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COIMBRA

Nélia Catarina Estêves Neves

THE PHYSICAL, MENTAL AND SOCIAL CONSEQUENCES IN VICTIMS OF CONFLICT-RELATED SEXUAL VIOLENCE: A SYSTEMATIC REVIEW (1992-2019)

Dissertação no âmbito do Mestrado em Psiquiatria Social e Cultural orientada pelo Professor Doutor Manuel João Rodrigues Quartilho e coorientada pela Professora Doutora Sílvia Roque apresentada à Faculdade de Medicina da Universidade de Coimbra.

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"We are still alive. We have been harmed but we are brave and strong"

Sexual violence survivor from Bosnia and Herzegovina

Medica Zendica and Medica Mondiale., 2014

Agradecimentos

À minha mãe;

"Ela disse tem cuidado
Vê se abrandas um bocado
Não ponderas nem sossegas
Não pertences nem te entregas
De verdade a nenhum lado

Ela disse meu rapaz
Sabes bem do que és capaz
O mundo espera por ti
Segue em frente e sorri
Não queiras ficar para trás

Ela lê no meu olhar
Ou na minha alma aberta
Não sei bem como consegue
Mas por muito que eu o negue
Minha mãe está sempre certa"

Os Quatro e Meia, "minha mãe está sempre certa", 2018

Ao meu pai e às mudanças.

À minha família, em especial as quatro grandes mulheres da minha vida. Avó obrigada pelo *tough love.* À minha Tia Célia que age como uma segunda mãe e a qual nunca vou conseguir demonstrar a minha infinita gratidão. À Marli e Isabela que são o meu pilar fundamental. Sem vocês nunca teria chegado onde cheguei.

À minha segunda família, os amigos. Aos de longa data e aos mais recentes. Os que aturaram os meus choros, o que me seguraram pela mão, os que foram inalcançáveis perante a minha doença e aos que nunca desistiram de mim, mesmo quando eu fui a pessoa mais difícil do mundo. Sem vocês tinha deixado de lutar, e se nunca deixei, foi porque vocês nunca me deixaram. Independentemente do percurso das nossas vidas, estarão sempre no meu coração.

Queria agradecer à Faculdade de Medicina da Universidade de Coimbra. À Faculdade de Economia da Universidade de Coimbra onde aprender a desenvolver o meu espírito crítico. Ao meu Orientador, Manuel João Quartilho e as minhas Co-orientadoras Sílvia Roque e à Rita Santos pelas oportunidades e as críticas construtivas.

Abstract

The aim of this systematic review is to look at the physical, psychological and social health outcomes for male and female civilian victims of conflict-related sexual violence. Data in armed-conflict tends to focus almost exclusively on the number of deaths and casualties which occurred, rather than outcomes of specific acts, such as sexual violence. The aim of this systematic review is to explore the data available and highlight the lack of attention male victims of conflict-related sexual violence receive from the international community to contribute towards the improvement of policy making and global health.

Keywords: Sexual Violence, Conflict, Global Health, International Community, Systematic Review.

Resumo

O objetivo desta revisão sistemática é analisar as consequências de saúde físicas, mentais e sociais em vítimas civis de violência sexual provenente de períodos de conflito armado. Os dados em conflito armado tendem a focar nas mortes e no número de lesionados que ocorreram, e não sobre actos específicos, como a violência sexual. O objetivo desta revisão sistemática é explorar os dados disponíveis e realçar a falta de atenção que vítimas maculinas recebem por parte da comunidade internacional de forma a contribuír ao policy-making e à saúde global.

Palavras-Chave: Violência Sexual, Conflito, Saúde Global, Comunidade Internacional, Revisão Sistemática.

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Abbreviations

Conflict-Related Sexual Violence – CRSV

Diagnostic and Statistical Manual of Mental Disorders – DSM

Human Immunodeficiency Virus – HIV

Inter-Agency Standing Committee Guidelines – IASC Guidelines

International Lesbian, Gay, Bisexual, Trans and Intersex Association – ILGA

International Criminal Court – ICC

International Criminal Tribunal for Rwanda – ICTR

International Criminal Tribunal for the Former Yugoslavia – ICTY

Post-Exposure Prophylaxis – PEP

Post-Traumatic Stress Disorder – PTSD

Secretary General of the United Nations – UNSG

Sexual Violence in Armed Conflict Dataset – SVAC Dataset

United Nations – UN

United Nations Secretary Council – UNSG

Uppsala Conflict Data Program – UCDP

Women's Peace and Security Agenda – WPS Agenda

World Health Organization – WHO

Introduction

Sexual violence is widespread globally, eroding progress toward human rights and public health, and is detrimental to the health of survivors of violence, as well as the well-being of their families and communities (Kuo *et al.,* 2018, p.291).

Armed conflict[1] between warring states and groups within states have been major causes of ill health and mortality for most of human history (Murray *et al.,* 2002, p.346; Williams et al., 2018). Wartime rape and sexual violence have likewise negatively impacted thousands physically, psychologically and socially and can be used by soldiers to destroy families, individuals and communities (Pruitt, 2012, p.300) (Ward, C.A. 2013, p.190). According to the World Health Organization (WHO), the victims of war and armed conflict are placed in situations where they become more vulnerable to sexual violence[2].

The world has been a continuous battleground for armed conflict[3] since the end of World War II. The Second half of the 20th century and the start of the 21st century has seen a staggering 254 armed conflicts take place worldwide[4] (Themnér & Wallensteen, 2014). Settings affected by armed conflict result in high levels of location insecurity which severely affect civilian populations[5] (Marsh *et al.,* 2006), leading to what internationally is defined as a *complex emergency*[6] incited by warfare which has occurred from the breakdown of political, economic and infrastructural collapses (such as health and social facilities) and continuous violence (Murray *et al.,* 2002; Mollica *et al.,* 2004; Cuadro & Gonzalez, 2014). Civilian populations are made vulnerable because they are incessantly at risk to the burden of conflict, due to mass violence, insecurity and human rights violations which occur systematically. The internal collapse of services along with injuries sustained from violent acts suffered from armed conflict has resulted in increasing global public

[1] Armed conflict like many other terms does not have a unitary definition. I have chosen to adopt the definition provided the United Nations Development Programme (UNDP) and developed by Uppsala Conflict Data Program (UCDP). "An armed conflict is a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year." For a conflict to reach the definition of war, the intensity of battle-related deaths is 1,000 (Themnér & Wallensteen, 2014).

[2] See link https://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/

[3] Armed conflict and wartime will be used simultaneously along the development of this dissertation.

[4] Between 1946 to 2013 (Themnér & Wallensteen).

[5] Armed conflict creates an environment which leads to heightened insecurity and unpredictability in daily life (Williams *et al.,* 2018).

[6] Although a complex emergency can also refer to other catastrophic events such as natural disasters, in this dissertation its definition is applied to the complexities caused by war. There is a need to underline the lack of access to medical facilities considering the aim of this dissertation. "A complex emergency is a social catastrophe marked by the destruction of the affected population's political, economic, sociocultural, and health care infrastructures" (Mollica *et al.,* 2004, p. 2058).

health concerns due to the short and long-term health and social consequences endured by those trapped in conflict zones and recent post-conflict settings[7] (Watts *et al.,* 2013; Zihindula & Maharaj, 2015; S/2018/250).

Conflict-Related Sexual Violence

Until recently, political scientists have tended to overlook or to minimize sexual violence, analysing instead other types of violence (Cohen & Nordas, 2014, p.418). In present terms and in accordance with the United Nations Secretary General (UNSG) 2019 report on *Conflict Related Sexual Violence*[8](S/2019/280) there are 19 countries which require the upmost attention in both conflict and post-conflict situations which shows that sexual violence is neither a unitary event or homogenous to one single region[9] (Cohen et al., 2013) (**SEE FIGURE 1-ANNEX)**. According to the Sexual Violence Armed Conflict (SVAC) systematic dataset concluded by Cohen and Nordas in 2014, which analysed conflict-related sexual violence cross-nationally during 1989-2009, out of the 79 countries included in the SVAC dataset, 17 countries[10] (14%) reported a high prevalence of experienced conflict-related sexual violence[11] (p.423). Conflict-related sexual violence is not mutually exclusive to a specific region, it seen as occurring in all conflicts but with very different levels and prevalence (Wood, 2010; Cohen & Nordas, 2014).

Globally[12], sexual violence continues to be registered, and has been verified in ongoing situations of armed conflict including Syria, Iraq, Nigeria, Myanmar, Central African Republic and the Democratic Republic of Congo (UNSC, 2019). Although we do not know the exact quantifiable extent of sexual violence in armed-conflict, its frequency is high

[7] Scientific, social, cultural, economic and political factors all contribute to the overall wellness of a community, be it local or international (Khaliq & Smego, 2007, p.1).

[8] See link https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/04/report/s-2019-280/Annual-report-2018.pdf

[9] As stated in Cohen et al., 2013 paper on the misconceptions surrounding sexual violence in armed-conflict, it is believed by many that conflict-related sexual violence is reserved to the African continent, however, sexual violence has been detected in war in all regions of the globe.

[10] Found in Africa, Europe and Asia (Cohen and Nordas, 2014, p.423).

[11] Cohen and Nordas, 2014, described the highest prevalence of conflict-related sexual violence as being synonymous with "systematic", "massive" or "innumerable" and as having 1,000 victims or more per one year of conflict (p.420)

[12] Levels of sexual violence differ significantly across countries and conflicts, however, rape in wartime is not specific to a type of conflict or region (Wood, 2009). There is often an ongoing misconception that armed conflict is a specific problem to Africa (Cohen *et al.,* 2013).

enough for the United Nations to legally define it as a "weapon of war"[13] due to its destructive use over the individual, families and communities (Supervie *et al.,* 2010).

Conflict-related sexual violence (CRSV) is not only an alleged weapon of war, but a human rights abuse which results in severe health and social consequences for the victims, the family and the community (Watts *et al.,* 2013, p. 2152; Zihindula & Maharaj, 2015). Even though CRSV has always been recorded as an existing incident on all continents during periods of armed conflict (Sivakumaran, 2007; Reilly, 2017), the past twenty years have paved the way towards the formal recognition of its frequency at a global scale (Wood, 2018), whereas previous research has tended to focus primarily on mortality and casualty rates of conflict (Murray *et al.,* 2002). This has led to a significant increase of attention at both the international political and judiciary level (Alison, 2007; Gaggioli, 2015; Gorris, 2015; Touquet & Gorris, 2016). Its recognition has been especially relevant in underlining the urgent need to focus on the physical, psychological and social consequences inflicted at the individual level and the need to interlink individual experiences of survivors, with that of the experiences and reactions the family and community held towards the violence endured by the individual (Claude *et al.,* 2013; Sidebotham *et al.,* 2016).

[13] Conflict-related sexual violence can be described as a pervasive systematic instrument used as a weapon or instrument of war (Wood, 2006). This is because when sexual violence is weaponized or instrumentalized through military force, armed groups, paramilitaries or militias, it's aim is to either exercise dominance over a certain population or as a form of ethnic cleansing (forms of elimination of the perceived enemy and power dominance). This war strategy is most recognized in the war in the former Yugoslavia, the Rwandan genocide and most recently in the ongoing civil conflict in the Democratic Republic of Congo (Gaggioli, 2015). However, there is an ongoing debate on whether sexual violence can be understood as a weapon and organized strategy of war, due to the heterogenous variance of sexual violence found. According to the systematic dataset on sexual violence in armed conflict (1989-2009) conducted by Cohen and Nordas (2014), only 17 out of the 79 countries analysed recorded a high prevalence of sexual violence. In their analysis, Wood (2006) and Cohen *et al*., 2013, demonstrate worrying about a created misconception that sexual abuse only occurs due to war and may take away from the opportunist framework conflict creates for rape and sexual abuse to occur due to other reasons such as the collapse of security and public services.

The development of international legislation regarding conflict related sexual violence

Sexual abuses in war were initially identified as a form of violence against civilian populations in the 1949 Geneva Convention IV[14] (Article 27º), subsequently to the mass atrocities of a sexual nature documented in the Second World War[15] (Wood, 2006).

"*Women shall be especially protected against any attack on their honor, in particular against rape, enforced prostitution, or any form of indecent assault*." Article 27º, IV Geneva Conventions, 1949.

Although the IV Geneva Conventions were reinforced by the 1977 Additional Protocols[16], article 27º still came under constant scrutiny for having a limited and narrow definition. It was understood as focusing on the defense of "women's honor" rather than focusing on other aspects, such as the health, judiciary and social consequences it could cause the victims (Alison, 2007; Gaggioli, 2015). The inclusion of rape as a war crime in the IV Geneva Convention, however, provided a base which would be used in the future to build upon, regarding the legal framework on sexual violence committed against civilians in war (Lewis, 2009). However, despite developments surrounding the issue of civilian victims of rape after the Second World War, sexual violence would not be considered a priority on the agenda of the international community for the next half of a century, despite the number of armed conflicts taking place between 1946-1992 (Gaggioli, 2015).

[14] The Geneva Conventions and their Additional Protocols are international treaties that contain the most important rules limiting the barbarity of war. The 1949 IV Geneva Conventions were built on the disasters of WW2 and included the protection of civilians for the first time. Article 3º marked a breakthrough, as it addressed for the first time situations of non-international armed conflicts. It includes traditional civil wars, internal armed conflicts that spill over into other States or internal conflicts in which third States or a multinational force intervenes alongside the government (ICRC, 2010). See link https://www.icrc.org/en/doc/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm

[15] Rape was described as occurring in various war affected countries throughout World War II. The most notorious example occurred in Nanjing, China which is often referred to as "The rape of Nanjing" or "Nanjing massacre"[15] (Wood, 2006, p.311). The inclusion of rape against women and forced prostitution in Article 27º of the IV Geneva Conventions was largely due to the mass rapes that were documented in Nanjing Massacre of Korean women by Japanese soldiers during the Second World War (Wood, 2006). This is very much like the development of sexual violence used against civilians in Rwanda and the Former Yugoslavia and it's prohibition in the 1998 Rome Statute.

[16] In 1977 the Protocols to the Geneva Conventions mentioned that women "shall be protected against rape, forced prostitution or any other form of indecent assault, but on as "humiliating and degrading treatment" (Protocol I, arts. 46 and 77, Protocol II, art, 4.2.e). According to Ward (2013), this mirrors the reality at the time when crimes against women acquired the status of humiliating and degrading, instead of being considered stand-alone crimes like torture or genocide. In this context, rape has invariably been conflated with the concepts of genocide, torture, or crimes against humanity rather than being characterized or prosecuted as a grave crime on its own (Ward, C.A.,2013, p.196),

In retrospective it could be considered that the actors of the international community were slow to pick up on the need to extend and further develop dialogue and international legislation adjacent to conflict-related sexual violence (Ward, 2013). After five decades of silence from the international community, the 90's lead to the wake-up call most desperately needed so as to address vulnerable populations in conflict.

The global development on conflict-related sexual violence began due to a remarkable and pivotal feminist movement which emphasized that rape is a part of warfare and not just a private matter and that the protection of rights and safety of women needed to be addressed internationally (Wood, 2018, p.2). These wave of movements in the 1990's took place in response to the massive sexual violence and abuses that were taking place in the Rwandan Genocide (1994) and the war in the former Yugoslavia (1992-1995) (Harrington, 2010). Sexual violence abuses along with the human immunodeficiency virus (HIV) frenzy that had begun in the 80's (Ba & Bhopal, 2017), lead to international groups of women protesting the need to improve the rights on the protection of female civilians' victims of these conflicts (Apperley, 2015).

Simultaneously, United Nations Conferences and Declarations were being held, which aimed at addressing the elimination of violence against women and the fight for the equality of women and girls[17] (Solangnon & Patel, 2012). The *International Criminal Tribunal for Rwanda* (1994) and the *International Criminal Tribunal for the Former Yugoslavia* (1993) were also created so as to address war crimes that had taken place. These two tribunals not only defined conflict sexual violence but also included sexual violence in their legislation as a war crime against the populations (Gaggioli, 2015, p.507)[18]. Thus, the issue obtained global media attention which opened the door towards an

[17] Dealing with this gender dimension issue has been a driving force behind a number of important documents pronouncements and conferences that have been held over the past three decades. This started with the *World Conference on Human Rights* and the *Vienna Declaration* in 1993 (Rosa & Lazaro, 2017, p.2). This declaration condemns all types of gender-based violence and all forms of sexual exploitation and encourages States to fight violence against women (United Nations (UN), 1993).
It was followed by the 1995, Fourth Women's World Conference in Beijing which is seen as the starting point for linking gender, war and peace (Jansson & Eduards, 2016). Its importance is emphasized because of the creation the *Beijing Declaration* and *Platform for Action*, an internationally endorsed document that highlighted the rights of women in situations of armed conflict (Rosa & Lazaro, 2017, p.2).

[18] The ICTR defined sexual violence as a "physical invasion of a sexual nature, committed on a person under circumstances which are coercive". The ICTY seemed to follow the approach taken by the ICTR, however due to the specific Furundziga case, in which the ICTY concluded that the objective element of rape are:

i) Sexual penetration, however slight: a) of the vagina or anus of the penis of the perpetrator b) of the mouth of the victim by the penis of the perpetrator;

ii) By coercion or force or threat of force against the victim or third person.

(Gaggioli, 2015, p.507)

increased international discourse on the issue in the fields of human rights, international politics, international law and global public health (Alison, 2007; Marsh *et al.,* 2006; García-Moreno, 2014).

This was due in part to the extremely high number of estimated victims disclosed of conflict-related sexual violence in Rwanda and the Former Yugoslavia. Around 20,000 cases were documented in the 1993 European Commission report[19] in the war of the former Yugoslavia and calculations made by the United Nations Special Rapporteur in Rwanda in 1996, estimated anywhere between 250,000 – 500,000 victims of sexual violence (Palermo & Peterman, 2012).

The emphasis of extreme pressure to improve women's rights internationally along with the creation of the *tribunals* and the high number of sexual violence victims reported in Rwanda and the Former Yugoslavia, led to an accumulation of mounting factors which created mass pressure on the issue at an international scale. This pressure ultimately led to the creation and inclusion of sexual violence as a crime against humanity in the drafting of the International Criminal Courts (ICC) legislation, the Rome Statute in 1998 (Palermo & Peterson, 2011; García-Moreno, 2014).

Thus, article 7º of the Rome Statute (ICC)[20] was created. Article 7º describes the list of acts in armed conflict which are stated as crimes committed against humanity[21], that is crimes committed against civilian populations in the context of armed-conflict. Sexual violence is found in the subheading 7ºg, and is described as "*Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity"* (ICC Rome Statute, 1998, 3-4). Although the definition is praised for going far beyond the standard vision which characterizes sexual violence merely as rape and for taking a gender-neutral stance (Sivakumaran, 2007; Gaggioli, 2015), researchers who focus on male victims of conflict-related sexual violence argue that there exists a persisting vagueness surrounding which acts constitute what is defined in the

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[19] Although the 1993 European Commission report is commonly used as a foundation for estimating the number of victims of conflict-related sexual violence in the conflict of the former Yugoslavia, Palermo & Peterman are quick to render its validity as flawed. The challenges posed with data collection will be further explored when analyzing the limitations to research (Palermo & Peterman, 2011, p. 924).

[20] See link: https://www.icc-cpi.int/nr/rdonlyres/ea9aeff7-5752-4f84-be94-0a655eb30e16/0/rome_statute_english.pdf

[21] The concept of "crime against humanity" first appeared in an international instrument in the Nuremburg Charter. A crime against humanity consists of an inhumane act typically a series of inhumane acts such as murder, rape and torture) committed as part of a widespread attack directed against a civilian population (Ward, A.C., 2013, p.193).

definition as "*any other form of sexual violence*" (Gorris, 2015; Touquet and Gorris, 2016). As Gaggioli, 2015, (p.506) states, is there a minimum threshold of gravity to consider an act sexual violence when committed under coercive circumstances?

Evolution of the international policy responses to conflict-related sexual violence

Acknowledging that the international community[22] has focused on the problem of conflict-related sexual violence only after acts of mass atrocities of its kind had taken place[23] (Pruitt, 2012) and that political scientists have, until recently, overlooked or minimized CRSV (Cohen, 2013), how has conflict-related sexual violence been perceived through the institutional international community lens?

Between the period of 2000-2019 policy measures were created by the United Nations Security Council (UNSC) along with annual reports of conflict-related sexual violence by the Secretary General of the United Nations (UNSG) which focus on addressing victims in current conflict and post-conflict situations in order to improve prevention tactics and highlight the needs of survivors in these circumstances. These policy tools are aimed at interacting with international and national legislation (s), international organizations and non-governmental organizations (Pruitt, 2012). This set of tools are aimed at tackling the multiple issues surrounding conflict-related sexual violence, which are described by Cohen, 2013, as "difficult to measure" in countries that due to the unstable nature of conflict are regarded at the international scale as fragile, vulnerable and volatile (Watts et al., 2013). Although the global understanding of sexual violence is constantly shifting the international community has highlighted the need to address the issue as a concern of international security and as a need to protect women facing inequalities worldwide.

As mentioned beforehand, sexual violence in conflict can be understood as a weapon, strategy or instrument of war. Although researchers can sometimes argue that sexual violence occurs due to opportunity, in which most often men, know they have a chance of committing sexual abuse because societal structures such as law enforcement no longer exist (Cohen *et al.,* 2013). The international community understood that the sexual violence which took place in Rwanda and the former Yugoslavia did not happen in such a

[22] Rape has tended to be associated with war throughout human history, but the community of actors has only just now begun to acknowledge its obligation to address sexual violence in an emergency response (Marsh, 2006, p.133).

[23] From the Nanjing Massacre during World War Two, the former Yugoslavia and Rwanda in the 90's[23], to the most researched conflict-affected territory of modern time, the Democratic Republic of Congo (Zihindula & Maharaj, 2015) and the now increased awareness of sexual violence committed against the Rohingya people by Myanmar troops (OHCRH, 2019).

massive scale due to mere opportunity[24]. Instead it was used as an instrument to guarantee an asymmetry of power through violence, fear, collapse of community values, spread of sexually transmitted diseases and enforced pregnancy (ethnic cleansing) (Eboe-Osujii, 2012; Supervie *et al.,* 2012; Luedke *et al.,* 2018). Due to the influence of gender, women and girls become more vulnerable in patriarchal societies because they carry the cross-cultural burden of virginity and childbearing, making them visible victims of sexual violence when virginity is lost, the ownership of husbands and father is contested, and children are bared (Marks, 2013). Men and boys also face the same pervasion, with sexual violence aimed at humiliating, retrieving power, emasculating their social status within the community and violating sociocultural norms of unacceptable homosexual behaviour (Christian *et al.,* 2011; Gorris, 2015). Although the discussion on how to interpret sexual violence in armed-conflict is valid, there is no denying that civilians can be used as incubators for the violation of international and human security norms which require the protection through international means (Jansson & Eduards, 2016).

This led to a stronger commitment on behalf of the international community in developing stronger responses over the next two decades towards the protection of women and girls, their equality and well-being, including addressing physical and mental health and working towards improving societal perceptions through the creation of the Women's Peace Agenda (Jansson & Eduards, 2016). In 2000 Resolution 1325 was introduced, which mentions for the first time the need to acknowledge women and girls who are victims of sexual violence in conflict (S/RES/1325)[25]. Meanwhile UNSC Resolution 1308 was also introduced in 2000, which highlighted the pervasive spread of the human immunodeficiency virus (HIV) worldwide and linked it to armed-conflict identifying the spread of sexually transmittable diseases as a possible instrument of war (Pruitt, 2012; S/RES/2106), however in the Resolutions developed to address the security issues of sexual violence in armed-conflict, HIV was only included in the 5th resolution (UNSC Resolution 2106) dedicated to the matter in point 20 and no other sexually transmitted disease is at all included (S/RES/2106).

Focus on conflict-related sexual violence through UNSC Resolutions was expanded with the introduction of five resolutions between 2008-2019, following the mass atrocities related to conflict-related sexual which took place in South Sudan, which took a direct

[24] Rape or sexual violence in conflict is not a recent phenomenon of war and conflict, with illustrations being traced back to the Roman era through the "Rape of the Sabine women" (Branche and Virgili, 2012).
[25] Found in point 10 of UNSC Resolution 1325.

approach on the matter (Pruitt, 2012, p.300); Resolution 1820 (2008), 1888 (2009), 1960 (2010), 2106 (2013) and the newly introduced Resolution 2467 (2019)[26]. These resolutions represent a growing and ongoing political acknowledgement of the need to address the climate of impunity and gender inequality that currently exists for mass violence against women and girls (Pruitt, 2012, p.300).

If we analyze the UNSC Resolutions specifically aimed at tackling the issues of conflict-related sexual violence between 2000-2010 [27] we are able to see that in regard to the protection of women and girls, the international community has made a formidable and conscience effort towards highlighting the much needed importance of politically acknowledging them as the main foreseeable victims of wartime sexual violence (Pruitt, 2012). However, in doing so they have almost entirely castoff male victims of sexual violence, resulting in the misconception that divides women and girls as victims and men and boys as perpetrators (Cohen *et al.,* 2013; Vojdik, 2014).

In 2013 under UNSC Resolution 2106 men and boys were acknowledged for the first time as victims of sexual violence[28] (Touquet & Gorris, 2016). Whilst male victims have been continuously overlooked within the international community's agenda, Otto 2010, points

[26] The United Nations Security Council Resolutions aim to reproduce highlighted issues on their security agenda in a "high politics context" with the objective of peace and security (Jansson & Eduards, 2016). The issue of women's security and protection was fought by feminist groups during decades in the 20th century, resulting in the first and most studied resolution of the Women's Peace and Security (WPA) agenda, Resolution 1325 (2000) (Pruitt, 2012).
The underlined objectives of Resolution 1325 referred to the prosecution of crimes against women in armed conflict and peace processes, the increased protection of women and girls during war, the appointment of more women in the UN peacekeeping operations and field missions and the increased participation of women in decision-making processes at all levels (Janson & Eduards, 2016, p. 591; S/RES/1325).
Eight years later, Resolution 1325 was followed up with Resolution 1820, which proceeded to reaffirm the former regarding the condemnation of all forms of sexual violence in armed conflict. The resolution recognizes sexual violence as a tactic of war and a security issue and argues that the different manifestations of sexual violence "can be defined as a war crime" (Jansson & Eduards, 2016, p.591; Pruitt, 2012, S/RES/1820).
There are seven resolutions in total aimed at the WPS, however, in the context of armed conflict, the following three resolutions introduced new instruments to make conflict-related sexual violence a security priority on the international agenda. Resolutions 1820 (2008), 1888 (2009) and 1860 (2010) increased pressure on the United Nation's Secretary General (UNSG) to have annual reports made on the pressing issues of CRSV (Reilly, 2017). Resolution 1888 (2009) highlighted the need for the appointment of a Special Representative of the UN Secretary-General, whilst also focusing on a more gender-sensitive framework for security, justice mechanisms and other related personnel dealing with victims and provisions for adequate monitoring and evaluation (Pruitt, 2012, p.300). Whereas, Resolution 2106 is relevant for its inclusion of the recognized violence towards men and boys (Gorris, 2015).
[27] Between the period of 2000-2010, the United Nations Security Council passed four resolutions regarding conflict-related sexual violence and the protection of women and girls with no mention of men and boys as possible victims of the same context; Resolutions 1325 (2000), 1820 (2008), 1888 (2009) and 1960 (2010). During the first decade of the 2000's the UNSC Resolutions were exclusively aimed at the protection of women and girls. Only with the development of Resolution 2106 in 2013, were men and boys included for the first time as possible victims of conflict-related sexual violence.
[28] "While also affecting men and boys" UNSC Resolution 2106 (S/RES/2106).

out that resolutions such as 1820 (2008) pinpoint women as having the exclusive role of "victim", which as Otto 2010, underlines as could be in itself contributing to women and girls also being perceived as victimized. The systematic language used has created an ongoing dichotomy legitimized through the international community as to which sex is considered within the role of victim and of perpetrator, manipulating the awareness of how conflict-related violence in war can be conducted, for example, if sexual violence against men and boys is understood to not exist, how can these victims access judicial and medical services? (Gorris, 2015). This however, does not take away from the international community's has efforts to increase political policies and awareness on the matter, but as Vlachova and Biason, 2005, point out, even though there may be an attempt in increasing information through political means on this matter, nationals governments may disregard this, as acknowledging the existence of conflict-related sexual violence may attract more negative attention towards them, which can lead to inadequate responses on behalf of the international community.

If the aim of a resolution is to contribute towards establishing peace and security, how are health matters and social consequences endured by the survivors, families and communities addressed within the international community resolution framework? When analysed we can spot nuances through the resolutions implemented[29], reflecting that there is a need the health and social spheres around conflict-related sexual violence. Although there is no denying the importance of feminist movements which led to the prioritization of conflict-related sexual violence on the international agenda, their strong influence on how resolutions were developed can also be felt in the fight for equality and protection displayed across the resolutions (Apperley, 2015). According to Harrington, 2010 (p.56), there was a lack of discussion by women's organizations on public health and sexual violence across different contexts, which has led to a less evidence-based approach when politicizing the issue[30]. For example, resolution 1960 (2010), calls out for the commitment

[29] UNSC Resolution 1820 (2008) makes one reference to health in point 10 where is underlines the importance to support and strengthen health facilities. UNSC Resolution 1888 (2009) encourages States along with the help of the international community to increase survivor access to health care, psychosocial support and socio-economic reintegration in point 11. UNSC Resolution 1960 (2010) reinforces what was presented in the previous resolution. Resolution 2106 (2013) made great strides when addressing health concerns, it included for the first time the urgent need for non-discriminatory health and psychosocial services in point 19, whereas point 20 included the need to address the spread of HIV through means of conflict for the first time.

[30] The United Nations *Women, Peace and Security Agenda* (WPS Agenda), 15 years after the introduction of Resolution 1325, is virtually synonymous with ending the impunity of perpetrators of CRSV (Reilly, 2017).

to "enhance data collection and analysis of incidents, trends and patterns of rape and other forms of sexual violence" (S/RES/1960) (Palermo & Peterman, 2011).

However, since the initial resolution 1308 (2000) which recognized the incidence between the HIV epidemic and armed conflict (S/RES/1308), health in armed-conflicts and post-conflict scenarios appeared to be an issue almost forgotten in high politics when contemplating the need to secure peace and security. UNSC Resolutions 2106 (2013) and 2467 (2019) have, however, began to pave the way to a more inclusive nature of health and social priorities. Point 19 of Resolution 2106 encourages the existence and extension of non-discriminatory health care services which cover physical health, sexual and reproductive health and psychosocial facilities. Whereas Point 20 links the dangers between HIV and armed conflict, highlighting the high numbers of HIV prevalence globally (S/RES/2019). UNSC Resolution 2467 (2019) emphasis the nature of the previous resolution in point 28, adding that sociocultural stigma around male victims of sexual violence needs to be addressed to facilitate male access to rehabilitation and health facilities (S/RES/2467)[31].

As described by Murray *et al.* 2002, (p.346) an improved collaboration between political scientists and experts in the public health field would benefit measurement, prediction and prevention in armed conflict. This seems to have awoken some interest between the two fields if we consider the 2012 collaboration between the *World Health Organization* (WHO) and the *Sexual Violence Research Initiative* (SVRI) which set out to define the 10 priority research needs concerning this issue in armed conflict and post-conflict scenarios. However, as Gaggioli, 2015, emphasises, the majority of international law and political instruments working towards conflict-related sexual violence tends to focus on prevention and the measures thus far implemented, do very little to call attention to physical, psychological and social damages survivors may face within contexts of fragile and vulnerable services, lack of infrastructure and negative cross-cultural perceptions set upon those who endure sexual violence.

[31] The 2019 UNSC Resolution 2467 came under scrutiny before its adoption on the 23rd of May, 2019. With the Trump Administration threating to veto the resolution due to the inclusion of language on sexual reproductivity and of family planning clinics. The Security Council which had initially proposed proposed a formal mechanism to report atrocities and gather data in Resolution 182 (Sivakumaran, 2010), was also opposed by the United States of America, Russia and China, leading to its non-inclusion in the resolution. See link https://www.theguardian.com/world/2019/apr/22/us-un-resolution-rape-weapon-of-war-veto. For a UNSC Resolution to be approved no permanent member of the Security Council can veto, otherwise the resolution will be failed (Ferreira de Almeida, 2003).

UNSC Resolutions 1820 (2008), 1888 (2009) and 1960 (2010) did however create pressure which led to new international instruments such as the *Conflict-related Sexual Violence Annual Reports* from the United Nations Secretary General (UNSG) from 2012 until the present date. Through these reports more emphasis have been placed on the need to address victims at both a health and sociocultural level, with the 2019 annual report reflecting the need to address physical and psychological needs of victims, pointing out that sociocultural barriers exist, whilst also recognizing (briefly) male victims in its narrative. Through Resolution 1888 (2009) the position of *Special-Representative of The Secretary General on Sexual Violence in Conflict* and the *United Nations Action Against Sexual Violence in Conflict.* The special-representative fulfils the role of representing the United Nations as the spokesperson and political advocate on the matter[32].

Although I would like to separate international institutional recommendations and resolutions from international law, I believe these cannot function without operating within an interchangeable manner, especially regarding the ever-growing list of sexual acts, which come under the judicial definition of conflict-related sexual violence. This however, poses a great deal of difficulty to health-related issues in conflict and post-conflict regions, in which terms such as sexual violence, sexuality, rape, infectious diseases such as HIV/AIDS are and the idea of mental illness, is still very much a taboo subject which are strongly stigmatized in many communities (Supervie *et al.,* 2010; Kolonda *et al.,* 2013). Along with the lack of access by civilian populations to health-related infrastructures, where health practitioners are faced with severe difficulties and realities caused by conflict choose to leave (Nickerson, 2015). Thus, leavings thousands at risk and in need of diverse medical attention, which leaves the population not only facing the dilemma of a sociocultural taboo issue, but also with no physical access to health services which are greatly needed to cater to injuries they may be enduring both at a physical and psychological level (Duroch *et al.,* 2011; Kolonda *et al.,* 2013).

[32] See link https://www.un.org/ruleoflaw/un-and-the-rule-of-law/the-special-representative-of-the-secretary-general-on-sexual-violence-in-conflict/ (Retrieved on the 24/04/2019).

Victims of conflict-related sexual violence

Female victims of conflict-related sexual violence

The extent of violence against women and girls across the world is alarming. Not only is it recognized as a grave human rights violation, but also as a public health problem that affects the lives and physical and mental health of women and girls (Heidari & Moreno, 2016, p.1).

Women's and girl's needs are largely marginalized in countries suffering from armed conflict (Rosa & Lazaro, 2017) and it is generally acknowledged that sexual violence against women and girls is a pervasive matter of a highly taboo nature which feeds into misconceptions on sexual violence and abuse mystified by social-cultural and religious understanding (Kuo *et al.,* 2018). Sexual violence against women in the context of conflict is particularly worrisome because it affects disproportionately those who are already perceived as vulnerable, such as women and girls (Williams *et al.,* 2018). Women and girls in conflict can be prone to sexual violence, sexual slavery[33] and ethnic cleansing[34] (Loncar, 2006).

Cross-culturally, men and women are still tied to strict hierarchical gender roles which they are expected to obey by in order to maintain their community norms, often meaning women have the lower status in the community[35] (Marsh, 2007; Trenholm *et al.,* 2009). In the context of constructed patriarchal communities, a woman's body is often viewed primarily as property of the household patriarch (Alison, 2007). This being highlighted it is imperative to underline the link between the economic value of virginity and the right to marriage (Kelly *et al.,* 2011; Marks., 2013; Luedke *et al.,* 2018). Sexual relationships in many cultures are still seen as a highly taboo subject, and the conservation of a women's virginity is not an individual matter, but rather a familial one, as many cultures perceive a daughter's virginity to be tied to family honor[36] (Marsh 2006; Claude, 2013). The loss of virginity outside of marriage regardless of its cause can lead to the victim being stigmatized or rejected by her family and community (Marsh, 2006; Marks, 2013) and in

[33] Sexual slavery refers to the abduction or selling of a person with the intention of abusing them sexually through verbal sexual humiliation or physical contact and acts of a sexual nature (Ibrahim, 2018).
[34] Forced impregnation to alter the make-up of society (Wood, 2014).
[35] Invisibility of conflict-related sexual violence may occur due to maintained societal factors such as gender constructions which ascribe passive and aggressive role on men and women (Osstem & Constanzo, 1993).
[36] With family honour being so closely tied to the preservation of a daughter's virginity until marriage, the sexual abuse will not only inflict harm on the women or girl, but also on her family and community which face a loss of honour (Marsh, 2006).

situations of sexual abuse, victims may be perceived as "belonging" to the perpetrator and families can often give their daughter away to them to avoid community stigma and shame (M'Pinga, 2008; Trenholm *et al.,* 2009).

In the cases where women are married, they may be blamed by their husband or their husbands family for the incident, as rape or abuse of a sexual nature is sometimes not understood as being caused by the perpetrator but rather as a provocation by the woman seen as wanting to engage in sexual interaction with another man who is not her husband (M'Pinga, 2008; Kelly *et al.,* 2011).

Women and girls not only face feelings of shame, guilt, humiliation and ostracism due to the horrific act they have endured, but also due to the negative response from their families and communities. Women are dependent on the acceptance of those who surround them, when women are highly stigmatized this leads to social consequences. The ability to marry, the ability to leave the house, to integrate back into normal social functioning's such as going to church and be able to lead normal daily activities can be disturbed because of sexual violence they have endured.

Male victims of conflict-related sexual violence

There is a high misconception surrounding men and boys as victims of sexual violence due to cross-culturally accepted views on masculinity (Gorris, 2015). Hierarchical gender roles often place men in a superior position to women in the eyes of the community on day to day tasks, this includes being a strong patriarchal figure, protecting one's family and being the main provider (Christian *et al.,* 2011; Cohen *et al.,* 2013). When a man endures sexual violence, he may be seen by his family and community as weak, as well as lose the respect of his family and in some global contexts rather than being perceived as weak they will accuse him of willingly partaking in homosexual activities. Homosexuality practices between men remain highly taboo cross-culturally. Men can fear being identified as homosexual and do not come forward to seek help or justice, turning them into silent victims of the international and national domain (Touquet and Gorris, 2016; HRW, 2019).

These result as barriers in their access to judicial and healthcare facilities but has also reflected upon the small interest in conducting studies on the matter (Sivakumaran, 2007;

Apperley, 2015; Touquet and Gorris, 2016). According to Sivakumaran[37], 2007, male victims of conflict-related sexual violence can be found in at least 25 armed conflicts from the past two decades. In Sivakumaran, 2010 paper, he addresses the sexual violence which occurred on male victims in Abu Ghraib[38] which even though received a considerable amount of media attention, is still often overlooked and did not increase research in the field of conflict-related sexual violence on men and boys.

The *SVAC Dataset* conducted between 1989 and 2009 found that out of all the data gathered, males only represented 1% of the victims found in armed conflict (Cohen *et al.,* 2013). However, as highlighted by Gaggioli, 2015 and Touquet & Gorris, 2016, because of male unwillingness to come forward and lack of studies addressing the issue we have no real empirical evidence of what numbers may be.

Men's unwillingness to come forward can also be due to the implementation of national laws, which may not foresee sexual abuse occurring between males (Kelly *et al.,* 2011). Identical to the situation women and girls face when they are blamed for either initiating or not fighting hard enough to stop the sexual violence from occurring, men can also be accused and blamed of instigating or consenting to the sexual act out of free will (Apperley., 2015). Acts of homosexuality or sodomy are still illegal until this day across regions of the globe, with some even implementing the death penalty on those found to have acted in a homosexual manner, without national policies and legal protection victims may avoid coming forward and seeking help from health or legal services because they fear prosecution (Vojdik 2014; Apperley 2015; ILGA, 2019).

According to the *International Lesbian, Gay, Bisexual, Trans and Intersex Association* (ILGA, 2019), 68 out of the 193 United Nations member-states in Africa, Asia, Latin America, the Caribbean and Oceania, still criminalize same sex acts, whether these are found to be consensual or not (**Annex – Figure 2**). Out of these 68 states, 8 criminalize same sex acts utilizing the death penalty (**Annex – Figure 3**). Although homosexuality has been decriminalized through various regions, the decriminalization through means of the law is not necessarily synonymous with sociocultural acceptance of homosexuality (Vojdik, 2014; Gorris & Touquet, 2016).

[37] Sandesh Sivakumaran in his 2007 research paper "*Sexual Violence Against Men in Armed Conflict*" is recognized as the first scholar in the field to address men and boys as victims of sexual violence, which led to other researchers and scholars focusing on the issue.

[38] Abu Ghraib was a United States of America military prison in Iraq, where male and female personnel from the U.S army were involved in provoking acts of a sexual nature, such as enforced masturbation, on the detainees (Caldwell, 2016).

International responses towards men and boys

Males as victims of any type of sexual abuse, be it in war or peace, is often questioned and largely ignored by national policies and services (Apperley, 2015; Gaggioli, 2015). Although international actors have begun to briefly introduce the topic in UNSC Resolutions and a handful of workshops and reports[39], there is still a great need to increase protection and recognition through international policy and awareness. UNSC Resolution 2106[40] (2013) briefly mentions men and boys as possible victims of *CRSV* for the first time*, however*, with UNSC Resolution 2467[41] (2019) the issue surrounding men and boys as victims of *CRSV* reflects the growing international attention dedicated to male survivors (HRW[42], 2019). However, although UNSC Resolution 2467 has greatly expanded on the previous resolution, because of its newness in the international arena, there is yet no way of knowing if it can achieve it desired effects of causing an impact on increased research and attention towards the issue. Until now men just like women see their access to health, psychosocial and legal care continuously incapacitated.

Health Consequences for survivors of conflict-related sexual violence

The number of health consequences for victims of sexual violence are numerous and varied, which affect survivors physical and psychological health and well-being both in the short and long-term[43] (MSF, 2007) – **Figures 1 and 2**. Analyzing these is a challenge due

[39] Men and boys have only been included as the focus of international workshops and reports on a number of occasions. These include the 2013 United Nations workshop of Men and Boys as victims of sexual violence in conflict, the inclusion of a conference in the 2014 summit entitled, End Sexual Violence in Conflict and lastly, in the United Nations High Commissioner for Refugee's (UNHCR) report on Sexual Violence against Men and Boys in the Syrian Crisis.

[40] "While also affecting men and boys" UN Security Council Resolution 2106 (S/RES/2106). See link http://undocs.org/en/S/RES/2106(2013)

[41] UNSC Resolution 2467 (2019) takes a giant leap in the inclusion of male victims of conflict related sexual violence, which can be found in points 28 and 32 of the resolution. Point 28 highlight the need for men and boys to also have access to national relief and reparations programmes, along with access to healthcare, psychosocial care and legal aid. The gender-neutral inclusion of men and boys is aimed at lifting the sociocultural stigma attached to this category of crime and facilitate rehabilitation and reintegration efforts. Point 32 underlines that although women and girls are the most probable victims, men and boys can also be targets of sexual violence in conflict and post-conflict scenarios, including in the context of detention and those associated with armed groups. The *security council* urges Member States to protect victims who are men and boys through the strengthening of policies that offer appropriate responses to male survivors and challenge cultural assumptions about male invulnerability to such violence. Lastly, the *security council* requests that monitoring and analysis on *CRSV* take a gender-neutral stance as to include men and boys. See link https://undocs.org/S/RES/2467(2019)

[42] See link - https://www.hrw.org/news/2019/05/03/men-can-experience-sexual-violence-war-too

[43] Health consequences can take shape in physical and mental disorders, but they can also surface in less obvious ways such as shame, guilt and difficulties in daily functioning and withdrawal (Hustache *et al.*, 2009; Garcia-Moreno, 2014).

to numerous barriers which exist, for example, survivors may not come forward until much later, survivors may inclusively be unaware of health issues they may be in risk of, legal and financial barriers may be a concern (for example, abortion may be illegal or survivors or families may not the financial means to access healthcare) and healthcare centers may be unavailable close by, either due to being destroyed in the circumstances of war[44] or because of the geographical location.

Figure 1 – Possible physical, sexual and reproductive injuries sustained by survivors of conflict-related sexual violence by sex (male and female)

Female	Male
Anal ruptures	Anal ruptures
Vaginal and anal incontinence	Anal incontinence
Sexually transmittable diseases (including HIV[45])	Sexually transmittable diseases (including HIV)
Fistula	Anal fistula
Cutting and burning of genitalia	Cutting and burning of genitalia
Pregnancy	
Sexual and Reproductive damages	
Vaginal infection	

AUTHORS: MSF 2007; Sivakumaran, 2007; Onsrud 2009; Loncar, *et al.,* 2010; Christian *et al.,* 2011; Sidebotham *et al.,* 2016.

[44] Armed conflict is in itself the direct cause of the population's inability to access any type of health care (Murray *et al.,* 2002).

[45] In 2010, it was estimated that 1.9 million people were infected with HIV just in Sub-Saharan Africa, which is also the region most affected by armed conflict. Estimates from UNICEF (2006) inform us that around 8-10% of people infected by HIV/AIDS are affected by armed conflicts, humanitarian crisis or population displacement (Claude, 2013). According to the *World Health Organization* (2019), there are approximately 36.9 million people living with HIV at the end of 2017 with 1.8 million people becoming newly infected in 2017 globally. The WHO designates HIV to be a major global public health issue, having claimed more than 35 million lives so far. In 2017, 940,000 people died from HIV-related causes globally. Estimates show that only around 75% of people with HIV know their status. See link https://www.who.int/news-room/fact-sheets/detail/hiv-aids

Figure 2 – Recognized psychological effects and disorder survivors may endure from conflict-related sexual violence

Short-Term Psychological Effects	Long-Term Psychological Effects
Rape trauma syndrome	Chronic Headaches
Post- traumatic stress disorder (PTSD)	Fatigue
Depression	Sleep disturbances (i.e. nightmares, flashbacks)
Social phobias	Recurrent nausea
Anxiety	Eating disorders
Increased alcohol and substance abuse	Menstrual pain
Suicidal ideation	Sexual difficulties

WHO Guide on Sexual Assault (Year), p.13-14

Note on suicide: A suicide attempt in the action of one trying to take his/her own life, whereas suicide ideation refers to thoughts, ideas and acts such as self-mutilation (Klonsky, D.E., May, A.M & Saffer, B.Y, 2016).

Objectives

Model: Systematic Review

Aim: The aim of this systematic review is to look at the physical, psychological and social health outcomes for both male and female civilian victims of conflict-related sexual violence. Considering that data research tends to focus almost exclusively on the number of deaths or casualties provoked by armed conflict rather than outcomes of specific acts of armed conflict (Murray, 2002), such as sexual violence, through the exploration of available data, in order to contribute towards the improvement of global health.

The decision to include male victims of sexual violence has the three following objectives: 1) Until very recently men and boys were largely ignored at the international political and judicial level as possible victims of sexual violence and portrayed solely as the perpetrators of sexual violence. 2) To understand if and how health and social outcomes differ between male and female victims of conflict-related sexual victims. In a sense, the aim is to explore if there is a common pattern, regarding the health and social consequences, between male and female victims in the data found and whether it is found that they are affected at the individual and also a societal level, especially when taking into account the set gender roles and practices of patriarchal societies. 3) If we consider the possibility that each victim has a heterogonous experience, is there enough of a discrepancy between the physical, psychological and social outcomes between men and women, that male and female conflict-related sexual violence is an issue which should be analysed individually? Should sexual violence on men and women be treated as two separate matters through the international lens or should it continue to be treated as a singular matter through the WPA agenda where men are portrayed as less of a priority because they are seen as less vulnerable to sexual abuse?

It is important to highlight the lack of recognition on this issue from high-level institutions, whose narrative poses a problem in the health and psychosocial fields, resulting in top-down frameworks which delegitimize men from being accepted as possible targets of coerced sexual violence. It also feeds into the narrative that if a sexual act between two men occurs, that it is ultimately related to homosexuality because it is not being openly contested, this is a grave issue, especially in countries which penalize homosexual acts or have no clear policy on the matter. The inability to recognise when men are victims of

sexual abuse leaves an imposing gap in public health policy with professionals being unable to recognize and treat victims. This is then further extended with the extensive stigma attached to homosexuality.

There is a need to understand how this issue should be incorporated with the global health context, which should be addressed and worked alongside using the collaboration of political scientists due to the breakdown of policies and infrastructure caused by armed conflict. Sexual violence is not homogenous across armed conflict and neither are the various sociocultural norms present in conflict-affected regions across continents, turning this complex issue into an interdisciplinary matter. If empirical and epidemiological medical research offers a fixed, but often flawed vision on this issue due to the lack of research available, we must use the various fluid perspectives given by political scientists, sociologists and anthropologists to investigate varying patterns of sociocultural norms and behaviours which may prevent victims from seeking medical help. The interrelationship between these two fields may offer a much-needed guideline on how to address conflict-related sexual violence as a global public health concern.

Methodology

Defining conflict-related sexual violence

There is no universal definition of conflict-related sexual violence[46] (Wood, 2009). In many contexts it is limited in a traditionalist sense to rape[47], occurring between a man and a woman, which characterizes women as victims and men as perpetrators (Cohen *et al.,* 2013)[48]. According to the World Health Organization, 2002, sexual violence is described as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (WHO, 2012, p.149) and recognizes conflict-related sexual violence as detrimental to the health of the victims.

For this study various definitions of conflict-related sexual violence were collected and analyzed to comprehend the various understandings of what can constitute as an act of sexual violence. One of the main issues regarding this topic is reaching a universal definition on acts are included as sexual violence[49]. This becomes especially relevant with the acknowledgment that sexual abuse can happen to men and women through the use of different acts of violence and that neither should be neglected because they do not fulfil the tradition designation of sexual abuse (Sivakumaran, 2007, Apperely, 2015).

The definition typology for the construction of my research follows the international definition provided in article 7ºg (crimes against humanity) by the International Criminal Court in the Rome Statue, due to its gender-neutral stance, meaning that conflict-related sexual violence can consist of: a) Rape b) sexual slavery c) enforced prostitution d) enforced sterilization e) or any other form of sexual violence of comparable gravity. The Elements of Crimes[50], which assist the Court in the "interpretation and application", list the

[46] Definitions of both sexual violence and what consists as sexual violence in conflict, differ greatly from study to study, which present significant obstacles to the accumulation of knowledge and data collection on conflict-related sexual violence (Wood, 2013).

[48] According to Cohen et al, 2013, the definition of sexual violence differs considerably from study to study which therefore present a significant obstacle to the accumulation of knowledge about wartime sexual violence which may leave researchers debating definitional matters rather than empirical observations.

[49] The definition given in each research study is provided in the Results section.

[50] The Elements of Crime (2011 edition) set out to establish practical information to reduce the ambiguity of Article (1)(g). Pages 8-10 set out to establish a context which allows judicial personal to better analyse an act committed of conflict-related sexual violence. However, as stated by Sivakumaran, 2007, p. 262 " See link https://www.icc-cpi.int/nr/rdonlyres/336923d8-a6ad-40ec-ad7b45bf9de73d56/0/elementsofcrimeseng.pdf

interpretation given to the definition as being "The perpetrator caused one or more persons to engage in one or more acts of a sexual nature by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or persons on another person, or by taking advantage of a coercive environment or such person's or persons' incapacity to give genuine consent" (Elements of Crimes, 2011, see link 30).

The 2019 *United Nations Secretary General's* report on conflict-related sexual violence was also analyzed to verify if it differentiated at all from the International Criminal Court's definition, however these were found to be homogenous, giving a all-encompassing perspective of the definition at the international policy level[51].

Although the International Criminal Court's (ICC) definition provides a more extensive list of acts which constitute as conflict-related sexual violence[52], some ambiguity is still significantly present, which leads me to build on the definition initially provided at the international level. Sivakumaran, 2007, agrees that the ICC's Article 7º is key to building a clearer gender-inclusive definition. As one of the first academic researchers to address male conflict-related sexual violence Sivakumaran's definition is more descriptive because he recognizes the need to elaborate on the gender specificities, which allows for a broader prospect on included types of abuse, such as; 1) Rape (which can occur through the insertion of a penis, the insertion of a physical object, or between two coerced victims); 2) Enforced sterilization (including castration and genital mutilation); 3) Sexual humiliation such as enforced nudity or sexual verbal abuse; 4) Enforced masturbation (Sivakumaran, 2007, p. 263).

The definition provided by Lunde and Ortmann (1998) is also included in the typology. Retrieved from the first (and only) systematic revision on the physical, mental and social outcomes of conflict-related sexual violence (Ba & Bhopal, 2017, p.2), this definition includes; a) violence against sexual organs, for example, introduction of objects into the vagina, shooting on the genital parts and various genital mutilation; b) physical sexual assault, for example, sexual acts involving direct physical contact between victims and

[51] The 2019 United Nations Secretary General's report on Conflict-Related Sexual Violence defines this act as "rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys directly or indirectly linked to a conflict" p.4 (S/2019/280).

[52] In comparison to the 1949 Geneva Conventions IV.

perpetrator, between victim and victim, between victim and animal, or all of the above; c) mental sexual assault, for example, forced nakedness sexual humiliation, sexual threats, or the witness of another being abused.

Lastly, the typology also included the definition provided by Wood, 2018 (p.458) in which she highlights that forced pregnancy, forced abortion and forced marriage also constitute as acts of sexual violence.

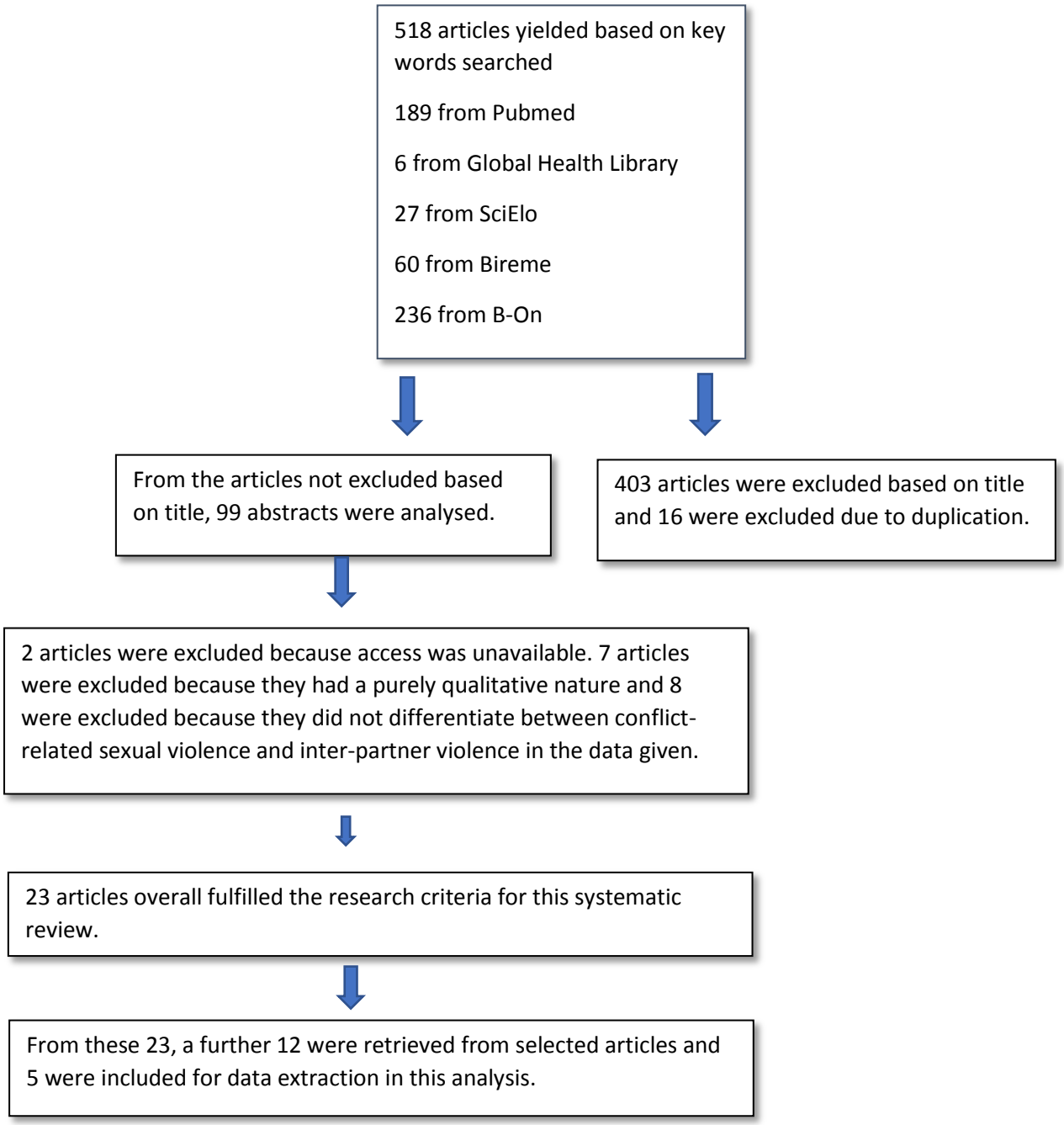
Search Criteria

In order to conduct this systematic review five research databases were searched; Pubmed, SciElo, Bireme, Global Health Library and B-on. Using the following search words in the databases searched, "Sexual violence", "health", "mental health", "war", "armed conflict", "male", "female", "rape" and "stigma", 518 results were yielded. The same search words were also searched in Spanish and in Portuguese, however only 27 results were yielded.

From the 518 results yielded, 403 were excluded on basis of title and 16 were excluded due to duplication. 99 abstracts were read. 2 studies out of the 99 could not be accessed, so therefore had to be excluded from this study. 7 studies were of a pure qualitative nature, not allowing for any data extraction, so therefore were excluded. 8 studies were excluded because they did not differentiate between conflict-related sexual violence and inter-partner violence in the results provided. Out of the 99 abstracts read from studies, 23 fulfilled the inclusion criteria (found in *Box 1*).

Out of the 23 articles studies chosen for analysis, a further 12 were retrieved and selected for analysis from the references in the chosen articles to be searched. Out of these 12 studies, 5 fulfilled the inclusion criteria and were included in this systematic review. To complete my research process, relevant articles from the selected articles were also checked and utilized, along with official reports from international organizations and non-governmental organizations (NGO).

Flow chart 1 – Description of the selection process for the inclusion of data in this systematic review.



Inclusion and exclusion criteria (*Box 1)*

Most research conducted on CRSV seem to focus on it as an issue of international security and a potential weapon of war (Cohen & Nordas, 2014). From the research conducted thus far, only Ba & Bhopals, 2017, systematic revision was found to address the health and psychosocial outcomes in civilian victims of conflict-related sexual violence. My search criteria differs in the sense that I do not consider the HIV/AIDs epidemic which appeared in 1981 to be the only pivotal factor in the internationalization of this issue, but also the feminist movements which grew in the 1990's due to the 1994 Rwandan Genocide and the war in the former Yugoslavia (1992-1995). It's international recognition lead to the possibility of increasing health-related research on this issue, where HIV/AIDs became one of the central issues of conflict-related sexual violence at the international level, with less light being shone on other health and psychosocial issues.

The search is limited to armed-conflicts from 1992 onwards after the start of the war in the former Yugoslavia due to its pivotal relevance in the growing feminist movements in the 1990's. This study includes international[53], interstate[54] and intrastate[55] conflicts and initial post-conflict scenarios[56] with the aim of improving access towards more reliable data. The subjects could be both male or female survivors of conflict-related sexual violence. Taking into consideration the sensitive nature of the topic alongside the difficulties in gathering research in conflict-torn societies no sample-size has been established, although restrictions are placed on the type of studies used which had to be either of a quantitative or mixed-method nature which were directly or indirectly linked to physical, mental and social health outcomes and consequences for the victims.

There was no limit placed on the ages of survivors, it was taken into consideration that the age of marriage and the perceived reaching of "adulthood" varies predominantly across

[53] An armed conflict between a government and a non-government party where the government side, the opposing side, or both sides, receive troop support from other governments that actively participate in the conflict (UCDP Definitions). See link https://www.pcr.uu.se/research/ucdp/definitions/#Ceasefire_agreements

[54] A conflict between two or more governments (UCDP Definitions). See link https://www.pcr.uu.se/research/ucdp/definitions/#Ceasefire_agreements

[55] A conflict between a government and a non-governmental party, with no interference from other countries (UCDP Definitions). See link https://www.pcr.uu.se/research/ucdp/definitions/#Ceasefire_agreements

[56] Formal cessation of conflict occurs when the involving parties come to an agreement, however, a formal agreement does not necessarily mean that violence comes to an immediate stop, especially when armed-groups and militias are a part of conflict. Which makes it important to not stop looking into conflict-related sexual violence in the months following the formal cessation.

various regions and contexts across the globe. However, I consider that the findings on children born out of conflict-related sexual violence would be a separate issue to conduct and develop research on in a different study, not only because they are the most vulnerable sub-group of victims, but also because the traumas they may endure may differ significantly to those which are direct victims of conflict-related sexual violence.

No exclusions were made by gender, socio-demographic characteristics or geographical-regions. Survivor included in the studies must be characterized as civilian's in armed conflict. Which results in perpetrators as conflict actors such as; military combatants, paramilitary combatants, combatants from armed groups and militias. Therefore, excluding inter-partner sexual violence, violence of a sexual nature perpetrated by civilians and sexual-violence perpetrated by peacekeepers.

Internally displaced or displaced victims in neighboring regions are also included, however asylum seekers and refugees[57] are not included in the included research criteria.

[57] Asylum seekers and refugees are excluded from the search criteria because it was concluded that due to the extreme dangers and inhumane treatments that both the categories of persons face during journey's and upon arrival in the receiving country/countries, that they have been exposed and become susceptible to other severe types of violent acts and traumas (Ba & Bhopal, 2017).

Box 1:

Inclusion Criteria	Exclusion Criteria
• Male or Female civilian victims of conflict-related sexual violence, with no limit placed on age, referring to or presenting any physical, mental or social health outcome. • International, interstate and intrastate conflict or post-conflict scenarios after 1992 occurring in any global region. • Perpetrators of the act must be identified as conflict actors in the included studies, which include combatants from an armed group, military combatants and militias. • Victims who are internally displaced and displaced in neighbouring regions. • Quantitative or mixed method research studies. • Sample-size was not limited.	• Any non-conflict sexual violence which includes inter-partner sexual violence, sexual violence perpetrated by civilian and sexual violence perpetrated by peacekeepers, ONG members or volunteers. • Asylum seekers and refugees. • Children born out of conflict-related sexual violence.

Results

Results of the search

Using the criteria set in *Box 1* (inclusion and exclusion criteria), studies had to meet one of the following set criteria; *physical health consequences, psychological consequences or social consequences*. Out of the 5 databases searched, 33 articles met these criteria; however 5 were excluded because these did not differentiate the results found between *conflict-related sexual violence* and *inter-partner violence.* This resulted in 28 studies with 21 within Africa, 4 within Europe, 2 within Asia and 1 which included Africa and Europe. 20 studies were focused exclusively on female victims of sexual violence, 2 exclusively on male survivors and 6 articles included male and female survivors. The characteristics of these articles along with the given or interpreted definition given by each study on sexual violence can be found in **Table 1.**

The studies are divided into continents and countries, and countries were organized from highest to the lowest amount of studies found, within each country studies are organized from the oldest to most recent studies belonging to that country. They have also been given a study number in order to facilitate the identification of each study throughout the results finding.

Table 1 – Characteristics of included studies				
Continent, Country, Study Number	**Author and Year of Publication**	**Definition of Sexual Violence**	**Number of subjects (total and by sex)**	**Study Design**
Africa **Democratic Republic of Congo – 17 studies**				
1	RFDA *et al.*, 2005	Rape, gang rape, forced rape between victims (including incestuous acts of rape), insertion of objects into victims' genitals[58]	492 = F	Snowball sampling technique
2	MSF, 2007	Any act of a sexual nature committed against a person's will	2695; F = 2462, M = 103	Retrospective study with patient notes
3	Onsrud *et al.*, 2008	Sexual assault occurring within a context of armed conflict	604 = F	Retrospective study
4	Mukwege & Nangini, 2009	Rape with extreme violence (gang rape, genital mutilation, intentional transmission of disease)	7519 = F	Case series using patient notes
5	Steiner *et al.*, 2009	Rape resulting from war persons'	20,517 = F	Case series with patient notes
6	Bartels *et al.*, 2010	Any unwanted physical contact of a sexual nature including acts such as gang rape and sexual slavery	1021 = F	Retrospective Cohort Study – Interviews with non-systemic convenience sample of hospital patients
7	Duroch *et al.*, 2011	Rape, or any act of a sexual nature which is committed on a person under coercive circumstances	2565; F = 2462, M = 103	Retrospective case study
8	Kelly *et al.*, 2011	Rape, gang rape, abduction lasting longer than 24h and forced incest	255 = F (193[59] experienced sexual violence)	Mixed-methods approach using a non-random sample of 255 women
9	Schalinski, Elbert and Schauer., 2011	Organized sexual violence	53 = F	Cross-sectional study

[58] The objects mentioned in this research article were; sticks, bottles, green bananas, pestles coated in chilli pepper and rifle barrels.
[59] This becomes the denominator for the statistics on women's experiences with rape.

10	Bartels *et al.*, 2012	Unwanted contact of a sexual nature[60].	4311 = F	Retrospective registry-based survivors
11	Christian *et al*., 2012	Forced sexual intercourse by the anus and mouth. Which included the insertion into orifices with objects such as stick or guns	15 = M	Qualitative study using purposive sampling, semi-structured interviews and focus groups
12	Mankuta *et al.*, 2012	Sexual violence characterized by sexual abuse	440 = F	Case series
13	Dossa *et al.*, 2014	Experience of forced sexual intercourse or other forms of forced sexual acts	320 = F	Cross-sectional population-based survey
14	Verelst *et al.*, 2014	Non-consensual sexual experience including but not limited to rape. Including fondling, sex in exchange for goods or forced prostitution.	1304 = F 183 were rape survivors 315 were non-consensual sexual violence survivors	Cross-sectional population-based survey
15	Zihindula & Maharaj, 2015	Any sexual attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force.	19 = F	Qualitative study with non-convenience sampling
16	Albutt *et al.*, 2016	Understood as being forced to have sex or into performing a sexual act against ones will.	310 = F (269[61] F experienced sexual violence)	Mixed method design
17	Ba & Bhopal, 2017	Used the definition provided by Lunde and Ortmann which includes; a) violence against the sexual organs b) physical sexual assault[62] c) mental sexual assault[63].	A total of 12 studies on the Democratic Republic of Congo were found. 9 of the studies focused only on female subjects and 3 studies included female and male subjects.	Systematic review

[60] *Sexual violence* was defined as any unwanted physical contact of a sexual nature. Sexual violence committed by 2 more assailants was classified as *gang rape*, and *sexual slavery* was defined as being held captive for the purpose of sexual violence for more than 24 hours. *Rape not otherwise specified* (rape NOS) was taken to be sexual violence committed by a single assailant and not involving sexual slavery and *Other* which includes acts of a sexual nature in front of family members, forced sexual assault between victims, anal penetration, forced oral sex, sexual harassment, forced to undress, and insertion of foreign objects into the vagina (Bartels *et al*., 2012, p. 394).

[61] This becomes the denominator for the statistics on women's experiences with rape.

[62] Such as; sexual acts involving direct physical contact between victims and torturer, between victim and victim, between victim and animal, or all of the above (Ba & Bhopal., 2017, p.122).

[63] Such as., forced nakedness, sexual humiliations, sexual threats and the witnessing of others being sexually tortured (Ba & Bhopal., 2017, p. 122).

Table 1 - Continued

Africa **Uganda – 3 studies**				
18	Kinyanda *et al.*, 2010	Violence against the sexual organs; physical sexual; mental sexual assault such as forced nakedness, sexual humiliations, sexual threats and witnessing other being sexually tortured. Acts which are involuntary, psychologically painful and whether or not they cause physical pain[64].	813; F = 573 M = 240	Cross-sectional study
19	P'Olak *et al.*, 2015	No definition is given – stating on *sexual violence*	210 = F	Longitudinal cohort study
20	Ba & Bhopal., 2017	As stated in previous section on the *Democratic Republic of Congo*.	2 studies were included both with the inclusion of female and male subjects.	Systematic review
Africa **Congo – 2 studies**				
21	Hustache *et al.*, 2009	Rape by unknown person identified as a military person through clothing worn	178 = F	Cohort of cases using interviews of patients at follow up in community
22	Ba & Bhopal., 2017	As stated in previous section on the *Democratic Republic of Congo*	1 study was found and is included in this systematic review	Systematic Review
Africa Kenya – 1 study				
23	Kuria *et al.*, 2014	N/A	272; F = 246, M = 22, Unknown = 1	Research-designed questionnaire

[64] Definition was also based on Lunde and Ortmann (1998).

Table 1 – Continued

Africa Liberia – 1 study				
24	Taylor-Smith et al., 2012	Utilized World Health Organization's definition[65] regarding sexual violence (2002)	1500; F = 1477, M = 23	Description of characteristics using routine data from 3 clinics offering care to sexual violence victims
Asia Iraq (Kurdish region) – 2 studies				
25	Ibrahim et al., 2018	Rape, sexual humiliation and sexual torture including forced marriage, gang rape, sex slavery and witnessing sexual abuse or rape.	416 = F	Conducted interviews
26	Kizilhan, J.I., 2018	Rape, gang rape including physical and verbal abuse and being forced to witness rape of others	296 = F	Conducted interviews
Europe Bosnia and Herzegovina – 2 studies				
27	Medica Zenica & Medica Mondiale, 2014	Rape	51 = F	Multi-method systematic design
28	Anderson *et al.*, 2019	Rape and other forms of gender-specific violence	104 = F	Retrospective Questionnaire
Europe Croatia – 2 studies[66]				
29	Loncar *et al.*, 2006	Unlawful sexual intercourse without the consent of the victim	68 = F	Structured clinical interviews
30	Loncar *et al.*, 2010	Physical torture to their genitals, such as beatings and castrations and psycho-sexual abuse. Insertion of objects in one's rectum. Performing acts of a sexual nature including anal sex, oral sex and mutual masturbation between victims.	60 = M	Structured interviews

[65] "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" WHO, 2002

[66] The studies included here are the same as the two included in the 2017 systematic review conducted by Ba & Bhopal.

Physical Health Outcomes (*Table 2*)

In total 16 studies out of the 28 searched contained physical health outcomes for survivors of conflict-related sexual violence (Table 2). From Africa the following studies were found; 9 studies were from the Democratic Republic of Congo, 2 were from Uganda and Kenya and Liberia had one study demonstrating theses outcomes, resulting in 13 studies in total. From Europe 3 studies were found, 2 from Croatia and 1 from Bosnia and Herzegovina. These were grouped into three categories; 1) Physical and reproductive health injuries; 2) Sexually transmitted diseases/related incidents and; 3) Results concerning pregnancy and abortion.

12 focused exclusively on female survivors, 1 on male survivors and 3 presented results for both male and female survivors, however, it is important to mention that Kinyarda *et al.,* 2010 study in Uganda, although included male and female survivors, results on any of the outcomes researched were only available for female survivors.

Physical, Sexual and Reproductive Health Injuries

The most common outcome in females relates to gynaecological symptoms. In Onsrud *et al.,* 2008 (study 3) which focused exclusively on prevalence of fistula as a result of conflict-related sexual violence 4% (*n*=24/604) were found to have fistulae. Studies 1, 2, 18 found a common pattern in either leaking blood, urine or faeces or vaginal discharge contaminated with blood, urine or faeces, these are signs that a fistula may be present (RFDA *et al.,* 2005).

The majority of the studies conducted (Studies 1, 3, 4, 5, 6, 12, 18, 24, 27, 30) showed that sexual violence survivors had a variety of genital injuries and symptoms which could be signs of a sexually transmitted disease, vaginal infection or could have a need for surgical intervention. If we analyse the physical and gynaecological injuries and symptoms column in table 2, data collected also shows that some symptoms such as Leucorrhoea (heavy periods), for example, immediately suggests the presence of a sexually transmitted infection. Dysuria (difficult or painful urinating), pains in the lower abdomen, and irregular periods can also all be symptoms of vaginal infections. These medical conditions can lead to primary sterility in women who have never given birth, or secondary sterility in those who have already had at least one baby. This is because, if they do not receive appropriate

treatment in time, the infection can travel up the vagina and uterus and infect and block the Fallopian tubes[67] (RFDA *et al.,* 2005, p.40).

Urine and faeces flowing from the vagina are signs of vesico-vaginal and recto-vaginal fistulas, which also need surgical intervention. Women suffering from this have to wear sanitary towels constantly or in most cases, because of the poverty in which most of them live, just a piece of cloth, which they have to wash frequently. Women with vaginal fistulas often live apart from the rest of the community, because of the bad smells that they give off (RFDA *et al.,* 2005)

Regarding male victims, only three studies contained any direct results concerning any physical or reproductive lesion. MSF, 2007 (study 2) and Taylor-Smith et al., 2012 (study 24) both refer to anal and rectal pain and lesions, however these two studies do not differentiate between male and female survivors of conflict-related sexual violence. The last study including male victims, Loncar *et al.,* 2010 (study 30) refers to beating of the testicles (68.3% *n*= 41/60) and semicastration's (11.6% *n*=7/60).

Sexually Transmitted Diseases and Related Information

6 studies made references to sexually transmitted diseases or to any related act, which included being tested for sexually transmitted diseases or undergoing any treatment such as the post-exposure prophylaxis (PEP) treatment.

Out of the 6 studies, 4 collected data on the number of people infected with a Sexually Transmitted Disease. Mukewege and Nangini, 2009 (study 4) found that 4.5% (*n*=338/7519) females included in the study had contracted the human immunodeficiency virus (HIV) and 3% (*n*=226/7519) females had contracted Syphilis. Zihindula and Maharaj, 2015 (study 15), found that out of the 19 females included in the study that 42.1% (*n*=8) had contracted the human immunodeficiency disorder (HIV). Kinyarda *et al.,* 2010 (study 18), found that out of the 164 women who had endured conflict-related sexual violence, 5.4% (*n*= 9) self-reported having the human immunodeficiency disorder and Taylor-Smith et al., 2012 (study 24), reported that out of the 28.9% (*n* = 433) of those

[67] This can render fertility almost impossible and thus can compromise the women's future childbearing prospects. The same is true for prolapse of the womb and for vaginal tearing, which requires surgical repair, especially in the case of women of childbearing age (RFDA *et al.,* 2005, p.40).

tested for the human immunodeficiency disorder 1% (*n*=4) came back with a positive status.

Steiner *et al.,* 2009 (study 5), also reported that out of the 42.3% (*n*=8,677) of the female participants in the sample underwent HIV testing, however the study fails to mention the final results of the testing. Whereas studies 23 and 24 include the number of survivors who accessed post-exposure prophylaxis treatment in the 72-hour time frame after possible exposure.

Pregnancy/Abortion

Four studies (6,7, 19 and 29) gathered data on women and girls who had become pregnant as a result of conflict-related sexual violence. However, only study 9 (Loncar *et al.,* 2009) collected evidence on women who accessed abortion and found that out of the 29 women who became pregnant due to rape, 17 had chosen to have an abortion and the remaining 12 gave the baby away for adoption.

Table 2 – Physical Health Outcomes

Study Number	Author (s), Year	Sex (*n*)	Physical, Sexual and Reproductive Health Injuries	Sexually Transmitted Diseases/Related Information	Pregnancy/Abortion
Africa **Democratic Republic of Congo** **1**	RFDA *et al.*, 2005	492 *f*	121 (24.6%) – Vaginal discharge (blood) 200 (40.6%) – Vaginal discharge (Urine and faeces) 21 (4.3%) – Sustained injuries with machetes or sticks 112 (22.8%) – Inflammation of the vulva 69 (14%) – Vaginal tearing		
2	MSF, 2007[68]	2462 *f* 103 *m*	1547 (57.7) – Pain in lower abdomen 554 (22.5%) – Dysmenrrehoea and Metrorragia[69] 531 (19.7%) – Pruritus[70] 391 (14.5%) – Mictalgia[71] 154 (5.7%) – Genital/Anus pain		
3	Onsrud *et al.*, 2008	604 *f*	24 (4,0%) – fistula[72]		
4	Mukwege & Nangini, 2009	7519 *f*	1594 (21.2%) – Vaginal itching 1368 (18.2%) – Urinary infection	226 (3,0%) – Syphilis 338 (4.5%) – HIV Positive	
5	Steiner *et al.*, 2009	20,517 *f*		8,677 (42.3%) were tested for HIV	
6	Bartels *et al.*, 2010	1021 *f*	220 (21.5%) – Pelvic pain 112 (10.9%) – Lumbar pain 70 (60.9%) – Abdominal pain 55 (5.3%) – Vaginal discharge 43 (4.2%) – Vaginal itching		62 (6%) pregnancies

[68] Symptomology by sex is not stated
[69] Disruptions to the menstrual cycle
[70] Itching of the genital area
[71] Pain when urinating
[72] A fistula is the connection between two hollow spaces. Onsrud, 2009 defines fistula as the communication between the vagina and the bladder or rectum.

7	Duroch *et al.*, 2011	2,462 *f*			88 (3.6%) pregnancies
12	Mankuta *et al.*, 2012	440 *f*	9 (2.1%) – Genital mutilation		
15	Zihindula & Maharaj, 2015	19 *f*		8 (42.1%) – HIV Positive 11 (57.9%) – Not tested for HIV	
Uganda **18**	Kinyanda *et al.*, 2010	164[73] *f = CRSV*	52 (31.7%) – Abnormal vaginal discharge 57 (34.7%) – Abnormal vaginal bleeding 31 (18.9%) – Vaginal and perineal tear 23 (14,0%) – Leaking urine 11 (6.7%) – Leaking faeces 17 (10.3%) – Genital laxity/prolapse 47 (28.6%) – Genital sores	9 (5.4%) – HIV positive	
19	P'Olak *et al.*, 2015	135/210 *f* conflict-related sexual violence survivors 68 *f* sexual violence survivors with no children (SVNC) 67 *f* sexual violence survivors with children (SVWC)			67/135 (49.6%) had resulted in pregnancies
Kenya **23**	Kuria *et al.*, 2014	249 *f* 22 *m* 1 *unknown*		136 (50.1%) had received post-exposure prophylaxis (PEP)	
Liberia **24**	Taylor-Smith *et al.*, 2012	1477[74] *f* 22 *m* 1500[75] *total*	133 (9,0%) – vaginal wall lesions 443 (30,0%) – Pathological vaginal discharge 33 (3,0%) – Anal and rectal lesions	28.9 % (*n* = 433) were tested for HIV status, which revealed 1,0% (n=4) to be HIV positive.	

[73] This becomes the denominator for the statistics on women's experiences with rape.
[74] Out of the 1477 females, 98% (1447) of them underwent a vaginal examination, this becomes the denominator for the statistics shown in **Table 2.**
[75] Out of the 1500 total, 73% (1095) underwent a rectal and anal examination, this becomes the denominator for the statistics shown in **Table 2.**

				Out of the 41.2% (*n* = 618) who were eligible for post-exposure prophylaxis treatment (PEP), 77.8% (*n* = 481) completed treatment	
Europe **Bosnia and Herzegovina** **27**	Medica Zenica, 2014	51 *f*	30 (58,0%) showed a gynaecological symptom		
Croatia **29**	Loncar *et al.*, 2006	68 *f*			29 (19.7%) pregnancies 17 (58.8%) abortion
30	Loncar *et al.*, 2010	60 *m*	41 (68.3%) – had severe beatings of testicles 7 (11.6%) – semicastration		

Mental Health Outcomes

Mental health outcomes were divided into two separate tables on relating to the psychological outcomes (Table 4) and the second table referred to psychiatric disorders identified in survivors of conflict-related sexual violence (Table 5).

Four studies from the Democratic Republic of Congo (studies 1,2, 5 and 6) and 2 studies from Croatia (studies 29 and 30) identified psychological outcomes in the victims of conflict-related sexual violence with reoccurring themes such as insomnias and nightmares, feeling anxious and avoidance and isolation (see Table 4).

Psychiatric disorders (see Table 5) in survivors of conflict-related sexual violence were found in 13 of the studies analysed. The most prevalent disorders found were post-traumatic stress disorder (PTSD) (studies 9, 11, 12, 21, 25, 26, 27, 28, 29), depression (studies 9, 14, 19, 21, 26 and 29), anxiety disorder (studies 19, 21, 26 and 27), suicide attempts and suicide ideation (studies 18, 26, 27 and 29). In the other category the following psychiatric disorders were also identified; psychological distress syndrome (studies 13 and 18), alcoholism (study 18), psychotic symptoms (study 19), adjustment disorder (study 21), acute stress disorder (study 21), social phobia (study 29) and the consumption of psycho-pharmacological drugs (study 27).

Although post-traumatic stress disorder (PTSD) was found to be the most common psychiatric disorder, its prevalence varies greatly from study to study, whereas in studies 11 and 25 all the participants were found to meet the criteria for PTSD. However, studies 21 and 29 found much lower prevalence's of PTSD, this can be due to several factors. Firstly studies 21 and 29 were conducted after a long-period of time and whereas studies 9, 25 and 26 state that the instrument used as criteria in identifying PTSD was the *Diagnostic* and *Statistics Manual* (DSM) IV or V, other studies do not refer which instrument was utilised to come to the diagnosis of PTSD.

PTSD and depression were found to have similar results throughout the analysed results, whereas anxiety disorder (studies 19, 21, 26 and 27) was less documented, but showed that conflict-related sexual violence survivors where highly affected by this disorder.

Studies 18, 26, 27 and 29 found that suicide ideation is a cause for concern, especially studies 27 and 29 which were conducted on sexual violence survivors from the war in the former Yugoslavia, which show that more than a decade later suicide ideation was still particularly high amongst the study sample.

Table 4 – Psychological Outcomes

Study Number	Author(s), Year	Sex (*n*)	Psychological Outcomes
Africa **Democratic Republic of Congo** **1**	RFDA *et al.*, 2005	492 *f*	383 (77.2%) – Insomnias/Nightmares
2	MSF, 2007	2462 *f* 103 *m* 2695 *total*[76]	353 (13.1%) – worrying, feeling anxious or feeling low 326 (12.1%) – Loss of appetite 294 (10.9%) – Insomnia 601 (22.3%) – Other psychological issue
5	Steiner *et al.*, 2009	20,517	17,075 (83.2%) received psycho-social treatment
6	Bartels *et al.*, 2006	1021 *f*	256 (25%) – Anxiety surrounding rape 57 (5.6%) – Anxiety about spousal abandonment 124 (12,0%) – Concern on sexually transmitted infections 84 (8.5%) – Concern over HIV status
Europe **Croatia** **29**	Loncar.*et al.*, 2006	68 *f*	55 (80.8%) – Depressiveness 40 (58.8%) – Avoidance 18 (26.4%) – Negation 18 (26.4%) – Self accusation
30	Loncar *et al.*, 2010	60 *m*	40 (66.6%) – Avoidance 28 (46.6%) – Isolation 24 (40,0%) – Numbness 60 (100%) – Sleep disturbances 47 (78.3%) – Feelings of hopelessness

[76] The study does differentiate between the sex of victims.

Table 5 – Outcomes for psychiatric disorders[77]

Study Number	Author(s), Year	Sex (*n*)	Post-Traumatic Stress Disorder	Depression	Anxiety Disorder	Suicide Ideation/Attempted Suicide	Other
Africa **Democratic Republic of Congo** **9**	Schalinski, Elbert & Schauer., 2011	53 *f*	37 (69.8%) – Met the criteria according to the DSM-IV	30 (56.6%) – Met the criteria according to the DSM-IV			
11	Christian *et al*., 2012	15[78] *m*	All victims met the criteria for PTSD				
12	Mankuta *et al.*, 2012	440 *f*	54 (12.2%)				
13	Dossa *et al.*, 2014	320 *f* 67 *f* victims of CRSV[79]					67 (100%) met the criteria for Psychological Distress Syndrome
14	Verelst *et al.*, 2014	1304 *f* 183 *rape survivors* 315 *non-consensual sexual violence survivors* 498 *total*		Found to be higher than in non-rape or non-sexual violence			
Uganda **18**	Kinyarda *et al*., 2010	813/573 (164[80] CRSV) *f*[81] 240 (16 CRSV) *m*				31 (18.9%) – attempted suicide	33 (20,0%) Alcoholism 112 (68.2%) fulfilled criteria for Psychological Stress Disorder

[77] Disorders recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM) – V.
[78] After learning about the nature of the study only 8 male victims decided to participate.
[79] This becomes the denominator for the statistics on women's experiences with rape.
[80] This becomes the denominator for the statistics on women's experiences with rape.
[81] Only females were analysed for psychiatric disorders.

19	P'Olak *et al.*, 2015	135/210 *f* conflict-related sexual violence survivors 68 *f* sexual violence survivors with no children (SVNC) 67 *f* sexual violence survivors with children (SVWC)		35 (51.4%) – SVNC 49 (73.7%) - SVWC	35 (51.4%) – SVNC 49 (73.7%) - SVWC		Psychotic symptoms – 14 (20.9%) – SVNC 16 (23.3%) - SVWC
Congo **21**	Hustache *et al*., 2009	70 *f*[82]	2 (3,0%)	6 (9.1%)	38 (59.1%)		2 (3,0%) – Adjustment disorder 9 (14,0%) – Acute stress disorder
Asia **Iraq (Kurdistan region)** **25**	Ibrahim *et al.*, 2019	65/416 *f* sexual violence survivors	65 (100%) all met the criteria according to the DSM-V.				
26	Kizilhan, J.I., 2018	296 *f*	144 (48.6%) all met the criteria according to the DSM-IV	158 (53.4%)	116 (39,0%)	159 (53.7%) – Suicide ideation	
Europe **Bosnia and Herzegovina** **27**	Medica Zendica, 2014	51 *f*	29 (51,0%)		39 (76,0%)	26 (40,0%) – Suicide ideation	46 (91.1%) took psycho-pharmacological drugs
28	Anderson, 2019	104 *f*	96 (92.3%)				
Croatia **29**	Loncar *et al*., 2006	68 *f*	21 (30.8%)	52 (76.4%)		25 (36.7%) – Suicide ideation	51 (75,0%) – Social phobia

[82] 6 conflict-related survivors were excluded due to severe psychological distress, leaving 64 survivors as the main denominator for given statistics.

Social Outcomes

In total, 12 studies, gathered data on family rejection, spousal abandonment, community rejection, feelings of shame, stigma, humiliation and fear or other behaviours which may have made a survivor of conflict-related sexual violence feel marginalized or looked down upon within their community or family.

Studies 5,6, 8, 13, 14 and 27 found that survivors had suffered from family rejection and spousal abandonment due to having endured an act of sexual violence during conflict. Whereas studies 8, 14 and 19 also found that conflict-related sexual violence survivors could also be rejected by their community. Study 1 also quantifies survivors which felt shame, stigma and fear due to the sexual abuse they had endured.

A very common outcome which reflects social perception regarding sexual violence is related to survivors that refused to participate in the studies due to the nature. This can be found in studies 11, 25 and 27. Study 21 tried to contact 178 identified sexual violence survivors, however, due to lack of shared information and deaths caused by HIV, only 70 women could be contacted to participate in the study, however 6 out of the 70 women were deemed too psychologically unstable to participate.

Study 19 showed particularly interesting results as it analysed female survivors with no children as an outcome for sexual violence and female survivors with children and questioned them separately to understand if they have distinguished differences regarding social outcomes. Study 19 shows that concerning community relations, sexual violence survivors with children were more prone to community stigma and hindered community relationship.

Study 14 also divided sexual violence survivors into two different terminologies. Those who identified the sexual abuse as rape and those who identified it as non-consensual sexual violence. In Verelst *et al*., 2014, the study states that rape victims in the Democratic Republic of Congo are perceived as being more damaged than those who identified having endured non-consensual sexual violence. The study reported a higher prevalence of sexual violence survivors being rejected and treated badly by their family (including corporal punishment) compared to those who identified as non-consensual sexual violence victims. It was also found that rape survivors were 8x more likely than non-sexual violence survivors to be accused of witchcraft and 4x less likely to access medical services.

Study 11 (Christian *et al.,* 2011), was the only study to focus on social outcomes for male survivors of conflict-related sexual violence in the Democratic Republic of Congo. It identified that men felt stigma, shame, fear and humiliation and that due to these feelings, they had all left the job they held previously and no longer worked outside the home because they did not want to face their community.

Studies 7 and 21 also found that in cases where conflict-related sexual violence was not necessarily public, survivors had not informed their family of the act they had endured. In study 7, it was found that 97.3% of survivors had not informed their families.

Table 5 – Social outcomes

Study Number	Author(s), Year	Sex (*n*)	Family Rejection	Community Rejection	Shame, Stigma, Fear and Humiliation	Other
Africa **Democratic Republic of Congo** **1**	RFDA *et al.*, 2005	492 *f*			450 (91.5%) – shame and fear	
5	Steiner *et al.*, 2009	20, 517 *f*	1092 (5.3%) – Family rejection			
6	Bartels *et al.*, 2006	1021 *f*	62 (6%) – Spousal abandonment			
7	Duroch *et al.*, 2011	2,462 *f*				2,496 (97.3%) had not notified the family that they had endured CRSV
8	Kelly *et al.*, 2011	193/ 255 *f* CRSV survivors	56 (29%) – Family rejection	12 (6.2%)		
11	Christian *et al.*, 2011	15 *m*				8 (100%) no longer worked outside the home due to fear and stigma within the community. 7 (46.6%) of male sexual violence survivors refused to participate in the study due to its nature.
13	Dossa *et al.*, 2014	67/320 *f* CRSV survivors	19 (28.4%) – Rejected by their husbands			67 (100%) stated that sexual violence had been the most traumatic event during war
14	Verelst *et al.*, 2014	1304 *f* 183 - rape survivors 315 - non-consensual sexual violence survivors	52 (28.4%) of rape survivors were rejected by their family whilst 94 (51.3%) of rape victims also stated being treated badly by their family due to being raped. 73 (21.1%) of non-consensual sexual violence stated being rejected whilst 88 (27.9%) reported being treated badly by their family due to sexual violence.	90 (41.9%) of rape survivors 57 (18%) of non-consensual sexual violence survivors		Rape survivors were 8x more likely to be accused of witchcraft. Rape survivors were found to be 4x less likely to access health care services due to stigma. 104 (57,0%) rape survivors reported corporal punishment by a family

						member. 132 (49.2%) non-consensual sexual violence survivors reported corporal punishment by a family member. 119 (65,0%) of rape survivors reported being publicly insulted due to the incident. 155 (49.2%) of non-consensual sexual violence survivors reported being insulted publicly due to the incident endured.
Uganda **19**	P'olak *et al.*, 2015	135/210 *f* 68 – sexual violence with no children (SVNC) 67 – sexual violence with children (SVWC)		33 (48.8%) – SVNC reported that their relationship with the community had worsen 45 (67.3%) – SVWC reported that their relationship with the community had worsen	42 (61.7) – SVNC reported feeling community stigma towards them 52 (77.6%) – SVWC reported feeling community stigma towards them	
Congo **21**	Hustache *et al.*, 2009	64 *f* Initially 178 women had been contacted. However only 70 women of those searched for were found to participate in the study. 6 were excluded because they were suffering from severe psychological conditions.				20 (31.3%) reported intense detachment in their familial, work and social spheres. 22 (34.3%) had not told their family about the sexual violence they endured.
Asia - Iraq **25**	Ibrahim *et al.*, 2018	436 *f*				22 (5,0%) refused to participate in the study due to its nature.

Europe **Bosnia and Herzegovina** **27**	Medica Zendica *et al*., 2014	51 *f*	38 (74.5%) reported that the relationship with their husband had been hindered due to CRSV.			28 of the women contacted to participate refused due to its nature. 43 (85,0%) see a doctor regularly. 46 (91,0%) use psycho-pharmalogical drugs

Discussion

Overview of findings

To my knowledge only one systematic review has been conducted on the health and social outcomes of civilian victims of conflict-related sexual violence (Ba and Bhopal, 2017)[83]. I have found various similarities between the results found in the original systematic review and the ones which are presented here. There were 28 studies included from eight countries[84] in three continents which matched the inclusion criteria set. Comparisons between studies were difficult to analyse, as there were little studies available which focused on collecting data on the same issue. The heterogeneity of definitions given on sexual violence also summarizes the difficulties for data collection and research, if there is no accepted homogenous definition across the board as to what constitutes as sexual violence then there are bound to be shortcomings in the range of studies offered for analysis.

Although studies proved heterogenous in sample and data collected, common themes were found across the data extracted in all three outcomes searched. Ten studies analysed found physical, sexual and reproductive injuries. HIV was present in all the studies where survivors were tested or asked if they knew their HIV status. Concerning the deficiency of the survivor's well-being, insomnias, isolation and worrying were common concerns when survivors were questioned and there was a strong prevalence of post-traumatic stress disorder, depression, anxiety and suicide ideation on those which analysed mental illness.

Social consequences were slightly more homogenous regarding survivors rejected by their families or spouses, although Steiner *et al*., 2009 study reported 5.3% victims to be rejected by their family a much higher quantity, 36.9% were successfully reintegrated back into their community. Of course, this does not relegate those who are rejected, but demonstrates that successful reintegration back into families and communities can be successful if reintegration methods are used. Community rejections were found to be less prevalent than family rejection, however results show that across all regions included survivors felt shame and stigma towards the incident endured, worry, anxiety and avoidance were found to be common among fears survivors had in regard as to how family

[83] There are differences recorded between this systematic review and Ba & Bhopal's 2017 original systematic review. This is due to differences in the inclusion and exclusion criteria set, for example, the original sample size in Ba & Bhopal's systematic review which required a sample size of 50 or over, this review did not set a sample size in the hopes to find more studies concerning outcomes for men and boys.

[84] Since the original systematic review was published two new studies from Iraq were found that fulfilled the inclusion criteria.

and community viewed them. When asked about whether they had disclosed the information to their family, studies showed that high numbers of survivors had not disclosed this information to their family.

Definitions on Sexual Violence

When looking through the exact or implied definitions of sexual violence given throughout the 28 studies, we can see a trend of inexact meanings of what sexual violence in the context of armed conflict can be. The inclusion of diverse definitions in the methodology section was intentional, because during my research no two definitions were found to be the same, and excluding one in favour of another, could potentially exclude survivors if one definition did not fit into one narrow view. As we can verify in ***Table 1*** fixed or implied definition were varied, which included anything from acts of humiliation, sexual slavery, gang-rape and the use of objects. Other definitions offered a much more limited or vague and subjective definitions such as; rape, acts of a sexual nature or organized sexual acts. These can limit the researcher's sample availability when for example sexual violence is limited to only rape. Readers understanding can also be wrought when vague and subjective definitions such as "acts of a sexual nature" are utilized, as one person's understanding of sexual violence does not indicate another person's understanding. Subjective or singular definitions are particularly dangerous when attempting to raise awareness and implement policies on victims of sexual violence, because it may be unconsciously agreeing with existing narrow views that already exist towards sexual violence, for example, that it can be limited to penetrative rape between a man and a woman, therefore possibly excluding protection and care of survivors who do not fit these definition frameworks.

Conflict-related Sexual Violence; A Global Health Issue?

The World Health Organization (WHO) designated three threats to global health[85] in 2019 that are particularly worrisome to conflict-related sexual violence; 1) Fragile and vulnerable settings[86]; 2) Weak primary health care; 3) Prevalence of HIV (WHO, 2019).

[85] The definition of Global Health is widely disputed with no consensus for its overall aim (Beaglehole & Bonita). However, there appears to be an overall agreement that recognises global health to be determined by problems, issues and concerns that transcend national boundaries usually in a low- and middle-income regional context (Kickbush, 2006; UK Government, 2008).

[86] The World Health Organization states that more than 1.6 billion people live in places where protracted crises (through a combination of challenges such as drought, famine, conflict and population displacement). The WHO equally recognises that many countries do not have adequate primary health care facilities (due to

The costs of conflict-related sexual violence to global health are substantial (Kuo *et al.,* 2018). Survivors are prone to numerous issues from the consequences resulting from the experience, such as; death and injury, depression, alcohol and substance abuse, sexually transmitted infections, unwanted pregnancy and abortion (WHO, 2013). These not only implicate monetary costs but more difficult to measure individual costs to survivors such as stigma, humiliation, shame and social ostracism (Loncar *et al.,* 2006; Wood, 2006; García-Moreno, 2014; Kuo *et al.,* 2018). Moreover, culture shapes community perception on illness, and considering that global health implicates the assessment of well-being and disease prevalence in cross-cultural contexts, there is a need to not underestimate the value of these cultural implications when addressing victims (Hustache *et al.,* 2009).

If Murray (2002), argues that epidemiological research requires more input from political scientists, Southall (2011), completes this by underlining direct input needed by medical professionals and local healers on global health in armed conflict contexts. The key is advocacy based on the understanding of the complexity of the issue so as to improve policies and research on the issue.

HIV and other Sexually Transmitted Diseases

The human immunodeficiency virus (HIV) was only addressed in studies conducted in Africa (Democratic Republic of Congo, Kenya, Liberia and Uganda). From the research collected, it was found that small percentages of those included in the samples knew their HIV status or had been tested for HIV, for example in Kinyanda's study in Uganda, out of the 164 survivors of sexual violence, 82.3% were unaware of their HIV status, therefore had not been tested. The same was found in the study conducted in Liberia, where less than one third of the sample size (n=433/1500) had been tested for HIV, the study from Liberia did however find that a high percentage of those offered PEP completed treatment. In the study conducted in Kenya, hospital records also found a positive percentage of those receiving PEP. Although the two studies are small in sample size, it gives hope and direction for more inclusion of PEP, because when PEP is offered to victims then they are susceptible to completing treatment. Research across the board found that other than stigma, shame and secrecy around sexual violence, lack of financial resources and absence

lack of resources in low or middle income countries) (WHO, 2019) See link https://www.who.int/emergencies/ten-threats-to-global-health-in-2019. Considering that armed conflicts lead to mass infrastructure destruction (complex emergency) limiting victim access to health care services, brutally committed acts of conflict-related sexual violence result as a cause for concern in the global health field. For example; in providing Pre- exposure prophylaxis and free testing for HIV.

of health clinics also prove major barriers to survivors of conflict-related sexual violence (MSF; 2007; Pruitt, 2012; Claude *et al.,* 2013).

The only other sexually transmitted disease documented was syphilis (Mukwege and Nangini, 2009), which leaves us with a gap in data which we are unable to comment on. Understandably, the prevalence of HIV worldwide is massive, and estimates believe that around 8-10% of those infected with HIV are affected by armed conflict and humanitarian crises (UNICEF 2006; Claude, 2013). However, due to the instability of conflict it proves difficult to monitor who and how HIV or other sexually transmittable diseases are spread (Kerridge, 2015).

Linking rejection, stigma and HIV

HIV is also a major cause for concern for the survivor, the family and the community. HIV globally is still very much understood as a death sentence, because of lack to adequate health care especially in lower- and middle-income countries (where the majority of armed conflict takes place), which leads to fear and stigmatization (WHO HIV; Levy & Sidel, 2016). This is detrimental to the marginalization of women and girls as they are ordered to prove to their husband, patriarchal family member or community that they have not contracted this disease so as to be allowed back into the familial home (RFDA *et al.,* 2005; Kelly *et al.,* Claude, 2013). Communities can also place pressure on the victim's family and husband to exclude and reject women and girls because they name them as being "contaminated" and "diseased" (Kelly *et al.,* 2008). According to the research developed by Trenholm *et al.,* 2009, husbands claimed that they were dissuaded from accepting their wife back because of a possible contamination (women are understood as bringing disease or sickness) and causing anxiety to their spouse due to this.

HIV is also a major concern to global health because victims such as men and boys are not dully identified as victims. This poses as extremely dangerous to the victim, but also to their wives if they are not identified and do not seek adequate health care. As shown in Verelst, 2014 study conducted in the Democratic Republic of Congo, rape survivors of conflict-related armed conflict were 4x less likely to access health-care due to shame and stigma. Whereas, in Hustache, 2009 study in Congo, a third of those victims of conflict-related sexual violence had not disclosed this information to family for fear of stigmatization and shame.

Sexual and Reproductive Injuries

Childbearing is an expected role of women found cross-culturally (Kelly *et al.,* 2011). Although the types of sexual violence survivors endured are not included in this study, sexual violence is widely recognized as being extremely cruel, through the usage of objects and systematic gang-rape (MSF, 2007; Kinyanda, 2010; Claude, 2013; Ba & Bhopal, 2017). A series of gynaecological injuries were found across the studies conducted in Africa, along with Loncar's, 2006 study in Croatia. Consequences such as fistula were only observed in Onsrud's, 2008 study in the Democratic Republic of Congo. However, the RFDA *et al.,* 2005 study along with Kinyanda *et al.,* 2010 study conducted in Uganda found injuries which could be possible signs of fistula, such as leaking blood and faeces or vaginal discharge also containing blood and faeces. Fistulae often require surgical interventions, and if not correctly addressed can lead to infertility and pain. Women and girls may not have the monetary means to promptly access surgery if these services are even available at all (MSF, 2007; Onsrud *et al.,* 2009). Worldwide, the most common causes of genital fistula are obstetric. Due to this, literature does not generally highlight rape or sexual violence as an important cause of traumatic gynaecological fistula, and indeed, some researchers have disputed an association of any significant public health magnitude (Longombe *et al.,* 2008, p.133). When women are perceived as being physically "damaged", that is, unable to conceive children, this may affect social perceptions of them. Not being able to fulfil their duties in motherhood can result in self and community stigmatization and shame. Paradoxically, when women bear children of combatants they are even more stigmatized, as found in P'Olak *et al.,* 2015 study conducted in Uganda, which found that ill-treatment on behalf of family members and community stigma was higher for those, who bore babies, sometimes referred to as "children of the enemy" (Marks, 2013).

The very limited studies available on the consequences endured by males of conflict-related sexual violence cannot unfortunately give us any solid evidence on whether males are susceptible to severe physical injuries and health consequences. There are three studies however with limitations, that may indicate that males are just as prone to severe physical outcomes as females. In MSF, 2007 study in the Democratic Republic of Congo, anal pain is also included as a sign, along with Tayler-Smith *et al.,* 2012 study in Liberia which found that anal and rectal lesions were prevalent among the small sample of male victims

of sexual violence. Loncar's, 2010 study in Croatia also found that one fifth of the men included in the study suffered from semicastration's. Anal and genital violation is according to Christian *et al.,* 2011, a grave form of shame and stigma. It not only weakens men but emasculates them, relegating them to the same inferior position of a woman in society. Masculinity is also closely tied with sexuality, fear of perceived homosexuality can also cause shame, stigma and prevent men from coming forward, as Alison 2007 puts it, homosexuality is the biggest threat to hegemonic masculinity, even in western societies (p.77). The issue of incapability to reproduce can also play a part in feelings of shame and stigmatization, although smaller of that of what a woman must endure (Sivakumaran, 2010).

Addressing mental health as a consequence for survivors of conflict-related sexual violence

Post-traumatic stress disorder, depression, anxiety and suicide ideation were common finds throughout all the countries which are included in this review. With the exception of Medica Zendica & Medica Modiale's 2014 study in Bosnia and Herzegovina, which highlights that the majority of women access a doctor regularly and take psycho-pharmacological drugs and Steiner *et al.,* 2009 study where 83% of victims were offered psychosocial treatment, the remaining studies underline that psychological treatment is often unavailable, leaving victims without adequate access to psychological or psychiatric treatment. The need for treatment is not only emphasised through common signs of PTSD, depression and anxiety, but also through anxiety provoked over the worry of rape and HIV found in the studies conducted by MSF, 2007 and Bartels *et al.,* 2006 in the Democratic Republic of Congo.

Health facilities in conflict and post-conflict zones

Armed conflicts, internal disturbances and other types of unrest create a generalized state of instability and insecurity, that often makes maintaining a minimally functional health system almost impossible (Nickerson, 2015, p.347). Conflict zones with health facilities are often destroyed, looted, isolated from communities or suffer from brain drain because health personnel flee the scenario (Cuadrados & Gonzalez,2014; MSF, 2014). Lack of access to health care is not only detrimental to victims of conflict-related sexual violence, but to all victims of conflict who are unable to seek treatment. This should be equally

addressed in the UNSG Resolutions along with prevention of sexual violence in conflict and bringing perpetrators to justice.

Socio-cultural perceptions and their danger to survivors

Men and women face discrimination and stigmatization cross-culturally due to sexual violence. Rather than discussing if discrimination and stigmatization is worse or easier on male or female victims, I propose to discuss the relevance in addressing them equally in the international context. As previously referenced men are often considered hidden or silent victims in this context (Solangon & Patel, 2009; Touquet & Gorris, 2015), the WPS Agenda and the UNSC Resolution 1325 (200) were introduced to increase protection and equality against dominance held and violence committed by men. As the primary victims of CRSV, acknowledging women and girls should never be considered less of a priority on the international agenda. Especially as the results included here demonstrate that women are still highly rejected and stigmatized in communities. The inclusion of males in Resolution 2106 (2013) was met with some backlash from feminist activists, politicians and literary scholars, who feared that the inclusion of men and boys alongside women and girls would take away attention and financial resources from the cause (Apperley, 2015).

The inclusion of men as victims of sexual violence should not exist to distract from women and girls, but rather include them in the narrative which fights for victims of sexual violence to be recognized alongside women and girls across contexts which do not accept that women and men do not participate in cruel and degrading acts out of free will, and who alongside women and girls should not be shamed, stigmatized and potentially accused of sodomy when accessing justice and health services.

Limitations

There were many limitations to this systematic review. The first being the number of studies available, although searches were made in English, Spanish and Portuguese, only studies in English were found. Out of the 28 studies included only 5 included male victims, and included no results on them. 17 were from the Democratic Republic of Congo. Studies conducted in other countries in conflict or post-conflict situations were sparse and far between, and even though, as identified by Ba & Bhopal, 2017, there were 18 prevalent conflicts with sexual violence at the time of the development of the study. This gives a rather biased look into health and social outcomes, as we may be incorrectly perceiving the sociocultural norms and views from the Democratic Republic of Congo as homogenous, because there is less of a focus on outcomes in other conflict areas. This is not to say that there have not been breakthroughs, for example, one of the main issues that the UNSG acknowledges in the 2019 sexual violence report is that gathering data from conflicts in the Middle-East is extremely difficult due to the strong barriers imposed by cultural and religious beliefs which strongly prohibit discussions of a sexual nature outside of marriage. Here we were able to identify two studies with survivors from Iraq (Kurdistan region), conducted in Germany, providing a way to counter-act the difficulties of conducting research where conflict is taking place and can be hindered through religious and cultural beliefs.

Only definitions given or implied by studies on what the term conflict-related sexual violence entails were included. One of the main limitations of this revision are that the types of sexual acts were not included. In future research, I would include the types of sexual abuses endured to help with definitional purposes and help further define the gravity of sexual violence on survivor's health outcomes. Acts such as gang rape, anal rape, oral rape, incest and the use of objects to conduct the sexual abuse, along with other acts such as enforced pregnancy, enforced abortion and acts of sexual humiliation such as enforced masturbation and sexual dancing can be found across literature, which I recognise I should have included here to further validate data found.

This revision includes 5 studies with male survivors of sexual violence. Duroch's 2011 study which includes a portion of male survivors only refers to the types of sexual violence these endured but presents none of the outcomes they suffered, although these were available for female survivors. When analysing male survivors, I found a gap concerning the understanding of civilians. In Ba & Bhopal's 2017 systematic review, Johnson *et al,*

2008 study of male and female victims of conflict-related sexual violence is included. The reason for not including it this revision was due to the results for civilians and non-civilians not being differentiated, finding what I consider to be a gap in international politics and law. Mechanisms of war do not split murky conflict into civilians and combatants[87], and whilst I recognise the importance of civilian protection, members of armed groups are not necessarily there out of free will, nor do they escape acts of violence. There is a thin line, and populations especially men may be coerced into partaking in crimes against civilians whilst they, themselves are sexually abused (Johnson *et al.,* 2008). This limits data collection, because men may be excluded due to combatant status, when they have endured the same acts of sexual violence but may fear coming forward or seeking access to healthcare because they live in fear due to being associated with the enemy (Johnson *et al.,* 2008; Sivakumaran; 2010; Cohen *et al;* 2013). This leave us with a gap to be filled in epidemiological research which could be seen as necessary to global health practices and also how should this issue be addressed at the political level?

No size of study sample was introduced to try to facilitate studies addressing male victims of sexual violence. However, even with no sample size set, only one study with less than 50 admitted survivors was found. In total only two studies were found on male victims, which does not give us a clear view on health and social outcomes they may endure. Across the field of research on male victims of conflict-related sexual violence initiated by Sandesh Sivakumara (2007), he states that male victims can be identified in 25 conflicts from the past three decades, this is followed by continuous research on the matter (solangon & Patel, 2009; Cohen *et al.,* 2013; Apperley, 2015; Gorris 2015; Touquet & Gorris; 2016). If males are being identified across the board, then undoubtedly there is a research void that should be further addressed.

[87] International Humanitarian Law states that there must always be a distinction between civilian and combatant. See link https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule1

Conclusion

This study highlights physical, mental and social consequences of male and female civilian victims of conflict-related sexual violence. Women and girls are unequivocally disproportionately affected by conflict-related sexual violence compared to men. An analysis of the international agenda was provided in relation to the UNSC Resolutions 1325 (2000), 1820 (2008), 1888 (2009), 1960 (2010) and 2106 (2013) on its inclusion of male victims and why along with prevention and justice in this scenario, health care services also need to be urgently addressed so to improve gaps in policy-making and global health research.

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Annex

Figure 1:

Countries which are considered by the United Nations Secretary General 2019 *Conflict Related Sexual Violence* report, relating to 2018, in urgent need of attention concerning this issue.

Sexual Violence in Conflict Settings

Country	Region
Afghanistan	Asia
Central African Republic	Africa
Colombia	South America
Democratic Republic of the Congo	Africa
Iraq	Asia
Libya	Africa
Mali	Africa
Myanmar	Asia
Somalia	Africa
South Sudan	Africa
Sudan (Darfur)	Africa
Syrian Arab Republic	Asia
Yemen	Asia

(S/2019/280, p. 10 – 35 see link https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/04/report/s-2019-280/Annual-report-2018.pdf)

Sexual Violence in Post-conflict Settings

Country	Region
Bosnia and Herzegovina	Europe
Côte d'Ivoire	Africa
Nepal	Asia
Sri Lanka	Asia

(S/2019/280, p. 36 – 43 see link https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/04/report/s-2019-280/Annual-report-2018.pdf)

Other situations the United Nations Secretary General considers to be of concern

Country	Region
Burundi	Africa
Nigeria	Africa

(S/2019/2018, p. 44 – 47 see link https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/04/report/s-2019-280/Annual-report-2018.pdf)

Figure 2:

Number of countries which still criminalize homosexual practices;

According to the *International Lesbian, Gay, Bisexual, Trans and Intersex Association* (ILGA) report 2019, 68 United Nations Members still criminalize consensual same-sex acts.

Continent	Number of Countries per Continent which still criminalize same-sex consensual acts	Percentage of countries per continent which still criminalize same-sex consensual acts
Africa	**32/54 countries**	**59%**
Latin America & Caribbean	**9/33 countries**	**27%**
North America	**0/2 countries**	**O%**
Asia	**21/42 countries**	**50%**
Europe	**0/48**	**0%**
Oceania	**6/14 countries**	**43%**
Total	**68/193**	**35%**

(ILGA, 2019, p.197 see link https://ilga.org/downloads/ILGA_State_Sponsored_Homophobia_2019.pdf)

Figure 3:

Number of countries which still apply the death penalty as punishment for homosexual practices

According to the *International Lesbian, Gay, Bisexual, Trans and Intersex Association* (ILGA) report 2019, 8 countries still apply the death penalty as punishment for homosexual practices

Country	Continent
Mauritania	Africa (however just applicable if the act is between men)
Nigeria	Africa
Somalia	Africa
Sudan	Africa
Iran	Asia
Saudi Arabia	Asia
UAE	Asia

(ILGA, 2019, p. 198 – 202 see link https://ilga.org/downloads/ILGA_State_Sponsored_Homophobia_2019.pdf)