Mothers with children born of sexual violence: Perceptions of global experts regarding support in social care settings

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Mothers with Children Born of Sexual Violence:

Perceptions of Global Experts Regarding Support in Social Care Settings

Abstract

Mothers with children born of sexual violence often have complex needs that are seldom adequately addressed in social care settings. The authors' objective was to investigate the current care provisions for these mothers and children, and how these might be enhanced in the future. Twenty-one experts were asked about their current approaches and difficulties in treating this population and to suggest recommendations for improving care. The same group was asked to comment on the relevance and feasibility of implementing suggested options. The authors suggest that a holistic and community embedded approach that can be applied across settings will be most beneficial.

Keywords: mother, children born of sexual violence, Delphi, expert panel, treatment

In an increasingly widespread topic such as sexual and gender-based violence, the silence surrounding children born of sexual violence is of note. Substantial research on the actual fate of and interventions for these mothers and children is extremely limited (van Ee & Kleber, 2013). The authors recognise the wealth of knowledge held anecdotally by researchers, healthcare professionals and advocates working in various settings. However, these informal observations leave a gap since they are not yet captured by rigorous scientific investigation. The Delphi method can be particularly useful to systematically gather expert knowledge and understanding of an intervention and in this case to prioritise the needs of mothers and children and matching treatment components. The results of our study mean that a collation of expertise on current practice, potential pitfalls, and future care options is in one place and can be used to address the very specific dyadic needs of mothers and children born of sexual violence and provide a basis for further investigation.

Background

Sexual violence and related crimes permeate societies worldwide (Koshin Wang & Rowley, 2007), particularly in conflict settings. In 2017, the United Nations Security Council documented cases of sexual violence in 19 countries (where data is available); 13 currently amidst conflict, six in varying stages of post-conflict life. The UN describes this type of violence as ‘a form of currency in the political economy of war’; an act of terrorism (United Nations, 2017). Frequently, women are kidnapped by armed groups; they might be held hostage as the ‘wife’ of an insurgent, and assaulted or raped many times, often by multiple assailants, often accompanied by other forms of violence (Human Rights Watch, 2002).

The repercussions of sexual violence for women are far-reaching and long-lasting. At an individual level, physical consequences can include genital injury, obstetric fistulae, sexually

transmitted diseases (including HIV/AIDS), and unwanted pregnancies (Bosmans, 2007). Psychosocial consequences at a meso-level can include stigmatisation, ostracisation, community rejection and spousal abandonment (Kohli et al., 2013; Verelst, De Schryver, Broekaert, & Derluyn, 2014). When pregnant or with child – often after unsuccessful termination attempts (Human Rights Watch 2016) – women can face further difficulties at a community-wide level. They can be feared as links to armed combatants, and accused of infidelity and acting shamefully within their culture (Albutt, Kelly, Kabanga, & VanRooyen, 2016). They can also be at risk of self-induced or enforced isolation (Scott et al., 2017).

Children conceived of sexual violence can face similar difficulties; they can become equal targets of ridicule and abuse (Carpenter, 2007) and the repercussions of this can endure a lifetime (Kuwert et al., 2014). An example of societal reactions to children conceived in this way comes from data collected in a focus group study in the Democratic Republic of Congo, by Kelly and colleagues (2017). Local men – relatives of female sexual violence survivors – shared their opinions towards children born of sexual violence (herein referred to as CBSV), and how they might choose to reject their wife or relative from the family household on the basis of this. Respondents described children born in this way as "being without a father", encapsulating the idea that the child is lacking a primary caregiver, but is also without a place in the traditional Congolese familial sense. This cultural premise may arise from the belief that children born of rape are often assumed to have the undesirable characteristics of their fathers, and women are accused of bringing into the world a replica of the rapist (van Ee & Kleber, 2013), which can lead to numerous negative consequences for the child. For instance, poor identity formation is known to afflict CBSV with some cultures later imposing the ethnic identity of the father upon the child, thus diminishing the mother's heritage and creating social barriers. As a result, children who are associated with another cultural group,

particularly a combatant one, are often cast to the lowest social level (Apio, 2008), which can mean they might miss out on obtaining social and educational services and support, but also fail to secure their place in society (Denov, 2015; Hamel, 2016)

At a mother-child dyadic level, children conceived of sexual violence face further difficulties. In a reciprocal process, mothers may become fearful with the reminder of their traumatic experience when looking at their child, but when displaying symptoms relating to posttraumatic stress disorder or depression they may become frightening themselves (Van Ee, Kleber, & Mooren, 2012). In addition, mothers may become emotionally dysregulated following their own trauma, and thus unable to provide optimal care to their children (Scott et al., 2017; Van Ee & Kleber, 2013). As a result, outcomes for mother-child dyads often include attachment difficulties; parental symptoms of PTSD are directly related to children's insecure and disorganised attachment styles (van Ee, Kleber, Jongmans, Mooren, & Out, 2016). Further, at a micro level, if women are able to access services following rape, practitioners can often attend to the most obvious concerns such as physical injury (Mukwege and Berg, 2016) . However, psychological damage can arise much later and be compounded by negative experiences in local communities, as well as displacement and migration (Laban, Komproe, Gernaat, & de Jong, 2008). It can be months or even years for women who seek asylum in new countries as a way of escaping conflict before they are able to access adequate support (Jasperse, Bala, & Hein, 2016). As such, this cycle of suffering warrants a need for attention beyond symptomatology on the individual level, in both conflict and non-conflict settings.

We used an approach based on Delphi methodology in this study. A Delphi is a process of collating knowledge in situations where the subjective information possible to obtain is

indispensable on a topic that is scientifically lacking. The Delphi method was developed by the RAND Corporation (Dalkey & Helmer, 1963), and relies on a panel of experts who answer questionnaires in multiple rounds. An anonymous summary is provided after each round, and experts are asked to comment on the discussion thus far. Delphi methodology enables the formation of a global perspective which is particularly relevant for the objective of this research.

Despite the compelling evidence on the complex dyadic needs for women and CBSV, there appears to be a lack of consensus on the most relevant, urgent or severe specifications of the problem(s) that should be addressed. Treatment elements such as individual psychotherapy, joint mother and child group programmes or promoting models of holistic care are implemented to varying degrees worldwide, but there remains a gap between knowledge, experience and expertise, and clinical practice, that could benefit from further exploration. Before (re)designing a future programme for mothers and CBSV, collating the scattered existing knowledge would contribute to understanding the successes and failures of current practice.

Method

For panel selection we began with criteria for eligibility based on previous work in the field and related publications. We looked primarily for people who had worked specifically with mothers and children born of sexual violence, and attempts were made to contact ethnically, culturally, geographically, professionally and gender diverse experts. Given the relatively small number of individuals with knowledge on such a specific topic, however, we were limited in our availability and many experts were now based in developed countries.

Nonetheless, a large number of these experts had worked in LAMICs and in conflict and post-conflict settings, thus their experience extended well beyond their current location. Invitations to participate were sent by email or in person, and then through snowball sampling we were able to contact more people based on recommendation from other experts. A second category for eligibility was expert knowledge on crimes of sexual violence; and psychosocial support or advocacy of SGBV survivors, followed by the same snowball sampling process. This enabled us to contact more people currently based outside of high income countries, possibly within conflict regions where SGBV is highly prevalent. All invitations were sent between March 2016 and January 2017.

Each expert was invited to participate in two stages of information gathering; of broadly qualitative and quantitative natures. The questions were prepared by the authors for use in this study, with the aim of the first round to open the conversation, followed by a second round to address the relevance and feasibility of suggested practices. The full questionnaire and ratings are provided in the online supplement).

Stage One – Current treatment and perceived needs

Based on knowledge of existing treatment and support, fifty experts from 15 different countries, working in the field of sexual violence were approached for participation in this study. Experts were located and contacted via email, and prompted one month later for their invitation to participate. They were asked to comment on the same questions regarding the current approaches and difficulties in treating women and their children born of sexual violence, and to recommend further experts. Upon receipt of responses, additional recommended experts were contacted for participation, and analysis was conducted once the survey closed.

Stage Two – Future implementation of treatment components

All experts who replied to stage one were prepared a summary of responses by email. A Likert scale response format was given for experts to rate their agreement with the description of needs, and to provide their judgement in terms of frequency and feasibility of implementation. This scale was from 1-5, one being least amount of agreement, lowest frequency or least feasible treatment option; five being the highest. Experts were prompted for response after six weeks, and again if necessary.

Coding and analyses

Data analyses at Stage One involved a thematic analysis of responses for each question. Transcripts were first reviewed separately and then coded based on emerging patterns. Key themes were collaboratively defined, and allowed for the identification of overarching narratives. Coding was conducted in NVivo v11.4. At stage Two, descriptive analyses were conducted in SPSS v24.

Results

Stage One – Current treatment and perceived needs

Stage 1 of this study achieved a response rate of 46% (*n*=23), consisting of nine researchers, 12 therapists (six of whom combined research with practice), and two advocates/advisors, from six different countries in Europe and North America (Bosnia, Belgium, Germany, Netherlands, Norway and USA). The panel featured 21 women and two men. Respondents were from various professional backgrounds including: social work, psychology, psychiatry, obstetrics and gynaecology, public health, emergency medicine, psychosomatics and

international relations. Four additional respondents declared that they did not feel capable or did not wish to take part in the survey.

Question 1: What specific difficulties do mothers raising a child born of sexual violence face?

Mother-child attachment

Mother-child attachment difficulties were explicitly addressed by seventy-percent of respondents, given that the child can be a reminder of the rape or bear a resemblance to the rapist father, and the concern of having a child that was not planned or even wanted. Several respondents mentioned that mothers currently raising a child conceived of sexual violence demonstrate extreme ambivalence; displaying conflicting emotions and oscillating affect states. This can be particularly evident with changing developmental stages, as one expert noted: "*In the developmental stage from nine months to two years, the ambivalence of this stage of the child can interfere with the underlying ambivalence of the mother for the child"*. Poor attachment was reported as reciprocal, most detrimentally affecting younger children and influencing the emotional availability of the mother. Forty-percent of respondents went on to clarify some of the many outcomes for children conceived through sexual violence, including neglect, rejection and abuse. Moreover, there can be much pressure on women who have children conceived of rape, to be a 'good mother', despite the origins of the child: *"In this form of violence, the attention shifts from being a victim and getting recognition for the horrible event, to the expectation of the people around her to be in love with her new-born child and to take care of him 'as he is not to blame for this'"*. Coupled with reduced social support and community discrimination, this can be overwhelming, as one expert states, se

Mental well-being

Mothers with children conceived of sexual violence were also described to have myriad personal difficulties. Psychopathology was noted as extremely common; whereby 61% of the panel emphasised traumatic stress reactions and depression (predominantly in the post-partum phase). However, in addition to these, mothers were described by 60% of expert respondents to suffer emotional reactions such as: anger, sadness, guilt, helplessness, shame, self-blame, feeling overwhelmed and overburdened, and regret. An accumulation of a negative affect and psychopathology was highlighted by four experts as resulting in problems with identity (e.g. social, ethnic, biological) that prevent recovery for mothers, as well as for the child itself.

Societal reactions

As a result of some social connotations associated with the act of rape, or of having a child outside of a 'normal' marriage, stigmatisation and discrimination (towards mother and/or child) were highlighted by 56% of experts as a major concern for this population. As well as being a catalyst for isolation and rejection, the stigmatisation sanctioned by communities may result in attachment difficulties between mother and child. Discrimination by the community was suggested to have the potential to lead to further difficult family dynamics and even possible abandonment.

Question 2: Which specific interventions do you currently apply, or recommend to treat this population?

Mother-child interactions

All members of the expert panel working in clinical practice (*n*=12) endorsed mother-child interactions as their primary focus of treatment. This included monitoring mothers currently in treatment for abuse/neglect, as well as attachment oriented work. Respondents expressed that this is important for mothers to understand how to respond to signals of the child, and to determine their own and their child's needs. Individual psychotherapy was recommended by approximately half of practitioners (48%) as a key proponent to current treatment interventions. However, six members also suggested that group work, incorporating family members, spouses and other women in similar situations would likely enhance the success of positive future interactions.

Combined psychotherapy & skills training

Importantly, both dyadic attachment work and individual psychotherapeutic support for the mother were not recommended in isolation. The majority of clinical experts (11/12) recommended to combine this with skills-based tasks to enhance the overall outcome for mothers and children; specifically parenting skills, life skills, formal education and fostering resilience. These were all observed as integral parts of building self-esteem for mothers, promoting social support and strengthening their ability to cope. In addition to their clinical roles, 75% of therapists also described their contributions to improving economic stability, access to healthcare services and family planning, and changing policy surrounding sexual violence. This was deemed especially necessary in the context of community, to address issues of stigmatisation, to reduce the isolation of mothers and their children born of sexual violence, to prevent further discord between families and to encourage empathetic support. Although, these were addressed less frequently and do not appear to currently constitute the 'core business' of treatment. Nor were details provided on what these actions constitute.

Question 3: What are the problems with current treatments for these mother-child dyads?

Untailored treatments

In several instances, current treatments were described to be unsuitable for mothers with CBSV because they were untailored and, for example, did not account for joint working, consider wider family members, or were culturally inappropriate. Further, current options were noted to focus only on weaknesses of the mother, *"A sole focus on parents (mostly mothers in this context) reinforces the idea that they are the sole persons responsible for the upbringing of their children, while there are many more actors"* or that treatments created isolation. It is also suggested that current treatments do not directly question the conception of the child, or address the profound struggle that accompanies feelings of having a child born of sexual violence, instead taking the time to build a supportive atmosphere by which this may be disclosed wilfully.

Lack of resources

Secondly, the lack of sufficient resources was noted by 40% of respondents across various disciplines. Limited financial support to conduct research, to establish a robust evidence base, or provide extensive treatment are often prohibitive to recovery of mothers and their children – in many instances, mother and child facilities are not even placed at the same location. Consequently, there are thought to be too few specialists working in the field, treatment is starting too late and there is little upwards engagement of local administrative leadership, which can be preventative to policy or legislative change on a wider sphere.

Question 4: What recommendations can you make for developing a new intervention to treat mothers and their children born of sexual violence?

Early screening & awareness raising

Early detection of pregnancy via sexual violence was stressed by some as key to working with these mothers. Screening mothers during pregnancy was highlighted by 22% of respondents as being critical to future recovery and preventing deteriorating relationships later on, *"Doctors need to screen [in order to] de-stigmatise the issue; so that women can have abortion options (if they want to) and can be monitored for post-partum depression as well as child abuse."* A strong majority (70%) of respondents recommended future treatment to feature wider family members as well as key persons in local communities. In doing so, the likelihood of raising awareness of the issue of sexual violence and receiving support from wider society is hoped to increase.

Holistic support

The content and structure of any new or modified intervention will be fundamentally holistic, as per expert recommendations. These included: a mix of verbal and non-verbal interactions that are bio-psychosocial in nature, psychological therapies, psychoeducation and formal schooling. Treatment should seek to address: attachment, empowerment, economic opportunity, isolation, spiritual beliefs, emotional availability, child development and positive mother-child interactions. Two experts suggested that there should be no explicit need to address the origins of the child, but instead foster a safe environment for women to discuss the most pertinent issues at any one time, which may ultimately lead to disclosure of the origin of their child or other traumas. Stigma was a topic discussed throughout the study, and was a particularly important consideration for improving outcomes for these mothers and

children, "*Interventions that shift the stigma away from women and from the children, and rather to the perpetrator of violence in a way that social attitudes would reinforce the need for perpetrators of violence to be held accountable for their actions"*.

Mixed treatment structure

Despite the highly diverse panel, recommendations for how to implement treatment in the future was largely agreed upon: a combination of group and individual treatments for mother-child dyads, that are based within community settings. Experts stressed the continued need for care to be within a framework of user-centred approaches, multidisciplinary team assessments, and recommendations suggest the interventions should be evidence-based and culturally sensitive.

Stage Two – Future implementation of treatment components

Nineteen experts (82%) responded to Stage 2 of this study. Two panel members felt the questions extended beyond their current expertise, and two failed to respond. This round sought to obtain consensus on opinions and suggestions from Stage One.

Stage Two began by outlining the difficulties faced by mothers with children born of sexual violence, as defined in Stage One. Experts were primarily asked to rank: 1) the self (including a change in mental states, psychopathology, physical and sexual health concerns); 2) relationships (including with their child, their family, their spouse or the local community); and 3) society (including access to healthcare, experiences of poverty, financial restrictions) from *least* to *most* difficult. The panel was then asked to rate the same aspects according to the frequency with which they are problematic for mothers and children born of sexual violence (Likert scale 1-5: *never* to *often*). Results show that 53% (*n*=10) of the expert panel

rated difficulties with relationships as the most problematic for this population, with 79% (*n*=15) describing these problems as occurring '*often'*.

The next question asked clinical panel members (*n*=12) about the treatments currently offered to mothers and CBSV, and the frequency with which these are implemented (Likert scale 1-5: *never* to *often*). Results showed that at present, fostering positive mother-child interactions is the most frequently addressed component, with 11/12 (91%) panel members working on this '*occasionally'* or '*often'*. Next, experts endorsed the use of individual psychotherapy, but fewer rated this as taking place as regularly; 7/12 rating '*occasionally'* or '*often'*. Table 1 outlines in more detail the current treatment methods implemented by the panel, and the average ratings given by panellists.

<Insert table 1. here>

The next questions presented the panel with the most common problems within treatment, as outlined in Stage One. It asked members to first indicate their agreement with the described difficulties in treatment, then rate the frequency with which they find them to be problematic (Likert scales 1-5: *strongly disagree* to *strongly agree* and *never* to *often*). Results showed a lack of financial resources as the most commonly rated problem with current treatment; endorsed by 8/19 panel members. This was confirmed subsequently as '*often'* problematic for 47% of panellists. Some experts also felt that there was a limited evidence base for treating mothers and CBSV, and that treatments were starting too late. For both, 8/19 panellists (42%) indicated that they '*strongly agree*' with these as being problematic, and 7/19 panellists (37%) rated these as '*often'* problematic. Following this, 7/19 members of the panel (37%)

strongly agreed that treatments being unavailable in conflict areas was a problematic area of current practice, and the same number again indicated that this was '*often'* a problem.

<Insert table 2. here>

The next set of questions turned to how future interventions might be developed and structured, based on the suggestions made in Stage One. For each item in the list, panellists were asked to first rate the relevancy of the treatment elements, and second the perceived feasibility of implementation (Likert scales 1-5: *highly irrelevant* to *highly relevant* and *highly unfeasible* to *highly feasible*).

As can be seen from table 3, enhanced training of practitioners was endorsed by 79% of panellists as being the most '*highly relevant*' component within the treatment of mothers and CBSV. However, fewer panellists (58%) were as optimistic about the feasibility of achieving this. Similarly, 13/19 panel members (68%) felt that more research and development would be '*highly relevant'* to treatment, yet, fewer (8/19) considered this as '*highly feasible'*. Interestingly, 63% of the panel (12/19) endorsed the inclusion of wider community members within treatment for this population, but only 26% (5/19) rated this as '*highly feasible'*. In fact, most people were '*unsure'* about the feasibility of implementing this component within treatment.

<Insert table 3. here>

The next three questions dealt with the content of a new or modified intervention, again addressing the relevance, feasibility and this time, the frequency of implementation, as can be seen in table 4. The response trend was similar across treatment components; namely, that

items rated as '*highly relevant*' to treatment, were not regularly deemed '*highly feasible*' to implement.

For almost all the expert panel (94%), fostering positive mother-child interactions was the most relevant treatment component. This was also deemed most feasible (58%), and that this was recommended to be addressed on a weekly basis. Following this, was the importance placed on anti-stigma work. Eighty-four percent of panellists (16/19) identified this component as being '*highly relevant*', and suggested addressing it on a monthly basis. Yet, only 32% of experts suggested this would be '*highly feasible*' to implement. Similarly, economic opportunity was endorsed by 15/19 panellists (79%) as being highly relevant to treatment, which dropped to only 21% rating it as '*highly feasible*'. Indeed, most experts were unsure about the frequency with which to address economic prosperity within care settings. Fostering positive child development was also rated as highly relevant to recovery, according to 15/19 panellists, with 9/19 also rating it is something that is '*highly feasible*' to implement. The panel rated this component as something to be addressed weekly.

<Insert table 4. here>

The final question explored the perceived relevance and frequency of methods of delivery. Above all, group work with mothers and children together was deemed the most relevant, according to 89% of the panel, with a frequency of once per week. Interestingly, 7/19 panellists indicated at least four out of the five suggested methods to be equally '*highly relevant'*; with a recommended monthly implementation.

Discussion

Within the framework of Delphi methodology, we attempted to identify the current care options for women who have children conceived through sexual violence, and how to address

the physical, psychological and social repercussions that are known to follow. Using the expertise of select subject-matter experts with experience in conflict and non-conflict settings, results from two rounds of information gathering identified the scattered knowledge regarding difficulties with existing treatment and possible modifications for an improved practice. Overall, experts rated difficulties with relationships as the overriding concern for this population; including with family, a husband or spouse, with children or with the wider community. This finding reflects current literature for these mother-child dyads (Dossa, Hatem, Zunzunegui, & Fraser, 2014), including feelings of isolation and fewer possibilities for integration (Scott et al., 2017). Panellists described how current treatment most often involves promoting mother-child interactions, but a lack of financial resources, a limited evidence base, and treatments starting too late were commonly identified barriers to achieving positive outcomes.

When asked to modify current treatment options, or indeed redesign them altogether, expert panellists suggested the most relevant and feasible component of treatment for mothers and CBSV would be to continue fostering mother-child interactions. This notion supports findings from Van Ee, Kleber, & Mooren (2012) who suggest that maternal stress reactions are associated with insensitive parenting. Improving this would likely lead to a more positive relationship. Group work with mothers and children together was deemed the most relevant treatment structure, but not to discount the benefits of more intense individual work. This combination of approaches has been documented within similarly vulnerable mother-child populations who experience violence within the family (Anderson & van Ee, 2018). The authors suggest that the theory of change comprises a combination of individualistic treatment mechanisms (a response to violence by managing one's own behaviour) and collaborative treatment mechanisms (where mothers and children work together within the

same session, and are encouraged to address both needs simultaneously) would likely bring about the most substantive change for mother-child dyads discussed here.

Despite a large proportion of high income countries represented in this study, several experts currently work in conflict settings or low and middle income countries (LAMIC) – or have done in the past - and report the unavailability of adequate support in these areas as similarly problematic. The impact of sexual violence appears to have many commonalities across both conflict and more stable settings. Thus, the repercussions so often felt by women and children are likely to be full interactional processes with the context or environment a mother and child find themselves. Moreover, women with CBSV from conflict regions may eventually become part of migrant populations in developed counties, and thus, their burden might be compounded by the experience of migration. Support for these women, regardless of location, may be rather to strengthen the capacity to deal with problems, needs and demands, thus increasing wellbeing, self-esteem and a sense of identity, and promoting a 'social recovery'.

From a clinical perspective, as per global healthcare systems, individual countries commit themselves to a specification for basic care, and strategies from the World Health Organisation (WHO) allow states to upscale their provisions accordingly. While LAMICs typically have poorer provisions for physical health care for female survivors with CBSV, as per the results of this study both developed and LAMICs experience meso-/micro-level problems with the acceptance and integration of these women into society. Such findings reflect the results of Laban et al. (2008), who reported within a similarly vulnerable population of Iraqi asylum seekers in the Netherlands, that family-related issues was a greater risk factor for impaired functioning and a lower quality of life, independent of any psychiatric

disorder. We found in this study that a lack of diagnoses was not endorsed by the expert panel as being particularly problematic, which likely reflects the degree to which this is only a small part of the problem, and that their difficulties sit within a wider social context. Further, although the need to increase availability of termination options was touched upon, little consensus was gathered to feature these centrally in future treatment practices. Nevertheless, a failure to address this altogether could lead to dangerous attempts at abortions by unqualified individuals (Human Rights Watch, 2016).

Enhanced training of practitioners and more research and development is highly recommended to reinforce any psychosocial support provided. In turn, this would lead to more numerous practitioners able to deliver specialist care, across the globe, and thus potentially address the lack of support in conflict zones. However, far fewer panellists were as optimistic about the feasibility of this being achieved, with some acknowledging a lack of financial resources available to them. Similarly, including wider community members within treatment and improving economic opportunities for clients, as well as using this as a platform for anti-stigma work were deemed highly relevant treatment components. This understanding is corroborated within existing literature, that women with CBSV face rejection and abandonment from their family and community, including access to their livelihoods, and social network (Rouhani et al. 2015; Albutt et al. 2016; Verelst et al. 2014, Kelly et al. 2017). However, experts in this study were less optimistic about the feasibility of implementation.

Results confirm the need for community-based work to achieve positive outcomes with regard to better health, anti-stigmatisation and integration and an interdisciplinary collaboration between community workers and psychosocial workers. Similar evidence

supporting the value of community comes from Wind & Komproe (2012). Results from 232 participants showed that in instances of highly traumatising events, community-based support can facilitate the capacity to deal with the demands at the individual level. Communities with high social capital appeared to rely on the social context to address the demands of recovering from a traumatic event, and not individual coping strategies. If communal resources are absent, the loss of social fabrics can alter the effectiveness of resources on the individual level, to deal adequately with the event. As results of their study showed, individuals in communities with high social capital suffered less from posttraumatic stress. Such findings are particularly relevant to the population described in this study.

Limitations

Applying Delphi methodology in this study resulted in a relatively small sample size and a narrow global representation of experts. Therefore, the applicability of data presented here and its generalisability would wisely be applied with caution, and act as a basis for future evidence gathering. Despite our best efforts to adopt a large, multi-cultural, highly diverse expert panel, it was ultimately determined by those who responded. Thus, only six countries have been represented – many neighbouring in Europe – and may essentially differ very little in their approaches to practice and treatment. While the recommendations outlined here are beneficial for mothers and children born of sexual violence, current care organisation may dictate the ability to integrate different approaches. Nonetheless, given the detailed knowledge of such a specific sample of experts and the paucity of local experts in countries where women are becoming pregnant due to war-related acts, the valuable data gathered in this study has been triangulated with other research in the field, to ensure its relevance and validity. Notwithstanding the small sample size, all research drawing attention to the needs of

mothers and children affected by sexual violence by engaging multiple stakeholders, is essential for long term change (United Nations, 2017).

Conclusion

Using the framework of Delphi methodology, we have been able to collate the scattered but valuable knowledge of care options for mothers and their children born of sexual violence across multiple settings. A multileveled, stepped-care model is suggested, in conjunction with a reliable screening procedure to inform what and when specific elements of the care modalities should be provided to whom. It is likely that all the tools needed to successfully support these women and children already exist; it is a matter of organising skills and knowledge, sharing them and training others, and obtaining funding that substantiates the continuation of research. In the words of one expert:

"I don't think there should be any 'overall' new interventions; I think interventions need to be addressed and adapted to the specific needs of the child, the mother and the family. In any intervention, one should acknowledge that war has an impact on the relational field or social network, and that problems often need to be seen in relation to this (and not for example only addressed at the individual e.g. trauma therapy only for the mother)".

Abbreviations

CBSV	child(ren) born of sexual violence
UN	United Nations
WHO	World Health Organisation
LAMIC	Low and middle income country
PTSD	posttraumatic stress disorder
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome

References

Albutt, K., Kelly, J., Kabanga, J., & VanRooyen, M. (2016). Stigmatisation and rejection of survivors of sexual violence in eastern Democratic Republic of the Congo. *Disasters*, *41*(2), 211–227.

Anderson, K., & van Ee, E. (2018). Mothers and Children Exposed to Intimate Partner Violence: A Review of Treatment Interventions. *International Journal of Environmental Research and Public Health*, 15(9), 1955.

Apio, E. (2008). Bearing the burden of blame – the children of the Lord's Resistance Army, Northern Uganda. *Coalition to Stop the Use of Child Soldiers.* Available at: https://www.child-soldiers.org/shop/forgotten-children-the-outcome-of-children-born-of-the-lords-resistance-army-norther-uganda-1.[Date accessed: 05-01-2018].

Bosmans, M. (2007). Challenges in Aid to Rape Victims: the Case of the Democratic Republic of the Congo. *Essex Human Rights Review*, *4*(1), 1–12.

Carpenter, C. (2007). *War's impact on children born of rape and sexual exploitation: Physical, economic and psychosocial dimensions*. *Coaltion to Stop the Use of Child Soldiers*. University of Pittsburgh.

Dalkey, N., & Helmer, O. (1963). *An experimental application of the Delphi method to the use of experts*. Santa Monica, California.

Denov, M. (2015). Children born of wartime rape: The intergenerational realities of sexual violence and abuse. *Ethics, Medicine and Public Health*, *1*(1), 61–68.

Dossa, N. I., Hatem, M., Zunzunegui, M. V., & Fraser, W. (2014). Social consequences of conflict-related rape: The case of survivors in the Eastern Democratic Republic of Congo. *Peace and Conflict: Journal of Peace Psychology*, *20*(3), 241–255.

Hamel, M. E. (2016). Ethnic belonging of the children born out of rape in postconflict Bosnia-Herzegovina and Rwanda. *Nations and Nationalism*, *22*(2), 287–304.

Human Rights Watch. (2016). *" I Just Sit and Wait to Die " Reparations for Survivors of Kenya's 2007-2008 Post Election Sexual Violence*. Human Rights Watch: United States.

Jasperse, A., Bala, J., & Hein, I. (2016). Kinderen geborn uit seksueel geweld; problematiek en behandeling. "Als ik naar mijn baby kijk, schaam ik me." In *Kinder- & Jeugdpsychptherapie* (pp. 68–83).

Kelly, J., Albutt, K., Kabanga, J., Anderson, K., & VanRooyen, M. (2017). Rejection, acceptance and the spectrum between: Understanding male attitudes and experiences towards conflict-related sexual violence in eastern Democratic Republic of Congo. *BMC Women's Health*, *17*(1), 1–11.

Kohli, A., Ramazani, P., Safari, O., Bachunguye, R., Zahiga, I., Iragi, A., & Glass, N. (2013). Family and Community Rejection and a Congolese Led Mediation Intervention to Reintegrate Rejected Survivors of Sexual Violence in Eastern Democratic Republic of Congo. *Health Care for Women International*, *34*(9), 736–756.

Kuwert, P., Glaesmer, H., Eichhorn, S., Grundke, E., Pietrzak, R. H., Freyberger, H. J., & Klauer, T. (2014). Long-term effects of conflict-related sexual violence compared with non-sexual war trauma in female World War II survivors: a matched pairs study.

Archives of Sexual Behavior, *43*(6), 1059–1064.

Laban, C. J., Komproe, I. H., Gernaat, H. B. P. E., & de Jong, J. T. V. M. (2008). The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, *43*(7), 507–515.

Mukwege, D., & Berg, M. (2016). A Holistic, Person-Centred Care Model for Victims of Sexual Violence in Democratic Republic of Congo: The Panzi Hospital One-Stop Centre Model of Care. *PLoS Medicine*, *13*(10), 1–9.

Rouhani, S. A., Scott, J., Greiner, A., Albutt, K., Hacker, M. R., Kuwert, P., … Bartels, S. (2015). Stigma and Parenting Children Conceived From Sexual Violence. *Pediatrics*, *136*(5), e1195–e1203.

Scott, J., Mullen, C., Rouhani, S., Kuwert, P., Greiner, A., Albutt, K., … Bartels, S. (2017). A qualitative analysis of psychosocial outcomes among women with sexual violence-related pregnancies in eastern Democratic Republic of Congo. *International Journal of Mental Health Systems*, *11*(1), 1–10.

United Nations. (2017). *Report of the Secretary-General on conflict-related sexual violence*. *United Nations* (Vol. 1373).

Van Ee, E., & Kleber, R. J. (2013). Growing up under a shadow. *Child Abuse Review*, *22*, 386–397.

van Ee, E., Kleber, R. J., Jongmans, M. J., Mooren, T. T. M., & Out, D. (2016). Parental PTSD, adverse parenting and child attachment in a refugee sample. *Attachment & Human Development*, *18*(3), 273–291.

Van Ee, E., Kleber, R. J., & Mooren, T. (2012). War Trauma Lingers On: associations between maternal posttraumatic stress disorder, parent-child interaction and child development. *Infant Mental Health Journal*, *33*(5), 459–468.

Verelst, A., De Schryver, M., Broekaert, E., & Derluyn, I. (2014). Mental health of victims of sexual violence in eastern Congo: associations with daily stressors, stigma, and labeling. *BMC Women's Health*, *14*(1), 106.

Wind, T. R., & Komproe, I. H. (2012). The mechanisms that associate community social capital with post-disaster mental health: A multilevel model. *Social Science and Medicine*, *75*(9), 1715–1720.