HOW TO GUIDE

Reproductive Health in Refugee Situations

A Community-Based Response On Sexual Violence Against Women

CRISIS INTERVENTION TEAMS

NGARA, TANZANIA January 1997

The **HOW TO GUIDE**: This is the first in a planned series to document field experiences on HOW various actors undertook the implementation of Reproductive Health activities. The document was compiled from field reports, discussions with key actors and selected telephone interviews.

The audience of the guide is field-based refugee workers including UN system, NGOs and governments staff in the health, community services, protection and other related sectors.

Each **HOW TO GUIDE** documents one field experience which demonstrates an innovative approach to a particular area of RH. It documents how one refugee situation undertook an activity. There are many more such examples. The HOW TO GUIDE is not meant as a definitive recommendation on how to do something, but should be used and adapted as appropriate for each refugee setting.

It is hoped that the **HOW TO GUIDE** series will stimulate a sharing of other similar examples of how various refugee situations are undertaking activities to strengthen responses to the reproductive health needs of refugees.

If you have any questions, please contact the specific actors directly involved in the example given. In this case, please direct your queries to the UNHCR, Branch Office, Dar es Salaam, P.O. Box 2666, Dar es Salaam, Tanzania, Tel: 255 51 15 28 17, Fax: 255 51 15 0075, e:mail tanda@unhcr.org, or the other actors mentioned in the document.

Special Note: The term "victim" is used in this document, the sitgmatization and perceived powerlessness associated with being a "victim" should be avoided by all concerned parties. While victims require compassion and sensitivity, their strength and resilience should also be recognized and borne in mid.

Compiled by UNHCR/PTSS

WHO IS THIS GUIDE FOR?

This guide is for anyone working with refugees who wishes to address the problem of sexual violence against women. Being based on real-life experience at Ngara refugee camps in Tanzania it is not a

definitive guide, but an attempt to share with others the thinking behind, and lessons learnt from, one successful approach. After reading the guide, the user should be able to:

- assess the problem of sexual violence in a given setting
- identify key players in a practical response to the problem
- draw up guidelines on steps to be taken, and roles & responsibilities of actors
- set criteria for selecting team members
- organize training
- evaluate the programme

WHAT WAS THE REFUGEE SETTING AT NGARA?

Ethnic conflict in Burundi in 1993 and in Rwanda in 1994 forced thousands to flee their homelands. 485,000 refugees from these countries were accommodated in 7 temporary camps in the Ngara district of Tanzania, a remote, poor area of the country with a native population of some 180,000. It was estimated that around 200,000 of the refugees were females between the ages of 10 and 50 years and 120,000 were children aged 7-14 years. The vast majority of refugees -- more than 400,000 -- were from Rwanda. They were given temporary asylum by the Tanzanian Government and were officially not permitted to farm or trade outside the camps. In late 1996 it became possible for the Rwandan refugees to return home, and all were repatriated between 13-24 December, leaving only about 80,000 Burundians in the camps.

At the height of the refugee crisis, the sudden huge increase in the population of Ngara put a strain on scarce resources such as water and fuel wood, and the Tanzanian authorities imposed on the refugees a 4km restriction zone around each camp. However, fuel wood supplies close to camps were soon exhausted and refugees -- women and children mostly -- regularly walked 20km or more to collect wood, thereby risking arrest and deportation.

The security, police and legal systems of Ngara were also overburdened by the influx of people. There was a backlog of petty crime cases in the courts and the prison was overcrowded. UNHCR assisted the Tanzanian Government by providing 250 additional policemen to help the local force and to be responsible for the security of the camps and the humanitarian workforce.

WHAT WAS THE ADMINISTRATIVE SET UP IN THE CAMPS?

UNHCR was given responsibility for overall coordination of the humanitarian operation in Ngara by the Tanzanian Government and worked closely with the Ministry of Home Affairs. The UNHCR team consisted of a coordinator for each of the specialist units, ie. health, nutrition, protection, security, community services, field, water & sanitation, information, and logistics.

From the start there was a determination to involve refugees in the activities and administration of the camps to the fullest extent possible. The primary purpose was to rebuild self-confidence and social cohesion among the refugees after the intense trauma of civil war. But it also allowed UNHCR and its partner NGOs to share with the refugees some of the heavy workload and responsibilities of running the camps. UNHCR Community Services had the leadership role in this process, and one NGO in each camp was designated to coordinate the community services programme in that camp, and signed a Memorandum of Understanding (MOU) with UNHCR. Other NGOs wishing to provide services in any camp had to have a formal agreement with the lead NGO and UNHCR before proceeding.

A major initiative of community services was a psycho-social programme which gave a core group of refugees intensive training in general psychology, child development, and communication skills and

looked specifically at the issues of trauma and stress.

WHAT WAS THE PROBLEM OF SEXUAL VIOLENCE AND HOW WAS IT ASSESSED?

During 1994 very few cases of sexual assault were reported in the camps. At the end of 1994 a report was published by an outside agency suggesting that a high proportion of women in Ngara had been sexually assaulted and that it was a continuing problem. UNHCR in collaboration with other actors, therefore accelerated discussions with select groups of refugees, including teenage girls and boys, married and widowed women, single parents, elderly people, and community workers, to find out what their experiences and views were concerning sexual violence.

In the discussion groups the following questions were raised:

- what are your main concerns?
- what do you think about security in and around the camps?
- do you feel the children and women are safe?
- what was the situation in your country of origin for victims of sexual violence?
- who would know about rape cases in the refugee community?
- what is done at present in the camps about sexual violence?
- are you satisfied with the way it is handled at the present time?
- do you perceive sexual violence as a major problem in your actual situation?
- how should it be tackled?

This was an extremely sensitive topic and it was considered crucial to allow the refugees to approach it in their own way and at their own pace as they developed confidence and trust. It was important too, to respect the refugees ' own evaluation of the problem. At first they talked about other matters of concern, such as food distribution, sanitation, and the care and protection of the vulnerable, especially children. With time they began to talk about sexual violence, indicating that this had not been a problem in the first few months since extreme overcrowding in the camps and lack of privacy had offered a degree of security against assault. Sexual violence had, however, become a problem lately, and the refugees felt it needed to be addressed, though it was not considered especially high priority. It emerged that women and children were particularly vulnerable to attack when venturing out to gather fuel wood (60% of reported rapes occurred during this activity), and when queuing for water, often in the darkness of evening or very early morning. Women were sometimes forced by men guarding the taps to pay for water with sexual intercourse. Sexual assault of boys never emerged as a concern in the discussions.

There were powerful reasons why sexual assault cases were frequently not reported. In the refugees ' home countries rape was heavily stigmatized. Occasionally compensation would be demanded by the victim's family, but often a raped woman would be rejected by her husband, family or community, or forced to marry the perpetrator to restore family honour. In the camps the train of events triggered by reporting a case to local authorities and/or UNHCR was often seen as adding to the trauma of the victim, with very little chance of the perpetrator being charged.

HOW DID THE IDEA FOR THE CRISIS INTERVENTION TEAMS (CITs)

ORIGINATE?

Having ascertained there was a problem of sexual violence, UNHCR staff from protection and community services facilitated a meeting with the NGOs coordinating activities in the camps and with

representatives from women groups, and community and psycho-social health teams among the refugees to decide what should be done.

The main concern was that unless they were physically injured in the assault, victims did not come forward and thus received no medical attention, no psychological support in dealing with the trauma, fears of pregnancy, disease and rejection.

The idea of Crisis Intervention Teams made up of refugees and supported by the community services NGOs in each camp developed out of the intensive brainstorming sessions. The immediate attractions of the idea were that:

- refugees themselves would provide the first line of response in sexual assault cases. Victims would be more willing to report an assault to a refugee who shared the same language and culture, and understood the social ramifications and significance of the events.
- the CIT members - always present in the community - could offer more sustained support for victims than the overburdened NGO or UNHCR staff, amongst whom there was a high turnover.
- the CIT members could act as mediators for the victims, gathering all the relevant information, and sparing them the ordeal of answering the same basic questions - often through translators - for many different professionals, eg. protection, health, community services, police.

WHO WAS INVOLVED IN DEVELOPING THE IDEA?

The community services and health network of NGOs (namely African Education Fund, CARE, Christian Outreach, Diaster Relief Agency, GOAL, International Rescue Committee, Norwegian People Aid, Tanzanian Red Cross Society/Internatioanl Federation of Red Cross and Red Crescent Societies) within the camps were fully involved throughout the development process, and a UNICEF psychosocial consultant provided valuable technical assistance.

Importantly too, the CIT programme was discussed with local Tanzanian authorities, including the police, the Ministry of Home Affairs responsible for refugee matters, the local medical officer, and relevant people within the justice system.

HOW WERE THE TEAMS CONSTITUTED AND RUN?

The CIT members, all refugees, were selected by the Community Services coordinating NGO in each camp from between existing community and social work groups. The following criteria were used in the selection process:

Criteria for Selection of Team Members

- to be skilled at communicating and able to deal with other people's distress and social problems;
- to be able to adopt an objective and neutral stance in dealing with cases;
- to respect the need for strict confidentiality;
- to have the respect and trust of the community;
- to be able to work in a team;
- to have the interest and confidence to work with victims of sexual abuse.
- to be literate
- (Team should have representation of both women and men)

One person from each team was designated as the coordinator. As a general principal women were

given priority in the selection process, although it was considered important that there be at least one male on each team to deal with situations where a man's intervention was more appropriate. These might include dealing with the husbands or families of victims, with male victims of sexual assault, or with male perpetrators. In practice in one camp, males predominated in the teams simply because more men than women had shown an interest in the work. The CIT in this camp took on a broader domestic violence mandate.

It was also considered crucial to have at least one member with medical experience who could give advice on such matters as sexually transmitted diseases and pregnancy and assist with medical consultations.

All team members had other jobs already and were expected to assume CIT duties on a voluntary basis. No incentives were given, but being a member of a CIT added to their status within their communities.

The Community Services NGOs in the camps were responsible for day to day supervision and monitoring of the teams, and the Community Services Coordinator at UNHCR had overall responsibility for the programme, with technical assistance from UNICEF and NGOs. In each camp a facility was put at the disposal of the CITs where they could meet and conduct confidential interviews with victims.

The CITs held weekly meetings to discuss individual cases, share experiences and information, and resolve together any problems they had with their work. These meetings generated new ideas and identified weaknesses in the system which were then communicated to the Community Services NGO. An NGO staff member would often be present at the weekly meeting.

It took approximately six months of planning and negotiation from the conception of the idea to the establishment of the first teams, which were in place by March 1995.

HOW WERE THE TEAMS TRAINED?

Once teams had been selected, they received an initial three day intensive training organized by UNHCR, followed by another 3-4 day block of training about eight months later. Neither a curriculum nor training materials existed already, so the organizers drew up a framework for the courses, consisting of a list of key issues to be addressed and the resources at their disposal -- especially the people with relevant skills and expertise who could be called upon to assist. Within this framework, the content of training was dictated to a large extent by the needs and requests of team members, as well as their existing levels of knowledge and experience. These varied greatly across a team, so flexibility was a crucial requirement.

Besides imparting information and skills, the training sessions were intended to develop a team spirit among people who did not necessarily know one another at the start. For this reason, participation was restricted to team members only, and they were encouraged to discuss things among themselves as much as possible. This also kept the need for translation to a minimum.

Subjects & Issues Covered in Training

- sexual violence, and traditional responses in country of origin;
- communication skills and interview techniques;
- community awareness and mobilization;
- mediation techniques;
- laws of the host country pertaining to sexual offences, and legal procedures to follow;
- reproductive health, and medical protocol;
- prevention measures;

- procedures to follow when a case was reported and how to link up with other players in the programme, eg. Protection and Security, Health, Community Services etc.

Staff members from UNICEF, CARE and UNHCR with special experience of working with victims of sexual abuse assisted in training, which also drew heavily on information contained in UNHCR's manual, *Sexual Violence against Refugees: Guidelines on Prevention and Response*. In addition, staff from Protection and Security were asked to talk to teams about preventive measures, what they could do to assist the CITs and offer to victims. In meetings subsequently, CIT members said they thought it would be helpful to meet occasionally with teams from other camps to learn from each others experience.

Most training sessions were ad hoc, and unfortunately the programme never had time to consolidate its experiences and produce materials that could be used elsewhere.

A weakness in the system that was not anticipated was that staff of the NGOs and UNHCR involved in the CIT programme were not necessarily comfortable with the subject of sexual violence and most lacked experience in dealing with it. This limited their effectiveness as supervisors and coordinators of the programme, and shortly before the camps closed down steps were being taken to give them training. It was recognized too, that local authorities such as police and health service personnel could benefit from training in this specialized field.

WHAT WERE THE GUIDING PRINCIPLES OF THE CITs?

Guidelines on how the CITs should work were developed during the regular fortnightly meetings of the psycho-social coordinating committee which comprised representatives of the community services/health NGOs working in the camps, refugees from the psycho-social core groups, UNHCR and UNICEF. This was the main decision-making body for the CITs; issues that could not be handled by the committee were referred to UNHCR, which had highest authority. The committee had a wide range of responsibilities and a heavy workload, so a special effort was needed to ensure CIT business, which was sensitive and uncomfortable for some people, was not overlooked. At least half an hour was allocated at every meeting to discussing the programme.

Guiding Principles of the CIT Programme,

- That it should ensure confidentiality of cases;
- that multiple interviews of the victim -- by staff from Protection, Community Services, Health, and sometimes police - should be avoided as they increased the trauma;
- That the wishes of the victim should be respected: if she did not want to involve the law, for example, no legal action should be taken;
- that support to the victim should take priority over any other measures;
- that there should be continuity of support, with, ideally, the person to whom the victim had reported handling her case throughout;
- that there should be close cooperation among all sectors involved in the humanitarian operation because all had a role to play in preventing or responding to sexual violence. (For example, the tensions created round the collection of water and fuel wood required staff from many different sectors, including field officers, community service, security and logistics staff, and refugee groups to find a solution together.)

WHAT WAS THE ROLE OF THE CITs?

The CITs were the first line of response in cases of sexual violence.

Their job was to listen to victims and conduct the first interview, and then to provide information and

advice on:

- the possible health consequences of the assault and the medical care available in the camp;
- the legal ramifications and the procedure to follow if the victim wanted to involve the law;
- possible psycho-social counseling and reintegration within the community;
- in rare cases, possible relocation to another part of the camp if this seemed necessary.

Depending on what course of action the victim wanted to take, the CIT member would accompany her to the dispensary, hospital, or AIDS/STD programme and see that she received appropriate attention. Or the team member would assist in her contacts with the Protection and/or Security Staff or police, translating interviews if necessary.

CIT members were also expected to provide psychosocial counseling and support to the victims and their families, and to mediate between the victims's and perpetrators's families if need be. It was their responsibility to provide basic non food items (NFI) such as clothes, blankets, and cooking pots if these were required. (Each Community Service NGO had a small stock of NFIs for use in meeting the needs of vulnerable groups.) And they were expected to make contact with community groups with a view to helping victims reintegrate into society by getting involved in community activities -- for example, income generating schemes, cultural or education programmes, or women, youth or religious groups.

An additional duty of the CITs was to raise awareness in the community of the problem of sexual violence, how it could be prevented, and what to do when it occurred

In practice, the effectiveness of the CITs depended very much on the personality of individual members, their motivation and efficiency. Inevitably, some were better than others at dealing with authority figures in the health and legal systems, and some needed more support from their supervisors than others. It gradually became clear, too, that members rarely had time to spend on awareness raising work and that this duty should be handed over to others.

WHAT WAS THE PROCEDURE WHEN A RAPE CASE WAS REPORTED?

When a rape was reported, the following steps were taken:

1. The CIT member would fill in a Sexual Violence Report Form specially designed by UNHCR, giving details of the incident. (See Annexe D)

2. This form would be sent, the same day if possible, to the UNHCR Community Services and Protection units. The form would state whether the person wanted to proceed with legal action or not. To protect confidentiality, only one copy of the form existed. A separate Sexual Violence Follow-up Form would be kept by the CIT in a central file in the offices of the Community Services NGO working in the camp.

3. As soon as possible, the CIT member would accompany the victim to a medical facility for STD treatment, pregnancy prevention of other medical care as necessary.

4. If the victim wanted to take legal action, the CIT would inform the Community Services NGO who would then inform UNHCR. If a prosecution was intended, Tanzanian law stipulated that a police form, PF3, be filled out, requesting a medical examination. This examination had to be performed by the District Medical Officer (DMO), within 24 hours of the attack. The district hospital was 30-80 km away, and the victim had to be accompanied on the journey by an agency staff member. Sometimes the CIT member would go too, to translate and give moral support.

5. In the camp, the Protection and Security units would take over from the Community Services for legal follow up of the case with the police.

6. Meanwhile, the CIT member would start providing the support mentioned in the previous section.

The procedure required by the Tanzanian authorities to bring a legal action and the extremely limited time allowed presented major difficulties for the programme. It implied that the rape was reported immediately to the CIT; that the Community Services NGO had a vehicle and staff member available to make the journey; that copies of the PF3 form were available at the local police station; and that when the party reached the hospital the DMO was present and willing to do a forensic examination without delay. Moreover, because the hospital was outside the 4km exclusion zone, a refugee CIT member wanting to accompany the party as translator had to have police permission. In cases where the perpetrator was a Tanzanian national, police and medical officers were sometimes reluctant to cooperate.

UNHCR took up these matters with the Tanzanian authorities and an agreement was reached eventually that the forensic examinations could be done at any appropriate facility by any Tanzanian certified physician, national or expatriate. However, the new ruling came into force only shortly before the majority refugee population was repatriated.

Another problem encountered by the CITs in the early days was lack of cooperation from some hospital-based health staff in some camps. They had a heavy workload already and considered sexual assault a low priority for their services, especially when the damage was psychological. They were also reluctant at first to deal directly with CIT members accompanying a victim and demanded a referral note from the Community Services NGO. This frustrated and undermined the CIT members and caused unnecessary delay.

With time, however, the health staff came to recognize the valuable and complementary role played by the refugee members of the CITs and were more willing to work with them. An agreement was reached between UNHCR Community Services and Health sectors on a standard medical protocol (See Annexe C) and that respected the status of the CITs. These problems underlined the importance of involving the health sector and getting their commitment to the idea from the start of the process.

HOW WAS THE ISSUE ADDRESSED WITH THE COMMUNITY?

A Refugee Information Network (RIN) was created in the camps in late

1994 after it became apparent that the existing channels of communication between the humanitarian organizations and the refugees were too narrow, and information was frequently going no further than the refugee leaders. Poor communication was believed to be a factor behind unrest in the camps, including riots.

The RIN consisted of inter-camp newsletters (originally started by refugee youth), radio broadcasts in both Swahili and KynyaRwanda, bulletin boards, posters, public address systems, video, discussion sessions and theatre groups. It was vital to have audio and visual media as well as the newsletters because many of the refugees were illiterate.

The RIN was run by Camp Information Committees (CICs), which typically included the camp Field Officer and three refugee volunteers. The CICs were supervised by the Community Services NGO, and there was an editorial board headed by UNHCR which cleared articles for publication in the newsletters.

This information system was used for an awareness campaign on sexual violence. Topics covered included:

- What is sexual violence? Traditional beliefs and changing attitudes toward victims.
- Who is most vulnerable in the refugee community? (These were identified as unaccompanied minors, especially girls, children in foster care, female heads of households, women and children venturing outside the camp alone, physically and mentally disabled.)
- Consequences of sexual violence: a) for the victims, ie. health risks, psychosocial

- affects, legal implications; b) for the perpetrators, ie. host country laws pertaining
- to sexual violence; c) for the families.
- Where to seek assistance, and information about the CITs
- What can be done to prevent sexual violence?
- The community?s responsibility to protect, especially, its most vulnerable members.

In addition to using the RIN, some CIT members also convened special discussion groups to make the community aware of their presence and their work. Such groups involved, for example, youths, community leaders, members of religious and women's organizations, children in schools and on the streets. Meetings were also organized between Community Services, Protection and CITs with local authorities such as the police, the ministry in charge of refugee affairs, judiciary and medical staff.

In Ngara most of the effort to raise awareness of sexual violence was made during the process of setting up the CITs, and the flow of information lessened somewhat as time went by. This was subsequently identified as a weakness: commitment to overcoming sexual violence requires constant discussion of the issues and constant awareness.

WHAT OTHER MEASURES WERE TAKEN TO PREVENT SEXUAL

VIOLENCE?

The awareness campaign was a vital element in preventing sexual violence.

In addition, steps were taken to identify causative factors and threatening situations. Antisocial behaviour, including sexual assault and domestic violence, tends to flourish when people feel bored, frustrated, powerless and lacking hope for the future, and the various programmes and projects involving the refugees -- from educational and cultural projects, to income generating schemes, youth and women's organizations, and social work -- were seen as important preventive measures.

As already described, women and children appeared to be specially vulnerable to attack while collecting water and firewood. Community workers in the camps organized meetings, discussions and interviews at tap stands to discuss the problems surrounding water collection and a report was sent to UNHCR's Water unit. Solutions were worked out between the refugees, field officers, and staff of the Community Services and Water units. Opening times at water points were restricted to daylight hours thereafter, and refugees in some camps organized a timetable for different groups using the same taps. Security guardians at the water points caught bribing refugees were summarily dismissed from their jobs.

The dangers surrounding the collection of wood proved more difficult to address. Provision of fuel wood to the camps by humanitarian agencies was costly, and efforts to do so were short-lived. For some months, UNHCR's Community

Services and Environment units organized a truck to collect and deliver wood to the most vulnerable individuals in the camps, but this too was stopped for financial reasons. Meetings between Community Services, Protection, Programme, Logistics and Environmental staff, refugees, and the Tanzanian authorities were organized to try to resolve the problems, and various solutions were suggested. These included organizing distribution sites for wood, but no satisfactory system was worked out before the camps closed. Another idea was to use the Refugee Information Network to raise awareness of fuel saving measures, such as using improved stoves. The CITs took their own initiative in helping women to organize groups to gather wood, and in some camps men also participated.

WHAT WAS THE TOTAL COST OF THE CIT PROGRAMME?

Having developed gradually as a response to a problem that became apparent in the refugee camps, the CIT programme was never given a budget of its own. All costs were absorbed by the various units and

organizations that became involved. In practice this was not as constraining as might be expected, but it was far from ideal: it meant that the programme was always dependent upon the goodwill, time and resources of the various players, and had no scope to hire personnel, or buy in expertise or materials. It also meant that nonessential activities such as producing prototype training materials and guidelines were overlooked.

WHAT EFFECT DID THE CIT PROGAMME HAVE? SUCCESSES?

As a result of the CIT programme:

- The refugee community became more aware, more confident and more ready to deal with sexual violence rather than suppress it;
- This resulted in an increase in the rate of reported cases of rape from an average of four per month in 1995 to seven per month in 1996.
- Support for the victims of sexual violence improved markedly;
- The refugee leaders and local authorities became more aware of the problem and more ready to respond;
- Medical attention given to victims improved;
- The dangers associated with water collection were removed;
- Refugees working on the CITs grew in self confidence and began to take their own initiative in supporting victims;
- Inter-sectoral cooperation in the camps was enhanced.

WHAT WEAKNESSES AND PROBLEMS DID THE PROGRAMME ENCOUNTER?

Problems and weaknesses already discussed in this guide include:

- the difficulty of meeting the requirements of the Tanzanian legal process;
- the difficulties associated with gaining recognition and cooperation from the
- health staff especially those with a curative focus;
- the lack of experience among humanitarian workers of dealing with sexual assault issues, and the need for offering them and local authority staff special training.
- inadequate resources put into awareness campaigns
- lack of a budget

In addition the programme encountered the following:

- Initially, there was lack of understanding among humanitarian workers of the rationale behind the development of the CITs. Traditionally, rape was the responsibility of the Protection unit who would liaise with the local police, and many people believed this was a satisfactory way of dealing with the problem in emergency settings such as refugee camps. By contrast the CIT =s mode of operation was much less clear cut, and it made demands on staff who were already very busy. It took time to convince the sceptics of the need for change and the value of involving Community Services in order to offer victims vital psychosocial support. It took time, also, to gain general

acceptance of the principle that the victim =s wishes should be respected; that if she did not wish to get involved in legal action, the police should not be informed.

- At the beginning there was a lack of clarity about the chain of command, and who among the humanitarian personnel was responsible for supervision and monitoring of the CITs.

- CIT members all had other jobs and were expected to carry out their new responsibilities in addition and on a voluntary basis. Most members were overburdened, which meant that sometimes they were unavailable when an incident occurred; and sometimes members neglected their other duties, or were unable to commit themselves as much as they would have liked to CIT work. This issue was raised again and again at meetings. It was agreed that, ideally, each team should have a paid full-time refugee coordinator with no other job. However, lack of a dedicated budget for the programme made this difficult to implement and necessary changes were not made before the camps closed down.

- The humanitarian workers also had full time jobs in addition to the CIT duties they took on. This meant that CIT work had to compete for time with many other things.

- The regular turnover of expatriate staff made the programme vulnerable. It was agreed that the best solution would be to identify local staff members who could act as links between the CITs and the authorities.

- Discussions with the CITs after they had been operating some time revealed that they felt weak on technical information, and wanted additional training -- on medical protocol, and legal and police procedures, for example. This problem was partly due to the fact that Community Services NGOs did not always brief the CITs adequately on new developments.

- There was also a general feeling among the refugees that counseling skills were somewhat neglected in training.

- The discussion groups mentioned above were very valuable in identifying problems and gaps in training, and it was felt that they should be used more frequently in a constant process of evaluation.

- The rate of arrest of perpetrators when the legal procedure was activated was very low, and this frustrated and discouraged refugees, particularly the CIT members who tended to invest an inordinate amount of time and effort in such cases. The poor results also frustrated the Community Service NGO staff involved in CIT programme.

- There was a tendency among the CITs not to pay enough attention to the reintegration of victims into their communities, and it was felt that this problem should be addressed in their training.

- There was also a tendency among CIT members to rely too much on the CIT coordinators, who would frequently assume responsibility for most of the cases.

- It was felt that coordinators should be trained specially in the art of team organization and delegation.

- The issue of personal security of CIT members needed more consideration. In discussions held with the teams, many people mentioned that they sometimes felt threatened by perpetrators and their families and supporters when they were following up a case. It was felt necessary that the CITs should have a low profile. However, since it was necessary for the refugee population including the victims to know who to contact and how, this made CIT members and their families vulnerable to those who opposed their work. It was agreed that they should work more closely with camp Security staff when dealing with perpetrators.

- People who had been sexually assaulted tended to delay reporting the incident, sometimes until they developed a STD. This was seen as an indication that more work needed to be done on

raising awareness.

WHAT WOULD BE DONE DIFFERENTLY NEXT TIME?

- Focus greater attention on gaining cross-sectoral commitment to the programme, and cross sectoral cooperation in implementing it.
- Involve the health staff in the programme from the very start.
- Have a dedicated budget for the programme.
- Give someone among the humanitarian workers full-time responsibility for the programme so that it got the priority it deserved.
- Provide training for humanitarian workers and local authorities.
- Select the team members more carefully, paying more attention to the workload of potential candidates.
- Consolidate the experiences of training to produce prototype materials.
- Conduct more frequent refresher training
- Continue to conduct community awareness campaigns
- Document the process so that others could learn from the experience.

ANNEX A
SUMMARY OF ROLES OF DIFFERENT ACTORS

UNHCR

Head of Office Liaise with local authorities as necessary specifically on policy issues and with Branch Office for liaison with national authorities, ensure cross sectoral coordination

Community Services: Coordination, cross sectoral awareness and liaison; promotion of community-based approach; training of CITs; guidance and support of implementing NGOs.

Protection: Support for Community Services staff on legal aspects; training of CITs on protection matters; liaison with local and national authorities for legal and medical procedures; follow-up of cases in which legal action is indicated.

Health: Coordination of development and follow-up of medical protocol; support for CITs and Community Services on medical issues and AIDS/STD counseling; communication with local authorities over the issue of the medical examination for the legal procedure.

Programme: Provide support and allocate resources as necessary.

Field: Field support for CITs and Community Services; general camp security; assistance with awareness campaigns; follow-up of some cases.

Security: Work (in cooperation with Protection and Community Services) with refugee security guardians and local police on legal procedure and arrest of perpetrators; training of CITs on security matters.

Water: Coordination of effort to improve water distribution system in discussion with Community Services, refugees and Field staff.

Environment: Coordination of inter-sectoral effort (involving also Community Services, Field, Security,

Protection, and CITs) to resolve problems associated with fuel wood distribution.

Information: Working in cooperation with Community Services and refugees on awareness campaigns.

NGOs

Community Services: Responsibility for ensuring community participation and consultation in addressing issue; support and monitoring of CITs; on-the-job training; provision of a facility where CITs can receive victims; liaison with other humanitarian workers involved (see above); awareness.

Health: Development of medical protocol; responsibility for ensuring availability of drugs; AIDS/STD counseling;

Water: Responsibility for improvement of water distribution system.

Environment: Responsibility for action to resolve fuel wood problems.

OTHER UN AGENCIES (eg. UNICEF): Assistance with training, and technical support of UNHCR, CITs and NGOs.

LOCAL PERSONNEL:

Police: Assistance with preventive measures between refugees and local population, including security measures; provision of form PF3 for medical examination for legal purposes; arrest of perpetrators.

Health: Medical examination and report for legal purposes.

Judiciary: Prosecution of perpetrators;

Ministry in Charge/Refugee Affairs: To be kept informed of activities and issues; able to raise awareness of sexual violence and ensure it receives due attention, and to take steps to improve general security of the camps and surrounding area.

ANNEX B
A CHECKLIST OF STEPS TO BE TAKEN IN DEVELOPING A PROGRAMME

1. SITUATION ANALYSIS

Arrange meetings with refugees and other relevant groups (eg.NGOs, UNHCR Units, UN Partners, local authorities) to establish:

* the extent of the problem of sexual violence
* the community's perceptions of, and attitudes towards the problem
* contributory factors (eg. the camp layout or situation, involvement of alcohol etc)
* how the community is dealing with the problem already
* the traditional response of the host country (ie. social, medical, and legal procedures)
* weaknesses of existing response (especially unmet needs of victims)

2. PLANNING A RESPONSE

Decide who should be involved in planning a new response (ie. who is most appropriate to represent the refugees, and the various humanitarian organizations). Arrange meetings with these people to decide

upon:

* the objectives of the response (this will be dictated largely by the weaknesses and unmet needs identified during the situation analysis)

* the guiding principles of the programme

* who should be involved and in what capacity. Develop a Atask force/coordination team)

* how to get effective cross-sectoral cooperation

* ascertain what funding will be available for a programme and advocate for a dedicated budget.

3. STAFFING THE PROGRAMME

* selection criteria for team members

* how selection should be made (eg. whether posts should be advertised and people asked to volunteer their services, or whether candidates should be proposed by the community, or appointed by UNHCR or relevant NGO)

* terms of employment (ie. whether workers are to be voluntary or paid; full- or part-time; given any incentives or not)

4. OPERATION OF TEAMS

* the exact roles of the various players and their relationship to one another

* procedure to follow when a case is reported, from initial interview to longer-term follow-up

* how often teams should meet

* how, and by whom, day to day operational decisions should be made

* who will monitor and supervise the work of the teams and how often this will take place. Keep in mind staff turnover at the NGO and UNHCR level.

5. TRAINING

The organization or person given responsibility for training should:

* identify who needs training

* decide who should be included in each group

* draw up curricula for the different groups

* draw up an inventory of expertise, resources and materials available for training

* decide on training schedule

* draw up a timetable acceptable to participants.

6. SUPERVISION AND MONITORING

The Coordination Team should:

* make sure staff are clear about who is supervising whom

* draw up a schedule of supervision (ie. objectives, activities and timetable)

* draw up a schedule for monitoring programme (ie. indicators of strengths and weaknesses, recording

and reporting systems, timetable.)

7. AWARENESS CAMPAIGN

The Coordination Team should decide:

* what channels of communication to use
* who should be involved
* what messages to convey
* an appropriate time schedule for the campaign.

8. OTHER CONSIDERATIONS

The following issues also need to be addressed during the development phase of the programme:

* security of the CITs
* medical protocol (to be worked out in consultation with camp health services)
* strengthening of preventive measures
* provision of facilities/premises for CITs to interview victims in private
* protection of refugees on the move, especially crossing borders.

ANNEX C
MEDICAL PROTOCOL FOR TREATMENT OF RAPE VICTIMS, NGARA, TANZANIA

In addition to counseling, rape victims need to receive a careful physical examination and prophylactic antibiotic treatment, especially in the present setting where laboratory support is minimal at best and inadequate to screen for most sexually transmitted diseases. In addition, it may be difficult or impossible to initially examine some girls and young women adequately and follow-up examinations to assess for development of disease may be impossible due to lack of patient cooperation.

HISTORY

A thorough history should be taken and should include:

(1) Time and location that rape occurred, number of persons involved, and age and appearance thereof.

(2) Parts of the body involved and manner in which the assault was conducted.

(3) What, if any, weapons or objects were used.

(4) Date of last menstrual period to assess need for postcoital contraception if desired (statistics show that 3-5% of raped women become pregnant).

PHYSICAL EXAMINATION - ***Refer 3.8 Medical Response: UNHCR Guidelines p.42.***

- Note all bruises, contusions and scratches and assess for any injury that may need further treatment (such as head injury or lacerations) and refer to other facilities as indicated.

- Examine external genitalia and vaginal wall for trauma or lacerations.

- If a microscope available check specimens from appropriate sites for semen (sperm)/trichomonad.

PROPHYLACTIC TREATMENT:

Antibiotic therapy should cover for potential infection with syphilis, gonorrhoea, chlamydia and trichomonas. At present HIV testing is not available for rape victims, but should be encouraged in the future should such testing become widely available. Pregnancy testing is also not presently generally available and thus women should be encouraged to return to the clinic should they miss a menses. Women who were raped near mid-cycle and are able to give a good history of LMP assuring that they are not pregnant at time of visit should be offered postcoital contraception. Exam must also confirm non pregnant state (i.e., normal uterine size and lack of other symptoms of pregnancy).

ANTIBIOTIC THERAPY: (Includes antibiotics for syphilis, gonorrhoea, chlamydia and trichomonas).

For syphilis coverage: 2.4 million units Benzathine Penicillin IM or

4.8 million units Procaine Penicillin IM or

Amoxicillin 3 Grams PO PLUS Probenecid 1 Gram PO or

Ampicillin 3.5 Gram PO PLUS Probenecid 1 Gram PO

REGIMEN FOR TREATMENT OF VARIOUS STAGES OF SYPHILIS AFTER TESTING A.S.A.P:

Primary and Secondary and Late Latent Syphilis of less than one year duration:

Rx: 2.4 million units Benzathine Penicillin IM (in one dose). Although some sources now recommend that even at this stage treatment should be with two doses of 2.4 million units penicillin one week apart. Alternative treatments at this stage:

Doxycycline 100 mg Po 2 times/day for 14 days or

Erythromycin 500 mg PO 4 times/day for 14 days

Late latent syphilis of more than one year duration:

All patients should have a thorough clinical examination to rule out sequelae of long term syphilis infection. Lumbar puncture and evaluation of cerebrospinal fluid are indicated with any symptoms of neurosyphilis, if HIV is suspected of if non penicillin therapy is planned.

Rx: 7.2 million units total, administered as 3 doses of 2.4 million units IM, given one week apart for 3 consecutive weeks. Doses of penicillin must be given consecutively or patient must restart the entire regimen.

SYPHILIS IN PREGNANCY

Pregnant women should be treated with the penicillin regimen recommended for the particular stage of syphilis. Doxycycline and Tetracycline should not be used in pregnancy and erythromycin should not be used because of the high risk of failure to cure infection in the fetus. If there is no possibility to admit the penicillin-allergic patient and desensitize to penicillin then erythromycin should be used and the child treated after birth.

PLUS

For Chlamydial coverage:

Doxycycline 100 Mg PO 2 times/day for 7 days or

Tetracycline 500 Mg PO 4 times/day for 7 days or

Erythromycin 500 Mg Po 4 times/day for 7 days (or 2 times/day for 14 days if not tolerated 4 times/day).

PLUS

For Gonorrhoeal coverage:

Ciprofloxacin 500 mg PO (one dose only)

Ciprofloxacin is the drug of choice in the situation of rape since there is a greater likelihood of resistance to other therapies used and as noted above it may be impossible to do follow-up examinations to assure adequate treatment.

PLUS

For coverage for Trichomonas:

Metronidazole 2 Grams (one time does)

<u>POST COITAL CONTRACEPTION</u>

- Must be taken within 72 hours of unprotected sex (preferably within 24 hours)
- The woman must not already be pregnant when taking postcoital contraception
- Medication must be taken with food as it may (most probably will) cause nausea
- Emergency hormonal contraception may alter the timing of the woman's next menstrual period (may be a few days earlier or later)
- Health screening must be done before treating; oral contraceptives should not be used if contraindicated for medical reasons and the potential for side effects must be reviewed as for all prescribing of oral contraceptives.

1. The Post Coital Pills are available in terms of combined oral contraceptives.

Namely : **Microgynon, Lo-femenal or Marvelon in all Family Planning Clinics in the camps.** Since one pill contains 30 mcg of ethinyl-estradiol and the required dose is 100mcg whence one can use 4 pills to get 120mcg within 72 hrs of unprotected sex (preferably within 12 - 24 hrs) and 4 more pills within 12 hrs.

2. The following instruction must be given:

2.1 Take 4 pills of either Mycrogynon, Lo-femenal or Marvelon within 72 hours (preferably within 12 - 24 hrs) of unprotected intercourse. Then take 4 more 12 hrs after the first dose of pills.

2.2. Nausea can appear as a result from the pills. The nausea, usually mild, should stop within a day or so after the treatment. If the patient vomits an hour after taking the pills, she should report back to the clinic. The patient might need to take additional pills to make up for the ones lost in vomiting and anti-nausea medication may be prescribed.

2.3. Next menstrual period should begin sometime within the next 2 or 3 weeks. If the period has not started in 3 weeks, a pregnancy test should be done to confirm pregnancy.

2.4. Watch for pill danger signals; if any danger sign is experienced, a clinician should be consulted immediately.

2.5. Danger Pill Signs:

- Severe abdominal pain,
- Severe chest pain, cough, shortness of breathe;
- Severe headache, dizziness, weakness, numbness;
- Eye problems (vision loss or blurring), speech problems;
- Severe leg pain (calf or thigh).

3. Some antibiotics do interact with hormonal contraceptives to the extent of reducing effectiveness. Since the use of Post Coital Contraceptive is short, it is advisable not to administer antibiotics with the contraceptive pills.

4. If possible, proper data be collected as for the age of the victim, specific time in the menstrual cycle, post coital contraceptive given, out come (pregnancy, ectopic pregnancy, vaginal bleeding, etc.).

5. The patient must be evaluated for pregnancy if she misses a menses. She must be advised before being given postcoital contraception that this method reduces the risk of pregnancy by 75%, but should the pregnancy continue the effects of such high levels of hormones at early stages of pregnancy are unknown but there may be negative effects to the foetus.

References:

1) Sexually Transmitted Diseases Treatment Guidelines, 1993. Center for Disease Control and Prevention; MMWR 1993

2) Sexually Transmitted Diseases Treatment Guidelines: MMWR, Vol 38, Number S-8, 1989. U.S. Department of Health and Human Services, Centers for Disease Control.

3) Havens C, Sullivan N, Tilton P. Manual of Out patient Gynecology, Boston, MA: Little, Brown and CO., 1988.

4) Sanford JP. Guide to Antimicrobial Therapy, Dallas, TX, 1993.

Also refer to the Inter-Agency Field Manual on Reproductive Health in Refugee Situations and UNHCR Guidelines of Sexual Violence Against Refugees

Annex D

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES
NATIONS UNIES HAUT COMMISSARIAT POUR LES REFUGIES

CONFIDENTIAL

SEXUAL VIOLENCE INCIDENT REPORT FORM

IKARITA YO UMENYESHA IMPANUKA YO KUFATWA QUFATWA KU NGUFU

Camp: Reporting Officer: Date:

Inkambi *Umwanditsi* *Itariki*

1) Affected Persons:

Name: DOB: Sex: Card No:

Izina *Igihi Yavukiye* *Igitsina* No Yikarita

Address: Comm: Sect: Cell:

Aho Abarizwa *Komini* *Segiteri* *Serile*

Married: Yes No Single: Yes No Children No:

Arubatse *Ingaragu* *Umubara W's abana*

2) Incident/*Kyabaye*:

Place: Date: Time

Ahantu *Itariki* *Igihe*

3) Description of Incident/*Uko Impanuka Yagenze*

4) Persons involved/Perpetrator(s)*/Ababikoze:*

5) Action Taken/*IGamba Zakozwe:*

5.1 Medical/*Kwa Muganga:*

Did the person have a medical examination? Yes No

Bhanaze Kukususuma? *Yego* *Oya*

When was the medical examination?*/Rya Ri?*

Which IPD/OPD?/ *Wivujehe IPD/OPD?*

Seen by whom?/*Wavuwe nande?*

5.2 Protection/*Kurinda (File No?)*

Does the Person want involvement of UNHCR Protection? Yes No

Urashaka ko UNHCR Ibigufashamo? *Yego* *Oya*

6. Remarks:

Signature: Date:

Umukono *Itariki*

Title: Agency:

Uwo Ariwe *Umushinga*

Akazi Akora

CONFIDENTIAL
IBANGA

SEXUAL VIOLENCE INCIDENT FOLLOW UP FORM
IKARITA YO UMENYESHA IMPANUKA YO KUFATWA QUFATWA KU NGUFU

Camp: Reporting Officer: Date:

Inkambi *Umwanditsi* *Itariki*

Name: DOB: Sex: Card No:

Izina *Igihi Yavukiye* *Igitsina* No Yikarita

Address: Comm: Sect: Cell:

Aho Abarizwa *Komini* *Segiteri* *Serile*

Psycho-social/Imico Rusange:

Medical Follow-up, if any:

Recommendations/ Igamba Zafatwa:

Will be followed up by/ Bizakurikiranwa Na:

Signature: Date:

Umukono *Itariki*

Title:

Uwo Ariwe

Akazi Akora

Agency:

Umushinga