

**Barriers and Facilitators to Physical and Mental Health Help-Seeking
among Congolese Male Refugee Survivors of Conflict-Related Sexual
Violence living in Kampala.**

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Philosophy in Public Mental Health in the Faculty of Arts and Social Sciences
at Stellenbosch University*



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DECLARATION

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ABSTRACT

Background. Armed conflicts place ordinary people at risk of injury, displacement, sexual violence, and hunger among other challenges. The United Nations High Commissioner for Refugees (UNHCR) states that conflicts result in people fleeing their countries, and consequently, a significant increase in the number of people affected, such as the over half a million found in Uganda. The DRC has one of the largest population of refugees in the Great Lakes Region, with Uganda hosting about 195 746 refugees from the country. A salient feature of the conflict in DRC is the widespread sexual violence inflicted on males and females of all ages. Male victims of rape often fall through the cracks especially regarding the delivery of services as most focus on female survivors. Few studies on conflict-related sexual violence (CRSV) in general have been conducted among male refugee survivors in urban post-conflict settings. Specifically, very few studies have been conducted to investigate barriers and facilitators among male survivors who are seeking help from physical and mental health services. This study explored barriers and facilitators encountered by male refugee survivors of CRSV seeking physical and mental health assistance, and elicited suggestions for overcoming the identified barriers.

Methods. Sixteen participants were recruited in total, and of these, ten were male refugee survivors of CRSV from DRC, aged between 18 and 47 years, living in Kampala, Uganda. The rest of the participants were six service providers including: medical practitioners, psychologists and counsellors. 4 were male and 2 female, aged between 25 and 58 years, working in Kampala, Uganda. The study adopted a qualitative research design using semi-structured in-depth interviews. The study was mainly conducted at the premises of the head office of the Refugee Law Project (RLP), an organisation providing support to refugees. Qualitative research computer software, NVivo 11 for Windows, was used to analyse the data, with the aid of the framework approach, which ensured a systematic analysis of the data.

Results. Regarding barriers to accessing treatment, themes that emerged from the analysis included socio-cultural and political barriers, poor health and infrastructural systems, poverty and lack of livelihood, physical effects of CRSV, fear of marital disharmony and breakup, and self-sufficiency. Facilitators to accessing treatment described by the respondents included social support, symptom severity, professionalism among service providers, availability of free tailored services; and information, education and communication. To

overcome the barriers, participants suggested strategies such as increasing information and communication, providing education and training, providing required infrastructure, developing and implementing gender inclusive policies and models, increasing research and addressing basic food and employment needs. In order to attain a broad understanding of the issues raised, the Ecological Systems Theory by Bronfenbrenner was used in the discussion.

Conclusion. Overall, findings of the study show that male survivors of CRSV are faced with several barriers in seeking physical and mental health assistance. A multidisciplinary and multisectoral approach is important to address the issues raised. In addition, participants recommended that government should effect change in several legal and health policies to recognise that sexual violence against men is an issue of genuine concern.

OPSOMMING

Agtergrond. Gewapende konflik hou onder andere die gevaar van beserings, verplasing, seksuele geweld en honger vir gewone mense in. Volgens die Verenigde Nasies se Hoë Kommissaris vir Vlughtelinge, lei konflik daartoe dat mense uit hul lande vlug en dat die aantal mense wat daardeur geraak word gevolglik aanmerklik toeneem, waarvan die meer as half miljoen vlughtelinge in Uganda 'n voorbeeld is. Die Demokratiese Republiek Kongo (DRK) het een van die grootste bevolkings vlughtelinge in die Groot Mere-streek, en daar is bykans 195 746 vlughtelinge van dié land in Uganda. 'n Hoof trek van die konflik in die DRK is die wydverspreide seksuele konflik wat deur mans en vroue van alle ouderdomme ervaar word. Manslagoffers van verkragting word dikwels oorgesien, veral wat dienslewering betref, aangesien die meeste dienste op vroue-oorlewendes gefokus is. Min studies oor konflikverwante seksuele geweld (KSG) in die algemeen is onder mansvlughtelinge in stedelike nákonflikomgewings uitgevoer. Baie min studies is spesifiek gedoen om ondersoek in te stel na hindernisse en fasiliteerders onder mansoorlewendes wat hulp by fisiese en geestelike gesondheidsdienste vra. Hierdie studie het hindernisse en fasiliteerders ondersoek soos wat dit ervaar is deur mansvlughtelingoorlewendes van KSG wat fisiese en geestelike gesondheidshulp versoek het, en maak voorstelle oor hoe die geïdentifiseerde hindernisse oorkom kan word.

Metodes. Sestien deelnemers is altesaam gewerf, en hiervan was tien mansvlughtelingoorlewendes van KSG uit die DRK, tussen die ouderdom 18 en 47 jaar, wat in Kampala, Uganda, woon. Die res van die deelnemers was ses diensverskaffers, insluitende mediese praktisyns, sielkundiges en beraders. Vier was mans en twee was vroue, tussen die ouderdom 25 en 58 jaar, wat in Kampala, Uganda, werk. Die studie het 'n kwalitatiewe navorsingsontwerp gevolg met semigestruktureerde diepte-onderhoude. Die studie is hoofsaaklik by die perseel van die hoofkantoor van die Refugee Law Project, 'n organisasie wat hulp aan vlughtelinge bied, uitgevoer. Rekenaarprogrammatuur vir kwalitatiewe navorsing, NVivo 11 for Windows, is gebruik om die data te ontleed, met behulp van die raamwerkbenadering, wat 'n stelselmatige ontleding van die data verseker het.

Resultate. Ten opsigte van hindernisse tot toegang tot behandeling, het temas wat uit die ontleding na vore gekom het sosio-kulturele en politieke hindernisse, swak gesondheid- en infrastruktuurstelsels, armoede en gebrek aan lewensonderhoud, fisiese gevolge van KSG, vrees vir onenigheid in die huwelik en egskedding, en selfonderhoudendheid ingesluit.

Fasiliteerders tot toegang tot behandeling wat deur die deelnemers beskryf is, het sosiale ondersteuning; erns van simptome; professionalisme onder diensverskaffers; beskikbaarheid van gratis pasgemaakte dienste; en inligting, opvoeding en kommunikasie ingesluit. Om die hindernisse te oorkom, het die deelnemers strategieë soos toename in inligting en kommunikasie, verskaffing van opvoeding en opleiding, verskaffing van die nodige infrastruktuur, ontwikkeling en implementering van geslagsinklusiewe beleide en modelle, toename in navorsing en voldoening in basiese voedsel- en werkbehoefte voorgestel. Om 'n breë begrip van die kwessies te verkry, is Bronfenbrenner se ekologiese stelselteorie in die bespreking gebruik.

Gevolgtrekking. Die algemene bevindinge van die studie toon dat mansoorlewendes van KSG voor verskeie hindernisse te staan kom ten opsigte van toegang tot fisiese en geestelike gesondheidshulp. 'n Multidissiplinêre en multisektorbenadering is belangrik om hierdie kwessies aan te pak. Hierbenewens het deelnemers aanbeveel dat die regering verandering in verskeie regs- en gesondheidsbeleide aanbring om erkenning daaraan te gee dat seksuele geweld teen mans 'n kommerwekkende kwessie is.

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DEDICATION

To the male survivors of conflict related sexual violence that took part in this study. Thank you for speaking up so that others with the same experience can receive help. You are stronger than you know.

To the service providers that treat male survivors of sexual violence with empathy, thank you for standing out of the crowd.

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LIST OF ABBREVIATIONS

CBTI	Cognitive-behavioral therapy for insomnia
CRSV	Conflict-Related Sexual Violence
DRC	Democratic Republic of Congo
DBTF	Development-Based Trauma Framework
HIAS	Hebrew Immigrant Aid Society
IRT	Imagery Rehearsal Therapy
MOH	Men of Hope
OPM	Office of the Prime Minister
PEP	Post-Exposure Prophylaxis
PTGI	Posttraumatic Growth Inventory
PTSD	Post-Traumatic Stress Disorders
RLP	Refugee Law Project
STSS	Secondary Traumatic Stress Scale
SGBV	Sexual and Gender Based Violence
UNHCR	United Nations High Commissioner for Refugees

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CHAPTER ONE

INTRODUCTION

1.1 Background

Since 1946, there has been documentation of 245 armed conflicts globally, of which 144 were wars (Themner & Wallensteen, 2014). The United Nations High Commissioner for Refugees (UNHCR) states that such conflicts, wars and gross human rights violations, including sexual violence, are some of the reasons people flee their countries. This kind of forced migration has resulted in a significant increase in the number of persons of concern under the UNHCR mandate which was estimated at 16.1 million people at the end of 2015 (UNHCR, 2016a). In Uganda alone, there were 509 077 people of concern under the UNHCR mandate (UNHCR, 2016b). UNHCR defines people of concern as persons that have been forcefully displaced from their homes and they include refugees, asylum seekers, internally displaced persons, among others (UNHCR, 2016b). They come from neighbouring countries such as South Sudan, Burundi, Somalia, Ethiopia, Democratic Republic of Congo (DRC), among others. As a country grappling with civil war since 2008, the war in the DRC has been referred to as Africa's world war (International Rescue Commission, 2007). The conflict in DRC is mentioned as one of the most intense wars, because it has more than 1000 battle-related deaths in a calendar year (Themner & Wallensteen, 2014). As a result of this protracted situation, the DRC is the largest source of refugees to countries in the Great Lakes region, with Uganda hosting about 195 746 refugees from DRC alone (UNHCR, 2016b).

A salient feature of the conflict in DRC is the widespread sexual violence meted out against males and females of all ages which has been a major reason for flight among nationals seeking to escape and find refuge elsewhere. DRC lies in the conflict area of the great lakes region where sexual violence has been reported as a widespread phenomenon (Cohen & Nordas, 2014; Kinyanda et al., 2010; Nelson et al., 2011). In the DRC, war rape has been carried out on an enormous scale prompting the former U.N. Special Representative on Sexual Violence in Conflict Margot Wallstrom to refer to Eastern Congo as "the rape capital of the world" (Africa Research Bulletin, 2011). Several studies note that sexual violence has always been part of many armed conflicts worldwide, but it differs in the scale, type, target group and tactics (Jewkes, Sen, & Garcia-Moreno, 2012; Tol et al., 2013), and it

is globally recognised as a human rights violation and security issue (Cohen & Nordas, 2014).

There are still limited data about conflict-related sexual violence (CRSV) against women and girls. Yet for the men and boys, the data gap is alarming, making it hard to prioritise sexual violence against males as an issue for discussion in the human rights discourse (United Nations, 2013). A known and documented fact however, is that women and girls, as well as men and boys, can be victims of CRSV (Carpenter, 2006; Kinyanda et al., 2010). Male victims of rape often miss out in the delivery of health care services, as most are focused on female survivors (Kohli et al., 2012; Médecins sans Frontières, 2009). Regardless of whether victims of CRSV are male or female civilians, their physical, psychological and social well-being are affected (Kohli et al., 2012). The effects of CRSV are many and diverse, and they are categorised into the five Ps in the United Nations (UN) workshop report on sexual violence against men and boys in conflict situations (United Nations, 2013). These are Physical, Psychological, Psycho-sexual, Psycho-social, and Political.

Studies such as Weaver and Burns (2001) have documented trauma among asylum seekers but the focus of this thesis is on the physical and psychological aspects. Various researchers have noted that studies which have documented physical and psychological effects of CRSV on victims have mainly focused on women (Colombini, 2002; Dossa, Zunzunegui, Hatem, & Fraser, 2014; Heise, Ellsberg, & Gottmoeller, 2002; Hustache et al., 2009; Longombe, Claude, & Ruminjo, 2008; Mukwege & Nangini, 2009). The UN workshop report on sexual violence against men and boys in conflict situations however highlights the specific physical and psychological effects of sexual violence against men and boys (United Nations, 2013). Physical effects include but are not limited to: bruising, lacerations, abrasions and tearing of the anal and genital area, rectal damage, and sexually transmitted infections (STIs) such as gonorrhoea, HIV, hepatitis, chlamydia, and syphilis. Male victims of sexual violence may also experience chronic pain in the back, head, abdomen, rectum, infections due to untreated wounds, chronic fatigue and gastro-intestinal difficulties (Tewksbury, 2007b; United Nations, 2013).

The same report also notes that the psychological effects of CRSV against men and boys may be very serious and prolonged (United Nations, 2013). They note that victims may experience acute stress disorders, especially in the first three months after the incident, and a substantial proportion of the victims may later develop post-traumatic stress disorder (PTSD)

(United Nations, 2013). For example, a study conducted in Masisi, DRC in 2008 found that the prevalence of PTSD was 81% among sexually abused male combatants (Médecins sans Frontières, 2009). PTSD has been noted to exist in up to 30% of the victims, ten years after the occurrence (United Nations, 2013). Other psychological effects include depression, low self-esteem, emotional numbing, anxiety disorders, panic attacks, phobias, suicidal ideation and substance abuse as a coping mechanism (Akinsulure-Smith, 2014; Clifford, 2008; Tewksbury, 2007a; United Nations, 2013). Sexual violence is a medical emergency that has various effects on the lives of the victims, their families, and communities (Médecins sans Frontières, 2009) and yet few studies have explored barriers and facilitators to physical and mental health help-seeking among CRSV survivors in general, and in men specifically.

The studies conducted among female survivors of CRSV have identified a few factors which act as barriers to physical and psychological help-seeking. They include: stigma, ignorance about available resources, the high cost of medical care, under-resourced facilities, high staff turnovers, long geographical distances to the health centres, political insecurity and under-resourced facilities are some of the reasons for delayed help-seeking. Additional barriers include lack of psychosocial services and the stigma attached to seeing a psychologist (Cohen & Nordas, 2014; Harris & Freccero, 2011; Kohli et al., 2012). CRSV is aggravated by the lack of health services for victims in most conflict areas (Médecins sans Frontières, 2009). Important to note is the fact that even fewer studies have investigated facilitators to physical and mental health help-seeking among CRSV survivors, and yet this could perhaps help in motivating other survivors to seek help. The few that have ventured into this field have focused only on female survivors.

Research findings indicate that a victim's level of education and marital status play a role in facilitating them to seek help as a result of sexual violence. An example is a study conducted in South Kivu, DRC, which found that female survivors of sexual violence who were more likely to report rape were more often single, and had completed secondary education (Bartels et al., 2012). This study seems to suggest that a higher education level is a facilitator for help-seeking among victims of sexual violence. Another study, albeit conducted among college students that are female survivors of sexual violence identified factors such as encouragement from family and friends, knowledge that rape is wrong and the desire to speak out and help other women get help facilitated help-seeking (Guerette & Caron, 2007).

Available literature suggests that the barriers and facilitators faced by survivors of sexual violence in the process of seeking help are multilayered and multifaceted. Theories such as the Ecological Systems Theory (EST) can be used to analyse this phenomenon. EST espouses that a person's surrounding environment affects their development (Bronfenbrenner, 1994). The theory suggests that this environment is divided into five different levels which include: the microsystem, which is the immediate environment, the mesosystem, which is the connections, the exosystem, representing the indirect environment, the macrosystem, which is the social and cultural values, and finally, the chronosystem, which is known to change overtime (Bronfenbrenner, 1994). An individual's life and behaviour are affected and influenced by these levels.

1.2 Rationale of the Study

Few studies on CRSV in general have been conducted on male refugee survivors in post-urban conflict settings. Specifically, there are hardly any studies conducted to investigate barriers and facilitators to physical and mental health help-seeking among male survivors. This study therefore sought to bridge that gap by exploring barriers and facilitators among service providers and male refugee survivors of CRSV in urban post-conflict settings, seeking help regarding their physical and mental health. The study also explored solutions to overcome these barriers, and also the practitioners' experiences in working with refugee male survivors of CRSV. By so doing, knowledge was generated and it may be used to influence practice and further research in physical and mental health, plus other relevant fields. It is also hoped that the knowledge will sensitise policy makers to make gender inclusive policies in the health service delivery system, not only in Uganda but in all countries where male survivors of sexual violence can hardly access services.

1.3 Aim

To investigate barriers and facilitators to physical and mental health help-seeking, among Congolese male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda.

1.4 Objectives

This study therefore sought:

1. To explore survivors' experiences and perceptions regarding barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
2. To elicit survivors views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
3. To explore the experiences of practitioners working with male survivors of conflict-related sexual violence.
4. To elicit practitioners views on barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.

1.5 Outline of the Dissertation

The previous section of this chapter has provided the background, rationale, aim and objectives of this study. In chapter two, I present the literature review and the methodology used for this study is described in chapter three. Chapters four and five will present the findings of the study and the discussion of the findings will cover chapter six. In chapter six, I will also compare the findings with available literature, make recommendations for practice, policy and research, and also present a conclusion on the study.

CHAPTER TWO

LITERATURE REVIEW

2. 1 Introduction

The literature review for this study will begin by defining the concept of conflict-related sexual violence (CRSV), followed by its causes and then a brief discussion on what makes it a global security concern. This explanation will establish a background as to why it predominantly features in the seemingly unending conflict in the Democratic Republic of Congo (DRC). The background will be followed by a discussion of the characteristics of CRSV in DRC specifically, highlighting who the victims and perpetrators are. After that, a literature review on the medical and mental health consequences of sexual violence will be presented in order to facilitate understanding on why CRSV survivors need to seek medical and psychological help. All these sections will provide a background for this study. The rationale for this study will be put forward in a discussion on the barriers and facilitators to physical and mental health help-seeking among victims and survivors of CRSV. This will be followed by a discussion on the experience of professionals working with survivors of trauma. After this, the chapter will look at the recommendations available in current literature on how to overcome barriers to physical and mental health seeking among survivors of sexual violence. The last section of this chapter will be a discussion on the Ecological Systems Theory which will be applied in discussing the findings of the study.

Sources of the literature included online databases at Stellenbosch University Library and Information service, as well as “grey literature” (Giustini and Thompson, 2012) from colleagues and refugee service organisations, who responded to a request for relevant documents for this study. It included reports, conference papers, and policy documents, among others. This grey literature widened the scope of literature analysis and helped to overcome possible bias that may have been contained in published information. The EBSCOhost research database that contains journals such as Humanities Source Ultimate, Health Source, Psychology and Behavioural Science Collection, among others, produced high returns for this literature search. Search terms used included ‘Barriers and Facilitators AND ‘Help-Seeking AND Sexual Violence OR Rape AND War.’

2.2 Conflict-Related Sexual Violence

In this study, the definition of CRSV is drawn from a report on mental health and psychosocial support for CRSV:

“It includes rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence . . . against women, men, girls or boys. Such incidents or patterns occur in conflict or post-conflict settings or other situations of concern (e.g. political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e. a temporal, geographical and/or causal link” (World Health Organisation, United Nations Population Fund, & United Nations Children's Fund, 2011).

CRSV features in most civil wars that have been documented, dating as far back as ancient Babylon, and it is used as a weapon of war, ethnic cleansing and genocide (Cohen & Nordas, 2014; Trenholm, Olsson, & Ahlberg, 2011). Brownmiller (1975) notes that some of the first reports on sexual violence in war in the twentieth century were on the riots of Kristallnacht in 1938, in Nazi Germany, and also the Japanese abuse of Chinese women in the ‘rape of Nanking’ in 1937-1938. As a weapon of war, the United Nations Security Council Resolution (UNSCR) number 1820 notes that sexual violence escalates conflicts and is a threat to global peace and security (United Nations, 2013). In the past years, wartime sexual violence was framed as an affair only for women, but since the issue gained widespread notoriety in the mid-1990s after the war in Yugoslavia, it has shifted to being understood as a ‘security issue’ and has also been regarded as a weapon of war (Crawford, 2013; Oosterhoff, Zwanikken, & Ketting, 2004).

CRSV has become a global discussion over the years due to the work of feminists and human rights activists, and also due to the nature and visibility of warfare across the globe (United Nations, 2013). War rape has been documented in countries like Rwanda where it was used for genocide purposes, and in Bosnia, Afghanistan, Cambodia, Colombia, Central African Republic, Uganda, and South Sudan, among others, but data remains scarce (United Nations, 2013). Data on sexual violence in conflict areas are not easily available and what is available suggests that CRSV is not uncommon. For example, a study in Liberia found that while 42.3% of women combatants and 9.2% of civilian women had experienced sexual violence during the conflict, the same was true for 32.6% of male combatants and 7.4% of male civilians (Johnson et al., 2008). Nagai, Karunakara, Rowley, and Burnham (2008), in

their study of South Sudanese Refugees in Arua, Uganda and in Yei County, South Sudan, found that 30.4% of both male South Sudanese refugees and 46.9% of male Sudanese non-refugees had witnessed or experienced male rape or sexual abuse. Koss, Heise, and Russo (1994) argue that studies aimed at understanding the prevalence and consequences of rape are not common because rape and assault in war have become institutionalised norms and the victims are silent.

Male victims of sexual violence in particular have been reported in 33 different conflicts (Cohen & Nordas, 2014). Male rape and castration were reported in Serbia, Bosnia, Sarajevo, Sierra Leone, Cambodia and many other countries but actual figures are not easy to collect (Carpenter, 2006; Storr, 2011; United Nations, 2013). In the post-conflict dimension, many male refugees continue to face sexual abuse and exploitation in exile and this is still considered to be CRSV as seen in Sri-Lanka among male returnees (United Nations, 2013). Dolan (2014) provides figures from a systematic screening and documentation from eastern DRC provided by the Refugee Law Project (RLP) and the Johns Hopkins University School of Public Health which seem to suggest that in some refugee populations, more than one in three men have experienced sexual violence in their lifetime.

2.2.1 Conflict-Related Sexual Violence in the Democratic Republic of Congo

The current war in DRC escalated after the 1994 Rwanda genocide and, coupled with the collapse of the Mobutu government, has claimed millions of civilian lives and has left people's property pillaged (Bartels et al., 2012; Christian, Safari, Ramazani, Burnham, & Glass, 2011b). DRC's natural resources and its position as involuntary host to armed rebel groups from the neighbouring countries are the main reasons for the unending war in Eastern DRC (Longombe et al., 2008; Lwambo, 2013). As 'Africa's world war' not only is it linked to the Rwanda genocide, but it also has a stake in other regional uprisings like the rebel situation in Uganda, including the Sudanese and Angolan civil wars (Meger, 2010). For that reason, many foreign armies, including the UN army, have been drawn into the country to combat it. Furthermore, many new rebel groups, some without obvious reasons to fight and some clamouring for economic power, have joined the conflict.

As the conflict in the DRC escalates, sexual violence against women, girls, men and boys has also increased leaving victims with physical and emotional wounds as documented in several studies (Bartels et al., 2010; Longombe et al., 2008; Mukwege & Nangini, 2009).

Although data are scarce, a few studies have been conducted in the DRC to try and understand the magnitude of CRSV in DRC. An example is the study by Johnson et al. (2010) in Eastern DRC which found that 23.6% of their male respondents had been victims of sexual violence while 32.2% to 47.2% of female respondents were victims of sexual violence. Another survey conducted by Peterman, Palermo, and Bredenkamp (2011) in DRC documented figures as high as 407397 to 433785 civilian women aged between 15 to 49 years who had been raped 12 months prior to the survey. This figure means that 1150 women were raped every day, 48 women raped every hour and 4 women raped every 5 minutes (Peterman et al., 2011). Armed actors in the conflict have been reported by respondents in some studies to be the primary perpetrators of sexual violence and such armed actors include state armies, pro-government militias (PGMs) and rebel groups (Cohen & Nordas, 2014; Dolan, 2010). In the conflict areas of the DRC, sexual violence is also perpetrated by civilians, including key societal figures like “teachers, pastors, priests, catechists and peacekeepers” (p. 6) (Dolan, 2010). Such figures are often viewed as pillars of strength, comfort and refuge, and to have them on the list of perpetrators of such human rights abuse may be an indicator of a crime that is being committed with impunity.

A study of rape and sexual violence in the South Kivu region of DRC identified four types of rape that included: individual rape, gang rape, rape where victims are forced to rape each other, and using blunt objects that are inserted into the genitals of women (Ohambe, Galloy, & Sow, 2004). Rape with objects is also employed in cases where perpetrators, especially males, are unable to get physiological reactions in such situations (Dolan, 2010). Some of these forms of rape are particularly offensive to those adhering to tradition and social norms (Cohen & Nordas, 2014). Examples include victims that have been forced to rape their relatives or family members, such as sons with mothers, fathers with daughters, brothers with sisters, men with men, or watch their close family members getting raped (Carpenter, 2006; Dolan, 2010). Dolan (2010) therefore cautions that there is a need to recognise that perpetrators of CRSV may also be victims and this also applies to armed combatants who are forced by their superiors and peers to rape and kill.

Several forms of sexual violence in the DRC have been mentioned in various studies and they include rape with sexual organs and rape with objects, for example, bottles, bayonets, gun butts, pestles smeared with chilli pepper, sticks, oranges, rape in public, and urogenital mutilation, among others (Harvard Humanitarian Initiative, 2009; Peterman et al., 2011; Wakabi, 2008). Sexual violence perpetrated against men in particular in the DRC takes

the forms of oral and anal rape, genital torture, castration and forced sterilisation, gang rape, sexual slavery and rape by proxy (Dolan, 2014). Reports from the DRC indicate that men have also been forced to sit with their genitals over fire, drag rocks tied to their penis, or dig holes in trees with acidic sap or in the ground and then sexually penetrate the holes (Storr, 2011). Available literature also reveals that both women and men can be victims and can also be perpetrators although it is mostly men that perpetrate this violence (Carpenter, 2006; Kinyanda et al., 2010; Storr, 2011; United Nations, 2013).

2.2.2 Causes of Conflict-Related Sexual Violence

A number of researchers have come up with various explanations as to what causes rape during war. The increased attention to CRSV has led to a better understanding of why and how sexual violence occurs and evidence shows that CRSV is in most cases uncoordinated, not planned and may result from collapsing legal and social structures (Ward & Vann, 2002). Some scholars however disagree with this school of thought. Milillo (2006), for example, argues that war rape is systematic because of several themes that emerge from the different studies of war rape. She writes that such themes include the fact that it is used as a punishment and those targeted are people related to those known to the perpetrators as enemies. Female rape victims interviewed in Kosovo revealed that they were raped in the process of flight or when abducted (Milillo, 2006). This may be an indication that the perpetrators knew where, when and how to find them. To this, Milillo (2006) adds another theme that points to the fact that CRSV is done in more brutal ways in terms of frequency and weapons used as compared to everyday accounts of sexual violence.

In the case of DRC, one study organises the causes into two categories: individual and institutional causes (Meger, 2010). Individual causes include the definition of manhood by society and the low status of women in society (Milillo, 2006; Trenholm et al., 2011). This notion seems to suggest that CRSV is a gender struggle. “It is inflicted on men as a means of disempowerment, dominance and undermining concepts of masculinity” (p.12) as stated in the Guidance Note 4 on Working with Men and Boy Survivors of Sexual and Gender Based Violence in Forced Displacement (United Nations High Commissioner for Refugees & Refugee Law Project, 2012). Male survivors of sexual violence in DRC shared that the rape meted out against them by soldiers or rebels is an attack on who society thinks they are and was meant to destroy “their status and role in the household, extended family and community (p.234)” (Christian, Safari, Ramazani, Burnham, & Glass, 2011a). Skjelsbaek (2001)

criticises the gender argument saying that it exhibits ignorance of the fact that men too can be assaulted in male dominated systems. Meger (2010) writes that the institutional reason as a cause of CRSV is for the economic gain of the groups involved in this conflict, but that this does not rule out the contribution of individual agency. She writes that in the DRC, CRSV is an effective gender weapon used to quell the masses, and that war is a business model used by warring factions and global traders to extract minerals from resource laden areas.

Brownmiller (1975) adds a sociobiological theory to the concept of masculinity when she observes that once men knew that their genitals could be used as a weapon of force, they all became potential threats to all women. This is an issue of contention however because men are raped too, as cited in several studies and women also have been documented to perpetrate rape (Crawford, 2013; Mezey & King, 2000; Oosterhoff et al., 2004). Several previous studies however agree that victims of sexual violence are mostly women and girls, and men are most often the perpetrators (Christian et al., 2011b). However, a survey of 998 households in Eastern DRC reported that 29.9% of male respondents had been victims of sexual violence and that 10.0% of these particular cases were perpetrated by women (Johnson et al., 2010). In addition to this, objects such as sticks and gun bayonets are used to perpetrate rape (Christian et al., 2011b) as opposed to only genitalia as espoused by Brownmiller (1975). Sexual violence also occurs in several forms “depending on the social cultural context” (Koss et al., 1994), and has several consequences, including medical and psychological, that not only affects individuals, but families and communities as well.

2.3 Medical and Mental Health Consequences of Conflict-Related Sexual Violence

Globally, the negative effect of war on civilians is reflected in their poor physical, psychological, economic and social well-being (Kohli et al., 2012). Responses of sexual violence victims to their trauma are based on their personality and life experiences (Akinsulure-Smith, 2014; Follette, Polusny, Bechtle, & Naugle, 1996). A study conducted in the Walungu territory of South Kivu, Eastern DRC, revealed that sexual and gender-based violence against men is an important but neglected public health issue for male survivors, their families and communities in rural DRC (Christian et al., 2011b). In the DRC, the health consequence of rape has led to rape being labelled as ‘the new pathology’ (Mukwege & Nangini, 2009). All this serves to show that there is a need to count the economic cost of this pathology, along with its prevalence and accompanying disability.

2.3.1 Medical Consequences of Conflict-Related Sexual Violence

The consequences of war rape are many and varied and they may be dependent on the form of rape perpetrated against the victims. However, the physical effects of CRSV against men and boys so far identified and mentioned earlier include: bruising, lacerations, abrasions and tearing of the anal and genital area, rectal damage, sexually transmitted infections (STIs), chronic pain the back, among others (United Nations, 2013). Alarmingly, few studies on physical and mental health effects have been conducted among male CRSV survivors, and studies that have included men have actually primarily focused on the female participants as survivors of CSRV (United Nations, 2013).

An example is a study conducted among female internally displaced persons (IDPs), and their male and female family members in northern Uganda on war related sexual violence and its consequences on physical and mental health (Kinyanda et al., 2010). The study found that 4.25% of male respondents to the study were also victims of sexual violence and that reproductive, surgical and psychological problems were found in both males and females despite the investigators' focus on female IDPs (Kinyanda et al., 2010). Kinyanda et al. (2010) further note that "as surgical consequences, survivors of war related sexual violence may report lower lumbar pain sometimes radiating to the pelvis or gluteal region, with many having difficulties in standing or sitting for long periods." This is also noted by Storr (2011) and it means that the physical effects of CRSV at times require surgical procedures whose effects further physically incapacitate the victims. However, among the men, it is not necessarily as a result of surgery, but rather a direct consequence of the sexual violence meted out against them (Médecins sans Frontières, 2009; Mukwege & Nangini, 2009). Cases have also been documented among male survivors reporting uncontrolled leakage of faecal matter due to sphincter injury sustained during the rape (Christian et al., 2011b; Storr, 2011). Available literature also discusses both the general and specific psychological effects of CRSV against men.

2.3.2 Mental Health Consequences of Conflict-Related Sexual Violence

Sexual violence against men is a "frightening and dehumanizing experience that shatters their sense of autonomy and personal invulnerability, leaving them feeling contaminated" (p.3) (Mezey & King, 2000). This statement seems to suggest that individualised therapeutic responses are needed to effectively deal with personal trauma.

Tewksbury (2007b) writes that “the mental health status of men who are sexual assault victims can vary quite widely, ranging from highly emotional responses that inhibit normal functioning to very calm and subdued approaches where victims are highly introspective and would not likely be perceived to have suffered trauma” (p.31). Choudhary, Coben, and Bossarte (2010), in a study of male survivors of sexual violence in the USA, also found that the type of sexual violence perpetrated determines the kind of impact it will have on the health of the victims. They present with acute stress disorders, posttraumatic stress disorder (PTSD), depression, phobia, suicide ideation, and many others as discussed above (Choudhary et al., 2010; United Nations, 2013; Watts, Hossain, & Zimmerman, 2013). In addition, victims of CRSV also experience non-pathological distress such as fear, sadness, anger, self-blame, shame and guilt (World Health Organisation et al., 2011). Mezey and King (2000) found that men who suffer sexual assault easily lose their temper, harbour feelings of worthlessness, avoid social gatherings, are fearful of fellow men and may not want anything to do with the place where the assault occurred. Victims also face medically unexplained somatic complaints, and may engage in self-harming behaviour. Already, some of these psychological experiences have also been documented among refugee male survivors of CRSV living in Kampala (Hebrew Immigrant Aid Society, 2014).

2.3.3 Other Consequences of Conflict-Related Sexual Violence

CRSV survivors also experience psycho-sexual and psycho-social effects in addition to the above (United Nations, 2013). Sexual violence may physically damage the genitalia, making sexual activity become painful or impossible. It may also cause impotence and may even cause victims to question their sexual orientation (Mezey & King, 2000; United Nations, 2013). Damage to the genitalia impacts an individual’s ability to engage in normal intimate sexual relationships. Psycho-socially, physical wounds limit the capacity of survivors to work and so they may not be able to fend for the family. This undermines the position of the man in the family as the head of the household (United Nations, 2013).

Despite the fact that there are a number of studies on the physical and mental health consequences of CRSV, most of them are conducted among women and girls and very little research has been conducted to explore the health effects for male survivors of sexual and gender-based violence in conflict and post-conflict settings (Christian et al., 2011b; Mezey & King, 2000). A systematic review of mental health and psychosocial interventions for sexual and gender-based violence in conflict areas highlighted the gap on data concerning men and

CRSV (Tol et al., 2013). Tol et al. (2013) showed that, of the 5684 returned records, only seven met the criteria, and no evaluation concerning male participants or survivors was found. In addition, as Kinyanda et al. (2010) note, few systematic studies of the reproductive, surgical and psychological effects of war-related sexual violence have been undertaken in the African socio-cultural setting. This study aimed to narrow that research gap by exploring barriers and facilitators to physical and mental health help-seeking among Congolese refugee male survivors of CRSV living in an urban post-conflict setting.

2.4 Barriers and Facilitators to Physical and Mental Health Help-Seeking

Research shows that one of the top priority needs for survivors of CRSV is access to medical care. In a survey on the characteristics of sexual violence among females in the DRC, 40.2% of the women shared that access to medical services was the most helpful intervention after encountering sexual violence (Harvard Humanitarian Initiative, 2009). Despite the fact that rape is termed as a medical emergency because of the physical and mental health risks involved, the Harvard study discovered that 45% of its respondents waited a year or more before they could access services for sexual violence. A study conducted in Britain on sexual assault against men in peacetime revealed that 79% of the respondents took several months or years to seek the help of a counsellor (Mezey & King, 2000). Mezey and King (2000) add that male victims of sexual violence are faced with the same challenges faced by female victims of rape twenty years ago. Such challenges include the fact that they are blamed and doubted when they eventually open up, and that services for male sexual abuse victims are very limited (Mezey & King, 2000). The few available studies on this topic found a number of similar reasons that serve as barriers or facilitators to physical and mental health help-seeking among victims of sexual violence.

2.4.1 Barriers to Physical Health Help-Seeking

Available literature has identified stigma, shame, fear of reprisals, and lack of knowledge about available services, physical insecurity and under resourced facilities as some of the reasons for victims not seeking help (Harris & Freccero, 2011; Kohli et al., 2012; Médecins sans Frontières, 2009). The long distances to the health service centres also serve as barriers to access medical care for victims. A study by the Harvard Humanitarian Initiative (2009) quantified some of the barriers in their study sample whereby they found out that 55% of the CRSV survivors had to travel for more than 24 hours to access medical services.

Findings also show that 27.1% of the respondents in this study sample confessed that they had no knowledge of the existence of medical services for victims of sexual violence, with only 4.2% of the respondents having received medical assistance within 72 hours of the attack (Harvard Humanitarian Initiative, 2009). Harvard Humanitarian Initiative (2009) further highlights that during conflict situations, it is hard for victims to move about in search of medical help as they run the risk of encountering sexual violence again. This may also be facilitated by the poor transport network and even a lack of money to foot the transport bill to hospital. The statistics discussed are a dangerous trend for survivors of CRSV in accessing medical care. In cases of sexual assault, time is a key element because it guards against further medical and psychological effects that may result from the direct consequences of the abuse. Swift medical response to sexual violence against men and women may prevent infections. For example, the administration of Post-Prophylaxis Exposure (PEP) may prevent HIV infection, and emergency contraception may prevent unwanted pregnancy in female survivors. Failure to prevent these consequences could exacerbate stigma and add to their psychological distress.

A study conducted in South Kivu, DRC demonstrated that the lack of statistical evidence of male victims, coupled with under-reporting, hinders the formulation of a definition concerning sexual and gender-based violence against men (Christian et al., 2011a). Because of this, little or no resources are allocated to the care of male victims of sexual violence. In addition, the non-stop conflict has destroyed the health system to an extent that there is no health infrastructure, and the few facilities in place lack basic resources (Christian et al., 2011b; Linos, 2009). As it is a conflict setting, it is possible that some qualified medical personnel have also fled for their safety. Where medical services are available, survivors of CRSV have identified the high costs of medical services, such as surgeries, as a barrier to physical and psychological help-seeking (Harris & Freccero, 2011; Hebrew Immigrant Aid Society, 2014). If a male survivor was in need of rectal repair surgery, they would have to spend approximately \$1,400USD and \$2,000USD in Nairobi and Uganda respectively (Hebrew Immigrant Aid Society, 2014). Additionally, the lack of shelter and economic opportunities hinders the ability to recover physically and psychologically (Hebrew Immigrant Aid Society, 2014).

Limited services for male victims of sexual violence are also due to a fear among humanitarian workers that focusing on male victims of sexual violence will overshadow the issue of sexual violence against women as funds will be directed to the cause of men

(Carpenter, 2006). These unfounded fears also serve as a medical and psychological help-seeking barrier for the male survivors of CRSV because there will be a deliberate attempt to exclude them in programme planning and response. Lack of skills among professionals in handling medical and psychological issues of male victims of CRSV has also been identified as a barrier (Carpenter, 2006). Other barriers include homophobia and laws that oppress same sex relationships (Dolan, 2014; Hebrew Immigrant Aid Society, 2014; United Nations, 2013). Such reactions are facilitated by false assumptions that CRSV against men in war is only perpetrated by fellow men (United Nations, 2013), and yet literature reviewed provides evidence of women perpetrating rape against men (Johnson et al., 2010; Mezey & King, 2000).

2.4.2 Barriers to Mental Health Help-Seeking

In general, there is a paucity of literature on the relationship between sexual assault and mental health help-seeking (Ullman, 2007). However, some of the literature reviewed reported that meagre funds are channelled towards the provision of psychological services as emphasis is mostly on the physical effects of CRSV (Christian et al., 2011a; Harris & Freccero, 2011). This is definitely a barrier that may have wide implications on the accessibility of mental health services. Very few sexual assault victims seek psychological support (Harvard Humanitarian Initiative, 2009; Ullman, 2007). In a study conducted in rural DRC, findings reveal that the reasons for not seeking mental health services were unclear as to whether mental health services were not available, or whether clients found it more stigmatising to seek such services (Harvard Humanitarian Initiative, 2009).

Another study by Harris and Freccero (2011) identified respondents that simply resisted seeing a psychologist. Such resistance may be due to unfavourable past encounters with mental health professionals, or even the fear of societal reactions to mental health help-seeking (Campbell, Dworkin, & Cabral, 2009; Ullman, 2007), and many other reasons. The lack of on-going medical and psychological services among victims of CRSV in their villages was also identified as a barrier to help-seeking (Christian et al., 2011a). Like many studies on CRSV, there is a gap in investigating barriers to physical and mental health help-seeking among refugee male survivors of CRSV in an urban and post-conflict setting. This study sought to address that gap.

2.4.3 Facilitators to Physical and Mental Health Help-seeking

Available literature identifies a few facilitators to physical and mental health help-seeking among male survivors of CRSV. One of the facilitators is the unbearable physical pain that the CRSV survivors experience, forcing them to seek treatment for the wounds (Christian et al., 2011a). Christian et al. (2011a) also note that some male survivors of CRSV only sought help because they were advised, probably by people who cared about them or who were concerned about their situation. Studies conducted in Chad, Kenya, South Africa and Uganda on protecting at-risk refugee survivors of sexual and gender-based violence found that the availability of free medical services facilitates physical and mental health help-seeking among male survivors of sexual violence (Hebrew Immigrant Aid Society, 2014). In South Africa, for example, the government clinics provide efficient medical services that include PEP for HIV, rectal and sphincter repair, and that organisations like Health4Men supplements the government's efforts (Hebrew Immigrant Aid Society, 2014). This particular finding may indicate that coordinated efforts from government and civil society in responding to CRSV may effectively facilitate the physical and mental recovery of victims.

Notably, this literature review identified only one study conducted among male refugee survivors of CRSV in an urban setting and it was done by the Hebrew Immigrant Aid Society (2014). The study however lacks an in-depth approach as barriers were mostly identified and very few facilitators were explored or discussed. Identifying facilitators to physical and mental health help-seeking among male survivors of CRSV may be instrumental in programme design and implementation by seeking to build on those particular strengths that are already in place. Furthermore, in the study conducted by Hebrew Immigrant Aid Society (2014), little emphasis is placed on the barriers and facilitators to mental health help-seeking. This study is a response to those gaps.

2.5 Experiences of Practitioners Working with Victims of Trauma

Studies have been undertaken among caring professionals like counsellors, social workers, nurses, doctors and psychologists to understand their experiences of working with survivors of sexual trauma. Some of these studies have aimed at shedding light on how victims seek services (Ullman, 2007), while others aimed at knowing what effect this kind of work has on service providers. Findings reveal that intervention among trauma clients is risky, and that some professionals have been reported to develop psychological issues like

anxiety, nightmares, numbing or avoidance, intrusive thoughts, and other symptoms of PTSD as a result of exposure to their clients' traumatic experiences (Bercier & Maynard, 2014; Dunkley & Whelan, 2006; Elwood, Mott, Lohr, & Galovski, 2011; Gil & Weinberg, 2015; O'Halloran & Linton, 2000). To various authors, these symptoms refer to a state of secondary trauma. Figley (1995) coined the term secondary trauma, to highlight the emotional effects of helping people that have been through trauma. Gil and Weinberg (2015) define secondary trauma as "the consequences of indirect exposure to the details of a traumatic event through the direct victim" (p. 552).

Figley (1995) mentions that it is a "cost of caring" (p.1), and that it is a natural reaction to working with people that have been through stressful situations. He adds that secondary trauma happens over time, as professionals constantly engage with victims of trauma and are constantly exposed to their experiences and respond to them with empathy (Figley, 1995). Manning-Jones, de Terte, and Stephens (2016) write that this exposure may yield both positive and negative psychological consequences, but it is the negative psychological effects that are referred to as secondary trauma. Secondary trauma is not an automatic consequence of working with trauma survivors as some literature may seem to imply. For example, in their study among senior social workers in clinical settings affected by September 11 terrorist attacks in the United States of America (USA), Boscarino, Adams, and Figley (2010) found that not all professionals exposed to such clients were vulnerable to the effects of such exposure, and that reactions may be dependent on one's social origin and history of psychological trauma.

There is a growing body of literature that provides both preventive and response mechanisms to secondary trauma. Increased resiliency skills, use of self-care strategies, social support from other people like co-workers, development of care giving skills and use of conflict resolution as some of the strategies mentioned (Boscarino et al., 2010; Manning-Jones et al., 2016; Whitfield & Kanter, 2014). Manning-Jones et al. (2016) add that humour, religion, debriefing, engagement in fun activities, separation of work and private lives, and acceptance of professional limits can also help professionals to counter secondary trauma. Ga-Young (2011) and Finklestein, Stein, Greene, Bronstein, and Solomon (2015), in their studies, also found that receiving support from fellow workers, supervisors and team members lowered the risk of developing secondary trauma.

With most of these studies having been conducted in developed countries, there is need therefore to explore experiences of working with trauma survivors like male refugee survivors of CRSV in developing countries, and also explore if these experiences may serve as barriers or facilitators to help-seeking by male survivors. This study hopes to address that gap.

2.6 Solutions to Overcoming Barriers to Physical and Mental Health Help-Seeking among Survivors of Sexual Violence

Current literature suggests several measures that can be put in place to overcome barriers to physical and mental health help-seeking among survivors of CRSV. Ullman (2007) writes that “in terms of theory on mental health service seeking, a broader ecological approach to service seeking is needed that accounts for the contexts in which survivors may be able to obtain help and the barriers at both macro and micro levels that hinder help-seeking” (p.76). Although their recommendations focus on the wellbeing of female survivors of CRSV, Jones, Cooper, Presler-Marshall, and Walker (2014) make recommendations that are relevant to overcoming barriers to physical and mental health help-seeking for male CRSV survivors. They suggest that (1) the provision of mental health services should be interconnected, right from the grassroots to the formal structures, (2) perpetrators of sexual violence should be prosecuted, (3) stakeholders should raise awareness about CRSV in the community, (4) stakeholders should help survivors engage in livelihoods, and (5) more funding should be provided to implement CRSV prevention and response programs at local and international levels (Jones et al., 2014). Literature also suggests the need to tackle survivors’ other needs alongside their mental health needs (Ullman, 2007). There is need to display evidence about the existence of male rape in order to counter myths, and this can be done through research (Davies, 2002). There is also need for production of gender blind literature on rape, plus the needs of the victims (Davies, 2002).

Available literature also suggests that counselling services should be made available to the spouses and families of male victims of CRSV, because there is need for victims’ families to understand and come to terms with what happened to their loved ones (Davies, 2002). Davies (2002) adds that professionals responding to the needs of survivors should be in position to refer them to support groups that are tailored to suit the needs of male survivors of sexual violence. However, this can only be achieved with appropriate education for service providers, to train them on how to handle male victims of sexual violence (Davies, 2002;

Harris & Freccero, 2011; Ullman, 2007). Ullman (2007) observes that professional training is inadequate if the professionals are not warm, genuine and empathetic towards the victims. Several relevant suggestions are made as seen in the literature available. However, many of them are suggestions made by researchers and practitioners, and not many studies include suggestions from male CRSV survivors. This study sought to close that gap.

2.7 Ecological Systems Theory

Psychologist Urie Bronfenbrenner is credited to have formulated the Ecological Systems Theory (EST) to analyse child development in 1979, and since then, it has been used by several social science disciplines like psychology to explain the relation between an individual and their social environment (Blok, 2012; Pittenger, Huit, & Hansen, 2016). According to Bronfenbrenner (1994), there are five systems in the environment which surround an individual, namely the microsystem, mesosystem, exosystem, macrosystem and the chronosystem. All these systems influence an individual and ultimately affect their development. The microsystem is closest to an individual and Bronfenbrenner (1994) defines it as “a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social, and symbolic features that invite, permit or inhibit engagement in sustained, progressively more complex interactions with, and activity in the immediate environment” (p. 1645). Examples of the micro system include family, siblings, peer group, neighbours, among others (Blok, 2012).

The mesosystem is the second layer in a person’s environment and it connects relationships from many other microsystems surrounding the individual Bronfenbrenner (1994). Examples in this system include the interaction between the immediate neighbours and the person’s family, interaction between the person’s family and their school or work place, among others (Blok, 2012). The next layer, which is the exosystem, contains factors that an individual cannot cause or change, but whose actions or decisions indirectly affect the individual (Bronfenbrenner, 1994). It represents connections between domains where the person is not directly involved, for example neighbourhood relationships and politics. The fourth layer, which is the macrosystem, is the largest of them all because it contains multiple but different groups. Culture, religion, ethnicity and social class are found in this layer which changes over time, and may give an individual an opportunity to influence that change. Changes in this system also have an effect on the individual (Bronfenbrenner, 1994). The

fifth and final layer is the chronosystem, which, according to Bronfenbrenner (1994), “encompasses change or consistency over time not only in the characteristics of the person but also of the environment in which that person lives” (p. 1646). Examples of the chronosystem include friendships, responsibilities, place of residence, family structure, socioeconomic status and many more (Blok, 2012). Notably, these systems are not constant, as change in one may give rise to changes in the others (Shen-Miller, Isacco, Davies, Jean, & Phan, 2013).

Help-seeking behaviours of CRSV survivors are either obstructed or facilitated by a number of factors inherent in both the survivors and their environment (Christian et al., 2011a; Harris & Freccero, 2011; Kohli et al., 2012). Given its holistic approach, EST will be used to understand these factors, their relation to each other and the key players involved in order to facilitate help-seeking among CRSV survivors. I will discuss the results of this study according to EST (see chapter six). Many authors have used EST to explain the impact of sexual violence on mental health, to explore factors contributing to revictimisation, to design interventions. In a research review on the impact of sexual assault on women’s mental health, Campbell et al. (2009) used EST to conclude that negative mental health outcomes following sexual violence are not only dependent on the victim’s character, but on several other factors as well. Factors like the abuse itself, disclosure, help-seeking and sociocultural norms influence the level of trauma on the women’s psychological wellbeing (Campbell et al., 2009).

Similarly, in a literature review of sexual revictimisation of youth, Pittenger et al. (2016) note that EST recognises “the influence of factors within and between systems” (p. 42), and this is important because it aids understanding of sexual revictimisation, thus guiding research and intervention. In their review, it was found that external factors such as perpetrators, family and professionals influence the risk of revictimisation of sexual violence survivors (Pittenger et al., 2016). This has been documented by other studies as noted in the previous section (Ullman, 2007). In a study of college men’s health in the USA, Shen-Miller et al. (2013) used EST to analyse college men and masculinity. They concluded that men’s health beliefs and behaviours revealed a discomfort relating to gender socialisation which consequently influenced the systems in the lives of individuals. In designing interventions, it was recommended that EST be used together with another theory to design intervention strategies to address their behaviours, and at the same time figure out which level of the model will yield the best results (Shen-Miller et al., 2013).

EST has also been used in designing strategies to prevent sexual violence. For example, Banyard (2011) used it to analyse the behaviour of bystanders witnessing such incidents, and the reasons for their intervention or lack thereof. She notes that EST facilitates a deeper analysis of the individual bystanders and the environment around them. In so doing, this highlights the challenges and fears individual bystanders face in responding to sexual violence, and how the various systems in their environments can be influenced to facilitate their willingness to help (Banyard, 2011). Neal and Neal (2013) note that the “different levels of ecological systems are viewed as nested within one another” (p. 722), but over the years, different authors have disputed or suggested an improvement to the theory. As a result, alternatives have been raised, including the view that EST will be more efficient if viewed as overlaying systems (Neal & Neal, 2013).

2.8 Conclusion

In conclusion, this literature review has discussed what is meant by CRSV in this study, who the victims and perpetrators are, and, the reasons why CRSV predominantly features in the DRC conflict to the extent of attracting scholastic attention. The review also highlights that male survivors of CRSV suffer from various psychological and physical effects that include acute stress disorders, PTSD, depression, hyper-arousal, anxiety disorders, suicidal ideation, phobias, low self-esteem, emotional numbing and substance abuse, bruising, lacerations, abrasions and tearing of the anal and genital area, rectal damage, STIs and many others (United Nations, 2013), and are in need of urgent and comprehensive medical care. Furthermore, the literature review also reveals that there are a limited number of reports and articles about the physical and psychological impact of CRSV against males and how to address their needs, thus making it a research priority (Jewkes et al., 2012; Oosterhoff et al., 2004). The literature review also reveals that most research and intervention efforts among victims of sexual violence have been centred on women, and men are not given much attention in the discussion concerning CRSV (Carpenter, 2006). It has also highlighted some barriers to seeking help and just a few facilitators, because most studies concentrated on the barriers. The effect of working with survivors of trauma, including sexual trauma, plus solutions suggested in available literature on how to overcome barriers to physical and mental health help-seeking have also been discussed.

The present study therefore addressed the gaps identified in the literature by exploring barriers and facilitators to physical and mental health help-seeking among male refugee

survivors of CRSV in an urban setting. It also elicited views on how these barriers can be addressed. The next chapter focuses on the methodology that guided this study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter begins by restating the study aims and objectives of this study. This is followed by a description of the study design and scope of the study which includes the time, population and geographic setting as well as the study participants and the selection criteria used. In addition, the methods used for data collection, management and analysis, and finally, the ethical considerations employed in this study are also described.

3.2 Study Aim and Objectives

This study investigated the barriers and facilitators to physical and mental health help-seeking among Congolese male refugee survivors of CRSV living in Kampala, Uganda. The specific objectives of the study were:

- to explore survivors' experiences and perceptions regarding barriers and facilitators to physical and mental health help-seeking among male refugee survivors of CRSV.
- to elicit survivors' views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of CRSV.
- to explore the experiences of practitioners working with male survivors of CRSV.
- to elicit practitioners' views on barriers and facilitators to physical and mental health help-seeking among male refugee survivors of CRSV.

3.3 Study Design

A qualitative study design using semi-structured, in-depth interviews was used to obtain rich responses that can address the research question (Dudley, 2010). Although qualitative approaches are often criticised for their inability to make generalisations of study

findings (Ritchie, Lewis, Nicholls, & Ormston, 2013), they provide an in-depth understanding of sensitive issues like the one investigated by this study.

3.4 Geographic Scope and Setting

The study was mainly conducted at the premises of the head office of the Refugee Law Project (RLP), based in Kampala, the capital city of Uganda as shown in the map in appendix A. RLP was established in 1999 as an outreach project of the School of Law, Makerere University and its mission is “To empower asylum seekers, refugees, deportees, IDPs and host communities in Uganda to enjoy their human rights and lead dignified lives” (Refugee Law Project, 2015b). Kampala has an urban population of 1,516,210 people according to the recently conducted population and housing census (Uganda Bureau of Statistics, 2014). Outside the RLP office, three other interviews among service providers were conducted at their places of work, still in Kampala city. Kampala city was chosen for this study because as an urban area, it is the preferred place of abode for refugees who opt not to stay in gazetted refugee settlements. According to UNHCR (2015), Kampala has an urban refugee population of 72,019, which is 17% of the total number of refugees and asylum seekers in Uganda.

3.5 Study Population

This study recruited a sample of 10 male refugee survivors of CRSV and 6 service providers, two of whom were female. All participant male refugee survivors of CRSV were recruited from RLP between August 2015 and May 2016. Participants were sampled to data saturation. The criteria for selecting participants for this study were as follows:

1. Male refugee survivors of CRSV from DRC aged 18 years and above, and have resided in Kampala for over a year.
2. Medical practitioners working in private health facilities having a partnership with RLP to provide services to male refugee survivors of CRSV.
3. Psychologists and counsellors both at RLP and other facilities that have attended to male refugee survivors of CRSV.

3.6 Sampling Procedure

This study employed purposive and snowball sampling techniques to collect data. Because these methods are non-probability in nature, this enabled me to select only the participants that fitted the research (Silverman & Marvasti, 2008). At the conception of this study, I hoped to gain access to male survivors of CRSV who had not sought physical and psychological help, using the snowball sampling method because it would allow for the selection of participants who are not readily available (Browne, 2005). However, efforts to recruit this category of participants to be included in the study were futile as most of the sources of reference, who were the CRSV survivors interviewed for this study, did not know of any male refugee survivor of CRSV that had not sought physical and psychological help. Only two respondents could identify this category of people but unfortunately one was deceased due to a CRSV related illness, and the other was not willing to be part of the study when contacted. No reason was given for his unwillingness to be part of the study. Overall, a total of sixteen respondents took part in the study. Ten of these were male refugee survivors of CRSV while the remaining six were service providers. The ages of the survivors ranged between 18 and 47 while those of service providers ranged between 25 and 58. This study had two female respondents and they were in the category of service providers. The remaining fourteen participants were all male. Details of the participants including their education background are listed in Table 4.1 below. Data from both categories of participants was simultaneously integrated for common themes during the analysis.

Refugee participants for this study were recruited through a support group for male refugee survivors of CRSV called Men of Hope (MOH) that is under the guardianship of RLP. Permission was obtained to attend one of the MOH fortnight meetings and after their discussions, an invitation was made to introduce the study. After explaining the details of the study, information sheets (see appendix B, C & D) with all the details of the study and researcher contacts were distributed to the MOH members, to take home for further reading. The sheets were written in English but also translated into French and Lingala by RLP's community interpreters, who also provided interpretation services during the interviews and transcription. As an employee of RLP, the researcher had no influence on the participants to coerce them to be part of the study. Participants interested in the study voluntarily approached the researcher and dates for the interviews were set. For the service providers, the researcher approached them physically and through telephone to explain the study and also

request to interview them. Two pilot interviews were conducted to test the interview guide and ensure clarity on the part of the respondents. The actual interviews commenced after obtaining all the relevant ethical approval and a detailed explanation of this is provided in section 3.9 of this report. The interviews were conducted by the researcher who is a social worker, with the help of a qualified community interpreter who is an employee of RLP where necessary and they lasted between 30 minutes and 1.3 hours.

3.7 Data Instrument and Management

As male rape is a sensitive topic, face to face interviews were conducted using semi-structured guides with open-ended questions (See appendix E) to allow probing and an in-depth understanding of the participant's perception. The questions on the interview guide were derived from the literature review that revealed some of the gaps in the area of CRSV against males that needed to be addressed. Before the interviews, rapport with the respondents was established to make them feel at ease and the interviews were conducted in their language of preference. Male survivors of CRSV were interviewed in various languages while all interviews with service providers were conducted in English. The languages used in the interviews include English, Swahili, French and Lingala. Questions regarding barriers and facilitators to physical and mental health help-seeking among refugee male survivors of CRSV and strategies to overcome them were asked. Service providers were further asked to share their experiences about working with male survivors of CRSV (See appendix F for the service provider's semi-structured interview guide).

The researcher took notes to capture any non-verbal language. All interviews were audio recorded and transcribed in English by qualified community interpreters employed by RLP. Anonymous identification codes were given to the participants and all data were stored on the researcher's personal laptop in password protected files. Demographic variables such as age, gender etc. were captured using both Microsoft Word and NVivo 11 for Windows.

3.8 Data Analysis

Qualitative research computer software, NVivo 11 for Windows was used to analyse the data. To ensure a systematic analysis of the data using software, a qualitative data analysis technique called the framework approach was used (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The framework approach is a form of thematic or content analysis that is

often used in qualitative studies (Gale et al, 2013). It helps identify differences and similarities within the data, establishing the connections in the different aspects of the data, thus allowing the researcher to draw themes and interpretation from the data (Gale et al, 2013). The framework approach involves familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation. In this study audio recordings were both transcribed verbatim and played back by the researcher for familiarisation with the interviews. This was followed by transcription of both verbal and non-verbal data. After transcription, an initial reading of the transcripts was done, line by line, to become familiar with the data. At this stage, the researcher made analytical notes and initial codes from the transcripts and audios. Coding during transcription of interviews helps to ensure credibility and trustworthiness of the data (Saldaña, 2013).

Thereafter, transcripts were re-read, line by line to create labels or codes on key aspects of the data. This stage is known as coding (Gale et al, 2013). Codes were basically a word or short phrase to describe that aspect of the data (Saldaña, 2013). During the coding process, it was ensured that the codes encapsulated what the respondents meant. Six sets of data were also independently coded by a second researcher to validate the categories and also create an analytical framework to ensure rigor and consistency. Codes were compared by both researchers and any overlaps in the codes were merged. The final codes agreed on by both researchers were then used as a framework to code all transcripts in a process known as indexing (Gale et al, 2013). Similar codes were then merged into themes relevant to this study. The qualitative research computer software, NVivo 11 for Windows facilitated the charting of the data, i.e., 'entering the data into the framework method matrix' (Gale et al, 2013, p.2). The matrix used in this approach organises the data in such a way that each case is represented in a row and each theme, a column. Quotes for each case were entered into the column corresponding to the theme represented by the quote. This allowed the researcher to interpret the data by theme, and to identify similarities and contrasts across participants.

3.9 Ethical Considerations

Violence, abuse and war might be considered sensitive research topics, but findings support the importance of continuing to conduct research on such issues for a balanced understanding of risk factors and helpful interventions to address them (Apollis, Lund, De Vries, & Mathews, 2015). Specifically, research into vulnerable populations like refugees raises many ethical problems (Jacobsen & Landau, 2003). In order to mitigate any ethical

concerns, various ethical considerations were employed in this study. Written consent was obtained from all participants and each of them kept a copy of the consent form (See appendix G, H, I, J & K). These forms were written in English and translated into French, Swahili and Lingala. Participants were assured of their confidentiality and also informed that they had a right to refuse to be part of the study without any consequences to the services they receive at RLP. In addition to this, participants who volunteered to take part in the study were given the liberty to withdraw from the interview at any point if they felt that they could no longer proceed. They were assured that this withdrawal would not affect the services they received at RLP. They were also told not to answer any questions they did not feel comfortable with (Ellsberg & Heise, 2005). All questionnaires, consent forms and notes were locked away in the researcher's office drawer. Data were protected with a password on the researcher's personal computer and only shared with the community interpreter for transcribing.

Ethical approval was obtained from the Health Research Ethics Committee at Stellenbosch University before commencing the study (see appendix M). After this, additional approval was obtained from the Research Ethics Committee of The Aids Support Organisation (TASO) and the registration of the study was done at the Uganda National Council of Science and Technology (UNCST) (see appendix L). Further permission was obtained from the director of RLP (see appendix M) as participants from this study were clients of the project, and the data collection took place at the office premises. Furthermore, the interviews were conducted in a private room, and all RLP staff members involved were reminded of the need for confidentiality. The respondents were given refreshments and 20 USD as a refund for their transport. The names used in this study were also changed in respect to the respondents' confidentiality.

3.10 Conclusion

In conclusion, the methodology used in this study has been described in this chapter. Notably, a qualitative research design was adopted because of its effectiveness in capturing information on complex issues. The views of both refugee male survivors of CRSV and refugee service providers were drawn to get a broader view on the barriers and facilitators of CRSV, and strategies to overcome the barriers. Because of the sensitivity of the study topic, strict ethical guidelines were followed to safeguard the participants from any harm, and also produce quality results. The next two chapters present the findings of the study with cut out

texts from the data to serve as examples. This will be followed by a discussion of the findings, limitations and a conclusion.

CHAPTER FOUR

RESULTS: BARRIERS AND FACILITORS ACCORDING TO SURVIVORS AND SERVICE PROVIDERS

4.1 Introduction

This chapter contains the first part of the results of this study from both survivors and service providers, which are presented in the following three sections: i) Characteristics of study participants, ii) Barriers to physical and mental health help-seeking among male refugee survivors of CRSV and iii) Facilitators to physical and mental health help-seeking among male refugee survivors of CRSV.

4.2 Characteristics of Study Participants

For this study, a total of 16 interviews were conducted. Of these, 10 of the respondents were male refugee survivors of CRSV, while the remaining 6 were service providers. These 6 respondents comprised of 2 clinical psychologists, 2 psycho-social counsellors, 1 medical doctor and 1 plastic surgeon. All respondents, except 2 were male. The two female respondents were service providers. The socio-demographic characteristics are presented below in Table I.

Table I

Socio-demographic characteristics of respondents

Male refugee survivors of CRSV=(10)		
Years spent in Uganda (range)		1-7
Age range		18-47
Marital status	Single	4
	Married	6
Level of education	Secondary	3

	Vocational training	1
	Diploma	1
	University	5
Employment status	Employed	6
	Unemployed	4
Service providers = (6)		
Age range		25-58
Number of years in practice	1-10	3
	11-20	2
	21+	1
Occupation	Consultant surgeon	1
	Medical doctor	1
	Clinical psychologist	2
	Psychosocial counsellor	2
Highest level of education	Masters degree	3
	Bachelor degree	2
	Post-graduate diploma	1

4. 3 Barriers to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of CRSV

One of the key objectives of this study was to investigate barriers to physical and mental health help-seeking among Congolese male refugee survivors of CRSV and several themes emerged from the dataset. For easy explanation and identification, these themes are clustered into six categories: (i) socio-cultural and political factors, (ii) health system and infrastructural barriers, (iii) poverty and livelihood barriers, (iv) physical effects of CRSV, (v) fear of marital disharmony and breakup, and (vi) self-sufficiency.

4.3.1 Socio-Cultural and Political factors

Participants reported that socio-cultural factors are a hindrance to physical and mental health help-seeking among male refugee survivors of CRSV. Several themes emerged under this category and they are discussed below.

4.3.1.1 Cultural Conceptualisation of Masculinity

A key theme that emerged under this category is the cultural conceptualisation of masculinity. Both survivors and service providers shared the view that in some African cultures, a man is a symbol of strength and authority, and as such perceived to be less prone to certain forms of abuse. Such abuse includes sexual violence, because men are expected to be physically strong and capable of fighting off any attackers as shared below:

“... You can imagine a man with his masculinity, these are people who are considered to be strong and act like men and then an act that is done to a woman is done to them. This reduces them and it lowers their self-esteem and they find themselves feeling like women and of course the perception of women in the community is that we are a weaker sex so it also makes them feel they are a weaker sex.” (Psychosocial counsellor, 34 years)

These same sentiments were also shared by another service provider who mentioned that:

“My perception of men is that they are strong. They are able to protect themselves. They are able to fight and so it was not really familiar with me that men could undergo sexual violence ...” (Clinical psychologist, 25 years)

These known ideals and notions among males in African cultures make sexual violence against men a cultural shock for many regardless of whether they are victims or service providers. Male refugee CRSV survivors interviewed for this study repeatedly mentioned culture as a barrier to disclosure and help-seeking:

“I didn’t explain about the male rape because in my culture a man or in my tribe if a man is raped it’s a disaster... in my tribe you are called like a ‘Mukumbira’. You are not supposed even to be talking to people; you are not supposed to sit where men are seated or even where kids are seated.” (Baraka, 31 years)

Another interesting finding under this particular sub-theme was that this stereotypical conceptualisation of masculinity in many African cultures is not just limited to the sexual violence but also to the act of men seeking help, as one interviewee said:

“I think culturally here... there is a cultural belief that every man should be strong. So if you cry, if you go begging asking for help here and there, you are showing weakness and no man would like to be weak ... they suppress it and keep at home not to go for help because going out to seek help is a sign of weakness.”(Clinical psychologist, 43 years)

This issue was raised by a few participants and it shows that male survivors of CRSV are faced with multi-pronged cultural dilemmas that hinder physical and psychological help-seeking.

4.3.1.2 Sexual Violence against Males Considered a Taboo or Curse

Participants’ responses also denoted that, in the unfortunate event that a man is subjected to sexual violence, he is considered an abomination, a disgrace, as this is contrary to African norms, and this hinders help-seeking. One survivor shared that:

“Remember when I came here, when I opened a file. I never shared these issues of being raped. I never shared it. I could not afford. I am an African.” (Djamba, 34 years)

Similar views were also noted by service providers as one psychosocial counsellor noted that:

“... there is a survivor that has quoted that ‘when you are raped you are useless, a taboo and no one can consider you like a man’ ... one of the male survivors told me that they are considered as sinners and they are not considered man enough ...”(Clinical psychologist, 25 years)

These cultural misconceptions about masculinity ultimately shape community attitudes towards male survivors of sexual violence, and also play a great role in policy formulation regarding responses to sexual violence.

4.3.1.3 Homophobia: Social and Legal

Many participants shared that the way community perceives them acts as a barrier to help-seeking because they are considered to be homosexuals hiding under the guise of being

male victims of rape. Attempts to share it with the community have been met with disbelief and labelling. One survivor shared that:

“Because the most question you find in the community is, ‘if the males are the rapists, so who rapes them?’ And then the confusion of saying homosexuality and male rape ... homosexuality is not allowed in the law of Uganda ...” (Baraka, 31 years)

All respondents noted that homophobia is not just in the communities but also among service providers as some survivors that tried to seek help were turned away as illustrated below:

“... I was down, my health was not good; I was dying. I went to many organisations that help refugees. Really I did not get any assistance because they were saying that a man cannot be raped; they were regarding me as a gay ...” (Alongi, 42 years)

Some service providers who took part in this study confessed to having had this kind of attitude the first time they encountered a male survivor of CRSV as shared by one clinical psychologist:

“I could not imagine ever in my life that a man could be raped. It was ... it was quite a new concept for me and I thought that it could never happen actually. I thought that these men that had undergone rape were homosexuals ... But, um, it opened my eyes to the fact that men too can be raped.” (Clinical psychologist, 25 years)

Another service provider added that:

“There was tension or a situation where we had the anti-homosexuality bill being discussed and these people who cannot know the difference between the two. It’s a problem too and maybe I didn’t mention it before it makes it hard to come and seek services.” (Psychosocial counsellor, 58 years)

Uganda’s homophobic legal environment has further exacerbated the community’s negative attitudes towards male survivors of CRSV. This has bred trouble for the survivors as some have been physically attacked due to such misconceptions as shared by one survivor:

“... I am put in the group of homosexuals. But I am not in that category. Last time I was beaten because of that. I explained to them what I am, then they thought that I am a homosexual.” (Fumu, 18years)

Reactions to male survivors like the one in the excerpt above impairs their ability to function daily and may also hinder integration into the community. The legal denial of the existence of sexual abuse against men hinders policy programming and the designing of gender sensitive responses to CRSV.

“Also the law barrier, we have the law barrier ... there is also the ignorance of the law. If the police can clarify by clearly trying to show that there is a man who can be raped without his consent, without his agreement, so that if it is acceptable ...”
(Baraka, 21 years)

Homophobia as a barrier appeared across the entire data set, and respondents emphasised that it gives rise to stigma and discrimination.

4.3.1.4 Stigma and Discrimination

Stigma and discrimination, both experienced and anticipated, serves as a barrier to help-seeking among male survivors of CRSV. For example, one survivor shared that:

“There is also stigmatisation. This when you open up they start to identify you everywhere when you are passing ... But it was a shame I feared also for being stigmatised.” (Lisanga, 47 years)

The consultant surgeon in this study shared that there is stigma attached to sexual injuries for both male and female survivors.

“Yeah, I know how patients behave in some of these situations that may not be so different from female sexual violence as well. There is stigma attached to this particular form of injury, and initially the person may be ashamed or may be shy or may be so traumatised to come and tell another person of their experience and the need for the help ...” (Consultant surgeon 45 years)

This was echoed by one of the clinical psychologists who noted that:

“There’s a lot of stigma and discrimination in the communities regarding male rape because it’s a new area that has not been known and most people do not have the information ...” (Clinical psychologist, 25 years)

Responses from the interviews seem to imply that these cultural conceptions about masculinity and, attitudes towards issues surrounding sexuality and homophobia give rise to another barrier, namely a feeling of shame.

4.3.1.5 Shame

The role that shame plays in hindering help-seeking was often stated by both survivors and service providers as explained below:

“When I was in front of people I had fear, I was ashamed ... I did not know what could be their reaction after explaining what I went through.” (Kangelu, 43 years)

Many service providers shared this same opinion concerning shame as a barrier as clearly explained below:

“Shame is the main problem. They are ashamed of talking about their problem, even when I am taking them through narrating their own story. They are very, very hesitant in telling their story; they feel humiliated, ashamed and they are not even willing to talk more about it ... but there is this shame that comes up due to the extreme humiliation and distress that they are experiencing ...” (Psychosocial counsellor, 34 years)

4.3.1.6 Culturally Insensitive Services

Another sub-theme that emerged under socio-cultural factors is the culturally insensitive services that were offered to male survivors that sought help. Some survivors shared that when they approached institutions that offer medical and psychosocial help, they were received by female staff and this served as a barrier. One respondent shared that:

“I discussed with a counsellor called Salome that also was a barrier to me because I couldn’t talk to a woman that this happened to me.” (Elombe, 41 years)

In summary, study findings show that cultural conceptualisations of masculinity influence community attitudes and perceptions towards male survivors of sexual violence. These attitudes are characterised by homophobia, stigma and discrimination together with shame and the provision of culturally insensitive services. All these create a category of barriers that are socio-cultural in nature.

4.3.2 Health System and Infrastructural Barriers

Another category of barriers that emerged out of the interviews were structural in nature. Under this, several themes were mentioned by the respondents and are discussed below.

4.3.2.1 Language

A key theme that emerged from the responses as a structural barrier was the issue of language. The majority of the respondents asserted that the language barrier built a communication wall between the survivors and service providers. One of the service providers noted that:

“Number one, I think there is an aspect of language. I will speak for me ... what helped is being able to speak to them in their language ... once you’re able to speak the language then this guy doesn’t have to be in the room with anyone else ...” (Medical doctor, 45 years)

Not only does the language barrier delay or hinder help-seeking, it also breaches the confidentiality of the survivors as CRSV is a sensitive issue that would rather be shared without middlemen involved. A survivor shared that:

“When I come to meet a counsellor, she is speaking English. I am not speaking English; I need an interpreter. It breaks some other things I had to say ... I won’t be sure that this interpreter should hear what I went through because I like confidentiality ... I don’t know whether he is going to leave and talk about it.” (Baraka, 31 years)

4.3.2.2 Ignorance about CRSV against Men among Service Providers

Ignorance about sexual violence against men was mentioned as a barrier to help-seeking. This emerged as a key theme across the entire data and was identified by both the survivors and service providers as shared below:

“I went, I arrived there, I met the doctor. ‘I am here but I was raped.’ So the doctor was like, ‘You raped someone?!’ I said ‘No, I was raped’.” (Baraka, 31 years)

Another survivor shared a similar experience when he narrated that:

“I remember during that time I was looking for the best service I suffered a lot because I would be in some organisation meeting some counsellors. I would sit with a counsellor who is a professional social worker and tell him my problem but he was the first person to laugh. And he could be amazed and say I have never heard this ... You can go to a counsellor, you talk to him, but the way he will take your trauma, your stresses, your problems to a counsellor; you went with two you can come back with five.” (Elombe, 41 years)

Such reactions only served to re-traumatise survivors and consequently hinder help-seeking. Respondents shared that because of this ignorance, service providers also did not know how to handle survivors' problems. One survivor shared that:

"...ignorance was the first barrier for me which was blocking me to get help. But also there were the lack of may be information for the medical staff or medical for different institutions where I went before, especially in Mulago; they didn't know about this, so that's for me I understood that they were lack of qualification to deal or to treat, to assist people who came through such problem ..." (Kangelu, 43 years)

In addition to the survivors' experiences, one service provider opined that:

"... if you may ask me this disease or this violence and its effects, it probably warrants special medical intervention and that special medical intervention will probably be similar to what the gynaecologists have in management of fistula. ... the male equivalent is on the opposite side; it's incontinence for stool as an adult for gas and so on and so they end up living similar to that woman who is leaking because of the mismanaged delivery. Others may be continent but they have a constant remainder every time they go to the toilet every moment." (Consultant surgeon, 45 years)

Respondents also mentioned that there was ignorance concerning where to access services for male survivors of CRSV and many refugee organisations were referring clients to public health facilities that neither had the time, expertise and resources to comprehensively attend to male survivors.

4.3.2.3 Transport and Distance to Facilities

Respondents mentioned lack of transport and long distances to refugee service organisations and health facilities as a barrier to seek help. One interviewee commented that:

"... But I found myself being sick again. Because I could walk from where I am, staying up to there, walking on foot. When you go back even you cannot even breathe at night. The whole body is paining ..." (Djamba, 34 years)

One service provider added that:

"... Just coming from Bondeko centre and Masajja and going back you need at least 5,000 Uganda Shillings and then for those who cannot even walk you can use 5,000

Uganda shillings when you can walk some distance but how about those ones who cannot walk?” (Psychosocial counsellor, 58 years)

Participants noted that the distance to service centres, and the lack of transport hinders many survivors from accessing help and this is especially the case for many survivors living in settlement because services there are not readily available. Participants also added that on some occasions, survivors that are able to physically walk in pursuit of services are also hindered by climatic conditions. An example is the rain which leaves them drenched and unfit to enter an office as noted by one respondent:

“I came under the rain; I said, ‘No’. I was almost dying. No one is ... how are you going to ask someone accept you in this place when it is raining like that?” (Djamba, 34 years)

Notably, the lack of transport and long distances to service providers serve as a barrier to an already vulnerable group of people that often lack physical and mental strength. It is an obstacle owing to the fact that refugees do not know their way around the city.

4.3.2.4 Inadequate, Ineffective and Sporadic Services

Survivors also mentioned that the kinds of services they receive are inadequate, sometimes ineffective and sporadic in nature. They mostly complained about the services provided in government health facilities, stating that the doctors did not know how to handle their problems and therefore prescribed medication that was ineffective. In addition to this, doctors in government hospitals were reported to be uninterested in the survivors’ problems as they had several other patients in line that needed to be attended to, as shared by one survivor below:

“I got the treatment in KCCA clinic. But I was not satisfied with the treatment I got there. Then I went to Mulago but there the challenge was that they did not have time to listen to me and the treatment I got there was not efficient.” (Imani, 36 years)

On a positive note, respondents shared that they received good quality care and medication when referred to private health facilities. The challenge with this, however, is that such referral depended on the availability of funding and in its absence the treatment procedure came to a halt because they could not afford the bills for the private care. One participant said:

“I was supposed to go back in the hospital where I used to go but the problem they will tell you that they haven’t renewed the contract with that hospital because they need money ... They told me, ‘We didn’t renew the contract’...” (Elombe, 41 years)

This uncertainty in the treatment process is definitely a barrier because, as indicated by several respondents in this study, the physical and psychological effects of CRSV against males are treated over a long period of time. Survivors also complained that the services they receive are not accessible in one place. They found it tiring to acquire different forms of help in several places as this has cost and time implications. Survivors also reported that at times, they were referred to facilities in so much pain, only to arrive there and be told that the person that could handle their case works on a certain day of the week and they would need to report back:

“When I reached there they gave me an appointment there they receive patients only on Friday. Just imagine for example you went there on Monday with pains, then from Monday they tell you to come on Friday ...” (Matadi, 32 years)

This quote also implies that there are only a limited number of knowledgeable people in the health care workforce that can handle issues relating to CRSV against men. This makes them lose confidence in the health system as one service provider noted:

“Some would say, ‘Look, I was scheduled for an operation but I declined and left at that particular stage’. So they would lose confidence at certain points for whatever reason and they would not proceed with the surgery and then two years or one year later, they have issues still there and they eventually get referred to me” (Consultant surgeon, 45 years)

Respondents complained about the long waiting hours at the health facilities, despite the fact that they would wake up early and arrive at the health facilities in the wee hours of the morning. This complaint was mainly made against the public health facilities. One participant said:

“I went to Mulago very early. When I reached there the doctor received me at the end of the day at around 4:00 p.m. when they were almost closing. ... I was the second person to reach there. But they received me after 15 or 18 people.” (Matadi, 32 years)

Another survivor shared that:

“The third time when I went there, I took a risk of starting my journey at 5:00 a.m. It was still dark. I reached Mulago hospital and there I was received at 1:00 pm, then the doctor left for lunch only to come back at 3:00 p.m. ... From there the doctor received me; he received me not even for 5 minutes ...” (Matadi, 32 years)

Participants added that they are made to wait for several hours without food and yet they also have the responsibility of looking for means of survival as they have families and responsibilities back home. Participants also shared that some of the methods used in delivering services are not favourable. One survivor shared what stopped him from attending counselling sessions:

“... when I came here I got counselling and in the process the lady who was counselling me brought me a knife there. Since that day I did not come for counselling again because I hate a knife it’s the one which killed my mother.” (Tambwe, 26 years)

4.3.2.5 High Turnover of Service Providers

Regarding help-seeking concerning psychological effects of CRSV specifically, a key barrier that came out was the high turnover of staff in the agencies that offered psychological help. For example, one participant said:

“And for psychological problems, yes, in the beginning I talked to one or two counsellors. I was also having these issues; the counsellor who used to help me left her office and went somewhere. And I had to get another counsellor from another organisation but this counsellor was not really interested; she is also a woman.” (Elombe, 41 years)

The frequent change of staff re-traumatizes survivors as they have to retell their experiences, at times to people who are ignorant about CRSV against men.

4.3.2.6 Poor Infrastructure

Participants shared that the poor health infrastructure in the country serves as a barrier to help-seeking. One service provider mentioned that:

“I think one is sometimes just plain infrastructural; there are no facilities that you can get help where you have gone ... so they say, ' We don't have this' or 'We can't do this', so you don't get attention that you need.” (Medical doctor, 45 years)

Several participants reported referrals to more than one healthcare provider simply because they lacked the equipment needed to offer comprehensive services. Survivors also noted that in government facilities, they were always given pain-killers for relief and no serious medical interventions were conducted on them for proper treatment. Additionally, poor infrastructure resulted in a breach of the respondents' privacy and confidentiality. One survivor shared a harrowing story of how he was referred to a gynaecological ward because he reported that he was bleeding from the anus:

“... that doctor told me to sit in a line of people, in the middle of ladies. ... The more I was hesitating, the more she was shouting, the more people were coming. ... Then she asked me, ‘You have lain on the bed with your belt tightened. How will I check how you are bleeding?’ I came back down; I opened my belt. I lay on the bed, she opened my pants. When she saw me she was like, ‘No! No!’ So when she shouted everyone who was around, even these women who were seated, they stood up. I felt embarrassed in front of everyone. I just wore my clothes and marched out.” (Baraka, 31 years)

Lack of privacy and confidentiality hinders survivors from seeking further help and may also serve as a barrier to others that may need to seek help.

In conclusion, findings in this study reveal that health system and infrastructural barriers such as language, ignorance, lack of transport, distance to services, inadequate and sporadic services, high turnover of staff, poor infrastructure and previous experiences while seeking help serve as barriers to physical and mental health help-seeking among male refugee survivors of CRSV.

4.3.3 Poverty and Livelihood Barriers

Poverty and the lack of livelihood support emerged as critical barriers to physical and mental health help-seeking among male refugee survivors of CRSV. The key themes that emerged out of this category were the lack of livelihood support and also the lack of food to facilitate adherence to medication.

4.3.3.1 Lack of Livelihood Support

Respondents in this study noted that the lack of livelihood support in terms of a job or psychosocial help hindered help-seeking. A number of survivors interviewed for this study

are heads of families that have households to take care of. The fact that they are refugees puts them in a vulnerable situation where they cannot easily get jobs and therefore any meagre source of income received is spent on taking care of the family. Many of them delay help-seeking because there are more urgent needs that need to be attended to as explained by one service provider:

“...you cannot expect them to come for counselling on arrival in Uganda. They must find shelter, they must find food, they must find some social connection either to a friend or to some neighbours, or kind-hearted person. ... Most of the time it’s the last thing after other basic needs are met.” (Clinical psychologist, 43 years)

Some survivors noted that when they sought help, they were ordered by the doctors not to engage in heavy work as shared below:

“When they operated me, they gave me six months of not doing heavy work, not eating hard food, but being a refugee I don’t have any support where I can get someone to pay me house rent, so I was forced to work for the survival of my family.” (Alongi, 42 years)

Given Uganda’s high unemployment rate, refugees are most likely to be employed on a casual basis, poorly paid and given labour intensive tasks. Some of the survivors in this study mentioned that they are builders or carry heavy merchandise for businessmen. Service providers also noted instances where survivors forfeited medical and psychological interventions because they needed to find means of survival, and until that was met, it could only be a combination of many factors that would propel them to seek help. The lack of livelihood also hits them hard when organisations can no longer afford free health care services. In the absence of that, survivors cannot afford medical care because it is expensive. One survivor said:

“What stopped me from accessing help it’s the means of living, the means of living such as the financial means. Really this caused many problems. ... Because by myself, by ourselves in the family really we could not afford ...” (Fumu, 18 years)

4.3.3.2 Lack of Food

The lack of food to facilitate adherence to medication was mentioned as another barrier to help-seeking. Many times survivors are given strong medication that cannot be taken without food if it is to be effective, as one respondent put it:

“...He also gave me some pain killers for the waist which was painful because even now I am still having severe backache. The medicines were very strong and I failed to swallow them because I had no food.” (Tambwe, 26)

In addition to that, because of the nature of physical injuries sustained, many times service providers recommend that male survivors of CRSV follow a prescribed diet to facilitate recovery. Given their situation as refugees that are unemployed or extremely low income earners, survivors are not able to conform to these special diets. In summary, poverty and lack of livelihood emerged as resounding themes across the entire data-set and are seen as core psychosocial issues for survivors.

4.3.4 Physical Effects of CRSV

Service providers also identified physical effects of CRSV as a barrier to physical and mental health-seeking. They mentioned that the abuse the survivors were subjected to had adverse medical effects that may hinder help-seeking. For example, one service provider shared that:

“I remember one time there, things that touched me when I was interviewing a client and he urinated where he was sitting. Can you imagine that?! We were just sitting out on the grass as we talked. He told me, ‘I am sorry. I am going to urinate where I am sitting’, because he could not go anywhere ...” (Psychosocial counsellor, 58 years)

In cases like the one above, survivors may need to wear adult diapers, which they cannot afford as shared by the participants. This makes it hard for a survivor to leave home in pursuit of treatment as they may be embarrassed due to their inability to hold stool and urine. Another service provider explains that:

“In the injury, they might lose their sphincter that is what makes the anus continent. ... If it is unable to hold the gas it can be a social embarrassment ... you will not attend parties, and you will not be comfortable to be with visitors in the house, even with your own children, because suddenly, you let go. And if it cannot hold stool, then when people start holding their nose, you begin to feel uncomfortable to be in society.” (Consultant surgeon, 45 years)

The above quotations show that some of the physical effects of the violence exacerbate social stigma and hinder help-seeking.

4.3.5 Fear of Marital Disharmony and Breakup

Respondents shared that physical and mental health help-seeking among male refugee survivors of CRSV led to marital disharmony and at times breakup. One survivor shared that:

“I am sorry because I lied to my wife; I could not tell my wife that I was sexually abused. I was risking; I thought myself was going to risk my marriage so I decided to keep quiet.” (Elombe, 41 years)”

These fears were not unfounded as shared by another survivor who revealed that:

“I had problems in my family because my wife ... when I told her that I was a male survivor, she told me, ‘I don’t deal with homosexuals. You have become a homo, thank you. Please keep your ways and I am not ready to be a refugee in Uganda.’ She left.”(Baraka, 31 years)

The fear of marital breakup as a barrier to help-seeking was also noted by service providers as one of the reasons given by survivors for not seeking help.

4.3.6 Self-Sufficiency

Self-sufficiency was mentioned as another barrier to physical and mental health help-seeking among male refugee survivors of sexual violence. In this context, self-sufficiency means that the survivors preferred to treat the effects of the CRSV themselves rather than seek help. This however varied from individual to individual depending on their circumstances. For some, it was because of previous experiences while seeking help, to others it was shame, while others, like the respondent below, were fleeing the conflict areas and also had some medical knowledge to try and handle the issue themselves:

“Yeah, and because I am a medical personnel, I tried to get some medicine in the pharmacy, while running to here.” (Lisanga, 47 years)

This was re-echoed by one service provider who noted that:

“I wasn’t the first person to these patients. They had got first aid elsewhere. They tried to find out about it, and sometimes they nursed themselves.”(Consultant Surgeon, 45 years)

At times, this self-sufficiency was facilitated by unwillingness on the survivors’ part to talk about what happened, as one of them shares below:

“I was not ready to talk about the problem I got. I was feeling bad by the time I reached here in Uganda. I had thoughts of taking a knife and killing myself.”

(Tambwe, 26 years)

To summarise this section, results from this study revealed that there are several barriers to physical and mental health help-seeking among Congolese male refugee survivors of CRSV. These barriers were presented as themes grouped into six categories as presented above. Despite the numerous barriers faced by the male survivors of CRSV, a number of facilitators to help-seeking were also identified.

4. 4 Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of CRSV

The second key objective of this study was to investigate the facilitators to physical and mental health help-seeking among Congolese male refugee survivors of CRSV. Participants in this study mentioned a number of facilitators which have been summarised under the following themes: (i) social support, (ii) symptom severity, (iii) professionalism among service providers, (iv) availability of free tailored services and (v) information, education and communication.

4.4.1 Social Support

Social support, in various forms, was often mentioned as a key facilitator to physical and mental health help-seeking among Congolese male refugee survivors of CRSV. Four themes emerged from the analysis and they are discussed below.

4.4.1.1 Support Groups

During data analysis, I found that this was the most commonly mentioned facilitator by respondents, as most of them emphasised the importance that support groups play in such situations. Exclusively, a group of male survivors of CRSV, the Men of Hope Refugee Association under the guardianship of the Refugee Law Project, was mentioned as having played an instrumental role in facilitating help-seeking as one respondent shared:

“I underwent an operation and after the operation I was integrated in the group and in that group we have had many counselling sessions. So from joining the group I now see that I am not alone. We are many victims and because of counselling and

other things the trauma has started to reduce just by the fact of knowing that I am not alone.” (Alongi, 42 years)

Seeing other survivors openly share their experiences of rape and help-seeking through the support groups encouraged others to follow suit. Some had the connections to free services and so they readily referred those in need of similar services. Some of the support group members have received training in trauma and peer counselling and they have been able to encourage other survivors to seek help. In the process of receiving training, some of them have been able to receive therapy as one survivor shares:

“... through now the association, Men of Hope, and through organisations like Refugee Law Project and HIAS, I got the opportunity to be selected among people who could get some training in psycho-therapy; we had some psycho-therapy sessions. So, through those sessions and different exercises, I got psychological support.” (Kangelu, 43 years)

The support group members also went out of their way to engage in community sensitisations, creating awareness about CRSV. This enabled survivors in the communities to boldly go and seek help as shared by a service provider below:

“... seeing those ones whose lives changed so they want to be like them and we also have these group members like the Men of Hope who always go out they encourage people. ... when they hear other people talking about the experience so now they say if this one managed to speak up or to open up. Then they also say, ‘Let me go and seek assistance.’ ” (Psychosocial counsellor, 58 years)

Support group members were also reported to have offered financial, material and moral support to male survivors of CRSV undergoing treatment out of the little money collected amongst group members for such contingencies. This result shows that support groups play a very crucial role in facilitating help-seeking among male survivors of CRSV.

4.4.1.2 Friends and Family

Mentioned mostly by the service providers, it was noted that friends and family also played an important role in encouraging male refugee CRSV survivors to seek help. One service provider shared that:

“There is a case which surprised me when a wife came to me telling me that her husband was a male survivor. ... Actually we went to her home, we talked to the husband, and he was highly traumatised; he could not move from home.”
(Psychosocial counsellor, 58 years)

Another service provider added that:

“... most of the time it’s a recommendation either by a friend, when they see that someone is really suffering, they make a recommendation saying ‘No, you have to’, and at sometimes it is insisted, insisted recommendation.” (Clinical psychologist, 43 years)

This showed that confiding in friends and family about an experience of CRSV by male survivors facilitated their quest for help to handle the physical and mental health effects of CRSV. On the other hand however, some of them were motivated to seek help by family responsibilities as one respondent shares:

“... in this city where we have come as refugees I am a man with responsibility of children and I have a wife. If I close myself and keep quiet and die in this city, where will my children go? So I had to open up and because of opening up that is why I am here like this. If I hadn’t opened up I wouldn’t be alive today.” (Alongi, 42 years)

4.4.1.3 Livelihood Support

As earlier mentioned among barriers, the lack of food and livelihood support hindered help-seeking among survivors but, once this was addressed, survivors were able to seek help and adhere to treatment as one respondent put it:

“The medicines were very strong and I failed to swallow them because I had no food. I came back here. Then sister (name withheld) helped me and gave me money to buy food so that I can take the medicine. After that I felt a bit better.” (Tambwe, 26 years)

These findings therefore suggest that provision and availability of social support is crucial to facilitating physical and mental health help-seeking among Congolese male refugee survivors of CRSV.

4.4.2 Symptom Severity

A recurrent theme in the interviews was a view among the respondents that survivors of CRSV reach a crisis point where they can no longer bear the pain but seek professional help as noted by one survivor:

“I was suffering, personally, I was suffering, I was suffering. For me it was a good luck that I found people who had same problem with me. In the beginning they are the ones who helped me ... ” (Djamba 34 Years)

This notion was shared by all service providers who noted that the pain alone was enough to facilitate help-seeking. One service provider shared that:

“Nonetheless, the pain can be so bad that you may be not be able to handle. The relatives around will say, look, they take you and they are forced by the circumstances, by the family to seek the help.” (Consultant surgeon, 45 years)

In relation to this, survivors also noted that the desire to achieve emotional stability pushed them into seeking help as one of them put it:

“I went to seek help because I wanted to be mentally, physically and socially well. Yeah, and also I wanted as I many others to know that there is a problem to speak out as they are helping women who are raped, they can also help us.” (Lisanga 47 years)

This longing to be healed as shown by the responses played a role in facilitating help-seeking.

4.4.3 Professionalism among Service Providers

Another key facilitator to physical and mental health help-seeking mentioned by respondents in the study was the professionalism exhibited by some of the service providers contacted. This study revealed that as any other people seeking help, male CRSV survivors need to be respected and received with a non-judgemental attitude. One respondent shared that:

“When I came to know about Refugee Law Project through Men of Hope Association, Refugee Law Project recommended me to Ntinda Family Doctors, which was already at that time aware about the case of male rape and sexual violence against men. ... they took charge of my case properly.” (Kangelu, 43 years)

Service providers also shared the view that many CRSV survivors sought help once they realised that other survivors had been received with respect and dignity. One service provider shared that:

“Most of the time any other kind of factor that facilitates others coming is acting professionally. When they trust that the service you give is authentic they will come and they will inform others and others will come.” (Clinical psychologist, 43 years)

This professionalism is also exhibited by making appropriate referrals for survivors where necessary in order to enable them to acquire a comprehensive intervention for their situation. One service provider shared that:

“... I think that most of the time a referral, a recommendation by a friend, a colleague, a recommendation by the doctor or another health or whatever service providers and trust that they develop once they interface with the service providers. These will come as factors that facilitate.” (Clinical psychologist, 43 years)

Whilst the majority of survivors mentioned professionalism as a facilitator, they clearly made a distinction between public and private agencies. The general consensus was that public facilities do not care enough about the feelings and problems of CRSV survivors. Some of the reasons to explain the attitude of public service providers have already been mentioned earlier on in this chapter.

4.4.4 Availability of Free Tailored Services

The availability of free medical and psychological services tailored to the needs of CRSV survivors motivated some of the respondents to seek help. This notion was shared by all respondents and one of them stated that:

“But I do believe that what really facilitated a number of the patients whom I eventually saw in private to come, was the availability of health services provided through the organisation. The organisations, InterAid, Refugee Law Project or any other refugee organisation ...” (Consultant surgeon, 45 years)

Having noted lack of finances as a barrier to help-seeking, respondents clearly highlighted that the provision of free services would motivate them to seek help as, after all, their desire was to get well and be restored to normal functioning.

4.4.5 Information, Education and Communication

A final but very crucial facilitator mentioned by respondents in this study was the availability of information regarding prevention and responses to CRSV. Respondents noted that information was availed through several channels, including community outreaches. A very effective way of doing this was engaging male refugee survivors in the community outreaches as shared by a clinical psychologist below:

“...we take the proactive approach ... We sensitise the communities about male rape and we sensitise the communities about the need to open up when these issues come and aaah ... the other means we use to facilitate these men to come for support is; we involve the men, the survivors of sexual violence to actually go out in the communities ... in the end, they come to us ...” (Clinical psychologist, 25 years)

In addition to this, respondents noted that the other channel used to avail information, specifically to service providers, is through training them on how to respond to CRSV. These trainings have been effective in changing attitudes of service providers as shared below:

“... So the information is not only at the level of clients but also at the level of service providers. They also now understand better with the help of Refugee Law Project, with the trainings we have with different service providers. They now understand better they can deal also with those cases like the way they deal with any other cases. So there is this information.” (Psychosocial counsellor, 58 years)

An interesting observation regarding this facilitator is that it also provides a solution to overcoming some of the barriers mentioned by the respondents.

4.5 Conclusion

Overall, the results in this chapter indicate that there are more barriers than facilitators to physical and mental health help-seeking among Congolese male refugee survivors of CRSV living in Kampala. Additionally, these barriers include a broad spectrum of factors from societal level barriers, such as cultural taboos to personal barriers, such as the survivors' need to prioritise providing for their families. The next chapter, therefore, moves on to present the experiences of practitioners working with male survivors of CRSV, and also all respondents' views on how to overcome the barriers to physical and mental health help-seeking among male refugee survivors of CRSV.

CHAPTER FIVE

RESULTS: SERVICE PROVIDERS' EXPERIENCES, AND STRATEGIES TO OVERCOME BARRIERS

5.1 Introduction

This chapter presents responses regarding the last two objectives of this study, namely: 1) exploring the experiences of service providers working with male refugee survivors of CRSV and 2) participants' views of overcoming barriers to physical and mental health help-seeking among male refugee survivors of CRSV.

5.2 Experiences of Service Providers Working with Male Refugee Survivors of Sexual Violence

This section presents findings in four categories that highlight the experiences of service providers working with male refugee survivors of CRSV, namely: (i) first experience of working with male survivors of CRSV, (ii) similarities and differences in treating female and male survivors of CRSV, (iii) professional, family and government reaction to their work with male survivors of CRSV, and (iv) impact of working with male survivors of CRSV on service providers.

5.2.1 First Experiences of Working with Male Survivors of CRSV

Responses from service providers show that their first encounter with male survivors of CRSV was difficult and overwhelming. When asked to share their first experience, one service provider exclaimed that:

“Oh my! It was a hard experience from me because I could not imagine ever in my life that a man could be raped ... So the first time I encountered a male survivor it was a very traumatic experience for me too ...” (Clinical psychologist, 25 years)

For some, their first encounter was met with disbelief and marked with an uneasy silence:

“...there would be an uneasy silence as you try to gauge how best to enlist the history. To get a good diagnosis, you must have a clear history of what happened ... and then assess what can be done. (Medical doctor, 45 years)

It was also mentioned that during the first encounter, service providers feared that they were re-traumatising the survivors through the process of documenting their history:

“... the history taking time it was fairly uncomfortable because you are keenly aware that you are taking the client through the same experience all over again, yet you need to be able to understand fully what exactly is happening or what happened to the patient.” (Consultant surgeon, 45 years)

Some service providers mentioned that what made intervention easy for them was the fact that the survivors provided a background to their health condition, thus providing a starting point for intervention. Service providers in this study also revealed that on average, it takes male survivors of CRSV between six months and three years to seek formal help in their countries of asylum, and this often occurs when the effects of the abuse have reached a crisis point. The majority of the service providers seemed to agree that the most immediate needs of the survivors were medical and psychological intervention. Findings indicate that even though the psychological trauma of the abuse was so apparent, it was imperative to handle the physical trauma first in order to effectively deal with it:

“The male survivor that I was handling had anal bleeding, had severe lower abdominal pain, had back pain and the first thing I had to do was to refer this client for medical support that was my first intervention to try to save the life of this client and then after they had obtained medical treatment I, um, took the client through counselling to support and build hope ...” (Clinical psychologist, 25 years)

This is not always the case however, and findings reveal that clients are handled on an individual basis as some present with severe psychological distress:

“The client had appeared with a lot of psychological distress, especially post-traumatic stress disorder, and immediately I took him into therapy and because it was really, really severe and difficult; he was in total avoidance.” (Psychosocial counsellor, 34 years)

Another service provider noted that intervention among male survivors of CRSV is multidisciplinary but requires a change of attitudes and mind-set amongst all involved:

“... it is all the other things that come in that you sometimes you have to bring everybody on board ... So it's dealing with stereotypes; it's dealing with attitudes.

That's the bigger thing but in terms of treating the physical thing is 30% of the work; it's very easy." (Medical doctor, 45 years)

On being asked what they knew about sexual violence against men before their first encounter with a victim, most service providers, except one, noted that they knew about it but had never come face to face with a victim:

"... sexual violence against men exists; sodomy exists, from very old types, from the biblical times I read that as a kid, and, aah, so in medical training you get to know that you have this as a big issue - in the developed world it is well articulated. In our environment we are not really certain of what is there, but, we also hear about it. And we have heard of assaults with objects to the man as well, but I was not keenly aware that it was a systematic way of behaviour among the combatants in Congo."
(Consultant surgeon, 45 years)

Although a few service providers shared that their academic training prepared them to handle such cases, the majority of service providers shared that it did not and as such, they applied general theory and skills they had been taught, until they gained expertise through regular interaction with such male survivors of CRSV. The medical doctor shared that:

"No, I would say that it gave me the theory and then you need to practice, you need to practice. Yah, knowledge in a book is one thing but like I said the context is so different in conflict setting and sometimes the paralysis many doctors experience because you haven't moved this condition to this context ..." (Medical doctor, 45 years)

This view was echoed by another service provider who shared that:

"No, it prepared me to work generally with all conditions, mental health conditions, but in the event of conflict, a health provider needs some specialised training. I have had extensive specialist training on working with trauma survivors, and trauma survivors including war related trauma. So I am prepared to work on this type of population - not at my school where I had my degree, but on my job." (Clinical psychologist, 43 years)

The service providers interviewed for this study had each treated over 10 male refugee survivors of CRSV, depending on the nature of service they offered. Service

providers offering psychological intervention had seen over forty male refugee survivors of CRSV while the consultant surgeon had dealt with only ten given the fact that the referrals made to him are those that require advanced surgical procedures. Services offered to male refugee survivors of CRSV were dependent on the organisation mandate and expertise of the service providers. Notably, service providers endeavoured to provide holistic care to survivors, in the face of limited resources because the needs of the survivors are many and most times interrelated. One service provider noted that:

“I am very aware that health is not just treating the physical. Actually health is defined as in total, as physical, mental, spiritual and there is the fourth, general state of well-being. So as a primary care giver, I instil confidence in my clients to know that one, I understand what they are going through ...” (Consultant surgeon, 45 years)

Overall, findings in this study reveal that service providers are aware of the many different needs of male survivors on CRSV and recommend that if intervention is to be effective, it has to be holistic.

5.2.2 Similarities and Differences in Treating Female and Male Survivors of CRSV

Responses to this question raised more differences than similarities. Service providers noted that what is similar about treating female and male survivors of CRSV is the fact that one has to focus on self-esteem issues because they both experience abuse and humiliation. The general consensus among respondents was that both female and male survivors of CRSV need medical intervention. One respondent noted that:

“... when you look at medical complications they are not different. Of course the pains they have, low abdominal pain, backache, so the physical health complications are almost the same. Though the organs are different, maybe a man will suffer from anal pains, when a lady suffers from various infections. So we have haemorrhoid cases for men and remember we have women who are raped both in anus and vagina so with that side of anus, we have similar complications ... what is similar, we have the same issues psychologically but again they are similar, psychologically physically, socially, economically and other aspects of life.” (Psychosocial counsellor, 58 years)

Commenting about the differences, the general consensus was that it is easier for women to open up about the abuse and seek for help as compared to men. Service providers

also noted that the female narratives of CRSV were more believable, generally, as compared to those of men due to the cultural perceptions that surround sexual violence as discussed in the previous chapter. It was also mentioned that the physical and psychological trauma may be more severe among men, although, more services were readily available for the women as compared to the men. Respondents shared that help-seeking habits of women are higher than those of the men, and that men tend to cope more negatively as compared to women. One service provider shared that:

“... Women tend to cope better than men. They cope better; they probably seek care a lot earlier so on the psychological front they may need a lot of help there. With the women they tend to somatise more, which means they are much physical symptoms compared to the men but men turn more into ... they become more angry. There is more substance abusive men; there is more negativity in terms of wanting to commit suicide.” (Medical doctor, 45 years)

One respondent however preferred to analyse the differences in terms of impact of the abuse and she noted the effects of CRSV have a longer impact on the females as compared to the males because of the fact that some females conceive and bear children out of rape:

“... There is one thing that I personally consider as protective for the men that they are not able to give birth to children so even when they recover they may recover very well and they don't have any more reminders but for the female they have children. They live to see the reminders. Even when they try to cope with it, but they will not forget or clear it completely from their lives; they walk with that experience.” (Psychosocial counsellor, 33 years)

Concerning the gender difference in pain, one respondent had a divergent view and said that two genders cannot be compared. He explained that:

“I don't think anybody can compare and have a scientific justification for comparison between PTSD in male sexual violence survivors and female sexual violence survivors. I don't think there is a scientific justification to say men suffer more than women or women suffer more than men because there is no justification even to compare two different people. No. Each one will suffer it according to who they are and their personal experiences. But we can categorise whether it's severe or profound for the individual, but not across.” (Clinical psychologist, 43 years)

Another respondent seemed to agree with him, saying that the discussion presupposes that women are raped through the vagina while the men are raped through the anus, which is not always the case, as several women are sexually tortured through the anus. He suggested that what should be investigated is the difference between anal and vaginal violation, and concluded by saying that:

“Yeah, it is difficult to compare the two because they are anatomically different parts; they are functionally different and whatever happens to them interferes with the original design and function of those places.” (Consultant surgeon, 45 years)

Respondents also noted that in as much as women have a gynaecologist who is specialised to handle the medical issues that arise for the abuse, the men have no equivalent or specialised person to deal with them and may end up having to see a range of medical specialists:

“A Urologist could be one but again the Urologist basically just deals with the urinary system. Okay? So we have worked with a combination of general surgeons who basically know most about the different surgical complications and general practitioners because this is a complex person; it’s not just one thing but probably many things in there so you need someone who can help unpack what’s going on. ... There is no equivalent of a gynaecologist for the other side ...” (Consultant surgeon, 45 years)

One service provider added that even if the gynaecologist can handle multiple effects relating to CRSV against females, at times they too have to see other specialists depending on the nature of injury. To conclude this section therefore, the study findings seem to suggest that female victims of CRSV readily seek medical and psychological help as compared to men, and that services are more available to them as compared to their male counterparts. There is no easy comparison however on which gender is more affected, in physical and psychological terms. Results also indicate that the treatment seeking process for the men seems to be much longer and more complicated as compared to that of female survivors.

5.2.3 Professional, Family and Government Reaction on their Work with Male Survivors of CRSV

Given the various misunderstandings on the occurrence of sexual violence against men, service providers interviewed for this study were asked how they were perceived by the government, professional colleagues and families due to their engagement with male

survivors of CRSV. They largely noted that they received support mainly from their families and colleagues. Regarding family, some noted that they don't take work home and so the family members are not privy to those details. Those with spouses that are aware mentioned that they are very helpful and understanding of their work. Regarding colleagues, respondents had divergent views, with some reporting that their colleagues understood the nature of their work, respected them for it and even consulted them about it:

“But those that know me am very comfortable and respected, and I must tell you that I am consulted by many, many, many. Not just by individuals but also by some organisations.” (Clinical psychologist, 43 years)

One service provider agreed with this and added that his colleagues in the medical field recognise that they have limitations, and this is an area that they are not very knowledgeable about. On the other hand, two service providers said that their work with male survivors of CRSV was viewed negatively by some of their family, and especially colleagues. Specifically, they were accused of working with homosexuals as one service provider shared:

“I think some think that I support homosexuality ... some people think that it's a waste of time because there is always going to be another conflict somewhere, why break yourself down trying to solve problems that are not of your own making. Some people just label these people and just call them complainers, whiners ... So yeah, but you get misunderstood because when you work with anal and intestinal conditions ...” (Medical doctor, 45 years)

The majority of respondents shared that the political environment in which they conduct their work is what affects them the most. They noted that government makes gender exclusive policies and also drafts legislature that creates a tense situation for them since most people misunderstand male survivors of CRSV to be homosexuals:

“Remember the other environment, where there was a tension or a situation where we had the anti-homosexuality bill being discussed and these people who cannot know the difference between the two. It's a problem too and maybe I didn't mention it before; it makes it hard to come and seek services.” (Psychosocial counsellor, 58 years)

One respondent actually mentioned that this is the reason male refugee survivors are reaching out to other service providers like the Uganda Police Force and Uganda Prisons

Service to create awareness, albeit with a slow impact. Another service provider actually felt persecuted by the political environment and he shared that:

“(sighs) ... I recently had a break in, (giggles); I had computers stolen here [the office], I had computers stolen at home. You know when someone breaks into your house anonymously and makes away with computers. What do you think is going on?” (Medical doctor, 45 years)

Although many service providers share feelings of political insecurity due to their engagement with male survivors of CRSV, one respondent was of the view that the government is in dire straits concerning the health sector and therefore it accepts any form of help:

“No, I think government is in deep waters in terms of health delivery and it will appreciate anybody doing something. It is the mandate of government to provide health to all citizens the - framework is not available. I know that the private health facilities take over 50% of the services delivered and I think they are given some leeway; they’re regulatory bodies that ensure that it is done safely so I don’t think that there is any difficulty.” (Consultant surgeon, 45 years)

In conclusion to this section, responses from participants show that largely, work with male survivors of CRSV is misunderstood. Even if there are some effects of initiatives that raise awareness concerning CRSV against men, the impact is still very low and more sensitisation is needed.

5.2.4. Impact of Working with Male Survivors of CRSV on Service Providers

Results of this study indicate that service providers working with Congolese male refugee survivors of CRSV are affected both positively and negatively, although the effect on them is mainly negative. A recurrent theme in the interviews was a sense among respondents that they develop secondary trauma. Respondents shared that, due to the nature of their work, they are forced to relive the experience of the survivors and this affects them emotionally:

“... it is very stressful ... so there are issues of secondary trauma that come about but, aah these we are able to deal with them through self-care and care for caregivers.” (Clinical psychologist, 25 years)

Another service provider stated something similar when he said:

“...you get to a place where you don’t have to hear it any more. Ok you get to a place where you say you know what; I am going to have to hand this person to someone else. Because I think for our own sanity it becomes important to realise that it’s the way to go. But you know I think the part that gets to you is how painful and how hopeless you feel when you’re listening to these stories ...” (Medical doctor, 45 years)

Several service providers mentioned that their work with these survivors leaves them filled with an array of emotions, both positive and negative, that include empathy, sympathy, anger and shame at what human beings are capable of doing to each other. One service provider mentioned that this whole experience leaves her broken at times while another said it shows the depravity of mankind:

“I think I have never been more aware of I will call it the depravity of mankind, because, ... the actual violence that these people describe is bad, so you get to realise, you know, potentially this can happen to anyone; all you need is the right set of circumstances because the perpetrators are different. It’s not just soldiers, okay, it is local leaders, vigilantes. ... anybody in the position of power, potentially could do this so, you realise how depraved people are.” (Medical doctor, 45 years)

Service providers further shared that this experience also made them sensitive to what happens in society and the injustice therein. Some service providers also noted that seeing grownup men cry is a very humbling experience to them:

“I think that for me the most humbling thing is seeing grown men cry. You see grown men cry, you see grown men go through crying and it changes all your ‘men are strong’ sort of beliefs ...” (Medical doctor, 45 years)

Despite all these emotional reactions, service providers noted that there is a need to control one’s emotions in order to effectively address the survivors’ issues. A respondent noted that:

“... one needs to retain one’s independence from the situation to be able to address the situation without their emotions ... So it is a delicate combination of really reliving with the patient their experience, and then on the other hand trying to give them hope and confidence that things can work out and sometimes it is not very easy ...” (Consultant surgeon, 45 years)

With regards to service delivery, one respondent mentioned that working with survivors of CRSV has revealed gaps in the health care system:

“But I think another thing you realise is that our health services are not well suited for men who have been through this sort of violence, because even counsellors struggle with what to tell them ... so you get to realise how limited health systems are.” (Medical doctor, 45 years)

On the other hand, two service providers noted that their work with male refugee survivors of CRSV had a positive impact on them. Data analysed however reveals that the positive impact was only due to the knowledge gained about working with this vulnerable population and the dispelling of cultural myths, as one explains below:

“Mostly it has affected me positively, because it has opened my eyes to the fact that men also have vulnerabilities, men can also be raped, and probably I would say that men are also at risk so that means that in my practice, it has made me become more sensitive to men.” (Clinical psychologist, 25 years)

Taken together, the results in this section provide important insights into the experiences of service providers working with male refugee survivors of CRSV. They seem to suggest that the impact has been negative for the majority due to the secondary trauma that results from their engagement with CRSV survivors. For some, there is a positive impact, but it's minimal as explained above.

5.3 Strategies to Overcome Barriers to Physical and Mental Health Help-Seeking among Male refugee survivors of CRSV

The final objective of this study was to elicit participants' views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of CRSV. Multiple solutions were mentioned and they were grouped into seven themes, namely: (i) information and communication, (ii) education and training, (iii) provision of infrastructure, (iv) developing gender inclusive policies and models, (v) increasing research on CRSV against men, (vi) curbing vulnerability, and (vii) offering family counselling and prosecuting perpetrators.

5.3.1. Information and Communication

A key theme that emerged under this section was the need to inform people about the reality of CRSV against men. Data analysed revealed that there are three important things that need to be done and they are discussed below.

5.3.1.1 *Talk about the Experience*

Respondents in this study stressed the importance of sharing their experience on local and international platforms, not only as a way of curbing ignorance about CRSV, but also for therapeutic purposes:

“I know when male survivors are telling their stories; there the process of healing starts because keeping it kills. It’s as if you are hiding a snake in your house but when you open a door you give an access to that snake to walk. So, the remedy is to talk. I remember one time I told my friend like if someone is in the house and then the house catches fire, how will you know that the person is inside? He said that he will start shouting. Then I came up and said, ‘My friend, we need to start shouting’.” (Elombe, 41 years)

This view was shared by the majority of survivors interviewed for this study, and they advised that opportunities should be provided for male survivors of CRSV to open up.

5.3.1.2 *Sensitisation and Raising Awareness*

Respondents mentioned that an important way of overcoming barriers was to use proactive approaches like community sensitisation. They shared that sensitisation has to be done at all levels, starting with the survivors themselves, making them aware of their responsibilities and then also including the communities and all stakeholders. The community was mentioned to be the first contact for the survivors and so it is important for them to be knowledgeable about prevention and response mechanisms for CRSV as shared by one respondent below:

“What should be done is raising awareness about this issue among the community, among the service providers, among the potential victims and among the actual victims ... we need to train people on how to deal with such cases but also how to identify them. We need to talk to the community especially the community leaders at the lowest level ... Because those are the people who spend most of their time with our refugees, with our forced migrants.” (Psychosocial counsellor, 58 years)

They added that sensitisation should be done at the local and international level, and that overcoming barriers cannot be done without proper sensitisation. Respondents shared that sensitisation should be specific, and provide examples for people:

“Sensitisation that is really specific and giving evidence is very good. Sensitisation on availability of services is also very important. At the same time, sensitisation that has proof or that has evidence that people who have suffered like this, also experience this, but this can go away if this and this has been done.” (Clinical psychologist, 43 years)

This advice led to another sub-theme mentioned by the respondents, which is the need to work with male refugee survivors of CRSV.

5.3.1.3 Working with Male refugee survivors of CRSV through Support Groups

The need to form and work with support groups of male refugee survivors of CRSV was emphasised by respondents in this study. Survivors noted that there is a need for stakeholders to involve them in prevention and response programmes for purposes of accountability and intervention design. One survivor shared that:

“I always say nothing for us without us; we need also to work with male survivors in advocacy programs ... I will encourage so much service providers to work in hand with the male survivors to understand the challenges they are facing, the gap. Then they will be able to provide the service which is necessary.” (Elombe, 41 years)

Many service providers shared this view and one added that:

“... the male survivors themselves are in a better position to advocate for the inclusion of males in different programmes in Uganda and world over ... they have actually gone through and experienced; they know the symptoms; they know the struggles that are attached to male rape ... they should be used as a tool to actually facilitate other men who have gone through these experiences to come out and speak out and seek help.” (Clinical psychologist, 25 years)

Service providers added that the most effective way of doing this is by organising survivors into support groups from where they can be engaged in several activities that include peer counselling and advocacy:

“I think that like we have seen from the support groups, once communities are empowered enough to help people who have been through this, sometimes they identify them before you, the medical practitioners, have identified them. So then, we have willing people in communities, who can help move these people, identify them, bring them from home, and show them where they can get help.” (Medical doctor, 45 years)

The excerpt above sums up the importance of spreading awareness about CRSV against men and also working together with the survivors. Findings from this study also emphasise the importance of support groups in overcoming barriers to physical and mental health help-seeking among male refugee survivors of CRSV.

5.3.2. Education and Training

Responses from participants underscored the importance of educating and training all stakeholders that deal with refugees about CRSV against men. One survivor shared that:

“I want service providers to go through training. Service providers have to be trained in sexual violence against men, because they have been trained against women; they know. Even we see many NGOs in charge of raped women but not men. If they can be trained in sexual violence against men and boys, it can be better ...” (Lisanga, 47 years)

Service providers mentioned included doctors, policemen and a host of other frontline staff who work with refugees. Respondents indicated that training and education is an effective tool in raising awareness about CRSV against men among stakeholders in humanitarian settings, and most especially in the refugee settlements. Respondents also noted that where this has been implemented, the impact is positive:

“.... We have trained medical practitioners, we have trained the Uganda Police, we have trained the Uganda prisons service, and people are beginning to become enlightened about these issues of male sexual violence ... When people have information, there is power” (Clinical psychologist, 25 years)

Participants felt that stakeholders needed to know that CRSV against men is real, and taught how to respond to it as a way of preparing them for such cases. Having identified gaps in the education system across almost all disciplines involved in humanitarian response,

respondents suggested that the education curriculum in the relevant disciplines be revised to be more gender inclusive and relevant:

“There is need to influence the education system in Uganda, not only in Uganda but worldwide and especially in these countries where we have a lot of conflict going on; let’s say, Congo, Rwanda, Burundi, Uganda, Sudan. I think we have one of the best ways of passing on the knowledge. I think we should have this as part of the curriculum at all levels: at primary people should know, at secondary schools, even universities ...” (Psychosocial counsellor, 58 years)

They noted that the curriculum should empower professionals to deal with male survivors of CRSV. The need for professionals to upgrade their knowledge and skills was also mentioned. Respondents also said that creating awareness about CRSV against men will inform law makers and put an end to the confusion between CRSV and homosexuality.

5.3.3. Provision of Infrastructure

Also mentioned as a solution to overcoming barriers was to provide the infrastructure needed. One respondent shared a concern that an end to the refugee situation was not anywhere in sight and therefore there is need to provide medication in hospitals and fill all other infrastructural gaps:

“The next thing is the infrastructure - things that we talked about earlier. Just make sure that facilities are equipped to handle these things at points of call, that there are translators, there are people who understand the language, and the medicine is there ... so there are things we can do to intervene at that initial level and this is all at the infrastructural” (Medical doctor, 45 years)

This task was specifically directed towards the government, as it is the government’s responsibility to provide quality health care to everyone within the borders of Uganda. Participants called for the filling of the human resource gap relevant to meeting the physical and mental health needs of male refugee survivors of CRSV:

“But without a doubt we need more of counsellors; we don’t have enough of those. We need, I think beyond counselling; we need physiotherapies, we need occupation therapists, we need people who can help these people who have been very traumatised get integrated back into the society.” (Medical doctor, 45 years)

The suggestions in these responses provide a remedy to the various infrastructural barriers that were mentioned earlier by participants in this study.

5.3.4. Developing Gender Inclusive Policies and Models

There were also calls for the government to formulate a mental health model for men that have undergone such violence. One service provider advised that:

“But then also, it’s required for government, for agencies to establish authentic mental health services for male sexual violence survivors. Yes. It’s very harmful for such person to come to a centre like this and meet somebody who has a training of 3 months in basic skills of counselling. It is very dangerous.” (Clinical psychologist, 43 years)

He further advised that one way of doing this would be for government to provide capacity building projects for staff. Another service provider called for stakeholders to come up with ways of identifying victims at the port of entry so that they can receive psychological first aid:

“... At points of entry of these people into the country, there needs to be mechanisms that pick those people ... we talked about the concept of psychological first aid ... to help them process and deal with this better. I think the worst kind of scars that this condition gives you is the emotional scars; those last, but they are not as bad if we start you on the journey to recovery early ...” (Medical doctor, 45 years)

At the international level, respondents called for a formulation of gender inclusive policies as a solution to overcoming barriers:

“I know people in the international level are still struggling. I have read so many reports. While even being given to UNHCR, UN are still struggling to accept male survivors as survivors of sexual violence ... I always say sexual violence is a gender issue ... not just for certain categories of people. It is not just for a woman and a girl. ... When we talk about gender, we mean gender equality in service provision - in every service provision legal, social physical, health, everything - because men and boys are also human beings...” (Psychosocial counsellor, 58 years)

One respondent advised refugee serving organisations to make use of some of the models available that have been tested and proved to be effective to provide services to this

group of people. He mentioned that such a model includes having an efficient and effective referral system that can enable survivors to receive specialist care in the health system.

5.3.5. Increasing Research on CRSV against Men

Respondents also suggested an increase on research to be conducted on the issue regarding CRSV against males and publishing of findings in visual and print media. They mentioned that this would enable survivors to overcome the fear of seeking help, and also know where to access services:

“The first one is this: that they research on raped men, then they publish it in the newspapers, journals and radios because when a male victim of rape reads or hears about it, he will feel that he is not the only one, knowing that there are others who were raped before them. He will feel relieved, and he will get courage to look for that office that has published it so that he can come and open up to that office.” (Tambwe, 26 years)

Another respondent added that research would also inform donors so that they can channel resources to male victims and restore them to normal functioning.

5.3.6. Economic/Livelihood Support

The majority of the respondents noted that male survivors of CRSV are a vulnerable group whose needs are vast and multiple. They noted that some of the steps required for them to seek help were to deal with the other barriers, such as food, finances and livelihood, in order to curb vulnerability:

“We need - I will say this over and over again - we need to think through ways to empower these people when they come here. Because the moment you have been vulnerable and you come back and you are still vulnerable, this thing can keep happening. ... Many of these people end up in sex work; ok? It is one thing that they can go back again to increase vulnerability. So we need to break that cycle of vulnerability and help empower them again.” (Medical doctor, 45 years)

As a way of curbing vulnerability, one respondent suggested that male refugee survivors of CRSV should be resettled to other countries, far away from the place where the abuse happened:

“And then, to see if organisations can see how they can help survivors to have a durable solution which can put them in a situation where they can have work, they

can have a job, they can be able to take care of ... to address some needs, primary needs. ... So there are others who if they see may be this case needs a resettlement, yes let them facilitate them to where everyone can fit better.”(Kangelu, 43 years)

Respondents shared that not only would resettlement enable them to access the best quality care, it would also facilitate psychological healing.

5.3.7. Offering Family Counselling and Prosecuting Perpetrators

Other solutions suggested by respondents to overcoming barriers to physical and mental health help-seeking among male refugee survivors of CRSV included the need to offer family therapy or counselling. This creates awareness in their spouses about CRSV against men so that they can understand the effects, such as sexual dysfunction, and how it can be dealt with. Finally, one service provider suggested that one of the ways to enable psychological healing was to bring perpetrators of CRSV against these men to justice. This would also curb impunity.

5. 4 Conclusion

In conclusion, the results in this chapter indicate that there is still a lot of work to be done in order to remove the barriers to physical and mental health help-seeking among male refugee survivors of CRSV. A number of possible actions or interventions were raised by both the CRSV survivors and the service providers. Some of these suggestions related to broader underlying problems, such as poor healthcare infrastructure, while others addressed gaps particularly affecting male survivors of sexual violence, such as training of healthcare providers in provision of services to male survivors. The next chapter, therefore, moves on to discuss these findings and also makes suggestions to respond to this problem.

CHAPTER SIX

DISCUSSION

6.1 Introduction

The aim of this study was to investigate the barriers and facilitators to physical and mental health help-seeking among Congolese male refugee survivors of CRSV living in Kampala, Uganda. The study's objectives stated in Chapter One of this thesis were used as a basis to discuss the findings of the study in relation to international literature, while applying EST (Bronfenbrenner, 1994). The application of EST will help us understand various factors influencing physical and mental health help-seeking at different levels of the system. In turn, the application of EST will then enable us to conceptualise future responses to these factors, informed by respondents' suggestions of how to overcome barriers to physical and mental health help-seeking among male refugee survivors of CRSV. This is vital as interventions should be implemented at the right level of the ecological system, i.e. target the most appropriate audience, to achieve optimum results.

During the discussion, some factors will be seen to cut across several levels of the EST. However, they can be viewed and addressed differently at each level. The issue of factors cutting across several levels of EST is discussed in other studies that have used the theory. For example, when analysing the impact of sexual assault on women's mental health, Campbell et al. (2009) noticed that self-blame appeared at all levels of the theory and therefore formed a meta-construct. At the individual level, Campbell et al. (2009) noted that self-blame manifested when victims blamed themselves for the rape due to their character or behaviour leading to the event. The lack of empathy from informal systems then compounded self-blame at the microsystem level, while victim-blaming by legal and medical providers led to self-blame at the meso/exosystem level. Older women often blamed themselves for the rape of younger women at the macrosystem level, while at the chronosystem level, victims of multiple sexual assaults have higher levels of self-blame. This shows that the different levels at EST are not nested, rather networked and connected as Neal and Neal (2013) suggest.

This chapter begins with a discussion of the findings of this study alongside literature from previous studies. This discussion is structured according to the study objectives and

followed by the implications for policy, practice, and research, the limitations of this study, and finally, the conclusion.

6.2 Perceptions of Barriers and Facilitators to Help-seeking

This section covers the discussion on objectives one and four of this study, which is the perception of barriers and facilitators to physical and mental health help-seeking among male refugee survivors of sexual violence, according to survivors and service providers.

6.2.1 Barriers to Physical and Mental Health Help-seeking

Respondents in this study mentioned that the key barriers to physical and mental health help-seeking among male refugee survivors of CRSV include (i) socio-cultural legal and political factors, (ii) the poor health system and infrastructure, (iii) ignorance, (iv) poverty and lack of livelihood support, (v) the physical effects of CRSV on the survivors, (vi) fear of marital disharmony and break up, and (vii) self-sufficiency. (See Figure 6.1, below, for the factors identified at various levels of EST).

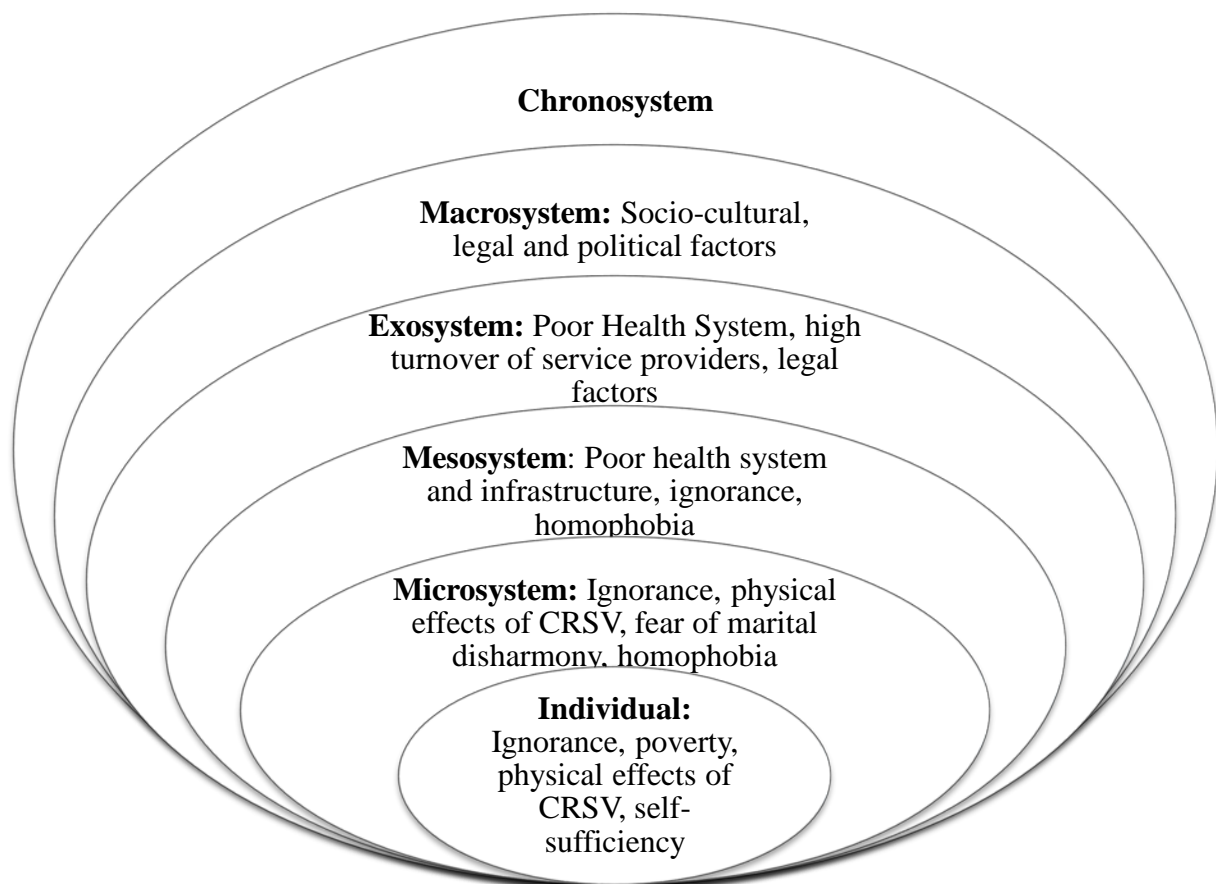


Figure 6.1: EST Model Depicting Barriers to Physical and Mental Health Help-seeking among Male Refugee Survivors of CRSV in Kampala

6.2.1.1 Socio-cultural and Legal, Political Factors

The socio-cultural and political factors mainly come into play at the macrosystem and exosystem levels, but the impact of these factors filters through all the levels. The macrosystem includes concepts such as culture, religion and ethnicity (see section 2.7) and respondents in this study touched on macrosystemic factors as they repeatedly mentioned that the most important barriers to help-seeking are the conceptualisation of masculinity and homophobia in many African cultures. This seems to result from the belief that sexual violence against men is a taboo or curse, as also shared by participants in this study. Prior studies in Uganda and DRC depict idealised notions of masculinity where men are thought to be strong enough to protect themselves from any risk of harm (Dolan, 2010, 2014). Such biased conceptualisations of masculinity are rooted in ignorance of events experienced by male rape survivors and only serve to promote myths about male rape (Davies, 2002; Loncar, Henigsberg, & Hrabac, 2010). This macrosystemic barrier mirrors the predominant societal

view of CRSV in Uganda and this view results in undesirable responses to male CRSV survivors themselves and to issues such as male rape in general and CRSV against men.

Respondents in this study experienced the effects of these macrosystemic factors at the exosystem, microsystem and individual levels. Two types of responses from community members and service providers characterised this impact: (i) people exhibited shock that men could be raped and were ignorant of this phenomenon, and (ii) people expressed the belief that help-seeking among males is a sign of weakness. At the exosystem level, some service providers in this study confessed that they were initially ignorant that men could be raped. This initially shaped their responses to male survivors of CRSV, with some service providers feeling unsure of how to respond. Other studies confirm that service providers are not immune to such cultural biases (Davies, 2002; Godia et al., 2013). A study on health service providers' experiences of providing sexual and reproductive health services to young people in Kenya revealed that personal feelings, and cultural and religious biases among service providers hindered them from providing quality services (Godia et al., 2013).

At the microsystem level, respondents noted that their families and friends consider help-seeking for a man as a sign of weakness, as men are culturally considered to be strong and self-sufficient. This study found that such beliefs led to stigma towards male survivors of CRSV which further hindered help-seeking at the microsystem level. This stigma seemed to result from two different sources, namely cultural bias specifically against male rape, and a negative response to sexual violence in general, which resulted in shame. The survivors reported that they were ashamed to be identified as CRSV survivors, and felt shame when exposed to others' negative reactions to their CRSV experiences. Existing literature on a study among male refugee survivors of CRSV in Uganda by Edström, Dolan, Shahrokh, and David (2016) found that stigma is encountered at several points of the recovery process, and that there is a strong relationship between stigma and silence. This is detrimental to the recovery of male survivors because disclosure about CRSV is often instrumental in accessing the necessary help from family members and other social networks. Such help may include emotional support and livelihood support during the treatment and recovery process.

In this study, results also show that the cultural conceptualisation of masculinity is related to homophobia in relation to male rape at the various levels of the EST. Respondents mentioned that these cultural underpinnings blind many people to the difference between male rape and homosexuality. This barrier is also mentioned in existing literature of studies

conducted in Uganda, Kenya, Chad, DRC and other war affected countries (Dolan, 2014; Hebrew Immigrant Aid Society, 2014; United Nations, 2013). Homophobia is indeed common in Ugandan society, as noted by several authors (Lebrón, 2011; Strand, 2012; Thoreson, 2014). Tamale (2013) criticises this homophobia which some claim is an attempt to uphold the local cultures in Uganda. She stresses that homosexuality has always been present in many African traditional settings and there is oral, literal and visual evidence to prove it (Tamale, 2013). In her paper, Tamale (2013) compiles evidence of homosexuality in various cultures across the African continent, for example the paintings of the San people of Zimbabwe, the Shona of Southern Africa, the Wolof in Senegal, and King Mwanga of Uganda, among many others. This macrosystemic factor was also experienced at the exosystem level by the study respondents. At the exosystem level, this study found that not only is homophobia prevalent in the social structures, it is also embedded in the legal structures that govern the country and also influence service delivery.

The laws in Uganda concerning sexual and gender-based violence mainly highlight the needs of women and girls (Hebrew Immigrant Aid Society, 2014). Through omission, this discriminates against male survivors of CRSV, and this discrimination is exacerbated by laws legislating against same sex relationships in a society that is highly homophobic, and can hardly distinguish between a survivor of male rape and a homosexual person (Dolan, 2014). As such, male survivors of CRSV encounter longer and more complicated help-seeking processes. Ignorance by government on how to treat victims of sexual violence affects the larger community (Clifford, 2008). In this aspect, therefore, cultural underpinnings facilitate homophobia and play a role in influencing legislation in Uganda. Changes in the legal environment are also seen at the choronsystem and further influence access to free medical help. For example, many male refugee survivors of CRSV were left without medical and psychological care for over ten months when the government of Uganda suspended RLP's activities due to accusations that the organisation promotes homosexuality as per the now repealed Anti-Homosexuality Act (Kansiime & Tusasiirwe, 2017).

Study respondents also mentioned that some service providers openly displayed homophobic tendencies towards them and offered culturally insensitive services, such as examining them in a gynaecological ward in full view of female patients. Such unethical practices, as this study found, are also exacerbated by the poor health system and infrastructure in Uganda as discussed in the next section.

6.2.1.2 The Poor Health System and Infrastructure

The barriers encountered due to the poor health system and infrastructure in this study are mainly seen at the exosystem and mesosystem levels. Participants in this study shared that the inadequate and sporadic services available to male refugee survivors of CRSV, the poor health system and infrastructure, and the high turnover of service providers deterred male survivors of CRSV from seeking help. In the context of this study, these factors are predominately seen at the exosystem level. The high turn over rates of service providers mentioned in this study as a barrier is also noted in prior literature (Harris & Freccero, 2011) and it is damaging to the survivors because it destabilises the helping relationship. Many of the new staff would need to undergo training on handling male survivors of CRSV, and not all organisations have the resources to conduct the trainings. For example, RLP trains police and prison staff, including those in charge of gender desks (Kansiime & Tusasiirwe, 2017), only to have them transferred to other parts of the country, and new staff are then assigned to those desks who do not know how to respond to CRSV against men.

At the mesosystem level, respondents complained about the long waiting hours, the negative attitudes by medical personnel, plus the lack of privacy and confidentiality in government hospitals due to congestion. These complaints are similar to those in rural DRC where infrastructure was found to be poor and lacking basic resources (Christian et al., 2011a). This scenario portrays Uganda's dire need of financial and human resources in the health care system. Coupled with poor pay, it is no doubt that Uganda, sadly, with the help of its own government, is facing a massive brain drain of doctors and nurses to countries like Trinidad and Tobago (Ighobor, 2016). This has worsened the shortage of health care workers in Uganda, and burdened the few health personnel left in the system.

Respondents shared that there are few psychosocial services available to them, especially in government facilities. This could be explained by poor funding of the mental health sector in Uganda, as reported by Harris and Freccero (2011), and also the fact that both the government and NGOs put emphasis on the physical aspects of CRSV and largely ignore mental health issues. A survey to assess Uganda's mental health system, found that the government health department only channelled 1% of its expenditure to mental health in primary health care (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyabangi, 2010). The sector is only bailed out by funding from donors and in this particular year when the study was done, donor funding only increased the amount spent on mental health to 4% of the overall health budget (Kigozi et al., 2010). Furthermore, over half of the amount was spent on

Uganda's only national psychiatric referral hospital, thus leaving very little funds to be spent at the regional mental hospitals. In terms of human resources for mental health, Kigozi et al. (2010) found a ratio of 1.13 mental health workers to 100,000 people. This highlights the need for more training or use of lay health workers to cover up the service gap.

6.2.1.3 Ignorance

In this study, ignorance as a barrier to help-seeking can be seen at the individual, microsystem and mesosystem level. Findings on ignorance included ignorance about available services, and ignorance about CRSV from service providers. At the individual level, respondents shared that male refugee survivors of CRSV did not seek help because they were ignorant about where to find the services. A study conducted in the DRC among female victims of CRSV noted this barrier and recommended that information about the services available should be distributed to people in the communities (Médecins sans Frontières, 2009). Refugees in Uganda encounter several challenges as they settle into the new environment. Along with the issues of a language barrier, and other challenges that come with moving to a new and unfamiliar environment, they may not know where to access relevant services. With time, refugees become familiar with their environments and eventually get to know where the health centres are so that they can seek help.

Respondents also noted that many health care personnel they sought assistance from were ignorant about CRSV against men, and about how to handle their CRSV-related ailments, as already discussed above. This mesosystemic factor was mentioned by CRSV survivors regarding the ignorance of many service providers, especially those in the government health facilities. The service providers in this study shared that they were not given any specific training in school on how to handle this unusual issue, and that many of their colleagues were ignorant about CRSV against men, and often, how to respond to it. Ignorance on how to respond to such injuries resulted in poor quality services, plus ineffective medication given to male survivors, especially at the government health facilities, as also noted in other studies conducted on sexual and gender-based violence (SGBV) against men in conflict situations (Carpenter, 2006). Such experiences with service providers, when shared among peers, deterred other survivors from seeking help. Dolan (2010) found a similar scenario in DRC, whereby poor attitudes of health workers and their ignorance about CRSV deterred survivors from seeking help.

6.2.1.4 Poverty and Lack of Livelihood Support

Campbell et al. (2009) note that after rape, survivors are left with the daunting task of seeking help amidst many challenges. The factor of poverty and lack of livelihood support as a key barrier to help-seeking is predominantly seen at the individual level. Although 'the individual' is not mentioned in EST, he or she is essentially the key person in this theory and his or her unique characteristics should be taken into consideration before analysis at the different EST levels. Respondents in this study shared that access to medical intervention after the sexual abuse is important, a fact also shared by female survivors of CRSV in DRC (Harvard Humanitarian Initiative, 2009). However, in the face of multiple vulnerabilities that they face, participants said that they consider needs like food and shelter to be much more urgent as compared to seeking medical help. Some argued that, in addition, the medication received often necessitates a prescribed diet that is hardly affordable. In Uganda, organisations that offer free medical and psychological services to respondents in this study are all donor funded. Therefore, in the event that there are no free medical services due to funding cuts, participants noted that they simply could not afford the medical expenses as they are either jobless or extremely low income earners.

Furthermore, some survivors require expensive surgeries that are simply unaffordable to them. The Hebrew Immigrant Aid Society (2014) compared the costs of rectal surgery between Nairobi and Kampala and found them to be at \$1400 USD and \$2000 USD respectively, a figure hardly affordable for male refugee survivors with minimal access to gainful employment. Poverty as a barrier to help-seeking among survivors is exacerbated by factors at the exosystem level, where health facilities are out of reach for male survivors due to lack of transport to access them. Available literature also suggests that long distance between health facilities and survivors may serve as barriers to help-seeking, or may hinder after-care (Harris & Freccero, 2011).

In seeking employment to pay for basic needs and medical care, refugee CRSV survivors encounter many problems in the Ugandan setting. Even though extreme poverty in Uganda has consistently reduced since 1993, currently, 19.7% of the population still lives below the poverty line (World Bank Group, 2016b). The World Bank Group (2016b) notes that 72% of the total Ugandan population still depends on subsistence agriculture. However, only 5% of refugees in urban areas in Uganda are engaged in agriculture (World Bank Group, 2016a), and it seems not to be a viable employment option for respondents in this study, due to their health problems. Furthermore, when refugees in Uganda search for other

employment, they encounter barriers like language, discrimination, legal issues, lack of relevant documents and inadequate interview skills (World Bank Group, 2016a).

6.2.1.5 The Physical Effects of CRSV on the Survivors

It is mostly at the individual and microsystem levels that the physical effects of CRSV on the male survivors serve as a barrier to physical and mental health help-seeking. Respondents in this study shared that urine and faecal incontinence resulting from traumatic injury to the genitals and anus at times hinders help-seeking. This is because this incontinence hinders movement and social interactions at the microsystemic level, among family, friends and the wider community. Survivors are regarded as social misfits on the grounds of hygiene as documented among female survivors of CRSV in DRC, some of whom suffered from rectovaginal fistulae (Longombe et al., 2008; Onsrud, Sjøveian, Luhiriri, & Mukwege, 2008). Rectal fistulae among men are documented in prior literature, although there is little data to show how often they occur (Ba & Bhopal, 2017; Christian et al., 2011a; Tewksbury, 2007a). When interviewing male refugee survivors of CRSV in Chad, Kenya, South Africa and Uganda, the Hebrew Immigrant Aid Society (2014) also found that incontinence and lack of sphincter control made them abstain from food thus damaging their already frail health. This barrier could also explain why some respondents in this study initially resorted to treating themselves as opposed to seeking professional help.

6.2.1.6 Fear of Marital Disharmony and Break Up

In this study, the fear of marital disharmony and break up is at the microsystemic level. Respondents reported that they did not seek help because they feared the impact of the disclosure on their marriages. This fear has been documented in previous studies of CRSV in conflict areas, as well as actual examples of marital problems caused by CRSV experiences. When characterising sexual violence in DRC for example, the Harvard Humanitarian Initiative (2009) found that female victims of CRSV were abandoned by their spouses on learning about the attack, and the men that took part in this study felt that it is only natural to be repulsed by a spouse that has been sexually violated. At the individual level, respondents feared that disclosure of their CRSV experiences would damage the gender assigned role of protection in the eyes of their spouses, as prior literature also documents (Harvard Humanitarian Initiative, 2009).

Fear of such negative reactions to disclosure of sexual violence to an intimate partner is an effect of the cultural interpretation at the broader macrosystem level. In his study on challenges for mental health providers working with African female survivors of CRSV,

Akinsulure-Smith (2014) mentions that in many African cultures, sexual violence brings shame on the victim, and this could render them ineligible for marriage.

6.2.1.7 Self-sufficiency

Self-sufficiency as a barrier to help-seeking as shared by respondents in this study is at the individual level. In analysing the relationship between masculinity and psychological help-seeking, Mahalik, Good, and Englar-Carlson (2003) found that men were found to be overly independent and not keen on seeking help, from peers or professionals, when ill. Respondents in this study gave reasons why they initially preferred to treat themselves and they mentioned issues such as having some medical knowledge, poor responses from health personnel in previous attempts to seek help, and shame. Shame was repeatedly mentioned as a barrier by respondents in this study and it cuts across different levels of the EST. As a psychological reaction to sexual violence, shame creates fear and despair among survivors (Harris & Freccero, 2011; Médecins sans Frontières, 2009) and this ultimately influences their help-seeking decisions. A study in Colombia among female survivors of sexual violence found that 81% of respondents at mobile clinics and 95% of respondents at clinics and hospitals reported shame as the main barrier to help-seeking (Médecins sans Frontières, 2009).

In conclusion, this study found that the key barriers to physical and mental health help-seeking among among male refugee survivors of CRSV are found at every level of the EST, and their effects cut across different levels. Interestingly, the consequences of barriers such as the physical effects of CRSV facilitated some of the factors to help-seeking mentioned in this study, as discussed in the next section.

6.2.2 Facilitators to Physical and Mental Health Help-seeking

The facilitators to physical and mental health help-seeking among male refugee survivors of CRSV mentioned by respondents in this study were (i) symptom severity, (ii) social support (iii) information, education and communication, (iv) availability of free tailored services, and (v) professionalism among service providers. (See Figure 6.2, below, for the factors identified at various levels of EST).

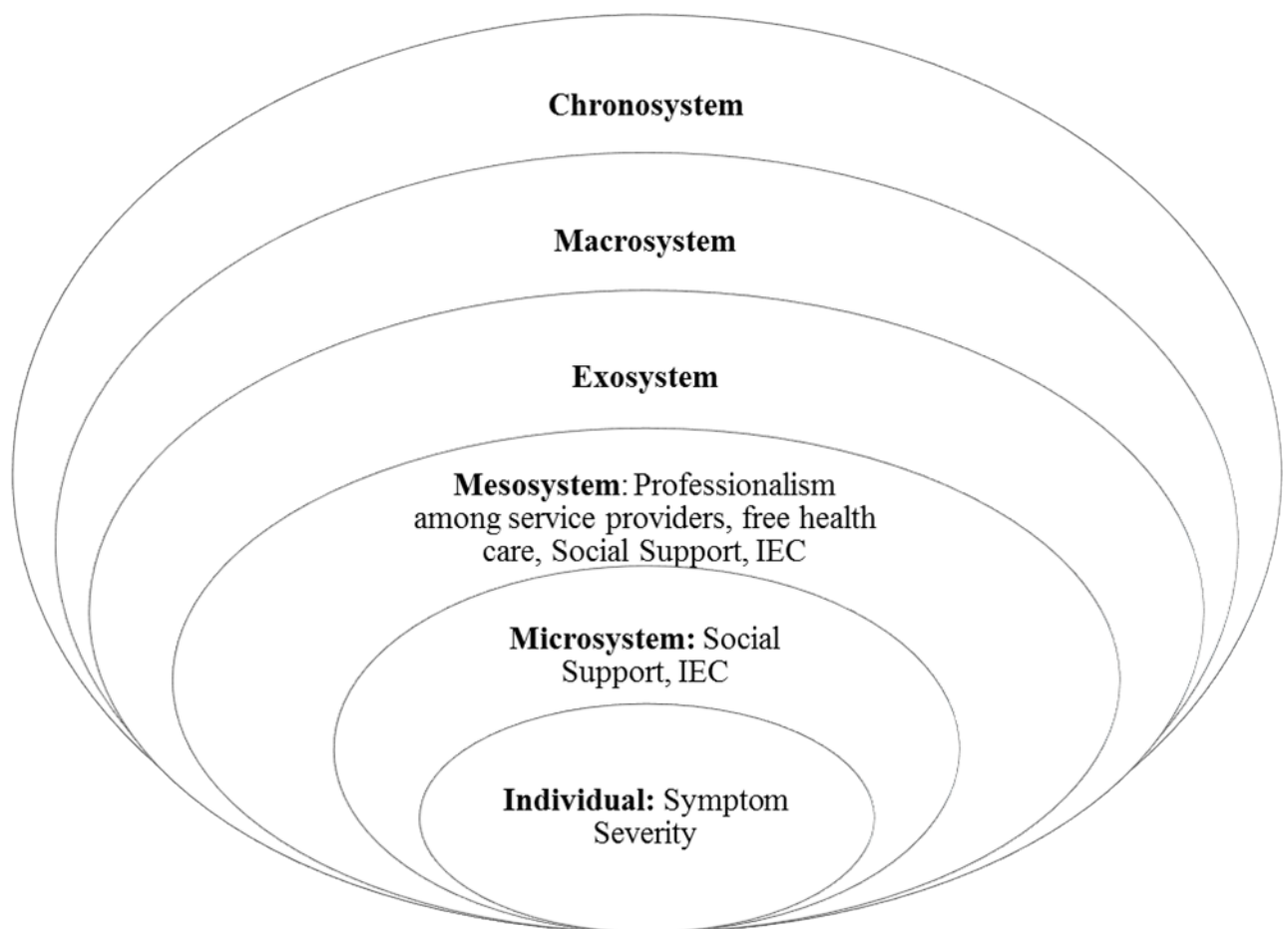


Figure 6.2: EST Model Depicting Facilitators to Physical and Mental Health Help-seeking among Male Refugee Survivors of CRSV in Kampala

6.2.2.1 Symptom Severity

This study found that symptom severity and most often unbearable pain led them to seek help in a bid to find relief from the effects of CRSV. This factor plays out at the individual level and it may occur immediately after the abuse or may develop overtime. The time that male survivors of CRSV take to seek help varies from one individual to another and is also dependent on several other factors besides the pain. Such factors include language, knowledge of where to find the services, accessibility of the services, among others, as discussed above. Existing literature shows that on average, it takes several months or even years for male survivors of sexual violence to seek help (Mezey & King, 2000).

6.2.2.2 Social Support

Respondents mentioned the availability of social support as one of the facilitators to help-seeking. Social support was mainly received at the microsystem and mesosystem level.

At the microsystem level, social support systems such as family, friends and a peer support group were specifically mentioned as facilitators. Upon disclosure, some respondents shared that their family and friends were empathetic to their plight and offered emotional and livelihood support. The peer support group for male survivors of CRSV further helped respondents with care during hospitalisation, livelihood support and also provided peer counselling services. Prior literature records that, when sexually assaulted victims receive a positive response to their disclosure in the social networks, they heal better and the severity of PTSD is also mitigated (Ullman, Foynes, & Tang, 2010; Ullman & Peter-Hagene, 2014). Researchers advise that it important to take note of the impact of such violence on families and social networks, and also to explore the potential of these networks as key facilitators in healing trauma (Brown & Testa, 2008; Walsh, 2007). At the mesosystem level, respondents shared that they received livelihood support in the form of food stuff or money to buy dietary supplements from some refugee service organisations. With the availability of food, respondents noted that they were able to adhere to prescribed medication and get better.

6.2.2.3 Information, Education and Communication

Mentioned by respondents in this study as a key facilitator, information, education and communication are seen at the microsystem level. Respondents revealed that peer support groups of CRSV survivors held community sensitisation events to educate people about CRSV. During these events, the survivors taught the community prevention and response strategies for CRSV, and also let people know where they could seek help to counter the effects of CRSV. In effect, this information helped change people's mindsets about male rape and facilitated help-seeking. The importance of information, education and communication (IEC) is also documented in prior literature (Apperley, 2015; Solangon & Patel, 2012), and in Uganda, another study confirms that both male and female refugee support groups of CRSV survivors have taken on this role through various community outreaches (Edström et al., 2016).

Furthermore, they educate service providers on the realities of CRSV against men by telling their stories. They are also engaged in both local and global advocacy through sharing their experiences, attending conferences, and conducting interviews plus participating in research (Edström et al., 2016). Previous studies have documented the effectiveness of community sensitisations on CRSV in post-conflict areas like northern Uganda (Durick, 2013) and in the DRC (Harvard Humanitarian Initiative, 2009). Community sensitisation efforts helped reduce stigma against survivors of CRSV and also created awareness about the

availability of services to survivors and their families (Durick, 2013). The impact of IEC undertaken at the microsystem level displayed positive results at the mesosystemic level in this study. Respondents shared that service providers, especially those at the government health facilities reached with this kind of information by CRSV survivors, changed the way they responded to male survivors of CRSV and were more empathetic towards them.

6.2.2.4 Availability of Free Tailored Services

At the mesosystem level, this study clearly highlighted that referral by some refugee service organisations, such as the RLP and the Hebrew Immigrant Aid Society, to free medical and psychological help facilitated help-seeking. These referrals improved accessibility as the respondents noted that they were not in a financial position to procure medical and mental health services crucial to their recovery from the sexual trauma. The need for free health services for this population at community level has been mentioned in other studies conducted in Kampala and Nairobi (Hebrew Immigrant Aid Society, 2014; Jones et al., 2014).

6.2.2.5 Professionalism among Service Providers

At the mesosystem level, respondents mentioned that the warm and empathetic attitude of some service providers towards male survivors of CRSV facilitated help-seeking. This kind of attitude was mostly seen in the private health care facilities that received referrals from a few refugee service organisations which provide tailored services for male survivors of CRSV. Due to the efforts of support groups in sensitising service providers about their plight, respondents also noted a few healthcare personnel in government institutions changing their attitudes towards male survivors. However, at the time of this writing, there were still many health care workers that needed to be reached with information regarding the complexity of CRSV. This study shows that it is not just a matter of professionals having the skills to handle such cases, although this is also very important, but that it is the warm and empathetic attitude that Ullman (2007) recommends that matters.

The next section discusses the experiences of service providers working with male refugee survivors of CRSV.

6.3 Experiences of Service Providers Working with Male Refugee Survivors of CRSV

The experiences of service providers with male refugee survivors of CRSV in this study provide a different perspective on CRSV survivors' encounters at the mesosystem level. According to the responses given to this question, the key issues highlighted include (i) ignorance on how to respond to the physical and mental health effects of CRSV against men, (ii) different approaches in treating male and female rape survivors, (iii) the stress experienced by working with large numbers of survivors, and (iv) the self-care strategies they employed. These responses partly shed light on the barriers to help-seeking discussed earlier in this chapter, by highlighting the factors which influence service provider responses to male survivors.

Some service providers mentioned that, initially, they were unsure of how to handle issues presented by male survivors. As time went on they gained knowledge and experience and this instilled confidence in them, while improving the quality of services offered to the survivors. In this study, the effect of the service providers' knowledge and skill is seen at the individual and microsystemic levels, where positive reviews by survivors that have sought help instill confidence in the others and facilitate help-seeking. Service providers also shared that there is no medical or psychological basis to measure the difference in the degree of physical and psychological harm between male and female survivors of CRSV; CRSV experiences are traumatic for any victim. However, the participants noted that there are different forms of rape and that the male and female genital anatomies differ, concluding that survivors should be handled on an individual basis. Additionally, some service providers felt that it is easier for women to disclose sexual violations, that they are taken more seriously than male victims and that services are more readily available to them as compared to men, as also noted in previous studies (Kohli et al., 2012; Médecins sans Frontières, 2009).

Service providers shared that they felt overwhelmed by the caseload because there are only a few of them with the necessary knowledge and skills to respond to the needs of male survivors of CRSV. This and other reasons such as the details of the gruesome nature of the abuse narrated to them by the survivors led to stress (Figley, 1995; Gil & Weinberg, 2015). Service providers noted that some of the strategies they use to overcome stress include limiting their emotional involvement, supervision and other self-care strategies. Prior studies also recommend these self-care strategies (Finklestein et al., 2015; Ga-Young, 2011).

6.4 Strategies to Overcome Barriers to Physical and Mental Health Help-Seeking among Male Refugee Survivors of CRSV

During this study, respondents shared that refugees face multiple challenges as they go through the different phases of migration and encounter several changes in their lives and environment, which leaves them vulnerable. When they are attacked and sexually violated, they are left with physical and psychological scars to deal with, and there is also a likelihood of being abused again during flight and in the countries of asylum. They are highly stigmatised, and as male refugee survivors of CRSV in a foreign country, they encounter multiple barriers to help-seeking (Edström et al., 2016; Hebrew Immigrant Aid Society, 2014). Their lives seem to be a cycle of vulnerability, and as they emphasised, they are economically disadvantaged, an issue that may even be passed on to other generations. Participants suggested strategies to address this vulnerability, through the various recommendations discussed at the different levels below. The study's main findings in response to this question can be categorised as follows: (i) information and communication, (ii) education and training, (iii) gender inclusive policies and models, (vi) research on CRSV against men, and (v) economic/livelihood support. (See Figure 6.4. below for the factors identified at various levels of EST).

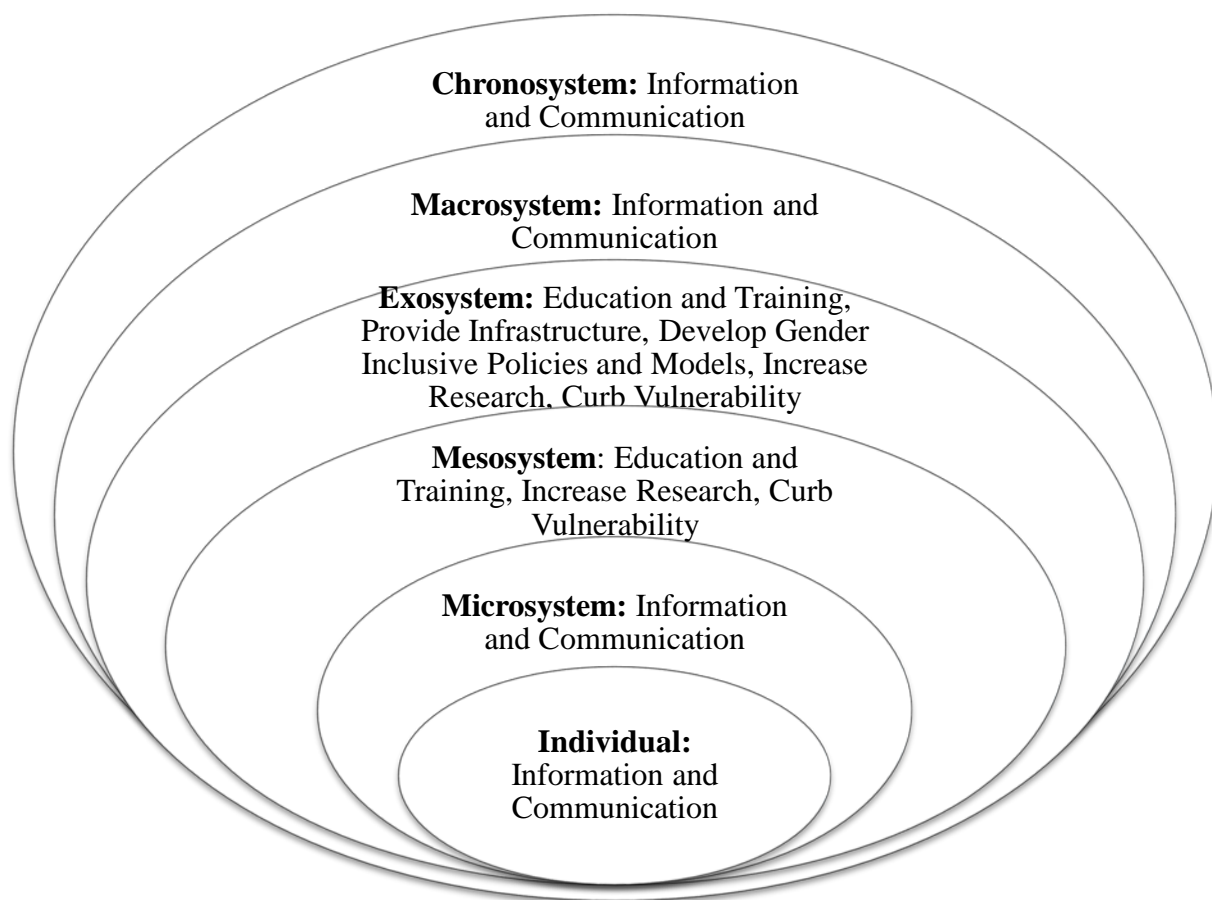


Figure 6.4: EST Model Depicting Strategies to Overcome Physical and Mental Health Help-seeking among Male Refugee Survivors of CRSV in Kampala

6.4.1 Information and Communication

In this study, participants recommended that information and communication about CRSV against men should be prioritised at all levels of the system. Respondents shared that some of the most effective ways of doing this include community sensitisation and awareness events which allow survivors to talk about their experiences publicly. This information helps other male and female CRSV survivors to know where and how to seek help. It also equips service providers with knowledge on how to interact with and help male survivors of CRSV. Clark (2014) underscores the advantages of such sensitisation activities and gives an example of a model that is used by a women's media group in South Kivu which can be replicated to achieve the same results for men. In this model, the Women's Media Association of South Kivu (AFEM), based in Bukavu, organises radio talk shows to sensitise the community about

gender-based violence, specifically against females. In Uganda, the MoH Refugee Support Group is taking the lead on similar activities. With support from RLP, the group has published reports and shared testimonies in print and visual media at both domestic and international levels, and has also written and produced a film and documentaries about CRSV against men through its Media for Social Change programme. An example is the film ‘Men Can Be Raped Too’, which was written, acted and filmed by support group members (Kithima, 2016).

Another strategy mentioned by respondents to create awareness about CRSV against men is to work with male refugee survivors of CRSV, especially through their support groups in order to facilitate their recovery, dispel myths about male rape and encourage others to come and seek help. This is also emphasised in prior literature (Davies, 2002; Solangon & Patel, 2012) and it is noted that peer support groups are safe places to discuss the issue and foster healing. In Uganda, male refugee survivors of CRSV and their spouses strongly advocate for working with peer support groups, sharing that they facilitate individual and group healing, by counteracting the isolation and discrimination that they are usually exposed to (Edström et al., 2016). Respondents also emphasised the need to work with spouses and families of male survivors by counselling them and providing information concerning CRSV against men. Prior literature notes that when professionals reach out to families and spouses, and include them in the rehabilitation process, they foster understanding of the situation and how to come to terms with it (Brown & Testa, 2008; Davies, 2002; Kohli et al., 2014).

6.4.2 Education and Training

In relation to the preceding strategy of providing information and communication, respondents in this study urged that education and training on CRSV against men for service providers is a key strategy in overcoming barriers and facilitating help-seeking among male survivors. This recommendation is directed at the mesosystem and exosystem levels. It was mentioned that service providers should be trained on how to handle issues specific to male survivors of CRSV. Respondents also highlighted the need to modify the education curriculum to equip the incoming workforce with relevant skills as prior literature also suggests (Christian et al., 2011a; Davies, 2002; Harris & Freccero, 2011; Turchik & Edwards, 2012; Ullman, 2007). Médecins sans Frontières (2009) adds that, not only does education dispel myths about rape, but it also reduces guilt among survivors. RLP staff in Uganda have provided education about CRSV to professionals in the medical and legal field – both government and private. In addition, they train other government employees such as the

Uganda Police Force, the Uganda Prisons service, and the Uganda People's Defence Forces, especially those going for missions on how to provide gender neutral responses to CRSV (Refugee Law Project, 2015a).

6.4.3 Gender Inclusive Services, Policies and Models

Respondents called for further exosystemic changes by urging the government to provide appropriate infrastructure and enact gender inclusive health policies and models. Countries like Kenya have changed their health policy to make it gender inclusive so that all survivors of sexual violence, whether male or female, can access medical and psychological services (Ministry of Medical Services and Ministry of Public Health & Sanitation, 2009). Furthermore, governments and organisations can utilise international policies or models on tackling CRSV against men (Touquet & Gorris, 2016) and tailor them to fit the local contexts. An example of such policy is the UNHCR "Need to know" series, which includes the Guidance Note 4 on working with men and boy survivors of sexual and gender-based violence in forced displacement (United Nations High Commissioner for Refugees & Refugee Law Project, 2012).

This note addresses survivors, their partners, staff and communities, and stresses the need to include men and boys in SGBV programming, and it provides guidelines on how to reach out to survivors, protect them, and also help them to access the necessary services, including medical services (United Nations High Commissioner for Refugees & Refugee Law Project, 2012). Refugee service organisations, which are at the mesosystem level, should also take heed and design organisational policies and programs that provide equal services to both genders.

6.4.4 Research on CRSV Against Men

The importance of research on the issue of CRSV against men was underscored in this study. This should mainly be done at the exosystem and mesosystem levels by the government and relevant domestic and international humanitarian organisations. Having noted that there is a dearth of research and literature in this field (Davies, 2002; Dolan, 2010), respondents in this study added their voice, stating that efforts in this direction would create awareness and knowledge on this phenomenon. Respondents shared that it is also necessary to widely disseminate the research findings so that information can be accessed to inform interventions.

6.4.5 Economic/Livelihood Support

Participants emphasised the need to create economic opportunities for male refugee survivors of CRSV, as also suggested in prior studies (Solangon & Patel, 2012; Ullman, 2007). Efforts geared towards this should be concentrated at the mesosystem and exosystem levels. Failure to respond to this issue would hamper efforts to address the multiple problems faced by this group, as these men need to provide for their families and lack resources to access health care (Hebrew Immigrant Aid Society, 2014). Such socioeconomic difficulties also serve as risk factors for further problems, such as repeat victimisation or violence within families, further perpetuating the cycle of vulnerability (Edström et al., 2016; Hebrew Immigrant Aid Society, 2014). Survivors elsewhere have made such a recommendation: for example, in a study of male survivors of CRSV in DRC, participants expressed a great need for economic assistance and requested start-up capital for small businesses in order to be able to fend for their families again (Christian et al., 2011a). Policy makers should therefore take this into consideration when designing intervention programmes for male refugee survivors of CRSV.

Notably, recommendations made by participants in this study are similar to those suggested in studies that focused mostly on female survivors of CRSV (Harvard Humanitarian Initiative, 2009; Kinyanda et al., 2010; Mukwege & Nangini, 2009; Ullman, 2007) and they have implications for policy, practice and research.

6.5 Implications for Policy, Practice and Research

This study has provided support for the conceptual premise that male survivors of CRSV are faced with many barriers to physical and mental health help-seeking, in peace or conflict situations. Clearly, more attention is needed from policy makers, practitioners and researchers in addressing these obstacles at all levels of EST.

6.5.1 Policy

In order to formulate and implement effective strategies, the government needs to effect change in several legal and health policies at the exosystem level. These policies need to formally recognise that sexual violence against men does occur, that it is different from homosexuality and that services should be provided for these individuals (Dolan, 2014). In Kenya, for example, the government, through the Ministry of Public Health and Sanitation and Ministry of Medical Services, introduced a gender inclusive guide to medical care of survivors of sexual violence. These practice guidelines include sections on genito-anal

examination for boys and the medical management of adult male survivors of sexual violence, alongside sections on female survivors (Ministry of Medical Services and Ministry of Public Health & Sanitation, 2009). The government should also aim at improving infrastructure through expansion of medical facilities to ensure privacy, and also provide adequate medication and tools needed for the work of practitioners at the mesosystem level.

6.5.2 Practice

Practitioners in various sectors can be involved in addressing the problems identified in this study. At the mesosystem level, practitioners and community organisations may address misconceptions of masculinity through information, communication and education programs. Key recommendations in this study also include the need for practitioners, policy makers and educators to engage survivors, their families, and also survivor support groups. This study has found that a support group for male survivors of CRSV is a key facilitator in help-seeking, advocacy, and raising awareness about the CRSV. Prior studies (Davies, 2002) recommend support groups tailored to suit the needs of male survivors of CRSV. Further work is required to establish their dynamics and viability in both rural and urban settings, and especially in refugee camps or settlements in countries with a gender biased definition of sexual violence.

Educators should adjust school curriculums of all helping professions to include sections on working with both male and female survivors of CRSV. Professionals should know that empathy is paramount in working with such vulnerable populations. This will help with the reduction of stigma and discrimination against male survivors of CRSV and facilitate help-seeking. Already, some organisations in Uganda are training practitioners on CRSV, with the help of survivors in order to dispel the cultural myths about male rape (Refugee Law Project, 2015a), although further research is needed to explore the impact of these trainings on practitioners. On the issue of secondary trauma among healthcare personnel, organisations and staff should employ strategies recommended by previous studies to overcome secondary trauma (Manning-Jones et al., 2016; Whitfield & Kanter, 2014).

6.5.3 Research

Further research is needed on a number of different aspects related to CRSV and treating male survivors of CRSV. First, as mentioned in section 2.2, data is scarce regarding the prevalence of CRSV against males, and studies amongst refugee populations often do not address the issue. This study focused on refugees living in an urban setting and not in

designated refugee settlements; research is required in refugee populations in settlements, as well as among refugees who are more integrated into communities in their 'adopted' country. Given the significant impact on CRSV survivors' physical and mental health, and their families, it is important that these cases are detected and provided with holistic treatment.

Second, the mental health effect of CRSV on male survivors has not been adequately investigated and yet it is important to detect as it is debilitating. There is need to know what disorders to target and therefore implement pharmacological/psychosocial interventions which address the needs of the survivors.

Third, there is need to know what interventions are most effective in this group, which professionals should deliver them, and the best approach to use in delivering services. At RLP, for example, the use of a support group for male survivors of CRSV has been very effective, however, we do not know if this could work for survivors elsewhere. Research in this area could also show if using a group approach in delivering interventions is better and most cost-effective as compared to individual intervention. Many different approaches have been tested around the world for treating various mental disorders. For example, approaches used to treat PTSD include exposure therapy (PE) and cognitive processing therapy (CPT), which have proved to be very effective in treating specific traumas (Karlin, 2012). Karlin (2012) also mentions cognitive-behavioral therapy for insomnia (CBTI) and imagery rehearsal therapy (IRT) used for people with PTSD that present with insomnia but regrets that many of these innovations are not used in practice. When working with refugee populations, Kira and Tummala-Narra (2015) recommend the use of a development-based trauma framework (DBTF). Tested among refugees from Iraq living in the United States, DBTF can be used to effectively assess and provide interventions within an ecological framework, to refugees that present with trauma due to political violence exposure.

Fourth, research is needed to identify professionals at risk of compassion fatigue and other psychological difficulties by using validated tools such as burnout and vicarious trauma scales, and to develop compassion fatigue prevention strategies for professionals working with victims of trauma. Samios, Abel, and Rodzik (2013), for example, have used the 10-item Secondary Traumatic Stress subscale of the 30-item Professional Quality of Life Scale and the 10-item Compassion Satisfaction subscale of the 30-item Professional Quality of Life Scale, both developed by Stamm (2003) to measure secondary traumatic stress and

compassion satisfaction respectively. However, at the present time, there is no record of these tools having been tested or used in Uganda.

6.6 Limitations

While interpreting these findings, there are certain issues to consider. They include the fact that the sample size was limited to refugees in an urban setting and only used qualitative interviews. Thus we cannot generalise the findings to all male survivors in Uganda or other post conflict settings. However, sexual violence is an issue of human rights and the number of respondents should not be considered as a priority. Secondly, some of the interviews were conducted in languages other than English such as French and Lingala, therefore there is a likelihood that some information may have been lost during the translation and transcription process, from those languages to English. Male survivors of CRSV for this study were recruited from RLP, where I worked, and this may have biased their responses. These limitations however are not enough to overlook the importance of this study.

6.7 Conclusion

In conclusion, refugees and asylum seekers encounter violence, including sexual violence in conflict situations, and are in urgent need of physical and mental health services. This study has identified the barriers and facilitators to accessing physical and mental health services for male refugee survivors of CRSV. This study is one of the first of its kind to be conducted in Uganda, and it provides important information concerning this vulnerable but under researched and underserved population. It has also explored the experiences and implications of working with male victims of sexual trauma among service providers, and has also detailed strategies on how to overcome barriers to help-seeking. The most important findings of this study are the barriers that male refugee survivors of CRSV face while seeking help, their magnitude and implications, and how they can be overcome. Despite its limitations, an analysis of the issues raised in this study using EST can serve to inform future interventions.

Reference list

- Africa Research Bulletin. (2011). Democratic Republic of Congo: FARDC accused of rape. *Africa Research Bulletin*, 48(1), 18701B–18701C.
- Akinsulure-Smith, A. M. (2014). Displaced African female survivors of conflict-related sexual violence: Challenges for mental health providers. *Violence against Women*, 20(6), 677-694.
- Apollis, M. T., Lund, C., De Vries, J. P., & Mathews, C. (2015). Adolescents' and adults' experiences of being surveyed about violence and abuse: A systematic review of harms, benefits and regrets. *American Journal of Public Health*, 105, 31–45.
- Apperley, H. (2015). Hidden victims: A call to action on sexual violence against men in conflict. *Medicine, Conflict and Survival*, 31(2), 92–99.
- Ba, I., & Bhopal, R. S. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: A systematic review (1981–2014). *Public Health*, 142, 121–135. doi:10.1016/j.puhe.2016.07.019
- Banyard, V. L. (2011). Who will help prevent sexual violence: Creating an ecological model of bystander intervention. *Psychology of Violence*, 1, 216–229. doi:10.1037/a0023739
- Bartels, S. A., Scott, J. A., Leaning, J., Kelly, J. T., Joyce, N. R., Mukwege, D., & Van Rooyen, M. J. (2012). Demographics and care-seeking behaviors of sexual violence survivors in South Kivu province, Democratic Republic of Congo. *Disaster Medicine and Public Health Preparedness*, 6(4), 393–401.
- Bartels, S. A., Scott, J. A., Mukwege, D., Lipton, R. I., Van Rooyen, M. J., & Leaning, J. (2010). Patterns of sexual violence in Eastern Democratic Republic of Congo: Reports from survivors presenting to Panzi Hospital in 2006. *Conflict and Health*, 4:9. doi: 10.1186/1752-1505-4-9.
- Bercier, M. L., & Maynard, B. R. (2014). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice*, 25(1), 81-89. doi: 10.1177/1049731513517142.
- Blok, W. (2012). *Core social work: International theory, values and practice*. London and Philadelphia: Jessica Kingsley.
- Boscarino, J. A., Adams, R. E., & Figley, C. R. (2010). Secondary trauma issues for psychiatrists. *The Psychiatric Times*, 27(11), 24-26.

- Bronfenbrenner, U. (1994). Ecological models of human development. *Readings on the Development of Children*, 2(1), 37–43.
- Brown, A., & Testa, M. (2008). Social influences on judgments of rape victims: The role of the negative and positive social reactions of others. *Sex Roles*, 58(7/8), 490–500. doi:10.1007/s11199-007-9353-7
- Browne, K. (2005). Snowball sampling: Using social networks to research non-heterosexual women. *International Journal of Social Research Methodology*, 8(1), 47–60.
- Brownmiller, S. (1975). *Against our will: Women and rape*. New York, NY: Simon Schuster.
- Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma Violence Abuse*, 10(3), 225–246.
- Carpenter, R. C. (2006). Recognizing gender-based violence against civilian men and boys in conflict situations. *Security Dialogue*, 37(1), 83–103. doi:10.1177/0967010606064139
- Choudhary, E., Coben, J., & Bossarte, R. M. (2010). Adverse health outcomes, perpetrator characteristics, and sexual violence victimization among U.S. adult males. *Journal of Interpersonal Violence*, 25(8), 1523–1541. doi:10.1177/0886260509346063
- Christian, M., Safari, O., Ramazani, P., Burnham, G., & Glass, N. (2011). Sexual and gender based violence against men in the Democratic Republic of Congo: Effects on survivors, their families and the community. *Medicine, Conflict and Survival*, 27(4), 227–246. doi:10.1080/13623699.2011.645144
- Clark, J. N. (2014). A crime of identity: Rape and its neglected victims. *Journal of Human Rights*, 13(2), 146–169.
- Clifford, C. (2008, May). *Rape as a weapon of war and its long-term effects on victims and society*. Paper presented at the 7th Global Conference Violence and the Contexts of Hostility, Budapest, Hungary.
- Cohen, D. K., & Nordas, R. (2014). Sexual violence in armed conflict: Introducing the SVAC dataset, 1989–2009. *Journal of Peace Research*, 51(3), 418–428. doi:10.1177/0022343314523028
- Colombini, M. (2002). Gender-based and sexual violence against women during armed conflict. *Journal of Health Management*, 4(2), 167–183. doi:10.1177/097206340200400206
- Crawford, K. F. (2013). From spoils to weapons: Framing wartime sexual violence. *Gender & Development*, 21(3), 505–517. doi:10.1080/13552074.2013.846622

- Davies, M. (2002). Male sexual assault victims: A selective review of the literature and implications for support services. *Aggression and Violent Behavior, 7*, 203–214. doi:10.1016/S1359-1789(00)00043-4
- Dolan, C. (2010). *War is not yet over: Community perceptions of sexual violence and its underpinnings in Eastern DRC*. London: International Alert.
- Dolan, C. (2014, May 14). *Into the mainstream: Addressing sexual violence against men and boys in conflict*. Paper presented at the Overseas Development Institute, London.
- Dossa, N. I., Zunzunegui, M. V., Hatem, M., & Fraser, W. D. (2014). Mental health disorders among women victims of conflict-related sexual violence in the Democratic Republic of Congo. *Journal of Interpersonal Violence 30(13)*, 2199-2220. doi: 10.1177/0886260514552447
- Dudley, J. R. (2010). *Research methods for social work: Being producers and consumers of research*: Boston: Allyn & Bacon.
- Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatisation: Current status and future directions. *British Journal of Guidance & Counselling, 34(1)*, 107–116. doi:10.1080/03069880500483166
- Durick, H. E. (2013). *Post-conflict development in Northern Uganda: The importance of holistically addressing sexual and gender-based violence*. University of Tennessee Honors Thesis Projects. http://trace.tennessee.edu/utk_chanhonoproj/1603
- Edström, J., Dolan, C., Shahrokh, T., & David, O. (2016). *Therapeutic activism: Men of Hope Refugee Association Uganda breaking the silence over male rape in conflict-related sexual violence*. IDS Evidence Report 182, Brighton: IDS.
- Ellsberg, M., & Heise, L. (2005). *Researching violence against women: A practical guide for researchers and activists*. Washington, DC: World Health Organization.
- Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31*, 25–36. doi:10.1016/j.cpr.2010.09.004
- Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In H. B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). Baltimore, MD: The Sidran Press.
- Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work 40* (2): e25-e31. DOI: <https://doi.org/10.1093/hsw/hlv026>

- Follette, V. M., Polusny, M. A., Bechtle, A. E., & Naugle, A. E. (1996). Cumulative trauma: The impact of child sexual abuse, adult sexual assault, and spouse abuse. *Journal of Traumatic Stress, 9*(1), 25–35.
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(117), 1471-2288. DOI: 10.1186/1471-2288-13-117
- Ga-Young, C. (2011). Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work, 35*(3), 225–242. doi:10.1080/03643107.2011.575333
- Gil, S., & Weinberg, M. (2015). Secondary trauma among social workers treating trauma clients: The role of coping strategies and internal resources. *International Social Work, 58*(4), 551-561.
- Giustini, D., & Thompson, D. (2012). *Finding the hard to finds: Searching for grey literature*. Vancouver: University of British Columbia.
- Godia, P. M., Olenja, J. M., Lavussa, J. A., Quinney, D., Hofman, J. J., & Van den Broek, N. (2013). Sexual reproductive health service provision to young people in Kenya: Health service providers' experiences. *BMC Health Services Research, 3*(1), 476. doi: 10.1186/1472-6963-13-476
- Guerette, S. M., & Caron, S. L. (2007). Assessing the impact of acquaintance rape: Interviews with women who are victims/survivors of sexual assault while in college. *Journal of College Student Psychotherapy, 22*(2), 31–50.
- Harris, L., & Freccero, J. (2011). *Sexual violence: Medical and psychosocial support*. Berkeley, CA: Human Rights Center, University of California.
- Harvard Humanitarian Initiative. (2009). *Characterizing sexual violence in the Democratic Republic of the Congo. Profiles of violence, community responses, and implications for the protection of women*. Final report for the Open Society Institute. Accessed at <http://hhi.harvard.edu/publications/characterizing-sexual-violence-democratic-republic-congo-profiles-violence-community> on 16th/April/2015.
- Hebrew Immigrant Aid Society. (2014). *Triple jeopardy: Protecting at-risk refugee survivors of sexual and gender-based violence*. Retrieved from <http://www.hias.org/triple-jeopardy-protecting-risk-refugee-survivors-complete-report>
- Heise, L., Ellsberg, M., & Gottmoeller, M. (2002). A global overview of gender-based violence. *International Journal of Gynecology and Obstetrics, 78*(1), S5–S14.

- Hustache, S., Moro, M. R., Roptin, J., Souza, R., Gansou, G. M., Mbemba, A., ... Baubet, T. (2009). Evaluation of psychological support for victims of sexual violence in a conflict setting: Results from Brazzaville, Congo. *International Journal of Mental Health Systems* 3, 1-10. doi:10.1186/1752-4458-3-7
- Ighobor, K. (2016). Diagnosing Africa's medical brain drain: Higher wages and modern facilities are magnets for Africa's health workers. *Africa Renewal Online*. Accessed at <http://www.un.org/africarenewal/magazine/december-2016-march-2017/diagnosing-africa%E2%80%99s-medical-brain-drain> on 17th/July/2016.
- International Rescue Commission. (2007). *Mortality in the Democratic Republic of Congo: An ongoing crisis*. Retrieved from http://www.theirc.org/resources/2007/2006-7_congomortalitysurvey.pdf
- Jacobsen, K., & Landau, L. B. (2003). The dual imperative in refugee research: Some methodological and ethical considerations in social science research on forced migration. *Disasters*, 27(3), 185–206.
- Jewkes, R., Sen, P., & Garcia-Moreno, C. (2012). Sexual violence. In L. L. D. Etienne, E. G. Krug, J. A. Mercy, A. B. Zwi, R. Lozano (Eds.), *Executive summary: A research agenda for sexual violence in humanitarian, conflict and post-conflict settings* (149-181). Switzerland: World Health Organization.
- Johnson, K., Asher, J., Rosborough, S., Raja, A., Panjabi, R., Beadling, C., & Lawry, L. (2008). Association of combatant status and sexual violence with health and mental health outcomes in postconflict Liberia. *Jama*, 300(6), 676–690.
- Johnson, K., Scott, J., Rughita, B., Kisielewski, M., Asher, J., Ong, R., & Lawry, L. (2010). Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *Jama*, 304(5), 553–562.
- Jones, N., Cooper, J., Presler-Marshall, E., & Walker, D. (2014). *The fallout of rape as a weapon of war*. Overseas Development Institute. Retrieved from <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8990.pdf>
- Kansiime, P., & Tusasiirwe, S. (2017). Social work practice with war-related humanitarian refugees through the Refugee Law Project in Uganda. In M. Gray (Ed.) *The handbook of social work and social development in Africa* (pp. 341–351). London: Routledge.
- Karlin, B. E. (2012). Bridging the gap in delivery of psychological treatments for posttraumatic stress disorder. *Journal of Rehabilitation Research & Development*, 49(5), xiii–xvi.

- Kigozi, F., Ssebunnya, J., Kizza, D., Cooper, S., & Ndyabangi, S. (2010). An overview of Uganda's mental health care system: Results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal Of Mental Health Systems*, 4, doi:10.1186/1752-4458-4-1
- Kinyanda, E., Musisi, S., Biryabarema, C., Ezati, I., Oboke, H., Ojiambo-Ochieng, R., Walugembe, J. (2010). War related sexual violence and its medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study. *BMC International Health and Human Rights*, 28. doi:10.1186/1472-698X-10-28
- Kira, I. A., & Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss & Trauma*, 20(5), 449–467. doi:10.1080/15325024.2014.949145
- Kithima, B. P. (2016). *Men can be raped too*. Kampala: Refugee Law Project.
- Kohli, A., Makambo, M. T., Ramazani, P., Zahiga, I., Mbika, B., Safari, O., ... Glass, N. (2012). A Congolese community-based health program for survivors of sexual violence. *Conflict & Health*, 6(1), 6-14. doi:10.1186/1752-1505-6-6
- Kohli, A., Perrin, N. A., Mpanano, R. M., Mullany, L. C., Murhula, C. M., Binkurhorhwa, A. K., ... Glass, N. (2014). Risk for family rejection and associated mental health outcomes among conflict-affected adult women living in rural Eastern Democratic Republic of the Congo. *Health Care for Women International*, 35(7–9), 789–807. doi:10.1080/07399332.2014.903953
- Koss, M. P., Heise, L., & Russo, N. F. (1994). The global health burden of rape. *Psychology of Women Quarterly*, 18(4), 509–537.
- Lebrón, T. M. (2011). “Deaths to gays!” Uganda's ‘one step forward, one step back’ approach to human rights. *Buffalo Human Rights Law Review*, 17, 173–206.
- Linos, N. (2009). Rethinking gender-based violence during war: Is violence against civilian men a problem worth addressing? *Social Science & Medicine*, 68(8), 1548-1551.
- Loncar, M., Henigsberg, N., & Hrabac, P. (2010). Mental health consequences in men exposed to sexual abuse during the war in Croatia and Bosnia. *Journal of Interpersonal Violence*, 25(2), 191–203.
- Longombe, A. O., Claude, K. M., & Ruminjo, J. (2008). Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: Case studies. *Reproductive Health Matters*, 16(31), 132–141. doi:10.1016/s0968-8080(08)31350-0
- Lwambo, D. (2013). ‘Before the war, I was a man’: Men and masculinities in the Eastern Democratic Republic of Congo. *Gender and Development*, 21(1), 47–66.

- Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help-seeking: Implications for practice and training. *Professional Psychology: Research and Practice, 34*(2), 123–131. doi:10.1037/0735-7028.34.2.123
- Manning-Jones, S., De Terte, I., & Stephens, C. (2016). Secondary traumatic stress, vicarious posttraumatic growth, and coping among health professionals: A comparison study. *New Zealand Journal of Psychology, 45*(1), 20–29.
- Médecins sans Frontières. (2009). *Shattered lives: Immediate medical care vital for sexual violence victims* (2nd ed.). Brussels: Médecins Sans Frontières.
- Meger, S. (2010). Rape of the Congo: Understanding sexual violence in the conflict in the Democratic Republic of Congo. *Journal of Contemporary African Studies, 28*(2), 119–135.
- Mezey, G. C., & King, M. B. (2000). *Male victims of sexual assault*. Place: Oxford University Press.
- Milillo, D. (2006). Rape as a tactic of war social and psychological perspectives. *Affilia, 21*(2), 196–205.
- Ministry of Medical Services & Ministry of Public Health & Sanitation. (2009). *National guidelines on management of sexual violence in Kenya*. Nairobi: Authors.
- Mukwege, D. M., & Nangini, C. (2009). Rape with extreme violence: The new pathology in South Kivu, Democratic Republic of Congo. *Plos Medicine, 6*(12), 1–5. doi:10.1371/journal.pmed.1000204
- Nagai, M., Karunakara, U., Rowley, E., & Burnham, G. (2008). Violence against refugees, non-refugees and host populations in southern Sudan and northern Uganda. *Global Public Health, 3*(3), 249–270. doi:10.1080/17441690701768904
- Neal, J. W., & Neal, Z. P. (2013). Nested or networked? Future directions for ecological systems theory. *Social Development, 22*(4), 722–737. doi:10.1111/sode.12018
- Nelson, B. D., Collins, L., Van Rooyen, M. J., Joyce, N., Mukwege, D., & Bartels, S. (2011). Impact of sexual violence on children in the Eastern Democratic Republic of Congo. *Medicine, Conflict and Survival, 27*(4), 211–225. doi:10.1080/13623699.2011.645148
- O’Halloran, T. M., & Linton, J. M. (2000). Stress on the job: Self-care resources for counselors. *Journal of Mental Health Counseling, 22*(4), 354–364.
- Ohambe, M. C., Galloy, M. R., & Sow, N. (2004). Women’s bodies as a battleground: Sexual violence against women and girls during the war in the Democratic Republic of Congo: South Kivu (1996–2003). In: M. Galloy, N. Snow and C. Hall, eds. *Re’sseau des Femmes pour un De’veloppement Associatif (RFDA), Re’sseau des Femmes pour la*

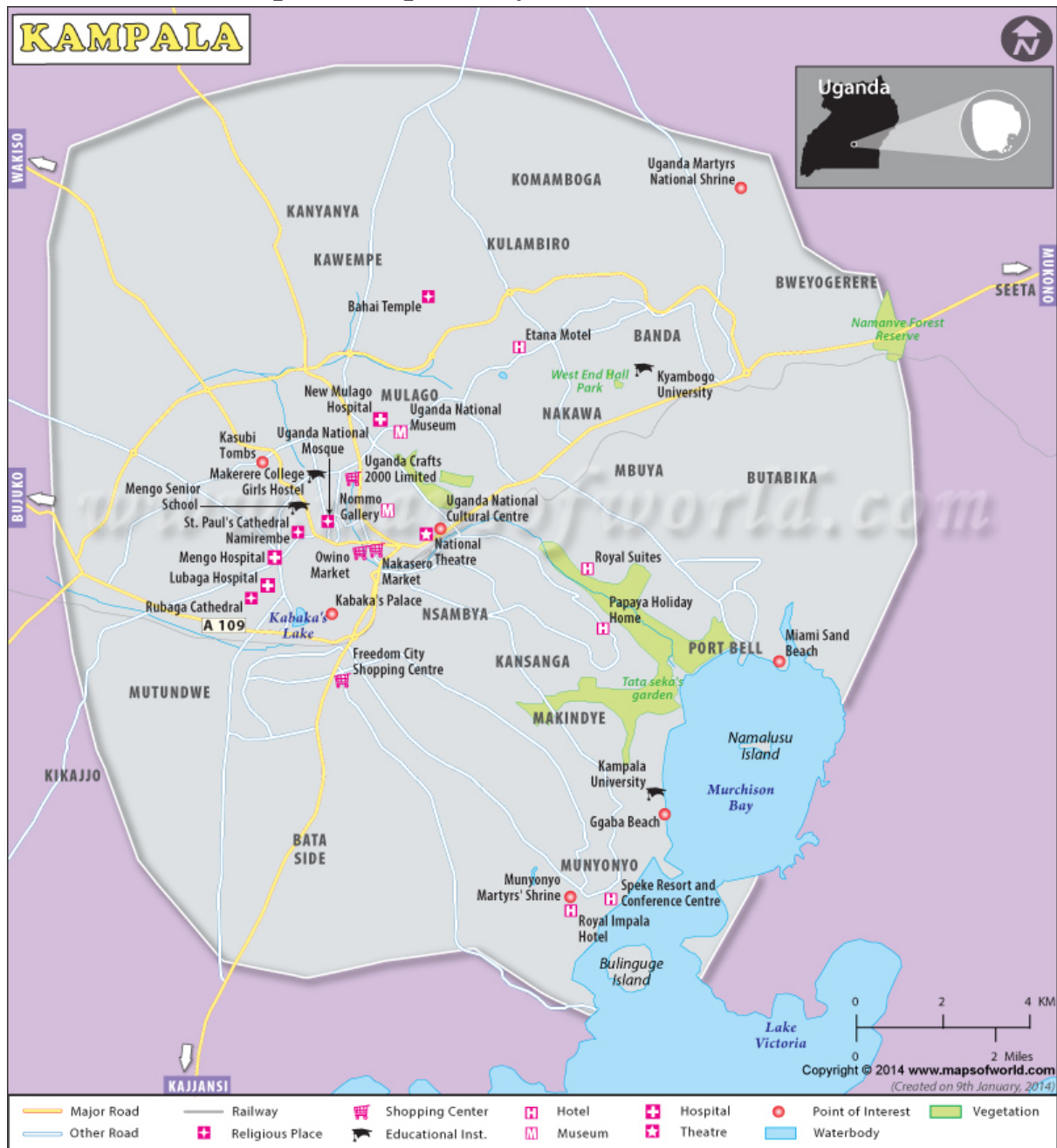
- De'fense des Droits et la Paix (RFDP) and International Alert. Available from: <http://reliefweb.int/sites/reliefweb.int/files/resources/5580BDB3C610B971C125701C0031D6A4-ia-cod-02jun.pdf> [Accessed 24th October 2015].
- Onsrud, M., Sjøveian, S., Luhiriri, R., & Mukwege, D. (2008). Social issues in reproductive health: Sexual violence-related fistulas in the Democratic Republic of Congo. *International Journal of Gynecology and Obstetrics*, *103*, 265–269. doi:10.1016/j.ijgo.2008.07.018
- Oosterhoff, P., Zwanikken, P., & Ketting, E. (2004). Sexual torture of men in Croatia and other conflict situations: An open secret. *Reproductive Health Matters*, *12*(23), 68–77.
- Peterman, A., Palermo, T., & Bredenkamp, C. (2011). Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. *American Journal of Public Health*, *101*(6), 1060–1067.
- Pittenger, S. L., Huit, T. Z., & Hansen, D. J. (2016). Applying ecological systems theory to sexual revictimization of youth: A review with implications for research and practice. *Aggression and Violent Behavior*, *26*, 35–45. doi:10.1016/j.avb.2015.11.005
- Refugee Law Project. (2015a). *Mentoring police officers to end SGBV tolerance and complicity*. Retrieved from http://www.refugeelawproject.org/files/others/Mentoring_police_officers_to_end_sgbv_tolerance_and_complicity.pdf
- Refugee Law Project. (2015b). *Our profile*. Retrieved from <http://www.refugeelawproject.org/who-we-are/our-profile.html>
- Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. Los Angeles, California: SAGE Publications.
- Saldaña, J. (2013). *The coding manual for qualitative researchers* (2 ed.). London: SAGE.
- Samios, C., Abel, L. M., & Rodzik, A. K. (2013). The protective role of compassion satisfaction for therapists who work with sexual violence survivors: An application of the broaden-and-build theory of positive emotions. *Anxiety, Stress & Coping*, *26*(6), 610–623.
- Shen-Miller, D. S., Isacco, A., Davies, J. A., Jean, M. S., & Phan, J. L. (2013). The men's center approach: Ecological interventions for college men's health. *Journal of Counseling & Development*, *91*(4), 499–507. doi:10.1002/j.1556-6676.2013.00123.x
- Silverman, D., & Marvasti, A. (2008). *Doing qualitative research: A comprehensive guide*. Los Angeles, California: SAGE Publications.

- Skjelsbaek, I. (2001). Sexual violence and war: Mapping out a complex relationship. *European Journal of International Relations*, 7(2), 211–237.
- Solangon, S., & Patel, P. (2012). Sexual violence against men in countries affected by armed conflict. *Conflict, Security & Development*, 12(4), 417–442. doi:10.1080/14678802.2012.724794
- Stamm, B. (2005). . The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales. Retrieved January 15, 2017, from <http://www.compassionfatigue.org/pages/ProQOLManualOct05.pdf>
- Storr, W. (2011, July, 17). The rape of men. *The Observer*. Accessed at <https://www.theguardian.com/society/2011/jul/17/the-rape-of-men> on 18th /August/2015.
- Strand, C. (2012). Homophobia as a barrier to comprehensive media coverage of the Ugandan Anti-Homosexual Bill. *Journal of Homosexuality*, 59(4), 564–579. doi:10.1080/00918369.2012.665679
- Tamale, S. (2013). Confronting the politics of nonconforming sexualities in Africa. *African Studies Review*, 56(2), 31–45.
- Tewksbury, R. (2007). Effects of sexual assaults on men: Physical, mental and sexual consequences. *International Journal of Men's Health*, 6(1), 22–35. doi:10.3149/jmh.0601.22
- Themner, L., & Wallensteen, P. (2014). Armed conflicts, 1946–2013. *Journal of Peace Research*, 51(4), 541–554. doi:10.1177/0022343314542076
- Thoreson, R. R. (2014). Troubling the waters of a ‘wave of homophobia’: Political economies of anti-queer animus in sub-Saharan Africa. *Sexualities*, 17(1/2), 23-42.
- Tol, W. A., Stavrou, V., Greene, M. C., Mergenthaler, C., Van Ommeren, M., & Garcia Moreno, C. (2013). Sexual and gender-based violence in areas of armed conflict: A systematic review of mental health and psychosocial support interventions. *Conflict & Health*, 7(1), 1-9. doi:10.1186/1752-1505-7-16
- Touquet, H., & Gorris, E. (2016). Out of the shadows? The inclusion of men and boys in conceptualisations of wartime sexual violence. *Reproductive Health Matters*, 2436-46. doi:10.1016/j.rhm.2016.04.007.
- Trenholm, J. E., Olsson, P., & Ahlberg, B. M. (2011). Battles on women’s bodies: War, rape and traumatisation in eastern Democratic Republic of Congo. *Global Public Health*, 6(2), 139-152. doi:10.1080/17441690903212065.

- Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. *Psychology of Men and Masculinity, 13*(2), 211–226.
- Uganda Bureau of Statistics. (2014). *National Population and Housing Census 2014: Provisional results*. Kampala: UNFPA.
- Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women & Therapy, 30*(1/2), 61–84. doi:10.1300/J015v30n01_04
- Ullman, S. E., Foynes, M. M., & Tang, S. S. S. (2010). Benefits and barriers to disclosing sexual trauma: A contextual approach. *Journal of Trauma & Dissociation, 11*(2), 127–133. doi:10.1080/15299730903502904
- Ullman, S. E., & Peter-Hagene, L. (2014). Social reactions to sexual assault disclosure, coping, perceived control, and PTSD symptoms in sexual assault victims. *Journal of Community Psychology, 42*(4), 495–508. doi:10.1002/jcop.21624
- United Nations. (2013). *Workshop on Sexual Violence against Men and Boys in Conflict Situations: Report and recommendations*. New York, NY: Office of the United Nations Special Representative of the Secretary-General on Sexual Violence in Conflict.
- United Nations High Commissioner for Refugees. (2015). *Uganda Fact Sheet 2015*. Accessed at <http://reliefweb.int/sites/reliefweb.int/files/resources/UgandaFactSheet--January2015.pdf> on 16th/February/2015.
- United Nations High Commissioner for Refugees. (2016a). *Global trends: Forced displacement in 2015*. Geneva: UNHCR.
- United Nations High Commissioner for Refugees. (2016b). *Uganda Fact Sheet February 2016*. Accessed at <http://reliefweb.int/report/uganda/unhcr-uganda-factsheet-february-2016> on 29th/June/2016.
- United Nations High Commissioner for Refugees, & Refugee Law Project. (2012). *Working with men and boy survivors of sexual and gender-based violence in forced displacement*. Need to Know Guidance 4. Geneva: United Nations High Commissioner for Refugees.
- Wakabi, W. (2008). Sexual violence increasing in Democratic Republic of Congo. *The Lancet, 371*(9606), 15–16.
- Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process, 46*(2), 207–227.
- Ward, J., & Vann, B. (2002). Gender-based violence in refugee settings. *The Lancet, 360*, s13–s14. doi:10.1016/s0140-6736(02)11802-2

- Watts, C., Hossain, M., & Zimmerman, C. (2013). War and sexual violence: Mental health care for survivors. *New England Journal Of Medicine* 368, no. 23: 2152-2154. *Science Citation Index*, EBSCOhost (accessed May 31, 2017).
- Weaver, H. N., & Burns, B. J. (2001). 'I shout with fear at night': Understanding the traumatic experiences of refugees and asylum seekers. *Journal of Social Work*, 1(2), 147–164.
- Whitfield, N., & Kanter, D. (2014). Helpers in distress: Preventing secondary trauma. *Reclaiming Children & Youth*, 22(4), 59–61.
- World Bank Group. (2016a). *An assessment of Uganda's progressive approach to refugee management*. Washington, DC: Author.
- World Bank Group. (2016b). *The Uganda Poverty Assessment Report: Farms, cities and good fortune: Assessing poverty reduction in Uganda from 2006 to 2013*. Washington, DC: Author.
- World Health Organization, United Nations Population Fund, & United Nations Children's Fund. (2011). *Mental health and psychosocial support for conflict-related sexual violence: Principles and interventions*. Accessed at http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf on 19th/April/2016.

APPENDIX A: Map of Kampala City



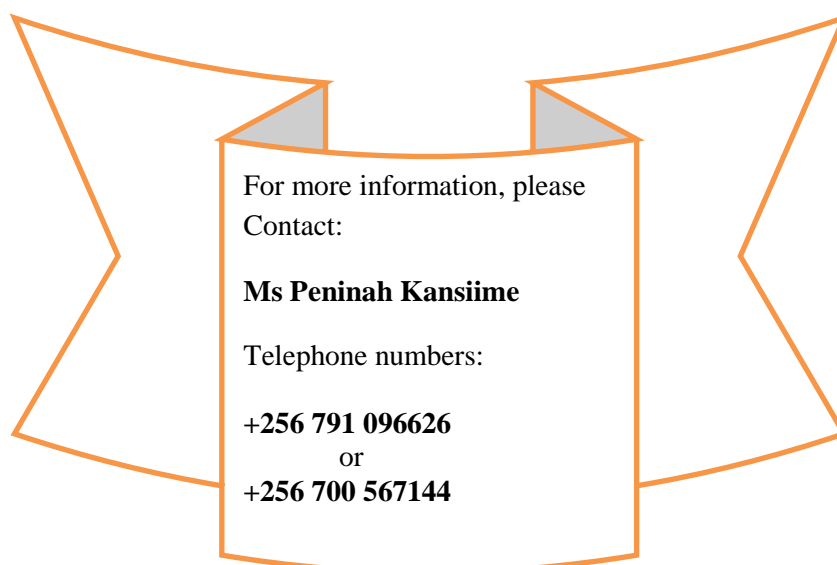
Source: <http://www.mapsofworld.com/uganda/kampala.html>

APPENDIX B: Information Sheet - English

Study on Physical and Mental Health Help-Seeking Barriers among Male Refugee Survivors of Sexual Violence

This is to invite you take part in a study on barriers and facilitators to physical and mental health help-seeking, among male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda. Research shows that men and boys, as well as women and girls are victims of conflict-related sexual violence. However, due to the shame and stigma that surrounds sexual violence, not many male victims of sexual violence seek any form of help. The purpose of this research therefore is to investigate the obstacles that prevent male victims of sexual violence from seeking physical and mental health services in the aftermath of the sexual violence. The research also aims at unearthing factors that encourage male victims of sexual violence to open up and seek health services.

This study is for male survivors of conflict-related sexual violence, plus medical and psychological service providers. It will take place at the premises of the Refugee Law Project. It is not however, part of the services offered by the Refugee Law Project and your decision to participate or not will not in any way affect the services you receive at the Refugee Law Project.



This research project is being conducted by Ms. Kansiime Peninah a student at Stellenbosch University, South Africa and staff of Refugee Law Project. Her contact details are above. Professor Ashraf Kagee at the Psychology Department, Faculty of Arts and Social Sciences in Stellenbosch University, and Dr. Claire van der Westhuizen at the Department of Psychiatry and Mental Health at the University of Cape Town, South Africa are supervising this research project.

APPENDIX C: Information Sheet - French

Feuille d'information

Etude sur les obstacles rencontrés dans la recherche de l'aide d'ordre physique et mental parmi les réfugiés de sexe masculin survivants de la violence liée aux conflits vivant à Kampala.

Nous vous invitons à participer dans une étude sur les obstacles et facilités dans la recherche de l'aide d'ordre physique ou mental, parmi les réfugiés de sexe masculin survivants de violence liée aux conflits, vivant à Kampala, Uganda. La recherche montre que les hommes et les garçons, aussi bien que les femmes et les filles, sont victimes de violences sexuelles liées aux conflits. Toutefois, étant donné la honte et la stigmatisation qui entourent la violence sexuelle, il n'y a pas beaucoup de personnes de sexe masculin qui vont chercher une forme quelconque d'assistance. Ainsi, l'objet de ce travail de recherche est de faire une enquête sur les obstacles qui entravent les personnes de sexe masculin victimes de la violence sexuelle à chercher de l'assistance d'ordre physique et mental après les événements malheureux de violence sexuelle. L'étude a aussi pour objet de rechercher et montrer les facteurs qui encouragent les personnes de sexe masculin victimes de violence sexuelle à s'ouvrir et chercher des services de santé.

Cette étude est destinée aux personnes de sexe masculin survivants de violence sexuelle liée aux conflits, aussi bien que les prestataires de services en matière médicale et psychologique. Toutefois, elle ne fait pas partie des services offerts par Refugee Law Project, et votre décision d'y participer ou pas ne va affecter en aucune façon les services que vous recevez à Refugee Law Project.



Ce projet de recherche est mené par Madame Kansiime Peninah, étudiante à l'Université de Stellenbosch en Afrique du Sud. Il est supervisé par Professeur Ashraf Kagee du Département de Psychologie, Faculté des Arts et Sciences Sociales à l'Université de Stellenbosch, et Docteur Claire van der Westhuizen du Département de Psychiatrie et de Santé Mentale à l'Université de Cape Town en Afrique du Sud.

APPENDIX D: Information Sheet – Lingala

Lokasa na Liyebisi

Koyekola (étude) na oyo etali kokoso mpo ya lisungi ya bokolongono ya nzoto mpe ya bongo na ba refugees ya mibali baye bazwamaka na makasi

Tozali kobengisa bino nakozala moko ya biso mpo na koyekola na oyo etali kokoso mpe basungi ya bokolongono ya nzoto mpe ya bongo na oyo etali ba Réfugiés oyo bafandi awa na Kampala/Uganda kasi babikaka sima ya kozwama na makasi.

Reherche elakisi ete Mibali mikolo mpe bilenge, ndenge moko na Basi mikolo mpe bilenge bazali kozwama na makasi na nzela ya kimwasi-mobali. Kasi mpo ya soni mpe kolakisa bango misapi, mingi na baye bazwamaka na makasi bakoki koluka lisungi te. Litomba ya Recherche eye ezali mpo ya koluka bakokoso nyoso oyo esali ete baye bazwamaka na makasi (victimes ya Viol) babanga koluka lisungi na oyo etali bokolongono ya nzoto (santé physique) mpe ya bongo (santé mentale) oyo eyeli bango na nzela ya kozwama na makasi. Recherche eye etali mpe Koyikisa mpiko (encourager) na baye bazwamaka na makasi mpo ete bayeba kozwa lisungi ya munganga.

Koyekola eye ezali mpo ya mibali eye babikaki sima ya kozwama na makasi na tangu ya bitumba mpe basungi na nzela ya kimunganga mpe basungi na nzela ya bokolongono ya bongo. Ekosalema na bureau ya Refugee Law Project. Kasi ezali te moko na lisungi oyo Refugee Law Project apesaka ; mpe ezali décision kowuta epai na yo soki olingi o'participer to te. Tolobi bongo ete ata oyei te, ekosala eloko te na oyo etali lisungi Refugee Law Project apesaka.



Recherche eye ekosalema na Maudemboke Peninah oyo azali moyekoli na Université ya Stellenbosch ya Afrique du Sud. Professeur Ashraf kagee na Département ya Pshycologie, Faculté des Arts et Sciences Sociales na Université ya Stellenbosch mpe Docteur Claire Van Der Westhuizen ya Département ya Psychiatrie mpe Santé mentale ya Université ya Cape Town na Afrique du Sud bango nde bakokamba Recherche eye.

APPENDIX E: Interview Guide - Survivors

Semi-Structured Interview Guide for Survivors

Study Topic: Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence living in Kampala.

Aim: To investigate barriers and facilitators to physical and mental health help-seeking, among male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda.

Objectives:

5. To explore survivors' experiences and perceptions regarding barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
6. To elicit survivors views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
7. To explore the experiences of practitioners working with male survivors of conflict-related sexual violence.
8. To elicit practitioners views on barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.

Interview Date:

Time:

Participants ID:

Socio-demographic Data

1. Age
2. Marital Status
3. Gender
4. Religion
5. Occupation
6. Number of Children

7. Number of people in the household
8. Highest form of Education
9. Place of origin in DRC
10. Years spent in Uganda

Thank you for accepting to take part in our study. Your participation will benefit a lot of people in identifying the medical and psychological challenges that male refugee survivors of sexual violence face and how they can be overcome. You will be asked some sensitive questions in this interview; if you feel that cannot answer these questions, you can skip a question or you can stop the interview at any point.

1. I am interested in your experiences of the medical and psychological care that you have received; can you please tell me about this? **(If care has been received, move to question 5 and if no care has been received, continue to question 2)**

Prompts:

- Where did you seek help from? (Hospital [private or government], refugee serving agency, religious institution, traditional institution, friends)
 - What was the reaction of the people in those institutions when you shared your problem with them?
 - What kind of assistance have you been given?
 - How long have you been receiving medical or psychological treatment for your condition?
2. Why haven't you sought help yet?
 3. Kindly tell me how you cope with the physical and psychological effects.

4. What would you need to enable you access services to cope with the effects? (**Skip to question 8**)

5. Tell me about the changes in your physical and mental state since you started receiving help.

- Opinion about the services received.

6. What made it hard or difficult for you to access help?

Prompts: barriers e.g. shame, stigma, ignorance about available services

7. What made it easy for you to seek help?

- **Prompts:** Caring staff members, access to doctors

8. What additional support have you received to facilitate your recovery?

- Care from religious institutions, community etc.

9. What other forms of support would you need to facilitate recovery?

10. Do you know of any other men that have not received help? What do you think keeps them out of care?

11. How have the medical and psychological consequences of sexual violence impacted on your normal functioning?

Prompts:

- Working life
- Relationships with family
- Relationships with the community

12. How does the community react towards male victims of rape?

13. What is the attitude of the community towards male victims of rape that seek help?

14. What is the attitude of the service providers towards you?

15. So, how do you interpret or understand the way people treat and react towards you?

16. Can you please share with me what role you think you can play in helping other survivors access help?

17. In your opinion, what can be done to overcome the barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence?

Do you have any questions for me?

If yes, provide answers where possible, if no thank the participant and dismiss them.

APPENDIX F: Interview Guide – Service Providers

Semi-Structured Interview Guide for Service Providers

Study Topic: Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence living in Kampala.

Aim: To investigate barriers and facilitators to physical and mental health help-seeking, among male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda.

Objectives:

9. To explore survivors' experiences and perceptions regarding barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
10. To elicit survivors views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.
11. To explore the experiences of practitioners working with male survivors of conflict-related sexual violence.
12. To elicit practitioners views on barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence.

Interview Date:

Time:

Participants ID:

Socio-demographic Data

1. Age
2. Gender
3. Occupation
4. Highest form of Education
5. Number of years in practice

6. Name of Medical facility

Thank you for accepting to take part in our study. Your participation will benefit a lot of people in identifying the medical and psychological challenges that male refugee survivors of sexual violence face and how they can be overcome. You will be asked some sensitive questions in this interview; if you feel that cannot answer these questions, you can skip a question or you can stop the interview at any point.

1. Kindly tell me about your first experience of dealing with a male survivor of conflict-related sexual violence?

Prompts:

- How did you handle the case?
- Briefly share with me what you knew about sexual violence against men before that experience.
- Give me your opinion about the care that the facility was able to offer to the patient. (**Prompts;** was it satisfactory?)

2. As a service provider, can you tell or estimate the number of male survivors of conflict-related sexual violence have you handled to date?

3. What are the physical or mental health problems that male survivors of conflict-related sexual violence present with?

4. Do you think your organisation is helping survivors? In which way?

5. On average, how long does it male survivors of sexual violence to seek for physical or mental health services?

6. What do you think causes delays or hinders physical and psychological help-seeking among male refugee survivors of sexual violence?

7. In your opinion, what pushes them to finally seek physical and psychological help for the effects of sexual violence?

8. I understand that there are some male victims of sexual violence that seek help immediately after the violence. According to you, what factors facilitate this particular help -seeking behaviour?

9. Female survivors of conflict-related sexual violence with rectal and genito-urinary or reproductive health issues are sent to the gynaecologist; is there an equivalent for the men?

Prompt;

- Please describe the services for men with genitourinary, rectal and reproductive problems after victimisation.

10. Would you say that your training in school prepared you to deal with conflict-related sexual violence against men?

11. How does working with male survivors of sexual violence affect you?

Prompts;

- How are you perceived by your fellow colleagues in the medical profession that have not had an opportunity to handle such cases?
- How are you perceived by your family and the wider community?
- How are you perceived by the government?

12. What is similar and what is different in handling male and female victims of conflict-related sexual violence?

13. In your opinion, what can be done to overcome the barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence?

Do you have any questions for me?

If yes, provide answers where possible, if no thank the participant and dismiss them.

APPENDIX G: Consent Form for Survivors – English



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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence living in Kampala.

Consent Form for Male Survivors of conflict-related sexual violence

You are asked to participate in a research study conducted by Peninah Kansiime, Student, MPhil. Public Mental Health from the Psychology Department, Faculty of Arts and Social Sciences at Stellenbosch University. Data collected from this study will contribute to a thesis leading to an MPhil. Award in Public Mental Health. You were selected as a possible participant in this study because you are a male victim of conflict-related sexual violence, a refugee from the Democratic Republic of Congo (DRC), and are above 18 years of age.

PURPOSE OF THE STUDY

The purpose of the study is to investigate barriers and facilitators to physical and mental health help-seeking, among male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda. The study will also elicit participants' views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence. Congolese male refugee survivors and health practitioners providing them with physical and mental health services will be interviewed for about 45-65 minutes with the help of an interpreter that will be briefed about the study before it starts.

Interviews will be audio-recorded and I will take notes to ensure that all relevant information is captured. Information will be kept confidential and be destroyed after serving the purpose for which they will be collected. Information will be used in compiling my thesis for the MPhil in Public Mental Health and published in relevant academic journals. It is hoped that the information gathered will be an advocacy tool for the improvement of mental health services among refugees in Uganda, and also helps the Refugee Law Project further design appropriate and research based interventions for its clients. This study is sponsored by Africa Focus on Intervention Research for Mental Health (AFFIRM) based at the Alan J. Fisher Centre for Public Mental Health based at the University of Cape Town in South Africa.

1. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

You will be given a flier with information about the study that you will take home with you, to further think about the purpose of the study and decide whether you want to be a part of it. If you agree to take part, an appointment will be set for the actual interview to take place. Interviews will be held at a room allocated at the Refugee Law Project.

Consent

At the start of the interview, the aim and objectives of the study will be explained, and if you still wish to proceed, you will be given a consent form. Information on the consent form will be read to you, and you can ask questions or seek clarification. If you further wish to proceed with the interview, you will sign two copies of the consent form. One will be kept by the principal investigator, and the other will be your copy that you shall take home with you.

The Interview

The actual interview will then proceed, with the help of an interpreter if necessary. The interview is expected to last between 45-65 minutes. Only one interview will be conducted per person.

2. POTENTIAL RISKS AND DISCOMFORTS

I do not foresee any physical harm resulting from your participation in this study. However, it is anticipated that the nature of the study may cause emotional disturbances for you. In case that happens, kindly let me know so that I can stop the interview immediately. I have arranged with the counsellors in the Mental Health and Psychosocial Well-being Programme here at Refugee Law Project and they are on standby to render necessary help to you. You don't have to answer all the questions asked if you are not comfortable and also feel free to withdraw from this interview if you feel you can't go on.

3. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There are no direct benefits for you in this study and you will not be paid any money for it, however, the information that you will provide will contribute to the understanding of barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence. This information will help improve physical and mental health responses for male refugee survivors of sexual violence by service organizations locally and globally.

4. PAYMENT FOR PARTICIPATION

There is no payment for participation in this study. However, during the interview, you will be provided with a soft drink and a transport refund back to your home after the interview.

5. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of conducting the interview in a private room, and where the use of an interpreter is necessary, permission will be sought first from the interviewee.

With permission from you, data will be audio recorded and all audios, transcriptions, and personal notes will be stored on the investigator's personal computer. The files where the data is stored will be password protected and accessed by the investigator only. As a participant, you have the right to request for audios and deny their inclusion if you are not comfortable. After the transcription, the audios and their transcripts will be destroyed.

Data will be coded using NVIVO 10, qualitative data analysis software. The information may be released only to the academic supervisors for this study if there is need but the identity of the participant will be withheld by the researcher. Participants will be given pseudonyms to protect their real identity. The study findings will be published in relevant journals and as noted, pseudonyms will be used to safeguard the identity of the participants.

6. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Such circumstances may include severe emotional distress manifested by uncontrollable

crying, failure to speak due to emotional pain and any other circumstance that may arise. *[If appropriate, describe the anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent.]*

7. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Principal Investigator: Peninah Kansiime, Student, MPhil. Public Mental Health at the Psychology Department, Faculty of Arts and Social Sciences in Stellenbosch University.

Contact Number: (+275) 791 096626 or (+256) 700 567144

Student Supervisors: Kagee Ashraf, Professor at the Psychology Department, Faculty of Arts and Social Sciences, Stellenbosch University

Email: skagee@sun.ac.za

Contact Number: + 27 021- 8083442 (Office): +27 834433002 (Cell).

Dr. Claire van der Westhuizen, Department of Psychiatry and Mental Health, University of Cape Town

Email: clairevdwest@gmail.com

Contact Number: +27 834456016 (Cell)

8. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development. You can also contact the TASO IRB Chairperson Mr. Bakanda Celestion on 0752774178.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE
--

The information above was described to *[me/the subject/the participant]* by *[name of relevant person]* in *[Lingala/English/Swahili/French/other]* and *[I am/the subject is/the participant is]* in command of this language or it was satisfactorily translated to *[me/him/her]*. *[I/the participant/the subject]* was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant*] and/or [his/her] representative _____ [*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in _____ and [*no translator was used/this conversation was translated into* _____ by _____].

Signature of Investigator

Date

APPENDIX H: Consent Form for Survivors – French



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STELLENBOSCH UNIVERSITY CONSETEMENT POUR PARTICIPER A LA RECHERCHE

Obstacles et facilités dans la recherche des services de santé physique et mentale faite par soi-même parmi les réfugiés congolais de sexe masculin survivants de violence sexuelle liée aux conflits qui vivent à Kampala

Formulaire de consentement pour les survivants de violence sexuelle liée aux conflits

Vous êtes invité à participer à une étude de recherche menée par Peninah Kansiime, étudiante, MPhil.. La santé mentale du Département de la psychologie, Faculté des lettres et des sciences sociales de l'Université de Stellenbosch. Les données recueillies par cette étude contribueront à une thèse menant à un MPhil. Award dans la santé mentale. Vous avez été sélectionné en tant que participant possible dans cette étude parce que vous êtes une victime de sexe masculin de la violence sexuelle liée aux conflits, un réfugié de la République Démocratique du Congo (RDC), et avez plus de 18 ans.

OBJET DE L'ETUDE

Le but de l'étude est d'examiner les obstacles et les facilitateurs à la santé physique et mentale de recherche d'aide, parmi les survivants masculins des réfugiés de la violence sexuelle liée aux conflits, vivant à Kampala, en Ouganda. L'étude permettra également de recueillir les points de vue des participants sur les solutions pour surmonter les obstacles à la santé recherche d'aide physique et mentale chez les survivants masculins des réfugiés de la violence sexuelle liée aux conflits. Congolais réfugiés survivants de sexe masculin et les praticiens de la santé en leur fournissant des services de santé physique et mentale seront interviewés pendant environ 45-65 minutes avec l'aide d'un interprète qui sera informé à propos de l'étude avant qu'elle ne commence.

L'objet de l'étude est de faire des investigations sur les obstacles et facilités dans la recherche des services de santé physique et mentale parmi les réfugiés congolais de sexe masculin survivants de violence sexuelle liée aux conflits vivant à Kampala, en Ouganda permettra également de recueillir les points de vue des participants sur les solutions pour surmonter les obstacles rencontrés dans la recherche services de sante physique et mentale parmi les refugies congolais de sexe masculin survivants de violence sexuelle liée aux conflits. Les personnes qui leur donnent des services de sante physique et mentale seront interviewes pendant à peu près 45-65 minutes avec l'aide d'un interprète qui sera préparé sur l'étude avant qu'elle ne commence

Les interviews seront enregistrés et je vais prendre notes pour faire en sorte que toutes les informations nécessaires sont captées. Toutes les informations seront gardées confidentiellement et seront détruites après qu'elles seront utilisées à des fins dont elles seront connectées. Les informations seront utilisées pour compiler mon thèse pour le MPhil en Santé Mentale Publique et publié dans les journaux académiques appropriés. Nous espérons que l'information collectée servira de plaidoyer pour l'amélioration des services de santé physique et mentale parmi les réfugiés en Ouganda, et vont aussi aider Refugee Law Project à élaborer des interventions pour ses clients qui soient appropriées et basées sur les travaux de recherche. Cette étude est sponsorisée par « Africa Focus on

Intervention Research for Mental Health (AFFIRM) » basée à the Alan J. Fisher Centre for Public Mental Health based à l' Université de Cape Town en Afrique du Sud.

1. PROCEDURES

Si vous vous portez volontaire à participer dans cette étude, nous allons vous demander de faire les choses suivantes:

On va vous donner un prospectus contenant des informations concernant l'étude que vous allez prendre chez vous, ce qui va vous aider à comprendre davantage l'objet de l'étude et ainsi décider si vous voulez y participer ou pas. Si vous acceptez d'y participer, on va vous donner un rendez-vous pour l'interview proprement dit. Ces interviews seront menées dans une salle à Refuge Law Project.

Consentement

Au début de l'interview, le but et les objectifs de l'étude vous seront expliquées, et si vous voulez continuer, vous serez donné un formulaire de consentement. Les informations contenues dans le formulaire de consentement vous seront lues, et vous pouvez poser des questions ou demander des clarifications. Si vous voulez bien continuer avec l'interview, vous allez signer deux copies de formulaire de consentement. L'une sera gardée par la personne qui va mener l'interview, et l'autre sera votre copie que vous allez prendre à la maison pour vous-même.

L'Interview

Après ça, l'interview proprement dit va continuer, avec l'aide d'un interprète en cas de besoin. L'interview devrait durer de 45-65 minutes. On va mener seulement une interview par personne

RISQUES ET MALAISES POTENTIELS

Je ne vois pas en avance aucun danger physique qui pourrait resulted de cette etude. Toutefois, nous anticipons que la nature de l'étude pourrait vous causer un peu de malaise emotionnels. Si cela vous arrive, veuillez bien m'arreter pour que je puisse stoper l'interview immediatement. J'ai fait des arrangements avec les conseillers du Programme de Sante Mentale et Bien-etre psychosocial ici a Refugee Law Project et ils sont prêts a vous apporter l'aide necessaire pour vous aider. YVous n'etes pas obligé de repondre a toutes les questions posees si vous ne vous sentez pas a l'aise d'y repondre et vous pouvez vous retirer de cet interview quand vous trouvez que vous ne pouvez pas continuer.

2. BENEFICES POTENTIELS AUX PERSONNES INTERVIEWES ET/OU A LA SOCIETE

Il n'y a pas de bénéfices directs pour vous dans cette étude et vous ne serez pas payé aucune somme d'argent pour y participer, toutefois, les informations que vous allez donner vont contribuer à comprendre les obstacles et facilités dans la recherche des services de santé physique et mentale faite par soi-même parmi les réfugiés congolais de sexe masculin survivants de violence sexuelle liée aux conflits. Ces informations vont aider à améliorer la façon dont les organisations qui offrent des services apportent des réponses localement et globalement en matière de santé physique et mentale en faveur des réfugiés de sexe masculine survivants de violence,

PAIEMENT POUR PARTICIPATION

Il n'y a pas de paiement pour participation à cette étude. Cependant, on va vous donner une boisson non alcoolisée et le remboursement de vos frais de transport pour retourner a la maison après l'interview.

3. CONFIDENTIALITE

Toute information obtenue en relation avec cette étude et qui peut vous être identifiée sera gardée confidentiellement et ne sera révélée qu'avec votre permission comme le veut la loi. Confidentialité sera maintenue par les moyens de mener l'interview dans une sale privée, et si nous devons travailler avec un interprète, on va d'abord demander la permission au participant.

Avec votre permission, les données seront enregistrées, et tous les enregistrements, transcriptions, et notes personnelles seront gardées dans l'ordinateur personnel de la personne qui va mener l'interview. Les fichiers ou seront gardées les données seront protégées par un mot de passe et ne seront accédés que la personne qui mène l'étude.

Comme participant, vous avez droit de demander qu'on vous donne les enregistrements et refuser leur inclusion si vous ne vous sentez pas à l'aise. Après la transcription, les enregistrements et les transcriptions seront détruites.

Les données seront codées en utilisant NVIVO 10, qui est un logiciel d'analyse qualitative des données. Les informations pourraient être données uniquement aux superviseurs académiques pour cette étude, mais les noms du participant seront retenus par la personne qui mène la recherche. Les conclusions de l'étude seront publiées dans les journaux appropriés comme noté, et on va utiliser les pseudonymes afin de sauvegarder l'identité des participants.

4. PARTICIPATION ET RETRAIT

Vous pouvez choisir de participer à cette étude ou pas. Si vous vous portez volontaire à participer à cette étude, vous pouvez vous retirer à tout moment sans aucune conséquence. Vous pouvez aussi refuser de répondre à n'importe quelles questions tout en continuant de rester dans l'étude. L'enquêteur peut vous retirer de la recherche si des circonstances surviennent qui justifient le faire. Ces circonstances peuvent inclure la détresse émotionnelle sévère qui se manifeste par des pleurs incontrôlables, l'incapacité de parler causée par la douleur émotionnelle ou toute autre circonstance qui pourrait survenir.

5. IDENTIFICATION DES ENQUETEURS

Si vous avez des questions ou des préoccupations au sujet de la recherche, n'hésitez pas à contacter

Chercheur principal: Peninah Kansiime, étudiante, MPhil. Santé mentale Publique au département de psychologie de la Faculté des Lettres et des sciences sociales à l'Université de Stellenbosch.

Numéro de téléphone: (+275) 791 096 626 ou (+256) 700 567144

Superviseurs des étudiants : Kagee Achraf, professeur au département de psychologie de la Faculté des Lettres et des sciences sociales, Université de Stellenbosch

Email: skagee@sun.ac.za

Numéro de téléphone: + 27 021- 8083442 (Bureau): +27 834 433 002 (portable).

Dr Claire van der Westhuizen, Département de psychiatrie et de santé mentale, Université de Cape Town

Email: clairevdwest@gmail.com

Numéro de téléphone: +27 834456016 (cellulaire)

6. DROITS DES PARTICIPANTS A LA RECHERCHE

Vous pouvez retirer votre consentement en tout temps et cesser votre participation sans pénalité. Vous ne renoncez pas à toute réclamation juridique, droit ou recours en raison de votre participation à cette étude de recherche. Si vous avez des questions concernant vos droits en tant que participant à cette recherche, veuillez contacter Mme Malene Fouché [mfouche@sun.ac.za; 021 808 4622] à la Division pour le développement de la recherche. Vous pouvez aussi contacter la personne en charge de TASO IRB, Monsieur Bakanda Celestin à travers le No 0752774178.

SIGNATURE DU PARTICIPANT A LA RECHERCHE OU SON REPRESENTANT LEGAL SUJET DE RECHERCHE OU SON REPRESENTANT LÉGAL

Les informations ci-dessus ont été décrites [a moi /au participant] par [nom de la personne concernée] en [lingala / anglais / swahili / français / autre] et [moi/ le participant] connais/connait bien cette langue ou elles ont été traduites de façon satisfaisante à [moi / lui]. [J' / le participant /] ai/a été donné l'occasion de poser des questions et ces questions ont été répondu à [ma/ sa] satisfaction.

Par la presente, je consens volontairement à participer à cette étude / par la présente je consens que le participant peut participer à cette étude.] J'ai été donne une copie ce formulaire.

Nom du participant

Date

Nom du représentant légal (le cas échéant)

Date

SIGNATURE DE L'ENQUETEUR

Je déclare que je ai expliqué l'information donnée dans ce document a _____
 [nom du participant] et / ou a [son] représentant _____ [nom du représentant]. [II]
 a été encouragé et donné amplement de temps pour me poser des questions. Cette conversation a été menée en
 _____ et [on n'a pas utilise un interprète / cette conversation a été interprétée en
 _____ par].

Signature du chercheur

Date

APPENDIX I: Consent Form for Survivors – Lingala



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UNIVERSITE YA STELLENBOSCH ENDIMI KOZALA NA RECHERCHE EYE

Kokoso mpe basungi na oyo etali bokolongo ya nzoto mpe ya bongo, koluka lisungi na kati ya Bayi mboka Congo baye bazali awa na Kampala, mpe babika sima ya kozwama na makasi na nzela ya kimobali na tango ya bitumba.

Lokasa ya Bondimi (Consentement) mpo ya mibali baye babika sima ya kozwama na makasi na tango ya bitumba.

Tosengi na yo na kozala moko na biso na koyekola recherche oyo epesami na Peninah Kansiime, moyekoli, MPhil. Santé Publique mentale ya Département ya Psychologie na Faculté ya Arts et Science Sociale na Université ya Stellenbosch. Ba données eye ekozwama mpo ya étude eye ekosalisa mpo ya These oyo ekopesa Mphil. lifuti na Santé Public mentale. Oponamaki po na kozala moko na eye étude mpo ete ozali Victime ya mobali oyo azwamaka na makasi na tango ya bitumba, Réfugié moyi mboka République Démocratique ya Congo (RDC) oyo azali na mbula koleka 18.

Etude eye azali mpo

Etude eye ezali mpo ya kolukisa bakokoso mpe basungi na oyo etali lisungi ya bokolongono bwa nzoto mpe bwa bongo na kati na ba Réfugiés ya mibali baye bazwamaka na makasi na nzela ya kimobali tango na bitumba, mpe baye bafandi na Kampala, Ouganda. Etude eye esengi mpe liloba ya baye babengami mpo ya koluka lisungi eye ekolonga bakokoso ya bokolongo bwa nzoto mpe ya bongo kati na baréfugié ya mibali baye bazwamaka na makasi na nzela ya kimobali na tango na bitumba. Ba réfugié bayi mboka Congo baye babikaka mpe Minganga baye basungaka bango na kisi mpo ya bokolongo bwa nzoto mpe ya bongo bakoleka na Mituna (interview) oyo ekoki kosala kobanda na minute 45 tii na 65 mpe lisungi ya interprete oyo bakolimbola muke liboso étude eye ebanda.

Na Mituna (interview) eye mingongo mikoza eregistrées mpe nakokoma muke muke mpo ya kolakisa ete nioso ozali koloba ezwami. Mpe nioso okoyebisa biso ekotikala sekele (confidentiel) mpe sima ya musala tokobomba yango lisusu te, tokoboma yango. Information eye ekozwama mpo ya These na ngai ya MPhil na Santé Publique Mentale mpe toko panza yango na ba journaux académiques oyo esengeli. Toza na elikia ete information tokozwa ekozala lisungi mpo ya kosambelela (plaidier) mpo ya kobongisa lisungi ya Bokolongono bwa bongo (Santé Mentale) kati na ba Réfugiés nioso na Ouganda, mpe mpo ya kosunga Refugee Law Project na kozala na makomi mpo ya kosunga ba clients na ye. Etude eye esalami na lisungi ya misolo kowuta epai ya Africa Focus na oyo etali Intervention mpe Recherche po na Santé Mentale (na Anglais Africa Focus on Intervention Research for Mental Health (AFFIRM) oyo ezali na Centre Alan J. mpo ya Santé Publique Mentale, oyo ezwami na Université ya Cape Town na Afrique du Sud.

9. ELANDELI (PROCEDURES)

Soki ondimi kozala moko na Kati na Etude eye, tokosenga yo kokisa makambu oyo elandi:

Okopesamela Depliant moko oyo eza na information na oyo etali etude eye, okomema yango na ndaku mpo ete okanisa lisusu mpo ya litomba ya étude eye mpo oyebisa biso soki okozala moko na étude eye to te. Soki ondimi kozala moko na étude eye, tokolaka yo mukolo ya Interview ekosalama. Ba Interviews eye ekosalama na esika ya musala na Refugee Law Project.

Bondimi to pe Consentement

Na ebandeli ya Interview litomba mpe objectifs ya étude oyo ekolimbolama, soki olingi kokoba okopesama lokasa ya Bondimi (formulaire de consentement). Bakotangela yo makomi kati na lokasa eye, bongo okotuna mutuna mpo olimbolama koleka. Na sima soki olingi okoba na interview, okotiya linzaka (signature) na makasa ya bondimi mibale. Lokasa moko ekotikala epai ya Molukisi (investigateur) ya liboso, mosusu ekozala ya yo.

Mituna to pe Interview

Mituna mpenza ekobanda sika oyo na lisungi ya molimboli (interprete) soki olingi. Interview eye ekoki kosala kobada minute 45 tii na 65. Mutu moko akosala interview moko kaka.

1. MAKAMA OYO EKOKI KOSALAMA MPE KOZANGA KIMIA

Nazali komona ata mabe moko te oyo ekoki koyela yo mpo ya kozala moko na biso na étude eye. Kasi tokoyebisa liboso ete étude eye ekoki kotungisa makanisi na yo. Soki esalemi, na sengi ete oyebisa ngai mpo ete na kata interview mbala moko. Nasi na yokani na mopesi toli na Programme ya Santé Mentale et du bien-naitre psychologique awa na Refugee law Project, bazali kozela mpo bapesa lisungi. Totindi yo te oyanola na makasi soki ozangi kimia, mpe nazala na kimia ya koboya interview eye soki omoni ete okoki kokoba te.

2. MBANO MPO YA BAYI BAKOSALA NA BISO MPE/TO NA LINGOMBA YA BATO NIOSO

Lifuti moko te ezali mpo na yo na étude eye, tozali bongo na mbongo ya tokofuta yo te. Kasi mayebisi kowuta epai na yo ekosunga mpo ya koyeba mpenza bakokoso mpe lisungi na oyo etali santé ya nzoto mpe ya bongo na lingomba ya ba Réfugiés ya mibali baye bazwamaka na makasi na tango na bitumba. Information eye ekosalisa mp ete tobongisa na oyo etali lisungi ya santé ya nzoto mpe ya bongo mpo ya ba Refugies ya mibali baye bazwamaka na makasi na ba Organization nioso oyo esalisaka awa na Uganda mpe mokili mobimba.

3. LIFUTI MPO YA KOZALA MOKO NA ETUDE EYE

Lifuta moko te ezali mpo ya kozala moko na étude eye. Kasi, tangu tokobanda interview, toko pesa yo eloko ya komela mpe mbongo muke eye ekosalisa mpo nakozongisa yo na ndako na sima ya interview.

4. SEKELE (CONFIDENTIALITE)

Eloko nioso okoyebisa biso oyo ekamatani na étude eye na oyo etali yo ekotikala sekele kasi tokoki kobimisa yango kaka soki opesi biso nzela to pe soki ezali na nzela na mibeko. Sekele ekozala mpenza tango interview ekobanda na ndaku ya sekele, mpe soki kaka tozali na mposa ya molimboli; toko senga nzela epai ya moto tokotuna mituna.

Bongo soki opesi biso nzela, nioso okolobela biso ekozala bongo enregistré, tokotiya mongongo na yo na makomi, mpe tokokoma muke muke tangu tozali ko enregistrer, mpe kaka investigateur akobomba yango na Ordinateur na ye. Esika information ekozala na Ordinateur bakotiya fongola mpo ya kobomba yango malamau, mpe kaka investigateur akozala bongo na fongola wana. Moto nioso akosala interview eye akoki kosenga Audio ya interview na ye, mpe koboya soki ekozangisa yo kimia. Na sima ya kotiya audio na yo na makomi, ba mingongo wana mpe makomi wana tokoboma yango.

Information wana ekopesamela code NNVIVO 10, analyse qualitative ya information ya logiciel. Information ekoki koposama kaka na ba superviseurs mpo ya koyekola soki bazali na posa na yango kasi kombo na yo ekoyebana te na mutu oyo azali kosala recherche. Mutu nioso oyo akozala moko na étude eye akopesama kombo Mosusu mpo ya kobomba kombo na yo ya solo. Etude eye ekozala publié na ba journaux lokola tolobaki, na bakombo mosusu mpo ya kobatela mpe kobomba identité na bino ya solo.

5. KOPARTICIPER MPE KOBENDANA

Okoki kopona soki okozala na bison a étude eye to te. Soki ondimi kozala na etude eye, okoki mpe kobendana tango nioso olingi, ekosala mpe mabe moko te. Okoki mpe koboya koyanola mituna mosusu oyo olingi te kasi okotikala kaka na etude eye. Investigateur akoki mpe kolongola yo na etude eye soki tokomi na tango mpenza amoni ete tokoki kokoba lisusu te. Tango ya bongo ekoki kozala tango otungisami mingi, makanisi ekomi kolekela yo moto, okomi kelela, tango okoki lisusu koloba ata soki moke te mpo makanisi epesi yo mpasi mpenza, to mpe likambo mosusu ya ndenge wana salami

6. KOYEBA BA INVESTIGATEURS

Soki ozali na mituna to kotungisama na oyo etali recherche eye, sala makasi omona to obenga:

Investigatrice Principale: Peninah Kansiime, Moyekoli, MPhil. Santé Publique mentale au Département de la Psychologie, Faculté des Arts et Sciences Sociales a l'Université de Stellenbosch.

Numéro ya Téléphone: (+275) 791 096626 or (+256) 700 567144

Etudiants Superviseurs: Kagee Ashraf, Professor at the Psychology Department, Faculty of Arts and Social Sciences, Stellenbosch University

Email: skagee@sun.ac.za

Numéro ya Téléphone: + 27 021- 8083442 (Esika ya musala): +27 834433002 (Cell).

Dr. Claire van der Westhuizen, Département of Psychiatrie et Santé Mentale, Université de Cape Town

Email: clairevdwest@gmail.com

Contact Number: +27 834456016 (Cell)

7. ALIMA TO PE DROIT YA BAYI BAZALI BA SUJETS YA RECHERCHE

Okoki mpe kobendana ata osi ondimaki kosala interview eye tango nioso olingi, to mpe kobendana, ekosala eloko ata moko te. Awa ezali makambo y aba zuzi te, ba droits to mpe kisi mpo obengami kosala eye interview. Soki oza na mituna mpo na oyo etali ba droits na yo mpo oponami kosala recherche eye, mona Elenge mwasi Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] Developpement de recherche. Okoki pe kobenga Responsable ya TASO IRB na kombo ya Bakanda Celestin na Numero oyo 0752774178.

MANZAKA YA MOTO AZALI KOSALA RECHERCHE TO MPE REPRESENTATION LEGALE

Information oyo ezali likolo ezali kolimbola mpo ya [ngai/Sujet/participant] na [kombo ya moto oyo esengeli] na [Lingala/Lokota ya Anglais/Lokota ya Francais/ to mpe mosusu] mpe [na zali/moto oyo azali/ moko na etude eye azali] na bosenga ya lokota eye, to mpe soki kokoma yango esepelisi [ngai/ye]. [ngai/moko na etude eye/ Sujet] na pesameli opportunité ya kotuna mituna, mpe mituna eye eyanolamaki [ngai/ye] ndenge elongobani.

[Na ndimi mpenza kozala moko na etude eye/ Na pesi liloba ya bondimi ete Sujet/Participant akozala moko na etude eye.] Na pesameli lokasa moko ya formulaire eye.

Kombo ya Sujet/Participant

Kombo ya Représentant Légal (Soki esengeli)

Manzaka to Signature ya Sujet/Participant/Représentant Légale **Date**

MANZAKA TO SIGNATURE YA INVESTIGATRICE

Na tatoli awa ete na limbolaki sango oyo ezali na lokasa eye epai ya _____ [*Kombo ya sujet/participant*] pe/to [ya] représentant _____ [*kombo ya représentant*]. [A] yikamaki mpilo mpe apesamaki tangompo ya kotuna mituna. Masolo oyo ekambamaki na _____ mpe [Molimboli (interprete) azalaki/Masolo eye elimbolamaki na _____ na _____].

Manzaka/signature ya Investigatrice

Date

APPENDIX J: Consent Form for Survivors – Swahili

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**CHUO KIKUU CHA STELLENBOSCH
KUKUBARI KUSHIRIKI KATIKA UTAFITI**

Vizuizi na vitu vinavyorahisisha kutafuta msaada wa kimwili na kiakili miongoni mwa wakimbizi wanaume wakongomani walionusurika unyanyasaji wa kingono unaotokana na vita wanaoishi kampala

Fomu ya kukubali kwa ajiri ya wanaume walionusurika unyanyasaji wa kingono

Unaombwa kuhusika katika utafiti unaofanywa na Peninah Kansiime mwanafunzi anaye soma mambo ya Afya ya Akili katika idara ya Kisaikolojia kwa shule ya sayansi za kijamii kwa Chuo kikuu cha Stellenbosch. Taarifa itakayokusanywa kwa utafiti huu itakuwa mchango kwa kupata Shahada ya pili (maitrise) ya Afya ya uma. Ulichaguliwa kama mmoja wa washiriki katika utafiti huu kwa sababu wewe ni mwathirika wa unyanyasaji wa kingono kutoka Kongo ya kidemokrasia na una umri wa myaka zaidi ya 18.

LENGO LA UTAFITI HUU

Lengo la utafiti huu ni kuchunguza vizuizi na vitu vinavyorahisisha kutafuta msaada wa kimwili na wa kiakili miongoni mwa wakimbizi wanaume wakongomani walionusurika unyanyasaji wa kingono wanaoishi kampala, Uganda. Utafiti utaweza tena kukusanya maoni ya washiriki kuhusu ufumbuzi (solutions) ya kushinda vizuizi vya kupata msaada wa afya ya kimwili na ya kiakili miongoni mwa wakimbizi wa kiume wakongomani walionusurika unyanyasaji wa kingono uliotokana na vita. Wakimbizi wakiume wakongomani walionusurika pamoja na wafanyakazi wa afya wanaowapa huduma za kimwili na za kiakili watahojiwa kwa muda wa dakika 45-65 wakisaidiwa na mtafsiri ambaye atapewa kwanza maelezo kuhusu utafiti huu kabla ya kuanza.

Mahojiano yatachukuliwa na vinas sauti pia nitaandika kuhakikisha ya kwamba taarifa inayohitajika yote imechukuliwa. Taarifa itawekwa kwa siri na itateketzwa baada ya kuitumia na kumaliza kazi yake. Taarifa itatumiwa kwa kuandika kitabu cha Shahada ya pili(maitrise) ya afya ya uma na katika vitabu kwa ajiri ya masomo. Inatumainiwa ya kwamba taarifa ambayo itakusanywa itakuwa kifaa cha kutetea uboreshaji wa afya ya kiakili miongoni mwa wakimbizi nchini Uganda pia itasaidia Refugee Law project kupanga uingiliaji kati kwa wateja wake. Utafiti huu umedhaminiwa na Shirika linaloitwa “Africa Focus on Intervention Research for Mental Health (AFFIRM)” linalopatikana kwa kituo cha Afya ya Uma cha Alan J. Fisher kinachopatikana kwa chuo kikuu cha Cape town nchini Afrika ya kusini.

1. UTARATIBU

Ikiwa umejitolea kushiriki katika utafiti huu tutakuomba ufanye mambo yafwatayo:

Utapewa karatasi ambayo inataarifa kuhusu utafiti huu karatasi hii utaipeleka nyubani ili uweze kufikiri zaidi kuhusu lengo la utafiti na kuamua kama unaweza kushiriki. Ikiwa utakubali kushiriki miadi (rendez-vous) itapangwa kwa ajiri ya mahojiano sahihi. Mahojiano yatafanyika katika chumba cha Refugee Law Project.

Kukubali

Kwa mwanzo wa mahojiano maelezo kuhusu lengo na shabaha vya utafiti huu yatatolewa na ikiwa bado unapenda kuendelea utapewa fomu ya kukubali. Utasomewa taarifa ambayo inapatikana kwa fomu ya kukubali, na unaweza kuuliza swali au kutafuta maelezo zaidi. Na ikiwa unapenda kuzidi kuendelea na mahojiano utaweka mkono kwa nakala mbili za fomu ya kukubali. Nakala moja itakuwa ya mtafiti mkuu na ingine itakuwa yako utaenda nayo nyumbani.

Mahojiano

Mahojiano kamili yataandalea tukusaidiwa na mtafsiri kama itakuwa lazima. Mahojiano yatachukuwa mda wa dakika 45-65. Mahojiano moja pekee yatafanywa kwa mtu mmoja.

2. UWEZEKANO WA KUTOJISIKIA VIZURI

Sioni madhara yoyote yanayotokana na kushiriki katikia utafiti huu. Lakini inatarajiwa ya kwamba kulingana na jinsi utafiti huu ulivyo inaweza kusumbua hisia (Emotions) zako. Ikiwa itakuwa hivyo tafadhali unijulishe ili niweze kusimamisha mahojiano mara moja. Nimepanga na mshauri katika programu ya afya ya akili na ustawi wa kisaikolojia hapa Refugee Law Project na wakotayari kutowa msaada wowote ambao unahitajika kwako. Kama hujisikii vizuri Hulazimishwi kujibu maswali yote na pia unauhuru wa kutoka kwa mahojiano haya kama unajihisi huwezi kuendelea.

3. FAIDA KWA WASHIRIKI AU/NA KWA JAMII

Hakuna faida ya moja kwa moja kutoka kwa utafiti huu na hautalipwa pesa kwa ajiri ya utafiti huu, lakini taarifa ambayo utatowa kwa utafiti huu italeta mchango wa kuelewa viziwi vitu vinavyorahisisha kutafuta msaada wa kimwili na wa kiakili miongoni mwa wakimbizi wa kiume walionusurika unyanyasaji wa kingono uliotokana na vita. Taarifa hii itasaidia mashirika ya hapa na ya dunia nzima kuboresha majibu yao kwa afya ya kiakili na kimwili ya wakimbizi wakiume walionusurika unyanyasaji wa kingono

4. MALIPO YA KUSHIRIKI

Hakuna malipo ya kushiriki katika utafiti huu. Lakini katika utafiti huu utapewa kinywaji kitamu na utarudishiwa pesa yenye ulitumia ukikuja kwa mahojiano na ile ya kukuridisha nyumbani.

5. SIRI

Taarifa yoyote ambayo inahusiana na utafiti huu na ambayo inaweza kujulikana ya kwamba imetolewa na wewe itabaki kuwa ni siri kubwa na itajulikana tu kwa ruhusa kutoka kwako kulingana na mujibu wa sheria. Siri itachungwa kwa njia yakufanya mahojiano ndani ya chumba cha siri na ikiwa lazima kutumia mtafsiri ruhusa itatoka kwa mhojiwa.

Kwa ruhusa kutoka kwako taarifa itachukuliwa kwa vinaso sauti, utafsiri na maandiko yatawekwa kwa kompyuta binafsi. Na faili kwanye taarifa imewekwa itakuwa na neno la siri ya kulinda na mtafiti mkuu ndie ataweza kuifikia yeye peke yake. Kama mshiriki una haki ya kuomba sauti zilizonaswa na kukataa zisitumiwe ikiwa hutajisikia visuri. Baada ya kunakili (transcription) sauti zilizonaswa na utafsiri wote vitateketewa.

Taarifa itakusanywa kwa kutumia mfumo wa kompyuta unaoitwa “NNVIVO 10, qualitative data analysis software”. Taarifa itapatwa msimamizi wa masomo ya utafiti huu peke yake kama kuta kuwa haja lakini mtafiti hatatambua mshiriki. Washiriki watapewa majina ambayo si yao ya ukweli kwa kulinda utambulisho wao.

Matokeo ya utafiti huu yataandikwa kwa vitabu husika na vile imesemwa majina ambayo si ya ulkweli yatatumiwa kwa kulinda utambulisho wa washiriki.

6. KUSHIRIKI NA KUJIONDOA

Unaweza kuchagua kuwa kwa utafiti au la. Ikiwa anajitolea kuwa kwa utafiti huu unaweza kujiondoa wakati wowote bila matokeo mabaya ya aina yoyote. Pia unaweza kukataa kujibu swali ambalo hutaki na unabaki kwa utafiti huu. Mtafiti anaweza kukutoa kwa utafiti huu ikiwa kunahali itakyojitokeza ambayo inalazimisha kufanya hivo. Hali hiyo ni kama usumbufu mkali wa kimawazo ambao utaonekana kwa kulia bila kujizuia, kushindwa kuongea sababu ya uchungu ndani ya moyo na hali ingine yoyote ambayo inaweza kujitokeza.

KITAMBULISHO CHA WATAFITI

Ikiwa unaswali au jambo lolote kuhusu utafiti huu tafadhali jisikie huru kuwasiliana na sisi:

Mtafiti mkuu: Peninah Kansime, Mwanafunzi, ambaye ansoma Shahada ya pili (maitrise) kwa idara ya Afya ya kiakili na Saikolojia kwa shule ya Sayansi ya kijamii kwa chuo kikuu cha Stellenbosch.

Nambari ya mawasiliano: (+275) 791 096626 or (+256) 700 567144

Msimamizi wa mwanafunzi: Kagee Ashraf, Profesa, idara ya kisaikolojia, Shule ya sayansi za kijamii, chuo kikuu cha Stellenbosch

Barua pepe: skagee@sun.ac.za

Nambari ya mawasiliano: + 27 021- 8083442 (Office); +27 834433002 (Cell).

Dr. Claire van der Westhuizen, Idara ya kisaikolojia na Afya ya kiakili, Chuo kikuu cha Cape town

Barua pepe: clairevdwest@gmail.com

Nambari ya mawasiliano: +27 834456016 (simu ya mkononi)

7. HAKI ZA WASHIKI WA UTAFITI

Unaweza kujiondoa wakati wowote na kusitisha kuendelea, hakuna adhabu. Huweki kando madai yoyote ya kisheria, haki au marekebisha sababu ya kushiriki kwa utafiti huu. Ikiwa una swali kuhusu haki zako kama mshiriki wa utafiti huu wasiliana na Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] kwa kitengo cha maendeleo ya utafiti. Unaweza Kuyita mwenye kiti wa TASO IRB, Bwana Bakanda Celestin kwa numberi ihi 0752774178.

SAHIHI YA MSHIRIKI AU MWAKIRISHI WAKE WA KISHERIA

Taarifa iliyo hapo juu imeelezwa [*kwangu/mshiriki*] na [*jina la mtu husika*] kwa lugha ya [*Lingala/Kiingereza/Kiswahili/Kifaransa/Nyingine*] na [*Mimi nina/Mshiriki ana*] elewa vizuri lugha hii na ilielezwa kwa njia inayolidhisha [*kwangu/kwake*] [*Mimi mshiriki*] nilipewa nafasi ya kuuliza maswali na maswali hayo yalijibiwa yakanilidhisha [*mimi/yeye*].

[*Hapa ninakubali bila kulazimishwa kushiriki kwa utafiti huu/ Hapa ninakubali ya kwamba mshiriki anaweza kushiriki katika utafiti huu*]. Nimepewa nakala ya fomu hii.

Jina la mshiriki

Jina la mwakirishi wa kisheria (ikiwa inatumika)

Sahihi ya mshiriki au ya Mwakirishi wa kisheria

Tarehe

SAHIHI YA MTAFITI

Ninakubali ya kuwa nimeeleza taarifa ambayo imetolewa ndani ya maandiko haya kwa _____ [*jina la mshiriki*] na/au [*mwakilishi wake*] _____ [*jina la mwakirishi*]. [*Yeye*] alipewa moyo na mda wakutosha wa kuuliza maswali. Mazugumza haya yaliendeshwa kwa lugha ya _____ na [hakuana mtafsiri aliyetumiwa/mazugumzo haya yalitafsiliwa na _____ kwa lugha ya _____].

Sahihi ya mtafiti

Tarehe

APPENDIX K: Consent Form for Service Providers



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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence living in Kampala.

Consent form for physical and mental health service providers of male survivors of conflict-related sexual violence

You are asked to participate in a research study conducted by Peninah Kansiime, Student, MPhil. Public Mental Health from the Psychology Department, Faculty of Arts and Social Sciences at Stellenbosch University. Data collected from this study will contribute to a thesis leading to an MPhil. Award in Public Mental Health. You were selected as a possible participant in this study because you are a male victim of conflict-related sexual violence, a refugee from the Democratic Republic of Congo (DRC), and are above 18 years of age.

PURPOSE OF THE STUDY

The purpose of the study is to investigate barriers and facilitators to physical and mental health help-seeking, among male refugee survivors of conflict-related sexual violence, living in Kampala, Uganda. The study will also elicit participants' views on solutions to overcoming barriers to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence. Congolese refugee male survivors and health practitioners providing them with physical and mental health services will be interviewed for about 45-65 minutes with the help of an interpreter that will be briefed about the study before it starts.

Interviews will be audio-recorded and I will take notes to ensure that all relevant information is captured. Information will be kept confidential and be destroyed after serving the purpose for which they will be collected. Information will be used in compiling my thesis for the MPhil in Public Mental Health and published in relevant academic journals. It is hoped that the information gathered will be an advocacy tool for the improvement of mental health services among refugees in Uganda, and also helps the Refugee Law Project further design appropriate and research based interventions for its clients. This study is sponsored by Africa Focus on Intervention Research for Mental Health (AFFIRM) based at the Alan J. Fisher Centre for Public Mental Health based at the University of Cape Town in South Africa.

1. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

You will be given a flier with information about the study that you will take home with you, to further think about the purpose of the study and decide whether you want to be a part of it. If you agree to take part, an appointment will be set for the actual interview to take place. Interviews will be held at a room allocated at the Refugee Law Project.

Consent

At the start of the interview, the aim and objectives of the study will be explained, and if you still wish to proceed, you will be given a consent form. Information on the consent form will be read to you, and you can ask questions or seek clarification. If you further wish to proceed with the interview, you will sign two copies of the consent form. One will be kept by the principal investigator, and the other will be your copy that you shall take home with you.

The Interview

The actual interview will then proceed, with the help of an interpreter if necessary. The interview is expected to last between 45-65 minutes. Only one interview will be conducted per person.

2. POTENTIAL RISKS AND DISCOMFORTS

I do not foresee any physical harm resulting from your participation in this study. However, it is anticipated that the nature of the study may cause emotional disturbances for you. In case that happens, kindly let me know so that I can stop the interview immediately. I have arranged with the counsellors in the Mental Health and Psychosocial Well-being Programme here at Refugee Law Project and they are on standby to render necessary help to you. You don't have to answer all the questions asked if you are not comfortable and also feel free to withdraw from this interview if you feel you can't go on.

3. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There are no direct benefits for you in this study and you will not be paid any money for it, however, the information that you will provide will contribute to the understanding of barriers and facilitators to physical and mental health help-seeking among male refugee survivors of conflict-related sexual violence. This information will help improve physical and mental health responses for male refugee survivors of sexual violence by service organizations locally and globally.

4. PAYMENT FOR PARTICIPATION

There is no payment for participation in this study. However, during the interview, you will be provided with a soft drink and a transport refund back to your home after the interview.

5. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of conducting the interview in a private room, and where the use of an interpreter is necessary, permission will be sought first from the interviewee.

With permission from you, data will be audio recorded and all audios, transcriptions, and personal notes will be stored on the investigator's personal computer. The files where the data is stored will be password protected and accessed by the investigator only. As a participant, you have the right to request for audios and deny their inclusion if you are not comfortable. After the award of the transcription, the audios and their transcripts will be destroyed.

Data will be coded using NNVIVO 10, qualitative data analysis software. The information may be released only to the academic supervisors for this study if there is need but the identity of the participant will be withheld by the researcher. Participants will be given pseudonyms to protect their real identity. The study findings will be published in relevant journals and as noted, pseudonyms will be used to safeguard the identity of the participants.

6. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer

and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Such circumstances may include severe emotional distress manifested by uncontrollable crying, failure to speak due to emotional pain and any other circumstance that may arise. *[If appropriate, describe the anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent.]*

7. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Principal Investigator: Peninah Kansiime, Student, MPhil. Public Mental Health at the Psychology Department, Faculty of Arts and Social Sciences in Stellenbosch University.

Contact Number: (+275) 791 096626 or (+256) 700 567144

Student Supervisors: Kagee Ashraf, Professor at the Psychology Department, Faculty of Arts and Social Sciences, Stellenbosch University

Email: skagee@sun.ac.za

Contact Number: + 27 021- 8083442 (Office): +27 834433002 (Cell).

Dr. Claire van der Westhuizen, Department of Psychiatry and Mental Health, University of Cape Town

Email: clairevdwest@gmail.com

Contact Number: +27 834456016 (Cell)

8. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development. You can also contact the TASO IRB Chairperson Mr. Bakanda Celestion on 0752774178.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE
--

The information above was described to *[me/the subject/the participant]* by _____ *[name of relevant person]* in *[Lingala/English/Swahili/French/other]* and *[I am/the subject is/the participant is]* in command of this language or it was satisfactorily translated to *[me/him/her]*. *[I/the participant/the subject]* was given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the subject/participant*] and/or [his/her] representative _____ [*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in _____ and [*no translator was used/this conversation was translated into* _____ by _____].

Signature of Investigator

Date

APPENDIX L: Uganda National Council of Science and Technology Approval Letter

Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Our Ref: SS 4040

18th April 2016

Peninah Kansiime
Refugee Law Project
Kampala

Re: Research Approval: Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict- Related Sexual Violence Living in Kampala

I am pleased to inform you that on **14/03/2016**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **14/03/2016** to **14/03/2017**.

Your research registration number with the UNCST is **SS 4040**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project.

As Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the research protocol or the consent form (where applicable) must be submitted to the designated local Institutional Review Committee (IRC) or Lead Agency for re-review and approval **prior** to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local IRC for review with copies to the National Drug Authority.
4. Unanticipated problems involving risks to research subjects/participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST review.
5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. A progress report must be submitted electronically to UNCST within four weeks after every 12 months. Failure to do so may result in termination of the research project.

Below is a list of documents approved with this application:

	Document Title	Language	Version	Version Date
1.	Research proposal	English	N/A	N/A
2.	Semi-Structured Interview Guide for Survivors	English	N/A	N/A
3.	Semi-Structured Interview Guide for Service Providers	English	N/A	N/A
4.	Consent Forms	English, Swahili, French and Lingala	N/A	N/A

Yours sincerely,


Hellen N. Opoot
For: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

cc Chair, The AIDS Support Organization (TASO), Research Ethics Committee

LOCATION/CORRESPONDENCE

Plot 6 Kimera Road, Ntinda
P. O. Box 6884
KAMPALA, UGANDA

COMMUNICATION

TEL: (256) 414 705500
FAX: (256) 414-234579
EMAIL: info@uncst.go.ug
WEBSITE: <http://www.uncst.go.ug>

APPENDIX M: RLP Approval Letter



Refugee Law Project

*School of Law, Makerere University
A Centre for Justice and Forced Migrants*



29th July 2015

The Chairperson
Research Ethics Committee
Faculty of Arts and Social Sciences
Stellenbosch University
South Africa

Dear Sir/Madam,

RE: Permission for Ms. Peninah Kansiime to conduct research at Refugee Law Project

This letter serves to inform you that, *Peninah Kansiime*, student number **19697627**, has been granted permission to conduct research at the Refugee Law Project. Peninah works as a Sexual and Gender Based Violence/ Persecution officer, and she is also pursuing a Master of Philosophy in Public Mental Health at Stellenbosch University. She intends to conduct a study on *“Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence Living in Kampala.”*

I have reviewed her proposal and study tools, and with approval from your committee, she may commence data collection, with consent from the study participants. I believe that the results of this study will support the provision of relevant and comprehensive medical and psychological services towards male victims of conflict-related sexual violence.

Yours sincerely

Dr Chris Dolan

Director

Plot 7 & 9 Perryman Gardens, Old Kampala P.O.Box 33903, Kampala, Uganda
Tel: 0414 235333 Fax: 0414 346491 E-mail: dir@refugeelawproject.org
www.refugeelawproject.org

APPENDIX N: HREC Approval Letter



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Approval Notice

Stipulated documents/requirement

21-Oct-2015

Kansiime, Peninah P

Proposal #: SU-HSD-000586

Title: Barriers and Facilitators to Physical and Mental Health Help-Seeking among Congolese Male Refugee Survivors of Conflict-Related Sexual Violence living in Kampala.

Dear Miss Peninah Kansiime,

Your **Stipulated documents/requirements** received on, was reviewed and has been **accepted**.

Please note the following information about your approved research proposal:

Proposal Approval Period: 14-Aug-2015 - 13-Aug-2016

General comments:

Please take note of the general Investigator Responsibilities attached to this letter.

If the research deviates significantly from the undertaking that was made in the original application for research ethics clearance to the REC and/or alters the risk/benefit profile of the study, the researcher must undertake to notify the REC of these changes.

Please remember to use your **proposal number (SU-HSD-000586)** on any documents or correspondence with the REC concernin your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guideli for Ethical Research: Principles Structures and Processes 2015 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-

032. We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Sincerely,
Clarissa
Graham REC
Coordinator

Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrolment. You may not recruit or enrol participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using only the REC-approved consent document and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but no less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrolment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You may not initiate any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the REC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC.

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.