

MSF
November 2019

Nowhere to go

Challenges faced by
sexual violence survivors in
accessing services in Bangui,
Central African Republic



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survivors in accessing services
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Tatiana was held imprisoned by armed men in her hometown of Bambari after her husband was killed. She was raped over the course of several days until she was able to flee to Bangui. She received treatment at the MSF clinic for several months.

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Introduction

Sexual violence (SV) has garnered a lot of attention at international fora in recent months, with millions of dollars in donor funding pledged towards ending this “epidemic”, particularly in areas of armed conflict. However, survivors of sexual violence in Central African Republic (CAR) aren’t feeling the impact of this international momentum due to services often being absent or dysfunctional.

In 2018, there were 1,969 cases of sexual violence reported to the Gender Based Violence Information Management System (GBV-IMS) in CAR, and a further 4,256 were identified in MSF (Médecins sans frontières/ Doctors Without Borders) projects. However, the actual figure is likely to be much higher given the limited access to services and well-documented underreporting of cases.

The population of Bangui has been repeatedly exposed to high levels of violence, displacement, and other human rights abuses. Although Bangui is not currently under active conflict, as it was in 2013 and 2016, tensions remain high in the capital's communities, resulting in peaks of violence, including sexual violence.

Access to medical, mental health and psychosocial care, justice, protection, and economic security are essential elements of any response to sexual violence. However, in Bangui, these services are largely unavailable for survivors. Although the scope of this document focuses on Bangui, it is not to say that survivors do not face obstacles in accessing services in the rest of the country. However, Bangui has specific challenges, given the large numbers of people who are displaced to the capital, that to our knowledge, have not been presented before.

In this paper, MSF calls on donors and implementing partners to scale up activities across all pillars of the response in Bangui and elsewhere in the country, to ensure survivors are given adequate access to care to support their basic needs and recovery.

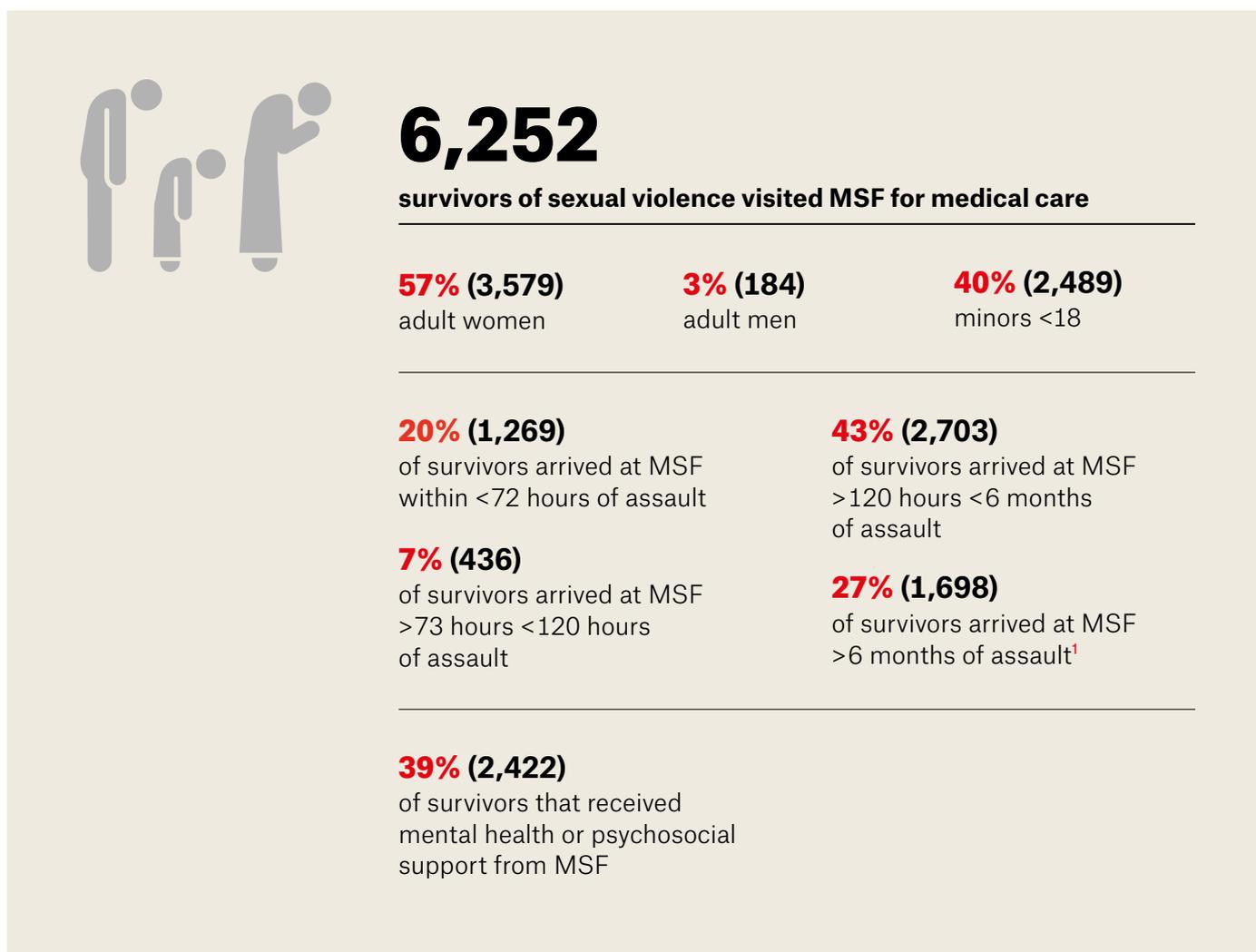
MSF's response to sexual violence in CAR

FIGURE 1. MAP OF MSF ACTIVITIES IN CAR



MSF is the main actor providing medical and psychosocial care to survivors of sexual violence in CAR. At the provincial level, MSF has integrated sexual violence activities into nine programmes in Basse Kotto, Haut Kotto, Mambere-Kadei, Mbomou, Ouaka, Ouham, and Ouham-Pende prefectures.

FIGURE 2. MSF RESPONSE TO SEXUAL VIOLENCE IN NUMBERS. JANUARY 2018–JUNE 2019



In Bangui, MSF treats survivors of sexual violence in four health facilities: Castor Hospital, SICA Hospital, Hôpital Communautaire and Bédé Combatant Health Centre

In Bangui, MSF treats survivors of sexual violence in four health facilities: the Castor Hospital (as part of a broader sexual health programme), the SICA Hospital (vertical programme), Hôpital Communautaire and Bédé Combatant Health Centre (vertical programme). The latter two represent the *Tongolo* programme, the data from which the majority of this document is based on. *Tongolo* is a vertical project that is exclusively engaged in providing assistance to survivors of sexual violence.

¹ The time of the assault was not recorded in 146 (2%) of cases.

THE TONGOLO PROJECT

Survivors arriving at the facility receive medical care that includes: HIV prophylaxis, prevention of unwanted pregnancy, prevention and treatment for sexually transmitted infections, vaccination, and family planning

“Tongolo”, which means “star” in the local Sango language, is a project that was launched in December 2017. It started after an evaluation that revealed a lack of quality services for survivors of sexual violence in Bangui, particularly for men, children and adolescents.

Through this project, MSF strives to provide a high quality holistic programme of care that is free, accessible, and inclusive, with specific adaptations for males, children and adolescents; this includes staff being trained to recognise and treat cases, as well as community outreach activities with associations that target these specific groups.

Survivors arriving at the facility receive medical care that includes: HIV prophylaxis (if within 72 hours of the assault), prevention of unwanted pregnancy (if within 120 hours of the assault), prevention and treatment for sexually transmitted infections, vaccination, and family planning. If a survivor is pregnant, MSF also offers the possibility of terminating the pregnancy or is able to provide the necessary care after complications resulting from an abortion, whether spontaneous or provoked. For cases that might require hospitalisation or advanced care, the survivors are referred to a secondary health care centre.

Alongside medical care, survivors also receive mental health and psychosocial support. Once in the programme the survivor returns for follow up mental care appointments until they show improvements. All survivors receive a medical certificate and are followed by caseworkers.

Between January 1, 2018 and June 30, 2019, *Tongolo* assisted 2,095 survivors. From January to June 2019, 770 survivors were treated, 42% more than during the same period of the previous year. This increase is likely due to an expansion of activities at Bédé Combatant Health Centre, as well as increased awareness of activities due to the work of health promotion and community engagement teams.

FIGURE 3. NUMBER OF SURVIVORS SEEN BY THE TONGOLO PROJECT. JANUARY 2018-JUNE 2019



In order to achieve a holistic approach of care, *Tongolo* aims to have a network of actors in different domains to refer survivors to

Tongolo aims to have an approach that places survivors of sexual violence at the centre of care. However, sexual violence is more than just a medical intervention and, as a medical organisation, MSF is unable to offer the full range of services that a survivor of sexual violence may need. Therefore, in order to achieve a holistic approach of care, *Tongolo* has put in place a network of actors in different domains to be able to refer survivors to, if they wish to pursue legal action, or if they are in need of protection, emergency shelter, or socio-economic support. However, these partnering organisations are unable to cope with the sheer amount of survivors who wish to access these services, meaning they are left with limited options to receive appropriate assistance.

Challenges faced by survivors of sexual violence to access care in Bangui

The international humanitarian system no longer considers Bangui to be in a state of emergency, so the majority of funding goes to provinces directly affected by the conflict

There are a number of barriers that prevent survivors of sexual violence from receiving the comprehensive care they need across the pillars of medical, psychological, legal, protection, and socioeconomic support. Here we elaborate on the systemic gaps that limit a survivor’s recovery process.

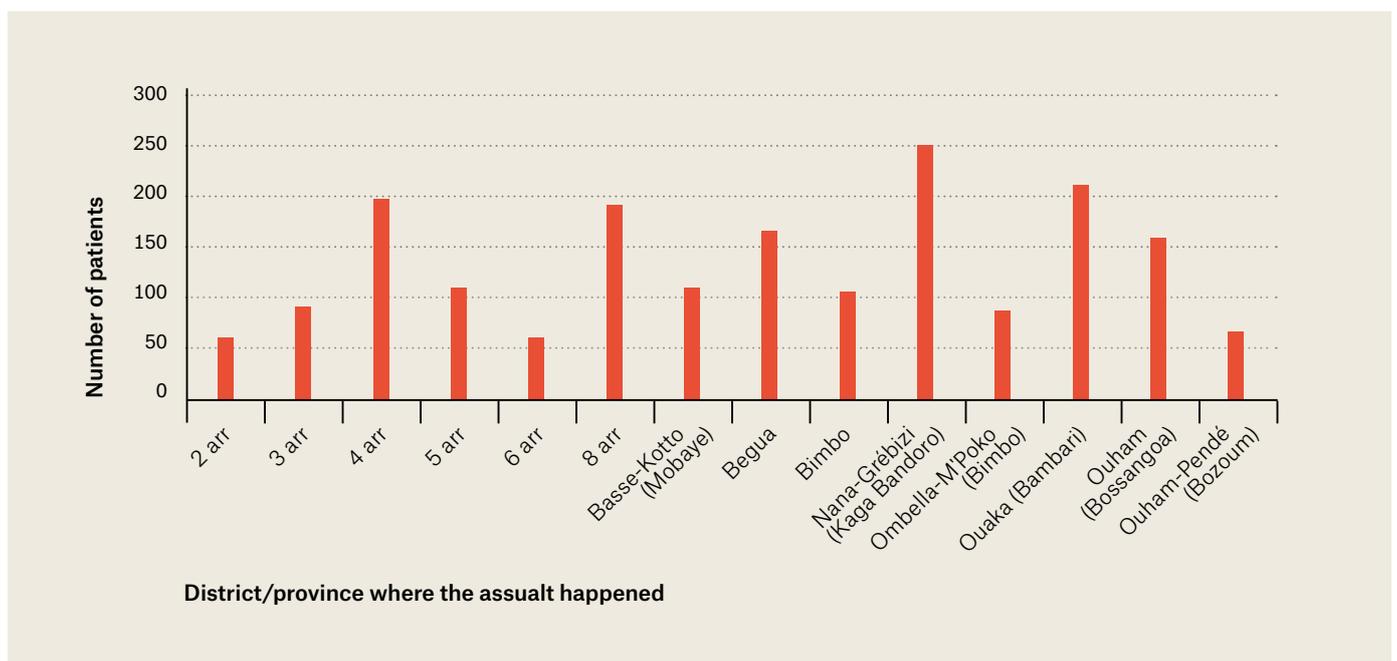
A. THE RESPONSE FROM THE INTERNATIONAL COMMUNITY IS UNABLE TO SUPPORT LONG-TERM SUSTAINABLE SEXUAL VIOLENCE CARE IN BANGUI

I. Bangui – neglected by the donor community and humanitarian response

The international humanitarian funding system no longer considers Bangui to be in a state of emergency, so the majority of funding for health and protection services for sexual violence goes to provinces directly affected by the conflict.

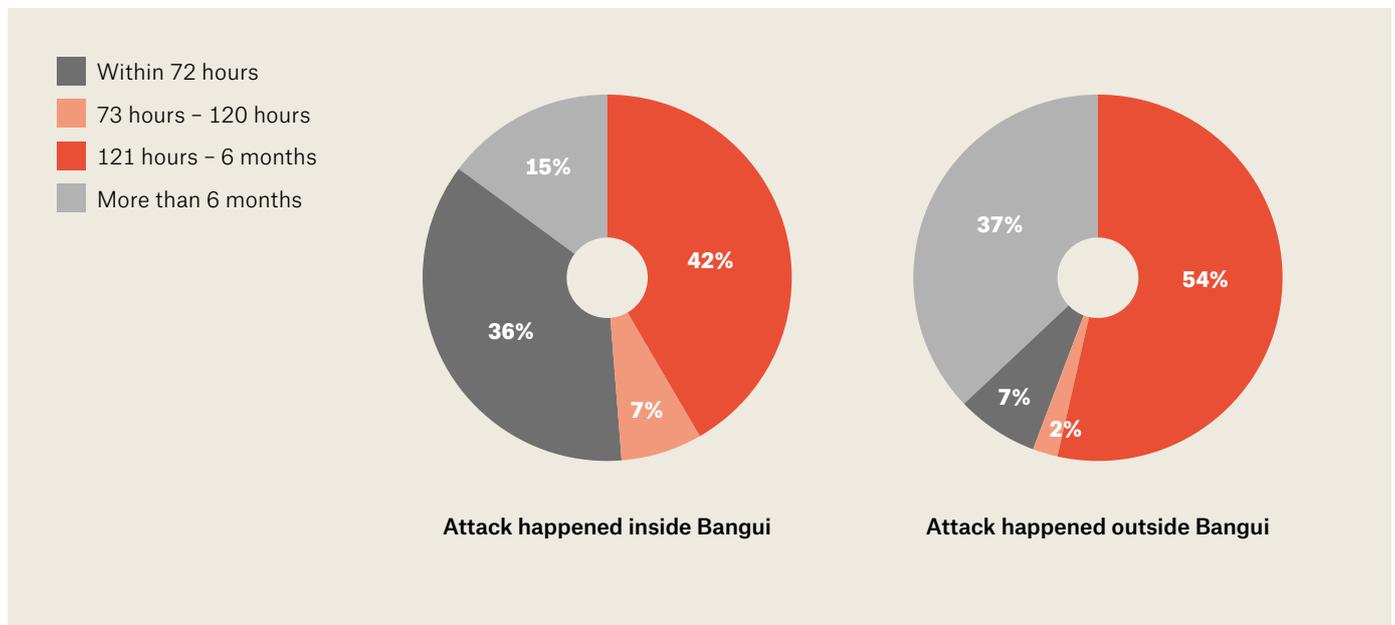
Half of the survivors MSF has seen in the *Tongolo* project were survivors of a sexual assault that happened in Bangui, but for the rest of the survivors, the assault took place in the provinces and they were either displaced or referred directly to Bangui for treatment. This suggests survivors may not have been able to access services in the provinces either.

FIGURE 4. PROVINCE OR DISTRICT (IN BANGUI) WHERE THE ASSAULT OCCURRED (ALL CASES ADMITTED TO TONGOLO, FROM JANUARY 2018 TO JUNE 2019)



If the assault happened outside of Bangui, survivors are more likely to be delayed in receiving treatment (43% of survivors attacked in Bangui were seen within 120 hours of the assault vs 9% of survivors who were attacked outside of Bangui – see figure 5).

FIGURE 5. DIFFERENCE IN TIME BETWEEN ASSAULT AND REACHING THE TONGOLO HEALTH FACILITY FOR SURVIVORS THAT WERE ASSAULTED WITHIN BANGUI OR IN ONE OF THE PROVINCES



In addition, some of these people have experienced sexual violence directly related to the conflict as 58% of the survivors seen (January 2018–June 2019) were attacked by a person bearing a weapon.

Given that many people in Bangui are originally from areas considered a “humanitarian emergency” but have been displaced to Bangui, adequate services must also be provided for sexual violence in the capital, as this is where survivors actually have, or seek, access to care.

II. Sexual violence – beyond a consequence of armed conflict

While the international community rightly seeks to eradicate the use of sexual violence as a “weapon of war” and to prosecute the armed groups that use such tactics, it is also important to consider the structural drivers of sexual violence that are not directly related to conflict but are in fact exacerbated by a context of war, poverty, insecurity and displacement.²

² OCHA states the number of displaced people in CAR in August 2019 stands at 581,000 and 2.6 million people are failing to maintain dignified and protective living conditions.

Civil society organisations in CAR wish to implement or expand services for survivors of sexual violence, but many do not have the funding nor the resources

Some organisations, such as the International Committee of the Red Cross (ICRC), work closely with armed groups to try and prevent these practices. However, to focus solely on violations of International Humanitarian Law committed by armed groups leaves many survivors of community-based sexual violence without such support.

For 33% of *Tongolo* patients (January 2018–June 2019), the perpetrator was known by the survivor. Sexual violence at the community level has been allowed to proliferate with impunity following the degradation of the rule of law and erosion of public services and institutions after years of insecurity.

III. Lack of investment in national NGOs & local associations

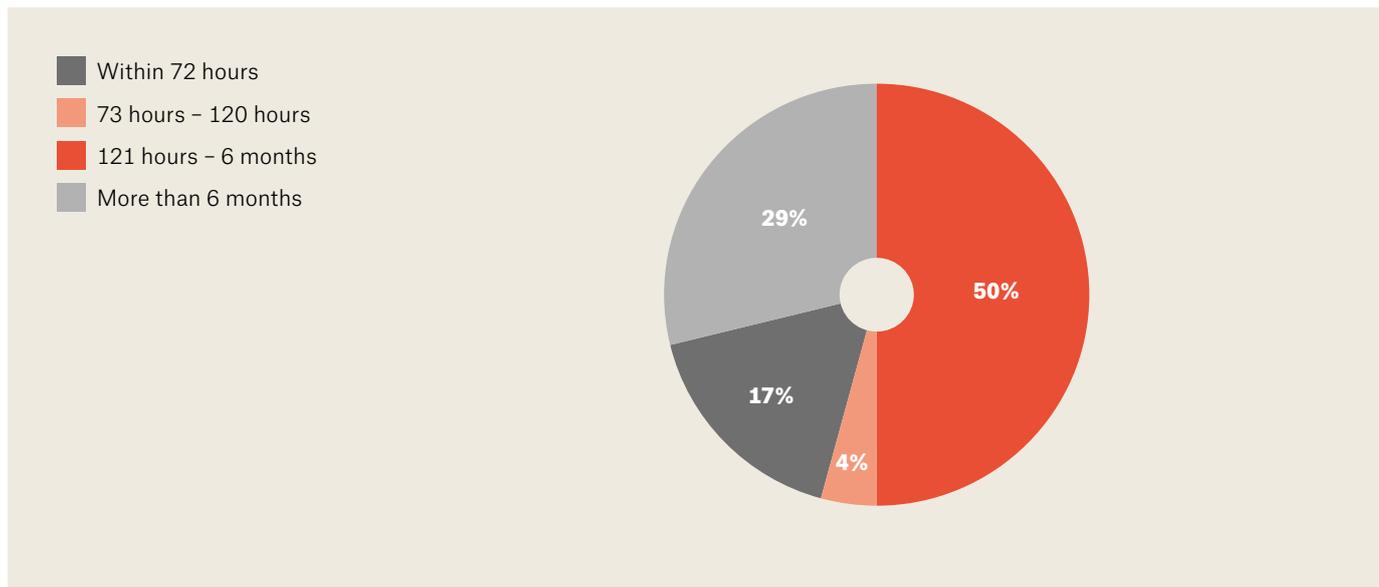
There are a number of civil society organisations (CSOs) in CAR (see appendix for list) that wish to implement or expand services for survivors of sexual violence, but many do not have the funding or resources to do so. They must be included as actors in the recovery process for survivors of sexual violence, but for reasons related to the mode of financing, it may be difficult for them to strike the appropriate partnerships. Better rooted in the local context and thus able to better understand survivors' needs, they must be supported by international organisations and donors as they have the potential to run long-term, sustainable programmes.

B. MEDICAL SERVICES FOR SV SURVIVORS ARE INADEQUATE AND ARE NOT WELL SUITED TO PROVIDING QUALITY CARE TO SV SURVIVORS

Rape is a medical emergency. Ideally, the survivor should be seen within 72 hours of the assault to receive post-exposure prophylaxis to prevent HIV infection, or to provide emergency contraception within 120 hours to avoid unwanted pregnancy. It is also important they be seen soon after the assault to collect evidence that may facilitate access to justice.

From January 2018 to June 2019, only 17% of *Tongolo* patients were treated in this 72-hour window (326 women and 30 men). However, this proportion rises to 76% for children under five and 63% for children between 6 and 10 years.

FIGURE 6. TIME BETWEEN ASSAULT AND ACCESS TO CARE, TONGOLO DATA JANUARY 2018-JUNE 2019 (TOTAL NUMBER OF PATIENTS = 2095)



The reasons for survivors arriving after 72 hours are multifaceted — they fear stigmatisation or reprisals, or do not have the money to pay for transport. However, there are a number of systemic issues at health system level that limit a survivor’s chance to get medical care on time.

I. No minimum care package for sexual violence at primary health level

As there is no minimum package for sexual violence at primary care level, survivors often have to find ways to reach higher levels of health facilities, which can delay access

No minimum package for survivors of sexual violence exists at primary health care level. Survivors often have to find ways to reach higher levels of health facilities themselves, which can delay access to care. If sexual violence services were more decentralised, this could reduce the time needed to reach the facility and increase the chance of survivors arriving within 72 hours. Initiatives are underway to strengthen CAR's primary health care system, such as the World Bank's SENI programme;³ however it is currently unclear if a minimum package for sexual violence will be rolled out in Bangui.

II. Limited capacity of health staff to recognise and treat cases of sexual violence

Health workers are often poorly trained to recognise and treat cases of sexual violence, and for those who are, many do not have the necessary supplies to do so. Patients often have to pay user fees for consultations and other services, which creates further financial barriers to accessing services.

³ <https://projects.worldbank.org/en/projects-operations/project-detail/P164953?lang=en>

III. Extremely limited provision of mental health support

In Bangui there are a number of “listening centres” that offer survivors a confidential space to receive psychological support. These are mostly managed by local organisations and are sometimes supported by international NGOs, including the Danish Refugee Council and Premiere Urgence International. However, with limited human resources it is often difficult for these centres to follow up on survivors. These centres do not offer mental health services as there are currently no psychologists working with survivors of sexual violence in CAR outside of MSF.

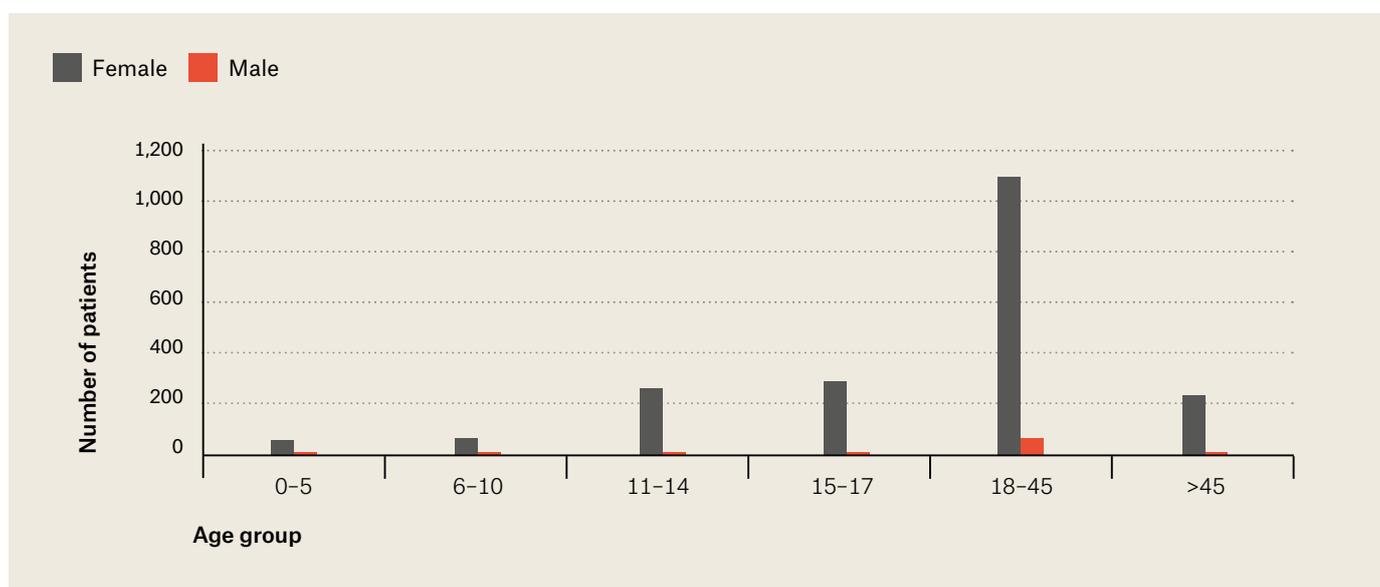
Honorine* (female) is 8 years old. Her mother entrusted her to her godmother in Bangui before going back to the bush. One morning, the godmother went to buy coal, on the road to Damara about 75 km from Bangui, which she would then sell to support her family and her godchild. As usual, she left Honorine at home. But on that day in August, a neighbour, a 27-year-old man who shared the same yard, called her to pick up a bucket of water. The neighbour then locked her up. While he was raping her, the neighbour’s brother, who is a policeman, was coming back from work and heard Honorine screaming. He rushed to his brother and said "you, you have HIV, you cannot do that". Aware of the crime committed by his brother, the police handed him to UMIRR, before accompanying Honorine and her godmother to a health centre. From there, she was referred to MSF for emergency treatment. She is now on antiretrovirals and is receiving psychosocial support from MSF.

**Names have been changed.*

IV. Services poorly adapted to children, adolescents and males

106 male patients sought MSF assistance in *Tongolo* between January 2018 and June 2019, representing 5% of the survivors in care.

FIGURE 7. AGE GROUP AND GENDER OF *TONGOLO* PATIENTS. JANUARY 2018-JUNE 2019



All Survivors Project have reported critical gaps in the delivery of quality services to men and boys who are survivors of sexual violence, as these groups are often systematically neglected since the design and delivery of services in CAR⁴ are geared towards females. Many programmes, (including MSF's), are based in the maternity wards, which can create a barrier for children, adolescents and males seeking treatment, as they may not want to be seen in such an environment. In addition, health workers often do not have the expertise to identify male survivors of sexual assault, meaning that, unless a male discloses what has happened, they go unidentified.

"I celebrated my 32nd birthday in June of this year. I share my birthday with a colleague from work. We decided to organise a small joint party. I cannot say her name... We can call her Albertine*. She insisted on organising the party herself. When I arrived home that night, I was surprised of how few people were there. There was almost no work colleague. I took a little alcohol. When I woke up, I was at home, naked. I do not remember anything. I think she drugged me. I am married, have children, and I am faithful to my wife. I have health problems, I am diabetic and hypertensive. I'm afraid of having HIV too, because that will make my condition even more difficult. I did not take the medical certificate from MSF because I do not want my wife to see that. I asked MSF to keep it. I'm waiting for the month of September. It will be three months, and with the tests, I will know if I have been infected with HIV. If that's the case, then I'll get the certificate back and go and file a complaint". Jospin*, Male, 32.

**Names have been changed.*

C. LACK OF PROTECTION MEASURES

Many cases of sexual violence seen by MSF in Bangui took place in a family or community setting that is often extremely difficult for survivors to escape

The humanitarian response in CAR is conceived as a protection crisis, yet donor investments are incredibly low. The protection cluster is only 18% funded for 2019, which means that operational partners have limited capacity to deal with the number of cases reported by MSF in the country.⁵ Protection actors should be putting in place measures, such as providing shelter, to ensure survivors are able to move away from danger and to limit the recurrence of violence. However, given the absence of services in Bangui, survivors increasingly have no place to go.

1. Lack of emergency shelter and long-term accommodation

Many cases of sexual violence seen by MSF in Bangui took place in a family or community setting that is often extremely difficult for survivors to escape. For example, of the 616 children and adolescents seen in *Tongolo* between January 2018 and June 2019, 68 (11%) lived in the same household as the perpetrator, and 382 (62%) lived in the direct vicinity of their attacker (62%).

⁴ <https://allsurvivorsproject.org/country/central-african-republic>

⁵ <https://fts.unocha.org/appeals/674/flows>

Armande* (female) is 10 years old. Her mother lives in the provinces, where life is very difficult. Armande was therefore adopted by her aunt, who lives in the PK3 district of Bangui. One day the aunt found money in Armande's school bag. She then asked her where she found the money, accused her of stealing it, and beat her. Armande started to feel very bad, and her aunt realised that something was wrong. When she visited the MSF clinic, Armande revealed that she has been raped many times by her aunt's husband. "It's happened so many times. Sometimes he gave me sweets and biscuits, sometimes 500 francs or even 1,000 francs. I was afraid to tell. I'm afraid he'll kill me or my aunt". Armande never wanted to return to the house she shared with her abuser. She was sheltered for three days in an emergency shelter provided by MSF. Meanwhile, her aunt left to find members of Armande's family, until she managed to reintegrate her into her family, sheltered from her own husband.

**Names have been changed.*

An integrated response that caters to needs of children must involve a pathway for them to reintegrate the education system. There is no functional sub-cluster for the city of Bangui to facilitate this

There is a dearth of accommodation for survivors to access, both in terms of emergency shelter and long-term housing, which is particularly important for survivors where the abuser is known to them. In urgent cases, MSF can provide emergency shelter for up to 48 hours but the only other available option is a ten-bed structure called the "House of Hope" which was built by the International Rescue Committee and will be managed by the Ministry for the Women's Empowerment. However, this is far from enough to accommodate all survivors and also excludes males from access. In fact, male survivors do not have any options for shelter. Other organisations, such as SOS Children's Villages, currently do not provide emergency shelter for child survivors of sexual violence but would be able to if they were to secure funding.

//. Limited opportunities for educational reintegration for minors

The humanitarian system recognises the link between insecurity and the risk of sexual violence towards children. In "crisis zones", the education cluster prioritises access to secure educational environments, strengthens the protection of out-of-school children and the protection of children's rights.⁶ An integrated response that caters to the specific needs of children must involve a pathway for them to reintegrate the education system, however there is no functional sub-cluster for the city of Bangui to facilitate this as it is not considered a humanitarian crisis. Some actors are willing to provide these services, such as SOS Children's Villages and BETHANIE, but funding remains largely insufficient.

⁶ 2019 Humanitarian Response Plan for the Central African Republic.

D. SOCIAL SERVICES TO SUPPORT BASIC NEEDS AND RECOVERY ARE INSUFFICIENT

I. Lack of investment in mid-long term economic empowerment

The role of economic empowerment in the recovery process from sexual violence is well documented.⁷ Providing comprehensive sexual violence care must therefore include promoting socio-economic empowerment for survivors, or their guardians, so they can live a dignified, independent life.

Marie-Bénédicte (female) fled Bossangoa shortly after turning 30. She was raped by the same men who killed her husband. Like many women, men and children around her, she took the road to Bangui, hoping to find security and stability. In Bangui, she was cared for by MSF. After she was raped, she became HIV-positive and pregnant. Fortunately, the infection was not passed on to her baby. In Bangui, she never managed to find a job, or training. She could not receive any support allowing a minimum of economic security. Since she and her husband owned parcels in Bossangoa, she decided to return, despite the presence of armed actors. “Bangui may be less dangerous, but there are no opportunities.” Before returning to the provinces, she was referred to MSF to continue her antiretroviral treatment in Bossangoa.

To have a real impact, more investments need to be made into socio-economic reintegration programmes to give survivors a chance at economic security

In Bangui, there are some non-governmental organisations (NGOs) that provide a small amount of food and cash assistance (approximately 1,000 CAF = €1.50) to survivors. This mostly helps with transportation costs and is often accompanied by “dignity kits” which can contain items such as underwear and sanitary products. Although this type of one-off assistance is welcomed, it is not enough to sustain a survivor for more than a day or so. To have a real impact, more investments need to be made into socio-economic reintegration programmes to give survivors a chance at economic security.

In 2015–2016 there was a comprehensive support framework aimed at the socio-economic reintegration of survivors of sexual violence in Bangui that was supported by United Nations Development Program (UNDP). It had a multidisciplinary approach that theoretically helped to build the capacity of survivors, through the implementation of micro-financing and income-generating programmes. Today, there are very few international NGOs working on socio-economic integration.

The International Rescue Committee (IRC) is also implementing an economic recovery programmes for survivors of gender-based violence across CAR, providing professional training in trades such as tailoring, hairdressing, and catering, as well as access to literacy classes. In Bangui, this programme is partially funded by the European Union (EU) Bêkou Fund,

⁷ <https://www.svri.org/documents/economic-empowerment>

while other donors support such activities in the provinces. If funding were to become available, IRC would be able to scale up this initiative.

There are also examples of programmes being implemented in other contexts that could be applied in CAR. For example the Food and Agriculture Organization of the United Nations (FAO) has developed an empowerment approach through “resilience funds” aimed at strengthening the social, technical and financial capacities of subsistence farming groups in rural Central Africa. Similar initiatives could support groups of survivors in urban and semi-urban areas in Bangui.

E. WEAKNESSES IN THE LEGAL SYSTEM COMPROMISE ACCESS TO JUSTICE

In Bangui, several organisations are implementing solutions to facilitate access to justice for victims of sexual violence

Rape in CAR is defined as “any act of sexual penetration, of any kind, on the person of others by violence, coercion, threat or surprise”,⁸ but whether to pursue legal action is the decision of the survivor.

If legal action is not pursued, some survivors seek justice or compensation through out-of-court settlements or resolution is sought within the community.⁹ MSF supports an approach that doesn’t focus on the perpetrator and wants to put the survivor at the centre of the problem. However, if a survivor wishes to file a complaint or open legal proceedings, this can often be a step towards “devictimisation” and helps them regain the control lost during the assault.

In Bangui, several organisations are making efforts to facilitate access to justice for victims of sexual violence, such as Association des Femmes Juriste de Centrafrique (AFJC), which has programmes that work with communities and local leaders to refer survivors for legal assistance.

I. Court sessions infrequent and non-confidential

The judicial system requires rape cases to be tried in court sessions that only take place twice per year, but limited resources can make it impossible to hold these two sessions

The judicial system requires rape cases to be tried in court sessions that only take place twice per year. Limited resources can make it impossible to hold these two sessions, which are already far from what is needed to meet the needs of the population.

During court hearings survivors, witnesses and perpetrators appear publicly. They are almost always broadcast on radio or other media, therefore not protecting the survivor’s anonymity. The State does this to raise awareness around rape crimes, but in practice, it only serves to increase victim stigmatisation. Although there is already a law in place that prescribe court sessions should be held behind closed doors, it is seldom used and applied.

⁸ Article 87 of the Penal Code.

⁹ Study on the prospects of deployment of the legal profession in Central African territory. Lawyers Without Borders. September 2018.

“At the last criminal session in Bangui, the perpetrator of a rape on a 13-year-old girl was sentenced to 20 years in prison. The trial had been broadcast on the radio and the images broadcast on television as is still the case for these cases. The stigma in the community was such that the family had to leave the neighbourhood and relocate elsewhere”. Representative of Rule of Law Initiative in CAR.

II. Lack of qualified legal professionals

Extra funding is required for such organisations to scale up their activities and support all survivors who wish to pursue legal justice

If a survivor initiates legal proceedings, the likelihood of a conviction is much higher with the involvement of a lawyer. However, Central African lawyers are too few in number to meet the legal needs of the population. There are on-going initiatives to strengthen the availability of legal professionals, for example the Institut Francophone pour la Justice et la Démocratie offers a training programme for current and future lawyers. The American Bar Association (ABA) offers trainings to magistrates, lawyers, and judicial police officers specifically related to sexual violence, and continues to be an important actor in supporting survivors to navigate the legal system. Extra funding is required for such organisations to scale up their activities and support all survivors who wish to pursue legal justice.

III. Absence of evidence

The courts theoretically do not require the provision of a medical certificate in cases of rape. However, a Human Rights Watch report explained that “a conviction without a certificate was unlikely” and they undoubtedly strengthen any investigation.¹⁰ Even in older cases of sexual violence, the issuance of a certificate can contribute to the recognition of the suffering experienced by the patient, and can help psychological rehabilitation.

If survivors have to pay for medical certificates, this creates more financial barriers to accessing justice. These should be offered free of charge in any facility

MSF is currently the only organisation that provides free medical certificates to all survivors of sexual violence. If survivors have to pay for the medical certificate, this creates more financial barriers to accessing justice. Therefore, these should be offered free of charge in any facility that offers sexual violence services. However, they must also be accompanied by a reinforcement of the clinical skills of health workers, to ensure they capture as much relevant information as possible when preparing the certificate so it can serve as tangible evidence, particularly in the case of children and adolescents.

Currently, only 5% of survivors seen in *Tongolo* refuse to take the certificate. The reasons for this are many — some fear stigmatisation, or in the context of sexual assault within a family, partner, or community, they may feel unsafe to carry this document with them. MSF stores these documents for 25 years in case the survivor wishes to access it at a later time.

¹⁰ <https://www.hrw.org/video-photos/interactive/2017/10/05/they-said-we-are-their-slaves>

“In 2013, I was working in my uncle's field in Bossangoa. A small group of men arrived. They drove away the women, and forced me against the ground. One of them forced me to suck his cock, and another raped me. Later, I managed to move to Bangui. Today I want to make a complaint. I enrolled in an association of survivors of war. I was asked for a medical certificate to validate my membership in the association and to be able to lodge a complaint. Thanks to MSF, I was able to obtain the certificate for free”. Bienvenu*, (male) 30 years.

**Names have been changed.*

Recommendations

- **Sexual violence is an epidemic that goes beyond situations and locations of active armed conflict and affects communities across CAR. The humanitarian response cannot be solely focused on the link between sexual violence and war. Financing must be increased to Bangui (and elsewhere) to ensure services are available to all survivors.**
 - The humanitarian community and the cluster system must not exclude Bangui from the allocation of funds despite it not being considered a “crisis zone”. There are large numbers of people that are displaced to Bangui from crisis zones and services need to be available in the capital to ensure needs are met.
 - International non-governmental organisations must facilitate, through the cluster system, the channelling of funds that cannot be directly granted to local CSOs, to allow for more long-term, sustainable programming.
 - Advocacy on sexual violence needs to include all survivors, not just those attacked by armed groups. Protection actors like ICRC can play a highly needed role to support this, using their leverage and resources to engage national and local actors in improving the protection response to all survivors of sexual violence.
- **Donors and their partners should increase support to public services to promote more sustainable solutions.**
 - Sexual violence services need to be supported, not only with infrastructure but with on-going operational costs. Investments in public services are essential for long-term programming. In addition to providing “one-shot” donations, to for instance cover construction costs, donors should improve longer-term investments that will guarantee these services continue to operate.
- **Coordination and referral pathways between different actors and sectors should be improved.**
 - Referral mechanisms must be strengthened. Links between the various sub-clusters should be improved to ensure referrals, particularly for emergency medical care, are quick and timely.
 - Inter-cluster coordination should be improved to identify and strengthen the funding of local actors.

- **The public health system must be strengthened to expand access to medical and psychological care for survivors of sexual violence.**
 - The decentralisation of services is essential for survivors to have access to emergency medical care within 72 hours of an assault. A minimum care package for sexual violence needs to be put in place at primary health care level, supported by donors and implementing partners. This should include post-exposure prophylaxis for HIV, emergency contraception, preventive treatment for sexually transmitted infections, and psychological first aid. Any initiatives to strengthen primary health care, such as those supported by the World Bank, should make it a priority to rolled these out across all states, including Bangui.
 - Secondary health services must have many different entry points to access sexual violence care, such as the emergency room, outpatient department, maternity etc. Staff across all departments must be trained to identify signs and symptoms of sexual violence, and how to approach survivors appropriately, in case the patient does not openly disclose what happened to them.
 - Family planning services, including the provision of termination of pregnancy, must be scaled up. Family planning is one of the best points of entry for sexual violence and by ensuring the adequate expansion and strengthening of these services, more survivors will be able to be identified.
 - Medical certificates must be free of charge in all health facilities that provide sexual violence care. This should be accompanied by a reinforcement of health worker skills to recognise and treat all survivors of sexual violence, thus guaranteeing the provision of comprehensive medical certificates.
 - Donors and implementing partners should consider collaborations with training institutes and academic organisations to increase the number of psychologists available to treat survivors of sexual violence in CAR. In addition, existing health workers, such as nurses and clinical officers, should be trained in line with World Health Organisation (WHO) mental health gap, so they are able to give the necessary care to survivors that require mental health support.
- **The availability of, and access to, secure accommodation for survivors must be improved in Bangui (and the rest of the country).**
 - Investments must be made to construct more emergency shelters that are safe, dignified and adapted to the specific needs of the populations concerned, including children, adolescents and males.
 - Longer-term housing that allows for a more sustainable solution to a survivor's protection needs must be established and supported by donors and protection actors.

- Donors must provide long-term funding to public institutions and non-governmental organisations to guarantee the on-going management and maintenance of shelters.
- Long-term funding must be provided for child survivors of sexual violence to allow them to reintegrate the education system. This support must cover the costs of schooling and associated fees until a child reaches 16 years of age.
- **Socio-economic initiatives to support societal reintegration and recovery for survivors, and their guardians, must be rapidly expanded.**
 - Donors must scale up funding for long-term, sustainable initiatives aimed at reintegrating survivors of sexual violence into society.
 - Development actors, such as UNDP, should commit to (re)supporting the development of socio-economic empowerment centres and other innovations that support income-generating activities for survivors in Bangui.
- **Services across all pillars of the sexual violence response need to be better adapted to children, adolescents and males.**
 - When allocating their support, donors must include criterion that ensure children, adolescents and males are factored into the design and implementation of sexual violence services.
 - Health services for survivors should avoid being located in places, such as maternity wards, that might deter children, adolescents and males from seeking care. Offering sexual violence services in emergency departments and paediatric units can improve access for these specific groups.
 - Children, adolescents, and males should be specifically targeted in awareness raising and outreach activities. For males, actors should collaborate further with associations for marginalised groups, such as LGBT, to reach these difficult populations. For children and adolescents, schools and youth associations should be incorporated into outreach activities.
 - Any protection and socioeconomic services must recognise that the challenges faced by children, adolescents and males are specific, and must make sure to include safe spaces for these groups to access care.

- **The government of CAR should develop a more efficient and effective judicial process that puts the interests of the survivor at the centre.**
- Existing laws, such as those that allow for rape trials to be held behind closed doors, should be enforced by the Ministry of Justice to protect survivors.
- The international community should support legal aid organisations such as American Bar Association, Association des Femmes Juriste de Centrafrique (AFJC), so they can scale up activities, including the training of legal personnel, and improve access to justice for survivors.

Conclusion

Despite Bangui not being considered a humanitarian emergency, the situation for survivors of sexual violence in the capital is a crisis that remains silent. The international community must increase support to governmental and non-governmental institutions so all pillars of the response to sexual violence — medical, psychosocial, legal, protection, and reintegration — can be strengthened.

Appendix

This is a non-exhaustive list of local civil society organisations that partners may wish to consider collaborating with:¹¹

NAME OF ASSOCIATION	TYPES OF ACTIVITIES OFFERED
Amicale des femmes de Centrafrique	Income-generating activities
Association Cercle des Jeunes	Education
Association des forces vives pour un avenir meilleur en CAR	Income-generating activities
Arbre de Vie	Protection, income-generating activities
Association de Gbassore	Child protection and income-generating activities
Association Groupe Charite	Education and microfinancing
Voix de Coeur	Children's organisation working on literacy, education and reintegration
Maison Prisca	Listening centre
Movement of Central African Survivors	Legal support
Enfants Sans Frontieres	Listening centre also offering income-generating activities
Clira	Psychosocial support
Cread	Legal support working mostly with children. Support survivors with food and schooling
Flamboyant	Listening centre
Aresdi	Listening centre
Association de femmes engages dans la prévention de la VBG	Listening centre offering referrals for legal support

¹¹ These organisations were identified as part of a comprehensive actor mapping conducted by the *Tongolo* team, however the capacity of these organisations has not been validated by MSF.

