Maintenance staff	2	1	1	4
TOTAL				82

In addition to MDA human resources, ten (10) State doctors, fifteen (15) State midwives and sixteen (16) State nurses from CAR were recruited for the project after receiving capacity building in specific SGBV treatment. Beyond the additional human resources, the advantage of this strategic approach lies in the transfer of skills which will benefit the national human resources in favour of victims. This is a demonstrated added value in terms of national ownership and sustainability of the response to sexual violence in CAR. Overall, it means a total of eighty-two (82) professionals who were mobilized during this first phase of the project on the prevention and response to sexual violence in CAR.

2.1.2 ESTABLISHMENT OF A PILOT MODEL FOR THE PROMOTION, IDENTIFICATION AND REFERRAL OF VICTIMS

This pilot model consisted in creating a dense network of listening units within the various sub-prefectural councils, health facilities and displaced person sites in project intervention areas. This gave a total of thirty-one (31) listening units that were operational during the project. Given the shortage of psychologists in CAR, MDA decided to recruit and train forty (40) psycho-social workers (PSW) and one hundred and ten (110) community relays (CORE) who will be responsible for facilitating and running the listening units. As shown in the diagram below, the principle of intervention will be the devolution of community promotion and awareness activities to CORE. Listening, counselling, screening and possibly (medical) referral of victims will devolve upon the PSW found in the listening units.

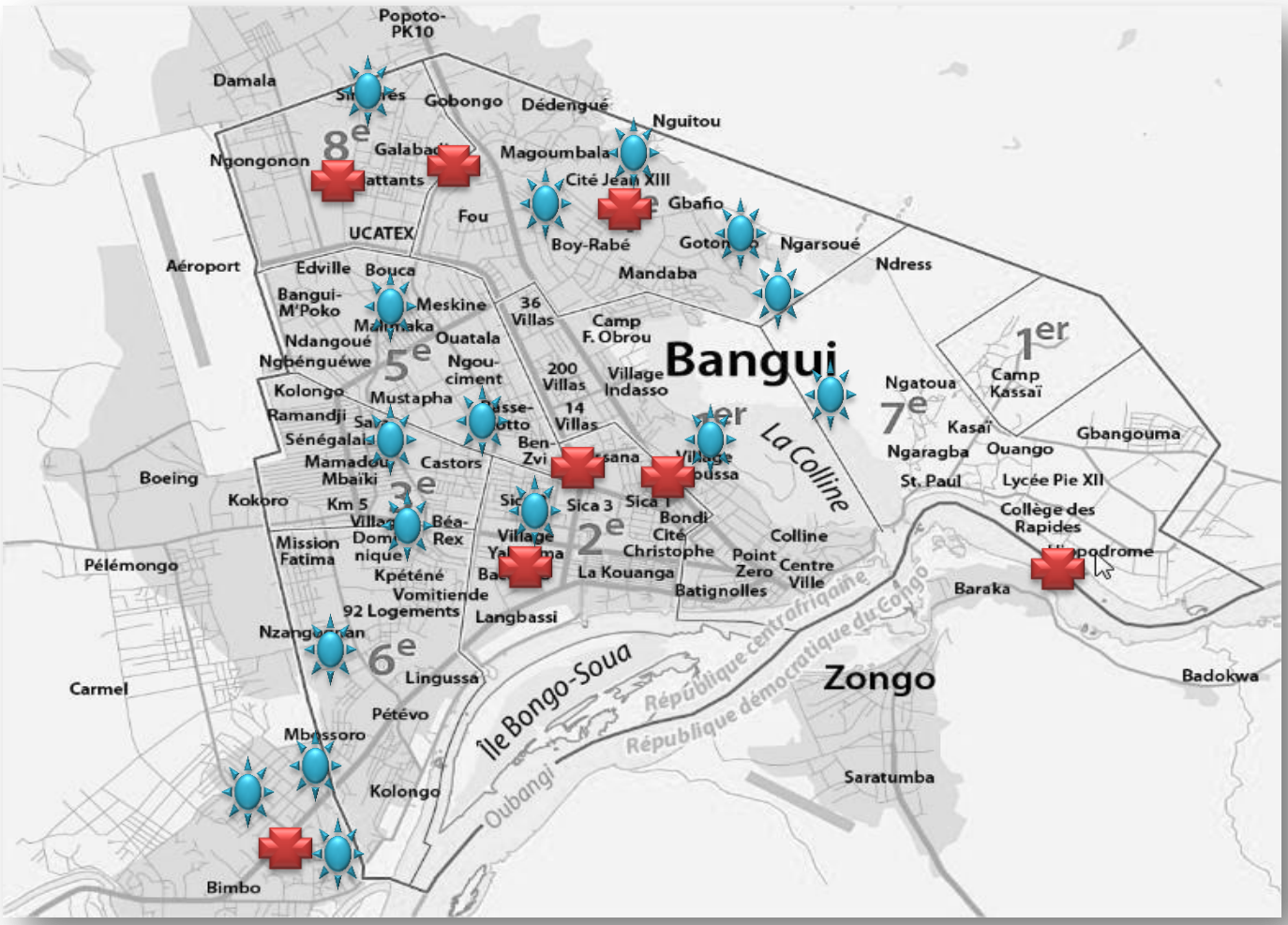


2.1.3 ESTABLISHMENT OF A NETWORK OF LISTENING UNITS AND HEALTH FACILITIES FOR RESPONSE TO SGBV

In all, thirty-one (31) listening units and ten (10) health facilities were operational for the response to victims of sexual violence in the cities of Bangui, Kaga Bandoro and Paoua.

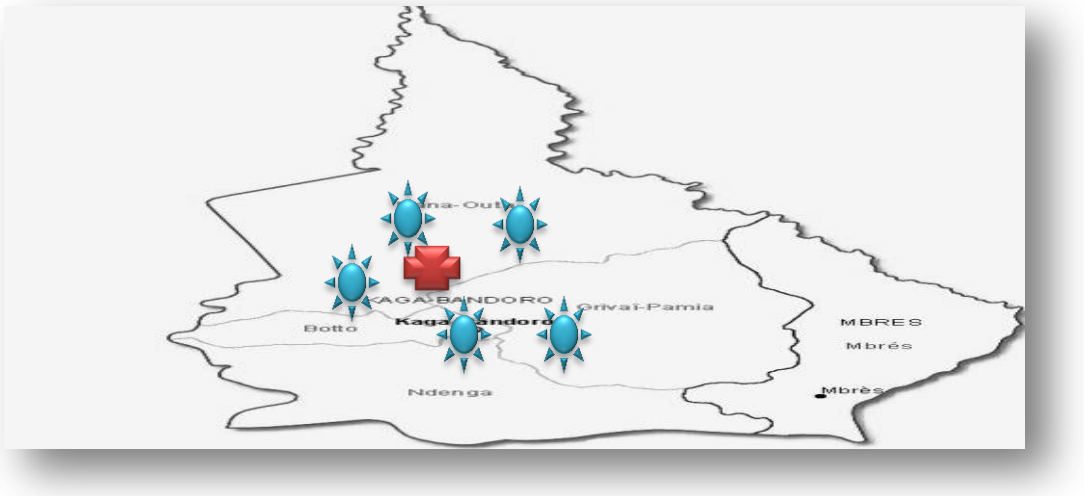
(i) In Bangui, they were distributed as follows: eight (8) listening units in the eight (8) sub-prefectures of the capital, six (6) units in different internally displaced person sites (Fateb, Castor, Benz-vi, Votobo, Capuchin, Maison Micheline, Eglise St Antoine de Padoue) and one (1) unit in Bimbo (a commune adjoining the capital, Bangui). So for Bangui, that gives a total of sixteen (16) listening units, managed by twenty (20) PSW and forty-five (45) CORE who were active. There were a further forty-four (44) medical and paramedical professionals in Bangui, working in eight (8) health facilities to provide medical and psychological care for victims of sexual violence.

Map N 1: Network of SGBV Listening Units and Health Facilities in Bangui



(ii) At Kaga Bandoro in Nana Gribizi Prefecture (centre of the country), the network consisted of five (5) listening units managed by ten (10) PSW and thirty-five (35) CORE who were active at the “height” of the project. Pending the construction of the Kaga Bandoro Health Centre, MDA signed a partnership agreement with the Urban Health Centre (UHS) of the city. There were a total of five (5) medical and paramedical professionals who provided care for victims of SGBV in Kaga Bandoro.

Map N 2: Network of SGBV Listening Units and Health Facilities in Kaga Bandoro



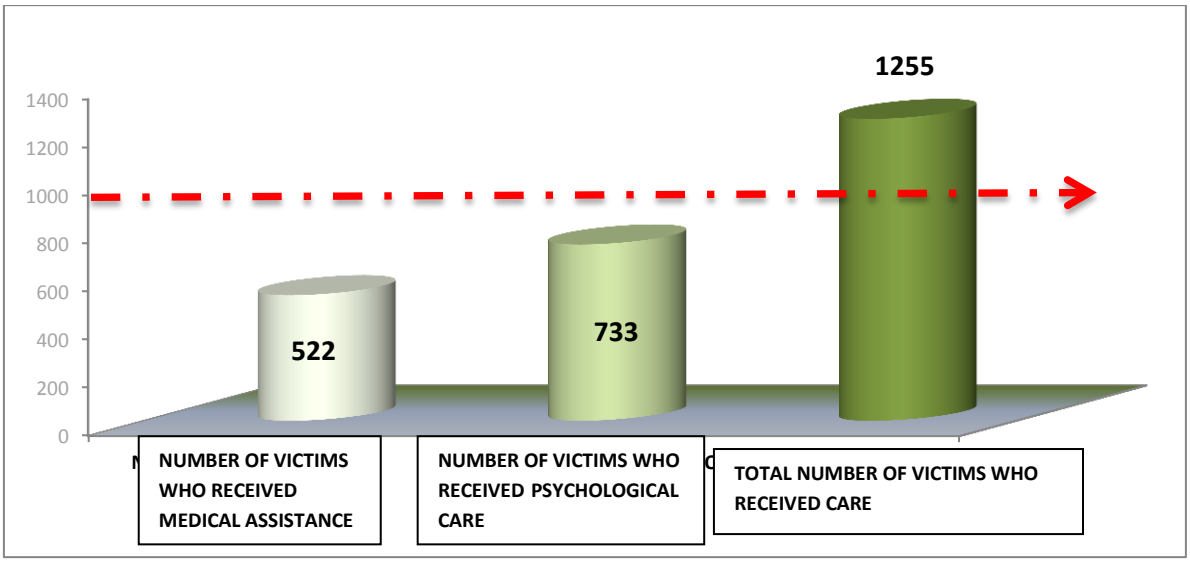
(iii) Finally, in the city of Paoua located in Ouham Pende Prefecture (North-western CAR), there were ten (10) listening units, with ten (10) PSW and thirty-five (35) CORE who were recruited, trained and paid to run the said units. A total of three (3) medical and paramedical professionals also provided medical and/or psychological care for victims in Paoua and neighbouring localities.

Map N 3: Network of SGBV Listening Units and Health Facilities in Paoua

2.2 RESULTS ACHIEVED IN RELATION TO STRATEGIC OBJECTIVE 2: "MEETING THE URGENT NEEDS OF VICTIMS OF SEXUAL VIOLENCE"

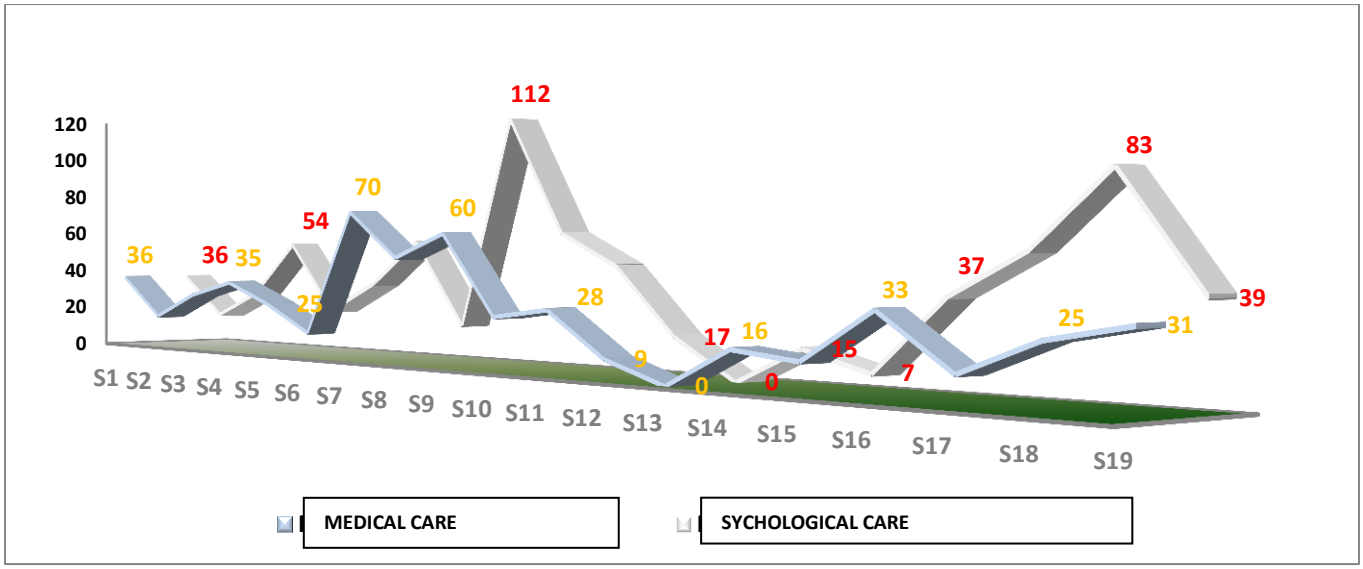
The initial objective sought by the project to take care of one thousand (1000) victims of sexual violence has been fulfilled and exceeded, as illustrated by the graph below. A total of one thousand two hundred and fifty five (1,255) victims benefited from medical and/or psychological care during the six (6) months of intervention by the implementing partner MDA in ten (10) health facilities in Bangui, Kaga Bandoro and Paoua. In this respect, the strategies implemented were cascaded and consisted in:

- Providing health facilities with specific medicines and medical consumables for the care (initially) of one thousand (1000) victims of sexual violence. These included, among others, prophylactic molecules, HIV post-exposure prophylaxis kits, testing for HIV/STI, etc. These supplies were provided through purchases by MDA as well as grants from UNFPA;
- Establishing a victim identification mechanism and implementing victim care protocols. The care protocols were defined by the team of MDA experts, and take into account the experience of MDA, the environment, the specificity of targets as well as all the realities and constraints of the context which were understood in order to have standardized protocols. Community relays and psychosocial workers were mainly responsible for identifying victims, sorting them according to the type of vulnerability and referring them (for medical and/or psychological care);
- Finally, actually providing medical and/or psychological care to victims previously identified or who spontaneously reported at project health facilities.

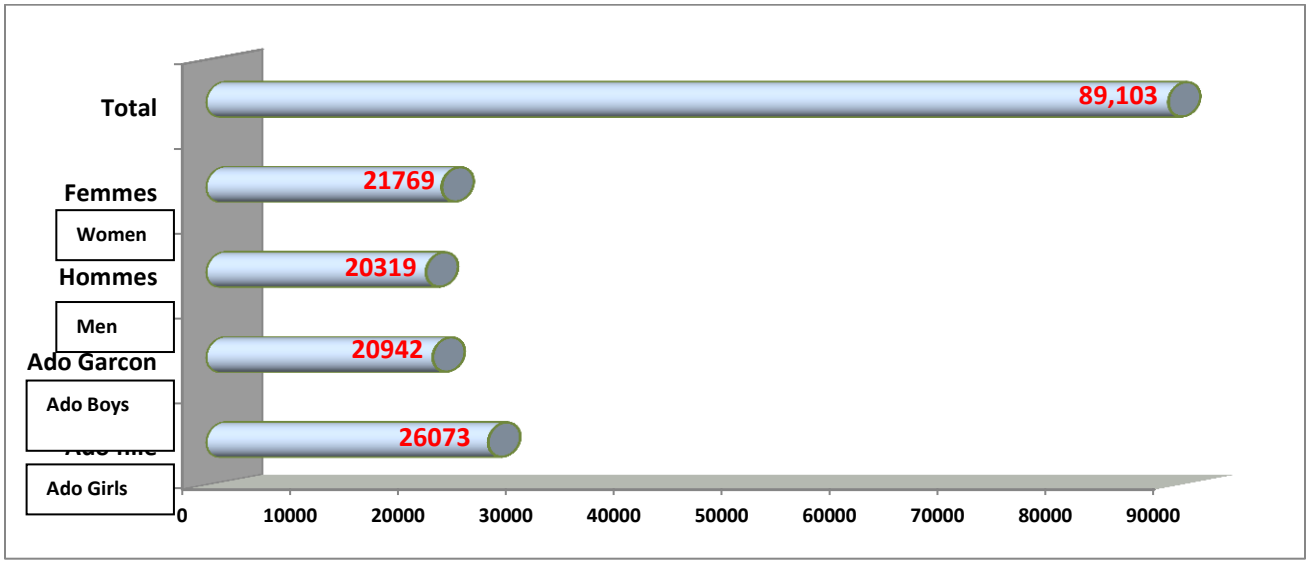


Indeed, **one thousand two hundred and fifty-five (1255)** victims received medical and/or psychological care during the nineteen (19) weeks of the project. The curves in

the following graph show that the actual number of victims who received care fluctuated from week to week. The "peaks" for psychological and medical care for victims were registered between the seventh and eleventh week of project implementation. These weeks mark the paroxysmal phase of victim care, and correspond approximately to the median period of total project duration. It can be deduced that this was the stage at which the project outreach activities had their maximum impact within communities in general and with victims specifically.

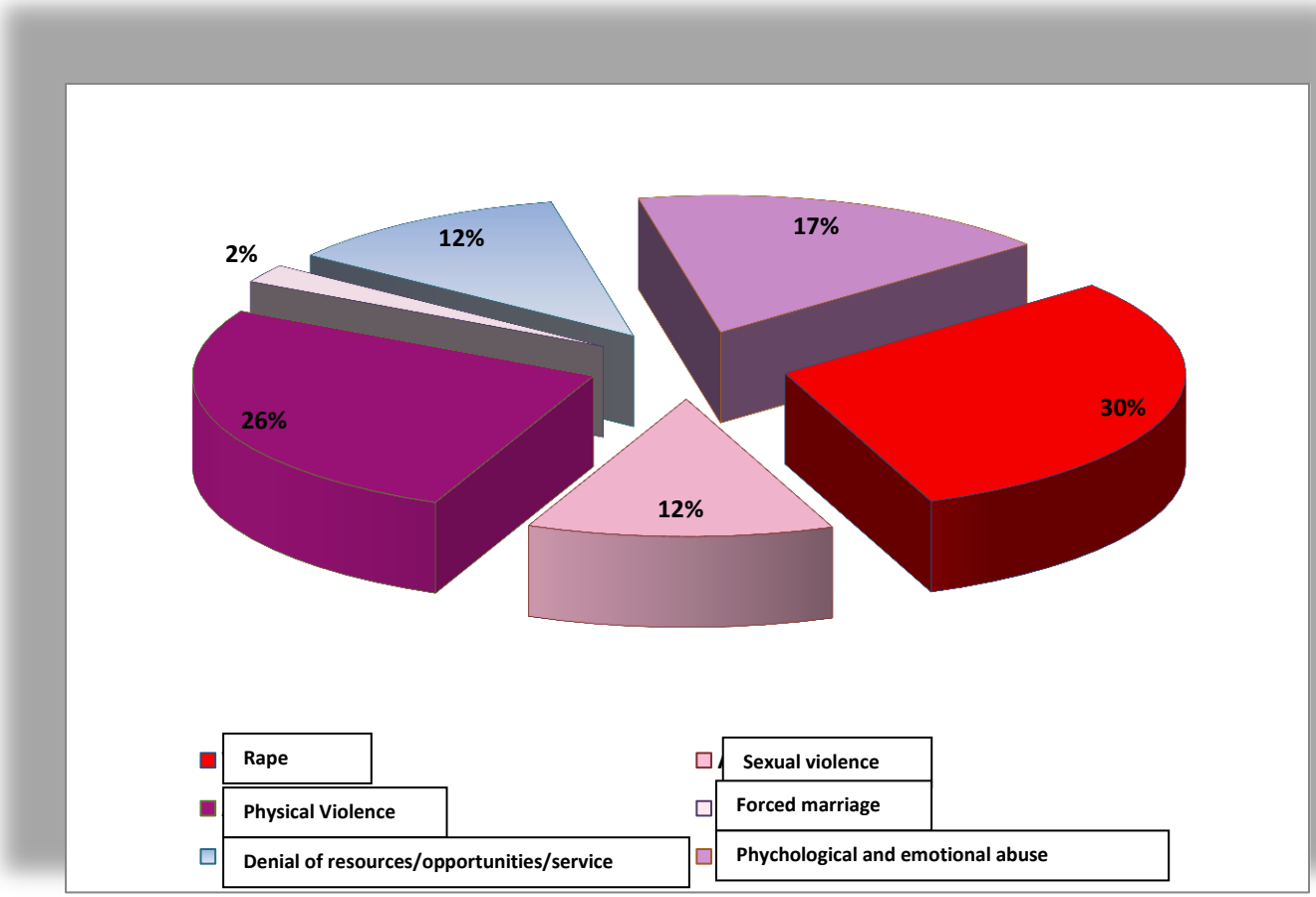


Concurrently with these direct care activities, a total of eighty-nine thousand one hundred and three people (89 103) were made aware of the issue of care and community response to SGBV. This number is broken as follows:



It can be noted that the "teenage girls" category represents the largest cohort of people made aware, followed by that of "women".

Lastly, three thousand five hundred and thirty-eight (3538) people were directly received and "listened to" by PSW at the 31 listening units in Bangui, Kaga Bandoro and Paoua. As shown in the chart below, the issues raised by the people received range respectively, in order of occurrence, from cases of rape, physical assault and psychological abuse to denial of resources. Although cases of forced union are residual compared to the previous themes discussed, they however represent two percent (2%) of the total issues raised by the 3538 persons received in the listening units.



2.3 RESULTS ACHIEVED IN RELATION TO STRATEGIC OBJECTIVE 3: "CAPACITY BUILDING OF COMMUNITIES IN THE PREVENTION AND RESPONSE TO SGBV"

2.3.1 Strategy 8: Establishment of a Network of Actors to Combat Sexual and Gender-Based Violence

This strategy was mainly structured around the following activities: mapping and institutional audit of NGOs and CBOs in target prefectures and Bangui - identification of health facilities involved in the care of SGBV victims – production of a directory of SGBV actors in the localities - fostering of exchange and dialogue between organizations of the network and local authorities - strengthening of the system of collecting data on

sexual violence followed by the collection of data on SGBV in health intervention areas. Finally, this strategy relating to the establishment of a network of actors to combat sexual and gender-based violence focused on strengthening the capacity of national NGOs involved in the fight against SGBV and validating a protocol on the provision of medical care for SGBV, especially by organising participatory and inclusive workshops. Accordingly, a total of four hundred and thirty six (436) people received capacity building in various topics relating to response to sexual violence (see table below).

Table 1: Number of National Human Resources Trained Through the Project

TARGETS	SITES	#
* COMMUITY RELAYS	➢ Bangui	84
	➢ Paoua	35
	➢ Kaga Bandoro	35
* PSYCHOSOCIAL WORKERS	➢ Bangui	12
	➢ Paoua	10
	➢ Kaga Bandoro	10
* CARE PROVIDERS	➢ Bangui	25
	➢ Paoua	5
	➢ Kaga Bandoro	10
* FINANCIAL AND LOGISTIC MANAGEMENT OF	➢ Bangui	25
* LOCAL NGOs	➢ Bangui	185
⇨ **TOTAL NUMBER OF PEOPLE TRAINED**		**436**

2.3.2 Strategy 9: Implementation of SGBV prevention and response mechanisms

Apart from activities concerning recruitment and training of RECOs and PSWs (on preventing SGBV, trauma-counselling, listening to and referral of victims as well as on reconciliation) and paying their monthly remuneration, other major events under the implementation of this strategy included: *the establishment of a network of thirty-one (31) listening and referral units for victims of SGBV* (as described above), as well as *the establishment of a referral/counter-referral system for SGBV victims*. This system proved effective as a result of the participation of some ten health facilities, as shown in the table below.

Table 2 Health facilities participating in the VSV referral /counter-referral system

LOCATION	HEALTH FACILITY	#
* BIMBO COMMUNE	➢ *HOPITAL MAMAN ELISABETH* IN BIMBO	1
* OUANGO COMMUNE	➢ OUANGO URBAN HEALTH CENTRE	1
* BANGUI	➢ *COMPLEXE PEDIATRIQUE*	1
	➢ *HOPITAL DE L'AMITIE*	1
	➢ BOYE RABE URBAN HEALTH CENTRE	1
	➢ BEDE COMBATTANT URBAN HEALTH CENTRE	1
	➢ LAKOUANGA URBAN HEALTH CENTRE	1
	➢ CNSS URBAN HEALTH CENTRE	1
* LOUHAM PENDE PREFECTURE	➢ PAOUA URBAN HEALTH CENTRE	1
* NANA GRIBIZI PREFECTURE	➢ KAGA BAMBORO URBAN HEALTH CENTRE	1
⇨ **TOTAL NO. OF PARTICIPATING HEALTH CENTRES**		**10**

2.3.1 Partnership and contribution to consultation and coordination frameworks

Lastly, the good results and the positive indicators shown by the project have been the outcome of partnerships with various institutions that contributed to providing the response to VSV in the CAR. These partnerships were developed with a view to ensuring better coordination and synergy of actions among partners involved, namely, State actors, agencies of the United Nations system, international NGOs, as well as Central African associations and NGOs. These partnerships were formalized by signed agreements or MoUs.

Table 3 List of partnership arrangements and consultation frameworks

PROJECT PARTNERS	PARTNERSHIP STRATEGY
* MINISTRY OF HEALTH (CENTRAL & PERIPHERAL LEVELS) * MINISTRY OF SOCIAL AFFAIRS * MINISTRY OF JUSTICE * UNFPA * UNHCR * WHO * OCHA * VARIOUS CLUSTERS (Gender - SGBV – Health – Protection …) * NATIONAL NGOs * *ASSOCIATION DES FEMMES JURISTS CENTRAFRICAINES*	⇨ Establishment of a multi-stakeholder partnerships involving key stakeholders ⇨ Communication plan and identification of strategic partners; ⇨ Organisation of multi-stakeholder discussion meetings; ⇨ Coordination to ensure more synergies in actions with partners; ⇨ Each partnership formalized by MoU or agreement

3 SWOT ANALYSIS FOR SIX (6) MONTHS EXECUTION OF THE SGBV PROJECT

The matrix below highlights the *strengths, weaknesses, opportunities and threats* relating to the support project for the prevention and response to sexual violence which was implemented over a period of six (6) months in the localities of Bangui, Kagga Bandoro and Paoua. The strengths and weaknesses identified are endogenous to the project, while the opportunities and threats relate to the milieu and to factors outside the project.

SWOT Analysis

STRENGHTS	***WEAKNESSES***
▪ Mobilization, commitment & structuring of actors providing the response to SGBV ▪ Existence of a pilot and efficient model for detection, raising awareness, referral and counter-referral of SGBV victims ▪ Institutional audit of national NGOs conducted ▪ National human resource capacities enhanced for managing SGBV cases ▪ Existence of CAR-specific protocol for managing SGBV cases, ▪ Commitment and presence of proven pan-African expertise (MDA, PALU) for providing response to SGBV	▪ Limited zone and response time ▪ Incomplete execution of planned activities ▪ Absence of productive system which gives room for women's empowerment ▪ Insufficient human resources, health infrastructure, education, roads ▪ CAR's Family Code still lopsided ▪ Specific needs of women and girls not taken into account ▪ Failed health system, as well as the judicial and penal chain ▪ Collapse of Central African State authority, whole swathes of territory wherein the administration and rule of law are absent
OPPORTUNITIES	***THREATS***
▪ Existence of *SNEEP/IPNEEP*[i] ▪ Existence of roadmap on Bangui Forum "Gender" recommendations ▪ Improved response to GBV with several actors in the CAR ▪ AU support through establishment of an office in the CAR, provision of a Gender Adviser and mobilisation of substantial financial resources for the response to SGBV ▪ AU support to Central African Government ▪ Commitment and support from project donors	▪ Insufficient financial resources. ▪ Failure to abide by recommendations of the Bangui Forum and the "Gender" roadmap ▪ Non-compliance with UN Resolution 1325 on women's inclusion in post-conflict reconstruction processes. ▪ Resurgence of the crisis following failed electoral and DDR[ii] processes ▪ Impunity for perpetrators of gender-based abuses ▪ Proliferation of weapons and armed groups that abuse women ▪ Persistence of camps for displaced persons and refugees in the CAR and neighbouring countries, ▪ Donor fatigue in the face of repeated crises in CAR

4 SUMMARY OF ACHIEVEMENTS DURING SIX (6) MONTHS OF SGBV PROJECT IMPLEMENTATION

The Project helped to ensure:

- ☑ case management of a total of one thousand two hundred and fifty (1250) victims of sexual and gender-based violence;
- ☑ awareness raising for three thousand five hundred thirty-eight (3538) and eighty-nine thousand one hundred and three (89,103) persons;
- ☑ training and remuneration for forty (40) psychosocial workers (PSWs) and one hundred and fifteen (115) Community Relays (RECOs);
- ☑ establishment of a network of 31 Listening Units in three (3) prefectures of the CAR, and inclusion of sixteen (16) health facilities;
- ☑ capacity building for four hundred and eighty-six (486) nationals in the various themes concerning SGBV response;
- ☑ establishment of pilot model, coupled with one (1) case management protocol that is specific to the CAR; and,
- ☑ initiation of the process of construction and rehabilitation of two (2) health centres in Kaga Bandoro and Paoua, respectively.

Therefore, over a period of six (6) months, the support project for the prevention and response to sexual and gender-based violence which was executed in Bangui, Kaga Bandoro and Paoua fully attained the objectives initially assigned to it.

The expected outcome concerning the case management of one thousand (1000) victims of sexual violence was greatly exceeded. Indeed, a total of one thousand two hundred and fifty (1250) victims were provided medical and/or psychological care by the project. The project achievements listed above are obvious and unanimously recognized by the country's Ministry of Health, as well as by the stakeholders of the various consultation and coordination frameworks, namely, members of clusters on gender, health, sexual and gender-based violence, and the protection of civilians.

4.1 LIMITATIONS OF THE PROJECT

Though the main objective was attained, delays relating to (i) aspects of the construction and rehabilitation of two (2) health centres, and (ii) the legal aspects of case management of victims of sexual violence have significantly dampened expected results. It is regrettable that there were delays on the part of UNFPA-CAR with regard to signing the MoU with MDA, the implementing partner as well as with some aspects of drug supplies, kits, and medical consumables. Finally the limitations of the project are also related to its relatively short execution period of half a year.

5 RECOMMENDATIONS FOR IMPROVING SGBV PROJECT PERFORMANCE IN THE FUTURE

Should the project be renewed, it would be advisable to consider the following recommendations, with a view to improving its performance:

		A :
R.1.	Speed up the construction of the Kaga Bandoro Health Centre;	➔ **AU HQ**
R.2.	Relaunch the bidding procedure for the rehabilitation of Paoua Health Centre;	➔ **AU HQ** ➔ **AU-MISAC**
R.3.	Expedite the intervention of the Pan African Lawyers Union (PALU) in the CAR to meet the legal and judicial needs of victims of sexual violence; and also to contribute to strengthening the judicial and penal chain;	➔ **AU HQ** ➔ **AU-MISAC** ➔ **PALU**
R.4.	Identify strategies which help in understanding and providing response to the issue of SGBV among women from ethnic minorities in the CAR (Aka and Fulani Bororo groups) ;	➔ **MDA** ➔ **AU-MISAC** ➔ **MIN. HEALTH** ➔ **SGBV**
R.5.	Facilitate the financing of activities related to communication and enhancing project visibility, by promoting greater flexibility of action from the MISAC office in Bangui;	➔ **AU HQ**
R.6.	Make provision and budget for income generating activities (IGAs) that can promote the economic empowerment of victims and thereby, facilitating their reintegration;	➔ **AU HQ** ➔ **AU-MISAC** ➔ **MDA**
R.7.	Enhance understanding of and negotiate contract provisions binding MDA to AU, notably, among others, those aspects relating to vehicles, logistics etc.;	➔ **MDA**
R.8.	Improve accountability mechanisms for resources disbursed by MISAC in a bid to ease disbursement and relations with the "Finance" department of MISAC;	➔ **MDA**
R.9.	Rationalize the system for the supply of drug, kits, and medical consumables by (i) speeding up the tax exemptions on imports thereof and (ii) improving cooperation with UNFPA	➔ **MDA** ➔ **AU-MISAC** ➔ **UNFPA**
R.10.	Improving and sustaining the referral and counter-referral system for victims of sexual violence	➔ **MDA** ➔ **MIN. HEALTH**

ANNEXES

ANNEX 1: DISTRIBUTION OF PERSONS LISTENED TO BY TYPE OF ABUSE

TYPES OF ABUSE IN BANGUI (WEEK 1 TO WEEK 19)	DESPLACED PERSONS		RESIDENTS		TOTAL	
	M	F	M	F		
Rape						613
Adults	34	289	21	218	**562**	
Below 18 years	2	18	2	29	**51**	
Sexual assault						251
Adults	7	84	12	112	**215**	
Below 18 years	1	13	3	19	**36**	
Physical assault						537
Adults	123	147	121	101	**492**	
Below 18 years	16	6	4	19	**45**	
Forced marriage						44
Adults	4	12	2	23	**41**	
Below 18 years	0	3	0	0	**3**	
Withdrawal of resources/opportunities/services						237
Adults	55	92	16	56	**219**	
Below 18 years	4	10	3	1	**18**	
Psychological/emotional abuse						349
Adults	17	133	49	131	**330**	
Below 18 years	2	9	3	5	**19**	
Excluding GBV						1507
Adults	37	646	63	401	**1147**	
Below 18 years	4	159	3	194	**360**	
Grand total						3538
Total adult GBV	240	757	221	641	**1859**	
Total youth GBV	25	59	15	73	**172**	
Total GBV	265	816	236	714	**2031**	
Total excluding GBV	41	805	66	595	**1507**	
TOTAL	**306**	**1621**	**302**	**1309**	**3538**	

ANNEX 2: NUMBER OF PERSONS SENSITIZED ON SGBV

WEEK	PERIOD	ADO GIRLS	ADO BOYS	MALES	FEMALES	TOTAL
W1	16 to 22/2	248	62	86	842	**1 238**
W2	23/2 to 1/3	780	592	680	731	**2 783**
W3	2 to 08/3	940	770	450	580	**2 740**
W4	9 to 16/3	1100	655	349	837	**2 941**
W5	17 to 22/3	1717	1266	1695	1140	**5 818**
W6	23 to 29/3	2652	2461	2187	1282	**8 582**
W7	30/3 to 5/4	1863	1427	1971	1338	**6 599**
W8	6 to 12/4	3033	2486	3307	2035	**10 861**
W9	13 to 19/4	3128	2292	2090	3334	**10 844**
W10	20 to 26/4	2010	1894	1419	2128	**7 451**
W11	27/4 to 3/5	2115	1737	1146	1763	**6 761**
W12	4 to 10/5	491	361	396	618	**1 866**
W13	11 to 17/5	283	182	171	344	**980**
W14	18 to 24/5	508	395	403	588	**1 894**
W15	25 to 31/5	459	343	605	371	**1 778**
W16	1 to 7/6	892	764	653	860	**3 169**
W17	8 to 14/5	1207	963	854	1248	**4 272**
W18	15 to 21/5	1529	1348	978	1130	**4 985**
W19	22 to 28/5	1118	944	879	600	**3 541**
TOTAL		**26 073**	**20 942**	**20 319**	**21 769**	**89 103**

ANNEX 3: NUMBER OF VICTIMS PROVIDED WITH MEDICAL AND PSYCHOLOGICAL CARE

WEEK	DATE	LISTENING UNIT	MED CARE	PSY CARE
W1	16 to 22/2	**1152**	36	36
W2	23/2 to 1/3	**281**	16	16
W3	2 to 8/3	**423**	28	28
W4	9 to 16/3	**217**	35	54
W5	17 to 22/3	**171**	25	21
W6	23 to 29/3	**104**	12	35
W7	30/3 to 5/4	**158**	70	56
W8	6 to 12/4	**116**	49	17
W9	13 to 19/4	**194**	60	112
W10	20 to 26/4	**167**	24	60
W11	27/4 to 3/5	**134**	28	46
W12	4 to 10/5	**14**	9	17
W13	11 to 17/5	**12**	0	0
W14	18 to 24/5	**26**	16	15
W15	25 to 31/5	**33**	13	7
W16	1 to 7/6	**82**	33	37
W17	8 to 14/5	**85**	12	54
W18	15 to 21/5	**139**	25	83
W19	22 to 28/5	**30**	31	39
		3 538	522	733

ANNEX 4: TABLE OF ACTIVITIES CONDUCTED BY STRATEGY AND SPECIFIC OBJECTIVE AS WELL AS PERCENTAGE ACHIEVEMENT PER ACTIVITY		
ACTIVITIES	**M 9**	**PERCENTAGE ACHIEVEMENT**
STRATEGIC OBJECTIVE (SO) 1. DEPLOYMENT OF A TEAM OF EXPERTS		
Strategy 1. MDA personnel deployment		
1.1 Deployment of international staff	(M1)	100 %
1.2 Identification strategic partners, establishment of mechanisms for consultation and coordination with partners	(M1)	100 %
1.3 Officialising the administrative framework for intervention	(M1)	100 %
1.3 Officialising the administrative framework for intervention	(M4)	100 %
1.4 Installation of the intervention bases in the 2 target prefectures and in Bangui	(M2-3)	100 %
1.5 Recruitment and deployment of local personnel		
Strategy 2. Rehabilitation of health facilities	(M1)	100 %
2.1 Survey on the state of health structures, quality of health care and needs assessment in the target zones	X	40 % (i)
2.2 Execution of small rehabilitation or construction works on health facilities for enhancing medical care	X	50 % (ii)
SO2. RESPONDING TO URGENT NEEDS OF VICTIMS OF SEXUAL VIOLENCE		
Strategy 3 : Providing health facilities with medicines and kits for medical care for 1000 victims of SGBV		
3.1 Provision of basic medical material, medical kits, emergency care material, specific kits and medicines	X	100 %(iii)
3.2 Supervision of the distribution and consumption of these medicines	X	100 % (iii)
Strategy 4 : Identification of victims of SGBV establishment of management protocols		
4.1 Identification and opening of individual health care files	X	100 %
4.2 Sorting of cases	X	100 %
4.3 Referral of victims (health, psychology, legal, economic assistance)	X	100 %
Strategy 5 : Provision of medical care to victims		
5.1 Identification and training of health personnel on clinical management of sexual violence	X	100 %
5.2 Provision of medical care to victims of SGBV	X	100 %
Strategy 6. Providing psychological care		
6.1 Identifying and functionalizing case management sites	X	100 %
6.2 Mobilising and training professionals to provide assistance to families and individuals (PSWs)	X	100 %
6.3 Psychological counselling of victims	X	100 %
Strategy 7. Economic empowerment		
7.1 Selection of possible IGAs	X	(iv)
7.2 Recruitment trainers	X	(iv)
7.3 Training on IGAs	X	(iv)
7.4 Assistance for socio-economic reintegration	X	(iv)

SO2. RESPONDING TO URGENT NEEDS OF VICTIMS OF SEXUAL VIOLENCE		
Strategy 3 : Providing health facilities with medicines and kits for medical care for 1000 victims of SGBV		
3.1 Provision of basic medical material, medical kits, emergency care material, specific kits and medicines	X	75% (v)
3.2 Supervision of the distribution and consumption of these medicines	(M1)	100%
Strategy 4 : Identification of victims of SGBV establishment of management protocols	(M1)	100%
4.1 Identification and opening of individual health care files	X	100%
4.2 Sorting of cases	X	100%
4.3 Referral of victims (health, psychology, legal, economic assistance)	X	100%
Strategy 5 : Provision of medical care to victims	(M2-3)	100%
Activity 9 : Establishment of SGBV prevention and response mechanisms	X	0 % (vi)
9.1 Mobilisation and training of RECOs on the prevention of SGBV, trauma-counselling, listening and referral of victims and on		
9.2 Establishment of a referral and counter-referral system for victims of SGBV	(M2-3)	100%
9.3 Establishment of a network for listening and referral of victims of SGBV	X	50%
9.4 Awareness raising drives (in schools, places of worship, through posters, radio announcements, door-to-door contacts) on SV,	X	100%
9.5 Organisation of focus group discussions with the participation of RECOs, NGOs and health sector actors	X	100%
Activity 9 : Establishment of SGBV prevention and response mechanisms	X	0 % (vii)

[i] *Stratégie Nationale d'Egalité et d'Equité de Genre / politique Nationale d'… (National Strategy on Equality and Gender Equity/National Policy on…)*

[ii] Demobilisation, Disarmament and Reinsertion (DDR)