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Sexual Violence in Fragile Settings: Practice, Policies and Research

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Editorial
Sexual violence in fragile settings: Practice, policies and research

*Laura Pasquero**

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Sexual violence is a widespread human rights violation and a public health problem happening across all continents and societies.[1] The devastating physical and psychosocial health impacts sexual violence has on individuals, families and communities require timely and quality survivor-centred responses for victims and survivors as well as robust and long-term prevention efforts. Despite a growing body of evidence-based standards and guidance on how to effectively prevent and address sexual violence and survivors needs, including in conflict and other humanitarian contexts,[2,3,4] less is known about what is needed and wanted by specific groups of survivors whose realities and narratives are under-researched, and about the particular characteristics of certain settings where their experiences of violence and survival are situated.

This journal issue focuses on some of these less-visible and less-studied individual and collective experiences I am choosing to call "fragile realities". The issue adopts a broad understanding of "fragility", conceived as the wide range of experiences encountered by populations who are exposed to risks and vulnerabilities in environments where systemic social, political, and environmental challenges intensify, and in contexts marked by a loss of trust between communities and the systems that provide health and psychosocial support.[5] The articles centre the voices, silences, and experiences of a broad range of populations of survivors in conflict, post-conflict, and displacement settings, as well as in chronic crises and contexts of natural disasters across a range of geographical areas – from Rwanda to Haiti, from Italy to Tunisia, from Colombia to Japan, among others.

This special issue contains six articles. The first three adopt an intersectional approach to analyzing the realities and needs of groups of survivors that lie at the interface of systems of power imbalance based on gender, age, social status, sexual orientation, gender identity and gender expression: children conceived in genocidal rape; victims of sexual exploitation and abuse; and lesbian, gay, bisexual, transgender, intersex, queer/questioning plus (LGBTIQ+)[i] populations in conflict settings. The authors shed light

[i] Different versions of this acronym and terminology around LGBTIQ+ populations are used in this issue. The journal has chosen to leave the terminology authors used.

on the lived experience and expertise of these populations and suggest relevant recommendations to inspire competent and creative practice and evidence generation.

Based on 30 months of ethnographic research in Rwanda, Loes Loning's article on children and youth conceived in sexual violence centres the voices and agencies of children conceived in rape during the genocide, and critiques those discourses that reduce their experience and identities to mere "legacies of violence". An under-researched group, children conceived by rape in war often remain unacknowledged and underserved also within humanitarian interventions programming. While calling for more child-centred research and programmes, Loning's article illustrates fascinating insights into the work with children by grassroot organizations in the country and delves into these youths' own understanding of their lives and realities.

The cross-sectional study by Mackenzie Maskery and al. on Peacekeeper-perpetrated sexual exploitation & abuse (PP-SEA) in Haiti examines communities' micronarratives to investigate the relations between PP-SEA and satisfaction with life (SWL) among Haitian community members. Authors highlight how the unexpected findings point to the complexity of the association between PP-SEA and SWL in the Haitian setting and call for additional research on transactional sex in the country to further inform context-relevant interventions that meet the needs of SEA survivors and their families.

Patricia Ollé's article focuses on the realities of another group that has been surrounded by "loud silences",[7] i.e., populations with diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC) in conflict settings. Ollé's article provides an articulate and comprehensive overview of the current evidence on sexual violence against LGBTIQ+ people in conflict across the globe. Arguing that a limited understanding of sexual violence perpetrated against this diverse community has direct implications on the scarcity of accessible and competent responses for victims, the author calls for urgent recognition and action around this issue by the international community, and for agendas to be survivor-centred from a diverse SOGIESC perspective.

The final three contributions in this issue address a range of "fragile" settings, each characterized by unique legislative and societal systems that hinder survivors' access to comprehensive survivor-centred responses in different ways.

Wenqin Zhang et al. conducted a review of the current literature and international guidelines for humanitarian practitioners on the topic of mandatory reporting of sexual violence in humanitarian settings. The authors delve into the intricate nature and challenges that arise from mandatory reporting for health and other practitioners as they strive to provide survivor-centered responses. The article emphasizes the need for additional research to deepen the understanding of the implications of mandatory reporting and inform evidence-based comprehensive guidance for humanitarian personnel.

The two other articles are authored by members of women's organizations and activist collectives in Italy, Tunisia and Japan, and provide insights into the transformative role of feminist networks in tackling violence against women and girls in these countries over the last decades. Both contributions situate sexual violence within a "continuum",[8] where rape and other types of sexual abuse are extensions of structural systems underpinned by everyday gender-based discriminations and inequalities against women and girls and most marginalized groups.

In their article on the policies and practices that tackle violence against women in Italy and Tunisia, Souad Gharbi and the other members of LeNove feminist research group describe the extent and nature of gender-based violence against women and girls in both countries, and advocate for sufficiently-resourced multisectoral systems and measures to both respond to and prevent such violence. In

illustrating how feminist movements have been the drivers of societal change for women's and survivors' rights on both sides of the Mediterranean, the article draws particular attention to the role of women's activism in shaping effective intervention models such as anti-violence centres, which offer empowerment-based support to women and girls throughout the whole cycle of violence, as well as promising preventive approaches to addressing harmful social norms around masculinity and perpetration.

Finally, in their text on gender-based violence in times of disaster in Japan, Reiko Masai and Yukie Suzuki from Women's Net Kobe critically analyze two major earthquake and tsunami disasters in Japan, in 1995 and 2011, from a gender perspective. Through a gendered reconstruction of these historical events as commented by the narratives of women, gender-based violence victims and women's groups, the article pleads for the adoption of gender-competent disaster management approaches that can effectively address this "emergency within the emergency" and ensure that women's leadership is fully incorporated into decision-making. The authors also invite us to learn lessons from past failures and call for long-lasting and resourced structural reforms which can be effective in responding to gender-based violence both in times of disasters and in "normal" times.

The wide thematic and geographical scope of this journal issue has large potential for inspiring reflective and transformative policy, research and practice towards addressing sexual violence more deeply and structurally in a range of contexts. While the authors emphasize that it is crucial to put the diversity and complexity of survivors from specific groups and settings at the core of prevention and response interventions, they also highlight the importance of adopting non-categorial and non-homogenizing approaches to responding to violence and trauma which transcend conventional labels and preconceived assumptions.[9] This issue also emphasizes the significance of critically examining and unsettling the systems of power that perpetuate and recreate violence and discrimination for women and girls and oppressed communities and groups, and calls for policies and interventions to adopt a profound and structural approach to sexual violence prevention and response efforts.

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Beyond "Born of War": Children, youth and young adults conceived in sexual violence

*Loes Loning**

ABSTRACT

Children and youth conceived in sexual violence have increasingly become part of research on Conflict-Related Sexual Violence (CRSV), but largely remain an invisible group within responses to sexual violence and psychosocial support programming. This article details insights into the lived experiences of youth conceived in sexual violence and questions the language through which they are viewed. Research findings are based on 30 months of ethnographic research that explored the social worlds and family relations of young people conceived in rape during the Genocide against the Tutsi in Rwanda. The research took place from January 2019 to July 2021 and was conducted in close collaboration with NGOs that organised youth camps to bring young people together to share experiences and connect. By looking at support programmes such as these, ideas around 'disclosure' of young people's conception as well as ethical considerations within research and practice are discussed. In highlighting a survivor-centred approach, this article calls for a re-thinking of the language used globally to perceive children "born of war". It argues that current discourses centre a violent conception rather than the person or the child. Ultimately, this article invites a conversation on how children conceived in violence should safely and ethically be included in psychosocial support and sexual violence response programmes, while being seen as an individual being in the present instead of "symbols" or "legacies" of violence.

"I love a mirror, when you break it, you see so much of you. You will see yourself in pieces. You can perceive the pieces as mistakes, when you look at those, you see a hundred images of yourself – those are the scars. So why do we go in front of a broken mirror? If you don't look at the broken pieces but take one, even if it's small, you will see yourself clearly." – Claudine[i]

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INTRODUCTION

An estimated 25,000 children were conceived through genocidal rape during the 1994 Genocide against the Tutsi in Rwanda.[1] Claudine, in my interview with her in 2020, gave her example of seeing herself in a broken mirror, many different pieces, scars in her reflection. In this article, I argue that we as scholars and humanitarians see these different pieces too, and in doing so, forget to pick up the one piece that allows us

[i]All names are pseudonyms and locations, professions or other identifiers have been changed. As Rwanda is a very small country and people are easily identified, in writing about this research the use of pseudonyms is critical but insufficient. I have changed all identifying aspects of individual narratives, or not used those that would possibly expose the identity of participants. Particularly when writing about conception through rape, it is essential to assume that those close to research participants do not know about their conception and revealing this knowledge in any writing is extremely harmful and dangerous. Written informed consent was provided by participants, agreeing to the protection of their anonymity and privacy.

to see children and young people conceived in sexual violence as persons looking back at us. Studies have shown that we clearly see the different characteristics that shape their lived experiences; a haunting past, socio-economic adversity, intergenerational trauma, and a difficult sense of identity and belonging.[2-7] Yet, discourse around these children, young people and young adults, seem to eclipse their individuality and present being. We refer to them as "born of war", "war babies" or "born of rape", terminology that centres violence rather than the person or the child.

This article draws on extensive ethnographic research in Rwanda, where I worked closely with young people and their families. These relationships indeed developed in a broken-mirror landscape, but they allowed me to look at a few pieces deeply, including my assumptions and interpretations. The young adults, in their early twenties, who were the subjects of this research were trying to find their different ways in life, just as I found ways in this research. I learned to see them for their determination, resourcefulness, and commitment as sons, daughters, siblings, parents, and friends rather than for a violent past associated with them or the complex environment they grew up in – an important distinction.

This article elaborates on this distinction as I present nuances around the process of 'disclosure' of young people's conception, ethical considerations in research and practice, the importance of acknowledging women's choices in pregnancy and birthing, and young people's agency in moving beyond labels tying them to a violent past. Thus, this article calls for increased participation of a largely invisible group of children and youth in sexual violence response and psychosocial support programming in (post-) conflict contexts.

Children Conceived in Conflict-Related Sexual Violence

It is estimated that tens of thousands of children have been born as a result of mass rape or sexual exploitation during times of war and conflict "whether as an accidental by-product or strategic campaign of violence."[8] Sexual violence has always been part of conflict and warfare, resulting in children being conceived in rape. Yet, it was only during the Bosnian war in the early 1990s, that the children conceived in rape first became subjects of human rights discourse. As a group, these children came to symbolise a kind of atrocity that was seen as unprecedented in scope and brutality.[9] In the former Yugoslavia, rape and forced impregnation were used systematically and deliberately against women and the nations they were assumed to represent. Research on this topic has been conducted in a variety of contexts including the First and Second World War,[10] Bangladesh,[11,12] Peru,[13,14] Sudan,[15] Cambodia,[16] Sierra Leone,[17] Uganda,[18-21] Nigeria[22] and Iraq.[23]

Language and terminologies are significant shapers of how we understand phenomena. A large body of work on "children born of war" comes from the field of politics and international relations.[8,9,24] Human rights discourses refer to "war babies" as symbols of conflict or secondary-victims of violence and speak in terms of children's rights – or lack thereof. An example of this use of language is that researchers argue that to a 'receptor group', children conceived by enemy soldiers in war are symbolic of the war atrocities.[24-26] This suggests that communities re-imagine the aggression in the children. In Rwanda, they were called "devil's children;"[27] in Kosovo, "children of shame;"[28] in East Timor, "children of the enemy;"[29] in Nicaragua, "monster babies."[30] However, whereas in some situations the children were seen as constant reminders of suffering to their mothers and communities, research has also shown that this rejection of children is not uniform.[31,32] In Goma, The Democratic Republic of Congo, Helen Liebling et al.[32] found that while children were a reminder of bad memories, women's conflicting feelings towards their children stemmed from the pressures of caring for a child in a socio-economically adverse situation, rather than the child itself. Odeth Kantengwa[31] finds that in Rwanda, even though mothers of children conceived in rape face stigma and isolation, motherhood is "the major reason for living after genocide".

Kimberly Theidon refers to children in Peru as "living legacies of sexual violence."[13] Donna Seto emphasises that these children can be seen as reminders of the past, or as an opportunity for communities to reinvent themselves.[8] Sara Kahn and Myriam Denov found that in Rwanda, youth believe that they have a central role to play in post-genocide reconciliation. A young person in their study said: "Society should consider us [children born of genocidal rape] as a symbol of reconciliation."[33] Siobhán McEnvoy-Levy argues that such children symbolise the political tension that the victimised and perpetrator community embody.[34] Therefore, rather than considering these children to represent only one side of the conflict – that of the perpetrator – these children can also offer a way to reconcile community, and even national differences. Thus, "children born of war" are not "enemies or friends, but both."[34] I ask – can they be neither?

A Survivor-Centred Approach

In 2019, the UN Security Council adopted a new resolution on the Women, Peace and Security (WPS) agenda that "recognises the need for a survivor-centred approach in responding to sexual violence in conflict and post-conflict situations."[35] Resolution 2467 also recognised "women and girls who become pregnant as a result of sexual violence in armed conflict, including those who choose to become mothers [and recognises] harms often faced by those women, girls and their children born as result of sexual violence in conflict, including economic and social marginalisation, physical and psychological injury, statelessness, discrimination, and lack of access to reparation."[35] While the language in the resolution is clear, including the phrase "children born as a result of sexual violence in conflict", this language has been transformed into terminology that, I argue, is at odds with a survivor-centred approach. For example, in her important analysis of a survivor-centred approach to sexual violence, Janine Natalya Clark states that Resolution 2467 has noted "its recognition of 'children "born of war" as a particular victim group.'"[36] While the intention behind the words corresponds to the resolution, there is a distinct difference between speaking of "children born as a result of sexual violence" or "children born of war". The term "born of war" is the accepted and frequently used term to describe children conceived through rape, hence using "born of war" would speak to its intended audience.[2] Alessia Rodríguez Di Eugenio and Erin Baines[37] argue that the term "children born of war" is "wholly insufficient to capture the varying experiences and diversity of identities of persons whom we usher under this category" and note that "the category infantilises such persons".[3] They also state: "We also recognise that the lack of language in which to frame their experiences also contributes to their invisibility."[37] I build on these insights by using a survivor-centred approach[4] to reflect on data from Rwanda.

While I recognise the difficulties in positioning children conceived in rape within political frameworks around war-affected children, war crimes, conflict-related sexual violence, and justice, given that no first-hand act of violence has been committed against them,[34,38] in this article, children and young people conceived in rape are considered survivors. Rodrigues Di Eugenio and Baines[37] conceptualise a survivor-centred approach beyond individual victimisation through considerations of structural and cultural violence:

A survivor-centred approach, as we conceptualise it here, moves beyond individual victimisation due to an act of overt or direct violence (such as rape), to

[2] This is not intended as any criticism towards Janine Clark's work. I solely mean to emphasise the accepted terminology and discourses relating to children "born of war", which is not attributed to a single or group of authors.

[3] In this article, I refer to the research participants as young people. At the time of research, they were 24 to 27 years old, and some would identify as young adults rather than "youth". I am aware that writing about them as "young people" risks infantilising them and I discuss the nuances of my choice in the "ethical considerations" subsection under Methodology.

[4] By discussing language in this article, I recognise the complexities of terminology, which includes nuances relating to a "survivor-centred approach". Some prefer a "person-centred approach" as feelings of survivors' are not uniform in being referred to as survivors vis-à-vis victims or being labelled either way. An alternative would also be a "survival-centred approach" centering the process rather than the person. This discussion is beyond the scope of this article, but important to mention.

recognise the ways war violence shapes and divides communities, blurs victim and perpetrator categories and generates structural (the result of intersecting institutions that diminish and limit one's life chances and choices) and cultural violence (social stories that legitimate and normalise structural violence, displacing responsibility onto the targeted group, in this case, 'child born of war'). Together, structural and cultural violence are often described as invisible violence, felt but not seen by persons denied opportunities by it. Furthermore, we understand the word survivor in this study as a reference to the accretive harm children 'born of war' experience throughout their lifetime and as related to socially endured harms due to mass or political violence, but also as a term that recognises their agency to respond to and reimagine a future without harm.

A survivor-centred approach emphasises principles of dignity and respect and prioritises the needs and wishes of a survivor without discrimination.[39] I argue that "born of war" discourses are potentially harmful to the dignity of children conceived in rape, as well as their mothers because they emphasise violence over the agency of the living. When we speak of "children born of war", how do we think about those women "who choose to become mothers" as specified in the UN Resolution? Are children born from war or from their mothers?

METHODOLOGY

Design and Setting

This study was conducted over 30 months of fieldwork, between January 2019 and July 2021.[5] Due to the sensitivity of this topic and significant ethical considerations, fieldwork was conducted in close collaboration with partner organisations that provide young people and their mothers with psychosocial support.[6] Through these organisations I gained access to young people conceived in genocidal rape, and subsequently, their families. This approach was chosen deliberately. Many young people in Rwanda do not know the history of their conception and consequently were not included in this research, to prevent the risk of compromising people's interpersonal relationships. A holistic ethnographic approach was used through participant observation in organisations, in-depth interviews and visits to participants and their families. I lived in Kigali and visited the research participants where they lived. Families in this research did not necessarily live together as young people attended universities in different places or worked away from their hometowns. Therefore, on occasion the study provided an opportunity for family members to visit each other with me.

Interviews

In-depth interviews were conducted with 32 young people conceived in genocidal rape and 7 of their mothers. After meeting young people for interviews, I stayed in touch with them and visited them in their homes, with their families, at university, or at a location of their choice. We saw each other multiple times over the years. During these visits, I saw their lives take shape, while in the interviews we explored their experiences of growing up. This allowed for a comprehensive understanding of their difficulties, transformations, and growth, as well as their own reflections on their childhood and youth.

Interviews were conducted in Kinyarwanda with the support of my translator, Christian Ngombwa. My own comprehension of Kinyarwanda allowed me to pick up on nuances in answers and specific wording to describe experiences and I was able to comfort participants and build rapport with them in their own language. Christian was born shortly after the genocide and is the same age as the research participants. This allowed for a comfortable dynamic with participants in which he could translate and explain answers in the context of being young adults in Rwanda. His gender may have influenced certain

[5] Due to the Covid-19 pandemic, I left Rwanda for six months in 2020, but fieldwork continued remotely.

[6] I do not name the organisations I worked with, as association with these organisations can present risks to the privacy and anonymity of young people and their mothers.

answers being withheld or changed, or for people to decide not to be interviewed. My own gender may have too. Importantly, Christian being a young adult in Rwanda meant there was a risk of him and research participants crossing paths socially. Some participants told us that if they would meet Christian outside of the research setting, they would pretend they did not know him. Christian always leaves the decision with participants to approach him or not, being aware of his ethical responsibilities towards protecting participants and himself.[7]

I recruited mothers from a group counselling session where I introduced the research and consent forms. I emphasised that my research was about their present lives, their families, social worlds and relationship with their children, not about their lived experiences during the genocide. The questions reflected this. During these interviews, Carine Ingabire, a female translator, supported me. A counsellor, who the women have known intimately for many years, spoke to them after each interview to ensure their well-being.[8]

Interviews were semi-structured with twenty prepared questions. The first and last questions were always "how are you feeling?". In most cases, responses to the third question "can you tell us about your family" would instigate specific follow-up questions, for example, if young people were married or a parent, or if they knew their biological father or his family. The first section of questions asked about their family and social worlds, the second section was about their childhood. The third section of questions was about their experience with finding out about their conception. These questions would be adjusted when young people knew about their conception without having had a specific conversation with their mother; they grew up with their biological father's family or in tight-knit communities where this information was distilled as a child comes to 'know' the world. The final section included questions directed towards positive experiences, such as "what are you most proud of?" and "what are your wishes for your future?". The final question was: "There are many children and young people conceived like you in the world. Do you have any advice for those children in other places?". Answers to some of these questions are presented in this article.

Participants and Youth Camps

Many children and youth conceived in rape have not been told about their conception and were automatically excluded from this research. Asking questions in communities has the potential to disrupt relations that are often carefully controlled by mothers, to protect children from learning about their conception. If a woman came to be married after the genocide, she might also have concealed this information from her husband or other children. Approaching women or children directly would be a real danger to safety in homes and communities.

In their study on young people's experience with disclosure – the process of learning about one's conception – Hogwood et al. (5 p560) found that "young people described the value of knowing and meeting others in the same situation to discuss and share problems, helping to normalise the situation and provide them with strength to manage the disclosure". For young people to connect with others in a similar social position, NGOs organised youth camps where young people conceived in genocidal rape were brought together. The young people invited to these camps are the children of mothers who were part of a counselling programme aimed at supporting mothers with disclosing their children's conception to them, hence counsellors knew that the young invitees had been told about their conception. Youth camps were attended by approximately thirty young people and lasted four days. The camps consist of a programme with guest speakers and workshops around resilience and self-acceptance, games and

[7] Christian's ethical responsibilities were outlined in his contract, but they were also part of our regular debriefs. The protection of participant's privacy was a continuous practice reflected in everyday decisions we made together – where to meet people, where to do interviews and where not to do interviews, what to ask or say depending on who was present, who would see us, what people's possible perception of us was and its implications for research participants, amongst many others. Christian often advised me on these considerations given the cultural context.

[8] Counsellors were also available to speak to young people after their interviews with us, either in person or on the phone.

sports, business and entrepreneurship workshops, and small groups encounter sessions for sharing experiences. Multiple young people told me that their free time in the evenings was most valuable to them, where they shared rooms with others and spent time talking at night.

The youth camps were the place where I met most young people who became research participants. At the camps, Christian read out the consent form and we asked who would be willing to participate in an interview. In the first instance, only 6 of the 30 youth requested an interview. At the second camp, 12 out of 30 young people volunteered. It is important to note that most young people did not want to be interviewed. Therefore, the sample of research participants is not representative of the entire population of children conceived in genocidal rape in Rwanda. All research participants were supported by an organisation and lived experiences might be different for those who are not.

On multiple occasions in daily life when I met people in Rwanda and they heard about my research, they said "I believe my niece was born from rape"[9] or "a young man in my home village is born from rape" or "a woman I work with has a child born from rape, but the child does not know". The numerous occasions that people told me this made me wonder about the experiences I did not – and could not – hear about. Thus, the findings of this research need to be understood within its wider context and as a very small sample of experiences.

Ethical Considerations

The research was approved through the University of Cape Town and the Rwanda National Ethics Committees. Risk mitigation measures were put in place to protect the research participants and their communities, as well as myself. These measures consist of methodological concerns but became everyday practices. Everyday ethical practices included consistent reflections on what to say and what not to say, where and to whom, who I was meeting where, who would see me and with whom, where I kept my notes, books and if I would take photos on my phone or not – any connections between myself and participants were an enormous responsibility. This gave me a small glimpse into the lengths young people and their mothers go to in their everyday lives to protect themselves and their children from others knowing about their conception.

Besides everyday considerations about ethics, responsibility also lies in writing about lives that are not my own, particularly as a white European woman conducting research on the African continent. In conducting research of this nature, there is a real danger of reinforcing representations of "Africa as a Dark Continent."[40] Caroline Williamson Sinalo refers to a "narrative of ethnocentrism which sees Africa as a troubled, indescribable, unknowable place in which sexual violence is inevitable and can only be prevented by Western civilization."[41] In highlighting reconstruction and survival, it is important to find a delicate balance between acknowledging young people's painful experiences growing up and representing their lived experiences as young adults who move away from being seen as "conceived in rape" as they live lives away from their hometowns and start families of their own. Experiences they recounted of their childhood, including emotional and physical abuse, extreme loneliness and for some, suicide attempts, must be recognised as themes in the lives of young people conceived in rape to better support them and advocate for their rights. Yet, common themes also include a fierce determination to care for their mothers, successful careers and land ownership (despite the difficulty in acquiring land without a paternal lineage). In showing all sides of young people's lives in the present, our language in referring to them through connotations to the past, will transform.

[9] I use the term "born from rape" here because that is the wording that was used in Rwanda; either "born of rape" in English, or "yavutse ku ngufu" in Kinyarwanda.

Young People vs Young Adults

I choose to refer to the young adults in this article as young people. It is critical to recognise that despite the common appellation of 'children born of …", the young people in this study were aged between 24 and 27 years at the time of research. That is to say, they are young adults. In Rwanda, unmarried youth are usually referred to as *urubyiruko*, "young people" in Kinyarwanda. Organisations referred to young people conceived in rape as *urubyiruko rwavutse ku ngufu.* In the four years that have passed between the start of the research and this writing, some young people married and started their own families. They would now not be considered youth in Rwandan society while those still unmarried continue to be considered *urubyiruko*. That is, nomenclature rests more on social roles than chronological age. Considering the widespread continued use of "children born of…" without considering the actual stages in life of these persons, I believe it is important to make these careful distinctions.

Data Analysis

The data are derived from ethnographic fieldnotes and interview transcriptions. After consent, interviews were recorded. I transcribed the youth interviews and interviews with mothers were transcribed by Carine. I took extensive interview notes around specific phrasing, body language and silences. I used descriptive analysis of fieldnotes, interview notes and transcripts to identify themes and patterns. Throughout the research, as part of what Karen O'Reilly[42] calls "grounded theory in practice", I created integrative memos to clarify and link analytic themes and categories. After fieldwork was completed, I used NVivo qualitative analysis software to organise and code the data, to establish themes and categories from the integrative memos. My fieldnotes consisted of descriptive notes and reflexive notes. Descriptive notes detailed experiences and observations.[43] Reflexive notes held my personal thoughts and feelings about these experiences as well as questions shaped by observations. Some of these questions are explored in this article.

FINDINGS

Challenging Preconceptions

I first visited Rwanda in 2017, to assess the feasibility of my doctoral research. I met with organisations active in the field to ask whether the research would be valuable and whether they would be able to support it by providing safe access to families. A careful literature review had informed my perception of young people as "vulnerable", "hidden", "forgotten" and "traumatised" and I had developed a careful methodological approach to offset risk. An organisation I hoped to work with invited me to see them working at one of their youth camps. I was nervous but excited to test whether the research would be seen as valuable by young people.[10] The camp, hosted in a school, consisted of about twenty people in their early to mid-twenties and the camp facilitators. I introduced myself in Kinyarwanda and, switching to English, explained that my research aimed to understand their lives with their families so as to inform how to better support them. Some nodded their head in agreement. When I asked them if they had any questions for me, a young, trendily-dressed man, raised his hand and asked: "Are you married?". We all laughed. I felt relieved.

That single question changed my perception that I was standing in front of a group of "vulnerable" and "traumatised" young people to standing in front of a group of 23-year-olds.

It was the little moments like these, that became big data points, as is common in ethnographic research. This experience showed me as much about the young people as it did about myself. It was a moment where I almost let my concerns for ethics, fears of the unknown and representations of "children born of war" that fed these fears, allow me to place my concerns above the participation of young people in

[10] Part of my nervousness stemmed from feeling inadequately prepared to meet with young people directly as it was an opportunity that arose unexpectedly. I had ethical and methodological safeguarding measures in place, but had not yet applied for my research permit. The organisation assured me that no ethical clearance was required at this time, as this was an initial exploratory meeting under their supervision. I believe that even if I did have my research permit at that time, I would still have been nervous and felt adequately prepared due to my views solely based on literature.

my exploration of the feasibility of this research – research about them. I wanted to ask them what they thought about the research, and I almost had not. My ethical concerns were valid, but my fears were unfounded.

I include this excerpt from my fieldwork because I believe many humanitarians, psychosocial support service providers and programme managers may face similar dilemmas. It might be easier choosing not to involve children and young people that are considered vulnerable and at risk, but not allowing them to participate in decision-making, research and programmes that concern them is an even greater risk – it allows perceptions about them to remain unchallenged.

Disclosure

I found that mothers worked every day to create barriers between their past and their children's present, protecting their children from living with painful knowledge. Yet, young people grew up asking questions about their biological father and asked why they were treated differently from other children. Sometimes, as Glorieuse Uwizeye et al.[6] found, despite mothers' best efforts, some young people became aware of their birth origins as "their mother might get angry with her child and tell them that they look like their father-perpetrator, or a neighbour might disclose who their father was". My research found the exact same. The Survivors Fund in Rwanda made similar findings as well:

Mothers expressed feeling overwhelmed at how to manage adolescent behaviour, communicate with their son or daughter, and answer questions about who their father is. Such questions became additionally important as their children applied for a national ID at 18 years old, where mother's and father's names are required. Furthermore, some young people are considering marriage and encountering land inheritance, both of which rely heavily on the identity of the father and the father's family. Many have also experienced community gossip and rumours and sensed that they were treated differently from their siblings.[5]

A group of mothers who attended counselling group sessions with the Survivors Fund and expressed these concerns, asked for "help in disclosing to their child the circumstances of their birth."[5] Thus, The Survivors Fund created a 'disclosure programme' where mothers are counselled through the process. This involves having a conversation with their children about the circumstances of their conception. Evidence collected by The Survivors Fund suggests that disclosure led to an improved relationship between mothers and their children as the children came to understand their mother's reactions.[5] In my research, young people expressed similar feelings of understanding towards their mothers. Some emphasised their mother's bravery for living with her genocide memories, some expressed feeling thankful for being alive (as their mother could have chosen an abortion) and others said they now understood why their mother would cry or get angry when they asked about their biological father. Some young people said they stopped asking because they did not want to upset their mother, anticipating her reaction but not understanding the reasons for it.

A range of studies have shown that disclosure can be a starting point for young people's construction of positive identities.[5,31,44,45] However, this is not straight-forward. In Bosnia and Herzegovina, Erjavec and Volčič[45,46] explored how young girls conceived in rape viewed themselves. 17 out of the 19 young girls interviewed used metaphors like "cancer" and "shooting target" to describe themselves, while two girls said they were "warriors for peace" and wanted to use their story of origin for positive change.[45,46] The majority of girls felt immense pain when talking about the moment they found out about their conception and refer to it as "the most traumatic event of their lives."[46] Therefore, the disclosure process requires caution and careful guidance, to avoid it being a "traumatic event."[46] Odeth Kantangwa emphasises this caution:

Disclosure without preparation was reported to be challenging to mothers. In cases where something would provoke disclosure, the end result would be hard to manage. School registration was reported to be one of the provoking factors that led some mothers to disclose unprepared. The mothers who did so as forced by circumstances said it was difficult to deal with the negative consequences of disclosure.[31]

It is worth noting that it is often encounters with the state that precipitate the conditions under which disclosure becomes necessary. In my research, I found that some mothers had anticipated these encounters with the state and prior to school registration told their children to write down the name of their own fathers or brothers to circumvent questions.

Disclosure processes require caution, as does the way in which 'disclosure' is thought about. For children and young people conceived in rape in research or support programmes, a "certainty" of disclosure is required, generally meaning a conversation with their mothers. However, in Rwanda, some young people have grown up with their biological father's family in the same village and have always "known" without any conversation. Cedric, for example, told me that his mother had never discussed her experience during the genocide or disclosed the conditions of his conception; he had 'just known'. Cedric's mother confirmed that they never spoke about it and repeated his assertion: she did not have to, he has always known. Cedric could not identify a specific event which generated this knowledge; it was just his reality growing up. Clara Han beautifully describes this tacit knowledge in "Seeing Like a Child"[47] where she describes how family memories of violence are embedded in everyday life and normalised.

We must therefore be careful about imagining 'disclosure' as an event in time – a conversation – with a distinct "before" and "after", despite the emphasis on 'disclosure' in programmes of support. Knowledge about genocide is transmitted in various ways, not always through 'disclosure' per se. Woolner, Denov and Kahn[48] also found that the roots of "knowing" were transmitted through communities:

"Truth-telling" was often complicated by the fact that family or community members had already insinuated to children through insults and name-calling that they were born from the genocide, as "bastards" or born of "killers." Indeed, for many mothers, "truth-telling" was not merely a matter of disclosing the child's true origins but rather finding the courage to share a complete and honest account of their own painful experiences leading up to conception. The shame experienced by mothers and stigma imposed upon them by community mores influenced a mother's decision to discuss this information with their child.

In my research, one of the main themes of young people's childhood was the experiences with name calling in their neighbourhoods and at school. Some young people did not want to speak about this topic and were emotional when mentioning that children in the school yard called them "bad names" (*amazina mabi*); they described it as one of their worst childhood memories. In many instances, when young people would come home to ask their mothers why other children would call them "a child of killers", their mothers, and at times other family members, would create elaborate explanations to avert their children from having to live with knowledge that would hurt them. Yet, most mothers eventually told their children about their conception after attending the 'disclosure programme'.

Woolner et al. also note that some mothers chose not to have a 'disclosure conversation' with their children so as not to further disrupt their children's lives, stating "In this way, a mother's silence could be seen as a strategy to protect her child from additional hardship and emotional distress"[48]

I too encountered a mother who had chosen not to tell their child, even though he was part of this research. She had told counsellors that she had 'disclosed' and the young man was invited to a camp, where, hearing

stories of others and recognising his own in them, he realised the circumstances of his conception. Although he told us that his mother still considered him "too young" to be living with this painful knowledge, his experience of finding out at the camp was a positive one because he immediately had a support system and knew he was not alone in his experiences.

In designing programmes to support mothers and their children, it is important to recognise that not all mothers need to "find the courage" to disclose, but some consciously choose not to, even after having been given the tools and support to do so.

Beyond "Conceived in Rape"

Young people explained that they aimed to be perceived as something other than "a child conceived in rape". As they graduated from university, found jobs in cities away from the places they grew up in, or became parents, they frequently moved to spaces where their familial circumstances were not known, which enabled them to be seen for who they are and what they achieved, or where the status they attained outweighs their connection to a violent past. Their thoughts on the advice they would offer to others conceived similarly repeatedly showed the importance of their own goals and the possibilities of transformation. Grace, for example, said: "*Work hard and become successful. No one can say bad things about you when you make it and when you take care of your family*". Fidele said:

A life of sadness is not easy. If God allows you to be born, do something good with your life. It will clean the bad things you went through. Don't give up on school, work hard and become someone of importance in this life and do great things. When you do good things, society will see that someone born this way is doing something good for society. You will feel less bad.

Most advice included the building of self-confidence and self-acceptance, working hard and not giving up on oneself. Joseph, who had been very quiet and soft-spoken during his interview suddenly started speaking louder when he answered this question. He spoke and gestured passionately, saying: "*Don't be afraid of anything, of course the past will be there, but think about the future. Have hope and work hard.*"

Answers were often thoughtful and practical. Alphonse advised:

Even if you are born with this history, it is not the end of your life. Tomorrow will be better. Try to meet others like you, even if no one knows who the others are, speak out and find opportunities to know they are there. Search for information on where they gather and plan your next steps. You have the responsibility for your own life. You are not the only one in the world like you.

The question about their hopes for the future elicited answers that showed how much young people think about how they are perceived by others, not always in a negative light. Felix and Chantal gave almost identical answers: "*I wish to be a role model, someone people look up to*" (Felix) and "*I wish to be an example for others and inspire them, regardless of my [financial] level of living.*" (Chantal).

When asked what they were most proud of, many spoke of their self-reliance and hard work, studies, and graduation. Others answered that they were proud of their mothers, for giving birth to them and "standing up" for them. Faustin said he was most proud of the strength with which he faced the difficult journey he called his life: "*I have gone from being that child to becoming this person.*"

DISCUSSION

"Children Born of War" Discourses

Scholars such as Charli Carpenter and Donna Seto have called for children conceived in wartime rape to be placed on global human rights agendas and through their advocacy efforts, global discourses have brought attention to "forgotten children born of war."[9] In recent years, further research has been conducted on children conceived in rape and children and young people are increasingly involved as active

subjects in research about them. With this progress, it is important to re-evaluate the discourses that were initially created to provoke global policy. As I built close personal relationships and friendships with young people in Rwanda, I became uncomfortable with reading about them as "children born of war" or "war babies". Besides the sensationalising tone – which was perhaps necessary in the early 2000s to generate global advocacy – calling children "born of war" precludes them from being seen for who they really are. It plays into ideas of them as merely political agents, symbols of suffering or of reconciliation. Why can they not just be children? Children are born from their mothers. Humans are born from humans, not from events. Linking the birth of a person, a human being, to a violent past event, creates a basis for seeing them as representations of this violence.

In Rwanda, I asked Mariya, a young woman conceived in rape, what she was most proud of in her life. She answered: "*I think I am a trustworthy person, I work hard to be independent, and people see me as a good person*". Do we, through our discourses, see her in that light? We see Mariya for a past event she seemingly cannot escape even as she "works hard to be independent". In the context of her interview, she meant that she works to be financially independent from her mother and her mother's husband, but in doing so, she also becomes less dependent on how she was seen growing up – a child of rape. Now, she says, people see her as a good person. Yet, in the advocacy mode of speech, her hard work or character are not seen.

Re-thinking the discourses used to refer to children conceived in rape is not solely important with respect to them, but because local organisations and community groups supporting these children and their mothers create "social worlds out of global words."[49] Global advocacy for children's rights results in local communities using rights discourse and terminologies, shaping the understandings and support given to recipients and ultimately affecting their daily lives. In Rwanda, the youth camps and workshops play a role in how young people see themselves and their place in society. Young people's experiences are directly influenced not only by globalised terminologies, but ideas about what they are – symbols, representations, memories, legacies –; that is, anything but a person. In Rwanda, young people have access to the internet and study social studies, sociology and political science, they can easily come across academic work written about them, referring to them as "war babies". I have not heard about this happening over the years of this research, but I wonder what they would say. We cannot speak about them as if they will never read or hear our words.

From "Born of Rape" to "Conceived in Rape"

Having discussed the problematic nature of "born of war" discourses, it is important to also evaluate the terminology around being "born of rape". In Rwanda, children conceived in genocidal rape were called "enfants mauvais souvenirs" (children of bad memories). That is, they were represented as memories rather than human beings. Additionally, in Kinyarwanda, young people conceived in rape are referred to as "born of rape" (*yavutse ku ngufu*). While respecting local terms and including these in the analysis, these terms can be seen as rooted in patrilineal structures related to women's roles in giving birth as well as the adoption of international discourses around genocide, sexual violence and children "born of rape". I propose to use the term 'conception' rather than 'birth'. The terminology "born of rape" assumes that the act of rape is still present in birth. While the effects of rape are still present and the birthing process can regenerate traumatising experiences, there is a distinction to be made between the act of rape and conception, and the act of birthing. Some women chose to have abortions and not give birth, whereas others chose to keep their babies or were unable to make different decisions.[27,50] Many of the mothers in my research had actively chosen to give birth to their children, resisting pressures from their families, even when taken to hospital for an abortion. Therefore, many of the children conceived from rape were born through maternal choice. The phrase "born of rape" bypasses

this choice. The Kinyarwanda term *kuvuka ku ngufu* (to be born of rape) stems from the verb *gufata ku ngufu* (rape) which literally translates to "to take by force" (*ku ngufu* means *by force*) and therefore *kuvuka ku ngufu* translates as "to be born by force". Some children were conceived by force, but born because women resisted the attempt to force them to undergo abortions. Of course, having made the choice to have their children does not imply that raising the child was less difficult. They worked hard to protect them from family members who did not accept them, or abused them. They also worked hard to protect them from hurt through knowing about their conception, and generally went to great lengths to shield their children from harm.

Literature written about mothers of children conceived from conflict-related sexual violence often highlights the ambivalent mother-child relationship[31,48] and represents these children as "living reminders of suffering."[27] This creates the assumption that these children might be unwanted due to being perceived as symbols or representations of the past rather than human beings born from other human beings. My research challenges the assumption that all children conceived in rape are unwanted. My findings reiterate literature that shows how some mothers have found survival and meaning in motherhood in their lives after the genocide.[31,51] For example, Martin separated his conception from his birth, saying:

We were conceived with no love because of the rape, but we were born with love. Some women chose an abortion or committed suicide, but the mothers that carried us for nine months and breastfed us, that is love.

UN Resolution 2467 recognises "women and girls who become pregnant as a result of sexual violence in armed conflict, including those who choose to become mothers."[35] The language we use should reflect this choice. Therefore, I suggest that scholars, policy makers and service providers in places facing conflict-related or genocidal sexual violence, should not assume that women would choose abortions if this option were available, and should question existing ways of thinking about the children yet to be born, as they are more than manifestations of violence.

Collective Identities and Participation

An additional risk inherent in the use of terminologies such as "born of war", "born of rape" and also "conceived in rape" is viewing people in purely categorical terms. A continued conversation is required about how we represent and illustrate people with vastly different lived experiences, with only the circumstances of their conception in common. Labelling them as a "group" does not always reconcile how they see themselves. Claudine, in her interview, spoke of "those children" when she answered questions about her life as having been "conceived in rape", distancing herself from "the group" as she does not view her own lived reality as common with others'. In the research, I asked young people to share 'their story' but the story they told me, their life story, did not always centre around being conceived in rape. That is, their conception does not necessarily characterise their lives. Writing about them as a group isolates them from their peers – their age mates – which is something they identified as very painful while growing up.

Hogwood et al. discuss that after the process of disclosure, young people "now had the power and agency to do something about it and could construct a narrative that makes sense of their experience and connect with others in a similar social position."[5] My research confirms this: young people told me that at the youth camps they came to know they are not alone, or that they had found their only friends at the camp. However, there is a fine line between the benefits and risks associated with bringing young people together. Whereas "being together" shows pathways to healing, there is a risk of furthering stigma by being seen as a "group". Indeed, an organisation supporting children conceived in rape in Bosnia and Herzegovina decided to discontinue their group programmes as they found it increased

stigmatisation of children and young people in those groups. Ethical considerations need to be weighed differently in different contexts, ultimately finding a context-appropriate balance between protection and participation. UNICEF's Youth Participation Protocol outlines participation as follows:

Participation ensures the right of young people (individually or collectively) to form and express their views and influence matters that concern them directly and indirectly. Participation is about being informed, engaged, and having an influence on decisions and matters that affect one's life – in private and public spheres, in the home, in alternative care settings, at school, in the workplace, in the community, in social media, in broader governance processes, and in progrmmes.[52]

In 2017, Denov and Lakor included young people conceived in rape directly in their research as co-researchers.[3] Steps are being taken to increasingly involve young people as individuals and collectives. It is our responsibility to hear them, without imposing labels onto them.

CONCLUSIONS

Alen Muhic, co-founder of the Forgotten Children of War Association in Bosnia and Herzegovina spoke at the UN in New York: "We are called by various names that are often inhumane and stigmatizing."[53] This article has explored ways in which scholars and humanitarians can start to think about children, young people and adults conceived in rape, in the first instance by making language used less "inhumane and stigmatising". In doing so, increasing visibility of young people and their mother's agency and narrative about themselves. As I have shown, some of the key terms in contemporary humanitarian discourse such as "children born of war", and "children born of rape" as well as ideas about 'disclosure' may be useful at one moment in a life cycle but may undermine young people's strategies to live beyond the circumstances of their conception. Faustin saying "I have gone from being that child to becoming this person" shows that life is not static, an unchanging connotation to one's conception is at odds with the dynamic nature of living. Following Claudine's beautiful example of a mirror, we can start by picking up the single pieces. We see the different pieces of a broken mirror, the war and rape around the rough edges, but we have to continue to strive towards seeing the individual, the survivor. Then, we can work towards using a survivor-centred approach; an approach in which we see the individual lived experiences of children and young people, invite them to share them with us, so that we speak with them rather than about them. Ethical considerations discussed in this article are an invitation to organisations to assess contexts where they can accommodate "the right of survivors to decide what help is best for them and who should know about what happened."[39] It is an invitation to explore safe pathways for young people to know about their conception and then be brought together to participate in programmes and advocacy efforts. My apprehension to meet with young people in 2017 showed how "born of war" discourses and its associations can misrepresent our understanding of young people's agency and capacity to advocate for themselves and others like them, pre-framing them as non-agentive and representing them in categorical terms. I ask that we look beyond the scars, the "symbols" and "legacies", pick up individual pieces of the mirror, and let the reflections speak to us. As I have shown, young people have ideas about their lives to which we should pay attention.

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INFORMED CONSENT

Ethical clearance was obtained from the Rwanda National Ethics Committee (RNEC) with numbers 029/RNEC/2019 and 025/RNEC/2020. Statements of Informed Consent were obtained from all participants in this research. Prior to interviews, we read the detailed consent forms out loud, discussed questions and clarifications, we emphasised their rights including the right to withdraw at any time. The form included phone numbers of RNEC, NGO counsellors, the researcher and translator. All participants signed the form and were provided with a copy. The Informed Consent forms were reviewed and cleared by RNEC.

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Peacekeeper perpetrated sexual exploitation and abuse, and life satisfaction: A cross-sectional study in Haiti

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ABSTRACT

Peacekeepers from the UN Peacekeeping Operation 'Mission des Nations Unies pour la stabilisation en Haïti' (MINUSTAH) have been accused of widespread sexual exploitation and abuse throughout their time in Haiti. However, victims have not received adequate reparations, support, or justice. To date, no research has been done to quantifiably examine how peacekeeper-perpetrated sexual exploitation and abuse (PP-SEA) has affected the lives and well-being of those who have experienced it.

Using multivariate linear regression analysis, this research examines the association between PP-SEA and Satisfaction With Life (SWL) among Haitian community members. Among those who shared third-person micronarratives (n=1588), experiencing PP-SEA was associated with higher average SWL scale scores compared with those who did not. There was no association between PP-SEA and SWL among individuals who shared first-person micronarratives (n=887). Potential contextual factors that may have contributed to these findings were examined, e.g. the occurrence of transactional sex, nuance in peacekeeper-civilian relationships, and other negative experiences with MINUSTAH within the unexposed group. These results highlight the complexity of the relationship between PP-SEA and SWL in the Haitian context and provide direction for future research.

Keywords: Haiti, MINUSTAH, Peacekeeping, Satisfaction With Life (SWL), Sexual Exploitation and Abuse (SEA), United Nations

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INTRODUCTION

From 2004-2017, the UN Peacekeeping Operation 'Mission des Nations Unies pour la stabilisation en Haïti' (MINUSTAH) was active for the purposes of stabilizing the political environment as well as reducing gang presence and drug-related crime in Haiti.[1] Following the 2010 earthquake, the role of MINUSTAH peacekeepers expanded to include human rights protection & humanitarian assistance.[2]

MINUSTAH personnel have been accused of widespread sexual exploitation and abuse (SEA) throughout their time in Haiti, including rape, prostitution, sex trafficking, transactional sex, child prostitution, and child molestation.[3] The UN has declared peacekeeper-perpetrated SEA (PP-SEA) to be the most significant risk to peacekeeping operations,[4] and allegations against MINUSTAH peacekeepers make up ~26% of all PP-SEA allegations, despite MINUSTAH only representing 7% of UN peacekeepers globally.[5] As of April 2022, 121 SEA allegations against MINUSTAH peacekeepers have been formally reported to the UN, in addition to 38 paternity claims related to PP-SEA.[6] These numbers are believed to be gross underestimates as PP-SEA is widely underreported due to stigma, an environment of impunity for peacekeepers, and the breakdown of the rule of law in Haiti.[7–9]

Peacekeeper-Perpetrated SEA

The UN defines sexual abuse as: "Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. All sexual activity with a minor (a person under the age of 18) is considered as sexual abuse."[6] Sexual exploitation is defined as: "Any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. This includes acts such as transactional sex, solicitation of transactional sex, and exploitative relationships."[6] The UN's zero-tolerance policy prohibits these acts of SEA and strongly discourages all sexual interactions between UN staff and beneficiaries of assistance (for example, local women/girls) due to the inherently unequal power dynamics in these relationships.[10]

Violation of this policy could result in disciplinary measures, up to and including summary dismissal of the UN staff involved.[10] However, accountability for PP-SEA is complicated by agreements between troop-contributing countries and the UN, which outline that military peacekeepers can only be prosecuted by their own country's military justice system.[11] With many countries unable or unwilling to conduct criminal investigations into PP-SEA allegations, this creates an environment of impunity for peacekeepers.[12]

Previous studies on this topic have primarily been qualitative, examining community perceptions of PP-SEA in Haiti,[13] gendered differences in perceptions of civilian-peacekeeper sexual interactions,[14] and how experiences of PP-SEA affect the desire to engage with MINUSTAH.[15] Moreover, analyses of the lived experiences of women/girls who are raising a peacekeeper-fathered child,[8,12,16,17] and experiences of transactional sex,[3,16] have been published. Financial and material support was commonly identified as a key element of sexual interactions between local women/girls and peacekeepers,[13,14,16] and it was found that most women who engaged in transactional sex did so to fill unmet economic needs.[3] Many abusive interactions were also documented in these studies, including PP-SEA committed against children and other vulnerable individuals.[13] Women/girls were found to face stigma, discrimination, and damaged reputations as a result of PP-SEA, especially those raising a peacekeeper-fathered child.[8,17] Moreover, it was found that women who are raising a peacekeeper-fathered child are typically not supported financially by the peacekeeper father when he is repatriated to his home country, leaving the mother and child in exacerbated poverty.[8,12] This is confirmed by a recent UN report which revealed that 273 of 305 paternity and child support claims associated with PP-SEA allegations have still yet to be resolved.[18]

Response to Peacekeeper-Perpetrated SEA

The UN has made some attempts at providing assistance and support to survivors of PP-SEA and children fathered by peacekeepers, including the implementation of a voluntary Trust Fund;[19] however, this has failed to meet the needs of many affected women and children and fails to recognize their legal entitlements. Due to widespread underreporting of PP-SEA, especially in Haiti,[9] many victims do not benefit from the UN Trust Fund's programmes.

Additionally, the Trust Fund does not provide funds directly to the affected individuals or their children,[20] but rather intends to provide vocational training to those affected by PP-SEA to allow for income generation. For women who are raising a peacekeeper-fathered child in poverty, this type of support may not be as useful as receiving child support payments. Consequently, the attempted support from the UN is inadequate to remedy victims of PP-SEA in Haiti. When advocating for reparations for those affected, quantitative data about the impact of PP-SEA on Haitian's lives and well-being is valuable; however, no research on this has been done to date.

Satisfaction With Life

Examining Satisfaction With Life (SWL) is one way to assess well-being. SWL is an integral component of subjective well-being that is associated with a variety of outcomes including mental and physical health, academic success, and quality of social relationships.[21,22] Higher overall SWL is also inversely correlated with several clinical distress measures and is predictive of suicide risk, with lower SWL indicating a higher risk of suicidal behaviors.[21] Furthermore, studies have shown that experiencing trauma (including sexual abuse) is associated with lower life satisfaction.[23–25] Considering this, SWL measured by the Satisfaction With Life Scale (SWLS) can provide a useful quantitative measure of how people's lives have been affected by PP-SEA. This scale has demonstrated validity and been applied across a diverse range of geographical settings and populations, including those who have experienced trauma.[26–28]

In addition to traumatic experiences, other circumstances have demonstrated an association with SWL. Higher income and education levels are associated with higher SWL,[29,30] as is being female. In contrast, being unmarried, divorced, or separated,[31] living in poverty,[32] and living in rural areas of low and middle-income countries is associated with lower SWL.[33] Age does not demonstrate a linear association with SWL, however several studies have found that individuals between 40-60 years old tend to have the lowest SWL scores of all age groups.[31]

The nature of the SWLS allows individuals to evaluate their lives according to their own criteria and beliefs, making it an effective tool for assessing life satisfaction in different contexts.[28]

The current study aims to utilize SWLS to address the present gap in literature regarding the impact of PP-SEA on affected individuals in Haiti.

Objectives

The current analysis has two objectives:

1) To evaluate the association between PP-SEA and SWL among Haitian community members. It is hypothesized that those who shared a micronarrative about PP-SEA will have lower SWLS scores compared with those who did not share such a micronarrative.

2) To examine whether the association between PP-SEA and SWL among Haitian community members differs when stratified by who experienced the PP-SEA. It is hypothesized that the association between PP-SEA and SWLS scores will be stronger among those who directly experienced PP-SEA in comparison with those with indirect experience.

METHODS AND MATERIALS

Study Design and Setting

This is a secondary analysis of raw data collected from a larger mixed-methods, cross-sectional study conducted in 2017.[12] The parent study was conducted in 11 Haitian communities located within 30km of MINUSTAH bases, including Cité Soleil, Charlie Log Base, Tabarre, Gonaïves, St. Marc, Hinche, Léogâne, Port Salut, Morne Cassé, Fort Liberté, and Cap Haïtien (see Appendix A). Between June and August 2017, a total of 2541 micronarratives were collected about interactions between local women/girls in these communities and MINUSTAH peacekeepers using Cognitive Edge's SenseMaker tool. The parent study did not ask about PP-SEA specifically, and as such not all micronarratives collected were about this topic.

Study Participants

Individuals aged ≥11 living in the above-mentioned Haitian communities were eligible to participate in the parent study. Potential participants were recruited through convenience sampling in public locations (for example, markets, shops, transportation hubs, and parks) during the daytime. To be included in the current analysis, participants had to have complete information on the exposure and outcome variables of interest (n=2521).

Survey Instrument

Cognitive Edge's SenseMaker is a mixed-methods tool that allows for the collection of micronarratives using audio recordings and subsequent interpretation of these micronarratives by participants through a series of pre-defined questions.[34]

At the beginning of the survey, participants were asked to share a brief narrative (referred to as a micronarrative) about the experiences of women/girls interacting with MINUSTAH peacekeepers in their communities. The experience could be first-hand or about a family member, friend or neighbour, or something that the participant had heard about in their community.

After audio recording the micronarrative, participants interpreted the shared experience by responding to a series of questions, including several multiple-choice questions used to contextualize and understand the micronarrative.

Exposure

The exposure of interest is PP-SEA. Individuals who shared micronarratives that mentioned PP-SEA and/or a peacekeeper-fathered child were included in the exposed group (n=586). This was indicated by the research assistant facilitating the interview through their response to multiple choice questions asking whether the experience shared was about/mentioned PP-SEA and/or about/mentioned a peacekeeper-fathered child. The unexposed group consisted of those who did not share such a micronarrative (n=1935).

Outcome

SWL is the outcome of interest, measured using the SWLS.[35] Participants were asked to rank their agreement with each of five statements, with options ranging from 1– strongly disagree, to 7 – strongly agree (see Appendix B). Other studies utilizing this scale treat SWL as a continuous numerical variable using the sum scores across the five statements, which can range from 5–35, with higher scores reflecting higher SWL.[35] The psychometric properties of the SWLS have been tested in numerous studies, the unidimensional structure has been supported and internal consistency has been proven.[35–37]

Covariates

Marital status, gender, age, income, education, and location have demonstrated an association with SWL,[29–31,33,38] and were therefore considered as potential confounders on the association of interest. These demographic data were collected in the parent study (see Appendix C for relevant survey questions).

Analysis

The exposure variable (PP-SEA) was treated as a binary categorical variable, with the options of "yes" or "no" indicating whether the participant shared a micronarrative about PP-SEA. Earlier studies utilizing the SWLS have typically used the mean scores across participants in their analyses.[31,39,40] As such, this outcome was measured by mean SWLS scores. To evaluate potential confounding, bivariate analyses including t-tests, chi-square tests, and Fisher exact tests were used to examine the differences between the exposed and unexposed groups for each covariate of interest. Fisher tests were used for the variables of gender and age as some of their expected values were too small for conventional chi-squared tests.[41] Those covariates that had p-values lower than 0.1 were then evaluated using the change-in-estimate (CIE) approach to create the final multivariate model.[42] P<0.1 was chosen as the threshold for the bivariate tests to reduce the possibility of potential confounders being removed prematurely.[43] In marital status, the groups "Divorced/Separated from spouse" and "Widowed" were collapsed as both had small

sample sizes (n=21 and 16, respectively) and similar definitions. The new variable used throughout analysis was "Disrupted marriage" to be consistent with existing literature that combines these groups.[44] The locations used in the initial study were also collapsed based on geographic proximity (see Appendix A).

To assess which variables produced the largest change in the effect estimate, a full model was first created that included all potential confounders identified in the bivariate analysis. Subsequent linear models with one less covariate each were generated, and the relative difference in effect estimates between these and the full model were individually computed. Only variables that changed the effect estimate by >10% were kept in the model as this was considered indicative of confounding[45].

Ultimately, a linear model that controlled for all significant confounders was created to evaluate the primary objective.

For the secondary study objective, a stratified analysis was undertaken based on who experienced the events of the micronarrative shared. Direct experiences included those who indicated in the survey that their micronarrative was "about me" (n=887), while indirect experiences included micronarratives designated as being about someone other than the participant (n=1588). Those who responded that they "prefer not to say" who their micronarrative was about (n=46) were excluded from this analysis.

Stratified linear regression was used to evaluate the associations between direct/indirect experiences of PP-SEA and mean SWLS scores while controlling for the confounding variables identified in the primary analysis. R software was used for data analysis and P<0.05 was considered statistically significant.

Ethics

The Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board approved the parent study in which the data was collected (protocol # 6020398), in addition to this sub-analysis (protocol # 6035394). Informed consent was obtained from all participants and no identifying information was collected. As the survey was brief, no compensation was offered for participation.

This study was designed and implemented in partnership with three Haitian partner organizations: Enstiti Travay Sosyal ak Syans Sosyal (ETS), Komisyon Fanm Viktim pou Viktim (KOFAVIV), and Bureau des Avocats Internationaux (BAI), as well as BAI's US-based partner Institute for Justice & Democracy in Haiti (IJDH).

RESULTS

Characteristics of Study Participants

Table 1 summarizes the demographic characteristics of the study participants. Of the 2521 micronarratives included, 586 (23.2%) were about PP-SEA against Haitian civilians. Despite intention to recruit roughly equal numbers of men and women, males made up the majority of participants (70.9%). Most participants were single (60.8%) and reported having an average household income (63.7%). Participants were most frequently between the ages of 25-34 (33.0%), located in Port-au-Prince (22.8%), and had completed some secondary education (38.0%). Those who shared a micronarrative about PP-SEA had statistically significantly higher mean SWLS scores than those who did not share such a micronarrative. Bivariate testing indicated that gender, education level, income level, and location differed significantly between the exposed and unexposed groups. More males than females shared micronarratives about PP-SEA, and individuals living in Port Salut shared more micronarratives about PP-SEA than any other location. While not being perfect linear relationships, generally those with higher income and education levels shared more micronarratives about PP-SEA than those with lower income and education levels. Based on the CIE confounder selection approach, education was the only covariate controlled for in the linear regression analyses.

Table 1 Bivariate Analysis Comparing Those Who Did and Did Not Share a Micronarrative about PP=SEA

Characteristic	Shared a Micronarrative about PP-SEA			
	All Participants [n(%)]	Yes [n(%)]	No [n(%)]	P value
Gender				
Male	1788 (70.9)	429 (24.0)	1359 (76.0)	0.02*
Female	731 (29.0)	155 (21.2)	576 (78.8)	
Prefer not to say	2 (0.1)	2 (100)	0 (0)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
Age (Years)				
11 – 17	238 (9.4)	50 (21.0)	188 (79.0)	0.15
18 – 24	583 (23.1)	142 (24.4)	441 (75.6)	
25 – 34	833 (33.0)	215 (25.8)	618 (74.2)	
35 – 44	432 (17.1)	92 (21.3)	340 (78.7)	
45 – 54	234 (9.3)	42 (17.9)	192 (82.1)	
> 55	138 (5.5)	28 (20.3)	110 (79.7)	
Prefer not to say	61 (2.4)	17 (27.9)	44 (72.1)	
Missing	2 (0.1)	0 (0)	2 (100)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
Marital Status				
Married/living together	911 (36.1)	201 (22.1)	710 (77.9)	0.21
Disrupted marriage	37 (1.5)	11 (29.7)	26 (70.3)	
Single never married	1534 (60.8)	369 (24.1)	1165 (75.9)	
Prefer not to say	39 (1.5)	5 (12.8)	34 (87.2)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
Education Level				
No formal education	125 (5.0)	12 (9.6)	113 (90.4)	< 0.01*
Some primary school	283 (11.2)	62 (21.9)	221 (78.1)	
Completed primary school	279 (11.1)	59 (21.1)	220 (78.9)	
Some secondary school	959 (38.0)	239 (24.9)	720 (75.1)	
Completed secondary school	492 (19.5)	101 (20.5)	391 (79.5)	
Some post-secondary school	279 (11.1)	82 (29.4)	197 (70.6)	
Completed post-secondary school	104 (4.1)	31 (29.8)	73 (70.2)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
Income Level				
Poor	745 (29.6)	169 (22.7)	576 (77.3)	< 0.01*
Average	1606 (63.7)	361 (22.5)	1245 (77.5)	
Well-off	170 (6.7)	56 (32.9)	114 (67.1)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
Location				
Port-au-Prince	576 (22.8)	128 (22.2)	448 (77.8)	< 0.01*
Léogâne	354 (14.0)	50 (14.1)	304 (85.9)	
St. Marc / Gonaïves	361 (14.3)	89 (24.7)	272 (75.3)	
Port Salut	364 (14.4)	170 (46.7)	194 (53.3)	
Hinche	359 (14.2)	76 (21.2)	283 (78.8)	
Cap Haïtien	287 (11.4)	52 (18.1)	235 (81.9)	
Morne Cassé / Fort Liberté	220 (8.7)	21 (9.5)	199 (90.5)	
Total	2521 (100)	586 (23.2)	1935 (76.8)	
SWLS Score	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	
Mean SWLS Score	21.19 (6.0)	22.26 (5.8)	20.87 (6.0)	< 0.01*
Total	2521 (100)	586 (23.2)	1935 (76.8)	

SD Standard Deviation * Statistically Significant

Table 2 Unadjusted and Adjusted Results of Multivariate Linear Regression Analysis Comparing Average SWLS Scores of Those Who Shared a Micronarrative about PP-SEA and Those Who Did Not

	Unadjusted results (n=2521)		Adjusted Results (n=2521)	
	Coefficient#	95% CI	Coefficient#	95% CI
Intercept	20.87*	20.60*, 21.14*	22.49*	21.35*, 23.63*
Exposed to PP-SEA	1.39*	0.83*, 1.94*	1.12*	0.58*, 1.67*

*CI Confidence Interval *Statistically Significant # Adjusted for Education Level*

Table 3 Results of Stratified Multivariate Linear Regression Analysis Comparing Average SWLS Score Between Those Who Shared a Micronarrative about PP-SEA and Those Who Did Not, Stratified by Whether it was a Direct or Indirect Experience

	Direct Experience (n=887)		Indirect Experience (n=1588)	
	Coefficient#	95% CI	Coefficient#	95% CI
Intercept	21.94*	20.28*, 23.60*	22.79*	21.22*, 24.35*
Exposed to PP-SEA	0.65	-0.81, 2.10	1.19*	0.57*, 1.81*

*CI Confidence Interval *Statistically Significant # Adjusted for Education Level*

Table 4 Results of Multivariate Linear Regression Analysis Comparing Average SWLS Score Within the Exposed Group of Those Who Shared a PP-SEA Micronarrative Involving a Peacekeeper-Fathered Child and Those who Shared a PP-SEA Micronarrative That did not Involve a Peacekeeper-Fathered Child (n=586)

	Coefficient#	95% CI
Intercept	24.96*	22.93*, 26.99*
Mentioned Peacekeeper-Fathered Child	-0.87	-1.85, 0.12

*CI Confidence Interval *Statistically Significant # Adjusted for Education Level*

Association between PP-SEA and SWL

In the adjusted multivariate linear regression analysis, sharing a micronarrative about PP-SEA was associated with higher mean SWLS scores (Table 2).

Association Between PP-SEA and SWL Stratified by who Experienced the PP-SEA

The results of the stratified linear regression analyses evaluating SWL among participants with direct and indirect exposure to PP-SEA are shown in Table 3. Among participants who shared first-person (direct) experiences (n=887), there was no association between mean SWLS scores and experiencing PP-SEA when compared with those who did not experience PP-SEA. However, among participants who shared third-person (indirect) experiences (n=1588), sharing a micronarrative about PP-SEA was associated with higher mean SWLS scores in comparison to those who did not share about PP-SEA.

Association Between Having a Peacekeeper-Fathered Child and SWL

Table 4 includes the results of a *post hoc* linear regression analysis within the exposed group of those who mentioned a peacekeeper-fathered child in their micronarratives (n=196) and those who did not (n=390). Those who shared a micronarrative about PP-SEA and a peacekeeper-fathered child had lower average SWLS scores than those who shared PP-SEA micronarratives that did not involve a peacekeeper-fathered child; however, this difference was not found to be statistically significant.

DISCUSSION

In this secondary data analysis evaluating the association between PP-SEA and SWL in Haiti, sharing a micronarrative about PP-SEA was associated with higher average SWLS scores. This finding was consistent among those who shared micronarratives about indirect experiences, but not those who shared about direct experiences.

Based on these unexpected results, an additional *post hoc* linear regression analysis was conducted to examine whether the association between PP-SEA and SWL varied based on whether a child was conceived and born from the PP-SEA. This decision was based on previous literature that found many women experience extreme economic hardship and stigma as a result of raising a peacekeeper-fathered child.[12] No significant association was found between whether a PP-SEA micronarrative involved a peacekeeper-fathered child or not and SWL.

These findings are inconsistent with both our hypotheses and existing literature which has found that exposure to trauma (including sexual trauma) is generally associated with lower life satisfaction.[23-25] The findings do, however, support some literature that has found exposure to moderate lifetime adversity/trauma predicts higher life satisfaction over time, likely due to the resilience it fosters.[24,25] Though information regarding time since the events of the micronarrative was not collected as part of the parent study, it is possible that resilience over time could be contributing to the observed results. This may be an area to explore in future studies.

There are also several contextual circumstances that may help to explain these unexpected results. Primarily, many experiences of PP-SEA involved transactional sex, which is the exchange of sex for money, material goods, protection, or other benefits.[4,6] Since transactional sex with peacekeepers is often motivated by poor economic circumstances,[3,16] and poverty is associated with reduced SWL,[32] it is possible that participants who experienced transactional sex faced such economic deprivation that the ability to meet their basic needs through transactional sex resulted in higher SWL. Moreover, women who engage in transactional sex or other sexual relationships with peacekeepers may not necessarily view these experiences as traumatic, but rather as a means of survival or simply the norm.[16] Additional nuance in the nature of sexual relationships between Haitian women and MINUSTAH peacekeepers should also be considered, as the UN definition of PP-SEA includes relationships that may be perceived by affected women as romantic in nature.[16] In these cases, an individual's SWL may not have been negatively impacted by these relationships, despite it technically being considered PP-SEA according to the UN definition. In future studies, distinguishing transactional sex and romantic relationships from other forms of PP-SEA could provide more comprehensive insights around how these sexual interactions impact SWL.

Many micronarratives shared in the unexposed group discussed negative experiences with MINUSTAH unrelated to PP-SEA, including violent events and cholera. As such, it is possible that these other experiences greatly reduced the SWL in this group. This may also help to explain the findings of the stratified analysis. The lack of significant association between PP-SEA and SWL for direct micronarratives could be due to other non-PP-SEA traumatic experiences in both the exposed and unexposed groups. Among the indirect micronarratives, it is difficult to confidently attribute the reported SWL to the experiences shared, as the SWL scores were for the narrator rather than the individual who experienced the events of the micronarrative. As such, a variety of other contextual and personal factors could have impacted this association. One possible explanation for the observed association between PP-SEA and SWL among those with indirect experience of PP-SEA is that the events of the micronarratives shared in the unexposed group could have posed greater physical harm to the individuals involved than in the exposed group. Extreme injury, illness, death of a loved one from violence, or cholera may have had a greater impact on their life and subsequent SWL than would the PP-SEA of such an individual.

LIMITATIONS AND STRENGTHS

Due to the cross-sectional design of the parent study, it is not possible to make causal inferences. Additionally, the convenience sampling reduces the generalizability of this study, and the study sample was not representative of the Haitian population overall due to women, children, and older adults being underrepresented. Convenience sampling may also have introduced a potential selection bias, affecting the study's internal validity.[47] The limited number of first-person micronarratives about PP-SEA in this study may have impacted the results, as we hypothesize that those micronarratives would provide the most accurate assessment of the association between PP-SEA and SWL.

Since the current study is a secondary data analysis, assessment of confounding variables is limited to the demographic data collected in the original study. It is possible that other cultural or contextual factors contribute to the associations but were not considered here, such as occupational status, smoking status, overall perception of one's health, and mental illness.[31] A final limitation is the potential for misclassification of exposure, as participants were never directly asked if they had been exposed to PP-SEA. It is therefore possible that some participants who were designated as unexposed could have experienced PP-SEA but chose not to share it in their micronarrative. This would have resulted in a decrease in the SWLS scores of the unexposed group thereby obscuring the true association.

The study also had several strengths, including SenseMaker's mitigation of three types of bias. Interpretation bias is greatly reduced as participants were asked to interpret their own micronarratives.[48] Social desirability bias is also reduced as SenseMaker questions are designed in such a way that the possible responses for any given question are all positive, negative, or neutral,[48] therefore there is no response that is more clearly socially acceptable or desirable. Finally, not prompting for micronarratives about PP-SEA reduced reporting bias, as participants were not led to share such micronarratives. Another key strength of this study is that six of the most common covariates for SWL identified in the literature were assessed as potential confounders.

Future studies that aim to evaluate the impacts of PP-SEA on SWL could mitigate some of the above-mentioned limitations by collecting more direct narratives and specifically asking about PP-SEA to ensure accurate exposure allocation. Expanding demographic questions to include other variables could allow for further evaluation of other potential confounders.

CONCLUSIONS

The relationship between PP-SEA and SWL in the Haitian context is complex and transcends other studies, which have concluded that increased trauma leads to lower SWL. Further research is needed to better understand why those with exposure to PP-SEA reported higher average SWL than those who did not. Additional research should examine the perceptions and effects of transactional sex in Haiti, specifically on the SWL of those affected.

The results of the current study do not minimize, in any way, the serious and damaging effects of PP-SEA. Instead, the findings encourage consideration of contextual factors that may play a role in the relationship between PP-SEA and SWL, in addition to providing direction for future research that may contribute to a more adequate response to meeting the real needs of PP-SEA victims in Haiti.

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ACRONYMS

BAI Bureau des Avocats Internationaux
ETS Enstiti Travay Sosyal ak Syans Sosyal
IJDH Institute for Justice & Democracy in Haiti
KOFAVIV Komisyon Fanm Viktim pou Viktim
MINUSTAH Peacekeeping Operation 'Mission des Nations Unies pour la stabilisation en Haïti'
PP-SEA Peacekeeper-perpetrated sexual exploitation and abuse
SEA Sexual exploitation and abuse
SWL Satisfaction With life
SWLS Satisfaction With Life Scale
UN United Nations

APPENDIX A

SenseMaker Interview Locations

The locations of the SenseMaker interviews conducted in the parent study are shown in the following figure. Port-au-Prince includes UN bases at Cité Soleil, Charlie Log Base, and Tabarre. In this study, data from St. Marc is combined with Gonaïves, and Fort Liberté is combined with Morne Cassé due to their geographic proximities.

Fig 1A Map of Interview Locations in Haiti

APPENDIX B

Satisfaction With Life Scale

Here are some questions about your life.

7 – Strongly agree, 6 – Agree, 5 – Slightly agree, 4– Neither agree nor disagree, 3 – Slightly disagree,2 – Disagree, 1 – Strongly disagree

____In most ways my life is close to *my* ideal.

____The conditions of my life are excellent.

____I am satisfied with my life.

____So far I have gotten the important things I want in life.

____If I could live my life over, I would change almost nothing.

Text was translated from English to Haitian Kreyol

APPENDIX C

Collection of Demographic Information

Demographic information was collected using multiple-choice questions as part of the SenseMaker survey. Responses were used to evaluate covariates of interest. All text was translated from English to Haitian Kreyol.

What is your gender?
Female
Male
Prefer not to say

How old are you?
11– 17 years old
18– 24 years old
25 – 34 years old
35 – 44 years old
45 – 54 years old
≥ 55 years old

What is your marital status?
Married or living together as if married
Divorced/Separated from spouse
Widowed
Single, never married
Prefer not to say

What is your highest educational qualification?
No formal education, some primary school, completed primary school, some secondary school, completed secondary school, some post-secondary school, completed post-secondary school

I'll read you a list of 5 items that some people have at home. Please tell me which of these you or your household owns. Your household consists of people who sleep under the same roof andeat the same meals. Choose as many as your family has:
1) radio
2) mobile phone
3) refrigerator or freezer
4) vehicle such as a truck, a car or a motorcycle
5) generator, inverter or a sun panel that provides electricity to your home
6) none of the above.

In what location was the interview conducted?

Cité Soleil	Léogâne	Morne Cassé/Fort Liberté
Charlie Log Base / Tabarre	Port Salut	Cap Haïtien
Gonaïves / St. Marc	Miragoane	
Hinche	Port-au-Prince	

Demographic questions and possible responses

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Long Overdue: Exploring sexual violence against LGBTI+ people in conflict

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ABSTRACT

Despite the heightened vulnerability of lesbian, gay, bisexual, transgender and intersex (LGBTI+) people to violence in situations of conflict, studies focusing on conflict-related sexual violence (CRSV) against this population are scarce, reducing it to just 'another' form of violence people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) are forced to endure. This has very practical and serious implications. Lack of recognition of LGBTI+ people as a category of victims of CRSV contributes to a lack of documentation, data, knowledge and survivor-centred responses for victims. Against this background, this paper explores some aspects of what is known about sexual violence against LGBTI+ people in different conflict settings based on available evidence, with the aim to build knowledge on the nature, patterns and consequences of this form of violence and contribute to a long overdue conversation. This study argues that armed actors strategically perpetrate sexual violence against LGBTI+ people in conflict in an attempt to punish, 'correct' or 'cure' their diverse SOGIESC by directly targeting their sexual autonomy and integrity, which serves to reaffirm their position and exert social control. In addition, it identifies situations of deprivation of liberty and of displacement, as well as within the ranks of armed groups and armed forces as settings of heightened vulnerability to CRSV. The data also suggests that not all LGBTI+ people are equally vulnerable to CRSV and that children, members of ethnic groups, people living in rural areas and those whose diverse SOGIESC is more visible may be at particular risk. The issue is compounded by multiple barriers in access to healthcare and other essential responses.

Keywords: Sexual violence, Conflict-related sexual violence, CRSV, Gender-based violence, LGBTI+, Diverse SOGIESC, Conflict settings, Survivor-centred responses.

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INTRODUCTION

Several studies have demonstrated that lesbian, gay, bisexual, transgender and intersex (LGBTI+) people are more likely to be victims of physical and sexual violence than the general population.[1] Evidence suggests that the risk of people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) being subjected to various forms of abuse is exacerbated in situations of conflict. In such contexts, LGBTI+ people become targets for armed actors and are routinely subjected to human rights violations including in the form of threats, arbitrary detention, torture, forced

displacement, murder, and sexual violence[2,3,4,5] In spite of the slow but steady recognition that sexual violence is prominent among the wide diversity of acts of violence perpetrated against this population, little is known about it, reducing it to just 'another' form of violence LGBTI+ people are forced to endure.

The urgent need to address this knowledge gap has been identified over recent years. For example, in their literature review of sexual minorities in conflict zones, Moore and Barner (p.35) note that *"(f)urther studies are needed in order to precisely ascertain the prevalence of sexual violence in conflict areas as well as dynamics that contribute to discriminatory, exclusionary or violent climates for sexual minorities as a targeted group."*[4]

In addition, a systematic review published in the bulletin of the World Health Organization concluded that *"(m)ore data are needed on the prevalence, risk factors and consequences of physical and sexual violence motivated by sexual orientation and gender identity in different geographical and cultural settings. National violence prevention policies and interventions should include sexual and gender minorities."*[1]

This is not only an epistemological issue but also has practical implications. Lack of or inadequate data obscures the understanding of the victimization of LGBTI+ people in conflict and renders the community invisible before community members, policymakers, law enforcement personnel, non-governmental organizations and healthcare practitioners.

This, in turn, fuels a climate of impunity in which perpetrators have room to continue to target the community without consequences.[6] The design and development of appropriate medical and mental health and psychosocial support (MHPSS) services is hindered, as well as the implementation of other responses which are needed to effectively address the devastating and differential health, psychosocial and economic impacts of conflict-related sexual violence (CRSV) on LGBTI+ victims/survivors.[7]

Simply put, what seems to not exist and is therefore not understood cannot be prevented or adequately responded to. Against this background, this paper will explore some aspects of what is known about sexual violence against LGBTI+ people in different conflict situations with the aim of contributing to filling this gap. In addition, by building knowledge on the nature, patterns and consequences of this form of violence, it aims to add to the emerging scholarship on CRSV that studies these relatively overlooked victims.

METHODS AND MATERIALS

Terminology

Before moving forward, it is important to discuss the terminology used within this paper. This study employs the terms 'LGBTI+' and 'people with diverse SOGIESC' since these are commonly used in international human rights discourse and are seen as necessary to successfully contest and make human rights claims.[8] It does not include the term 'Queer' (Q) as it has not been used by international and most national institutions for reasons that remain unclear.[9] However, the plus sign (+) intends to ensure an inclusive approach and capture other diverse identities. The paper often uses the two terms interchangeably as it understands both terms to represent individuals who do not conform to norms around gender and sexuality. Nevertheless, in cases where there is a direct reference to a source which uses a different term, this paper will adhere to the terminology employed by that source. This explains possible variation between terms.

The focus on 'LGBTI+ people' and 'people with diverse SOGIESC' as a whole risks homogenizing their experiences and realities as a single social group and failing to incorporate individual experiences, including within each group. Moreover, these terms originated in the West and have limited capacity to adequately represent LGBTI+ people globally as many survivors do not see themselves as being represented by any of the used acronyms.[10] To minimize this limitation, the study has aimed to disaggregate intersectional data where it is available and unpack the differential motivations and experiences of CRSV. This is noted by the United Nations (UN) Independent Expert on

protection against violence and discrimination based on SOGI. He concludes that not considering the unique manner in which communities and individuals identify and define themselves, through concepts and terminology that are inclusive and locally appropriate, not only misrepresents the population, negatively impacting the quality of data, but by definition violates their right to self-determination.[6] Research is also needed into the experiences of victims with diverse SOGIESC who identify themselves differently.

Methodology

Given that the issue of CRSV against LGBTI+ people has been underreported and continues to be under-researched, this research is exploratory and, while it aims to provide insights into the problem, it does not intend to provide conclusive answers. To this end, this research has employed a qualitative approach based on an extensive literature review of secondary sources, including academic papers and grey literature such as reports from international and national non-governmental organizations, transitional justice mechanisms, and the United Nations.[i]

The specific objectives of the desk review were to gather the necessary interdisciplinary contextual information for the study to:

1) Explain the invisibility of LGBTI+ people among those particularly vulnerable to CRSV;
2) Identify patterns of sexual victimization of people with diverse SOGIESC in conflict;
3) Discuss health impacts for LGBTI+ victims/survivors; and
4) Explore access barriers to healthcare and other responses.

Given that the study does not entail human research subjects it did not necessitate a review from an Institutional Review Board (IRB).

RESULTS

The criminalization and pathologization of diverse SOGIESC have institutionalized and socially legitimized prejudiced-based imaginaries around gender and sexuality, reproducing and perpetuating the gender binary, gender stereotypes and cis/heteronormativity that intersect to portray LGBTI+ people as 'abnormal' and in need of 'cure', 'correction' or even elimination. These profoundly discriminatory ideas are often transmitted through violent means all over the world. In situations of conflict, the breakdown of state infrastructure, social fabric, weakened rule of law and increased pressure on scarce resources exacerbate pre-existing inequalities and patterns of discrimination.[11]

Sexual violence is often listed as one of the forms of widespread abuses this population is subjected to, failing to recognize the strategic use and devastating differential impacts it can have. LGBTI+ people have been made invisible in the theory, data collection, policy and practice of CRSV, and this is also a result of assumptions that portray women and girls as naturally sexually vulnerable only due to their condition of being female, and obscure other categories of victims/survivors of sexual violence.

Particularly since the mid-2000s there has been a slow but steady recognition, especially in academia, that men and boys can also be victims of CRSV. From around 2015 until the present day, and although much remains to be done, there has been an increasing number of actors in academia, human rights research and in the humanitarian field who have started engaging on this issue whilst recognizing the importance of remaining accountable to women and girls. Only in very recent years has the sexual targeting and victimization of LGBTI+ people in conflict settings began to surface as an issue that needs to be explored and addressed. In many cases, this has resulted in 'adding on' LGBTI+ people to women, girls, men and boys without acknowledging the overlap and thus reproducing harmful imaginaries. However, despite sporadic and often tokenistic references, this study

[i] A significant part of this desk review was conducted in the context of the author's professional involvement with the NGO All Survivors Project.

shows that there is a dearth of research on the issue and little is known about the specific motivations, patterns, impacts of this form of violence, the responses of service providers and the barriers victims/survivors face in accessing support.

Through an extensive review of available sources and applying the Hague Principles' definition of what constitutes sexual violence, the present study demonstrates a high vulnerability of LGBTI+ people to sexual violence in contexts of conflict and political violence. It draws upon examples from very diverse contexts both in terms of geography and time and argues that cases have not been isolated incidents but instead have been perpetrated in the pursuit of clear strategic objectives of punishing and 'correcting' or 'curing' the diverse SOGIESC of the individual. This form of violence has also been instrumentalized to 'set an example' and exercise social control through the policing of gender and sexuality, often by the state.[12] This is illustrated by the various examples of authoritarian powers across the world which have enforced, reproduced and legitimated the gender binary, 'compulsory' heterosexuality, cisnormativity, and gender stereotypes. In particular, evidence suggests that transgender women and real or perceived gay and bisexual men are sexually victimised as a form of punishment for 'renouncing' the privilege of masculinity and to 'cure' femininity, whereas for transgender men, and lesbian and bisexual women misogyny and trans/homophobia intertwine in the form of 'corrective rape'.

This study suggests a heightened vulnerability of LGBTI+ people to CRSV in contexts of deprivation of liberty by official and unofficial armed actors. In countries where same-sex relations are criminalised, diverse SOGIESC often motivates detention and leads to torture and ill-treatment of LGBTI+ people.[13] In particular, this study has compiled evidence of forced anal examinations against transgender women and gay men in at least 10 different countries.[14] In addition, it shows that state security forces perpetrated other forms of sexual violence motivated by diverse SOGIESC, historically in Nazi concentration camps, and more recently in Iraq, Myanmar, Nigeria and Syria, all of which criminalised same-sex relations at the time of the reported incidents. This form of state violence has also been documented in jurisdictions which did not criminalise same-sex consensual conduct at the time of the reported incidents such as Colombia, Ecuador and Paraguay.

The analysis also reveals that LGBTI+ people face heightened vulnerability to CRSV during and after their displacement as well as within the ranks of armed groups and state security forces, with cases reported in South Africa under Apartheid and in the context of the armed conflicts in Colombia and Syria.

Despite their widespread vulnerability, this study suggests that not all LGBTI+ people are equally at risk of CRSV. Age and ethnicity seem to be particularly relevant intersectional factors that can influence the risk of sexual violence, with children and adolescents with diverse SOGIESC being particularly targeted as well as LGBTI+ members of ethnic groups. The literature also indicates that sexual victimization is higher among those whose diverse gender expression is more visible. For example, in many different settings armed actors have targeted men with long hair and women with short hair who are presumed to have a diverse sexual orientation because of their gender expression.

Provision of and access to appropriate support responses is often lacking both in conflict and non-conflict settings. The situation is aggravated in conflict settings where services are scarce for all victims of CRSV, and where LGBTI+ victims/survivors face endless barriers. Some of these include discriminatory treatment by healthcare personnel who often use trans/homophobic language or deny services to LGBTI+ victims/survivors such as safe abortions. In addition, mandatory reporting requirements of cases of sexual violence by healthcare providers often deter survivors from coming forward. This is particularly the case in contexts where same-sex relations are criminalized as survivors fear legal repercussion against them if authorities are notified. The origins of such discrimination within institutions need to be understood in the context of historical and

ongoing processes of pathologization and criminalization of diverse SOGIESC discussed in this paper.

While LGBTI+ people face significant levels of sexual violence with severe impacts, the publications reviewed and the analysis presented indicate that, although some promising practices are beginning to emerge, there is a near complete absence of programmes and interventions that target the multiple, very diverse and specific needs of LGBTI+ victims/survivors.

DISCUSSION

Defining CRSV against LGBTI+ People

The Special Representative of the Secretary-General on CRSV defines this form of sexual violence as:

"[R]ape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict".[15]

This study, however, applies the definition of the Hague Principles on Sexual Violence. This is because it is based primarily on consultations with self-identified survivors of sexual violence and presents a broader view of sexual violence by understanding it to encompass all violations of sexual autonomy and sexual integrity and because it also recognizes the targeting of non-binary individuals which the UN definition fails to do.

According to this definition, examples of other acts of sexual violence that can relate to LGBTI+ victims include: punishing or humiliating someone for perceived non-compliance with gender norms; forcing someone to undergo procedures to determine or change their SOGIESC; or marking someone as sexually deviant, impure or as a victim of sexual violence.[16]

Root Causes and Contributing Factors

In order to adequately prevent and respond to violence against people with diverse SOGIESC, it is important to consider its causes and enablers. As such, this study argues that violence and discrimination against LGBTI+ people are rooted in social imaginaries around gender and sexuality, partly fueled by religious and ideological positions. Based on the analyzed information, these are organised in four main imaginaries:

1) there are only two genders, male and female and all human beings are born as female or male based on their bodily characteristics (*gender binary*);
2) human beings' gender identity matches their biological sex, with no choice in the matter (*cisnormativity*);
3) given that males and females are biologically different, their roles in society must be different and they need to act and appear in a particular way. For males this includes having short hair, being strong, virile, being the breadwinner and not being vulnerable or showing signs of vulnerability; whereas females have long hair and are seen as fragile and vulnerable and in need of male protection, they need to preserve their virginity and purity prior to marriage and their role is in the household and as mothers (*gender stereotypes*);
4) males are solely sexually attracted to females and vice versa (*heteronormativity*).

In this order of ideas:

1) the gender binary invisibilises non-binary people and does not account for intersex individuals;
2) cisnormativity excludes all those who do not sit comfortably with their biological sex, mainly transgender women and transgender men;
3) gender stereotypes discourage diverse gender expression; and
4) heteronormativity excludes those with diverse sexual orientation, mainly lesbian, gay and bisexual individuals.

These prejudicial assumptions fuel discriminatory beliefs based on the idea that people who fall outside these norms are 'abnormal' and therefore 'not acceptable' as they are perceived to defy the *status quo*. Such imaginaries and social stigma have become institutionalised through the pathologization and criminalization of diverse SOGIESC.[17]

The characterization of diverse sexual and gender identities as medically and psychologically deviant is far from new. Historically, LGBTI+ people have been defined as 'abnormal' in healthcare and diverse SOGIESC has been seen in healthcare as something that *should* and *can* be 'cured'.[18] Prior to the 1970s, homosexuality was treated as a mental disorder and it was not until recently, in May 2019, that the World Health Organization removed 'Gender Identity Disorder' from its list of mental illnesses.[19] Despite this progress, homosexuality is still considered an illness in many countries and people experiencing gender dysphoria (distress a person experiences due to a mismatch between their gender identity and their sex assigned at birth) continue to be seen as sick and in need of treatment.[11] Even in countries where these are not classified as mental health conditions, these prejudices have remained and to this date, conversion therapies continue to be widely reported around the world. These harmful practices, also known as 'reparative therapies', particularly target LGBTI+ youth in an attempt to 'cure' diverse SOGIESC.[20] This may indicate that medical definitions are also potentially a reflection of other aspects including religious influences, and that the redefinition of terms is just an element of a more complex process.

The 'demonization' of diverse SOGIESC has also been enshrined in law through the criminalization of LGBTI+ people. In discussing the proscription of same-sex relations, it is important to recognise that several studies show that although homosexuality may have been opposed by some people, it was not criminalised before colonialism.[21] In the pre-colonial period, identities including sexuality were fluid.[ii] The British played a central role in spreading this colonial legacy throughout their empire after introducing the law in the Indian penal code in 1860.[22] 'Sodomy' laws introduced by the British colonizers were reflective of Christian doctrine that stated that sexual intercourse was only permitted if it furthered reproduction.[22] They were used as a means to control the social behavior of the colonized and to prevent the engagement of colonizers in what were considered immoral sexual practices. As such, the colonial state legally relegated non-conforming sexualities to inferior status.[22]

As of January 2023, 67 countries continue to criminalize consensual same-sex sexual acts (almost half of which were once part of the British empire); at least six UN member states implement the death penalty on these acts, and 14 countries criminalize the gender identity and/or expression of transgender individuals.[23] In many countries where they are not explicitly prosecuted, same-sex relations are indirectly criminalized under laws addressing 'public morality' or 'unnatural practices'.[24] Even where same-sex relations are no longer directly or indirectly proscribed, homophobic and transphobic attitudes often prevail and surface violently in times of conflict.[2]

The result of this process of institutional stigmatization in both healthcare and law has been the structural discrimination and systematic violence against these population groups in all spheres of life including the household, school and the workplace. In situations of conflict, evidence suggests that the vulnerability of LGBTI+ people to various forms of abuse is exacerbated as they become targets for armed actors.[2,3,4]

Unrecognized Victims/Survivors of CRSV

Conflict and violence result in the breakdown of state infrastructure, social fabric, rule of law and pressure on scarce resources. This exposes LGBTI+ people to

[ii] Numerous scholars have shown that same-sex relations were common before colonialism. For instance, the anthropologist E. E. Pritchard (1970) examined in depth the custom practice among the Azande in Central Africa of marriage between older men and boys; Chukwuemeka (2012) has discussed the practice and concept of female husbands in Igbo land, southeastern Nigeria; and Epprecht's 2008 study of the San people in Guruve, Zimbabwe also highlights same-sex partnerships.

heightened multidimensional vulnerabilities as pre-existing stigma intensifies.[2]

Among the various forms of violence LGBTI+ people are exposed to in conflict, the risk of sexual victimization in areas under the control of armed groups has been described as concerning.[3] The Annual Report of the United Nations Secretary-General on CRSV recognizes that victims are frequently "*targeted on the basis of actual or perceived sexual orientation or gender identity*".[15] Similarly, the UN Special Rapporteur on Torture has noted that rape and other forms of sexual violence are rampant in armed conflict and are being used against LGBTI+ persons and perpetrated by State and non-state actors alike.[25]

However, despite the acknowledgment of the heightened vulnerability of LGBTI+ people to CRSV, the severe health and other consequences for victims/survivors and the lack of appropriate responses, much of the body of literature on CRSV focuses on the victimization of women and girls who remain widely affected. This has reinforced the neglect of individuals with diverse SOGIESC as a population vulnerable to CRSV. [10]
The invisibility of LGBTI+ people in the theory and practice of CRSV should be understood as a result of the above-mentioned hegemonic norms. Gender stereotypes reproduce the notion that men are invulnerable to sexual violence whereas women are naturally vulnerable.[4,26,27] Linked to this idea is the myth which limits our understanding of males as only perpetrators and females as victims.[28,29,30] When men experience sexual violence it therefore tends to be miscategorized often as torture, obscuring the sexual component.[31] Apart from men, lesbian women also experience exclusion from discourse on CRSV. Although they have the gender recourse in human rights protections, this constitutes only one reason why a woman may be abused and leaves out considerations based on diverse sexual orientation.[4]

The assumptions surrounding discourses on CRSV are being increasingly challenged by a new generation of scholars which considers issues such as male-directed sexual violence, women as perpetrators or the targeting of LGBTI+ people.[29,32,33,34,35,36] Sivakumaran's seminal work on male-directed CRSV argued that this form of violence is perpetrated to 'emasculate' the victim through a process of 'homosexualization', depriving him of his heterosexual identity.[32]
However, as Eichert pointed out, this theory fails to account for situations in which the victim's sexuality falls outside the heterosexual norm.[34]

Queer and feminist scholar Jamie J. Hagen discusses the loud silences surrounding CRSV against LGBTI+ people in the UN Security Council, particularly within the Women, Peace and Security framework.[10] As a result of the historical lack of attention paid to CRSV, women's rights activists advocated for the global recognition of wartime sexual violence against women and girls and partly realized this objective in the passing of UN Security Council Resolution 1325 in 2000, which defined how CRSV is understood and the criteria for inclusion and exclusion of victims.
Although this approach has been successful in ensuring that this form of abuse gains attention, it has achieved this through a cis/heteronormative lens that has obscured other categories of victims,[29] inadvertently contributing to a lack of data, knowledge and adequate responses for LGBTI+ victims/survivors of CRSV.

Sixteen years after Hagen's original publication, the silence remains. This is illustrated by the fact that UN Security Council resolutions have recently recognized other categories of CRSV victims such as men and boys and children born of rape,[37] whilst explicit reference to victims with diverse SOGIESC continue to be the elephant in the room. Moreover, the annual reports of the UN Secretary-General on CRSV had no references to cases against LGBTI+ people until 2014 and, even since then, these have been extremely scarce.[38] This despite the above-mentioned recognition in the UN definition that diverse SOGIESC often motivates CRSV.[15]

Unsurprisingly, in light of the above, the UN Expert on SOGI has noted that "*there are no accurate estimates regarding the world population affected by violence and*

discrimination based on sexual orientation and/or gender identity".[17] This invisibilization and resulting negation of the issue precludes the collection of relevant data and the adoption of measures to address this and other forms of violence against LGBTI+ people. Even where States compile data, this is often inadequately captured resulting in inaccurate and unreliable information.[6] For example in Colombia, the national Victims Unit manages the registration and recognition of victims of the armed conflict by the state, and mandates humanitarian assistance and reparations measures for them. As of October 2022, there were 590 recognized LGBTI+ victims of CRSV by the Unit.[39] This is the only official national figure this study has found. The Unit registers victims under one of the following categories based on sex: *man, woman, LGBTI, intersex or does not report*.[39] The pioneering recognition of the targeting of LGBTI+ people during the conflict is a result of decades of activism by national LGBTI+ organizations and civil society. However, such categorization illustrates the shortcomings of data collection around LGBTI+ issues and reinforces the above-mentioned imaginaries. Firstly, it reproduces ideas around cis/heteronormativity by implying that men and women are inherently heterosexual and cisgender; secondly, it represents intersex people in two categories and thirdly, it does not recognize the existence of non-binary or gender non-conforming people. This illustrates a common issue in the human rights field in which males, females *and* LGBTI+ people are presented as mutually exclusive categories and therefore failing to recognize, for example, that a gay man is a man and that a lesbian woman is a woman. Even if well intended, 'adding on' LGBTI+ people can be harmful as it perpetuates rigid and inaccurate classifications that reproduce social prejudices. Further dialogue with LGBTI+ people and organizations representing them needs to go into safely and adequately capturing data which can be utilized to inform policy prevention and responses. Despite the chronic underreporting and lack of data, a review of publicly available sources in this study has identified and reviewed cases of victimization and perpetration of CRSV against LGBTI+ people. Although not providing conclusive answers, the evidence-based analysis provides opportunities to inform future research and practice.

Motivations for Victimization and Perpetration

As will be shown by the evidence below, CRSV against LGBTI+ people is perpetrated by state and non-state armed actors with clear objectives, mainly to communicate that:

1) the gender binary;
2) cisnormativity;
3) gender stereotypes and/or
4) heteronormativity

are not questionable and those who do not comply or are perceived to do so will face consequences. CRSV has therefore been used by armed actors against those "who do not fulfil social expectations of what it means to be man-masculine-heterosexual and woman-feminine-heterosexual".[12]

This message is communicated by armed actors using various forms of violence including systematic threats, unlawful killings, persecution, torture and forced displacement as well as sexual violence.[11]

The use of the latter becomes particularly strategic when perpetrated against LGBTI+ people as it directly impacts the victim's sexual autonomy and integrity in a way that punishes and humiliates victims for being themselves.[40] For this reason, sexual violence should not be seen as just 'another' form of violence perpetrated against this community.

It is also important to recognize that CRSV against LGBTI+ people does not happen in isolation. Rather, the available evidence clearly indicates that CRSV against this population is overwhelmingly perpetrated along with other forms of violence, particularly threats, torture and displacement in the armed actor's attempt to use all available means to correct or eliminate non-compliance with social norms.

In this sense, the perpetrator not only targets the victim to send an individual message of subordination but to, more broadly, reaffirm the status quo through

the policing of gender and sexuality.[41] As such it has been misnamed as 'moral' or 'social cleansing'.[25,42]

Transgender Women and Gay and Bisexual Men

Understanding the victim's (self) identity is essential to explain the differing motivations of male-directed sexual violence and the victimization of those who are perceived to defy norms *"of what it means to be man-masculine-heterosexual"*.[12] On the one hand, when it is directed towards heterosexual males it is perpetrated with the intent to 'feminize' them, to erase their masculinity.[32] Whereas when it is against transgender women or men with real or perceived diverse sexual orientation, its intent is to "cure" femininity. In the words of a child protection officer working with Rohingya with diverse SOGIESC:

> "*Transgender [women refugees] are the most vulnerable and most invisible group* [to sexual violence]. *They don't even have to be transgender—it's any man or boy showing feminine qualities. They are the first to be attacked. I don't know why rape is used to 'cure' femininity.'"*[43]

It is therefore important to avoid the homogenization of all experiences of male-directed sexual violence,[36] including when trying to understand the motivations for their targeting as they often bear a direct link with their sexual and gender identity.

In many cases the perpetrator's objective is not to "cure" but rather to punish real or perceived-to-be gay men and transgender women for "renouncing their masculinity" which is seen as a privilege.[42] A transgender woman targeted in Cambodia during the Khmer Rouge regime described this:

> "*Some people accused me by saying, 'you are a man why you want to be a woman? Your behavior is too bad because when you walk, it looks like a woman, whatever you do is too weak, not strong as men'".*[44]

Sexual violence as a form of punishment against these groups stands out from high numbers of reports of genital mutilation and rapes often perpetrated through the forcible introduction of objects into the anus with the intent to inflict severe pain and which may lead to their death[40,44]. Armed actors often exercise social control and exert power over communities through this type of terror.

Another aspect to consider is that the male perpetrator's heterosexual orientation is not called into question for his same-sex conduct in perpetrating rape or other forms of sexual violence against males with diverse SOGIESC. Instead, the subjugation and violent rejection of non-compliance with prevailing social norms reaffirms his heterosexual masculinity.[32] This is one of the seemingly paradoxical aspects of male-on-male sexual violence.

Transgender Men and Lesbian and Bisexual Women

Lesbian and bisexual women and transgender men are similarly targeted for their perceived non-compliance with social norms around what it means to be "*woman-feminine-heterosexual".*[12] Moreover, armed actors see them as women and therefore bodies they have power over. Thus, they face double victimization for their real or perceived condition as women. CRSV is often perpetrated against them with the intent to 'correct' their behaviors and 'remind' them of their place in society. According to the Inter-American Commission on Human Rights (IACHR), these so-called 'corrective rapes' are perpetrated particularly against lesbian and bisexual women with the objective of 'correcting' their sexual orientation or make them "'*act' more like their gender*".[40] The misogynistic and trans/homophobic rationale behind this hate crime lies in the mistaken idea that "*being penetrated by a male will render the woman 'normal' again*"[40] and in that the reason behind their diverse sexual orientation is because "*they have not been taught what a good macho is"*.[42]

This form of violence has been reported in Colombia against lesbian women (often in front of their partners).[45] In the revealing words of a lesbian victim of the non-state armed group the Revolutionary Armed Forces of Colombia — People's Army in 2012:

> "*When they exercised sexual violence against me, they told me that this was the only way for me to*

> *be a real woman, to teach me to be one, and that after that I would not go around doing things with other women or harming society or the villagers, or coming with these strange things that I brought from the city, in other words, they wanted to correct me".*[46]

Thus, sexual violence is not perpetrated with the sole intention of 'correcting' the victim but also to stop the spread of these perceived harmful and contagious ideas. However, as rightly recognized by the IACHR, this term should be used with caution as the concept of 'corrective rape' and 'corrective sexual violence' is erroneous and can feed into existing homophobic rhetoric, "*since any attempt to 'correct' a fundamental aspect of a human being's identity by violence is repugnant to human dignity and decency."*[40]

The sexual victimization of transgender males is relatively underreported. However, there is some evidence that sheds light into the motivations of armed actors. The Colombian National Centre for Historical Memory argues that transgender men have been subjected to CRSV as a way of punishment because they are perceived by armed actors as wanting to "*occupy the privileges of masculinity"* which they are not entitled to as women.[42] Some cases against transgender men also illustrate the alleged 'corrective' purpose. A transgender man in Colombia who was subjected to sexual violence by members of an armed group noted:

> *"Because I am a trans guy, I have received insults from paramilitaries, from guerrillas, in fact I was a victim of sexual violence, and as a result of this rape I have a child. During the rape they were always telling me that I was not a man, that they could do to me what they could do to any woman, that the man had a penis and that where was my penis?"*[42]

Intersex and Non-binary People

This study has found very limited reported cases of CRSV against intersex and non-binary people. This could be explained by the fact that data collection systems and the response sector are based on the gender binary and that victims may not see the benefit of reporting such cases. However, there is indication that the targeting of intersex people is strongly related to their pathologization. For example, in a 2015 report the IACHR noted that the Commission had received reports of sexual violence against intersex people as a way to '*cure intersex bodies'*.[40]

Heightened Vulnerability Settings

Although people with diverse SOGIESC are generally vulnerable to violence including sexual violence, the evidence seems to point to certain situations in which they faced heightened risks of sexual victimization particularly. These include situations of deprivation of liberty but also during and after displacement, and combatants within the ranks of armed forces and armed groups.

In Situations of Deprivation of Liberty

Despite the limited data, it is well-established that people with diverse SOGIESC are disproportionately imprisoned in times of conflict.[2] In situations where liberty is deprived, the sexual victimization of LGBTI+ people is prevalent and can be perpetrated by other inmates and prison guards as a form of 'correction', in line with the above.[47] Forms of reported sexual violence include rape, threat of rape, forced nudity, forced prostitution and sexual humiliation.[13] The Association for the Prevention of Torture identifies certain contexts where LGBTI+ detainees are at heightened risk of being subjected to sexual violence. These include during transfers; in 'self-government' detention facilities;[iii] during body searches; at checkpoints; in police custody; and in immigration detention facilities. In addition, LGBTI+ children are identified as more likely to be arrested and particularly vulnerable to sexual violence[48] and transgender women are reported to be at higher risk of sexual

[iii] APT describes "self-government" detention facilities as prisons in which "*State authorities informally delegate powers, including those of management and governance, to detainees themselves, while keeping control over the external perimeter of the prison. (…) and is often, but not always, linked to organised crime and gangs.*". APT, *Towards the Effective Protection…*, *op. cit.*, p.61.

violence in detention settings, particularly where they are incarcerated with men.[47] Moreover, the Special Rapporteur on Torture has noted that fear of retaliation and mistrust in the complaint mechanisms often prevent LGBTI+ people from reporting violence in detention.[13]

The criminalization of same-sex consensual conduct has legitimated violence including sexual violence by armed actors against LGBTI+ people. This is particularly evident in situations of deprivation of liberty where they are at heightened risk of being subjected to torture and ill-treatment, particularly if the reason they are incarcerated is because they are seen or believed to have violated "sodomy" laws.[2] For example, in several States where homosexuality is criminalized, men and transgender women suspected of same-sex conduct and arrested on homosexuality-related charges have been subjected to non-consensual and/or forced anal examinations with the alleged objective of obtaining physical 'proof' of same-sex relations. Forced anal examinations often involve law enforcement officials working with forensic medical personnel who forcibly insert their fingers, and sometimes objects, into the anus of the accused for 'evidence' to be used in court.[13]They claim that by doing so they can determine the tone of the anal sphincter or the shape of the anus and draw conclusions as to whether or not the accused person has engaged in same-sex conduct. This argument is based on long-discredited 19th century science largely derived from forensic doctor Auguste Ambroise Tardieu's book *Forensic Study of Assaults against Decency* which provided guidelines for investigating sexual assault and rape as well as 'pederasty and sodomy'.[49] Although the use of forced anal examinations varies from country to country,[14] it has been reported in at least Cameroon, Egypt, Kenya, Iraq, Lebanon, Tunisia, Turkmenistan, Uganda, and Zambia.[14,49, 51] There have also been reports of forced anal exams by police in Syria but these have yet to be independently verified.[14] This form of sexual violence not only constitutes anal rape but should be understood as sexual violence also, because of its objective of *"having someone undergo procedures or rituals to determine or alter their sexual orientation or gender identity"*.[16]

Other forms of CRSV against LGBTI+ people in detention settings have also been documented in other countries that used to criminalize same-sex consensual activity such as in Nazi Germany and where it continues to be criminalized including in Iraq, Myanmar, Nigeria and Syria.

Nazi leaders believed that homosexuality was a social disease that should be cured or eliminated in order to protect the Aryan race. In 1929 they prevented the repeal of paragraph 175 of the criminal code which criminalized homosexuality throughout the German empire. Under this provision, gay men were detained and many were sent to concentration camps where they were forced to wear a pink triangle for their identification and separated from the rest of the detainees.[50] The Hague Principles' definition includes *"marking someone as sexually deviant"* as a form of sexual violence.[16] Other forms of sexual violence against gay detainees were commonplace in these camps including castration, genital beating, anal rape and forced nudity.[34] Some were injected with male hormones in an attempt to try to alter their sexual orientation as part of medical experiments to find a 'cure' for homosexuality. [34, 50]

In Iraq, people with diverse SOGIESC can be detained under several criminal provisions around morality, public decency and freedom of expression. Recent research reported that 27 out of 54 LGBTI+ interviewees endured sexual violence by armed groups and state actors including rape, genital mutilation and unwanted touching, several of which took place in the context of arbitrary arrest, detention and after being stopped at checkpoints.[51] An earlier report had denounced a killing campaign against those considered not "manly enough", or whom they suspected of same-sex conduct.[52] In this context, the armed groups targeted at least 11 gay men in 2009 for CRSV because of their real or perceived sexual orientation. Most incidents happened in the context of deprivation of liberty and forms of sexual violence

included genital mutilation, rape, injecting glue into victim's anus, and forced nudity. [52]

In Myanmar LGBTI+ people, same-sex conduct between men and the gender expression of transgender individuals are criminalized.[53] Colors Rainbow, a national LGBTI+ rights organization, conducted a study in 2012 and 2013 which found that transgender individuals are at heightened risk of sexual violence and other forms of physical violence in detention settings. Sexual violence was perpetrated particularly by the police and included forced stripping, oral and anal rape as well as gang rape.[54]

In Nigeria, the 2014 Same-Sex Marriage Prohibition Act (SSMPA) criminalized a number of activities associated with homosexuality, including registering gay clubs, societies and organizations as well as public showing of same-sex relationships. In this context, Human Rights Watch (HRW) documented cases of sexual violence against LGBTI+ people perpetrated by mobs and police, including the rape of men and women post-SSMPA in apparent attempts to punish or 'cure' their sexual orientation.[55] For instance, a young gay man from Lagos was gang-raped by a group of men who then reported him to the police for being gay. The victim was subsequently arrested in August 2015 and subjected to beatings and anal rape with a stick by the police in detention.[56] Although LGBTI+ people faced violence and discrimination before the SSMPA, the report finds that the law has worsened an already bad situation as it contributed significantly to a climate of impunity for crimes committed against LGBTI+ people. LGBTI+ victims of crime said the law inhibited them from reporting to authorities due to fear of exposure and arrest. [56]I
In Syria, where same-sex sexual activity continues to be criminalized, detainees of all genders have been routinely subjected by state security forces to sexual violence since 2011 throughout the armed conflict, regardless of their sexual orientation and/or gender identity. However, it has been reported that LGBTI+ detainees faced increased sexual violence including in the form of electric shocks and beatings to the genitals, forced nudity, and threat of rape.[57] As in Iraq, there have also been reports of rapes at checkpoints.[57]

The final report of the 2008 Truth and Justice Commission of Paraguay provides a historical record of abusive practices from 1954 to 2004, including during the Stroessner dictatorship (1954-1989). Although same-sex sexual acts had been legal since 1880, the report describes the persecution and arbitrary detention of hundreds of gay men in 1982 and the sexual torture several of them, including children, were subjected to by the police.[58]

The 2007 Ecuadorian truth commission was mandated to investigate, clarify and prevent impunity for violent acts and human rights violations committed between 1984 and 2008. Despite Ecuador's decriminalization of homosexual acts in 1997, the final report describes cases of sexual violence against LGBTI+ people both during the period 1984-1988 and 1989-2008. It was perpetrated by state security forces particularly against 'transvestites', transgender women and transsexual individuals who were placed in male detention centres and abused by male inmates and guards.[59] The report also describes how transgender people underwent sexual exploitation to avoid their detention, as well as cases of sexual violence against gay men. For example, the report includes details regarding the arbitrary detention of a gay man by the national police who after identifying him as gay, took him to an isolated place and subjected him to rape with an object while they told him *"you're a faggot so you'll like this"*, revealing the motivations for his detention. [59]
Whilst same-sex consensual acts have been decriminalized in Colombia since 1989, the armed conflict active since the 1950s exacerbated pre-existing discrimination and violence against people of diverse SOGIESC including in contexts of deprivation of liberty. National LGBTI+ organizations have been fundamental in documenting and denouncing such human rights violations, highlighting the disproportionate number of reports of CRSV against LGBTI+ people as compared to other conflict situations.[12,42,60,61] For example, the organization Caribe Afirmativo reports widespread arbitrary detention, sexual violence and torture of LGBTI+ individuals by the national police in Carmen de Bolívar between 2001 and 2004 with the objective of

punishing, humiliating and subordinating them because of their diverse SOGIESC. LGBTI+ people were often taken in groups and among the reported forms of sexual violence were forced nudity, anal and oral rape and forced witnessing of sexual violence of other LGBTI+ people.[60]

More recently, there have also been allegations of targeted violence including sexual abuse and arbitrary detention by Russian forces of Ukrainian citizens with diverse sexual orientation and/or gender expression.[62]

In Situations of Displacement

Systematic violence including CRSV against LGBTI+ persons has also resulted in their forced displacement.[3] For example in Colombia, the Victims Unit has registered 4,408 LGBTI+ people as victims of forced displacement.[39] In many cases, and reported particularly in Colombia, this takes place after direct intimidation and death threats by armed actors (often through the use of pamphlets with victims being explicitly told the number of days they have to leave the territory) but also following threats during their sexual victimization.[63,64,iv] LGBTI+ people in Iraq have also reported being threatened with death and forced to leave their homes by armed actors.[3] Transgender individuals can face additional difficulties when trying to leave conflict zones if their identity documents do not match their gender identity, as reported in the context of the 2014 conflict in Ukraine.[65]

To compound the issue, evidence shows that LGBTI+ people face heightened vulnerability to CRSV both during and after their displacement process in what has been referred to as a continuum of violence.[5,66] The examples are countless. Rohingya men and boys with diverse SOGIESC have been subjected to sexual violence both in Myanmar by state security forces, non-Rohingya civilians, and Rohingya community members,[43,67] as well as in Cox Bazar following their displacement.[43] Similarly, LGBTI+ Syrians who fled to neighbouring countries such as Lebanon were discriminated and subjected to violence, and in some cases were arrested and allegedly tortured by security forces while in detention.[3] The case of two Syrian gay men who were escaping persecution within their country of origin and were forced to undergo anal examinations by Lebanese Internal Security Forces illustrates the issue.[68]

In Kenya, transgender refugees camping in front of United Nations High Commissioner for Refugees (UNHCR) Kakuma refugee camp reported they were beaten by police officers and others and violently forced to expose their genitals and identify as either women or men.[69] Similar cases also take place in European host countries. For example, LGBTI+ refugees, asylum seekers and migrants in Italy have described being subjected to sexual exploitation by various perpetrators, including male and female clergy and Italian men and women.[66] Members of the LGBTI+ community have described being subjected to violence and abuse in refugee camps in Greece, Austria and the Netherlands.[70]

Within the Ranks of Armed Groups and Armed Forces

Not only LGBTI+ civilians but also combatants with diverse SOGIESC have been targeted for CRSV for 'correction' or punishment purposes.

The South African Truth and Reconciliation Commission, which investigated serious human rights abuses under Apartheid, reported allegations including that of a psychologist who used electric shocks on gay military men "*as part of a treatment for their 'gayness'*".[71,v] This and similar examples point to increased pathologization of diverse SOGIESC in highly militarized environments.

In Colombia, a study showed through qualitative interviews with LGBTI+ ex-combatants that sexual violence was used as a form of punishment within the United Self-Defense Forces of Colombia (AUC), the main paramilitary group until its demobilization in 2005, for deviation from heterosexual norms within its

[iv] In Colombia threats and forced displacement were the most frequently reported forms of violence against LGBT+ victims.

[v] As noted by the International Center for Transitional Justice (ICTJ), the South African TRC final report describes the use of electrocution to the genitals against homosexual men in police detention and military hospitals but the commission failed to code it as sexual violence and code it only as "electric shocks". This exemplifies how the sexual component tends to be obscured when referring to men: ICTJ, *When No One Calls It Rape…, op. cit.*

ranks, and describes a case of gang rape against a lesbian combatant.[72]

In addition, among guerrilla groups, FARC-EP was known for holding a strict anti-LGBTI+ policy within the organization.[72] It is noteworthy how they even reported the sexual condition of combatants in the "guerrilla life sheets" (*hojas de vida guerrilleras*, in Spanish); men who were identified as gay within the ranks were categorised as "faggot" (*marica*).[73]

In Syria, GBT individuals who serve in the military have also been reported to be targeted by fellow soldiers because of their diverse SOGIESC, particularly those who were perceived as having feminine traits, in an attempt to correct them. Interviewees participating in research conducted by HRW spoke about harassment, rape and having "to act like a man" in order to keep safe.[57]

Intersectional Vulnerabilities

Feminist scholar Kimberly Crenshaw coined the term 'intersectionality' thirty years ago. Crenshaw's argument is based on the notion that, to wholly capture how the social world is constructed, there is a need to account for multiple identities. By analyzing violence against black women, she was able to identify intersecting patterns of racism and sexism.[74] In addition, Crenshaw argued that ignoring intragroup differences by not taking into consideration issues of class and poverty prevents an accurate analysis of the situation.[75] The value of the 'intersectionality approach' lies in the recognition of the impracticability to fully disentangle different relations of power, discourses and oppressive practices around issues such as ethnicity, gender, class and sexuality[76] and its usefulness in understanding coexisting and cross-cutting abuses.[10] Hence, an intersectional analysis that takes into account a person's varied vulnerabilities, is needed to effectively prevent and respond to CRSV. These include not only sexual orientation, gender identity, gender expression and sex characteristics but also age, disability, ethnicity and socioeconomic status.[29]

The data reveals that not all LGBTI+ people are equally vulnerable to CRSV. Age and ethnicity have been noted as important factors.[12] In many contexts, LGBTI+ children and adolescents are described to be particularly vulnerable to CRSV as young age creates and increases vulnerability.[12,46] Similarly, LGBTI+ people perceived to belong to certain ethnic communities can also be at heightened risk of sexual violence as shown by the targeting of Rohingya people with diverse SOGIESC and of Afro-Colombian and indigenous LGBTI people in Colombia.[67]

In addition, the individual's visibility of their diverse gender expression has emerged as one of the most significant aspects. For example, in some conflict contexts women with short hair and masculine appearance are often presumed to be lesbian and men with long hair are seen as 'not manly enough' and are considered to be gay. For example, In Iraq hairstyles which defy ideals around femininity constitute a punishable offence in what HRW has termed "the politics of hair". [51] In 2020 an 18-year-old gay man was arrested at a checkpoint due to his long hair and accused of engaging in sex work. The victim said that police officers checked if he was wearing makeup by wiping a tissue paper across his face before taking him to the police station. While detained, he was subjected to sexual touching and humiliation and to forced anal examination[51]. Similarly, according to a key informant, in Syria a 11-year-old boy was sexually molested by members of Islamic State of Iraq and the Levant (ISIL) as a form of punishment for having long hair and considered to be gay based on his appearance.[77]

The recent final report of the Colombian truth commission states that CRSV against lesbian and bisexual women and transgender men is especially perpetrated when the victims' gender expression is considered masculine by armed actors.[12,46] Invisibility thus may serve LGBTI+ people as a necessary survival measure in certain situations of conflict. Individuals have recurrently reported self-censorship of their diverse SOGIESC and in cases, including self-imposed lockdown. This is also explained in the pioneering work of Kasumi Nakagawa on gender-based violence

against sexual minorities during the Khmer Rouge regime in Cambodia from April 1975 to January 1979. In her study, all gay men reported suffering sexual violence as well as a large percentage of transgender women. In addition, LGBTI+ respondents reported having to hide their sexuality or gender identity for fear of being targeted. For transgender women this meant cutting their hair short, wearing pants and staying with other men.[44]

LGBTI+ individuals living in rural areas as well as those from lower socioeconomic backgrounds also seem to be at higher risk. For example, the Victims Unit in Colombia has reported the highest number of human rights violations against LGBTI+ people in departments with higher numbers of people living in rural areas.[42] In addition to villages being traditionally more conservative than urban areas, this could be linked to the issue of visibility. In places with lower population density, people who deviate from locally dominant cis/heterosexual norms stand out more. Similarly, those with limited economic resources might have less means to hide their diverse SOGIESC. For example, they might engage in work that exposes them more to the public such as sex work which particularly affects transgender women.[1]

Finally, it is important to note that the risk of sexual violence against individuals with disabilities has gained attention, particularly in non-conflict settings.[78] However, no studies or cases which shed light on the intersection of diverse SOGIESC and disability, in terms of a person's risk of exposure to CRSV, have been identified.

Impacts of CRSV and Access to Healthcare

Pathologization, criminalization and demonization of diverse SOGIESC has contributed to LGBTI+ people's avoidance of health services. This has exacerbated their stigmatization and has turned them into a neglected group of healthcare consumers all over the world.[79] However, studies that discuss healthcare disparities among LGBTI+ individuals focus mainly on high income countries [7, 18,80] and very few explore their access to healthcare in situations of conflict, displacement or post-conflict.[1] In recent words of the Norwegian Red Cross and the International Committee of the Red Cross (ICRC) (p.23): "*little is known in humanitarian settings about the distinct challenges, in terms of access to appropriate services and support, faced by LGBTIQ+ victims/survivors of SGBV*".[47]

In such contexts, where health infrastructures are weakened and humanitarian access is often limited, people with diverse SOGIESC face additional and mutually reinforcing barriers.

It is clear that LGBTI+ people face a myriad of forms of violence in conflict situations with multiple impacts. This study does not suggest that the consequences of CRSV on LGBTI+ people are more severe than others deriving from other forms of violence, as each individual experience is different. Rather it argues that, because of its nature and purpose, sexual violence can have differential and long-lasting impacts on these victims/survivors, which should be properly understood and addressed.

As all victims and survivors, LGBTI+ survivors also suffer serious immediate and long-term physical, mental health and psychosocial, and socioeconomic impacts. Physical consequences of sexual violence can include unwanted pregnancy, HIV and other sexually transmitted infections (STIs), sexual dysfunction, genital injuries, and chronic pain.[81] In addition, sexual violence can result in mental ill-health including suicidal behavior, depression, post-traumatic stress disorder (PTSD), substance abuse and other behavioural problems.[81] Loss of self-esteem, feelings of shame and self-blame have also been described as well as dilemmas and internal conflicts related to confusion or rejection of their identity.[12] As mentioned above, many LGBTI+ victims/survivors feel forced to conceal their sexual orientation, gender identity and/or expression to prevent further victimization.[47,51] This comes at the expensive price of not being able to express who they really are, how they feel and to be able to openly belong to a community which inevitably carries serious mental health and psychosocial consequences such as depression, feelings of isolation and ostracization. A transgender woman who lived through the Khmer Rouge regime in Cambodia described this impact

(p.34): "*I dared not to show that I was transgender. I need to hide it so that I can stay alive and survive. But it seemed to be staying in a prison without wall*".[44]

Finally, LGBTI+ victims can also experience severe socioeconomic consequences. These are often linked to forced displacement and can manifest in difficulties to find a job or to continue studying and loss of support networks.[12,47]

Despite the extensive mental and psychological health needs that LGBTI+ victims/survivors may have, many do not trust these kinds of services because of harmful practices such as 'conversion therapy' and the way in which the psychiatric field has attempted to treat and 'correct' homosexuality.[18] A systematic realist review of healthcare interventions in low and middle-income countries for CRSV survivors conducted in 2020 identified 26 evaluations of interventions. Whilst nine of these studies included male survivors and 12 focused on female survivors, none focused on LGBTI+ survivors of CRSV.[82] Moreover, a 2017 review of existing literature on LGBTI+ people in conflict settings concluded that community-based medical programmes, specifically for LGBTI+ survivors of sexual violence, and psychosocial interventions in post-conflict settings are needed.[4] This may point to shortcomings related to the humanitarian and development sectors being built on and designed around the gender binary. Against this background, various scholars emphasize the importance of gender- and age-disaggregated data, which is not systematic in humanitarian practice, in order to begin to adequately evaluate the public health needs of LGBTI+ people in conflict contexts.[10]

Despite the lack of knowledge, some studies point to several consistent barriers and challenges in various conflict settings. Mandatory reporting requirements of sexual violence by healthcare providers can constitute an obstacle for healthcare uptake by LGBTI+ victims/survivors, particularly in countries where same-sex relations are punishable by law. These laws can cause health workers to refuse to treat gay and transgender patients, either fearing repercussions, or because the law legitimated their own prejudice.[5] These factors also hinder public health policies and HIV/AIDS prevention efforts.[13] Mandatory requirements on healthcare providers to report sexual violence to the police or other public authorities can also deter victims/survivors who do not wish to pursue legal action, and may also conflict with principles of confidentiality, self-determination and may increase risks of further victimization.[83] Even in cases where there is no mandatory reporting, LGBTI+ victims/survivors may fear healthcare professionals breaching medical confidentiality around their experiences of sexual violence and/or their SOGIESC, which can put them at risk and result in stigmatization and violence by their families and communities.[47]

Lack of adequate medical and MHPSS services is influenced by rigid gender norms, but also lack of training and sensitivity towards the diverse needs of LGBTI+ people by healthcare personnel who often endorse and violently reproduce ideas around cis/heteronormativity, gender binary and gender stereotypes.[7] Negative perceptions and real attitudes and practices among healthcare providers discourage many LGBTI+ victims/survivors' access to care. A recent study on barriers faced by male victims/survivors of sexual violence in Afghanistan highlights that those with diverse SOGIESC experience increased fears of being sexually re-victimized by healthcare providers, which deters them from seeking care. The study also refers to the criminalization of same-sex consensual relations and internalized stigma and blame of victims/survivors among the barriers faced by this population in Afghanistan.[84] Meanwhile in Syria, while awareness among humanitarian actors on these issues has increased, sensitized targeted services for LGBTI+ survivors of sexual violence are very rare.[85] An extensive literature revealed that in Europe, refugees, asylum seekers and undocumented migrants are more vulnerable to sexual victimization than European citizens and they face more challenges when seeking care.[86]

For transgender men and non-binary individuals assigned female at birth, unwanted pregnancies can bring the added impact of resulting in, or aggravating gender dysphoria.[87] Moreover, they can face additional barriers in accessing safer abortions. There

is a lack of official statistics on the issue. However, the Trans Male Abortion Alliance of Colombia (ATAC) and the organization Profamilia recently conducted the first survey on access to abortion for transgender men and non-binary people. Of the 141 people interviewed, the study identified 14 who expressed having sought an abortion at some point in their life, but many were unable to access it.[88] They often feel forced to resort to unsafe procedures because of founded mistrust and fears of being discriminated against by healthcare providers, thus putting their lives at risk.

In other cases reported in Colombia, healthcare providers in public health centres have refused to perform abortions on transgender men, including cases of victims of CRSV. Part of the issue is the legal loophole that exists where terminology around the right to abortion refers explicitly to "women", unlike for example in Argentina, where the law on the legalization of abortion refers to both "women" as well as "*people with other gender identities with gestational capacity*".[89]

In recent years, the concept of 'survivor or victim-centeredness' has gained wider recognition, particularly at the international level. Survivor-centered responses for victims of CRSV were endorsed in 2019 by UN Security Council Resolution 2467, with States recognizing that the needs of survivors should be prioritized in prevention and response efforts.[90] However, what this concept means in practice for LGBTI+ victims/survivors, considering their multiple and very diverse needs, remains largely unexplored.

Notwithstanding, some promising practices have been identified, including some implemented by the International Red Cross and Red Crescent Movement. For example, in 2017 the Thai Red Cross created the first transgender-specific sexual health clinic with trained transgender personnel, to enable transgender persons to access health services, also providing medical and MHPSS services for sexual violence victims/survivors. For its part, the Nepal Red Cross society partnered in 2015 with Blue Diamond, a local LGBTI+ organization, to provide support and safe shelter specifically for transgender individuals to respond to their needs and reduce the risk of sexual violence.[47]

CONCLUDING REMARKS

The contexts and particular cases of CRSV against people of diverse SOGIESC referenced in this study span across continents and time. The four imaginaries of cis/heteronormativity, gender binary and gender stereotypes that are evident across the data explain the neglect of LGBTI+ people as a category of people vulnerable to CRSV. However, the compiled evidence provides proof of the systemic instrumentalization of CRSV against LGBTI+ people by state and non-state armed actors to enforce gender and sexuality norms. Hence, there is a need to broaden and deepen this conversation in order to inform much needed action.

Given how deeply rooted the gender binary, gender stereotypes and cisgender and heterosexual norms are in all spheres of life, this will be a laborious process that will necessitate a multi-sectoral approach at the international, regional and local level.

This study shows that CRSV against LGBTI+ people is under-researched and victims have been overlooked with devastating consequences. However, it should be noted that there are certain conflict situations and certain groups within this population whose experiences are more invisible than others. The analysis presented is based on available data which inevitably means that more information is discussed in relation to certain groups and contexts, such as the Colombian armed conflict or the experiences of gay men and transgender women.

Culturally-competent research, which takes into account the culture and diversity of these populations when designing and conducting research, must continue and be deepened and expanded in these cases. However, survivor-centered studies are urgently needed into the even more neglected experiences of transgender men, bisexual and intersex individuals[40] the experiences of females with diverse SOGIESC (with regards to whom a particular research gap has also been identified)[36] and non-binary individuals as well as LGBTI+ people living with disabilities.

Given the historical silencing and invisibilization of LGBTI+ people as victims of CRSV, more research is needed to assess the scale of this form of violence to inform policy. Similarly, more studies on the needs

and wishes of these populations in accessing healthcare and other responses such as protection, livelihood support, justice or education, along with better documentation and research into promising practices at the local level, are needed to inform survivor-centered programming.
Efforts to better respond to this issue will benefit from consultations with LGBTI+ survivors, where safe and appropriate, as well as research partnerships with national and local community organizations which can be beneficial to inform safe, respectful and context-specific research approaches that truly put LGBTI+ victims/survivors of CRSV at the centre.

Although this study does not provide conclusive answers it offers much to consider particularly in light of the four imaginaries. Some of the questions which arise and could be addressed in future discussions and research include:

1) What do the results of this study mean for current, broad, international agendas to reduce gender-related violence within conflict settings?
2) How can data collection be improved to enable a better understanding of the issue, the realities of individual groups within the LGBTI+ community and their intersecting vulnerabilities?
3) How can primary research be conducted in a survivor-centred way that guarantees the safety and security of victims and of the LGBTI+ community in each context, particularly where discriminatory legal frameworks continue to be in place?
4) To what extent are interventions for CRSV survivors trauma-informed, and how does the definition of 'trauma-informed' take into account the diversity of survivors, if at all?
5) How can development and humanitarian sector responses on CRSV move beyond the gender binary and become more inclusive and specialized?

Many questions remain yet one thing is clear: LGBTI+ people are at heightened risk of sexual violence in situations of conflict and this can no longer be ignored. Recognition by the international community of this issue is imperative in order to begin to dismantle the four imaginaries and to sensitize the whole of society while contributing to the individual and collective healing journey of those affected.

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Mandatory reporting of sexual and gender-based violence in humanitarian settings: A qualitative analysis of international guidelines for humanitarian practitioners and scoping review of existing evidence

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ABSTRACT

Background

Mandatory reporting requirements create an ethical and legal dilemma for humanitarian practitioners working with survivors of sexual and gender-based violence (SGBV), as they are required to report known instances of SGBV to law enforcement, sometimes without the consent of victims or as a precondition to administering care. However, there remains a paucity of research on this topic in the context of humanitarian settings to guide practitioners on how to navigate mandatory reporting requirements from a survivor-centered approach. This study seeks to contribute to the existing knowledge and debate on mandatory reporting for SGBV in humanitarian settings by reviewing the current literature and international GBV guidelines for humanitarian practitioners.

Methods

We conducted an abductive thematic analysis of key international GBV guidelines for humanitarian workers to explore the practices and guidance developed around mandatory reporting. GBV guidelines were identified by a search on agencies' websites under consultations with experts in the field of sexual and reproductive health. In parallel, we conducted a scoping review of five academic databases with no earliest inclusion date, and a final inclusion date of 31 March 2023 to identify the scope and extent of research on SGBV mandatory reporting in humanitarian settings.

Findings

We identified thirty-one relevant international GBV guideline documents which provide guidance for humanitarian practitioners on implementing mandatory reporting requirements. The availability and depth of information regarding mandatory reporting varies in the international guidelines. Three themes, including "GBV guiding principles", "consideration for the impact of mandatory reporting and the reporting obligations" and "guidance for humanitarian providers on how to implement mandatory reporting requirements" emerged from the GBV guideline content analysis. As part of the scoping review, 1474 records were reviewed, with only 5 publications meeting our eligibility criteria. The 5 selected publications contained only limited information about mandatory reporting.

Conclusion

Existing guidelines would benefit from incorporating more systematic and detailed guidance on how to navigate mandatory reporting requirements while upholding survivor-centered responses. There remains little evidence on the implementation or effectiveness of mandatory reporting in humanitarian settings, and of the implementation of guidance pertaining to mandatory reporting included in international GBV guidelines. Further research is necessary to clarify its implications and support evidence-based guidance for humanitarian personnel.

Keywords: Mandatory Reporting, Sexual Violence, Sexual and Gender-Based Violence, SGBV, Gender-Based Violence, GBV, Humanitarian Settings, Conflict, GBV Guidelines, Survivor-Centered Approach, GBV Guiding Principles

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INTRODUCTION

Background

Sexual and gender-based violence (SGBV) in conflict settings is a human rights, health and protection issue that can impact all genders and ages. In conflict settings, sexual violence, especially rape, can also be used as a weapon of war against individuals of all ages, genders, and backgrounds. The breakdown of social networks, displacement, an uptick in generalized violence, and other factors increase the risk of SGBV.[1,2]

Gender-based violence (GBV) is "an umbrella term for any harmful act that is perpetrated against a person's will and based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty".[3(p.5)] Even though the term "GBV" is mostly used for "violence that reflects or reinforces unequal power relations between males and females", it is increasingly used to "describe violence committed with the explicit purpose of reinforcing prevailing gender-inequitable norms of masculinity and/or norms of gender identity—for example, when referencing some forms of sexual violence against males or targeted violence against LGBTI populations."[3(p.321)] Sexual violence is a form of GBV and is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work."[3(p.22)]

Some countries have laws or policies requiring known or suspected cases of certain sexual and gender-based violence (SGBV) to be reported to the police or relevant authorities. This has become known as "mandatory reporting", which refers to the legal obligation of individuals or organizations to report known or suspected cases of sexual violence to relevant authorities, generally with the disclosure of identifying information about the sexual violence survivor without requiring their consent.[2]

Mandatory reporting requirements may vary by the type of SGBV. The definition of SGBV criminal offenses may also vary from country to country, having implications on reporting requirements. For example, in Iraq, public servants are obligated to report criminal offences according to Article 48 of the Criminal Procedure Code 23/1971.[4] The Iraqi Penal Code 111/1969 specifies that sexual violence offenses include acts such as sexual assault, rape, seduction, engaging in sexual activity with a minor, inciting or assisting a minor in sexual intercourse, and indecent advances.[4]

In the Republic of Moldova, under Law No.45 on the Prevention and Combating of Domestic Violence, responsible individuals or those aware of a threat to the victim's life and health are mandated to report cases of family violence to the appropriate authorities.[5] Article 2 of Law No. 45 stipulates that family violence encompasses domestic, physical, spiritual, economic, and sexual violence. Sexual violence, in this context, includes intimate partner violence, with examples provided by the law such as marital rape, forbidding the use of contraception, sexual harassment, any unwanted or forced sexual conduct, forced prostitution, and any illegal sexual conduct with a minor family member.[5] Therefore, implications of different types of SGBV for reporting may be vastly different by settings.

As shown in Annex 1, only some guidelines provide a clear definition of what types of sexual or gender-based violence are mandated to be reported. To be more inclusive of the types of violence addressed by the guidelines, we use the term "SGBV" to encompass both sexual violence and other forms of GBV in the context of mandatory reporting. When the guidance specifically refers to sexual violence, the specific term "sexual violence" will be used.

Mandatory reporting requirements are intended to ensure survivors of SGBV receive the necessary services, to improve access to justice, and to pursue legal action against perpetrators. Mandatory reporting also has the potential benefit of improving data collection and relieving the burden of reporting from SGBV survivors themselves. Despite their best intentions, mandatory reporting requirements have a multitude of potentially harmful consequences, including further traumatizing or revictimizing survivors, limiting their agency and autonomy, hampering their access to healthcare and other support and assistance, the criminalization of survivors under certain laws, and increased risk of retaliation.[2,4]

The survivor-centered approach is an internationally recognized standard for GBV case management that prioritizes the needs, rights, experiences, and decisions of the survivor.[7] This approach emphasizes the importance of believing and respecting survivors, providing care and support with kindness and empathy, and recognizing the unique strengths, resources, and coping mechanisms of each individual survivor. It also recognizes that each case is different and that survivors may have different needs as a result. Importantly, survivors should have the right to decide who is informed about the violence they have experienced and whether to report it to the police. Survivors should also hold agency over their care and support plan.[1]

Humanitarian agencies have developed a common concept known as the GBV Guiding Principles to underpin the survivor-centered approach in GBV programming and guide best practices in GBV case management whenever working with survivors. This study refers to the 2019 *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies*' definition of the GBV Guiding Principles, which includes:

i) Safety, both physical safety and security and a sense of psychological and emotional safety;
ii) Confidentiality, a person's right to choose whether and with whom to share information about the case;
iii) Respect for the choices, rights and dignity of SGBV survivors, which requires that survivors are the primary actors in all aspects of service delivery; and
iv) Non-discrimination, ensuring that all care is provided equitably for individuals, regardless of any intersectional differences.[8]

Terminology Clarification

This study uses the term "humanitarian setting" to define a context in which an event or series of events, either natural or man-made, "has resulted in a critical threat to the health, safety, security or well-being of a community or other large group of people", and as a result, "the coping capacity of the affected

community is overwhelmed and external assistance is required."[9] Humanitarian settings may be conflict-related and/or due to natural disasters and other emergencies.

"Humanitarian Practitioners" or simply "practitioners" refer to persons working in humanitarian emergencies. These individuals may have a range of roles, including healthcare workers, caseworkers, or managers, who may be international or national staff. Although the guidelines reviewed under this study are published by international agencies, the applicability of these guidelines to various staff positions may vary. Lastly, this study uses the term "GBV international guidelines" or simply "guidelines" to refer to international manuals, protocols, guiding documents and other literature addressed at humanitarian practitioners and providing guidance on how to respond to cases of SGBV.

Justification for Research

In 2020, the British Red Cross (BRC) and the International Committee of the Red Cross (ICRC) published the results of a multi-year study on the impact of mandatory reporting of sexual violence on survivors in conflict-affected contexts and other emergencies. The study was conducted in four undisclosed settings and data were collected via legal analysis, semi-structured interviews with key informants, focus-group discussions, and consultations with experts in the field of humanitarian health-care provision, SGBV case management, law, and human rights.[2] The BRC and ICRC's research was largely limited to the impacts of mandatory reporting on healthcare access and only minimally addressed its impact on sexual violence prevention outcomes, access to justice, and protection for survivors.

Mandatory reporting requirements and their implementation tend to vary by context. Hence, it is imperative that humanitarian workers receive clear, robust, and context-specific guidance on how to handle mandatory reporting requirements. This will ensure their preparedness to effectively assist and support survivors within the context they are operating in. However, aside from the BRC and ICRC's report, there remains a paucity of research on this topic in the context of humanitarian settings and there is currently no known analytical review of international guidelines for humanitarian practitioners to analyze their guidance on mandatory reporting.

The executive short course "Addressing Sexual Violence in Conflict and Emergency Settings" managed by the Geneva Centre of Humanitarian Studies aims to provide mid-level and senior humanitarian managers with the knowledge, competencies, and skills required to conceive multidisciplinary, survivor-centered interventions in the field of sexual violence response and prevention. During the course evaluation conducted between December 2021 and February 2022, several participants, both practitioners and managers, flagged the need for the course to provide more guidance in situations where mandatory reporting for sexual violence is required.[10] In response to this feedback, and to the Centre's decision to provide course students with evidence-based resources and increase discussions on this topic, this study aims to contribute to a deeper understanding of the existing guidance on mandatory reporting of SGBV in conflict and emergency settings. Therefore, this study seeks to answer the following research questions:

i) How is mandatory reporting of sexual and gender-based violence in humanitarian settings framed in international GBV guidelines?
ii) What is the scope of the existing evidence base on mandatory reporting of sexual and gender-based violence in humanitarian settings?

METHODS

This study comprises two parallel reviews – a guideline review and a scoping review (Figure 1). We conducted an abductive thematic analysis of GBV international guidelines to understand how the concept of mandatory reporting is framed. In conjunction with the analysis of key GBV international guidelines, we

conducted a scoping review to map the available evidence in mandatory reporting for SGBV in humanitarian settings.

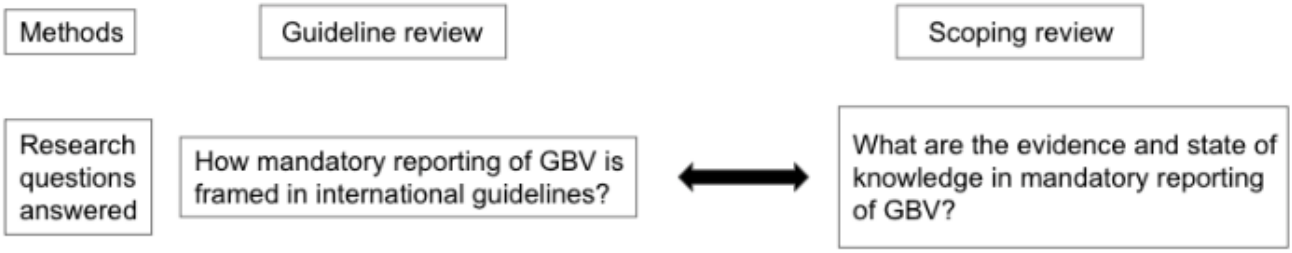

Fig 1 Sequence of Methodology

Qualitative Analysis of SGBV International Guidelines

Selection of Guidelines

The selection of GBV international guidelines was conducted via manual search on the websites of ICRC, International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations (UN) agencies and inter-agency coordination bodies with a mandate in health, including mental health and psychosocial support (MHPSS), and/or SGBV (n=16). Experts in the field of sexual and reproductive health (SRH) in humanitarian settings, including researchers and practitioners from Médecins Sans Frontières (MSF) and the Geneva Centre of Humanitarian Studies were consulted, and advised on the selection of guidelines for this analysis. Whenever several successive editions of the same guidelines exist, all available editions are included to observe changes between them.

Inclusion Criteria:

i) Guidelines that focused on or included sections on mandatory reporting of SGBV required by state's law.
ii) Publicly published guidelines authored or endorsed by the UN, ICRC, IFRC, and inter-agency coordination bodies.*
iii) Target audience of managers and practitioners in humanitarian settings.
iv) Guidelines in the fields of medical care and/inclusive of MHPSS that mention or address SGBV.
v) Guidelines in other humanitarian sectors, such as protection including child protection, which mention components of response linked to the health and/or MHPSS sectors for SGBV survivors.
vi) Guidelines written in English.
vii) Period of publication: 1995 – December 2022.

Exclusion Criteria:

i) Documents other than guidelines, such as reports, policy briefs, etc.
ii) Guidelines produced by organizations other than those indicated in the inclusion criteria.
iii) Guidelines not including components of response for SGBV survivors.

*This study includes guidelines by these international agencies because their guidelines usually serve as references for other organizations. Other organizations adapt their guidelines to the context based on guidelines produced by ICRC, IFRC, UN agencies and inter-agency coordination bodies.

Qualitative Analysis of the Selected Guidelines

From the selected guidelines, two researchers (WZ and DE) independently extracted the author, year, definition of mandatory reporting, section with relevant text, population/group covered by the guidance, the target audience, and language versions.

The researchers then independently extracted relevant text excerpts related to mandatory reporting of SGBV into Excel workbooks for analysis. Lastly, WZ and DE merged the analyses, with inconsistencies resolved through deliberation.

This study utilizes the four GBV Guiding Principles of safety, respect, confidentiality, and non-discrimination as a conceptual research framework. These principles serve as crucial parameters to assess the guidelines pertaining to the mandatory reporting of SGBV. Themes emerging outside of the four guiding principles were identified using the process developed by Vaismoradi et al.[12] which includes initialization, construction, rectification, and finalization. Using this framework, WZ and DE employed an abductive thematic analysis approach to generate themes and subthemes from the guideline texts. The abductive approach is an alternative to the inductive or deductive approaches. It engages equally with empirical data and theoretical frameworks and therefore avoids the shortcoming of thematic analysis which sometimes leads to "the discovery of abstract and arbitrary results irrelevant to the research question" and concurrently ensuring the findings are not limited to a "simplified testing of existing theoretical frameworks."[13(p.1411)]

To measure the extent to which mandatory reporting is included in the guidelines and the selected articles from the scoping review, we define a high level amount of information as guidelines or articles that have a dedicated section on mandatory reporting, a medium level amount of information as guidelines or articles that have more than 3 paragraphs of concentrated content on mandatory reporting, medium-low level amount of information as guidelines or articles that have 1 to 3 paragraphs of concentrated content on mandatory reporting, and low level amount of information as guidelines or articles that mention mandatory reporting in less than 1 paragraph.

Scoping Review of Available Literature

The scoping review followed the five-stage process developed by Arksey and O'Malley, which includes identifying the research question (stage 1), identifying relevant studies through different sources (stage 2), studies selection (stage 3), data extraction (stage 4), and collating, summarizing and reporting the results (stage 5).[14]

Five databases (Embase, PubMed, Web of Science, Cochrane Library, and Google Scholar) were searched for both free text keywords and Medical Subject Headings (MeSH) to identify all relevant search terms. The terms were categorized into three concepts:

i) Sexual and gender-based violence;
ii) Mandatory reporting; and
iii) Humanitarian settings.

We hand-searched related references of identified literatures for additional eligible studies. Boolean operator "OR" was used to link free text keywords and MeSH terms for the same concept, and the term "AND" was used to link the groups of terms for different concepts. The search syntaxes were adapted for corresponding databases and can be found in Annex 2. To ensure a comprehensive search of the literature, there was no lower date of inclusion, and the last date of inclusion was 31 March 2023. No relevant literature was found before 2008.

The scoping review includes both peer-reviewed and grey literature containing text that explicitly discusses mandatory reporting of SGBV in humanitarian settings. We included the emergency onset, relief, and recovery phases of humanitarian settings in countries of any income level. We also included any affected populations and any study design. Literature unavailable in English and not including all three aspects -- mandatory reporting, sexual and gender-based violence, and humanitarian settings, were

excluded. Due to the limited availability of the relevant literature and aim to understand the scope of the evidence base, data quality was not used as an exclusion criterion.

All citations were exported to Zotero. After removing duplicates, two authors (WZ and DE) independently screened the titles and abstracts of all exported references and reviewed the full text of potentially relevant literature based on the inclusion and exclusion criteria as described above. Discrepancies in article selection were resolved through discussion. The same abductive thematic analysis method employed in the examination of the guidelines was applied to the scoping review literature.

RESULTS

Guidelines Review Results

A total of 39 guidelines were selected for the review, of which 31 mentioned mandatory reporting. These guidelines were published between 1995 and 2020 by 6 inter-agency coordination bodies (The Alliance for Child Protection in Humanitarian Action, The Child Protection Working Group, GBV Area of Responsibility, Gender-based Violence Information Management System Steering Committee, Inter-Agency Standing Committee, Inter-Agency Working Group on Reproductive Health in Crises), 8 UN agencies (UNDP, UNFPA, UNHCR, UNICEF, UNODC, UN Women, World Bank, WHO), ICRC and IFRC.

Among the 31 guidelines that mention mandatory reporting, 5 have a high-level amount of information, 6 have a medium level amount of information, 13 have a medium-low level amount of information, and 7 have a low-level amount of information. Since the other 7 guidelines do not have any content on mandatory reporting, the amount of information in those guidelines is not assessed (Table 2).

Most guidelines have more than two language versions, and 7 guidelines only have English version. Following English (39 guidelines), the most commonly available language versions are French (25 guidelines), Arabic (18 guidelines), and Spanish (16 guidelines).

Despite that the type of SGBV have different implication for mandatory reporting (as discussed in the introduction section), most of the guidelines are unclear about the scope of mandatory reporting they are referring to. Only 9 guidelines give a definition of mandatory reporting. The types of SGBV covered by mandatory reporting is different from guideline to guideline: most guidelines refer to general SGBV, such as sexual violence, intimate partner violence, domestic violence, act of criminal offences, suspected violence against women cases; a few refer to more specific types such as rape, sexual assault, child abuse (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse); some do not specify any type of SGBV at all.

It is also not very clear who should make the report and who should be notified. "Service providers", "certain agencies", "persons in helping professions", "GBV case worker", "certain individuals or professionals", "healthcare providers", and "UN staff" (in the case of protection from sexual exploitation and abuse, PSEA) are the actors responsible to report mentioned by the guidelines and some do not specify any. Sixteen guidelines do not specify to whom the report should be made, the rest guidelines specify "police", "authorities", "legal system", "child protection agency", and "PSEA network" as the entity to be notified. The definition of mandatory reporting, responsible actor to report and the entity to be notified defined by each guideline is compiled in Annex 1.

In addition to the GBV Guiding Principles,[8] which was used as a conceptual framework for the international guideline analysis, two other themes, "consideration for the impact of mandatory reporting and the reporting obligations" and "guidance for humanitarian providers on how to implement mandatory reporting requirements" emerged from the abductive thematic analysis (Table 1). A minimal text related to the GBV Guiding Principle "non-discrimination," which addresses the equal provision of healthcare, was found. Thus, the theme "GBV Guiding Principles" only encompasses "safety,"

"respect," and "confidentiality." A list of themes included in each guideline is available in Table 2.

Table 1 Description of the Three Emerged Themes from the Abductive Content Analysis of GBV Guidelines and the Subthemes under Each Theme

Theme	Sub-Theme	Description
GBV guiding principles	Safety Respect Confidentiality	Content related to the GBV guiding principles are coded under this theme. Because there is a minimal text related to non-discrimination, this guiding principle is not included in the emerged sub-theme
Consideration for the impact of mandatory reporting and the reporting obligations	Factors to evaluate the impact of mandatory reporting requirements Interrelation between mandatory reporting requirements and other legislation pertaining to sexual and reproductive health (SRH) Balance between ethics and mandatory reporting requirements	This theme addresses the impact of mandatory reporting (including what factors practitioners should consider when evaluating the impact and how the interconnection between mandatory reporting requirements and other SRH-related laws would affect the survivor), and how to balance ethics and mandatory reporting requirements given the potential impact mandatory reporting might have on the survivor
Guidance for humanitarian providers on how to implement mandatory reporting requirements	Aspects to understand before implementing mandatory reporting requirements Guidance on how to communicate with survivors about mandatory reporting Coordination between different sectors to implement mandatory reporting requirements Personnel capacity building	This theme provides guidance for humanitarian providers to implement mandatory reporting requirements along the process, starting from aspects of the requirements to understand before implementing them, to how to communicate with survivors and coordinate with other actors during the process, as well as long term capacity building for personnel to handle mandatory reporting in a survivor-centered manner

Table 2 Mandatory Reporting Related Contents of Guidelines Mapped by Emerged Themes
(Cells marked with "X" denote guidelines with text relating to the selected theme)

#	Guideline Title	Author	Year	GBV guiding principles	Guidance for humanitarian providers on how to implement mandatory reporting requirements	Consideration for the impact of mandatory reporting and the reporting obligations	Depth of mandatory reporting Information
1	The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming	GBV Area of Responsibility (AoR)	2019	X	X	X	High
2	Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action	GBV Area of Responsibility (AoR)	2015	X	X	X	Medium-low
3	Handbook for Coordinating GBV Interventions in Humanitarian Settings	GBV Area of Responsibility (AoR)	2019	X	X	X	Medium
4	Handbook for Coordinating GBV Interventions in Humanitarian Settings	GBV Area of Responsibility (AoR)	2010		X		Low
5	Inter-Agency Gender Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings	Gender-based Violence Information Management System (GBVIMS) Steering Committee	2017	X	X	X	Medium
6	Violence Against Women and Girls (VAWG) Resource Guide: Health Sector Brief	Global Women's Institute, World Bank and Inter-American Development Bank	2015	X	X		Low

7	Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area	IASC (Inter-agency Standing Committee)	2015		X		Low
8	Guidelines for Gender-Based Violence Interventions in Humanitarian Settings	Inter-Agency Standing Committee (IASC) and Humanitarian Assistance	2005			X	Medium-low
9	Caring for survivors of sexual violence in emergencies. Training guide	Inter-Agency Standing Committee (IASC) and Humanitarian Assistance	2010	X			Low (there's a handout for information regarding mandatory reporting, but not in the guideline)
10	Establishing Gender-based Violence Standard Operating Procedures (SOPs) for multi-sectoral and inter-organisational prevention and response to gender-based violence in humanitarian settings	Inter-Agency Standing Committee (IASC) and Humanitarian Assistance	2008	X	X	X	High
11	Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (Revision for Field Review)	Inter-Agency Working Group on Reproductive Health in Crises (IAWG)	2010		X		Low
12	Inter-agency Field Manual on Reproductive Health in Humanitarian Settings	Inter-Agency Working Group on Reproductive Health in Crises (IAWG)	2018	X	X	X	Medium-low

13	Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings	International Rescue Committee (IRC), UNICEF	2012	X	X	X	High
14	Advancing the Field: Caring for Child Survivors of Sexual Abuse in Humanitarian Settings (A Review of Promising Practices to Improve Case Management, Psychosocial & Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse)	International Rescue Committee (IRC), UNICEF	2011	X	X	X	Medium
15	Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies	UNFPA	2015	X		X	Medium-low
16	Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines	UNFPA, UN Women, WHO, UNDP, UNODC	2015	X	X	X	Medium-low
17	Managing Gender-based violence programmes in emergencies	UNFPA	2012	X	X		Medium-low
18	Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (see IAWG entry)	UNFPA and Save The Children	2009	X	X	X	Low
19	A practical approach to GBV: A programme guide for health care providers and managers	UNFPA	2001				N/A
20	Sexual Violence against Refugees: Guidelines on Prevention and Response	UNHCR	1995				N/A

21	Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response	UNHCR	2003				N/A
22	UNHCR Handbook for the Protection of Women and Girls	UNHCR	2008				N/A
23	SGBV prevention and response - A training package	UNHCR	2016	X	X	X	Medium-low
24	Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement	UNHCR and Refugee Law Project (RLP)	2012				N/A
25	Guidelines for medico-legal care for victims of sexual violence	WHO	2003	X	X	X	Low
26	Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines	WHO	2013	X	X	X	High
27	Strengthening medico-legal responses to sexual violence	WHO	2015	X	X	X	Medium-low
28	Responding to children and adolescents who have been sexually abused	WHO, UNODC	2017	X	X	X	Medium
29	Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers	WHO	2017	X	X	X	Medium-low
30	Clinical Management of Rape Survivors - Developing protocols for use with refugees and internally displaced persons	WHO, UNFPA, UNHCR	2004				N/A
31	Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook	WHO	2014	X	X		Medium-low
32	Mental health and psychosocial support for conflict-related	WHO	2012				N/A

	sexual violence: principles and interventions						
33	RESPECT women - Preventing violence against women	WHO, UN Women	2019				N/A
34	Gender-based violence Quality assurance tool – MINIMUM CARE VERSION	U.S. Centers for Disease Control and Prevention (CDC), and WHO	2020	X	X	X	Medium-low
35	Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings	WHO, UNFPA, UNHCR	2020	X	X	X	Medium
36	Minimum Standards for Child Protection in Humanitarian Action	The Alliance for Child Protection in Humanitarian Action	2020	X	X	X	Medium-low
37	Interagency Guidelines for Case Management and Child Protection	The Child Protection Working Group	2014			X	Medium
38	Checklist: Domestic Implementation of International Humanitarian Law Prohibiting Sexual Violence	ICRC	2020			X	High
39	Sexual and Gender-Based Violence (A two-day psychosocial training) – Training Guide	IFRC	2015	X	X		Medium-low

Among the 39 GBV guidelines reviewed in this study, only 31 include content on mandatory reporting and the amount of information in most guidelines is low to medium-low. Three themes, "GBV guiding principles", "Guidance for healthcare providers on how to implement mandatory reporting requirements" and "Consideration for the impact of mandatory reporting and the legal obligations" emerged from the guidelines. Guidelines that do not mention mandatory reporting are marked as "N/A" under the column "Depth of mandatory reporting information".

GBV Guiding Principles

Ten guidelines prioritize the safety of survivors above adherence to mandatory reporting requirements.[1,8,9,15-21] Those guidelines suggest that practitioners should understand the implications of reporting and make ethical decisions that ensure the safety of the survivor, which is a relevant concern at every stage of the care process.

To ensure that survivors are safe throughout the provision of SGBV care services, three guidelines recommend providing them with various forms of support, including psychological, social, economic, and other relevant assistance and protection.[19,22,23] Seven guidelines advise humanitarian practitioners to ensure survivors have adequate access to healthcare first before presenting them with options for reporting to the police.[1,9,18-21,24] Mandatory reporting procedures that require survivors to first report to the police can delay or obstruct access to medical care.[1] Practitioners should fully understand their legal obligation to report in the setting where they are working and have a nuanced understanding of potential impacts to survivors' safety. For instance, disclosing the identity of a perpetrator may put a survivor at risk of further harm in some cases.[19]

"Survivors should always be able to seek care (including clinical management of rape, case management, PSS support) without disclosing the identity of an alleged perpetrator."[21(p.38)]

Children and adolescent survivors of SGBV are particularly vulnerable, two guidelines on child sexual abuse response suggest that special safety considerations must be made regarding child sexual abuse, especially if there is suspicion that the perpetrator may be a parent, guardian, family member, or any other individual that may be able to access the child's case file.[7,16]

The principle of respect shifts power back into the hands of survivors and acknowledges their resilience.[1] The involvement of survivors in their treatment process is imperative to uphold a survivor-centered approach. Even if a report has to be filed due to the reporting obligation by the law, survivors' perspective and input regarding the contents of the report, "*how and when the report is made*" should be given full consideration.[13(p.95)]

Informed consent of the survivor is a critical element of respect highlighted by 11 guidelines.[1,3,18,21,22,25-29] Three guidelines address how practitioners can facilitate the decision-making of survivors by providing survivors with clear and accurate information, including other available options such as local organizations that might be able to help the survivor.[22,24,30] Practitioners also need to inform the survivor about the organization's policy regarding mandatory reporting, along with the reporting process and its consequences.[9] Five guidelines stress that such information needs to be shared at the very beginning of the encounter with a survivor, to enable them to decide what to share with the organization.[16,17,22,25] This allows the organization to ensure a balance between compliance with mandatory reporting requirements and respect and informed consent.

"By ensuring survivors are aware of mandatory reporting requirements, health-care providers can help survivors make informed decisions about what to disclose during a health visit." [28(p.16)]

Confidentiality implies that individuals with access to survivors' sensitive information must not disclose this at any time to any party without the consent of the person concerned.[32] If a survivor's confidentiality is compromised, it can put them at risk of secondary harm.[1] Eight guidelines recommend that practitioners should be transparent about the limitations of confidentiality.[1,6,9,22,26,33-35] To achieve transparency, practitioners must understand relevant laws and organizational protocols, along with their implications for the survivor.[24,36] Practitioners should inform survivors of any limitations of confidentiality from the start of service provision and provide reminders throughout the process, to allow them to decide whether to share information that may trigger mandatory reporting requirements.[24] One guideline also suggests that practitioners should not "*promise*"

confidentiality if mandatory reporting requirements are in place, as "*it is not acceptable to make promises to survivors that you know you might not be able to keep.*"[19(p.52)] With this stated, practitioners should do everything within their power to protect survivor confidentiality.

One GBV coordination guideline and two child sexual abuse response guidelines give guidance on how to uphold confidentiality with regard to information sharing, as well as the reporting mechanisms and investigation.[16,19,24] This includes understanding who is obligated to report the case, identifying the designated officials responsible for receiving such reports, and ascertaining the existence of policies safeguarding confidentiality.[16,24] Acquiring this knowledge enables the development of strategies aimed at compiling reports with minimal disclosure of survivor information, ensuring that information is shared exclusively with relevant individuals.[16,19]

Stringent documentation and record-keeping policies are necessary to ensure confidentiality when working with survivors of SGBV. Documentation can become a safety concern for anyone whose files may be accessed by potential perpetrators or other individuals that may put a survivor's safety at risk.[19] For this reason, if the survivor remains concerned after being informed of what is being documented, providers should "*set aside the procedures and focus on providing help*."[19(p.54)] The three guidelines mentioned above also instruct how to coordinate information sharing between institutions, including what, when, how, and to whom the information will be shared.[16,19,24] Anonymized data should be used for monitoring and risk mitigation actions, and the actors should agree on the least amount of information necessary to share.[11,14]

Consideration for the Impact of Mandatory Reporting and the Reporting Obligations

Five guidelines emphasize that while mandatory reporting requirements are often passed with the intention of protecting survivors, these same requirements may cause more harm and conflict with international human rights standards and GBV guiding principles.[9,17,22,37,38] Eight guidelines list the factors to be considered to evaluate the impact of mandatory reporting on survivors, including the safety of survivors, survivors' healthcare-seeking behavior, the delay in care provision, and the intersecting vulnerability of marginalized groups such as women, children, and Lesbian, Gay, Bisexual, Transgender Intersex Queer/Questioning plus (LGBTIQ+) individuals.[1,6,16,19,21,22,29,38] The impact of mandatory reporting may vary depending on the circumstances. For example, the risk of harm is higher when the system lacks protection measures for survivors, or when the perpetrator is a member of law enforcement or of an armed group/army.[16,17,24]

Four guidelines reflected the interplay between mandatory reporting requirements and other laws pertaining to sexual and reproductive health (SRH).[1,9,21,29] For example, instances such as third-party authorization for a survivor to access abortion care or laws requiring a police report prior to providing a survivor emergency contraception can potentially activate the obligation to report incidents of sexual violence.[29] It is important to note that the reporting of incidents of sexual violence may also trigger additional reporting requirements. For example, the clinical management of sexual violence survivors for HIV prevention may require reporting HIV-positive cases, an important consideration for medical practitioners in humanitarian settings.[9]

There are inconsistencies between guidelines regarding the balance that humanitarian practitioners should maintain between ethics and mandatory reporting requirements. Some guidelines simply highlight ethical dilemmas posed by mandatory reporting, while others state that legal requirements to report override the survivor's agency—conflicting with a survivor-centered approach. For example, one guideline points out that mandatory reporting requirements have potential conflict with the "*principle of respect for confidentiality, respect for autonomy and the need to protect the vulnerable*,"

while two others state that "*legal requirements override the survivor's permission.*" [1(p.48),19(p.51),20(p.20)]

Most guidelines that address children and adolescent populations suggest that the best interests of the child should be the primary consideration for practitioners when addressing mandatory reporting.[3,8,16,17,19,20,24,42,43] Only one guideline states that "*child maltreatment and life-threatening incidents must be reported to the relevant authorities by the health-care provider, where there is a legal requirement to do so.*" [30(p.4)]

Child and adolescent populations may entail more complex legal considerations. Five articles reviewed in this study focus particularly on this population.[16-19,42] It should be noted that many countries have laws mandating the report of suspected child abuse and that these may differ from laws regarding SGBV. More detailed legal analysis is required to investigate these key differences.

In many countries, the legal obligation to report suspected child abuse is governed by more stringent criteria than mandatory reporting for SGBV cases in adults. Furthermore, the legal age of consent for children and adolescents is a crucial factor that necessitates attention, particularly concerning both the age of sexual consent and the age of consent for medical treatment. As stated in the Inter-Agency Working Group on Reproductive Health in Crises Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, "*SRH Coordinator must understand and disseminate information about country-specific laws with regard to the age of consent for treatment, the professional who can give legal consent for clinical care if a parent or guardian is the suspected offender (for instance, a representative from the police, community services, or the court.*" [9(p.34)]

Guidance for Humanitarian Practitioners on How to Implement Mandatory Reporting Requirements

The instructions on the implementation of mandatory reporting requirements for humanitarian practitioners covered by the guidelines include aspects to understand before implementing mandatory reporting requirements, how to communicate with the survivors, coordinating with different actors during the process and personnel capacity building.

Before implementing the mandatory reporting requirements, three guidelines suggested humanitarian providers to check:

i) What criteria would trigger the obligation to report? (for example, is the obligation to report triggered when healthcare providers have reasonable cause to suspect the survivor is subjected to SGBV and what qualifies as reasonable cause?)[16]
ii) What is the timeframe requirement for the report?[3]
iii) Does the humanitarian provider hold special immunities from reporting obligations? (Humanitarian practitioners may hold special immunities due to their affiliation to an international organization such as the UN or their respective role within their organization)[22]
iv) What are the legal implications of not reporting accounting for the context and the strength to which the legal framework is enforced?[16]

While the guidelines generally encourage practitioners to understand the importance of effective, clear, and concise communication and apply it to their practice, largely, the guidelines include only general guidance on how to communicate with survivors about reporting obligations. In a notable exception, interagency guidelines (such as those published by the IASC) provide more detailed technical guidance on communication and on how to handle mandatory reporting more broadly.[1,9,22] These guidelines encourage active listening by practitioners and provide helpful communication tips to make survivors feel supported. In rare cases, the guidelines contain sample scripts on how to achieve this. A sample of scripts is included in Annex 3.

Seven guidelines also address coordination among different sectors to implement mandatory reporting requirements.[1,9,16,17,19,24,33] Those guidelines are largely inter-agency coordination guidelines (three out of seven) or child sexual abuse response guidelines (three out of seven). In terms of intersectoral coordination, the guidelines comprise actors from SGBV, healthcare, protection and child protection agencies, the PSEA network, and the humanitarian country team. Those guidelines address the necessity of healthcare providers coordinating with local law enforcement. Coordination with law enforcement is recommended to ensure survivors' access to healthcare and to collaboratively develop standard operating procedures:

"It is strongly recommended that GBV and health-care actors coordinate with the police to ensure survivors can access health care first and then choose whether to report GBV incidents to the police." [1(p.28)]

Personnel capacity building is another important element addressed by eight guidelines to ensure mandatory reporting requirements are implemented in a survivor-centered manner.[1,9,16,19,20,22,24,44] Six guidelines highlight the need to develop protocols and standard operating procedures (SOPs) for personnel to guide case management.[1,9,16,20,22,24] Supervisors and health service managers also play an important role in helping personnel to navigate mandatory reporting requirements by facilitating relevant trainings, providing guidance in urgent and complex situations, as well as addressing *"health-care providers' beliefs and values that can adversely affect their reporting practices."* [16(p.40)]

Scoping Review Results

1474 records were initially retrieved. Following the removal of duplicates, 1088 records remained. Upon screening the title and abstract, 996 records were excluded, resulting in 122 articles for comprehensive assessment. Among the fully assessed articles, 14 were inaccessible, 31 did not address mandatory reporting, and 73 were not related to humanitarian settings. Four articles met the criteria after the complete screening process and one additional article was added through manual search: to supplement the findings, we conducted a citation search on mandatory reporting within the selected articles, which led to the identification of one additional article, for a total of five records included for analysis (Figure 2) (Table 3).

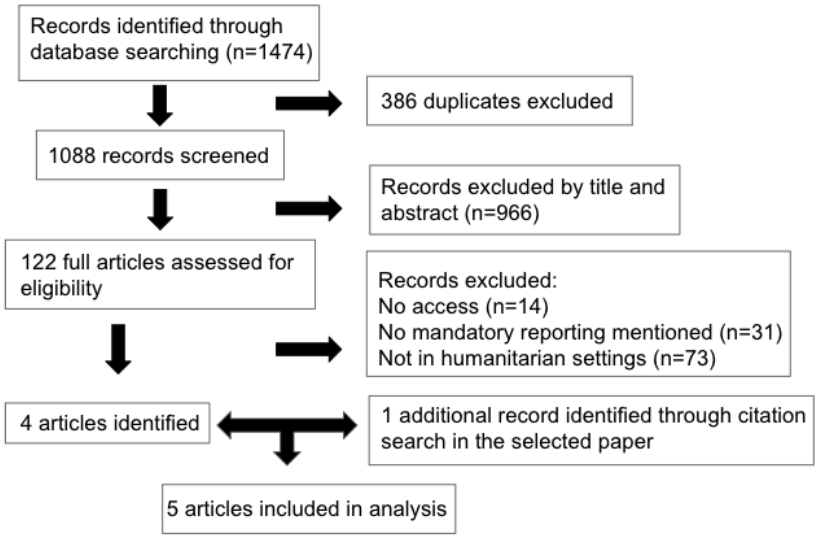

Fig 2 Flow Diagram of Documents through Scoping Review

Of the 73 articles that were excluded for being unrelated to humanitarian settings, most took place in high-income countries, particularly the United States. The search strategy included the word "emergency," thus yielding results related to emergency medicine, rather than humanitarian settings. A few articles contained studies that were conducted in low- and middle-income countries such as India, Tanzania, and Brazil—but not in humanitarian contexts. These studies predominantly took place in clinical settings, such as hospitals and primary healthcare facilities. Additionally, a small number of studies were conducted in alternative settings such as schools, police departments, and legal departments. These studies explore the effects of mandatory reporting, examine reporting behaviors, assess individuals' knowledge pertaining to mandatory reporting, and analyze the ethical conflicts that arise in relation to mandatory reporting.

Table 3 Selected Articles from Scoping Review

Author, Publication Year	Title	Publication	Country Setting	Study Method	Depth of mandatory Reporting Information
Sarah Chynoweth, Dale Buscher, Sarah Martin, Anthony Zwi, 2020	A social ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refugee settings: a qualitative exploratory study[45]	Conflict and Health	General	Document review, semi-structured key informant interviews, semi-structured focus group discussions, observation of service delivery points	Low
Sarah Chynoweth, 2017	"We keep it in our heart" - Sexual violence against men and boys in the Syria crisis[46]	UNHCR Report	Syria	Document review, key informant interviews, focus group discussions, group discussion, survey	Medium
David Wells, 2017	Sexual violence interventions: Considerations for humanitarian settings[47]	Forensic Science International	General	N/A	Low
Wilma Doedens, Noreen Giga, Sandra Krause, Monica	Reproductive health services for Syrian refugees in Zaatri refugee camp and Irbid city, Jordan - An	Joint report of Boston University School of Public Health, UNHCR, UNFPA,	Jordan	Key informant interviews, health facility assessment, and	Medium-low

Onyango, Samira Sami, Erin Stone, Basia Tomczyk, Holly Williams, 2013	evaluation of the Minimum Initial Service Package[48]	US CDC, Women's Refugee Commission		focus group discussions	
Sarah Chynoweth, 2008	The need for priority reproductive health services for displaced Iraqi women and girls[49]	Reproductive Health Matters	Jordan	Field mission, interviews	Low

A list of the five selected articles from the scoping review. Three articles are from the same author and the amount of information related to mandatory reporting in all the articles is low.

Limited research regarding mandatory reporting in humanitarian settings was found - with two studies conducted in Jordan, one in Syria, and two referring to humanitarian settings more generally. Mandatory reporting in humanitarian settings was not a primary focus of any of the five articles selected. The pre-identified 2020 BRC and ICRC report was not a result of the scoping review. Of the five selected articles, three made only brief mention (1-2 sentences) of mandatory reporting. The other two articles each contained 2-3 paragraphs regarding mandatory reporting. Three of the articles have the same primary author (Chynoweth), further confirming the limited scope of available research on this topic.

Due to the minimal data returned, the researchers were only able to conduct a limited analysis.

Four out of five articles identify mandatory reporting as a barrier to accessing health services.[45,46,48,49] One article defends this notion by stating *"(mandatory reporting) discourages survivors who do not want to pursue legal action or who fear public scrutiny from accessing health services."* [43(p.57)] In addition, survivors' fear of disclosure is heightened by mandatory reporting, thereby impeding accessibility to health services.[46,48]

Among the five articles, four of them included recommendations for healthcare providers to navigate mandatory reporting requirements. However, these recommendations were relatively limited and did not provide specific steps for implementing it in practice. For example, in one of the studies examining sexual violence against men and boys in the Syria crisis and their access to services in Jordan, Lebanon, and the Kurdistan Region of Iraq (KRI), the informants and refugees suggested to *"promote 'men's health services' without specifying sexual violence. [Ensure these efforts are complemented by protection-sensitive analyses of policies such as mandatory reporting of sexual violence cases by health providers to the police, which could raise additional protection risks.]."*[43(p.65)] The recommendation states to ensure that policies such as mandatory reporting are analyzed and accounted for.

Of note, the same article advocates for reform of mandatory reporting requirements for health providers: *"...work to repeal (sexual violence) mandatory reporting for adults and ensure mandatory reporting for children complies with children's best interest principles...."*[43(p.72)] This was the only found example advocating for change.

In addition, two articles discussed the challenges in implementing mandatory reporting requirements and its reform; these include people's fear of disclosure and health workers' lack of awareness on the updates in mandatory reporting laws.[46,48]

DISCUSSION

The State of Knowledge on Mandatory Reporting in Humanitarian Settings

This scoping review confirms a gap in knowledge on mandatory reporting and the need for increased data collection and analysis to inform policies and practices on mandatory reporting of SGBV in humanitarian settings. Apart from the pre-identified 2020 BRC and ICRC report, no study was found on the impact of mandatory reporting of SGBV in humanitarian settings. One article cites mandatory reporting as a barrier to service accessibility and another simply suggests practitioners be aware of mandatory reporting requirements.[43,45] The remaining articles containing mandatory reporting comprise only an ancillary outcome in these studies.

There is a larger evidence base from non-humanitarian settings on mandatory reporting. A few studies from non-humanitarian settings propose potential solutions to the ethical challenges associated with mandatory reporting, including enhancing comprehension and effective management of reporting responsibilities, ensuring survivors are informed about reporting mandates, advocating for policies that uphold survivors' autonomy in decision-making, providing specialized training for sexual assault forensic examiners, and establishing well-defined protocols.[50,51] However, the impacts of mandatory reporting in humanitarian settings, especially in armed conflict, may be notably different from research conducted elsewhere, due to factors such as displacement, destruction of protective community ties, changes to social norms, differing legal frameworks, and weakened state and community services.[2] Therefore, the protection of survivors is less likely to be ensured in humanitarian settings where the system is malfunctioning. For international humanitarian agencies to generate evidence-based guidance on mandatory reporting of SGBV, extensive research on this topic must be conducted.

Similarly, there is significant variation in the availability and depth of information regarding mandatory reporting in the international guidelines reviewed in this study. In some cases, guidance on mandatory reporting was only included in separate text boxes and not included in the primary text of the guideline. Those text boxes are used to highlight specific content, but while they give a topic more visibility, they do not necessarily address the topic structurally. In addition, mandatory reporting was seldom given a standalone section. The variability of information on mandatory reporting and its inclusion as part of a lengthy guideline which covers a broad range of topics, presents a challenge to humanitarian practitioners to gain reliable guidance on this topic.

While international GBV guidelines adhere to the GBV guiding principles and are survivor-centered, many fail to provide clear guidance on how to navigate the complex ethical and practical considerations of mandatory reporting, leaving practitioners with limited knowledge on how to provide survivor-centered care and support while fulfilling their reporting obligations. Guidelines published by inter-agency bodies such as the IASC tend to have the most comprehensive guidance on how humanitarian practitioners should approach mandatory reporting. Moreover, while guidance was sometimes offered on how to handle mandatory reporting requirements when managing SGBV cases, this seems to be an area that is lacking consensus. For example, there is a lack of consensus on whether legal requirements to report should override survivor consent, despite this being contradictory to the GBV Guiding Principles.

Establishing an ethical foundation for mandatory reporting procedures is relevant to the responsibilities of practitioners. However, the recommendations on how to approach mandatory reporting when working with SGBV survivors may be better achieved by incorporating job-specific and context-sensitive training modules aligned with this ethical framework. Further research is needed to form an ethical consensus on the topic and advise the creation of training modules for humanitarian organizations that specifically cover mandatory reporting in humanitarian settings. This may explain why technical guidance is often left out of international guidelines,

as the broad array of humanitarian roles involved in responding to SGBV, coupled with the highly sensitive nature of the work, can potentially discourage agencies from making conclusive statements on this complex and contentious topic. This is especially true when considering the diverse range of stakeholders that the guidelines need to address.

Potential Impact of Mandatory Reporting Requirements

Mandatory reporting requirements may have negative impacts on survivors' access to health services due to their concerns for safety, fear of losing custody of children, public scrutiny, and potential legal consequences. Evidence from both humanitarian settings and non-humanitarian settings have confirmed the barrier to health services posed by mandatory reporting requirements.[2,51-53] Research conducted in non-humanitarian settings exploring the perspectives of survivors has indicated that mandatory reporting requirements have the potential to diminish help-seeking behaviors and impede survivors' access to support services. These obligations can introduce obstacles for patients seeking to communicate with and disclose instances of abuse to healthcare providers.[41,52-54] Furthermore, the act of reporting itself can exacerbate the circumstances faced by survivors.[53] According to studies from non-humanitarian settings, the view of health providers differs, depending on their medical department, gender and the training they received on the law, with female physicians more likely to believe mandatory reporting law would increase the risk of retaliation faced by the patients, and emergency physicians more likely to report domestic violence cases compared to primary care physicians.[41,52]

Healthcare for sexual violence survivors in humanitarian settings focuses on emergency care needs such as the prevention of sexually transmitted infections (STI), including post-exposure prophylaxis (PEP) for HIV, emergency contraception, and access to safe abortion care. Survivors are less likely to seek healthcare if medical practitioners are required to report, due to a lack of trust in the justice system, fear of retaliation, stigmatization, fear of being criminalized for an extramarital sexual relationship, and the risk of being traumatized by invasive forensic examinations.[2] In addition, the lengthy procedure to obtain a police report can delay or prevent survivors from obtaining time-sensitive emergency contraception, PEP for HIV, and treatment for other STIs in those settings where such report is needed as a precondition to receive care or the law is interpreted in this way.[2]

Differences between Population Groups

As shown in the results section, there are interconnections between mandatory reporting requirements and other laws pertaining to sexual and reproductive health. This interconnection can impact the clinical management of sexual violence cases and exacerbate intersecting vulnerabilities of marginalized groups, as mandatory reporting requirements can also carry legal consequences for survivors belonging to specific groups, under the laws of some countries and in specific social norms contexts.

Mandatory reporting may lead to the prosecution of survivors from specific groups, such as LGBTIQ+ people and sex workers, for instance in countries where homosexuality, adultery, or sex work are criminalized. In these contexts, this also poses further barriers for male survivors and sexual and gender minorities to seek services after experiencing SGBV, due to fears of health providers' reports that might expose their sexual orientation.[21,46] In countries where extramarital sex is illegal, mandatory reporting can lead to survivors being accused of adultery, survivors being punished under local law, or forced marriage with the perpetrator as a mitigation of sentences for rape.[55]

Considering the implications of reporting SGBV cases for women and girls and marginalized groups and sub-groups in countries that have discriminatory legal frameworks and social norms, greater attention should be paid to those groups in contexts where mandatory reporting requirements and practices

exist. Because reporting to authorities may pose a particular threat to the safety and security of specific groups of survivors, it is paramount to prioritize the application of GBV guiding principles, with a strong emphasis on maintaining utmost confidentiality. Practitioners must always inform survivors when confidentiality cannot be protected from the start, and respect the survivor's choice, as it is the survivor who ultimately bears the consequences. Conducting an intersectional gender analysis is imperative within SGBV programming to ensure non-discrimination and access to care for all people, regardless of their intersecting vulnerabilities.[1]

Health providers should have special considerations for child and adolescent survivors when implementing the mandatory reporting requirements. Compared to adults, children and adolescents have specific vulnerabilities and face specific risks and consequences when it comes to mandatory reporting as illustrated in the two UNICEF and International Rescue Committee (IRC) guidelines.[16,17] Thus, additional caution should be heeded during documentation, follow-up, and referral to health, social, or other essential services. Practitioners should observe the best interests of the child when deciding whether to file a report by determining if quality child protection and safe reporting and referral mechanisms are in place. They should consider the identity of the perpetrator and any potential consequences of reporting the case (e.g., separation from family, placement in institutions). In addition, practitioners should be familiar with relevant laws concerning child protection in the respective countries, such as laws in child abuse and the legal age for consent, as well as with the nature and quality of child protection and judicial systems.

Way Forward

Mandatory reporting of SGBV in humanitarian settings is undoubtedly a complex and emerging topic of research. Further studies must be considered to better understand this issue and fill the gap between guidance and implementation. The findings of this study support a few key recommendations—

For researchers and donors:

i) Allocate resources and conduct research on the following areas related to mandatory reporting of SGBV in humanitarian settings.

ii) Better understand the impact of mandatory reporting in humanitarian settings, taking safety and security issues into utmost consideration. While the BRC and ICRC's research has attempted to do this, it narrowly focuses on healthcare access.

iii) Evaluate the gap between guidance and implementation — comparative studies should be conducted to analyze the implementation of mandatory reporting and of GBV guidelines by healthcare and other humanitarian workers in various contexts and regions and to highlight and promote promising practices.

iv) Understand the implications of mandatory reporting in different types of humanitarian settings (for instance, conflict v. natural disaster v. complex emergencies), where the types of prevalent SGBV may differ, and the types of SGBV cases that are compulsory to be reported may also differ, as well as for different types of humanitarian practitioners (healthcare workers v. caseworkers, etc.); and explore specificities by group and sub-group of survivors through an intersectional lens.

v) Investigate the interplay of international and domestic law (e.g. when mandatory reporting requirements exist in countries affected by armed conflict where International Humanitarian Law (IHL) applies).

vi) Conducting a comprehensive global analysis of the legal requirements surrounding mandatory reporting, resulting in the generation of a database that highlights the requirements on a country or regional basis,

would provide context-specific guidance for humanitarian workers in these areas.

For humanitarian organizations:

i) Ensure that mandatory reporting guidance is structurally embedded and expanded in all GBV guidelines, and that the guidance is more specific for humanitarians to navigate this complex issue in accordance with a survivor-centered approach and contextually specific.
ii) Support Ministries of Health to include survivor centered guidance on mandatory reporting in national strategies to combat SGBV, and national SRH, clinical management of rape, and protection guidelines.
iii) Enhance capacity building for practitioners to navigate mandatory reporting requirements. Create opportunities for constructive discussions and debate on mandatory reporting and ways to respond to dilemmas in the light of a survivor-centered approach and without exposing survivors to further harm.
iv) Provide mentorship and training to humanitarian practitioners that work with survivors on how to provide care that better protects their health, safety, and well-being, where safe and possible. The trainings should include reporting procedures (who, when, what, how) based on the mandatory reporting requirements by the duty station country, other relevant laws, the potential impact of mandatory reporting, and how to interact with the survivor from a survivor-centered perspective.
v) Training to ensure non-discrimination is strongly recommended, such as training on intersectional gender analysis skills, value clarification workshops to address stigma and cultural taboos related to SGBV, and attitudes perpetuating gender inequality and blaming victims, which would adversely affect healthcare workers' reporting practices.

It should be noted that it is crucial for the guidelines and training to be grounded in empirical evidence, with research informing both the development of guidelines and personnel capacity building. For both research and training, survivor organizations and survivor leaders should be consulted, where safe and possible, to ensure that their expertise is incorporated and centered.

Limitations

The guidelines review has a few key limitations. Firstly, our selection criteria were limited to international organizations, largely within the UN system. Future research should include guidelines produced by other international organizations and Non-Governmental Organizations (NGO), especially those based in low- and middle-income countries. The nature of international guidelines precludes them from being context-specific, necessitating future research on specific regional, national, and sub-national guidelines and their impacts. Secondly, the selected guidelines were in English, with translations to French, Arabic, Spanish and other languages such as Burmese, Bengali, and Hausa in some instances. This type of review should be expanded to include guidelines in other languages, especially in local contexts.

The scoping review of available research included broad terminology for humanitarian settings to identify relevant articles. Further research could narrow the scope be context-specific which may yield different results. For example, the search strategy could be modified to include the name or region of a past or ongoing humanitarian crisis. Furthermore, the scoping review primarily targeted medical databases. Future research could be expanded to explore mandatory reporting in humanitarian settings through the lens of other relevant disciplines such as law or social sciences.

CONCLUSIONS

While existing GBV guidelines offer some degree of general guidance on navigating mandatory reporting requirements, they often do not offer systematic and detailed guidance. Recommendations for practitioners in these guidelines are survivor-centered but often lack specificity; guidelines would therefore benefit from incorporating more systematic and detailed guidance on how to navigate mandatory reporting requirements while upholding survivor-centered responses. Mandatory reporting of SGBV in humanitarian settings remains an emerging field of study. Significant research is required to clarify its implications, support evidence-based guidance for humanitarians and provide perspectives for international organizations that needs to intervene in a new context where the local laws on mandatory reporting are contrary to international laws and standards. Research must also inform policy change and advocacy for legislative changes that are survivor-focused. Both guideline development and research on mandatory reporting for SGBV should further include the voice of SGBV survivor organizations and survivor leaders to ensure their expertise is incorporated and centered. A sensitive topic with significant implications, mandatory reporting must be brought to the forefront of attention for humanitarian agencies that work with SGBV survivors.

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Annex 1 Definition of mandatory reporting (MR) given by the GBV guidelines

#	Guideline Title	Types of SGBV mandatory reporting refers to	Who is required to report	To whom the report should be made	Definition of MR
1	The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming	Sexual violence and intimate partner violence / any acts that are believed to be criminal offences (in another paragraph)	Survivors, service providers (in another paragraph)	Police or authorities	Not defined
2	Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action	Actual or suspected child abuse (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse); or in cases where a person is a threat to themselves or another person; or sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population	Certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.); or humanitarian actors	Not specified	Laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.
3	Handbook for Coordinating GBV Interventions in Humanitarian Settings	Sexual exploitation and abuse (SEA)	GBV case worker	PSEA network	Not defined
4	Handbook for Coordinating GBV Interventions in Humanitarian Settings	Suspected incidents of SEA	GBV service providers	PSEA network	Not defined
5	Inter-Agency Gender Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence	Any acts that are believed to be criminal offences; SEA	Service providers	Police or other government authorities; humanitarian organizations	Many countries have laws that require service providers to report to police or other government authorities any acts that are believed to be criminal offences. In addition, in humanitarian settings, all organizations are mandated to have

	Survivors in Humanitarian Settings				protocols in place for responding to sexual exploitation and abuse by humanitarian workers
6	Violence Against Women and Girls (VAWG) Resource Guide: Health Sector Brief	Suspected violence against women cases	Not specified	Not specified	Not defined
7	Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area	Not specified	Not specified	Not specified	Not defined
8	Guidelines for Gender-Based Violence Interventions in Humanitarian Settings	Cases of sexual violence	Health care providers	Police or other authorities	Not defined
9	Caring for survivors of sexual violence in emergencies. Training guide	Not specified	Not specified	Not specified	Not defined
10	Establishing Gender-based Violence Standard Operating Procedures (SOPs) for multi-sectoral and inter-organisational prevention and response to gender-based violence in humanitarian settings	Certain types of GBV cases	Certain individuals or professionals	Not specified	Not defined
11	Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (Revision for Field Review)	Cases of sexual abuse and sexual assault	Healthcare provider	Not specified	Not defined
12	Inter-agency Field Manual on Reproductive Health in Humanitarian Settings	Certain cases of sexual violence	Service providers	Authorities	Not defined
13	Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings	Actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse)	Certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.)	Not specified	State laws and policies which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse)

14	Advancing the Field: Caring for Child Survivors of Sexual Abuse in Humanitarian Settings (A Review of Promising Practices to Improve Case Management, Psychosocial & Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse)	child sexual abuse cases	Not specified	Not specified	Not defined
15	Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies	SEA	UN staff	PSEA focal point	Not defined
16	Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines	Incident of actual or suspected domestic violence or intimate partner violence	Individual or designated individuals such as health-care providers	Usually to the police or legal system	Legislation passed by some countries or states that requires individual or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.
17	Managing Gender-based violence programmes in emergencies	Certain types of violence or abuse (such as sexual exploitation and abuse by humanitarian staff); child physical and sexual abuse and other forms of sexual violence (such as rape)	Health care providers	Not specified	Not defined
18	Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (see IAWG entry)	Not specified	Not specified	Not specified	Not defined

19	A practical approach to GBV: A programme guide for health care providers and managers	N/A	N/A	N/A	N/A
20	Sexual Violence against Refugees: Guidelines on Prevention and Response	N/A	N/A	N/A	N/A
21	Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response	N/A	N/A	N/A	N/A
22	UNHCR Handbook for the Protection of Women and Girls	SEA by a fellow worker	UN staff	PSEA network	Not defined
23	SGBV prevention and response - A training package	Certain types of violence or abuse (such as sexual exploitation and abuse by humanitarian staff); criminal offence	Not specified	Police or other authorities	Not defined
24	Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement	N/A	N/A	N/A	N/A
25	Guidelines for medico-legal care for victims of sexual violence	Child sexual abuse	Professionals working with children	Not specified	Not defined
26	Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines	Incident of actual or suspected domestic violence or intimate partner violence	Individuals or designated individuals such as health-care providers	Usually to the police or legal system	Legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.
27	Strengthening medico-legal responses to sexual violence	Not specified	Not specified	Not specified	Not defined

28	Responding to children and adolescents who have been sexually abused	Known and reasonably suspected cases of specified types of child abuse and neglect, normally including child sexual abuse	Designated individuals, such as health-care providers, teachers or social workers	Usually to the child protection agency or the police	legislation passed by some countries or states that requires designated individuals, such as health-care providers, teachers or social workers, to report (usually to the child protection agency or the police) known and reasonably suspected cases of specified types of child abuse and neglect, normally including child sexual abuse.
29	Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers	Incident of known or suspected domestic violence or intimate partner violence	Individuals or designated individuals such as health-care providers	Usually to the police or legal system	legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of known or suspected domestic violence or intimate partner violence. In many countries mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.
30	Clinical Management of Rape Survivors - Developing protocols for use with refugees and internally displaced persons	N/A	N/A	N/A	N/A
31	Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook	Not specified	Not specified	Police	Not defined
32	Mental health and psychosocial support for conflict-related sexual violence: principles and interventions	N/A	N/A	N/A	N/A
33	RESPECT women - Preventing violence against women	N/A	N/A	N/A	N/A
34	Gender-based violence Quality assurance tool – MINIMUM CARE VERSION	Not specified	Not specified	Not specified	Not defined
35	Clinical management of rape and intimate partner violence	Sexual violence/rape and intimate partner/ domestic violence	Not specified	Police or authorities	Not defined

	survivors: developing protocols for use in humanitarian settings				
36	Minimum Standards for Child Protection in Humanitarian Action	Actual or suspected child abuse and other forms of violence; SEA	Certain agencies and/or professionals	Not specified	State laws and policies which mandate certain agencies and/or professionals to report actual or suspected child abuse and other forms of violence. Protection from sexual exploitation and abuse (PSEA) policies typically include mandatory reporting of sexual exploitation and abuse allegedly committed by humanitarian actors.
37	Interagency Guidelines for Case Management and Child Protection	Certain categories of crimes or abuse (e.g. sexual violence, child abuse, etc.)	Service providers	Not specified	Legal or statutory systems that require service providers to report certain categories of crimes or abuse (e.g. sexual violence, child abuse, etc.)
38	Checklist: Domestic Implementation of International Humanitarian Law Prohibiting Sexual Violence	Known or suspected cases of sexual or gender-based violence	Health-care personnel and other professionals	Designated public authorities, notably law enforcement agencies	The obligation in certain countries for health-care personnel and other professionals to report known or suspected cases of sexual or gender-based violence to designated public authorities, notably law enforcement agencies. It includes providing identifying information, without requiring the consent of the victim/ survivor. In some contexts, the victim/survivor is required to report as a precondition for accessing care.
39	Sexual and Gender-Based Violence (A two-day psychosocial training) – Training Guide	Not specified	Not specified	Not specified	Not defined

This table summarizes each guideline's definition of mandatory reporting, what types of SGBV the mandatory reporting requirement is referring to, who is the responsible actor to report and to whom the report should be made. Most of the guidelines do not give a definition of mandatory reporting. The types of SGBV mandatory reporting requirements refer to, as well as the actors involved in the reporting process, is different from guideline to guideline – most are vague, some are not specified. Guidelines that do not mention mandatory reporting are marked as "N/A" in this table.

Annex 2 Scoping Review Search Strategy

Concept	PubMed Syntax	Web of Science Syntax	EmBase Syntax	Cochrane Library Syntax	Google Scholar Syntax
#1 Sexual and gender-based violence	(Gender-Based Violence [MeSH] OR Sex Offenses [MeSH] OR Domestic Violence [MeSH] OR Intimate Partner Violence [MeSH]) OR (Gender-Based Violence* [Title/Abstract] OR Sex Offense* [Title/Abstract] OR Domestic Violence* [Title/Abstract] OR Intimate Partner Violence* [Title/Abstract] OR Gender Based Violence* [Title/Abstract] OR Sexual Assault [Title/Abstract] OR Rape* [Title/Abstract] OR Sexual Violence [Title/Abstract])	"Sexual Assault$" OR Rape OR "Sexual Violence" OR "Conflict-related sexual violence" OR CRSV OR "Non-consensual sex" OR "Forced sex" OR "Coerced Sex" OR post-rape OR "GBV victim$" OR "GBV survivor$" OR "Gender-based violence" OR GBV OR "sexual abuse$" OR "dating violence" OR "sex offence$" OR "sexual offence$" or "Intimate Partner Violence" OR "Domestic Violence"	'battered woman'/exp OR 'partner violence'/exp OR 'dating violence'/exp OR 'gender based violence'/exp OR 'sexual violence'/exp OR 'forced sex'/exp OR 'sexual trauma'/exp OR 'sexual assault kit'/exp OR ('battered woman' OR 'partner violence' OR 'dating violence' OR 'gender based violence' OR 'sexual violence' OR 'forced sex' OR 'sexual trauma' OR 'sexual assault kit' OR 'Sexual Assault' OR 'Rape' OR 'Sexual Violence' OR 'Conflict-related sexual violence' OR 'CRSV' OR 'post-rape' OR 'GBV victim' OR GBV 'survivor' OR 'Gender-based violence' OR 'GBV' OR 'sexual abuse' OR 'intimate partner violence' OR 'partner abuse' OR 'spouse abuse' OR 'battered wife' OR 'battered wife syndrome' OR 'intimate partner rape' OR 'spousal	Sex Offenses/ [MeSH], Gender-Based Violence/ [MeSH], Intimate Partner Violence/ [MeSH], Domestic Violence/ [MeSH] OR (sex NEXT (offense* or assault* or abuse* or violence*)):ti,ab,kw OR (sexual NEXT (offense* or assault* or abuse* or violence*)):ti,ab,kw OR ((domesitc or family) NEXT violence*):ti,ab,kw OR ("intimate partner violence" or "Dating Violence" or "Intimate Partner Abuse"):ti,ab,kw OR ("gender based violence" or "gender-based violence"):ti,ab,kw OR (rape or "Conflict-related sexual violence" or "CRSV" or "post-rape" or "GBV victim" or "GBV survivor" or GBV):ti,ab,kw OR ((forced or coerced or non-consensual) NEXT sex*):ti,ab,kw	("Gender-based violence" OR "sexual violence")

			rape' OR 'child abuse, sexual' OR 'child molestation' OR 'child sex abuse' OR 'sexual child abuse' OR 'sex abuse' OR 'sexual aggression' OR 'coerced pregnancy' OR 'coerced reproduction' OR 'pregnancy coercion' OR 'assault, sexual' OR 'sex assault' OR 'harassment, sexual' OR 'sex harassment' OR 'military sexual trauma' OR 'sexual abuse trauma' OR 'sexual assault trauma'):ab,ti OR ((non-consensual OR forced OR coerced) NEAR/2 sex):ab,ti		
#2 Mandatory reporting	("mandatory reporting" [Mesh] OR mandatory reporting [Title/Abstract] OR mandatory report* [Title/Abstract] OR compulsory report* [Title/Abstract] OR Mandated report* [Title/Abstract] OR Mandated to report [Title/Abstract])	"mandatory reporting" OR "compulsory reporting" OR "mandated to report" OR "mandated reporting" OR "mandated report" OR "mandated reporter"	'mandatory reporting'/exp OR ('mandatory reporting' OR 'compulsory reporting' OR 'mandated to report' OR 'mandated reporting' OR 'mandated report' OR 'mandated reporter'):ab,ti	mandatory reporting/ [MeSH] OR ("mandatory reporting" or "compulsory reporting" or "mandated to report" or "mandated reporting" or "mandated report" or "mandated reporter"):ti,ab,kw	[("mandatory report*" OR "compulsory report" OR "mandated to report"
#3 Humanitarian settings	("Armed Conflicts"[Mesh:NoExp] OR "Natural Disasters"[Mesh] OR "Relief Work"[Mesh] OR Armed Conflict* [Title/Abstract] OR Natural Disaster* [Title/Abstract] OR Relief Work [Title/Abstract] OR	Conflict OR "Armed conflict" OR Emergency OR emergencies OR Disaster$ OR "Humanitarian setting$" OR war OR warfare	'humanitarian intervention'/exp OR 'war'/exp OR 'warfare'/exp OR 'disaster recovery'/exp OR 'disaster response'/exp OR 'victim'/exp OR 'disaster'/exp OR 'humanitarian aid'/exp OR	Warfare and Armed Conflicts/ [MeSH], Emergencies/ [MeSH], Disasters/ [MeSH] OR ("Warfare and Armed Conflicts" or Emergencies or Disasters or conflict or "armed conflict" or	("humanitarian*" OR "armed conflict*" OR "war")]

	Humanitarian* [Title/Abstract] OR Emergency Setting* [Title/Abstract])	('humanitarian intervention' OR 'war' OR 'warfare' OR 'disaster recovery' OR 'disaster response' OR 'victim' OR 'disaster' OR 'humanitarian aid' OR 'Conflict' OR 'Armed conflict' OR 'Emergency' OR 'Humanitarian settings'):ab,ti	emergency):ti,ab,kw OR (humanitarian NEXT setting*):ti,ab,kw
#1 AND #2 AND #3			

Annex 3 Sample Script from Guidelines

Handbook for Coordinating GBV Interventions in Humanitarian Settings
GBV Area of Responsibility (GoR), 2019, Page 38
GBV case management script related to PSEA In a case management context, to explain confidentiality and its limitations with regards to PSEA before a disclosure is received you can say: "If a UN or humanitarian worker has hurt you, I would need to tell my supervisor and report what the person has done so he/she can't hurt anyone else"
— For more detailed information see the Inter-agency GBV Case Management Guidelines (2017) pp. 51-52, from where this text was adapted.

Inter-Agency Gender Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings
Gender-based Violence Information Management System (GBVIMS) Steering Committee, 2017, Page 52
To explain confidentiality and its limitations, you can say:
It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during our meetings. This means that I will not tell anyone what you tell me, or share any other information about your case, without your permission.
There are only a few situations when I may have to speak with someone else without asking your permission.
If you tell me you that you may hurt yourself, I would need to tell my supervisor or others who could help keep you safe.
If you tell me that you plan to hurt someone else, I would have to tell [relevant protection authorities] so we could prevent that action.
If a UN or humanitarian worker has hurt you, I would need to tell my supervisor and report what this person has done, so he/she can't hurt anyone else.
If… [Explain mandatory reporting requirements as they apply in your local setting].
Sharing information during these times is meant to keep you safe and get you the best help and care you need.
Other than these times, I will never share information without your permission.

Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook
WHO, 2014, Page 36
If your law requires you to report violence to the police, you must tell her this. You can say, for example, "What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is….."

Interagency Guidelines for Case Management and Child Protection
Child protection working group, 2014, Page 113-114
The script below should accompany an informed consent/assent form used in your practice setting.
Hello [name of client]. My name is [name of staff] and I am here to help you. I am a caseworker with [name of agency] and my role is to help children and families who have experienced difficulties. Many children benefit from receiving our services. The first thing we will do is talk about what has happened to you. The purpose of doing this is for me to learn about your situation so we can provide you with information about the services available and help you connect with these service providers. The benefits for receiving case management services include helping you access [insert description of services available such as medical, psychosocial, legal/justice, and safety opportunities in your community]. There are limited risks to receiving case management services [insert risks based on your local settings/program].

It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during case management. This means that I will not tell anyone what you tell me or any other information about your case, unless you ask me to, or it is information that I need to share because you are in danger. I may not be able to keep all the information to myself, and I will explain why. The times I would need to share the information you have given me is if:
» I find out that you are in very serious danger, I would have to tell [insert appropriate agency here] about it.
» Or, you tell me you have made plans to seriously hurt yourself, I would have to tell your parents or another trusted adult. If you tell me you have made a plan to seriously hurt someone else, I would have to report that. I would not be able to keep these problems just between you and me.
» [Explain mandatory reporting requirements as they apply in your local setting].
» [Add any other exceptions to confidentiality. For example, in cases of UN or NGO workers perpetrating sexual abuse and exploitation].
» There is another person or agency that can provide you with the support you need, and I have your permission to share your case with them. We will talk more about this later in our discussion.

Therefore, we will not take any action in relation to your matter without your agreement, unless we need to in order to protect your safety and comply with the law.

Before we begin, I would also like to share with you your rights as we work together. I share this same information with everyone I speak with:
» You have the right to refuse to have your whole story–or parts of your story–documented on case forms. It's okay if there is something you want to tell me, but you'd rather I not write it down while we talk.
» You have the right not to answer any question that I ask you. You have the right to ask me to stop or slow down if you are feeling upset or scared.
» You have the right to be interviewed alone or with a caregiver/trusted person with you. This is your decision.
» You have the right to ask me any questions you want to, or to let me know if you do not understand something I say.
» You have the right to refuse case management services and I will share with you other options for services in the community.

Do you have any questions about my role and the services that we can offer you? [Allow for time to answer any questions the child and caregiver may have before moving forward to obtain their informed consent/assent to proceed].
May I have your permission to proceed with case management services at this time?
» If YES, ask the child and caregiver to sign the informed consent/assent form for engaging in case management and proceed with case management services.
» If NO, provide information about other case management, safety, health and legal/justice services in the community.

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Tackling violence against women: Policies and practices from Italy and Tunisia

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ABSTRACT

This article reflects the Italian association LeNove's research experience over the past 20 years on male violence against women, and violence prevention and response in Italy and Tunisia. The authors' intention is not to offer a comparative analysis, but to show the importance of sharing and exchanging practices across different contexts. The data, based on national and international literature, a statistical dataset and information provided by non-governmental organisations, as well as the findings of field research carried out by LeNove since the 2000s in Italy and Tunisia, show the extensive and structural nature of gender-based violence (GBV) in both countries, despite the relevant contextual differences. The authors consider it necessary and urgent for the governments of both countries to develop and sufficiently fund multisectoral policies to both respond to and prevent GBV. The authors call for particular attention to be given to the unique role of anti-violence centres, which offer empowering support to women and girls throughout the whole cycle of violence. The role and potential of programmes for perpetrators of violence against women is also highlighted, despite the weak presence of this type of intervention in both countries. The article also calls for stronger training efforts to be deployed for professionals working in direct contact with victims of violence against women, including law enforcement agencies, coupled with widespread educational initiatives to address harmful social norms and strengthen state and society responses to gender-based violence.

Keywords: Sexual Violence, Gender-Based Violence, Violence Against Women and Girls, Patriarchy, Anti-Violence Centres, Training for Professionals

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INTRODUCTION

The article focuses on sexual violence as a form of violence against women (Gender-based violence, GBV) and patriarchal domination that uses sexuality for this purpose. The thread running through the article reflects the path followed by LeNove, a non-governmental Italian association, in its action research activities over a long period of time, in Italy and in other countries on the southern shore of the Mediterranean Sea.

The purpose of this article is to contribute to a better understanding of what underpins sexual and other forms of GBV, what factors contribute to it, and what makes a culture of violence against women's bodies all

too-often acceptable and persistent. In this regard, the article will analyse the reality, and the legal and policy frameworks that enable and inhibit this reality, in two countries on opposite sides of the Mediterranean: Italy and Tunisia.

While it is important that a single, consistent voice is raised against GBV from different regions and continents, it is equally important that this voice reflects the differences in individual histories and collective cultures, and thus captures the fractures that exist within each social group. In this way, continuities and differences are delineated between generations, between individuals who suffer from GBV and those who don't, and between places and forms in which violence manifests itself. Communication and comparison between different countries and continents therefore helps to make visible GBV in its many forms, and to find the words that make it possible to fight it with a common articulated strategy. In particular, the aim is to emphasise how important it is for health systems to be involved in providing functional, professional and culturally-competent services.

LeNove Association – social studies and research

LeNove Association was founded in Italy in the wake of the 1970s wave of feminism. It was created as a theoretical and practical response to the need, highlighted by women's movements, to better understand and analyse the changes that occur in women's lives in both the public and private spheres, with a lens that centres on women's embodied and situated subjectivity. LeNove did not focus on the subject area of gender-based violence (GBV) from the outset, but rather intersected it as the association's work evolved. With time, this encounter with GBV came to affirm itself not only in the projects the association developed in Italy, but also in the transnational projects that have been carried out in partnership with associations and institutions on the southern shore of the Mediterranean Sea, particularly in Tunisia, since the 2000s.

The association's action research and studies on GBV so far have been carried out in various and interrelated fields and topics, namely:

- Design and management of the Italian national 1522 telephone hotline for victims/survivors of gender-based violence (2006 – 2011).

- Organisation and management of anti-violence centres, services and networks, and cooperation with public and private entities responsible for the reception and assistance of women victims/survivors.

- Setting-up and management of centres for the rehabilitation of abusive men in Italy, mapping of centres, and management of activities to facilitate comparisons between anti-violence centres for women and centres for perpetrators.

ROOT CAUSES, RISK FACTORS AND CONSEQUENCES OF GENDER-BASED VIOLENCE

GBV against women of all ages and social backgrounds is rooted in gender inequality and relations of domination that result from a long process of socialisation through learning and internalising the social norms and roles attributed to males and females. Violence is therefore an indicator of discrimination against women, and also contributes to its perpetuation as the patriarchal system is historically based on a form of family and social organisation in which relationships are hierarchical and women are subordinate.[1] Violence is present in both a girl's and a woman's life – creating a *continuum* of violence across the life span – and affects women and girls from all walks of life. It is exercised in the private sphere, but also makes women a target in the public space: all the places where social relations are intertwined are places of production and reproduction of social

representations, attitudes and practices underpinned by a gendered division of roles and discrimination. When the established order is not respected, these social relations are regulated by violence.[2] Different forms of abuse often combine in the life of the same woman, who thus suffers over-victimisation.[3]

The Committee on the Elimination of Discrimination against Women (CEDAW) first stated that the causes of violence are rooted in discrimination. The Committee made the first recommendations concerning the protection of women in 1989. Subsequently, the United Nations (UN) adopted the Declaration on the Elimination of Violence against Women during its General Assembly in December 1993, defining "violence against women" and what forms it manifests itself in, as stated in Articles 1 and 2.[i] All subsequent international declarations and definitions refer to this Declaration: from the 1995 Beijing Platform for Action to the 2011 Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (the so-called Istanbul Convention), in which the concepts of domination, discrimination and subordination that underlie violence are once again affirmed.[4]

The different forms of violence can be grouped into:[5]

i) Physical violence: hitting, kicking, hitting with objects, threatening with a weapon...
ii) Psychological violence (or moral, verbal, emotional abuse): devaluation as a woman and/or mother, humiliation, isolation from family and friends, denigration in public, blackmail of children, death threats and threats of suicide
iii) Sexual violence: sexual acts perpetrated against a woman's will, including rape
iv) Economic violence (financial abuse): control over money, preventing the woman from working – this is a form of violence that is still greatly underestimated and confused with psychological violence
v) Stalking: persecutory behaviour, repeated over time
vi) Assisted violence: violence in the presence of children who become victims

Forced marriage, genital mutilation (FGM) and forced sterilisation are also forms of violence against women.

Often, different forms of violence are perpetrated against the same person and repeated over time. GBV affects women as wives or partners by the hands of their partners or ex-partners; daughters can suffer from violence by their fathers and sisters by their brothers.

Ever since the first alarm was raised on the impact of gender-based violence on individual and social health in 2002,[6] the WHO has continued denouncing this problem and has issued guidelines for a global plan of action addressing states on how they should intervene, increase prevention capacities and strengthen health systems.[7]

[i]Article 1. For the purposes of this Declaration, the term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Article 2. Violence against women shall include, but not be limited to, the following:
(a) Physical, sexual and psychological violence occurring in the family, including beatings, sexual abuse of girls in the domestic setting, dowry-related violence, rape by the husband, female genital mutilation and other traditional practices harmful to women, non-marital violence and violence related to exploitation;
b) Physical, sexual and psychological violence occurring within the community as a whole, including rape, sexual abuse, sexual harassment and intimidation in the workplace, educational institutions and elsewhere, trafficking of women and forced prostitution;
c) Physical, sexual and psychological violence perpetrated or conducted by the State, wherever it occurs. (CEDAW, Declaration on the Elimination of Violence against Women).

As the following diagram indicates, GBV exerts adverse consequences on women's physical as well as mental health, both of which can be severely undermined.

Table 1 Consequence of Violence on Women's Health[6,8]

Physical	Sexual and Reproductive	Psychological Behavioral	Death
Abdominal injuries	Gynecological disorders Infertility	Substance abuse	AIDS-related mortality
Bruises	Pelvic inflammatory disease	Depression and anxiety	Maternal mortality
Chronic pain syndrome	Complications of pregnancy/miscarriage	Eating and sleep disorders	Murder
Disability	Sexual dysfunctions	Feelings of shame and guilt	Suicide
Fibromyalgia	Sexually transmitted infections including HIV/AIDS	Phobias and panic attacks	
Fractures	Abortion in conditions of risk	Physical inactivity	
Gastrointestinal disorders	Unwanted pregnancies	Low self-esteem	
Irritable bowel syndrome		Post-traumatic stress disorder (PTSD)	
Lacerations and abrasions		Psychosomatic disorders	
Eye damage		Suicidal and self-harming behavior	
Reduced physical functionality		Risky sexual behaviors	

From a holistic perspective, it is the woman's entire vital functioning that is affected by violence. Domestic violence and its direct and indirect consequences are the leading cause of death or serious injury of women between the ages of 16 and 44 in the world, more significant than cancer, malaria or road accidents.[9] Moreover, as philosopher Martha Nussbaum states, no woman in the world is safe from violence or the threat of it, and this leads to less appreciation of a woman's capacities and potential.[10] Violence also damages the development of the central capacities that enable a subject to function at her best. The central capacities of the female subject that are impaired according to Nussbaum are: Physical integrity (*life)*, Physical and psychological health, Feelings, Imagination *(senses and thoughts)*, Practical reason, Belonging *(affiliations)*, Play/enjoyment, and Control over environment. In the process of recovering herself and her self-esteem, the woman must therefore regain her damaged core capacities, for example practical reasoning, which animates the idea of a future that is possible to build and enables and guides the search for autonomy and the exercise of freedom. For a woman to recover from the violence she suffers, which may have lasted for years, the process of *empowerment* through instruments set up by the state and civil society to combat the phenomenon and protect women's lives becomes essential.

Legal and Policy Frameworks

Policies put in place by countries to combat GBV are related primarily to the legislative and judicial systems, along with other interventions to support victims, which consider the multiple discriminations they are subjected to. Assistance to victims is offered in anti-violence centres and other women's specialist services, which provide a safe space for women to begin a pathway towards autonomy. In order to be effective, policies must act in several areas and be part of a deeper "cultural investment" that must not be superficial or improvised by public institutions.

Moreover, it is indispensable that patriarchal violence is analysed and countered through a paradigm that goes beyond the mainstream, monolithic vision centred on a European/Western ethnocentric perspective, and instead embraces a contextualised and intersectional perspective. Women's own narrative and their ability to disclose and undertake pathways towards their autonomy can prove even more challenging if they find themselves in a condition of cultural deprivation, job insecurity and poverty, racial discrimination, or discrimination linked to their disability or diverse gender identities. To take all these dimensions into account means to adopt a perspective that incorporates gender, class, culture, age, geographical and socio-political positionality, where these variables do not simply add up but reinforce each other, creating intersections between the various relations of oppression.[ii]

Interventions Focused on Perpetrators of Violence

Perpetrators and their responsibilities must also be understood in depth and tackled through effective communication and lasting interventions. The primary responsibility for GBV against women lies with men embodying and enacting harmful models of masculinities. What is needed is to unveil the power dynamics that lurk in the grey areas of 'normality' in order to identify the set of factors that contribute to the social construction of such models, as analysed by R. Connell,[11] i.e. first and foremost hegemonic masculinity capable of creating complicity and consensus among men through intra-gender relations.[12] The male homosocial context ('homosociality') has been identified as a key dimension in the construction of toxic masculinity that aims at subordination, not necessarily through the use of force, including in non-heterosexual relationships through homophobia. Effective interventions for men who have engaged in violence is therefore a necessary preventive action that ultimately also takes into account the health conditions of the whole community. This type of intervention, however, should not detract from the activities for and focused on women, while conveying, at the same time, the positive message that the relationship between women and men can change positively.

Extent and Nature of Gender-Based Violence: An Italian and Tunisian Transnational Perspective

The social relevance of the problem of violence against women is very high. It first and foremost affects the physical and mental health of the community in all its components: women, girls, children, and men. As numerous international and national studies show, large parts of the population are affected, particularly when we abusive men are considered as well as women and their children.[13] We are not, therefore, dealing with marginal situations either quantitatively or qualitatively, but rather with a transversal phenomenon that involves, with various nuances, different social classes and cultural strata in all countries in the world. As a special issue on sexual violence in *The Lancet* reported in 2014: "*the abuses [...] pose an ongoing threat to public health and social progress*".[14]

Sexual violence in its multiple forms is a phenomenon that generates extensive and long-term consequences. In addition to damaging the relations

[ii]As Kimberlé Crenshaw states, "While it is true that all women bear the brunt of gender discrimination to some degree, it is also true that other factors concerning women's social identity, such as class, caste, race, colour, ethnicity, religion, national origin and sexual orientation, are differences that make a difference in the way various groups of women experience discrimination. Kimberlé Crenshaw, "The Crossroads of Discrimination", revised version of the basic text presented at the meeting of the UN Group of Experts on Race and Gender Discrimination, Zagreb, 21-24 November 2000.

between men and (cisgender) women, it such violence stems from patriarchal norms that also manifest themselves against lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) individuals and takes the form of verbal, physical and sexual violence by people who reject their right to self-expression. A 2022 study in *The Lancet* found that almost 500 million women had been abused worldwide in 2018, with the highest prevalence among girls aged 15 to 24 – an age group that is at a crucial stage in the definition of the self and of their personal and social relationships; this is undermined by physical, sexual, and psychological abuse. The WHO has reiterated the urgency of the issue, calling violence against women "a health problem of enormous global proportions".[15]

Over the past three years, the COVID-19 global pandemic has contributed to an increase of domestic and family violence across the world. The imposed lockdowns and consequent isolation, which prompted increased prevalence of depression, anxiety, substance abuse, made it more difficult for women to escape family or partner control, and to access public and private support services.[16]

If we look briefly at Italy, the phenomenon of gender-based violence is widespread. According to the second (and latest) national survey in 2015, more than 30% of women have suffered psychological or sexual violence in their lifetime at the hand of partners, relatives or people they would consider friends. Rape was committed in 62.7% of cases by partners, and only 27% of the victims reported what had happened.[8] Similarly in Tunisia, according to the first national survey of the Ministry of Women, Family, Childhood and seniors in 2010, at least 47% of women, aged between 18 and 64, have experienced some form of domestic violence in their lifetime, while 15.7% claim to be victims of sexual violence.[17]

Cases of sexual violence, including sexual harassment and rape, increasingly started to become more acknowledged in the early 2000s in both Italy and Tunisia, mainly when they took place in public situations, in workplaces and urban spaces. This increased awareness was mainly due to the political and social work by grassroot women's associations in the field, as well as from the evolving international legal and policy framework (described further below), and the stimuli deriving from transnational bodies. At the time, sexual violence was rarely recognised in the context of the family, intimate partner relationships or in other private spheres such as friendship. However, the 'normality' of GBV started to be gradually uncovered: instead of being a rare behaviour acted out by marginalised men, mostly unknown to the victims, it started to be seen as acts committed by 'normal and respectable' men, in most cases bound by family or friendship relations with the victims. The private context of the family was thus revealed as one where GBV takes the shape of severe abuse, repeated violence and humiliation which is often invisible to the outside world, even when it lasts for years. The family gradually started to be understood as a 'fragile' and dangerous context for many women, one that can weaken their physical and mental capacities and expose them to severe risks. An understanding that addressing male violence towards women was a fundamental component of the larger fight for women's freedom was one of the main outcomes of the actions of the feminist militant movements that were active for years in both countries. Many women who are victims of GBV show resourcefulness and courage when they decide to report the violence they have suffered, seek emergency care or access anti-violence centres. Often, the straw that breaks the camel's back is when the physical and psychological health of their children is severely affected, and risks impacting their development.

DATA AND METHODS

In this article we triangulate three types of data:

i) international and national data published by organisations such as the WHO and National Statistical Institutes;
ii) governmental research centres; and
iii) data provided by non-governmental organisations working in the field of GBV prevention and response.

These sources have been enriched by the results of field research carried out by the LeNove Association since the 2000s in Italy and Tunisia. The field research mainly employed qualitative surveys aimed at capturing the objective and – above all – subjective experiences and living conditions of women. Drawing from women's experiences, needs and desires, qualitative methods were chosen to give them a say in their respective cultural, social and economic contexts.

Although the article focuses on two countries, Italy and Tunisia, it does not intend to draw a comparison between the two realities. Theis is mainly due to the different methodologies and timeframes employed, and to the diversity of LeNove's contexts of work on GBV in each country – within institutional and anti-GBV networks in Italy, and within the field of women's rights and labour, particularly in the agricultural sector, in Tunisia. Yet, common and comparable threads emerge from both contexts, which illustrate both the uniqueness and the universality of GBV against women and girls.

THE CASE OF ITALY

A Brief Overview of GBV Data in Italy

The second and latest national survey on GBV carried out by the Italian National Institute of Statistics (ISTAT) and the government's Equal Opportunities Department, "Violence against women inside and outside the family" was conducted in 2014-15. The survey compares the data with that of the previous survey, conducted in 2006, and captures the submerged phenomenon of GBV.[8] The picture that emerges from the 2015 survey illustrates a reality of violence with many facets: 6,788,000 women between 16 and 70 years old (31.5%) have experienced GBV at least once in their lifetime; 20.2% of women have experienced physical violence, 21% sexual violence and 5.4% have experienced rape (652,000) and attempted rape (746,000); 62.7% of rapes were committed by partners or ex-partners, while 12.7% by acquaintances (relatives or friends).[iii]

Moreover, the data also shows that:

i) 76.8% of women have been sexually harassed by strangers and 10.6% were sexually assaulted before the age of 16 (80% by acquaintances);
ii) 65% of children witnessed violence perpetrated against the mother and in 25% of the cases, the children too were directly affected by violence;
iii) 11.8% of pregnant women experienced violence from their partner;
iv) The percentage of cases where violence committed by the partner caused physical injuries was high (40.2%), as was the percentage of women who feared for their lives because of their partner (34.5%).

The survey also provides other insights into the complex picture of the reality of GBV, including: the diverse group of women who are affected, the different types of violence they suffer, the perpetrators, the rates of reporting to the police, the access to specialised services (such as anti-violence centres and emergency shelters) and to other territorial services such as emergency hospital care.

While it will be helpful to compare these data with the findings from the next national survey, to identify trends and inform policy recommendations, other survey systems, such as those carried out by law enforcement agencies, confirm the prevalence of male violence against women in its various forms. A specific analysis of the 2018-21 police data on "persecutory acts", "ill-treatment against family members and cohabitants" and "sexual violence" conducted by the Criminal Analysis Service of the Italian Ministry of the Interior, shows an increase in these violent crimes by 18%, 30% and 2% respectively, in which women account for more than 80% of the victims. The persistence of violent acts is also

[iii] Italy's population is 59,236,213 individuals, 48.7% of whom are male and 51.3% female (data as of 2021), in constant decline due, in particular, to the decrease in the birth rate.

exacerbated by the dramatic reality of femicides, the number of killings of women by partners or ex-partners being almost constant over time, against an overall decline in homicides. For example, in the period between 2018 and 2021, femicides went from 111 to 119 to 103 per year, almost one every three days.[i] Many red benches stand today in Italian parks and streets in memory of women who were brutally murdered because they are women, by their male intimate partners. The crime of forced marriage is also a hidden reality in Italy, one that can be 'disguised' as a custom in some migrant communities. In the 30 months that followed the new legislation related to the protection of victims of domestic and gender-based violence (No.69/2019, art.7), the Ministry of the Interior recorded 35 cases of forced marriage.[iv]

Response and Protection Systems

The Italian response and protection system for women who are affected by GBV against women stands on three pillars:

i) The legislative pillar, i.e., the set of laws that define the State's regulatory guidelines on combating the phenomenon, introduce and amend the offences and related penalties in the Criminal Code. At the central level, this pillar also includes the actions and directives on prevention and response that the State promotes in central and peripheral institutions and bodies such as the judicial system, the health system, and the information and educational system, as well as the so-called operational agreements between the central State and the regional governments.

ii) The judicial pillar, formed by law enforcement and the courts which act against perpetrators according to the Criminal Code, and the directives issued by the Ministry of the Interior on how police forces should act when faced with situations of violence against women.

iii) The support and protection pillar, formed by the reception and protection structures for victims, such as anti-violence centres, shelters and other specialist services for women, run mostly by women's associations who act according to an empowerment approach in collaboration with the public health system, in particular the emergency hospital care.

The Legislative Pillar

As of today, Italy lacks a legal framework on GBV that comprehensively addresses this as a structural societal issue and deals with all aspects in a consistent manner. Over time, several laws have been passed to respond to situations that were 'urgent' or appeared to be so according to the approach of the ruling parties; right-wing governments and parties, for instance, have traditionally considered gender-based violence as a matter of security and public order, to be tackled mainly through criminal law instead of prevention and protection policies. Today, the Italian gender-based violence body of legislation includes the following:

i) Act No. 96/1996 treats crimes of sexual violence as crimes against the person (and no longer against public morality); it also removes the distinction with violent lechery and carnal conjunction, introduces prosecution on irrevocable complaint, protects the confidentiality of victims and introduces the crime of gang rape.

ii) Law No. 38/2009 introduces the offence of 'persecutory acts' (*stalking*) and aggravates the penalties if the offence is committed by a partner or former partner.

iii) Law No. 77/2013 ratifies the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (known as the Istanbul Convention, 2011).

[iv] Changes to the Criminal Code to introduce the new crime of compelling a person to contract marriage or a civil union through violence or threat or inducing a person to do so owing to their vulnerability: https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:2019;69

iv) Law No. 119/2013, the so-called Femicide law, establishes increased penalties for several types of crimes and when the victim is pregnant; it also foresees the removal of the victim from the man's family home and a restraining order, among other measures. It also stipulates that the Government shall adopt a National Plan of measures to accommodate and protect women and encourages the establishment of centres for the rehabilitation of abusive men.

v) Law No. 69/2019, the so-called Red Code, provides an immediate 'fast track' for victims who report violence, as well as compulsory training for all Police officers; it introduces new offences such as the deformation of the person's appearance through permanent facial injuries, unlawful dissemination of sexually explicit images or videos, and coercion or inducement to enter a marriage.

vi) Law No.53/2022 guarantees an adequate and constant flow of information on GBV against women in order to design adequate policies for prevention, contrast and monitoring of the phenomenon.

At the national level, directives are issued by various Ministries to the peripheral bodies to make certain procedures of response, reception and assistance homogeneous across regions. In 2017, for example, the Italian Ministry of Health adopted National Guidelines for health authorities and hospitals to ensure adequate and integrated emergency interventions to treat the physical and psychological consequences of male violence on women's health. The Guidelines outline a protected and timely pathway for victims: from hospital triage, to treatment provision, risk assessment and safety planning, to referrals to dedicated public and private services if the victim consents. The Guidelines also indicate the best way to manage the documentation of violence in order to report to the police, and continuous training of all health personnel is promoted for good reception, care and prevention of victims. These Guidelines complement the national legislation on gender-based violence, where the regions are responsible for establishing, co- funding and running the reception and support services such as anti-violence centres and shelters, provincial anti-violence networks, prevention and training actions, and the collection of data that feed into the National Anti-Violence Observatory.

To promote the implementation of law enforcement and protection activities by the various State bodies as enshrined in the legislative provisions (Law 119, Art. 5), the Government adopted an Extraordinary Action Plan against sexual and gender-based violence in 2015, and subsequently a National Strategic Plan on Male Violence against Women (2017-2020) and a National Strategic Plan against Violence 2021-23. The latter includes combating economic violence, through paid internships and regulations to promote job placement in order to achieve the more general objective of women's empowerment.

Due to the commitment of the Italian Parliament, two Parliamentary Commissions of enquiry on feminicide and all forms of GBV were created in 2017 and 2018-22 respectively, chaired by two women. These commissions have been addressing, among other things, the decisive and sensitive issue of how GBV is dealt with in the judicial reality, denouncing the secondary victimisation of women and their children in proceedings governing custody and parental responsibility.

The national free-toll hotline 1522 for anti-violence and stalking (https://www.1522.eu), promoted by the Department for Equal Opportunities since 2006, offers multilingual, 24/7 assistance in connection with the network of anti-violence centres. The 1522 service plays an important referral role between victims and specialised services. In the third quarter of 2021 during the pandemic, 69.5% of victims were referred to a territorial service and 91.2% of them (2,381 victims) were referred to an anti-violence centre.[19]

The Judicial Pillar

With regard to the judicial system, the progressive review of the Penal Code due to the laws mentioned above dating from 1996 to 2019 has played a major role in including new offences and heavier penalties for perpetrators. Moreover, thanks to the pressure of lawyers' associations specialised in victim assistance, in 2018 the Superior Council of the Magistracy established a pool of magistrates in the Courts with specific gender-based violence expertise. Similarly, within the Police, ad hoc procedures and tools have been established in the areas of investigation, reporting and victim defence, such as the ability of the *questore* (i.e., the public security authority at provincial level) to make decisions on admonition and removal of the violent man from the victim's home.

The Support and Protection Pillar

Anti-violence centres and shelters have been set up since the 1980s on the impetus of associations that emerged from the feminist movement. Centres and shelters have gradually spread throughout the peninsula – thought not homogeneously – and have since been run by thousands of volunteers who started to provide active listening to the suffering of women and supported them start a pathway towards a life without violence. Today, women who survive GBV can count on the support provided by 350 anti-violence centres and 366 shelters, for a total of 1.2 shelters per 100,000 women and 1.1 anti-violence centres per 100,000 women.[20]

These services rely on public funding from the Department for Equal Opportunities at the Presidency of the Council of Ministers, the Regions and the Municipalities, private donors, and on the pro bono work of many volunteers. These funding sources are not stable, are delivered with bureaucratic delay and do not guarantee sufficient long-term financial support. In the year 2019, for example, the Department of Equal Opportunities allocated 30 million euros among the Regions, but despite the urgency, six months later only five Regions have disbursed the funds.[21] This creates organisational and planning challenges for core services that are the backbone of the entire response and protection system at the local level.

Anti-violence centres and shelters have their specific organisational characteristics in relation to the services provided, including for instance the protection and safety of women and their children (undisclosed address), accessibility by women seeking support, and a conducive environment to enable a tailored pathway out of violence. Anti-violence centres are the core of the territorial network for supporting victims, working jointly with other services such as emergency hospital care, police units, lawyers' associations, and municipal and social services. The services generally offered by the centres include telephone reception, legal counselling, active listening and physical reception/case management, support for employability, psychological counselling, specific counselling for refugees, migrants and other non-Italian women. In feminist anti-violence centres, particularly those that are part of the national D.*i*.Re anti-violence network run by women's organizations (https://www.direcontrolaviolenza.it/en/), the methodology of receiving and supporting the woman who voluntarily accesses centres stems from the feminist experience of non-judgmental peer woman-to-woman relations, respectful of the woman's choice and pace, and aimed at enabling a pathway towards self-empowerment and autonomy.

In order to support women victims in a state of poverty, the "freedom income" (Law No.77) was introduced in 2020 to provide financial assistance towards personal and housing autonomy. This subsidy amounts to 400 euros per month for 12 months. However, the funds allocated by the government are sufficient only for 2,500 requests, while there are around 21,000 applicants every year.[22]

According to the aforementioned ISTAT survey, in 2020, 54,609 women contacted anti-violence centres at least once, 3,964 more than did so in 2019. Those who have started to receive structured support from anti-violence centres that adhere to the State-Regions Agreement, on the other hand, number

30,359, 20,223 of whom started receiving support in 2020 (69.1% in the previous year). The percentage of foreign women in charge of such centres is 27.7% (no figures are available for how this compares to the number of women in similar management positions across Italy as a whole).[23]

Challenges: Key factors and Difficulties

In recent years, Italian institutions have prompted the development of normative and policy actions to fight violence against women, by promoting awareness and accountability by actors in a variety of sectors – from medical and paramedical personnel in emergency care and hospital wards to police officers; from magistrates to social service workers. This has contributed to making the phenomenon of violence against women an acknowledged reality in the public discourse. However, in individuals' behaviours and attitudes, and in institutional approaches, a culture persists that denies or trivialises, even justifies, the existence of the violence it claims to combat. This adversely impacts on the application of the laws and on women directly, as support requests are not responded to promptly, and the pursuit of justice often ends up in acquittals or inadequate sentences for perpetrators. Too often women are not believed by the authorities, discouraged from reporting, and sent back home to the perpetrator. Too many reports to the justice system and law enforcement officers result in dismissals of complaints by magistrates, due to an underestimation of the seriousness of the facts and a failure to adopt warnings, protection orders or other precautionary measures to remove the perpetrator from the victim's home. Many women end up being killed at the hand of their violent partners, even though the perpetrator had been reported to police several times for stalking and violence.

The transformation of social and behavioural models dictated by a traditional culture marked by deeply rooted patriarchal codes is a key factor of change; while this transformation is ongoing in Italy, its progress remains too slow, particularly in the conception of women's public and private roles within the context of gendered relations between men and women. A 2018 survey carried out by the Italian National Institute of Statistics highlighted that social behaviours are marked by norms and stereotypes typical of a patriarchal conception.[24] As pointed out by the report, almost a third of the surveyed population believes that, "it is very important for men, more than for women, to be successful at work" (32.5%), and that "men are less suited to take care of household chores" (31.5%). More than 60% of respondents consider violent experiences in the family during childhood to be the cause of violence enacted by perpetrators, and many believe that some men are violent because they cannot stand female emancipation (69.9% women and 55.2% men). When asked why some men are violent with their partners/wives, 77.7% of respondents answered that women are considered as objects of property (84.9% women and 70.4% men). However, 64.5% of responders (65% men, 64% women) would advise a woman victim to report her husband and 33.2% (33.0% men, 33.4% women) would tell her to leave him. Regarding sexual violence, the prejudice that holds women victims responsible for the violence they suffer persists. As many as 39.3% of the surveyed population believe that a woman is capable of evading sexual intercourse if she really does not consent. The percentage of those who think that women can provoke sexual violence by the way they dress is also high (23.9%).

In light of the reflections above, prevention policies are decisive factors in the fight against gender-based violence. First, it is important to raise awareness among journalists and the media in general not to be indulgent and 'understanding' towards the behaviour of violent men and even feminicide. The world of advertising should also be free of gender stereotypes and sexist language. Every message should promote gender equality and respectful gender relations. Above all, in this regard, education programmes from kindergarten to high school must be organized extensively and constantly as a fundamental pillar to prompt a cultural change of respect and gender equality that contributes to the gradual modification of individual and collective mentality and behaviours.

But these prevention policies remain insufficient and discontinuous today in Italy.

THE CASE OF TUNISIA

Brief Overview of Gender-Based Violence Data in Tunisia

53.5% of Tunisian women are victims of gender-based violence in public spaces, where sexual violence (75.4%) and physical violence (41.2%) are the most prevalent forms.[25]

As of 24 November 2020, 14,000 reports of gender-based violence were filed on the 1899 hotline, 71% of which were cases where the perpetrator was the spouse of the victim.[26] In 2021, the number of calls received on the Hotline 1899 decreased compared to 2020, even if the overall number of calls is twice as high as in 2018 and 2019. Concerning the different forms of violence against women, psychological violence is the most widespread one (with an estimated percentage of 84%), followed by physical violence (estimated at 72%), and economic violence (estimated at 42%).[27] A closer analysis of the variants related to notifications of violence against women received on the hotline 1899 proves that women aged 30 and 40 are the ones who call the most (40%), followed by women aged between 41 and 50 (25%). The husband is the perpetrator in 74% of the cases received on the hotline.[28]

In 2019 alone, the Police Units Specialised in Combating Violence against Women registered 65,000 complaints, of which 2,500 related to domestic violence, according to reported presented by the Minister of Women, Family, Childhood and Seniors (*MFFES*).[28] 89% of these women are victimised on social media and, of these, 95% do not file a complaint.[29] Statistics published by the Forensic Medicine Unit at the Charles Nicole Hospital in Tunis in 2019 revealed that 800 cases of rape occur every year on average, which amounts to almost 3 rapes per day, 80% of whom are female and 65% are under 18.[30] According to *MFFES*, during the mobility restriction period due to the COVID-19 pandemic, from 22 March to 4 May 2020, the number of cases of violence against women multiplied by a factor of 7 compared to the same period in 2019.[31]

National data on femicides have not yet been made public, despite being known to the Tunisian Ministry of Justice. A few academic papers, published sporadically, report a total of 52 femicides in 2017, 12 of which were against girls under 17, which account for the 16% of the total number of murders in the same year (311).[32] The impacts of sexual violence against women are extremely severe: 70% of victims suffer heavy psychological consequences; couple relationships are undermined when the woman has previously been the victim of non-consensual sexual relations.[33] The 2010 national survey (the only one conducted to date) shows that 45% of women who have suffered from sexual violence have reported negative consequences in the sphere of sexuality – with only 37.5% of domestic violence victims having regular sexual relations, and 65% of women reporting an increase of the risk of "frigidity".[17] The study, conducted in 2017 by Ouertani,[33] shows that suicide attempts are more frequent among women victims of domestic violence, that 6.25% of domestic violence survivors suffer from post-traumatic stress disorder (PTSD) and that 66.7% of victims of spousal violence are more depressed than non-abused women (20%) suffering from PTSD. Self-harm has also been shown to be frequently practiced by abused girls, as an expression of feelings of shame and guilt.[34]

Response and Protection Systems

The backbone of the Tunisian public and private/nongovernmental ecosystem of support for victims of GBV is the Organic Law 58/2017 on the Elimination of Violence against Women, largely inspired by international standards and by the Spanish Organic Law 1/2004 of 2004. Its entry into force in February 2018 crowns three decades of struggle by the autonomous Tunisian women's movement and by civil society mobilising against GBV.

This law adopts a broad definition of GBV, embracing all of its various forms, and uses a human rights-based approach which considers violence against women a

violation of their rights and defines it as a form of gender-based discrimination.[v] The Tunisian law also incorporates the four pillars of the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (the so-called Istanbul Convention), i.e. prevention, protection, prosecution, and coordinated policies.

In the area of prevention, the organic law foresees the revision of school curricula and textbooks to incorporate the principles of gender equality and non-discrimination, the training of teachers and all professionals who come in contact with victims of violence (e.g., magistrates, police officers, social workers and medical professionals), and prohibits the media from trivialising gender-based violence by reproducing gender stereotypes.

In the area of protection of victims, the law establishes that anyone who witnessed gender-based violence or its effects on a victim, including those bound by professional secrecy, are obliged to report it. In addition, the judge may issue a precautionary measure, including the removal of the aggressor from the marital home, in the event of danger or threatening the victim's life, without the need to go through a criminal complaint or divorce petition.

In the criminal justice field (proceedings against the perpetrator), the law compensates for some of the shortcomings of the Tunisian Criminal Code to combat impunity, for instance by filling the loophole that used to allow a child sex offender to evade prosecution by marrying the victim. Moreover, all forms and incidents of violence against women are now recognised as crimes and public order offences, in particular intimate partner violence, the notion of which has been extended to former spouses, fiancés and boyfriends, even in those cases where the complaint is withdrawn by the victim. New acts of gender-based violence have also been recognised, including moral harassment, intimidation of women in public spaces, incest, unequal pay for equal work, political violence against women, and stronger penalties in cases of sexual violence and assault against minors and vulnerable women.[vi] Any agent of the Specialised Units who exerts pressure or any other form of coercion on a woman to force her to abandon or change her complaint has criminal liability.

In the area of protection, the law provides for the creation of structures for receiving and supporting women victims of gender-based violence, including through the provision of active listening, legal and psychological counselling, health and psychological support, and socio-economic integration.

The Shelter Centres for women and girls are organised into 9 centres under the supervision of *MFFES* and 18 Reception Centres, providing listening, counselling, guidance and support for women victims of violence.[26]

The Law also foresees coordinated policies for the assistance of victims of gender-based violence through an inter-sectoral agreement (Article 8 of Law No. 58/2017) which provides for the creation of a Coordination Committee. Twenty-four Regional Coordination Committees have been set up so far, with 379 members, 62% of whom are women's representatives and 17% representatives of civil society associations.[26]

The Specialised Units, established within the Police Stations and the National Guard (128 units were set up as of 2019), are expected to have an average of five officers including the head of Unit, at least one of whom must be a woman.[26]

The Forensic Medicine Unit at the Charles Nicole Hospital in the capital Tunis is responsible for documenting the violence suffered by women who have been sexually assaulted. In the health sector, more than 500 workers have received at least one

[v]This law concerns all forms of discrimination and violence suffered by women based on discrimination between the sexes, regardless of the perpetrators or the field (Art. 2 Organic Law 58/2017 "author's translation).

[vi]The situations of vulnerability contemplated in the law include: the situation of fragility linked to young or advanced age, serious illness, pregnancy, or mental or physical deficiency affecting the victim's ability to resist the perpetrator (Art.3 Organic Law 58/2017, author's translation).

training session on responding to gender-based violence.[35]

The National Observatory for Combating Violence against Women, established in 2020, has the mission to collect data and keep track of cases of violence against women, monitor the implementation of laws and policies, assess their effectiveness and efficiency, and draft regular reports proposing necessary reforms (Art. 40 of Organic Law No. 58-2017).

Challenges: Key Factors and Difficulties

There are several obstacles to an effective implementation of the Organic Law 58/2017 and therefore to a full functioning of GBV protection and prosecution systems in Tunisia. The lack of financial, technical and logistical means on the ground results in insufficient training and information sharing, with poor knowledge and awareness of the law, and sub-optimal legal proceedings as a result. Moreover, an insufficient number of human resources in the public sector for processing all reports of GBV has the effect of slowing down the procedures considerably. Importantly, the fact that women's shelters are not present in all cities and regions is concerning and limits effective access to protection measures as well as comprehensive support for all women.[36]

Some of the existing 128 Specialised Police Units are understaffed, with some having one agent only. The presence of women in these Units (foreseen by the Law) would guarantee a higher degree of security for victims of violence, but as the data by the Ministry of Interior show, only 38% of all the officers of these Units are women and some units have no female presence (figures are not available for how this compares to the number of women police officers across Tunisia as a whole).[26]

The lack of sufficient specialised personnel, such as from psychologists or social workers, to support child victims of sexual violence as foreseen by Article 29 of Law 58/2017, is another relevant gap with considerable impacts on the victim's mental health. The lack of equipment for audio and video recording of the hearing of child victims of sexual offences requires them to be heard more than once, which runs contrary to the legal provision that would prevent this and the related re-traumatising effect this can have on the child.

As women and feminist groups report, most officers in police stations are not adequately trained to respond to disclosure and reporting by victims of GBV, even though this is part of their duty, particularly in the absence of specialised officers. The environment of police stations is also perceived by the victims as hostile: reports are filed in police stations, where women victims, often accompanied by their children, often feel intimidated, especially when alleged criminals are waiting in the same common (mostly male) environment, due to lack of adequate space.[37]

As some reports highlight, some public officials even oppose the application of the Law, for instance by discouraging victims from filing a complaint and by minimising the importance of the facts/incidents, particularly marital violence.[36] Some officials also seem to interpret their role as "mediators" in cases of domestic or intimate partner violence, helping couples to reconcile (as the report mentions "Most said they were trying to "fix" marital issues to prevent victims from taking legal action"), even though the attempt to reconcile is punishable by imprisonment.[36] General practitioners, who are often the first contact point for many women victims of violence, who need to request an initial certificate in order to file a complaint, often advise women against going to a victim support centre, claiming "they are badly attended" and encourage instead behaviours that go against traditional norms "such as smoking and leaving their spouse".[38]

Some judges are also reported to refuse applying the Organic Law n.58, which protects the integrity of the victim of violence, and instead apply the old provisions of the Criminal Code which mainly focused on preserving a 'public morality'. An AFTD-Oxfam report from 2021 mentions a judge saying "The law n.58 is catastrophic [...], [it] produces disasters [...] it aims to

destroy the family".[39] Moreover, courts have not yet set up special rooms reserved for the reception and interviewing of women victims of violence.

In terms of the functioning of the justice sector, very few complaints related to GBV cases have so far led to actual prosecutions. According to the data of the Ministry of the Interior and the Ministry of Justice, between 2018 and 2020 a total of 3,941 cases of violence against women, including 2,500 cases of domestic violence, were dealt with by the courts; this number appears low when compared to the 65,000 cases of GBV that were filed with the Specialised Police Units.

Media in Tunisia play an important role in reinforcing some gender stereotypes and roles that have an adverse effect on women who are victims of gender-based violence. For instance, in 2021 during the Ramadan period, the Tunisian national TV contributed to representing rape as a normal 'incident of life'. In three TV series – *Ouled el Ghoul*, *El Foundou* and *Harga* – a number of misrepresentations were reflected: in one the victim ends up falling in love with her rapist; in another one the rape victim entertains a non-problematic romantic relationship with her rapist throughout the series; in another the perpetrator is portrayed as a man with an uncontrolled libido who justifies his conduct as he 'couldn't restrain' himself from raping the woman. These narratives represent an adherence to the dominant culture that ends up justifying and/or authorising rape by romanticising and trivialising sexual and gender-based violence.[40]

WORKING WITH PERPETRATORS OF VIOLENCE

An International View of Gender-Based Violence Prevention Work

As part of the Beijing+ 20 campaign to engage men and boys on gender equality and women's empowerment, UN Women developed a series of global initiatives and activities on responsible fatherhood and positive masculinity. This type of initiative involves the promotion and support of places for the recovery of abusers.[41]

The first interventions with perpetrators to take a preventive perspective date back to the United States in the 1970s. Edward Gondolf and his colleague David Russel have recorded two decades-long experiences in the US – one in Boston, Massachusetts with the *Emerge* programme created in 1977 and one in Duluth, Minnesota created in 1980.[47] These were the years where the first feminist anti-violence centres started to operate in the United States to support women victims of structural situations of violence.

In their main work *Man to Man* (1987) Gondolf and Russel called into question, in a definitive and more decisive way, men's responsibility in GBV and dismissed couple and family therapy as a solution.[42] The two authors articulated the idea that violence in intimate relationships is not a fact of nature or a disease, and is therefore not limited to a minority of disturbed, *borderline* violent men. As they explain, men perpetrate violence not because they lose control of their emotions, but because when they lose dominion over the relationship, they try to re-establish their position of power through violence. Therefore, the authors' intention is not to shift the focus from those who suffer violence to those who perpetrate it, but rather to point out that violence affects society as a whole and is underpinned by unequal gendered power relations.

In Europe too, the first programmes to focus on men and boys also started in close cooperation with feminist organisations. Originally, these programmes were organised by civil society groups and only later received institutional support. This was the case, for instance, of the programme *Alternative to Violence* carried out in Norway in 1987, soon followed by other similar experiences in Great Britain, Spain, Austria, France and Ireland.[43] The central idea that unites these programmes is that GBV is also a man's issue and the first step men must take is to acknowledge their responsibility in violence perpetration. These programmes follow four main, but different, models:

i) Initiatives led by the justice system and carried out in prisons by institutional operators;
ii) Programmes – common in Central and Northern Europe – informed by a value and behavioural-based approach focusing on the family and on the caring roles of its members;
iii) Initiatives aimed at perpetrators and adopting a socio-cultural and behavioural-change approach, common in Anglo-Saxon contexts;
iv) Interventions aiming to address the problem in its psycho-pathological aspects through clinical recovery therapies.[43]

These approaches have common traits. None of the above models involve couple or family therapy, due to the underpinning concept that the violence originates from cultural constructs, which the man needs to take responsibility for. Moreover, in all interventions, an initial phase concerns the assessment of both risks and possibilities of positive outcomes of the psycho-socio-educational pathway for the perpetrator. When the participant selection and onboarding phases are completed, in all programmes participants are invited to sign an agreement that signifies their commitment to participate in the intervention and respect some ground rules for the entire duration of the programme. In most programmes, the group is the main context of work, coupled, in some interventions, with individual sessions. Group work is functional to breaking the isolation in which the perpetrator of GBV often finds himself and to deconstructing the silence through verbalisation of thoughts and emotions. Furthermore, in all interventions the methods aim at enabling the perpetrator to:

i) recognise all forms of violence, i.e., not only physical and sexual violence, but also psychological, emotional, economic, and other forms of GBV;
ii) accept responsibility for their violent behaviour, avoiding denial, minimisation or justification;
iii) become aware of the suffering GBV produces in women and children;
iv) become aware of the deep-seated cultural stereotypes linked to masculinity and femininity in society;
v) develop individual strategies to stop the inner psycho-emotional processes that lead to the outbreak of violence (use of *time-out* techniques).

At the beginning of the 1990s, the first groups of men gathered to reflect on men's cultural models and to take responsibility for the violence perpetrated. They sought ways to experience and express their masculinity in different, non-aggressive or harmful ways. The White Ribbon campaign started in Canada in 1991. In the aftermath of several killings of women feminists, a group of men decided to come together and speak out against violence against women. The political reflection that emerged from these first groups of men on their gendered experience was the starting point of a critical questioning of the dominating patriarchal culture. The questioning of this culture by men themselves was globally recognised as the preliminary way to achieve the elimination of all forms of GBV. The White Ribbon campaign was picked up in Italy in 2007 by the men's association *Maschile Plurale [Plural Masculinity]*, which has since continued working intensively on deconstructing stereotypes, critically reflecting on masculinity models, and by rolling out interventions in schools and prisons.

A push for the establishment in Europe of Men's Centres, which carry out different programmes, has come from the European Union institutions since the late 1990s and further increased with the signing in 2011 of the Istanbul Convention, the first instrument in Europe to combat GBV by also providing for the need to initiate interventions with abusers.

Centres for Violent Men in Italy

Over the last twenty years, debates surrounding male violence against women in Italy has grown considerably and has gradually created growing public awareness. Violence against women has increasingly started to be understood not as an emergency or

"exceptional" event but rather as a structural phenomenon that is closely connected to dominant socio-cultural models. Feminist movements across the country have shed light on the substratum that underpins gender-based violence and have identified the origins of violence in the patriarchal traits of rigid division of gender roles and unequal distribution of power among genders. This debate developed mostly within feminist women's associations that were established to support women victims through anti-violence centres, shelters, and prevention and educational programmes. However, the responsibility of perpetrators was not, at first, analysed in-depth within these movements. Similarly, at the institutional level, the measures that focused on abusers were initially limited to harsher prison sentences and restraining orders. What has been lacking for a long time, and is still lacking to a certain extent, are ongoing interventions that focus on men's awareness of masculine gendered roles in society, of gendered power relations, of women's autonomy and freedom, and of the need for men to contribute to challenging patriarchal systems.

It is in this context that the association LeNove has been focusing its research on the male universe, its weaknesses and peculiarities, from a gender perspective.[vii] In Italy, the first interventions that focused on perpetrators of violence emerged at the end of the 1990s, upon the initiative of men's associations such as *Cerchio degli uomini*[viii] *[Men's circle]* and *Maschile plural.*[ix] The first structured intervention of this kind took place in the Bollate prison in Milan, where specific educational pathways were made available for inmates who had committed sexual offences. The first centre dedicated to perpetrators of violence was set up in 2009 in Florence by the civil society association *Centro Ascolto Uomini Maltrattanti (CAM)*[x] *[Abusive Men's Listening Centres]*. Other centres and initiatives of similar nature followed in other cities such as Turin, while in Modena the initiative *Liberiamoci dalla violenza (LDV)*[xi] *[Let's free ourselves from violence]* was set up in 2011 by the city health authorities. This field is well-established today and is continuing to expand since Italy's ratification of the Istanbul Convention in 2013 (Law No. 77/2013).

In more recent years, actions focused on perpetrators of GBV have also been promoted at the governmental level within the Extraordinary Action Plan against Sexual and Gender-based Violence (2015-2017).[xii] The plan emphasises the need to implement prevention and rehabilitation interventions for perpetrators of violence, with the aim of "putting an end to violent behaviour and countering the denial of male responsibility and the values legitimising gender-based violence". As the Plan specifies, these interventions must be integrated within a response system to the phenomenon of violence coordinated at territorial level, through interagency conventions and collaboration protocols.

The latest census of centres for violence men in Italy was carried out in 2017 by the Italian National Research Centre on behalf of the Equal Opportunities Department of the Presidency of the Council of Ministers.[xiii] The census certified the existence of 69 centres throughout the country, mainly in the northern regions and mainly adopting a cognitive-behavioural and/or a psycho-educational approach. The creation of these centres is favoured by men's associations, individual professionals, and public institutions.

[vii] An initial research carried out by the LeNove Association made it possible to study in depth what had spread overseas and in the rest of Europe – the theoretical frameworks and intervention methodologies – which resulted in the collective volume *Il lato oscuro degli uomini* (the first edition was published in 2012, the third in 2017). An important part of the volume is represented by the analysis of the main European experiences and the mapping and monitoring of the Italian experiences that, in just a few years, have seen the rapid spread of Men's Centres throughout the country, albeit not homogeneously.

[viii] http://cerchiodegliuomini.org/

[ix] https://maschileplurale.it/

[x] https://www.centrouominimaltrattanti.org/page.php?sede_di_firenze

[xi] https://www.ausl.mo.it/ldv

[xii] The Plan ('Recovery of Abusers' 5.7) is provided for in Law 119/2013, with which Parliament partially implemented the recommendations of the Istanbul Convention.

[xiii] Project Viva: monitoring, evaluation, and analysis of interventions to prevent and combat violence against women, 2017 data published in 2019; survey suspended due to the COVID-19 pandemic. https://viva.cnr.it/

As per the access to these centres, the law 119/2013, also known as the Femicide Law, provides that the Questore [the provincial chief of the state-run police] can indicate the closest Centre to the perpetrating man against whom a report or complaint has been filed. Along these lines, in 2018 the ZEUS Protocol was created for Police Headquarters, which foresees that the recipients of the Questore's warning for persecutory acts, domestic violence and cyberbullying must attend a treatment course aimed at raising awareness of the social and criminal disvalue of their conduct, with a view to preventing recidivism.[xiv]

The emergence and rapid spread of men's centres has, however, given rise to criticism and doubt from several feminist anti-violence centres and other actors within the territorial anti-violence network who fear that a feminist perspective may not be reflected in these Centres' approach. In these actors' view, listening to men, to their reasons and narratives bears the potential risk of feeding an ambiguous and slightly 'victimistic' discourse around men's violence and perceived victimhood. This suspicion of 'collusiveness' of men's centres with a certain non-feminist narrative around GBV, coupled by the concern related to competition for increasingly limited resources, has often fed women movements' deep mistrust of these centres.

In order to guarantee the validity of the methodologies adopted in men's centres, the first network of these centres, *Work With Perpetrators,* was established in Europe in 2014. The network currently includes 69 centres from 34 European countries.[xv] *Relive*, the first network of Italian men's centres, was established in 2014 and includes 22 of the 69 centres surveyed by the Italian National Research Centre. These networks' objective is to develop evidence-based guidelines to certify centres and, most importantly, guarantee shared approaches, methodologies and aims with other anti-violence services that promote training courses for practitioners.

Male Social Representations of Violence Against Women in Tunisia

To date, neither centres nor programmes serving perpetrators of violence have been established in Tunisia.

In its 2018 study on the social representations of violence in Tunisia, *the Centre de Recherches, d'Etudes, de Documentation et d'Information sur la Femme (CREDIF*) [*the Centre for research, studies, documentation and information on women*] illustrated that persistent traditional gender norms in Tunisia society aiming at subjugating and oppressing women. The following excerpts from the study's interviews well reflect this patriarchal male mentality: "*In relationships, it is necessary to learn obedience, to be firm with the woman and beat her if necessary. The important thing is that you keep the pressure on her…*"; *"You must understand that there are times when the woman deserves to be beaten, she is so extravagant and not forgiving…a man has the right to use force if the woman misbehaves.*"; *"it is normal for them [men] to use the power given to them by God, nature and society*."[44]

According to several interviewees in the study, violence against women is overestimated in the Tunisian media, which tends to exalt an excessive degree of female victimisation. In many media outlets, the use of force by men, their behaviour of deprivation, or their jealous outbursts are not portrayed as violence but rather a means of legitimate control to 'protect the family'. As for economic violence, this form of violence is often not perceived as such but rather an agreement in financial management or a mutual consent to share family expenses.[44]

This social and public representation of violence is intimately linked to men's social representations of the rights of women and men, as well as their roles in the public and private spheres. Male social representation, especially among young people,

[xiv] From the start of the project until 19 March 2021, the Milan Police Headquarters cautioned 429 persons. Of these, 381 (89 per cent) were invited to come to the accredited centre for a first treatment interview. Of those invited, 300 showed up at the scheduled appointment, i.e. 69.93 per cent of the total number of cautioned persons: given the voluntary nature of participation, this is a decidedly satisfactory percentage.

[xv] https://www.work-with-perpetrators.eu/

assimilates women that are not their mothers to a seductive body provoking men's desire, therefore an object of sexual pleasure but at the same time also a source of 'dishonour'. Women are often perceived as the 'lower half of society' who 'cannot equal men' as they are 'created from the rib of man'.[48] In these views, women do not therefore deserve respect as human beings in their own right, but only through association to another man to whom she is bound by marriage or kinship. Some commonly held expressions that draw from the cult of honour and reputation based on chastity, fidelity and virginity among other qualities, are particularly eloquent in this regard – e.g., the woman is perceived as "*milk that gets dirty quickly … a glass of milk that changes even with a single drop of coffee*".[25]

In both rural and urban contexts, women's work in the labour market is often seen as an additional contribution to the family well-being. According to certain prevailing views of gender roles, women must first and foremost take care of the children and of the home and must manage to reconcile professional and domestic tasks, should they also work outside of the home.

In some narratives that exist in society, the primacy of the male is often expressed through religious language which emphasises the legitimacy and sacredness that surrounds the head of the family: "*Men have authority over women because of the favours God grants them*"; "*In our society we have two different entities (the man and the woman) … the man always wants to keep the power for himself… he wants to rule the kingdom… that is why he has to exclude the woman*'. Men believe that it is up to them to control the women in the family because "*when a woman deviates from the norms, it is the fault of her husband or father or brother who have failed to keep her under control*".[44] These narratives are underpinned and complemented by others that support an idea of women's sexuality as a marital or religious duty, which implies an impossibility for the woman to reject her husband – being disobedient towards him equates being disobedient towards God.[44]

Other popular representations of women support the opinion that they have been given "*too many rights…, to the detriment of men, and too much freedom, fuelling men's fear of dishonour*",[48] which is in turn conceived as the main 'source' legitimising male violence. In certain economically disadvantaged contexts in the country, some views tend to delegitimise the idea of women as rights holders and again justify men's use of violence towards them. Some commonly held views in this sense include: "*If the woman shows strength by referring to the law, … the relationship between the spouses worsens, which results in violent reactions towards women themselves*"; "*the man reacts violently when the woman is stronger than him*".[44]

In these type of conceptions, women's determination to share power with men within the family is one of the main triggers for conflict and domestic violence. The woman is perceived, even by young people, as the man's 'rival' in competition with him. The feeling of 'superiority' that a woman's cultural capital can exert in men can also lead a husband to devalue and at the same time envy his wife's position, which can translate in attitudes aimed at making her feel guilty for pursuing a career at the expense of her family life, pushing her to give it up – "*If the woman is more educated, the spouse will tend to show his superiority in order to compensate for some of his weaknesses through contempt, humiliation, abandonment*".[44] The change of roles within the family and women's financial autonomy have caused tensions within couples, and often violence. Poverty and the economic precariousness of families, which cause disputes about financial management within the home and tensions related to scarcity or lack of income, also remain important risk factors that generates and maintains violence against women.

In some male representations of violence against women, women are the ones to blame. The woman who 'walks slowly', 'wears make-up', 'puts on jeans without hiding her bottom', 'talks on the phone for a long time', 'smokes in public', 'walks', 'laughs loudly' is perceived as intending to provoke men and is therefore responsible for the violence she may

suffer.[25] According to these victim-blaming views, it is up to women to avoid violence by adopting adequate dress codes and low profile attitudes: women should *'look straight ahead and keep their heads down … above all ignore those who harass them (elbléda), never respond … pretend not to hear'*.[25] These views hold certain women responsible for the violence they suffer both in the private and public sphere. Women who are excessively liberal or display westernised behaviour do not respect societal norms and values and are therefore deserving of violence. In rural areas or disadvantaged peri-urban regions, women's freedom and modern lifestyles are often pointed at as a contributing factor fostering GBV – "*it is not normal nowadays for girls to do what they want with their lives… I know girls who go clubbing, smoke, drink… do the same things as boys…*".[44] The rejection by a large part of the male society of the emancipated model of the woman who claims full gender equality reveals a crisis of the traditional male identity which appears today discredited and weakened.[xvi] Studies also report women being considered blame worthy in a wide range of other situations, e.g., when she 'lacks understanding' towards her husband, when she is 'demanding', when she 'refuses to participate in household expenses', when she makes 'futile requests' that exceed her husband's financial capacity and when she is a 'spendthrift ', when she scolds the man for using drugs or alcohol, or when she 'controls him in matters of money'.[44] Several perpetrators also claim that the accusation of violence was a pretext because divorce proceedings were in progress; that his wife's injuries were caused by a car accident because she wanted to commit suicide and he tried to save her; that his wife had rejected him and left the marital home; that the accusation was only to extort money from him; that she was a psychologically unstable woman; that his girlfriend was accusing him because she was experiencing their separation badly.[45]

In restrictive conceptions of gendered relations, the husband legally exercises full authority over his partner, who is placed under his guardianship. Disobedience to the husband and disrespect for the man are cited by adults mainly from lower socio-economic classes as common 'causes' of violence against the woman. Within these webs of social gendered norms, women are often led to feel guilty, minimise the violence and keep silent, internalising in this way a form of 'symbolic violence' – as Pierre Bourdieu would put it – which is invisible to the victims themselves.[46] This internalisation of gendered norms leads several women to be an accomplice in the perpetuation of violence against them and its reproduction. According to a study by CREDIF, 30% of women think that a husband has the right to beat his wife if she burns the meal, argues with him, goes out without his permission, neglects the children or refuses to have sexual relations.[44] Some women also justify violence as an 'excess of love', evidence of 'amorous jealousy' accepted as 'good heart' of the partner.

Gender relations have been at the heart of Tunisian's recent revolutionary journey. The broad participation of women from different political parties and sectors of society in the events of 2011, reflected a certain transgression of the established order within both the private and the public space. During the revolution, a "political" use was made of the female body: many women claimed that their bodies were their own property, many denounced violence, particularly sexual violence, and claimed the right to dress or undress according to their will.[47] The coming to power of the Islamist Ennahdha party in 2011, which claimed an intention to put women's acquired rights into question and establish a religious state, made the women's struggle even more radical and determined. This attitude by women resulted in an escalation of violence even during the democratic transition period

[xvi] 40% of Tunisian men suffer from sexual dysfunction. Tunisians consume more than 48,000 pills a month to compensate for their virile deficit. Erectile dysfunction is another humiliation that adds to a long list of hardships suffered by Tunisian men, including their considerable backwardness in school (67% of graduates are women) and the abandonment of the 'bread-winner' role. They are often heard to say: "How can I believe I am a real man, when I am just a poor unemployed man and it is my wife who takes care of me?" Adnène Khaldi, "Pourquoi la virilité tunisienne n'est plus ce qu'elle était?", *Leaders*, 1 October 2018, https://www.leaders.com.tn/article/25590-crise-de-la-masculinite-en-tunisie

because "*when the dominated group tends to narrow the power gap, there is an escalation of violence by the dominant group to maintain the status quo*".[48]

There have been several 'attacks' on male 'sovereignty' throughout the revolutionary and transitional path: the most significant was the imposition of the term 'equality' in the Tunisian Constitution of 2014 by feminist deputies supported by street demonstrations, to counter the Islamist proposal of the principle of complementarity underlying the male-female relationship.[49] Sadly, recent events in Tunisia have challenged the country both economically and democratically (including a questioning of the Constitution) and threaten to undo some of the progress.

CONCLUDING CONSIDERATIONS

Despite their different history, traditions, religious background and current political situation, Italy and Tunisia share some common traits in their attempts to combat violence against women.

Legislation

This article has highlighted the importance of the legislative framework and legal norms to define sexual assaults and violent behaviours as offences, to specify their seriousness and to establish relative punishments. Both countries have achieved some consistent advancements in this regard, however a lot remains to be done. While in Italy there is a need for a more comprehensive and consistent legal framework, in Tunisia some laws need to be amended, namely the Personal Status Code, from a gender equality perspective.

Law Enforcement and Judiciary

Institutions in both countries that are mandated to combat gender-based violence, including the police and the judiciary, must embrace a gender-based understanding of violence against women. The situation is particularly serious in Tunisia, where the implementation of the 2017 Organic Law is severely lagging behind. The mere existence of laws is insufficient without an effective enforcement driven by a radical shift away from the prevailing male-dominated culture that justifies and perpetuates violence. It is essential that this shift is built upon and amplifies women's voices and narratives.

Training of Practitioners

Both countries show the need for consistent and continuous investment in ongoing training of all practitioners and officials, from law enforcement to health workers, who come across abusive men and their victims as part of their professional practice. Both long-term funding and strong political will are key to make these training requirements a reality. It is equally important that any capacity-building intervention goes beyond technical tools to embrace reflections and skills that make professionals able to question and deconstruct the factors contributing to gender-based violence, such as discriminatory gender attitudes and beliefs.

Anti-violence Centres

Funding for anti-violence centres and shelters for women must be adequate and long-term to ensure sustainable provision of specialist support services for women and their children. It is crucial that in both contexts these services and the women's feminist movements that underpin them continue working on survivors' economic autonomy as a crucial component of the empowerment-based approach towards building a life of autonomy free from violence. Only by addressing women's structural fragility in the labour market and acknowledging the importance of their productive role and career development can these services make women able to achieve economic independence.[50]

Men's Centres

A comprehensive approach to combating GBV cannot leave out interventions focused on male perpetrators of violence and acknowledging that violence against women is first and foremost a men's issue. These interventions, whether institutional or run by civil society, are still few in Italy and are almost absent in Tunisia. They should therefore be further encouraged.

Observatories

For policy frameworks to be evidence-based, they need to be backed by a detailed knowledge of the phenomenon and robust data and monitoring systems through national and local observatories. These institutions are well-placed to follow trends of GBV on quantitative and qualitative levels and give a voice to victims. Sufficient funding for the establishment of observatories is therefore crucial.

Education for Equality

Educational initiatives addressed at young generations are key to influencing the cultural models that in both contexts regulate and can transform societal relations between genders. The educational change that is necessary in both Italy and Tunisia would require a comprehensive approach: from the revision of school textbooks, to free them of sexist prejudices and stereotypes, to the development and adoption of compulsory educational curricula and programmes in educational settings addressed at girls and boys but also parents and teachers.

The Strength of Women

Both countries count on powerful women's groups and movements that continue growing – the "Me Too" and "Ni Una Menos" movements are just two examples of the relevance and force feminist groups are acquiring in both contexts and globally, including on the crucial issue of sexual consent.[ii] Women from the younger generations are also increasingly on the frontline of feminist combats in both Italy and Tunisia and show unprecedented strength and ability to react to all forms of violence.

If we want to promote equality and psycho-physical well-being in a fair and just society – which is also economically more solid – it is on women and on gender relations that policies and efforts should focus. Women's awareness and pathways towards autonomy are foundational components of freedom, equal gender relations, and expansion of citizenship rights for all.

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Gender-based violence and women's rights in times of disaster: Thirty years of Women's Net Kobe and its activities in Japan

*Reiko Masai** [1], *Yukie Suzuki* [1]

ABSTRACT

This paper is an empirical record of the voices of gender-based violence (GBV) survivors following disasters in Japan and a report on the realities of GBV activism from the 1990s to the present. It examines how the situation of women and their vulnerability to GBV during disasters in Japan has changed after two major events: the Great Hanshin-Awaji Earthquake in 1995 and the Great East Japan Earthquake in 2011. These disasters made gender inequality, sexual violence and other forms of GBV visible but did not lead to the establishment of disaster management measures that reflected gender and diversity perspectives. International disaster management plans specify the need for a gender perspective, but this was not implemented in Japan and has not been addressed since. In order for gender and diversity perspectives to be incorporated into disaster management and planning, and to be put into practice during actual disasters, it is necessary to implement policies that incorporate and reflect the perspectives of women and minorities in 'normal' times. This will create mechanisms, systems and policies that enable women and minorities to participate in political and administrative decision-making and guarantee safe and secure housing following disaster events.

Keywords: Gender-Based Violence, Sexual Violence, GBV in Natural Disaster, Japan, Shelter Management, Disaster Management, Women Support for Women

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INTRODUCTION

In the 2022 World Economic Forum's Global Gender Gap Report, Japan scored 0.650 and ranked 116th out of 146 countries, a position which has not changed much and is among the lowest in the developed world. Of the four key dimensions – Economic Participation and Opportunity, Educational Attainment, Health and Survival, and Political Empowerment – a particularly large gap has been recorded in Political Empowerment, with no signs of improvement. [i] Gender inequality in Japanese society has been evident across many domains, and its impacts have further escalated in the aftermath of disasters. This article examines the challenges gender inequality poses in Japan, focusing on a case study of gender-based violence (GBV) following two major earthquakes occurring two decades apart, in 1995 and

[i] According to the International Parliament Union (whose data the Gender Equality Bureau in Japan quoted), while Sweden, France, and the United Kingdom have increased the percentage of women in parliament in the 30 years since 1980 to over 30 percent, Japan has remained flat at 9 percent (Gender Equality Bureau 2021 https://www.gender.go.jp/policy/positive_act/pdf/pamphlet_03_07.pdf).

2011. The analysis encompasses the advancements made between these two events, as well as the further progress necessary to ensure women's safety during similar occurrences.

Elaine Enarson, a sociologist with expertise in gender and disaster, argues that women are forged by oppression into a social group highly vulnerable to disaster but marginalized in emergency management and preparedness efforts, even though they possess valuable knowledge that deserves attention.[1]
Enarson also points out that the voices of women as disaster subjects often go unheard, which results into missed opportunities to gain insights into events and processes through their lived experience. This lack of attention hinders our ability to document their decision-making regarding survival strategies during disasters and adequately address their needs in both disaster management practice and policy. This signifies not the irrelevance of women's needs and interests, but rather a failure to ask the right questions.[1]

On 17 January 1995, the western Japanese city of Kobe in Hyogo Prefecture, a city with a high concentration of socioeconomic functions, and the surrounding area, were hit by a major earthquake with a magnitude of 7.3. According to official reports, 6,434 people were killed and 43,792 were injured. More than 700,000 homes were damaged, and approximately 7,000 were destroyed by fire. Furthermore, lifelines in the affected areas were severely damaged, and water, electricity, gas, and telephones were out of service. In addition, numerous public transportation systems were non-operational, which affected emergency recovery efforts, including rescue, first aid, firefighting, and procurement of supplies.

At this time, members of the civil society group Women's Net Kobe (WNK) were unaware that disasters exacerbated risks of gender-based violence, as demonstrated by a growing body of academic literature since the early 1990s. Listening to the voices of women affected by the disaster, both through women-only seminars and telephone consultations, the members of WNK noted an increase of the number of women who reported GBV, especially sexual violence in shelters and temporary housing. Building upon this, WNK embarked on a project aimed at capturing and documenting women's experiences which were then compiled into a booklet.[2] That was the first time that the increase of risks of sexual violence following a disaster was pointed out in Japan.

On 11 March 2011, the Great East Japan Earthquake and Tsunami involved the Fukushima Daiichi Nuclear Power Plant and forced thousands of people over a wide area to evacuate and live in shelters and temporary housing for a long period of time. The 9.0 magnitude earthquake was felt as far away as Russia and was followed by several strong aftershocks including a 7.2 magnitude event, all of which contributed to highly destructive Tsunami waves, some measuring 33 feet/10 meters high. Two weeks after the disaster, the Japanese government's official count had exceeded 15,500 deaths, 18,500 missing people and 300,000 displaced residents. It is during her support to women and children in temporary shelters that Reiko Masai, one of the authors of this article, became increasingly aware of the magnitude and impact of GBV, which motivated her to conduct a survey on GBV during disasters in cooperation with other researchers.[3,4]

The purposes of this paper are to illustrate what gender activists in Japan have achieved since the 1990s, to examine how Japanese society has evolved with regard to protecting women from GBV following disasters, and to recommend actions in view of future challenges.

WOMEN'S NET KOBE: POST-DISASTER SUPPORT ACTIVITIES FOR WOMEN IN THE 1990s

In 1992, the Non-Governmental Organization (NGO) WNK was created to protect women's human rights and to promote a gender-equal society in Japan. Two years later, in 1994, WNK established the Women's House, a space where women could freely express their emotions and find empowerment. WNK soon also began offering telephone consultations for women. Hearing women speak about years of abuse

by their husbands led WNK to rent another secure shelter for women. The first woman to be hosted in the house with her three children was a nurse-midwife with 15 years of work experience, beaten by her husband for being "cheeky just because she had a job". WNK lost its base in the 1995 earthquake: among the buildings and infrastructure destroyed was the Women's House.

In the month following the Great Hanshin-Awaji Earthquake in 1995, although many support groups were created to provide assistance to people living with disabilities, the elderly, children and foreigners, there was no specific support for women. WNK set up the Women's Support Network, which immediately offered women relief supplies such as sanitary products, underwear, milk for infants, bicycles, and washing machines for the shelters, to complement the stocks provided by the local government. However, the ongoing challenges posed by evolving needs and the scarcity of vehicles and volunteers, made it increasingly challenging to sustain the project.

Following the disaster, numerous articles appeared in the mass media shedding light on inspiring stories of families and communities helping each other to overcome hardship. WNK made the decision to publish a booklet to amplify the voices of women residing in the affected regions. As WNK explained: "We have gathered the thoughts of women who had fallen away from the idyllic 'family fantasy' often portrayed in the mass media and have compiled their stories in a book."[2] WNK also held gatherings of mothers with infants, offered seminars to support women victims of the disaster and established telephone counselling services for women. Female counsellors also facilitated basic training sessions for volunteers to enable them to run the helplines themselves. Sixty percent of the calls were made by women who were victims of domestic violence, while women who had relocated to other prefectures reached out to express their feelings of loneliness and seek guidance due to a lack of information on available support services.[ii] Moreover, there were women who sought guidance, feeling burdened by the responsibility of safeguarding their children amid the ongoing aftershocks. Some mothers expressed regret for scolding their children and, on occasion, resorting to acts of violence.

Women also began convening in conferences, establishing spaces for collective empowerment, knowledge exchange, and collaboration. In July 1995, WNK held a conference called 'No to Sexual Violence' which for the first-time initiated discussions about sexual violence in the aftermath of the disaster. The network invited about 30 female survivors of the disaster to attend as audience members. Alongside them, lawyer, women's rights activists and a public health nurse were invited as speakers to discuss the topic of GBV in disaster situations, including in shelters and urban areas. In September 1995, Reiko Masai attended the World Conference on Women in Beijing, China, where she gained profound insights into the pervasive problem of domestic violence, and its global prevalence.[iii] In March 1996, women's organizations from Japan jointly held the conference "Kobe-Okinawa: Connecting Women's Thoughts: We Will Not Allow Sexual Violence!" which was attended by 240 people.[iv] The keynote speech was titled "It's not your fault", and participants provided updates and shared experiences from Kobe and Okinawa Rape Relief Centre.

Nevertheless, women were absent from other emerging public forums that emerged following the disaster. The International Disaster Reduction

[ii] The only data available on the number of telephone consultations are 137 cases <duplicate breakdown> for the period 10 March 1995 - 14 June 1996. Based on Masai's recollection that 60% of these consultations were about violence by husbands and partners.

[iii] The Fourth World Conference on Women held in Beijing during September 4-15, 1995, organised under the UN initiative. The Beijing platform of action aims to remove all obstacles to women's active participation in all spheres of public and private life; eradicating poverty, eliminating gender inequalities access to education, eliminating violence against women, providing equal participation of men and women in power structures and decision making, and so on.

[iv] In Okinawa, where there are several US military camps, a girl was gang raped by US military personnel and a mass protest rally was held in 1995.

Alliance Forum has been held every year since 2003 by the Great-Hanshin-Awaji Earthquake Memorial Disaster Reduction and Human Renovation Institution (DRI). This forum primarily consists of a group of male researchers predominantly focus on subjects such as the earthquake resistance of buildings, active faults and lifelines. While these topics are relevant the challenges faced by women are seldom included in the agenda, and no women are represented to discuss their specific experiences and challenges in responding to disasters.

The invisibility of women and their concerns in discussions surrounding disaster management was further exacerbated by certain attempts to delegitimise women's voices. For instance, in July 1996, the conservative magazine *Shokun* published an article titled "How rape myths were created in disaster area", which suggested that all reports of sexual violence in the disaster area were fabricated, undermining the credibility and experiences of survivors.[5] Masai was falsely accused of spreading rumours about rape in the disaster area in order to promote the activities of her organization. In April 1997, the female journalist who wrote the article received a journalism award and her paper was published in a book. WNK's motion to file an injunction against the book ultimately proved unsuccessful, on the grounds that the network had failed to raise objections when the article was initially published in the magazine.

GENDER APPROACH TO DISASTER MANAGEMENT

At the international level, the Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disaster, adopted at the 2nd UN World Conference on Disaster Reduction (WCDRR) held in Kobe in 2005, served as the guiding framework for international disaster management during the period from 2005 to 2015. The framework clearly states that "General considerations require integration of gender-based thinking into all disaster risk management policies, plans and decision-making processes."[6] In 2007, the United Nations International Strategy for Disaster Reduction Secretariat (UNISDR) published "Gender Perspective: Working Together for Disaster Risk Reduction Good Practices and Lessons Learned,"[7] a collection of good practices of mainstreaming gender into the disaster risk reduction processes. In 2011, a group of NGOs and the International Red Cross and Red Crescent Movement (IFRC) published the third edition of the Sphere Handbook, a set of minimum standards for all key areas of humanitarian aid, including international standards for disaster relief. The standards include the integration of diversity of the affected population, the need to improve living conditions in shelters and the importance of ensuring women's participation in disaster relief to improve the quality of aid operations and minimize the risks of violence and marginalization for women and girls. As an example, the standards highlight that women and girls are increasingly vulnerable to GBV, including sexual violence, when using communal water and sanitation facilities. It also states that "in pre-assessment surveys, a comprehensive range of women, men, girls and boys of all ages, and other vulnerable people affected by disasters, as well as the surrounding population, should be heard, and barriers, if any, that make it difficult to speak out should be removed."[8] The importance of adopting a gender perspective has also been repeatedly pointed out by NGOs that provide support to women, as well as by others engaged in international advocacy work in disaster-affected areas.

Keiko Ikeda, a specialist in the field of disaster risk management, notes that in the 1990s, social science research on disasters began to consider the importance of gender perspectives. She highlights that her extensive empirical research in disaster areas, such as the gender analysis of flood damages in Bangladesh, has revealed that men and women experience the impact of disasters, the extent of damage and suffering differently. Ikeda emphasizes that without comprehending these dynamics, response efforts will be ineffective.[9]

LEARNING LESSONS FROM SRI LANKA

In 2005, a short newspaper article reported: "In Sri Lanka, where the Indian Ocean tsunami caused major damage, women's groups are demanding the

government to take action against sexual harassment of women [...] and to take measures such as involving women in the running of shelters. In response to these requests, the Minister of Women's Affairs replied that there is nothing that can be done in a situation where survivors are extremely numerous."[10] Undeterred by the government's lack of response, Sri Lankan women took their report to the 49th session of the UN Commission on the Status of Women (CSW), 'Beijing+10', in New York. Participants to the CSW session discussed integrating a gender perspective in post-disaster relief, recovery, rehabilitation, and reconstruction efforts, including in the aftermath of the Indian Ocean tsunami disaster. The official Report of the CSW session mentions that CSW "strongly urges Governments, United Nations entities and other relevant bodies to take necessary measures, including the development and implementation of gender-sensitive codes of conduct, to protect women and girls from sexual exploitation and sexual abuse, and all other forms of violence in the context of natural disasters and to provide appropriate care and support for women and girls who have been exposed to sexual abuse and all other forms of violence."[11]

Inspired by these developments and by women activists' actions, WNK organized the meeting "Disaster and Women: Women's Participation in Disaster Prevention and Recovery" in November 2005. Representatives of Japan and Sri Lanka women's rights organizations, women journalists, women parliamentarians and other experts and activists were invited to discuss women's experiences and problems in disasters. A website called Disaster and Women Information Network[v] was also launched.

A GENDERED READING OF THE GREAT HANSHIN-AWAJI EARTHQUAKE IN 1995

During the Great Hanshin-Awaji Earthquake in 1995, one thousand more women than men died in the disaster, and many of them were in their 60s and 70s.[vi] The overwhelming majority of elderly people living alone were women[vii] and due to their low income, several elderly single women lived in houses that were fragile to earthquakes. The poverty rate among single mothers and their children, heavily affected by the disaster, was also high, with the income of single-mother headed families amounting to only one-third of the average income of all households with children.[2]

Violence against women is particularly widespread in complex emergencies and natural disasters, where women and children are often the most vulnerable to exploitation, violence and abuse because of their gender, age and status.[12] Melissa Jo Kelly, the coordinator of the City of Santa Cruz Commission for the Prevention of Violence Against Women, summarizes the result of the survey on violence against women that was conducted in the City of Santa Cruz following the San Francisco Earthquake of 1989. The report, which includes hearing from several agencies, including Santa Cruz Police department, District attorney's office, Victim Witness Program, and Sexual Assault Program,[13] highlighted that during the disaster the number of reported rapes by strangers tripled and that the number of calls from women suffering from the trauma of past sexual assaults and sexual abuse increased by 25% in the months following the earthquake. Reported cases of domestic violence also grew, and protection orders issued against offenders also rose by 50% after the disaster. The feelings of hopelessness and helplessness caused by the earthquake can be a contributing factor to assaults as a way of expressing male power. Amid ongoing severe aftershocks, child abuse by mothers, often burdened with the responsibility to protect their children, also increased.[13] The report also highlighted that since violence against women should be expected to increase after a disaster, it is essential that prevention work is integrated into disaster preparedness and

[v] https://wn-kobe.or.jp/bosai/index.html?t=domestic_violence [retrieved on Mar. 14, 2023].

[vi] According to government data, 2,211 men and 3,277 women died; for those aged 65 and over only, the number of deaths was 803 men and 1,598 women were lost (Ministry of Health and Welfare, Minister's Secretariat, Statistics and Information Department 1995).

[vii] According to the Vital Statistics of the Ministry of Health, Labor and Welfare, the average life expectancy in 1995 was 76.38 years for men and 82.85 years for women.

relief. As Glen Fitch, the Executive Director of Men's Alternative, said "Earthquakes should not be used as an excuse for violence."[13]

The "Sexual Violence in Disaster Areas – A Manual for Prevention and Response" planning guide was published in 2008 by the Louisiana Foundation Against Sexual Assault (LaFASA) and the National Sexual Violence Resource Centre (NSVRC) after Hurricane Katrina in 2005 and other disasters.[14] The guide includes survivor-centred messages such as "It is not your fault that the incidents happened. We are on your side, deeply hurt and concerned that you were victimized and made to think about it. And we want you to know that we have started working to make sure it doesn't happen again … in the future."

The likelihood of an increase in violence against women was not considered at the time of the Hanshin earthquake response. After the earthquake, the number of telephone calls received by WNK by victims of domestic violence continued to increase, highlighting an urgent need for shelters to accommodate and support survivors. Several women calling WNK voiced their concern about whether it was self-centered of them to seek support for domestic violence while everyone was enduring hardship due to the calamity. Some of them were asking: "Am I being selfish for consulting on such trivial domestic disputes while we are all suffering so much from the disaster?"

Challenges faced by women living in collective shelters included fear and risks of violence, lack of private spaces to change clothes and breastfeed, insufficient relief supplies relevant to women such as period products, baby food/formula and underwear, and lack of mother and child healthcare services.[15,16] Some mothers with infants voiced their apprehension about the lack of privacy in the shelters – "I was concerned [in the shelter] because I bothered other people when my child cried at night."[2] In her report on sexual abuse in evacuation centres[viii], Kyoko Kitazawa stated: "In the shelters, although families put up partitions with cardboard boxes and other materials, their privacy was not protected. Young children were frequently sexually assaulted in the shelters during the day when people left for work and there were few people around. The shelter was illuminated at night to prevent men from touching the breasts and genitals of sleeping girls on their way to the toilet. Infants were molested while playing in the corner of the schoolyard. A woman was raped when sleeping with an infant at a shelter and a member of a patrol was attacked and seriously injured when trying to stop the perpetrator."[17] An obstetrician-gynecologist in Kobe who visited the shelters after the earthquake provided the following anecdotal evidence: "There is usually an increase in rape-related consultations in summer, but this year [in 1995] the number looks particularly high. I heard many stories of people being dragged into deserted places at night at the shelters, of people victim of rape or sexually harassed in blind spots, and of people having other unpleasant experiences. Specifically, high-school and university students were dragged into unoccupied houses and raped. I could only listen to these stories, but I worry that this sexual violence will traumatize them in the future".[2]

These problems can be seen as strictly correlated to the fact that women rarely participated in shelter management. Although almost no official data exists on the ratio of male to female leaders in shelters, the figures that are available show that of 25 shelters, 23 had a male leader and 2 had a female leader,[17 ix] which mirrors the broader trend of low representation of women in decision-making positions throughout Japan.

In its attempt to respond to women's needs in the aftermath of the Great Hanshin-Awaji Earthquake, WNK engaged with the government and local authorities to ensure preventive action is included in disaster response plans. For instance, WNK obtained

[viii] Kyoko Kitazawa is a sex education practitioner.

[ix] This data is about Ashiya City. Ashiya City is next to Kobe City and which was also severely damaged. At that time, the mayor of Ashiya was Harue Kitamura, the first female mayor in Japan.

the translation rights, translated, and published the above-mentioned planning guide "Sexual Violence in Disaster Areas – A Manual for Prevention and Response" in Japanese.

THE GREAT EAST JAPAN EARTHQUAKE AND GENDER

While Japan made significant advances in disaster preparedness following the Great Hanshin-Awaji Earthquake of 1995, the way the disasters were managed from a gender perspective saw minimal progress.

In the week following the March 2011 earthquake, which damaged the Fukushima Daiichi Nuclear Power Plant, more than 750,000 people were displaced, including those who were forced to evacuate due to increased radiation levels. It was heart-breaking for WNK to hear people say that they wanted to get their children and grandchildren out of Fukushima due to concerns over the damage caused to the high radiation levels in the atmosphere and the local seawater. "I can't see my grandchildren who live in Tokyo because I told them not to come here" said a woman resident in Fukushima who belonged to an action group of women, called 'Josei no Jiritsu wo Ouen-suru Kai' (a Group for supporting women's independence). In areas that were severely affected by the earthquake, tsunami, and radiation, mothers developed anxiety over the potential future impact of radiations on their children's health. Furthermore, the displacement of people which followed the disaster broke up families all over Fukushima.[19] As shelters were overwhelmed with evacuees, many additional temporary shelters were established. Evacuation centre managers were designated amongst the affected communities rather than trained civil servants or teachers, and a gender perspective was completely absent.

Despite women activists' repeated requests to local authorities and the Gender Equality Bureau of the Cabinet Office that women's participation in the shelter management be encouraged, and that women's needs and perspectives in disasters be better taken into account, very little progress was achieved on the ground. According to the Cabinet Office's survey, separate women's changing rooms were set up only in about a quarter of the shelters. A high number of evacuation centre management and operation manuals never reached shelters along the coastal areas. As one of the few female leaders[x] interviewed by Masai explained, she was completely unaware about where to start and which authorities to turn to. Participation in the Reconstruction Council represented only around 10% of the people in the affected areas. Initially, the reconstruction committee in Iwate Prefecture, which had been severely impacted by the tsunami, consisted entirely of 18 male members. However, following demands from women, two women were included in the committee during the second session. One represented the Women's Organization Council, while the other served as the chairperson of the Iwate Dietitians Association. The local fishery cooperative, which included 8,300 women, did not have a representative on the recovery committee.[xi,20]

In order to respond to women's and girls' needs, women NGOs leveraged their local networks to provide gender and diversity-based support at the shelters. The Women's Network for East Japan Disaster, composed of several organizations and individuals, promoted the human rights of women and vulnerable groups in disaster recovery and reconstruction process as well as in prevention strategies, respecting the diversity of the affected people. The assistance they provided differed based on beneficiaries' gender, sexual identity, age, disability, nationality, language, family structure, and employment status. However, limitations to mainstreaming a gender perspective in the processes of disaster management for these organizations included difficulties with limited transport, financial restrictions, and the fact that those providing support

[x] There are a few examples we knew that female principals of elementary schools became a leader. However, this woman voluntarily ran for the leadership of the shelter.

[xi] A chair of the women's division of a local fishery cooperative became a Vice-Chairman of the Special Committee for the Promotion of Women's Participation of Iwate Prefecture Great East Japan Earthquake Tsunami Reconstruction Committee in 2014.

were themselves affected by the disaster.[18] Ikeda pointed out that the gender gap in Japan is structurally significant. "Firstly, women's perspectives in evacuation assistance are often overlooked compared to other countries, resulting in increased and prolonged challenges for women, particularly during the emergency response phase. Secondly, the lack of women's perspectives hindered women's proactive involvement in the recovery."[19]

Despite these gaps, there were some relevant efforts to introduce a gender lens in certain areas of disaster management. The Gender Equality Bureau of the Government of Japan Cabinet Office conducted a survey on the response to the disaster from a gender equality perspective, targeting local authorities and private organizations in the affected areas. The findings revealed that women had faced many difficulties due to the fact that national and local government policies were based uniquely on a male-centred perspectives. The survey also captured a range of diverse voices, including those of people with specific needs and LGBTIQ+ individuals. This included adolescents and adults who expressed a preference for non-gendered clothing and facilities, such as restrooms and other spaces that are not segregated by gender.[20] Moreover, in 2012 and 2013 the Gender Equality Bureau of the Cabinet Office also carried out a consultation on women's concerns and violence in the areas affected by the Great East Japan Earthquake.[21,22] [xii] Masai, who visited the shelters, temporary housing and sites where women received support in the aftermath of the earthquake, noted that the survey and the consultations carried out by the Gender Equality Bureau were a promising sign of the government's intention to prevent violence against women and marked a considerable improvement in the approach to disaster management compared to 16 years earlier.[23]

THE GREAT EAST JAPAN EARTHQUAKE AND GENDER BASED VIOLENCE

After the Great East Japan Earthquake, cases of gender-based violence including domestic violence, sexual abuse and rape in shelters started to be recorded in the devastated coastal region of Tohoku. Following the earthquake, Mieko Yoshihama, Masai and others conducted a quantitative survey on post-disaster GBV between October 2011 and December 2012 and a report was published in 2013.[3,4] The report[xiii] presents 82 cases of GBV. The majority of the cases (n = 70) took place in the three most affected prefectures—Fukushima, Iwate, and Miyagi—and the remaining cases occurred in other areas where the victims and/or perpetrators were residing or visiting at the time of the incidents. The majority of the cases (n = 45) involved domestic violence or intimate partner violence. A total of 26 cases involved violence against adult women by someone other than an intimate partner, and 11 cases involved violence against minors.[4] Reports of violence most often involved single, separated or divorced women, single mothers, widows, and women living alone.[3,4] The study revealed a considerable number of cases of violence against women and children occurring within everyday living spaces. This underscored the need for additional efforts to improve shelter design and management, such as installing partitions in communal spaces to ensure greater privacy and safety.

Concerning the causes and contributing factors of the violence, Yoshihama emphasizes the importance of recognizing that while trauma and stress from the disaster may have influenced the behaviour of the perpetrators, it is important to acknowledge that trauma and stress alone should not be considered as direct causes of violence, nor should they serve as excuse for it.

[xii] Gathering local counselors of the affected area and women's counselors from all over the country, the Gender Equality Bureau of the Cabinet Office conducted a consultation program on various concerns of women and violence against women caused by the Great East Japan Earthquake. The goal is to connect as many women who are suffering alone as possible to the support they need by listening attentively to them and sorting out their anxiety and worries.

[xiii] Data were collected using a structured questionnaire from informants who worked with the disaster-affected populations (The Research Team of Women's Network for East Japan Disaster 2013, Yoshihama 2018).

While disaster experiences are likely to contribute to some individual engaging in GBV, it is important to note that not all disaster-affected individuals, regardless of gender, would necessarily perpetrate violence at an increased rate. Although both men and women were exposed to the disaster and its effects, it is evident that the perpetrators were overwhelmingly men.[4]

The data also showed that most survivors were reluctant to report the violence for fear of reprisals or stigma. At the time, GBV was a custodial offence, meaning it was not considered a crime unless the survivor reported it to the police. Alarmingly, in some cases, the affected women were advised to tolerate the violence due to the ongoing disaster, which furthered increased the challenges to reporting the incidents. This led to a form of secondary victimization of survivors, further isolation and an increased sense of guilt for the violence they endured.

However, the report also revealed a significant increase in awareness since the 1995 Hanshin-Awaji Earthquake, that sexual violence occurs after disasters. It also highlighted that numerous shelter managers and supporters of disaster survivors had acquired improved knowledge and skills in handling incidents of GBV, demonstrating a more appropriate response compared to previous experiences. When women NGOs first started to receive reports of GBV that was being perpetrated in the shelters, women's rights groups began to file requests to urge the local government to improve the security for women and girls. Funded by the Cabinet Office, a new hotline was set up at the time, and civil society organizations were able to provide more and better support to women in need. As a result, GBV was made more visible and began to gain social recognition as a widespread and structural social problem.

THE SITUATION TODAY: CHANGES IN THE LEGISLATION CONCERNING GBV

Based on the Cabinet Office's 2020 survey on domestic violence, the number of consultations with survivors of domestic violence in Japan remains high, reaching a total of 182,188 in the same year.[23]

According to the report, one in four women has experienced violence, while one in 10 has experienced multiple incidents of GBV. Many survivors of spousal abuse said that they felt their lives were in danger.

This situation persists despite some significant advancements in the period between the 1995 and 2011 earthquakes, and after 2011. The Act on the Prevention of Spousal Violence and the Protection of Victims, enacted in 2001, was passed as parliamentary legislation mainly by female legislators.[24] Amended first in 2004 and then 2007, the act expanded the scope of its application thanks to the 2013 amendment. This amendment expanded the act's reach beyond spouses, including de facto and former spouses, to encompass "partners who share a living base." This broader interpretation could potentially include individuals seeking refuge in temporary shelters following a disaster. This amendment made it also possible to provide relief to survivors in cases of cohabitation, where it is difficult to apply a restraining order under the Stalking Regulation Law. An additional amendment in 2019, passed after a mother and a child were killed in a domestic abuse case, further enhanced the cooperation between domestic violence response and child abuse response efforts. This amendment also clarified that family members accompanying the victim are eligible for protection under the law.

Advancements have been registered also in the anti-stalking legislation. There are some stalking cases reported around shelters and temporary housing. In recognition of these incidents, the Anti-Stalking Act was legislated and subsequently amended in 2016. These changes enabled the prosecution of stalkers without requiring a complaint from the survivor, offering a stronger legal framework to address stalking offenses.

Furthermore, the offences of rape and indecencies were custodial sentences, requiring a complaint from the survivor. This placed a heavy burden on survivors of sexual assault. However, in 2017, amendments were made to the Penal Code (as "forced sexual

intercourse"), transforming these offenses into non-custodial ones. These amendments represented the first major change to sexual offences laws since the enactment of the current Penal Code in 1907. The 2017 amendments brought other significant changes, including extending the law's application to male survivors. Despite these noteworthy changes in 2017, the requirement of an assault threat for the offense of forcible sexual intercourse still remains. As of 2023, this requirement is under deliberation for potential modification. Although further deliberation is necessary regarding the specific requirements, it is evident that the landscape surrounding GBV is continuously evolving.

DISCUSSION

This paper attempted to illustrate the narratives and lived realities of women and girls during two disasters in Japan – the 1995 Great Hanshin-Awaji Earthquake and the 2011 Great East Japan Earthquake – which made gender inequality, sexual violence and other forms of GBV against women more visible than in 'normal' times. It also aimed to reflect upon the role of women organizations and activists in Japan during and after these two events, and to what extent they managed to promote change in how Japan envisions and implements disaster management from a gendered perspective.

Disaster Prevention Starts with Everyday Life

The ability to prevent and challenge GBV in post-disaster Japan will inevitably be a reflection of Japanese societal approaches to GBV during 'normal' times.

The issuance of notices by the Cabinet Office's Gender Equality Bureau in March 2011, that urged local governments to pay attention to violence against women after disasters, represents a notable step forward. However, these and other measures adopted the Bureau tend to focus on mechanisms aimed at mitigating risks of violence by strangers, for example encouraging women to take preventive measures such as "not walking in deserted areas alone."[20] Equivalent guidance is not provided for preventing violence from family members, colleagues or others people known to the women. Such guidance would prove effective in safeguarding women during post-disaster periods, when they are particularly vulnerable and face high risks of exploitation, and are dependent on family members.

Policies to Ensure Safe Housing

WNK currently focuses on ensuring safe housing for women survivors of violence, one of their most urgent needs. In 2021, the network issued a statement titled "Support for women survivors of domestic violence and their children-Economic support and housing are essential to escape from domestic violence", addressed to the Minister in charge of gender equality, the Minister of Land, Infrastructure and Transport and the Minister of Health, Labour and Welfare.[25] The statement urged ministries to demonstrate flexibility in operating the existing system and create a new system, while emphasizing the responsibility of both the state and local governments to ensure adequate housing for women survivors of domestic violence. In summary, the network requested the ministries to:

i) Support women and children who are unable to live safely and securely due to domestic violence or abuse by including them in the Homeless Independence Support Act;
ii) Design activities that will support women survivors of domestic violence, including those living with their husbands, to secure housing through public assistance;
iii) Identify vacant public housing options that could be suitable for women survivors of domestic violence; and
iv) Expand the safety net function within housing policy, ensuring that it provides comprehensive support for women facing domestic violence and addresses their specific housing needs.

Women in Leadership Roles in Disaster Management

By actively involving women in decision-making processes regarding shelters provided to women fleeing domestic violence, and by providing training to women to become shelter managers, we can ensure

that more qualified women with appropriate skills take on the task of managing disaster relief shelters in the aftermath of disasters. This inclusive approach would enhance the representation of women and strengthen the capacity to address the unique needs and challenges faced by women in times of crisis. Qualified women managers will be well-versed in accommodating the needs of women, including nursing mothers and elderly widows, and will be available to provide emotional support and recovery advice to women in need.

At the time of the 1995 earthquake, few women served on the Reconstruction Council due to the national criteria which excluded women. Nonetheless, the 2005 Disaster Reduction Forum Appeal statement states[xiv] that "Women's knowledge and abilities are essential for disaster reduction and reconstruction and women should be employed as responsible persons. Women's expertise and networks should be used, and the knowledge and experience accumulated at the local level should be utilized when deciding on recovery and disaster management measures."[28]

Japan's Basic Plan for Disaster Reduction, which was revised following the experience of the 2011 Great East Japan Earthquake, states that "In order to improve local disaster preparedness, the participation of women, the elderly and persons with disabilities in policy-making and decision-making process on disaster reduction and in the disaster management field, should be expanded and a gender equality system should be established". The Plan also points out that the participation of women should be promoted in the management of voluntary disaster management organization[xv] shelters, and emergency temporary housing, and that women's and men's different needs and perspectives should be kept into account in the dissemination of disaster prevention knowledge as well as in the implementation of drills and training.[19]

In 2020, the Gender Equality Bureau of the Cabinet Office released the "Women's Perspective on Strengthening Disaster Response Capability Guidelines for Disaster Prevention and Recovery from a Gender Equality Perspective". These guidelines provide comprehensive and detailed recommendations on various aspects, including stockpiling, shelter management, collecting gender-specific data during disasters, housing considerations, breastfeeding support, and more.

The government initially aimed to achieve a 30% representation of female members in local disaster prevention councils established by each prefecture by 2020. However, this target has been postponed to 2025. Currently, the percentage of women on prefectural disaster management councils remains low at 16.1% and in municipalities, it is even lower at 8.8%. Moreover, 21.8% of municipalities (348 cities, wards, towns, and villages) do not have a single female member of the committee.[29] These statistics highlight the need for increased efforts to improve gender diversity and inclusivity in disaster management decision-making bodies at both prefectural and municipal levels.

In order for gender and diversity perspectives to be incorporated into disaster management and planning, and to be operationalized during disasters, it is necessary to implement policies that incorporate and reflect the perspectives of women in 'normal' times. This will create policies, systems and mechanisms that enable women to participate in political and administrative decision-making and guarantee safe and secure housing following disaster events.

Despite the slow pace of change in Japan, WNK has been observing incremental progress and is determined to further scale up their efforts and activism to continue improving the life and safety of women everywhere in Japan. Gender inequality is a significant cause of violence and suffering against

[xiv] 2005 in Kobe, Japan.

[xv] Deemed temporary housing is a kind of temporary housing which local governments rent private rental housing and provide them to disaster survivors who have lost their residences due to disasters and are unable to obtain new housing.

women during disasters. When visiting Iwate prefecture, one woman told WNK members that "the community of Tohoku [devastated region encompassing Iwate prefecture] is a community which silences women." She also expressed hope that after the disaster the area will transform into a brand-new community that embraces gender equality and does not revert to its previous state.

Raising awareness alone is insufficient to achieve gender equality. It is essential to create new systems and policies that facilitate women's meaningful participation in disaster prevention and reconstruction efforts. Unfortunately, the current systems often hinder women's involvement. As a solution, why not create a new and inclusive system? Disaster prevention should start in our everyday life, and it is crucial to create a society where women and children can live free from violence, even during "normal" times. To achieve this, it is vital to have more women in decision-making positions across various spheres of society, including politics, corporations, and the media, as this will also contribute to creating a society that is more resilient to disasters and better equipped to respond efficiently to them.

Over the past thirty years, Women's Net Kobe has been promoting women's rights and providing long-term support services to women, from offering temporary protection to helping rebuild livelihoods. Gender equality education has also been an area of the network's work. Encouragingly, the younger generation has begun to participate in the WNK's initiatives, strengthening the organization's foundation. Women's Net Kobe remains committed to continuing their movement and striving for a society that upholds gender equality.

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