Medicus Mundi Schweiz
Gesundheit für alle

MMS Bulletin #130
Sexuelle Gewalt und HIV zusammen angehen

Experiences from SDC's Psychosocial Programme, Great Lakes Region

A comprehensive Approach to address Sexual and Gender based Violence in a post-conflict Context

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In line with the WHO definition of health, SDC adopts a comprehensive approach to health and aims to address the physical as well as the mental and social dimensions of health. It is in this spirit that SDC's psychosocial programme in the Great Lakes region has been developed in order to tackle Sexual and Gender Based Violence.

Survivors of SGBV during a community therapy session (© Ursula Salesse, SDC)

Sexual and Gender Based Violence (SGBV) occurs across the world in various forms. There is, however, the risk that the number of such cases will increase in post-conflict contexts, which may become a collective problem with serious consequences for community life. It is precisely in situations such as these that approaches which focus on the individual only address part of the problem. In the Great Lakes region programme, the SDC has therefore decided to adopt a comprehensive psychosocial approach. In addition to emergency medical and psychological care, there is a strong focus on involving the community in treating individual and collective traumas. The community's dealing with the issue should have a preventive effect and reduce the number of cases of Sexual and Gender Based Violence.

But what is a psychosocial approach?

The word "psycho" refers to a person's soul, to his or her inner world and is reflected in feelings, thoughts or desires. On the other hand, "social" makes allusion to an individual's relationship and environment with the outer world. Consequently, the "psychosocial"

approach deals with the well-being of individuals in relation to their social environment. By using a psychosocial approach, the programme focuses on different levels. Firstly, it concentrates on individuals but at the same time also on couples, families and communities, compared with for instance an approach that only focuses on medical care for survivors of SBGV. Furthermore, the programme aims to change social norms, particularly with regard to the status of women in society as well as the stigmatisation, victimisation and social exclusion of SGBV survivors. Moreover, the programme applies this comprehensive and multisectoral approach to address the various consequences of SGBV (sexual, physical, emotional, economic) by offering different types of services (e.g. medical, psychological, legal).

The Psychosocial Programme in the Great Lakes: from emergency response to a long-term perspective

The Great Lakes Region, Rwanda, Burundi and the east of the Democratic Republic of Congo (DRC) were an area of particularly violent intra- and inter-state conflict during the 1990s which inflicted great suffering on the population and weakened the states concerned. In the DRC, SGBV was used a systematic and efficient weapon of war: collective, carried out in front of husbands, neighbours and children who were forced to watch, with devastating effects not only on the survivors' physical and mental health but also on the social structure of their communities. The war has been over in the east of the DRC for almost ten years but rebel groups continue to be rife, particularly in the province of North Kivu. SGBV has become widespread and tragically commonplace. It is used by almost all armed groups but also by military and civilian groups often carrying HIV/AIDS. The SDC estimates that the number of survivors of SGBV in the east DRC is almost 5,000 per year. The question of impunity concerning SGBV coupled with the authorities' inability to identify, find and pursue the culprits has got to a point where even children are no longer shielded from these acts. But the rebels and the soldiers are not the only ones to commit SGBV in the region. In the DRC and neighbouring Burundi and Rwanda, women are exposed to all kinds of violence, especially within the family, in a context of strong deterioration of the social fabric and the normalisation of SGBV. In addition to physical and mental violence, there is also the issue of social exclusion, the number of raped women driven out by their husbands or rejected by their communities, often forcing them into highly precarious social and economic circumstances.

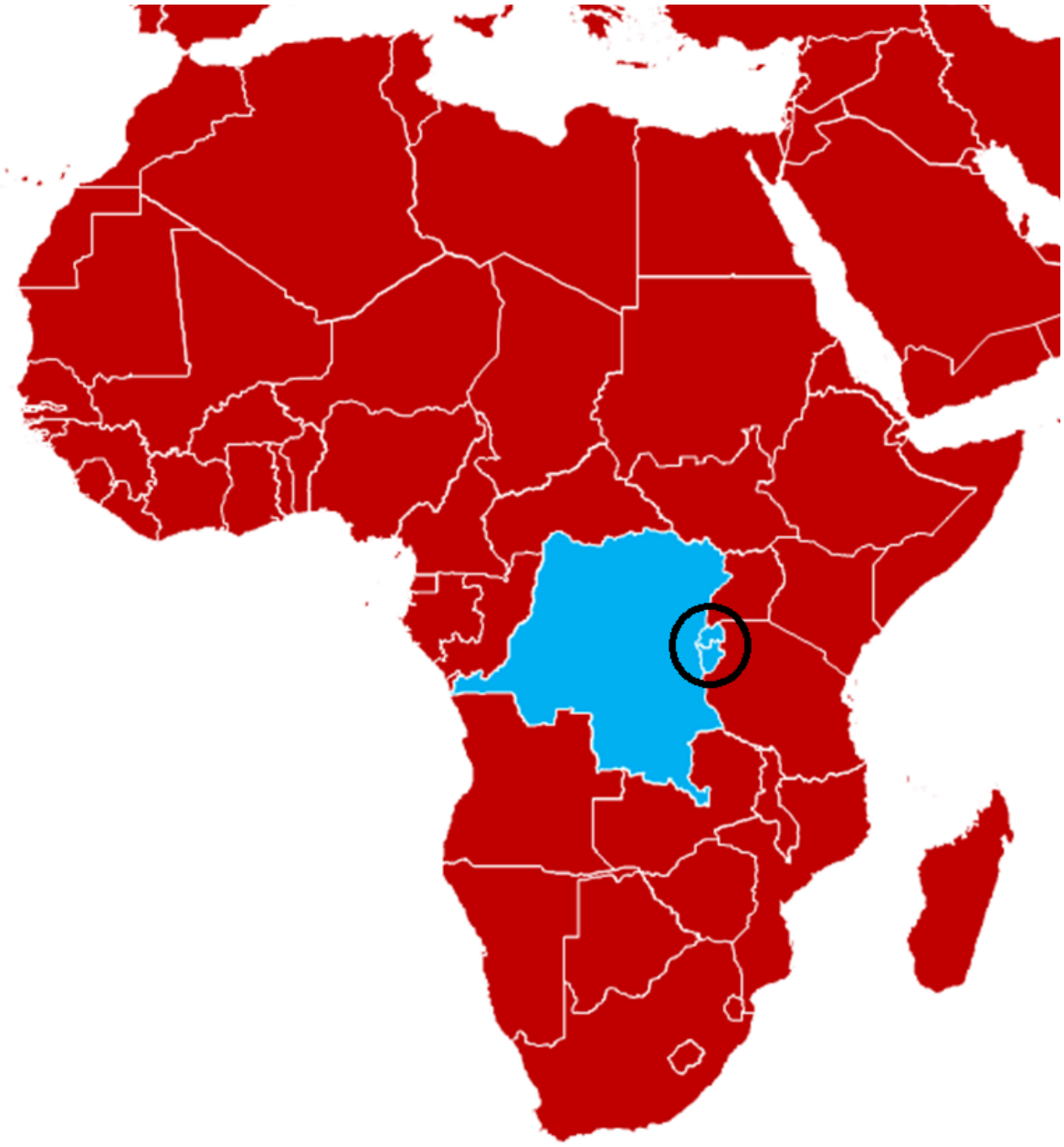
Testimonial by a nurse at a welcome centre in South Kivu, DRC, supported by the SDC

"Before we didn't know what do with people with mental illnesses. They wandered around everywhere, their families considered them to be under a spell. Some of them called witchdoctors into their homes but their problems didn't go away. Since the awareness sessions, people have understood that these survivors can fall ill without any physical symptoms, this is the mental suffering which follows this state of confusion. Gradually, families trust us and bring along their brothers and sisters to the centre. Here we treat the cases that we can and send the difficult cases to a

specialised centre. After staying there for a few days, sometimes a few weeks, they return a lot calmer and not angry. We then monitor their health and I also make home visits. This is how families learn to take care of them, remind them to take their medicine, recognise the signs of relapses, accompany them to the field. They are no longer marginalised because their behaviour is better. The only problem is that they can't cope when armed conflicts start again, there are many who suffer relapses in these cases."

The origin of the SDC's intervention

The SDC has been present in the Great Lakes Region since the 1960s. Over three decades, it has implemented development cooperation programmes in Rwanda and Burundi. From the 1990s onwards, the focus has been on humanitarian aid and peace policy. Considerable humanitarian aid has been provided from 1993 onwards to the benefit of refugees and displaced people, particularly in east DRC. In October 2002, the DRC was alarmed by a case of mass rape, carried out on more than 2,000 women in the town of Uvira, located in South Kivu on the border with Burundi. The SDC decided to support a local NGO with CHF 50,000 so it could provide medical care for 500 survivors. This was followed by other one-off funding in 2003 for survivors of SGBV in the provinces of Maniema and North Kivu. The magnitude of this SGBV, the seriousness of the medical, psychological and social consequences revealed to the SDC following these initial interventions drove it to launch in 2004 a more substantial programme of around CHF 300,000 per year, also involving Burundi and including not only medical care for survivors of SGBV with HIV/AIDS tests but also individual support for their mental and economic rehabilitation and legal aid.



Great Lakes Reason (SDC Map)

In 2009, the primarily humanitarian programme was gradually transformed into a development programme with a strategy that assured greater sustainability of interventions. This was firstly characterised by the granting of far greater financial sums of around CHF 3 million per year and by the implementation of both a multisectoral and community-based approach. The implementation was assured by local organisations that were close to the communities and the local realities. Since 2010, the SDC's support for SGBV survivors has translated into a programme of integrated support (medical, legal and reintegration), accompanied by a community-based, psychosocial approach which includes families and neighbours in the trauma and recovery management process. This approach enables SGBV to be treated at its root source. It serves to launch social processes which enable a reaction to the destruction of the social fabric and to support community-based, mutual assistance.

Results and lessons learned

Results

Over the years, some positive changes and results have been observed at different levels:

- **Individuals**: Around 14,000 women and 2,000 men have been supported through the structures established by the programme: over 3,200 women have received support in being reintegrated in their communities (socio-economic support). Around 5,700 victims have received medical treatment and over 1,600 women have received support in legal procedures (2012: 25% have been judged, in 87% of the cases in favour of the women).
- **Communities**: Through active collaboration with local leaders, partner organisations currently reach over 90 rural communities with sensitization and prevention programmes. Furthermore, visible positive changes can be observed among the community workers of partner organisations and among communities in view of more equal gender relations.
- **Partner organisations**: All staff of the partner organisations are aware of the psychosocial approach and how to integrate it in their specific area of work.
- **National and regional level**: Through the efforts of the International Conference of the Great Lakes Regions (CIRGL), the Kampala Declaration was signed in 2011. The Declaration concretizes the commitment of member states to address SGBV, which will hopefully also allow the challenging area of legal reforms and law enforcement related to SGBV to be addressed.

Lessons Learned

Over the years, the programme has adapted to the changing contexts and reacted to experiences and evidence. Generally, two major changes introduced in 2009 have significantly contributed to obtaining results: the move away from providing support to individuals in isolation and towards a clear and strong focus on communities, as well as the programme's increased financial volume. Furthermore, the following lessons can be shared:

- **Addressing the causes and consequences of SGBV:** The community approach has proven relevant in addressing the root causes of SGBV and more generally its contribution to social cohesion which is disrupted due to conflicts. Some success has been observed regarding the re-insertion of survivors into their communities. Nevertheless, the programme is labour-intensive and must acknowledge its limited reach and limited capacity to really prevent SGBV as long as impunity persists.
- **Differentiation of target groups**: Working with the entire community and particularly with women and survivors of SGBV remains important. However, specific intervention for men and young people are crucial and need to be consolidated. In addition, involvement of men is important in order to break with the simplistic dichotomy of men being seen as perpetrators and women the survivors. Both men and women have a role to play in society and can have a positive role in overcoming stigma and conflicts.

- **Strategic partnerships**: The comprehensive approach through a diversity of partners closely working together with communities is challenging but necessary. The implementation of the programme through the seven partner organisations offers clear added value, despite the challenges, such as the difference in approaches or capacities. Together, they bring a multitude of skills, ranging from medical and psychological care, to legal counselling or particular approaches in working with communities. It is crucial here that everyone understands each other's roles and responsibilities. In addition, partnerships beyond the scope of the programme are not a choice but a must if structural and policy changes and in particular the question of impunity shall be addressed.
- **Institutionalization and professionalisation of care:** Particularly in this fragile context, the community approach has proven relevant to address root causes and the consequences of SGBV. However, a professionalisation of care, such as psychological care and therapy, which is embedded in the existing health system is required in order to adequately respond to SGBV. Non-professional intervention can even be counter-productive as it might create demand for the care of SGBV survivors without being able to respond to it.
- **Continuous engagement**: Last but not least, addressing SGBV in a comprehensive manner and at different levels requires long-term commitment from all partners, including donors.

The psychosocial approach is certainly challenging and complex, often difficult to "touch" and measure. However, over the years, this approach has shown some encouraging changes and has been confirmed as a way to go if root causes and consequences of SGBV are to be addressed. In the coming years, the psychosocial programme in the Great Lakes region will be pursued in its current form but efforts will be made to increasingly use experience to change policies at national and regional level.

Further information :

- SDC Programme in the Great Lakes region http://www.sdc-health.ch/en/Home/Intervention/Bilateral_Development_Cooperation/Great_Lakes_and_Chad
- SDC Toolkit "Gender, Conflict Transformation and the Psycho-Social Approach" (pdf): http://www.sdc-gender-development.net/en/Home/Publications/document.php?itemID=5077&langID=1

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