

Concept Note and Plan of Action A Multi-Sectoral Response for Survivors of Sexual Violence

Concept Note

This Concept Note and Plan of Action for Multi-Sectoral Response constitute the fourth strategic component of the Comprehensive Strategy on Combating Sexual Violence in DRC. It should serve as a platform for action and a basis for discussion and should be seen as a dynamic document that needs to be adjusted, based on practice and as comments and suggestions flow.

The aim of this component is to develop a common framework for the key actors involved in programming activities in relation to reproductive health, psychosocial assistance and reintegration. This component needs to be viewed in particular in conjunction with the first component of the Comprehensive Strategy on Combating Impunity for Cases of Sexual Violence, as any reintegration assistance needs to also involve access to justice for survivors. The intention is:

- To improve access of survivors to health, psychosocial and reintegration/judicial assistance,
- To seek a common understanding by all actors, and seek inter-ministerial agreement on the minimum standards applicable in the provision of assistance,
- To establish a simple referral pathway¹ and follow-up mechanisms at the local/ community level.

The Plan of Action contains two main objectives:

- 1. Improve the referral pathway for a multi-sectoral response for survivors of sexual violence.** *This objective is aimed at the community / local level and involves the following actors: UN agencies and INGOs together with provincial authorities and state institutions.*
- 2. Develop a National Protocol for Multi-sectoral assistance amongst the competent DRC ministries.** *This objective is aimed at the national governmental level and will be applied at the provincial level with the assistance of UN agencies, INGOs and relevant government ministries, in particular Public Health, Gender, Family and Children, Social Affairs and Justice.*

Rationale

The Plan of Action aims to incorporate ongoing initiatives and processes under a common framework. These are:

- The *Initiative Conjointe*: its protocols, tools for data collection, training modules and referral systems, adopted in 2005.²
- The National Medical Protocol, DRC Ministry of Health, 2007.³

¹ See terminology used in the Gender-based Violence (GBV) Standard Operating Procedures (SOPs) for Multi-sectoral and Inter-organizational Prevention and Response to GBV in Humanitarian Settings, IASC Sub-working group on Gender and Humanitarian Action, May 2008. The referral pathway is defined as a “clear reporting and referral system in each setting so that survivors and/or witnesses to an incident know to whom they should report and what sort of assistance they can expect to receive from health, legal, psychosocial, security and other sectors”.

² *Initiative Conjointe de lutte Conjointe de Lutte contre les Violences Sexuelles Faites aux Femmes aux Hommes aux Jeunes et aux Enfants en République Démocratique du Congo, Les outils harmonisés des collectes, modules de formations, protocoles dans de la carte de la lutte contre les Violences Sexuelles, 2005.*

³ *République Démocratique du Congo, Ministère de la Santé Direction de Développement des Soins de Santé Primaire, Ordigrammes des soins au Centre de Santé, 2eme édition Révisé avec l'appui de IRC, Octobre 2007, p 99-101, Plainte d'une violence Sexuelle*

- The Plan of Action of the government-led *Sous Groupe Thematique* on Sexual Violence, (Ministry of Gender, Family and Children).
- The Programmatic Axis of the Ministries of Health, Social Affaires, Gender and Justice to be incorporated into the *Plan des Activites Prioritaires* (PAP) by the Ministry of Planning.

Problematique

An effective response to sexual violence is complex as this Plan of Action highlights. Several aspects of current initiatives, interventions and programmes need to be improved; this will allow for more effective and life-saving responses for victims, better access to services and a clearer delineation of roles and responsibilities for key agencies, individuals and the government. The following aims to both highlight the challenges and summarize the recommendations of the Plan of Action on Multi-sectoral Response.

1. *Comité Provincial / Territoriale Synergies de la Lutte contre les Violences Sexuelles*(CP/TLVS) ⁴

The *Comité/Synergie Provinciale/Territoriale de la Lutte contre les Violences Sexuelles* (CP/TLVS) is a coordination mechanism for UN agencies, NGOs and the Government in most DRC provinces. Established in 2004, the CP/TLVS functions under the umbrella of the *Initiative Conjointe*, administered and coordinated by UNFPA and the Ministry of Gender, Family and Children.

The CP/TLVS consists of four thematic *fora* of *sous-comites* and ‘synergies’: medical, psycho-social, justice and reintegration, and is the current forum for informing-sharing on programming activities by UN agencies involved in the *Initiative Conjointe*. However, a consensus has emerged that some of its programming activities and methodology are not well adapted to field realities, as survivors of sexual violence still do not have adequate access to assistance.

Recommendation: It is proposed that the CP/TLVS should be responsible for implementing the multi-sectoral response in line with the four main areas of assistance, which will allow existing coordination structures to continue. However, the CP/TLVS should be improved and strengthened in terms of methodology and programmatic orientation by relying on commonly agreed guidelines. Consequently, this plan proposes the development of standardized protocols of assistance, with a National Protocol for Multi-sectoral assistance and a clearer definition of the referral pathway.

2. Referral Pathway for Multi-Sectoral Response:

- a) The existing referral pathway for multi-sectoral response is not applied consistently in most provinces and localities and is particularly weak in regard to judicial and reintegration assistance. The *Initiative Conjointe* proposes a referral system, called a ‘*reference contre reference*’⁵. Confusion has arisen because the referral system, as applied within the *Initiative Conjointe*, appears to merge referral procedures for survivors with information collection, based on an elaborate monitoring and reporting mechanism (‘*outils harmonisés de collect*’).⁶

Recommendation:

- *The referral pathway for a multi-sectoral response for survivors needs to be separate from monitoring and data collection. Whilst, a functioning referral pathway will also facilitate better monitoring and information gathering, its purpose needs to be clearly defined in advance.*

⁴ *Comite Territorial ou Provincial de la Lutte Contre les Violences Sexuelles* (CP/TLVS),

⁵ Refer to the terminology used by the *Initiative Conjointe de lutte Conjointe de Lutte contre les Violences Sexuelles Faites aux Femmes aux Hommes aux Jeunes et aux Enfants en République Démocratique du Congo : Les outils harmonisés de collecte, dans de le carde de la lutte contre les Violences Sexuelles UNFPA octobre 2006*

⁶ *Ibid* : *Les outils harmonisés de collecte, dans de le carde de la lutte contre les Violences Sexuelles UNFPA octobre 2006*

- *Care providers have the duty to inform survivors of their rights and opportunities for services and assistance. Survivors have the right to control how information about their cases is shared with responsible agencies or individuals.*
- *The Plan of Action proposes that the referral pathway apply the Standardized Operating Procedures (SOPs)⁷, developed by the IASC (May 2008). These SOPs are based on good field practices and were developed clarify roles and responsibilities of agencies in each setting.*

b) The *Initiative Conjoint* boasts a 73-page guide, containing tools for data gathering and referral systems. Frequently, it is not well understood by local implementing partners. For example, local NGOs or health centers are often the entry point for survivors of sexual violence. They have neither the capacity nor time to apply the elaborate forms (“*fiches techniques*”). Consequently, when a survivor arrives at a rural health center she/he often receives only basic medical treatment and is often neither referred nor informed about any possibilities of psycho-social counseling or judicial assistance.

Recommendation:

- *Referral mechanisms need to be as simple and accessible as possible.*
- *The referral pathway should be communicated in local languages and via graphic/pictorial representation. This needs to contain instructions on priority actions to be taken by survivors within the first 72 hours and any available contacts of each service/actor.*
- *The rules and responsibilities of each actor involved in multi-sectoral response need to be clearly outlined. They need to be aligned to the DRC administrative division of health zones, down to the local/community level.*
- *Two to three focal points responsible for managing the referral path in each health zone need to be appointed.*
- *Programme planning has to take into account the need to appoint and support two to three fully operational focal points per health zone. These will be based in locations with the highest concentration of incidents of sexual violence, such as in health centers or religious institutions.*

c) **Breach of confidentiality:** Existing data on survivors of sexual violence frequently contains confidential information, such as the result of HIV testing or surgical intervention. This is often communicated without the survivors consent to actors responsible for other sectors, such judicial or reintegration.

Recommendation:

- *The survivor’s file (‘fiches techniques’ or other tools) needs to remain in a safe location and not be circulated or transmitted to other sectors.*
- *A one page standardized form with minimum information about the survivor needs to be developed and completed at point of first contact (‘entry point’), ensuring absolute confidentiality.*

3. National Protocol of Multi-Sectoral Assistance amongst the competent DRC ministries:

At present, there is no agreed protocol for multi-sectoral assistance amongst the competent DRC ministries that is widely accepted and implemented by the relevant actors. Such a protocol would provide guidance for care providers on, e.g. the provision of appropriate assistance by outlining basic steps and defining a set of minimum standards of assistance for survivors. Existing protocols are as follows:

- The Protocols of the *Initiative Conjointe*, drafted in 2004, are not widely adhered to in UN agency and INGO programmes, unless they form part of the two main Initiative Conjoint Projects⁸.

⁷ Gender-based Violence (GBV) Standard Operating Procedures (SOPs) for Multi-sectoral and Inter-organizational Prevention and Response to GBV in Humanitarian Settings, IASC Sub-working group on Gender and Humanitarian Action, May 2008

⁸ The two main projects of the *Initiative Conjointe* were financed by the Belgian and Canadian Cooperations and were jointly executed by UNFPA, UNICEF and OHCHR, in Province Orientale, Maniema Equateur South and North Kivu Provinces.

- The National Medical Protocol issued by the Ministry of Public Health (2007)⁹, provides a description for medical treatment for survivors of sexual violence. However, it does not explain how to perform a thorough physical examination, record findings or administer medical care to a survivor.

Recommendations:

- *A National Protocol for multi-sectoral assistance needs to be developed. It should serve as an aide memoire and include guidance on the provision of medical, psychosocial, reintegration and judicial assistance and a clear delineation of roles. The aim would be to assist care providers in each sector. For example, survivors should be systematically informed of their rights and services available to make an informed choice (e.g. a survivor needs to be informed of the existence and composition of PEP kits but should choose whether or not to take the morning-after pill).*
- *The National Protocol need to define minimum standards for intervention in each sector and incorporate the following:*
 - ☑ *Define ethics for care providers*
 - ☑ *Incorporate IASC guidelines (as listed below, see Reference tools)*
 - ☑ *Apply the “survivor-centered skill” approach.¹⁰*
 - ☑ *Minimum services accessible for survivors (e.g. the provision of PEP Kits or proper physical examination).*
 - ☑ *A checklist of materials and equipment required for each locality (such as medication, provision of separate rooms for survivors)*
- *Programming priorities need to be aligned with the National Protocol. Agencies whose mandate includes protection, reproductive health, development, reintegration, human rights and justice, should lead on the programmatic activities that correspond to their domain of expertise.*
- *The National Protocol needs to be applied in a decentralized manner. Its aim should be to improve existing structures in rural areas with high incidents of sexual violence. Logistical support and training is required for those in first contact with survivors. In the short term, initiatives such as mobile clinics need to be supported.*

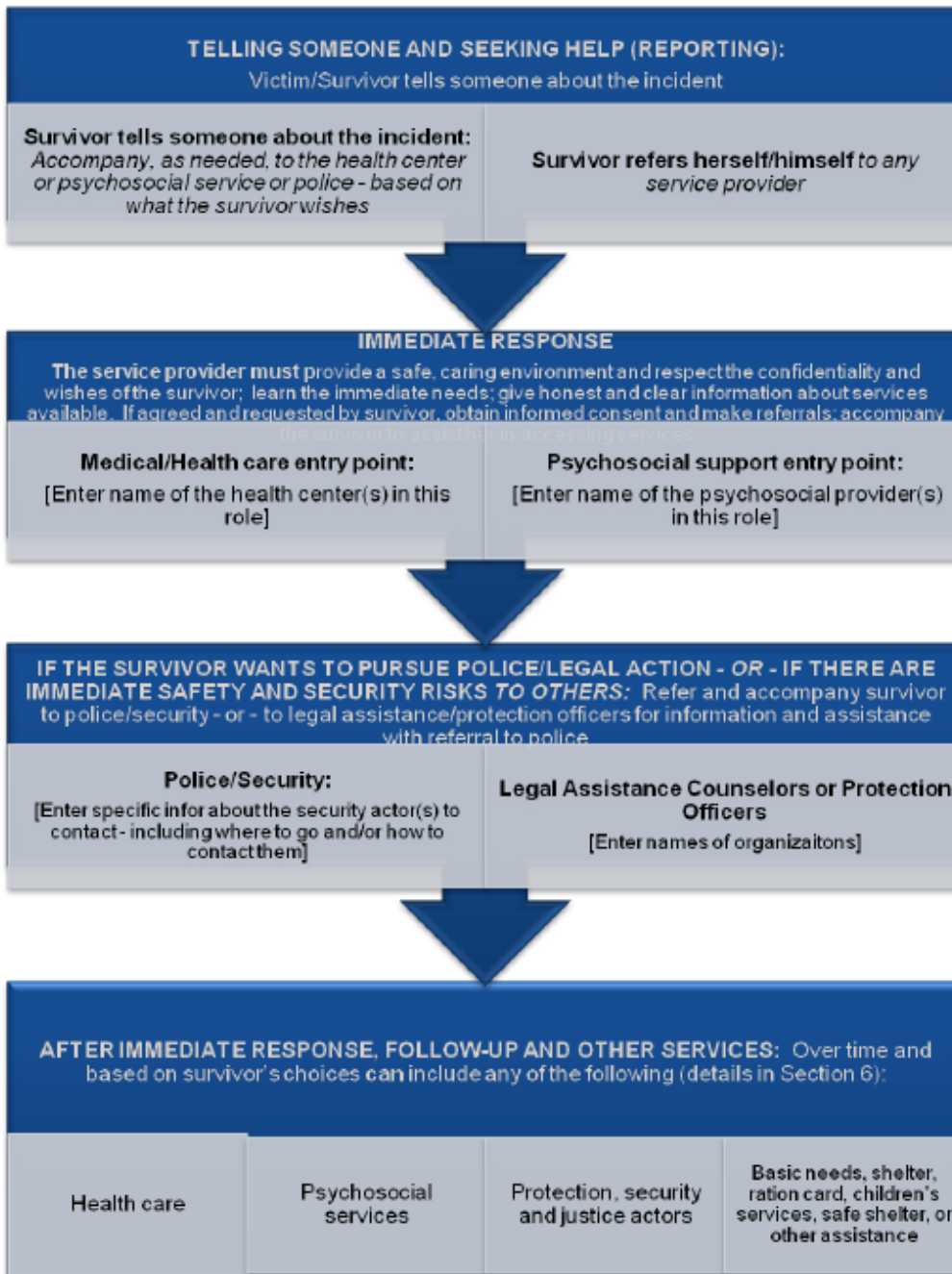
4. Strategic Component Lead

It is proposed for either UNICEF or UNFPA to be the designated lead of this strategic component. UNICEF has a large programmatic presence throughout DRC. UNFPA is coordinating a wide range of SGBV actors in North and South Kivu. This is under discussion and a decision is likely to be taken in the context of the meeting of the UN Action Principals in April 2009.

⁹ République Démocratique du Congo, Ministère de la Santé Direction de Développement des Soins de Santé Primaire, *Ordinogrammes des soins au Centre de Santé, 2eme édition Révisé avec l'appui de IRC, Octobre 2007, p 99-101, Plainte d'une Violence Sexuelle*

¹⁰ The “survivor-centered skill approach” defines the ethical framework for care providers. It provides guidance on interaction with survivors, e.g. respecting their rights, assuming a supportive attitude, trying to give back survivor's dignity and control etc.

SAMPLE HELP-SEEKING AND REFERRAL PATHWAY



Reference Tools

This Plan of Action for a Multi-sectoral Response to Sexual Violence relies on the following:

a) International

1. Gender-based Violence (GBV) Standard Operating Procedures (SOPs) for Multi-Sectoral and Inter-organizational Prevention and Response to GBV in Humanitarian Settings IASC sub-working group on Gender and Humanitarian Action May 2008
2. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Inter-Agency Standing Committee, 2007
3. The Clinical Management of Rape Survivors, developing Protocols for use with Refugees and Internally Displaced persons, (revised ed), Geneva, World Health Organization, UN High Commissioner for Refugees, 2004
4. WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. Geneva, World Health Organization 2007.
5. The Reproductive Health Response in Conflict Consortium annotated Bibliography
6. Guidelines for Gender-Based Violence Interventions in humanitarian settings: Focusing on prevention and response to sexual violence in emergencies. Geneva Inter-Standing Committee 2005.
7. Sexual and Gender Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response. Geneva UN High Commissioner for Refugees, 2003.
8. Various training materials and good practices applied in various settings, such as Clinical Care for Sexual Assault Survivors, A Multi-media Tool; International Rescue Committee 2008.

b) National

1. Initiative Conjointe de lutte Conjointe de Lutte contre les Violences Sexuelles Faites aux Femmes aux Hommes aux Jeunes et aux Enfants en République Démocratique du Congo :
 - Les outils harmonisés de collecte, dans de le carde de la lutte contre les Violences Sexuelles UNFPA octobre 2008
 - Les Modules des Formations et les Protocoles des volets Medico-Sanitaire, Psychosocial, Judiciaires et Protection, Réinsertion/Réintégration Sociale, Familiale et Economique, dans de le carde de la lutte contre les Violences Sexuelles, 2005.
2. République Démocratique du Congo, Ministère de la Sante Direction de Développement des Soins de Sante Primaire, Ordinogrammes des soins au Centre de Sante, 2eme édition Révisé avec l'appui de IRC, Octobre 2007, p 99-101, Plainte d'une violence Sexuelle

Plan of Action

Multi-Sectoral Response

A. Improve the referral pathway for a multi-sectoral response for sexual violence survivors ¹¹

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	A.1: Assemble inventory for each health zone on existing actors in multi-sectoral response	A.1.1 Identify existing establishments on sectoral assistance for sexual violence survivors per health zone. <ul style="list-style-type: none"> Evaluate human resources Identify available material resources (materials, facilities, safe places, etc) if possible per health zone Conduct a quick survey of the capacities and the credibility actors 	Inventory on existing resources and capacity	Overview of needs and capacities for referral pathway	SGBV working groups where present or UN leading agency in the province in cooperation with Ministries of Gender, Health	6 months	Identify best practices for referrals. Examine how referrals were conducted in each situation and the availability of human and material resources
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	A.2: Disseminate and ensure the application of the IASC Guidelines	A.2.1 Ensure the dissemination and application of the IASC Guiding Principles for care providers and others interacting directly with SV survivors A.2.2. Ensure respect for the IASC Guiding Principles in programming activities and application of the Do No Harm Approach	Number of activities applying IASC Guidelines in practice	Actors collaborate and adhere to the IASC Guiding Principles	SGBV working groups at provincial level Leading UN agency where there is no WG	6 months	Follow up on the application of the Guiding Principles
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	A.3: Define respective roles and responsibilities of actors involved in	A.3.1. Identify the coordinating entity for each setting A.3.2: Identify the health, psycho-social, reintegration/judicial entity for each setting	Number of agreements on responsibilities of each actor in multi-sectoral response per	Accountability and coordination of actors intervening in multi-sectoral response per health zone is improved	SGBV working groups where present or UN leading agency in the	6 months	Follow up on the roles and responsibilities of each actor, based on accountability,

¹¹ Gender-based Violence (GBV) Standard Operating Procedures (SOPs) for Multi-Sectoral and Inter-organizational Prevention and Response to GBV in Humanitarian Settings, IASC Sub-working Group on Gender and Humanitarian Action, May 2008

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
	multi-sectoral response in each health zone	<p>A.3.3: Agree on respective roles and responsibilities for each actor and agree to a common memorandum</p> <p>A.3.3: Identify local counterparts (local authorities, police, IDPs, site coordinators, judicial authorities)</p> <p>A.3.4: Disseminate the memorandum and the contact list of actors</p>	health zone		<p>province in cooperation with Ministries of Gender, Health, Justice</p> <p>MONUC/OHCHR</p>		capacities and available resources per health zone
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	A.4: Appoint at least two focal points per health zone to manage the referral pathway	<p>A.4.1: Plan programming activities to include 2-3 fully operational focal points per health zone</p> <p>A.4.2: Base focal points at the location of the most frequent point of contact (such as a health centers). Seek advice from the community and women's associations where to locate the focal points.</p> <p>A.4.3: Meet guarantees of safety, privacy and confidentiality</p> <p>A.4.4: The focal points managing the referral pathway should:</p> <ul style="list-style-type: none"> • Have previous counseling experience and training with SV survivors, and know the basic Guiding Principles. • Collect initial information once survivor is identified. • Have the Memorandum of roles and responsibilities and contact list of actors on multi-sectoral response for respective zones. • Know whom to refer to on a provincial level in case of severe trauma (physical or psychological). • Guarantee confidentiality and inform the survivor of the basic rights and services 	Number of focal points appointed managing the referral pathway per health zone	<p>Coordination, facilitation and follow-up on the referral pathway of the survivor is improved</p> <p>Clear and practical guidance are given to survivors</p>	<p>SGBV working groups where present or UN leading agency in the province in cooperation with Ministries of Gender, Health, Justice, NGOs, UNFPA, UNICEF.</p>	6 months	Follow-up in each health zone on successes and failures of the system of focal points managing the referral pathway

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<p>available.</p> <ul style="list-style-type: none"> Have appropriate equipment to assist survivors. Have means of communication and transport. 					
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	<p>A.5: Publish and disseminate simple, language appropriate, pictorial representations or charts of available services on the referral pathway in each health zone</p> <p><i>Provincial level</i></p>	<p>A.6.1: Adopt a one page simple pictorial chart of the referral pathway with available contacts points, including the referral pathway focal point. Highlight that medical/health care needs to be immediate, within the 72 hours. Disseminate in the local language.</p> <p>A.6.2: Advertise and place in frequent assembly points of the community posters and flyers on the referral pathway key messages and the contact points via sector (health psycho-social, reintegration, judicial).</p>	Number of sensitization materials per health zone distributed	Potential survivors know where to go to seek assistance	SGBV working groups where present or UN leading agency in the province in cooperation with Ministries of Gender, Health, Justice, NGOs, UNICEF and UNFPA	6 Months	Review the sensitization materials if any change in contacts or focal points or in assistance providers
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	<p>A.6: Develop and adopt a simple user - friendly form at the national level to collect a minimum amount of SV survivor's information at first contact (entry point)</p>	<p>A.7.1: Focal points managing the referral pathway have to complete the form, ensuring confidentiality at the entry point:</p> <ul style="list-style-type: none"> Name Age Date/location/time of incident Nature of incident(rape/enslavement etc) Perpetrator's identity if known /number of perpetrators First necessities <p>A.7.2: The survivors have the right to control how information about their case is shared with other agencies or individuals.</p>	Standard form agreed to and applied on a regular basis	Avoidance of abusive and unnecessary reporting practices that might cause trauma recurrence	Ministries of Gender, Social Affairs, Justice and Health, NGOs, UNFPA/UNICEF, Focal Points Coordinating entity: UNFPA/UNICEF	6 Months	<p>The use of information contained in the form for follow-up, prevention and protection to be agreed upon by all actors.</p> <p>Indicators to be evaluated regularly by all actors</p>

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
A: Improve the referral pathway for a multi-sectoral response for sexual violence survivors	A.7: Agree to and adopt referral systems in each health zone ¹²	<p>A.8.1: Establish practical rules (SOPs):</p> <ul style="list-style-type: none"> Focal points managing the referral pathway or any other actor in first contact with the survivor to ensure transfer to medical care within 24 hours. SV survivor can enter the referral system at any point and are not obliged to benefit from all available services. Survivor should be informed about all available services, counseling and assistance. A consent form needs to be signed. All services within the referral system should be free of charge. Services specializing in children need to be available in the health zone <p>A.8.2: Develop Referral Form to facilitate survivor's access to services at different stages:</p> <ul style="list-style-type: none"> Give to survivor in the case that she/he can not be accompanied by Focal Points. Form should contain name, address of the agency and contact person, (i.e. Focal Points, medical/health psychosocial support, police, security, legal counsel or protection officers). 	Number of health zones who use referral form	Clear referral system established in each setting so that survivors / witnesses know whom to report to, type of assistance available in terms of health, legal psycho-social, security, and other.	<p>Ministries of Gender, Social Affairs, Justice and Health, NGOs, UNFPA/UNI CEF, Focal Points</p> <p>Coordinating entity: UNFPA/UNI CEF</p>	6 Months	Follow-up on roles and responsibilities of each actor in the referral pathway – taking into account accountability, capacities and available resources per health zone

¹² Viz pp 21–22 Standard Operating Procedures (SOPs) for Multi-sectoral and Inter-organizational Prevention and Response to GBV in Humanitarian Settings

B. Develop a National Protocol for Multi-sectoral Assistance amongst the competent DRC Ministries.

The proposed National Protocol for Multi-sectoral Assistance will consist of four thematic sub-protocols: medical, mental health, judicial and reintegration

The National Protocol for Multi-sectoral Assistance will need to underline and define how the sub-protocols are inter-related, as outlined in Objective A above.

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.1: Examine the application of the DRC specific Health Protocol	<p>B.1.1: Examine if medical care for SV victims has taken into account:</p> <ul style="list-style-type: none"> • Documenting injuries • Forensic evidence • Treatment of injuries • Assessment of any sexually transmitted infections and preventive care • Assessment of risk of pregnancy and prevention <p>B.1.2: Identify available resources per health zone (medication, laboratory facilities, medical and paramedical staff)</p>	Number of Health Zones contacted for these assessments	Better basis for developing Health Care Protocol	WHO with Ministries of Health Chief Medical Officer or staff, Provincial Coordinators of health zones, Medical NGOs, WHO /UNFPA Coordinating: WHO/ UNFPA	6 months	Identify best practices in clinical management. Evaluate how national protocol is adapted in each situation and availability of resources and materials
B: Develop a National Protocol for multi-sectoral	B.2: Update the National Medical Protocol related	B.2.1: Include an STI Treatment Protocol, a Post Exposure Prophylaxis (PEP) Protocol and a vaccination schedule (including anti-hepatitis and anti-tetanus)	Medical Protocols updated and completed	National Protocol includes clear guidelines on management of	WHO with Ministry of Health Chief Medical	6 months	Follow-up on how provincial health coordinators are

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
assistance amongst the competent DRC Ministries	to SV survivors ¹³	<p>B.2.2: Insert two additional sections:</p> <p>A: Develop Standard Procedure for medical care of SV:</p> <ul style="list-style-type: none"> • Deontological rules • Inform and prepare the survivor for examination • Special considerations for child survivors, men and elderly women • Perform physical examination (laboratory testing) • Prescribe treatment (prevention of STIs, HIV infections, wound care, pregnancy) • Medical referral (secondary health care and follow up visits, psychiatry, surgery, pediatrics, gynecology/obstetrics) • Referral to psycho-social, reintegration and judicial assistance <p>B: Introduce a check-list for the clinical management of SV survivors, taking into account low resources:</p> <ul style="list-style-type: none"> • Copy of the Protocol • Trained Personnel • Supplies including rape kit for collection of forensic evidence • Drugs (SIT and PEP kit) • Administrative supplies (medical 		<p>medical consequences of SV (contraception, HIV, infection)</p> <p>Basic guidance on psycho-social and ethical aspects of collection and preservation of forensic evidence, treatment and follow up</p>	Officer or staff, Provincial Coordinators of health zones, Medical NGOs, UNFPA		ensuring that basic guidance and minimum standards on clinical management are incorporated into practice.

¹³ République Démocratique du Congo, Ministère de la Santé Direction de Développement des Soins de Santé Primaire, Ordigrammes des soins au Centre de Santé, 2eme édition Révisé avec l'appui de IRC, Octobre 2007, p 99-101, Plainte d'une violence Sexuelle.

The Clinical Management of Rape Survivors, developing Protocols for Use with Refugees and Internally Displaced Persons, (revised ed), Geneva, World Health Organization, UN High Commissioner for Refugees, 2004.

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		certificate, pictograms, consent form, safe storage or external location for keeping medical records) <ul style="list-style-type: none"> Operating procedures (working hours, etc) 					
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.3: Ensure that medical and para-medical staff are trained in the Medical Protocol ¹⁴	B.3.1: National and Provincial Health Coordinators to ensure that health care providers (doctors, medical assistants, nurses etc) are trained as a priority. B.3.2: Intensify training and recruitment of female health workers	Number of health care providers trained Number of female health providers trained	Health facilities dealing with rape survivors, from reception staff to health care professionals sensitized and trained. Specific attention given to female and health providers in rural areas with high concentration of SV cases	Ministries of Health, Chief Medical Officer or medical staff, Provincial Coordinators of health zones, Medical NGOs, WHO/ UNFPA SGBV working groups	1 year	Follow-up to training
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.4: Evaluate available resources and capacities for mental health care ¹⁵	B.4.1: Conduct an assessment of available personnel for psychological treatment: <ul style="list-style-type: none"> How many provincial clinical mental health establishments exist? How many are attached to health coordination mechanisms? How can universities contribute to clinical mental health treatment? 	Number of Health Zones contacted for this assessment	Better guidance for developing a Mental Health Care Protocol	WHO with ministry of Health, Chief Medical Officer or staff, Provincial Coordinators	6 months	Identify best practices in mental care health management. Consider how health counseling is

¹⁴ Ibid¹⁵ The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Inter-Agency Standing Committee, 2007

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<ul style="list-style-type: none"> How many local counseling structures exist (<i>maison d'ecoute</i>, women's associations etc)? <p>B.4.2: Identify available resources (facilities, safe places, etc) per health zone.</p>			of health zones, Medical NGOs, UNFPA/ UNICEF		conducted and availability of resources and materials in each situation.
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.5: Adopt a Protocol on Mental Health Care Management for SV survivors ¹⁶	<p>B.5.1: Adopt a Mental Health Care Protocol including three sections:</p> <p>A: Introduce minimum procedures for para-mental health care (<i>maison d'ecoute</i>, <i>parois</i>, women's associations)</p> <ul style="list-style-type: none"> Deontological rules Inform and prepare the survivor Special considerations for child survivors, men and elderly women Emphasize the symptoms (disorders, blame, isolation, substance abuse, sexual dysfunction, psycho-somatic complaints, uncontrollable emotions) Address the after-effects of SV through e.g. survivor-centered skills, coping mechanisms. Outline referral to specialized mental health referral (psychiatric support) Outline process of referral to medical services, reintegration and judicial assistance. <p>B: Establish Standard Procedures on mental health care:</p>	Mental Health Protocol Adopted	<p>National Protocol contains section on management of possible mental health consequences of SV (trauma, etc)</p> <p>Basic guidance developed on psycho-social treatment and follow-up</p>	WHO with Ministries of Health, Chief Medical Officer or staff, Provincial Coordinators of health zones, Medical NGOs, WHO/ UNFPA/ UNICEF	6 months	Follow-up on how provincial mental health coordinators incorporate basic guidance and minimum standards on mental health management.

¹⁶ ibid

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<ul style="list-style-type: none"> • As above plus • Address trauma and extreme distress • Treat after effects of sexual violence (survivor-centered skills) • Prescribe treatment • Invite psychological and legal expertise to allow for consideration of trauma during the judicial process. • Further referral to specialized mental health centers or a psychiatric hospital (for suicidal patients and severe emotional reactions) <p>C: Introduce a check-list for a mental health management of sexual violence survivors, taking into account low resources:</p> <ul style="list-style-type: none"> • As in B.2.3 above 					
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.6: Train mental health professionals and para-mental health staff (<i>staff des maison d'ecoute ou paroisse</i>) on the Mental Health Protocol	<p>B.6.1: Provincial and National Health Coordinators to ensure that mental health providers in rural areas (psychologists, social counselors, people working in <i>maison d'ecoute etc</i>) are trained as a priority.</p> <p>B.6.2: Intensify training and recruitment of female health workers to be intensified</p>	<p>Number of para-mental health care providers trained</p> <p>Number of female para-mental health providers trained</p>	<p>Mental health facilitators dealing with rape survivors sensitized and trained. Specific attention should be given to female and to health providers in rural areas with high concentration of SV cases</p>	<p>WHO/ UNFPA/UNI CEF</p> <p>SGBV working groups</p>	1 year	Follow-up on training
B: Develop a	B.7: Evaluate available	B.7.1: Assess human resource available for Bar Associations, the <i>Barreaux et clinic</i>	Number of provinces where	Better platform to develop a situation	MONUC/OH CHR with	6 months	Identify best practices in

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	resources and capacities for judicial assistance Note Reference to Strategic Component on Impunity for Cases of Sexual Violence	<i>juridique</i> and para-judicial NGOs : <ul style="list-style-type: none"> Judicial assistance available Ability of Provincial Bar Associations and other legal entities to respond 	evaluation conducted	specific Judicial Assistance Protocol	Ministry of Justice, <i>Batonier</i> , National/ Provincial Bar Associations and Legal Clinics, NGOs, REJUSCO		judicial assistance, including: how judicial assistance is conducted in each situation and what is the availability of resources and materials
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.8: Adopt a Protocol on Judicial Assistance for SV survivors ¹⁷	B.8.1: Judicial Assistance Protocol to incorporate the following two sections: A: Introduce minimum procedures for para-legal assistance (local human rights/development <i>NGOS</i> , women's associations) <ul style="list-style-type: none"> Deontological rules. Inform and prepare the survivor Special considerations for child survivors, men and elderly. Explain criminal process and rights of the survivor. Basic instruction on relations with survivor to ensure non-recurrence of trauma and confidentiality. Complete standardized forms to allow for complaint to be lodged. Evaluate personal security of survivors and witnesses who are pursuing the 	Judicial Protocol Adopted	National Protocol for Judicial Assistance harmonized with approaches by e.g. <i>Clinique Juridique</i> and <i>Bureau de Consultation Gratuite</i> of the Bar Association	MONUC/OH CHR with Ministry of Justice Ministry of Justice, <i>Batonier</i> , National and Provincial Bar Associations, Legal Clinics, NGOs, REJUSCO	6 months	Follow-up on how provincial legal and para-legal personnel are ensuring that basic guidance and minimum standards of survivors are applied

¹⁷ WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. Geneva, World Health Organization 2007

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<p>complaint.</p> <ul style="list-style-type: none"> • Ensure Defense Council. • Information to survivors on criminal proceedings. • Information on referral systems for medical psychosocial etc support. <p>B: Establish standard procedure for legal assistance:</p> <ul style="list-style-type: none"> • As above, plus: • Ethical standards to be applied to representing defendants. • Plan to collect information on the survivor, alleged perpetrator, evidence - including through standardized forms for paralegals. • Evidence including a list of witnesses if applicable. • Initial investigation phase (role of defense)-filing a complain. • <i>Partie civile</i> constitution. • Investigation phase and instructions. • Trial stage. • Execution of judgment and follow up. • How to follow up by informing survivors at the criminal proceeding stage. <p>B.8.2: Introduce a check-list for a legal assistance, taking low resources into account:</p> <ul style="list-style-type: none"> • One copy of the protocol. • Trained Paralegals (minimum 2 for each zone). • Administrative supplies (standardized form, safe location for keeping evidence and recording). 					

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<ul style="list-style-type: none"> Modalities of operating (working hours etc). 					
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.9: Ensure that legal and paralegals are trained in the Judicial Protocol	<p>B.9.1: Train of paralegal and legal professionals based on standardized materials (such as a practical guide on judicial support to victims. Give priority to rural areas.</p> <p>Intensify training and recruitment of female health workers.</p>	<p>Number of paralegal and legal professionals trained</p> <p>Number of female paralegals and legal individuals engaged</p>	<p>Paralegals and legal individuals sensitized and trained.</p> <p>Special attention given to females and health providers in rural areas with a high concentration of SV cases</p>	MONUC/OHCHR with Ministry of Justice, <i>Batonier</i> National and Provincial Bar Association and Legal Clinics, NGOs	1 year	Follow-up on training
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.10: Assessment of available resources and capacities for reintegration assistance	<p>B.10.1: Develop an inventory of associations / entities dealing with economic and social reintegration</p> <ul style="list-style-type: none"> How many provincial establishment exists involved in reintegration assistance. Evaluate existing reintegration and mediation structures (<i>maison d'ecoute</i>, women's associations etc). <p>B.10. 2 : Identify available resources (facilities, safe places, etc) per zone.</p>	Number of Zones per province incorporated in evaluations	Guidance for the development of a situation specific Reintegration Protocol	Ministry of Gender, Social Affairs, UNICEF UNDP NGOs	6 month	Identify best practices in terms of reintegration and empowerment. Examine how reintegration assistance is conducted in each situation. What are available resources and materials?

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.11: Adopt a Reintegration Protocol for SV survivors ¹⁸	<p>B.11. 1: Develop and adopt reintegration Protocol to include the following sections:</p> <p>B. Introduce minimum procedures for reintegration (NGOs, <i>maison d'ecoute</i>, <i>paroisse</i>, women associations)</p> <p>Social reintegration:</p> <ul style="list-style-type: none"> • Deontological rules • Mediation, family and community consultations • Adopt a social services manual for SV survivors • Evaluate risks factors for individual safety • Identify after-care services in safe houses/shelters • Safe return in case of displacement or refugees • Minimum standardized reporting on survivors <p>Economic empowerment:</p> <ul style="list-style-type: none"> • Educational & mentoring services • Soft skills training • Micro credit loans • Liaise and refer to other existing services, if appropriate <p>B.11. 3: Introduce a check-list for reintegration assistance, taking into account low resources:</p>	Reintegration and Mental Health Protocols adopted	<p>National Protocol on Reintegration with survivor-centered skills approach</p> <p>Provision of basic guidance on reintegration services and follow-up</p>	Ministries of Gender, Social Affairs, UNICEF UNDP NGOs	6 months	Monitoring on how provincial coordination structures apply basic guidance and minimum standards on reintegration

¹⁸ IASC Guidelines for Gender-Based Violence Interventions in Humanitarian settings: Focusing on prevention and response to sexual violence in Emergencies, Geneva, 2005.

Objective	Steps	Activities	Indicators	Outcome	Actors	Time Frame	Monitoring & Evaluation
		<ul style="list-style-type: none"> • One copy of the protocol • Trained Personnel per zone • Equipment and Administrative supplies • Operational modalities (working hours etc) 					
B: Develop a National Protocol for multi-sectoral assistance amongst the competent DRC Ministries	B.12: Train those involved in social and economic reintegration and empowerment	<p>B.12.1: Conduct practical training on social and economic reintegration and empowerment for those involved. (e.g. how to manage microcredit’s program with victims etc).</p> <p>B.12.2: Intensify training and recruitment of female health workers.</p>	<p>Number of trainings on social and economic reintegration and empowerment</p> <p>Number of female trainers engaged</p>	<p>Reintegration structures sensitized and trained</p> <p>Specific attention given to females and to providers in rural areas with concentration of SV cases</p>	Ministries of Gender, Social Affairs, NGOs, UNICEF UNDP	1 year	Follow-up to review effectiveness of training

Annexe

Sample of referral for judicial assistance:

OÙ POUVEZ-VOUS OBTENIR DE L'AIDE ?

QUE FAIRE APRES UN VIOL?

Vous avez droit à une réparation !

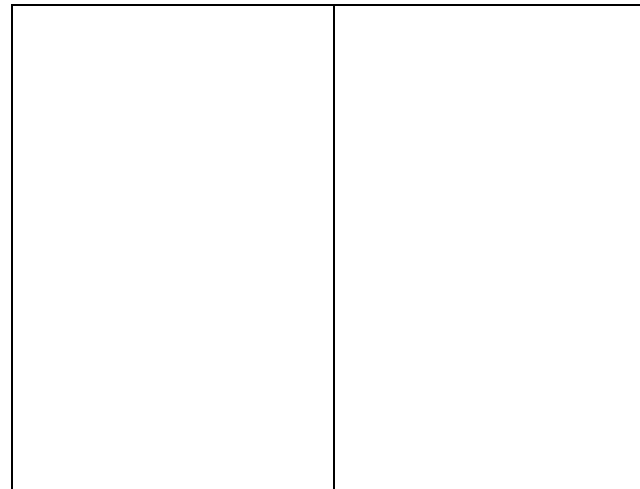
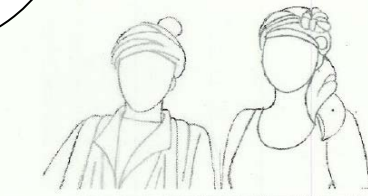
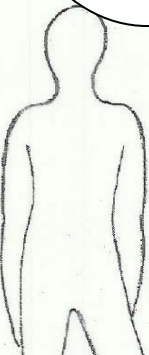
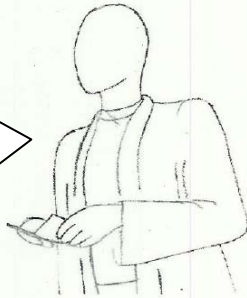
ADRESSEZ-VOUS À :

Le tribunal peut vous rétablir dans vos droits

- Un hôpital ou un centre de santé
- Une maison d'écoute
- La Police Nationale Congolaise
- Le Parquet
- L'Auditorat Militaire
- Le Barreau
- Une ONG d'assistance judiciaire

VOUS POUVEZ EXERCER UNE ACTION EN JUSTICE !

Ce tribunal vous reconnaît coupable de viol et vous condamne à 15 ans de servitude pénale et au paiement de 3000 \$ de dommages-intérêts



Si vous craignez pour votre sécurité ou dignité, vous pouvez bénéficier de mesures de protection, comme demander que le procès se tienne à huis clos.

Quelles que soient les circonstances du viol, vous n'êtes pas responsable de ce qui vous est arrivé. Vous n'avez pas à en avoir honte.

Parlez-en à une personne de votre entourage ou à une ONG d'assistance judiciaire.



C'est un message du Bureau des Nations Unies aux Droits de l'Homme de la MONUC



1. Allez dans un hôpital ou un centre de santé le plus tôt possible pour :

- recevoir les premiers soins
- éviter d'être contaminée par une maladie
- éviter une grossesse non désirée
- faire établir un certificat médical



Ne vous lavez pas avant la consultation médicale et conservez dans un sac les vêtements que vous portiez lors de l'agression ainsi que tout objet qui pourrait vous aider à prouver le viol et à identifier votre agresseur. *

2. Allez vers une ONG locale d'assistance judiciaire ou un cabinet d'avocat : vous pouvez obtenir des conseils gratuits pour défendre vos droits.



Vous avez le droit de vous faire assister par un avocat avant, pendant et après le procès.

3. Portez plainte au plus vite :

- À l'Auditorat Militaire, si votre agresseur est un militaire ou un policier
- À la Police ou au Parquet dans les autres cas



N'acceptez pas un arrangement à l'amiable ! Le violeur peut être condamné :

- à une peine de 5 à 20 ans d'emprisonnement
- à une amende ne pouvant être inférieure à cent mille francs congolais
- au paiement de dommages – intérêts à la victime