Creating safe spaces: lessons from South Africa and Burundi

by Christine Lebrun and Katharine Derderian

Médecins sans Frontières (MSF) Belgium currently addresses sexual and gender-based violence (SGBV) in many of its projects worldwide, in countries including South Africa, Burundi, Liberia, Sierra Leone, Ivory Coast, Sudan, Chad, Rwanda and Colombia. Two of our most successful interventions are in South Africa and Burundi.

South Africa has one of the highest incidences of rape in the world. It is estimated that one person is raped every 26 seconds. In Khayelitsha, a township of around 500,000 people close to Cape Town, the incidence of rape is one of the highest in the country. Since 2003, MSF has supported the Simelela Rape Survivors Centre in Khayelitsha.[1] We work in partnership with provincial health and social service professionals, the police and a local organisation specialising in rape crisis work. Simelela offers medical, psychological and social care, including post-exposure prophylaxis (PEP) for preventing HIV,[2] liaison with the police and monitoring of patients. In 2005, MSF expanded activities to include forensic examinations and increased its hours to 24 hours a day, seven days a week, to respond to the need for services. In one month alone, Simelela's staff assisted more than 130 rape victims, about half of them children under the age of fourteen.

Women at MSF project in Burundi

In response to rape and war-related sexual violence, MSF opened Seruka health centre[3] for women in Bujumbura, Burundi, in 2004. Starting such a project was not easy in a country where the term 'rape' itself does not exist in the local language. To avoid stigmatisation, the centre offers a range of women's health services, including family planning, care for sexually transmitted infections and care for victims of SGBV. Patients receive medical follow-up for six months, as well as psychosocial support. MSF's social workers refer patients to other NGOs and local community groups who can provide ongoing assistance and guide victims through legal proceedings and contacts with the authorities. Every month more than 100 women overcome the taboos surrounding sexual violence to make their way to the clinic.

In our experience, the key to the success of the SGBV projects in South Africa and Burundi lies in ensuring that all services – medical, psychosocial and legal – are accessible to patients through the same facility. But challenges and questions remain.

SGBV programmes seem to work best in post-conflict or non-conflict contexts – a trend best exemplified by our project in Burundi, which gained significant momentum once the civil war began to subside. During a conflict, rape victims have additional concerns about security or repercussions in a chaotic environment characterised by violence and impunity. In such a context, SGBV represents one of many kinds of violence and mere survival may be seen as a more immediate priority.

Even if services are available, sometimes rape victims do not make use of them (both in conflict settings and beyond). This can be due to lack of absolute confidentiality and privacy within a medical facility. In addition, acknowledgement of rape can have repercussions within the family, such as rejection or divorce, and wider social consequences of stigmatisation and economic marginalisation. The political and legal system can represent a hurdle, especially when extensive bureaucracy and contact with a proliferation of different authorities are required in order to report and file suit for rape. In some conflict areas, there are no authorities available to document violence or to provide legal recourse. National authorities can play a key role in facilitating SGBV projects simply by recognising that SGBV is an issue and enabling medical services or agencies such as MSF to respond.

To encourage women to consult medical services after SGBV, MSF focuses on communicating simple 'information-education-communication' (IEC) messages, emphasising the urgency for and availability of PEP against HIV infection within 72 hours after exposure. MSF reinforces these

messages by promoting awareness of SGBV and the availability of PEP among its own national staff, patients and other local organisations.

Where rape victims seek care outside conventional health structures, with midwives or traditional birth attendants (TBAs), MSF is starting to liaise more closely with them. TBAs can tell victims about the availability of PEP and refer SGBV cases to MSF health structures. In Sudan, MSF is considering employing qualified TBAs as community health workers, both to better reach out to rape victims and to encourage TBAs to liaise with MSF facilities without fear of losing income from their own patients.

Which approach – horizontal or vertical?

MSF combines both approaches. Where we identify a specific, acute problem of violence, we adopt a 'vertical' programme specifically addressing SGBV. In our experience, this works best using a comprehensive approach – providing medical care within a framework including IEC, psychosocial support, legal assistance and liaison with other women's organisations who can provide continued material and social support.

In contexts without acute problems of violence, MSF employs a horizontal approach. SGBV is part of all our healthcare programmes globally – over 35 projects worldwide. The challenge for horizontal programmes is that SGBV becomes just one issue of many faced by medical staff in their hectic day's work. The impact of stigmatisation makes it all the more difficult for SGBV to be handled in a general medical structure. One way that MSF counters this problem is by establishing 'safe spaces' in every health structure, where women can speak about their health questions and about SGBV with the assurance of full privacy and confidentiality. MSF would ideally like to open separate women's clinics in all its projects, if availability of female medical staff allows it.

As MSF's main expertise is medical, both horizontal and vertical approaches rely heavily on the presence of others who can assume responsibility for psychosocial, legal and material/economic follow-up. Due to the complexities inherent in these contexts, legal assistance is often lacking. To truly respond to SGBV, international and national actors must demonstrate political will to invest significant financial and human resources in all these inseparable and indispensable dimensions of care for victims of sexual violence.

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1. For more information, see www.msf.org.au/stories/twfeature/2006/129-twf.shtml
2. In the case of HIV infection PEP is a course of antiretroviral drugs which to be effective must be started as soon as possible – and certainly no longer than 72 hours – after risk of exposure.
3. See www.msf.org/msfinternational/invoke.cfm?component=article&objectid=14FF2307-A697-4FA9-8CD375699378AB1B&method=full_html