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CHARU: *Hello and welcome to In The Center, produced by All Survivors Project. This broadcast aims to deepen and broaden dialogue by addressing conflict-related sexual violence affecting men, boys and LGBTI+ people. We bring together victims and survivors, researchers, and policy makers from around the globe to talk about their work and experiences and to explore key themes around prevention, care and support for survivors through national and international level responses.*
My name is Charu Hogg, and I am one of your hosts with my colleagues from All Survivors Project. Let's get started.

LAURA: Good morning, or good afternoon everyone and welcome to our podcast *In the Centre*. This episode aims at exploring the issue of access to health from men, boys and LGBTI+ people who are survivors of sexual violence in conflict and displacement settings. My name is Laura Pasquero, I am Senior Humanitarian Advisor with the All Survivors Project, and I would like to give a warm welcome to our two guest speakers. We have with us today Eva de Peckler, Sexual and Reproductive Health Advisor of Médecins Sans Frontières (MSF) Belgium and the leader of MSF Reproductive Health and Sexual Violence Care Working Group, welcome Eva; and we have Lea, the Justice Advisor for the organisation Lawyers and Doctors for Human Rights (LDHR). We are so happy to have you with us Eva and Lea. And what I'd like to do is to briefly introduce you to our audience before we get started with our conversation. So Eva you are a midwife by profession and have been working with MSF since 2004 in numerous sexual and reproductive healthcare projects, in eastern, central and southern Africa, Indonesia, Haiti among other contexts. And since 2011, you have been the Sexual and Reproductive Healthcare Advisor in the Brussels operational centre in since 2019 you are leading the intersectional reproductive health and sexual violence working group. You have vast experience in operational, research in the sexual and reproductive health field, including on male survivors of sexual violence and have authored and co-authored, important publications on this topic. Welcome Eva, again. And Lea you are an international criminal lawyer and investigator who worked for several years with the UN Refugee

agency, as well as with international organisations such as Lawyers without Borders, MSF, the Open Society Foundations, the Commission for International Justice and Accountability and Justice Rapid Response. You also work for the International Criminal Court and the Inter-American Court of Human Rights, and you are currently the Justice Advisor for Lawyers and Doctors for Human Rights, a grassroots Syrian organisation that documents torture and sexual violence mainly in detention centres in Syria to support universal jurisdiction cases related to the Syrian conflict. Welcome again, Lea. And I have to say, I really feel so privileged to have two guests like you with us today. And I would like to start our conversation with a first question for both of you. If we think about health responses, which includes physical sexual, and mental health, what does a survivor-centred health response for male survivors look like? and what are your organisations MSF and LDHR doing to respond to the needs and demands of male survivors? Eva, would you like to start?

EVA: Yes, thanks Laura. So a survivor-centred health response for male survivors means that the needs, the wishes, opinions and also the safety of male survivors are put at the centre of medical and psychosocial care. Survivor-centred principles also guide how healthcare providers provide care for survivors of sexual violence. By for instance, assuring that always informed consent is asked before examination or testing but also to ensure that male survivors are treated with respect, privacy, confidentiality and in a non-discriminatory way. So, to answer to your question, what is MSF doing to respond to the needs of male survivors? As a medical organisation for sure our main priorities to ensure that all male survivors have access to comprehensive quality medical and psychosocial support. Sexual violence is a medical emergency. So it's really key that male survivors have access to HIV and STI screening and preventive treatment. But also vaccinations and treatments of wounds. In all MSF projects we always try to adapt to services to the needs of male survivors by, for instance, adapting the opening hours or we work sometimes with male support groups, to allow that, or to facilitate access to care and to work as a through the male support groups for an entry door. But we also integrate sometimes social services, or care for survivors of torture or sometimes even physiotherapy. What is really key is to engage with communities and to raise awareness. We are gradually learning also in MSF that working through peers with specific target populations, like male sexual sex workers or men who have sex with men, and they also function as champions and representatives of target populations, who are more at risk also of violence, including sexual violence.

LAURA: Thank you so much, Eva. It's a very comprehensive overview of MSF role. Now, Lea, what is your view? What does a survivor-centred health response for male survivors look like based on LDHR's work?

LEA: At LDHR we have a network of doctors who document cases of torture and sexual violence of ex-detainees in government health facilities in Syria, and that is for accountability purposes. So to either use them in universal jurisdiction, cases or an international tribunal and of course those doctors and mental health practitioners are very well trained in how to deal with survivors of torture and sexual violence and this includes, of course, male survivors. This is to, let's say, address the survivors demand for justice and accountability. But in order to address their needs in a more holistic manner, LDHR has a system in place to refer the survivors we document to receive medical and mental health care, or even legal assistance. So we have MOUs with a range of service providers that are vetted and trusted by us. And we also have confidentiality protocols that we apply within our organisation, but also by the service providers and then after they receive the services they need, survivors provide us with feedback on their experience. So we can ensure that they are satisfied with the services. For us I would say, the survivor is

not only a number but our target is not to just document as many cases as possible and show donors that we reach our objectives, but it's rather the quality of the documentation and the safety and security of the survivors. So, we explained to the survivor right from the beginning, what their rights are and also what are the advantages and disadvantages of documenting their case. So the survivor always has the choice to withdraw their case at any time they wish. And again, before using the case in our reports or sharing it with international justice actors, we make sure that the survivor fully agrees with the procedure and, and also I'd like to say that, we make sure that our staff members and volunteers are healthy. So we have a self-care unit for that because I think, if you want to take care of the survivors you work with, you also have to take care of your own staff.

LAURA: Thank you so much Lea. You raised incredibly important points and you both reminded us about certain core principle about a survivor-centred approach and I was wondering because both of your organisations conduct research that inform your operational decisions as well as policies and projects, so I would like to ask you, what does MSF and what does LDHR research tell us about the main challenges that male survivors including those with diverse sexual orientation, gender identity, gender expression, sex characteristics face in various settings in accessing health responses? And also, what does your research tell us about what works to adequately respond to the needs of this group? Lea, would you like to go first?

LEA: Sure, as you said, we currently have a research project on male sexual violence. It's still ongoing. It's a research that has the objective of understanding and addressing the impact of invisibility on conflict-related male sexual violence specifically in Syria. We're at currently at the very early stages. So I cannot talk about the results of the research, but from the work that we have been doing since 2016 with Syrian survivors, and you can refer to our report on male sexual violence called "The Soul has Died", we know some of the challenges the groups that you mentioned face in accessing healthcare. First of all, there's a lack of awareness of what constitutes sexual violence. So in Syrian society men who suffered sexual violence in detention often don't consider themselves as survivors of sexual violence. They perceive themselves as survivors of torture. So for them only women and girls can suffer from sexual violence, not men. And even when they do realise what they were subjected to like forced nudity, beating or electrocution of genitals, or penetration with objects, even when they realise this is sexual violence they wouldn't talk about it because of the stigma that's associated to it. And this is stigma, not only from the community, but also from the survivors' own family and even from the health providers. So that's a big issue. And another challenge is the lack of specialised healthcare so both physical and psychological. In Syria there are usually no specialised units within health centres, and there are very few qualified health professionals who are trained to deal with such issues. So these issues were not dealt with at all before the conflict. This is, this is something new for Syria. And, and of course, since we are talking about sexual violence committed by government authorities, impunity for perpetrators is also a huge challenge because survivors don't see the value of reporting the abuses they were subjected to if the perpetrators remain unpunished at the end of the day and actually on the contrary, they fear reprisals from those actors. As you may know, under Syrian law health professionals have the obligation to report sexual violence to the authorities. So, in regime-held areas it's impossible for survivors to talk about what happened to them in detention because they could be arrested again and tortured or even killed.

LAURA: Thank you so much Lea for these insights, and we certainly look forward to reading the findings of the research conducted. And Eva, what is your view on this point?

EVA: In 2020 MSF published a research where we really wanted to better understand the assault and the characteristics of male sexual violence. This research was conducted in in 11 countries and it included more than a thousand male survivors. So it was one of the largest research at MSF ever conducted on male sexual violence. What was one of the key findings was the importance of our clinic set up, meaning that the projects where we actually saw a larger proportion of males presenting for care, sexual violence services were integrated in other departments as, for instance, mental health, the emergency department or the outpatient. It's important to know that in the past, MSF care for sexual violence was mainly linked to female sexual reproductive health services and few males came to seek care. They physically had to enter a maternity ward to disclose and request care and it's very obvious that, you know, this is a major barrier for men. We also saw that these projects that has a larger proportion there was no need for the initial disclosure to access care. So male could first gain more trust into the healthcare provider before they disclosed. These projects were also offering other services and responding to other needs not only the medical and psychological response, but also care for social and protection services. And this is particularly key also for male survivors with diverse sexual orientation. As Lea also said, they face a lot of barriers in order to access care, they are stigmatised because of their gender identity and their sexual behaviour and the experience is at home, in the health facilities and in the communities, and they are exposed to various forms of violence. So safety and protection is very key. In MSF we are more learning to work with peer workers to ensure that there is a link to community and to make sure that there is awareness-raising, and that men also are aware that male sexual violence is a medical emergency and they need to seek care. I can give a few examples: in Mozambique we work with peer workers that are representatives of men having sex with men groups. They offer HIV testing and they work predominantly on work spaces, like the truck spots or the hot spots of the bars and they also sensitised on male sexual violence. For instance, in Rustenburg, that is a project that that was running in South Africa, we also have male health promotion officers and they are actually conducting sensitisation sessions on alternative activities, but this is also done at schools or other events. So, I do think that the importance of representatives of specific male populations that are engaged into community awareness and to make this peer-led model supported that is really key in order to ensure that men are aware and that they can have access to care.

LAURA: Thank you. This is so deeply interesting. You both work in health and you both pointed at stigma, being a major obstacle for many survivors, including male survivors and LGBTI+ survivors to access health, and I'd like to focus on this a little bit more. Last year researchers from ASP and the London School of Hygiene and Tropical Medicine published a literature review on health interventions for male, and LGBTI+ survivors in lower and middle-income countries. And one of the key issues that emerged from this review is that addressing stigma misconceptions and prejudices within the community and within the health worker is really key to tackle survivors barriers to care. How do LDHR and MSF tackle stigma with a view to facilitate access to services for this group? Should we start from you, Eva?

EVA: In MSF training on male sexual violence is always a part of sexual violence training curriculum. Now, in order that your staff applies the survivor-centred principles it's really key that they are trained and they are aware of the different types, the nature, the consequences and the barriers of male sexual violence. More and more we are also organising sensitisation workshops on gender and sexual diversity. We organise these workshops ourselves or we do this through partnerships and we sometimes use

exercises that are based on, for instance, reality of the lived experience, or where we work with, for instance, LGBTI representatives, because we have seen that this allows that healthcare workers have a better understanding of people's lives and because LGBTI or male sex workers they are also men, they have families, so in order for them also to better understand their lives and also understand better the barriers and all the challenges they encounter, and we have seen that it allows for staff to have more compassion to these criminalised and stigmatised populations. For us in MSF we really see that one of the success stories to reduce stigma is the recruitment of peer workers who represent the stigmatised populations. They are a part, they are an essential part of our teams, they work with us and that also makes that their voice leads our program design. That we actually designed our projects like "nothing about us without us". And I think they are an equal part of our teams and this also makes that we continuously adapt our programs to the needs. And that also our staff is continuously sensitised and trained because they are colleagues, you know, they are a part of our team.

LAURA: Thank you so much, Eva. Lea, what does LDHR's experience look like?

LEA: This is a bit of a difficult question. LDHR does work with the Syrian communities on sexual violence related stigma because it's a huge issue as you both said. We recently actually issued a report on the subject. We worked with Syrian communities in Jordan and Syria, and we measured the stigma levels before and after the sigma awareness sessions that we conducted with these communities, but it's important to note that this work was focused on female survivors. Unfortunately, until now we haven't been able to tackle stigma related to male sexual violence. We believe that Syrian society at this moment, is not ready for it yet because there are too many taboos, societal and religious that don't allow us to work on the issue. So for our stigma work, we normally collaborate with influential people within the Syrian communities. So, doctors, lawyers, school teachers, but even these influential people have misconceptions about male sexual violence, and especially when it's committed against the LGBTI community. So we believe that there's some important preparation work required before we're able to address these issues. And we also hope that our research project will help us identify the ways to start working on that.

LAURA: Thank both of you for highlighting what seems to be promising practice that both organisations are developing and the need to conduct more research and produce more evidence on this very sensitive issues. So thank you for this. I'd like to discuss now a little bit capacity-building. You both mentioned it a little bit but I was wondering what practice and evidence show us is that building the capacities of health providers and providing guidance, whether it's technical or behavioural is really key to facilitate access for male survivors; in your experience, what are the crucial skills and capacities of teams and providers? That must be built to enable them to respond to male survivors adequately? And in your view, what evidence and guidance is still needed on health responses for male survivors? Eva, would you like to start with MSF experience?

EVA: It's really key that staff understand the survivor-centred principles and that they are trained on the nature of the dynamics of male sexual violence and that it's a part of your sexual violence training curriculum, but we also have seen that it's not because you're trained that you also have experience to apply this in practice. In the projects where we see a higher number of male survivors presenting for care we have seen that the staff has gained more confidence and more experiencing in consulting of male survivors. So the theoretical training is not sufficient. I do think it's really important that staff

regularly consults male survivors also to gain confidence and also into male experience. So I do think in MSF that we need to work still more on sharing over resources between projects because to break this vicious circle, we sometimes see in projects like there is no focus on male sexual violence, nobody is responsible for implementing the protocol, there is no sensitisation, so this is vicious circle of that at the end there are no males presenting for care and then the staff has no experience. So, I do think that this is something that we need to work more on that projects that see less male survivors that they are also have the opportunity to go and work in projects where we see a higher number of males presenting for care. However in projects where we have staff that if we may say are more experienced in male sexual violence, we still need to continue more to train on diverse sexual orientations because there is still stigma and incorrect behaviour of our staff towards, for instance, the LGBTI community, and this needs to be included in MSF training program. There is a change, but I do think it needs to still be more prioritised and be a part or some part of our sexual violence training curriculum.

LAURA: Thank you and thanks for reminding us that training indeed is not a standalone activity and needs to be really integrated in a larger sort of span of efforts and support. Lea, do you agree with this and what is your experience with LDHR?

LEA: Yes, yes, absolutely. I think training is key as Eva said and not only a one-time training but a continuous training and capacity-building. In terms of skills what's very important is the need to understand the political and cultural context. So this is why, for example, our documenters and service providers are Syrian who perfectly understand the Syrian context and have experience dealing with detainees who were subjected to torture and sexual violence. So it's a very specific context where violations occur in a systematic manner and only to understand that, you're already one step closer to the survivor who experienced it and who will have to trust you and tell you about what happened to him in detention. So I would say knowing the context and also, I would say, very important to be as non-judgmental and compassionate as a human being can be, especially when you're dealing with sensitive issues like this in societies where these things are not talked about. And to answer your second question, also, in terms of what is missing for Syrian NGOs working on those issues. So yes, the continuous technical and behavioural training but also to deal with child survivors of sexual violence, whether boys or girls, I think this is still missing to make sure that we do no harm and we avoid re-traumatising them and maybe I would say clear policies and guidance on documenting cases of handicapped people.

LAURA: Thank you for reminding us of the complexities that this work involves including for specific groups, and I really value both your reflections. And I would like to ask you something that we very much reflect upon in ASP and it's the fact that the focus on and attention to male survivors' experiences and needs should never deviate attention, or funding from the sexual violence and other forms of gender-based violence that women and girls experience in and out of conflict settings. What are your thoughts on how responses both local and global can be stepped up to adequately address the needs of male survivors in a way that does not take away attention from women and girls? Lea, would you like to start?

LEA: Sure. So, I think organisations working with survivors should always respond to the needs of both male and female survivors of sexual violence and have specialised staff to address both to have strategies in place to access both males and females. For example, in LDHR at every level, whether at

the first responders level, the case managers, or the documenters we have both male and female staff members to make sure that we access both male and female survivors and then we give the survivor the choice to either talk to a male or female. In our reports, we publish reports on women survivors of sexual violence and other one on males, a third one on children... so we always try to address everything to have a global picture and to amplify the voices of both male and females. And of course, I would say, in order to do that, donors should be able to fund projects where the beneficiaries are both male or female survivors.

LAURA: Thank you. Eva, what's your view on this?

EVA: It's in line with what Lea said. I think also in MSF we always offer care for male and female survivors, but we have seen in project that when it comes to male sexual violence prioritisation is key. We have seen that the project that has been, if I may seem more successful, they also prioritised to work on male sexual violence. I think that locally and globally, it may be said male sexual violence has not received enough support and attention and it needs to be strengthened. It's very clear that the impact for sexual violence requires an effective coordinated and a multi-sectoral approach. It should not only be the medical and the psychological care, but we MSF, as an emergency organisation, we are sometimes confronted that we are the only actors working or offering care and that we are sometimes we don't have other actors working with us in particular regions that are offering protection, or legal, or socio-economic support. And this whole multi-sectoral approach is really needed to respond to their needs for the male survivors. We also see that there is an increased vulnerability of certain groups. So as men, children, sex workers people on the move and it's definitely needed that the services need to be identified and respond to the needs of these particular groups with a higher vulnerability as they are exposed to different forms of violence, and there is definitely a need for adapted care and identification of male victims and also the inclusion of male representatives populations. As I already said earlier, this is really needed to make sure that we connect with these often hidden and stigmatised populations, and that we continuously sensitise and guide our healthcare staff on this. I think this is really key.

LAURA: These are thoughtful considerations and thank you both for bringing up an intersectional lens in every question. This is absolutely key in terms of the way we read into vulnerability needs and really can develop nuanced responses for different groups of survivors. I'd like to discuss partnership now with both of you. Our experience at ASP in the countries where we work in, in Central African Republic, in Afghanistan, in Colombia, consistently shows that ensuring the work is built with national partners, including women's groups, survivor groups, LGBTI organisations, is really key. Work built with partners really shows the greatest of durability in terms of perspective, work and guarantees the best outcome for survivors themselves. What is your experience in working with local partners? And how do you think organisations should best amplify let's say the knowledge power and voices of these actors?

EVA: In MSF we definitely have learned that, you know, community engagement is essential, and from the start of our projects and to ensure that there is definitely a certain level if I may say of sustainability to the service that we propose to deliver. We have a variety of experiences in different contexts and countries where we work, but it's also clear that it also depends on MSF staff awareness and the capacity also to network. There is a need to plan regular engagements and meetings with partner organisations, both at national and international level and it again needs to be prioritised by the field teams because this is really key to work together to strengthen the knowledge and the advocacy also of

the field experiences. Gradually MSF is developing more experience in how to ensure that this community-led organisations, which are initially link to the objectives of our project goals, that they can also remain functional after that MSF leaves; again, through capacity-building and networking with related to local and international organisations, to make sure that we really engage in participation and leadership with the desired activities with the same vision.

LAURA: Thank you so much. Lea, what's your view on this?

LEA: LDHR works with a network of first responders, so as I said, these are key figures in the community, they can be religious leaders, school teachers, directors, hairdressers, whatever. And after we train them, we try to integrate them in our team and invite them to participate and propose activities that we will conduct with the communities, with their own communities. And this is how we try to build trust between us by offering them continuous training and support but also making sure that we listen to them, before we conduct our activities in their communities. And then these community leaders that we train are going to go and train other people. And this is how we widen our network and have better access to survivors and their families. And we do the same with our partner organisations in Turkey, and Jordan and Syria, so we train them, we support them and we have this continuous relationship with them. And this is how I think international organisations can amplify the voices of local organisations, so not only by funding them but offering them continuous support and training, keeping with them a relationship that's based on mutual trust and respect and also mutual knowledge sharing because at the end of the day, they are the ones working on the ground and dealing directly with the survivors, so their suggestions should always be taken into account to inform new policies and make decisions.

LAURA: Thank you, it's really beautiful listening to both of you and I really hope this conversation will further amplify the important experience and knowledge and work that both your organisations are doing. Thank you very much. I have a final question. So your organisations offer services in a survivor-centred manner, how can an organisation integrate and amplify survivor's voices, survivor's needs and rights putting them really at the centre of their work? You've shared already so much today and so many of your experiences, but can you give us some more practical examples of how you're doing this in the settings where you work, and how you involve or try to involve survivors directly in ways that are really ethical safe and respectful? How are you doing this, Eva, please?

EVA: I think more and more in MSF we are now also inviting voices or representative of sexual violence survivor groups to allow them to speak out, to also present their stories and also their solutions. So really to echo their needs to make sure that we adapt our project design... Their inclusion I think is really key, we cannot design projects without listening to their concerns and also not listening to the solutions they propose. I think also something that is very key is to continue partnerships with local and national organisations, because at the end we all advocate for the same specific and social needs that are needed for survivors of male sexual violence. And then I also think at project level, it's needed to share project experiences, the reports, the research... and many countries are having roundtable discussions. This is happening. So I do think that we need to share more our lessons learned with the main focus on sexual violence care and also on male sexual violence care that there is a particular focus on and attention. I think that's really key. But my main measures would be definitely the peer leadership that leads training sensitisation and project design. I think that's the way forward. Definitely.

LEA: Yes. I perfectly agree with you, Eva. And as I said before, it's the quality of the care we provide and not the numbers of survivors we work with that should matter the most. So also keeping a relationship with the survivor. So, in our work, for example, in LDHR even after the documentation process, we keep a relationship with the survivor. We make sure that there are legal, medical psychosocial needs are met and that they are satisfied with the services they received. And also, I think it's really important to work with the community as a whole. So this is where the stigma work that we do, for example, is fundamental. So not only address the immediate needs of the survivor in terms of healthcare, but also work with their community so they can reintegrate their own community and get the support they need from their own families and the people around them as well. And of course, we try to amplify the voices of survivors through our advocacy work, participation in events, human rights reports... where we include the personal stories of survivors and make recommendations to the Syrian government and the international community based on the needs of the survivors themselves.

LAURA: Thanks, you brought up incredibly important and inspiring points. I really thank you for that. We are reaching the end of our conversation today. I would like to thank you once more Eva and Lea, it was wonderful to have you and to learn from you. Thank you for all the work you are doing and it is our hope that further research and work to address sexual violence against people of all genders and ages in collaboration with experts like you and other organisations on the ground will continue bringing more effective and competent responses to all survivors of sexual violence. Thank you very much again to both of you and goodbye everyone.

CHARU: *That brings us to the end of this episode of "In the Centre"! Thank you very much for joining All Survivors Project. We would like to give a special thanks to our sound editor Daniel Frankhuizen. If you found this discussion useful, please subscribe to and access all our monthly forthcoming episodes. We are also on Twitter and you can check out our website allsurvivorsproject.org. We would very much like to hear your thoughts and suggestions for future podcasts—all views are welcomed, so please stay in touch, and see you next time!*

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