



Assessment Report: Bocaranga Central African Republic February 2014

Sector(s): Health & Women's Protection and Empowerment

Contact(s): Jota Echevarria jose.echevarria@rescue.org
Elisabeth Roesch elisabeth.roesch@rescue.org

Data Collection: 4 – 10 February, 2014

BACKGROUND AND JUSTIFICATION

The Central African Republic (CAR) is arguably one of the poorest and most troubled countries in Africa. Before the crisis erupted in late 2012, the indicators for human development were already among the lowest in the world, ranking 180 of 186 on the Human Development Index.

Violence resulting from the formation of the Séléka rebel coalition in December 2012 and the subsequent coup in March 2013 has had disastrous effects on the population. Subsequent retaliation by the predominantly Christian “anti-balaka” movement has increased the violence which reached a peak in the capital city, Bangui, in December 2013. As of late December, over 512,000 people were displaced within Bangui itself and nearly a million throughout the country.

In Ouham Pende prefecture, where populations are entirely cut off from health and protection services and needs are some of the highest in the country,¹ UN OCHA reports there are a total of 33,864 Internally Displaced People (IDP), 18,760 of which are in Bocaranga sub-prefecture.

ASSESSMENT SITES: OUHAM PENDE PREFECTURE

Town / Health Facility	Places (Villages) in facility Catchment Area	Est. Population
Bocaranga Hospital	Bocaranga town; referral hospital for health district	60,000
Koui Health Center	Geodi 2, Bakoussa, Segdou, De Gaulle	13,500
Létélé Health Post	Beth, Kouga, Bitao, Mbouzara, Ndouzo, Zoe	5,500
Ngoutéré Health Post	Galanga, Baforo, Ngoutéré 2	3,300
Bokaya Health Post	Koutende, Moundi, Kpokeya, Nambori	3,000
Kellé Clair Health Post	Borodou, Kellé 2, Bezere	2,500

ASSESSMENT OBJECTIVES:

- Assess targeted health facilities and determine their capacity to deliver basic primary and reproductive health services
- Assess protection concerns for women and girls living in the catchment areas of targeted health facilities

¹ MIRA and Protection Assessment Report, 13 January 2014

- Gather key informant and data to inform possible, future food security and child protection programming

SAMPLING & DATA COLLECTION METHODS

See Annexes 3, 4, 5 and 6 for data collection tools.

Primary data were collected through key informant interviews, focus group discussions (FGD), health facility assessments and service mapping. The IRC interviewed 52 key informants (6 women, 46 men): teachers, health committee members, women's leaders, doctors and local chiefs. The IRC also held seven focus groups with a total of 94 women and girls of different age, background and marital status.

Limitations

Safety and logistical constraints limited the duration and scope of this assessment. The IRC only assessed areas that had a health structure and in a one to two hour perimeter of Bocaranga. It is likely that the health and protection needs are as great, or greater, in villages that have no health facility. In five out of six sites assessed, the Muslim population had fled. The IRC was only able to conduct interviews with Muslims in Kouï. Therefore, the health and protection concerns of the Muslim population who had previously lived in Bocaranga sub-prefecture are not well represented. Also, while many of the places that the IRC assessed had experienced recent displacement and violence, the IRC did not travel far north toward Mann, due to insecurity caused by the presence of ex-Seleka rebels in the border area with Chad. This particular axis is a major corridor for departing ex-Seleka and the ongoing violence is likely to have only increased protection concerns which are not represented in this assessment.

In assessed areas, while adolescent girls were included in four out of seven focus groups, only one group was held with only girls. This may have given more weight to the views of adult woman in such discussions.

Finally, this assessment involved facility assessments, key informant interviews and focus group discussions. These tools provide in-depth information on assessed health facilities, women's and girls' perception of risk, and how violence has affected women and girls. It does not speak to overall patterns or prevalence of violence and is not generalisable the population as a whole.

KEY FINDINGS

HEALTH

Pharmaceuticals: Less than a one month supply of drugs

Health services have been seriously impacted by the conflict. At the time of the assessment, the entire health district of Bocaranga was not receiving any regular material or financial support from the Ministry of Health (MoH) in Bangui or the international community. In January of 2014, after the last attack on Bocaranga that included the looting of the hospital, *Medcines Sans Frontiers – France* provided the hospital with a one-time donation of drugs and supplies which, along with a small stock of essential medicines provided by the IRC at the time of the assessment, should allow for the provision of basic primary health care and surgery for one month. The pharmacies of the four assessed health posts (Létélé, Ngoutéré, Kellé Clair and Bokaya) were completely empty. The IRC was able to provide a 15-day supply of drugs for essential primary care to each assessed facility. The assessment team was not able to check the drug stock at the Kouï health center because the pharmacist did not have the key to the store. However, the president of the Health Management Committee confirmed that the facility is functioning normally and is not experiencing stock-outs. Moreover, the health center's revenues have increased slightly due to the influx of IDPs from Bocaranga.

Hospital: Looted but functioning

The Bocaranga hospital was looted in December 2013 and twice again in January 2014. While much of the furniture, including beds and mattresses, were saved, the entire stock of drugs and medical supplies was stolen and many doors and windows were destroyed. The hospital is open and offering services, but its supplies are limited to what remains of the MSF and IRC donations mentioned above.

Primary and Reproductive Health Care: Trained staff but no resources

Protocols for standard primary health care treatment and antenatal care are in place at all assessed sites. Family Planning protocols were in place at five² of the six facilities. While the clinical staff at these facilities are familiar with these protocols, they do not have the drugs, supplies or basic equipment necessary to implement them. Of the five primary care facilities assessed, only the Kouï health center is able to provide essential services and the hospital would need additional drugs, supplies and equipment in order to offer the level of referral services expected of a hospital. The Kellé Clair and Bokaya health posts have some of the basic equipment necessary to assist with uncomplicated births, while Ngoutéré and Létélé do not have the capacity to provide even the most basic of services, given the complete lack of drugs, supplies and essential equipment.

Care for Survivors of Sexual Violence

Health services for survivors of sexual violence remain a key challenge. The hospital has a private space for receiving survivors, the correct protocols in place and assigned GBV focal points. However, due to the looting mentioned above, drug stocks are in short supply and it is unclear how long the existing supply of post-rape kits will last. However, outside of Bocaranga, health posts and centers have been pillaged, have no dedicated staff or spaces for GBV, and lack essential drugs. Further, MoH policy dictates that only doctors may administer post-exposure prophylaxis and there are no doctors in any of the health posts and centers visited. All survivors reporting within 72 hours will have to travel to Bocaranga (which for the farthest village is up to 2-3 hours away in dry season). Therefore, any WPE program will need to invest significantly in transport and other survivor assistance to meet minimum standards for health care.

The health system: Staffing and fees

The health system in CAR relies on a decentralized cost recovery model, with facilities managed by Health Management Committees (HMC), which are established by the MoH in each locality. The MoH is responsible for the technical oversight of the system, but supports only a fraction of its financial requirements. The local HMC is largely responsible for the fiscal management of the health system. Patients seeking care pay for health services and treatments at each health facility and the revenues are managed by the HMC, which is responsible for paying salaries, maintaining the facility and replenishing the stock of drugs. Of the 6 health facilities assessed, only the head doctor of the Bocaranga hospital and the head nurse of Kouï's health center are paid directly by the MoH, while the other staff throughout the health district of Bocaranga (estimated to be over 90 individuals) are paid by each local HMC. As such, there is a great disparity between facilities in all aspects of health system development, including personnel management. While hospital staff and personnel at Kouï's health center were paid regularly until January 2014, health workers and staff³ in the four assessed health posts (Létélé, Kellé Clair, Bokaya and Ngoutéré) had not received their salary since August or September 2013, due to lack of revenue.

Barriers to accessing health services

Access to health has become extremely difficult for both host communities and IDPs. According to the health staff from the assessed health facilities and all key informants, insecurity, distance and fees are the main barriers accessing health services. As explained during key informant interviews and facility assessments, those that have fled their villages to seek refuge in the bush are afraid to leave those settlements to seek care, especially knowing that the facilities do not have drugs, they are not willing to risk their security and pay

² Bocaranga Hospital, Kouï, Ngoutéré, Kellé Clair and Bokaya

³ Health posts are staffed by one head of post (a *secouriste* with one year of clinical training at the district hospital), one midwife and one pharmacist.

the 100 CFA (\$0.20) consultation fee when there is no treatment available. The additional cost of transportation to and from facilities was mentioned as an additional financial barrier by the head of each assessed health facility, 20 key informants, and was also echoed by many community members present during key informant interviews. Thus patients cannot access health facilities and health staff are not able to bring services closer to populations because they lack the resources needed for outreach activities and services. Community health workers (CHW) – a network of volunteer focal points who are responsible for raising awareness of health services and providing health referrals - have either fled the area or have been displaced. The IRC was able to identify only two former CHW, in Kellé Clair and Bokaya, who were still in town but are currently not conducting any community health activities.

A broken surveillance system:

The MoH disease surveillance system is inaccurate and incomplete as health posts do not regularly send reports to the hospital. Surveillance reports have not been collected from the assessed health posts since August 2013. The hospital could provide epidemiological information about main pathologies and services provided up to June 2013, but according to the head doctor, all other files have been burned. None of the facilities visited were able to provide accurate epidemiological information about the incidence of malaria, diarrhea or respiratory infection in children under five or adults. However, the assessment team did use loose records and registration information available at the health posts and Kouï health center to extract the basic epidemiological information presented below.

Number of cases of the main diseases in the assessed health facilities											
Health Facility	MALARIA		DIARRHEA		ARI		OTHER		TOTAL		
	<5	≥5	<5	≥5	<5	≥5	<5	≥5	<5	≥5	TOTAL
Bocaranga Hospital*	300	244	NDA	NDA	121	NDA	NDA	NDA	421	244	1,184
Kouï Health Center**	92	35	25	19	28	2	15	30	160	86	246
Létélé Health Post**	60	55	20	5	15	23	6	9	101	92	193
Bokaya Health Post***	38	7	19	6	18	4	18	10	93	27	120
Ngoutéré Health Post***	24	10	11	4	11	2	6	10	52	26	78
Kellé Clair Health Post**	15	7	10	5	3	5	5	12	33	29	62

* Data from June 2013

** Data from November 2013

*** Data from October 2013

WOMEN'S PROTECTION & EMPOWERMENT

VIOLENCE AGAINST WOMEN AND GIRLS

Rape

Women and girls in focus groups cite rape as the most significant form of violence and threat to their safety (5/7) that they face. In almost all groups, women spoke about incidents of rape in their village carried out by "rebels" (4/5). Women recounted armed men going house to house, threatening families, stealing belongings and raping girls and women, sometimes in front of their husbands. In other instances, women and girls have been targeted by armed men or by *coupeurs de route* (*bandits*) as they travelled on roads, heading to their fields.

“The rebels told us that they were just there to get food. They knocked on the doors “cousin, cousin, come out” and then they would enter the house and rape all the women, it didn’t matter if your husband was there.”
–Key Informant.

In two focus group discussions, women and girls raised specific instances (three cases) in which young girls had been abducted. While this was not seen as a widespread problem, it instilled outrage and fear in both focus groups and was mentioned first when asked about violence.

Daily Threats: Harassment and fear of attack

While most discussion of violence focused on rape, women and girls also described a general environment of fear and harassment due to the non-stop presence of armed groups, ranging from daily insults (5/7) to incidents of forced undressing in public (1/7). While key informants spoke of violence related to the tremendous upheaval of December and January (and in some cases the 8 months preceding), women and girls indicated that they continued to feel unsafe, even as rebels had left. Men have mobilized to protect their families and communities and were visibly armed (with machetes, hunting rifles, etc) in every town and along roads that the IRC visited. In three focus groups, women and girls note feeling unsafe in areas where armed men continue to be present.

Intimate partner violence and other forms of violence

Intimate partner violence was noted to be an additional risk facing women, mentioned by five key informants and the participants of one focus group. Intimate partner violence was seen by one group as increasing because of constant insecurity, deprivation and scarcity of food and other goods. Secondary sources indicate that partner violence is a serious problem throughout CAR, with one study finding that 22% of women in five targeted prefectures reported serious physical beating by their partner.⁴ The focus group that discussed IPV highlighted the serious consequences of it (broken bones and teeth, public humiliation) but did not mention it as a problem until asked, indicating that this type of violence is seen as more of the “norm.”⁵

One focus group also discussed pregnancy following rape as a key problem while all seven groups mentioned theft, pillaging, and the burning of houses as widespread, noting specific instances in which they had witnessed the murder of their neighbors and family members.

Finally, when asked about violence, women and girls often raised the difficulties around giving birth when fleeing to the bush (5/7). Women indicated that some had miscarried, that newborn babies had received no neo-natal care and that food scarcity while displaced had led to multiple health problems. With no health centers functioning, people were not able to receive care. Even as focus groups discussed specific forms of violence, women reiterated that this was one of the biggest challenges they faced and wanted it to be considered in discussions about their safety and well-being.

SERVICES FOR SURVIVORS: COMMUNITY SUPPORT IS THE ONLY SUPPORT

Lack of general services

The IRC was the first NGO to return to Bocaranga following the December/January upheaval and therefore the assessment team encountered few to no services in the towns visited. Three of the six sites (Bocaranga, Ngoutéré, and Bokaya) had suffered tremendous damage to houses and markets, which in some places had been burned to the ground. In all but one town, key informants reported that the population had fled into the bush for at least a few nights on multiple occasions. As of the dates of assessment no response had been launched to address the health, psychosocial, protection food, shelter, water or material needs of the

⁴ “Building peace, seeking justice” Human Rights Center University of California, Berkeley, 2010

⁵ The focus group laughed when asked about IPV, commenting that it is widespread and offering examples of daily abuse.

population. In some places, the IRC was entering towns that had been attacked as recently as five days previously, and therefore security had prohibited any type of aid.

Psychosocial services

GBV Focal Points present but not supported

Against a backdrop of severe need, the IRC found traces of an infrastructure which could support women's and girls' protection needs. The IRC had implemented "GBV" programs in Bocaranga up until early 2013 and in 4 out of 6⁶ sites visited, GBV focal points previously supported by the IRC were present and approached the assessment team upon their arrival. In Kouï, the focal point had continued to refer cases to the health center even when the IRC had left, up until the most recent period of upheaval. The IRC was also able to reestablish contact with one of two former GBV partners, RECAPEV who is present in 5 out of 6 of the sites where the IRC plans to respond.⁷ RECAPEV had just one staff who had received training on GBV and no staff with case management skills.

Women's associations functional but not focused on VAWG

In every town visited, women's associations were organized. Women in Ngoutéré, Létélé, Bokaya and Kellé Clair indicated that their villages had two to three women's associations (with ten to twenty members in each) while in the larger towns of Bokaya and Kouï, there are several associations organized within each neighborhood. All were engaged in three primary activities: agriculture, small market trade and *tontine* (small group savings clubs). However, all had lost all or a significant portion of the common resources that had formed the basis of their collective activity, whether that be money, seeds, or other goods. These groups also provide assistance to vulnerable women and many focus groups related specific instances in which groups paid for the care and shelter of elderly women or women abandoned by husbands. In general, these types of women's associations show promise as a means to socially and economically support survivors, and to empower women and girls more generally.

No case management services

Case management and counseling services for survivors were found to be completely lacking in the IRC's service mapping. Focal points and women's groups show promise for general referrals and community-based support, yet there are no social workers, case managers, or psychosocial officers in the areas assessed. The IRC will need to address this gap through direct service provision until local actors or NGOs are identified. It is unlikely that the IRC will be able to move to a partnership or capacity building approach for case management services in the emergency period.

Town/ Village	PSYCHOSOCIAL			
	Case Management	Psychosocial Support	Community-based GBV focal points	Women's Groups
Bocaranga		X (HIV-focused)	X	X
Létélé			X	X
Ngoutéré			X	X
Bokaya				X
Kouï		X (not currently active)	X	X
Kellé Clair				X

⁶ No GBV focal points had been established in Kellé Clair or Bokaya.

⁷ RECAPEV works in Kouï, Bokaya, Létélé, Ngoutéré and Bocaranga.

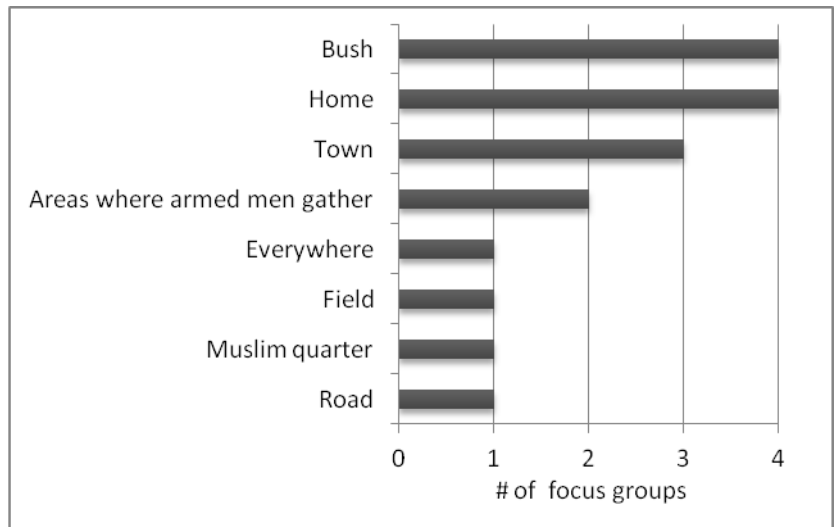
PROTECTION IN A LAWLESS LAND: CURRENT STRATEGIES AND DESIRED SOLUTIONS

Women’s and Girls’ Safety Strategies

Go together or don’t go

Women and girls discuss two main protection strategies – limiting movement (2/7) and moving in groups (4/7). Women and girls describe severe limitations to their daily routine – not going out at night (one group said that after 4pm it’s not safe), not traveling between towns as they used to for either market activities or to seek health care, and keeping girls at home. When they do move, they do so in groups or with family members. Women travel to their fields with their husbands, who now visibly carry their hunting rifles as a risk deterrent. Girls go with older brothers to fetch water or with other girls or family members to bath.

Where Women and Girls Feel Unsafe



There is no protection:

These strategies are seen as the only recourse for communities where there are no authorities, no police, and no formal protection. Four out of the six sites visited had suffered attacks within two weeks of the assessment, with one attacked just five days before IRC’s visit. In these instances, most families fled to the bush and at the time of IRC interviews many were still either still living in the bush or spending nights there as a safety measure. Women in four groups mentioned that they felt unsafe in their own home because of house to house raids by armed groups.

“The road has many bandits (coupeurs de route). We are afraid, b/c they stop you, they trap you, they take off all your clothes, rape you and sometimes they try to kill you” –Member of focus group.

Protection Solutions

Re-establishment of authorities and NGO presence

Women and girls had diverse views on how to improve security. Some (2/6FGDs) focused on the return of government authorities: “without the authorities, we can’t be safe” (FGD, Bocaranga). Most discussions, however, focused on the establishment of basic services (6/7) and a firm NGO presence (3/6). Women and girls felt that health services, reopening schools, and rebuilding burned houses (or replacing pillaged belongings) was the best way to repair broken communities, thereby creating a more secure environment in general.

“If we see a car pass, we are scared because we think it will be rebels but when we see “IRC” we have hope.”

– FGD participant.

Targeted health and economic support to women

Women noted specific support that they required to feel safe and secure, generally around reinforcing their ability to make money and getting urgent health care. Economic insecurity and an inability to feed their families was a recurrent theme in focus groups. All female focus group participants expressed a severely restricted ability to make money (7/7) while facing sharp increases in the cost of food and basic goods (7/7 FGDs and all KIs).

More money is key to women's safety but violence is a barrier to reestablishing women's income

During focus groups, women noted that those with two primary sources of income in the past (agriculture, small market trade) (6/7), now find themselves forced into riskier activities, which include going to markets that are farther away (and facing *coupeurs de route*) or looking for firewood even when they don't feel safe (6/7), saying "if we don't do this, we don't eat." Having income again was seen as critical (6/7), with most groups mentioning agricultural support (5/7), support to women's groups (3/7) and in Bocaranga, access to credit (a credit union had closed and Bocaranga's more business-oriented women had lost a vital source for small loans). Lastly, all groups mentioned the urgent need for health services. In all seven focus groups, women agreed that a significant number of women continued to suffer complications from giving birth, fleeing into the bush or sexual violence.

Girls want education and money

Discussions with girls revealed many of the same priorities. However, girls placed a high emphasis on reopening schools and ensuring that routes to school were free from bandits, rebels and other threats (Mentioned as priorities in the 1 focus group with only girls and by girls in three other focus groups). Adolescent girls also are engaging in fieldwork and small market trade and wanted to be included in efforts that aim to put more money into the pockets of the community.

RECOMMENDATIONS

HEALTH

- Provide comprehensive support to the four targeted health posts (Létélé, Kellé Clair, Bokaya and Ngoutéré), including drugs, medical supplies, basic equipment and incentive payments or stipends to personnel
- Reestablish the surveillance system within the four targeted areas of Bocaranga health district by providing support for the transportation and transmission of data and reports and to establish regular supervision and monitoring from health district.
- Support mobile clinics to provide basic primary health care and community awareness raising activities for populations facing substantial barriers to accessing health services along the main road axes within the district, as follows:
 - Boca-Létélé-Boca-Kellé Clair. (Population 6,500; IDPs 800)
 - Boca-Ngoutéré (Population 14,400 ; IDPs 1,500)
 - Boca-Bokaya-Bomari1 (Population 18,700 ; IDPs 1,100)
- Rebuild the community health structure by selecting and training 5 CHW and 2 traditional birth attendants (TBA) from the areas surrounding each targeted health post, and 5 CHWs and 2 TBA from the other health posts supported by the mobile clinics.(Kortacu, Bocongo, Dibono, and Sangami).
- Address the absence of post-rape care outside of Bocaranga by advocating with health and government officials to allow health staff aside from doctors to administer PEP. This will lessen the burden on survivors who otherwise will be forced to travel up to 3 hours for lifesaving care.

WOMEN'S PROTECTION AND EMPOWERMENT

- **Establish psychosocial services and advocate for expanded health care**
The IRC should establish basic health and psychosocial services in Bocaranga and surrounding areas to address the near complete absence of any assistance for survivors. The approach used should be

age-appropriate, survivor-centered and flexible to both meet the demands of fixed rural and town populations and to rapidly respond to areas that have had recent violence or displacement.

- Identify safe spaces for the provision of psychosocial services: The IRC should establish, or identify within existing structures, safe spaces for the provision of case management and basic counseling in Bocaranga, Kouï, Ngoutéré, Kellé Clair, Bokaya, and Létélé. Prioritizing locations with health facilities will ensure quick access to medical care and take advantage of synergies with the IRC's health programs.
- Mobile services: Mobile services will allow the IRC to rapidly respond to towns and villages that have experienced recent upheaval. Women and girls indicate that the risk of rape is higher during attacks on villages and periods of displacement. The IRC will not be able to quickly reach survivors with only a static approach. Therefore, the IRC should deploy psychosocial and community mobilization staff with mobile health clinics and possibly with RRM teams to increase the speed of delivering lifesaving services. This will be a more time-limited approach that focuses on emergency case management and referrals in an indeterminate number of sites that have experienced recent conflict or displacement.

→ **Rebuild women's networks as a key entry point for services and for women's and girls' empowerment.**

- Make the first response a local one: In rural areas and villages, priority must be placed on reinforcing existing women's networks and associations for a rapid, local, first response. The IRC should provide training to women's associations in the six targeted sites so that they can provide basic support: referrals, safety planning, and basic emotional and material support. These groups can complement the IRC's individual psychosocial services by strengthening community-based structures' ability to open access to specialized services and to support survivors' recovery.
- Girl-centered programs: Women's associations can provide a basic response for adult women and married young girls, but they will not reach unmarried adolescent girls, who this assessment found to be acutely at risk. Programming for girls could begin with basic outreach and special sessions for girls in the six targeted sites and capacity building in caring for child survivors within psychosocial teams.

→ **Reduce risks to women and girls**

Women and girls cited a number of basic needs that were not being met and which posed a severe risk to their safety. As many communities have been pillaged, homes burned and populations displaced, the IRC must put women at the center of their overall emergency response.

- Advocate for or directly distribute dignity kits and other risk mitigation materials directly to women and girls.
- Address women's economic insecurity
Economic interventions that put resources and money into women's hands are key to reducing vulnerability to violence and responding to women's expressed priority needs. In villages, the IRC should consult with the Economic Recovery and Development team to develop a way to support the agricultural activities and petty trade that are women's main source of income. In Bocaranga, as women are more used to accessing credit to support their businesses, a credit or cash-based response may be more relevant. The IRC has tried such interventions in Kaga

Bandoro and a first step may be to seek lessons learned from supporting women in that context.

- Include women leaders and women's groups in beneficiary registration and verification, developing criteria for targeting, carrying out distributions and post-distribution monitoring. As the IRC, and other NGOs, directly respond to the food, shelter and other basic material needs in Bocaranga a systematic approach to involving women and girls will help the IRC to reduce the risk of exploitation and to ensure that women's and girls' needs are fully met. The IRC may consider distributing through women's groups directly.

ANNEXES

Assessment Tools

1. Food security, child protection & WASH findings
2. Assessment Plan
3. Key Informants Questionnaire
4. FGD PAF
5. IRC Service Mapping Tool
6. Rapid Health Facility Assessment
7. Key informants data table
8. Rapid Health Facility Compilation
9. Facility Assessment Locations / Targeted sites