MSF experience from Salamabila: lessons learned for a community-based strategy to address sexual violence

Based on documentation from the Community Strategy for Responding to Sexual Violence in Salamabila, DRC 2019–2025. (For more information, contact Angie.Carrascal@barcelona.msf.org)

- **Main objective of the strategy**: to guarantee rapid (<72 hours), confidential, and safe access to quality care for survivors of sexual violence (SV), as close as possible to their communities, while facilitating referral to health facilities.
- **Direct beneficiaries**: survivors of SV of all ages.
- **Indirect beneficiaries**: local communities, through reduced stigma and greater awareness of health services and facilities, via better referral and earlier access to care.

KEY ELEMENTS TO CHECK BEFORE IMPLEMENTATION

Context analysis

Identify factors that **promote or limit access** to care for survivors of SV.

Identify **survivors' needs**, existing services (medical, psychological, socioeconomic, and legal) and gaps.

Map geographical access to health areas and health facilities.

Qualitative assessment: perceptions, myths, and stigma surrounding SV; healthcare-seeking behavior; barriers to access (gender, distance, safety).

Risk analysis

Conduct prior to **implementation and review regularly**, considering changes in context, perceptions within the community, and incidents reported or observed in the field

Involve reproductive health community workers (agents de santé reproductive – ASR) in this process and organize practical exercises (role-playing/simulations) to prepare responses in the event of an incident.

Clarification of strategy objectives

Focus on **response and access to care**, not on structural prevention of SV.

Clear definition of the **community care package** and its limitations.

Coordination

Early **discussion with the Ministry of Health** on possible roles.

Mapping of medical, social, legal, or community actors (leaders and potential ASR) active in the area

STRATEGIC PILLARS

COMPREHENSIVE SURVIVOR-CENTERED CARE

- Confidential reception and initial medical and psychological care at community level.
- Free care and care packages tailored to the level and conditions in the field (see table).
- Integration with other components of the project (i.e., family planning) with the aim of standardizing the role of ASRs and ensuring confidentiality.

- Regular coordination between ASRs, health facilities and MSF teams to ensure a common understanding of roles, care pathways, and procedures.
- Functional exchanges with key local actors (MoH staff, CODESA, community leaders), taking into account the context and existing capacities.
- Specific risk analyses for and with ASRs on a regular basis.
- Implementation and monitoring of security protocols adapted to the context.
- Simple and clear incident reporting mechanisms.
- Limitation of travel and exposed roles, depending on the evolution of the context.

Security and protection

SAFE ACCESS AND EFFECTIVE REFERRAL NETWORK

- Systematic referral of cases to health facilities for the full package (ASR -> PHC -> Hospital).
- Clear, simple, and understandable referral system for all stakeholders.

- Women (and/or men, depending on the context and acceptance) who are recognized and respected locally, selected for their local legitimacy, community acceptance, and availability
- ASR selection criteria defined with local stakeholders (CdS, community leaders).
- Ability to read and write, adapted to the context.
- The number and geographical distribution of ASRs must be adapted to the population, distances, and security context (indicative ratio of 1 ASR per 500-1,000 people).

Recruitment of ASR

COMMUNITY AWARENESS AND INFORMATION

- Community awareness focused on access to services, non-blaming, reducing stigma, and information on available care.
- Strength social support.
- Increase case disclosure.
- Involvement of men.

- Initial practical and structured training: concept of SV, basic medical care, psychological first aid, confidentiality, referral, data collection.
- Continuous training (regular refresher sessions) and case discussions.
- Simple, visual data collection tools adapted to the level of ASRs.
- Regular supervision (on-site and/or remote, depending on the context).
- Forums for ASRs to exchange ideas (feedback and quality improvement mechanisms).
- Emotional and psychological support to prevent emotional exhaustion.

Training, Supervision, and Support

COMMUNITY PARTICIPATION AND ACCOUNTABILITY

- Local leadership, feedback mechanisms, and complaint systems.
- Clarification of the role of ASRs within the community to avoid misunderstandings and build trust.

- Simple and harmonized data collection tools.
- Aggregate data collection at the ASR level to ensure confidentiality.
- Avoid the development of parallel files.
- Data triangulation (survivor, ASR, health facilities, staff).

Monitoring, evaluation, and continuous learning

STAFF WELL-BEING (DUTY OF CARE)

- Regular psychosocial support and debriefing sessions for ASRs.
- Early identification of signs of burnout or emotional distress.
- Clear access to individual support in the event of a critical incident.

- Provide the immediate material needs of survivors (basic dignity kit: food, clothing, shelter), which are a key factor in their vulnerability.
- Define what is MSF's responsibility, knowing that in some contexts the presence of other partners is limited.

Socio-economic component

QUALITY, ETHICS & GBV PRINCIPLES (DO NO HARM)

- Strict respect for confidentiality and anonymity of survivors at all levels of care.
- Informed consent before any care, referral, or sharing of information.
- Non-judgmental and active listening, respectful attitude, focused on the survivor.
- Limiting the number of people involved to avoid the person having to repeat their story several times.

- Equipment kit for ASRs, and clear criteria for equipment replacement and/or supply frequency.
- Medicine kits for ASRs and supply frequency.
- Means of communication and transportation to be made available.
- Financial incentives.

Logistical support

- Clarify from the outset what is realistic and what is not in terms of strategy continuity.
- Do not make implementation conditional on the existence of a handover, but anticipate possible scenarios.
- Develop a clear exit strategy from the outset of the project.

Sustainability

Additional information on the next page

TRANSVERSAL THEMES

EXAMPLE OF SURVIVOR-CENTRED COMPREHENSIVE CARE

(adapted to the context)

Standard PEC VS Protocol	Community Level (ASRs)	Primary Level (CdS)	Secondary Level (HGR)
Post-Exposure Prophylaxis (PEP) and STI prevention + Emergency contraception	X	X	X
HIV/STI diagnosis and treatment, wound care		X	X
Vaccination (Hepatitis B, Tetanus)		X	X
Safe abortion care (SAC)		X	X
Psychological First Aid	X	X	X
Consultation SM		X	X
Issuance of medical certificates		X	X
Dignity kits, emergency accommodation, transportation			X
Family planning (FP)	X	X	X

Recruitment of ASR

Important :

- **ASRs do not replace qualified health personnel.**
- **ASRs do not issue medical-legal certificates.**
- **The collection of sensitive data is strictly limited.**

In the Salamabila health zone (2019-2025), the **ASR network has transformed access to care for survivors of sexual violence** by becoming the first point of contact, ensuring local, rapid, and confidential care. This success shows that **ASRs are a key element of a community strategy** to facilitate access to care and strengthen communities' capacity to respond to GBV.