Barriers and facilitators to physical and mental health help-seeking among Congolese male refugee survivors of conflict-related sexual violence living in Kampala

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Abstract: In Uganda, over 1.3 million refugees have fled armed conflicts from neighbouring countries, with about 251 730 refugees from the Democratic Republic of Congo (DRC) alone. In this article we report on a qualitative research study on the help-seeking behaviour of Congolese male refugee survivors of conflict-related sexual violence (CRSV) living in Kampala, Uganda. We recruited 10 Congolese male survivors of war-related rape and 6 Ugandan service providers (psychologists, social workers and physicians) who participated in individual interviews focused on barriers and facilitators to care seeking in Kampala, Uganda. We found that the major barriers to help-seeking were socio-cultural and political factors, health system and infrastructural barriers, poverty and livelihood barriers, physical effects of CRSV, fear of marital disharmony and breakup, and self-sufficiency The major facilitators were social support, symptom severity, professionalism among service providers, availability of free tailored services and information, education and communication. On the basis of our findings, we recommend that a multidisciplinary and multisectoral approach is important to address these barriers. In addition, we suggest that the Ugandan government should develop legislation and health policies to create protection for men who have experienced sexual violence.

Keywords: armed conflict, conflict-related sexual violence, male refugee survivors, help-seeking, physical and mental health, barriers, and facilitators

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Introduction

The conflict in the Democratic Republic of Congo (DRC) has endured for several years, resulting in the displacement of hundreds of thousands of Congolese men, women and children. By February 2018, there were 509 077 Congolese people of concern living in Uganda alone (United Nations High Commissioner for Refugees, 2018). The UNHCR defines people of concern as persons who have been forcefully displaced from their homes. These include refugees, asylum seekers, internally displaced persons, and stateless persons (United Nations High Commissioner for Refugees, 2016). Congolese refugees are among the largest foreign populations living in Uganda. A salient feature of the conflict in the DRC is the widespread sexual violence against males and females of all ages, which has been a major reason for flight among nationals seeking to escape and find refuge elsewhere (Cohen and Nordas, 2014; Kinyanda et al., 2010; Nelson et al., 2011). In Africa, conflict-related sexual violence (CRSV) against men and boys has also been documented in over 25 countries including Uganda, Liberia, South Sudan, Libya, and Burundi (Dolan, 2014; Hebrew Immigrant Aid Society, 2014; Onyango and Hampanda, 2011).

In the DRC, CRSV has been carried out on an enormous scale, prompting the former UN Special Representative on Sexual Violence in Conflict, Margot Wallstrom, to refer to Eastern Congo as 'the rape capital of the world' (Africa Research Bulletin, 2011). Several studies note that sexual violence has always been part of many armed conflicts worldwide, but it differs in the scale, type, target group and tactics (Tol et al., 2013; Jewkes, Sen, and Garcia-Moreno, 2012). CRSV features in ancient Babylonian manuscripts (Trenholm, et al, 2011) but it became globally recognised as a human rights violation and security issue during the International Criminal Tribunal for Rwanda (ICTR) and the International Criminal Tribunal for the Former Yugoslavia (ICTY) (Anholt, 2016; St. Germain, 2012). This was after several decades of a spirited fight by feminists and women's organisations to have CRSV against women discussed as a war crime and human rights violation (Drumond, 2016).

Data on the prevalence of CRSV in any population is limited, and particularly scarce regarding male victims. In Uganda, male survivors of CRSV have been documented in studies conducted among former internally displaced persons (IDPs) in Northern Uganda, and among refugee populations (Refugee Law Project, 2012; Kinyanda et al., 2010). Available statistics reveal that 33% of the refugee male population in Uganda has been subjected to CRSV (Women's Refugee Commission, 2016). Agaba (2016) reports that out of a population of 20,000 refugee men in Kampala alone, 6,500 of them have been subjected to CRSV. In the DRC, prior studies on CRSV against men and boys reveal that CRSV is perpetrated through various forms such as rape with sexual organs, including incestuous rape, rape with objects such as sticks and gun butts, oral rape, castration and forced sterilisation, rape by proxy, gang rape, and sexual slavery, among others (Cohen and Nordas, 2014; Dolan, 2014; Carpenter, 2006).

For so long, literature on CRSV portrayed a female-victim and male-perpetrator gender binary (Dolan, 2014), but recent studies provide evidence that both males and females can be perpetrators and victims (Meger, 2016; Onyango and Hampanda, 2011). Examples of female perpetration of CRSV are documented in Rwanda, Serbia, and Iraq (Leatherman, 2011; Onyango and Hampanda, 2011). Prior studies mention state armies, rebel groups, pro-government militias (PGMs), civilians, aid workers, and peacekeepers as perpetrators of CRSV (Cohen and Nordås, 2015; Bastick et al., 2007). CRSV against men is used as a weapon of war to emasculate, humiliate, and torture victims, among other reasons (Leatherman, 2011; Sivakumaran, 2007). Despite the fact that there is evidence to prove that men experience CRSV, male survivors of CRSV still lurk in the shadows of policy, research and service delivery. Literature suggests that the absence of men in the CRSV debate is due to cultural perceptions surrounding male rape leading to under-reporting, under-documentation, and under-acknowledgement (Dolan, 2014).

Furthermore, the discussion on CRSV against men is lost in humanitarian language that classifies it as torture, and concern from feminists that believe it will turn away attention from issues affecting women (Drumond, 2015; Sandesh, 2010). Such reasons make it difficult to prioritise sexual violence against males as an issue for discussion among human rights activists (Drumond, 2015). As a consequence, male survivors of rape are often missed in the delivery of health care services, as these mostly are made available to female survivors (Kohli et al., 2012; Médecins sans Frontières, 2009). Yet, the effects of CSRV on men are considerable in magnitude and severity. These effects can be categorised as physical, psychological, psycho-sexual, psycho-social, and political. Physical effects include, but are not limited to, bruising, lacerations, abrasions and tearing of the anal and genital area, rectal damage, and sexually transmitted infections (STIs) such as gonorrhoea, HIV, hepatitis, chlamydia, and syphilis. Male victims of sexual violence may also experience chronic pain in the back, head, abdomen, rectum, infections due to untreated wounds, chronic fatigue and gastro-intestinal difficulties (Leatherman, 2011; Tewksbury, 2007). In the DRC, Mukwege and Nangini (2009) have labelled the health consequence of rape as a new pathology.

Psychological consequences include acute stress disorders, post-traumatic stress disorder (PTSD), depression, and anxiety (Solangon and Patel, 2012; Tewksbury, 2007). For example, 81% of sexually abused male combatants in Masisi, DRC reported symptoms of PTSD (Médecins sans Frontières, 2009). Other psychological effects include depression, low self-esteem, emotional numbing, anxiety disorders, panic attacks, phobias, suicidal ideation and substance abuse (Akinsulure-Smith, 2014; Clifford, 2008; Tewksbury, 2007). Additional problems include poor anger management, feelings of worthlessness, social isolation, avoidance behaviour, somatic complaints, and deliberate self-harm (Mezey and King, 2000). Several of these psychological experiences have also been documented among refugee male survivors of CRSV living in Kampala (Hebrew Immigrant Aid Society, 2014).

Psycho-sexual problems may include damage to genitalia, painful intercourse, impotence and confusion about sexual orientation (Sivakumaran, 2007; Tewksbury, 2007). Psycho-social problems include incapacity of survivors to work and thus provide for their families. It has been reported that such circumstances may undermine the traditional role of men as head of the household (Dolan, 2014). Prior studies reveal that political consequences include survivors joining rebel groups in a bid to seek revenge, and hostility towards government and political programs (Haer, et al, 2015; Leatherman, 2007).

Thus, CRSV places a significant burden on a vulnerable group. Despite the high prevalence amongst refugees and numerous negative effects, few male CRSV survivors access help (Hebrew Immigrant Aid Society, 2014)). In order to address this, data is required on the barriers and facilitators to physical and mental health help-seeking among male survivors of CRSV. However, data is sparse, with studies only reporting help-seeking among female survivors in rural DRC (Christian et al., 2011; Linos, 2009). To our knowledge, this is the first study exploring these issues in male refugees from DRC living in Uganda. To address this gap, this study sought to investigate the chief barriers and facilitators to physical and mental health help-seeking among Congolese male refugee survivors of CRSV, living in Kampala, Uganda. We also sought to elicit participants' views on solutions to overcoming barriers to help-seeking.

Method

Study setting

The study was conducted with the assistance of an NGO tasked with providing psychological and legal services to forced migrants living in Kampala, Uganda.

Participants

Participants were 10 male refugee survivors of CRSV recruited from male survivors attending a support group of refugee male survivors of CRSV at the NGO between August 2015 and May 2016. The ages of the survivors that participated in this study ranged from 18 to 47. The study also involved 6 service providers, male and female, aged between 25 and 28.

Study procedures

We obtained permission from the NGO and the support group facilitators to attend one of their fortnightly meetings. After the meeting we introduced the study to the support group members and handed out information flyers that explained it. The information was made available in English, French, and Lingala. Those support

group members who were interested were asked to approach study personnel and dates for the interviews were set. We conducted two pilot interviews to test the interview guide and ensure clarity of the questions to the respondents. The interviews were conducted by the first author who is a social worker, with the help of a qualified community interpreter. Each interview lasted between 30 and 90 minutes. Data collection took place in a private room at the office premises. Participants were given refreshments and US$6 as a refund for their transport. The names used in this study were changed to ensure respondents' confidentiality.

The data were collected by means of face to face semi-structured interviews with open-ended questions and probes. The questions on the interview guide addressed the nature of care participants had received so far, the reactions of people when they stated their presenting problem, the kind of assistance they received, reasons for not seeking help, how they coped with physical and psychological effects of their experience of CSRV, and the range of resources they needed to cope effectively. They were also asked what made, or would have made help-seeking easier, what additional support they thought they required, and what they thought kept others similar to them out of care. Finally, they were asked general questions about how they thought people in their communities responded to male survivors of rape; the attitude of service providers towards them, and how they interpreted these reactions. The interviewer took notes to record non-verbal expression. All interviews were audio recorded and transcribed in English by qualified community interpreters employed by the NGO.

Ethical considerations

All participants were asked to complete and sign an informed consent form that was available in English, French, Swahili and Lingala. Participants were assured of confidentiality of the data and were informed that they had a right to decline participation in the study without consequences. Those who agreed to participate were informed of their right to withdraw at any time. All completed questionnaires and notes were kept in a locked cabinet in the NGO office. Consent forms were kept in a separate cabinet, away from other study documents. Data were password-protected and were only shared with the community interpreter for transcribing.

We obtained ethical approval from the Health Research Ethics Committee at Stellenbosch University. Additional approval was obtained from the Research Ethics Committee of The Aids Support Organisation (TASO) and the study was registered at the Uganda National Council of Science and Technology (UNCST). We also obtained permission from the director of the NGO.

Data Analysis

Qualitative research computer software, NVivo 11 for Windows was used to analyse the data which followed a framework approach (Ritchie and Spencer,

1994). The framework approach is a form of thematic analysis that identifies differences and similarities within the data, establishes connections in the different aspects of the data, and allows the researcher to draw themes and make interpretations (Gale, et al., 2013). The framework approach involves familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation.

Audio recordings were transcribed verbatim and read and re-read by the research team. We made analytical notes and initial codes from 16 transcripts and audios. Coding during transcription of interviews helped to ensure credibility and trustworthiness of the data (Saldaña, 2013). Codes were compared by members of the research team and overlaps in the codes were merged. The final codes agreed on by both researchers were then used as a framework to code all transcripts in a process known as indexing (Gale et al., 2013). Similar codes were then merged into the relevant themes. The qualitative research computer software, NVivo 11 for Windows facilitated the charting of the data, i.e., 'entering the data into the framework method matrix' (Gale et al., 2013, p.2). The matrix used in this approach organised the data in such a way that each case is represented in a row and each theme, a column. Quotes for each case were entered into the column corresponding to the theme represented by the quote. This allowed us to interpret the data by theme, and to identify similarities and contrasts across participants.

Results

Table 1 overleaf summarises the demographic characteristics of the participants.

The themes related to barriers to help-seeking were: socio-cultural and political factors, (ii) health system and infrastructural barriers, (iii) poverty and livelihood barriers, (iv) physical effects of CRSV, (v) fear of marital disharmony and breakup, and (vi) self-sufficiency.

The themes related to facilitators to help-seeking were: i) social support, (ii) symptom severity, (iii) professionalism among service providers, (iv) availability of free tailored services and (v) information, education and communication.

The themes related to solutions to overcome barriers to help-seeking were: (i) information and communication, (ii) education and training, (iii) provision of infrastructure, (iv) developing gender inclusive policies and models, (v) increasing research on CRSV against men, (vi) curbing vulnerability, and (vii) offering family counselling and prosecuting perpetrators.

Table I
Socio-demographic characteristics of respondents

Male refugee survivors of CRSV=(10)		
Years spent in Uganda (range)		1-7
Age range		18-47
Marital status	Single	4
	Married	6
Level of education	Secondary	3
	Vocational training	1
	Diploma	1
	University	5
Employment status	Employed	6
	Unemployed	4
Service providers = (6)		
Age range		25-58
Number of years in practice	1-10	3
	11-20	2
	21+	1
Occupation	Consultant surgeon	1
	Medical doctor	1
	Clinical psychologist	2
	Psychosocial counsellor	2
Highest level of education	Masters degree	3
	Bachelor degree	2
	Post-graduate diploma	1

Barriers to help-seeking

Socio-cultural and political factors

One of the major socio-cultural factors that emerged in the data was the way in which masculinity was conceptualised. Participants stated that in many African cultures, a man is a symbol of strength and authority, and is expected to fight off abuse, including sexual abuse. Baraka stated:

> *In my culture a man … or in my tribe … if a man is raped it's a disaster… in my tribe you are called like a 'Mukumbira'. You are not supposed even to be talking to people; you are not supposed to sit where men are seated or even where kids are seated.*

For him, his experience of being raped stripped him of his masculinity and his place as a respected member of society.

Sexual violence was also considered a taboo or curse and was considered an abomination that goes contrary to African norms. Djamba stated *'I never shared these issues of being raped. I never shared it. I could not afford. I am an African.'* His identity as an African did not permit him to share information of his abuse with others.

Some participants were concerned that they would be considered homosexuals hiding under the guise of being male victims of rape, as community members would react with disbelief and labelling. Baraka stated:

> *The most (important) question you find in the community is, 'if the males are the rapists, so who rapes them?' And then the confusion of saying homosexuality and male rape.*

Respondents stated that homophobia existed in communities and also among service providers. Alongi stated:

> *I went to many organisations that help refugees. Really I did not get any assistance because they were saying that a man cannot be raped; they were regarding me as a gay …*

Shame emerged as an important theme among participants. Shame was related to stigma and discrimination, all of which impeded help-seeking. Kangelu stated:

> *When I was in front of people I had fear, I was ashamed … I did not know what could be their reaction after explaining what I went through.*

A service provider participant stated:

> *There is stigma attached to this particular form of injury, and initially the person may be ashamed or may be shy or may be so traumatised to come and tell another person of their experience and the need for the help …*

Some participants stated that the nature of services was a barrier to help-seeking. For example, having to disclose their experience to a female counsellor. Elombe stated:

> *I discussed with a counsellor called (name of the counsellor). That also was a barrier to me because I couldn't talk to a woman that this happened to me.*

Health system and infrastructural barriers

Health system and infrastructural barriers also emerged as a major theme in the data. Participants stated that the language barrier created a communication gap between themselves and service providers which delayed help-seeking and delivery and compromised confidentiality. Baraka stated that

> *I am not speaking English; I need an interpreter … I won't be sure that this interpreter should hear what I went through because I like confidentiality.*

Several participants also noted that ignorance about sexual violence against men was a barrier to help-seeking. Elombe stated that: *'I would sit with a counsellor who is*

a professional social worker and tell him my problem but he was the first person to laugh. And he could be amazed and say I have never heard this.' The data also revealed that there was limited information about the availability of services for male survivors of CRSV and where to find them. The public health facilities to which participants were referred did not have the skilled personnel and resources to attend to the peculiar needs of male survivors. The data also revealed that long distances to health facilities and refugee service organisations, in addition to the lack of transport fare to access them, hindered help-seeking. Djamba stated that:

> *I found myself being sick again. Because I could walk from where I am … walking on foot. When you go back even you cannot even breathe at night. The whole body is paining …* Participants added that at times the climatic conditions did not provide an environment conducive for walking.

Participants shared that the inadequate, ineffective and sporadic nature of services, especially in government health facilities were a barrier to help-seeking. Imani shared that:

> *I got the treatment in KCCA clinic but I was not satisfied with the treatment I got there. Then I went to Mulago but there the challenge was that they did not have time to listen to me and the treatment I got there was not efficient.*

Participants also stated that they found it tedious to seek various forms of help in different places and at times as they were made to wait in the queue for long hours without food. Matadi stated:

> *I took a risk of starting my journey at 5:00 a.m. It was still dark. I was received at 1:00 pm, then the doctor left for lunch only to come back at 3:00 p.m. … He received me not even for 5 minutes ...*

We found that some of the methods used to deliver services were barriers to help-seeking. Tambwe said:

> *…the lady who was counselling me brought me a knife there (as part of the counselling therapy to overcome the fear of knives). Since that day I did not come for counselling again because I hate a knife. It's the one which killed my mother.*

Furthermore, the high turnover of staff in organisations offering psychological services was a barrier to help seeking. Elombe stated that,

> *… the counsellor who used to help me left her office and went somewhere. And I had to get another counsellor from another organisation but this counsellor was not really interested ...* Participants also stated that the poor infrastructure of the health facilities was a barrier to help-seeking, as they were forced to visit more than one facility for different services. A service provider participant stated: *'There are no facilities that you can get help where you have gone … so they say, ' We don't have this' or 'We can't do this', so you don't get attention that you need.'* Also, some care organisations did not maintain their privacy and confidentiality. Baraka stated:

… that doctor told me to sit in a line of people, in the middle of ladies. … She opened my pants. When she saw me she was like, 'No! No!' So when she shouted everyone who was around, even these women who were seated, they stood up. I felt embarrassed in front of everyone. I just wore my clothes and marched out.

Poverty and livelihood barriers

The data revealed that male survivors of CRSV were heads of households who had competing priorities, the most important of which was to provide a livelihood for their families. Fumu shared that, *'what stopped me from accessing help is the means of living … the financial means. Because by myself, by ourselves in the family really we could not afford ....'.*

Participants stated that due to medical and treatment-related problems, they were unable to work and earn a living. Alongi stated:

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

Some participants found it hard to adhere to their medication regimens due to the lack of food. Tambwe stated:

…He also gave me some pain killers for the waist which was painful … The medicines were very strong and I failed to swallow them because I had no food.

Physical effects of CRSV

Some participants did not seek help because of the adverse physical effects on their bodies as a result of CRSV. Some survivors reported losing control of their sphincter muscles. A service provider participant stated:

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

Such injuries required survivors to wear adult diapers if they needed to go in public, which many could not afford. A service provider participant stated:

In the injury, they might lose their sphincter that is what makes the anus continent. … If it is unable to hold the gas it can be a social embarrassment …And if it cannot hold stool, then when people start holding their nose, you begin to feel uncomfortable to be in society.

Fear of marital disharmony and breakup

Some participants stated that seeking help led to marital disharmony and breakup.

Elombe stated:

> *I could not tell my wife that I was sexually abused. I was risking; I thought I was going to risk my marriage so I decided to keep quiet.*

Baraka stated:

> *I had problems in my family because my wife … when I told her that I was a male survivor, she told me, 'I don't deal with homosexuals.' She left.*

Self-sufficiency

Some participants stated that they did not seek help for personal reasons. For example, Lisanga stated: '*… because I am a medical personnel, I tried to get some medicine in the pharmacy, while running to here (Uganda).*' Other participants were not willing to talk about what happened and therefore preferred to handle their experiences their own way.

Facilitators to help-seeking

Social support

One of the major facilitators to help-seeking that emerged was the social support that participants received. Some support groups, especially the one exclusively formed for male survivors of CRSV offered financial, material, psychological and moral support to members. Alongi stated '*… joining the group I now see that I am not alone. We are many victims and … the trauma has started to reduce just by the fact of knowing that I am not alone.*' Psychological support involved counselling and psychotherapy.

Other forms of social support mentioned by the participants were friends and family who encouraged them to seek help. Some organisations also offered livelihood support such as food to help them adhere to medication. Tambwe shared that:

> *The medicines were very strong and I failed to swallow them because I had no food. I came back here and they helped me and gave me money to buy food so that I can take the medicine. After that I felt a bit better.*

Symptom severity

Some participants stated that they sought help because they could no longer contain the physical and psychological pain and yet they wanted to be well. One service provider participant stated: '*The pain can be so bad that you may be not be able to handle. The relatives around will say, look, they take you and they are forced by the circumstances, by the family to seek the help.*' Lisanga stated '*I went to seek help because I wanted to be mentally, physically and socially well. …they are helping women who are raped, they can also help us.*'

Professionalism among service providers

Data also revealed that the professionalism exhibited by some service providers, especially in some refugee service organisations and private health facilities facilitated help seeking. Kangelu stated that:

> *When I came to know about (name of NGO)… who recommended me to (name of health facility), which was already at that time aware about the case of male rape and sexual violence against men. … They took charge of my case properly.'*

Availability of free tailored services

Participants shared that the availability of free tailored medical and psychological services in some organisations facilitated help-seeking as they did not have to be concerned about paying for services. A service provider participant stated:

I do believe that what really facilitated a number of the patients whom I eventually saw in private to come, was the availability of health services provided through the organisation.

Information, education and communication.

Participants stated that community outreach programmes in refugee communities encouraged them to seek help. They stated that the deliberate efforts by some organisations to sensitise other service providers on how to respond to CRSV created a change in the attitudes of service providers towards male survivors.

Strategies to overcome barriers to help-seeking

Information and communication

Participants identified several strategies on how to overcome barriers to help-seeking. For example, information and communication could provide platforms for male survivors to share their experiences and sensitise the public about CRSV. A service provider participant stated:

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

Participants stated that increasing public awareness about sexual violence in the context of war was an important way of finding appropriate ways of helping survivors. Indeed, involvement of survivors in public campaigns emerged as an important theme. Elombe stated:

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

Education and training

Participants emphasised the importance of providing education and training on CRSV against men to refugee service providers such as counsellors, doctors, policemen, psychologists among others. Lisanga stated: *'Service providers have to be trained in sexual violence against men, because they have been trained against women …'* (by which he meant that the service providers were trained to deal only with women in relation to this issue). Participants also called for a revision of the education curricula provided in various disciplines involved in humanitarian work to be relevant and gender inclusive. A service provider participant stated:

> *There is need to influence the education system in Uganda, not only in Uganda but worldwide and especially in these countries where we have a lot of conflict going on; let's say, Congo, Rwanda, Burundi, Uganda, Sudan … I think we should have this as part of the curriculum at all levels: at primary people should know, at secondary schools, even universities …*

Provision of infrastructure

Participants also tasked the government with the provision of adequate and proper infrastructure. A service provider participant stated:

> *Just make sure that facilities are equipped to handle these things at points of call, that there are translators, there are people who understand the language, and the medicine is there …*

The participants recommended an increase in the number of service providers, especially in the medical and psychological sectors to cater for the physical and mental health needs of male refugee survivors of CRSV. The same service provider participant added:

> *But without a doubt we need more of counsellors; we don't have enough of those. We need, I think beyond counselling; we need physiotherapists, we need occupation therapists. We need people who can help these people who have been very traumatised get integrated back into the society.'*

Developing gender inclusive policies and models

Study participants also urged government to develop gender inclusive policies such as a mental health model for men who have undergone such violence. They added that this could be done by building the capacity of staff at the frontline to identify and offer psychological first aid to male survivors. A service provider participant stated:

> *It is required for government, for agencies to establish authentic mental health services for male sexual violence survivors. Yes. It's very harmful for such person to come to a centre like this and meet somebody who has a training of 3 months in basic skills of counselling. It is very dangerous.*

Participants also noted that gender inclusive policies should be drafted and implemented at all levels. One service provider participant stated:

I know people in the international level are still struggling. I have read so many reports. While even being given to UNHCR, UN are still struggling to accept male survivors as survivors of sexual violence … I always say sexual violence is a gender issue … When we talk about gender, we mean gender equality in service provision - in every service provision legal, social physical, health, everything - because men and boys are also human beings...

Increasing research on CRSV against men

Participants called for an increase in research on CRSV against men and the publication of findings in all possible media channels. Tambwe stated: *'research on raped men, then they publish it in the newspapers, journals and radios …'*

Curbing vulnerability

Several participants called for a multi-pronged approach that would meet several of their needs such as medication, food, shelter and livelihood to curb vulnerability. A service provider participant stated:

We need - I will say this over and over again - we need to think through ways to empower these people when they come here. … So we need to break that cycle of vulnerability and help empower them again.

Participants shared that durable solutions for refugees such as resettlement would enable them to access quality medical care and foster psychological healing. Kangelu stated: *'So there are others (organisations) who if they see may be this case needs a resettlement. Yes let them facilitate them to where everyone can fit better.'*

Offering family counselling and prosecuting perpetrators

Participants suggested family therapy and counselling for male survivors of CRSV to enable affected spouses to understand effects such as sexual dysfunction and how to deal with them. Participants further stated that indictment of CRSV perpetrators would curb impunity and also foster psychological healing.

Discussion

Socio-cultural and political factors

Culture contributes to conceptualisations of what masculinity is in the African setting (Dolan, 2010). Its patrilineal bias creates beliefs that seem to imply that men and boys are immune to sexual violence and, therefore, it is a taboo or a curse for men to undergo such experiences, as reported by the participants in this study. Previous studies conducted in Uganda and DRC reveal that ideal masculinity is reflected by strength in men to fight off any harm (Dolan, 2010, 2014). Such an understanding

of masculinity enforces myths about male rape (Loncar, et al., 2010; Davies, 2002). In a study among service providers of sexual and reproductive health services to young people in Kenya, Godia et al. (2013) found that culture and religious biases were an obstacle to providing effective responses. Responses from our participants reveal that both service providers and the people in the community expressed shock and ignorance that men could be raped, and that help-seeking is a sign of weakness. Unfortunately, this barrier is a reflection of how society views male survivors of CRSV in Uganda, resulting in inappropriate responses.

The cultural misunderstanding of sexual violence against men among family and friends, also leads to stigma and shame. A study conducted in Uganda by Edström, et al. (2016) revealed that refugee male survivors of CRSV were stigmatised throughout the entire recovery process, and that there is a relationship between silence and stigma. Participants' responses, therefore, concurred with prior research conducted in Uganda, DRC, Chad and Kenya that revealed that cultural misconceptions about male rape occur within a wider context of homophobia (Dolan, 2014; Hebrew Immigrant Aid Society, 2014) . This line of thinking conflates homosexuality and male rape and blinds people to the difference between the two. Ultimately, this bias is reflected in policy formulation that caters only for women and girls in addressing CRSV, and fails to take into account the reality that CRSV can also be perpetrated against men (Dolan, 2014; Hebrew Immigrant Aid Society, 2014). Consequently, male victims of CRSV are left in a position where disclosure of abuse potentially exposes them to accusations of involvement in homosexual behaviour. In Uganda, such an accusation has serious consequences, given that homosexual activity is considered an offence in the country's penal code.

Strategies to overcome socio-cultural factors require a change of people's mind-sets at all levels of society through information, education and communication. The information disseminated is effective if informed by research, as there is a paucity of research on CRSV against men, as noted in prior studies (Dolan, 2010; Davies, 2002). A revision of the education curriculum, training of service providers and community sensitisation have been mentioned as effective methods by participants in the current and previous studies conducted in DRC and Northern Uganda (Durick, 2013; Harvard Humanitarian Initiative, 2009). Education challenges cultural myths about rape and also mitigates guilt among survivors (Médecins sans Frontières, 2009). Service providers such as police, prisons and army officers, lawyers, doctors, nurses and other frontline staff that come into contact with male survivors of CRSV have been equipped with skills and knowledge on the effects of CRSV on men and how to work with them by the Refugee Law Project (Kansiime and Tusasiirwe, 2017). Such information influences policy changes such as the UNHCR 'Need to Know' series, that has the Guidance Note 4 on working with men and boy survivors of sexual and gender-based violence in forced displacement (United Nations High Commissioner for Refugees and Refugee Law Project, 2012).

The suggestion by participants in this study to include survivors in overcoming

barriers to help-seeking by male CRSV survivors has been documented as an effective strategy in a prior study conducted in Uganda (Edström et al., 2016). Not only does it provide evidence and a platform for survivors to advocate for their rights and appropriate interventions, it also fosters healing, especially when delivered through peer support groups (Solangon and Patel, 2012; Davies, 2002). In South Kivu, DRC, for example, the Women's Media Association of South Kivu (AFEM), based in Bukavu, organises radio talk shows to sensitise the community about gender-based violence, and specifically against females (Clark, 2014). Similarly, members in a support group of male survivors of CRSV in Kampala have written, acted and filmed a film entitled 'Men Can Be Raped Too', as a means of raising awareness about CRSV against men (Kithima, 2016). Such information can also help other survivors to know where to seek help.

Families and spouses of survivors should be engaged in sensitisation about CRSV as a way of mitigating marital disharmony and encouraging disclosure. Positive reactions to disclosure among social networks can facilitate trauma healing and mitigate the impact of PTSD (Ullman and Peter-Hagene, 2014; Ullman, et al., 2010). In a study conducted in the DRC, female participants revealed to having been abandoned by their spouses once they revealed that they were sexually violated (Harvard Humanitarian Initiative, 2009).

Health system and infrastructural factors

The effect of poor health systems and the local inappropriate infrastructure as a barrier to help-seeking among CRSV survivors have been cited in studies conducted in prior studies conducted in Uganda and the DRC (Hebrew Immigrant Aid Society, 2014; Christian et al., 2011; Linos, 2009). Coupled with the high turnover of service providers, as reflected in prior literature (Harris and Freccero, 2011), this barrier destabilises the helping relationship. Christian et al., (2011) also mention the negative attitudes of service providers towards survivors of CRSV, and the lack of basic health resources and congestion in government health facilities. All these issues were mentioned by participants in this study. Participants also mentioned that few psychosocial responses are available to male survivors in general. Mental health issues are not prioritised in Uganda as the mental health sector is poorly funded (Harris and Freccero 2011). A survey of Uganda's mental health system revealed that mental health in primary health care was only 1% of the entire budget of the government health department (Kigozi, et al., 2010). The study also revealed a ratio of 1.13 mental health workers to 100,000 people, further highlighting the need for more health workers in this sector. Where health systems and infrastructure are functional however, survivors of sexual violence have sought help (Hebrew Immigrant Aid Society, 2014). This study also reveals that the provision of free tailored services to male survivors of CRSV facilitates help-seeking.

Poverty and lack of livelihood support

After sexual violence, survivors are tasked with seeking help amidst multiple challenges (Campbell et al., 2009). Prior studies reveal that poverty and the lack of livelihood hinder help-seeking among survivors of CRSV (Harris and Freccero, 2011; Harvard Humanitarian Initiative, 2009). In a comparative study of surgical costs for male survivors of CRSV in Kampala and Nairobi, the Hebrew Immigrant Aid Society (2014) found that it was more expensive to have rectal surgery in Kampala than in Nairobi at $2000 USD and $1400 USD respectively. This is unaffordable to refugee male survivors with no source of income. The inability to afford such expensive surgery impacts survivors as some are forced into social isolation due to the effects of the violence. For example, faecal incontinence due to rectal and genital trauma limits social interaction as survivors are rendered social misfits on hygienic grounds. Prior studies (Ba and Bhopal, 2017; Tewksbury, 2007) document rectal fistulae among male survivors in Uganda, Chad, Kenya and South Africa and report that it forces them to abstain from food, which exacerbates poor health. Research among female survivors of CRSV in DRC revealed a similar effect among women with rectovaginal fistulae (Longombe et al., 2008; Onsrud, et al., 2008). This underscores the need to economically empower male survivors of CRSV (Solangon and Patel, 2012; Ullman, 2007). Service providers need to take the issue of economic empowerment into consideration when designing intervention programs for male survivors.

Recommendations

The results of this study present evidence that male survivors of CRSV are faced with multiple barriers while seeking help to address the effects of CRSV. There is need for policy makers, practitioners and researchers to address these barriers at all levels of the ecological system. At the exosystemic level, governments of countries that offer refuge to people of concern need to overhaul the health and legal policies relevant to male survivors of CRSV. Additionally, governments need to expand health facilities, recruit more personnel and provide the medication and tools required by the practitioners at the mesosystem level. Still at the mesosystemic level, practitioners from relevant disciplines and community organisations should use education as a tool to address cultural misconceptions. School curricula should be gender inclusive, highlighting the effects and responses of CRSV against both men and women. Such an approach may combat stigma and discrimination by dispelling ignorance among professionals, and facilitate empathy for male survivors, which will in turn facilitate help-seeking. The results show that survivor support groups are instrumental to help-seeking advocacy.

Research should be instituted to investigate the feasibility of support groups in

both urban and rural settings, especially in countries where the definition of sexual violence is gender biased. Research should also be instituted among refugee male survivors living in camps or settlement areas to understand their specific needs. There is a need for research on the mental health effects of CRSV which will help practitioners to understand the problems that need to be addressed, and to provide relevant pharmacological/psychosocial interventions. Furthermore, such research will guide practitioners on the effectiveness and efficiency of various intervention approaches and the different modes of delivery. Our findings suggest that a support group for male survivors of CRSV can be effective in addressing the effects of CRSV although this may not be the case elsewhere. Such research would guide policy makers and practitioners on whether it is more cost-effective to use group, individual, or both approaches in delivering interventions. For example, Kira and Tummala-Narra (2015) suggest that the use of a development-based trauma framework (DBTF) is effective while working with refugees. Its efficacy among Iraqi refugees living in the United States shows that DBTF can effectively assess and provide interventions within an ecological framework to refugees that suffer with trauma resulting from exposure to political violence.

Conclusion

The research has highlighted the barriers that Congolese male refugee survivors of CRSV living in Kampala encounter while seeking medical and psychological help. The study also revealed facilitators and strategies on how to overcome the barriers to help seeking. Obstacles to help-seeking are majorly socio-cultural legal and political factors, poor health system and infrastructure, ignorance, poverty and lack of livelihood support, physical effects of CRSV on the survivors, fear of marital disharmony and break up, and self-sufficiency. Since these barriers are embedded at all levels of society, the strategies suggested by participants on how to overcome these should also be implemented at all levels of society, in a bid to holistically respond to CRSV against men and boys.

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