ALL SURVIVORS PROJECT

Enhancing Survivor-Centred Healthcare Response for Male Victims/Survivors of Sexual Violence in Central African Republic

July 2025

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All Survivors Project (ASP) is an international non-governmental organisation that supports global efforts to eradicate conflict-related sexual violence (CRSV) and strengthen national and international responses to it through research and action on CRSV against men and boys.

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Definitions

Conflict-related sexual violence (CRSV): refers to "Rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage, and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict. This link may be evident in the profile of the perpetrator, who is often affiliated with a State or non-State armed group, including those designated as terrorist groups by the United Nations; the profile of the victim, who is frequently an actual or perceived member of a persecuted political, ethnic or religious minority, or targeted on the basis of actual or perceived sexual orientation or gender identity; a climate of impunity, which is generally associated with State collapse; cross-border consequences, such as displacement or trafficking; and/or violations of the provisions of a ceasefire agreement."[1]

Health responses: for the purpose of this report, health responses for victims/survivors are defined as those services providing medical care, mental health and psychosocial support, case management, referrals, and medico-legal care (including medical certification or forensic services).[2]

Mental health and psychosocial support (MHPSS): MHPSS is part of health responses and refers to any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. Although the terms mental health and psychosocial support are closely related and overlap, they often reflect different yet complementary approaches.[3]

Victim/survivor: refers to a person of any age who has suffered CRSV, including being forced to witness CRSV against another person or persons. The term "victim/survivor" acknowledges that those who experience sexual violence may identify themselves as a victim, as a survivor, or as both, and that every individual has the right to choose their preferred language. This report uses the term "victim/survivor" except where key informants or interviewed victims/survivors use a different terminology.

Sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC): refers to the gender(s) to which a person is sexually or emotionally attracted (sexual orientation), how a person identifies or expresses their gender (which may or may not correspond with their assigned sex at birth) (e.g., dress, appearance, speech, behaviour, mannerisms), and a person's primary sex characteristics (e.g., genitalia, chromosomal structure and hormonal structure) and secondary sex characteristics (e.g., muscle mass, hair, stature).[4]

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1 UN Secretary-General, Report: Conflict-related Sexual Violence, 29 March 2022, UN Doc. S/2022/272.

2 Inter-Agency Standing Committee (IASC), Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 1 June 2007.

3 Inter-Agency Standing Committee (IASC), Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 1 June 2007.

4 ARC International, International Bar Association's Human Rights Institute, and International Lesbian, Gay, Bisexual, Trans and Intersex Association, Sexual Orientation, Gender Identity and Expression, and Sex Characteristics at the Universal Periodic Review, November 2016. See also Yogyakarta Principles (2006), which address a broad range of international human rights standards and their application to sexual orientation and gender identity issues (also Yogyakarta Principles plus 10 (2017).

Survivor-centred approach: A survivor-centred approach ensures that the rights, needs and choices of victims/survivors of sexual violence, as identified by themselves, are at the centre of all prevention and response efforts. A survivor-centred approach to health service provision, for example, recognises that all victims/survivors are different and have unique needs, but have equal rights to care and support, personal autonomy and empowerment, and control and choice over the care they receive.[5]

5 GBV Area of Responsibility (GBV AoR), Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, 2019.

Acronyms

AoR	Area of Responsibility
ASP	All Survivors Project
CAR	Central African Republic
CRSV	Conflict-related Sexual Violence
DRC	Democratic Republic of the Congo
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
GSF	Global Survivors Fund
IASC	Inter-Agency Standing Committee
ICC	International Criminal Court
ICESCR	International Covenant on Economic, Social and Cultural Rights
IHL	International Humanitarian Law
I/NGO	International / Non-Governmental Organisation
IOM	International Organisation for Migration
KI	Key Informant
LGBTI+	Lesbian, gay, bisexual, transgender and intersex
MHPSS	Mental Health and Psychosocial Support
MINUSCA	United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (Mission multidimensionnelle intégrée des Nations Unies pour la stabilisation en République Centrafricaine)
MOHRAU	Men of Hope Refugee Association Uganda
MOSUCA	Movement of Central African Republic Survivors of Sexual Violence (Mouvement des Survivantes de Violences Sexuelles en Centrafrique)
MSF	Médecins Sans Frontières
NSAGs	Non-state Armed Groups
PEP	Post-exposure Prophylaxis
PTSD	Post-traumatic Stress Disorder
RAG	Research Advisory Group
SCC	Special Criminal Court (Cour Pénale Spéciale)
SOGIESC	Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics
STI	Sexually Transmitted Infection
TJRRC	Truth, Justice, Reparation and Reconciliation Commission (Commission vérité, justice, réparation et réconciliation)
UMIRR	Joint Unit for Rapid Intervention and Eradication of Sexual Violence against Women and Children (Unité mixte d'intervention rapide et d'éradication de la violence sexuelle contre les femmes et les enfants)
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	UN Refugee Agency
WHO	World Health Organisation

Executive summary

Conflict-related sexual violence (CRSV) against men and boys remains an underreported issue and one which is often overlooked in healthcare and other responses. In the Central African Republic (CAR), where the healthcare system is fragile, there are significant obstacles to accessing timely, quality, gender-competent, survivor-centred medical care and mental health and psychosocial support (MHPSS) for all victims/survivors of sexual violence, both conflict and non-conflict-related. However, the relative invisibility of sexual violence against men and boys, along with the associated taboos, stigma, and shame, also create a range of gender-specific barriers.[6]

All Survivors Project (ASP), with the support of Médecins Sans Frontières (MSF) Spain, conducted interviews with male victims/survivors of sexual violence and with key governmental and non-governmental stakeholders responsible for designing, implementing, or otherwise supporting healthcare and associated responses to sexual violence in CAR. Based on these interviews, ASP and MSF Spain explored the experiences of individual male victims/survivors in accessing healthcare. In particular, they explored, in a survivor-centred manner, the aspects of care that victims/survivors valued, good or promising practices by healthcare providers, and how healthcare and associated responses could be strengthened to fully address the rights, needs and wishes of male victims/survivors including those with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC).

The scale of sexual violence, including CRSV, in CAR, is such that it has been described as a public health crisis. [7] Although most documented incidents involve sexual violence against women and girls, there is also a discernible pattern of CRSV against men and boys that is particularly common during armed attacks or when they are held captive by non-state armed groups (NSAGs).[8] Despite efforts to improve responses, CAR's public health system is unable to provide even basic services to most victims/survivors of all genders, particularly those living outside of the capital Bangui. In practice, most medical and MHPSS services for sexual violence victims/survivors, both conflict and non-conflict-related, are provided or supported by non-governmental organisations (NGOs).

All 25 victims/survivors interviewed for this report accessed care through MSF's Tongolo Project in Bangui – a project which provides holistic care including medical treatment, MHPSS, and guidance on pursuing legal action and obtaining protection.[9] Male victims/survivors' responses to questions about what aspects

6 The research formed part of multi-country project by ASP in Afghanistan, CAR and Colombia aimed at strengthening understandings of and responses to the experiences, needs and wishes of men and boys, including those with diverse SOGIESC. See ASP and Youth Health and Development Organization (YHDO), Enhancing Survivor-Centred Healthcare Response for Male Victims/Survivors of Sexual Violence in Afghanistan, March 2021; ASP, Enhancing Survivor-Centred Healthcare for Male Victims of Conflict-Related Sexual Violence in Colombia, September 2023.

7 Médecins Sans Frontières (MSF), "Sexual violence remains a public health crisis in Central African Republic", 15 April 2021.

8 See for example, All Survivors Project (ASP), "I don't know who can help": Men and boys Facing Sexual Violence in Central African Republic, 14 February 2018.

9 For further information about Tongolo and other MSF projects in CAR see, MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

of the care from MSF they valued provided important insights into what constitutes a survivor-centred approach. They highlighted in particular:

- ***The safe location and accessibility of facilities:*** MSF clinic was described as easy to find and victims/survivors said they felt safe and secure in the enclosed compound.
- ***Timely access to treatment:*** Several victims/survivors said that they valued the speed with which they were seen after arriving at MSF health facilities.
- ***Assurances of confidentiality:*** Due to the fear that others could find out that they were victims/survivors of sexual violence, great store was placed on confidentiality by victims/survivors. Almost all interviewed victims/survivors said that the principle of and procedures for ensuring confidentiality had been explained to them and they understood it and felt reassured.
- ***Avoidance of repeated disclosure of experience of sexual violence:*** Victims/survivors appreciated not having to repeatedly disclose their experience of sexual violence, with most saying they only had to explain what had happened to them once throughout their care journey with MSF.
- ***Free care:*** The fact that MSF's services were free of charge was important to many of the victims/survivors and an important enabler in their ability to seek care.
- ***The welcoming and respectful attitudes of healthcare workers:*** Victims/survivors spoke about having felt "welcome" or "well received", describing their reception variously as "calm", "kind" and "empathetic." All felt that they had been treated respectfully, in a non-judgmental manner, and that they were listened to and believed.
- ***The professionalism of staff:*** Victims/survivors referred to feeling that the staff were well-trained and had the appropriate skills to work with people who have suffered the trauma of sexual violence. This perception instilled confidence among victims/survivors, fostering trust in the care provided.

Principles of a Survivor-Centred Approach

A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. It is based on the guiding principles of:

- Safety
- Confidentiality
- Respect
- Non-discrimination

GBV AoR, Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, 2019.

However, most interviewed victims/survivors only sought or were able to access healthcare weeks, months, or in several cases, years after the incident of sexual violence. Access to healthcare in all except five cases occurred outside the recommended window of 72 hours.[10] The reasons given for the delays highlighted broader, systemic barriers both to the availability and accessibility of survivor-centred healthcare. Key informants provided further insights into these barriers and, although not all appeared to be familiar with

10 72 hours is the timeframe for emergency contraception, HIV prophylaxis and treatment for sexually transmitted infections to be effective and during which specimens for evidentiary purposes are ideally collected. See World Health Organisation (WHO), Guidelines for Medico-legal Care for Victims of Sexual violence, 2003.

the concept of a survivor-centred approach, they were acutely aware of both general and gender-specific obstacles facing victims/survivors in accessing timely, safe, quality healthcare. This indirectly indicates the need to strengthen the operationalisation of the principles of survivor-centredness across healthcare responses in CAR.

Following a social-ecological model of public health,[11] the barriers identified can be understood according to four interrelated levels: structural, organisational, community/interpersonal and individual, all of which must be addressed if victims/survivors of sexual violence are to receive the care they require and to which they have a right.

At a structural level, barriers included: the limited availability of basic medical and MHPSS care for immediate, emergency needs of victims/survivors of conflict-related and other forms of sexual violence (particularly outside of the capital Bangui) and for longer-term care; the scarcity of specialist MHPSS; the inadequate financial support for victims/survivors to address their immediate material needs including shelter, food and transportation; the absence of longer-term support for income-generation and livelihood opportunities; and insufficient or short-term funding for the public health system's response to sexual violence and for United Nations (UN) and international non-governmental organisation (INGO)-led programmes which in both instances undermines the availability, sustainability and continuity of responses.

At an organisational level, barriers include: the lack of sufficient numbers of healthcare workers with the training, skills and experience to recognise and respond appropriately to sexual violence against men and boys; a failure to fully consider either barriers to healthcare for men and boys or the needs and wishes of male victims/survivors in the design and implementation of healthcare services; the stigmatisation and other negative attitudes and behaviours by healthcare workers towards male victims/survivors, which may also be pronounced for male victims/survivors with diverse SOGIESC; a lack of basic equipment and medication at some healthcare facilities; a lack of respect for patient confidentiality and privacy; and the imposition of fees and other costs which make healthcare services unaffordable for many.

At a community and interpersonal level, ASP identified barriers related to taboos around sexual violence against men and boys, along with the perpetuation of misunderstandings and myths about sexual violence against men and boys. This feeds victims'/survivors' fears of stigmatisation by family and community members and subsequent shame, rejection, loss of standing in the community and family breakdown. This fear often causes victims/survivors to hide their experiences of sexual violence and isolate themselves.

And finally, ***at an individual level***, the internalisation of social stigma leads to the reproduction of shame and "blame the victim" discourses by the victims/survivors themselves. This internalisation prevents them from

11 Sarah Chynoweth et al., A social ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refuge settings: a qualitative exploratory study, Conflict and Health, 14: 43, 8 July 2020.

seeking care and assistance. Moreover, male victims/survivors often lack knowledge of available services and/or perceive them to be for women and girls only.

Beyond these barriers to accessing healthcare, victims/survivors spoke of other unfulfilled needs and how these continued to hinder their full recovery. The main gaps highlighted by victims/survivors and reinforced by key informants were:

- ***The absence of longer-term medical and mental healthcare for the consequences of sexual violence.*** Interviewed victims/survivors described how they continued to suffer physical and psychological consequences of sexual violence, but that in the absence of a quality and universally accessible public health system that is free of charge, symptoms often went untreated.
- ***The lack of livelihood support.*** Only two of the interviewed victims/survivors received any form of livelihood support (in both cases cash or items to address immediate needs). All described significant economic harms associated with their experience of sexual violence, with many having been displaced and lost their means of generating income. The lack of immediate and long-term economic support/opportunities for training and the lack of possibilities to find a job was a source of concern among both victims/survivors and key informants. This lack of support also acts as a barrier to accessing healthcare and undermines the prospects of a full recovery.
- ***The justice gap***. Although rule of law institutions dedicated to addressing sexual violence and transitional justice mechanisms have been established in CAR,[12] prospects for justice for most victims/survivors of sexual violence are limited. Interviewed victims/survivors had little confidence in the justice system and chose not to pursue criminal complaints for reasons including the cost, the lengthy process, and fear that it would be re-traumatising or would expose them to public shame. Yet even if justice appeared unobtainable, it was regarded by victims/survivors as something that could contribute to their recovery and rehabilitation.

The widespread awareness of and efforts to address these barriers among policymakers, practitioners, and other informants with whom ASP spoke was encouraging. However, considering the mutually reinforcing barriers and the enormous needs in CAR, a considerable investment by state and non-state actors is required. This investment would strengthen healthcare responses and ensure these responses are complemented and reinforced by effective justice processes that provide victims/survivors with redress and reparations for human rights abuses committed against them. Victims/survivors must be at the centre of this process – both informed about, and involved in the design, implementation, monitoring and evaluation of

12 These include: the UMIRR, the Joint Unit for Rapid Intervention and Eradication of Sexual Violence against Women and Children (Unité Mixte d'Intervention Rapide et de Répression des Violences Sexuelles Faites aux Femmes et aux Enfants) composed of elements the police and gendarmerie and civilian which provides an integrated response (investigation, basic medical care, psychosocial support and legal service) to victims/survivors of sexual violence; the Special Criminal Court established to investigate and prosecute serious human rights violations and violations of International Humanitarian Law committed since 2003; and The Truth, Justice, Reparation and Reconciliation Commission with a mandate to establish the truth about "serious national events" from 1959 to 2019 and recommend reparations for victims of serious human rights violations, which was closed down in 2024, https://www.ohchr.org/en/press-releases/2024/07/central-african-republic-independent-expert-calls-transparency-and.

healthcare services. Services must be designed and implemented in a survivor-centred manner, taking into account differentiated harms, needs, and wishes according to gender, age, and other intersecting individual and group factors.

Summary of key recommendations

The following recommendations are addressed to all relevant national and international stakeholders, including but not limited to, government entities, INGOs/NGOs and civil society organisations who operate, support, fund or influence decision-making within the healthcare sector. The recommendations aim to strengthen healthcare and related responses for victims/survivors of conflict-related and other forms of sexual violence.

While these recommendations specifically address sexual violence against men and boys, many also apply to broader measures needed to enhance responses for all victims/survivors, ensuring that victims/survivors of all genders and ages have access to safe, ethical, quality, and gender- and age-competent medical care and MHPSS, consistent with the principles of survivor-centred care. The provision of health support for male victims/survivors should not affect, limit or otherwise negatively impact services for women and girls.

1. ***Ensure victim/survivor safety, confidentiality, respect and non-discrimination in all medical facilities and referral systems.***
    - Medical facilities should offer comprehensive, quality, timely, and free-of-charge care to all victims/survivors of sexual violence, addressing the diverse needs of individuals based on gender, age, sexual orientation, gender identity and expression, and other characteristics.
    - Healthcare facilities must be designed to allow discreet access, avoiding public exposure and ensuring privacy. Private, soundproofed rooms should be available for consultations to maintain confidentiality and respect.
    - Medical facilities should implement strict protocols to safeguard the confidentiality of victims/survivors. This includes the secure storage of medical records and controlled access to sensitive information. All healthcare staff, including doctors, nurses, administrative personnel and security staff, should receive training on maintaining confidentiality, privacy, respect and non-discrimination in their interactions with victims/survivors.

2. ***Ensure that competent and adequate healthcare services are tailored to meet the specific needs and preferences of male victims/survivors, including by centring the views, experiences and expertise of these victims/survivors.***
    - Long-term partnerships with victims/survivors and victim/survivor groups should be established to ensure their experiences guide the development of healthcare services. Meaningful engagement with these groups as peer partners should be implemented throughout the entire programme cycle, from development to evaluation.
    - Targeted needs assessments should identify the specific risks and vulnerabilities faced by men and boys affected by sexual violence. The collection of sex- and age-disaggregated data is key to

monitoring access of male victims/survivors to services and ensuring equal access for all.

- Creating safe and discreet entry points into healthcare facilities for male victims/survivors is crucial, with clear pathways throughout the care process. Male survivors should be allowed to request providers of their preferred gender, and healthcare teams should include professionals trained in the specific needs of male victims/survivors, including those with diverse SOGIESC.
- Psychosocial support programmes specific for male victims/survivors should be designed to provide a safe, non-judgmental environment for discussing their experiences. These programmes could include individual counselling and group support to help address self-stigmatisation, guilt and the impact of sexual violence on relationships and self-perception.

3. ***Provide specialised capacity-building for healthcare providers on sexual violence against men and boys, including care for male survivors.***
    - Healthcare providers must receive specialised training on the unique challenges faced by male victims/survivors of sexual violence. This training should address common myths, negative attitudes and discriminatory behaviours, equipping providers to offer respectful and empathetic care.
    - National medical curricula should incorporate the specific harms and challenges associated with sexual violence against men and boys. This includes detailed training on clinical case management that centres identification, assessment, physical examination and treatment protocols.
    - Training should also emphasise the importance of survivor-centred medico-legal documentation, ensuring that physical and psychological findings are recorded accurately and ethically.

4. ***Enhance awareness and access to healthcare for male victims/survivors of sexual violence through community-based education and outreach.***
    - Community-based education and outreach efforts should improve awareness of and access to healthcare for male victims/survivors of sexual violence. This includes targeted awareness campaigns designed to inform male victims/survivors of their rights and available services, as well as the protocols in place to protect their safety and confidentiality.
    - Community health workers, gender-based violence (GBV) and child protection workers, and other relevant actors should be trained to provide sensitive and survivor-centred care to male victims/survivors. This training should equip them to offer appropriate support and referrals, ensuring the needs of male victims/survivors are met with dignity and respect.

5. ***Work towards the development of long-term, nationwide medical responses embedded in a holistic care framework.***
    - National and international stakeholders should work to expand the geographical reach of public healthcare, ensuring that comprehensive, high-quality, and free-of-charge medical and psychosocial support is accessible to all victims/survivors across the country.
    - Stakeholders should develop nationwide, long-term medical responses integrated into a holistic care framework. This should not only include immediate healthcare but also ongoing mental

health services and support. Survivors should be able to access legal assistance and socio-economic reintegration support, fostering full recovery and well-being for all victims/survivors.
- National strategies and protocols addressing sexual violence should incorporate the needs of male victims/survivors.

6. *Further enhance understandings of sexual violence against men and boys through research and data.*

- In-depth research is needed to continue improving the understanding of the specific needs and experiences of male victims/survivors. This could include in-depth consultations with survivor groups and a thorough assessment of how existing healthcare services are responding — or failing to respond — to their needs and wishes. Consultations such as this would help identify gaps and improve the effectiveness of support and care provided.
- Ongoing monitoring, data gathering and documentation efforts must be strengthened to include incidents of sexual violence against men and boys. Personnel involved in these processes must be trained to safely and ethically identify and document such cases. Information must be shared securely and anonymously among relevant stakeholders.

7. *Strengthen financial support for responses to CRSV for all victims/survivors.*

- Adequate and sustained funding is crucial to developing comprehensive services that address the diverse needs of victims/survivors. These services include healthcare, mental health support, legal assistance, socio-economic reintegration and support groups. Securing robust financial resources ensures that interventions are effective, sustainable, and accessible to all victims/survivors regardless of gender, age or other characteristics.
- Stakeholders should fund and facilitate the development of male survivor networks and peer support groups, empowering victims/survivors to offer mutual support and actively shape the services victims/survivors receive.

1. Introduction

Research for this report on health responses to male victims/survivors of sexual violence in the Central African Republic (CAR) was conducted in 2023 by All Survivors Project (ASP) with the support of Médecins Sans Frontières (MSF).[13] It forms part of a multi-country project by ASP and its in-country partners on survivor-centred healthcare in Afghanistan, Colombia and CAR. The project aims to explore perspectives on and practices in survivor-centred healthcare for male victims/survivors of conflict-related sexual violence (CRSV). It also aims to improve understandings of and strengthen responses to the experiences, needs and wishes of men and boys who have survived CRSV.[14]

ASP interviewed 25 adult male victims/survivors who had received care through MSF's Tongolo project, a project implemented with two structures in the capital city of Bangui (the Centre Tongolo and the unit in Hôpital Communautaire) and provides holistic care, including medical treatment, mental health and psychosocial support (MHPSS) and guidance on pursuing legal action and obtaining protection.[15] The research explored the experiences of these victims/survivors in accessing healthcare and other support. It looked at what aspects of the care they valued, what other needs they had or still have, and sought their perspectives on how these could be fulfilled in a survivor-centred manner.

ASP discussed with national and international governmental and non-governmental stakeholders the availability and accessibility of services for sexual violence victims/survivors more generally. Discussions explored how these could be strengthened to respond more effectively to the needs and wishes of male victims/survivors, including those with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC).

13 The Leader of the MSF international Reproductive Health and Sexual Violence Care Working participated in the Research Advisory Group (RAG) which provided guidance during the project and reviewed outputs, and MSF Spain in CAR supported the implementation of the research and the required revisions.

14 ASP and Youth Health and Development Organization (YHDO), Enhancing Survivor-Centred Healthcare Response for Male Victims/Survivors of Sexual Violence in Afghanistan, March 2021; ASP, Enhancing Survivor-Centred Healthcare for Male Victims of Conflict-Related Sexual Violence in Colombia, September 2023.

15 For further information about Tongolo and other MSF projects in CAR see, MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

This report reflects the findings from these interviews and discussions and includes recommendations on measures needed to strengthen healthcare responses for male victims/survivors of CRSV and other forms of sexual violence.[16]

A survivor-centred approach - Definition

A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, they are treated with dignity and respect and is based on the following guiding principles:

- **Safety:** The safety and security of survivors and their children are the primary considerations.
- **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
- **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
- **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic. See, GBV AoR, Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, 2019.

16 Although ASP's focuses specifically on CRSV against male victims/survivors, the research extended to other forms of sexual violence against men and boys – for example sexual violence by employers or others with no or no obvious links to the armed conflict. This recognises both the challenges of distinguishing between conflict and non-conflict-related sexual violence in highly insecure contexts such as CAR, and the need for appropriate health and other responses for all victims/survivors regardless of the circumstances in which the sexual violence occurred.

2. Overview and Methodology

Research for this report was conducted by ASP in partnership with MSF and supported by a research advisory group (RAG) set up to provide technical and strategic guidance to the project and to review outputs.[17]

The research was designed to respond to three overarching questions:

- How a survivor-centred approach to victims/survivors of sexual violence, including men and boys, is defined and operationalised in the healthcare sector in CAR?
- What are the perceptions and experiences of male victims/survivors of sexual violence, including those with diverse SOGIESC, in relation to healthcare services including MHPSS and, where relevant, other intersecting forms of support?
- What are the gaps in existing healthcare responses with respect to men and boys, including those with diverse SOGIESC, who have experienced sexual violence?

A qualitative methodology[18] was used, employing semi-structured interviews with two main groups: adult male victims/survivors of sexual violence and selected national and international stakeholders working in policy or programming in support of victims/survivors of sexual violence. In addition to a global literature review of survivor-centred approaches to service provision for survivors of sexual violence in the health, justice and livelihoods sectors that was conducted to inform the wider three-country study, the research for this report involved:

- A desk review of literature on sexual violence against men and boys in CAR and of relevant national laws and policies.
- In-depth interviews with 25 male victims/survivors of sexual violence, all of whom had completed the full cycle of care from MSF's Tongolo project in Bangui.[19]
- Key informant interviews or consultations with 31 representatives of 22 different national and international institutions or organisations.

17 Members of the RAG included representatives of two survivor networks, Survivors Speak Out (UK) and Men of Hope (Uganda), sexual violence experts and academics from UNHCR, the International Organization for Migration (IOM), MSF International Reproductive Health and Sexual Violence Care Working Group, the Mukwege Foundation, and The Havens, Kings College Hospital NHS Foundation Trust, and a research ethics specialist.

18 For additional details of the methodology see Annex I.

19 To complete a cycle of care at MSF means that the individual has completed a course of medical and psychological care, and their files are closed/they are no longer in active follow-up.

Participation criteria and sampling of victims/survivors and key informants

Victims/survivors were initially identified by MSF based on the criteria that they were a victim/survivor of sexual violence; 18 years old or over at the time of the research; assigned male sex at birth and/or identified as male/men, including of diverse SOGIESC; had completed a cycle of care from MSF; were not experiencing or receiving treatment for serious mental health conditions; and could provide informed consent to participate in the research.

Key informants were identified through an initial stakeholder mapping exercise and subsequently through recommendations during interviews or consultations with key informants. The 31 key informants included government representatives from the Ministry of Health and Population (*Ministère de la Santé et de la Population*) (Ministry of Health) and the Ministry for the Promotion of Women, the Family and the Protection of the Child, (*Ministère de la Promotion de la Femme, de la Famille et de la Protection de l'Enfant*) (Ministry of Women and Children); representatives of the Joint Unit for Rapid Intervention and Eradication of Sexual Violence against Women and Children (*Unité Mixte d'Intervention Rapide et de Répression des Violences Sexuelles Faites aux Femmes et aux Enfants,* UMIRR); national victims/survivor networks, the UN and national and international NGOs and civil society organisations involved in providing services and other forms of support including healthcare, gender-based violence (GBV) responses and legal support to male, female and/inclusive of lesbian gay bisexual transgender intersex (LGBTI+) victims/survivors of sexual violence. Although all key informants were based in Bangui, representatives from the Ministry of Health and Ministry of Women and Children have national responsibilities and most other informants had responsibilities or worked for institutions or on projects with a more national reach.

Data collection

Interviews and other data collection activities were carried out between April and July 2023. All victims/survivors were interviewed by a male researcher from CAR, and key informants were interviewed by a female international research consultant.

Interviews with male victims/survivors took place in person at an MSF facility in Bangui and were conducted in Sango or French depending on interviewee preference.[20] Consultations and interviews with key informants were conducted in person and remotely by telephone or Zoom. Most were conducted in French, although English was also used according to interviewee preference.

Most interviews were audio-recorded, except in the case of eight key informants and two victims/survivors who chose not to be recorded and where verbatim notes were taken instead. All key informant interviews were transcribed and those held in French translated directly into English. Victim/survivor interviews in Sango were translated into French and subsequently into English.

20 A discreet area in the MSF office was prepared for interviews to ensure privacy.

Data analysis and validation

English transcripts were coded using NVivo software through an inductive approach that allowed for ongoing open-coding of themes as they emerged. Coded transcripts were then reviewed to develop themes and sub-themes, using a social ecological framework to support analyse and organise findings relating to barriers to accessing healthcare.

The themes that emerged were shared and discussed with MSF and selected key informants during a visit by ASP to CAR from 28 October to 4 November 2023. An additional review of transcripts was undertaken in May and June 2024 to further clarify findings and support the drafting of the report. A draft of the report was reviewed by MSF and by members of the RAG.

Ethical considerations

Various measures were taken to ensure that the research was ethical and that the safety, security and confidentiality of research participants was protected before, during and after interviews. These included:

- Ethics approval was obtained from MSF's Ethics Review Board and the Ethics and Scientific Committee of the Faculty of Health Sciences *(Comité Ethique et Scientifique de la Faculté des Sciences de la Santé)* at the University of Bangui.[21] The Ethics and Scientific Committee reviewed the report and approved publication in December 2024.
- Training of the researcher conducting victim/survivor interviews on research ethics, including ensuring privacy, confidentiality and data protection and on obtaining informed consent for interviews and the use of information, including anonymised quotations, in the report.
- Written informed consent was also obtained from key informants prior to interviews.
- Confidentiality was ensured by removing identifying data from transcripts, including the names of individuals. To further protect identities of victims/survivors, detailed demographic information or other identifiable information is not included in the report. Key informants and the organisations to which they belonged are also not named, although limited information about their role and sector they work in is referenced where relevant.
- In order to prevent re-traumatisation, victim/survivors were not asked about their experiences of sexual violence, although some chose to discuss limited details of what had happened to them. Nevertheless, recognising that even recounting experiences associated with the health impacts of sexual violence could be distressing, post-interview support was offered to all interviewed victims/survivors by MSF.

21 MSF's Ethics Review Board approval no. ID:2210 obtained in June 2022 and Ethics Review Board and the Ethics and Scientific Committee of the Faculty of Health Science approval no. 44/UB/FACSS/IPB/CES/022) obtained in October 2022.

Research limitations

Ethical considerations, time constraints, insecurity and other challenges inevitably led to some limitations in the research which impacted on the findings. These included:

- All interviewed male victims/survivors were former patients of MSF and none had received healthcare from other providers which meant it was not possible to explore individual experiences of accessing and receiving healthcare from other services.
- Because all interviewed victims/survivors were adults and all had experienced sexual violence when they were over 18 years old, there is a gap in relation to the experiences of boys in accessing healthcare which should be addressed in future research.
- In accordance with the research protocol, victims/survivors were not asked about their SOGIESC, and none disclosed information about this during interviews. Some key informants were asked about the provision of healthcare support to male victims/survivors with diverse SOGIESC but because gender non-conformity is widely regarded as taboo in CAR there was little experience of this among informants, with the exception of those working directly with LGBTI+ communities. As a result, there are limited findings specific to the experiences, needs and wishes of men and boys with diverse SOGIESC. Likewise, the potential impact of other intersecting characteristics including ethnicity or religion of victims/survivors was not explored.
- The number of key informants interviewed was lower than the target number (representatives of 40 relevant institutions or organisations) although the 31 key informants interviewed were representative of the relevant sectors - health, MHPSS and GBV. All 31 key informants were based in Bangui because security and time constraints prevented travel outside the capital to conduct interviews with key informants located in other regions where CRSV against men and boys has been documented.

3. Background: CRSV in CAR and Responses to it

3.1 CRSV – an ongoing protection concern

CAR has endured decades of instability and has effectively been in a state of civil war for most of the past 20 years. Despite successive peace agreements and commitments to end sexual violence by parties to the armed conflict in the 2019 Political Agreement for Peace and Reconciliation in the Central African Republic (known as the Khartoum Accord), CRSV remains among the leading protection concerns today.[22]

Almost all UN-verified incidents of CRSV involve women and girls, although some cases of CRSV against men and boys have been documented. However, previous research by ASP has identified a discernible pattern of CRSV against men and boys that is particularly common during armed attacks or when men and boys are held captive by NSAGs .[23] There are also verified incidents in which men were subjected to sexual violence because they refused to join NSAGs , as well as indications that boys (as well as girls and other genders) associated with armed groups are vulnerable to sexual violence or used for sexual purposes.[24] Sexual exploitation and abuse of children – including boys – by international military personnel, UN peacekeepers and humanitarian workers also remains an ongoing concern.[25]

In CAR, the relationship between instances of sexual violence and armed conflict can be blurred and CRSV figures alone do not necessarily provide an accurate picture of the full extent of the problem. The Gender-Based Violence Information Management System (GBVIMS), which records all conflict- and non-conflict-related incidents of GBV based on information provided by service providers, contributes to building a

22 See Report of the UN Secretary-General, Conflict-related Sexual Violence, 22 June 2023, UN Doc, S/2023/413, which identifies Retour, Réclamation et Réhabilitation, Front Populaire pour la Renaissance de la Centrafrique (FPRC), Unité pour la Paix en Centrafrique (UPC) and Anti-balaka, all affiliated with Coalition des Patriotes pour le Changement (CPC) as the main perpetrators among NSAGs. See also United Nations Office or the Coordination of Humanitarian Affairs (OCHA), République centrafricaine: Aperçu des besoins humanitaires (Central African Republic: Humanitarian Needs Overview), 3 January 2024.

23 ASP, "I don't know who can help": Men and boys Facing Sexual Violence in Central African Republic, 14 February 2018.

24 Office of the Special Representative of the Secretary-General for Children and Armed Conflict (OSRSG CAAC), Responding to Conflict-related Sexual Violence Against Boys Associated with Armed Forces and Armed Groups in Reintegration Programmes, December 2022.

25 ASP, "I don't know who can help": Men and boys Facing Sexual Violence in Central African Republic, 14 February 2018; Report of the UN Secretary General, Children and Armed Conflict in the Central African Republic, January 2024, UN Doc. S/2024/93, 24. See also OCHA, République centrafricaine: Aperçu des besoins humanitaires (Central African Republic: Humanitarian Needs Overview), 3 January 2024, which notes that "...men and boys are equally confronted by sexual violence in diverse contexts, notably during armed conflict, in detention and as child soldiers".

fuller picture.[26] According to the GBVIMS, in 2023 there were 25,554 registered incidents of GBV in CAR, an 8% increase from 2022. Sexual violence was the most reported form of GBV, accounting for 37% of recorded cases.

The report shows that women and girls constituted the majority of victims/survivors of GBV (96%) in 2023, but 862 incidents of GBV involving men (including 202 cases of rape and four cases of sexual violence) and 168 cases of GBV involving boys (including 60 cases of rape and three cases of sexual violence) were also recorded. However, the report notes that these figures represent only a small part of the total number of cases. This is often because not all organisations involved in providing GBV services are members of the GBVIMS and thus do not share their data with it, and because many victims/survivors do not have access to services.[27]

These high levels of sexual violence and other forms of GBV occur against a backdrop of instability, poverty, vast humanitarian needs and entrenched gender inequality and discrimination. The situation in CAR remains fragile with frequent armed clashes between government armed forces and NSAGs and attacks on civilians as well as extortions, kidnappings and other human rights abuses against civilians by NSAGs in many areas of the country.[28] CAR is also one of the poorest countries in the world,[29] ranking 191st in the United Nations Development Programme (UNDP)'s Human Development Index.[30] Approximately 71% of the population lives below the international poverty line (US$1.90 per day)[31] and, as of early 2024, nearly half of the population (2.8 million people) were in need of humanitarian assistance.[32] According to the UN Refugee Agency (UNHCR), 518,075 people were internally displaced as of April 2024, and hundreds of thousands more were refugees in neighbouring countries.[33] Additionally, there were over 36,000 refugees in CAR from Sudan, the Democratic Republic of the Congo (DRC), South Sudan, Chad and other neighbouring countries.[34] The country has some of the largest gender gaps in the world, ranking 188th out of 191 countries in terms of gender equality. These gender gaps are recognised as contributing to high rates of GBV that are a major obstacle to the full participation of women in social and economic life.[35]

26 The GBVIMS is an inter-agency initiative created to harmonise data collection by GBV service providers in humanitarian settings which provides a system for collecting, storing, analysing and sharing data on GBV incidents and services.

27 GBVIMS, Rapport Annuel GBVIMS 2023 - Republique Centrafricaine (GBVIMS Annual Report 2023, Central African Republic), 14 April 2024.

28 Report of the Secretary-General, Central African Republic, 18 June 2024, UN Doc. S/2024/473.

29 World Bank, The World Bank in Central African Republic, Overview, updated version, 30 March 2023.

30 UNDP, Human Development Report 2023-24. Breaking the gridlock: Reimagining cooperation in a polarized world, March 2024.

31 World Bank, The World Bank in Central African Republic, Overview, updated version, 30 March 2023.

32 OCHA, Central African Republic Situation Report, 13 February 2024.

33 OCHA, Dashboard, Central African Republic, accessed on 7 March 2024.

34 UNHCR, Dashboard, Central African Republic, accessed on 4 May 2024.

35 World Bank, The World Bank in Central African Republic, Overview, updated version, 30 March 2023.

3.2 National legal and policy framework on sexual violence

CAR's 2010 Penal Code criminalises rape and other forms of sexual violence in a gender-inclusive manner that is consistent with international standards. Articles 153-157 of the Penal Code also incorporate war crimes and crimes against humanity, including sexual slavery, rape, forced prostitution, forced pregnancy, forced sterilisation and other forms of sexual violence of a similar level.

The 2016 Constitution guarantees the right to healthcare of all citizens,[36] reflecting CAR's obligations under international treaties that it has ratified, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human Rights.[37]

Over the years, various strategies and plans have been adopted to combat and respond to gender-based violence and/or CRSV. Among these are the Strategy to Combat Gender-based Violence, Harmful Practices and Child Marriage in the Central African Republic, 2019-2023 (*Stratégie Nationale de Lutte Contre les Violences Basées sur le Genre, les Pratiques Néfastes et le Mariage d'enfant en République Centrafricaine, 2019-2023*) (National Strategy to Combat GBV). ASP is aware that existing strategies primarily focus on women and girls; women and girls represent the majority of victims of GBV, a fact which highlights the importance of engaging men and boys in combatting GBV against them. Nevertheless, a 2019 strategy notes "the importance of remembering that men and boys can also be victims of GBV and that women can also be perpetrators"; it also categorises men and boys as among the most at-risk groups to GBV and highlights their particular vulnerability to sexual violence in the context of armed conflict.[38]

The overarching objectives of the 2019 national strategy and many of the actions contained in it are drafted in a gender-inclusive manner. These gender-inclusive objectives include those relating to reducing the vulnerability of at-risk groups, ensuring the availability of integrated, multi-sectoral responses (medical and mental health, legal support and social-economic reintegration) to victims/survivors, and improving access to justice. The strategy also explicitly includes a plan to conduct a study on GBV, "including against men" (activity 6.1.2.1), and to strengthen the capacity of communities to provide psychosocial and psychological support for survivors of GBV, including male victims/survivors (activity 4.1.1.14). However, the strategy makes no reference to people with diverse SOGIESC.

36 Central African Republic Constitution 2016, articles 8 (unofficial translation).

37 Article 12 of the ICESCR (acceded to in 1981) requires State parties "...to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and to take measures to realise this right including "the creation of conditions which would assure to all medical service and medical attention in the event of sickness." See also Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The right to the highest attainable standard of health., 11 August 2000, UN Doc. E/C.12/2000/4. According to ICESCR Article 2.2, State parties should ensure that rights under the Covenant are exercised without discrimination of any kind. See also CESCR, General Comment No. 20, Non-discrimination in economic, social and cultural rights., 2 July 2009, UN Doc. E/C.12/GC/20, para. 7. Also General Comment No. 14. Article 16 of the African Charter on Human Rights recognises the right of every individual to enjoy the best attainable state of physical and mental health and requires State parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

38 Ministry of Women and Children, Strategy to Combat GBV, November 2019, p. 11, 14, 17 and 48. On file with ASP.

In May 2019, a Joint Communiqué was signed between the United Nations and the Government of the Central African Republic to address CRSV. The communiqué recognises the differing needs of victims/survivors (women, men, girls and boys) and under the joint communiqué, the government committed to enhance protection and to develop and implement, in coordination with relevant national and international actors, measures to ensure holistic, multi-sectorial, gender-sensitive medical, mental health and psychosocial services and legal aid. The government is also committed to criminal justice processes and a reparations programme to ensure accountability of perpetrators and access to justice for victims/survivors.[39]

A special adviser on CRSV within the Office of the President was subsequently appointed and a strategic committee to combat GBV linked to armed conflict was established (*Comité Stratégique dans le Cadre de la Lutte Contre les Violences Basées sur le Genre Liées au Conflit en République Centrafricaine*). The strategic committee is co-chaired by the United Nations Multidimensional Integrated Stabilization Mission in the Central African Republic (MINUSCA) and the United Nations Population Fund (UNFPA), with members from the CAR government, UN agencies, the International Organization for Migration (IOM), MSF and the Global Survivors Fund (GSF). The Committee is responsible for the political and strategic coordination of and mobilisation of resources for responses to CRSV, including reparations for victims/survivors. Its work is guided by an operational action plan, originally for 2022-2023 but since extended to 2026.[40]

3.3 Health responses

The scale of sexual violence in CAR, including CRSV, is such that it has been described as a public health crisis, and although access to healthcare has improved over the years, many gaps remain.[41]

CAR's public health system is in a fragile state and is unable to provide even basic services to most victims/survivors, particularly those living outside of Bangui.[42] Decades of under-investment and armed conflict have degraded already weak healthcare infrastructure – of the 1,168 healthcare structures, only 1,019 (or 58%) were accessible in 2023 for a population of 5.3 million people.[43] There is a chronic shortage of qualified healthcare workers, with just 6.03 healthcare workers per 10,000 inhabitants in 2020/23, [44] well below the World Health Organisation (WHO) Sustainable Development Goal threshold of 4.45 health workers per 1,000 population needed to achieve universal healthcare coverage.[45] Medical equipment and medicines are

39 Communiqué conjoint entre le République Centrafricaine et l'Organisation des Nations Unies: Prévention et lutte contre les violences sexuelles liées au conflit (Joint communiqué between the Central African Republic and the United Nations: Prevention and fight against conflict-related sexual violence), 31 May 2019.

40 Report of the Secretary-General, Central African Republic, 18 June 2024, UN Doc. S/2024/473.

41 MSF, Sexual violence remains a public health crisis in Central African Republic, 15 April 2021; MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

42 World Bank, The World Bank in Central African Republic, Overview, updated version, 30 March 2023.

43 OCHA, République centrafricaine: Aperçu des besoins humanitaires (Central African Republic: Humanitarian Needs Overview), 3 January 2024.

44 OCHA, République centrafricaine: Aperçu des besoins humanitaires (Humanitarian Needs Overview: Central African Republic), 30 November 2022.

45 WHO, Global Strategy on Human Resources for Health: Workforce 2030, May 2016; OCHA, République centrafricaine: Aperçu des besoins humanitaires (Humanitarian Needs Overview: Central African Republic), 30 November 2022.

also in short supply. The cost of healthcare is prohibitive for many – in 2022 it was reported that 40% of the population were unable to cover the cost of healthcare.[46]

In practice, most medical and MHPSS services for victims/survivors of GBV, including CRSV, are provided directly by or supported by international organisations.[47] These include MSF who provided care to over 19,500 survivors of sexual violence between 2018 and 2022 in its projects across the country; the Tongolo project in Bangui accounted for 66% of the cases seen by MSF.[48] During the same period, another 14,907 victims/survivors of sexual violence in CAR were reported to have received support from other humanitarian organisations or by state structures.[49] Others, such as the Nengo Project, which is based in a public hospital in Bangui (the Amitié Sino-Centrafricaine Teaching Hospital) are also dedicated to victims/survivors of sexual violence and have a holistic model of care, providing medical, psychological, legal and socio-economic support in one setting.[50] Others provide broader GBV or protection responses, or focus on particular elements of care such as psychosocial support.

Nevertheless, as MSF has noted, chronic gaps persist "from comprehensive to basic medical care; from sophisticated psychiatric care for complicated cases to initial psychosocial support."[51] The lack of healthcare is most acute in rural and remote areas. Access to services that do exist are often constrained by lack of or costly transportation and compounded by insecurity which makes movement difficult in some areas. Attacks on healthcare facilities and workers are also frequent.[52]

According to the GBVIMS, just over a quarter (28%) of victims/survivors of rape in CAR received either medical care within 72 hours or timely psychosocial support in 2023. Delays in access to medical care were attributed to the lack of availability of services, social and cultural constraints, shame, fear of reprisals, stigmatisation of victims/survivors by society, medical costs and the long distances needed to travel to access services.[53]

46 OCHA, République centrafricaine: Aperçu des besoins humanitaires (Humanitarian Needs Overview: Central African Republic), 30 November 2022.

47 In 2022, 70% per cent of health services were provided by humanitarian organisations. See OCHA, Two years after the Central African Republic confirmed the first COVID-19 case, 20 September 2022.

48 For further details on MSF projects in CAR see, MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

49 MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

50 The Nengo Project was set up in 2020 by the Pierre Fabre Foundation, Panzi DRC Foundation, Dr. Denis Mukwege Foundation and Francophone Institute for Justice.

51 MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

52 UN Secretary-General, Annual Report on Conflict-related Sexual Violence, 29 March 2022, UN Doc. S/2022/272. According the Surveillance System for Attacks on Healthcare (SSA) there were 30 attacks on healthcare facilities and healthcare workers in CAR in 2023, https://extranet.who.int/ssa/LeftMenu/Index.aspx

53 GBVIMS, Rapport Annuel GBVIMS 2023 - Republique Centrafricaine (GBVIMS Annual Report 2023, Central African Republic), 14 April 2024. According to MSF, "*although 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, there has been a significant improvement from 15.98% in 2018 to 35.12% in 2022, with constant yearly gains*." See MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

As a result of the above challenges, most victims/survivors do not have access to post-exposure prophylaxis (PEP) within the required 72-hour timeframe to effectively prevent HIV transmission. Likewise, they often lack timely access to other urgent emergency care including prevention and treatment of other sexually transmitted infections (STIs), hepatitis and tetanus, and treatment of injuries including through surgical care. Opportunities to gather specimens or other evidentiary material for subsequent justice processes also dramatically decrease if not done within 72 hours after the incident of sexual violence.[54] Such delays can lead to long-term complications for victims/survivors such as chronic pain, HIV and other STIs, unwanted pregnancies, and mental health issues such as post-traumatic stress disorder (PTSD), depression and anxiety.

The majority of victims/survivors of sexual violence who do receive medical care and MHPSS support are women and girls. However, a significant number of men also seek support. For example, in the five years between 2018 and 2022, 992 out of 19,519 (or 5%) survivors of sexual violence treated by MSF projects across the country were male.[55] Representatives of other INGOs interviewed for this report also noted that it was not uncommon for them to see cases of men and boys who had experienced sexual violence, including CRSV; according to a key informant working for an international child protection organisation, around 10-20% of the GBV cases they manage are boys.[56]

3.4 Justice responses

Significant challenges remain in establishing rule of law and in strengthening justice institutions. However, the CAR government, supported by the UN and other actors, has established various institutions and transitional justice processes aimed at ensuring accountability and improving access to justice by victims/survivors of serious human rights violations, including CRSV.

Among these institutions is UMIRR which became operational in 2017 and is composed of elements of the police and gendarmerie, and civilian personnel. UMIRR is designed to provide an integrated response (investigation, basic medical care, psychosocial support and legal services) to conflict and non-conflict-related sexual and gender-based violence (SGBV) and child abuse.[57] Although most of its cases involve women and children, UMIRR also addresses sexual violence against men. In 2022, UMIRR's Bangui unit received over 3,000 complaints of SGBV of which 2,377 were from women and 650 from men.[58]

54 See WHO, Guidelines for Medico-legal Care for Victims of Sexual violence, 2003.

55 MSF, Invisible Wounds: MSF's findings on sexual violence in CAR between 2018 and 2022, 24 October 2023.

56 In-person interview with representative of INGO, child protection (KI 18), 13 July 2023.

57 UMIRR was established by Decree No. 15/007 of 8 January 2015 on the Creation of a Joint Unit for Rapid Intervention and Eradication of Sexual Violence against Women and Children *(Decree No. 15.007 portant Création d'une Unité Mixte d'Intervention Rapide et de Répression des Violences Sexuelles).*

58 United Nations Development Programme (UNDP), Central African Republic, Global Focal Point Profile, accessed on 5 March 2024.

Although accountability for CRSV remains rare, some cases have been prosecuted in national courts.[59] In 2015, the Special Criminal Court (SCC) (*Cour Pénale Spéciale*), a special jurisdiction within the CAR justice system, was established to investigate and prosecute serious human rights violations and violations of International Humanitarian Law (IHL) committed since 2003.[60] Although the early years of the SCC were beset with delays, its first verdict, delivered in 2022, found three members of the non-state armed group known as 3R (*Retour, Réclamation et Réhabilitation*) guilty of crimes against humanity and war crimes committed in 2019. This verdict included the conviction of one member of rapes perpetrated by his subordinates on the basis of his command responsibility.[61] Other cases of CRSV have been investigated by the SCC and are thought to involve CRSV against men.[62] Additionally, in 2007, the International Criminal Court (ICC) opened investigations into alleged war crimes and crimes against humanity in CAR, including CRSV.

A truth-seeking process is also underway and although progress is limited, it offers the possibility of broader forms of justice to victims/survivors of CRSV. The Truth, Justice, Reparation and Reconciliation Commission (TJRRC) (*Commission vérité, justice, réparation et réconciliation*), was established to investigate and establish the truth about "serious national events" from March 1959 until 31 December 2019. The TJRRC, which is also mandated to propose a reparation programme and establish a national reparations fund, also got off to a slow start and its work has been constrained by multiple factors including a lack of resources, insecurity and concerns about its own independence.[63] The mandate of the eleven commissioners was ended in May 2024 and a selection process for the recruitment of new commissioners was launched.[64]

In the absence of a comprehensive national reparations programme, there are various routes through which victims/survivors of CRSV can access reparations, although all are very limited in reach. These include via the SCC,[65] the ICC Trust Fund for Victims,[66] and through an interim reparations programme for victims/survivors of CRSV established by the NGO, the GSF, and partners. The programme supported 597 victims/survivors of

59 The Bangui Appeal Court "…continued to try cases concerning sexual violence in hearings closed or partially closed to the public, with preventive measures in place to protect the identity of victims and witnesses." See Report of the UN Secretary-General, Central African Republic, 15 February 2024, UN Doc. S/2024/170.

60 The SCC was established under Organic Law No. 15.003.

61 For further information on the case see JusticeInfo.Net, Central African Republic: Special Criminal Court Hands Down First Judgment, 1 November 2022.

62 In December 2022, 77 cases were submitted to the SCC following investigations conducted by UMIRR, supported by MINUSCA, UNDP and the Team of Experts on the Rule of Law and Sexual Violence in Conflict. The investigations focused on CRSV perpetrated by the Front populaire pour la renaissance de la Centrafrique and the Unité pour la paix en Centrafrique in Haute-Kotto and Mbomou Prefectures. See, Report of the UN Secretary-General on the Central African Republic, 16 February 2023, UN Doc. S/2023/108.

63 For further information see, Report of the Independent Expert on the Situation of Human Rights in the Central African Republic, 22 August 2022, UN Doc. A/HRC/51/59; Report of the UN Secretary-General on the Central African Republic, 16 February 2023, UN Doc. S/2023/108; Center for the Study of Violence and Reconciliation, African Transitional Justice Hub, Central African Republic Truth, Justice, Reparation and Reconciliation Commission (2021-present), 1 November 2023.

64 Office of the High Commissioner for Human Rights (OHCHR) Central African Republic: Independent Expert calls for transparency and independence in the selection process of new Commissioners for Truth Commission, 20 July 2024.

65 In June 2023, the SCC handed down its first reparations decision relating to its first trial. For further information see, JusticeInfo.Net, Central African Republic: Special Court Hands Down First Reparations Decision, 19 June 2023.

66 The TFV launched a pilot project in September 2020 and a five-year programme under its assistance mandate in CAR aimed at supporting « the most vulnerable victims and their families in Bangui, living in precarious conditions and suffering long-term harm as a result of sexual violence in conflict ». For further information see, ICC Trust Fund for Victims, Central African Republic, accessed on 24 May 2024.

CRSV including 52 men in Dékoa in the southeast of the country, involving compensation, socio-economic support and vocational coaching, medical, psychological and psychosocial care, and identity documents for survivors and their children.[67]

67 Global Survivors Fund (GSF) partners are the Association des Femmes Juristes Centrafricaines in Central African Republic, the Mukwege Foundation, Mouvement des Survivantes de Centrafrique (MOSUCA) and the Collectif National des Associations de Victimes de Centrafrique. For further information see, GSF, Central African Republic, accessed on 9 July 2024.

4. The Consequences of Sexual Violence

4.1 Profile of interviewed victims/survivors and harms experienced as a result of sexual violence

Of the 25 male victims/survivors who took part in research for this study:

- The youngest was in his early twenties and the oldest in his early fifties at the time of data collection. All were aged between their early twenties and early fifties when they first experienced sexual violence.
- All were living in the capital, Bangui, or surrounding areas at the time of the interview, although some originated from other areas.
- All had been subjected to at least one incident of sexual violence. In some cases, this was directly related to the armed conflict, while in others, victims/survivors referred to sexual violence having occurred at their workplace, in the context of domestic violence or during attacks by strangers.[68]
- Two victims/survivors reported having physical disabilities, with one attributing his disability to violence associated with the incident of sexual violence.[69]
- None identified as being of diverse SOGIESC.

For all, the consequences of sexual violence were diverse, frequently long-lasting, and included severe physical, psychological, and socio-economic impacts, while their families and broader communities can also experience associated negative repercussions.

> *"I lost all my belongings and I was sick afterwards. At some point I had psychological problems."*
>
> (Victim/Survivor, Interview 2)

Male victims/survivors who were interviewed shared a range of physical, mental, social and economic harms that they experienced as a result of sexual violence. Key informants also spoke about a range of different harms often experienced by male victim/survivors. In both cases, it was apparent that the harms were often mutually reinforcing and that individual victims/survivors were uniquely affected based on their individual circumstances, resources and support systems.

68 In accordance with the research protocol, victims/survivors were not asked for details of the incident/s of sexual violence experienced which meant that the researchers were not always aware of nature of the incident or the circumstances in which it occurred unless victims/survivors volunteered the information.

69 Information on disabilities was not consistently asked for or recorded, so the actual number may be higher.

Physical injuries referenced included anal and rectal health issues such as anal bleeding, leakage and/or faecal incontinence, impotency and/or erectile dysfunction, mobility problems, chronic pain and haemorrhoids. Several victims/survivors said that they had tested positive for HIV or other STIs, had rashes or a fever. Other physical injuries such as fractured bones and loss of eyesight were also reported as having resulted from violence associated with sexual violence.

> *"I wasn't in good spirits after my incident. I used to get angry every time I saw a uniform carrier go by ..."*
>
> (Victim/Survivor, Interview 11)
>
> *"Sometimes I dream about the same things again and again."*
>
> (Victim/Survivor, Interview 22)

One key informant described the "catastrophic" repercussions on the mental health of some male victims/survivors, the difficulties they often have in rebuilding their lives and that suicidal thoughts are common.[70] Others referred to symptoms of hypervigilance, anger, depression, lack of self-esteem and shame. Post-traumatic stress disorder was also considered common by key informants who reported manifestations such as flashbacks and nightmares that can occur many years after the original event. As one informant explained, "even for 10, 15, 20 years...the person will experience it. The person will think about what has happened and it will continue to traumatise him. Once you have given your messages, you can see that the person is remembering what happened to him. You can tell. They start to cry, and their face changes and you know then that the person is a victim".[71]

> *"After the incident, I couldn't have sexual relations with my wife and she eventually abandoned me and left me with the children. What's more, I have no way of earning money or pay for my children's schooling. All of these things make my head turn."*
>
> (Victim/Survivor, Interview 18)
>
> *"After the incident, I had to stop working ... The mother of my three children abandoned me. But I don't like talking about it."*
>
> (Victim/Survivor, Interview 22)

Key informants also explained that, beyond depression and suicidal thoughts, victims/survivors often question their masculinity and experience anxiety about their sexual orientation and gender identity as a result of sexual violence. According to one, survivors "will ask how [a man can] have sex with another man? ... Why did that happen to me? This kind of person is likely to have a lot of symptoms of depression, or a lack of self-esteem, sometimes he will think about suicide".[72] Another explained the reaction of one male victim/survivor that they encountered in their work: "'I sleep with women, so how can a man sleep with men?' It's impossible in our culture! This man told me that it was really hard for him to be in the community with other men, to the point where he wanted to end his life".[73]

Analysis of interviews with victims/survivors and key informants also shows how the repercussions of sexual violence extend

70 Remote interview by Zoom with representative of INGO, justice sector (KI 1), 29 June 2023.
71 In-person interview with representative of an INGO providing medical care to victims/survivors of sexual violence (KI 6), 10 July 2023.
72 In-person interview with representative of INGO supporting victims/survivors of sexual violence (KI 24) 17 July 2023.
73 Remote interview by Zoom with representative of INGO, justice sector, (KI 1), 29 June 2023.

far beyond the individual, profoundly affecting relationships with partners, other family members (particularly children) and friends, as well as broader social interactions and community dynamics. For example, victims/survivors and practitioners emphasised how feelings of shame coupled with sexual dysfunction have strained relationships with spouses, sometimes leading to family separation or divorce. According to one key informant, "We had two cases like that here, where a man had left his home and hadn't gone back. He says he can't stay at home with his wife and children because his wife knew what had happened to him ... He puts up a barrier between himself and his family".[74] For several victims/survivors, their experience of sexual violence resulted in the breakdown of marriages.

> *"...after what I went through, I didn't go outside. I stayed quietly at home. My friends would all meet up, but I didn't feel comfortable with them and I would stay away ... The problem is that I was ashamed after the violence ... I didn't want to talk. Because when I'm in a group with friends, it's like I'm reliving the scene of the act. So, I withdrew to be alone."*
>
> (Victim/Survivor, Interview 5)

Five victims/survivors spoke about how the experience of sexual violence and associated stigma and shame caused them to isolate themselves from others to avoid going out and to withdraw from social/community life.

> *"I stay at home. I lost all the money I had on me. I have nobody, no other source of income ... and the state I was in, I had nobody at my side who could come to my rescue."*
>
> (Victim/Survivor, Interview 3)
>
> *"Before ... I used to sell groceries and do telephone recharge transfers. I've lost of my equipment, and now my sister is the one who looks after me. Today I'm forced to do temporary work."*
>
> (Victim/Survivor, Interview 15)
>
> *"I used to be a tailor but during that time my machine and all my belongings were taken. Now I have to go from door to door looking for temporary work just to survive."*
>
> (Victim/Survivor, Interview 24)

The experience of sexual violence also had significant economic consequences for victims/survivors, often aggravated by physical injuries and which, in turn, contributed to worsening mental health outcomes while also impacting the family unit. This created a complex cycle of interrelated harms. Several victims/survivors explained that they had not been able to return to work and had also been unable to find an alternative source of income. One explained that he had been unable to complete his education. Insecurity or the fear of being stigmatised by their communities led many to leave their place of origin, leaving behind their homes, land and livelihoods. This forced many who had been farmers or small business owners into unemployment or arduous, insecure and low-paid work.

74 In-person interview with representative of an organisation providing support to victims/survivors of sexual violence (KI 11) 12 July 2023.

5. Victim/Survivor Health-Seeking Attitudes and Behaviours

> *"I needed money because I'd lost all my money. But my first thought was to get to hospital."*
>
> (Victim/Survivor, Interview 7)
>
> *"It was when I noticed that I had pimples starting to appear on my skin that I decided to go to hospital to avoid the worst."*
>
> (Victim/Survivor, Interview 11)

Of the 25 victims/survivors interviewed for this report, five accessed medical and other care from MSF within 72 hours of being subjected to sexual violence. Seven sought assistance from MSF one to two weeks after the incident, while others visited MSF only several months later, or in the case of two, several years after the event.

> *"I thought that I must already be sick [HIV positive] and then if I had the results to confirm it at least I would be able to get counselling and treatment. But on the other hand, I thought about killing myself if I was HIV positive. Those were the two options I had."*
>
> (Victim/Survivor, Interview 6)
>
> *"My first concern was to know my HIV status because I don't know the status of the person whose violence I am a victim of. I didn't know his HIV status and I was worried about my health. It affected my morale. Every time I thought about it, I didn't feel good."*
>
> (Victim/Survivor, Interview 4)

In all cases, MSF was the only service through which professional healthcare was accessed, although three victims/survivors took steps before visiting the Tongolo project to address health concerns resulting from sexual violence: one victim/survivor went to a district hospital who referred him to MSF, another bought medicine from villagers to treat his fever while travelling to Bangui to seek professional care, and a third bought medication from a "little place" to try and ease his symptoms while trying to find the money to travel to Bangui for care.

> *"It was the mental health service. Because I was so shocked. I didn't want to do anything. Everything was going wrong. I felt betrayed."*
>
> (Victim/Survivor, Interview 13)
>
> *"My need is to protect my family. Because of what I'm going through mentally, a friend of mine advised me to get counselling."*
>
> (Victim/Survivor, Interview 23)

Even where they had other urgent needs such as money and shelter, many victims/survivors said that their immediate priority after the incident was their own health and that of their wives or partners who they feared they may infect with STIs. However, in some cases, care was only sought when there was a noticeable deterioration in their health and their symptoms became more severe.

Eight victims/survivors spoke about the intense anxiety related to whether they had contracted HIV or other STIs. Others had physical symptoms such as rashes for which they wanted treatment.

Two victims/survivors in their interview specifically referenced motivation to go to MSF because of their mental health needs, although many more said that they had particularly benefitted from counselling provided as part of MSF's care cycle.

5.1 What victims/survivors value about the care they received

The research findings explore the experiences of victims/survivors when seeking MSF services and shed light on what aspects of care were valued and why, thereby informing understandings of survivor-centred care from the perspective of male victims/survivors.

Interviewed victims/survivors were generally very positive about and grateful for the care they received from MSF. Based on their responses, the following emerged as features of the care that were most valued or which were otherwise acknowledged as having been particularly good or beneficial. The aspects of care highlighted by victims/survivors align with and illustrate the values underpinning a survivor-centred approach of safety, confidentiality, respect and non-discrimination.

The Tongolo Project

The Tongolo Project opened at the end of 2017 in Bangui to provide reproductive healthcare and holistic care to victim/survivors of sexual violence of all genders and ages. The project includes medical treatment and mental health support, as well as guidance and management of referrals to pursue legal action and obtain protection such as emergency shelter or socio-economic support. The project offers support, free of charge, through a team of social workers, midwives, nurses, counsellors, psychologists, and health promoters, and through partnerships with legal services. Tongolo ensures a gender-sensitive approach with both male and female staff to accommodate victims'/survivors' needs and preferences.

Patients receive a range of medical services, including HIV PEP, pregnancy prevention, treatment for STIs, vaccinations and family planning. The project also offers mental health and psychosocial support, with follow-up appointments until improvement is observed. All victim/survivors are offered a medical certificate and are assigned a caseworker. The clinic follows a well-defined process, starting with triage and confidential discussions with social workers, followed by medical care from midwives and psychosocial support from the mental health department. MSF has adapted its services to cater to male victims/survivors, recognising their specific challenges in accessing care.

In addition to the Tongolo Project, MSF teams also provide care for patients of sexual violence at another facility in Bangui and in other locations in CAR (Bambari, Bangassou, Batangafo, Bossangoa, Bria, Bouar Bossangoa, Carnot, Kabo and Paoua and locations where emergency responses are provided by the EURECA team).

Location of and accessibility of facilities: Most of the victims/survivors interviewed described the MSF clinic as easy to find and explained they felt safe and secure in the enclosed compound. Although some said they

felt it was a bit isolated or too far away from where they were staying, it was also recognised that this had benefits as it is more discreet and they were less likely to run into people they knew. One victim/survivor said that "in terms of discretion, it's good that it's like that to avoid people who go there being stigmatised"(Victim/Survivor, Interview 4).

Timely access to treatment: Several victims/survivors said that they had valued the speed with which they were seen after arriving at MSF. As one noted "I was well received; even the times of the appointment. The guard welcomed me and settled me in as soon as I knocked on the door. Although there are more women, I'm taken from among them to go straight through" (Victim/Survivor, Interview 15).

Assurances of confidentiality: Many feared that friends, members of their community, or other patients or staff would find out that they were victims/survivors of sexual violence. As such, great store was placed by interviewed victims/survivors on knowing that MSF had systems in place to ensure confidentiality, including the handling and storage of information. One victim/survivor explained that he had not gone to the public hospital in his neighbourhood both because he feared that he would be judged by nursing staff there and because "they might talk about the patients in public, in a way that links them with their cases or their needs. They might say something like 'GBV patients, come over here!' or 'these patients, come over there!' That's why I didn't want to go to the local hospital and I only wanted to go to MSF; because I know there is confidentiality there" (Victim/Survivor, Interview 4). (For further information on measures put in place by MSF to protect confidentiality protocols, see section 6.1.7 "Protecting patient confidentiality and privacy".)

Almost all said that the principle of confidentiality had been explained to them, that they understood it, and felt reassured. According to one: "I didn't want to talk to anyone about it, not even my wife [but at MSF] I wasn't embarrassed, because I was reassured by the confidentiality … I trusted them, which is why I continued to explain to them what happened" (Victim/Survivor, Interview 21).

Avoidance of repeated disclosure of experience of sexual violence: Most victims/survivors said they only had to explain what happened to them once throughout their care with MSF. The importance of avoiding repeated explanations/disclosure was clear from the interviews, during which several explained how difficult it was to talk about the incident – some had not told family members what had happened.

Free care: The fact that MSF's services were free of charge was important to many of the victims/survivors. In theory, all victims/survivors of sexual and other forms of GBV are entitled to free care (see section 6.1.10 below), although in reality, research suggests that this is not always the case. Many victims/survivors lost their livelihoods because of their experience of sexual violence, and others were on low or precarious incomes. At least eight stated that knowing they would not have to pay for care had been an important enabler in seeking care. For others, free care was among the reasons given for their satisfaction with the care: "I don't have the means to go to other hospitals like the community hospital – what am I supposed to do if I don't have money? These are the reasons I chose to go to MSF" (Victim/Survivor, Interview 3).

According to another victim/survivor, "it's not like in other public hospitals where patients are asked for money and where the nursing staff have their medicines on the side, which they sell to patients instead of sending them to the pharmacy" (Victim/Survivor, Interview 23).

Welcoming and respectful attitudes of healthcare workers: Many victims/survivors spoke about having felt welcomed or "well received", describing their reception variously as "welcoming," "calm" and "kind". All felt that they had been treated respectfully, in a non-judgemental manner and that they were listened to and believed. As explained by one victim/survivor, "I was welcomed as a human being, listened to, not judged, believed. When I told my story, I was treated with care. The staff sympathised with me and also gave me advice" (Victim/Survivor, Interview 4).

Several explained that they had to overcome fear and embarrassment to go to MSF. One explained that they were "afraid that when [they] explained the incident [they] might be mocked by the staff... [but] by the second appointment [they were] no longer worried" (Victim/Survivor, Interview 14).

Others valued the empathetic manner with which they were treated; one survivor explained, "when I started to explain my experience to them, I cried. The staff member sympathised with me. He gave me a handkerchief and gave me time and then offered me a bottle of water. And then he continued with his questions" (Victim/Survivor, Interview 6).

Professionalism/confidence in staff: Several victims/survivors referred to feeling that the staff were well trained and had the appropriate skills to work with people who have suffered a traumatic experience such as sexual violence. This perception of competence and expertise instilled confidence in victims/survivors regarding MSF staff and services, fostering trust in the care provided.

One victim/survivor explained that MSF are "really amazing. They're good, trained and I am speaking to you today in good health" (Victim/Survivor, Interview 10). Another said that "[MSF have] all done a good job because their way of working motivates patients to feel good and happy; because they give advice and reassure patients to support them. And that's what they told me, and I agreed to follow the treatments to the end" (Victim/Survivor, Interview 11).

Most victims/survivors were treated by both male and female staff and, although offered the choice, they appeared not to have a preference either way. One victim/survivor specifically noted that he had felt equally "comfortable" with the men and women involved in his care (Victim/Survivor, Interview 3).

6. Barriers to Accessing Survivor-Centred Healthcare

Despite the urgency of seeking healthcare, as noted above, in many cases there was a significant time lapse between the incident of sexual violence and seeking care from MSF. The main reasons given by victims/survivors for the delays were:

- Lack of availability of healthcare services where they lived or where the incident of sexual violence occurred.
- Lack of knowledge of available services.
- Lack of confidence in the public healthcare system.
- Lack of financial means to travel or pay for healthcare.
- Feelings of shame or fear of being stigmatised.

Key informants identified similar barriers and added others which can make access to timely, survivor-centred healthcare difficult or in some cases impossible :

- Insufficient training and expertise for healthcare staff on male-specific sexual violence care.
- Scarcity of mental health services.
- Lack of essential medication and equipment.
- Poor patient confidentiality and privacy.
- Stigmatising attitudes and behaviours of healthcare workers towards male victims/survivors and discrimination against men and boys and other people with diverse SOGIESC.
- Lack of consideration of the needs and wishes of male victims/survivors in the design of healthcare services and programmes.
- Lack of data on sexual violence against men and boys to inform responses.
- Insufficient funding for responses to sexual violence.

Following a social ecological model of public health,[75] these barriers can be understood according to four different levels:

- ***Structural:*** relating to the design of the healthcare system, including the availability and accessibility of primary and specialised healthcare services.

75 Sarah Chynoweth et al., A social ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refuge settings: a qualitative exploratory study, Conflict and Health, 14: 43, 8 July 2020.

- ***Organisational:*** relating to the functioning of services, including attitudes and behaviours of healthcare workers, their training and expertise, resourcing of healthcare facilities, and quality of care and patient confidentiality and privacy.
- ***Community/Interpersonal:*** relating to attitudes and behaviours of communities and families towards male victims/survivors, as rooted in gendered social norms.
- ***Individual:*** relating to beliefs, knowledge and personal experiences of individual victims/survivors which can enable or prevent them from seeking healthcare or from accepting or disclosing their experience of CRSV.

ASP's and others' research points to how barriers identified at different levels of the social ecological framework are interconnected, overlapping and interacting. For example, structural barriers such as inadequate training of healthcare workers can contribute to the limited availability of specialised services, negative attitudes of healthcare workers towards victims/survivors of sexual violence and other organisational barriers to accessing or receiving appropriate care. While discriminatory community attitudes and gendered social norms prevail, they can influence behaviours and beliefs, including individuals' willingness to seek care and organisational-level attitudes of healthcare providers.[76]

In addition, both victims/survivors and key informants identified key gaps that extended beyond their immediate medical and mental healthcare needs but which are also essential for full recovery and rehabilitation. These are in particular:

- The difficulty in accessing longer-term healthcare support.
- The lack of economic and livelihood support.
- The lack of justice.

While many of the identified obstacles and gaps are common to anyone who has experienced sexual violence, the research findings suggest that men and boys also face some gender-specific barriers. A wide range of barriers faced by men and boys are explored further below.

76 Sarah Chynoweth et al., A social ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refuge settings: a qualitative exploratory study, Conflict and Health, 14: 43, 8 July 2020.

6.1 Overcoming barriers and ensuring survivor-centred care

As noted in Section 5.1, the aspects of care provided by MSF that were valued by victims/survivors are consistent with the core principles of a survivor-centred approach: safety, confidentiality, respect and non-discrimination. Interviewed victims/survivors were asked to share their perspectives on how responses could be improved to better address their wide-ranging and complex needs.

Some key informants also spoke about the importance of placing victims'/survivors' needs and wishes at the centre of their work. There were indications that significant efforts are being made to do this by some of those involved in providing healthcare and other support to victims/survivors of sexual violence. Although there was limited understanding of the concept of survivor-centredness among some key informants, all were acutely aware of the barriers facing victims/survivors to accessing timely, safe, quality healthcare. Key informants placed much emphasis on the need for holistic, long-term support.

A survivor network representative underscored the importance of more universal understanding and operationalisation of survivor-centredness at all levels of healthcare responses, from policy through to the design and implementation of responses. She explained the challenges faced by victims/survivors in having their voices heard in the design and implementation of responses. As she noted, "it's us who have experienced things, let us explain what we went through … so that the government can take concrete measures, make concrete laws, so that things can advance".[77]

Victims/survivors appear to have little representation on the national bodies responsible for the design of responses to CRSV and other forms of sexual violence. Several key informants explained how vital systematic feedback mechanisms are to capturing individual victim/survivor experiences of accessing and receiving services, and to receiving suggestions to help inform and improve the work of their organisation. However, to ASP's knowledge, there is very limited representation of victims/survivors in higher-level policy and planning discussions, and no male victims/survivors are known to have participated in consultations on the development of national policies, plans, procedures or guidelines on responding to sexual violence.

In addressing barriers set out below, victims/survivors must not only be consulted, but substantively involved in decision-making. This would help ensure that outcomes are responsive to their lived experiences and differing needs and wishes depending on, for example age, gender and socio-economic circumstances which influence how both harms and recovery from these harms are experienced.

6.1.1 Extending the availability of basic healthcare services

The absence of health services in the areas in which they lived or where the incident of sexual violence took place was among the most common reasons given by victims/survivors for not being able to access healthcare more quickly. Several incidents were described as having taken place in "the bush" or otherwise outside

77 In-person interview with representative of national survivor network (KI 5), 8 July 2023.

of Bangui; reaching health facilities in the capital from these locations requires difficult, expensive and often dangerous journeys.

One victim/survivor explained why it took him seven months to get to Bangui: "It's because of the distance from the place where the incident occurred. MSF Tongolo doesn't exist there. You need to find ways of getting to Bangui. It was a time of war, and there was total destitution. You had to feed yourself while you were on the run, and you had to do odd jobs from time to time to keep your strength up while you travelled to Bangui. That's what took me so long" (Victim/Survivor, Interview 9).

According to another, "There's no hospital where I was. They're just little places selling medication which I thought could ease my symptoms a little … The problem was that I was in the bush. Someone brought me here – I was delayed in coming [to Bangui] because I didn't have any money" (Victim/Survivor, Interview 12).

A third summed up broader barriers, "In Bangui, the capital, it's already bad! But it's worse in the interior of the country. Assuming MSF isn't there and the survivor lives in a very rural part of the interior of the country, his life would be in danger. Firstly, he won't be able to get help because of the insecurity, and secondly, his health will deteriorate because of the lack of access to appropriate healthcare services. The traditional healthcare provider would not be able to treat HIV effectively. This is a real problem" (Victim/Survivor, Interview 5).

The uneven geographic coverage of healthcare services is the product of many factors including lack of investment in infrastructure and the absence of basic social services. This situation is compounded by insecurity and the weak presence of the state, including state security forces in some areas, and ongoing attacks on healthcare facilities and workers by non-state armed groups, which severely undermine access to healthcare.[78]

Against this backdrop, the lack of services equipped to provide holistic care to victims/survivors of sexual violence and other forms of GBV has been an ongoing concern for the humanitarian community. According to the 2023 GBVIMS annual report, some localities may have several service providers while others are devoid of services. However, the report notes that psychosocial support is the most available and most accessible service. Every GBV victim/survivor who was registered with GBVIMS members and asked for this service received it. This was followed by medical care, which was received by 76% of victims/survivors requiring it , even though for nearly three-quarters (72%) it was outside of the 72-hour window.[79]

78 For example, clashes between national forces and armed groups have escalated since early 2024 in the southeast of the country. On several occasions, armed elements have occupied the Nzacko medical center, severely disrupting essential health services for vulnerable populations. In May 2023, armed men looted the base and pharmacy of the NGO providing healthcare in Mboki, resulting in a total shortage of essential medicines. The Kadjemah health post was also looted and destroyed. As a result of insecurity, the NGO teams were evacuated from Mboki. Furthermore, armed men issued death threats against healthcare personnel and humanitarian workers. A midwife was killed for allegedly supporting one of the parties to the conflict. In early 2024, health posts in Maboussou and Gpabou were looted by armed men. See OCHA, Central African Republican, Situation Report, 5 June 2024.

79 GBVIMS, Rapport Annuel GBVIMS 2023 - Republique Centrafricaine (GBVIMS Annual Report 2023, Central African Republic), 14 April 2024.

Key informants also highlighted the lack or limitation of healthcare services outside of Bangui and the resulting implications for victims/survivors of sexual violence. As one explained, "in Bangui, there are health centres and a victim goes there for medical or judicial services, services dedicated to them... But if you think about the rest of the country, you have to go into insecure areas and for someone to come here, come into town, it's difficult".[80] Others pointed to the enormity in number of victims/survivors in need of support relative to the lower number and capacity of service providers.[81]

The interviewed representatives of national authorities also recognised the lack of available healthcare, with one explaining their ambition to build capacity at the primary healthcare level so that cases can be managed in communities rather than referring all victims/survivors to Bangui for treatment.[82] Another government representative acknowledged the poor quality of services for victims/survivors of sexual violence.[83] Although, as another key informant noted, this poor quality reflects broader weaknesses in the public health system and a resulting lack of trust "... people don't want to go to the hospital because they don't trust it. Even for small things".[84]

In the meantime, INGOs make up many of the shortfalls in the public health system, however, resources of INGOs are stretched thin. Several key informants raised concerns about the long-term durability of this model of reliance on the humanitarian community and stressed the need to build the capacity of the national system. In the words of one, "...you need to put steps in place so that the community can take over the services one day. We understand the work of MSF because MSF is here, but what do we do after MSF have gone? Those are the kinds of things we need to think about".[85]

6.1.2 Strengthening mental health and psychosocial support services

Although most interviewed victims/survivors initially sought care from MSF because of physical health concerns, when asked what aspect of the care they most valued, a significant number stated counselling services. While research constraints did not allow detailed exploration of this, victim/survivor responses point to the positive impact that short-term counselling by well-trained and experienced practitioners has on recovery.

As noted above, psychosocial support is the most available and most accessible service. Several key informants worked for organisations or institutions providing such services, either as part of an integrated medical/MPHSS response or as a standalone programme. Of these, some offered psychosocial support in "listening centres" both in Bangui and elsewhere and provided individual counselling and group therapy as well as referrals to medical and other services.

80 In-person interview with representative of NGO, protection/GBV sector (KI 25), 17 July 2023.
81 In-person interview with representative of NGO, GBV prevention and response (KI 21), 14 July 2023.
82 In-person interview with representative of government ministries (KI 19), 14 July 2023.
83 In-person interview with representative of government ministries (KI 23), 17 July 2023.
84 In-person interview with representative of INGO, health sector (KI 28), 17 July 2023.
85 In-person interview with representative of INGO supporting children and families (KI 20), 14 July 2023.

These key informants explained that their psychosocial support services primarily targeted women and girls, but one said that they ran group sessions exclusively for men. Another explained that they were exploring how to adapt the existing model for women and girls (which is based around a knitting circle) to something that might be more appealing or suited to men – in particular, they were considering developing literacy classes for victims/survivors in which both women and men could participate. In their words, "We did... listening therapy, where people are also knitting at the same time ... But men asked me ... yes, you have this for women, but what about for us? What are we supposed to do? It's true, we do this kind of thing for women but what about for men?".[86]

> *"It's only because of the counselling that I received at MSF that I feel comfortable to go out now."*
>
> (Victim/Survivor, Interview 5)
>
> *"The advice the counsellor gave me about the different stages of life comforted me."*
>
> (Victim/Survivor, Interview 19)

These and other similar experiences are encouraging and could be used to further explore the psychosocial needs of male victims/survivors and identify other ways of extending psychosocial support to them. These explorations would also be done while ensuring they are not detrimental to women and girls, including by avoiding diverting already scarce resources (see Section 6.2.6).

However, for those victims/survivors requiring specialised mental health care from trained professionals such as psychologists who can provide more advanced mental health interventions, services are extremely limited. There are very few national practitioners; according to one key informant, the public health system has just one psychiatrist and one clinical psychiatrist both of whom are based in a public hospital in Bangui (Hôpital Général).[87] Specialist mental, psychosocial and neuropsychiatric healthcare is also provided by the NGO Fracarita International in the city of Bimbo (approximately 25km from Bangui); this care is open to all, including victims/survivors of sexual violence and treats all types of psychological or psychiatric disorders.[88] Beyond this, there appears to be little in-country capacity to support those who suffer more severe mental disorders, such as severe PTSD, as a result of their experience of sexual violence.

6.1.3 Ensuring the supply of equipment and medication

Several key informants highlighted the lack of basic equipment and medication in public healthcare facilities in CAR. According to one, "Even if people are trained, the post-rape kits aren't always in the facilities to provide to people. Even if the kits are there, the medication might be missing".[89] This same point was reinforced by another informant working for an INGO in the health sector: "There isn't any medication. The kits aren't available everywhere".[90] This lack of essential equipment has serious implications for victims/survivors and

86 In-person interview with representative of INGO supporting victims/survivors of sexual violence (KI 24) 17 July 2023.
87 In-person interview with representative of government ministries (KI 19), 14 July 2023.
88 Fracarita International is a not-for-profit organisation of the Congrégation of the Brothers of Charity based in Belgium.
89 In-person consultation with representative of international humanitarian organisation (KI 14), 12 July 2023.
90 In-person interview with representative of INGO, health sector (KI 28), 17 July 2023.

can determine whether HIV transmission is prevented. It can also lead to missed opportunities to prevent and treat other harmful consequences of sexual violence.

Among INGOs providing medical services to victims/survivors, informants said that post-rape kits are standard but that because their facilities are concentrated in Bangui (although are also present in some other larger urban centres), it can be difficult for victims/survivors to benefit from them within the 72-hour window.

6.1.4 Developing the capacity of healthcare workers

Key informants spoke about challenges involved in identifying cases of sexual violence among men who, as many noted, often do not disclose what has happened to them. According to one, "a raped man … would try to find a way of talking about his problems without actually saying that he is a victim of sexual violence".[91] Another explained that "he will hide the incident. He'll say he has a headache, [or] that he has a pain in his anus. That he has this, that he has that. But really, it's a sexual violence case, it's a sexual violence case but it just passes [healthcare workers] by".[92]

The lack of healthcare workers with experience or qualifications to work with male victims/survivors of sexual violence was attributed to, on the one hand, a lack of awareness of and cultural taboos surrounding sexual violence against men and boys. On the other hand, this inexperience was attributed to the lack of formal training on the subject, including how to respond to disclosures and how to recognise non-verbal signs that men and boys may have experienced sexual violence.

ASP did not review university or other curricula for medical or other healthcare training. However, a key informant from the national authorities noted that "a lot of healthcare workers aren't trained in the management of rape, they don't know how to do the clinical management of rape".[93] Another, who had trained as a midwife at university in Bangui, said that they had touched briefly on the subject of rape but only in a theoretical manner.[94]

Further, more in-depth formal education or training is either not available in CAR or is costly. Referring to the training of psychologists, a key informant explained that the initial, general training takes four years and a further one year is needed to become a clinical psychologist. However, they noted that, since the course was first set up, nobody had done the clinical training because "[informants] say they have financial difficulties, that they want to go and work."[95]

91 Remote interview by Zoom with representative of INGO, justice sector (KI 1), 29 June 2023.
92 In-person interview with representative of an INGO, health sector (KI 15), 13 July 2023.
93 In-person interview with representative of government ministries (KI 16), 13 July 2023 and in person interview with representative of INGO, health sector (KI 28), 17 July 2023.
94 In-person interview with representative of an INGO, medical sector (KI 15), 13 July 2023.
95 In-person interview with representative of government ministries (KI 19), 14 July 2023.

One key informant spoke favourably about training provided by WHO and UNFPA, but most said that in-depth, practical experience of working with victims/survivors of sexual violence is mainly gained through working with INGOs. This transfer of skills is positive, but formal training on and mentoring of practitioners ultimately needs to be built into national training and education programmes. And it must be built into practice in health facilities to ensure sustainability and foster local ownership of these crucial skills and knowledge.

Any training, whether formal or informal, also needs to be gender-inclusive, with specific attention given to identifying sexual violence against men and boys and responding to it appropriately. Even among INGOs engaged in responding to sexual violence and other forms of GBV, it can be challenging to build staff awareness that men and boys can also be victims/survivors of sexual violence. A representative of an INGO at the forefront of providing health responses to child victims/survivors of sexual violence explained that social stigmas around sexual violence directed at men and boys meant that, despite training on the issue, their national staff were uncomfortable talking about sexual violence against men and boys. The representative gave an example of a boy who had been treated for beatings inflicted on him by a member of his family: their colleague had not considered the possibility that he may also be a victim of sexual abuse. In their words, "The boy was beaten by someone in the family and he was always in pain so I asked: have you tried to see if he was raped, sexually assaulted, harassed...? Radio silence. I don't know if I shouldn't have asked about it, or if they suddenly realised that it could be an issue".[96]

6.1.5 Overcoming negative attitudes and behaviours of others towards victims/survivors and responding to internalised stigma

Most victims/survivors said they experienced self -stigmatisation and felt shame and humiliation – emotions that not only deterred them from telling their family and friends, but also made them hesitant to seek professional care and support.

According to one victim/survivor who first visited MSF two weeks after the incident of sexual violence: "What happened to me I didn't want to tell anyone for fear of being made fun of. I didn't even tell my mother, I kept it to myself. It was when I realised that I was in such a state that I had to go to my sister and tell her indirectly, without letting anyone know that I was the victim" (Victim/Survivor, Interview 11).

Two other victims/survivors who sought care only years after the event also explicitly attributed the delay to feelings of shame . The first explained that he felt so ashamed that he did not want to talk to anyone about it, including his wife. According to the second, who was among several men subjected to sexual violence in the same incident, "it's already difficult to be accepted when you are a survivor. I was also ashamed of the stigma that could push me to suicide ... Many of us are victims of rape, but we don't dare come forward. There were five of us survivors of this incident, and I don't know if the others were lucky enough to have access to a service like this" (Victim/Survivor, Interview 19). A third said he had avoided going to a public

96 In-person interview with representative INGO, child protection, (KI 18), 13 July 2023.

hospital because he was worried about how he would be received by nursing staff and feared being judged for what had happened to him (Victim/Survivor, Interview 4).

As suggested by these and other responses, shame and stigma operate on different levels . On an individual level, victims/survivors often internalise social stigma and victim-blaming discourses. At an interpersonal level, victim/survivors often fear stigma and other negative reactions from family and community members. At an organisational or institutional level, wider social stigma and sociocultural sensitivities around sexual violence may be reproduced in harmful attitudes or behaviour by healthcare workers.

Key informants reinforced the way in which these multi-layered, mutually reinforcing layers of stigma act as a barrier to accessing care, and that fears of mistreatment and humiliation may be particularly pronounced among men and boys in the CAR context, and potentially even more so for those with diverse SOGIESC (see Section 6.1.6).

Gender norms dictate socially accepted roles for all genders and perpetuate deep gender inequality and discrimination experienced by women and girls, the normalisation of sexual violence against them, and a culture of victim-blaming.[97] These norms also create distinct and specific barriers for male victims/survivors of sexual violence, particularly by preventing recognition of their experience and significantly impeding their ability to seek help. As one key informant noted, in CAR, "men are victims, but their traditions and their environment don't allow them to be".[98]

Key informants noted how the first barrier to male victims/survivors seeking assistance is often their own fear and confusion. According to one informant, "They say that if they're a victim then that means they're not a man anymore … They are stuck, they are like this at the level of the individual so then it becomes difficult for them to share".[99] The same key informant added that in CAR's culture, "a man shouldn't complain. A man doesn't cry … Never mind what you've been through, a man shouldn't cry here".[100]

A child protection expert highlighted the particular intensity of feelings of shame among boys, explaining that "there are some practices which are…against the culture. It's as if it's too heavy for him. It's not normal, it's inhumane".[101] They went on to explain that this can lead to boys isolating themselves, losing hope and wanting to kill themselves, and putting up barriers between themselves and their families".[102]

Such attitudes, as well as being internalised, also contribute to fear among male victims/survivors of being ridiculed or rejected by their families and communities and regarded as "weak" or "unmanly". Several key

97 See Global Protection Cluster, République Centrafricaine, Analyse de Protection, (CAR, Protection Analysis), July 2022.
98 Remote interview by Zoom with representative of INGO, justice sector, (KI 1), 29 June 2023.
99 In-person interview with representative of government ministries (KI 31), 17 July 2023.
100 In-person interview with representative of government ministries (KI 31), 17 July 2023.
101 In-person interview with representative of INGO supporting children and families (KI 20), 14 July 2023.
102 In-person interview with representative of INGO supporting children and families (KI 20), 14 July 2023.

informants described how shame and stigma can lead to marriage breakdown (as experienced by several victims/survivors interviewed for this report) or to family separation when victims/survivors leave their communities to avoid negative reactions. One key informant explained that "a man who is head of the household, has a wife and children, and then he is raped by another man or men, if he talks about it … it could even lead to the breakup of their marriage. He will be stigmatised not only by himself, but by all the members of his family including his wife".[103] Another key informant recalled several patients who, after experiencing sexual violence, left their homes permanently due to shame.[104]

Other key informants described concerns about the broader community relations, fear of negative reactions, and fear of being perceived as "no longer a man" and losing social standing and recognition within their communities.[105]

Key informants noted that fear of being mocked or judged also represents a significant barrier to seeking professional care. According to one, "it's shame … maybe they say, if I go there, they'll make fun of me".[106] Another explained that people are scared to go hospital, preferring not to "break the stigma" and remaining silent; they explained that this often leads male victims/survivors to self-medicate using traditional drugs.[107]

Other key informants explained how stigma can prevent disclosure to healthcare and other professionals involved in providing support. One described how taboos and traditional beliefs around the subject make it difficult for men to seek help because it is considered dishonourable to have been victim of rape.[108] Another similarly noted that "it's really hard for men to say the words. Some of them say they were 'brutalised', sometimes they say they were 'tortured'. Some say 'they made me into a woman, they treated me like a woman', instead of saying that they were raped".[109] A representative of an INGO running listening centres explained that it can take several sessions before a male victim/survivor is able to talk about what happened to them and that only "little by little they open up and then they tell you the root cause of their suffering".[110]

There was recognition among key informants of the need to counter negative attitudes and help those who have experienced sexual violence to overcome feelings of shame and self-blame and enable them to seek and receive appropriate care. But this will take concerted work by multiple actors on many levels. The work of MSF and other medical and MHPSS service providers shows that progress is possible at an organisational level. However, a coordinated, national strategy may also be needed to help tackle the underlying causes

103 In-person interview with representative of NGO, GBV prevention and response (KI 21), 14 July 2023.
104 In-person interview with representative of an organisation providing support to victims/survivors of sexual violence (KI 11), 12 July 2023.
105 In-person interviews with representative of government ministries (KI 16), 13 July 2023 and of national survivor network (KI 5), 8 July 2023.
106 In-person interview with representative of INGO, health sector (KI 15), 13 July 2023.
107 In-person interview with representative of national survivor network (KI 5), 8 July 2023.
108 In-person interview with representative of NGO, GBV prevention and response (KI 21), 14 July 2023.
109 Remote interview by Zoom with representative of INGO, justice sector (KI 1), 29 June 2023.
110 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023.

of stigma and the way it manifests itself at different levels of society and against different victims/survivors depending on their gender, age, SOGIESC, religion and other intersecting characteristics.[111]

6.1.6 Challenging discrimination against people with diverse SOGIESC

Sexual violence against men and boys is widely stigmatised, particularly against men and other people with diverse SOGIESC. Although consensual homosexual relationships are not illegal in CAR, they are not socially tolerated, and LGBTI+ people are highly vulnerable to discrimination and violence, including sexual violence.

Key informants described the enormous stigma associated with being gay (including routine verbal and physical abuse and family rejection) and explained how fear of discriminatory attitudes and behaviour deters men and boys with diverse SOGIESC from seeking healthcare. According to one, "People die because of it, especially because of discrimination … The majority of the population are scared to go to hospital. If you're ill today and I take you to the hospital, they say that the staff of the hospital will stigmatise you. They'll say 'oh, he's gay'!".[112] Another explained that "when a doctor or a nurse finds out that you're like that [gay] they start to make fun of you. They say 'you're like this, you're like that'. They don't care about the person. It makes the person feel alone. He has no choice but not to go into the healthcare centres anymore".[113]

The sensitivities and silence surrounding diverse SOGIESC were reflected in the fact that most key informants, other than those working directly with LGBTI+ populations, said that they had never come across cases of sexual violence against people with diverse SOGIESC in their work. One explained that although they do occasionally see cases, they do not ask questions about diverse SOGIESC, and men do not talk about it because it "is perceived as linked with weakness".[114]

Healthcare providers acknowledged the need to serve people with diverse SOGIESC but explained the challenges they face in providing these services. One explained that the issue is not even considered in responses, "it's really a cultural taboo. It's a taboo. It's something that people don't talk about".[115] Another spoke about the difficulty of talking about the issue among colleagues and the implications on ensuring an organisation's openness to all and principles of non-discrimination: "it's impossible. You cannot talk about it. I don't know what other organisations are like, because I really believe diversity in teams makes a difference, at least just to talk about it internally. Even talking about it internally is impossible".[116]

111 For guidance on addressing stigma see, Preventing Sexual Violence in Conflict Initiative (PSVI), Principles for Global Action: Preventing and Addressing Stigma Associated with Conflict-Related Sexual Violence, 19 December 2017.

112 In-person interview with representative of an organisation providing support to victims/survivors of sexual violence (KI 3), 8 July 2023.

113 In-person interview with representative of an organisation providing support to victims/survivors of sexual violence (KI 4), 8 July 2023.

114 In-person interview with representative of INGO, health sector (KI 13), 12 July 2023.

115 In-person interview with representative of government ministries (KI 19), 14 July 2023.

116 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023.

The same key informant and others also spoke about how this silence perpetuates myths in which being a male victim/survivor of sexual violence is associated with being gay. Such myths, while not unique to CAR, are deeply rooted in prevailing sociocultural norms around gender and sexuality and the associated discrimination against any who does not conform, or who is seen as not conforming. Such misunderstandings are often internalised by male victims/survivors, preventing them from disclosing their experience and seeking help in case they are labelled as gay. As noted above, they can also manifest in negative reactions by healthcare workers and others involved in responding to victims/survivors of sexual violence.

Despite the sensitivities, there are NGO-led efforts to challenge discrimination against those with diverse SOGIESC and to put in place support networks and healthcare responses for LGBTI+ people, including through a network of peer educators and training for medical staff. Just as tackling stigma requires a coordinated, multi-stakeholder approach, overcoming discrimination against people with diverse SOGIESC and dismantling barriers to survivor-centred healthcare requires government leadership and concerted, adequate efforts from all stakeholders.

6.1.7 Protecting patient confidentiality and privacy

As noted in Section 5, victims/survivors appeared confident in MSF assurances that their confidentiality would be protected. One explicitly noted that he had avoided going to a public health facility precisely because he feared other people would find out what had happened to him.

According to some key informants, patient confidentiality is often compromised in public hospitals or clinics, or at least there is a fear that it might be. One explained that "sometimes the person knows that they are going to share something with this person or that person, but it ends up being spread around the community or you hear it from someone else's mouth".[117] Key informants working with LGBTI+ communities suggested that it might be particularly problematic for men/boys with diverse SOGIESC as not only could their experience of sexual violence be made public, but also their SOGIESC. One explained the devastating consequences of this: "There's no confidentiality. For example, we prefer to go to the hospital and just get medication. We can't tell anyone what really happened".[118]

Several key informants referred to measures they have put in place to ensure confidentiality. In the case of MSF, this includes a system called "Code A", which involves the distribution of tokens to survivors by outreach workers. Patients can present these tokens to security personnel or other staff upon arrival, eliminating the need to explain the reason for their visit.[119] A representative of another INGO said that they have protocols on which all staff were trained.[120] And a representative of a governmental service explained

117 In-person interview with representative of national survivor network (KI 5), 8 July 2023.
118 In-person interview with representative of an organisation working with vulnerable populations (KI 2), 8 July 2023.
119 In-person interview with representative of INGO, health sector (KI 6), 10 July 2023.
120 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023.

"It was thanks to the Tongolo outreach team who were passing through the neighbourhood and talking about the consequences of the violence in the country that I learned about it and decided to go to their centre."

(Victim/Survivor, Interview 13)

"I told a woman that I knew about what had happened and she gave me a flyer that I could take to Tongolo to access services there."

(Victim/Survivor, Interview 16)

that it has redesigned its reception area to avoid having lots of people milling about, thus preserving victims/survivors' privacy and confidentiality.[121]

6.1.8 Building awareness and targeting men and boys in outreach activities

Among the interviewed victims/survivors, a significant number said that a lack of knowledge about available services was among the reasons they had not sought healthcare earlier. One explained that it took several months before he went to MSF Tongolo because it was not until an MSF outreach worker visited his educational institute that he learnt about their services (Victim/Survivor, Interview 15). Another explained that it was only after hearing about MSF services many years after the incident of sexual violence occurred that he sought assistance: "I didn't have any information about Tongolo. This service hasn't existed for that long. It was only after listening to a report on the radio about the activities carried out by MSF Tongolo for victims of sexual violence that I found out about them and went there" (Victim/Survivor, Interview 21).

Others seemed to be aware that there were services for victims/survivors of sexual violence, but they thought they were only for women and girls. One victim/survivor explained that, until MSF community outreach workers visited his neighbourhood, he thought "the services were only for female survivors of sexual violence, but then when they told me that men also had the right to go, I went" (Victim/Survivor, Interview 8).

All interviewed victims/survivors learnt about MSF Tongolo through MSF community outreach workers or by word of mouth from relatives, friends, neighbourhood chiefs (chefs de quartier) or local religious leaders. Two said that they had heard about the service on the radio. Several said they had been given leaflets

"I'd like to see more awareness-raising, clearly informing the public that care for victims of sexual violence concerns men as well as women. Even me, I thought it only concerned women and it was thanks to my friend that I found out."

(Victim/Survivor, Interview 14)

"We need to put up posters and talk on the radio and on social networks to publicise the services available."

(Victim/Survivor, Interview 16)

"You should do more awareness-raising in the media, share flyers or brochures, posters and other information focused on male survivors. You should send more health promoters and community outreach workers out into the field because many survivors are not aware yet that this service is available to them."

(Victim/Survivor, Interview 23)

121 In-person interview with representatives of national rule of law institution (KI 7 & 8), 10 July 2023.

containing information about the service or tokens either by the MSF outreach teams or others, including in one case a fellow student.

MSF has invested significant resources in its outreach and has deliberately targeted men and boys in these activities, including by using gender-inclusive messaging. Other service providers have done the same, including a governmental agency, whose representatives explained that they had put a lot of effort into encouraging men and boys to access their services by changing their outreach/awareness-raising approach and ensuring that messaging is more gender-inclusive. According to their analysis, this has helped shift perceptions of this agency as solely for women and girls and accounts for the steady increase in male victims/survivors benefiting from their services.[122] A representative of a UN agency also explained that there is increasing awareness and inclusivity of men and boys in the work of GBV actors and that steps are being taken to ensure greater inclusivity. [123]

"I myself raise awareness during talks with other young people. We need to give more precise information on this subject. It's true that many men are victims of sexual violence but it's hard for them to come forward."

(Victim/Survivor, Interview 15)

"I would like Tongolo to hire survivors to act as community outreach staff."

(Victim/Survivor, Interview 25)

"What I always think after what I have experienced is to work as a humanitarian to help people or to sensitise the community against this violence and the consequences that harm a person's life. I would go to the locality where I was assaulted, to raise awareness there ... because these cases are very frequent."

(Victims/Survivor, Interview 4)

However, several key informants also stated the need for greater awareness-building efforts regarding the reality that men and boys can be victims/survivors of sexual violence and regarding the services available to them. Among victims/survivors, increased awareness-raising and outreach to men and boys was the most common recommendation.

Others emphasised the importance of having more men in community outreach teams. Several victims/survivors expressed interest in participating in outreach activities, with one describing how he already uses his experience to reach out to others who may be affected. This highlights the important role survivors play in peer support (see Section 6.2.2).

6.1.9 Tailoring services towards the needs of male victims/survivors

Beyond awareness-raising and outreach to men and boys, it is also important to consider how services are designed and whether adaptations are needed to ensure they are easily and safely accessible to and otherwise appropriate for men and boys. This includes considering their accessibility for those with diverse SOGIESC.

122 In-person interview with representatives of national rule of law institution (KI 7 & 8), 10 July 2023.
123 In-person consultation meeting with UN representative (KI 29), 18 July 2023.

In this regard, the main issue raised by interviewed male victims/survivors was feeling awkward or embarrassed when entering the waiting room or reception area where all the other patients were women. In the words of one, "I felt uncomfortable because I was the only man surrounded by women. Personally, I felt ashamed, because the women might question my presence among them" (Victim/Survivor, Interview 5). Another explained that he "felt stigmatised in the presence of all these women and those that I got to know. The worst thing was the women asking questions, which irritated me" (Victim/Survivor, Interview 15). One victim/survivor said that he thought some men would refuse to enter the clinic if they saw lots of women there (Victim/Survivor, Interview 8).

MSF has sought to address such concerns through procedures which provide for different "pathways" depending on criteria such as age, gender or severity of injuries. Nevertheless, several victim/survivors suggested that more could be done to reduce the possibility of discomfort or embarrassment, with several recommending separate entrances/reception areas for men and women. One explained, "I would like to see a change made so that men and women are not together on the same benches at the beginning of the circuit through the clinic. That would stop them being frustrated and make it easier for them to get help" (Victim/Survivor, Interview 5). Another said, "When I first arrived, I didn't feel confident because there were so many people there … What I would like to [do to] avoid frustrating survivors with the dominant presence of women is to direct or separate the reception services for men and boys" (Victim/Survivor, Interview 13).

Key informants, including a representative of a survivor network, also suggested that long waits in crowded waiting rooms could deter male victims/survivors from attempting to access health facilities.[124] However, others suggested that the problem runs deeper; according to several informants, the misconception that sexual violence is exclusively a women's issue and that men are always/only perpetrators remains quite prevalent in the health/GBV sector. One explained that "we haven't really considered the fact that men can be victims too. Even at the level of the hospital – we've thought about it for women, but what about men?".[125] According to this informant, directing victims/survivors to gynaecology departments deters men from seeking care, while insufficient attention is paid to understanding and addressing the gender-specific needs and wishes of male victims/survivors. They explained that "there isn't an appropriate framework to enable us to respond to men in an appropriate way. So, he complains that he was used like a woman, is he really going to want a response which is feminised and aimed at women?". [126]

Similar concerns were raised in relation to MHPSS services. Although some organisations have or are developing initiatives targeted towards male victims/survivors (such as male-only therapy sessions like those described in Section 6.1.2), others do not currently have the capacity to do so.

124 In-person interview with representative of national survivor network (KI 5), 8 July 2023.
125 Remote interview by Zoom with representative of INGO, justice sector (KI 1), 29 June 2023.
126 Remote interview by Zoom with representative of INGO, justice sector (KI 1), 29 June 2023.

Concern was raised about the lack of safe houses or shelters for men and boys. According to two key informants, even in Bangui, safe houses for male victims/survivors are not available. They explained that this is the case for boys as well as adult men and described the difficulty they had in finding safe accommodation for street children or other boys who are victims/survivors of or are at risk of sexual violence.[127] Key informants and victims/survivors additionally highlighted the lack of support for economic reintegration and income-generating activities specifically designed for male survivors (see Section 6.2.3).

At the same time, there were positive examples of how health services have been adapted to men and boys. As a simple example, MSF has developed a dignity kit for men which includes clothing and washing/hygiene items. Several other key informants indicated plans to do the same, although some noted that the extent of the need was unclear and that resource implications for stocking separate dignity kits for men and boys must be weighed against the high demand for women's and girl's kits.

Such responses highlight both the need for additional resources (see Section 6.2.6) and the importance of developing a deeper understanding of male victims'/survivors' needs and wishes. This understanding requires close consultation with men and boys who have experienced sexual violence, including those with diverse SOGIESC, who can speak to the challenges they have faced in accessing appropriate services and define what such services would entail.

6.1.10 Providing free healthcare for victims/survivors of sexual violence

The GBVIMS 2023 annual report notes that state services not only fail to cover the entire country but also are not free for GBV victims/survivors in CAR.[128]

Many of the victims/survivors interviewed did not have the financial means to pay for healthcare, and the fact that they were not charged by MSF was therefore not only essential but greatly valued. Free care is also provided elsewhere, notably by UMIRR as well as by other INGO-run projects such as Nengo. But based on feedback from key informants, free care is often not available in public health facilities where patients may be required to pay for consultations, tests, medicines and medico-legal certificates. One INGO said that when they refer patients to the hospital, they pay for the medication, explaining that "in the zones where we work, even if there is a decree about free treatment, the law … isn't applied".[129] Another explained how charges accumulate at each step, from security guards demanding money to obtaining a medical certificate: "even to get that, they'll ask you for money! All these things create a barrier for access to healthcare."[130]

127 In-person interview with representatives of national rule of law institution (KI 7 & 8), 10 July 2023.

128 GBVIMS, Rapport Annuel GBVIMS 2023 - Republique Centrafricaine (GBVIMS Annual Report 2023, Central African Republic), 14 April 2024.

129 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023.

130 In-person interview with representative of INGO, health sector (KI 28), 17 July 2023.

Others highlighted the high costs of medication. According to one informant, a course of psychiatric medicine costs more than most people's monthly income.[131] Another explained that although antiretroviral treatment is free in the country, HIV tests often have to be paid for, and if you don't have the money to pay for the tests "you can't do anything apart from stay at home and then you lose hope. People fall into a bad state that way".[132]

Even where there is no charge for services or medication, the cost of transport to and from healthcare facilities can still present a barrier. For example, although MSF reimburses transport costs, one interviewed victim/survivor said he had had to borrow money to travel to Bangui, and two or three others said that the amount reimbursed (500 CFA or just under US$1.00) did not fully cover their transport costs. A representative of one organisation providing support to sexual violence victims/survivors explained that they lack both vehicles and funds to transport people to MSF or other facilities for specialised care. In their words, "it costs them money to get there … But they go through something traumatic like that, and then they don't even have money to pay for medical services to have tests done, or the transport to get there. We have to put our hands in our own pockets to help them to get medical care. That's one of the big challenges we have".[133]

6.2 Additional needs and gaps in responses

Interviews with victims/survivors revealed additional unmet needs where assistance was either unavailable or inaccessible, particularly for longer-term healthcare, income and livelihood support, and access to justice. Key informants identified the same and other gaps, and most were acutely aware of the shortfalls in current responses and offered suggestions on how these might be addressed.

> *"But you mustn't abandon us, the victims. You have to help us get access to legal services, even financial assistance. Health-wise, the work is good, and that's why I'm healthy. But we need to improve the follow-up of survivors."*
>
> (Victim/Survivor, Interview 11)
>
> *"I would like male victims to be given healthcare until they have fully recovered and be given the financial means to reintegrate into society and the economy. This might encourage other survivors who are still ashamed to come forward."*
>
> (Victim/Survivor, Interview 21)

Ultimately, responses highlighted the need for more holistic, multi-sectoral, long-term support to enable the full rehabilitation of victims/survivors and help them recover from physical injuries and psychological trauma. This means addressing the complex and unique needs and wishes of individual victims/survivors while recognising that sexual violence may be one of many human rights abuses they have experienced.

6.2.1 Long-term medical and mental healthcare

Several victims/survivors described ongoing health issues that required follow-up treatment, though not all were exclusively

131 In-person interview with representative of government ministries (KI 19), 14 July 2023.
132 In-person interview with representative an organisation working with vulnerable populations (KI 3), 8 July 2023.
133 In-person interview with representatives of national rule of law institution (KI 7 & 8), 10 July 2023.

related to the sexual violence they experienced. Some reported skin infections requiring antibiotics — which they either still needed to purchase or had paid for themselves — while others mentioned various untreated medical conditions.

According to one, "I fall ill almost every month. Even now I'm ill. The only way I can go to hospital for treatment is if I have money. Failing that, I have to self-medicate, getting medication from the street; but that doesn't do anything" (Victim/Survivor, Interview 7). Another said that the attack had left him with a visual impairment: "But what's left is a problem with my eyes, where they pissed on me – it hurts and I can't see clearly. As I have no way of being treated … I would like to be evacuated or treated so that it can be cured" (Victim/Survivor, Interview 21).

Some victims/survivors appealed for follow-up care to be more systematically available. One noted that "you have to give the survivor a general check-up and follow-up with them from start to finish until the survivor's problems are over" (Victim/Survivor, Interview 23). Another emphasised the need for follow-up "because some survivors at the end of treatment seem to be doing well, but actually they are not well and still need assistance" (Victim/Survivor, Interview 4). A third explained "we have to treat the person until their health returns back to normal … It's important to take treatment over a period of time appropriate to what has happened and to follow someone up until they have fully recovered" (Victim/Survivor, Interview 18).

One victim/survivor focused on his need for follow-up counselling, explaining that "we need to be taken into consideration as survivors and called from time to time for counselling and the rest. It's been one year now … The services are only about [immediate] healthcare, and once you are healthy again, it's over" (Victim/Survivor, Interview 8).

These and other similar responses point to the general lack of healthcare services in CAR, and the need to put in place arrangements for free, available, long-term, specialist, survivor-centred medical and MHPSS support for all victims/survivors of sexual violence. However, as the following sections indicate, this medical support must be complemented by other forms of assistance.

6.2.2 Peer support

There are well-established networks of victims/survivors of sexual violence in CAR, including the Movement of Central African Republic Survivors of Sexual Violence (Mouvement des Survivantes de Violences Sexuelles en Centrafrique, MOSUCA) which is open to and includes male victims/survivors. However, as one key informant explained, stigmas around acknowledging and speaking publicly about sexual violence against men and boys means that men are reluctant to join or become active members. Several key informants suggested that a victim/survivor network specifically for men could be helpful for providing support to one another and

for potentially developing the confidence, skills and capacities to play a more public role in advocating for the rights of male victims/survivors.[134]

Some victims/survivors also suggested that this would be helpful and some envisaged themselves playing an active role in supporting other men and boys who have experienced sexual violence. Several said they would like to be hired as outreach staff and one spoke about victims/survivors acting as "first counsellors" and organising forums for male victim/survivors where experiences could be shared, advice given, and referrals made.

> *"... these would be good moments for us to share and educate these survivors with our testimonies. If you haven't experienced it yourself, you can't tell someone else how to overcome it... This would really make them feel better, even if they are in a terrible state. It is enough to tell them that 'I myself was a victim and I was in the same situation as you. But thanks to the advice I received I have recovered'."*
>
> (Victim/Survivor, Interview 3)

There is experience of male victim/survivor networks in other countries, including in Colombia and Uganda which have demonstrated significant benefits.[135] Such groups not only contribute to the overall well-being of victims/survivors but can also play a crucial role in raising community awareness about sexual violence against men and boys and challenge societal misconceptions and stigma; in advocating for institutional and policy change; and engaging with healthcare institutions to promote more responsive and survivor-centred care. In terms of victim/survivor well-being, peer support groups can provide emotional support and understanding from those with shared experiences, a safe space for processing trauma and sharing coping strategies, opportunities for personal growth and empowerment, and contribute to reduced feelings of isolation and stigma.

6.2.3 Livelihood gap

Both victims/survivors and key informants repeatedly emphasised how crucial income and stable livelihoods are for recovery. MSF refers its patients to other INGOs for livelihood support, but only two of the interviewed victims/survivors said that they had received anything – in the case of one, some money (42,000 CFA or the equivalent of approximately US$69) and in the other, some food items. Almost all described the economic hardships resulting from their experience of sexual violence and their need for livelihood support – whether through immediate cash assistance, education, vocational training or financial support for establishing businesses or other income-generating activities.

One victim/survivor explained, "The real problem for survivors is their lack of means. Many survivors have lost their possessions, but if they had an income-generating activity like being a guard for example, which

134 In-person interviews with representative of national survivor network (KI 5), 8 July 2023 and with representatives of national rule of law institution (KI 7 & 8), 10 July 2023.

135 In Uganda, the Men of Hope Refugee Association Uganda (MOHRAU) emerged out of Refugee Law Project's work with individual survivors. It started in 2011 as a support group where members met once a week to discuss and share experiences and evolved into an association engaged in different activities. For further information about MOHRAU see, Men of Hope Association Uganda, May 2015. In Colombia, two focal groups for male victims/survivors of sexual violence were set up in 2020 (one for cisgender-heterosexual men and another for men with diverse SOGIESC) with the support of Red de Mujeres Víctimas y Profesionales (a network of women victims of sexual violence) to support male victims/survivors to participate in justice processes.

> *"I used to have a shop, but now I'm unemployed. If I could get some financial assistance that would help me. But now I have to work as a baker to survive. But financial assistance could help me."*
>
> (Victim/Survivor, Interview 12)

can make them 25,000 or 50,000 CFA, that would help them to overcome the thoughts that often lead to depression, especially when you compare your previous life to your current situation" (Victim/Survivor, Interview 2).

Another victim/survivor elaborated further on the situation of male victims/survivors and the responsibilities they have to look after their families. They explained that "Because survivors from this conflict lost almost all their possessions at the time of the attack. With the insecurity that still persists, they are unable to move around freely; some of them have resumed their activities, but others find it difficult to do so. Those who have been displaced can no longer return to their place of origin. It's not easy to find an income-generating activity when you have left your home, and most of us are heads of households with responsibilities for the whole family" (Victim/Survivor, Interview 21).

Many victims/survivors stressed the close relationship between financial security and well-being, with many forced to rely on family members or to undertake arduous, poorly paid, insecure, manual work to survive. One explained that "many of us survivors do not have a good education … there is the need for vocational training for survivors, and eventually we should have the possibility of having an income-generating activity that could provide relief for us. Because once you've been through this, it's not easy to recover and be completely as you were before. There will always be a psychological gap" (Victim/Survivor, Interview 5).

Another explained, "Remember that he's a survivor, and the head of the household. But after being attacked, he was forced to move. Deprived of all his possessions, he has no choice but to seek medical care. He no longer has the means to go back to work, and this is what causes psychological problems for the survivors" (Victim/Survivor, Interview 15).

> *"I'm not an intellectual, I don't need to go far … I'm a trader. I just want to have the means to go back to my old business and take care of my family."*
>
> (Victim/Survivor, Interview 6)

Several victims/survivors emphasised the need for livelihood programs specifically designed for male victims/survivors. One said that he would "like to see a reintegration programme set up for men who have been victims of sexual violence so that we can get back to work and finally have the means to live. Because as a survivor, you have lost everything," and suggested training programmes in sewing, mechanics and other areas (Victim/Survivor, Interview 14). Others spoke about their ambitions to set up small trading or other businesses. One victim/survivor said that he would like "access [to] driving courses in driving schools which could help [them] to get a driving licence which would then give [them] the possibility to work and to take care of our children" (Victim/Survivor, Interview 2).

The lack of economic support was highlighted by many key informants, several of whom worked for organisations which have small funds for socio-economic support for victims/survivors. Short-term support examples included providing cash payments and food kits to ensure victims/survivors can eat before taking

> *"I continue to hope for economic assistance... to start a small business because, being someone very small [referring to dwarfism] makes it difficult for us in life."*
>
> (Victim/Survivor, Interview 13)

medication. Key informants emphasised the need for longer-term support to prevent victims/survivors and their families from falling into poverty, but noted that organisations rarely have the capacity to provide this assistance.[136]

This inability to provide long-term economic support was a source of anxiety and frustration among many key informants, and one that acts as a barrier to accessing healthcare and undermines the prospects of a full recovery. According to one, among the reasons that men do not attend follow-up appointments is because they cannot afford to take time off from work . Others pointed to the longer-term health impacts: "a man who has lost everything. You can give him mental health support, medical care, but there is still the socio-economic side which he struggles with ... All I can do is plead with other organisations".[137] One key informant explained that victims'/survivors' difficulties are often linked to their socioeconomic status, but without resources to assist them, these problems persist. The informant noted that this situation raises uncomfortable questions that remain unanswered due to a lack of resources: "we don't have the funds to help them so ... we are worried that the survivor won't be able to manage their reintegration well ... Do we just close the door on them? These are the kinds of questions I have. The same survivors come back again".[138]

6.2.4 Justice gap

Of the 25 victims/survivors interviewed, only two had pursued justice after being referred to legal aid services by MSF. While some accepted the free medico-legal certificate (which can support complaints and has led to convictions, though not mandatory under CAR law), others refused it. None of the remaining victims/survivors appeared to act on MSF's legal aid referrals.

The reasons given for not pursuing a criminal complaint varied – that the process would take too long, be too expensive, be shameful or retraumatising, and that they could not identify the perpetrator(s) and/or it would be unlikely to lead to any positive outcomes.

> *"It would bring me so much shame too, because the trial would be in public. I would be so ashamed telling them what happened."*
>
> (Victim/Survivor, Interview 5)
>
> *"It's fear stopping me, and because you need money to hire a defense lawyer to go to court."*
>
> (Victim/Survivor, Interview 14)
>
> *"... they offered, but I refused it to avoid suffering even more. I don't even know the faces of my attackers, and you need money to pay for legal procedures. I didn't want to be tortured in the beginning just to end up traumatised, so I ended up giving up."*
>
> (Victim/Survivor, Interview 18)

136 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023.
137 In-person interview with representative of INGO, health sector (KI 15), 13 July 2023.
138 In-person interview with representative of INGO supporting children and families (KI 20), 14 July 2023.

Responses to questions about seeking legal assistance were underlaid with a lack of confidence in the justice system, with many victims/survivors viewing criminal justice pursuit as futile.

Key informants highlighted similar and additional reasons why victims/survivors of sexual violence often do not attempt to access justice processes. Despite steps towards establishing transitional justice processes, one described the situation in the country as one of "total impunity" in which insecurity, fear of reprisals, the slowness of justice processes, and the costs involved even where services are meant to be free (to pay for a medico-legal certificate, to file a complaint with the police, to pay for a lawyer, court fees, the cost of travel to and from hearings, etc.) mean that pursuing justice "stops being worth it and you just go back home".[139]

A representative of a legal aid organisation noted that it was very rare for male victims/survivors of sexual violence to seek their assistance for reasons including lack of financial means, reluctance to disclose their experience, concern that they will "ruin the name of their family," and feelings of insecurity including because of the continued presence of perpetrators in their communities and the connections that perpetrators often have with powerful people.[140]

> *"Most of the time in CAR, even if you go to court and the person has reparations to pay after the trial, the victim won't receive it before they die. That's why there's no point in asking for justice."*
>
> (Victim/Survivor, Interview 13)
>
> *"Knowing that the legal process is very slow in the Central African Republic, and that I have my wife and three children, I need to go back and take care of them first."*
>
> (Victim/Survivor, Interview 19)
>
> *"How long do you think it would take for the truth to come out and to be able to benefit from justice? It's all nonsense ... I didn't have time for that!"*
>
> (Victim/Survivor, Interview 22)

Yet even if justice appeared unobtainable, victims/survivors appeared to regard it as something that would contribute to their recovery and rehabilitation. When asked what justice would mean to them, most victims/survivors referred to criminal justice processes in which perpetrators were held accountable for their actions and punished. Even though justice was a remote possibility, they explained that this could help them to feel "good" or "calmer"; to be "at peace" or "free"; to enable them to "relax", "cope better" or "reclaim rights that were lost"; and to "forget their experiences".

Some also spoke about the broader impact of justice in restoring rights that had been violated and bringing peace and stability in the country.

Such responses highlight both the role of justice in long-term recovery from sexual violence and the need for victim/survivor-centred justice processes, both criminal and non-criminal. These processes should enable victims'/survivors' full participation in their design and implementation, ensuring their rights,

139 In-person interview with representative of national survivor network (KI 5), 8 July 2023.
140 In-person interview with representative of INGO, justice sector (KI 26), 17 July 2023.

> *"This will make you feel calmer and able to get on with things. If before you weren't able to carry out your daily work, now you can."*
>
> (Victim/Survivor, Interview 6)
>
> *"It would allow the person to feel relief and they would be able to forget their experience."*
>
> (Victim/Survivor, Interview 8)
>
> *"I would feel more relaxed if the person who committed the crime was arrested and put in prison. It really would be a good feeling."*
>
> (Victim/Survivor, Interview 12)

needs, and aspirations are addressed at every step.[141] As with all other responses to sexual violence, justice processes must be comprehensive and gender-inclusive and address the complex experiences of sexual violence of all victims/survivors, including on the basis of their SOGIESC and other intersecting characteristics, and must also consider both individual and collective harms including on children and partners.[142]

6.2.5 Information gap

Research for this report and previous ASP studies confirms that men and boys in CAR are vulnerable to conflict-related and other forms of sexual violence. However, significant gaps remain in data and analysis, with a notable disconnect between recorded cases and the number of male victims/survivors receiving medical or MHPSS care.

Key informants suggested that documented numbers of incidents of conflict-related sexual violence against men and boys fail to capture the scale of the problem, as many cases involving men and boys (particularly those with diverse SOGIESC) go unreported due to stigma, resulting in no data. This is problematic because it renders sexual violence against men and boys largely invisible and therefore more easily overlooked in the design and implementation of responses. This includes being overlooked in healthcare, a particularly critical gap in CAR, where resources for responding to women and girls are already severely limited.

> *"When there's justice, people are afraid of attacking others and won't attack anyone anymore. But when there's no justice, people take the law into their own hands."*
>
> (Victim/Survivor, Interview 9)
>
> *"Justice would be a way of bringing peace to the country."*
>
> (Victim/Survivor, Interview 13)

In a situation where difficult decisions must be made about the allocation of scarce resources, one key informant noted that service providers may be reluctant to dedicate resources to adapting or developing services for men and boys without more evidence about precisely what is required and by whom.[143]

Service providers emphasised the importance of enabling male victims/survivors to safely report their experiences and ensuring that all potential points of contact (including law enforcement,

141 For further discussion on victim/survivor-centred justice processes see, OHCHR, Human Rights and Transitional Justice, 12 January 2022, UN Doc. A/HRC/49/39; UN Special Rapporteur on the Promotion of Truth, Justice, Reparation and Guarantees of Non-Recurrence, Contemporary Perspectives on Transitional Justice Issues, January 2022; UN Secretary General, Guidance Note of the UN Secretary-General: Reparations for Conflict-Related Sexual Violence, June 2014.

142 See UN Secretary-General, The Gender Perspective in Transitional Justice Processes, Report of the Special Rapporteur on truth, justice, reparation and guarantees of non-recurrence, 17 July 2020, UN Doc. A/75/174.

143 In-person meeting with UN representative (KI 30), 18 July 2023.

healthcare workers, and human rights professionals) are sensitised to recognise men and boys as potential victims/survivors of sexual violence. They also stressed the need to develop systems for safe, confidential information sharing and analysis across sectors, including GBV, protection/child protection, health, human rights, rule of law/justice.

6.2.6 Funding gap

Ultimately, the availability of timely, quality services for all victims/survivors of sexual violence is dependent on funding. Unsurprisingly therefore, key informants highlighted the lack of sufficient and long-term/sustainable funding as a particular challenge for the provision of services. One INGO representative described this as being "at the root of everything". They gave an example of a project their organisation set up for 200 victims/survivors in Bangui that ended because, despite ongoing needs, they only had funding for a year. They explained that the limited and/or short-term funding cycles mean that their projects are primarily emergency responses that cover short- to medium-term needs, "but the kind of assistance that allows people to re-establish themselves, to strengthen their resilience, is rare".[144]

Others also raised concerns about the lack of sustainability of interventions due to funding constraints, and that international organisations are often forced to pull out of the country once their funding ends. One representative of a national NGO working on GBV prevention and response explained that an organisation might work in a particular location or sector for two or three years, but when their funding ends, they leave, and the community lacks the capacity or funding to continue their work.[145]

One key informant noted how the reduction in funding will force NGOs to leave certain locations or to close their operations completely.[146] This loss of capacity, expertise, and experience, and the enormity of funding shortfalls, will impact negatively on the availability and quality of assistance for the tens of thousands of victims/survivors of GBV who are already under-supported. The number of victims/survivors is ever-growing. Reduced funding will also make it even more challenging for the humanitarian community to adapt their services or develop more tailored interventions for men and boys when they are unable to meet the needs of women and girls.

144 In-person interview with representative of INGO, protection sector (KI 17), 13 July 2023. According to the GBVIMS 2023 Annual Report, most GBV programs provided by humanitarian actors have a duration of just six to nine months. GBVIMS, Rapport Annuel GBVIMS 2023 - Republique Centrafricaine (GBVIMS Annual Report 2023, Central African Republic), 14 April 2024.

145 In-person interview with representative of NGO, GBV prevention and response (KI 21), 14 July 2023.

146 In-person consultation with representative of international humanitarian organisation (KI 14), 12 July 2023.

7. Conclusion

This report highlights the many complex needs of male victims/survivors of CRSV and other forms of sexual violence. It examines the multi-faceted, interconnected barriers male victims/survivors of CRSV face in accessing survivor-centred medical care, MHPSS and other support.

The interviews with male victims/survivors highlighted key aspects of care and support provided by MSF that they particularly valued. These included their sense of safety and security when visiting the facility; the clarity and efficiency of the care pathway; the respect for their confidentiality; the empathetic, professional and respectful way they were treated by MSF staff; and the absence of discrimination against them as male victims/survivors. Their responses spoke to the elements of a survivor-centred approach needed to create a supportive environment that is respectful of victims/survivor's rights and wishes, in which their safety is ensured, and where they are treated with dignity and respect.

However, victims/survivors and key informants also highlighted the multi-level barriers faced by male victims/survivors in accessing survivor-centred care in CAR.

At a structural level, barriers include the limited availability of basic medical and mental health care for immediate, emergency needs of victims/survivors of CRSV and other forms of sexual violence , particularly outside of Bangui; the limited access to ongoing healthcare to support the recovery from longer-term physical and psychological consequences of sexual violence; the scarcity of specialist mental health support; the inadequate financial support for victims/survivors to address their immediate material needs including shelter, food and transportation; the absence of longer-term support for income-generation and livelihood opportunities; and the insufficient and short-term funding for responses to sexual violence both within the public health system and for UN and INGO-led programmes which undermines the availability, sustainability, and continuity of responses.

At an organisational level, barriers include the lack of sufficient numbers of healthcare workers with the training, skills and experience to recognise and respond appropriately to sexual violence against men and boys; a failure to consider men and boys in the design and implementation of healthcare services and programmes or to tailor them to the specific needs and wishes of male victims/survivors; the stigmatisation and other negative attitudes and behaviours by healthcare workers towards male victims/survivors, which may be pronounced for male victims/survivors with diverse SOGIESC; a lack of basic equipment and medication at some healthcare facilities; a lack of respect for patient confidentiality and privacy; and the imposition of fees and other costs for treatment and medication which makes healthcare services unaffordable for many.

At a community and interpersonal level, barriers include stigmas around sexual violence against men and boys and the perpetuation of misunderstandings and myths about it. These in turn feed victims'/survivors'

fear of stigmatisation by family and community members and subsequent shame, rejection, loss of standing in the community and family breakdown. This often causes victims/survivors to hide what has happened and isolate themselves.

And finally, at an individual level, the internalisation of social stigma leads to the reproduction of shame and "blame the victim" discourses by the victims/survivors themselves, often preventing them from seeking assistance. Moreover, male victims/survivors often lack knowledge of available services and/or perceive them to be for women and girls only.

The widespread awareness among healthcare providers and others in CAR of these barriers and the efforts being made to address them were encouraging. Additionally, the key informant interviews highlighted some promising developments towards more gender-inclusive responses in the healthcare sector. However, the multiplicity of mutually reinforcing barriers, coupled with the significant needs in CAR, requires a substantial investment by state and non-state actors. This investment would strengthen healthcare responses and ensure that they are complemented and reinforced by effective justice processes that provide victims/survivors with redress for the human rights abuses committed against them and reparations for the resulting harms.

Victims/survivors must be at the centre of this process, involved in the design, implementation, monitoring and evaluation of healthcare services. This would ensure truly survivor-centred services that address differentiated harms based on gender, age, and other intersecting individual and group characteristics.

8. Recommendations

The following recommendations aim to strengthen healthcare and related responses for victims/survivors of CRSV and other forms of sexual violence. They are based on research conducted for this report and reflect input from victims/survivors and key informants. They are addressed to all relevant national and international stakeholders including government entities, national and international NGOs, United Nations agencies, and civil society organisations who operate, support, fund, or influence decision-making within the healthcare sector.

While these recommendations specifically address sexual violence against men and boys, many also apply to broader measures needed to enhance responses for all victims/survivors, ensuring that victims/survivors of all genders have access to safe, ethical, quality, and gender-competent medical care and MHPSS, consistent with the principles of survivor-centred care. Provision of health support for male victims/survivors should not affect, limit, or otherwise negatively impact services for women and girls.

1. ***Ensure victim/survivor safety, confidentiality, respect, and non-discrimination in all medical facilities and referral systems.*** Ensure that medical facilities offer comprehensive, quality, timely, and free medical care and MHPSS for victims/survivors of sexual violence of all genders and ages. Ensure that individual experiences and differential needs according to gender, age, SOGIESC, ethnicity, and other intersecting individual and group characteristics are taken into account.
    - *Discrete access and facility design:* Healthcare facilities should be designed to ensure that they can be accessed discreetly and that public exposure of victims/survivors of CRSV is avoided. Private, soundproof rooms must be available for consultations and treatment, ensuring safety, confidentiality and respect.
    - *Protocols and training:* Medical facilities should implement strict protocols for handling victims/survivors' information, including secure storage of medical records and controlled access to sensitive data. Training on maintaining confidentiality, privacy, respect, and non-discrimination in interactions with and management of CRSV victims/survivors should be put in place in all healthcare facilities for healthcare personnel including doctors, nurses, administrative and security staff.
    - *Referral systems:* Referral systems should protect victims'/survivors' confidentiality and safety through secure communication methods and clear, privacy-focused protocols. It is also crucial that all referral partners, including NGOs and law enforcement, are trained to uphold the principles of safety, confidentiality, respect and non-discrimination.

2. ***Establish processes to ensure that competent and adequate healthcare services are tailored to meet the specific needs and preferences of male victims/survivors.*** This includes by centring their views, experiences and expertise.

- *Engagement and partnership with victims/survivors and victim/survivor groups:* Long-term partnerships with male victims/survivors and victim/survivor groups should be established to ensure their experience and understanding guide the development of services and programmes or adaptation and expansion of existing ones to meet their specific needs. Survivor groups and leaders should be meaningfully consulted as peer partners throughout the entire cycle of programme development, implementation, and monitoring and evaluation. Comprehensive feedback from male victims/survivors should be regularly collected and analysed to enhance understanding of their preferences and choices regarding entry points and services received, including by adopting their suggestions for improvement. This process will help ensure continuous service enhancement and better alignment with victims'/survivors' needs.
- *Needs assessments:* It is important to incorporate assessments of the specific risks and vulnerabilities faced by men and boys in sexual violence into broader GBV, health, and protection sector needs assessments. The gathering, via the GBVIMS, of sex- and age-disaggregated data upon access to GBV services could be reinforced by closer monitoring of the extent to which women, girls, men and boys, including those with diverse SOGIESC, enjoy equal access to responses.
- *Safe entry points and gender-competent healthcare teams:* Safe and discreet entry points into healthcare facilities must be ensured for male victims/survivors, with adequately designed pathways guiding them through the care process, to ensure timely access to treatment and to minimise exposure to potential re-traumatisation. Moreover, it is crucial to include healthcare professionals of different genders in care teams and provide male victims/survivors with the choice of the gender of their healthcare provider. All healthcare personnel must also be adequately trained in skills, knowledge, attitudes, and practices relevant to male victims/survivors of sexual violence, including those with diverse SOGIESC.
- *Specific support programmes:* Actors must develop support programmes specifically for male victims/survivors where they feel safe and comfortable discussing their experiences without fear of judgment or stigma. These programmes should offer both individual counselling and group support, addressing issues such as self-stigmatisation, guilt, sexual orientation, and the impact of these factors on relationships and on their self-perception.
- *Survivor-centred care for children:* Healthcare responses must incorporate age-competent, survivor-centred care for children that addresses, among other factors, the developmental changes of different genders as well as their evolving cognitive and emotional capacities and levels of understanding.

3. ***Provide specialised capacity-building for healthcare providers on the issue of sexual violence against men and boys.*** Healthcare providers should receive specialised capacity-building focused on the skills, knowledge, attitudes and practices required to effectively support male victims/survivors of sexual violence. This training should include both formal instruction and ongoing mentoring to ensure healthcare professionals are equipped to respond appropriately to sexual violence against men and boys.
    - *Curriculum review and revision:* National medical and other relevant curricula should incorporate

gender-specific harms resulting from sexual violence against men and boys, including those with diverse SOGIESC. The revised curricula should provide detailed training on appropriate response and care.

- *Addressing myths and attitudes:* Training should challenge common misconceptions about the causes of sexual violence against men and boys, address negative attitudes towards male victims/survivors, including those with diverse SOGIESC, and counter judgmental or discriminatory language and behaviours. Healthcare workers must be equipped with the knowledge and skills to treat all victims/survivors with respect and empathy.
- *Clinical management skills:* All healthcare workers, including doctors, nurses and midwives, should receive thorough training in the clinical management of sexual violence, including with a specific focus on male victims/survivors. This training should include identification, assessment and physical examination techniques tailored to the needs of male victims, as well as effective treatment protocols. Practical skills training should also emphasise creating safe and supportive spaces for male victims/survivors, employing effective communication strategies, and ensuring appropriate referral pathways to specialised support services.
- *Documentation:* Training for healthcare personnel should include detailed instructions on carrying out survivor-centred medico-legal documentation for physical and psychological findings and for the history of assault.

4. ***Enhance awareness and access to healthcare for male victims/survivors of sexual violence through community-based education and outreach.*** National and international actors and organisations working with victims/survivors must improve awareness and access to healthcare for male victims/survivors of sexual violence by strengthening education and outreach efforts within communities. This involves targeted awareness campaigns, community engagement, and education initiatives designed to inform and empower male victims/survivors, reduce stigma, and reduce barriers to healthcare and support services.
    - *Raise awareness and inform male victims/survivors of their rights and of available services:* Awareness campaigns are needed to inform male victims/survivors of CRSV about their rights to healthcare, available medical and MHPSS services, and how to access them. These campaigns should also explain the protocols in place to protect their safety and security. It is important to ensure that these campaigns are coordinated among relevant government and non-governmental stakeholders, including those from the health, GBV, child protection, justice and rule of law sectors. The design of these campaigns should be informed by existing outreach strategies developed by INGOs and healthcare providers to effectively reach male victims/survivors.
    - *Train and support community-based actors:* It is crucial to provide training to community health workers, GBV and child protection workers, and other relevant community-based actors on the provision of survivor-centred care to male victims/survivors. Training should equip them to offer appropriate support and referrals, ensuring that the needs of male victims/survivors are met with dignity and respect, and reinforce existing community-based support and protection mechanisms.

5. ***Work towards the development of long-term, nationwide medical responses integrated into a holistic care framework.*** This would comprehensively address the physical, psychological and social needs of all sexual violence victims/survivors, providing immediate healthcare alongside ongoing mental health services, legal assistance, and social reintegration to foster full recovery and well-being.
    - *Expand geographical coverage:* National and international stakeholders should work to expand the geographical reach of public healthcare, ensuring that comprehensive, high-quality, free and timely medical and psychosocial support is available across the country to victims/survivors of sexual violence of all gender and ages .
    - *Ensure national strategies and protocols for addressing sexual violence integrate the needs of male victims/survivors:* National and international actors should ensure that all strategies, action plans, and protocols addressing CRSV and sexual violence integrate the needs of male victims/survivors, including those with diverse SOGIESC. This could be assisted through establishing a working group consisting of representatives of national authorities, the UN, and international and national NGOs responsible for or involved in responding to sexual violence against men and boys. The working group could seek the views of male victims/survivors, including those with diverse SOGIESC, on measures required to prevent and respond to CRSV.
    - *Build national capacity for holistic and long-term care:* National capacity to provide long-term healthcare for victims/survivors of sexual violence must be strengthened by offering holistic care that integrates medical services and MHPSS with access to justice and economic empowerment. Offering holistic care for victims/survivors includes taking steps to strengthen justice responses to sexual violence and ensuring that all victims/survivors of sexual violence are fully informed of their right to justice and provided with the necessary support to pursue it.
    - *Consider the broader ecosystem:* Sexual violence responses must consider the broader ecosystem in which victims/survivors live. Support should extend to partners, children, and other relatives and community members to address the collective psychological, social, and economic harms often experienced by families and communities affected by sexual violence. Recognising that healing occurs within a social context, this broader, holistic approach strengthens community cohesion and resilience, creating a more supportive environment for the recovery and successful reintegration of victims/survivors into their families and communities.

6. ***Further enhance understanding of sexual violence against men and boys to inform responses.*** To continue deepening the understanding of sexual violence against men and boys and ensure that healthcare services and support systems are adequately equipped to meet their unique needs, both comprehensive research and the development of targeted strategies for data collection, documentation and information sharing are needed.
    - *Conduct in-depth research and consultations:* In-depth research is needed to better understand the specific needs and experiences of male victims/survivors in CAR. This could include in-depth consultations with victim/survivor groups and a thorough assessment of how existing healthcare services are responding (or failing to respond) to their needs and wishes to identify gaps and improve the effectiveness of support and care provided.
    - *Strengthen monitoring, data gathering and documentation:* As part of a comprehensive

approach, it is imperative that ongoing monitoring, data gathering, and documentation efforts by humanitarian, human rights, and other relevant stakeholders be expanded to specifically include incidents of sexual violence against men and boys, including those with diverse SOGIESC. Personnel involved in these processes should receive specialised training to safely and ethically identify and document cases involving male victims/survivors. Additionally, strengthening safe and anonymous information-sharing among all relevant national and international stakeholders is essential; prioritising at all times the safety and well-being of victims/survivors is also crucial.

7. ***Strengthen financial support for CRSV response for all CRSV victims/survivors.*** Adequate and sustained funding is essential to develop comprehensive services that address the multiple and diverse needs of victims/survivors including healthcare, MHPSS, legal assistance, social reintegration, and support groups. By securing robust financial resources, we can ensure that interventions are effective, sustainable, and capable of reaching all victims/survivors, regardless of gender or background.
    - *Ensure sufficient funding:* Actors should ensure the government allocates adequate budgetary resources and that donors increase long-term funding for sexual violence and GBV responses in CAR. Funding should also be made available for healthcare services and programs for male victims/survivors, addressing their comprehensive needs across health, protection, livelihoods, and justice.
    - *Support male survivor networks:* National and international stakeholders should provide funding and support for the development of survivor networks, including for male victims/survivors, and peer support groups, in line with a survivor-centred approach. These initiatives can empower victims/survivors to offer mutual support, navigate services, and actively shape the design and implementation of interventions that best meet their needs and wants.

Annex I: Methodology

Research objectives and approach

The objectives of the research were to identify:

- How is survivor-centred approach to victims/survivors of sexual violence, including men and boys, defined and operationalised in the healthcare sector in CAR?
- What are the perceptions and experiences of male victims/survivors of sexual violence, including those with diverse SOGIESC, in relation to healthcare services including mental health and psychosocial support and, where relevant, other intersecting forms of support?
- What are the gaps in existing healthcare responses with respect to men and boys, including those with diverse SOGIESC, who have experienced sexual violence?

Building on previous research by ASP in Afghanistan and Colombia, the overall research approach was qualitative in order to understand the perceptions and lived experiences of male victims/survivors of sexual violence as they navigate the barriers and enablers of access to quality healthcare services in CAR, and of the healthcare providers who provide these services.

The research design applies a hybrid deductive-inductive approach with study research tools developed deductively based on the findings of the literature review particularly in relation to elements of a survivor-centred approach identified. The data coding and analysis framework was developed deductively, but with provision for supplementary inductive coding that will allow for the addition of new codes to capture unexpected phenomena, experiences or processes.

Data collection methods and piloting of research tools

Both the interviews with victims/survivors and the stakeholders involved semi-structured interviews (SSIs) where topics and key questions were predetermined and phrased as open-ended questions with scope for probing topics of interest that emerge during the interview.

For interviews with victims/survivors, the topic guide explored their experience, perception, needs and wishes following their experience of sexual violence including whether and why they did or did not access healthcare services immediately following the experience of sexual violence; their perceptions of the healthcare or MHPPS services received (by MSF or other providers if they were accessed prior to assistance from MSF); their interactions with the providers and the level of control and autonomy they had over the process. Although this research has an explicit focus on the healthcare (including MHPSS) sector, the topic guides include questions about victim/survivors' needs and access to other services or support where these interconnect with healthcare response.

No details of about the sexual violence experienced were asked, instead interviews focused on their experiences and perceptions of services, and their needs and wants from services and support. Similarly, no questions about victims/survivors' SOGIESC were asked due to the fact that this may not be respectful,

appropriate or safe. Additional psychological support was made available and offered to anyone who felt they needed it.

The stakeholder interviews were conducted in accordance with one of two topic guides, one for stakeholders working in healthcare response (including MHPSS), and the second for stakeholder working in GBV cross-sectoral services or organisations. The stakeholder topic guides were designed to elucidate experiences and perceptions with regards to policy making, intervention development and implementation, as well as monitoring and evaluations of interventions. They also sought to examine survivor-centred practices and protocols in service provision, and to what extent and how victims/survivors of all genders and ages were consulted or involved at the different stages of policy and service design, implementation, monitoring or evaluation.

Both victim/survivor and stakeholder topic guides were reviewed by MSF and the RAG. The guides were revised following feedback from this exercise and, once ethical approval for the study was obtained, were piloted among a small number of victims/survivors. The final versions were translated into French/Sango. All translated tools were vetted and approved by in-country partners and/or researchers for cultural appropriateness and accuracy and pilot tested.

Sample and Sampling

SSIs were conducted with two key populations:

- Adult men, including those with diverse SOGIESC, who have experienced CRSV (victims/survivors) and who have completed a cycle of care from MSF; and
- Key national and international stakeholders working in CAR in humanitarian response in policy or programme implementation targeting victims/survivors of sexual violence, with a focus on healthcare response, including MHPSS, and cross-sectoral sexual and gender-based violence response.

Male victims/survivors

Eligibility criteria required that all adult male victims/survivors had completed a cycle of care from MSF and additionally:

- Were 18 or older;
- Had experienced sexual violence;
- Had been assigned male sex at birth and/or identify as male/men, including of diverse SOGIESC;
- Were not experiencing or receiving treatment for serious mental health conditions; and
- Were able to voluntarily consent to participate.

Minors were excluded from the study due to issues of ethics and consent or assent, and the need for a parent /guardian/ caregiver approval. Given limitations in the sample size (maximum of 25) and given that MSF does maintain details of victims/survivor's characteristics it was not possible to conduct quota or

purposive sampling to ensure that victims/survivors with different characteristics (such as diverse SOGIESC or the age at which sexual violence had been experienced) were sampled to saturation.

MSF identified potential victims/survivors that meet the inclusion criteria and were accessible to be approached for inclusion. Eligible participants were first approached by an MSF social worker who made initial contact to gauge whether they were interested in participating in the study. Subsequently they were invited to an MSF facility where a fuller description of the study and its rationale were provided, as well as the reason why the individual had been invited to take part; the risks and benefits of participation; and contact details for further information.

Key informants

An initial stakeholder mapping was undertaken to identify suitable stakeholders, in which potential key stakeholders were identified based on their role in national policy making, decision-making about services, the provision of such services or those responsible for monitoring or evaluating services. The eligibility criteria for stakeholder interviews included those who were:

- In a professional role that contributes to policy, service/support decision-making in at least one of the key sectors, or in cross-sectoral organisations; or
- Involved in implementing programmes and interventions targeting victims/survivors of CRSV

Based on the stakeholder mapping, a target sample of 15 stakeholder interviews from individuals from the health sector, 15 from the MHPSS sectors, and 10 interviews with stakeholders working in GBV cross-sectoral organisations, with a maximum of 40 stakeholder interviews. The sample was not calculated to reach saturation, rather it was an exhaustive sample aimed at including all identified in the stakeholder mapping exercise from: the national authorities, multilateral organisations and the UN, international NGOs, national NGOs and civil society networks. Recommendations for other key informants were also requested during key informant interviews.

Voluntary participation and informed consent

The concept of informed consent stipulates that research participants should voluntarily decide to take part after receiving all the relevant information with no coercion. In the case of victims/survivors they were informed that their participation is voluntary and that their decision to participate or not would have no implications for any care or other support received from MSF.

Consent forms and pens were placed in the private room where the interviews took place and the interviewer guided participants through them. Participants were told that they could change their mind about taking part at any point even after consenting, choose to not answer specific questions or choose to stop the interview at any time without giving a reason and without repercussion (see Annex 2 Study information sheet and consent form for participating victims/survivors).

Managing potential distress and harms

Although the study did not focus on the sexual violence that victims/survivors experienced and they were not asked for details of the violence they experienced, the topics discussed in relation to services and support were connected to their experience of sexual violence. Recognising that talking about such experiences could cause that victims/survivors to relive the event and cause psychological distress, the interviewer was trained to check-in with participants throughout the interview and to decide whether or not to omit certain questions and/or halt the interview.

In case participants did experience distress, support was available from MSF both on the day that interviews took place and subsequently. Specifically, an MSF counsellor followed up with each research participant two days after the interview to assess their wellbeing and provide further support if necessary. MSF also made available a list of local services and support to victims/survivors should they need additional support after the interview.

Annex II: Study information sheet and consent form for participating victims/survivors

Central African Republic

Hello. My name is _____ and I am working with the All Survivors Project (ASP) in collaboration with MSF on a research project. We would like to invite you to take part in a research project. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read/listen to this information carefully and discuss it with others if you wish. Please ask if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Why are we doing this study?
We are conducting a research project to understand the experiences and perspectives of male survivors of sexual violence in attempting to access healthcare, justice and livelihood services and support, as well as other issues that are important for survivors' recovery. We would like to understand the needs and wishes of survivors when accessing services/support and to what extend the existing services meet survivors' needs.

Why have I been asked to take part?
We are inviting men who have experienced sexual violence to take part in this study. You have been selected because you have accessed services/support from MSF for the sexual violence you have experienced.

Do I have to take part?
It is up to you to decide whether or not to take part. You do not have to take part if you do not wish to and even after agreeing to take part you can choose not to answer any questions you do not wish to or stop the interview at any time without giving a reason. Whether you decide to take part or not there will be no consequences to you or your family. This study is separate from any health services you have received or may receive in the future from MSF or any other organisation, so your decision to participate or not will not affect any services or support you can receive, now or in the future.

What does participation in the study involve?
If you agree to take part, I will ask you to sign a consent form to show you have agreed to join the study. You will then take part in a confidential interview with me. The interview will take approximately one-and-a-half hours. You will not be asked details about your experience of sexual violence or your gender or sexual identity or orientation, but only on your experiences with accessing services or support, and what would have supported your recovery. There are no right or wrong answers and we encourage you to be as open and honest in your responses as possible so that we can learn what support is useful for survivors.

Risk and benefits of participation
Although I will not be asking you any details related to the sexual violence you experienced, talking about services and support following your experience of sexual violence may cause discomfort. If you feel uncomfortable or upset at any time, you can pause or stop the interview. I will give you a card with details of healthcare or psychosocial support services that you can access if you feel upset or distressed at any time during or after the interview and would like support. There are no direct benefits to you by participating in this interview, although your help in responding to these questions will be used to provide recommendations on how programmes and services can better meet the needs of male survivors of sexual violence.

How my privacy will be protected
Your answers will be confidential. With your permission I would like to audio record the interview so that I can capture our discussion correctly, but if you would prefer that I don't audio record the interview, I will take notes during the interview. The audio recordings will only be kept until the analysis is completed in case there is a need to go back to-check details from the original interview. Once the analysis is completed all audio recordings will be deleted. The transcription of the interview will be anonymized so that no names will be included anywhere. In line with ASP policy, the transcript will be kept for seven years and then destroyed. Your name will not be included in any reports that we write about this study. Each participant will be given a fake name to protect their identity. We will analyse the data from your interview script alongside the interviews of other survivors of violence. The only people who will have access to the interview transcript or notes are the people who are working directly on this study. Nobody else will know what we have spoken about.
In the following section we explain the type of information we will collect from you and how we will protect your privacy. If you are interested in participating in this study we will then ask you to sign this document, which means you give us permission to use the information in the way we describe below.

1.-Who can see the data about you

There are two organizations involved in this study. Both of them will use the information you give us.

INTERVIEWER AND DATA ANALYST	ALL SURVIVORS PROJECT, Neugasse 17, 9490 Vaduz, Liechtenstein (written as "ASP" in this document)
STUDY COORDINATOR	MÉDICOS SIN FRONTERAS ESPAÑA, at Calle Zamora.54, 08005, Barcelona, Spain (written as "MSF" in this document)

2-.DATA PROTECTION OFFICER
The Data Protection Officer is in charge of protecting your privacy in relation to the information you give us, which we call "data". If you have any questions about how we protect your privacy you can contact them through the email address or phone number provided at the end of this form.

3.-HOW WE HAVE OBTAINED YOUR DATA?
This data about you we want to protect is what we collect through questions we ask you during this study.

4.-WHAT INFORMATION DO WE COLLECT FROM YOU, FOR WHAT PURPOSES, AND ON WHAT BASIS?
There are 3 types of information we otain from you and need your specific permission to use.
-What you give us when you sign this form agreeing to participate in the study. Information we collect from your clinical file, sensitive data sch as health information.
-What you tell us when you answer the questions, we ask you in this study.
- What we analyze when we put your information together with what others have said, and anything we publish to share with other people and organizations. Anything we publish will not contain the names of the people who participated in the study.
Your data will only be used for carrying out the study and only if you have given us permission to do so here. We will not use your data for anything else or without your previous agreement. **The reports, presentations and articles written from this study will not use your name or any other personal data that can identify you so that we can keep your information private and confidential.**

5.-CONSENT FOR USING YOUR INFORMATION:
By signing this form, you give us express and explicit permission to use the personal information you provide us for this study. This information can include sensitive data such as health data, sexual data, ideological data, etc. and will only be used for this study and as described in this information sheet. If you do not want us to use your Personal Data, you will not be able to participate in the study. Even if you agree to participate now, you can tell us later that you do not want to participate anymore, and we will erase any information you gave us and not use it in any way.

If you agree to participate, the information you give us permission to use might also be used to do statistics so we can monitor our services. For this, we will only use everyone´s information joined together and without any names, so that the numbers show what groups of people said, and not what any one study participant said. This type of combined data is therefore not used for making decisions about any particular person.

Whenever we share our results, for example in in a report, an article or a presentation, we will not share names or who said what so that we can protect the privacy of all the study participants. **The results of the research shall be also used for statistical purposes, meaning that, in those cases, MSF will not use your data as personal data, but aggregate data, and thus it will not be used in support of measures or decisions regarding any particular natural person.**

6.-DO WE DISCLOSE YOUR INFORMATION TO THIRD PARTIES?
If MSF needs to involve another scientist or suppliers to help manage or analyze the study data, they will follow the same rules meant to protect your privacy. These scientists or suppliers have signed the confidentiality and data processing contracts required by the applicable regulations.

7.-INTERNATIONAL DATA TRANSFERS
We will ensure that when we send any information from this study to parties in other countries that your privacy will be protected in the same way and with the guarantees and safeguards necessary to preserve your privacy.
For more information on the guarantees of your privacy, you can contact the Data Protection Officers, which appear at the end of this document.

8.-HOW LONG WE WILL KEEP YOUR DATA FOR
All study data, including your personal information will be carefully stored to protect your privacy and destroyed after 7 years.

9.-YOUR RIGHTS
You have several rights regarding your personal data collected for this study and so you can decide what happens to it at any time. You have the right to ask and see what data we have collected about you, for it to be corrected, moved to another study coordinator or investigator, limit the uses of your data, change what can be done with it or ask for it to be destroyed and to take back your permission to let us use it for this study.
To exercise these rights or If you feel your rights related to privacy are not being respected, you can contact either of Data Protection Officers, through the postal and electronic addresses given or the Spanish Data Protection Authority at the following postal and email addresses:

1. DPO MSF - MEDICOS SIN FRONTERAS postal address: C/Zamora 54, 08005, Barcelona, Spain. You can also exercise the abovementioned rights at the electronic address: DPO.BCN@MSF.ORG. DPO ASP - ALL SURVIVORS PROJECT postal address: Neugasse 17, 9490 Vaduz, Liechtenstein. You can also exercise the abovementioned rights at the electronic address: hoggc@allsurvivorsproject.org

2. Spanish Data Protection Authority - Agencia Espa.ola de Protecci.n de Datos : C/ Jorge Juan, 6. 28001, Madrid, Espagne

What if I have questions about this study?
You have the right to ask, and have answered, any questions you may have about this research and your participation. If you have questions, complaints, or concerns please contact the Research Team:
- Elisabet Le Roux, eleroux@sun.ac.za Charu Hogg, hoggc@allsurvivorsproject.org
- Françoise Niamazime, msfe-bangui-vs-fieldco-assist@barcelona.msf.org All research on human volunteers is reviewed by an Ethics Committee that works to protect your rights and welfare. This study has been approved by [Comité Ethique et Scientifique (CES), Université de Bangui, N. 44/UB/FACSS/IPB/CES/022]. If you have questions or concerns about your rights as a research participant, you may contact this committee via the following email: cesfacss@gmail.com

By signing this document, I confirm that I have read (or been read) these documents, and that I agree with how it says my data will be processed and protected. I promise that the data I am providing is true and current.

1) I confirm that I have read / heard and understood the information sheet for the above study	- Yes	- No
2) I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	- Yes	- No
3) I understand that my participation is voluntary and that I am free to withdraw my consent at any time without giving a reason, or to not answer any questions.	- Yes	- No
4) I consent to take part in this study	- Yes	- No
5) I understand that any personal information collected will be kept private	- Yes	- No
6)I agree that my interview can be audio recorded.	- Yes	- No
7) (If no to statement number 6) I agree that the interviewer can take notes during the interview	- Yes	- No
8) I agree to be quoted anonymously in reports, presentations and articles written from this study as long as my details are kept secret.	- Yes	- No

In summary, I, Mr./Ms. _____, consent to the use of my PERSONAL DATA necessary for the execution of the study "Enhancing Survivor-Centred Healthcare Response for Male Victims/Survivors of Sexual Violence in Central African Republic" as described in the information and consent sheet.

First name and last name of the patient: _____
Date: _____

Signature: _____

In case participant is unable to read and write

Witness signature _____

Participant's thumbprint _____

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