

Care for victims of sexual violence, an organization pushed to its limits: The case of Médecins Sans Frontières

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Abstract

Over the past ten years, Médecins Sans Frontières (MSF) has provided medical care to almost 118,000 victims of sexual violence. Integrating related care into MSF general

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assistance to populations affected by crisis and conflicts has presented a considerable institutional struggle and continues to be a challenge. Tensions regarding the role of MSF in providing care to victims of sexual violence and when facing the multiple challenges inherent in dealing with this crime persist. An overview of MSF's experience and related reflection aims to share with the reader, on the one hand, the complexity of the issue, and on the other, the need to continue fighting for the provision of adequate medical care for victims of sexual violence, which despite the limitations is feasible.

Keywords: sexual violence, rape, victim, medical care, MSF, unwanted pregnancy, caring for sexual violence victims, children born out of rape, medical certificates.

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Sexual violence occurs in all societies and in all contexts at any time. Destabilization of societies often results in increased levels of violence, including sexual violence. These are the contexts in which MSF works most, bringing assistance to people affected by crisis and conflict. Sexual violence is particularly complex and stigmatizing and generates long-lasting consequences; care for its victims is a priority, and every MSF project should be prepared to offer related assistance. However, the challenges are multiple and need to be considered as part of care efforts: legal considerations, confidentiality, protection, stigma and perception, as well as access to, and acceptance of, assistance and its instrumentalization.

This article aims to share an analysis of Médecins Sans Frontières' (MSF) involvement in the care for victims of sexual violence. MSF has been providing assistance to victims of sexual violence in numerous locations since 1999. The strategy and organization of assistance vary depending on the location and context. MSF focuses on medical care for victims of sexual violence; most of the victims seen by MSF teams are victims of rape.¹ Assistance includes treatment of injuries, prevention of sexually transmitted infections (STIs), prevention and management of unwanted pregnancy, post-exposure prophylaxis (PEP) for the prevention of HIV infection, vaccinations for tetanus and hepatitis B, psychological support and the provision of medico-legal certificates.

Over the past ten years, MSF has provided medical care to almost 118,000 victims of sexual violence in over sixty countries.² The ten countries with the highest caseload during this period were the Democratic Republic of the Congo (DRC),

1 For the purposes of this article, we understand sexual violence to mean “any sexual act or attempt to obtain a sexual act by violence or coercion, unwanted sexual comments or advances, acts to traffic a person or acts directed against a person’s sexuality, regardless of the relationship to the victim”, according to the World Health Organization (WHO). See WHO, *World Report on Violence and Health*, 2002, p. 149. In turn, we understand rape as an act of obliging an individual to have sexual intercourse against his or her will, using force, violence and any other form of coercion. It is considered a felony in the criminal laws of most countries. See Françoise Bouchet-Saulnier, *The Practical Guide to Humanitarian Law*, 2nd English-language ed., Rowman & Littlefield, Lanham, MD, 2007, p. 355.

2 A review of reports and websites of different humanitarian actors, while reflecting involvement in sexual violence, does not provide details on medical care; comparison is thus difficult. The International Rescue Committee states that it “[c]ounselled and provided essential services to over 27,000 survivors of gender-based violence” in its 2013 report, available at: www.rescue.org/blog/2013-annual-report-read-about-irc%E2%80%99s-lifesaving-work-and-impact (all Internet references were accessed in December 2014).

Liberia, Burundi, Zimbabwe, Kenya, Guatemala, Nigeria, Haiti, South Africa and Papua New Guinea. They account for 90% of all the victims of sexual violence that MSF has assisted.³

The first part of this article looks at the main events and circumstances that led the organization to develop specific medical care for victims of sexual violence. The second part gives an overview of the assistance that has been provided over the past ten years. The third part discusses the challenges MSF encounters in the implementation of assistance and includes reflection on the limits of MSF action, which highlight the complexity of the issue of sexual violence as part of an aid response in contexts of armed conflict and other crisis.

MSF's history of response to victims of sexual violence

For several years following its creation in 1971, MSF offered a limited response to victims of rape until the need for specific medical care became clear. The first treatment programme for victims of sexual violence was established in the Republic of the Congo (RC) in 1999.⁴ Former members of the MSF leadership⁵ in the 1970s and 1980s state that the issue of rape had long been on the agenda of the board of directors but was not followed up with the launch of specific action because it was considered to relate more to human rights than to emergency medical action.

Historically, several events led MSF to realize both the magnitude of the sexual violence problem and its human and medical consequences.⁶ First, in the Bosnian and Rwandan conflicts in the 1990s,⁷ where MSF ran important assistance programmes, large-scale sexual violence terrorized the population. Both contexts had high international media coverage, and the violence to which the civilian population was subjected led to the creation of two *ad hoc* international tribunals resulting in the indictment of Jean-Paul Akayesu regarding his role in the Rwandan genocide, to name but one.⁸ While the organization was appalled by the human suffering of such violence, it took time and other events for MSF to assume an institutional role regarding sexual violence and to develop a

3 MSF, International Typology data, internal MSF document. Yearly figures as of 2005–2006 are available in the *MSF International Activity Reports*, available at: www.msf.org/international-activity-reports.

4 Marc Le Pape and Pierre Salignon (eds), *Une guerre contre les civils: réflexions sur les pratiques humanitaires au Congo Brazzaville (1998–2000)*, Khartala, Paris, 2003, p. 109.

5 Personal verbal communication with former members of the board of MSF France, 2008.

6 Françoise Duroch and Sophie Marchand, *Forgotten Crimes: Sexual Violence in the Context of Armed Conflict*, MSF, Etat d'Urgence Production, 2006, available at: www.dailymotion.com/video/xrn91h_forgotten-crimes-sexual-violence-in-the-context-of-armed-conflict_news.

7 Claire Fourçans, "De la répression par les juridictions internationales des violences sexuelles pendant les conflits armés: rappel de quelques exemples récents", *Science and Video*, No. 2, 2010, pp. 155–156.

8 The *Akayesu* case, which found Jean-Paul Akayesu guilty of rape as a crime against humanity, amongst other crimes, was the first international judgement to define rape, thereby setting an important precedent. International Criminal Tribunal for Rwanda (ICTR), *The Prosecutor v. Jean-Paul Akayesu*, Case No. ICTR-96-4-T, Judgement (Chamber I), 2 September 1998. See also F. Bouchet-Saulnier, above note 1, p. 551.

systematic medical response for victims. The awareness of the political nature of systematic rape in both contexts contributed to the initial caution when approaching sexual-violence-related needs.⁹

Second, the threat of the HIV pandemic¹⁰ and the discovery of post-exposure prophylaxis (PEP) in 1997, as a means to preventing the deadly consequences of HIV infection for rape victims, became the starting point for relevant medical activity¹¹ in MSF. PEP presented a treatment with a proven added value for the patient. It would allow MSF to function within the known framework of medical care and a “patient–medical staff” relationship.¹²

Finally, the Mano River scandal in 2002¹³ created a new perspective regarding sexual violence that required urgent action: the role of assistance in creating opportunities for sexual violence and other forms of abuse, as well as the direct responsibility of humanitarian actors in preventing their own contribution to such forms of abuse. An Inter-Agency Steering Committee report¹⁴ stated that “[t]he foundations of sexual exploitation and abuse are embedded in unequal power relations”, and while the conclusions of the report were not validated,¹⁵ the suggestion that systematic exploitation could involve all humanitarian actors did resonate in the international aid arena. Most sexual violence programmes started as of 2003.¹⁶

The latter two elements were the main factors that influenced MSF’s current perception of activities relating to care for victims of sexual violence.

The call to act: An epidemic of rape and an aid scandal

In the RC in 1999, the medical assistance that MSF could offer victims of rape began to take shape. MSF assisted the displaced population who were fleeing fighting in the

9 Jean-Hervé Bradol, former president of MSF France, remembers his own reaction when, during a discussion with a European Community Humanitarian Office consultant about the Burundian refugee camps in Rwanda in 1993, he was asked: “You have nothing planned for the women?” He explains: “The question annoyed me at the time, because of the degree of difficulty we had to deal with in the camps. But overall, the consultant was right. In these camps, single women were at a high risk of being raped. At the very least we can spread the word that contraceptives exist. A raped woman does not have to fall pregnant.” See M. Le Pape and P. Salignon (eds), above note 4, p. 161.

10 United Nations High Commissioner for Refugees (UNHCR), *Sexual Violence against Refugees: Guidelines on Prevention and Response*, 1995, p. 7.

11 François Bourdillon, *Compte rendu de mission Congo Brazzaville: prise en charge médicale des femmes ayant subi des violences sexuelles*, internal MSF document, 2000.

12 Françoise Duroch, “Le viol, l’humanitaire en désarroi”, *Revue Les Temps Modernes*, No. 627, 2004, p. 3.

13 The Mano River scandal erupted in 2002, when UNHCR and Save the Children Fund published a report accusing tens of non-governmental organizations of exchanging help for sexual favours in the refugee camps of Guinea, Sierra Leone and Liberia. See Daphne Lagrou, *Sexual Violence Response in OCB-Projects: Recommendations and Analysis*, internal MSF report, 2011, p. 13. See also Note for Implementing and Operational Partners by UNHCR and Save the Children UK, “Sexual Violence and Exploitation: The Experience of Refugee Children in Guinea, Liberia and Sierra Leone”, February 2002, available at: www.unhcr.org/3c7cf89a4.html.

14 Inter-Agency Standing Committee, Report of the Task Force on Protection from Sexual Exploitation and Abuse in Humanitarian Crisis, June 2002, p. 1.

15 Pierre Hazan, “L’Onu relativise les dérives de l’humanitaire”, *Libération*, 25 October 2002.

16 D. Lagrou, above note 13, p. 7.

Pool region and returning to Brazzaville, offering medical aid at way-stations and upon arrival in the capital. Apart from the obvious needs, which included high levels of malnutrition and trauma, people's accounts of events in Pool and on their way to Brazzaville described the systematic rape of women and children.¹⁷ The main effort of assistance was initially focused on malnutrition, and it took months for MSF to get involved in assisting victims of rape. Some of the rape victims received care in the form of a specialized consultation at the Makelekele or Talangai hospital, supported by a non-governmental organization called the International Rescue Committee. Care was basic: antibiotics were provided when available. Prevention of HIV infection, management of unwanted pregnancy and psychological support were not part of any systematic care. The potential of HIV infection changed the perception of the consequences of rape; it attributed a gravity that was measurable in terms of morbidity-mortality. A request to let victims of rape benefit from PEP was met with months of refusal from the Ministry of Health in Brazzaville. The MSF team also had to fight strong resistance within the organization and among other aid actors, who disregarded the need for specific assistance because, as some said at the time, "one does not die of rape".¹⁸ The shocking lack of empathy implied in that statement still resonates. At the time, the tensions such attitudes created, and eventually the overwhelming number of victims, led to an agreement for a systematic medical approach.¹⁹ A medical doctor of the Brazzaville team²⁰ had worked with HIV-positive patients in Europe and knew the potential of PEP; the team pushed for its use for victims of rape, together with the morning-after pill and treatment for the most common STIs.²¹

In Brazzaville MSF invested for years and explored different avenues to assist victims of sexual violence far beyond the organization's core medical role, including social and legal support, and understanding the importance of public awareness as a tool to reduce stigma. The "Tika Bika Viol" campaign²² in 2003 aimed to foster political will and generated a more favourable environment for

17 MSF, "MSF Top 10 Under-Reported Humanitarian Stories of 1999", available at: www.msf.org/article/msf-top-ten-under-reported-humanitarian-stories-1999. In the RC, the problem of rape had been known to the community since the end of the first war in 1997 and an awareness campaign had been organized by the United Nations Fund for Population (UNFPA) and the International Rescue Committee before the war broke out again. F. Bourdillon, above note 11, p. 2.

18 Personal interview with Dr Joanne Lui, MSF International President, Geneva, October 2014.

19 Dr Jean-Herve Bradol, "Images du malheur et qualité des secours", in M. Le Pape and P. Salignon (eds), above note 4, p.10.

20 Personal interview with Dr Jean-Clément Cabrol, Director of Operations, MSF Switzerland, Geneva, September 2014.

21 Marc Le Pape, "Guerres et viols au Congo: des urgentistes à Brazzaville, 1999–2000", *Seconde journée d'étude Guerre et Médecine*, February 2004, Paris, available at: www.msf-crash.org/drive/2b0a-mlp-2004-guerre-et-viols-au-congo-des-urgentistes-a-brazzaville_fr-art-p.8_.pdf. MSF had just started a campaign to push for access to essential drugs (see Access Campaign, available at: www.msfaccess.org/the-access-campaign), including antiretrovirals, which were practically inaccessible to HIV patients in the contexts where MSF worked. The MSF clinical guidelines at the time (1999) did not yet include PEP as a protective measure for health staff, and neither was it considered a preventive option for victims of sexual violence (MSF, *Clinical Guidelines*, 1999, p. 191).

22 MSF, *Tika/Bika, viol. Viol, je dis non!*, briefing paper, February 2003, available at: www.msf.fr/actualite/publications/tikabika-viol-viol-je-dis-non.

victims to come forward and receive assistance. An assessment in 2005, however, showed no increase in the number of victims attending MSF sexual violence consultations in Brazzaville,²³ a context where the incidence of rape is likely to have stayed high for quite some time.

The experience of responding to sexual violence has also pushed MSF to its limits in terms of legal and social support:

If the legal environment was explored in the interest of better understanding, it seems clear that, beyond the medico-legal certificate, MSF does not have a particular added value in an environment where the juridical system is dysfunctional. The same applies to social support; the activities directly related to patient care have proven to be a real added value, but beyond this, MSF does not have the means to assume a larger role in this area.²⁴

The situation in the RC was brought to international public attention,²⁵ but the recognition of the problem and the clarification of the relevant medical role that MSF could have²⁶ did not immediately result in an expansion of assistance to victims of rape in other contexts, such as in the DRC, where MSF had worked for many years. That change happened in 2002 with the Mano River scandal.²⁷ The public exposure²⁸ of the problem galvanized MSF into assessing the reality of abuse in MSF operations, establishing related preventive measures,²⁹ reflecting on the challenges inherent to the work in contexts where insecurity and violence are prevalent³⁰ and animating a movement-wide discussion on MSF's role in reducing/preventing rape and assisting victims of violence.³¹ Most importantly, however, it triggered the start-up of several projects in Burundi, South Africa, Sierra Leone and Guinea in 2003 in order to respond to the needs of victims of sexual violence.³² Public pressure played some role in this, but equally important was the need to understand the reality of the victims and how best to assist them.

23 Emmanuelle Chazal, Gaëlle Fadida and Claire Reynaud, *Victimes de violence sexuelles: L'expérience de Brazzaville 2000–2005*, internal MSF document, p. 3.

24 *Ibid.*, p. 29.

25 MSF, above note 17.

26 “The programme has allowed MSF to understand that a patient who has been raped requires specific care. Much has been said about the ‘victims of sexual violence’ model; from a medical perspective, it took time for the approach to adequately address basic questions – hepatitis B vaccination, provision of antiretroviral treatment to those patients tested HIV positive, termination of pregnancy ... Today, the protocol is distributed throughout missions and medical kits have been adapted according to this [new] need.” E. Chazal, G. Fadida and C. Reynaud, above note 23, p. 29 (our translation).

27 See above note 14.

28 “Sierra Leone: les agences réagissent aux problèmes des abus sexuels”, *IRIN News*, 6 June 2002, available at: www.irinnews.org/fr/report/66876/advancedsearch.aspx.

29 MSF, Code of Ethical Behaviour, internal MSF document, 2005.

30 Guillaume Le Gallais, *Quelques réflexions sur les enjeux de sécurité*, internal MSF document, 2004, p. 2.

31 Françoise Duroch, “Violence sexuelles: éléments historiques et anthropologiques”, *Messages* (internal MSF journal), No. 130, May 2004, p.8, available at: www.msf.fr/sites/www.msf.fr/files/2004-05-01-Messages130VF.pdf.

32 *MSF International Activity Report 2003–2004*, available at: www.msf.org/international-activity-report-20032004.

For MSF, it was necessary to gain experience and to strengthen the medical approach when responding to the needs of this particular group of people. Also, it was necessary to act in order to gain the legitimacy needed to speak out about the relatively underexposed problem of sexual violence in the context of conflict and crisis. Indeed, there was tension within MSF regarding the organization's initial imbalance between voice and action regarding sexual violence:

While we are just starting to work on some of these issues, i.e. to provide care to women who were victims of rape, it is indecent for MSF to embark on large pontificating speeches that demand the immediate end of the impunity and universal access to healthcare in a devastated country where the state postpones the resumption of its operations.³³

Over 100,000 victims assisted in ten years: Development of operational support and policies, 2004–2013

Since 2004, MSF has undertaken a yearly inventory of key medical activities in the field. This data collection includes the number of victims of sexual violence treated medically³⁴ in MSF projects; it does not yet include a breakdown according to sex and age, but this is planned for the near future. The data reflected in the *MSF International Activity Reports*³⁵ are strictly defined and only include action that is implemented under the direct responsibility of MSF.³⁶ Over a ten-year period, MSF teams assisted a total of 117,618 victims³⁷ of sexual violence, predominately rape, in sixty-one countries.

Figure 1 shows the number of projects providing care (blue line) and the number of victims who received medical care. It reflects a relatively stable investment over the past ten years.

In the DRC, large numbers of sexual violence victims come forward and the task of helping them comes under the general assistance that MSF provides in situations of conflict and displacement. Elsewhere, the majority of projects with high caseloads (more than 500 cases in one year) were set up specifically with the intention of addressing sexual violence care either as specialized care or as part of HIV or women's health care. These interventions are in post-conflict or stable settings rather than in conflict areas. In the latter, where sexual violence can be expected as part of the general upsurge of violence, few MSF projects apart from those in the DRC have seen a large caseload of victims of sexual violence. Rather than representing the incidence of sexual violence, this shows the difficulty that

33 Jean-Hervé Bradol, "Dossier: l'offre de soins aux femmes", *Messages*, No. 30, May 2004, p. 5.

34 MSF, *Typology Definitions*, internal MSF document, 2010, p. 4.

35 *MSF International Activity Reports* are available at: www.msf.org/international-activity-reports.

36 "All recorded activities should be conducted by MSF teams. In other words, MSF assumes the entire responsibility of the medical act. Medical activities conducted by others (Ministries of Health) through donations or funding should not be considered as an activity." MSF, *Typology Definitions*, internal MSF document, 2005, p. 1.

37 MSF, *International Typology data and MSF International Activity Reports, 2004–2013*, see above note 35.

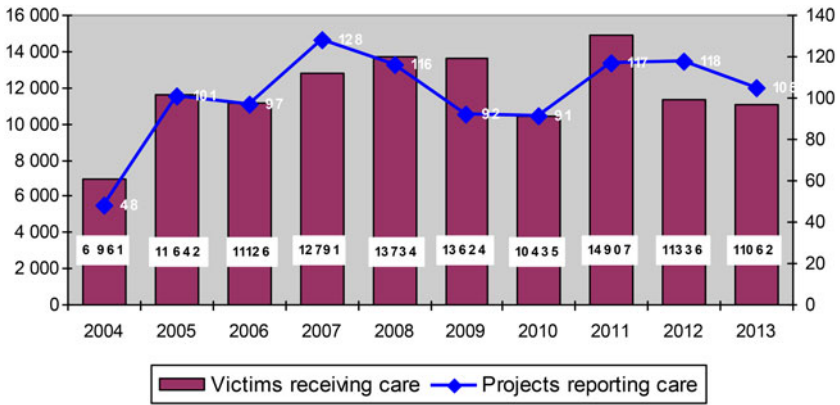


Figure 1. Medical care for victims of sexual violence in MSF projects, 2004–2013. Source: MSF, International Typology data, 2004–2013.

teams have in offering care in conflict settings and the difficulty that victims have in coming forward, be it for lack of access or fear of stigma and retaliation.

Data on the age and sex of victims of sexual violence are generated at project level; variations in age groups are partly due to an effort to adapt to countries’ national data reporting on the issue. What we do know from different reports and studies is that the overwhelming majority of the victims of sexual violence seen in MSF projects are female. Men and boys represent approximately 5%, which, according to other reports is low³⁸ and reflects the additional barriers men may have³⁹ in coming forth to seek assistance. Around half of the victims seen in MSF projects are under the age of 18, with a significant number being young and even very young children.⁴⁰

Ensuring more and better training and guidance for staff

MSF is essentially a “generalist” organization with multiple medical ambitions; care for victims of sexual violence is one of many health needs that MSF responds to as

38 Kirsten Johnson, Jennifer Scott, Bigy Rughita *et al.*, “Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo”, *The Journal of the American Medical Association*, Vol. 304, No. 5, 2010, pp. 553–562.

39 Clayton M. Bullock and Mace Beckson, “Male Victims of Sexual Assault: Phenomenology, Psychology, Physiology”, *Journal of the American Academy of Psychiatry and Law*, No. 39, No. 2, pp. 197–205, April 2011, available at: www.jaapl.org/content/39/2/197.long.

40 MSF, *Final Report: Comprehensive Care Project for Sexual Violence Survivors, Guatemala City, 2007–2012*, 2012, p. 15; Vincent Buard *et al.*, “Characteristics, Medical Management and Outcome of Survivors of Sexual Gender-Based Violence, Nairobi, Kenya”, *Public Health Action*, Vol. 3, No. 2, 2013, p. 110; MSF, *Rapport de capitalization du partenariat MSF Suisse et Sofepadi 2010–2013, Bunia, RDC*, internal MSF document, 2013, p. 28; Jerlie Loko Roka, Rafael Van den Bergh, Sokhieng Au, Eva De Plecker *et al.*, “One Size Fits All? Standardized Provision of Care for Survivors of Sexual Violence in Conflict and Post-Conflict Areas in the Democratic Republic of Congo”, *Public Library of Science*, Vol. 9, No. 10, 2014, p. 3.

part of its assistance to populations in need. Any prepared medical team needs to be able to provide medical care to victims of rape; this cannot rely only on specialists. Other aid actors seem to increasingly opt for specific sexual violence advisers and officers to increase their response capacity. In MSF, the main strength for response is seen in the critical mass of staff that has organized sexual violence care over the past ten years in many different contexts and which allows the increasing integration of care, despite competing priorities and limitations, into all relevant operations, be they emergency response or regular programmes.

Preparing staff to respond to needs arising from sexual violence is increasingly addressed in briefings and training, but a number of other issues are on the list of priorities. MSF policy on sexual violence and related care is not systematically included in relevant trainings and meetings.⁴¹ There are one-week-long sexual violence trainings offered in the field,⁴² and a day session on sexual violence is part of the two-week training for midwives and medical doctors involved in women's health-care projects.⁴³

Since 1999, different MSF projects have documented the approach to sexual violence care, the strategies that were used, and related outcomes. These projects also reflect important efforts made in terms of awareness, both of the problem of sexual violence itself and of the barriers to adequate assistance. Local, regional and international advocacy efforts have contributed to overcoming some of these obstacles in different contexts and to creating an environment for dialogue with national and international actors. This is part of the experience of sexual violence care, and can help to inform teams of its added value – but also of the backlash that can be experienced when taking a public stance on issues as sensitive as sexual violence.⁴⁴

Different operational centres of MSF have developed tools and guidance for sexual violence care.⁴⁵ These practical guides are developed to allow staff with no specific experience to be able to recognize needs related to sexual violence, to organize medical care including patient flow, to manage outreach and public

41 Sexual violence training is generally presented as a part of reproductive health-care sessions. MSF, *Overview SV Related Documents and Tools*, internal MSF document, 2014. Limited e-learning tools are available.

42 In Nairobi for Somali staff, and in Kampala for staff in the region, in 2012; two trainings are forthcoming in 2015 in Kampala and for staff in the Central African Republic.

43 These trainings have included forty to forty-five MSF staff, both international and national, every year since 2008. Debbie Cunningham, *Follow-Up Evaluation of MSF Intersectional Sexual and Reproductive Health Course 2006–2010*, MSF, 2012, available at: http://issuu.com/msfuk/docs/cunningham_srh/1?e=1061369/9715426.

44 In 2005, MSF's head of mission in Sudan was arrested and charged with crimes against the State following MSF's report on sexual violence. See MSF, "MSF Shocked by Arrest of Head of Mission in Sudan – Charged with Crimes against the State", press release, 31 May 2005, available at: www.msf.org/article/msf-shocked-arrest-head-mission-sudan-charged-crimes-against-state.

45 MSF, *Care for Victims of Sexual Violence: Situations with Displacement of Population*, pocket guide, Version 3.0, 2013; MSF, *Sexual Violence: Guidelines for Medical and Psychological Care of Rape Survivors*, 2010 ed.; MSF, *Sexual and Gender-Based Violence: A Handbook for a Response in Health Services Towards Sexual Violence* (internal documents). To facilitate the preparation of teams in the field, a "rape kit" was developed; it includes enough drugs and vaccines to treat fifty adults and twenty-five children.

information, to deal with medical certificates and patient confidentiality, and to record data and monitor activities.

There is agreement on the medical preventive and therapeutic measures that should be offered to any victim of sexual violence approaching MSF for assistance. However, the lack of common implementation guidelines within MSF on why, when, where and how to start specific sexual violence care seems somewhat symbolic of the lack of consensus on the organization's role. The absence of a transversal effort to address sexual violence throughout relevant MSF trainings may be indicative of the subject being overlooked among the organization's priorities.

Challenges in caring for sexual violence victims

Sexual violence as part of conflict is as old as humankind itself.⁴⁶ As an aid organization, however, it is the ten-year delay between the direct exposure to large-scale sexual violence in Rwanda and Bosnia and the implementation of a specific aid response which concerns MSF. Related dynamics have been analyzed closely in MSF and beyond, and several challenges emerge as factors explaining the delay in starting specific care in the first place.

Conflicting priorities are a central challenge that continues to be relevant today, and implementing programmes related to sexual violence remains a particularly difficult task.⁴⁷ The issue obliges humanitarian organizations to rethink their strategies, including their position regarding the provision of contraception and safe abortion care – a situation that might isolate them from the political support they need, notably (but not solely) to obtain funds. Moreover, due to the risk of victims' stigmatization, humanitarian actors need to ensure a sensitive approach, adapted to local possibilities and the cultural environment and able to evolve with the setting.⁴⁸ The issue of sexual violence forces them to assess and study with particular care the environment in which they are working before delimiting their scope of intervention. Several people in MSF have highlighted the technical and ethical challenges inherent in caring for victims of sexual violence, particularly those related to the status of women and the difficulty that staff face in dealing with the sensitivities around sexuality in societies where MSF is called to assist and where the organization's understanding of cultural norms is limited.⁴⁹ Furthermore, the concrete medical needs arising from rape and the way to address the most delicate of these, in a

46 Sylvie Joye, "La femme comme butin de guerre à la fin de l'Antiquité et au début du Moyen Âge", in Marion Trevisi and Philippe Nivet (eds), *Les femmes et la guerre de l'Antiquité à 1918*, Economica/Institut de Stratégie Comparée, Paris, 2010, pp. 91–108.

47 Françoise Duroch, "Violences sexuelles en République Démocratique du Congo: résistances et appropriations institutionnelles par les ONG", *L'Autre, Cliniques, Culture et Sociétés*, Vol. 11, No. 2, 2010, p. 209.

48 F. Duroch, above note 12, p. 3.

49 Rapes directly compete with other priorities that also require action, and predominantly Western teams have a hard time understanding the cultural components involved: phenomena linked to sexuality are a

context where customs and perceptions are relatively unknown, are recognized as important challenges:

All areas dealing with the status of women make us feel uneasy. Speaking to a raped woman about psychological support, what does that mean in Africa? She tells us she needs an abortion. What do we do? We know very well that we will be dealing with difficult questions, which will permanently lead us back to the role of women in society.⁵⁰

Another issue that emerges for MSF – as for other humanitarian actors, particularly emergency organizations – is the difficulty in determining the limits of its role and responsibilities when faced with victims who require medical care, but also assistance and consideration beyond the medical, often in the longer term.⁵¹ The social and cultural perception of rape – as well as its inherently sensitive nature – requires that any medical intervention be undertaken in such a way as not to contribute to harming the victim any further. Victims are often invisible,⁵² as women and particularly men are frequently very reluctant to seek assistance; consequently, reaching them requires a proactive approach. Meanwhile, the structure of operations may make it extremely difficult to maintain victim confidentiality – a major concern, given that the stigma and taboos surrounding sexual violence in many cultures can potentially lead to harm rather than help. The difficulty lies in reaching a justifiable balance between the added value that medical care can have for the victim, both in the short and long term, and the exposure to the social risk that rape-related stigma involves, including the risk of the victim being ostracized.

Finally, a persistent inability within MSF to agree on a common terminology regarding sexual violence seems somewhat symbolic of the varying ambitions that are pursued implicitly and explicitly around the subject. “Rape” describes a specific act of violence; the majority of victims of sexual violence MSF sees are actually victims of rape. “Sexual violence” defines a larger scope of sexual acts and attempts thereof that use force, including coercion,⁵³ and that violate the physical and/or emotional integrity of a person. “Gender-based violence” and “violence against women” emerge from a rights-based concern for gender inequity and for the reduced status of women that allows violence to be committed against them. The term “gender” in this case tends to implicitly exclude concern for male victims of sexual violence, although this is the result of

sensitive point (taboos, discrimination, sensitivity). Joanne Liu and Pierre Salignon, “Victimes de viols, dispositifs de soins”, in M. Le Pape and P. Salignon (eds), above note 4, pp. 112–113.

50 Quote by former MSF France President Jean Hervé Bradol in M. Le Pape and P. Salignon (eds), above note 4, p. 160.

51 Augustin Nallet, “Violence Against Women in Conflict Affected Settings: An Overview of the Policies Designed and Implemented by NGOs”, cited in Françoise Duroch, “Résistance et appropriations institutionnelles des Organisations Non Gouvernementales autour de la notion de violences sexuelles”, Thèse de Sciences de l’éducation, UMR Education et Politique, presented 17 December 2008.

52 Françoise Duroch, “Figures de l’altérité féminine victimaire”, *Science and Video*, No. 2, 2010, available at: <http://scienceandvideo.mmsh.univ-aix.fr/numeros/2/Pages/Duroch.aspx>.

53 WHO, above note 1, Chapter 6, p. 3.

an erroneous interpretation of the term. The term “gender” was promoted through the 1995 Beijing conference in strong association with the subject of women’s empowerment.⁵⁴ “Victim” is the term used in legal documents and procedures,⁵⁵ but “the stigmatization and perceived powerlessness associated with being a victim” was seen as a drawback of the terminology as early as 1995.⁵⁶ “Patient” describes the medical status of a person who has been subjected to an assault, with its related need for medical assistance and the commitment to confidentiality that is due to all patients. Further, the denomination “patient” recalls the medico-legal responsibility of medical practitioners when treating a victim of an assault, which is regulated under most national legislation. Finally, “survivor” is a commonly used term that addresses the above-mentioned concerns regarding stigmatization. Literally, a survivor is a person who has overcome a deadly threat, be it violence, disease or accident, but related to sexual violence the term is often used specifically to honour the strength of an individual and their efforts to heal, and to empower them.⁵⁷ The implications that different terms involve can be in contradiction and can, when used systematically or for the sake of political correctness, lead to misunderstanding regarding the objective pursued. In MSF, this discussion has happened on and off for years, with strong opinions against the systematic use of mainstream language.⁵⁸ For MSF, as a medical and humanitarian actor, the terms “patient” and “victim” seem most appropriate.

Regarding mainstream language, the inherent risk of the near-systematic denomination of sexual violence as a “weapon of war” should be highlighted. This term is often used by international agencies and organizations when referring to large-scale rape in the eastern DRC. Such labelling risks introducing a hierarchy of victims, with priority attention given to those thought to be a result of military practice. In reality, the distinction between sexual violence as a planned military strategy or a tolerated practice amongst armed groups and the

54 The 1995 Fourth World Conference on Women in Beijing marked a significant turning point for the global agenda for gender equality. The Beijing Declaration and the Platform for Action, adopted unanimously by 189 countries, is an agenda for women’s empowerment and considered the key global policy document on gender equality. It sets out strategic objectives and actions for the advancement of women. Available at: www.unwomen.org/en/how-we-work/intergovernmental-support/world-conferences-on-women#sthash.hjeATv8c.dpuf.

55 See, for example, Rome Statute of the International Criminal Court, 17 July 1998 (entered into force 1 July 2002), UN Doc. A/CONF.183/9 (Rome Statue).

56 “The term ‘victim’: Although the term ‘victim’ is used in these Guidelines, the stigmatization and perceived powerlessness associated with being a ‘victim’ should be avoided by all concerned parties. While victims require compassion and sensitivity, their strength and resilience should also be recognized and borne in mind.” UNHCR, above note 10, p. 3.

57 Clark University, “A Definition of Rape, Sexual Assault and Related Terms”, available at: www.clarku.edu/offices/dos/survivorguide/definition.cfm.

58 “It is not worth supporting a mass of political correctness. When I hear MSF in the DRC denouncing ‘rape as a weapon of war’ and at the same time calling the victims ‘rape survivors’, I am baffled by the contradiction. A survivor is someone who exceptionally escaped near-certain death. Often, combatants aim for the large-scale use of rape, as a strategy of terror that wants women to survive, even wants them to become pregnant ... Survival in this case is not the exceptionally happy outcome the term suggests.” Jean-Hervé Bradol, above note 33, p. 5.

sexual violence that occurs in a conflict setting but has no direct relation to military instructions is rarely clear. The label is also highly counterproductive to efforts that seek to reintegrate victims of sexual violence into a social framework of ever-evolving ethno-political alliances in some contexts.⁵⁹

The above challenges, which all contributed to the organization's initial hesitation to engage, continue to be relevant and to influence decisions relating to maintaining and expanding sexual violence care in MSF projects. Experiences in care for victims of sexual violence over the past decade have revealed additional challenges, including the need for continuous efforts to overcome both internal resistance and external factors that stand in the way of adequate assistance to victims of sexual violence.

Challenges related to the organization and acceptance of medical treatment

More than the medical treatment itself, the challenges involved in caring for victims of sexual violence are related to the organization and acceptance of care within the specificities of each context.

For the most part, the medical treatment of victims of sexual violence, particularly rape, is straightforward. There are cases, however, where the trauma inflicted is so extreme that intensive care and emergency surgery are required and reparative surgery may be necessary to avert long-term suffering from traumatic fistula.⁶⁰ For most victims of sexual violence, however, medical care consists of a set of basic curative and preventive measures, which can be provided in any prepared health facility – but there are a number of technical and ethical challenges involved. Without this care, rape can lead to important short- and long-term health consequences.

Timely medical assistance

MSF will assist any victim of sexual violence, even if the assault took place a long time ago. Coming forward and speaking about the event is important, even months or years afterwards. Vaccinations against tetanus and hepatitis B⁶¹ will be relevant for months after the assault, and treatment of some STIs can prevent significant long-term health consequences. The potential of some preventive measures is, however, limited to the first few days after the assault. PEP for the prevention of HIV infection has to begin within seventy-two hours of the assault, and although emergency contraception can be offered up to 120 hours after the

59 Véronique Moufflet, "Le paradigme du viol comme arme de guerre à l'Est de la République démocratique du Congo", *Afrique Contemporaine*, Vol. 3, No. 227, 2008, pp. 119–133, available at: www.cairn.info/revue-afrique-contemporaine-2008-3-page-119.htm.

60 A medical condition in which trauma leads to the development of a hole between the vagina and bladder and/or rectum, resulting in chronic incontinence among other issues.

61 MSF, *Medical Protocol for Sexual Violence Care*, 2nd ed., MSF Reproductive Health and Violence Care Working Group, internal document, 2014, p. 2.

event, it is most effective in the first seventy hours; after this, the success rate halves. Even in established programmes where MSF works specifically on sexual violence, not all and sometimes not even half of the victims come within seventy-two hours of the assault. This was observed as early as the initial Brazzaville intervention⁶² and remains valid today.⁶³

Adherence to treatment and follow-up

Another challenge is adherence to prophylactic treatment and vaccination schedules. PEP to prevent HIV infection as a result of rape requires a twenty-eight-day regimen of a triple therapy of antiretroviral drugs.⁶⁴ Studies from different MSF projects providing sexual violence care confirm compliance with the full treatment in around half of patients. Some patients may finish their treatment but do not come back for follow-up; their compliance cannot be confirmed by MSF.⁶⁵ Vaccination against tetanus and hepatitis B infection poses a similar problem: several doses are necessary to achieve adequate protection, but few patients come for follow-up.⁶⁶

The additional exposure to risk that follow-up visits can involve needs to be taken into account: the risk related to the stigma of being identified as a patient going to a health facility that offers sexual violence care, and the risk that is inherent in breaching geographical distance in many of the contexts where MSF works and which involves potential attack, robbery and rape. Coming to follow-up consultations requires patients to weigh the balance of risk and benefit, and often patients seem to err on the side of caution.

Prevention and management of unwanted pregnancy

A girl or woman who has been a victim of sexual violence may want to know whether she fell pregnant as a result of the rape or whether she was pregnant at the time of the rape, especially if she is considering terminating the pregnancy or putting the child up for adoption. A pregnancy test and emergency contraceptives are routinely offered to female victims of rape.⁶⁷ In projects where MSF cares for victims of sexual violence, a large number of the girls and women at risk of

62 E. Chazal, G. Fadida and C. Reynaud, above note 23, p. 5.

63 MSF, *Hidden and Neglected: The Medical and Emotional Needs of Survivors of Family and Sexual Violence in Papua New Guinea*, 16 June 2013, p. 1818, available at: www.doctorswithoutborders.org/sites/usa/files/06-15-Papua-New-Guinea-Sexual-Domestic-Violence%20report.pdf; Katie Tayler-Smith, Rony Zachariah *et al.*, "Sexual Violence in Post-Conflict Liberia: Survivors and Their Care", *Tropical Medicine and International Health*, Vol. 17, No. 11, 2012; MSF, *Final Report*, above note 40, p. 24; J. Loko Roka *et al.*, above note 40, p. 4.

64 MSF, above note 61, pp. 5–6.

65 Patients came back for follow-up consultation and completion of treatment was confirmed. Other patients may have completed, but did not return for a follow-up consultation. K. Tayler-Smith *et al.*, above note 63, p. 3158; MSF, *Final Report*, above note 40, p. 27.

66 V. Buard *et al.*, above note 40.

67 MSF, *MSF Policy for Reproductive Health and Sexual Violence Care*, final version, International Working Group on Reproductive Health and Sexual Violence Care, internal MSF document, March 2014.

pregnancy following rape accept the offered emergency contraception.⁶⁸ Most countries make specific allowances for the use of emergency contraceptives, generally and in the case of rape;⁶⁹ only exceptionally is the use of emergency contraceptives challenged in case of rape, and this situation then requires particularly careful handling by the teams.⁷⁰

Much more challenging is the question of abortion, where opposing forces include legal, religious and cultural dynamics. The first draft for field-testing of the *Clinical Management of Rape Survivors* guide elaborated by the World Health Organization in 2001 alludes to the problem of unwanted pregnancy as a result of rape and the need for safe abortion care. The guidelines seem to propose a compromise between political acceptance and medical needs, recommending that women be referred to safe⁷¹ and legal⁷² abortion services –in light of the lack of such services in many contexts, this continues to be a correct but impractical statement. The guidelines add:

Where safe abortion services are not available, women with unwanted pregnancies may undergo unsafe abortions. These women should have access to post abortion care, including emergency treatment of abortion complications, post abortion family planning counselling, and linkages to other reproductive health services.⁷³

Not much has changed in international guidance; in general, the legal directive rather than women's needs are stated as the reference frame determining the availability of safe abortion care. The specific provisions and restrictions coming from some donors⁷⁴ present a significant additional barrier for many organizations and agencies in their efforts to adequately address the need for safe abortion care.

Emergency contraceptives are only an effective measure against pregnancy in the first 72 hours after an assault. MSF sees women who arrive weeks or months after a rape with an advanced pregnancy, and who request termination. Provision of safe abortion care is part of MSF's medical protocol for sexual violence care⁷⁵ based on the medical and human needs of patients,

68 MSF, *Hidden and Neglected*, above note 63, p. 21; MSF, *Final Report*, above note 40, p. 29.

69 Center for Reproductive Rights, *Governments Worldwide Put Emergency Contraceptives in Women's Hands: A Global Review of Laws and Policies*, briefing paper, September 2004, available at: <http://reproductiverights.org/en/document/governments-worldwide-put-emergency-contraception-into-womens-hands>.

70 Anastasia Moloney, "No Option to Unsafe Abortion for Many Rape Victims in Honduras – MSF", Thomson Reuters Foundation, September 2014, available at: www.trust.org/item/20140909174405-khgtc/.

71 WHO, *Clinical Management of Rape Survivors*, 2001, p. 23.

72 This includes "[c]ountries where abortion is otherwise illegal [but where] pregnancy termination is allowed after rape". WHO, *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, 2003, p. 66.

73 WHO, *Outcome of the Inter-Agency Lessons Learned Conference: Prevention and Response to Sexual and Gender-Based Violence in Refugee Situations – Draft for Field Testing*, Geneva, 27–29 March 2001, p. 19.

74 On US funding, see Louisa Blanchfield, *Abortion and Family Planning-Related Provisions in U.S. Foreign Assistance: Law and Policy*, Congressional Research Services, 31 January 2014, p. 3.

75 MSF, above note 61, p. 14; *MSF International Activity Report 2013*, p. 19, available at: www.msf.org/international-activity-report-2013-addressing-women%E2%80%99s-health-needs.

whenever feasible. Despite ongoing efforts to expand safe abortion care and independently of the legal framework which often makes allowances for specific circumstances (incest, rape, etc.),⁷⁶ ensuring care for all women and girls in need continues to be a challenge and is still not offered in all relevant MSF projects.⁷⁷ Religious, cultural and social dynamics in many contexts continue to render abortion unacceptable and stigmatizing, for women, communities and even for some health staff.

Caring for children

A number of MSF projects have reported that around half or sometimes more than half of the victims of sexual violence are children, including very young children.⁷⁸ Caring for children presents additional challenges, such as treatment protocols, the need for drugs in syrup form rather than pills and, more importantly, dealing at times with severe physical and psychological trauma. It is important that staff are at ease with children and can make them feel safe, and to ensure this, specific preparation of staff may be required. Often, however, immediate challenges are less related to the treatment itself; they are related to the child's safety, to the risk of future aggression and to the natural desire to protect the child.

This is particularly relevant as MSF's first project in Brazzaville already noted an increasing percentage of children among the victims of sexual violence in the post-conflict phase, and a shift to an increasingly complex domestic environment in which the future exposure of children to violence was a growing concern.⁷⁹ Similar situations have been observed in other MSF post-conflict situations, such as Burundi and Liberia, and MSF programmes with a specific focus on violence, like those in Papua New Guinea, Guatemala and Honduras. In a number of these MSF projects, the majority of the perpetrators are known to the victim and the assault happens in the home or close vicinity.⁸⁰ The question of the protection of the child becomes an inevitable one, but there are no ready-made answers. It seems that none of the alternatives are good: sending the child back to family or community and the known aggressor or exposing the child to an unknown environment, separated from family and community, and which may also then harbour risk of violence and abuse. For a medical team to see the same child over and over again, to treat the results of abuse a second and a third time without wanting to do something to protect the child, is impossible. In many contexts the capacity for MSF to contribute to an acceptable solution is, however, very limited.

76 UNFPA, *World Abortion Policies*, 2013.

77 MSF, *Reproductive Health and Sexual Violence Care in MSF*, activity report, 2013.

78 MSF, *Hidden and Neglected*, above note 63, p. 17; MSF, *Final Report*, above note 40, p. 16; K. Tayler-Smith *et al.*, above note 63, p. 1358; V. Buard *et al.*, above note 40, p. 110.

79 MSF, *Civilians Under Fire: Humanitarian Practices in the Congo, 1998–2000*, available at: www.doctorswithoutborders.org/civilians-under-fire-humanitarian-practices-congo-1998-2000.

80 K. Tayler-Smith *et al.*, above note 63, p. 1358; V. Buard *et al.*, above note 40, p. 110; MSF, *Hidden and Neglected*, above note 63, p. 16.

Caring for men

How to adequately respond to the needs of male victims also poses a great challenge,⁸¹ as the taboo around the subject remains huge, both for victims and for their families, and even for doctors and humanitarian workers.⁸² Sexual violence stays largely invisible due to the attached stigma, especially when committed against men.⁸³ Some polemics⁸⁴ have questioned whether MSF structures and the provision of care are well adapted to this type of patient: “One problem with the exclusive focus on sexual violence is that it tends to downplay the ways in which sexual violence is not only (or simply) – as sometimes suggested – a war against women or a ‘systematic pattern of destruction toward the female species’.”⁸⁵

Trauma, fear and guilt: The role of psychological support

The deepest wounds for a sexual violence survivor are often the ones that are invisible, with the trauma having long-lasting effects on a person’s ability to function and carry on with their lives. Psychological care is therefore part of MSF’s overall sexual violence care, and aims to reduce the impact of trauma related to the violence.⁸⁶

A baseline study that MSF undertook in 2011 in Mbare, Zimbabwe, in order to prepare a sexual violence response showed that 71% of people interviewed in the community acknowledged that psychological problems were one of the consequences of sexual violence.⁸⁷

In conflict and emergency situations, or within highly insecure contexts, providing psychological care can be a challenge. Teams are overwhelmed with work, or staffing may be reduced for security reasons, limiting the focus to life-saving activities. Space, together with language barriers, can be a constraint to adequate privacy and confidentiality for medical examinations and counselling. It is not only the knowledge of vocabulary but also the comprehension of different metaphoric

81 K. Johnson *et al.*, above note 38, pp. 553–562.

82 Wynne Russell, Alastair Hilton and Michael Peel, *Care and Support of Male Survivors of Conflict-Related Sexual Violence*, Sexual Violence Research Initiative Briefing Paper, 2011, available at: www.svri.org/CareSupportofMaleSurviv.pdf; Will Storr, “The Rape of Men: The Darkest Secret of War”, *The Observer*, 17 July 2011.

83 W. Russell, A. Hilton and M. Peel, above note 82, p. 4.

84 Marc Le Pape, “Viols en temps de guerre, les hommes aussi”, *Issues de secours* (blog of *Libération*), 1 November 2011, available at: <http://humanitaire.blogs.liberation.fr/msf/2011/12/-viols-en-temps-de-guerre-les-hommes-aussi-.html>.

85 Maria Eriksson Baaz and Maria Stern, *The Complexity of Violence: A Critical Analysis of Sexual Violence in the Democratic Republic of Congo (DRC)*, Nordiska African Institutet, Sida, 2010, p. 43.

86 Sarah Hustache, Marie-Rose Moro *et al.*, “Evaluation of Psychological Support for Victims of Sexual Violence in a Conflict Setting: Results from Brazzaville, Congo”, *International Journal of Mental Health Systems*, Vol. 3, No. 7, 2009, available at: <http://link.springer.com/article/10.1186%2F1752-4458-3-7#page-1>.

87 MSF, *Baseline Study Report on the Perception of Sexual and Gender-Based Violence in Mbare, Harare, Zimbabwe*, 2011, p. 14.

terms used to describe anything related to sexuality, and also applying the description of rape, that may cause problems. A translator may or may not be able and willing to understand and transmit the subtlety of exposed information and implications related to different social norms. Also, when working with translators, there is a degree of uncertainty as to the attitude that is displayed towards victims. Another (sometimes self-imposed) barrier can be the lack of expertise (or self-perceived expertise) needed to address psychological needs: “At times the medical care giver feels helpless when there is no psychologist in the project. This may lead to him/her avoiding the emotional aspect of caring for victims of sexual violence as it is considered too specialized.”⁸⁸

Psychological support is an integral part of the medical consultation of any victim of sexual violence; the dialogue with the patient aims to understand the circumstances of the assault and the specificities of the patient’s situation in order to propose the most adapted treatment approach and counselling. Compassionate listening and a respectful professional attitude towards the patient, as well as privacy and the assurance of confidentiality, are the bases for patients’ trust and willingness to share.

Often, the initial medical visit will be the only opportunity to assist the victim; though the figures differ depending on context, in general few patients come for follow-up visits. Reinforcing the skills of medical staff to ensure “psychological first aid” as part of the immediate care for victims of sexual violence is therefore a priority and is included in the majority of MSF projects.⁸⁹ That said, while data show low return rates of victims for follow-up sessions, MSF has not ventured into assessing the psychological support needs that victims may experience in the longer term. These may well manifest months or years after an assault, affecting emotional, sexual and physical well-being and requiring specialized follow-up and care at that time. The degree to which MSF could assist in the longer term requires further reflection and will depend largely on the context.

Medical examination and treatment: A patient’s choice

It is a legal and ethical principle that medical staff should seek patients’ valid consent before starting any kind of physical examination or medical intervention. This includes the medical examination of victims of sexual violence.⁹⁰ Medical staff who conduct examinations without the patient’s prior consent can be charged for assault in some contexts, and in some jurisdictions the results of an examination conducted without prior consent cannot be used in legal proceedings.⁹¹

88 D. Lagrou, above note 13, p. 41.

89 Experiences from different MSF projects seem to indicate that only a small number of patients require more specialized counselling than the “psychological first aid” that is part of the victim’s initial medical consultation. “Characteristics, Medical Management and Outcome of Survivors of Sexual Gender-Based Violence, Nairobi, Kenya”, *Public Health Action*, Vol. 3, No. 2, 21 June 2013, p. 111.

90 MSF, *Medico-Legal Issues: Case Management of Victims of Sexual Violence: Care and Protection*, internal MSF document, 2014, p. 3.

91 WHO, above note 72, p. 34.

Obtaining informed consent from a patient requires explaining all aspects of the consultation to the patient⁹² and asking for agreement to proceed. It requires ample time to put the patient at ease, to explain what is going to take place in understandable terms, to listen to the patient and to understand her/his needs and reactions. Consent of minors is particularly challenging; establishing the legal responsibility of an adult over a minor needs to be assessed case-by-case with the best interests of the child in mind.

Ensuring confidentiality: A long-term commitment

As a medical humanitarian organization, MSF's actions are driven by solidarity with individuals affected by conflict and crisis: the most vulnerable, the excluded, the victims of violence. Medical assistance is primarily an individual action, a "patient–medical staff" relationship based on a commitment that the assistance given will directly benefit the patient. It is this implicit promise and the related obligations to act at all times in the best interests of the patient and to preserve their confidentiality that are the foundation of trust which may motivate patients to come forward and seek assistance.

Medical confidentiality is a transversal notion to the whole process of medical care, but it is especially complex in relation to sexual violence. Considering MSF's contexts of intervention and activities, challenges are multiple with regard to the organization and identification of medical services, the flow of patients, communication and advocacy efforts, outreach and patient tracing activities, patient referral, and networking with other aid actors or authorities.

First, considering that the issue of sexual violence is heavy with stigma, privacy is a precondition for ensuring medical confidentiality, which is difficult to implement in some contexts – particularly emergency interventions, as already pointed out above. The sensitive nature of photographs, especially in a world of global communication,⁹³ adds to the challenge. Victims are increasingly anonymized as a means to ensure confidentiality, but also due to society's discomfort with the subject. The flip side of this preoccupation is underexposure, which does not permit victims to see their own resilience through voluntary and public exposure.

The second aspect of confidentiality is related to documentation and requires specific procedures, as well as a person in charge of the proper management of sensitive files.⁹⁴ MSF keeps a copy of each certificate available to each patient, and so that it can validate or invalidate the authenticity of a medico-legal certificate presented by a person as part of a criminal pursuit and/or compensatory claim.⁹⁵

92 *Ibid.*, p. 34.

93 Laure Wolmark, "Portraits sans visage, des usages photographiques de la honte", *Science and Video*, No. 2, 2010, available at: <https://scienceandvideo.mmsh.univ-aix.fr/numeros/2/Pages/Wolmark.aspx>.

94 MSF, *Be Prepared: 10 Steps* and "5 Step 2014 Analysis, Operational Center Amsterdam", internal MSF documents.

95 MSF, above note 90; V. Buard *et al.*, above note 40, p. 1357.

Thirdly, certain countries impose an obligation to report sexual violence to local authorities or the police.⁹⁶ This leads to the dilemma of medical confidentiality versus the fight against impunity.⁹⁷ Despite many obstacles that make victims unwilling or unable to seek justice,⁹⁸ important efforts of governments and international agencies focus on the fight against impunity. To this end, it is important that victims are identified and encouraged to file their cases. In the DRC, the identification of victims was sought by approaching medical facilities and requesting the patient files of victims of sexual violence. The resulting threat to patient confidentiality prompted MSF to call on the United Nations, saying that “[t]he UN strategy has to ensure a strict separation of roles, both in their attribution and in the way the medical and juridical roles are perceived amongst victims, perpetrators and the population at large”,⁹⁹ as the increasing political drive for the elimination of impunity may impact on the capacity to offer direct, independent and confidential medical care to victims. In several MSF projects in the DRC, staff now refuse to sign certificates because of threats and the potential legal obligations. From MSF’s perspective, it is not trivial to put one of its staff through a national or international judicial process, not only due to security risks but also due to the dangers of political repercussions; furthermore, the act of testimony is a delicate practice that few people are comfortable with.

Finally, confidentiality is a concern when working with local organizations. MSF’s assistance to victims of sexual violence requires forging relations with local actors, women’s groups and social and legal entities in order to create referral options that may address the needs of victims to which MSF has no or limited response. Within the communities associated with opposing parties to a conflict, the use of sexual violence is often endorsed as a statement of condemnation of the adversary and the resulting polarization requires MSF to seek dialogue and working relations with diverse organizations in order to safeguard independence and the capacity to assist all victims, independently of their chosen or perceived alliance.

96 MSF, *Lessons Learned: MSF’s Projects Working on Violence in Urban Settings*, internal MSF document, 2011 p.6.

97 United Nations Joint Human Rights Office, *Progress and Obstacles in the Fight against Impunity for Sexual Violence in the Democratic Republic of the Congo*, 2014, available at: www.monusco.unmissions.org/LinkClick.aspx?fileticket=Gyh_dUBNGcs%3D&tabid=10770&mid=13783&language=en-US.

98 As confirmed by internal MSF reports in the DRC, victims may be reluctant to report the attack to the authorities, often because of fear of reprisals or lack of trust in the judicial and penitentiary system – reinforced by the not uncommon prospect that the perpetrator will escape prison. Geographical distance and the perception of long and difficult judicial procedures (and even fruitless ones – see the recent *Minova* case) can also be strong disincentives.

99 UN Human Rights Council, “Human Rights Council Holds High-Level Dialogue on Combatting Sexual Violence in the Democratic Republic of the Congo”, 25 March 2014, available at: www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=14435&LangID=E#sthash.jVEwL4wl.dpuf. The MSF statement was read during the Human Rights Council session in Geneva on 25 March 2014 (internal document).

The legal framework around sexual violence

The legal framework around sexual violence and its related consequences has implications for MSF's capacity to provide timely and adequate medical care. As mentioned above, laws regarding consent, medico-legal obligations, abortion, police involvement or the obligation to denounce, to name only a few, may represent a barrier to offering care to an individual who has been subject to aggression, rather than ensuring his/her protection.

Since the beginning of MSF's involvement in sexual violence care, much effort has been put into developing medico-legal documents and guidance regarding legal proceedings. General guidance cannot, however, respond to the specific situations and needs of each patient, and therefore a legal department in MSF ensures that case-by-case analysis and support is available.

With regard to the medico-legal obligations, the medical care of a victim of sexual violence requires the preparation of a medical certificate under the law of most countries,¹⁰⁰ where a template of such a certificate is usually available. MSF provides medico-legal certificates for all victims of sexual violence,¹⁰¹ including in emergencies.¹⁰²

Amid conflict-like situations, legal systems may collapse, leaving crimes unpunished; a medico-legal certificate can allow a person seeking legal action to provide evidence even years after the assault.¹⁰³ Experience from the RC shows the potential value that medical certificates have in legal proceedings; nine out of ten of the medical certificates produced by MSF and used by victims in court were admitted by the judge.¹⁰⁴

The justification for collecting patient data

For MSF, collecting patient data is part of the daily routine of medical staff. For victims of sexual violence, information is needed in order to provide adequate medical treatment and also to address potential needs for protection of the patient and for the purpose of the medico-legal certificate.

Basic information includes personal data (name, age, address) and when the assault took place, in order to establish the relevance of PEP and emergency contraception. Further information is required to guide the approach towards dealing with potential HIV infection and pregnancy. Both subjects involve a

100 MSF, above note 90.

101 The medico-legal certificate states the patient's account of the assault, including all elements that may prove relevant (e.g. time, place, characteristics of the aggressor/s), as well as the findings of the medical examination and related treatments of physical and mental injuries. It is important to note that the information on the assault is a transcript of the patient's account; medical practitioners have no role whatsoever in judging its veracity.

102 MSF pocket guide, above note 45, Sheet 20, "Need to Establish a Medico-Legal Certificate".

103 For crimes under the jurisdiction of the International Criminal Court, statutes of limitations do not apply. See Rome Statute, Art. 29; see also UN Res. A/RES/2391 (XXIII), Convention on the Non-Applicability of Statutory Limitations to War Crimes and Crimes against Humanity, 26 November 1968, Preamble.

104 E. Chazal, G. Fadida and C. Reynaud, above note 23, p. 26 (our translation).

number of delicate questions: “Was there penetration? Were you bitten or did you bite the aggressor? Do you know your HIV status? Have you already had your period? Are you sexually active? Are you pregnant? Do you want to prevent potential pregnancy?”, and so on.

Information is required for the treatment approach, for the medico-legal certificate; as part of collective data, such information serves programme management purposes like medical supply management, staffing, location and opening hours of the clinic and the potential need for additional care sites. Finally, information on specific vulnerability of victims and the alleged aggressor’s characteristics may be sought as a means to identify potential individual protection needs and as a potential contribution to preventive efforts – for example, changing the location of water and wood for collection and providing recurrent facts regarding assaults to local or international protection forces.¹⁰⁵

The amount of questions addressed to one patient in the first consultation after a sexual assault can be overwhelming and can potentially alienate the patient and jeopardize the establishment of trust. Actors involved in providing assistance to victims of sexual violence do so with very different objectives in mind; from this emerges a demand for all organizations to contribute sexual-violence-related data on a large range of questions. For MSF, the central objective is the medical care of victims in order to avert the short- and long-term consequences of rape and to help victims recover. Information sought by MSF from individual patients and the corresponding analysis should focus on doing this more effectively.¹⁰⁶

Conclusion

Ensuring care for victims of sexual violence as part of MSF’s general assistance to populations affected by conflict and crisis has represented a considerable institutional struggle and continues to be a challenge. Some resistance within the organization may be seen in relation to the charged nature of the issue, which is at the crossroads of personal opinions and subconscious attitudes regarding the status of women, the notion of violence and the sexual character of this particular type of violence.

Over the past ten years, MSF has garnered important experience from the medical care provided to almost 118,000 victims of sexual violence, primarily victims of rape. This experience reflects limits in the organization’s capacity as

105 A central component of the UN’s strategy for preventing conflict-related sexual violence is addressing impunity and identifying perpetrators. Different resolutions outline related calls for timely and detailed information on assaults and perpetrators. The efforts to compile a database shared among agencies are another example of the drive for data related to sexual (and gender-based) violence. See Gender Based Violence Information Management System (GBVIMS) Steering Committee, “Overview of the GBVIMS”, Version 14, 2010, p. 1.

Claire Magone, “Collecting Data on Sexual Violence: What Do We Need to Know? The Case of MSF in the Democratic Republic of Congo”, *Humanitarian Exchange Magazine*, No. 60, February 2014, p. 20.

106 *Ibid.*

well as in the victims' acceptance of sexual violence care in the contexts where MSF works. Large caseloads of patients seeking care for sexual violence are seen more frequently in the projects MSF runs in post-conflict settings and in projects responding to urban violence. In the midst of emergencies and conflict, MSF's capacity to assist victims of sexual violence remains, with the exception of the DRC, limited. In these contexts, where MSF strives to address numerous competing needs, sexual violence is often not amongst the immediate priorities, which focus, in general, on actions with a direct impact on mortality.

In addition to the contextual constraints, the invisibility of patients and the need for a proactive approach, as well as the practical and ethical challenges involved in care for victims of sexual violence, all contribute to teams' difficulty in providing adequate and timely care. Where care is offered, the impact of medical treatments is limited; only half of the victims come in time to allow protective measures against HIV infection and unwanted pregnancy, and only some patients return for medical and psychological support follow-up.

Also, victims of sexual violence require more than medical assistance; protection, prevention and legal pursuit are the responsibility of national governments and need international support. But efforts to end sexual violence and related impunity need to be developed in complementarity to medical assistance, and must at all times safeguard and promote the capacity to provide direct, independent and confidential medical care. Further, victims excluded from family and community as a consequence of rape and those in danger of continuous assault and violent repercussions require psychosocial support and protection. These areas of assistance tend to be underserved in general and more so in the middle of a crisis; the benefit of medical care in those cases may be overshadowed by the forsaken perspectives of the victim. When other aid actors are present, be they local or international, it is necessary for MSF to seek collaboration and dialogue with both non-aligned actors and those aligned with the opposing powers in order to facilitate support to all victims in need.

The specific challenges related to care for victims of sexual violence accentuate the general difficulties that MSF faces in providing medical care to populations in crisis, because national laws and powers (State, Church or common perception) may create additional barriers for victims to access care and for care providers to be able to respond fully to the medical needs of victims of sexual violence, including those related to unwanted pregnancy.

MSF continues to struggle with the limits of its role: while the provision of medical care remains a central commitment, the specific difficulties arising from the criminal nature of rape, in legal, political and security terms, cannot be ignored. The potential instrumentalization of the subject of rape and related assistance – for a variety of purposes, including human rights in general, the status of women and the dynamics of conflict – presents a constant challenge. Finally, the multiple unmet needs of victims, beyond medical care, have to be acknowledged. The response to such needs often surpasses MSF's capacity and legitimacy, but few other actors seem to step up with concrete measures. Internally, the degree to which MSF engages in different contexts and at different

times in advocacy, prevention and protection efforts is subject to debate, differences and tensions.

Sexual violence care is one of many health needs that MSF aims to address; often, MSF teams are generalists with multiple medical-humanitarian ambitions. Guidelines, trainings and tools cannot replace the need for continuous investment and reflection at all levels of the organization; the main challenges MSF encounters are those inherent to each context, and they change over time. Sexual violence is often part of a larger dynamic of violence, be it during conflict, in post-conflict settings or in stable areas impacted by poverty, precarious living conditions and exclusion. Any assistance is ultimately faced with the complex social dynamics out of which sexual violence is born and with respect to which MSF, as an external actor, is in a delicate position.

MSF will need to continue challenging the limits of the organization's role and actions in order to expand medical care for victims of sexual violence to all relevant contexts and particularly in conflict settings, but will also need to remain vigilant to the risks of instrumentalization and strive to maintain independence from the political pursuits of national and international powers, however promising they may appear.