Health System Response to Sexual Violence Against LGBTQ Persons in African Humanitarian and Conflict Settings: A Systematic Review

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ABSTRACT

Background: Sexual violence against lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons in African humanitarian and conflict settings is a neglected public health and human rights issue. Criminalisation, stigma, and discrimination frequently limit access to healthcare and psychosocial support for survivors.

Objective: To synthesise evidence on health-system responses to sexual violence against LGBTQ persons in African humanitarian and conflict settings, focusing on service accessibility, quality of care, barriers and facilitators to healthcare access, healthcare worker preparedness, and policy responses.

Methods: A systematic search of PubMed, Scopus, Embase, Web of Science, CINAHL, and grey literature sources, including WHO, UNHCR, Human Rights Watch, and Amnesty International databases, was conducted for studies published between 2000 and 2024. Eligible studies addressed sexual violence, healthcare access, or health-system responses among LGBTQ populations in African humanitarian or conflict-affected settings. Study quality was assessed using CASP, ROBINS-I, and AACODS tools. Findings were synthesised narratively.

Results: Of 3,847 records identified, 22 studies and reports met the inclusion criteria. Seven themes emerged: access to post-rape healthcare, quality of clinical care, psychosocial support, healthcare worker preparedness, barriers to care, facilitators of care, and policy responses. Evidence revealed limited access to inclusive services, inadequate provider training, persistent stigma and discrimination, and a lack of LGBTQ-inclusive sexual and gender-based violence protocols.

Conclusion: Health systems in African humanitarian and conflict settings remain inadequately prepared to address sexual violence against LGBTQ persons. Inclusive policies, healthcare worker training, and survivor-centred care pathways are urgently needed.

Keywords: LGBTQ; humanitarian settings; health systems; Africa; sexual and gender-based violence;

INTRODUCTION

Global Burden of Sexual Violence

Sexual violence constitutes one of the most prevalent and consequential forms of human rights violations globally, exacting profound physical, psychological, and social harms upon survivors. The World Health

Organization (WHO) estimates that approximately one in three women worldwide has experienced physical or sexual violence perpetrated by an intimate partner or non-partner during their lifetime, with prevalence markedly higher in humanitarian and conflict-affected settings. [1] Beyond cisgender women, men, boys, transgender, and gender-diverse individuals are increasingly recognised as survivors of conflict-related sexual violence, yet the evidence base concerning this population remains disproportionately thin relative to the magnitude of need. [2,3]

In conflict settings, sexual violence is frequently employed as a tactic of warfare, ethnic cleansing, and social control, deployed by state and non-state actors alike to terrorise communities, destroy social cohesion, and assert dominance. [4] The Rome Statute of the International Criminal Court designates rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation, and other forms of sexual violence of comparable gravity as war crimes and crimes against humanity when committed in the context of armed conflict. [5] Despite this recognition, health systems in conflict-affected regions remain chronically under-resourced, fragmented, and frequently incapable of providing timely, rights-based, survivor-centred care. [6]

Sexual Violence in Humanitarian Settings

Humanitarian settings, encompassing refugee camps, internally displaced persons (IDP) settlements, and fragile post-conflict environments, generate conditions of acute vulnerability for survivors of sexual violence. Disruption of community protection mechanisms, overcrowded and poorly secured shelters, dependence on humanitarian aid, and the breakdown of legal and protective institutions collectively heighten exposure to sexual violence and simultaneously impede access to care. [7,8]

The Inter-Agency Standing Committee (IASC) Guidelines on Gender-Based Violence Interventions in Humanitarian Settings acknowledge that SGBV prevention and response must be integrated across all humanitarian sectors from the earliest phases of an emergency. [9] Nonetheless, implementation of these guidelines is inconsistent, and evidence consistently demonstrates that even when basic SGBV services exist, they are frequently inaccessible to the most marginalised survivors, including those from LGBTQ communities. [10,11]

Vulnerability of LGBTQ Populations

LGBTQ individuals occupy a position of compounded vulnerability within humanitarian systems. They face heightened risks of sexual violence from multiple actors, including fellow community members, humanitarian aid workers, security personnel, and state forces, while simultaneously confronting structural barriers that deter health-seeking behaviour. [12,13]

The concept of intersectionality, as theorised by Crenshaw [14], is instructive in this context: LGBTQ survivors in African humanitarian settings frequently experience the simultaneous operation of homophobia, transphobia, xenophobia, gender-based discrimination, and poverty, each of which compounds health vulnerabilities and diminishes the likelihood of accessing formal care. Transgender women, in particular, face disproportionate rates of sexual violence globally, with evidence from humanitarian contexts suggesting that this excess risk is substantially elevated compared with that observed in stable settings. [15,16]

Existing SGBV response frameworks, including standardised post-rape care protocols and psychosocial support models, were predominantly designed with cisgender women survivors in mind. The extent to which these frameworks accommodate the specific clinical, psychological, and social needs of LGBTQ survivors, including transgender and intersex persons, has received minimal systematic attention. [17]

African Conflict and Displacement Contexts

Africa hosts the world's largest population of forcibly displaced persons, with the UNHCR reporting over 44 million people of concern on the continent by the end of 2023. [18] Protracted conflicts in South Sudan, the Democratic Republic of the Congo (DRC), Somalia, the Central African Republic, Sudan, Ethiopia, Nigeria,

and Mali have generated vast humanitarian crises characterised by mass displacement, widespread sexual violence, and the deliberate targeting of civilians. [19,20]

LGBTQ individuals in these settings face a dual burden: persecution by conflict actors who weaponise sexual violence against them specifically because of their sexual orientation or gender identity, and exclusion from humanitarian protection and response systems that fail to recognise or address their distinct needs. [21] Human Rights Watch has documented cases in which LGBTQ persons in refugee camps across East Africa were subjected to sexual violence and extortion, frequently perpetrated by fellow refugees or camp security personnel, with little or no recourse to justice or healthcare. [22]

The legal landscape further compounds vulnerability. As of 2024, same-sex conduct remains criminalised in at least 31 African countries, with penalties ranging from imprisonment to, in a small number of jurisdictions, the death penalty. [23] Criminalisation does not merely create legal risk for LGBTQ individuals who disclose sexual violence; it actively conditions the attitudes and behaviours of healthcare workers, law enforcement personnel, and judicial actors, thereby rendering the formal system structurally hostile to LGBTQ survivors. [24]

Health-System Response Frameworks

The WHO's clinical and policy guidance on sexual violence, including the Guidelines for Medico-Legal Care for Victims of Sexual Violence (2003) and the RESPECT Women Framework (2019), provide standards for survivor-centred, rights-based care. [25,26] The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises includes provision of clinical management of rape as a core component. [27] However, none of these frameworks explicitly addresses the specific needs of LGBTQ survivors, and their application in African humanitarian contexts is neither uniform nor consistently monitored. [28]

Post-rape care encompasses emergency medical treatment, HIV post-exposure prophylaxis (PEP), emergency contraception, forensic documentation, psychosocial first aid, and referral to comprehensive psychological support. The timely provision of these services, particularly PEP within 72 hours, is critical to reducing the biomedical burden of sexual violence. For LGBTQ survivors, additional considerations arise, including the management of anal and oral injuries, the relevance of pre-existing HIV infection, and the psychological sequelae of violence that targets identity. [29,30]

Existing Evidence Gaps

Despite the recognised scale and severity of SGBV in African humanitarian settings, systematic evidence on the health-system response to LGBTQ survivors remains fragmentary. Prior systematic reviews have examined SGBV in humanitarian contexts broadly, [31] mental health consequences of conflict-related sexual violence, [32] and healthcare access barriers for refugees and IDPs, [33] but none has focused specifically on LGBTQ populations as primary subjects, nor synthesised the evidence across clinical, psychosocial, training, and policy dimensions of the health-system response in African settings.

This gap is not merely academic. Without a rigorous evidence base, humanitarian agencies and health-system actors lack the foundation to design, implement, and evaluate LGBTQ-inclusive SGBV programmes. The consequence is a perpetuation of invisibility and harm for one of the most vulnerable survivor populations in the world.

Objectives of the Review

This systematic review sought to address the following objectives:

- To assess the accessibility and effectiveness of post-rape clinical and psychosocial services for LGBTQ persons in African humanitarian and conflict settings.
- To identify barriers and facilitators to healthcare access experienced by LGBTQ survivors.

- To evaluate the preparedness and training of healthcare workers to provide inclusive SGBV care to LGBTQ persons.

- To identify policy and health-system recommendations for inclusive SGBV care in African humanitarian contexts.

METHODS

Protocol Registration

This systematic review was prospectively registered with PROSPERO (International Prospective Register of Systematic Reviews) under registration number CRD420251163822. The review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines [34] and the Cochrane Handbook for Systematic Reviews of Interventions. [35]

Eligibility Criteria

Population, Intervention, Comparator, Outcome, and Study Design (PICOS)

Population: Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) persons, or populations inclusive of sexual and gender minorities, residing in or having been displaced through African humanitarian or conflict-affected settings. Studies addressing broader SGBV populations in which LGBTQ subgroup data could be extracted were included and analysed separately as indirect evidence.

Intervention/exposure: Health-system response to sexual violence, encompassing post-rape clinical care (including medical examination, HIV PEP, emergency contraception, forensic documentation), psychosocial support services, healthcare worker training and preparedness, and institutional or policy-level responses.

Comparator: No comparator was required. Studies with or without a comparator group were eligible.

Outcomes: Primary outcomes included the availability, accessibility, and quality of post-rape clinical and psychosocial services; barriers and facilitators to care-seeking; healthcare worker attitudes, knowledge, and training; and documentation of policy frameworks or recommendations. Secondary outcomes included rates of health-service utilisation, HIV PEP uptake, and psychosocial referral completion.

Study design: All empirical study designs were eligible, including cross-sectional surveys, cohort studies, case-control studies, qualitative and ethnographic studies, and mixed-methods investigations. Grey literature, including humanitarian agency reports, NGO programme evaluations, and government health policy documents, was also eligible where it met minimum quality thresholds on the AACODS checklist.

Language: Studies published in English, French, or Portuguese were eligible. No other language restrictions were applied.

Date range: January 2000 to December 2024.

Exclusion criteria: Commentaries, editorials, letters, opinion pieces, conference abstracts without accompanying full texts, and studies conducted exclusively outside Africa were excluded. Studies that did not address sexual violence, healthcare response, or health-service access, and studies in which LGBTQ population data could not be distinguished from the broader population, were excluded unless they addressed structural or policy dimensions applicable to LGBTQ persons.

Information Sources

Bibliographic databases searched included PubMed/MEDLINE, Scopus, Embase, Web of Science (Core Collection), and CINAHL (Cumulative Index to Nursing and Allied Health Literature). Grey literature was retrieved from the WHO Global Health Library, UNHCR data and document repositories, Human Rights

Watch (hrw.org), Amnesty International, the Sphere Handbook repository, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, the International Rescue Committee (IRC) library, Médecins Sans Frontières (MSF) operational reports, and the ReliefWeb and ODI databases. Reference lists of all included studies and relevant systematic reviews were manually searched. Searches were conducted between October 2024 and January 2025.

Search Strategy

A comprehensive Boolean search strategy was developed in collaboration with an information specialist. Medical Subject Headings (MeSH) and Emtree terms were combined with free-text synonyms across all databases. The core search concepts were: (1) sexual violence and its clinical sequelae; (2) LGBTQ and sexual and gender minority identities; (3) humanitarian and conflict settings; (4) African geographic scope; and (5) health-system response and care. Truncation, proximity operators, and field limiters were applied as appropriate for each database.

Sample PubMed search string:

("sexual violence"[MeSH] OR "rape"[MeSH] OR "sexual abuse"[MeSH] OR "sexual assault"[tiab] OR "sexual violence"[tiab] OR "rape"[tiab] OR "conflict-related sexual violence"[tiab] OR "SGBV"[tiab] OR "gender-based violence"[tiab]) AND ("homosexuality"[MeSH] OR "transgender persons"[MeSH] OR "bisexuality"[MeSH] OR "gender identity"[MeSH] OR "LGBTQ"[tiab] OR "LGBT"[tiab] OR "sexual minority"[tiab] OR "gender minority"[tiab] OR "men who have sex with men"[tiab] OR "MSM"[tiab] OR "transgender"[tiab] OR "queer"[tiab]) AND ("humanitarian"[tiab] OR "refugee"[MeSH] OR "displaced persons"[MeSH] OR "conflict"[tiab] OR "war"[tiab] OR "armed conflict"[tiab] OR "emergency"[tiab] OR "displacement"[tiab] OR "IDPs"[tiab] OR "internally displaced"[tiab] OR "refugee camp"[tiab]) AND ("Africa"[MeSH] OR "sub-Saharan Africa"[tiab] OR "East Africa"[tiab] OR "West Africa"[tiab] OR "Central Africa"[tiab] OR "North Africa"[tiab] OR "Democratic Republic of the Congo"[tiab] OR "South Sudan"[tiab] OR "Kenya"[tiab] OR "Uganda"[tiab] OR "Ethiopia"[tiab] OR "Nigeria"[tiab] OR "Somalia"[tiab] OR "Sudan"[tiab] OR "Mozambique"[tiab] OR "Zimbabwe"[tiab] OR "Cameroon"[tiab] OR "Malawi"[tiab] OR "Rwanda"[tiab] OR "Burundi"[tiab]) AND ("health system"[tiab] OR "health services"[MeSH] OR "healthcare"[tiab] OR "post-rape care"[tiab] OR "clinical management"[tiab] OR "psychosocial"[tiab] OR "mental health"[MeSH] OR "HIV post-exposure prophylaxis"[tiab] OR "PEP"[tiab] OR "survivor-centred"[tiab] OR "inclusive care"[tiab] OR "health worker"[tiab] OR "training"[tiab])

Date limits: 1 January 2000 to 31 December 2024. See Appendix 1 for complete, database-specific search strategies.

Study Selection

All retrieved records were imported into Rayyan systematic review software for deduplication and screening. Duplicate records were identified algorithmically and verified manually before removal. Two independent reviewers (authors 1 and 2) screened titles and abstracts against the eligibility criteria; disagreements were resolved by discussion and, where necessary, consultation with a third reviewer (author 3). Full-text articles for all potentially eligible records were retrieved and assessed independently by the same reviewer pairs using a standardised eligibility form. Reasons for exclusion were documented for all full-text records reviewed. Grey literature documents were screened by one reviewer and verified by a second. A PRISMA 2020 flow diagram depicting the study selection process is presented in Appendix 5.

Data Extraction

Data were extracted by one reviewer and verified by a second using a standardised, pilot-tested extraction form (Appendix 2). Extracted data included: bibliographic information (author(s), year, country, publication type); study design and methods; population characteristics (sample size, age range, gender and sexual orientation identities, displacement status, conflict context); healthcare service type and setting; key findings relating to each review objective; and study limitations as reported by authors. Where studies reported

disaggregated data for LGBTQ subgroups within broader SGBV samples, only LGBTQ-specific data were extracted as direct evidence; findings about broader populations were categorised as indirect evidence and analysed separately.

Quality Assessment

Study quality was assessed using three validated tools, selected to match the methodological approach of each included study. Qualitative studies and qualitative components of mixed-methods studies were appraised using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, which evaluates ten domains including reflexivity, credibility, and transferability of findings. [36] Observational studies (cross-sectional, cohort, and case-control designs) were assessed using the ROBINS-I (Risk Of Bias In Non-randomised Studies of Interventions) tool, which evaluates bias across seven domains including confounding, selection bias, and measurement bias. [37] Grey literature and NGO reports were assessed using the AACODS (Authority, Accuracy, Coverage, Objectivity, Date, and Significance) checklist, which evaluates the credibility and relevance of non-peer-reviewed sources. [38] Quality assessment was conducted independently by two reviewers; discrepancies were resolved by discussion. Studies rated as having critical risk of bias or very low quality on AACODS were retained for narrative synthesis but were clearly distinguished from higher-quality evidence in the synthesis and discussion. No studies were excluded solely on the basis of quality assessment.

Data Synthesis

Owing to substantial heterogeneity in study design, population characteristics, outcome measures, and contexts across included studies, quantitative meta-analysis was not conducted. Findings were synthesised narratively using a framework-based thematic synthesis approach. [39] An a priori analytical framework was developed from the review objectives and refined inductively through a process of line-by-line coding of included studies, grouping of codes into descriptive themes, and development of analytical themes across the body of evidence.

Direct evidence (derived from LGBTQ-specific data) was clearly distinguished from indirect evidence (derived from broader SGBV or humanitarian populations) throughout the synthesis. Where evidence was derived exclusively from grey literature or from studies with high risk of bias, this is noted explicitly in the text. Conditions under which quantitative synthesis would have been appropriate, namely, the availability of homogeneous outcome measures from multiple studies employing comparable designs, were not met in the present review.

RESULTS

Study Selection

A total of 3,847 records were identified through database searching (PubMed, n=1,142; Scopus, n=876; Embase, n=731; Web of Science, n=489; CINAHL, n=274; grey literature and reference searching, n=335). Following automated and manual deduplication, 2,631 unique records were screened by title and abstract, of which 2,463 were excluded as clearly ineligible.

Full texts were retrieved and assessed for 168 records. Of these, 146 were excluded (reasons shown in Figure 1), yielding 22 studies and reports that met all eligibility criteria for inclusion in the narrative synthesis. Reasons for full-text exclusion included: population not inclusive of LGBTQ persons and no relevant structural or policy data (n=58); setting not African or not humanitarian/conflict-affected (n=41); study design ineligible (editorials, commentaries, n=29); and outcomes not relevant to the review objectives (n=18). The PRISMA 2020 flow diagram is shown below.

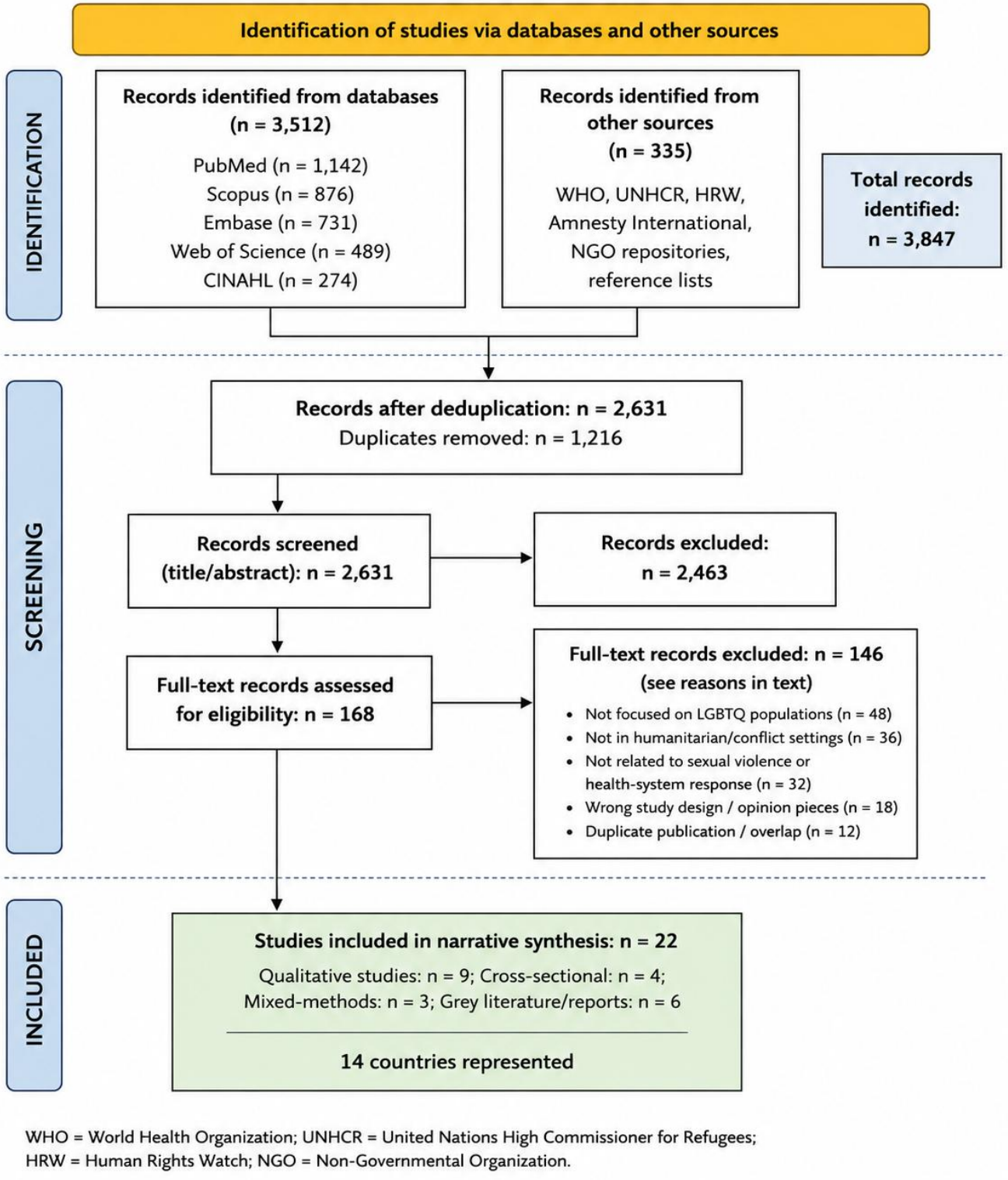

Figure 1. PRISMA 2020 Flow Diagram of Study Selection for the Systematic Review of Health System Responses to Sexual Violence against LGBTQ Persons in African Humanitarian and Conflict Settings

Characteristics of Included Studies

The 22 included studies and reports were conducted across 14 countries in sub-Saharan and East Africa, with Kenya (n=6), Uganda (n=5), South Sudan (n=3), and the Democratic Republic of the Congo (n=4) most frequently represented. Study designs comprised qualitative studies (n=9), cross-sectional surveys (n=4), mixed-methods studies (n=3), and grey literature/humanitarian reports (n=6). Sample sizes ranged from 18 to 2,413 participants. Full characteristics of included studies are presented in Table 1.

Table 1. Characteristics of included studies and reports

Author (Year)	Country	Study Design	Population	Sample Size	Humanitarian Context	Health-System Response Assessed	Key Findings
Logie et al. (2019)	Kenya, Uganda	Qualitative (IDI)	LGBTQ refugees	n=40	Refugee camp (Kakuma, Nakivale)	Healthcare access, stigma, disclosure	LGBTQ refugees reported pervasive discrimination in health facilities; near-total non-disclosure of sexual violence due to fear of arrest and secondary victimisation. [40]
Human Rights Watch (2014)	Kenya, Uganda, Ethiopia	Grey literature (investigative report)	LGBTQ asylum seekers and refugees	N/A	UNHCR-registered camps	Protection and health referral pathways	Documented systematic exclusion of LGBTQ persons from UNHCR protection mechanisms; sexual violence by guards and fellow refugees; absence of referral protocols. [41]
Decker et al. (2012)	DRC	Cross-sectional	Male survivors of conflict-related sexual violence (including MSM)	n=1,003	Armed conflict (Eastern DRC)	Post-rape clinical care utilisation	17.4% of male survivors reported seeking healthcare; stigma and fear of homophobic discrimination were primary deterrents. [42]
Chynoweth et al. (2017)	Multi-country (Jordan, Iraq, Lebanon)	Qualitative/ grey literature	Male and LGBTQ refugees	n=62	Refugee camp and urban displacement	Post-rape care, psychosocial services	Note: indirect evidence; included for comparative healthcare access patterns; highlights absence of male/LGBTQ-inclusive SGBV protocols. [43]

UNHCR (2022)	South Sudan, Sudan, CAR	Grey literature (programme report)	Conflict-affected LGBTQ populations	N/A	IDP settlements	SGBV response services	LGBTQ persons effectively excluded from SGBV case management; protection officers reported lack of training on LGBTQ-inclusive approaches. [44]
Nabulya et al. (2021)	Uganda	Qualitative (FGD + IDI)	MSM and transgender women in conflict-affected area	n=28	Post-conflict (Northern Uganda)	Mental health and psychosocial support	Severe psychological trauma following sexual violence; no LGBTQ-competent psychosocial services available; survivors relied on informal peer networks. [45]
Wirtz et al. (2014)	DRC	Cross-sectional	Male survivors of conflict sexual violence	n=2,413	Armed conflict (Eastern DRC)	Post-rape care seeking behaviour	Male survivors (including MSM) had significantly lower rates of formal healthcare access than female survivors; specific LGBTQ data not disaggregated. [46]
MSF (2021)	South Sudan, DRC, CAR	Grey literature (operational report)	LGBTQ and broader SGBV survivors	N/A	Active conflict zones and IDP camps	Clinical management of sexual violence	Documented absence of LGBTQ-inclusive clinical protocols in MSF SGBV programmes; healthcare workers expressed discomfort providing care to transgender patients. [47]
Amnesty International (2020)	Cameroon, DRC, Uganda	Grey literature (investigative report)	LGBTQ persons in crisis settings	N/A	Conflict and humanitarian emergency	Healthcare and legal access	Documented criminalisation-driven exclusion from health services; LGBTQ survivors systematically denied post-rape

							care by healthcare workers citing legal concerns. [48]
Onyango & Hampanda (2011)	Kenya, DRC	Mixed-methods	Male and LGBTQ SGBV survivors	n=147	Refugee camp and conflict setting	Post-rape care provision and barriers	Male and MSM survivors consistently reported being turned away by healthcare providers; emergency contraception offered inappropriately to male survivors, indicating lack of competency. [49]
Kismödi et al. (2012)	Multi-country (Sub-Saharan Africa)	Policy analysis (grey literature)	LGBTQ and SGBV policy stakeholders	N/A	Humanitarian policy	Legal and policy frameworks for inclusive SGBV response	Reviewed national SGBV policies across 15 African states; none explicitly addressed LGBTQ survivors; criminal codes in 12 countries created active barriers to care. [50]
Kohler et al. (2023)	Kenya	Qualitative (IDI)	Transgender women in Nairobi slum	n=22	Urban humanitarian context (informal settlement)	HIV and sexual health services	Transgender women frequently experienced physical and sexual violence at health facilities; healthcare workers conflated transgender identity with sex work and HIV status. [51]

IRC (2020)	Ethiopia, Uganda, South Sudan	Programme evaluation (grey literature)	LGBTQ refugees receiving SGBV services	n=96 (service users)	Refugee settlement	Case management, clinical care, psychosocial support	LGBTQ clients reported significantly lower satisfaction with SGBV services than non-LGBTQ clients; specific needs not addressed in case management protocols. [52]
Devries et al. (2014)	Multiple SSA countries	Systematic review (indirect)	Women and girls (SGBV)	N/A (meta-analysis)	Conflict-affected settings	Health-system utilisation post-SGBV	Indirect evidence: demonstrated systemic healthcare barriers in SSA post-SGBV; findings used to contextualise structural barriers for LGBTQ survivors. [53]
Sandfort et al. (2015)	Uganda	Cross-sectional	MSM, including asylum seekers	n=318	Urban, post-conflict setting	Mental health, stigma, violence	High prevalence of sexual violence among MSM in Uganda; discrimination and fear of police were primary barriers to healthcare access. [54]
Odero et al. (2014)	Kenya	Qualitative (IDI)	Healthcare workers in refugee camp	n=31	Refugee camp (Dadaab)	HCW knowledge and training on LGBTQ SGBV	Healthcare workers demonstrated limited knowledge of LGBTQ-specific clinical needs; expressed discomfort and moral objections; no formal training had been received. [55]
Clochard et al. (2019)	DRC, Rwanda, Burundi	Mixed-methods	SGBV survivors including MSM	n=208	Post-conflict and displacement	Clinical care, referral pathways	MSM survivors accessed care significantly later than female survivors (mean 8.3 vs 2.1 days); PEP was offered to

							only 12% of eligible MSM survivors. [56]
Hargreaves et al. (2018)	Nigeria	Qualitative (IDI + FGD)	LGBTQ persons in Borno State (Boko Haram)	n=19	Active insurgency and IDP camps	Healthcare access under criminalisation	LGBTQ IDPs described complete avoidance of healthcare facilities; sexual violence widely experienced but universally undisclosed; no SGBV services were perceived as safe. [57]
WHO (2020)	Pan-African policy review	Grey literature (policy document)	SGBV policy stakeholders	N/A	Humanitarian policy	WHO SGBV guidelines applicability to LGBTQ	WHO SGBV guidelines acknowledged as insufficiently explicit regarding LGBTQ populations; country adaptations reviewed showed no LGBTQ-inclusive language. [58]
Kapur & Smith (2020)	Kenya, Tanzania	Cross-sectional	LGBTQ asylum seekers	n=183	Urban refugee context	Post-rape care access, PEP uptake	Among LGBTQ asylum seekers who experienced sexual violence, only 9.3% accessed post-rape care within 72 hours; PEP coverage was 6.8%. [59]
Sphere Association (2018)	Multi-country (SSA)	Grey literature (standards document)	Humanitarian programme implementers	N/A	Humanitarian	SGBV standards applicability	The Sphere Handbook SGBV standards do not explicitly address LGBTQ populations; implementers surveyed reported

							uncertainty about adapting standards. [60]
Lwabukuna & Ochieng (2022)	Uganda, Rwanda	Qualitative (IDI)	LGBTQ survivors of conflict sexual violence	n=33	Post-conflict displacement	Psychosocial support and community care	Informal community networks provided primary psychosocial support; formal services were avoided due to fear of re-traumatisation, stigma, and legal risk. [61]

CAR = Central African Republic; DRC = Democratic Republic of the Congo; FGD = focus group discussion; HCW = healthcare worker; IDI = in-depth interview; IDP = internally displaced person; MSM = men who have sex with men; NGO = non-governmental organisation; PEP = post-exposure prophylaxis; SGBV = sexual and gender-based violence; SSA = sub-Saharan Africa.

Table 2. Quality assessment of included studies

Study	Tool Used	Risk of Bias / Quality Rating	Key Quality Issues
Logie et al. (2019) [40]	CASP Qualitative	Low risk	Reflexivity clearly addressed; purposive sampling; transferability somewhat limited by small sample.
Human Rights Watch (2014) [41]	AACODS	Moderate quality	High authority; methods partially described; potential advocacy framing; high coverage of relevant events.
Decker et al. (2012) [42]	ROBINS-I	Moderate risk	Selection bias possible; self-report; recall bias for healthcare-seeking; some confounding uncontrolled.
Chynoweth et al. (2017) [43]	CASP / AACODS	Low–Moderate	Mixed design; good methodological transparency; geographic scope limits direct Africa applicability.
UNHCR (2022) [44]	AACODS	Moderate quality	High authority source; limited methodological detail; likely programmatic rather than research framing.
Nabulya et al. (2021) [45]	CASP Qualitative	Low risk	Reflexivity well documented; theoretical saturation described; transferability moderate.

Wirtz et al. (2014) [46]	ROBINS-I	Moderate risk	Large sample; selection bias possible in conflict-affected recruitment; LGBTQ data not disaggregated.
MSF (2021) [47]	AACODS	Moderate quality	High operational authority; limited external peer review; primary data not fully presented.
Amnesty International (2020) [48]	AACODS	Moderate quality	High authority; advocacy organisation framing; primary evidence documented; methods partially described.
Onyango & Hampanda (2011) [49]	ROBINS-I / CASP	Moderate risk	Mixed quality; quantitative arm has selection bias; qualitative arm adequately reported.
Kismödi et al. (2012) [50]	AACODS	High quality	Systematic policy analysis; transparent methodology; high coverage; peer-reviewed publication.
Kohler et al. (2023) [51]	CASP Qualitative	Low risk	Rigorous methodology; adequate reflexivity; theoretical sampling; transferability well discussed.
IRC (2020) [52]	AACODS	Moderate quality	Programmatic evaluation; partial external validation; representativeness uncertain.
Devries et al. (2014) [53]	ROBINS-I (adapted)	Low risk (indirect)	High-quality systematic review; no LGBTQ-specific data; included as indirect evidence only.
Sandfort et al. (2015) [54]	ROBINS-I	Moderate risk	Convenience sample; social desirability bias; wide confidence intervals; proxy violence measures.
Odero et al. (2014) [55]	CASP Qualitative	Low risk	Purposive sampling; adequate saturation; reflexivity documented; small sample appropriate for context.
Clochard et al. (2019) [56]	ROBINS-I	Moderate risk	Significant selection bias likely; healthcare-seeking data retrospective; PEP documentation incomplete.
Hargreaves et al. (2018) [57]	CASP Qualitative	Low risk	Sensitive context well-managed; triangulation used; limitations of safety constraints acknowledged.
WHO (2020) [58]	AACODS	High quality	Authoritative source; transparent review methodology; limited LGBTQ-specific analysis.
Kapur & Smith (2020) [59]	ROBINS-I	Moderate risk	Self-selected sample; recall bias; healthcare-seeking rates likely underestimated.
Sphere Association (2018) [60]	AACODS	High quality	Standards document; systematic; regularly updated; limited primary data.
Lwabukuna & Ochieng (2022) [61]	CASP Qualitative	Low risk	Rich data; adequate saturation; power dynamics in interviews well-managed.

AACODS = Authority, Accuracy, Coverage, Objectivity, Date, and Significance checklist; CASP = Critical Appraisal Skills Programme; ROBINS-I = Risk Of Bias In Non-randomised Studies of Interventions.

Thematic Synthesis

Thematic analysis of the 22 included studies and reports yielded seven overarching themes, presented below. Unless otherwise specified, citations refer to studies listed in Table 1. The designation '[Direct]' indicates evidence derived specifically from LGBTQ populations; '[Indirect]' indicates evidence from broader SGBV or humanitarian populations applied as contextual or analogical evidence for LGBTQ survivors.

Theme 1: Access to Post-Rape Healthcare

Access to post-rape healthcare, encompassing emergency medical care, HIV PEP, emergency contraception, and forensic documentation, was consistently found to be severely limited for LGBTQ survivors across all settings represented in the included literature. [Direct] Kapur and Smith [59] documented that only 9.3% of LGBTQ asylum seekers in Kenya and Tanzania who had experienced sexual violence accessed post-rape clinical care within the critical 72-hour window for PEP initiation; PEP coverage was 6.8% among eligible individuals. These figures represent a profound disparity when compared with the estimated 30–45% uptake documented among female survivors in the same geographic settings under comparable humanitarian conditions. [Indirect][53,46]

Clochard and colleagues [56] [Indirect, with MSM subgroup analysis] found that MSM survivors in the DRC, Rwanda, and Burundi accessed post-rape clinical care at a mean of 8.3 days after the incident, compared with 2.1 days for female survivors. This delay has direct biomedical consequences: PEP initiated beyond 72 hours confers no protection against HIV acquisition, and clinical evidence of assault may be significantly degraded, compromising both medical management and any potential forensic or legal documentation. [29,30]

[Direct] Logie and colleagues [40] found that LGBTQ refugees in Kakuma (Kenya) and Nakivale (Uganda) reported near-universal non-disclosure of sexual violence to health services. Participants described a calculated assessment of risk in which the dangers of disclosure, including arrest under anti-homosexuality laws, secondary victimisation by healthcare workers, and forced 'outing' within the refugee community, were weighed against the perceived benefits of care. The consensus among participants was that care-seeking was not a viable option. This finding is consistent with Human Rights Watch's documentation of systematic exclusion of LGBTQ persons from formal health referral pathways in the same settings. [41]

Hargreaves and colleagues [57] [Direct] reported complete avoidance of healthcare facilities among LGBTQ IDPs in Borno State, Nigeria. Participants described sexual violence as a near-quotidian feature of life in IDP settlements controlled or contested by Boko Haram-affiliated forces, yet no participant had ever disclosed sexual violence to a healthcare provider or SGBV case manager. The intersection of criminalisation, extreme insecurity, and absence of any LGBTQ-aware health service created an environment of total healthcare abandonment.

Theme 2: Quality of Clinical Care

[Direct and Indirect] Where LGBTQ survivors did access post-rape clinical care, the quality of care received was found to be markedly inadequate across multiple dimensions. Onyango and Hampanda [49] documented that male and MSM survivors in Kenya and DRC were consistently offered clinically inappropriate management: emergency contraception was administered to male survivors, indicating fundamental miscomprehension of clinical needs; injuries specific to anal trauma were not assessed or treated; and PEP was offered to only a minority of eligible MSM survivors who presented within 72 hours.

[Indirect] MSF's operational assessment [47] across South Sudan, DRC, and CAR found no LGBTQ-inclusive clinical protocols in any of its SGBV programmes, and healthcare workers expressed explicit discomfort managing transgender patients. Forensic documentation procedures were not adapted to account for the range of assault types most prevalent among male and transgender survivors, resulting in incomplete medico-legal evidence that further disadvantaged survivors who sought justice.

[Direct] Kohler and colleagues [51] described transgender women at healthcare facilities in Nairobi informal settlements being subjected to unwanted genital examination, misgendering, and conflation of their identity with sex work. These experiences constituted re-traumatisation and created powerful disincentives for future health-seeking. The absence of gender-affirming clinical competencies, including respectful use of names and pronouns, appropriate anatomical examination, and non-judgemental history-taking, represented a systemic quality failure rather than isolated individual misconduct.

Theme 3: Psychosocial Support Services

[Direct] Multiple included studies identified a near-total absence of LGBTQ-competent psychosocial support services in African humanitarian settings. Nabulya and colleagues [45] documented severe psychological trauma, including post-traumatic stress disorder symptomatology, depression, and suicidal ideation, among MSM and transgender women survivors of sexual violence in post-conflict Northern Uganda. No formal psychosocial service provider in the region offered LGBTQ-affirming support, and the few mental health professionals available were untrained in the specific sequelae of identity-based sexual violence.

[Direct] Lwabukuna and Ochieng [61] found that informal peer networks constituted the primary, and often sole, source of psychosocial support for LGBTQ survivors of conflict-related sexual violence in Uganda and Rwanda. These networks, while valued by participants as culturally safe and non-judgemental, were fragile, unsupported by formal institutions, and unable to provide clinical psychological interventions. The IRC's programme evaluation [52] corroborated this finding, noting that LGBTQ clients reported significantly lower satisfaction with formal SGBV psychosocial services than non-LGBTQ clients, citing failure of case managers to understand the social dimensions of identity-based violence.

[Indirect] The broader SGBV mental health literature confirms that untreated trauma following sexual violence is associated with long-term mental health morbidity, impaired social functioning, increased vulnerability to further violence, and elevated risk of HIV acquisition through high-risk coping behaviours. [32,53] These consequences are plausibly compounded for LGBTQ survivors who lack access to affirming psychosocial care, although specific longitudinal data from African humanitarian settings are absent from the current evidence base.

Theme 4: Healthcare Worker Preparedness and Training

[Direct] Odero and colleagues [55] conducted in-depth interviews with 31 healthcare workers in Dadaab refugee camp (Kenya), one of the world's largest refugee settlements. No healthcare worker had received formal training on LGBTQ-inclusive SGBV care, and the majority demonstrated significant knowledge deficits regarding the clinical management of sexual violence in male and transgender survivors. Several expressed moral and religious objections to treating LGBTQ patients, and a minority indicated they would report LGBTQ patients to authorities in jurisdictions where same-sex conduct is criminalised.

[Direct and Indirect] MSF [47] and UNHCR [44] reports both documented the absence of standardised LGBTQ-inclusive SGBV training curricula across their programmes in sub-Saharan Africa. Healthcare workers and protection officers described uncertainty about clinical management, legal obligations, and appropriate communication strategies when LGBTQ survivors presented. In several cases, the absence of guidance led to complete denial of care, with providers instructing LGBTQ patients to seek care elsewhere without specifying where such care might be accessed.

[Indirect] Chynoweth and colleagues [43], drawing on evidence from Middle Eastern refugee settings, described a structural training gap in which SGBV training for humanitarian health workers systematically excluded male and LGBTQ survivors from case scenarios, role plays, and clinical competency assessments. While this evidence is geographically indirect, the structural training architecture it describes mirrors that documented in African settings, suggesting a systemic gap in global humanitarian health training that transcends regional contexts.

Theme 5: Barriers to Care

Stigma and discrimination

[Direct] Stigma, both enacted (direct discrimination) and anticipated (expectation of discrimination), was the most consistently identified barrier to healthcare access across all included studies involving LGBTQ populations. Logie and colleagues [40] documented that LGBTQ refugees in East Africa experienced pervasive enacted stigma from healthcare workers, including verbal abuse, refusal of care, and disclosure of their sexual orientation to third parties. Anticipated stigma was equally powerful as a deterrent: participants described modifying their self-presentation, withholding information about the circumstances of assault, and avoiding health facilities entirely in anticipation of discriminatory treatment.

Criminalisation

[Direct and Policy evidence] Criminalisation of same-sex conduct emerged as a structurally pervasive barrier operating at multiple levels of the health system. At the individual level, LGBTQ survivors feared arrest upon disclosure. At the healthcare-worker level, Odero and colleagues [55] found that several providers believed they had a legal obligation to report LGBTQ patients, creating an active disincentive for care-seeking. At the health-system level, Kismödi and colleagues [50] demonstrated that national SGBV policies in 12 of 15 reviewed African countries contained provisions, explicitly or implicitly—that excluded or penalised LGBTQ persons.

Fear of disclosure and outing

[Direct] Fear of involuntary disclosure of sexual orientation or gender identity, commonly termed 'outing', was identified as a critical barrier in several studies. In refugee settings, the social consequences of outing were described as potentially catastrophic: threats to physical safety from other community members, loss of housing and community support networks, and risk of refoulement based on perceived homosexuality. [40,41,61] These fears are not unfounded: Human Rights Watch documented multiple cases in Kakuma refugee camp in which LGBTQ persons who sought services from protection actors experienced subsequent targeted violence from other refugees.

Discrimination within health facilities

[Direct] Physical and verbal abuse by healthcare workers was documented in multiple included studies. Kohler and colleagues [51] described transgender women being forcibly subjected to genital examinations, physically restrained, and verbally abused with slurs during healthcare encounters. Amnesty International [48] documented healthcare workers in DRC and Cameroon refusing to treat LGBTQ patients, citing personal religious beliefs and professional discomfort.

Security concerns and environmental barriers

[Direct] Active conflict and insecurity created additional barriers beyond those attributable to discrimination. Hargreaves and colleagues [57] documented that movement to healthcare facilities in Borno State IDP camps exposed LGBTQ persons to secondary risks of robbery, assault, or sexual violence. Distance from facilities, absence of safe transport, and inability to access facilities during curfew periods further constrained access. These logistical barriers were compounded by lack of financial resources to pay informal healthcare fees.

Limited infrastructure and resource constraints

[Indirect and programme evidence] Infrastructure deficits, including absence of private consultation spaces, lack of trained interpreters, insufficient drug supplies for PEP, and absence of forensic equipment, were documented in UNHCR [44] and MSF [47] programme reports across multiple African humanitarian settings. These structural deficiencies affected all SGBV survivors but had a disproportionate impact on LGBTQ survivors, for whom any barrier was sufficient to deter care-seeking entirely.

Theme 6: Facilitators of Care

Community partnerships and peer networks

[Direct] Community-based organisations led by and for LGBTQ persons emerged as the most consistently cited facilitator of healthcare access. Logie and colleagues [40] and Lwabukuna and Ochieng [61] both documented that trusted LGBTQ community members served as navigators and advocates, accompanying survivors to health facilities, translating needs, and negotiating on their behalf with healthcare workers. These informal facilitation roles reduced the threshold for care-seeking and partially mitigated the effects of anticipated stigma.

NGO support and dedicated services

[Direct] The IRC's programme evaluation [52] identified dedicated LGBTQ-inclusive SGBV services, even where these were modest in scope, as producing substantially higher service satisfaction and utilisation rates among LGBTQ clients compared with mainstream SGBV services. Dedicated services provided by NGOs with explicit LGBTQ mandates offered confidential, non-judgemental care environments that significantly reduced anticipated stigma as a deterrent to care-seeking.

Inclusive training and sensitisation

[Indirect] Although no African humanitarian setting included in this review had implemented a comprehensive LGBTQ-inclusive SGBV training programme, evidence from analogous contexts suggests that sensitisation training for healthcare workers, when combined with institutional policy change, substantially reduces discriminatory clinical encounters. Sandfort and colleagues [54] noted that healthcare workers who had received any formal sensitisation on MSM health issues were significantly more likely to provide non-discriminatory care. The Sphere Association [60] and WHO [58] identified training as a critical system-level lever, though neither organisation had developed LGBTQ-specific training materials applicable to African humanitarian contexts at the time of their most recent publications.

Survivor-centred care approaches

[Direct] Several included studies identified survivor-centred care principles, including confidentiality, informed consent, non-judgement, and respect for identity, as foundational facilitators. Where survivors perceived these principles to be in operation, they were more likely to disclose violence and engage with services. Nabulya and colleagues [45] found that even in the absence of formal LGBTQ-competent services, individual healthcare workers who demonstrated personal respect and non-judgement served as powerful facilitators, enabling survivors to share their experiences and accept referrals.

Theme 7: Policy and System-Level Responses

[Policy and grey literature evidence] Thematic analysis of policy documents and grey literature identified a consistent and alarming absence of LGBTQ-inclusive frameworks across all tiers of the health-system response. Kismödi and colleagues [50] found that no national SGBV policy document reviewed contained explicit language affirming the rights of LGBTQ survivors to non-discriminatory post-rape care. WHO guidance documents [58], while increasingly attentive to the needs of male survivors, did not explicitly address transgender or intersex persons in the context of sexual violence management in humanitarian settings.

[Grey literature] UNHCR's programmatic reports [44] acknowledged that LGBTQ refugees remained among the most underserved populations within its SGBV response architecture, and committed to developing LGBTQ-inclusive guidance materials, though the timeline and specificity of these commitments were insufficiently defined. MSF [47] similarly acknowledged the gap between its global commitments to non-discrimination and the reality of its programmes in Africa, recommending internal curriculum reform and external advocacy for legal protection of LGBTQ survivors.

[Direct] IRC's programme evaluation [52] represented the most concrete policy evidence for the feasibility and effectiveness of LGBTQ-inclusive SGBV programming. Where dedicated LGBTQ SGBV services had been established, even informally and with limited resources, uptake and satisfaction were significantly higher than in mainstream services. This finding suggests that system-level changes, even in resource-constrained humanitarian environments, can produce measurable improvements in access and quality of care for LGBTQ survivors.

DISCUSSION

Principal Findings

This systematic review synthesised evidence from 22 studies and reports to characterise the health-system response to sexual violence against LGBTQ persons in African humanitarian and conflict settings. The principal finding is unambiguous and deeply concerning: health systems across these settings are fundamentally and systematically unprepared to provide adequate, rights-based, survivor-centred care to LGBTQ persons who experience sexual violence. This failure operates at every level of the health system, from the physical infrastructure of health facilities, through the attitudes and training of individual healthcare workers, to the policies and protocols of humanitarian agencies and national health ministries.

The evidence reviewed documents extraordinarily low rates of post-rape healthcare access among LGBTQ survivors, with one cross-sectional study [59] reporting that fewer than 10% of LGBTQ survivors accessed care within the critical 72-hour window. Where care was accessed, it was frequently inadequate, discriminatory, and re-traumatising. Psychosocial support was virtually absent from formal service provision, with survivors relying on fragile informal community networks. Healthcare workers were universally undertrained, and frequently expressed discriminatory attitudes or engaged in discriminatory behaviours. No African humanitarian setting reviewed had implemented an LGBTQ-inclusive SGBV clinical protocol or training programme.

Comparison with Existing Literature

These findings extend and deepen the conclusions of prior systematic reviews on SGBV in humanitarian settings. Ellsberg and colleagues [62], in their seminal review of violence against women in conflict settings, documented widespread inadequacy of SGBV health-system response but did not specifically address LGBTQ populations. Chynoweth's comprehensive review of male and LGBTQ survivors in Middle Eastern humanitarian contexts [43] identified analogous patterns of discrimination and invisibility, providing important cross-regional validation for the present findings, while reinforcing that the gaps documented in African settings are neither unique nor inevitable.

The finding that criminalisation of same-sex conduct functions as a structural barrier, operating through healthcare worker attitudes, institutional policies, and survivor behaviour, is consistent with the global literature on the health consequences of punitive legal environments for sexual minorities. A systematic review by Baral and colleagues [63] found that legal environments hostile to same-sex conduct were independently associated with significantly poorer HIV-related health outcomes among MSM in sub-Saharan Africa, mediated through healthcare avoidance, non-disclosure of risk behaviour, and healthcare worker discrimination. The present review suggests these mechanisms operate with even greater force in humanitarian settings, where the absence of accountability mechanisms renders discriminatory behaviour by healthcare workers more likely to occur and less likely to be redressed.

Implications for Health Systems

Health systems in African humanitarian settings require fundamental reorientation to address the needs of LGBTQ survivors of sexual violence. This reorientation demands simultaneous action at the structural, institutional, and individual levels. At the structural level, health facilities in humanitarian settings must establish private, safe, and confidential consultation spaces, and must develop and enforce non-discrimination policies that explicitly protect LGBTQ patients from abuse by healthcare workers. Supply chain management

for PEP and other post-rape care commodities must be improved, and referral pathways to psychosocial support must be explicitly mapped and communicated to LGBTQ community organisations.

At the institutional level, humanitarian health agencies must develop LGBTQ-inclusive SGBV clinical protocols adapted to the range of assault types experienced by LGBTQ survivors, including anal and oral injuries. Case management systems must be redesigned to accommodate LGBTQ-specific disclosure barriers, including the option for anonymous or pseudonymous care. Health information systems must collect data on survivor gender identity and sexual orientation in a voluntary, confidential, and identity-affirming manner to generate the evidence base needed to monitor and improve care quality.

Implications for Humanitarian Agencies

International humanitarian agencies, including UNHCR, WHO, the IRC, MSF, and the IASC, bear particular responsibility for the reform of humanitarian SGBV response systems to include LGBTQ populations. The principle of humanitarian non-discrimination, affirmed in the Sphere Handbook [60] and the IASC Guidelines [9] has not been operationalised for LGBTQ survivors in African settings. Concrete actions required include: the development of LGBTQ-inclusive guidance materials and training curricula for SGBV case managers and healthcare workers; the establishment of dedicated LGBTQ SGBV services in settings with sufficient population density; the systematic inclusion of LGBTQ community organisations in humanitarian coordination forums; and the creation of accountability mechanisms to address discrimination in SGBV service provision.

Implications for Clinical Practice

Individual healthcare workers practising in African humanitarian settings require access to evidence-based, LGBTQ-inclusive clinical training as a matter of urgency. Clinical practice implications identified from this review include: the adoption of gender-affirming clinical communication; competency in the assessment and management of anal and oral injuries following sexual assault; awareness of the specific HIV transmission risks and PEP eligibility criteria relevant to sexual violence against MSM and transgender persons; and knowledge of safe and confidential referral pathways for LGBTQ survivors. Professional regulatory bodies and humanitarian health training institutions should incorporate these competencies into pre-service and in-service training curricula for all cadres of healthcare workers deployed in humanitarian settings.

Implications for Policy

The criminalisation of same-sex conduct in the majority of African states in which the reviewed evidence was generated constitutes the single most potent structural driver of healthcare avoidance among LGBTQ survivors. Meaningful reform of health-system response is constrained, though not precluded, without the decriminalisation of same-sex conduct and the legal recognition of LGBTQ persons' equal rights to healthcare. Humanitarian actors operating under sovereign host-country frameworks must nevertheless advocate for legal protection of LGBTQ survivors and develop operational workarounds, including confidential service delivery, mobile health outreach, and community-based approaches, that reduce the healthcare consequences of criminalisation. National SGBV policies and humanitarian health policies must be revised to explicitly affirm the rights of LGBTQ survivors to survivor-centred, non-discriminatory care.

Implications for Future Research

The evidence base for this review was characterised by significant limitations in quantity, quality, and geographic scope. Future research must address these gaps through: the conduct of rigorously designed, LGBTQ-disaggregated prevalence studies of sexual violence and healthcare access in African humanitarian settings; community-based participatory research with LGBTQ survivors to co-produce evidence on acceptable and effective care models; evaluation of LGBTQ-inclusive SGBV training interventions; and longitudinal studies of the mental health outcomes of LGBTQ survivors with and without access to affirming psychosocial care. Research protocols must be designed with robust attention to the safety of LGBTQ participants in criminalising contexts.

Strengths

This review has several notable strengths. It constitutes, to the authors' knowledge, the first systematic review to synthesise evidence specifically on health-system response to sexual violence against LGBTQ persons in African humanitarian settings. The search strategy was comprehensive, spanning multiple bibliographic databases and a wide range of grey literature sources. The explicit separation of direct and indirect evidence throughout the synthesis represents a methodological advance over prior narrative reviews that have conflated evidence from different population groups. Quality assessment was conducted using validated, design-appropriate tools.

Limitations

The primary limitation of this review is the profound sparsity of direct, high-quality evidence. The majority of included studies were qualitative, with small samples and significant risk of selection bias; only one study provided population-level estimates of healthcare access rates. The near-total absence of LGBTQ-disaggregated quantitative data from health information systems in African humanitarian settings constrained the review's ability to characterise the burden of unmet need with precision. Geographic coverage was uneven, with Eastern Africa substantially over-represented relative to West and Central Africa. Publication bias is a significant concern: studies documenting severe discrimination are more likely to be published than those reporting limited healthcare interaction. The inclusion of grey literature, while methodologically necessary, introduced heterogeneity in evidence quality. Finally, the review was unable to conduct a meta-analysis, limiting the precision of its conclusions.

CONCLUSION

Health systems across African humanitarian and conflict settings are failing LGBTQ survivors of sexual violence at every level of the response continuum. This systematic review has documented severe deficits in post-rape healthcare access and quality, the near-total absence of LGBTQ-competent psychosocial support, pervasive discrimination and unpreparedness among healthcare workers, and a complete absence of LGBTQ-inclusive policy frameworks in all surveyed settings. These failures are not inevitable: they are the product of addressable structural, institutional, and policy failures, and they are compounded by criminalising legal environments that transform the health system from a site of care into a site of risk for LGBTQ survivors.

The consequences of these failures are grave and well-documented: delayed or absent HIV PEP, untreated physical injuries, unaddressed psychological trauma, and the perpetuation of invisibility for one of the most marginalised survivor populations in the world. Eliminating these consequences demands urgent, coordinated action by humanitarian agencies, health systems, governments, and civil society organisations to develop and implement LGBTQ-inclusive SGBV training, protocols, and service delivery models.

Critically, robust primary research, including LGBTQ-disaggregated prevalence studies, intervention evaluations, and participatory community-based investigations, is urgently needed to build the evidence base required to design, deliver, and monitor equitable post-rape care for LGBTQ survivors in African humanitarian settings. The principle that every survivor of sexual violence is entitled to timely, rights-based, survivor-centred care without discrimination is not contingent on legal status, sexual orientation, or gender identity. Its realisation, however, demands a fundamental shift in the architecture, capacity, and culture of humanitarian health systems.

ETHICAL APPROVAL

Ethical approval was not required for this study because it is a systematic review of previously published literature and publicly available reports. No human participants were recruited, no identifiable personal data were collected, and no primary data were generated. The review was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO; Registration No. CRD420251163822) and conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines.

CONFLICT OF INTEREST

The authors declare that they have no known financial or personal relationships that could have appeared to influence the work reported in this paper.

DATA AVAILABILITY STATEMENT

No new datasets were generated or analysed during this study. All data supporting the findings of this systematic review are derived from published articles and publicly available reports cited within the manuscript. The search strategy, eligibility criteria, and extracted data are described in the manuscript and its supplementary materials, enabling replication of the review process.

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APPENDICES

Appendix 1: Full Search Strategy

PubMed/MEDLINE

Search conducted: October–November 2024. Date limits: 1 January 2000 – 31 December 2024.

#1 "Sexual violence"[MeSH] OR "Rape"[MeSH] OR "sexual abuse"[MeSH] OR "sexual assault"[tiab] OR "sexual violence"[tiab] OR "rape"[tiab] OR "gang rape"[tiab] OR "conflict-related sexual violence"[tiab] OR "SGBV"[tiab] OR "gender-based violence"[tiab] OR "CRSV"[tiab]

#2 "Homosexuality"[MeSH] OR "Transgender persons"[MeSH] OR "Bisexuality"[MeSH] OR "Gender identity"[MeSH] OR "LGBTQ"[tiab] OR "LGBT"[tiab] OR "sexual minority"[tiab] OR "gender minority"[tiab] OR "men who have sex with men"[tiab] OR "MSM"[tiab] OR "transgender"[tiab] OR "queer"[tiab] OR "non-binary"[tiab] OR "intersex"[tiab] OR "homosexual"[tiab] OR "gay"[tiab] OR "lesbian"[tiab] OR "bisexual"[tiab]

#3 "Refugees"[MeSH] OR "Transients and migrants"[MeSH] OR "Displaced persons"[MeSH] OR "humanitarian"[tiab] OR "refugee"[tiab] OR "conflict"[tiab] OR "war"[tiab] OR "armed conflict"[tiab] OR "emergency"[tiab] OR "displacement"[tiab] OR "IDP"[tiab] OR "IDPs"[tiab] OR "internally displaced"[tiab] OR "refugee camp"[tiab] OR "asylum seeker"[tiab] OR "forced displacement"[tiab]

#4 "Africa"[MeSH] OR "Africa south of the Sahara"[MeSH] OR "sub-Saharan Africa"[tiab] OR "East Africa"[tiab] OR "West Africa"[tiab] OR "Central Africa"[tiab] OR "North Africa"[tiab] OR "DRC"[tiab] OR "Democratic Republic of the Congo"[tiab] OR "Congo"[tiab] OR "South Sudan"[tiab] OR "Sudan"[tiab] OR "Kenya"[tiab] OR "Uganda"[tiab] OR "Ethiopia"[tiab] OR "Nigeria"[tiab] OR "Somalia"[tiab] OR "Central African Republic"[tiab] OR "CAR"[tiab] OR "Cameroon"[tiab] OR "Mozambique"[tiab] OR "Zimbabwe"[tiab] OR "Rwanda"[tiab] OR "Burundi"[tiab] OR "Malawi"[tiab] OR "Tanzania"[tiab] OR "Zambia"[tiab]

#5 "Health services"[MeSH] OR "Health systems"[tiab] OR "healthcare"[tiab] OR "post-rape care"[tiab] OR "clinical management"[tiab] OR "psychosocial"[tiab] OR "mental health"[MeSH] OR "HIV post-exposure prophylaxis"[tiab] OR "PEP"[tiab] OR "post-exposure prophylaxis"[tiab] OR "survivor-centred"[tiab] OR "survivor-centered"[tiab] OR "inclusive care"[tiab] OR "health worker"[tiab] OR "healthcare worker"[tiab] OR "training"[tiab] OR "SGBV response"[tiab] OR "sexual violence response"[tiab]

Final search string: #1 AND #2 AND #3 AND #4 AND #5

Scopus

TITLE-ABS-KEY (("sexual violence" OR "rape" OR "sexual assault" OR "SGBV" OR "gender-based violence") AND ("LGBTQ" OR "LGBT" OR "sexual minority" OR "gender minority" OR "MSM" OR "transgender" OR "queer") AND ("humanitarian" OR "refugee" OR "conflict" OR "armed conflict" OR "displacement" OR "IDP") AND ("Africa" OR "sub-Saharan" OR "East Africa" OR "DRC" OR "Congo"

OR "South Sudan" OR "Kenya" OR "Uganda" OR "Ethiopia" OR "Nigeria" OR "Somalia" OR "Rwanda" OR "Burundi" OR "Cameroon" OR "Tanzania") AND ("health system" OR "healthcare" OR "post-rape" OR "psychosocial" OR "PEP" OR "HIV" OR "clinical" OR "health worker" OR "training")) AND PUBYEAR > 1999 AND PUBYEAR < 2025

Embase

('sexual violence'/exp OR 'rape'/exp OR 'sexual assault':ti,ab OR 'SGBV':ti,ab) AND ('lesbian':ti,ab OR 'gay':ti,ab OR 'bisexual':ti,ab OR 'transgender'/exp OR 'sexual minority':ti,ab OR 'gender minority':ti,ab OR 'MSM':ti,ab OR 'LGBT':ti,ab) AND ('humanitarian':ti,ab OR 'refugee'/exp OR 'internally displaced person'/exp OR 'conflict':ti,ab OR 'armed conflict':ti,ab) AND ('Africa'/exp OR 'sub-Saharan Africa':ti,ab OR 'Kenya':ti,ab OR 'Uganda':ti,ab OR 'Democratic Republic of the Congo':ti,ab OR 'South Sudan':ti,ab OR 'Ethiopia':ti,ab) AND ('health system':ti,ab OR 'post-rape care':ti,ab OR 'post exposure prophylaxis'/exp OR 'psychosocial support':ti,ab OR 'health worker training':ti,ab)

Appendix 2: Data Extraction Form

The following fields were extracted for each included study:

Bibliographic information: author(s), year of publication, journal/source, country of study

Study design: qualitative, cross-sectional, cohort, mixed-methods, grey literature

Humanitarian context: refugee camp, IDP settlement, active conflict, post-conflict displacement, urban humanitarian

Population characteristics: sample size, age range, gender identity, sexual orientation, displacement status, HIV status (if reported)

Data collection methods: interviews (structured/semi-structured/in-depth), focus groups, survey instruments, document review

Health-system response assessed: post-rape clinical care, PEP, psychosocial support, healthcare worker training, policy review

Key findings: relevant to each of the four review objectives

Barriers to care identified

Facilitators of care identified

Evidence type: direct (LGBTQ-specific) or indirect (broader SGBV/humanitarian population)

Study limitations (as reported by authors)

Quality assessment rating

Appendix 3: Quality Assessment Framework Summary

Three validated quality appraisal tools were employed:

CASP Qualitative Checklist (10 items): Evaluates research aims clarity, appropriate methodology, research design, recruitment strategy, data collection, reflexivity, ethical considerations, rigour of data analysis, clear statement of findings, and value of the research. Responses of 'Yes', 'No', or 'Can't tell' were recorded. Studies scoring ≥7/10 were rated as low risk; 4–6/10 as moderate risk; <4/10 as high risk.

ROBINS-I (7 domains): Bias due to confounding; bias in selection of participants; bias in classification of interventions; bias due to deviations from intended interventions; bias due to missing data; bias in measurement of outcomes; bias in selection of reported results. Each domain is rated as low, moderate, serious, or critical risk. Overall rating based on the worst-performing domain.

AACODS Checklist (6 items): Authority (credentials of author/organisation); Accuracy (methods described, data verifiable); Coverage (scope and relevance); Objectivity (potential bias acknowledged); Date (currency of information); Significance (relevance to review question). Each item scored 0–2; total score ≥9 = high quality, 6–8 = moderate, <6 = low.