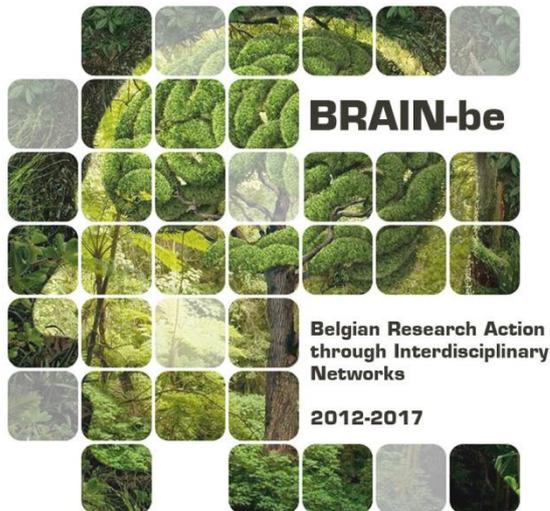


UN-MENAMAIS

Understanding the Mechanisms, Nature, Magnitude and Impact of Sexual Violence in Belgium

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Axis 5: Major societal challenges



NETWORK PROJECT

UN-MENAMAIS

Understanding the Mechanisms, Nature, Magnitude and Impact of Sexual Violence in Belgium

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ABSTRACT

Sexual violence (SV) is a major public health, judicial and societal concern in Belgium. A comparative and representative study of SV in Belgium was still lacking. The UN-MENAMAIS study aimed to contribute to a better understanding of the mechanisms, nature, magnitude and impact of sexual violence on female, male and transgender victims, their peers, offspring, professionals and society in Belgium and generate policy recommendations and prevention and response strategies. This mixed methods study showed that sexual violence is prevalent in Belgium and affects people of all ages, genders, sexual orientations and legal statuses. Being sexually victimized is linked to worse mental health outcomes across the life course. Moreover, victims find it difficult to disclose what happened, to seek professional help and to report to the police. Furthermore, doctors are not sufficiently aware of the care they should provide, nor of the potential impact of a forensic examination and do not systematically refer victims of sexual violence to adequate care, forensic or legal authorities. Regardless of the forensic model considered, victims find it difficult to gain recognition from the courts because of the judicial logic, which involves specific principles of proof and for which forensic evidence is not always sufficient.

1 INTRODUCTION

Sexual violence (SV) is a major public health, judicial and societal concern in Belgium. Previous studies have shown that 11% of male and 36% of female Belgian citizens and up to 32% of male and 56% of female migrants in Belgium have experienced SV. Yet, a comparative and representative study of SV in Belgium covering all ages, genders, sexual orientations and legal statuses was still lacking. Moreover, previous studies mostly apply a dichotomous view focussing solely on female victims and male assailants.

Extensive research has demonstrated that SV may induce long lasting sexual, reproductive, physical and mental ill-health in victims, but may also potentially harm the victim's peers, offspring and community. People who were directly or indirectly exposed to violence during childhood, are susceptible to subsequent (re)victimization, perpetration and to maladaptive parental practices, which contributes to the intergenerational transmission of violence. However, the complex mechanisms behind this coping behaviour as well as the effectiveness of response measures to all genders and ages had not yet been studied.

Furthermore, judicial follow-up is important for victims in terms of recognition. In Belgium we are in a transition phase in which a variety of medical-judicial models are being applied e.g. Sexual Aggression Set (SAS) and Sexual Assault Care Centres (SACCs). Hence the necessity to conduct a Belgian representative prevalence SV study examining all vulnerabilities to victimisation and perpetration.

2 STATE OF THE ART AND OBJECTIVES

Sexual violence (SV), ranging from sexual harassment to gang rape, is a major public health, judicial and societal concern worldwide. At the onset of our project in 2017, sexual violence prevalence in Belgium was estimated to be 11% in male and 36% in female Belgian citizens and up to 32% of male and 56% of female migrants in Belgium (FRA, 2014; Buysse et al., 2013; Krahe et al., 2015; Keygnaert et al., 2012). Yet, a comparative and representative study of SV in Belgium covering sexes, ages and vulnerabilities was still lacking. As for the impact of SV, it is evidenced that SV may induce long lasting sexual, reproductive, physical and mental ill-health, primarily affecting the victim yet also potentially harmful to the victim's peers, offspring and community (Greenfield, 2015; Jina & Thomas, 2013; Mason & Lodrick, 2013; McLean, 2013; Siegel, 2013; Carbone-Lopez, 2012; Merksey et al., 2012). Furthermore, it has been robustly demonstrated that people who have been directly (personally victimised) or indirectly (witnessed) exposed to violence during childhood, are susceptible to subsequent (re)victimisation, perpetration and to maladaptive parental practices, which contributes to the intergenerational transmission of violence (Minh et al., 2013; Risser et al., 2006; Williams, 2003; Godbout et al., 2009). However, the complex mechanisms behind this coping behaviour in male, female and transgender persons as well as the effectiveness of response measures to all genders had not yet been studied.

Also at political level in Belgium, the national action plan on violence for 2016-2020 advocated for a holistic management of victims of SV which already had resulted, among others, in the ratification of the Convention of Istanbul and in the feasibility study of developing and implementing Belgian Sexual Assault Care Centres (SACC) (Keygnaert et al., 2016; Vandenberghe et al., 2018; Hendriks et al., 2018; Peeters et al., 2019), upon which the government took the decision to pilot three SACCs in Belgium as of October 2017. Furthermore, the Col SAS (10/2005) had been evaluated and we were in the midst of changing the content and analysis procedure of the SAS. Finally, a process of transferring federal competences to the regions reorganising the Belgian judicial landscape was launched. Hence the necessity to conduct a Belgian representative prevalence SV study examining all vulnerabilities to victimisation and perpetration.

The general aim of this 4-year UN-MENAMAIS project was to contribute to a better understanding of the mechanisms, nature, magnitude and impact of SV on female, male and transgender victims, their peers, offspring, professionals and society in Belgium as well to generate policy recommendations and prevention and response strategies.

- *Objective 1:* To map how Belgian citizens and migrant residents in Belgium aged 16-100 (= research population) frame SV. To this end we specifically want to examine what they consider as SV and what they perceive as causal mechanisms (risk and protective factors) as well as their acceptance of SV and perpetration myths in all genders and for all sexual orientations.
- *Objective 2:* To explore to what extent the research population has been directly and indirectly exposed to sexual victimisation and perpetration since childhood. We hereby not only study personal experiences but also those in peers and family of different generations taking intergenerational transmission into account.

- *Objective 3:* To map indicatory pathways of how this exposure impacted the victims' lives as well as that of their family, peers and professionals they contacted for assistance. We specifically want to a) study their coping style and help seeking pathways, their evaluation of the SAS and of the impact of the SV exposure on their health, well-being, relations, education, work and societal functioning and b) inquire on their perceived drivers for their specific coping and help-seeking behaviour as well as the obstacles they encountered when trying to do so.
- *Objective 4:* To map the historical social and technical construction of the SAS and its impact on current SAS practices performed by professionals and new ones in the light of the implementation of sexual assault care centres in Belgium.
- *Objective 5:* To formulate recommendations for future policies and practices that might prevent and respond more effectively to SV in Belgium for current and future generations.

3 METHODOLOGY

The project objectives were to be realized through a mixed methods methodology that combined a literature review of the extant empirical research on sexual violence (SV) victimisation and perpetration (WP1) with a large scale nationally representative quantitative self-report study on SV victimisation and perpetration (WP2.1), face-to-face questionnaires with vulnerable people (WP2.2) and a quantitative study of healthcare professionals (WP2.3), follow-up in-depth interviews among a purposive sample of SV victims (WP3.1) and focus groups with professionals on SAS (WP3.2) and a seminar with a Café Dialogue set of rotating focus groups with professionals and SV victims on policy recommendations (WP4). A multidisciplinary and (inter)national expert follow-up committee assured the quality of the study. Ethical approval from the ethical committee of UGent/UZ Gent was obtained on the 16th of November 2018 (Belgian registration number: B670201837542).

3.1 WP1: Literature review and desk study

To realise our first study objective, we critically studied both academic literature as well as policy and legal documents. We therefore conducted five critical interpretative synthesis (CIS) reviews, which resulted in a report of nine chapters to be used as evidence base for the study design. CIS methodologies were developed to rigorously and systematically synthesize a broad and heterogeneous body of research evidence generated by diverse research methodologies. Particularly suitable to combine academic and grey literature including legal texts and policy documents in a single interpretive synthesis, CIS addresses some limitations inherent to conventional systematic review techniques (for a detailed discussion and comparison, see Depraetere et al., 2020a) and allows to combine research results from quantitative and qualitative empirical studies but also epidemiological studies, theoretical papers, reviews and commentaries (Schick-Makaroff et al., 2016). Further, in a CIS, the study relevancy is prioritized over study design quality, since studies with a weaker designs could still provide important theoretical insights (Entwistle et al., 2012). A CIS thus also considers studies that would not meet the inclusion criteria of systematic literature reviews and allows to

integrate a heterogeneous body of literature including grey literature such as research reports from non-governmental organisations (NGOs) regarding their fieldwork with populations that could be of interest for this study. This approach broadens the scope significantly and adds to developing a more in-depth understanding of the topic under study.

CIS methods have primarily been applied in health equity studies (e.g. Entwistle et al., 2012; Heaton et al., 2012; Gysels et al., 2012) but may be equally suitable to study discrepancies between men and women in SV victimisation prevalence, and the judicial aspects. Though a large number of conventional systematic reviews of SV research were available and served well to aggregate and summarize research findings of this vast body of research (e.g., inter alia Peterson et al., 2011; Krahe et al., 2014), interpretative reviews are rarely applied. Yet, CIS methods may yield new insights and interpretations and help to develop concepts to further develop the existing theoretical frameworks surrounding differences in the mechanisms underlying sexual victimisation vulnerabilities and consequences. This latter method thus seemed most fitted to reach the UN-MENAMAIS project objectives.

The CIS method was applied as an overall method for WP1 and the preparation of WP2 and WP3. For all individual CIS, the Web of Science, PsycINFO, Medline/PubMed and Google Scholar databases were searched to identify relevant studies and (inter)national policy documents on SV. The search focused on published English, Dutch and French language articles and policy documents. Further, they benefited from all partners' previously conducted literature reviews on subgroups and –themes of SV victimisation, perpetration, impact, care and policies and this in different research areas.

Yet, per population group specific inclusion and exclusion criteria and key or MESH terms were used. Via multidisciplinary collaboration, the consortium partners bundled the different CIS' into nine chapters. These chapters can be consulted separately or be read as a whole. After an introductory chapter, this bundle of CIS' continues with a chapter on defining SV, contextualising SV and an overview of SV observed in males and females. After these first four chapters, specific subpopulations are discussed. Chapter five covers SV in older adults, chapter six studies SV in sexual and gender minorities and chapter seven investigates SV in migrants, applicants for international protection and refugees. Chapter eight covers the judicial aspects associated with SV victimisation. The final ninth chapter concludes with an overview of the most important findings of each separate chapter. The findings of each CIS have been integrated into this report in the introductions of the corresponding results section and have been published in several peer-reviewed papers (see PUBLICATIONS).

3.2 WP2: Quantitative Study

3.2.1 WP2.1: Nationally Representative Self-Report Study on Sexual Violence

3.2.1.1 Survey Development¹

3.2.1.1.1 Conceptual Definition

This study relied on the World Health Organization (WHO) definition of SV as being “Any sexual act that is perpetrated against someone’s will, can be committed by any person regardless of their relationship to the victim, in any setting. It includes, but is not limited to, rape, attempted rape and sexual slavery, as well as unwanted touching, threatened sexual violence and verbal sexual harassment.” (World Health Organisation (WHO), 2015).

Based on this definition and research literature, SV was broadly conceptualized. Depending on the level of physical contact and the objective of the sexual act, five distinct forms can be identified (items 2 until 6) (Keygnaert, 2014). One additional item was added based on the revised definition of elder abuse and neglect (CIUSS, 2017; item 1) and broadened for applicability to the entire research population (Nobels et al., 2020):

1. Sexual neglect, including disrespect of a person's sexual privacy, sexual orientation or gender identity, treating people as asexual beings and/or preventing them from expressing their sexuality;
2. Sexual harassment, including forms of SV without physical contact;
3. Sexual abuse, including forms of SV with physical contact but without penetration;
4. (attempted) Rape, including (the slightest) forms of penetration with an object or body part in any body opening;
5. Sexual exploitation, including any abuse of a position of vulnerability, differential power or trust for sexual purposes (e.g., forced prostitution, (gang) rape as bale for passage, food or shelter,...);
6. SV as a weapon of war/torture, including crimes against humanity such as sexual slavery, forced abortion, forced childbearing.

3.2.1.1.2 Procedure

First, as part of content validation, literature and existing questionnaires were consulted in addition to the revised Sexual Experiences Survey (SES-R; Koss et al., 2006, 2007), such as the National Intimate Partner and Sexual Violence Survey (NISVS) (Smith et al., 2017), the Senperforto Questionnaire (Keygnaert et al.; 2014a) and the Sexual Aggression and Victimization Scale (SAV-S) (Krahé & Berger, 2013). Based on this information various changes were made in line with the applied conceptual definition of SV. These initial revisions of the SES-R were developed in English by a multidisciplinary research consortium with a background in health sciences, sociology, psychology, psychiatry, criminology, human sexuality studies, and anthropology.

Aside the revisions to the SES-R, literature and existing questionnaires were also consulted to validate in terms of content the modules inquiring about participant’s sexual and gender identity, their mental health and their experiences as minority group members in

¹ The description below is based on the following paper: Depraetere, J., Inescu, A. C., De Schrijver, L., Nobels, A., Keygnaert, I., & Vandeviver, C. (2020). Measuring sexual victimisation and perpetration in today’s society: modifications to the sexual experiences survey. SocArXiv.

Belgium. Following guidelines on collecting data on sexual orientation and gender identity (Gates & Badgett, 2009; Motmans et al., 2020), self-identification questions were used to identify whether participants considered themselves to be heterosexual, homosexual/lesbian, bisexual, pansexual, omnisexual, or asexual and/or identified as a man, a woman, a trans man, a trans woman or as other with an option to complete with the preferred gender identity. Further we asked about sex at birth, diagnosed intersex or disorders of sex development (DSD), how masculine and feminine other people would describe them, about their sexual attraction and sexual behaviour. The variable describing LGBTQIA+ was created by merging the self-identification questions regarding gender and sexual orientation into one. Every participant was also asked to indicate whether they considered themselves to belong to a minority group in Belgium and to if so, related to which characteristic (i.e. sexual orientation, gender identity, intersex or DSD condition, religion or life philosophy, skin colour, ethnicity, disability, age or another characteristic). Participants who indicated to belong to a minority group, received an adapted version of the minority stress measure (Outland, 2016) relevant to the characteristic they had indicated.

To measure mental health, we used international scales which were validated in several age groups. Depression was assessed using the Patient Health Questionnaire (PHQ)-9 (Kroenke & Spitzer, 2002) and anxiety was measured using the General Anxiety Disorder (GAD)-7 (Löwe et al., 2008), which assessed symptoms in the two weeks before the interview. A cut-off score of five on both scales was regarded as a positive screening for depression and anxiety. Posttraumatic Stress Disorder (PTSD) was measured with the PC-PTSD-5, which questioned symptoms in the month before the interview (Prins et al., 2015). A score of three on a maximum of six was regarded as PTSD. Resilience was assessed using the Brief Resilience Scale (BRS) (Smith et al., 2008). This scale comprised a 6-item 5-point-Likerscale. A score from 1.00 to 2.99 was considered as low resilience, 3.00 to 4.30 as normal resilience, and 4.31 to 5.00 as high resilience. We screened for hazardous alcohol use with the AUDIT-C (Babor et al. 2001). In accordance to the guidelines of 'Vlaamse Expertisecentrum voor Alcohol en andere Drugs (VAD)' we used a cut-off score of four for females and five for males on this 3-item scales with a total score between zero and 12 (VAD, 2017). In addition to the validated scales, participants received yes-no questions on suicide attempt, self-harm, and use of sedatives, cannabis and other drugs, both during lifetime and in the past 12 months.

Second, discussions were held with the (inter)national experts that were members of the project's Interdisciplinary Guidance Committee (henceforth IGC). The IGC consisted of 32 members, including academics with outstanding expertise in the field of SV research in Europe, Canada, the United States of America (U.S.) and the global South. Other members were representing several Belgian federal institutes and organizations (e.g., federal legal institute for criminal policy, federal institute for public health, organizations against the maltreatment of elderly, federal agency for the reception of applicants of international protection, federal institute for equality between women and men, the Belgian police). This phase included additional content validation (including evidence based on test content) of the questionnaire focusing on expert opinions. The IGC members were asked to provide their feedback on the revisions made to the SES-R focusing on whether the applied theoretical construct of SV was measured adequately. More specifically, the conceptual definition was

presented and discussed with the members of the IGC. Next, discussions were initiated about the included items and whether the theoretical construct was well represented. Tapping on a diverse panel of experts is especially relevant in this aspect to detect complexities and underrepresentation's in the construct that otherwise remain undetected (AERA et al., 2014). Afterwards, the questionnaire was adapted based on their feedback and the revised questionnaire was again discussed with the IGC. This continued until the researchers and the IGC reached consensus regarding the included items. Overall, three feedback waves occurred. After reaching consensus regarding the items included in the questionnaire, the questionnaire was translated from English to Dutch and French and approved by the Medical Ethical Committee of Ghent University Hospital (2018/1204).

Third, a face and final content validation was conducted among 49 (20 male and 29 female) potential participants of the final survey, hence called population panel, and 36 experts that were not a member of the project's IGC. This expert panel consisted of psychiatrists, psychologists, policy makers, academics, people working in LGBTQIA+ organizations, in associations for older adults, and in the asylum reception sector. The participants of the population panel were recruited through personal and professional networks (i.e. friends, family, colleagues and then snowballed) of the researchers and members of the project, provided they met the criteria for inclusion for the eventual study. The majority (i.e. $n = 39$) of the population panel identified as heterosexual. Twenty participants indicated that they or one of their parents were born outside Belgium (i.e. first or second generation migrant). Participants were selected within four age groups (16-24, 25-49, 50-69 and 70-100). Most participants were between 25-49 years old ($n = 28$), followed by the 70+ age group ($n = 12$). The 50 until 69 year olds only accounted for six participants and finally only three participants were aged between 16-24 years old. Respondents were provided with the questionnaire in the language of their choice along with an evaluation form. The majority of the participants filled in the questionnaire in Dutch ($n = 31$), followed by French ($n = 11$) and English ($n = 7$).

The validity testing was either done by the participants themselves ($n = 17$) or with a researcher being present in order to elicit discussion and evaluate the cognitive processes of the participants when answering the items (i.e. evidence based on response processes) ($n = 32$). Members from the expert panel were asked to perform the validation test by themselves. All respondents were asked to provide comments on the questions in terms of wording, format and presence of ambiguities. In addition, they were presented with several statements regarding the content and difficulty of the questionnaire and the acceptability of the questions included. They were asked to indicate their agreement/acceptability on a five-point Likert scale ranging from *completely disagree/unacceptable* to *completely agree/acceptable*. Based on the comments received by the participants and the expert panel, the questionnaire was adapted and proofread before implementation in the project.

In the following, we present the various changes made to the SES-R based on the three main phases as described above. This includes a description of the theoretical discussions pointing out the limitations in the SES, changes made to improve these limitations, and changes made based on the feedback received through content and face validation efforts.

3.2.2 *First and second phase – the initial revisions made to the SES-R*

After developing a first draft of the questionnaire, the draft was presented and discussed with the IGC. The team reached consensus regarding the changes presented below that were the result of the literature readings, comparisons with existing questionnaires and theoretical definitions of SV, and discussions and feedback waves between the researchers and the IGC.

3.2.2.1 The consent language

Given the emphasis on the aspect of wantedness in our study, this phrase was replaced by 'when I didn't want it to happen/to look at them/to see it' (depending on the type of incident that is asked). These phrasings were based on the consent language used in NISVS survey (Smith et al., 2017).

3.2.2.2 A gendered bias

To avoid a gender bias in the items, we used the term "someone" to refer to the assailant regardless of the anatomy, sex and gender of the respondent and did not include separate questions for men and women, thus resolving the inequality in the number of questions for each gender. The item was rephrased as follows: 'Someone put their penis, finger(s) or object(s) into my vagina or anus against my will'. As pronoun, we used "their" to be inclusive to trans, non-binary and intersex persons as well.

3.2.2.3 Double-barrelled questions and merging items

Generally, a questionnaire should include straightforward, unbiased language and avoid double-barrelled questions (i.e., asking two things in one question) (Williams, 2003). The researchers and members of the IGC, however, felt some double-barrelled questions were still visible in the SES-R. Therefore, the item 'someone fondled, kissed, or rubbed up against private areas of my body or removed some of my clothes' was split up to three separate items: fondling or rubbing, kissing, and removing clothes.

Additionally, various items without physical contact (visible in the SES-R long forms; Koss et al., 2006) were combined given the overlap between these items and to reduce the length of the scale. For example, the items 'someone sent me sexual or obscene materials such as pictures, jokes, or stories in the mail or over the Internet' and "someone showed me pornographic pictures' were combined to 'someone showed me sexual or obscene materials such as pictures, videos,... directly or over the internet (including email, social networks and chat platforms)'.

Similarly, the items assessing someone watching the victim while they were undressing, nude, or having sex and the item asking about taking photos or videotapes while being in the same circumstances were merged. This merged item aimed to assess voyeurism with one question in accordance with the definition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Voyeurism, or voyeuristic disorder, is defined as "a condition characterized by deriving intense and recurrent sexual arousal from watching unsuspecting person(s) while they are having sex, disrobe or are nude" (Balon, 2016, p. 63). These two items were merged because taking photos of or videotaping someone implies that the assailant is watching the victim at some point. Based on the opinions of the IGC members, we added that the person had to have caught someone conducting these behaviours (i.e. 'I caught someone watching me, taking photos or filming me when I didn't want it to happen while I was

undressing, nude or having sex') since the victim had to become aware of this behaviour at some point to be able to state that this had happened to them.

Finally, in line with recommendations of behavioural specification we added an explanation of oral sex to ensure that the item is interpreted in a similar manner by all respondents. We therefore included the following phrase 'with oral sex we mean placing the mouth on genitals'.

3.2.2.4 Reference period

The SES-R utilizes two timeframes (i.e. "in the past 12 months" and "since age 14") to assess the incidence of sexual victimisation (Koss et al., 2007). These time frames, however, do not measure childhood sexual assault (CSA) before the age of 14. In the current study, the reference period "since age 14" was replaced by "lifetime" to allow for a complete overview of the incidence of SV in people's lives that also includes CSA. However, the current phrasing does not enable one to distinguish CSA from adult sexual assault. Therefore, a follow-up question was added in which participants were asked how old they were when this happened for the first time. The timeframe "in the past 12 months" was kept identical. These timeframes are often used in SV research (see Depraetere et al., 2020a) allowing for greater comparability between studies.

3.2.2.5 Missing items

Based on the literature search and consultation of additional questionnaires, the researchers and IGC felt various items were missing to comprehensively measure the concept SV. These items include:

1. being made to show their intimate body parts;
2. receiving sexual or obscene text(s) in addition to phone calls;
3. distribution of naked pictures or videos of the victim via internet or directly;
4. not allowing someone to express their sexual orientation;
5. denying someone's sexual needs;
6. not having explained the sexual side effects of a treatment by a health professional;²
7. touching the intimate body parts of someone during care; and
8. being made to penetrate the perpetrator or someone else.

Item 1: This item was already recognized as a form of sexual harassment since 2003 by the UNHCR as being forced to undress in a sexual context (Keygnaert, 2014; UNHCR, 2003). The item in particular was derived from the NISVS survey (Smith et al., 2017) who phrased it as "made you show your sexual body parts to them when you didn't want it to happen?". In their study from 2010-2012, they found that over 32% of U.S. women were victim of non-contact unwanted sexual experiences in their lives that included exposing sexual body parts, masturbating or flashing in front of the victim or making the victim show his or her sexual body parts. A Belgian study performed in 2013 (Hellemans & Buysse, 2013) also found being forced to be naked was reported by 5.2% of the male and female participants before the age of 18

² Items 4-6 were ultimately not included in the questionnaire; see Third phase – additional validation of the revisions

and by 1.9% after the age of 18. These numbers indicate that this items should be included as a form of SV.

Item 2: In addition, we added “sexual or obscene text” in addition to phone calls as it was the opinion of the researchers and IGC that in today’s society, texts are more often used compared to phone calls.

Item 3: This item includes a measure for sharing naked pictures or videos of someone. Generally, this sexual behaviour can fall under various terms, such as sexting, non-consensual sharing of images, revenge pornography, and sextortion. Sextortion may include any of these acts but, additionally, also needs to include some form of coercion where the victim is forced to provide additional pictures, engage in sexual activity, or agree to other demands (Wolak et al., 2018). This type of SV is only relatively recently recognized in research, whereby prevalence numbers remain rather scarce (Wolak et al., 2018). A recent study from Patchin and Hinduja (2020) performed in 2016 among 5,569 high school students found that approximately 5% of students reported being victim of sextortion. Another recent study from Powell and Henry (2016) regarding technology-facilitated SV, among 2,956 Australian respondents aged 18 to 54 years old, showed that approximately 10.7% of the respondents reported that they were photographed online while being nude. Over 9% of the participants reported that nude images were posted online or sent to others without their permission. Approximately 8% reported that the same thing happened for a photo or video of an unwanted sexual experience. These initial numbers indicate that this form of SV is relatively often reported and should be included in SV scales.

Items 4 until 7: Item 4 was added to the operationalization of sexual neglect that includes not respecting someone’s sexual orientation or gender identity. Research has shown that sexual minorities encounter unique challenges as a result of their sexual orientation, gender identity, or gender expression. Various scholars showed that they are often the victim of bullying, harassment, and discrimination, have a higher risk of sexual (re)victimisation, and often fear for their physical safety (Heidt et al., 2005; Knauer, 2009; Meyer, 2012; Rankin, 2005). In her study among 1669 self-identified lesbian, gay, bisexual or transgender college students, Rankin (2005) found 38% felt pressured to conceal their sexual orientation or gender identity and over 50% did so to avoid intimidation. Knauer (2009) even states that research among older adults needs to include questions about sexual orientation and gender identity given the lack of research regarding experiences with homophobia in this population.

Other aspects of sexual neglect include not treating people as sexual beings (item 5) and disrespect of sexual intimacy (e.g. touching during care; item 7). This is particularly relevant for older adults who are often considered as people without any sexual needs (Kessel, 2001; Nobels et al., 2020; Nobels et al., 2018) but also among people who need care due to a disability (Basile et al., 2016; Shaqiri et al., 2018). Additionally, not explaining the sexual side-effects of a treatment (item 6) can be considered as a form of denying one’s sexual needs. Scholars showed that sexual side effects are often minimized among older patients compared to younger patients (Schroyen et al., 2018) and older patients often feel too embarrassed to discuss loss of sexual function because they believed they would be considered as ‘too old’ to worry about this (O’Brien et al., 2011). While research has already examined attitudes of caregivers regarding sexual health among older adults (e.g. Gott et al., 2004; Saunamäki & Engström, 2014), the prevalence of sexual neglect remains largely under-researched (Nobels

et al., 2020). Generally, sexual neglect was recently added to the definition of mistreatment of older adults by the Research Chair on Mistreatment of Older Adults (CIUSSS, 2017). While this definition was specific for older adults, a limitation based on age was not included for these forms of SV to allow applicability of these items in the general population.

Item 8: Both Anderson et al. (2018) and Canan et al. (2020) point out that the SES-R does not assess men being forced to penetrate the perpetrator or someone else. Koss et al. (2007) have stated that this form of penetration did not fall within the U.S. legal definition of rape at the time the revisions were made to the original SES. The applied legal definition only focused on penetration of the victim's body. However, since then, the definition of rape in the U.S. was broadened to penetration that occurs without the victim's consent without specifying whether this only included the victim's body being penetrated (Canan et al., 2020). In addition, the WHO defines rape as "contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object" (WHO, 2015). This definition does not specify whether the victim's body is the one being penetrated or the one performing the penetration. A recent literature review from Depraetere et al. (2020b) showed that forced penetration is often used in surveys and is found to be an important aspect when measuring male sexual victimisation. However, to avoid a gendered bias, the current study did not only present this item to men because women may also be forced to penetrate the perpetrator or someone else by hand, finger, or objects. We, therefore, added the item "someone made me put my penis, finger(s) or object(s) into their (or someone's) vagina or anus against my will" for all respondents.

3.2.2.6 Coercion strategies

Finally, the coercion strategies were changed according to the SAV-S scale from Krahé and Berger (2013). They based their scale on the SES-R but provided a cross-classification of three forms of coercive strategies: (1) the use or threat of physical force, (2) exploitation of the victim's inability to resist due to for example alcohol or drugs consumption, and (3) verbal pressure. In addition to these three coercion types, exploitation of one's position of authority or power of someone was added as a coercion type. This tactic was not included in the SES-R with the reasoning that this coercion strategy is seldom used. Yet, previous research about sexual victimisation against forced migrants found this type of coercion to be a prevalent strategy (Keygnaert, 2014a; Keygnaert et al., 2014). Also, a representative study by Garcia et al. (2003) among the active working population in Belgium showed that 8% were victim of unwanted sexual behaviours at work and mostly involved a superior. The researchers and IGC, therefore, believed that this coercion strategy could occur in other positions of authority and can be considered as an important aspect for developing policy measures.

3.2.3 *Third phase – additional validation of the revisions*

After reaching consensus regarding changes made to the SES-R and approval by the Medical Ethical Committee, the questionnaire was translated and a face and additional content validation was performed. Based on the feedback received by both the population and expert panel, additional changes were made.

Generally, respondents indicated a high acceptability of the SV items and did not indicate the questionnaire to be embarrassing or upsetting. The questionnaire was thus well

received. Respondents, however, indicated that the questionnaire layout was difficult to navigate. The piloted questionnaire used a similar format as the one used in the SES-R, including a table where respondents are asked to indicate how many times they experienced a certain incident in their lives and in the past 12 months. Respondents had to indicate a number going from 0 to 3+ for each coercion strategy. Several respondents commented that this format was confusing and stated that it was unclear how to answer these questions if none of the presented coercion strategies were applicable when the incident occurred under other circumstances.

We, therefore, simplified the questionnaire format to individual questions regarding the prevalence of the incident, followed by a question regarding the circumstances of the incident (i.e. coercion strategies). The questionnaire now starts with a question regarding the lifetime incidence in a yes/no format. If the respondent indicated yes, they were asked whether this had happened to them more than once in their lives, followed by a question asking them how many times it happened in the past 12 months. The used coercion strategy was asked as a follow-up question where participants were instructed that multiple answers were possible and the option 'none of the above' was added. While a yes/no format was not recommended in the SES-R (Koss et al., 2007), we believed that simplifying the format would benefit the respondents, their willingness to answer these sensitive questions, and diminish questionnaire fatigue that would lead to higher non-response rate. This assumption was, however, not experimentally tested.

Some members of the expert panel as well as the population panel commented that various items had to be deleted or adapted. As a result, items 4, 5 and 6 (cf. supra) regarding sexual neglect were deleted. Only item 7 (i.e. 'touching the intimate body parts of someone during care') was kept. The other items were considered too broad for respondents to appreciate what the researchers were inquiring and prohibiting meaningful interpretations afterwards. Moreover, the item "someone made sexual motions to me" (incorporated from the SES-R) was deleted since members of the expert panel believed this item allowed for too much interpretation from the respondent. Moreover, the items measuring "showing the private areas of their body" and "masturbating in front of someone" were combined to one item since both items overlap (someone masturbating in front of someone often show their intimate body parts at the same time). Keeping these items separate would otherwise result in overlapping prevalence rates. The item was rephrased to "someone showed their intimate body parts (e.g. breasts, vagina, penis, anus) to me in a sexual way and/or masturbated in front of me when I didn't want to see it."

3.2.4 Sampling Procedure³

The National Register, containing information on all Belgian residents, was used as a sampling frame from which Belgian residents were sampled to participate in an online survey. A random disproportionate stratified sample consisting of an equal number of male and female participants equally divided in three age groups was drawn by the National Register. By

³ The findings presented below have been published in Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>

applying a disproportionate stratified sample method certain subgroups are overrepresented. This overrepresentation is corrected by applying survey weights.

In total, 20,760 Belgian residents between 16 and 69 years were contacted in three waves by post by the Belgian National Register in October and November 2019. The desired sample size was calculated using a margin of error of 2% and a significance level of 5%. The effect size was estimated at 10% based on previous research on prevalence rates for Belgium (e.g. Krahe et al., 2015). These sample size calculations resulted in an a-priori sample size of $n = 864$ per subgroup leading to a total of 5,190 participants. Taking non-response and refusals to participate into account, four times this number of participants were contacted (i.e. $N = 20,760$).

To limit self-selection bias, the study was presented as a survey about health, sexuality, and well-being. The respondents could access the self-administered online survey using either a link or a QR code indicated in the letter sent by the National Register. The survey was administered through the survey software Qualtrics. Prior to participation, respondents were provided additional information on the study and an informed consent form. Only those who gave informed consent were able to participate in the survey. To increase response rates, participants received one reminder letter after two weeks and were informed about the possibility to receive a randomly assigned voucher worth 30 EUR. For the latter, they were redirected to a separate short questionnaire after completing the main survey to ensure that survey answers could not be linked to personal contact information.

3.2.5 *Second data collection*

Initially, we planned to send out three reminders to the potential participants to increase response rates. Due to new data protection regulations (Regulation 2016/679 of the European Parliament and of the Council, 2016) and requirements of the National Register, only one reminder was allowed. This may be one reason for the response rate to this online survey being lower than expected. To increase sample size, a second data collection was conducted. This was requested at the National Register shortly after the first data collection was concluded but was ultimately only approved after the COVID-19 pandemic had started. The National Register resumed their activities in Summer 2020, and so, the second data collection could begin. However, the pandemic was not yet over, and therefore, the data obtained in this second wave need to be viewed with the pandemic, lockdown measures, and the changes to everyday life in mind. As this report's focus is not on the implications of COVID-19 on SV, we will only provide a brief overview of the differences in prevalence between Wave 1 (Oct – Dec 2019) and Wave 2 (Sept 2020 – Jan 2021).

3.2.6 *WP2.2: Face-to-face structured interviews of vulnerable groups*

3.2.6.1 Older adults

3.2.6.1.1 Acceptability of the questionnaire in older adults

We performed a two-phase pilot study to test the acceptability and feasibility of the questionnaire in older adults. In the first face validity phase, we consulted 12 older adults and ten experts to measure the extent to which the questionnaire appeared relevant, important, and interesting to our target population (Holden, 2010). In the second phase, we conducted 50

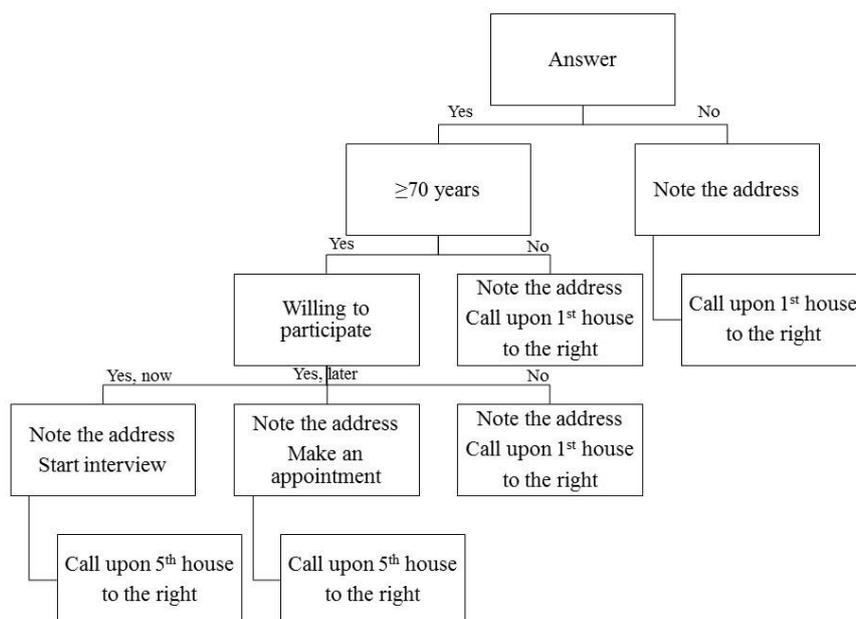
structured face-to-face interviews with community-dwelling older adults to assess the feasibility of the data collection procedure. Based on the recommendations of participants and experts, we made some final adaptations to the questionnaire.

3.2.6.1.2 Interviewers

The interviews were performed by Anne Nobels (consortium member) and 48 external interviewers (67% female, 33% male, mean age of 43 years). The interviewers were carefully selected and received specialised training in which they were confronted with their own attitudes, fears and stereotypes towards SV and older adults. Moreover, the training gave them the opportunity to come to terms with their own (direct or indirect) exposure towards SV (WHO, 2016). The research team provided close guidance to the interviewers via a social media group, email or telephone. They were instructed to call after the first day of interviewing and in the case of experiencing a dangerous situation. Additionally, all interviewers participated in at least two debriefing meetings. Individual debriefing sessions were organised if needed.

3.2.6.1.3 Data collection procedure

Originally, the intention was to acquire the contact details of a representative sample of older adults living in Belgium through the National Register. However, since the implementation of GDPR, the National register can only provide personal details of possible participants of scientific research via an active opt-in procedure. A representative sample of potential participants would be contacted by the National Register, informing them of the study's goals and asking them to provide their written consent and contact details to the research team. As, this procedure could lead to bias in participation and could endanger the representativeness of the sample and the validity of the research results (Bijleveld, 2015), we decided to change our data-collection procedure to a cluster random probability sampling with a random route finding approach. Eligible participants within each cluster were identified using a random walk finding approach (Lewis-Beck et al., 2003). Interviewers were provided with a randomly selected starting address and followed a strict set of rules that guided the selection of subsequent houses at pre-specified intervals (see Figure 1). One cluster was completed after six interviews.



1

Figure 1. Flowchart random walk procedure (Nobels et al., 2021a)

Interviewers called upon every house on their route. After conducting an interview or making an appointment, they called on the fifth house. At every crossing, they alternated between left and right. Every household was only invited once to participate. In nursing homes and assisted living facilities, we randomly invited one person per unit using the Kisch selection method (Lavrakas, 2008).

Face-to face interviews were conducted in Dutch, French, or English in the participant's home using a tablet or computer. Both older adults living in the community and living in nursing homes or assisted living facilities were included. Only one older adult per household could participate and proxy respondents were not allowed. Participants had to be 70 years or older, live in Belgium, and have sufficient cognitive ability to complete the interview. Cognitive status was not formally assessed but was evaluated based on the ability to maintain attention during the interview and the consistency of the participant's answer by means of a control question comparing the participant's birth year and age (Boaz et al., 2018).

The random probability sampling method has proven to be time consuming and inefficient, especially given the specific safety constraints in SV research (Nobels et al, 2021a). Between July 2019 and March 2020 we contacted 15,599 households, of which 1,805 (12%) were eligible to participate. Eventually, 513 interviews were conducted. Time spent going from-door-to-door eclipsed time spent interviewing. One interview took on average 54 minutes. In order to conduct one interview, interviewers had to contact on average 37 households and spent on average 88 min. In total, we spent approximately 68 working days only calling at doors. As a result, the random walk finding approach was perceived as very challenging, leading to a premature drop out of 21 interviewers and the need for additional recruitment and training (Nobels et al, 2021a). Moreover, due to the COVID-19 pandemic and associated lockdown measures data-collection was stopped prematurely in March 2020. As a result, we conducted 513 instead of 845 interviews.

3.2.6.2 Applicants for international protection

Applicants for international protection (AIPs) are considered a hard-to-reach population because of their high mobility, accessibility through asylum reception centres, frequent restricted internet access, language barriers, possible low levels of literacy (Thomas & Byford, 2003; Correa-Velez & Gifford, 2007; Benseman, 2012; Sydor, 2013; Alam & Imran, 2015; De Schrijver et al., 2018). In order to increase the response rate among this population and to allow persons with lower literacy levels to participate in the study, we chose to collect data in this population using the same questionnaire as in the Nationally Representative Self-Report Study on Sexual Violence (see WP2.1: Nationally Representative Self-Report Study on Sexual Violence) but conducted in structured laptop or tablet assisted face-to-face structured interviews by trained interviewers.

The questionnaire was designed in such a way to be suitable for structured tablet/laptop assisted personal interviews with AIPs and tested on face validity between August and September 2018 (see WP2.1: Nationally Representative Self-Report Study on Sexual Violence). The face validity evaluation process followed two steps for this target population:

1. Experts and various members of the target population (from different age groups, genders, sexual orientations, migration status,...) were asked to fill in the questionnaire and to evaluate the acceptability and phrasing of the questions using a standardized evaluation form to evaluate the acceptability of the questionnaire in the AIP population. Per target population, 5 to 10 persons were asked to make an evaluation.
2. The standard questionnaire was adapted based on the feedback from the experts and members of the target population in order for the questionnaire to be used efficiently in structured tablet/laptop assisted personal interviews with AIPs. Where needed, instructions for interviewers were added to enhance the flow of the personal interview.

The questionnaire was (back-)translated into English, French, Dutch, Arabic, Dari, Farsi and Pashtu. These languages were chosen based on the most frequently spoken languages in AIPs when data collection was planned. We worked with an offline version of the questionnaire to make it possible to conduct the structured interviews on locations without internet connection. We recruited and trained interviewers speaking at least one of the languages participants were fluent in.

Originally, participants would have been selected through a probability sampling scheme to ensure that representative and significant statements could be made regarding sexual victimisation in the AIP population residing in Belgium.

We based our sample size calculations on previous studies done on AIPs, which resulted in a target of approximately 400 interviews with AIPs: 200 in Flanders and 200 in Brussels and Wallonia. Taking into account non-response and refusal to participate due to the sensitivity of the topic, we estimated that up to 4 times as many people would have to be contacted to reach the targeted response rate.

The Waiting Register of the Belgian National Register was foreseen to serve as the sampling frame, as it contains the (contact) data of those foreign persons who declare

themselves or ask to be recognized as refugees. Via this register it's possible to access information on all AIPs. Participants would have been randomly selected from the register.

Due to the implementation of the GDPR legislation, inviting AIPs directly via the Waiting Register was no longer possible because selected potential respondents for interviews could no longer be contacted without their permission. An alternative sampling procedure was thus required, which was developed in collaboration with Fedasil and Rode Kruis. The reception facilities for AIPs in Belgium comprise collective and individual reception structures (Federal Agency for the Reception of Asylum Seekers - Fedasil, 2020). The individual reception structures or 'local reception initiatives', are housing organised by the Public Social Welfare Centres and NGO's. Fedasil, "Rode Kruis – Vlaanderen (Rode Kruis)" for the Flemish region and "Croix-Rouge de Belgique, Communauté francophone (Croix-Rouge)" for Wallonia and Brussels or other partners manage the collective structures or 'reception centres' (Federal Agency for the Reception of Asylum Seekers - Fedasil, 2020).

The Match-it database is the online database that contains information about AIPs in Belgium in function of the management of both collective and individual reception places and residents (usually AIPs) in the Belgian reception network (see Sociale Zekerheid, 2020). The Match-It database was put forward to serve as the new main sampling frame. However, in period of implementing the new recruitment strategy (July 2019), the Match-It database was still under development. AIPs staying in reception initiatives of the Rode Kruis and Croix-Rouge were planned to only be included in this database as of the second half of 2019. To draw a representative sample, a proportionate number of AIPs had to be randomly selected from the internal Rode Kruis and Croix-Rouge databases as well using the same sampling criteria: 65% of the AIPs were selected from the Match-It database and 35% from the Rode Kruis and Croix-Rouge databases. The following waves in 2020 had to be drawn in the same manner from these 3 main databases since the integration of those into the Match-it database had not been completed by the end of 2019.

Because of the GDPR legislation, drawing the lists with selected AIPs from the existing databases had to be done in an encrypted manner. The head offices of the reception structures (Match-it, Rode Kruis and Croix-Rouge) drew a random sample, based on the criteria provided by the research team, such as legal status, age, gender and nationality. 'Language' was not included in the databases, therefore nationality was used as a proxy to sample respondents who were likely to speak one of seven languages (cf. supra). The 142 nationalities included were based on list of countries where at least one of the languages (English, French, Dutch, Arabic, Dari, Farsi or Pashtu) is spoken.

We received three lists of unique codes that corresponded to respective potential participants: one from Fedasil based on the Match-it database, one from Rode Kruis and one from Croix-Rouge. This unique code allowed to identify where the potential respondent was staying: either in a reception centre or in a local reception initiative. By complying to the GDPR, a supplementary step to ask for consent to acquire contact details of the participants from Fedasil, Rode Kruis or Croix Rouge was introduced.

Potential respondents were contacted and helped by the social services of Fedasil and Rode Kruis to visit a newly designed the website. The website was translated in six languages (English, Dutch, French, Arabic, Farsi, Pashto) and could be consulted in written or audio version. Croix Rouge couldn't apply this procedure and asked to send letters with instructions

to potential respondents residing in their centres. If a participant agreed to be contacted for an interview, the research team was notified automatically via this website and contacted the local persons of contact in the centres to obtain the contact details of this potential participant. At this stage the AIP did not yet agree to participate in the interview. Consent to participate in the study was only officially given before the interview. Interviewers speaking the corresponding language would then plan the interview. If the potential participant refused participation at that stage, no data would be collected. This recruitment procedure is described in full details elsewhere (see De Schrijver et al., 2021).

Unfortunately, our study had to be stopped before we reached the target sample size of 400 AIPs due to the COVID-19 containment measures taken by the Belgian government in the beginning of March 2020. To be able to reach our target of 400 interviews, an alternative approach was designed in consultation with the Fedasil and Rode Kruis. The face-to-face interviews were replaced by an online survey and the questionnaire was translated into Spanish and Tigrinya to match the new comer AIP population at that time and to increase the target population. Upon ethical approval in July 2020, this new strategy was applied in August 2020 in collaboration with Fedasil and Croix Rouge. Due to the many challenges the pandemic introduced, Rode Kruis was not longer able to participate in our study. Data collection ran until October 31st, 2020 but as the pandemic continued, insufficient AIPs could be reached to participate in our study. The target of 400 AIPs could thus not be reached.

3.2.7 WP2.3: SAS Knowledge, Attitude & Practice (KAP)- Survey in Professionals

To grasp the knowledge, the attitudes and practices (KAP) of doctors regarding the SAS (Sexual Aggression Set)- the medico-legal tool used in Belgium in the response to SV-, and therefore to realize objective 4 of this study, an online questionnaire has been designed. This questionnaire was based upon a literature review and general interviews with key actors and build around several sections: background characteristics, prevalence of SV, and the KAP, which consists of three parts: knowledge of the SAS (and SACC⁴), experience with the SAS and opinion on SV and the SAS.

Firstly, a test version of the survey was designed. This version was validated by sending it, on paper, to 72 doctors selected according to different criteria: type of specialization, language (French and Dutch), geographical location (Flanders, Brussels and Wallonia), gender, type of institution,... Twenty doctors sent back their commentaries. Secondly, several face to face interviews were conducted allowing in depth live commentaries on the survey. Finally the survey was updated and questions were reformulated based upon the commentaries given both on paper as during the interviews. The Dutch and French versions were discussed repeatedly so as to ensure that all phrases and questions were formulated as identically as possible.

To reach as many doctors in a limited time and because of the limited project funding, the researchers resorted to an online survey. The online survey was conducted using SurveyMonkey, because it is both user friendly for respondents and also budget friendly.

⁴ The Sexual Assault Care Centre for victims which is currently being developed in Belgium.

Unfortunately, the lack of available means to use a paper survey introduced a kind of coverage error, in that medical doctors without a known email address could not be reached.

The survey was administered with the collaboration of the National Council of the Order of doctors. Through their newsletter the survey was sent to all doctors active in Belgium (i.e. not retired, active abroad,...) with a certain specialization: general practitioners, gynaecologists, urologists, paediatricians, geriatricians, emergency doctors, gastroenterologists, psychiatrists and sport doctors. These specializations were chosen based upon the interviews with key actors (cfr. *supra*) and because these are doctors to whom victims of SV can turn directly without being referred to by another doctor.

By sending the survey through the newsletter of the National Council of the Order of doctors the researchers have no access to the name or e-mail addresses of the doctors. Basic population characteristics were provided by the National Council, including sex, age, specialisation and the place of registration as a medical doctor. The survey was first sent on the 7th of June 2019, with two reminders on the 21st of June 2019 and on the 1st of August 2019.

The KAP approach was chosen because it allows a much more rapid view of a certain issues, domains or instruments. Given the fact that many doctors are flooded with propositions to participate in research projects and many are so occupied by their day- to day work with patients, this type of approach seemed most suited as an instrument for this study. It also meant that the survey introduction had to include a note on the time needed to fill out the questionnaire and the importance of the topics covered in it. For most of the respondents, the time to fill out the entire survey would approximately be 5 minutes. In spite of this short length, which seemed more of an advantage (in promoting participation) than a loss (of information in terms of details), it could not prevent a limited participation rate. Since the survey was sent with the newsletter of the National Council (amidst the outpour of mails that arrive on a daily basis), only a segment of all doctors carefully took a look at it. This non-response rate means that it cannot be precluded that those who decided not to participate in the survey differ in one or several meaningful variables from those that did participate in the survey. Thus, any result from the survey has to be dealt with using caution. As far as the representativity of the results are concerned, corrections can be made using weights related to basic demographic characteristics (such as the distribution of age, sex), but these will not correct the non-response bias.

3.3 WP3: Qualitative Study

3.3.1 WP 3.1: In-depth interviews with victims of all ages, genders and sexual orientations

3.3.1.1 Objectives

The objective of the qualitative study was to address objectives 2, 3 and 5 of the UN-MENAMAIS study. In short, this study was aimed to explore to what extent people were exposed to SV, how this impacted their lives but also how it may have had an impact on the family, friends, colleagues and so on. Further, we also wanted to understand better how victims cope with SV and whether or not they sought help upon victimisation. Based on the in-depth interviews with victims, we strived to formulate recommendations for prevention of SV and for

care upon sexual victimisation. Ethical approval of an amendment containing the topic list, information letters and informed consent files to be used in the qualitative study was received on May 21st, 2019 from the ethical committee of UGent/UZ Gent (Belgian registration number: B670201837542).

To reach this goal, we planned to conduct interviews with victims of all ages, gender identities, sexual orientations and legal statuses. We estimated that we would need to do 140-168 interviews with persons in the age category of 16 years up to 69 year olds to reach saturation in every subgroup. Further, we also planned to do 15 to 18 interviews with older adults. The planned number of interviews per subgroup can be found in TABLE I.

TABLE I. Number of planned in-depth interviews per identified subgroup

| Subgroup | Target number (Min-Max) |
|---|------------------------------------|
| Men | 30 - 36 |
| Women | 30 - 36 |
| Non-cis gender persons | 15 - 18 |
| Non-heterosexual persons | 15 - 18 |
| 1 st , 2 nd , 3 th generation migrants; including Applicants for international protection | 15 - 18 |
| 16-24 years old | 10-12 |
| 25-34 years old | 10-12 |
| 35-49 years old | 10-12 |
| 50-69 years old | 10-12 |
| Total number of participants aged 16-69 years old | 140-168 |
| Older adults (+70 years) | 15-18 |
| Total number of participants aged 16-100 years old | 155-186 |

3.3.1.2 Interview guide

We started the project with a thorough literature review (cf. WP1: Literature review and desk study). Based on that review we identified essential questions for this study. Some of these questions were better suited for the online and face-to-face survey; while others required rather a semi-structured interviewing approach. The questions were assigned to the methodology with the best fit for collecting qualitative data with minimal bias. In a later stage these data would be triangulated for complementarity.

Starting from our hypotheses and the final version of the survey, we developed a script for conducting the in-depth interviews as well as a relevant topic list as a guide for the semi-structured in-depth interviews with victims. We have tested this topic list for face validity and interviewers were trained to apply the script and topic list in a sensitive, disclosure enhancing but flexible way.

During the in-depth interviews, participants received questions regarding:

- their definition of SV
- the context of direct and indirect exposure to SV victimisation and perpetration
- consequences and impact of SV for all involved

- impact on family & peers and transgenerational transmission
- perceived reasons for victimisation and/or perpetration
- coping with SV victimisation
- help-seeking behaviours and the help they did or did not received
- suggestions for SV prevention
- suggestion for care upon sexual victimisation

The final script with topic list as used in the in-depth interviews can be found in annex.

3.3.1.3 Recruitment strategy

Most participants for in-depth interviews were recruited upon their participation in the online survey and the face-to-face interviews conducted with older adults and AIPs (see WP2: Quantitative Study).

When participants indicated in the survey that they had been exposed to a type of SV, they were asked at the end of the questionnaire whether they would be interested in participating in an in-depth interview regarding their experiences. Since we targeted to interview victims for all age groups, genders, sexual orientations and legal statuses, additional recruitment was needed for specific subgroups: older adults, male victims, victims with a migration background and LGBTQIA+ victims. These additional recruitment rounds took place via the piloting phase in light of WP2, via social media, relevant organisations (e.g. Cavaria; Vluchtenlingenwerk Vlaanderen; Rainbow House Brussels; Transgender Infopunt;), sexual assault care centres, psychiatry wards (i.e. for older adults) and so on.

3.3.1.4 Qualitative data collection

In-depth interviews were planned between January 2020 and June 2020. Unfortunately, the COVID-19 pandemic forced us to stop data collection in March 2020. Since the social distance measures to prevent a further spread of the virus prevented us from continuing with real life face-to-face interviews, we explored other options to continue our data collection in a time-efficient, qualitative and safe way. As such, after receiving ethical approval for the adapted methodology in July 2020, we switched to doing the interviews online through a secure connection (via Belnet) or via telephone and resumed interviewing from August 2020 until January 2021. Qualitative data was collected up to saturation (see TABLE II).

The pandemic did have an important impact on reaching specific harder to reach subgroups such as AIPs who do not always have access to the internet in a place where they can talk freely about their experiences. Also sexual and gender minorities became harder to reach as we could not actively recruit them at LGBTQIA+ friendly events. However, switching to online interviews did not impact the quality of our data. Based on the transcriptions of the interviews, one cannot identify based on the data collected whether it concerns a real life or digitally conducted in-depth interview.

In the end, we managed to collect data from 140 persons aged 16-69 years who were exposed to SV and from 18 persons aged +70 years. TABLE II presents the number of in-depth interviews done per subgroup. We like to stress that all interviewees are counted in more than one subgroup (e.g. gender and age). Overall, recruitment of female victims ($n = 109$) was easier than male ($n = 46$), non-cisgender ($n = 6$) and intersex ($n = 0$) victims. Some victims

identified both with male or female gender and as non-cisgender ($n = 3$). Unfortunately, some of the audio recordings of the interviews conducted online or over the telephone were of too poor quality to be transcribed and analysed. We ultimately included 153 interviews in the analysis. The only subgroup we did not reach saturation for was for the subgroup 'non-cisgender persons'.

TABLE II. The adjusted target number of in-depth interviews per subgroup for WP3.1 and the final number of in-depth interviews (n).

| Subgroup | Adjusted target number | n |
|---|-------------------------------|------------|
| Men | 30 | 41 |
| Women | 30 | 95 |
| Non-cis gender persons | 15 | 6 |
| Non-heterosexual persons | 15 | 41 |
| 1 st , 2 nd , 3 th generation migrants | 20 | 24 |
| Applicants for international protection | 15 | 12 |
| 16-24 years old | 15 | 43 |
| 25-34 years old | 15 | 45 |
| 35-49 years old | 15 | 26 |
| 50-69 years old | 15 | 26 |
| Total number of participants (16-69 years) | 140-168 | 140 |
| Older adults (+70) | 15-18 | 18 |
| Total number of participants (16-100 years) | 145-189 | 158 |

The interviews included in the analysis were conducted in four languages: Dutch ($n = 117$); French ($n = 21$); English ($n = 6$) and Arabic ($n = 8$). Two of the Arabic interviews were conducted by an interviewer who is a native speaker and six of them were done by a Dutch speaking interviewers with native speaker translator.

3.3.1.5 Qualitative data-analyses

To analyse the data we applied a thematic analysis and followed Braun and Clarke's protocol (Braun & Clarke, 2006). The goal of this thematic analysis was to identify relevant themes or patterns of meaning relevant to objectives 2, 3 and 5 within the collected data. The following steps were followed:

1. *Transcription.* All interviews were transcribed verbatim and analysed in the language of the interview. Only the transcriptions of the Arabic interviews were translated into English before analysis.

2. *Second listening.* The accuracy of the transcriptions was verified by another researcher than the one who made the transcription. The transcriptions were compared to the audio recordings before the start of first coding round. Initial ideas for analysis were noted down. The verified text files were processed and analysed using the software NVivo 12.
3. *Construction of the baseline code tree.* Based on the literature review for WP1 and the notes taken by the interviewers and the researchers conducting the second listening, an baseline code tree was developed.
4. *First coding round.* In the first coding round, researchers performed a line-by-line coding with codes derived from the narratives and further developed the baseline code tree inductively.
5. *Second coding round.* Every interviews was individually coded by at least 2 researchers. The code trees from the individual researchers were merged into one and initial reflections on the themes identified in the data were discussed. The merged code tree further served as the backbone of the analysis. By alternating the researchers who transcribed and those who proceeded with the first and second coding rounds, we tried to avoid as much interpretation bias as possible.
6. *Identification of relevant themes.* The codes from the merged code trees were collated into potential themes, which were in turn reviewed to ultimately result in a thematic map for analysis (Braun & Clarke, 2006).
7. *Analysis.* In different loops of analysis, the identified themes were refined and regrouped according to key ideas in light of relevant theoretical frameworks and previous studies until the overall story of the analysis emerged and became clear and definable.

3.3.2 WP 3.2: Focus Groups with professionals and in-depth interviews with victims on SAS
To finalize the realisation of objective 4, a qualitative study was also conducted.

A first part of the qualitative study focused on professionals involved, in any way, in the forensic care of victims of SV and on the victims themselves. The aim was to understand the structural and organizational conditions in which ongoing practices develop, to learn about the experience (or inexperience) that these professionals have with the SAS or other forensic practices, and to better grasp their representations of the victim's experiences and expectations.

Originally, focus groups were planned with members of the judiciary, law enforcement agencies, victim services and the socio-medical sector. Due to the COVID-19 pandemic, such focus groups could not be organized and were replaced by one-on-one semi-structured interviews with these actors, both on- and offline.

A second part of this qualitative study aimed to grasp the knowledge that victims themselves have regarding SAS or other forensic practices, to understand their experiences with it, their representation of the different actors in the process (e.g. judicial, medico-legal, psychological, social,...) and to gather victims' expectations and recommendations regarding the collection of evidence.

Victims were recruited through an announcement on social media, specifically through victim support groups. Judicial and police authorities, hospitals and victim support services

were also contacted to inform victims of the existence of the study so that they could contact the researcher themselves

In addition, various literature and small-scale empirical studies have been carried out on the forensic reception of victims of SV: a prevalence study, an analysis of the legislation and already carried out evaluations and a mapping of the policy on this subject within the Belgian police districts.⁵

3.4 WP4: Policy Recommendations: seminar with Café Dialogue focus groups

A virtual international closing seminar called 'Beyond the tip of the iceberg: Sexual violence in Belgium' was organised on June 17th, 2021 to present the results of the quantitative and qualitative study in a plenary session.

On June 10th 2021, participants to the virtual seminar received a link to five pre-recorded capsules in which the results of the UN-MENAMAIS study were presented by the research team. In the first capsule we explained the methodology applied in the quantitative and qualitative studies in the different populations of interest. The second capsule presented the quantitative and qualitative findings regarding SV in Belgian residents aged 16-69 years. The third capsule focussed on SV in older adults and was followed by a capsule on SV in minority groups such as LGBTQIA+ persons and AIPs. Finally, the findings regarding forensic responses to victims of SV were discussed in Capsule 5.

After viewing these capsules, the seminar participants could send questions to the research team which would be answered during the plenary session hosted on June 17th. The plenary session started with pre-recorded political opening statements and with an introduction and presentation of the state of the art by the project coordinator. The project introduction was followed by five Q&A sessions corresponding with the pre-recorded capsules. During these Q&A sessions researchers answered the previously submitted questions as well as ad hoc questions from the audience.

The plenary session ended with a debate among (inter)national experts on the impact of the UN-MENAMAIS findings on future SV research, on the framing of victimhood and defining sexual violence, and the development of policies, clinical guidelines and care strategies.

Following the virtual international seminar, a Café Dialogue with different rotating focus group tables on specific policy recommendations was held. Based on the findings from the quantitative and qualitative study, the research team had formulated policy recommendations in preparation to this Café Dialogue. After multiple rounds of internal review these recommendations were presented to the participants of the Café Dialogue for validation. These were stakeholders and professionals from various backgrounds including but not limited to SV victim associations, healthcare services, law enforcement and judicial agencies. The goal of these focus groups was to triangulate results from the victim interviews, formulate policy recommendations and test the feasibility of implementing these recommendations. Additionally, they served to gain additional insights into barriers that impede victims from

⁵ These elements were carried out with the support of various interns: Mahé DESMET, Mérédith PIRMEZ, Konstantina KYPRIOTI, Cécilia TALAVERA and Laurence PALMIERI.

reaching out to law enforcement agencies and healthcare services. In total, we organised eighteen focus groups (9 in Dutch and 9 in French) regarding care upon sexual victimisation, judicial approaches and sensitisation and societal image of SV.

The Café Dialogue was organised by means of a rotating system. That way, each participant contributed to the three different tables debating the three different topics. At the first table, the Chair introduced five policy recommendations before opening the debate. The notetaker took minutes. The debate was guided by the following questions (1) What do you think of these policy recommendations? (2) What policy recommendations should be added in response to the obstacles that came out of the study? (3) What should be the focus for politics and policy? (4) How should these recommendations be translated into concrete actions? (5) Who are the stakeholders for these concrete actions?

After 25 minutes of debate, the Chair concluded and the participants moved on to the next online table. At the second table, the Chair presented the conclusion of the first debate. The second group of participants continued the debate, building further on the statements and ideas from the first group. After 25 minutes, the Chair concluded again, and the participants moved on to the third table for the last time. Again, the same procedure was followed. At the end of the third table, each participant had debated the three different topics. By building on the previous group's debate, the recommendations were developed and validated more profoundly as a result of the cooperation and exchange of a large group of people.

The focus group dataset covers objectives 2 through 4 and, in particular, offers additional insights with regard to objectives 2 and 3 and allows to fully achieve objective 4. Finally, we used the gathered information to make scripts for sensitisation campaigns on SV in Belgium (see Annex II. Sensitization scripts following the Café Dialogue).

3.5 Ethical considerations

This study was approved by the Commission for Medical Ethics of Ghent University Hospital on the 21st of November 2018. Amendments were made to the original dossier to conduct the study in line with the new GDPR requirements and the social distance measures installed to prevent a further spread of the COVID-19 virus. The last amendment was approved on the 21st of May 2019. It was designed and performed in line with the principles of the Declaration of Helsinki. This study only included participants of 16 years and older given ethical and practical regulations related to the legal age of consenting to sex, which is 16 years old in Belgium.

4 SCIENTIFIC RESULTS AND RECOMMENDATIONS

4.1 Mechanisms, nature, magnitude and impact of sexual violence on (in)direct victims aged 16-69 years old in Belgium

4.1.1 Introduction

A preparatory CIS was dedicated to SV in males & females. Our aim was to advance our understanding concerning gender differences in prevalence rates. As such, this review was structured around three central research questions, namely how gender differences in prevalence rates can be explained (RQ1), how these gender differences influence the place of men and women within the ideal victim framework of Christie (Christie, 1986) (RQ2) and how this influences the prevalence rates of SV? (RQ3). By doing so, our ultimate goal was to acquire new insights within this theoretical framework.

In general, this CIS once again found most literature focussing on female victims and male assailants. This dichotomist view places male victims and female assailants out of the picture within scientific research and further impacts policy framework developments, since policy is based on research data (Keygnaert, 2014). One of the major objectives of the UN-MENAMAIS project included to explore to what extent the research population has been exposed to SV victimisation and perpetration since childhood (Obj. 2). By specifically mentioning 'exposed' in the objective we aimed to exclude the gender-biased view and include male and female victims and assailants as well as witnesses of SV. As such, the project could have large implications on the overall policy developments and in extend on future research. Furthermore, results of the UN-MENAMAIS project could potentially change these gender-biased attitudes and alter the ideal victim perspective.

Additionally, several important findings in literature were taken into consideration during the execution of the UN-MENAMAIS project. For starters, survey characteristics have a large impact on the prevalence rates of SV. The project therefore applied behaviourally specific questions (BSQs). BSQs describe an incident in concrete terms instead of using more general, likely ambiguous terms (e.g. rape, sexual assault,...) which is strongly recommended in SV research as it limits ambiguity in participant interpretation (Wilson & Miller, 2016; Peterson et al., 2011). Previous research has shown the large influence the framing of a survey has on the answers of the participants (Galesic & Tourangeau, 2007). The UN-MENAMAIS survey was therefore framed as a survey on sexual health, leaving out concepts as 'sexual violence, rape or sexual assault'. Furthermore, given the large differences in the interpretation of non-consent language (Rueff & Gross, 2017; Strang & Peterson, 2017), the project described specific examples of behaviours associated with a lack of consent, as suggested by Strang and Peterson (2017) and left out statements like 'when she didn't want to' or 'without her consent' without further explanation. By taking these aspects into account we aimed to obtain correct estimates regarding the prevalence of SV in the Belgian population.

Finally, within this CIS the central place of gender roles and sexual scripts on the influence of prevalence rates of SV came forward. A major influence thus potentially originates

from society and its current cultural ideas, social norms and shared expectations. However, further research was needed to clarify their relation with sexual victimisation. The project therefore specifically included several variables representing cultural ideas, social norms and shared expectations in the form of gender equality, rape myths acceptance and conformity & agreement with gender roles stereotypes in the survey.

4.1.2 Sample³

Out of the 20,760 Belgian residents that were invited to participate in the first wave of this study, 2,791 respondents initiated the survey, 76% of which completed it. Respondents were excluded due to either not providing informed consent ($n = 261$), not completing the survey ($n = 394$), not meeting the age criteria for participation (i.e., between 16 and 69 years old; $n = 5$), completing the survey more than once ($n = 15$), and concerns about the quality of the responses ($n = 1$). This leaves a total final sample of $n = 2,115$ and an overall response rate of 10.2%. This final sample allows calculating prevalence estimates with a margin of error of 2%. The margin of error in the six sex-by-age groups ranges from 3 to 6%.

Sociodemographic characteristics of the unweighted sample are summarized in TABLE III. When comparing the highest level of education in this sample with that of the entire population, using publicly available population data, it can be seen that higher educated people are overrepresented in the current study. Almost half of all respondents (i.e. 46.7%) completed a level of higher education, while, on the population level, 36% of Belgian residents between 15 and 64 years completed a higher educational level (Statbel, 2020). The number of people that completed no education or only primary education reflects the proportion on the population level (i.e. 7.6%; Statbel, 2020). The amount of non-heterosexual persons taking part in our survey is with 11% similar to rates obtained in other online surveys (Coffman et al., 2017; Herbenick et al., 2010).

The researchers were provided with the distribution of men and women across age groups in the entire population aged 16 to 69. These comparisons show that young females are overrepresented in this sample. In the analysis of prevalence estimates, sample weights are used to correct for this bias in order to obtain representative estimates with respect to sex and age. A correction for other factors, such as education, was not possible because these numbers could not be obtained from the National Register.

Due to changes in EU law on data protection (Regulation 2016/679 of the European Parliament and of the Council, 2016), sampling information drawn from the National Register could not be shared with the researchers. Thus, the sampling and contacting of the participants was executed by the National Register. We were, therefore, limited in the number of reminders that could be sent to potential participants and were not able to perform a non-response analysis.

³ The findings presented below have been published in Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>

TABLE III. Sample composition ($n = 2,115$), unweighted

| Variable | | <i>n</i> (valid %) |
|-----------------------------------|--------------------------------|----------------------|
| Sex | Female | 1164 (55.0) |
| | Male | 951 (45.0) |
| Age in years (M (SD), range) | | 35.84 (16.75), 16–69 |
| Educational level | Primary education or none | 155 (7.3) |
| | Secondary education | 974 (46.1) |
| | Higher education | 986 (46.6) |
| Occupational status | Active ¹ | 996 (47.1) |
| | Student | 693 (32.8) |
| | Inactive or other ² | 426 (20.1) |
| Sexual orientation ($n = 1997$) | Heterosexual | 1871 (89.2) |
| | Bisexual | 95 (4.5) |
| | Homosexual | 53 (2.5) |
| | Pan-, omnisexual | 43 (2.0) |
| | Asexual | 11 (0.5) |
| | Other | 24 (1.2) |

¹ Combines the following categories: Employed/independent, contributing family member, voluntary work.

² Combines the following categories: Financial self-sufficiency or any other type of alternative choice of living, housewife/-man, not able to work because of ill health, on the job market / looking for a job, retired, other.

Source: Schapansky et al. (2021)

In the qualitative phase of the study, a total of 129 victims aged 16 up to 69 years old participated in the in-depth interviews. 124 of these interviews were included in the analysis. The bulk of interviews was conducted with direct victims of SV. Saturation was reached for each age category. Among the interviewees, 40 persons were between 16 and 24 years old, 39 between 25 and 34, 21 between 35 and 49 and 24 between 50 and 69. In this subpopulation we reached 86 victims who identified as female, 32 as male, 3 as non-binary and 3 victims who identified both as female and as non-binary. Most of the participants identified as heterosexual; 40 persons identified as not-heterosexual. Specificities regarding sexual and gender minorities will be discussed in 4.3.1 Sexual and gender minorities.

The data collected in the quantitative and qualitative study were triangulated for complementarity and interpreted in light of the findings in the CIS that was relevant for that specific research population.

4.1.3 Prevalence of Sexual Victimization³

Overall, 64.1% (95% CI: 61.9-66.1) of Belgian residents between 16 and 69 years experienced some form of sexual victimisation during their lifetimes, and 44.1% (95% CI: 41.9-46.2) in the

³ The findings presented below have been published in Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>

past 12 months. More specifically, 59.3% (95% CI: 57.2-61.4) have experienced at least one form of hands-off victimisation, and 30.4% (95% CI: 28.5-32.4) at least one form of hands-on victimisation during their lifetimes.

4.1.3.1 Sex Differences

The lifetime prevalence of sexual victimisation for women was 81% which is 1.7 times higher than the estimate for men (47.5%; $X^2(2, n = 2,117.2) = 256.6; p < 0.001; \phi = 0.35$). About four in five women (78%) and two in five men (41%) reported some form of hands-off sexual victimisation. Hands-on victimisation was reported by two in five women (42%) and one in five men (19%).

The difference in victimisation rates between women and men in the past 12 months was smaller compared to lifetime prevalence rates but still significant ($X^2(2, n = 2,117.2) = 123.7; p < 0.001; \phi = 0.24$). More than half of women (55%) and a third of men (31%) experienced some form of hands-off sexual victimisation in the past 12 months. Prevalence rates of hands-on victimisation in the past 12 months were 10% and 6% for women and men, respectively.

4.1.3.2 Age Differences

Lifetime prevalence rates show that, in general, respondents younger than 50 years were significantly more likely to report hands-off forms of SV compared to those aged 50 to 69. The prevalence in the past 12 months for both men and women was highest in the youngest age group and lowest in the oldest for nearly all forms of sexual victimisation. Women between 16 and 24 showed the highest prevalence (79%) and men between the ages of 50 and 69 the lowest (22.7%).

Hands-off. Women under the age of 50 reported more hands-off victimisation than women between 50 and 69 years, both over the life course and in the past 12 months. More specifically, the prevalence of display and distribution of sexual images was more than six times higher among women between 16 and 24 compared to those aged 50 to 69. The results for men were similar. Prevalence rates for both men and women between 16 and 24 did not differ significantly from those aged 25 to 49.

Hands-on. The age differences for hands-on sexual victimisation were smaller among the female respondents compared to the hands-off forms. About 45% of women aged 16 to 24 and 40% of women aged 25 to 49 reported some form of hands-on victimisation during their lifetime. No significant age differences were found for lifetime hands-on victimisation among women. However, women younger than 50 years reported unwanted rubbing/fondling significantly more often than women aged 50 to 69. Women between 16 and 24 years reported unwanted touching during care more often than women between 50 and 69 years.

For men, the highest prevalence rates of hands-on victimisation were found in the youngest age group while the oldest age group reported the lowest prevalence rates. A significant age difference was found for unwanted rubbing/fondling and overall hands-on sexual victimisation in the past 12 months.

4.1.3.3 Coercive Strategies

Most respondents (60%) indicated that none of the provided coercion strategies applied. This is the case for all forms of sexual abuse, except for being undressed against one's will, where

the (threat of) using physical force was indicated most often (33%). For completed rape, using physical force, or the threat thereof, was also indicated most often (26%). Overall, the coercion strategy indicated most often the exploitation of the victim's incapacitated state (25%), followed by (threat of) using physical force (21%), exploiting a position of authority or power (18%) and verbal pressure (13%). Respondents could provide multiple answers unless 'None of the above' was indicated.

4.1.4 Comparison with Other Prevalence Studies³

We further made a comparison of the current study's prevalence estimates to those obtained by other prevalence studies. These studies were selected because they were conducted within the past ten years in Belgium (Buysse et al., 2013; Krahé et al., 2015) or in neighbouring countries. The latter includes a representative Dutch study (Haas et al., 2012) and a non-representative but large-scale German study (Krahé & Berger, 2013). To match our prevalence estimates as much as possible with these prevalence rates, we adjusted our analysis regarding respondents' age and victimisation items. This comparison shows that our prevalence estimates are substantially higher than those obtained in the Netherlands (Haas et al., 2012) and in Belgium (Buysse et al., 2013; Krahé et al., 2015). Only the study conducted with a large student sample in Germany yielded similar results (Krahé & Berger, 2013).

The study by Buysse et al. (2013) is representative of the Dutch-speaking part of Belgium and included both hands-off and hands-on behaviours. However, the authors did not use BSQs and provide no overall lifetime prevalence rate which limits the comparability with other studies. The Dutch nationally representative study (Haas et al., 2012) also assessed hands-off and hands-on behaviours, but used at least in parts BSQs to do so, and found higher rates than Buysse et al. (Buysse et al., 2013) in Flanders, Belgium. However, not all items were behaviourally specific (e.g. "I was raped.", p 600). As both studies included an age range similar to or larger than ours, we did not adjust the sample to match our results.

In a study with German students aged 19 to 31, Krahé and Berger (2013) used BSQs but excluded hands-off victimisation and incidents that occurred before the legal age of consent (i.e. 14 years in Germany). The authors also paired the questions with four coercion strategies, namely, verbal pressure, (threat of) physical force, the exploitation of an incapacitated state or of a position of authority or power over the victim. Consequently, experiences that did not involve one of those coercion strategies were not assessed.

The same applies to the study by Krahé et al. (2015) conducted in Belgium. Furthermore, the authors also assessed sexual victimisation that occurred after the legal age of consent, which is 16 years in Belgium. For these two studies, we matched the age range of the respondents and included only hands-on victimisation from which we excluded the item 'Someone touched my intimate body parts during care'. In our data, it was not possible to exclude experiences that occurred before the legal age of consent to match the results further.

³ Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>

TABLE IV. Comparison of prevalence studies on sexual lifetime victimisation

| Author | Country | Sample | | Prevalence rates (%) | | Items |
|---|---------------|--------|----------|-----------------------------|-----------------------------|--|
| | | Age | <i>n</i> | Men | Women | |
| Buyse et al. (2013) | BE (Flanders) | 14-80 | 1,825 | <18y: 6.3% >18y: 2.3% | <18y: 10.6% >18y: 17.4% | Hands-off and hands-on, non-BSQ |
| Current study | BE | 16-69 | 2,117.2 | 47.5 (95% CI: 44.4-50.5) | 80.8 (95% CI: 78.3-83.1) | Hands-off and hands-on, BSQ, entire lifespan |
| Haas et al. (2012) | NL | 15-70 | 6,428 | 20.5 | 55.9 | Hands-off (limited) and hands-on, partially BSQ |
| Current study | BE | 16-69 | 2,117.2 | 47.5 (95% CI: 44.4-50.5) | 80.8 (95% CI: 78.3-83.1) | Hands-off and hands-on, BSQ |
| Krahé and Berger (2013) | GER | 19-31 | 2,149 | 19.4 | 35.9 | Only hands-on, BSQ, based on SES, only experiences after age 14 |
| Current study | BE | 19-31 | 508.6 | 19.9 (95% CI: 15.1-25.6) | 41.1 (95% CI: 35.2-47.2) | Only hands-on (without 'touching in care'), BSQ, entire lifespan |
| Krahé et al. (2015) – Belgian subsample | BE | 18-27 | 393 | 10.1 | 20.4 | Only hands-on, BSQ, based on SES, only experiences after age 16 |
| Current study | BE | 18-27 | 368.8 | 20.5 (95% CI: 14.9-27.4) | 41.6 (95% CI: 34.6-48.9) | Only hands-on (without 'touching in care'), BSQ, entire lifespan |

Source: Schapansky et al. (2021)

4.1.5 Changes in Prevalence During COVID-19 Pandemic

The second data collection was not only initiated to increase sample size overall but also to balance out differences in response rate across the subgroups in order to achieve sufficient statistical power in each group. Therefore, the sample of the second data collection is, on average, older. Applying sample weights is here especially important when comparing the prevalence of SV in these two waves to reduce a gender and age bias in the results. The prevalence estimates of each wave presented below (TABLE V) are representative of the Belgian population aged 16 to 69 with regard to sex and age. The only significant difference in overall rates can be found for hands-on sexual victimisation in the past year. Here, the prevalence was significantly lower in Wave 2.

TABLE V. Differences in prevalence rates before and during Covid-19 pandemic

| | Wave 1 | Wave 2 | Difference | |
|----------------|-----------------|-----------------|------------|-----------------|
| | <i>n</i> = 2115 | <i>n</i> = 2710 | χ^2 | <i>p</i> -value |
| Lifetime | | | | |
| Hands-off | 59.3 | 56.7 | 3.24 | .072 |
| Hands-on | 30.4 | 30.5 | 0.00 | .989 |
| Past 12 months | | | | |
| Hands-off | 0.7 | 1.0 | 1.1 | .294 |
| Hands-on | 1.2 | 0.6 | 4.32 | .038 |

4.1.6 Risk Factors of Sexual Victimization³

We conducted a logistic regression analysis to identify factors associated with sexual victimisation that may constitute risk factors.. This analysis has the advantage that it controls for the effects of all other variables in the model. The results indicated that young, female and non-heterosexual people are more likely to be victimized. Also, a higher number of sexual partners was related to a higher likelihood of sexual victimisation as was being in a relatively difficult financial situation. Education level had no effect.

4.1.6.1 Sex and Age

All other factors being controlled, women were more likely than men to be sexually victimized, both in their lifetimes and in the past 12 months. Comparing the different age groups, young adults were most likely to be victimized as compared to those aged 25 years or older and those between 25 and 49 years old were more likely than the oldest age group to be victimized, both in their lifetimes and in the past 12 months.

4.1.6.2 Sexuality and Relationships

Seventy-eight percent (95% CI: 71.0-83.1) of non-heterosexual persons experienced some form of sexual victimisation in their lifetimes and were significantly more likely to be victimized than heterosexual persons. About four in five of all respondents (82%, $n = 1,739$) reported that they ever had sexual intercourse in their lives. For 15.3% ($n = 318$) of the entire sample, this occurred before the age of 16. This early sexual initiation was linked to an increased likelihood of sexual victimisation. The association was, however, only significant for past-year victimisation. Furthermore, half of the participants ($n = 1,043$) indicated that they had three or more sexual partners in their lives which was associated with a higher likelihood of sexual victimisation.

Almost half of all respondents (48.7%, $n = 1,030$) reported to be living with a partner and 17.5% ($n = 370$) reported having a partner but not living together. Living with a partner was linked to a decreased risk of sexual victimisation in the past 12 months when compared to respondents without a partner.

4.1.6.3 Socio-Economic Factors

Respondents' level of completed education was not significantly associated with the likelihood of sexual victimisation. Also, being a student was not associated with an increased likelihood compared to (self-)employed people or voluntary workers. Inactive respondents, on the other hand, were less likely to be victimized. Furthermore, the logistic regression analysis revealed an increased likelihood of sexual victimisation for those who described their financial situation as difficult.

³ Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>

4.1.7 Perceived Consequences of SV & Mental Health in Victims

Self-reported negative consequences of hands-on victimisation were on average rather low. Respondents were asked to indicate on a scale from 1 (= not at all) to 5 (= very much) whether they had, for example, emotional consequences or avoided certain places and/or persons. Item number 6 that someone felt they became stronger due to what happened was reversed for the overall mean.

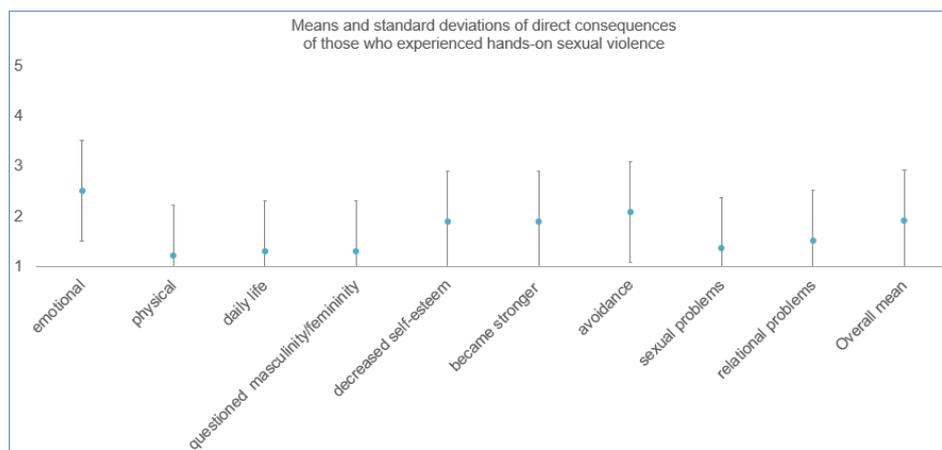


Figure 2. Self-reported consequences of victimisation

Comparing those who ever experienced hands-on SV with those who have not, that substance use and mental health are worse among victims. The effects are, however, small. Sample weights were applied to better reflect the proportion in the population.

People who ever experienced hands-on SV were significantly more likely to consume alcohol or other drugs than non-victims. A problematic drinking behaviour over the past was reported by 42% of victimized persons compared to 37% of non-victimized persons ($\chi^2(1, n = 2105.7) = 5.58, p = .018, \phi = .05$). Ever having used sleep medication or other sedatives was reported by 48% vs. 32% ($\chi^2(1, n = 2105.2) = 47.26, p < .001, \phi = .15$), 32% vs. 23% have ever consumed cannabis ($\chi^2(1, n = 2101.7) = 17.37, p < .001, \phi = .09$), and 9 vs. 5 % have ever consumed stimulants ($\chi^2(1, n = 2097.2) = 8.38, p = .004, \phi = .06$).

A comparison of these two groups on indicators of mental health showed that mental health was significantly worse in those who ever experienced hands-on SV. Depressive symptoms over the past two weeks were reported by 55% of victims vs. 36% of non-victims ($\chi^2(1, n = 2097.0) = 64.29, p < .001, \phi = .18$). Self-harming behaviour over the lifespan was reported by 15% vs. 8% ($\chi^2(1, n = 2108.3) = 27.06, p < .001, \phi = .11$), and having ever attempted to commit suicide by 9% vs. 4% ($\chi^2(1, n = 2106.3) = 17.6, p < .001, \phi = .09$).

Furthermore, anxiety symptoms over the past two weeks were reported by 21% vs. 10% ($\chi^2(1, n = 2093.4) = 43.06, p < .001, \phi = .14$), and post-traumatic stress symptoms over the past month by 19% vs. 8% ($\chi^2(1, n = 2104.7) = 56.97, p < .001, \phi = .16$).

4.1.8 Disclosure & Help-Seeking Behaviour

Respondents were asked whether or not they told anyone about their experience. Both disclosure to informal (e.g., partner, parent, family, friend) and formal (e.g., general practitioner, psychologist, helpline) instances were questioned along with reporting the incident

to the police. In case they had experienced multiple incidences, respondents were asked to refer to the incident that had the biggest impact on them. About half of victimized men and two-thirds of victimized women disclosed their experience to someone in their personal network. Only 7% sought formal help, most of which turned to a mental health care professional and 4% reported the incident to the police or know that someone else did so.

TABLE VI. Disclosure and formal help-seeking behaviour ($n = 1,415$)

| | Women ($n = 948$) % (n) | Men ($n = 467$) % (n) |
|---|-------------------------------------|-----------------------------------|
| Informal disclosure | | |
| Partner | 20.4 (193) | 14.1 (66) |
| Parent | 13.1 (124) | 7.1 (33) |
| Another family member | 8.8 (83) | 3.6 (17) |
| Friend | 37.3 (354) | 27.8 (130) |
| Someone else | 10.0 (95) | 8.6 (40) |
| Did not disclose to anyone | 34.5 (327) | 50.3 (235) |
| Formal help-seeking | | |
| General practitioner | 1.1 (10) | 0.2 (1) |
| Specialist (e.g., gynaecologist) | 0.4 (4) | 0.2 (1) |
| Mental health practitioner (e.g., psychologist) | 3.8 (36) | 0.6 (3) |
| Sexual assault care centre | 0.1 (1) | 0 (0) |
| Helpline | 0.5 (5) | 0.2 (1) |
| Support group | 0.6 (6) | 0 (0) |
| Other | 3.8 (36) | 3.6 (17) |
| Total | 8.3 (79) | 4.9 (23) |
| Police | | |
| No, nobody did | 84.02 (794) | 79.4 (370) |
| No, and I don't know if somebody else did | 11.5 (109) | 18.2 (85) |
| Yes, I did | 3.2 (30) | 1.3 (6) |
| Yes, someone else did it for me | 1.3 (12) | 1.1 (5) |

4.1.9 Prevalence and Characteristics of Sexual Aggression⁶

Due to the overall prevalence of self-disclosed sexual aggression was much lower than the prevalence of victimisation, the two waves of data collection were taken together. Furthermore, only those who filled in the perpetration block of the survey were included, leaving a total sample of $n = 4,693$.

4.1.9.1 Type of Sexual Aggression

Overall, 167 respondents (3.6%) disclosed at least one incident of hands-on sexual aggression (5.7% of men; 1.5% of women). Forty-three respondents (0.9%) reported at least one incident in the past 12 months.

⁶ The findings presented below are derived from the following publication: Schapansky, E., Keygnaert, I., & Vandeviver, C. (2021, June 29). Characteristics and associated factors of self-disclosed sexual aggression in a national representative sample of Belgian adults aged 16-69. SocArXiv. <https://doi.org/10.31235/osf.io/3d2tm>

All questions that followed lifetime and past-year perpetration refer to the most recent incident in case of multiple types or cases. Out of the 167 respondents who reported having perpetrated at least one form of hands-on SV, 62 indicated that kissing someone against their will was the most recent one and 63 indicated fondling or rubbing up against someone's intimate body parts against that person's will. Undressing someone was indicated by four respondents as being the most recent incident. Attempted unwanted oral penetration was indicated by ten respondents, and completed unwanted oral penetration by six respondents. Attempted unwanted vaginal or anal penetration was indicated by nine respondents and completed by ten respondents. Forcing someone else to penetrate the perpetrator was indicated by two respondent.

4.1.9.2 Target of Sexual Aggression

In most cases ($n = 48$, 28.9%), the partner or ex-partner was the target of sexual aggression, in 47 cases (28.3%) a friend, in 32 cases (19.3%) an acquaintance, in 18 cases (10.8%) a colleague or classmate, in 14 cases (8.4%) someone else, in 16 cases (9.6%) someone unknown, and in 9 cases (5.4%) a family member. The answer "Someone I was responsible for" was never selected.. Multiple answers were possible. 119 of the 132 male perpetrators (90.2%) indicated that the act was directed towards one or multiple women, ten (7.6%) towards another man, and three 2.3 indicated the sex was unknown. Out of the 34 female perpetrators, 29 (85.3%) acted towards one or multiple men and five (14.7%) towards another woman.

4.1.9.3 Coercive Strategies Reported by Assailants

Most respondents ($n = 134$, 80.7%) indicated that none of the provided answer options regarding the coercion strategy used applied. Twenty respondents (12.0%) indicated that they exploited the fact that the other person was unable to resist due to consuming too much alcohol or being incapacitated for another reason. Five respondents (3.0%) had used or threatened to use physical force. Four respondents (2.4%) each indicated having exploited their position of authority or power or verbal pressure.

4.1.10 *Framing sexual violence, impact and help-seeking behaviour upon victimisation*

4.1.10.1 What is sexual violence?

Central to the definitions given by the participants in the qualitative study was the notion of consent. Overall, SV was considered behaviour that is sexual in nature without the consent of at least one person involved. Consent could be implicit or explicit in this context. Respondents described that SV can occur by using coercion or as the result of a misuse of power. Further, SV can be both hands-off and hands-on, may exist in all type of relations and all genders can be either victim or assailant. Participants also mentioned that assailants do not necessarily need to be motivated by harming the victim for it to be considered as violence.

4.1.10.2 Exposure to sexual violence

SV experiences seem to be endlessly diverse and to go beyond stereotypical rape myths. Interviewees talked about both hands-off and hands-on SV, often in contexts where the assailant was someone known to them and who applied grooming.

“Indeed it started with kisses on my cheek and then I had to give him a goodnight kiss. And then, if my mom wasn't there, it was on the mouth. And - I didn't like that, but I didn't say that. [...] Yes, it was mostly touching as I passed. That touching, the body, the chest, - the intimate area” (Yasmine, 34).

4.1.10.3 'I did not want this, but is this sexual violence?'

Although victims seem to be able to define SV, many of them indicated that recognising it when they were involved themselves, was not that easy. Many victims link the difficulty of identifying their experience as SV, to the lack of diversity in the societal image of what is considered as SV. The ruling stereotypical images of SV being young women being brutally raped by a stranger with a lot of physical violence rarely matched the SV experiences of the interviewed victims. As such, it was often difficult for them to label their experiences under the same category as the stereotypical image. Many victims go through a phase characterised by knowing that what happened was not something they wanted, but confusion about whether it could be considered as SV.

We extracted from the interviews that victims find it easier to objectively define SV and consent, but initially struggle with naming their subjective experience because of doubts about their own role in what happened. Identifying SV seems easier when the victims themselves said “no, I don't want this” out loud or defended themselves physically. However, when SV occurs in intimate relations, in contexts in which sexual interest can be expressed (e.g. dating, parties, etc.) or where grooming was used to approach the victim, the violence identification process appeared to be interfered by the victim's cognitions – coloured by existing rape myths - about their part and responsibility in what happened. Feelings of guilt and shame tend to be associated with violence identification difficulties and remaining silent.

Tillie (25) for example, experienced SV within her first relationship. She explained:

“I, I thought for a long time actually, ... One, that it was normal, and two, that it was my fault. That that, that, because that was one of his arguments too, is that, um, my libido was too low, and he had urges to um, he had to do that, and um ... And that was my mistake as a person that I couldn't, uh, yeah ... I don't know how it was a bit ... Allez, yeah ... flaw as, as um, as a person that I did not have enough. And so it was my fault that he had to constantly ask for it. And he said like: 'Hey, but, if you, if you ask something every day, and you don't get an answer, then you also become frustrated,' he said.”

She indicated that to her it was not yet clear that you can say 'no' in a relationship as well. Another interviewee, who had been abused by her older brother ever since she was little, explained that the identification of what was happening to her as SV, only occurred as a response to seeing how someone else responded with disgust to her disclosure. Many victims testified having an external viewpoint on the sexual victimisation they were exposed to, helped them to understand the incident(s), their role in it and to recognise it as SV.

4.1.10.4 The impact of sexual victimisation may resonate until years later

The impact of SV ranges from little for some, to life disrupting for others. The consequences of sexual victimisation reported by the victims in the qualitative study were endlessly diverse.

For some it led to trust issues, for others to financial difficulties as a result of having to move out from the house where the assailant lives and still others described how the psychological impact of sexual victimisation set a chain of other negative consequences into motion. The described consequences in the qualitative study were physical, psychological, sexual, reproductive, socio-economic or relational. TABLE VII gives a non-exhaustive summary of the many consequences discussed by victims in our study to give an idea of the diversity in impact.

TABLE VII. Summary of consequences reported by victims aged 16-69 years old.

| | |
|---------------------------------|--|
| Physical | Bleeding |
| | Bruises |
| | Muscle pain |
| | Physical reactions to internal and external triggers |
| Psychological | Anxiety |
| | Acute stress symptoms (ASS) |
| | Symptoms of Post-Traumatic Stress (PTSD) |
| | Obsessive-Compulsive Behaviours |
| | Depressive symptoms |
| | Self-harming behaviours |
| | Suicidal ideation |
| | Suicide attempt(s) |
| | Questioning one's own gender & sexuality |
| | Existential questions |
| | Need for feeling in control |
| Sexual/reproductive | Attachment problems |
| | Need for control in sexual situations |
| | Hypersexual behaviour |
| | Specific triggers preventing full sexual experiences |
| | Vaginism |
| | Dyspareunia |
| | Decreased libido |
| Pregnancy | |
| Miscarriage | |
| Social/relational | Ruptures in families |
| | Relational problems |
| | Difficulties in trusting others: <ul style="list-style-type: none"> • Partners • Friends • Caregivers |
| | Relationship to own children worsened or improved |
| | High medical costs (doctors & psychologist) |
| Financial/socio-economic | Not being able to study well |
| | Losing jobs |
| | Poor employment prospects |
| | Having to leave the house at an early age/before age of majority |

Physical consequences of SV entailed mostly immediate injuries resulting from the physical violence during the SV incident. On the long term, some victims experienced physical reactions to certain triggers associated with the SV incident or the assailant. Loss of energy and fatigue have also been mentioned as results from SV. However, many victims explained that they did not have any physical consequences – which made it hard to prove to others that it had happened and to recognise it as violence – and if they did, they did not consider these as the most important consequences of their victimisation.

Highlighted as more impacting consequences were the need for control in different areas of one's life; specific or generalised trust issues in intimate, familial or friendship relationships; changed sexual experiences and existential questions such as “what would my life have been like if I would not have experienced that”. The psychological impact was stressed by most of the interviewed victims. Many struggled with anxiety and depressive complaints, acute stress symptoms (ASS), post-traumatic stress disorder (PTSD), obsessive and compulsive behaviours (OCD). To cope with the psychological consequences and the physical reactions to certain triggers, some victims tend to display avoidant behaviour. They evade contexts, people, objects etc. that could possibly remind them of the SV. This avoidant behaviour does not only reinforce their anxiety, but it often also hampers their daily functioning.

Some interviewees described how SV had impacted their life by altering their relationships with their loved ones. Either via trust issues and/or the avoidant behaviour but also by “changing” them. As a victim of SV, they had experienced something that others did not, something that others could or did not want to understand and as such that they felt they could not always share. They described that SV changed them and the way they perceived themselves, but also how others perceived them. As a result they felt detached from their partners, families and friends.

The impact and consequences of SV often only become apparent years after the violence started or took place. Many interviewed victims recognised that SV had a significant impact on different areas of their lives, but indicated that it is rather difficult to name that impact. In one way this is caused by not finding the words to explain how they have been affected by SV. In another way, as the effects of sexual victimisation often only emerge over time, victims are sometimes uncertain about whether something can be traced back to the SV or whether this is a characteristic or evolution that would have emerged in their lives even if they would not have been victimised. Cause and effect are not always possible to identify over time.

From the qualitative data, a specific coping mechanism emerged as important underlying mechanism influencing the impact of SV. This coping mechanism resembles ‘motivated reasoning’, which is the tendency to look for arguments in favour of the most desired conclusions rather than those that accurately reflect the evidence for conclusions we do not want to believe. Experienced cognitive dissonance is as such reduced based on emotionally biased reasoning (Kunda, 1990). It appears to be a common coping strategy to cognitively change the story of what has happened to make it bearable. One way or another victims convince themselves that what happened or what is going on, is not as bad as it is. We learned from the qualitative data that as long as story holds, victims seem to be capable to continue their lives with minimal impact of the SV. However, once the violence is recognised and

reasoning shifts, this is often the moment that victims start to realise what the impact on their lives has been or that SV consequences start to emerge. Yet, we cannot derive from the interviews whether victims at that point only became aware of the consequences or whether the SV consequences only arose at that moment.

4.1.10.5 Help-seeking behaviour upon sexual victimisation

As diverse the impact of sexual victimisation is on the lives of those involved, three overarching patterns of help-seeking behaviour surfaced from the qualitative data. In the first one, victims suffer from the violence themselves. In the second, their partners or family are impacted by it. They experience for example relational problems, troubles in daily life, trust issues, excessive need for control, etc.. In these cases, victims seem to turn to informal help sources like family and friends or to professional help such as a psychologist, a social assistant and so on. In the third pathway, victims are rather looking for a way to stop the assailant. Either to protect themselves, someone else or to have the assailant punished. In this pathway, victims will turn to the police.

Many victims stressed that reporting to the police and receiving help to cope with SV consequences are two separate things. Some explained that although they felt the need to disclose the violence to their support network or to talk to a professional about it, they did not feel the need to ever go to the police. Others indicated that in order to be able to set the step to reporting, they first needed to process the victimisation. And still others explained that they did not feel the need to seek help as such, they did want justice and the assailant to be stopped.

Help-seeking appears to be conditional. It depends on whether the victim recognises being wronged (i.e. violence identification process) and that they are in need of help. Further, it also depends on the context in which they find themselves. Is it safe to disclose what happened? And if it is safe to disclose, is it possible to get help? Are care services available and accessible to them? Based on these conditions, help-seeking can occur immediately, but also in the weeks or months following the SV even up to years and years later.

“And then afterwards I told it to someone and he said ‘you could have called the police, hey, that’s just assault’. And then it started sinking into me like, okay, what happened to me was really not okay. And uhm, yes I then told it to my manager” (Chanaia, 29).

Disclosing SV experiences is a continuous process of weighing the pros and cons. Victims are more likely to talk about their experiences when SV happens more frequently, when they are worried about the consequences and when they realise that the violence and/or its consequences are impacting the victim significantly. To disclose SV, one needs to a certain degree identify as “being wronged”.

From the interviews, we learned that disclosure is selective and motivated by the expectation that it will improve their situation or the situation of someone they care about. Often victims disclose because they feel that their own or someone else’s wellbeing is being threatened. There should thus be a good enough reason to do so. If such a reason is not identified, victims remain silent. In selecting when, where and to whom one is going to disclose,

expecting that the response to the disclosure will be positive and that the context in which it takes place is safe, is crucial.

The quantitative study already revealed that most victims do not seek professional help or go to the police (see Disclosure & Help-Seeking Behaviour). This has been confirmed in the in-depth interviews. Many victims say that they did not need any help, they were too ashamed or felt guilty, they could not find the words to explain it or thought that it was no use because they would not be taken seriously or nothing could be done about it.

Not seeking help is often a combination of different reasons. The taboo on talking about both sex and violence also plays a role. The following list of reasonings that resulted into barriers to seeking help is not exhaustive, but highlights the most common themes identified throughout the in-depth interviews. When asked why they did not disclose the SV or why they did not seek help, victims replied with the following reasons:

- *I didn't know yet that this was also violence;*
- *I was not yet aware that I needed help;*
- *I had not yet found the words to ask for help;*
- *I didn't know I could be helped;*
- *No one has ever asked me anything;*
- *I thought it was my fault;*
- *Talking about it hurts too much;*
- *I didn't want to get the assailant in trouble;*
- *The assailant has power over me;*
- *The consequences would be worse if I talked about it than if I were silent about it*
- *Men don't talk about such things*
- *We do not talk about such matters*
- ...

When victims do seek help, they are often confronted with waiting lists and unclear info about where to find help.

4.1.11 A circle of sexual violence

We have learned from this study that everyone – regardless of gender, age, sexual orientation or legal status - can be exposed to SV and that the process of identifying what has happened as violence (i.e. violence identification process), plays an important role in the impact that SV has on one's life. Further, this process influences the seeking help upon victimisation as well. Based on the findings from the CIS, the quantitative and qualitative results from this study, a circle of SV can be drawn to illustrate the underlying mechanisms to sexual victimisation, its impact and help-seeking upon sexual victimisation. Figure 3 shows a basic visualisation of the circle of SV.

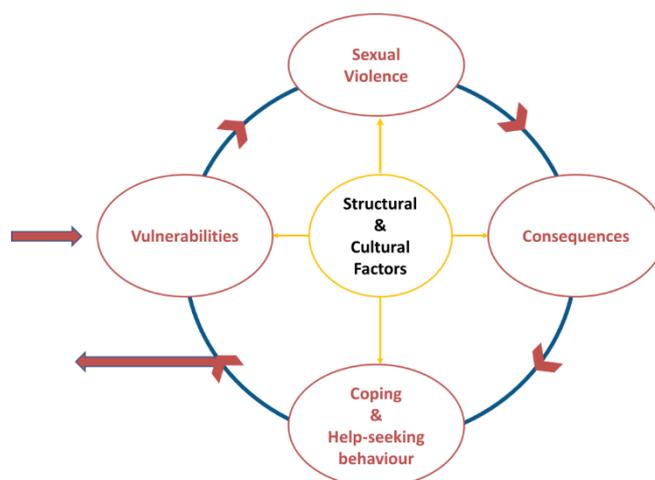


Figure 3. Circle of sexual violence

SV does not exist in a vacuum. Structural and cultural factors impact the underlying mechanisms that give rise to this circle. Simplistically said: one enters the circle when they become in one way or another vulnerable to SV. Being vulnerable may mean that one exhibits the identified risk factors or that one is basically somewhere in the wrong place on the wrong time.

Depending on the context and situation, SV will result in certain consequences. These consequences may for some victims become vulnerabilities for (re)victimisation (e.g. psychological consequences).

When exposed to SV, one has to cope with what has happened and may or may not seek help upon victimisation. This is a crucial stage in the circle, because help-seeking may be the way out of the circle of SV. Seeking help may help to reduce vulnerabilities, help to cope with what happened and prevent (re)victimisation and as such alter the impact SV has on the lives of victims, partners, their family members, friends and peers.

In conclusion, to break the circle of SV, it will be important to invest in exit strategies namely:

- By making individuals and communities less vulnerable to SV
- By providing adequate care to ensure that the consequences of SV do not generate additional vulnerabilities that lead to (re)victimisation
- And by investing in prevention of perpetration.

4.1.11.1 Recommendations for prevention and care given by participants

In the in-depth interviews, victims were asked about what they think would make a difference in terms of prevention and care upon sexual victimisation. This resulted in 2 general recommendations.

Recommendation 1: Break the taboo around SV and teach kids how to set and respect boundaries. This should be done in a variety of ways, but with as essence showing that SV is

much more than what stereotypical rape myths describe. Victims ask for public campaigns regarding SV using public advertisement (posters, slogans on public transportation), public services announcements and by integrating it into popular tv shows and soap operas. Further participants stressed age-appropriate relational and sexual education should start already when kids are still in kindergarten and that this education should address setting and respecting personal boundaries, not only related to sexual behaviour but also in other contexts.

Recommendation 2: Guide victims to specialised, high-quality accessible care. Victims recommend to foresee accessible, affordable and specialised high quality care. It should be clear where to find the right care and this both for acute and historical victimisation. Further, they ask that specific attention does not only go to acute direct victims, but also to indirect victims such as partners, parents, children etc. and victims of historical violence

Further, they highlight the importance of reimbursing (evidence-based) psychological care without limitation on sessions and to respect that people need time to do the psychological work at their own pace. This means that victims should also be able to benefit from the social support system when the SV consequences and therapeutic process to overcome them, hinder the victim to work fulltime.

And lastly, victims explain that they could be better helped if caregivers would be trained to deal with victims, to create safe disclosure contexts and to initiate the conversations regarding SV.

4.1.12 Conclusions and recommendations for science, society and policy makers

Main findings:

- Our study demonstrates that 64% of Belgian inhabitants aged 16 to 69 indicated to have experienced some form of sexual victimization in their lives (81% of women and 48% of men). Moreover, 44% were sexually victimized in the past 12 months.
- Lifetime prevalence: About four in five women (78%) and two in five men (41%) reported some form of hands-off sexual victimization (no physical contact between the assailant and the victim). Hands-on victimization was reported by two in five women (42%) and one in five men (19%). For 19% of the women and 5% of the men this hands-on form of sexual violence, was rape.
- Past-year prevalence: More than half of women (55%) and a third of men (31%) experienced some form of hands-off sexual victimization in the 12 months prior to their participation. Prevalence rates of hands-on victimization in the past 12 months were 10% and 6% for women and men, respectively.

4.1.12.1 Prevention & training

- Start age-appropriate education and training regarding setting and accepting boundaries, sexual consent, relationship and positive sexuality at an early age (during early childhood education), and design trainings that target adults and older adults.

- All public institutions and private companies (e.g. schools, hospitals, government institutions, factories, associations, nursing homes,...) should have policies as well as prevention and care strategies in place to protect and support (future and historical) victims of SV, including creating safe disclosure contexts and providing person-centred support and referral plans.
- Healthcare professionals need to be qualitatively trained to address SV as well as sexual and mental health issues in their patients, including how to provide trauma-informed care in a diversity sensitive manner.
- Training of all law enforcement officials, encompassing the police and the court, who could potentially come into contact with SV victims is essential to ensure the necessary quality and level of a victim-centred approach for the tasks at hand, avoiding further secondary victimisation and/or victim blaming during the interrogation, investigation and judicial follow-up (e.g., in court), enhancing disclosure as well as the eventual willingness to file a complaint.

4.1.12.2 Qualitative, accessible and affordable care

- Victims should be better guided towards adequate care by making the landscape of care upon victimisation more transparent and by developing comprehensive and user-friendly referral guidance tools, that include pathways for direct and indirect victims of both acute and historical SV.
- Provide person-centred care to victims of sexual violence
- Disconnect access to care from police reporting
- Reimburse evidence based psychological care for victims of sexual violence without limitation on sessions.
- Officially recognise sexologists as healthcare professionals as a reference for qualitative care to victims experiencing sexual consequences of victimisation.
- Need for better and faster screening and referral of victims of sexual violence in primary, secondary and tertiary care.
- More attention should be paid to long-term psychological, legal and financial assistance and care. SV can have long-lasting consequences, which may not be borne for years. Victims of historical abuse should also be able to rely on holistic care.
- Improve access to, and increase the number of, trauma specialists for victims of acute and historical SV. In addition, trauma centers should be established to reduce fragmentation.
- Investing in outreaching care for victims and perpetrators.
- Paying attention to care for caregivers by organising intervision and supervision within the institution and/or appointing a reference person to whom caregivers can turn with questions or cases.

4.1.12.3 Communication & campaigns

- Support more adequate communication around SV in public images (e.g. campaigns, television programmes,...) avoiding the perpetuation of rape myths and stereotypical rape

scenarios but rather showcase the different types of SV (such as hands-off and hands-on sexual victimisation and offline and online occurrence) that occur in reality.

- All policy documents should reflect that every individual can be affected by sexual victimisation and thus be inclusive when it comes to gender, age and sexual orientation.
- Involve the media in their educational and awareness-raising role regarding SV and develop guidelines for them on how to create an image of sexuality, gender roles and SV (including trigger warnings) and how they should communicate in a nuanced way.

4.1.12.4 Judicial approach

- Invest in a greater proximity of the police in order to increase the confidence of citizens. There is a need for an outreach and proactive approach. In this context, the possibility of an online declaration of SV can be explored.
 - (Improve) attention for victims in the police and judicial process. This implies that:
 - All victims should be interviewed by specially trained inspectors (vice inspectors);
 - There should be a better flow of information and long-term legal support;
 - There should be attention for the psychological impact of SV and the burden of proof (psychological reports);
 - There should be a better protection of the victim in the whole judicial process;
 - The possibility of anonymous complaints must be examined for certain crimes, in order to increase the willingness to report and to sensitise certain target groups to file a complaint;
 - The process of lodging a complaint with the police and the negative image surrounding it must be improved, especially with regard to vulnerable groups;
 - A (forensic) care policy for victims of historic SV must be developed.
 - There should be more and better links between the social services and police.
 - The judicial response must be accelerated and research must be done on the legal follow-up of cases of SV.

4.1.12.5 Needs for future research

- Clarify the prevalence and impact of technology-facilitated SV in different age groups
- Investigate a wide range of coercion strategies and how they relate to types of SV and impact on victims.
- Define the professional competencies to provide adequate care for victims of SV.
- Investigate how non-judicial recognition of victims can be improved.
- Organise an evaluation of the different models of forensic care in Belgium.
- Investigate the link between severe punishment/tough criminalisation versus assailant assistance and victims' willingness to report.

4.1.13 *Further reading*

Capsule 2: Sexual violence in the Belgian population aged 16-69:

<https://vimeo.com/559891909/9a49e99237>

Published papers:

- Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>
- Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Seksueel geweld in België : aard, omvang en risicofactoren van slachtofferschap van seksueel geweld in een nationaal representatieve bevolkingssteekproef. *Panopticon*, 42(3).
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4.2 Mechanisms, nature, magnitude and impact of sexual violence on (in)direct victims aged +70 years in Belgium

4.2.1 Introduction

Until now older adults were forgotten in research, policies and practices regarding SV (Nobels et al., 2020). Previous research suggests that SV in older adults barely occurs. Meta-analyses from 2017 and 2019, showed that 0.9% of older adults and 2.2% of older women worldwide were sexually victimised in the past year (Yon et al., 2017, Yon et al., 2019). European studies showed past 12 months SV prevalence numbers between 0 and 3% (Nobels et al., 2020). A Belgian study from 1998 demonstrated a lifetime prevalence of SV of 6.3% (Vandenberk et al., 1998). However, these prevalence numbers are underestimated as studies only focus on criminal cases and judicial response or conflate SV with other types of violence into the broader

context of elder abuse and neglect, domestic violence or intimate partner violence (Bows, 2018; Fileborn, 2017; Nobels et al., 2020; Pathak et al., 2019). Moreover, most studies only included hands-on SV (e.g. unwanted kissing, rape), whereas hands-off SV (sexual harassment without physical contact) was not assessed. Yet, research on SV in older adults from a public health perspective, using a broad definition of SV, was lacking.

Evidence shows that sexuality remains important in older age (Lyons et al., 2017). A recent Belgian survey on the sexuality and sexual satisfaction of older adults between 60 and 75 years old found that 84.2% of men and 60.9% of women indicated they were still sexually active during the past 12 months (Traen et al., 2019). However, older adults are still too often considered “asexual” in policies and practices (Gewirtz-Meydan et al., 2018). A group of Canadian researchers, policy makers and healthcare professionals defined sexual neglect as: “a failure to provide privacy, a failure to respect a person’s sexual orientation or gender identity, treating older adults as asexual beings and/or preventing them from expressing their sexuality, etc.” (Leading Practice to Counter the Mistreatment of Older Adults et al., 2017). Recent United Nations (UN) and WHO policy documents dealing with sexual and reproductive health, rights and ageing neither recognise SV in older adults as a potential health risk to be addressed nor mention older adults as a potential risk group for sexual victimisation (Nobels et al., 2020).

Furthermore, this assumption of asexuality may increase the risk of ignoring that older adults can be sexually victimised and in need of tailored care (Nobels et al., 2018). Older adults may internalise the stereotypical image of ‘the asexual older adult’, and as a consequence may not see themselves as possible victims of SV. In turn, this could lead to a reluctance to disclose sexual victimisation, and to seek medical or psychological help (Bodner et al., 2018). In addition, SV in older adults remains largely undetected by health care workers (Nobels et al., 2021b). Many health care workers feel that it is not appropriate to discuss SV with older adults. They are worried it will be upsetting for the victim and are afraid to feel helpless and shocked when confronted with SV disclosure by older victims (Goldblatt et al., 2020).

Extensive research has already shown that SV is linked to mental health problems in adulthood such as depression, anxiety, posttraumatic stress syndrome (PTSD), and alcohol abuse (Hailes et al., 2019, Jonas et al., 2011). However, research on mental health impact of sexual victimisation in older adults is limited. There are some studies showing that childhood sexual abuse is linked with internalising disorders in old age (Ege et al., 2015; Rapsey et al., 2019), but there is no information on the link between SV and alcohol abuse in old age. Also, none of the existing studies apply a life course perspective, including SV during childhood, adulthood and in old age.

To our knowledge, the UN-MENAMAIS study was the first in its kind to assess lifetime and past 12 months sexual victimisation, correlates, assailant characteristics and the way that older victims framed their SV experiences. Moreover, we studied the impact of sexual victimisation on mental health outcomes in old age and the help seeking behaviour of older adults upon sexual victimisation.

4.2.2 Sample

We conducted 513 interviews across Belgium. The study sample was a valid representation of the Belgian population aged 70 years and older (Nobels et al., 2021a). The majority of participants were female (58.3%), mean age was 79 years (SD: 6.4yrs, range 70-99yrs), 89.8% was community-dwelling, 90.4% was born in Belgium, 31.2% completed higher education, 50.3% was in a relationship and 7.4% labelled themselves as non-heterosexual. A detailed description of the sample composition can be found in TABLE VIII.

TABLE VIII. Sociodemographic characteristics of the study population aged 70 and older ($n = 513$)

| Variable | | n (%) |
|---------------------|-----------------------------------|------------|
| Sex at birth | Female | 299 (58.3) |
| | Male | 214 (41.7) |
| Age (mean 79y) | 70-79y | 283 (55.2) |
| | 80-89y | 201 (39.2) |
| | 90-99y | 29 (5.7) |
| Living situation | Community-dwelling | 462 (89.8) |
| | Assisted living facility | 25 (4.9) |
| | Nursing home | 27 (5.3) |
| Country of origin | Belgium | 464 (90.4) |
| | Other | 49 (9.6) |
| Education level | No formal education | 10 (1.9) |
| | Primary education | 117 (22.8) |
| | Secondary education | 116 (22.6) |
| | Technical or vocational education | 109 (21.2) |
| | Religious school | 1 (0.2) |
| | Higher education | 160 (31.2) |
| Sexual orientation | Heterosexual | 475 (92.6) |
| | Non-heterosexual ^a | 38 (7.4) |
| Relationship status | Living together with partner | 225 (44.0) |
| | Relationship, but living apart | 32 (6.3) |
| | No relationship/ partner | 254 (49.7) |

^aThis group contains participants who labelled themselves as homosexual, bisexual, pansexual, asexual or other. In this last group, several participants labelled themselves as “normal”. Since it was not clear whether they had difficulties understanding the different terms defining sexual orientation or whether they indeed labelled their sexual orientation as “other”, we decided to classify these participants as non-heterosexual.

4.2.3 Sexual violence in older adults in Belgium

4.2.3.1 Sexual activity and physical tenderness in later life

Our study refutes the perception that older adults are 'asexual'. Among the participants, 31% indicated to be currently sexually active (including masturbation, sexual intercourse, ...). Among sexually inactive older adults, 32% reported having experienced forms of physical tenderness in the past 12 months. On average, participants indicated having three sexual partners during their lifetime. Only 2% of older adults indicated an absence of lifetime sexual activity. Overall, regardless of their sexual status (sexually active or inactive) older adults reported positive satisfaction with their sexual life and having good or very good quality of life.

4.2.3.2 Prevalence of sexual victimisation in older adults

Overall, we found a lifetime prevalence of SV of 44.2% in our sample of older adults. More than half older females (55.2%) and 29.0% of older males experienced a form of SV during their life. Almost half of women (45.2%) and one in four men (22.4%) experienced hands-off SV, 35.1% of women and 15.9% of men reported hands-on SV. Rape or attempted rape was disclosed by one in twelve females and one in 30 males. In the past 12 months, 8.4% reported at least one form of SV, 7.0% reported hands-off and 2.5% hands-on SV. Unwanted sexual staring, sexual innuendo and kissing were the most commonly reported sexually transgressive behaviours; both during lifetime and in the past 12 months. Exhibitionism was the third most reported hands-off behaviours. Vaginal or anal penetration and attempt of oral penetration were the second and third most reported hands-on behaviours. More information on the SV prevalence of older adults in Belgium can be found in Figure 4, 5 and 6.

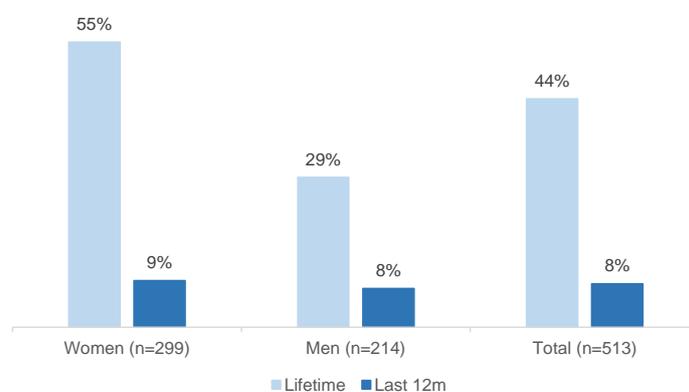


Figure 4. Prevalence of sexual victimisation in older adults in Belgium

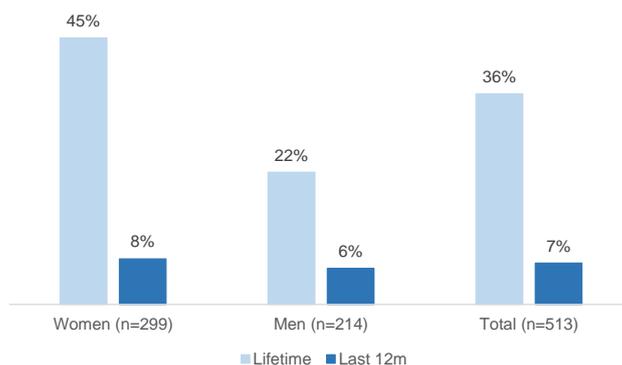


Figure 5. Hands-off sexual violence in older adults in Belgium

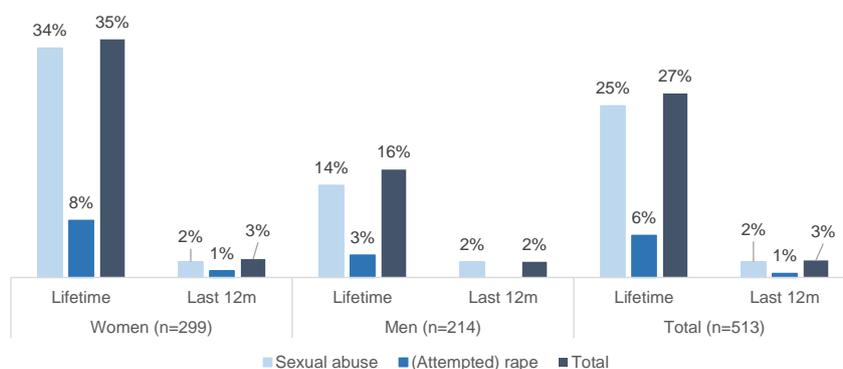


Figure 6. Hands-on sexual violence in older adults in Belgium

4.2.3.3 Context of sexual violence in older adults

Regarding coercion strategies for hands-on SV, one in five victims (21.6%) indicated the (threat of) using physical force, 12.2% reported exploitation of authority, 10.1% verbal pressure and 7.2% exploitation of incapacitation. Moreover, 38.8% indicated that none of the provided response options applied to their situation, indicating that coercion strategies for SV are more diverse than the provided options. For (attempted) rape specifically, (threat of) using physical force was the most commonly identified coercion strategy.

The vast majority of assailants of lifetime SV were male (83.6%), 15.0% were female, and in 1.4% of the cases the sex of the assailant was unknown. In the past 12 months, we found that almost one in four assailants were female (24.4%), 73.3% were male, 24.4% were female and in 0.2% of the cases the sex of the assailant was unknown. The mean age of the assailant committing SV in the past 12 months, as estimated by the victim, was 48.9 years (SD 18.9 years). For lifetime SV, the assailant was most often 'someone unknown' (41.4%), followed by a friend (23.3%), an acquaintance (22.5%), an authority figure (13.7%), a colleague/classmate (11%), a family member (7%), and an (ex)-partner or date (both 5.3%). In the past 12 months, 'someone unknown' was also identified as most common assailant (44.2%), followed by an

acquaintance (37.2%), a friend (27.9%), an authority figure (11.6%), a colleague/classmate (9.3%) and a family member (4.7%). An (ex)-partner or date were not identified as assailants of SV in the past 12 months.

Regarding framing of SV, we found that 47.6% of the cases, SV was framed as 'just something that happened', in 34.4% as 'wrong, but not a crime' and in 23.3% as a crime. Concerning rape, we identified that in 28.1% of cases victims framed it as 'just something that happened', in 28.1% as 'wrong, but not a crime', and in 43.8% as a crime.

4.2.3.4 Characteristics of victims of sexual violence

Women had a 3.6 higher odds to be sexually victimised during their lifetime. However, for the past 12 months we found no difference between women and men regarding sexual victimisation. Older adults with two or more lifetime sexual partners experienced were more likely to have experienced SV in their life compared to participants with fewer than two sexual partners. This difference was not significant in the past 12 months. Moreover, we found that older adults who identified themselves as non-heterosexual experienced significantly more SV in the past 12 months. However, for lifetime SV this difference was not significant.

TABLE IX. Sexual Victimization Correlates in Older adults

| Predictors | | Lifetime SV aOR (95% CI) | Past 12 months SV aOR (95% CI) |
|--|------------------|-----------------------------|-----------------------------------|
| Sex | Female | 3.60 (2.35-5.52) * | 1.57 (0.74-3.34) |
| | Male | Ref | Ref |
| Sexual orientation | Heterosexual | Ref | Ref |
| | Non-heterosexual | 0.80 (0.38-1.70) | 3.23 (1.17-8.94) * |
| N of lifetime sexual partners ^a | <2 | Ref | Ref |
| | ≥ 2 | 1.54 (1.01-2.34)* | 1.93 (0.92-4.04) |

Abbreviations: SV = Sexual violence, aOR = adjusted odds ratio
**p<.05*
^aNumber of lifetime sexual partners was dichotomized based on the median

4.2.3.5 Mental health consequences of sexual victimisation in older adults

Our results confirm previous research indicating that mental health problems are common in older adults (WHO, 2017). More than one in four participants (28%) reported depressive symptoms, 25% reported anxiety symptoms, and 5.7% suffered from PTSD. Almost 2% had attempted suicide in the past 12 months and 1.4% reported self-harm in the same period. Almost one in four older adults (22.4%) reported hazardous alcohol use and 38.8% used sedatives in the past 12 months. You can find the mental health outcomes of the study population in Figure 7.

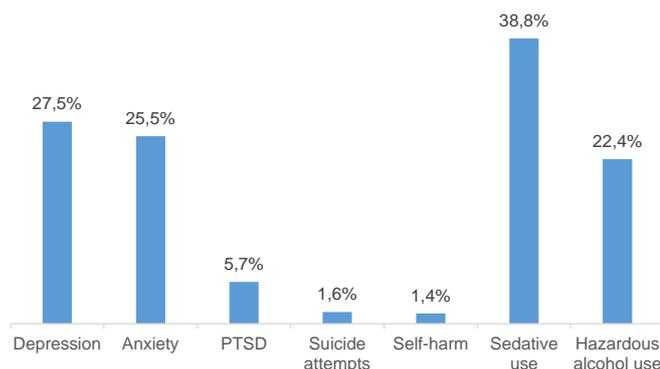
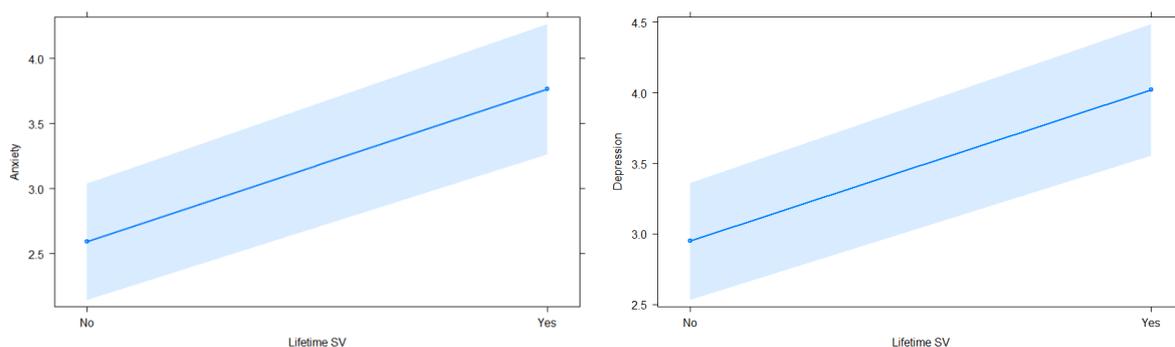


Figure 7. Mental health outcomes in older adults living in Belgium ($n = 513$)
 Depressive and anxiety symptoms in the two weeks prior to the interview.
 PTSD one month prior to the interview.
 Suicide attempts, self-harm and sedative use in the past 12 months.

Furthermore, our study showed that lifetime sexual victimisation was associated with current depression, and anxiety in old age. For PTSD we found an association in older adults with a chronic illness/disability or no/lower education. Figure 8 shows the direction of the association between lifetime sexual victimisation and depression, anxiety and PTSD. Regarding alcohol use we found that female victims have a 2.9 higher odds to report hazardous alcohol use in old age, compared to older women who did not experience SV. In males we found no difference between victims and non-victims regarding hazardous alcohol use in old age. We found no link between lifetime sexual victimisation and suicide attempts, self-harm, and sedative use in old age.

Exposure to SV in the past 12 months did not influence the relation between lifetime sexual victimisation and mental health outcomes, suggesting that exposure to SV earlier in life had such an important impact on the victims' mental health, that the impact of a recent SV event made no difference. Also, resilience and social support did not moderate the relation between lifetime SV and mental health problems, which shows that even older victims with a high resilience and social support have an increased risk to suffer from mental health problems in old age.



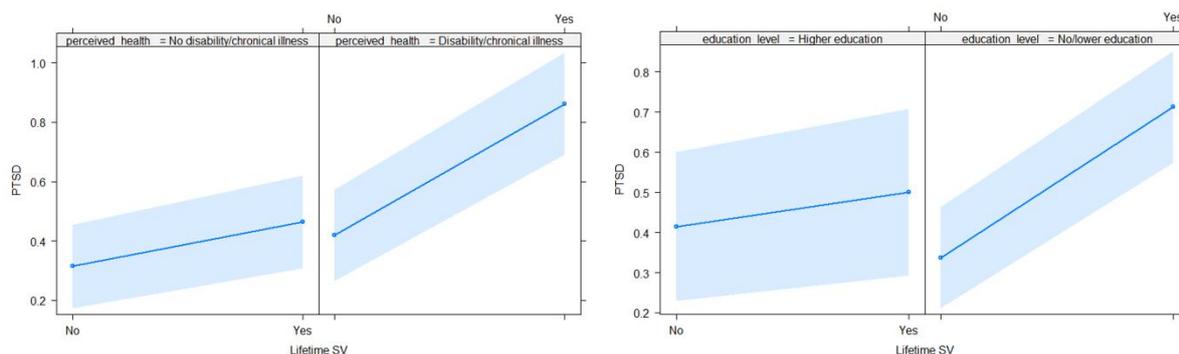


Figure 8. Association between lifetime sexual victimisation with depression, anxiety and PTSD in older adults (Nobels et al. 2021c)

4.2.3.6 Help seeking behaviour upon sexual victimisation in older adults

Information on help seeking behaviour upon sexual victimisation can be found in Table X. The vast majority of older victims (59.9%) never disclosed their SV experience(s). Victims who disclosed did this most often to their partner (41.8%), a friend (30.8%) and other family members (26.4%). However, many victims did not receive support after disclosing their SV experience, were blamed for its occurrence or even experienced more SV upon disclosing. These reactions withheld victims from further disclosure or seeking help:

“It was not credible, even if you told so. You always got the blame. In fact, the blame was always bounced back to you And in the end you keep silent.” (Francine, 76 years)

Some victims waited for a very long time before disclosing their experience, sometimes more than 50 years, such as Thiery:

“I told this for the first time to the person I now have a relationship with, [...] who I really trust. She is the only one who knows.” (Thiery, 72 years)

TABLE X. Help seeking upon sexual victimisation in older adults

| Variable | n (%) | | n (%) ^a | |
|------------------------------------|-------|------------|---|-----------|
| Disclosure ^b (n=227) | No | 136 (59.9) | | |
| | Yes | 91 (40.1) | Partner | 38 (41.8) |
| | | | Parent | 15 (16.5) |
| | | | Other family member | 24 (26.4) |
| | | | Friend | 28 (30.8) |
| | | | Acquaintance | 21 (23.1) |
| Professional help (n=227) | No | 214 (94.3) | | |
| | Yes | 13 (5.7) | General practitioner | 6 (46.2) |
| | | | Medical specialist | / |
| | | | Mental health practitioner | 1 (7.7) |
| | | | Other | 6 (46.2) |
| Police | No | 160 (95.8) | | |
| | Yes | 7 (4.2) | Yes, I did this | 4 (57.1) |
| | | | Yes, someone else contacted the police for me | 3 (42.9) |

^aParticipants could indicate multiple options, therefore the total is >100%

^bDisclosure= disclosure prior to the interview

Less than 6% of older victims sought professional help and only 4.2% contacted the police upon sexual victimisation. Similar to younger victims, older victims experience many barriers to seek professional help (Dartnall & Jewkes, 2013, DeLoveh et al., 2017). More information on the barriers for help seeking upon sexual victimisation in older adults can be found in table XI. Most frequent reasons not to seek help are linked to the victim. Almost half (49%) indicated they did not need help. However, this is often more a kind of acquiescence with the fact that the SV cannot be undone, which is explained in the following quotes:

“What happened, happened and it cannot be mended anymore.” (Francine, 76 years).

Other victims indicated shame (15%) and fear not to be believed (11%) as reasons not to seek help. Moreover, some victims indicated reasons linked to others as a barrier to seek help, such as wanting to protect the assailant (7.5%). A small group experienced barriers linked to accessibility and 10% indicated other barriers. Many victims indicated that the taboo on sexuality when they were growing up prevented them from seeking help, which is expressed by Maria:

“At home we did not talk about sexuality. This was taboo. Conceal it, don’t speak about it.” (Maria, 80 years).

Another victim indicated that, because of this taboo on sexuality, she did not have the rights words to describe what happened to her, which off course impaired her ability to seek help.

She also explains that the fact she is now more able to talk about it altered her thinking about what she experienced:

“It is difficult to say what I mean exactly. It’s difficult, because you never thought about it concretely. You experienced it, but you never put it into words [...]. Maybe we did not think about it, because we could not talk about it. Then you stay in your own thoughts and you don’t hear other [opinions]. You look blind [...]. The more you can talk about it, the more thoughts you get about it.” (Hortensia, 73 years)

TABLE XI. Barriers for help seeking upon sexual victimisation in older adults

| Variable | | | n (%) ^a | |
|---|--|--|---|------------|
| Barriers to contact professional help (n=214) | Reasons linked to the victim | I didn’t need help | 104 (48.6) | |
| | | I thought nothing could be done | 13 (6.1) | |
| | | I felt embarrassed about what happened | 32 (15.0) | |
| | | I would not be believed or taken seriously. | 23 (10.7) | |
| | | I didn’t trust anyone. | 11 (5.1) | |
| | Reasons linked to others | I was afraid of further violence | 10 (4.7) | |
| | | I didn’t want the person who did this to me to get in trouble | 16 (7.5) | |
| | | I didn’t want to bring a bad name to the family or group I belong to | 10 (4.7) | |
| | Reasons linked to accessibility | I didn’t know where to go. | 14 (6.5) | |
| | | I wasn’t able to go due to financial or transportation limitations. | 1 (0.5) | |
| | Other reason | | 10 (4.7) | |
| | Barriers to contact the police (n=160) | Reasons linked to the victim | It was not severe enough. | 100 (62.5) |
| | | | I felt embarrassed about what happened. | 26 (16.3) |
| Reasons linked to the assailant | | I felt partly responsible for what had happened. | 11 (6.9) | |
| | | I did not know what would happen after I told the police. | 11 (6.9) | |
| | | The one who did this to me was someone I know. | 18 (11.3) | |
| Reasons linked to accessibility | | It was difficult to get to the police or to contact them. | 1 (0,6) | |
| Reasons linked to the police | | The police would not believe me or take me seriously | 16 (10.0) | |
| | | The police would not do anything. | 19 (11.9) | |
| | | The who did this to me would not get caught or get punished. | 12 (7.5) | |
| | | I have had previous negative experiences with the police. | 0 (0.0) | |
| | | I felt endangered at the police. | 1 (0.6) | |
| Other reason | | | 27 (16.9) | |

^aParticipants could indicate multiple options, therefore the total is >100%

4.2.3.7 Suggestions for better care by older victims

Although many older victims recognised that the taboo on sexuality and SV is diminishing, they still emphasize the importance to talk about what happened:

“Don’t stay silent. When something is wrong, talk about it” (Henrica, 73 years)

“Be open to professionals who can help you” (Francine, 76 years)

Moreover, they advise healthcare workers to be attentive to signals and listen:

“If you feel something is wrong, ask about it... several times” (Mieke, 75 years)

“If people indicate something, give them the floor” (Maurice, 72 years)

Furthermore they stressed the importance of specific programmes for young people as a prevention tool for SV. This programmes should not only focus on sexual education, but should also encompass boundaries, respect for each other, and gender norms:

“At school they teach the more technical side of sexuality not the emotional. They should learn to ask: Is this ok?” (Paula, 77 years)

“However, a bit psychology should also be given at school. To interact with each other as human, as female-male, but also just as humans, to interact with each other. It’s important to provoke less aggression I think. Understand each other. It’s not because you say no, the other should offend you. To say no is just to stand up for who you are.” (Paula, 77 years)

“It starts with young boys at school, in the courses on sexual education and ethics or something like that. [...] There it starts! Being a little less cool and it is not weak or soft to show your feelings. [...] That has nothing to do with being gay or soft or whatever. No, you should dare to express your feelings instead of being a macho.” (Thiery, 72 years)

4.2.4 *Conclusions and recommendations for science, society and policy makers*

Main results

- Sexual violence continues into old age. One in 12 older adults (8.4%) experienced sexual violence in the past 12 months, 7% experienced hands-off sexual violence, 2.5% hands-on and 0.6% reported (attempted) rape. Females and males were equally victimised in the past 12 months.
- Older adults are not asexual, 31% of adults aged 70 and older are sexually active and 32% experienced physical tenderness in the past 12 months.
- Many older adults experienced sexual violence, 44% experienced a form of sexual violence during their lifetime (55% of women and 29% of men). Almost half of women (4%) and one in four men (22%) experienced hands-off sexual violence. One in three females (35%) and one in six males (16%) experienced hands-on sexual violence. One in 12 women (8%) and 3% of men reported (attempted) rape.

4.2.4.1 Communication & campaigns

- Include older adults as a risk group for sexual victimisation in the national and regional action plans and programmes regarding (sexual) health, (sexual) violence, and elder abuse and neglect.
- Sensitisation of society about positive sexuality and respect of sexual intimacy in older adults as well as the prevention of sexual victimisation and other forms of violence against older adults.

4.2.4.2 Training

- Health care professionals working with older adults need to be qualitatively trained to initiate conversation around sexual health, SV and its mental health impact through training, detection tools and care procedures.
- Train legal professionals regarding SV and its disclosure in older adults.

4.2.4.3 Prevention & care

- Every institution working with older adults should have a policy on sexual health, emphasizing the need for positive sexuality and respect of intimacy as well as the prevention of and tailored response to sexual victimisation.
- Provide person-centred care for older victims of SV.

4.2.4.4 Needs for future research

- What is the nature and magnitude of SV in older adults with cognitive decline?
- What is the effectiveness and feasibility of clinical guidelines on the detection, prevention and response to SV in older adults?
- How can we correctly measure sexual neglect as a form of SV?
- What is the long-term impact of sexual victimisation on physical health (e.g. frailty) and financial health?

4.2.5 Further reading

Capsule 3: Sexual violence in older adults in Belgium:

<https://vimeo.com/559892123/d3232ac805>

Published and in press papers:

- Cismaru-Inescu, A., Adam, S., Nobels, A., Kempeneers, P., Beaulieu, M., Vandeviver, C., Keygnaert, I., Nisen, L. (2021). The elephant in the room - a critical interpretive synthesis of older adults' sexuality. *In press at International Journal of Sexual Health*.
- Nobels, A., Cismaru-Inescu, A., Nisen, L., Hahaut, B., Lemmens, G., Vandeviver, C., & Keygnaert, I. (2021). Challenges in conducting sexual health and violence research in older adults beyond GDPR: A Belgian case study. *Journal of Interpersonal Violence*, 1-21. DOI: 10.1177/08862605211015256
- Nobels, A., Vandeviver, C., Beaulieu, M., Cismaru-Inescu, A., Nisen, L., Van Den Noortgate, N., Vander Beken, T., Lemmens, G. & Keygnaert, I. (2020). "Too grey to be true?" Sexual violence in older adults: a critical interpretive synthesis of evidence. *International Journal of Environmental Research and Public Health*; 17(11).
- Nobels, A., Vandeviver, C., Beaulieu, M., Lemmens, G., & Keygnaert, I. (2018). Are older women forgotten in the fight against sexual violence? *Lancet Global Health*, 6(4). p.e370-e370.

Preprints and papers in progress:

- Nobels, A., Cismaru-Inescu, A., Nisen, L., Hahaut, B., Beaulieu, M., Lemmens, G., ... Keygnaert, I. (2021). Sexual violence in older adults : a Belgian prevalence study. *In review*
- Cismaru-Inescu, A., Hahaut, B., Adam, S., Nobels, A., Beaulieu, M., Vandeviver, C., Keygnaert, I., Nisen, L. (2021). Sexual activity and physical tenderness in older adults: prevalence and associated characteristics in a Belgian national study. *In progress*
- Nobels A., Lemmens G., Thibau L., Beaulieu M., Vandeviver C., & Keygnaert I. (2021). "Time does not heal all wounds": Sexual victimisation is associated with depression, anxiety, and PTSD in old age. *MedRxiv*. <https://doi.org/10.1101/2021.06.05.21258397>. *In progress*.
- Nobels A., Lemmens G., Van Hove J., Beaulieu M., Vandeviver C., & Keygnaert I. (2021). Sexual violence and substance abuse in older adults. *In progress*.
- Nobels A., De Schrijver, L., Van Landuyt, M., Vandeviver, C., Lemmens G., Beaulieu, M., & Keygnaert I. (2021). Help seeking behaviour upon sexual victimisation in older adults. *In progress*.

4.3 Mechanisms, nature, magnitude and impact of sexual violence on minority groups in Belgium

4.3.1 Sexual and gender minorities

4.3.1.1 Introduction

Research consistently shows alarming high rates of SV within the general population (see Mechanisms, nature, magnitude and impact of sexual violence on (in)direct victims aged 16-69 years old in Belgium). Overall, SV research has received a lot of attention in the framework of sexual and gender based violence (SGBV) and more specifically in light of violence against women (VAW). When talking about SV, often women becoming sexually victimised by a male assailant is what is intuitively thought of. Yet, both genders can become victim and/or assailant of SV (see Mechanisms, nature, magnitude and impact of sexual violence on (in)direct victims aged 16-69 years old in Belgium). This one directional and binary thinking about SV goes beyond its true complexity and leaves non-heterosexual and non-cisgender people out of account.

There is reason to believe that the vulnerability of experiencing SV throughout one's lifetime is related to more than gender alone. Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and other non-heterosexual and/or non-cisgender identifying persons (LGBTQIA+) are a minority group that deserves specific scientific attention with regard to SV as their experiences with SV appears to be as high as or even higher than in their heterosexual and cisgender peers (Brown et al., 2015; Edwards et al., 2015; Rothman et al., 2011). Sexual and gender minorities (SGM) have thus been identified as a vulnerable group for SV exposure.

In preparation of the quantitative and qualitative study on SV in SGM in Belgium, we conducted a critical interpretive synthesis (CIS) regarding the prevalence of SV in SGM in Europe and Belgium, vulnerabilities and effects associated with SV and help-seeking behaviours (HSB) after sexual victimisation in sexual and gender minorities. Both peer-reviewed and grey literature in the areas of public health, social science, and sexual rights and policies were included ($n = 125$) (see WP1: Literature review and desk study for more details on the methodology).

Although the prevalence of SV varies among studies and countries worldwide, the CIS confirmed the hypothesis that SV in SGM is higher than in the general population, with bisexual persons reporting more sexual victimisation than gay/lesbian persons, and trans persons reporting the highest SV prevalence (Brown & Herman, 2015; Rutgers, 2013). Further, the CIS revealed specific vulnerabilities for SV, as well as specific consequences and help-seeking behaviours related to SGM's sexual orientation and gender identity (SOGI). LGBTQIA+ individuals differ in sociodemographic factors and the degree to which sexual orientation (SO) or gender identity (GI) are considered as important to their self-identification (Bränström & van der Star, 2013). Yet, they have very similar experiences when it comes to discrimination, stigma, rejection, and threat of violence (Bränström & van der Star, 2013).

Research has shown that transgression of gender norms and the experience of minority stress play a crucial role in SGM's vulnerability for exposure to violence (Bockting & Motmans, 2013; Meyer, 2003). Minority stress refers to the excess stress one is exposed to

as a result of being in a stigmatized social position (Meyer, 2003). The fact that LGBTQIA+ do not comply to prescribed stereotypical gender roles often elicits negative responses from the social networks they are part of. Minority stress has an additive effect on general stressors, requiring additional adaptation efforts to cope with stressful situations compared to non-stigmatized peers (Meyer, 2003). Direct and indirect confrontation with victimisation, prejudice, and discrimination negatively influences the well-being and health of this population disproportionately (Russell & Fish, 2016).

Minority stress – resulting from SOGI-related stigma, prejudice, and discrimination – emerged throughout the literature as a possible mediator for increased risk of SV and its effects in SGM (Bockting & Motmans, 2013; Meyer, 2003; 2015; Meyer, 2012). Minority stress appears to increase the risk of experiencing SV in SGM, to SV having a larger and more lasting impact, and to creating barriers for victims who seek help upon sexual victimisation. The combination of multiple-minority identities may increase the impact and probability of sexual victimisation.

The bulk of studies on SV in SGM originates from research within Anglo-Saxon countries, mostly the USA. The European context may be comparable in terms of western cultural heritage, but norms and stigma may differ and could influence reported cases and experiences of SV. It is therefore crucial to dispose of reliable prevalence numbers collected in the European context and to identify both risk and protective factors in this context to guide the development of preventive and care programs.

4.3.1.2 Sample

Using a mixed methods methodology, we studied sexual victimisation in SGM, potential specific vulnerabilities for victimisation, the specific impact SV has on SGM's lives and help-seeking behaviour upon SV in SGM.

Out of the 2,097 participants in the first wave of the nationally representative self-report study on SV in the age-group 16-69 years old (see WP2.1: Nationally Representative Self-Report Study on Sexual Violence), 11% ($n = 239$) identified as LGBTQIA+. The non-heterosexual subgroup ($n = 226$, 95%) consisted of bisexual (40%), gay/lesbian (22%), pan-/omnisexual (18%), asexual (5) and other sexually identifying (10%) persons. The non-cisgender subgroup was much smaller ($n = 4$), with three persons identifying as trans, one as genderfluid and nine persons reported being intersex or having disorders of sex development (DSD). The same trend was observed in our qualitative sample. Out of the 135 participants included in the analysis, 43 persons identified as not heterosexual and/or cisgender with six of them identifying as non-cisgender and 41 as non-heterosexual.

The data collected via these two methods were triangulated for complementarity and interpreted in light of the findings from the CIS.

4.3.1.3 Prevalence and vulnerabilities

In line with the literature, LGBTQIA+ persons ($n = 239$) reported a significantly higher lifetime prevalence of all types of SV victimisation compared to the non-LGBTQIA+ persons ($n = 1858$) in our quantitative sample. 80% indicated to have been exposed at least once to any type of SV, with 42% reporting hands-on SV of which 24% having ever been exposed to (attempted) rape. Figure 9 shows the distribution over the different types of SV.

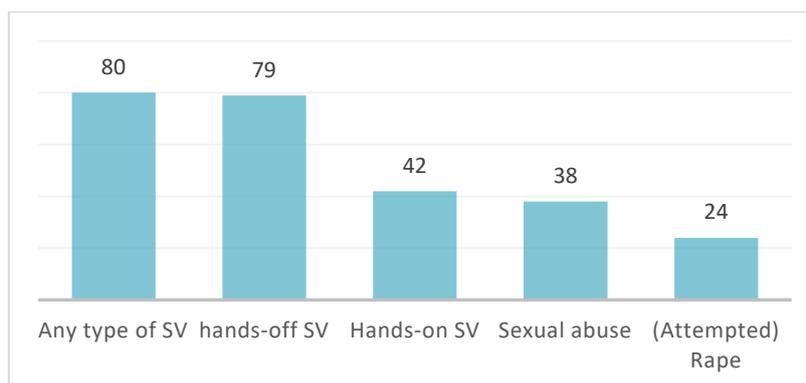


Figure 9. Percentage of lifetime SV prevalence reported by LGBTQIA+ persons in the first study wave ($n = 239$)

The same trend was found for exposure in reference to the past 12 months: LGBTQIA+ persons reported again a significantly higher prevalence of all types of sexual victimisation compared to the non-LGBTQIA+ persons in our sample. Still 68% ($p < .001$) of the LGBTQIA+ respondents was confronted with at least one type of sexual victimisation in the last year. Figure 10 shows the incidence distribution over the different types of SV reported in reference to the past 12 months. We would like to draw your attention to how all of the victims, experienced hands-off SV in this period and 20% ($p < .001$) of them was also exposed to a form of hands-on sexual victimisation.

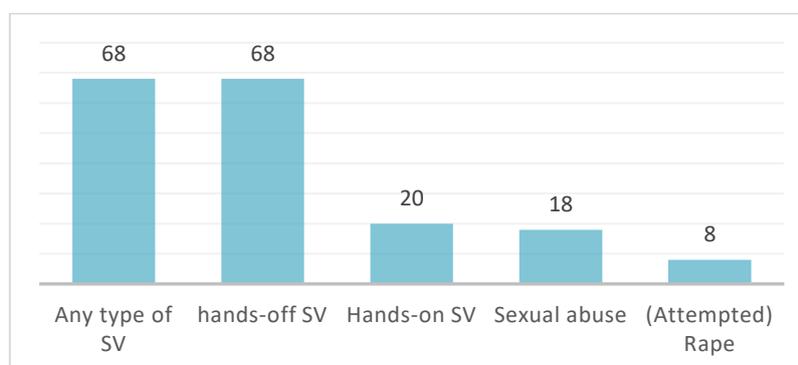


Figure 10. Percentage of past 12 months sexual victimisation prevalence reported by LGBTQIA+ persons in the first study wave ($n = 239$)

With regard to the contexts in which sexual victimisation occurs, LGBTQIA+ victims described in the in-depth interviews a large variety of contexts in which they experienced SV. Interviewees experienced SV both in public and private places and this by known (e.g. family members, (ex)partners, friends, colleagues, etc.) and unknown assailants. LGBTQIA+ victims were also exposed to different coercion. A homosexual cisgender man (30 years) testified about how his former boyfriend locked him up in a room and forced him to have sex with another man. Another interviewee – a non-heterosexual non-binary person (24 years) - was victimised as a child by her godfather while on a sleepover and then another one – a bisexual cisgender woman (20 years) - was forced by a friend with benefits to have sex when she didn't want it.

The places where SV occurred, the nature of the relationship between victim and assailant, the age of the victim and the age of the assailant at the time of the exposure etc. reported during the interviews was as diverse as observed in the general population (see Mechanisms, nature, magnitude and impact of sexual violence on (in)direct victims aged 16-69 years old in Belgium).

"[...] then [he] managed to get my clothes off, basically. And uhm, he pushed my head between his legs, uh, and I really tried to resist, uhm, but eventually that didn't work anymore so I just gave in, I didn't say anything anymore. Uhm, but what I've really said several times, that I didn't want to or something." (Lillith, bisexual cisgender woman, 20 years)

The significantly higher exposure rate of LGBTQIA+ persons to SV can be explained by several vulnerabilities that make them more at risk for sexual victimisation. First, as in the general population, females are the most at risk (aOR 12.72 (4.43-36.53)). This is in line with what we found in the literature (Krahé et al., 2015). Individuals expressing a female gender – regardless of sex at birth – experienced the highest risk of sexual victimisation, followed by individuals showing any type of gender non-conforming behaviour (Testa et al., 2012; Stotzer, 2009; Doorduyn & Cense, 2014). Considering the testimonies in the qualitative study, this vulnerability can at least partly be explained by the contexts in which SV occurs. Most of the LGBTQIA+ interviewees were female victims who identified as bisexual and testified about SV that occurred within an intimate relationship with someone with a male gender. Research on SV has shown that most violence occurs within relational or familial contexts (Cox, 2015; Mulder et al., 2021).

Further, early sexual initiation (i.e. first sexual experiences before the age of 16), having had more than 3 sexual partners, and only having completed high school increased the risk as well. In addition, for victimisation in the past 12 months, being a student and identifying as gay were also important risk factors.

With this study we can also confirm the hypothesis that LGBTQIA+ persons who identified as belonging to a minority group (RD= .81 (.76-.86; p<.000)) and those who experienced minority stress (OR= 2.935 (1.190-7.238; p=.019) were more at risk of SV exposure.

4.3.1.4 Impact of sexual violence

Overall, LGBTQIA+ participants experienced significantly more negative consequences after SV than non-LGBTQIA+ respondents. They most frequently reported emotional consequences such as anger, fear, sadness, shame, guilt etc., but also a negative impact on their self-esteem and an increase in avoidant behaviour to avoid being triggered.

"I am perhaps not really ashamed, but I was many years afterwards, because I never you know, because I let it drag on for so many years. And also guilty because - that I could not communicate clearly enough to him that what he did was wrong" (Selena, bisexual cisgender woman, 30).

We also found a gender effect in these consequences. Female LGBTQIA+ respondents reported significantly more negative consequences after SV compared to male LGBTQIA+ respondents.

Because of the assailant's gender, some LGB+ persons also indicated confusion about whether this has impacted their sexual orientation or not. A lesbian cisgender respondent explained that, though she had always felt an attraction to women, she kept wondering for a long time if she was unattracted to men because she had a history of SV perpetrated by men.

4.3.1.5 Help-seeking behaviour upon sexual victimisation

Although LGBTQIA+ persons were more exposed to SV and experienced more negative consequences upon victimisation, almost half of the victims did not tell anyone about the violence they experienced. Those LGBTQIA+ victims who did ($n = 191$), disclosed mostly to a friend (35%), a partner (15%) or a parent (15%). So someone who was rather close to them. Less than 10% told another family member (6%) or someone else (8%).

LGBTQIA+ victims explained that disclosing sexual victimisation entails certain risks. Not only do they risk victim blaming and receiving negative responses to the disclosure, for LGBTQIA+ persons this may also lead to unwanted or premature outing of oneself or someone else, risking stigmatisation of the LGBTQIA+ community and questions about their sexual and/or gender identity and roles.

Nine out of 10 LGBTQIA+ victims did not seek any professional help. If they did ($n = 19$), they mostly consulted a mental health practitioner (e.g., psychologist, psychiatrist, ...) (5%), a general practitioner (3%) or another professional service (3%). It was striking to see that the specialised care was even less consulted. Specialists such as gynaecologists (0.5%), specific helplines or support groups (1%), sexual assault care centres (0.0%) etc. were rarely or not consulted by the LGBTQIA+ victims in our sample. Those who did seek professional help ($n = 19$) were mostly satisfied about the help they received.

With regard to reasons for not seeking help upon sexual victimisation, LGBTQIA+ victims who didn't seek help ($n = 172$) indicated in the quantitative study "I didn't need any help" (64%) as the most important reason. The other most important reasons given for not seeking help were: shame (18%), other reasons than we listed in our survey (15%), believing that nothing could be done (11%), expecting that one would not be taken seriously or believed (11%), not knowing where to go to seek help (8%) and a lack of trust in others (8%). These barriers were confirmed in the qualitative study. Many LGBTQIA+ persons stated that they felt that they were not taken seriously or believed.

Moreover, many of the respondents explained that they often felt safer not to disclose their LGBTQIA+ status to avoid stigmatising responses or prejudice from health care professionals. In addition to not seeking professional help, LGBTQIA+ victims overall did not report to the police about their sexual victimisation. The numbers on police reporting can be found in figure 11.

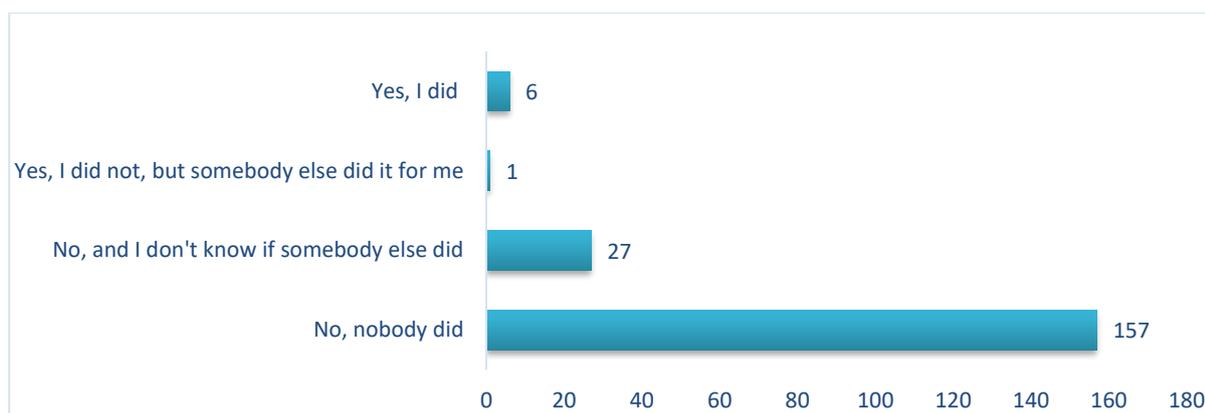


Figure 11. Police reporting upon sexual victimisation in LGBTQIA+.

From the quantitative study, we learned that 67% of LGBTQIA+ SV victims thought their experience was not severe enough to go to the police. Barriers for going to the police ($n = 185$) entailed being uncertain about what would happen next (24%), the assailant was known to victim (22%) and victims did not want to bring this person into trouble, because they were afraid of their reaction, or feared further violence from the assailant. Shame (21%), believing that the police would not do anything (15%) and that the assailant would not get caught or punished (12%), and feeling partly responsible for what had happened (14%) also made it to the list of important reasons for not consulting the police. In addition to the options provided in the survey, 13% indicated that other reasons played a role for them. Further research is needed to identify these other reasons. Again, expecting that one will not be taken seriously or believed was mentioned by 12% as a reason for not reporting to the police.

4.3.1.6 Conclusions

Based on the findings in this study and the recommendations LGBTQIA+ victims formulated themselves during the interviews, we have formulated some conclusions and recommendations for prevention and care upon sexual victimisation.

In conclusion, we learned that LGBTQIA+ persons are more at risk of SV and especially when they identify as belonging to a minority group and when they experience minority stress. Further, it seems that they also experience more negative consequences after SV victimisation than the general population and they report important barriers for disclosing SV and seeking help from professional services or the police. Based on our result, we believe that there is an urgent need for public health measures and sociocultural changes preventing sexual victimisation and decreasing minority stress in LGBTQIA+ persons.

We recommend to conduct more research that is inclusive of LGBTQIA+ persons to better inform and develop prevention and care strategies that may respect the specificities of LGBTQIA+ SV victims. Studies incorporating an intersectional perspective and addressing both shared and unique vulnerabilities for the general population as well as minority groups are crucial to fully understand the dynamics underlying SV and its impact on sexual and gender minorities.

More research including LGBTQIA+ persons is necessary to inform inclusive SV prevention and care strategies. Further, there is an urgent need for public health measures

and sociocultural changes preventing SV and decreasing minority stress in LGBTQIA+ persons.

Future research should incorporate an intersectional perspective and address both shared and unique vulnerabilities for the general population as well as minority groups to fully understand the dynamics underlying SV and its impact on sexual and gender minorities.

4.3.2 *Applicants for international protection*

4.3.2.1 Introduction

The CIS conducted regarding Migrants, Applications of international protection and Refugees (MAR) in Europe showed that MAR are more prone to SV exposure than the general population. Yet, research on SV in Applicants for International Protection (AIPs) is extremely scarce compared to the number of studies in the general population. Reliable numbers on the prevalence of SV in this population in Europe were lacking. This is probably the result of the many challenges related to conducting research in hard-to-reach populations such as AIPs, but also because SV research comes with another set of important challenges (De Schrijver et al., 2018).

During the CIS we conducted as preparation to this study, only 5 studies were identified that gave an indication of the magnitude of the problem. Although these studies could not be considered as real prevalence studies, they did provide us with estimations of the magnitude of the problem in this population. From the literature review conducted in 2017 (De Schrijver et al., 2018), we concluded that:

- AIPs appear to be more at risk of SV exposure than the general population (FRA - European Union Agency for Fundamental Rights, 2014; Freedman, 2016);
- Almost 60% of the applicants were directly or indirectly exposed to SV (Keygnaert et al., 2012; Keygnaert et al., 2015);
- All genders seem to be vulnerable (Keygnaert et al., 2015);
- Also professionals were among the assailants and victims of the reported violence (Keygnaert et al., 2012; Keygnaert et al., 2015);
- European citizens make up an important part of the assailants (Keygnaert et al., 2015; Keygnaert et al., 2012).
- SV does not only take place in home country, but also during transit and upon arrival in destination country (Chauvin, 2015; Keygnaert et al., 2012; Keygnaert et al., 2015);
- Often victims reported to be exposed to multiple and gang rape and the assailants are in most cases known to the victim (Keygnaert et al., 2012; Keygnaert et al., 2015).

With this information as a background, the UN-MENAMAIS study was designed to explore whether this was also the case for AIPs residing in Belgium. To generate qualitative and comparable data, we needed a clear definition of the concerned population and acts of SV (De Schrijver et al., 2018). The impact of SV on the lives of AIPs may be far greater than in the general population due to the specific risk factors emerging from the vulnerable situation they

find themselves in (De Schrijver et al., 2021b). Given the necessity of taking the specific experiences related to different migratory stages and motivations into consideration, qualitative research using interviewers trained in cultural and linguistic competence, seemed essential to fully grasp the complexity of interplaying determinants of SV in AIPs.

We designed our quantitative and qualitative study in such a way that we could avoid as much bias as possible, while still collecting data in this hard-to-reach population that could be generalized to the group residing in Belgium. More detailed information regarding the applied methodology can be found elsewhere (see De Schrijver et al., 2021a).

4.3.2.2 Sample

A mixed method study (see Applicants for international protection and WP 3.1: In-depth interviews with victims of all ages, genders and sexual orientations) triangulating both quantitative and qualitative data for complementarity was applied. This work package came with many challenges in different stages of the study (see De Schrijver et al., 2021a). On the 12th of March, due to the COVID-19 pandemic and the lockdown measures installed to prevent a further spread of the virus, our quantitative data collection had to be stopped earlier than foreseen. At that point, we had collected quantitative data via face-to-face structured interviews from 62 randomly selected AIPs, whose average residence time in Belgium was 11,2 months. Three out of four participants in our sample were assigned the male sex at birth. The sociodemographic information regarding our study population can be found in TABLE XII. This data was triangulated with data from 12 in-depth interviews with AIP victims of SV. One interrupted interview had to take place on two different moments, but the participant dropped out in the second part. As such, 11 interviews were hence included in the analysis. Four heterosexual women and seven heterosexual men between the age of 23 and 53 years old and who were (in)directly exposed to SV made up our sample. These participants all resided in an asylum reception centre located in Flanders.

TABLE XII. Sociodemographic characteristics of the study population ($n = 62$)

| Variable | | n | % |
|----------------------------------|--------------------------------|--------------------|------|
| Sex at birth | Female | 15 | 24.2 |
| | Male | 47 | 75.8 |
| Age in years (M(SD), range) | | 32.5 (10.2), 16-61 | |
| Months in Belgium (M(SD), range) | | 10.8 (11.2), 0-60 | |
| Education level | Primary or none | 14 | 22.6 |
| | Secondary | 25 | 40.3 |
| | Higher | 23 | 37.1 |
| Occupational status | Active ^a | 6 | 9.7 |
| | Student | 20 | 32.3 |
| | Inactive or other ^b | 36 | 58.1 |

^aThis group contains participants who are employed/independent, perform voluntary work or work as a contributing family member

^bThis group contains participants who are housemaker, on the job market, not able to work because of ill health, financial self-sufficiency or any other type of alternative choice of living or other

4.3.2.3 Framing Sexual violence

Based on the study findings, it appears that people from different cultures and nationalities define SV in comparable ways. Overall, SV was defined as sexual behaviour without the consent of at least one of the persons involved. Several AIPs described that SV is lust driven manner and resembles the way in which animals have sex. Sex for sex, not out of love or with respect for one another. Respecting each other and being on equal power relations between sexual partners are perceived as essential for a healthy sexuality. AIPs agreed that SV could be both hands-off and hands-on.

4.3.2.4 Are AIPs vulnerable for sexual victimisation?

84% of our sample reported to have ever been exposed to any type of SV and 61% in the past year. The mean time of residence in Belgium was 11 months, hence a big part of the violence in the past year, occurred in Belgium. Yet, interviewees reported incidents of SV that occurred in the country of origin, in transit and upon arrival in Europe and Belgium.

AIPs report different types of SV over their entire life as well as within the past 12 months. Half of our sample had ever been exposed to hands-on SV and one in four reported exposure to rape. The division of occurrence per SV type is presented in figure 12.

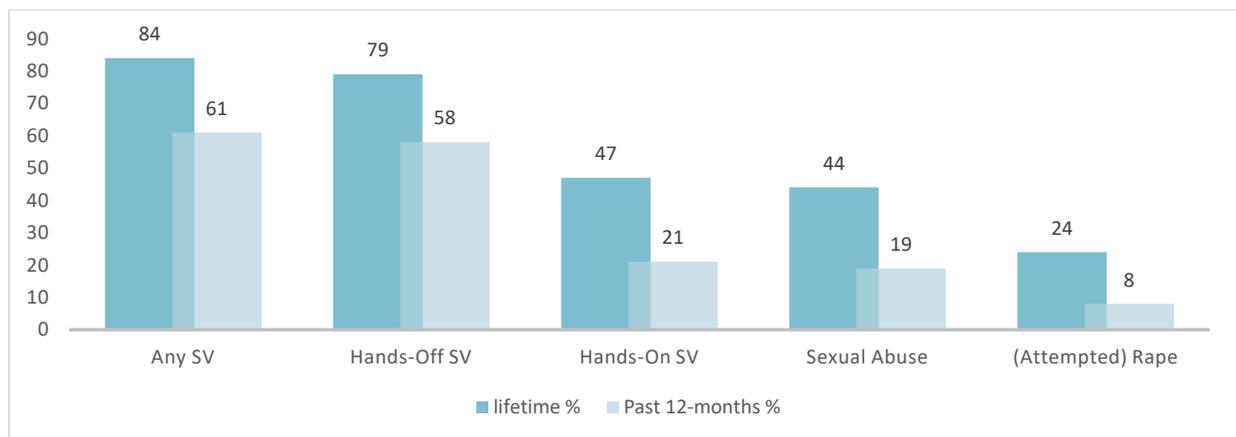


Figure 12. Lifetime and 12 months occurrence per type of sexual violence (%), $n = 62$.

In line with previous studies, we found that men and women follow the same trends in terms of victimisation risks. SV victimisation in AIPs appears to be more gender balanced than in the general population (see figure 13). In contrast with the general population – where mostly male perpetrators are identified – AIPs experienced SV by as many female as male assailants (see figure 13).

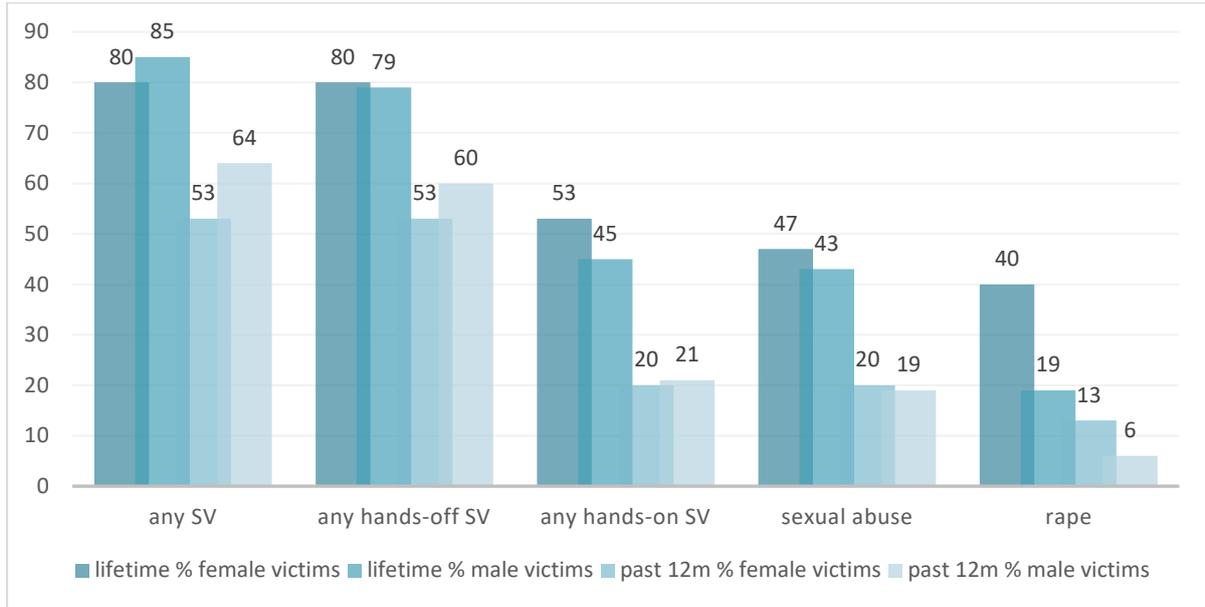


Figure 12. Lifetime and 12 months occurrence of sexual violence per gender (% , n = 62).

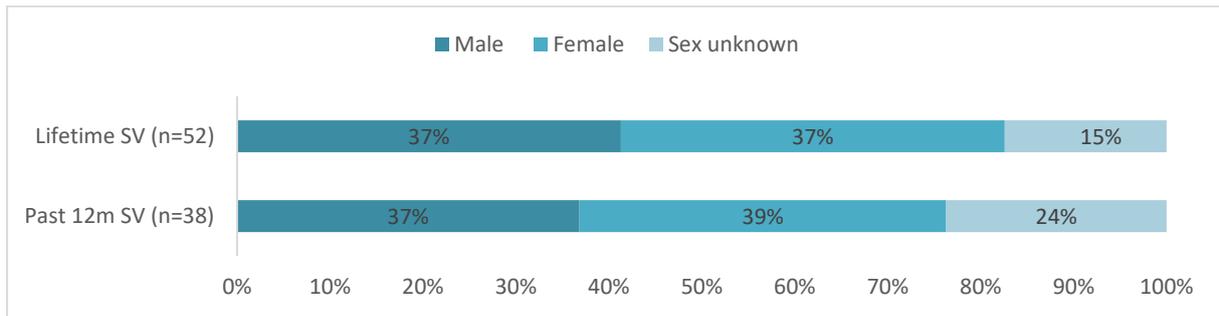


Figure 13. Sex of assailants of lifetime and sexual violence in the past 12 months (% , n = 52).

Also in contrast to what we know from the general population, about 60% of the reported SV incidents were perpetrated by someone unknown to the victim (see figure 14).

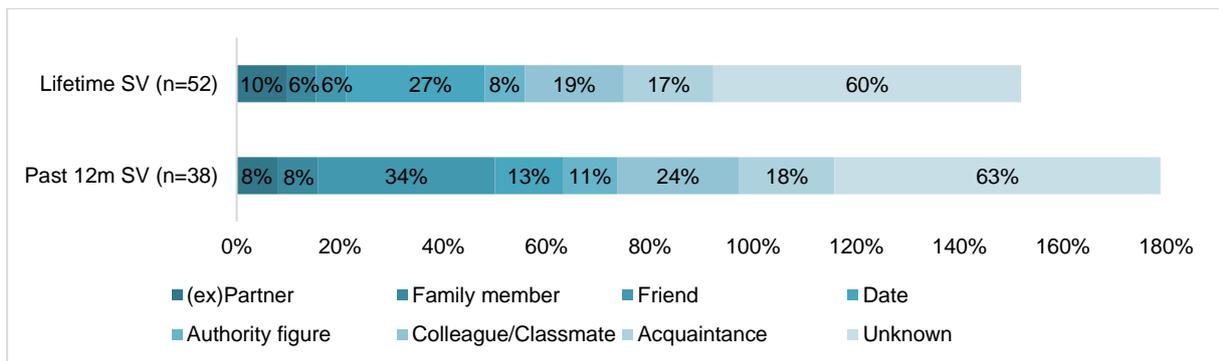


Figure 14. Relationship between victims and assailants for lifetime and 12 months occurrence of sexual violence (% , n = 52).

This may be related to the vulnerable position AIPs find themselves in. When asked about reasons why AIPs are potentially sexually victimised in the in-depth interviews, most AIP interviewees stressed explicitly that this was related to the vulnerable situation in which they find themselves and that this vulnerability was a consequence of their legal status. Throughout the interviews, AIPs described how they or their family, friends or peers were exploited because of their difficult socio-economic situations. Many respondents highlighted that especially those refugees who are homeless or undocumented are very vulnerable for different types of violence. AIPs also indicated that staying in a reception centre made them more at risk. On the one hand, because it makes it possible for outsiders to identify them as AIPs, but also on the other hand because it is not always possible to protect oneself in a reception centre.

Further, participants perceived previous exposure to different forms of violence and a lack of protection from one's social network as reasons for sexual victimisation.

Lastly, because AIPs have a lot of worries which impact their mental health, they are not always immediately able to protect themselves or to identify that someone is taking advantage of them.

4.3.2.5 Impact of sexual violence

The impact of SV can be immediate or postponed and be minimal to life disrupting. Many AIP victims described how stigma and shame related to the direct and indirect SV had major impacts on their lives. In some cases, SV has forced them to become a refugee or hide certain parts of their identity. One female respondent explained that she started to wear a headscarf to protect herself from sexual harassment, while another reported sexual harassment because she wore the headscarf.

Psychological and sleeping problems were mentioned regularly, as well as difficulties in trusting others which impaired social relationships. Feeling frustration and hatred, revenge, questions about masculinity, femininity, societal and parental roles, and sexual orientation were neither uncommon. Because of these consequences and the stigma around SV, the impact could even lead to total social rejection by one's community or family and even death.

The interviewees agreed that on top of the worries associated with their migratory process, being aware of being vulnerable to SV increased their mental strain. Moreover, to cope with sexual victimisation, AIPs have strategies in place to protect themselves. One interviewee explained how she behaves differently in public than when she's alone to avoid attracting unwanted attention. Another one, who was the victim of SV as a weapon of war, explained during his interview how he always watches his back. Everywhere he goes, he is always making sure that he has eye on an escape route in case he would be in danger or feel threatened.

4.3.2.6 Help-seeking behaviour upon sexual victimisation

Though AIPs are vulnerable to SV, most of them do not seek help upon victimisation. 62% of the AIP victims ($n = 52$) in our sample did not talk about the SV with anyone. When they did ($n = 20$), they were most likely to confide in a friend (70%) (see figure 15.) Of the 52 AIPs in the quantitative sample who indicated sexual victimisation, only 2 consulted professional help and no one reported to the police.

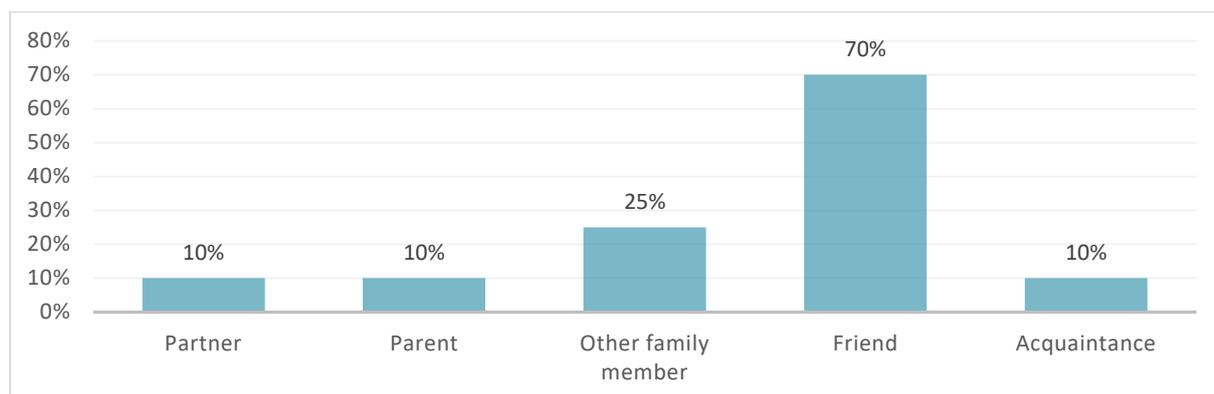


Figure 15. Percentage of victims disclosing to their informal network ($n = 20 / N = 52$).

The most important motives for remaining silent, were shame and taboo. In many families and communities it is kept a secret to avoid stigmatisation of the victim. Even when one feels supported by friends and family, disclosing what happened is experienced as a too big of a step to take.

When it comes to not reporting to the police, the stated reasons were very diverse and quite often influenced by previous negative encounters with the police. And this not only in host countries such as Belgium, but also in the home country and during their journey. One AIP interviewee explained that she doesn't feel like the police can protect her – or wants to protect her – because of her legal status. After a violent attack in Athens, upon reporting, the police had sent her away because she was an AIP and told her that she didn't have any rights there. Yet, reasons for not reporting were very divers. Another interviewee testified for example that as he was still on the run and didn't feel safe yet, he wanted to remain under the radar. He judged that going to the police would bring him into more trouble than it would help him.

4.3.2.7 Recommendations for prevention and care formulated by AIP victims of sexual violence
In the interviews, AIPS were asked about how prevention and care upon sexual victimisation could be improved to match their needs. This resulted in some recommendations.

According to AIP victims of SV, the key to both prevention and care is to break the taboo around SV. Almost all respondents suggested that starting early on with a suited age appropriate sexual education is crucial. This should be both taught at school and be part of the upbringing at home.

Further, sensing that they would be taken seriously by the police and that they could benefit protection could lower the barriers for reporting.

Lastly, AIPs stressed that stigmatisation of the victims should end. Safe disclosure should be the norm, not social rejection.

4.3.3 *Conclusions, limitations and recommendations for science, society and policy makers regarding minority groups*

Main results:

- LGBTQIA+ persons are more exposed to sexual violence than non-LGBTQIA+ persons: 80% has been exposed to at least one type of sexual violence; 79% experienced hands-off sexual violence and 42% hands-on sexual violence, of which 24% concerned (attempt to) rape.
- LGBTQIA+ persons who identified as belonging to a minority group and who experienced minority stress reported significantly more sexual violence exposure.
- 43% of LGBTQIA+ victims did not tell anyone about the SV they experienced; 90% did not seek any professional help upon sexual victimisation.
- 84% of applicants for international protection have ever been exposed to sexual violence and 61% of applicants for international protection were exposed to sexual violence in the past year. Most of the victims were already residing in Belgium at that moment.

4.3.3.1 Prevention & training

- Prevention strategies should be inclusive to minority groups and taking the specific risk factors relevant to these groups into account.
- Train professionals (e.g. health care workers, law officials,..) in diversity sensitive communication and sexual assault care service provision.
- Relational and sexual education should be sex positive and go beyond heteronormative and cis normative approaches.

4.3.3.2 Qualitative, accessible and affordable care

- Take public health measures and set up campaigns for sociocultural changes preventing SV and decreasing minority stress in LGBTQIA+ persons.
- Increase access to mental health care and social support for applicants for international protection informing them about their right to health care and supporting them in navigating the health care system.

4.3.3.3 Communication

- Policies should be inclusive to all minority groups as risk groups for sexual victimisation in policies on violence, mental and sexual health and they should be developed in participation with those target groups
- Include persons of all genders, sexual orientation, colour of skin, cultural background etc. in campaigns on sexual health and SV.
- Positively change the image of police to increase reporting minorities, as negative experiences with police reporting in the past, can hinder reporting sexual victimisation as well as their trust in the potential outcomes and benefits of judicial processes.

4.3.3.4 Needs for future research

- Explore both shared and unique vulnerabilities for the general population as well as minority groups to fully understand the dynamics underlying SV and its impact on applicant for international protection, sexual and gender minorities and other minority groups.
- More research is needed to understand how minority stress may impact minority groups and the underlying mechanisms that increase their risk for sexual victimisation.

4.3.4 Further reading

Capsule 4: Sexual violence in minority groups in Belgium (LGBT+ & AIPs):

<https://vimeo.com/559892366/ec05ba53f6>

Published and in press papers:

De Schrijver, L., Cismaru-Inescu, A., Hahaut, B., Vandeviver, C., Nisen, L. & Keygnaert, I. (2021). Research in hard-to-reach populations: challenges and strategies for conducting sexual violence studies in applicants for international protection beyond GDPR. <https://doi.org/10.31235/osf.io/8nhbr>. *In press at International Journal of Health Policy and Management*.

De Schrijver, L., Vander Beken, T., Krahe, B., & Keygnaert, I. (2018). Prevalence of sexual violence in migrants, applicants for international protection, and refugees in Europe: a critical interpretive synthesis of the evidence. *International journal of environmental research and public health*, 15(9), 1979. <https://doi.org/10.3390/ijerph15091979>

Preprints and papers in progress:

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4.4 Mapping the historical, social and technical construction of the SAS and its impact on current and new practices in Belgium

4.4.1 Introduction

In preparation of this work package, a CIS was conducted to study the evolution from a judicial and forensic approach to a holistic and victim-centred care upon SV. In this CIS, we provided an overall description of the current judicial situation in Belgium in the context of rape and sexual assault, including the forensic aspects, as well as the psycho-medical dimensions attached to the handling of this phenomenon. By including both academic and grey literature (e.g. policy and legal documents) we aimed to advance our understanding of the working principles and the impact of the policies and judicial framework in general, and on the victim of SV in particular.

Even though a large amount of research had already been conducted to map the influences on court decisions and prosecution, such research was lacking within the Belgian context. Furthermore qualitative research focussing on the motivations and overall functioning of the judicial system and its actors could provide a more in-depth understanding of their activities, potentially leading to a less negative view on the functioning of the judicial system. Although the UN-MENAMAIS project was not conceived to be specifically looking into the aspect of the judicial settlement, several aspects of formal and informal help along with the presence of possible secondary victimisation were included. This information, along with the formulation of recommendations for future policies and practices (as put forward as a fifth objective of the project) thus provided a base for possible indications for improvement and complement the current state of affairs in the Belgian context.

In regard to the current legal definitions of rape, this definition is restricted to sexual acts committed on a person who does not give consent. As such, the gender biased view on rape is still present excluding male victims and female assailants. In addition, several ambiguities were still visible specifically in regard to the age specification within the Belgian legislation. In order to avoid the exclusion of victims and/or assailants and minimize the ambiguities within the project itself, the project utilized a broad description of SV not related to the legal definition and include participants older than 16. As such a complete gender neutral description of the specific sexual acts was provided and ethical issues regarding the report of sexual acts under the age of 16 was minimized.

The literature review also raised the issue of the forensic examination and of broader reactions to the victims of SV. At his level, it showed the pertinence of studying the SAS (Sexual Assault Set), currently largely applied in Belgium, but also of a new holistic model –

including forensic examination in a broader psycho-medical model directed towards the victims - , the SACC, currently in three judicial districts and undergoing a national roll-out. So far, both SAS and SACCs were subjected to few published evaluation up till now, especially regarding the victim's issues. Scientific SACC evaluation is done within the SACC piloting project, this includes evaluation by staff, victims, significant others and all stakeholders. The UN-MENAMAIS was thus a good opportunity to evaluate the historical, social and technical constructions of the SAS as well as its impact on current and future practices as for example the SACCs.

4.4.2 SAS Knowledge, Attitude & Practice (KAP)- Survey in Professionals

4.4.2.1 Sample

The survey designed to grasp the knowledge, attitude and practices of doctors regarding the SAS was sent out to all doctors registered under the categories mentioned above and are (supposed to be) active in Belgium. A targeted population of 29,786 medical doctors were qualified to participate to the survey (registered under the selected categories with the National Council and with a known e-mail address). The number of doctors that participated is 2,178. However, during the analysis of the first questions, it became clear that some of the respondents did not fulfil the conditions to receive the survey in the first place because they did work abroad, were retired or did not practise medicine anymore or worked for example in the research field. Therefore they did not have contact with patients, which was essential to fulfil the questionnaire. In total, 90 respondents were deleted because they did not fulfil the selection criteria. A total of 57 doctors decided not to answer the first question and therefore immediately dropped out of the survey. The total amount of doctors that participated is therefore 2,031.

The questionnaire had been set up in such a way that respondents received questions adapted to their knowledge of, practices with and attitudes towards the SAS. So, not all respondents received all the questions. When presenting the results, it is always clearly stated how many respondents answered the question.

Two important types of bias are thus present in the survey results: on the one hand, the way respondents were contacted, leading to non-coverage bias and, on the other hand, the non-response bias, where the high rate of non-response raises questions about the representativity of the results.

Schematically, the above can be presented as follows:

TABLE XIII. Overview of population and respondents

| | |
|---|-------------|
| Target population of medical doctors registered with the National Council: | $n = 36532$ |
| Population with an email known to the National Council (survey population): | $n = 29786$ |
| MD's that opened the link to the survey: | $n = 2576$ |
| MD's that participated: | $n = 2178$ |
| MD's that participated after data cleaning: | $n = 2031$ |
| MD's that completed the questionnaire: | $n = 1765$ |

As already mentioned, the primary aim of the KAP survey was to grasp the knowledges, attitudes and practices of general practitioners (GP), gynaecologists, paediatricians, and emergency doctors. For these four groups, based on the population data obtained by the National Council, following rates, showed in the table below, emerge. This table also mentions the other contacted specialisations.

TABLE XIV: Specialisation of doctors within population and survey

| Specialisation | n population | n survey | Response rate | Completion (rate) |
|--------------------------------|-----------------|----------|---------------|-------------------|
| General Practitioners (GPs) | 1,5424 (1,9669) | 1084 | 7.03% | 961 |
| Gynaecologists | 1752 | 138 | 7.88% | 119 |
| Paediatricians | 2033 | 175 | 8.61% | 149 |
| Emergency doctors | 1031 | 110 | 10.67% | 91 |
| Urologists | 562 | 30 | 5.33% | 30 |
| Geriatrists | 415 | 15 | 3.61% | 14 |
| Psychiatrists | 2266 | 185 | 8.16% | 151 |
| Gastro-enterologists | 764 | 30 | 3.93% | 27 |
| Internists | 1999 | 84 | 4.20% | 74 |
| Anatomist-pathologists | 763 | 15 | 1.97% | 14 |
| Other (e.g. sports doctor,...) | * | 165 | * | 135 |
| Total | 29786 | 2031 | | 1765 |

**Population data included an unspecified group for which details about their group membership (specialisation) were not included in the data received from the National Council (they were registered in the database with a reference to their date of registration as a doctor). This 'other' group was (supposedly) composed of doctors with a specialisation in one of the above, but we do not have the data. We did notice that in the end, only few of all surveyed doctors worked in another kind of job (e.g. research, cardiology,...). This suggests the 'other' category was not a 100% match with our focus on certain disciplines; part of the non-response can be attributed to this, but we do not have a means to find out. The total number of respondents that were surveyed was communicated to us and amounted to 29786. This represents the group of doctors that were contacted by the National Council with the newsletter that included the survey link and a brief presentation about the project.*

In what follows, we will elaborate on the sociodemographic characteristics of the respondents and the results of the survey.

The language of the respondents is based on the language in which they received the questionnaire, which is dependent upon a choice by the National Council of Medical Doctors, based on where the MDs are registered. The survey was only administrated in Dutch and French. Thus, the variable of 'language' here does not really indicate anything about the language spoken by the MD, but is based on an administrative classification by the National Council. Respondents did not have to choose a language, they were already divided into a language group. Whether and how this fits their actual language, that is not clear. This is especially the case for those in Brussels.

Of all respondents that participated ($n = 2,031$), 1,132 (55.7%) are Dutch speaking and 899 (44.3%) are French speaking. Age was measured in categories. Interestingly, the category of doctors older than 65 years of age is very well represented.

TABLE XV: Age of the respondents

| | Frequency | Percent |
|---------------------|-----------|---------|
| Max 30 years | 434 | 21.4 |
| 31-40 years | 417 | 20.5 |
| 41-50 years | 308 | 15.2 |
| 51-60 years | 382 | 18.8 |
| 61-65 years | 195 | 9.6 |
| Older than 65 years | 295 | 14.5 |
| TOTAL | 2031 | 100 |

More women than men participated (55.4% vs. 44.5%). The response option 'X' was also given, with the possibility to specify further. Four people answered 'X' but in the text box, three of them referred to another characteristic beyond their sexual identity.

Over half of the respondents are working as a general practitioner (53.4%), followed by paediatricians (8.6%), gynaecologists (6.8%) and emergency doctors (5.4%). Our main interest lies within those categories and together, these four specialisations represent three out of every four answers (i.e. 74.2%). 19.5% work in Brussels, 52.3% work in Flanders and 28.2% work in Wallonia. 28% of the respondents work in a group practice, 24% in a hospital and 22% in a private practice.

4.4.2.2 Knowledge, attitude and practices of doctors regarding the SAS

4.4.2.2.1 Sexual victimisation

In the second part of the survey, the doctors' experience with victims of SV was questioned. However, throughout part one of the questionnaire, some respondents decided to stop their participation. As a result, 1951 doctors reached this part of the questionnaire. This brings us to 133 original respondents who are missing (57 as from the first question and 76 throughout part one).

Almost 70% of the respondents ($N = 1951$) have seen at least one victim of SV during their career. Doctors that answered positively on this question ($N = 1363$) were asked to estimate how many victims of SV they've seen throughout their career. These numbers cannot be generalised, but they can be indicative for the extent to which doctors are dealing with victims of SV. Over half of all doctors responded having seen at most 5 victims of SV throughout their career. Almost 10% of the respondents indicated having seen over 40 patients that were a victim of SV.

TABLE XVI. Amount of victims of SV during career

| N victims | Frequency | Percent |
|------------------|------------------|----------------|
| 1 | 162 | 13.4 |
| 2 | 167 | 13.8 |
| 3 | 157 | 13.0 |
| 4 | 83 | 6.8 |
| 5 | 143 | 11.8 |
| 6-10 | 192 | 15.8 |
| 11-15 | 45 | 3.7 |
| 16-20 | 97 | 5 |
| 21-25 | 15 | 1.2 |
| 26-30 | 42 | 3.5 |
| 31-35 | 9 | .7 |
| 36-40 | 20 | 1.7 |
| >40 | 116 | 9.6 |
| Total | 1212 | 100 |
| Missing | 151 | |

Over the past 12 months prior to the survey also almost 70% of the doctors ($n = 1,324$) have seen a victim of SV. Approximately 50% of the respondents met with at most 3 victims of SV: mostly with 1 victim (26.2% , $n = 347$) but 15.4% ($n = 204$) met with 2 victims, and 7.2% ($n = 95$) with 3 victims. All others saw more than 3 victims. A number of 28 doctors (2.1%) reported meeting over 40 victims of SV. In order to focus and to reduce memory bias the following results relate only to the last patient that came to the doctor because of SV, regardless when this took place.

It emerges that the last patient that was a victim of SV mostly contacted the doctor for a consult on a different matter than the SV ($n = 721$; 54%). This shows that the doctor could have an active role in detecting SV. However, 40.2% (537 doctors) reported that the victim came specifically for a consult concerning the SV. Only 5.8% of the doctors mentioned that the victim did not bring up the SV during a consultation (e.g. by e-mail, over the phone or during an informal contact).

For GPs, gynaecologists, paediatricians and emergency doctors, this was as follows:

TABLE XVII. Type of consultation with a victim of sexual violence

| Specialisation | Consultation SV | Consultation other matter | No consultation | Total |
|-----------------------|------------------------|----------------------------------|------------------------|--------------|
| General practitioners | 274 (40.4%) | 379 (55.8%) | 26 (3.8%) | 679 (100%) |
| Gynaecologists | 72 (58.1%) | 46 (37.1%) | 6 (4.8%) | 124 (100%) |
| Paediatricians | 55 (43.0%) | 61 (47.7%) | 12 (9.4%) | 128 (100%) |
| Emergency doctors | 62 (72.9%) | 19 (22.4%) | 4 (4.7%) | 85 (100%) |
| Total | 463 (45.6%) | 505 (49.7%) | 48 (4.7%) | 1,016 (100%) |

$Chi^2 = 51.453$; $df = 6$; $p = .000$; $Cramer's V = .159$; $p = .000$

A weak association can be found between the type of specialisation and how SV was mentioned by the victim. Gynaecologist and emergency doctors were mostly contacted for a consultation concerning the violence whereas GP's and paediatricians were mostly contacted for a consultation on other matters. Given the fact that the police accompanies the victim to a hospital in case they filed a complaint within 72 hours upon the sexual victimisation, where they are mostly examined by an emergency doctor or gynaecologist, this is a logical association.

In what follows, characteristics of the victim are surveyed. Most of victims were woman (88.7%), 8.3% were man and 2% were identified as 'other' (but none of the respondents specified this category). More than 60% of the victims were between 18 and 44 years old (63%). Twenty-two percent of the victims were minors, mostly between 10 and 17 years old (16.1%).

When consulting a doctor, most patients were not accompanied by a support figure (63.4% vs. 33.5% who was accompanied). An association was calculated drawing on a re-categorisation of all minors into one group. A moderate association could be found between the age of the victim and whether or not the victim was accompanied by a support figure ($\chi^2 = 418.541$; $df = 10$; $p = .000$; Cramer's $V = .482$; $p = .000$). This is probably because of the high percentage of minors that is accompanied, as opposed to a much more mixed picture among adults. This is tested re-categorizing all adult age groups together ($n = 702$), showing a moderately strong association (slightly higher than the Cramer's V) between whether the victim is a minor or an adult and whether s/he is accompanied by a support figure. Out the 302 victims accompanied by a support figure, 301 gave further details about who accompanied them. Most victims (93.0%) were accompanied by one supportive figure. Mostly a parent, a friend, a guardian or their (ex-)partner. Both alone or in combination with other supportive figures.

Doctors ($n = 900$) also gave an indication about the lapse of time between the SV and the victim reporting it to them. Slightly less than one third visited a doctor after at most 72 hours after the SV had taken place. This also means most victims waited much longer, with implications for forensic evidence that still could be retrieved. Victims take a long time to come forward about what happened to them: 29.4% of the victims that waited over a month to contact a doctors even waited more than 10 years. 33.4% came forward within the year following the violence.

Only 14.2% visited a doctor within 24 hours and 18.1% between 24 and 72 hours. Emergency doctors saw most of their patients within 24 or 72 hours. Also gynaecologist saw most of their patient within 24h after the violence took place. Again, this corresponds to the fact that the SAS kits are usually administered in a hospital by an emergency doctor or gynaecologist.

Most of the respondents also indicated that the last victim of SV they met, was victimized by somebody they knew. Only in 111 cases (or ca. 12.5% out of 886 answers), doctors mentioned that the assailant was unknown to the victim. In 245 cases, the (ex-)partner is mentioned as (at least the co-)assailant of the SV, in 114 cases the parents are referred to as (at least the co-)assailant of the SV, and in 111 cases, an acquaintance is mentioned as (at least the co-) assailant.

Less than half (44.4%) of the doctors ($n = 887$) said they had performed a treatment on the last patient. Treatments consisted of referral to another type of medical activity, treatment and aftercare, diagnosing the patient and collection of forensic materials or a combination of all of those. Referral is mostly to mental healthcare, police and victim support services.

4.4.2.2.2 Knowledge of the SAS and SACC

The next three parts of the questionnaire strongly built upon whether or not respondents were familiar with the SAS. This also implied that most of the questions were answered by differently composed subpopulations of the respondents.

In the third part of the questionnaire the respondents were questioned on their knowledge of the sexual aggression set (SAS). Are there any protocols in the hospital or region where they work, did they know of the existence of the SAS and what do they know about it?

Both in hospitals ($n = 627$) as in regions ($n = 1,530$) protocols were being implemented but with focus on the care of victims of SV (49% and 65.1%) and less with focus on collaborations with judicial services (18.6% and 16.1%). Considering the fact that an SAS kit is usually taken in a hospital, this is a remarkable result.

An important part of this questionnaire was to know whether doctors were familiar with the SAS and if so what they knew about it.

The existence of the SAS was widespread within these respondents ($n = 1,842$): 72% say they know it exists. Especially gynaecologist (98.4% of them) and emergency doctors (90.9% of them) were aware of its existence. Again, this corresponds to the fact that the SAS kits are usually administered in a hospital by an emergency doctor or gynaecologist. Most of these doctors ($n = 1,326$) got to know the SAS during their general medical training (26.2%) or during their career (20.7%).

Knowledge about where to obtain an SAS was limited. Most doctors ($n = 1,320$) thought that it is available in the hospital (45.5%). Less than half of the respondents were aware of the limited timeframe within which an SAS can best be taken: 46.8% believed this is best done within 72 hours and 25% within 24 hours. 20% does not have an idea and 3.6% even thought that it does not matter when you perform it on your victim.

To grasp the knowledge of the doctors about the SAS they were presented with 9 statements. Each doctor ($n = 1,262$) had to indicate whether they agreed with the statement or not. These statements showed that most doctors were aware that a SAS can collect DNA material, can be used without penetration and can be taken from minors (in that descending order).

TABLE XVIII: Statements to agree or not concerning the possibilities of the SAS

| Statement | Agrees |
|---|--------|
| The SAS provides for the collection of a DNA material | 95.4% |
| The SAS allows the collection of hairs that can allow the identification of the perpetrator | 58% |
| The SAS provides for the collection of a blood sample | 53.3% |
| The SAS can be used in trace investigations without penetration in the case of SV | 73.4% |
| The SAS collects traces that learn something about how the perpetrator acted | 35.7% |
| The SAS aims to identify sexually transmitted diseases (e.g. HIV) as a result of the SV | 27.4% |
| The SAS may be taken from minors | 64.7% |
| The SAS may only be taken at the request of a magistrate (following a complaint) | 26.4% |
| The traces collected by means of the SAS are sometimes partly or not analysed | 27.9% |

However, it is striking how few doctors were aware of the possibilities and technical guidelines regarding the SAS. For example, about half of them were aware that hair or blood samples can be collected. And even more striking: only 26.4% were aware that the SAS can only be taken at the request of a magistrate. The lack of analysis or only partial analysis is also unknown to the doctors.

Based on these answers, it can be said that for doctors, a SAS is the same as and limited to the collection of DNA.

Next to the SAS, doctors ($n = 1,290$) were also asked about the new Sexual Assault Care Centres in Belgium. More than half of the respondents knew that those centres exist (56.1%), 30.5% did not and 13.3% were in doubt. Those who knew the SACC ($n = 709$) were aware of the psychological care that is given (91.4%), but were less aware that forensic traces can be collected (70.1%) in a SACC as well as medical treatment (71.2%) and psycho-medical aftercare (69.3%). Doctors seemed to link the main goal of the SACC to psychological care for the victim.

4.4.2.2.3 Experience with the SAS

In the fourth part of the survey doctors were questioned about their experiences with the SAS ($n = 1,285$). Only 16.1% did ($n = 207$). Half of them are gynaecologists (49.7%), 14% are general practitioners and 12.1% are emergency doctors.

From all the doctors who have used a SAS during their career 55% worked in a hospital. This could be because doctors working in a hospital may use SAS more often than other doctors, but this cannot be retrieved clearly from the data. The survey is cross-sectional in nature, so it is hard to ascertain any type of causality (e.g. working in a hospital leads to more use of the SAS by the respondents themselves).

Three percent ($n = 27$) of the doctors ($n = 914$) said they have collected forensic traces in the past year on their own initiative so without being asked to do so by the police or the public prosecutor. It was mostly (33.3%; $n = 9$) done to verify if the patient had a STD or not or to collect forensic evidence to be sure to have them if necessary later (11.1%). But mostly

doctors still collected traces on the initiative of the court. From all the doctors who have received the question ($n = 913$) 6.9% ($n = 63$) used a SAS in the past year after being asked to do so by the court, while using the provided document for communicating their findings (77.8%).

4.4.2.2.4 Opinion on the SAS

Finally doctors were questioned on their opinion about SV and the SAS. All doctors, whether or not they said they knew the SAS, were sent to this part of the survey ($n = 1,798$, $n = 1,776$ answered the question)

Six situations were given for them to decide whether they believe they should intervene or not. More than half (53%) of the doctors felt they have to intervene in all of these situations.

Respondents indicated that they are most likely to intervene when a victim is raped and shows mental distress, regardless of whether the victims presents with physical injuries or not. Emotional destabilisation is deemed a sufficient condition to act.

TABLE XIX: Situation in which doctors belief they have to intervene

| Situation | n | Percentages |
|---|------|-------------|
| A patient comes to them with physical injuries (e.g. bruises) and claims to have been assaulted. There was no penetration. | 1565 | 88.1% |
| A patient claims to have been raped and has physical injuries | 1698 | 95.6% |
| A patient testifies to having been forced into sexual intercourse actions, but these have been going on for a while. There are no physical indications, however, the patient is emotional destabilized. | 1553 | 87.4% |
| A patient comes for a check-up and you will find at a routine examination suspicious bruising and/or other injuries that indicate SV. The patient says nothing about this. | 1418 | 79.8% |
| A patient shows severe psychological problems and states that these are due to recent SV. | 1593 | 89.7% |
| A patient claims to have been touched without permission to have given, but there are no injuries and the patient won't go through with it. | 1145 | 64.5% |

Finally doctors were questioned on what they thought of the SAS and its use.

First of all they were asked how important they considered standardization to be for trace investigations in cases of SV? ($n = 1,776$). They had to score the answer between 1 (completely not important) to 10 (really important). Around three quarters of the respondents found standardisation important (score 6 or above). For 45.3% of the doctors it was really important (10). Gynaecologists mostly believed this is important (62% of them gave a score of

10), followed by paediatricians (54%) and emergency doctors (53.2%). Psychiatrists were less convinced of the importance of standardisation (30.1%).

Next some more detailed questions were asked. These questions were only asked at those doctors who previously said they have ever used a SAS ($n = 201$). Most doctors felt the SAS is complete in terms of the collection of possible forensic traces (73.1%).

Opinions were however divided on the user-friendliness for both doctors and victims of the SAS: 52.3% found the SAS not user-friendly for the doctors and 53.8% found it is not adapted to patients. This has probably to do with the amount of times a doctor may or may not have used the SAS. Feedback on the quality of the traces was important for 9 out of every 10 respondents. Feedback on the transfer of the collected traces was found important by 70.2% of the respondents. Same went for analyses of the traces (84.1%), feedback on the usefulness of the traces (71.2%) and feedback on the medical report (81.6%). They were all perceived as very important. However this feedback is non existing for the moment.

4.4.3 *Focus groups with professionals and in-depth interviews with victims on SAS*

4.4.3.1 Sample

A total 50 professionals were interviewed in different judicial districts. Action scenes were selected where SAS and other practices (such as SACC) were applied, as well as action scenes where only SAS is applied.

A number of 11 victims were interviewed: 10 woman and 1 man mostly between 20 and 25 years of age. This self-selection procedure safeguarded the privacy of the victim and ensured that the victim give their informed consent to participate in the interview. On the other hand, this method made difficult to create diversity in the sample and did not guarantee that all victims had to undergo a SAS. In five of the interviews, this appeared not to be the case. However those interviews provided very interesting information for the study and were therefore retained for analysis.

4.4.3.2 Experience with the forensic care for victims from a professional and victims' point of view

4.4.3.2.1 Transitional phase

The forensic care for victims of SV in Belgium is undergoing a major change. For almost three decades the Sexual Assault Set (SAS) provided to the police and, in particular to medical services was seen as the ideal solution to ensure the prevention of traces and the production of material evidence of rape and other sexual assaults. In 2012, this forensic kit was fully evaluated and improvements were made, especially regarding the procedure.⁷ In spite of these evolutions yet in accordance with the Council of the European Convention on Preventing and Combating Violence against Women and Domestic Violence, also known as the Istanbul Convention, Sexual Assault Care Centres (SACC) have been set up as from October 2017, giving health actors a central role in caring for victims of SV. This convention requires “the creation of appropriate, easily accessible, and sufficient emergency care centres for victims of

⁷ Taeymans, M., Defour, M-E., Gengoux, V. & Marcotte, A. (2014). *Eindrapport: Evaluatie van de COL10/2005 betreffende de Seksuele Agressieset*. Dienst voor Strafrechtelijk beleid en NICC.

rape and SV, to provide them with medical and forensic examination, trauma support and counselling” (Article 25, Istanbul Convention 2011) It is in this transitional context that this study was conducted.

In this context, one important result of our research is that the SAS can be put into contrast with the existence of other models of forensic care in Belgium at the moment:

- 1) SAS: The Sexual Assault Set is a kit designed to collect traces from victims of sexual assault during a medical examination, at the request of the court, by a forensic doctor, a specialist or general practitioner. So after a victim files a complaint with the police, he or she is examined by a doctor, with permission, at the request of a magistrate. For this examination the doctor will use a SAS-kit, meaning a packaged box containing a file, a series of numbered samples (for clothing, oral, gynaecological, hair, toxicological traces, etc.), appropriate instruments, and a list of instructions to be followed systematically in order to collect evidence of the assault. This kit will then be kept and possibly analysed by a laboratory, also at requested of the responsible magistrate. The latter receives the result and can use this evidence to establish the crime and/ or identify the perpetrator.
- 2) The forensic Institute: In this model, a forensic examination is carried out by a forensic doctor within a specialised structure, also at the request of the judge.
- 3) The SACC: The Sexual Assault Care Centre is a multi-disciplinary centre providing holistic care comprising of forensic, psycho-social and medical care as well as the possibility to file a complaint at the SACC itself and be interviewed by trained vice inspectors.

These systems differ in several ways:

- a) The quality of the forensic intervener: A doctor on duty; a forensic doctor and a forensic nurse;
- b) The setting where the procedure starts : sometimes judicial, sometimes medical and psycho-social;
- c) The framework of the intervention : medical, forensic institute, hospital.

Currently, those three systems function side by side. Some districts use only the SAS (e.g. Antwerp), others only the SACC (e.g. Ghent), but combinations are also possible. For example, a combination of the SAS and the SACC as in the Brussels region. There are also differences within each of these systems. While some districts have strongly regularised the use of such a system, for example by means of cooperation protocols, in other districts this remains a general fact, involving diversity.

4.4.3.2.2 Lack of homogeneity

A closer look at the SAS reveals that different actors are involved and that they all have different views on the procedure. One reason for this is that there seems to be a lack of homogeneity in the way a SAS procedure is applied in different judicial regions in Belgium.

A first lack of homogeneity concerns the way in which a victim is informed, welcomed and accompanied by the police when he/she agrees to undergo a SAS. Some victims will benefit from information and reception and will be accompanied by services specifically trained in the

issues of SV, while others will be accompanied by less specialised actors. The same applies to the way in which they are being treated, both in the police station as in the hospital. Some victims will be seen in a separate room, while others have to wait in the general waiting room next to many other people. Especially in a hospital when they are accompanied by police officers in uniform, they feel uncomfortable.

This lack of homogeneity in the practices surrounding the SAS may also be related to the type of actor who performs the forensic act itself. Sometimes the SAS is performed by a forensic doctor (someone experienced in the a priori identification of relevant traces). Sometimes it is done by an experienced specialist (as in certain hospitals that have organized themselves to receive and treat such victims). But sometimes the SAS is carried out by an emergency doctor with little experience in this field.

In some areas, informal exchanges or even collaboration protocols have been set up between psycho-medical-social services, police and judicial actors. In others practices are much less coordinated and standardised. Some actors have denounced the lack of mutual knowledge and collaboration, including the mutual ignorance that persists, in particular, between medical and judicial actors whose disciplines and requirements in relation to the victims are more distant than those of other actors.

Although practitioners' perceptions of the procedure may vary according to their position, their role and the structural and organisational resources specific to the implementation of the SAS procedure in their territory, they generally emphasise the fact that:

- It is inevitable that the victim and the actors accompanying him or her must travel from one place to another (especially from the police station to the hospital), especially when no collaboration protocol has been established between these are drawn up between these actors. It is therefore time consuming and can be very tiring for the victim, especially as it has to be carried out as soon as possible after the event.
- It is also time consuming because the SAS is often performed by a doctor who take on this procedure in addition to his regular work.
- Moreover, the lack of training of doctors who have to perform a SAS, which was confirmed by the quantitative part of this research (see Knowledge, attitude and practices of doctors regarding the SAS) was also often mentioned by professionals.
- Finally the lack of a central place for the victim's story during the forensic investigation was also mentioned. Due to the lack of experience, some doctors collect all samples available in the SAS, even when it may not be necessary.

It should be noted that the systematisation of the SAS procedure is precisely due to the nature of the tool, which is to accompany every medical staff member, even those with little training, in a forensic examination.

Finally, professionals point out the lack of a systematic complementary medical approach that takes into account the physical and mental health of the victim (follow-up of STD's, unwanted pregnancies, psychological, social and legal follow-up, etc.). The professionals denounce the often heavy, long and cold climate that weighs on victims.

However it should be noted that the intervention of certain victim support services created in Belgium within the police structure and the existence of a protocol within hospitals on this subject may improve this situation. However, there is still a lack of means for proper collaboration and coordination between the actors, including systematic feedback between

them on the quality of the samples taken, on their analysis or not, on the general follow-up given to the victim by the different actors, which prevents them from improving their practices. According to many professionals these dimensions have a very negative impact on the victim in terms of quality of his or her reception and support, but also in terms of the validity and future impact of this type of examination on the judicial process.

In this regard, the victims themselves, met during the interviews, confirmed some of the observations already mentioned, but also revealed their own needs.

On the one hand, they confirmed that it was difficult to access the SAS procedure because of the trauma they had suffered and the difficulty they had in putting into words what had happened to them, especially if the perpetrator was known or if they were in a situation where they felt that they themselves had not sufficiently expressed their non-consent or had somehow participated in a form of confusion (alcohol abuse, making appointments with the perpetrator, etc.). Shame, guilt, fear of the reaction of family members, poor perception of the police and the justice system, lack of help they have already experienced in similar or nearby situations, are also among the elements that prevent them from filing a complaint.

On the other hand, the victims who were in optimal conditions to offer and carry out a SAS show interesting results with regard to their perception of the forensic examination itself but also their expectations of it. Their experience of the forensic examination seems to vary greatly depending on who is conducting it. For some, it is primarily a gynaecological examination that has gone well, for others, it is an examination that must be done because their desire to be believed or to identify the perpetrator makes it necessary, in their opinion, to submit to this examination. But their main criticism is that had no information about the SAS procedure at the time they were subjected to it (at least that is how the victims remember it).

Furthermore, they strongly criticise the lack of information on the follow-up of the judicial file and the follow-up of the samples. Once the interrogation is over, they no longer appear to be part of the proceedings and are not informed.

These interviews were also eloquent when it came to shedding light on the traumatic effects of these types of violence on people, both psychologically and socially, in the short, medium and very long term.

The most important difficulty for victims is the difference between their truth and the judicial truth. Both professionals and victims point out this mismatch. The results of the SAS are often complementary to other available evidence. Evidence of sexual contact between two people is not sufficient for a person to be prosecuted. The issue of the victim's non-consent is central to a judge's conviction of SV but this non-consent is hard to prove, even with forensics evidence e.g. toxicological analyses. Victims on the other had hope that the forensic procedure will provide proof of what happened, confirms the reported facts and ensure recognition of their status as a victim. They also hope to have evidence (unlike police and judicial professionals, who are aware that evidence is not always available at the end of the process) and agree to undergo this procedure because they believe it will matter, since it is part of the process and therefore normal to undergo it.

4.4.3.2.3 The Sexual Assault Care Centres

Although our research focused primarily on the evaluation of SAS practices, it was nevertheless essential to observe them in the light of the evolution of the landscape of forensic care in Belgium and, in particular, the creation of new facilities, the Sexual Assault Care Centres for Victims of Sexual Violence (SACC), which we have already mentioned. Especially during the interviews, the practices of the SAS were systematically contrasted by these professionals with other existing forensic practices in Belgium.

Many of the criticism of the SAS raised by evaluation in the past and confirmed by this research, are addressed in the SACC. All care is centralised in a hospital structure where the victim also can be questioned on the spot by the trained police officers if she/he decides to file a complaint. Unlike the SAS procedure these centres have the special feature that victims can come forward without having to file a complaint. Forensic samples are taken in a less systematic way by specialised personnel. They are still starting from a scheme to collected traces but it is depending on the level and sort of physical contact where the story of the victim is taken more into consideration. The collected traces can be preserved for six months even without a complaint from the victim (Baert & Keygnaert, 2019). The stated advantages of this system are that the forensic, as well as the psychological, medical and social needs of the victim are central and not the exclusive needs of the judicial authorities.

Finally, the lack of feedback on the impact of the SAS and on the judicial process has been repeatedly criticised. Victims must find their own way through the range of legal and psycho-social services, especially in the long term.

4.4.4 *Conclusions and recommendations for science, society and policy makers*

4.4.4.1 Qualitative and accessible care

- Until the SACCs are fully developed in all Belgian judicial districts all the existing forensic models should be taken into consideration to avoid unequal treatment for victims.
- One person should be in charge of the coordination of the network of actors (police, magistrate, victim support services, etc.) involved in the Sexual Aggression Set (SAS) procedure.
- Proximity and accessibility of help seeking and forensic services should be guaranteed, independently of the model.
- Existing networks and expertise should be mobilised within SACC and specialised support should be extended in the long term.
- Psycho-social-legal support should be extended in time to meet the long-term needs of the victim.
- Non-judicial recognition of victims should be further developed and considered to meet the profound expectations of victims.

4.4.4.2 Training & campaigns

- Provide specialised training and dedicated staff in all different disciplinary frameworks (judicial, medical, police, psycho-social etc.) to take care of a victim undergoing a SAS-procedure.

- Awareness-raising and primary prevention campaigns must be set up for victims, assailants and those close to them, to enable them to recognise SV and label it as such.

4.4.4.3 Needs for future research

- Conduct an evaluation study on the quality of forensic traces according to various models and on their judicial impact in SV cases and further explore the impact of forensic examination on the judicial procedure (e.g. by doing a case-study of judicial files).
- Evaluate the position of forensic medicine and its capacity to respond to forensic tasks, in cases of SV, and more generally in the judicial system.
- Examine new ways allowing victims of SV to strengthen social and judicial recognition (feeling of justice).

4.4.5 Further reading

Capsule 5: Forensic responses to victims of sexual violence:

<https://vimeo.com/559892526/ff23a9ac80>

4.5 In summary

Context

Sexual violence (SV) is a major public health, judicial and societal concern in Belgium. Previous studies have shown that 11% of male and 36% of female Belgian citizens and up to 32% of male and 56% of female migrants in Belgium have experienced SV. Yet, a comparative and representative study of SV in Belgium covering all ages, genders, sexual orientations and legal statuses was still lacking. Moreover, previous studies mostly apply a dichotomous view focussing solely on female victims and male assailants.

Extensive research has demonstrated that SV may induce long lasting sexual, reproductive, physical and mental ill-health in victims, but may also potentially harm the victim's peers, offspring and community. People who were directly or indirectly exposed to violence during childhood, are susceptible to subsequent (re)victimization, perpetration and to maladaptive parental practices, which contributes to the intergenerational transmission of violence. However, the complex mechanisms behind this coping behaviour as well as the effectiveness of response measures to all genders and ages has not yet been studied.

Furthermore, judicial follow-up is important for victims in terms of recognition. In Belgium we are currently in a transition phase in which a variety of medical-judicial models are being applied e.g. Sexual Aggression Set (SAS) and Sexual Assault Care Centres (SACCs). Hence the necessity to conduct a Belgian representative prevalence SV study examining all vulnerabilities to victimisation and perpetration.

Objectives

The general aim of the UN-MENAMAIS project was to contribute to a better Understanding of the MEchanisms, NAture, MAgnitude and Impact of SV in Belgium, as well to generate policy recommendations and prevention and response strategies. We defined five core objectives:

- Objective 1: Map how citizens and migrant residents in Belgium aged 16 -100 years, with different sexual orientations, frame SV.
- Objective 2: Explore to what extent the research population has been exposed to sexual victimisation and perpetration since childhood. We studied experiences of victims, perpetrators, peers and family of different generations.
- Objective 3: Map indicatory pathways of how this exposure impacted the lives of victims, their family and peers and professionals they contacted for assistance.
- Objective 4: Map the historical social and technical construction of the SAS and its impact on current and future forensic sexual assault practices performed by professionals.
- Objective 5: Formulate recommendations for future policies and practices concerning SV in Belgium and provide sensitization script

Methodology

This study was conducted by an interdisciplinary research consortium from Ghent University, ULiège and NICC, led by Prof. Ines Keygnaert. We applied a mixed method approach. We started with an extensive literature review. Moreover, we conducted a quantitative study in which performed an online survey in a representative sample of > 5000 persons aged 16-69, face-to-face structured interviews with the same survey questionnaire in 513 older adults (70+) and 62 applicants of international protection and a Knowledge, Attitude & Practice Survey in 2031 medical doctors. In addition, we carried out a qualitative study in which we completed 158 in-depth interviews with victims of SV of different ages, genders, sexual orientations and legal statuses on the impact of SV and help seeking behaviour. Furthermore, we interviewed 50 healthcare professionals, law enforcement officials and 11 victims on forensic aspects of SV. Finally, we integrated our results into policy recommendations which were refined based on the World café Dialogue discussions during our final seminar. Throughout the whole project we applied a broad definition of SV, based on the WHO definition: “Any sexual act that is perpetrated against someone’s will, committed by any person regardless of their relationship to the victim, in any setting”.

Results

Sexual violence in the Belgian population aged 16 to 69 years

In people between 16 and 69 years, 64% (81% females and 48% males) experienced SV during their life. Two in five women and one in five men indicated to have been subjected to hands-on SV (with physical contact between the assailant and the victim) with 5% of men and 16% of women indicating to have been raped. In the past 12-months, 55% of women and 31% of men experienced some form of hands-off sexual victimization, 10% of women and 6%of

men reported hands-on SV. Hands-on SV was linked to adverse mental health outcomes such as depression, anxiety, PTSD and suicide attempts. Most victims had not sought for help so far. Only 7% looked for professional help and 4% reported their victimisation to the police.

Sexual violence in older adults in Belgium aged 70 years and older

More than 44% of older adults aged 70 and older (55% females and 29% males) experienced SV during their life. One in three women and one in six men indicated to have been subjected to hands-on SV, with 8% of women and 3% of men indicating (attempted) rape. Moreover, one in 12 older adults (8%) said they had been victimised in the past 12 months: 7% reported hands-off, 2.5% hands-on SV and 0.6% (attempted) rape.

Women and men were equally victimised at this age. Older victims continue to cope with mental health problems, such as depression, anxiety, PTSD and hazardous alcohol use, as a result of SV earlier in life.

Less than half of the older victims had ever talked about their experience, 6% sought professional help, and only 4% reported the violence to the police.

Sexual violence in minorities in Belgium

80% of LGBTQIA+ persons were exposed to any type of SV; 79% experienced hands-off SV (e.g. sexual harassment, forms without physical contact between the assailant and the victim) and 42% hands-on SV, of which 24% concerned (attempt to) rape. Moreover, 68% of LGBTQIA+ persons were exposed to SV in the past 12-months.

For applicants of international protection residing in Belgium victimisation rises to over 84%, in 61% this happened in the last 12 months when they were already in Europe or Belgium.

Both LGBTQIA+ persons and AIPs reported even more barriers to seek help or report the SV to the police compared to the general population.

Forensic responses to sexual violence in Belgium

The majority of doctors (70%) working in Belgium have seen at least one victim of SV during their career. However, victims usually come forward after several years.

In terms of forensic responses, we are currently in a transitional phase in which different forensic models are being implemented, such as the SAS and the SACCs. Regardless of the forensic model, victims are systematically confronted with secondary victimisation due to the long judicial process about which they get little information. Often their victimisation is also not recognised because of the judicial logic, which implies the use of specific means of evidence, and for which forensic evidence is not always sufficient. Finally, in general, there is a clear lack of forensic doctors to carry out all the forensic tasks that would allow the best results to be obtained for the judicial investigation and, ultimately, to contribute to the optimal care of the victims.

Main conclusions

Sexual violence is prevalent in Belgium and affects people of all ages, genders, sexual orientations and legal statuses. Being sexually victimised is linked to worse mental health outcomes across the life course. Moreover, victims find it difficult to seek help and to report to the police.

Furthermore, doctors are not sufficiently aware of the care they should provide, nor of potential impact of forensic examination and do not systematically refer victims of sexual violence to adequate care, forensic or legal authorities. Regardless of the forensic model considered, victims find it difficult to gain recognition from the courts because of the judicial logic, which involves specific principles of proof and for which forensic evidence is not always sufficient.

Based on these findings, we formulated policy recommendations which can be consulted here: Annex I. UN-MENAMAIS Policy recommendations.

5 DISSEMINATION AND VALORISATION

5.1 Final seminar

As described under 3.4 WP4: *Policy Recommendations: seminar with Café Dialogue focus groups*, an international virtual seminar was organised on June 17th, 2021 called 'Beyond the tip of the iceberg: Sexual violence in Belgium'.

Online capsules presenting the methodology and findings of the UN-MENAMAIS project were shared with the participants prior to the virtual seminar. These capsules remained available to anyone at for up to six months after the virtual seminar took place. The presentations on the research results can be consulted individually per topic via:

- Capsule 1: Methodology of the UN-MENAMAIS survey & qualitative study:
<https://vimeo.com/559891663/bbd76ac566>
- Capsule 2: Sexual violence in the Belgian population aged 16-69:
<https://vimeo.com/559891909/9a49e99237>
- Capsule 3: Sexual violence in older adults in Belgium:
<https://vimeo.com/559892123/d3232ac805>
- Capsule 4: Sexual violence in minority groups in Belgium (LGBT+ & AIPs):
<https://vimeo.com/559892366/ec05ba53f6>
- Capsule 5: Forensic responses to victims of sexual violence:
<https://vimeo.com/559892526/ff23a9ac80>

During the international virtual seminar Q&A sessions per capsule were organised as well as a debate with (inter)national experts. The full seminar can be revisited via <https://vimeo.com/565683481/4682c8ed05>.

5.2 Café Dialogue focus groups

Immediately following the debate during the international virtual seminar, we embarked on a Café Dialogue with relevant stakeholders to discuss the main findings of the UN-MENAMAIS study and to validate and valorise the policy recommendations developed by the UN-MENAMAIS consortium based on the project findings. Eighteen focus groups were organised on three topics, namely (1) sensitization and societal image, (2) care and (3) judicial approach. Three groups were held in Dutch and three in French so that each participant could express himself in his own language.

5.2.1 *Specific policy recommendations following the Café Dialogue focus groups*

Based on the Café Dialogue, different policy recommendations were developed. These recommendations are included in the conclusions and recommendations for science, society and policy makers of the various chapters of this final report and can be consulted in full detail in Annex I. UN-MENAMAIS Policy recommendations.

5.2.2 *Sensitization scripts following the Café Dialogue focus groups*

In addition to concrete policy recommendations, several sensitization scripts were developed based on the Café Dialogue and the results of the UN-MENAMAIS study. These

scripts provide guidance for future campaigns on SV in Belgium. They provide guidance on how SV and victimization should be portrayed in campaigns, which myths surrounding SV should be addressed, which specific target groups campaigns should focus on and so on. These sensitization scripts are enclosed to the final report (see Annex II. Sensitization scripts following the Café Dialogue).

5.3 Scientific dissemination

The consortium actively communicated about the project, its design and methodology, preliminary and final results within the scientific community. This resulted in 8 published peer reviewed papers, several papers under review and in progress and 2 other published publications (see PUBLICATIONS), 36 oral, and 9 poster presentations.

5.3.1.1 Oral presentations

- De Schrijver, L., Schapansky, E., Vander Beken, T., Janssen, E., Roelens, K., Vandeviver, C., & Keygnaert, I. (2020). Sexual violence in sexual and gender minorities: preliminary results from the UN-MENAMAIS study in Belgium. To be presented at ISRA World Meeting 2020, Ottawa, Canada. (postponed to 2022)
- Nobels, A., Cismaru-Inescu, A., Nisen, L., Degomme, O., Hahaut, B., Vandeviver, C. & Keygnaert, I. (2020). Conducting sexual health and violence research in older adults in a post-GDPR era: a Belgian case study. To be presented at ISRA World Meeting 2020, Ottawa, Canada (postponed to 2022)
- Nobels, A., Vandeviver, C., Cismaru-Inescu, A., Hahaut, B., Nisen, L. & Keygnaert I. (2020). Sexual Violence in Older Adults: A Belgian Prevalence Study. To be presented at ISRA World Meeting 2020, Ottawa, Canada (postponed to 2022) .
- De Schrijver, L., Nobels, A., Janssen, E., Krahe, B., Roelens, K., Vander Beken, T., & Keygnaert, I. (2021). Sexual violence in applicants for international protection residing in Belgium. To be presented at the 14th European Public Health Conference 2021, Virtual Edition.
- Nobels, A., Lemmens, G., Thibau, L., Beaulieu, M., Vandeviver, C., & Keygnaert, I. "Time does not heal all wounds": mental health impact of sexual victimisation in older adults. To be presented at the 14th European Public Health Conference 2021, Virtual Edition.
- De Schrijver, L., Schapansky, E., Vander Beken, T., Janssen, E., Krahe, B., Roelens, K., Vandeviver, C. & Keygnaert, I. (19 July 2021). Sexual violence in gender and sexually diverse persons: results from the UN-MENAMAIS study in Belgium. To be presented at the 32nd International Congress of Psychology, Prague, Virtual Edition.
- Cismaru Inescu, A. & Nobels, A., Hahaut, B., Berg, N. (2021). Sexual violence in older adults in Belgium. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition
- De Schrijver, L. (2021). Methodology of the qualitative UN-MENAMAIS study on the impact of sexual victimization. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- De Schrijver, L. (2021). Sexual violence in the Belgian population aged 16-69: impact and help-seeking behaviour upon victimisation. Presented at "Beyond the tip of the iceberg:

- Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- De Schrijver, L. (2021). Sexual violence in applicants for international protection residing in Belgium. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- De Schrijver, L. (2021). Sexual violence in sexual and gender minorities in Belgium. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Nobels, A. (2021). Conducting sexual violence research in older adults beyond GDPR. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Nobels, A. (2021). Mental health impact and help seeking behaviour upon sexual victimisation in older adults. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Schapansky, E. (2021). Methodology of the UN-MENAMAIS online survey in the Belgian general population. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Schapansky, E. (2021). Sexual violence in the Belgian population aged 16-69. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Hahaut, B. (2021). Nature and Magnitude of sexual violence in older adults in Belgium. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Stappers, C., Lemonne A. & Renard, B. (2021). SAS practices : perspectives professionals and victims. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Stappers, C., Lemonne A., Renard, B. & Robert, L. (2021). Knowledge, Attitudes and Practices of doctors regarding sexual violence and SAS. Presented at "Beyond the tip of the iceberg: Sexual violence in Belgium". UN-MENAMAIS final seminar, 17 June 2021, Ghent, Virtual Edition.
- Berg, N., Cismaru-Inescu, A., Nobels, A., Hahaut, B., Keygnaert, I., Beaulieu, M., Adam, S., Vandeviver, C., Nisen, L. (10-11 June 2021). Les aînés, une population fragile oubliée dans la lutte contre les violences sexuelles. Fragilité du sujet âgé, Virtual Edition.
- De Schrijver, L., Nobels, A., Janssen, E., Krahé, B., Roelens, K., Vander Beken, T., & Keygnaert, I. (9 June 2021). Sexual violence in applicants for international protection: results from the UN-MENAMAIS study in Belgium. Presented at the 7th International Conference on the Survivors of Rape (ICSOR), London, Virtual Edition.
- De Schrijver, L., Schapansky, E., Janssen, E., Krahé, B., Roelens, K., Vander Beken, T., Vandeviver, C. & Keygnaert, I. (9 June 2021). Sexual violence in sexual and gender minorities: results from the UN-MENAMAIS study in Belgium. Presented at the 7th International Conference on the Survivors of Rape (ICSOR) , London, Virtual Edition.
- Nobels, A., Cismaru-Inescu, A., Nisen, L. Hahaut, B. Beaulieu, M., Lemmens, G., Vandeviver, C., & Keygnaert, I. (10th of June 2021). Sexual violence in older adults: a Belgian

- prevalence study. Presented at the 7th International Conference on the Survivors of Rape (ICSOR) , London, Virtual Edition.
- Renard, B., Lemonne, A. & Stappers, C. (17-21 May 2021). La prise en charge médico-légale des victimes de violence sexuelle en Belgique - En faveur d'un approche holistique ? Réflexion à la lumière d'un perception du corps médical, des acteurs de la justice et du discours des victimes. Presented at Colloque international de psycho-criminologie et victimologie : évolutions, innovations, perspectives, Rennes, France, virtual presentation.
- Cismaru-Inescu, A., Hahaut, B., Adam, S., Nobels, A., Beaulieu, M., Vandeviver, C., Keygnaert, I., Nisen, L. (15 April, 2021). American Society on Aging "To be or not to be. Older adults, sexuality and ageist stereotypes", Virtual Edition
- De Schrijver, L., Nobels, A., Keygnaert, I. (31 March 2021): Seksueel geweld in gender en seksueel diverse en oudere personen in België. Presented at the 23e Nederlands-Vlaams Hybride Doelencongres: Infertiliteit, Gynaecologie, Obstetrie, Rotterdam, The Netherlands, Virtual Edition.
- Cismaru-Inescu, A., Adam, S., Kempeneers, P., Nobels, A., Keygnaert, I., Vandeviver, C., Beaulieu, M., Nisen, L. (26-27 March, 2021). Synthèse interprétative critique sur la sexualité des aînés, Virtual Edition
- Nobels, A. (21 October 2020). Lecture: "Ouderenmis(be)handeling: Setting the Scene". Symposium Elder abuse and Neglect Orde Van Geneesheren Oost-Vlaanderen, Ghent, Belgium.
- Nobels, A. Webinar: (Sexual) violence in older adults. Vlaamse Vereniging voor Psychiatrie (VVP), 12th of October 2020, Online.
- De Schrijver, L., Nobels, A., Baert, S., Verplancke, J. & Keygnaert, I. (13 December 2019). Seksueel geweld in België: omgaan met kwetsbaarheden, gevolgen en hulpzoekgedrag. To be presented at "Let's talk about sex", Annual conference of Vlaamse Vereniging voor Gedragstherapie (VVGT), Deinze, Belgium.
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- Depraetere, J., Vandeviver, C., Vander Beken, T., & Keygnaert, I. (13-16 November 2019). The prevalence and correlates of male sexual victimization among the Belgian population. Presented at the Annual meeting of the American Society of Criminology "Criminology in the New Era: Confronting Injustice and Inequalities". San Francisco, CA, United States: ASC.
- Renard, B. & Lemonne, A. (6-9 November 2019). La prise en charge médico-légale des victimes de violences sexuelles sous la loupe – Entre confiance et défiance. Presented at Congres of Société de criminologie du Québec and Association canadienne de justice pénale, Québec, Canada.
- Nobels, A., Van Den Noortgate, N., Lemmens, G., Vandeviver, C. & Keygnaert, I. (21 September 2019). Sexual violence in older adults: Results from a pilot study. Presented at EuroCrim, Ghent, Belgium.

- De Schrijver, L. & Keygnaert, I. (3 July 2019). Understanding sexual violence victimisation in migrants, sexual and gender minorities in light of an othering based stress model. Presented at “XVI European Congress of Psychology”, Moscow, Russia.
- De Schrijver, L., Vander Beken, T., Janssen, E. & Keygnaert, I. (3 July 2019). Sexual violence in sexual minorities: A critical interpretive synthesis. Presented at “XVI European Congress of Psychology”, Moscow, Russia.
- De Schrijver, L., Vander Beken, T., Krahé, B. & Keygnaert, I. (3 July 2019). Sexual violence in migrants, applicants for international protection and refugees: a critical interpretive synthesis. Presented at “XVI European Congress of Psychology”, Moscow, Russia.
- Lemonne, A. & Renard, B. (14 March 2019). UN-MENAMAIS: une meilleure compréhension des mécanismes, de la nature, de l'importance et de l'impact des violences sexuelles en Belgique. Séminaire des Midis du CRID&P, UCLouvain, Belgium.
- De Schrijver, L. (10 January 2019). Discrimination in Health Care. Presented at the CESSMIR PhD Meeting – Ghent University, Ghent, Belgium.
- De Schrijver, L., Vander Beken, T., Krahé, B. & Keygnaert, I. (11 December 2018). Sexual violence in migrants, applicants for international protection and refugees: a critical interpretive synthesis. Presented at “International Conference on the Survivors of Rape”, Helsinki, Finland.
- De Schrijver, L., Vander Beken, T., Janssen, E. & Keygnaert, I. (11 December 2018). Sexual violence in sexual minorities: A critical interpretive synthesis. Presented at “International Conference on the Survivors of Rape”, Helsinki, Finland.
- Nobels, A., Vandeviver, C., Beaulieu, M., Cismaru-Inescu, A., Nisen, L., Van Den Noortgate, N., Vander Beken, T., Lemmens, G. & Keygnaert, I. (11 December 2018). Are we forgetting older adults in sexual violence research, policies and practices. Presented at the 6th International Conference on the Survivors of Rape, Helsinki, Finland.
- De Schrijver, L., Vander Beken, T., Krahé, B., & Keygnaert, I. (2018). Sexual violence in migrants, applicants for international protection and refugees : a critical interpretive synthesis. Presented at the 1st Annual CESSMIR conference: Needs and care practices for refugees and migrants, Ghent, Belgium: Centre for the Social Study of Migration and Refugees (CESSMIR).
- Renard, B. & Lemonne, A. (5 Juin 2018). Deux modèles de prise en charge médico- légale des victimes d'abus sexuel sous la loupe – indifférence institutionnelle et négation d'un traitement différentiel des catégories de victimes. Presented at XVIème Colloque de l'Association Internationale des Criminologues de la Langue Française (AICLF). Penser et pratiquer la criminologie au-delà de nos (in)différences, Lausanne, Switzerland.
- Vandeviver, C., Depraetere, J., De Schrijver, L., Nobels, A., Inescu, A., Nisen, L., Lemonne, A., et al. (2018). UN-MENAMAIS : understanding the mechanisms, nature, magnitude and impact of sexual violence on female, male and transgender victims, their peers, offspring, professionals and society in Belgium. *European Society of Criminology, 18th Annual conference, Abstracts*. Presented at the 18th Annual conference of the European Society of Criminology (EUROCRIM 2018): Crimes against humans and crimes against humanity : implications for modern criminology.

5.3.1.2 Poster presentations

- De Schrijver, L., Nobels, A., Vander Beken, T., Krahé, B., Roelens, K., Vandeviver, C., & Keygnaert, I. (2020). Sexual violence in applicants for international protection: preliminary results from the UN-MENAMAIS study in Belgium. To be presented at ISRA World Meeting 2020, Ottawa, Canada. (postponed to 2022)
- De Schrijver, L., Schapansky, E., Janssen, E., Krahé, B., Roelens, K., Vander Beken, T., Vandeviver, C. & Keygnaert, I. (2021). Sexual violence in gender and sexually diverse persons in Belgium. To be presented at the 14th European Public Health Conference 2021, Virtual Edition.
- Cismaru-Inescu, A., Hahaut, B., Adam, S., Nobels, A., Keygnaert, I., Beaulieu, M., Vandeviver, C., Nisen, L. (11-12 June 2021), The continuum of sexuality in older age: a Belgian cross-sectional study. Presented at European Sexology Congress, Aalborg, Denmark, Virtual Edition.
- Cismaru-Inescu, A., Nobels, A., Hahaut, B., Adam, S., Beaulieu, M., Vandeviver, C., Keygnaert, I. & Nisen, L. (11-12 June 2021). Past 12-months sexual violence in older adults – a Belgian prevalence study. Presented at European Sexology Congress, Aalborg, Denmark, Virtual Edition.
- Cismaru-Inescu, A., Nobels, A., Hahaut, B., Keygnaert, I., Beaulieu, M., Adam, S., Vandeviver, C., Nisen, L. (10-11 Juin 2021) La fragilité des politiques de santé sexuelle face aux aînés. Presented at Fragilité du sujet âgé, Toulouse, France, Virtual Edition.
- Renard, B., Lemonne, A. & Stappers, C. (17-21 mai 2021). La prise en charge médico-légale des victimes de violence sexuelle en Belgique - Acteurs impliqués et enjeux spécifique. Presented at Colloque international de psycho-criminologie et victimologie : évolutions, innovations, perspectives, Rennes, France, virtual presentation.
- Nobels, A., Van Den Noortgate, N., Lemmens, G., Vandeviver, C. & Keygnaert, I. (24 May 2019). Sexual violence in older adults: Results from a pilot study. Presented at the International Association of Gerontology and Geriatrics European Region Congress, Gothenburg, Sweden.
- Cismaru-Inescu, A. & Berg, N. (4-5 April 2019). Violences sexuelles, maltraitances des aînés : un risque de fragilisation des personnes âgées. Presented at 7ème Congrès Fragilité du Sujet Âgé Le Vieillissement en Santé Prévention de la Perte d'Autonomie, Paris, France.
- Lemonne A., Renard B., Keygnaert I., Vandeviever Ch., Vander Beken T., Nisen L., Nobels A., De Schrijver L., Depraetere J., Cismaru-Inescu A., Stappers C., Robert L. (5 Juin 2018). UN-MENAMAIS: Une meilleure compréhension des mécanismes, de la nature, de l'importance et de l'impact des violences sexuelles en Belgique. Presented at au XVIème Colloque de l'Association Internationale des Criminologues de la Langue Française (AICLF). Penser et pratiquer la criminologie au-delà de nos (in)différences, Lausanne, Switzerland.

5.4 Press, media and other communications

5.4.1 Press release and conference

On June 15th, 2021 a press release was delivered to the media and virtual press conference was held to disseminate the findings from the UN-MENAMAIS study. The project coordinator, Prof. dr. Ines Keygnaert, presented the main results and conclusions during a plenary session upon which the attending journalists had to opportunity to ask general questions which were answered by the project coordinator and the researchers: Evelyn Schapansky answered questions regarding the general population; Anne Nobels and Adina Cismaru-Inescu covered the results on older adults; Lotte De Schrijver responded to questions regarding minority group and findings from the qualitative study; and Caroline Stappers replied to questions related to forensic aspects. After the plenary session, question on specific subgroup or research topic could be asked to the researchers in breakout rooms and their contact details were communicated for follow-up interviews.

5.4.2 Media coverage (amongst others)

- Newspaper articles (list is not exhaustive):
 - o 15/06:
 - Twee derde van de Belgische bevolking geconfronteerd met seksueel geweld – BELGA
 - Two-thirds of Belgian population experience sexual violence, study shows – The Brussels Times
 - Les violences sexuelles n'épargnent personne, selon une étude - RTBF
 - o 16/06:
 - Seksueel geweld treft veel mensen en stopt niet bij zekere leeftijd - De Standaard - Pagina 8
 - Meer hulp en expertise nodig - De Standaard - Pagina 9
 - Twee op drie Belgen ooit slachtoffer van seksueel geweld - Het Laatste Nieuws - Pagina 1
 - 2 op 5 senioren slachtoffer van seksueel geweld - Het Laatste Nieuws - Pagina 15
 - 42% van de vrouwen (fysiek seksueel geweld) - Het Nieuwsblad - Pagina 11
 - “Er worden niet alleen jonge meisjes verkracht” - Gazet van Antwerpen - Pagina 11
 - Les personnes âgées sont aussi victimes de violences sexuelles - L'Avenir - Pagina 2
 - Des chiffres effrayants recensés en Belgique - Le Soir - Pagina 10
 - Les personnes âgées sont aussi victimes de violences sexuelles - L'Avenir – Online
 - Seksueel geweld groter probleem dan gedacht - De Morgen - Pagina 1
 - Factchecker - Knack - Pagina 53
- Radio:
 - o News coverage at MNM, Radio 1 June 15-16
 - o News coverage at RTBF:
https://www.rtbef.be/auvio/detail_le-journal-de-13h?id=2781128
- Television:

- Twee derde van de Belgische bevolking heeft ooit seksueel geweld meegemaakt- Journaal VRT, June 15 2021: <https://www.vrt.be/vrtnws/nl/2021/06/14/twee-derde-van-belgische-bevolking-heeft-ooit-seksueel-geweld-me/>
- Deux tiers de la population belge victimes de violences sexuelles au cours de leur vie- journal RTL 19H info, June 15, <https://m.rtl.be/videos/783578>
- Débat Deux tiers de la population belge victimes de violences sexuelles au cours de leur vie, C'est pas tous les jours dimanches, RTL, <https://www.rtlplay.be/cest-pas-tous-les-jours-dimanche-p-8455/emission-du-20-06-21-c-12878759>

5.5 Communication to BELSPO, scientific guidance committee (SGC) and relevant stakeholders

- **The UN-MENAMAIS Literature review report:** A draft of the literature review report was sent to all SGCs and BELSPO prior to the SGC of December 2017. The feedback was taken into account for finalization early 2018. The different chapters engendered articles to be submitted to international peer-reviewed journals that were available through open access. The procedure as lead out by BELSPO was followed and the final report was submitted to BELSPO early 2018 as a final deliverable of WP1. The report was not made publicly available as it might have disclosed too much information that could bias the quantitative and qualitative research phase which was to be avoided at all times.

6 PUBLICATIONS

6.1 Peer reviewed articles

6.1.1 Published

- Nobels, A., Cismaru-Inescu, A., Nisen, L., Hahaut, B., Lemmens, G., Vandeviver, C., & Keygnaert, I. (2021). Challenges in conducting sexual health and violence research in older adults beyond GDPR: A Belgian case study. *Journal of Interpersonal Violence*, 1-21. DOI: 10.1177/08862605211015256
- Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Prevalence and associated factors of sexual victimization: Findings from a national representative sample of Belgian adults aged 16–69. *International Journal of Environmental Research and Public Health*, 18(14), 7360. <https://doi.org/10.3390/ijerph18147360>
- Schapansky, E., Depraetere, J., Keygnaert, I., & Vandeviver, C. (2021). Seksueel geweld in België : aard, omvang en risicofactoren van slachtofferschap van seksueel geweld in een nationaal representatieve bevolkingssteekproef. *Panopticon*, 42(3).
- Depraetere, J., Vandeviver, C., Beken, T. Vander, & Keygnaert, I. (2020). Big Boys Don't Cry: A Critical Interpretive Synthesis of Male Sexual Victimization. *Trauma, Violence, and Abuse*, 21(5), 991–1010. <https://doi.org/10.1177/1524838018816979>

- Nobels, A., Vandeviver, C., Beaulieu, M., Cismaru-Inescu, A., Nisen, L., Van Den Noortgate, N., Vander Beken, T., Lemmens, G. & Keygnaert, I. (2020). "Too grey to be true?" Sexual violence in older adults: a critical interpretive synthesis of evidence. *International Journal of Environmental Research and Public Health*; 17(11).
- De Schrijver, L., Vander Beken, T., Krahé, B., & Keygnaert, I. (2018). Prevalence of sexual violence in migrants, applicants for international protection, and refugees in Europe: a critical interpretive synthesis of the evidence. *International journal of environmental research and public health*, 15(9), 1979. <https://doi.org/10.3390/ijerph15091979>
- Depraetere, J., Vandeviver, C., Vander Beken, T., & Keygnaert, I. (2018). Nood aan een kritisch Interpretatieve synthese : genderverschillen in prevalentiecijfers van seksueel geweld gekaderd. *Panopticon*, 39(5), 389–406.
- Keygnaert, I. , Vandeviver, C., Nisen, L., De Schrijver, L., Depraetere, J., Nobels, A., Cismaru Inescu, A., Lemonne, A., Renard, B., Vander Beken, T. (2018) Les violences sexuelles en Belgique : première étude de prévalence représentative sur la nature,l'ampleur et l'impact des violences sexuelles en Belgique. *Science Connection*,59, 28-31.
- Keygnaert, I. , Vandeviver, C., Nisen, L., De Schrijver, L., Depraetere, J., Nobels, A., Cismaru Inescu, A., Lemonne, A., Renard, B., Vander Beken, T. (2018).Seksueel geweld in België. Eerste representatieve prevalentiestudie naar de aard, omvang en impact van seksueel geweld in België. *Science Connection*, 59, 28-31.
- Nobels, A., Vandeviver, C., Beaulieu, M., Lemmens, G., & Keygnaert, I. (2018). Are older women forgotten in the fight against sexual violence? *Lancet Global Health*, 6(4). p.e370-e370.

6.1.2 *In press*

- Cismaru-Inescu, A., Adam, S., Nobels, A., Kempeneers, P., Beaulieu, M., Vandeviver, C., Keygnaert, I., Nisen, L. (2021). The elephant in the room - a critical interpretive synthesis of older adults' sexuality. *In press at International Journal of Sexual Health*
- De Schrijver, L., Cismaru-Inescu, A., Hahaut, B., Vandeviver, C., Nisen, L. & Keygnaert, I. (2021). Research in hard-to-reach populations: challenges and strategies for conducting sexual violence studies in applicants for international protection beyond GDPR. *SocArXiv*. <https://doi.org/10.31235/osf.io/8nhbr>. *In press at International Journal of Health Policy and Management*.

6.1.3 *Under review, preprints and in progress*

- Cismaru-Inescu, A., Hahaut, B., Adam, S., Nobels, A., Beaulieu, M., Vandeviver, C., Keygnaert, I., Nisen, L. (2021). Sexual activity and physical tenderness in older adults: prevalence and associated characteristics in a Belgian national study. *In progress*
- De Schrijver, L., Krahé, B., Vander Beken, T., Roelens, K., & Keygnaert, I. (2021). Vulnerabilities, Consequences, and Help-seeking Behavior Related to Sexual Victimization in Migrants, Applicants for International Protection, and Refugees in Europe: A Critical Interpretive Synthesis. *SocArXiv*, <https://doi.org/10.31235/osf.io/85wxh>. *Under review*

- De Schrijver, L., Nobels, A., Harb, J., Nisen, L., Janssen, E., Roelens, K., Vander Beken, T., Vandeviver, C., & Keygnaert, I. (2021). Sexual violence and help-seeking behavior in applicants for international protection residing in Belgium. *Under review*
- Nobels, A., Cismaru Inescu, A., Nisen, L., Hahaut, B., Beaulieu, M., Lemmens, G., ... Keygnaert, I. (2021). Sexual violence in older adults : a Belgian prevalence study. *Under review*.
- Nobels A., Lemmens G., Thibau L., Beaulieu M., Vandeviver C., & Keygnaert I. (2021). "Time does not heal all wounds": Sexual victimisation is associated with depression, anxiety, and PTSD in old age. *MedRxiv*. <https://doi.org/10.1101/2021.06.05.21258397>. *In progress*.
- Nobels A., Lemmens G., Van Hove J., Beaulieu M., Vandeviver C., & Keygnaert I. (2021). Sexual violence and substance abuse in older adults. *In progress*.
- Nobels A., De Schrijver, L., Van Landuyt, M., Vandeviver, C., Lemmens G., Beaulieu, M., & Keygnaert I. (2021). Help seeking behaviour upon sexual victimisation in older adults. *In progress*.
- Schapansky, E., Keygnaert, I., & Vandeviver, C. (2021, June 29). Characteristics and Associated Factors of Self-Disclosed Sexual Aggression in a National Representative Sample of Belgian Adults Aged 16-69. *SocArXiv*. <https://doi.org/10.31235/osf.io/3d2tm>. *Under review at SN Social Sciences*.
- Depraetere, J., Cismaru-Inescu, A., De Schrijver, L., Nobels, A., Keygnaert, I., & Vandeviver, C. (2020, October 1). Measuring sexual victimization and perpetration in today's society: modifications to the sexual experiences survey. *SocArXiv*. <https://doi.org/10.31235/osf.io/cgevu>. *Under review*.
- De Schrijver, L., Vander Beken, T., Janssen, E. & Keygnaert, I. (2018). Sexual violence in sexual minorities in Europe: a critical interpretive synthesis. *In progress*.

6.2 Other publications

- Nobels, A., & Keygnaert, I. (2021). Older adults : forgotten in research, policies and health care practices regarding sexual violence. In E. Peeters & A. Seeuws (Eds.), ANSER : five years of global academic collaboration building evidence for sexual and reproductive health and rights policies (pp. 60–63). Ghent, Belgium: Academic Network for Sexual and Reproductive Health and Rights Policies (ANSER).
- De Schrijver, L., Vander Beken, T., Krahé, B., & Keygnaert, I. (2018). Sexual violence in migrants, applicants for international protection and refugees : a critical interpretive synthesis. In I. Derluyn (Ed.), Book of abstracts : 1st annual CESSMIR conference 2018, Ghent (Belgium) : needs and care practices for refugees and migrants. Presented at the 1st Annual CESSMIR conference: Needs and care practices for refugees and migrants, Ghent, Belgium: Centre for the Social Study of Migration and Refugees (CESSMIR).
- Cismaru Inescu, A. (2020). Les violences et les négligences sexuelles envers les aînés, une réalité méconnue. *Revue L'observatoire, Vulnérabilités et avancée en âge*, no 104.

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9 ANNEXES

Annex I. UN-MENAMAIS Policy recommendations

Annex II. Sensitization scripts following the Café Dialogue

Annex III. Press release

Annex IV. Topic list in-depth interviews