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Adapting Médecins Sans Frontières (MSF)'s sexual violence care training approach to Middle Eastern contexts: what does this mean in practice?

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ABSTRACT

Background

This article shares the learnings of Médecins Sans Frontières (MSF)'s experience of adapting its sexual violence care training for its staff and missions in the Middle East and North Africa (MENA) region in 2019. It explores some of the implications of MENA operational and sociocultural specificities for MSF's training approach, as well as theoretical and practical aspects of working in sexual violence response in specific settings and addressing contextual structural barriers to survivors' accessing such services. It contributes to sharing knowledge among practitioners about adapting a sexual violence training approach for different contexts.

Methods

Methods employed included a scoping review of literature; qualitative data collection via consultations with MENA organisations and interviews with MSF experts and staff working in Yemen, Palestine, Syria, Lebanon, Jordan, Turkey and Greece; collaborative content adaptation and issue integration; translation in Arabic and proofreading; testing of training modules in different settings; and feedback integration.

Results

The adaptation work shows the importance of context and suggests that culturally and contextually adapted training bears potential for effectively strengthening staff members' survivor-centered skills and attitudes, as well as technical knowledge and skills in care provision. The revision process shows that the overall approach of the training is constitutive to its effectiveness since the approach to – in addition to the substance of – most core principles and elements bears the potential to make training more acceptable and effective in encouraging staff reflectivity on local existing social and gender norms and their own beliefs and attitudes.

Conclusions

The article concludes that capacity-building efforts alone must not be overestimated in their ability to mobilize change in complex settings but highlights their potential to catalyze change if embedded in institutional longstanding efforts involving operational strategies, political advocacy and organizational culture. The process represents a first step which needs to be further tested, evaluated and continuously fed by MSF practice-based knowledge and dialogue with other organizations around response and training approaches and practices.

Keywords: Sexual violence, Training, Capacity building, Middle East and North Africa, Cultural and contextual adaptation

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INTRODUCTION

In 2021 alone, Médecins Sans Frontières (MSF) provided medical care to more than 33,000 individuals who were victims/survivors of sexual violence in numerous conflict and other humanitarian settings,[1] including women, girls, men and boys, and persons with diverse sexual orientations, gender identities and gender expressions (SOGIE).

Since the start of its presence in the Middle East and North Africa (MENA) region, MSF has experienced a very low uptake of its sexual violence care services in Iraq, Lebanon, Syria, Jordan, Palestine, Yemen and Turkey compared to other world settings such as countries and projects in Sub-Saharan Africa and Latin America. Today, the number of victims/survivors seeking support in MSF medical facilities remains minimal. MSF's experience and assessments in recent years show that several cultural, social, political and economic factors interact to pose particular challenges with regard to both care provision and patients' access to sexual violence medical services in the region.

The barriers to disclosure and seeking medical help for sexual violence facing victims/survivors in MENA are numerous, and partly common to those in several other contexts. Feelings of shame, guilt and fear of repercussions deter victims/survivors from reporting to medical facilities, particularly in contexts where sexual victimization and its disclosure involve high risks for the victim, such as honour killing and re-exposure to violence, stigma and retraumatizing or disempowering experiences.

The normalization of violence that many women and girls experience in numerous contexts, coupled with the lack of awareness of potential medical impacts of sexual violence and of the existence of safe and confidential medical services, also reduce access significantly. Access may be further hindered by the lack of trust that survivors often have in the medical system, especially if previous experiences have not been positive and if mandatory reporting obligations – inscribed in several Middle Eastern legislations – require that medical personnel report sexual violence incidents to the authorities regardless of survivors' choice. Sometimes, the concern of many medical practitioners who may feel unprepared, unequipped or simply uncomfortable, to respond to disclosure in an appropriate manner may represent an obstacle to the creation of an enabling and supportive environment for survivors. This is common in countries where sexual violence care is not part of the medical education and where the complexities of medico-legal aspects of care may generate concerns in senior and junior staff alike.

Barriers can also be high for male survivors, including those with diverse SOGIE. The stigma associated with male-directed sexual violence is common in most MENA contexts and is embedded within and compounded by several misconceptions and prejudices that can undermine access to health services by male survivors, and identification of and response to cases by health providers[2].

The relevance of sexual violence training for MSF professionals

MSF's experience shows that supportive attitudes and behaviours of medical staff, along with solid knowledge and skills in care provision, are key to mitigating the numerous barriers to accessing medical services and to facilitating victims' journeys towards survival and recovery. This is why training of frontline workers has been a key strategy of intervention for MSF for several years.

Since 2004, MSF has developed multiple types of training on sexual violence care, conceived to build or improve MSF headquarters and field staff's capacity to set up and implement care provision for victims/survivors of sexual violence as well as to prompt their critical self-reflection and motivation to become proactive responders. Trainings are addressed at all staff who are directly or indirectly involved in care provision, including midwives, nurses, medical doctors, psychologists, psychosocial counsellors, social workers, health promotion staff and middle and senior managers such as project managers, medical coordinators and heads of

mission. The training programme walks trainees through key principles, operational guidance and available tools and resources for every stage of the project cycle. The training is divided into five thematic blocks which address core aspects related to: understanding sexual violence, strategies for addressing sexual violence care related needs, preparation of projects and structures, provision of care, and evaluation and programme improvement.

A training toolkit for facilitators has been developed by MSF, based on documents and tools available, and selected material from other organizations which were, where necessary, adapted to MSF's needs. The training methodology is focused on developing practical skills and uses case studies, simulations, group exercises, video screenings and group discussions.

Rationale for adaptation work

The low number of sexual violence patients seeking care in MSF programmes in the MENA region led the organization to embark on a general critical self-reflection about the effectiveness of MSF's overall approach to sexual violence care in the MENA contexts.[a] Reflections revolved mainly around issues of operational strategies, including institutional partnerships with health authorities and collaboration with other actors, but also involved a more internal questioning of MSF teams' understanding of and approach to the complexities of the sociocultural realities and legal frameworks surrounding sexual violence in MENA settings. In this context, a number of sexual violence context assessments by the organization in the MENA region in recent years shed light on the need to invest more in training of national and international staff working in all the MENA missions. At the same time staff were encouraged to question the adequacy of the existing sexual violence training approach to this diverse region, including content, resources, thematic focus areas, and language and discourse. A critical group of managers and implementers started questioning whether MSF sexual violence care training, originally and predominantly developed around programmes' needs in several African and predominantly rural contexts, could be valid for training in other sociocultural contexts. A will slowly emerged, within MSF operational and learning departments, to better analyze the dissonance that could arise from the application of the existing training approach in the MENA contexts.

This self-reflection process eventually prompted MSF to pilot a localization and adaptation exercise of its sexual violence care training to the MENA region, which ultimately led to the development of a separate training toolkit. The inception concept for the review posited a number of hypotheses:

1) Addressing, in the training, the specific barriers that legal frameworks and contextual socio-cultural norms in MENA contexts often pose to victims/survivors' ability to disclose and access treatment is likely to improve MSF staff's awareness, knowledge, attitudes and professional skills in service set-up, patient care provision and community engagement;
2) Adapting the training to the legal framework of each of the various MENA countries is likely to contribute to mitigating staff's concerns about and challenges related to the medico-legal aspects of sexual violence care, as well as strengthen their ability to learn how to apply legal requirements to the care for victims/survivors, recognize and handle potentially complex cases;
3) Developing culturally adequate and contextually relevant narratives, approaches, language and imageries into modules' content, material and audio-visual tools specific to the MENA region will help mirror trainees' experience, facilitate discussions on sensitive issues, and provide field projects with adapted tools;
4) Translating training resources in Arabic is likely to ensure a wider reach of Arabic-speaking participants, a better understanding of concepts and contents by trainees, and a wider use of these resources on projects.

METHODS AND MATERIALS

The adaptation work was carried out during an overall period of five months, from February to June 2019. The MENA toolkit was the product of a collective effort and was carried out with the direct involvement and inputs from 35 MSF staff and thematic and regional experts from field missions and headquarters, and benefitted from the advice of representatives of ten organisations from the MENA region[b]. The revision team, constituted by three sexual violence care implementers, sought collaboration with field and headquarters staff from different departments – operations, medical including mental health, legal and health promotion – and ensured that the voices and experiences of field staff working on missions in MENA countries were central throughout the process. The methodology involved the following five stages:

Stage 1: Scoping review of literature

A non-systematic review of specific literature and resources from the MENA region was conducted based on MENA experts' advice and sourced from journal articles, guidelines, grey literature reports and publications from international and national organizations and NGOs. Inclusion criteria included literature focused on the MENA region or by MENA authors or organizations. The search focused on sexual and gender-based violence (SGBV) prevention and response programming, social norms and societal attitudes around SGBV, gender, sexuality and mental health. The findings from the literature review oriented the identification of the key areas and topics in the toolkit that needed specific adaptation and/or development and on which qualitative data collection was going to focus. The desk review also involved identification of training tools and resources from other organizations working in the MENA region. A specific tool was designed to assess and rate the adequacy of identified external training resources for MSF's training scope, objectives and operational role.

Stage 2: Qualitative data collection

Qualitative data collection was achieved through consultations with key MSF staff from headquarters and field missions[c] currently working in Yemen, Palestine, Syria, Lebanon, Jordan and Turkey. Staff from the mission in Greece were also included, since the majority of the populations assisted in MSF's projects in Greece come from the MENA region. Semi-structured interviews focused on issues around staff's understanding of sexual violence, including root causes and contributing factors; societal attitudes towards SGBV, victimhood and survival and the underlying gender and power relations; perceived barriers and enablers to access to medical care by survivors; concerns and suggestions about service provision, community engagement and collaboration with other actors; specificities of translating and interpreting during sexual violence medical consultations and challenges of working with translators and cultural mediators. Interviews with Arabic-speaking staff also focused on specific terminology around sexual violence used by the staff and the community in every country and sub-context and the sensitivities around each term. It was particularly important to involve female and male MSF staff who had consistent experience in sexual violence care provision or project management in a variety of MENA contexts.

Consultations were also carried out with ten practitioners from local NGOs based in the MENA region and working in the areas of gender, SGBV prevention and response, child protection and mental health. Priority went to organizations MSF had ongoing contacts or field collaboration with. The main goal of these consultations was to better understand organizations' models of work and approaches to addressing sensitive issues, taboo and stigma in areas such as survivors' support, community engagement work, programme set-up, and staff training and supervision. An analysis of these organizations' training approaches and tools was also carried out during interviews. Some interviewees agreed to share manuals and material they routinely use in the training of their staff.

Stage 3: Adaptation of content or issue integration

Findings from the literature review, qualitative data collection and training tools analysis oriented the

actual review and adaptation of MSF training modules' content, including lesson plans, presentations, facilitators' guide, handouts and further resources. The depth and type of content review varied from small adaptations of existing modules – where the content remained the same but the approach to how topics were addressed was reviewed – to the development of new topics which were not included in the original training programme. With organizations' permission, a number of training tools such as video resources, manuals, exercises and other material developed by other international and national organisations were also included as part of the training material and further resources. A balance was constantly sought between openness to innovation and basic alignment with MSF's core concepts, messages and priority focuses, in order to minimize the risk of inconsistency.

Stage 4: Translation and proofreading in Arabic

Once the content adaptation was completed, the material was submitted for English-to-Arabic translation. The goal was to constitute a bilingual English-Arabic toolkit which could be used by English and Arabic-speaking facilitators alike for training addressed at Arabic- or mixed Arabic-English speaking groups of trainees. Three proofreading rounds were undertaken following the translation, in line with recommendations from other organizations, to ensure that the Arabic terms employed were understandable in different MENA areas.

A first proofreading was provided by a senior MSF medical certified translator based in Jordan, a second one by an MSF translator based in Iraq, along with two Arabic mother tongue mental health staff members for mental health resources. A third and final proofreading was carried out by an experienced sexual violence responder from the region and with solid experience in several MENA countries. Since she had not been directly involved in the revision process, her expert external look on the final product proved very useful to test the conceptual fluidity as well as the cultural adequacy of language and approach to sensitive topics.

Stage 5: Testing of the modules

The adapted toolkit was tested in two five-day field trainings in two different regions in Iraq (one in Mosul, Ninewa and one in Sinuni, Sinjar) and some modules were also tested in shorter trainings delivered to national staff in Palestine, Yemen and Turkey as well as in Sudan[d]. These trainings received feedback from trainers and participants, which was subsequently analysed and, where necessary, incorporated into the toolkit. Feedback from trainees was aimed at collecting opinions and suggestions about training content, approach, tools and language measured against the criteria of clarity, sociocultural sensitivity, correctness and preciseness. This encouraged interviewees to suggest terminology specific to their country, region and/or community. A feedback questionnaire and a guidance document were developed to support facilitators collecting feedback from trainees in the context of semi-structured individual interviews. The reviewed toolkit was submitted to MSF's reproductive health and sexual violence care working group – an internal decision-making platform – on sexual violence programming, and was finally approved.

Limitations of the study

The review has several limitations. The main one regards the lack of survivors' voices to inform the review, mainly due to the minimal presence of sexual violence survivors in MSF patient cohorts in the MENA region. While MSF sexual violence services' poor uptake in the MENA contexts itself prompted the review exercise, the fact that the review was not based on survivors' opinions, experience, feedback nor on MSF staff's significant experience in patient care in the region makes the review *de facto* not survivor informed. Methodologically, the literature review was not systematic and was conducted almost solely in English, which limited the findings that could have been achieved through a wider search.

Some limitations were also related to the coordination team. Only one of the review coordination team was from the MENA region and an Arabic native speaker. This left room for improvement

in terms of specific cultural and linguistic competence. Capacity was also an issue, since none of the members were fully dedicated to the revision work; all of them worked on the revision while attending to other tasks and responsibilities related to their respective positions. This diluted the efforts over a longer period of time and did not optimize the resources involved. Due to contractual and organizational reasons, the testing phase was neither structured nor followed by the same team that carried out the revision. This limited consistency in the follow-up collection and integration and did not allow for a more thorough monitoring and evaluation of the testing phase.

Moreover, a number of challenges such as access, partnership, capacity and data availability led the revision exercise to be focused more predominantly on some MENA countries where MSF is present (such as Iraq, Lebanon and Jordan), less on others (such as Yemen, Palestine or Syria), and not at all on other countries in Northern Africa such as Egypt and Libya, which inevitably resulted in some imbalances and biases in the sociocultural representation and analysis of a vastly diverse region.

Finally, due to operational reasons also linked to the global COVID-19 pandemic, a formal evaluation of the revised training's impact on staff knowledge, attitude, capacity and performance in different countries and settings is pending.

DISCUSSION

Analysis of the results led to a number of adaptations to the existing material. The main adaptations are listed below and discussed in turn.

Introducing the topic: graduality, professionalism

The revision showed that a sensitive and gradual approach to the topic of addressing sexual violence is needed to bring audiences with diverse cultural, social and religious backgrounds into the same training space. The revised training recommends expanding the welcome session to take the time to slowly establish a respectful, non-judgmental classroom where all opinions are taken into account. Facilitators are invited to put particular emphasis on confidentiality, non-judgment and safety for all participants. MSF staff and other practitioners from the MENA regions recommended to slow down the rhythm of the introductory sessions and pause more often than facilitators would normally do in the original training[e]. It was also noted that it is crucial for the opening session to acknowledge and address trainees' potential concerns and anxieties about discussing the issue in class with other participants, and emphasize the existence of a safe training space, where participants can explore both their beliefs and new ideas about SGBV in a supportive learning environment, in confidence. This session also needs to clarify that the training is aimed at building professional skills and knowledge and defining participants' roles and duties as MSF staff in responding to sexual violence. Bringing this professional lens from the start helps to reassure people and establish a common ground and clear boundaries: during the training, participants will explore their beliefs and opinions about the subject of sexual violence while building critical capacity to comply with their professional obligations as members of a humanitarian medical organization.

Unpacking sociocultural norms and addressing stigma and taboo

The revised training attempts to unpack social and gender norms surrounding sexual and gender-based violence and its impacts on staff perceptions of and attitudes towards violence perpetration and victimization. Patient-centered principles such as non-judgment, confidentiality and compassionate, empathic response to disclosures are particularly reinforced throughout the training through specific interactive exercises, role play, simulations and group discussions to ensure MSF personnel's role in supporting survivors is clarified and practiced. While exercises allowing participants to critically explore norms and stereotypes surrounding sexual violence and victims/survivors is common to the standard training, the revised training puts a particular emphasis on exploring contextual commonly-held assumptions, and analyzing local meanings of key notions such as 'consent', 'family honour' and 'stigma' to gradually establish a common understanding.

Specific interactive exercises were developed, where trainees could directly experience and explore the impacts of both unsupportive and supportive responses to disclosure and better understand the grounds of their ethical and medical duty as MSF staff in patients' support. The module focusing on health promotion and community engagement, which is addressed later in the week, also explores the gender and sociocultural norms prevailing in some MENA contexts, this time putting participants in the position of identifying culturally competent and contextually relevant ways to gradually create safe opportunities for discussions on violence, stigma and survivors' support with local communities and key actors.

Topic integration

A new sub-module of the session on mental health and psychosocial support explores the issue of stigma around psychological distress, mental illness, and psychological and psychiatric services that exists in various MENA contexts[3-5] as well as MSF personnel's role and duty to mitigate or address it in the context of sexual violence care provision.

A sub-module on the practice of so-called 'virginity testing' was also developed, to explore the myths and realities around 'virginity examinations' as well as clarifying MSF requirement of medical staff to refuse to engage in this practice. Emphasis is put on the harmful impacts of the practice and on its lack of scientific merit or clinical indication[6-9].

A new module on working with interpreters and cultural mediators focuses on emerging practices in this area and provides clear guidance and practical tools for both interpreters and field staff working with them, to increase the quality of translations, and mitigate the risks and impacts of potential misunderstandings or cultural biases related to sexual violence in the MENA region[10]. A document with definitions in both English and Arabic of key sexual violence-related terms mostly used during medical consultations was also developed for interpreters and medical practitioners, to ensure accurate translation of key terminology.

Reference to sexual violence against men and boys in the context of some MENA settings has also been mainstreamed throughout the toolkit, with a particular emphasis being put on analyzing masculinities and gender norms and the specific barriers male survivors face in seeking medical services. MENA-specific literature and audiovisual materials on the issue were among the resources [11-15].

Managing medico-legal aspects of sexual violence care in the MENA

The revised medico-legal module walks trainees through the main legal mechanisms that may pose barriers to free and confidential access to medical care for victims/survivors in the MENA contexts. The medico-legal assessment conducted by MSF International legal department in three MENA countries allowed for in-depth illustration of country-specific elements and realities. A number of context-relevant case studies aim at strengthening trainees' ability to apply legal requirements to the care for sexual violence victims/survivors and how to recognize and handle potentially complex cases. Case studies put trainees in front of contextually relevant situations they might face, involving issues such as: responding to a request to perform a 'virginity test' on a child survivor, ensuring strict medical confidentiality in complex situations, and practicing decision-making around mandatory reporting in line with the core principles of survivor-centered care. The toolkit also includes a detailed guidance document developed for facilitators on the steps to follow to best prepare and localize the medico-legal session, with the support of the MSF international legal department.

Contextual adaptation of images and audio-visual resources

The revised toolkit uses images, artwork and audio-visual material which better reflect local MENA communities, avoiding cultural sensitivities and stereotyping, and replace the predominance of Africa-centered visual language of the original MSF training toolkit. In selecting the photographs and images for the training presentations and handouts, attention was given to portray the diversity of the MENA region

and avoid simplistic stereotyping, e.g. by including images of distinguished styles of clothing for men and women. As per audiovisual resources, some existing adapted resources from other organizations were introduced. For example, the medical consultation video by the International Rescue Committee (IRC), usually screened during the medical module, was replaced by the IRC's adapted version of the same video for Arabic settings[16].

Models of culturally adapted tools developed on MSF missions are also provided in the training toolkit, including posters, scripts for information and sensitization sessions with communities, and storyboards for storytelling sessions with children. One animation video produced by a European NGO was also included, which focuses on the benefits of accessing care and support by women and girl survivors of violence in migration settings[17].

Challenges and opportunities

The thoroughness of the multiple and multi-level barriers to ensuring access to safe and confidential sexual violence responses in many MENA contexts call for long-term commitments and dedication by MSF teams, along with profound and structural efforts, of which training is only one component.

A training adaptation can be a meaningful contribution to strengthening providers' skills, capacities and reflexivity but training approaches and tools should certainly not be regarded as a ready-made solution to the complexities in, or of providers' practice in, the MENA realities. These require structural and long-term efforts, as they are partly – and will remain – out of MSF teams' control.

At programming level, training needs to be one of the components of a wider whole-of-mission approach to sexual violence prevention and response. This includes, for example, meaningful partnerships with local women's groups and medical and humanitarian organizations, which is crucial to patients' access to comprehensive support and can be a vector for collective growth and joint political advocacy. Partnership with and support to health authorities in sexual violence response is key for the sustainability of responses and for ensuring that survivor-centred care is embedded in national policies, protocols, practices and specialized service delivery. Staff training efforts need also to be matched by longer-term professional support and supervision and day-to-day, whole-of-mission institutional policies and approach to staff growth, well-being and empowerment.

This comprehensive long-term engagement can prove challenging, especially in light of MSF staff's and mission's competing priorities in emergency settings and the short- to medium-term nature of some MSF interventions. Moreover, challenges remain high around ensuring protection responses to survivors. Tensions often emerge between an emphasis on the need for staff to create entry points in medical services and the common inability to offer survivor physical protection options in a context that often remains not survivor friendly.

While training alone is obviously not enough to address the complexities of care provision and access, it can constitute a strategic entry point and an opportunity to build on. In MSF's experience, this work on training adaptation was able to catalyze internal attention and foster discussions on the complexities of these issues among teams and departments across MSF programmes and headquarters. This emergence of critical reflexivity across teams and departments is to be acknowledged as a potential engine for further action.

This adaptation also provided the opportunity to better unpack and address certain topics, aspects and resources, which can be applicable across other contexts. Beyond its explicit focus on the MENA region, the localized training toolkit can inform training efforts in other countries, including non-MENA contexts, where MSF responds to medical needs of populations coming from the MENA region – in countries such as Greece and Italy – and other contexts where similar social norms around gender, sexuality and sexual violence exist.

CONCLUSION

This article has explored some of the implications of MENA sociocultural specificities for MSF sexual violence training approach, as well as theoretical and practical aspects of working in sexual violence medical response. The review process and outputs, whilst by no means exhaustive, show the importance of context and the difficulties and challenges inherent in applying mainstream approaches in specific settings.

The review shows findings which are partial, tentative and which need a formal evaluation and repeated trials and iterative adaptations. The process represents, therefore, a first step which needs to be further tested, evaluated and continuously fed by MSF practice-based knowledge and dialogue with other organizations around response and training approaches and practices.

This first revision exercise highlighted that the overall approach of the training is constitutive to its effectiveness. By adopting a gradual approach into a self-exploration of commonly held assumptions and beliefs around sexual violence perpetration and victimization, the training attempts at 'meeting participants where they are' while, at the same time, equipping them to become agents of positive change for their respective teams, services and communities. While some ad-hoc topic and resource integration built added value in the toolkit, the core changes regarded the *approach to* rather than *the substance* of most core principles and elements, with an emphasis on challenging assumptions underlying social and gender norms around sexual violence.

The complexities related to an effective, culturally adequate and contextually relevant sexual violence care implementation, and the structural challenges and barriers to survivors' care in several MENA contexts, suggest that training and tools must not be overestimated in their ability to mobilize change. However, while context-related complexities and challenges need to be acknowledged, it is important that they do not translate into a reason for deferring long-term commitment, and rather prompt long-standing efforts involving capacity-building along with operational strategies, political advocacy, organizational culture and continued reflexivity.

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FOOTNOTES

a) Due to the fact that the initiative was led by MSF Switzerland and MSF Spain, other MENA contexts such as Libya and Egypt where other MSF sections are present were not directly focused on or involved in the revision process.
b) This number includes MSF staff who directly contributed to the revision work, were interviewed or otherwise contributed to the revision process.
c) Headquarters staff included sexual violence providers and experts, sexual violence trainers, mental health advisors and health promotion and community engagement advisors. Field interviewees included medical doctors, midwives, nurses, psychologists, cultural mediators and health promoters.
d) Sudan was chosen since it is an Arabic-speaking country where MSF faces similar challenges to some MENA countries, in terms of the cultural, social and political factors hindering care provision and patients' access to sexual violence medical services.
e) Facilitators were, for example, encouraged to ask "Shall we continue?" after introducing sensitive topics, and wait for participants' express reply, in order to strengthen their sense of control and consent to proceed.