Differences in sexual violence against younger and older adults in complex humanitarian settings: a retrospective analysis from Médecins Sans Frontières in 2019–24

Elburg Van Boetzelaer, Tesfahun Biru, Amina Idris, Patrick Keating, Marion Staunton, Favila Escobio, Umberto Pellecchia, Judith Van de Kamp, Amrish Baidjoe, Jason W Nickerson, Martins Dada, Oscar H Franco, Grazia Caleo, Meggy Verputten, Joyce L Browne, Hanna Reinholdz

Summary

Background Sexual violence against older adults in humanitarian settings is poorly documented, leading to gaps in prevention and delivery of support services. This study aimed to document differences in assault characteristics between younger and older adults, by sex and displacement and disability status and region.

Methods This retrospective, descriptive observational, multi-country study included survivors aged 20 years or older who accessed sexual violence services supported by Médecins Sans Frontières in humanitarian settings across 11 countries between Nov 1, 2019, and Nov 1, 2024. Assault characteristics (context and circumstances of the assault and perpetrator characteristics) were compared between younger (20–49 years) and older survivors (50 years and older) stratified by sex and region using regression analyses. Among older survivors, analyses were mutually adjusted for age group, displacement, and disability status.

Findings We included data from 35 248 survivors who accessed care in the study (33 548 [95·2%] survivors were aged 20–49 years and 1700 [4·8%] were aged 50 years or older). 34 007 (96·5%) participants were female and 1241 (3·5%) were male. Rape was the most frequently reported type of sexual violence across sexes and age groups, including in older female survivors compared with younger female survivors (odds ratio [OR] 2·01 [95% CI 1·34–3·22]). Compared with their younger counterparts, older female survivors were more likely to report assault during armed attacks (OR 1·85 [95% CI 1·65–2·07]), by multiple assailants (OR 1·66 [1·50–1·84]), by armed groups (OR 1·21 [1·09–1·34]), while gathering food or wood (OR 1·51 [1·36–1·68]), and with regional variation, and less likely to report sexual violence from an intimate partner (OR 0·29 [0·23–0·36]). Older male survivors were more likely to report sexual violence other than rape (OR 2·85 [95% CI 1·51–5·07]), and to report a female assailant (OR 1·65 [1·01–2·78]). Older female survivors with disabilities were more likely to report sexual violence from an intimate partner (adjusted [a]OR 3·57 [95% CI 1·42–7·84]), and repeat assaults by the same assailant (aOR 4·01 [1·68–8·57]).

Interpretation This study reveals distinct patterns of sexual violence among older women, particularly assaults by multiple unknown armed assailants during survival tasks, and among older men, whose experiences often fall outside dominant sexual violence narratives. Disability and displacement further compound the vulnerability of older adults, influencing the type, context, and recurrence of violence. Findings underscore the urgent need for age-sensitive and disability-sensitive sexual violence support strategies in humanitarian settings.

Funding None.

Introduction

Sexual violence is exacerbated by humanitarian crises, resulting in immediate and long-lasting physical, social, and mental health harms.[1] Humanitarian crises tend to amplify the root causes of sexual violence, including abuse of power, gender inequalities, discrimination, and harmful societal norms.[1] Specific factors that increase the risk of sexual violence in crises include disrupted family and community protection structures, loss of legal and protective mechanisms, mass displacement, exposure to armed conflict, economic and food insecurity, traumatic stress, increased substance abuse, and disruptions in access to basic resources and services.[1–3] Sexual violence reproduces inequalities of age, gender, ethnicity, sexual orientation, socioeconomic status, displacement status and disability status,[4] and the intersection of these factors affects the individual risk of sexual violence in humanitarian settings.

By 2050, a fifth of the global population will be older than 60 years, of whom 80% will live in low-income and middle-income countries (LMICs).[5] The continued increase of more complex and protracted humanitarian crises caused by conflict, natural disasters, food insecurity, malnutrition, and outbreaks of infectious diseases, further exacerbated by climate change, will have an effect on a rapidly growing ageing population,[6]

Lancet Glob Health 2025

Published Online October 16, 2025 https://doi.org/10.1016/S2214-109X(25)00318-3

See Online/Comment https://doi.org/10.1016/S2214-109X(25)00402-4

For the Arabic translation of the abstract see Online for appendix 1

For the Spanish translation of the abstract see Online for appendix 2

For the French translation of the abstract see Online for appendix 3

Médecins sans Frontières, Operational Centre Amsterdam, Amsterdam, Netherlands (E Van Boetzelaer MPH, P Keating PhD, M Dada MSc, M Verputten MSc, H Reinholdz MSc); **Global Public Health & Bioethics, Julius Centre for Health Sciences and Primary Care, University Medical Centre Utrecht, Utrecht University, Utrecht, Netherlands** (E Van Boetzelaer, J Van de Kamp PhD, Prof O H Franco PhD, J L Browne PhD); **Médecins sans Frontières, Juba, South Sudan** (T Biru BA); **Médecins sans Frontières, Abuja, Nigeria** (A Idris BSc); **HelpAge International, London, UK** (M Staunton PhD, F Escobio MSc); **Médecins sans Frontières, Operational Centre Brussels, Brussels, Belgium** (U Pellecchia PhD, A Baidjoe PhD); **Médecins sans Frontières, Luxembourg Operational Research Unit, Luxembourg City, Luxembourg** (U Pellecchia, A Baidjoe, G Caleo PhD); **Médecins sans Frontières, Toronto, ON, Canada** (J W Nickerson PhD); **Bruyère Health Research Institute, Ottawa, ON, Canada** (J W Nickerson); **Centre for Health Law, Policy and Ethics, Faculty of Law, University of Ottawa, Ottawa, ON, Canada** (J W Nickerson); **Department of**

Clinical Sciences, Division of Social Medicine and Global Health, Lund University, Malmo, Sweden (H Reinholdz)

Correspondence to: Elburg van Boetzelaer, Médecins sans Frontières, Operational Centre Amsterdam, 1018 DD Amsterdam, Netherlands
elburg.vanboetzelaer@london.msf.org

Research in context

Evidence before this study

We searched PubMed, Google Scholar, and Google combining terms related to "sexual violence", "humanitarian" and "older adults". We found that sexual violence against older adults is severely under-researched. For example, a global prevalence review by WHO identified 392 studies on sexual violence, of which only 66 (17%) included any data on women aged 50 years or older. Evidence from humanitarian contexts is even more scarce. In several displacement settings (Uganda, Iraq, Panama, and Pakistan) surveys found that 11% of respondents aged 50 years or older reported experiencing conflict-related sexual violence. However, older adults are rarely analysed as a distinct group in humanitarian crises, and most studies did not explore how age, displacement, or disability shaped survivors' risks and sexual violence experiences. To our knowledge, no large-scale, multi-country study has compared sexual violence characteristics between younger and older survivors in humanitarian contexts using an intersectional lens that includes sex, contexts, age, and disability.

Added value of this study

To our knowledge, this is the largest and only multi-country analysis to date examining the characteristics of sexual violence among younger and older adults (N=35 248) in humanitarian settings through an intersectional lens. Although older adults made up a small proportion of survivors who accessed care (4·8%), our findings documented that they face distinct forms of sexual violence, shaped by intersecting vulnerabilities such as displacement status and disability status. Older women had significantly higher odds of reporting rape, being assaulted by multiple perpetrators, and experiencing violence at the hands of armed actors or criminal groups. These assaults were more likely to occur during survival activities such as gathering food or firewood, or during attacks on homes and villages. Older male survivors, while fewer in number, were more likely than younger men to report non-rape forms of sexual violence, assaults involving property destruction, and female assaulters, experiences that often fall outside conventional narratives of sexual violence, highlighting the need to broaden gendered understandings of sexual violence beyond rape.

Implications of all the available evidence

These findings challenge the invisibility of older adults in sexual violence research and programming. They underscore the urgent need for prevention, protection, and response services that are age-inclusive, sex-inclusive, and disability-inclusive across humanitarian contexts. They highlight the urgent need to recognise and respond to the specific risks and lived experiences of older survivors through inclusive, rights-based, and intersectional approaches. Humanitarian sexual violence prevention, protection, and response efforts need to reassess whether current activities truly reach and serve older adults, and whether the vulnerabilities they face, such as sexual violence during survival tasks or within their homes, are adequately addressed. Crucially, older adults, including older people with disabilities, must be directly involved in shaping these responses. Their participation in the design of sexual violence programmes, research agendas, and support services is essential to ensure relevance, accessibility, and effectiveness. Training health-care workers and humanitarian responders on the severity, patterns, and manifestations of sexual violence among older populations is also crucial. Future research should include population-based studies and qualitative methods, co-designed with older adults, to better capture the scale, dynamics, and lived experiences of sexual violence in later life, not as research done for older people, but as research shaped with them.

including an increased risk of experiencing sexual violence. Globally, evidence on the prevalence, patterns, and types of sexual violence against adults aged 50 years and older is scarce, particularly in LMICs.[7,8] Data on sexual violence against older populations in humanitarian settings is even more scarce. Across displacement contexts in Iraq, Pakistan, Panama, and Uganda, surveys showed that 11% of respondents aged 50 years or older reported some form of sexual violence associated with conflict.[9] Other studies that included older adults did not study them independently of other age groups, making it difficult to understand specific characteristics of sexual violence against older adults.[9] This lack of data directly results in a lack of visibility of older adults' sexual violence-related experiences and affects appropriate prevention programmes and available support systems.[10]

This study includes 5-year data from survivors who accessed Médecins Sans Frontières-supported sexual violence services in complex humanitarian settings, in which a series of events (eg, armed conflict, environmental disaster, epidemic, or malnutrition) has resulted in a critical threat to the health, safety, and security of a community.[11] This study aimed to document how the characteristics of sexual assaults in complex humanitarian settings differ between younger and older survivors, by sex. The study sought to apply an intersectional lens to investigate whether assault characteristics varied among older survivors based on advanced age, displacement and disability status, and region.

Methods

Study design and participants

This retrospective, descriptive, observational study allowed for the systematic documentation and analysis of patterns in assault characteristics between age groups as they occurred in humanitarian settings. The study population consisted of survivors aged 20 years or older who reported sexual violence as the reason for their presentation at Médecins Sans Frontières-supported sexual violence

services in humanitarian settings between Nov 1, 2019, and Nov 1, 2024. All survivors who accessed sexual violence care for an incident were included in this analysis, regardless of the timing between the incident and the time of care seeking. Only countries where at least one older survivor of sexual violence who accessed services supported by the Médecins Sans Frontières, Operational Centre Amsterdam during the study period were included, which resulted in 11 LMICs across sub-Saharan Africa, South Asia, Latin America and the Caribbean, and East Asia and the Pacific. Due to the sensitivity of the topic of sexual violence and security considerations, the names of countries included in this study are not disclosed. In many of the included humanitarian settings, life expectancy is low, and many conditions usually associated with older age, such as disability and chronic disease, are present at earlier ages. Therefore, the term older survivor was defined as a person aged 50 years or older,[12,13] and the term younger survivor was defined as a person aged 20–49 years, given that adolescence is defined by WHO as 10–19 years.[14] We included survivors of all sexual violence (categorised as rape and sexual violence other than rape) in this study. Rape was defined as forced, coerced, or non-consensual penetration of the vagina, anus, or mouth with a penis or penetration of the vagina or anus with any other part of the body or any other object.[15] Sexual violence other than rape included attempted rape, unwanted kissing, fondling, forced masturbation or touching of genitalia or buttocks, torture directed at the genitals while in captivity, or other forms of sexual harassment not resulting in, or including, penetration.[15]

This research fulfilled the exemption criteria set by the Médecins Sans Frontières Ethics Review Board for a posteriori analyses of routinely collected clinical data and thus did not require review from the ethics review board or informed consent. It was conducted with permission from the Medical Director of Operational Centre Amsterdam, Médecins Sans Frontières.

Procedures

Data were collected as part of the routine monitoring of Médecins Sans Frontières-supported sexual violence services. In the included programmes, Médecins Sans Frontières offers a comprehensive package of care to survivors of sexual violence following survivor-centred principles of safety, respect, privacy, confidentiality, informed consent, and non-discrimination. The package of care includes post-exposure prevention of infections, treatment of injuries, prevention, or management of unwanted pregnancy, psychosocial support, provision of a medico-legal certificate, and referrals to partner organisations for additional support services including protection, legal aid, and social support.[15]

Data were recorded on the paper-based patient file by medical staff, which is standardised across Médecins Sans Frontières-supported sexual violence services. Subsequently, data encoders entered these data in an event program configured by Médecins Sans Frontières in the District Health Information System 2. Demographic characteristics included age, sex, and displacement and disability status. Assault characteristics included circumstances associated with the incident; context of the assault; and number, type, and sex of the assailants. All variables were self-reported by the survivor. Data from age groups over 50 years were presented in 10-year increments as suggested by HelpAge International.[16] Gender data were not collected; sex was recorded as male, female, or unknown or unspecified. Unknown or unspecified sex was reported for less than 0·20% of adults, and these survivors were excluded in this analysis. Disability status was completed by medical staff and could include physical disability, mental disability, both, other, none, or unspecified. Ethnicity data were not collected. All data were pseudonymised to ensure confidentiality. An overview of included variables can be found in appendix 4 (pp 1–3).

See Online for appendix 4

Statistical analysis

Each assault characteristic was considered as a dependent outcome variable, while sex, age group, displacement status, and disability status were independent variables. The record was removed from data analysis if any independent variables were missing. We did an available case analysis for the assault characteristics. Variables were presented either as proportions or medians with their range. Differences in proportions for the demographic variables were measured using Kruskal-Wallis rank sum test and Pearson's χ^2 test. Differences in proportions for the assault characteristics were measured using logistic regression, presented as odds ratio (OR) and 95% CI. For female survivors, we adjusted for intimate partner as the type of assailant, and stratified by region (sub-Saharan Africa *vs* Latin America and the Caribbean, as the numbers for South Asia and East Asia and the Pacific were too small). For older female survivors we presented the OR and adjusted OR (aOR) mutually adjusting for advanced age, displacement status, and disability status. Due to small numbers, we were unable to do similar adjustments and stratifications for male survivors. Since this is a descriptive observational study, we present effect size and 95% CIs as a measure of the magnitude of the effect to guide interpretation rather than p values. Analyses were conducted using RStudio.

Role of the funding source

There was no funding source for this study.

Results

A total of 35 248 survivors of sexual violence from 11 countries who accessed care at Médecins Sans Frontières-supported sexual violence services between Nov 1, 2019, and Nov 1, 2024, were included in the study. Among these, 33 548 (95·2%) survivors were aged

	Survivors aged 20–49 years (n=33 548)	Survivors aged 50 years and older (n=1700)	p value
Age, years	28·0 (23·0–34·0)	55·0 (50·0–60·0)	<0·0001*
Age category, years			
50–59	..	1183 (70·0%)	..
60–69	..	434 (26·0%)	..
70–79	..	74 (4·4%)	..
80 and older	..	9 (0·5%)	..
Sex			0·0005†
Female	32 393 (97·0%)	1614 (95·0%)	..
Male	1155 (3·4%)	86 (5·1%)	..
Displacement status			<0·0001†
Non-displaced	16 826 (50·2%)	747 (43·9%)	..
Internally displaced person, refugee, asylum seeker, migrant	16 722 (49·8%)	953 (56·1%)	..
Disability status			0·0045†
None	31 980 (95·3%)	1646 (96·8%)	..
Mental and physical disabilities	611 (1·8%)	9 (0·5%)	..
Physical disability	400 (1·2%)	22 (1·3%)	..
Mental disability	221 (0·7%)	10 (0·6%)	..
Other	217 (0·6%)	9 (0·5%)	..
Unspecified	119 (0·4%)	4 (0·2%)	..
Region			<0·0001†
Sub-Saharan Africa	24 710 (73·7%)	1248 (73·4%)	..
Latin America and the Caribbean	5429 (16·2%)	415 (24·4%)	..
South Asia	2866 (8·5%)	28 (1·6%)	..
East Asia and the Pacific	543 (1·6%)	9 (0·5%)	..

Data are n (%) or median (IQR). *Kruskal-Wallis rank sum test. †Pearson's χ^2 test.

Table 1: **Demographic characteristics of survivors of sexual violence aged 20 years and older who accessed Médecins Sans Frontières-supported sexual violence services**

20–49 years and 1700 (4·8%) were aged 50 years or older (table 1). 34 007 (96·5%) participants were female and 1241 (3·5%) were male.

Rape was the most frequently reported type of sexual violence across sexes and age groups. Compared with younger female survivors, older female survivors had higher odds of reporting rape (OR 2·01 [95% CI 1·34–3·22]), and that the assault was perpetrated by members of a criminal group (OR 1·78 [1·58–2·01]) or a non-civilian assailant (OR 1·21 [1·09–1·34]; table 2). Older female survivors had lower odds of reporting that the assault was perpetrated by a known civilian (OR 0·69 [95% CI 0·57–0·83]) or intimate partner (OR 0·29 [95% CI 0·23–0·36]). Older female survivors had higher odds of reporting an assault by multiple assailants (OR 1·66 [95% CI 1·50–1·84]).

Compared with younger female survivors, older female survivors had higher odds of reporting that the assault took place during, or as a direct result of, an armed attack against the entire household or village (OR 1·85 [95% CI 1·65–2·07), and that the assault occurred while working in the fields, collecting wood, or looking for food (OR 1·51 [1·36–1·68]). They had lower odds of reporting that the assault took place at the assailant's home (OR 0·45 [95% CI 0·36–0·55]) or a friend or relative's home (OR 0·36 [0·20–0·57]). Older female survivors had higher odds of reporting armed assailants (OR 2·05 [95% CI 1·81–2·33]). Finally, older female survivors had lower odds of reporting repeat assaults by the same assailant (OR 0·39 [95% CI 0·31–0·48]). When adjusting for intimate partner as type of assailant there was moderate confounding observed for some variables, but effect sizes remained very similar between the unadjusted and adjusted ORs. Only when the patient was assaulted in the home was the effect of the confounding seen (OR 0·98 [95% CI 0·88–1·10]; aOR 1·16 [1·04–1·30]; table 2).

Patterns in assault characteristics were similar in sub-Saharan Africa and Latin America and the Caribbean. In both regions, compared with younger female survivors, older female survivors had higher odds of reporting that there were multiple assailants and that the assailant was armed (appendix 4 pp 4–5). They had lower odds of reporting that the assault was perpetrated by a known civilian or intimate partner and of reporting repeat assaults by the same assailant. In sub-Saharan Africa, older female survivors had higher odds of reporting being assaulted while working in the fields, collecting wood, or looking for food (OR 1·68 [95% CI 1·49–1·89]); in Latin America and the Caribbean, older female survivors had higher odds of reporting being assaulted at their home (OR 1·69 [1·38–2·06]). In sub-Saharan Africa, older female survivors had higher odds of reporting that the assault was perpetrated by a non-civilian group (OR 1·31 [95% CI 1·17–1·48]). In Latin America and the Caribbean, older female survivors had higher odds of reporting that the assault was perpetrated by a member of a criminal group (OR 2·82 [95% CI 2·15–3·74]; appendix 4 pp 4–5).

Globally, compared with younger male survivors, older male survivors had higher odds of reporting sexual violence other than rape (OR 2·85 [95% CI 1·51–5·07]), and lower odds of reporting rape (OR 0·35 [0·20–0·66]). Older male survivors had higher odds of reporting looting or destruction of property associated with the assault (OR 5·54 [95% CI 1·18–20·3]) and higher odds of reporting their assailant's sex as female (OR 1·65 [1·01–2·78]; table 3).

Older female survivors, irrespective of their age group, displacement status, or disability status, most frequently reported rape as the reason for their presentation at Médecins Sans Frontières-supported sexual violence services (appendix 4 pp 6–7). Compared with older female survivors of less advanced age, older female survivors of more advanced age had, with each increase of 10-year increments in age group, higher odds of reporting that the assault was perpetrated by a non-civilian group (aOR 1·35 [95% CI 1·13–1·61]) and lower odds of reporting an intimate partner as the assailant (aOR 0·55 [0·33–0·86]; table 4).

Compared with older female survivors of less advanced age, older female survivors of more advanced age had higher odds of reporting physical violence associated

	Survivors aged 20–49 years (n=32 393)	Survivors aged 50 years and older (n=1614)	OR*	95% CI	Adjusted OR†	95% CI
Type of violence: reason for first presentation						
Rape	31 555 (97·4%)	1593 (98·7%)	2·01	1·34–3·22	1·54	1·02–2·47
Sexual violence other than rape	838 (2·6%)	21 (1·3%)	0·50	0·31–0·75	0·65	0·41–0·98
Circumstances associated with incident						
Torture or other forms of ill-treatment	4398/28 744 (15·3%)	225/1516 (14·8%)	0·96	0·83–1·11	0·95	0·82–1·10
Kidnapping or abduction of patient	745/28 744 (2·6%)	12/1516 (0·8%)	0·30	0·16–0·51	0·28	0·15–0·47
Sexual exploitation and abuse	5801/28 744 (20·2%)	358/1516 (23·6%)	1·22	1·08–1·38	1·23	1·09–1·39
Physical violence	11 663/28 744(40·8%)	614/1516 (40·5%)	1·00	0·90–1·11	0·98	0·88–1·09
Looting or destruction of property	382/28 744 (1·2%)	28/1516 (1·7%)	1·40	0·93–2·02	1·28	0·85–1·84
Violence against a family member	265/28 744 (0·9%)	11/1516 (0·7%)	0·79	0·40–1·37	1·06	0·54–1·86
Transactional sex	264/28 744 (0·9%)	12/1516 (0·7%)	0·86	0·46–1·47	0·77	0·40–1·35
None of the above	5226/28 744 (18·2%)	256/1516 (16·9%)	0·91	0·80–1·05	0·96	0·83–1·10
Context of assault						
Survivor's home	8887/31 638 (28·1%)	441/1590 (27·7%)	0·98	0·88–1·10	1·16	1·04–1·30
Friend or relative's home	822/31 638 (2·6%)	15/1590 (0·9%)	0·36	0·20–0·57	0·39	0·23–0·63
Assailant's home	4013/31 638 (12·7%)	97/1590 (6·1%)	0·45	0·36–0·55	0·59	0·47–0·72
Workplace	926/31 638 (2·9%)	24/1590 (1·5%)	0·51	0·33–0·75	0·47	0·30–0·69
Path or road while travelling	8084/31 638 (25·6%)	439/1590 (27·6%)	1·11	0·99–1·24	0·96	0·86–1·08
Working in the fields, collecting wood or water, or looking for food	8180/31 638 (25·9%)	549/1590 (34·5%)	1·51	1·36–1·68	1·30	1·17–1·45
Detention or captivity	135/31 638 (0·4%)	8/1590 (0·5%)	1·18	0·53–2·26	1·06	0·47–2·02
Other	591/31 638 (1·9%)	17/1590 (1·1%)	0·57	0·34–0·89	0·52	0·30–0·83
Armed attack against entire household or village	5596/31 721 (17·6%)	446/1573 (28·4%)	1·85	1·65–2·07	1·64	1·46–1·84
Number of assailants						
Single	20 916/32 062 (65·2%)	846/1596 (53·0%)	0·60	0·54–0·67	0·71	0·64–0·79
Multiple	11 146/32 062 (34·8%)	750/1596 (47·0%)	1·66	1·50–1·84	1·40	1·26–1·55
Type of assailant						
Non-civilian (military, police, other security forces, or non-state armed group)	10 020/32 072 (31·2%)	568/1601 (35·5%)	1·21	1·09–1·34	..	..
Intimate partner	5231//32 072 (16·3%)	86/1601 (5·4%)	0·29	0·23–0·36	..	..
Family or household member other than intimate partner	789/32 072 (2·5%)	30/1601 (1·9%)	0·75	0·51–1·06	..	..
Known civilian (not household member)	3254/32 072 (10·1%)	116/1601 (7·2%)	0·69	0·57–0·83	..	..
Unknown civilian	7511/32 072 (23·4%)	412/1601 (25·7%)	1·14	1·01–1·27	..	..
Multiple types	432/32 072 (1·3%)	5/1601 (0·3%)	0·23	0·08–0·50	..	..
UN or non-governmental organisation staff	26/32 072 (<0·1%)	0	..	..	..	..
Member of criminal group	4553/32 072 (14·2%)	365/1601 (22·8%)	1·78	1·58–2·01	..	..
Other	256/32 072 (0·8%)	19/1601 (1·2%)	1·48	0·90–2·30	..	..
Assailant's sex						
Male	28 245/28 838 (97·9%)	1489/1520 (97·9%)	1·01	0·71–1·48	1·02	0·72–1·49
Female	353/28 838 (1·2%)	28/1520 (1·8%)	1·51	1·00–2·19	1·60	1·06–2·32
Both male and female	240/28 838 (0·8%)	3/1520 (0·2%)	0·24	0·06–0·62	0·21	0·05–0·56
Repeat assault by the same assailant	4260/31 248 (13·6%)	91/1572 (5·8%)	0·39	0·31–0·48	0·60	0·47–0·75
Armed assailant	20 235/31 127 (65·0%)	1228/1550 (79·2%)	2·05	1·81– 2·33	1·63	1·43–1·86

Data are n (%) or n/N (%), unless otherwise specified. OR=odds ratio. *Reference group was younger women (aged 20–49 years). †Adjusted for intimate partner as type of assailant.

Table 2: **Assault characteristics of female survivors of sexual violence who accessed Médecins Sans Frontières-supported sexual violence services**

with the assault (aOR 1·19 [95% CI 1·00–1·43]), and that the assault took place while working in the fields, collecting wood or water, or looking for food (aOR 1·26 [1·05–1·51]). They had lower odds of reporting that the assault took place while on the road travelling (aOR 0·85 [95% CI 0·69–1·04]). Older female survivors of more advanced age had lower odds of reporting that the assault took place during, or as a direct result of, an armed attack against the entire household or village (aOR 0·88 [95% CI 0·71–1·09]; table 4).

	Survivors aged 20–49 years (n=1155)	Survivors aged 50 years and older (n=86)	OR*	95% CI
Type of violence: reason for presentation				
Rape	1075/1155 (93·1%)	71/86 (82·6%)	0·35	0·20–0·66
Sexual violence other than rape	80/1155 (6·9%)	15/86 (17·4%)	2·85	1·51–5·07
Circumstances associated with incident				
Torture or other forms of ill-treatment	151/1039 (14·5%)	9/83 (10·8%)	0·72	0·33, 1·39
Kidnapping or abduction of patient	24/1039 (2·3%)	0	..	..
Sexual exploitation and abuse	214/1039 (21·0%)	18/83 (21·7%)	1·07	0·61–1·80
Physical violence	329/1039 (31·7%)	25/83 (30·1%)	0·93	0·56–1·50
Looting or destruction of property	7/1039 (0·7%)	3/83 (3·6%)	5·54	1·18–20·3
Violence against a family member	3/1039 (0·3%)	1/83 (1·2%)	3·16	0·16–21·7
Transactional sex	12/1039 (1·2%)	0	..	..
None of the above	299/1039 (28·8%)	27/83 (33%)	1·19	0·73–1·90
Context of assault				
Survivor's home	354/1139 (31·1%)	27/85 (31·8%)	1·04	0·64–1·65
Friend or relative's home	69/1139 (6·1%)	6/85 (7·1%)	1·18	0·45–2·60
Assailant's home	364/1139 (32·0%)	24/85 (28·2%)	0·84	0·51–1·35
Workplace	38/1139 (3·3%)	2/85 (2·4%)	0·70	0·11–2·34
Path or road while travelling	123/1139 (10·8%)	9/85 (10·6%)	0·98	0·45–1·91
Working in the fields, collecting wood or water, or looking for food	91/1139 (8·0%)	9/85 (10·6%)	1·34	0·61–2·62
Detention or captivity	13/1139 (1·1%)	1/85 (1·2%)	1·03	0·06–5·29
Other	87/1139 (7·6%)	7/85 (8·2%)	1·09	0·45–2·28
Armed attack against entire household or village	73/1136 (6·4%)	9/86 (10·5%)	1·71	0·77–3·38
Number of assailants				
Single	979/1143 (85·7%)	71/85 (83·5%)	0·85	0·48–1·60
Multiple	164/1143 (14·3%)	14/85 (16·5%)	1·18	0·63–2·08
Type of assailant				
Non-civilian (military, police, other security forces, or non-state armed group)	177/1136 (15·6%)	9/86 (10·5%)	0·64	0·29–1·23
Intimate partner	147/1136 (12·9%)	9/86 (10·5%)	0·78	0·36–1·51
Family or household member other than intimate partner	29/1136 (2·6%)	1/86 (1·2%)	0·45	0·03–2·15
Known civilian (not household member)	389/1136 (34·2%)	30/86 (34·9%)	1·03	0·64–1·62
Unknown civilian	338/1136 (29·8%)	32/86 (37·2%)	1·39	0·88–2·18
Multiple types	6/1136 (0·5%)	2/86 (2·3%)	4·50	0·65–19·9
UN or non-governmental organisation staff	1/1136 (<0·1%)	0	..	..
Member of criminal group	36/1136 (3·2%)	3/86 (3·5%)	1·11	0·26–3·15
Other	13/1136 (1·1%)	0	..	..
Assailant's sex				
Male	384/1043 (36·8%)	20/83 (24·1%)	0·54	0·32–0·90
Female	656/1043 (63·0%)	61/83 (73·5%)	1·65	1·01–2·78
Both male and female	4/1043 (0·4%)	2/83 (2·4%)	6·43	0·88–33·5
Repeat assault by the same assailant	93/1129 (8·2%)	7/82 (8·5%)	1·04	0·43–2·18
Armed assailant	311/1068 (29·1%)	26/80 (32·5%)	1·17	0·71–1·89

Data are n/N (%), unless otherwise indicated. OR=odds ratio. *Reference group is younger men (aged 20–49 years).

Table 3: **Assault characteristics of male survivors of sexual violence who accessed Médecins Sans Frontières-supported sexual violence services**

Compared with non-displaced older female survivors, displaced older female survivors had higher odds of reporting that the assault was perpetrated by a single assailant (aOR 3·76 [95% CI 3·05–4·65]), a non-civilian person (aOR 3·04 [2·44–3·81]), or a family or household member other than their intimate partner (aOR 2·72 [1·22–6·91]). Displaced older female survivors had higher odds of reporting that the assailant was female (aOR 3·65 [1·49–10·9]). Compared with non-displaced older female survivors, displaced older female survivors had higher odds of reporting physical violence associated with the assault (aOR 2·73 [95% CI 2·20–3·41]). Displaced older female survivors had higher odds of reporting that the assault took place while working in the fields, collecting wood or water, or looking for food (aOR 4·88 [3·85–6·24]), and lower odds of reporting that the assault took place at their home (aOR 0·60 [0·48–0·75]) or workplace (aOR 0·26 [0·09–0·63]) or while travelling (aOR 0·31 [0·24–0·39]). Displaced older female survivors had lower odds of reporting that the assault took place during, or as a direct result of, an armed attack against the entire household or village (aOR 0·18 [0·14–0·23]; table 4).

Compared with older female survivors without disabilities, older female survivors with disabilities had higher odds of reporting sexual violence other than rape (aOR 8·02 [95% CI 2·23–22·8]) as the reason for their presentation at Médecins Sans Frontières-supported services. Older female survivors with disabilities had higher odds of reporting an intimate partner as the assailant (aOR 3·57 [95% CI 1·42–7·84]) and repeat assaults by the same assailant (aOR 4·01 [1·68–8·57]; table 4). Differences in assault characteristics of older male survivors by age group, displacement status, and disability status can be found in appendix 4 (pp 8–12).

Discussion

Overall, this study documented that sexual assaults and associated characteristics varied across age, sex, contexts, and disability status. Only 4·8% of survivors of sexual violence who accessed care at Médecins Sans Frontières-supported services during the study period were aged 50 years or older. In addition to barriers to sexual violence care that the general population might experience,[17,18] older adults can face barriers including inaccessible or inappropriate services, low mobility, and dependence on others to access services.[19] Assumptions around ageing and ageism further affect care-seeking behaviours of older survivors. Older adults are often excluded from research, policy, practice, and education, as they are often not perceived as sexual or desirable by society, especially in comparison to younger counterparts.[20] This ageist perspective aligns with the stereotype of the so-called typical rape victim as a young, attractive female assaulted by a stranger, motivated by desire. Such ageist and sexist rape myths, along with misconceptions about disability, hinder the ability of health-care providers to recognise and address sexual violence in older adults.[21] Additionally, internalised ageist beliefs further act as barriers to care seeking, as older

	Age group in 10-year increments				Displaced				Disabled			
	OR*	95% CI	Adjusted OR*	95% CI	OR†	95% CI	Adjusted OR†	95% CI	OR‡	95% CI	Adjusted OR‡	95% CI
Type of violence: reason for first presentation												
Rape	1·08	0·55–2·53	1·13	0·57–2·67	1·15	0·48–2·74	1·12	0·46–2·70	0·13	0·04–0·45	0·12	0·04–0·45
Sexual violence other than rape	0·93	0·40–1·83	0·88	0·37–1·76	0·87	0·36–2·10	0·89	0·37–2·17	7·91	2·21–22·4	8·02	2·23–22·8
Circumstances associated with incident												
Torture or other forms of ill-treatment	0·93	0·73–1·18	0·98	0·76–1·25	0·56	0·42–0·74	0·56	0·42–0·74	1·22	0·49–2·64	1·25	0·50–2·72
Kidnapping or abduction of patient	0·68	0·17–1·80	0·69	0·17–1·86	0·52	0·15–1·64	0·54	0·16–1·71	3·41	0·18–18·2	3·76	0·20–20·5
Sexual exploitation and abuse	0·82	0·66–1·01	0·86	0·69–1·06	0·62	0·49–0·79	0·63	0·50–0·80	1·08	0·50–2·16	1·13	0·52–2·27
Physical violence	1·30	1·09–1·54	1·19	1·00–1·43	2·80	2·25–3·49	2·73	2·20–3·41	0·98	0·51–1·84	0·92	0·47–1·77
Looting or destruction of property	1·30	0·70–2·18	1·28	0·69–2·17	1·14	0·54–2·52	1·09	0·51–2·44	1·38	0·08–6·73	1·30	0·07–6·39
Violence against a family member	0·25	0·01–1·09	0·25	0·01–1·12	0·88	0·26–3·07	0·99	0·29–3·45	..	..	..	..
Transactional sex	0·68	0·17–1·80	0·60	0·15–1·61	8·17	1·58–150	8·69	1·68–159	..	..	..	..
None of the above	0·89	0·70–1·11	0·94	0·74–1·19	0·56	0·43–0·73	0·56	0·43–0·74	0·70	0·24–1·64	0·71	0·24–1·70
Context of assault												
Survivor's home	0·89	0·73–1·07	0·93	0·76–1·12	0·60	0·48–0·75	0·60	0·48–0·75	1·50	0·80–2·71	1·53	0·82–2·79
Friend or relative's home	0·36	0·06–1·14	0·37	0·06–1·16	0·90	0·32–2·58	0·99	0·35–2·84	..	..	..	..
Assailant's home	1·10	0·77–1·51	1·05	0·74–1·45	1·82	1·18–2·87	1·81	1·17–2·87	0·33	0·02–1·52	0·32	0·02–1·50
Workplace	0·81	0·34–1·58	0·88	0·37–1·76	0·26	0·09–0·62	0·26	0·09–0·63	3·07	0·48–10·9	3·25	0·50–11·8
Path or road while travelling	0·77	0·63–0·93	0·85	0·69–1·04	0·30	0·24–0·38	0·31	0·24–0·39	0·90	0·44–1·69	0·93	0·45–1·81
Working in the fields, collecting wood or water, or looking for food	1·41	1·19–1·67	1·26	1·05–1·51	5·01	3·95–6·39	4·88	3·85–6·24	0·80	0·41–1·48	0·73	0·37–1·41
Detention or captivity	0·69	0·11–2·18	0·67	0·11–2·16	0·79	0·19–3·34	0·81	0·19–3·47	4·77	0·25–27·6	5·07	0·27–29·7
Other	0·81	0·29–1·78	0·83	0·29–1·83	0·89	0·34–2·37	0·91	0·34–2·45	..	..	..	..
Armed attack against entire household or village	0·77	0·63–0·93	0·88	0·71–1·09	0·18	0·14–0·23	0·18	0·14–0·23	1·19	0·60–2·22	1·37	0·67–2·72
Number of assailants												
Single	1·31	1·10–1·55	1·16	0·97–1·39	3·83	3·11–4·72	3·76	3·05–4·65	1·59	0·88–2·96	1·60	0·85–3·07
Multiple	0·77	0·65–0·91	0·86	0·72–1·03	0·26	0·21–0·32	0·27	0·22–0·33	0·63	0·34–1·14	0·63	0·33–1·17
Type of assailant												
Non-civilian (military, police, other security forces, or non-state armed group)	1·47	1·24–1·74	1·35	1·13–1·61	3·14	2·52–3·93	3·04	2·44–3·81	1·62	0·90–2·91	1·59	0·86–2·91
Intimate partner	0·57	0·34–0·88	0·55	0·33–0·86	0·90	0·59–1·40	0·95	0·61–1·48	3·27	1·31–7·10	3·57	1·42–7·84
Family or household member other than intimate partner	0·84	0·40–1·53	0·77	0·37–1·42	2·64	1·18–6·69	2·72	1·22–6·91	1·14	0·06–5·53	1·16	0·06–5·68
Known civilian (not household member)	0·93	0·66–1·28	0·89	0·63–1·22	1·68	1·13–2·53	1·71	1·15–2·58	1·55	0·53–3·65	1·56	0·53–3·70
Unknown civilian	1·01	0·83–1·22	0·99	0·81–1·19	1·34	1·07–1·69	1·35	1·07–1·70	0·68	0·30–1·35	0·67	0·30–1·35
Multiple types	0·55	0·03–2·51	0·65	0·04–2·98	0·20	0·01–1·33	0·21	0·01–1·41	..	..	..	..
Member of criminal group	0·66	0·52–0·82	0·78	0·61–0·99	0·10	0·08–0·14	0·11	0·08–0·14	0·22	0·05–0·62	0·20	0·05–0·59
Other	1·35	0·64–2·49	1·25	0·59–2·34	3·00	1·08–10·6	2·91	1·04–10·3	..	..	..	..
Assailant's sex												
Male	1·42	0·76–3·12	1·55	0·82–3·43	0·47	0·19–1·01	0·44	0·18–0·96	0·38	0·11–2·40	0·36	0·10–2·27
Female	0·68	0·29–1·34	0·61	0·26–1·21	3·46	1·42–10·3	3·65	1·49–10·9	1·38	0·08–6·74	1·45	0·08–7·22
Both male and female	0·92	0·05–4·31	0·88	0·04–5·10					18·90	0·87–202		
Repeat assault by the same assailant	0·84	0·56–1·21	0·85	0·56–1·23	0·57	0·37–0·87	0·57	0·37–0·87	3·76	1·58–7·94	4·01	1·68–8·57
Armed assailant	1·04	0·85–1·28	1·13	0·92–1·40	0·42	0·32–0·55	0·41	0·31–0·54	0·78	0·40–1·63	0·78	0·40–1·65

OR=odds ratio. *OR for trend: increased odds per increase in age group, unadjusted and adjusted for displacement and disability status. †Reference group: non-displaced older women, unadjusted and adjusted for age group and disability status. ‡Reference group: older women without disabilities, unadjusted and adjusted for age group and displacement status.

Table 4: **Assault characteristics of older women (aged 50 years or older) who accessed Médecins Sans Frontières-supported sexual violence services**

survivors can struggle to access the support they need due to societal stigma and self-doubt.[21]

This study revealed that older female survivors who accessed care were more likely to report sexual assault by multiple unknown assailants, while younger female survivors were more likely to report sexual assault by an intimate partner. Our study shows that older women are raped by unknown armed assailants during survival tasks, including working in the fields, collecting wood or water, or looking for food. In many contexts, older

adults rely on subsistence farming or gathering resources for their survival or that of their household, which can push them into unsafe environments without adequate community support or safety structures.[13] A narrative synthesis review summarising global evidence showed that older adults less frequently report physical forms of intimate partner violence than do younger adults.[22] Explanations for this under-reporting include widowhood; decreased willingness to report or seek care for intimate partner violence due to dependency on their intimate partner; fear of not being believed by family or community members including health workers; normalisation of intimate partner violence over time due to prolonged exposure; or negative self-perception and internal feelings of guilt, shame, embarrassment, and powerlessness.[22]

Compared with younger male survivors, older male survivors who accessed care were more likely to report sexual violence other than rape, a female assailant, and looting or destruction of property associated with the assault. The number of male survivors who accessed sexual violence services is low and might indicate that they had even less access to services. Although sexual violence against men in conflict is described elsewhere,[23,24] to our knowledge, there are no comparable studies from humanitarian settings that describe the assault characteristics of sexual violence against older men.

Compared with non-displaced older female survivors, displaced older female survivors who accessed care were more likely to report sexual violence by a member of a non-civilian group, or a family or household member. Displaced female survivors, due to the disappearing normal social structures, are at an increased risk of opportunistic sexual violence during an attack, but might also face abuse from family, neighbours, and acquaintances while negotiating precarious and crowded living situations after displacement.[25]

Compared with older female survivors without disabilities, older female survivors with disabilities who accessed care were more likely to report sexual violence other than rape as the type of violence experienced and an intimate partner as the assailant. Similarly, other studies reported higher levels of past-year and lifetime intimate partner violence in women with disabilities than in those without disabilities.[26,27] These findings are congruent with other studies showing that the risk of sexual violence by an intimate partner was twice as high among women with disabilities than in those without disabilities.[28]

Awareness is slowly growing that older adults in humanitarian settings also experience sexual violence, and that adaptations of sexual violence services, including prevention and risk mitigation and response activities are necessary.[10,29] To realise this, humanitarian actors should be trained in the existence of sexual violence and intimate partner violence in older adults to increase awareness and understanding. The under-reporting of intimate partner violence among older women and sexual violence among men suggests a need to invest in more efforts to ensure that older survivors have access to care, for example through highlighting the benefits of seeking care and ensuring safe and discrete service entry points. Crucially, humanitarian actors should work together with older people when designing, implementing, and evaluating care and support services to ensure their accessibility, appropriateness, and acceptability. Further research is needed, for example through the inclusion of older people in population-based surveys and qualitative studies, including participatory research approaches, to better understand their experiences and perceived barriers to support and care and inform the design of sexual violence services in humanitarian settings.

To our knowledge, this is the largest multi-country analysis comparing assault characteristics of sexual violence between younger and older adults by sex, displacement status, disability status, and region in humanitarian settings. All data were self-reported by the survivor, which might have led to a risk of recall bias and social desirability bias. In some instances, adults might not know their age and might instead have given an estimation. Considering that this analysis was conducted by age group, we believe that no gross misclassifications of age will have occurred that would have altered our results. Disability status was analysed as a binary variable, and we were unable to assess how different disability types affect experiences of sexual violence. Further studies should include a more nuanced analysis of disability and sexual violence in older people in humanitarian crises, considering different types of disabilities. This study exposed patterns of sexual violence across humanitarian contexts. However, some differences in assault characteristics were found between sub-Saharan Africa and Latin America and the Caribbean, indicating the need for more context-specific studies to understand how patterns of sexual violence vary between contexts. We only included data from adults who accessed Médecins Sans Frontières-supported sexual violence services. This excludes any adults who experienced sexual violence for whom services were not accessible, which might have led to an under-representation of specific groups of adults who were more impacted by barriers to services, including men or older people of specific ethnicities. Although we aimed to apply a lens of intersectionality to this analysis, Médecins Sans Frontières does not routinely collect data on socioeconomic status, gender identity or sexual orientation, education level, social support system details, or other characteristics, and we were therefore not able to include those factors in our analysis.

Older adults, regardless of sex, displacement status, or disability status, are affected by sexual violence in humanitarian settings, yet their experiences remain largely invisible in research, policy, protection, and response efforts. This study reveals distinct patterns of sexual

violence among older women, particularly involving multiple, armed, and unknown assailants during survival activities, and among older men, whose experiences often fall outside conventional narratives of sexual violence. Displacement and disability substantially shape the nature of violence experienced by older adults, affecting who perpetrates it, where it occurs, and whether it is repeated, pointing to the need for targeted protection strategies and tailored support services.

These findings underscore the urgent need to recognise and respond to the specific risks and lived experiences of older survivors through inclusive, rights-based, and intersectional approaches to sexual violence prevention, care, and protection especially in humanitarian settings. This includes training front-line health and protection staff to recognise the diverse presentations of sexual violence in older populations; designing accessible and inclusive services; and investing in qualitative and participatory research to inform survivor-centred approaches. Recognising and addressing the unique vulnerabilities of older adults is vital for ensuring equitable and effective sexual violence responses, that are shaped in close collaboration with older people and their communities.

Contributors

EVB, PK, and HR conceptualised the study. EVB was responsible for the data analysis and writing of the original draft. Only authors affiliated with Médecins Sans Frontières, Operational Centre Amsterdam headquarters had access to the underlying data (EVB, PK, HR, and MD). EVB and HR have accessed and verified the underlying data reported in the manuscript. No authors were prohibited from accessing the data. TB, AI, PK, MS, FE, UP, JVdK, AB, JWN, MD, OHF, GC, MV, JLB, and HR were responsible for data interpretation and reviewing and editing of the manuscript. All authors reviewed and approved the final manuscript and accept responsibility for the decision to submit for publication.

Declaration of interests

We declare no competing interests.

Data sharing

Médecins Sans Frontières has a managed access system for data sharing that respects its legal and ethical obligations to its patients to collect, manage, and protect their data responsibly. Ethical risks include, but are not limited to, the nature of Médecins Sans Frontières operations and target populations being such that data collected are often highly sensitive. Data are available on request in accordance with Médecins Sans Frontières' data sharing policy. For individual data requests, please contact: oca.research@london.msf.org

Acknowledgments

We sincerely thank the teams that provide vital support to those in need in humanitarian emergencies. We would also like to attest to the resilience that is exerted and unnecessarily demanded from the survivors of sexual violence. We would like to thank Cono Ariti for his statistical support.

References

1 Spangaro J, Toole-Anstey C, MacPhail CL, Rambaldini-Gooding DC, Keevers L, Garcia-Moreno C. The impact of interventions to reduce risk and incidence of intimate partner violence and sexual violence in conflict and post-conflict states and other humanitarian crises in low and middle income countries: a systematic review. *Confl Health* 2021; **15:** 86.

2 Bitenga Alexandre A, Moke Mutondo K, Bazilashe Balegamire J, Emile A, Mukwege D. Motivations for sexual violence in armed conflicts: voices from combatants in eastern Democratic Republic of Congo. *Med Confl Surviv* 2021; **37:** 15–33.

3 Baaz ME, Stern M. Why do soldiers rape? Masculinity, violence, and sexuality in the armed forces in the Congo (DRC). *Int Stud Q* 2009; **53:** 495–518.

4 Armstrong EA, Gleckman-Krut M, Johnson L. Silence, power, and inequality: an intersectional approach to sexual violence. *Annu Rev Sociol* 2018; **44:** 99–122.

5 United Nations Department of Economic and Social Affairs. World Population Prospects 2024. 2024. https://population.un.org/wpp/ (accessed June 17, 2024).

6 UN Office for the Coordination of Humanitarian Affairs. Global Humanitarian Overview 2023. 2023. https://reliefweb.int/report/world/global-humanitarian-overview-2023-enaresfr (accessed Dec 12, 2023).

7 WHO. Violence against women 60 years and older. 2024. https://www.who.int/publications-detail-redirect/9789240090996 (accessed May 31, 2024).

8 Meyer SR, Lasater ME, García-Moreno C. Violence against older women: a systematic review of qualitative literature. *PLoS One* 2020; **15:** e0239560.

9 American Association for the Advancement of Science. Age is no protection: prevalence of gender-based violence among men and women over 49 years of age in five situations of protracted displacement. 2017. https://www.aaas.org/resources/age-no-protection-prevalence-gender-based-violence-among-men-and-women-over-49-years-age (accessed Sept 20, 2024).

10 Creighton J. Tip Sheet: the inclusion and participation of older women in GBViE Programs. 2024. https://www.gbvaor.net/node/1990 (accessed Sept 20, 2024).

11 Inter Agency Working Group on Reproductive Health in Crises. Inter-agency field manual on reproductive health in humanitarian settings. 2010. https://eeca.unfpa.org/en/publications/inter-agency-field-manual-reproductive-health-humanitarian-settings (accessed Aug 21, 2024).

12 United Nations High Commissioner for Refugees. Older persons. 2025. https://emergency.unhcr.org/protection/persons-risk/older-persons (accessed Sept 23, 2025).

13 HelpAge International. Protection interventions for older people in emergencies. 2013. https://www.helpage.org/silo/files/protection-interventions-for-older-people-in-emergencies.pdf (accessed Aug 31, 2023).

14 WHO. Adolescent health. https://www.who.int/health-topics/adolescent-health (accessed June 13, 2025).

15 Médecins Sans Frontières Operational Centre Amsterdam. Sexual violence: guidelines for creating access and providing care to survivors of sexual violence and intimate partner violence. Médecins Sans Frontières Operational Centre Amsterdam, 2019.

16 HelpAge International. Sex, age and disability disaggregated data. 2018. https://www.helpage.org/silo/files/sex-age-and-disability-disaggregated-data.pdf (accessed June 13, 2025).

17 Karakosta A, Riza E. Increased vulnerability to gender-based violence (GBV) in refugee women in humanitarian settings. Identifying the gaps. *Dialogues Clin Neurosci Ment Health* 2020; **3:** 117–25.

18 Bitenga Alexandre A, Mukwege A, Mutondo KM, et al. Bridging theory and praxis in the comprehensive treatment of conflict-related sexual violence in the Great Lakes Region of Africa. *Glob Public Health* 2025; **20:** 2486440.

19 van Boetzelaer E, Rathod L, Keating P, et al. Health needs of older people and age-inclusive health care in humanitarian emergencies in low-income and middle-income countries: a systematic review. *Lancet Healthy Longev* 2025; **6:** 100663.

20 Hand MD, Lee MY, Kaiser ML, Mengo C, Dabelko-Schoeny H. Sexual violence against adults aged 50 years and older and implications for prevention: a thematic analysis of service providers' perceptions. *Int J Environ Res Public Health* 2024; **21:** 1220.

21 Hand MD, Lee MY, Dabelko-Schoeny H, Kaiser M, Mengo C. Societal, organizational, relational, and individual perceptions of sexual violence against older adults and its prevention: a systematic scoping review. *Gerontologist* 2022; **62:** e597–613.

22 Pathak N, Dhairyawan R, Tariq S. The experience of intimate partner violence among older women: a narrative review. *Maturitas* 2019; **121:** 63–75.

23 Sivakumaran S. Sexual violence against men in armed conflict. *Eur J Int Law* 2007; **18:** 253–76.

24 Broban A, Van den Bergh R, Russell W, et al. Assault and care characteristics of victims of sexual violence in eleven Médecins Sans Frontières programs in Africa. What about men and boys? *PLoS One* 2020; **15:** e0237060.

25 Kelly J, Holmes M, Gibbons N, Matabaro Tom A, Voors M. Conflict, displacement and overlapping vulnerabilities: understanding risk factors for gender-based violence among displaced women in Eastern Democratic Republic of Congo. *J Dev Stud* 2024; **60:** 2022–49.

26 Gupta J, Kanselaar S, Zhang C, Zaidi J. Disability and intimate partner violence in fragile states: a multi-country analysis. *Glob Public Health* 2023; **18:** 2204339.

27 Beaudrap PD, Mouté C, Pasquier E, et al. Burden of and risk factors for sexual violence among women with and without disabilities in two sub-Saharan African countries. *Glob Health Action* 2022; **15:** 2077904.

28 Chirwa E, Jewkes R, Van Der Heijden I, Dunkle K. Intimate partner violence among women with and without disabilities: a pooled analysis of baseline data from seven violence-prevention programmes. *BMJ Glob Health* 2020; **5:** e002156.

29 International Rescue Committee. Safe at home: Module 3: Women and children with disabilities and older persons safe at home. Part 6: Guidelines for integrating an older-age lens to existing case management. 2021. https://globalprotectioncluster.org/index.php/publications/2000/training-materials/presentation/safe-home-module-3-women-and-children (accessed Sept 29, 2025).