MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMMES

CENTRAL AFRICAN REPUBLIC COUNTRY REPORT

CHILD PROTECTION SECTION
PROGRAMME DIVISION
August 2016
MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMME

CENTRAL AFRICAN REPUBLIC COUNTRY REPORT
August 2016

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This report for the Central African Republic is one of seven country evaluations which form part of the Multi-Country Real Time Evaluation of UNICEF Gender-based Violence in Emergencies Programmes global evaluation. The Central African Republic country report was prepared by Vine Management Consulting Ltd, an independent company recruited by the Child Protection Section of Programme Division to conduct this evaluation. A five-person internal UNICEF Evaluation Management Group was responsible for the management of this evaluation including inputs to quality assurance.

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The Evaluation Management Group, whose responsibilities have included supervising and guiding the evaluation team in each step of the process; reviewing, commenting and approving the evaluation deliverables; approving the final report and supporting dissemination and management response process, is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.
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<td>AoR</td>
<td>Area of Responsibility (global sub-cluster of the Global Protection Cluster)</td>
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<tr>
<td>AFJC</td>
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<tr>
<td>C4D</td>
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<td>UNICEF Core Commitments for Children in Humanitarian Action</td>
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<td>Clinical Management of Rape</td>
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<td>CO</td>
<td>Country Office</td>
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<td>COOPI</td>
<td>Cooperazione Internazionale</td>
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<td>Child Protection in Emergencies</td>
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<td>CPIMS</td>
<td>Child Protection Information Management System</td>
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<td>CPD</td>
<td>Country Programme Document</td>
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<td>CRSV</td>
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<td>Direct Cash Transfer</td>
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<td>Demobilization, Disarmament and Rehabilitation</td>
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<td>HRBP</td>
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<td>ICWG</td>
<td>Inter-Cluster Working Group</td>
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<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<td>INGO</td>
<td>International Non-Government Organization</td>
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<td>IP</td>
<td>Implementing Partner</td>
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<td>Intimate Partner Violence</td>
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<td>IMC</td>
<td>International Medical Corps</td>
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<td>L3</td>
<td>Level 3 Emergency</td>
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<td>MARA</td>
<td>Monitoring, Analysis and Reporting Arrangements</td>
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<td>MASPAGH</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MINUSCA</td>
<td>United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic</td>
</tr>
<tr>
<td>MoGCSW</td>
<td>Ministry of Gender, Children and Social Welfare</td>
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<tr>
<td>MRM</td>
<td>Monitoring and Reporting Mechanism for grave violations against children</td>
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<td>NatCom</td>
<td>UNICEF National Committee</td>
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<tr>
<td>NFI</td>
<td>Non-Food Item</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>PCA</td>
<td>UNICEF Programme Cooperation Agreement</td>
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<tr>
<td>PSEA</td>
<td>Protection from Sexual Exploitation and Abuse</td>
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<tr>
<td>PSS</td>
<td>Psycho-social Support</td>
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<td>RC/HC</td>
<td>Resident Coordinator/Humanitarian Coordinator</td>
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<td>Regional Office</td>
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<td>RRM</td>
<td>Rapid Response Mechanism</td>
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<td>Real Time Evaluation</td>
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<td>SEA</td>
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<td>SOP</td>
<td>Standard Operating Procedures</td>
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<td>Strategic Response Plan</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<td>TLS</td>
<td>Temporary Learning Space</td>
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<td>United Nations</td>
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<td>UNHCR</td>
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<td>United Nations Population Fund</td>
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<tr>
<td>USAID/BPRM</td>
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EXECUTIVE SUMMARY

The Child Protection Section of UNICEF’s Programme Division, New York, is undertaking a multi-country real time evaluation of UNICEF’s Gender-based Violence in Emergencies (GBViE) programming with the overall purpose of strengthening UNICEF’s current and future GBViE programming based on real time learning. The core of the evaluation is seven RTEs which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic (CAR) and a brief study of the GBViE programme the Democratic Republic of Congo conducted by telephone.

This report presents the findings, conclusions and recommendations of the mission conducted in the Central African Republic, May 10-20, 2016.

CONTEXT

Central African Republic (CAR)—a country that has experienced decades of political instability, widespread poverty, weak state institutions and external military interference—remains mired in a complex humanitarian crisis. Most recently, following the coup in March 2013 by Seleka rebels and the subsequent upsurge of violence that displaced thousands in December 2013, the United Nations (UN) declared CAR a Level 3 (L3) emergency. Despite some improvements that have made it safer for sections of the population to return home, the security situation at the time of the evaluation remained volatile. More than half of the population, an estimated 2.3 million people, are in need of humanitarian assistance, with more than 385,750 internally displaced. An estimated 455,000 Central Africans have fled to neighbouring countries. Armed groups still control substantial parts of the country and there is a low redeployment of state representatives and lack of basic services throughout the country. Serious human rights violations have been reported, especially against children, women, internally displaced people (IDPs) and minority groups. The presence of international peacekeeping forces including Sangaris—a French military force which were operating as peacekeepers under authorization of the Security Council but not under UN command—and United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA) has been contentious, with widespread allegations of sexual exploitation and abuse (SEA) at the hands of peacekeepers. The United Nations has been heavily criticized for failure to respond adequately to reports of SEA, which has led to a recent upsurge in resources and attention devoted to this issue. Even with this attention, only 15% of the Humanitarian Response Plan is funded for 2016, and CAR is stuck in a state of economic paralysis and collapsed infrastructure.

CONCLUSIONS

Successes

1. UNICEF’s programming to establish minimum essential services for GBV survivors is highly relevant to the needs on the ground as reflected by affected populations, key informants, and GBVIMS statistics, which all indicate GBV is a rampant problem in CAR. UNICEF is undertaking all the Minimum Actions the UNICEF GBViE Resource Pack suggests should be addressed in immediate crisis-response with the exception of risk mitigation across clusters and sectors. The Listening Centres are a particularly contextually appropriate intervention, allowing IDPs, returnees, and community members the opportunity to access support.

2. UNICEF’s corporate commitments to GBViE are well understood at a country level, with attention to GBV described at the highest level of the CO as a “big priority.”

3. The development and finalization of the Standard Operating Procedures (SOPs), represents a major step forward in terms of establishing criteria and systems for GBV care and support in CAR. (Effectiveness)
4. UNICEF partners are undertaking monitoring activities that are being used to enhance prevention and response to survivors and those at risk. For example, risk mitigation kits for women and girls were distributed following safety monitoring by IRC. One partner is also testing a quality of care tool, which can be scaled up for use in other locations and by other partners. (Effectiveness)

5. Regional and HQ technical support have been extremely valuable to the country office, signalling the importance of ensuring this technical support is available on an ongoing basis. (Efficiency)

6. UNICEF’s strong relationship and work with government makes it a credible partner and creates space to continue work on GBV, particularly in the area of systems building for multisectoral response as well as implementation of protective laws and policies. (Connectedness/Sustainability)

7. UNICEF’s nascent capacity-building efforts of local implementing partners (IPs), e.g. periodic training for national IPs, have not only improved local capacity to address GBV, but several IPs report that this support has also increased staff motivation. To date, however, approaches have focused on technical issues related to services for survivors. In the extremely challenging context of CAR, management skills and the promotion of a healthy workplace (including strategies for self-care) are unaddressed areas for capacity building among all IPs, as well as among UNICEF staff. (Connectedness/Sustainability and Efficiency)

8. UNICEF is a key coordination partner in a number of fora. UNICEF has been largely responsible for ensuring a strong and positive link between the GBV and child protection (CP) subclusters.

9. UNICEF’s plans to leverage incoming SEA funds to improve GBV programming reflects strategic thinking related to fundraising and planning, as well as a vital understanding of the links at the community level between the causes and risk factors for SEA committed against affected populations by humanitarian personnel and GBV generally. Linking response to SEA at the community level with GBV services should not be confused with the need to maintain a distinction between SEA and GBV at the organizational/management level. (Efficiency)

Gaps/Challenges

1. The CAR CO does not have a theory of change or clearly articulated strategy for addressing GBV, including an approach to link emergency GBV programming to early recovery and development programming.

2. UNICEF’s commitment to coordination is not yet reflected at the subnational level, where coordination for GBV is currently weak. Linkages between the Monitoring and Reporting Mechanism (MRM), the Monitoring, Analysis and Reporting Arrangements (MARA) and GBV prevention, response and coordination are not well-established. (Coordination)

3. There are significant gaps in a multi-sectoral approach to GBV response in CAR, for which there does not appear to be a sector-wide or UNICEF strategy to address. Security sector response is a particularly weak area, especially outside Bangui. Challenges also exist in accessing health care due to availability of skilled staff and demands that survivors pay for services. While UNICEF supports legal aid, the lack of a functioning judiciary means that cases are not adjudicated and justice cannot be achieved. (Relevance and Effectiveness)

4. Although adolescent girls are a group which is at very high risk of GBV, GBV programming (both specialized and integrated) has not adequately focused on the needs of adolescent girls. The multiple levels of trauma being experienced by adolescent girls, many of whom were forced into marriage at a young age, have multiple children, were orphaned or abandoned as a result of the conflict, and/or abducted, recruited and used by armed groups warrants specific attention and programming. UNICEF’s Country Programme Document (CPD) and annual workplans related to GBV group women and children together in the strategic outcomes and activities, making it impossible to distinguish how
GBV programmes are designed and implemented with the specific respective needs of women and girls in mind. (Relevance)

5. Prevention work in CAR has to date been focused on community awareness raising. The ability of Listening Centres to serve a preventative role, particularly through livelihoods and other empowerment initiatives, has not yet been fully exploited; at present they offer a safe space for survivors to report and are used primarily for counselling survivors and social activities. (Relevance and Effectiveness)

6. In accordance with good practice linked to emergency response, UNICEF has prioritized a focus on sexual violence (including SEA). As yet, the widely reported problem of intimate partner violence (IPV) and other forms of GBV are not being targeted by UNICEF or others in the GBV community. (Relevance)

7. Integrated programming across UNICEF sectors has been undertaken mainly in the health section. Perhaps due to high staff turnover and competing demands, other sectors do not appear to have integrated GBV prevention and risk mitigation measures as recommended in the revised 2015 IASC GBV Guidelines, despite technical visits to CAR focused on training related to the Guidelines. Nor has GBV yet been integrated into UNICEF structures that have the greatest reach in CAR, including the Rapid Response Mechanism (RRM) and at the level of UNICEF’s field offices. This represents a significant missed opportunity for improving GBV-related protections for girls and women. (Relevance and Efficiency)

8. Data collection through the Gender-based Violence Information Management System (GBVIMS) continues to present challenges in terms of accuracy in the types of incidents recorded as well as the number. UNICEF’s suggestion to link the GBVIMS to reporting on SEA has the potential to undermine confidentiality and other principles of ethical care for survivors if not done carefully, because of the requirement of humanitarian actors for mandatory reporting of SEA.

9. UNICEF’s delegation of many PSEA responsibilities to the UNICEF GBV specialists and the burden of time required to meet those responsibilities has compromised GBV staff ability to guide and strengthen UNICEF’s GBV programme. While there is a recognition at the highest level within the CO of the importance of separating the remit of PSEA from GBV, there is no indication that plans to expand staffing for support to SEA will be informed by a strategic approach that clarifies how PSEA responsibilities are distinct from GBV at the organizational level. This clarification is critical moving forward, as is ensuring that GBV staff no longer assume primary responsibility for PSEA, but rather assist dedicated PSEA staff to link complainants to services. At the same time, given the scope of GBV in CAR, similar staffing commitments as those for PSEA must be considered for GBV. (Efficiency)

RECOMMENDATIONS

RECOMMENDATION 1. Develop a GBViE strategy for CAR that aligns with global Theory of Change (ToC), but is adapted to the specific needs of the context.

   a. Explicitly link GBViE programming to longer-term development programming in the GBV strategy and within country programme documents.

   b. Highlight specific preparedness activities for GBV which the CAR Country Office (CO) will undertake for ongoing and future emergencies.

   c. Consider inclusion of other recommendations highlighted below.

Lead responsibility: CP GBV Team
When: 2016-2017
RECOMMENDATION 2. Strengthen UNICEF’s role in subnational coordination.
   a. Support the national GBV SC to develop a strategy with clear roles and responsibilities of key partners at the subnational level.
   b. Consider assuming coordination leadership in key locations at the subnational level.
   c. Ensure coordination strategies support linkages between GBV, MRM and MARA mechanisms.

*Lead responsibility: CP GBV Team*

*When: 2016-2017*

RECOMMENDATION 3. Build on the CAR CO’s existing GBV specialized programming approaches in order to improve prevention and response programming.
   a. Ensure Standard Operating Procedures (SOPs) are rolled out to all prefectures, as well as in all sub-prefecture locations where UNICEF is supporting GBV prevention and response programmes.
   b. Standardize and regularize efforts to monitor the needs of women and girls and their perceptions of the value of support services available to them through UNICEF IPs, using the community outreach groups and Listening Centres as vehicles for this monitoring.
   c. Strengthen psychosocial support at Listening Centres by broadening services to incorporate more group activities for women and girls, and by sharing tools and resources with IPs for facilitating structured discussions and activities with women and adolescent girls, e.g. Communities Care dialogue sessions.
   d. Identify and implement approaches to meet the specific needs of adolescent girls, particularly with targeted activities in the Listening Centres that provide services including social support, economic strengthening strategies, vocational and literacy classes, and reproductive health education.
   e. Consider engaging with UNPOL and national police to improve police response through designated focal points for GBV in UNPOL, presence of trained UNPOL staff in key police stations, as well as UNPOL training of national police.
   f. As a first priority in justice response, scale up targeted advocacy and resources to ensure that existing courts are enabled to safely and ethically adjudicate GBV cases.
   g. Undertake efforts to improve community awareness and services related to IPV and child marriage nationwide, and particularly through community groups and the Listening Centres. Review IP interventions related to family mediation and couples counselling to ensure safe and ethical approaches.
   h. Begin work to transform the conditions that foster GBV. Identify priorities, existing evidence and strategies for GBV prevention, including social norms work, economic empowerment, etc. In the immediate to medium-term, review the content of existing awareness-raising messages as a first step towards more in-depth social norms work, and engage with communication for development (C4D) and/or an external consultant to align it to accepted good practice. Also identify ways to link GBV programming with more substantial livelihoods initiatives for women in order to reduce their risk of GBV.

*Lead responsibility: CP GBV Team*

*When: 2016-2017*
RECOMMENDATION 4: Strengthen integration of GBViE across all UNICEF sectors in line with the 2015 IASC GBViE Guidelines recommendations, with the objective of each sector proactively leading integration in all phases of the programme cycle.

a. Assist all UNICEF sections to adopt relevant recommendations from the IASC GBV Guidelines on systematic integration of GBV prevention and risk mitigation strategies in their humanitarian response, with indicators to be monitored regularly in the Results Assessment Module (RAM).

b. Ensure Chiefs of Section identify a focal point to work with a dedicated (short-term) GBV specialist to support this systematic integration across programmes.

c. Routinely integrate attention to GBV into the Rapid Response Mechanism (RRM) missions as well as in the TORs of CP staff in the suboffices that include specific, safe and measurable activities to facilitate identification of GBV needs in underserved areas and provide referrals.

Lead responsibility: Chief CP; GBViE Specialist; Chiefs of Sections; Deputy Representative
When: 2016 and ongoing

RECOMMENDATION 5. Ensure GBV human resource needs are addressed through adequate numbers of staff working specifically on GBV (not with a dual mandates for GBV and PSEA), as well as capacity-building of partners and support to staff well-being.

a. Given the scope of need in CAR, consider two P3 international staff and two national staff to comprise the GBV team at the national level, with an eye to experts who may be able to strengthen work on IPV and with adolescent girls. Hire national GBV staff for the field offices.

b. Introduce a dedicated (short-term) GBV specialist to the team to work with section focal points to facilitate integration of GBV across UNICEF sectors as per the revised 2015 IASC GBV Guidelines.

c. Ensure continued support from GBV experts in the Regional Office (RO) and headquarters.

d. Create a capacity-building plan for implementing partners. Review the types of technical assistance that UNICEF can provide to IPs beyond training, e.g. onsite support, content review, asking strategic questions, check-ins, promotion of self-care strategies. Discuss how the team can utilize these methods more strategically to monitor and strengthen the quality of programming. Incorporate technical assistance activities into the workplans of UNICEF GBV staff.

Lead responsibility: CO Senior Management, Chief of CP, CP Team
When: On-going

RECOMMENDATION 6. While ensuring UNICEF CAR continues to meet its commitments related to PSEA, make certain there is a clear division of responsibility for PSEA and GBV within the CO as well as with IPs.

a. Develop an internal CO guidance note that details UNICEF staff structures responsible for managing different elements of PSEA, and that illustrates when linkages might occur between PSEA staff and GBV staff (e.g. related to mapping services and sharing referrals pathways with PSEA experts so those experts can facilitate services for SEA complainants).

b. Ensure ongoing training for all IPs related to managing care and support for SEA complainants that aligns the Secretary General’s (SG) mandate to report on SEA cases with the principles for GBV care and support, particularly confidentiality.

c. Closely monitor data collection and reporting of partners through the GBVIMS and ensure that any links between SEA data collection and the GBVIMS support safe and ethical survivor response (particularly confidentiality).

d. Share learning on leadership related to PSEA with other COs in UNICEF.

Lead responsibility: CO Senior Management, SEA specialists, Chief of CP, CP Team
When: On-going
1 INTRODUCTION

1.1 UNICEF’s Approach to GBViE

UNICEF defines Gender-based Violence (GBV) as an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. This definition draws on UNICEF’s core mission to protect the health and well-being of children and women and its mandate to support states and other duty bearers, civil society and communities to prevent all forms of violence against children and women in emergencies, including GBV, and to ensure availability of appropriate systems and services for children and women survivors.

UNICEF is committed to providing comprehensive and coordinated programming across sectors to address the rights and needs of girls and women at risk of GBV holistically, leveraging UNICEF’s leadership and programming across humanitarian response, especially in Child Protection (CP), Education, Health, HIV/AIDS, Nutrition and WASH sectors. In addition to a programme response, UNICEF is global co-lead of the GBV Area of Responsibility (AoR), part of the Global Protection Cluster, with associated responsibilities for coordination and as a provider of last resort.

The Theory of Change (ToC) for UNICEF GBViE programming (see below) has been developed by the evaluation team and the Child Protection Section (CPS) Gender-based Violence in Emergencies (GBViE) Specialist based on the Resource Pack and other UNICEF GBViE guidance and strategies. The ToC was used to inform the evaluation approach and tools and is discussed during country evaluations with CO colleagues. As relevant the ToC will be updated to reflect evaluation findings.

1.2 Impact of Armed Conflict and Natural Disasters on GBV

GBV occurs in all societies in the world. However, conflict situations and disasters typically intensify many forms of GBV with which children and women live, even in times of peace and stability. Tensions at household level can increase intimate partner violence (IPV) and other forms of domestic violence (DV) specifically aimed at females and affecting all children. The pervasive impunity which characterizes conflict settings can exacerbate sexual violence, including its use as a weapon of war. Poverty, displacement and increased dependency resulting from crises may increase the risk for women and girls of being forced or coerced to engage in sex in return for safe passage, food, shelter or other resources. Insufficient security in camps and informal settlements increases the risk of sexual and physical assault, as well as trafficking.

The consequences of exposure to violence are as extensive as the scope of violence itself, in terms of the myriad acute and chronic health problems that accompany many types of GBV, and because victimization can increase risk of future ill-health for survivors. In humanitarian settings, where community support systems and formal health and psychosocial services are often severely

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1 UNICEF programmes to address GBViE generally focus on the rights and needs of women and girls given their high vulnerability to violence rooted in systemic gender-based inequality in all societies and the importance of developing targeted programming to address violence against them. While prioritizing the protection of women and girls within UNICEF’s GBViE programmes, UNICEF’s CP programmes may target specific protection-related rights and needs of boy survivors and those at risk, promoting their access to care and support.

compromised, the results can be even more profound than in peacetime. The extent and impact of GBV not only affects survivors, it also limits the ability of entire societies to heal from conflict. Violence may affect child survival and development, raising infant mortality rates, lowering birth weights and affecting school participation. GBV can limit women’s access to reproductive health services including family planning, leading to unwanted pregnancies and unsafe abortions, and increasing women’s risk of HIV infection. At the same time that GBV increases costs to public health and social welfare systems, it decreases women and children’s abilities to participate in social and economic recovery.

While the primary responsibility to ensure people are protected from violence rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV. According to the *IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015,* (‘2015 IASC GBV Guidelines’) “All humanitarian actors must be aware of the risk of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation” (p 14). This responsibility is supported by a framework that encompasses international and national law, UN Security Council Resolutions, Humanitarian Principles and Humanitarian Standards and Guidelines.

1.3 Background to the GBViE Evaluation
In the past decade, UNICEF has been at the forefront of efforts to prevent and respond to GBV in emergencies, both globally and at country level. UNICEF HQ is committed to supporting Regional and Country Offices (ROs/COs) to continue to deliver on UNICEF’s mandate to protect children and women from GBV, and ensure the well-being of all children, through consistent and effective GBV prevention and response in emergencies. The Child Protection in Emergencies Team (CPiE), is currently developing a range of resources for COs to use for designing, monitoring and evaluating stand-alone GBV programmes and improved integration of GBV prevention and response across all sectors of UNICEF’s humanitarian response, in line with the Core Commitment’s for Children (CCCs) and other humanitarian standards. This includes the development of the new UNICEF GBViE Programme Resource Pack (‘Resource Pack’).

To facilitate continuous learning and improvement within UNICEF’s ongoing GBV response in emergency-affected countries and to inform the development of the Resource Pack, the CPiE Team of the CPS, in collaboration with ROs and COs, is undertaking this multi-country evaluation of UNICEF’s GBViE programming. The evaluation is being conducted between November 2015 and July 2016.

2 EVALUATION SCOPE AND METHODOLOGY
2.1 Purpose and Objectives
The overall purpose of the multi-country GBViE evaluation is to strengthen UNICEF’s current and future GBViE programming based on real time learning.

The objectives are to:
1. Assess GBViE programming in UNICEF country programmes using standard criteria for evaluating humanitarian action to generate learning that informs future UNICEF GBViE programming.
3. Develop a real-time GBViE programming evaluation methodology that can be used by UNICEF and other GBViE actors.
4. Develop recommendations to help UNICEF operationalise its organizational commitments to GBViE at HQ, regional and country levels.

During the country missions, the evaluation team focused primarily on objective 1 (above), but has also addressed objective 2, especially through the short case studies and the longer comparative Intervention Specific component of the evaluation. Objective 3 was addressed through the inception phase when the evaluation tools were developed, and was also a particular focus of the first two missions (to Pakistan and Lebanon), after which some tools were revised. But through each of the country missions the team has been aware of minor revisions which were required in the evaluation tools in the light of the particular context. The final version of the tools is included in the final overall evaluation report as well as in the Resource Pack (see below). Objective 4 has been addressed in the country reports with recommendations developed for the specific countries visited. The recommendations in the final evaluation report focus on agency-wide and some regional level recommendations.

This evaluation assesses UNICEF’s programming response to GBV in seven current emergencies against standard criteria for evaluating humanitarian action, namely: relevance, effectiveness, connectedness/sustainability, coordination, coverage and efficiency. Evaluation questions to be addressed under each of these criteria are included in Annex 1.

For this RTE, guidance on good programming practice from two documents is being used as the benchmarks on which UNICEF GBViE programmes should be modelled, representing current thinking on best practice for GBViE programming for specialised and integrated programming respectively:

(i) The GBViE Programme Resource Pack (the ‘Resource Pack’) currently being developed by the Child Protection Section of Programme Division, (CPS) provides detailed guidance for conducting assessments and designing and implementing specialised GBV programmes relevant to UNICEF’s operations. The Resource Pack (due to be finalized in 2016) includes information and resources for implementing a minimum package of essential services for GBV protection and response in the aftermath of an emergency or population displacement. It also contains guidance for expanded programming to strengthen structures, systems and services and institutionalize prevention, protection and response to GBV during ongoing response and throughout recovery.

(ii) The recently launched IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015, (‘IASC GBV Guidelines’) provides detailed guidance and good practice

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3 This component will provide a comparative study across several of the evaluation mission countries, in more depth than the short case studies, of three types of intervention: child marriage, safe spaces and capacity strengthening activities and strategies which will inform the Resource Pack and provide examples of good practice for these GBV interventions.

4 To clarify programming terms being used in the evaluation as well as the nature of GBViE programmes to be evaluated:

'GBV specific programmes' are understood to be:
(a) Multi-sectoral response and referral services for survivors focusing on health care; security (including safe spaces) and psychosocial support (including within schools);
(b) Dignity kits (distributed by Child Protection (CP) and Water, Sanitation and Hygiene (WASH) teams or just CP teams), economic strengthening for adolescent girls, community based protection activities;
(c) Prevention programming including work on social norms, economic and social empowerment of women and girls, legal and policy reforms.

'Integrated' programming refers to the mainstreaming of GBV prevention and risk mitigation approaches/activities across other sectors.

2.2 Evaluation Focus and Scope
The evaluation includes data gathering at global, regional and country levels. The core of the evaluation is seven real time evaluations (RTEs) which were conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic, with missions lasting one to two weeks each and one brief country assessment conducted remotely for the Democratic Republic of Congo. The primary focus of the evaluation is on learning:

- To promote learning in each of the RTE COs on how existing programmes can be enhanced in the light of good and emergent practice as captured in the 2015 IASC GBV Guidelines and in the Resource Pack; and,
- To promote learning at HQ and ROs through the CO reports and the final evaluation, as well as short case studies of good practice and a detailed comparative review of three GBViE specific interventions across three to four of the mission countries which will inform the development of the GBViE Resource Pack.

To provide an overall picture of UNICEF’s GBViE programming, a mapping exercise is being conducted by electronic survey of 39 UNICEF COs which are reporting against corporate targeted priorities within the Gender Action Plan (GAP).

Implementing Partners
Any evaluation of UNICEF programming means, de facto, an evaluation of the programming of their implementing partners (IPs). The country missions will clarify UNICEF’s role vis-à-vis their IPs and how these roles may differ in different contexts and in different types of emergencies. This will include clarification of the nature of support UNICEF staff are offering their partners, (national and international); and how UNICEF staff are overseeing partnerships and ensuring programme quality.

GBV Sub-clusters
The evaluation will not include an assessment of the global GBV Area of Responsibility (AoR), or of country level GBV sub-clusters (or other GBV coordination mechanisms) per se, as it is focused on the GBV programming function of UNICEF. It will, however, consider the extent/nature of UNICEF’s programming contribution in realizing sub-cluster strategy/plans for addressing identified gaps/priorities, and will address how the agency has added value to the whole GBV response (including leadership and advocacy activities) within the CO and across the response as a whole.

GBV and Sexual Exploitation and Abuse (SEA)
The evaluation ToR doesn’t specifically include SEA within the scope of this evaluation. However, in the light of the recent report on the UN response to allegations of SEA in CAR, several donor interviewees have indicated that UNICEF, in common with all UN agencies, needs to have clear policies and guidelines in place to implement the UN Secretary-General’s October 2003 bulletin: Special Measures for Protection

5 The length of each mission is dependent on the extent of the GBV programme and access to programme areas.
6 An evaluation of the coordination function was not included in the ToR. Additionally, the UNICEF, via the Cluster Management Unit of UNICEF EMOPS and UNFPA HQ are undertaking a Review of the GBV AoR leadership function.
from Sexual Exploitation and Sexual Abuse. The evaluation scope therefore includes questions on the existence of protection from SEA (PSEA) policies and action plans, and familiarity with them by CO staff, and whether alleged victims of SEA are referred to for care and support services.

Audience
The primary audience for the overall evaluation findings and collated good practice is the CPS, (who commissioned the evaluation and will use the findings to inform future priorities as well as the GBViE Resource Pack). Findings will also be used by GBV specialists, CP specialists and Gender Advisors in Regional and Country Offices (CO) who are implementing, managing and providing support to GBV programmes. The secondary audience includes other sectors and UNICEF senior management at headquarters (HQ), Regional Offices (RO) and COs.

Given the paucity of evaluations on GBViE programming, it is hoped that the final evaluation report will also be of interest and use to non-UNICEF actors implementing and/or resourcing GBViE programmes.

2.3 Methodology
The evaluation is based on collection and analysis of primary and secondary data. Data collection includes document review (at global level and for each mission country); key informant interviews (KIIs) with stakeholders at global, regional and country levels; focus group discussions (FGDs) with programme recipients in country; and field observation by the evaluation team. As a learning tool for country office personnel, staff are being asked to assess their programming against good practice checklists based on the 2015 IASC GBV Guidelines and the Resource Pack that were distributed prior to and during the field trips. National consultants are recruited to support the evaluations in each country to ensure that approaches and tools used are culturally sensitive and appropriate, and to support the team with language translation.

The evaluation team are visiting a selection of projects in each mission country to make field observations, interview IP staff and conduct FGDs with different groups among the affected population. Criteria have been developed for the selection of projects to be visited, but, in practice, final decisions have been taken by the CO evaluation focal point and CP Chief in advance of the evaluation team mission in light of accessibility, willingness of IPs to host visits and arrange FGDs, those projects with the most learning potential, and safety of affected populations, in-country staff and partners and the evaluation team.

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8 ST/SGB/2003/13, 9 October 2003
9 UNICEF and all other protection actors are obliged to mainstream prevention of GBV within all programmes. Along with mainstreaming GBV prevention, UNICEF also delivers targeted programming where possible to address identified risk factors for GBV. All of these efforts will contribute to protection against SEA.
10 SEA committed by UN/UNICEF staff or related personnel against any persons of concern is based on abuse of power and—in the case of women and girls, who are the primary victims of SEA—gender inequality and gender discrimination. The SG’s Bulletin requires that all humanitarian personnel ensure action is taken to prevent SEA in their areas of operation, and report it when they observe any risks or abusive behaviour. PSEA should link with GBV programming to ensure survivors’ rights are respected and to improve victim assistance and the development of community-based complaints mechanisms. SEA agency focal points should link with GBV actors to develop referral systems that support survivor-centred care. While CP and GBV staff in UNICEF country programmes should know and promote the key principles and standards of conduct outlined in the Secretary-General’s Bulletin, the accountability for PSEA lies with senior management (Country Representatives) and human resources (Heads of Human Resource Departments). The IASC GBV Guidelines fully support the mandate of the SG’s Bulletin and provide several recommendations within each sector guidance chapter on programming that mitigates SEA, including incorporating PSEA strategies into agency policies and community outreach.
11 Including both self-reported data by mission CO staff and data gathered by the evaluation team.
Tools developed by the evaluation team guide country mission preparation and data collection and analysis. These tools were reviewed the Evaluation Management and Reference Groups and were tested and refined during the first two missions. The final versions of the evaluation tools will be included in the Resource Pack to support future GBViE evaluations.

In line with RTE methodology, a workshop is held at the end of each country mission to share and validate the initial findings and reflect, with CO colleagues, about how the findings can be used to enhance GVBiE programming in that setting.

A country mission report, based on the workshop presentation and discussion is drafted by the evaluation team, and reviewed by the COs and the Evaluation Management Group. The findings section of the country mission reports addresses the evaluation questions relating to each of the evaluation criteria. The country reports will inform the final, overall evaluation report.

2.4 Evaluation Management
The evaluation has been commissioned by the Child Protection Section (CPS) of UNICEF Programme Division, who also selected the case study countries and has closely overseen the process throughout.

A five-person UNICEF EMG was formed with responsibility for ‘daily management of the evaluation’ including supervision of the evaluation team, review of all products (Inception Report, tools, workplan, country and final reports, coordinate with the Evaluation Reference Group (ERG) and disseminate the final evaluation findings).

The Evaluation Reference Group (ERG) is composed of internal and external experts who provide quality oversight to the evaluation. Responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks. The ERG includes the following individuals: Mary Ellsberg, Director, Global Women’s Institute at George Washington University; Mazeda Hossain, Social Epidemiologist, London School of Hygiene and Tropical Medicine (LSHTM); Jina Krause-Vilman, Senior Area Practice Lead, Refugees, Gender and Livelihoods, Near East Foundation; Diana Jimena Arango, Senior GBV and Development Specialist, World Bank; Verena Phipps, Social Development Specialist, World Bank; Maha Muna, Regional Gender Advisor, UNICEF CEE-CIS; Michael Copland, Regional Child Protection Advisor, UNICEF ESARO; Laurent Chapuis, Regional Child Protection Advisor, UNICEF MENARO; and Kate Alley, Emergency Specialist: Assessment, Planning, Monitoring and Evaluation, Humanitarian Policy Section, UNICEF EMOPS.

3 CENTRAL AFRICAN REPUBLIC MISSION OVERVIEW
3.1 Mission Overview
The country mission to the Central African Republic (CAR) was conducted from 10-20 May, 2016 as part of the UNICEF Gender-based Violence in Emergencies (GBViE) Multi-Country Real Time Evaluation (RTE). Two consultants from the evaluation team travelled to 3 prefectures (for a total of nine cities/towns) in CAR: Ombella-Mpoko (Bangui, Yaloke, Bossembele, Boali); Ouham Pende (Bocaranga, Ngaoundaye, Mboum, Doko); and Haute-Kotto (Bria). Data was collected through a series of key informant interviews

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12 EMG Terms of Reference.
13 The evaluation team discussed and agreed on the proposed in-country itinerary with the GBViE specialist focal point in CAR, and were guided in the choice of projects and partners to visit within the 10 days allotted for the research using a real time approach.
(KII)s as well as focus group discussions (FGDs) with members of the affected population accessing UNICEF-supported programmes.

Two government representatives (1 female and 1 male) from the Ministry of Social Affairs (MOSA) were invited to participate in the evaluation as part of UNICEF’s partnership approach in work with the Government of CAR (GoCAR). Two external national consultants were hired on the second day of the evaluation team’s arrival for translation purposes. On the final day of the mission, a debriefing workshop was conducted in Bangui with members of the UNICEF CP team, as well as the Deputy Representative and representatives from UNICEF Education and WASH sections. The UNICEF Deputy Representative was further debriefed separately on the findings of the mission.

3.1.1 Data Collection
A document review was compiled before the mission to provide background on the CAR and country office (CO) contexts as well as the humanitarian response and the current GBVIE programmes. During the mission additional programme documentation was received from the CO that has been used to inform this report.¹⁴

Good practice self-assessment checklists for integrating GBV were completed by UNICEF Child Protection (CP), health, nutrition/food security, WASH and education. A UNICEF GBV specialist completed the GBV-specific self-assessment.

Given the high profile of the issue of sexual exploitation and abuse (SEA) in CAR and UNICEF’s role in addressing it, this mission also included some data collection on UNICEF’s protection from sexual exploitation and abuse (PSEA) efforts. While not central to the mission, the evaluation team was particularly interested in examining the linkages between PSEA programmes and GBV programmes within the CO.

During the mission, a total of 44 KII s were conducted (59% female, 41% male) with UNICEF staff in Bangui and with partners in government, UN agencies, international non-government organisations (INGOs), NGOs/IPs in Bangui, Yaloke, Bossembele, Bria, Bocaranga, Ngaoundaye, Mboum, and Doko.¹⁵ Twelve FGDs were conducted with UN and I/NGO representatives, as well as communities affected by the conflict (both those who are currently displaced and those who had recently returned home). FGDs were conducted separately with adult women, adult men, and adolescent girls who were users of UNICEF-supported programmes implemented by the International Rescue Committee (IRC), Cooperazione Internazionale (COOPI), and the Association des Femmes Juriste de Centrafrique (AFJC). Key informants and FGD participants were generally positive about participating in the evaluation and willing to share their perspectives and experiences.

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<th>Stakeholder Group</th>
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<th>Male</th>
<th>Total</th>
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<tr>
<td>UNICEF staff</td>
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<td>8</td>
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<tr>
<td>Donors</td>
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<td>0</td>
</tr>
</tbody>
</table>

¹⁴ See Annex 4 for bibliography.
¹⁵ See Annex 2 for list of interviewees.
### 3.1.2 Limitations

The original mission was cancelled at the last minute due to a UN ban on all non-essential missions in anticipation of insecurity related to the presidential inauguration and public holiday. It proved challenging to find new dates to accommodate both the CO and evaluation team, such that final arrangements were made quickly, resulting in limited advanced notice to partners. The evaluation team had to send one non-French speaker, as the other French-speaking team member was no longer available. The national government partners originally designated as translators had not been vetted by UNICEF and it was discovered on the first day of the evaluation that they did not have strong English skills. It was necessary to hire additional consultants, only one of whom was fluent in English. However, she was not a professional translator and did not speak any local languages. This resulted in challenges with information collection, including in focus groups discussions and document review, resulting in less detailed data collection—and therefore less detail about programmes in this report—than might have otherwise occurred.

Logistics related to transport for field trips were also challenging, with long delays and overly-optimistic calculations about distances to/from field sites. This meant that the team had to stay overnight in remote locations that were unplanned and partners/consultants had to shift arrangements at the last minute to accommodate delays, resulting in changes to the evaluation schedule that led to less time for KII.

Also, because of the specific areas to which the team travelled and the projects observed, there was not an opportunity to conduct FGDs with Muslim users of UNICEF-supported projects, such that their particular experiences were not captured by the evaluation team. Another challenge was that there were no donors based in CAR to interview because most are based in regional offices and/or at headquarters, thus the views of donors are not reflected in this report.

### 3.2 Country Overview

#### 3.2.1 Country Context

Central African Republic—a country that has experienced decades of political instability, widespread poverty, weak state institutions and external military interference—remains mired in a complex humanitarian crisis. After gaining independence from France in 1960, CAR was ruled by a series of autocratic leaders, with the first multi-party democratic elections held in 1993. Ange-Félix Patassé became president, but was later removed by General François Bozizé in a 2003 coup. The CAR “Bush War” began in 2004 and, despite a peace treaty in 2007 and another in 2011, fighting broke out between various factions in November 2012, when Seleka, a coalition of rebel groups, took over towns in the northern and central regions of the country. These groups reached a peace deal with the Bozizé government in January 2013 involving power sharing, but this deal broke down and the rebels seized the capital in March 2013.
2013, the United Nations (UN) declared CAR a Level 3 (L3) emergency. While this designation was deactivated in May 2015, the security situation at the time of the evaluation remained volatile. More than half of the population, an estimated 2.3 million people, are in need of humanitarian assistance, with more than 900,000 displaced, of which an estimated 455,000 are refugees in neighbouring countries. Despite some improvements that have made it safer for sections of the population to return home, armed groups still control substantial parts of CAR and there is a low redeployment of government representatives and lack of basic services throughout the country. Serious human rights violations have been reported, especially against children (including recruitment of and use of children by armed forces/groups), women, IDPs and minority groups.

The presence of international peacekeeping forces including Sangaris — a French military force operating as peacekeepers under authorization of the Security Council but not under UN command— and the United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA) — has been contentious, with widespread allegations of SEA at the hands of peacekeepers. In the spring of 2014, allegations of rampant sexual exploitation and abuse by international armed forces serving as peacekeepers were revealed in an international report. The alleged perpetrators were largely from the French Sangaris forces but include MINUSCA. The United Nations has been heavily criticized for failure to respond adequately to reports of SEA, which has led to a recent upsurge in resources and attention devoted to this issue. Despite the issue of SEA bringing global attention to the humanitarian needs in CAR, only 15% of the Humanitarian Response Plan is funded for 2016 and CAR is stuck in a state of economic paralysis, with a collapse of socio-economic infrastructure.

16 Retrieved from https://en.wikipedia.org/wiki/Central_African_Republic
19 One of the main challenges that Central African Republic (CAR) is facing is the massive recruitment and use of children by armed groups. As many as 10,000 children are estimated to have been recruited and used by armed groups in CAR. Boys and girls who were released from these groups informed UNICEF that they were subjected to physical, psychological and sexual abuse. These children have been forced to fight alongside adults, or are used as porters, cooks, and servants. One in four recruited children are girls, who are particularly vulnerable to sexual abuse. Their childhood has been jeopardized by the acts they committed under the command of armed leaders. With the prolonged and complex conflict in CAR, the number of armed groups is increasing, putting more children at risk of recruitment. (SM-2015-0066, PROPOSAL, 23 January 2015)
3.2.2 GBV Context

Nature of the problem
CAR ranks 147 out of 155 countries in the UN’s Gender Equality Index, making it one of the worst countries in the world in which to be a woman. The huge disparities existing between men and women contribute to a culture of acceptance of all forms of GBV, including intimate partner violence, sexual violence, and child marriage. According to the 2010 Multiple Indicator Cluster Survey, more than 70% of men reported that physical violence against females is “normal.” Marital rape is not recognized socially or legally and some communities believe that forced sex with a girl who is not a virgin is not rape. In 2011, UNHCR reported on the high incidence of child marriage, particularly amongst displaced communities in the north, where young girls are married off in exchange for gifts. These married girls often give birth to multiple children before their reproductive systems are fully mature.

The widespread problem of GBV has been exacerbated by the most recent crisis. In addition to the violence that has been commonplace in their homes, women and girls living in areas affected by conflict are routinely targeted for sexual violence by armed actors and subject to opportunistic violence by armed actors and community members as a result of displacement and the absence of any social or legal protections. UNICEF partners and community members report that all forms of GBV are common, with intimate partner physical violence being the most reported, followed by sexual violence and psychological

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24 KII, UNICEF.
25 KIIs, UNICEF.
violence in the home and in the community.\textsuperscript{27} An estimated 7000 survivors were recorded through the Gender-Based Violence Information Management System (GBVIMS) to have received services in 2015.

The consequences of widespread GBV are severe. Women and girls suffer from continued trauma, long-term health complications, abandonment by their husbands and risk of death.\textsuperscript{28} They may be left to raise children without means or support, and face shame and stigma if they report GBV. Adolescent girls in particular experience multiple layers of trauma, some orphaned by the conflict, and/or forced to endure the consequences of child marriage, pregnancy and child-rearing, some abandoned by their husbands, all before reaching adulthood. Exposure to GBV can wreck opportunities for economic recovery for women, girls, and their families. Those women who have returned to their villages often fear going to the fields to cultivate—their primary source of income—or traveling to obtain goods to sell in the market, for risk of being raped. Those living in camps lack economic opportunities and socio-economic support.\textsuperscript{29}

Legal Framework

Though CAR is signatory to key international legal instruments promoting women’s and girls’ rights and protecting them from GBV—including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC)—in practice, the legal framework for GBV in CAR is extremely weak and there is an absence of rule of law throughout the country. According to women’s rights organizations, the national penal code is “not at all gender oriented.”\textsuperscript{30} The few legal protections that do exist for women and girls tend to be overridden by customary laws that offer little protection from multiple forms of GBV for women and girls.

In 2006, the government introduced a law on the protection of women against violence. The law makes rape illegal (excluding marital/spousal rape). However, there is no minimum sentence for rape and the law is not enforced; rape is customarily tolerated as long as the survivor agrees to marry the man who raped her.\textsuperscript{31} The 2006 law also prohibits sexual harassment, but as with rape, it does not carry a defined penalty and the law is not implemented in practice.\textsuperscript{32} At the same time, article 46 of the Penal Code states that spousal murder under circumstances of adultery is considered a “forgivable murder.”\textsuperscript{33}

The minimum age for marriage in CAR is 18, as stated in article 209 of the Family Code. An exemption to this provision can be granted by the public prosecutor on serious grounds. However, child marriage remains rampant, as highlighted by the CEDAW Committee in 2012 and observed during the evaluation. Similarly, under civil law in CAR, women are granted equal inheritance and property rights. However, women are customarily denied access to property and subsidies to which they are entitled, and are not recognized as heads of household. The same is true for divorce rights. Women and girls are systematically discriminated against, economically, socially, professionally and otherwise, even though laws call for equality.

\textsuperscript{27} KII, UNICEF and IPs; FGDs with women.


\textsuperscript{29} FGDs

\textsuperscript{30} FGD, IPs.

\textsuperscript{31} FGD, IPs

\textsuperscript{32} OECD Development Center. Social Institutions & Gender Index: CAR Data Sheet.

\textsuperscript{33} Ibid.
Sexual Exploitation and Abuse
Between 2014 to February 2016, 39 cases were reported of sexual abuse and exploitation committed by international military forces and UN peacekeepers at the Mpoko IDP camp (Bangui), PK-5 (Bangui), Bambari, Boda and Bria.\(^{34}\) In December 2015, an Independent Review was published that identified significant failures across the humanitarian community, including failures by UNICEF to ensure that child survivors were receiving adequate care.\(^{35}\) At the time of this evaluation, additional cases of sexual violence, many of which were reportedly linked to peacekeepers, had emerged in Dekoa. The revelations of SEA have rocked the entire humanitarian response, with human and financial resources being dedicated across the UN system to more immediately and effectively prevent and respond to this grave problem.

3.2.3 Humanitarian Response

3.2.3.1 General Overview of Humanitarian Response
The current crisis in CAR comes on the heels of decades of instability as a fragile state. Plagued by ongoing conflicts, there was a period of relative stability in 2009 following the signing of a peace agreement in Gabon. This caused a shift in international assistance from relief to recovery. However, with the declaration of the L3 emergency by the UN in 2013, international aid returned to emergency programming. There was a relatively rapid inflow of humanitarian staff to the capital, Bangui, followed by a gradual increase in staffing in humanitarian field offices around the country and strengthening of humanitarian coordination mechanisms.\(^{36}\)

The Multi-Sector/Cluster Initial Rapid Assessment report was published in January 2014, followed by Disaster Needs Analysis reports published in February and July of the same year. Despite these efforts, significant challenges persisted in responding to the crisis. Observers have noted that it was difficult for the humanitarian community to understand and prioritise the needs of the affected population following the crisis: some agencies focused on establishing emergency programming for newly displaced persons, while others continued to implement programmes aimed at addressing the chronic problems that existed before the most recent crisis. Different types of programming sometimes existed within the same location.\(^{37}\)

Access to populations has been significantly constrained by insecurity and poor infrastructure, leaving some areas of the country with little to no assistance.\(^{38}\) There have also been problems in sharing assessment data, communication between agencies, and high staff turnover, as well as questions about the reliability and quality of humanitarian information. Threats to humanitarian actors were and remain high.\(^{39}\) In addition, lack of global attention and donor interest has left the crisis chronically underfunded

\(^{34}\) UNICEF Spanish Proposal, 2016.

\(^{35}\) "The manner in which UN agencies responded to the Allegations was seriously flawed. The head of the UN mission in CAR failed to take any action to follow up on the Allegations; he neither asked the Sangaris Forces to institute measures to end the abuses, nor directed that the children be removed to safe housing. He also failed to direct his staff to report the Allegations higher up within the UN. Meanwhile, both UNICEF and UN human rights staff in CAR failed to ensure that the children received adequate medical attention and humanitarian aid, or to take steps to protect other potential victims identified by the children who first raised the Allegations." p. i, Taking Action on Sexual Exploitation and Abuse by Peacekeepers, Independent Review on Sexual Exploitation and Abuse by International Peacekeeping Forces in the Central African Republic, December 2015.


\(^{37}\) Ibid.

\(^{38}\) E.g Vakaga in the northeast.

\(^{39}\) These threats remain in May 2016, the International NGO Safety Organisation (INSO), an NGO dedicated to the safety of aid workers, registered 26 security incidents affecting NGO operations in CAR; higher than those registered in Syria (24),
while severe staffing and capacity gaps continue. Moreover, years of foreign intervention have caused distrust and distaste amongst the population for further external influence. The recent allegations of widespread SEA by MINUSCA and humanitarian actors cast a dark shadow over the humanitarian effort, while diverting financial and human resources to PSEA efforts.

Amidst these challenges, efforts have been made to strengthen humanitarian systems at the national level, and also ensure support is available throughout the country (see graphic below). There are ten clusters operating in CAR, with UNICEF CAR leading the nutrition, education and water, sanitation and hygiene (WASH) clusters, and the child protection subcluster.

3.2.3.2 General Overview of Humanitarian GBV Response

The GBV Subcluster (SC) has been coordinated by UNFPA since 2014, with Mercy Corps as the co-lead. UNICEF is a member of the strategic advisory group for the SC. MOSA has two designated staff that serve as GBV focal points at the national level and who are reportedly active in the SC. From 2014-2015, the GBV SC operated according to a workplan (it is not clear whether this has been updated for 2016), of which key activities included:

- Provision of health, psychosocial (including socio-economic support) and legal response for sexual violence survivors
- Support to women’s groups (existing and newly developed)
- Community sensitization related to GBV
- Sensitization to police related to GBV


• Institutionalization of a standard referral system for GBV
• Establishment of an alert system for sexual violence

In July 2015, in an initiative in which UNICEF was very engaged, standard operating procedures (SOPs) for GBV prevention and response in CAR were adopted by the government and GBV SC. International aid organizations including COOPI, Mercy Corps, Medicines Sans Frontiers (MSF), IRC, and DRC are designated as the primary service providers (see map below for a summary of GBV actors). Since 2013 DRC has managed an humanitarian fund “green line”, or hotline, for survivors that provides referrals to health and psychosocial care. DRC uses SMS to send messages about the availability of services for sexual assault survivors and the importance of seeking care.

WHO is leading the development of national Clinical Management of Rape (CMR) protocol as part of a joint initiative on GBV funded by a UNDP multi-donor trust fund that includes UNFPA, UNICEF, UNDP, WHO, and the Ministry of Health. MOSA has designated a mobile team of social workers (3 women and 4 men) who can be deployed to respond to urgent complaints. The largest local NGO working on GBV is AJFC (focused on psychosocial and legal services), and they offer sub-grantee support to smaller local NGOs.

Currently, some type of GBV humanitarian response exists 47 sub-prefectures, mainly in cities and big villages, which corresponds to 67% of the national territory. In Bangui, health, psychosocial, and legal services are available for survivors. There are also 21 police precincts in Bangui, each with one UNPOL staff, that can receive survivor reports. However, in the rest of the country services remain limited. It is estimated CMR services (that includes post-rape exposure [PEP] and emergency contraceptive [EC]) exist in approximately one third of CAR’s prefectures, and psychosocial services (PSS) in approximately half. The majority of PSS services are provided by humanitarian I/NGOs, with MOSA representatives also reportedly responding to individual cases and supporting some community sensitization. The police and judiciary are not yet functioning in most of the country, and even where they are functioning, there is a fee to file of 2000 CFAs, and it is reportedly often the case that a perpetrator’s family will pay money for his release. Because of a lack of capacity within the judiciary, the few cases brought to justice in 2015 have generally not being judged as rape crimes but as indecent assaults.

The GBVIMS was established in CAR in 2014. At the time of the evaluation, eight GBV actors were reporting through the GBVIMS. A GBVIMS coordinator oversees the process through a GBVIMS technical working group, which UNFPA leads and other organizations (UNICEF, UNHCR and IRC) support. The GBVIMS global surge team was in Bangui while the evaluation was taking place because of concerns

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41 This document was prepared by more than 20 government and humanitarian entities, including inter alia the ministries in charge of gender, security, justice and health, COOPI, Mercy Corps, Medicines Sans Frontiers, International Rescue Committee, UNFPA, UNICEF, UNHCR and the UN peace-keeping mission (MINUSCA).
42 KII, WHO.
43 The mobile team is linked to the SEA response. It is not clear how they are deployed in response to other incidents of sexual violence, and/or other forms of GBV.
46 KII.
47 KII.
related to data and the need for more technical support to partners related to the use of the GBVIMS tools.


Other mechanisms related to GBV include:

**Monitoring, Analysis, and Reporting Arrangements on Conflict-related Sexual Violence (MARA) Working Group**: A Women’s Protection Advisor (WPA) in MINUSCA is leading monitoring of sexual violence according to MARA responsibilities, with 53 community liaison assistants on the ground that act as the link between the mission (of which there are 35 military operation bases) and the community. While a MARA working group exists (comprised of WHO, UNHCR, UNICEF, UNFPA and MINUSCA), it is reportedly not currently active. The mission has recently undertaken a pilot programme in Bangui that will serve as a “rapid intervention unit” for sexual assault survivors in police precincts. The MARA has verified 54 cases of conflict related sexual violence (CRSV). An addendum to the GBVIMS ISP has been developed for sharing data with the MARA Working Group and the MRM Task Force.

49 KII, MINUSCA.
Monitoring and Reporting Mechanism for Grave Violations against Children (MRM) Task Force: UNICEF and the SRSG of MINUSCA co-chair the MRM task force. 3,011 individual cases of grave violations (recruitment, rape, abduction, maiming and killing of children) and 160 cases of attacks against schools, health facilities and humanitarians were identified in 2015, representing almost double the cases in 2014.\textsuperscript{50} Existing capacities of the MRM are being harnessed to monitor and link SEA incidents to current engagement with the Ministries of Justice and Social Affairs, UN system [including the UN Office of Internal Oversight Services (UN-OIOS)] and NGO partners, to enable children to have access to services and facilitate prosecution of cases.\textsuperscript{51}

PSEA Technical Task Forces and Working Group: The UN peacekeeping mission and the UN humanitarian mission each maintain an internal (P)SEA Task Force, the former under the leadership of the Resident Humanitarian Coordinator (RC/HC) and the latter managed by the SRSG. These Task Forces are meant to promote vertical accountability within the respective missions for addressing PSEA adequately and responsibly. Collectively, the two groups comprise a broader PSEA Task Force, led by MINUSCA and composed of UN agencies, civil society, local government services and NGOs, that works laterally with other partners in an effort to ensure that lessons drawn from the SEA crisis in CAR are shared and built upon, and that standards and protocols are understood and applied at community level.

### PSEA Coordination mechanisms in CAR

<table>
<thead>
<tr>
<th>Humanitarian</th>
<th>UN Agencies</th>
<th>Peacekeeping mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>February 2016</td>
<td>December 2015</td>
</tr>
<tr>
<td>Humanitarian Coordinator (HC)/Deputy HC/ Humanitarian Country Team (HCT)</td>
<td>Resident Coordinator (RC)</td>
<td>Sexual Exploitation and Abuse Task Force (SEA TF)</td>
</tr>
<tr>
<td>PSEA Task Force (13) UNFPA</td>
<td>UNCT Crisis Committee (7) UNICEF/UNFPA</td>
<td>SRSG</td>
</tr>
<tr>
<td>PSEA Focal Points Network in Bangui (50) UNFPA</td>
<td></td>
<td>Information referral/ case management</td>
</tr>
<tr>
<td>Field PSEA Focal Points (ongoing) Agencies</td>
<td>UNICEF/UNFPA/UNHCR/OCCHA/CHR</td>
<td>Investigation</td>
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<tr>
<td></td>
<td></td>
<td>OIOS</td>
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<td></td>
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<td>CDT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Field SEA Joint Prevention Team Force</td>
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<tr>
<td></td>
<td></td>
<td>MINUSCA holds</td>
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<tr>
<td></td>
<td></td>
<td>support</td>
</tr>
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</table>

3.3 UNICEF GBV Programme

UNICEF’s current Country Programme Document (CPD) runs from 2012-2016. Under this CPD, UNICEF CAR works in six sections: Health and Nutrition (specifically Child Survival and Development), WASH, Education (specifically Basic Education and Gender Parity), Child Protection, Social Policy Planning and M&E, and Communication for Development (C4D).\textsuperscript{52} GBV is situated within the Child Protection section (which is often referred to simply as “Protection” within UNICEF programme documents).

3.3.1 GBViE-Specific Programmes

Within the current CPD, GBV response for women and children is listed as the second of two main focus areas for Child Protection; it also features directly as a corresponding result in the CPD results matrix and

\textsuperscript{50} UNICEF Country Office Annual Report, 2015.
\textsuperscript{51} UNICEF, internal memo, 2016.
\textsuperscript{52} UNICEF CAR Country Programme Document 2012-2106.
specific outcome within the 2016 workplan, in which there is a specific outcome that is directly related to GBV and SEA (4.2.3).  

- **Specific Outcome 4.2.3:** Survivors of sexual violence benefit from holistic assistance (medical, psychosocial, socio-economic and legal) and protection against all forms of violence, exploitation and abuse and PSEA is upheld within SOPs (Standard Operating Procedures).

UNICEF has a designated team for GBV (one international and one national staff) in the CO. They currently work with three implementing partners (IRC, COOPI and the national NGO AFJC). UNICEF CAR estimates that it is supporting GBV-related programming in 50% of the country. Specific activities are detailed in the table below.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Listening Centres** | UNICEF is supporting 20 GBV listening centres (run by IRC, COOPI AND AFJC) throughout the country: Bangui, Baoro, Yaloké, Bossemptelelé, Mbaiki, Boda, Boali, Gremari, Berberati, Carnot, Sibut, Bocaranga, Ngaoundaye, Bossangoa, Mbomou, Bangassou and Rafai. The listening centres carry out a series of activities including:  
  - Psychosocial support for victims of violence and abuse (including SEA)  
  - Referral to health services for diagnosis and treatment  
  - Referral to legal services  
  - Social activities and classes, such as for literacy  
  - Socio-economic support through small-scale livelihoods supplies, such as for soap making and knitting  
  - Distribution of hygiene kits |
| **Community safety mechanisms and awareness raising** | • UNICEF supports its IPs to undertake a variety of community awareness-raising and community mobilizing activities on GBV, including door-to-door visits by women’s community groups/community protection groups, dance groups for mass sensitization, focus groups on key issues such as education for girls, early marriage, etc., and radio programmes  
  • UNICEF has also supported the development of capacity-building of community protection networks that assist in the identification of cases and referral to services, such as community health workers, community “agents”, community leaders, etc. |
| **Legal Support** | UNICEF’s legal partner is AFJC. AFJC provides assistance to clients from their own programmes, and they also receive clients from other GBV providers such as IRC. They “build files” for judicial support (in one of their reports which the evaluation team had access, they received 86 cases in 2 months). |
| **Psychosocial Training** | Most of the psychosocial support provided through UNICEF-funded programmes is delivered in the listening centres. Outreach teams also providing home visits that include family mediation |

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53 UNICEF CAR CPD (2012-2016), section on Child Protection: “A second focus of the programme will be an integrated approach to gender-based violence centred in the post-conflict provinces of the country, in partnership with NGOs, United Nations partner agencies, and based on a community-based approach. 50 per cent of known victims will receive an integrated legal, security, psycho-social and health response.”; UNICEF CPD Results Matrix: Child Protection/ Result (RCP) 2: “The ability of institutional protection and non-institutional actors is strengthened at national and regional levels to provide medical, psychosocial and legal taking into account gender equality, training for the workforce and support livelihoods for women and girls vulnerable and victims of sexual violence.”; 2016 Draft Annual Workplan for Protection, Specific Outcome 4.2.3: “Survivors of sexual violence benefit from holistic assistance (medical, psychosocial, socio-economic and legal) and protection against all forms of violence, exploitation and abuse in accordance with the SOPs in effect. Specific Outcome 4.2.4: “In 2016, support the resilience of families, “tuteurs” and communities to build a protective environment for women and children in a post-conflict situation.  

54 Save the Children will soon be implementing a project for UNICEF in Dekoa in response to sexual violence cases identified there (many linked to the peacekeeping forces).
and couples’ counselling. In January 2016, after undertaking an assessment of partner training needs, UNICEF supported a training on PSS in work with children affected by armed conflict.55

**CMR Protocol**
UNICEF has supported CMR training to health care providers in a joint project with UNFPA, WHO, UNDP and the MOH.

**Supply Mobilization**
UNICEF has supported the distribution of hygiene/dignity kits to their partners and continues to maintain stock. They also supported the distribution of PEP for children, but this has been discontinued as UNFPA has been designated the provider of PEP kits.

**SOPs/referrals**
UNICEF supported the development of national SOPs, signed by government, UN, and I/NGO partners in June 2015. AFJC trains judiciary, police and social workers and community leaders on referral systems.

**Interim care centre for children**
UNICEF works with COOPI to support an interim care centre for demobilized children (including GBV survivors) that offers case management, group PSS and individual counselling in Bria.

**Coordination**
At the national level, UNICEF participates in the GBV Subcluster and the MARA Working Group, and also leads the MRM Working Group as well as a UNCT Crisis Committee for SEA that reports to the RC/HC.

**SEA**
UNICEF’s SEA response is linked with its GBV programming. SEA sensitization, including information about referral, is provided through GBV partners. Health, psychosocial, legal and economic support is provided through child friendly spaces, listening centers, and community outreach programmes.

### 3.3.2 Integrated GBVIE Programming

Integrated programming is not explicitly articulated anywhere within UNICEF planning or reporting documents as part of a broader strategy for addressing GBVIE. However, in February 2015, UNICEF conducted training for all sections on the 2015 IASC GBV Guidelines. As a follow up, the UNICEF GBV Specialist from NY met with representatives of the different sections during a technical visit in August of that year.56 As described below, the majority of UNICEF operational sections report that they are integrating some elements of GBV into their programmes in some way (notably CP and WASH), though these are not linked to specific indicators within workplans. Therefore, the full extent of actions undertaken that are linked to the recommendations in the GBV Guidelines for risk mitigation is not captured by UNICEF colleagues.

#### 3.3.2.1 Child Protection

GBV is integrated in Specific Outcome 4.2.4 of the Child Protection Annual Workplan 2016 that calls for support to families and communities to build a protective environment both for women and children. This protection work includes supporting demobilization, disarmament and rehabilitation (DDR) for boys and girls formerly associated with armed forces and armed groups as well as services for SEA complainants. As noted above, the ICCs integrate services for child survivors, and UNICEF is also leading the CP Subcluster in GBV mainstreaming.

#### 3.3.2.2 Health (including Nutrition)

The health and nutrition section has worked with the CP section to enhance availability of CMR services to survivors. In 2015, UNICEF health colleagues worked with CP to facilitate the provision of CMR training.

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55 In this training, future priorities that were identified by participants included: increased sensitization for communities about the risk factors for sexual violence and the psychosocial impact of violence; training for policemen, judges, lawyers, health workers and teachers on engagement skills; improved coordinator among medical, legal, judicial and psychosocial actors to provide holistic and structured response.

to district-level health providers (hospital and NGO staff) as well as supplies (e.g. PEP kits) and provide support for operational costs.

3.3.2.3 Education
The emergency education programme has included some attention to GBV in their training curriculum for teachers in IDP sites. The education programme also aims to create safer schools more broadly by working with school directors on positive discipline and developing and posting codes of conduct. However, implementation is a challenge as violence against children (VAC) and GBV are not prioritised. Schools in CAR were some of the lowest functioning in Africa before the current crisis and hardest hit during the conflict, so attendance is poor and the Ministry of Education (MoE) is inundated with competing priorities.  

According to one KII, “girls are raped every day at latrines” in schools, particularly primary schools. In a case where violence or exploitation might be committed by a teacher against a student, a teacher might be moved by her family to another school, because “no one is going to put a teacher in prison.”

3.3.2.4 WASH
A WASH KII reported that women’s safety and dignity is a priority for the programme, with specific attention paid to distances women need to walk to access services and participation of women in WASH decision-making, e.g. at least 50% of participants on water committees must be women, and women are engaged in site selection for water points and in latrine management. WASH distribution of hygiene kits is not connected to the GBV programme’s distribution of hygiene or dignity kits and do not include female sanitary supplies.

3.3.2.5 C4D
The integration of GBV and C4D focuses on community messaging around PSEA. C4D utilize an interpersonal communication approach, through which social mobilizers engage in educational discussions with community members about SEA.

3.3.2.6 PM&E
PM&E incorporates GBV information received from the CP section into the SitRep. PM&E is also supporting an upcoming review of the CAR CO alignment with the UNICEF Gender Action Plan (GAP), of which one targeted priority is GBViE.

3.3.3 Funding for UNICEF CAR GBViE Programmes
The annual CP programme budget for 2016 is $11,732,500 with less than half funded ($5,308,52.35) at the time of the evaluation, and more than 50% of funds still needing to be secured ($6,423,997.65). Multi-sectoral response to GBV and SEA (combined under Specific Outcome 4.2.3) makes up 20% of the total annual CP programme budget, at $2,380,000 for 2016. This budget for GBV-specific programming was only 10% funded ($210,000) at the time of the evaluation, with more than 90% of funds remaining to be secured ($2,170,000). In response to the SEA scandal, UNICEF CAR is receiving an internal allocation of $1.8 million dollars from UNICEF HQ in 2016. The CO intends to leverage those SEA funds to strengthen

57 KII.
58 KII.
59 KII.
60 KII.
61 UNICEF, 2016 Draft Annual Workplan for Protection- Final Review.
their GBV programme. There is an additional $1,500,000 per year budgeted for Specific Outcome 4.2.4, which is not GBV-specific, but aims to build a protective environment for women and children more broadly. This outcome is more than 50% funded ($830,000).

4 EVALUATION FINDINGS

The section addresses the questions related to the evaluation criteria outlined in the ToR and Inception Report.

4.1 Relevance

Alignment of UNICEF programming with assessed needs of affected populations (which may change over time), good GBViE programme practice and relevant UNICEF strategies and policies.

4.1.1 Alignment with Assessed Needs of Affected Populations

UNICEF’s programming to establish minimum essential services for GBV survivors is highly relevant to the needs on the ground as reflected by affected populations, key informants, and GBVIMS statistics, which all indicate GBV is a rampant problem in CAR. UNICEF’s GBV programme has been informed by analyses of beneficiary need through direct assessment, as well as inputs from other sources. UNICEF’s GBV programming—and, in fact, the entire humanitarian community’s GBV programming—has also been influenced by efforts to respond to SEA following media allegations in 2015 highlighting a system-wide failure to address this concern. In the wake of these reports and subsequent investigations, including by the Special Representative to the Secretary-General (SRSG), UN agencies asked NGOs to strengthen their activities on GBV to improve reporting of, and response to, cases of SEA.

Implementing partners (IPs) undertake community monitoring and dialogues with women and adolescent girls on a regular basis to identify their security concerns. IRC, for example, conducts safety audits among IDPs using a globally verified tool. In one process observed by the evaluation team, COOPI community protection monitors in Bria gathered for a debriefing on the findings of their outreach related to GBV issues, discussing a range of issues, from the nature of GBV problems to suggestions about solutions (see table below). This exercise not only served as a learning tool for the community protection monitors, but is also being used to inform community awareness-raising efforts.

<table>
<thead>
<tr>
<th>GBV issues in the community</th>
<th>Family abandonment, Physical Violence, Men drinking, Theft, Domestic Violence, Rape Forced Marriage, Early Marriage, Denial of resources, Denial of opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perpetrators</td>
<td>Men: Husband (&quot;My husband abandoned me with children&quot;) Young people (ex Seleka)</td>
</tr>
</tbody>
</table>

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62 KII, UNICEF.
63 In February 2014, UNICEF sent a technical staff member from HQ to CAR to help the GBV subcluster develop and undertake a GBV assessment. The assessment was conducted in March 2014 in IDP sites inside and outside of Bangui. The assessment also contained some questions on child protection and involved the child protection subcluster. In addition, IPs have conducted preliminary assessments in order to inform programme design (e.g. IRC conducted focus groups and service mapping to identify protection and service needs and gaps among IDPs in Bangui and Ouham Pende).
64 Following a multi-sectoral evaluation led by OCHA in May 2014, recommendations were made to increase activities for GBV prevention and response outside Bangui, which UNICEF referenced in seeking funding for expanded services. In seeking financial support for improved health services, UNICEF also referred to the Health Resource Availability Mapping survey (HeRAMs), conducted in early 2014, which found that out of the 810 health facilities in the country, only 55 per cent were functioning and 27 per cent were totally or partially destroyed by the ongoing crisis. (SM-2015-0066, 23 JANUARY 2015)
<table>
<thead>
<tr>
<th>Causes</th>
<th>Armed Conflict, Social Norms, Poverty, Illiteracy, Abandonment, Death of Parents, Divorce Maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequences</td>
<td>Suicide, Death, Sterility, Handicaps, Infidelity</td>
</tr>
<tr>
<td>Resources</td>
<td>NGOs, Religious Leaders, Authorities, Police, Gendarmerie, MOSA, Mayor</td>
</tr>
<tr>
<td>Strategies for Prevention</td>
<td>Mass Sensitization, Family Mediation, Home Visiting, Talks/Debates, Medical referral for rape, Listening Centres for counselling, Social Services</td>
</tr>
</tbody>
</table>

Notes from Community Protection Monitor Debriefing, Bria, May 2016

Notably, however, one key informant from a local NGO revealed that they do not engage women in assessments related to programme planning. They assumed that UNICEF does assessments “and then they [UNICEF] decide what the priorities are”, to which the local NGOs respond when there are calls for proposals.

### 4.1.2 Alignment with relevant UNICEF Strategies and Guidance

#### 4.1.2.1 Alignment with UNICEF GBVIE Resource Pack

**Area of alignment.** UNICEF is undertaking all the Minimum Actions the UNICEF GBVIE Resource Pack suggests should be addressed in immediate crisis-response (see Table 1), with the exception of risk mitigation across clusters and sectors (described further below). UNICEF is considered to be a “key partner” in the national GBV Subcluster. As a first priority for response, and in collaboration with the UNICEF health section as well as other partners, the CP/GBV team supported the scale-up of CMR services through training and provision of PEP supplies to government hospitals and I/NGO partners. UNICEF also supported community-based mechanisms (e.g. women’s and other groups) to provide support and referral to survivors and those at risk, and have opened 20 “listening centres” country-wide, which serve many of the same support functions as safe spaces (e.g. counselling, social activities, access to dignity/hygiene kits, some limited income-generation, etc.). In 2015, nearly 2,697 women and children received access to psychological support, medical referral (including payment of medical fees if necessary) and hygiene kits through the listening centers. Other community-based mechanisms, such as community volunteer outreach workers, have been developed to identify vulnerable individuals, refer and accompany survivors to the Listening Centres, link vulnerable children with protection activities and conduct community awareness-raising activities.

With regard to the expanded GBV prevention and response interventions included in the draft Resource Pack, CAR CO is most aligned in terms of its efforts to improve multi-sectoral services. UNICEF has been instrumental in supporting the development and distribution of national GBV SOPs. All of UNICEF’s IPs contribute to the GBVIMS, for which UNICEF has supported training. UNICEF is the only UN agency focused on improving access to legal assistance for GBV issues through advocacy to the Ministry of Justice (MoJ) to reinstate courts, as well as support to the local NGO AFJC, whose paralegal services now reach ten areas of the country (whereas previously legal assistance was only available in Bangui). While UNICEF no longer supplies PEP kits (now designated as a UNFPA responsibility), it maintains contingency stocks of dignity/hygiene kits and continues to ensure that kits are distributed via listening centres and community outreach. UNICEF also works with GBV focal points at MOSA as part of coordination and training.

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65 KII.

In addition, the CP team has supported gender sensitive DDR programming. A total of 2,662 children aged 7 to 17 (613 girls and 2,049 boys) were released from armed forces and groups in 2015. According to the UNICEF Country Office Annual Report for 2015, the CAR CO provided gender-sensitive holistic care to girls released from armed groups, ensuring that interim care facilitated their access to support for physical/sexual abuse.67

**Areas for growth.** As highlighted in points below, there are several areas for growth in UNICEF’s support to GBV programmes. UNICEF CAR’s GBV specialist scored its GBV programme relatively low on all areas of GBV intervention in the self-assessment checklist, most notably safety response, economic strengthening for adolescent girls, and dignity kit distribution (see Table 2). These generally low scores across all intervention areas likely indicates that the scope of interventions—even where they exist—are at basic levels, reflecting the significant contextual challenges to scaling up programmes in CAR. Even so, the evaluation team is surprised by the low score related to dignity kits, but attributes this to the fact that the checklist focuses primarily on design of the kit and participation of women, rather than kit distribution itself, or perhaps to the fact that the kits UNICEF is distributing do not have all of the supplies of a dignity kit.68 The evaluation team would also score UNICEF higher on its safe space programming relative to other GBV interventions.

<table>
<thead>
<tr>
<th>GBV Specific Self Assessment</th>
<th>Score 1= Not Met</th>
<th>Score 5= Fully Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Strengthening for Adolescent Girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NFI WASH and Dignity Kit</td>
<td></td>
<td></td>
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<tr>
<td>Safety Response</td>
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<td></td>
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<tr>
<td>Health Response</td>
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</tbody>
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67 The evaluation team visited one interim care center for demobilized boys in Bria, but did not have the opportunity to observe any DDR services for girls.

68 AFJC reported to the evaluation team that they had requested dignity kits several times, explaining that they had only received hygiene kits. When asked the difference, they said dignity kits contained “cloth (panga), blankets (which can be used for babies as well), bras, slips, slippers.” They said AFJC received them in Bangui but not elsewhere.
The evaluation team agrees that **security sector response is an area of programming that requires greater attention if protection for survivors is to be improved**. Limited training to police has been conducted in Bangui, but among police interviewed, knowledge and capacity appeared low. Many police units are not functional; there are no computers, no electricity, no transport, no female police officers, etc. Instead it is the *gendarme*ri*é* that provides security in large areas of the county. UNPOL operates in some police precincts, but their presence is not country-wide. While it may be premature to support capacity building of the security sector at large given considerably infrastructure challenges, UNPOL may represent an entry point to build police capacity in some areas in the country outside of Bangui. One UNPOL officer interviewed by the evaluation team in Bria felt that UNPOL should scale up its capacity to address GBV, with a GBV focal point position funded within UNPOL to provide training and support to national police.

The evaluation team also noted that **attention to adolescent girls is an area for growth**. UNICEF’s self-assessment is that **GBV programming is not supporting economic strengthening of adolescent girls**. More generally there do not appear to be particular strategies within the listening centres for targeting the needs of adolescent girls, who gave mixed reports to the evaluation team of how relevant they find services.69 Adolescent girls expressed fear of stigma in reporting and were experiencing confounding traumas with unique impacts based on their age, e.g. being married with children, orphaned, abandoned by husbands and survivors of GBV, etc. UNICEF’s CPD and annual workplans related to GBV group women and children together in the strategic outcomes and activities, making it impossible to distinguish how GBV programmes are designed and implemented with the specific needs of girls in mind.

Another area for future growth identified by the evaluation team is related to the **problems of IPV and child marriage, which are both widespread in CAR, but which humanitarian response has not yet tackled in any targeted way**. While psychosocial support and urgent medical care are critical for all survivors (and a priority in the early stages of emergency response), skills and are not in place to respond to other types of violence in a more specialized way, e.g. safety planning for IPV. Some UNICEF IPs are providing mediation between husbands and wives, but there is no evident guidance and/or oversight for this potentially dangerous work.70

Finally, **prevention programming represents an important focus area for future programming**. Current community outreach activities include discussion of human rights and general community awareness related to GBV, but to date there has not been programming targeting social norms and legislative and policy interventions. The ability of Listening Centres to serve a preventative role, particularly through livelihoods and other empowerment initiatives, has not yet been fully exploited; at present they offer a safe space for survivors to report and are used primarily for counselling survivors and social activities. More expansive programming focused on empowering women and girls is not currently available.71

### 4.1.2.2 Alignment with UNICEF Corporate Commitments

UNICEF CAR’s commitment to GBVIE programming aligns with UNICEF corporate commitments including the UNICEF Strategic Plan, Equity Approach, and Gender Action Plan (GAP) though they are not articulated as such in planning and programme documents. UNICEF has applied the Equity Approach and has carried out a determinant analysis. However, one staff member noted that while there has been some focus on how to make programmes more equitable, there is no follow up “to see whether the programmes are

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69 FGDs, adolescent girls.
70 KII, UNICEF IP.
71 IRC provides supplies for small-scale income generation through distribution of supplies for knitting and soap-making.
really equitable enough.”72 Another KII noted that he was not sure how the Equity Approach was linked to GBV programming, suggesting that “GBV is taking a lot of emphasis due to the [SEA] situation [in CAR], but even in the most stable countries I haven’t seen this equity approach regarding GBV”—in other words, no overt linking of the equity approach to GBV programmes such that inequities affecting women and girls are an explicit aspect of GBV response.

UNICEF’s global commitments to GBViE are well understood at a country level, with attention to GBV described at the highest level of the CO as a “big priority.” Some interviewees feel that this strong commitment to GBV has largely to do with UNICEF’s reputational concerns around accountability to SEA rather than a commitment to addressing the broader social problem of violence against women and girls. However, another interviewee suggested that it was not just the problem of SEA that provoked UNICEF to invest more resource in GBV programming, but also the number of sexual violence cases emerging as a result of the conflict.

4.1.3 Risk Mitigation Integration into UNICEF Sections
While the UNICEF Representative expressed a desire to see GBV integrated into all aspects of UNICEF programming, suggesting that “it falls into the protection mandate that we have in general”, UNICEF sections’ self-assessment checklists (see Table 3) generally reflect the findings of the evaluation team: UNICEF’s mainstreaming work has been limited. Perhaps not surprisingly, CP and WASH scored themselves highest. Surprisingly, however, health scored themselves lowest. Based on information from the health team about their work with CP to support CMR, the evaluation team would have expected a higher score. (Note that nutrition is part of the health section in the CAR CO, but for the purposes of the self-assessment, a specific checklist related to nutrition interventions was completed.) The low score from the health section may be explained by the fact that the health section does not currently have any specific programming in their workplan related to CMR. The health focal point identified to link with the CP team on CMR does not have that responsibility in his Terms of Reference [TOR], suggesting that work with the GBV team is informal. However, it was reported to the evaluation team that the health section supported some activities linked to CMR in 2015 (an activity apparently stimulated by the SEA crisis73), which is not reflected in the assessment checklist, perhaps because the activities were in support of the GBV team’s programming rather than undertaken as stand-alone programmes.

Table 3

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72 KII, UNICEF staff. The same respondent indicated that there is limited knowledge of the GAP and only slightly more understanding of the Equity Approach amongst staff, following a training on the Equity Approach in 2014.
73 A KII noted, “UNICEF’s involvement in CMR was driven by SEA reports. Rape is not seen by the community as a problem [including among national staff], but from UN perspective it is a problem.”
A potentially significant area for improvement that is not captured in the self-assessments is **GBV integration in UNICEF Emergency Operations’ (EMOPS) Rapid Response Mechanism**. The Rapid Response Mechanism (RRM) was an important part of the CAR CO’s emergency response, reaching 230,136 highly vulnerable affected people. Early warning systems established through the RRM generated 193 alerts on humanitarian shocks, mainly caused by conflict. Those alerts led to a total of 93 exploratory missions, 93 rapid multi sectorial assessments and 47 NFI and 32 WASH relief operations. Emergency assessments conducted by EMOPS include some basic protection information, and the evaluation team was told that when/if information is gathered about GBV concerns it can be shared with the CP team. However, RRM activities are focused on NFI and WASH and, according to the EMOPS section, GBV is not within their mandate.

**Another entry point for mainstreaming is in C4D.** A colleague within C4D recommended that a strategy for addressing GBV through C4D programmes be developed at the global level, cautioning that it should be on GBV specifically, rather than protection: “If it is on protection, it is too broad.” At the CAR level, the C4D chief has experience in GBV, but the existing messages are focusing specifically on PSEA, representing a missed opportunity.

In general, and aside from the CP team’s link to the health section, **coordination across sections for the purpose of mainstreaming does not yet exist.** The evaluation team agrees with one KII, who stressed that “One of the aspects that we need to improve is coordination between sections—as you can see we have many sections, so if you want to mainstream protection or GBV in other sections, this will need coordination and collaboration.” Notably interviewees in CP were not aware of any GBV mainstreaming efforts in UNICEF sections (other than health). The CP/GBV team had, however, worked with the Programme Review Committee (PRC) in an effort to ensure that GBV is included in partner agreements as part of the proposal validation process. To date, however, GBV inclusion in PCAs is not a criterion for agreement.

**4.1.4 Theory of Change**

The GBV programme does not have a Theory of Change (ToC) or clearly articulated strategy for GBV, other than what is observable through the programme itself (a focus on ensuring basic services and protections are available to survivors, along with preliminary efforts to build the health and psychosocial systems in CAR). Because the CAR CO’s GBV programming approach and activities are embedded within general Child Protection plans and documents rather than in a stand-alone strategic document focused on GBV, there is no specific articulation of UNICEF CAR’s GBViE programme approach that can be compared with UNICEF’s global ToC.

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74 KII, UNICEF. The main objective of the RRM is to “ensure humanitarian watch through rapid sectoral and multi-sectoral assessments, in areas of displacement and return, as well as the dissemination of these assessments at coordination and humanitarian community levels; to contribute to the improvement of the capacity of the affected population to carry out essential daily activities for their survival and dignity; and to ensure access to drinking water and a healthy environment for vulnerable populations affected by shocks through water emergency, hygiene and sanitation.” (http://www.reach-initiative.org/central-african-republic-reach-support-to-the-rapid-response-mechanism-2015-overview)

75 KII, UNICEF.

76 Implementing partners are required to use a logframe to ground and guide their programme, but this is not linked to a UNICEF strategy or ToC.
4.1.5 Adapting to Changing Needs
Problems of access and volatility significantly constrain humanitarian actors’ abilities to ascertain and address the changing needs of the population, particularly outside of IDP sites.\(^7^7\) Perhaps the most relevant adaptations that the UNICEF GBV programme has made to the changing needs of the population was the establishment of Listening Centres across the country. As populations began to return home to areas where services are limited, Listening Centres have been introduced to create a stable and safe presence where women and girls can receive support.\(^7^8\) The community protection mechanisms established by UNICEF IPs are also an important strategy in identifying community concerns related to GBV and in supporting women and girl survivors and those at risk to access care and support, described further in section 4.2.5.

At an institutional level, the massive increase in workload caused by UNICEF’s response to SEA allegations against peacekeepers has made it challenging for the GBV programme to continue to adapt to the needs of the population. One KII suggested that: “I don’t think UNICEF has the internal capacity to deal with GBV. SEA is taking up everything…and UNICEF is tasked with a large proportion of addressing this issue.” The small GBV team have been responding directly to individual cases and have been heavily involved in internal and external consultations on SEA. This shift away from a focus on GBV programming means that the GBV team have not had time to strengthen and/or further develop their programme.

4.2 Effectiveness
The extent to which the programme/activity is achieving or is likely to achieve its stated purposes, on the basis of outputs delivered.

4.2.1 Improved Access to GBV Services
Improved access to basic health and psychosocial services is at the heart of UNICEF’s GBV programming. One important contribution that UNICEF has supported in order to facilitate access to services is the development and rollout among partners of national SOPs, which have been adapted in some sites to ensure referral pathways are in place. The evaluation team reviewed referral pathways for Bimba and Bangui, both of which were in line with good practice.

Where UNICEF is supporting GBV services, data suggests that over 71% of survivors who access assistance receive a complement of health and psychosocial care (legal assistance is also available, through AFJC, although there is no evidence that cases are being addressed in courts).\(^7^9\) Reporting levels (for sexual violence) have increased in the last quarter of 2015 and the first quarter of 2016; the majority of the reports (an estimated 80%) are from incidents that occurred 6 months to a year previously.\(^8^0\) This suggests that survivors are progressively more willing to access care.

One explanation for this apparent increased willingness to access care is the community outreach about availability of services that is an integral part of several UNICEF-funded GBV interventions. IRC’s programmes reported that they conduct periodic assessments of community members’ knowledge of services. In one assessment conducted in 2014, 94% of community members knew of services for health

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\(^7^7\) KIIs and document review. Where services are being provided in IDP sites, regular monitoring of needs allows for adjustments in programming as described in 4.1.1.

\(^7^8\) KIIs, IPs and UNICEF; FGDs.

\(^7^9\) (SM-2015-0066, 23 JANUARY 2015)

\(^8^0\) KII, UNICEF.
and psychosocial support; in another in the same year but with a different community, over 90% of participants were able to identify some or all of the services available to survivors.⁸¹

Despite these positive outcomes, the evaluation team identified several issues negatively impacting access for survivors to existing services. One is the fact that efforts to prevent survivors from paying for health care are not working reliably. While the listening centres and I/NGOs providing support to survivors have gone some way to try to address this issue by accompanying survivors to hospitals to ensure services are free and/or to provide funds for payment, FGD participants in Bria identified the fees as an obstacle to receiving care. Survivors may not always be accompanied, and they can reportedly be expected to pay if hospitals procure drugs from the GoCAR rather than INGO partners. As well, service providers may expect an “incentive” for “extra work” and without such an incentive may refuse to provide care.⁸²

One partner further noted that they do not have PEP kits in dosages for children.⁸³

Another is that the SOPs—a great tool for promoting accountability and coordination— are not yet being implemented in all settings where UNICEF is supporting programmes. In Bria, for example, the evaluation team noted that there was no coordination mechanism for GBV partners, nor was there an established referral pathway. Thus the procedures for referral have not been standardized and are not known to all relevant partners (in the case of Bria, MINUSCA—a potentially important referral actor—was not aware of referral pathways for GBV survivors⁸⁴).

Still another issue is that there is very little that NGOs providing legal services can do without a functioning judiciary. AFJC is UNICEF’s key local partner, and their added value is that they provide paralegal support. However, the legal advice they and other NGOs provide typically consists of listening to the survivor and documenting the complaint. This illustrates the significant need for investment in advocacy and human resources to build the judiciary in stable parts of the country. UNICEF has already reportedly conducted advocacy with government partners to expand the court system and is well-placed to continue to provide support in this area as governance mechanisms improve in CAR.

### 4.2.2 Timely Response

UNICEF’s response to GBV in the early days of the crisis (2012/2013) involved support to the national coordination mechanism (UNICEF was originally the lead, before UNFPA arrived in country and it was agreed with the RC/HC that UNFPA would lead), and support to programming in Bangui. As important as this initial response was, the fact of its small scale means that UNICEF’s overall response to GBV cannot be interpreted as timely. There was no designated GBV focal point in the CAR CO until January 2014, when an international P3 position was filled. This focal point was the only one in the UNICEF CO (importantly, however, receiving critical assistance from HQ and the RO, highlighted in section 4.2.5). A national staff person was hired in 2015. One UNICEF KII described how the response to GBV was driven by reports of sexual violence (including SEA): “In the beginning it was not a priority, but after so many cases of GBV it became a priority.” This approach does not align with good practice that suggests that programming to address GBV should be established from the outset of humanitarian response whether or not data is available.

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⁸¹ IRC, Responding to Child Protection Needs and GBV in Bangui, Final Report, March 2015. A similar outreach to community members about key GBV issues and understanding related to services was being conducted by a COOP! community team during the evaluation team’s visit.

⁸² KII.

⁸³ While UNICEF has supported the distribution of PEP kits in the past, this is a role that UNFPA is currently leading on. These kits reportedly do normally include dosages for children.

⁸⁴ KII.
Another missed opportunity for timely response, as mentioned above, is related to the RRM within EMOPS. In particular, EMOPS collaborates with MOSA on capacity building for preparedness, and yet no gender or GBV elements have been included in that work to date.

4.2.3 GBV Prevention and Risk Mitigation

UNICEF IPs have illustrated some good practices related to risk mitigation. For example, after conducting a safety audit that showed women were exposed to GBV when they collect water and firewood, IRC distributed “mitigation kits” to 369 women and 492 girls from Baria, Yade and Sangrelim. The Kits were composed of a 12 litre bucket to reduce the frequency of travel to the water point, and improved stoves and sandals. Other risk mitigation materials that have been distributed by IRC are solar lamps and dignity/hygiene kits. IRC and COOPI have also supported small-scale income-generation activities, such as soap-making and knitting. Even so, in FGDs with affected populations, the issue of poverty—and its link to violence—surfaced repeatedly. Women and adolescent girls in every FGD suggested that violence against them was commonplace, often linking the violence to poverty: women and girls needing to travel after dark, or outside protective areas to get firewood to sell, or being beaten by husbands because of stressors associated with money, or families being abandoned by husbands because of burdens of extreme poverty. According to one female IDP, “Since we moved we became like chicken looking for food.” It is evident that developing income-generating activities to the scale that might serve to protect women against violence is an area for future growth of UNICEF IPs.85

While UNICEF has supported some basic prevention activities such as community awareness raising efforts and a media campaign (posters and banners) related to sexual violence and an audio spot on SEA86, prevention is an area in which to develop targeted, evidence-based approaches. The evaluation team noted that in Yaloke, Bossembelee, and Boali, partners were raising awareness but without any clear communication principles/strategies. In Bocaranga, the image board that an IP used showed extreme violence, women in undignified positions, etc. which are not typically considered good practice.

4.2.4 Capturing and Using Programme Results

In terms of systematically capturing and using programme results, UNICEF IPs have illustrated several good practices. The distribution of risk mitigation kits described above is a nice example of UNICEF CAR using data to inform programming: IRC’s on-going security monitoring of its programming for women and girls allowed them to adjust the contents of the kits to meet identified needs. Another potentially positive approach to capturing programme results—and facilitating coordination among UNICEF sections at the same time—is joint monitoring: the evaluation team were informed of a good practice example where colleagues from CP, WASH, and Health were deployed to Dekoa to assess implementation of UNICEF’s projects there following reports of sexual violence, including SEA.

However, these practices have yet to be systemized so that they are standard. In addition, there are other areas in which information on programme results can be strengthened. For example, partners are not yet adequately capturing information about quality of care and the value of services to the survivor. UNICEF supported IRC to implement a quality of care assessment tool, but no specific information about the uptake of the tool was available to the evaluation team. Community outreach teams hold discussions with community members about perceptions related to value of services. These are apparently the only

85 It is important to emphasize that poverty is a risk factor for GBV, rather than underlying cause. Thus while addressing poverty is important in reducing risk, any long-term efforts to eradicate GBV require addressing gender discrimination as the root cause.
86 KII, UNICEF.
measures currently available to monitor quality of care, and they are not yet generating data that can be used to inform UNICEF’s strategic approach to improving access to and quality of services—or even basic information about whether survivors accessed support from referrals provided. Recognizing this limitation, a UNICEF GBV colleague noted that improving the ability to assess service usage, quality of care and value of services was “the next big step.”

Data collection through the GBVIMS also continues to be a significant challenge. On the positive side, UNICEF shares data on a monthly basis with the GBV Subcluster, and this data is used to inform SitReps and other documents, which suggests that data is trickling up to the national level and being shared with the larger humanitarian community. More problematically, however, it is not entirely clear that the incident data being obtained is accurate, as there are challenges in the proper use of the tools. While UNICEF supported training for its partners on the GBVIMS, KII’s reported that the training was insufficient; service providers collect data, but they don’t have computers to input the information and using written forms is a challenge. As well, partners may not have a clear understanding of what constitutes “GBV” and how violence should be captured in the GBVIMS incident recorder.

For example, one IP shared with the evaluation team that of the 153 cases they had registered in the GBVIMS over a four-month period, more males than females experienced “physical aggression” (28 males vs 14 females) as well as “denial of resources” (10 males vs 9 females). It was clear that the IP understood “GBV” to be any violence experienced by males or females, rather than violence affecting females due to gender discrimination. As a result, in this example, all physical aggression reported to the IP was recorded as GBV.

Another area of potential concern related to the GBVIMS is that UNICEF has suggested to adapt the incident recorder (IR) and information sharing protocol (ISP) in order to systematically include information about SEA cases. Given the requirement for mandated reporting related to SEA, such an adaptation, if not done very thoughtfully, could undermine confidentiality and other principles of ethical care of survivors, particularly if providers are required to share specific case information during investigations of SEA incidents reported through the GBVIMS.

4.2.5 Leadership Contribution and Technical Support from UNICEF Regional Office and Headquarters

UNICEF has shown leadership most strongly in its response to the SEA crisis, using its role in the UN PSEA Task Force to underscore the importance of accountability across the UN system to SEA. UNICEF has issued regular advocacy statements regarding PSEA and well as regular updates on monitoring of activities, striving not only to ensure services to survivors, but also to hold MINUSCA—including “the highest authorities of the peacekeeping mission”—accountable. UNICEF is one of the organizations that steered the peacekeeping mission to inform troop contributing countries (TCCs) about allegations and the responsibility for prosecution. UNICEF has provided psychosocial support to survivors linked to their interviews by national investigators from TCCs. One KII noted that in relation to SEA, UNICEF’s head of office “is very present and engaged in senior level discussions.”

UNICEF’s leadership has not emerged as strongly related to GBV. It seems that the SEA crisis has signalled to UNICEF the urgency of addressing GBV and leadership currently expresses a strong desire to link SEA response to GBV programming, while also acknowledging the need for specific expertise on SEA so that

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87 Spanish Proposal, March 2016. The IR already collects information relevant for MARA and MRM, in which the issue of possible exploitation and abuse comes up.
88 KII, UNICEF.
SEA work does not overwhelm the GBV team. Even so, there is no specific plan that identifies what is both distinct and similar about the issues of SEA and GBV, and how they should—and should not—be linked. One INGO partner of UNICEF noted that while UNICEF was holding MINUSCA to account for SEA, they were not expending a similar degree of effort in advocating to MINISCU (and UNPOL) to scale up security response for GBV more generally.

Technical support from HQ and the RO in 2014/2015 was widely perceived as being extremely valuable. As important as missions from technical staff were perceived to be, ongoing remote assistance was also hailed as an extremely important mechanism for continued support, which one KII described as “very, very helpful” in tracking cases, resource and advocacy needs and other support to the CO.

Of note, however, there appears to be no institutional memory among colleagues outside of CP of technical support related to mainstreaming GBV risk mitigation across sections. This seems to suggest that external technical support on mainstreaming GBV risk mitigation—particularly if delivered in short-term field visits with no explicit plans for follow up—may not be the most effective method for ensuring uptake of mainstreaming responsibilities.

There were mixed reports from UNICEF CAR colleagues on support from the regional office related to integration of gender in proposals. One noted in a KII that he had “never known a colleague at the regional office to see if gender or GBV is mainstreamed.” By contrast, another colleague remembers sending a proposal that was over 1 million USD to the regional office for review, for which they received feedback regarding inclusion of gender and GBV concerns.

4.3 Efficiency
Measure of outputs versus inputs in terms of having appropriate levels of financial and human resource capacity in place, both within UNICEF and via implementing partners, and how well these have been used to generate outputs.

4.3.1 Funding

“I think SEA is an opportunity for UNICEF to strengthen the GBV programme. We can strengthen the activities, because with SEA we have more human resources and more funding.” (KII)

The humanitarian effort in CAR is chronically underfunded, which creates a competitive environment for limited funds. Even though UNICEF is the third highest recipient of HRP funds following WFP and UNHCR, KIIs reported that the whole 2016 humanitarian response plan (HRP) was less than 20% funded at the time of the evaluation. In the midst of these challenges, UNICEF’s 2016 budget for GBV programming almost doubled from 2015 to 2016. In 2015, the annual budget for multi-sectoral response to GBV and SEA was $1,260,569, making up approximately 10% of the total annual budget for UNICEF CAR CP programme, which was $10,196,094. Multi-sectoral response to GBV and SEA (combined under Specific Outcome 4.2.3) makes up 20% of the total annual CP programme budget, at $2,380,000 for 2016.

The considerable upswing in UNICEF’S 2016 budget is due in large part to the attention CAR—and UNICEF specifically—has received related to SEA. That UNICEF is committed to reducing SEA, and to ensuring services are available to child survivors, is further evidenced by the fact that UNICEF CAR received an internal allocation of $1.8 million dollars from UNICEF HQ specifically to address SEA. This money has

89 http://reliefweb.int/sites/reliefweb.int/files/resources/RCA_OCHA_FTS_Central_African_Republic.pdf
90 KII, UNICEF.
91 UNICEF, 2015 Annual Workplan for Child Protection ("Protection Harmonized with RAM").
been designated to “meet the need for an immediate increase in staffing...and the costs of associated programme activities for the prevention, reporting, response and monitoring of SEA.” While this attention to SEA is laudable, it is critical that activities for the prevention of and response to SEA at the community level is not taken out of the larger context of the problem of GBV (even if, within UNICEF offices, responsibility for SEA is discrete from GBV). Recognizing this, the CO intends to leverage the internal funds to strengthen their GBV programmes.

There were two other GBV/SEA proposals that were being fielded at the time of the evaluation. In an approach which the evaluation team strongly support, at least one proposal has insisted on linking SEA response to support for GBV response more broadly.

4.3.2 Human Resources

One CP/GBV colleague estimated that more than 50-60% of the work of the CP/GBV team was on SEA. This was not just work to ensure that GBV services are available to SEA complainants, but rather issues that were beyond the scope of a GBV specialist, veering more into higher-level agency responsibilities for promoting PSEA accountability within UNICEF and the wider humanitarian community.

The evaluation team observed that scheduling and other activities in the CO reflected an emergency approach, with competing demands limiting the ability for advance planning and strategic thinking. There was consensus in the evaluation team as well as among interviewees that UNICEF’s current GBV staffing levels are insufficient to meet responsibilities for SEA and support GBV programmes. This is not an unacknowledged concern: during 2016 UNICEF is trying to hire four staff to strengthen the CP team, three of whom will be focused on SEA. As mentioned above, there is additional funding from HQ to support a further increase in staffing to address SEA, which will be leveraged to support GBV.

However, this increase in staffing is only planned for the national level. As mentioned above, there are no GBV experts within UNICEF’s field offices, which represents a significant gap in terms of UNICEF’s ability to provide regular support to GBV field partners and/or support sub-national coordination. Even among IPs themselves, there is not always sufficient staffing to support a GBV response: COOPI, a key GBV partner for UNICEF responsible for running a Listening Centre as well as an interim care center for demobilized children, does not have a GBV technical expert on staff. Moreover, to date capacity-building approaches have focused on technical issues related to services for survivors. In the extremely challenging context of CAR, addressing management skills and the promotion of a healthy workplace is also a key area for capacity building among IPs, as well as among UNICEF staff.

4.3.3 Value for Money

There is no mechanism for computing value for money of UNICEF’s GBV interventions. However, the evaluation team has observed that the resources that UNICEF has allocated to SEA may be disproportionate to assessed need: cases of SEA number in the hundreds, while cases of sexual violence

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92 UNICEF internal memo on SEA. Of note, this internal memo made no reference to the link (and distinction) between SEA and GBV, conceptually or programmatically.

93 One KII noted, “SEA is an emergency now—but it seems to me we are forgetting GBV—we are putting everything on SEA and ignoring GBV, because this is a high profile issue—everybody in New York and the regional office is taking the head of everyone here. And the result is that there has been shrinking attention to GBV.”

94 KII, UNICEF. While the budget for programming increased, UNICEF’s overall funding decreased: according to KII with UNICEF senior management, UNICEF funding at the time of the evaluation was 10% below its funding from last year at the same time.

95 A COOPI colleague suggested that the funds received from UNICEF were not enough to support a GBV technical expert. A national staff person was “learning on the job.”
committed by armed actors and community members number in the tens of thousands, and IPV is also a significant problem (according to the GBVIMS). Noting that there is an unquestionable responsibility of the humanitarian community to meet its mandate to ‘do no harm’, this is not to suggest that UNICEF should not be allocating funding for SEA. Rather it is to suggest that **UNICEF’s commitment to addressing GBV at the corporate level is not often met with a similar commitment to generating resources for GBV programmes, even when the problem of GBV is at a scale significantly greater than SEA.** In CAR, this is a tension that has been recognized by many interviewees, but which some interpret as potentially positive for GBV programming. One senior UNICEF staff person noted that, “From managerial point of view, we have to be mindful that this brings more pressure and demand, but we have to interpret this situation as a kind of momentum...for any progress, we must build on this kind of momentum.”

**4.3.4 Partnerships**
UNICEF was recognized by KIIs as key partner among UN agencies in GBV coordination and response. IPs generally felt very positive about UNICEF’s approach to partnership. However, there were requests, as noted above, for greater technical assistance from UNICEF, most notably from international partners, who may not be receiving as much support as local partners and who, in the context of CAR where challenges recruiting international staff mean that capacity building needs exist for INGOs as well as NGOs.

**4.3.5 Operational Processes**
Some efficiency concerns were raised by partners related to short-term PCAs (6 months, 10 months), which contributed to challenges in programme continuity. One IP noted that UNICEF tends to announce “at the last minute” that they are coming for a monitoring visit, and, similarly, requests for documentation were not always predictable, sometimes also occurring at the last minute. Expectations around monitoring may be different for UNICEF and its partners.

**4.4 Coverage**
*The extent of UNICEF’s programming reach (geographic and numerical) compared with the needs of those at risk of or affected by GBV as assessed by UNICEF and/or the GBV sector as a whole.*

UNICEF’s funding to IPs has significantly increased GBV programme coverage across CAR—particularly for psychosocial services, support to women’s groups and community-based awareness raising. Starting with services in Bangui, Bangassou and Rafai, UNICEF has expanded such that the GBV team reports that UNICEF currently covers more than 50% of all those prefectures or sub-prefectures in CAR that offer GBV services. UNICEF facilitated the provision of support to almost 2,700 survivors in 2015, and funded 20 Listening Centres across the country.

While this illustrates significant progress in coverage, a key critical ongoing concern identified by several KII is the **accessibility of services** to women and girls living outside cities and towns. According to one KII, most women and girls will not be able to access the static services available at major hospitals and Listening Centres because they have no means to reach the facilities. There are also large geographic areas not yet covered. While I/NGOs will use mobile services in the areas where they work in order to access people living outside of the immediate intervention area (typically a city or town), strategies for a broader application of mobile services do not appear to have been considered as a way to address lack of access throughout the country. One KII from UNICEF noted that “we need to get off the beaten path”:

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96 Children in Crisis in CAR: A Four-month Progress Report, May 2014.
97 KII, UNICEF.
“What we’re seeing in Dekoa [where a high number of sexual violence cases have recently emerged] is that there was no response mechanism, no basic services...that’s more the rule. It’s a matter of people being isolated, lack of alert mechanisms for response, a culture of silence, and people seeking protection from the perpetrators, who can’t be confronted.” (KII)

In this case, the UNICEF colleague was speaking about incidents reported by peacekeepers, but this also applies to all forms of GBV.

4.5 Sustainability / Connectedness
To what extent emergency response activities take into account and support a longer-term approach, including in connection with UNICEF’s regular development programming.

4.5.1 Building National Capacity and Ownership

Relationship with government. UNICEF has a positive relationship with government partners, particularly MOSA. UNICEF has worked with UNFPA to push government partners to engage in GBV coordination; while this was originally a challenge, one KII suggested that MOSA is now more actively involved, and that subcluster meetings have recently moved to government offices. UNICEF was also instrumental in the SOPs process, which engaged all sections of government. The CAR CO has trained 240 governmental representatives on human rights-based approaches to programming, gender mainstreaming and humanitarian principles.99 Even so, the CP/GBV team recognized that government capacity continues to be weak, most especially at the prefecture level, where MOSA social workers are only beginning to return to posts.

Capacity-building of local partners. One UNICEF colleague characterized capacity building as “the main activity we put into the programme to help GBV partners...and they have come a long way.” AFJC reports that UNICEF holds quarterly trainings in Bangui for staff from 10 Listening Centres across the country, and that this has increased staff motivation in the field: “you can see people are motivated here, and thanks to UNICEF for this.”

The SEA crisis has created an entry point to facilitate some of this capacity building. For example, UNICEF recruited an international consultant psychologist to build the capacity of national partner organizations to provide psychosocial support to victims of SEA, holding three training sessions for 53 stakeholders (28 men and 25 women) in January 2016. UNICEF has also made an important advancement in developing a specific protocol for interviewing children for protection monitoring related to SEA (which may be able to be used beyond SEA to consider violence and abuse of children more broadly).100 Still, virtually all partners—including UNICEF colleagues—pointed out the urgent need for additional capacity building on a range of issues, such as engagement skills and data management. A UNICEF colleague noted that field visits should be scaled up, suggesting monthly visits. One partner reported that monitoring visits happen 1x/year, while another suggested that monitoring happened quarterly. A member of the CP/GBV team suggested that this monitoring should happen monthly. In any case, some I/NGOs felt that this monitoring did not provide enough targeted technical guidance on GBV programming issues. At the field level, it is typically staff from UNICEF’s field offices who undertake monitoring; however, none of the staff in UNICEF’s four field offices have GBV expertise. A UNICEF colleague relayed to the evaluation team a plan for the CP section to map all facilities that are supposed to offer services with respect to CP, including GBV, with the intent to “identify their weakness

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99 UNICEF CAR Annual Report 2015
100 KII, UNICEF.
and develop tools to strengthen information management”—this might be a useful entry point in which to identify GBV technical capacity-building needs in existing programmes.

4.5.2 Linking Emergency to Longer-term Programming

“Given the recent visibility and media coverage on SEA, I think it’s very much of an opportunity...to highlight and look at underlying and structural issues related to GBV in this country. My fear is everyone is looking at SEA....and my feeling is the problem of SEA in CAR is more a symptom of a larger problem of a culture of sexual violence in this country that is accepted.. I think there’s more to be done. I think we have to really remind ourselves to push that point.” (KII)

In December 2014, two years after the implementation of the humanitarian response, a Strategic Moment of Reflection was facilitated by the UNICEF CO in order to draw lessons from UNICEF humanitarian interventions and consider ways in which to move forward with an early recovery and development agenda. According to the 2015 Annual Report, peacebuilding, social cohesion and capacity building are critical components of an early recovery framework. The Annual Report also recognized that “building resilience and coping mechanisms at the community level is critical.”

To date, explicit links between emergency GBV programming to an early recovery or development frame as a part of a framework for sustainability remain to be made. UNICEF’s PSS work at the community level can be said to be promoting resilience in line with priorities identified in the 2015 Annual Report. The GBV work with women’s groups is also a potentially important mechanism for giving women greater agency which, in the long term, may produce positive outcomes in reducing their risk for GBV. At the moment, however, these approaches seem incidental rather than tactical. There is no explicit strategic approach linking emergency GBV response to longer-term planning (and, as mentioned above, no explicit ToC). This includes efforts to address the underlying issues that inform the high prevalence of GBV and SEA in CAR.

4.6 Coordination
The extent/nature of UNICEF CO programming contribution to realizing GBV-sector strategies/plans/priorities and how UNICEF has added value to/been affected by the GBV sector response within the CO and across the response as a whole.

4.6.1 UNICEF’s Added Value to the GBV Sector
UNICEF is considered by KII to be a strong partner in national-level GBV coordination and describes its principal added value as advocacy and resource mobilization. UNICEF has also served to link the GBV SC and the CP SC, which all interviewees report work positively together.101

UNICEF’s GBV work is in line with the priorities identified in the 2014-2015 action plan of the GBV SC that prioritize the delivery of health, PSS and legal services for survivors. UNICEF also supports joint initiatives that promote GBV sector-wide collaboration, such as the SOPs, the GBVIMS, as well as the UNDP multi-donor trust fund project. However, there is currently no national/SC strategic plan for GBV, which is a particular gap noting the impending shift from humanitarian to development planning, which requires a tactical approach to linking humanitarian response with longer-term strategic planning for GBV prevention and response.

101 In an example of good practice, a representative of the GBV subcluster sits on the CP strategic advisory group.
UNICEF’s added value as a leading partner in GBV in CAR was noted by coordination actors at the national. At the prefecture and sub-prefecture level, UNICEF has not applied its leadership to support coordination. Several UNICEF IPs felt that the linkages between national and subnational coordination were weak, expressing an expectation that UNICEF would use its influence in the national coordination mechanism to advocate more proactively for enhanced coordination at the field level. Given how critical coordination is to GBV programming, ensuring partners are engaged in coordination—not only in terms of referrals, but for other aspects of GBV programming—is a very important part of UNICEF oversight of its programmes. MOSA’s deployment of officers to the prefecture level presents an opportunity to ensure government is actively engaged in coordination activities, even if government structures are not strong enough to lead coordination.

Other additional opportunities for coordination that have not been fully exploited are through the MRM and MARA. UNICEF co-leads coordination of MRM with MINUSCA. This group was able to train all members of the relevant sub-clusters (Protection, Child Protection and GBV) on monitoring and reporting on violations against children, and also organized guidance for health and education clusters. It is not clear, however, whether UNICEF GBV colleagues have been active in this group. Nor has the GBV team been actively engaged in the MARA working group, perhaps because it is not fully functioning. Led by MINUSCA and UNFPA, coordination has not been as regular as with the MRM. In addition, it is not clear how the UN SEA Task Force has formally and/or strategically linked with the MRM, MARA, and/or the GBV SC, although it was noted that UNFPA has partnered with UNICEF to raise awareness on the Code of Conduct (CoC), the SG’s Bulletin, complaints mechanisms and referrals services, and the GBV SC is streamlining messaging around PSEA for its partners.

5 PROTECTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA)

As described in section 2.2 above, a detailed investigation on UNICEF’s approach to PSEA is outside the scope of this evaluation. However, given the importance of the issue in CAR, the team included additional questions for KII’s about the existence of clear policies and guidelines in the CO and levels of familiarity among CO staff of these. The evaluation team also took special note of referral pathways for SEA complainants, as well as staff familiarity with these services and how referrals are (or should be) made when a report emerges. Many points about PSEA have been highlighted in the findings above. Additional points detailing coordination processes as well as complaints mechanisms and awareness of them among UNICEF staff are briefly elaborated here.

Coordination. According to KII’s, coordination between UN actors to respond to SEA cases has been strong in recent months. Complaints trigger an alert mechanism to inform the UN senior staff/ country leadership about what has happened. The agency who receives the complaint has primary responsibility to alert the senior management within their agency. e.g. UNICEF staff must alert the head of office directly. The agency Representative then alerts the head of the UN and head of agency involved. The alert system continues with investigation and substantiation of the facts by the relevant office, according to who has been named in the complaint, i.e. if the complaint involves a peacekeeper, then the Member State conducts the investigation through the Office of Investigation and Oversight (OIS). UNICEF takes the lead on providing support to survivors who are children, both in terms of service provision such as medical screening, reintegration and/or relocation, and linking them to education and support during the interview and investigation process. UN agencies in CAR recently signed a shared code of conduct, while MINUSCA is taking major steps to manage information and systems,102

102 KII, UNICEF Bangui.
Complaints mechanisms. UNICEF works at virtually every level of the complainant process – the pre-verification of cases, support for the treatment of survivors, support for legal proceedings, support for protection and reintegration, etc. When UNICEF is alerted by partners or community members or another source about an allegation perpetrated by peacekeepers involving children, before sharing the information with the UN mission’s Special Representative to the Secretary-General, UNICEF conducts pre-verification of the information. Pre-verification includes cross-checking the information provided, verifying the age of the victim, and ensuring that survivors have access to services. During this stage, UNICEF uses a protocol they established for interviewing children.\(^{103}\)

After UNICEF shares the information with the SRSG, UNICEF also notifies the UNICEF Regional Office. The SRSG in turn notifies the Member State that provided the contingent of which a member has been accused. If the case involves another UN agency (rather than a peacekeeper), the report will be shared laterally from the UNICEF Representative to the other agency representative.

In terms of response, this is where GBV programming is relevant. UNICEF ensures that victims are referred to the appropriate medical facilities, if needed and if the victim consents to services. UNICEF also ensures that victims have access to psychosocial support through existing community structures such as Listening Centres. When necessary, UNICEF supports victims with reintegration into their communities, as many victims suffer from stigmatism following abuse. Reintegration can take many forms: assistance with education, vocational training, sensitization of the community, etc.

TCCs are reportedly taking the issue of SEA seriously, sending investigators from their countries to follow up on allegations and gather information. UNICEF is striving to ensure that children’s rights are respected and that a social worker provides support during interviews. Often, to protect victims and witnesses, UNICEF works with implementing partners to relocate survivors and their families. UNICEF also supports families with school fees, food, hygiene kits and income generating activities. If the perpetrator is outside of MINUSCA, usually the local authorities are informed. UNICEF also works closely with MOSA, which has a mobile team composed of three women and four men that can be quickly deployed to participate in a response.

Staff and IP awareness of complaints mechanisms. The CO has conducted several trainings on PSEA, most recently for the whole of office in April 2016. While all staff persons—within UNICEF as well as IPs—with whom the evaluation team spoke were familiar with the issue of SEA, understanding of reporting mechanisms and responsibilities varied from vague to strong. Not all UNICEF staff in Bangui understood the mandate to report, and those who did understand the mandate to report did not always know what services might be available to complainants.

“If I got an allegation and I assume it’s serious by my own perception, then I might report it. If you just heard about it—we are advised to anyway report. But I don’t know, it will depend on situation. I would report to head of protection and head of office. And I don’t really know what would happen if I refer—I think it’s psychological care, referrals to hospital, etc. Depends on the case.” (UNICEF KII)

“I mean there is prevention activities and referral to medical and psychological services. If someone reported to me would talk with colleagues immediately—I would talk to senior management directly. It’s up to me. I know there are these systems are in place but I’m not familiar with them.” (UNICEF KII)

\(^{103}\) A similar protocol has not been developed for adults.
“I have heard of allegations—but I don’t know how they were being addressed. I think they have to investigate and listen to him or her, and they have to report it and investigation has to be done.” (UNICEF KII)

At the level of IPs, most of those interviewed explained that survivors of SEA would receive the same services as survivors of other types of GBV, and did not differentiate between the two in terms of service provision. However, in terms of specific complaint mechanisms for SEA, reports were mixed. Some expressed clear understanding of referral protocols, while others did not know how they would respond to SEA beyond their standard service provision. One IP explained that they would report to the GBV SC coordinator, who would then be responsible for sharing information with other UN agencies. Some IPs felt that the system worked efficiently and survivors were able to receive services, particularly medical and PSS. Other IPs expressed concern that response to a report was not always “organized well”, particularly outside Bangui where access to services is more of a challenge because of the lack of providers, as well as the fact that there are large swaths of the country that have not received support to roll out basic GBV response services. Concerns were also expressed that the system lacks accountability because when peacekeepers are involved “they just send them back to their countries” and there is, therefore, a need to put more accountability mechanisms in place.

Prevention. UNICEF is involved in efforts to prevent SEA, supporting PSEA trainings with UN actors and working with other agencies to set up SOPs and Codes of Conduct. Emphasis has been within the UN system, though there are plans to expand trainings to implementing partners and civil society. One interviewee mentioned that UNICEF management is involved in zero tolerance work that includes vetting troops and potential peacekeepers. To date, the GBV Guidelines have not been rolled out as part of the PSEA trainings to support prevention.

Linking GBV and SEA. As highlighted in the findings above, several UNICEF staff have noted that the attention and resources allocated to SEA—both within UNICEF and externally in CAR—has significantly exceeded that allocated to GBV. Some interviewees see this as a problem that undermines the importance of focusing on GBV as well the ability to address it. As one respondent noted “We risk to forget the rest of the cases...SEA cases are not going down now, also GBV is not going down.” Others feel that the attention to SEA could be used as an entry point for scaling up UNICEF’s attention to GBV, not just at the country level, but globally: “What we are doing today on SEA...is paving the way for advancing the agenda of gender, women’s rights, child rights, and child protection.” The evaluation team agrees with the importance of UNICEF committing itself holistically to the problem of GBV, not just through the lens of SEA.

6 GOOD PRACTICE CASE STUDIES

- Joint CMR Project
- PSEA

7 CONCLUSIONS

Successes

1. UNICEF’s programming to establish minimum essential services for GBV survivors is highly relevant to the needs on the ground as reflected by affected populations, key informants, and GBVIMS statistics, which all indicate GBV is a rampant problem in CAR. UNICEF is undertaking all the Minimum Actions
the UNICEF GBViE Resource Pack suggests should be addressed in immediate crisis-response with the exception of risk mitigation across clusters and sectors. The Listening Centres are a particularly contextually appropriate intervention, allowing IDPs, returnees, and community members the opportunity to access support.

2. UNICEF’s corporate commitments to GBViE are well understood at a country level, with attention to GBV described at the highest level of the CO as a “big priority.”

3. The development and finalization of the Standard Operating Procedures (SOPs), represents a major step forward in terms of establishing criteria and systems for GBV care and support in CAR. (Effectiveness)

4. UNICEF partners are undertaking monitoring activities that are being used to enhance prevention and response to survivors and those at risk. For example, risk mitigation kits for women and girls were distributed following safety monitoring by IRC. One partner is also testing a quality of care tool, which can be scaled up for use in other locations and by other partners. (Effectiveness)

5. Regional and HQ technical support have been extremely valuable to the country office, signalling the importance of ensuring this technical support is available on an on-going basis. (Efficiency)

6. UNICEF’s strong relationship and work with government makes it a credible partner and creates space to continue work on GBV, particularly in the area of systems building for multisectoral response as well as implementation of protective laws and policies. (Connectedness/Sustainability)

7. UNICEF’s nascent capacity-building efforts of local implementing partners (IPs), e.g. periodic training for national IPs, have not only improved local capacity to address GBV, but several IPs report that this support has also increased staff motivation. To date, however, approaches have focused on technical issues related to services for survivors. In the extremely challenging context of CAR, management skills and the promotion of a healthy workplace (including strategies for self-care) are unaddressed areas for capacity building among all IPs, as well as among UNICEF staff. (Connectedness/Sustainability and Efficiency)

8. UNICEF is a key coordination partner in a number of fora. UNICEF has been largely responsible for ensuring a strong and positive link between the GBV and child protection (CP) subclusters.

9. UNICEF’s plans to leverage incoming SEA funds to improve GBV programming reflects strategic thinking related to fundraising and planning, as well as a vital understanding of the links at the community level between the causes and risk factors for SEA committed against affected populations by humanitarian personnel and GBV generally. Linking response to SEA at the community level with GBV services should not be confused with the need to maintain a distinction between SEA and GBV at the organizational/management level. (Efficiency)

Gaps/Challenges

10. The CAR CO does not have a theory of change or clearly articulated strategy for addressing GBV, including an approach to link emergency GBV programming to early recovery and development programming.

11. UNICEF’s commitment to coordination is not yet reflected at the subnational level, where coordination for GBV is currently weak. Linkages between the Monitoring and Reporting Mechanism (MRM), the Monitoring, Analysis and Reporting Arrangements (MARA) and GBV prevention, response and coordination are not well-established. (Coordination)

12. There are significant gaps in a multi-sectoral approach to GBV response in CAR, for which there does not appear to be a sector-wide or UNICEF strategy to address. Security sector response is a particularly weak area, especially outside Bangui. Challenges also exist in accessing health care due to availability of skilled staff and demands that survivors pay for services. While UNICEF supports legal aid, the lack
of a functioning judiciary means that cases are not adjudicated and justice cannot be achieved. (Relevance and Effectiveness)

13. Although adolescent girls are a group which is at very high risk of GBV, GBV programming (both specialized and integrated) has not adequately focused on the needs of adolescent girls. The multiple levels of trauma being experienced by adolescent girls, many of whom were forced into marriage at a young age, have multiple children, were orphaned or abandoned as a result of the conflict, and/or abducted, recruited and used by armed groups warrants specific attention and programming. UNICEF’s Country Programme Document (CPD) and annual workplans related to GBV group women and children together in the strategic outcomes and activities, making it impossible to distinguish how GBV programmes are designed and implemented with the specific respective needs of women and girls in mind. (Relevance)

14. Prevention work in CAR has to date been focused on community awareness raising. The ability of Listening Centres to serve a preventative role, particularly through livelihoods and other empowerment initiatives, has not yet been fully exploited; at present they offer a safe space for survivors to report and are used primarily for counselling survivors and social activities. (Relevance and Effectiveness)

15. In accordance with good practice linked to emergency response, UNICEF has prioritized a focus on sexual violence (including SEA). As yet, the widely reported problem of intimate partner violence (IPV) and other forms of GBV are not being targeted by UNICEF or others in the GBV community. (Relevance)

16. Integrated programming across UNICEF sectors has been undertaken mainly in the health section. Perhaps due to high staff turnover and competing demands, other sectors do not appear to have integrated GBV prevention and risk mitigation measures as recommended in the revised 2015 IASC GBV Guidelines, despite technical visits to CAR focused on training related to the Guidelines. Nor has GBV yet been integrated into UNICEF structures that have the greatest reach in CAR, including the Rapid Response Mechanism (RRM) and at the level of UNICEF’s field offices. This represents a significant missed opportunity for improving GBV-related protections for girls and women. (Relevance and Efficiency)

17. Data collection through the Gender-based Violence Information Management System (GBVIMS) continues to present challenges in terms of accuracy in the types of incidents recorded as well as the number. UNICEF’s suggestion to link the GBVIMS to reporting on SEA has the potential to undermine confidentiality and other principles of ethical care for survivors if not done carefully, because of the requirement of humanitarian actors for mandatory reporting of SEA. (Relevance)

18. UNICEF’s delegation of many PSEA responsibilities to the UNICEF GBV specialists and the burden of time required to meet those responsibilities has compromised GBV staff ability to guide and strengthen UNICEF’s GBV programme. While there is a recognition at the highest level within the CO of the importance of separating the remit of PSEA from GBV, there is no indication that plans to expand staffing for support to SEA will be informed by a strategic approach that clarifies how PSEA responsibilities are distinct from GBV at the organizational level. This clarification is critical moving forward, as is ensuring that GBV staff no longer assume primary responsibility for PSEA, but rather assist dedicated PSEA staff to link complainants to services. At the same time, given the scope of GBV in CAR, similar staffing commitments as those for PSEA must be considered for GBV. (Efficiency)
8 RECOMMENDATIONS

RECOMMENDATION 1. Develop a GBViE strategy for CAR that aligns with global Theory of Change (ToC), but is adapted to the specific needs of the context.
   d. Explicitly link GBViE programming to longer-term development programming in the GBV strategy and within country programme documents.
   e. Highlight specific preparedness activities for GBV which the CAR Country Office (CO) will undertake for ongoing and future emergencies.
   f. Consider inclusion of other recommendations highlighted below.

Lead responsibility: CP GBV Team

When: 2016-2017

RECOMMENDATION 2. Strengthen UNICEF’s role in subnational coordination.
   d. Support the national GBV SC to develop a strategy with clear roles and responsibilities of key partners at the subnational level.
   e. Consider assuming coordination leadership in key locations at the subnational level.
   f. Ensure coordination strategies support linkages between GBV, MRM and MARA mechanisms.

Lead responsibility: CP GBV Team

When: 2016-2017

RECOMMENDATION 3. Build on the CAR CO’s existing GBV specialized programming approaches in order to improve prevention and response programming.
   i. Ensure Standard Operating Procedures (SOPs) are rolled out to all prefectures, as well as in all sub-prefecture locations where UNICEF is supporting GBV prevention and response programmes.
   j. Standardize and regularize efforts to monitor the needs of women and girls and their perceptions of the value of support services available to them through UNICEF IPs, using the community outreach groups and Listening Centres as vehicles for this monitoring.
   k. Strengthen psychosocial support at Listening Centres by broadening services to incorporate more group activities for women and girls, and by sharing tools and resources with IPs for facilitating structured discussions and activities with women and adolescent girls, e.g. Communities Care dialogue sessions.
   l. Identify and implement approaches to meet the specific needs of adolescent girls, particularly with targeted activities in the Listening Centres that provide services including social support, economic strengthening strategies, vocational and literacy classes, and reproductive health education.
   m. Consider engaging with UNPOL and national police to improve police response through designated focal points for GBV in UNPOL, presence of trained UNPOL staff in key police stations, as well as UNPOL training of national police.
   n. As a first priority in justice response, scale up targeted advocacy and resources to ensure that existing courts are enabled to safely and ethically adjudicate GBV cases.
   o. Undertake efforts to improve community awareness and services related to IPV and child marriage nationwide, and particularly through community groups and the Listening Centres. Review IP interventions related to family mediation and couples counselling to ensure safe and ethical approaches.
   p. Begin work to transform the conditions that foster GBV. Identify priorities, existing evidence and strategies for GBV prevention, including social norms work, economic empowerment, etc. In the immediate to medium-term, review the content of existing awareness-raising messages as a first step towards more in-depth social norms work, and engage with communication for development (C4D)
and/or an external consultant to align it to accepted good practice. Also identify ways to link GBV programming with more substantial livelihoods initiatives for women in order to reduce their risk of GBV.

Lead responsibility: CP GBV Team
When: 2016-2017

RECOMMENDATION 4: Strengthen integration of GBViE across all UNICEF sectors in line with the 2015 IASC GBViE Guidelines recommendations, with the objective of each sector proactively leading integration in all phases of the programme cycle.

d. Assist all UNICEF sections to adopt relevant recommendations from the IASC GBV Guidelines on systematic integration of GBV prevention and risk mitigation strategies in their humanitarian response, with indicators to be monitored regularly in the Results Assessment Module (RAM).

e. Ensure Chiefs of Section identify a focal point to work with a dedicated (short-term) GBV specialist to support this systematic integration across programmes.

f. Routinely integrate attention to GBV into the Rapid Response Mechanism (RRM) missions as well as in the TORs of CP staff in the suboffices that include specific, safe and measurable activities to facilitate identification of GBV needs in underserved areas and provide referrals.

Lead responsibility: Chief CP; GBViE Specialist; Chiefs of Sections; Deputy Representative
When: 2016 and ongoing

RECOMMENDATION 5. Ensure GBV human resource needs are addressed through adequate numbers of staff working specifically on GBV (not with a dual mandate for GBV and PSEA), as well as capacity-building of partners and support to staff well-being.

e. Given the scope of need in CAR, consider two P3 international staff and two national staff to comprise the GBV team at the national level, with an eye to experts who may be able to strengthen work on IPV and with adolescent girls. Hire national GBV staff for the field offices.

f. Introduce a dedicated (short-term) GBV specialist to the team to work with section focal points to facilitate integration of GBV across UNICEF sectors as per the revised 2015 IASC GBV Guidelines.

g. Ensure continued support from GBV experts in the Regional Office (RO) and headquarters.

h. Create a capacity-building plan for implementing partners. Review the types of technical assistance that UNICEF can provide to IPs beyond training, e.g. onsite support, content review, asking strategic questions, check-ins, promotion of self-care strategies. Discuss how the team can utilize these methods more strategically to monitor and strengthen the quality of programming. Incorporate technical assistance activities into the workplans of UNICEF GBV staff.

Lead responsibility: CO Senior Management, Chief of CP, CP Team
When: On-going

RECOMMENDATION 6. While ensuring UNICEF CAR continues to meet its commitments related to PSEA, make certain there is a clear division of responsibility for PSEA and GBV within the CO as well as with IPs.

e. Develop an internal CO guidance note that details UNICEF staff structures responsible for managing different elements of PSEA, and that illustrates when linkages might occur between PSEA staff and GBV staff (e.g. related to mapping services and sharing referrals pathways with PSEA experts so those experts can facilitate services for SEA complainants).

f. Ensure ongoing training for all IPs related to managing care and support for SEA complainants that aligns the Secretary General’s (SG) mandate to report on SEA cases with the principles for GBV care and support, particularly confidentiality.
g. Closely monitor data collection and reporting of partners through the GBVIMS and ensure that any links between SEA data collection and the GBVIMS support safe and ethical survivor response (particularly confidentiality).

h. Share learning on leadership related to PSEA with other COs in UNICEF.

*Lead responsibility: CO Senior Management, SEA specialists, Chief of CP, CP Team*

*When: On-going*
Annex 1: Evaluation Questions

Relevance
1. To what extent is UNICEF GBVIE programming for care, support, protection, and risk reduction based on:
   a. assessed needs and data analysis? (Are the different needs of women, adolescents, and children considered separately?)
   b. established good practice for GBVIE service provision, risk reduction and prevention? (Is UNICEF employing the most appropriate strategies to ensure further violence is reduced and survivors provided with appropriate services and support?)
2. To what extent has risk reduction been integrated into other UNICEF sector programmes?
3. To what extent do GBVIE programmes adapt to changing needs, and how well are the changing needs documented?
4. How well have views of survivors and other high risk groups (adolescent girls, women, children) been reflected in programme assessment, design, implementation and monitoring? (covers AAP)
5. Are programmes built on a clear Theory of Change for GBViE programming? To what extent is this consistent with a corporate/regional Theory of Change and with UNICEF standards and guidelines expressed through the CCs or elsewhere?)
6. To what extent has a HRBA been taken in design, implementation, and monitoring of GBViE programming?

Effectiveness
7. To what extent have UNICEF GBVIE programmes improved survivors' access to quality, life-saving, multi-sectoral services for care and support?
8. How quickly has UNICEF been able to establish services at the scale required?
9. To what extent has the programme contributed to preventing and mitigating risks of GBV for women, adolescents and children?
10. Are programme objectives clear and specific for different GBViE areas of programming? How far have programme objectives been achieved / likely to be achieved?
11. Which have been the most/least effective programmes? Why?
12. How systematically have results been captured/used/learned from?
13. How and how effectively has 1) UNICEF leadership and 2) technical support from HQ, regional and country levels contributed to the effectiveness of UNICEF GBViE programming? Including ensuring that GBViE is included in the earliest response strategies and funding priorities?

Connectedness and Sustainability
14. How, and how effectively does UNICEF GBViE programme design and implementation link emergency programming with UNICEF’s longer-term programming to prevent and respond to GBV? Is UNICEF’s approach to GBViE built into its conceptualisation and implementation of sustainable resilience programming?
15. How effectively have partnerships with civil society and government been built to address planned GBViE outcomes?
16. How and to what extent has the capacity of local and national partners been strengthened through the programme?
17. To what extent has UNICEF’s internal and external advocacy contributed to improved GBV response and prevention? (Including clarifying UNICEF’s specific programme and leadership roles?)

Coordination
18. To what extent are programmes consistent with good practice (Resource Pack and revised GBViE Guidelines)
19. Does/how does UNICEF add value to the GBViE response (through leadership, standard setting, coordination)?

Coverage
20. Are there any gaps in GBViE programming (specialised and integrated) in terms of geographical and demographic coverage? - how has UNICEF (a) identified the gaps and (b) taken action to close the gaps?

Efficiency
21. To what extent have UNICEF financial and human resource inputs been commensurate/adequate to the task of meeting GBV programming need?
22. To what extent have UNICEF inputs achieved value for money outputs?
## Annex 2: Interviews/Workshops participants

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**Focus Group Discussions**

- **Yaloke**: 12 adult female and 13 adult male, 11 adolescent girls (9 married, 2 unmarried)
- **Doko**: 19 adult men
- **Boali**: 17 adult female, 16 adolescent girls
- **Ngaoundaye**: 13 adult female
- **Mboum**: 18 adolescent girls (2 married, 16 unmarried)
- **Bossembelee AFJC Listening Center**: 1 adult female, 4 adult male
- **Ngaoundaye Police**: 9 adult male
- **FGD with NGO Partners AFJC Bangui**: 7 adult female, 4 adult male
- **FGD Bria COOPI Listening Center**: 10 adult female, 7 adolescent female
- **Fiche Presence RECOPE MANDE Bria**: 6 adult female, 6 adult male
- **Comité des Sages Bria**: 3 female, 3 male
- **MINUSCA Bria**: 4 adult female, 9 adult male
## Annex 3: Mission Itinerary

<table>
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<tr>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
<th>Location</th>
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<td><strong>Tuesday, 10 May 2016</strong></td>
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<tr>
<td>11:00</td>
<td>Arrival of team to Bangui on Kenya airways</td>
<td>MovCon to facilitate visa issuance</td>
<td>M’Poko Airport – UNICEF Guesthouse</td>
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<tr>
<td>13:30-15:00</td>
<td>Meeting with consultants</td>
<td>consultants</td>
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<tr>
<td>15:00-18:00</td>
<td>Meeting with Hans</td>
<td>Hans+Team 1</td>
<td>Bangui</td>
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<td><strong>Wednesday, 11 May 2016</strong></td>
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<tr>
<td>9:00-9:30</td>
<td>Security briefing</td>
<td>Consultants</td>
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<td>9:30-12:30</td>
<td>Training national consultants</td>
<td>consultants+Traducteurs</td>
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<td>9:30-10:30</td>
<td>Meeting with Dep Rep</td>
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<td>10:30-12:30</td>
<td>Meeting with the CP team</td>
<td>Marie Louise + Hans</td>
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<td>12:30-13:00</td>
<td>Lunch Break</td>
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<td>Rencontre Sea colleague</td>
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<td>13:00-2:00</td>
<td>Meeting with AFJC/Bethanie/CRAED</td>
<td>Team 2</td>
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<td>2:00-4:00</td>
<td>Meeting with IRC</td>
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<td>4:00-5:00</td>
<td>Preparatifs for field visits</td>
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<td><strong>Thursday-Saturday 12-15 May 2016</strong></td>
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<tr>
<td>7:30</td>
<td>Field visit, Boali, Bossemptele, Yaloke</td>
<td>CONSULTANTS+Team 1</td>
<td>One day per sites with the Team in Baoro, Boali, Bossemptele, Yaloke by Cars.</td>
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<td>16:00</td>
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<td>Meeting with Unicef’s Heads of section</td>
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<td>Meeting with Minister of social-Affairs</td>
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<td><strong>Friday-Saturday 13, 2016</strong></td>
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<td>Field visit Boali</td>
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<td><strong>Sunday 16 May 2016</strong></td>
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<td>Bangui/Bria by flight Return flight on Wednesday</td>
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<td>Bangui/Bocaranga by flight Return flight on Thursday</td>
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<td>12:00</td>
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<td>PM</td>
<td>Preparatifs presentation and debriefing</td>
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<td>Debriefing with Head of sections and management and CP Team</td>
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<td>12:00</td>
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Annex 4: Bibliography


Inter-Agency Standing Committee (IASC) Violences Basées sur le Genre. 2015. “Procedures Operationnelles Standard Pour la Prevention et la Reponse a la Violence Basee Sur le Genre en Republique Centrafricaine”.


Individuel (SSA)
