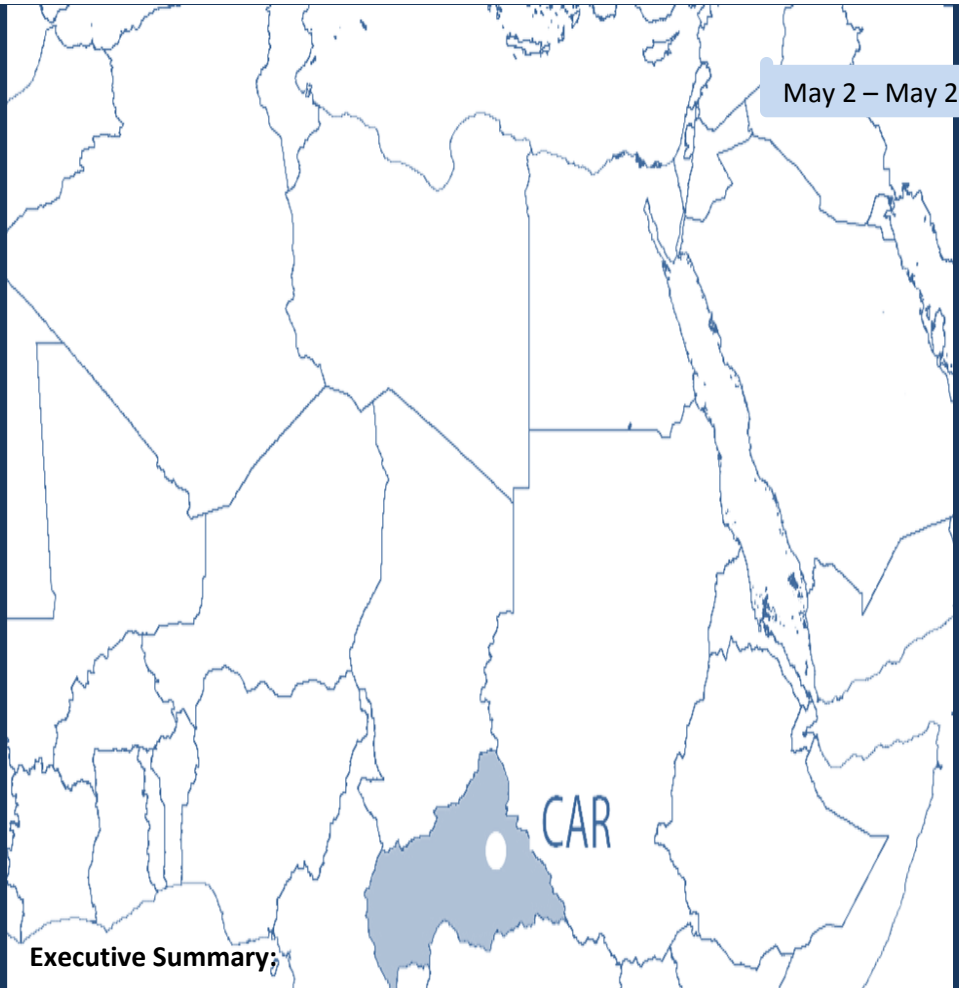
Child Protection

MISSION REPORT

CENTRAL AFRICAN REPUBLIC

May 2 – May 23, 2017



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Executive Summary:

Due to the scope and scale of the crisis in Central African Republic (CAR), the Child Protection Cluster (CP-SC) requested and obtained support from the Global Child Protection Area of Responsibility (CP AoR) for a mission to CAR to improve the coordination of response activities supporting child survivors of sexual abuse.

While there is a need to improve access to and quality of response services for any survivor of sexual abuse in CAR, there is a critical gap in providing quality services for child survivors of sexual abuse; especially quality case management services. Few actors have the capacity or resources to provide quality care, even though global resources exists. While some actors state they are providing case management, most actors do not align with global guidance, good practices, or tools used by other actors in CAR.

Comprehensive and effective global guidance on clinical care can be adapted to fill the gaps in human resources, if effective mentoring was provided and local interest presented a drive to institute good practices. Actors that have strong clinical backgrounds, but do not always focus on gender-based violence (GBV) or participate in the cluster system, have enormous potential to fill clinical and psychosocial gaps. Efforts started by the CP-SC and GBV-SC to implement a one-system approach to case management needs to be supported.

The Global CP AoR, stands ready to work with international, regional, national, and local actors to improve quality care services for child survivors of sexual abuse in CAR.

Image by: Fred Mugabi Morjan

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INTRODUCTIONS

Call for a mission:
Due to the scope and scale of the crisis in Central African Republic (CAR), the Child Protection Sub-Cluster (CP-SC) requested and obtained support from the Global Child Protection Area of Responsibility (CP AoR) for a mission to CAR to improve quality care for child survivors of sexual abuse.

The plight of an emergency situation exacerbates gender-based violence (GBV). While funds and increasing attention has put prevention and response to GBV on many key agendas[1]; often GBV response programs in emergencies, while appropriate for adults, fall short of meeting the specific needs of children – especially for child survivors of sexual abuse. This gap in response services make children more vulnerable and further harmed, leading to a plethora of clinical and psychosocial challenges which can consequently destroy a child's life because of inadequate survivor-centred care after violence.

United Nation Children's Fund (UNICEF), as the global champion of children's rights and the elimination of discrimination and violence against children, is taking measures to scale up quality GBV prevention and response programming[2]. As the global lead of three clusters and the Global CP AoR, this includes – but is not limited to – a continued focus on building human resource capacity for specialized GBV services, implementing standards across sectors to operationalize the *IASC GBV Guidelines* (2015), and providing leadership to facilitate increased attention to address GBV. Through conversations with CP actors in emergencies, the Global CP AoR recognized the immediate need to ensure effective and efficient coordination of activities supporting child survivors of sexual abuse.

In CAR several factors pose significant risks to the protection of especially for children: including sexual violence.[3] The weakening of community institutions, due to the conflict, has increased GBV, which estimates that at least 100,000 women and girls are at risk.[4] Therefore, survivors – especially children – are in need of access to holistic services.[5]

Mission objective:
The goal of the mission was to ensure effective and efficient coordination of programs and activities supporting child survivors of sexual abuse. On this basis the focus of the proposed mission was on improved coordination.

Location:
In CAR, the mission focused on CP-SC in three cities:

- Bangui
- Bossangoa
- Kaga-Bandoro

Extensive conversations were had with partners within the CP-SC and GBV-SC that work within each of these cities on how to take the mission to scale. Therefore, the conclusions and recommendations provide a scope of suggestions for actor who could support a child survivor of sexual abuse.

[1] There have been many key forums, including – but not limited to, The World Humanitarian Summit (2016), The Call to Action on Prevention from GBV in Emergencies (2013 - Present); and the Real-Time Accountability Partnership (2015 - Present)
[2] Several documents have outlined key commitments and/or provided recommendations related to preventing and responding to GBV, including – but not limited to, UNICEF Strategic Framework 2018 – 2021 (2017); the Office Management Plan for UNICEF's Office of Emergency Programs (2017), the Multi-Country Real Time Evaluation of UNICEF's GBViE Programs (2016), UNICEF's commitment to the Sustainable Development Goals in the 2030 Agenda for Sustainable Development (2015), the Global Cluster Coordination Unit's Contribution to the Strategic Planning Process 2018-2016 (Draft 2016), and UNICEF's Gender Dashboard: Gender Action Plan (2014).
[3] Humanitarian Needs Overview 2017 – Republique Centrafiqicaine (October 2016)
[4] Ibid
[5] Ibid

CONCLUSIONS

There were two outcomes to this mission:

1. The CP-SC has improved coordination on responding to child survivors of sexual abuse
2. The CP-SC has resources to guide the response to child survivors of sexual abuse

Outcome #1: CP SC has improved coordination on responding to child survivors of sexual abuse

To accomplish the first outcome, the GBV Consultant delivered five outputs:

1.1. An aligned referral protocol for responding to child survivors that the CP-SC and GBV-SC can use ;
1.2. Case management tools for responding to child survivors that the CP-SC and GBV-SC can use;
1.3. Referral suggestions for Bangui;
1.4. Good practices of coordinating assessments for child survivors of sexual abuse; and
1.5. Recommendations on how coordination activities started during this mission can be continued into incorporated and planned CP-SC and GBV-SC activities.

1.1. Output: Provided a referral protocol that the CP-SC and GBV-SC can use to support child survivors of sexual abuse in Bangui

Interviews with several actors, including – but not limited to – health, CP, and GBV actors working in Bangui provided the foundation for understanding the current situation of clinical, psychosocial, safety, and legal services available to child survivors of sexual abuse. The referral protocol is listed in Annex 1 of this report.

1.2. Output: Identified case management tools that the CP-SC and GBV-SC can use to support child survivors of sexual abuse

The *Interagency GBV Case Management Resource Package* (2017) should be used as the primary resource to providing case management services to GBV survivors in humanitarian settings.

Case management did not appear to be aligned especially for child survivors of GBV. In addition, several actors had different understanding of what case management entails. As a kind reminder, case management is a process – not a single event, in which the caseworker and the survivor work together to identify and connect needed services in a safe and supportive way. Quality case management ensures the promotion of the survivor-centred approach – where the survivor's experiences, needs, rights, and decisions are at the centre of a case management relationship. The six steps of case management can be found on Part II: The Steps of GBV Case Management. The overall goal in case management, especially with a child survivor, is to establish a relationship that promotes his/her emotional and physical safety, builds trust, and helps him/her restore some control over her life. Case managers must be comfortable with case action planning, safety planning, and safe documentation; and must know which services the survivor could have access to obtaining. Case action planning is a step-by-step process and case managers must have a specific attitude to support survivors; for example, each case worker must maintain that violence is never the fault of the survivor. Case management tools, including – assessment tools, templates, supervision, and related forms to GBV IMS – can all be found in the *Interagency GBV Case Management Resource Package* (2017) annexes.

1.3. Output: Provided referral suggestions for Bangui

Interviews with several actors, including – but not limited to – health, CP, and GBV actors working in Bangui provided the foundation for understanding the current situation of clinical, psychosocial, safety, and legal services available to child survivors of sexual abuse.

The most comprehensive institution, observed, for a child survivor of sexual abuse to receive support services in Bangui are MSF-Paris and Médecins du Monde.

The suggest referral protocol, located in Annex 1, has detailed contact information for case management, clinical, and psychosocial services in Bangui. Annex 1 is encouraged for public and wide dissemination.

There was inclusive results on safety and legal services; therefore, no referral suggestions were provided for those services.

1.4. Output: Provided a list of good practices of coordinating assessments for child survivors of sexual abuse

During the mission, there were several good practices observed. The following list outlines good practices that could be replicated in future activities.

- In each city visited, there are actors capable of providing quality clinical care to GBV survivors; and a few improvements could make each location ideal for child;
- In each city visited, there is awareness to the term "case management"; although understanding of a quality responses was not harmonized;
- In each city visited, there is a referral pathways for GBV survivors; although most referral pathways have outdated information and need to be updated;
- Every city has a significant number of actors actively participating in the cluster, including – but not limited to: United Nation (UN) agencies, international non-government organizations (INGOs), and national NGOs;

- Cluster members are discussing key issues around child survivors; but there is a lack of capacity in actors to respond to the plethora of issues; and
- Several actors are knowledgeable that global resources exists.

1.5. Output: Provided a list of recommendations on how coordination activities started during this mission can be continued into incorporated into planned CP-SC and GBV SC

There is potential for CAR to have effective services to child survivors of sexual abuse. Based on the quantity of actors that are present in CAR, especially Bangui, CAR is rife with opportunities. While, CP and GBV actors have provided a multi-sectoral response to survivors, more could be done to ensure that quality services are provided.

In particular, actors – especially CP; GBV; protection; health; camp coordination and camp management (CCCM); shelter; and water, sanitation, and hygiene (WASH) actors - can work together, for child survivors, to:

- Break down silos across clusters – and engage actors who to ensure holistic prevention and response in programming and in coordination;
- Document and share good practices of improved availability, access to and quality of services;
- Align the case management and referral pathways between CP and GBV actors;
- Improve the availability and access to age-appropriate clinical and psychosocial services;
- Improve the quality of age-appropriate clinical and psychosocial services; and
- Partner on advocacy and funding.

While actors aspire for a single panacea to provide access to quality services for child survivors of sexual abuse in CAR; the current situation in CAR needs a sustainable plan for ensuring future resources invested have long term impact. Over the years, capacity building resources – especially on case management – have been provided. However capacity building has yet to transform into quality care. The actors providing the best quality care are thoroughly engaged in providing responses; and due to their resources – especially human – being stretched to their capacity they are less likely to interact in coordination meetings. In addition, actors sometimes act in silos for a variety of reasons – including, but not limited to:

- The lack of trust in other actors to practice a survivor centered approach and humanitarian principles has discouraged actors from promoting referrals;
- The lack of capacity in actors to provide a quality response; and
- The low productivity to respond to the issue in a qualitative and timely fashion.

In the Dropbox, created for the mission, two comprehensive documents outline recommendations. This includes, but is not limited to supporting actors to:

- Advocate for increased presence of GBV actors that have mentorships for comprehensive programming, based on identified service gaps;
- Build on MSF's directory of service providers – especially clinical, psychosocial, and case workers: including training capacity of each individual;
- Ensure case management materials used by CP and GBV actors are the same or complementary: *Interagency GBV Case Management Resource Package* (2017);
- Ensure continued stock of appropriate medicines and supplies in health facilities for children in each clinic;
- Ensure that preventing/responding to child children is a standing agenda item on local Protection Sector meetings;
- Maintain updated mapping of quality services available in Bangui;
- Provide individual and/or group psychosocial support through trained staff using Mental Health and GBV resource;
- Train clusters in Bangui on *IASC GBV Guidelines* (2015);
- Train existing health facility support staff / non-clinical staff on the GBV guiding principles, especially for working with children using *Caring For Child Survivors of Sexual Assault* (2012), *Clinical Care for Sexual Assault Survivors* (2009); and *Interagency GBV Case Management Resource Package* (2017).

As clinical, psychosocial, and case management are crucial steps that need timely responses; actors should prioritize the following actions, especially in clinics:

- Align case management systems used by CP and GBV actors using guidance from the *Interagency GBV Case Management Resource Package* (2017);
- Ensure that each clinic is child friendly, including – but not limited to – having the following items: baby doll, clean clothing, snacks, water, juice, toys, and mat;
- Have a directory of service providers for child survivors of sexual abuse available, for the location chosen of Output 1.1 building off the document that MSF-Spain has already provided ; and
- Work with UNFPA and procure necessary kits ensuring that every clinic has and knows how to use child friendly medicines; especially oral suspensions for Azithromycin, Cefixime, Zidovudine, and Lamivudine.

Outcome #2: The CP-SC has resources to guide response and support to child survivors

To accomplish the second outcome, the GBV Consultant delivered three outputs:

2.1. A list of key coordination resources;
2.2. A list of coordination gaps; and
2.3. A roadmap document of coordinating distribution of clinical resource to child survivors.

2.1 Output: Created a list of key coordination resources is available

A Dropbox was created to store key resources. This Dropbox includes:

1. Clinical procurement resources related to output 2.3;
2. Final report (which has this document);
3. Key global resources, to support any actor in coordinating or implementing activities to provide access to and quality of services for children survivors of GBV, which have been hyperlinked through-out the report; and
4. Presentations made during the mission.

In addition the Global CP AoR, procured several items and voluntarily donated the following resources CP-SWG members:

- Baby dolls for clinics;
- *CP Minimum Standards* (2010);
- *IASC GBV Guidelines* (2015)*: Health Section*;
- *Caring For Child Survivors of Sexual Assault* (2012);
- *Inter-Agency Network for Education in Emergencies Minimum Standards* (2010); and
- *Fundraising Handbooks for GBV and CP* (2013).

2.2 Output: Created a list of coordination gaps

During the mission the GBV Consultant met with key actors providing coordination to and program implementation of CP and GBV activities. This included, but was not limited to, meeting with members of the CP-SC, GBV-SC, Health Cluster, WASH Cluster, Education Cluster, and CCCM Cluster. Actors were both male and female, local, and expatriate. Actors also worked for international, national, and local non-government organizations; national and state government ministries; and UN agencies. During each individual consultation or meeting, the GBV Consultant obtained information on the access to and quality of services for child survivors of sexual abuse. This data and information, lead to knowledge of five critical gaps:

1. Lack of aligned case management systems between CP and GBV actors;
2. Lack of access to quality clinical care and psychosocial support, especially for a child survivor of sexual violence;
3. Lack of consistency between actors who provide response services to child survivors of sexual violence;
4. Lack of knowledge on actors that have the capacity to support child survivors; and
5. Lack of mentorships, fellowships, or shadowing opportunities, especially to local NGOs

To fill these gaps the following steps are encouraged. A comprehensive review of each topic should be considered to improve access to and quality of services to children survivors of GBV.

- **Align case management systems between actors and sectors**: Case management did not appear to be aligned especially for child survivors of sexual abuse. While the CP-SC is in the process of creating standard operating procedures for case management; the materials in Annex 1 should be used for child survivors. In addition, several actors had different understanding of what case management entails. As a kind reminder, case management is a process – not a single event, in which the caseworker and the survivor work together to identify and connect needed services in a safe and supportive way. Quality case management ensures the promotion of the survivor-centred approach – where the survivor's experiences, needs, rights, and decisions are at the centre of a case management relationship. The overall goal in case management, especially with a child survivor, is to establish a relationship that promotes his/her emotional and physical safety, builds trust, and helps him/her restore some control over her life. Case managers must be comfortable with case action planning, safety planning, and safe documentation; and must know which services the survivor could have access to obtaining. Case action planning is a step-by-step process and case managers must have a specific attitude to support survivors; for example, each case worker must maintain that violence is never the fault of the survivor. Actors implementing and providing case management should use guidance from the *Interagency GBV Case Management Resource Package* (2017) and *Caring For Child Survivors of Sexual Assault* (2012).

- **Improve clinical and psychosocial care for a child survivor of sexual violence**
  Communities often have limited access clinical care. Therefore, each setting needs to ensure there are quality care services, especially clinical and psychosocial, for child survivors of sexual abuse, within a reasonable distance. Mobile clinics have been used and could be re-considered; especially if the mobile clinics are made to be child friendly. Each clinic needs to be evaluated, to ensure quality services exists for children aligned with *Caring For Child Survivors of Sexual Assault* (2012).

- **Update the list of actors that have the capacity to support child survivors**
  Children survivors need to have 24 hour access to a clinical professional. To ensure actors know where to locate a trained professional, an open source directory of clinical and psychosocial workers should exist. A list of health consultants, care workers, and GBV actors has been started due to colleagues within MSF-Spain (see Dropbox).

  A quality clinical care professional caring for a child survivor of GBV should have the following experience and training:
  1. Educational background in clinical care
  2. GBV Basic Training;
  3. *Clinical Care for Sexual Assault Survivors* (2009);
  4. *Caring For Child Survivors of Sexual Assault* (2012); and
  5. *Interagency GBV Case Management Resource Package* (2017).

  A quality psychosocial professional caring for a child survivor of GBV should have the following experience and training:
  1. Educational background in psychology
  2. GBV Basic Training;
  3. *Caring For Child Survivors of Sexual Assault* (2012);
  4. *Interagency GBV Case Management Resource Package* (2017); and
  5. Psychosocial First Aid.

- **Align support between GBV, CP, protection, and health actors to aid child survivors of sexual abuse**
  The CP-SC has an obligation to support children. Cooperation from other sectors to implement recommendations, drive initiatives, and ensure access to and quality of services for child survivors of sexual abuse will make recommendations feasible to implement. The CP-SC, while a strong sector, must have cooperation from several sectors – including but not limited to – the GBV-SC, Protection Cluster and Health Cluster, to implement the following:
  - Advocate for mentorships to support the capacity of actors support child survivors of sexual abuse
  - Create a directory of clinical, psychosocial, and case workers: including training capacity of each individual;
  - Ensure case management materials follow guidance of *Interagency GBV Case Management Resource Package* (2017);
  - Ensure continued stock of appropriate medicines and supplies in health facilities for children in each clinic;
  - Ensure that responding to children is a standing agenda item on local Protection Sector meetings;
  - Maintain updated mapping of quality services available in Bangui;
  - Provide psychosocial support through trained staff using *Mental Health and GBV* (2015);
  - Train clusters in Bangui on *IASC GBV Guidelines* (2015);
  - Train existing health facility support staff / non-clinical staff on the GBV guiding principles, especially for working with children using *Caring For Child Survivors of Sexual Assault* (2012), *Clinical Care for Sexual Assault Survivors* (2009); and *Interagency GBV Case Management Resource Package* (2017).

- **Create a mentorship, fellowship, or shadowing opportunity to build capacity of actors providing clinical care, psychosocial support, and case management services**
  Capacity building on the aforementioned topics has repeatedly occurred in CAR; but there are still large gaps in quality services. To build capacity in the future, agencies should look at fruitful opportunities that allow on-the-job training; opposed to short-term one to five day trainings. For example, mentorships should be able to build capacity to identify individuals, especially in national and local organizations; and each mentorship should be able to answer the following questions:
  - How will the mentoree contribute to quality services for child survivors within CAR within one year?
  - How will the mentoree contribute to quality services for child survivors within CAR within five years?
  - How will the mentoree contribute globally to improving quality services for child survivors?
  - How will the mentoree and the mentor be held accountable to ensure sustainable capacity in CAR?

2.3 Output: Created a document of coordinating distribution of clinical resources to child survivors is available
Comprehensive resources were identified and placed in a folder in the Dropbox for this mission. This includes, but is not limited to, a manual on procurement and a list of clinical supplies.

ANNEX 1

REFERRAL PROTOCOL FOR BANGUI, CENTRAL AFRICAN REPUBLIC

Purpose

The purpose of this referral protocol is to establish a clear system so that GBV survivors and others know to whom they should report and what sort of assistance survivors can expect to receive.

Principles

A GBV survivor has the right to disclose an incident to anyone. The person may disclose their experience to a trusted family member, friend, or seek help from a trusted organization in the community. Anyone the survivor tells about their experience has a responsibility to give honest and complete information about services available; and to make sure the survivor has support throughout the process.

Always observe the basic guiding principles:

- Safety
- Confidentiality
- Dignity
- Non-discrimination

Keep the number of people informed of the case to an absolute minimum to ensure client confidentiality. Good practices ensure the survivors tells his/her story only once and when s/he chooses to share.

When you meet a survivor, take the following step:

	Take	Example of what to say
1	Validate the person's experience	• I believe you
2	Value the relationship	• I am glad that you told me, you can trust me
3	Explain what you are and are not capable of providing	• I am a friend you can trust; • I am not a specialist in clinical care • I know a safe place to obtain clinical care
4	Explain options that exists	• We can go to MSF-Paris or MdM for clinical care
5	Empower the person to make decisions	• You can choose how you want to respond; • The decision on what to do next is your choice;
6	Emphasize the person's strengths	• I am sorry that this happened to you; • You can choose how you want to respond;
7	Validate the person's experience	• I am sorry that this happened to you

Reminder on clinical treatments:

Prevention of HIV	Within 3 days
Prevention of unwanted pregnancy	Within 5 days
Prevention of STIs	No time limit, but the sooner the better
Treatment of physical injuries	No time limit, but the sooner the better
Emotional and psychosocial support	No time limit, but the sooner the better

NO ACTION SHOULD BE TAKEN WITHOUT THE EXPRESS PERMISSION OF THE SURVIVOR, within the bounds of the law.

PATHWAY FOR DISCLOUSRE AND REPORTING

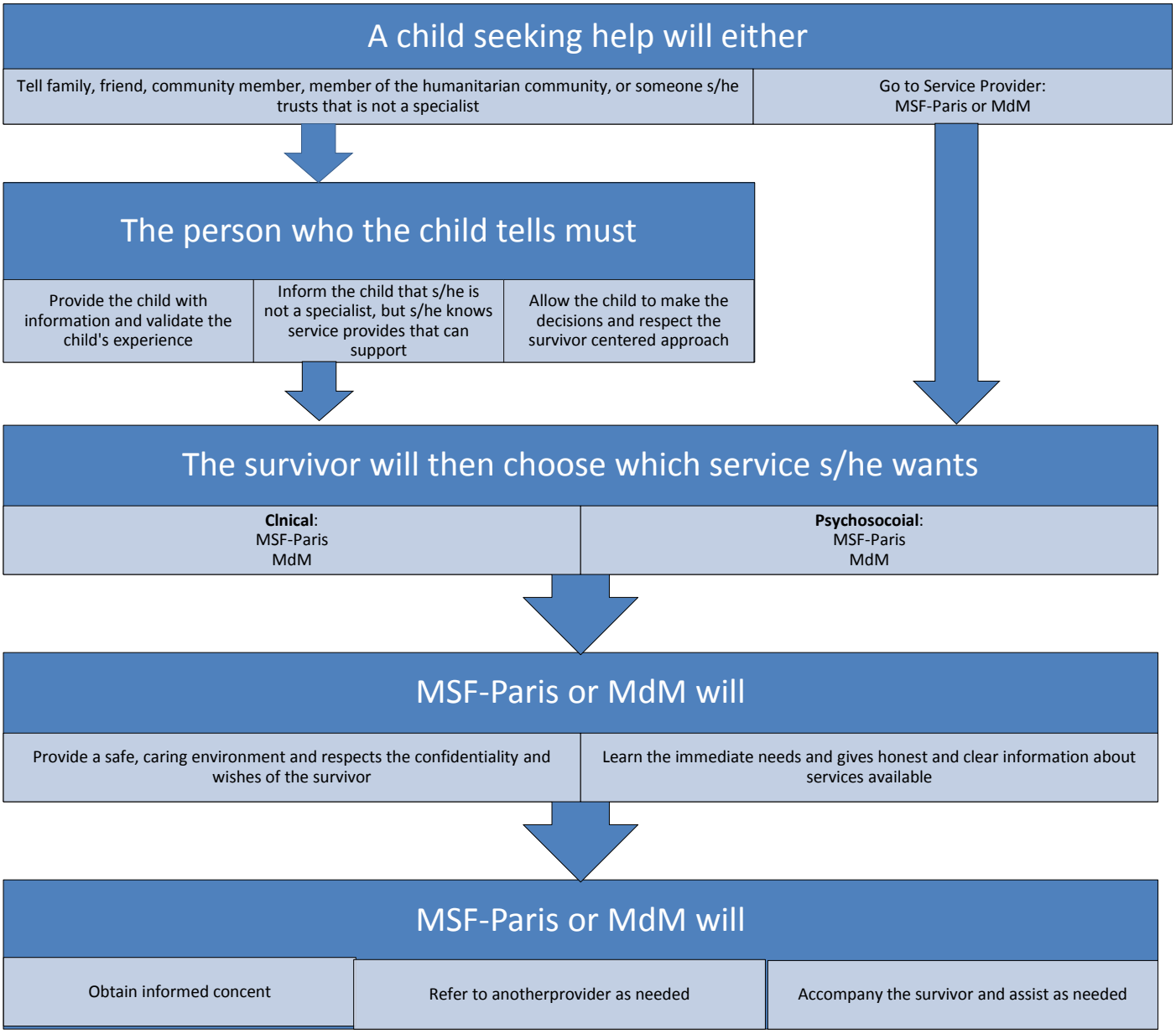
Date of last update

22 June 2017

Location

Bangui, République de Centrafrique

Appropriate action steps to take



CONTACT INFORMATION FOR MEDECINS DU MONDE

MdM DIRECTEMENT		
Nom	Princesse	Kelly
Tire	Superviseure VBG	Referente VBG
Téléphone	72 02 76 80	72 72 06 00

	PRISE EN CHARGE CLINIQUE	PRISE EN CHARGE PSYCHOSOCIALE
Centre de santé Bégoua - PK12		
Nom	Suzanne	Kelly
Téléphone	72 15 52 72	72 53 63 48 (Pulchérie, chargée de projet CIAF)
Titre	Sage femme	Conseillère psychosociale
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h
Centre de santé Gobongo - 8ème arr		
Nom	Castella	Patricia
Téléphone	72 55 45 10	72 53 63 48 (Pulchérie, chargée de projet CIAF)
Titre	Sage femme	Conseillère psychosociale
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h
Centre de santé Malimaka - 6ème arr		
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Téléphone	72 63 24 10 (cheffe de centre)	75 08 29 93
Titre	Sage-femme	Conseillère psychosociale
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h
Centre de santé Liton (PK 22 - Route Damara)		
Nom	Thérèse & Stella	Cyril
Téléphone	Chef de centre: 72 53 00 09 **Attention : pas de réseau téléphonique à Liton**	Chef de centre: 72 53 00 09 **Attention : pas de réseau téléphonique à Liton**
Titre	Sage femme	Conseiller psychosocial
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h
Centre de santé Gbango (PK 42 - Route Damara)		
Nom	Brigitte	Brigitte
Téléphone	72 72 22 74 **Attention : pas de réseau téléphonique à Gbango**	72 72 22 74 **Attention : pas de réseau téléphonique à Gbango**
Titre	Sage femme	Conseiller psychosocial
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h
Centre de santé Bouboui (PK 45 - Route Bouali)		
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Téléphone	Chef de centre: 72 60 13 67	Chef de centre: 72 60 13 67
Titre	Sage femme	Conseiller psychosocial
Formation	Prise en charge médicale des violences sexuelles - Médecins du Monde / Ministère de la santé Technique de faible intensité en soutien psychosocial - Médecins du Monde	Formation soutien psychosocial - ONU Femmes Formation et recyclages des conseillers psychosociaux - Médecins du Monde Formation sur le stress post-traumatique - Action contre la Faim
Horaires	8h - 16h	8h - 16h

CONTACT INFORMATION FOR MEDICINE SANS FRONTIER - FRANCE

	PRISE EN CHARGE CLINIQUE	PRISE EN CHARGE PSYCHOSOCIALE
Nom	Sylvie	Sophie
Téléphone	72 17 13 47	72 17 13 47
Titre	Sage femme	Conseillère psychosociale
Formation	Prise en charge médicale des MSF Prise en charge psychologue MSF	Prise en charge médicale des MSF Prise en charge psychologue MSF
Horaires	0-24h	0-24h
Nom	Tatiana	Abel
Téléphone	72 17 13 47	72 17 13 47
Titre	Sage femme	Conseillère psychosociale
Formation	Prise en charge médicale des MSF Prise en charge psychologue MSF	Prise en charge médicale des MSF Prise en charge psychologue MSF
Horaires	0-24h	0-24h
Nom	Hermine	
Téléphone	72 17 13 47	
Titre	Sage femme	
Formation	Prise en charge médicale des MSF Prise en charge psychologue MSF	
Horaires	0-24h	

ANNEX 2

CHILD PROTECTION SUB-CLUSTER INITIATIVE TO ENSURE: CHILDREN ARE PROTECTED FROM GBV IN EMERGENCIES[6] IN CENTRAL AFRICAN REPUBLIC						
Child survivors have access to appropriate services in a safe and timely manner				**Interventions to address GBV, especially to children, are coordinated**		**Key decision-makers take action to improve protection of children**
Quality psychosocial services are provided for child survivors	Quality case management services are provided child survivors	Health services are provided in line with *Caring for Child Survivors of Sexual Abuse* (2012)	Communities know which GBV-related services are available, especially to children, and how to access them	Other sectors identify factors that increase risks to children, and develop strategies to address them	Gaps in services or geographic coverage are identified and solutions proposed	Advocacy strategy implemented for increased funding and improved policies/systems to protect children
• Train and support existing child friendly actors that can provide emotional support to survivors using *Caring For Child Survivors of Sexual Assault* (2012) • Provide individual and/or group psychosocial support through trained staff using Mental Health and GBV resources • Ensure that organizations offering broad psychosocial services are aware of GBV-specific services and referral pathways for children	• Ensure case management materials used by CP and GBV actors are the same or complementary: Use *Interagency GBV Case Management Resource Package* (2017); • Train pre-existing GBV caseworkers, emphasizing GBV guiding principles and survivor-centered, age-appropriate approaches using *Interagency GBV Case Management Resource Package* (2017);	• Ensure continued stock of appropriate medicines and supplies in health facilities for children in each clinic, following the list in the clinical audit • Ensure on-site mentoring and follow-up with GBV focal points, who can work with children • Train existing health facility support staff / non-medical staff on the GBV guiding principles, especially for working with children using *Caring for Child Survivors of Sexual Abuse* (2012) and *Clinical Care for Sexual Assault Survivors* (2009)	• Train local community outreach team to continue dissemination of specific, tailored messages about services to children	• Ensure that preventing/responding to children is a standing agenda item on local Protection Cluster meetings • Train all sectors in Bangui and service providers on *IASC GBV Guidelines* (2015)	• Based on identified service gaps, advocate for increased presence of GBV actors and/or increased funding for comprehensive programming • Maintain updated mapping of quality services available in each IDP camp and host community • Articulate service gaps in Bangui to HCT •	• Disseminate recommendations widely to improve the protection of children to appropriate target audiences, such as other sectors, donors, and governments • Build inter-agency consensus around advocacy messages and strategies where possible (especially with GBV Sub-Cluster, Health Cluster, and Protection Cluster)
Ongoing and cross-cutting activities: • Ensure safety plans for staff, partners, and volunteers are in place. • Establish a policy to reinforce the importance of staff self-care and to provide concrete options for staff support, including regular debriefing for staff involved in service provision to GBV survivors.						

[6] Adapted from International Rescue Committee, Women's Protection and Empowerment Team in South Sudan (2013)