

MSF
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Invisible Wounds

MSF's findings on sexual violence in CAR between 2018 and 2022



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Introduction

Between 2018 and 2022, teams from Médecins Sans Frontières / Doctors Without Borders (MSF) in the Central African Republic (CAR) they took care of over 19,500 survivors of sexual violence across the country. Over this five-year period MSF **multiplied by threefold the number of patients** seen thanks to, among other reasons, increased community-based activities, sensitisation, improved referral pathways in coordination with other aid agencies and the Ministry of Health, as well as the extension of our programs, both in terms of geographical reach and care offering.

During the same period, the United Nations sexual and reproductive health agency (UNFPA) documented 14,907 other cases of sexual violence in CAR reported by other humanitarian organisations working in the country, or by state structures.

Tongolo (“Star” in Sango), a holistic project opened at the end of 2017 in the capital, Bangui, accounted for 66% of the cases seen by MSF. The project provides medical treatment and mental health support, as well as guidance to pursue legal action and obtain protection, such as emergency shelter or socio-economic support. MSF teams also took care of patients for sexual violence at a dozen other locations, in nearly every corner of the Central African Republic. Numerous gaps were noted at different levels in terms of assistance for the survivors as well as huge challenges for them to access care.

The recurrent outbursts of hostilities amid the long-lasting conflict in CAR accentuated the problem, with consequences on some occasions such as episodes of widespread rape, and, on others, the disruption of our programmes and outreach activities, delaying or impeding access to healthcare for survivors. **The conflict also exacerbated the conditions of precariousness and vulnerability** of large sections of the society.

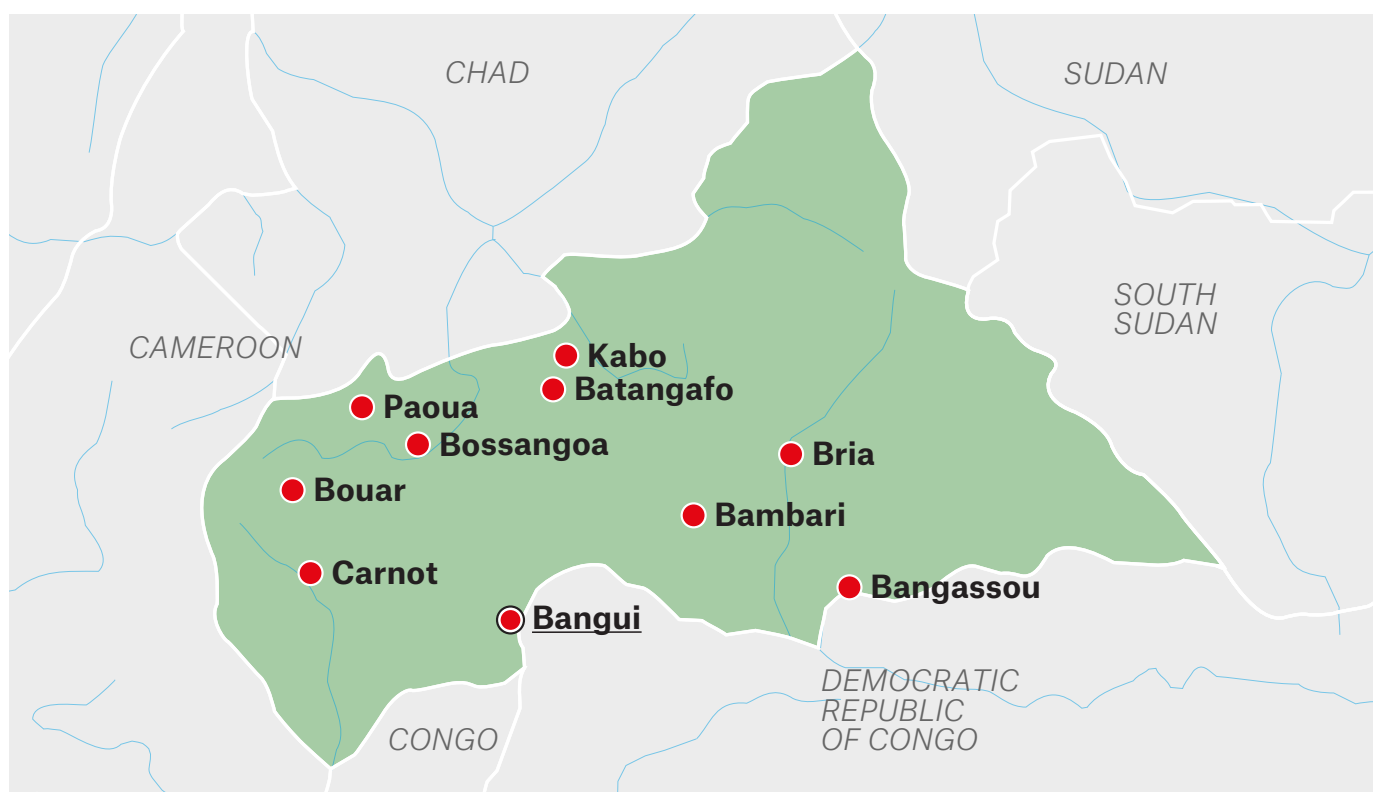
Today **sexual violence may be better documented than in 2018, but what we know is still only the tip of the iceberg.** It is a taboo and under-reported public health emergency in CAR and while **perpetrators remain by default unpunished** due to a blatant impunity, **survivors face acute stigmatisation** and big obstacles to continue with a normal life in the community.

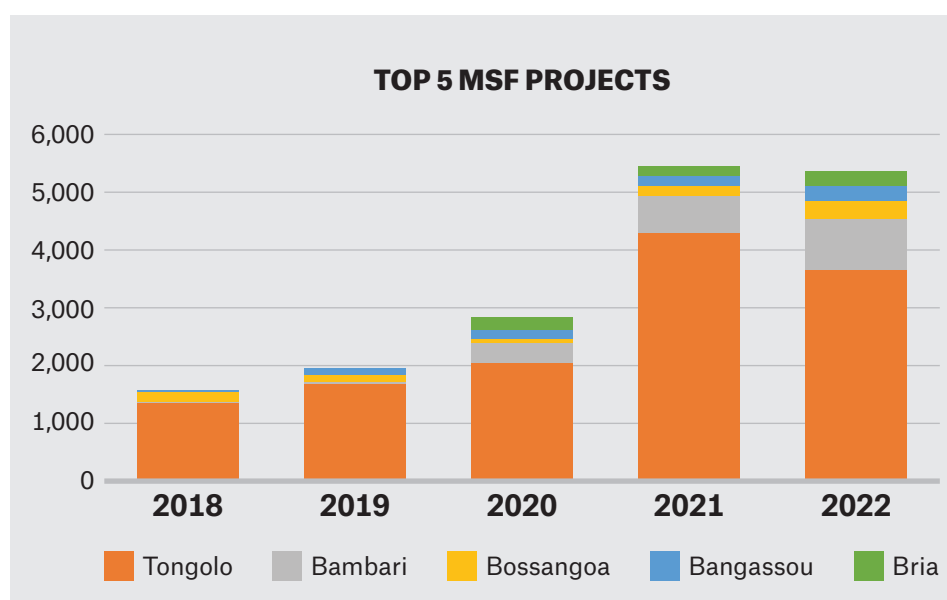
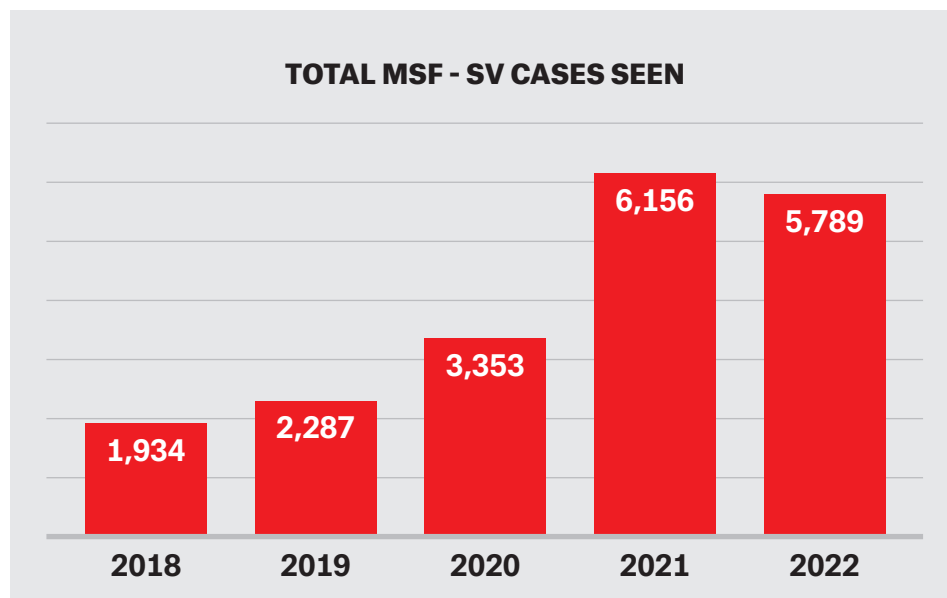
In the light of this, MSF reviewed the work done in the field between 2018 and 2022, in order to try and shed a bit more light on the problem and help to renew calls for more concrete actions by both the government and other national and international organisations. The aim of this approach is **to improve the availability and quality of services for sexual violence survivors in the country.**

DATA OVERVIEW

TABLE: REPORTED CASES OF SEXUAL VIOLENCE IN MSF PROJECTS IN CAR

Project	2018	2019	2020	2021	2022	Total
TOTAL MSF	1,934	2,287	3,353	6,156	5,789	19,519
Bangui - Tongolo	1,326	1,653	2,025	4,263	3,647	12,914
Bambari	16	45	332	650	868	1,911
Bangui - Castors	321	263	142	259	288	1,273
Bossangoa	163	109	79	152	313	816
Bangassou	32	112	142	182	264	732
Bria			232	182	248	662
Paoua			188	152	N/A	340
Batangafo	27	77	87	24	53	268
Kabo	47	27	30	87	35	226
Carnot			59	73	73	205
Eureca	2	1	37	53	0	93
Bouar				79	N/A	79





A COMPLEX AND EVOLVING SUBJECT

Between 2018 and 2022, MSF provided healthcare to the Central African population at 10 different stable projects¹ and through its emergency response team EURECA temporarily in other locations.

In total, our teams took care of at least 19,519 survivors, with the numbers increasing from 1,934 cases seen in 2018 to the 5,789 treated in 2022, **with a peak of 6,156 survivors in 2021, in which year the Central African Republic saw renewed conflict.** This factor

¹ Two of these projects, Kabo and Paoua, finished their activities in 2022 for different reasons (insecurity and operational choices).

contributed to the growth in the caseload, but it was not the only one leading to it (see reasons for growth cited in the introduction).

To gain a better understanding of the situation across CAR, we **zoomed out and analysed the overall quantitative data of the period**, including indicators like the **delay in seeking assistance, the gender and age of the survivor**, and, when possible, the **type of perpetrator** and the place where the aggression took place.

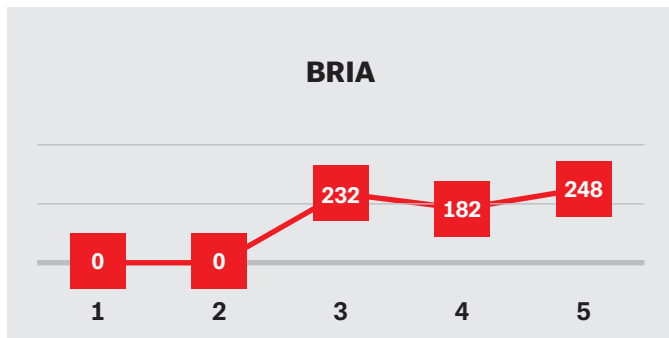
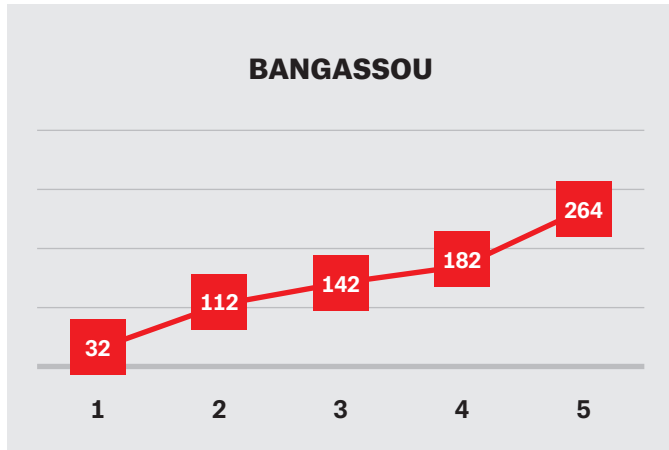
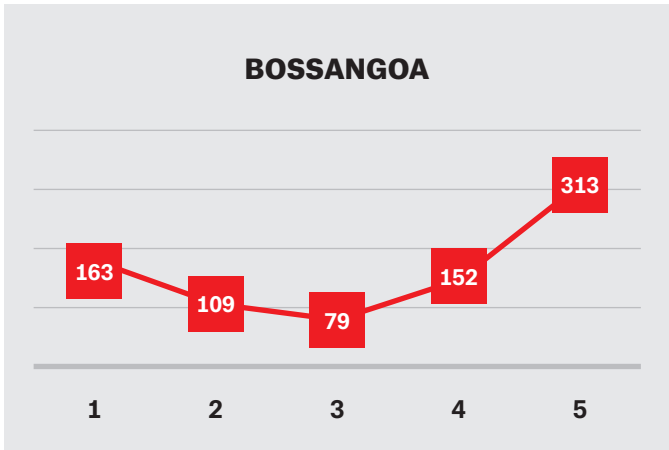
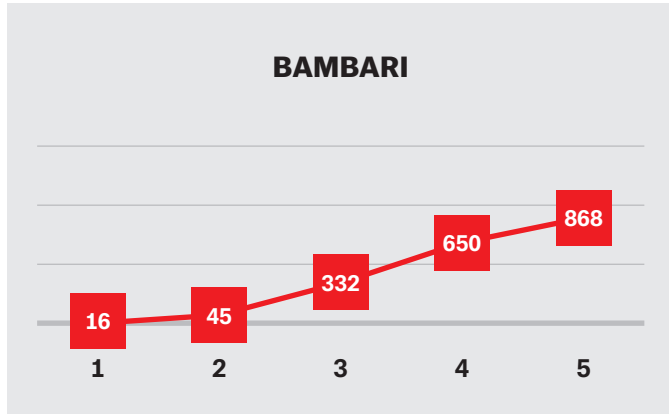
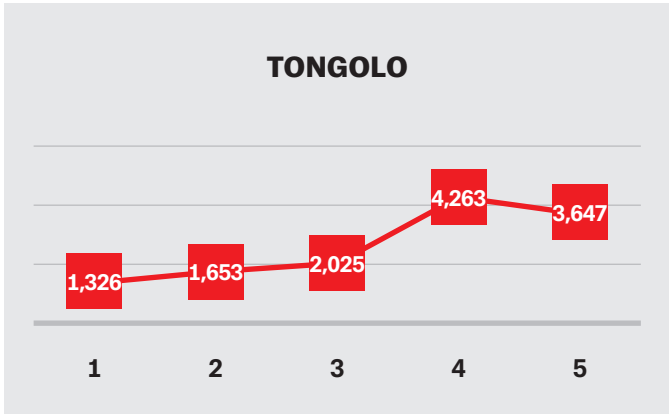
Meanwhile, **we also zoomed in and examined more in-depth the situation at five of the projects with a bigger caseload**, to obtain some qualitative insights through tailored interviews with MSF workers in charge of or dealing with sexual violence programmes. This allowed us to understand the kind of services available for the communities, either implemented by MSF or by other organisations, and the challenges for MSF to provide care and for patients to access healthcare.

These five projects were: Tongolo (Bangui); Bambari (in the centre of the country); **Bossangoa** (west); **Bangassou** (south), **and Bria** (east). MSF activities ranged **from the holistic care** in Tongolo **to the most common denominator of providing medical assistance**, normally - but not always - comprising care for trauma injuries, prophylaxis for HIV exposure, prevention of sexually transmitted diseases (STDs), vaccinations against tetanus and hepatitis B, sexual and reproductive healthcare and contraception for unwanted pregnancies. In general, our teams provided care to all age groups but in the case of Bria, we focused on paediatric activities and another organisation treated adults.

In other places, like Bambari and Bossangoa, we provided a **combination of medical care and psychosocial activities**, but in Bangassou and Bria MSF teams referred these cases to other aid agencies.

The lack or insufficient presence of other organisations working in this field across vast expanses of the country meant that we received patients from very distant locations, up to 130 kilometres away, something that in CAR can mean a lengthy journey due to the poor road network.

All these projects **experienced a general pattern of increase** in the number of consultations over the five-year period, most notably Bambari and Tongolo (see graphs on next page).



“As of 2020, we **integrated all the activities** including medical care, sexual and reproductive healthcare and psycho-social support. This, combined with the improving **security situation** in the second half of 2021 and **more activities in the peripheral areas**, led to a significant increase in the number of patients,” says Christian Serpande, MSF’s data analyst, about Bambari.

Sensitisation through door-to-door awareness, radio spots, theatre groups (Bria), identification of focal points in the community to facilitate the referral of patients (Bambari), and a more active engagement with the local authorities, police and other partners were cited by the MSF workers as factors contributing to the increase.

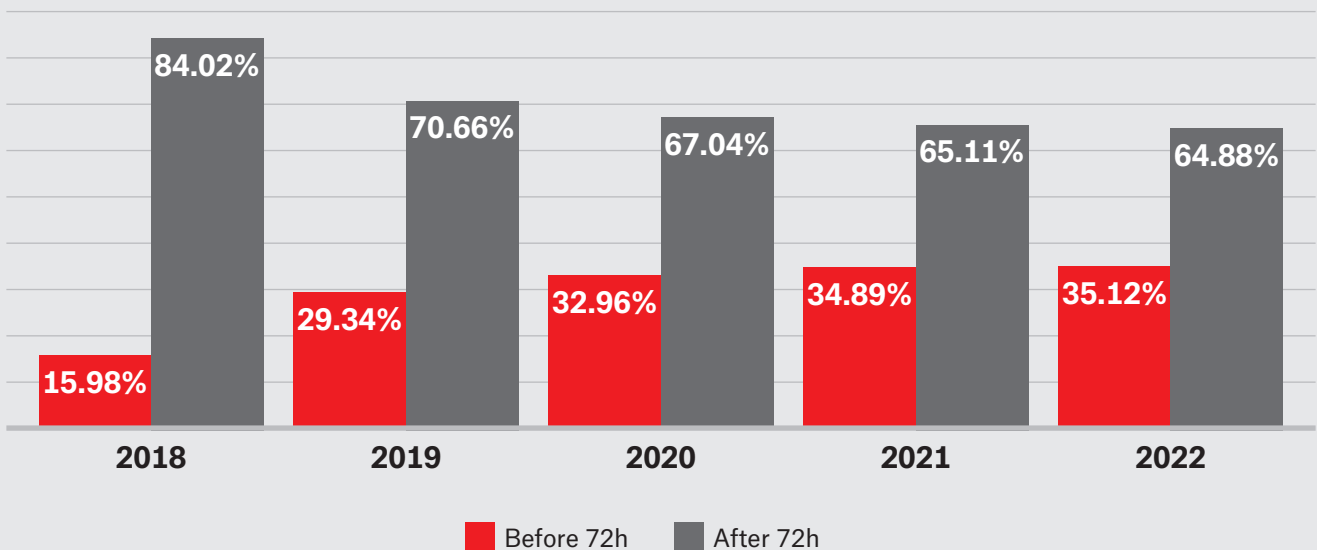


MOST PATIENTS ARRIVE LATE

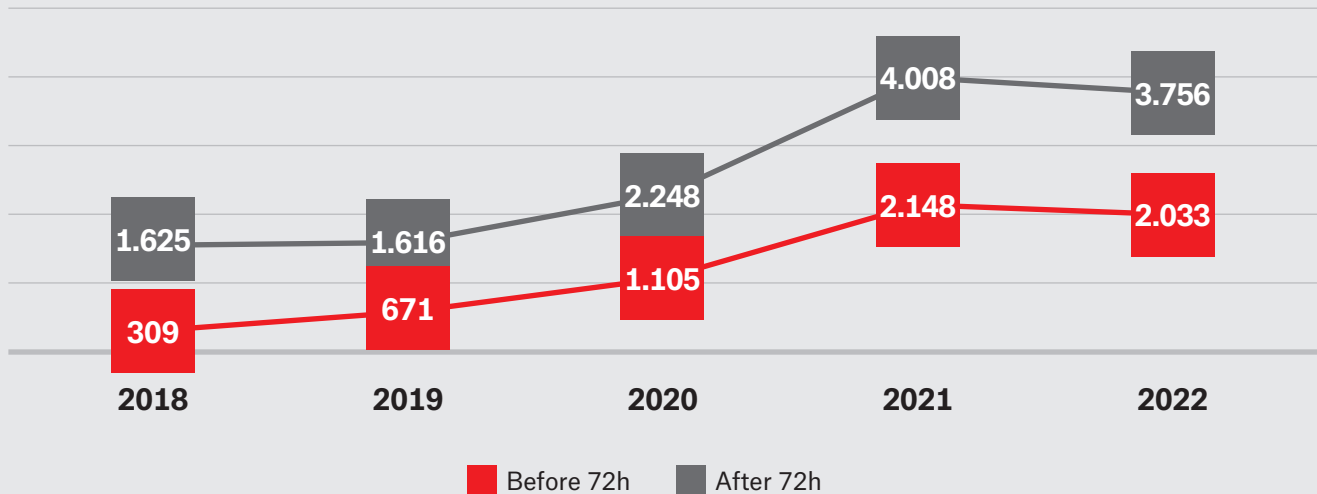
Rape is a medical emergency. Ideally, the **survivor should be seen within 72 hours of the assault** to receive post-exposure prophylaxis to prevent HIV infection, and, if necessary, receive emergency contraception within 120 hours to avoid an unwanted pregnancy. It is also important that survivors are seen soon after the assault in order to carry out medical examinations that may facilitate access to justice. Outside of this time period, it remains important that survivors access medical care and other services.

Over the period 2018-2022 barely three out of 10 survivors (32%) arrived at our health facilities within this window of the first 72 hours since the assault. Notwithstanding, there has been a **significant improvement** from **15.98% in 2018 to 35.12% in 2022**, with constant yearly gains.

TIME OF ARRIVAL OVER THE YEARS (in percentage)



TIME OF ARRIVAL OVER THE YEARS (in figures)

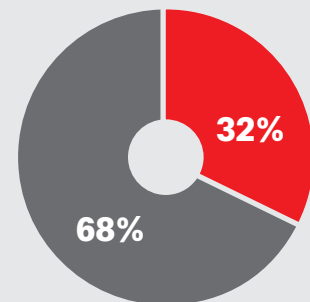


PERCENTAGE OF PATIENTS ARRIVING BEFORE 72H AT FIVE MAIN MSF PROJECTS:

- Bangassou: 20%
- Tongolo: 29%
- Bossangoa: 37%
- Bambari: 39.5%
- Bria: 45%

TIME OF ARRIVAL (5-year average)

- Before 72h
- After 72h



* Out of the total number of cases seen by MSF between 2018 and 2022

Across projects there are sharp variations. In Bangui, which has nearly 900,000 inhabitants representing about a sixth of the country's total population, access issues due to insecurity are less of a recurrent problem as compared to the provinces, where the situation can be more volatile. However, the **cost of going to the facility and the fact that many people come from the rural areas to the capital seeking support**, sometimes displaced by the conflict, contribute to the delay. **Some patients seen at Tongolo, for instance, sought assistance only years after suffering the aggressions.**

Fortunée, an MSF midwife, explains the high numbers in Bria: "The service is free, and we are open 24/7 to provide care. We have created **awareness at supported health centres in the peripheral areas**. We have decentralised some activities. All this, along with the provision of HIV prophylaxis, have been positive factors to boost an early demand for services." MSF staff based at other project locations cite similar reasons

and highlight the importance of measures like building **networks of community health workers in rural areas in order to attract more patients to the services.**

Meanwhile, reasons for delaying care requests are the **stigmatisation, the fear**, the often **long distance from the health facility**, the lack of transportation means or resources to be able to pay for it, and the **ineffective care pathways** that are sometimes in place. “You need to know that there are healthcare providers that can give you the necessary assistance, but unfortunately this is not always guaranteed,” says Christian Serpande.

In Bangassou, “**survivors tell you often that they try to solve problems amicably.** Before coming directly to the hospital, they go to the police or try to sort things out within the community, and this often leads to them coming late in the end,” says MSF’s medical team leader Jean Nepo Hakizamungu.

“**In locations like Nana-Bakassa or Boguila, which are about 70 and 110 kilometres from Bossangoa, there are no other organisations that provide medical care to survivors.** Considering the distance from the health facilities, it is common for patients from the periphery to arrive late. Not only this, when there are security problems, our movements and activities are usually cancelled,” adds Serpande. “In early 2021, the conflict was more accentuated, and until June, most of the cases arrived after 72 hours, because the victims did not have access.”

According to MSF workers at Bria, the security situation forces them to suspend sensitisation and outreach activities in the periphery regularly, up to three or four times a year, and each time the activities stop for a month, two months, up to three months... This has a very big negative impact. It mainly affects HIV prevention and the follow-up care.



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SURVIVORS: AFRAID AND STIGMATISED

Most patients seen by MSF in the period between 2018 and 2022 were adults (64%) and the vast majority were female (95%); this also means that nearly **four out of 10 patients were minors and that nearly 1,000 (992) were male.** Across the projects there were significant variations. While the percentage of minors seen in Bossangoa was limited (13.8%), in Bangassou it was extremely high (more than 81%). In Bria, most of the patients treated by MSF were children and adolescents as this is the target population, while another organisation looked after the adult survivors in the area.

“In the maternity ward, we often see pregnant girls who are 13 and 14 years old. Locals have the habit of staying **until very late working in the fields,** which are at times very far away from the family houses. Some even go to farm in the fields in the neighbouring Democratic Republic of Congo. Hence many **young girls stay alone in the house and are more exposed to the risk of assault,**” explains Jean Nepo Hakizamungu.

Bangassou is the only project of the five projects analysed where our teams did not receive a single male case in the 2018-2022 period. While there is not a clear explanation for this, stigma is believed to be one of the main reasons. In Tongolo, where nearly 7% of the survivors were men and our teams have been treating hundreds of cases in the last years, we know that it is extremely difficult for male survivors to come forward.

Gwladys Ngbanga-Yema, a psychologist at Tongolo, says: “Men who have suffered an attack often become dependent, they feel worthless. And this is not acceptable for them. Most male patients end up requiring psychiatric treatment. **There are more women who experience assaults, but men feel more alone.**”

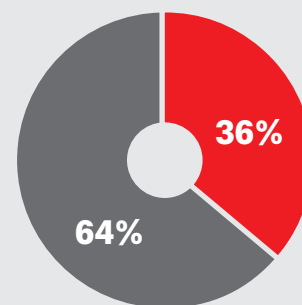
According to Serpande, forced marriages and rejection by the community and/or the family are habitual consequences in Bambari and Bossangoa, which is something that the other interviewed MSF workers also noted. “Sometimes there is a **lack of respect for their private life,** criticism, negative attitudes... This makes patients arrive stressed. They are afraid to speak because they could be criticised, and some even develop **suicidal thoughts,**” says Serpande. On the other hand, the Tongolo project team, which receives many minors, says it's clear that young people are more afraid of explaining what they've been through.

PERCENTAGE OF MINORS (UNDER 18 YEARS OLD) AT THE TOP 5 PROJECTS:

- Bossangoa: 13.85%
- Bambari: 31.5%
- Tongolo: 37.9%
- Bangassou: 81.83%
- Bria: N/A (focus on minors and adolescents)

AGE OF SURVIVOR

- <18
- >18



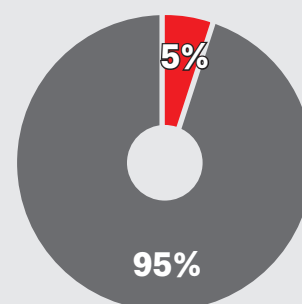
* Out of 93.39% of the total cases seen by MSF between 2018 and 2022

PERCENTAGE OF MALE PATIENTS AT THE TOP 5 PROJECTS:

- Bangassou: 0%
- Bossangoa: 0.37%
- Bambari: 2.51%
- Bria: 5.2%
- Tongolo: 6.79%

GENDER (5-year average)

- Male
- Female



* Out of the total cases seen between 2018 and 2022

PERPETRATORS: OFTEN KNOWN, HARDLY EVER PUNISHED

The Central African Republic has gone through **decades of intermittent conflict**, with armed rebellions, recurrent fighting involving a multiplicity of armed groups, and exactions that **have led to the forced displacement of hundreds of thousands of people across the country and many more to seek refuge in neighbouring countries as well**. A recurrent form of violence during peaks of conflict has been sexual violence.

However, sexual violence in CAR goes way beyond the conflict. **In Tongolo, MSF's data shows that around 40% of the perpetrators were armed², while more than half of the nearly 13,000 survivors knew their aggressor or aggressors**. In Bria, 25% of the attackers were armed and 80% of the survivors knew the attacker. "When the perpetrators are known this is because they are **from the same neighbourhood, from the school, the**

² Those considered armed can include members of non-state armed groups, pro-government forces and criminal gangs.

church or they live together with the survivor,” says Fortunée. She adds that **“unknown aggressors are usually the ones who belong to (non-state) armed groups,”** something that is also corroborated by MSF workers from other projects.

In Bangassou, where detailed information has existed for the last years, **5.1% of the perpetrators of the aggressions were armed.** In 2022, in **80% of the cases** treated by MSF teams here the **perpetrators were known civilians,** in 16.5% of the cases they were unknown civilians, in 2% they were family members, and only in 0.5% were they armed men. In relation to this, **the largest proportion of incidents of sexual violence** in Bangassou **happened at the house of the survivor,** followed by those occurring in the fields and in the forest.

Meanwhile, **in Bria, the majority of the cases were identified as happening in a big camp for displaced people.** This underlines the fact that the conflict not only directly accentuates the problem of sexual violence, but also indirectly. Indeed, **the precarious living conditions** resulting from it also **expose some people to more vulnerable situations** in which they can suffer this kind of aggressions.

Liliane Nicaise Tartoudzou, MSF’s social worker supervisor in Tongolo, says: **“Not many survivors decide to sue.** Those who are victims of armed groups usually do nothing because they do not know their aggressors. **Sometimes there is a financial settlement before going to the judge, especially if the survivor is a minor.** Most of the patients have socioeconomic problems, as there is a high level of poverty in the country. Many people experience rejection in the community, especially by the people who are closest to them. People often say it's the victim's fault and sometimes religion or tradition are used to justify what happened.”



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BEYOND MSF'S WORK

Almost a decade ago, in 2014, **UNFPA set up the gender-based violence information management system (GBVIMS) in the Central African Republic**, which according to their mandate “helps harmonize gender-based violence (GBV) data generated by services provided by organizations to survivors in humanitarian settings”. These data include, among other types of violence, sexual violence, which accounts for both rapes and sexual aggressions, in the same way MSF does.

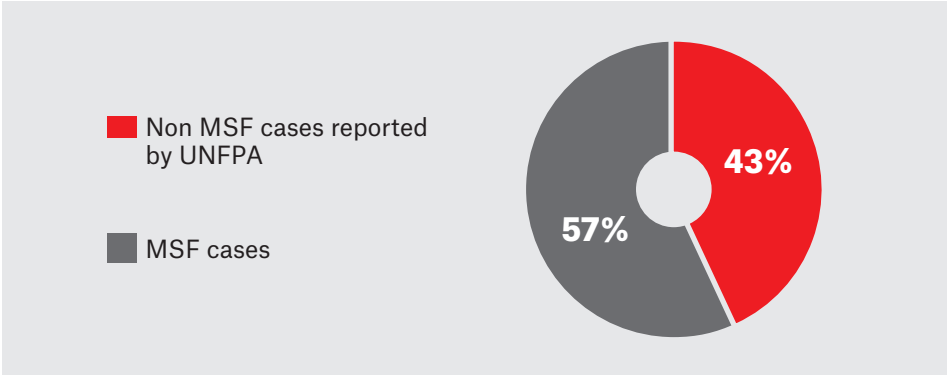
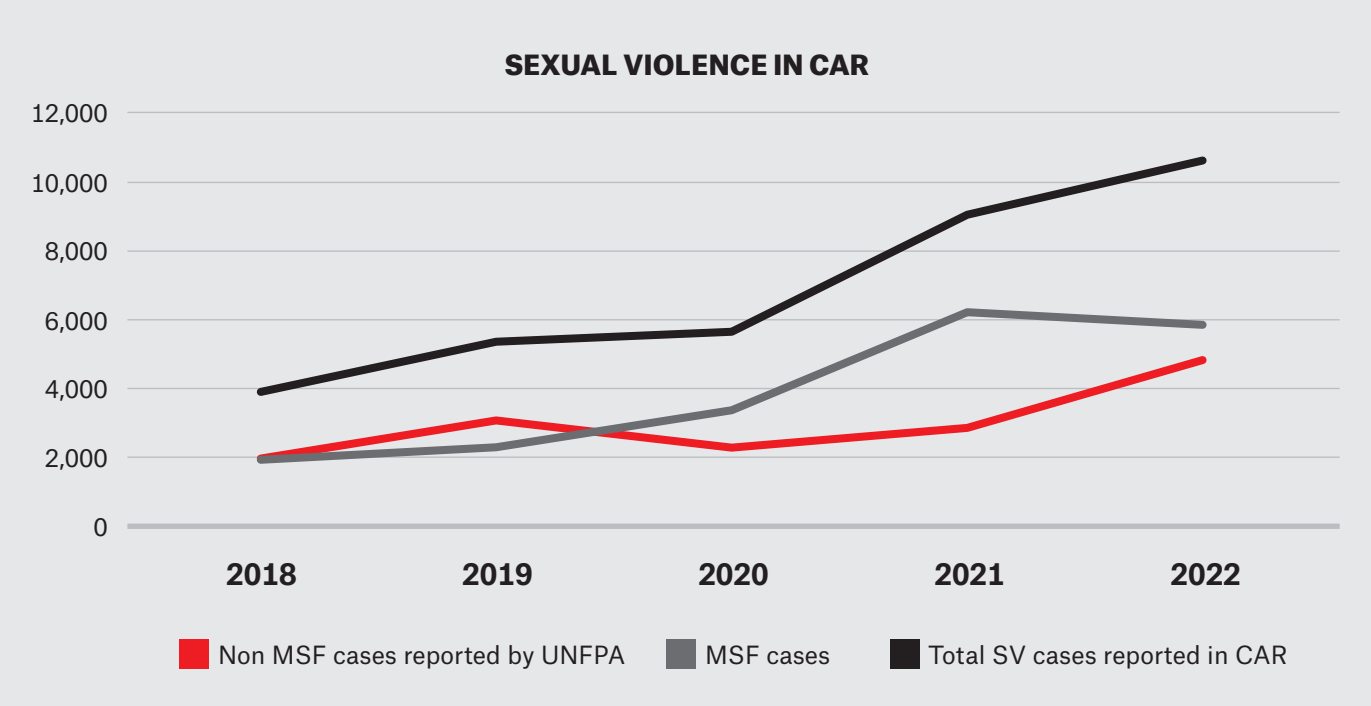
In 2022, the GBVIMS had 21 signatory organisations, 10 more than in 2018, including 17 that provide care to survivors and four that provide technical support, among which there is the Ministry for the Promotion of Gender, Protection of Women, Family and Children. These organisations and state structures covered 35% of the sub-prefectures of the country. **In 2021, MSF partially joined this system and provided the data on 3,647 cases compiled at the Tongolo project during 2022** but has not yet provided the data relative to other projects across the country.

To obtain a more accurate, although imperfect, picture of the magnitude of the problem of sexual violence in CAR, we have combined the MSF data with those provided by other organisations and governmental structures to the UNFPA system: **at least 34,426 people who experienced sexual violence were cared for in the Central African Republic during these five years, with more than half of them (57%) being seen by MSF.**

While the number of cases seen at MSF's facilities increased nearly threefold (199.2%), there was also a similar sharp increase (142%) in the number of cases seen by other organisations and government services reported to UNFPA.

However, this is only an inaccurate representation of reality. First of all, it is possible that not all the cases handled by humanitarian organisations have been counted. Furthermore, and more substantially, **a very significant number of survivors of sexual violence, if not the majority of them, don't report their cases and don't seek treatment for them.** As such, the increase in the number of cases reported in CAR is not necessarily indicative of an increased prevalence of sexual violence cases.

Year	Non-MSF cases reported by UNFPA	Sexual violence cases treated by MSF	Total sexual violence cases reported in CAR (MSF + non-MSF compiled by UNFPA)
2018	1,969	1,934	3,903
2019	3,054	2,287	5,341
2020	2,281	3,353	5,634
2021	2,836	6,156	8,992
2022	4,767	5,789	10,556
Total	14,907	19,519	34,426





CONCLUSIONS

- **Sexual violence in the Central African Republic is a taboo public health emergency and cannot be solely addressed as an armed conflict-related problem.** While there have been some positive developments over the last five years, the number of survivors seeking for help is still just the tip of the iceberg.
- **There are many gaps everywhere,** from comprehensive to basic medical care; from sophisticated psychiatric care for complicated cases to initial psychosocial support.
- **The survivors face structural barriers** in reporting aggressions and asking for care. Additional barriers exist for specific groups (men, children, adolescent).
- **In CAR, too often there is blatant impunity for perpetrators,** while **survivors face acute stigmatisation** and significant obstacles to continue their life in the community.
- A lot **more needs to be done to provide legal and socio-economic support** to allow survivors to reintegrate into society without being penalised.

RECOMMENDATIONS

- **Expand the geographical coverage with decentralisation of services**, including full medical package and psychosocial support, that can guarantee access 24/7 with a **survivor-centered approach** based on confidentiality, empathy, respect and privacy.
- **Increase support for a multi-sectoral response**, including health, mental health, psychosocial support, protection, social support and safe spaces for survivors.
- Offer survivors **the possibility of therapeutic pregnancy intervention in safe conditions** in order to prevent maternal deaths due to unsafe abortions.
- **Encourage the development of strategies that tackle the root causes of sexual violence** and seek to change harmful social norms, with the aim of reducing the risk of sexual violence, including support at the legislative, policy and community levels.
- **Provide access to free legal services** to help survivors overcome their victim status.