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Sexual Violence against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh, Italy, and Kenya

Synthesis Report

October 2020



The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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****Note that this report contains graphic descriptions of sexual violence.****

Cover: Kutupalong refugee camp, Cox's Bazar, Bangladesh. © Sarah Chynoweth

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Executive Summary

Despite increasing scholarship on conflict-related sexual violence against men and boys, knowledge gaps remain regarding the forms, repercussions, and responses to this violence. To help build the evidence base, the Women's Refugee Commission (WRC) undertook exploratory, qualitative research examining the characteristics and impacts of sexual violence against men and boys, as well as assessing the availability and accessibility of services for male survivors, in three refugee settings.

Study populations and sites were Rohingya refugees from northern Rakhine state, Myanmar, living in Cox's Bazar, Bangladesh; refugees and migrants who had traveled the central Mediterranean migration route through Libya and now living in Rome and Sicily, Italy; and refugees from the eastern Democratic Republic of the Congo, Somalia, and South Sudan living in Nairobi and Mombasa counties, Kenya. Field work was undertaken in 2018 and 2019. Methods included semi-structured key informant interviews with 148 frontline aid workers and human rights experts and 55 semi-structured focus group discussions with 310 refugees, including adolescent boys, young men, adult men, adult women, men with physical disabilities, and refugees with diverse (i.e., non-heteronormative) sexual orientation, gender identity and expression, and sexual characteristics (SOGIESC). Data were coded and analyzed thematically using NVivo 12. The University of New South Wales and the Kenya Medical Research Institute (KEMRI) provided ethics oversight and approval for this study, and the University of Palermo's Department of Psychological, Pedagogical, and Education Services reviewed and approved the research protocol.

Key Findings

Conflict-affected settings

- Findings suggest that sexual violence against men and boys may not be rare in Myanmar (northern Rakhine state), Libya, eastern DRC, and South Sudan. Findings from Somalia were unclear.
- Men and boys were reportedly subjected to a variety of forms of conflict-related sexual violence in these settings. Frequently reported forms of sexual violence included forced witnessing, genital violence, and anal rape.
- Sites at which sexual violence against men and boys was reported included border crossings, along the roadside, during village raids, and in the context of imprisonment and captivity.
- Frequently cited perpetrators were men involved with armed groups. In addition, sexual victimization by predominantly male family and community members was also reported, particularly by persons with diverse SOGIESC.
- Groups that appear to be especially vulnerable to sexual victimization included adolescent boys, young men, persons with diverse SOGIESC, and detainees.

Refugee hosting settings

- Forms of sexual violence in the three refugee settings (Bangladesh, Italy, Kenya) included sexual abuse, sexual exploitation, and rape.
- Perpetrators included other refugees (including family members), members of the host community, landlords, taxi drivers, and state authorities such as the police. The large majority of reported incidents involved male perpetrators.
- Groups particularly vulnerable to sexual victimization included young boys, adolescent boys, persons selling sex, and persons with diverse SOGIESC, especially transgender refugees.

Impacts

- Mental health consequences were varied and included anxiety, depression, post-traumatic stress disorder, dissociation, auditory hallucinations, paranoia, memory loss, confusion, somatization, sexual dysfunction, suicidal ideation, and attempted or completed suicide.
- Physical impacts included sexually transmitted infections; anal trauma such as fissures and fistulae; genital trauma, including penile and testicular amputation; pelvic and groin pains; fecal incontinence; hemorrhoids; urination difficulties; and sexual dysfunction.
- Social repercussions included stigma and social sanctions, such as shunning, shaming, humiliation, and familial rejection.
- Other impacts included limitations to livelihoods and associated financial stresses, and for boy survivors, difficulty performing or staying in school.

Intersections with violence against women and girls

- At times, conflict-related sexual violence was perpetrated in ways that involved men and women, such as forcing men and boys to witness or perpetrate sexual violence against women and girls. A few incidents of women and girls being forced to witness or perpetrate sexual violence against men and boys were reported.
- Gendered impacts of male sexual victimization included social sanctions against wives and daughters of male survivors, including ostracism, humiliation, and compromised marriageability of daughters; damaged familial relationships; challenges to emotional and physical intimacy challenges; separation or divorce; and possible intimate partner violence.

Service availability and accessibility

- Across all settings, some specialized medical, mental health, and legal aid services for male survivors of sexual violence were identified; however, quality was inconsistent, need exceeded supply, and coverage was inadequate.
- Enabling factors that promoted service uptake included specialized, confidential services with qualified staff; designated entry and referral points; and targeted outreach, awareness-raising, and trust-building with refugee communities.
- Key barriers that impeded service uptake included lack of clarity on sectoral responsibilities for addressing sexual violence against adult men and persons with diverse SOGIESC, restrictive legislative frameworks, limited staff capacity, negative provider attitudes and practices, a dearth of designated entry and referral points, limited awareness-raising and community outreach, poor knowledge of benefits and availability of services among refugees, social stigma, and self-stigma.

This study presents initial insights. More research is needed to better understand the manifestations, repercussions, and impacts of sexual violence against men and boys in conflict and displacement, as well as how best to meet the needs of survivors of all genders, including those with diverse SOGIESC, in humanitarian settings.



Key Recommendations

Protection for vulnerable groups and post-sexual services for survivors of all genders require strengthening. Targeted efforts should be undertaken to enhance protection, expand service provision, and enable access to services for women, girls, men, boys, and nonbinary persons, including disaggregated approaches to address the unique needs of persons with diverse SOGIESC.

For refugee-hosting governments

1. Ensure timely access to refugee documentation, including registration, renewal, and refugee status determination processes, and expand access to international protection for vulnerable refugees, which helps enable access to services for survivors.
2. Ensure legal definitions of rape and other forms of sexual violence are inclusive of male victims and female perpetrators and address common forms of sexual violence against men and boys, such as forced witnessing and forced perpetration, as well as common forms of sexual violence against women, girls, and nonbinary persons.
3. Abolish anti-LGBTIQ+ legislation and institute comprehensive protections for persons with SOGIESC, which will facilitate access to service for survivors.

For humanitarian service providers

1. Recognizing that both the services and the service providers may need to be different for persons of different genders, collaborate with communities—particularly survivors—to understand where they are likely to access services, and then establish targeted, specialized services with dedicated entry points for male survivors and survivors with diverse SOGIESC, in addition to targeted services and entry points for women and girls.
2. Support capacity development of service providers, identify and address negative attitudes and misconceptions, and support staff to improve respectful, confidential responses to women/girl and men/boy survivors, survivors with diverse SOGIESC, child and adolescent survivors, survivors with disabilities, and survivors who sell sex.
3. Establish sexual violence-related referral pathways for male survivors (adult and child) and survivors with diverse SOGIESC (adult and child) and ensure robust referral pathways for survivors of all genders, sexual orientations, ages, and abilities.
4. Meaningfully engage refugee communities to develop targeted communication strategies for men, women, girls, and boys, including persons with diverse SOGIESC, to raise awareness about sexual violence, dispel myths, and clarify how, where, and why to access sexual violence services.
5. Map risks by population group and sector and develop prevention and risk mitigation strategies to enhance protection and reduce risk.

For donors and refugee resettlement countries

1. Increase resettlement slots and quotas for refugees with diverse SOGIESC who are particularly vulnerable to sexual victimization and face specific protection barriers.
2. Provide funding to support and expand (as appropriate) effective service delivery models for male survivors and survivors with diverse SOGIESC in addition to increased and equitable funding for women and girls.
3. Support the capacity development of existing structures and systems to improve prevention, mitigation, and response to sexual violence for survivors of all genders and sexual orientations.

4. Fund relevant local and community-based organizations to help strengthen community-based protection, particularly for persons with diverse SOGIESC.
5. Fund and advocate for the development of capacity development tools for frontline service providers and evidence-based programming to improve care for survivors.

For researchers

1. Learn from methods and approaches employed by researchers focused on gender-based violence against women and girls to ethically and safely gather data on sexual violence against men, boys, and persons with diverse SOGIESC.
2. Evaluate programs and approaches, such as survivor-led support models, to contribute to more effective prevention, mitigation, and response to sexual exploitation of boys, men, and persons with diverse SOGIESC, and assess feasibility of application to other humanitarian settings.
3. Assess effective ways to enhance enablers and minimize barriers to service utilization, such as training members of the displaced community to facilitate survivors' access to services and integrating men, boys, and persons with diverse SOGIESC when undertaking analyses of barriers to care for sexual violence survivors.
4. Examine the gendered impacts of sexual violence against men and boys, including any potential linkages between sexual victimization and perpetration of intimate partner violence and other forms of violence.

WRC's work with men and boys is feminist in its approach and prioritizes accountability to women and girls. We do this by:

- Exploring the ways in which sexual violence against men and boys impacts the lives of women and girls;
- Exploring the ways in which sexual violence against men and boys intersects with violence against women and girls;
- Advocating for services for and attention to survivors of all genders;
- Working to dispel the myth that sexual violence services are widely available for women and girls but not for men and boys: across humanitarian settings, they need strengthening for survivors of all genders; and
- Including experts on violence against women and girls and persons with diverse SOGIESC on our Global Advisory Committee.



Background

Sexual violence¹ is a serious human rights violation. Existing evidence demonstrates that women and girls bear the brunt of sexual victimization in conflict and non-conflict-affected settings.² At the same time, some men and boys are also sexually victimized in these contexts. Persons with diverse (i.e., non-heteronormative) sexual orientation, gender identity and expression, and sexual characteristics (SOGIESC) are particularly vulnerable to sexual victimization.

In 2018 and 2019, the Women's Refugee Commission (WRC) undertook qualitative, exploratory research on sexual violence against men and boys³ in conflict and displacement. The study explored the characteristics and impacts of sexual violence against refugee⁴ men and boys and examined the availability and accessibility of selected services for male survivors in three refugee settings. This report presents a synthesis of the key findings and provides the rationale and context for our key recommendations.⁵

Overview of Methods

This qualitative, exploratory study examined the characteristics and impacts of sexual violence against men and boys in five conflict-affected settings and three refugee settings. Availability and accessibility of services for male survivors and survivors with diverse SOGIESC were also explored in the three refugee settings. The study focused on individuals who identify as men or boys or were designated as male at birth.⁶

Study Sites and Populations

Data collection sites	Refugee populations
Cox's Bazar, Bangladesh	Rohingya refugees from northern Rakhine state, Myanmar
Rome and Sicily, Italy	Refugees and migrants who had traveled the central Mediterranean migration route through Libya
Nairobi and Mombasa counties, Kenya	Refugees from the eastern Democratic Republic of the Congo, Somalia, and South Sudan

- 1 See Key Definitions at the end of the report for definitions of sexual violence, sexual exploitation, sexual abuse, and other terms used in this report.
- 2 See, for example, D. Ligiero et al. (2019), What works to prevent sexual violence against children: Evidence Review. Together for Girls; I. Ba, & R. S. Bhopal. (2017), Physical, mental and social consequences in civilians who have experienced war-related sexual violence: A systematic review (1981–2014). *Public Health*, 142, 121-135; R. Jewkes et al. (2013), Prevalence of and factors associated with non-partner rape perpetration: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health*, 1(4), e208-e218.
- 3 This report uses the term "men and boys" for ease of reading and acknowledges that it does not capture many persons of diverse gender identity and/or expression who are included in the scope of the study.
- 4 Few research participants had received formal refugee status; however, in this paper, we use the term "refugee" for ease of reading and because many meet the definition of a refugee as defined in the 1951 UN Refugee Convention and 1967 Protocol.
- 5 Detailed reports separated by study site (Bangladesh, Italy, and Kenya) can be found at www.womensrefugeecommission.org/svproject.
- 6 The refugees with diverse SOGIESC who participated in this study were assigned male at birth (including cisgender gay men, men who have sex with men, and trans women). This study uses the language "refugees with diverse SOGIESC" because some of the refugees who participated in this research were assigned male at birth but did not explicitly identify as gay, bisexual, transgender, nonbinary, or other well-known categories.

Research sites



Four methods of data collection were employed:

- document review
- 55 semi-structured focus group discussions with 310 refugees
- semi-structured key informant interviews with 148 frontline aid workers and human rights experts
- observation of service delivery points.

The University of New South Wales and the Kenya Medical Research Institute provided ethics oversight and approval for this study. The University of Palermo's Department of Psychological, Pedagogical, and Education Services reviewed and provided written approval of the research protocol. A Global Advisory Committee and three National Reference Groups were established to provide additional guidance and ethics oversight. Data were thematically coded and analyzed using NVivo 12. Limitations included possible translation and note-taking error and lack of participation of trans men and Rohingya with diverse SOGIESC. See Appendix A for further details on research ethics, methods, and limitations.

Conflict-Affected Settings

Men and boys were targeted for sexual violence in eastern DRC, Libya, northern Rakhine state in Myanmar, and South Sudan.

Across all conflict-affected settings apart from Somalia, refugees reported that men and boys were targeted for sexual violence. In 52 of 55 focus groups, participants shared first-, second-, or third-hand accounts of conflict-related sexual violence against men or boys. Most accounts involved perpetration by men involved with armed groups, but some included predominantly male family and community members. Refugees from all settings except Somalia used the same language: that male sexual victimization by armed groups was "common." Key informants in Italy and Kenya



corroborated these findings; in Bangladesh, however, few key informants were aware of sexual violence against Rohingya men or boys in Myanmar.

In Italy, refugees and key informants underscored that sexual violence against refugee and migrant men and boys was widespread in Libya. Input from Somali refugees was inconsistent: some reported that male sexual victimization was common in Somalia, while others said that it was rare or that they had never heard of any such accounts. (See Limitations in Appendix A.)

"Sexual violence against men and boys is a massive issue. I've met so many men and boys who are deeply traumatized on a level I have not experienced before because of their experiences in Libya." -Health provider, search and rescue boat off Libya

Men and boys were subjected to a variety of forms of conflict-related sexual violence, including forced witnessing, genital violence, and rape.

Conflict-related sexual violence against men and boys involved varying forms, including penile-oral rape; penile- and object-anal rape; forced sexual violence against others; genital violence, including castration and penis amputation; forced witnessing of sexual violence against others; forced nudity; forced sex acts; and sexual humiliation. The accounts described by research participants frequently involved three forms, although it is unclear to what extent they reflect true frequency:

1. forced witnessing of sexual violence against others, particularly rape of female family and community members;
2. genital violence, including beating, burning, tying, cutting, electroshock, castration, and penis amputation; and
3. anal rape, both penile- and object-anal rape.

Incidents involving men and boys who were forced to perpetrate sexual violence against others were cited across settings apart from Somalia, particularly in Libya and eastern DRC. In Libya, research participants reported accounts involving men and boys who were forced to rape other men and boys, particularly in the context of imprisonment and captivity, as well as women and girls. In DRC, participants reported that some men and boys were forced to rape female family and community members, such as during village attacks by armed groups.

In Libya, additional forms of sexual violence against men and boys were reported, including forced intercourse with corpses, sexual slavery, and forcing women to perpetrate sexual violence against men. Lethal sexual violence against men and women was also reported in Libya, including forcing men and boys to witness lethal sexual violence against women and girls.

In Myanmar, refugees reported that sexual violence against men and boys, particularly rape and penis amputation, was often inflicted as a precursor to execution. Eleven of the 89 Rohingya men and boys who participated in focus groups spontaneously reported having seen dead bodies with violently amputated penises and genitals, although it was unclear if the violence occurred before or after death.

Across settings, some men and boys were subjected to multiple forms of sexual violence, sometimes during a single assault or through multiple assaults by different perpetrators over time.

"In my village, Ali Yaung Para, the incident happened on a Friday in August. Some military came to my neighbor's house and raped his wife. When he tried to stop them, they caught him and burned his penis. They then killed her and detained the man."
 –"Arif," focus group with Rohingya men in Cox's Bazar, Bangladesh

Reported Data on Sexual Violence against Men and Boys in the Five Conflict-Affected Settings

Democratic Republic of the Congo (DRC)

- Of 399 male respondents surveyed in selected conflict-affected settings in eastern DRC in 2010, **23.6 percent** disclosed having suffered sexual violence.

Libya

- Of 55 male migrants who had transited through Libya to Europe since 2017, **78.2 percent** reported witnessing sexual violence and **18.9 percent** disclosed experiencing sexual violence in Libya.

Myanmar (northern Rakhine state)

- Of 70 Rohingya refugee men surveyed in 2013, **14.3 percent** reported experiencing rape and **20 percent** reported experiencing other types of sexual abuse, sexual humiliation, or sexual exploitation.

Somalia

- Of 2,257 adult men surveyed in 2014–2015, **1.4 percent** disclosed sexual victimization during adulthood and **1.8 percent** reported sexual victimization during childhood.

South Sudan

- Of 434 South Sudanese refugee men surveyed in Uganda in 2018, **29 percent** disclosed ever experiencing forced nudity, **9.7 percent** genital harm, **3.7 percent** rape, and **1.6 percent** sexual slavery.

Sources:

Kristen Johnson et al., [“Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo.”](#) *JAMA* 304:5 (2010), p. 553–562.

Laura Reques et al., [“Episodes of violence suffered by migrants transiting through Libya: a cross-sectional study in Médecins du Monde’s reception and healthcare centre in Seine-Saint-Denis, France.”](#) *Conflict and Health* 14:1 (2020), p. 1–6.

Andrew Riley et al., “Daily Stressors, Trauma Exposure, and Mental Health Among Stateless Rohingya Refugees in Bangladesh” (unpublished raw data), 2013.

Andrea Wirtz et al., [“Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia.”](#) *BMJ Global Health* 3:4 (2018).

Refugee Law Project, [Hidden Realities: Screening for Experiences of Violence amongst War-Affected South Sudanese Refugees in Northern Uganda](#) (August 2017).

Sexual violence was perpetrated across a variety of geographic sites, including at border crossings, along the roadside, and in imprisonment and captivity.

Research participants described incidents of sexual violence against men and boys across varied sites and locations. Sites of sexual violence reported in all study settings were in the context of imprisonment and captivity, at border crossings, and at roadsides. Imprisonment involved formal state-run prisons, official detention centers, as well as informal or makeshift sites of detention. Sexual violence was reportedly perpetrated at border crossings by armed groups and border security forces, including as punishment for the inability to pay for passage.

The incidents described in DRC, Myanmar, and South Sudan frequently occurred during village attacks and home raids. In Libya, many of the accounts involved state-run detention facilities for undocumented migrants as well as unofficial places of captivity frequently run by militias and other armed groups; additional sites identified included during random stops and at checkpoints by armed



groups, in urban settings by armed gangs, and in private homes. In Myanmar and Libya, incidents of male sexual victimization were also reported in the context of slavery and forced labor.

"[The Interahamwe] came to Bunia. They were raping some of the families. They knock on the door and break in. They rape the girls, the mother, and then the father in front of everyone. I saw that happen." –"Jeremy," focus group with Congolese men in Mombasa, Kenya

Particularly vulnerable groups include adolescent boys, young men, persons with diverse SOGIESC, and detainees.

The findings contribute to a growing body of evidence highlighting that men and boys are vulnerable to sexual violence in specific conflict-affected settings. Some groups of men and boys appear to be particularly vulnerable. Across settings, many of the reported incidents involved adolescent boys and young men, with several focus groups noting that boys and young men were specifically targeted for victimization, including rape, castration, and enforced rape of others. Sexual abuse from family and community members was also reported as a push factor for some adolescent boys to flee.

Persons with diverse SOGIESC reported significant sexual victimization in conflict-affected settings and during flight. All 26 persons with diverse SOGIESC who participated in focus groups in Kenya spontaneously disclosed victimization. In contrast to heterosexual, cisgender men and boys, persons with diverse SOGIESC from DRC, Somalia, and South Sudan reported victimization primarily by family and community members rather than by armed groups. Like some adolescent boys, sexual victimization—as well as other forms of violence, discrimination, and social stigmatization—was a primary reason for flight, rather than conflict alone. Some key informants reported that, in Libya, persons with diverse SOGIESC were particularly targeted for sexual violence, including sexual exploitation, once their diverse SOGIESC status was revealed to potential perpetrators.

Detainees or those held in captivity were highly vulnerable to sexual violence, including sexual torture. Other vulnerable groups were specific to the setting. For example, Rohingya religious and community leaders were reportedly targeted for sexual violence and other abuse in Myanmar. In DRC, specific ethnic groups such as the Banyamulenge were reportedly targeted.

Globally, persons with disabilities, including men and boys, are especially vulnerable to sexual violence and abuse.⁷ Although seven focus groups with 35 participants (adult men with disabilities) were undertaken, only a few—primarily in Kenya—perceived men and boys with disabilities as particularly vulnerable to sexual victimization. This may in part be because participants were adults with physical disabilities, many of whom had become disabled at an older age.

"I think there is major sexual violence towards homosexual [sic] men rather than heterosexual men in Libya—once they realize that they are gay. The moment that [traffickers or armed groups] steal their telephones, they check the photos and videos and they understand from that point that these people are together [a romantic couple]. One gay couple...was separated from the rest and put into a specific camp because they were gay and were going to be sexually exploited." –Legal aid officer, Italy

⁷ Emily Lund and J. Vaughn-Jensen, "Victimisation of children with disabilities," *The Lancet*, vol. 380, No. 9845 (2012), pp. 867–869. Monika Mitra et al., "Prevalence and characteristics of sexual violence against men with disabilities," *American Journal of Preventive Medicine*, vol. 50, No. 3 (2016), pp. 311–317.

Refugee-Hosting Settings

Sexual abuse of boys, sexual exploitation of adolescent boys and male youth, sexual violence against persons with diverse SOGIESC, and other sexual violence against male refugees were reported in Bangladesh, Italy, and Kenya.

In the refugee-hosting settings, incidents of male sexual victimization described by research participants generally fell into three categories:

1. Sexual abuse of boys by members of their family, community, or the host community.
2. Sexual exploitation of adolescent boys and male youth, including in the context of selling sex.
3. Sexual violence, including sexual exploitation, of persons with diverse SOGIESC.

Service providers reported accounts of sexual abuse and exploitation of boys, including young boys and adolescents, across all settings. Some perpetrators lured boys through showing them pornography on phones; incidents of perpetrators grooming boys through social media sites, such as Facebook, were reported in Italy and Kenya. In Bangladesh, service providers reported that young boys made up the majority of their male survivor caseloads. In Mombasa, Kenya, focus group participants reported that sexual exploitation of adolescent refugee boys and male youth was commonplace. In urban settings in Italy, some refugee and migrant boys and young men were also being sexually exploited in the context of selling sex, although the extent of this practice is unclear. The large majority of the reported perpetrators were men, although some women were also said to perpetrate sexual exploitation and sexual abuse.

Across settings, refugees with diverse SOGIESC were targeted for sexual violence and exploitation by police, employers, clients, taxi drivers, landlords, neighbors, other refugees, and host community members, including other persons with diverse SOGIESC. Perpetrators may lure refugees through dating or hook-up apps by feigning romantic or sexual interest and then sexually assaulting them on meeting. Transgender refugees were particularly vulnerable to victimization, which was exacerbated by insecure and unsafe housing and livelihoods. In Kenya, all refugees with diverse SOGIESC (26 in total) who participated in this research spontaneously disclosed suffering sexual victimization after arrival in Kenya.



Camp for Rohingya refugees in Cox's Bazar, Bangladesh.

Photo © Dale Buscher



In Italy and Kenya, incidents of sexual violence against adult, cisgender, heterosexual men were reported, including in the context of selling sex, on the street by strangers, and by police officers. Some perpetrators from DRC reportedly followed their victims to Kenya, where they continued to sexually terrorize them. Across refugee-hosting settings, a few accounts of sexual violence against refugee men and adolescent boys were reported in local prisons or while detained.

"The men and the women both target [the boys]. If they know you are a boy and have come alone [unaccompanied], then they say that they will help you, but you have to 'be their husband' [have sex with them]. Both the men and the women." – "Kantu," focus group with adolescent Congolese boys, Mombasa, Kenya

Impacts of Sexual Violence

Mental health

Reported mental health consequences of sexual victimization included anxiety, depression, post-traumatic stress disorder (including complex post-traumatic stress disorder), dissociation, auditory hallucinations, paranoia, memory loss, confusion, suicidal ideation, and attempted or completed suicide. Mental health providers and survivors themselves described feelings of overwhelming loneliness, guilt, anger, shame, and self-blame; some reported insomnia due to hypervigilance, nightmares, or intrusive thoughts or images. Somatization was also reported, including headaches, body pains, and a feeling of itchiness on the skin, the soles of the feet, or inside the body.

A survivor's gendered sense of self may be disrupted. Heterosexual survivors may believe that rape or other sexual violence "turned them gay," causing confusion about their sexuality. For gay men and others with diverse SOGIESC, sexual victimization can trigger feelings of self-blame and self-hatred, including that they "deserved" the violence as punishment for their diverse SOGIESC. Mental health providers caring for male survivors underscored that all forms of sexual violence can be potentially traumatic or disruptive, including less physically violent forms such as forced nudity or sexual humiliation. They also noted that pre-existing psychiatric conditions may conceal sexual victimization. Many survivors suffered myriad forms of loss, violence, and abuse, and mental health impacts may not be attributable to sexual victimization alone.

"Isolation, nightmares, dreams about what happened to you—you are angry all the time. If you see someone who looks like the rapist, you are angry. We are stressed out, we are traumatized. It's really hard to trust anyone." – "Hawa," focus group with Somali refugees with diverse SOGIESC, Nairobi, Kenya

Physical health

Physical impacts, as reported by service providers, refugees, and survivors who spontaneously disclosed victimization, included sexually transmitted infections; anal trauma, including fissures and fistulae; genital trauma, including penile and testicular amputation; pelvic and groin pains; fecal incontinence; hemorrhoids; urinary difficulties; and sexual dysfunction. In Kenya, rectal trauma among male survivors was more frequently reported than in the other refugee settings. HIV and Hepatitis B were also reported among survivors, although transmission could not be definitively linked to sexual victimization.

"In Libya, they were kept in the prison and were kidnapped. The people from the prison used to rape the men. It was very common but it was very difficult for the men to talk about it... [The male survivors have] pain in the anus, pain in the penis, but

are also presenting with general pain in the body. Physical and psychological pain.”
-Health provider, Italy

Social well-being

Social repercussions included stigma and social sanctions by family and community members. Refugees reported that male survivors may be shunned, shamed, and humiliated; some were threatened with violence, including death. In all settings, research participants reported that a male survivor is “no longer [perceived as] a man” by community members. Families of boys who had suffered sexual abuse and exploitation may not believe the survivor, or blame him for the assault, or eject him from the family. For persons with diverse SOGIESC, participants reported that exposure of their sexual orientation or gender identity could compromise the security and well-being of themselves and their families. Heterosexual male survivors expressed concern about being perceived as gay. In light of such social repercussions, male survivors may flee to cities or other countries. Survivors with malodorous fecal incontinence faced additional social sanctions.

“People will judge [a boy survivor]. They will not allow him to mix with the community. Others will not allow their child to play with this child. The parents may also beat him—that’s why he won’t speak. He feels very ashamed.” –“Nura,” focus group with Rohingya women, Cox’s Bazar, Bangladesh

Economic and other impacts

Research participants reported that sexual victimization can compromise a survivor’s ability to engage in livelihood activities. Income generation opportunities available to refugees in the study sites often involve physical strength or close social interactions (like selling food or goods), which may not be tenable for survivors, particularly those with rectal trauma. Key informants reported that ostracism, time spent pursuing medical and mental health care, fears of revictimization, and, for survivors with fecal incontinence, lack of incontinence products, can further compromise a survivor’s ability to engage in income generation activities. According to key informants working with boy survivors, the repercussions from sexual victimization can undermine boys’ ability to perform or stay in school. For boys suffering sexual exploitation, shame and humiliation can push them to self-isolate and disconnect from their families and communities.

“These [male survivors with incontinence] have to keep going to hospital and for follow-ups—it takes a lot of time. They can’t settle down and focus on their livelihoods. It’s hard to support them to be self-reliant. If someone is going to hospital all the time, plus you have leakage and people are saying, ‘This guy is stinking, we won’t buy from him.’ It’s difficult. Most refugees do business like selling shoes, hairdresser, barber. It makes it very difficult for them to carry on, to support themselves and their families. What they are losing economically, it is really hard on them. And then the psychological part—you can’t think about business, you are depressed and in a ditch and can’t get out.” -Health provider, Kenya



Intersections with Violence against Women and Girls

Conflict-related sexual violence was perpetrated in ways that impacted and involved men and women.

Forcing men and boys to witness sexual violence against women and girls was frequently reported across all conflict-affected settings. Some incidents of forcing women and girls to witness sexual violence against men and boys were reported across settings, but to a much lesser extent. Forcing men and boys to perpetrate sexual violence against women and girls was also reported across all conflict-affected settings, more frequently so in DRC and Libya. In Libya, incidents of women being forced to perpetrate sexual violence against men, such as enforced oral sex among detainees, were also documented.

"A brother and sister from Somalia were traveling together with the brother's best friend. The best friend was going out with the sister, he was her boyfriend. They were held captive in Al Kufrah [in Libya] for a few months. The captors gang-raped the sister for six days in a row in front of the two boys. They did that to exert pressure on the boys to have their families send money. She was in a serious condition—she had internal injuries from the rape and died after 15 days. She died one week before we rescued them. These boys were 16 and 17 years old. This sexual violence was used as a method of torture for extortion—to force her brother and her boyfriend to witness this, unable to defend or protect her. They were then forced to ring their families and they begged for help. By the time the money came, she was dead." -Health provider, search and rescue boat off of Libya

Research participants described various gendered impacts resulting from male sexual victimization.

The wife and children of an adult male survivor may be stigmatized and ostracized, and daughters may be deemed unmarriageable. The inability to earn an income—due to the physical, mental, and social impacts of sexual victimization—may further strain a family's scarce financial resources or lead to separation or divorce. Wives of male survivors described intimacy difficulties (both physical and emotional) post-victimization, and some research participants reported that male survivors may engage in increasingly controlling behaviors due to fears of female family members being victimized. Some mental health providers and refugee women reported intimate partner violence as a direct result of sexual victimization; this requires further investigation given the existing high rates of intimate partner violence within the studied refugee communities as well as the variety of potentially traumatic experiences experienced by male refugees that may be linked to an increase in violent behavior, not sexual victimization alone. In Italy and Kenya, key informants described cases in which adolescent survivors attempted to reassert their masculinity through aggression toward girls, violence, or gang involvement. Finally, male victimization by a female perpetrator may inspire anger or aggression toward women.

"Men, when they come to these prisons, they torture them properly and beat their manhood. Then they come back home, and they are not normal. They don't talk, they just keep quiet. They don't want to be talked to. They become hostile; they can become violent. They will drink more alcohol. The man just keeps it inside and gets angry." -"Nyadhial," focus group with South Sudanese women, Nairobi, Kenya

Service Availability

Across all settings, some specialized services for male refugee survivors of sexual violence were identified; however, quality was inconsistent, need far exceeded supply, and coverage was inadequate.

Table 1 outlines the services identified for male survivors during data collection. Service availability was determined through key informant interviews with service providers and triangulated through interviews with other key informant interviews and focus groups with refugees. Note that in Cox's Bazar, Bangladesh, several agencies self-reported providing mental health and/or medical care during data collection in 2018.⁸ However, follow-up activities by WRC in Cox's Bazar in 2019 revealed that few male survivors had been able to successfully access mental health and medical care.⁹ Some organizations, including governmental agencies, offered services where male refugee survivors may theoretically receive care, but these services were not designed to be inclusive of male survivors and staff were not specifically trained to care for male survivors. Additional specialized services may be available that were not identified during data collection; new services may have been established since data collection ended.

More services were available in Nairobi, where an informal referral network had been established for male refugee survivors and refugee survivors with diverse SOGIESC. In the other settings, functioning referral systems were either not established (i.e., in Rome, Sicily, and Mombasa) or male survivors and survivors with diverse SOGIESC were not sufficiently integrated into existing networks (i.e., in Cox's Bazar.)



In Ongata Rongai, near Nairobi, home to many South Sudanese refugees.
Photo © Sarah Martin

⁸ Women's Refugee Commission, *It's Happening to Our Men as Well*: Sexual Violence Against Rohingya Men and Boys* (2018). <https://wrc.ms/symb-rohingya>.

⁹ See forthcoming WRC report on findings from pilot projects in Bangladesh, Italy, and Kenya.



Table 1: Specialized sexual violence services for male refugee survivors per study setting

	Bangladesh* (as of July 2018)	Italy (as of October 2018)		Kenya (as of May 2019)	
	Cox's Bazar	Rome	Sicily	Nairobi	Mombasa
Health care	Inconclusive*	Salute Migranti Forzati (SaMiFo) Medici Contro la Tortura (MCT)/ MSF Medici per i Diritti Umani (MEDU)	MEDU	Kenyatta National Hospital LVCT Health MSF Nairobi Women's Hospital National Council of Churches Kenya (NCCCK) at Jumuia Huruma Hospital RefugePoint	Nairobi Women's Hospital (Mombasa branch)
Mental health and psychosocial support	Inconclusive*	SaMiFo MCT/MSF MEDU	Center for Transcultural Psychiatry Centro Penc Association MEDU	Center for Victims of Torture HIAS Health Options for Young Men on HIV/AIDS & STIs (HOYMAS) Kenyatta National Hospital Kituo Cha Sheria LVCT Health MSF Nairobi Women's Hospital Refugee Consortium of Kenya	Nairobi Women's Hospital (Mombasa branch) Trace
Legal aid	Bangladesh National Women Lawyers Association Technical Assistance Inc. (TAI)	Differenze Donna	None identified.	Kituo Cha Sheria HIAS HOYMAS Refugee Consortium of Kenya UNHCR	Kituo Cha Sheria
Livelihood support	None identified	None identified.	None identified.	None available at the time of data collection.	None identified.

*Although some agencies self-reported providing medical and/or mental health care for male survivors in Cox's Bazar, WRC's post-data collection follow-up activities found that few male survivors were able to successfully access mental health or medical care as of December 2019.

Enablers and Barriers to Service Utilization

Key Enablers

Key enablers that promoted service uptake among male survivors, as reported by service providers and refugees, included:

1. Specialized, confidential services provided by respectful, empathetic, and experienced staff with grounding in a survivor-centered approach and gender-based violence guiding principles (which promotes service uptake for female survivors as well).
2. Clearly designated entry points for male survivors and survivors with diverse SOGIESC to access care—particularly health care, as this was often male survivors' first point of contact with services.
3. Targeted outreach and awareness-raising on sexual violence against men and boys and persons with diverse SOGIESC, with messaging that addressed:
 - a. the frequency of male sexual victimization—that it is not rare and that male survivors are not alone;
 - b. the forms of sexual violence—given that male survivors may not understand that the violence they experienced constitutes sexual violence or may associate sexual violence with violence against women and girls alone;
 - c. how and where to access services—since many refugees were unaware of available services or were unclear whether men and boys were welcome; and
 - d. the benefits of accessing care—noting that some form of recovery is possible with care and support.
4. Sensitized referral points with respectful, nonjudgmental providers for male survivors and survivors with diverse SOGIESC integrated into referral pathways.
5. Trust-building with refugee communities, including women who helped to facilitate service uptake for male survivors within their family, such as husbands and sons.

"[Services] have to be very confidential. The best way is to do awareness raising around the issue.... If there is awareness, they will know there is a service where they can get support. They need to know it [sexual violence] is something that happens to men. This was the first time I have ever talked about this." –"Samson", focus group with South Sudanese men, Nairobi, Kenya

Service Uptake: Insights from MSF

Of 13,350 sexual violence survivors who received care from MSF clinics in seven African countries, 7.5% (1,009) were male. Clinic set-up influenced service uptake: male survivors were more likely to access sexual violence care at a clinic providing integrated care (medical and psychological) for victims of violence, which did not require upfront disclosure of sexual violence, rather than a standalone clinic for sexual violence or sexual violence care linked with maternity services.

Source: Broban et al., [Assault and care characteristics of victims of sexual violence in eleven Médecins Sans Frontières programs in Africa. What about men and boys?](#), *PLoS ONE* 15(8).



Recommendations from Research Participants to Service Providers Caring for Male Survivors

All services

1. Collaborate with affected communities, particularly survivors, to identify where and how they prefer to access services and establish programs and/or entry points accordingly.
2. Ensure services are confidential and safe.
3. Ensure providers and staff are nonjudgmental and respectful, are trained in receiving disclosures, and do not pressure, force, or rush a survivor to disclose.
4. Offer the option of women or men providers, including providers with diverse SOGIESC, if possible.
5. Explicitly acknowledge that sexual violence against men and boys is common in certain conflicts, migration routes, and refugee settings.
6. Define sexual violence and provide examples of forms against men and boys (such as genital violence), and explain that sexual violence entails medical and psychological impacts that can be treated or managed.
7. Share anonymized success stories of other survivors to demonstrate that recovery is possible.
8. Recognize and document sexualized forms of torture—such as genital beatings, forced witnessing, and object-anal rape—as sexual violence (and not solely torture) because sexual violence has specific medical and psychological consequences and legal implications.
9. Understand that boy survivors rarely explicitly disclose sexual abuse or exploitation and instead often use euphemisms or allude to victimization.

Medical services

1. Explain that experiencing an erection or orgasm during an assault (including forced witnessing) is a common physiological response and has no bearing on sexual orientation or desire or that the survivor enjoyed, wanted, or deserved the assault.
2. Explain that, for survivors without an underlying medical condition, therapy may help with sexual function recovery.
3. Recognize that back pain may be a sign of sexual victimization among men and boys due to genital, rectal, or abdominal trauma, physical or psychological trauma responses, or sexually transmitted infections.
4. For survivors with incontinence, provide a free and consistent supply of incontinence products as well as free, sensitized medical care, including specialized surgery when necessary.
5. Be aware that medical care can facilitate male survivors' disclosure of sexual violence, especially if there are observable physical impacts that health care providers can sensitively inquire about during the medical history and interview.

Mental health services

1. Prioritize trust-building, grounded in the respect for privacy and confidentiality, to support disclosures rather than probe victimization.
2. Underscore to survivors that sexual violence against men and boys, including those with diverse SOGIESC, may be common in the conflicts in their country of origin as well as in the context of forced displacement, and that there is nothing "special" about the survivor that attracted the perpetrator(s).
3. Explain that sexual violence is about power, violence, and control, not about sexual desire, and that surviving sexual violence does not define current or future sexual orientation.
4. Address harmful myths such as "only gay men are sexually assaulted" or "all raped men become gay."
5. Offer counseling to survivors and their family members, if desired by the survivor.

6. Support survivors to develop empathy for themselves and other survivors.
7. Support survivors to access art, music, and other creative outlets that may aid the healing process.

Social services

1. Facilitate access to refugee documentation and other forms of protection.
2. Offer income generation activities for survivors to meet their basic needs, including appropriate activities for refugees with diverse SOGIESC and adolescent boys.
3. Support access to safe shelter, including for refugees with diverse SOGIESC.
4. Assist child survivors to resume or begin schooling.
5. Identify and help survivors with diverse SOGIESC access LGBTIQ-friendly religious services, which may help with their recovery and build resilience.

Key Barriers

Key barriers to service utilization identified in the study sites included:

1. Lack of clarity on sectoral responsibilities for addressing adult male sexual victimization and persons with diverse SOGIESC.
2. Narrow and restrictive legislative frameworks, including the criminalization of same-sex sexual activity, definitions of rape that exclude male victims and female perpetrators, and restrictions to accessing some form of international protection or refugee status.
3. Limited staff capacity, lack of awareness (including denial) of male sexual victimization, and negative provider attitudes and practices, such as homophobic and transphobic attitudes, humiliation, disbelief, denial of services, and confidentiality breaches.
4. A dearth of clearly designated entry points for male survivors and the lack of integration into referral systems, frequently resulting from poor awareness of male sexual victimization, a misconception that male sexual victimization is rare, or a lack of prioritization.
5. Scarce awareness-raising among refugees and subsequent poor knowledge of male sexual victimization, available services, and benefits of accessing care, which were aggravated by low formal health seeking behaviors.
6. Social stigma and fears thereof, such as ostracism, humiliation, and expulsion from families (particularly feared by boy survivors), as well as negative social repercussions to and from family members in country of origin.
7. Self-stigma (internalization of negative public attitudes and beliefs), including shame and self-blame.

Additional barriers reported in some but not all settings included financial constraints, fears of revictimization, a dearth of sensitized interpreters/cultural mediators at service points, and, for survivors with disabilities, few physically accessible services. The findings suggest that boys, particularly adolescent boys, may face specific or greater barriers to service uptake, as they may have less knowledge and understanding of what constitutes abuse, and they may be less aware of available services.

“On behalf of the son [who was victimized], the community will abuse the family. They cannot even live in the community anymore; all the family will be impacted. Because it happened to their son, they will have to leave. Even if he is working with [the community], they will shun him.” – “Fatima,” focus group with Somali refugee women, Nairobi, Kenya

“They are in complete denial in [my UN agency] that anything like that [sexual violence against boys] would have happened. An MHPSS specialist said that he had not found any evidence of sexual abuse, therefore he doubted that anything like that was happening.” –Gender-based violence specialist, Bangladesh



Potentially Promising Practices and Approaches

The following practices and approaches were identified through key informant interviews with representatives from the various agencies. ***Interventions were not assessed by WRC and therefore cannot be recommended for replication or application to other settings based on the information gathered for this study.***

Integrated services

- **Gender Violence Recovery Centers** at Nairobi Women's Hospital and Kenyatta National Hospital in Nairobi provided free, 24-hour medical care, psychosocial support, and paralegal services for survivors of all genders and ages.
- **Center for Transcultural Psychiatry in Catania**, Italy, provided specialized, culturally sensitive psychological and psychiatric care for refugees and migrants through teams that include a cultural mediator, caseworker, and therapist.
- **Centro Penc Association—Ethnopsychology Service in Palermo**, Italy, provided specialized, ethnopsychological support for refugees and migrants, including unaccompanied minors, children, women, and victims (of all genders) of torture and sexual violence. The Center also engaged in advocacy, training, and clinical supervision of mental health operators working in Italian reception centers for refugees and migrants.
- **MCT (Medici Contro la Tortura or Doctors Against Torture)**, in partnership with MSF, developed an interdisciplinary, ethnopsychiatric methodology at their center for torture victims in Rome that involves a five-member team for each patient: a doctor, cultural mediator, social worker, physiotherapist, and psychologist.
- **MEDU (Medici per i Diritti Umani or Doctors for Human Rights)** provided specialized medical and mental health care to vulnerable refugees and migrants, including male survivors, in Rome, Sicily (Ragusa), and Calabria.
- **SaMiFo (Salute Migranti Forzati or Health for Forced Migrants)** in Rome provided specialized medical, mental health, and forensic services, including medico-legal certificates, for refugees and forced migrants of all genders who survived sexual violence.

Safe shelter

- The **Community Empowerment and Self Support Organization (CESSO)**, a refugee-led organization in Nairobi, established a discreet safe house for refugees with diverse SOGIESC from anglophone countries and a second safe house for those from francophone countries.
- **LITOS**, a community-based organization in Nairobi, established a low-profile safe house for persons (including refugees) with SOGIESC attached to a small farm where residents raise animals, grow vegetables, and engage in other income-generation activities.

Staff capacity development and well-being

- The **Center for Victims of Torture (CVT)** in Nairobi sensitized its staff to ensure the provision of respectful, survivor-centered care for all clients, including male survivors of sexual violence, refugees with diverse SOGIESC, and persons selling sex.
- At its sexual and gender-based violence clinic in Nairobi, **MSF-France** prioritized staff self-care among its staff, including making available peer-to-peer counseling, as well as external supervision and counseling.

Support groups

- **HIAS** in Nairobi facilitated monthly support groups for male survivors which addressed managing stress, mindfulness exercises, and writing and drawing, among other activities. HIAS also provided free incontinence products to survivors, engaged in community outreach, sensitized authorities, and accompanied survivors who have been threatened to court.

Targeted outreach and awareness-raising

- **HESED** engaged in community dialogues that included discussions on sexual violence against men, boys, and persons with diverse SOGIESC with refugees in Eastleigh, Nairobi, including one-on-one dialogues with men, during which some survivors have disclosed victimization.
- **Kituo Cha Sheria** conducted refugee community sensitization on sexual violence against women and men in Nairobi. They use examples of women, men, and child survivors during their legal aid clinics in the community.
- **The Refugee Consortium** of Kenya engaged anti-sexual-violence “champions” in five refugee communities in Nairobi. Champions are refugees or asylum seekers sensitized to survivors of all genders. They attempt to connect survivors with services as soon as possible.
- **RefugePoint** engaged refugee “community navigators” around Nairobi who are trained to support anyone who has been sexually assaulted, including male survivors and those with diverse SOGIESC.

Trust-building with community

- In Tripoli, **Cesvi** established confidential services, employed qualified, empathetic men and women gender-based violence case managers, and engaged in trust-building efforts with community members. As a result, the number of male survivors accessing services tripled between 2017 and 2018 (from six to 18).

Supporting Service Uptake at Sea

On the *Aquarius* search and rescue vessel in the Mediterranean, MSF health providers raised awareness about male sexual victimization and available services through convening private groups of 10 to 15 men and adolescent boys who spoke the same language.

One man and one woman health provider met with the groups and gave a short speech acknowledging how difficult their journey had been and that many other men and boys had disclosed suffering sexual violence in Libya, during transit, and in their home country. They clearly defined sexual violence and provided examples of different forms, and explained that sexual violence has medical and psychological consequences that can be treated or managed. They underscored that free, confidential medical care was available on the ship, that refugees had the option of speaking with a man or woman health provider, and that staff could be approached at any time.

The providers said that sexual violence can happen to anyone, that it was not survivors' fault, that they did not need to feel ashamed, and that they were not alone. Providers emphasized the medical consequences of sexual violence, which they found helped enable disclosures due to men's and boys' fears of existing or potential sexually transmitted infections.

Posters about the availability of post-sexual violence medical care that depicted male survivors were placed in the men's bathrooms. As a result, the proportion of male survivors who came forward for medical care increased from 3 percent in 2017 to 33 percent in 2018.



**Sexual violence can affect your health.
We can treat you with medication and support you.**

**Les violences sexuelles peuvent affecter votre santé.
Nous pouvons vous fournir un traitement et vous soutenir.**

يمكن للعنف الجنسي أن يؤثر على صحتكم، يمكننا أن نقدم العلاج و الدعم اللازم

*Example of MSF poster on the Aquarius search and rescue ship.
(Courtesy of Aoife Ní Mhurchú)*



Acronyms and Abbreviations

DRC	The Democratic Republic of the Congo
FGD	Focus group discussion
HIV	Human immunodeficiency virus
KEMRI	Kenya Medical Research Institute
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, and queer
MCT	Medici Contro la Tortura
MEDU	Medici per i Diritti Umani
MHPSS	Mental health and psychosocial support
MSF	Médecins Sans Frontières
NGO	Nongovernmental organization
SaMiFo	Salute Migranti Forzati
SOGIESC	Sexual orientation, gender identity and expression, or sex characteristics
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WRC	Women's Refugee Commission



Key Definitions

Cisgender means “having a gender identity that matches one’s assigned sex.”¹⁰

Conflict-related sexual violence refers to “incidents or patterns of sexual violence, that is rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity, against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g., political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e., a temporal, geographical and/or causal link. In addition to the international character of the suspected crimes (that can, depending on the circumstances, constitute war crimes, crimes against humanity, acts of torture or genocide), the link with conflict may be evident in the profile and motivations of the perpetrator(s), the profile of the victim(s), the climate of impunity/weakened State capacity, cross-border dimensions and/or the fact that it violates the terms of a ceasefire agreement.”¹¹

Conflict-related sexual violence against men and boys includes oral and anal rape and attempted rape (including gang rape and rape with objects), genital violence (including beatings, burning, electric shock, and mutilation), castration, penile amputation, sterilization, forced sexual activity with or sexual harm against others (including family members, animals, or corpses), sexual humiliation, forced masturbation of self and others, forced nudity, forced witnessing of sexual violence against others, and other forms of sexual violence of comparable gravity.¹²

Corrective rape refers to rape perpetrated with the intent to force a person with perceived diverse SOGIESC to become heterosexual or cisgender and as punishment for transgressing gender norms. The term “corrective rape” originated in South Africa to describe the widespread practice of men raping lesbians in order to “cure” them of and punish them for their sexual orientation.¹³

Forced witnessing is a form of sexual violence that involves compelling a person to watch or listen to the perpetration of sexual violence against another person, such as a family or community member or fellow detainee, using coercion, threats of harm, or physical force.¹⁴

Gender-based violence is “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females. The term ‘gender-based violence’ is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. As agreed in the Declaration on the Elimination of Violence against Women (1993), this includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. The term is also used by some actors to describe some forms of sexual violence against males and/or targeted violence against LGBTI populations, in these cases when referencing violence related to gender-inequitable norms of masculinity and/or norms of gender identity.”¹⁵

10 World Health Organization, *FAQ on Health and Sexual Diversity An Introduction to Key Concepts* (2016), p. 3.

11 United Nations Security Council, *Conflict-related Sexual Violence: Report of the Secretary-General, S/2015/203* (March 23, 2015), para. 2.

12 See: Sarah Solangon and Preeti Patel, “Sexual Violence Against Men in Countries Affected by Armed Conflict,” *Conflict, Security & Development* 12:4 (2012), pp. 417–442, and Sandesh Sivakumaran, “Sexual Violence Against Men in Armed Conflict,” *European Journal of International Law* 18:2 (2007), pp. 253–276.

13 Michelle Denton, *Rape Culture: How Can We End It?* New York: Greenhaven (2017), p. 31.

14 S.K. Chynoweth et al. “Characteristics and impacts of sexual violence against men and boys in conflict and displacement: a multi-country exploratory study”. *Journal of Interpersonal Violence*. 2020.

15 Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian*

Gender identity “is understood to refer to each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech, and mannerisms. Gender identity exists on a spectrum. This means that an individual’s gender identity is not necessarily confined to an identity that is completely male or completely female. When an individual’s gender identity differs from their assigned sex, they are commonly considered to be transgender, gender fluid, and/or gender queer. Whereas when an individual’s gender identity aligns with their assigned sex, they are commonly considered cisgender.”¹⁶

Queer is “an umbrella term which is commonly used to define lesbian, gay, bi, trans, and other people and institutions on the margins of mainstream culture. Historically, the term has been used to denigrate sexual and gender minorities, but more recently it has been reclaimed by these groups and is increasingly used as an expression of pride and to reject narrow reductive labels. Queer can be a convenient, inclusive term when referring to issues and experiences affecting the many groups subsumed under this umbrella. Because it is still used to demean lesbian, gay, bisexual, and transgender people, those who do not identify as queer are urged to use the term with caution, or not at all.”¹⁷

Rape is “physically forced or otherwise coerced penetration—even if slight—of the vagina, anus, or mouth with a penis or other body part. It also includes penetration of the vagina or anus with an object. Rape includes marital rape and anal rape/sodomy. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.”¹⁸

Refugees refer to “people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country.” Refugees are protected under the 1951 Refugee Convention and its 1967 Protocol.¹⁹

Sex workers and sex work include “female, male, and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work may vary in the degree to which it is ‘formal,’ or organized. ‘Sex work’ is used ... when referring exclusively to adults aged 18 years or older. When referring to those below the age of 18, including 10- to 17-year-olds, reference is made to sexual exploitation of children, in accordance with Article 34 of the Convention on the Rights of the Child, which ensures the protection of all children from all forms of sexual exploitation and sexual abuse.”²⁰

Sexual abuse refers to “the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.”²¹

Action: Reducing Risk, Promoting Resilience and Aiding Recovery (2015), p. 322.

16 World Health Organization, *FAQ on Health and Sexual Diversity An Introduction to Key Concepts* (2016), p. 1.

17 World Health Organization, *FAQ on Health and Sexual Diversity An Introduction to Key Concepts* (2016), p. 3.

18 Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (2015), p. 322.

19 UNHCR, *What is a refugee?* (n.d.), <https://www.unhcr.org/what-is-a-refugee.html>.

20 World Health Organization, *Technical Brief: HIV and Young People Who Sell Sex* (2015).

21 Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, p. 322.



Sexual exploitation refers to “any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category.”²²

Sexual orientation “refers to a person’s physical, romantic, and/or emotional attraction towards other people. Sexual orientation is distinct from gender identity. Sexual orientation is comprised of three elements: sexual attraction, sexual behavior, and sexual identity. Sexual orientation is most often defined in terms of heterosexuality to identify those who are attracted to individuals of a different sex from themselves, and homosexuality to identify those who are attracted to individuals of the same sex as themselves.”²³

Sexual violence includes “at least, rape/attempted rape, sexual abuse and sexual exploitation. Sexual violence is ‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.’ Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion.”²⁴

Transgender “(sometimes shortened to ‘trans’) is an umbrella term used to describe people with a wide range of identities—including transsexual people, people who identify as third gender, and others whose appearance and characteristics are perceived as gender atypical and whose sense of their own gender is different to the sex that they were assigned at birth. Trans women identify as women but were assigned as males when they were born. Trans men identify as men but were assigned female when they were born. Some transgender people seek surgery or take hormones to bring their body into alignment with their gender identity; others do not.”²⁵

Unaccompanied children (also called unaccompanied minors) “are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.”²⁶

Vulnerability in humanitarian contexts refers to “the conditions determined by physical, social, economic, and environmental factors or processes which increase the susceptibility of an individual, a community, assets, or systems to the impacts of hazards.”²⁷

22 Ibid.

23 World Health Organization, *FAQ on Health and Sexual Diversity An Introduction to Key Concepts*, p. 1.

24 Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, p. 322.

25 World Health Organization, *FAQ on Health and Sexual Diversity An Introduction to Key Concepts*, p. 3.

26 International Committee of the Red Cross, International Rescue Committee, UNICEF, UNHCR, World Vision, *Inter-agency Guiding Principles on Unaccompanied and Separated Children* (2004), p. 13.

27 United Nations Office for Disaster Risk Reduction, *Terminology* (December 2017), <https://www.unisdr.org/we/inform/terminology>.

Appendix A. Methodology & Methods

Primary research questions

1. What are the characteristics (who, where, when, how) of sexual violence against refugee men and boys (including those with diverse SOGIESC) residing in the three study sites (in their country of origin, during flight, and in their current setting)?
2. What is the impact of sexual violence on the survivors, their families, and their communities, including women and girls?
3. What services (medical, psychosocial, legal, and other) are available for cisgender male and transgender refugee survivors in the three study settings?
4. What are the barriers and enablers to accessing these services?

Secondary research questions

1. What, if any, targeted mechanisms to protect men and boys (including those with diverse SOGIESC) from sexual violence are in place in the study sites?
2. How does sexual violence against men and boys intersect with violence against women and girls?

Data collection methods

The key informant interview and focus group discussion tools were used in Lebanon, Iraq, and Jordan in 2016 for a similar study commissioned by UNHCR undertaken by the principal investigator (Sarah Chynoweth). The tools were subsequently refined.

Four data collection methods were employed:

- **Document review** was undertaken to identify and summarize existing data related to sexual violence in the countries of origin and against refugees residing in the study sites. Documents included published research and gray literature, including external and internal UN and NGO documents.
- **Semi-structured key informant interviews with 137 humanitarian aid workers and 11 human rights experts** to determine the availability of services for survivors, identify protection and prevention-related interventions, and provide insights into knowledge, attitudes, and behaviors of humanitarian responders with regard to sexual violence against refugees. Interviews (approximately 45 minutes each) were held in person and by Skype and phone.
- **Focus group discussions (FGDs)**
 - » **55 FGDs with 310 refugees and asylum seekers** were held to document second- and third-hand accounts of sexual violence against men, boys, and trans women, gather data on community knowledge, attitudes, and behaviors related to sexual violence, and explore barriers and enablers to accessing services. Discussions took approximately 60 minutes.
 - » **Two FGDs with 10 guardians, psychologists, and reception center operators** were held in Italy to elicit insights into the mental health impacts of sexual violence and ways to increase service uptake.

Recruitment and inclusion criteria

Refugee research participants were recruited by local and international humanitarian agencies and community mobilizers based on age, nationality, refugee status, disability status, gender identity, gender assignment, and sexual orientation. Key informants were purposively selected based on their roles (e.g., providers serving refugees, technical focal points) and their agency's mandate. Chain referral sampling, in which purposively selected informants refer other potential study participants, was used to identify additional key informants.



Translation

FGDs were conducted in English or were held in local languages with simultaneous translation into English. Interpreters were oriented to the topic, briefed about how to respond and manage any spontaneous disclosures of sexual violence, and were requested to sign a code of conduct stating that they would adhere to principles of confidentiality, nondiscrimination, and respect.

Analysis

Multiples waves of coding were undertaken. Data were thematically analyzed²⁸ using NVivo 12, a qualitative data management software.

Validity

Findings were discussed with key service providers and/or human rights experts in each setting. A draft version of the report was shared with all key informants, Global Advisory Committee members, and National Reference Group members for review.

Ethical Considerations

This study was conducted in accordance with WHO's (2007) Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies. Interviews or focus group discussions with survivors were not deemed necessary or ethical in order to achieve research aims. However, some refugee research participants spontaneously disclosed victimization during focus group discussions. Participants' anonymity was strictly maintained. Names of refugees who participated in this research were not requested or recorded. All quotes and inputs were anonymized. Key informants are identified only by a participant ID on all documents. Those quoted in this report were given generic professional titles to protect their identity. Electronic transcripts and typed documents related to the study are kept on a password-protected personal computer in an encrypted file. No monetary or material incentives were provided to the participants, apart from basic refreshments and reimbursement for travel costs. A summary of the findings was translated into local languages and distributed to local service providers and refugees in each study site.

Ethics Oversight and Approvals

The University of New South Wales (HC180126) and the Kenya Medical Research Institute (KEMRI) granted ethics approval for this study in May 2018 and April 2019, respectively. The University of Palermo's Department of Psychological, Pedagogical, and Education Services reviewed and provided written approval of the research protocol because official ethics review was not available for non-medical research. In lieu of local ethics approval in Bangladesh, which was cost and time prohibitive, a national reference group of experienced local practitioners and academics was established to review the research protocol and provide ethical oversight. National reference groups were also developed for Italy and Kenya. In addition, a 12-member Global Advisory Committee was established to promote further ethical and technical oversight. Members included a mix of practitioners and researchers, with expertise in public health, protection, gender-based violence, child protection, and LGBTIQ+ issues in humanitarian contexts. They reviewed the protocol, provided technical inputs, and considered ethical concerns throughout the research process. Research permits and approvals were received from Kenya's National Commission for Science, Technology, and Innovation (NACOSTI), the Government of Kenya's Refugee Affairs Secretariat (RAS), and the Nairobi and Mombasa County Commissioners, as required.

28 Jennifer Fereday et al., "Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development," *International Journal of Qualitative Methods* 5:1 (2006), p. 80-92.

Informed consent and assent

Due to the sensitive nature of the topic, only verbal consent was obtained from key informants and focus group participants. Research participants were provided with a participant information statement and consent form, which was available in local languages.

For focus groups with adolescent boys (ages 15-17), parental consent was requested and received in addition to assent from adolescents. To enable adolescents to refuse participation, several examples of declining and withdrawing assent were provided before requesting assent. The voluntary nature of participation was underscored. Several times throughout the group discussion, the facilitator paused to check in with the participants to reinforce that they did not have to answer any questions and that they were free to leave at any point.

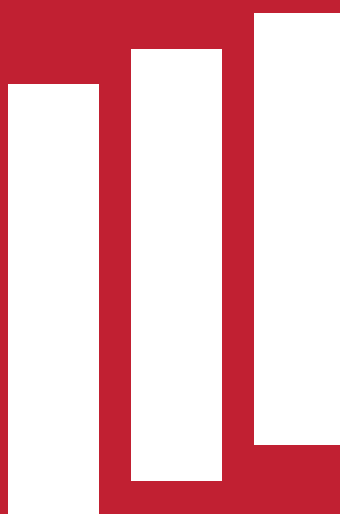
Referrals

Localized referral points for medical and psychosocial services were documented on the back of the translated participant information and consent forms. The principal investigator adapted an interview distress protocol developed by Draucker et al. (2009)²⁹ to identify indications of distress during an interview or focus group and respond accordingly. The distress protocol outlines the actions of the interviewer if, during the course of the interview, a participant exhibits acute distress or safety concerns, or imminent danger to self or others.

Limitations

This study faced numerous limitations. Translation and note-taking errors are a possibility. In Bangladesh, focus group discussions were held in Chittagonian, a similar but not identical language to the Rohingya language, due to the inability to identify Rohingya interpreters with training in gender-based violence. Focus group discussions with Rohingya with diverse SOGIESC in Bangladesh and trans men across all settings were not undertaken due to the inability to safely access these communities. However, data on these populations were collected through service providers. Bias may have been introduced by purposive sampling. In Kenya, four focus groups with Somali refugees were held during Ramadan, which limited discussion of this sensitive topic.

29 Claire Burke Draucker et al., "Developing Distress Protocols for Research on Sensitive Topics," *Archives of Psychiatric Nursing* 23:5 (2009), p. 343-350.



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