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. 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, 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.

In response to rape and war-related sexual violence, MSF opened Seruka health centre 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.

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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.

**Uganda: early marriage as a form of sexual violence**

by Noah Gottschalk

Evidence is mounting that early marriage is a form of sexual and gender-based violence (SGBV) with detrimental physical, social and economic effects. Policymakers need to focus on the complex interactions between education, early marriage and sexual violence.

Uganda currently hosts at least 230,000 refugees, the vast majority of them southern Sudanese. With very few exceptions, only refugees living within designated settlements are officially recognised and offered protection and assistance. Refugees receive seeds, tools and small plots of land on which to grow their own food, which government and UNHCR officials expect will supplement or replace rations, with any surplus sold to earn money to meet basic needs including the cost of schooling. Refugees adopt a lifestyle similar to Uganda’s rural poor but with several crucial differences. Years of cultivating the same land – without the possibility of crop rotation – have reduced soil fertility and yields. Moreover, refugees are generally unable to take their products to market and thus depend on Ugandan middlemen who buy cheaply from individual households and sell goods in urban markets for significant profits.

Early marriage is often seen as a survival strategy by those unable to move from these isolated settlements, forced to depend on subsistence farming and trapped in poverty. Some girls hope to enjoy greater economic security if married. For their parents the brideprice can be an important financial asset. Many parents also view early marriage as the best – and often only – means of safeguarding their daughters from the high levels of SGBV prevailing in Uganda’s refugee settlements. Officials often ascribe early marriage to cultural preferences but it is clear from talking with refugees themselves that motivations of economic and physical security, often linked to basic survival, are more important determinants.