THE CONDITION OF WOMEN GIRLS IN YIDA REFUGEE CAMP, SOUTH SUDAN

A Reproductive Health and Gender-Based Violence Rapid Assessment

Yida Refugee Camp, Unity State, South Sudan
February 2012

BACKGROUND

Violence between the Sudan People's Liberation Movement - North (SPLM-N) and the Sudan Armed Forces (SAF) has worsened over the last nine months as more than 300,000 people have been displaced from their homes in South Kordofan state, Sudan. Civilians living within the Nuba Mountains in South Kordofan face regular aerial bombardment as they seek shelter in caves, and are now effectively besieged by SAF forces on all sides. South Kordofan remains inaccessible for international humanitarian organizations, with Khartoum refusing all entry to humanitarian aid organizations. Since the onset of conflict in Sudan's Nuba Mountains, approximately 25,000 civilians[1] have fled into South Sudan, seeking shelter in an informal refugee camp known as Yida.

Gender-based violence is a weapon in the mounting conflict, and women and girls are suffering in the conflict-riven areas they are fleeing from, during their flight across the border, and upon arrival at refugee camps such as Yida. This February, the International Rescue Committee's Emergency Response Team conducted a rapid gender-based violence (GBV) and reproductive health(RH) assessment among the Nuban refugee women and girls in Yida.

The IRC's rapid RH/GBV assessment identified ongoing violence against women and girls, as well as critical reproductive health and protection concerns at Yida camp. Adult women and adolescent girls reported that rape was a common feature of life within Yida camp. Adult women also reported very high levels of intimate partner violence and adolescent girls reported that girls under the age of 14 are frequently forced into marriage. This is accompanied by a fear of speaking out; the participants reported that women or girls who had been raped or physically assaulted would be extremely unlikely to report it to anyone. One participant stated, "We are always expected to keep silent. These same men will come back and kill you."

The Nuban women and girls fleeing conflict in Sudan are caught in a silent crisis. As the two countries continue their confrontations, civilians, and women and girls in particular, continue to suffer. This report conveys the findings of the rapid assessment and lays out key recommendations to mitigate the suffering of women and girls.

Women Collect Shelter Material, Yida Refugee Camp, Unity State, South Sudan

Women report being attacked and harassed when venturing out of Yida camp to collect shelter material and firewood. Here the women venture out in a group, seeking safety in numbers.

Photo: IRC/Elizabeth Pender, February 2012

1 The current WFP food registration indicates that approximately 30,000 refugees reside in Yida. A UNHCR led registration process was ongoing while this report was being finalized.

SUMMARY OF KEY FINDINGS

1. Gender-Based Violence

- **Rape and sexual violence** have been identified by focus groups and key informants alike as the most pressing concern for women and girls while fleeing Nuba and as an ongoing concern in Yida. All eight focus groups identified sexual violence as "one of the most common" types of GBV experienced by women and girls. Among key informants, more than half identified rape inside and outside of the camp as types of violence currently experienced by women and girls.
- **Intimate partner violence (IPV) and early marriage** were identified by adult women and adolescent girls, respectively, as other forms of violence currently perpetrated against women and girls living the camp. Adult female participants in several focus groups reported that IPV has increased since the community relocated to Yida.
- **Survivors are reluctant to report GBV,** due to restrictive cultural values and stigma: women, girls, and key informants reported that survivors would be extremely unlikely to seek support due to shame, concern about rumors spread by the community, or fear of being beaten, killed, or married to the perpetrator.
- **Unaccompanied adolescent girls[1] and single women,** especially those with children, are most at risk of GBV, particularly when collecting grass or firewood, at night, in the market, or when trying to build shelter (typically using wood and grass).

2. Reproductive Health Concerns

- **Girls are expected to have their first child before the age of 15,** according to one third of individuals surveyed. Pregnancy at this age increases the risk of complications during delivery considerably. Anecdotal information from key informants and focus group participants suggests that girls giving birth at a younger age are most likely to have as many as 14, 15, or reportedly 17 children in their lifetimes.
- **72% of respondents had never heard of any birth control method.** Women and girls among all the groups reported that they frequently use breast-feeding as a way to try and delay the next pregnancy.
- **37% of respondents had no knowledge of sexually transmitted infections (STI) or how to prevent their spread.** The displaced nature of the population, the presence of the military among and near civilian populations and the particular vulnerabilities of women and girls in Yida all contribute to an environment in which STIs are a priority health concern.

3. General Health & Protection Concerns

- Yida's shortage of services, compounded by women and girls' **restricted movement** throughout the camp, means they have acutely limited access to support and services, including general and reproductive health care, emotional support services, and information.
- Women and girls are **prevented from making decisions** about their own health and safety, both by their family and the community. Decisions about where to give birth, the number of children to have, when and where to access services, and where and when to collect firewood and grass are determined by male members of the family, with no input from the women or girls themselves.
- **Camp design puts women and girls at risk.** A lack of site planning and nighttime lighting, pervasive military presence, and numerous households with no access to latrines force women and girls to the bush for privacy. Consolidation of "unaccompanied girls" into one separate compound with minimal adult supervision puts girls at further risk.
- Currently there is **no formal camp management** NGO or UN Agency in place to address these concerns.

1 "Unaccompanied minors" and "Separated children" are terms used interchangeably in reference to a large population of adolescent girls living in the camp without their families. It is still unclear if these girls are unaccompanied, separated, or even under the age of 18. Many of them crossed the border in groups, having collectively fled from various boarding schools in Nuba.

METHODOLOGY

In February 2012, the IRC Emergency Response team conducted a rapid GBV/RH assessment among Nuban refugee women and girls in Yida. In an effort to rapidly collect data, the assessment methodology included focus group discussions (FGDs), scenario analysis, individual surveys, key informant interviews, and safety audits. The assessment, conducted by the IRC Women's Protection and Empowerment Senior Emergency Coordinator and the Emergency Reproductive Health Technical Advisor, relied on nine focus group discussions, 35 individual surveys, 19 key informant interviews, and four safety audits. The quantitative and qualitative information obtained provides a rapid overview of women's health and protection issues among the Nuban refugee women and girls in Yida camp, and will be used to inform the IRC's program design for women and girls in Yida.

Focus Group Discussions

The FGDs were conducted in Arabic and included female participants interviewed in same-sex and same-age groups (broken down into age groups of 14–18, 19–25, 26–40, and over 40 year olds). Discussions were held over a 1½ - 2 hour period (groups including girls under the age of 18 were conducted over a 1 hour period). The assessment team conducted the nine focus groups in the four "quardrants "[1] of the camp in an attempt to access individuals from different bomas[2] and with distinct experiences. Reproductive health questions in the FGDs emphasized cultural considerations of health seeking behaviors, family planning, and delivery practices and consisted of three types of questions:

1. General questions related to reproductive health needs and experiences of women and girls, emphasizing birth practices, numbers of children, types of birth control, sexually transmitted infections, and condom use.
2. More targeted questions about safety, security, the kinds of violence experienced by women and girls, barriers to reporting, and women's and girls' vulnerabilities.
3. Scenarios and related questions read by facilitators, depicting four types of GBV reportedly common in the region: rape in the camp, rape while fleeing from Nuba, Intimate Partner Violence (IPV), and early marriage. After reading the scenarios, the facilitators then asked participants a series of questions that addressed their familiarity with the types of violence mentioned in the scenarios, the prevalence of the types of violence presented, the barriers to reporting, and the types of support available to the survivors referenced in the scenarios.

Key Informant Interviews

To supplement the information collected in the focus group discussions, the GBV assessment team conducted 12 key informant interviews and the RH conducted seven key informant interviews with camp leadership and service providers, including the camp chief, midwives, teachers, protection monitors, adolescent girl "caretakers ,"[3] child protection officers, and representatives from the Women's Association and Social Affairs. Questions on the key informant interviews were consistent with, and followed the same framework as, the focus group discussion questions.

Individual Surveys

Individual reproductive health surveys were conducted with 35 people (16 males and 19 females) from among the refugee and host communities. Survey respondents were asked a series of 26 questions covering a range of topics: pre- and post-pregnancy health, birth practices, family planning, Sexually Transmitted Infection (STI) awareness, availability of health education and promotion, and cultural considerations around health seeking behaviors.

Safety Audits

The final element of the rapid assessment included a series of safety audits in the four quadrants of the camp. The safety audits (an observational analysis) focused on identifiable problems in the categories of overall layout and site planning, overcrowding, water and sanitation, safety and security, schools, safe space allocation, firewood and grass collection routes, and the presence of markets, security or armed actors. The safety audit was used as a method to identify risk factors and problems with access to service provision that might particularly impact women and girls.

1 No official camp map exists to date. The IRC team conducted a GPS mapping of the main road running through the camp. They drew on that map to plot key points, and then divided the camp into quadrants for the purposes of the assessment.

2 A "boma," as per camp leadership representatives, is defined as a "neighborhood" or village in Nuba. The camp is settled and segregated by "boma." Reports indicate that there are as many as 30 bomas in the camp.

3 Adolescent girl caretakers are adult women volunteers identified by camp leadership to "supervise" or take care of the large number of older adolescent girls living in the camp without their families.

FINDINGS

1. Gender-Based Violence: Rape, IPV, and Early Marriage

Rape

All nine focus groups and all key informants identified rape as a key feature of the experience of women and girls as they were fleeing the Nuba Mountains and when crossing into South Sudan. Participants reported that women and girls were raped in front of family members, raped by multiple perpetrators, and "taken" for a prolonged period of time, sometimes never to return. One participant reported that her sister had been taken by soldiers: "we still have never found her."

"Violence against us was happening all the time. Raping was happening frequently."
-Adult female focus group participant

When asked to describe types of violence women and girls were experiencing currently in the camp, both focus group participants and key informants confirmed that women and girls are at continued risk of rape in Yida camp. Participants in all eight female focus groups reported that sexual violence was likely to occur when a woman or girl was collecting grass or firewood. A large majority of key informants stated that rape occurs within the boundaries of the camp, while more than half report that it's likely to occur when a woman or girl is outside the camp, collecting firewood or grass. Adolescent girls also identified the market, located within the boundaries of the camp, as a location in which girls are very likely to be targeted and attacked. One girl stated: "These men are looking for girls. They don't want the older women."

Women, adolescent girls, and key informants also reported that, in addition to sexual violence, women are particularly exposed to violence in the home, while adolescent girls are at particular risk of forced or early marriage.

Intimate Partner Violence (IPV)

Adult women reported that Intimate Partner Violence (IPV) is the most common form of violence experienced by married women in the camp. This was corroborated by the majority of key informants, with several participants reporting an increase in the frequency of IPV since arriving in Yida. One female participant stated:

"It is so common. Who would you tell? Everyone is being beaten."

While rape and IPV were identified as the most prevalent types of violence that women and girls currently experience at the camp, key informants also reported high levels of harassment and physical violence at distribution points. This is a particular risk for the women and girls that work in the market.

Early Marriage

Participants in all of the groups, both adult and adolescents, confirmed that there were girls under the age of 15 who were married, which was reinforced by a large majority of key informants (all but two of the key informants reported this). The focus groups with participants between the ages of 14 and 18 were most likely to identify early marriage, in addition to rape, as the most common form of violence experienced by women and girls.

Reasons most often cited for early marriage included lack of access to secondary education in the camp, the receipt of money or resources in exchange for the marriage, the need to reduce the burden on the family, the priority placed on having as many children as possible, and marriage as a means for families to "protect" or "control" their daughters. Several focus group participants voiced the perception that females age faster than males: "A girl of 12 years should marry a man of 30 years. A woman gets old very fast, but a man has more time" stated one adolescent girl focus group participant.

Photo: IRC/Bob Kitchen, February 2012

Insecurity

"When we go to the forest we get so scared because of the men who can attack us."
- Female focus group participant

Participants in all eight of the female focus groups, when questioned about locations in or near the camps where they felt least secure, identified areas where they travel to collect grass or firewood. Participants in multiple groups reported that they feared attack or rape when collecting firewood or grass, had been harassed themselves, or had heard of women or girls who were attacked while doing so.

Several focus group participants, specifically adolescent girls, reported feeling particularly afraid of and at risk in the market, especially at night. These same participants reported that groups of men, both military and non-military, congregate in the market and near water points, where they often harass or attack women and girls. These findings were confirmed by key informants, particularly those who work closely with adolescent girls: half of key informants identified "presence of military" as a major safety and security concern for adolescent girls. As one girl focus group participant reported: "We do not go to the market alone. The men wait for us there, and the military wait for us there. If she is alone, the military men will grab her and make her have sex with them."

Unaccompanied Women & Girls

Key informants and focus group participants confirmed that there are large numbers of unmarried women and girls in the camp without their families. Although there is no clearly delineated space for female headed households within the camp, there is an unfinished compound where unaccompanied girls have gathered (at the time of this report, over 200 girls had relocated into the space, with 300 more preparing to do the same).

This compound presents multiple protection concerns, including the risk of further isolating an already-marginalized group, insufficient sleeping space, lack of bathing areas or latrines, the absence of an appropriate female adult living within the compound, close proximity to places where groups of men and boys congregate, and the "prison-like" nature of the compound itself. Unaccompanied girls are relegated to this space, and are not permitted to leave after 6pm. Though this compound was identified as an "ideal solution" by camp leadership for the "problem" of unaccompanied girls in the camp, no best interest determination (BID) or risk analysis was conducted, and the community was provided no technical guidance on practical alternatives or best practice for the provision of appropriate and safe living spaces for this vulnerable population.

Who is Most at Risk of Gender-Based Violence?

Many groups identified unaccompanied girls under 18 and single women, especially those with children, as the most vulnerable to violence at the camp. In addition, some focus group participants identified married women as particularly vulnerable: "Married women are beaten all the time. If you are married, you are hit." Participants also identified more recent arrivals as more exposed and vulnerable to violence, due to their association with certain tribes, their locations within the camp, and the limited resources they were able to bring with them at the time of displacement.

All of the key informants confirmed the presence of high numbers of single women and girls at the camp, and that these groups were most at risk of violence. Half of the key informants reported that unmarried women and girls are more at risk of violence, particularly physical violence at distribution points. All but one reported that they would have less access to safe shelter, and almost all reported that these women would be forced to leave their children at home alone while they went to collect water, grass, food, or other resources.

2. Women and Girls' Reproductive Health Concerns

Limited Family Planning

Nearly all key informants reported that women and girls in the community utilize very few methods to prevent pregnancies, and those that are used are mostly non pharmaceutical. Although 43% of women interviewed had heard of injectable contraception, and 36% ingestible, almost none say they use these methods. More than three quarters of individuals interviewed reported that women and girls will breast-feed for as many as 18-24 months in the belief that it will help postpone the next pregnancy. This dependence on breast-feeding contributes to poor weaning practices, while also indicating the low awareness levels and limited presence of modern methods for family planning. Focus group participants, key informants and individuals interviewed reported that women and girls typically give birth to high numbers of children. Nearly all individuals interviewed reported on average families have seven or more children, with focus group participants reporting numbers that range from 12 -17 children per family.

Risks & Limited Awareness of STIs

In Yida camp the risk of Sexually Transmitted Infections (STI) is high, while awareness, particularly of HIV, is extremely low. Yida camp poses multiple aggravating factors that contribute to the spread of Sexually Transmitted Infections (STI): a displaced and still migratory population, military presence near and within the camp, and extremely vulnerable women and girls. Lack of awareness compounds the risk: among respondents, more than a third did not know of any STIs. Focus group participants were often able to name one or two diseases (usually AIDS and syphilis), but were unable to provide any further information about those diseases, including symptoms.

Very few respondents were aware of condoms or their role in the prevention of STI transmission; approximately half of the respondents had never heard of condoms. Among the 35 individuals surveyed, 14% said condom use was not acceptable, 36% stated that condom use was somewhat acceptable, 9% reported condom use was acceptable and 43% reported that they didn't know. Acceptance of condom use was higher among key informants, with over 85% stating they were acceptable.

Low Ante-Natal and Very Low Post-Natal Care Utilization

70% of individual respondents reported that women and girls will seek assistance from a midwife during delivery, 32% reported they would go to a medical doctor, and only 11% reported they would seek support from a traditional birth attendant (TBA). In the event of complications during delivery, 80% of the individual community members reported that women go to the health facility. 20% of those surveyed reported that most women or girls would seek no care or treatment from a midwife or doctor after giving birth, while only 29% of individuals surveyed reported that women or girls would seek treatment from a midwife or doctor three times after the child's birth. This was confirmed by more than one-third of key informants.

This minimal access to post-natal care contributes to the risk of puerperal infections and newborn illnesses. There are missed opportunities for medical check ups, education, promotion of good breast-feeding practices, and family planning. Women reported that they would not typically seek health monitoring after giving birth. Just 44% of pregnant women go for three ANC visits at the health facility while only 29 % of women are said to go for post natal care.

Limited Infrastructure for Complicated Deliveries

A preliminary facility assessment revealed that there is limited infrastructure capacity within Yida camp to directly intervene in cases of complicated delivery and when surgery is required. Although almost half of respondents reported that they seek pre-natal services at least three times during pregnancy, the large majority of women and girls confirmed that they prefer to give birth at home. Focus group participants reported that, particularly with first pregnancies, women and girls will choose to give birth at home, some with a midwife present, unless there is "significant pain" or "complications" during birth. For any serious delivery or obstetric complications, due to the limited health infrastructure within Yida camp, women or girls would have to be referred to a facility offering surgical interventions, requiring road travel of up to four to five hours.

3. General Health & Protection Concerns for Women & Girls

Camp Layout

While some of the more established areas of the refugee camp are well planned and laid out, the safety audits found that the overall layout of the camp lacks basic site planning, security measures, safe space allocation, and adequate lighting. All four quadrants audited lacked consistent planning and had few discernible walkways, and a significant portion of the community is living in makeshift shelters that can guarantee no safety or privacy.

While none of the quadrants are overcrowded, the ad hoc nature of the settlement process has led to noticeable differences in the quality of shelter across the camp. While some refugees live in established, fenced-in compounds, including multiple grass structures and usually a latrine, others live in exposed, unstable single room structures. All of the sites audited have access to water points that are relatively close by, but many of these points are overcrowded, flooded, and are used by males and females, and sometimes livestock.

Lack of Secondary Education in Yida

The absence of secondary education in the camp was identified in multiple groups as a major concern for women, and for adolescent girls in particular. While secondary schools were established in another refugee camp elsewhere in Unity State, families report that they prefer to send their boy children and not their girl children due to cultural and safety concerns. Girls report that the lack of readily-available education for girls makes families more inclined to marry their daughters at an earlier age to "minimize the burden" girls place on their families. One woman reported, "if they don't have schools, they need to marry at 12 or 13." This risk factor was confirmed by key informants, particularly those working with adolescent girls.

4. Help-Seeking Behaviors for Women & Girls

The participants reported that women or girls who had been raped or physically assaulted would be extremely unlikely to report it to anyone. Many participants explained this resistance and reluctance to report, especially among survivors of rape, as rooted in a fear of being blamed, fear of rumors spread by the community, fear of being forced to marry the perpetrator, or shame. One participant stated, "We are always expected to keep silent. These same men will come back and kill you." Women beaten by their husbands are expected to "keep the secret" and "not shame the family." Participants in focus groups stated that a survivor of IPV is obligated to endure the abuse. Several participants reported that Intimate Partner Violence (IPV) is culturally accepted and even encouraged. One adult female participant stated, "This is a secret for the home. No one will even ask the husband why he is hitting. You are married to him and he can do it if he wants. The husband has the right to do this." All but two of the key informants confirmed the focus group participants' statements that most survivors would seek no support out of "fear of being identified as a survivor," and three quarters confirmed that there was a "lack of confidential services".

Women and girls' limited decision-making power is a contributing factor in delaying critical health care and accessing services. 50% of the individual respondents, and more than half of the RH key informants, reported that the father or husband is most likely to make decisions determining whether a woman or girl will seek treatment during pregnancy or delivery. Women and girls in the focus groups confirmed that any decision around reproductive health will require "final approval" from her husband.

Data related to health seeking behaviors and cultural practices around women and girls' access and use of reproductive health services indicate an alarming lack of awareness around safe practices and access to care. There is very limited awareness of access to safe and confidential clinical management of rape and other forms of GBV, safe and comprehensive pre- and post-natal care, delivery care and services, effective birth control methodology, and effective breast-feeding and weaning practices

CONCLUSION & RECOMMENDATIONS


Photo: IRC/Elizabeth Pender, February 2012

The IRC is uniquely prepared to meet the needs related to the specific protection and health concerns of women and girls within Yida camp. While it is still unclear whether the refugee population will remain in Yida, be relocated to another site, or increase in size as the situation in South Kordofan continues to deteriorate, there is every indication that this will be a protracted emergency. It is essential that the international donor community mobilize funding to appropriately staff and resource a holistic GBV/RH program in order to meet the immediate and longer terms needs of women and girls from Nuba.

An untold number of survivors are crossing into South Sudan and efforts must be made to ensure they get at least the minimum health and emotional support outlined in the recommendations in this report. For those women who have already suffered gender-based violence, it is possible to drastically mitigate the health consequences by ensuring they get immediate care. Arrival at Yida camp does not guarantee safety; efforts must also be made to mitigate the clear and ongoing protection and health risks for women and girls once they arrive at Yida refugee camp.

The gender-based violence, reproductive health and protection concerns identified in this report can be mitigated by meeting the minimum standards in responding to emergencies though out all sector interventions as outlined in the Minimum Initial Service Package (MISP) and the IASC Guidelines for GBV Interventions in Humanitarian Settings. Comprehensive reproductive health services should include safe and comprehensive delivery service, contraceptive supplies and related counseling, ante and post natal care services, clinical care for sexual assault survivors (CCSAS), and treatment and mitigation of sexually transmitted infections. The MISP criteria prioritize the provision of clinical support for survivors of sexual violence, the reduction of HIV transmission, maternal and neonatal care and availability of family planning commodities. Particular attention should be given to vulnerable groups (such as adolescent girls). Clinical care for sexual assault survivors should be consistent with the standards outlined by the World Health Organization (WHO).

The following recommendations will help increase women and girls access to critical and life-saving health and protection interventions:

1. Ensure access to quality reproductive health services (as per MISP standards) for women and girls, including survivors of rape, sexual assault and other forms of GBV.

In addition to comprehensive RH services emphasizing safe delivery services, pre- and post-natal services, STI control and awareness, post abortion care, and family planning, health staff should be resourced with GBV survivor-centered capacity, age-appropriate treatment methodologies, case identification, and GBV case management protocols. Programming should ensure immediate access to comprehensive health services to survivors of sexual violence. All health promotion activities, both in the camps and at the reception center health screening sites, should include information about health services available to adult and child survivors of rape, sexual assault, intimate partner violence and other forms of GBV. This includes:

- Clinical management of rape for adult and child survivors
- Uncomplicated delivery services
- Contraceptive supplies and related counseling services
- Ante and post natal care services
- Clinical care for survivors of sexual assault
- Treatment for sexually transmitted infections

2. Establish female-only safe spaces for women and girls to report protection concerns and access age appropriate health and emotional support services.

Accessible safe spaces for women and girls must be made available within the camp. This will allow for a safe environment for women and girls to report protection concerns and incidents of GBV, and to effectively access support activities. As per minimum standards, psychosocial support and health program strategies should include:

- Provision of case management
- Counseling services
- Group support services
- Outreach activities
- Immediate referrals to health services and other relevant support services
- Distribution of dignity kits (done in coordination and collaboration with relevant partners)
- Provision of age-appropriate medical dosages and equipment
- Key messages designed for adolescent girls to ensure they know where to access services
- Training for health workers, child protection actors and new GBV staff on Guiding Principles for working with child and adolescent survivors.

These services must be relevant to adult and older adolescent girls, potentially requiring separate hours for different age groups and different outreach techniques and strategies.

3. Adapt referral pathways to provide the refugee population access to comprehensive, safe and confidential support services.

Referral protocols should be established to ensure that the refugee population has immediate access to comprehensive, safe, and confidential GBV and health support services. Survivors who present at any service provider should be able to immediately access age-appropriate health or emotional support services, with follow up on case management of survivors by appropriate and trained staff. It is imperative that there referral mechanisms and structures are established immediately to minimize any confusion around treatment of survivors of GBV or to unnecessarily involve multiple service provides in survivor support actions.

4. Advocate with UNHCR to ensure minimum standards are met to prevent or mitigate the risk of violence to women and girls.

All sectors of intervention have a role to play in reducing the risk of violence against women and girls and increasing women's and girls' access to services and support. Messages and information distributed by other sectors on accessing safe and appropriate health and emotional support for women and girls should be in line with minimum standards and ensure the protection and rights of women and girls.

All service providers should be meeting the minimum standards as outlined in the IASC Guidelines for GBV Interventions in Humanitarian Settings and the Minimum Initial Service Package to minimize the risks faced by women and girls. Specifically this includes prioritizing risk reduction in:

- Child Protection/Education
- Camp management (specifically site planning)
- Security
- Food and NFI distribution

This will minimize the potential of women and girls being exposed to violence when trying to access latrines, when living in their shelters, when collecting grass or firewood, when in the market, or when collecting food or NFIs. Priorities should include increased provision of secondary education to adolescent girls, appropriate safe living areas for girls and young women living in the camp without their families, firewood or grass collection patrols, better site planning of the camp (including areas identified for female headed-households, fences around shelters, safe access to latrines and water points), and gender-specific food/NFI distribution times.

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For more than twenty three years, and throughout the brutal civil war, the IRC has worked hand in hand with South Sudanese communities to promote a safe, healthy and protective environment. Empowering communities to move from requiring life-saving assistance to contributing to their own development, the IRC maintains programs in Lakes, Unity, Northern Bahr el Ghazal, and Eastern Equatoria states.

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