ALL SURVIVORS PROJECT

The Health of Male and LGBT Survivors of Conflict-Related Sexual Violence

CONTENTS

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ALL SURVIVORS PROJECT

All Survivors Project (ASP) is an independent, impartial, international organisation that conducts research and advocacy and facilitates inter-disciplinary dialogue and learning to improve global responses for every victim/survivor of sexual violence including men and boys in situations of armed conflict and forced displacement. Through work with governmental and non-governmental stakeholders and with male survivors of sexual violence, ASP seeks to ensure that conflict-related sexual violence is prevented and that the rights of all victims/survivors, including men and boys, are fulfilled, and the dignity of all survivors is respected and protected.

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LIST OF ABBREVIATIONS

ASP	All Survivors Project
BADT	Behavioural Activation Treatment for Depression
CAR	Central African Republic
CBT	Cognitive-Based Therapy
CETA	Common Elements Treatment Approach
CPT	Cognitive Processing Therapy
CRSV	Conflict-Related Sexual Violence
DRC	Democratic Republic of Congo
EMDR	Eye Movement Sensitisation and Reprocessing
EMDR-IGTP	EMDR Integrative Group Treatment Protocol
GBV	Gender-Based Violence
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
IRC	International Rescue Committee
LGBT	Lesbian, Gay, Bisexual, Transgender and other gender non-conforming individuals
LSHTM	London School of Hygiene and Tropical Medicine
MHPSS	Mental Health and Psychosocial Support
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
PTSD	Post Traumatic Stress Disorder
SDC	Swiss Agency for Development and Cooperation
SGBV	Sexual and Gender-Based Violence
STIs	Sexually Transmitted Infections
TII	Trauma-informed Intervention
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

EXECUTIVE SUMMARY

KEY FINDINGS

- Weak and sparse evidence base for intervention development and evaluation;
- No studies on interventions targeting men, boy and LGBT survivors specifically and explicitly;
- No evaluations of interventions addressing physical health, sexual and reproductive health and medico-legal responses;
- De-contextualised findings of many impact evaluations on mental health;
- Studies conducted only in a few countries;
- Most interventions are single sector approaches, but flexible and comprehensive models are valued.

Conflict-related-sexual-violence (CRSV) against women and girls has received increasing attention globally. At the same time, less is known about men, boys and LGBT persons who suffer CRSV. Research estimates that, in some context, the magnitude of CRSV against men and boys is extremely high, with prevalence rates ranging from 32.6% in Liberia to 21% in Sri Lanka. The health and social consequences of CRSV for the lives of men, boys and LGBT persons are severe and long-lasting. CRSV against men, boys and LGBT persons is largely motivated by gendered expression of domination and control. Despite the severe health and social burden associated with CRSV, evidence on interventions addressing the health and wellbeing of male and LGBT survivors of CRSV remains scarce, and limited resources and support are available to target their needs.

This report addresses these gaps by summarising and expanding on key findings from a forthcoming realist review by the authors on health interventions for men, boys and LGBT survivors of CRSV. The review was preceded by a first workshop with key international stakeholders (London, 11-12 October 2018) to identify parameters and scope of a conceptual framework on responses for male and LGBT survivors in conflict and displacement settings. Findings from the realist review were complemented with results from a second experts meeting (Geneva, 5 March 2019) with international stakeholders and a rapid review of medical and mental health guidelines and protocols for assisting survivors of sexual violence. This report aims to contribute to the growing field of research, intervention development and implementation on CRSV against men, boys and LGBT persons.

A systematic approach was used to identify evaluations of interventions addressing the medical and mental health of male and LGBT survivors of CRSV. To inform a theory of change for interventions responding to the health needs of survivors, the review then used a purposive approach to explore gender differences in implementation, mechanisms of change and outcomes of interventions.

We did not find any evaluation of interventions that specifically and explicitly targeted the needs of male or LGBT survivors of CRSV. Most studies we identified were on Mental Health and Psychosocial support (MHPSS) interventions. Although some interventions identified in our systematic search included male participants, the results were not disaggregated by gender. No studies evaluated interventions that explicitly included LGBT participants.

This report uses the umbrella term LGBT to include a number of groups defined by diverse sexual orientations and gender identities. Our analysis focussed on sexual minority men and transgender people, though studies which present data disaggregated by the categories within the LGBT concept, remain extremely limited. Therefore, our review does not provide a basis for conclusions about each of these groups individually.

The results of our rapid review of international guidelines and protocols also suggests that the specific needs and vulnerabilities of male and LGBT survivors still receive limited attention in international documents guiding policy and practice. Although CRSV against male and LGBT survivors have been increasingly recognised in these documents, most still do not provide specific recommendations on how to design and implement interventions that respond to the specific needs and concerns of these populations.

Evidence on the implementation, evaluation and effectiveness of these guidelines is also sparse. In our literature review, we found only one pilot evaluation of implemented guidelines on CRSV that offered promising results.

Our literature review found that **access and continuity of care** are deeply affected by insecurity, population mobility, limited infrastructure, gender and social norms, and restricted financial and human resources. In settings where the nature and duration of the conflict are particularly severe, health systems are largely affected or inexistent. In many settings, the presence of armed groups hinders dislocation from home to the nearest point of care both for clients and providers and affects home visits. Looting and pillage of health facilities may also reduce adherence by forcing clients to travel further to seek care. This politically fragile and resource limited context affects how priorities are defined in the policy agenda, and the availability, accessibility, acceptability and quality of services. Interventions that rely on community-based models of care may provide valuable alternatives to access and treatment for all survivors.

Community-based interventions can also tackle common barriers in access to care for male and LGBT survivors, including lack of knowledge about existing services, the belief that available services only provide care for women and girls, or uneasiness to access services.

The review identified different interventions aiming to facilitate survivors' access to services, although none reported specific strategies to engage male or LGBT survivors. Strategies to improve access to care included training community leaders, core groups and "counsellor mothers"; relying in internet-based treatment and local service networks; implementing home visits, mobile clinics and one-stop strategies.

Strategies that rely on community-based organisations and resources, and on faith-based organisations, have been promoted as a feasible and cost-effective way to reach vulnerable populations in fragile settings. However, there are limited evaluations of how community-based and faith-based components may foster awareness, help-seeking behaviours and social inclusion among male and LGBT survivors of CRSV. Researchers have also expressed concerns in relation to tension between specific religious agendas and core values of the rights-based policy framework.

Access to care for survivors of CRSV is also affected by lack of **services preparedness** to respond to the needs of male and LGBT survivors. Research has suggested that the fear of negative reactions, such as homophobia, disbelief, and blame from the police or health providers may prevent male survivors from disclosing sexual abuse and accessing timely services. Negative attitudes by providers are likely to reinforce survivors' self-blame, prevent adherence to treatment and prevent recovery. Research also suggests that in some contexts less sympathy is displayed by providers in relation to male survivors when compared to female survivors. LGBT survivors are also more likely to be blamed than those who do not identify as such.

Our review identified three studies of interventions that provided training and sensitisation to health care providers. These interventions targeted both community health workers and clinical personnel. Results from these evaluations were mixed, indicating that more studies are needed.

Key stakeholders in the field recognise the need for **inter-sectoral and integrated models of care** for survivors of CRSV. Key links identified in our review as important for health responses to CRSV were education and health; protection and MHPSS; physical and mental health; basic needs and mental health; and medico-legal assistance, justice and accountability. However, evidence on the feasibility and effectiveness of these strategic links in different contexts is still missing. One study in our review highlighted the challenges of coordinating different sectors in poorly resourced settings. We did not find data specifically addressing male and LGBT needs.

Findings from evaluations of **Mental Health and Psychosocial Support (MHPSS) interventions** that included men and boys reported effectiveness in reducing symptoms of depression, anxiety, PTSD, dysfunction or post-traumatic grief. No data on effect-size by gender were published in these studies. Therefore, we cannot determine whether the interventions were equally effective for women and men, or whether they were effective at all for male survivors. This gap in knowledge is particularly important in light of the gender differences in access,

uptake and response to psychological or mental health treatments. Research has indicated that men employ riskier coping strategies, are often less successful in resolving trauma and may find it difficult to share their experiences and emotions. These barriers to interventions' effectiveness are probably linked to gender differences in motivation, commitment and responses to psychological treatment.

Additionally, in contexts of humanitarian emergencies, the access and effectiveness of mental health interventions depends on the basic needs of survivors being addressed. For example, mental health is unlikely to be prioritised by survivors who are struggling to feed themselves or find shelter. At the same time, mental health can deteriorate if these needs are not met. Factors such as poverty and armed conflict may act as daily stressors in the lives of CRSV survivors, and can further hinder access to basic health services, compromising positive mental health outcomes.

Initiatives on **sexual and reproductive health** often focus exclusively on women and girls and refrain from targeting men. However, male and LGBT survivors of CRSV may experience, as a result of the violence, sexually transmitted infections (STIs) including HIV, sexual dysfunctions, genital infections, impotence and infertility among other impacts. These potential health consequences affect not only individual survivors, but their partners, families and communities. To date, no review, including ours, has identified interventions addressing the long-lasting impact of CRSV on the sexual and reproductive health of men, boys and LGBT survivors. Nonetheless, male involvement is fundamental for the prevention of STIs and HIV.

There is some evidence supporting HIV and STI education, and condom distribution campaigns in conflict settings. However, to date there is no data on how male and LGBT involvement can help prevention, and even less on targeted initiatives for survivors. Evidence on fertility and reproductive assistance for male survivors of CRSV is also missing.

To our knowledge, our review was the first systematic realist review investigating medical and MHPSS interventions for male, boys and LGBT survivors of CRSV. We identified many evidence gaps on interventions for male survivors of CRSV, including the absence of: studies including LGBT survivors; results disaggregated by gender; studies on physical health, sexual and reproductive health and medico-legal and forensic responses including male and LGBT survivors. Studies including male survivors also had a limited geographical scope. Moreover, there is an age gap in knowledge about CRSV. In the literature, girls and boys are often mentioned in conjunction with women and men respectively, but data disaggregated by age is rarely presented.

The almost exclusive focus of research and policy on heterosexual cis-women's risk obscures the experience of men, boys and LGBT survivors of CRSV. The neglect of male and LGBT needs may further enhance health and protection risks among these groups. It is therefore critical for researchers, policymakers, providers and other key stakeholders to recognise that the needs of male and LGBT survivors are real and require attention.

BACKGROUND

MAGNITUDE AND SCOPE

Gender-based violence (GBV) against women and girls in conflict situations has gained sustained attention by international organisations, governments, organised civil society and celebrities in the past two decades. This attention was translated into campaigns, policies, guidelines, research and interventions to address survivors' health and protection needs.

Although progress has been achieved as a result of these initiatives, considerable gaps persist in knowledge and assistance to survivors of CRSV. Importantly, little is known currently about men, boys and LGBT people's specific vulnerabilities to sexual violence in conflict and their health needs (Apperley, 2015; Myrttinen, 2017; Myrttinen, 2018; Dolan, 2014; Carpenter, 2006; Priddy, 2014; Garcia-Moreno, 2014; Krugg, 2002; Grey & Shepherd, 2012).

Estimates on the magnitude of CRSV are difficult to obtain both because of underreporting by survivors and restrictions of access to affected populations (United Nations, 2019). Even though current reports affirm that CRSV affects women and girls disproportionately (Goodley, 2019), data indicates that, in some contexts, the magnitude of CRSV against men and boys is also extremely high. For example, a survey in Liberia found that 32.6% of male former combatants experienced sexual violence (Johnson et al., 2008). In the Democratic Republic of Congo (DRC), 23.6% of men interviewed in another survey reported CRSV (Johnson et al., 2010). In a survey of key countries neighbouring Syria, 19.5 to 27% of male respondents reported sexual harassment or unwanted sexual contact as boys (Chynoweth, 2017b). Evidence from Sri Lanka shows that 21% of detained men experienced sexual abuse, of whom 7% reported electric shocks to their genitals and 5% were raped (Peel et al., 2000).

To our knowledge, data on the prevalence of CRSV against LGBT persons is not available.

CONTEXT AND DEFINITIONS

Anal rape has received more attention than other forms of sexual violence against men, but this is only one of many forms of male sexual assault (Carlson, 2006). Acts of sexual violence against men and boys also include oral rape, gang rape, enforced sterilisation, mutilation, castration, blunt trauma to the genitals, forced nudity, forced sexual acts against another person or oneself, and forced witnessing of sexual violence against family members or peers (Sivakumaran, 2007; Apperley, 2015; Carlson, 2005; Dolan, 2014; Onyango, 2011). These abuses can occur in many settings, including detention centres, military sites, refugee camps and people's homes during and after conflict (Gorris, 2016). Recent reports indicate that CRSV against men and boys occurs primarily in villages and detention facilities (United Nations, 2019).

CRSV against men and boys has often been recognised as torture, mutilation or degrading treatment (Sivakumaran, 2007; Carpenter, 2006; Priddy, 2014), but the gendered aspects of these abuses are often not recognised (Carpenter, 2006). Nonetheless, gender is a central aspect of CRSV against men, women and LGBT people (Priddy, 2014; Sivakumaran, 2007, Dolan, 2016; Myrttinen et al., 2017; Myrttinen, 2018; Javaid, 2014). Some of the reasons why men sexually abuse other men are similar to the reasons why they target women: to humiliate, impose domination, power and control (Javaid, 2014; Loncar et al., 2010). Gender stereotypes that motivate these abuses rest on the notion that men and boys are emasculated and feminised as a result of sexual violence (Sivakumaran, 2007; Myrttinen et al., 2017). Violence against LGBT persons in conflict settings is also often motivated by homophobic and transphobic attitudes (Dolan, 2016; Myrttinen et al., 2017).

CRSV can be used as a form of torture aiming to inflict psychological suffering, terrorise, humiliate, disempower and break down the identity of perceived enemies or political prisoners (Apperley, 2015; Carlson, 2005). This form of conflict-related violence is known as *militarised sexual violence* (Spangaro et al., 2013) and has been used for torture and interrogation, for initiation into military or paramilitary forces, to destabilise families, terrorise communities, hinder social cohesion, and to perpetrate ethnic cleansing (Onyango, 2011). The use of this type of violence has been internationally recognised as a strategic "weapon of war" symbolising conquest and degradation of enemies (Krug et al., 2002). The UN recognises sexual violence as an essential component in the political economy of terrorism (United Nations, 2019). These forms of sexual violence often occur jointly with other crimes, such as killing, looting, pillage, forced displacement and arbitrary detention (United Nations, 2017). Impunity for perpetrators is usually the norm (Priddy, 2014).

Sexual abuse against men, boys and LGBT people can also be opportunistic or used as punishment in paramilitary trainings (ASP, 2018b). Opportunistic sexual exploitation has been widely noted among the rising number of male unaccompanied minors fleeing from conflict zones, and cases have been documented among asylum-seekers in the Mediterranean region and Europe, in Central America and in Southeast Asia (Chynoweth, 2017a; Freccero et al., 2017). Some factors that increase the vulnerability of asylum seekers and refugees are scarce employment opportunities, inadequate access to protection and support services, lack of access to food and basic supplies, loss of family and community support mechanisms (Freccero et al., 2017). Additionally, age can also heighten risks of sexual abuse in conflict settings, with recent reports noting a trend on sexual violence against very young girls and boys in countries such as Afghanistan, Burundi, the Central African Republic (CAR), the DRC, Myanmar, Somalia, South Sudan, Sri Lanka, the Sudan (Darfur) and Yemen. Unaccompanied child migrant refugees and asylum seekers are particularly vulnerable to this type of abuse (United Nations, 2019).

It is often impossible to determine intentions behind specific acts of sexual violence, and therefore the distinction between militarised and opportunistic sexual violence in conflict is blurred (Spangaro et al., 2013).

In addition, reports of sexual abuse by peacekeepers and humanitarian staff have been widespread in the recent past (House of Commons, 2018), calling attention to the vulnerability of local populations in conflict-affected settings, where resources are scarce, and insecurity is paramount. The precarious situation of local and displaced communities leads to a heightening effect on power differentials between aid providers and receivers. Refugees and internally displaced persons (IDPs) report sexual violence by state authorities, armed groups, smugglers, traffickers and other agents who control access to resources in humanitarian contexts (United Nations, 2019). In the recent past, reports have graphically illustrated how providers relied on privileged access to resources to demand or negotiate sexual favours from local populations in crisis affected settings (Spangaro et al., 2013). The majority of reported survivors from this type of violence are girls, but there is some evidence that boys have also been exposed to sexual abuse by peacekeepers and humanitarian staff. Boys have, however, certainly remained virtually invisible in public debates about sexual abuse by this type of agents (House of Commons, 2018). LGBT individuals, especially transgender and intersex, persons are considered particularly vulnerable to sexual exploitation and sexual violence by security forces in barracks, police stations, prisons, detention centres, refugee and IDP camps and border facilities (Myrttinen et al., 2017).

CONSEQUENCES

CRSV is associated with severe and long-lasting health and social burden, including mental health disorders, sexual and reproductive health problems and physical health symptoms. Figure 1 describes some common health and social consequences of CRSV.

Figure 1. Common health consequences, social and emotional problems associated with CRSV

Mental health disorders and symptoms	Negative emotions and antisocial behavior	Reproductive and sexual health	Physical health symptoms
• post-traumatic stress disorders • depression • anxiety disorder • self-harm • suicidal behaviour • impaired memory and concentration • sleep problems • nightmares • cognitive impairment	• alcohol and drug abuse • low self-esteem • difficulty engaging in intimate relationships • anger outbursts • explosive rage • hostility • emotional withdrawal • detachment • apathy • helplessness • fear • stigma • self-blame	• sexually transmitted infections • HIV • infertility • sexual dysfunction • genital infections • genital injuries • unwanted pregnancies	• abcesses and rupture of the rectum • diarrhea • loss of body parts • chronic pain • somatic disorders • palpitation • headaches

Sexual violence is stigmatising for all survivors in most cultures, often casting a permanent taint on their perceived dignity and honour (McGlynn et al., 2019). Social norms related to gender, sexuality, and emotion regulation and expression influence the reactions from survivors and their social network, including: how much others are allowed to know, to which extent they should give credit to the reports, how should they accept these reports; and what they mean to the social identity of survivors and to their communities. Male survivors often "retreat into themselves" and feel unable to fulfil family and community expectations (Myrttinen et al., 2016). Sexual violence can happen behind closed doors and survivors can often prefer not to disclose or report it. Perpetrators of opportunistic sexual violence will likely abide by this tacit rule. On the other hand, the perpetrators of *militarised sexual violence* often seek some publicity of their acts locally, in line with the aim of humiliating and terrorising individuals, their families and communities (Spangaro et al.; 2013; Henry, 2015).

The GBV guidelines (GBV AoR, 2015) highlight the following types of GBV against LGBT individuals:

- Social exclusion;
- Sexual assault;
- Sexual exploitation and abuse;
- Domestic violence (e.g. violence against LGBT children by their caretakers);
- Denial of services;
- Harassment/sexual harassment;
- Rape expressly used to punish lesbians for their sexual orientation.

Furthermore, these guidelines suggest that people with disabilities, among other groups, are at increased risk of GBV. Research on intersectional vulnerabilities is, however, virtually absent for men, boys and LGBT people.

In post-conflict settings, LGBT people often experience harassment and need to hide their sexual orientation, gender identity and expression, and sex characteristics. Abuse and violence by security agents, local community members and other asylum seekers or refugees is common (United Nations, 2019; House of Commons, 2018). Exclusion from economic opportunities or from access to services may also occur as a result of negative attitudes associated with LGBT status (Myrttinen et al., 2017; UNICEF, 2015). They may also be targeted for 'honour killings' (Banwell, 2018).

In spite of its high magnitude in some contexts and devastating consequences, there continues to be very limited evidence on how interventions work for men, boys and LGBT survivors of CRSV. Three reviews of the literature on CRSV and interventions targeting survivors were conducted in the past (Spangaro et al., 2015; Hossain et al., 2013; Tol et al., 2013). However, male and LGBT survivors were not explicitly considered in these publications due to the lack of specific quantitative studies on these groups. This report builds on this body of knowledge

and on our own recent realist review on health interventions for male and LGBT survivors of CRSV (Kiss et al., 2020) to examine how health interventions may work (or not) for men, boys and LGBT survivors of CRSV.

METHODS

NARRATIVE AND REALIST REVIEW

This report is based on an extensive narrative review of academic and grey literature, guidelines and protocols on GBV, and on input from a workshop with key stakeholders in the field. It also summarises the key results from a realist review of the literature on medical and MHPSS care for male and LGBT survivors of CRSV. We conducted the work described in this report aiming to understand how, why, and in what circumstances medical and MHPSS interventions can improve the physical and mental health outcomes among male and LGBT survivors of CRSV.

We used a realist approach in our review aiming to unpack how complex interventions work and complement the answer to the question of *what works* about particular interventions, addressed by systematic reviews, with information about *what works for whom and under which circumstances* (Pawson et al., 2005). We used the RAMSES quality standard for realist reviews to guide our methods (Wong et al., 2013).

The research questions that guided the review were:

- What are the **mechanisms** by which medical and psychosocial interventions may improve the health of male and LGBT survivors of CRSV?
- What are the aspects of **intervention design and delivery** which influence whether the different mechanisms lead to an improvement in health including mental health?
- What are the relevant **contextual and individual characteristics** that influence whether health is improved because of interventions?
- What are the potential **unintended** outcomes, risks or adverse consequences of interventions?
- What are the **key knowledge gaps** that need to be addressed to enable more successful design and implementation of health and psychosocial interventions for male and LGBT survivors of CRSV?

Our realist review comprised four main steps:

1. Systematic search of the relevant literature, including reference search of relevant systematic reviews and grey literature;
2. Identification of underlying theories and mechanisms;
3. Identification of relevant evidence to refine intervention theories;
4. Summary of main findings and implications for interventions design and implementation.

In this report, we will not present the detailed methods and findings of the realist review. We will only summarise key findings from this review and expand on the discussion of these findings aiming to inform research, policy and interventions on CRSV against men, boys and LGBT people.

WORKSHOP IN LONDON (OCTOBER 2018): *Building Knowledge to Improve Existing Service Responses for All Survivors*

A first international workshop was co-organised by LSHTM and ASP in London, UK on 11-12 October 2018 with 22 representatives from Gender-Based Violence (GBV) AoR, Child Protection (CP) AoR; United Nations Children's Fund (UNICEF); United Nations Population Fund (UNFPA) at headquarters and country (Turkey) levels; the United Nations High Commissioner for Refugees (UNHCR) both at headquarters and country (CAR and Turkey) levels; World Health Organisation (WHO); Médecins Sans Frontières (MSF); the Afghan NGO Youth and Health Development Organisation (YHDO); the University of St. Andrews, London; the Havens, King's College Hospital NHS Foundation Trust; the Swiss Agency for Development and Cooperation (SDC) and the International Committee of the Red Cross (ICRC) as an observer.

The objectives of the workshop were to: (i) Share research findings from the research conducted by ASP so far on CRSV against men and boys and LGBT people in different contexts; (ii) Examine the available responses for survivors in CAR, Turkey and Afghanistan and deepen understanding of the barriers and good practices for male and LGBT survivors in each context; (iii) Develop a consensus on parameters and scope of a conceptual framework on responses for male and LGBT survivors in conflict and displacement settings. The workshop was conceived as the first step in a multi-staged process, which included the realist review and a second experts meeting in Geneva (below).

The workshop catalysed a widespread acknowledgment of the importance of this problem and a determined commitment by all stakeholders to address this issue. It was also a conducive context for a collective and constructive process of discussion and information sharing which fed into developing the conceptual framework and theory of change, further illustrated in this report.

EXPERTS MEETING IN GENEVA (MARCH 2019): *Improving Responses for Male Survivors of Conflict-Related Sexual Violence*

A second workshop was held on 5 March 2019 in Geneva, Switzerland with representatives from the UNHCR; the UNFPA at headquarters and country (Turkey) levels; WHO; International Rescue Committee (IRC); International Organisation for Migration (IOM) in CAR; The Havens, King's College Hospital NHS Foundation Trust, and MSF. The objectives of the workshop were to: (i) share findings from the realist review and draft conceptual framework; (ii) seek guidance and critiques from key international stakeholders; and (iii) present a synopsis and agreement on next steps.

We specifically sought feedback to refine the research questions and theory, identify further resources and aid the interpretation of emerging findings. Notes from the meeting and participant feedback were analysed and integrated in this report.

One of the outcomes from the meeting was to conduct a guideline and protocol review, which will be explained in further detail below. The argument for the guidelines and protocols review was that within the field of CRSV, there was not a consistent practice to evaluate interventions. As such, experts from the meeting recommended investigating policymakers' and providers' assessments from their experiences in the field.

REVIEW OF GUIDELINES AND PROTOCOLS

A rapid review of forty-nine existing international guidelines, protocols manuals and other documentation (hereby referred to generally as "guidelines") providing guidance on medical and MHPSS responses for survivors of sexual violence including in crisis was carried out, based on the recommendations from experts at the Geneva expert meeting and searches of relevant websites.

The aim of this rapid review was to assess to what extent and in what contexts the existing guidance on medical and MHPSS responses for survivors of sexual violence, explicitly or specifically address men, boys, and LGBT survivors in conflict settings within guidelines, protocols, manuals and other documentation from international and inter-agency organisations and policy experts.

Publicly-available guidelines that were from UN agencies or inter-agency organisations, and focussed on medical and/or MHPSS and included or addressed sexual and GBV (to any extent) were included, as well as those that addressed other sectors such as such as GBV or child protection, and included medical or MHPSS components or were linked to medical and/or MHPSS. In the case where several editions of the same guideline existed, these were analysed to identify the changes from one edition to the next. Exclusion criteria included: regional and national guidelines; guidelines published by other international or national non-governmental organisations; and guidelines that were internal or unpublished.

The guidelines and protocols were identified through websites and experts' suggestions. The sites we searched included WHO, Global Protection Cluster (GPC), GBV and CP AoR, UNHCR, UNFPA, UNICEF, IRC, and the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) among others.

RESULTS

SCOPE OF THE EVIDENCE

None of the studies we identified in the systematic review of CRSV interventions evaluations presented gender disaggregated data. Therefore, we were unable to draw any conclusions on the effectiveness of interventions on male survivors of CRSV. Additionally, the geographical scope of existing intervention research is restricted to a few countries and is not representative of the contextual diversity of affected settings. Experts who participated in our workshop called for attention to the lack of research on male and LGBT survivors of CRSV, associated with a very limited number of services providing assistance to these groups.

The results of our rapid review of guidelines and protocols also suggest that the specific needs, vulnerabilities and concerns of male and LGBT survivors have received increasing attention in international documents guiding policy and practice in the field, but are coupled with still limited guidance and recommendations on operationalising adequate responses for these individuals and groups.

ACCESS TO CARE

Emergency Context

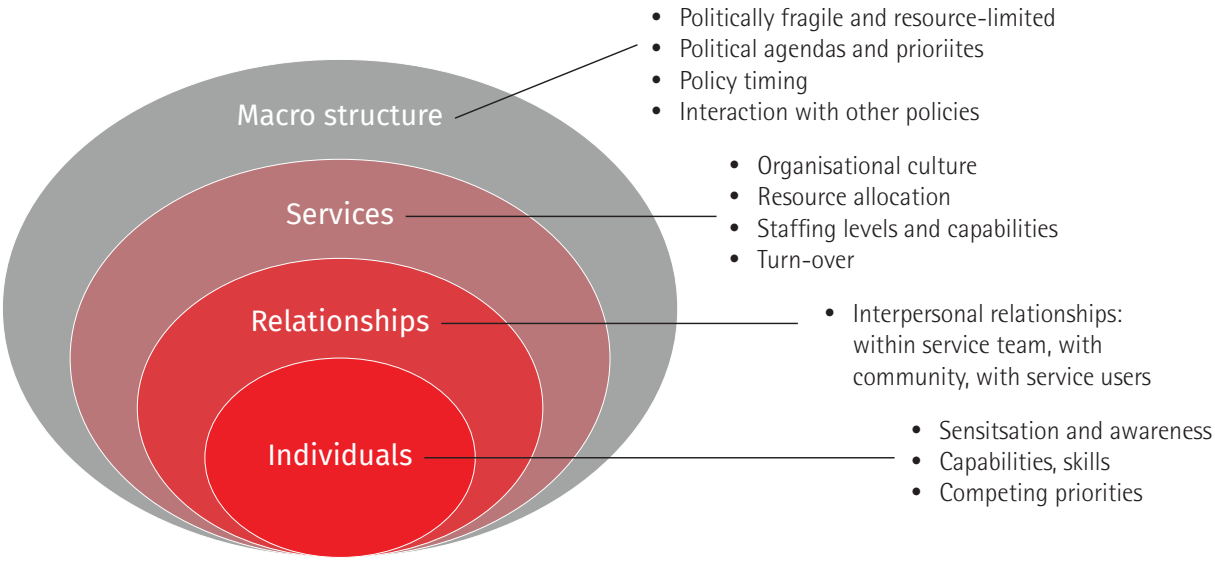
Access to and continuity of care in conflict and displacement settings is affected *inter alia* by insecurity, population mobility, limited infrastructure, and restricted financial and human resources (Warren et al., 2015).

Insecurity is an important barrier to treatment access and uptake for any survivor, including men, boys and LGBT people (Bolton et al., 2014a; Bass et al., 2016; Weiss et al., 2015; Loko Roka et al., 2014; Bolton et al., 2014b; Bernath et al., 2013; Kohli et al., 2013). Among men who receive care, many do not follow up treatment and have interrupted treatments at each stage of the assistance process (Apperley, 2015). Reasons for this high loss to follow-up may include lack of time, return to home country or community, insecurity, unavailability of transport, lack of resources and death (Bolton and colleagues, 2014b; Bernath et al., 2013; Mbeya et al., 2018; Weiss et al., 2015; Loko Roka et al., 2014).

Fragile and conflict-affected countries often have the weakest health systems (Martineau, 2017). When in place, health systems may be particularly affected in settings where the extension and brutality of conflicts are particularly severe (Ahmad et al., 2018; Bennett et al., 2017; Bass et al., 2016; Weiss et al., 2015; Wagner et al., 2012; Loko Roka et al., 2014). In these settings, looting and pillage of health services may force people to travel further to seek care. Armed groups and individuals often threaten the safety of health services' clients and survivors and prevent home visits by health workers (Mbeya et al., 2018; Weiss et al., 2015; Loko Roka et al., 2014). In these contexts of limited service provision, the expectation of community members of the quality of care is often also low.

Figure 2 proposes an ecological model describing different levels in which health systems function and associated issues that may affect service provision in conflict settings.

Figure 2. Health systems' organisational levels of service provision: an ecological model.



At the macro structure level, the politically fragile and resource limited context has an important influence in shaping the political agenda and setting priorities. The interplay of local interests with international funding schemes and political agendas influences how much resources are dedicated to the prevention and assistance of CRSV, and whether there is a policy specifically targeting male and LGBT survivors. The effectiveness of providers' training on responding to needs of male and LGBT survivors is likely affected by the prevailing cultural norms and by the organisational culture as well as resource allocation, staffing level and capabilities, and turn-over. The translation of training content into practices will also depend on the health teams' and staff buy-in and their competing priorities. The relationship of providers with the community and with service users are likely to affect disclosure of CRSV by survivors, referral follow-up and adherence to treatment. The design of health system interventions for male and LGBT survivors of CRSV needs to take into account the interplay of factors between each of these levels. Additionally, interventions will need to be adaptable to the specific needs and barriers to care of different types of conflict-affected settings and populations (e.g. camp-like, urban and rural dispersed) (Spiegel et al., 2010).

Barriers to Disclosure

Most barriers to disclosure of CRSV are common among female, male and LGBT survivors of CRSV and include fear of retaliation, lack of protection, concerns about being abandoned by family and friends, and stigma (Bennett et al., 2017; Kohli et al., 2013; Mbeya, 2018; Bennett et al., 2017).

Among men and boys, barriers may be associated with specific reactions related to confusion, guilt or self-blame around their sexuality (Monteith et al., 2019; ASP, 2017). Misconceptions and prejudices about sexual violence against men and boys are common (Forde & Duvvury, 2016; Davies, 2000; Gold et al., 2007; Davies & Rogers, 2006; WHO, 2003) and include:

- sex is the primary motivation for rape;
- men cannot be raped;
- "real" men can defend themselves against rape;
- women cannot sexually assault men;
- men are not affected by rape;
- male rape only happens in prisons;
- sexual assault by someone of the same sex causes homosexuality;
- male rapists and their victims tend to be homosexuals;
- homosexual and bisexual individuals deserve to be assaulted;
- if a male survivor physically responds to an assault, he must have wanted it;
- homosexual individuals are to blame for the assault.

These beliefs are anchored in traditional masculine norms that reinforce strength, assertiveness, sexual dominance and heterosexuality (Davies, 2000). Conversely, these norms assign a subordinate status to homosexuality, particularly male homosexuality, since homosexuality is associated with feminisation, subordination and victimisation (Turchik & Edwards, 2012; Bullock et al., 2011; Carlson, 2005; Davies, 2002; Javaid, 2018). Male survivors often embody notions of "broken" masculinities that hinder their self-esteem and contribute to the fear, stigma and silence associated with sexual violence against both heterosexual and gay men (Javaid, 2018; Turchik & Edwards, 2012). This silence can worsen depression and PTSD symptoms and prevent male survivors from actively seeking help (Gold et al., 2007). These rape myths are often shared within the survivors' community, contributing to perpetuate the invisibility of male and LGBT survivors of CRSV (Turchik & Edwards, 2012; Bullock et al., 2011; Carlson, 2005; Davies, 2002).

Additionally, experts in our London workshop and Geneva meeting called attention to the perception of some men, including sexual and gender minorities among them, that accessing available services may put themselves at risk. This perception is corroborated by research in

Lebanon, where Syrian LGBT refugees were often unwilling to access services fearing that their sexual orientation or gender identity could be revealed to other refugees (Sivakumaran, 2007).

Service Availability

Additional barrier to the provision of and access to care for men, boys and LGBT survivors of CRSV is the lack of available specialised assistance, resources and training (Chynoweth, 2017). Barriers reported by providers include lack of capacity to respond to the needs of male and LGBT survivors of CRSV, discomfort and limited experience and knowledge in treating these populations (Chynoweth, 2017).

Furthermore, providers may harbour some of the prejudices and misconceptions listed above. For example, Chynoweth and colleagues (2017a) report some negative reactions from health providers participating in a post-rape care training who laughed about the topic and showed disbelief regarding the possibility of men being raped. Both for men and women, providers sometimes blame survivors for the abuse and question the credibility of their reports (Smith et al., 2013). More context-specific studies on the implementation and effectiveness of sensitisation, awareness raising and capacity building among health providers are needed.

Male and LGBT survivors may not know about services or think they target only women and girls (Apperley, 2015; Chynoweth, 2017b; Chynoweth, 2017a). When the only services available are female-oriented, male and LGBT survivors may be uncomfortable accessing care, as was identified by organisations working in Iraq, Jordan and Lebanon, and by a study among Syrian refugees in Lebanon (Chynoweth, 2018; Sivakumaran, 2007).

Services provided to male and LGBT survivors may not be designed to enable disclosure by them and meet their specific needs (Chynoweth, 2017). Men and boys may be discouraged to seek care by the perception of health services, particularly offering sexual and reproductive health services, as feminised spaces (Myrttinen et al., 2017). Indeed, research from high income countries has found that, overall, men are less likely to seek mental and physical health care services (Galdas et al., 2005; Seidler et al., 2016). Delaying provision of or access to health care services not only reduces the effectiveness of post-rape medical interventions, but also increases risks related to externalising behaviour such as antisocial behaviour, substance abuse and suicidal behaviour (Haegerich & Hall, 2011; Donne et al., 2018). These behaviours are more common among men than women (Teram et al., 2006; Romano & DeLuca, 2001; Rosenfield, 2000). In conflict settings, seeking help can be further delayed by imprisonment, detention and escape (ASP, 2018b).

Moreover, in many conflict-affected countries, men who experience sexual violence are not protected by the national legislation and, in some, they are criminalised when reporting abuse (Dolan, 2014). Men and boys' inclinations to report sexual violence are further decreased in these contexts, where they can risk incrimination and legal procedures as a result of a denounce (Forde & Duvvury, 2016).

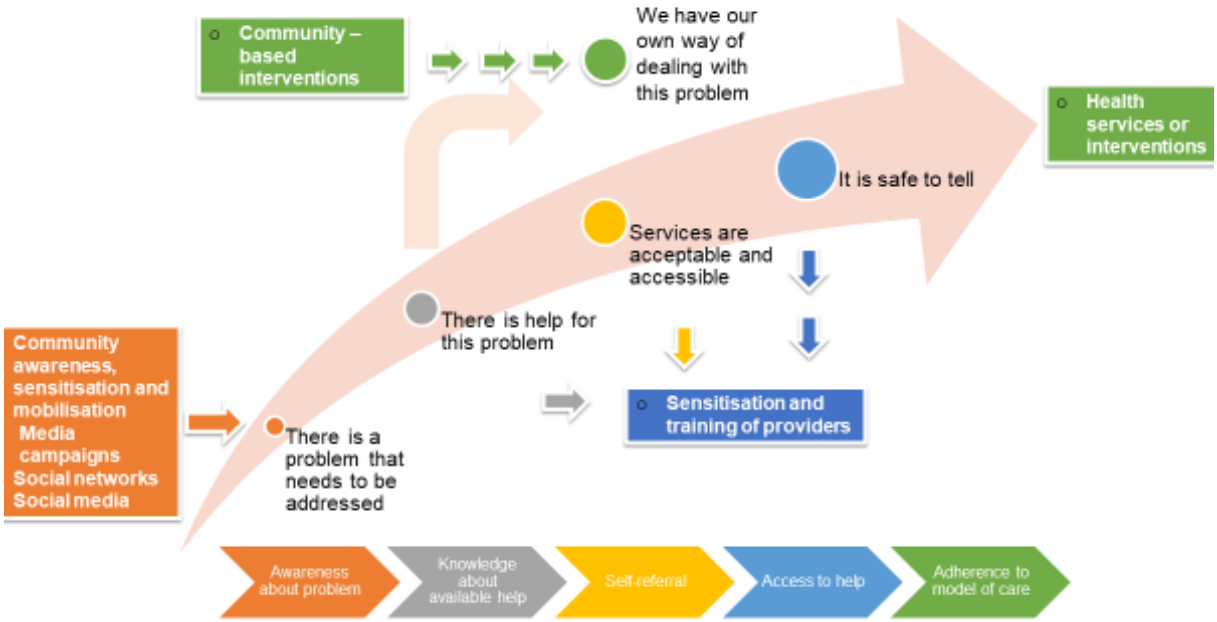
Research has found that some male survivors of CRSV may prefer to have a same-sex provider (Murray et al., 2014; Chynoweth, 2017). This preference may complicate the logistics of service provision for survivors of CRSV, especially when considering universal access to care (Murray et al., 2014).

In their realist review of interventions targeting female survivors of CRSV, Spangaro and colleagues (2015) identified five mechanisms that underpin interventions from a survivor's perspective:

- there is help for this problem;
- services are acceptable and feasible;
- it is safe to tell;
- we can work together to address this problem;
- we have our own ways of dealing with this problem.

These conditions correspond to a sequence of motivations, expectations and choices that the authors identified as necessary conditions for female CRSV survivors' access to care. Women and girls need to be willing to access services, accept them, disclose their experiences, trust providers and trust their proposed model of care in order to seek care, engage and adhere to proposed health interventions that are culturally relevant (Spangaro et al., 2015). Figure 3 describes the mechanisms underpinning survivors' access to services based on the work by Spangaro and colleagues (2015) and illustrates how services and interventions may relate to these mechanisms.

Figure 3. Mechanisms for service access among survivors of conflict-related sexual violence (loosely based on realist review by Spangaro et al., 2015) Content based on article by: Spangaro J et al. 2015. Mechanisms underpinning interventions to reduce sexual violence in armed conflict: A realist-informed systematic review. Conflict and Health 9: 19.



Interventions involving community awareness, sensitisation and mobilisation may help survivors recognise that they have problems associated with their experience of CRSV and inform them that: there is help for this problem; services are acceptable and accessible; and it is safe to tell providers. Media campaigns, such as information on the radio, and social media can also play this role. In addition, sensitisation of providers can foster the recognition that there is help available for survivors, that services are acceptable and accessible and that it is safe to tell. Conversely, when survivors consider that they have their own ways of dealing with the problem, the use of survivor-centred approaches to design community-based interventions can help make care more acceptable and accessible. A gender-sensitive approach that considers the specific issues and needs of male and LGBT survivors in each of these stages could improve access and adherence to care.

Interventions that promote access to services for survivors of sexual violence in different contexts include training on health and psychosocial care of community leaders or core groups (Bennett et al., 2017; Loko Roka et al., 2014), involvement of local organisations (Bolton and colleagues, 2014b), internet-based technology (Wagner et al., 2012), home-visits (Kohli et al., 2013), mobile clinics (Kohli et al., 2012) and one-stop strategies (Roka et al., 2014). The authors emphasise that all such interventions remain highly context specific. Evaluations of these interventions showed positive results in health outcomes but have not necessarily reported improvements in accessibility. One evaluation reported the challenges of patients' accessibility to the specialised referral network (Kohli et al., 2013).

One-stop strategies may be a potential solution to overcome privacy and confidentiality barriers associated with CRSV. It is not clear, however, whether this strategy is effective at maintaining confidentiality, how male clients' perception of care is impacted, and whether it influences continuity of care (Roka et al., 2014). Furthermore, one challenge to one-stop strategies is being able to address psychosocial and mental health needs of survivors without referral to a specialised network.

The review found four studies that focussed on psychological treatments and included male participants (Bolton et al., 2014a; Bass et al., 2016; Weiss et al., 2016; Bolton et al., 2014b). However, these studies did not investigate accessibility and acceptability of interventions among participants. Health interventions in conflict affected settings would benefit from comprehensive process evaluations, focussing on:

- recruitment of participants;
- delivery strategies;
- mechanisms of change;
- barriers and enablers of adherence to treatments and interventions;
- potential unintended outcomes.

INTERVENTION MODELS AND TARGETS

Sensitisation and Training of Healthcare Providers and Community Members

Provider sensitisation, training on how to care for male and LGBT survivors of CRSV, and service norms and models of care will influence survivors' self-referral and disclosure of CRSV. Male and LGBT survivors who fear they could be met with blame, homophobia, and scepticism from police and healthcare providers will be less likely to seek for help (Davies, 2000; Smith et al., 2013; Chynoweth, 2017). Ultimately, providers' negative perceptions, beliefs or attitudes towards male survivors of CRSV contribute to perpetuate the stigma and silence around the problem (Dolan, 2014; Davies, 2002; Smith et al., 2013; Martin et al., 2007).

Research indicates that providers often hold negative beliefs about heterosexual and homosexual male survivors of sexual violence and are less compassionate towards these groups when compared to women and girls (Davies, 2000; Javaid, 2018; Davies & Rogers, 2006). For LGBT survivors more generally, in comparison to their heterosexual counterparts, they experience greater blame for the assault (Davies, 2000; Gold et al., 2007). These negative attitudes by providers are likely to hinder the recovery of survivors (Davies, 2002; Herek et al., 1999).

We identified a few interventions that promoted sensitisation, awareness and training on survivors of CRSV to improve knowledge and attitudes of healthcare providers (Bass et al., 2016; Smith et al., 2013; IRC, 2012; Naimer et al., 2017; Mishori et al., 2017; Tanabe et al., 2013). Results from the evaluation of these interventions were mixed with some studies showing that some healthcare providers continued to hold negative beliefs, blaming, and questioning the credibility of survivors after the training while other studies showed improvement in knowledge and rights-based practices.

Integrated Models of Care

Researchers and key stakeholders in the field recognise the need for survivor-centred, inter-sectoral and integrated models of care for survivors of CRSV (for example, IASC, 2015; UNHCR, 2003; Freccero et al., 2011; Greene et al., 2018; Tol et al., 2015; Wessels, 2008; ASP, 2018b; WHO, 2003). Survivor-centred models of care propose the integration of actions from diverse sectors prioritising the rights, needs and wishes of survivors. Sectors involved in the assistance of CRSV include: food and shelter; physical and mental health; medico-legal and forensic evidence; education; child protection; livelihood; nutrition; protection and justice; housing, land and property; police; and camp coordination and management (IASC, 2015; Freccero et al., 2011; Greene et al., 2018; WHO, 2003; WHO, 2015).

Findings from our review highlighted the following links:

Education and MHPSS assistance. The education sector can facilitate the access of children and adolescent survivors of CRSV to health care and provide brief MHPSS interventions to students. According to Greene and colleagues (2018), interventions integrating education and MHPSS assistance include actions to:

- strengthen coping strategies;
- disseminate information related to survival and protection;
- train teachers to identify mental health and psychosocial needs of students;
- manage mild behavioural problems.

Schools can be used as an effective setting to reach survivors of CRSV, address their needs and facilitate their access to specific services. One school-based study in Palestine investigated the effectiveness of a trauma-focused cognitive behavioural therapy intervention for students, delivered by trained counsellors. Students that participated in the therapy were significantly less likely to display symptoms of posttraumatic stress, depression, traumatic grief, negative school impact, and mental health difficulties in comparison to those students who did not participate (Barron et al., 2013).

Protection and MHPSS. CRSV is an important protection as well as health issue. Data on a protection intervention that integrated MHPSS into its services for female refugees from the DRC who survived intimate partner violence (IPV) suggested this to be a feasible model. The intervention used Cognitive Processing Therapy to help participants recognise and change their thinking associated with their experience of severe trauma. Negative thinking (e.g. self-blame, feelings of worthlessness) is related to worse mental health outcomes (Trick et al., 2016). The protection component of the intervention included safety planning and advocacy, including group discussions on empowerment, coping and support methods. This component was delivered by protection staff in the refugee camp. The trial concluded that with partners' ownership and buy-in, intersectoral integration was possible (Greene et al., 2018). Similar models targeting CRSV among males, females or LGBT persons have not been evaluated.

Media, police and health. In certain contexts, community participation, media and police collaborations could be potentially beneficial for survivors of CRSV (IASC, 2015; Dolan, 2014). For example, Bernath and colleagues (2013) described training of police officers on how to use standard operating procedures for the prevention and handling of sexual and gender-based violence (SGBV) cases in Rwanda. The police also annually held a national GBV week to raise awareness among the community about GBV and how to deal with it. However, issues around male and LGBT survivors were not explicitly mentioned. Specific concerns about stigmatisation, safety and protection of male and LGBT survivors need to be considered (Bernath et al., 2013).

Physical and mental health. The integration of physical and mental health provision has been advocated in both high and low resource settings. Greene and colleagues (2018) highlight the

benefits of integrating screening and brief interventions into primary health care services as a way to:

- identify people in need of referral to specialised services;
- prevent mental disorders among people with sub-syndromal symptoms;
- increase awareness about mental health and the consequences of displacement and disaster;
- reduce the stigma commonly associated with seeking mental health services by delivering care in neutral settings;
- improve outcomes for a variety of chronic and infectious diseases.

Basic needs and mental health. Within humanitarian emergencies, meeting the basic needs of survivors is priority. Survivors who cannot feed themselves or find safe shelter are unlikely to prioritise mental health (Mbeya et al., 2018). At the same time, when these needs are not met, survivors' mental health can deteriorate (Greene et al., 2018). Poverty and armed conflict are daily stressors for CRSV survivors in humanitarian emergencies. As such, access to basic health services may be blocked, influencing survivors' mental health and wellbeing (Pacichana-Quinayáz et al., 2016). However, MHPSS support should not be viewed as a "second-tier operation", postponed until basic survival needs are met. In emergencies, the psychosocial shocks experienced by survivors are not secondary to material losses (Wessels, 2008). Our review did not find evaluations of interventions addressing basic needs alongside physical or mental health interventions. However, the need for food assistance and income generating activities was discussed in a study (Mbeya et al., 2018) in CAR, which found that the disruption of basic services was a significant barrier to the effectiveness of mental health interventions.

Medico-legal assistance, justice and accountability. Medico-legal evidence of sexual violence is at the intersection of the medical and justice processes. The implementation of effective medico-legal responses requires the coordination between a range of sectors, including health services, social services, forensic medicine, forensic lab services, police/ investigation, and the legal system, including lawyers and judges. Guidelines from the WHO and the United Nations Office on Drugs and Crime (UNODC) recommend that in conflict-affected settings, concentrated efforts should also be directed to coordination between national and international organisations, including the United Nations and potentially international criminal tribunals (WHO, 2015).

Challenges. There are challenges to the implementation of integrated and intersectoral care. The allocation of resources is usually siloed in humanitarian emergencies and overcoming coordination challenges requires engagement from all sectors involved (Greene et al., 2018). Furthermore, the use of different terminology, definitions and frameworks has historically hindered coordination between sectors and agencies. However, the construction of common approaches and tools has increased through practical, concrete steps and an active avoidance of theoretically contentious issues, a direction clearly demonstrated between the 2007 and 2015 IASC guidelines (Tol et al., 2015). Evaluations of processes and effectiveness of integrated

and intersectoral interventions that take into account the specific needs, vulnerabilities and realities of male and LGBT CRSV survivors are needed.

Community-based Interventions

Community sensitisation, awareness and involvement are important strategies to overcome stigma and discrimination against CRSV survivors, which is a major barrier for survivors' access to healthcare (Loko Roka et al., 2014; Bennett et al., 2017; Mooren et al., 2013; Bernath et al., 2013; Kohli et al., 2012).

Community-based interventions that rely on community leaders, organisations, core groups and other resources have been used in conflict settings to:

- promote awareness of health issues;
- identify survivors;
- motivate survivors to seek help;
- provide information on services;
- facilitate access to care;
- relay information about the consequences of not seeking services, and about legal and protection issues;
- make referrals to medical, legal, and socioeconomic services;
- manage feelings of survivors' guilt.

Our review identified three evaluations of community-based interventions that included men. These interventions relied on different communication strategies, including street drama, theatre (Loko Roka et al., 2014), radio programmes (Mooren et al., 2003), information brochures, TV broadcasts, and talk show interviews (Bernath et al., 2013).

Culturally embedded responses seem to offer promising avenues to address the mental health and psychosocial needs of survivors by building on shared meanings of suffering that can help individuals process trauma. For example, girls and boys who were part of the Lord's Resistance Army in Uganda benefited from an intervention based on local Acholi traditional rituals performed by community elders. These rituals promoted practices of reconciliation and reintegration to reduce girls' and boys' feelings of shame and guilt associated with both violence perpetration and victimisation (Olak, 2006; Spangaro et al., 2013).

Organisations working on the ground with male and LGBT survivors in Iraq, Jordan and Lebanon recommend integrating CRSV against men, boys and LGBT into traditional GBV interventions, such as community awareness raising around sexual violence (Chynoweth, 2018). Survivor-centred approaches and feasibility testing are recommended to prevent unintended harm among male and LGBT survivors of CRSV.

Faith-based and community organisations have also been engaged in interventions to promote the health of survivors of CRSV. For example, in the DRC faith-based organisations were involved in addressing stigma among survivors, informing them about available services, and providing basic psychosocial support (Bennett et al., 2017). Indeed, strategies that rely on community-based organisations, key resources and faith-based organisations have been promoted as a feasible and cost-effective way to reach vulnerable populations in fragile and low resource settings (GBV AoR, 2015). Nonetheless, researchers point out potential existing tension between specific religious agendas and core values of the rights-based policy agenda (Pyles, 2007; Tomkins et al., 2015).

Guidelines and Protocols

Participants in the Geneva expert meeting highlighted the centrality of protocols, guidelines and grey literature in the production and dissemination of knowledge about CRSV prevention and response. International guidelines have indeed been central to coordinating the efforts by different agencies in the humanitarian field and created some consensus around practices to prevent and respond to CRSV (Tol et al., 2015; Wessels & van Ommeren, 2008).

The results of our rapid review confirm stakeholders' perception that indeed the amount of published international guidelines, protocols and other documentation guiding policies and practice seem to exceed the volume of academic publications in the field. However, both in the grey and academic literatures, the information on male and LGBT survivors' specific vulnerabilities, needs, risks and barriers and enablers for their access to healthcare and MHPSS remains limited.

That said, there has been an increasing recognition of male and LGBT survivors of sexual violence over the years, a growing acknowledgement that there is a need to design recommendations to address male and LGBT survivors of sexual violence and increasing guidance on how to manage and respond to cases of sexual violence perpetrated against men, boys and persons who identify as LGBT and better tailor medical and MHPSS services and responses for these groups. For example, UNHCR and the Refugee Law Project (2012) have outlined how to address male survivors needs, within inclusive sexual violence programmes that target women and girls as well. In addition, UNHCR developed a document in 2011 to address the needs of LGBT survivors of sexual violence (UNHCR, 2011). At the same time, care and service provision for males and LGBT survivors have been addressed in other guidelines (WHO, 2003; WHO et al., 2004; UNICEF and IRC, 2012; UNFPA, 2015; UNHCR, 2012; GBVIMS Steering Committee, 2017 among others). We also found that subsequent editions of guidelines from the GBV AoR, UNHCR and IAWG have increasingly called on considering intersectoral actions to respond to male and LGBT survivors (GBV AoR 2005 and 2015; IAWG 2010 and 2018; UNHCR 1995 and 2003).

Yet evidence on the implementation, evaluation and effectiveness of these guidelines is sparse. In the literature review, we found one study that implemented guidelines (Tanabe et

al., 2013). The authors assessed the safety of implementing the WHO's Clinical Management of Rape Survivors at the community level, with mainly positive results on the knowledge and awareness of community health workers. The authors recognised, however, the challenges in implementing multi-sectoral approaches, as recommended by most GBV international guidelines, in poorly resourced settings.

Evidence gaps. Ours and other reviews in the field (Tol et al., 2015; Blanchet et al., 2017), noted several gaps in the evidence on MHPSS interventions, particularly for men and LGBT survivors of CRSV, including the lack of:

- data disaggregated by gender and age;
- interventions targeting LGBT survivors;
- evaluation on integrated or intersectoral models of care;
- process data in intervention evaluations;
- evidence on interventions to reduce alcohol and substance misuse;
- data on interventions employing faith-based and community resources;
- evidence on how interventions influence individuals' overall functioning (in contrast to specific mental health disorders);
- interventions using different modes of delivery (e.g. primary health setting, home visits, mobile clinics).

HEALTH INTERVENTIONS: RATIONALE AND IMPLEMENTATION

Mental Health and Psychosocial Well-being

Psychological and social consequences. The costs of sexual violence on mental health can be severe and lifelong (IASC, 2005). Symptoms and behavioural responses associated with sexual torture, sexual trauma and sexual violence includes: alcohol and drug abuse, impaired memory and concentration, low self-esteem, difficulty relating to others, difficulty engaging in intimate relationships, anger outbursts, explosive rage, poor emotional regulation and anger, depression, emotional withdraw, hopelessness, detachment, lack of adherence to family life, IPV perpetration, violence against children (VAC), self-mutilation, suicidal behaviour, sleep disturbances, nightmares, apathy, helplessness and cognitive impairment (Van der Kolk, 2014; Turner, 1990; Apperley, 2015; Dolan, 2014; Loncar et al., 2010; Krugg, 2002).

These symptoms are manifested among female survivors as well. However, anxiety and depression are more common among female survivors, while male survivors tend to display externalising behaviours, such as antisocial behaviour and substance abuse, more often (Teram et al., 2006; Romano & DeLuca, 2001; Rosenfield, 2000). In addition, male survivors may be particularly concerned about their masculinity, sexual orientation, opinions of other

people, not being able to prevent the abuse, and re-victimisation (WHO, 2003; Davies, 2000; Forde & Duvvury, 2016).

Families and communities are also affected by sexual violence. Due to the stigma, families may reject or abandon survivors (Apperley, 2015; UNHCR, 2012). This can lead to isolation and disruption of family life (WHO, 2003). Similar reactions from the community can happen against male survivors (ASP, 2018), negatively affecting their recovery and economic survival (UNHCR, 2012; Apperley, 2015).

LGBT survivors of sexual violence may face not only an increased vulnerability associated with their sexual orientation and gender identity, but also feel they need to hide their sexual orientation as a way to protect themselves from violence (Garnet, 1990; Myrttinen et al., 2017). This can also impact mental health symptoms (Garnets et al., 1990).

Exposure to sexual violence during childhood and adolescence often results in severe consequences to the mental health of survivors and may lead to impaired cognitive, emotional and social development (Tol et al., 2015).

Evidence on childhood sexual abuse suggests that male survivors have a hard time coping with sexual violence and resolving the trauma associated with the abuse. They are more likely to display aggressive behaviour, risky sexual behaviour and suicidal behaviour than female survivors. Substance abuse is also a common way for male survivors to cope with the trauma (Forde & Duvury, 2016). This type of coping mechanisms often replaces positive strategies such as access to specialised services and contribute to the invisibility and silence around sexual violence against men and boys.

Mental Health and psychosocial interventions. Historically, the MHPSS-humanitarian field has experienced a deep divide that still persists to date in a more nuanced form. On one side of the argument are those who favour a more holistic approach focussing on comprehensive primary care provision and addressing the social determinants of mental health. On the other side, are those who believe priority should be given to biomedical approaches focussing on the treatment of mental disorders. This conflict has been tackled mainly through inter-agency efforts to build consensus around practical guidelines and concrete steps starting with the 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, 2007 (Wessels & van Ommeren, 2006; Tol et al., 2015; Jong et al., 2015). Participants in our workshops seemed to mostly favour holistic approaches that included different sources of support to promote psychosocial well-being and survivors' functioning beyond medical classifications of symptomatology. Nonetheless, findings from our review confirm that the dividing line between mental health and psychosocial approaches is sometimes blurred and, in reality, interventions do not fall clearly within one versus the other paradigm (Tol et al., 2015; Blanchet et al., 2017).

According to a review by Tol et al., (2014), the five most common interventions reported in humanitarian settings are: individual basic counselling (39%); facilitation of community

support of vulnerable individuals (23%); provision of child-friendly spaces (21%); support for community-initiated social support (21%); and basic counselling for groups and families (20%) (Tol et al., 2014).

The interventions identified in our review did not reflect this distribution. Instead, many evaluations that included male participants focussed on psychological treatments, including:

- Behavioural Activation Treatment for Depression (BADT);
- Cognitive Processing Therapy (CPT);
- Trauma-informed intervention (TII);
- Common Elements Treatment Approach (CETA).

Findings from evaluations of treatments that included men and boys reported effectiveness in reducing symptoms of depression, anxiety, PTSD, dysfunction and post-traumatic grief (Bolton et al., 2014a; Bolton et al., 2014b; Bass et al., 2016; Weiss et al., 2015). However, results from these evaluations were not disaggregated by gender.

Evidence suggests that group therapy has positive effects on mental health of female survivors of CRSV (Bass et al., 2013; Lekskes et al., 2007; Allon, 2015; Walstrom et al., 2013; Manneschmidt et al., 2009). Evaluation of different models of group therapy targeting female survivors of CRSV reported improvements in:

- PTSD symptoms, and combined depression and anxiety symptoms (Bass et al., 2013);
- Disturbance levels related to trauma (Allon, 2015);
- Social capital (Hall et al., 2014);
- Group membership and participation, and emotional support (Hall et al., 2014);
- Safety perception, social functioning, mental and physical health, self-esteem and self-efficacy (Walstrom et al., 2013);
- Decrease in shame and stigma, and a greater understanding of the importance of medication and treatment adherence (Walstrom et al., 2013);
- Mood and behaviour, social skills, family interactions, and handling stress and making decisions (Manneschmidt et al., 2009).

These promising results cannot, however, be automatically generalised to male and LGBT survivors. Despite the potential benefits of group therapy, male survivors may find it difficult to share their personal stories in a group (Rapsey et al., 2017). Research also suggests that therapeutic groups with male survivors of sexual violence may have particular gendered dynamics in which anger, fantasies of retribution and drive to isolation can be prominent features (Friedman, 1994). Specific studies on the effectiveness of group therapy for male and LGBT survivors of CRSV are needed.

For psychosocial interventions, there is limited evidence on the most effective components to improve mental health and social wellbeing. However, there is evidence that interventions promoting social connectedness, safety, and security can improve mental health as among female CRSV survivors (Hall et al., 2014; Walstrom et al., 2013; O'Callaghan et al., 2013; Manneschmidt et al., 2009).

Gender differences on MHPSS treatment effectiveness. Motivation, commitment and response to psychological treatments differ by gender (Grubbs et al., 2015). Research on gender and access to mental health assistance suggests that men are less likely to seek assistance and engage in treatment than women (Alison et al.,1992; Forde & Duvvury, 2017). Male survivors of sexual violence are more likely to respond with anger, aggression, risk behaviours and hyper masculinity (Cason et al., 2002; Street & Dardis, 2018; Friedman, 1994). They also often close-up and deny what happened (Krumm et al., 2017; Forde & Duvvury, 2017).

Women often show greater improvements associated with mental health treatments (Felminham, 2012; Wade et al., 2016; Voelke et al., 2015). These differences have been attributed to the gender socialisation and women's increased reliance on social support, greater inclination to seek for help, less sensitiveness to mental health stigma, enhanced willingness to talk about problems and openness to stronger therapeutic alliances (Cason et al., 2002; Street & Dardis, 2018; Johnson, 2010).

Physical Health

The physical health consequences of sexual violence against men and boys include genital injuries, blood in stools, incontinence, abscesses, fissures and rupture of the rectum, diarrhoea, acute abrasions of the penis, scrotum or perineum, full or partial castration, significant anal dilatation or scarring and chronic pain, (Apperley, 2015; Oosterhoff, 2004; Turner, 1990; WHO, 2003; Garnets et al., 1990; Chynoweth et al., 2017a). Non-genital and rectal injuries may include bruises and contusions, lacerations, ligature marks to ankles, wrists and neck and pattern injuries (handprints, finger marks, belt marks, bite marks), palpitations, headaches and somatisation (WHO, 2003; Chynoweth et al., 2017a).

Our review has found no evaluations on the treatment of any of these symptoms. A recent systematic review of interventions in humanitarian settings found 46 studies on injury and rehabilitation (Blanchet et al., 2017). However, our review of these studies found none that addressed injuries or rehabilitation associated to CRSV among female, male or LGBT survivors.

Although there is extremely scarce data on the physical health of male survivors of CRSV, there are important indications that their physical health needs remain largely unaddressed because of the reasons discussed above (e.g. underreporting by survivors, lack of identification by providers, unpreparedness of providers, lack of or limited resources and infrastructure). As a result, survivors are likely to experience long-term severe symptoms that may affect their wellbeing, relationships, and social and economic integration. For example, some injuries

such as rectal trauma may require specialised surgery to reduce pain and malodorous leakage. However, reparative surgery may not be available in conflict-affected settings, or referral systems may not be established. Incontinence, sexual dysfunction and genital scarring may also go unnoticed by providers who tend to focus on anal rape (Chynoweth et al., 2017a). Further evidence on access, implementation and effectiveness of physical health responses to CRSV against boys, men and LGBT persons is urgently needed.

Forensic and medico-legal care are important in the offer of STI treatment and HIV prophylaxis and to facilitate survivors' access to protection, justice and other accountability mechanisms. The documentation of cases by medical staff can also inform policies and interventions by providing estimates of CRSV (WHO, 2003). However, there is very limited evidence on the proportion of survivors who seek redress mechanisms after receiving forensic and medico-legal care, and on the effect of protection and accountability on the mental health, social wellbeing and integration of survivors. Moreover, the effectiveness of forensic and medico-legal care depends on the existence of a working justice system, legal support and access to care in the conflict-setting, which cannot be taken for granted.

Our review identified one intervention seeking to improve the links between medico-legal services and protection mechanisms. This intervention relied on a smartphone application to assist health professionals conducting medical exams in sexual violence cases. The app combines a custom-designed medical intake form for forensic documentation with a secure mobile camera for forensic photography. Clinicians can use the app to compile medical evidence, photograph survivors' injuries, and securely transmit the data to their law-enforcement counterparts who may be located at a police station many kilometres away. This tool includes sophisticated encryption, cloud data storage, and tamper-proof metadata. Nonetheless, the authors recognise the significant technological, ethical and safeguarding threats posed by collection and transfer of sensitive electronic data (Naimer et al., 2017). However, at the same time, a participant in our workshop recognised similar ethical and safeguarding threats in one site where advanced technology for data collection was completely absent. As an example, this participant referred to a situation where the paper-based forensic evidence for a case of CRSV was not properly stored and disappeared from the service facilities. This is a reminder that risks to CRSV survivors can result both from failures in interventions' design and/or from their poor implementation.

Evidence gaps. Specific guidelines addressing the health needs of survivors are starting to be developed (El Kak, 2015). However, many gaps in knowledge remain unaddressed, for instance:

- effective outreach strategy for health care provision to male and LGBT survivors of CRSV;
- interventions addressing physical sequelae of CRSV against men, boys and LGBT persons;
- results of sensitisation and training of health providers on male and LGBT survivors' specific needs;

- primary research to inform tailoring of existing protocol and guidance to male and LGBT survivors of CRSV;
- access to and effectiveness of forensic and medico-legal interventions;
- use of new secure technologies to facilitate referrals.

Sexual and Reproductive Health

Male and LGBT CRSV survivors may experience STIs including HIV, infertility, sexual dysfunctions, genital infections, impotence and infertility (Apperley, 2015; Oosterhoff, 2004; Turner, 1990; WHO, 2003; Garnets et al., 1990; Chynoweth et al., 2017a). These health consequences have devastating effects not only on individual survivors, but on their partners, families and communities. To date, no reviews, including ours, have identified interventions addressing the long-lasting impact of CRSV on the sexual and reproductive health of men, boys and LGBT survivors.

Initiatives on sexual and reproductive health often focus exclusively on women and girls and refrain from targeting men and boys. Nonetheless, male involvement is fundamental in the prevention of STIs and HIV (Varga, 2001). Furthermore, gender norms blaming and ostracising male survivors of CRSV can be harmful to men, women, boys, girls and their families. Changes in those norms require sensitisation, engagement and buy-in from men and boys, as well as women and girls (Ruane et al., 2018).

There is some evidence supporting HIV and STI education and condom distribution campaigns in conflict settings (Warren et al., 2015). However, there is no data on how male and LGBT involvement can help prevention, and even less on targeted initiatives on survivors on CRSV.

Additionally, fertility and reproduction can be an area of concern for male survivors of CRSV and their partners. Consequences of CRSV against men may include infertility, sexual dysfunction and castration or partial castration, all of which may affect reproductive outcomes. Evidence on culturally appropriate and effective interventions for male, gay and transgender survivors is missing.

Gaps in evidence. Our review, along with a systematic review on sexual and reproductive health in humanitarian settings (Blanchet & Roberts, 2015), recognise that crucial evidence is needed in the field, including:

- evidence collected with survivor-centred approaches;
- interventions addressing the needs of male and LGBT survivors of CRSV;
- evidence on the needs of particular groups of survivors (e.g. people with disabilities, adolescents);
- the effectiveness, feasibility and acceptability of new technologies;
- availability, acceptability and use of sexual and reproductive health services.

DISCUSSION

IMPLICATION OF FINDINGS

To date, the health of men, boys and LGBT survivors of CRSV has received limited attention by researchers and the international community. As a result, we have restricted information on what models of care could work better to respond to the specific needs of this population. Most existing evidence about interventions that targeted men as well as women was from evaluations of MHPSS interventions. However, because data was not disaggregated by gender, we could not draw any conclusions on the effectiveness and mechanisms of these initiatives. We identified no evaluation of interventions addressing the physical health of survivors, or that were relevant to the sexual and reproductive health of male and LGBT survivors of CRSV.

This limited evidence could be partially due to the more recent focus on men, boys and LGBT persons when compared to research and policy on female survivors of CRSV (Dolan et al., 2014; UN, 2018). Political agendas and priorities may drive humanitarian responses in politically fragile, insecure and resource-limited settings. This could be dependent on policy timing, other policies and local actors (ODI, 2001; McGoldrick, 2016). With increased recognition of widespread and systematic CRSV experienced by men, boys and LGBT persons in many conflict-affected settings (Dolan, 2014; Johnson, 2008; Johnson, 2010; Chynoweth, 2017), the time is now ripe for investments in evidence-building and intervention development and evaluation that addresses the needs of all survivors, independent of gender, sexual orientation, gender identity or other sex or gender differences.

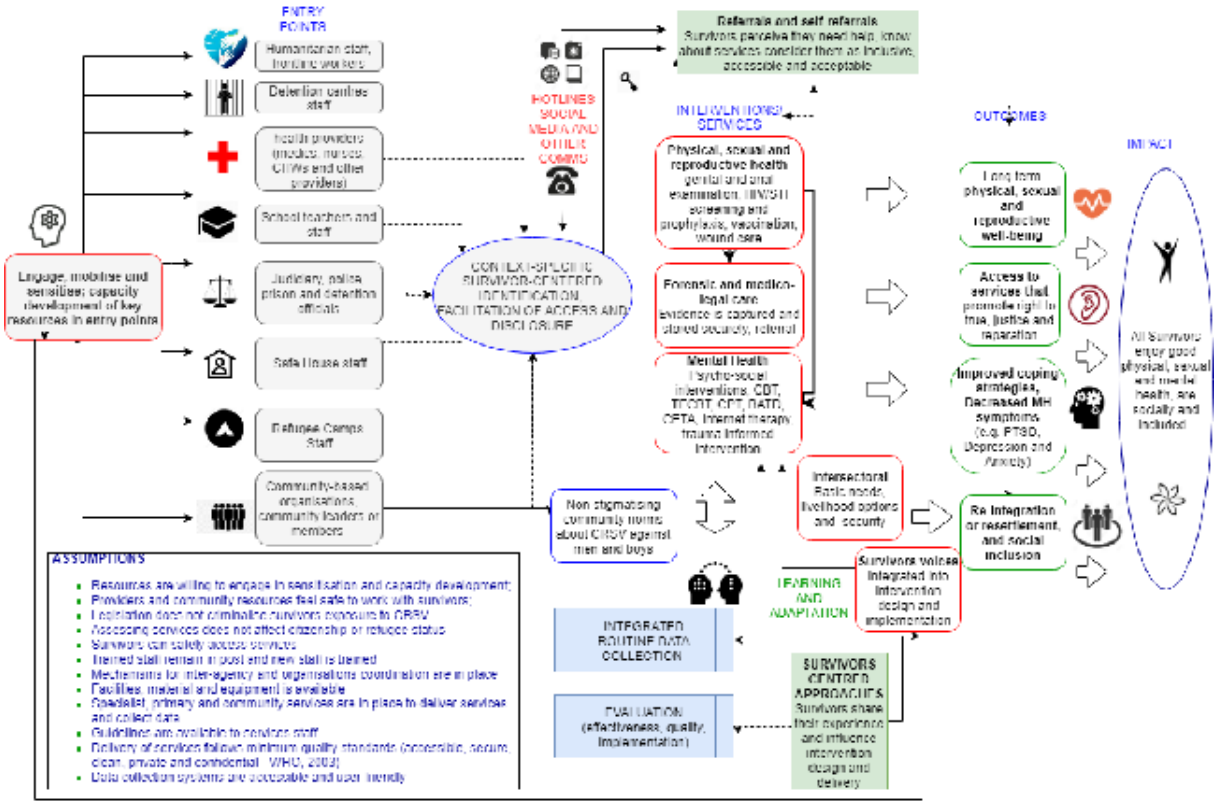
These investments, however, need to take into account the specificities of experiences, needs and expectations between different groups of survivors. Research suggests that there are important gender differences on how men, boys and LGBT survivors experience the trauma of sexual violence, access services and respond to interventions. For example, negative coping mechanisms such as antisocial behaviours, anger outbursts, aggression, self-mutilation, alcohol and drug abuse, risky sexual behaviour and suicidal behaviour tend to manifest more often among men than women (Forde & Duvvury, 2017; Street & Dardis, 2018; Kessler et al., 1995; Romano et al., 2001; Rosenfield, 2000; Teram et al., 2006; Donne et al., 2018; Haerich & Hall, 2011; Liang et al., 2017). These coping strategies can bring devastating consequences for survivors, their families and communities. These differences should be taken into account when designing research or developing and implementing health intervention that target these different groups.

Community resources and frontline workers are in a strategic position to respond to the needs of CRSV survivors. They can receive self-referrals, recognise cases, offer intersectoral referrals and provide assistance (Russell et al., 2011; Chynoweth, 2017a; Dolan, 2014; Gruber et al., 2018). However, they need to be aware and have the knowledge to deal with the specific needs of male and LGBT survivors (Davies, 2000). Primary health care providers and health professionals in refugee settings should also be sensitised and capable of responding to the

physical and mental health needs of men, boys and LGBT persons (ASP, 2018; Chynoweth, 2018). Women, girls, boys, and young men are all vulnerable to sexual violence, especially when during conflict or when they are fleeing these situations (Chynoweth, 2017a; Freccero et al., 2017; Hemono et al, 2018). It is also important that the health providers are alert to symptoms of CRSV and know how to link with other sectors to protect survivors.

Figure 4 proposes a high-level theory of change summarising interventions and models of care identified in our realist review of the literature. This framework was modified based on a critical review by experts and practitioners who participated in our Geneva expert meeting.

Figure 4. High-level theory of change for provision of health services in conflict-affect settings based on a realist review of health interventions for male and LGBT survivors of CRSV.



This framework is a general articulation of interventions' mechanisms as identified in our review. It summarises the rationale underpinning current interventions addressing the health of CRSV survivors, particularly emphasising issues relevant to male and LGBT survivors. This framework also lists main assumptions around mechanisms and outcomes, as described by the sparse body of evidence identified in our study. It can serve as a basis for developing context-specific theories of change based on input by potential service users and implementers but should not be interpreted as representing definitive pathways to effective service provision, which are inevitably context-specific.

The context of cultural and social norms affects how survivors, communities, and providers perceive and react to CRSV against women and girls as well as men, boys and LGBT persons

and available sources of help. Sometimes, local communities and stakeholders have specific understandings of violence, mental suffering and healing and can resist models of care developed or implemented by international organisations (McGoldrick, 2015; Spangaro, 2017; M'Cormack, 2018). Engaging local stakeholders and community influencers through sensitisation and awareness can help increase acceptability of interventions and inform their design, planning and implementation (Mbeya et al., 2018; Bennett et al., 2017; Loko Roka et al., 2014; Kohli et al., 2012). Moreover, relying on local resources may help design more feasible of interventions in contexts where funding, resourced and infrastructure are limited (Murray et al., 2014). Indeed, local practices, concerns, health infrastructure and social norms around CRSV against men, boys and LGBT are likely to vary in different conflict-affected settings. The interventions that mobilised social resources, used street drama or theatre, or relied on faith-based organisations were mostly designed for and used by women and girls. Faith-based organisations can be an important source of support in the access to and provision of health care (Tomkins et al., 2015). Nevertheless, disagreements between religion and health promotion should be considered in the design and implementation of faith-based models of care (Pyles, 2007; Tomkins et al., 2015). For example, controversies surrounding the religious treatment of homosexuality may prevent universal care targeting all survivors, and particularly the LGBT population (Tomkins et al., 2015).

In our review, we did not identify any models of sensitisation and awareness about CRSV that were designed for male and LGBT survivors of CRSV, or that took their voices and specific needs into account. Interventions targeting male and male and LGBT survivors need to be informed by evidence and understanding of the local culture to avoid causing harm to survivors.

Future studies should explore how men, boys and LGBT survivors interact (or not) with interventions, and whether the fact that they are generally designed for female survivors tend to push other groups away. Participatory research can help design, implement and disseminate research that is of higher quality, and is relevant and appropriate to each context. This type of approach also promotes more targeted research, stakeholders' ownership and capacity-building (Cargo & Mercer, 2008).

Supporting partners and families of male and LGBT survivors with services and treatment is important as well (Davies, 2000). As Coates (1979) stated the "partner's own grief may severely interfere with any support that the victim may need at this time".

International guidelines for the prevention and response to survivors of CRSV have been developed by UN agencies, inter-agency bodies and international NGOs. Both in our review and in consultation with experts, there was acknowledgment of the role and importance of these guidelines, protocols, and documents. They are considered instrumental in establishing consensus in the field around concrete actions and promoting best practices. Our review of medical and MHPSS guidelines developed by main international agencies found that attention to specific needs of men, boys and LGBT survivors of CRSV is increasing but still remains limited. Monitoring and evaluation approaches that access the implementation and

effectiveness of these guidelines in different contexts, and for diverse target groups, including men, boys and LGBT individuals can inform more inclusive models of care.

CONCLUDING REMARKS

The review found that there is a gap in the evidence on the provision of healthcare services to male and LGBT survivors of CRSV. To inform gender-appropriate and effective medical and MHPSS responses, further research needs to be conducted on these population groups.

The focus on male and LGBT survivors of sexual violence should not deviate attention, resources or otherwise negatively impact from the serious and pervasive problem of sexual violence against women and girls in conflict settings (Apperley, 2015; Myrttinen, 2018; Carlson, 2005). Instead, all survivors should have the right to receive assistance, regardless of their age, gender, sexual orientation or gender identity. This review was intended to inform health care models that go beyond binary constructions of gender to help create services that address the needs of all survivors.

Research and policies focussing only on heterosexual cis-women's risk to, and consequences of, CRSV restrict awareness and responses to the needs of male and LGBT survivors (Banwell, 2018; Hilhorst, 2018). This could expose these survivors, their families and communities to further health risks, and long-lasting social and economic problems (Arsenijević et al., 2018). With increasing attention to CRSV against men, boys and LGBT persons, the development and implementation of evidence-based responses that focus on the specific needs of these groups should not be postponed.

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