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Erasmus

**REFUGEE MALE SURVIVORS SEEKING
HEALTH CARE IN UGANDA.**

EXPERIENCING AND OVERCOMING STIGMA AND CATEGORIZATION

A Research Paper presented by:

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Abstract

In this study, I looked at the experiences of survivors of sexual violence among the overall refugee population in Uganda and how the issue of sexual violence against men during conflict can become more visible, given stigmatization of male survivors of sexual violence by public opinion and the media. This study aims at exploring how stigmatization and categorization of refugee male survivors of sexual violence as homosexuals has made them invisible when it comes to accessing medical care and services in Uganda. By exploring experiences of refugee male survivors of sexual violence before, during and after accessing medical and health services in Uganda, the study seeks to make more visible how the stigmatization of male survivors of sexual violence by public opinion and medical personnel affects these survivors. By interviewing thirty individuals, including some 20 refugee men, and around 10 services providers NGO staff, and ministry officials, this study confirms that cultural stigma and categorization affect the services provided to male survivors of sexual violence in Uganda. These factors play a significant role in making it harder for refugee men who have survived sexual violence to obtain adequate medical and health care. In conclusion, the findings of this research lead to a number of recommendations as to how refugee male survivors of sexual violence could be better supported in future to obtain the medical and psycho-social services they so urgently need and deserve.

Relevance to Development Studies

Men need to be in a state of health to be able to contribute to development locally, nationally and internationally. Issues concerning their wellbeing, mental health and environment needs to be given more priority in official policies and embedded institutionally in state and private sector interventions. Uganda is a country which hosts a large number of refugees among whom are regular reports of cases connected with sexual violence among men as well as women. Men's issues concerning sexual violence are generally ignored, or have received relatively little attention, both domestically and internationally. Given that men as victims of violence clashes with the patriarchal system and hegemonic masculinity, a lot of information about sexual violence against men has been hidden or silenced, possibly to maintain masculinity norms. Most research done on the topic of sexual violence has concentrated exclusively on women. In the case of refugee men, there is double vulnerability because of their status as both victims of sexual violence and refugees, outsiders with little insider knowledge that might reduce the destructive impact of sexual violence on their lives. The study focused on exploring common myths around male rape and how it can impact on their lives, in the case of refugees.

Keywords

Refugees; Survivors; Sexual Violence; Stigma; health; medical services; experiences; invisibilization.

List of Acronyms

ACTV tims	African Centre for Treatment and Rehabilitation of Torture Vic-
FGD	Focus Group Discussion
GBV	Gender Based Violence
IDI	Individual Interviews
IDP	Internally Displaced Person
NGO	Non-Government Organization
MOHAU	Men of Hope Association Uganda
MOPAU	Men of Peace Association Uganda
OPM	Office of the Prime Minister
RLP	Refugee Law Project
RMSSV	Refugee Male Survivors of Sexual Violence
SGBV	Sexual Gender Based Violence
UNDP	United Nations Development Programme
UNHCR	United Nation High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women

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Chapter 1 : Introduction

1.1 Background to the study

In many conflict settings, sexual violence against men and boys is a common phenomenon even though attention has been on sexual violence against women (Feron, 2015). However, in the last two decades there have been documented cases of sexual violence against men in not less than 25 countries (eg DR Congo, Bosnia, Croatia) and against boys in 59 countries that have witnessed conflicts (Ba & Bhopal, 2017; Russell et al. 2007:1; Bastick et al., 2007). Sexual violence is not only destabilizing with multi-dimensional consequences, but the physical and mental impact on male survivors is also huge. Even though the 1951 Refugee Convention “states that refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to the highest standards of physical and mental health.” Many male sexual violence survivors among the refugees found it difficult to access medical care to treat traumatic genital injury (Ba & Bhopal, 2017), anxiety, depression, post-traumatic stress disorder (Priddy, 2014, pain as well as malodorous fecal leakage (Chynoweth et al., 2017:91-92).

Unfortunately, thousands of NGOs that deal with sexual violence in conflicts rarely mention the challenges of male survivors of sexual violence in accessing medical and health care, and if they do mention it, it will only be insignificant mentioning (Apperley, 2015:92). The effect is that less attention given to male survivors of sexual violence in conflict influenced the planning and designing of intervention programs such as medical and healthcare services to focus primarily on women and girls survivors of sexual violence (Christian et al., 2011:227). The implication of lack of attention makes the sensitized health services for adult, and adolescent male sexual violence survivors in conflict settings to be scarce, and obstacles to accessing care remain high (Chynoweth et al., 2017:90). Some of these barriers are cultural as well as institutional, this includes but not limited to stigma, categorization, discriminatory laws against refugees, and societal construction of masculinity and heteronormativity that depicts the survivors as weak men.

In this study, I looked at the experiences of survivors of sexual violence among the overall refugee population in Uganda and how the issue of sexual violence against men during conflict can become more visible, given stigmatization of male survivors of sexual violence by public opinion and the media. This choice was influenced by the fact that Uganda has hosted considerable population of refugees and asylum seekers and refugees from countries such as South Sudan, Eritrea, Somalia, Burundi, DR Congo, and Ethiopia all from the Great Lake Region of Africa. By the end of 2015, the total population of refugees and asylum seekers in Uganda was well over half a million (UNHCR, 2015).

In the space of three years, the figure of refugees has increase to 1.5 million with over 1.1 million refugees originating from South Sudan, the DRC contributing 288,434, Burundi, 41,932 and more than 37,000 from Somalia make the country to overtake Kenya and become the largest refugee hosting country in Africa (UNICEF-Uganda, 2018:2). The average daily new arrivals from January to June 2018 was 185 individuals from South Sudan and 488 from DRC with Eighty-two per cent of the newly arrived population are women and children,

this continuous arrival of refugees to Uganda now make the refugees to account for 3% of the Uganda population (UNICEF-Uganda, 2018:2).

While Uganda is a popular destination for many refugee fleeing conflicts in the Great Lake region, Uganda was also a massive producers of hundreds of thousands Internal Displaced Persons (IDP) due to the Lord Resistance Army rebellion led by Joseph Kony in the Northern part of the country against the Uganda army. Given the global trend of urbanization and the growing restrictions in refugee settlements; the increasing numbers of refugees in Uganda end up settling in urban centers rather than in relatively remote refugee camps or settlements in rural areas (Omata and Kaplan, 2013:6). They settle in urban areas even when this leaves them without access to UNHCR support or other support services. Unfortunately, language can also be a major obstacle for many refugees in a country like Uganda that English is the official language. This affects them by hindering them to improve livelihood as well as express themselves in fighting for their rights (Jacobsen 2006; Dryden-Peterson 2006). The vast majority of refugees with no exceptions to gender, in most cases arrives at the country of asylum with an array of traumatic issues, but due to a number of legal and socio-cultural conditions in the host country such as Uganda, they are unable to find a solution.

1.2 Statement of the Problem

Contrary to a lot of countries, Uganda is adjudged by the international community as one of the most refugee-friendly states in the region, with relatively liberal and generous refugee policies that respect almost all asylum seekers and refugees that are in line with the 1951 Refugee Convention and 1967 Protocol (UNHCR, 2015; Dryden-Peterson, 2011; Schlindwein, 2016). The Uganda refugee policy under the Refugee Regulation Act 2010 offers the opportunity to anybody fleeing threats or crisis in his/her country, who manages to enter Uganda free access to health as well as settle down in a place of their choice, including urban centers and camp settlements (UNHCR, 2015: 55). Unfortunately, several reports and studies (Dolan, 2014; Dolan et al., 2013) have revealed that the male survivors of sexual violence in Uganda couldn't access the medical and health care services because of the fear of prosecution of being gay, shame of stigma that they are not man enough to defend themselves, and the attitude of the government officials saddled with the responsibility of addressing refugees related problems

The problem is a whole series of myths that make it very difficult for people to acknowledge male sexual violence victims as genuine victims. A major issue that arose during my past work experience, during various workshops about sexual violence against men, was that many community participants rejected the notion that men could be victims of rape and other forms of sexual violence. Instead, it was believed by some that "a real man" would be able to defend himself against another man. In this case, it is concluded, a male who claims to be a victim of sexual violence must be a homosexual and must have consented.

Both victims and perpetrators are thus placed in the same category of 'deviants' as a social category, stigmatized not as perpetrators or victims of sexual violence, but as homosexuals in a society where homosexuality is a widespread

taboo. Since popular culture in Uganda is steeped in heterosexist ideology, this concurrently makes the problems of male victims of sexual violence unseen or invisible, and tends to support violence and discrimination against them, on the grounds of their imputed 'homosexuality' (Garnets et al. 1990:367)

Since homosexuals are generally assumed to engage in sexual intercourse with men also during peacetime, it is sometimes assumed this applies even during wartime sexual relations between men, where sexual violence is not viewed as victimizing men. As suggested by Sivukamaram (2005: 1285), this is to some extent a problem of language and of how male rape is conceptualized. The implication of prevailing social attitudes in Uganda is that male sexual violence survivors deserve to be sexually violated, since they are really homosexuals. Some men that were sexually violated in prison are dismissed as criminals, who again it is believed cannot be real heterosexual men if they were able to be raped and abused. Real men would resist and would not be subject to sexual abuse of any form. Since a woman cannot sexually violate a man (or so it is assumed) any man who responds to sexual abuse - for example gains an erection as a result of sexual acts with another man - through this sexual abuse has become more like a woman - therefore passive and therefore gay - than a 'real man'.

It is against the above analysis that this study aimed at exploring how stigmatization and categorization of male survivors of sexual violence as homosexuals invisibilized them in accessing medical care services and other support for refugees in Uganda; also to find out the experiences of refugee male survivors of sexual violence have before, during and after accessing medical and health services in Uganda, and finally determine how the notion of sexual violence against men during conflict become more visible to break stigmatization of male survivors of sexual violence by public opinion.

1.3 Justification and Rationale for Study

In several ways, sexual violence against men can be reinforced and perpetuated by the silence that is created by active invisibilization of victims. Some institutions have created silencing norms around male sexual violence victims as homosexuals. In many cases, these are more than physical in their impact on health. Due to profound harm suffered by most male survivors of sexual violence during conflict and during flight, they may require months of medical attention before the victim can get back to normal functionality and full productivity. While there are several studies that have looked into the impact of societal stigmatization of the male survivors of sexual violence among the refugee community, this study intends to take a step further to add to the body of knowledge by investigating how such impact can be understood by the concept of Invisibilization, therefore providing a deep understanding of the experiences of the survivors.

1.4 Myths around male victims of Sexual violence.

In Uganda the perception is that the moment a man is penetrated by another man, he is feminized (Sivakumaran 2005:1282) and becomes a sort of woman, having been emasculated. In working with a Ugandan NGO, it was shocking that some refugees internalized such stigmatization of their situation. One case

previously handled by Refugee Law Project involved a male client who called himself a woman because he had completely internalized the various myths of the community. As with any form of stigmatization, the people targeted may internalize them.

Secondly; the idea that all sexual violence against men takes the form of anal rape. Yet this is far from the truth. Harry Van Tienhoven working with Refugees Health Care Centre in Utrecht, The Netherlands, described how health and social workers assume that sexual violence against men takes the same form, anal rape (Tienhoven, 1993). Sexual violence can take many forms, including sexual slavery, enforced prostitution, genital mutilation, or being made to dance naked in front of villagers or community members - or being forced to assault someone else like a member of a family or the dead person (Lewis, 2009: 14), including another man or boy. Other forms include being forced to witness family members being atrociously raped or gang raped or even being used as a mattress as your family members are being raped. The only type of sexual abuse that women experience and which men cannot experience are forced pregnancy and forced abortion.

The UNHCR sometimes appears to have the view that male refugees who claim to have been sexually violated may be saying this in order to qualify sooner for resettlement in a third country. Scepticism and disbelief tend to meet a refugee man who tries to open up and present his case honestly to officials, counsellors and other professionals in the immigration system and oftentimes this affects their levels of disclosure and hence affecting or delaying their healing process. If the survivors feel like talking about their experiences of sexual violence, it is the hardest thing to do, because they may never have told these things to anyone. Yet sometimes he will end up being further traumatized when he is met with disbelief. It should be noted that not only UNHCR but also Government of Uganda immigration officials have this tendency to cast doubt on refugee male sexual violence victims' narratives. Washington (1999: 3) explains that official asylum institutions have played a major role in re-victimizing male survivors who go to seek the help of such agencies, and instead are often stigmatised.

Thirdly, in policy circles there is the myth that numbers involved in cases of male sexual violence are so low as to be worthy of any serious attention. Del-Zotto and Jones (2002) confirms that 4,076 NGO's work on issues related to sexual abuse yet 3% of those implement men's issues and a quarter does not recognize sexual violence against men as serious problem. This is argued that most of the NGO's depend on the government or private enterprises for funding (Zaum, 2009). This attitude emerges quite often among Ugandan NGO's for example, even those working on sexual and gender-based violence against women. To make it even more complicated, male sexual violence is not seen as a gender-based crime since it almost always involves males sexually violating males. Between agencies responsible for humanitarian assistance, there is a clique of those that push this argument that sexual violence against men is not a gender-based crime. It is implied that it should not be taken as seriously as sexual violence against women. In circles where GBV prevention and response is discussed, men's victimization is rarely considered.

Historically as well as the modern times, medical institutions have played a big role in ignoring issues related to male sexual assault but rather link them to homosexuality and calling it mental and physical disorder (Turchik and Edwards 2012). This is so because some medical personnel are still not informed or aware

about sexual violence against men and boys. This refers not only to private medical facilities but also to staff in government hospitals. Medical personnel either do not believe that male sexual violence exists among refugees or allege that those who do report such cases are insane, are homosexuals, are trying to cover over their own sexual war crimes, or are seeking special treatment as refugees (RLP, 2014:5). In most cases the perpetrator especially from conflict settings is perceived to be masculine through his power over the victim yet for the victim is labelled as feminine or gay person (Lewis, 2009: 7). In Uganda the situation is even worse, since survivors of sexual violence are stigmatized as homosexuals, in a country where homosexual acts are punishable by life imprisonment (Dolan, 2014; Dolan et al., 2013). Besides the 2012 Refugee Law Project video documentary of “Gender against Men”¹ revealed there are cases where police, rather than going after the perpetrators, have accused male survivors of rape of engaging in homosexual acts

Some other places where these myths are officially legitimated and institutionalized are within legal frameworks. There are many places where the law defines rape as something perpetrated by men against women. Uganda provides a perfect example of this. The Penal Code 123, Chapter 120 defines rape:

“as any person who has unlawful carnal knowledge of a woman or girl without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind or by fear of bodily harm or by means of false representations as to the nature of the act, or in the case of married woman, by personating her husband, commits the felony termed rape”

However it is not only in Uganda that the government laws invisibilized male survivors by the definition of rape, recently in 2006 Protocol on Prevention and Suppression of Sexual violence against women and Children also excluded men from the definition of rape (the great lakes of Africa). What was interesting about this was the huge discussion of whether there should be women and girls, girls and boys, women and children and many others but the opponents of including men and boys were United Nations Development Fund for Women (UNIFEM). They completely blocked the inclusion of men and wanted to block the boys but compromised with women and children.

1.5 Objectives

- i. Investigate the extent to which stigmatization and categorization of Refugee male survivors of sexual violence as homosexuals invisibilized them to medical, healthcare access and other government and nongovernment intervention supports
- ii. Critically examine the experiences of the Refugee male survivors of sexual violence in dealing with the invisibilization to access health services in Uganda.
- iii. Identify governmental and nongovernmental support interventions for Refugee Male Survivors of sexual violence.

¹ Gender Against Men; A Refugee Law Project Documentary
<https://www.youtube.com/watch?v=mJSl99HQYXc>

1.6 Research Questions

Main Research Question

To what extent have stigmatization and categorization of refugee male survivors of sexual violence living in Uganda influenced their experiences in accessing medical care and related support services?

Sub-Questions

- What experiences do refugee male survivors of sexual violence have before, during and after accessing medical and health services in Uganda?
- What are the factors that contributed to shaping the invisibility of refugee male survivors in their attempt to access health and medical care?

In addition, the study explores how and whether governmental and nongovernmental actors could respond more holistically or appropriately to the health needs of refugee male survivors of sexual violence in future.

1.7 Organization of the Study

This chapter has set the background for the study that sought to examine the experience of male refugee survivors of sexual violence in accessing health and medical care in Uganda. In this chapter, the statement of problem, contextual background, justification and rationale for the study as well as objectives and the research questions were discussed in details. While the next chapter focus is on the conceptual framework discussion around the concepts of stigma, categorization, masculinity, heteronormativity, invisibilization and holistic health, the third chapter focus is on the method of data collection. In chapter four, the discussion as regard the findings will be presented while the recommendation and conclusion of study will be presented in the last chapter.

Chapter 2 Conceptualizing sexual violence against men

2.1 Introduction

The focus of this chapter is to explore the literature on the discussion around sexual violence against men in conflict setting, the consequences for the survivors in relation to access to medical and health care services, in particular the refugees in their country of asylum. Considering the fact that the experiences of the refugee male sexual violence survivors are not homogenous and there are a number of concepts that are mutually inclusive in shaping these experiences. This chapter also looked into the relevant literature on the various concepts that shape the experiences of male survivors of sexual violence in conflict settings to sufficiently guide us and set the foundation for the data analysis in Chapter four of this study.

2.2 Refugee men as victims of sexual violence

Sexual violence against men in armed conflict is not a new phenomenon, in fact it has been documented for thousands of years under the various wars in ancient times where men were tortured, raped, mutilated and castrated to show conquest by the Amelike, Egyptian, Persian, Chinese, and Roman Empire armies (Graham, 2006; Solangon and Patel, 2012). However, it is only in recent times conflicts in Liberia (1989–1996, 1999–2003), Bosnia (1992–1995), Rwanda (1994), East Timor (1976–1999), Colombia (1964–present), the Democratic Republic of the Congo (DRC) (1996–present) that more attention around the impact of sexual violence on men start to gain attention from the international community (Palermo and Peterman, 2011:924).

Nevertheless sexual violence against men is often neglected mainly because of overwhelming stigma and shame surrounding it (Solangon and Patel, 2012:417) which is further invisibilized by the international media predominantly reporting women as victims (Zarkov, 2006:222) while men are stereotyped as perpetrators (Carpenter, 2006). There has been instead and understandable but too exclusive focus on sexual violence against women and girls, which has received a lot of attention (Weiss 2010; Schopper, 2015; Emily Mick, 2011; Nowrojee, 2005; Ward and Marsh, 2006).

Unfortunately, this has led to the numbers of men affected by sexual violence being underestimated by researchers (Dolan, 2014). The argument is supported due to lack of conducive environment provided to male survivors to speak freely about their past sexual violence experiences. Also it should be noted that male victims fear of prosecution by the existing laws which perceive them to be homosexuals for example Anti Sodomy laws (Dolan et al. 2013) plays a role in limiting their disclosure.

A few studies are now emerging on male sexual violence victims, and these studies have adopted different methodological approaches. Such studies are starting to reveal that men - like women if on a lesser scale - especially encounter serious sexual violence in conflict settings, during war and displacement. For

example, Johnson et al. found that 23.6% of men (or an estimated 760,000 men), almost one-quarter of the total male population in the Eastern Democratic Republic of Congo (DRC) had firsthand experience of sexual violence themselves (Johnson et al., 2010: 553-562). In the Liberia case, the same study found the figure was even higher among former male combatants - 32.6%. Even though sexual violence against men is usually much lower than against women in such conflict situations², the problem is still a serious one and should not be minimized (Johnson et al., 2010: 676-690).

The study by Johns Hopkins hospital on the incidence of sexual violence against men shows 447 male refugees aged 18 years and older settled in the Western Uganda settlement were screened on issues regarding sexual violence. The study showed that 13.4 percent were victims of sexual violence. 99 percent of male victims came from Conflict related area known as the Democratic Republic of Congo and had stayed over a year in the settlement ranging from 0-17 years old. 38.5 percent suffered sexual violence in their whole lives (Dolan, 2014:2).

Nagai and colleagues had previously looked into the Sudanese refugees in Uganda and discovered that 30.4 percent of men had either witnessed or experienced sexual violence while 46.9% of non-refugee Sudanese men residing in conflict-affected areas in Sudan had experienced or seen the sexual violation of a man (Nagai et al., 2008). Besides the All Survivors Projects March 2018 reports on Central African Republic revealed that between the months of January and October of 2017, 121 male survivors of sexual violence were received by an NGO working the Obo region of the country (ASP, 2018: 15)

Although not as vulnerable as women during wartime, however, studies revealed that about 80% of men had expressed suffering sexual abuse during torture (Meger, 2015). Duroch, & Schulte-Hillen, (2014) examined the data of Médecins Sans Frontières (MSF) on sexual violence in 61 countries that have witnessed conflicts between 2004 and 2013. The study revealed that approximately 5% of the survivors of sexual violence out of 118,000 were male. Yet, Duroch, & Schulte-Hillen cautioned that it is possible the data did not truly represents the extent of the sexual violence on men considering the fact that there are various barriers that hinder men and boys not only from reporting but also to seek medical care. Barriers such as social ridicule categorizing them as weak and not able enough for allowing themselves to be assaulted. The consequences of this categorization are discrimination, stigmatization, and in some cases ostracized from the community: For those that are married, they might be abandoned by immediate families and wives (Feron, 2015; Dolan, 2014; Johnson et al., 2010; Carlson, 2005; Osterhoff et al., 2004) Moreover, the line between homosexuality and male rape is more and more becoming blurry in eyes of the public with the help of Uganda media shaping opinions (Sivakumaran, 2005; Gear, 2007;).

In an article by the former Prosecutor of the International Criminal Court, Luis Moreno Ocampo, wrote about the issue of investigating sexual gender-based crimes. He pointed out that even in the 1979 Convention on the Elimination of All forms of Discrimination Against Women, sexual violence was not

discussed. In late 1992, the recommendation stated that definitions of now include gender-based violence against women, since women are affected disproportionately. The dominant thinking, as already stated, is that gender-based violence is only about women (Moreno-Ocampo, 2010).

UN Security Resolution 1325 and the resultant Women, Peace and Security Architecture (UNSCR 1325, 2000), called on all parties in conflict to take special measures to protect women and girls from Gender Based Violence (GBV) and other forms of sexual abuse and violations in situations around conflict (United Nations Security Council, 31 October 2000). This declared urgency of GBV as safety problem (Carpenter, 2006: 85). More focus is concentrated on the women issues not giving more attention to issues affecting men. For example, the dominant narrative about sexual violence as a weapon of war is around women while little attention is given to sexual violence against men as a weapon of war (Manivannan, 2013). Moreover, many international organizations are not thinking big, their thinking is about a particular sub group. They are still stuck with the idea that they should break the silence of gender-based violence against women or girls, male and female inequality in patriarchal systems which is very good but as the UN body it is not enough because issues of men and other genders are not fully captured under this body.

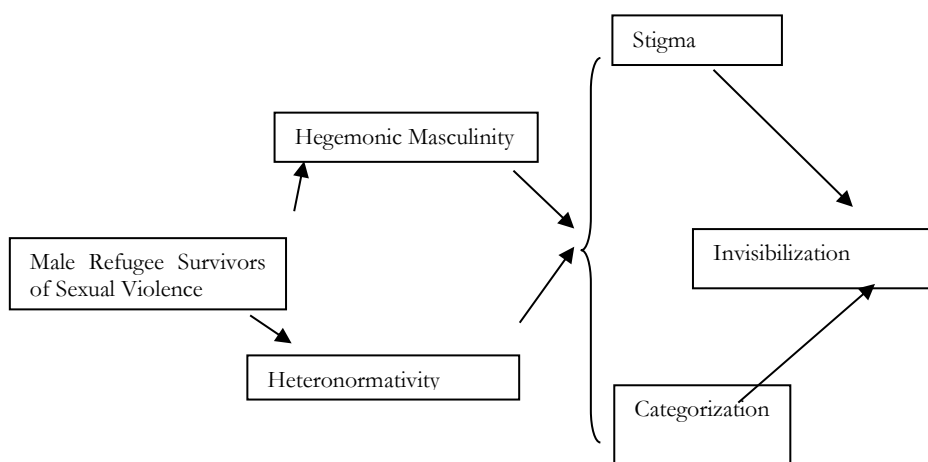
The underreporting and nondisclosure of male victims of sexual violence in conflict setting to the authority is deeply embedded in the societal narrative and construction of masculinity even during the peacetime. For example, a survey that was conducted in the United Kingdom shows that 40 of the sexually abused men, 5 got the confidence to report to police about their past sexual violence experience (Walker et al., 2005). According to US department of Justice, 2003 numbers of women victimized are higher than men due to the fact that male victims compared to female victims may skewed because of gender differences in reporting rates (Chapleau et al. 2008;601).

For men, however, there has been under-reporting, poor detection and recording and a lack of support services. Another problem has been narrow legal definitions of rape that do not include sexual violence against men, and so do not protect male survivors of rape (Chynoweth, 2017:12). The few reported cases of male survivors to the authorities or medical practitioners are justified by the little attention given, little knowledge and lack of skills on how responders should identify and treat men who have experienced sexual violence (Tienhoven, 1993). However, it is not surprising that men that are skeptical to report sexual violence during peacetime also find it difficult to disclose the experiences during conflict

2.3 Conceptual framework

In this research, the concept of intersectionality was used in explaining the mutual inclusive relationship between various concepts and how they reinforce each other in shaping the experiences of male refugee survivors of sexual violence in conflict setting in accessing required medical and health care services in the country of Asylum.

Diagram 1: Intersectionality of sub-concepts that impact on the Access to Medical and Health services



Ordinarily, refugees that settle in the urban centers face untold hardship and challenges; however, it is a triple burden on those that are survivors of sexual violence during the war. Intersectionality is crucial to the understanding of the intersect of heteronormativity and hegemonic masculinity that led to stigma and categorization among others to that end up to invisibilized the survivors to medical and health care services that other refugees enjoys.

Apart from setting the foundation to understand how various concepts intersect with each other in denying the survivors access to medical care in Uganda, it also helped in examining fundamental roles that certain social factors plays in contributing to the undesirable medical and health services opportunity available to the male refugee survivors of sexual violence. Considering the fact that refugees experiences are heterogeneous as a result of differences in religion, ethnicity, age, just to mention a few, intersectionality served as an interlocking systems that help us to understand how all various concepts and social factors of oppression overlaps to establish imbalanced social relations (Lutz Vivar and Supik 2011:3-8) when it comes to access to medical and health services.

2.3.1 Stigma and Categorization

In an attempt to have a clearer understanding of how the conceptualization of sexual violence against men impacts on the lives of survivors and their access to medical and healthcare services, a number of concepts were useful in analyzing the data which was collected from the field. One such concept is stigma. According to Khan and Loewenson (2005:3): “the term stigma originated in ancient Greece where slaves and criminals were branded to show that they were outcasts. Stigma can be experienced internally (self-stigma) or externally (discrimination)”.

Although the concept of stigma is widely used from diverse perspectives, the meanings and interpretation of the term are often quite vague (Parker and Aggleton 2003:15). Stigma implies a high level of cultural intricacy and complexity, and according to Goffman, is “an attribute that is significantly discrediting, which, in the eyes of society, serves to reduce the person who possesses it” (1963:12). For Goffman, groups and individuals that are stigmatized are often condemned as unworthy or ‘cheap’ in public perceptions, and are downgraded

from a 'normal', or whole person to a discounted or tainted person. They may also become ostracized or even prohibited from public and private spaces that offer real-time opportunities required for health, well-being and survival, such as hospitals or clinics, for example. Those in society who are subject to stigmatization may also lack the confidence, or may be afraid, given the tendency for violence to be used against them with impunity, to confront directly the stigma and the negative attitudes that may influence them. Indeed, the stigmatized may eventually opt to exclude themselves from mainstream society.

While Goffman tends to accentuate that stigma and discrimination work in relation to variances, For Parker and Aggleton (2003), stigma works more noticeably in relation to social and structural inequalities. Parker and Aggleton maintained that, stigmatization is a component of multidimensional wrangles for power that are entrenched at the crux of social life. "Stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality" (Parker and Aggleton, 2003: 18). This explains why barriers, including homophobia, biased legal frameworks, gendered stereotypes and prejudice, social taboos, and government limited funding frustrate men and boys that survive sexual violence efforts from accessing the services they need. Various scholarships (Touquet, & Gorris, 2016; Sivakumaran, 2007) shows that male survivors struggle to divulge or seek support for their predicament as a result of the social constructions of masculinity which abhor the idea that a male can be sexually victimized. This is why it takes many male survivors more than a decade to reveal their sexual violence experiences as they find it difficult to articulate their experiences of sexual abuse because, if they do so, they will be violating the masculinity norms which might lead to social stigma (Peel et al., 2000). Besides, they find it difficult to intellectualize what they have been through as sexual violence because traditionally, such experiences are most often socially constructed to be a "woman's issue" (Féron, 2015; Apperley, 2015; Sivakumaran, 2007).

To facilitate the data analysis from the field study and, above all, to highlight the consequences of stigmatization on male survivors of sexual violence among the refugees in Uganda to access medical and healthcare services. The study critically examined the practices of categorization of refugee male survivors of sexual violence as homosexuals in Kampala, Uganda. Categorization as articulated by Leuda et al., (2004: 244-245) shows that the day to day understanding about people is structured in membership categories, which are created by category-bound undertakings, together with the rules for their application. As Hausendorf (2000) argued, "knowledge about people as it is locally invoked and reproduced...and categorizing is normally done to accomplish something other than just categorizing" (Hausendorf, 2000 cited in Leuda et al, 2004:244). The idea of categorization is typically used in the creation of social construction that reinforce separation terms such as We, Them, Us, and Ours usually deployed to reject others people interest in specific circumstances and not just a mere representation.

The Categorization of male survivors of sexual violence provides an explanation as to why refugee male survivors of sexual violence may be struggling with guilt and deep shame. Some survivors struggle with their own gender identity and sexual orientation, leading to the public myth that male survivors are, or have become, gay (Solangon & Patel, 2012). Others, subjected to social ridicule, are blamed for their own assault, and are ostracized. There are, for example,

adult men who are abandoned by their wives and families (Feron, 2015). Several studies (Krug et al., 2002:154; Priddy, 2014: 271) have revealed that societal stigma and categorization of male survivors of sexual violence can lead to anxiety and depression, self-harm, sleep disorders, and even suicide attempts, to mention a few negative outcomes. Again, according to Goffman,

“society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories ...The routines of social interaction in established settings allow us to deal with anticipated others without special attention or thought” (1963: 11–12).

As a result, categorization is principal to the social construction of identities that are essential to how Ugandans, both government officials and the general populace perceives male survivors of sexual violence. As Bourdieu argued, the way people are categorized is critical to whether they will be on the losing or gaining side of social relations (Bourdieu, 1980 cited in Moncriffe, 2006: 41). The implication of Bourdieu position is that, the people in charge of government policies might have different interpretation to the label and categorization of the male survivors of sexual violence as homosexuals.

Without a doubt, male survivors of sexual violence among the refugees in Uganda have been categorized and stigmatized as homosexuals which is a crime punishable by life jail term in Uganda. It is noteworthy to emphasize that social categorizations are exceptionally dominant in the construction as well as the reproduction of social identities (Jenkins, 1994: 197). Nevertheless, Jenkins upheld that “the impact on identity of categorization depends not simply on cognitive internalization, but also on its consequences, and the capacity of actors to make their identifications of others counts” (Jenkins, 2000: 7). Therefore, making the categorization of refugee male survivors of sexual violence count depends on the acceptability or rejection of such label by the male survivors of sexual violence themselves among the refugee population in Uganda. For all intent and purposes, this study seeks to understand how refugee male survivors of sexual violence react to the categorization as homosexuals by the community in their bid to access medical and health care services.

2.3.2 Heteronormativity and Other Masculinities

Empirically, it has been established that men suffer sexual violence just as the women in conflict setting but due to men underreporting of their sexual violence encounter because of shame, stigma, categorization and in some cases societal exclusion. The concern now is that why do men have to be ashamed of violence perpetrated against them, the best explanation is deeply rooted in the concept of Hegemonic masculinity and heteronormativity. Hegemonic masculinity connotes the dominant model or ideal of masculinity in societies which is contrary to the subordinate masculinities that do not meet up with the required expectation of the social construction of masculinity (Connell, 2005).

The concept of hegemonic masculinity was developed by Connell (1987) to represent the type of masculinity that exist within a specified “society-wide and historical setting that legitimates and structures hierarchical gender and power relations between women and men; between femininity (although femininities can be constructed in and through male bodies) and masculinity; and between

masculinities, such as ethnic minority masculinities and gay masculinities” (Javaid, 2017:200). In this instance, the refugees can be regarded as ethnic minority masculinities in Uganda. Masculinities is a “social construction” and scholars (Connell & Messerschmidt, 2005; Connell, 2005; Kimmel, 2003) have argued for years that what it means to be a woman or a man is not defined by the biological morphological sex marker but depends on the culturally defined expectations and conducts expected from each sex category.

Therefore, when a man failed to meet up with the culturally defined conducts expected from them based on masculinity, it might be detrimental to their sense of self-identities as men. For example, the cultural expectation of men is to be invulnerable, powerful, impenetrable, sturdy, and reliable is alien to the reality that men can be sexually victimized (Connell, 2005; Connell & Messerschmidt, 2005; Lees, 1997) most especially in a conflict setting. The hegemonic masculinity narrative of men are not supposed to be a victim of sexual violence because real men ought to fight off perpetrators symbolized male survivors of sexual violence have failed as men (Javaid, 2014). The implication is that male survivors of sexual violence will be reluctant to seek for medical help because they will not want to be labeled as a victim because the label of the victim has the propensity to suggest stigmatized connotations of weakness and loss. These stigmatized connotations openly dare or threaten the general norms of men’s hegemonic masculinity

When it comes to the conceptualization of the heteronormativity, it can be conceptualized in multifaceted ways because what appears to be clear from one perspective can be obscured from another point of view (Jackson, 2006: 106). Although the diverse conceptualizations of heteronormativity enable us to see relevant social issues, for example, sexual violence in ways that are the construction of one’s cultural understanding (Weeks, 2017). The cultural understanding of heteronormativity as suggested by Rich (1980) is useful in comprehending the process involved in how sexual violence against a male is constructed through social structure, social institutions, and social practices. The construction is so ‘normal’ that it becomes undisputable except proven otherwise. For Jackson (2006:107), heteronormativity defines not only a normative sexual practice but also a standard way of life”. It is a normalization that epitomized the culturally hegemonic heterosexuality that shapes the ill-treatment experiences of male non-combatants during the conflict (Jones, 2006:451). As a result, male survivors of sexual violence in conflict setting tends to become invisible because their experiences during conflict setting are tantamount to a taboo in a heteronormative defined society.

2.3.3 Visibility and Invisibilisation

The impact of stigma and categorization of male survivors of sexual violence among the refugee population in Uganda can be understood better through the concept of invisibilization. Invisibilization figuratively means making something invisible. According to Herzog (2018:17-19), invisibilization is a social construct that establishes a discourse around issues that concern specific minority groups, so that the issue becomes hidden from the mainstream discourse or visible. This type of construct can either make the problem facing refugee male survivors of sexual violence in Uganda invisible to government policy intervention and public amenities such as health care or to be misrepresented by invisibilizing them, something that is not their fault but as a result of social construction.

The implication of making male refugee sexual violence survivors invisible will not only exacerbate their vulnerability to be exploited and used but also it will deny them of their basic needs of survival going by the argument of Herzorg (2018). While invisibilization makes vulnerable group invisible, it also highlights the impossibility of perceiving the other in an empathic way (Scotland-Stewart 2007). Nonetheless, as Honneth (2001) suggested, there is also social invisibilization (Honneth 2001). This term refers to the socially “created capacity “to look through” the other even when physically present. Invisibility involves current behavior and the determination to “look through” the other, which “demands gestures or ways of behaving that make clear that the other is not seen not merely accidentally, but rather intentionally” (Honneth, 2001:112). For Honneth, this invisibilization becomes a “public fact,” that create the prospect of looking at others that seem not to kowtow to the conventional and cultural acceptable norms differently. It is apparent that the male sexual violence survivors suffered the invisibilization as described by Honneth because the society did not see them as a true representation of men that cannot be sexually violated.

2.4 Conclusion

This chapter explores the role of heteronormativity and Hegemonic masculinity as they strengthened the culturally hegemonic heterosexuality that shape the experiences of male Sexual violence survivors in conflict setting. This is because both concepts remains strongly in tact in many segments of society. It is the normalization of heterosexuality through social structures, social practices, and social institutions. It looks at how the concept produced stigma and categorization that in turn invisibilized the refugee male survivors from the mainstream society basic amenities such as health care. We also look at the concept on intersectionality and how the concepts such as stigma, categorization leads to invisibilization of the refugee male survivors in accessing healthcare.

Chapter 3 Methodology and Fieldwork

3.1 Introduction

The essential component of any research lies in how the study is conducted, in particular, the research method adopted for both the data collection and the analysis of the data collected. This is because research methods help us collect samples, data and find a solution to a problem. In this chapter, the manner in which the study was conducted most especially, the key components such as the research design, scope of the study, population, sample size and sampling techniques, research instruments, procedure and data analysis are discussed in details. The first part of the chapter focuses on the research design while the second gives a brief description of the study area. The third and fourth sections discuss the process of selecting respondents and the process that data were collected from the respondents respectively. The fourth section also focuses on the ethics and challenges encountered during the research

3.2 Research design

The study adopted a qualitative research technique, to be specific semi-structured interviews and focus group discussions. This design was employed because it is more appropriate in obtaining views on precise areas of research that is more personal to the targeted respondents. Moreover, “interviews are a useful tool which can lead to further research using other methodologies such as observation and experiments” (Jensen and Jankowski 1991:101). The method enabled the researcher to inquire about the experiences of male survivors of sexual violence among the refugee population in Uganda deeply when they attempt to access health care services.

The adoption of focus group discussions as another method of collecting data was because focus groups discussion “are capable of bringing into play important discourses that people use to establish social bonds and identities” (Kvale & Brinkmann 2009: 158). Those that are shy to express their opinion individually might gain the confidence to speak out. During data collection; eight respondents participated in each of the two focus group discussions. The rest of the participants were engaged in using individualised interviews (IDIs). The questions asked can be found in Appendices 1, 2 and 3. Generally, qualitative research enabled the researcher to ask participants broad and open-ended questions which were relevant in obtaining detailed views which were pertinent in addressing the research questions.

3.3 Study Area and Target respondents

This study was conducted in Kampala and Isingiro districts in Uganda. The focus on the two environments was to help understand the differences in the experiences of male survivors within two sampled areas in accessing health services.

Although it is becoming more common to confine refugees to settlements, even in Uganda, this study considered both urban refugees, self-settled in Kampala (Targeted Men of Hope Association) and Nakivale settlements in Isingiro district (Targeted Men of Peace Association).

To achieve the objective of this study, Men of Hope (MOH), Men of Peace Uganda (MOPAU) Associations for male survivors of conflict-related sexual violence were contacted for data gathering. These groups emerged out of Refugee Law Project's work with individual survivors. They started as support groups but later became associations due to the increased male individuals presenting with challenges resulting from conflict-related sexual violence areas and the enthusiasm to advocate and create awareness or give hope to victims around the country. I decided to choose MOPAU in particular because there were refugee protests in 4th September 2017 against the United Nations High Commission for Refugees and World Food Programme for failure to provide them with basic needs, so this made me interested in visiting this camp.

Also, key informants (medical service providers, Counsellors and policy makers) were selected from some NGOs and government agencies working with refugees. This was done to enable the researcher to gather data from both male survivors and available lead players in providing services to the victims. Data collected from MOHAU and MOPAU through semi-structured interviews and focus group discussions was analysed through the lens of various concepts as discussed in the previous chapter.

3.4 Sample size and selection

For this study, a sample of 30 participants was targeted. For gender equality, out of the ten targeted key participants, 5 were males, and 5 were females. Generally, the study captured a small but focused sample which reduced expenses and time as compared to studying the whole population. Being qualitative; the researcher considered the selected participants to ably supply relevant and detailed information for this study based on the flexible data collection tool. The sample breaks down is shown in the table below.

Table 1: Sample size

Category	Target Quota		Achieved Quota	
	Male	Female	Male	Female
Refugee Male Survivors of Sexual Violence	20	0	20	0
Medical Attendants	2	2	2	1
Counsellors	1	2	1	1
Policy Makers	2	1	1	1
Total	25	5	24	3

The study employed non-random sampling techniques, and particularly purposive sampling was used. Purposive sampling also known as judgement, selective or subjective sampling is a sampling technique in which a researcher relies on his or her judgement when choosing members of the population to participate in the study. This sampling technique allowed the researcher to choose people whom he was sure could correspond to the objective and purpose of the study.

3.5 Data collection Process and Ethics

During the initial stage, the researcher reviewed existing literature and information about male survivors of sexual violence, drafted research tools (interview guide, consent forms and this phase were closed with tool approval. This was followed with primary survey activities including sampling (see Table 1 above), pilot data collection and final data collection. During the pilot, 3 participants were engaged in this exercise including two male survivors of sexual violence and one key participant, but these were not part of the final data collection. The Key objectives of this pilot included; determining whether the interview guide was understood by participants, testing the interview length, testing the flow of the interview guide, assessing the appropriateness and relevance of the questions and testing completeness of the questions (for final questions see Appendices 1, 2 and 3). After the pilot exercise, some changes were made on the interview guides to come up with the ultimate tools which were used during data collection following appropriate research ethics.

According to Chris (2000) ethics of research refers to the moral justification of the investigation or intervention; as regards the minimal abuse, disregard, and safety, social and psychological well-being of the person or community. Attention to ethical issues in qualitative research is increasingly recognised as essential. There is no set of standards which can address every ethical circumstance. However, the researcher sought permission from the research coordinator of academic affairs to conduct the study. The study was strictly academic, and utmost confidentiality was observed since names of the participants were not requested for and during data analysis, each participant was given a unique code. Although Refugee Law Project; the organisation that the researcher is affiliated to works directly with some of the targeted respondents, nevertheless, the researcher ensured that participants' consent was sought to participate in research by signing a consent form. Research ethics are part of the survey exercises from the preliminary stages to the final stage of reporting.

After getting an approved interview guide for male survivors and key participants were employed during data collection. Before conducting an interview, several appointments were made with the targeted respondents. Through purposive sampling, I managed to get the survey participant's contacts (phone contacts & emails) through participants' referrals. Making appointments for IDIs was easier compared to FGDs appointments. Therefore for male survivors, in particular, the researcher utilised the Male survivors' associations which are affiliated to Refugee Law Project. Contacts of the associations' leaders were sought for, appointments made and finally accepted to participate in the survey. This process consumed much time because I started on it four weeks before the commencement of data collection. RLP staff in Kampala and Nakivale played a significant role in linking me to MOHAU and MOPAU respectively.

Before heading to Uganda, my target group was Men of Hope Association in Kampala, Family Doctors clinic and ACTV. However, during sampling, I consulted with different refugee law project staff, I realised that there was also Men of Peace Association in Nakivale settlement and Men of Courage in Gulu district. Therefore I revised my sample splits to target MOHAU in Kampala and MOPAU in Isingiro for comparisons. I started with MOPAU in Nakivale refugee settlement because it was very far from my area of residence. This area

is located 308km away from Kampala (my residential area). I incurred much money to hire a private car for some days since in the camp; there was no public transport to go to all the places where I wanted to visit. More still, some respondents lived in deep villages which complicated the mobilisation process. Therefore, I had to put more extra money to transport them to the agreed venue, offering transport back home and offering them lunch.

Before the FGD MOPAU, three days were spent having interactions and discussions about the purpose of this research. This was mainly between the researcher, MOPAU president and the vice president. When they accepted, they engaged their members who agreed to participate in the survey. Since they were coming from long distances to the agreed venue, I had to foot their transport facilitation and refreshments. The venue was confidential since other refugees who were not part of the association could not hear the discussion. It took them around 3 hours to have the full FGD team. Therefore, the researcher started with an IDI with the vice chairperson of MOHAPU. This was also done to build confidence in the rest of the members that the survey was confidential and straightforward.

Fig 1: Male Survivors Survey Timelines



**Male Survivors
Survey Timelines.xlsx**

Finally; the expected participants (8 participants) arrived, RLP staff in Nakivale officially introduced the researcher who was dressed in the RLP attire and informed them that he is also part of RLP. The chairman and vice chairman informed their colleagues this is the researcher we were telling you. The researcher briefed the participants on survey background, interview length, and confidentiality and survey objectives. Finally, 1 FGD and 2 IDIs were completed since respondents opened up. The whole exercise in Nakivale settlement Refugee camp took three days. On the 4th day, I travelled back to Kampala. Following the same strategy, the chairman of MOHAU connected me to the team, and I managed to conduct one FGD and 2 IDIs. Most of the respondents reached in the time since they were not staying very far from the venue. After completing the quota for male survivors of sexual violence, I started to work on the key participants' quota. Throughout data collection, all participants participated voluntarily, and that is why some three key participants never participated. After data collection; there were other activities which followed including; coding, gridding, data analysis and reporting. This data collection process had so many activities which happened on different dates as detailed above in the excel insert.

3.6 Conclusion

In this chapter, the detail discussion as regards the process and tools deployed to acquire relevant data for the study are presented in details. Based on the data collected, it is evident that making use of qualitative interview and focuses group discussion research method offer the opportunity to acquire a wide-

range on credible information that speaks to the heterogeneity of the male refugee survivors of sexual violence. This methodological approach also helped in covering the limitations of some refugee male survivors of sexual violence who could neither read nor write. The approach adopted in this study offered them the opportunity to have their voices heard. While the method of data collection, as well as sample size adopted for this study, has proven to be the most suitable for addressing the study objectives and research questions of the study.

Chapter 4 Providing Health Care: A Herculean Task?

4.1 Introduction

This chapter presents findings derived from the semi-structured interviews and focuses groups discussion conducted for data collection to answer the research questions posed in chapter one of this study. The presentation and discussion of findings are done concurrently. The chapter explores the experiences of refugee male survivors of sexual violence before, during and after accessing medical and health services in Uganda as well as the factors that contributed to shaping the experiences of refugee male survivors that are stigmatised in their attempt to access health and medical care. This is done to answer the main research question that seeks to understand to what extent stigmatisation and categorisation of male survivors of sexual violence have as homosexuals invisibilized refugee male survivors in accessing medical care services and other support for refugees in Uganda

In this chapter, we also look at the governmental and nongovernmental responses in relations to support interventions available for refugee male survivors of sexual violence and how best they could respond in future to the plights of the survivors. However, it is important to emphasise that, throughout this chapter, the views of survivors that decided to stay in the government refugee settlement and those that choose to reside in the city of Kampala are represented. This was deemed necessary because it allows us to make sense of the responses of both the relevant government officials and NGOs to the plights of survivors as well as helping in having clarity on the argument of differences in the survivor's experiences in accessing health care in the city and the settlement.

4.2 Limited Capacity or Limited Will? The question of Access

When it comes to experiences of survivors in accessing health care, many studies had identified different barriers which include non-disclosure of their health conditions until when their condition became worse as well as shame that hinders them to access required health care. However, when survivors eventually muster the courage to disclose their health condition, one of the main concerns of the participants of this study that resonates with previous findings of other studies (For example Christian et al., 2011:237) is the limited capacity of health care providers to care for male survivors. Besides, there are inadequate medical supplies in the local village health centres and hospitals to provide them with the necessary treatment required for their wellbeing.

From the discussion with survivors during the focus group discussions both at the Kampala city and Nakivale refugee settlements, improper treatment services, untrained staff (medical staff, counsellors and protection officers) and unreliability of medical services are on the top of the list of issues they encountered when they attempt to seek medical attention. While one can argue that survivors

in Kampala city can still access the health facilities in the Kampala been the capital city with modern day health RMSSV, the situation the Nakivale Refugee settlement camp. According to a survivor from DRC that have been in Uganda for the past 15 years:

“I cannot call what we have in Nakivale a medical facility or service because even the conditions of the medical service back home during the war is not as worse in comparison to what we have here in Nakivale. You can imagine, only one counsellor in the whole camp to provide psycho-socio support to all refugees who are over 5000. Besides, doctors are so limited even to address a large number of women survivors not to talk of the men as the limited doctors will want to attend to women injuries and need first” (Anonymous 2, a married man aged 62 years from DRC, current resident of Nakivale Refugee Settlement).

The accounts of the survivors echo the UNHCR 2017 report that there is a paucity of health facilities, life-saving drugs as well as essential medical supplies most especially in areas with high numbers of new arrivals (UNHCR,2017:77). Similarly, a joint report by the UN and the Uganda government revealed that the health workforce is overstretched, affecting the delivery of health services, in particular, 43% of health services are operating from temporary structures and ambulances are old and inadequate (Government of Uganda and UN, 2017:8). With the experience of the MRSSV in the refugee settlement that shows the inadequacy of both the medical facilities and staffs impacted their access to health care, one would have expected that the experiences of accessing medical care in the city should be more encouraging.

Unfortunately, the accounts of the survivors in the city are even more frustrating. From the discussion I had with them, they were more frustrated with disappointment since their expectation of what to meet in a city regarding access to health care because many of them used to stay in camps before relocating to the city with the hope of accessing better medical care. One of refugee male survivors from DR Congo who resides in Kampala was of the opinion that, the pain of not accessing medical facilities would not be much if everybody knows that there is no hospital or medical staffs that can attend to male survivors in Kampala. At least they knew that it was not there in the settlement that was why many choose to reside in Kampala. The respondent was so emphatic about his disappointment in what he met in Kampala;

“You see many of my friends that are male survivors have given up, and some have committed suicide while others have decided to pick up arms and join the government or the rebel’s forces to avenge the violation they suffered. I decided to stay alive and continue moving with the hope that when I get to Kampala, I will be able to access health care. Unfortunately, when I went to one of the government hospitals to complain about the sleepless night I am having and flashbacks that in most cases make me to blackout or fall, the doctor just recommended sleeping tablets that on my own I have been using for more than six months that did not work. I went to other hospitals, at least three of them to see different doctors with the hope that the first one did not know what he is doing, but they are all the same recommending sleeping tablets” (Anonymous 1, Age 25, Resident in Kampala city, FGD).

It is evident from the expression of the respondents that Psycho-social support is a critical protection need for survivors. Most refugees are witness to or are victims of varying forms of violence, and therefore have a need for psycho-social support on arrival in Uganda (UNHCR, 2017:77) because suicide has been reported among South Sudanese refugees shortly after their arrival (Government

of Uganda and UN, 2017:8). The concerns of receiving inappropriate treatments, declined appointments from health care providers is widespread among the survivors both in Kampala and Nakivale settlement but in the settlement is very common. Survivors they mentioned that they usually go to hospitals when they have psychological problems but doctors end up giving them strong medicine for deep sleeping. From their perspective, they believed that the decision of many doctors to give them strong medicine was a calculated attempt to make them forget what happens to them which in real sense does not work. The consequences of delays in appointments or not honouring the appointment given to survivors intentionally or unintentionally as a result of the shortage of staffs as well as mistreatment is that the health condition of male survivors is at risk of getting exacerbated when not addressed at the appropriate time. One participant in his early 50s, resident in the Nakivale settlement also said that :

“...it seems in Uganda there is no hospital available to treat trauma problems. When we go to the hospital, instead of giving you the counselling you need, they rather give you medicine for mental disorders. You can even see an example from my medical record book. They wrote that I am suffering from trouble sleeping or bad dreams” (Anonymous 5, Age 50, FGD).

Be that as it may, it becomes imperative to understand where survivors are getting treatments if they could not access necessary medical services for their wellbeing as the findings suggest. From the conversation with all the survivors during the focus group discussion, it was discovered that not less than 14 of the 20 of them received proper treatment from one private hospital located in Ntinda (Ntinda Family Doctors hospital), just some few miles outside the central Kampala. Survivors claimed they found well trained medical attendants who understood their predicaments by administering the proper treatments to them, and as a result, they feel better and witnesses significant improvement. However due to financial hardships, most especially those that have to travel from Nakivale to Kampala were unable to complete their treatments because Refugee Law Projects, a non-governmental organisation that referred them to the private hospital was not in a position to foot all the bills for entire costs of treatments. One of the respondents explained further that;

“I think, it is only in private hospital one can get fair treatments because the doctors at the Ntinda Doctor's clinic understood us, although, after the first or second treatments the vast majority of us could not continue the treatments because of lack of money. For example transportation from Nakivale to Kampala is too costly which end up making the so call initial proper treatments becomes inconsequential when one could not finish the treatments” (Anonymous 4, Age 40, FGD)

From the experiences of the male survivors in accessing health care, it is now clear that having the rights to access health care as stipulated in the Uganda Refugee Act and other international legal documents do not necessarily mean accessibility of such rights. It has been broadly stated that health personnel's are not trained to spot the signs of sexual violence against men, as men are not perceived as being vulnerable to it (Oosterhoff et al., 2004:68). Even those who are trained to look for signs of sexual abuse of men may focus only on the crime of rape, due to their familiarity with female sexual violence, which often takes the form of rape (Sivakumaran, 2007:256). For many male victims, the sexual violence they have experienced is "ignored or treated as physical violence", meaning that they fail to receive adequate treatment or reparations (Kapur and

Muddell, 2016: 12-13). This practice omits the many forms of male sexual violence that are frequent in armed conflict, but that may not leave any physical scars to stand out to medical workers (Sivakumaran, 2007:256).

4.3 A Medical Myth “A raped man is a homosexual.”

During the interviews, many participants shared varied experience concerning the societal centred difficulties in the quest to recover as survivors. Several issues were reported including social discrimination from the host communities, insecurity due to fear of arrest and prosecution, stigma from fellow refugees and, unpleasant social judgments from arising attitudes of health care workers as well as some NGOs officials to mention a few. All these contribute to the categorisations of male survivors basing on the community stereotypes. From the findings of this study, survivors alleged that the community people including community leaders and fellow refugees who are not survivors identify male survivors as gays. The situation became alarming because they belong to their self-help associations of survivors, people allege that these are well-organised groups to promote gay behaviours. They are isolated by several community organisations and activities like community policing that can assist them or help them in the awareness of getting the medical aid they required. Most importantly, those people that are in power (local council leaders) to help survivors labelled them homosexuals, and therefore stigmatisation and insecurity come into play. One Burundian male survivor who passed through a traumatic experience in Burundi when the soldiers forced sharp objects to his anal region shared his frustration that:

“In my country before the war, community and charity organisations usually help sick people that cannot go to the hospitals. Unfortunately, the community and charity organisations here refused to render medical assistance to us as they think we are gays. I remember that day that one organisation comes to my area offering medical support to people that are suffering from the similar illness I had then, the moment the doctor wants to give me an injection and sees my anus, he shouted this guy must be a Gay. It was because I have an ID that shows that I am a war refugee that lower the tension that day. Although eventually I was attended to, the shame that I was subjected to cannot make me go back to the area. In fact, I had to relocate to my present house and I keep everything to myself” (Anonymous 1, Age 25, Resident in Kampala city. FGD)

Lack of disclosure as demonstrated so far in the findings was deeply rooted in the fear of being categorised as homosexuality or labelled as suffering from mental and physical disorder based on the narratives that a man cannot be raped. Eight survivors shared that during their first attempts to disclose, they were challenged by different people including medical attendants with this stereotype that a man cannot be raped due to his nature. This to a greater extent blocks the confidence of some male survivors to disclose what they are going through. One refugee male survivor, a father of 2 children who was forced to undress and gang-raped by soldiers for three days in front of his family in DRC, alleged that:

“In 2009, my brother took me to INTERAID, and when I told them I was raped, all the staffs at INTREAID could not understand me; they just laughed because it was strange to them to have a man raped. It was when we got to RLP I was attended to, and after attending to me I was referred to go to the hospital” (Anonymous 6, Age 29, Resident in Kampala city, 20th August, FGD)

From the general accounts of all the respondents, I discussed with it was clear that some medical personnel are still not informed or aware of sexual violence against men and boys. This refers not only to private medical facilities but also to staff in government hospitals. With this perspective in place, many health care service providers do not believe that male sexual violence exists among refugees and some of them ascertain that there are homosexuals who are using this avenue to achieve their hidden agendas. This also relates to what RLP identified in 2014 that Medical personnel either do not believe that male sexual violence exists among refugees or allege that those who do report such cases are insane are homosexuals, are trying to cover over their sexual war crimes, or are seeking special treatment as refugees.

4.4 Culture and Religious Beliefs around Masculinity

Due to the negative social judgments and strong cultural norms attached to men, the victims are compelled to stay in the culture of silence. In this instance, the refugees can be regarded as an ethnic minority masculinities in Uganda. Masculinities is a “social construction” and scholars (Connell & Messerschmidt, 2005; Connell, 2005; Kimmel, 2003) have argued for years that what it means to be a woman or a man is not defined by the biological morphological sex marker but depends on the culturally defined expectations and conducts expected from each sex category. Therefore, when a man failed to meet up with the culturally defined conducts expected from them based on masculinity, it might be detrimental to their sense of self-identities as men. The few reported cases are justified by little attention and some with negative conclusions from inexperienced responders. This is purely evidenced by the weak legal terms to paint a picture on male sexual violence as it is widely presented from a female’s perspective. This was not a surprise when 14 out of the 20 male survivor participants shared that non-disclosure largely comes from cultural ideology. Social constructions of masculinity, gendered stereotypes, social taboos and other factors against masculinity norms elucidate why many male survivors take decades to open up. A 47-year-old Congolese male survivor who was a chief in his village against the government grubbing the land of his people was violated sexually with the wife by soldiers in front of their three children said that;

“In African culture, a man is raised to be the head of a family by caring about the children and the wife; that is how we grow up. We always take ourselves as people responsible for taking care of our families. So when you are raped, everything changes and when we go for medical attention; they cannot understand that a man can be raped” (Anonymous 9, Resident at Kampala, FGD)

It is clear that the cultural expectation of men to be powerful and invulnerable is the foundation of stigmatisation and categorisation that gave birth such as marginalisation and exclusion which together all play crucial role in invisibilizing important social groups in the society (Herzorg, 2018:13). There is no doubt that stigmatisation led to invisibilization (Brule and Kazi-Tani, 2015; Trawalé & Poiret, 2017), and due to the invisibilization, a male survivor of sexual violence among the refugee population are primarily unrecognised or captured in data and statistical reports in Uganda. This argument of fear of cultural and societal stigmatisation was further elaborated by Mr Kigonya a medical doctor with the experience of 4 years working on GBV issues said that;

“The biggest problem male survivors have is fear because the society perceives a man to be strong, so when it comes to those sexually violated to speak out publicly, it reduces their integrity as men. That is why some of them decide to keep quiet” (Health Care worker, Kampala City, Interview, Mulago National Hospital, Kampala city)

The situation was alarming when it comes to the family as the majority of the refugee male survivor that I discussed with were married before SGBV happened to them. These participants in particular articulated the hardship in disclosing to their family members and some of them decided to suppress the reality. Those who shared with their families also shared a lot of discomfort and fear to lose others’ respect for their masculinity. One refugee male survivor participant in his mid-50s who was a nurse in his country alleged that:

“This is considered as a taboo. Socially, stigma from people and culturally, it is not allowed to tell the people that a man was raped. When you are to tell the family; the kids might want to know where you got the problem from. Then you will have to be open and explain, but it is not easy to be open to the family” (Anonymous 19, Age 55, a resident at Nakivale settlement, FGD)

Additionally, ten refugee male survivor participants claimed that failure of some refugee male survivors to completely open up roots from some religious norms. They witnessed that, there are some refugee male survivors from countries including Somalia, Eritrea, Ethiopia and Sudan that refused to open up due to strong Sharia Law against sexual violence against men. One of the leaders of the association from Kampala district who is in his early 50s said that:

“It took us some time to inform our families on what happened because of our culture. So it can take you like ten years to tell them. Around here, we also have male Eritrean and Ethiopians who were raped, but they cannot come out because they fear to be identified since in their shariah laws; they are taken to be sinners, and this can lead them to be killed” (Anonymous 9, Age 51, Resident at Kampala city, FGD)

The above finding is line with Herzog (2018) argument that, the invisibilization are often done through, suppression, silencing, or through categories that define away or hide the real problem the groups are facing. The findings show that many refugee male survivors are dying in culture silence due to their cultural norms.

4.5 Attitudes of Health Care Providers

From the findings of this study, survivors have lost confidence in the health workers due to the widespread of negative responses and subtle mockery towards them from the nurses and doctors that they have encountered in the Mulago national hospital that the Uganda government dedicated to the treatment of survivors of forms of GBV most especially rape in Uganda. According to a South-Sudanese that has been in Uganda for six years with three children, the kind of remarks from the doctor is even more traumatising than the sexual violence that he suffered in South-Sudan. For example, he said that;

“after suffering discrimination from both family and the society that ostracise you, the last hope of succour is with the doctors or nurses. To my disgust, they make jokes of your conditions among themselves laughing hysterically, or they quickly go and call their colleagues to come and see a ninth wonder of the world speaking in their local language not knowing that as refugees we also learn local language

for proper integration. You just become a circus to them” (Anonymous 10, Age 32, Resident in Kampala city)

Another Burundian male survivor who was kidnapped in Uganda in 2008 by unknown people, tortured and sexually violated with the aim to steal his family inheritance shared his traumatic experience when trying to seek for medical help, in his words said that:

“RLP sent me to Mulago hospital, and I went to the front desk, and some doctor asked; what is the problem? He was working with six nurses; I told him I was raped. But already his facial expression was showing that I am a curse to them. He told me to lie on the bed, and I told him, can I do this when all of these people are around? He said yes and put on the gloves, just pressed the figure in my anus, then pus and blood started flowing out. He said; I am sorry I did not know, I looked at him, and I was like fuck you. All the interns cried and then I left the place in anger. When I reached home, I almost wanted to kill myself”. (Anonymous 6, Age 29, Resident in Kampala) (Narrates in tears).

From my perspective, it is understandable if healthcare providers lack the requisite training that is required in treating male survivors as expressed earlier by the survivors that were interviewed in this study. One might want to argue that it is not their fault because many of them might just be seeing a male survivor for the first time asking for medical help in their hospitals and might not know how to proceed because of lack of training. However, lack of training in handling male survivors is not a premise to discriminatory attitudes of some health workers towards the survivors that have been documented by various studies (Lawrence, 2017; Bolton et al., 2007; Feron, 2015). Since the health workers are also part of the larger community, it is not impossible that the societal discrimination towards male survivors of sexual violence has overridden the professional ethics of patient confidentiality regardless of gender that they were taught in medical school.

Although, as discussed earlier that the health workers in the private hospital they visited were both competent in providing treatments as well as acting professionally in addressing confidentiality issues with courtesy. The survivors believe that the reasons for the effectiveness of private hospitals are because it is a business and to the owner of the business they are interested in making money. One male survivor from DRC with a family of 4 children that used to live in Kampala before moving to Nakivale shared his experience

“if not because of money, with the private hospital we will not have any issue. The doctors are always nice treating us with respect. I remember a day that one of us had a misunderstanding with a nurse on her attitude towards him and he threatened to report her, she and three other colleagues were begging us not to report because she can lose her job. She called for three days begging. However, in the government hospital, you will be lucky even to see a doctor to attend to you, not to now talk of reporting bad behaviour of a doctor or nurse”(Anonymous 12, Age 40, Resident Nakivale, FGD)

The experiences of the survivor so far has further established the need for both access to medical health care and psycho-social support. However, if men are not recognised as victims of sexual violence most especially by health workers such as nurses and doctors, they will have no access to this support, and thus the societal notion that they cannot and should not be victims will be reinstalled-then the cycle continues (Lawrence, 2017).

4.6 State and Non-State Interventions

From the experiences of the survivors in both Kampala city and the Nakivale refugee settlement, without a doubt, it would be difficult to conclude based solely on the accounts of survivors without cross-checking with the relevant government agencies or NGOs, as well as health care providers. Many might want to argue that it is the characteristics of the government to deny unfavourable reports that question the obligation of government to certain issues. To my surprise, both the officials at the Ministry of Gender, Labour and Social development and that of Ministry of Health responses corroborated the accounts of male survivors that there is no specialised training for medical staffs to treat male survivors. For example, one of the key respondents from the Ministry of Health headquarters and has been the focal person of health issues for the 13 years in Uganda, opined that;

“We are not focusing on male survivors because when you look at sexual violence, it is rampant among women than men and using the public health approach you would go for women who are more in numbers of survivors. However, in our training, we do inform the health workers to understand that as much as the majority are women, there are also men and when they are dealing with men we also give them guidance on how to deal with them. Nevertheless, I will make sure that we have special programs for men” (Grace, GBV Focal Person Ministry of Health, Kampala city IDI)

Despite recognising the facts that there are men that are survivors of sexual violence, the government pay little attention to the necessity of having specialised programs for the male survivors. However, from what I have discovered so far with my interactions with survivors, the urgent need for specialised programs targeted at male survivors is non-negotiable because the experiences of woman and men that survive sexual violence’s are not homogenous. From the findings, even if the Ministry of Health wants to design programs that will help male survivors in the nearest future, those in Nakivale refugee settlement will not benefit from such program unless they travel 380 kilometres to Kampala. This because the Ministry of Health does not deal with refugee’s health directly, it is under the Office of the Prime Minister (OPM).

“The programs that the Ministry of Health designs in regards to GBV survivors are designed for the general population because women and girls do suffer GBV on a daily basis. It does not matter whether you are a citizen or refugee; therefore, programs and guidelines that I promised that we would design to address male survivors of GBV will not be targeting the refugees, but they can benefit from it because they have the right to access health care. Although if the OPM ask for our collaboration, we will surely be of help” (GBV Focal Person Ministry of Health, Kampala city, IDI).

While I do not want to consider the above response as a textbook response to newsmen and researchers asking questions from government officials when it comes to addressing the plights of survivors of sexual violence, existing evidence and programs have primarily focused on prevention and response to women and girl survivors of SGBV (Christian et al, 2011: 227). This explains why most male survivors do not bother to reveal their predicaments because those that have attempted to seek help discovered that the existing programs or interventions to deal with survivors have limited or no accommodation for men. Therefore, they would have furnished others with such information because the first point of contacts for information on how to get treatments when the new

survivors arrived at the country of asylum from my interaction with the refugees was the survivors they meet on the ground. However, the findings also revealed the policy of exclusion and discrimination against male survivors as discussed below

Christian et al. (2017) position on programs and intervention focusing on women survivors as a factor that further invisibilized the male survivors was further validated by the responses I got from the Gender Personnel at the Ministry of Gender, Labour and Social Development that deals with GBV issues. The Ministry programs of intervention were designed to address women survivor's needs even though the respondents claimed that both men and women could benefit from the programs of intervention. However, what captivated my attention most in her response was on the justification not to include male survivors in the shelter programs of the Ministry. It was gathered from the discussion I had with Jane, who previously worked in the president's office and currently works as the senior GBV officer with 26 years of experience with the Ministry of Gender, Labour and Social Development that the Ministry has a shelter provision program for the women sexual violence survivors but not for the men. This is because putting men in the shelter might be counter-productive to the recovery of the women. The shelter program allows the ministry staffs to monitor the recovery of the survivors and make sure that they keep up till date their medical treatment. From the policy point of view, she said that:

“we decided that there is no need to put the male survivors in the shelter because it can affect the women mentally of losing hope since they all look up to the men as the protector. You can imagine the implication of the thinking that if a man can be raped and sexually assaulted, what hope now remain for the women of not getting sexually violated again even after they leave the shelter” (Jane, Gender Officer, Ministry of Gender and Labour, interview occurred at 12:04 pm).

What one can deduced from the above argument is that the government policy in an attempt to address concerns about women survivors indirectly reinforced the narrative of masculinity of a dominant male that should be able to protect himself and his family. As suggested by Russell (2007:3), psychosocial strategies targeted at addressing the specific needs of male survivors must be designed in a way that will not subtly reinforce the idea of homophobia or male dominance over women. Although, for the most part of human history, regardless of culture and religion, a woman had on most occasions depends on a man to physically protect her and her children physically. However, Neave (2006: no page) argued that the feeling of women depending on men for protection was a social construct as women are preprogramed to feel dependent on men. Even today women may be more affluent and enjoy all the trappings of success but, deep down in their psyche, they fear they cannot survive alone. (Neave, 2006: no page). This explains why half of women survivors turn to a male (brother, father) as their first source of help and advice (Atkinson, 2008:1). Therefore one can make sense of the reason why the Ministry decided to invisibilized the pain of the male survivors to the women survivors by ignoring their needs for equal treatments that can help them survive the trauma of sexual violence. At this juncture, humanitarian actors and other stakeholders should realise that for male survivors, sexual violence goes beyond torture, it is a particularly rancorous attack on their personal and social identity with devastating psychological consequences that outlive any other forms of physical violence (Russell, 2007:3).

4.7 Towards More Appropriate Health Care Services

Out of the medical need that survivors claimed that is urgent are the immediate and effective health care services ranging from psycho-social counselling sessions to final physical medication. Addressing this needs have been suggested to follow a holistic approach that will provide holistic health care for survivors. Holistic healthcare refers to an approach analysing illness and providing healthcare that acknowledges and responds to all factors relevant to the health (or illness) of a person. (Derick, 2009:34). Without a doubt, trauma affects survivors in many ways, so both state and non-state actors as suggested the Poore et al. (2013) must be able to respond to a multiplicity of needs with a variety of healing paths (Poore et al., 2013: 4).

4.7.1 Counselling Services

Due to the traumatic sexual violence experience and severe consequences, participants valued the relevance of immediate counselling of the victim and the families to enable them to accept and learn to adapt to the situation. Counselling sessions should also happen concurrently with the provision of medication to treat the physical repercussions of sexual assault. In addition, participants mentioned an initiative of training survivors and equip them with relevant health knowledge to attend to their fellow survivors. One respondent from Burundi suffered traumatic experiences when he was forced by rebels to have sexual intercourse with his sister and mother. One of the rebels also raped him during the same incident. He shared his experienced, and his story further reinforced the need for a more holistic health approach

“I am a Boda Boda (Motorcyclist transporter) cyclist in Nakivale, and it is my only source of livelihood. I have so far had three accidents. These happened in the event that at times I forget that I am riding because I find myself instantly virtually and invisibly watching what happened to me in the past. Personally, I can tell you that being forced to play sex with your sister and mother in the presence of all your family members including your father is not easy. That is what I see while riding, it controls my mind and senses, and I find myself involved in accidents.....”(Anonymous 19, Age 55, Resident at Nakivale, FGD).

During this study participant reported on long-term memories of post-traumatic consequences. The highly reported issues include the low functionality of senses, short-term memory, short temper, depression, sadness, shouting, nightmares, visual blackout and suicidal behaviour. I probed further if the survivors tried to seek for counselling, it was gathered that they tried to seek counselling services to help him to cope with the situation and the counselling has not thoroughly helped. After very many sessions with a counsellor and having constant relapses, he was referred to Butabika National Mental Hospital located in Kampala, but many of them have problems of reaching there because of the very high costs involved but also fear of going far from his family. As Poore et al. (2013) suggested that "holistic healing approaches can be incorporated into the work of rape crisis centres in a wide variety of ways from simple community referrals to in-house practitioners to culturally specific programs that focus mainly on traditional healing practices" (Poore et al., 2013: 5). Without a doubt, the conventional western approaches of dealing with sexual assault such as crisis intervention and talk therapy still remain crucial services for the vast majority of survivors. However, different studies have clearly show that the healing of sexual

trauma must be done holistically, and this body, mind, and the spirit. For Peter Levine, it will be tantamount to efforts in futility addressing sexual violence trauma without taking into cognisance of both the physiological and non-verbal elements of the survivor's experience (Levine, 2007).

4.7.2 Economic support activities

All survivors reported the call for financial assistance to accommodate their livelihood, and this will be as a milestone in responding to the massive loss of their sources of livelihood. They mentioned that they lost their jobs, gardens, leadership positions and other small-scale businesses. Most survivors greatly asked for two durable solutions including resettlement and livelihood. They added the need to get financial support to strengthen their projects within their initiated associations. They, for instance, mentioned mushroom growing, cyber-café, poultry and animal rearing. One refugee male survivor said that:

“We want to open up a small office where we can help each other like teaching survivors English. We are also thinking to have some farms so that we can create jobs among us in order to break the undermining from the people. We want to have a cyber café where we could communicate with partners outside. If we can get money to put up these projects; it can help us. So I will be happy to see myself working expecting to have something at the end of the day that I can give to my family” (Anonymous 14, Age 35, Resident in Kampala city, FGD).

As demonstrated above the needs of men survivors to overcome trauma is firmly attached to their inability to fulfil their role as the breadwinner of the family. Unfortunately, many of the reported counselling strategies are based on therapists' observations, trauma theories, and research related to child abuse or sexual assault of females which may not be transferable to men who have been raped. Education and counselling of survivors' support networks must be considered as part of a holistic approach to management (Ellis, 2002:34). Apparently, from the findings when counselling male survivors the impact of the economic burden should be considered, a burden that is not so much on children or women except if they single mothers.

4.7.3 Awareness campaigns

Addressing the invisibilization of sexual violence against men requires massive awareness exercises to inform the general public about the existence of SGBV against men. At the outset, such campaigns will mostly pull back the mental problems encountered by male survivors and therefore creating an opportunity to lead policymakers to support the male victims of sexual violence. Health service professionals should also be part of the awareness campaigns.

“The general public needs to be trained, and therefore they can understand that such things exist. Because if we talk to them; they will never understand. If they are trained, they will be ready to understand you, know how to answer your questions other than irritating us because as male survivors we easily feel irritated. Personally, even at home, I can feel irritated on just a pitchy thing because of the pain I passed through” (a Medical doctor with four years of experience treating patients in Mulago National Hospital, Kampala city).

The overall accounts of survivors as demonstrated above pointed to one main argument which is also in line with D'Anniballe (2011) and Poore et al.

(2013) positions that traditional western healing approach is not relevant or suitable for many survivors and communities that are deeply connected to non-western cultural norms. Programs and intervention designed to address the problems of survivors should not only be holistic but must also be culturally relevant approaches. These approaches do not need to be a new one; it might be a long-held tradition that "support communities' access to holistic pathways to healing" (Poore et al., 2013: 3). Generally, the findings of this study raise fundamental questions about the narrative of Uganda as the most are in contrast with the narrative of Uganda refugee-friendly states in the region considering the plights of male refugee survivors of sexual violence. For RMSSV profiles refer to table below.



Fig 2: MRSSV Respondent Profiles

4.8 Conclusion

When it comes to health care access for male survivors, the above findings in this chapter highlight health care service gaps stemmed mainly in the reluctance of available health care providers, including doctors, nurses, counselors, protection officers, government institutions and responsible nongovernmental organizations, to fully support the male survivors to live a happy life. As demonstrated in the findings, the public hospitals of the government lack adequate and competent personnel are to handle male rape victims. However, the lack of well-trained medical personnel and medical facilities was not the only experiences they shared; they were also concern about poverty.

Chapter 5 Conclusion and Recommendations

5.1 Introduction

In this study, the set out objectives is to critically examine the experiences of the Refugee male survivors of sexual violence in dealing with the invisibilization to access health services in Uganda and the extent to which stigmatization and categorization of Refugee male survivors of sexual violence as homosexuals invisibilized them to medical, healthcare access and other government and nongovernment intervention supports. In order to achieve the set out objectives and answer the main research question, two research questions were proposed. 1) What experiences do refugee male survivors of sexual violence have before, during and after accessing medical and health services in Uganda? , and 2) what are the factors that contributed to shaping the experiences of refugee male survivors that are stigmatized in their attempt to access health and medical care?

For clear understanding, we also look at how the governmental and non-governmental actors responded to support the predicaments of Refugee Male Survivors of sexual violence in accessing health care in Uganda. While data collection was done through interviews and focus groups discussions for a number of key informants as well as refugee male survivors both in Kampala city and the Nakivale refugee settlement, concepts such as stigma, categorization, heteronormativity, hegemony masculinity, invisibilization were used in analyzing the data collected from the field. This chapter main focus is to draw a conclusion from the findings as well as suggests a number of recommendations and response to various actors dealing with refugee-related issues in Uganda. The discussion in this chapter is organized along the theme of the research questions asked in this study.

5.2. Summary of Key Findings

The findings for the first research questions that seek to explore experiences that refugee male survivors of sexual violence have before, during and after accessing medical and health services in Uganda revealed that the major obstacles they encounter in accessing the health care services in Uganda is due to lack of both adequate facilities and skilled healthcare workers that specialized in dealing with male survivors of sexual violence. Subjecting survivors to generic treatment rather than case-by-case treatments has worsened the medical conditions of a number of survivors as demonstrated in this paper.

To complicate matters, the economic situation of survivors continue to deprived them treatment even when they discovered that they could be treated in a private medical facility. Since many refugees flee their countries leaving everything behind and they could not get a job due to their medical predicaments, they have no means of livelihood to be able to afford treatments. It is noteworthy to emphasize that, the situation of survivors in Nakivale refugee settlements are worse due to lack of medical facilities and they find it difficult and expensive to travel a long journey to Kampala where they can get treatment in private hospitals since the staffs in government hospitals are either not competent or discriminatory.

In dealing with second research questions that seek to understand the factors that contributed in shaping the experiences of the survivors that are stigmatized when accessing medical care services and other support for refugees in Uganda, the findings revealed that the social construction of masculinity and heteronormativity which in turn have some expectation of men to behave in certain ways both in peacetime and during crisis make the survivors of sexual violence to imbibe the culture of silence. To avoid the shame of failing to represent the identity of real men that are invulnerable, powerful, impenetrable, sturdy, and reliable, many survivors keep mute on their health predicaments which continue to deteriorate rather than seeking medical attention. This social construction of masculinity did not only shape the thinking of the host communities to refugees, the construction of hegemony masculinity place survivors as inferior among the larger refugee communities that are not survivors of sexual violence. Besides, the social construction of the “typical man” as invulnerable also shape the thinking of government officials and health responders that ought to be of help to the survivors since they are all part of the larger society. It is evident from the claims of the survivors on the discriminatory attitudes of government’s health workers and a number of NGOs dealing with refugee-related health issues to either alleged survivors as homosexuals or make a jest of survivors with mockery statements that reinforced the men cannot be raped or sexually violated myth. This explained why there is a paucity of data that captured male survivor’s medical history in Uganda since there are few reported cases and this is further justified by the account of some of the government and health care workers that participated in this study that they have not come across male rape survivor cases.

In general, considering the fact that the experiences of the refugee male sexual violence survivors are not homogenous the concept of stigma helped to highlight the consequences of sexual violence for male survivors among refugee men in Uganda in relation to access medical and healthcare services. Categorization of male survivors of sexual violence provided an explanation as to why refugee survivors of sexual violence may be struggling with guilt and deep shame. As a result, the concept of categorization became relevant because they are principal to the social construction of identities that are essential to how Ugandans, both government officials, and the general populace perceives male survivors of sexual violence which in turn hindered their access to medical and healthcare.

On how the governmental and nongovernmental actors responded to support the predicaments of Refugee Male Survivors of sexual violence in accessing health care in Uganda? The findings show that there are no specific government intervention programs designed for male survivors in Uganda except the Refugee Law Project which is non-governmental that render assistance to male survivors. Besides, the assistance is limited. While the government focus has been on women which is understandable considering the population of women survivors, government response to exclude men from shelter arrangement on the ground of affecting the women psyche of losing hope when they see men that ought to be a protector of women also violated sexually

like them play significant role in reinforcing the narrative and myth of men cannot be rape as well as the masculinity behavioural expectation of the society from men. Nevertheless, from this findings, “holistic health” approach seems to be the best response that state and non-state actors ought to adopt in dealing with the refugee male survivors health predicaments in Uganda. An approach that looks beyond the physical treatment needs of male survivors but focuses on an all-encompassing treatment from emotional to psychological as well as spiritual.

Be that as it may, the functionality or the effectiveness of this approach also depends on how the economic situations of the survivors can be improved. After all, the relapsing memories of the survivors as this study demonstrated are exacerbated by their inability to work which has denied them their gender role assigned authority as the breadwinner of the family. Therefore, they lose respects of the family, in particular, their wives that now view them as useless that cannot perform their duties. Although improving the economic status of survivors is crucial to psychological and emotional healing, for many of the male survivors, traditional western approaches to healing have little relevance within their cultural context. Therefore, more holistic, culturally relevant approaches such as the inclusion of religious and traditional leaders in the counselling to deal with trauma.

5.3 Recommendations

5.3.1 Government:

- **Need for the national database:** due to the increasing numbers of male survivors of sexual violence the government should come up with the computer system to capture cases related to male sexual violence so that this can show the need in terms of service delivery and also gain the urgency of funding from the donors.
- **More sensitization related to issues on sexual violence on men:** this can be done on media, in schools through education curriculum adjustment that can bring to awareness that sexual violence happens to men and boys too. This can as well be done to the different stakeholders basically those who respond to refugees directly in order to change the negative perception, prevent and bring to justice to perpetrators in sexual violence among men.
- **Training Programs:** Government should come up with the training programmes to sensitize public institutions that respond directly to refugees on issues related to male sexual violence so that this reduces on the negative attitude or perceptions.
- **Establishing of GBV clinics:** government should build GBV clinics in different districts with proper laboratories and skilled and knowledgeable GBV doctors, nurses, counselors trained in identifying, handling and making the right procedure for the male survivors of sexual

violence. This can improve on opening up and seeking of medical attention by the male survivors.

- **Initiation of the policy:** the government should work hand in hand with the community development officers and local council leaders in order to come up with the best policy which can bring a solution to pressing matters of sexual violence affecting refugees in the communities rather than ignorance or following the different funders agendas which doesn't reflect with what is happening on ground or in their lives.

5.3.2 Non-government organizations:

Increase in Advocacy:

- RLP should circulate videos or documentaries to different stakeholder, media offices, authorities, health workers and in the community to change the negative perception of categorizing male survivors of sexual violence as homosexuals.
- NGO's and medical institutions, especially in the settlements, should sensitize the refugees their mandates or roles so that they easily access the needed services.
- Refugee Law Project should circulate videos or documentaries to different stakeholders, authorities, health workers and in the community to change the negative perception of categorizing male survivors of sexual violence as homosexuals.

5.3.3. Medical institutions

- Medical institutions and counseling agencies should encourage couple counseling among male survivors with sexual violence and their spouses to avoid family breakups or domestic violence in homes which are seen unstable because of the challenges happening to the male survivors especially when he can no longer satisfy the wife anymore or cannot easily open up traumatic incidences to his wife.

5.3.4. General recommendations

- **Couple counseling for the survivor and family:** This is one of the urgent needs of improving stability and quick healing process for the male survivors, the counselors should endeavor to involve the wives of the male survivors in the counseling process so that they give hope and encouragement to receive the better medication.
- **Redefining the term sexual violence:** The policymakers should adjust the definition of sexual violence to include issues related to male survivors so that they can be equal service delivery in terms of treatment and justice.
- **Inclusion of male survivors of sexual violence to resettlement criteria:** Men and women are affected in the same way on issues related to sexual violence, the difference comes in the long run (Pregnancy) so, UNHCR should adjust on resettlement criteria to also support male

survivors of sexual violence where they can as well get better medical services and support for their family as this is offered to women (Women at risk).

- **The need of screening tools for identification of male survivor cases:** All stakeholders and medical practitioners who receive refugees on the point of entry should come up with the screening tools which identify and keep track on the cases related to sexual violence on men and women. This will improve on the service delivery for both women and men affected by sexual violence.
- **Support shelters for the victims:** Ministry of Gender, Labour, and Social Development should come up with support shelters that have provisions for male survivors of sexual violence so that this can as well help in the easy treatment as it is provided to their counterparts.

5.4 Overall Conclusion

By and large, this study has confirmed the important role of stigmatising myths in preventing refugee survivors from accessing the range of medical and health services they need. Social and cultural attitudes contribute to making these survivors invisible to most service providers. Policymakers, government institutions (medical institutions) and NGO's hence marginalization in service delivery especially medical. This study does not undermine the efforts and tasks in the prevention of sexual violence against women. However, the findings of this research are to bring to awareness that refugee male survivors are vulnerable to sexual assault and recommendations in providing proper medical services. Further research should focus on the reactions and support of male survivors (refugees and nationals) families healing process.

Appendices

Appendix 1: Interview Questions for Male Sexual Violence Survivors

INTERVIEW GUIDE MALE SEXUAL VIOLENCE SURVIVORS GROUP / IDI SESSIONS

PART I: INTRODUCTION (10 Mins)

- Indicate purpose of the research
- Reassure the respondents (Confidentiality or purpose of survey recording)
- Create a “safe” atmosphere

A short introduction about survey and what the conversation will be about, i.e.: to learn about one's impressions, one's own subjective reality. The researcher will put the participants at ease as much as possible and will ensure confidentiality. He will also help them establish contact with their own experiences and with their inner world of emotions.

For the record:

1. Name
2. Codename
3. Nationality
4. Year and place of birth
5. Language spoken
6. Language of interview /mother tongue (s)
7. Current residence or address
8. Number of years in Uganda
9. Phone number
10. Email if any
11. Occupation (Former.....? Pre-sent.....?)
12. Date, place time of interview
13. Persons present during interview and positions or roles

PART II: MALE REFUGEE SEX VIOLENCE SURVIVORS' EXPERIENCE AND SUPPORT IN UGANDA? (15 Mins)

The objective of this part is to gain insight into the factual and subjective experiences of survivors of male sexual violence. It is also to explore the emotional meaning of life after sex violence. Then this part will also help to explore “typical” or “ideal” victims' awareness and readiness to seek for support. Then, we gain insight into the victims' behaviour and support.

1. When you came to Uganda, did you talk about your problem with anyone?
2. If YES, what was their response?
3. If NO, why did you not talk about your problem?
4. Since then, in relation to suffering sexual violence, did you seek medical and psycho-social support?
5. If YES; from who or what organisation?
6. Were you supported medically? YES or NO Psycho-socially? YES or NO?
7. If YES to either of the above, please explain what support you received?
8. How often do you go for treatment or health-related appointments?
9. If you did NOT seek help or support with your health, please explain why you did not?
10. Does your family know about your problem? If YES, are they supportive? Family status
11. Who else has provided you with informal or formal support? Church? Friends? Fellow sufferers?

PART III

Now, let's talk about the medical or other personnel who attended to you...

- *Note moderator: Ask the respondents' general experience during medical services? Be specific for all medical processes. Ask if the victim interacted with medical and other health personnel (nurses, NGO workers, psychologist, social worker etc).*
 1. Can you remember your first impression when you met health staff?
 2. Did you feel supported and understood?
 3. Did the health personnel/doctor/ nurse respond sympathetically to your problem?
 4. What kind of medication or health advice were you given?
 5. Did you feel better after the doctor's assistance? Explain your answer, please.
 6. Did you go back again to the same or another health provider? If not, why? And if yes, how did this go the second and later times?
 7. Did you ever try other health services, NGOs and hospitals around Uganda or elsewhere?
 8. How did that go?
 9. Did you ever face bad attitudes from individuals or organisations that you went to for help or treatment? Were you ever refused treatment, for example?
 10. If yes, describe what you experienced.
 11. Did health staff treat you confidentially, and respectfully, given your status as a victim of sexual violence?
 12. Do you feel as a male sexual violence survivor in Uganda you are treated just as any other refugee man by health staff and organisations?
 13. What kind of challenges do you face in getting to regular treatment or hospital?

14. What other non-medical institutions have given you support as a male survivor of sexual violence? Please describe that support.
15. Does your family know about your problem, if not ?Why
16. If yes , are they supportive ? How
17. Do people around you like neighbours no about your problem if not? Why
18. If yes, how do they treat you? ... + PROBING

PART IV: ANALYSIS OF VISIBILIZING MALE SEXUAL VIOLENCE ACROSS LEAD POLICY MAKERS, MEDIA PLANNERS AND THE PUBLIC (13Mins)

The objective of this part is to gain insight into the factual and subjective feelings towards making sexual violence against men more visible and also to break categorization and stigmatization of victims as gays.

What advice would you give medical centres or NGO's on the ideal policies that could help them?

- What type of support activities (programs) would you recommend to medical centres or NGO's?
- Which organisations should be supported that work well with male victims of sexual violence?
- What kinds of specific information and campaigns should be promoted by the government and health providers to help victims' access health services?
- Which kinds of specific support should be ensured by health professionals?
- What other questions would you like to ask the medical professionals and NGO'S about health support for male victims of sexual violence?
- PROBE

PART IV: ADVICE AND RECOMMENDATIONS (10MINS)

The purpose at this point is to understand the respondent's overall expectations regarding the general support towards male sex violence survivors.

- What would you say about the male survivors of sexual violence in general?
- Which values does appropriate medical support fit with? Does not fit with? How come?
- How would you like to see Ugandan government supporting the male sexual violence survivors? Why? Why not?
- What is really important to you in this respect? What is less important?
- + PROBING

Note moderator: Wrap up and thank the respondent (2 mins).

Appendix 2: Interview Questions for Medical Professionals

Interview Guide for the Doctors

1. What is your understanding of conflict related sexual violence?
2. When I talk about male sexual violence; what comes to your mind?
3. How often do you attend to male survivors of sexual violence as opposed to their female counterparts?
4. Why the variance in numbers?
5. Do survivors of male sexual violence independently seek for medical support? Or do they see need for medical support?
6. In your opinion, how would you describe the medical environment in this country in regards to male survivors of sexual violence?
Conducive and Friendly? WHY?
Hostile and Unfriendly? WHY?
7. From your experience working with survivors of male sexual violence, what is your take on their levels of disclosure?
8. Proper diagnosis follows detailed investigations and examinations which can be hampered by failure to disclose. What in your opinion are the determinants of full disclosure or reasons for failure to disclose?
9. How often have you received cases related to male rape?
10. Do you think that sexual violence can change the sexuality of men?
11. Do you think that men perceive sexual violence differently from women? If yes why?
12. Do men show hesitation or fear to talk about their problem or suffering?
13. Do men ever report that sexual violence experiences have damaged their intimate and social relationships? If so, can you give one or two examples?
14. Can you observe effects of sexual violence as a doctor, even if a man does not report it?
15. Have you ever identified cases of sexual violence that were not reported?
16. How do you refer medically to those male survivors of sexual violence?
17. Are the resources both Human and otherwise available supportive to male survivors of sexual violence? Are there any instances where survivor with conditions such as rectal prolapse have been put gynaecological wards?
18. How do women look at such male survivors in a facility that originally is supposed to handle women issues?
19. Aware that the issue of male sexual violence is increasing become do prevalent, how do you think male survivors should be encouraged to report and scale up their efforts to seek medical support?
20. Any key messages to different stakeholders to ensure that they support the survivors of sexual violence to access medical and healthcare services?

21. Stakeholders such as your fellow medical personnel, government, survivors themselves, the general public among others

PART IV: ANALYSIS OF VISIBILIZING MALE SEXUAL VIOLENCE ACROSS LEAD POLICY MAKERS, MEDIA PLANNERS AND THE PUBLIC (13Mins)

The objective of this part is to gain insight into the factual and subjective feelings towards making sexual violence against men more visible and also to break categorization and stigmatization of victims as gays.

1. What advice would you give medical centres or NGO's on the ideal policies that could help them?
2. What type of support activities (programs) would you recommend to medical centres or NGO's?
3. Which organisations should be supported that work well with male victims of sexual violence?
4. What kinds of specific information and campaigns should be promoted by the government and health providers to help victims' access health services?
5. Which kinds of specific support should be ensured by health professionals?
6. What other questions would you like to ask the medical professionals and NGO'S about health support for male victims of sexual violence? PROBE

PART IV: ADVICE AND RECOMMENDATIONS (10MINS)

The purpose at this point is to understand the respondent's overall expectations regarding the general support towards male sex violence survivors.

1. What would you say about the male survivors of sexual violence in general?
2. Which values does appropriate medical support fit with? Does not fit with? How come?
3. How would you like to see Ugandan government supporting the male sexual violence survivors? Why? Why not?
4. What is really important to you in this respect? What is less important? + PROBING

Note moderator: Wrap up and thank the respondent (2 mins).

Appendix 3: Questions for Ministry Officials

Interview questions (Ministry of Health and Ministry of Gender, Labour and Social Development)

1. How long have you been working at OPM?
2. What is your understanding of sexual violence?
3. Have you ever heard of sexual violence against men and how many cases have you ever encountered with?
4. Currently how do you describe the medical environment in regards to male survivors of sexual violence?
5. As we have a criteria on sexual violence against women , are there steps taken to include male survivors of sexual violence?
6. What policies or frameworks exist to promote appropriate responses to sexual violence in regards to male survivors?
7. How effective are existing programs at recognizing and addressing the existence and medical needs of male survivors of conflict related sexual violence?
8. What are the factors affecting access and utilization of sexual violence service by male survivors?
9. Any steps taken in act in order to bridge the gaps
10. What are the recommendations you give to health workers , media personnel's and other stake holders in viblizing issues related male survivors of sexual violence?

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