



Sexual Violence in Six African Nations

A CALL FOR INVESTMENT

RAINN

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RAINN (Rape, Abuse & Incest National Network) is the nation's largest anti-sexual violence organization. RAINN created and operates the National Sexual Assault Hotline (800.656.HOPE, online.rainn.org y rainn.org/es) in partnership with more than 1,000 local sexual assault service providers across the country. RAINN also carries out programs to prevent sexual violence, help survivors, and ensure that perpetrators are brought to justice.

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KEY TERMS AND ABBREVIATIONS

- Criminal Automated Biometric Identification System - CABIS
- Egyptian National Council for Women - NCW
- Forces of the Democratic Republic of Congo - FARDC
- Gender-Based Violence Recovery Center - GBVRC
- Great Lakes Region - Countries in the African Great Lakes region include Burundi, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Zambia, Tanzania, and Uganda.
- Human Immunodeficiency Virus - HIV
- Internally Displaced Person - IDP
- International Conference on the Great Lakes Region - ICGLR
- Justice for All Program - J4A Programme
- Lagos State DNA and Forensic Center - LSD&FC
- Liverpool Care and Treatment Center - LVCT Health
- Ministry of Health 363 - MOH 363
- National Plan of Action - NPA
- Partnership for Justice - PJ
- Post-Exposure Prophylaxis - PEP
- Physicians for Human Rights - PHR
- Police Form 3 - PF3
- Police Gender and Children's Desks - PGCD
- Post-Traumatic Stress Disorder - PTSD
- Prevention Pack Program - PPP
- Rule of Law and Anti-Corruption in Nigeria - ROLAC
- Sexual Assault Nurse Examiner - SANE
- Sexual Assault Referral Center - SARC
- Sexual and Gender-Based Violence - SGBV
- Sexually Transmitted Infection - STI
- Uganda Association of Women Lawyers - FIDA Uganda
- United Nations Development Program - UNDP
- United Nations Organization Stabilization Mission in the Democratic Republic of Congo - MONUSCO
- United Nations Population Fund - UNFPA

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FOREWORD

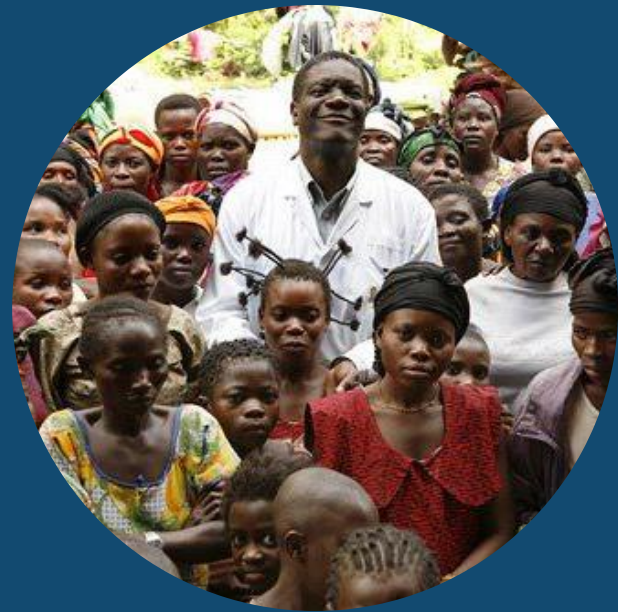
Since the dawn of time, conflict-related sexual violence has been an invisible and ignored crime, widely regarded as inevitable collateral damage of war.

For too long, indifference and inaction have prevailed, but since the adoption of United Nations Security Council Resolutions 1325 and 1820, the use of sexual violence has been recognized as a method of warfare that exacerbates situations of armed conflict and prevents the restoration of peace and security. In addition, these heinous acts may constitute a war crime, a crime against humanity, or an act constituting the crime of genocide.

This evolution is essential because to treat a problem, it must first be recognized.

Yet these advances in international law should not obscure the fact that the scourge of sexual violence—a true pandemic—continues to spread tragically across all conflicts. This strategy of war is cheaper than conventional weapons but extremely effective, since it causes enormous suffering and generates the same dramatic consequences in the short, medium and long term, and in a trans-generational way: massive displacement of populations, demographic reduction, and the destruction of the social fabric and economic capacities of the affected communities.

And unfortunately, sexual violence is not limited to areas experiencing only active conflict. In this report, you will read about the varying contexts that women and girls—as well as men and boys—experience sexual violence in Kenya, Tanzania, Egypt, Uganda, Nigeria, and the Democratic Republic of Congo (DRC), my home country, and where I founded Panzi Hospital and Foundation.



Dr. Denis Mukwege
Founder and Medical Director,
Panzi Foundation

For more than a quarter of a century, civilians in the DRC have been the daily victims of mass atrocities that defy the imagination and deeply shock the human conscience. The human and humanitarian toll of repeated conflicts is one of the highest since World War II: more than 6 million dead, more than 5 million displaced, and countless women and girls who have been subjected to rape and other forms of sexual violence.

When we founded Panzi Hospital in 1999 in Bukavu, the capital of South Kivu Province, I intended it to be a center of excellence and safe place for women in my community to deliver, in an area of the world with sky-high maternal mortality rates. I could never have imagined that my first patients would not be laboring mothers, but instead women and girls who had been raped with extreme violence. We are no longer facing a simple humanitarian crisis, but a true crisis of our humanity. Therefore, it is our common responsibility to respond to the needs of survivors that society has failed to protect in a timely manner.

This is what we have been striving to do for more than 20 years at Panzi, where cycles of violence persist to this day in the context of a volatile political and security situation that continues to deteriorate. To address the consequences of these cruel, inhumane, and degrading acts committed on the bodies of women and girls—sometimes even babies as young as six months old—and to meet the various needs of survivors, we have developed a holistic care model to provide a comprehensive care package to victims.

The "One Stop Center" model has been developed progressively over the course of our experience to respond to the different needs of our patients in one place, so that they only have to tell their story once—thus avoiding re-traumatization—and are then guided through an internal "à la carte" referral system, where they can receive personalized accompaniment centered on their needs, which includes psychological and medical care, economic and social reintegration, and free access to justice.

One of the great advantages of this model is that it provides, in addition to everything else it offers, the integration of mental health into the pre-existing primary health care system, without discrimination or stigma. Moreover, our care is not limited to the period of hospitalization but continues with the accompaniment of our patients in their home environment. Through mediation and networking, our mobile teams of the Panzi Foundation contribute to rebuilding family and community ties that have been severely tested by this barbarism and thus participate in the reconstruction of the social fabric and socio-economic integration.

Our strategy aims to turn suffering into strength, transform grief into power, and equip women to develop their capacity to become self-sufficient when they leave. Holistic care helps women regain their confidence and self-esteem. Moreover, we are pleased to note that many of our patients, after a few weeks or months of treatment, accompaniment and capacity building, become true activists, protecting not only their rights, but also those of their children and their communities, making them true leaders in their environment.

This One Stop Center model has the potential to be replicated in other areas of the world where sexual and gender-based violence is prevalent, both in regions experiencing conflict and those that are experiencing relative peace. We aspire to have this holistic care recognized as a human right to rehabilitation for all survivors of sexual violence—in DRC and around the world—and applaud RAINN's efforts to mobilize elected officials to allocate federal funds to enable the establishment of "One Stop Centers" in the DRC and in various African countries plagued by sexual violence.

It is also about mobilizing real political will on the part of the U.S. administration to address the root causes of the violence that have destabilized the heart of Africa for decades and undermine any effort toward development and sustainable peace: the illegal extraction and trade of mineral resources that keep local populations in extreme poverty, and the culture of impunity that fuels the recurrence of conflict and prevents the consolidation of the rule of law.

Finally, we urge the United States and policymakers to draw a red line against the use of sexual violence as a tactic of terror, a red line that would mean legal, political, and economic sanctions against individuals and states that commit or tolerate these heinous crimes, and we call for the adoption of a new international convention to eliminate sexual violence as a method of warfare. Together, with our American partners, we can build a world where women live free from fear and violence, and act for human dignity, justice, and peace.



Dr. Denis Mukwege

EXECUTIVE SUMMARY

Following discussions with African criminal justice professionals about issues of sexual violence in 2019, RAINN set out to conduct a study about the existence and quality of crisis response to sexual assault in six African nations. The aim of this research was to identify: (1) the availability of comprehensive post-rape care for survivors, and (2) the capacity to hold offenders accountable through DNA evidence in the Democratic Republic of the Congo (DRC), Egypt, Kenya, Nigeria, Tanzania, and Uganda. While the true rates of sexual violence are difficult to determine and assaults are often not reported, the United Nations Global Database on Violence Against Women reports that the lifetime prevalence of physical and/or sexual violence against women in these six countries ranges from 17.4 percent in Nigeria to a high of 51 percent in the DRC. In evaluating the current state of crisis response to sexual assault, we also set out to identify the ways in which additional funding could expand access to post-rape care and increase the use of DNA to identify and convict offenders. Our research revealed five key points:

1. There is a scarcity of reliable, easily accessible data and information on sexual and gender-based violence.
 - In the 2015-2020 National Strategy For Combating Violence Against Women, Egypt’s National Council for Women emphasized the lack of information and data on violence against women as an impediment to all agencies seeking to eradicate such violence in the country.
 - The most recent study on the prevalence of sexual violence in the DRC was published in 2012.
 - Throughout the course of RAINN’s research on Tanzania, it was difficult to access data or make contact with sources on the ground.
2. Many survivors of sexual violence in these countries elect not to report their assault or abuse due to fear of ostracization or stigmatization from their family and community.
 - In the DRC, research showed that more than a third of survivors of sexual violence studied were rejected by their families and communities after disclosure.
 - Rates of sexual violence are dramatically underreported in Nigeria, where victims and their families choose not to report to authorities out of fear of stigmatization, police extortion, and a lack of trust in the judicial process. Often, when survivors do report, they and their families are pressured into withdrawing their cases and accepting financial settlements to preserve “family respect.”

-
- A climate of impunity for sexual violence in Egypt has resulted in more than 90 percent of women saying they have been sexually harassed in their lifetimes and an estimated 20,000 cases of rape reported each year. Though civil society organizations have pushed for reforms to make reporting more accessible to survivors, shame and fear of retaliation prevent many survivors from ever coming forward. Further, survivors and witnesses are often targeted by police for “improper use of social media,” “debauchery,” and “violating family values and principles.”

3. Survivors of sexual violence in these nations have difficulty accessing post-exposure prophylaxis (PEP) treatment for HIV after an assault, either because they do not present within 72 hours—after which point the medication would be ineffective—or other unknown reasons.

- At Kenya’s Coast Provincial General Hospital Gender Based Violence Recovery Centre, only 48 percent of survivors who tested negative for HIV between 2007 and 2018 received PEP.
- Between 2013 and 2017, approximately 10-12 percent of survivors who sought treatment at Panzi Hospital in Bukavu, DRC arrived within 72 hours of their assault.
- Most doctors at primary healthcare units and hospitals in Egypt do not have access to basic supplies for post-rape care, such as PEP.

4. Numerous barriers, such as healthcare costs, distance to clinics or hospitals, and the unavailability of supplies, limit or prevent survivors from accessing care.

- Implementation of post-rape care at public hospitals in Kenya is limited by the unavailability of equipment like HIV kits, speculums, and rape kits.
- Survivors in Tanzania are often unable to pay for the hospital registration fees, transportation, and medical supplies associated with accessing post-rape care.
- In Uganda, survivors in rural areas may be required to walk for hours to reach facilities equipped to provide comprehensive care.

5. Inadequate or nonexistent DNA infrastructure in these countries limits their ability to identify and hold offenders accountable for sexual assaults.

- There is no forensic DNA laboratory in the DRC.
 - Nigeria has three forensic DNA laboratories, one of which was burned during protests in the fall of 2020. The lab is currently sending samples to the U.S. for testing. However, even before the fire, the lab processed only 38 sexual assault cases between 2017 and 2019.
 - Due to technological, financial, and infrastructural challenges, DNA evidence in Uganda is rarely collected, and when it is, it often ends up lost or improperly stored.
-

Each of these countries has an unmet need for both trauma-informed care and DNA evidence collection and analysis in cases of sexual violence. In-country non-profit organizations, governments, and international NGOs are all working on the ground to find sustainable solutions to support survivors and hold offenders accountable. Additional funding to one-stop centers, hospitals, and forensic labs can assist these programs in reaching survivors, providing quality care, and using DNA evidence to identify and convict perpetrators.

INTRODUCTION

In 2019, RAINN provided multiple briefings on U.S. efforts to combat sexual violence to high-level criminal justice professionals visiting the United States from across the EMEA (Europe, Middle East, and Africa) region. Through these briefings, RAINN gained a deeper understanding of the challenges facing professionals in Africa and the Middle East to access resources to provide post-rape care. RAINN has long advocated for U.S. policies that expand access to comprehensive, trauma-informed care for survivors, in addition to holding offenders accountable through the use of DNA evidence. Right now, there is a significant shortage of sexual assault nurse examiners (SANEs) in American hospitals, with only 17-20 percent of hospitals having SANEs on staff. In some parts of the country, survivors have to travel by plane or across state lines to see a SANE for a forensic exam. RAINN works to increase access to SANEs across the U.S., especially in rural, tribal, and other underserved communities. Additionally, RAINN advocates for full funding of the Debbie Smith Act, which provides money to state and local DNA laboratories to build capacity to end the rape-kit backlog.

Throughout other parts of the world, medical institutions and governmental and nongovernmental institutions similarly recognize the dual benefits of providing survivors of sexual assault with access to trauma-informed care provided by professionals who are also qualified to collect DNA evidence. This report focuses on the availability of post-rape care and the capacity to identify and hold offenders accountable through DNA testing in six African nations: the DRC, Egypt, Kenya, Nigeria, Tanzania, and Uganda. Sexual violence can have significant, often debilitating, short- and long-term physical and mental health effects on survivors in these nations, including significant numbers of HIV infections. This problem is compounded by lack of access to post-rape care services, limited use of sexual assault kits, and minimal DNA collection and processing infrastructure. Timely access to care after a sexual assault is critical, as the efficacy of post-exposure prophylaxis (PEP) for HIV decreases over time and treatment must begin within 72 hours. However, it is difficult for many survivors in these countries, particularly those in rural communities, to reach care within that window. For instance, the majority of individuals seeking post-rape care at Panzi Hospital in the DRC must travel days to reach a hospital or clinic or seek care

months after the assault. Only 10-12 percent of survivors presenting at their hospital in Bukavu, DRC, were eligible to receive PEP. Additionally, at Heal Africa's hospital in Goma, DRC, only 49 percent of survivors of sexual violence treated in 2020 were seen within 72 hours. This was a decline from 57 percent in 2019.

While these countries may represent those with some of the highest rates of sexual violence in the region, they can also build capacity of existing programs to reach more victims sooner and improve criminal justice outcomes. Many of these countries offer “one-stop centers”—facilities that provide “survivor-centred health services alongside some combination of social, legal, police and/or shelter services” and operate in one location to avoid the retraumatization of traveling to multiple locations to obtain care. This model of care has developed in a number of countries to provide quality services for survivors of sexual violence in conflict and low-resource settings. However, access to these centers is limited, and they often operate with inadequate funding and capacity. Nigeria, a country of over 210 million people, has a total of 30 one-stop Sexual Assault Referral Centres (SARCs) in only 18 of 36 states and the capital city. Recently, the U.N. Population Fund in Egypt and Egypt's National Council for Women began to partner with universities to establish “Safe Women's Units” to treat violence against women, though providers are in need of training and greater accessibility to survivors. Tanzania's National Plan of Action to End Violence Against Women of Children calls for the expansion of one-stop centers from the 10 that currently exist to a total of 26.

DNA evidence collection, analysis, and comparison to DNA databases enables law enforcement to connect crimes and identify perpetrators and serial offenders. In South Africa, establishing a national DNA database assisted in connecting 123 sexual offenses to 22 serial rapists. However, DNA infrastructure is inadequate or nonexistent in the six countries studied. Nigeria does not have a national DNA database, and DNA evidence is often collected by a lab technician who is not trained to work with sexual assault victims. In Uganda, police rely on the Government Chemist for DNA forensic testing but, due to infrastructural problems, DNA is rarely collected and often lost or improperly stored, though the Ugandan government has undertaken efforts in recent years to address pervasive sexual violence and hold offenders accountable.

To comprehensively combat sexual violence, it is imperative to address both the well-being of survivors and the crimes of the perpetrators. Post-rape care must be readily accessible, free of charge, and trauma-informed. Additionally, the criminal justice system must have the ability to identify offenders, connect serial crimes, and obtain evidence to corroborate survivors' disclosures. While many in-country organizations are doing incredible work with the resources they have, they need additional support to build upon successes and turn these goals into realities.

KENYA

"Who am I to trust, if not my parent?
Where am I safe, if I'm not safe at
home?"

- Aisha, a 12-year-old survivor of rape by both her
neighbor and father ¹*

*Name has been changed to protect identity of the
survivor

KENYA

Percentage of women aged 20-24 who gave birth before age 18 or 15

Before 15: 4.1%
Before 18: 23.3%



Child marriage by age 18
23% (almost 1 in 4 girls)



Intimate Partner Violence

25.5% of ever-partnered women and girls aged 15-49 were subjected to intimate partner violence in the last 12 months

Number of new HIV infections
1.02 per 1,000



Total population size of women and girls age 15-49
12,638 (in thousands)



Female Genital Mutilation
11% of girls between 15 and 19 years of age

PREVALENCE OF RAPE

Kenya is home to roughly 52 million people, making it the seventh-largest country by population on the African continent. Millions of tourists visit each year to watch the Great Wildebeest Migration in the Masai Mara, to bask on the beaches of Malindi, and to experience Nairobi Fashion Week. The vibrant, rapidly growing economy is the largest and most developed in sub-Saharan Africa. The country also boasts a robust network of both private and public hospitals and clinics, many of which house Gender Based Violence Recovery Centres. However, despite these advantages, sexual assault is persistent, and obstacles remain for survivors seeking comprehensive post-rape care and justice.

Sexual violence was particularly acute after the 2017 presidential elections, where government forces, police, and organized gangs seized upon widespread protests to attack civil society organizations, civilians, and towns that were perceived to have voted for the other party's candidate: out of 65 women interviewed by Human Rights Watch (HRW) on sexual violence during the post-election period, more than half reported that they were raped by policemen or men in uniform.² One survivor, Mary Awiti, told HRW that:

“They were three men dressed in spotted green uniforms. Two had guns and one a baton. The one with the baton started touching my breast. He also touched my private parts. I tried to run away, but I fell at the door. He grabbed me and dragged me back into the house. I was terrified, I thought he would kill me. I was fighting him, but he kicked me, slapped me hard on the face, and raped me as the others were watching. My 18-year-old daughter saw what happened.”³



Another survivor, Mercy Maina, said that she became pregnant after a policeman raped her during the post-election violence in 2007-2008.⁴ Ten years later, she and her sister were both raped during the post-election violence in 2017.⁵

Though these attacks have garnered international attention, sexual violence is commonplace in the lives of Kenyan women and girls. UN Women reports that 40.7 percent of ever-partnered women in Kenya have experienced physical and/or sexual intimate partner violence in their lifetime; 25.5 percent in the past year.⁶ The 2019 Violence Against Children Survey found that, of the 15.6 percent of women surveyed who experienced childhood sexual violence, nearly two-thirds experienced multiple incidents before age 18.⁷

POST-RAPE CARE

Although there are national guidelines in Kenya for post-rape care, implementation at public hospitals is “limited by lack of staff training, poor coordination between service delivery points, lack of specific protocols for different categories of survivors as well as unavailability of basic equipment such as HIV kits, speculums and rape kits.”⁸ Healthcare providers have limited staff trained to handle survivors, particularly child survivors.⁹ These issues hinder both the quality of care for survivors and the collection of forensic evidence.

Though medical and police infrastructure exist to support survivors when they do come forward, “limited financial and human resources; lack of training on managing sexual violence; poor coordination of services; poor referral systems; costs to survivors; stigma; and lack of active follow [up]” contribute to why many survivors do not access care.¹⁰ Survivors also cited distance to care, transportation costs, and fear of reprisal from the perpetrator as reasons for not reporting or delaying reporting.¹¹

These obstacles retraumatize survivors who have often suffered severe physical injuries that leave them unable to work or care for their families and exacerbate the “profound mental trauma and anguish...feelings of hopelessness, self-hatred, fear and anxiety, sleeplessness, and suicidal thoughts” felt by many survivors in the wake of their sexual assaults.¹² This is all further reinforced by fear of rejection from their families and communities if the survivor discloses her sexual assault.

For survivors who do access post-rape care, three models exist in Kenya: healthcare centers and outpatient clinics, integrated care within hospitals, and one-stop centers.¹³ Health centers and clinics are closer to the community and can offer basic services but do not offer laboratory or specialist care.¹⁴ One-stop centers and integrated care within hospitals have the ability to provide comprehensive medical, legal, and psychological services.¹⁵



The Nairobi Women’s Hospital and Gender Violence Recovery Centres

The Gender Violence Recovery Centre (GVRC) is an example of the one-stop care model and was established in March 2001 as a non-profit, charitable trust of the Nairobi Women’s Hospital to provide free medical treatment and psychosocial support to survivors of gender-based violence.¹⁶ The GVRC, in partnership with the Danish Embassy, is working to implement programming in nine counties in Kenya.¹⁷ There are an additional six operational GVRCs in Kenya with the flagship center hosted at Kenyatta National Hospital in Nairobi and two GVRCs in Uganda.¹⁸

The GVRC treats approximately 3,000 patients per year and has provided free, comprehensive services to more than 48,000 survivors since its

opening.¹⁹ The GVRC implements a three-part protocol for managing gender-based violence, focusing on medical management, psychosocial support, and legal aid. At GVRC, medical treatment includes post-exposure prophylaxis as well as specialized care for injuries such as fistula.²⁰ Centers also provide individual and group therapy and facilitate access to support groups.²¹ Additionally, GVRC doctors have provided expert testimony in more than 400 court cases.²² From 2017-2020, the GVRC received funding through Denmark’s Kenya Country Programme to implement “Enhancing Services and Advocacy on Gender-Based Violence in Kenya.”²³ The project increased access to medical, psychological, and legal services to survivors in nine countries.²⁴

Liverpool Care and Treatment

LVCT Health is a Kenyan non-profit organization that uses research and technical resources to inform HIV and AIDS policy. Its post-rape care (PRC) program provides technical assistance to the Kenyan government on the provision of comprehensive PRC services, including the development of national guidelines on medical management of sexual violence and training manuals for healthcare providers.²⁵ They have worked directly with 19 public health facilities to incorporate the delivery of comprehensive PRC services, resulting in the treatment of 9,000 survivors.²⁶

The standard of care includes evidence collection, legal documentation, provision of HIV post-exposure prophylaxis, sexually transmitted infection (STI) prevention and treatment, counselling, preparing survivors

for the criminal justice system, and referral for additional services at the community level.²⁷

LVCT worked to develop a locally-assembled PRC kit that facilities could put together with materials already available.²⁸ However, funding is needed to train providers to use the kits and incorporate them into standard practice.²⁹ LVCT also partnered with members of the Division of Reproductive Health, the laboratory of the government chemist, and the Director of Public Prosecution’s Office to train healthcare providers at Kitui District Hospital on forensic examination, completion of the Ministry of Health 363 post-rape care form and P3 police medical examination form, and referrals between the police and health facilities.³⁰

LIMITATIONS OF PUBLIC HEALTH FACILITIES

Despite the work of LVCT and other NGOs, survivors seeking care at public health facilities still face numerous obstacles to receiving comprehensive post-rape care. While survivors are, in theory, not required to pay for services, there is an administrative fee to open their file, which many may not be prepared for.³¹ In the past, facilities have received funding for a project to cover these fees, but it has been discontinued.³² Additional funding could reinstate this project to ensure that survivors are not barred from care due to inability to pay.

The Coast Provincial General Hospital Gender Based Violence Recovery Centre (GBVRC) provides emergency clinical care to survivors of sexual violence that includes psychosocial support and community and legal assistance.³³ Between 2007 and December 2018, 6,575 survivors received services at GBVRC.³⁴

However, of survivors who tested HIV negative, only 48 percent received post-exposure prophylaxis (PEP); other prophylactic STI treatment was provided to only 52 percent.³⁵ The center also lacked adequately trained staff to provide comprehensive services 24 hours a day.³⁶

Such treatment gaps are not uncommon. A 2018 study of care provided at two hospitals in Kenya that treat high numbers of sexual violence survivors also highlighted these issues. Of 543 survivor records reviewed, 30 percent did not receive PEP; of those, 41 percent presented within the treatment window—no explanation for why the medication was not provided was documented in the medical records.³⁷ Lack of supplies was also an issue. In some cases, survivors were required to buy their own HIV test kits.³⁸ Furthermore, “lack of speculums...limited the ability of clinicians to collect quality specimens necessary for both treatment and forensic evidence.”³⁹



DNA INFRASTRUCTURE



Kenya opened three government-run forensic laboratories located in Kisumu, Nairobi, and Mombasa in 2019.⁴⁰ The labs handle more than 1,500 cases of sexual and gender-based violence annually.⁴¹ Despite government backing and state-of-the-art equipment, these labs have struggled, particularly during the COVID-19 pandemic, to obtain reagents necessary for testing, which cannot be sourced locally and are usually obtained from the U.S. or U.K.⁴² Importation and servicing of DNA equipment has also been an issue.⁴³

Forensic DNA is admissible in Kenyan courts under the 2006 Sexual Offenses Act.⁴⁴ Such evidence must be properly managed, though, for it to support the state's case against a perpetrator. In Kenya, chain of custody management begins when a survivor presents at a hospital or police station and the filing of a Post Rape Care (MOH 363) or Kenya Police Medical Examination P3 Form (P3) is initiated, respectively. However, the MOH 363—the form that records a survivor's first contact with a medical professional after an attack—is woefully inadequate, and the P3 is outdated.⁴⁵ Globally, but especially in countries like Kenya where the use of forensic evidence in sexual assault cases is relatively new, these shortcomings contribute to “the consistent lack of well-managed forensic evidence... [which] remains one of the major causative factors in the significantly low number of convictions. This in turn leads to the inability to rein in repeat offences which remains core to the prevention...of SGBV.”⁴⁶

In 2019, Kenya enacted amendments to its national identification law that enable the state to collect precise data including DNA, geolocation, and biometric information.⁴⁷ While implementation of the new law has been partially suspended because of its broad application, the purpose has been, in part, to support the creation and implementation of the National Sexual Offenders Register.⁴⁸

CONCLUSION

Over 40 percent of ever-partnered Kenyan women have experienced physical and/or sexual intimate partner violence in their lifetime—a quarter of them experienced it within the past year. For survivors seeking care in Kenya, there is a network of Gender Violence Recovery Centres and a network of hospitals that receive support from LVCT Health to incorporate delivery of post-rape care services. Though the will and framework exist, lack of staff training and unavailability of basic equipment such as HIV kits, speculums, and rape kits plague effective delivery of post-rape care. Additionally, while such care is supposed to be free, survivors are often expected to pay administrative fees at hospitals. Previously, facilities were eligible for funding that covered these fees for survivors, but it has since evaporated, leaving these fees to serve as an additional barrier to reporting and seeking care.

The landscape for collection and testing forensic DNA is much the same: reality does not match ambitions. Forensic DNA is admissible in Kenyan courts and the police have measures in place to document, collect, and test evidence collected during a post-rape exam. In reality, outdated documentation and mishandling of forensic evidence contribute to low conviction rates and an inability to capture repeat offenders. Additionally, importation of reagents for testing from the U.S. and U.K. is difficult, as is arranging for servicing of the equipment. These challenges will only be overcome with additional funding to support training for medical staff and law enforcement, expansion and reinforcement of Kenya's forensic DNA capacity, and grants and material to ensure survivors receive care without cost.



TANZANIA

"Girls are very innocent and dependent. . .
And the men will threaten them and say, 'If
you don't do it, I will throw you out of the
house.'"

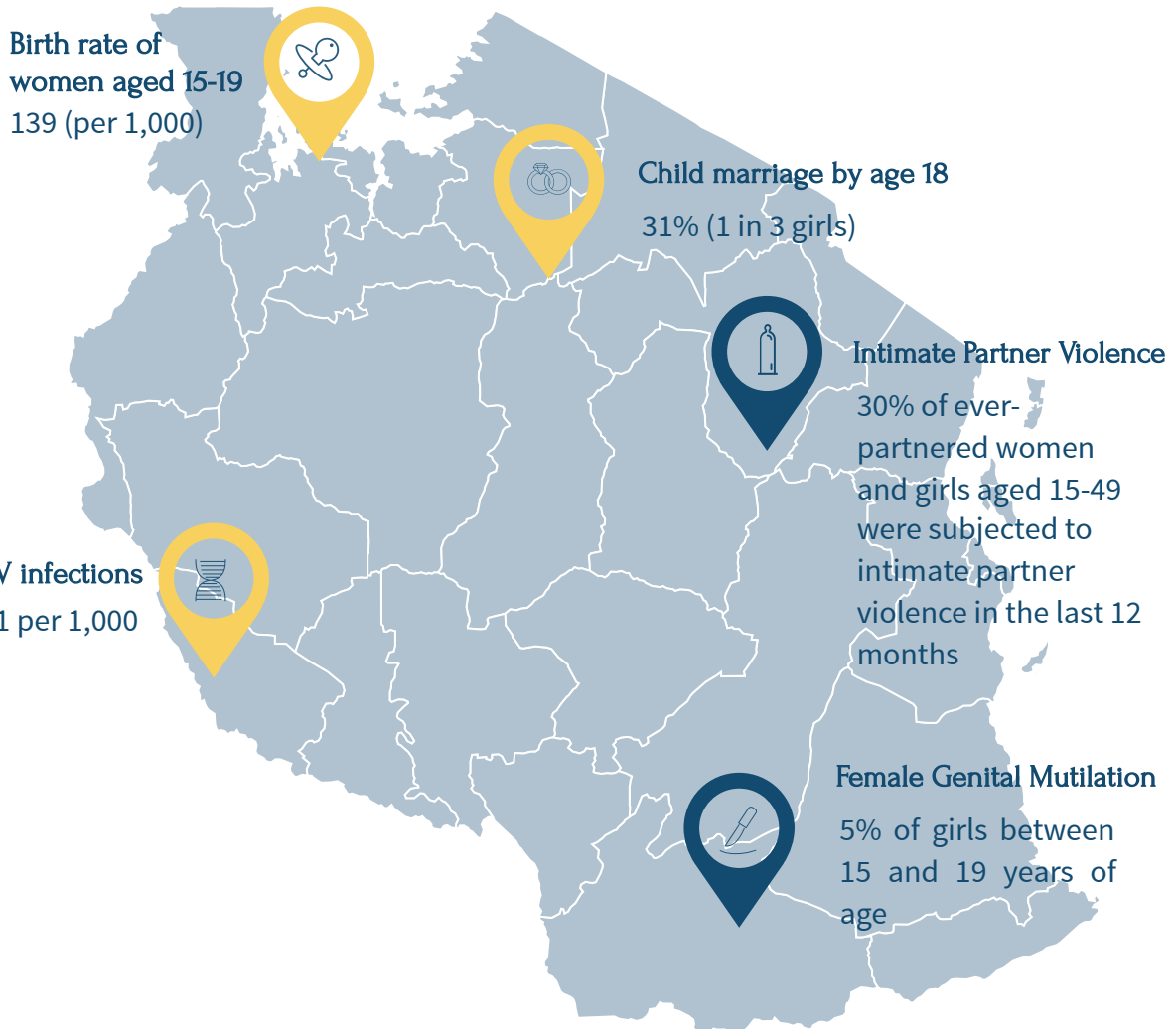
- Mzuri Issa,

*Director of the Zanzibar chapter of Tanzania Media Women's
Association (TAMWA)¹*

TANZANIA

For most Americans, the sweeping landscapes and biodiversity of Tanzania are the images conjured when they think of the African continent. Tanzania is home to the beautiful Serengeti National Wildlife Park and Mt. Kilimanjaro, both of which bring hundreds of thousands of tourists to the country each year. The mainland is roughly the size of the entire southeastern United States—making it the largest and most populous country in East Africa. To the east is the Zanzibar archipelago, where Swahili, Arab, and Indian influences converge in Stone Town, a medieval-period port on the

Swahili Coast that operated as a major hub in early global trade. The main island’s minarets, winding cobblestone streets, and lush beaches are a paradise for foreign travelers. Despite its ranking as one of the top tourist destinations in the world, a recent economic downturn has pushed more than 600,000 residents below the poverty line and has made it a top destination for child sex tourism.² Economic instability increases vulnerability for women and children and, for many, “violence is now a daily reality.”³



DATA FROM: United Nations Population Fund Tanzania Dashboard
<https://www.unfpa.org/data/TZ>

One in every five women in Tanzania will experience sexual violence in her lifetime.

Fewer than half will ever seek help.

As is the case in the other countries studied in this report, survivors of sexual violence in Tanzania face a panoply of challenges to receiving care and achieving justice. The reasons include the inability to pay for hospital registration fees, transportation, and medical supplies; under-resourced police and judiciaries; fear of blame from the community; and fear—on the behalf of the survivor and of the medical professionals caring for them—of retaliation from the perpetrator.⁸



POST-RAPE CARE

Tanzania's National Plan of Action calls for an expansion in the number of one-stop centers for post-rape care from ten existing facilities to a total of 26 total facilities on the mainland and Zanzibar.⁹ One-stop centers collect forensic evidence and provide medical treatment, psychosocial guidance, counseling, and legal assistance to survivors of violence free of charge. The first one-stop center was established in 2011 at Mnazi Moja Hospital in Zanzibar.¹⁰ Another four centers were established in 2016 in Dar es Salaam (Amana Hospital), Shinyanga (Regional Referral hospital), Mwanza (SekouToure Hospital), and Iringa (Regional Referral hospital).¹¹ In February 2019, UNFPA Tanzania, through its implementing partner-Children's Dignity Forum in partnership with the Ministry of Health, Community Development, Gender, Elderly and Children opened a one-stop center at Mwananyamala Hospital in Dar es Salaam.¹² It is estimated that the cost of fully implementing the National Plan of Action will be 267.4 billion Tanzanian shilling (approximately \$115 million USD) to be spent over a period of five years and will be financed by the government, private sector, international organizations, and development partners.¹³

Children and Gender Desks

Because sexual violence is seen as a private or women's issue—if it is even considered a crime—very few survivors report their experiences to the police.¹⁴ In an effort to encourage reporting, the Tanzanian Police Force established Police Gender

and Children's Desks (PGCD) throughout the country following recommendations by the Tanzanian Police Female Network.¹⁵ This was in response to criticisms of the existing methods of reporting where survivors were required to go to the main office of a police station and state their business in front of other police, complainants, and individuals in police custody. Survivors were often met with disbelief, apathy, negligence, and even violence at the hands of male officers.¹⁶ There was no privacy, and the threat of reprisal from the perpetrator or his family for naming him as the assailant was real.¹⁷



The PGCDs were established so that survivors could receive services specific to their trauma in a private setting.¹⁸ As of 2016, there were more than 400 PGCDs in the country's police stations, including seven in Zanzibar. Additionally, over 2,700 PGCD officers, lawyers, and social workers had been trained, and convictions increased as a result.¹⁹ Despite these successes, chronic underfunding remains an impediment for PGCDs trying to meet the standard of being housed in a private, separate area from the main station, resulting in survivors remaining reluctant to report due to privacy concerns.²⁰ All incidences of sexual violence are first reported at the nearest PGCD. A survivor who wishes to pursue a criminal case must first describe and document the incident at the police station. Then, she will be issued a Police Form 3 (PF3) at the station. The PF3 must then be taken by the survivor to a public hospital, as only doctors in government-supported health facilities are authorized to complete it.²¹ The doctor will record any evidence of physical trauma on the victim to be used in both the investigation and court proceedings. Once completed, the PF3 is used as the basis of the criminal case. A survivor must have a PF3 to receive treatment at a public hospital for non-life-threatening injuries.²² If a survivor is afraid to go to the police or does not wish to pursue criminal charges, she can receive medical care without the PF3 at a private clinic. Unfortunately, average Tanzanians cannot afford to pay out of pocket for private care. This leaves many survivors without meaningful choice: without money to pay out of pocket, a survivor must report to police to receive medical care. For survivors who do not want to report to police, the PF3 is an impediment to receiving necessary care in the aftermath of a sexual assault.

DNA INFRASTRUCTURE

The government of Tanzania has expressed its commitment towards application of forensic science techniques in the identification and deterrence of crimes in both policy statements and legislation.²⁰ However, all forensic evidence must be delivered to either the Government Chemist Laboratory or the forensic laboratory under the Police Force in Dar es Salaam.²³ In Zanzibar, the United Nations Development Programme and the President's Office of Constitution, Legal Affairs, Public Service, and Good Governance engaged in the five-year Support to Zanzibar Legal Sector Reform Program that sought to support comprehensive legal sector reform, including the establishment of forensic DNA analysis capabilities on Zanzibar.²⁴ While the program was a success by many measures there is still no active forensic laboratory on Zanzibar, and samples from survivors must be sent to the mainland, which results in expensive, lengthy delays in criminal cases.

CONCLUSION

One in every five women in Tanzania will experience sexual violence in her lifetime. Fewer than half will ever seek help. PGCDs were established to address under-reporting, but privacy concerns remain for survivors who fear retribution from their communities. For those who do pursue care or attempt to report, a labyrinth of government regulations exist, requiring survivors without life-threatening injuries to first report to police, then receive a form, which they must then take to a hospital, where they will likely be charged an administrative fee for opening a file. In the event that the medical professional working with the survivor does collect forensic DNA evidence, the likelihood of it being tested is very low: evidence must be delivered to one of only two government-run labs in the country of more than 58 million people. Despite these constraints, Tanzania has made strides toward supporting survivors.

There are currently 10 one-stop Centers in the country that collect forensic evidence and provide medical treatment, psychosocial guidance, counseling, and legal assistance to survivors of violence free of charge. The government has also made a commitment to expand that number under its National Plan of Action to End Violence Against Women and Children over the next five years at a cost of \$115 million USD. Though the Tanzanian government is eager to protect survivors and hold offenders accountable, expanding one-stop Centers and establishing comprehensive collection and analysis procedures for forensic DNA is only possible with funding and coordination from governments and international donors.



DEMOCRATIC REPUBLIC OF THE CONGO

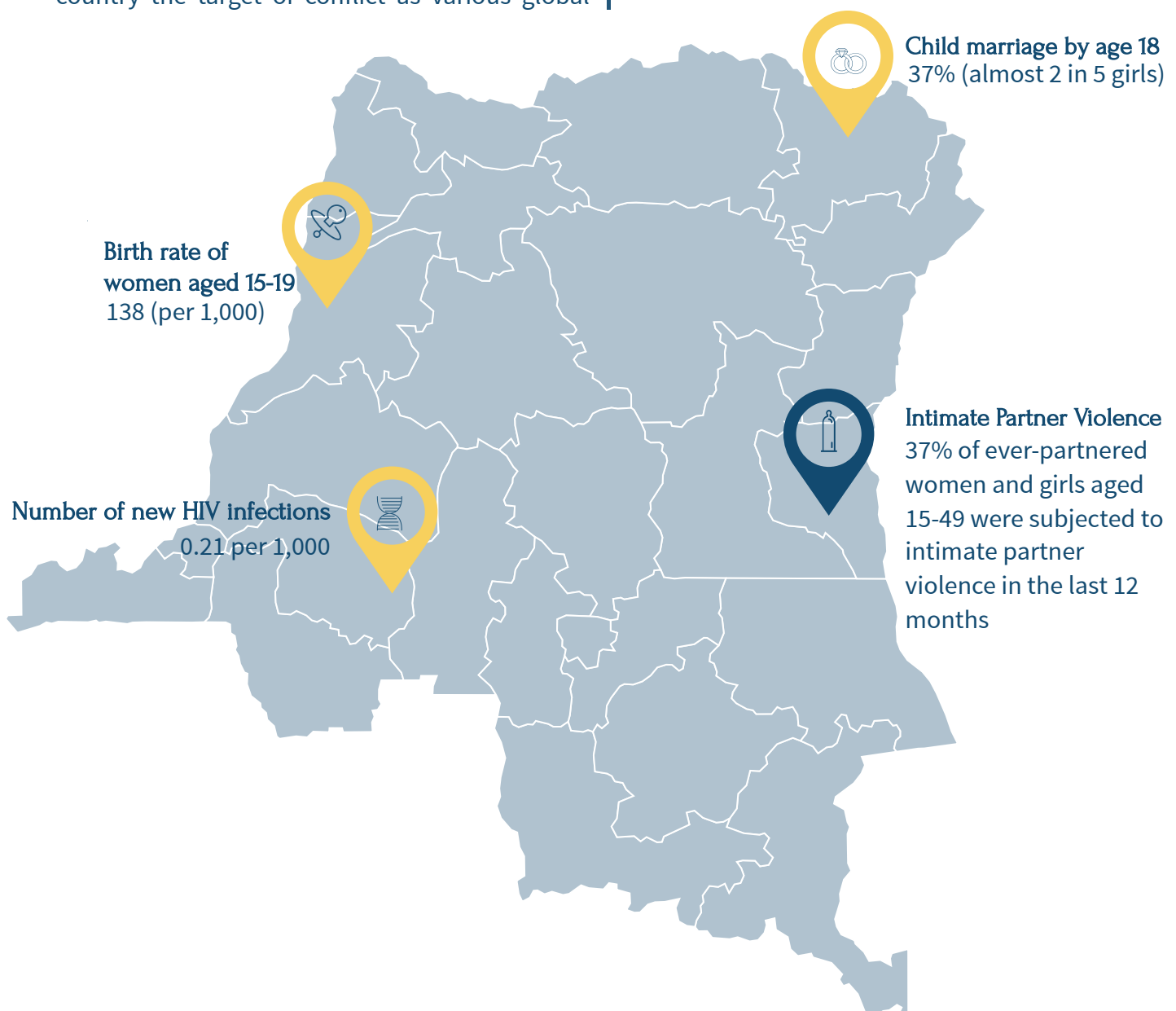
“When you talk about rape in New York or Paris, everyone can always say, 'Yes, we have rape here too,' but it's not the same thing when a woman is raped by four or five people at the same time, when a woman is raped in front of her husband and children, when a woman is not just raped but then after the rape her genitals are attacked with a gun, a stick, a torch, or a bayonet. That's not what you see in New York. That's not what you see in Paris.”¹

– Dr. Denis Mukwege, Co-Founder, Panzi Hospital, DRC, on the nature of conflict-related sexual violence in the DRC.

DEMOCRATIC REPUBLIC OF THE CONGO

The Democratic Republic of the Congo is the 12th largest country in the world with almost ninety million inhabitants. Its land mass, by comparison, would cover two-thirds of Europe. It is a country rich in minerals, diamonds and gold. This wealth of minerals—in high demand worldwide, including the United States, for use in devices like smartphones—has made the country the target of conflict as various global

and domestic interests vie for control over these "conflict minerals." Women and children have suffered the worst as a result. Rape is widespread and often used as a method by militia, security forces and armies to terrorize localities in an effort to control mining areas. In DRC, rape is more than just a crime or cultural issue, it is a method of war.



DATA FROM: United Nations Population Fund DRC Dashboard
<https://www.unfpa.org/data/fgm/CD>

Rape is more than just a crime or cultural issue—it is a method of war.

In December 2018, after the elections, North Kivu, South Kivu, Maniema and Ituri Provinces in eastern DRC were affected by heightened instability.² In 2019, The United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) recorded 1,409 incidents of sexual violence related to armed conflict, indicating an increase of about 34 percent from 2018.³ Of these, 955 cases were perpetrated by non-state actors. Of the state actors, the Armed Forces of the Democratic Republic of Congo (FARDC) were found to have been involved in 383 of these cases, representing a 76 percent increase compared to the previous year.⁴ The National Police of the DRC were responsible for 62 of the cases and the remaining nine cases were attributed to other state actors.⁵ Instability increased in eastern DRC in 2020, with conflict-related sexual violence remaining widespread in North Kivu, South Kivu, Ituri and Tanganyika as militants continued to use sexual violence to further their attempts to take control of natural resources in North Kivu.⁶ MONUSCO documented 1,053 cases of sexual violence, with 177 dating back to earlier years.⁷ Seven hundred were attributed to non-State armed groups; 239 to FARDC, 76 to DRC police, and 38 to other state actors.⁸

Of note, MONUSCO only reports cases that have been 100 percent verified.⁹ True prevalence rates of rape are difficult to measure. UN Women reports that 51 percent of ever-partnered women have experienced physical and/or sexual intimate partner violence in their lifetime, with 37 percent experiencing such violence within the past 12 months.¹⁰

One of the most comprehensive studies in DRC concluded that approximately 1.69 to 1.80 million women reported having been raped in their lifetimes (with 407,397–433,785 women reporting having been raped in the preceding 12 months), and approximately 3.07 to 3.37 million women reported experiencing intimate partner sexual violence.¹¹ Given the number of women that are experiencing intimate partner sexual violence, not just sexual violence in the context of armed conflict, the study's authors recommended “...that future policies and programs should focus on abuse within families and eliminate the acceptance of and impunity surrounding sexual violence nationwide while also maintaining and enhancing efforts to stop militias from perpetrating rape.”¹²

Looking past just the existence of armed conflict, it is important to recognize that attitudes about rape may add obstacles for women to report or receive the care they need post-rape.

Challenges exist in studying and accurately measuring prevalence rates of rape throughout DRC. “Many women and girls living in areas still under armed control are fearful of reprisals if they attempt to report or seek medical care for rape.”¹³ Many survivors also refrain from reporting sexual violence due to fears of social stigmatization; as a result, “rates of non-reporting of the event at the time of seeking medical care are as high as 75 percent and may be higher in conflict settings.”¹⁴ “For the tens of thousands rape victims that seek help, there are many more that remain unregistered because of the inability for victims to reach health centres, shame, fear for repercussions and fear for being stigmatized by the victim’s own community.”¹⁵

Unfortunately, even those who are working in DRC to provide much-needed aid in armed conflict zones and medical relief efforts are also perpetrating acts of sexual violence against women and children. Multiple investigations into conduct by aid workers during the 2018-2020 Ebola crisis documented at least 73 women who reported sexual abuse by aid workers, including those from the World Health Organization, World Vision, UNICEF, the DRC ministry of health, and other groups.¹⁶



Attitudes

Consistent with studies that have documented many westernized attitudes surrounding rape, in 2012, Sonke Gender Justice, Promundo-US, and the Institute for Mental Health of Goma implemented the International Men and Gender Equality Survey (IMAGES) in Goma, North Kivu, DRC. The results were startling but not unrecognizable from many of the same attitudes seen about rape in Western countries.¹⁷

SURVEY RESULTS	% who agree
A woman who is raped has provoked this by her own attitude	31.7
Sometimes, women want to be raped	27.9
A man can force a woman to have sex and she may enjoy it	27.3
When a woman does not show physical resistance when she is forced to have sex, you cannot speak of rape	42.7
A man should reject his wife when she has been raped	43.4
A woman who does not dress decently is asking to be raped	74.8
Women deserve sometimes to be beaten	61.4
Women should accept partner violence to keep the family together	64.9



48% of men report ever carrying out any form of GBV against a female partner



53% of women report having ever experienced GBV from a male partner



37% of men surveyed reported having raped a woman

“When a girl is asking for water in such a way, she wants sex. So I took her in the middle of my shop, I think she liked it, because her body accepted me to enter.”

- 58-year-old man relating account of an 18-year-old woman entering his shop to ask for water



Survivors of all types of sexual violence in DRC must have access to both immediate medical care as well as ongoing holistic services. In eastern DRC, armed conflict has led to the destruction of many health centers and resources making it extremely difficult for survivors to access healthcare, particularly in rural areas.¹⁸ This is particularly concerning because a survivor must receive HIV prophylaxis (PEP) within 72 hours. Additionally, while DNA testing in sexual assaults is rare in DRC, to build capacity in this area, survivors must be seen as soon as possible for evidence collection, ideally within five days.¹⁹

ACCESS TO POST-RAPE CARE

Sexual violence in DRC has a significant impact on both the short- and long-term physical and mental well-being of survivors and their ability to function and thrive in their communities. In the immediate aftermath of a rape, survivors are at risk for pregnancy, sexually-transmitted infections, including HIV/AIDS, and may require medical treatment for injuries, particularly gynecological trauma. Conflict-related sexual violence in DRC is often characterized by “extreme forms of violence, such as gang rape, genital mutilation, torture...the intentional transmission of sexually transmitted diseases . . . and

penetration with foreign objects such as guns, knives, and sticks...”²⁰ Long-term, many survivors suffer from “PTSD, anxiety, depression, sexual dysfunction, poor reproductive outcomes, social isolation and stigmatization, the breakdown of community and family relationships, and economic hardship.”²¹ Studies have shown that “survivors experience their lives as oppressive and difficult,” and “more than a third are rejected by their families and communities.”²²

Panzi Hospital

The Panzi Hospital, located in Bukavu, South Kivu Province, DRC, specializes in providing post-rape care to survivors, particularly those requiring treatment for conflict-related gynecological trauma.²³ Founded in 1999 by Dr. Dennis Mukwege, the hospital has treated more than 68,000 survivors of sexual violence since it opened its doors.²⁴ Dr. Mukwege received the Nobel Prize in 2018 for his work at Panzi.²⁵ The hospital treats survivors, regardless of their ability to pay, using a four-pillar, holistic care model: medical treatment, psychosocial support, socioeconomic reintegration, and legal services.²⁶ The model is designed to avoid the retraumatization of survivors by ensuring they do not need to travel to multiple locations to receive holistic care.²⁷ In addition to the main hospital in Bukavu, Panzi operates three one-stop centers in Bulenga, Malamba, and Kinshasa, and hopes to replicate this model throughout DRC.²⁸

Due to limited resources in some areas, the services at Panzi cannot be exactly reproduced. However, the hospital has developed a reduced and adapted one-stop center model to bring services to these communities.²⁹ Additionally, through its rapid-response missions and mobile clinics, Panzi is able to deploy teams of medical staff, psychosocial assistants, and legal advocates to provide holistic care to survivors of sexual violence and mass rape in more remote areas of DRC.³⁰ The hospital aims to become a global center of excellence on holistic treatment of sexual violence, where medical personnel can receive training in the repair of gynecological trauma to expand access to these life-changing procedures.³¹



Panzi has also partnered with Global Strategies, an American non-governmental organization, to distribute HIV PEP kits to rural clinics and health centers.³² The Prevention Pack Program (PPP) uses a cloud-based and GPS-enabled tracking system to distribute and monitor consumption of Prevention Packs at Panzi Hospital and 12 rural clinics in South Kivu Province that refer survivors to Panzi.³³ Each pack includes a 30-day supply of PEP medication, antibiotics to treat sexually transmitted infections, and emergency contraception.³⁴ Between 2013 and 2017, 8,206 patients presented for care following rape at all 13 sites; 1414 (17.2 percent) at the 12 rural locations and 6792 (82.8 percent) at Panzi.³⁵ Of those who presented at the rural locations, 85.6 percent did so within 72 hours of the rape.³⁶

However, timely access to care for survivors who come to the hospital for treatment is an issue: only about 10 percent of these patients arrive at Panzi Hospital within 72 hours of assault, the window for which PEP is effective.³⁷ The vast majority travel for days to get to the hospital, or come months after an assault takes place.³⁸ Of those who do arrive, overcrowding presents yet another obstacle to receiving post-rape care. In its current state, Panzi Hospital is treating 200 survivors in a space designed for 100 beds.³⁹

Though a master plan for renovations was commissioned by the Luxembourg Red Cross in partnership with the Panzi Team, lack of technical infrastructure and insufficient resources restrict the hospital's ability to meet the growing need for post-rape care in the country. Increasing funding will support renovation of the hospital and development of infrastructure.⁴⁰ This will both serve patients who arrive at Panzi Hospital and allow for an increase in the number of "one-stop" Panzi centers throughout the country, thereby enabling more survivors to receive care during that critical window of time. Additionally, the PPP has shown that women presenting at rural clinics are likely to do so within 72 hours; increasing funding to expand the PPP to additional rural sites which refer to Panzi would increase access to necessary medication within the treatment window.⁴¹





HEAL Africa

HEAL Africa is a non-governmental, peace-building organization that operates a hospital in Goma, North Kivu province, and a number of community development programs in eastern DRC. The hospital, through its Heal My People program, provides medical treatment, such as HIV prophylaxis and fistula repair, as well as psychological and social support for survivors of sexual violence.⁴² In 2018, the hospital opened a new Fistula Care Center on its first floor, with capacity to expand to a total of three floors.⁴³ HEAL Africa is in need of additional funding to increase the number of beds available in the Center and

reduce the wait times for patients.⁴⁴ As seen at Panzi, many survivors seeking care at HEAL Africa arrive too late to receive PEP: in 2020, only 49 percent of survivors of sexual violence were seen within 72 hours,⁴⁵ a decline from 57 percent in 2019.⁴⁶ Additional transportation funding to bring staff into communities could increase the number of survivors seen within the treatment window. HEAL Africa Board Member Catherine Peterson noted that it is often a struggle to get people transported, as funding must often go towards more urgent needs.⁴⁷

FORENSIC CAPACITY & DNA INFRASTRUCTURE

There is no existing forensic DNA laboratory in DRC. Previously, one police-run laboratory was established in Kinshasa with funding from Europol, but could not be sustained when funding ran out.⁴⁸ While in a few cases, DNA samples taken during a forensic exam have been sent to Kenya for testing, this is rare.⁴⁹ However, building DNA capacity in DRC would assist in identifying perpetrators, particularly in cases of mass and gang-rape. While the use of DNA evidence proving sexual violence cases is extremely limited, organizations have been working to increase the use of forensic techniques which can be implemented in low-resource settings to provide evidence for prosecution. Physicians for Human Rights' (PHR) Program on Sexual Violence in Conflict Zones works to strengthen medico-legal systems by focusing on five key areas: capacity development, building networks, research, advocacy, and innovation.⁵⁰ In DRC, they've partnered with Panzi Hospital to integrate forensic medical exams.

The benefits of this program were demonstrated when, beginning in 2013, dozens of girls were raped in Kavumu over a three-year period. During that time, PHR worked with Panzi clinicians to document the injuries sustained by the victims, assisted in coordinating the investigation, and provided technical assistance to clinicians and police investigators.⁵¹ PHR's expert medical consultant, Dr. Muriel Volpellier, trained medical staff to conduct and document comprehensive medical examinations.⁵² PHR and Panzi

psychologists conducted three dozen interviews of survivors to document psychological findings.⁵³

In 2016, Frederic Batumike, a regional legislator and the alleged leader of an armed militia group, and dozens of militants, were arrested by military justice officials.⁵⁴ Ultimately, in 2017, he and 10 of his militia were convicted of crimes against humanity by rape and murder and were sentenced to life in prison.⁵⁵ This was the first time a sitting lawmaker faced trial in DRC.⁵⁶ PHR's Director of the Program on Sexual Violence in Conflict Zones, Karen Naimer, stated: "Good evidence. Good forensics. Good police and medical work. These are the kinds of practices that can bring justice, and that's why we've trained hundreds of health professionals, police, judges, and community activists in these best practices across Congo."⁵⁷



CONCLUSION

Women in the DRC face shockingly high rates of sexual violence. While hospitals like Panzi and Heal Africa can provide comprehensive post-rape care for survivors, many cannot arrive at hospitals within the critical 72-hour window. Programs established in, or that travel to, remote areas have greater success in seeing patients within that time.

Expanding the number of one-stop centers in these locations will increase the number of survivors that receive care and decrease the length of time between an assault and treatment. These centers can also play a critical role in holding perpetrators accountable. Equipping hospitals and centers with the resources, knowledge, and training necessary to effectively document and collect evidence will improve prosecution outcomes and are a building block towards establishing the use of DNA analysis to convict perpetrators and deter future offenses.



UGANDA

“Do you ever feel like you are suffocating under layers and layers of debris and your body feels numbed by the minute ... with sharp daggers constantly poking at your soul? That’s how I have felt every day for the last 12 years of my life.”

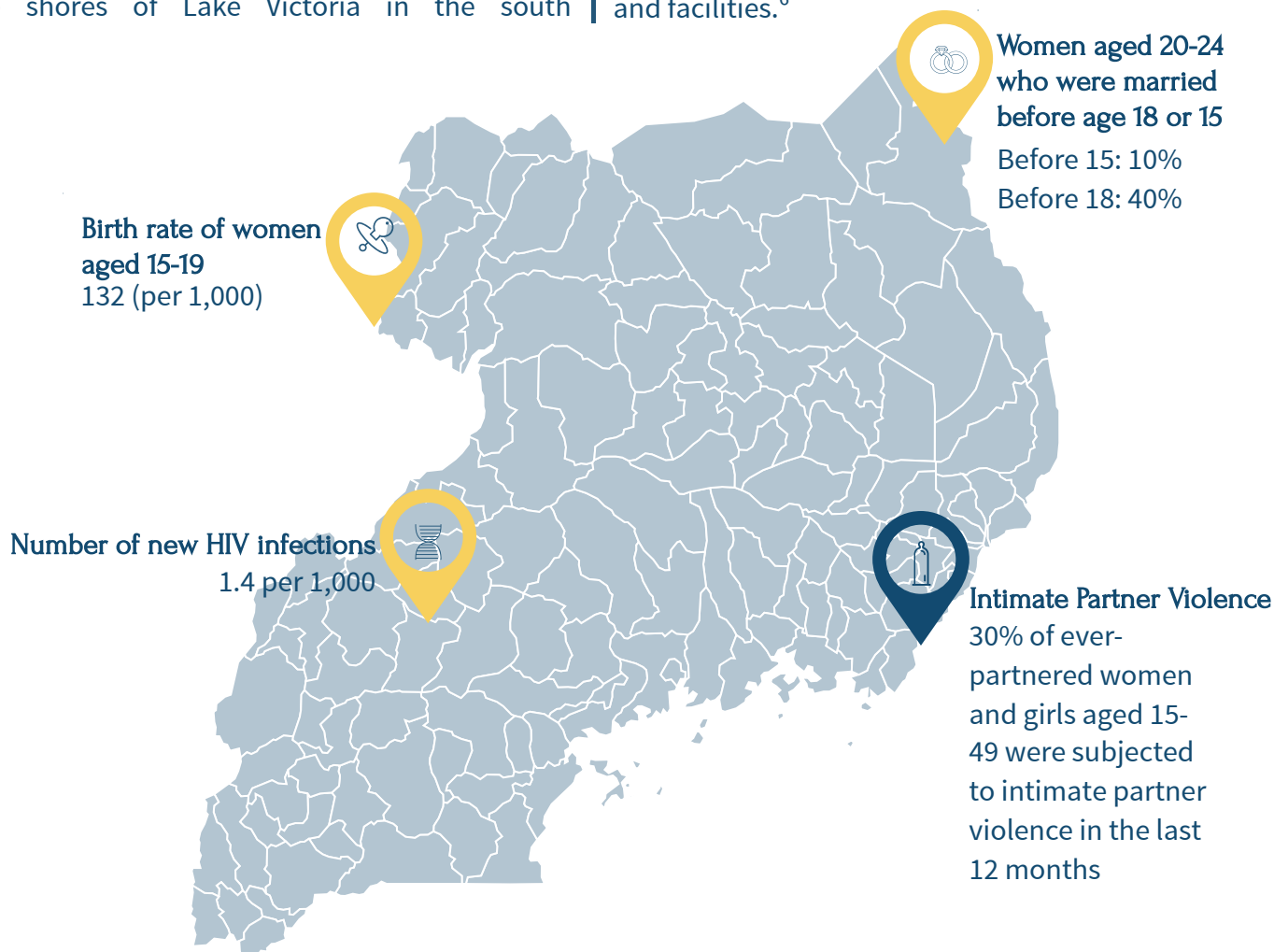
Farida - Survivor of Childhood Sexual Abuse¹*

**name changed to protect anonymity*

UGANDA

Uganda is located in East Africa on the northern shore of Lake Victoria, the continent's largest freshwater lake. Dubbed "the Pearl of Africa" by Winston Churchill, the country is well known for the Mountains of the Moon, Kasubi Tombs, Nyero Rock Paintings, and Bwindi Impenetrable Forest, where tourists can track the endangered mountain gorillas thanks to Uganda's vibrant ecotourism industry.² Only slightly smaller than the state of Oregon and home to about 45 million people, Uganda is one of the most densely populated countries in sub-Saharan Africa.³ Despite the high concentration of people near the shores of Lake Victoria in the south

and Lake Albert in the west, 75 percent of Ugandans live in rural areas far from basic infrastructure and government services: only 18 percent of the rural population has access to electricity, and 32 percent of Ugandans must travel more than 30 minutes to access safe drinking water.⁴ These urban-rural disparities translate to outcomes for survivors of sexual violence as well. Women in rural areas experience physical and sexual violence at higher rates than their urban counterparts yet have access to fewer services.⁵ The majority of the population has the minority of doctors, nurses, and facilities.⁶



DATA FROM: United Nations Population Fund Uganda Dashboard
<https://www.unfpa.org/data/world-population/UG>

PREVALENCE OF SEXUAL VIOLENCE

For a quarter of Ugandan women, their first sexual experience was rape.⁷ For Ugandan children, the statistics are largely the same: one in every three girls and one in every six boys between the ages of 18 and 24 in Uganda experienced sexual abuse before they were 18.⁸ Within the past 12 months, one in four girls and one in 10 boys between the ages of 13 and 17 experienced sexual abuse.⁹ One in three children who had been sexually abused in the

past year reported that the first time they were sexually abused occurred before they were 13 years old and that the abuse occurred multiple times.¹⁰ Most of the children who said they had been sexually abused in the past year reported that the abuse had happened multiple times.¹¹ In all cases, shame, embarrassment, and lack of knowledge deterred the majority of survivors from seeking services.¹²



POST-RAPE CARE



A survivor's first contact with a healthcare provider is often through a Village Health Team, who is responsible for basic health interventions within local communities and villages. A Village Health Team will refer a patient to a higher-level health center depending on the complexity of his or her injuries. In the case of survivors of sexual assault, the Ugandan Ministry of Health has issued guidelines that require a survivor be referred to a Health Center level IV, at a minimum, as these facilities operate as miniaturized hospitals with labs, specialty clinics, and surgical suites.¹³ However, some Health Center level III facilities offer Post-Exposure Prophylaxis (PEP), medical care, and connect survivors with psycho-social support and legal resources.¹⁴ The adoption of the

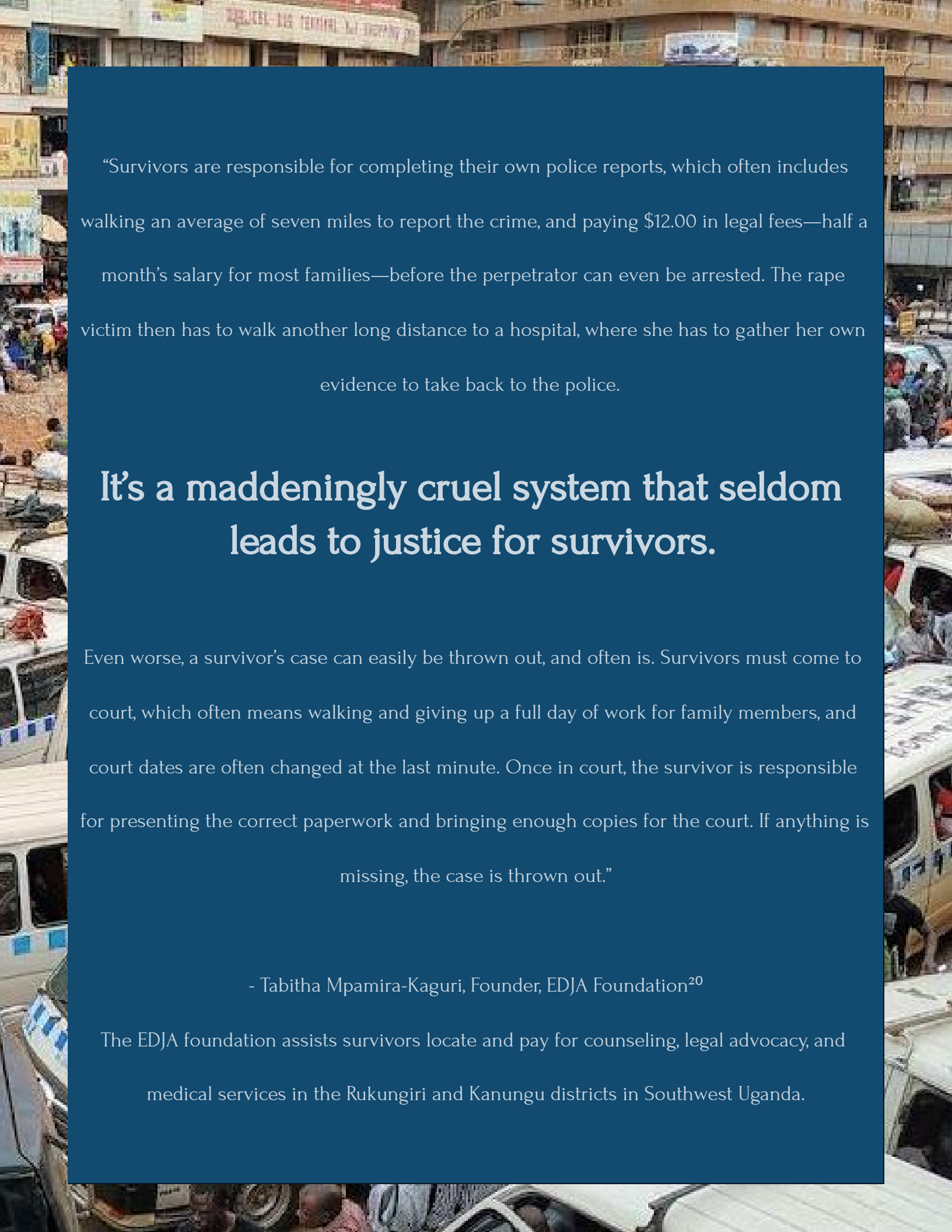
2016 Ministry of Health guidelines is a significant step by the Ugandan government to address sexual violence. Despite this commitment to more and better training, specialized facilities and equipment, and stronger responses to sexual violence, many survivors cannot access care. Health Center level IV facilities and hospitals tend to be clustered in urban centers, with the National Referral Hospitals located in Kampala, the capital, while lower-level health facilities not equipped to assist survivors are more widely distributed among rural communities.

The average time a survivor must walk to get to a health facility is an hour.¹⁵ Often, treatment limitations at the health center where a survivor first presents result in referral to a facility that can offer a higher level of care but is, on average, an additional hour away from the referring facility.¹⁶

Care delivered at government hospitals is completely free of charge. However, charging for supplies is common practice.¹⁷ Additionally, if there are out-of-stock items or if equipment is broken or otherwise unavailable, then patients and their families must purchase those goods from outside the government facility—usually from a pharmacy—before care can be rendered. Stock-outs of gloves, bandages, antibiotics, and other medications happen frequently at government hospitals around Uganda.¹⁸

Alternatively, survivors can seek care at a private facility. However, costs fall to the survivor and are often too high for the majority of Ugandans.¹⁹





“Survivors are responsible for completing their own police reports, which often includes walking an average of seven miles to report the crime, and paying \$12.00 in legal fees—half a month’s salary for most families—before the perpetrator can even be arrested. The rape victim then has to walk another long distance to a hospital, where she has to gather her own evidence to take back to the police.

It’s a maddeningly cruel system that seldom leads to justice for survivors.

Even worse, a survivor’s case can easily be thrown out, and often is. Survivors must come to court, which often means walking and giving up a full day of work for family members, and court dates are often changed at the last minute. Once in court, the survivor is responsible for presenting the correct paperwork and bringing enough copies for the court. If anything is missing, the case is thrown out.”

- Tabitha Mpamira-Kaguri, Founder, EDJA Foundation²⁰

The EDJA foundation assists survivors locate and pay for counseling, legal advocacy, and medical services in the Rukungiri and Kanungu districts in Southwest Uganda.

DNA INFRASTRUCTURE

Despite financial and infrastructural challenges, Uganda has been proactive in addressing the pervasiveness of sexual violence. Until recently, the Uganda Police had to rely solely on the Government Chemist for DNA Forensic testing.²¹ In January 2021, however, a new lab operated by the Directorate of Forensic Sciences was commissioned. Since its commissioning, the lab has received 127 cases and processed 987 samples, primarily from murder, defilement, and rape cases.²² The lab estimates that they can process 100 cases per quarter at a cost of 450 million Ugandan Shillings (\$126,602 USD).²³ This includes any case where DNA evidence has been collected.

This is only a small number of the cases reported, though. In 2020 alone, 16,144 sex-related crimes were reported, with the majority of those (14,134) being acts of defilement—sexual intercourse with a person under 18 years of age.²⁴ Another 1,519 cases of rape were reported. The conviction rates for these crimes were abysmal: 1,639 and 19 convictions, respectively. Though this can be partially explained by the delays in hearing cases due to court closures associated with the COVID-19 pandemic, the gap between reporting and conviction is also a product of a lack of evidence. Additionally, lack of funding for police training and investment in chain of custody management leads to DNA evidence not being collected or being lost or improperly managed in transit from the point of collection to the lab.²⁵ This has contributed to a significant backlog in cases, placing a strain on

criminal enforcement that cannot be attributed to COVID-19-related causes.²⁶ Expansion of existing DNA infrastructure will improve investigations, lead to more convictions, and offer justice to survivors of sexual violence in Uganda. The police lab builds upon Uganda's status as a leader in forensic DNA analysis in the region. In 2012, Uganda was chosen as the host nation for the East African Regional Referral Center of Excellence which will serve to strengthen the investigative capacity and forensic service delivery in the Great Lakes region and will host both the East African Police Chiefs Cooperation Organisation and the African Police Cooperation Organisation. In 2018, Ugandan courts, in cooperation with the Uganda Association of Women Lawyers (FIDA Uganda) and ActionAid, began holding special sessions to clear the backlog of cases of violence against women and girls.²⁷ In April 2019, "End Impunity of Sexual and Gender Based Violence" was launched in Kampala at the Regional Training Facility on Prevention and Suppression of Sexual Violence in the Great Lakes Region.²⁸ This project builds on training programs already established by the International Conference on the Great Lakes Region.²⁹ In the same year, the Uganda Police launched its Criminal Automated Biometric Identification System (CABIS).³⁰ The system was responsible for the identification of 854 habitual criminals in 2020.³¹ With the establishment of the Uganda Police commissioned the Forensic Laboratory Capabilities at Police Headquarters, Naguru, in 2021, CABIS will be deployed in tandem with the DNA capabilities system.³²

CONCLUSION

The prevalence of sexual violence in Uganda is startling, but the country has taken steps to stem the tide and hold offenders accountable. Slow implementation of the Ministry of Health guidelines is due to a lack of resources—not a lack of will. Medical staff across the country have gone beyond the mission of providing survivor-centered medical care and taken steps to educate communities about sexual violence; the government has dedicated increased resources for the collection and testing of forensic DNA; the Uganda Police have adopted survivor-centered training; Ugandan courts have worked to provide justice to survivors by holding special sessions to clear the backlog of pending sexual violence cases; and Parliament has been active in passing legislation that will ensure repeat offenders can be identified and held accountable. Despite these positive steps, chronic underfunding and lack of resources mean that the costs associated with medical care, such as life-saving medication and any out-of-stock materials, fall on the survivor and their family—intensifying the shame and stigma many survivors feel that leads to their decision not to report. In such a context, the goal of ending impunity for sexual violence cannot be fully realized until additional funding and support is secured.



NIGERIA

“No matter where you are in Nigeria, in the north or south, in the city or rural, Christian or Muslim, every woman and girl is at risk of rape. Nowhere is safe or immune to this violent crime against women.”

- Osai Ojigho

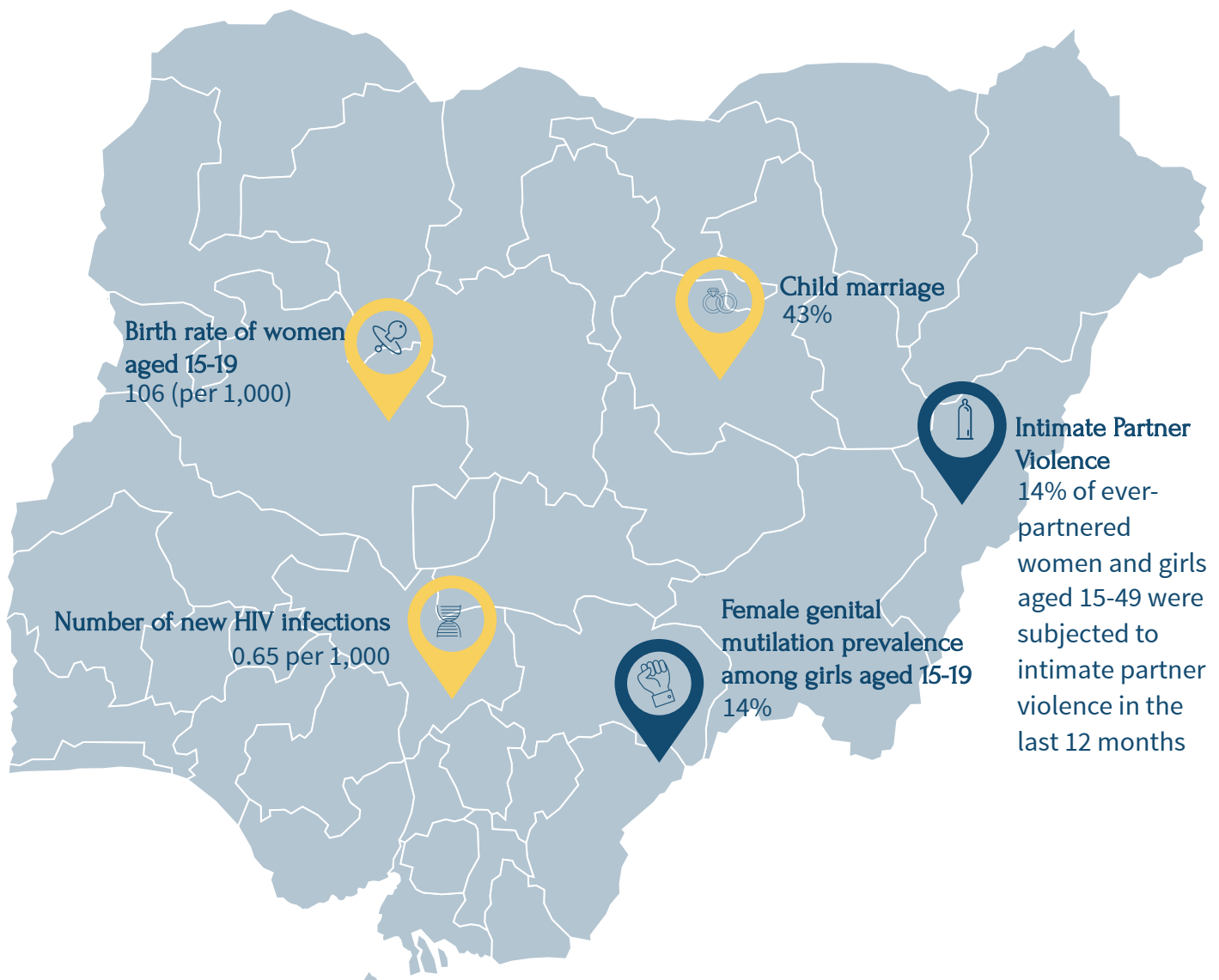
*Amnesty International*¹



NIGERIA

Nigeria, home to more than 200 million people, is the most populous African country.² At roughly twice the size of the state of California, its 36 states and capital city, Abuja, comprise a diverse population with varying cultures, religions, and systems of government.³ Approximately 46

percent of the population identifies as Christian and 53.5 percent identifies as Muslim.⁴ Islamic, or Shari'ah, penal and criminal procedure codes have been reintroduced in 12 northern states since 1999.⁵ Regardless of geography, religion, or criminal justice system, sexual violence is a problem throughout the country.



DATA FROM: United Nations Population Fund Nigeria Dashboard
<https://www.unfpa.org/data/world-population/NG>

SEXUAL VIOLENCE IN NIGERIA

Estimating the prevalence of sexual violence in Nigeria is difficult. UN Women indicates that 17.4 percent of women have experienced physical and/or sexual intimate partner violence in their lifetime.⁶ While 9 percent of ever-married Nigerian women report having experienced sexual violence in their lifetime,⁷ only 56 percent of married women say that they can say no to their husbands if they do not want to have sex.⁸ Rates of sexual violence are dramatically underreported. “Some victims and their families, fearing stigmatisation, police extortion and a lack of trust in the judicial process, choose not to report cases to the authorities.”⁹ Additionally, women living under Shari’ah law may choose not to report an assault out of fear of reprisal.

Under Shari’ah, rape is classified as “zina,” – illicit sexual intercourse.¹⁰ Therefore, a survivor must confess to a zina to report a rape; if she cannot meet the high bar to prove the case, she risks punishment for both zina and bearing false witness.¹¹ Polling in Nigeria showed that “47 [percent] of Nigerians blamed rape on indecent dressing, and fewer than half thought offenders should be punished.”¹²

Nigeria, like other countries, has seen a rise in sexual violence during the COVID-19 pandemic. Minister of Women Affairs Pauline Tallen stated in July 2020 that reported rapes surged to 3,600 during the lockdown.¹³ Official data from Lagos state indicated a 40 percent increase in domestic and sexual violence.¹⁴ However, from 2019 to 2020, only 32 perpetrators were convicted of

rape.¹⁵ “Survivors and their families are often pressured into withdrawing their cases and accepting a financial settlement to preserve so-called family respect rather than go through a protracted public investigation or trial.”¹⁶ However, the 2020 rape and murder of 22-year-old undergraduate student Uwaila Vera Omozuwa, and other horrendous incidents, have brought sexual violence to the forefront of public discourse. In May 2020, Omozuwa was found inside her church, lying half naked in a pool of blood and died a few days later.¹⁷ Her death was one of a series of attacks that have motivated women to call on authorities to address gender-based violence in Nigeria.¹⁸

The week of Omozuwa’s murder was also marked by multiple gang rapes and the disclosure of the rape of a 12-year-old girl by 11 men over a two-month period.¹⁹ In response, the government declared a nationwide state of emergency.²⁰

Nigerians took to the streets to protest, and began using the hashtags #JusticeForUwa, #SayNoToRapists, and #WeAreTired to bring attention to gender-based violence and the culture of victim-blaming.²¹ Unfortunately, the past year has also seen a series of defamation lawsuits filed against survivors who have publicly disclosed their rapes, which may discourage other survivors from coming forward.²²

SEXUAL VIOLENCE IN ARMED CONFLICT

Since 2009, armed conflict between Nigerian forces and the militant group Boko Haram has taken its toll on northeast Nigeria.²³ This conflict has put women and girls at risk for abduction, rape, exploitation, and sexual slavery, with “[n]early two-thirds of women in the northeast [having] experienced one or more forms of gender-based violence.”²⁴ “The Government’s special investigations panel on sexual and gender-based violence documented 210 cases of conflict-related sexual violence committed in 2020, including rape and forced marriage, affecting 94 girls, 86 women, and 30 boys, noting that such crimes continue to be chronically underreported owing to stigma and harmful social norms. Several governments declared a state of emergency in response to a spike in gender-based violence during lockdowns.”²⁵

In February and March of 2021, Amnesty International conducted interviews in northern Borno state regarding village raids in which militants targeted women and children for rape and sexual violence.²⁶ One witness, a traditional healer who cared for several of the women who were raped, stated, “I could see the pain on their faces. [The first survivor] told me what happened. I saw her private parts. They were very swollen. So I understood it was more than one or two people who had raped her. She was suffering.”²⁷ Amnesty International reported that no survivor they interviewed appeared to have accessed formal health services, and at least one was still suffering health complications months later.²⁸ They noted that, even within their own communities, stigma

and survivors’ fear of repercussions result in significant underreporting.²⁹ Survivors who do report do so at great risk: “She may lose her status in her community or her husband may leave her if she is a married woman. She may even lose her life. In cultures where female sexuality is a taboo like Nigeria, the victims will find it difficult if not impossible to discuss their plight with male authorities.”³⁰ As of March 30, 2021, no member of Boko Haram has been prosecuted for a crime of sexual violence.³¹

The conflict has also displaced over 2 million people in the northeast region;³² of those, 80 percent are women and girls.³³ “[T]he confinement of women and girls within IDP [Internally Displaced Person] camps make[s] them especially vulnerable to exploitation and abuse, including by those mandated to protect them, as well as by Boko Haram members who have allegedly infiltrated some camps.”³⁴ A 2016 study that surveyed 4,868 internally displaced people found that about one-third had experienced some type of sexual violence, either before or since their displacement.³⁵ A facility assessment conducted as part of the study also found that health facilities and police stations in IDP camps and host communities were lacking basic necessities needed to manage sexual violence cases and prosecute perpetrators.³⁶

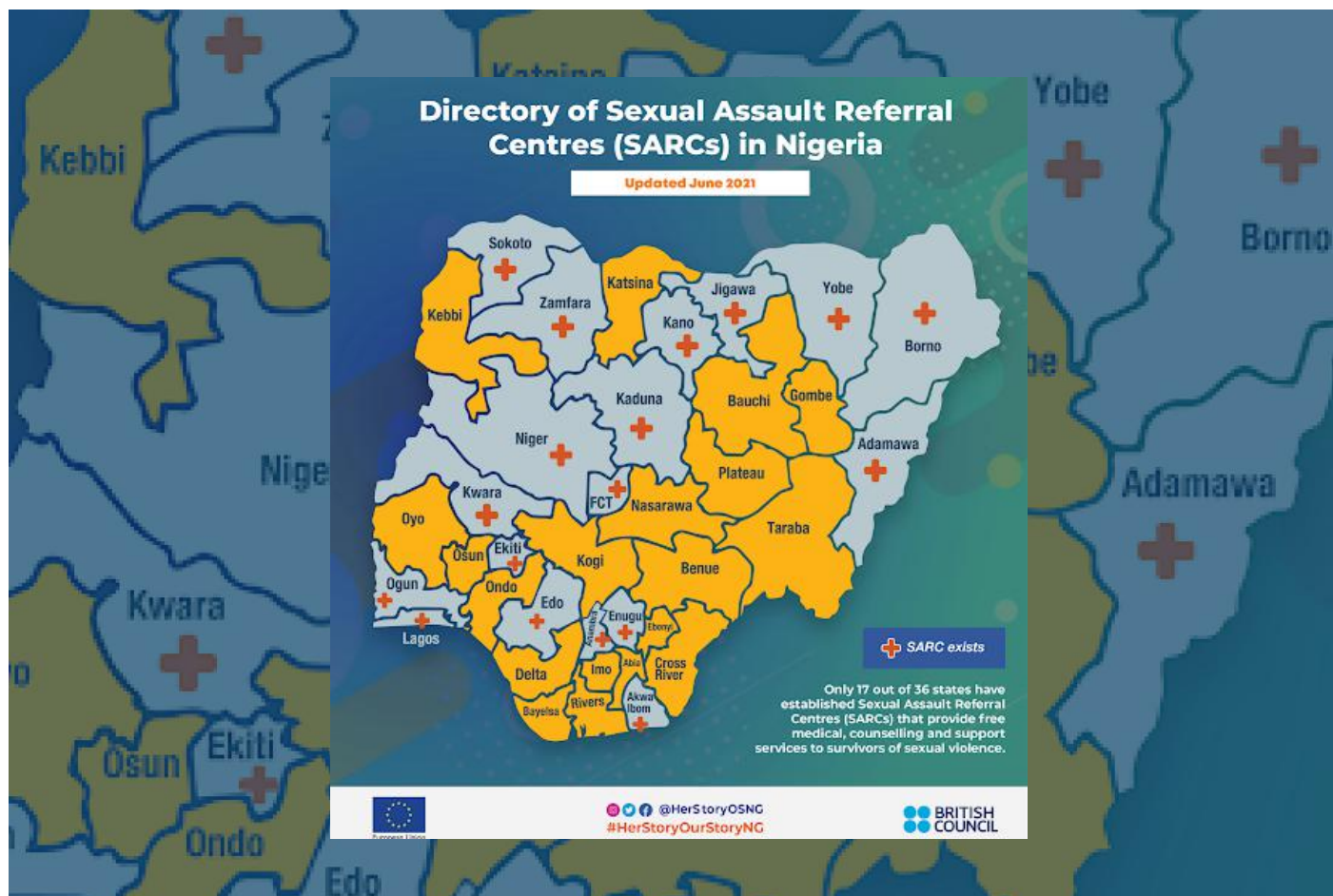
In its 2019 Annual Report on Sexual and Gender-Based Violence, North-East Nigeria, UNHCR stated,

"The population has been exposed to increasing incidences of sexually transmitted infections including HIV, unwanted pregnancies, and obstetric fistula caused by sexual violence. Overall, this has led to poor sexual and reproductive health outcomes. Sexual abuse and other violations against women and children are widespread inside and outside IDP camps, and a culture of impunity for perpetrators contributes to the continued violations."³⁷

POST-RAPE CARE

It is imperative that all survivors of sexual violence in Nigeria have access to comprehensive post-rape care. However, many survivors run into roadblocks when attempting to access care at hospitals. Survivors may be required to pay bills associated with their care, or be turned away unless they have a police report, even if a case is time-sensitive.³⁸ A 2020 study of services available to survivors at 11 units in four health facilities in Edo state concluded that all provided poor quality care due to inadequate facilities.³⁹ For example, none of the units had pre-packaged rape kits, nor did they conduct routine forensic or DNA testing.⁴⁰ The study also highlighted the lack of privacy and long wait times for survivors to receive care.⁴¹

Dr. Oluwajimi Sodipo, a physician at Lagos State University Teaching Hospital who treats sexual assault survivors, has advocated for increasing the number of Sexual Assault Referral Centres (SARCs) to improve the response to sexual violence in Nigeria.⁴² SARCs, which provide comprehensive post-rape care to survivors free of charge, have existed in Nigeria since 2013 and have treated more than 16,000 patients.⁴³ Over 6,000 of those patients were seen between March 2020 and March 2021.⁴⁴ However, there are only 30 centers to serve a population of over 200 million people, and they exist in only 18 of 36 states and Abuja.⁴⁵ The Rule of Law and Anti-Corruption in Nigeria (RoLac) project, funded by the European Union through 2022 and implemented by the British Council, has worked to establish a number of SARCs since 2017.⁴⁶



RoLAC recommends that state governments throughout Nigeria establish and fund additional SARCs to meet the need.⁴⁷ On March 31, 2021, an additional SARC, the nation's 30th, was established in Lagos with the assistance of the RoLAC program.⁴⁸

While SARCs provide medical treatment, counselling, forensic medical examinations and support in contacting law enforcement and other government services, research did not find evidence that any SARC currently collects DNA evidence.⁴⁹ This may be due to the limited availability of DNA labs. In areas where DNA labs do exist, often it is a lab technician, rather than a healthcare provider, who is obtaining samples from a survivor's body. With additional funding for training and sexual assault evidence kits, SARCs could expand their ability to collect samples for DNA analysis.

The Mirabel Centre, which opened its doors at the Lagos University Teaching Hospital on July 1, 2013, was the first Sexual Assault Referral Centre in Nigeria.⁵⁰ It was established and is managed by Partnership for Justice (PJ), a nonprofit human rights organization. The Centre provides holistic medical and psychosocial assistance to survivors of sexual violence; services include: medical treatment, forensic examination, counseling, assistance with the criminal justice system and connection to other services not offered at the Centre.⁵¹ As of December 2020, the Mirabel Centre provided services to more than 6,000 clients from all over Lagos state.⁵²

In 2020, Partnership for Justice established the first SARC in northwest Nigeria, the Nana Khadija Centre, in Sokoto state, with support from EU/UN Spotlight Initiative.⁵³ Partnership for Justice relies on donations from organizations and individuals to operate the centers. The centers are currently in need of additional funding sources.

The Mirabel Centre was established with funding from the Justice for All (J4A) Programme, through the U.K.'s Department for International Development.⁵⁴ However, that funding ended in 2016, and it has been difficult for PJ to obtain sustained funding. New funding is needed to provide continuous training for doctors and counselors, obtain new office space for staff, and purchase a staff vehicle which would be used pick up and drop off clients, provide transportation for doctors to testify in court, and implement community advocacy programs about rape and increase awareness of services provided by the center.⁵⁵

Despite the epidemic of conflict-related sexual violence in northeast Nigeria, there is only one SARC in Borno, the Nelewa (N3lewa) Centre.⁵⁶ The Centre is located in central Maiduguri, requiring survivors to travel from remote parts of Borno state, and limiting access to survivors in other nearby states.⁵⁷ Additionally, many women coming from IDP camps have difficulty making it to the Centre, and some rely on staff to pay for costs associated with traveling to and from the Centre.⁵⁸

DNA INFRASTRUCTURE

Nigeria currently has three forensic DNA laboratories, located in Lagos state, Abuja, and Adamawa state. The first lab established in Nigeria, Lagos State DNA & Forensic Center (LSD&FC), opened in 2017 and provides crime scene processing, forensic serology, and DNA analysis.⁵⁹ The lab is a public-private partnership between the state and ITSI-Biosciences, LLC, a U.S.-based company, organized under the Lagos State Ministry of Justice.⁶⁰ The lab also accepts samples from cases arising outside of Lagos state upon approval from the Center Director, if the submitting agency agrees to provide financial reimbursement for the testing.⁶¹ However, from 2017 to 2019, the lab only processed only 38 cases of sexual assault.⁶² Unfortunately, the LSD&FC was one of a number of government buildings damaged by fire during protests in October of 2020.⁵⁷ Work resumed in January and plans are underway to rebuild the center.⁶³ However, the lab is currently unable to test samples in-house and must send them to the lab in the U.S.⁶⁴

The National Biotechnology Development Agency in Abuja also operates a forensic DNA lab under its Department of Medical Biotechnology. While negotiations have been ongoing for the Agency to establish a facility to provide DNA analysis to the Nigeria Police and Armed Forces, it is unclear whether they are currently accepting samples for analysis in criminal cases.⁶⁵ Additionally, a third lab was established in 2020 at the Moddibo Adama University of Technology in Adamawa state.⁶⁶ The United Nations Population Fund and EU Spotlight Initiative supported the creation of the lab to improve prosecutions of sexual violence in the

northeast, which is marked by the highest rates of gender-based violence.⁶⁷ The state Commissioner for Health, Prof. Abdullahi Isa, stated that, “not a single case of rape has been successfully prosecuted even though the total number of cases is over 600. The establishment of this DNA forensic laboratory is, therefore, an unprecedented achievement.”⁶⁸

Expanding Nigeria’s capacity to use DNA evidence to identify perpetrators and prove criminal cases is paramount to ensuring that offenders are held accountable. In a recent study of 155 rape allegations reported to the Police in Anambra, Southeast Nigeria, only 12 were investigated and none resulted in conviction.⁶⁹ As stated previously, from 2019-2020, only 32 perpetrators were convicted of rape.⁷⁰ The low number of convictions may be in part the result of judges’ emphasis on corroboration of a victim’s testimony to find a defendant guilty.

While there is no statutory obligation or evidentiary rule requiring corroboration, in practice, a conviction will not stand without it.⁷¹ In *Iko v. State*, the Nigeria Supreme Court overturned the defendant’s conviction for rape on the grounds that the prosecution did not introduce sufficient corroboration in support of the victim’s testimony.⁷²

In *Ogunbayo v. State*, the defendant was charged and convicted of rape. On appeal, the Nigeria Supreme Court stated “that it is an established practice in criminal law, that though corroboration of the evidence of the victim in a rape case is not

essential in law, that it is in practice, always looked for and that it is also the practice for the jury or the Judge, to warn himself against the danger of acting upon an uncorroborated testimony.”⁷³ Corroboration, as defined by the Court, “must be an independent testimony, direct or circumstantial, which confirms in some material particular, not only that an offence has been committed, but that the accused person has committed it.”⁷⁴ Increasing the use of DNA evidence in rape prosecutions would provide the corroboration needed to prove these cases beyond a reasonable doubt in Nigerian courts. A 2019 study of police investigations in Nigeria recommended establishing a DNA database and at least one forensic DNA lab in each state.⁷⁵

Critical to the use of DNA in sexual assault cases is the establishment of a national DNA database,

which Nigeria currently lacks.⁷⁶ The database would allow law enforcement to identify an offender who is unknown to the victim and connect cases committed by serial offenders. However, a database requires the collection of a significant number of DNA samples that can be compared to an unidentified sample from a crime scene or victim’s sexual assault kit.

The Violence Against Persons (Prohibition) Act of 2015 (VAPP) authorizes police officers to collect DNA from those convicted of offenses penalized under the Act, such as rape, infliction of physical injury, female genital mutilation, depriving a person of his or her liberty, stalking, spousal battery, incest, and other crimes against the person.⁷⁷ However, it has only been adopted in the capital city of Abuja and 22 of 36 states.⁷⁸

CONCLUSION

One in 10 ever-married Nigerian women reports experiencing sexual violence in her lifetime. However, as high as that number is, it is misleadingly low: the best available data on the prevalence of sexual violence within the country does not account for unmarried women or girls. The way sexual violence is defined also matters—only 56 percent of married women report being able to say no to their husbands if they do not want to have sex. Despite these challenges, advocates in Nigeria have worked to ensure that survivors have access to a network of centers that offer comprehensive post-rape care. In that regard, they are fortunate, but more needs to be done. In a country of more than 200 million people, only 30 Sexual Assault Referral Centers offer comprehensive post-rape care to survivors. While other hospitals and clinics exist, their services are woefully inadequate by any standard: long wait times, lack of pre-packaged rape kits, no protocol for routine forensic or DNA collection or testing, lack of privacy, and fees that must be paid by the survivor. Even those survivors who seek medical care may not have access to justice. Nigeria has three DNA labs, but the one in Lagos State only processed 38 cases of sexual assault between its founding in 2017 and 2019. That lab only processes cases within Lagos State unless the evidence is accompanied by special approval.

The second lab was established to provide DNA analysis to the National Police and the Armed Forces, but it is unclear whether it accepts samples for other cases. The most recently established lab is in Adamawa State, in the country's northeast, which has the highest rates of gender-based violence in the country and where, of more than 600 cases, there has yet to be a successful rape prosecution.

Physicians and advocates have been calling for expansion of the number of SARCs and enhanced forensic DNA capacity in the country to address these shortcomings. Presently, the 30 existing SARCs are located in only 18 of the country's 36 states and the capital city, and a lack of funding prohibits centers from extending their reach to survivors in more rural parts of the country.

Without adequate support and funding, survivors will not have access to care or justice. Expanding the reach of SARCs and building upon existing DNA infrastructure will support survivors and end impunity for sexual violence in Nigeria.



EGYPT

“The price of being a woman here is that you are always on your guard.”

- Soraya Baghat, founder of Tahrir Bodyguard¹

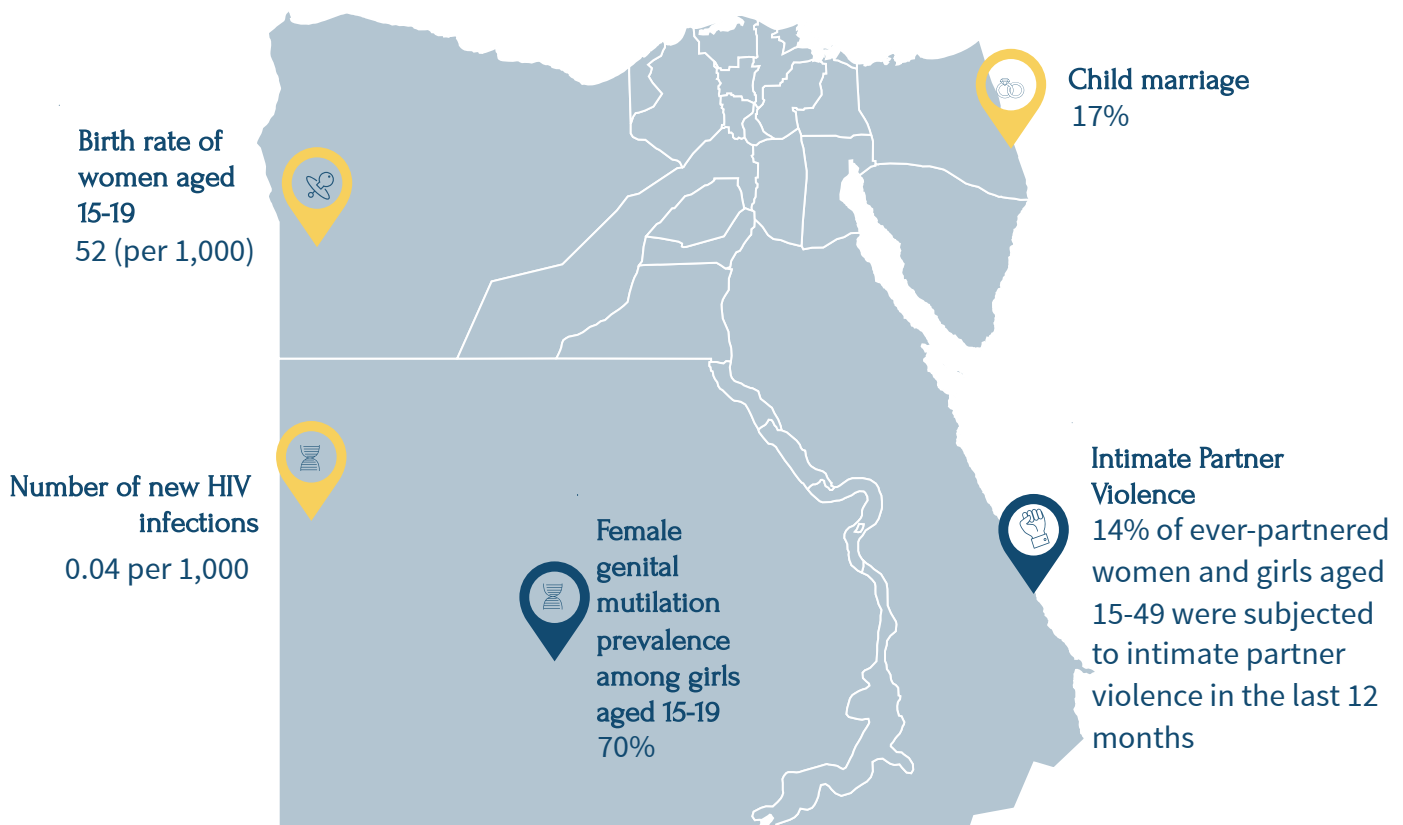


EGYPT

Egypt has one of the longest recorded histories in the world. Positioned in the northeast corner of Africa and extending to Asia via the Sinai Peninsula, the country has been a major trade hub between Asia, Europe, Africa, and the Arab world for thousands of years. Throughout this history, women have held places of respect and prestige and had legal rights that matched those of their male counterparts—they could inherit land, divorce their husbands, own and operate their own businesses, and pursue the education and training required to become doctors, scribes, or priestesses. These examples of equality should not be construed to indicate equity, though. Many customs and religious norms that shaped Egyptian society have perpetuated gender inequality in women’s private lives, even today.

These inequalities were challenged throughout the 19th and 20th centuries, with men and women pushing for reforms of institutionalized gender-norms, calling for an end to polygamy, gender segregation, veiling, and

arranged marriages. During the 1919 revolution, women played a central role in protesting colonial occupation and joined their brothers in the streets to demand independence. In 1924, Egypt was the first state to devalue women without state intervention.² When Egypt won independence in 1956, women also gained full political recognition. There is a rich culture of women’s political and legal participation in Egypt, and this makes the current situation regarding sexual harassment and sexual assault in the country even more alarming. Approximately 20,000 rapes are reported every year,³ 99.3 percent of women report being sexually harassed at some point in their lifetime,⁴ and 83 percent of women report that they do not feel safe walking down the street.⁵ In a country with such a rich heritage of women’s political participation and legal status, how do perpetrators of sexual violence and sexual harassment enjoy such impunity?



DATA FROM: United Nations Population Fund Egypt Dashboard
<https://www.unfpa.org/data/world-population/EG>

PREVALENCE OF SEXUAL VIOLENCE

Twenty-six percent of ever-partnered women between 15 and 49 years of age report experiencing intimate partner physical and/or sexual violence in their lifetime, with 14 percent reporting such violence within the previous 12 months.⁶ However, rates of sexual violence are extremely underreported. In Egypt, a pervasive victim-blaming culture surrounding sexual assault, shame, and fear of retaliation discourage victims from reporting.⁷ In the 2015-2020 National Strategy For Combating Violence Against Women, Egypt's National Council for Women emphasized the lack of information and data on violence against women as an impediment to all agencies seeking to eradicate such violence in the country.⁸

Women participating in and reporting on political protests have long been targets for sexual assault. Nihal Saad Zaghloul and three friends were attacked in June of 2012 by a large group of men in Tahrir Square.⁹ Nihal and her two female friends were attacked, groped, and men tried to tear their clothes from their bodies.¹⁰ Their male friend was severely beaten when he tried to intervene.¹¹ These protests were in response to the sentencing of former President Hosni Mubarak to life imprisonment for negligence in failing to prevent the killings of peaceful protestors during the revolution.¹² Women protestors have been subjected to beatings, being dragged through the streets, molestation, sexual harassment, and threats of sexual assault by security forces since 2005.¹³ However, such occurrences were most acute during the 2011-

Sexual violence during the 2011 protests was so brazen that Reporters Sans Frontières (RSF) briefly called on international news organizations to stop sending female journalists to cover the political upheaval in Egypt in response to female journalists being sexually assaulted by gangs of protestors and security forces.¹⁴ In 2013, NGOs documented 120 cases of sexual assault and rape that took place during public demonstrations and protests.¹⁵

Gender, wealth, and culture protect sexual predators in Egypt. For at least four years, 21-year-old American University of Cairo student Ahmad Bassam Zaki abused, sexually assaulted, threatened, and humiliated women with impunity.¹⁶ It was not until July 2020 that Zaki was arrested after dozens of women and girls disclosed allegations of sexual assault, harassment, and blackmail.¹⁷ The accusations were posted on the Instagram account, AssaultPolice, in coordination with the National Council for Women so that victims would feel empowered to file reports after their accounts were published.¹⁸ Within days, the page had identified 93 credible accusers.¹⁹ Many women who disclosed their assaults during the Instagram campaign stated that they did not come forward previously because they feared blackmail and defamation.¹⁷ In December 2020, Zaki was sentenced to three years in prison for blackmail and harassment over social media.²⁰ In April 2021, he was given an additional eight-year sentence for attempted rape and drug possession.²¹



ACCESS TO POST-RAPE CARE

For survivors of sexual violence, “there is a noteworthy gap in comprehensive healthcare.”²² When functioning as intended, the Ministry of Justice ostensibly has forensic evaluation centers throughout the country, such as the Violence Against Women and Children Unit in the Medicolegal Department of the Ministry of Justice at Alexandria. At these centers, medical providers conduct forensic evaluations and provide medical care for victims of sexual violence.²³ The exam includes swabs for collection of evidence if the victim presents within seven days of an assault for genital swabs, and within three days of an assault for anal swabs.²⁴ However, there is an apparent lack of trust in these facilities, as the number of survivors who report to such facilities is strikingly low. One study that reviewed victim presentation at the Alexandria MedicoLegal Department found that only 60 survivors aged 12 and older were referred to the Department over a six-month period.²⁵ The low number of patients presenting at the Medicolegal Department may in part be due to primary healthcare providers’ lack of knowledge of the procedures for treating victims of sexual violence. It may also be a result of the repressive environment survivors must navigate. Many fear retaliation from their families or their attackers, and widespread police and doctor misconduct discourages survivors from reporting for fear of being subjected to more violence.²⁶ Furthermore, issues of sexual assault are considered so private that most doctors at primary healthcare units and hospitals do not have access to basic supplies for post-rape care, such as PEP; even if they do, most are unaware that standard procedures exist for the treatment of survivors of sexual assault.²⁷

In 2020, the U.N. Population Fund and Egypt’s National Council for Women partnered with universities to establish “Safe Women’s Units” to provide specialized care for violence against women. The center located at Cairo University’s Kasr Al-Ainy Teaching Hospital has treated dozens of women daily since opening in late 2020.²⁸ The unit includes doctors specializing in family medicine, mental health, forensic medicine, and obstetrics and gynecology, along with a legal-assistance team to assist the women who visit the clinic.²⁹ One survivor who received treatment at the Cairo center following physical and sexual violence at the hands of her husband stated, “I felt a great change in my psyche and an improvement in my physical health after my first visit. . . It is enough that I got rid of the fear that overwhelmed me greatly.”³⁰

Following initial treatment at the center, the team maintains contact with the survivor to assist with access to comprehensive services.³¹ Cairo University’s Safe Women’s Unit is one of four similar centers opened at Ain Shams University and Mansoura University in late 2020, while another center opened at Assuit University Hospital on March 31, 2021.³² In addition to providing direct services for women subjected to violence, the clinics work within the national referral process to direct survivors to other available medical, legal, and social services.³³ While these clinics are a beginning, they require additional training and greater awareness, as many survivors do not know of their existence, and of those that do, those outside of the cities face many difficulties in accessing the centers.³⁴



DNA INFRASTRUCTURE AND LEGAL FRAMEWORK

In July of 2014, a criminal court in Cairo handed down lengthy sentences to nine men convicted of participating in mob sexual assaults and rape; however, the rulings were seen as outliers, rather than an indication of real change in the way sexual assaults are handled in the country.³⁵ More recently, four suspects in the Cairo Fairmont Hotel gang rape case were released due to insufficient evidence despite the attack being caught on film and each of the attackers signing their names on the survivor's body.³⁶ The authorities have not, however, dropped charges for “debauchery” and “immorality” against witnesses who came forward to support the survivor's account.³⁷ Instead, they have been subjected to virginity tests, forced anal exams, drug testing, and public ridicule.³⁸

Presenting such evidence should not pose such a significant challenge to achieving justice for survivors of sexual violence in Egypt. The country is home to a forensic laboratory at the Ministry of Justice, Forensic Medicine Authority, where DNA evidence is analyzed in rape and murder cases, and the information reviewed on survivor care in Egypt mentioned collection of samples and forensic exams.³⁹ Despite the availability of this technology, use of DNA evidence in prosecutions is not yet widespread. Additionally, there is no specific law to support the DNA database that the country established in 2004.⁴⁰

Survivors also face legal hurdles in holding perpetrators accountable. Until 1999, criminal law in Egypt allowed rapists to marry their victims as a way to escape punishment.⁴¹ Since that time,

amendments to the Egyptian Criminal Code have increased protections for women by increasing penalties under existing laws and criminalizing conduct such as trafficking.⁴² However, marital rape is still not a crime in Egypt.⁴³ Lexicon also poses challenges to combating widespread misogyny, violence, and harassment in Egyptian society. Until recently, harassment (taharrush) was referred to as “mu'aksa,” or flirtation.⁴⁴ Officially, sexual harassment was not criminalized until 2014.⁴⁵

Campaigns to address impunity for sexual violence have been ongoing since 2005's “Black Wednesday” event, where four women had their clothes ripped off, were beaten, and were sexually assaulted by plain-clothed police officers during political protests calling for a boycott of a referendum on constitutional amendments proposed by former President Hosni Mubarak.⁴⁶ In 2006, ECWR launched their first campaign, “Safe Streets for All.”⁴⁷ This was followed by “Respect Yourself,” “Be a Man,” “Syndicate the Harassers,” and OPANTISH 2011, between 2007 and 2011.⁴⁸ In 2010, Harassmap established an open-source database to receive anonymous SMS reporting that it has processed into a mapping system to render sexual harassment unacceptable.⁴⁹ In 2011, the Egyptian state recognized the problem and started to introduce legislative and institutional measures to end impunity for sexual violence and sexual harassment against women, including giving victims an automatic right to anonymity.⁵⁰ The legislative initiatives are welcome additions to the work that civil society and volunteers have been shouldering for the last twenty years. However, “such a step is useless if accountability is rare.”⁵¹

CONCLUSION

Although no official statistics on sexual violence exist, the Egyptian Interior Ministry estimates that that approximately 20,000 rapes are perpetrated annually in Egypt—though women's rights organizations estimate that figure to be ten times higher; 90 percent of women in Egypt report experiencing some form of sexual harassment; and more than one in four ever-partnered women report experiencing spousal violence, including sexual violence. Despite the lack of official statistics, advocates in the country have been pushing for better access to post-rape care. The National Council for Women spearheaded an initiative to create “Safe Women’s Units” in Egypt’s four largest universities. At these units survivors can receive medical care, psychosocial support, and receive referrals to a forensic medicine department and community support programs all at no charge. Due to a lack of engagement from the Ministry of Health, NGOs must fill the void in assisting survivors access post-rape care. This leaves many suburban and rural areas beyond the reach of facilities providing post-rape care. Further, the restrictive operating hours (8 am to 2 pm) of the Safe Women’s Units means that most survivors will still present at an emergency department or primary health facility.

Reporting an attack to the police is also a monumental task. Survivors have reported police and security forces demanding virginity tests (despite them being ruled illegal in 2011); being told to forego forensic exams so as to not publicize the rape and call attention to their shame; and re-victimization upon reporting to the police. Nazra for Feminist Studies, Al Shehab Institution, Médecins Sans Frontières, Care International, Assault Police, and the Center for Egyptian Women’s Legal Assistance are all pushing to establish comprehensive post-rape care for survivors and end impunity for sexual violence. Funding for this important work is critical, as many of these organizations operate in a country where even crimes as heinous and documented as the Fairmont gang-rape case go unprosecuted.



RECOMMENDATIONS

During the course of this project, we were often limited by the lack of recent data on the prevalence of sexual violence and rates of underreporting in these countries. New studies are needed to accurately capture the existing need for post-rape care. While the comprehensive services available to survivors of sexual violence fall short of meeting the current need, health systems and non-profit service providers could increase the quality of the services provided, and the number of survivors reached, with additional funding. Additionally, DNA infrastructure varies widely among the six countries studied; it is important that funding to improve forensic capacity is aimed toward realistic goals that can have a direct impact on improving the quality of evidence in cases of sexual violence. Increased investment should be targeted at specific areas of need:

Healthcare Infrastructure

Access to Comprehensive Care

DNA Infrastructure

Healthcare Infrastructure

- Hospitals and other healthcare facilities need additional funding to maintain and renovate existing infrastructure to meet the demand for services.
- Additional investment is needed to support delivery of holistic care to survivors of gender-based violence in conflict zones.
- Public health systems, including those that provide treatment for Internally Displaced Persons, require funding to ensure they have needed resources and that costs are not passed on to survivors.

RECOMMENDATIONS

Access to Comprehensive Care

- Additional one-stop centers are needed, particularly in the DRC, Tanzania, and Egypt. Existing one-stop centers should integrate the use of sexual assault kits to collect evidence in the course of providing healthcare. Funding is needed to increase the number of centers, as well as provide kits and train medical professionals to use them at existing centers.
- Innovative programs need additional funding to expand their reach to more survivors in rural areas. Feasibility studies are needed to assess how such programs could be implemented in more locations in these countries.
- Transportation and funding are needed to ensure that treatment providers can reach survivors, that survivors can reach facilities best suited to address their needs, and that survivors and advocates can reach court facilities.

DNA Infrastructure

- Establishing a sustainable DNA laboratory in the DRC is a long-term goal. However, funding is needed for infrastructure to transport samples to existing labs in nearby countries such as Uganda or Kenya.
- Funding is also needed to expand the use of forensic techniques that can be implemented in low-resource settings.
- Countries with nascent or limited DNA infrastructure require funding to increase testing capacity and build DNA databases, along with training on best practices for properly handling and transporting samples, and maintaining chain of custody.

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A nighttime photograph of a city skyline. The sky is a deep blue with some light clouds. In the foreground, there are silhouettes of trees and a building with a traditional roof. The middle ground is filled with various buildings, some lit up. The most prominent feature is a tall, cylindrical tower on the right side, which is brightly lit from within and has a distinctive top section. The overall atmosphere is urban and vibrant.

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