# Women and Girls Bearing Children through Rape in Goma, Eastern Congo: Stigma, Health and Justice Responses

Dr. Helen Liebling
Clinical Psychology and African Studies Centre
Coventry University
United Kingdom
e-mail: Helen.Liebling@coventry.ac.uk

Mrs. Henny Slegh
Medical Anthropologist
Institute of Mental Health,
Rwanda and DRC
e-mail: hennyslegh@gmail.com

Dr. Benoit Ruratotoye
Rector of Institute of Mental Health
Goma-DRC
e-mail: rutabenoit@yahoo.fr

## Abstract

Women and girls bearing children from rape is a poorly understood subject area in the Democratic Republic of Congo (DRC). It is essential to understand the underlying causes and consequences of sexual violence, and their impact on the Millennium Development Goals (MDGs). This article reports on British Academy funded research that examined the impact of bearing a child from rape, and the related health and justice responses. Individual interviews, focus groups and workshops with women, girls and health and justice service providers identified the social, health and psychological consequences of rape and bearing children. Our findings show the negative impact that rape and bearing a child has on Congolese society, and how this impedes the successful achievement of key MDGs. The current research should stimulate debate, and provide a useful resource for policy and service reviews.

**Key words: Women; Children; Congo; Girls; Rape; Stigma; Health; MDGs**

 

## 1. Introduction

Congolese and foreign militias have operated largely with impunity following the mid-1990s insurgency. Women and girls continue to be raped on a regular basis. Accurate data on sexual violence is difficult to obtain, and many survivors do not report rape due to fear, psychological effects and ineffective justice responses. Most data is obtained through medical and police records. As many survivors fail to access these services, the numbers reported are likely to be highly underestimated. However, according to UNFPA (2009), an average of 1100 officially documented rape cases per month were reported in Congo.

Survivors of rape often contract HIV/AIDS, and others become pregnant and bear children. The impact on women and girls includes physical, psychological and social suffering (Johnson, Scott, Rughita, Kisielewski, Asha, Ong and Lawry, 2010; Peterman, Palermo and Bredenkamp, 2010), yet the justice and health response to survivors is limited (Gorman, 2011; Pardoned, 2011; UNHCR 2011b). Furthermore, the psychological and medical support needed in such situations is poorly understood (Eckert and Hofling, 2008; Liebling and Baker, 2010).

The reduction of sexual and gender-based violence is a key priority for achieving the MDGs, particularly in relation to gender equality, child and maternal health. For example, Congo is one of the four war-torn African countries that continues to occupy the lowest ten positions in the Global Peace Index (Institute for Economics and Peace, 2010). The under-five infant mortality rate remains high (22.1%), and deaths from malaria are above the World Health Organisation (WHO) regional average. Congo has the highest maternal mortality rate of all the African sub-regions (MDG Report, 2010).

Previous research argues that the needs of young women bearing children from sexual violence are poorly understood, and that stigma negatively affects access and service responses (Liebling and Baker, 2010). For the purposes of the current research we define stigma as ‘a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons’ (Alonzo and Reynolds 1995, p.304).

While the health effects of rape are devastating, the service responses in Congo are poor, with needs left largely unmet (Ward and Marsh, 2006). In remote areas there is so little state infrastructure that access to services, justice or reparation is virtually non-existent. Thus victimisation continues, and is compounded by social exclusion. Responses are complicated by the fact that abortion is illegal in the country; punishable by imprisonment and only permitted to save a woman’s life. Furthermore, state laws are in conflict with Congolese culture. Sexual contact with a girl under 18 years is now defined as rape, however the Family Code permits women to marry at the age of 15 (World Bank, 2011).

 

A report by Wakabi (2008) in North Kivu (the Eastern province of Congo) found that sexual violence and psychological trauma was a major concern, and insecurity was causing a huge strain on the health sector. Given the scale and nature of sexual abuse; and the devastating consequences for women and their communities; Congo faces a serious public health problem. The majority of victims (91.5%, of a sample from South Kivu) suffer from one or more rape-related physical or psychological problems[1] (International Alert, 2005). A recent report carried out by Women for Women International (2010) recommended greater understanding about the effects of stigma in order for survivors to confidently access services. Hence, the objectives of the current research were to examine the impact of pregnancy, the stigma associated with bearing children from rape, and the related health and justice responses.

## 2. Methodology

The research used a qualitative approach that:

1. combined state and community providers of justice and health services;
2. explored the quality of responses;
3. focused on Goma, a region omitted during the recent reparations panel[2];
4. sought to provide greater understanding of stigma.

The researchers[3] spoke to 110 participants in North Kivu province, including individual interviews with 26 young women survivors who had given birth to children from rape. Interviews were carried out in Goma Town and in Bweremana, a rural area about 3 hours drive from Goma. Four survivors were interviewed regarding their experiences of taking rape cases to court. In addition, 5 separate focus groups were held with 50 women survivors. The majority of participants were girls under 18 years. Further information about participants is detailed in Appendix 1. Purposive sampling was utilised, and participants were recruited through churches and women's groups linked to the Institute of Mental Health. Women and girls who bore a child from rape volunteered to be interviewed. In addition, 30 interviews were carried out with key informants (health and justice professionals, police, human rights workers and professionals working in non-government and government organisations). Some examples of the questions for survivors included:

[1] Almost all (91%) of the interviewees from South Kivu claimed they were suffering from behavioural problems. The most frequently cited were latent fear and shame but they also mentioned self-loathing, excessive sweating, insomnia, nightmares, memory loss, aggression, anxiety, sense of dread and withdrawal into themselves (International Alert, 2005).

[2] In August 2010, a high-level panel was convened by the United Nations High Commissioner for Human Rights to hear directly from victims of sexual violence in Congo regarding a) their needs and b) perceptions of remedies and reparations available to them. (UNHCR, 2011a).

[3] The research was carried out by Dr. Liebling and Mrs. Slegh, in collaboration with Dr. Ruratotoye and the Institute of Mental Health in Goma.

 

- What were your experiences when reporting rape?
- What were the responses of services you accessed?
- What were the effects of those experiences on your life?

Interviews were transcribed verbatim and thematic analysis was utilised to develop emerging concepts and themes (Braun and Clarke, 2007). To protect participant's confidentiality and identity, pseudonyms are used. Findings were triangulated through discussion with key informants at a workshop held in Goma in September 2011.

## 3. Research Findings

### 3.1 Rape Experiences

> 'I was going for business with friends and on the way we were attacked and then taken. I was taken into the forest and spent four months there. There I did not only have one who raped me …there were about four.'
>
> (Mary, a 45 year old woman interviewed in Goma)

Analysis of the interviews carried out in the current study revealed women and girls experienced sexual violence, including rape and gang rape, and were also forced to witness violence and torture. A nurse at the maternal department in a rural hospital stated that 80% of rape survivors who sought medical help were girls under 18 years. The act of rape was carried out in a variety of locations (e.g. forests, working in the fields, going to the market, travelling to or from work, at home, in internally displaced persons camps, to or from school). In addition, some women were raped with a military weapon, although the majority of girls reported being raped by civilians[4].

Women and girls described different perpetrators including teachers, family members, military personnel, soldiers, rebels, police and community members. Many we spoke to said they were raped by men that could not be identified. See Appendix 1 and 2 for a breakdown of the data. Civilian perpetrators included people from the church, teachers, stepfathers, stepbrothers and neighbours. Though most adult women reported rapes by armed groups or soldiers that took place during the war, the research revealed increasing numbers being carried out by community members and families. The evidence borne out by the interviews was that sexual violence increased dramatically during the war but had now 'contaminated' the domestic sphere, particularly for girls. The Poverty Reduction Strategy Paper (Democratic Republic of Congo, 2007) also found 24% of girls aged 15-19 years are already mothers and the majority of offenders were civilians (81%) known to the family.

[4] For girls under 18 the perpetrators of the rape were largely community members including teachers, boys in the community and relatives. For women, the perpetrators were more likely to be rebels or soldiers, and rapes were mostly carried out as gang rapes in forests.

 

### 3.2 The Effects of Bearing a Child from Rape

Women and girls were asked about the impact of bearing a child from rape. Survivors reported socio-cultural, socio-economic, emotional and physical health effects. The authors argue that the effects of rape and bearing a child are closely enmeshed, and together have a profound impact on a) women's and girl's identities and b) those of their children (Liebling-Kalifani, 2010). Firstly, we report on the socio-cultural effects.

#### 3.2.1 Socio-Cultural Effects

The socio-cultural effects of experiencing rape, becoming pregnant and bearing a child included rejection by parents, families, community members and husbands. Social rejection includes young women chased away from their homes and villages, and also extends to children born from rape who are considered 'dangerous' by the community. In the context of Congolese society, rape is considered as 'a marriage' with the rapist. A girl that is pregnant is no longer viewed as a child who needs the care and affection of parents. A married woman who is raped is viewed as unfaithful. Almost all participants reported that they were chased from the house and family (see Appendix 1 and 2). Some reported being teased with names including 'the wife of interahamwe [5]'.

In contrast to married adult women, girls could not hide the fact that they had been raped, especially when they became pregnant. Their experiences were often 'known' in the social environment and families are often pressured for disclosure. Married women more often coped with rape experiences by keeping silent. Nevertheless, rape is perceived as a serious threat for all women living in Eastern Congo, irrespective of age, tribe or economic and marital status (Mukwege and Nangini 2009; Peterman et al. 2011; UNFPA, 2009).

As a result of their experiences and the rejection experienced, survivors often flee to unstable and insecure accommodation:

> 'The first effect is that I was chased from my Uncle's place where I was living and then I went to Katindo where I met a woman. That woman was a prostitute who accepted me to live with her on the condition that I had to look for what to eat and that is how we are living.'
>
> (Neema, a 16 year old girl interviewed in Goma)

Rejection included criticism and withdrawal of affection as Katherine described:

> 'She (my Aunt) attacks me with words like. 'Go to your parents. We don't want to take care of an orphan with a child'. This hurts me very much, because my parents passed away. They know I cannot go to them.'

[5] Interahamwe means literally 'those who work together', later translated as 'those who kill together' by Rwandans who fled the genocide of 1994 (USAID/DCHA Assessment Report, 1994).

 

Mary narrated what happened when she was chased away from school:

> 'They changed…they don't love me anymore (her parents). I had to leave school and have lost peace in my heart.'
>
> (Mary, a 15 year old girl interviewed in Goma)

Social rejection affected women and girls badly as Irene explained:

> 'It affects me negatively. Apart from the members of this women's association, other people reject me and I have no money to leave the village where I am known to move and live in another place to avoid gossip and ill-treatment from people.'
>
> (Irene, a 23 year old woman interviewed in Goma)

Women and girls described social exclusion and ridicule by family and community members:

> 'I am upset because when I think of if my father was here he would help me with the child to buy soap and food and when the child is sick he would help to take it to the hospital. Maybe if my parents were alive I could go and throw the child to my parents but my sister is ill treating me…mocking me and it is affecting me a lot. My sister forbids the child to call her husband the father and also when the child urinates she always beats the child.'
>
> (Juliet, a 15 year old girl interviewed in Bweremana)

As mentioned earlier, participants described how children of women born from rape are also considered 'dangerous' to the community. A government employer in Goma Town highlighted the seriousness of the situation:

> 'It is not right that a woman is left alone with the baby. Society, community and family should take care of her. If this does not happen, the rejected children will come back to society and take revenge: they are numerous about 6000-7000 children after rape. They can later become a real army that may fight against society, like rebels. The government should take the responsibility to implement activities to support these children and mothers.'
>
> (Erik, a minister interviewed in Goma)

Therefore, the main socio-cultural effects include the substantial social rejection of women, girls and their children. We focus now on reporting the socio-economic effects.

 

### 3.2.2 Socio-Economic Effects

In terms of socio-economic effects, women and girls reported the following:

- poverty;
- unable to continue with school;
- lack of means to earn a living and pay for fees;
- unable to work due to physical injuries.

Children born from rape were at risk of becoming street children as Irene described:

> 'What is hard is that I worry about their future how will the children (of rape) study because I have nothing they will just become street children. That is when I have the idea of taking and leaving them on the road and then a volunteer can take them and raise them because those children may also become useful for this society.'
>
> (Irene, a 23 year old woman interviewed in Goma)

Mary also talked about the hardships she faced following rape and bearing a child:

> 'I don't know how or what to say exactly as before experiencing rape I had a good life and could pay school fees for my children and feed them. But after that experience the family-in-law took my children and left me alone and I have nothing now. The family took the children from me when I was taken to the forest as they thought I had died there and when I came back and as I was pregnant they said 'no it is too difficult to accept you again in the community and that 'I was the wife of the interahamwe.'
>
> (Mary, a 45 year old woman interviewed in Goma)

We now move to discuss the effects of rape and pregnancy on physical health.

### 3.2.3 Effects on Physical Health

In terms of general health effects, women and girls described heart problems, back pains, headaches, skin diseases, being unable to walk properly, weaknesses and feeling ill:

> 'Also there is one thing about the effects on my health. Before (being raped) I was not suffering from heart problems but due to that experience I started suffering with heart problems.'
>
> (Charlotte, a 15 year old girl interviewed in Goma)

 

Survivors also reported the serious health impact from rape and bearing a child, in particular complex reproductive and gynaecological health difficulties. The reproductive health problems included vesico-vaginal fistula[6], often experienced following rape. It is also dangerous for young girls to deliver a child at a stage when their bodies are not yet mature. This can result in the rupture of the uterus and death of the child. Other problems included sexually transmitted diseases, problems with periods including abnormal bleeding, severe abdominal pain, cysts, feeling weak, HIV infection, AIDS and disabilities. Furthermore, there were additional health risks associated with illegal abortions. Sexually transmitted diseases were also prevalent as Faridah described during a focus group in Goma:

> 'The first effects were that I had some sexually transmitted diseases and my health is not good I am now weak. I am in a state when any disease can affect me and others can recognise I am sick and not strong and it is not possible to look for life. I am in such a state I have to go to the hospital when I am sick and I have to look for life so my children can survive and even myself as my husband rejected me and the children are not studying… it hurts inside.'
>
> (Faridah, a 29 year old woman during a focus group in Goma)

In summary, women and girls reported serious gynaecological, obstetric and reproductive health problems, in addition to other health issues. We now report on the emotional effects of rape and related stigma.

### 3.2.4 Emotional Effects and Stigma

Women and girls described the negative emotional impact on their sense of self, leaving them feeling devalued and suicidal. Due to a lack of trust in others, particularly men, survivors mainly kept their experiences to themselves. Women and girls narrated overwhelming psychological effects normally associated with traumatic experiences, including depression and suicidal behaviours, alienation, flashbacks, intrusive memories, disturbed sleep, withdrawal and avoidance, sexual concerns and identity problems. The consequences for teenage girls included a premature separation from childhood due to overwhelming responsibilities. During a girl's focus group held in Goma, Francesca said:

> 'It is even difficult for us to sleep as all of the time we are thinking about it. All night long I am thinking I have the child without a father that brings the idea of throwing the child…. (All the girls agree) throwing the child in the road somewhere but as a parent of that life it is something I did not want…I suffered and now the child is there.'

[6] One dreaded outcome of the trauma from sexual violence is genital fistula, defined as an abnormal communication between the vagina and the urinary tract (usually the bladder), or the vagina and the alimentary tract (usually the rectum). The fistula leads to uncontrollable leakage of urine or faeces or both through the vagina (Longombe et al. 2008).

 

Women and girls talked about feeling hopeless, overwhelmed and desperate; as well as angry, irritable and anxious. The relationship with their child from rape is extremely complex and intensified their distress. Several described a 'love/hate' relationship with their child, who was a constant reminder of the suffering they experienced:

> 'Sometimes I feel love for the child and sometimes not. Sometimes I really hate the child as it is not something I consented to.'
>
> (Christine, interviewed in Goma)

Lucinda, a girl from Bweremana said:

> 'I love the child but all the responsibilities are burdens for me. Sometimes I think when I see the father of the child on the road, I will put it in his arms and I will run away. But then I think, the child is innocent, it has no fault.'
>
> (Lucinda, a 17 year old girl interviewed in Bweremena)

Some stated the wish to abort the child as narrated by Angeline:

> 'When I came from the forest I had the idea of aborting the pregnancy as I also had other children so I could not afford feeding them. My decision was to abort and stay with the other children. I had friends who advised me to take some tablets. I can't know the name of the medicine. There is also Aloe leaves which I took but I did not abort unfortunately. I was not happy as my decision was to abort and stay with the other children as at the time I was unable to take care of them and it was what I wanted to do but it wasn't successful and I was hurt.'
>
> (Angeline, a 20 year old woman interviewed in Goma)

All the women and girls described feeling stigmatised and ashamed due to bearing a child, which further exacerbated the psychological effects. Sarah discussed the impact of the shame:

> 'It affects me in the sense that when I tell another person it feels shameful and that person can think it is something I wanted so that's why I prefer to keep quiet. It is shameful because when others of your age look at your child whilst I have no work and no occupation and no way of feeding the child. It is shameful when you have nothing. I am not in peace I am troubled by it and I have no happiness at all.'
>
> (Sarah, a 16 year old girl interviewed in Bweremena)

 

Marianne talked about the effect of her experiences on her perceived value as a woman:

> 'I have nothing to give the child. How can I return to the school? I am a woman with a bad reputation. I am a women without value, they look down on me, are disgusted with me. How can I get rid of this bad reputation? I have no future. I cannot go to study anymore. I am a woman without a future.'
>
> (Marianne, an 18 year old girl interviewed in Goma)

Women talked about the emotional effects on their children and during a focus group in Goma, Katrine, a 27-year old woman said:

> 'The children are not happy amongst others they feel rejected and I suggest support for our children, especially school and education. They are depressed and they cry.'

To briefly sum up here, women and girl survivors described a serious and traumatic emotional impact on their sense of self, leaving them feeling devalued and suicidal, resulting in a lack of trust of others, particularly men. The child born from rape as well as the social rejection experienced, intensified the psychological effects, resulting in complex and conflicting emotions towards and about the child. This was further complicated by abortion being illegal in Congo. Women and girls also describe their children as experiencing serious psychological affects exacerbated by social rejection. We now move on to address the health responses for survivors and their children.

## 4. Health Responses

The Congolese government spends only 4 per cent of its budget on health. Although it has pledged to increase this figure to 15 per cent, lack of funding, corruption, and unrest in the east affects progress. As a result, most Congolese are forced to rely on basic private facilities and funding from international and non government organisations (Financial Times, 2009).

Our interviews revealed that the poorly resourced state health system struggles to respond to the serious and widespread health needs of rape survivors and their children. There were very limited health responses and resources to treat rape mutilations and traumatic fistula (Ahuka, 2005 cited in The Acquire Project, 2005). Within Goma Town, government hospitals have no special services for raped women, and are only able to provide basic health care. There are two referral hospitals run by NGO's (Heal Africa and DOCS Hospital), for women who are suffering from injury and infection caused by violent rape. However, we were informed that funding was strictly for girls who could prove they were raped. In rural areas the health coverage was even more limited.

 

Most interviewees reported limited access to health services. For example, only 3 of 26 women and girls managed to access health centres or hospitals for emergency post-rape treatment within 72 hours (see Appendix 1). Occasionally post-exposure prophylaxis, PEP, was given. Free fistula operations were sometimes carried out, and there was some limited treatment for sexually transmitted diseases. However, free treatment stopped after delivery, when women needed it most. Free fistula treatment was provided in some hospitals. However most health services depend on donors (e.g., Heal Africa, Catholic Relief Network, UNFPA, Medicines of the World, Action AID, OXFAM, the United Nations Children's Fund and UNICEF). During the interview period PEP treatment was not available in Goma:

> 'I would suggest especially for the health response that women are taken care of when they become pregnant and for me when it came to delivery I had to pay. I would ask them to continue that care as after the delivery the child is there'
>
> (Rebecca, an 18 year old girl interviewed in Goma)

Women also described a lack of post-rape medical treatment (PEP and emergency contraception) within the 48 and 72 hour protocol. They also discussed:

- transport problems;
- a lack of consistent funding and staffing;
- a lack of follow up by government and community organisations;
- a lack of staff support and training.

A gynaecologist working in a private hospital explained:

> 'What we see with the women is there are fistulae, infections, prolapses and genital tears but the problem is to prove that there is a link between the tears and the rape because sometimes we are afraid to take it that all of these women have been raped as the women know that if they say they were raped then they will be treated without any fees. So one can be tempted to come and say that I was raped as that is when they don't pay any fees.'
>
> (Dr. Mwanja, a gynaecologist interviewed in Goma)

Lack of access to health care was exacerbated by social exclusion and rejection of young women. This was compounded by logistical problems, and a lack of available health care and specialists, particularly gynaecologists in rural areas:

> 'We cover all the zones in total 21 in this area. The first difficulty we have is that we cannot cover the whole district as Kathunda for example is 130 kilometres away from the hospital. In the forest the perpetrators can move easily. We have no transport to go and pick the victim and we don't have an ambulance.'
>
> (Dr. Mwasisi, a medical doctor interviewed in Bweremana)

 

As discussed earlier, abortion is illegal in Congo, and further limits access to safe health choices for women who become pregnant as a result of rape. A gynaecologist explains:

> 'For me the first problem is that the law in Congo does not agree with abortion so women here cannot decide to abort. Even if she is not ready to have that pregnancy grow and continue with it she cannot decide officially to abort it. If she did not decide to have the pregnancy then she can only abort it in other places as it is illegal. They do it in a small clinic or medical centre and there they commonly have complications, infections and trauma.'
>
> (Dr. Mwanja, a gynaecologist interviewed in Goma)

We now move to discuss the key outcomes that address mental health responses for young women and their children.

### 4.1 Mental Health Responses

The research found that professionals working in the mental health sector in eastern Congo were insufficient in number. The psychosocial assistance and mental health care were almost exclusively performed by community-based organisations. Basic health infrastructures appropriate to mental health needs, as well as qualified personnel to address these, were missing. The mental health of all women and girls that participated in the research had been seriously affected, and there was a lack of appropriately skilled professional responses. A senior NGO representative highlighted the enormous need for professional mental health care, and the absence of culturally appropriate responses. She particularly emphasised the inappropriate importation of western counselling methods for the Congolese culture. The representative also argued for more capacity building to develop local culturally appropriate counselling for survivors.

Some local organisations had initiated 'listening houses', where women could discuss their experiences with others. Most of the interviewed women had some counselling that was provided by such houses. Many counsellors worked for minimal payment (transport costs) and sometimes experienced rape themselves. In helping other women, they helped themselves. Counselling was perceived as extremely important. It helped women and girls to find their dignity and re-establish a connection to others (Slegh, 2011). However, the lack of qualified mental health professionals, clinical psychologists and counsellors resulted in limited treatment opportunities, and overburdening of lay counsellors. The extreme lack of funding for capacity building (and salaries for counsellors) meant their valuable work was limited and they had few support structures for dealing with stress. This was highlighted by a group of senior staff who trained 35 counsellors in north Kivu province:

> 'We have a problem as we are also stressed and we need a programme to de-traumatise us and help us relax. We also need security and protection.'

 

On a positive note, a woman capacity outreach officer described the value of bringing women and girl survivors together to share their experiences in groups:

> 'Group therapy of raped women has now been started. One organisation is for literacy and they brought women together in a group and run group therapy as well. Women make more progress in a group. It is called 'Alpha Ujuvi' which means curiosity.'
>
> (Isabel, woman capacity officer interviewed in Goma)

However, the research found an absence of integrated services for survivors at all levels of provision, as this male clinical psychologist explained:

> 'They are not available for every victim. One gets only medical help, another only psychosocial support. Every organisation has its own domain and transfers are not well co-ordinated because every organisation has its own principles and rules. There needs to be a co-ordinated response.'
>
> (Francis, a clinical psychologist interviewed in Goma)

Several key informants interviewed in health and justice services stressed the need for training to increase understanding of the psychological effects of rape and bearing a child. A woman capacity outreach officer suggested:

> 'With respect to the emotional aspects we need good services run by professional people as at the moment it is tokenistic. We need to think in the long-term as healing is a process. We need 3-6 month courses from those who really understand the African culture then they could come with external professionals and adapt their approaches to the Congolese culture.'
>
> (Isabel, woman capacity officer interviewed in Goma)

There was a pressing need for children born from rape to also receive psychological support, in order to prevent further problems; particularly anticipated future violence in Congolese society. The following informant explained:

> 'There are some women there who have children without fathers who recognise them or even know them and those women have very many difficulties to find a place in society with dignity. These children will be very dangerous for the future. It asks for an integration of psychosocial assistance for the women but also for the children as the women goes through a very...very difficult situation without help. She has to live with the horrible consequences of the violence and that will hinder her future and that of her children.'
>
> (Maurice, principal police commander interviewed in Goma)

 

To sum up here, the key messages from the mental health responses demonstrate an urgent need for expertise. There should also be a focus on increasing peer-support, training and supervision within community and government organisations to prevent 'burn out.' Every effort should be made to build a sensitive therapeutic response appropriate to the Congolese culture. We now turn to discuss justice responses.

### 4.2 Justice Responses

Interviewees primarily reported limited access to state services. In most cases, the woman or girl reporting the case had to pay for a) everything required at the police station (including the pen, paper and transport to locate the perpetrator) and b) throughout the justice process. At the time our research was being carried out, the Congolese government was just starting to register who was in the police (a mixture of state, army and military personnel). The justice response was further complicated by the fact that sexual contact with someone under 18 years is now automatically defined as rape in Congo, but the Family Code allows women to marry at 15 years.

As indicated in Appendix 2: Figure 2, almost half of the 26 women interviewed individually reported rape to the police. In terms of girls, 10 out of 21 interviewed individually reported rape. However, only 2 received a justice response. Of those found guilty, one received a 10 year sentence and had to pay costs to her parents (however the perpetrator could not pay). This girl is unable to live in her community due to stigma and social rejection. The second perpetrator received a sentence but after 3 months bribed his way out of prison. Appendix 2: Figure 2 shows that neither of the 2 women over 18 who reported rape to the police received a satisfactory justice response. Two of the girls interviewed individually benefitted from the assistance of an NGO that specialised in legal aid. Some women reported an arrest, however the perpetrator was often released from police cells within 48 hours. After that the accused left the region and was never seen again.

Women and girls were generally unaware of their rights or the procedures for reporting. Many felt there was little point as often they could not identify their perpetrator, and had little faith in the law. Some survivors described attempting to take cases with the assistance of community-based organisations. The majority described poor experiences with the police and justice process, and a lack of action. Those cases that reached judgement received no compensation. Bribes ensued at all levels of the justice system, and the perpetrator was often released (or escaped as several of the prisons lacked security). A magistrate explained further:

> 'There is authority interference as when the perpetrators are relatives they interfere to release him. The second reason is reparation the victims don't receive law damages, compensation or reparation and this discourages other victims from coming forward to justice.'
>
> (Thomas, a magistrate interviewed in Goma town)

 

In some cases family members attempted to report on behalf of their daughters, however survivors reported dissatisfaction with the legal processes. Recent changes in the law in Congo have made it illegal to resolve rape cases through traditional community practices, and this has further complicated the picture. There is rarely a positive outcome, and the perpetrator is usually not punished.

To sum up, those interviewed describe a series of challenges in the pursuit of justice (underfunding of the police and legal system, stigma and social exclusion, corruption and bribes, lack of awareness of their rights, inability to obtain evidence, the perpetrator not being located or escaping, poor security, threats and fear, lack of protection, impunity, investigations not proceeding, lack of choice to see a woman professional, and the community traditional justice systems being in conflict with state law). There were also several logistical problems for justice providers:

> 'We don't have all the facilities they have at Heal Africa (hospital) justice 'is a poor child' (compared to health). We lack logistics to move as quickly as possible we need vehicles. Magistrates and judicial police officers are not motivated. We are paid but it is not sufficient. There is not sufficient training.'
>
> (Thomas, a magistrate interviewed in Goma Town)

## 5. Discussion

The present study interviewed women and girls about a) their experiences of rape in Goma, eastern Congo, and b) bearing a child following rape. The study also sought the views from a range of organisations providing health and justice services in the region. We now discuss the main findings that emerged from our interviews.

### 5.1 Perpetrators of rape

The perpetrators of rape included teachers, family members, military personnel, soldiers, rebels, police and community members. One problem in reporting incidents was that it was difficult for women and girls to identify their perpetrators. Furthermore, community members also included former rebels who refused to integrate into the national army, making it dangerous for women to accuse them. The research found that rape and sexual violence, although extremely prevalent during the war, had now 'contaminated' the domestic sphere (Democratic Republic of Congo, 2007). This is particularly the case for girls, who were more likely to be raped by community members. Importantly, and in line with the current findings, sexual violence and rape is not limited to Congo's conflict zones, and domestic violence also occurs at high levels throughout the country (UNHCR. 2011a).

 

### 5.2 Social Consequences of Rape

The authors argue that the socio-cultural, socio-economic, physical and mental health effects; coupled with social exclusion, shame and rejection; have profound effects on women, girls' and children's identities. Young women are taken out of school and unable to gain employment. They frequently flee from their communities to seek 'safety', often living in unstable and vulnerable situations where they are prone to further exploitation. In contrast, adult women cope by keeping silent. This is to avoid rejection and isolation from husbands, family and community members.

Rejection also extends to young women's children who are considered 'dangerous' by the community. These children are also likely to remain angry with society, due to their rejection, leading to potential future instabilities. Their psychological difficulties must be addressed as Liebling-Kalifani et al (2008) have also argued in relation to former abductees in Northern Uganda 'Evidence indicates that unless these difficulties are addressed, this could lead to serious trans-generational effects with future instabilities (p.187).

#### 5.2.1 Physical Health Consequences

The experience of rape resulted in serious health effects, particularly reproductive and gynaecological health problems, and also fistulae, sexually transmitted diseases, prolapses, HIV infection and AIDS.

The lack of safe choices for women to pursue an abortion in Congo creates further distress for women who are forced to bear a child. As Boland and Katzive (2008, p.110) argue, 'women's lack of access to legal abortion is a major contributing factor to high rates of worldwide maternal mortality and morbidity'. The limited availability of the 'morning after pill' is also problematic with Congo having contraceptive prevalence rates below the regional average (WHO, 2010). The authors argue for increased access to the 'morning after pill' as an urgent priority and also for safe abortions to be made available to survivors. This would give women and girls increased control over their bodies and decisions.

#### 5.2.2 The Psychological Consequences of Rape

The psychological impact extends to the rejected children born from rape. We argue that these serious psychological effects on young women and their children require a gendered understanding and response appropriate to Congolese culture (Liebling-Kalifani, 2010; Liebling-Kalifani and Baker, 2010). Women and girl's trauma in this context can be conceptualised as a breakdown of cultural identity, manifested in physical, psychological, socio-cultural and socio-economic effects that are integrated and inseparable (Liebling-Kalifani, 2010). Studies on the consequences of traumatic experiences; and people's capacity to recover; indicates the salient importance of social support (Herman, 2002; Staub, 2003; Parents, Blum and Akhar, 2008). A place to experience the revival of basic trust and an emotional bond to the caregiver helps to assimilate the traumatic experience (Ornstein, 2008 as cited in Parents et al. 2008). The absence of social support, and lack of treatment for trauma-related problems create a vicious circle of violence (Liebling-Kalifani et al. 2008; Slegh 2010). The rejection of women who have been raped is also rooted in unequal gender

 

attitudes, where women are seen as 'useless'. The lack of current services only reinforces the prevalent view that raped women bearing children have little value in society, and further highlights gender inequalities.

### 5.3 Health and Justice Responses

Although women and girls reported the positive value of sharing in women's groups (and some minimal health treatment and counselling), the state health and legal systems are incapable of providing an effective response that is sensitive to the impact of stigma, social exclusion and other rape effects. There is also a lack of an effective and integrated response from community and government organisations. The problems of social rejection, fear, threats, shame and lack of trust all affect access to justice and health care. In addition, the context of continuing insecurity, threats to professionals and fear of reprisals, makes it dangerous for organisations to offer effective support. In addition, counsellors were mostly working as a result of their good will, without salaries and with minimal transport allowances. They are greatly at risk of 'burn out,' and often have had their own rape experiences. Professionals from NGOS's and community organisations require further support, training, and greater protection.

The poorly resourced state health system struggles to respond to the needs of rape survivors within the 48 and 72 hour timeframe required, and health care stops at delivery. Crucially, this is when young women need it most. The free treatment that exists is only available for those who can prove they were raped, creating a difficult situation for both women who need treatment, and health care providers who feel they have to establish this link prior to health care.

The inability to address young women's urgent reproductive and mental health needs excludes them from any effective contribution to peace-building and rehabilitation processes. This further impacts negatively on Congo's ability to achieve the MDGs in child and maternal health and gender equality.

The majority of interviewees saw little to be gained from reporting rapes. This is in part due to a culture of sexual exploitation, where the rape of young girls has become 'normalised' within the communities of eastern Congo. The police and judicial system suffers badly from a gross lack of funding, and struggles with overwhelming logistical problems. It is only recently that the Congolese government has attempted to register who is currently in their police force.

All women survivors reported feeling stigmatised and ashamed as a result of their experiences. The current findings support the study by Mukwege and Nangini (2009) who also found that rejection and weak service responses reduced women and girls coping capacity, and impacted on their identity and status within Congolese society. This rejection extends to the young women's children who are mistreated, and considered a danger within communities. However, those survivors that received support (i.e. spiritual guidance, education, health treatment and counselling) increased their resilience, and reported a greater ability to manage stigma and social exclusion.

 

### 5.4. Impact on the MDGs

The lack of justice, gender equality and empowerment continues to impact negatively on Congolese society and the achievement of key MDGs (DFID, 2000). The situation is exacerbated by years of instability, and its negative effect on poverty, poor health responses and continuing impunity in the region. According to the Africa Progress Panel (2011) and Millennium Development Goals Report (2010), Congo is regressing in terms of a) achieving universal primary education and b) gender equality. Congo is one of 2 countries showing the sharpest reversal in access to education. It is the second worst performer in Africa (following Kenya) for infant mortality rates, and has the highest maternal mortality rate for the African region. The lack of access to antiretroviral treatment and post-exposure prophylactic treatment (PEP) for rape survivors within the required time frames is a major concern. There is an urgent need to scale up free access to health treatment (Africa Progress Panel, 2011). As stated earlier, the lack of access to appropriate reproductive and gynaecological health services for young women is a major concern. According to the 2010 Global Peace Index (GPI), the Congo continues to occupy one of the lowest ten positions in the index, and has experienced continuing deterioration in scores (Institute for Economics and Peace, 2010). The UN General Assembly's review of progress towards the MDGs states 'Congo's indicators are amongst the worst in the world where governance, state authority and security are all chronically weak' (Mountain, 2011, p.1). There is little doubt that unless the continuing problems of sexual violence, torture and bearing a child from rape are tackled, Congo will continue to regress.

## 6. Conclusions

We make the following recommendations based on the research presented here.

All state and community-based organisations should treat rape victims with respect, and facilitate their involvement in programmes and groups. Community awareness programmes should encourage communities to accept survivors and their children. These strategies will go a long way to reduce the social rejection reported here.

Sensitisation programmes must also increase knowledge of the importance of access to post-rape treatment including PEP and the 'morning after pill' within 48 and 72 hours. Access to reproductive, mental health and justice services must be increased in rural areas (i.e. the provision of mobile clinics and access to safe abortions). The issue of providing safe abortions is very sensitive within Congolese culture, and debates about this should include recognition of the mental and physical health difficulties following rape.

Although health and justice findings have been reported separately, they were looked at together because rape, as Liebling and Baker (2010) have previously argued, is experienced simultaneously as a violation of the survivor's body and rights. The current research therefore argues; along with Liebling and Baker (2010) and Jewkes (2007); that there is real value in promoting increased collaboration between local health and justice services. This can improve joint working, communication and provision between sectors and services. A priority aim is to also promote capacity building within primary health care and justice services.

 

It is important to note that sexual violence also occurs against men and boys in eastern Congo and programmes should be sensitive to this (Christian et al. 2011). It could also be beneficial to involve men and boys in training and interventions that promote gender attitude change. Group education programmes at all community levels should be implemented to secure support networks, develop solidarity groups and produce role models of non-violent men.

Funding must be obtained for the police and justice services. However, this alone will not sufficiently improve service responses. More women police officers, lawyers and gender-sensitive training is needed. Finally, the authors recognise the current situation is extremely complex and there are no easy solutions. However, there is no doubt that urgent action needs to be taken to rehabilitate Congolese society. Our recommendations represent, we believe, valuable transitional steps towards a better health and justice provision for rape survivors bearing children in eastern Congo. It is offered to readers in the hope that it will stimulate debate, and be a resource for policy and service reviews.

 

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**References**

Africa Progress Panel. (2011) *The Millennium Development Goals.* Retrieved January 30, 2012 from http://www.africaprogresspanel.org/files/6513/0454/8341/Millennium_Development_Goals.pdf

Alonzo A.A. and Reynolds N.R. (1995). Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. *Social Science and Medicine,* 41 (3), 303–315.

Bartels, S., Scott, J., Leaning, J., Mukwege, D., Lipton, R. and VanRooyen, M. (2010). Surviving Sexual Violence in Eastern Democratic Republic of Congo. *Journal of International Women's Studies,* 11 (4), 37-49.

BBC News Africa. (2011) *Congo prison mass escape after attack by gunmen.* 7 September 2011. Retrieved 29 April, 2012 from http://www.bbc.co.uk/news/world-africa-10628245

Boland, R. and Katzive, L. (2008). Developments in Laws on Induced Abortion: 1998-2007 *International Family Planning Perspectives*, 34 (3), 110-120.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Brown, C. (2011). Women's Bodies as a Battleground: Sexual Violence against Women and Girls during the War in the Democratic Republic of Congo. *International Alert*. Retrieved February 20, 2012 from http://digitalcommons.calpoly.edu/socssp/47/.

Chen, S. and Ravallion, M. (2008). *The Developing World is Poorer than We Thought, but No Less Successful in the Fight against Poverty*. World Bank Policy Research Working Paper No. 4703. Washington, DC.

Christian, M., Safari, O., Ramazani, P., Burnham, G. and Glass, N. (2011) Sexual and gender based violence against men in the Democratic Republic of Congo: effects on survivors, their families and the community. *Medicine, Conflict and Survival*, 27 (4), 227-246.

Department for International Development (2000). *Halving World Poverty by 2015: economic growth, equity and security: strategies for achieving the international development targets.* London.

Democratic Republic of the Congo. (2007) *Poverty Reduction Strategy Paper*. International Monetary Fund Country Report No: 07/330. Retrieved 29 April, 2012 from http://www.imf.org/external/pubs/ft/scr/2007/cr07331.pdf

Eckert, R. and Hofling, J. (2008). *Breaking the Silence: Women and Girls at Risk and Children of Rape.* Australian Refugee Rights Alliance**.** Retrieved 3 February 2012, from http://www.refugeecouncil.org.au/docs/resources/reports/arra08_children_of_rape.pdf

Financial Times (2009). *Congo's Crippled Healthcare*. Retrieved February 27, 2012 from http://www.ft.com/cms/s/0/e376ef0e-a1f3-11de-81a6 00144feabdc0.html#axzz1nac0qEM6

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* U.S.A.: Prentice-Hall books.

Gorman, M. (2011). Sexual Violence in the Democratic Republic of Congo: Moving forward with Diminished Impunity for Crimes and Increased Support for Victims. *Undergraduate Transitional Justice Review,* 1 (2), 99-138.

Herman, J. (1992). *Trauma and Recovery: The Aftermath of Violence: From Domestic Abuse to Political Terror.* New York: Basic Books.

Institute for Economics and Peace (2010). Retrieved December 5, 2011 from http://www.visionof humanity.org/wp-content/uploads/2010-GPI-Discussion-Paper.pdf

Integrated Regional Information Networks, IRIN (2011). *New laws have little impact on sexual violence in DRC*. Retrieved 26 February, 2012 from http://www.unhcr.org/refworld/docid/4df1f1652.html

Jewkes, R. (2007). Comprehensive response to rape needed in conflict settings. *The Lancet,* 369 (9580), 2140-2141.

Johnson, K., Scott, J., Rughita, B., Kisielewski, M., Asha, J., Ong, R. and Lawry, L. (2010). Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo. *The Journal of the American Medical Association,* 304 (5), 553-562.

Liebling-Kalifani, H. (2010). 'Research and Intervention with Women War Survivors in Uganda: Resilience and Suffering as the Consequences of War,' in *Global Perspectives on War, Gender and Health: The Sociology and Anthropology of Suffering,* Bradby., H. and Lewando-Hundt., G. (Eds.). Surrey: Ashgate Books, 69-90.

Liebling. H. and Baker, B. (2010). *Justice and Health Provision for Survivors of Sexual Violence: a case study of Kitgum, northern Uganda.* Germany: LAP Lambert Academic Publishing AG and Co.

Liebling-Kalifani, H. and Baker, B. (2010). Women War Survivors of Sexual Violence in Liberia: Inequalities in Health, Resilience and Justice. *The Journal of International Social Research: Woman Studies Special Issue,* 3 (13), 188-199.

Liebling-Kalifani, H., Ojiambo-Ochieng, R., Marshall, A., Were-Oguttu, J., Musisi, S. and Kinyanda, E. (2008). Violence against Women in Northern Uganda: The Neglected Health Consequences of War. *Journal of International Women's Studies,* 9 (3), 174-192.

Longombe, A.O., Claude, K.M. and Ruminjo, J. (2008). Fistula and Traumatic Genital Injury from Sexual Violence in a Conflict Setting in Eastern Congo: Case Studies. *Reproductive Health Matters,* 16 (31), 132-141.

Millennium Development Goals Report (2010). *Assessing Progress in Africa toward the Millennium Development Goals.* Economic Commission for Africa, African Union, African Bank Group and United Nations Development Programme. Retrieved 24 February 2012, from http://web.undp.org/africa/mdg2010.shtml

Mountain, R. (2011). Democratic Republic of Congo: Past. Present. Future. *Forced Migration Review.* Retrieved 17th February from http://www.fmreview.org/DRCongo/mountain.htm.

Mukwege, D. and Nangini, C. (2009). Rape with Extreme Violence: The New Pathology in South Kivu, Democratic Republic of Congo. *PloS Medicine,* 6 (12), 1-5.

Pardoned, R. (2011). Democratic Republic of Congo. *African Research Bulletin: Political, Social and Cultural Series*, 48 (1), 18701C-19703A.

Parens, H., Blum, H. and Akthar, S. (Eds.) (2008). *The Unbroken Soul: Tragedy, Trauma and Human Resilience.* U.S.A.: Rowman and Littlefield Publishers.

Peterman, A., Palermo, T. and Bredenkamp, C. (2010) Estimates and Determinants of Sexual Violence against Women in the Democratic Republic of Congo. *American Journal of Public Health*, 101 (6), 1060-1067.

Slegh, H. (2011). Listening to women in the Congo: hearing being human. In Tankink, M, Vysma M. (Eds.) *Roads and Boundaries. Travel in search of reconnection.* Diemen: AMB publishers.

Slegh, H. (2010). Women's search for care in Mozambique: Different perceptions of care for Mozambican women exposed to gender-based violence. In, *Medische Anthropology* 22 (1), 109-123.

Staub, E. (2003). *The Psychology of Good and Evil. Why Children, Adults, and Groups Help and Harm Others.* Cambridge: Cambridge University Press.

The ACQUIRE Project (2005). *Traumatic Gynecologic Fistula as a Consequence of Sexual Violence in Conflict Settings: A Literature Review*. Prepared for the meeting "Traumatic Gynecologic Fistula: A Consequence of Sexual Violence in Conflict Settings," Addis Ababa, Ethiopia, September 6–8, 2005. New York: Engender Health/The Acquire Project.

United Nations High Commissioner for Human Rights, UNHCR (2011a). *Report of the Panel on Remedies and Reparations for Victims of Sexual Violence in the Democratic Republic of Congo to the High Commissioner for Human Rights*. Retrieved 8 January, 2012, from http://www.ohchr.org/Documents/Countries/ZR/DRC_Reparations_Report_en.pdf

United Nations High Commissioner for Human Rights, UNHCR (2011b). *UNHCR Country Operations Profile-Democratic Republic of Congo.* Retrieved December 10, 2011 from http://www.unhcr.org/pages/49e45c366.html

Wakabi, W. (2008). The Democratic Republic of Congo in Crisis. *The Lancet*, 372 (9655), 2011-2012.

Ward, J. and Marsh, M. (2006*). Sexual Violence against women and girls in war and its' aftermath: realities, responses and required resources*. Briefing Paper presented Symposium on Sexual Violence in Conflict and Beyond 21-23 June 2006, Brussels, Belgium. Retrieved February 1,2012,from http://www.unfpa.org/emergencies/symposium06/docs/finalbrusselsbriefingpaper.pdf

Women for Women International. (2010). *Briefing on Women's Status in DRC: July 2010. The Democratic Republic of Congo Survey: Stronger Women: Stronger Nations.*

World Bank (2011) Democratic Republic of Congo: Toward a Gender-Informed Country Strategy: A Background Paper for the FY13 CAS.

World Health Organization, WHO. (2010). *World Health Statistics 2009*, Geneva. Retrieved February 7, 2012 from http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf

## APPENDIX 1: Table of Individual Interviews with Women and Girls

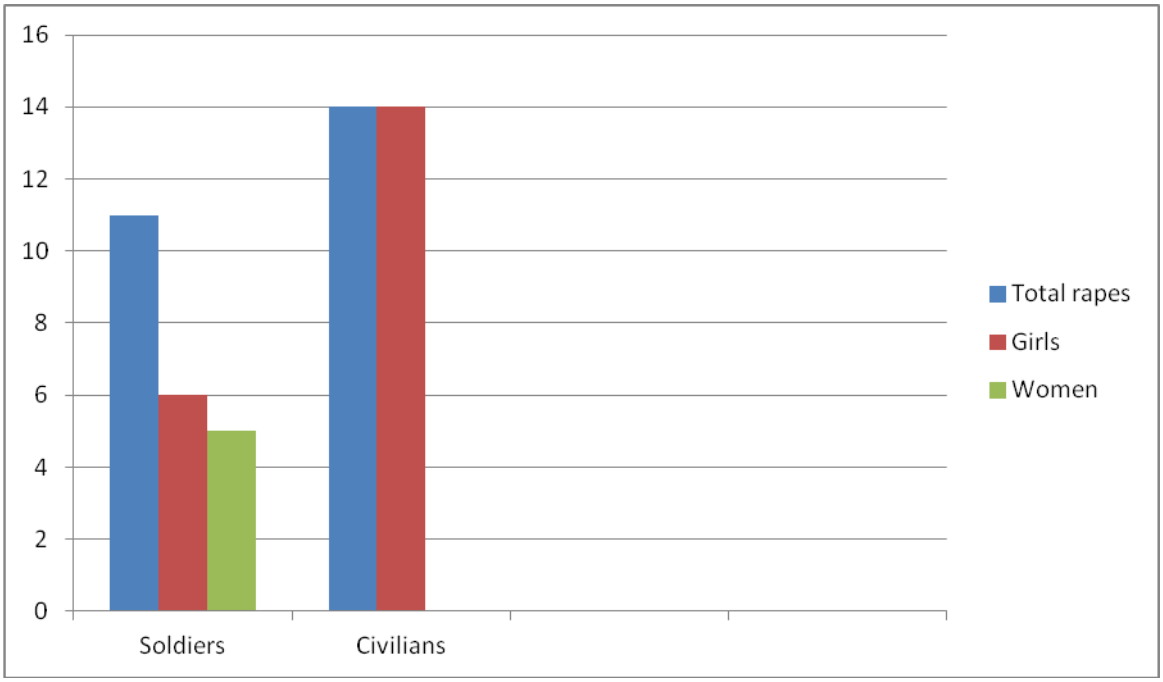
| No. | Age (age at rape) | Age of child | Raped by military | Raped by civilian | Visited HC in 72 hrs | Visited HC later | Police Report | Justice Response | Displaced/ Rejected |
|---|---|---|---|---|---|---|---|---|---|
| **1** | 18 (17) | 1 yr | | Yes | No | Yes | No | No | Yes |
| **2** | 16 (15) | 1 yr | | Yes | No | Yes | Yes-2 days in cell 300 | No | Yes |
| **3** | 17 (16) | 1 yr | | Yes | No | Yes | Yes- 2 days in cell 100 | No | Yes |
| **4** | 20(16) | P 4 | gang raped by 3 men | | No | Yes | No | No | Yes |
| **5** | 20 (16) | 4 yrs | yes | | No | Yes | No | No | Yes |
| **6** | 14 yrs (13) | 7 ms preg. | | Yes | No | No | No | No | Yes |
| **7** | 14 (13) | 1 wk | | Yes | No | Yes | Yes ABA support | No | No - support from mother |
| **8** | 16 (15) | 8 ms | gang raped by 3 men | | No | Yes | No | No | Yes |
| **9** | 15 (14) | 4 ms | | Yes | No | Yes | Yes | 3 months (Yes) | Yes |
| **10R** | 18 (16) | 2 yrs | | Yes | No | No | Yes -4 days cell | No | Yes |
| **11R** | 17 (14) | 3 yrs | | gang rape | No | Yes | No | No | Yes |
| **12R** | 17 (16) | 1 yr | | Yes | No | Yes | No | No | Yes |
| **13** | 15 (14) | 2 ms | | Yes | No | Yes | Yes | ABA support 10 yrs (yes) | Yes |
| **14** | 16 (15) | 1 ms | | no rape | N/A | Yes | Yes (not raped) | Yes (not raped) | No - support |
| **15** | 45 yrs | Baby died | gang rape/ abducted | | No | Yes | No | No | Yes |
| **16** | 20 (19) | 5 ms | gang raped by 2 men | | No | Yes | Yes | No | Yes |
| **17** | 23 (22) | 3 ms | gang raped by 3 men | | No | Yes | No | No | Yes |
| **18** | 17 (16) | 7 ms | | gang raped by 3 men | No | Yes | No | No | Yes |
| **19** | 20 (19) | 8 ms | gang rape/ abducted | | No | Yes | No | No | Yes |
| **20** | 18 (15) | 3 yrs | gang rape/ abducted | | No | Yes | Yes | No | Yes |
| **21** | 16 (15) | 1 yr | gang raped | | No | Yes | No | No | Yes |
| **22** | 17 (16) | 8 ms | | Yes | Yes | Yes | Yes | No | Yes |
| **23R** | 16 (15) | 1 yr | | Yes | No | Yes | Yes | No | Yes |
| **24R** | 15 (13) | 2 yrs | raped | | Yes | Yes | No | No | Yes |
| **25R** | 15 (14) | 1 yr | | gang raped by 2 men | Yes | Yes | No | No | Yes |
| **26** | 22 (21) | I yr | raped by 1 with gun | | No | Yes | Yes | No | Yes |
| | **TOTAL** | | **11** | **14** | **3** | **24** | **12** | **2** | **24** |

Preg = Pregnant
R = Rural area (Bweremana)
Yr = Year
Ms = Months
No rape-Father reported case against girl's will.
P = Primary School Year
ABA = American Bareaux Association (NGO supports with legal cases)
HC = Health Centre
Justice (Yes) = Prosecution was acted on

**APPENDIX 2**

**Figure 1 Number of rapes (soldiers and civilians) for girls and women interviewed individually**




Of a total of 26 individual interviews:

- 20 girls were raped
- 5 women were raped
- One girl did not perceive her experience as rape, however her father reported the boy as she was under 18 years old

The graph shows of those interviewed:

- Both girls and women were raped by soldiers
- Civilians only raped girls (18 years and younger)

**Figure 2** **Number of reports by women and girls interviewed individually to police and corresponding justice responses**