ALL SURVIVORS PROJECT

Survivor-centred healthcare for male victims/survivors of sexual violence

Multi-country synthesis report: Afghanistan, Colombia and Central African Republic (CAR)

December 2025

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All Survivors Project (ASP) is an international non-governmental organisation that supports global efforts to eradicate conflict-related sexual violence (CRSV) and strengthen national and international responses to it through research and action on CRSV against men and boys.

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1. Executive Summary

Healthcare systems in conflict-affected settings serve as critical entry points and healing pathways for male victims/survivors of sexual violence. Yet barriers such as internalised and social stigma, inadequate capacities and approaches, discriminatory attitudes, and policy gaps can prevent them from accessing healthcare.

Between 2020 and 2024, All Survivors Project (ASP), in collaboration with partners in Afghanistan, Colombia and Central African Republic (CAR), conducted research into these barriers and the opportunities available to address them. This multi-country study outlines how survivor-centred care for male victims/survivors is achievable when operationalised in line with the core principles of safety, confidentiality, respect and non-discrimination.

Methodology

This study prioritised victim/survivor perspectives and experiences as the foundation for understanding both the challenges and opportunities in healthcare provision and access. It centres the voices of those who have lived experience, including male victims/survivors who suffered sexual violence as children along with those with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC).

The study employed qualitative methodologies across all three country contexts to examine how survivor-centred approaches are defined and implemented in healthcare settings, and what the perceived gaps are in existing healthcare responses. Research methods included in-person interviews with 62 male victims/survivors and 135 key stakeholders. The stakeholders included healthcare providers, community health workers, gender-based violence (GBV) prevention and response practitioners, professionals working in LGBTI+ rights, advocacy and protection, child protection sectors, and those working in justice processes, including government officials and civil society representatives. Desk reviews of the literature on sexual violence against men and boys and of relevant laws and policies in each country were conducted, as was a mapping of the existing healthcare systems and relevant stakeholders in each setting.

The study adopted survivor-centred approaches that prioritised the safety and choice of participants throughout. It placed victim/survivor safety, well-being, and agency at the centre of all research activities. Ethics approval was secured from relevant Institutional Review Boards (IRBs) and national ethics committees in each country, with protocols designed for survivor-centred research. Rigorous ethical protocols ensured participant safety through trauma-informed approaches, secure data handling, in-country partnerships and established referral pathways to support services. Working through trusted national healthcare partner organisations, the study ensured safe access to victim/survivor participants while maintaining rigorous confidentiality and informed consent. An international advisory group comprised of survivor networks, sexual

violence and research ethics experts, academics, representatives from Médecins Sans Frontières (MSF), UN agencies, the Mukwege Foundation,[1] The Havens, and country experts also provided strategic guidance and country-specific oversight throughout the project.

Key findings

Using a socio-ecological framework, this study identifies multiple interconnected obstacles that male victims/survivors of sexual violence face when trying to access healthcare, with these obstacles operating at structural, organisational, community, interpersonal and individual levels. Many relate to the general weaknesses in the provision of healthcare and are therefore not specific to men and boys, however, some of the barriers identified were more gender-specific.

At the structural level, barriers included policy frameworks that were designed without consideration for male victimisation, limited healthcare infrastructure in rural areas, economic constraints, and legal complexities that may criminalise victims/survivors seeking help. Within healthcare services, provider knowledge gaps about male sexual victimisation and trauma-informed care, discriminatory attitudes, absence of clear protocols, resource constraints, and confidentiality failures undermining trust and access were identified as key obstacles. Community and interpersonal-level barriers included deep-rooted stigma, victim-blaming, family rejection, safety threats from perpetrators, poverty, and geographic isolation from facilities. At the individual level, internalised shame, a lack of awareness about available services, trauma symptoms affecting help-seeking ability, and compounded and specific challenges for boys and victims/survivors with diverse SOGIESC, further obstruct access to care.

Despite these persistent barriers, the study also reveals how survivor-centred care can be achieved when implemented thoughtfully. For example, facilities that are secure, private, in easily accessible locations and with rapid service provision can reduce barriers for male victims/survivors while maintaining confidentiality. The assurance of confidentiality, with clear explanations of principles and procedures, emerges as critical for victims'/survivors' willingness to engage with services across all contexts. Approaches that minimise re-traumatisation by requiring victims/survivors to share experiences only once rather than repeatedly to multiple providers respect dignity and psychological well-being. Eliminating financial barriers through free service provision and supporting transportation costs where needed proves essential given the economic constraints that prevent access for many victims/survivors.

Healthcare providers' attitudes and competence function as critical determinants of a victim's/survivor's engagement with services, serving as either significant barriers or enablers. When providers demonstrate calm, kind, and empathetic reception combined with professionalism and specialised training, they build victims'/survivors' confidence and willingness to engage with care. Holistic, integrated programmes addressing medical, psychosocial, and practical needs within coordinated models, (such as MSF's Tongolo

1 A member of the research advisory group moved from the Mukwege Foundation to Global Survivors Fund during this period.

Project in CAR, Youth Health & Development Organization's (YHDO) specialised services in Afghanistan, and Colombia's national Programme of Psychosocial Support and Holistic Health Care for Victims (PAPSIVI)) if designed and implemented adequately, have the potential to reduce the navigation burden for victims/survivors and ensure comprehensive support. Community-based support through trained community health workers serving as trusted intermediaries, and peer support networks helping reduce isolation, demonstrates powerful potential for bridging gaps between victims/survivors and formal healthcare systems. Where implemented, legal frameworks recognising conflict victims'/survivors' rights to priority healthcare access provide good foundations for advocacy and accountability.

Key recommedations

Addressing systematic barriers and implementing survivor-centred care for male victims/survivors of sexual violence will require coordinated interventions addressing all levels of the socio-ecological framework, from policy reform and provider training to community engagement and peer support networks.

Based on the study's findings, ASP makes the following recommendations to government representatives, policy makers, healthcare providers and all those who work with victims/survivors of sexual violence.

Structural level

- Expand existing healthcare services to include capacity for male victims/survivors through staff training on male victims/survivor needs, adapted physical spaces, and male-specific service pathways.
- Ensure strengthened primary healthcare in underserved areas as well as transportation support for victims/survivors.
- Update national protocols and guidelines to address male-specific needs, physiological differences, and trauma presentation variations.
- Clarify healthcare provider reporting obligations while protecting survivor confidentiality through clear guidance.

Organisational level

- Ensure robust training for all healthcare personnel and organisations providing support to survivors on survivor-centred care, thereby challenging myths about sexual violence and building professional competence.
- Train community health workers on confidential referral practices to serve as trusted intermediaries.
- Maintain adequate medical supplies and implement strict confidentiality protocols as critical enablers for service engagement.
- Design healthcare and other relevant facilities with discreet access and secure, private environments that respect victim/survivor dignity.
- Implement child-friendly services with age-appropriate and gender-sensitive communication and specialised care pathways. Train providers on evolving capacities of children and trauma-informed care.

- Implement staff training and inclusive and specialised services for victims/survivors with diverse SOGIESC.

Community, interpersonal and individual level

- Raise awareness about available services and victim/survivor rights through multiple communication channels. Challenge myths about male sexual victimisation through contextually-appropriate messaging designed in consultation with victims/survivors.
- Engage religious and community leaders to reduce stigma and increase support for victims/survivors.
- Fund male victim/survivor networks and peer support groups to contribute to recovery processes by, for example, reducing isolation, enabling survivor mobilisation and facilitating formal service access.
- Provide family-level interventions supporting reintegration and education about sexual violence.
- Balance trusted adult involvement with the protection of children's autonomy and privacy in accessing healthcare.
- Strengthen livelihood and economic support programmes to address displacement and poverty-related barriers to care.

Further research

- Deepen understanding of male victims/survivors' specific needs through further research. This includes research that is designed in consultation with victims/survivors and relies on context-appropriate methodologies, in-depth consultations and validation of findings with victim/survivor groups, and thorough assessments of healthcare service responses.
- Identify critical gaps in support and care to enable targeted and effective interventions.

2. Background

Over the past eight years, ASP has been conducting research on sexual violence against men and boys in several conflict-affected settings. In 2020, ASP initiated multi-country research in Afghanistan, Colombia and CAR examining how survivor-centred approaches are defined and implemented in healthcare settings, the perceptions and experiences of male victims/survivors, and the gaps in existing healthcare responses.[2] This report consolidates the findings from these three studies, taking into account the diverse and evolving forms, scales and patterns of violence in these three conflict-affected countries and populations. This research will help inform survivor-centred approaches in programmes and services relating to sexual violence in conflict settings to better address the multifaceted needs of male victims/survivors.

Across its body of research in all contexts, ASP consistently found that male victims/survivors face multiple challenges in accessing services such as healthcare, including mental health and psychosocial support (MHPSS) services, safety, and legal services. In some settings, men also raised concerns about their economic and livelihood situation. There is limited understanding of male victims'/survivors' specific needs and wishes for support and services, and how these may be different to those identified in studies relating to women and girls.

This study's focus on men and boys seeks to complement and reinforce existing work on sexual violence against women and girls, recognising the disproportionate impact of sexual violence on women and girls and the way in which gendered inequalities, institutions and identities drive this form of violence. This research aims to widen the scope of global efforts to include services and support to all victims/survivors regardless of their sexual orientation, gender identities and/or gender expressions and sex characteristics.

2 See individual reports for more country-specific information: Afghanistan (2020); Colombia (2023): Central African Republic (2025).

3. Methodology

Victim/Survivor voices

This study is grounded in the perspectives and experiences of 62 male victims/survivors of sexual violence and 135 key stakeholders, including healthcare providers, GBV experts, protection practitioners, UN Agency representatives, government officials and civil society representatives from across Afghanistan, Colombia and CAR. Research prioritised victim/survivor perspectives and experiences as the foundation for understanding both challenges and opportunities in healthcare provision, ensuring that recommendations reflect the actual needs and preferences of victims/survivors themselves. The research design incorporated specific consideration of boy victims/survivors, victims/survivors with diverse SOGIESC, and survivors of multiple marginalised communities.

Methods and research scope

Using qualitative methodologies across the three contexts, the studies conducted in Afghanistan, Colombia and CAR addressed three overarching questions:

- How are survivor-centred approaches to male victims/survivors of sexual violence defined and operationalised in healthcare?
- What are the perceptions and experiences of male victims/survivors in relation to healthcare services?
- What are the gaps in existing healthcare responses for men and boys who have experienced sexual violence?

The research combined multiple data collection methods, including in-depth interviews with male victims/survivors of sexual violence from diverse ages, ethnicities, sexual orientations, backgrounds and experiences.[3] All survivors interviewed (27 from Afghanistan, 10 from Colombia and 25 from CAR) met the following eligibility criteria: aged 18 or older,[4] documented experience of sexual violence, male-identified or identifying as male (including those with diverse SOGIESC), not currently experiencing or receiving treatment for serious mental health conditions, and having capacity to provide voluntary informed consent to participate.

3 These identities can substantially influence victims'/survivors' experiences, perspectives, support needs, and service preferences.

4 While the study excluded minors, adults who retrospectively reported experiencing sexual violence in childhood were included where such information was available.

Each in-country partner employed different engagement strategies with victims/survivors based on their organisational priorities and local context. In Afghanistan and CAR, interview participation focused on victims/survivors who had accessed services or support through in-country partners. In Colombia, interviewees were comprised of male victims currently in contact with a partner organisation. Sampling variations across countries reflected local safety and security considerations, and the need to capture victim/survivor diversity across multiple dimensions. The final sample included victims/survivors from diverse regions, with diverse SOGIESC, living with disabilities (all reportedly resulting from sexual violence), and some displaced as a result of victimisation. Several victims/survivors held community leadership roles.

Data collection with survivors employed contextually-appropriate methods tailored to each context. In Afghanistan, a vignette-based storytelling approach was used to enable culturally sensitive explorations of healthcare barriers. This method used hypothetical scenarios depicting sexual violence and healthcare pathways, allowing participants to discuss sensitive topics within a narrative framework that reduced direct personal disclosure, while still capturing meaningful data on access to care and service gaps. In Colombia, workshops were co-designed to create safe environments conducive to victim/survivor interviews, providing information about victims' rights, peer support, and referrals. These structured group settings facilitated trust-building among participants and enabled peer-to-peer support mechanisms while simultaneously allowing for individual data collection through interviews. The workshop format also provided opportunities to connect victims/survivors with relevant referral services. In CAR, victim/survivor interviews were conducted in-person at MSF facilities, ensuring access to a secure and familiar healthcare setting. All victim/survivor interviews were conducted in local languages (Dari and Pashto in Afghanistan, Spanish in Colombia and Sango in CAR), which was critical for ensuring linguistic accuracy, cultural understanding and rapport with participants.

In addition to interviews with male victims/survivors, other key stakeholders were approached and interviewed (in Afghanistan, 70 healthcare stakeholders were interviewed across three provinces, in Colombia, 34 key informants were interviewed, and in CAR, 31 key informants were interviewed). These key informants were identified through stakeholder mapping and snowballing processes, and represented diverse sectors including healthcare, MHPSS, forensic science, GBV, LGBTI+ rights, protection/child protection and justice. Research also included both desk reviews of available literature on sexual violence against men and boys and of relevant national laws and policies, and stakeholder mapping exercises to identify healthcare system structures and service providers.

Furthermore, the study employed a socio-ecological framework to examine both barriers and enablers across the three contexts, and what common patterns emerge. This approach recognised the interconnected nature of obstacles and facilitators, mapping how they function at structural, organisational, community, interpersonal and individual dimensions. The framework both demonstrates that male victims/survivors of sexual violence navigate multiple, compounding obstacles and identifies key facilitating factors that can improve access to appropriate care at all levels.

The image below provides definitions for each of these analytical levels.

Socio-ecological Framework

Ethics

The research across all three contexts adhered to rigorous ethical standards designed to protect participant safety and well-being. Ethics approval was obtained from relevant IRBs and local ethics committees in each country. The study in CAR also received MSF's Ethics Review Board approval. The research implemented comprehensive safety protocols with survivor access achieved through partnerships with trusted organisations and networks in each country. Trained and experienced researchers conducted interviews using trauma-informed approaches, with secure data storage, anonymised transcripts, and established referral pathways to appropriate support services should participants require assistance. All measures prioritised preventing additional risks or re-traumatisation. Particular attention was paid to ensuring informed consent processes were trauma-informed and contextually-appropriate, with participants retaining the right to withdraw consent at any time without consequence.

Research Advisory Group

An international research advisory group was established to provide high-level strategic and technical guidance for this research project. The group comprised of representatives from victims'/survivors' networks (Survivors Speak Out UK and Men of Hope Uganda), sexual violence experts, academics, representatives from UNHCR, UNFPA, UNICEF Research Office Innocenti, IOM, MSF, Mukwege Foundation, and The Havens (Kings College Hospital NHS Foundation Trust), as well as representatives from each of the three focus countries to provide country-specific oversight and guidance.

The advisory group supported the research by ensuring the quality of outputs, outcomes, and processes through several key functions. Members provided guidance on methodology and research ethics, reviewing and commenting on documents such as the concept note, research protocol, and interview guides. They identified relevant IRBs and supported ethics approval applications as needed. At the outset of the study, the overall international multi-country protocol was also submitted to the SEMA survivors' research advisory group as part of a consultation process to obtain their feedback regarding the relevance of the research to survivor groups.

Limitations

This research has several important limitations that should be acknowledged, and which have been previously detailed in the three separate country reports. In all three contexts, geographic scope was constrained, with the study not covering all departments and regions where sexual violence against men and boys has been documented, limiting the understanding of contextual variations in healthcare access and responses. Another significant limitation across all three contexts was the absence of direct input from boys, as only adult survivors participated in interviews. Retrospective insights were nonetheless gained from adults who experienced sexual violence as children and, in Afghanistan and Colombia, from healthcare providers who had treated boy survivors. Furthermore, there were limitations to capturing data on the specific experiences and needs of victims/survivors with diverse SOGIESC in some contexts. Another constraint related to

the healthcare experiences of victims/survivors included that all those interviewed in CAR were former MSF patients, preventing an exploration of the experiences of victims/survivors with other healthcare providers. In Afghanistan, the majority of interviewed victims/survivors and healthcare providers had limited or no direct experience with non-specialised healthcare services for male victims/survivors, meaning much of the data was based on perceptions or hypothetical scenarios rather than direct personal experience.

A survivor-centred approach - Definition

A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, they are treated with dignity and respect and is based on the following guiding principles:

- **Safety:** The safety and security of survivors and their children are the primary considerations.
- **Confidentiality:** Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
- **Respect:** All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.
- **Non-discrimination:** Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic. See, GBV AoR, Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, 2019.

4. Harms Affecting Male Victims/ Survivors

The research ASP and partners conducted across Afghanistan, Colombia, and CAR revealed that male victims/survivors of sexual violence endure profound and enduring consequences that extend far beyond the initial act of violence itself. These harms manifest across multiple dimensions of their lives, creating cascading effects that can persist for years or even decades without appropriate intervention and support.

Physical and psychological impacts

The **immediate physical trauma** experienced by male victims/survivors is often severe. Many victims/survivors, for example in Colombia, described requiring emergency medical intervention for injuries related to anal rape, with some cases resulting in **permanent damage to the sexual and reproductive health of victims/survivors**. This type of violence rarely occurs in isolation – some victims/survivors reported beatings and torture that left them with head injuries, broken bones, missing teeth, and permanent scarring. In some cases, the severity of these attacks resulted in lasting physical disabilities, chronic pain conditions, and sensory impairments, including vision and hearing loss that fundamentally altered their daily functioning and quality of life.

Beyond the immediate physical trauma, victims/survivors can contract **sexually transmitted infections (STIs)** that, without proper treatment, compound their long-term health challenges, as experienced by some of the interviewed victims/survivors. In CAR, for example, only five of the 25 interviewed victims/survivors and only one of the 10 in Colombia accessed healthcare within the critical 72-hour window to prevent HIV.

The **psychological and psychosocial consequences** of sexual violence against men and boys can be devastating and persistent. Victims/survivors consistently described experiencing depression, anxiety, and overwhelming feelings of hopelessness that permeated their daily lives. Victim/survivor participants in the three countries spoke explicitly about having suicidal thoughts, with some having attempted to take their own lives as the psychological burden became unbearable. The trauma manifests in disturbed sleep patterns, intrusive thoughts that interrupt their ability to function, and emotional dysregulation including anger, frustration and aggression that affects their relationships with family and community members.

Socio-economic consequences

The **socio-economic impacts** experienced by male victims/survivors create additional layers of vulnerability that can trap them in cycles of continued deprivation. In conflict settings like Afghanistan and Colombia, sexual violence was used as a deliberate tactic to force displacement, stripping victims/survivors

of their homes, land, livestock, and traditional sources of income. Approximately half of the interviewed victims/survivors in Colombia reported having been displaced as a direct result of the sexual violence they suffered. This forced displacement compounded the initial trauma by separating victims/survivors from their support networks and familiar environments, leaving them economically vulnerable and socially isolated.

Educational disruption represents another critical dimension of harm mentioned by participant victims/survivors, particularly for boys who experienced sexual violence during their formative years. In the three countries, male victims/survivors frequently referred to dropping out of school as a key impact of their experience of sexual violence, with **many of those who experienced it as children explaining that they were unable to complete their education**. For adult victims/survivors, the psychological impact was described as often interfering with their ability to **maintain employment** or complete professional development, creating long-term economic instability that affects not only the victims/survivors themselves but also their families and dependents.

Intersectional factors

The intersection of age and gender creates particularly **complex harm profiles for boys** who experience sexual violence. **In Afghanistan, the research showed that children's lack of knowledge about their bodies, including their sexual organs and how to recognise inappropriate sexual attention or touching,** means they often lack the understanding about what has happened to them or the vocabulary to communicate their experiences to adults. The research also showed that boys who are particularly vulnerable as victims/survivors often worry about negative family reactions and potential relationship breakdown due to cultural norms and shame associated with male sexual victimisation.

For male victims/survivors with diverse SOGIESC, harms are compounded by **additional layers of marginalisation**. In **Afghanistan**, the research found a lack of recognition by some healthcare providers of male victims/survivors with diverse SOGIESC as legitimate victims/survivors of sexual violence, with assumptions that these survivors may have consented to sexual acts. In **Colombia**, several victims/survivors who identified as gay or bisexual described wanting, due to the discrimination they would otherwise face, to be treated by healthcare workers who understood them.

5. Barriers and Enablers to Accessing Healthcare

Healing for male victims/survivors of sexual violence is shaped by a complex interplay of barriers and enablers operating across multiple levels, with the research showing how interconnected obstacles create a system of marginality that makes accessing even basic healthcare services extremely challenging. Many victims/survivors are surrounded by silence for months or years; in Colombia, for example, four victims/survivors had sought medical care only over a decade after the event, and one even 40 years later.

However, the research also revealed important factors and practices that can transform this landscape. The findings demonstrate what survivor-centred care can look like when implemented thoughtfully and comprehensively. These emerge both from programme examples and from survivors' own perspectives about what they need and value in healthcare services, illustrating how the same systems that currently present obstacles can be enhanced to provide accessible, dignified care for all victims/survivors. The studies show that for every barrier identified, there exist concrete approaches and enabling conditions that healthcare systems can adopt and develop to better serve male victims/survivors of sexual violence.

Structural level

At the structural level, the **scarcity of basic medical and mental health services** is particularly acute in remote and rural areas where many victims/survivors live, creating geographical barriers that are compounded by the absence of specialised care for sexual violence. In Afghanistan, Colombia, and CAR, long distances and prohibitive costs associated with travel were repeatedly highlighted by participants as a significant barrier to accessing healthcare. In CAR, basic medical and mental health services are particularly scarce in remote and rural areas, with CAR's public health system unable to provide most victims/survivors with care, especially those living outside of the capital, Bangui. In Colombia, remote and rural areas are poorly served, and there is a lack of availability of specialist services for victims/survivors of sexual violence outside of larger urban areas. The **chronic underfunding** of sexual violence responses further undermines the availability, sustainability, and continuity of services. In CAR, for example, insufficient and short-term funding for responses to sexual violence both within the public health system and for UN and INGO-led programmes undermines the availability, sustainability, and continuity of responses. The research also highlighted that the very architecture of existing healthcare systems across all three contexts is often designed without meaningful consideration for male victims/survivors of sexual violence.

The **legal and policy environment** creates additional structural barriers that can paradoxically harm victims/survivors even as it seeks to protect them. In Afghanistan for instance, the criminalisation of same-sex relationships creates a legal landscape where male victims/survivors fear that seeking healthcare might

expose them to prosecution, as healthcare providers may make assumptions about whether sexual acts were consensual or forced. In Colombia, a lack of clarity around health workers' obligations to report cases of sexual violence to judicial authorities, and in some cases a lack of willingness to report due to concerns of reprisals against them from the armed groups perpetrating these crimes, has affected the quality and confidentiality of care provided to male victims/survivors as they are not always referred to protection, justice and other services which they need and to which they have a right.

Despite these challenges, important structural enablers also emerged from the research. In Colombia, the **legal recognition** of conflict victims, including victims of sexual violence as "subjects of special protection" with priority access to healthcare, created an important structural foundation for ensuring victims/survivors' rights to appropriate care. In addition, jurisprudence by the Colombian Constitutional Court has established that travel to healthcare facilities located in another municipality should be covered by the state for both the victim/survivor and an accompanying person if required. While implementation challenges remain, this legal framework provides a basis for advocacy and accountability that, moving forward, could be leveraged to improve access to services.

Organisational level

Confidentiality

Victims/survivors in all three countries consistently reported **fears that their cases would be disclosed** by healthcare providers to family members, community leaders, or judicial authorities without their consent. These fears are often well-founded as healthcare facilities may lack proper protocols for confidentiality and information management or may operate in small communities where maintaining anonymity can be challenging in practice. In Afghanistan, male victims/survivors who were interviewed reported strong fears that healthcare providers would disclose their cases to judicial actors without their consent. In Colombia, a lack of privacy in healthcare facilities and a lack of respect for patient confidentiality by healthcare workers and non-medical personnel were seen as significantly contributing to the reluctance of victims/survivors to seek medical and other healthcare.

The **assurance of confidentiality and the implementation of concrete measures** therefore emerged as one of the most critical enablers for victims'/survivors' willingness to engage with healthcare services across all three contexts. In Colombia, where national protocols require that healthcare personnel ensure conditions of confidentiality and privacy throughout the care pathway, measures have been taken to comply with these requirements, including through the introduction of a colour coding system (Code Fuchsia). This is used to activate procedures under the Ministry of Health's sexual violence protocol, which helps to protect the identity of victims/survivors of

sexual violence. In CAR, a key learning from MSF's Tongolo Project was that the physical design and location of healthcare facilities were fundamental enablers, with victims/survivors describing how the enclosed, secure compound of the clinic made them feel safe and protected in a private setting. The accessibility of the location (easy to find yet discreet) removed practical barriers while maintaining the privacy that victims/survivors needed. Equally important was the rapid access to care that victims/survivors received once they arrived at the facility, something valued by several of the participants of this study. Moreover, participants in CAR reported that they felt reassured and engaged with services when confidentiality principles and procedures were clearly explained to them.

Another key enabler relating to confidentiality was identified through the MSF programme's approach in CAR of **minimising repeated disclosure** of traumatic experiences. Rather than requiring victims/survivors to retell their experiences to multiple providers throughout their care journey, the MSF model ensured that victims/survivors typically needed to share their story only once, respecting their dignity and psychological well-being. This approach aligned with what survivors in Colombia emphasised as essential: the need for holistic care without being referred from one place to another and having to repeat their experiences of sexual violence to multiple people.

Protocols & models

The **absence of adequate resources and specific medical protocols** for handling male-directed sexual violence cases means that healthcare providers often lack both clear guidance and essential tools for appropriate care provision. In Afghanistan, procedural gaps create inconsistent responses that may fail to meet victims/survivors' needs, or inadvertently cause additional harm through inappropriate questioning, examination, or referral practices. Resource limitations within facilities further compromise the quality of care that can be provided. In CAR, some healthcare facilities lack basic equipment and medication, while in Colombia, according to some key informants, under-resourced and ill-equipped health facilities can lack even basic diagnostic tests for HIV, post-exposure prophylaxis (PEP) kits and STI screening and treatment.

Despite these constraints, examples of effective models of healthcare provision for victims/survivors were identified. **Specialised, holistic programmes and facilities** that addressed medical, psychosocial, and practical needs within coordinated service delivery models reduce the burden on victims/survivors to navigate multiple systems while ensuring comprehensive support for their recovery. In CAR, MSF's Tongolo Project exemplified this approach by providing integrated medical treatment, MHPSS, and guidance on legal action and protection within a single, secure facility. In Afghanistan, the existence of standalone, specialised healthcare facilities for male victims/survivors of sexual violence most at risk (including those with diverse SOGIESC), such as the ones which were operationalised by YHDO, serve as a good example of holistic care,

providing psychosocial counselling, testing for HIV and other STIs, as well as services such as justice and livelihoods support. Afghanistan's Family Protection Centres have in the past provided a model of multi-sectoral response that integrates healthcare, legal support, and psychosocial services within government hospital settings. In Colombia, the Programme of Psychosocial and Integral Health Care for Victims provided a framework that could be strengthened to offer holistic support to victims/survivors through reform and integration into the regular healthcare system. With enhanced resources and gender-sensitive capacity, they could provide integrated care for all victims/survivors.

Findings across all three contexts showed how cultural competence that considered ethnic, cultural, and regional differences ensured that services were relevant and acceptable to diverse survivor populations.

Professional standards

The **capacities, attitudes and behaviours of healthcare workers** served as either significant barriers or powerful enablers to victims/survivors' healthcare experiences. Across the three contexts, the profound lack of healthcare worker capacity to recognise and respond appropriately to male victims/survivors was evident, with several healthcare providers who were interviewed reporting that they had never received training on supporting male victims/survivors, leaving them ill-equipped to provide appropriate clinical care or emotional support.

In Afghanistan, research showed that healthcare providers lack knowledge and awareness of the different needs of adult and child male victims/survivors of sexual violence, and an understanding of how the evolving capacities of the child should be integrated into healthcare responses. In Colombia, key informants pointed to a lack of knowledge and expertise among health professionals on responding to sexual violence in general, and of recognising the signs or knowing how to respond appropriately to male victims/survivors.

This knowledge gap is compounded by discriminatory attitudes that manifest as victim-blaming, scepticism about whether men and boys can be victims of sexual violence and linking experiences of sexual violence to a victim's/survivor's real or perceived sexual orientation. These assumptions are rooted in broader societal beliefs about who can legitimately experience sexual victimisation. These discriminatory attitudes intensify for victims/survivors with diverse SOGIESC, compounding their marginalisation within healthcare settings. Victims/survivors with diverse SOGIESC in Colombia, for example, reported encountering healthcare providers who questioned their responsibility for the violence, whether they truly experienced assault or if it was consensual activity, or made inappropriate comments such as they "were gay because they were raped" or that they were "promiscuous". In Afghanistan, male victims/survivors who identified as heterosexual highlighted the fear of being perceived as gay. Conversely, those who identified as gay said that they feared that they would be judged precisely because

> *"Many doctors and nurses and ordinary people see you there and the first thing you think is that they are going to point out that you have a sexually transmitted disease. So that's why I felt very bad. I felt ashamed, dirty, dirty...because most of the people who were there realised why I was going. I didn't feel judged, but I did feel singled out."*
>
> (Victim/Survivor, Colombia)

of their sexual orientation and reported heightened fears about safety in healthcare facilities, including concerns about experiencing additional discrimination or sexual abuse by providers themselves. In this same context, victims/survivors who identified as gay or bisexual emphasised their need for healthcare workers who understood them and the discrimination they face, reflecting the deeper trust deficit created by provider scepticism and victim-blaming attitudes.

> *"It's only because of the counselling that I received at MSF that I feel comfortable to go out now."*
>
> (Male Victim/Survivor, CAR)

The perceived professionalism and competence of healthcare staff emerged as a critical enabler that built victims'/survivors' confidence in the care they were seeking. Victims/survivors in CAR reported feeling that MSF staff were well-trained and possessed appropriate skills for working with people who had experienced sexual violence. In Colombia, male victims/survivors particularly emphasised the importance of being treated by skilled, experienced medical personnel and other healthcare professionals who are both trained in and have experience of working with victims/survivors of sexual violence. In Afghanistan, despite limited specific training on male victims/survivors, most healthcare providers interviewed had knowledge about the characteristics of a survivor-centred approach and were able to articulate how such an approach would be implemented.

Moreover, supportive and respectful attitudes by healthcare providers emerged as an important factor in a victim's/survivor's care. In CAR, participant victims/survivors used words like "calm", "kind", and "empathetic" to describe their reception in MSF facilities, highlighting how much these interpersonal dynamics mattered to their overall experience. In Afghanistan, when healthcare providers were asked how they would treat male victims/survivors of sexual violence attending their healthcare facility, the majority emphasised their commitment to respectful, empathetic care toward all victims/survivors, without blame or judgment.

Victim/Survivor participation

Across all three contexts, victims/survivors emphasised that a survivor-centred approach requires the involvement of those who have experienced sexual violence in conflict settings at all stages of the response, from design and implementation to monitoring and evaluation. In Colombia, while the Victims Law provides for the establishment of Victim Participation Roundtables at the national, department and municipal level, which include victims of sexual violence, participant victims/survivors in this study raised concerns about the lack or limited representation of male victims/survivors of sexual violence in these processes. In CAR, while several key informants explained how vital systematic feedback mechanisms are to capturing individual victim/survivor experiences of accessing and receiving services, and to receiving suggestions to help inform and improve the work of their organisations, to ASP's knowledge there is very limited representation of victims/survivors in higher-level policy and planning discussions in CAR, and no male victims/survivors are known to have participated in consultations on the development of national policies, plans, procedures or guidelines on responding to sexual violence.

Community and interpersonal level

At the community and interpersonal level, deep-rooted cultural taboos and safety concerns create significant barriers to care-seeking. At the same time, trusted community intermediaries and peer support networks can serve as powerful enablers for survivors to access healthcare.

The main barriers identified by the research relate to deep-rooted cultural taboos and misunderstandings about male sexual victimisation. These **social attitudes** feed into victims/survivors' fears of stigmatisation by family and community members, leading to concerns about shame, rejection, loss of social standing, and family breakdown that may seem worse than continuing to suffer in silence. The perpetuation of myths in Afghanistan, for instance, creates an environment of judgement and disbelief that victims/survivors anticipate encountering when they seek help. In Colombia, at a community level, stigmatisation (or fear of it) creates an environment which can make it difficult for victims/survivors to trust those around them.

Safety concerns represent another critical community-level barrier, as victims/survivors often face ongoing threats from perpetrators who may be powerful actors within their communities. The failure of protection systems to adequately safeguard victims/survivors means that seeking help may actually increase their risk of further violence or retaliation, creating an impossible choice between personal safety and access to care. In Colombia, almost all interviewed victims/survivors said that they had been threatened with death or other harm, to themselves or their families, by their perpetrators if they reported what had happened or sought help; this had prevented many of them from seeking emergency medical treatment. In CAR, interviewees expressed fears of punishment or retribution from powerful and armed actors if healthcare providers were to report cases of sexual violence to judicial authorities.

Alongside these barriers, the research identified **community-level enablers** that could support survivors' engagement with care. One concerns the **potential role of trained community health workers** who could serve as trusted intermediaries between victims/survivors and formal healthcare systems. In Afghanistan, when properly trained on confidential, survivor-centred care principles, these community-based providers help bridge the gap between victims/survivors' immediate needs and available services, reducing the initial barriers to accessing formal healthcare facilities. In Colombia, community-based education and outreach efforts showed potential for improving awareness and access to healthcare for male victims/survivors.

Peer support networks represent another powerful enabler that helps male victims/survivors overcome isolation and self-blame, while also providing practical support for navigating healthcare and other systems.

In Colombia, victims/survivors who had connected with other male victims/survivors described how these relationships helped them realise they were not alone in their experiences and provided valuable guidance about accessing services and advocating for appropriate care.

Individual level

At the individual level, the **internalisation of social stigma** potentially creates one of the most difficult barriers to help-seeking. Survivors often reproduce the same victim-blaming narratives that exist in their communities, directing shame and responsibility towards themselves rather than recognising their victimisation and right to support. In Afghanistan, 'blame the victim' discourses are reproduced and directed onto other victims/survivors. In Colombia, self-stigmatisation and feelings of shame and embarrassment were common among the interviewed victims/survivors and had not only prevented them from telling family and friends but also made them reluctant to seek healthcare or disclose what had happened to them if they did.

Knowledge gaps represent another critical individual-level barrier, as many victims/survivors lack basic information about what services might be available to them or how to access those services. In Afghanistan, a lack of knowledge of available services and how to access a healthcare facility was particularly noted among boy victims/survivors. In Colombia, when healthcare services for victims/survivors of sexual violence are available, male victims/survivors are often not aware of them, do not have information about how to access them, or believe they are only for women and girls. The barriers faced by boys introduce additional complexity due to their developmental stage and dependency on adult gatekeepers for accessing healthcare. In Afghanistan, healthcare providers explained that children's lack of knowledge about their bodies, including their sexual organs and how to identify inappropriate contact, means they may not understand that they have experienced violence, or may lack the vocabulary to communicate their experiences to adults. Their dependence on family members or other adults to facilitate healthcare access creates vulnerability if those gatekeepers are unwilling or unable to recognise and respond to signs of sexual victimisation.

Economic factors operate as both barriers and enablers in victims/survivors' access to healthcare. For many of the study's participants across the three contexts, the economic realities of their situations created insurmountable barriers to accessing healthcare, with measures such as free care provision and coverage of transportation costs transforming a victim's/survivor's ability to access services. In Afghanistan,

poverty and an inability to pay for services (including fees at private healthcare facilities, often perceived to be of higher quality and safer) and for medications or other services in government facilities, were highlighted as important barriers. In Colombia, victims/survivors explained how the direct costs of medical care, transportation to reach facilities, and lost income from time away from work can be prohibitive for families already struggling with poverty. These economic barriers are particularly acute for victims/survivors who have been displaced or whose livelihoods have been disrupted by the violence they experienced. Free care provision therefore emerged as a significant enabler to accessing healthcare. In CAR, for example, victims/survivors highlighted that MSF's free provision of services was a critical factor in their decision to seek care, particularly given the economic disruption many had experienced.

6. Recommendations

Based on the findings of this multi-country study, ASP makes the following recommendations to government representatives, policy makers, healthcare providers and all those working with victims/survivors of sexual violence in conflict settings to strengthen survivor-centred healthcare for male victims/survivors.

Structural level

Service development

- **Ensure existing healthcare services include capacity for male victims/survivors.**
    - Existing specialised sexual violence services provide valuable infrastructure that could be enhanced to adequately address the needs of male victims/survivors. Although currently some of these services have limitations in serving male victims/survivors, they represent multi-sectoral models that integrate health, legal, and psychosocial support. Expanding these models to offer care to male victims/survivors should include training existing staff on male victim/survivor needs, adapting physical spaces for privacy and safety, and developing male-specific service pathways within current facilities, all the while ensuring that comprehensive support, spaces and pathways are available for women and girl victims/survivors.
    - Comprehensive, survivor-centred care for male victims/survivors is achievable when services are appropriately designed with secure facilities and rapid access protocols. These services should integrate medical, psychosocial, and referral support all within accessible facilities, ensure single disclosure practices to avoid re-traumatisation and provide a choice of provider gender to ensure comfort and respect for victim/survivor preferences.
- **Ensure equitable geographic coverage of services including for remote and rural areas.**
    - Victims/survivors in remote and rural areas face significant additional barriers to accessing healthcare services, including a lack of specialist services outside urban centres, prohibitive travel costs, and limited transportation options. Geographic isolation compounds existing barriers and creates inequities where location determines access to care. Governments should prioritise expanding service coverage through mobile outreach teams, strengthening primary healthcare in underserved areas, and strengthening transportation support programmes to ensure access.

Protocols, guidance and legal frameworks

- **Update national protocols and guidelines to include male-specific needs and considerations.**
    - Responses to sexual violence within healthcare systems are often designed with limited acknowledgment that men and boys can be victims/survivors, leaving healthcare providers without guidance for male-specific needs and responses. Updated guidelines should address physiological differences, trauma presentation variations, and specific referral and care

pathways for male victims/survivors. These protocols must include considerations for boys and victims/survivors with diverse SOGIESC to ensure comprehensive coverage and appropriate clinical responses.

- **Clarify healthcare provider reporting obligations while protecting survivor confidentiality.**
    - Confidentiality considerations are paramount for male victims/survivors. Clear guidance on maintaining confidentiality while clarifying mandatory reporting requirements reduces provider uncertainty. It will also ensure informed consent and that victims/survivors understand and control disclosure decisions.

Organisational level

Capacity-building

- **Ensure robust training for all healthcare providers and other relevant personnel on survivor-centred care for male victims/survivors.**
    - Male victims/survivors have concerns for their safety when considering accessing health facilities, including concerns about potential non-respectful attitudes, emotional mistreatment, and abuse by healthcare providers and non-medical personnel. The research shows that many healthcare providers lack knowledge about male victims'/survivors' unique needs, and have had inadequate training to fill these knowledge gaps; as such, context-specific training should be offered to challenge myths about causes of sexual violence and justifications for perpetrator actions. Regular training can contribute to maintaining professional competency, helping to create safer, more supportive healthcare environments for all male victims/survivors. To ensure sustainable change, incorporating information about male sexual violence into national medical curricula would contribute to creating long-term capacity while normalising this as a health issue requiring professional response, ultimately building systemic competency and reducing stigma among future healthcare professionals.
- **Train community health workers on confidential, appropriate referral practices.**
    - Community health workers can play important roles in supporting male victims/survivors when properly trained on survivor-centred care. They can serve as trusted intermediaries, bridging gaps between victims/survivors and formal healthcare systems. Training of community health workers should emphasise confidentiality, trauma-sensitive communication, and safe referral procedures that protect victim/survivor autonomy while extending appropriate outreach into communities which have limited access to formal health services.

Service safety, confidentiality and quality

- **Ensure availability of essential medical supplies and implement strict confidentiality protocols.**
    - Health facilities are often under-resourced, lacking basic diagnostic tests, prevention kits, and treatment supplies, compromising care quality for victims/survivors. They also often do not implement robust confidentiality measures. Healthcare facilities must consistently maintain adequate medical supplies and establish clear procedures and practices covering information

sharing, record storage, and access controls, which build victim/survivor trust and prevent possible breaches in confidentiality that could endanger victims/survivors.

- **Design facilities to allow discreet access and secure, private environments.**
    - The physical design of healthcare facilities significantly affects victims'/survivors' feelings of safety and willingness to seek care. Facilities should provide secure spaces with discreet access and offer private consultation spaces for confidential disclosure and examination. Thoughtful facility design that uses participatory approaches to integrate the perspectives of victims/survivors demonstrates respect for survivor dignity, acknowledges the sensitive nature of sexual violence services, and creates environments where all victims/survivors feel safe to seek and continue care.

Age-responsive approaches

- **Implement child-friendly services with age-appropriate communication and specialised care pathways.**
    - Children may lack knowledge about their bodies and be unable to recognise inappropriate contact. In addition, children who have experienced sexual violence frequently face educational disruption due to the impact of trauma. Evidence emphasises the need for gender sensitive and age-appropriate approaches that respect developmental differences. Child-friendly services should use specialised communication techniques, visual aids, and age-appropriate language, as well as offer welcoming physical environments that respect a child's evolving autonomy and developmental needs.
- **Train healthcare providers on evolving capacities of children and trauma-informed care for boys.**
    - Healthcare providers often lack knowledge and understanding of the different needs of adults and children and the importance of integrating evolving capacities of children into care responses. Training of healthcare providers should address how sexual violence affects child development, should include communication strategies for different ages, should consider gender, and should include procedures for sensitive examinations and interviews that minimise the risk of further trauma.

SOGIESC-inclusive services

- **Implement inclusive services considering victim/survivor diversity.**
    - Victims/survivors with diverse SOGIESC face heightened risks of experiencing discrimination and further abuse by healthcare providers. Healthcare services must be designed to ensure inclusive access and must respond to the specific needs of these victims/survivors, taking into account their individual experiences. Providing a choice of healthcare provider gender respects comfort levels based on experiences and identity, while specialised safety protocols can address additional risks both within facilities and communities. Enhanced confidentiality measures, discrete service provision, and emergency safety planning may be necessary for high-risk victims/survivors.

- **Train providers and staff on SOGIESC-sensitive care to address discriminatory attitudes and assumptions.**
    - Evidence suggests healthcare workers can make harmful assumptions about victims/survivors based on their perceived sexual orientation or gender identity, heightening the risk of discrimination and further abuse within healthcare settings. Providers and staff require specialised training on delivering respectful, non-judgmental care that uses inclusive language, respects chosen identities, and acknowledges victims'/survivors' experiences without making assumptions based on perceived sexual orientation or gender identity. Training must help providers understand how discrimination intersects and can compound sexual violence trauma, as well as develop their skills to provide contextually-competent care that treats all victims/survivors with dignity, regardless of their SOGIESC. Comprehensive training must also address assumptions about consent, victim credibility and appropriate treatment throughout facilities, including for security and administrative personnel who interact with victims/survivors during their care journey.

Community, interpersonal and individual Level

Awareness and stigma reduction

- **Raise awareness about available services and survivor rights.**
    - There is a widespread lack of knowledge about available healthcare services among male victims/survivors, particularly boys, with many assuming services are designed only for women and girls. Victims/survivors need increased awareness about their rights and confidentiality protocols to address fears about seeking help. Multiple communication channels ensure a broad reach, while targeted approaches address specific community needs and provide practical information about available healthcare services and access procedures.
- **Promote community awareness that challenges myths about male sexual victimisation.**
    - Pervasive myths that justify violence perpetration and deep-rooted constructs of masculinity affect attitudes toward male victims/survivors. Community taboos and misunderstandings about male sexual violence also create stigma that prevents help-seeking. Awareness and educational efforts should challenge harmful myths by providing accurate information through contextually-appropriate messaging designed in consultation with victims/survivors to ensure stigma is reduced and that trust is built.
- **Work with religious and community leaders to reduce stigma and support victims/survivors.**
    - Community taboos represent major barriers requiring influential figure engagement to shift harmful social norms. Community and religious leaders, including those who are victims/survivors themselves, can play important roles in reducing community-level stigmatisation and obstacles to seeking support. Leaders require education and

> *"I'd like to see more awareness-raising, clearly informing the public that care for victims of sexual violence concerns men as well as women. Even me, I thought it only concerned women and it was thanks to my friend that I found out."*
>
> (Male Victim/Survivor, CAR)

information about sexual violence, victim/survivor needs, and appropriate support responses so they can effectively advocate for victims/survivors and promote positive community change.

Support systems

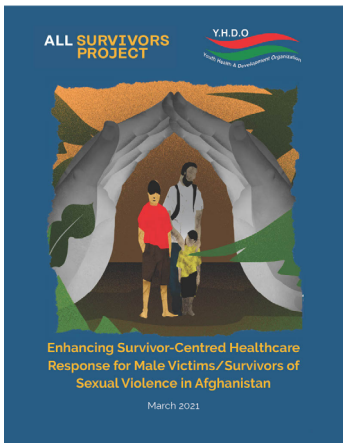
- **Fund and facilitate male victim/survivor networks and peer support groups.**
  - Peer support is particularly valued by male victims/survivors, with networks providing mutual understanding through shared experiences. These networks can effectively reduce self-blame and isolation, challenge internalised stigma and facilitate access to formal services. Dedicated funding is essential to establish and sustain these networks, enabling victims/survivors to mobilise as leaders, connect with others who share similar experiences, provide practical guidance for navigating healthcare systems and recovery processes, and advocate for their rights.
- **Provide family-level interventions that support reintegration.**
  - Victims/survivors carry significant fears about negative reactions from their families if their experiences become known, with the worry of family rejection representing a major barrier to help-seeking. This dynamic can compound trauma and deny a victim/survivor of a vital support system. Interventions should promote family and community healing through education about sexual violence, communication facilitation, and support for family members to strengthen survivor support systems.
- **Ensure trusted adult involvement while respecting children's autonomy and privacy.**
  - Boys often depend on trusted adults for healthcare access while requiring privacy protection. Care approaches should balance adult involvement with respect for children's preferences and comfort levels, particularly regarding disclosure and examination procedures. Clear guidelines can help providers navigate complex dynamics and prioritise child safety and evolving capacities. Providing information to adults through various communication channels about healthcare considerations and options for boy victims/survivors can help improve access.
- **Strengthen education, livelihood and economic support programmes.**
  - Many victims/survivors experience displacement, and education and economic disruption as a direct result of sexual violence. Conditions of poverty represent an important barrier to accessing services, for example affecting an individual's ability to afford transportation and other fees. Limited access to education, illiteracy, and economic vulnerability following sexual violence affect a victim's/survivor's ability to access care and can trap them in cycles of further exploitation. Programmes should include immediate assistance for basic needs, transportation support, and longer-term livelihood development and education opportunities to enhance victim/survivor agency.

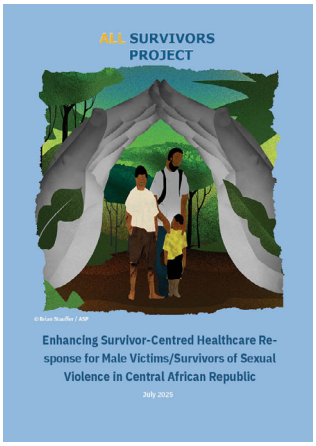
Further research

- **Enhance understanding of sexual violence against men and boys.**
  - Further research is essential to deepen understandings of male victims'/survivors' specific needs and experiences. This should include in-depth consultations and ongoing meaningful,

non-extractive collaborations with victim/survivor groups, combined with thorough assessments of how existing healthcare services are currently responding - or failing to respond - to their needs and wishes. Through these consultations and evaluations, critical gaps in support and care can be identified, enabling more targeted and effective interventions that genuinely address what male victims/survivors require.

For more detailed analysis and country-specific findings, see full reports:





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