Knowledge, Attitudes and Stigma Surrounding Sexual Violence and its Survivors in Syrian Communities

LDHR

SYNERGY for JUSTICE

Comments on the report are welcome and can be sent to: info@synergyforjustice.org and info@ldhrights.org.

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Acknowledgements

Lawyers and Doctors for Human Rights (LDHR) and Synergy for Justice (Synergy) would like to acknowledge and thank the brave survivors who have worked with us over the years, and who have shared their experience of stigma and secondary victimisation. We embarked upon these efforts to tackle stigma in Syrian communities for and because of the survivors so that they can feel connected, supported and accepted, and can find their path to recovery and justice.

We are indebted to the Stigma Action Teams for their hard work and commitment. They boldly raised difficult issues within Syrian communities to make changes which will benefit all Syrians. This report, and the results it conveys, underscores the importance and contribution of their hard work. We look forward to continuing to work shoulder to shoulder with them.

Special thanks to the LDHR and Synergy Stigma Experts who have trained, mentored and helped devise LDHR's stigma action programming in six Syrian communities. Their knowledge, enthusiasm and innovation have helped pioneer dedicated stigma work in Syrian communities.

We would also like to thank the LDHR and Synergy lawyers for their assistance in writing this report and their understanding of how stigma inhibits and reduces the rights and freedoms of survivors.

Finally, we would like to acknowledge the dedication and perseverance of all members of the LDHR and Synergy teams and thank them for their flexibility and ingenuity implementing programming in challenging times.

Special thanks to the artist whose painting of Syrian stigma won one of our community art challenges. [S/he has chosen to remain anonymous].

LDHR and Synergy are grateful to the UK government for its ongoing and generous support of our work.

Executive Summary

'Stigma is defined as shame and disgrace. It sets people apart and can be hurtful and dangerous. It is based on myths and misunderstandings, and it is always negative.'[1]

The importance of understanding the multiple reverberating impacts of social stigma on individual survivors, on their rights and prospects, on their families, and on their acceptance and reintegration within their communities cannot be overstated. Thus, it is critical to understand the different types of stigmas associated with sexual violence, the underlying root causes, and the misconceptions associated therewith, to determine how best to address them and mitigate their effects on the victims, their families, and the community.

In Syria, systematic sexual violence has been used as a weapon of war, to break opposition to authority, destroy families, and destabilise communities. The scale and nature of sexual violence inflicted against Syrians will have long-lasting destructive effects due to the aggravating effects of stigma, which is why it has been deployed so effectively as a weapon of war by different sides involved in the conflict. The destructive power of sexual violence lies in entrenched stigma and Syrian society's response to the survivor; it fuels division and further cycles of violence and trauma. This also means that Syrian communities have the power to reduce stigma and mitigate its harm to society and future generations.

How Syrian communities respond to sexual violence and its survivors will determine whether and how they can recover from the violence and trauma of this crisis. If stigma is reduced, likewise, its pervasive damage and impact are reduced - to individuals, to society and to the future. Stigma deepens the damage, bars paths to recovery and healing, and damages the social support and community bonds that can bring stability, cohesion, and resilience. Finally, by reducing stigma, communities effectively reduce the barriers to justice for both survivors and communities. Justice can appropriately shift the blame and shame onto the perpetrator, uphold human rights and delineated values and reinforce the change towards a future in which the human rights of Syrian citizens are at last protected and respected.

Before embarking on community-led action against stigma, LDHR conducted a baseline knowledge and attitude survey in six Syrian communities in order to better understand the communities' attitudes, understanding, and response to sexual violence. These communities include four inside Syria[2] and two in neighbouring countries: Turkey and Jordan. After completing pilot community stigma action plans in four of those communities, the surveys were repeated in those communities. While every effort was made to ensure robust methodology in the design and conduct of the surveys, this work was not conducted, intended to be, nor is presented or reported as academic research. The purpose was to better inform programmes and actions (for LDHR, Synergy, or others) through a deeper understanding of community attitudes and changes in those over time.

The results from these surveys are set out in detail and discussed in this report, which considers patterns across locations, results by theme (shame, blame, myths and misconceptions, attitudes to perpetrators and male sexual violence), as well as changes between the baseline and follow-up surveys. The report also discusses what stigma is, its layers and impacts, and why it is important for Syrians to

[1] National Child and Adolescent Mental Health Support Service, 'Tackling Stigma, A Practical Toolkit', *One East Midlands*, p.3 http://www.oneeastmidlands.org.uk/sites/default/files/library/TacklingStigmaToolkitFinal.pdf

[2] For the purposes of this report, and as the topic of sexual violence remains a sensitive topic in Syria, those working thereon might still find challenges in their work within the communities, we will refer to the in-country communities as Community A, Community B, Community C, and Community D.

take action against it. In addition, the report explains LDHR's community stigma action work, which LDHR believes, in light of the follow-up surveys, has contributed to reductions in stigma.

The baseline results showed high levels of stigma associated with shame, blame, and myths about sexual violence. Some of the harmful consequences which flow from these findings include focusing the blame on women, controlling their behaviour, isolating them at home, restricting their freedoms and rights, and forcing them into unwanted or early marriages as 'preventative' or 'protective' measures. This has extremely harmful consequences for women, gender equality, and justice. Families are also often blamed based on the expectation that the men of the family should protect the women and girls, which reinforces harmful gender norms that drive sexual violence and stigma in the first place.

The blame on victims and their families diverts focus and efforts away from perpetrators and underlying root causes such as harmful gender norms, the addressing of which could be effective in reducing or protecting against sexual violence. It also distracts from and can hinder justice and accountability against the perpetrators. Projected and internalised shame on survivors often prevents them from disclosing what has happened and receiving assistance or accessing justice; and projected and internalised shame on families can break family bonds and lead to sending away or isolating survivors, rejecting or ostracising survivors, or in extreme cases, honour killings. Continued blame, shame and division within families and communities impedes recovery and healing, drives further division and conflict within communities and undermines chances of sustained peace and development.

Myths and misunderstandings about sexual violence produce additional harms to young women and girls who are subjected to medically unnecessary, scientifically irrelevant, and invasive virginity testing by concerned families. Additionally, because of false expectations of physical injuries on the victim, in their absence, there is often a failure to convict perpetrators. Myths and misconceptions about sexual violence can also render some survivors entirely invisible, without rights and remedies and without access to the required support and recovery. These myths and misconceptions can also heighten or compound stigmatising identities onto the survivor. For example, if males are not recognised as sexual survivors, or if male sexual violence is misconceived as homosexuality, then survivors could also be stigmatised as homosexuals in addition to not receiving the required support.

Overall baseline stigma levels were higher for the communities inside Syria than those outside. The two Syrian refugee communities outside Syria showed the lowest levels of stigma overall. These refugee communities also had the highest levels of education among the surveyed groups. A clear correlation was found between the level of education and lower levels of stigma across all surveys.

Significant changes in attitude were recorded over short periods of time (16 months between baseline and follow-up surveys). Community A had the highest stigma score of the baseline surveys, and it also had the lowest levels of education compared to the other communities. However, following robust intervention of LDHR's stigma community action teams (SATs) over the course of ten months, Community A had reduced to the lowest stigma scores of all the communities surveyed. The results there give hope that stigma can be impacted by thoughtful interventions and community-driven dialogue. The SATs worked in the communities in two different configurations: a full-time mobile action team working in camps and proactively reaching people in the community, and a part-time team implementing community action plans with monthly activities with selected samples from the community.

The surveys indicated some positive attitudes towards criminalisation and accountability for sexual violence, and attribution of shame and blame on perpetrators. Additionally, there was low support or acceptance of 'honour killings', at least publicly. The same was observed with regard to treatment of children born of rape, with a public expression towards equal rights and treatment of those children.

Significant reductions in stigma were achieved across all four community action locations (Community A, Community D, Turkey and Jordan) for victim-shaming, family-shaming, and some aspects of victim and family blaming. However, some topics or aspects were more resistant to change. Those most deeply-held or more culturally-ingrained beliefs, myths, and misconceptions which did not change included beliefs around virginity and the symbolic importance placed on the hymen, and the long-held protection and prevention focus on women's behaviour (protecting and isolating them from harm), rather than focusing on perpetrator behaviour and risk of perpetration as the problem and target for prevention. Tackling and countering such myths and misconceptions are critical to the protection, recognition and recovery of survivors within communities, and also to their access to and outcomes for justice.

LDHR and Synergy hope that this report and the survey results can help spark community discussion about stigma, in its many forms and with its many dangers and impacts. The hope is that the recommendations set out below, as well as the lessons learned are taken up by programmers, implementers and funders, so that Syrians are supported in collective efforts within their communities to remove the divisions of stigma. Those addressing the issue of stigma need to create supportive, connected environments to allow those subjected to sexual violence to heal and fully participate in their community life again. Without this, the divisions and harms will remain within the communities for a long time to come.

Recommendations

The work that LDHR has done to understand stigma, the underlying root causes thereof, and changes observed following some interventions indicates that if communities work together to remove the 'othering' of stigma, create safer paths and responses to disclosure, and encourage empathetic inclusive survivor support, then recovery, reintegration, and full participation of survivors within communities will follow. Stigma reduction will lead to improved access to justice for survivors and for communities. Blame and shame will be shifted to the perpetrators, and Syrian civil society will progress towards a future in which the human rights of all Syrian citizens are protected and respected.

LDHR submits the recommendations below based on lessons learned from working with survivors and in pilot programmes to tackle stigma within Syrian communities. While most of the work must be done at the community level by community leaders and civil society, at some point this work could be done at the national level, particularly with regard to practices institutionalised by laws.

1. **Communities must drive initiatives to improve knowledge, change attitudes, and reduce stigma.** Programmes must be based on collective and cohesive community efforts, which must be co-ordinated by the community members to address and reduce stigma where it is doing harm. Long-term programmes are necessary to address and eradicate deeply rooted stigma.
2. **Civil society and community leaders and groups must step up and use their reach, access, and influence within their communities.** Radiating spheres of influence widen impact and improve outcomes. Influential trusted figures including clerics, community leaders, doctors, teachers, journalists, as well as heads of institutions, organisations, and households can catalyse change within their own arenas. Everyone can drive change by engaging with those around them to tackle stigma directly and focus efforts on supporting survivors and families.
3. **Communities must empower and deploy multi-gendered, trained mobile teams.** Their role is multi-faceted: to start discussion and debate, to engage and drive leadership and institutions, and to support and counsel those stigmatised to overcome both external and internal barriers to exercising their rights, including access to health (both physical and mental), welfare and justice. Anti-stigma teams must engage community members in thoughtful ways that encourage ongoing dialogue and awareness-raising. Continuous long-term efforts yield better results for both survivors and for communities as a whole by reducing stigma and its harmful impacts.
4. **Communities, key stakeholders, leaders, and supporters must ensure that stigma reduction efforts are thoughtful and comprehensive.** There are many different stigmas which impact victims and survivors in Syria, including sexual violence and torture stigma, as well as stigmas linked to societal attitudes toward sexual and reproductive health (SRH), mental health, divorce, children born of rape, arrest/detention, displacement, and poverty (to name a few). Furthermore, structural stigma, community and interpersonal stigma, and self-stigma should all be targeted in a combined strategy. Individualised recognition and support to those who are stigmatised is critical, as internalised stigma self-fuels and is associated with very poor health and welfare outcome.
5. **Communities, key stakeholders, leaders, and supporters must recognise and tackle underlying gender norms which shape and fuel these stigmas.** They must not shy away from the hardest and most sensitive subjects. They must find safe ways to raise subjects that are taboo and bring matters hidden by stigma to light so they are properly understood, and misconceptions corrected.
6. **Donors must prioritise funding to kickstart stigma reduction efforts at the community level across Syria and among refugee communities.** While the most important anti-stigma work is done at the community level at little to no cost, funding is needed to provide critically important training to mobile teams, facilitators, and other key stakeholders who will work with community leaders to raise awareness and educate about the harmful effects of stigma, and best practices to address sensitive and deeply-ingrained subjects. Funding to community-based organisations and service

providers should be conditioned on recognising and tackling stigma (including unconscious bias, manifested stigma and discrimination) in their organisational structures, procedures and practice.

7. **Donors must also prioritise funding to support education in communities.** Typically, where education levels are higher, stigma is lower. This clear correlation demonstrates the need to improve quality and access to ongoing education for all members of society.
8. **Donors, NGOs, and research institutions must support communities through funding and training, to measure and monitor changes in community attitudes and practices.** Implementation of surveys, stakeholder interviews, focus groups, and other methodologies can help to improve understanding of stigma, what works in tackling it, and its harmful effects.

Brief Methodology

After working with Syrian survivors of sexual violence to document cases and refer them for services, it became clear that stigma with all its layers (structural, community-interpersonal, and self), its manifestations (perceived, prejudice, and discrimination), and its consequences (failure to disclose, barriers to support services, poor health outcomes, broken family and community bonds, and continued impunity with no access to justice) were not well-understood or well-addressed in Syrian communities. In 2018, LDHR piloted its community stigma initiatives through workshops in three communities, aimed at mobilising its advanced first responders to catalyse community dialogue and action. Together LDHR and its new community Stigma Action Teams (SAT) considered what had been successful at tackling other forms of stigma, such as those surrounding HIV/AIDS, mental health, disabilities, drug use, and sex work. The SAT then devised tailored, localised Community Action Plans (CAP) to start tackling stigma in their own communities. Before implementing those pilot CAPs, LDHR wanted to measure the levels of stigma related to sexual violence within the target communities to understand what should be addressed and to be able to measure and monitor changes over time.

LDHR and Synergy researched stigma questionnaires and measurement tools from other stigma fields. Researchers took into consideration the work on 'rape myths' which measured attitudes and misunderstandings about sexual violence. LDHR aimed to ensure that the lived experiences of stigma, which Syrian survivors reported during medical documentation and which LDHR mapped in its gendered stigma community work, informed how to identify and measure stigma within Syrian communities.[3] LDHR and Synergy experts then designed a survey containing a mixture of statements which captured different kinds of stigma related to sexual violence, including shame, blame, myths and misconceptions, attitudes toward survivors and attitudes toward perpetrators, and accountability, contextualised for Syria. Later, an additional set of questions was added specifically about male sexual violence in order to understand gendered attitudes toward sexual violence survivors.

While every effort was made to ensure robust methodology in the design and conduct of the surveys, this work was not conducted, intended to be nor is presented or reported as academic research. The purpose was to better inform our programmes and actions through a deeper understanding of community attitudes and changes in those attitudes over time. The goal is for this report and the survey results to be also beneficial for other programmers and donors.

The methodology is described in more detail in Annex A.

[3] See for example: Lawyers and Doctors for Human Rights, 'Voices from the Dark', *Lawyers and Doctors for Human Rights*, 2017, http://ldhrights.org/en/wp-content/uploads/2017/07/Voices-from-the-Dark.pdf; Lawyers and Doctors for Human Rights, 'The Soul has Died', *Lawyers and Doctors for Human Rights*, 2019, http://ldhrights.org/en/wp-content/uploads/2019/03/The-Soul-Has-Died-Male-Sexual-Violence-Report-English-for-release-copy.pdf; Lawyers and Doctors for Human Rights, 'No Silent Witness', *Lawyers and Doctors for Human Rights*, 2019, http://ldhrights.org/en/wp-content/uploads/2019/12/NO-SILENT-WITNESSES.pdf; and Lawyers and Doctors for Human Rights, 'Understanding Gender, Gender Based Violence and Stigma in Syrian Communities', *Lawyers and Doctors for Human Rights*, http://ldhrights.org/en/wp-content/uploads/2018/12/LDHR-Gender-GBV-and-Stigma-Mapping-Report-FINAL.pdf.

About Stigma

The word 'stigma' in English derives from a Greek word indicating a mark or branding placed on a criminal or a slave. It is used now to denote a social 'stain' or 'taint' which society projects on to an individual or group which devalues 'others' and marginalises them because of a characteristic, experience, behaviour or other factors.[4] The social interaction dimensions of stigma and stigmatisation include shaming, blaming, negative judgement, misconceptions and stereotyping, enacted stigma, prejudice and discrimination (inter-personal stigma). All of these can be institutionalised in laws, systems and processes (structural stigma). In addition, stigma is internalised by its victims (self-blame, shame, anticipated negative interactions, perceived stigma), which is associated with PTSD, depression, and failure to disclose or seek help.[5] Stigma can be so deeply rooted that people are not even aware that they are stigmatising someone or acting in a way that treats them differently. Furthermore, as a collective societal construct, people do not necessarily believe themselves to be actors or agents, positive or negative, in stigmatisation or countering it.

> *"Stigmatisation is a social process that leads to the marginalisation of individuals or groups. [...] Stigma and stigmatisation occur within the context of violence and social inequality – leading to the creation, condoning or compounding of social exclusion for those that are (or are perceived to be) victims/survivors of Sexual Violence. Stigma involves penalising or placing blame on individuals, groups or communities for bringing shame or 'transgressing' from the standards of their community or society. Sexual Violence-associated stigma is not only the expression of individual values, beliefs or attitudes; it is the forceful expression of social norms that are cultivated within a given society through the behaviours and actions of groups of people and institutions."* — Principles for Global Action on Tackling the Stigmas of Sexual Violence in Conflict

Gender norms and expectations shape lives around the world, but their influence is stronger in some regions than others, and those impacts are often exacerbated by conflict. Gender norms, violence and stigma are intimately inter-related. Violence and stigma grow from the roots of harmful gender and societal norms. The resulting harm affects not just the survivor, but their family and the fabric of each community. For many, the experience of stigma is compounded by multiple stigmatized identities and at the intersection of multiple compounding factors.[6] Since stigma is a social construct, it exists and is structured among other social constructs and attitudes towards gender, social status, age, wealth, education, ethnic, religious or other affiliations. While stigma surrounding sexual violence is almost universal and global, how it plays out and impacts people is very much shaped by the culture and society in which it exists.

In the Syria context, for example, a survivor of sexual violence in conflict may also suffer from gendered stigmas associated with seeking mental health support, being a former detainee, being a divorcee, being displaced, having no home, or being unable to make a living. They are likely to have suffered

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[4] David M Frost, 'Social Stigma and its Consequences for the Socially Stigmatized', *Social and Personality Psychology Compass*, 5(11), 824–839, November 2011.

[5] See: Foreign & Commonwealth Office, 'Principles for Global Action on Tackling the Stigmas of Sexual Violence in Conflict'; Angie C Kennedy & Kristen A Prock, '"I Still Feel Like I Am Not Normal": A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence', *Trauma Violence & Abuse*, December 2018.

[6] Frost, 'Social Stigma and its Consequences for the Socially Stigmatized'.

other traumatic events, other forms of violence and other human rights violations, which may also be stigmatised or have socio-economic consequences which may be stigmatised.

Types or Themes of Stigma

i. Shame

In patriarchal societies, the concepts of honour and shame are inter-connected, strongly-held and deeply-set within rigid constructions of gender binaries. Whereas honour - a person's or family's value, worth and reputation within a community - is usually perceived to be attained by men through displays of strength, dominance and protection ('masculine' values in that culture), it is perceived to be lost by women through dishonour and shame, through the loss of expected purity, chastity, modesty and obedience ('feminine' values within that culture).

Shame is a judgement about who a person is: a bad person, an immoral person, one who is not pure or chaste, thereby devalued or deviating from expected values. Shame is an integral part of the stain of stigma. It can be community or inter-personally imposed, and it is often perceived and internalised by people (self-shame). It isolates and marks 'shamed people', causing them to hide or be separate from others and the community. Shame is associated with avoidance, silence and invisibility. It strongly inhibits disclosure to others; preventing and barring access to support, services, justice and pathways to recovery for many survivors.

Shame is an extremely powerful weapon because it is such a divisive social behaviour and once internalised, such a destructive emotion. It is closely connected to depression, anger and self-harm. Further feelings of shame and shaming can exacerbate and prolong PTSD and other psychological impacts of sexual violence.[7] In other words, systematic sexual violence can be used against communities and opponents because of the shame those communities place on survivors. How communities respond to survivors may very well worsen the social damage that the perpetrators have been seeking to inflict.

ii. Blame

Often societies look at elements of victims' behaviour to try to ascribe blame or culpability. Victim-blaming is an extremely common phenomenon within sexual violence stigma, and the extent of it also results in internalisation of blame. For example, survivors often ask themselves (or are asked), 'what could I (you) have done differently?' The common and recurring suggestion is that a victim must have done something to provoke the sexual violence. For example, women who smoke, women who dress less conservatively, women who go out of the house on their own - may all be seen to provoke or consciously choose to risk sexual violence. This moves the blame on to the survivor and removes the responsibility, culpability, and prevention from the perpetrator. Societies look to women and girls to reduce their risk and exposure to sexual violence through adopting more conservative and reserved behaviour, through greater controls on them and more restrictions on their freedoms, rather than looking to change perpetrator behaviours, or reduce the risk of perpetration.

[7] Amra Delić & Esmina Avdibegović, 'Shame and Silence in the Aftermath of War Rape in Bosnia and Herzegovina: 22 years later', 2015.

> *"When sexual assault survivors do tell people about what happened to them, they frequently face negative reactions such as victim blaming and disbelief, especially from formal providers such as law enforcement; these experiences, termed the second rape or secondary victimization, exacerbate survivors' PTSD and can impede the receipt of effective formal help that meets their needs and facilitates recovery (Campbell, 2008; Kennedy et al., 2012)."*

In the context of the Syrian conflict, women have been subjected to sexual violence during home raids or having been dragged from their homes, without distinction between women who cover or not, and often are targeted simply because they themselves or someone they are related to oppose the authority in question. Men, too, have been victims of sexual violence while held in detention centres.

When survivors face negative reactions involving blame from their loved ones, studies have shown that this results in deterioration of those relationships which are often critical for their support and recovery. Furthermore, studies have found that negative social reactions including hurtful, victim-blaming reactions from friends and family were associated with increased rates of PTSD, depression, and other health problems. For these reasons, it is critical for us to ensure that victim-blaming has no place within survivors' families, within communities, or within service providers and justice systems.

> *"Women and girls are often blamed for the violence that is committed against them – from sexual harassment on the street, to domestic violence and sexual violence: "Some people say that a girl will not receive such insults unless she is loose." (Adolescent girl from Ein Issa subdistrict, Ar-Raqqa governorate). The belief that GBV is the woman's fault results in punishment and retribution against the survivor rather than the perpetrator. Anger against the survivor was a common denominator in families' reactions to GBV survivors: "Most families blame, beat, isolate and maltreat women and girls for sexual violence against them." (May 2018 GBV Safety Audit, Nawa, Daraa, Jordan Cross Border Hub)."*[8]

iii. Myths and Misconceptions of Sexual Violence

Since the 1970s, 'rape myths' and misconceptions about sexual violence have been recognised as impacting survivors' access to justice and their justice outcomes. These are also deeply rooted in traditional gender norms and inter-connected with other forms of stigma, such as shame and blame. These myths and misconceptions can mean that types of perpetration/victimisation are not recognised by the law or by society. Sara Sharratt[9] noted that some of the most common myths are:

- Women often provoke rape through their appearance and behaviour.
- Women who do things like [frequenting certain social environments especially where men and women mix and/or alcohol is served, and those who might be sexually active outside marriage] are raped.
- Most rapists are oversexed.
- Rape happens when a man's sex drive gets out of control.

[8] UNFPA, 'Voices from Syria 2019 - Assessment Findings of the Humanitarian Needs Overview', *OCHA Humanitarian Response*, 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/voices_from_syria_2019_0_0.pdf

[9] Sara Sharratt, 'Gender, Shame and Sexual Violence: The Voices of Witnesses and Court Members at War Crimes Tribunals', 2011.

Researchers have found that people believing inaccurate myths about rape typically attribute greater responsibility to the survivor, rate the trauma suffered by the survivor less severely, and are likely not to recommend that the survivor goes to the police.[10] Rape myths are more widely accepted among males than among females, and men are more likely than women to blame the survivor. While myths about rape persist across countries and cultures, variances do exist, and research found that individuals who subscribe to traditional gender-role beliefs show greater acceptance of rape myths and adopt narrower definitions of what constitutes rape than those who are comfortable with more flexible gender roles.[11] Countering such myths and misconceptions is critical to both the recognition and recovery of survivors within communities but also to their access to and outcomes for justice. Importantly, studies have attributed the discontinuation of criminal prosecutions for rape and declining conviction rates to the "pervasive beliefs of myths about rape".[12]

Impact and Importance of Tackling Stigma

It is critically important to understand the multiple reverberating impacts of stigma on individual survivors, their rights and prospects, on their families, and on their acceptance and reintegration within communities. The scale and nature of sexual violence inflicted against Syrians has and will continue to have a long-lasting destructive effect, in large part due to the stigma surrounding it. That is why it has been deployed so effectively as a weapon of war. Syrian communities and individuals all need to act to prevent and mitigate its harm to Syrian society and to future generations.

(a) On Individual Survivors

> *"Stigma kills: it is possible to survive sexual violence, but not survive the ensuing ostracism, abandonment, poverty, 'honour crimes', trauma that can lead to suicide or self-harm, unsafe pregnancies, and untreated medical conditions, including STIs and HIV, that may result. There needs to be a heightened sense of urgency about fighting stigma because rape survivors are literally dying of shame."* — Letitia Anderson, Office of the UN SRSG on Sexual Violence, Wilton Park 2016[13]

Research demonstrates that the combination of labelling, discrimination, status loss, and isolation of survivors makes stigma self-reinforcing and leads to avoidance of disclosure. "Stigma and stigmatization play a critical role in shaping survivors' thoughts, feelings and behaviours as they recover; their risk of revictimization; and their help-seeking and attainment process". "Self-blame, shame and anticipatory stigma are powerful barriers to [...] survivors' disclosure and help seeking." Furthermore, "self-blame, shame and negative social reactions are linked to a host of poor outcomes, including PTSD, depression, psychological and physical distress, affect dysregulation, social withdrawal, maladaptive coping and beliefs, and reduced self-esteem."[14]

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[10] B. Frese, M. Moya, and J.L. Mejias, 'Social perception of rape: How rape myth acceptance modulates the influence of situational factors', *Journal of Interpersonal Violence*, 19, 2004, 143-61; B. Krahé, J. Temkin, S. Bieneck, and A. Berger, 'Prospective lawyers rape stereotypes and schematic decision making about rape cases', *Psychology, Crime and Law*, 14, 2008, 461-79.

[11] J. Temkin and B.V. Krahé, 'Sexual Assault and the Justice Gap: A Question of Attitude', *Oxford: Hart Publishing*, 2009, p.36.

[12] G. Bohner, F. Eyssel, A. Pina, F. Siebler, and G.T. Viki, 'Rape myth acceptance: Cognitive, affective and behavioural effects of beliefs that blame the victim and exonerate the perpetrator' (in M. Horvath and J. Brown (Eds.), 'Rape: Challenging contemporary thinking'), 2009, p. 17–45.

[13] Foreign & Commonwealth Office, 'Principles for Global Action on Tackling the Stigmas of Sexual Violence in Conflict', p.14.

[14] Kennedy & Prock, '"I Still Feel Like I Am Not Normal": A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence'.

There is a pervasive "negative, delimiting and contaminating effect" that stigma has on survivors' relationships, and it impacts their mental health, as a form of stress or traumatic stressor on survivors, with decreased access to health, support, and other services. Importantly, external negative reactions and discrimination inhibit access and participation in education and the work force.[15]

> *"However, given people who are stigmatized live their daily lives within societies that are shaped by social stigma, the socially generated negative meanings surrounding stigmatized characteristics and identities can easily be internalized and attached to the self. The result is socially generated but internally perpetuated self-devaluation. Internalized stigma can persist even in the absence of direct perpetrators of stigma, and is thought by some to never completely subside (e.g., Gonsiorek, 1988)."*

> *"Various physical, psychological, economic, political and social consequences of stigma are experienced by survivors/victims and children born of rape, across different countries. Effects are also experienced at family, local, national and international levels. The impact of stigma includes: direct and indirect threats to the lives of survivors/victims and their families, encompassing suicide, domestic and intimate partner violence, so-called 'honour' crimes, survivor/victims returning to unsafe, at-risk environments; shame; silence; re-traumatisation; harmful impacts of long term SVC-related health issues (e.g. sexually transmitted diseases (STDs), impotence, fistula and other damage to sexual organs, loss of interest in sexual relations, post-traumatic stress disorder (PTSD) and other mental health issues); forced pregnancy; forced abortion and forced marriage. Stigma may also result in under reporting of SVC and impunity for criminal acts. In addition, discrimination, social exclusion, spousal or familial abandonment, infidelity, loss of individual/family educational and economic opportunities, poverty, forced prostitution and other forms of sexual exploitation including human trafficking may occur."*[16]

(b) On Survivors' Human Rights

The broad range of civil, political, legal, social, cultural and economic rights jeopardized by stigma demonstrate how pervasive stigma is and how it restricts, controls, and shrinks the lives of those it affects. The table below illustrates some examples of stigma in Syrian communities and the rights they violate which are enumerated in some international covenants to which Syria is a party.

Political, Civil, Economic, Social and Cultural Rights	Examples in Syrian Communities
Gender inequality (ICCPR Art. 3, ICESCR Art.3)	Stigma is heavily gendered, with women often taking the brunt of stigma.
Freedom and protection from discrimination (ICCPR, Arts.24, 26)	Stigma has been institutionalised in Syrian laws and manifests as discrimination, creating differential treatment and barriers for those stigmatised.
Right to life (ICCPR, Art.6)	'Honour' Killings and other violence perpetrated against survivors as secondary victimisation and stigma.

[15] Frost, 'Social Stigma and its Consequences for the Socially Stigmatized'.
[16] Foreign & Commonwealth Office, 'Preventing sexual violence initiative: shaping principle for global action to prevent and tackle stigma', *Wilton Park*, 2016, p. 3, https://www.wiltonpark.org.uk/wp-content/uploads/WP1508-Report.pdf.

Right to liberty and security of the person (ICCPR, Art.9)	Often seen as a protective measure, women and girls can be kept at home 'away from harm' and deprived of their liberty. Furthermore, survivors may not receive legal protection if targeted under the pretext of 'honour-protection'.
Freedom of movement (ICCPR, Art.12)	Often women's movement is restricted based on 'protection', honour and reputation.
Right to legal recognition (ICCPR, Art.16)	Children born of rape are rarely registered, and cannot derive citizenship from their mother.
Right to privacy, home and family and freedom from unlawful attacks on honour and reputation (ICCPR, Art.17)	Stigma is an attack on a person's reputation and honour. Sexual violence stigma often shames and blames survivors, holding them responsible somehow for the crime committed against them and devaluing or dishonouring them. Stigma can also deprive a survivor of their home and family, if they are rejected or are forcibly displaced.
Freedom of expression (ICCPR, Art.19)	Stigma and anticipated negative social reactions are associated with avoiding disclosure. Stigma and taboos prevent community discussion and debate of sensitive topics.
Right to marry and form a family (ICCPR, Art.23, ICESCR Art.10)	Survivors often experience difficulties in their marriage or ability to marry.
Right to work, fair and equitable conditions of work (ICESCR, Arts.6-7)	Discrimination and negative social reactions impact survivors at work or from getting work. Internalisation of shame and blame inhibits engagement, and unaddressed mental health outcomes can also impair a stigmatised person's ability to work.
Protecting children and protected status (ICCPR, Art.24, ICESCR, Art.10)	Children born of rape are often abandoned and marked for life. Where the father is not known or cannot be declared, the child can be deprived of its citizenship.
Right to physical and mental health (ICESCR Art.12)	Impacted by violence and trauma, by social rejection and judgement, and stigma creates barriers to access services and support.
Right to education (ICESCR, Art.13)	Fear of sexual violence can lead to girls not being sent to school.
Right to participate in cultural life (ICESCR, Art.15)	Survivors often self-isolate from shame or are ostracised and rejected from their communities and families, denying the right to fully participate in society.

The Six Communities

LDHR worked with six communities, four inside Syria (Communities A, B, C, and D) and two Syrian refugee communities (one in Turkey and one in Jordan). Five of the six communities are clustered around the Turkey-Syrian border in Northern Idlib and Western Aleppo, and the sixth one in Jordan. The distance between the two farthest apart (Community A and Community D) is only 80 km. As a result, one might not expect too much of a difference in knowledge, attitude, and stigma among these communities. However, each place has some key differences from the others and quite different experiences during the Syrian conflict. These differences likely have impacted the communities' understanding of and reaction to stigma and sexual violence.

Community A is close to the northern Syrian border; prior to the conflict, its economy mostly depended on agriculture and some industries. The majority of its population is Sunni-Arab with tribal backgrounds and has a large IDP population displaced at least once from other parts of Syria during the conflict. It has been for most of the years of the Syrian conflict under the control of the opposition with presence of opposition factions, except for a few months, when it was under the control of ISIS.

Community B lies on a river close to the north-western Syrian border, with the economy being predominantly agricultural as it sits in a very fertile area. It has been under the control of different actors, and since 2018, it has been under the control of opposition groups. Ethnically it is highly diverse with many mixed groups including Kurds, Turkmen, Arabs, Circassians, Chechens, and Armenians.

Community C is close to the north-western Syrian border and surrounded by large areas of farmland. The majority of the population is Sunni-Arab. Hayat Tahrir al-Sham (HTS), an al-Qaeda offshoot, controls the area militarily, but there have been significant community protests against it.

Community D is a small town at a strategically important road/crossroad near the Turkish border. Due to its location and proximity to the borders, its economy is highly dependent on trading. The majority of the population is Sunni-Arab, and it has seen repeated influxes of IDPs in waves since 2015. Currently, HTS controls the area militarily and administratively.

Community in Turkey (will be referred to as 'Turkey') is a town near the Syria-Turkey borders. There is a large Syrian refugee population in the town due to its proximity to the border, and refugees live within the town and in 'refugee' camps. Early in the conflict there was an influx of Syrian refugees. There are many female-headed Syrian families whose husbands stayed in Syria. The majority of the Syrian refugees came from conservative areas in Syria.

Community in Jordan (will be referred to as 'Jordan') has a large number of Syrians displaced from southern Syria early on in the conflict as this area witnessed violent crackdowns since the beginning of the conflict, where it was one of the first spots of protests in the uprising in 2011. In 2013, a study found that 1/3 of Syrians in Jordan surveyed cited fear of sexual violence against their family members as the reason for leaving Syria. The majority of Syrians in this community come from Sunni-Arab areas that are somewhat conservative. The community for this work is from the refugees who are not living in the camps, which are some of the biggest Syrian refugee camps.

About LDHR's Stigma Community Action Work

LDHR began responding to sexual violence in the Syrian conflict in 2012 as a group of doctors and lawyers training to document torture and sexual violence using the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* (AKA "Istanbul Protocol").[17] LDHR documenters soon recognised that responding to sexual violence in a holistic way was necessary not only to complete their documentation and accountability work in an ethical and safe manner, but more importantly, it was critical to the outcomes for survivors. The challenges faced by survivors in their communities in the aftermath of enduring sexual violence could be as life-threatening and destructive as the horror of sexual violence itself. Societal attitudes and stigma could be fatal for survivors and could have negative effects on their families and communities.

Since then, LDHR doctors and lawyers have been on a journey to discover how best to help survivors of sexual violence and catalyse better community response and outcomes. In 2016, LDHR started training first responders in local Syrian communities so that survivors could access safer, more effective, and more supportive services and recovery supports. Since 2017, LDHR has been working with its trained first responders in three communities to map gender norms, gender-based violence, and stigma to better understand community attitudes toward sexual violence and its survivors, as a foundation to tackle stigma wherever it is found.

LDHR conducted a baseline knowledge and attitude survey in the six communities to better understand the communities' attitudes, understanding, and response to sexual violence. Later, and after completing pilot community stigma action plans in four of the six communities, LDHR conducted follow-up surveys in those communities to get an understanding of changes in attitudes over time and in response to the work done therein.

The initial baseline surveys and follow-up surveys are the subject of this report. Following administration of the baseline surveys in Community A, Community D, Turkey and Jordan, LDHR's Stigma Action Teams (SAT) developed pilot community action plans. Through this work in 2019-2020, they reached an overall number of 3,891 Syrians (91.8% women and girls, 8.2% men and boys).

The overwhelming percentage of women and girls reached (compared to men and boys) was a result of the gender composition of the SAT. Initially LDHR focused on increasing and building better practice amongst female first responders in recognition of the great barriers faced by female sexual violence survivors in regard to disclosing and seeking help. Later in the process, LDHR addressed the gender balance by recruiting more men to support male sexual violence survivors, and also to reach more men and boys through the stigma community action plans. This commitment to gender representation resulted in more male survey participants in Jordan, Community B and Community C surveys, which were conducted in late 2019 to early 2020.

LDHR's SAT operated in two different configurations during the pilot programme:

A) a full-time stigma mobile action team able to work in camps and proactively reach people (rather than bringing or waiting for them to come) (Community A), and
B) part-time teams implementing Community Action Plans through several activities a month focused on group work, discussions, and awareness raising events and activities (Community D, Turkey, Jordan).

[17] OHCHR, 'Istanbul Protocol', *Office of the United Nations High Commissioner for Human Rights*, 2004, https://www.ohchr.org/documents/publications/training8rev1en.pdf

Community A: A full-time mobile action team targeted two contrasting IDP camps (one more crowded with higher levels of poverty, the other more developed and better serviced) with a team of five (including four female field workers). The team worked for 10 months (January 2019 - February 2020, interrupted April 2019-July 2019 due to funding delays.) The team reached 2,233 people (93% women). The activities included:

1. Individual sessions to identify and support people suffering from different forms of gendered stigma and GBV (including SV) to ensure support and follow-up (health, MHPSS, and social support) services. These sessions included discussions and support around community and self-stigma. The team included trained PSS/PFA (psychological first aid) counsellors, a critical need when a survivor was in acute need or it was shortly after they had suffered trauma/violence. The teams also made referrals to mapped support services.
2. Awareness-raising small focus groups (up to 10 participants), and sometimes larger discussion groups. The team often broadened the topic to include wider gendered stigma and gender norms, initially to allow access to a difficult and sensitive topic but also because many stigmas overlap on survivors, including those associated with experiences of detention, disabilities, divorce, mental health, or others. There were 21 sessions with over 220 participants.
3. Meetings with camp managers, community leaders, service providers and local NGOs focused on structural stigma.
4. Wide distribution of brochures focusing on raising awareness about mental health (for adults and children), how to recognize it, and misconceptions about it.
5. A channel on the 'Telegram' application called 'STOP STIGMA' through which subscribers received regular messages and information.
6. An art installation about stigma and its impact on individuals and the community.

> The team found gender inequalities were almost always at the root of the discussions. As a result, the team also tackled girls' education, early marriage, discrimination, and stigma against female workers. Individual success stories include getting girls back to school, supporting a woman through a divorce following intimate partner violence (IPV), and supporting survivors to battle through their fear of stigma to allow them to access much needed MHPSS support.

Community D: Following administration of the baseline survey in October 2018, a team of 14 LDHR female advanced first responders worked part-time for six months from March 2019 to January 2020 (interrupted from April - August 2019 due to delayed funding). They reached 964 people (95% women) through the CAP that they devised, implemented, and periodically reviewed. The team divided the work into four geographical areas to cover the town and the surrounding area. The activities included:

1. Two-hour small focus group discussions (including groups of female teachers, mothers and their teenagers, adolescents and youth) to discuss the impact of stigma and the barriers it creates for survivors needing to access support. In this safe space, many participants shared stories of their own personal experiences of different kinds of stigma and how it affected their lives, choices, and communities, and how often women bore much of the brunt of stigma. These sessions also included a guided discussion on how to respond to survivors of SV/GBV. Each participant was challenged to think about how they can reduce stigma around them, thereby widening the influence and impact of the team and its work. The team conducted one session per month with seven groups, where each group included 14 participants.
2. Distribution of Brochures: 1,000 in March 2019 to service providers including hospitals and women's organisations. The brochures included information about mental health (for adults and children), how to recognize it, and misconceptions about it.

Turkey: Following administration of the baseline survey in October 2018, a team of 14 LDHR female advanced first responders also divided into four action groups, worked part-time for six months from March 2019 - January 2020 (interrupted from April - August 2020 due to delayed funding). They reached 404 Syrians (92% women). The activities included:

1. Focused small group workshops (up to 10 participants) on stigma and communities' perceptions of survivors and on shifting the blame and shame from survivors as innocent victims to the guilty perpetrators using a rights-based perspective. In these sessions, participants discussed rape and sexual violence myths and misconceptions, as well as how sexual violence has been used in the conflict.
2. Film screenings with discussion sessions on perceptions of survivors of domestic violence and sexual slavery/kidnap.
3. Focused campaigns on stigmas which compound sexual violence stigma (such as stigma attached to mental health concerns) and prevent people from accessing help and receiving quality stigma-free care from hospitals and services providers. These campaigns included group discussion targeting a diverse group, including female students and their mothers, persons with different educational levels, and former detainees.
4. Focus groups and sessions on the exploitation and sexual abuse of children, children born of rape, and the associated stigma on those children and their lives. These sessions also discussed the rights of the child, how to register children in Turkey, and how Syrian law needs to be reformed to protect children's rights.
5. Highly interactive small discussion groups (up to 10 people) with adolescents and school-age children to give them confidence to talk about gendered stigma, and small sessions with mothers and adolescents together to discuss stigma and societal attitudes.
6. Distribution of brochures: 200 brochures distributed in community centres. The brochures included awareness information about mental health (for adults and children) and about sexual violence targeting children.
7. A community art competition, the theme for which was stigma related to SV. Announcement about the competition was posted on social media and more than 25 people participated. The top three received prizes, and the first-place winner's entry is featured on the cover of this report.

Jordan: Following administration of baseline surveys in October 2019, a team of 15 LDHR advanced first responders worked part-time for six months until March 2020. They reached 290 Syrians (69% women). The activities included:

1. Small focus group discussions and workshops on stigma, its impact, and its role preventing disclosure of sexual violence and understanding the obstacles a survivor/stigmatised persons face including law, accessing services, etc. These included discussion/debate sessions specifically on how sexual violence and the resulting stigma are weaponised in conflict and against opponents; stigma facing female detainees; forced early marriage; child abuse; and gender inequalities in Syrian communities. Diverse target audiences included university students, widowed and divorced women, and married mothers.
2. Small focus groups on gendered aspects of stigma and sexual violence, using the case of a woman who was subjected to sexual violence while walking home at night. These sessions used a debate format to hear different views and identify different kinds of stigma, shaming, blaming, and misconceptions.
3. "What Do You Do If?" scenario exercises with adolescents, posing real life situations which involved stigma and discussing how they would react.
4. Awareness raising campaign on Facebook, brochures and cups with the tagline "Your strength, with your knowledge". The Facebook page, which is still active, includes posts with information about the different types of stigma, its effects on the victims, and ways to combat it.

The baseline surveys in Communities A, D, Turkey, and Jordan, were done early enough to allow time to launch and complete the Community Action Work in those communities and do a follow-up survey in each of them. LDHR conducted the baseline surveys in Communities B and C later, which did not allow enough time to train teams to carry out the Community Action Work in those communities and get follow-up surveys before completing the work for this report.

Overall Stigma Patterns

Below are stigma patterns that LDHR observed through the surveys; the detailed survey results are shown in Annex C and the survey questions are shown in Annex D. The results are divided into some basic themes or aspects of sexual violence stigma: (1) shame, (2) blame, (3) myths and misconceptions, (4) attitudes to perpetrators, and (5) male sexual violence. The detailed results look at the themes comparing results for the locations, and where applicable, the comparing baseline and follow-up survey results. Based on the results, LDHR was able to measure and get a better understanding of knowledge, attitudes, and stigma surrounding sexual violence and its survivors in the Syrian communities where LDHR conducted work related thereto.

Highest Stigmas across Locations

The highest levels of stigma were associated with the categories of 'Shame', 'Myths', and 'Misconceptions', based on the following statements, for each of which the range of percentage of agreement (indicating stigma) is shown:

"It is important to warn women against behaviour which can put them at risk of sexual violence." **89-97%** in baseline surveys
"If a woman has been raped, she will have physical injuries and her hymen will be broken." **75-85%** in baseline surveys
"Sexual Violence brings shame on a victim's family." **55- 83% in baseline surveys**
"Sexual Violence dishonours and shames a woman." **55-79% in baseline surveys**

Other high percent agreements were recorded for stigmatised beliefs such as sexual violence being driven by lust and sexual gratification, beautiful young girls being the main target of sexual violence, and that families are to blame for failing to protect the victim.

Importantly, as Table 1 below shows, attitudes towards victim-shame and some aspects of blaming, as well as family-shame and blaming saw significant reduction when the team conducted the follow-up surveys in the LDHR stigma action plan communities. The largest reduction in stigma levels were noted in Community A, where LDHR's mobile stigma action team worked full-time for 10 months.

TABLE 1: Stigma Reduction Levels in Community A and other locations		
	Stigma reduction in Community A	**Significant stigma reduction levels elsewhere**
Victim Shame[18]	**A reduction of 56% in stigma levels**	Community D 21% reduction, Turkey 15%, Jordan 12%
Family Shame[19]	**A reduction of 56% in stigma levels.**	Community D 20% reduction, Turkey 15%, Jordan 12%

[18] Question 13 of the Survey "Sexual Violence dishonours and shames a woman."
[19] Question 14 of the Survey, "Sexual Violence brings shame on a victim's family."

Victim Blame[20]	**A reduction of 38% in stigma levels** (outside home alone), **20% in stigma levels** (uncovered), **23%** in stigma levels (bad behaviour leads to sexual violence) less people agreed	
Family Blame[21]	**A reduction of 47% in stigma levels**	Community D 18% reduction, Turkey 21%

In contrast, sexual violence myths and misconceptions remained more ingrained and little change was seen in the levels of stigma for these propositions between the baseline and follow-up surveys. These had very high levels of stigma and appear to combine multiple reinforcing and embedded cultural values and influences: gender roles, protection of women, and the cultural and religious importance placed on virginity and the hymen as a symbol of that. Table 2 shows the sometimes-increasing levels of stigma recorded in the follow-up surveys in some communities.

TABLE 2: Changes in Stigma Levels for Sexual Violence Myths and Misconception

Stigmatised statement	Community A stigma levels	Community D stigma levels	Turkey stigma levels	Jordan stigma levels
"If a woman has been raped, she will have physical injuries and her hymen will be broken."	Increased by over 13%[22]	Increased by 0.2%*[23]	Decreased by 5.36%	Increased by 13.94%
"It is important to warn women against behaviour which can put them at risk of sexual violence."	Decreased by 0.6%*[24]	Decreased by 7.46%	Decreased by 3.2%*	Decreased by -2.29%*

* Within margin of error +/-5%.

Implications

The implications of the highest scoring statements/topic of stigma within Syrian communities include:

- Focusing the blame on women, controlling their behaviour, isolating them at home, restricting their freedoms and rights, and using forced or early marriages as 'preventative' or 'protective' measures. This has extremely harmful consequences for women, gender equality and justice.
- Blame on families based on the expectation and role of male protectors vis-a-vis female victims, which reinforces harmful gender norms that drive sexual violence and stigma in the first place.
- This blame on victims and their families diverts focus and efforts away from perpetrator behaviour and underlying root causes such as harmful gender norms which could be effective in reducing or protecting against sexual violence.
- This blame also distracts from and can hinder justice and accountability against the perpetrators.
- Young women and girls being subjected to medically unnecessary, scientifically irrelevant, invasive virginity testing by concerned families and some courts[25].

[20] Questions 18 "Sexual Violence will occur if a survivor behaves badly", 3 "Women who do not cover are more likely to be victims of sexual violence", and 2 "Women who go out of the house alone must take responsibility for what happens to them."
[21] Question 12 "The family of a victim are also to blame because they failed to protect their daughter, sister or wife.
[22] Meaning that levels of agreement with this stigmatised statement increased between the baseline and follow-up surveys. Noting that the percentage of those who strongly agreed with this statement (indicating strong stigma) decreased by 0.5% (within margin of error).
[23] Noting that the percentage of those who strongly agreed with the statement decreased by 6.44%.
[24] Noting an increase of 4.52% of those who strongly agree with this stigmatised statement.
[25] Some courts in areas outside the Syrian government's control order "virginity tests".

- A potential failure to convict suspects based on lack of physical injuries on the victim.
- Projected and internalised shame on survivors which prevents them from disclosing what has happened and from receiving assistance or access to justice.
- Projected and internalised shame on families which can break family bonds and lead to survivors being sent away or isolated, rejected or ostracised, or in extreme cases, to honour killings.
- Myths and misconceptions which render some survivors entirely invisible, without rights and remedies and without access to support and recovery; these myths and misconceptions can also heighten or compound stigmatising identities onto the survivor. For example, if males are not recognised as sexual survivors, or if male sexual violence is misconceived as homosexuality, then survivors could also be stigmatised as homosexuals within society.
- Continued blame, shame and division within families and communities impedes recovery and healing, drives further division and conflict within communities and undermines chances of sustained peace and development.

Lowest Stigmas across Locations

It is important to note that many of the statements which recorded the lowest levels of stigma were framed as "non-stigmatised" propositions – so that a survey participant would have to disagree or strongly disagree with the proposition in order to show stigma. For example, "Only a perpetrator of sexual violence should feel shame." Disagreeing or strongly disagreeing with this indicates a stigmatised attitude. It is possible that the low levels of stigma for these questions could simply reflect acquiescence or agreement bias – a tendency to agree, rather than disagree. However, for many of the survey questions, in both baseline and follow-up surveys there was a wide range of responses, including high levels of disagreement for many of the questions/propositions. For example, in the Community A follow-up survey, there were at least 10 questions with levels of over 80% disagreement.

The categories with the most positive attitudes (lowest levels of harmful stigma) included high levels of support for responsibility placed only on the perpetrator. They also included some aspects of shame: high levels of support on the marriageability of survivors and for the equal rights of children born of rape, and high levels opposing 'honour' killings. The lowest stigma-scoring statements are the following, included for each of which the range of percentage of disagreement (indicating stigma) is shown:

"Only the perpetrator should feel shame." **1- 29%** in baseline surveys
"A Perpetrator should be brought to court and if found guilty should be punished." **3 - 29** %in baseline surveys
"Survivors have the right to marry." **3 – 15%** in baseline surveys "If a woman is raped, her husband has the right to divorce her." **12 – 29%** in baseline surveys
"Honour killing removes the shame of sexual violence from a family." **5 - 26%** in baseline surveys
"Children born of rape should be treated like every other child." **8 - 25%** in baseline surveys

Again, it is noteworthy that baseline results indicating very low levels of stigma were more likely to stay at the same level or go up at the follow-up survey in the LDHR Stigma Action Communities. This may simply reflect the fact that more universally-held opinions are less likely to change over short periods of time. In addition, with only small percentage gains to be achieved in these areas, marginal changes may be accounted for within the surveys' margins of error (+/- 5%).

Based on the results, there are some implications arising from the lowest stigma levels and more positive attitudes found within these communities, in addition to some clear opportunities, and some which might require a more cautious approach:

- There is positive support for criminal justice and accountability for sexual violence.
- There is a positive attribution of shame and blame on perpetrators, which can have a deterrent effect on sexual violence and can support accountability processes.
- Few within the community will admit support or acceptance of 'honour killing', an extreme violent manifestation of stigma. While positive, there is a concern that public expressions against 'honour killing' might not match the practice in private. LDHR has worked with a number of female survivors who have faced, been threatened with or are at risk of violence from their family.
- There are potentially positive public community attitudes towards equal rights and treatment of children born of rape. Caution is required, given how much taboo and life-long stigma, as well as some legal problems attach to children born outside marriage in Syrian communities as discussed below.

All of these findings are discussed in more detail below.

Comparison among Locations

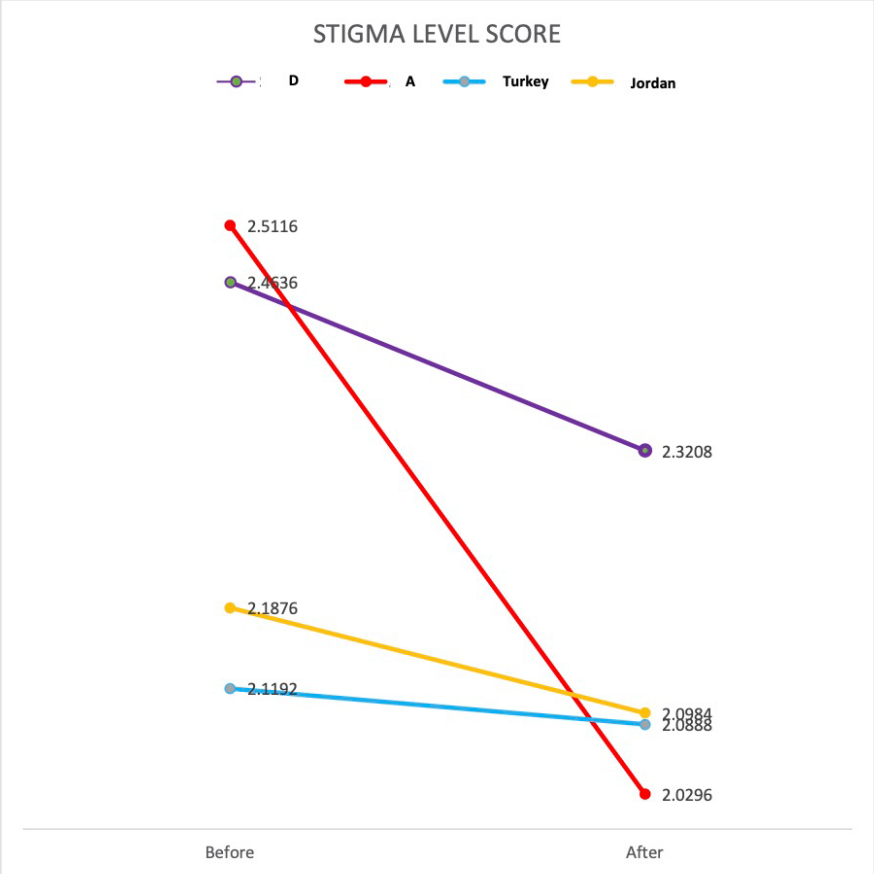
A scoring system allows comparison of overall stigma levels (beyond individual questions or topics) using a range of 1-4: 1 signified strong disagreement with the statement, 2 disagree, 3 agree and 4 strongly agree with the statement. For each question, an average score was calculated, as well as averaged over the whole questionnaire. This produced a stigma score for each survey location, with the scores indicating the following:

1 – Strongly disagree with stigmatised statements	1-2 Disagree with stigmatised statements	2-3 Agree with stigmatised statements	3-4 strongly agree with stigmatised statements
Positive Attitudes	Low Levels of Stigma	Medium Levels of Stigma	High Levels of Stigma

Overall stigma score for each location

TABLE 3: Overall Stigma Scores for Surveys in Each Location

Location	A	B	C	D	Turkey	Jordan
Survey Population	Almost all women, less educated, mostly married, almost all IDPs.	Mostly men, older, more married, high levels of IDPs, moderate levels of education.	Mostly women, mostly married, moderate levels of education, relatively low percentage of IDPs.	Mostly women, a little younger, more educated, mostly married, lowest % IDP.	Almost all women, older, most educated, mostly married, all refugees.	Mostly women, youngest group, highly educated, mostly single, all refugees.
Changes in Stigma Scores	2.51 to 2.03 0.48 reduction over time	2.46	2.37	2.46 to 2.32 0.14 reduction over time	2.20 to 2.11 0.09 reduction over time	2.19 to 2.10 0.09 reduction over time



Community A had the highest stigma score in the baseline period. Of note, the Community A survey groups also had the lowest levels of education compared to the other survey groups. Interestingly, at the follow-up survey, Community A achieved the lowest stigma scores of all surveyed communities, including the refugee communities which had the lowest baseline levels. LDHR's mobile stigma team had been active there for the longest period.

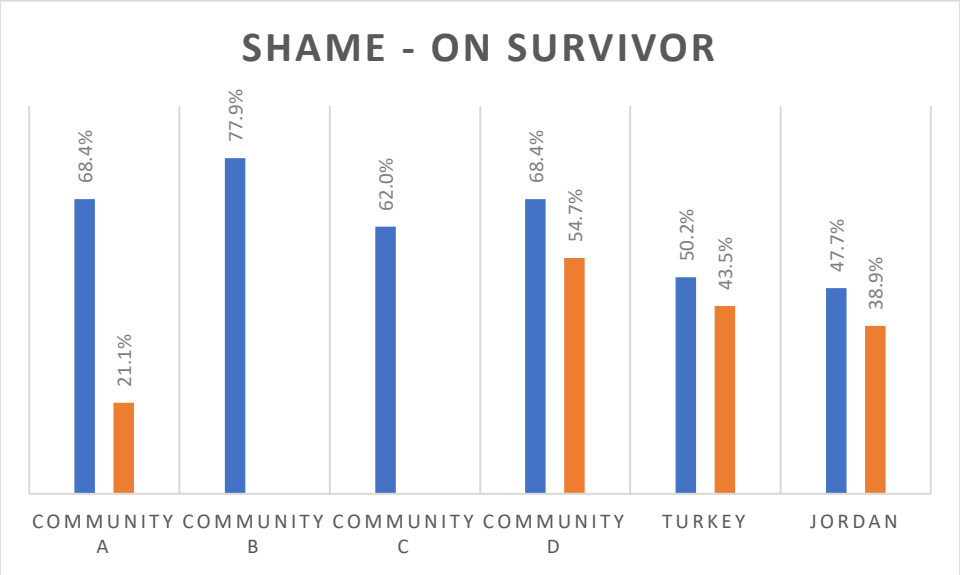
Overall baseline stigma scores were higher for the communities inside Syria, as compared with those outside. Turkey and Jordan, the two Syrian communities outside Syria, showed the lowest levels of stigma overall, and experienced a lower relative reduction in stigma in follow-up. These refugee communities reported the highest education levels among the surveyed groups.

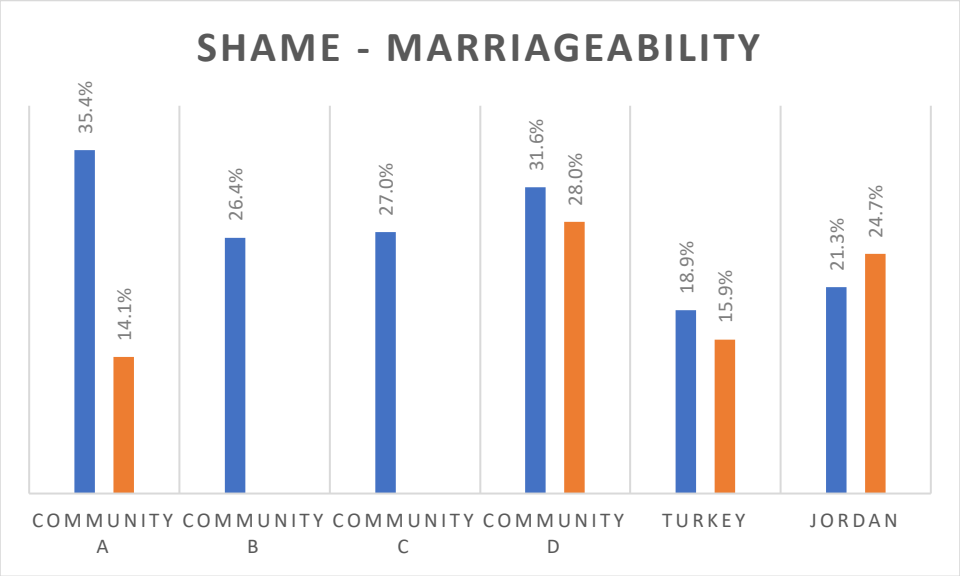
By Theme and Location

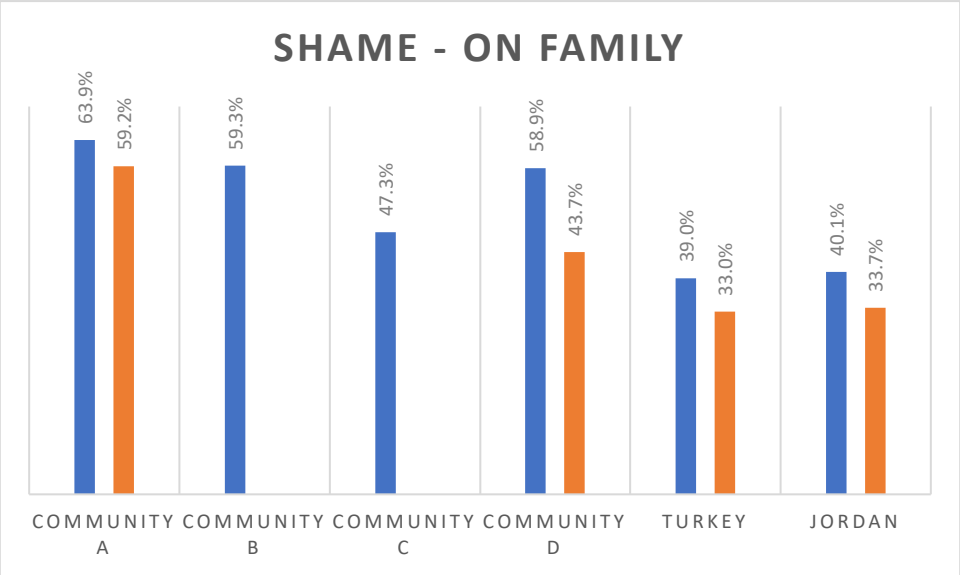
As can be seen from the charts below, baseline surveys show highest stigmatisation for shame and blame of the survivors and their families, as well as for myths and misconceptions. For each of the communities and the indicated theme, the charts below show the percentage of survey group showing stigma (either through agreement with a 'stigmatising statement' or disagreement with a 'non-stigmatised statement') and show the percentage where a follow-up survey was conducted.

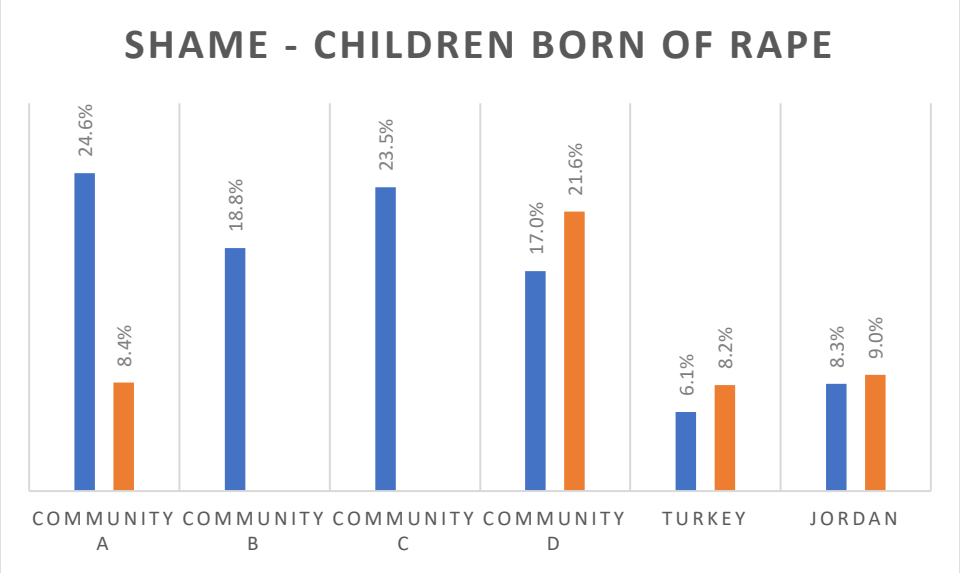
The blue bars indicate the baseline percentages and the orange the follow-up percentages. It should be noted that some of the charts below show only follow-up results for Communities A, D, Turkey, and Jordan, which is associated with some issues that were not presented in the initial baseline surveys in those communities either due to sensitivity of the issue or because additional questions on the topic

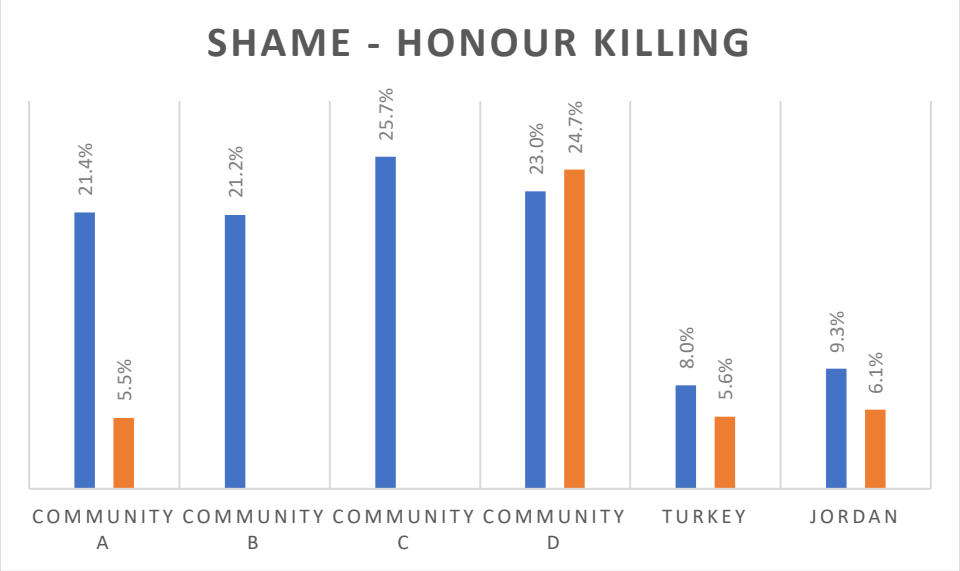
were added after the baseline surveys were conducted. Therefore, those results show the stigma levels after the teams had done work in those communities.

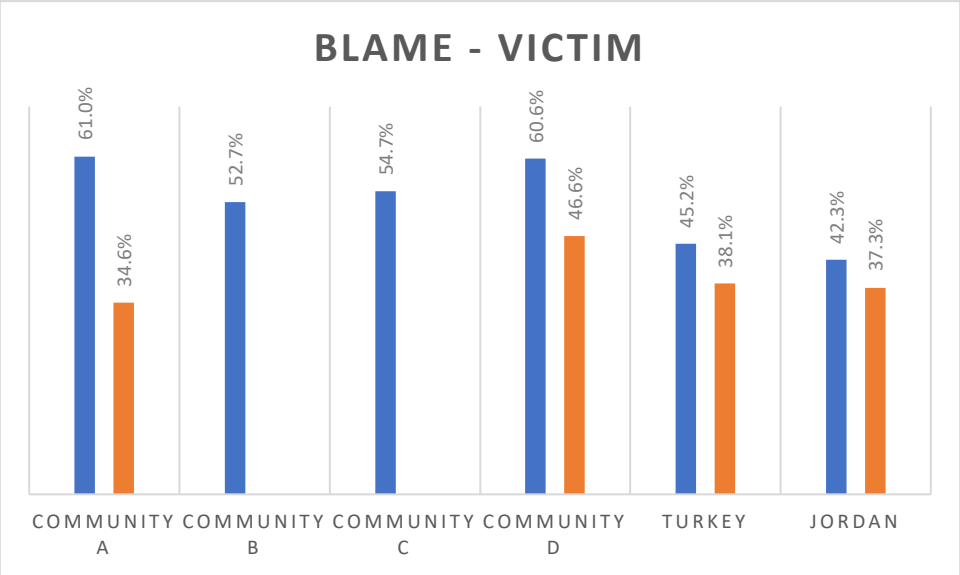


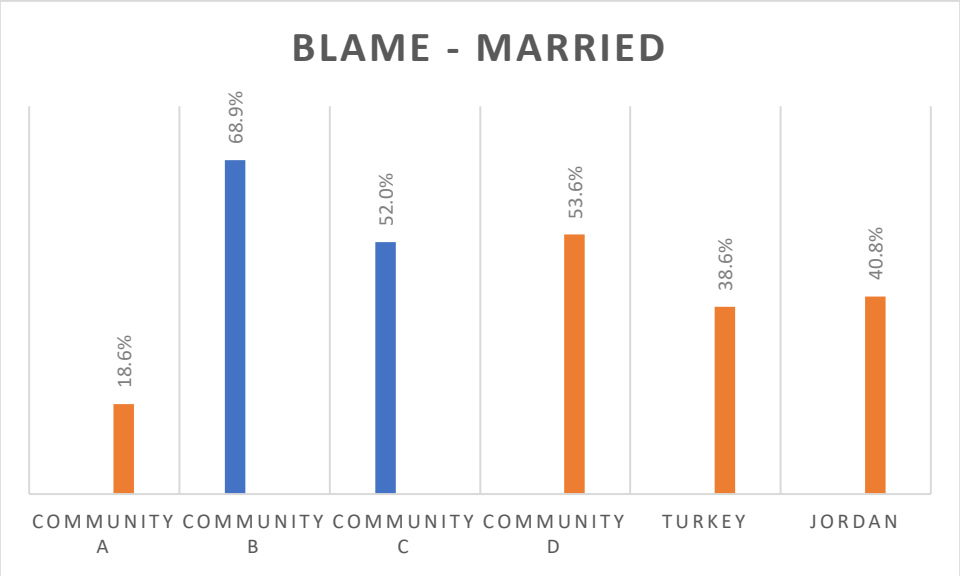


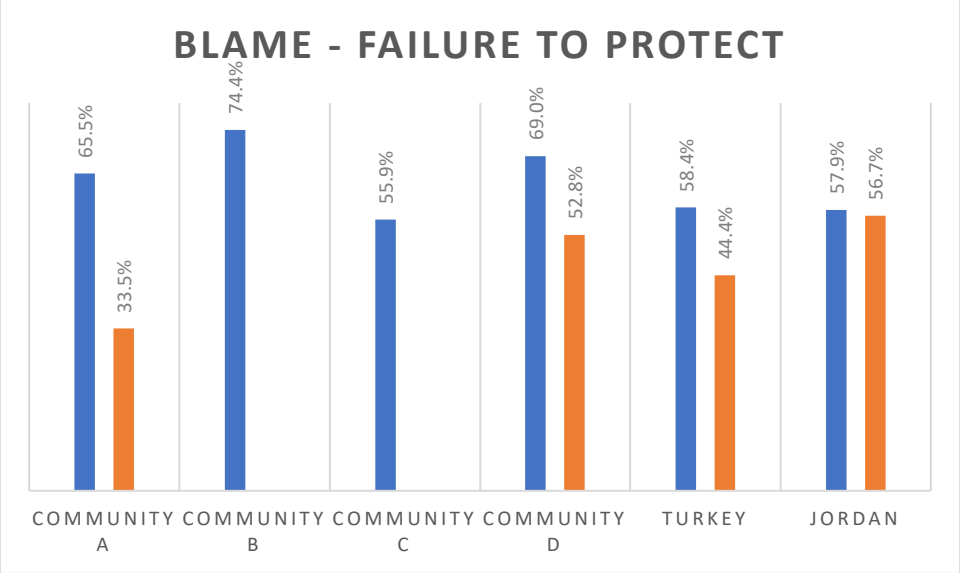

SHAME - ON FAMILY
63.9%
59.2%
59.3%
47.3%
58.9%
43.7%
39.0%
33.0%
40.1%
33.7%
COMMUNITY A
COMMUNITY B
COMMUNITY C
COMMUNITY D
TURKEY
JORDAN


SHAME - CHILDREN BORN OF RAPE
24.6%
8.4%
18.8%
23.5%
17.0%
21.6%
6.1%
8.2%
8.3%
9.0%
COMMUNITY A
COMMUNITY B
COMMUNITY C
COMMUNITY D
TURKEY
JORDAN


SHAME - HONOUR KILLING
21.4%
5.5%
21.2%
25.7%
23.0%
24.7%
8.0%
5.6%
9.3%
6.1%
COMMUNITY A
COMMUNITY B
COMMUNITY C
COMMUNITY D
TURKEY
JORDAN


BLAME - VICTIM
61.0%
34.6%
52.7%
54.7%
60.6%
46.6%
45.2%
38.1%
42.3%
37.3%
COMMUNITY A
COMMUNITY B
COMMUNITY C
COMMUNITY D
TURKEY
JORDAN


BLAME - MARRIED
18.6%
68.9%
52.0%
53.6%
38.6%
40.8%
COMMUNITY A
COMMUNITY B
COMMUNITY C
COMMUNITY D
TURKEY
JORDAN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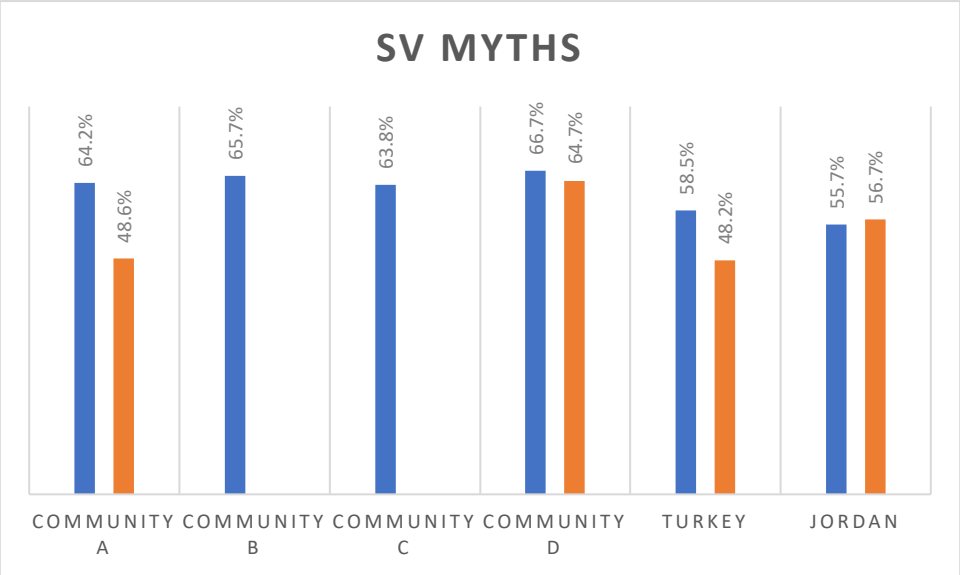
SV MYTHS
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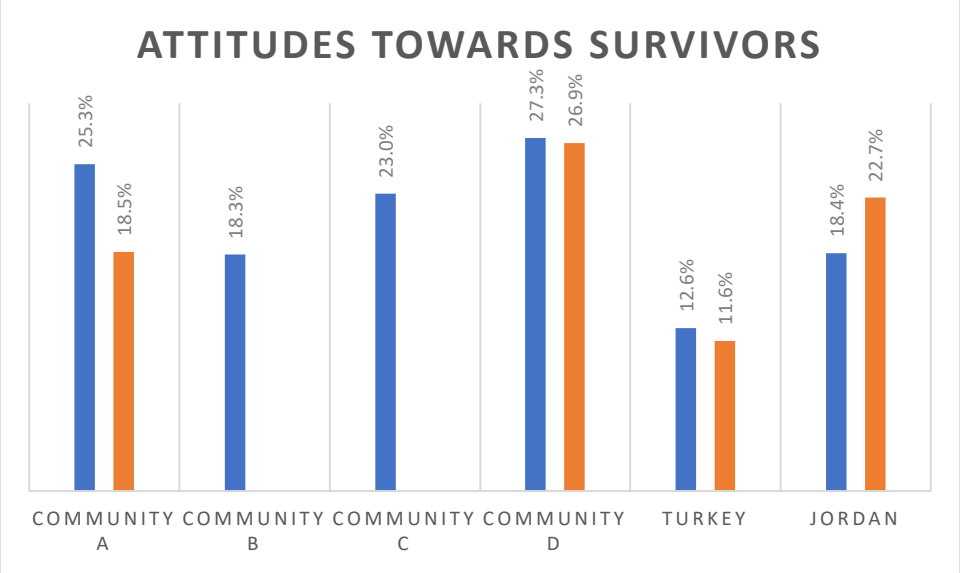
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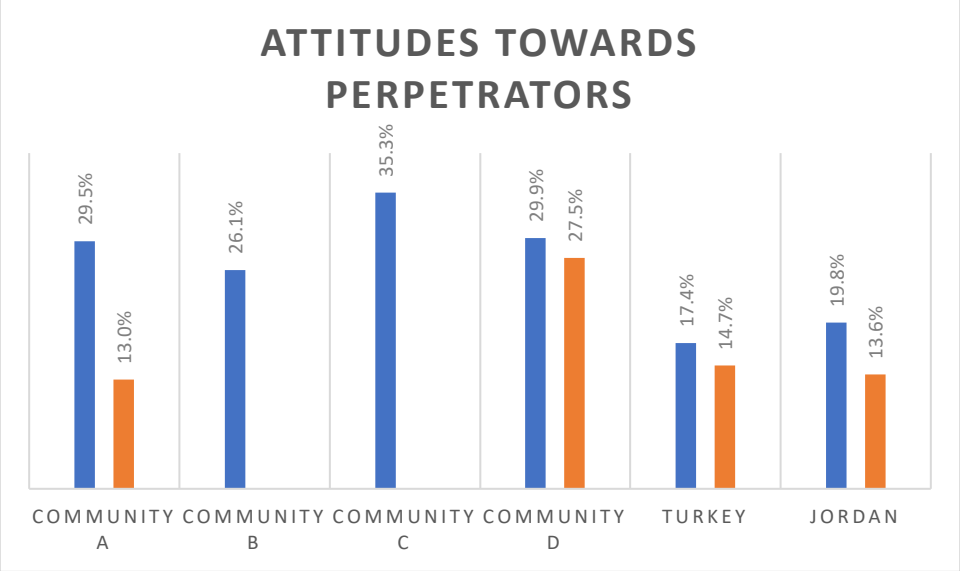
ATTITUDES TOWARDS PERPETRATORS
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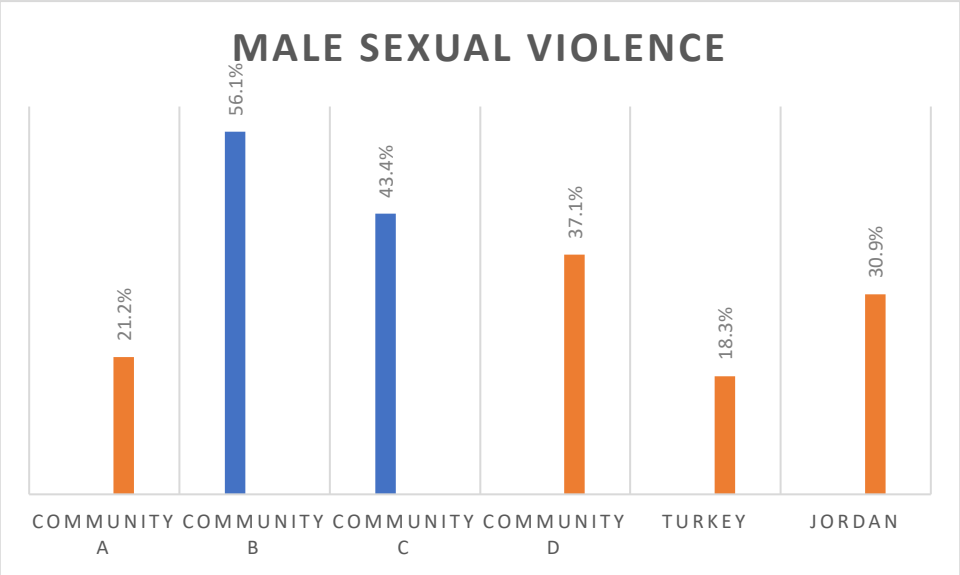
JORDAN



By Demographics

There was not an in-depth analysis of the relationship between demographics and stigma, but based on the demographics of the participants, LDHR was able to draw the following initial conclusions:

Educational Level: Education was found to be associated with stigma. Increasing levels of education correlated with lower levels of stigma. Table 4 below shows the stigma score for each location at each level of education for the participants.

TABLE 4: Education Level and Overall Stigma Score by Location					
	No education	Primary	Middle	Secondary	University
Community D	2.68*	2.67	2.55	2.42	2.30
	2.56	*2.36*	*2.30*	*2.31*	*2.23*
Community A	2.62	2.54	2.46	2.47	2.33*
	2.09	*2.02*	*2*	*1.96*	*2**
Turkey	2.4*	2.42*	2.33	2.18	2.12
	*2.53**	*2.32*	*2.12*	*2.13*	*1.99*
Jordan	2.52*	2.41	2.38	2.17	2.06
	*3.03**	*2.49**	*2.46**	*2.18*	*1.94*
Community C	2.49	2.47	2.42	2.34	2.27
Community B	2.49	2.47	2.49	2.47	2.34

Gender: Men showed higher stigma levels in baseline studies in Community B, Community C and Community D, but lower in Turkey and Jordan's baseline surveys. Stigma levels in Community A were the same for both genders. In the four follow-up surveys, women showed more stigma, except for Community A where only women were surveyed.

Age: In all surveys (except Community B), people over 45 years old showed higher levels of stigma as compared with the 18 – 44 years age group.

Marital status: Across all surveys, divorced and widowed respondents showed higher levels of stigma, but the small sample size of this sub-population in each survey makes it difficult to draw any conclusions. In the baseline and follow-up surveys in Jordan, stigma among the married group was higher than singles, and in Community B, singles reported higher stigma than married persons. For all

other surveys (Community A, Community C, Community D and Turkey) single and married respondents reported similar stigma levels.

Changes over Time

LDHR carried out its stigma community action work in four of the six communities; there were only 18 months between surveys in three of LDHR Stigma Action communities, and only four months between surveys in Jordan. Not much change was expected following the short pilot projects, since changes in attitudes and beliefs can be slow, especially those deeply held and inter-connected with religious or 'central' social norms, such as gender binaries. Further, when knowledge and attitudes relate to topics which are taboo, it is even harder to start the process of change through discussing, questioning, and debating and deliberating, given how they are shrouded in shame and embarrassment. Even mentioning these topics is stigmatised or socially sanctioned. In relation to sexual violence, the stakes are extremely high, with deep patriarchal gender norms and potential social sanctions which include killing and violence in the name of 'honour' or ostracism and rejection by the family and the community.

The significant decreases in stigma levels in the follow-up surveys were a remarkable and welcome finding, particularly where large reductions in shame and blame against the victim and their families were recorded across locations. The greatest impact was in Community A, where the LDHR full-time mobile stigma action team worked for 10 months. A detailed discussion of the survey results is included subsequently in this report.

Significant drops in stigma levels were seen for many of the stigmatised statements and topics. In general, more universally-held opinions are usually more culturally ingrained and reinforced, and are less likely to be changed over short periods of time. Additionally, some of the myths and misconceptions which appear to inter-connect deeply-held religious or cultural beliefs and long-standing gender norms, appear more resistant to change. It should be noted that changing in stigmatised attitude were achieved for more direct victim blaming.

What might be driving the changes?

Social norms can be changed through:

- Correcting misperceptions: through interpersonal communications [including survivor engagement and lived experience], mass media, information campaigns, small focus groups, observation and online platforms and games;
- Role models: religious leaders, elders, tribal chiefs, trusted and respected social influencers, and power dynamics – policy makers;
- Structural or institutional change: conflict, disaster, social, technological, as well as hierarchies, social structures or demographic change, and law.[26]

[26] Sophie Legros & Beniamino Cislaghi, 'Mapping the Social-Norms Literature: An Overview of Reviews', *Perspectives on Psychological Science*, vol. 15(1), 2020, p. 62– 80.

Conclusions and Next Steps

What was learned about attitudes?

1. It is the community's attitude towards survivors which allows sexual violence to be utilised as a weapon. It is up to the communities to remove the ammunition of stigma and social attitude.
2. Attitudes can change and have changed in some communities. Syrians - individuals and communities - must build on these positive outcomes, and maximise, spread and sustain change.
3. Some attitudes are harder to change, and subjects related thereto are hard to raise within some communities. Unfortunately, many of these are the most damaging and impact the rights of survivors the most. Therefore, they are the most important to change.
4. Community discussion, debate and understanding of stigma is a critical route to change. This report and the survey results are excellent tools to start that engagement.
5. Internalised stigma is very damaging for survivors, their welfare and rights, and self-perpetuates without intervention. Anticipated negative social reactions silence survivors.
6. It is possible to measure stigma impact for sexual violence survivors, measure changes over time, and capture data in this regard which is useful for taking action to effectuate reduction thereof.
7. Survey results do not always capture the true picture and extent of attitudes and how they manifest. For example, what is known about the hidden taboo of children born outside marriage does not appear to be reflected in the survey responses. More qualitative research is needed on some topics to be able to address more effectively.

Which attitudes/myths to target?

1. Those leading to victim shaming and blaming, as this internalises and creates barriers to disclosure, support and justice.
2. Those leading to family shaming and blaming, as this leads to division and conflict in the space survivors need most for support and connection.
3. Attitudes leading to further sexual victimization, for example virginity testing, forced marriage to perpetrators to remove shame, early marriage as 'protection' and 'preventative' measure, etc.
4. The myths that can leave some victims invisible or criminalised.
5. The myths and misconceptions which impact justice outcomes (for example, expectations of evidence of physical violence to prove guilt of perpetrators). It Is critically important to tackle these attitudes among those documenting, investigating, prosecuting and adjudicating sexual violence crimes.
6. The misconceptions which focus on women's behaviour to prevent sexual violence, rather than working on risks and drivers for perpetration.

Who to target?

1. Male members of the community, particularly for LDHR whose outreach has mainly been by and to women.
2. Institutions and service providers, including human rights organisations, documenters of violations, and other justice actors, and provide them with structural stigma and organisational change tools.
3. Community leaders and influencers, with whom work should be done to get their support and action for community change – policy, institutional and community attitudes.
4. Victims of stigmatisation, with whom work should be scaled up in order to counter the internalisation of stigma, the barriers that creates and the poor outcomes which follow. Sharing positive results and changes with survivors to reduce internalisation/self-shame and blame.
5. Civil society and other community-based leaders, with whom work can be done to build up stigma action teams and stigma action work, which is a long-term process.

6. Individuals and groups that document sexual violence for accountability or other purposes for them to raise awareness about possible unconscious bias and stigma in their work, and how to create non-stigmatising safer processes and support systems for survivors to whom they have access.
7. Actors and leaders at the national level, particularly those with whom work can be done to address institutionalized and structural stigma. This work might be more appropriate at a later stage, when there is one set of laws governing all areas, but this should be kept in mind during work at the community level, as in the future these communities can drive changes at the national level.

What was learned about community action?

1. Community-led, community-designed, and community-implemented action produced good, measurable results.
2. A full-time dedicated team which monitors, reviews, and reports on a regular basis achieves better results and can continuously adapt and respond to lessons learned.
3. The biggest impact was achieved through outreach by a mobile team which targeted community leaders and organisations, conducted small group discussions, and identified and assisted stigmatised individuals using responsible and safe case management and referral protocols.
4. The hardest, most taboo topics can be raised by less direct routes after building trust and discussing principles using other forms of stigma. Sexual violence survivors face multiple stigmatising factors which all act against disclosure and help-seeking.
5. Stigma is the result of many factors that work combinedly and most of those are deeply-ingrained, thus countering them requires long-term work and commitment to get positive and sustainable results within the communities and the entire system.

Annexes

Annex A – Detailed Methodology

The survey was originally a knowledge, attitude, practice (KAP) survey which could be used to measure stigma within institutions and service providers. In the end, the pilot work focused on community stigma and so the survey conducted tested knowledge and attitude only. LDHR's intention is to advance stigma work into tackling structural or institutionalised stigma within service providers and justice mechanisms. For this work, full KAP surveys will be utilized.

Those surveyed could select "Strongly Agree", "Agree", "Disagree" or "Strongly Disagree" for each statement. The questions were largely framed as statements or propositions which reflected stigmatised attitudes or understandings of sexual violence. For some topics, additional questions were also framed in a way that meant that stigma was reflected in the 'Strongly Disagree' or 'Disagree' responses. This was to test and counterbalance any agreement or 'acquiescence bias'.

Draft questions were tested on stigma teams and interviewers. Some issues were questioned through multiple different formulations or angles to triangulate results. Agreement or acquiescence bias is the tendencies for people to agree with a question or proposition, rather than to disagree. While a degree of agreement or acquiescence bias is possible in the results, high levels of disagreement recorded for many questions were also noted. For example, in the follow-up survey in Community A there were at least nine questions which received disagreement levels of over 80% of the surveyed group.

The team identified the target population and its size using humanitarian population data which took into account the influx of internally displaced persons (IDPs) or refugees. Though it is important to note that in dynamic and rapidly changing conflict situations, as is the case with the Syrian conflict, the size and underlying demographics of a target population can change, and accurate up-to-date information and data on these are impossible to obtain. This is particularly the case where there are high levels of displacement and where secondary and even tertiary displacement is occurring due to shifting frontlines and conflict dynamics.

Using a margin of error of +/-5% and a confidence level of 95%,[27] the SAT calculated a minimum sample size to be surveyed for each place to ensure the results could be representative and a useful measurement of stigma over time.[28] The desired sample sizes for each location are set out in Annex B, along with details of the survey populations. Baseline surveys were conducted in all six communities by each community SAT, who had been trained at workshops.

In each community, the team tried to select participants to reflect as diverse a group as possible in terms of sex, age, educational level, and marital status. As expected, due to the sensitivity of the subject, people approached to participate refused, thus the percentages for the categories were not consistent across all six communities. Thus, the team depended on contacts within the communities to identify potential and willing participants, and also approached community centres such as, for example, orphanages, women's centres, rehabilitation centres for those wounded / disabled as a result of the war, etc.

[27] Margin of Error = the range in percentage which the population's opinion may deviate from your sample results. Confidence Level = the probability that your sample accurately represents the knowledge and attitudes of your target population.
[28] http://www.raosoft.com/samplesize.html; https://www.qualtrics.com/blog/calculating-sample-size/

The overall numbers surveyed:

- 6 baseline surveys: 3,325 (890 men, 2435 women).
- 4 follow-up surveys after community action plan work: 1,848 (334 men, 1514 women).

In four of the six communities, after the SAT undertook pilot community action programmes, a follow-up survey was conducted using the same methodology and questions. For the follow-up surveys, the teams targeted the same community – e.g., IDPs – to ensure the follow-up surveys reflect the target segments with which they engaged or tried to target, but not necessarily the same people in order to be able to observe the impact on the community as a whole. The full demographic break-down for each survey is attached in Annex B.

Additionally, the demographic changes in the survey populations between baseline and follow-up surveys for a location were due to a number of factors including 1) conflict and crisis driven demographic change within the population or through movement of population, and 2) the selection methodology of the survey – for the follow-up survey, effort was made to ensure that the survey population closely reflected the target population of the community action plans/mobile team. For example, the gender representation was more aligned between the beneficiaries of the community action and the follow-up survey. In Turkey: the stigma team reached 92% women, and then surveyed 93% women in the follow-up. In Jordan, the team reached 69% women, the surveyed 67% in the follow-up survey. In Community A, the stigma mobile team reached 93% women, and surveyed 100% women in the follow-up. In Community D, the team reached 95% women, then surveyed 79% women in the follow-up - representing more women than in the baseline survey.

Comparison of Demographics across Survey Groups						
	Community A	**Community B**	**Community C**	**Community D**	**Turkey**	**Jordan**
Baseline	89% women *Av. Age: 28.3* *Secondary Education+: 26%* Married: 72% Displaced: 85%	*33% women* Av. Age: 34.7 Secondary Education+: 58% **Married: 81%** Displaced: 72%	75% women Av. Age: 30.6 Secondary Education+: 51% Married: 67% *Displaced: 67%*	67% women *Av. Age: 31.3* Secondary Education+: 55% Married: 72% Displaced: 65%	**98% women** *Av. Age: 31.6* **Secondary Education+: 72%** Married:63 % **Displaced: 100%**	75% women *Av. Age: 28.8* Secondary Education+:69% *Married: 36%* **Displaced: 100%**
Follow-up	**100% women** Av. Age: 30.3 *Secondary Education+: 19%* Married: 59% Displaced: 93%			79% women Av. Age: 30.3 Secondary Education+: 51% Married: 58% *Displaced: 65%*	93% women **Av. Age: 36.3** Secondary Education+: 66% Married: 55% Displaced: 100%	67% women Av. Age: 26.9 Secondary **Education+: 84%** *Married: 26%* Displaced: 100%

Annex B – Demographic Breakdowns for Each Surveyed Community

Community A

Target Population: 29,500
Minimum Sample Size: 380

Criteria	Indicators	Before			After		
		Numbers	%	Total	Numbers	%	Total
Gender	Male	56	10,77%	520	0	0,00%	382
	Female	464	89,23%		382	100,00%	
Age	Younger than 18	91	17,50%		58	15,18%	
	From 18 to 44	379	72,88%		275	71,99%	
	45 y/o or older	50	9,62%		49	12,83%	
Marital Status	Single	86	16,54%		85	22,25%	
	Married	376	72,31%		227	59,42%	
	Widow	47	9,04%		44	11,52%	
	Divorced	11	2,12%		26	6,81%	
Education	None	124	23,85%		141	36,91%	
	Primary School	131	25,19%		122	31,94%	
	Middle School	128	24,62%		45	11,78%	
	Secondary School	95	18,27%		42	10,99%	
	University or Institute	41	7,88%		32	8,38%	

In Community A, the first survey was conducted in October 2018. Almost 90% of respondents were women, mostly married (72%) and most half uneducated with either no or only primary school level education (49%). The average age was 28.3. Of those surveyed, 85% were IDPs.

In the follow-up survey conducted in February 2020, it rose to 100% women (reflecting the reach of the stigma community work), with less married (59.4%) and even lower levels of education (68.9% with no or only primary school education). The average age was 30.3 years old. The percentage of IDPs had risen to 93%.

Community B

Target Population: 225,000
Minimum Sample Size: 384

Criteria	Indicators	Numbers	%	Total
Gender	Male	257	67.10%	383
	Female	126	32.90%	
Age	From 18 to 44	317	82.77%	
	45 y/o or older	66	17.23%	
Marital Status	Single	61	15.93%	
	Married	309	80.68%	
	Widow	9	2.35%	
	Divorced	4	1.04%	
Education	None	51	13.32%	
	Primary School	44	11.49%	
	Middle School	65	16.97%	
	Secondary School	86	22.45%	
	University or Institute	137	35.77%	

This baseline survey was conducted in October 2019. In summary, the group surveyed were mostly men (67.1%), mostly married (80.7%) and 58.2% had been educated to secondary school or university level. The average age was 34.7 (32.3 women, 35.9 men). Most of those surveyed were IDPs (71.8%).[29]

Community C

Target Population: 13,500 town, 41,000 area (based on data from 2004)
Minimum Sample Size Calculation: 997

Criteria	Indicators	Numbers	%	Total
Gender	Male	246	24.67%	997
	Female	751	75.33%	
Age	Younger than 18	40	4.01%	
	From 18 to 44	859	86.16%	
	45 y/o or older	97	9.73%	
Marital Status	Single	186	18.66%	
	Married	664	66.60%	
	Widow	76	7.62%	
	Divorced	71	7.12%	
Education	None	103	10.33%	
	Primary School	149	14.94%	
	Middle School	235	23.57%	
	Secondary School	233	23.37%	
	University or Institute	277	27.78%	

This baseline survey was conducted in January and February 2020. In summary, the group surveyed were almost 75% women, mostly married (66.6%) and 51% had been educated to secondary school or higher. The average age was 30.6 (30 women, 32.9 men). Most of those surveyed were IDPs (67.3%).

Community D

Target population: 15,000
Minimum Sample Size Calculation: 540

Criteria	Indicators	Before			After		
		Numbers	%	Total	Numbers	%	Total
Gender	Male	178	32,54%	547	127	21,49%	591
	Female	369	67,46%		464	78,51%	
Age	Younger than 18	50	9,14%		55	9,31%	
	From 18 to 44	414	75,69%		478	80,88%	
	45 y/o or older	83	15,17%		58	9,81%	
Marital Status	Single	126	23,03%		160	27,07%	
	Married	394	72,03%		340	57,53%	
	Widow	16	2,93%		56	9,48%	
	Divorced	9	1,65%		35	5,92%	
Education	None	41	7,50%		96	16,24%	
	Primary School	97	17,73%		103	17,43%	
	Middle School	109	19,93%		90	15,23%	
	Secondary School	88	16,09%		98	16,58%	
	University or Institute	211	38,57%		202	34,18%	

In Community D, the first survey was conducted in October 2018. In summary, the group surveyed were almost 70% women, mostly married (72%) and mostly educated to secondary or university level (54.66%). The average age was 31.3. Of those surveyed, 65% were IDPs.

In the follow-up survey conducted in February 2020, almost 80% were women (reflecting the reach of the stigma community work), with less married (57.5%) and similar levels of education (50.76%

[29] Some sub-groups were too small to be representative for disaggregation and analysis purposes. These included under 18 years old, divorced and widowed.

education to secondary school or university). The average age was 30.25 years old (women 29.87, men 31.6). The percentage of IDPs was (64.64%).

Turkey

Target Population: 35,000 Syrians
Minimum Sample Size Calculation: 280

Criteria	Indicators	Before			After		
		Numbers	%	Total	Numbers	%	Total
Gender	Male	7	2,44%	287	23	7,21%	319
	Female	280	97,56%		296	92,79%	
Age	Younger than 18	22	7,67%		14	4,39%	
	From 18 to 44	227	79,09%		237	74,29%	
	45 y/o or older	38	13,24%		68	21,32%	
Marital Status	Single	94	32,75%		53	16,61%	
	Married	180	62,72%		177	55,49%	
	Widow	8	2,79%		73	22,88%	
	Divorced	4	1,39%		16	5,02%	
Education	None	9	3,14%		1	0,31%	
	Primary School	17	5,92%		48	15,05%	
	Middle School	53	18,47%		58	18,18%	
	Secondary School	63	21,95%		82	25,71%	
	University or Institute	145	50,52%		130	40,75%	

The first Turkey survey was conducted in October 2018. In summary, the group surveyed was almost all women (97.6%), almost two thirds were married (62.7%) and most were educated to secondary or university level (72.5%). The average age was 31.6.

In the follow-up survey conducted in February 2020, it remained almost all women (92.8%), with less married (55.5%) and less education (56.5% education to secondary school or university). The average age was 30.3 years old (women 29.9, men 31.6).

Jordan

Target Population: 200,000[30]
Minimum Sample Size Calculation: 600

Criteria	Indicators	Before			After		
		Numbers	%	Total	Numbers	%	Total
Gender	Male	146	24,70%	591	184	33,09%	556
	Female	445	75,30%		372	66,91%	
Age	Younger than 18	22	3,72%		9	1,62%	
	From 18 to 44	511	86,46%		510	91,73%	
	45 y/o or older	58	9,81%		37	6,65%	
Marital Status	Single	308	52,12%		362	65,11%	
	Married	214	36,21%		146	26,26%	
	Widow	47	7,95%		22	3,96%	
	Divorced	21	3,55%		26	4,68%	
Education	None	23	3,89%		16	2,88%	
	Primary School	86	14,55%		38	6,83%	
	Middle School	77	13,03%		35	6,29%	
	Secondary School	92	15,57%		117	21,04%	
	University or Institute	313	52,96%		350	62,95%	

[30] Estimated number of Syrian refugee community in Jordan, excluding those in the camps like Zaatari and Al-Azraq refugee camps

The first survey was conducted in September 2019. In summary, the group surveyed were 75% women, mostly unmarried (52%) and mostly educated to university level (53%). The average age was 28.8.

In the follow-up survey conducted in March 2020, it dropped to around two thirds women (66.9%), with more unmarried (65%) and even higher percentage educated to university level (63%). The average age was 28.8 years old (women 30.6, men 23.6).

Annex C – The Survey Results

The survey results are described below in detail by theme, illustrated by the results from specific questions and insights from LDHR's work with survivors.

Annex D shows the full set of survey questions.

I. Shame

The survey included a number of questions about shame - a key component of sexual violence stigma.

Shame on the Victim

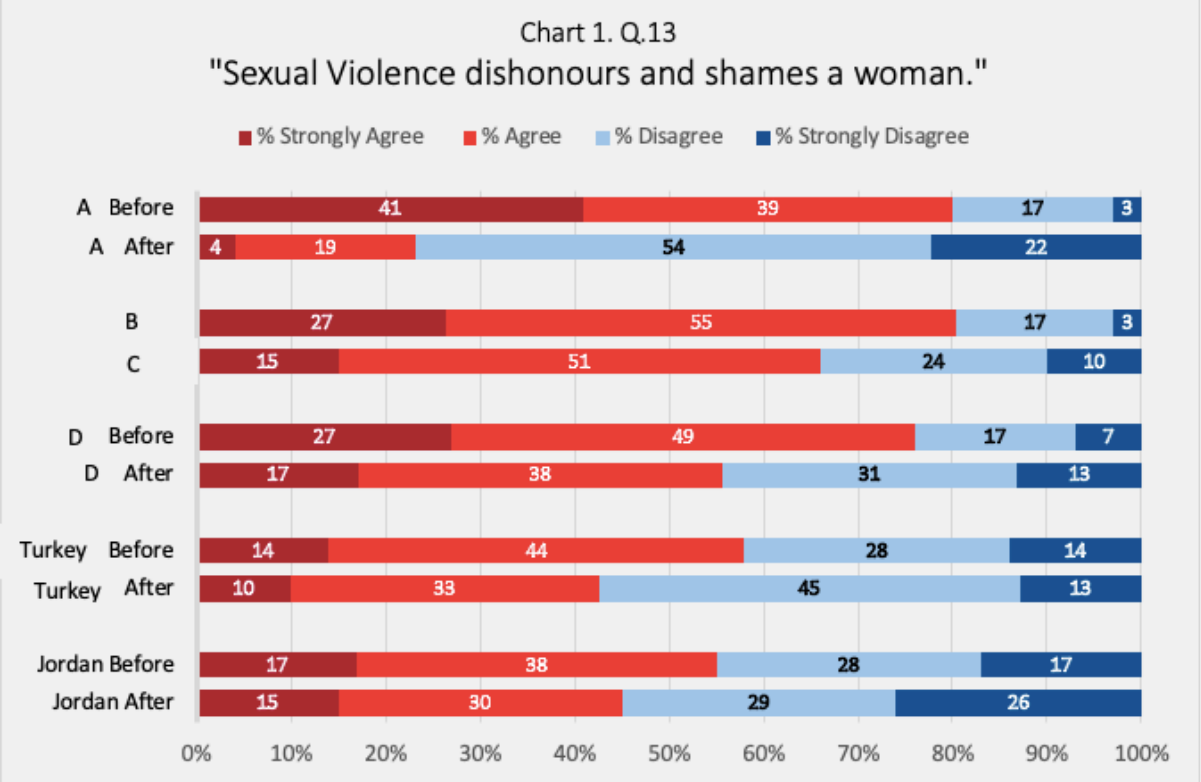
Where stigma is high, it often hits female victims the hardest. This is driven by binary patriarchal gender norms which imposes concepts of purity and virtue upon females, where the honour and family reputation centres around the 'purity' of its women. Women are expected to be virgins before marriage and while fidelity is expected from both men and women within marriage, there is a higher expectation from women in practice and in the law, where the Syrian Penal Code has different rules and sentences for men and women with regards to adultery. In some communities this also means there is an expectation of women to cover their hair, behave in a conservative, religious, reserved manner and be accompanied by male family members outside of the house.

Acts of a sexual nature outside marriage are judged as shameful, bad or 'dishonourable', and any female being involved in such acts as bad or shameful. In a society where rape in marriage is not recognised in law and women are permitted little agency or autonomy over their bodies, there is often a significant failure to recognise the absence of consent. Women who are subjected to sexual acts without their consent are still considered to have been tainted or be shamed.

It should be noted that there are exceptions to the above, and the degree to which they are imposed or applied can vary from one family to another and from one community to another.

> *"Culturally, heavy emphasis is placed on female virginity and modesty as part of personal and family honour. Experience of GBV threatens this honour in various ways, resulting in shame, scandal, and social stigma. The fear of these has a significant effect on controlling women's behaviour. For example, sexual violence, the assumption of sexual violence, or even being approached by a man on the street could be considered a defamation of women's sexual purity: "If someone comes to address a girl, young men start talking about her." (Adolescent Girl from Karama sub-district, Al Raqqa governorate). In addition, access to freedoms that are normal for men, such as being able to move freely or access justice in cases of violence, may be considered an offence to the notion of female modesty, and provoke similar reactions of shame and stigma."*[31]

[31] UNFPA, 'Voices from Syria 2019 - Assessment Findings of the Humanitarian Needs Overview'



The survey found that in all six communities there were high levels of stigmatised beliefs that sexual violence dishonours and shames women. Between 75-82% of respondents in the baseline surveys in Communities A, B and D agreed with this stigmatising statement. In Turkey and Jordan, 55-59% of respondents agreed.

By the time of the follow-up survey, there was a significant reduction in levels of stigma relating to victim dishonour and shame in the following communities: A 56.5% reduction, D 21%, Turkey 15.2% and Jordan 12.2%.

A similar question ("Rape is shameful for both parties") yielded similar results and levels of stigma (e.g. Community B 76.2% in agreement with 36.8% strongly in agreement with this stigmatising statement). The decreases in stigma levels for this question were somewhat more modest – 38.1% reduction in Community A, 6.4% in Community D, 8.5% in Turkey and 5.5% decrease in Jordan.

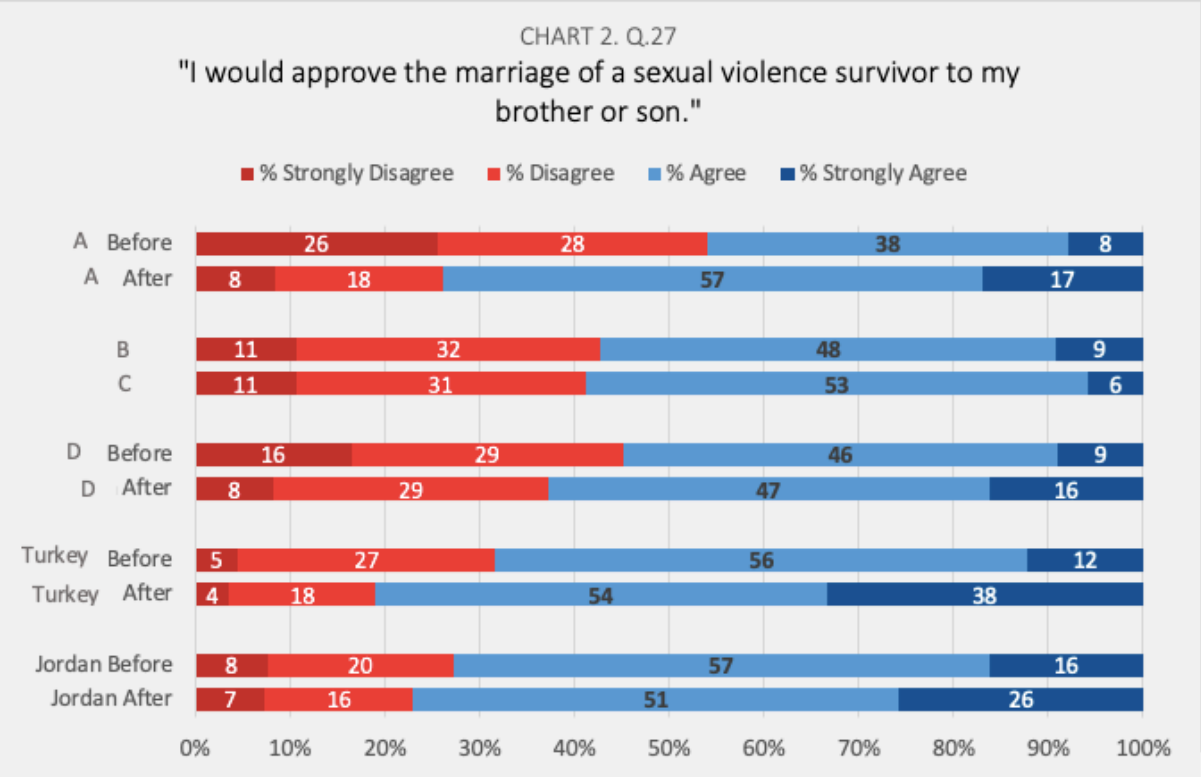
Impact of Sexual Violence on a Survivor's Marriage or Prospects of Marriage

Victim-shame and the impact of sexual violence on a survivor's marriage or prospects of marriage were also tested, particularly in relation to female survivors. It was asked in different ways from different perspectives, including gender-specific questions, rights-based approaches, what a husband's response should be, as well as testing whether the marriage of a family member to a female survivor would be acceptable.[32]

Interestingly, levels of stigma around this were relatively low, particularly so when framed from a survivor-rights perspective. This seems at odds with survivor-reported lived experience and from the LDHR stigma mapping which described frequent impacts on survivors' marriages or prospects of marriage. Of note, slightly higher stigma levels were shown by survey participants when it came to a

[32] For example, "A woman who has been raped will not get married."; "Survivors have the right to get married."; "A husband has the right to divorce his wife if she is raped."; "I would approve the marriage of a sexual violence survivor to my brother or son."

real-life scenario involving their own family (even with a statement which was non-stigmatising), as presented below in Chart 2.

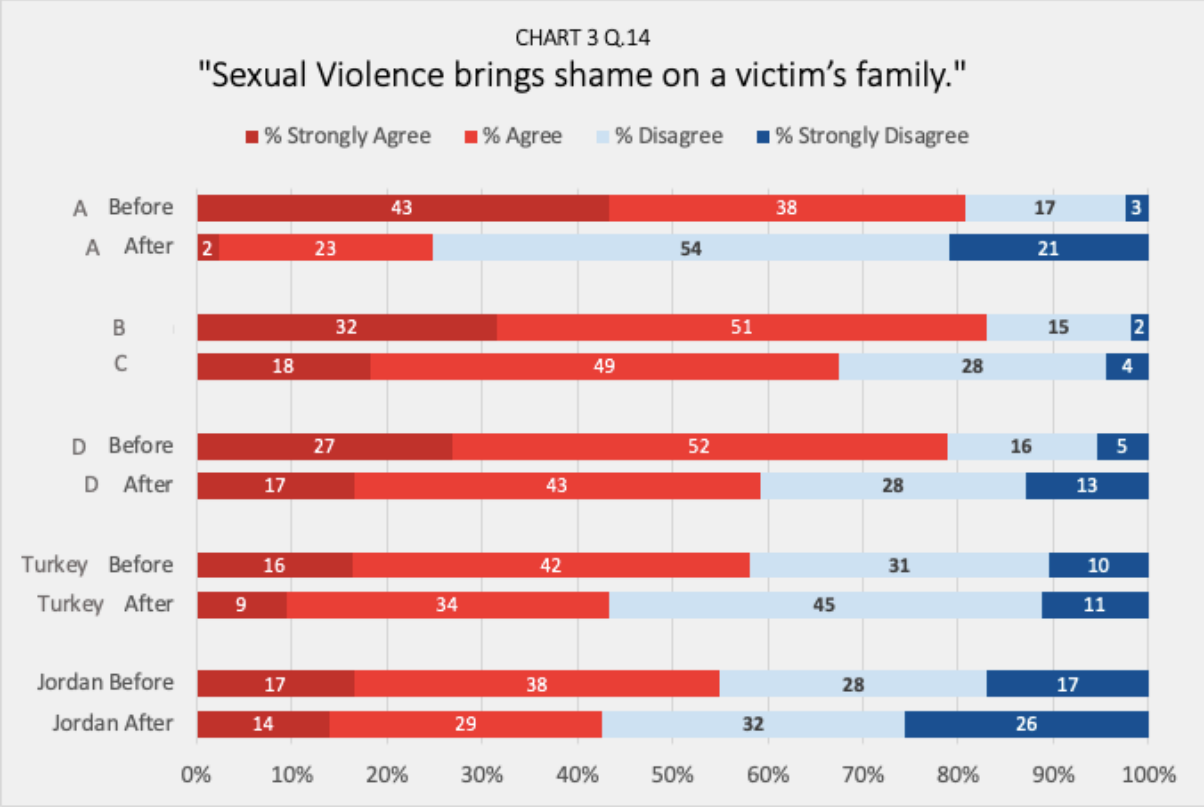


By the time of the follow-up surveys, decreases in stigma for this proposition were seen across all four LDHR communities: Community A reduced by 27.9%, Turkey by 10.1%, Jordan by 6.5%, and Community D by 7.9%. For the other questions relating to marriageability of survivors, most changes in attitude were within the margin of error (+/-5%). As an exception, in Community D, stigma levels showed an increase for "Survivors have the right to marry" (with 5.3% more survey participants disagreeing with this proposition).

Shame on the Family

As described above, the 'honour' or reputation of a family is often connected to its females' conformity with socially constructed values, including purity and chastity. A series of questions were asked in the survey about the impact of sexual violence on the victim's family and the extent of shame.[33]

[33] Q14 "Sexual Violence brings shame on a victim's family."; Q10 "It is better for a woman who has been raped to leave town and go somewhere where no one knows what happened to her."; Q19 "It is better for a family to pretend that their son or daughter has been killed in detention, than to have everyone know that they were victims of sexual violence."



Consistent with the high levels of stigma and shame of victims, equally or even higher levels of shame were found against the family of victims. Up to 83% of those surveyed in Community B agreed that sexual violence brings shame on a victim's family, 80.8% in Community A's baseline survey, and 78.8% in Community D's baseline survey. In the four communities where LDHR deployed stigma teams, there were significant reductions for this question between surveys. In Community A, 56% less agreement with the statement, in Community D 19.6% less, Turkey 14.9% less and Jordan 12.4% less.

After seven years of working with Syrian survivors, LDHR's experience suggested that survivors and their families moved away from their communities to escape the shame of sexual violence, choosing isolation or denial over community shame. Several survivors also reported that their family had pretended that they had died in detention (and asked them to leave) rather than face the shame. LDHR was determined to test these attitudes in the surveys so included statements in support of such attitudes: 1) "It is better for a woman who has been raped to leave town and go somewhere where no one knows what happened to her."; and 2) "It is better for a family to pretend that their son or daughter has been killed in detention, than to have everyone know that they were victims of sexual violence."

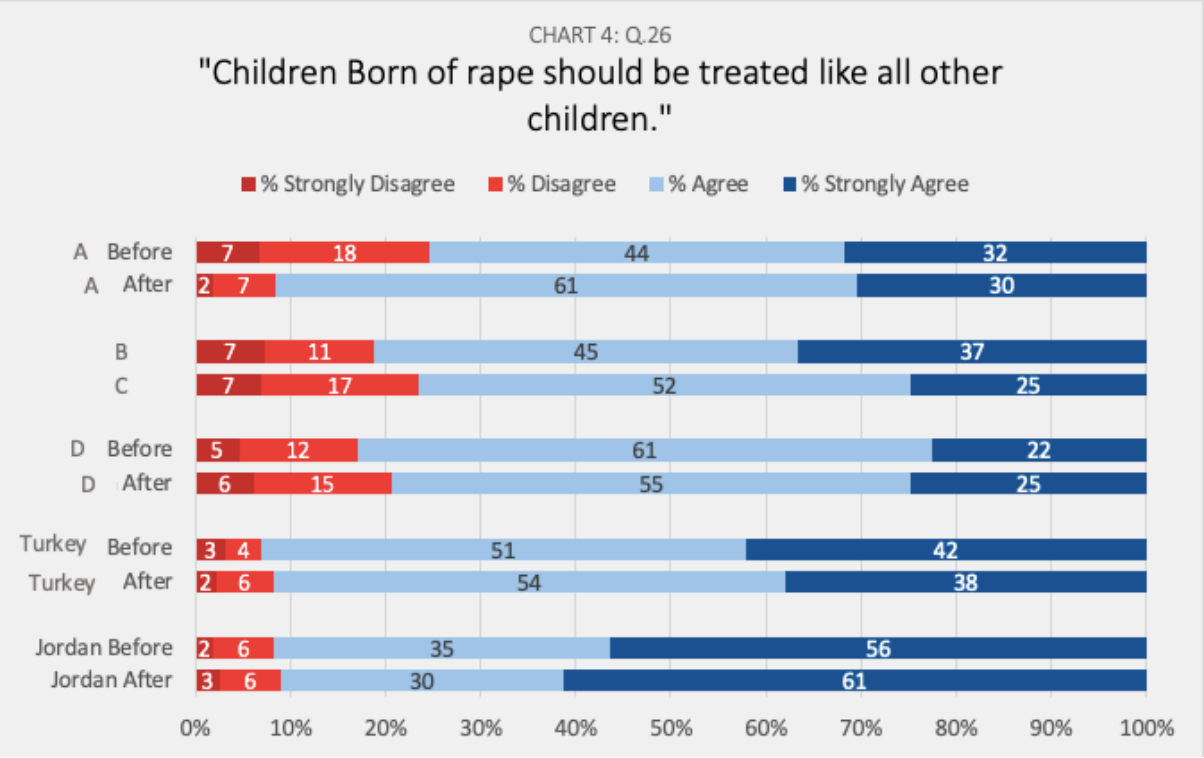
In some Syrian communities, support for such attitudes was moderately high reflecting the lived experience of survivors who had worked with LDHR: Community A (baseline) 61.2% (move away), 49.6% (pretend they had died); Community D (baseline) 55% (move away), 42.8% (pretend they had died). However, in Turkey and Jordan, attitudes were different and stigma was lower: Turkey (baseline) 33.1% (move away), 25.9% (pretend they had died), Jordan (baseline) 45.5% (move away) and 19.6% (pretend they had died).

Between the baseline and follow-up surveys, the trend showed decreased stigma (fewer people accepting these statements): Community A 38.1%, 38.4% reductions; Community D 12.6%, 13.3% reductions. There were smaller changes in Turkey and Jordan.[34]

The Impact on and Acceptance of Children Born of Rape

Under the Syrian Nationality Law, children derive their citizenship from their fathers. Where the father is unknown, the child risks being stateless. In north-eastern Syria, this issue has been acute and very public, as many children born in ISIS captivity have been abandoned, rejected by their mothers' communities and left in orphanages. The issue is less publicly acknowledged and does not appear to be as prevalent in north-western Syria or in the Syrian refugee communities in Turkey and Jordan.

Originally the survey included two questions about this issue. One question, whether a survivor should keep a child conceived through sexual violence, was deemed too sensitive and too provocative to ask by those conducting the survey. Interestingly, only one other original question was rejected on the same basis (about physiological sexual arousal during sexual violence). All other questions, many of which contain subjects which are sensitive and taboo, were asked without issue. The sensitivity of the question stems from that it combines two taboos: sexual violence and terminating a pregnancy something that is against religious beliefs and the law. Furthermore, cases of children born of rape in Syria are not disclosed or acknowledged, and the stigma of being a 'child of sin' remains with a child for life. Unmarried victims are often forced to marry the perpetrator to bring the child within a marriage. Where the perpetrator is not known or cannot be found, as is often the case for CRSV, the woman is sent away or hidden until birth, and then the child is left at an orphanage. This leaves a huge protection gap, where such children are unregistered, hidden and unacknowledged, and they are marked and impacted for life.



[34] Turkey showed an increase within the margin of error +/-5% (move away), and 7% decrease (pretend they had died); Jordan had a decrease within the margin of error+/-5% (move away), and 5% decrease (pretend they had died).

Contrary to the above understanding of community attitudes and practices in relation to children born from sexual violence, the survey results all indicate relatively low levels of stigma or negative attitudes towards them. Possible explanations for the surprising results may be that the question was framed as a non-stigmatised statement, and that it was stated using human rights language, rather than as a real-life scenario with personal implications for the survey participant. Based on this apparent contradiction, in future surveys, this could be triangulated with other questions using other approaches. These results could be further tested and further research could explore whether there is a difference between socially accepted and public expressions about this, and more hidden practices and private taboos. Other studies or work on children born outside marriage or as a result of rape in relation to Syrian communities could not be found, other than studies which consider children born as a result of sexual slavery of Yezidis taken from Iraq by ISIS.

The results also follow the usual pattern of higher stigmatised attitudes inside Syria and lower in refugee communities outside Syria, as described in the patterns section above.

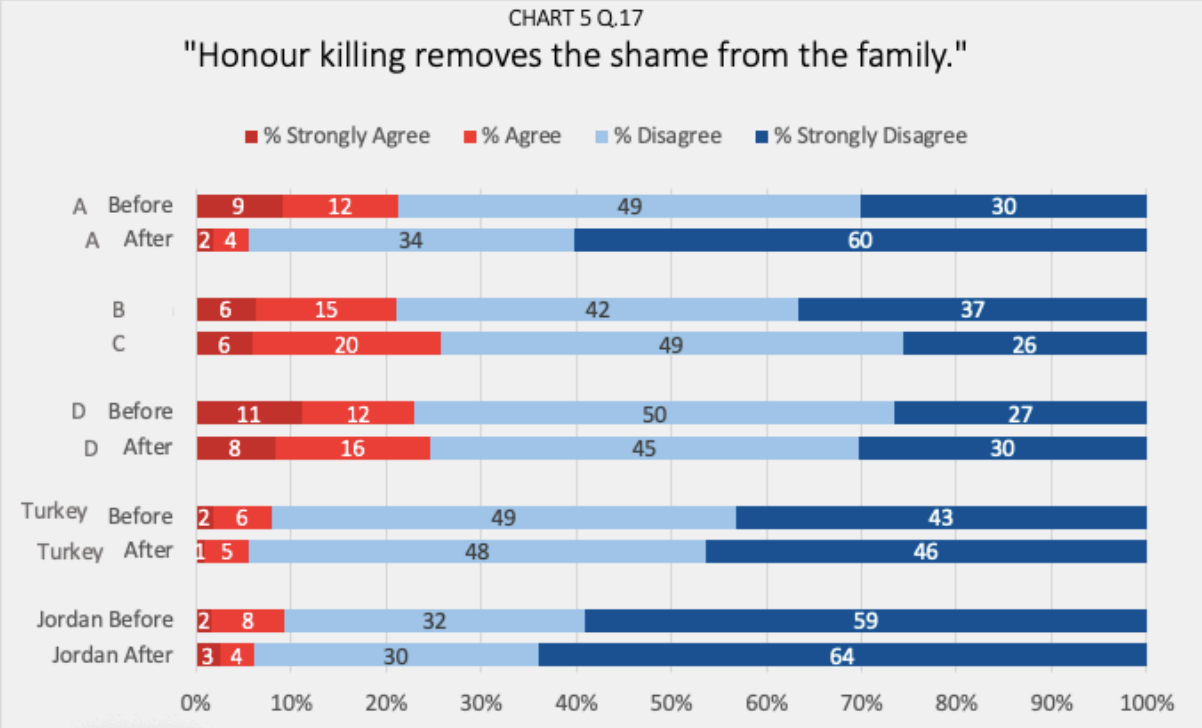
The stigma teams in Community A and Turkey chose to specifically tackle this issue during their work. However, only the Community A follow-up survey recorded a 16.24% drop in stigma levels. In the other three follow-up surveys (including in Turkey), there were small increases in stigma but all within the margin of error (+/-5%).

'Honour' killings against Sexual Violence Survivors

Throughout LDHR's work with survivors, the team became aware of a number of women facing violence from family members because of the 'shame' brought by the sexual violence on to her and her family. Acceptance of violence (and stigma) against women caught in an 'adulterous or illegitimate sexual act' or 'ambiguous situation' was embedded and institutionalised into the Syrian Penal Code (Article 548). This article provided for mitigation of sentence for men committing violence or homicide against their wives, sisters, mothers or daughters in such circumstances. In March 2020 this article was repealed; nevertheless, even though this is no longer institutionalised, structurally within some communities it might still be acceptable.

Before the conflict, it was reported that approximately every year 300 women and girls were the victims of 'honour' killings in Syria. Early in the conflict, a female LDHR lawyer noted a *perceived* drop in 'honour' killings and a relatively different attitude to survivors of sexual violence used as weapon of war from those subjected to sexual violence unrelated to the conflict. She believed this difference in attitude had come from the high prevalence of conflict-related sexual violence and that too many lives would be lost if this 'honour' system applied. This was anecdotal and her personal view.

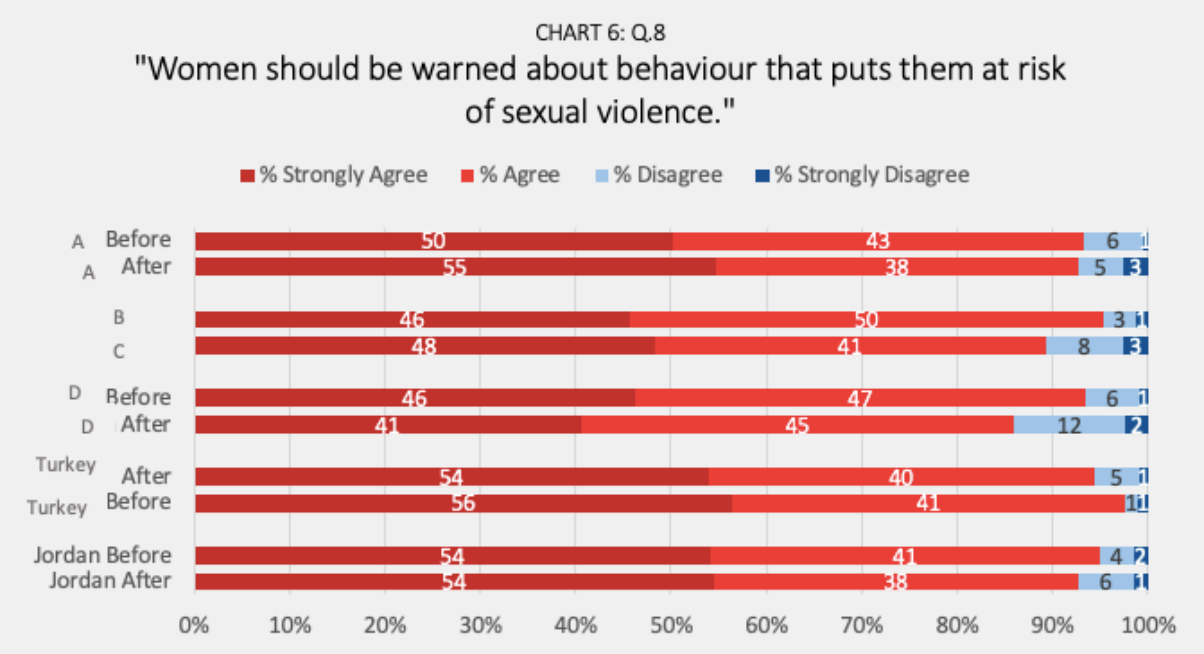
Yet since then LDHR has worked with female survivors who have been subjected to violence by their families, or who have been threatened or told of plans to kill them. They fled to safety in other countries. In 2017, The Day After (TDA) conducted surveys of 2,091 Syrians across six governorates in Syria which showed a small perceived prevalence, but support (62% of those surveyed) for the law which mitigates punishment for men if the woman was discovered to be in an 'illicit relationship'.



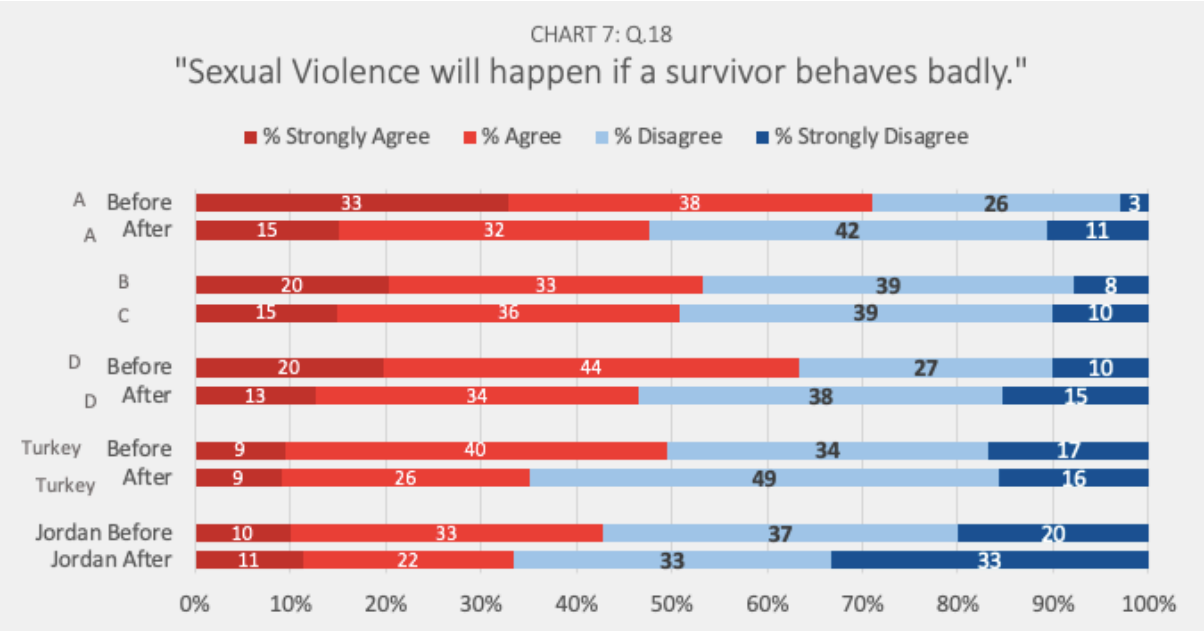
The surveys showed little acceptance that 'honour killing' would remove shame from the family, as shown in Chart 5 above. Again, we found a pattern of a significant reduction of stigma by the time of the follow-up survey in Community A (15.5% decrease in overall agreement with this stigmatised statement, and 30% more who strongly disagreed with it). Otherwise the changes in attitude were minor and well within the margin of error (+/-5%). Possible explanations for these results might be similar to those outlined above with regards to children born of rape, mainly a possible difference between socially accepted and public expressions about this issue. Again, further research or additional questions to triangulate this response in future surveys may help understand this result better.

II. *Blame*

The survey asked a series of questions to try to test the level of stigma and blame projected on to survivors as a result of sexual violence. A statement was posed: "Women should be warned about behaviour that puts them at risk of sexual violence." While this might, at first glance, seem like a reasonable measure seeking to protect women and girls, the actual implication is that a woman's behaviour affects whether or not she is subjected to sexual violence. This is a common and prevalent focus of sexual violence prevention and epitomises victim-blaming. The survey results produced the highest indications of this form of stigma in each community. Those in agreement with this statement ranged from **89.3% to 96%** of survey participants in baseline surveys. There was minimal improvement in this form of stigma after LDHR stigma work in the follow-up surveys.



A more direct proposition of victim-blaming: that sexual violence happens to women who behave badly also recorded high levels of stigma, although not at the same almost unanimous levels.

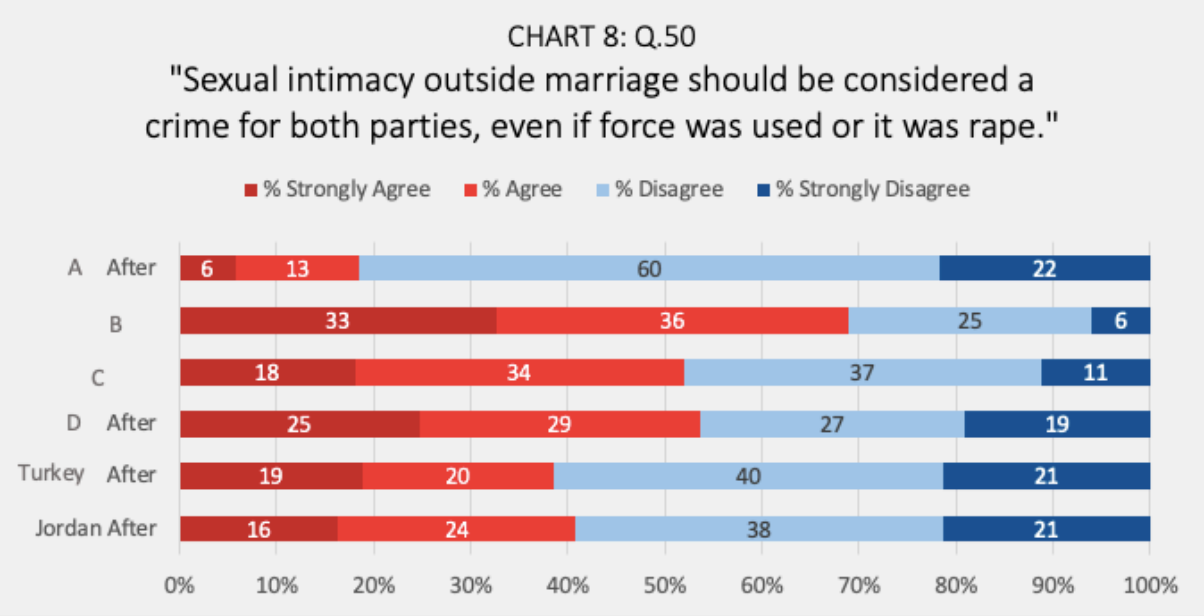


Survey participants tended to agree that “Women who do not cover are more likely to be victims of sexual violence” (ranging in baseline survey from 46.2%-59.8% inside Syria and 38.3%-45.3% outside Syria), and that “Women who go out of the house alone must take responsibility for what happens to them” (ranging from 54.4%-58.7% inside Syria and 40.8%-44.7% outside Syria).

Significant improvements in attitude (drops in levels of overall agreement) were seen in the follow-up surveys. For example, Community A reduced by 37.7% (outside home alone), 19.7% (uncovered), 23.3% (bad behaviour leads to sexual violence), and more modest improvements were recorded in other places. Turkey saw a 6.6% increase in blame for women leaving the house alone.

Blame for sexual acts outside of a marriage without victim's consent

Patriarchal gender norms fix very rigid values of purity and chastity on females. Traditional social expectations require virginity before marriage and fidelity within marriage, particularly from women. In a society where rape in marriage is not recognised in law, there is often a significant failure to recognise the absence of consent or to distinguish between a consenting participation and being subjected to sexual violence. Women who are subjected to sexual violence are still ascribed blame, regardless of the lack of their consent. Even in the law, there is no distinction between a female who was a willing participant and one who is a victim of sexual violence – prohibition of adultery, for example, does not distinguish between those who are victims or willing participants.

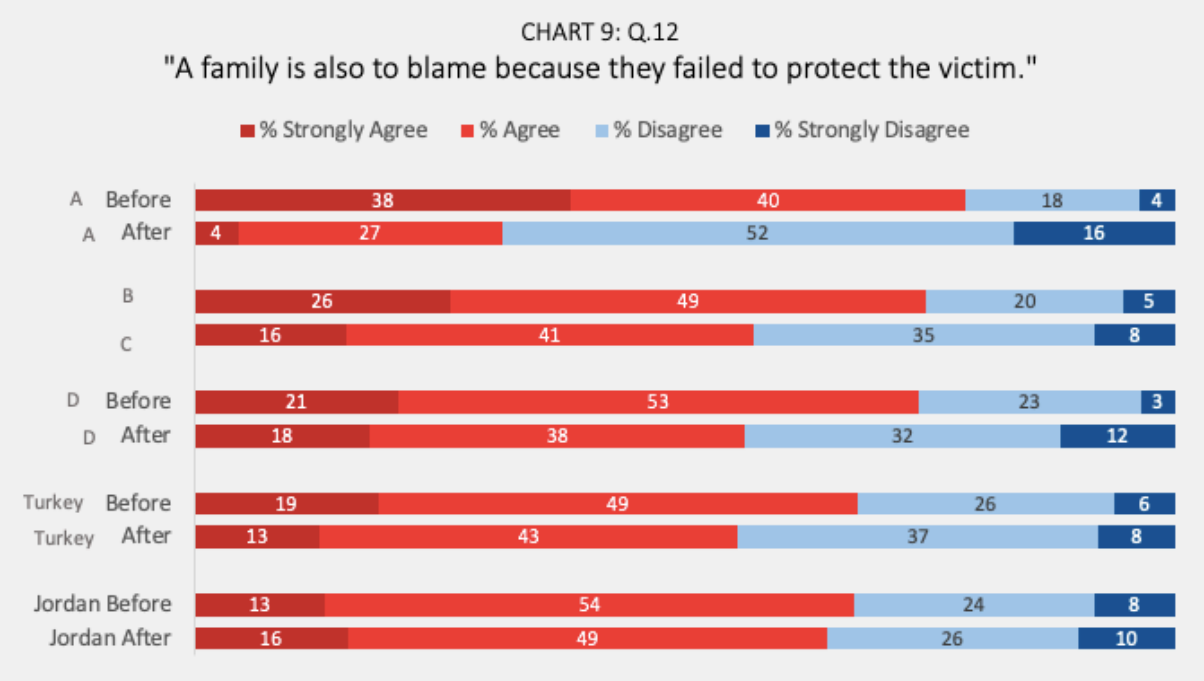


This question was only asked in the follow-up surveys for Community A, Community D, Turkey and Jordan, and in the baseline surveys for Community B and Community C. There is no comparison therefore and for the stigma action communities, work had already been done there. High levels of blame on survivors for sexual acts outside marriage even by force or as rape were recorded in Community B, Community C, Community D and among women in Turkey. Given that this is institutionalised in the law and deeply engrained in cultural values of chastity and fidelity, these high levels may not be surprising. However, the impact of this attitude and this law is significant. It can bar survivor disclosure for fear of blame and criminalisation. It indicates an area of important further work – to raise awareness and understanding of the clear distinction between sexual violence and consensual sexual intimacy.

Blame on Families and Husbands for Failure to Protect

The same gender norms which expect 'purity' of women, also place the duty of protection on husbands and other males in the family. They are expected to protect the family reputation and honour, therefore are required to protect the women, which often translates into also controlling them. In addition to victim-blaming, often husbands and families are blamed in their failure to prevent the sexual violence from happening.

The surveys revealed very high stigma levels for blaming families of survivors for their failure to protect within all communities.

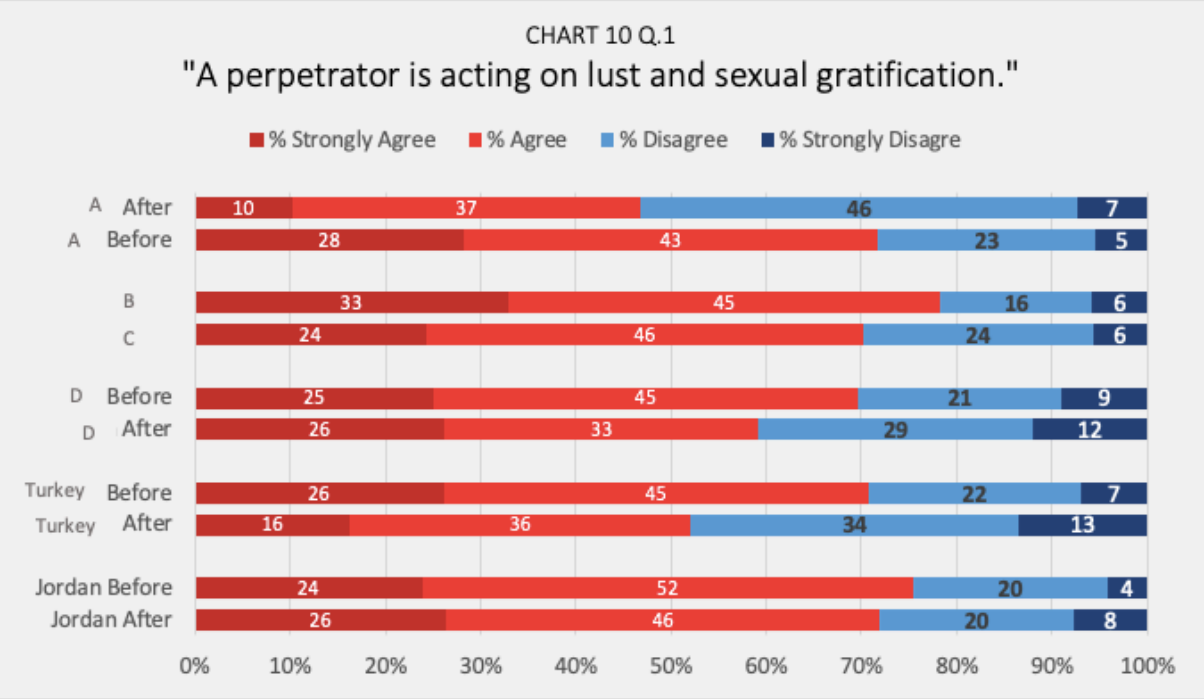


In LDHR's stigma action communities, some significant reductions in the stigma about blame against the family were recorded: Community A dropped 47.2%, Community D 17.7%, and Turkey 12.1%.

Stigma levels were similar for a proposition for a husband's guilt for the same failure-to-protect: in Community B there was 74.2% agreement with this stigmatised statement; Community D baseline 64.2% agreement; and Jordan had the lowest at 48.4% agreement.

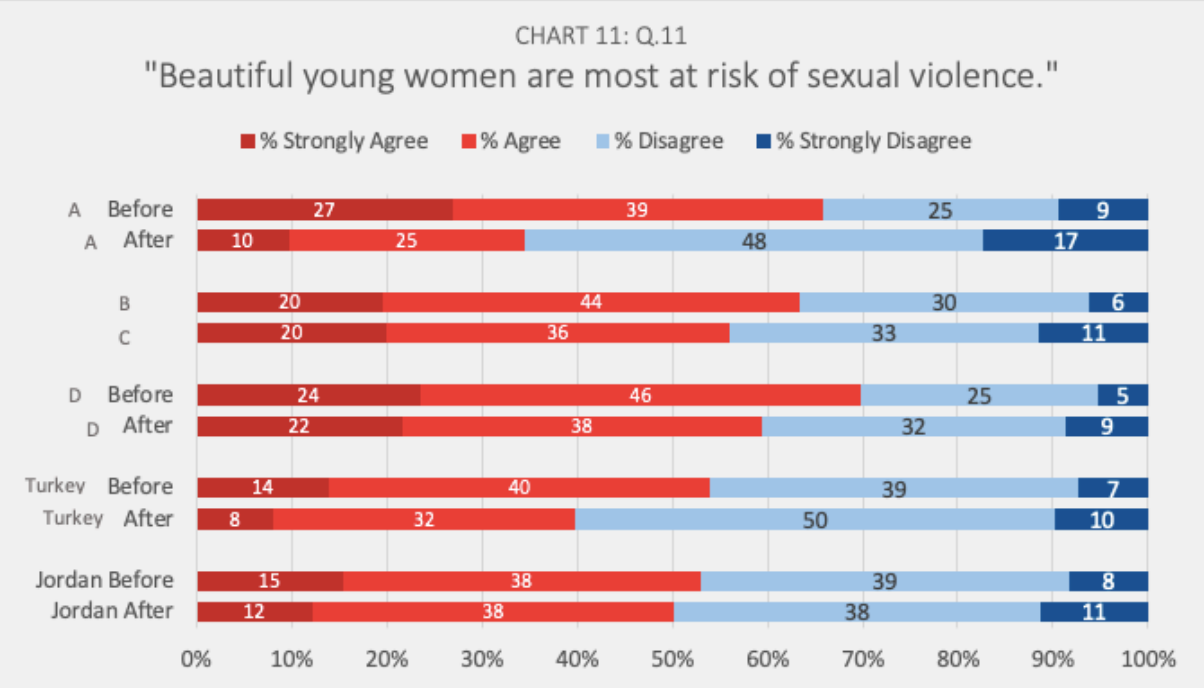
III. *Sexual Violence Myths and Misconceptions*

One common misconception is that sexual violence is predominantly about sex, rather than about violence. This is acutely so in societies where female consent is not required for all sexual acts - e.g. within a marriage. It then fails to recognise sexual violence as a weapon to dominate, subjugate and to break opposition. It also fails to acknowledge that men can also be the victims of sexual violence, often confusing homosexuality with sexual violence against men. It also usually means expecting or understanding sexual violence to be limited to rape, the act of sex, and by a man against a woman. As has been observed from the Syrian conflict's sexual violence typology, the forms and nature of systematic sexual violence go far beyond this form of sexual violence. Failing to recognise that, may lead to failing to get justice and support for many survivors.



High levels of stigma myths were found in the surveys across communities (see Chart 10 above). While reduction can be seen between baseline and follow-on surveys, the levels of stigma/misunderstanding remained above 50%. Only in Community A did the overall agreement rates drop below 50%.

Also connected to the same underlying myth, if sexual violence is about lust of men for women, then society expects that the victims are most likely to be beautiful young women. In reality, LDHR's work has shown that the survivors of sexual violence in the conflict have ranged from children to old men.[35]



[35] See http://ldhrights.org/en/?page_id=6032 for reports which detail sexual violence against children, and women and men of all ages.

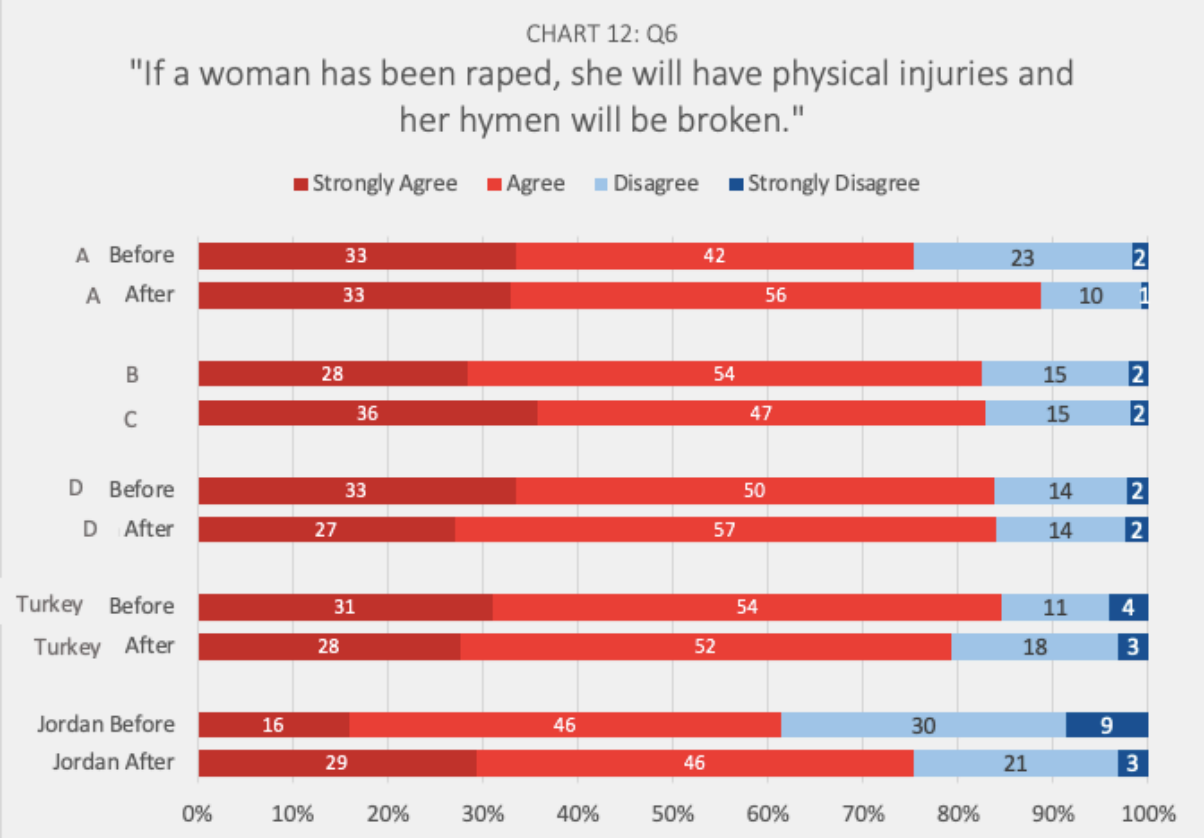
Despite countless men and boys subjected to sexual violence in detention centres and a recognition that sexual violence has been used as a weapon of war against opponents, these myths persist in Syrian communities. In all baseline surveys, more than 50% of those surveyed agreed with the proposition that beautiful young girls are most at risk of sexual violence. Only in Community A and Turkey in the follow-up surveys did these levels drop below 50%.

Another common misconception is that evidence of force and physical violence must always be present on a survivor. The expectation is that victims fight against their attacker, which results in failing to recognise fear, coercion and the myriad of other ways through which a person may be subjected to sexual violence with no discernible physical damage to his or her body. In addition, patriarchal gender norms, which value female chastity and virginity, have led to great cultural significance being placed on the 'integrity' of a female hymen in some societies. This is true for Syrian culture. There are still many families that seek 'virginity' tests, to reassure themselves and others of their daughter's virginity. The stigma associated with loss of virginity before marriage is considerable. This also explains why reconstructive hymen surgeries still happen in Syria.

Yet scientifically, this residual tissue offers no significance and no evidence as to a person's sexual activity or not. The World Health Organisation (WHO) has stated, "as shown in a systematic review on virginity testing, the examination has no scientific merit or clinical indication – the appearance of a hymen is not a reliable indication of intercourse and there is no known examination that can prove a history of vaginal intercourse. Furthermore, the practice is a violation of the victim's human rights and is associated with both immediate and long-term consequences that are detrimental to her physical, psychological and social well-being."[36] The Independent Forensic Expert Group (IFEG) declared "At puberty, the hymen is exposed to oestrogen, which alters its appearance, shape, and elasticity. Studies demonstrate that hymen configurations vary, and the hymen may exhibit changes prior to sexual intercourse. The belief that absence of the hymen confirms that there has been penetration of the vagina is incorrect; equally false is the notion that the presence of a 'normal' or 'intact' hymen means that penetration has not occurred. [...] It is our opinion that forcibly conducted virginity examinations have no clinical or scientific value and constitute cruel, inhuman and degrading treatment, and may amount to torture depending on the individual circumstances."[37]

[36] World Health Organization, 'Eliminating Virginity Testing: An Interagency Statement', *World Health Organization*, 2018, https://apps.who.int/iris/bitstream/handle/10665/275451/WHO-RHR-18.15-eng.pdf?ua=1.

[37] Independent Forensic Expert Group, 'Statement on Virginity Testing', *International Rehabilitation Council for Torture Victims*, 2015, https://irct.org/uploads/media/1d6e1087759460fd9e473273a85c7e95.pdf.



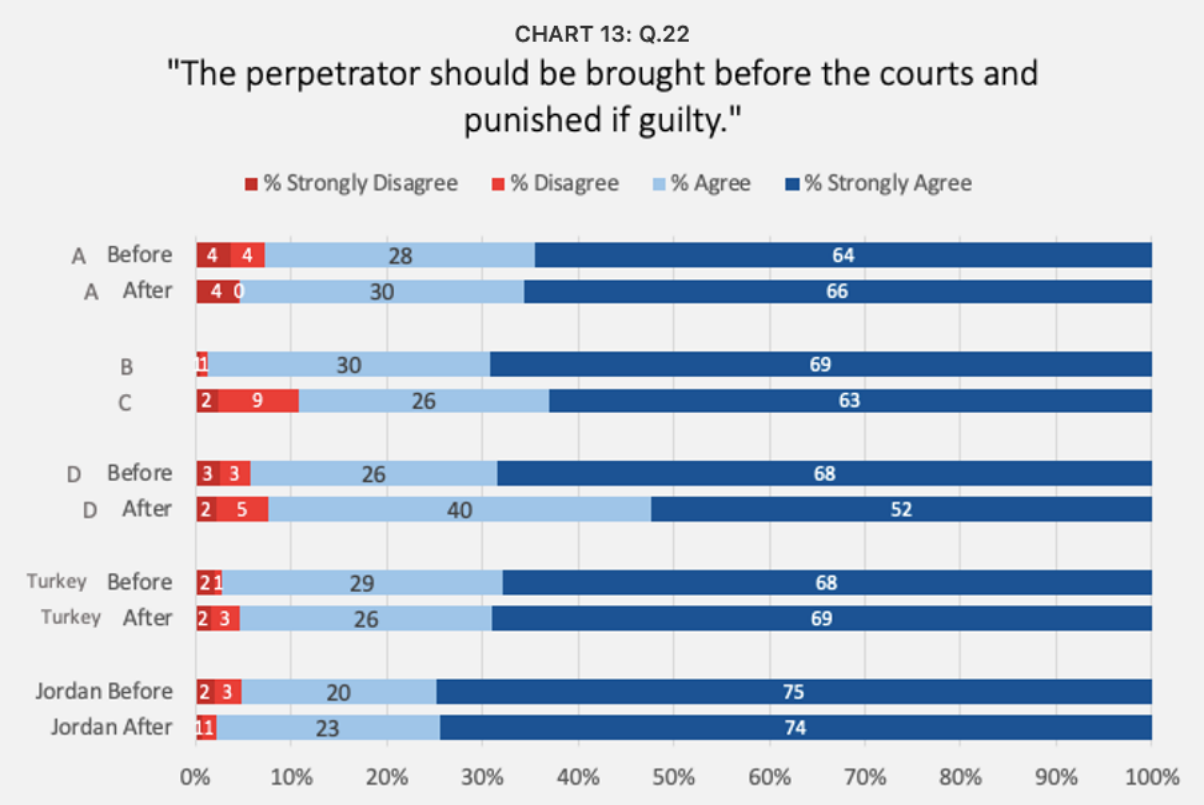
The survey communities showed very high levels of stigma-myths regarding expectations of physical injuries and a broken hymen. The results were also striking given the increased stigma on this topic shown in two of the LDHR Stigma Action communities, including Community A where otherwise stigma reductions were recorded. Such deeply-set cultural beliefs are hard to change in short periods of time, and hard to discuss or challenge early in such work. The importance of changing these beliefs cannot be understated. As described above, subjecting girls and women to 'virginity' tests can be harmful psychologically and physically. Without genuine voluntary consent, a 'virginity test' may be sexual violence in itself, as stated by the WHO and IFEG (above). LDHR are aware of virginity tests on young female former detainees, and a demand for medically unnecessary reconstructive hymen surgery to restore the perception of 'virginity' and to avoid the shame and blame of its absence.

IV. *Attitudes towards Perpetrators*

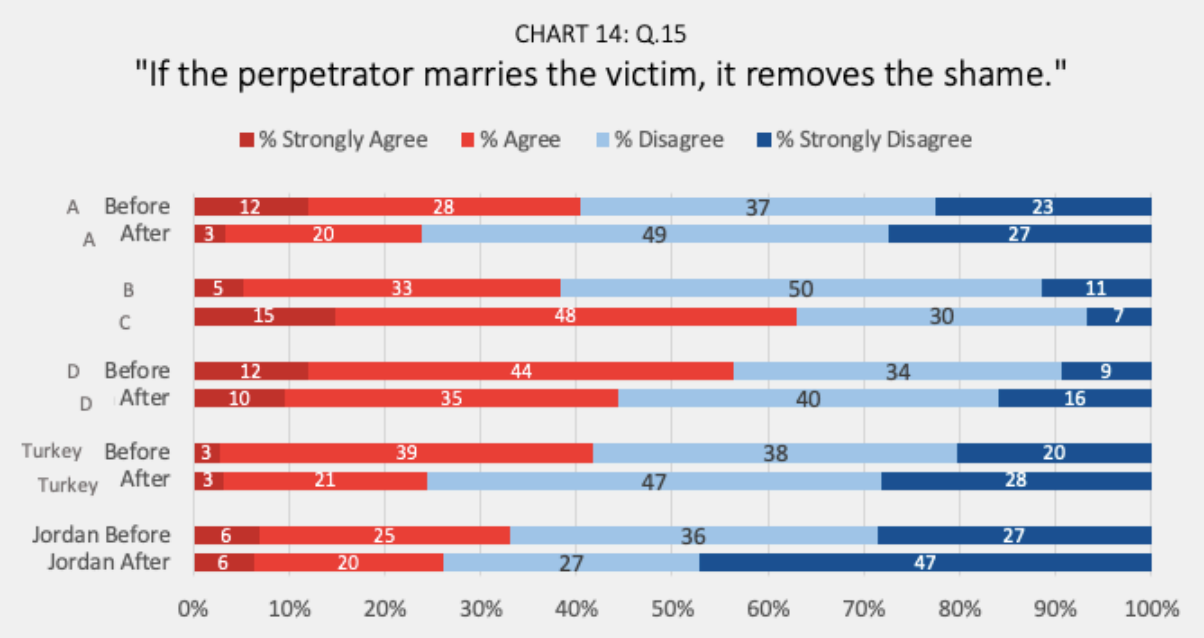
Attitudes towards perpetrators are extremely important both for support and demand for justice, but should also be important in shifting blame and shame to the perpetrator and to deter conduct. It can also be useful to move the focus of protective/preventative measures to reducing risks of the perpetration by the perpetrator. In this sense, stigma against perpetrators of sexual violence can be viewed as a constructive societal attitude, however it is only positive if limited to placing blame on those responsible.

Out of all of the questions/themes, the surveys revealed the most positive attitudes surrounding support for criminal justice accountability against perpetrators of sexual violence.[38]

[38] Q15 "If the perpetrator marries the victim, it removes the shame". Q24 "Only the perpetrator is to blame". Q21 "The perpetrator is the only one who should feel shame".



The Syria Penal Code provides for commutation of sentence if a perpetrator marries the victim (Art. 508). This appears tied to cultural gender norms, institutionalised into law, that permit rape or other sexual violence within marriage and cultural beliefs that sexual acts outside of marriage are forbidden and shameful. In addition, as noted above, any child born of sexual violence would then be brought within that marriage and be registered with and derive citizenship and status under the father's name. This provision represents institutionalising the removal and reduction of blame and shame from (most often) male perpetrators.



Despite this attitude being institutionalised in law, the surveys across most of the communities show low to moderate levels of acceptance of this (reflecting low to moderate levels of stigma). Only in Community C and Community D baseline surveys were acceptance levels over 50% - Community C 63% and Community D 56.5%, showing higher stigma levels.

As explained above, if societal attitudes only blame or shame the perpetrator (rather than the victims or others), this can be regarded as a constructive attitude which helps prevent the crime and ensure punishment of those responsible. The survey results were positive in this respect. In response to the statements 'Only the perpetrator should feel shame' and 'Only the perpetrator should be blamed', there were low levels of disagreement, where disagreement would indicate harmful attitudes and stigmas extending beyond the perpetrator. In Community A baseline survey, harmful stigma levels (disagreement with those statements) were at 33.7% (shame) and 36.5% (blame). In Community B, it was 31.9% (shame) and 32.9% (blame); Community C 29.6% (shame), 37.8% (blame); Community D (baseline survey) 5.6% (shame), 28.7% (blame); Turkey (baseline survey) 9.4% (shame), 15.7% (blame); Jordan (follow-up survey) 14.9% (shame), (baseline survey) 23.9% (blame).[39] This does contrast with the high levels of stigma initially recorded for victim and family blaming and shaming.

V. *Recognition and Attitudes Towards Male Sexual Violence Survivors*

As described above, traditional rigid gender binary understandings of sexual violence see women as the victim and men as somehow impenetrable. "Men rape, but don't get raped". "A real man would not get raped".[40] Just as sexual violence is often misunderstood as being limited to sex, there is also a common mistaken conflation and misconception of male sexual violence as homosexuality, around which there is complex, deeply ingrained taboo and stigma in Syria. As a result, discussion of male sexual violence in Syria remains taboo, though there has been more discussion thereof during the conflict.

The Syrian conflict has been marked by a high prevalence of sexual violence against men and boys, particularly in relation to sexualised torture and violence in detention centres against males. Since 2012, LDHR medical experts have documented hundreds of cases of male sexual violence in Syrian detention.[41] There has also been public discussion of this crime in both English and Arabic media,[42] and a criminal trial ongoing in 2020 based on universal jurisdiction in Germany includes charges relating to sexual violence against Syrian men.[43] Given the prevalence and public acknowledgement of such crimes, it is expected that Syrian communities are now more aware of sexual violence against men.

In the two baseline and four follow-up surveys conducted in 2020, LDHR added several questions specifically about stigma in relation to male sexual violence. LDHR has been trying to tackle and reduce barriers for male survivors to receive support, access justice and find paths towards recovery.

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[39] Through error, 'Only the perpetrator should feel shame' was not asked in the baseline survey in Jordan.

[40] See: I Elliott, C Kivlahan & Y Rahhal, 'Bridging the Gap: Between the Reality of Male Sexual Violence and Access to Justice and Accountability', *Journal of International Criminal Justice*, 18(2), 469-498, 2020; Michelle Lowe and Paul Rogers, 'The Scope of Male Rape: A Selective Review of Research, Policy and Practice', *Aggression and Violent Behaviour 35*, June 2017; Sue Lees, *Ruling Passions. Sexual Violence, Reputation and the Law*, Open University Press, Buckingham, 1997; and A Javaid, 'Male Rape in Law and the Courtroom', *Web Journal of Current Legal Issues*, 20(2), 2014.

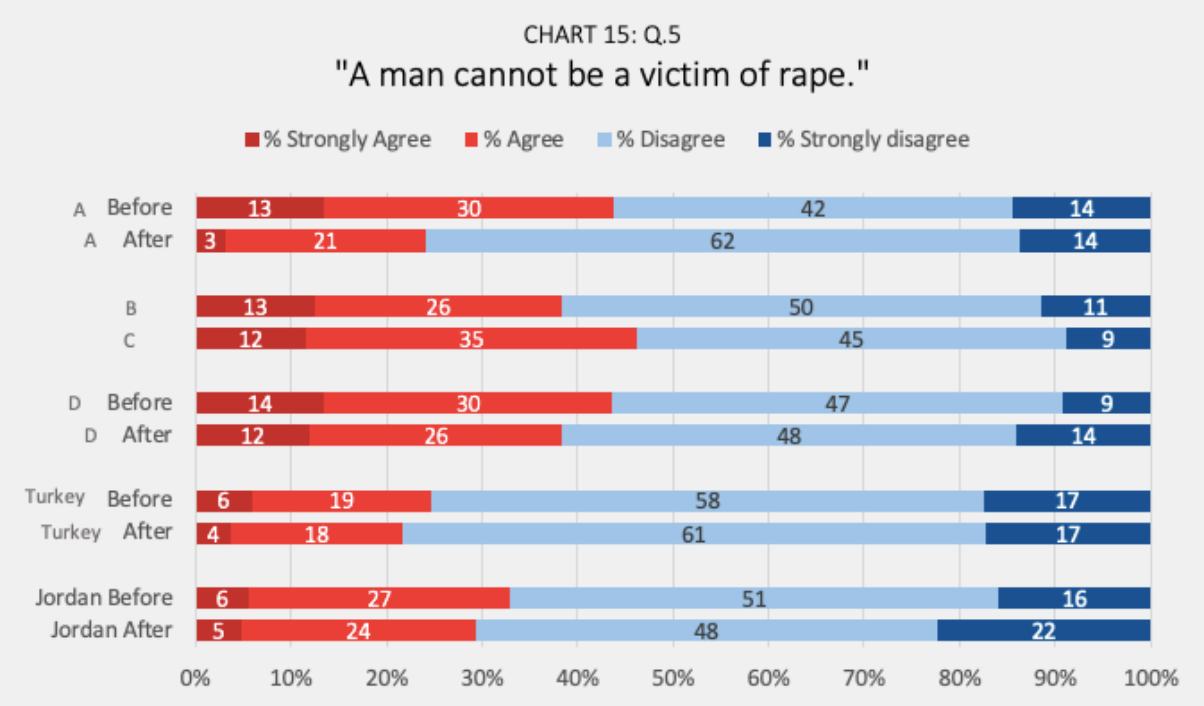
[41] Lawyers and Doctors for Human Rights, 'The Soul Has Died', *Lawyers and Doctors for Human Rights*, 2019, http://ldhrights.org/en/wp-content/uploads/2019/03/The-Soul-Has-Died-Male-Sexual-Violence-Report-English-for-release-copy.pdf.

[42] Louisa Loveluck, 'Syrian forces use widespread sexual violence to humiliate and silence male prisoners, new report says', *The Washington Post*, 2019, https://www.washingtonpost.com/world/syrian-forces-use-widespread-sexual-violence-to-humiliate-and-silence-male-prisoners-new-report-says/2019/03/11/2e1f5b12-43e4-11e9-9726-50f151ab44b9_story.html

[43] Ben Hubbard, 'Germany Takes Rare Step in Putting Syrian Officers on Trial in Torture Cases', *The New York Times*, 2020, https://www.nytimes.com/2020/04/23/world/middleeast/syria-germany-war-crimes-trial.html

Understanding Syrian attitudes and stigma towards this group of survivors is important given its prevalence and given the gender norms which act against help-seeking for men.[44]

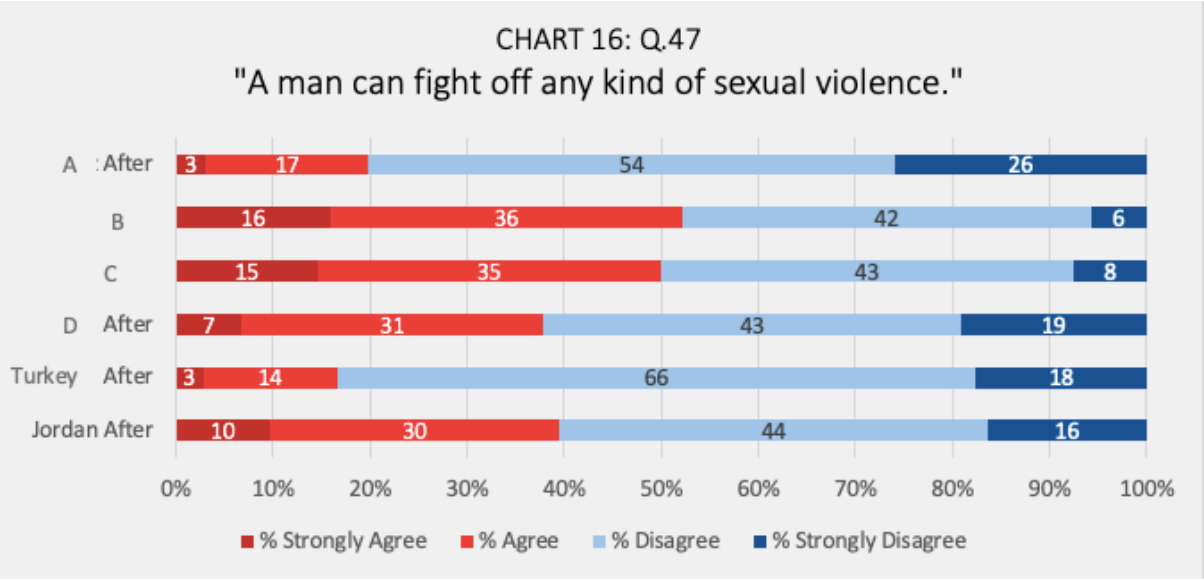
The survey results support an awareness of male sexual violence. All communities show only low to moderate agreement (indicating low stigma) with the statement that "a man cannot be a victim of rape" (see chart 15 below). The lowest acceptance rates were in Turkey, where many Syrians have fled the conflict. In the Turkey baseline survey, only 24.7% agreed, dropping to 21.6% by the follow-up survey. Community C showed the highest stigma-myth levels, with 46.2% agreeing with the statement.



By the follow-up survey, Community A recorded a 19.8% decrease in overall agreement. The decreases were less significant in Community D (5.3% decrease), and the other communities showing decreases within the +/-5% margin of error.

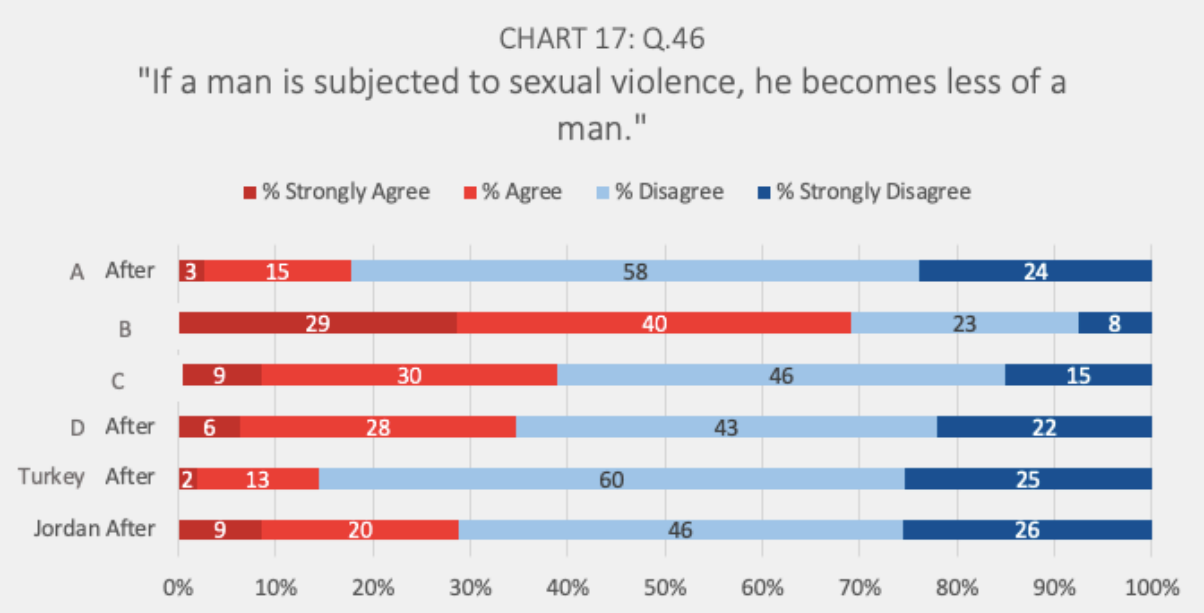
Equally there were only moderate levels of stigma associated with the proposition that men should be able to fight off any sexual violence (see Chart 16 below), higher levels of stigma/agreement occurring more in the men surveyed (except in Jordan and Turkey). The highest levels of agreement/stigma scores were found in the baseline surveys for Community B and Community C, where LDHR stigma community action has not started yet. It should be noted that LDHR initially deemed questions relating to stigma associated with male sexual violence to be too sensitive. However, LDHR added more questions relating to the subject for the follow-up surveys in Communities A, D, Turkey, and Jordan, and the baseline surveys for Communities B and C, after LDHR had done more work on male sexual violence. Thus, charts 16-19 only reflect stigma in Communities A, D, Turkey, and Jordan after LDHR teams had done work in those communities.

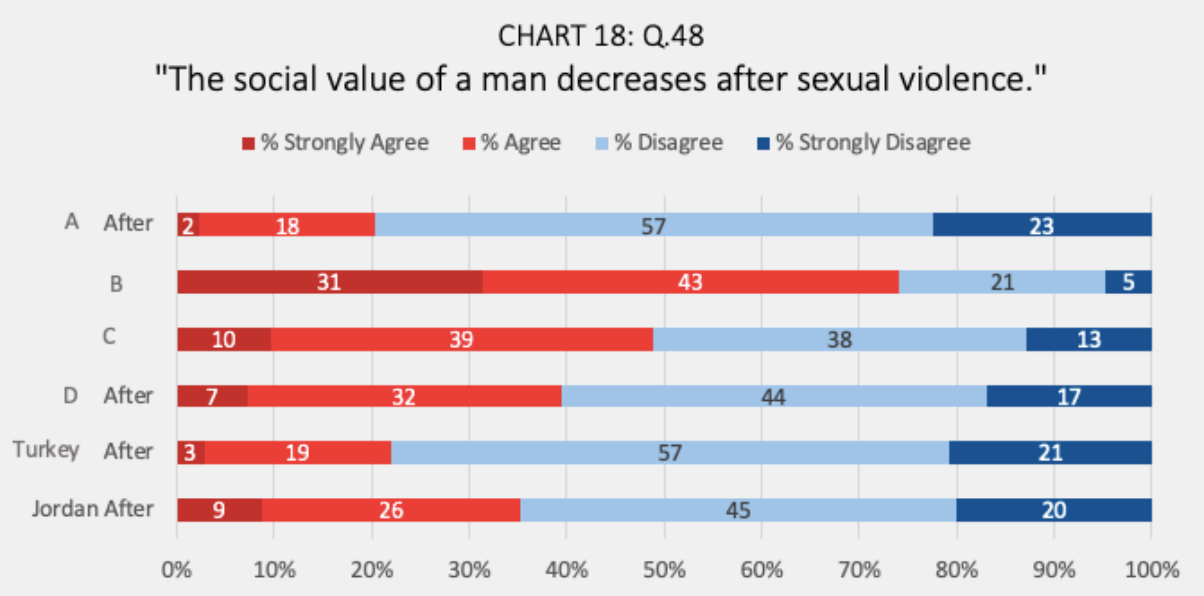
[44] See: Kirmayer et al, *Culture,* 'Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support Staff Working with Syrians Affected by Armed Conflict', *UNHCR*, Geneva, 2015, pp. 34-35.

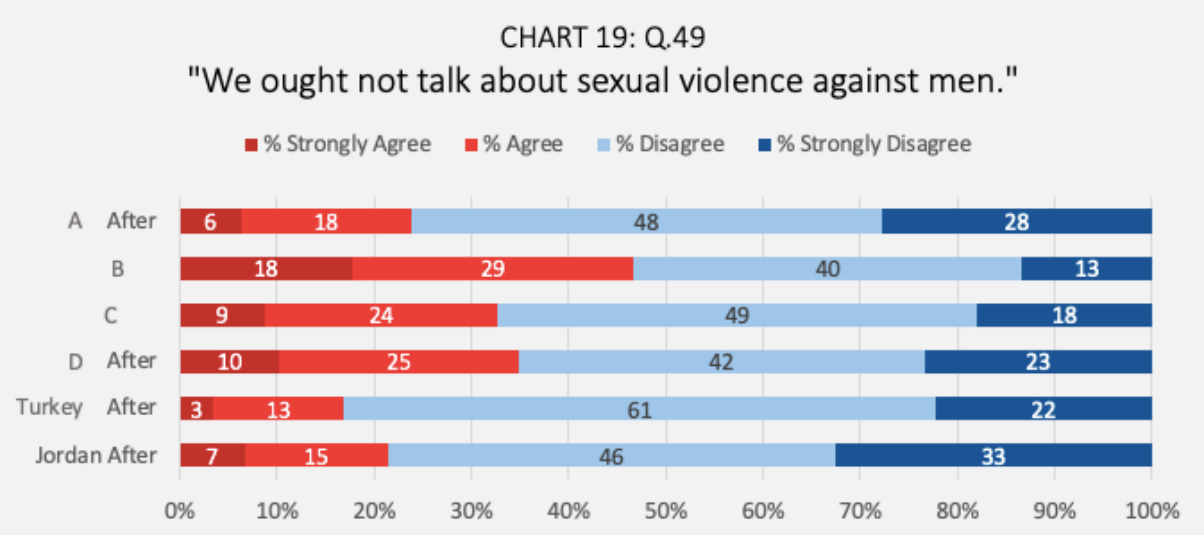


Higher levels of stigma regarding male sexual violence were found among women in the communities inside Syria, but higher levels among men in the communities outside Syria. The highest levels were found in the two baseline communities where LDHR has not started its Stigma Action work yet (Community B and Community C).

This pattern of stigma was mirrored almost exactly for the other three questions posed about this issue in the survey, as reflected in the charts below.







Using these results, LDHR hopes to do more work in communities to tackle the stigma against male sexual violence survivors, and to ensure that work also targets the attitude and awareness of Syrian men in those communities. To date, much of LDHR's stigma work has been aimed at gendered stigma against women, and as a result many of the stigma actors and beneficiaries who have worked together to reduce stigma levels have been women. With the estimated levels of Syrian male sexual violence, based on work in opposition-held areas or communities across borders (the areas to which LDHR has easy access), it is important to ensure audiences include men and discussions extend to male sexual violence and the well-being of its survivors.

What changes were observed?

Significant drops in stigma levels were seen for many of the stigmatised statements and topics. In particular, very significant changes were recorded in Community A – with decreases as large as 56.1% (victim shame), 55.9% (family shame), 47.2% (family blame).

In general, more universally-held opinions are usually more culturally ingrained and reinforced, and are less likely to be changed over short periods of time. The baseline level of overall agreement did not necessary predict the extent of the change but where overall agreement was near universal in the

baseline survey (above 90%), generally there was no significant change. For example, in Community D, for Question 8, there was 93.4% baseline overall agreement with 7.5% reduction in overall agreement/stigma level at follow-up, for Question 22 there was 94.3% baseline overall agreement with 1.94% reduction in agreement/stigma level at follow-up, and for Question 6 there was 83.7% baseline overall agreement with 0.2% increase in agreement/stigma level at follow-up; and in Community A, for Question 6 there was 75% baseline overall agreement with 13.4% increase at follow-up, for Question 8 there was 93.3% baseline overall agreement with 0.6% reduction at follow-up, and for Question 22 there was 92.7% baseline agreement with 2.6% increase at follow-up.

A baseline level of strong agreement with statements was not always a direct predictor of resistance to change. Some of the victim and family shame and blame statements with significant drops had high agreement (stigma) baseline levels. For example, victim and family shame in Community D had some of the highest rates of strong agreement in the baseline survey (both 26.9%) but also the highest rate of decrease of 21% and 19.6%, respectively, at follow-up. The same was the case in Community A: 41%, 43.3% strong agreement (victim shame, family shame), with decreases of 56.1% and 55.9%, respectively, at follow-up. While in Community D, the highest rates of strong agreement, 68.4% did also have the highest increase of 1.9% stigmatisation ("A perpetrator should be brought before the court and if found guilty should be punished".) In Community A, the same question also had the highest strong agreement level of 64.4% but only a 2.6% decrease at follow-up. Other questions had lower change (e.g. -0.6% and 13.4% increase).

Looking more qualitatively at the nature or topic of the question, the ones which appear resistant to change included some of the myths and misconceptions which appear to inter-connect deeply-held religious or cultural beliefs and long-standing gender norms, such as the significance of the hymen as a symbol of virginity and purity. Noting that in Community A, this was one of few statements which saw increased stigma and not a reduction (+13.4% overall agreement (reflecting increased stigma)). In Jordan, the follow-up survey recorded an increase of 13.9% overall agreement (again reflecting increased stigma), with an additional 13.4% strongly agreeing with the statement. This was despite Jordan's survey group being the most highly educated with stigma levels otherwise relatively low. The other was the long-held belief and assumption that protection of women can be achieved through warning them of risks aimed at changing their behaviour and limiting their exposure.

It should be noted that changing in stigmatised attitude were achieved for more direct victim blaming - that 'bad behaviour', being uncovered and being outside the home alone could lead to sexual violence.

Additionally, some of the statements reflecting the lowest levels of stigma were also resistant to too much change. This is particularly the case with the almost universally supported proposition supporting perpetrator criminal accountability. With only small percentage gains to be achieved in these areas, it may be that marginal changes got lost within the surveys' margins of error (+/- 5%).

Demographic Change

There were some changes to the demographics in surveyed groups. How might that influence the expected follow-up survey stigma levels? Based on the levels of stigma among certain demographics in the baseline surveys in each community, the changes in the demographics were expected to result in changes in the stigma levels as outlined below. However, as shown from the results above, the changes were not always as expected, particularly when it was expected to increase, but instead decreased, which can be an indication of the effect of the work done by the teams in those communities. For example, baseline surveys showed that lower levels of education had a strong correlation with higher stigma, thus in Community A the stigma levels were expected to rise due to a reduced level of education. However, the follow-up survey in Community A showed a lower overall stigma level.

Community A: ↑ (expected increase in stigma levels)

- All women: women and men show similar levels of stigma in the baseline.
- 2.5% more widows, 4% more divorced, 5% more single, less married: overall suggests a rise in stigma ↑
- Already low levels of education reduced further: suggests a rise in stigma levels ↑

Community D: ↑ (expected increase in stigma levels)

- Small increase in the number of women: women showed less stigma relative to men in the baseline survey, but they showed more stigma relative to men by the time of the follow-up. Suggests stigma levels might rise a little ↑
- 15% less were married, 7% more widowed, 4.5% more divorced, 4% more single: widowed and divorced groups showed higher levels of stigma. Suggests stigma levels might rise ↑
- Slightly lower education levels: would suggest stigma levels to go up ↑

Turkey: ↑ (expected increase in stigma levels)

- 5% less women: women were a little more stigmatised in baseline: suggests stigma levels would drop ↓
- 20% more widowed, 4% more divorced, 7% less married, 16% less single: suggests a rise in stigma levels ↑
- Lower educational level: suggests a rise in stigma levels ↑

Jordan: ↓ (expected decrease in stigma levels)

- Fewer women (more stigma shown in baseline): suggests stigma levels would drop ↓
- 13% more single, 10% less married, 4% less widowed, 1% more divorced – single less stigmatised in baseline: suggests stigma levels would drop ↓
- Higher educational level: suggests stigma levels would drop ↓

In summary, for most of the survey groups, the expectation based on demographics would suggest increasing levels of stigma, not decreasing. ↑

Conflict and rising conservatism (between October 2018 and February 2020)

There have been further waves of internal displacement in northern Syria, with more military operations and changing frontlines, more targeting of medical facilities, schools and civilians. Conflict and crises are associated with deepening conservative social norms. So then, we would expect to see an increasing social stigma around sexual violence. ↑ (expected increase in stigma levels)

Other changes

There have been some changes to Syrian laws which institutionalise stigma, but these are not likely to be seen as legitimate in the communities under study or expected to change norms, considering they were passed by the Syrian government and these communities are not under its control and are largely "opposition" to the government, where Syrian law is not fully enforced and the applicable laws vary depending on the local governance body and/or factions in the area.

The prevalence and pervasiveness of sexual violence, and the fear of it,[45] has impacted large swathes of communities that oppose the Syrian government and supported the uprising. This has meant more people subjected to stigma and potentially bringing the discussion of it more into the public in communities. ↓ (expected decrease in stigma levels)

[45] See: World Vision, 'Northwest Syria Gender Analysis: A Comprehensive Gender and Age Analysis for the Northwest Syria Humanitarian Response', *World Vision*, 2020 (noting the daily fear of sexual violence was pervasive for the women surveyed and interviewed).

Presence and work of humanitarian, human rights organisations and media activists

In all six communities, there are displaced populations and humanitarian crises, with which came more humanitarian workers and service providers, media activists and others who may well be talking about and raising awareness about sexual violence and other forms of GBV. There has been considerable coverage of Syrian detention centre sexual violence in Arabic media, including coverage of reports on male sexual violence. To LDHR's knowledge there is only one other group active in north-western Syria that has recently started working on stigma. ↓ (expected decrease in stigma levels)

LDHR's work

In combination with those other factors and influences, LDHR Stigma Action Teams worked in four pilot communities to reach 3,891 community members (92% women and girls: 8% men and boys). The most intensive work was done by the Community A LDHR Mobile Stigma team, which worked for 10 months and reached at least 2,233 people (93% women). The Community A survey population was the least educated, and all were camp-based IDPs. The demographic and conflict dynamics would also likely increase levels of stigma. Yet the changes in Community A were the highest across all four communities, with some very striking results achieved for victim shaming and blaming, and family shaming and blaming. It is hard to explain such changes without the presence of LDHR's mobile team outreach and numerous activities. It is likely that some of these significant changes were assisted by the LDHR Stigma Action Team, thus it is a potential model for tackling sexual violence stigma which should be repeated, then scaled and supplemented. It should be noted that the follow-up surveys were not conducted with the same participants of the baseline surveys.

Annex D – Full Set of Survey Questions

Stigmatised Statements

Q1. A perpetrator of sexual violence is acting on lust and sexual gratification.
Q2. If a woman leaves the house alone, she must take responsibility if bad things happen to her.
Q3. Women who do not cover their hair are more likely to be victims of sexual violence.
Q4. Rape is shameful for both parties, the rapist and the victim.
Q5. A man cannot be a victim of rape.
Q6. If a woman has been raped, she will have physical injuries and her hymen will be broken.
[Q7. Women lie about being subjected to sexual violence.] *NOT ASKED/MISUNDERSTOOD.*
Q8. It is important to warn women about behaviour that can put them at risk.
Q9. A woman who has been raped will not get married.
Q10. It is better for a woman who has been raped to leave town with her family, to go somewhere where no one knows her or what has happened.
Q11. Beautiful young women are most at risk of sexual violence.
Q12. The family of a victim are to blame because they failed to protect their daughter, sister or wife.
Q13. Sexual violence brings dishonour and shame to women.
Q14. Sexual violence brings shame to a victim's family.
Q15. If a perpetrator marries the victim, this removes the shame on her and on her family.
Q16. If a woman has been raped, her husband has the right to divorce her.
Q17. 'Honour' killings remove the shame of sexual violence from a family.
Q18. Sexual violence will happen if a woman behaves badly.
Q19. It is better for a family to pretend their daughter or son has been killed in detention, rather than have everyone know they were victims of sexual violence.
Q20. A husband should feel guilty if his wife has been raped because he could not protect her.

Non-stigmatising statements

Q21. A perpetrator is the only one who should feel shame because of what has happened.
Q22. A perpetrator should be brought before the courts and if found guilty, he should be punished.
Q23. Survivors of sexual violence have the right to marry.
Q24. Only the perpetrator is to blame when sexual violence has happened.
[Q25. Women should keep children conceived in rape.] *NOT ASKED – TOO SENSITIVE*
Q26. Children born of rape should be treated like every other child.
Q27. If my brother or son wanted to marry a woman who had survived rape, I would approve.

With victims of sexual violence, I feel:
Q28 Sympathy (non-stigmatising)
Q29 Embarrassment (stigmatising)
Q30 Discomfort (stigmatising)
Q31 Mercy and empathy (non-stigmatising)
Q32 Support (non-stigmatising)
Q33 Understanding (non-stigmatising)]

Additional Male Sexual Violence questions added in 2019/2020

Q46. If a man was subject to sexual violence, this will decrease his manliness.
Q47. A man is always capable of fighting off any type of sexual violence.
Q48. A man's social value decreases after being subjected to sexual violence.
Q49. We ought not to talk about sexual violence on men.

Q50. Sexual intimacy outside marriage should be considered a crime for both parties, even if force was used or it was rape.